AGENDA

A MEETING OF THE NHS FIFE CLINICAL GOVERNANCE COMMITTEE WILL BE HELD ON FRIDAY 2 MAY 2025 FROM 10AM TO 1PM VIA MS TEAMS

Note: There will be a pre meeting of Non-Executive Members only at 9.15am

Anne Haston
Chair

				Purpose	
10:00	**1.**	Apologies for Absence ***(AH)***			
	2.	Declaration of Members' Interests ***(AH)***			
	3.	Minutes of Previous Meeting held on Friday 7 March 2025 ***(AH)***		***(approval)***	(enc)
	4.	Chair's Assurance Report presented to Fife NHS Board on 25 March 2025 ***(AH)***		***(for information)***	(enc)
	5.	Matters Arising / Action List ***(AH)***		***(assurance)***	(enc)
		5.1	Orthopaedic Hip Fracture Audit Update & Action Plan ***(CM)***	***(discussion)***	(enc)
10:25	**6.**	**ACTIVE OR EMERGING ISSUES**			
		6.1	Victoria Hospital Water Supply Issue ***(CM)***	***(assurance)***	(enc)
		6.2	Safe Delivery of Care Health Improvement Scotland Inspection Action Plan ***(JK)***	***(assurance)***	(enc)
10:45	**7.**	**GOVERNANCE MATTERS**			
		7.1	Annual Assurance Statements & Reports from Clinical Governance Subcommittees & Groups ***(GM)***	***(assurance)***	(enc)
		7.2	Draft Clinical Governance Committee Annual Statement of Assurance 2024/25 ***(GM)***	***(assurance)***	(enc)
		7.3	Area Clinical Forum Annual Statement of Assurance ***(NR)***	***(assurance)***	(enc)
		7.4	Clinical Governance Oversight Group Assurance Summary from 8 April 2025 Meeting ***(GC)***	***(assurance)***	(enc)
		7.5	Mental Health Oversight Group Assurance Summary from 10 April 2025 Meeting ***(CM)***	***(assurance)***	(enc)
		7.6	Corporate Risks Aligned to the Clinical Governance Committee ***(CM/SAS)***	***(assurance)***	(enc)
		7.7	Review of Annual Workplan 2025/26 ***(GC)***	***(assurance)***	(enc)
11:30	**8.**	**STRATEGY / PLANNING**			
		8.1	Annual Delivery Plan Quarter 4 Report 2024/25 ***(BH)***	***(assurance)***	(enc)
		8.2	Realistic Medicine/Value Based Health and Care Delivery Plan ***(SAS)***	***(assurance)***	(enc)
		8.3	Clinical Services Redesign Programme ***(BH/CD)***	***(assurance)***	(presentation)

	8.4	North East Minor Injuries Unit Reconfiguration ***(LG)***	***(assurance)***	(enc)
12:00	**9.**	**QUALITY / PERFORMANCE**		
	9.1	Integrated Performance & Quality Report ***(CM/JK)***	***(assurance)***	(enc)
	9.2	Healthcare Associated Infection Report ***(JK)***	***(assurance)***	(enc)
	9.3	Public Protection, Accountability & Assurance Framework ***(JK)***	***(discussion)***	(enc)
12:30	**10.**	**PERSON CENTRED CARE / PARTICIPATION / ENGAGEMENT**		
	10.1	Patient Story ***(JK)***	***(assurance)***	(presentation)
	10.2	Patient Experience & Feedback Report ***(JK)***	***(assurance)***	(enc)
12:50	**11.**	**LINKED COMMITTEE MINUTES**		
	11.1	Area Clinical Forum held on 3 April 2025 (unconfirmed)		(enc)
	11.2	Cancer Governance & Strategy Group held on 19 February 2025 (confirmed)		(enc)
	11.3	Clinical Governance Oversight Group held on 8 April 2025 (unconfirmed)		(enc)
	11.4	Fife IJB Quality & Communities Committee held on 4 September 2024 (confirmed), 8 November 2024 (confirmed) and 10 January 2025 (unconfirmed)		(enc)
	11.5	Health & Safety Subcommittee held on 7 March 2025 (unconfirmed)		(enc)
	11.6	Infection Control Committee held on 1 October 2024 (unconfirmed)		(enc)
	11.7	Medical Devices Group held on 12 March 2025 (unconfirmed)		(enc)
	11.8	Medical & Dental Professional Standards Oversight Group held on 21 January 2025 (confirmed) & 15 April 2025 (unconfirmed)		(enc)
	11.9	Resilience Forum held on 20 March 2025 (unconfirmed)		(enc)
	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)

13. MEETING REFLECTIONS & AGREEMENT OF MATTERS FOR CHAIR'S ASSURANCE REPORT TO BE PRESENTED TO FIFE NHS BOARD ON 27 MAY 2025

14. ANY OTHER BUSINESS

Date of Next Meeting: **Friday 11 July 2025 from 10am – 1pm** via MS Teams

No Private Session

Fife NHS Board

Unconfirmed

MINUTE OF THE NHS FIFE CLINICAL GOVERNANCE COMMITTEE MEETING HELD ON FRIDAY 7 MARCH 2025 AT 10AM VIA MS TEAMS

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

In Attendance:
Bryan Archibald, Planning & Performance Manager *(items 8.1 & 9.1 only)*
Lisa Cooper, Head of Primary & Preventative Care *(deputising)*
Claire Dobson, Director of Acute Services
Fiona Forrest, Acting Director of Pharmacy & Medicines
Alistair Graham, Director of Digital & Information
Dr Gillian MacIntosh, Head of Corporate Governance & Board Secretary
Hazel Thomson, Board Committee Support Officer (Minutes)

Chair's Opening Remarks

The Chair welcomed everyone to the meeting.

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

1. Apologies for Absence

Apologies were received from routine attendees Lynn Barker (Director of Nursing, Health & Social Care Partnership), Norma Beveridge (Director of Nursing, Acute), Gemma Couser (Associate Director of Quality & Clinical Governance), Susan Fraser (Associate Director of Planning & Performance), Lynne Garvey (Director of Health & Social Care), Ben Hannan (Director of Planning & Transformation), Helen Hellewell (Deputy Medical Director, Health & Social Care Partnership), Dr Iain MacLeod (Deputy Medical Director, Acute Services Division), Margo McGurk (Director of Finance & Strategy), Neil McCormick (Director of Property & Asset Management) and Dr Shirley-Anne Savage (Associate Director for Risk & Professional Standards).

2. Declaration of Members' Interests

There were no declarations of interest made by members.

3. Minutes of Previous Meeting – Friday 17 January 2025

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

4. Chair's Assurance Report Presented to Fife NHS Board on 30 January 2025

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

5. Matters Arising / Action List

The Committee noted the closed item on the Action List.

It was noted that the Safe Delivery of Care Report has been published and will be presented to Committee at the May meeting.

5.1 Orthopaedic Hip Fracture Audit Update & Action Plan

The Medical Director provided a verbal update and reported that a comprehensive review has been undertaken by the Senior Clinical and Managerial Team in Orthopaedics and Acute Services in relation to theatre capacity. A paper has been prepared and will be discussed at the Executive Directors' Group before being presented to the Committee at the May 2025 meeting, along with the action plan.

The Committee **noted** the update.

5.2 Clinical Outcomes of Closed Loop System Insulin Therapy

The Medical Director advised that the report presented describes the clinical outcomes of the closed loop system insulin therapy and the reasons to continue to invest in the technology for patients, of which an overview was provided. It was advised that the introduction of this technology for people with diabetes in the short / medium term, will provide a significant reduction on consequences associated with the condition. An overview was also provided on the funding elements.

Following questions, it was advised that NHS Fife has the highest rate of implementation of this form of treatment, which is testament to the commitment and dedication of the team. It was noted that, meantime, there are only a small number of patients on the waiting list who are receiving standard treatment for diabetes and follow up. It was also advised that there is an element of choice for patients, however, there will be some patients who will not meet the strict criteria.

Discussion took place on early intervention outcomes, with it being noted that some aspects of using the technology are having an immediate positive impact. The impact, particularly for children trying to manage glucose levels, was also highlighted.

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

6. ACTIVE OR EMERGING ISSUES

There were no active or emerging issues to be raised.

7. GOVERNANCE MATTERS

7.1 Clinical Governance Committee Self-Assessment Report 2024/25

The Board Secretary advised that a self-assessment is carried out for all the Board's Standing Governance Committees on an annual basis. This paper provides the feedback for the recent survey undertaken for Clinical Governance Committee.

An overview on the themes of the self-assessment was provided, and it was noted that there were some common themes identified across all the Board's Standing Governance Committee self-assessment outcomes. The length of papers and ensuring that members feel confident to raise points during Committee meetings were highlighted. The Chair emphasised the importance of supporting members on the Committee and took the opportunity to encourage members to approach the Chair, should they have any issues that they would wish to discuss on a one-to-one basis. Work in the next year will attempt to address members' comments as part of a continuous improvement exercise, and a meeting has been arranged in the coming weeks with the Chair and Committee Chairs to start discussions on Board-wide enhancements.

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

7.2 Annual Review of Clinical Governance Committee Terms of Reference

The Board Secretary advised that a review of the Terms of Reference is carried out for all the Board's Standing Governance Committees on an annual basis, and any updates are taken forward through the Audit & Risk Committee, followed by the Board, and are reflected in the annual publication of the Code of Corporate Governance.

It was advised that, following an internal audit recommendation to review the respective Terms of Reference in relation to possible duplication between the Clinical Governance Oversight Group and the Clinical Governance Committee, the only duplication identified were items that had been escalated from the Group to the Committee.

An overview was provided on the updates, which were tracked as changes within the document. The addition to section 5.1, around receiving external reports from the Mental Health Welfare Commission, was highlighted.

The Board Secretary clarified that Best Value is covered explicitly in the Committee's year-end statement, with a section demonstrating how this has been achieved as part of the Committee's yearly workplan.

The Committee **endorsed** a final version for further consideration by the Board.

7.3 Clinical Governance Oversight Group Assurance Summary from 11 February 2025 Meeting

The Medical Director highlighted the key points from the Clinical Governance Oversight Group meeting held on 11 February 2025, as detailed within the assurance summary.

An explanation was provided on the reporting structure to the Clinical Governance Oversight Group, noting that a diagram explaining this is contained within the Clinical Governance Strategic Framework.

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

7.4 Mental Health Oversight Group Assurance Summary from 7 February 2025 Meeting

The Medical Director highlighted the key points from the Mental Health Oversight Group meeting held on 7 February 2025, as detailed within the assurance summary.

The Committee noted the risk of ligatures, and an explanation was provided that this related to use of Velcro on equipment and was being addressed.

Following a question relating to the Mental Health Welfare Commission unannounced visit and mental health legislation, an explanation was provided that this relates to patients with delayed discharge due to guardianship.

It was confirmed that there are plans in place to ensure that there is joint governance and oversight, in partnership with the Health & Social Care Partnership, for the new Mental Health Strategy.

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

7.5 Corporate Risks Aligned to Clinical Governance Committee, including updates on Whole System Capacity and Hospital Acquired Harm

The Medical Director provided a brief overview on the updates to the Whole System Capacity risk, Quality & Safety risk and Cyber Resilience risk, as detailed within the report. Following a question in relation to the Whole System Capacity risk being above the Board's risk appetite, it was explained that once the planned work for 2025/26 has taken effect, the risk level would then be reviewed. It was also confirmed that the Hospital Acquired Harm risk is specifically related to hospitals, and assurance was provided that the community aspect is considered within the Health & Social Care Partnership.

In terms of the new risk for Hospital Acquired Harm, it was advised that the wording of the new risk was agreed at the Committee meeting in January 2025 and a brief overview was provided on this risk, as detailed within appendix 3. It was reported that work is ongoing to mitigate each element of the risk through an action plan. It was questioned how the effectiveness of the Organisational Learning Group is measured, in terms of assessing the outcome impact of the Hospital Acquired Harm risk mitigations, and the Medical Director agreed to take this forward as an action and discuss with the Associate Director of Quality & Clinical Governance.

Action: Medical Director

Concern was raised in relation to the Information Governance and Cyber Security risk requiring clearer mitigation within the corporate risk register, and the incoming and outgoing Chair will meet with the Director of Digital to discuss further.

Action: Director of Digital & Information

The Committee:

- **noted** details of the corporate risks aligned to this committee as at 20 February 2025;
- **noted** the risk appetite status of the risks against the new risk appetite;
- **noted** and comment on the draft deep dive for the suggested new risk Hospital Acquired Harm; and
- **considered** and were assured of the mitigating actions to improve the risk levels and took a **"moderate" level of assurance**.

7.6 Proposed Annual Workplan 2025/26

Discussion took place, and it was advised that additional items for the workplan arising from the corporate objectives process will be added on, as appropriate.

The Committee **approved** the final annual workplan for 2025/26.

7.7 Delivery of Annual Workplan 2024/25

It was advised that the Value Based Health and Care Delivery Plan, the Public Protection, Accountability & Assurance Framework, Participation & Engagement Report and the East Region Neonatal Services Report, have all been deferred due to timings, and added to the 2025/26 workplan.

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

8. STRATEGY / PLANNING

8.1 Annual Delivery Plan (ADP) Quarter 3 Report

The Chair welcomed the Planning & Performance Manager to the meeting, who spoke to the report. It was highlighted that there are 87 deliverables within the ADP 2024/25, which are aligned to the 'Improving Quality & Care' strategic priority. A brief overview of the assessment section within the report was provided.

Discussion followed, and an update was provided in relation to rheumatology transformation, which has been paused since November 2024. It was noted that rheumatology is a national issue with input from the Centre for Sustainable Delivery, who are leading a programme of work at a national level. It was advised that there are significant issues for rheumatology, which are multi-factorial, and that a discovery phase is underway. Assurance was provided that an Oversight Board has convened who are monitoring the deliverables for this work. It was agreed to update the ADP report before submission, and the Head of Primary & Preventative Care agreed to provide wording.

Action: Head of Primary & Preventative Care

The Committee took a **"moderate" level of assurance** from the report and **endorsed** the Annual Delivery Plan Quarter 3 return for formal approval at the NHS Fife Board and for submission to the Scottish Government.

9. QUALITY / PERFORMANCE

9.1 Integrated Performance & Quality Report

The Director of Nursing advised that the falls position continues to be below the upper control limit, and that a lot of work is ongoing in this area, including an improvement plan. It was noted that the driver for the falls position is due to the patient cohort and the focus on preventing falls, which is complex. An improved position for pressure ulcers was reported, and it was advised that education and training continue to be delivered. An overview was provided on the position for healthcare-associated infections.

The Medical Director reported that the main area of focus for Significant Adverse Event Reviews (SAERs) relates to the improvement trajectory around the completion of reports, and it was advised that the governance process has improved over the previous year. It was noted that the number of SAERs is almost consistent with the previous year.

In terms of Hospital Standardised Mortality Ratio (HSMR), it was advised that the position is below the Scottish average 0.95.

The stroke bundle position was reported as having improved since the last reporting period, and that work continues in this area. It was advised that the National Audit Programme Board discuss the stroke bundle and indicators at each meeting. Further detail was provided in relation to door to needle time for thrombosis, and it was advised that improvements are expected due to a resource allocation from the Scottish Government. An explanation was provided on the reporting of the additional resource, and that any areas of concern or escalation would be brought forward to the Committee. It was agreed that a summary of the annual report that is submitted to the Managed Clinical Network will be presented to the Committee on an annual basis. The Board Committee Support Officer will add to the workplan.

Action: Board Committee Support Officer

It was noted that for the mental health quality indicators, control limits and targets have been added to the report. The anti-ligature work that is ongoing in relation to updating our estate was also highlighted.

The Committee took a **"moderate" level of assurance** from the report and **endorsed** the quality & care section.

9.2 Healthcare Associated Infection Report

The Director of Nursing spoke to the report and advised that the surveillance programme continues to be suspended at a national level. It was highlighted that an unannounced Health Improvement Scotland visit took place in December 2024 at Victoria Hospital and that the report is expected to be published the following week and will be presented to the Committee in May 2025. It was also highlighted that the national cleaning services specification remains at green status. In terms of COVID-19, it was reported that there has been two new Antimicrobial Resistance and Healthcare Associated Infection Scotland reportable outbreaks/incidents, which are detailed in the report.

The Director of Nursing agreed to provide additional information relating to the quarter 3 report for methicillin-resistant Staphylococcus aureus (MRSA) and carbapenemase-producing Enterobacteriaceae (CPE), out with the meeting.

Action: Director of Nursing

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

9.3 Quality of Care Review Framework

The Director of Nursing advised that the report provides assurance on NHS Scotland's Excellence in Care Programme and Quality of Care review process, and an overview was provided on the process. It was highlighted that the framework will ensure a standardised approach across Scotland. It was advised that an annual summary will be provided to the Committee, and the Board Committee Support Officer will add to the workplan.

Action: Board Committee Support Officer

The Committee agreed to commend the approach to the NHS Fife Board.

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

10. DIGITAL / INFORMATION

10.1 Information Governance and Security Steering Group Assurance Report

The Director of Digital & Information outlined the key points from the executive summary within the paper. It was highlighted that the Network and Information Systems (NIS) action plan primarily focusses on looking at resilience and disaster recovery testing, and recovery preparedness, which is a focus nationally. It was also highlighted that training, education and awareness continues for staff from a cyber resilience perspective. It was reported that work continues around the Information Asset Register to understand the data being held, and that this links to the accountability framework. Incident reporting was also highlighted, and it was advised that during the 12-month period from January 2024 to December 2024, eight incidents were reported to the Information Commissioner's Officer, and that during that period two incidents were not reported within the 72-hour period required. It was noted that further definition on the 72-hour period has been sought from the Information Commissioner's Office.

Questions followed, and assurance was provided in relation to the active incidents, and that there are no concerns to be raised in terms of any disclosure for this financial year. An explanation was also provided on compulsory audits.

The Committee agreed to commend to the NHS Fife Board, the comprehensive and robust approach to risk management.

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

11. PERSON CENTRED CARE / PARTICIPATION / ENGAGEMENT

11.1 Patient Story

The Director of Nursing presented on a patient story in relation to celebrating breastfeeding support. The peer supporters were acknowledged and praised for their breastfeeding support.

The Committee welcomed the presentation.

11.2 Patient Experience & Feedback Report

The Director of Nursing spoke to the report and highlighted the key points from the executive summary, noting that all the hard work that has been ongoing has resulted in positive traction for complaints performance. It was advised that there are 16 open cases with the Scottish Public Services Ombudsman.

It was also advised that NHS Fife continues to be the best performing Health Board in Scotland for Care Opinion, which has also improved staff morale. It was confirmed that patient volunteers are approached for feedback. It was agreed to include detail of the feedback within the next quarterly report.

Action: Director of Nursing

It was agreed to highlight to the NHS Fife Board in the Chair's Assurance Report the improvement work that has been undertaken.

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

12. ANNUAL REPORTS / OTHER REPORTS

12.1 Director of Public Health Annual Report 2024

The Director of Public Health advised that the report was presented to the Public Health & Wellbeing Committee on 3 March 2025, and that the final version will be presented to the NHS Fife Board at their meeting on 25 March 2025.

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

12.2 Medical Education Annual Report 2024

The Medical Director advised that, as NHS Fife achieves Teaching Board status, it is expected that more regular reporting to the Committee will take place on medical education. An overview was provided on the contents of the report, and the totality of undergraduate medical education that is underway was highlighted. It was also highlighted that positive progress has been made in relation to postgraduate training, and that further work will be ongoing to increase the numbers further.

An overview was provided on the improvement work being carried out for the areas of concern highlighted in the postgraduate survey of student feedback. The Medical Director agreed to provide more detail in relation to the undergraduate areas that are red flagged within the report.

Action: Medical Director

The Committee examined and considered the contents of the report and took a **"moderate" level of assurance** in relation the approach taken to ensure the delivery of high-quality medical education in NHS Fife.

12.3 Organisational Duty of Candour Annual Report 2023/24

The Medical Director advised that there are no significant changes in relation to the areas of reporting, since the previous year, and that positive progress has been made. Table 2 within the report was highlighted, and it was advised that it sets out the events where Duty of Candour applied in the years from 2018 – 2024 and that this additional information is being included for completeness, as Duty of Candour was applicable to events which concluded the review process after respective annual reports were submitted.

Following a question in relation to the uptake and engagement with training, the Medical Director agreed to discuss the relevance of the outdated TURAS module with the Clinical Governance team.

Action: Medical Director

The Committee took a **"significant" level of assurance** from the report and **noted** that any incidents that conclude after submission of the 2023/2024 report will then be included in the 2024/2025 report.

13. LINKED COMMITTEE MINUTES

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

13.1 Area Medical Committee held on 8 October 2024 (confirmed) & 10 December 2024 (unconfirmed)
13.2 Cancer Governance & Strategy Group held on 31 October 2024 (unconfirmed)
13.3 Clinical Governance Oversight Group held on 11 February 2025 (unconfirmed)
13.4 Fife Area Drugs & Therapeutic Committee held on 18 December 2024 (unconfirmed)
13.5 Mental Health Oversight Group held on 7 February 2025 (unconfirmed)
13.6 Resilience Forum held on 12 December 2024 (unconfirmed)

- NHS Fife is now accredited to provide Major Incident Medical management & Support (HMIMMS) internationally Advanced Life Support Group (ALSG) accredited training for all staff involved in Hospital Response.
- NHS Fife Acute Services & Health & Social Care Partnership has agreed to include Psychological Support Cell in any response event where Major Incident response is required.

14. ESCALATION OF ISSUES TO NHS FIFE BOARD

14.1 To the Board in the IPQR Summary

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

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

It was agreed to commend the Quality & Care Review Framework, the risk management approach used in the Information Governance & Security Steering Group Assurance Report, and the complaints improvement, to NHS Fife Board.

15. MEETING REFLECTIONS & AGREEMENT OF MATTERS FOR CHAIR'S ASSURANCE REPORT TO BE PRESENTED TO FIFE NHS BOARD ON 25 MARCH 2025

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

16. ANY OTHER BUSINESS

16.1 Chair

The Medical Director, on behalf of the Board, warmly thanked the Chair for her service and valuable contribution during her time on the Committee. Members joined in thanking the Committee Chair for her input into the work of the Committee. It was advised that Anne Haston, Non-Executive Director, will take over the role from 1 April 2025.

Date of Next Meeting – Friday 2 May 2025 from 10am – 1pm via MS Teams.

Meeting: **Clinical Governance Committee**

Meeting date: **7 March 2025**

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

1. Committee's Performance against Annual Workplan

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

The following item has been deferred and rescheduled:

- Value Based Health and Care Delivery Plan (May 2025)
- Public Protection, Accountability & Assurance Framework (May 2025)
- Participation & Engagement Report (Date to be confirmed)
- East Region Neonatal Services Report (Date to be confirmed)
- Safe Delivery of Care Health Improvement Scotland Inspection Report (May 2025)

The Committee approved the proposed workplan for the financial year 2025/26, noting that additional items from the corporate objectives process will be added on, as appropriate.

2. Matters Arising

2.1 Orthopaedic Hip Fracture Audit Update & Action Plan

The Committee received a verbal update, noting that a comprehensive review and full impact assessment is complete. The paper will go to the May 2025 Committee meeting following discussion at Executive Directors Group.

2.2 Clinical Outcomes of Closed Loop System Insulin Therapy

The report provided an overview of the clinical benefits to patients of closed loop insulin therapy and highlighted the short term and long term advantages of this technology in reducing the risk of complications associated with poor blood glucose control. Committee took a **"moderate" level of assurance** from the report. It was advised that NHS Fife has the highest rate of implementation of this form of treatment, which is testament to the commitment and dedication of the team.

3. GOVERNANCE

3.1 Clinical Governance Oversight Group Assurance Summary from 11 February 2025 Meeting

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

3.2 Mental Health Oversight Group (MHOG) Assurance Summary from 22 November 2024 Meeting

The Committee took a **"moderate" level of assurance** from the assurance summary and were advised that there are plans in place to ensure that there is joint governance and oversight, in partnership with the Health & Social Care Partnership, for the new Mental Health Strategy.

3.3 Corporate Risks Aligned to CGC

There are 4 corporate risks aligned to the CGC. The committee discussed the 'Deep Dive' review associated with the new risk of Hospital Acquired Harm. Mitigating actions were noted. The committee also had opportunity to review the Whole System Capacity risk.

Risk mitigation for Cyber resilience and Digital and Information to be provided on risk register, it was agreed to discuss the detail of this out with the meeting.

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

No.	Risk	Actions Required
9	Quality and Safety	Within risk appetite
17	Cyber Resilience	Above risk appetite
18	Digital and Information	Above risk appetite
22	Hospital Acquired Harm	Endorsed by CGC

4. STRATEGY AND PLANNING

4.1 Annual Delivery Plan (ADP) Quarter 3 Report

The Committee took a **"moderate" level of assurance** from the report and **endorsed** the Annual Delivery Plan Quarter 3 return for formal approval at the NHS Fife Board and for submission to the Scottish Government.

5. QUALITY AND PERFORMANCE

5.1 IPQR

The IPQR was reviewed and discussed with the Committee taking a "**moderate" level of assurance** from the report. There were no performance related issues for escalation to the Board. The stroke bundle was discussed and further detail was provided in relation to door to needle time for thrombolysis, it was agreed to consider a wider report around Stroke Care Standards at future CGC meeting.

5.2 HEALTHCARE ASSOCIATED INFECTION

The Healthcare Associated Infection report was reviewed and discussed. An

unannounced Health Improvement Scotland follow up visit took place in December 2024 at Victoria Hospital and the report is expected to be published in March 2025. A paper will be presented to CGC in May relating to the publication and progress with the action plan.
Information was requested by CGC relating to MRSA and CPE screening compliance rates, further detail to be provided.
There were no infection and prevention control issues for escalation to the Board with a **moderate level of assurance** taken.

5.3 Quality of Care Review Framework

The CGC were provided with an overview of the Quality of Care Review Framework. The report provided a moderate level of assurance on NHS Scotland's Excellence in Care (EiC) Programme and its Quality of Care (QoC) Review process, designed to continuously improve patient care standards. Noted further work is underway to consider the application to Mental Health and Community based services.

6. Information Governance and Security Steering Group Assurance Report

The Committee **noted** the progress being made across the Information Governance and Security domains and took a **"moderate" level of assurance** from the governance, controls and improvement plans in place. Assurance was provided in relation to the active incidents, and that there are no concerns to be raised in terms of any disclosure for this financial year.

7. PERSON CENTRED CARE / PARTICIPATION / ENGAGEMENT

7.1 Patient Experience & Feedback

The Committee took a **"moderate" level of assurance** from the overall report noting that all the hard work and improvements implemented have resulted in positive traction for complaints performance both in Stage 1 and Stage 2 complaints.

8. ANNUAL /OTHER REPORTS

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

- Director of Public Health Annual Report 2024 (**"moderate" level of assurance**)
- Medical Education Annual Report 2024 (**"moderate" level of assurance**)
- Organisational Duty of Candour Annual Report 2023/24 (**"significant" level of assurance)**

8. Delegated Decisions Taken by the Committee

- Endorsed final version of CGC Terms of Reference
- Endorsed the Annual Delivery Plan Quarter 3 Report

- Approved Annual CGC Workplan for 2025-26

9. Issues to Highlight to the Board

- There were no performance related matters to escalate to the Board
- There were no infection and prevention control issues for escalation to the Board
- The Quality & Care Review Framework was commended as a robust system of assurance in relation to elements of clinical care.
- The risk management approach used in the Information Governance & Security was commended
- The improvement work undertaken by the Patient Experience and Feedback team and achievements made in Stage 1 and Stage 2 Complaints was acknowledged

Arlene Wood
Chair
Clinical Governance Committee

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

CLINICAL GOVERNANCE COMMITTEE – ACTION LIST
Meeting Date: Friday 2 May 2025

NHS Fife

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	COMMENTS / PROGRESS	COMPLETION DATE
1.	07/03/35	**Organisational Duty of Candour Annual Report 2023/24**	To discuss the relevance of the outdated TURAS module with the Clinical Governance team.	**CM**	From 01/07/2021 - 11/02/2025 there have been 2482 completions of Duty of Candour TURAS training. Completions per calendar year: • 2022: 753 • 2023: 601 • 2024: 591 The TURAS module is developed nationally, and it is expected that this will be updated in view of new guidance that has been issued. GC will take forward in discussion with HIS. The new guidance is stronger in the requirements of Health Boards, to ensure that staff are trained, and that this will be a focus going forward. A paper on the new guidance will be presented to the Clinical Governance Oversight Group in July, and a paper can be presented to the Committee, if appropriate, in July, to include our approach to training and education.	July 2025 – **Members are asked to confirm if they would wish a further paper on our approach to training & education**

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

CLINICAL GOVERNANCE COMMITTEE – ACTION LIST
Meeting Date: Friday 2 May 2025

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	COMMENTS / PROGRESS	COMPLETION DATE
2.	07/03/25	**Corporate Risks Aligned to Clinical Governance Committee**	To take this forward as an action and discuss with the Associate Director of Quality & Clinical Governance, how the effectiveness of the Organisational Learning Group is measured, in terms of assessing the outcome impact of the Hospital Acquired Harm risk mitigations.	**CM**		May 2025
3.	07/03/25		To discuss further with the incoming and outgoing Chair, the Information Governance and Cyber Security risk, which members raised concern for regarding the risk requiring clearer mitigation within the corporate risk register.	**AG**		May 2025
4.	07/03/25	**Quality of Care Review Framework**	An annual summary on the framework will be provided to the Committee and added to the workplan.	**HT**	Closed. Added to workplan.	March 2025
5.	07/03/25	**Integrated Performance & Quality Report – Stroke Bundle**	A summary of the annual report, in relation to the door to needle time for thrombosis, that is submitted to the Managed Clinical Network will be presented to the Committee on an annual basis and added to the workplan.	**HT**	Closed. Added to workplan.	March 2025
6.	07/03/25	**Annual Delivery Plan**	To provide wording for the update to the ADP before submission in relation to rheumatology transformation, which has been paused since November 2024, and is a national issue.	**L Cooper**	Closed. Complete.	March 2025

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

CLINICAL GOVERNANCE COMMITTEE – ACTION LIST
Meeting Date: Friday 2 May 2025

NHS Fife

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	COMMENTS / PROGRESS	COMPLETION DATE
7.	07/03/25	**Healthcare Associated Infection Report**	To provide additional information relating to the quarter 3 report for methicillin-resistant Staphylococcus aureus (MRSA) and carbapenemase-producing Enterobacteriaceae (CPE).	**JK**	Following a noted reduction in compliance with both MRSA and CPE CRA screening in Quarter 3 (July- September 2024) below the Scottish national average, a deep dive identified some patient admission screening being undertaken on paper forms rather than the electronic Patientrak record used by both IPC Team and Excellence in Care, CAIR dashboard. Targeted support and collaboration between IPCT and clinical teams has seen a noted improvement in screening compliance rates for Quarter 4 2024. Further detail can be provided on request.	May 2025
8.	07/03/25	**Patient Experience & Feedback Report**	To include detail from the Care Opinion feedback in the next quarterly report.	**JK**	Closed. Will be included in the next iteration of the report.	May 2025
9.	07/03/25	**Medical Education Annual Report 2024**	To provide more detail in relation to the undergraduate areas that are red flagged within the report.	**CM**	Closed. More detail provided via email on 22/04/25.	May 2025

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**2 May 2025**
Title:	**Orthopaedic Hip Fracture Audit Update & Action Plan**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
	Claire Dobson, Director of Acute Services
Report Author:	**Claire Dobson, Director of Acute Services**
	Andy Ballantyne, Clinical Director Orthopaedics
	Sarah Mitchell, Clinical Lead Orthopaedics
	Fiona Cameron, NTC Manager

Executive Summary:

- NHS Fife has been identified as a significant outlier (-3SD from national average) for the 5th consecutive year in the Scottish Hip Fracture Audit (SHFA) KPI for time to theatre for acute hip fractures.
- Whilst this KPI relates to hip fractures, this condition is recognised as a surrogate measure of the management of all orthopaedic emergency trauma.
- NHS Fife meets all other KPIs within the Scottish Hip Fracture audit and is a positive outlier (+3SD) for Comprehensive Geriatric Assessment within 3 days.
- The recently completed Trauma Review process identified the need for additional trauma operating capacity as part of a wider improvement plan.
- There is a risk that without additional capacity patients in NHS Fife will suffer harm due to lack of access to timely surgery.
- The Theatre Utilisation Group developed options to increase trauma operating capacity for consideration.
- The preferred option is Option 1 to implement an additional emergency trauma theatre one full day operating every week has been supported by the Executive Leadership Team.
- This paper provides a moderate level of assurance.

1 Purpose

This report is presented for:

- Discussion
- Assurance

This report relates to:

- Emerging issue
- Government policy / directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This paper is presented to provide an update in relation to the NHS Fife response to the 2023 Scottish Hip Fracture SNAP Audit. The SNAP audit demonstrated that NHS Fife is an outlier for hip fracture time to theatre (<36 hours).

The paper provides an overview of the work completed to identify options to increase trauma theatre capacity. Moderate assurance is given.

2.2 Background

Scottish Hip Fracture Audit (SHFA) is part of the Scottish National Audit Programme (SNAP) governance process within NHS Scotland, it reports against 12 standards and feeds back to outlier boards via Public Health Scotland.

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

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

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

KPI Time to theatre	NHS Fife attainment	Scottish average
2019	65.9%	76%
2020	66%	71%
2021	61.4%	72.12%
2022	51%	69.9%
2023	60.17%	68.68%
2024	58.5% (provisional data)	68.8%

The main reason for delay to theatre is lack of theatre time.

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

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

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

2.3 Assessment

Considering the ongoing failure to meet the SHFA time to theatre target for hip fractures, options for performance improvement were considered by the Theatre Utilisation Group. The group identified four options:

Option 1:
Implement an additional emergency trauma theatre one full day operating every week to support the 36 hour hip fracture target and address NHS Fife outlier status. There are double theatre trauma sessions already in place on Mondays and Thursdays weekly. Bed capacity within the VHK site is often pressured on a Tuesday therefore Wednesday or Friday would be the most appropriate options for consideration of an increase in theatre operating. Financial investment required.

Option 2:
Displace theatre activity from another speciality and redistribute staffing to support additional trauma activity to support 36 hour hip fracture target and address NHS Fife outlier status. There would be a requirement to remove operating sessions from another surgical specialty impacting on waiting times, job planning, staff retention and reputation. Financial investment required.

Option 3:
Extend Saturday/Sunday operating to full days. Most significant level of financial investment required.

This option would have a significant impact on job planning for Orthopaedics and Anaesthetics with an impact on elective Orthopaedic capacity during the week impacting NTC activity. Modelling has demonstrated additional through week activity is less costly and has less impact on elective capacity

Option 4:

Maintain status quo. No additional resource required. Option 4 would not be viable as the consistent failure to meet the target over the past 5 years demonstrates that the position cannot be recovered with the current theatre provision, despite flexibly managing additional theatre lists.

The group opted to explore Option 2 in more detail by reviewing waiting list sizes and the clinical impact of reducing theatre sessions for particular specialties that could be reduced in order to accommodate an increase in trauma operating capacity (Table 2).

Table 2 Impact or dropping theatre session by specialty

Speciality	Wednesday	Friday	Impact of dropping 2 /week sessions
ENT	Full day list	Full day list (paediatric/adults)	ENT has a long waiting lsit for IP/DC. Friday paediatric activity should be protected due to long waiting list.
General Surgery	Full day list		Predominantly Cancer and patients requiring SHDU
Gynaecology	Full day list		Gynaeoncology activity must be maintained
OMFS		Full day list	Low numbers of patients on waiting list for surgery but may destabilise the OMFS Team.
Surgical Paediatrics		Morning list	No benefit, morning list only Surgeons come from NHS Lothian to operate
Urology	Full day list	Full day list	Both Wednesday and Friday lists require Radiology support. Friday Cancer list and urgent weekly list. Urology waiting times require improvement
Robotic surgery	Full day list (GS)	Full day list (Urology)	Robotic work protected due to Cancer activity

Reducing operating sessions for the specialties within Table 2 would be challenging. However the group considered the impact on the OMFS specifically due to low numbers of patients on the OMFS waiting lists with no long waiting patients for out-patients or surgery.

The OMFS provides Monday to Friday on call based within VHK and it is part of a network with NHS Tayside for weekend on call. Removing the OMFS theatre session on a Friday would have the least impact on current waiting times, but crucially it would remove any option for general anaesthetic operating for one surgeon and would result in them having no surgical sessions.

OMFS consultant recruitment across the UK is very limited due to the dual training required in Medicine and Dentistry. NHS Fife successfully recruited a new consultant in March 2024 as part of their future planning for consultant retrials expected in the coming year. There is a risk that reducing the operating sessions for the service could destabilise the team with Consultants opting to apply for roles elsewhere, impacting n NHS Fife's ability to provide an OMFS, a further reduction in waiting times performance, and potentially a reliance on other health boards for support.

In summary, despite extensive scoping the Theatre utilisation Group have not identified an option to increase trauma capacity that does not involve disruption to another specialty with a decline in patient care or financial investment. The preferred option is option 1.

This report provides the following Level of Assurance:

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

2.3.1 Quality, Patient and Value-Based Health & Care

There has been extensive work to transfer minor and elective surgery to the QMH site to create capacity in VHK for major surgery including trauma. Work is also ongoing to ensure efficient theatre scheduling to maximise capacity. This does not translate to releasing theatre staffing to support additional trauma.

When theatre efficiency is compared nationally, NHS Fife functions at a high level. NHS Fife already has the shortest combined anaesthetic and surgical time in Scotland for the two most common hip fracture repair procedures. The service is already working to maximise efficiency however, these will be marginal gains and will not release sufficient capacity to impact significant on hip fracture waiting times

The Trauma Service prioritises hip fracture care when it can. However, due to increasing trauma demand for hip fractures repair can be delayed due to clinical prioritisation. In 2024 there were 1800 emergency trauma surgeries were undertaken within NHS Fife across the QMH and VHK sites. The service anticipates an increasing trauma workload over the next 10 years. Increases in theatre resource have not matched trauma demand. Over the next 10 years further increases in trauma theatre resource will be required.

Patients who do not undergo hip fracture surgery within the 36 hours target have a higher mortality rate and longer length of stay. Even when those with a clinical reason for delay are excluded, delays to theatre and lack of theatre time as a reason were associated were associated increased mortality for the 2023 activity. The increased length of stay is associated with increased costs of care.

Any reduction in OMFS activity will impact negatively on patients in relation to waiting times. Increased waits are associated with increased costs if care. In addition as previously outlined changes to OMFS activity may destabilise the entire OMFS service and result in patients having to travel out with Fife for care at elevated costs to NHS Fife and to patients.

2.3.2 Workforce

Consultant job planning within the Orthopaedic service shows a 77% completion, showing a high degree of engagement. The service has sufficient flexibility within departmental job plans to support additional trauma sessions. Whilst physical theatre capacity exists and there is capacity within the Orthopaedic Consultant workforce, there is no theatre team, including anaesthetic support, available to provide additional sessions.

Whilst option 2 would require a lower level of investment there would be a negative impact to the OMFS workforce with the potential loss of staff which would de-stabilise this service.

A key part of any changes to the Trauma Service should include a Trauma Co-ordinator post to support trauma planning and delivery. This role currently does not exist within NHS Fife and we remain the only mainland board who has not implemented this role. Options have been explored from within existing workforce and budget, with no immediate solution.

2.3.3 Financial

The costs of the options are summarised in below:

Option 1	**Resources & Cost**
Implement an additional emergency trauma theatre 1 x full day (Wednesday 2 sessions) operating every week to support 36 hr hip fracture target and address NHS Fife outlier status	The resource required to an additional day of emergency trauma operating: • **Theatre Staffing £164,555** • **Theatre non-pay £127,443** • **Band 7 Trauma Co-ordinator £76,090** • **0.3 WTE Band 6 Radiographer £25,196** • **Image intensifier £80,000 capital plus £4,000 revenue**
Total	**Capital £80,000** **Revenue £393,288**

Option 2	Resources & Cost
Displace theatre activity from another speciality Wednesday/Friday and redistribute staffing to support additional trauma activity.	Use displaced theatre staff to support additional day of emergency trauma operating: • **Theatre non-pay £127,443** • **Band 7 Trauma Co-ordinator £76,090** • **0.3 WTE Band 6 Radiographer £25,196** • **Image intensifier- £80,000 capital plus £4,000 revenue**
Total	**Capital £80,000** **Revenue £228,733**

Option 3	Resources & Cost
Extend Saturday and Sunday	The resource required to an additional day of emergency trauma operating at weekends: • **Theatre Staffing £246,832** • **Theatre non-pay £127,443** • **Band 7 Trauma Co-ordinator £76,090** • **1.0 WTE Band 6 Radiographer £85,000** • **Image intensifier- £80,000 capital plus £4,000 revenue**
Total	**Capital £80,000** **Revenue £535,369**

Option 4

Continue with no additional trauma capacity

Option 1, the preferred option was supported by the Executive Leadership Team and work is now progressing to recruit the workforce required to support the additional trauma activity.

2.3.4 Risk Assessment / Management

Without action or investment there is a risk that NHS Fife would continue as an outlier against the Scottish Hip Audit Standards as the service will remain unable to resolve the delays to time to theatre.

There is a risk to patient harm by not being able to comply with time to theatre standards due to insufficient capacity to manage the current trauma volume, this risk will increase over time given the projections of increasing trauma if additional trauma theatre capacity is not identified. This risk extends to all emergency trauma surgery, not just hip fractures.

There is a risk of increased complaints and patient harm without appropriate support to manage and co-ordinate the volume and complexity of the emergency trauma waiting list.

Should changes to OMFS theatre capacity proceed there is a risk of delayed treatment for patients awaiting an in-patient/day case procedure.

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

An EQIA is under development. Whilst action is required to support access to trauma operating capacity there is a potential negative impact for patients awaiting OMFS support.

2.3.6 Climate Emergency & Sustainability Impact

NHS Fife is very active in supporting Green Theatre activity. A sustainable solution for best use of theatre resource is sought.

2.3.7 Communication, involvement, engagement and consultation

The Trauma review process was a multidisciplinary team process involving all key stakeholders. The outputs and recommendations from the group reports to Acute SLT and ASD CGC.

The Orthopaedic Peer Review process is a national process. External experts attend from peer boards, Scottish Government and relevant speciality organisations and reflects on areas of excellence and areas for improvement. Part of this relates to trauma delivery with comparison to other similar boards.

2.3.8 Route to the Meeting

- ASD CGC
- Clinical Governance Oversight Group
- Executive Leadership Team 20th March 2025

2.4 Recommendation

Members are asked to:

- **Discuss** this paper and the options that have been explored to address the challenges that NHS Fife faces in relation to Trauma operating capacity.
- **Note** that the Executive Leadership Team supported option 1 and that work is underway to recruit the necessary workforce to increase trauma theatre capacity.
- Take a **"moderate" level of assurance**.

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NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting Date:	**2 May 2025**
Title:	**Victoria Hospital Water Supply Issue**
Responsible Executive:	**Claire Dobson, Director of Acute Services**
Report Author:	**Claire Dobson, Director of Acute Services**
	Charlotte Myles, Service Manager
	Aileen Lawrie, Director of Midwifery

Executive Summary:

- Waste pipe leakage within Phase 3 at the VHK has identified that repairs and upgrades to pipe work are required to be undertaken as a matter of urgency.
- Whilst the leaks are within the Renal Dialysis Out-Patient area this situation also impacts upon the Neonatal Unit and the Paediatric Ward.
- Business continuity plans have been developed for each of the service areas that have been impacted.
- To ensure the safe and effective delivery of care temporary reductions in capacity across all three areas will be necessary.
- The remedial work is scheduled to commence on the 27th April 2025 and will conclude by the 19th May 2025.
- Stages 1 EQIAs for each area have been completed and are being considered by the Equalities and Human Rights Lead.

1 Purpose

This report is presented for:

- Discussion
- Assurance

This report relates to:

- Emerging issue

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

- Safe
- Effective
- Person Centred

2 Report Summary

2.1 Situation

Remedial work is required to repair waste pipes with Phase 3 of the Victoria Hospital Kirkcaldy (VHK). Whilst the leak is within the Renal Unit the works will also impact the Neonatal Unit and the Paediatric Ward. The purpose of this report is to provide a moderate level of assurance in relation to the actions underway to ensure the continuity of the safe delivery of care across all three areas.

2.2 Background

At the end of March 2025 pipe leakage within a bay in the Neonatal Unit was noted. EQUANS identified the need to repair/upgrade pipe work with the source of the stack system damage originating from the Renal Dialysis Unit.

The works are scheduled to commence 17th April 2025 and conclude by the 19th May 2025. To ensure the continued safe delivery of care changes to service delivery and capacity are required on a temporary basis.

2.3 Assessment

Mitigating actions to support the continuation of Renal Dialysis:

The existing clinical space within the unit and the ability to repurpose the area for continued clinical use has been assessed. In total 7 Dialysis spaces will be blocked off to allow for access to replace the pipe work.

Therefore 17 dialysis spaces will be available for current patients on the early and late shift, with a total of 28 patients requiring reallocation to an alternative shift. Current Haemodialysis patients have been assessed for suitability to be reallocated to alternative shifts or sites, the clinical team has opted to keep the majority of the patients at VHK (lower transport requirement, medical staff on-site and potentially less disruptive for patients). This will be achieved through additional dialysis activity in the evening. Discussions have taken place directly with the patients impacted.

The mitigation plan for new patients commencing dialysis over this period may involve dialysis at St Andrews Community Hospital if the VHK capacity cannot accommodate. A last resort option would be the use of an in-patient renal bed.

Mitigating actions to support the continuation of Neonatal Care:

A temporary reduction in cots will be required. The NHS Fife Neonatal Service will maintain 9 cots plus 1 stabilisation cot, with the potential to increase to 10 cots with 1 stabilisation cot in extremis

The reduction in cots will limit NHS Fife's capacity to fulfil the repatriation criteria as outlined within Best Start. In addition, there will be a negative impact on the Perinatal Managed Clinical Network as Fife will be unable to accept transfers into the Neonatal Unit from elsewhere in Scotland. The service is working closely with SCOTSTAR to ensure the safe movement of neonates to other units across Scotland for a period before and during the works.

The reduction in cots also requires a temporary change in NHS Fife's ability to care for some women with multiple pregnancy, threatened/actual pre-term labour and complex pregnancy.

Due to the reduction in cot numbers and dependent on capacity Fife may need support with the in-utero transfer of women (singleton < 32 weeks and multiple <35 weeks). To support the safe and timely movement of women to other maternity units additional ambulance provision has been arranged with the Scottish Ambulance Service.

Mitigating actions to support the continuation care within the Paediatric Ward:

Reconfiguration:
Efforts will be made to maintain capacity within the Paediatric Ward through early supported discharge. Should additional in-patient capacity be required, a 4-bedded bay within the Paediatric Ambulatory Care Unit can be re-purposed for in-patient care (through the cancellation/re-scheduling of elective interventions and day-case surgery).

Care Pathway :
In extremis, mutual aid to support the placement of in-patient Paediatric patients will be sought from neighbouring units in NHS Tayside and NHS Forth Valley.

This report provides the following Level of Assurance with all of the actions outlined in place:

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

2.3.1 Quality, Patient and Value-Based Health & Care

The mitigating actions outlined will support the delivery of safe care. However, over this period patients and their families will face disruption.

Renal Care
The Renal Association Project Mandate Template provides clinical practice guidelines for haemodialysis patients. NHS Fife has recognised this and have successfully implemented a successful, safe and high-quality model of care. The requirement to reduce patient capacity, even although temporary, will result in a cohort of patients who will be required to move their treatment sessions to later time slots, alternative days or to another site.

The team have reviewed all patients moving to an evening shift and deem these patients suitable to dialyse without senior medical staff on site. The majority of patients will remain at VHK to minimise disruption to normal routine and transport arrangements.

Neonatal Care
Available research suggests consolidation of Neonatal care to tertiary units improves outcomes for the smallest and sickest babies. NHS Fife has recognised this and successfully implemented

this model of care since 2019. The requirement to reduce cot capacity, even although temporary, will result in a cohort of women out with these recommendations requiring to be transferred out with Fife.

This will create an inequitable service for Fife families who will no longer be able to be cared for within their home board. There is recognition of the wider impacts on families already subject to the challenges of deprivation, for example, travel and sustenance costs, childcare costs, separation of mothers and babies.

Paediatric Care
Whilst it anticipated that the disruption on to the Paediatric ward may be minimal, if required the cancellation of Paediatric interventions/day-case surgery will prolong waiting times and negatively impact on patient satisfaction.

2.3.2 Workforce

Over the period of the remedial works staff may be required to work differently. This may include changes to working hours and additional hours.

The Employee Director and Co-Chair of the Acute Division LPF have been made aware of this situation.

2.3.3 Financial

To ensure the safe delivery of care there is a requirement to increase the nursing establishment for the period of the works for all three areas. There will also be costs for additional ambulance support.

2.3.4 Risk Assessment / Management

The Infection Prevention and Control Team and a Microbiology Consultant have been closely involved with the mitigation plans as well as the impact assessment of the remedial work.

There is a risk that there will be an increase in complaints regarding differing care provision, scheduling, location and timing.

Noise reduction strategies have been requested consideration for by EQUANS for the duration of the works, and the impact on other areas of the hospital; acknowledged and considered. EQUANS will provide acoustic panels to reduce industrial noise.

Risks within the Paediatric Department include lack of capacity for unscheduled admissions and risks relating to potential cancellation of elective Paediatric interventions/day-case surgery which will prolong waiting times and negatively impact on patient satisfaction.

There is a reputational risk for NHS Fife in relation to remedial works that are impacting on vulnerable care groups as well as concerns that vital services will be reduced in capacity.

There is a risk that further pipe leaks may occur. A wider assessment of pipe work is planned as well as a look back and learn exercise to determine how further pipe work issues within the Renal Unit could be avoided.

The risks identified are being monitored and managed via an Incident Management Team Chaired by a Senior Clinician, with escalation to the Acute SLT and to the ELT as necessary. The

look back and learn review will be considered by the Acute SLT and the Acute Clinical Governance Committee.

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

Stage 1 EQIAs have been completed and are being considered by the Equalities and Human

Rights Lead.

2.3.6 Climate Emergency & Sustainability Impact

As a result of the remedial works there will be an increase in vehicle use to support the travel requirements for patients accessing care either in another area in Fife or in another Health board area.

2.3.7 Communication, involvement, engagement and consultation

The Communications Team are key members of the IMT. A robust internal and external communications plan is in place.

Executive Directors have been communicating the impacts and mitigation plans with key leads at Scottish Government and with neighbouring boards, as well as via national bodies e.g. SCOTSTAR.

Daily huddles and IMT meetings will continue to take place.

2.3.8 Route to the Meeting

Twice weekly IMT meetings
Department and Service meetings
Acute SLT
Executive Leadership Team

2.4 Recommendation

This paper is provided to the Clinical Governance Committee for:

- The Clinical Governance Committee is asked to **discuss** the contents of this paper and review the mitigation plans proposed.
- The Clinical Governance Committee is asked to take a **"moderate" level of assurance** from the update.

Report Contact
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NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**2 May 2025**
Title:	**Safe Delivery of Care Health Improvement Scotland Inspection Action Plan**
Responsible Executive:	**Janette Keenan, Executive Director of Nursing**
Report Author:	**Norma Beveridge, Director of Nursing Acute Services**

Executive Summary:

- Healthcare Improvement Scotland (HIS) carried out an unannounced follow-up Safe Delivery of Care Inspection at Victoria Hospital from 3 to 5 December 2024.
- The inspection identified 13 new requirements and one recommendation. HIS acknowledged progress had been made on the nine requirements from the August 2023 inspection.
- Despite increased hospital capacity, the areas HIS inspected were calm and well led, with hospital teams working together to provide responsive, compassionate care.
- Patients and families spoke highly of the care received and staff stated they would recommend Victoria Hospital as a good place to work.
- Staff HIS inspectors spoke with reported feeling supported and listened to by senior managers. Senior managers were visible within the hospital and hospital safety briefings and huddles were well organised, with good multidisciplinary team representation.
- Areas of good practice included collaborative working in ED, structured safety huddles, development opportunities for staff, and positive patient-staff interactions.
- Requirements related to paediatric life support training, fire safety, documentation, safe patient placement, infection control, staffing assessments, and patient dignity.
- A detailed Improvement Action Plan was agreed and submitted to HIS. Oversight will be through the Acute Senior Leadership Team with governance reporting through ASD Clinical Governance and NHS Fife Clinical Governance Committee.
- This paper provides Moderate Level of Assurance.

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Government policy / directive
- NHS Board Strategic Priorities: 1. To Improve Health & Wellbeing; 2. To Improve Quality of Health & Care Services; 3. To Improve Staff Experience & Wellbeing

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

Healthcare Improvement Scotland (HIS) undertook an unannounced follow-up Safe Delivery of Care inspection of Victoria Hospital between 3 and 5 December 2024. This report provides an overview of the findings, improvement actions and governance arrangements to assure the Committee of NHS Fife's response.

2.2 Background

HIS Safe Delivery of Care inspections assess acute hospital care against national standards to ensure safe, effective and person-centred care. A previous inspection in July-August 2023 identified nine requirements and two recommendations. NHS Fife developed and implemented an action plan which was assessed during this follow-up inspection.

2.3 Assessment

The December 2024 inspection found areas of progress, including improvement in the built environment and infection prevention governance. HIS acknowledged that most previous requirements had been met or were progressing (Appendix 1)

To provide assurance of improvement within these areas during this follow-up inspection, HIS inspected the following areas in line with the safe delivery of care acute hospital methodology: • admissions unit 1 • children's ward • day intervention unit • emergency department • ward 31 • ward 32 • ward 34 • ward 41 • intensive care unit • renal day unit • ward 5 • ward 6 • ward 9 • ward 22

However, 13 new requirements and one recommendation were issued, focusing on staff training, fire safety, safe patient placement, infection control, and infrastructure.

The unannounced follow-up inspection resulted in nine **areas of good practice**:

1. Collaborative working was seen within the emergency department between hospital staff and Scottish Ambulance Service to ensure safe patient care
2. Wide range of training and development opportunities for staff
3. Safety huddles were structured, inclusive and informative
4. Timely escalation to request additional supplementary staff based on acuity and dependency
5. Students reported positive practice and learning environments and support from staff within clinical areas
6. Adults with Incapacity care plans were clear, detailed and completed appropriately
7. Positive interactions between patients and staff.
8. Development and training opportunities for staff within the emergency department
9. Visible senior leadership seen throughout the hospital.

The unannounced inspection resulted in one **recommendation**:

1. NHS Fife should ensure patients are assisted with hand hygiene prior to mealtimes

The unannounced inspection resulted in thirteen **requirements**:

1. NHS Fife must ensure all relevant staff are provided with and complete the necessary paediatric immediate life support training to safely carry out their roles
2. NHS Fife must ensure all relevant staff fire training is up to date and recorded appropriately, all portable electrical equipment is tested to ensure safe to use within hospital setting and all fire exits are not obstructed
3. NHS Fife must ensure all fire evacuation plans are updated to take into account the use of additional beds within clinical areas
4. NHS Fife must ensure the safe storage of patient belongings to ensure evacuation routes are not obstructed
5. NHS Fife must ensure staff follow risk assessments and selection criteria guidance for placement of patients within additional surge beds
6. NHS Fife must ensure boarding policies are followed and clear documentation is in place when deviations are made, and all staff are aware of policies procedures in place to support safe selection of and appropriate patient placement
7. NHS Fife must ensure staff follow policies and procedures for the safe care of vascular access devices
8. NHS Fife must ensure staff comply with safe management of linen policies
9. NHS Fife staff including nurses, domestic and estates must ensure the appropriate monitoring and cleaning of vents and escalate any concerns in relation to this
10. NHS Fife must ensure all patient care equipment is in a good state of repair, including trolley mattresses within the emergency department, and is decontaminated following use and stored safely
11. NHS Fife must ensure alcohol-based hand rub is available for use by staff and visitors
12. NHS Fife must ensure that there are suitable arrangements for real-time staffing assessment and escalation of risk for all clinical professions
13. NHS Fife must ensure patient dignity is maintained at all times. This includes but is not limited to access to shower facilities for all patients

NHS Fife has developed a comprehensive Improvement Action Plan (Appendix 2) to address the findings. Actions include:

- Site-wide PAT testing and fire safety reviews
- Enhancing paediatric life support and fire safety training compliance
- Improved documentation for boarding and patient placement decisions
- Enhanced IPC measures including vent and linen management
- Review and refresh policies and procedures for the safe care of vascular access devices and hand hygiene
- Refreshed real-time staffing processes for all clinical professions
- Review and refresh equipment audits
- Improvement of the healthcare-built environment (phase 1)

The Acute Senior Leadership Team (SLT) will oversee the progress and implementation of the improvement action at regular intervals, with escalation by exception to the Executive Leadership Team (ELT). Infection Prevention and Control Team (IPCT) and Estates colleagues will be invited to SLT meetings every six weeks to provide updates.

Assurance on progress will be provided through the Clinical Governance Oversight Group, ensuring appropriate scrutiny and governance.

This report provides the following Level of Assurance:

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

2.3.1 Quality, Patient and Value-Based Health & Care

The inspection and resulting improvement plan are directly aligned with safe and person-centred care. Improved patient flow processes, risk assessments, and care environments support better patient outcomes.

2.3.2 Workforce

Positive staff feedback was noted, but improvement is required in training compliance, particularly in fire safety and paediatric resuscitation. The plan supports sustainable workforce development and psychological safety.

2.3.3 Financial

No direct costs reported in this paper; however, actions such as environmental upgrades and training delivery require ongoing investment.

2.3.4 Risk Assessment / Management

Risks were identified relate to fire safety compliance, documentation, IPC practices, and staffing assessments. Implementation of the improvement plan is expected to reduce patient safety and reputational risks.

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

The actions taken are designed to ensure equitable, high-quality care across patient groups.

2.3.6 Climate Emergency & Sustainability Impact

Refurbishment and maintenance work will consider sustainability principles, including energy efficiency and waste reduction.

2.3.7 Communication, involvement, engagement and consultation

The Improvement Plan was developed collaboratively by Acute Division, IPCT, Estates, Health & Safety and front-line staff.

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.

- Acute Senior Leadership Team April 2025
- Executive Leadership Team 17 April 2025
- Verbal update provided to ASD Clinical Governance Committee and Clinical Governance Oversight group April 2025

2.4 Recommendation

This paper is provided to members for:

- **Assurance** – This report provides a **"moderate" level of assurance**.

3 List of appendices

The following appendices are included with this report:

- **Appendix No. 1, HIS Inspection report**
  Victoria-Hospital-Safe-Delivery-of-Care-Inspection-Report.pdf
- **Appendix No. 2, NHS Fife Improvement Plan**
  20250311-Improvement-action-plan-Victoria-Hospital-NHS-Fife-1.0-1.pdf

Report Contact
Norma Beveridge
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NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**2 May 2025**
Title:	**Annual Assurance Statements & Reports from Clinical Governance Sub-Committees & Groups**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author:	**Gillian MacIntosh, Board Secretary**

Executive Summary:

- All formal Committees of the NHS Board are required to provide an Annual Statement of Assurance for the NHS Board.
- Consideration of the annual statements of assurance from the Clinical Governance Committee's formal sub-groups is required to finalise the Committee's own report. These are provided as appendices to this paper.
- Members are asked to take a "significant" level of assurance that each group have delivered on their remit during the 2024/25 reporting year.

1 Purpose

This is presented to the Committee for:

- Assurance

This report relates to a:

- Legal requirement
- Local policy

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

- Effective

2 Report summary

2.1 Situation

All formal Committees of the NHS Board are required to provide an Annual Statement of Assurance for the NHS Board, which is consider initially by the Audit & Risk Committee. The requirement for these statements is set out in the Code of Corporate Governance. In order for the Clinical Governance Committee to finalise its own report, it first requires to

consider the annual statements of assurance from its formal sub-groups, including the Quality & Communities Committee of the IJB.

2.2 Background

The Clinical Governance Committee's sub-groups are: the Clinical Governance Oversight Group; the Digital & Information Board; the Health & Safety Sub-Committee; the Information Governance & Security Steering Group and the NHS Fife Resilience Forum. For assurance purposes, the minutes and an annual report of the Quality & Communities Committee of the IJB are also part of the Committee's workplan of business. The sub-groups each provide these assurance reports formally to the Committee to evidence the fact that each has fulfilled their remit outlined in their Terms of Reference over the course of the reporting year, given the fact that they have delegated authority from the Committee to undertake operational scrutiny of activities and improvement actions in their respective areas.

2.3 Assessment

The six separate reports are given as annexes to this paper. Each report should indicate the span of business considered by each group over the course of the last financial year and draw out any areas of concern to be highlighted to the Committee. These are then covered within the Clinical Governance Committee's own annual report (given in full in a following agenda item).

This report provides the following Level of Assurance:

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

A significant level of assurance is suggested, given each group have considered during the reporting year the full range of business delegated to each.

2.3.1 Quality, Patient and Value-Based Health & Care

Delivering robust governance across the organisation is supportive of enhanced patient care and quality standards.

2.3.2 Workforce

N/A.

2.3.3 Financial

The production and review of year-end assurance statements are a key part of the financial year-end process.

2.3.4 Risk Assessment/Management

The identification and management of risk is an important factor in providing appropriate assurance to the NHS Board.

2.3.5 Equality and Human Rights, including children's rights, 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. Detail is provided in each of the separate statements, however, where equality-related issues have been considered by each group as part of their annual business.

2.3.6 Climate Emergency & Sustainability Impact

No direct impact from this paper, but a number of the assurance statements detail how the respective groups are working to achieve this in their areas of work.

2.3.7 Communication, involvement, engagement and consultation

Each of the Committee's sub-groups have considered and commented on their annual statements of assurance at recent meetings.

2.3.8 Route to the Meeting

Each of the Committee's sub-groups have considered their annual statements of assurance at recent meetings and each are formally approved by the respective Chair.

2.4 Recommendation

The paper is provided for:

- **Assurance** – For Members' awareness and information

3 List of appendices

The following appendices are included with this report:

- Clinical Governance Oversight Group Assurance Statement
- Digital & Information Board Assurance Statement
- Health & Safety Sub-Committee Assurance Statement
- Information Governance & Security Steering Group Assurance Statement
- Resilience Forum Assurance Statement
- IJB Quality & Communities Committee Assurance Statement

Report Contact
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Assistant Director of Corporate Governance & Board Secretary
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DRAFT ANNUAL STATEMENT OF ASSURANCE FOR
NHS FIFE CLINICAL GOVERNANCE OVERSIGHT GROUP
1 April 2024 – 31 March 2025

1. Purpose

1.1 To provide the NHS Fife Clinical Governance Committee with the assurance that the Clinical Governance Oversight Group (CGOG) has fulfilled its remit during 2024/2025 to:

1. To take an overview of the quality and safety of care provided across Fife health systems and how this impacts on patient/user experience and provide assurance to the NHS Fife Clinical Governance Committee and NHS Fife Board.

2. Deliver the aim of the Clinical Governance Strategic Framework; to deliver safe, effective, person-centred care in an organisation which listens, learns and improves. Including overseeing the delivery of the Clinical Governance Strategic Framework and associated annual delivery plan.

3. To ensure the Quality Assurance Reports to the group, Acute Services Division (ASD) and Health and Social Care Partnership (HSCP) reflect key performance indicators of quality, safety and patient experience in line with national requirements and those contained within the NHS Fife Integrated Quality and Performance Report.

4. To maintain an awareness of evolving quality, safety and governance agendas, both internal and external to NHS Fife

5. To oversee and receive regular reports from sub- groups when relating to identified priorities, and from participating groups in national programmes. To ensure learning is identified and shared across the organisation

6. To promote learning and identify key learning points from all areas and ensure these are communicated and embedded where appropriate across primary, secondary, and the Health and Social Care Partnership (HSCP)

7. To oversee the development and implementation of local guidance relating to Adverse Events and Duty of Candour including monitoring of performance against agreed measures.

1.2 This assurance statement summarises the key aspects of business covered which evidence delivery of the CGOG's remit. Please note that this assurance statement does not cover all aspects of business covered during 2024/2025.

2. Membership

2.1 During the financial year to 31 March 2025 the membership of the CGOG comprised of:

Name	Roles / Designations
Dr Chris McKenna	Medical Director (Chair)
Janette Keenan	Director of Nursing (Deputy Chair)
Lynn Barker	Director of Nursing HSCP
Dr Sue Blair	Consultant in Occupational Medicine
Norma Beveridge	Director of Nursing for Acute Services Division
Gemma Couser	Associate Director of Quality and Clinical Governance
Pauline Cumming	Risk Manager (retired May 2024)
Fiona Forrest	Acting Director of Pharmacy
Claire Fulton	Lead for Adverse Events
Cathy Gilvear	Quality, Clinical & Care Governance Lead, HSCP
Robyn Gunn	Head of Laboratory Services
Dr Helen Hellewell	Deputy Medical Director, HSCP
Dr Aylene Kelman	Associate Medical Director, HSCP (from February 2025)
Aileen Lawrie	Director of Nursing and Midwifery
Dr Iain MacLeod	Deputy Medical Director, Acute Services Division
Dr Sally McCormack	Associate Medical Director for Emergency Care and Planned Care
Siobhan McIlroy	Head of Patient Experience
Dr John Morrice	Associate Medical Director for Women and Children's Services
Elizabeth Muir	Clinical Effectiveness Manager
Nicola Robertson	Director of Nursing for Corporate
Shirley-Anne Savage	Associate Director for Risk and Professional Standards
Amanda Wong	Director for Allied Healthcare Professionals
Prof Morwenna Wood	Director of Medical Education (until April 2024)
Dr Stephen Fenning	Associate Director for Medical Education (from August 2024)
Dr Andrew Durden	Chief Registrar (from December 2024)
Jane Anderson	General Manager Women, Children and Clinical Services Directorate (Providing General Management representation for Acute Services- from October 2024)
Jillian Torrens	Head of Complex and Critical Care (Providing General Management Representation for the Health and Social Care Partnership from October 2024)
Marie Richmond	Head of Strategic Delivery, Digital and Information (from October 2024)
Dr Gavin Simpson	Clinical Lead for Deteriorating Patients

2.2 CGOG has greatly appreciated the addition of Jane Anderson, Jillian Torrens, Dr Aylene Kelman, Marie Richmond, and Dr Stephen Fenning as members of the group in 2024/2025. It was agreed that the inclusion of General Management representation would strengthen the triumvirate approach to advancing the clinical governance agenda. Furthermore, with the growing importance of digital initiatives closely tied to clinical priorities, having Marie

Richmond's leadership in Digital and Information is a significant step forward. The group was also pleased to welcome a representative for Medical Education. Additionally, the inclusion of Dr. Andrew Durden as a Chief Registrar representative was highly valued. Dr Aylene Kelman joining the group has augmented the HSCP representation at the group.

2.3 The CGOG invites individuals to attend meetings for particular agenda items. Other attendees, deputies and guests are recorded in the individual minutes of each meeting and in Appendix 1 the attendance schedule.

3. Meetings

3.1 The Group met on 6 occasions during the financial 2024/2025, on the undernoted dates:

- 16th April 2024
- 18th June 2024
- 20th August 2024
- 22nd October 2024
- 10th December 2024
- 11th February 2025

The attendance schedule is set out in Appendix 1.

4. Business

4.1 The CGOG workplan facilitated agenda planning to ensure the group fulfilled its role and remit. New and emerging issues were incorporated as required through the agenda planning process. After each meeting, an Assurance Summary was shared with the Clinical Governance Committee, and this added assurance continues to be well received. Efforts to refine the process and clarify the basis for the assurance provided will extend into 2025/2026.

Assurance statements from both the Acute Services Division Clinical Governance Committee and the Health and Social Care Partnership Quality Matters Assurance Group were presented at each meeting.

The summary below evidences activities that demonstrate CGOG's effective delivery of its role and responsibilities in 2024/2025.

Table 1: Table Summarising Evidence of CGOG Activities to Deliver the Role and Remit of CGOG

1.	To take an overview of the quality and safety of care provided across Fife health systems and how this impacts on patient/user experience and provide assurance to the NHS Fife Clinical Governance Committee and NHS Fife Board
1.1	**Patient Experience** CGOG received flashcard reports outlining performance and improvement actions relating to complaints. Updates included: • CGOG was provided with assurance in June 24 of the work undertaken to ensure all complaints waiting over 200 days had been replied to with only 1 over 100 days. • In August 24 a specific update was provided to CGOG on the work being implemented to reduce the significant delays in responding to complaints within the HSCP. • Improvement actions implemented by the Patient Experience Team inlcuded: o New Single Point of Contact (SPOC): Streamlines complaint handling process across Directorates. o Local Resolution Emphasis: Encourages resolving complaints directly to enhance patient satisfaction and reduce workload. o Dashboard Utilisation: Provides clarity on complaint status with further work required. o Promotion and Training: Regular support visits to clinical areas to encourage staff engagement with Care Opinion. o Volunteer Recruitment: Aiming to gather diverse Care Opinion patient stories, particularly from underrepresented groups.
1.2	**Corporate Risk Register** The group continues to focus on risk with the Corporate Risk Register now a standing agenda item. The Group consider the risks aligned to the Clinical Governance Committee for scrutiny and assurance. The Group recognise their role in the review and continuing development of risk content relating to Clinical Quality and Safety. All risks aligned to the CGC have now undergone a deep dive.
2.	Deliver the aim of the Clinical Governance Strategic Framework; to deliver safe, effective, person-centred care in an organisation which listens, learns and improves. Including overseeing the delivery of the Clinical Governance Strategic Framework and associated annual delivery plan.
2.1	**NHS Fife Clinical Governance Strategic Framework Delivery Plan** CGOG received 3 reports during 24/25 on the progress of annual delivery plan for the NHS Fife Clinical Governance Strategic Framework: • Organisational Learning Leadership Group • Development of a Staff Support Pathway • The Deteriorating Patient Programme • Adverse Events Improvement Plan • Development of a Policy and Procedure Framework • Medicines Safety Programme

	• A Focus on Human Factors Training • Replacement of Datix • Implementation of National Early Warning Score 2 (NEWS2) • Refresh of the Clinical Governance Strategic Framework Throughout 2024/2025, the group received regular updates on the overall plan for assurance. In addition, specific workstream updates were presented to enable more detailed scrutiny and, in some cases, to facilitate decision-making.
3.	To ensure the Quality Assurance Reports to the group, Acute Services Division (ASD) and Health and Social Care Partnership (HSCP) reflect key performance indicators of quality, safety and patient experience in line with national requirements and those contained within the NHS Fife Integrated Quality and Performance Report.
3.1	**IPQR** • The assurance reports from the HSCP and ASD included performance data on IPQR quality performance indicators (QPIs) and any escalations. • The IPQR was presented for assurance, with discussions focused on the metrics and governance processes for setting local targets in comparison to national targets. • The group approved a new approach for monitoring QPIs related to Adverse Events. • The group requested that the Stroke Bundle standards be incorporated into the IPQR in December 2024. • The group endorsed the recommended improvement targerts for Mental Health quality performance inidicators (QPIs) that are included in the Integrated Performance and Quality Report (IPQR): o 10% for Ligature and Self Harm; and o 20% for restraint and violence and aggression
3.2	**HSCP Assurance Summary** The assurance summary presented to CGOG at each meeting contained oversight of key clinical governance business including quality performance indicators (QPIs) some of which are contained within the IPQR. Some key matters highlighted to the group included: • The Medication Assisted Treatment (MAT) Standards with CGOG seeking assurance by way of a SBAR to detail how the service is working towards delivering the standard. • NHS Fife HSCP Children's Service's Annual Report which highlighted some of the achievements of the service in 23/24 • The HSCP provided updates on Inspections such as the Mental Welfare Commission (MWC) visit to Daleview (20th June), • HSCP response to the Mental Welfare Commission (MWC) published investigation report in the care and treatment of Mr E, titled "They didn't ask me". • CGOG requested specific detail in relation to the suicide cluster review approach. The group endorsed the proposed approach for the reviews of suicides among patients in Mental Health, Learning Disability, Addiction Services, and Child and Adolescent Mental

	Health Services (CAMHS).
3.3	**ASD Assurance Summary** The ASD assurance summary also included narrative on QPIs within the IPQR. In addition some of the key matters highlighted to CGOG from ASD included: • Progress to complete the actions contained within the action plan further to the Healthcare Improvement Scotland (HIS) Safe Delivery of Care Inspection in the Victoria Hospital between 31 July and 2 August 2023. Assurance was provided to the group in terms of completion of the action plan. • Assurance of delivery of the action plan further to the Fatal Accident Inquiry (FAI) in the orthopaedic services was also provided. The group were pleased to receive confirmation of the appointment of three trainee Advanced Nurse Practitioners to support elective, acute hip fracture and trauma elements of the service. • Mothers and Babies: Reducing the risk through Audits and Confidential Enquiries (MBBRACE) report which provided assurance that the stabilised mortality rates for NHS Fife are similar or lower than other Health Boards and Trusts across the UK. • Improvement work underway to address the time to theatre for patients with a hip fracture as identified in the Scottish National Audit Programme (SNAP). • Risk and concerns escalated in relation to the proposal to transform the East Region Neonatal Service meaning that care for babies born at less than 27 weeks, lighter than 800 grams or who are critically ill will have care provided by Neonatal Intensive Care Units (NICU) under a new networked model at Aberdeen Maternity Unit, (AMU) Edinburgh Royal Infirmary (ERI) and Queen Elizabeth University Hospital (QUEH).”.
3.4	**Medicines Safety** The NHS Fife Medicines Safety Annual Report was presented to the group, outlining the Board's status regarding medication incidents. The group also received assurance about the well-established medicines governance framework, which effectively identifies, responds to, and learns from medication incidents. A multidisciplinary approach to medicines safety is in place, supported by expertise across various professional disciplines.
4.	To maintain an awareness of evolving quality, safety and governance agendas, both internal and external to NHS Fife
4.1	**Medical Devices** CGOG received assurance in response to the evolving regulatory changes for Medical Devices. The definition of medical devices now encompasses a broad range of instruments, apparatus, appliances, software, materials, and other items used in healthcare delivery. In light of the UK's exit from the European Union, changes are being made, and the Medicines and Healthcare products Regulatory Agency (MHRA) has been consulting on extensive revisions to the regulatory framework. The Scottish Government has recently released a Policy Framework for Medical Devices (SGHD/CMO(2024)1). The MHRA is in the process of implementing these changes to the Medical Devices Regulatory Framework,

	which will be rolled out in phases over the coming year. Furthermore, the Scan for Safety Programme will introduce Point of Care (PoC) scanning as part of the rollout of a new Inventory Management System (IMS). This initiative aims to improve patient safety while considering the practical aspects of implementing changes in a Health Board setting. Assurance was provided that a detailed plan will be developed for the Medical Devices Group to address the requirements outlined in the National Framework.
4.2	**Deteriorating Patient Improvement Work** The work of the Deteriorating Patient Group and implementation of the NHS Fife Deteriorating Patient Improvement Plan under Dr Gavin Simpson, Clinical Lead for Deteriorating Patients continued in 24/2. The aim of this work is by March 2025 to reduce the rate of cardiac arrests in Acute Services Division and Health and Social Care Partnership adult inpatients by improved Identification, Communication and Escalation of deteriorating patients in line with SIGN167. Seeking to deliver the following Know the Score process improvements: • 90% Obs on Time • 90% HACP use with DNACPR • 90% Structured Response use with high EWS. This work reported the following updates to CGOG: • Development of a flash card to share outcomes of cardiac arrest reviews with staff and support learning- sets out areas of good practice and areas for improvement further to cardiac arrest reviews • CGOG endorsed a new structure for Deteriorating Patient to oversee the implementation of NEWS2 and the associated improvement work required to deliver • Quarterly reports which have shown early improvements in cardiac arrest survival rates
4.3	**Infected Blood Inquiry** The group received an update on the Infected Blood Inquiry and the response that NHS Fife have provided to the Scottish Government to set out the Hospital Transfusion governance structures and use of tranexamic acid. This work will continue to feature on the workplan for CGOG in 25/26.
5.	To oversee and receive regular reports from sub- groups when relating to identified priorities, and from participating groups in national programmes. To ensure learning is identified and shared across the organisation
5.1	**NHS Fife Policy and Procedures** At each meeting CGOG received an update in relation NHS Fife Policy and Procedures. Assurance was given to the Group in relation to policy and procedures being out of date. Compliance across the year was 99%.. In addition, the group received updates of any new policy or procedures in the pipeline.
5.2	**Minutes and Escalations from Linked Groups** Minutes of Linked Groups noted at each meeting and points for escalation to

	Group raised as appropriate (as set out in the attached workplan) escalations from sub-groups were all acted upon.
5.3	**Child Death Annual Report** The second annual report of the Child Death Oversight Panel was presented in August 2024. Tragically, there were 20 child and young person deaths between January 2023 and March 2024. Due to the small number of deaths, it was noted that detailed learning points could not be shared. It was also highlighted that the development of a multiagency learning event, along with the evolving action plan, would be discussed at the Review of Children & Young Person Governance Meeting.
6.	To promote learning and identify key learning points from all areas and ensure these are communicated and embedded where appropriate across primary, secondary, and the Health and Social Care Partnership (HSCP)
6.1	**Organisational Learning Leadership Group** Organisational Learning Leadership Group provided two updates to the Clinical Governance Oversight Group in 24/25. This work sets out the approach being adopted to build on our capability as a learning organisation. Creating conditions to allow collaborative learning across our full healthcare system is at the core of the approach. This work majors on clinical learning but it is recognised that there could be wider benefit in extending the reach of this work. It is also important to note that this work is intended to augment our current systems of governance and learning - not to replace. The approach uses Myron's Maxims[1], a set of enabling living system principles, combined with the formal organisational requirements of governance, system and process. The Organisational Learning Leadership Group (OLLG) oversees this work and is comprised of a group of self selected leaders who are committed to taking forward this complex and adaptive agenda. For assurance the OLLG delivery plan for 24/25 was presented to the group twice. CGOG endorsed the approach proposed and presenting the work allowed for helpful discussion to inform the approach. The Medical Director has expressed the importance of learning from greatness and success and this will be incorporated into the plan for 25/26.
7.	To oversee the development and implementation of local guidance relating to Adverse Events and Duty of Candour including monitoring of performance against agreed measures
7.1	**Adverse Events Improvement Plan** Regular updates on the Adverse Event Improvement Plan were presented to CGOG over the course of 2024/2025. Key developments that were endorsed over the course of 2024/2025 include: • Launch of new a new adverse event trigger list for major and extreme events which was implemented on 6th January 2024

[1] Myron's Maxims: People own what the help create, real change happens in real work, those who do the work do the change, connect the system to more of itself, start anywhere, follow it everywhere, the process you use to get to the future is the future you get.

	• Supporting this work the group also endorsed changes to the significant adverse event review (SAER) process: o Implementation of processes for major and extreme events within the categories of cardiac arrest reviews, drug and alcohol related deaths, sudden unexplained death in infancy and suicide cluster reviews. o For outcome 4 events (defined as events where a different plan and or delivery of care, on balance of probability, would have been expected to result in a more favourable outcome, i.e. how case was managed had a direct impact on the level of harm) the group endorsed the associated improvement plans being overseen by the SAER Panel, chaired by the Medical Director. This change has improved the assurance and oversight for delivery of improvement actions.
7.2	**Adverse Event Themes and Quality Performance Indicators** The group received regular updates on the themes from adverse events and quality performance indicators (QPIs) associated with adverse events- improvement work to address long waits
7.3	**Staff Support Pathway** The group unanimously supported the Adverse Event Staff Support Pathway. This work recognises the impact that being involved in an adverse event has on our staff and seeks to implement a structured support response by trained individuals. The group noted the importance of supporting staff and the positive cultural impact of this work. Further discussion required with Senior Leadership Teams to embed this work.
7.4	**Duty of Candour Process Review** Work to review the organisational Duty of Candour (DoC) process was approved by the group with further work requested to finalise an updated DoC Procedural Guidance for NHS Fife.
7.5	**Duty of Candour Annual Report 2023/2024** Annually there is a requirement for Health Boards to publish an Annual Duty of Candour (DoC) Report. In February 2025 the 2023/24 Duty of Candour report was presented. There were 28 adverse events requiring DoC with the most common outcome, for 17 patients, being an increase in a person's treatment. The full report is contained within appendix 1. Overall NHS Fife has carried out the procedure in each case. Currently for 2024/25 there are 4 confirmed DoC. It has again been agreed that the full report should be presented January/ February 2026.

5. Self-Assessment

4.1 The group has undertaken a self-assessment of its own effectiveness, utilising a questionnaire. This was completed using Forms (an online portal). 41% of the membership completed the questionnaire. The output of this exercise provided the following key broad feedback that in 2024/2025 the group:

Good Practice to Build on

- Was provided with sufficient membership, authority and resource to perform its role effectively and independently
- Has been provided with sufficient membership, authority and resources to perform its role effectively
- Has a membership comprised of appropriate representatives
- appropriate membership and members are clear on their role
- Were provided with papers in sufficient time prior to the meeting to allow members to effectively consider, scrutinise and challenge the assurances or updates provided
- Had appropriate level of scrutiny and is provided with assurance to ensure clinical governance risks are being managed to an acceptable level
- Receives adequate information and provides appropriate oversight of the implementation of relevant strategies, guidelines, policy directions or instructions

Areas for Development

- Sometimes found the data included in the papers to be excessive and sometimes there isn't sufficient time for discussion of substantive matters. The group has this under review and looking at ways to reduce the content of the meeting while still providing assurance.

The areas for improvement above will be considered in the planning of CGOG for 25/26. The following comments will also be considered:

- Review of flow of assurance to avoid duplication
- Explore ways to disseminate the learning from the group
- How to ensure items at the end of the agenda are given sufficient time in view of time pressures in the meeting

6. Conclusion

5.1 As Chair of the Group during financial year 2024-2025, 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 Group has allowed us to fulfil our remit. As a result of the work undertaken during the year, I can confirm that adequate and effective governance arrangements were in place in the areas under our remit during the year.

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

6.3 I would like to express my gratitude and appreciation to all colleagues, both members and attendees, for their active participation, dedication, and commitment to the group. I also extend my thanks to the staff who have prepared reports and attended meetings.

Signed: Date:

Dr Christopher McKenna, Medical Director, Chair
On behalf of the Clinical Governance Oversight Group

APPENDIX 1

NHS Fife Clinical Governance Oversight Group Attendance Record

1st April 2024 to 31st March 2025

Member	Designation	16th Apr 2024	18th Jun 2024	20th Aug 2024	22nd Oct 2024	10th Dec 2024	11th Feb 2025
Jane Anderson	Interim General Manager, Women & Children's Services				✓	✓	✓
Lynn Barker	Director of Nursing, Health & Social Care Partnership	✓	✓	✓	✓	x	✓
Norma Beveridge	Director of Nursing, Acute Division	✓	x	✓	✓	x	x
Dr Sue Blair	Consultant in Occupational Medicine	x	x	x	x	x	x
Andy Brown	Principal Auditor - Finance	x	x	x	x	x	x
Gemma Couser	Associate Director of Quality & Clinical Governance	✓	✓	✓	x	✓	✓
Pauline Cumming	Risk Manager	✓					
Andy Durden	Chief Registrar, Obstetrics & Gynaecology					✓	X
Stephen Fenning	Consultant in Palliative Care			✓	✓	✓	✓
Fiona Forrest	Director of Pharmacy & Medicines	✓	✓	✓	✓	✓	✓
Claire Fulton	Adverse Events Lead	✓	x	✓	✓	✓	✓
Cathy Gilvear	Quality, Clinical & Care Governance Lead, Health & Social Care Partnership	✓	✓	✓	✓	x	x
Robyn Gunn	Lead Healthcare Scientist	✓	✓	✓	✓	✓	x
Ben Hannan	Director of Pharmacy and Medicines	x	x				
Dr Helen Hellewell	Deputy Medical Director, Health & Social Care Partnership	✓	x	x	✓	✓	x
Janette Keenan	Director of Nursing, Corporate Division	✓	✓	✓	x	✓	x
Aylene Kelman	Associate Medical Director, Health & Social Care Partnership						✓
Aileen Lawrie	Director of Midwifery	✓	✓	✓	x	✓	✓
Dr Sally McCormack	Associate Medical Director for Emergency Care & Planned Care	✓	✓	x	x	x	x
Dr Chris McKenna (Chair)	Medical Director, NHS Fife	✓	✓	✓	✓	✓	✓
Dr Iain MacLeod	Deputy Medical Director, Acute	x	✓	✓	✓	✓	✓
Siobhan Mcilroy	Head of Patient Experience	✓	x	✓	✓	✓	✓
John Morrice	Associate Medical Director for Women and Children's Services	✓	✓	✓	✓	✓	✓
Elizabeth Muir	Clinical Effectiveness Manager	✓	✓	✓	✓	x	✓
Marie Richmond	Head of Digital Strategic Delivery				✓	✓	✓
Nicola Robertson	Director of Nursing, Corporate Division	✓	x	✓	✓	✓	✓
Dr Shirley-Anne Savage	Associate Director for Risk & Professional Standards	✓	✓	✓	x	x	✓
Gavin Simpson	Consultant Anaesthetist	✓	✓	✓	x	✓	✓

Jillian Torrens	Head of Complex & Critical Care				✓	✓	✓
Prof Morwenna Wood	Associate Medical Director for Emergency and Planned Care	✓	x	x	x	x	x
Amanda Wong	Director of Allied Health Professionals	✓	✓	✓	✓	x	✓
In Attendance	**Designation**						
Tom McCarthy	Portfolio Manager	✓					
Susanna Galea-Singer	Clinical Lead, Addiction Services, HSCP	✓					
Rebecca Saunders	Lead Nurse, Children's Services Projects, HSCP		✓				
Susan Fraser	Associate Director of Planning & Performance			✓	✓		
Bryan Archibald	Planning & Performance Manager				✓		
David Moyle	Programme Manager, Digital & Information				✓		
Victoria Robb	Lead Pharmacist, Medicines Safety				✓		
Jennet Getty	Transfusion Practitioner for Fife						✓

ANNUAL STATEMENT OF ASSURANCE FOR NHS FIFE DIGITAL & INFORMATION BOARD

1. Purpose

1.1 To provide the Clinical Governance Committee with an assurance statement, for the financial year 2024-25, that relates to the effectiveness of the Digital & Information Board and its development and monitoring of the Digital & Information Strategy and resulting delivery plan in line with the National Digital Health & Care Strategy, NHS Fife's Population Health and Wellbeing Strategy, the Re-Form, Transform and Perform Framework and to support the delivery of the NHS Fife Annual Delivery Plan.

2. Membership

2.1 During the financial year to 31 March 2025, membership of the Digital & Information Board comprised: -

Members	
Dr Chris McKenna	Medical Director (Chair) (Caldicott Guardian)
Dr John Chalmers	Digital Clinical Lead
Nicky Connor (till August 2024)	Director of Health and Social Care
Lynne Garvey (from August 2024)	Director of Health and Social Care
Claire Dobson	Director of Acute Services
Alistair Graham	Associate Director Digital & Information
Benjamin Hannan (till May 2024)	Director of Pharmacy and Medicines
Fiona Forrest (from May 2024)	Acting Director of Pharmacy and Medicines
Janette Keenan	Director of Nursing
David Miller	Director of Workforce
Sharon Mullan	GP Sub Committee Representative
Margo McGurk	Director of Finance and Strategy (Co-Chair) (SIRO)
Matt Valenti	Partnership Representative
Joy Tomlinson	Director of Public Health
In Attendance	
Charlie Anderson	Head of ICT, Fife Council
Andy Brown	Principal Auditor
Helen Hellewell	Deputy Medical Director for H&SCP
Margaret Guthrie	Head of Information Governance & Security
Torfinn Thorbjornsen	Head of Information Services
Marie Richmond	Head of Digital Strategic Delivery
Amanda Wong	Director of Allied Health Professions
Allan Young	Head of Digital Operations

2.2 The Digital and Information Board may invite individuals to attend meetings for agenda items, but the list of attendees detailed in 2.1 will normally be in attendance at meetings. Other attendees, deputies and guests are recorded in the individual minutes of each meeting and attendance is included in Appendix 1.

2.3 The membership and attendance of the group was sufficient to support the work and oversight necessary. The membership and attendance will be reviewed as part of the group's annual workplan at the May 2025 meeting and remains under general review.

3. Meetings

3.1 The Digital & Information Board met on four occasions during the financial year to 31 March 2025, on the undernoted dates:

- 9 May 2024 (Papers issued 7 May 2024)
- 23 July 2024 (Papers issued 16 July 2024)
- 15 October 2024 (Papers issued 9 October 2024)
- 19 February 2025 (Papers issued 13 February 2025)

3.2 The attendance schedule is attached at Appendix 1.

4. Business

4.1 The Digital and Information (D&I) Board reviewed and commented on the Digital Strategic Update that incorporated elements from NHS Fife's Annual Delivery Plan. The Board recognised their responsibilities to ensure progress is made with delivering the strategic ambition, outlined in the final period NHS Fife's Digital and Information Strategy (2019-2024) and the work undertaken to link these priorities with NHS Fife's Population Health and Wellbeing Strategy and the emerging requirements of the Re-Form, Transform and Perform Framework. Continued prioritisation of activities was considered key by the Board and encouraged through stakeholder discussions.

4.2 In May 2024, the Board was provided an update and presentation on the learning and action plans undertaken following the NHS Dumfries and Galloway Cyber Incident. A timeline and sequence of events was outlined to the Board along with the raising of concerns that delays to necessary communications to all Boards across NHS Scotland to provide relevant information had negatively impacted the Digital and Information teams' ability to take timely action. The presentation outlined the activities taken since being notified and the opportunity for learning and re-prioritisation of existing Cyber Security action plans being undertaken as part of the annual Network and Information Systems (NIS) audit cycle. While the Board took a moderate level of assurance from the update the item was escalated and presented to the November 2024 meeting of the Clinical Governance Committee and the Board encouraged further action on a suitable national communication approach.

4.3 In July 2024, the Board reviewed and approved a revised and documented approach for the management of digital devices and equipment provided to users and services. The approach enhanced the grip and control measures necessary to support a reducing in spending, through the recovery of unused or additional digital equipment and the redistribution of equipment to offset cost spending. The approach also sought to tackle printing costs and the reduction in paper and costs associated with running printers and multi-functional devices. The Board was supportive of the clarity from the improved processes in place.

4.4 In July 2024, as part of the Board's discussion on the requirement to transition to a new Digital Framework, following the end of the period associated with the NHS Fife Digital Strategy (2019-2024). The Board agreed a closure report, for the Digital Strategy, should be presented to the Clinical Governance Committee, along with the development of the plan for a revised Digital Framework.

4.5 In October 2024, the Board was presented with the final review of NHS Fife's Digital Strategy 2019-2024 and provided the structure and reasoning to the development of the Digital Framework, aligned to NHS Fife's Population Health and Wellbeing Strategy. The Board provided direct guidance on the approach to stakeholder engagement and framework development and requested this to be added to the plan for developing the framework. The Board noted that the review of the NHS Fife Digital Strategy had been presented to the September 2024 meeting of the Clinical Governance Committee.

4.6 Also in October 2024, the Board received reports on the progress made through the pilot of the electronic observation monitoring project, that integrated medical devices into Patientrack for two ward areas and the progress being made with the Digital Hub project and the implementation of waiting list validation functionality, allowing our patients to have the option to engage via this digital channel. The Board were supportive of these projects and ongoing communications were key to enabling adoption and further success. The requirement for reallocation of funding to support a wider deployment of electronic observations was noted as a requirement.

4.7 In February 2025, the Board received a further update and initial draft of the revised Digital Framework document. Constructive feedback was received, and the Board recommended the draft make its way to professional leadership groups and SLTs for final engagement prior to presentation to Executive Directors Group (EDG), now Executive Leadership Team.

4.8 Throughout the year, the Board received quarterly updates on Digital and Information performance metric. Through the Board's active enquiry, particular attention was drawn to the Cyber Security scores; progress with the replacement of legacy systems and infrastructure that result in Cyber and Security vulnerability; the progress being made with the introduction of the Windows 11 operating system and the current performance rates for the completion of Scottish Morbidity Reports (SMR), with a request to provide and update to EDG on the factors currently influencing SMR performance rates. Some additional performance measures were requested and added during the year and included compliance with digital policy updates. The Board noted the breadth of activities undertaken and the maintenance of operational performance and improvement, while trying to support improved financial performance.

4.9 The status of the Strategic Delivery Update was presented quarterly to the Board. During the year the Board continued to highlight and support the work associated with key projects that included Digital Medicines, eRostering, Laboratory Information Management System (LIMS) and Electronic Health Record (E.H.R). In some cases, the Board advised the programme team to recommend further project risk mitigation activities, through updates to EDG or to the associated Programme Boards. The Board noted the approach to supplier management and its critical role to successful programme implementation.

4.10 The Board received papers and presentations relating to the revised approach to extending the capability of the Electronic Health Record (EHR). The Board monitored the work of the EHR Steering Group that had been introduced the previous year following the Board's recommendation.

4.11 Supplier Management continued to be a feature of the Board's work as they supported the reprioritisation of the Annual Workplan. Delays in several significant National Programmes (Child Health Systems, eRostering and GP IT Re-provisioning) resulted in a reprofiling of plans and associated financial risk for capital and revenue elements.

4.12 The Board were regularly updated on financial matters, with presentation on budgetary performance for delegated budgets, capital allocation and Scottish Government Strategic Funding. Assurance was taken by the Board from these reports, however, the Board noted the continued escalation of revenue costs associated with supplier behaviour and national governance decisions.

4.13 Throughout the year, the Board assured progress against the Annual Workplan and a review of Terms of Reference and Annual Workplan were conducted to ensure correct and appropriate alignment.

5. Risk Management

5.1 Throughout the year the Board 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 Board saw the complete listing of Digital and Information risk, in a more comprehensive risk report, that mirrored the approach taken with the Information Governance Security Steering Group. Visualisation of the risk profile, that averaged 51 in number in the year, supported the critique and assurance the Board were able to offer.

5.2 In addition, the report provided a reporting format that presented additional analysis on the risk association to agreed tolerance levels. This provided the Board with additional understanding of the risk and allowed them to consider if the management actions would mitigate the risk within a suitable timescale. The risk review associated with the Corporate Risk 17 (Cyber Resilience) was also given additional consideration, prior to the Deep Dive being presented to the Clinical Governance Committee.

5.3 During the period the Board noted that 15 risks had improved their rating, 12 moved to the target risk rating and moved to a status of monitor, and 17 risks were closed, during the period.

6. Other Highlights

6.1 The Board noted the most recent efforts and prioritisation necessary to contribute to the Re-form, Transform and Perform work and the Digital and Information plans to support achievement of financial resilience.

7. Conclusion

7.1 As Chair of the Digital and Information Board, during financial year 2024-25, 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 Digital and Information Board has allowed us to fulfil our remit. As a result of the work undertaken during the year, I can confirm that adequate and effective governance arrangements were in place in the areas under our remit during the year.

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

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

Signed: Date: XX April 2025

Dr Chris McKenna, Chair
Executive Medical Director
On behalf of the Digital and Information Board

Appendix 1 – Attendance Schedule

NHS Fife Digital & Information Board Attendance Record
1st April 2024 to 31st March 2025

	09/05/24	23/07/24	24/10/24	19/02/25
Members				
Dr Chris McKenna	√	√	√	√
Dr John Chalmers	√	x	x	√
Nicky Connor – Only till August 24	x	x		
Lynne Garvey – Only from August 2024.			x	x
Claire Dobson	√	x	x	√
Alistair Graham	√	√	x	√
Benjamin Hannan - only till June 2024	Duncan Wilson Deputising			
Fiona Forrest – from June 2024		√	√	Sally Tyson Deputising
Janette Keenan	x	√	Lynn Barker Deputising	√
David Miller	√	x	x	x
Sharon Mullan	x	x	x	x
Margo McGurk	x	√	x	x
Joy Tomlinson	x	√	√	√
Matt Valenti	√	√	√	√
In attendance				
Charlie Anderson	x	x	x	x
Allan Young	√	√	√	√
Andy Brown	√	√	√	x
Margaret Guthrie	√	√	√	√
Helen Hellewell	x	√	x	x
Marie Richmond	√	√	√	√
Torfinn Thorbjornsen	x	x	x	x
Amanda Wong	√	√	√	√

ANNUAL STATEMENT OF ASSURANCE FOR NHS FIFE HEALTH AND SAFETY SUB-COMMITTEE

1. Purpose

1.1 The purpose of the Health and Safety Sub-Committee is to ensure that the NHS Fife Board provides a safe and secure environment for patients, members of the public and its staff whilst meeting all of its statutory obligations in relation to health and safety.

2. Membership

2.1 During the financial year to 31 March 2025, membership of the Health and Safety Sub-Committee comprised: -

Name	Title
Neil McCormick (Chair)	Director of Property and Asset Management
Claire Dobson	Director of Acute Services
Janette Keenan	Director of Nursing
David Miller	Director of Workforce
Jillian Torrens	Head of Complex and Critical Care, HSCP
Dr Christopher McKenna	Medical Director
Conn Gillespie	Staff Side Representative

2.2 The Health and Safety Sub-Committee may invite individuals to attend meetings for particular agenda items, however, the Health and Safety Manager, Manual Handling Team Lead, Head of Estates and Head of Spiritual Care will normally attend meetings. Other attendees, deputies and guests are recorded in the individual minutes of each meeting.

3. Meetings

3.1 The Health and Safety Sub-Committee met on four occasions during the financial year to 31 March 2025, on the following dates:

- 7 June 2024
- 6 September 2024
- 6 December 2024
- 7 March 2025

The attendance schedule is attached at Appendix 1.

3.2 The Health and Safety Sub-Committee Annual Work Plan 2025-26 is attached at Appendix 2.

4. Business

4.1 <u>Attendance at Health and Safety Meetings</u>

Staff Side representation at Health and Safety Sub-Committee meetings is challenging and has been for some time. David Miller, Director of Workforce has advised that Lynne

Parsons, Employee Director has agreed to attend quarterly meetings in the interim until staff side arrangements are in place.

4.2 Health and Safety Services Team

The Health and Safety Services Team continue to support the Health and Safety Sub-Committee by providing up to date reports and guidance by subject matter experts within the department.

The team comprises:

Health and Safety Manager
Health and Safety Assistant Advisor x 2 posts
Manual Handling Team Lead/Health and Safety Advisor
Manual Handling Co-ordinator
Manual Handling Practitioner x 2 posts
Violence and Aggression Advisor
Violence and Aggression Physical Interventions Trainer (commencing 21/04/25)
Fire Advisors x 2 part-time posts (2 x Fire Advisors recently retired)
Administration support

4.3 Manual Handling

Previous restructuring plans have been implemented and embedded into the organisation. The team have now achieved accreditation from the Scottish Manual Handling Passport with a 93% compliance rate, registering NHS Fife as high compliance.

Retirement plans for the Quality and Training Manager who trains our Support Services staff has led to the further restructure of our current training plans.

The team are actively training Portering staff with resounding success at Victoria Hospital. The team is also in the planning phase with our Support Service Manager colleagues at Queen Margaret Hospital and Stratheden Hospital to have porters commence their training.

The Moving and Handling Policy has been fully rewritten and is available on Stafflink.

4.4 Link Worker

A Health and Safety Manager Teams page with direct live access to the Health and Safety team is now available on Teams. Staff are added to the page following their Health and Safety Manager Training. The main aim and objective of the page is to promote a positive health and safety culture by being a supportive line of communication, advice and guidance as well as advocating and empowering peer on peer support.

Currently, there are 56 managers who are trained from both Acute Services and the Fife Health & Social Care Partnership (HSCP).

4.5 Violence and Aggression

An agreement was reached with the Mental Health Service (HSCP) late in 2024 to take over responsibility for the Physical Intervention Trainer within Mental Health as the post had been filled on a temporary basis from January 2023.

The newly appointed Violence and Aggression Physical Interventions Trainer will start with NHS Fife on 21 April 2025 and comes with a wealth of experience having held a similar post within NHS Tayside. This will help to standardise the techniques used throughout NHS Fife.

4.6 Face Fit Testing

The Health and Safety team continue to provide support on an ad-hoc basis with face fit testing and recognise that requirements for testing need to be kept up-to-date. As a result, the refresher for face fit testing was extended to three years in line with other NHS Boards to allow more time to test staff.

Face Fit Trainer Training Course can be booked through Turas in order for teams to carry out their own face fit testing.

There is also a Face Fit Testing Support Teams channel that is open to those who have completed the tester training.

Investigations are on-going to accurately record who has been tested locally using the Hood method.

5. Risk Management

5.1 Health and Safety Enforcement Activity

There has been no Health and Safety Enforcement activity this year.

5.2 Sharps

The Sharps Strategy Group was disbanded and sharp incidents now form part of the incident reports provided to various committees and Local Partnership Forums.

These are also highlighted in any RIDDOR reporting as a result of any injuries sustained.

Sharps Audits, carried out by the Health and Safety team, continue throughout NHS Fife.

The Sharps Review Update remains a standard agenda item on the Health and Safety Sub-Committee agenda.

Sharps information and policy guidance is available for staff to access on Blink.

5.3 Reinforced Aerated Autoclaved Concrete (RAAC)

There has been no further degradation of the previously identified RAAC, 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.

The Scottish Government continue to issue guidance in support of NHS Fife actions.

6. Other Highlights

6.1 Mental Health Ligature Programme Board

The Mental Health Ligature Programme Board has been meeting to minimise risk and mitigate the likelihood and impact of ligature risk. The minutes of these meetings will be reviewed by the Health and Safety Sub-Committee going forward.

7. Conclusion

7.1 As Chair of the Health and Safety Sub-Committee during financial year 2024-25, 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 Health and Safety Sub-Committee has allowed us to fulfil our remit. As a result of the work undertaken during the year, I can confirm that adequate and effective governance arrangements were in place in the areas under our remit during the year.

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

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

7.4 Regular reports to the Staff Governance Committee and Area Partnership Forum have been extremely helpful in terms of Board and employee awareness.

Signed:  Date: 08 April 2025

Director of Property and Asset Management, Chair
On behalf of the Health and Safety Sub-Committee

APPENDIX 1

NHS Fife Health and Safety Sub-Committee Attendance Record
1 April 2024 to 31 March 2025

	7 June 2024	6 Sept 2024	6 Dec 2024	7 Mar 2025
Members				
Neil McCormick	✓	✓	✓	✓
Claire Dobson	x	✓	x	x
Janette Keenan	✓	x	✓	✓
David Miller	✓	✓	✓	✓
Jillian Torrens	x	x	x	✓
Dr Christopher McKenna	x	✓	✓	x
Conn Gillespie	x	x	x	x
In attendance				
Lynn Parsons	x	✓	x	x
Nicola Robertson	x	✓	x	x
Billy Nixon	✓	✓	✓	✓
Ann-Marie Marshall	✓	x	✓	✓
Paul Bishop	✓	x	✓	x
Ian Campbell	x	x	x	x
Andrea Barker	✓	✓	✓	x

APPENDIX 2

HEALTH AND SAFETY SUB-COMMITTEE
Annual Work Plan 2025-26

Meetings Scheduled: Quarterly

Standing Items	
Business	**Lead**
Welcome and Apologies	Chair
Minutes of Previous Meeting / Matters Arising	Chair
Governance Arrangements	Chair
Operational Updates - Health & Safety Incident Report - Reinforced Autoclaved Aerated Concrete (RAAC) Update (verbal) - Fire Prevention - Estate Improvements - Sharps Review Update (verbal)	 H&S Manager NMcC H&S Manager H&S Manager
NHS Fife Enforcement Activity	H&S Manager
Policies & Procedures	H&S Manager
Performance - ASD&CD H&S Committee Update - Minutes for noting - HSCP H&S Assurance Group Update - Minutes for noting - HSCP Ligature Programme Board Update - Minutes for noting	 H&S Manager Head of Complex Critical Care Service Fife HSCP Head of Complex Critical Care Service Fife HSCP
Any Other Business	All

6 June 2025 Meeting		
Business	**Lead**	**Purpose**
Incidents Exception Report (Mar - May 25)	H&S Manager	Update
Face Fit Testing Audits (testers / supplies / current staff with valid certificates / training need)	H&S Manager	Update
SHTM 80 Compliance Update	H&S Manager	Update
Procurement concerns relating to lack of consultation which can affect policies and equipment	H&S Team	Clarification

APPENDIX 2

5 December 2025 Meeting		
Business	**Lead**	**Purpose**
Incidents Exception Report (Sept - Nov 25)	H&S Manager	Update
DSEAR Policy GP/E8-8	H&S Manager	Update
FloJac Update - Manual Handling	MH Lead	Update
Lone Working Audit Update	H&S Team	Update
COSHH Audit	H&S Team	Update

6 March 2026 Meeting		
Business	**Lead**	**Purpose**
Incidents Exception Report (Dec - Feb 26)	H&S Manager	Update
Control of Vibration at Work Policy	H&S Manager	Update
Right Care for You - Manual Handling	MH Lead	Update
First Aid at Work Procedure	H&S Manager	Update
COSHH / DSE Online Training Package	H&S Manager	Update

ANNUAL STATEMENT OF ASSURANCE FOR NHS FIFE INFORMANCE GOVERNANCE & SECURITY STEERING GROUP

1. Purpose

1.1 To provide the Clinical Governance Committee with an assurance statement, for the financial year 2024-25, that relates to the effectiveness of the structures, policies and practice in place to ensure the confidentiality, availability and integrity of the information processed by or on behalf of NHS Fife, including patient records and all corporate records which are pertinent to regulations, and to enable the ethical and safe use of them for the benefit of individual patients and the public good.

2. Membership

2.1 During the financial year to 31 March 2025, membership of the Information Governance and Security Steering Group comprised:

Members	Designation
Margo McGurk	**Chair/Senior Information Risk Owner** (SIRO) - Director of Finance and Strategy/Deputy Chief Executive
Nicky Connor (till August 2024)	Director of Health and Social Care
Lynne Garvey (from August 2024)	Director of Health and Social Care
Claire Dobson	Director of Acute Services
Susan Fraser	Associate Director of Planning & Performance
Alistair Graham	Director of Digital & Information
Benjamin Hannan (till May 2024)	Director of Pharmacy and Medicines
Fiona Forrest (from May 2024)	Acting Director of Pharmacy and Medicines
Helen Hellewell	Associate Medical Director, Health & Social Care Partnership
Janette Keenan	Director of Nursing
David Miller	Director of Workforce
Sharon Mullan	General Practitioner
Dr Chris McKenna	**Vice Chair** - Medical Director and Caldicott Guardian
Frances Quirk	Associate Director, Research, Innovation and Knowledge
Dr Joy Tomlinson	Director of Public Health
Margaret Guthrie	Head of Information Governance & Security / Data Protection Officer
In Attendance	
Andy Brown	Principal Auditor, Internal Audit
Gillian MacIntosh	Head of Corporate Governance & Board Secretary
Kirsty MacGregor	Associate Director of Communications
Allan Young	Head of Digital Operations

2.2 The Information Governance & Security (IG&S) Steering Group invited individuals to attend meetings for agenda items and the list of attendees detailed in 2.1 have been in regular attendance at meetings. Other attendees, deputies and guests have been recorded in the individual minutes of each meeting.

2.3 The membership and attendance of the Group was sufficient to support the work and oversight necessary. The membership and attendance will be reviewed as part of the

Group's Terms of Reference review at the May 2025 meeting and remains under annual review.

3. Meetings

3.1 The Information Governance & Security Steering Group met on three occasions during the financial year to 31 March 2024, on the undernoted dates:

- 16 April 2024 (Papers issued 12 April 2024. Additional items issued 15 April 2024)
- 17 July 2024 (Papers issued 16 July 2024)
- 22 October 2024 (Papers issued 21 October 2024)
- 29 January 2025 (Papers issued 27 January 2025)

3.2 The attendance schedule is attached at Appendix 1.

4. Business

4.1 The Information Governance & Security Steering Group reviewed and commented on the annual activity plan that was presented to the Group. The Group recognised the responsibilities across the ten categories outlined in the Information Governance and Security Accountability and Assurance Framework. These 10 categories are:-

- Leadership and Oversight
- Policies and Procedures
- Training and Awareness
- Individual's Rights
- Transparency
- Records of processing on a lawful basis
- Contracts and data sharing
- Risks and Data Protection Impact Assessments (DPIA)
- Records Management and Security
- Breach Response and monitoring

The Group discussed and considered the priorities outlined and had an informed view, being able to review these alongside associated risks. Priorities were amended where necessary.

4.2 In May 2024, the Steering Group reviewed a report relating to the incident associated with St Andrews Community Hospital. The Steering Group noted the work associated with the related actions and learning from the incident. It was also confirmed the incident severity matched the requirement for inclusion in Fife NHS Board annual report. A further report was provided to the July 2024 meeting of the Steering Group, confirming that the incident had concluded according to the Information Commissioners Office. (ICO). The Steering Group requested that an update be provided to the Clinical Governance Committee, which was presented to the September 2024 meeting.

4.3 Starting in May 2024, and continuing throughout the year, the Steering Group responded to and supported the security risk assessment associated with the review of Policy GP/E7 - Non NHS Equipment Policy. Updates to the application and access risk assessments were provided quarterly and the Steering Group requested additional information be provided in order for decisions associated with the use of personal devices can be made. The final report is planned to be presented to the May 2025 meeting.

4.4 In May 2024 and July 2024, the Steering group received updates on the work associated with the Records Management Project. The particular focus of that work was aligned to support the Re-form, Transform and Perform Infrastructure programme and the records management approach was providing support to services relocating from Hayfield House and Stratheden Hospital to ensure secure transfer and storage of appropriate records. Impact to physical storage areas was also noted.

4.5 In October 2024, the meeting received a report outlining the progress made with the Network and Information System (NIS) audit cycle. The report outlined the improvement to 93% total compliance, an increase of 16% from the 2023 report. The report noted the areas of improvement and outlined areas of focus for the coming year to be included in the Accountability Assurance Framework. The Steering Group also recognised that despite the improvement, it is key the organisations remains vigilant and continue the work undertaken, in order to keep systems and data safe.

4.6 In January 2025, the Steering Group received updates on emerging risks associated with the GP IT system supplier administration process and the improvement work identified as necessary for the Community Electronic Patient Records System, Morse. Both items identified the level of risk associated and the Steering Group identified and agreed additional risk mitigations and communication activity for the digital and information teams to undertake.

4.7 Throughout the year the Steering Group received and noted the inclusion of Key Performance Indicators and measurements associated with the ten categories. The key measures made available 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 FOI performance; current policy and procedure review information; Cyber Resilience Framework compliance at time of audit; monthly event reporting; and summary information on reportable incidents to Information Commissioner's Office/Competent Authority. During the October 2024 meeting, the Steering Group received a detailed update on Key Performance Indicators and associated data availability.

The key measures are included in Appendix 2 to this report.

4.8. During the year, the Steering Group received quarterly updates to the Information Governance and Security Accountability and Assurance Framework. The framework includes the prioritisation of the action plan, and the Steering Group remained active and supporting to ensure appropriate progress with improvement activities. The group supported the recommendations made by the Head of Information Governance and Security to prioritise the ongoing development of the Information Asset Register, the continued implementation of our Records Management Project, review of existing and development of new policies and procedures, the approach to improvement training and education updates, and improved incident reporting arrangements.

4.9 Specific updates on the progress with the development of the Information Asset Register (IAR) were considered by the Group. The Group supported the consideration and a practical approach to the development of the IAR, while recognising the operational challenges to provide time and support to the necessary responses at a Directorate level. This item also presented to the Executive Directors Group in June 2024.

4.10 The Group took further assurance from the completion of the two Assurance Reports, provided to the Clinical Governance Committee (CGC). The reports were considered at the September 2024 and March 2025 meetings of the CGC.

4.11 The Group undertook, as scheduled, its annual review of Terms of Reference and update to the Annual Workplan

5. Risk Management

5.1 Throughout the year the 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 risk, in a more comprehensive risk report, that mirrored the approach taken with the Digital and Information Board. Visualisation of the risk profile, that averaged 51 in number in the year, supported the critique and assurance the Board were able to offer.

5.2 In addition, the report provided a reporting format that presented additional analysis on the risk association to agreed tolerance levels. This provided the Board with additional understanding of the risk and allowed them to consider if the management actions would mitigate the risk within a suitable timescale.

5.3 During the period the Board noted that 15 risks had improved their rating, 12 moved to the target risk rating and moved to a status of monitor, and 17 risks were closed, during the period.

6. Other Highlights

6.1 Through the year, 15 incidents were reported to the ICO, an increase of 3 from the 12 incidents reported the previous year. Of the 15, 13 (86.6%) were reported within the 72-hour requirement. Of the 15 incidents, 7 have been confirmed not to require any further follow up and 8 remain to be confirmed.

6.2 The Steering Group also noted the nomination and shortlisting to finalist of the Records Management team, who had been nominated multiple times for the NHS Fife Star awards.

7. Conclusion

7.1 As Deputy Chair of the Information Governance & Security Steering Group during Financial Year 2024-25, 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 Information Governance & Security Steering Group has allowed us to fulfil our remit. As a result of the work undertaken during the year, I can confirm that adequate and effective governance arrangements were in place in the areas under our remit during the year.

7.2 I would pay tribute to the dedication and commitment of fellow members of the Information Governance & Security Steering Group and to all attendees. I would thank all those members of staff who have prepared reports and attended meetings.

Signed: Date: xx April 2025

Dr Chris McKenna, Chair
Executive Medical Director
On behalf of the Information Governance & Security Steering Group

Appendix 1 – Attendance Schedule

Appendix 2 – IG&S Performance Summary

APPENDIX 1

NHS Fife Information Governance & Security Steering Group Attendance Record
1 April 2024 to 31 March 2025

	16/04/24	17/07/24	22/10/24	29/01/25
Members				
Margo McGurk	√	√	√	√
Nicky Connor	Audrey Valente Deputising	Audrey Valente Deputising		
Lynne Garvey – Only from August 2024.			x	Avril Sweeney Deputising
Claire Dobson	x	x	x	x
Susan Fraser	√	√	√	√
Alistair Graham	√	√	√	√
Benjamin Hannan - only till June 2024	√			
Fiona Forrest – from June 2024		x	x	x
Helen Hellewell	x	√	√	x
Janette Keenan	√	√	Nicola Robertson Deputising	x
David Miller	√	√	√	x
Sharon Mullan	x	x	X	x
Dr Chris McKenna	√	x		x
Frances Quirk	√	√	√	√
Dr Joy Tomlinson	√	√	√	x
Margaret Guthrie	√	√	Michelle Campbell Deputising	Michelle Campbell Deputising
In attendance				
Andy Brown	√	√	x	√
Kirsty MacGregor	√	√	x	√
Gillian MacIntosh	√	√	√	x
Allan Young	√	√	√	√

	Information Governance & Security Performance Summary	Target	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Operational Performance	Cyber Security - Exposure Score*	< 25	45	65	62	25	30	34	35	16	40	49
	FOI's - Responses within target	85%	83.3%	85.9%	84.8%	88.7%	96.3%	89.1%	88.5%	85.3%	77.9%	93%
	Number of SARs Received		241	243	204	198	213	201	210	195	164	
	SARs Received (% responded to timeously)	100%	89.9%	94%	94.2%	93.6%	87.8%	94.8%	88.8%	91.3%	86.6%	
	Information Governance Incidents	Avg 97	106	114	90	81	85	114	99	114	95	131
	Incidents Reported to ICO or CA		1	0	2	0	1	0	1	1	0	3
	Incidents Reported within 72 Hours		0		1		1	n/a	1	1	n/a	3
	Active Follow up required by ICO		0		0		0	n/a	0	0	n/a	2
	Mandatory Training Renewal **	80%		62%				65%				
	Annual Measures		**2020**	**2021**	**2022**	**2023**	**2024**					
	NISD Compliance Status		53%	69%	76%	87%						
	NISD Risk Exposure		13%	8%	3%							
	NISD Controls Completed		53%	58%	64%		88%					
	Public Sector Cyber Resileince Compliance					77%	93%					

		NIS / GDPR Reportable	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Technical Incidents	1. Negligible Incidents	N	3429	3215	2626	3172	3328	2910	2933	2844	2316	2973
	2. Minor Incidents	N	3		2	2	2	5				4
	3. Moderate Incidents	Y				1	1		2		1	
	4. Major Incidents	Y										
	5. Extreme Incidents	Y										

* - Scored out of 100; Low 0-29, Med 30-69, High 70-100

**- Source EDG Training Compliance Report

ANNUAL STATEMENT OF ASSURANCE FOR NHS FIFE RESILIENCE FORUM

1. Purpose

1.1 This statement provides assurance to the Clinical Governance Committee in relation to the work of the Resilience Forum in support of Emergency Preparedness, Resilience and Response for the financial year 1st April 2024 - 31st March 2025. The Resilience Forum has supported NHS Fife to meet the obligations within national legislation and the requirements set out in the NHS Scotland Resilience Standards.

1.2 NHS Fife has statutory duties with partners to provide Category 1 response under the Civil Contingencies Act 2004. This places additional duties on our organisation to support the assessment of risks (of different types of emergency and their impacts) including;

- Maintaining emergency response plans.
- Business continuity planning & the promotion of business continuity planning ensuring organisational response preparedness.
- Co-operation with multiagency responders.
- Communicating with the public & NHS Fife's workforce.
- The provision of information, instruction & training support for employees in relation to civil contingencies planning & preparedness.
- NHS Fife (as a public service organisation) being able to evidence resilience assurance to its statutory & moral obligations.
- Alignment with Integrated Joint Board partners to category 1 response & business continuity planning.
- Providing the conduit for National NHS Counter-terrorism (CONTEST) strategy support.

1.3 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.

1.4 The remit of the Resilience Forum covers the same areas of responsibility as reported last year, including:

- Strategic oversight of the resilience function for NHS Fife in line with the Civil Contingencies Act 2004 and relevant national guidance;
- Providing assurance to NHS Fife Board and Fife Health and Social Care Partnership (HSCP) on the NHS Scotland Standards for Organisational Resilience;
- To have assurance that local plans/arrangements in the event of an emergency and/or Business Continuity situation are reviewed and exercised regularly;
- To provide a link between NHS Fife, Fife HSCP and Local and Regional Resilience Partnerships and the Joint Health Protection Plan;
- To receive actions from meetings of Resilience groups within NHS Fife Acute Services Division and the Fife HSCP Resilience Group;
- To confirm that lessons learned from incidents related to resilience from incidents are communicated to partners where appropriate.

2. Membership

2.1 During the financial year to 31 March 2025, the Resilience Forum was chaired by Dr Joy Tomlinson, Director of Public Health. The lead officer supporting this group is Susan Cameron, Head of Resilience. Membership includes resilience leads from Acute and H&SCP, communications, sustainability, planning, and external partners in particular Scottish Ambulance Service. Full membership and attendees are listed in **Appendix 1**.

2.2 The Resilience Forum may invite individuals to attend meetings for particular agenda items, but the list of routine members in 2.1 will normally be in attendance at meetings. Other attendees, deputies and guests are recorded in the individual minutes of each meeting.

2.3 The group is quorate when 50% of the membership are present, one of which should be an NHS Fife senior executive (i.e. the Director of Public Health or the Vice Chair, the Director of Acute Services, Director of Nursing or the Director of Property and Asset Management).

2.4 NHS Fife's Business Continuity Management systems dashboard provides a governance & assurance report on the live position with business continuity planning compliance across directorates and operational areas of NHS Fife. Business continuity arrangements strengthen NHS Fife's response ability to prevent disruption to services, manage disruptive incidents and respond to internal & external emergencies (including major incidents). The resilience team offer tailored support to managers with business impact assessments needed to facilitate resilience in operational planning.

3. Meetings

3.1 The NHS Fife Resilience Forum met on four occasions during the financial year to 31 March 2025, on the undernoted dates:

Date	Month	Year
13	June	2024
18	September	2024
17	December	2024
20	March	2025

Emergency Preparedness Resilience & Response (EPRR) reports were presented across 2024/25 with a themed approach as follows:

Quarter 1: EPRR Risk Profile.
Quarter 2: EPRR Education, Training & Exercising.
Quarter 3: Emergency Planning.
Quarter 4: Business Continuity.

Reports are created in partnership with Fife HSCP and Digital resilience colleagues for whole systems insight.

3.2 **Communication, involvement, engagement and consultation**

Internally NHS Fife's quarterly resilience workforce briefing newsletter supports service area awareness to framework documents for workforce awareness. Externally NHS

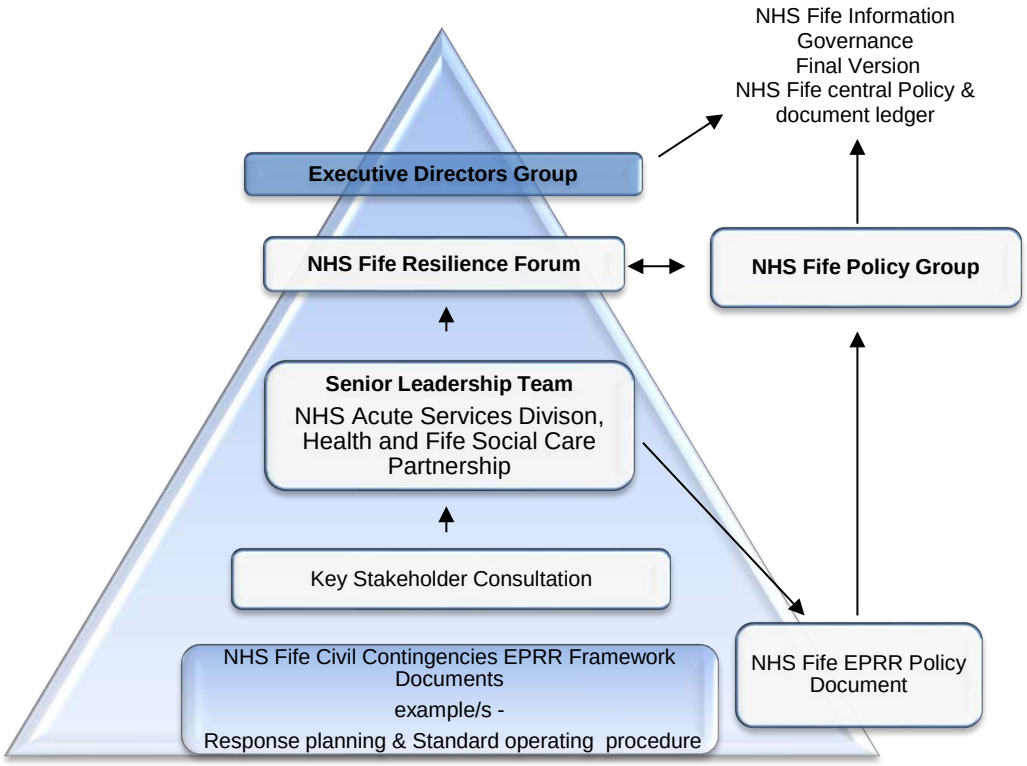
Fife Resilience function supports partner agencies' response planning in collaboration with the East Region Local Resilience Partnership and East of Scotland Resilience Response Partners.

NHS Fife's Resilience Forum scrutinised and approved reports for presentation to EDG on the following dates:

EPRR Quarter Report	Date of Meeting	Key Framework Documents
1	13 March 2024	CBRN/Hazmat Framework 2024-25 EPRR Training Plan
2	13 June 2024	Bomb Threat & Suspicious Package Framework Document LRP Power Outage plan (Resilience Direct) NHS Fife' s Business Continuity Policy
3	18 September 2024	Operation CONSORT [Police Scotland VVIP healthcare contacts planning] Commenced review: Standard Operating Procedures on contaminated waste [Hazmat/CBRN]
4	17 December 2024	Major Incident Response Plan NHS Fife's Business Continuity Policy

The Resilience Forum was assured that engagement had taken place with the following groups prior to receiving papers.

Governance process for all EPRR documents is a follows:



4. Business

4.1 An assurance process is established by means of a quarterly report, reviewed, and commented on by the Resilience Forum and considered by the Executive Directors' Group. Each report provides an overview of internal and external resilience activities supported by the resilience colleagues in Digital Health and within Fife HSCP who enable the collation of assurance metrics and resilience planning activity for Business Continuity Management Systems planning.

The Resilience Forum provides a key link regionally with membership including partner agencies covering Category 1 joint emergency response planning, testing & exercising. The Forum provides an opportunity for joint learning and awareness.

4.2 **Emergency Response Planning**

A key role of the Resilience Forum is in supporting emergency response planning. The Incident Management Framework, ratified in 2023, has a number of supporting planning frameworks all of which have been reviewed and supported through the Forum. The Incident Management Framework is undergoing review, and this has been undertaken reflecting the reporting structures of NHS Fife, and provides a common approach for internal escalation with any disruptive events (critical>Major Incident). The resilience team are working closely with key stakeholders to further develop associated guidance for NHS Fife as listed below;

NHS Fife Guidance	Date Approved / Progress
NHS Fife: Incident Management Framework	27/6/2023 - review in progress
Business Continuity Management Systems	18/1/2024
Business Continuity Policy	- review in progress

Buildings Lockdown Framework	18/1/2024
Severe Weather Framework	1/8/2024
CBRN/HAZMAT [Standard Operating procedures]	17/12/2024
NHS Fife Bomb Threat /Suspicious Item Response Plan [including buildings evacuation]	1/2/2024
East of Scotland Regional Resilience Scientific & Technical Advice Cell	26/1/2023
Missing Patients Procedure	19/06/2024

4.3 Business Continuity Management Systems

Following the launch of Business Continuity Management Systems, monthly summary forecasting reports are also provided to plan owners. The quarterly Emergency Planning Preparedness Resilience reports include a regular update on business continuity planning. These reports ensure a whole systems overview is provided to the Resilience Forum & Executive Directors' Group for governance & assurance.

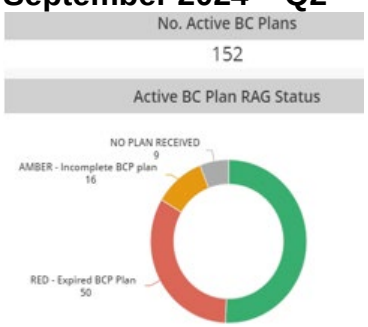
The number of active BC plans is currently 153 services areas across NHS Fife & Fife Health and Social Care Partnership. Current status in chart below: to note plan expiry daily is a fluid position. Supportive contact is ongoing where up to date business continuity plans have not been received by resilience.

Dashboard Extracts Q1-4

June 2024 – Q1

149 Active BCPs
83 Green Completed (+8)
42 Red Expired Plan (-2)
10 Amber Incomplete BCP (+9)
14 Areas no plans submitted (-11)

September 2024 – Q2

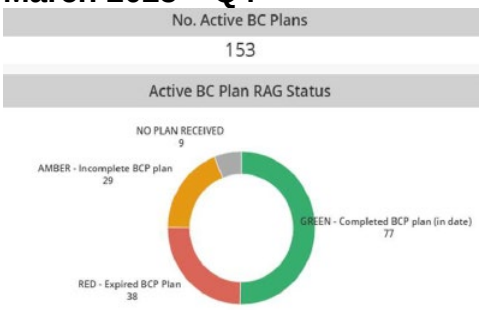


152 Active BCPs (+3)
77 Green Completed (-6)
50 Red Expired Plan (+8)
16 Amber Incomplete BCP (+6)
9 Areas no plans submitted (-5)

December 2024 – Q3

153 Active BCPs (+1)
72 Green Completed (-5)
58 Red Expired Plan (+8)
14 Amber Incomplete BCP (-2)
9 Areas no plans submitted

March 2025 – Q4



153 Active BCPs
77 Green Completed (-6)
38 Red Expired Plan (-20)
29 Amber Incomplete BCP (+15)
9 Areas no plans submitted

4.4 Testing, Training and Exercise [Live, or simulated live exercises]

4.4.1 CBRN/HAZMAT Exercise Night Star

Exercise Night star took place at the Simulation Suite in Queen Margaret Hospital with emergency department staff in alignment with NHS Fife's requirement to undertake an annual HAZMAT/CBRN exercise. This scenario focused on an ambulance arrival & the specialist management of a casualty suffering suspected fractures & significant radiological exposure.

The Office of Nuclear Radiation took significant learning to the protracted NHS impacts where a casualty requiring diagnostics internally needs to be moved around within the hospital setting & secondary exposure impacts/risks. The Office of Nuclear Radiation and NHS Fife's Radiation Protection Advisor shared learning with Strathclyde University Radiation Protection Advisor network in November 2024.

4.4.2 Exercise SAFE HANDS 3

In April 2024 NHS Scotland conducted a national Exercise to test the Major Incident with Mass Casualties National Planning. This was followed by an NHS Scotland Recovery Symposium following written feedback from all Health Boards who took part. A Post-Exercise Report analysis has been compiled which presents a number of recommendations to casualty distribution & data sharing. The national major incident mass casualties plan is identified to be reviewed and updated in alignment with the new NHSS National Incident Response Levels.

4.4.3 Exercise Black Guard

Exercise Black Guard (formerly 'Clearwater Forth') took place live at the Marine Emergency Centre (MEC) Grangemouth with a table top at Kirkcaldy Town House on 17th September 2024. The exercise tested the response to pollution incidents in the Forth, and was linked to the review of the Fife Council Pollution Contingency Plan. Multi-Agency partners from all responding organisations were in attendance.

4.4.4 **Suspected Drug Related Mass Casualties Exercise**

On 26 August 2024, the resilience team supported Public Health with the planning and delivery of a local multiagency interoperability exercise involving synthetic opiates. The exercise scenario involved suspected drug related mass casualty presentations. The symposium was aimed to share awareness and discuss the effectiveness of existing contingency and escalation plans and procedures in responding to a sudden increase in drug-related deaths & increase in drug related presentations via emergency services in interoperability in NHS Fife.

4.4.5 **Scottish Ambulance (SAS) Emergency Communications Tests**

SAS has undertaken quarterly emergency response interoperability communications tests with the emergency department at Victoria Hospital Kirkcaldy. These tests cover METHANE [M – Major incident. E – Exact location. T – Type of incident. H – Hazards. A – Access. N- Number Casualties. E- Emergency services]. The M/ETHANE model is an established reporting framework which provides a common structure for responders and their control rooms to share incident information, NHS Fife gains reports from SAS that enable us to monitor understanding for initial Major Incident Communication.

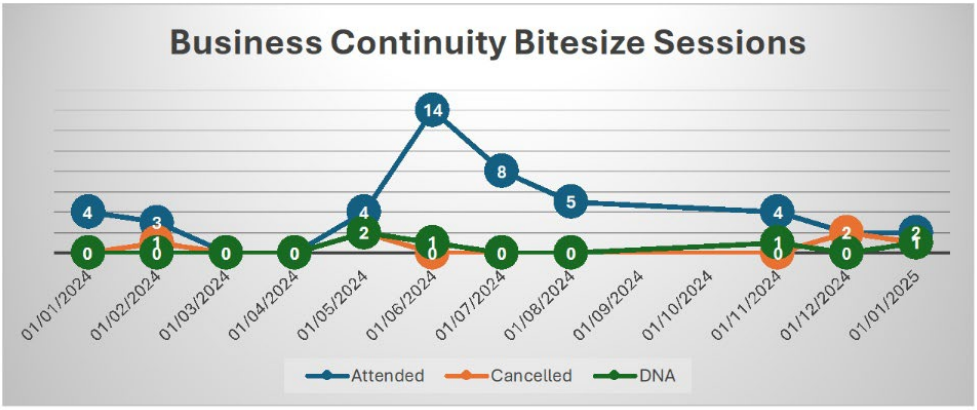
4.4.6 **Business Continuity Exercises**

Planning cannot be considered reliable until it is exercised and proven to be workable, especially since false confidence may undermine effectiveness of any written plans.

Service Area	**Date**	Testing, Training and Exercise
Children's Orthotic Unit	09/05/24	To review plan dated 2020, forward updated and assured plan to Resilience Team on completion
Ward 51 – Gen Med/Infect Disease	07/05/24	1:1 support given, now working on completion of BIA
Ward 32 - Medicine of the Elderly	03/07/24	1:1 support given, plan now up to date
Day Intervention Unit	30/09/24	1:1 support given, plan now up to date
Infection Prevention and Control Team (IPCT)	16/07/24	1:1 support given, plan now up to date
Head & Neck Cancer Nursing Team QMH Outpatient	18/06/24	1:1 support given, plan now up to date
Community Nursing	11/09/24	1:1 support given, now working on completion of BIA
Urology Diagnostic & Treatment Centre	12/09/24	1:1 support given, now working on completion of BIA
Quality and Clinical Governance	16/09/24	1:1 support given BIA now being refined
Regional Endoscopy Unit QMH	05/11/24	1:1 support given, plan now up to date
Ward 5 (ENT)	20/11/24	1:1 support given, now working on completion of BIA
Ward 53	22/01/25	1:1 support given BIA now being refined
Facilities – Laundry Services	29/01/25	1:1 support, BIA now being refined with BCP next to be compiled – will become part of Estates & Facilities sub-plans

4.4.7 **Business Continuity Bite size Sessions 2024-25**

Business continuity training for managers is provided by NHS Fife. To promote confidence in business continuity planning locally the resilience team continue to facilitate support with local update sessions. Uptake is monitored over the year and presented to the Resilience Forum. Activity is detailed in the table below.



Total: Attended – 46. Cancelled – 6. DNA - 5

4.5 NHS Fife EPRR Training Programmes 2024/2025

Across 2024-25 the resilience team have introduced an EPRR training programme that covers both statutory and non-statutory training needs [as outlined in the Civil Contingencies Act (CCA 2004) & Preparing Scotland Guidance for NHS Health Boards core standards]. Planning is focused to internal training for NHS Fife, but also recognises the ongoing training and exercising with multi-agency partners in meeting the statutory responsibilities set out within CCA 2004. Training planning for 2025-2026 is in progress.

The resilience team training links are accessible for all individuals that might have to respond to incidents should be properly prepared, including having clarity of roles and responsibilities, specific and generic plans, and rehearsing arrangements periodically. The training programme planning will be an annual process to ensure skills are maintained; training is a fundamental element of embedding resilience within organisations as part of the annual cycle of emergency planning.

4.5.1 **Introduction of Hospital Major Incident Medical Management (HMIMMS)**

NHS Fife became centre accredited on the 2 December 2024 with the Advanced Life Support Group (ALSG) to provide HMIMMS training locally. HMIMMS is designed to support internal training for all staff in Hospital Major Incident Response. The training programme is intended to improve outcomes for people in life-threatening situations, anywhere along the healthcare pathway. Those involved in major incident response gain an understanding to the seven principles encapsulated in Command & Control, Safety, Communication, Assessment, Triage, Treatment, and Transport for successfully navigating major incident response. HMIMMS is clinically led by NHS Fife's Emergency Department Lead consultant.

4.5.2 **Police Incident Officer Training**

NHS Fife Emergency Planning Officers participate as part of multiagency education at the Police College, Kincardine; this involves presenting and scenario-based training for Police Incident Officers. Emergency planning officers provide an overview to the role of the NHS in the management of Major Incidents and emergencies to support national Police Incident Officer Education. This has been delivered four times since April 2024.

5. CONTEST [Counter-Terrorism Strategy: *Prevent, Pursue, Protect & Prepare*]

5.1 ***Prevent***

Reporting to the Forum is incorporated within established quarterly updates which are scrutinised and then tabled for consideration with the Executive Directors' Group. Prevent Duty Guidance for Scotland became statutory for all Health and Healthcare workforce on 19 August 2024 [Prevent duty guidance].

There is currently no Scottish Government requirement to report metrics for staff completing any of the Home Office Prevent Modules or the Prevent Awareness Briefs enacted by the Resilience Team. The Resilience team are however carrying out internal work to ensure up to date training is linked for NHS Fife within TURAS, this will allow monitoring of compliance with the now mandated Prevent biennial training.

5.2 ***Prepare*: NHS Fife Bomb Threat – Suspect Item Response Plan**

NHS Fife's suspect package and bomb threat procedures were ratified in 2024. It brings awareness that healthcare premises may be target of terrorist crime, which includes bomb threats and suspicious packages that may contain chemicals or biological hazards, such as anthrax.

5.6 ***Protect*: NHS Fife Buildings Lockdown Framework**

The Resilience Forum considered and approved internal Lockdown framework procedures. This was subsequently ratified by the Executive Directors' Group. Lockdown is the process of controlling the movement and access, both entry and exit (egress), of people (staff, patients and visitors) around NHS Fife sites or other specific building/area, in response to an identified risk, threat or hazard that might impact upon the security of patients, staff and assets or, indeed, the capacity of that facility to continue to operate..

6. Risk Management

6.1 The Resilience Forum is responsible for strategic oversight of the resilience function for NHS Fife. The Forum receives assurance on local planning and arrangements through regular review and exercising of plans and consideration of any escalated issues from NHS Fife Acute Services Division and NHS Fife Health and Social Care Partnership Resilience Group. The Forum reports directly to the Executive Directors' Group and minutes from the Forum are presented to both the NHS Fife Board's Clinical Governance Committee and the Health & Social Care Partnership Resilience Group of the Integration Joint Board.

6.2 The Public Health Assurance Committee reviews overarching strategic resilience risks to ensure that appropriate management actions are in place. The Public Health Assurance Committee meets four times annually, where a review of Public Health risks (including resilience) is undertaken. The minutes are submitted to the NHS Fife Board's Public Health and Wellbeing Committee. The Public Health risk register is discussed and updated and frequency of the review period is in line with organisational requirements.

6.3 A second internal audit C3 B13/23 specific to business continuity planning assurance was progressed by NHS Fife internal audit services in November 2023. Action planning following audit recommendations has been enacted across 2024. Ongoing support is being provided via resilience team to enable a new Business Continuity Policy for NHS Fife. A new Datix risk has been established to monitor implementation of Business Continuity Management systems.

7. Other Highlights

7.1 Stirling University Field Based Student

During 2024, NHS Fife resilience team had an opportunity to coach and mentor a field based learning student studying an MSc in Disasters Management from Stirling University. Our field based student provided a study into red mud deposits in Fife. The study report looked into the long and short-term impacts of red mud deposits on the region of Southeast Fife. The report findings were presented to the Resilience Forum and members noted the positive benefits from this student attachment. This work strengthened awareness

7.2 Psychosocial and Mental Health needs of People affected by Emergencies

The Resilience Forum identified a key opportunity to strengthen the Incident Management Framework through its discussions in 2024/25. NHS Fife as an organisation has to respond to emergencies in which staff or members of the public might suffer psychosocially (e.g. where there is loss of life, physical harm, and threat to personal safety). All responder agencies have the potential to lessen or aggravate the psychosocial impacts of emergencies were in NHS Fifes the Psychological teams are supporting our organisation's major incident framework planning to ensure they have been reviewed from this perspective.

A mandate has been secured to form a Psychosocial & Mental Health cell in the event of major incident mass casualties following discussion of this issue and engagement within the Resilience Forum.

8. Conclusion

8.1 As Chair of the Resilience Forum during financial year 2024-25, I am satisfied that the developing internal reporting & monitoring systems provides an integrated partnership approach.

8.2 The frequency of Resilience Forum meetings and the range of attendees at meetings of the NHS Resilience Forum provide a platform for partnership consultation to facilitate policy and frameworks planning to fulfil our civil contingencies remit.

8.3 This report provides an annual overview of key work areas undertaken across 2024-25. I can confirm that governance procedures and assurance metrics are further developing across Emergency planning, Business Continuity and CONTEST portfolios, so that NHS Fife can evidence assurance that we operationally have civil contingencies arrangements.

8.4 The Head of Resilience has worked throughout the year to support the Forum and has progressed the key areas highlighted within the Interim Internal Audit Interim report C3 B13/23. While significant progress is evident the resilience team will continue to ensure ongoing support.

The Forum should note that assurance can be reported to the Clinical Governance Committee for the reporting year 2024/25, reflecting the work-in-progress underway to strengthen arrangements for resilience planning across NHS Fife and with its contracted partners.

8.5 As a result of the work undertaken in the 12 months from 1 April 2024, the Board has been able to improve its compliance against NHS Scotland’s core standards for EPRR

and is now substantially compliant with the standards. The Head of Resilience over the next 12 month will continue to further develop an annual EPRR work programme with key partners in primary, secondary & acute care service areas.

8.6 Planning arrangements would not be possible without support and ongoing commitment of the workforce in NHS Fife. I would thank all those members of staff (internal & external multiagency partners) who have taken time to prepare reports and attend Resilience Forum meetings.

Signed:

Joy Tomlinson, Chair
Director of Public Health
On behalf of the Resilience Forum

Susan Cameron
Head of Resilience

Date: 1 March 2025

Names	*Roles / Designations*
Dr Joy Tomlinson	Director of Public Health (Chair)
Margo McGurk	Director of Finance and Strategy/Deputy Chief Executive (Vice Chair)
Susan Cameron	Head of Resilience
Susan Fraser	Associate Director of Planning and Performance
Claire Dobson	Director of Acute Services [Chief Operating Officer]
David Miller	Director of Workforce
Nicky Connor	Director of Health and Social Care
Neil McCormick	Director of Property and Asset Management
Janette Keenan	Director of Nursing
Hazel Close	Head of Pharmacy
Dr Christopher McKenna	Medical Director
Paula Lee	Head of Procurement
Nicola Taylor	Primary Care Representative
Alistair Graham	Associate Director, Digital and Information
Kirsty Macgregor	Associate Director of Communications
Lynne Parsons	Employee Director
Craig Burns	Emergency Planning Officer
Samantha McLaughlin / Malcolm Landels	Scottish Ambulance Service Resilience
Holly Jones	Resilience Coordinator

NHS Fife Resilience Forum Attendance Record
1st April 2024 to 31st March 2025

Meeting Date	13/06/24	18/09/24	17/12/24	20/03/25
Members				
Joy Tomlinson	✓	✓	✓	✓
Margo McGurk	X	X	Maxine Michie	X
Susan Cameron	✓	✓	✓	✓
Craig Burns	X	✓	✓	X
Susan Fraser	✓	✓	X	✓
Claire Dobson	X	X	X	X
David Miller	X	X	X	Rhona Waugh
Nicky Connor	X	X	X	X
Neil McCormick	X	X	X	X
Janette Keenan	X	X	X	X
Hazel Close	X	X	X	X
Christopher McKenna	X	X	X	X
Paula Lee	X	X	X	X
Nicola Taylor	X	X	X	X
Alistair Graham	X	X	X	X
Kirsty MacGregor	✓	X	X	Neal Stevenson
Lynne Parsons	✓	✓	X	X
Samantha McLaughlin (SAS)	X	✓	Kirsty McRae	Kirsty McRae
Avril Sweeney	✓	✓	X	X
Alan Young	✓	✓	X	✓
Jeremy Stewart	✓	✓	✓	✓
Jane Anderson	X	✓	X	X
Holly Jones	X	X	✓	✓
Steven Rutherford	✓	✓	X	X
Other Meeting Representatives In Attendance				
Jimmy Ramsay	✓	X	Yasmin Morgan	Yasmin Morgan
Lorraine King	X	X	X	X
Paul Bishop	X	X	X	X
Maggie Currer	✓	X	✓	X
Kevin McMahon	X	X	X	X
Ian Campbell	X	X	X	Lynne Innes
Aileen Boags	✓	X	✓	✓
Morag Shaw (SAS)	X	X	X	X
Sharon Doherty	✓	X	✓	X

Jamie Doyle	✓	X	X	X
Tanya Lonergan	✓	X	X	X
Moira Rivers	X	X	✓	X
Christopher Conroy	X	X	✓	✓
Olivia Robertson	X	X	X	✓

Fife Health & Social Care Partnership
Supporting the people of Fife together

Meeting Title:	**Qualities and Communities Committee**
Meeting Date:	**25th April 2025**
Agenda Item No:	**9.2**
Report Title:	**Q&CC Annual Assurance Statement**
Responsible Officer:	**Audrey Valente, Chief Finance Officer**
Report Author:	**Vanessa Salmond, Head of Corporate Governance and IJB Secretary**

1 Purpose

The report sets out an annual overview of the work of the Fife Integration Joint Board (IJB) Quality and Communities Committee (QCC). This is in addition to the IJB receiving a Chairs Assurance Report and minute of each meeting, both ensuring effective scrutiny of the Committee

This Report is presented to the Board for:

- Assurance

This Report relates to which of the following National Health and Wellbeing Outcomes:

1 People are able to look after and improve their own health and wellbeing and live in good health for longer.

2 People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

3 People who use health and social care services have positive experiences of those services, and have their dignity respected.

4 Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

5 Health and social care services contribute to reducing health inequalities.

6 People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.

7 People who use health and social care services are safe from harm.

8 People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

9 Resources are used effectively and efficiently in the provision of health and social care services.

This Report Aligns to which of the Integration Joint Board 5 Key Priorities:

- Local
- Sustainable
- Wellbeing
- Outcomes
- Integration

2 Route to the Meeting

This has been shared with the Chair and Lead Officer for the QCC prior to presentation to Committee.

3 Report Summary

3.1 Situation

This report provides assurance to the IJB that adequate governance arrangements relating to the Quality and Communities Committee are in place allowing the IJB to discharge its duties in line with the Good Governance Framework.

3.2 Background

Each of the governance committees produce an annual assurance statement signed by the Chair of each relevant committee. Once each committee agree their annual assurance statement these are remitted for review by the Audit & Assurance Committee on 16 May 2025. The purpose of this review by the Audit & Assurance Committee is to provide the IJB with assurance on the effectiveness of the IJB committee structure and that the committees are fulfilling their statutory duties

3.3 Assessment

Based upon the assurance statements submitted by the committees, the Quality and Communities Committee are able to provide assurance to the IJB.

During the financial year to 31 March 2025, membership of the Quality & Communities Committee comprised of membership with a diverse range of skills, knowledge and attributes across the whole system of health and social care including NHS Fife, Fife Council, Third and Independent Sectors and Patients and Carers Representatives. Full membership and attendance details are attached at appendix 1.

This Annual Assurance Statement complements the Chairs Assurance Statement which is produced following each Committee. A full list of all Committee business transacted throughout 2024-25 is detailed at Appendix 2.

3.3.1 Quality / Customer Care

Provides assurance to the public that the IJB is working effectively, with the Quality and Communities Committee leading in relation to IJB statutory functions for quality of care governance.

3.3.2 Workforce

Assurance is provided that our staff are engaged and working in accordance with local governance arrangements with the Local Partnership Forum (LPF) providing a platform for engagement and adequate discussions on workforce matters. A Workforce Year 2 annual report was provided to the IJB having been endorsed by the Local Partnership Forum, Quality and Communities Committee and the Finance, Performance and Scrutiny Committee in November 2023.

3.3.3 Financial

Gives assurance that the financial regulations are being adhered to and managed appropriately and that scrutiny is in place through the Finance, Performance and Scrutiny Committee.

3.3.4 Risk / Legal / Management

Provides assurance that the appropriate level of risk is monitored and managed at an individual committee level with oversight provided at the Audit & Assurance Committee.

3.3.5 Equality and Diversity, including Health Inequalities

Provides assurance that equalities is monitored and managed effectively within the committee structure including Quality and Communities Committee and the Local Partnership Forum via the Finance, Performance and Scrutiny Committee.

3.3.6 Environmental / Climate Change

N/A

3.3.7 Other Impact

N/A

3.3.8 Communication, Involvement, Engagement and Consultation

All members have had the opportunity to comment, scrutinise and contribute to the assurance statements at each committee they attend.

4 Recommendation

Assurance – To provide assurance to members that good governance is in place across the partnership.

5 List of Appendices

The following appendices are included with this report:

Appendix 1 – Quality & Communities Committee Meeting Attendance 2024-25

Appendix 2 – Quality & Communities Committee Schedule of Business 2024-25

6 Implications for Fife Council

N/A

7 Implications for NHS Fife

N/A

8 Implications for Third Sector

N/A

9 Implications for Independent Sector

N/A

10 Directions Required to Fife Council, NHS Fife or Both (must be completed)

Direction To:		
1	**No Direction Required**	X
2	**Fife Council**	
3	**NHS Fife**	
4	**Fife Council & NHS Fife**	

Report Contact

Author Name: Vanessa Salmond

Author Job Title: Head of Corporate Governance and IJB Secretary

E-Mail Address: Vanessa.salmond@fife.gov.uk

Appendix 1

QUALITY & COMMUNITIES COMMITTEE – ATTENDANCE RECORD 1st April 2024 to 31st March 2025

Members	10 May 2024	5 Jul 2024	4 September 2024	8 November 2024	10 January 2025	6 March 2025
Sinead Braiden	√	√	√	√	√	x
Rosemary Liewald	√	x	√	√	√	√
Colin Grieve	x	√	√	√	√	√
Margaret Kennedy	√	√	x	x	√	√
Lynn Mowatt	x	x	x	√	√	√
Sam Steele	√	x	x	√	√	√
Amanda Wong	√	x	√	√	x	√
Kenny Murphy	x	√	√	x	x	√
Morna Fleming	√	√	√	√	√	√
Paul Dundas	√	√	x	√	√	√
Ian Dall	√	x	x	x	√	x
Alistair Grant	x	√	√	x	x	√
In Attendance						
Dr Helen Hellewell (Lead Officer)	√	√	√	√	x	x
Lynn Barker	√	x	√	x	*x*	√
Nicky Connor (ceased Jul 2024)	x	x				
Rona Laskowski (ceased May 2024)	x					

Appendix 1

Members	10 May 2024	5 Jul 2024	4 September 2024	8 November 2024	10 January 2025	6 March 2025
Jillian Torrens (wef June 2024)		√	√	√	√	√
Fiona McKay (ceased Jan 2025)	√	√	√	√		
Lynne Garvey	√	x	√	√	√	x
Jennifer Rezendes (ceased Dec 2024)	√	√	√	√		
Lisa Cooper	√	√	√	√	√	√
Catherine Gilvear	√	x	√	√	√	√

Appendix 2

Remit	Committee Business	Committee Cycle	Committee Decision	
Governance & Outcomes				
Provide assurance to the IJB that the mechanisms, activity and planning are supported and delivered effectively and that there is a culture of continuous improvement.	Minutes of Previous meeting	Standing agenda item at each Committee meeting	Decision	Approved
	Active or Emerging Issues	Standing agenda item at each Committee meeting	Decision	Approved There were no active or emerging issues highlighted at any Committee cycles throughout 2024-25
	Spring Booster Campaign	May 2024	Assurance	Assurance Provided
	Community OT Waiting Times	Sep 2024	Assurance	Assurance Provided
	Self-Directed Report	Sep 2024	Assurance	Assurance Provided
	Equality, Diversity & Inclusion Action Plan 2024-27	Sep 2024	Discussion/Decision	Support to progress to IJB
	Winter Planning 2024-25	Nov 2024	Assurance	Assurance Provided
	Smoking Cessation Deep Dive	Nov 2024	Discussion/Assurance	Assurance Provided Although Committee recognised the low quit rates and the emerging impact from vaping. Committee requested an update report in 6 months
	Mainstreaming the Equality Duty and Equality Outcomes Progress Report – January 2025	Jan 2025	Discussion/Decision	Support to progress to IJB
	Developing a Systems-Based Approach to Physical Activity in Fife	Jan 2025	Discussion/Decision	Support to progress partnership initiative

Remit	Committee Business	Committee Cycle	Committee Decision	
Governance & Outcomes				
Assure the IJB that appropriate and effective clinical and care governance mechanisms and structures are in place for clinical and care governance throughout the whole of the Health and Social Care Partnership.	Quality Matters Assurance	Standing agenda item at each Committee meeting	Assurance	Assurance Provided Committee were assured that all active or emerging issues were appropriately investigated and noted there were no issues requiring further escalation
	Fife Council and NHS Fife Duty of Candour Reports 2022-23	May 2024	Discussion/Decision	Support to progress to IJB – No issues raised from a Quality of Care perspective
Develop and approve an Annual Work Plan for the Committee beginning on 1 April each year monitoring progress throughout the year.	Quality and Communities Committee Terms of Workplan	Mar 2025	Discussion	The Committee workplan is prepared annually. A revised format has been developed for 2025-26 fiscal year and will be a standing agenda item at each Committee.
	Quality and Communities Committee Terms of Reference	Jul 2024 Sep 2024	Discussion/Decision	Following a number of required amendments, a revised ToRs were endorsed by the Committee and agreed to present to the IJB for formal approval.
Produce an Annual Statement of Assurance (as in Section 7 of the Governance Manual) for submission to the IJB and to both partner organisations.	Annual Assurance Statement	May 2024	Assurance/Decision	Assurance Provided No risks or weakness were identified for the previous financial year. It was agreed to submit the Statement to the IJB and NHS ** Committee.

Remit	Committee Business	Committee Cycle	Committee Decision	
Governance & Outcomes				
Monitor the implementation of locality capacity building, locality planning, community development, participation and engagement and support to carers and to seek assurance that the services being delivered are high quality, safe, effective, person-centred and provide best value for the people of Fife.	Community Led Support Services Progress Report 2023-24	Jul 2024	Assurance	Assurance Provided
	Locality Planning – Community Chest Fund	Nov 2024	Assurance	Assurance Provided
	Carer's Eligibility Criteria Review	Jan 2025	Discussion/Decision	Support to progress to IJB Committee recognised the merits to this framework to provide clarity and equity in application of criteria
Strategic Planning & Delivery				
Provide assurance to the IJB that the clinical and care governance requirements of recommendations for decision and/or direction have been considered by the Committee.	Draft Digital Strategy	May 2024	Discussion/Decision	Assurance Provided – Committee recognised the continuing difficulties arising from the lack on 'connectivity' between partner IT systems. Support to progress to IJB
	Prevention & Early Intervention Strategy	Sep 2024	Discussion/Decision	The Committee welcomed the development of this strategy and suggested a number of amendments to the report around carers. Support to progress to IJB.
	Assessment Rehabilitation Centre (ARC) Transformation	Sep 2024	Discussion/Decision	The Committee were assured quality of care aspects have been considered Support to progress to IJB.
	Professional Assurance Framework	Sep 2024	Discussion/Decision	The Committee commended this report and Framework. Support to progress to IJB.

Remit	Committee Business	Committee Cycle	Committee Decision	
Strategic Planning & Delivery				
Provide assurance to the IJB that the clinical and care governance requirements of recommendations for decision and/or direction have been considered by the Committee.	Fife Immunisation Strategic Framework 2024-27	Jan 2025	Assurance	Assurance Provided Further updates will be brought back to committee.
	Mental Health and Wellbeing Strategy	Mar 2025	Discussion	Following a robust discussion, Committee requested various amendments to the report An update will be presented to Committee at a future date
Oversee the integrated clinical and care governance and risk management activities in relation to the development and delivery of the Strategic Plan ensuring cognisance of the Plan for Fife and NHS Fife Health and Wellbeing Strategy.	Strategic Plan 2023-26 Year 2 Delivery Plan – Annual Report (2024) and Year 3 Delivery Plan (2025)	Jan 2025	Discussion/Decision	Following the request for a few revision to the report - Support to progress to IJB
Legislative Requirements & Annual Reports				
Assure the IJB that services respond to requirements arising from regulation, accreditation and other inspections recommendations.	United National Convention on the Rights of the Child (Scotland) Act 2024	May 2024	Assurance	Assurance Provided
	Mental Health Estates Initial Agreement - Update	May 2024	Discussion/Assurance	Members noted the updated status around the MH Estate, although disappointed at the lack of capital funding were assured by the planned work to ensure continued patent safety.
	Fife ADP Annual Report and Annual Survey 2023-24	Jul 2024	Assurance	Assurance Provided

Remit	Committee Business	Committee Cycle	Committee Decision	
Legislative Requirements & Annual Reports				
Assure the IJB that services respond to requirements arising from regulation, accreditation and other inspections recommendations.	Fife ADP Annual Report and Annual Survey 2023-24	Jul 2024	Assurance	Assurance Provided
	Annual Performance Report 2023-2024	Jul 2024	Assurance	Assurance Provided
	Creating Hope for Fife : Fife's Suicide Prevention Action Plan	Jul 2024	Assurance	Assurance Provided
	Children's Services Annual Report 2022-23	Jul 2024	Assurance	Assurance Provided
	IJB/HSCP Resilience Assurance Group Annual Report	Sep 2024	Discussion/Assurance	Assurance Provided Support to progress to IJB
	Primary Care Improvement Plan Annual Progress Update	Sep 2024	Assurance	Assurance Provided
	Primary Care Strategy 2023-26 – Annual Report	Sep 2024	Assurance	Assurance Provided
	Workforce Strategy Action Plan Year 2 Report 2023-24	Nov 2024	Discussion/Decision	Support to progress to IJB
	Pharmaceutical Care Services Report 2023-24	Nov 2024	Assurance	Assurance Provided
	MAPPA Report	Nov 2024	Assurance	Assurance Provided
	Adult Protection Report (Social Work/Social Care) 2023/24	Nov 2024	Assurance	Assurance Provided
	Mental Welfare Commission Report and Action Plan	Nov 2024	Assurance	Assurance Provided Committee were assured by outcome of these visits and the progress on improvement actions identified
	Armed Forces Covenant Duty	Nov 2024	Discussion/Assurance	Assurance Provided Support to progress to IJB

Remit	Committee Business	Committee Cycle	Committee Decision	
Legislative Requirements & Annual Reports				
Assure the IJB that services respond to requirements arising from regulation, accreditation and other inspections recommendations.	Fife Dental and Oral Health Improvement Annual Report 2024	Jan 2025	Assurance	Assurance Provided
	Learning from the Deaths of Fife's Children and Young People Annual Report 2023-24	Jan 2024	Assurance	Assurance Provided This report provided committee with assurance that any learning from child deaths is reviewed and any action implemented appropriately.
	AHP Professional Assurance Annual Update	Mar 2025	Assurance	Assurance Provided
	Sexual Health and Blood Borne Viruses in Fife 2024 Update	Mar 2025	Assurance	Assurance Provided
	Fife Violence Against Women Partnership Annual Report 2023-2024	Mar 2025	Assurance	Assurance Provided
Monitor integrated clinical and care governance risk register on behalf of the IJB.	QCC Strategic Risk Register	May 2024 Nov 2024	Discussion/Assurance	Assurance Provided – IJB Strategic Risks which may pose a threat to the Partnership in achieving its objectives in relation to clinical and care governance and quality of care continue to be managed by the relevant risk owners.
	Deep Dive Risk Review – Whole System Capacity	May 2024	Discussion/Assurance	Reasonable Assurance Provided – Risk being effectively managed
	Deep Dive Risk Review – Contractual/Market Capacity	May 2024	Discussion/Assurance	Reasonable Assurance Provided – Risk being effectively managed

Remit	Committee Business	Committee Cycle	Committee Decision	
Legislative Requirements & Annual Reports				
Monitor integrated clinical and care governance risk register on behalf of the IJB.	Deep Dive Risk Review – Adult & Child Support and Protection	Sep 2024	Discussion/Assurance	Reasonable Assurance Provided – Risk being effectively managed
	Deep Dive Risk Review – Transformation/Change	Jan 2025	Discussion/Assurance	Assurance Provided – Risk being effectively managed
	Drug Related Deaths Deep Dive Risk Assessment – NHS Board Corporate Risk Register	Jan 2025	Discussion/Assurance	Assurance Provided – Recognising the limitations of NHS and the work of the Alcohol and Drug Partnership in manging this risk.
	Deep Dive Risk Review – Information Governance and Digital Transformation	Mar 2025	Discussion/Assurance	Assurance Provided – Risk being effectively managed

As Chair of the Quality & Communities Committee during financial year 2024-25, 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 Quality & Communities Committee has allowed us to fulfil our remit. As a result of the work undertaken during the year, I can confirm that adequate and effective governance arrangements were in place in the areas under our remit.

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

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

Signed:  Date: 14th April 2025

Sinead Braiden
On behalf of the Quality & Communities Committee

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**2 May 2025**
Title:	**Draft Clinical Governance Committee Annual Statement of Assurance 2024/25**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author:	**Gillian MacIntosh, Board Secretary**

Executive Summary:

- All formal Committees of the NHS Board are required to provide an Annual Statement of Assurance to the NHS Board, detailing the work undertaken during the year and identifying any internal control weaknesses that might be considered for disclosure within the Governance Statement of the Annual Accounts.
- The draft statement is enclosed as an appendix, and this contains a textual account of the Committee's business during the financial year, to evidence to the Board that the Committee has delivered fully on its remit and delegated powers.
- Members are asked to take a "significant" level of assurance that the Committee has delivered on its remit during the 2024/25 reporting year and advise of any changes to the draft report text, prior to onward submission to the Audit & Risk Committee and thence the Board.

1 Purpose

This is presented for:

- Assurance

This report relates to a:

- Legal requirement
- Local policy

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

- Effective

2 Report summary

2.1 Situation

All formal Committees of the NHS Board are required to provide an Annual Statement of Assurance for the NHS Board, which is consider initially by the Audit & Risk Committee.

The requirement for these statements is set out in the Code of Corporate Governance. The Clinical Governance Committee is invited to review the draft of the enclosed report for 2024/25 and comment on its content, with a view to approving a final paper for onward submission.

2.2 Background

Each Committee must consider its proposed Annual Statement at the first Committee meeting of the new financial year, as per the Committee's workplan. The current draft takes account of initial comments received from the outgoing and incoming Committee Chair and Executive Lead (Medical Director).

2.3 Assessment

In addition to recording practical details such as membership and rates of attendance, the format of the report includes a more reflective and detailed section (Section 4) on agenda business covered in the course of 2024/25, with a view to improving the level of assurance given to the NHS Board.

This report provides the following Level of Assurance:

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

A significant level of assurance is suggested, given the Committee has considered all relevant items of business delegated to it during 2024/25, escalating directly to the Board any matters of concern. No matters for disclosure in the Governance Statement of the Annual Accounts have been identified.

2.3.1 Quality/ Patient Care

Delivering robust governance across the organisation is supportive of enhanced patient care and quality standards.

2.3.2 Workforce

N/A.

2.3.3 Financial

The production and review of year-end assurance statements are a key part of the financial year-end process.

2.3.4 Risk Assessment/Management

The identification and management of risk is an important factor in providing appropriate assurance to the NHS 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. Details on the Committee's general review of business concerning health inequalities and Anchor Institution related work is captured within the report.

2.3.6 Climate Emergency & Sustainability Impact

This is covered in a limited way within the assurance report, as per the Committee's reflections on related business during the year covered.

2.3.7 Communication, involvement, engagement and consultation

N/A.

2.3.8 Route to the Meeting

This paper has been considered in draft by the incoming and outgoing Committee Chair, and Executive Lead (Medical Director).

2.4 Recommendation

The paper is provided for:

- **Assurance and approval** – subject to members' comments regarding any amendments necessary, for final sign-off by the Chair and submission to the Audit & Risk Committee.

3. List of Appendices

- Appendix No. 1 – Annual Statement of Assurance for NHS Fife Clinical Governance Committee for 2024/25

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

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, 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

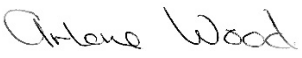
7.1 The Committee has undertaken a self-assessment of its own effectiveness, utilising a revised questionnaire considered and approved by the Committee Chair. Attendees were also invited to participate in this exercise, which was carried out via an easily accessible online portal. A report summarising 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			

	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

ANNUAL STATEMENT OF ASSURANCE FOR
NHS FIFE AREA CLINICAL FORUM

1. Purpose

1.1. The purpose of the Area Clinical Forum is to ensure that efficient and effective systems are in place which promote the active involvement of all clinicians from across NHS Fife in the decision-making process. The Area Clinical Forum also acts as a multi-professional reference group on proposals brought forward through the strategic planning / redesign process.

1.2. The Area Clinical Forum will be supported by ten Area Professional and Advisory Committees and Cognate Groups:

- Area Medical Committee
- Area Dental Committee
- Area Pharmaceutical Committee
- Area Optical Committee
- Allied Health Professions Clinical Advisory Forum
- GP Sub-Committee of the Area Medical Committee
- Healthcare Scientists Forum
- Clinical Psychology Group
- Nursing and Midwifery Professional Leadership Council
- Integrated Professional Advisory Group

1.3. The ten Chairs and nominated representatives of the Area Professional and Advisory Committees will form a multi-professional Area Clinical Forum.

2. Membership

2.1 During the financial year to 31 March 2025 membership of the Area Clinical Forum comprised: -

Name	Role / Designation
Aileen Lawrie	Chair
Ailie McKay	ACF Vice Chair / Allied Health Professions Clinical Advisory Forum
Dr Chris McKenna	Medical Director / Area Medical Committee
Dr Susie Mitchell	General Practitioner / GP Subcommittee
Aileen Boags	Lead Pharmacist for Public Health and Community Pharmacy / Area Pharmaceutical Committee
Jackie Fearn	Consultant Clinical Psychologist / Clinical Psychology
Robyn Gunn	Head of Laboratory Services / Healthcare Science
Amanda Wong	Director of Allied Health Professionals / Clinical Director

Name	Role / Designation
Nicola Robertson	Director of Nursing, Corporate / Nursing & Midwifery Workforce Planning Group
Emma O'Keefe	Consultant in Dental Public Health / Area Dental Committee
Steven Halstead	Specialist Optometrist / Area Optical Committee Chair

2.2 The Area Clinical Forum invited individuals to attend meetings for particular agenda items, for example the Director of Finance & Strategy, the Director of Planning & Transformation, and the Associate Director of Culture, Development & Wellbeing. The Executive Director of Nursing and the Medical Director are normally in attendance. Other attendees, deputies and guests are recorded in the individual minutes of each meeting.

3. Meetings

3.1 The Area Clinical Forum met on 6 occasions during the financial year to 31 March 2025, on the undernoted dates:

- 4 April 2024
- 6 June 2024
- 1 August 2024
- 3 October 2024
- 5 December 2024
- 6 February 2025

3.2 The attendance schedule is attached at Appendix 1.

4. Business

4.1 **Area Clinical Forum inclusion and engagement:** the work continues by the Chair and Vice Chair to increase engagement with portfolio leads across the multidisciplinary/multiagency clinical systems. By proactively involving a diverse group of healthcare professionals, the Area Clinical Forum aims to ensure a wide range of clinical perspectives and expert knowledge are considered in care planning and strategic planning. Engagement with and by the Area Clinical Forum members assists in identification of specific patient groups' needs and challenges which should lead to an increase in equitable and effective healthcare solutions. Engagement and inclusion in the wider strategic planning activity has been challenging, however, progress has been made in increasing the visibility of the Area Clinical Forum as an excellent resource to ensure the clinical voice is considered.

4.2 **Population Health and Wellbeing Strategy:** the strategy has set out a vision for NHS Fife until 2028. The strategy underpins NHS Fife's ongoing recovery from the Covid-19 pandemic and aims to address a range of current and emergent challenges. The Area Clinical Forum receives regular updates and feedback regarding the progress of the strategy and is regularly asked to input into emerging priorities.

4.3 **Scottish Government Women's Plan**: The Women's Health Plan is a comprehensive strategy aimed at improving women's health outcomes across Scotland. Despite some progress, there remain disparities in healthcare access and persistent challenges in issues relating to maternal health and reproductive rights. The Area Clinical Forum recognises the benefits for being included in the developing work to advance the objectives of the women's health plan and has received regular presentations regarding the progress of the women's health plan group.

One area of the plan which the Area Clinical Forum became directly involved in was menopause prescribing, after receiving feedback from the clinical teams regarding inequity of care for women in prescribing challenges locally. Work undertaken led to improvement in prescribing guidelines, with specific reference to testosterone prescribing, which has improved the quality of care and support for women experiencing menopausal symptoms.

4.4 **Public Participation Strategy:** The Director of Communications & Engagement provides progress reporting to the Area Clinical Forum members. In terms of next steps, implementation of the strategy is primarily aimed at supporting some of the immediate Re-form, Transform, Perform work being undertaken. The Forum members were able to highlight the challenges on staff time through implementing change, particularly due to staffing levels. An overview was provided on the action plan, including expected timescales for projects; it was advised that an audit will be carried out for service user groups. There will be representation from Area Clinical Forum as Engagement Champions moving forward.

4.5 **Scottish Government Rehabilitation Plan (2022):** This plan underpins the work within NHS Fife around Home First and aspects of the community hospital modelling. The Area Clinical Forum receives regular updates on progress of the Plan from the Director of Allied Health Professions. An oversight group is being considered to ensure that the principles within the framework are upheld and the Area Clinical Forum will have representation on that group.

4.6 **Health and Care (Staffing) (Scotland) Act 2019:** The Act aims to ensure safe and effective staffing levels across health and social care settings. The Area Clinical Forum has recognised the need for a strong clinical voice in the discussions around staff to patient ratios in ensuring safe and effective care. The Area Clinical Forum has offered to feedback regarding the current challenges being experienced in staff recruitment and retention strategies, workforce vacancies and workforce development. The Area Clinical Forum now receives regular feedback from the Director of Nursing on the development of the implementation of the Act and has been asked to provide professional feedback on the barriers to implementation of the Act locally.

4.7 **Escalations and Updates from Subgroups to the Area Clinical Forum:** The Area Clinical Forum can assist portfolio leads to escalate areas of concern to the Board, currently via the Clinical Governance Committee and bi-annually directly to NHS Fife Board. The Local Area Medical Committee had raised safety concerns directly relating to lack of GP capacity within the

Levenmouth areas. Mitigation for concerns was provided and feedback given to the Local Area Medical Committee from the Chair of the Clinical Governance Committee. A current area for possible escalation is the response and action plan to the Area Clinical Forum on the Audiology External Independent Review. Any consideration for escalation will be following the Area Clinical Forum review of the action plan. No other escalations were received this year.

4.8 **Reform, Transform, Perform portfolio**: The Area Clinical Forum receives regular updates and feedback regarding the financial position of the Board. There is recognition of the need to focus attention on the work being undertaken through the Re-form, Transform, Perform programme. The Area Clinical Forum Chair has requested a presentation to the group on the current initiatives being planned and has offered the group's availability for consultation from clinical portfolio leads on emerging initiatives.

4.9 **Equality & Diversity**: Work has been undertaken by the Area Clinical Forum Chair and the lead for inclusion at a national level regarding racialised inequalities. The current areas of development are a national guidance for interpretation services and locally development of clinical assessment and documentation. Close engagement with the Equality & Human Rights Lead within NHS Fife has led to a set of specific equality outcomes in maternity and neonatal care within NHS Fife for 2025.

5. Summary of the Work of the Area Clinical Forum

5.1 Reviewing the business of professional advisory committees to ensure co-ordination of clinical matters across each of the professional groups.

5.2 The provision of a clinical perspective on the development of the Annual Development Plan and the strategic objectives of the NHS Board.

5.3 Sharing best practice and encouraging multi-professional working in healthcare and health improvement.

5.4 Ensuring effective and efficient engagement of clinicians in service design, development and improvement.

5.5 Providing a local clinical and professional perspective on national policy issues.

5.6 Ensuring that local strategic and corporate developments fully reflect clinical service delivery.

5.7 Taking an integrated clinical and professional perspective on the impact of national policies at local level.

5.8 Through the Area Clinical Forum Chair, being fully engaged in NHS Board business.

5.9 Supporting the NHS Board in the conduct of its business through the provision of multi-professional clinical advice.

6. Other Highlights

6.1 The Chair and Vice Chair of the Area Clinical Forum have recently stood down following a highly successful 4-year term. The Forum acknowledges the progress made by the Chair and Vice Chair during their respective terms and formally thanks them for the success of the Forum to date.

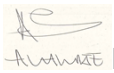
6.2 A new Chair and Vice Chair have recently been appointed and work is ongoing to continue to continue to promote the Forum's purpose.

7. Conclusion

7.1 As Chair of the Area Clinical Forum during financial year 2024-25, 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 Area Clinical Forum has allowed us to fulfil our remit. As a result of the work undertaken during the year, I can confirm that adequate and effective governance arrangements were in place in the areas under our remit during the year.

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

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

Signed:  Date: 28/03/2025

Aileen Lawrie, Chair
On behalf of the Area Clinical Forum

Appendix 1 – Attendance Schedule

NHS Fife Area Clinical Forum Attendance Record
1 April 2024 to 31 March 2025

	04.04.24	01.08.24	05.12.24	06.02.25 (Development Session)
MEMBERS				
Aileen Lawrie, Chair	⚑	⚑	⚑	⚑
Ailie McKay, Speech and Language Therapy SLT Operational Lead & Vice Chair	⚑	x		
Aileen Boags, Lead Pharmacist		⚑	⚑	⚑
Jackie Fearn, Consultant Clinical Psychologist	⚑	x	⚑	⚑
Robyn Gunn, Head of Laboratory Services	x	x	⚑	⚑
Stephen Halstead, Specialist Optometrist		⚑	x	x
Ben Hannan, Director of Pharmacy & Medicines	⚑ Item 5.1			
Chris McKenna, Medical Director	⚑	⚑	x	⚑
Susannah Mitchell, General Practitioner	x	x	⚑	x
Janette Keenan, Director of Nursing	⚑	⚑	⚑	⚑
Emma O'Keefe, Consultant in Dental Public Health	x	x	x	x
Nicola Robertson, Associate Director of Nursing	⚑	⚑	⚑	⚑
Amanda Wong, Director of Allied Health Professions	⚑	⚑	x	⚑
IN ATTENDANCE				
Lorna Brocklesby, Occupational Therapy Manager			⚑ Deputising	
Isla Bumba, Equality & Human Rights Lead	⚑			
Ian Campbell, Healthcare Chaplain			⚑ Items 1 – 5.2	
Susan Fraser, Associate Director of Planning & Performance		⚑ Item 5.3		
Alistair Graham, Director of Digital & Information			⚑ Items 1 – 5.1	
Kirsty MacGregor, Director of Communications & Engagement		⚑ Item 5.2		
Tom McCarthy, Portfolio Manager				
Sue Ponton, Head of Occupational Health Service			⚑ Item 7.1	
Lynne Riach, Senior Programme Advisor (HIS)				

	04.04.24	01.08.24	05.12.24	06.02.25 (Development Session)
MEMBERS				
Rhona Waugh, Head of Workforce Planning & Staff Wellbeing		Item 1 – 5.1		
Jenni Jones, Associate Director of Culture, Development & Wellbeing				Presenting

ASSURANCE SUMMARY
CLINICAL GOVERNANCE OVERSIGHT GROUP
8 APRIL 2025

1. Purpose

To provide the NHS Fife Clinical Governance Committee with an assurance summary from the Clinical Governance Oversight Group (CGOG) held on the 8 April 2025. This assurance statement summarises the key aspects of business covered.

	Summary	Assurance Level
1.	**Hospital Acquired Harm Risk- Deep Dive Review**	**Moderate**
	This newly defined risk was brought for noting. The Medical Director requested that this is closely monitored by the group; aligned to the review of the IPQR with assurance of any improvement interventions.	
2.	**NHS Fife Healthcare Improvement Scotland (HIS) Inspection**	**Moderate**
	A paper responding to the inspection will be presented at the Clinical Governance Committee (CGC). In summary the following updates were presented: • 9 areas of good practice, one recommendation and 13 requirements. • Staff recommended the hospital as a good place to work • Patients and relatives were complimentary • Safety huddles were well structured, inclusive and informative CGOG was assured of the approach to respond to the requirements. Agreed that assurance of progress with requirements will be provided to CGOG through the Acute Services Division Clinical Governance Committee.	
3.	**NHS Fife Orthopaedic Scottish National Audit Programme - Hip Fracture & Arthroplasty**	**Moderate**
	Paper outlining improvement approach will be presented at the CGC. The group received update that additional resource has been secured to increase theatre capacity along with a Trauma Co-ordinator post to improve patient pathways and experience. The Medical Director stated the importance of measuring the improvement impact of this investment with a further paper to return to CGOG in June.	
4.	**NHS Fife Organisational Learning Leadership Group Update**	**Moderate**
	The Clinical Organisation Learning Event (COLE) was launched on 9th April 2025. COLE seeks to complement the Grand Round programme by extrapolating learning that is of organisational significance. The events cover three broad themes: • Celebrating success and learning from a positive change or quality improvement • A micro learning element	

	• Learning from adverse events or when things don't go well The intention is to develop referral processes into the OLLG from Serious Adverse Event Review (SAER) panel meetings and Clinical Governance meetings across the divisions. As well as encouraging individuals to come forward and share their learning. A page has been created on Stafflink, where items presented at these meetings will be shared along with any other key clinical learning which is of organisational significance.	
5.	**Deteriorating Patient Updates**	**Moderate**
	Deteriorating Patient Q3 Report: • The group noted that the survival rate of patients experience a cardiac arrest has increased to 29%. Noted that it is too early to say if this is a sustained improvement but a potential indication of the Deteriorating Patient work to encourage a proactive and anticipatory approach to managing deteriorating patients. • There has been a small sustained improvement with observations taken on time with a new organisational median of 67.7%- the Clinical Lead for Deteriorating Patients advised of the continued improvement focus here that will continue through the Deteriorating Patient Group. • The ongoing work to improve the triage of patients with a DNA CPR was discussed. The critical importance of ensuring a person centred approach to discussing DNA CPRs with patients was recognised by the group. NEWS2 Implementation • Target date for implementation of NEWS2 is 30th September • A paper outlining the approach for implementation will be submitted for the June CGOG.	
6.	**Integrated Performance and Quality Report**	Moderate
	The Medical Director has requested a refreshed focus on the quality performance indicators (QPIs) contained within the Quality and Safety section of the Integrated Performance Report (IPQR). Further work was agreed as to how the group can strengthen assurance, understanding and assessment of improvement impact for the quality performance indicator metrics in the IPQR. The Medical Director also requested that this includes consideration as to how the system plans for quality and safety. A proposal will be shared with CGOG in June. There was a detailed review of the falls with harm data and the seasonal variation of a rise over winter months.	
7.	**Adverse Events Themes and Trends**	Moderate
	A new detailed themes and trends report was presented which sets out all 38 categories on datix in run charts. Sustained improvement was noted within specimen management improvements made here are to be understood so that improvement actions and learning can be shared. Assurance was sought on improvement activity across the following	

	categories which have seen a sustained increase in reporting: • Medication Incidents • Missing persons • Clinical Nutrition Update will be provided by respective leads at the next meeting on each of the above. It was noted that the Digital and Information team are working in collaboration with the Adverse Event Team to develop a dashboard to allow this data to be available at every level in the organisation.	
8.	**Healthcare Improvement Scotland (HIS) Learning from Adverse Events National Framework**	Significant
	In March HIS launched the new Learning from Adverse Events National Framework. A SWOT analysis of NHS Fife's current practice against the new framework was presented to the group. In summary: • Strengths were identified in process, approach and support for staff in adverse event reviews. • Weakness were identified in the level of engagement with patients/family and staff involved in the review, the process for management of events that has impacted on multiple patients and the implementation of improvement plans. • Opportunities in the expansion of human factors knowledge and training for staff involved in adverse events reviews was identified and increased prospect for shared learning both locally and nationally. • Threats were identified in additional training and education for staff in human factors both in the provision and attendance of training and the process for quality checking all stages of the adverse event cycle. It was agreed that the local Adverse Events Improvement plan would be updated to incorporate areas for development as set out in the SWOT analysis.	
9.	**NHS Fife HSCP Quality Matters Assurance Report from 24th January 2025**	Moderate
	No matters were escalated to CGOG. The January meeting of the Quality Matters Assurance Group (QMAG) was cancelled due to Storm Eowyn. CGOG was assured that a meeting took place in April 2025 with an assurance summary to be shared at the June 2025 CGOG meeting. The following items were approved virtually by QMAG and assurance provided to CGOG: • Spirometry Training: Approval to Utilise Pharmaceutical Companies. QMAG approved the use of pharmaceutical companies to deliver training as a short term solution as long as	

	approval was gained from medicines management before making contact or having discussions with the pharmaceutical companies. • Sexual Health & Blood Borne Viruses in Fife- 2024 Update • Progress towards elimination of hepatitis c in NHS Fife	
10.	**Acute Services Division Clinical Governance Assurance Report from 22nd January 2025**	
	No matters were escalated to CGOG Highlights to the group included: • Implementation of Active Clinical Referral Triage and Patient Initiated Return Toolkit. The project has released capacity in pressured services. Key areas of focus include Gastroenterology, Endocrinology, Vascular and Cardiology. • IV Fluids Standards- work has been intiated to integrate the electronic fluid balance charts with the lab system and acute kidney injury (AKI) alerts on Patient Trak- helping to improve prevention and management of AKIs • Assurance was sought by CGOG in relation to the increase in pressure ulcers within the gynaecology ward.	
11.	**NHS Fife Clinical Policy & Procedure Update 24th February 2025**	Significant
	CGOG were given assurance that there is a 98% compliance rate for all clinical policies and procedures overseen by the NHS Fife Clinical Policy and Procedure Group. The group was satisfied that plans are in place to update the two procedures which were are past their review dates. **NHS Fife Policy & Procedure Framework** The approved NHS Fife Policy & Procedure Framework was presented to the group. This has been developed in order to set out the requirements for the production, approval, implementation and dissemination of Board-wide policies and procedures and local procedures in NHS Fife.	
12.	**NHS Fife Activity Tracker 2025 - 2026**	Moderate
	One new Inspection has been issued: • Victoria Hospital - Safe delivery of care – discussed on agenda Reports and Publications have been issued: • A National Framework for Reviewing and Learning from Adverse Events in NHS Scotland- discussed on agenda • Hospital at Home Q3 report New standards issued: • Cervical Screening	
14.	**DRAFT NHS Fife Clinical Governance Oversight Group Terms of Reference - Review**	Moderate
	In view of the CGC confirming terms of reference for 25/26 an updated draft of the CGOG terms of reference was shared with the group with feedback sought in order to finalise at the June meeting.	
15.	**DRAFT NHS Fife Clinical Governance Oversight Group Assurance Statement**	Significant
	Endorsement was sought for the Clinical Governance Oversight	

	Assurance Statement which will be submitted to the CGC meeting.	
16.	**Linked Meeting Minutes**	N/A
	No escalations	
17.	**Items for escalation to committee**	N/A
	• NHS Fife Orthopaedic Scottish National Audit Programme - Hip Fracture & Arthroplasty • NHS Fife Healthcare Improvement Scotland Inspection • NHS Fife Clinical Governance Oversight Group Assurance Statement	
18.	**Items identified for noting to the committee for assurance**	N/A
	• Work has started to align national Learning from Adverse Events Framework into NHS Fife Policy and Procedure • Refreshed focus on the IPQR	
19.	**Items identified for updating the committee on in early course**	N/A
	• East Region Neonatal Service - TBC • Adverse Event Policy and Procedure – Sept 2025 • NHS Fife Actions in response to the Infected Blood Inquiry -TBC	

ASSURANCE SUMMARY
MENTAL HEALTH OVERSIGHT GROUP
10 April 2025

1. Purpose

To provide the NHS Fife Clinical Governance Committee with an assurance summary from the Mental Health Oversight Group held on the 10 April 2025. This assurance statement summarises the key aspects of business covered.

	Summary	Assurance Level
1.	**Service Flash Card Reporting**	
	Positive feedback received from Scottish Government at the last engagement session was noted regarding CAMHS activity as this has superseded what had been predicted. Due to the improvements, correspondence from Scottish Government is anticipated advising that the enhanced support for CAMHS will be removed and the service will no longer be on escalated measures. In addition, although Psychology has not achieved the 90% Target there is an improving picture, and the service has managed to outperform their local trajectory achieving 78%. It was noted that the enhanced measures remain in place for Psychology Services. There was discussion around referral patterns within the Addictions Team and the importance of ensuring that the workforce was appropriately aligned as 80% of referrals was related to alcohol dependency. The Pathway for people coming into the service is being reviewed with a test of change taking place with referrals coming through a central point, where all agencies go through the referrals together to ensure that the client is signposted to the appropriate agency. The service has highlighted some risks associated with recruitment issues and staffing to meet the service demands noting that the reduced administration team is having an impact on the support provided to the clinical teams.	
2.	**Adult Services Deep Dive**	
	Due to the apologies received, the decision was taken to reschedule the deep dive to the next meeting to ensure that the Professional Leads were present to hear the presentation.	
3.	**Mental Health Strategy**	

	There has been significant feedback received relating to the MH Strategy and the team are working on the final document. The document will be tabled at the Integration Joint Board in the summer and prior to this discussed in more detail at the IJB and NHS Fife Board Development Sessions.	
4.	**Mental Health Workforce**	
	A paper on International Recruitment is to be tabled at the Professional Standards Oversight Group which could potentially be positive for both substantive and portfolio pathways. It was noted that if the service request is approved at the Professional Standards Oversight Group discussion will be required around the commitment to support the financial impact associated with international recruitment. Assurance was provided that the Service was pressing on with Job Planning with a series of meetings set up for April and May. In addition, meetings with Clinical Leads and the Finance Team for each area is being held to get a better understanding of the overspend within the services. A full workforce report will be tabled at the next meeting.	
5.	**Mental Health Estate**	
	The ongoing work within the QMH site was discussed, and assurance provided that costings for the planned alterations at Cairnie Ward was being progressed. In addition, Stratheden is being looked at to see how the site can be consolidated. Assurance was provided that the improvement work is continuing, and plans are in place for Ward 1 to move to Ward 3 to allow for the upgrade of Ward 1 to allow Ravenscraig Ward to move. Although the timeframe has slipped slightly it was anticipated that the conclusion of works could still be ahead of schedule. A timeline for the remodelling work is to be presented at the next meeting.	
6.	**Mental Welfare Commission/HIS Updates**	
	No update was provided as there have been no inspections since the last meeting. It was noted that Tracey Ferguson will be taking up the role of Mental Health Commissioner shortly.	
7.	**Escalations**	
	It was confirmed that there were no items for escalation.	

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**2 May 2025**
Title:	**Corporate Risks Aligned to Clinical Governance Committee**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author:	**Dr Shirley-Anne Savage, Associate Director for Risk & Professional Standards**

Executive Summary:

- The report provides an update on the corporate risks aligned to this committee.
- The committee are asked to consider and be assured of the mitigating actions to improve the risk levels and note the risk appetite status of the corporate risks against the new risk appetite agreed by the Board in November 2024.
- Members are asked to take a "moderate" level of assurance that, all actions, within the control of the organisation, are being taken to mitigate these risks as far as is possible to do so.

1 Purpose

This report is presented for:

- Discussion

This report relates to:

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

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This paper provides an update on the corporate risks aligned to this Committee since the last report on 7 March 2025.

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.

2.3 Assessment

The risks aligned to this Committee are summarised in Table 1 below and at Appendix 1.

Risk Title	Target Score	Current Score	Feb 2025	Dec 2024	Oct 2024	Aug 2024	June 2024	April 2024	Risk Appetite
9. Quality & Safety	6	12	12	12	12	12	12	12	Within
17. Cyber resilience	12	16	16	16	16	16	16	16	Above
18. Digital and Information	12	15	15	15	15	15	15	15	Within
22. Hospital Acquired Harm (awaiting final adoption)	*12*	*15*	*15*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*Within*

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

- Three risks are currently aligned to the Committee.
- One new risk has been endorsed by this and the Audit and Risk Committee– Risk 22 - Hospital Acquired Harm and is now awaiting final adoption at the Board in May 2025
- The risk level breakdown is - 2 High and 1 Moderate.

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

- The risk has a current moderate 12 risk level and is therefore within appetite.

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

- Risks 17 has a current high-risk 16 level and is therefore above risk appetite.
- Risk 18 has a current high-risk 15 level and is therefore within risk appetite

Risk Updates

Risk 9 - Quality and Safety

The Organisational Learning Leadership Group (OLLG) is starting to shape the workplan for 2025/2026. A key focus of this work is the Clinical Organisational Learning Event which launched on 9th April. This event extrapolates learning of organisational significance and brings multiprofessional groups together across the NHS Fife healthcare system to share learning as a collective. Topics presented at the event will be referred from the Significant Adverse Event Panel, Clinical Governance Meetings and individuals who are eager to share learning. Each meeting will have topics under the following themes:

- Learning from celebrating success
- Learning from things that haven't gone well
- Micro learning e.g. human factors or the Infected Blood Inquiry

The content of presentations and recording of the presentation will be shared on the Organisational Learning Blink page. Topics which are not presented but are of significance will also be uploaded to this page.

Risk 18 – Digital & Information

A strategy completion report was presented to the NHS Fife Board in November 2024 outlining the scale of demand.

Digital and Information operate within the financial governance structure of NHS Fife and participate in the planning and governance work of FCIG, where capital allocations are agreed, following consideration of risk, to support Infrastructure lifecycle activities.

A revised Digital Framework is being created via the Digital Information Board and will be presented to governance committees for review and comment in 2025 and will outline financial pressures and workforce planning, to support the mitigation of this risk.

Work continues of service lead prioritisation of digital activities.

This report provides the following Level of Assurance:

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

2.3.1 Quality, Patient and Value-Based Health & Care

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

2.3.2 Workforce

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

2.3.3 Financial

Effective management of financial risks will support delivery of our strategic priorities including delivering value and sustainability.

2.3.4 Risk Assessment / Management

Management and oversight of the corporate risks continue to be maintained, with risk reporting provided regularly to the relevant groups and committees.

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 on Option 1: No further action required.

2.3.6 Climate Emergency & Sustainability Impact

This paper does not raise, directly, issues relating to climate emergency and sustainability.

2.3.7 Communication, involvement, engagement and consultation

This paper reflects a range of communication and engagement over time

2.3.8 Route to the Meeting

- Gemma Couser, Associate Director of Quality & Clinical Governance on 24 April 2025
- Alistair Graham, Associate Director of Digital & Information on 24 April 2025
- Dr Chris McKenna, Medical Director, on 24 April 2025

2.4 Recommendation

Members are asked to:

- **note** details of the corporate risks aligned to this committee as at 22 April 2025
- **note** the risk appetite status of the risks against the new risk appetite
- consider and be assured of the mitigating actions to improve the risk levels and take a **"moderate" level of assurance**

3 List of appendices

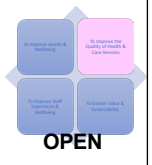
Appendix 1, NHS Fife Corporate Risks aligned to the CGC as at 22 April 2025

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

NHS Fife Corporate Risk Register as at 22/04/25

No	Strategic Priority and Risk Appetite	Risk Title and Description	Mitigation	Risk Appetite Status	Current Risk Level/ Rating	Target Risk level & rating by dd/mm/yy	Current Risk Level Trend	Risk Owner	Primary Committee
9	 OPEN	**Quality & Safety** There is a risk that if our governance, arrangements are ineffective, we may be unable to recognise a risk to the quality of services provided, thereby being unable to provide adequate assurance and possible impact to the quality of care delivered to the population of Fife.	Effective governance is in place and operating through the Clinical Governance Oversight Group (CGOG) providing the mechanism for assurance and escalation of clinical governance (CG) issues to Clinical Governance Committee (CGC). There are also effective systems & processes to ensure oversight and monitoring of national & local strategy / framework / policy /audit implementation and impact. One of the root causes of this risk is that there are "no effective system of supporting effective organisational learning". The Organisational Learning Leadership Group (OLLG) is starting to shape the workplan for 2025/2026. A key focus of this work is the Clinical Organisational Learning Event which launched on 9th April. This event extrapolates learning of organisational significance and brings multiprofessional groups together across the NHS Fife healthcare system to share learning as a collective. Topics presented at the event will be referred from the Significant Adverse Event Panel, Clinical Governance Meetings and individuals who are eager to share learning. Each meeting will have topics under the following themes: - Learning from celebrating success - Learning from things that haven't gone well	Within	Moderate 12	Low 6 by 31/10/25	◀▶	Medical Director	Clinical Governance (CGC)

			- Micro learning e.g. human factors or the Infected Blood Inquiry The content of presentations and recording of the presentation will be shared on the Organisational Learning Blink page. Topics which are not presented but are of significance will also be uploaded to this page. Another change which aligns to the work of the OLLG and the Adverse Events Improvement Plan is that from 1st August all significant adverse events graded as a 4 (i.e. (*"A different plan and or delivery of care, on balance of probability, would have been expected to result in a more favourable outcome, i.e. how case was managed had a direct impact on the level of harm")* will now have the associated improvement plans returned to the Executive SAER panel for oversight and monitoring of improvement actions. The next phase of this work is to embed governance processes for outcomes 1-3 within divisional clinical governance structures. The intention is to redefine the risks relating to Quality and Safety beyond the process/governance focus that we currently have.						
17	 **OPEN**	**Cyber Resilience** There is a risk that NHS Fife will be overcome by a targeted and sustained cyber attack that may impact the availability and / or integrity of digital and information required to operate a full health service.	The Network Information System Directive (NISD) and now Cyber Resilience Framework Audit has concluded for 2024. The compliance rate has increased to 93%, up from 77% from the previous year. The action plan for improvement will be presented to the Information Governance and Security Steering Group for review and progress tracking.	Above	High 16	Mod 12 by 30/09/25	◄►	Director of Digital and Information	Clinical Governance (CGC)

			The associated and linked Risks for Cyber Resilience will be reviewed in line with the Audit report. Management actions continue to be progressed.						
18	 **OPEN**	**Digital & Information** There is a risk that the organisation maybe unable to sustain the financial investment necessary to deliver its D&I Strategy and as a result this will affect our ability to enable transformation across Health and Social Care and adversely impact on the availability of systems that support clinical services, in their treatment and management of patients.	A strategy completion report was presented to the NHS Fife Board in November 2024 outlining the scale of demand. Digital and Information operate within the financial governance structure of NHS Fife and participate in the planning and governance work of FCIG, where capital allocations are agreed, following consideration of risk, to support Infrastructure lifecycle activities. A revised Digital Framework is being created via the Digital Information Board and will be presented to governance committees for review and comment in 2025 and will outline financial pressures and workforce planning, to support the mitigation of this risk. Work continues of service lead prioritisation of digital activities.	Within	High 15	Mod 12 30/04/26	◄►	Director of Digital and Information	Clinical Governance (CGC)
22	 **OPEN**	**Hospital Acquired Harm** There is a risk that patients may come to hospital acquired harm (falls, pressure damage, hospital acquired infection, medication) resulting in adverse clinical outcomes as a result of a reduction in resource, availability of workforce and whole system pressures.	Work is underway in the following areas: • Falls Prevention • Pressure Ulcer Prevention • Hospital Acquired Infection • Medicine Incidents • Unscheduled Care Programme Board • Emergency Access • Delayed Transfer of care and Surge	Within	High 15	Mod 12 by 31/03/26	◄►	Medical Director and Nurse Director	Clinical Governance (CGC)

Risk Movement Key

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

CLINICAL GOVERNANCE COMMITTEE
ANNUAL WORKPLAN 2025 / 2026

Governance - General							
	Lead	**02/05/25**	**11/07/25**	**29/08/25**	**07/11/25**	**09/01/26**	**06/03/26**
Minutes of Previous Meeting	**Chair**	✓	✓	✓	✓	✓	✓
Action list	**Chair**	✓	✓	✓	✓	✓	✓
Escalation of Issues to Fife NHS Board	**Chair**	✓	✓	✓	✓	✓	✓
Active or Emerging Issues							
	Lead	**02/05/25**	**11/07/25**	**29/08/25**	**07/11/25**	**09/01/26**	**06/03/26**
Victoria Hospital Water Supply Issue	**Medical Director**	✓					
Governance Matters							
	Lead	**02/05/25**	**11/07/25**	**29/08/25**	**07/11/25**	**09/01/26**	**06/03/26**
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**	✓					
Area Clinical Forum Annual Assurance Statement	**Director of Nursing, Corporate (Chair of ACF)**	✓					
Annual Committee Assurance Statement (inc. best value report)	**Board Secretary**	✓					
Annual Internal Audit Report	**Director of Finance**		✓				
CGOG Assurance Summary Report	**Associate Director of Quality & Clinical Governance**	✓	✓	✓	✓	✓	✓
Committee Self-Assessment Report	**Board Secretary**						✓
Corporate Calendar / Committee Dates	**Board Secretary**			✓			
Corporate Risks Aligned to CGC	**Medical Director/Associate Director for Risk & Professional Standards**	✓	✓	✓	✓	✓	✓
Internal Controls Evaluation Report 2024/25	**Chief Internal Auditor**					✓	

Governance Matters (cont.)							
	Lead	**02/05/25**	**11/07/25**	**29/08/25**	**07/11/25**	**09/01/26**	**06/03/26**
Mental Health Oversight Group Assurance Summary Report	**Medical Director**						
Review of Terms of Reference	**Board Secretary**						✓ Approval
Review of Annual Workplan	**Associate Director of Quality & Clinical Governance**	✓	✓	✓	✓	✓	✓ Approval
Strategy / Planning							
	Lead	**02/05/25**	**11/07/25**	**29/08/25**	**07/11/25**	**09/01/26**	**06/03/26**
Annual Delivery Plan 2025/26 Scottish Government Response	**Director of Planning & Transformation**	**Removed from workplan – will be presented at FP&R only**					
Annual Delivery Plan Quarterly Reports	**Director of Planning & Transformation**	✓ **Q4/2024**	**Removed from workplan for 2025/26**				
Cancer Strategic Framework & Delivery Plan	**Medical Director/Associate Director for Risk & Professional Standards**				✓		
Clinical Governance & Strategic Framework Delivery Plan 2025/26	**Medical Director / Associate Director of Quality & Clinical Governance**		✓		✓ **Mid-year update**		
Corporate Objectives	**Director of Planning and Transformation**	**Removed from workplan – presented to NHS Fife Board in March 2025**					
Value Based Health and Care Delivery Plan (Realistic Medicines)	**Associate Director for Risk & Professional Standards**	✓ **c/f from March '25**					✓
Scottish Healthcare Associated Infection (HCAI) Strategy 2023-25	**Director of Nursing**			✓			
Quality / Performance							
	Lead	**02/05/25**	**11/07/25**	**29/08/25**	**07/11/25**	**09/01/26**	**06/03/26**
Deteriorating Patients Improvement Programme Annual Report – timing tbc	**Medical Director**	**TBC**					
Integrated Performance and Quality Report	**Medical Director / Director of Nursing**	✓	✓	✓	✓	✓	✓

Quality / Performance (Cont.)							
	Lead	**02/05/25**	**11/07/25**	**29/08/25**	**07/11/25**	**09/01/26**	**06/03/26**
Healthcare Associated Infection Report (HAIRT)	**Director of Nursing**	✓	✓	✓	✓	✓	✓
Public Protection, Accountability & Assurance Framework - Self Evaluation	**Director of Nursing**	✓ **c/f from March '25**				✓	
East Region Neonatal Services	**Medical Director**	**Removed from workplan – No longer to go to the Committee**					
Safe Delivery of Care Health Improvement Scotland Inspection Action Plan	**Director of Nursing**	✓					
Digital / Information							
	Lead	**02/05/25**	**11/07/25**	**29/08/25**	**07/11/25**	**09/01/26**	**06/03/26**
Digital and Information Strategy 2019-24 Update	**Director of Digital & Information**			✓		✓	
Hospital Electronic Prescribing and Medicines Administration (HEPMA) Programme	**Medical Director**			✓			
Information Governance and Security Steering Group Update	**Director of Digital & Information**			✓			✓
Person Centred Care / Participation / Engagement							
	Lead	**02/05/25**	**11/07/25**	**29/08/25**	**07/11/25**	**09/01/26**	**06/03/26**
Equalities Outcome Report 2027 *(also goes to PHWC)*	**Director of Nursing**	Interim report 2025/29 will be presented in March 2027 (Two yearly)					
Patient Experience & Feedback	**Director of Nursing**	✓	✓	✓	✓	✓	✓
Patient Story	**Director of Nursing**	✓	✓	✓	✓	✓	✓
Professional Standards							
	Lead	**02/05/25**	**11/07/25**	**29/08/25**	**07/11/25**	**09/01/26**	**06/03/26**
Allied Health Professional Assurance Framework	**Director of Nursing**			✓			

Professional Standards (cont.)							
	Lead	**02/05/25**	**11/07/25**	**29/08/25**	**07/11/25**	**09/01/26**	**06/03/26**
Nursing & Midwifery Professional Assurance Framework	**Director of Nursing**			✓			
Advanced Practitioners Review Update	**Director of Nursing**			✓			
Annual Reports / Other Reports							
	Lead	**02/05/25**	**11/07/25**	**29/08/25**	**07/11/25**	**09/01/26**	**06/03/26**
Adult Support & Protection Annual Report 2023/25 *(also goes to PHWC)* *(next report after 2025 due 2027)*	**Director of Nursing**	**Deferred to next mtg due to timings**	✓				
Area Clinical Forum Mid-Year Report	**Director of Nursing, Corporate**				✓		
Care Opinion Annual Report 2024/25	**Director of Nursing**			✓			
Clinical Advisory Panel Annual Report 2024/25	**Medical Director**		✓				
Controlled Drug Accountable Officer Annual Report 2024/25	**Director of Pharmacy & Medicines**			✓			
Director of Public Health Annual Report 2025 *(also goes to PHWC)*	**Director of Public Health**					✓	
Fife Child Protection Annual Report 2024/25 *(also goes to PHWC)*	**Director of Nursing**		✓				
Hospital Standardised Mortality Ratio (HSMR) Update Report 2024/25	**Medical Director**				✓		
Medical Appraisal and Revalidation Annual Report 2024/25	**Medical Director/Associate Director for Risk & Professional Standards**				✓		
Medical Education Annual Report 2024/25	**Medical Director**						✓
Medicine Safety Review and Improvement Report 2024/25	**Director of Pharmacy & Medicines**				✓		
Occupational Health Annual Report 2024/25	**Director of Workforce**					✓	
Organisational Duty of Candour Annual Report 2024/25	**Medical Director**						✓

Annual Reports / Other Reports (cont.)							
	Lead	**02/05/25**	**11/07/25**	**29/08/25**	**07/11/25**	**09/01/26**	**06/03/26**
Participation & Engagement Report and Quality Framework for Participation & Engagement Self-Evaluation 2024/25	**Director of Nursing**					✓	
Prevention & Control of Infection Annual Report 2024/25	**Director of Nursing**				✓		
Radiation Protection Annual Report 2024/25	**Medical Director**		✓				
Research, Innovation and Knowledge Strategy 2022-2025 Progress Update	**Medical Director**					✓	
Research, Innovation and Knowledge Annual Report 2024/25	**Medical Director**					✓	
Review of Deaths of Children & Young People 2024/25	**Director of Nursing**			✓			
Stroke Bundle/Thrombosis Annual Report *(action from March '25 mtg)*	**Medical Director**					✓	
The Patient Rights (Feedback, Comments, Concerns and Complaints) (Scotland) Annual Report	**Director of Nursing**			✓			
Linked Committee Minutes							
	Lead	**02/05/25**	**11/07/25**	**29/08/25**	**07/11/25**	**09/01/26**	**06/03/26**
Area Clinical Forum	**Chair of Forum**	03/04	-	05/06	07/08	02/10	04/12
Area Medical Committee	**Medical Director**	-	03/04 & 05/06	07/08	02/10	04/12	05/02
Area Radiation Protection Committee	**Medical Director**	-	07/05	-	-	12/11	-
Cancer Governance & Strategy Group	**Medical Director**	19/02	01/04	12/06	09/09	27/11	-
Clinical Governance Oversight Group	**Medical Director**	08/04	-	17/06	19/08	14/10	09/12
Digital & Information Board	**Director of Digital & Information**	TBC					
Fife Area Drugs & Therapeutic Committee	**Medical Director**	-	13/03 & 23/04	18/06	27/08	29/10	17/12
Fife IJB Quality & Communities Committee	**Associate Medical Director**	04/09, 08/11 & 10/01	06/03 & 25/04	04/07	05/09	05/11	07/01

Linked Committee Minutes (cont.)							
	Lead	**02/05/25**	**11/07/25**	**29/08/25**	**07/11/25**	**09/01/26**	**06/03/26**
Health & Safety Subcommittee	**Chair of Subcommittee**	07/03	06/06	-	05/09	05/12	-
Infection Control Committee	**Director of Nursing**	01/10	02/04	04/06	06/08	01/10	03/12
Ionising Radiation Medical Examination Regulations Board (IRMER)	**Medical Director**		06/05	-	17/09	-	-
Information Governance & Security Steering Group	**Director of Digital & Information**	TBC					
Medical Devices Group	**Medical Director**	12/03	11/06	-	-	10/12	-
Medical & Dental Professional Standards Oversight Group	**Medical Director**	21/01 & 15/04		15/07	-	21/10	-
Mental Health Oversight Group	**Director of Health & Social Care**	-	10/04	04/06	05/08	17/10	10/12
Research, Innovation & Knowledge Oversight Group	**Medical Director**	-	24/04	-	-	13/11	-
Resilience Forum	**Director of Public Health**	20/03	-	18/06	18/09	-	17/12
Ad-hoc/Additional Items							
	Lead	**02/05/25**	**11/07/25**	**29/08/25**	**07/11/25**	**09/01/26**	**06/03/26**
Annual Summary of Quality of Care Framework *(action from March '25 mtg)*	**Director of Nursing**	TBC					
Clinical Services Redesign Programme *(added)*	**Director of Planning & Transformation/Director of Acute Services**	✓ **Presentation**					
North East Minor Injuries Unit Reconfiguration *(added)*	**Director of Health & Social Care**	✓					
Matters Arising							
	Lead	**02/05/25**	**11/07/25**	**29/08/25**	**07/11/25**	**09/01/26**	**06/03/26**
Development Sessions							
	Lead						

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**2 May 2025**
Title:	**Annual Delivery Plan Quarter 4 Report 2024/25**
Responsible Executive:	**Ben Hannan, Director of Planning & Transformation**
Report Author:	**Susan Fraser, Deputy Director of Planning & Transformation**

Executive Summary:

This report contains quarter 4 update on progress for Annual Delivery Plan (ADP) 2024/25.

There are 88 deliverables within ADP 2024/25 aligned to 'Improve Quality of Health and Care Services' Strategic Priority. As of the end of Mar-25 (quarter 4 of 2024/25), there are 28 deliverables that are **'complete'** and two that have been **'suspended /cancelled'**. There are 58 deliverables that will continue into 2025/26 with 34 **'on track'**, 22 at **'at risk'** and two that are **'unlikely to complete on time/meet target'**.

Summary of status of all deliverables in ADP, by Strategic Priority, displayed below. Total includes deliverables that cover multiple Strategic Priorities. Not all completed deliverables achieved desired outcomes.

Strategic Priority	Unlikely to complete on time	At risk	On track	Complete	Suspended /Cancelled	Total
Improve Health and Wellbeing	2	7	19	7	-	35
Improve Quality of Health and Care Services	2	22	34	28	2	88
Improve Staff Experience and Wellbeing	-	2	20	1	-	23
Deliver Value and Sustainability	5	14	19	22	-	60
Total	**9**	**46**	**93**	**58**	**2**	**208**

Progress report is to be reviewed for Annual Delivery Plan (ADP) 2025/26 following approval/feedback from Scottish Government. Revised report will focus on Corporate and ADP Objectives as detailed in ADP 2025/26 with ongoing deliverables, where applicable, to be aligned to ADP 2025/26. Reconciliation exercise will take place on deliverables not aligned to ADP, ensuring appropriate mechanisms for scrutiny and assurance are in place.

This report provides Moderate Level of Assurance.

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Annual Delivery Plan 2024/25

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

- Safe
- Effective
- Person Centred

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

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

2 Report summary

2.1 Situation

This paper presents the Q4 update to deliverables incorporated in the NHS Fife Annual Delivery Plan for 2024/25

2.2 Background

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

The ten Drivers of Recovery were used to frame planning 2024/25, have remained broadly in line with those used in 2023/24.

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

2.3 Assessment

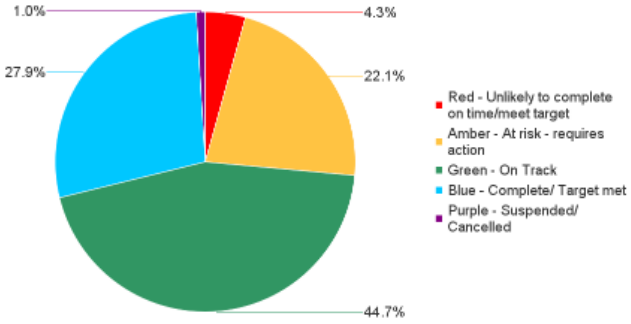
2024/25 Quarter 4 Update

There are now **208** deliverables incorporated in ADP for 2024/25 across both NHS Fife and Fife HSCP. There are a number of deliverables carried over from 2023/24 as well as those relating to RTP. Additionally, there are **43** deliverables that are not aligned to a Recovery Driver.

Recovery Driver	n=165
1. Primary and Community Care	22
2. Urgent and Unscheduled Care	15
3. Mental Health	18
4. Planned Care	9
5. Cancer Care	6
6. Health Inequalities	30
7. Women & Children Health	13
8. Workforce	18
9. Digital & Innovation	21
10. Climate	13

Strategic Priority	n=208
All	2
Improve Health and Wellbeing	35
Improve the Quality of Health and Care Services	88
Improve Staff Experience and Wellbeing	23
Deliver Value and Sustainability	60

As of end of Mar-25 (Quarter 4 of 2024/25), there are **58** deliverables that are **'complete'** with most **(44.7%/93) 'on track'**. There are **nine** deliverables that are **'unlikely to complete on time/meet target'**. There is also **two** deliverable that has been **'suspended/ cancelled'**.



There are 88 deliverables aligned to 'Improve the Quality of Health and Care Services' Strategic Priority. Further detail on deliverables that are **'unlikely to complete on time/meet target'** as well as deliverables **'at risk'** at quarter 4 that were **'on track'** at quarter 3 are tabled below.

Improve Quality of Health and Care Services
Unlikely to complete on time/meet target
Implement IP Workforce Strategy 2022-24 Progress has been hindered due to delays in national deliverables, affecting local implementation. the 2-week CNS, Professional Judgement and Quality workforce planning tools run for the IPCT in March 2025 completed. A gap analysis and options paper are being developed, for review by the Executive Delivery Group to address these challenges and align future actions with strategy goals.
Review of Specialty Paediatric Nursing workforce/services in line with safer staffing legislation and Working Paper 8 "Review of Clinical Nurse Specialist roles within Scotland" of the Scottish Governments Transforming Roles Program. Progress paused due to workforce challenges and inability to consider development of new/ additional nursing roles this financial year.

At risk – requires action
Best Start We have introduced CoC TO Intrapartum areas, now 50% achieved, 75% is the national target. Progress with Transitional Care in the Neonatal Unit, dependent on clinical space. Work being taken forward with Patient Experience regarding the Maternity Engagement Strategy.
Development and Implementation of an Adult Neurodevelopmental Pathway with clear links to CYP NDD Pathway. Options paper presented to CCCS QMAG. Paper being revised following feedback. To go back to CCCS QMAG for sign-off before being sent to SLT.
Improve compliance with CAPTND dataset Psychology Service has worked closely with Digital and Information to develop TrakCare package that will meet service and CAPTND reporting requirements. D&I implementation target date is now June 2025.
Local Enhanced Services Review In order to progress with the review of Enhanced Services currently available to GP practices an options appraisal has been drafted which will be shared with the Enhanced Services SLWG for discussion and decision.
Implement Paperlite / Electronic Patient Record Implementation of Morse extended to September 2025 Implement of Results Reconciliation reprioritised
Delivery of Research Innovation and Knowledge Strategy Four priority themes identified (Sustainability, Collaboration, Culture and Communication), Microsoft Forms Survey of RIK Dept staff and revised Microsoft Survey of internal and external stakeholders and partners. Data reviewed by Leadership team and considered in the context of objectives. University of St Andrews School of Medicine is refreshing strategy due to appointment of new Dean and agreed that will develop and finalise Strategies in parallel.
Delivery of Clinical Governance Strategic Framework 4 out of the 11 workstreams have been delivered 2023/2024 2 out of the 11 workstreams have been partially delivered 5 out of the 11 workstreams have been allocated a revised timescale for completion - outstanding workstreams will be carried over to 25/26
Pandemic Preparedness: Critical to major incident levels. The draft Pandemic response framework plan is circulating to key stakeholders for subject specialist advice /input - SLWG will take forward to final version
To develop the resilience risk profiling for Emergency Planning for NHS Fife. Reporting analytics work is currently still underway for governance and assurance to evidence-based practice with EPRR response planning
Committed to controlling, reducing and preventing Healthcare Associated Infections (HAI) and Antimicrobial Resistance (AMR) in order to maintain individual safety within our healthcare settings. NHS Fife remains committed to controlling, reducing, and preventing HCAI and AMR to ensure individual safety within healthcare settings. The ongoing IPC and robust surveillance programme, continues to focus on minimising the risk of HAIs and AMR. Throughout this quarter, NHS Fife sustained its participation in the national surveillance programme, monitoring SAB, CDI, and ECB. Efforts align with the reduction targets outlined in DL (2023) 06. The team are preparing for the recently published new targets for 2025/26.

The anticipated updates to the NIPCM and TBPs has been further postponed to Spring 2026. The team remains actively engaged, contributing to this critical work through the national extraordinary NPGE Working Group. The eCatheter bundle group met on 12th March 2025 to finalise the pathways for the catheter insertion & maintenance systems for both the acute & HSCP. IPC continue to work with D&I to fully integrate these updated bundles onto Patientrack
Embed the National Leading Excellence In Care Education and Development Framework into existing and new education programmes EiC Support Nurse has been encouraging staff to utilise resource.
Support the creation of a digitalised person-centred record Significant progress has been made to identify patient pathways. Project lead has left post and EiC lead going on secondment May 2025
Support the creation of Person-Centred Care Planning Principles Delayed due to capacity

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

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

2.3.1 Quality, Patient and Value-Based Health & Care

The ADP process ensures the delivery of high-quality, safe, and person-centred care through strategic planning and system-wide collaboration. A value-based healthcare approach is embedded to ensure services are clinically effective, financially sustainable, and aligned with patient needs, while prioritising equity of access, prevention, and early intervention.

Key enablers include workforce development, digital transformation, clinical service redesign, and infrastructure investment. Through continuous improvement, evidence-based decision-making, and governance oversight, the ADP drives measurable improvements in patient outcomes, operational efficiency, and system resilience, aligning with national quality standards and long-term sustainability goals.

2.3.2 Workforce

The ADP sets out the approach to workforce planning, ensuring alignment with the Workforce Plan for 2024/25. This includes optimising staffing models, recruitment, retention, and skill mix to build a resilient and adaptable workforce that meets service demands and future challenges.

A focus on sustainable workforce planning will support service transformation, productivity improvements, and financial sustainability, while also addressing national workforce priorities, staff wellbeing, and training needs to ensure a high-performing health and care system.

2.3.3 Financial

The ADP and Financial Plan for 2024/25 are developed through a joint approach, ensuring financial resources are aligned with strategic priorities and operational requirements. The Financial Plan underpins the delivery of ADP actions, balancing investment, efficiency savings, and long-term sustainability to maintain financial resilience while supporting service transformation.

2.3.4 Risk Assessment / Management

The ADP is aligned with the Corporate Risk Register, ensuring that delivery risks are proactively identified, monitored, and managed through the risk management framework. Each ADP delivery area is mapped to the relevant corporate risks, with this alignment detailed in the ADP 2024/25 appendix, supporting robust governance and accountability.

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

An Equality Impact Assessment (EQIA) is not required for the ADP itself but remains an integral part of the planning process for associated service changes. The plan explicitly references the UNCRC, reinforcing commitments to children's rights, while also embedding Anchor Institution principles to support inclusive employment, procurement, and community engagement.

Health inequalities are a core ADP delivery area, with actions woven throughout the plan to address equitable access, prevention, and early intervention. Additionally, a dedicated corporate objective ensures a strategic commitment to equality, diversity, and inclusion (EDI), reinforcing alignment with national and local ambitions to create a fairer, more inclusive health system.

2.3.6 Climate Emergency & Sustainability Impact

Climate action is embedded throughout the plan as a key delivery area. The ADP includes specific commitments to carbon reduction, sustainable estate management, and environmental impact mitigation, aligning with national net-zero targets and NHS Scotland's climate resilience strategy.

2.3.7 Communication, involvement, engagement and consultation

The ADP has been developed through extensive communication, involvement, and engagement across the organisation, ensuring alignment with strategic priorities, operational planning, and workforce considerations. Key stakeholders, including clinical, managerial, and corporate teams, have contributed throughout the process, with consultation informing priorities and delivery planning to support effective implementation.

2.3.8 Route to the Meeting

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

- Executive Directors Group 24 April 2025

2.4 Recommendation

This Committee are asked to:

- **Assurance** – this report provides a moderate level of assurance.
- **Endorse**– Endorse the ADP Q4 return for endorsement at the committees, formal approval at Board and for submission to Scottish Government.

3 List of appendices

The following appendices are included with this report:

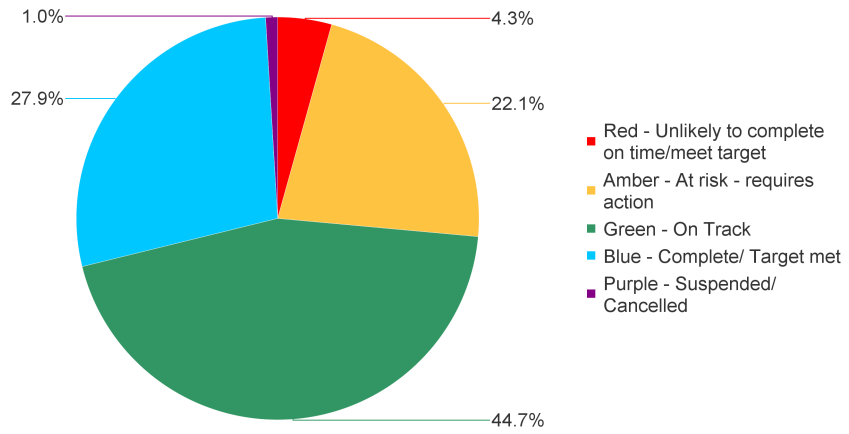
- Appendix No. 1, NHS Fife ADP 202425 Quarterly Report Q4

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

Annual Delivery Plan 2024/25 - Q4 Progress Summary

Q4 Status	Red - Unlikely to complete on time/meet target	Amber - At risk - requires action	Green - On Track	Blue - Complete/ Target met	Purple - Suspended/ Cancelled	Total
1. Primary and Community Care	2	4	7	9		**22**
2. Urgent and Unscheduled Care		4	8	2	1	**15**
3. Mental Health		5	10	3		**18**
4. Planned Care			1	8		**9**
5. Cancer Care	1		3	2		**6**
6. Health Inequalities		2	20	8		**30**
7. Women & Children Health	1	3	8	1		**13**
8. Workforce		3	13	2		**18**
9. Digital & Innovation	3	9	3	6		**21**
10. Climate		3	1	8	1	**13**
Other	2	13	19	9		**43**
To Improve Health and Wellbeing	2	7	19	7		**35**
To Improve the Quality of Health and Care Services	2	22	34	28	2	**88**
To Improve Staff Experience and Wellbeing		2	20	1		**23**
To Deliver Value & Sustainability	5	14	19	22		**60**
ALL		1	1			**2**
Total	**9**	**46**	**93**	**58**	**2**	**208**

Q4 RAG Status



Q3 V \ Q4 >						Total
	4		2	1		**7**
	4	22	9	3		**38**
	1	24	82	41		**148**
				12		**12**
				1	2	**3**
Total	**9**	**46**	**93**	**58**	**2**	**208**

Annual Delivery Plan 2024/25 - Q4 Progress Summary

RTP - Re-form, Transform, Perform

Deliverable	Directorate	2024/25 Q4 Narrative Highlight achievements, reflecting on planned activities and impact on stated outcomes, as well as any associated risks and challenges that impacted delivery	2024/25 Q4 Planned Milestones	NHS Fife Strategic Priority	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status	Deliverable 24/25 Q3 RAG Status	Deliverable 24/25 Q4 RAG Status
Business Transformation	Digital	Mapping and engagement activities underway Programme Brief and Plan redrafted for presentation to governance	Case for change provided to RTP Exec and Fife NHS Board Staff cohorts identified Supporting Digital Product enhancements confirmed	To Deliver Value & Sustainability	Red - Unlikely to complete on time/meet target	Red - Unlikely to complete on time/meet target	Amber - At risk - requires action	Amber - At risk - requires action
Surge Capacity - Improve flow within the VHK site, reducing length of stay and number of patients boarding to ensure patients are looked after in the most appropriate setting. Accurate PDD to inform planning for discharge, coordinated with the Discharge Hub.	Acute Medical	No reduction in bed footprint possible due to over capacity. SBAR agreed at SLT in March and to be discussed at EDG - model of care re prioritised with PDD focus, review of criteria and staffing & bed base to flex between 30-44 patients acknowledging seasonal variation/demand.	Reduction of Ward 9 to 11 to 30 beds and associated maintenance of new footprint Continue to monitor Locum Surge Consultant post	To Deliver Value & Sustainability	Red - Unlikely to complete on time/meet target	Red - Unlikely to complete on time/meet target	Amber - At risk - requires action	Amber - At risk - requires action
Attracting & Recruiting Staff to deliver Population Health & Wellbeing Strategy; Bank Governance – Enhanced Management & Staff Bank Consolidation.	Workforce	Medical locums transferred on 3 February 2025 and next phase of transition is to focus on AHP and Medical Records Banks.	Direct Engagement model in place and work transitioned over. Bank model changes fully in place and operating as Business as Usual.	To Deliver Value & Sustainability	Amber - At risk - requires action	Amber - At risk - requires action	Amber - At risk - requires action	Green - On Track
Non-compliant Rotas	Office of Medical Director	Savings target exceeded for the year with second stage of monitoring complete. Final savings to be reported once all results received and any re-monitoring completed and reviewed. Clinical Management to continue with existing processes to sustain compliance and online resources available to be updated by individual services and directorates for new cohorts.	Results of surveys cascaded to be reviewed. Second stage of monitoring to begin Services to address any concerns of rota monitoring results prior to second round beginning in February	To Improve the Quality of Health and Care Services	Green - On Track	Green - On Track	Green - On Track	Green - On Track
SLA and External Activity	Finance & Strategy	Agreement made nationally on SLA uplift of 6.64% therefore the NHSF 3% target was not met.	Planned implementation of PLICS locally Meeting scheduled with NHS Tayside to discuss decontamination service Ongoing development of Performance Management dashboard Ongoing discussions with other Boards Chief Executives relating to transition into more formal Performance Management arrangements RTP/SLA Moving towards a business as usual model in 2025/26 - Closing report to be developed	To Deliver Value & Sustainability	Red - Unlikely to complete on time/meet target	Red - Unlikely to complete on time/meet target	Red - Unlikely to complete on time/meet target	Blue - Complete/ Target met
Digital & Information Projects	Digital	The Digital RTP activities have now concluded for 2024/25.	Assess Benefits for Quarter	To Deliver Value & Sustainability	Green - On Track	Amber - At risk - requires action	Amber - At risk - requires action	Blue - Complete/ Target met

Deliverable	Directorate	2024/25 Q4 Narrative Highlight achievements, reflecting on planned activities and impact on stated outcomes, as well as any associated risks and challenges that impacted delivery	2024/25 Q4 Planned Milestones	NHS Fife Strategic Priority	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status	Deliverable 24/25 Q3 RAG Status	Deliverable 24/25 Q4 RAG Status
Medicines optimisation. Design and support delivery of medicines optimisation work to ensure optimal use of medicines budgets	Pharmacy & Medicines	The revised target for acute medicines efficiencies is likely to be surpassed by the end of financial year. Within the HSCP, delivery is expected to be 91% of target (noting the target was revised upwards, and delivery has surpassed original targets). Medicines waste comms activity has been undertaken, aimed at clinicians and the public.	Monthly monitoring of the Medicines Optimisation plan and continued identification of opportunities. Identification of /and quantification of efficiencies to meet an extended £3M target is ongoing, however it is very unlikely that this target Review of current prescribing guidelines across a number of specialties to more clearly define treatment pathways and access to medicines Comms and engagement plan with all staff. Reducing medicines waste in hospital.	To Deliver Value & Sustainability	Green - On Track	Amber - At risk - requires action	Green - On Track	Blue - Complete/ Target met
Procurement Savings within Acute Services	Acute Services	Projecting £456,299 as at end of month 11 for in year impact and recurring saving of £500,000 target.	Ongoing reviews of expenditure and savings opportunities.	To Deliver Value & Sustainability	Amber - At risk - requires action	Green - On Track	Green - On Track	Blue - Complete/ Target met
Estates Rationalisation	Property & Asset Management	24/25 targets met with consolidation of 3 buildings including Hayfield House, Cameron House and Haig House. Sharing of office assets with Fife Council enabled the buildings to be decanted.		To Deliver Value & Sustainability	Green - On Track	Green - On Track	Green - On Track	Blue - Complete/ Target met
Infrastructure - Workforce	Digital		Decommission Sites Establish other hotdesking locations	To Deliver Value & Sustainability	Green - On Track	Green - On Track	Blue - Complete/ Target met	Blue - Complete/ Target met

Annual Delivery Plan 2024/25 - Q4 Progress Summary

To Improve Health and Wellbeing

Deliverable	ADP Reference	2024/25 Q4 Narrative Highlight achievements, reflecting on planned activities and impact on stated outcomes, as well as any associated risks and challenges that impacted delivery	2024/25 Q4 Planned Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status	Deliverable 24/25 Q3 RAG Status	Deliverable 24/25 Q4 RAG Status
Increase capacity for providing in-hours routine and urgent dental care	1.5	The SDAI initiative is still ongoing as this is a government funded scheme. We are hopeful a new practice in Dunfermline will open this year but still have not heard regarding the Kirkcaldy area. There remains limited options to register with NHS dentists in Fife but this is updated regularly. The dental adviceline continues to receive around 2500 calls each month providing information to residents of Fife and to offer emergency care within PDS for unregistered patients. The sheer volume of calls and numbers of emergency appointments, on top of referrals and our registered patients does mean the PDS is under huge pressure - it is a credit to our staff that we are continuing to manage all of this.		1. Primary and Community Care	Red - Unlikely to complete on time/meet target	Red - Unlikely to complete on time/meet target	Red - Unlikely to complete on time/meet target	Red - Unlikely to complete on time/meet target
National - Child Health Replacement	9.1	National Programme Delay and new baseline of programme being undertaken	Services testing of new Child Health System	9. Digital & Innovation	Amber - At risk - requires action	Amber - At risk - requires action	Amber - At risk - requires action	Red - Unlikely to complete on time/meet target
Deliver a more effective BCG and TB programme. Public Health Priority 1 and 2		Ongoing work to understand and manage complex clusters of TB in vulnerable populations. Developing ways to support TB patients in a way that works for them and improves uptake of treatments. Developing systems to be able to prioritise TB work among other health protection pressures. Supporting increasing workload to support clinics and associated work.	Review of local and regional TB demand and ensure capacity to manage within clinical and health protection teams.		Amber - At risk - requires action	Amber - At risk - requires action	Amber - At risk - requires action	Amber - At risk - requires action
Improved Fife-wide ADHD pathways for children & Young people	7.1	Fife Wide review completed. Recommendations shared with SLT of Fife H&SCP in February 2025 - outcome awaited	Fife wide multi professional review of provision of services to children/ young people with suspected/ diagnosed ADHD Identify core functions within CCH service and review CCH clinicians job plans/ clinic templates accordingly Development of Fife wide business case to support ADHD service improvements.	7. Women & Children Health	Amber - At risk - requires action	Amber - At risk - requires action	Amber - At risk - requires action	Amber - At risk - requires action
Development of improved digital processes to support OH activity and staff health and wellbeing.		Upgrade of Cority system in place which will improve digitisation of activities, subject to resolution of multiple initial difficulties with new system.	Decision on future system procurement or further extension of current service provider.	8. Workforce	Green - On Track	Green - On Track	Amber - At risk - requires action	Amber - At risk - requires action
Growth of OH services and establishment of resources to assure function sustainability meets the changing needs of the organisation and supports the delivery of care goals through a variety of services including mental health / wellbeing / fatigue management support.	8.3	Plans for service delivery model to be re-visited as part of Directorate modernisation.	New model of service delivery in place, to be monitored and reviewed.	8. Workforce	Green - On Track	Green - On Track	Amber - At risk - requires action	Amber - At risk - requires action

Deliverable	ADP Reference	2024/25 Q4 Narrative Highlight achievements, reflecting on planned activities and impact on stated outcomes, as well as any associated risks and challenges that impacted delivery	2024/25 Q4 Planned Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status	Deliverable 24/25 Q3 RAG Status	Deliverable 24/25 Q4 RAG Status
Refreshed Mental Health and Wellbeing Strategy for Fife for 2025 - 2028	3.2	The draft strategy and supporting documents (Year One Delivery Plan, Equality Impact Assessment, Risk Register, and the Participation and Engagement Reports) have been reviewed by key stakeholders as they have progressed through the Partnership's governance process. Constructive feedback and comments have been received from the Partnership's Senior Leadership Team, the Strategic Planning Group, the Quality and Communities Committee, and other stakeholder groups. These updates will be included in the strategy and supporting papers before the documents are shared with the Integration Joint Board in July 2025 for final review and approval prior to publication and wider circulation. A summary version and an easy read version of the strategy will also be provided.	Progress Year One Delivery Plan	3. Mental Health	Green - On Track	Amber - At risk - requires action	Green - On Track	Amber - At risk - requires action
Improve access for patients and carers through improved communication regarding transport options	1.7	Suite of transport information and resources for public and patients. The Community Transport information and leaflet and the refresh of the NHS travel reimbursement information and leaflet have been completed and distributed. Completion and distribution of information and resources - NHS Fife How to get to our main hospitals. Patient information letters now include a sentence highlighting transport options and travel cost reimbursement information. Monitoring and evaluation not available for Q4 - this will be provided in June as a financial year comparison to 2023/24.	Monitoring data Evaluation and feedback from patient and carers and staff	1. Primary and Community Care	Green - On Track	Green - On Track	Green - On Track	Amber - At risk - requires action
Support the implementation of the Food 4 Fife Strategy and associated action plan as part of ambition to make Fife a sustainable food place	6.4	Food4Fife Strategy agreed May 2024. Action Plans agreed and being implemented by subgroups. Partnership has continued to meet bi-monthly. Future of partnership co-ordinator post is at risk for 25/26 as no funding identified for next year. Funding maybe available from April 2026 via Good Food Nation. Eating well as one of two themes in DPH annual report.	explore with Fife Council colleagues support for the partnership/co-ordination of the Food4Fife Partnership beyond April 2024	6. Health Inequalities	Green - On Track	Green - On Track	Green - On Track	Amber - At risk - requires action
Children's speech, language and communication development Plan		CYP Operational Lead attended the national meetings. Key members of CYP SLT staff are attending feedback sessions with NELC to learn more about the national work. CYP SLTs have received information about the key bonding/ interaction/communication messages. There are local links being made, e.g. HV and SLT in Kirkcaldy and Cowdenbeath working together to support conversations around this and putting it in to practice.	Want national work to influence local partners and universal work. Ensure that SLTs are aware of key early interaction and bonding messages being shared with local partners and universal workforce. SLTs need to be aware of focus of message and robustly support this in local conversations.	7. Women & Children Health	Green - On Track	Red - Unlikely to complete on time/meet target	Green - On Track	Green - On Track

Deliverable	ADP Reference	2024/25 Q4 Narrative Highlight achievements, reflecting on planned activities and impact on stated outcomes, as well as any associated risks and challenges that impacted delivery	2024/25 Q4 Planned Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status	Deliverable 24/25 Q3 RAG Status	Deliverable 24/25 Q4 RAG Status
Work to address poverty, fuel poverty and inequality through ensuring the prioritisation of income, housing, education and employment programmes as part of the Plan 4 Fife.	6.4	Pathway in development for housing needs of young poeple with substance use issues. DPH annual report drafted, consulted on and taken to Fife Board March 2025. DPH report aligned with 10 year Population Health Plan. stakeholder workshop held and framework agreed for inclusion health network	Contributing to Fife housing partnership ending homelessness together priority group pathways. Contributing to opportunities Fife partnership priorities. Revise evidence review submitted to Scottish Government. Consider contribution and strategic direction following release of 10yr Population Health Plan. Review feedback from Inclusion Health workshop to shape future development of Inclusion Health Network.	6. Health Inequalities	Amber - At risk - requires action	Amber - At risk - requires action	Green - On Track	Green - On Track
Review existing wellbeing indicator collection data to develop multi-agency response in line with GIRFEC framework.	7.1	We have fostered strong multi-agency communication by establishing clear pathways for information sharing and collaboration, recognising the urgency of child protection, and building flexibility to ensure swift and effective response. The implementation of the National Child Protection Guidance 2021 has enabled us to review and update our processes for sharing information, ensuring that critical details are communicated effectively across services. Additionally, we have strengthened our shared language around risk and vulnerability factors, promoting consistency and clarity across agencies.. The Child Protection Steering Group, the Child Health Management Group and the Health and Wellbeing Strategy Group, provide oversight and assurances on these processes and play a key role in driving improvements. These groups report to Fife Child Protection Committee and Children in Fife, providing updates on deliverables within Fife Children's Plan to ensure the best possible outcomes for children and young people.	Include Wellbeing Indicators as standing agenda item within Child Health Management Team meetings.	7. Women & Children Health	Green - On Track	Amber - At risk - requires action	Green - On Track	Green - On Track
Specialist clinic provision to increase by 25% in our most deprived areas with a view to achieving 473 quits in FY 20024-25 Increase targeted Very Brief Advice (VBA) information sessions by 25% Fife wide to include mental health in patient sites. Establish a drop in and bookable clinic within maternity units to receive as early as possible referrals for maternity clients. Create referral pathway for in patient discharge on an opt out basis	6.3	The service has delivered a plan of promotional activities across all 7 localities which has resulted in a significant increase in service uptake and retention with our target groups. Offering 3,593 appointments from April to December 2024. We have worked with colleagues from the HSCP and 3rd sector to raise awareness of VBA model and referral pathways. Appropriate referrals from Fife maternity services for pregnant smokers has also increased with 115 referrals in Q4, We have established weekly clinics in the VHK & QMH maternity units offering advice and support to pregnant smokers and their support networks.	Increase awareness that the service is available using a variety of mechanisms; consider available opportunities to promote service and establish a marketing and communication plan Provide out-reach service provision in most deprived communities; assess appropriate sites and permissions to park, signage Deliver financial inclusion referral pathways for pregnant women and families with young children Support NHS actions in the Fife Child Poverty Action Report including income maximisation for pregnant women and parents of under 5s	6. Health Inequalities	Green - On Track	Amber - At risk - requires action	Green - On Track	Green - On Track

Deliverable	ADP Reference	2024/25 Q4 Narrative Highlight achievements, reflecting on planned activities and impact on stated outcomes, as well as any associated risks and challenges that impacted delivery	2024/25 Q4 Planned Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status	Deliverable 24/25 Q3 RAG Status	Deliverable 24/25 Q4 RAG Status
Deliver the child aspects of Fife Annual Poverty Plan with Fife Council and other partners.	7.3	Funding confirmed from the Child Poverty Practice Accelerator Fund to sustain the income maximisation worker to support maternity services for 2024/25. Positive feedback received on actions within Child Poverty Action Plan. Progressive recruitment approaches to support pathways into employment will be a focus next year.	Influence NHS Fife Anchor Strategy to focus ambitions relevant to child poverty Support NHS actions including income maximisation for pregnant women and parents of under 5s; explore expansion to community child health services	7. Women & Children Health	Amber - At risk - requires action	Green - On Track	Green - On Track	Green - On Track
CAMHS will build capacity in order to deliver improved services underpinned by these agreed standards and specifications for service delivery.	3.1	CAMHS continues to work on the development of Clinical Pathways, which is near completion. CAMHS continues to develop strategies to improve communication and promote participation and engagement through, for example, the introduction of Patient/Carer Consultation Groups Medical Consultation Pilot with Looked After CAMHS Services is completed and the evaluation findings will be incorporated in service delivery, as appropriate, to ensure mental health support is available for those who are most vulnerable. A review of Tier 4 services has commenced to align with the CAMHS National Specification and the recently published Eating Disorders National Specification. This will include an appraisal of out of hours/extended working.	Implement CAMHS improvement plan derived from gap analysis against the national service specification Focus resources on prioritised improvement dimensions - access and response, care pathways, communication and engagement Development of Clinical Pathways for Core CAMHS for young people presenting with low mood, anxiety, trauma and eating which will include use of outcome measures, enable future audit of access to evidence-based interventions and work towards providing a good quality service. Fife CAMHS Urgent Response Team will pilot extension in hours to provide timely assessment within Acute Hospitals for those presenting with increased risk which will improve throughput within Accident and Emergency and ensure use of paediatric beds for patients who have self-harmed is limited and appropriate. Medical Consultation Pilot with Looked After CAMHS Services will be evaluated and incorporated in the service delivery, as appropriate, to ensure mental health support is available for those who are most vulnerable.	3. Mental Health	Green - On Track	Green - On Track	Green - On Track	Green - On Track
CAMHS will build capacity to eliminate very long waits (over 52 weeks) and implement actions to meet and maintain the 18- week referral to treatment waiting times standard.	3.1	The service has reviewed and implemented additional strategies to enable them to continue to meet and sustain the national waiting times standard. CAMHS continue to maintain Early Intervention services to ensure children and young people receive timely access to specialist services. Ongoing recruitment continues to ensure workforce is at full capacity. CAMHS have initiated Parent/Carer consultation groups, ensuring their participation and engagement underpins service developments and their needs are met.		3. Mental Health	Green - On Track	Green - On Track	Green - On Track	Green - On Track

Deliverable	ADP Reference	2024/25 Q4 Narrative Highlight achievements, reflecting on planned activities and impact on stated outcomes, as well as any associated risks and challenges that impacted delivery	2024/25 Q4 Planned Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status	Deliverable 24/25 Q3 RAG Status	Deliverable 24/25 Q4 RAG Status
Child and Adult weight management programmes: Develop a sustainable workforce within the resources available via regional funding award	6.3	Achievements Baseline funding secured, ensuring recurring financial stability Approval for some fixed-term posts to be recruited substantively, improving workforce sustainability Performance framework embedded in reporting to Scottish Government, supporting ongoing monitoring and QI Continued QI approach to optimise resource use and maintain person-centred care Risks and Challenges Uncertainty due to unapproved substantive posts, risking staff turnover and unsustainable service delivery Admin post delays from Business Transformation increase workload and divert Clinicians from clinical tasks Formal governance structures delayed due to pending GLP-1 introduction, which may strain services further without substantive recruitment	Develop performance framework to evidence impact, improvement and targeted QI approaches Establish governance and assurance structure to ensure effective oversight, reporting and assurance of programme development	6. Health Inequalities	Green - On Track	Green - On Track	Green - On Track	Green - On Track
Contribute to NHS Fife's High Risk Pain Medicines Patient Safety Programme to support appropriate prescribing and use of High-Risk Pain Medicines and ensuring interventions take into consideration the needs of patients who are at risk of using or diverting High Risk Pain Medicines.	6.7	Public Health perspective provided to new HRPM Safety Group Evaluation advice and support provided to ongoing HRPM work Working with ADP colleagues to gain further insights into the needs of people with lived experience	Continue to provide PH input to HRPM Safety Group Continue to provide evaluation advice and support to ongoing HRPM work Continue to work with colleagues from ADP to engage the Scottish Drugs Forum to gain further insights into the needs of Lived Experience individuals	6. Health Inequalities	Green - On Track	Green - On Track	Green - On Track	Green - On Track
Design and delivery of a comprehensive medicines safety programme for NHS Fife, enhancing the safety of care and ensuring the Board meets its obligations to Scottish Government direction	6.7	Five new Valproate prescribing pathways to fully deliver the legislative requirements have been created by the group and await final governance approval by the ADTC. GP sub Committee currently reviewing the SLA and Model of Care for Lithium in NHS Fife. A DOAC prescribing and review toolkit are being developed with the aim to improve patient safety and support safe monitoring of these medicines	Circulate guidance on Topiramate and commence audit. Develop a Lithium model of care document (inc. shared care agreement). Agree dissemination pathways for high risk pain meds. Anticoagulant focus group to identify adverse events and training needs.	6. Health Inequalities	Green - On Track	Green - On Track	Green - On Track	Green - On Track

Deliverable	ADP Reference	2024/25 Q4 Narrative Highlight achievements, reflecting on planned activities and impact on stated outcomes, as well as any associated risks and challenges that impacted delivery	2024/25 Q4 Planned Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status	Deliverable 24/25 Q3 RAG Status	Deliverable 24/25 Q4 RAG Status
Develop and Enhance Children's Services		Revised GIRFEC guidance now embedded Wellbeing Pathway also refreshed and embedded into practice. Implementation of the revised child protection guidance across NHS Fife/HSCP and support the embedding of changes across the Children services partnership To embed in cross organisational policy and practice in preparation for incorporation in law for UNCRC / Children's rights The promise - Corporate Parenting Plan agreed and shared across partnership. Health Actions & routemap identified by NHS Health Leads Network	Child Wellbeing Pathway Implementation Complete and report submitted to CHMT Implementation of health raised IRD for CAMHS. Full implementation of CPPM via IRD process. 16-17 year olds progressing via IRD. progress single agency information sharing guidance. Progress a process for adult health checks IRD. UNCRC - SBAR to EDG & SLT Outcome agreed. SLWG continuing to meet regularly to support CS UNCRC commitments. The promise - Actions & routemap identified by NHS Health Leads Network and brought to HC & The Promise Group for discussion	7. Women & Children Health	Green - On Track	Green - On Track	Green - On Track	Green - On Track
Ensure effective coordination and governance for adult screening programmes in Fife	6.3	Adult Screening published statstics for Breast, Bowel and AAA and were presented as part of public health indicatorss and IPQR for the Public Health and Wellbeing Committee in December 2024. This provided greater awareness and opportunity for scrutiny of the uptake of the three screening programmes by the members of the PHWC. The NHS Fife annual Integrated Screening Report was produced in October 2024 and it was presented at the Executive Directors Group Meeting and the Public Health Assurance Committee. A Screening Inequaities Outreach Officer was employed in December 2024 to oversee the implementation of the Inequalities Action Plan. This has lead to a very active period of work since December 2024. This is ongoing. The "No Cervix Cervical Exclusion Audit" was completed within NHS Fife in September 2024 and clinics to follow up some patients were held up until December 2024. Consultations were held in Q4 regarding the audit of a smaller cohort of patients with "No Further Recall" exclusion applied. This audit will be carried out in the 2025/26 financial year.	Lead the coordination, governance and quality assurance of adult screening programmes including monitoring uptake and performance Produce the annual NHS Fife Integrated Screening Report Continue work to understand and address inequalities in the uptake of screening among Fife residents including the Bridging the Gap Project and implement the Screening Inequalities Action Plan Investigation and management of screening programme incidents and adverse events.quality assurance of adult screening programmes including monitoring uptake and performance Produce the annual NHS Fife Integrated Screening Report Continue work to understand and address inequalities in the uptake of screening among Fife residents including the Bridging the Gap Project and implement the Screening Inequalities Action Plan Investigation and management of screening programme incidents and adverse events. Complete the "No Further Recall" (NFR), Cervical Exclusion Audit. This is part of the National Cervical Exclusion Audit which started in 2021.	6. Health Inequalities	Green - On Track	Green - On Track	Green - On Track	Green - On Track
Home First: people of Fife will live long healthier lives at home or in a homely setting	2.6	Hospital at Home multi-factorial review and 'hub and spoke' model feasibility study completed. A number of actions were identified and an SBAR paper is being prepared for SLT to seek approval to progress some of these.	Implement measurement and reporting tool for the successful implementation of the Home First vision Leadership workshop to review the Home First Delivery structure and ensure alignment with strategic direction.	2. Urgent and Unscheduled Care	Green - On Track	Green - On Track	Green - On Track	Green - On Track

Deliverable	ADP Reference	2024/25 Q4 Narrative Highlight achievements, reflecting on planned activities and impact on stated outcomes, as well as any associated risks and challenges that impacted delivery	2024/25 Q4 Planned Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status	Deliverable 24/25 Q3 RAG Status	Deliverable 24/25 Q4 RAG Status
Locality Planning Groups will utilise Public Health Scotland data, the Fife Strategic Needs Assessment, and local intelligence to develop and finalise Locality Plans for 2025-26, outlining key priorities and measurable actions. Quarterly locality meetings will provide a forum for health and social care professionals to take accountability for the delivery and evaluation of these plans	6.5	Locality Event was attended by 115 delegates - feedback survey highlighted attendees had an increased knowledge and understanding of locality planning. The Senior Leadership Team endorsed the current locality planning approach would continue in 2025/26. Locality Delivery plans updated with Q4 actions. Monitoring and evaluation of Community Chest Round 1 projects is ongoing - no decision will be made in regard to future funding till all round 1 projects have submitted evaluation report. PHS and local strategic needs assessment data was presented at the March locality meetings to support discussions that may inform new priorities for 25/26.	Review and evaluate Locality Fife wide event. Locality Planning development session with the Senior Leadership Team planned for 10th Feb 2025 and actions from this session will be taken forward. Continue to monitor and develop the locality delivery plans 24/25. Decide on the approach to Community Chest funding for 2025-26 and communicate with carers on the way forward. Co-ordinate and facilitate the 7 locality planning meetings in March 2025.	6. Health Inequalities	Green - On Track	Green - On Track	Green - On Track	Green - On Track
Public Health Priority 4: National Drugs Mission Priorities; MAT treatment standards; Fife NFO strategy; Fife ADP strategy	6.2	Working with ADP colleagues to gain further insights into the needs of people with lived experience. Adressing Alcohol Harm and Death Group have worked to identify and priortise actons required and progress is being made in two key projects to deliver these actions. SDF have added questions to their MIST survey on use of high risk pain medicines and results are awaited.	Continue to work with colleagues from ADP to engage the Scottish Drugs Forum to gain further insights into the needs of Lived Experience individuals. Actively participate in the multidisciplinary Fife Addressing Alcohol Harm and Death Group to support delivery of actions to improve services and pathways.	6. Health Inequalities	Green - On Track	Green - On Track	Green - On Track	Green - On Track
To embed a working business continuity management systems process that is measurable and able to be easily monitored.		Business continuity mangment systems (BCMS) are bedding in with reporting mechanisums and analytics now being available. The number of service areas has expanded. Resilience coordinator post now being in situ aupports the continued momentum to BCMS dashboard and visibility to plans and master ledgers. B13/23 audit has been provided with evidenced actions .	Compliance and performance metrics is reported quarterly through the Resilience Forum. To continue working towards revising and updating NHS Fife Business Continuity policy	2. Urgent and Unscheduled Care	Green - On Track	Green - On Track	Green - On Track	Green - On Track
Work with local authorities to take forward the actions in their local child poverty action report	7.3	Briefing and training sessions have been delivered to key staff groups. Communication Action Plan has been delivered. Annual reporting data and information has been collated. A total of 520 referrals and an overall annual financial gain to families of £515,433.84	Workforce development – delivering training sessions for staff and managers, refresher training sessions and staff briefings. Communication strategy – delivering communication action plan 2024-25. Meeting quarterly reporting requirements, auditing data and quality assurance.	7. Women & Children Health	Green - On Track	Green - On Track	Green - On Track	Green - On Track
Work with partners to increase efforts to reduce the impact of climate change on our population.		Participated in sustainabilitry ambassador network meetings and CPD sessions	Support any activity of the Sustainability Ambassador network that has been established.	10. Climate	Green - On Track	Green - On Track	Green - On Track	Green - On Track

Deliverable	ADP Reference	2024/25 Q4 Narrative Highlight achievements, reflecting on planned activities and impact on stated outcomes, as well as any associated risks and challenges that impacted delivery	2024/25 Q4 Planned Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status	Deliverable 24/25 Q3 RAG Status	Deliverable 24/25 Q4 RAG Status
Work with the Chief Executive of NHS Fife to establish NHS Fife as an Anchor Institution in order to use our influence, spend and employment practices to address inequalities.	6.4	Anchor progress has been self assessed 6 monthly using PHS Progression Framework. This has been reported through Anchor Institution Programme Board on a 6 monthly basis. Feedback from the Anchor Institution Programme Board steers the operational group and assists with the AI workplan for the coming year. Annual metrics reporting submitted in draft to SG on 17/03/2025. 25/26 Anchor objectives submitted in draft to SG on 17/03/2025. Focussed intentions on partnership working and communicating Anchor ambitions more widely.	Align Anchor ambitions with Population Health & Wellbeing Strategy Align Anchor ambitions with NHS Fife Mid-term Delivery Plan and Public Health Mid-term Delivery Plan focussing on recovery drivers. Support leads to report on NHS Fife progression within Anchor ambitions Continue developing and AI workplan, reporting to AI Programme Board Strengthen and explore links with partners and third sector agencies and community planning groups Submit metrics and focussed objectives to SG. Communicate our Anchor ambitions more widely	6. Health Inequalities	Green - On Track	Green - On Track	Green - On Track	Green - On Track
Fife will eliminate Hepatitis C as a public health concern.		Increased treatment initiation from 2024/25 rate	Create implementation plan. Task Group for HCV elimination in fife has not yet been reestablished due to operational pressures.	1. Primary and Community Care	Amber - At risk - requires action	Amber - At risk - requires action	Green - On Track	Blue - Complete/ Target met
Carry out focused work to make sure we proactively improve access and uptake of vaccinations across our whole population	1.2	Area Immunisation Steering Group monitoring of vaccine uptake by geography & deprivation - meeting February 2025. First meeting of the Immunisation Transformation Oversight Group in January 2025 - TOR and membership established. Improvement plan for teenage programme reviewed. Follow-up meeting with senior staff from education and headteachers from schools with lower uptake. Additional clinics in weekends and evenings targeting teenage and MMR for <5 years.		1. Primary and Community Care	Green - On Track	Amber - At risk - requires action	Green - On Track	Blue - Complete/ Target met
Deliver an effective public health intelligence function to provide multifaceted high-quality intelligence that supports the portfolios of work within Public Health and supports the strategic development, policymaking and the planning, delivery, and evaluation of services within NHS Fife and its partners.		Lead or collaborate on work across all six Public Health priorities and ensure outputs from this work are produced to agreed timescales and standards and disseminated in a range of formats as appropriate.	Investigation and management of screening programme incidents and adverse events.	6. Health Inequalities	Green - On Track	Green - On Track	Green - On Track	Blue - Complete/ Target met
Ensure effective direction and governance for the delivery of immunisation programmes in Fife and provide assurance that the Fife population is protected from vaccine preventable disease.	6.3	Area Immunisation Steering Group met 03/04/25 and reviewed annual shingles, pneumococcal RSV and MSM HPV data as planned. Strategic Framework taken to Fife IJB January 2025 and approved. Updated deliverables for 2025/26 taken to programme Board Feb 2025 and approved.	Review of annual adult shingles, pneumococcal and RSV data as well as selective immunisation programme activity data at Feb 25 meeting of Area Immunisation Steering Group. Approval of 2024 - 2027 Immunisation Strategic Framework by Fife IJB.	6. Health Inequalities	Green - On Track	Green - On Track	Green - On Track	Blue - Complete/ Target met

Deliverable	ADP Reference	2024/25 Q4 Narrative Highlight achievements, reflecting on planned activities and impact on stated outcomes, as well as any associated risks and challenges that impacted delivery	2024/25 Q4 Planned Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status	Deliverable 24/25 Q3 RAG Status	Deliverable 24/25 Q4 RAG Status
New risks identified through this surveillance by urgently convening incident meetings to evaluate the risks and agreeing shared actions. The results of these meetings can be quickly cascaded to networks of people who are able to intervene – frontline workers, peer networks and individual people who use drugs can be provided with information on the risks and advice on how to keep as safe as possible	6.2	New alert process and protocol in place and several alerts issued over the year for novel substances posing a public health risk to the population of Fife. The new protocol is aligned to "Guidance on the management of clusters of drug related harms - Publications - Public Health Scotland". In partnership with NHS Fife Resilience team a nitazene preparedness and contingency planning session was successfully completed with services outwith treatment and support for addiction. A library of alerts and a monthly monitoring group chaired by SAS and supported by PHS is established. This is proactively monitoring trends across Scotland and enabling Fife ADP to respond in advance of instances of harm. .	Continue to monitor process in line with the changeable nature of drug trends Improvement to harm reduction advice made	6. Health Inequalities	Green - On Track	Green - On Track	Green - On Track	Blue - Complete/ Target met
Partners within Fife HSCP will continue to build capacity across services in order to achieve the standards set within the National Neurodevelopmental Specification for children and young people	3.1			3. Mental Health	Green - On Track	Blue - Complete/ Target met	Blue - Complete/ Target met	Blue - Complete/ Target met
Develop and maintain an integrated community drop-in model provided by specialist Alcohol and Drug Teams and community services and partners. Focus on locality data, voices of local communities and services to repeat the process of locality-based service development	6.2	The 6 month review of KY Glenrothes was conducted and decision made to stop/ suspend the extension into Glenrothes. The one stop shops have continued in Kirkcaldy, Levenmouth and Cowdenbeath localities. Kirkcaldy and Cowdenbeath were reviewed and a decision was made to move one from Lochgelly to Cowdenbeath town as a result of the review.	6 month review of KY Glenrothes to be conducted and decision made by SLWG to continue or cease or make adaptions to deliver dependent on review findings Review of Kirkcaldy additional one stop shop and continued support provided by ADP Services	6. Health Inequalities	Green - On Track	Purple - Suspended/ Cancelled	Purple - Suspended/ Cancelled	Blue - Complete/ Target met

To Improve the Quality of Health and Care Services

Deliverable	ADP Reference	2024/25 Q4 Narrative Highlight achievements, reflecting on planned activities and impact on stated outcomes, as well as any associated risks and challenges that impacted delivery	2024/25 Q4 Planned Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status	Deliverable 24/25 Q3 RAG Status	Deliverable 24/25 Q4 RAG Status
Review of Specialty Paediatric Nursing workforce/services (including Diabetes, Epilepsy, Rheumatology, Endocrinology, Respiratory, Cystic Fibrosis) in line with safer staffing legislation and Working Paper 8 "Review of Clinical Nurse Specialist roles within Scotland" of the Scottish Governments Transforming Roles Program.	7.1	Progress paused due to workforce challenges and inability to consider development of new/ additional nursing roles this financial year	Review of updated Workforce Tools / Safer Staffing guidance (in relation to caseload and role) in each specialty	7. Women & Children Health	Amber - At risk - requires action	Amber - At risk - requires action	Red - Unlikely to complete on time/meet target	Red - Unlikely to complete on time/meet target
Implement IP Workforce Strategy 2022-24		Progress has been hindered due to delays in national deliverables, affecting local implementation. the 2 week CNS, Professional Judgement and Quality workforce planning tools run for the IPCT in March 2025 completed. A gap analysis and options paper are being developed, for review by the Executive Delivery Group to address these challenges and align future actions with strategy goals.	Take forward EDG agreed actions from recommendations paper.	1. Primary and Community Care	Amber - At risk - requires action	Amber - At risk - requires action	Amber - At risk - requires action	Red - Unlikely to complete on time/meet target
Adherence to the NHS Scotland Model Complaints Handling Procedures (DH 2017) and compliance with National targets - Stage 1		Improvement in Stage 1 compliance target has been noted; however, ongoing absence within PET and Directorates has impacted ability to consistently maintain this. Standard template letters have improved response times.	Streamline PET Stage 1 process to prevent delays, encourage verbal resolution and increase compliance. Create bank of standard template letters for common complaint themes which require little or no investigation, e.g. wait times / car parking / immunisation clinic locations.		Red - Unlikely to complete on time/meet target	Amber - At risk - requires action	Amber - At risk - requires action	Amber - At risk - requires action
Adherence to the NHS Scotland Model Complaints Handling Procedures (DH 2017) and compliance with National targets - Stage 2		Challenges experienced within PET and Directorates due to absences impacting on the ability to deliver the MCHP in a timely manner. Planning a Quality Improvement project with H&SCP CCS to test new template for response letters and review systems and processes to improve the final response process and timeframes.	Quality Improvement Project with CCS New Process in PET to streamline administration burden		Red - Unlikely to complete on time/meet target	Amber - At risk - requires action	Amber - At risk - requires action	Amber - At risk - requires action
Deliver Patient Experience focused work across NHS Fife, gathering patient feedback and lived experiences		NHS Fife TV screens now have Care Opinion advertised on them Further Volunteer going through recruitment process, will support raising the awareness of Care Opinion and gathering patient stories.	PET supporting Care Assurance Walkarounds Further Volunteer Recruitment to raise awareness of Care Opinion and gather patient Stories Explore Lived Experience Groups 15-step Challenge to be explored Care Opinion Kiosks to be tested Advertising Care Opinion on NHS FIfe TV screens		Amber - At risk - requires action	Amber - At risk - requires action	Amber - At risk - requires action	Amber - At risk - requires action
Digital / Scheduling: Digital systems will be enhanced to realise full potential of integration across health and social care	2.1	SPOA work suspended (see row 5 above) TOC underway in Levenmouth where ANP's are supporting 3 x Care homes to upload FCP key details onto NHS portal. [Jun25 deliverable date may need to ne reviewed as impacted by SG removing the funding for the ReSPECT tool)	AWI: digital system / application to enable relevant multi-agency access to a single Anticipatory Care Plan	2. Urgent and Unscheduled Care	Amber - At risk - requires action	Amber - At risk - requires action	Amber - At risk - requires action	Amber - At risk - requires action

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Fife Psychology Service will increase capacity to improve access to PTs, eliminate very long waits (over 52 weeks) and meet & maintain the 18 week referral to treatment waiting times standard	3.1	Service development and redesign to increase access to lower-intensity options has been implemented and is being evaluated. Initial evaluation suggests positive effect on RTT target. Recruitment has been delayed, with 10.5 WTE clinical posts currently wating for authorisation to recruit. This is limiting improvement in RTT performance and progress in eliminating very long waits.	Recruitment to maintain/increase capacity Service development and redesign	3. Mental Health	Amber - At risk - requires action	Amber - At risk - requires action	Amber - At risk - requires action	Amber - At risk - requires action
Rheumatology workforce model redesign		2 Advanced Nurse Practitioners now in post and competencies near completion. Substantive Consultant vacancy out to advert. Podiatrist recruited to ensure succession planning. Band 5 & 6 nursing posts out to advert and interview dates set. Nursing Workforce planning created to ensure maximum development and utilisation of the team. Clinical Coordinator post has been approved and will be advertised. Advanced practice training needs analysis underway with Nursing, Physio and Podiatry Leads.	Develop and roll-out revised workforce plans Review roll-out plan and Consider future/next steps	1. Primary and Community Care	Green - On Track	Amber - At risk - requires action	Amber - At risk - requires action	Amber - At risk - requires action
Translation and implementation of agreed Business case Options for Co-badged Clinical Trials Unit/ Clinical Research Facility with University of St Andrews		Development track for this milestone has changed due to change of Dean at University of St Andrews School of Medicine, revisiting impact of Scottish Brain Sciences leasing space at Eden Campus (USTAN) and likely trajectory for VPAG investment coming to NHS Fife via SLA with NHS Tayside. Planned meeting with Director of Estates and Director of Transformation in 1Q 25/26 to review potential space in Phase 1 (4 Bed Bay in Ward 9 which abuts current CRF footprint)	Collaborative development of agreed business case with University of St Andrews Business Transformation Team.	6. Health Inequalities	Green - On Track	Amber - At risk - requires action	Amber - At risk - requires action	Amber - At risk - requires action
Improving effective governance and monitoring systems for IPC to ensure there is a co-ordinated and rapid response to reduce the risk of infections and to drive continuous quality improvement		The team remains actively engaged and contributing to the national SLWG exploring a surveillance solution for One for Scotland - end date Jan 2027. Delay in InPhase rollout has impacted the possibility of introduction an IPC Audit on this platform	Planning for recommencing local InPhase meetings to explore electronic auditing			Amber - At risk - requires action	Amber - At risk - requires action	Amber - At risk - requires action
To meet the recommendations of the Women's Health Plan	7.2	Progress made on development of enhanced Women's Health / Gynaecology centre at QMH site (due to open towards end of April 2025). Developments relating to other deliverables rolled-over to 2025/26 due to lack of development funding and training opportunities	Plan and funding to be in place for Specialist Gynaecology Centre at QMH	7. Women & Children Health	Green - On Track	Green - On Track	Amber - At risk - requires action	Amber - At risk - requires action
Support the creation of Person Centred Care Planning Principles		Delayed due to capacity	Meeting with ADON and HON with MH to discuss next steps			Amber - At risk - requires action	Green - On Track	Amber - At risk - requires action

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Committed to controlling, reducing and preventing Healthcare Associated Infections (HAI) and Antimicrobial Resistance (AMR) in order to maintain individual safety within our healthcare settings.		NHS Fife remains committed to controlling, reducing, and preventing HCAI and AMR to ensure individual safety within healthcare settings. The ongoing IPC and robust surveillance programme, continues to focus on minimising the risk of HAIs and AMR. Throughout this quarter, NHS Fife sustained its participation in the national surveillance programme, monitoring SAB, CDI, and ECB. Efforts align with the reduction targets outlined in DL (2023) 06. The team are preparing for the recently published new targets for 2025/26. The anticipated updates to the NIPCM and TBPs has been further postponed to Spring 2026. The team remains actively engaged, contributing to this critical work through the national extraordinary NPGE Working Group. The eCatheter bundle group met on 12th March 2025 to finalise the pathways for the catheter insertion & maintenance systems for both the acute & HSCP. IPC continue to work with D&I to fully integrate these updated bundles onto Patientrack	Prepare for upcoming changes to NIPCM and TBPs. eCatheter insertion and maintenance bundle update to have been completed on patientrak, then planned role out in NHS Fife.		Amber - At risk - requires action	Green - On Track	Green - On Track	Amber - At risk - requires action
Best Start 1. Full implementation of Continuity of Carer by 2026 2. Minimising separation of late preterm and term babies from birth 3. Recommencement of full Antenatal Education 4. Expand Service User Feedback 5. Review need and gaps for, and embed Psychological services	7.1	We have introduced CoC TO Intrapartum areas, now 50% achieved, 75% is the national target. Progress with Transitional Care in the Neonatal Unit, dependent on clinical space. Work being taken forward with Patient Experience regarding the Maternity Engagement Strategy.	Recommencement of ANC audits post RSV vaccinations	7. Women & Children Health	Green - On Track	Green - On Track	Green - On Track	Amber - At risk - requires action
Delivery of Clinical Governance Strategic Framework		4 out of the 11 workstreams have been delivered 2023/2024 2 out of the 11 workstreams have been partially delivered 5 out of the 11 workstreams have been allocated a revised timescale for completion - outstanding workstreams will be carried over to 25/26	Completion of the 2024/25 workplan actions		Green - On Track	Green - On Track	Green - On Track	Amber - At risk - requires action
Development and Implementation of an Adult Neurodevelopmental Pathway with clear links to CYP NDD Pathway.	3.1	Options paper presented to CCCS QMAG. Paper being revised following feedback. To go back to CCCS QMAG for sign-off before being sent to SLT.	Agreement regarding preferred option at CCCS QMAG. Sign-off by SLT including authorisation of funding if required for preferred option.	3. Mental Health	Green - On Track	Green - On Track	Green - On Track	Amber - At risk - requires action
Improve compliance with CAPTND dataset	3.1	Psychology Service has worked closely with Digital and Information to develop TrakCare package that will meet service and CAPTND reporting requirements. D&I implementation target date is now June 2025.	All Psychology Service staff will have access to TrakCare, supporting Psychology Service full compliance with CAPTND reporting requirements.	3. Mental Health	Green - On Track	Green - On Track	Green - On Track	Amber - At risk - requires action

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Local Enhanced Services Review		In order to progress with the review of Enhanced Services currently available to GP practices an options appraisal has been drafted which will be shared with the Enhanced Services SLWG for discussion and decision.		1. Primary and Community Care	Green - On Track	Green - On Track	Green - On Track	Amber - At risk - requires action
Local - Implement Paperlite / Electronic Patient Record	9.5	Implementation of Morse extended to September 2025 Implement of Results Reconciliation reprioritised	Implementation of Morse to be completed Implementation of Results Reconciliation	9. Digital & Innovation	Green - On Track	Green - On Track	Green - On Track	Amber - At risk - requires action
Pandemic Preparedness: Critical to major incident levels.		The draft Pamemic respone framework plan is circulating to key stakholders for subject specialist advice /input - SLWG will take forward to final version	Pandemic response framework plan draft is now circulating to key stakeholders for their input		Green - On Track	Green - On Track	Green - On Track	Amber - At risk - requires action
To develop the resilience risk profiling for Emergency Planning for NHS Fife.		Resporting analytics work is currently still underway for governance and assurance to evidnce based practice with EPRR response planning	Monitor and evaluate incidents that relate to emergency planning through use of incident management software	2. Urgent and Unscheduled Care	Green - On Track	Green - On Track	Green - On Track	Amber - At risk - requires action
Delivery of Research Innovation and Knowledge Strategy		Four priority themes identified (Sustainability, Collaboration, Culture and Communication), Microsoft Forms Survey of RIK Dept staff and revised Microsoft Survey of internal and external stakeholders and partners. Data reviewed by Leadership team and considered in the context of objectives. University of St Andrews School of Medicine is refreshing strategy due to appointment of new Dean and agreed that will develop and finalise Strategies in parallel.	RIK Strategy approved by Executive Directors Group and Clinical Governance Committee	9. Digital & Innovation		Green - On Track	Green - On Track	Amber - At risk - requires action
Embed the National Leading Excellence In Care Education and Development Framework into existing and new education programmes		EiC Support Nurse has been encouraging staff to utilise resource.	Delayed due to workload challenges, but is part of PPD workplan for Sept 2025. PPD will also support Band 6 development which will be aligned to EiC LEIC			Green - On Track	Green - On Track	Amber - At risk - requires action
Support the creation of a digitalised person-centred record		Significant progress has been made to identify patient pathways. Project lead has left post and EiC lead going on secondment May 2025	meeting organised for April 4th with Heads of D & I to discuss next steps.			White - Not Started	Green - On Track	Amber - At risk - requires action
Development of a new OP specialist Gynaecology Unit	7.2	Progress made on development of enhanced Women's Health / Gynaecology centre at QMH site (due to open towards end of April 2025).	Seek approval of funding from FCIG to commence architect commission and scope of work within amended business case.	7. Women & Children Health	Red - Unlikely to complete on time/meet target	Red - Unlikely to complete on time/meet target	Red - Unlikely to complete on time/meet target	Green - On Track

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Community Rehab & Care: To develop a modernised bed base model in Fife that is fit for the future	2.6	Following a pause in the reconfiguration work while there was a bed modelling exercise across NHS Fife undertaken, the HSCP has restarted the project to transform the bed base. The clinical pathways are under discussion and the transformation of the bed numbers and locations is being agreed as part of a multi disciplinary working group. Staff side are involved in all planning conversations and there are plans for wider communication and engagement with staff, patients and public. Engaged with estates to commence costings	Map existing workforce and develop workforce configuration requirements Review data available and undertake strategic needs assessment to achieve the right balance between bed base and community based provision. Review all existing pathways and referral processes to enable redesign in line with transformed bed numbers. Review and redesign inpatient services in line with RTP Deliver enhanced care and rehabilitation community services to support the delivery of care within the right environments for the people of Fife	2. Urgent and Unscheduled Care	Green - On Track	Amber - At risk - requires action	Red - Unlikely to complete on time/meet target	Green - On Track
Develop and scope an SDEC model of care to support same say assessment and increase our ambulatory models of care.	2.2	TOC commenced Feb 2025 for two weeks. Stakeholder feedback triangulated with quantitative data utilised . Further 3 month TOC now in progress. Scheduling of GP patients also commenced and redirection to OOH / Urgent care service overnight.	TOC to be commenced . Scheduling of GP patients to be implemented	2. Urgent and Unscheduled Care	Green - On Track	Amber - At risk - requires action	Amber - At risk - requires action	Green - On Track
Continue to deliver the Community Listening Service.		Risk has been diminished with Volunteer Team in PET taking on aspects of administration function.	Aspects of CCL management have moved across into Volunteer Team within Patient Experience team. Milestones are ongoing review to see how this is working in a collegiate sense whilst Spiritual are retains operational and strategic delivery of CCL service.	8. Workforce	Amber - At risk - requires action	Amber - At risk - requires action	Green - On Track	Green - On Track
Implement new referral management and electronic patient records system (TrakCare/morse) within P&PC Physiotherapy service.		Services went live with MORSE on 25/03/25 and currently in the supported transition phase. Work continues on testing phase for transition from TIARA to TrakCare scheduled for 14th May 2025	Staff training and implementation of new digital processes across the P&PC Physio services Transition P&PS Physiotherapy services from Tiara onto TrakCare/morse digital system with support from eHealth	1. Primary and Community Care	Amber - At risk - requires action	Amber - At risk - requires action	Green - On Track	Green - On Track
Develop mechanism for Health Visiting data analysis to assist partnership working with associated agencies, ensuring early intervention measures and anticipatory care needs are identified expeditiously.	7.1	Robust Data Analysis Framework: Begun to implement a comprehensive data analysis framework within the Health Visiting service with support from digital team. Enhanced Professional Interfaces: Improved collaboration across children's services by implementing similar and linked digital systems. Planned Activities and Impact: Continued refinement of data analysis tools to ensure proactive identification of care needs, enhancing the effectiveness of interventions. Ongoing training for staff on new digital system to maximise their utility and improve multi-agency collaboration. Challenges: Resistance to change from staff adapting to new digital systems, impacting on effective implementation. Delay within digital teams to update electronic system.	Establish a pathway in reflection to the improvement plan to allow all services working with children's and young people access to relevant data for further development.	7. Women & Children Health	Green - On Track	Amber - At risk - requires action	Green - On Track	Green - On Track

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Forensic Mental Health services are reviewed and restructured to ensure appropriate pathways that enable patient flow and maximise rehabilitation and recovery.	3.4	Multidisciplinary workforce paper in progress covering all MH&LD services. This will be presented to the Mental Health Oversight Group. Redesign of rehabilitation services is under consideration. This is led via the Mental Health Redesign Programme Board. There is an ambition to improve flow to/from inpatient services through redesign. Processes related to out of area placement are being strengthened e.g. return/update process for Clinical Advisory Panel, development of single spreadsheet to monitor out of area placements and progress towards repatriation/discharge	Workforce review	3. Mental Health	Green - On Track	Amber - At risk - requires action	Green - On Track	Green - On Track
MAT based outcomes embedded in all ADP service level agreements. The standards implemented and fully maintained and PHS assessment supports this	6.2	In May 2024, Fife ADP and its partners including NHS Fife achieved a green status on implementation for 2023/24 for standards 1 to 5 from the external PHS assessment process. Provisional green was achieved for MAT Standards 6 to 10. This was an improvement on the previous year. Monthly numerical monitoring has shown a consistency and sustainability of this performance in year.	Completion of the FAIR (Facts, Analyse, Identify and Review model) in partnership with lived experience panel. Information gathering for end of year PHS assessment. MAT 3 reporting reviewed and additional service added to the numerical reporting mechanism	6. Health Inequalities	Green - On Track	Amber - At risk - requires action	Green - On Track	Green - On Track
CAMHS will achieve full compliance with CAMHS and Psychological Therapies National data set and enhance systems to achieve compliance.	3.3	Work continues with system supplier to embed supplementary questionnaire in TrakCare as part of the current clinical workflow to allow recording. Work continues with NHS Fife information services to ensure reporting of items from the supplementary questionnaire. Work continues on both these aspects so full compliance can be achieved.		3. Mental Health	Green - On Track	Green - On Track	Green - On Track	Green - On Track
Community Mental Health Teams for Adult and Older Adult services that are responsive to need and reduce admission by offering alternative pathways	3.2	Pathways now embedded within service with last pathway- PDS submission for SG about to go live on 31st March 2025. There will be a 6 month service review to ensure that all three localities are adhering to the new pathways and will also allow the service to action any difficulties in a timely manner.	OA CMHT have developed pathways for the whole service - in the process of being implemented to bring consistency across the 3 localities within the service.	3. Mental Health	Green - On Track	Green - On Track	Green - On Track	Green - On Track
Comply with the requirements of the COVID enquiry and Operation Koper, Crown Office.		This is being coordinated through the PET. Learning and adapting the process.	Provide information and expert advice as required		Green - On Track	Green - On Track	Green - On Track	Green - On Track
Deliver a VAM Covid response in alignment with SG guidance and in collaboration with East of Scotland workforce with full investigatory and outbreak management and community testing functions.		Regional helth protection workforce is available and able to respond as needed. Relationships across the region with other services are being developed and maintained. Pandemic preparedness ongoing, and being aligned with national plans where possible.	National VAM plans and funding remain in place. Health Protection workforce at expected numbers. Outbreak management and community testing capacity is available as needed.	1. Primary and Community Care	Green - On Track	Green - On Track	Green - On Track	Green - On Track
Delivery of Care at Home / Commissioning: Maximise capacity, and commission and deliver care at home to meet locality needs	2.3	More than 2/3 home care staff trained, more than 2/3 of Fife reviewed. On target savings.	Continue / conclude review of double-up packages of care	2. Urgent and Unscheduled Care	Green - On Track	Green - On Track	Green - On Track	Green - On Track

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Delivery of the objectives set within the Pharmacy and Medicines Strategic Framework for 2024-2026		Key workstreams continue to progress. Review will be undertaken mid-2025 in preparation for next version.	Year end position stock take and review of plans for 2025	8. Workforce	Green - On Track	Green - On Track	Green - On Track	Green - On Track
Develop, Enhance and re-invigorate Regional Networks	4.4	All network clinical pathways performing well supporting delivery of planned care.	Maintaining safe network arrangements between neighbouring boards.	4. Planned Care	Green - On Track	Green - On Track	Green - On Track	Green - On Track
Development of Medical Education Strategic Framework		Engagement session with team has been held and framework is in draft. For completion by end of Q2 25/25			Green - On Track	Green - On Track	Green - On Track	Green - On Track
Engage with Higher Education Institutions locally and regionally to develop collaborative way of working	9.5	Collaboration with Southeast HEIs regularly through Academic Liaison Group. NIHR Funding application with Queen Margaret University lead to be submitted focussing on decarbonising Healthcare services and MRC funding application with University of St Andrews to expand work of Fife Community Advisory Council.	Support at least 2 funding applications either locally in NHS Fife, in partnership with University of St Andrews, or as part of the Southeast Academic Liaison Group	9. Digital & Innovation	Green - On Track	Green - On Track	Green - On Track	Green - On Track
Improve the mental health services build environment and improve patient safety	3.6	Ligature refurbishment programme is in place and work underway to improvement MH inpatient estates. Ward 3 refurbishment on target with move date from Ward 1 May 2025. Timeframes established for Ward 1 refurbishment and Ravenscraig move. Ligature project board in place to oversee development.		3. Mental Health	Green - On Track	Green - On Track	Green - On Track	Green - On Track
Increase NHS Fife Innovation Test Bed activity		Phase 2 projects are running to milestone targets with the exception of one project seeking extension currently. Other projects have had milestones delayed, with mitigations in place to meet the milestone within the September deadline. Steering Group informed monthly of project progress and monthly meetings with projects leads provides feedback loop.	Ensure milestones for Phase 2 projects are on track, or risk mitigations in place. Ensure Steering Group fully informed of milestone progress and feedback provided to project leads.	9. Digital & Innovation	Green - On Track	Green - On Track	Green - On Track	Green - On Track
Increase redirection rate utilising flow and navigation	2.2	Redirection rate from NHS 24 - 77% Full utilisation of MIU at QMH & scheduling. GP redirection rate increased to 15%. Further work required to fully optimise H@H and respiratory and mental health pathways to offer alternatives to hospital admission. CBC in place to support Care Home admissions but with no ACP model in place success has been limited.	Fully embed Scheduling of GP patients	2. Urgent and Unscheduled Care	Green - On Track	Green - On Track	Green - On Track	Green - On Track
Legal Services Department (LSD) role within the Board is to manage all clinical negligence, employers and public liability claims intimated against NHS Fife; Fatal Accident Inquiries in which NHS Fife is an involved and interested party and all other legal intimations and challenges which involve the organisation			Ongoing. Raise awareness of claims - similar claims and implement new procedures to avoid future claims		Green - On Track	Green - On Track	Green - On Track	Green - On Track

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Mental Health and Wellbeing in Primary Care and Community Settings - Development and delivery of service provision in line with Scottish Government reports and planning guidance relating to the remobilisation and redesign of mental health & wellbeing services and supports in primary care and community settings.	3.3	Development work on test of change, including initial meeting with stakeholders completed.	Implement phase 4 coproduction activity (deliver), to include a six-month test of change to improve access to mental health & wellbeing services and supports in NEF	3. Mental Health	Green - On Track	Green - On Track	Green - On Track	Green - On Track
Non-compliant Rotas		Savings target exceeded for the year with second stage of monitoring complete. Final savings to be reported once all results received and any re-monitoring completed and reviewed. Clinical Management to continue with existing processes to sustain compliance and online resources available to be updated by individual services and directorates for new cohorts.	Results of surveys cascaded to be reviewed. Second stage of monitoring to begin Services to address any concerns of rota monitoring results prior to second round beginning in February		Green - On Track	Green - On Track	Green - On Track	Green - On Track
Ongoing development of Community Treatment and care (CTAC) services, supporting more local access to a wider range of services.	1.2	Recruitment to vacancies remains positive, and locality hubs have been established to enhance capacity and strengthen resilience towards delivering sustainable services. A review of accommodation and space for CTAC and MDT services is underway. However, the lack of additional funding for service expansion or backfill poses a risk to sustainability, potentially leading to inequitable service provision across Fife, unmet patient needs, and dissatisfaction among primary care partners. The next steps involve reviewing activity and demand to improve efficiencies in processes and procedures, including scheduling, ensuring the most effective use of resources within the available financial envelope..	Continues to be scoped , planned and financial envelope to be confirmed	1. Primary and Community Care	Green - On Track	Green - On Track	Green - On Track	Green - On Track
Preventing alcohol specific and drug related harm and death affecting children and young people	6.2	Rapid Action Group established in March 2024 has achieved the following outcomes: Develop an approach to surveillance of drug related harms in the community that assesses data gathered from a range of sources including data that is currently collected (such as hospital rates, drug-related deaths, non-fatal overdoses) and key stakeholder data (such as SAS, RADAR, ADP commissioned services) Community based Hospital Liaison Service and pathway for all CYP attending ED or admitted to hospital for a 24 to 48 hour response via a QR code THINK again campaign co-produced with CYP on raising awareness about harms, risk of overdose and death from substances typically prevalent in the age group	Review of action plan and resetting of plan for the remainder of the year and into next financial year. Review will include support for school, parents and carers including residential school and children not in school. Public messaging and harm reduction advice about continual use in young people and risk of overdose. Full drug awareness campaign to launch.	6. Health Inequalities	Green - On Track	Green - On Track	Green - On Track	Green - On Track

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Prevention & Early Intervention: new models of care ensuring early discharge and prevention of admission, and local frameworks for frailty	2.6	Heart Failure training for Diuretic IV in the Community - creating pathways with Hospital at Home Needs assessment and Action Plan completion as part of the DWD collaborative. Fife are well represented on each sub group. Frailty, Discharge to assess, Home First Community Hospitals and Integrated Hubs. Work will commence to progress the whole system outcomes Completion of the Assessment and Rehabilitation Centre model transformation nearing completion. Awaiting for the digital aspects of the redesign to be finalised. Discussions have taken place regarding patient self administration of IV antibiotics and 24 hour IV pumps however this requires to be progressed collectively between Acute and the Partnership. Head of Service has agreed to discuss this at a more senior level with the relevant Acute partners.	Heart Failure training for Diuretic IV in the Community - creating pathways with Hospital at Home South West Fife Locality currently trained and on patient 5 out of 6 on Test of Change. Dunfermline also now have trained staff that can undertaken IV Abs. Additional staff across Fife are now also undertaking training. Review and redesign of Assessment and Rehabilitation Centre model Develop processes to implement patients self management of IV Antibiotic Therapy	2. Urgent and Unscheduled Care	Green - On Track	Green - On Track	Green - On Track	Green - On Track
Reprovision of unscheduled care/ crisis care provision for patients presenting out of hours with a mental health crisis	3.1	Options appraisal completed. To be presented at MH programme board on 31/03/25	Report to Programme Board with recommended option for service improvement.	3. Mental Health	Green - On Track	Green - On Track	Green - On Track	Green - On Track
Review of actions outlined in the Framework for Effective Cancer management to improve delivery of Cancer Waiting Times	5.3	Introduction of new cancer tracking reports to streamline workload and effectively highlight patients who require action from individual services. Introduction of new cancer tracking reports to streamline workload and effectively highlight patients who require action from individual services.	Collaborate nationally to learn from NHS Lanarkshire model to improve cancer waiting times performance. Review and identify actions once the Framework for Effective Cancer Management is published.	5. Cancer Care	Green - On Track	Green - On Track	Green - On Track	Green - On Track
Support for Doctoral Training Program (DTP) Fellows		2 new Fellows (1 is a Global Fellow) appointed and commenced with University of St Andrews School of Medicine on 1 Day week lead in to 0.8 commencement in August 2025.	Cohort 5 (final) cohort launched and project proposals invited.	8. Workforce	Green - On Track	Green - On Track	Green - On Track	Green - On Track
To support preparations within NHS Fife for the implementation of the HCSA Act (on-going during 2023/2024), which comes into force from 1 April 2024.	8.4	New data capture process introduced for Q3 HCSA reporting, utilising business objects and aligned to ADP format, allowing path to green to be demonstrated and generation of evidence. Annual Report being prepared for submission to SG by 30/04/2025.	Continued review of SG HCSA feedback, submission of HCSA quarterly returns in line with agreed reporting mechanisms and governance cycles. Board actions progressed.	8. Workforce	Green - On Track	Green - On Track	Green - On Track	Green - On Track
Update cancer priorities and develop associated delivery plan as outlined in the Cancer Framework and support delivery of the 10 year Cancer Strategy	5.1	2024/25 Annual Delivery Plan finalised and for circulation.	Finalise and circulate to relevant stakeholders and sign off.	5. Cancer Care	Green - On Track	Green - On Track	Green - On Track	Green - On Track

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Work with Secondary care to develop shared care initiatives to continue to reduce the requirement for patients to attend ED	1.6	OOH Telehealth: Increased use of video calls and other technologies to provide remote consultations and access to urgent care services, this is being achieved through project development, and staff engagement OOH Improving urgent care pathways in the community and enhancing links between primary and secondary care, working with mental health services to increase access to OOH mental health care Emergency Department to urgent care OOH redirection, closely monitoring and promoting referrals to OOH from ED, including co-ordinator to co-ordinator liaising during the OOH period	Plans for the rollout of the national glaucoma shared care scheme within NHS Fife to alleviate the burden of glaucoma care on the hospital eye clinic are well underway with the aim of 'going live' In April 2024	1. Primary and Community Care	Green - On Track	Green - On Track	Green - On Track	Green - On Track
Embed Quality of Care Review Guidance (QoC) within all adult inpatient and community areas		2 areas within Acute are testing new EiC QoC Boards with the hope of rolling out across all Acute inpatient areas. Acute has embedded national QoC Guidance. 15 areas have completed reviews using guidance. Acute has also tested the guidance on the Right Decision Platform. Community Nursing is completing a QoC at present. Discussions with AHP Director about using QoC Guidance within AHP areas	Influence use of new QOC guidance with HSCP, Supporting Care Assurance is with HSCP April			Green - On Track	Green - On Track	Green - On Track
Increase the number of SCN utilising the CAIR dashboard to inform improvements whilst creating a culture of learning and sharing between areas		Increased over the last 3 months from 70 to 95 users due to drive from EiC Support nurse. PHS Supported session for Acute Staff. A further one planned for HSCP staff.				Green - On Track	Green - On Track	Green - On Track
Contribute Public Health perspective and evaluation support to Fife's Mental Health & Wellbeing Strategy		PH input to development of Mental Health & Wellbeing Strategy/Delivery Plan has continued. Strategy due to go to IJB May 2025 following which PH input relating to evaluation can commence.	PH representation and advisory role within the Mental Health Strategy Implementation Group	3. Mental Health	Amber - At risk - requires action	Amber - At risk - requires action	Amber - At risk - requires action	Blue - Complete/ Target met
Implement preventative podiatry service in care homes		This work is ongoing but the bulk has been completed.	Implement the care plan for all moderate and high risk diabetics	1. Primary and Community Care	Amber - At risk - requires action	Amber - At risk - requires action	Amber - At risk - requires action	Blue - Complete/ Target met
Expand on current system wide Urgent Care Infrastructure to develop more integrated, 24/7 urgent care models	2.1	In Hours Urgent Care ANPs provide urgent care to those patients during in-hours seeking healthcare, they support all general practices across Fife, including support with home visiting and care homes across Fife. This care is provided until 6pm every weekday, providing a seamless transition to the OOH period for patients to access 111 and be supported by the urgent care OOH team	Develop dual nursing posts which support rostering to encompass 24 hour approach to urgent care. Further enhance and develop capacity and accessibility to HSCP led MIU/urgent Care centres	2. Urgent and Unscheduled Care	Amber - At risk - requires action	Amber - At risk - requires action	Green - On Track	Blue - Complete/ Target met

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Targeted actions to improve the quality of our Immunisation services	1.2	Immunisation QMAG meeting took place 31st January 2025 Improvement work progressed with Care Home Consent Processes through Care Home SLWG Vaccine Stock SLWG convened to improve pathways of ordering, delivery, storage & wastage of vaccine stock.		1. Primary and Community Care	Green - On Track	Amber - At risk - requires action	Green - On Track	Blue - Complete/ Target met
Begin preparation to review the 2022-25 Cancer Framework in NHS Fife to ensure still relevant and up to date	5.1	Refreshed Cancer Framework has been drafted and aligns with the Population and Wellbeing Strategy and 10 year Cancer Strategy.	Finalise refreshed Cancer Framework which will align with the Population and Wellbeing Strategy and 10 year Cancer Strategy.	5. Cancer Care	Green - On Track	Green - On Track	Green - On Track	Blue - Complete/ Target met
Continued development of digital front door for patients	9.5	Digital Letters functionality operational Waiting List Validation extended	Implementation of Digital Letters - TrakCare Extension of Waiting List Validation	9. Digital & Innovation	Green - On Track	Green - On Track	Green - On Track	Blue - Complete/ Target met
Deliver an effective health protection function, including in- and out-of-hours duty cover to prevent and respond to communicable disease prevention.		Regional service working well in-hours. OOH service remains with individual boards. Ongoing staff development and training. Recruitment progressing to plan.	Provide a 24/7 specialist health protection service for Fife	1. Primary and Community Care	Green - On Track	Green - On Track	Green - On Track	Blue - Complete/ Target met
Delivering year on year reductions in waiting times and tackling backlogs focusing on key specialities including cancer, orthopaedics, ophthalmology, and diagnostics.	4.1	Weekly monitoring has improved position from last year with plans in place to further reduce long waits.	Waiting times overall should improve, particularly in >104 and .78 week position.	4. Planned Care	Green - On Track	Green - On Track	Green - On Track	Blue - Complete/ Target met
Delivery of Clinical Governance Strategic Framework - Adverse Events		Staff support pathway in place			Green - On Track	Green - On Track	Green - On Track	Blue - Complete/ Target met
Delivery of the Risk Management Framework		The Risk Management Framework was endorsed by the Audit and Risk Committee on the 12 December 2024 and approved by the Board on 28 January 2025.	Completion of the 2024/25 workplan actions		Green - On Track	Green - On Track	Green - On Track	Blue - Complete/ Target met
Enabling a “hospital within a hospital” approach in order to protect the delivery of planned care.	4.2	Successful utilisation of QMH over winter months, reducing cancellations due to bed capacity limitations. BADS data under review as coding of procedures unable to account for DC activity which has moved	Maximise use of QMH and reduce day surgery within VHK	4. Planned Care	Green - On Track	Green - On Track	Green - On Track	Blue - Complete/ Target met
Enhance Theatre efficiency	4.10	Successful utilisation of QMH over winter months, reducing cancellations due to bed capacity limitations.	Maintain theatre utilisation above 85% across VHK and QMH sites	4. Planned Care	Green - On Track	Green - On Track	Green - On Track	Blue - Complete/ Target met
Ensure people have clear information and are sign posted to the HSCP Wells to enable tailored access to support via a 'good conversation', while awaiting a secondary care appointment / treatment.	4.8	Delivery of 'Waiting Well' workshop following a mapping exercise. Waiting Well information forms a part of waiting list letter for patients.	Waiting times letters include signposting for waiting well information. Key engagement with the national waiting well network.	4. Planned Care	Green - On Track	Green - On Track	Green - On Track	Blue - Complete/ Target met

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Ensuring there is a sustainable Out of Hours service, utilising multi-disciplinary teams.	1.3	Integrating a diverse team of healthcare professionals who work with the General Practitioners (GPs) as the Senior Clinical Decision Makers in urgent care settings, significantly enhances patient experience through comprehensive, efficient, and specialised care. Each team member brings unique skills and expertise that contribute to a holistic approach to patient management. Fife Urgent Care (Out of Hours) multi-disciplinary team includes: I. General Practitioners ii. Senior Advanced Nurse Practitioners iii. Advanced Nurse Practitioners iv. Urgent care Practitioners (UCP)s v. Advanced paramedic practitioners (APP)s vi. Health care support workers (HCSW)s vii. Scot Gem Medical Students viii. trainee GPs and medical students ix. student nurses x. student paramedics xi. Foreign exchange students North East Fife Minor Injury Units provide care to those of Fife seeking minor injury care, scheduled via FNC, promoting right care, in the right place, with ongoing collaboration with the local ED to ensure patients are supported by the right clinician, at the right time. This care provided includes rotating urgent care ANPs being trained in minor injury care to support a more sustainable workforce	Introduce integrated roles across In-hours and out of hours Review the role and scope of practice of ENPs Review new dual roles across Injury and Illness clinical skill sets	1. Primary and Community Care	Green - On Track	Green - On Track	Green - On Track	Blue - Complete/ Target met
Expanding Endoscopy capacity and workforce	5.2	NHS Fife among best performing boards for endoscopy across Scotland.	Reduce waiting times for USC diagnostics and surveillance patients	5. Cancer Care	Green - On Track	Green - On Track	Green - On Track	Blue - Complete/ Target met
Extending the scope of day surgery and 23-hour surgery to increase activity and maximise single procedure lists.	4.5	Treatment room usage now part of BAU releasing theatre space within QMH.	Increased utilisation of treatment room throughout 24/25	4. Planned Care	Green - On Track	Green - On Track	Green - On Track	Blue - Complete/ Target met
Implement outcomes of Specialist Delivery Groups including reducing variation.	4.6	Monitored through heatmap presented at IPCPB	Increase in services and conditions covered through ACRT and PIR	4. Planned Care	Green - On Track	Green - On Track	Green - On Track	Blue - Complete/ Target met
Infection Prevention and Control support for Care Homes Continue to support Fife Care Homes to have a workforce with the necessary knowledge and skills in infection prevention and control to ensure they can practise safely, preventing and minimising the risks of HCAI to their residents, visitors, their co-workers and themselves.		IPC Programme for 2024/25 complete, work progressed for 2025/26 programme and alignment with AMR NAP.	Promote outbreak training sessions to care homes in Fife	8. Workforce	Green - On Track	Green - On Track	Green - On Track	Blue - Complete/ Target met
Maximising Scheduled Care capacity	4.3	End of year figures within trajectories identified for 24/25. Full utilisation of Non-recurring funds allocated to manage waiting times	Delivery of TTG and OP targets within DCAQ plan	4. Planned Care	Green - On Track	Green - On Track	Green - On Track	Blue - Complete/ Target met

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Reducing the time people need to spend in hospital by promoting early and effective discharge planning and robust and responsive operational management	2.5	FELS management change process has completed. Drivers have now been upgraded to Technicians and fitting equipment releasing clinician time. Two substantive H@H In-Reach Nurse Practitioners commenced within Acute Services during January 2025.	Fife Rehab Model Undertake required organisational/change management processes	2. Urgent and Unscheduled Care	Green - On Track	Green - On Track	Green - On Track	Blue - Complete/ Target met
Undertake regular waiting list validation and maximise digital hub solutions	4.7	Exploration of 'overbooking' DC lists at QMH where it is anticipated there will be DNA patients.		4. Planned Care	Green - On Track	Green - On Track	Green - On Track	Blue - Complete/ Target met
Continue to ensure EiC is represented in all improvement and fundamentals of care delivery groups		This is business as usual across Acute and HSCP. SG reports Bi Annual.				Green - On Track	Green - On Track	Blue - Complete/ Target met
Develop a Nursing and Midwifery Strategic Framework 2023 - 25; establishment of shared governance model Framework based on CNO and NHS Fife priorities, Recover to Rebuild, Courage of Compassion, Three Horizon Model				8. Workforce	Green - On Track	Green - On Track	Blue - Complete/ Target met	Blue - Complete/ Target met
Scoping further areas to support Public Health/ NHS Fife priorities for evaluation and research.				6. Health Inequalities	Green - On Track	Green - On Track	Blue - Complete/ Target met	Blue - Complete/ Target met
Fife Mental Health Service will work alongside partners in acute services, primary care services and third sector agencies to ensure robust and equitable pathways of care are in place for those in police custody and for those transferring into the community from prison.	3.4			3. Mental Health	Green - On Track	Blue - Complete/ Target met	Blue - Complete/ Target met	Blue - Complete/ Target met
Implement national Excellence in Care (EIC) objectives within NHS Fife In line with 3 Year strategy, embed in Fife by 2025.					Green - On Track	Blue - Complete/ Target met	Blue - Complete/ Target met	Blue - Complete/ Target met
7 Day Pharmacy Provision. This will focus on provision of clinical and supply services across hospital care settings, reviewing the current position and additional need					Blue - Complete/ Target met	Blue - Complete/ Target met	Blue - Complete/ Target met	Blue - Complete/ Target met
Ensure the delivery of an effective resilience function for NHS Fife.				6. Health Inequalities	Blue - Complete/ Target met	Blue - Complete/ Target met	Blue - Complete/ Target met	Blue - Complete/ Target met
Digital / Scheduling: create a centre of excellence for scheduling across community services	2.6			2. Urgent and Unscheduled Care	Green - On Track	Amber - At risk - requires action	Purple - Suspended/ Cancelled	Purple - Suspended/ Cancelled

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Set out approach to implement the Scottish Quality Respiratory Prescribing guide across primary care and respiratory specialities to improve patient outcomes and reduce emissions from inhaler propellant	10.6			10. Climate	Green - On Track	Amber - At risk - requires action	Purple - Suspended/ Cancelled	Purple - Suspended/ Cancelled

To Improve Staff Experience and Wellbeing

Deliverable	ADP Reference	2024/25 Q4 Narrative Highlight achievements, reflecting on planned activities and impact on stated outcomes, as well as any associated risks and challenges that impacted delivery	2024/25 Q4 Planned Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status	Deliverable 24/25 Q3 RAG Status	Deliverable 24/25 Q4 RAG Status
National - eRostering	9.1	Pace of implementation will take longer to conclude the implementation. Focus remains on clinical areas as priority.	Replanning of implementation completed	9. Digital & Innovation	Amber - At risk - requires action	Amber - At risk - requires action	Amber - At risk - requires action	Amber - At risk - requires action
Delivery of Staff Health & Wellbeing Framework aims for 2023 to 2025.	8.3	Core wellbeing support provision highlighted through Staff Care rebranding and consideration of Framework and Action Plan for 2025 -2028 underway. Absence trajectory not met to date, so Recovery Plan developed to support improvement.	Review of Action Plan to inform development of 2025/2026 aims.	8. Workforce	Green - On Track	Green - On Track	Green - On Track	Amber - At risk - requires action
We will raise awareness of the challenges faced by carers and provide information and advice to carers on their rights and what supports are available.	6.1	In Quarter 4 we undertook a full review of activity relating to unpaid carers, and consulted with IJB representative and key stakeholders resulting in a refreshed delivery plan for 2025-26 in order to deliver our objectives within the current resource landscape and ensure that our actions are fully aligned to strategic objectives. Three specific actions will be taken forward in relation to this deliverable in 2025-26: 1. Review and update to Carers Information on the HSCP webpage. 2. Development, implementation and evaluation of Carers awareness raising campaign 25-26 3. Explore options for additional staff resource to support delivery of future carers information campaigns.	A revised short-term action plan will be developed to address the challenges of delivering the objectives within the current resource landscape.	6. Health Inequalities	Amber - At risk - requires action	Amber - At risk - requires action	Amber - At risk - requires action	Green - On Track
We will work collaboratively to design and deliver services to reduce the negative impact of caring and support wellbeing, and promote supportive workforce environments for working carers	6.1	All SLAs have been reviewed as part of the Reimagining the third sector project. End of year reports of performance currently in production. Actions have been agreed to make progress towards our deliverable, in 2025-26 we will: 1. Undertake a review of all commissioned support for adult carers, ensuring a whole system approach to supporting carers 2. Carer provider Forums (x4)- improving cross organisation working 3. Support commissioned partners to achieve carer positive status (level 1 engaged) by March 2026	Work with HSCP Contracts to review the effectiveness of SLA's with partners in meeting the needs of carers, linked to the Reimagining the Third Sector project. Work with CARF and other partners where required to develop an action plan to deliver the income maximisation project.	6. Health Inequalities	Green - On Track	Amber - At risk - requires action	Amber - At risk - requires action	Green - On Track
Delivery of the eRostering (eR) Implementation Programme in conjunction with Digital & Information.	8.4	Revised plan and implementation within clinical areas progressing within Acute and HSCP, taking account of deep dive feedback / lessons learned.	Implementation of revised eRostering roll-out plan agreed for clinical areas, alongside SafeCare.	8. Workforce	Green - On Track	Green - On Track	Amber - At risk - requires action	Green - On Track

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We will increase the range of breaks available to carers and ensure that carers have access to information about how to access a break.	6.1	The review of travel requirements will be incorporated into the SLA review in action above, and will be subject to financial assessment of capacity for each organisation. The NCS is still subject to the process of development by ScotGov. This action will remain part of a watching brief to be progressed once further confirmation of the Duties and resources become available. Decision taken to postpone the refresh of the SBSS until after further confirmation of the Duties and Resources that will come through the NCS has been confirmed. Actions agreed for 2025-26 include: 1. Provide 300 carers with a microbreak via Crossroads crisis prevention service 2. Provide 100+ short breaks per year through the Respitality Scheme 3. Work collaboratively to review and assess the implications of recent government decisions around the NCS, and update Short Breaks Service Statement accordingly 4. Ensure that information about how to access a break is available to all carers.	Continue the review of the contractual arrangements with external partners to ensure carers have access to travel support. As part of the short-term action plan development, analyse the impact of the National Care Service changes on our strategy to support the range of short breaks offered to carers. Work with external partners to understand the existing capacity and future potential to develop these offers to carers.	6. Health Inequalities	Green - On Track	Green - On Track	Amber - At risk - requires action	Green - On Track
We will seek the views of carers and involve carers in the planning of our services and supports.	6.1	Two specific actions will be taken forward in 2025-26 to make progress towards our deliverable: 1: The Annual Carers Experience Survey. Planning is already underway and will include Young Carers. 2. Carers Forums (x4)	Previously included above	6. Health Inequalities			Amber - At risk - requires action	Green - On Track
Where carers choose to, we facilitate good conversations with carers about what matters to them and how services and supports could help	6.1	Two specific actions will be taken forward to work towards this deliverable: 1. We will build capacity within system to support completion of carers support plans 2. We will strengthen quality assurance processes to ensure that we can routinely report on the number and quality of Adult Carer Support Plans completed within the HSCP and the impact this is having on quality of life of the carers we support.	Previously included across multiple rows- relating to recruiting social work assistants and completion of ACSPs	6. Health Inequalities			Amber - At risk - requires action	Green - On Track

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Develop a Health Visiting workforce model in alignment to the wider Primary Care Nursing with a focus on sustainable and flexible responses to agreed Health Visiting pathways and prioritisation for vulnerable families.	7.1	Workforce Alignment with Primary Care Nursing: - Integrated Health Visiting (HV) Services within primary care, enhancing communication and referral processes for coordinated family care. - Developed clear protocols and SOPs outlining Health Visitors' roles. - Established a flexible workforce model with a mix of experienced practitioners and newer recruits. Enhanced Focus on Vulnerable Families: - Developed targeted interventions for vulnerable families, including prioritised home visits for at-risk groups and community groups/HV clinics. IRD attendance. - Implemented outcome measurement strategies through regular supervision and appraisals. - Established feedback mechanisms via Care Opinion for families to share experiences. Challenges: - Resource constraints have halted HV post advertisements. - Staffing levels have reduced HV pathways due to capacity issues.	Implement identified strategies and evaluate.	7. Women & Children Health	Amber - At risk - requires action	Amber - At risk - requires action	Green - On Track	Green - On Track
We will build workforce capacity by developing skills and knowledge, and enhancing systems, processes and workflows to ensure that carers are recognised and supported in their role at the earliest possible time.	6.1	The first collaborative session between operational teams has been held. The event was successful and agreed as a starting point for ongoing direct collaboration. Eligibility criteria- supporting carers framework was endorsed by IJB in March, implications for social work practice are being considered by CSWO and operational managers to support practice. The actions which will be taken towards this deliverable in 25-26 are: 1. Develop a suite of learning and development resources for frontline staff 2. Review and enhance the hospital discharge support service	Partnership workshop designed and delivered involving Social Work Assistants and Fife Carers Centre Locality Workers to strengthen collaboration and deliver better support for carers. Post-sign off of the Eligibility Criteria for social work, begin a review of the impact for carers who have an Adult Carer Support Plan (ACSP). Work with colleagues in nursing and Fife Carers Centre to develop a plan to extend the scope of the carers support hospital discharge service to the hospital admissions service, as set out in the carers strategy	6. Health Inequalities	Amber - At risk - requires action	Amber - At risk - requires action	Green - On Track	Green - On Track
PPD Succession Planning		Significant increase in number of mandatory resuscitation training places offered and delivered this financial year. Face-to-face clinical skills sessions now re-established. Cohort 3 of Assistant Practitioners (APs) finished in September with a further cohort of 9 Acute Trainee APs commenced in February 2025. 4 Return to Practice students commenced in February 2025. Financial constraints limiting staffing resources has limited our activity, particularly the delivery of leadership training.			Amber - At risk - requires action	Green - On Track	Green - On Track	Green - On Track

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Pre Registration Trainee Pharmacy Technicians (PTPT) The development of a pipeline of Pharmacy Technicians is crucial to the sustainability of Pharmacy services and in providing optimal care. Scottish Government funding for this pipeline was withdrawn in Autumn 2022, meaning a local solution is required to cover intakes from April 2023 onwards		PTPT recruitment paused until June Established PTPTs continuing progress through the programme	Ongoing progress through the programme		Amber - At risk - requires action	Green - On Track	Green - On Track	Green - On Track
Continue to deliver and enlarge on Staff Support/VBRP Project.		Current risk and challenges are around ongoing financial support for this project. However planning is in place to submit an additional bid to the Charity Committee to build upon the positive evaluation which has now been obtained.	Interim evaluation has been completed which shows highly positive quantitative and qualitative information. Plans gong forward are to present these finds to Charity Grants Committee in May 25 to demonstrate value of project with a view to embedding methodology in NHS Fife	8. Workforce	Green - On Track	Green - On Track	Green - On Track	Green - On Track
Delivering Anchor Institution workforce aims - Promoting employability priorities.	6.4	Updates to workforce content and metrics submitted to overall Anchors Framework.	Review of programme aims for 2025/2026 identified and progressed in line with Anchors Ambitions, ADP and Workforce Planning priorities.	6. Health Inequalities	Green - On Track	Green - On Track	Green - On Track	Green - On Track
Development and implementation of the NHS Fife Workforce Plan for 2022-2025.	8.5	Workforce Plan drafted in line with template provided by SG and shared with key stakeholders for comment in preparation for submission to SG.	Develop draft Workforce Plan for 2025/2026 (national direction now received).	8. Workforce	Green - On Track	Green - On Track	Green - On Track	Green - On Track
Development of workforce planning for Pharmacy and Medicines, including readiness for pharmacist graduate prescribers from 2026, education and training of staff groups and development of the Pharmacy Technician pipeline.		Recruitment of PGFTPs in progress - challenging to maintain numbers of staff within the system. Work ongoing to finalise identification of DS and DPPs for this group. Skill mix in aseptic has improved following creation of PSW post, releasing Pharmacy Technician and Pharmacist capacity	Recruitment complete for Post Grad Foundation Trainee Pharmacist (PGFTPs) DS and DPP identified for first cohort of PGFTPs that will register as prescribers 2nd cohort of Pharmacy Support Workers complete Modern Apprenticeship Review of IP legacy staff approach/ position Progress on scope of practice and available support for DPPs	8. Workforce	Green - On Track	Green - On Track	Green - On Track	Green - On Track

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Education reform for Pharmacy -Facilitate local implementation and delivery of revised NES programmes, and more broadly support the development of Pharmacy staff to deliver a modern, patient focussed pharmacy service, across NHS Fife. -Foundation training programmes and embedding the advanced practice framework for Pharmacists -Developing Pharmacy and Support workers through accredited courses and modules. -Collaborative working across the East Region to support simulation training for post graduate foundation trainees -Support for undergraduate experiential learning is also being developed to enhance the quality of education at that level -Work is also ongoing to develop clinical skills and leadership across all roles and increase research capability across the professions		Review of supervisory approach ongoing, incorporating detailed skills and experience mapping exercise. Modelling work on DPP requirements for FTY and post-reg programme for coming years, and progressing plan for identification Submission to NES for FTY programme capacity completed	Identification of DS and DPPs for FTY programme. Holistic review of staff providing support, allowing for identification of best local approach		Green - On Track	Green - On Track	Green - On Track	Green - On Track
Improving support and developing the Mental Health workforce	3.5	Workforce continues to be a central factor as part of the wider Mental Health redesign. Options appraisals in development for Urgent care, Older Adults and Rehab services focussed on alternative to admission, bed reduction and reallocation of workforce to ensure sustainable staffing models are in place.	Establish whole system options; define all options for skill mix and maximised use of available budget.	3. Mental Health	Green - On Track	Green - On Track	Green - On Track	Green - On Track
Medical Workforce Recruitment and Retention Strategic Framework		Medical Workforce Recruitment and Retention Strategic Framework currently being drafted	Present the final draft of the Medical Workforce Recruitment and Retention Strategic Framework to the committees		Green - On Track	Green - On Track	Green - On Track	Green - On Track
Progression with ScotCOM in collaboration with the University of St Andrews		Recruitment underway for hub 1 posts			Green - On Track	Green - On Track	Green - On Track	Green - On Track
We will launch and develop a leadership framework – Our Leadership Way in Fife.		Different forums/settings have engaged in the Leadership framework during this quarter, including; Digital & Information Leaders, Maternity Services, Acute Heads of Nursing/Clinical Nurse Managers, Extended Workforce Leadership Team, Corporate Nursing Directorate, AHP Professional Leadership Council, Area Clinical Forum, Finance & Performance Directorate, Pharmacy Leaders, Respiratory Nursing Leaders, Staff Side - Area Partnership Forum. The design, development and publication of the Leadership Framework has been celebrated, endorsed and approved by EDG, APF, SGC and NHS Fife Board. The framework will be published in April/May 2025.	Publish leadership framework. Celebrate the influences of leaders at all levels in bringing life to the shared leadership ethos that matters to Fife.	8. Workforce	Green - On Track	Green - On Track	Green - On Track	Green - On Track

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We will plan and deliver a range of services and support to young carers to help them to meet their personal caring, social and learning goals.	6.1	Actions carried over from previous quarter with clear plan for delivery. We have drafted the Carers Strategy delivery plan for 2025-26. The following actions have been agreed: 1. Work with education colleagues to complete an options appraisal for a study support service for young carers, assessing and comparing different delivery models against set criteria to identify and recommend a preferred option. 2. Provision and evaluation of Young carers education support service in all 152 Fife schools 3. Review approach to identifying young carers at school gate 4. Development of a monitoring and evaluation framework to support learning and improvement of young carers support services.	Work with Education colleagues and others to review the Study Support pilot initiative and develop a Plan for 2025-26 and beyond.	6. Health Inequalities	Green - On Track	Green - On Track	Green - On Track	Green - On Track
Develop an immunisation workforce model in conjunction with wider Primary Care Nursing structure which is sustainable and flexible to respond an ever evolving immunisation need	1.2			1. Primary and Community Care	Green - On Track	Green - On Track	Blue - Complete/ Target met	Blue - Complete/ Target met

To Deliver Value & Sustainability

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Hospital Pharmacy Redesign Introduction of automation in hospital Pharmacy stores, dispensaries and clinical areas. Centralisation of Pharmacy stores and dispensaries		No direct progress on this area. However, progress noted below on digital medicines programme will serve as an enabler, particularly Pharmacy Stock Control system	-		Red - Unlikely to complete on time/meet target	Red - Unlikely to complete on time/meet target	Red - Unlikely to complete on time/meet target	Red - Unlikely to complete on time/meet target
Roll out of Digital Pathology	5.1	Caldicott required for validation, achieved Mar-25 and meetings with supplier commenced to increase capacity in test environment to allow validation to commence.	Complete verification of scanner and IMS and validation of Consultant reporting.	5. Cancer Care	Amber - At risk - requires action	Red - Unlikely to complete on time/meet target	Red - Unlikely to complete on time/meet target	Red - Unlikely to complete on time/meet target
Delivery of New Laboratory Information system (LIMS) as part of accelerated implementation followed by implementation of national roll out.	9.1	Final update to resolve agreed issues with local implementation (phase 1) which can't wait until the nation build (phase 2) due to be released to testing environment by end of Q4. Once tested update will be deployed to live, timeframe for this not currently clear but likely to be first month of Q1 25/26. A number of configuration changes have been tested and deployed in Q4. Work to input into National build commenced.	Complete phase one, prepare for national LIMS project.	9. Digital & Innovation	Red - Unlikely to complete on time/meet target	Amber - At risk - requires action	Amber - At risk - requires action	Red - Unlikely to complete on time/meet target
National - GP IT Reprovisioning - GP Sustainability	9.1	Activities paused following GP IT supplier being in administration.	Complete Docman 10 Upgrade	9. Digital & Innovation	Amber - At risk - requires action	Amber - At risk - requires action	Amber - At risk - requires action	Red - Unlikely to complete on time/meet target
Support delivery of Re-form, Transform, Perform (RTP) through supporting service change		Reporting is now established - complete 25/26 programme plans still being developed 25/26 programme plans not complete so not yet agreed	Monthly RTP performance reporting delivered 2024/25 Programme Plan delivery underway 2025/26 Programme plans developed and agreed		Amber - At risk - requires action	Green - On Track	Green - On Track	Red - Unlikely to complete on time/meet target
Business Transformation		Mapping and engagement activities underway Programme Brief and Plan redrafted for presentation to governance	Case for change provided to RTP Exec and Fife NHS Board Staff cohorts identified Supporting Digital Product enhancements confirmed	9. Digital & Innovation	Red - Unlikely to complete on time/meet target	Red - Unlikely to complete on time/meet target	Amber - At risk - requires action	Amber - At risk - requires action
Surge Capacity - Improve flow within the VHK site, reducing length of stay and number of patients boarding to ensure patients are looked after in the most appropriate setting. Accurate PDD to inform planning for discharge, coordinated with the Discharge Hub.	2.5	No reduction in bed footprint possible due to over capacity. SBAR agreed at SLT in March and to be discussed at EDG - model of care re prioritised with PDD focus, review of criteria and staffing & bed base to flex between 30-44 patients acknowledging seasonal variation/demand.	Reduction of Ward 9 to 11 to 30 beds and associated maintenance of new footprint Continue to monitor Locum Surge Consultant post	2. Urgent and Unscheduled Care	Red - Unlikely to complete on time/meet target	Red - Unlikely to complete on time/meet target	Amber - At risk - requires action	Amber - At risk - requires action
Delivery of digital medicines programme, including the roll out of HEPMA and progressing commitments to implement automation within the hospital dispensary function		IDL system has been implemented, with support and supplementary development ongoing Final preparation for go-live of pharmacy stock control system, including, UAT training and development of SOPs	Ongoing support of IDL system implementation and learning/ developments as required Stock control system implementation and go live	9. Digital & Innovation	Amber - At risk - requires action	Amber - At risk - requires action	Amber - At risk - requires action	Amber - At risk - requires action

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Enhanced data availability and sharing		Implementation of GP Data Sharing delayed.	Implementation of GP Data Sharing (early adoption) Assessment of GP Data Sharing - early adoption phase	9. Digital & Innovation	Amber - At risk - requires action	Amber - At risk - requires action	Amber - At risk - requires action	Amber - At risk - requires action
Maximise models of care and pathways to prevent presentations and support more timely discharges from ED using a targeted MDT approach	2.4	ED performance remains off trajectory. Respiratory and Mental health pathways not yet in place. H@H & frailty pathways being developed and optimised further.	ED performance to achieve 77%	2. Urgent and Unscheduled Care	Amber - At risk - requires action	Amber - At risk - requires action	Amber - At risk - requires action	Amber - At risk - requires action
National - LIMS Implementation	9.1	Risk continues to be identified with the national LIMS Programme - delays expected.		9. Digital & Innovation	Amber - At risk - requires action	Amber - At risk - requires action	Amber - At risk - requires action	Amber - At risk - requires action
Set out approach to develop and begin implementation of a building energy transition programme to deliver energy efficiency improvements, increase on-site generation of renewable electricity and decarbonise heat sources.	10.1	In absence of funding to deliver projects, we have been proactively identifying assets and systems for replacement/upgrade to enable net zero progress.		10. Climate	Amber - At risk - requires action	Amber - At risk - requires action	Amber - At risk - requires action	Amber - At risk - requires action
Work towards mental health services receiving 10% of NHS frontline spend by 2026 and plan to invest 1% of this spend on the mental health of children and young people.	3.4	Finance colleagues have provided financial data and continue to provide support to enable the services to review.	Priority areas identified and improvements costed	3. Mental Health	Amber - At risk - requires action	Amber - At risk - requires action	Amber - At risk - requires action	Amber - At risk - requires action
Develop and Implement the Public Participation and Community Engagement Strategy		NHS Fife has made significant progress in embedding meaningful public participation in service planning and delivery inline with the Scottish Governments Planning with people. The Public Participation and Community Engagement Strategy and operational plan was agreed by EDG and the NHS Fife Board. Key achievements include strengthened collaboration with Fife Health and Social Care Partnership, and the integration of public feedback into service redesign projects. Challenges have included ensuring wide-reaching engagement and managing expectations around service changes, but ongoing efforts in transparency and responsiveness have helped address these issues. Further challenges are associated with no financial or workforce support being allocated to NHS Fife Corporate Communications to fully take forward the aspirations outlined in the strategy and to fully implement the operational plan. This will become particularly problematic as the NHS transformation agenda and financial sustainability targets require service redesign and for NHS Fife to adhere to planning with people best practice and guidance.	• Formalise the established relationship with Fife Health and Social Care Partnership to ensure joint working aligned with delegated NHS Fife services, The transformation agenda and financial sustainability. Align the NHS Fife Public Engagement and Participation Strategy with the new Fife Health and Social Care Partnership strategy being developed in 2025/26 • Continue to develop key mechanisms where public input can directly influence service improvements.		Amber - At risk - requires action	Green - On Track	Green - On Track	Amber - At risk - requires action

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Develop Strategic vision across all of Primary Care	1.2	Data gathered of allocation at individual practice level; KPIs for each service being introduced; Clearer understanding of gaps in delivery, significant challenges in realising revised models for non priority MoU2 services to reach improvement in parity. Local milestone of July 2025 for operational transition of pharmacotherapy; challenges remain, not withstanding national directive. Progression to BAU not started.	Evaluate the effectiveness of delivery in the revised non-priority MoU2 services. Commence progression of Pharmacotherapy to a state of business as usual.	1. Primary and Community Care	Amber - At risk - requires action	Green - On Track	Green - On Track	Amber - At risk - requires action
Achievement of Waste Targets as set out in DL(2021) 38	10.3	We have made great progress with our a 10% reduction in clinical waste target however we are still working towards our 70% reduction target. We are 381 tonnes short but have achieved 790 tones so far.	Achieve a 10% reduction in clinical waste & ensure that 70% of all domestic waste is recycled and composted	10. Climate	Green - On Track	Green - On Track	Green - On Track	Amber - At risk - requires action
Development and initiation of NHS Fife Innovation Project Review Group (IPRG)	9.5	NHS Fife IPRG to be restructured following review of the content of the meetings. Restructure will separate out initial project screening review, developed project paperwork and oversight and ANIA projects into 3 separate groups to provide better governance.	develop implementation pathway for supported projects to be handed over to appropriate service/ directorate for implementation.	9. Digital & Innovation	Green - On Track	Green - On Track	Green - On Track	Amber - At risk - requires action
Outline plans to implement a sustainable travel approach for business, commuter, patient and visitor travel	10.4	Due to publication of new SHTM, we need to re-review our current strategy to ensure it aligns with national guidance.	Publish NHS Fife sustainable travel strategy	10. Climate	Green - On Track	Green - On Track	Green - On Track	Amber - At risk - requires action
Delivery of Digital and Information Framework		Work continues to develop the Digital Framework. Consultation is ongoing with key stakeholders	Completion of Digital Framework	9. Digital & Innovation		Green - On Track	Green - On Track	Amber - At risk - requires action
Implement Same Day Emergency Care (SDEC) and rapid assessment pathways	2.2		Effective SDEC in operation	2. Urgent and Unscheduled Care	Green - On Track	Red - Unlikely to complete on time/meet target	Amber - At risk - requires action	Green - On Track
Attracting & Recruiting Staff to deliver Population Health & Wellbeing Strategy; Bank Governance – Enhanced Management & Staff Bank Consolidation.	8.1	Medical locums transferred on 3 February 2025 and next phase of transition is to focus on AHP and Medical Records Banks.	Direct Engagement model in place and work transitioned over. Bank model changes fully in place and operating as Business as Usual.	8. Workforce	Amber - At risk - requires action	Amber - At risk - requires action	Amber - At risk - requires action	Green - On Track

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To achieve additional capacity to meet 6 week target for access to 3 key Radiology diagnostic tests (MR,CT and US)	5.2	Radiology have delivered the projected activity required to ensure that 90% of patients are waiting less than 6 weeks. CT have continued to maintain on target performance by making efficient use of Scottish Government waiting times(SG WT) funding. MRI also have maintained on target performance. Successful trials for “Deep Resolve” software have been successful, and the software will be implemented in Q4. This will reduce the requirement for SG funded mobile scanners in the next financial year. US waiting lists reduced significantly (from 26 weeks to 10 weeks) in Q1 and Q2 using SG WT funding. Following the withdrawal of funding, activity has reduced and further improvements to routine waiting times has been limited.	90% of patients waiting less than 6 weeks for MRI/ CT & US imaging.	5. Cancer Care	Green - On Track	Amber - At risk - requires action	Green - On Track	Green - On Track
Develop and Implement the Corporate Communication Strategy		During Q4, NHS Fife successfully finalised its five-year Corporate Communications Strategy, ensuring a clear, cohesive approach to internal and external communications. Engagement sessions were conducted with key stakeholders, including staff, community partners, and service user feedback, allowing for a more inclusive strategy development process. The strategy aligns with NHS Scotland’s wider transformation agenda, supporting efficiency, innovation, and improved access to healthcare services. Key achievements include the development of a refreshed website development plan, improved staff communication channels, and an enhanced approach to public health messaging. Challenges included capacity constraints and balancing communication priorities amidst evolving service demands. However, mitigation strategies ensured continued progress.	Review annually the Corporate Communications Strategy, ensuring alignment with NHS Fife’s key priorities and national health strategies. Conduct internal staff survey to refine the strategy and inform a new internal communications plan for 2025/26 inline with the new staff intranet development. Develop individual communications plans, addressing key themes such as workforce health and wellbeing, transformation agenda and digital innovation.		Amber - At risk - requires action	Green - On Track	Green - On Track	Green - On Track
Attracting & Recruiting staff to deliver Population Health & Wellbeing Strategy; Recruitment Shared Services Implementation Consolidation & enhanced International Recruitment service.		Test of change of two additional functionalities in Job train, add a vacancy and vacancy approval being undertaken.	Continue to review of ERRS model to gain wider service benefits across the model.	8. Workforce	Green - On Track	Green - On Track	Green - On Track	Green - On Track
Developing a system wide Prevention and Early intervention strategy which will underpin delivery of the HSCP strategic plan and the NHS Fife Population Health and Wellbeing Strategy	1.4	Delivery groups established and progressing the 10 priority areas in Year 1 Action Plan. Auditing workforce development 2024-2025 and workforce planning for 2025-2026 is being progressed. Dissemination of strategy and comms.	P&EI Oversight Group to meet for the first time. Creation of more detailed action plan to sit below Delivery Plan.	1. Primary and Community Care	Green - On Track	Green - On Track	Green - On Track	Green - On Track

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Enhance the capacity and capability across the team		The capacity and capability across the procurement team has greatly improved over the year. An enhanced level of engagement and support has been provided across NHS Fife to increase the benefits derived from procurement.	Develop Learning programme to ensure team remain aware of and comply with extant legislation and SFIs, to provide and develop robust advice and information to services Engage with Finance Business Partners, review compliance of procurement contracts, Explore with services potential value and sustainability opportunities Work with services to scope out and deliver cost improvement opportunities and identify potential future cost pressures Complete review of authorisation limits, updating Financial Operating Procedures and other procurement procedures as required Take forward outcomes of 2024 PCIP to implement best practice across the department.		Green - On Track	Green - On Track	Green - On Track	Green - On Track
Further developing agile working and use of digital solutions in Directorate through investment in Workforce Analytics provision to support series of organisational priorities, including Health and Care Staffing Act and eRostering Programme.		New data capture process introduced for Q3 HCSA reporting, utilising business objects and aligned to ADP format, allowing path to green to be demonstrated and generation of evidence. Workforce modelling data and potential shared with People & Change Board. Proposal for Trainee Workforce Information / Analyst progressing.	On-going production and analysis of workforce information to support workforce planning and service delivery, including HCSA reporting requirements.	8. Workforce	Green - On Track	Green - On Track	Green - On Track	Green - On Track
Further strengthen our business partnering model, supported by a strong management accounting team, to improve business performance and decision making support.		Following protracted significant vacancy levels (c22%) within the FMT, we have filled vacancies through a combination redesign and internal development opportunities. We have reduced our vacancy level to 7% at the end of 24/25. The Financial Management Team has designed and delivered face to face finance training to 161 budget holder colleagues equivalent to 65% of eligible attendees. Candidate feedback has been very positive; demand remains high; and training will be picked up again next financial year.	Make financial reporting more concise, action focused and forward looking Proactive recruitment following service redesign to add capacity and improve support to organisational decision making Increase the use and sharing of available data and information to provide finance business insight e.g. Discovery reporting tool / learning from national Financial Improvement Network Review financial data and reporting to confirm improvements made and identify further opportunities Identify learning needs, consolidate improvements across the FBP team ensuring best practice adopted by all		Green - On Track	Green - On Track	Green - On Track	Green - On Track
Improve sustainability of Primary Care	1.1	Sustainability loans for 3 of the applications have been progressed and paid out in 2024/25 with 3 applications being carried forward into 2025/26. Contract for x2 of the 2C Practices has been awarded and date to return to independent 17J status is 1 September 2025.	Create tailored support to practices across Fife, dependent on individual need to proactively support sustainability Transfer of 2C practices to stable 17j Independent Practices	1. Primary and Community Care	Green - On Track	Green - On Track	Green - On Track	Green - On Track

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Increase capability within the team to deliver service improvement and meet growing service demand		The Financial Services Accountant post has been successfully imbedded within the team during the year, providing enhanced support for corporate reporting and decision making across the organisation. The Direct Engagement Payment Process has been effectively imbedded during the year.	Support the Direct Engagement workstream to a successful conclusion, imbedding new process for the payment of Agency Doctors and AHP's		Green - On Track	Green - On Track	Green - On Track	Green - On Track
IPQR Review		Monthly reports continue to be produced accordingly on time. Comments relating to IPQR to be included in report to Board, previously focussed solely on escalations. Collation of trajectories for 2025/26. Work ongoing testing PowerBI for dashboard for IPQR metrics.	Quarterly review of trajectories/targets Monthly reports produced and distributed accordingly Incorporate agreed metrics relation to Primary Care		Green - On Track	Green - On Track	Green - On Track	Green - On Track
Local - Records Management Plan Implementation	9.2	Records Management Teams continue to work with services to implement		9. Digital & Innovation	Green - On Track	Green - On Track	Green - On Track	Green - On Track
Mental Health Services will have a robust data gathering and analysis system to allow for service planning and development	3.3	MH Data and Information group in place which reviews high-level data requests, system requirements and reporting functions. Input from D&I team and establishment of MH Data hub provides robust analysis function.		3. Mental Health	Green - On Track	Green - On Track	Green - On Track	Green - On Track
Post successful transition to the SE Payroll Consortium arrangement, work with the senior leadership of the consortium to ensure effective continuity of a payroll service for NHS Fife and contribute to service redesign to ensure NHS Fife's needs are addressed.		Continued support to the payroll consortium through constructive discussions whilst attending the payroll quality board meetings. Ensuring NHS fifes needs in relation to payroll are met.	Consult and agree with the consortium service re-design arrangements, ensuring NHS Fife priorities are addressed Develop and agree SLA to ensure a robust and timely payroll service inclusive of all pre transfer needs Agree service monitoring process with consortium including key performance indicators		Green - On Track	Green - On Track	Green - On Track	Green - On Track
Refreshed Performance Reporting	6.1	Significant progress has now been made. A full suite of power BI reports have now been created and power platform is now being used to develop this further.	Automation of Performance Reporting	6. Health Inequalities	Green - On Track	Green - On Track	Green - On Track	Green - On Track
Support Delivery Strategic Planning function		Public Holiday debrief took place in Jan-25 with output forming basis of introductory presentation at System Flow event in Feb-25. Summary to be presented at IUCPB with relevant actions taken forward. ADP Q3 report produced, presented at Committees and Board, to be submitted to SG following. Draft for ADP 25/26 was presented at FPR Committee as draft. Plan was submitted to SG on time (17 Mar) and approved by Board (24 Mar).	"Hot Debrief" of festive period to take place (Jan-25) Organise Planning/Review Event (Feb-25) ADP24/25 Q3 to be produced Submission of draft and final ADP25/26		Green - On Track	Green - On Track	Green - On Track	Green - On Track
Transfer our referral system and EPR from Tiara to Morse and TrakCare within the Podiatry service		Move to MORSE completed, move to TrakCare deferred to May 25 in order to ensure that TrakCare build meet service needs	Expands digital admin process for example, use of patient hub.	1. Primary and Community Care	Green - On Track	Green - On Track	Green - On Track	Green - On Track

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Transformation of HR transactional activity enhancing the HR Operational delivery model through case management and manager support building on manager / employee self-service.		There is a risk the work required to build level 0 and level 1 in the shared service centre is delayed due to other priorities.	Part of Shared Service Centre, work underway to identify transactional activity and volume to build service level 0 and level 1. Continue to embed new service delivery model and review.	8. Workforce	Green - On Track	Green - On Track	Green - On Track	Green - On Track
SLA and External Activity		Agreement made nationally on SLA uplift of 6.64% therefore the NHSF 3% target was not met.	Planned implementation of PLICS locally Meeting scheduled with NHS Tayside to discuss decontamination service Ongoing development of Performance Management dashboard Ongoing discussions with other Boards Chief Executives relating to transition into more formal Performance Management arrangements RTP/SLA Moving towards a business as usual model in 2025/26 - Closing report to be developed		Red - Unlikely to complete on time/meet target	Red - Unlikely to complete on time/meet target	Red - Unlikely to complete on time/meet target	Blue - Complete/ Target met
Digital & Information Projects	9.5	The Digital RTP activities have now concluded for 2024/25.	Assess Benefits for Quarter	9. Digital & Innovation	Green - On Track	Amber - At risk - requires action	Amber - At risk - requires action	Blue - Complete/ Target met
Medicines optimisation. Design and support delivery of medicines optimisation work to ensure optimal use of medicines budgets		The revised target for acute medicines efficiencies is likely to be surpassed by the end of financial year. Within the HSCP, delivery is expected to be 91% of target (noting the target was revised upwards, and delivery has surpassed original targets). Medicines waste comms activity has been undertaken, aimed at clinicians and the public.	Monthly monitoring of the Medicines Optimisation plan and continued identification of opportunities. Identification of /and quantification of efficiencies to meet an extended £3M target is ongoing, however it is very unlikely that this target Review of current prescribing guidelines across a number of specialties to more clearly define treatment pathways and access to medicines Comms and engagement plan with all staff. Reducing medicines waste in hospital.	6. Health Inequalities	Green - On Track	Amber - At risk - requires action	Green - On Track	Blue - Complete/ Target met
Procurement Savings within Acute Services		Projecting £456,299 as at end of month 11 for in year impact and recurring saving of £500,000 target.	Ongoing reviews of expenditure and savings opportunities.		Amber - At risk - requires action	Green - On Track	Green - On Track	Blue - Complete/ Target met
Action plan for the National Green Theatres Programme	10.6	Neptune system is installed in theatre 10 phase 3 at Victoria Hospital. We are keeping up to date with the bundles released from CfSD and have achieved all outstanding targets from these bundles.	Create a timeline and plans for achieving remaining targets	10. Climate	Green - On Track	Green - On Track	Green - On Track	Blue - Complete/ Target met
Decarbonisation of Fleet in line with Targets	10.4	We are 80% complete in respect to the 2025 target with clear plans in place to be 100% complete by December 2025.	Have plans in place to replace 12 ICE vehicles to electric	10. Climate	Green - On Track	Green - On Track	Green - On Track	Blue - Complete/ Target met
Delivery of ICO and NISD Audit Improvement Plans Architecture and Resilience Developments	9.2	Current Year actions now complete	Key System Architecture and Resilience Documented	9. Digital & Innovation	Green - On Track	Green - On Track	Green - On Track	Blue - Complete/ Target met

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Delivery of integrated drug and alcohol education age and stage appropriate throughout the full school life by school-based staff and specialist support from ADP commissioned services	6.2	Completed pilot and roll out of additional and flexible support working well in schools. Alcohol information sessions are being delivered at S2 level by guidance teachers in all schools. Thus creating capacity for tailored support to CYP at their and the schools request. Delivery has also occurred to CYP not in the school environment therefore reaching more CYP at risk. Educational sessions on new emergent drug trends and support on how to have a positive conversations about drugs and alcohol have ben delivered to parents online and in group settings. School nursing now trained in alcohol and drug awareness and progressing to drug brief intervention and alcohol brief intervention training	Further training delivered in pilot schools and outputs/outcomes gathered from training and delivery to students Assessment of workforce development approach between third sector and school nursing	6. Health Inequalities	Green - On Track	Green - On Track	Green - On Track	Blue - Complete/ Target met
Delivery of Property and Asset Management Strategy		Phase 1 target met with submission of the plan in January 25 as agreed.	Submit Phase 1 to SG by end January 2025 or any amended timescale determined by SG	10. Climate	Green - On Track	Green - On Track	Green - On Track	Blue - Complete/ Target met
Development of a delivery plan to embed and deliver the Realistic Medicine Programme in NHS Fife			Ensure Realistic Medicine principles are embedded in Fife To work with colleagues to promote sustainable and greener healthcare to fit in with the greener action plan To encouraging staff to access RM module on Turas To encourage parents and families to ask BRAN questions To Evaluate shared decision making from patients' perspectives		Green - On Track	Green - On Track	Green - On Track	Blue - Complete/ Target met
Develop plans to make sure CIS delivers on key operational priorities	1.2	Participation in national Task & Finish Group around Childhood schedule changes including 18 month visit. Scottish Government financial return completed for childhood schedule changes including 18 month visit. Maternity immunisation improvements made to the RSV programme - funding for maternity post.	Maternity immunisations Preparation for children's 18 month visit	1. Primary and Community Care	Green - On Track	Green - On Track	Green - On Track	Blue - Complete/ Target met
Digital Enablement Workplan for patients and staff ITIL 4 Improvement	9.3	Work has completed on the necessary ITIL4 changes. Focus turns to the processes being embedded into day to day operations and planning.	Implementation Complete	9. Digital & Innovation	Green - On Track	Green - On Track	Green - On Track	Blue - Complete/ Target met
Estates Rationalisation		24/25 targets met with consolidation of 3 buildings including Hayfield House, Cameron House and Haig House. Sharing of office assets with Fife Council enabled the buildings to be decanted.			Green - On Track	Green - On Track	Green - On Track	Blue - Complete/ Target met

Deliverable	ADP Reference	2024/25 Q4 Narrative Highlight achievements, reflecting on planned activities and impact on stated outcomes, as well as any associated risks and challenges that impacted delivery	2024/25 Q4 Planned Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status	Deliverable 24/25 Q3 RAG Status	Deliverable 24/25 Q4 RAG Status
Implementation of environmental prescribing improvements per the Scottish Government Quality Prescribing for Respiratory guide 2024 while delivering patient level reviews and appropriate clinical guidance to drive high quality clinical care.	10.6	Primary care pharmacy team continue to deliver medication reviews relating to respiratory prescribing, within broader Polypharmacy based approach. Formulary position remains in place. Inhaler technique support work ongoing	Ongoing delivery of review Continued embedding of communication and engagement approaches	10. Climate	Green - On Track	Green - On Track	Green - On Track	Blue - Complete/ Target met
Outline plans to implement an approved Environmental Management System.	10.5	We have made good progress with developing the legal register, we have also set out a SharePoint process for document control. We have carried out 3 audits and have more planned	Have made progress with carrying out a legal review for all sites	10. Climate	Green - On Track	Green - On Track	Green - On Track	Blue - Complete/ Target met
Outline plans to increase biodiversity and improve greenspace across our estate	10.5	We have planted trees and UKHab survey is will be funded by SG. We are engaging with Fife Coast and Countryside Trust (FCCT) who now maintain our grounds and gardens, to improve biodiversity by the regimes of maintenance.	Have made progress with creating biodiversity audits for all key sites	10. Climate	Green - On Track	Green - On Track	Green - On Track	Blue - Complete/ Target met
Reduction of Medical Gas Emissions through implementation of national guidance	10.1	External assessment of Entonox within maternity, demonstrates staff are not being exposed to unsafe levels. This work is now completed. Other areas are working under BAU. The technical update for Entonox migration is ongoing and will conclude Q1 2025/26 The SLWG will be wound up early in 25/26 and work managed through the medical gas committee		10. Climate	Green - On Track	Green - On Track	Green - On Track	Blue - Complete/ Target met
Set out our approach to adapting to the impacts of climate change and enhancing the resilience of our healthcare assets and services	10.2	NHS Fife have created a Business Continuity Plan dashboard that will link to flood risk. NHS Scotland climate mapping tool has been developed. Initial partnership with Fife Council has been established to develop a climate model, this will identify highest risk sites	Have created a dashboard for climate risk	10. Climate	Green - On Track	Green - On Track	Green - On Track	Blue - Complete/ Target met
Complete NHS Fife's Phase 2 M365 Programme				9. Digital & Innovation	Green - On Track	Green - On Track	Blue - Complete/ Target met	Blue - Complete/ Target met
Infrastructure - Workforce	9.3		Decommission Sites Establish other hotdesking locations	9. Digital & Innovation	Green - On Track	Green - On Track	Blue - Complete/ Target met	Blue - Complete/ Target met
Refresh of the Primary Care Improvement Plan	1.1			1. Primary and Community Care	Blue - Complete/ Target met	Blue - Complete/ Target met	Blue - Complete/ Target met	Blue - Complete/ Target met
Review existing arrangements which support children with neurodevelopmental differences.				7. Women & Children Health	Blue - Complete/ Target met	Blue - Complete/ Target met	Blue - Complete/ Target met	Blue - Complete/ Target met

ALL

Deliverable	ADP Reference	2024/25 Q4 Narrative Highlight achievements, reflecting on planned activities and impact on stated outcomes, as well as any associated risks and challenges that impacted delivery	2024/25 Q4 Planned Milestones	Recovery Driver	Deliverable 24/25 Q1 RAG Status	Deliverable 24/25 Q2 RAG Status	Deliverable 24/25 Q3 RAG Status	Deliverable 24/25 Q4 RAG Status
Develop the NHS Fife Organisational Change Model to support delivery of change.		1. Update to NHS Fife Board (March 2025)- update provided to Director of Planning and Transformation. 2. Develop a 'Change Hub' and teaching programme to support organisation (March 2025). Work has commenced on delivery of this. This work will continue into Q1 2025-26. 3. Develop evaluation plan for 2025-26 onwards. This has not started. This work will continue into Q1 2025-26. 4. Completed all-staff survey on the staff experiences of change.	1. Update to NHS Fife Board (March 2025) 2. Develop a 'Change Hub' and teaching programme to support organisation (March 2025). 3. Develop evaluation plan for 2025-26 onwards. This has not started.		Green - On Track	Green - On Track	Green - On Track	Amber - At risk - requires action
Supporting implementation of the Population Health & Wellbeing Strategy		We have commenced drafted the annual report to the NHS Fife Board. A draft is on track to be completed by the end of March 2025.	Commence annual report for 2024-25		Green - On Track	Green - On Track	Green - On Track	Green - On Track

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**2 May 2025**
Title:	**Realistic Medicine/Value Based Health and Care Delivery Plan 2025/26**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author:	**Emma O'Keefe, Linda McGourty, Shirley-Anne Savage**

Executive Summary:

- The NHS Fife Realistic Medicine/Value Based Health and Care Delivery Plan was updated in April 2025 for the year 2025/26.
- It is presented to the Clinical Governance Committee for assurance.

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 NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The NHS Fife Realistic Medicine/Value Based Health and Care Delivery Plan for 2025/26 is presented to the Clinical Governance Committee for assurance.

2.2 Background

The NHS Fife Realistic Medicine/Value Based Health and Care Delivery Plan was updated in April 2025 for the year 2025/26.

The Realistic Medicine/Value Based Health and Care Annual Delivery Plan RAG status and narrative is updated monthly and reports are sent as required 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."

This report provides the following Level of Assurance:

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

2.3.1 Quality, Patient and Value-Based Health & Care

The 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.

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 2024-2027 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 2025/26, the Scottish Government will fund £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.
- 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 report has been discussed with Dr Chris McKenna, Medical Director

2.3.8 Route to the Meeting

ELT 24 April 2025

2.4 Recommendation

Members are asked to take a **"moderate" level of assurance** from the report.

3 List of appendices

The following appendices are included with this report:

- Appendix No. 1, NHS Fife Realistic Medicine/Value Based Health Care Delivery Plan

Report Contact
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Realistic Medicine/Value Based Health and Care Delivery Plan 2025-2026

- 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 an annual delivery plan.
- The NHS Fife Realistic Medicine Team Report to Shirley-Anne Savage, Associate Director for Risk and Professional Standards and Dr Chris McKenna Medical Director
- The Realistic Medicine (RM) Delivery Plan for 2025-2026 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)	RAG	Timescale	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 and Organisational Learning Leadership Group to explore the expansion of Secondary Care outpatient letters to patients. Use RM Pillars when responding to complaints and as part of team learning after Datix/Significant Event analysis.	Director of Nursing (Corporate)/ RM Team/Head of Patient Experience/ Associate Director of Quality and Clinical Governance		Mar 26	Engaged with Patient Experience team and the Organisational Learning Leadership Group (OLG) to explore the development of outpatient letters to patients.
	1.2	BRAN/ Questions That Matter (QTM) (Benefits, Risks, Alternatives, Do Nothing) Patients and families encouraged to ask	Engage with patients in primary care to ask QTM Engage with patients in secondary care and empower them to ask BRAN/QTM questions. Continue to pursue the possibility of QR codes on out-patient letters Work with colleagues to evaluate using CollaboRATE tool.	RM Team /HSCP/Health Records/Digital and Information		Mar 26	QTM to be developed on QR code. QTM continues to be shared out with appointment letters. Working with Comms to evaluate the uptake of the current link contained within the patient letters.
	1.3	Raise awareness of RM /VBHC	Use mainstream person-centred stories in comms.	RM Team		Mar 26	Work with Communications Team to develop public facing information

			Ensure consistent comms in outpatient waiting rooms and TV/banners. In line with recommendations from Citizens Panel 14 explore opportunities to promote RM /VBHC using social media and TV Campaigns	Comms and Medical Director			
Workforce	2.1	Engage with Exec and Non-Exec Directors/workforce and committees to ensure RM learning is recommended	Use different opportunities to signpost to online training	RM Team		Dec 25	Monitor training uptake by using local data and quarterly data from NES and engage with clinical areas showing lower uptake. Adapt GGC staff survey to role out to HSCP Staff early summer 25 and assess our response from the national survey when available to compare awareness levels.
	2.2	Engagement with pharmaceutical staff on realistic prescribing	Re-establish Realistic Prescribing Group	NHS Fife Pharmacy staff		Dec 25	Planned re-establishment of realistic Prescribing Group . RM team presented to Extended Pharmacy Leadership Team June24 . Progressing Priorities Report available.
	2.3	Engagement with Health and Social Care workers to embed RM in practice	Disseminate message in grand round. Engage with GP clusters. Attend Rapid Cancer Diagnostic Service (RCDS)	Medical Education/Public Health Department		Mar 26	Grand round delivered Oct 24 One GP Cluster is planning to undertake the blood monitoring work in collaboration with SG around demand optimisation. RM training is now part of training for FY2 andScotGEM doctors.

			Meeting to engage with practice nurses. Engage with nurses in training. Engage with Undergraduate (UG)/Postgraduate (PG) Doctors /Dentists in training. Scottish Graduate Entry Medicine (SCOTGEM)				Exploring working with the ScotCOM programme. Engagement with Chief registrars around procedures with Low Clinical Value
Systems Alignment	3.1	Establish RM Programme Governance arrangements	Audit impact of the inclusion of VBHC in Board Papers	RM team		Mar 26	Provide assurance that RM principles are considered across the organisation and reported through committee papers.
	3.2	Embedding of TURAS modules into Board members mandatory corporate training		RM Team /Associate Director of Corporate Governance and Board Secretary /		Sep 25	Add TURAS module into training for Board members as agreed at Fife Risks and Opportunities Group (April 2025)
	3.3	Link with local teams around ongoing pathways work eg Active Clinical Referral	This is now integrated in some specialties.	Clinical teams		Apr 25	First Case Study submitted to SG RM Policy Team for Publication

		Triage (ACRT), Patient Initiated Reviews (PIR),					
	3.4	RM/VBHC embedded across the organisation and considered as part of all transformation work	This is now integral to NHS Fife	Director /Depute Director of Planning and Transformation/		April 25	NHS Fife RTP Framework was established in April 2024 to enable change and to work towards a financially sustainable future . This is now considered “Business as usual”

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**2 May 2025**
Title:	**North East Minor Injuries Unit Reconfiguration**
Responsible Executive:	**Lynne Garvey, Director HSCP**
Report Author:	**Lisa Cooper, Head of Service** **Martyn Berrie, Interim Clinical Services Manager, Urgent Care Services Fife (UCSF)**

Executive Summary:

- The paper is presented for assurance around the reconfiguration of North East Fife MIU, based upon the findings from a robust evaluation, including participation and engagement work and a clinically led options appraisal
- The decision will be taken at the integration joint board as this is a delegated service.
- Following a clinically led option appraisal the preferred options is that Minor Injuries Care Service currently delivered at Adamson Hospital in Cupar would relocate into one single Minor Injuries Unit based at St Andrews Community Hospital
- The current model is not sustainable with existing nursing workforce unable to cover both MIU in northeast fife
- NHS Fife unavoidable clinical and operational decision to decommission Adamson Hospital's X-ray machine due to safety concerns and lack of capital funding for replacement.
- Reconfiguration at Adamson to provide an enhanced site offer taking into accounts the needs of the population including development of increased frailty and minor illness offer

1. Purpose

This report is presented for:

- Assurance

This paper is presented for Committee ***assurance*** regarding the progression of recommendations to the Integrated Joint Board for a ***decision*** to progress with the North East Fife MIU reconfiguration based upon findings from a robust evaluation, including participation and engagement work and a clinically led options appraisal.

This report relates to:

- IJB Strategic Priorities

- National Health and Wellbeing Outcomes
- IJB Medium-Term Financial Strategy
- National Transforming Urgent Care programme
- Centre for Sustainable Delivery Unscheduled Care Programme
- NHS Fife Population Health and Wellbeing Strategy - priority 2 - Quality of Care. Focusing
- Urgent and Unscheduled Care priorities in line with National Strategy Supporting "Right Care, Right Place, Right Time."

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This paper is presented for ***assurance*** and is focused on the delivery of Minor Injury care in North East Fife, Monday to Friday, 08:00–18:00 and all other urgent care services are out with scope of this proposal.

The proposal supports key strategic priorities of the Integrated Joint Board, including the Home First and Primary Care strategies, aligns with the national Transforming Urgent Care Programme directed by the Centre for Sustainable Delivery, and contributes to NHS Fife's Population Health and Wellbeing Strategy—Priority 2: Quality of Care and promotes alternative models of care in line with the IJBS Strategic Plan (2023–2026) and the Medium-Term Financial Strategy (2024–2027).

Following a clinically led options appraisal led jointly by stakeholders in the NEF Minor Injury Units Group, Option 3 (a single-site model at St Andrews) scored highest based on criteria including person-centred care, sustainability, and equity. A public consultation and engagement plan was then implemented in line with *Planning with People* guidance. A comprehensive Participation and Engagement Plan was implemented to inform staff, the public, and stakeholders, raise awareness of available services, and promote the principle of right care, right place, right time, alongside the development of a Stage 1 & 2 Equality Impact Assessment (EQIA).

This paper provides ***assurance*** that appropriate communication, engagement, and EQIA have been undertaken and formally requests a ***decision*** from the Integrated Joint Board to proceed to implementation of Option 3.

2.2 Background

Both Adamson and St Andrews Community Hospital (SACH) Minor Injury Units (MIUs) operate from 08:00 to 18:00 and are staffed by Emergency Nurse Practitioners (ENPs) and Health Care Support Workers (HCSWs), but workforce shortages impact the ability to consistently and safely deliver care across both sites. A proposed reconfiguration to a

single site MIU at St Andrews, with full radiology services, is expected to manage activity comparable to that of Queen Margaret Hospital MIU.

A robust options appraisal process followed (Appendix 1) underpinned by a comprehensive participation and engagement plan (Appendix 2) to inform healthcare staff, stakeholders, and the public, using various channels to explain the rationale, address concerns, and gather feedback. This included meetings, surveys, and events, alongside a robust EQIA (Appendix 3) that assessed impacts on protected groups and children's wellbeing, ensuring mitigations were in place.

This process supports the proposal for a sustainable single MIU in Northeast Fife Locality and aligns with statutory duties under the Equality Act 2010.

It is important to advise and assure that Adamson Hospital, Cupar as a community based hub for Patient care is not within scope and there is a commitment from the HSCP to continue to invest within the site to further develop it as a thriving health and social care hub for the Community within the Royal Burgh of Cupar and Beyond.

2.3 Assessment

A series of key factors have influenced this proposal, underpinned by robust review of the qualitative and quantitative data presented during the options appraisal process which can be found in Appendix 4

- The current model is not sustainable with existing nursing workforce unable to cover both Adamson and St Andrews MIUs across their combined 100 weekly operating hours.
- Current establishment includes:

• **Band 6 ENP**	• **4.64 WTE**	• **0.77 WTE Bank**
• **Band 3 HCSW**	• 1.61	•
• **Total**	• 7.01 WTE	•

- There is variable shift cover with some ENPs starting late or finishing early.
- Occasionally, one or both sites lack HCSW cover

Key benefits of Option 3 include:

- A single MIU in North East Fife would enhance resilience and sustainability using the current substantive workforce and would require no staff to be redeployed.
- The proposed model would include 22.5% Predicted Absence Allowance (PAA) to include annual leave and absence, supporting workforce resilience and sustainability
- Predicted daily attendance: ~25 patients, managed by two ENPs (12.5 patients per ENP)

To note, data analysis advises St Andrews MIU is the more frequently used minor injuries unit across North East Fife and surrounding areas, including by a notable proportion of residents from Glenrothes, Levenmouth, and Cupar, while Adamson

MIU sees higher use mainly from nearby burghs like Falkland, Newburgh, and Ladybank. MIU access data can be seen in Appendix 4.

A working group will be established co-chaired by the Heads of Services for Primary and Preventative Care and Community Care Services working in collaboration with Medical and Nursing Leads, AHP Leads, GPs and 3rd and Independent Sector representation to explore and build the Capacity, resources and services available in line with strategic priorities including Prevention and Early Intervention to develop a model based on the needs of the Cupar community.

This report provides the following Level of Assurance:

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

2.3.1 Quality, Patient and Value-Based Health & Care

Reconfiguring services into a single North East Fife (NEF) MIU will reduce duplication and optimise resource utilisation, leading to more efficient patient care, care scheduled in right place at the right time reducing the risk of a disjointed care experience and shorter wait times.

A single site allows for improved planning regards workforce allocation, with adequate Emergency Nurse Practitioners (ENPs) and Health Care Support Workers (HCSWs) to deliver high quality, safe and effective care in line with patient demand.

Cohorting staff at a single location will enhance peer support, supervision, and collaboration, ultimately improving the quality of care, patient outcomes, and overall staff and patient satisfaction.

The proposal is aligned to strategic Right Care, Right Place, in line with national messaging, encouraging patients to contact NHS 24 (111) for appropriate triage and scheduling.

Scheduled and planned care ensures improved planning and operational performance and service efficiency.

Patients may experience longer travel times to the single NEF MIU, there was a perception from public consultation that these could be particularly challenging for those with limited mobility or transportation options. This will be mitigated as Fife offers various transport options, including support for patients returning home, bus services, NHS Fife Community Transport Services, disability bus passes, Go-Flexi on-demand bus service, and NHS 24 (111) for minor injury advice and scheduled urgent care (2.3.7).

2.3.2 Workforce

A single site allows predictable and consistent staffing levels, leading to a stable work environment, improved staff wellbeing and team collaboration and mutual support and supervision. Additionally, concentrating expertise in one location fosters professional growth and development through better collaboration and knowledge sharing among staff.

Reconfiguration to a single NEF MIU will require only existing workforce, requiring minimal change, building capacity and resilience into workforce including a 22.5% cover for annual leave and sickness.

Reconfiguring services into a single MIU will make better use of available resources and reduce strain on staff. The proposal aims to continuously engage with staff through various channels, including professional drop-in sessions, individual discussions, team meetings, and the development of FAQs to address concerns and mitigations.

Staff side support from NHS Fife colleagues has been integral to this process, ensuring that staff have access to the necessary resources, guidance and support.

2.3.3 Financial

The HSCP have a duty ensure to **resources are used effectively and efficiently in the provision of health and social care services** in line with national health and wellbeing outcome 9.

Current operational costs for Adamson and St Andrews MIUs are approximately £557,000. Reconfiguration to a single NEF MIU would only require the substantive workforce, reducing bank and extra staff costs to cover sickness and leave.

Reconfiguration of the NEF MIUs to one unit, would propose a cost saving of £140,000

2.3.4 Risk Assessment / Management

To take no action means a potential for organisational reputational risk. Insufficient staffing has already resulted in the temporary closure of Adamson MIU twice in the last 6 months and this remains a live issue.

To comply with the Health and Care (Staffing) (Scotland) Act 2019, ensuring safe and high-quality care, we must ensure staffing is utilised under a using the common staffing method, appropriate staffing ratios and safe to start, by maintaining both NEF MIU with the current workforce puts Fife HSCP and staff at risk.

Utilising the extant workforce within this proposal will ensure there is no risk of redeployment in line with HR policy.

There is a perceived risk that reconfiguring services will lead to higher patient volumes, potentially resulting in longer wait times and increased staff pressure. This has been mitigated by data analysis and forecasting and will be mitigated by promoting the "Right Care, Right Place" initiative and encouraging NHS 24 (111) for appropriate triage and scheduling.

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

EQIA output and actions

Age: Data analysis for 2024 indicates that Adamson Hospital sees 3% more patients over 65 years old. Increased travel distances and equitable access are mitigated by financial reimbursement, supportive transport services, and the promotion of "Right Care, Right Place" campaign.

Disability: Both MIUs are accessible; St. Andrews MIU has more disabled parking spaces (12) compared to Adamson Hospital (5). It is therefore not expected to negatively impact accessibility for disabled service-users.

Race and Ethnicity: There will be no impact in accessing interpreters with processes already in place to ensure access to these services.

Religion and Belief: No anticipated impacts. Both sites have prayer/faith rooms.

All other protected characteristics were considered as part of the EQIA individually and there was no anticipated impact identified.

The EQIA Stage 1 concluded that a Fife HSCP EQIA Stage 2 including a Children's Rights and Wellbeing Impact Assessment (CRIWA) was necessary as potential impacts have been identified that require further evaluation and mitigation prior to presentation and decision making at the Integration Joint Board. This EQIA2 and CRIWA were shaped as a result of the consultation and engagement process and specific questions within the survey enabled themes to be identified and ensure concerns were heard and appropriate mitigating actions provided as per section 3.3.8

See **Appendix 3** for full EQIA stage 1

2.3.6 Climate Emergency & Sustainability Impact

By considering variable factors, and optimisation of scheduling and transport links, Fife Health and Social Care Partnership can work towards minimising the environmental impact while ensuring equitable access to care for all Fife residents.

2.3.7 Communication, involvement, engagement and consultation

Communication with Health Improvement Scotland (HIS) took place in February 2025.

HIS advised that:

- An EQIA is completed on the recommended option with a focus on transport and access
- People and communities are involved in developing communications for the engagement/informing proposal
- Communication is accessible, clear and easily available allowing enough time for people to analyse any information shared in advance of engagement meetings
- The level of influence on the proposal is clearly articulated to the community

HIS highlighted section 4.5 of Planning with People guidance - 'There may be occasions where the number of practical options is limited, for example, by requirements to comply with national policy or legislation. Where this is the case, the option development process should still be used to involve potentially affected people and communities, and to seek to achieve a consensus around the limited number of practical options'

This advice was incorporated into the communications and engagement planning process.

Engagement Design:

This proposal was underpinned by a Participation and Engagement Plan which is available at Appendix 2. This was designed and delivered in line with Planning with People National Guidance with the purpose being to inform and consult.

- **1,300 participants** were consulted, with the engagement open across Fife with **96%** of responses were received from people living within North East Fife.

- **78%** of survey responses were concerned about how the clinically preferred model might impact on them, their family and those who care for them, with **85%** of survey responses concerned for other people within their community.

A breakdown of those that expressed concerns by 'type of responder' shows that Unpaid Carers were also concerned. The concerns they had were reflective of the general population concerns and are themed within table below.

Key Themes	Mitigating Comments /Actions
Logistics and Inability for people to get to St Andrews in terms of time and distance, especially for those without cars, the elderly, the disabled and those reliant on the poor public transport options.	• Transport options reviewed and advised within the EQIA 2 • Discussions with Scottish Ambulance Service advise following clinical triage after contact via 111, if appropriate an ambulance may be arranged • Recent work lead by Health Promotion service with NHS and third sector organisations advises other transport options referenced within EQIA 2 • NHS Estates Team advised and considering St Andrews parking concerns • Home visiting model available if clinically appropriate to schedule care via flow navigation centre to appointments in out of hours period
Financial implications associated with the additional travel requirement, especially for low-income families.	Considerations given within EQIA 2: • There is transport support and financial reimbursement for travel costs which can help alleviate the economic burden, and travel support to and from the St. Andrews MIU
Increased pressure on GPs, patient transport, ambulances and Accident & Emergency services.	• Communication Campaign NHS24 (111) • Working with local GPs, community council members and communication officers to refresh and share widely the messaging on accessing care, clinical leads advise this model and

	robust communication plan will reduce pressured on the system by ensuring scheduling of care via 111 and care in the right place, right time
Delays in receiving treatment, through travel and potential increase waiting times.	• Access for care via NHS 24(111) right place at the right time for the care needed • Workforce planning advises positive impact on waiting times due to the increase resilience and sustainability of ensuring sufficient staff are available across the full shift during the day, including absences with capacity available to manage surges in activity
Stress and Anxiety caused by additional travel, when in pain, if mobility issues and/or to an unfamiliar environment.	• Robust and clear communication plan will ensuring scheduling of care via NHS24 (111) and care in the right place, right time reducing clinical risk and improving care experiences

10% of survey responses identified **benefits** if the clinical preferred option was to go ahead:

- Better quality of care through efficient use of resource.
- Availability of radiology in the same place.
- Support to maximise cost and efficiencies.

Engagement identified a variation in how the MIU at Adamson Hospital is utilised and peoples expectations and understandings of how to access care in comparison to other MIU's services across Fife. Through consultation it is apparent that action is required to ensure design and delivery of a high profile widely accessible communication plan to support and encourage people to access care via NHS 24 (111) and not to 'walk in' to services, as well as promotion of services available at Adamson Hospital. This aligns with national strategy also to enable care in the right place, right time.

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:

- 22nd January 2025 - FHSCP SLT
- 10th February 2025 - Engagement with staff & stakeholders
- 17th February to 30th of March 2025 - Participation & Engagement, including public survey, open evening events within Royal Burgh of Cupar and Royal Burgh of St. Andrews and online drop in public events.
- 14th April 2025 - FHSCP SLT
- 17th April 2025 - NHS Fife Executive Directors Group

- 25th April 2025 - Fife HSCP Quality and Communities Committee
- 2nd May 2025 - NHS Fife Clinical Governance Committee

Route Following the Meeting:

- 13th May 2025 - Fife HSCP Finance, Performance and Scrutiny Committee
- 14th May 2025 - Local Partnership Forum
- 28th May 2025 - Integrated Joint Board

2.4 Recommendation

- Members are asked to:
- **Note** the risks and drivers for change articulated within this paper indicating the need to review service delivery models for Minor Injury Care within the North East Fife locality to ensure delivery of sustainable, safe, high quality effective minor injury care.
- **Note** the process followed regarding the clinically led options appraisal as per appendix 1 with option 3 as the clinically preferred option being recommended for **decision** by the Integrated Joint Board.
- **Note** the EQIA stage 1 and outcome of consultation with assurance re considerations and mitigating actions regarding access to care and how this will be assured within the preferred option 3.
- **Note** the detailed report and the summary of the consultation as per appendix 2 and consider this within decision making.
- Be **assured** regarding the HSCPs and SLTs continued commitment to investment in the ongoing development of Adamson Hospital as a thriving hub for access to care within North East Fife Locality.
- Members are asked to **consider and support** recommendation 3 for progression to IJB for **decision.**

3 List of appendices

The following appendices are included with this report:

- Appendix 1 Options Appraisal
- Appendix 2 Summary Participation & Engagement Report (Full Participation & Engagement Report - Available on request)
- Appendix 3 Stage 1 EQIA (Draft Stage 2 EQIA – Available on request)
- Appendix 4 Summary of Analytics

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Options Appraisal

Transforming Urgent Care Northeast Fife Minor Injuries Units – Joint Provision Review

Contents

Background

St. Andrews Community Hospital MIU supports an average of 78 patient presentations per week, and Adamson Hospital MIU supports 48 per week, totalling 125 presentations weekly across both sites. Both hospitals are staffed by two Emergency Nurse Practitioners, with a total of four practitioners covering both locations. This staffing model is necessary due to the dual-site coverage.

Over the past 3-4 years, particularly during the Covid-19 pandemic, the way people access urgent care services has significantly evolved. There has been a notable shift towards remote and virtual consultations, as well as a movement from unscheduled to scheduled care. This approach ensures that patients receive the right care at the right time and in the right place.

Patients across Fife now have the option to contact NHS 24, available 24/7, to discuss their clinical needs and receive guidance towards the most appropriate local services, including self-care where appropriate. Supported by local Flow and Navigation Centre (FNCs), this system enables patients to speak directly with clinical teams in MIUs and A&E departments. This development has led to a significant reduction in the number of patients self-presenting at MIUs across Fife and schedule urgent care for minor injury treatment.

When an in-person visit to an MIU is necessary, it is now coordinated to ensure it is scheduled at a time that is convenient for the patient while addressing the clinical urgency of their condition.

As part of our ongoing commitment to service transformation, aligned with both national and local directives, the Health and Social Care Partnership (HSCP) is proposing to transform the MIU services currently provided at Adamson and St Andrews into a single location at St Andrews Community Hospital. By realigning resources, staffing, and services, our goal is to deliver a more effective, efficient, and resilient urgent care service that meets the needs of the population of Northeast Fife (NEF), ensuring that care is accessible by the right person, in the right place, at the right time.

Strategic Overview

As outlined within the Re-form, Transform, & Perform Framework (2024), Fife's population is now estimated at 370,400 as of Census Day 2022, an increase of around 1% since the 2011 census. However, of significant note is Fife's age structure which continues to change, with fewer children and working aged people than in 2011, and a significant increase in its older population.

NHS Fife's Population Health and Wellbeing Strategy 2023-28 notes that while the Fife population is predicted to decline there is an anticipated 30% increase in the over 65 population by 2043. We know this age group is likely to experience multiple health conditions with increasing frailty and will require to access support from health services more frequently than others. To enable delivery of sustainable services to meet current and future need, we need to change how we deliver services in response to these drivers.

Supported by the Integrated Joint Board in line with our Medium-Term Financial Strategy "Transformation" involves alternative models of care in line with the ambitions of the Health and Social Care Strategic Plan 2023-2026 and most recently the Medium-Term Financial Plan for 2024-2027.

Transforming unscheduled care is also aligned to the NHS Fife Population Health and Wellbeing Strategy aligned to priority 2 for Quality of Care. Focusing on Urgent and

Unscheduled Care is in line with National Strategy Supporting “Right Care, Right Place, Right Time” and the IJB also has key strategies that are aligned to this work including our home first strategy and primary care strategy and this work is a continuation of the national transforming urgent care programme supported by the Centre for Sustainable Delivery.

In line with values of whole system working this transformation plan will be developed and brought forward with full engagement and joint working with the HSCP and Acute Services. This proposal will consider the interfaces and dependencies relating to unscheduled and urgent care across the system to support the future model. There is already an Integrated Unscheduled Care Programme Board in place which is co-chaired by the Director of Health and Social Care and the Director of Acute Service. This will enable us to have joint oversight on the development and delivery of this plan and work together on opportunities, impacts and outcomes for the people of Fife.

Current Service

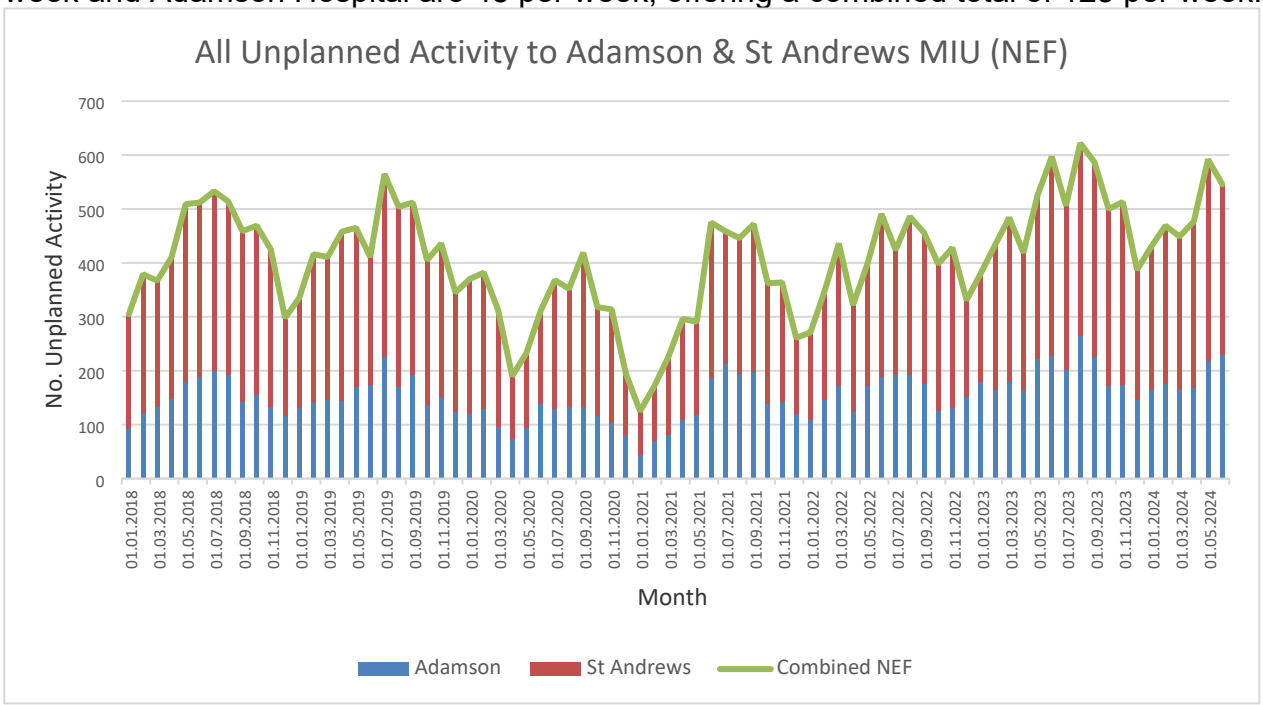
Service Provision

The current service model for minor injuries units in Northeast Fife, is two centres covered by 4 WTE ENPs:

- Adamson Hospital is operational Monday to Friday 08:00-18:00 (with x-ray facilities available from 08:00-12:00).
- St Andrews Community Hospital is operational 7 days a week, Monday to Friday 08:00-16:00, Saturday 08:00-22:00 and Sunday 09:00-21:00 (with x-ray facilities available Monday to Friday from 08:00-16:00).

Service Activity

On average the number of presentations at St Andrews Community Hospital are 78 per week and Adamson Hospital are 48 per week, offering a combined total of 125 per week.



Options Appraisal Process

Review Process

Engagement took place with a joint stakeholder group including representatives from NHS Fife & Fife HSCP to understand areas for improvement and identify any gaps and barriers within the current model of delivering Minor Injury Units at Adamson Hospital and St Andrews Hospitals in Northeast Fife.

Representatives were selected from the NEF Review SLWG group to develop a list of options to present back to the oversight group for review and comment. The aim of the activity was to identify service delivery functions and the workforce required with costings and outline any benefits and/or risks. A long list of options was provided to the group (Appendix A) and final shortlist for appraisal agreed by the chairs of the Integrated Unscheduled Care Board as listed below in Section 5.

Scoring Criteria

The scoring criteria has been developed with the following focuses:

1. Enabling right care, right place, first time ethos
2. Ensuring financial sustainability and value for money service

The options detailed will be scored using the following criteria utilising the Guiding Principles in Health and Care Service Design and Delivery (Ritchie, 2015), the list of stakeholders involved in the scoring process are available within Appendix B.

Criteria	Description
Person-centred	For those who receive and those who deliver services
Intelligence-led	Making the most of what we know about our people and their needs
Asset-optimised	Making the most of all available assets and resources
Outcomes-focused	Making the best decisions for safe and high-quality patient care and wellbeing
Desirable	High quality, safe and effective
Sustainable	Resilient on a continuous basis
Equitable	Fair and accessible to all
Affordable	Making best use of public funds

Table 1 – Scoring Criteria

Score	Description
0 Unacceptable	Criteria requirements are not met.
1 Poor	Criteria is partially delivered but generally requirements are not met.
2 Acceptable	Criteria is partially delivered and will broadly deliver on the requirements.
3 Good	Criteria is mostly delivered, and requirements are mostly met.
4 Excellent	Criteria requirement will be met in full.

Table 2 – Scoring Description

Options

Option 1: Maintain Status Quo	
Description	• Deliver two NEF MIU's and Out of Hours Urgent Care Centre (UCC) at St Andrews: • MIU Adamson & St Andrew's 8am – 6pm M-F • MIU & UCC St Andrew's 6pm-10pm M-F, SAT 8am-10pm & SUN 9am-9pm
Benefits	• Cupar and surrounding area residents can attend the MIU at Adamson or St. Andrews Monday to Friday. • The two MIUs help manage the demand for minor injury care in Northeast Fife. • NHS Fife Flow Navigation Centre directs unscheduled care to the appropriate MIUs across Fife, ensuring patients receive the right care in the right place. • Cupar and surrounding area GP practices have direct access to the Adamson MIU. • Patients who receive an x-ray at Adamson or St. Andrews and require immediate treatment can access either MIU directly.
Disbenefits / Risks	• Difficulty in staffing both MIUs with ENPs. • High staffing costs for ENPs at Adamson relative to the number of patients. • Low patient attendance at Adamson, leading to inefficiency. • Underutilisation of the available capacity at both MIUs in Northeast Fife. • Limited radiology services at Adamson, available only until 12:30 pm, resulting in patient redirection to St. Andrews and hindering the delivery of consistent high-quality minor injury care. • Radiology services at both NEF MIU will remain unavailable on weekends due to low demand
Costs / Savings	• Cost £500K

Option 2: Transform NEF MIUs to one MIU based at St. Andrews (2 ENP Model)	
Description	Transform NEF MIUs to one MIU based at St. Andrews MIU 8am – 10pm M-Sa, & Sun 9am – 9pm 1 ENP 8am-7pm M-F, 1 ENP 10am – 10pm M-F, 1 ENP 8am-10pm SAT and 1 ENP 9am-9pm SUN
Benefits	• Aligns with current ENP workforce. • Workforce costs are proportional to patient attendance. • Fully utilises clinical capacity for minor injury treatment in NE Fife. • Radiology Services are available until 16:30 • NHS Fife Flow Navigation Centre ensures patients receive appropriate care by directing unscheduled cases to the correct MIUs across Fife. • Eliminates the need for patients to transfer from Adamson to St. Andrews for radiology after 12.30pm • Opportunities for nursing staff to develop skills in urgent care and advanced practice. • Patients who receive an x-ray at St. Andrews and require immediate treatment can access the St. Andrews MIU directly.
Disbenefits / Risks	• Displaced HCSW will need alternative duties or redeployment. • A single clinician will be working alone from 8am to 10am.

	• Radiology services at St. Andrews MIU will remain unavailable on weekends due to low demand. • Staff morale and wellbeing negatively affected by contractual changes, shift pattern, and changes in their base of work. • Cupar and surrounding area GP practices will not have immediate access to the Adamson MIU. • Cupar and surrounding area residents will need to travel to St. Andrews or Kirkcaldy Emergency Department for minor injury care. • Patients who receive an x-ray at Adamson, either as outpatients or referred by Cupar and surrounding area GP practices, and require immediate treatment, will have to travel to St. Andrews or Kirkcaldy Emergency Department
Costs / Savings	• Cost £300k • Saving £200k

Option 3: Transform NEF MIUs to one MIU based at St. Andrews (2 ENP, 1 HCSW Model)	
Description	• Transform NEF MIUs to one MIU based at St. Andrews MIU 8am – 10pm M-Sat, & Sun 9am-9pm • 1 ENP 8am-7pm M-F, 1 ENP 10am-10pm M-F, 1 ENP 8am-10pm SAT and 1 ENP 9am-9pm SUN & 1 HCSW 8am-2pm Mon-Fri Only
Benefits	• Aligns with current ENP workforce. • Workforce costs are proportional to patient attendance. • Fully utilises clinical capacity for minor injury treatment in NEF Fife. • Radiology services are available until 16:30. • NHS Fife Flow Navigation Centre ensures patients receive appropriate care by directing unscheduled cases to the correct MIUs across Fife. • Eliminates the need for patients to transfer from Adamson to St. Andrews for radiology after 12:30 pm. • Eliminates risk of lone working between 8 am and 10 am is removed. • Eliminates the risk of Healthcare Support Worker displacement. • Opportunities for nursing staff to develop skills in urgent care and advanced practice. • Patients who receive an x-ray at St. Andrews and require immediate treatment can access the St. Andrews MIU directly
Disbenefits / Risks	• Radiology services at St. Andrews MIU will remain unavailable on weekends due to low demand. • Staff morale and wellbeing negatively affected by contractual changes, shift pattern, and changes in their base of work. • Cupar and surrounding area GP practices will not have immediate access to the Adamson MIU. • Cupar and surrounding area residents will need to travel to St. Andrews or Kirkcaldy Emergency Department for minor injury care. • Patients who receive an x-ray at Adamson, either as outpatients or referred by Cupar and surrounding area GP practices, and require immediate treatment, will have to travel to St. Andrews or Kirkcaldy Emergency Department.
Costs / Savings	• Cost £320k • Saving £180k

Options Appraisal

9 out of 11 participants completed the options appraisal scoring activity. The table below shows the consolidated average scoring results for each option by criteria. A breakdown of anonymised individual scores is available in Appendix D.

Criteria	Description	Weighting	Option 1	Option 2	Option 3
Person-centred	For those who receive and those who deliver services	12.5%	3	4	5
Intelligence-led	Making the most of what we know about our people and their needs	12.5%	2	4	5
Asset-optimised	Making the most of all available assets and resources	12.5%	1	4	4
Outcomes-focused	Making the best decisions for safe and high-quality patient care and wellbeing	12.5%	3	4	5
Desirable	High quality, safe and effective	12.5%	2	4	4
Sustainable	Resilient on a continuous basis	12.5%	1	4	4
Equitable	Fair and accessible to all	12.5%	2	4	4
Affordable	Making best use of public funds	12.5%	1	4	4
Total			17	30	33

Assessment

The process of options consultation included representation from Acute Medical Services, Health and Social Care Primary and Preventative Care Services, Finance, Partnership and Communications. The assessment has been completed following all options being scoped in full. The weighting has taken into consideration the aims of each option that are viable within the current financial constraints of the organisation and considering the best possibility of success.

To support the scoping of options an Equality Impact Assessment (EQIA) was completed to understand any potential adverse impact as a result of the potential change. As a result of this it was agreed that if Option 2 was selected, a Stage 2 EQIA would be developed to monitor activity during implementation.

A consultation was undertaken with Health Improvement Scotland (HIS) to seek guidance on whether the proposed change would meet the criteria of ‘Major Service Change’. HIS recommended that as the public were not involved during the consultation period of the options selection, this would not meet the ‘Major Service Change’ threshold and instead can be delivered as ‘service change’ following board approval.

Recommendation

- **Decision –** For reaching a conclusion after the consideration of potential models in the Options appraisal and to proceed with Option 3 – Transform NEF MIUs to one MIU based at St. Andrews (2 ENP, 1 HCSW Model).
- **Decision –** To also agree to enforce the following surrounding the implementation of a consolidated model:
    - Delivery of Communications and Engagement plan in line with standard service change – to engage and inform the public on the decision made and raise awareness of the services available promoting right care, right place, right time. Communications and Engagement are being developed in line with planning with people principles and seek to be carried out between a 4 – 8 week period.
    - Development of Stage 2 EQIA to monitor impact assessment throughout delivery of change.

Document Control Sheet

Key Information

Title	Options Appraisal – Northeast Fife – Minor Injuries Joint Provision Review
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Approver	Transforming Urgent Care Oversight Group
Approved by and Date	TBC
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Approvals

Version	Date	Name	Role	Signature
0.1	30/08/2024	Transforming Urgent Care SLWG	SLWG	

Distribution

Version	Date of Issue	Name	Role / Area
0.1	16/07/2024	Transforming Urgent Care SLWG	First Review

Appendices

Appendix A –List of Options for Appraisal

MIU Options

Option 1: Maintain Status Quo	• Deliver two NEF MIU's and Out of Hours Urgent Care Centre (UCC) at St Andrews: • MIU Adamson & St Andrew's 8am – 6pm M-F • MIU & UCC St Andrew's 6pm-10pm M-F, SAT 8am-10pm & SUN 9am-9pm
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Option 3: Transform NEF MIUs to one MIU based at St. Andrews (2 ENP, 1 HCSW Model)	• Transform NEF MIUs to one MIU based at St. Andrews MIU 8am – 10pm M-Sat, & Sun 9am-9pm • 1 ENP 8am-7pm M-F, 1 ENP 10am-10pm M-F, 1 ENP 8am-10pm SAT and 1 ENP 9am-9pm SUN & 1 HCSW 8am-2pm Mon-Fri Only • Eliminates risk of lone working between 8 am and 10 am is removed. • Eliminates the risk of Healthcare Support Worker displacement

10.2 Appendix B – List of Stakeholders involved in Options Appraisal Activity

Name	Role
Angela La Porte	Service Manager – UCSF
Moontarin Ansar	GP Clinical Director
Belinda Morgan	General Manager – Emergency Care Directorate
Christopher Conroy	Senior Portfolio Manager – Primary and Preventative Care (HSCP)
Daniel Low	Head of Nursing – Integrated Professional Services
Esther Davidson	Interim Clinical Nurse Manager – Emergency Department
Fran Simpson	Interim Lead Nurse – Urgent Care Services Fife (HSCP)
Lisa Cooper	Head of Primary and Preventative Care (HSCP)
Nilesh Champaneria	Consultant in Emergency Medicine
Martyn Berrie	Interim Clinical Services Manager – Urgent Care Services Fife (HSCP)
Wendy Hutchison	Service Manager – Emergency Care Directorate

1. Background

This briefing is intended for stakeholders involved in the transformation of urgent care services Northeast Fife's Minor Injuries Units (MIUs). Our objective is to identify the safest, effective and person-centred model of urgent care for the people of Fife, within the constraints of our available resources.

St. Andrews Community Hospital MIU supports an average of 78 patient presentations per week, and Adamson Hospital MIU supports 48 per week, totalling 125 presentations weekly across both sites. Both hospitals are staffed by two Emergency Nurse Practitioners, with a total of four practitioners covering both locations. This staffing model is necessary due to the dual-site coverage.

Over the past 3-4 years, particularly during the Covid-19 pandemic, the way people access urgent care services has significantly evolved. There has been a notable shift towards remote and virtual consultations, as well as a movement from unscheduled to scheduled care. This approach ensures that patients receive the right care at the right time and in the right place.

Patients across Fife now have the option to contact NHS 24, available 24/7, to discuss their clinical needs and receive guidance towards the most appropriate local services, including self-care where appropriate. Supported by local Flow and Navigation Centre (FNCs), this system enables patients to speak directly with clinical teams in MIUs and A&E departments.

This development has led to a significant reduction in the number of patients self-presenting at MIUs across Fife and schedule urgent care for minor injury treatment. When an in-person visit to an MIU is necessary, it is now coordinated to ensure it is scheduled at a time that is convenient for the patient while addressing the clinical urgency of their condition.

As part of our ongoing commitment to service transformation, aligned with both national and local directives, the Health and Social Care Partnership (HSCP) is proposing to transform the MIU services currently provided at Adamson and St Andrews into a single location at St Andrews Community Hospital. By realigning resources, staffing, and services, our goal is to deliver a more effective, efficient, and resilient urgent care service that meets the needs of the population of Northeast Fife, ensuring that care is accessible by the right person, in the right place, at the right time.

2. What is an Options Appraisal?

Option Appraisal is a process often used when thinking about a new way to provide services. It allows different views to be included, so there is a full assessment of options. It ensures all stakeholders inform the decision-making process in an open and clear way. The most promising options, the short-list, will then be worked up in more detail to be assessed, comparing their benefits, risks and costs. This intensive and involved process is the main method for reviewing, testing and scoring options, to produce a preferred option(s) proposal for NHS Fife and the H&SCP to review.

3. Who will take part in and who will lead the Options Appraisal?

Representatives of NHS Fife & Fife Health and Social Care Partnership will take part in appraising the short-list of options.
The Options Appraisal will be led by someone from the Corporate Project Management Office, who is not involved with the services concerned.

4. What will you do?

On the following pages, you will be presented with the short-list of options and scoring methodology for appraising. Please individually assess and score the options according to the criteria on a scale of 1-5:

1. Unacceptable – Criteria requirements are not met.
2. Poor – Criteria is partially delivered but generally requirements are not met.
3. Acceptable - Criteria is partially delivered and will broadly deliver on the requirements.
4. Good – Criteria is mostly delivered, and requirements are mostly met.
5. Excellent – Criteria requirement will be met in full.

Please return completed forms to fife.corporatepmo@nhs.scot by **9am on Thursday 29th August 2024** for collation of scores.

Option 1: Maintain Status Quo	
Description	• Deliver two NEF MIU's and Out of Hours Urgent Care Centre (UCC) at St Andrews: • MIU Adamson & St Andrew's 8am – 6pm M-F • MIU & UCC St Andrew's 6pm-10pm M-F, SAT 8am-10pm & SUN 9am-9pm
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Disbenefits / Risks	• Difficulty in staffing both MIUs with ENPs. • High staffing costs for ENPs at Adamson relative to the number of patients. • Low patient attendance at Adamson, leading to inefficiency. • Underutilisation of the available capacity at both MIUs in Northeast Fife. • Limited radiology services at Adamson, available only until 12:30 pm, resulting in patient redirection to St. Andrews and hindering the delivery of consistent high-quality minor injury care. • Radiology services at both NEF MIU will remain unavailable on weekends due to low demand
Costs / Savings	• Cost £500K

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Disbenefits / Risks	• Displaced HCSW will need alternative duties or redeployment. • A single clinician will be working alone from 8am to 10am. • Radiology services at St. Andrews MIU will remain unavailable on weekends due to low demand. • Staff morale and wellbeing negatively affected by contractual changes, shift pattern, and changes in their base of work. • Cupar and surrounding area GP practices will not have immediate access to the Adamson MIU. • Cupar and surrounding area residents will need to travel to St. Andrews or Kirkcaldy Emergency Department for minor injury care. • Patients who receive an x-ray at Adamson, either as outpatients or referred by Cupar and surrounding area GP practices, and require immediate treatment, will have to travel to St. Andrews or Kirkcaldy Emergency Department
Costs / Savings	• Cost £300k • Saving £200k

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Benefits	• Aligns with current ENP workforce. • Workforce costs are proportional to patient attendance. • Fully utilises clinical capacity for minor injury treatment in NEF Fife. • Radiology services are available until 16:30. • NHS Fife Flow Navigation Centre ensures patients receive appropriate care by directing unscheduled cases to the correct MIUs across Fife. • Eliminates the need for patients to transfer from Adamson to St. Andrews for radiology after 12:30 pm. • Eliminates risk of lone working between 8 am and 10 am is removed. • Eliminates the risk of Healthcare Support Worker displacement. • Opportunities for nursing staff to develop skills in urgent care and advanced practice. • Patients who receive an x-ray at St. Andrews and require immediate treatment can access the St. Andrews MIU directly
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Costs / Savings	• Cost £320k • Saving £180k

1 Unacceptable – Criteria requirements are not met.	2 Poor – Criteria is partially delivered but generally requirements are not met	3 Acceptable - Criteria is partially delivered and will broadly deliver on the requirements.	4 Good – Criteria is mostly delivered, and requirements are mostly met.	5 Excellent – Criteria requirement will be met in full.	
Criteria	**Description**			**Option 1 Score (1 – 5)**	**Option 2 Score (1 – 5)**
Person-centred	For those who receive and those who deliver services				
Intelligence-led	Making the most of what we know about our people and their needs				
Asset-optimised	Making the most of all available assets and resources				
Outcomes-focused	Making the best decisions for safe and high-quality patient care and wellbeing				
Desirable	High quality, safe and effective				
Sustainable	Resilient on a continuous basis				
Equitable	Fair and accessible to all				
Affordable	Making best use of public funds				

Appendix D - Options Appraisal Scoring

1 Unacceptable – Criteria requirements are not met.	2 Poor – Criteria is partially delivered but generally requirements are not met	3 Acceptable - Criteria is partially delivered and will broadly deliver on the requirements.	4 Good – Criteria is mostly delivered, and requirements are mostly met.	5 Excellent – Criteria requirement will be met in full.

Criteria	Description	Option 1 Score (1 – 5)										Option 2 Score (1 – 5)							Option 3 (Score 1-5)								
		A	B	C	D	E	F	G	H	I	A	B	C	D	E	F	G	H	I	A	B	C	D	E	F	G	H	I
Person-centred	For those who receive and those who deliver services	3	3	4	4	3	4	4	3	3	5	5	2	3	5	2	3	5	4	5	5	5	4	5	5		5	4
Intelligence-led	Making the most of what we know about our people and their needs	3	3	2	1	2	2	4	2	3	4	4	2	5	5	2	3	4	5	5	5	5	5	5	5		4	5
Asset-optimised	Making the most of all available assets and resources	1	1	1	2	1	1	3	1	1	3	4	2	4	4	2	4	4	5	5	5	5	4	4	5		3	4
Outcomes-focused	Making the best decisions for safe and high-quality patient care and wellbeing	4	4	2	4	1	2	3	2	2	3	4	2	3	4	2	4	5	5	5	5	4	4	4	4		5	5
Desirable	High quality, safe and effective	3	3	2	3	2	2	4	2	1	4	4	2	3	4	2	4	5	5	5	5	4	3	4	4	4	5	5
Sustainable	Resilient on a continuous basis	1	1	1	2	1	1	2	1	1	4	4	1	4	4	1	5	5	5	5	5	3	5	4	3	5	3	4
Equitable	Fair and accessible to all	2	2	3	4	2	3	2	1	3	4	4	3	3	4	3	5	5	4	4	4	4	3	4	4	5	5	4
Affordable	Making best use of public funds	1	1	1	2	1	1	2	1	1	5	5	2	5	4	2	5	5	5	4	4	5	4	5	5		3	3
Total		18	18	16	22	13	16	24	13	15	32	34	16	30	34	16	33	38	38	38	38	35	32	35	35	14	33	34

Appendix 2

NE Fife MIU Reconfiguration

Summary Participation and Engagement Report

Feedback was gathered through an online survey, online engagement sessions and in-person meetings. Despite the presentation of three clinical options which outlined patient safety risks, operational challenges, and long-term sustainability concerns, public respondents expressed support for the Status Quo, Option 1 – maintaining the current MIU services at Adamson.

The following clinical and sustainability realities were highlighted:

- NHS Fife unavoidable clinical and operational decision to decommission Adamson Hospital's X-ray machine due to safety concerns and lack of capital funding for replacement (a requirement for MIU operation) and a decision out with the Integration Joint Boards Influence.
- NHS Fife's clarification that public fundraising could not legally cover the purchase of new NHS equipment due to capital expenditure rules and staffing implications.
- Many participants at the in-person meetings questioned why the X-ray machine from St Andrews could not be moved to Cupar instead, despite explanations around infrastructure suitability, staffing, and service viability.

Feedback from the online survey and Cupar Community Council engagement identified further public concerns, including:

- Transport barriers affecting older residents, families with children, and those without reliable access to transportation.
- Insufficient parking at the St Andrews MIU site.
- Increased waiting times and delays in receiving treatment.
- Challenges with Nationally run NHS 24 - 111 service, particularly long call waiting times, raised during the Cupar session.

There was overall support for the proposal at a session hosted by St Andrews Community Council, although concerns were raised around travel for residents of Cupar, particularly older people, those with disabilities, and individuals without access to transport or reliable transport. In addition, there was a request for extended operating hours at St Andrews.

The public engagement activities highlighted the following clinical and operational factors which require be addressed:

1. Clinical and Service Viability of Current Model

Review and reassessment of the clinical sustainability of retaining MIU services at Adamson Hospital. This should include workforce availability, patient safety considerations, and alignment with modern models of urgent care. Explore all possible avenues (including partnership funding models or temporary solutions) to retain MIU at Adamson, even if only in a reduced capacity.

2. Evidence-Based Rationale for Relocation

Clearly articulate the clinical and operational benefits of relocating to St Andrews, ensuring the decision is based on patient outcomes, service efficiency, equitable access and with data-driven explanations.

3. Mitigation of Access Barriers

Implement measures to ensure continued accessibility for Cupar and surrounding rural populations. This may include:

- Reviewing and ensuring effective communication regarding transport links, particularly for urgent care needs.
- Expand Community Treatment and Care CTAC services to maintain local access to appropriate care requirements.
- Enhancing digital and community-based healthcare options to reduce unnecessary travel.

4. Continued Community and Stakeholder Engagement

Maintain transparent, ongoing dialogue with local stakeholders, including patients, clinicians, and community representatives, to monitor the impact of any changes and adapt services accordingly. This engagement should focus on ensuring the revised care model continues to meet patient needs effectively.

These issues emphasise the importance of ensuring that any changes to the MIU address not only clinical and sustainability priorities but also practical accessibility and equity for vulnerable groups. The findings reinforce the need for solutions that mitigate unintended impacts on patient care and community trust.

The disconnect between clinical imperatives and public expectations emphasises the need for a balanced decision that is both evidence-based and takes account of the concerns raised by the community.

Appendix 3

Equality and Children's Rights Impact Assessment (Stage 1)

This is a legal document as set out in the

- **Equality Act (2010), the Equality Act 2010 (Specific Duties) (Scotland) regulations 2012,**
- **the UNCRC (Incorporation) (Scotland) Act 2024,**

and may be used as evidence for cases referred for further investigation for compliance issues.

Completing this form helps you to decide whether or not to complete to a full (Stage 2) EQIA and/or Children's Rights and Wellbeing impact Assessment (CRWIA). Consideration of the impacts using evidence, and public/patient feedback may also be necessary.

Question 1: Title of Policy, Strategy, Redesign or Plan

Transformation of Urgent Care – Reconfiguration of minor injury care service delivery in the Northeast of Fife

Question 2a: Lead Assessor's details

Name	Martyn Berrie	**Tel. No**	01592740240
Job Title:	Interim Clinical Services Manager	**Ext:**	28918
Department	Urgent Care Services Fife	**Email**	Martyn.berrie@nhs.scot

Question 2b: Is there a specific group dedicated to this work? If yes, what is the title of this group?

Transformation of Urgent Care: Northeast Fife MIU Group

Question 3: Detail the main aim(s) of the Policy, Strategy, Redesign or Plan. Please describe the specific objectives and desired outcomes for this work.

Aim	This work seeks to propose the reconfiguration of the provision of available minor injury units (MIUs) in the Northeast Fife and make a recommendation on providing a value based, safe and effective sustainable service ensuring that people can access the right care, in the right place, at the right time. An options appraisal process was undertaken to review opportunities for service change to promote right care, right place, right time, and a preferred option was selected to

	reconfigure resources from the Adamson & St. Andrews MIUs to a combined service delivery, to be solely delivered from the St. Andrews MIU. The proposed changes of the reconfigured resources will be explored through this EQIA, a separate Stage 2 EQIA will be completed to ensure community engagement meets the need of the locality. **Identified Positives that impact all protected characteristics** **Centralised Expertise**: We will continue to deliver high-quality minor injury care within the North East of Fife. This care will continue to be delivered by highly specialised Emergency Nurse Practitioners (ENP)s and Health Care Support Workers (HCSW)s . By having the ENPs and HCSWs in one location, increases the staff availability and resilience, working closely together and increasing the sustainability of the service. This has the potential in improving overall health outcomes for all patients seeking minor injury care. **Extended X-ray Services**: There is more availability of diagnostic capabilities at St. Andrews. By ensuring that all patients seeking minor injury care attend the St. Andrews MIU first time, can ensure quicker and more accurate treatment for injuries, reducing anxiety, reduce the need for additional travel, especially if attending Adamson MIU and then must commute to St. Andrews for imaging. The Minor Injury Unit at Queen Margaret (QMH) is not included within this proposed reconfiguration, only the MIUs within the North East of Fife at Adamson and St. Andrews Hospitals. **Transport Support**: NHS Fife and Fife HSCP is committed to ensure anyone can access minor injury health care. We can reduce the economic burden of travel, especially for low-income families. Financial reimbursement can help mitigate the costs associated with travel, making healthcare more affordable. This is not available at Adamson MIU and provided at St. Andrews MIU. There is range of transport support available at: final-community-transport-services-leaflet-151024.pdf **Accessibility Issues & Equity Concerns**: There may be concerns about equitable access to the combined MIU, particularly if transport support and reimbursement services are not widely known or easily accessible. Furthermore, increased travel distance may disproportionately affect low-income families who may not have access to reliable transportation, impacting their right to timely and adequate healthcare. We provide assurance that there is available reimbursement and a range of supportive transport services. This will be widely shared as part of the Communication Plan, including a local Right Care, Right Place campaign with the public should the proposal progress to a single NEF MIU. This communication plan will be presented to within the comprehensive SBAR to be submitted to the Integrated Joint Board who will make the final decision on this proposal including a complete Participation and Engagement report, data analysis, public, stakeholder, elected officials feedback and this EQIA 1 & Stage 2 EQIA /full CRWIA).

Question 4: Identifying the Impacts in brief

Consider any potential Impacts whether positive and/or negative including **social and economic impacts** and human rights. Please note, in brief, what these may be, if any. **Please do not leave any sections blank.**

Relevant Protected Characteristics	Impacts negative and positive Social / Economic Human Rights
Age - *Think: adults, older age etc.* *For impacts on 0-18 year old, please refer to the below Question 5 - children's rights assessment (CRWIA).*	Data analysis indicates the following: • For attendances to Adamson MIU in 2024: (555) - 24% under the age of 17 years old - (612) 27% of those over 65 years old - (1136) 49% of those between 18 and 64 years old • For attendances to St. Andrews MIU in 2024: - (717) 19% under 17 years old - (2123) 24% over 65 years old - (917) 57% of those between 18 and 64 years old The data indicates that St. Andrews Community Hospital MIU has a higher number of patient attendances across all age groups compared to Adamson Hospital, however, it can be noted that 3% more over 65-year-olds attend Adamson Hospital compared to St. Andrews. While there are concerns about increased travel distances and equitable access, the implementation of financial reimbursement and a range of supportive transport services, along with the promotion of the Right Care, Right Place campaign, will help mitigate these impacts. Data analysis indicates that St. Andrews Community Hospital MIU already serves a higher number of patients across all age groups compared to Adamson Hospital, suggesting that the proposed changes will continue to support the healthcare needs of the community effectively. By ensuring that these measures are widely communicated and accessible, we can uphold the right to timely and adequate healthcare for everyone in North East Fife.
Disability – *Think: mental health, physical disability, learning disability, deaf, hard of hearing, sight loss etc.*	St. Andrews Community Hospital MIU is easily accessible on the ground level from the main car park. The entrance is an automatic door and the MIU is on the ground level. This is similarly available at the Adamson MIU. There are 12 disabled parking spaces available at St. Andrews MIU and only 5 at Adamson Hospital, however, important to note that there are more disabled spaces available at Adamson Hospital, but down a hill next to the dental centre. The proposed change therefore is not expected to negatively impact accessibility for disabled service-users or those in wheelchairs. If the

	number of disabled parking spaces is found to be insufficient, a reasonable solution with NHS Fife estates team will be sought. Interpreting Services are available at both MIUs and there are no anticipated changes in accessibility to BSL interpreters or Deafblind guides due to this service change.
Race and Ethnicity – *Note: Race = "a category of humankind that shares certain distinctive physical traits" e.g. Black, Asian, White, Arab* *Ethnicity = "large groups of people classed according to common racial, national, tribal, religious, linguistic or cultural origin/background"* *Think: White Gypsy Travellers, Black African, Asian Pakistani, White Romanian, Black Scottish, mixed or multiple ethnic groups.*	No adverse impact anticipated. The communities of North East Fife are becoming ever diverse. This proposal is not anticipated to impact groups in relation to Race and ethnicity. There will be no impact in accessing interpreters. The MIU staff have access to Language Line available 24/7 for the majority of languages to service users.
Sex – *Think: male and/or female, intersex, Gender-Based Violence*	No adverse impacts identified for people dependent on this protected characteristic. For cases of Gender-based violence, it is not anticipated that this change will result in any differences to care. All NHS Fife staff must complete mandatory training in Gender-Based Violence. Any person presenting to either MIU will be triaged and referred to specialists and safeguarding processes remain unchanged. The Gender-Based Violence team would then contact persons affected, if arranging to see the person this would be at another site. NHS Fife offers comprehensive support for individuals affected by gender-based violence (GBV) through the Fife GBV Team which • Provide help and advice for those affected by domestic abuse and/or sexual violence. They can be contacted from any location across Fife at 01592 729258 (Monday to Friday, 8:30 am - 5 pm) or email **Fife.gbvteam@nhs.scot** • Link: Gender-Based Violence (GBV) | NHS Fife
Sexual Orientation - *Think: lesbian, gay, bisexual, pansexual, asexual, etc.*	There are no anticipated impacts on this group as care provided to this protected characteristic group will not differ following the closure of Adamson MIU.

Religion and Belief - *Note: Religion refers to any religion, including a lack of religion. Belief refers to any religious or philosophical belief including a lack of belief.* *Think: Christian, Muslim, Buddhist, Atheist, etc.*	There are no anticipated impacts on this group. Both sites have prayer/faith rooms available. The St. Andrews hospital has a multifaith room available for prayer, meditation, and reflection. This room is designed to accommodate the spiritual needs of people from various faiths and beliefs. It is expected this facility will have space for any increased capacity caused by the closure of Adamson MIU.
Gender Reassignment – *Note: transitioning pre and post transition regardless of Gender Recognition Certificate* *Think: transgender, gender fluid, nonbinary, etc.*	No adverse impact identified as neither MIU currently provide Gender-affirming care therefore there will be no change to care provided for this group. All staff are appropriately trained, and care provided will not differ depending on this protected characteristic.
Pregnancy and Maternity – *Note: Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after birth.* *Think: workforce maternity leave, public breast feeding, etc.*	No adverse impact anticipated. Persons who are pregnant or in the postpartum period, who have an injury will continue to have access to minor injury care. If specialised input is required from the obstetrics and gynaecology teams, the MIU ENP will discuss the persons injury with those teams, and if required direct the person to Victoria Hospital in Kirkcaldy for further review, as per existing processes. Access to Pregnancy and maternity services remain unchanged. Mother and baby room are available at both Adamson and St. Andrews MIUs. It is anticipated that the mother and baby room at St. Andrews will have space to include any increased capacity caused by this change.
Marriage and Civil Partnership – *Note: Marriage is the union between a man and a woman or between a same-sex couple. Same-sex couples can also have their relationships legally recognised as a civil partnership.* *Think: workforce, inpatients visiting rights, etc.*	No adverse impact identified.

Question 5: Children's Rights & Wellbeing Impact Assessment

From July 2024, the UNCRC is enforceable by law. This means public bodies must act compatibly with children's rights. Please consider here any impacts of your proposal on children's rights as per the UNCRC articles. The UNCRC applies to all under 18s, with no exceptions.

Even if your proposal does not directly impact children, there may be indirect impact, so please work through the below regardless.

UNCRC Right	Anticipated Impacts & Relevant Mitigations
Article 3 - Best Interests of the Child *Note: Consideration to how any proposal may impact children must be made. Decisions must be made whilst considering what is best for children.*	**Ensuring Timely and Appropriate Care:** • **Access to Care**: Decisions about the location and availability of minor injury units (MIUs) must ensure that children can access timely and appropriate medical care. This includes considering the distance to the nearest MIU and the availability of transport support to avoid delays in treatment. • **Quality of Care**: The consolidation of services, such as having a team of Emergency Nurse Practitioners (ENPs) and extended X-ray services in one location, can improve the quality of care children receive. High-quality care is essential for the best health outcomes and aligns with the principle of prioritising children's well-being. **Reducing Anxiety and Stress:** • **Minimising Travel**: By ensuring that children can receive comprehensive care at the first point of contact, such as at St. Andrews MIU, the need for additional travel is reduced. This can help minimise anxiety and stress for both children and their parents. • **Support Services**: Providing transport support and financial reimbursement for travel costs can alleviate the economic burden on families, ensuring that children from low-income households can access necessary care without added stress. **Promoting Equity and Accessibility:** Ensuring that all children, regardless of their socio-economic background, have access to high-quality minor injury treatment is a key aspect of upholding their rights. This includes making information about available services and support widely known and easily accessible. This will be achieved through our communication plans to ensure the public know how to access minor injury care, where this will be, how to get there, what will happen when they get to the minor injury unit and potential outcomes, including discharge with advice, treatment and plan or potential further care at the Victoria Hospital in Kirkcaldy
Article 6 & 19- Life, Survival and Development & Protection *Think: Children have the right to life. Governments should make sure that children develop and grow healthily and should protect them from things*	Providing high-quality healthcare services, including minor injury treatment, contributes to the overall physical and mental development of children. This aligns with the obligation to create conditions that do not negatively impact their well-being. The ENPs will continue to have access to Consultants in Paediatric & Emergency Medicine at the Victoria Hospital for advice related to children and young people injuries, should this be required. St. Andrews MIU is a safe and supportive environment where children can receive care without fear of harm or neglect. Including that the ENPs and HCSWs are trained to handle children's needs sensitively, appropriately and

or people which could hurt them.	protected. ENPs are trained to identify any protection concerns and stringent process are in place to ensure children and young people can be referred for comprehensive support services, including psychological support for children who have experienced trauma, ensures that their right to protection is upheld. This holistic approach helps children recover fully and continue to develop healthily.
Article 12 & 13 – Respect for Children's Views and Access to Information *Note: every child has the right to have a say in decisions that affect them this could include making a complaint and accessing information.*	• **Making Complaints**: NHS Fife provides information for all patients about their right to make complaints if they are unhappy with the care they receive. This empowers all patients including children to voice their concerns and ensures their experiences are taken seriously. • **Support for Expression**: Providing a supportive environment where children feel comfortable expressing their views is crucial. There is a children's room available at St. Andrews MIU, which is not available at Adamson MIU. Therefore, by redirecting all children to St. Andrews, there will be improved access to children's rooms.
Article 22 & 30 – Refugee &/or Care Experienced Children *Note: If a child comes to live in the UK from another country as a refugee, they should have the same rights as children born in the UK. Some children may need additional considerations to make any proposal equitable for them (e.g. The Promise, Language interpretation or cultural differences).*	• **Equal Access to Healthcare**: Refugee children will have the same access to high-quality minor injury treatment as other children. • **Language Interpretation**: This change will result in no differing access to NHS Fife interpretation services. For information on impact on religion and faith, please refer to Q4 above.
Article 23 – Disabled Children *Note: Disabled children should be supported in being an active participant in their communities.* *Think: Can disabled children join in with activities without their disability stopping them from taking part?*	There are no additional impacts on Disabled children compared to the wider Protected characteristic. Please refer to Q4 for details on impacts regarding disability.

Article 24 & 27 – Enjoyment of the Highest Attainable Standard of Health *Note: Children should have access to good quality health care and environments that enable them to stay healthy both physically and mentally.* *Think: Clean environments, nutritious foods, safe working environments.*	• **Good Quality Health Care**: Fife HSCP can assure that St. Andrews MIU will continue to ensure that children receive high-quality minor injury treatment supporting their right to health. This includes access to well-equipped facilities, trained healthcare professionals, and timely minor injury care. • **Clean Environments**: Fife HSCP can assure that the St. Andrew MIU is clean and safe to prevent infections and promote healing. This includes maintaining hygiene standards and providing a healthy environment for recovery.
Other relevant UNCRC articles: *Note: Please list any other* UNCRC articles *that are specifically relevant to your proposal.*	

Question 6: Please include in brief any evidence or relevant information, local or national that has influenced the decisions being made. This could include demographic profiles, audits, publications, and health needs assessments.

- **Workforce**: Current staffing does not allow for full coverage at both Adamson and St. Andrews MIUs throughout the total 100 operating hours per week (Monday to Friday 8am-6pm). This requires Band 6 ENPs (4.64 WTE + 0.77 Bank) and Band 3 HCSWs (1.61 WTE) at a total of 7.01 WTE, some ENPs starting later and finishing early, and some days there is units with no HCSW cover. Reconfiguration of minor injury services into a single North East Fife (NEF) Minor Injury Unit (MIU) would require to **only** utilise the substantive workforce, resulting in no redeployments and a sustainable workforce including a 22.5% cover for annual leave and sickness.
- **Attendances**: The single NEF MIU is expected to support approximately 25 attendances per day, with each ENP managing 12.5 patients. Queen Margaret Hospital MIU, which manages 38 patients per day with each ENP treating 13 patients, serves as a benchmark for efficient patient management.
    - **Usage**: St. Andrews MIU is more frequently accessed by residents from North East Fife and surrounding areas, indicating a preference for this location. **Access**: Adamson MIU has 11% of planned attendances (scheduled minor injury appointments), while St. Andrews MIU has 7%. Queen Margaret MIU has a higher percentage at 38%, highlighting the need for more appropriate appointment scheduling via NHS 24 on 111 to.

  - **Presenting Conditions**: Over 110 inappropriate conditions were presented at NEF MIUs in 2024. Data analysis and clinically led forecasting promoting NHS 24 (111) for triage could redirect 8% of patients to the appropriate care professional.
  - In conjunction with the proposed reallocation of all minor injury care in the North East of Fife to one MIU, Fife HSCP is committed to re-vitalising a local Right Care, Right Place campaign, in collaboration with communication colleagues, to encourage patients with an injury to contact NHS 24 on 111, to be triaged appropriately, and scheduled to the most appropriately healthcare for their needs.
- **Demographical Analysis**: St. Andrews MIU has higher patient attendances across all age groups compared to Adamson MIU, with a slight increase in over 65-year-old patients at Adamson.
  - **Clinically Led Options Appraisal**:
  - The process included representation from Acute Medical Services, Health and Social Care Primary and Preventative Care Services, Finance, Partnership and Communications.
  - The assessment was completed following all options being scoped in full and a weighting was applied to ensure equity of assessment in the scoring criteria.
  - Scoring Criteria: The scoring criteria was developed with the following focuses:
    - Enabling right care, right place, first time ethos
    - Ensuring financial sustainability and value for money service.
  - Option 3, reconfiguring NEF MIUs to a single MIU at St. Andrews Hospital, scored highest in criteria and was significantly preferred, scoring 16 points (94%) higher than Option 1.
- **Radiology Facilities**: Adamson MIU lacks x-ray facilities after 12:30 pm, requiring patients to travel to St. Andrews or Kirkcaldy. Furthermore, NHS Fife has taken the clinical decision to decommission the x-ray facilities at Adamson Hospital as the machinery has reached the end of its service and no available capital to fund a replacement or the running costs. St. Andrews MIU offers x-ray services throughout the day.
- **Quality / Customer Care**: Reallocation to St. Andrews MIU will improve efficiency, resource availability, and patient care, addressing access issues and managing higher patient volumes.
- **Risk**: This proposal aims to reduce risk to patients and staff, by implementing a single NEF MIU model, will optimise workforce use, ensure adequate coverage, and reduce staff burnout, provide a single safe environment with effective person-centred care, without the need to commute to another MIU for x-ray imaging after 12.30pm.
- **Transport Options to Access St. Andrews MIU for Minor Injury Care**
- **Regular Public Transport**: Regular bus services are available to St. Andrews Community Hospital.
- **Support for Patients Returning Home**:
  - We will now be exploring that the St. Andrew MIU can provide travel tickets for bus services for eligible patients to return home, similar to what is currently provided at the Emergency Department in Kirkcaldy.
  - Travel reimbursement and community transport leaflets and posters are available to guide patients on how to get to the main hospitals. Reimbursement can be claim at: St Andrews Hospital – Cashier - Monday to Friday 8.30am - 4.30pm, Leaflet link: Travel expenses - information for patients

  - **Anyone requiring transport support to an NHS appointment can access NHS Fife Community Transport services. The link is available at: NHS Fife Community Transport Services Leaflet.**
  - **The type of services available include:**
  - Scottish Ambulance Service - Patient Transport
  - Royal Voluntary Service
  - Continuing Care North East Fife (CCNEF)
  - Alliance Ambulance Service
  - **Fife Bus:** Provides door-to-door transport for people who are unable to access mainstream public transport due to reduced mobility.
- **Disability Bus Pass**:
  - Free bus travel for carers with a companion pass.
  - Travelling with a companion - MyGov.Scot
- By consolidating services at St. Andrews MIU, the proposed reconfiguration aims to enhance efficiency, quality of care, and sustainability while addressing potential challenges and ensures ongoing comprehensive public, staff, patients, carers, elected members, care providers, third sector providers and stakeholder engagement.

Question 7: Have you consulted with staff, public, service users, children and young people and others to help assess for Impacts?

(Please tick)

Yes	x	**No**	

If yes, **who** was involved and **how** were they involved?
If not, why did you not consult other staff, patients, or service users? Do you have feedback, comments/complaints etc that you are using to learn from, what are these and what do they tell you?

- **Communications Plan & Participation and Engagement**: Comprehensive communications and thorough engagement has taken place with local stakeholders through meetings, surveys, and online events.
- Fife HSCP engaged with the local population, including patients, carers, elected members, care providers, third sector providers, and the Royal Burgh of Cupar and St. Andrews Community Council through meetings on March 25th and April 7th, 2025.
- Additionally, they provided an online engagement survey for 6 weeks between the 17th of February and 30th of March and hosted an open online event on March 27th, 2025.
- The team explained the drivers, improvements, and proposed changes, highlighting the benefits and mitigations for patients and visitors, and addressing the needs of new families in the area, particularly regarding Minor Injuries care services.

Question 8: Which of the following 'Conclusion Options' applies to the results of this Stage 1 EQIA and why? Please detail how and in what way each of the following options applies to your Plan, Strategy, Project, Redesign etc.

Note: This question informs your decision whether a Stage 2 EQIA is necessary or not.

Conclusion Option	Comments
1. No Further Action Required. Impacts may have been identified, but mitigations have been established therefore no requirement for Stage 2 EQIA or a full Children's Rights and Wellbeing Impact Assessment. (CRWIA)	
2. Requires Further Adjustments. Potential or actual impacts have been identified; further consideration into mitigations must be made therefore Stage 2 EQIA or full CRWIA required.	FHSCP EQIA Stage 2 will be completed as this proposed service change has identified potential impacts that require further consideration by the Fife Integrated Joint Board (IJB) will make the final decision on this proposal following EQIA assessment, participation and engagement and final SBAR paper review.
3. Continue Without Adjustments Negative impacts identified but no feasible mitigations. Decision to continue with proposal without adjustments can be objectively justified. Stage 2 EQIA /full CRWIA) may be required.	
4. Stop the Proposal Significant adverse impacts have been identified. Proposal must stop pending completion of a Stage 2 EQIA or full CRWIA to fully explore necessary adjustments.	

To be completed by Lead Assessor	
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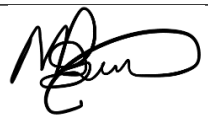
Signature	
Date	**9th of April 2025**

To be completed by Equality and Human Rights Lead officer – for quality control purposes	
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Appendix 4 – Summary of Analytics

1. Summary

Data relating to the Minor Injury Units (MIU) across Fife was analysed, in particular for those situated in North East Fife (NEF).

It shows performance at the NEF units falling significantly below what would be expected at present. The profile of the 2 NEF units shows greater attendances at St Andrews; with slightly more working age population; musculoskeletal attendances; and attendances from people based outwith NEF and visitors to Fife.

Some limited stress testing of data shows that there are unlikely to be implications from future demographic change and that differences in travel distances between options for siting a single MIU in NEF are relatively low.

2. Performance and Length of Stay

Performance the NEF units are broadly similar, but falling significantly behind performance at the QM unit (Table 1). This is serving to reduce the overall performance level in Fife to around 61% for 1 hour waiting. The performance at the 4 hour level is high in all units at just below the 100% level. The main difference is in the 1 hour performance level, with NEF units at around 45% compared to 67% at QM, while the average waiting time in NEF units is at least 43% longer than at QM (Adamson 76 min; St Andrews 79 mins; QM 53 mins) as shown in Table 1 and figure 1.

The proportion of planned appointments is relatively low but similar in the two NEF units at about 8% (table 2)

	Performance %				Percentage people in Length of Stay category				
	4 hrs	2 hrs	1 hr	Average stay (mins)	<=1 hr	>1 hr <=2 hr	>2 hr <=3 hr	>3 hr <=4 hr	>4 hr
Queen Margaret, Dunfermline	99.9	95.7	66.9	53	66.9	28.8	3.7	0.5	0.2
Adamson, Cupar	99.7	84.8	45.8	76	45.8	38.9	11.1	3.7	0.5
SACH, St Andrews	99.6	82.4	44.9	79	44.9	37.7	12.5	4.6	0.3
All MIU	99.8	92.1	60.6	60	60.7	31.5	6.1	1.6	0.2

Table 1. Average monthly performance and length of stay at the Fife MIUs

Based on 13 months of data from Dec 2023 to Dec 2024

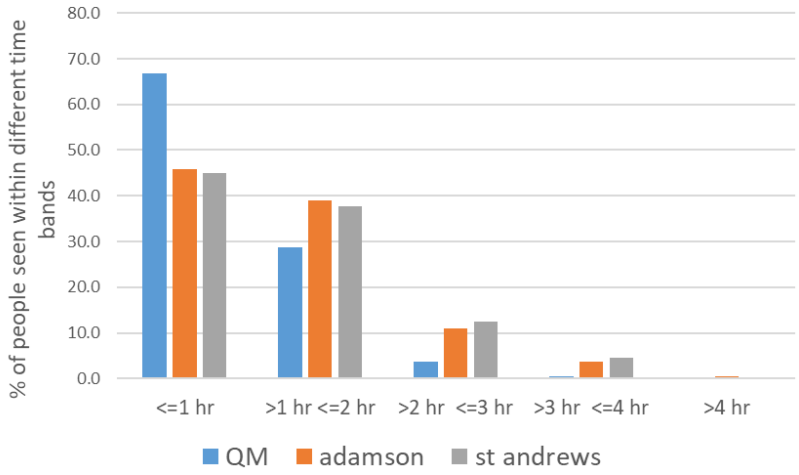

Figure 1. Length of Stay Compared across Fife MIU

Presented as percentage of all stays, average based on 13 months of data from Dec 2023 to Dec 2024

Weekly planned and unplanned presentations	Adamson	St Andrews	All NEF
Planned	5	5	10
Unplanned	57	59	116
% Planned	8.1%	7.8%	7.9%

Table 2. Number and proportion of planned and unplanned presentations at North East Fife MIUs

3. Attendance Levels

By far the bulk of Fife MIU attendance is to Queen Margaret (QM) with 71% of all attendances. All other MIU attendances occur in the 2 NEF units, which are open during daytime hours only.

St Andrews Community Hospital handles 61% of all attendances within North East Fife with around 305 attendances per month (table 3). This translates to around 7 visits per day at Adamson and 10 at St Andrews, compared to around 40 at QM. Even combined, these units would have less than half the attendances seen at QM.

Throughout the year attendance levels are fairly static and similar across the three Fife units, with only a minor peak in the spring which is most obvious at QM (Figure 2).

	All	Morning	Day	Evening
Queen Margaret, Dunfermline	1208	6	1031	171
Adamson, Cupar	189	0	189	0
SACH, St Andrews	305	0	305	0
All MIU	1703	7	1525	171

Table 3. Monthly average attendances at the Fife MIUs

Based on 13 months of data from Dec 2023 to Dec 2024

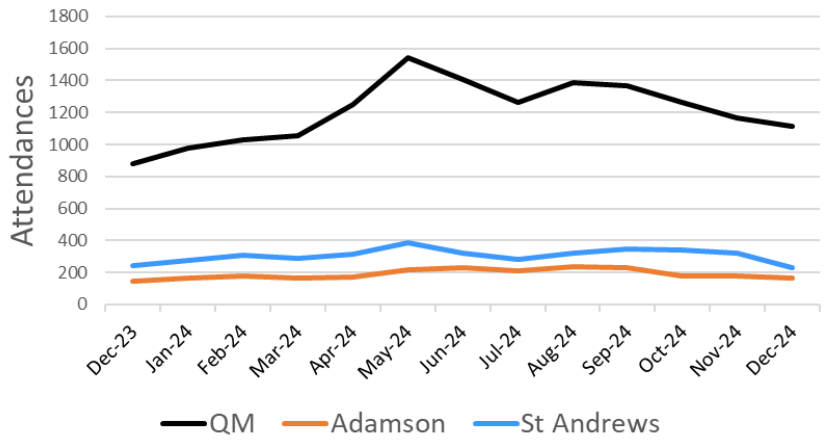

Figure 2. Attendance at Fife MIU through the year (monthly Dec 2023 to Dec 2024)

4. Geographic coverage

People attending both NEF MIUs come from all over Fife and visitors from beyond Fife (Table 4). St Andrews handles significantly more people from outwith Fife (20% of all attendances versus Adamson at 4%) and more people from elsewhere in Fife (outside NEF).

Unsurprisingly, the majority of those attending come from the area immediately around the units (figure 3) but with significant overlap. The St Andrews unit sees around 17.1% of people from the Cupar Burgh and District, while the Adamson Unit only sees 3.8% of people from the St Andrews Burgh and District. In other words the St Andrews unit already handles a significant proportion of the Adamson units nearest 'catchment area' with around 224 attendances per year in that regard (table 5)..

%	Adamson	St Andrews
NEF	89.3	73.7
Fife excl NEF	7.1	6.2
Fife	96.4	79.9
Outwith Fife	3.6	20.1

Table 4. Source of Attendances at North East Fife MIUs as a percentage of all attendances at each unit.

*note the columns will not add to 100% as 'Fife' value includes the 'NEF' and 'Fife excl NEF' values

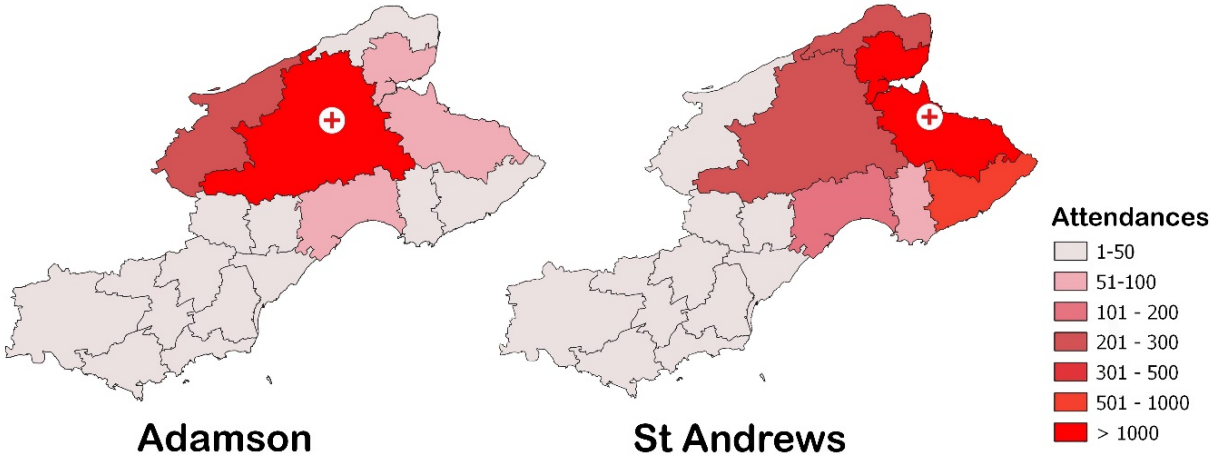

Figure 3. Comparison of geographic coverage of NEF MIUs, attendance per year.

District	Postcode	Adamson	St Andrews
Auchtermuchty Burgh	KY14 7	202	11
Crail Burgh, Kilrenny, Anstruther Easter and Anstruther Wester Burgh	KY10 3	6	350
Cupar Burgh & District	KY15 4 & 5	1309	224
Elie and Earlsferry Burgh	KY9	1	94
Falkland Burgh, Ladybank Burgh	KY15 7	357	20
Newburgh Burgh	KY14 6	84	2
Newport-on-Tay Burgh, Tayport Burgh	DD6	42	222
Pittenweem Burgh, St Monance Burgh	KY10 2	4	170
St Andrews Burgh & District	KY16	63	1654
Outwith North East Fife		247	978

Table 5. Detailed breakdown of geographic source of North East Fife attendees in 2024

5. Profile of Attendances

The age profiles are slightly different, with slightly more working age people attending in St Andrews (table 6), likely due to the presence of the University.

In terms of diagnoses injuries account for most attendances at over 90% for both units (table 7). For more specific diagnoses, the 2 units appear similar (table 8), however some statistically significant differences are present with regard to Musculoskeletal (more in Adamson and less in St Andrews) and in the Unknown/redirected and Other categories.

	Adamson %	St Andrews %
Under 18	24	19
18 to 64	49	57
65+	27	24

Table 6. Age profile of North East Fife MIU attendees

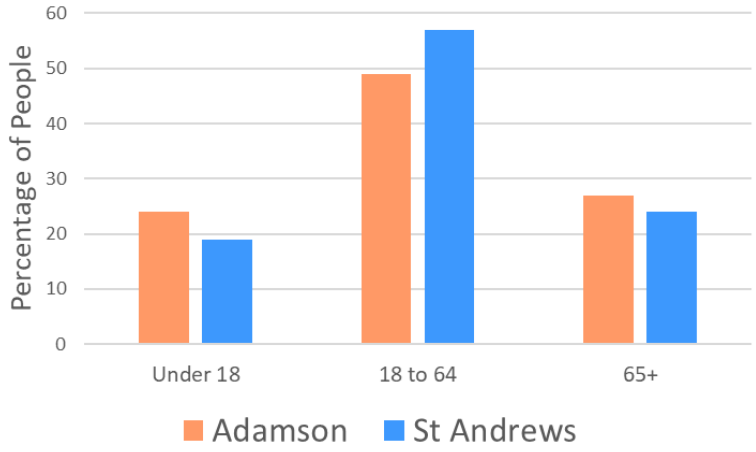

Figure 4. Age profile of North East Fife MIU attendees

	St Andrews %	Adamson %
Illness	8.7	6.7
Injury	91.3	93.3

Table 7. Breakdown by percentage illness or injury at Fife MIU

Broad Diagnosis	Adamson %	St Andrews %	All NEF MIU %
Wound	33.9	32.7	33.1
Soft Tissue Injury	27.3	28.9	28.3
Fracture	15.6	14.9	15.2
Other	6.6	9.0	8.1
Unknown and/or redirected	7.5	4.3	5.5
Musculoskeletal	1.6	4.4	3.4
Dermatology	3.2	2.2	2.6
Burn	2.1	2.1	2.1
Ophthalmology	2.2	1.4	1.7

Table 8. Broad categorisation of Diagnoses for the North East Fife MIUs as percentage of attendances

This is a summary of 275 diagnostic categories, most of which are represented with very small numbers of cases.

6. Stress Testing Data

Two stress tests were applied to the data for the purposes of due diligence in regard to –

1. Will changing demographics have any impact
2. In selecting a single NEF MIU are there significant travel time considerations

Future demographic change was tested by applying the most up to date (2018) National Records for Scotland population projections for Fife to attendance data by age category for a combined unit. These projections show no expected change from now until 2043 (figure 5). There will however be small but noticeable differences in the age profile of future attendees (figure 6) notably, A slow reduction in working age population attendees equating to a 5% reduction in 10 years; no change in under 18s attending; and an increase of about 17% of those aged 65 and over

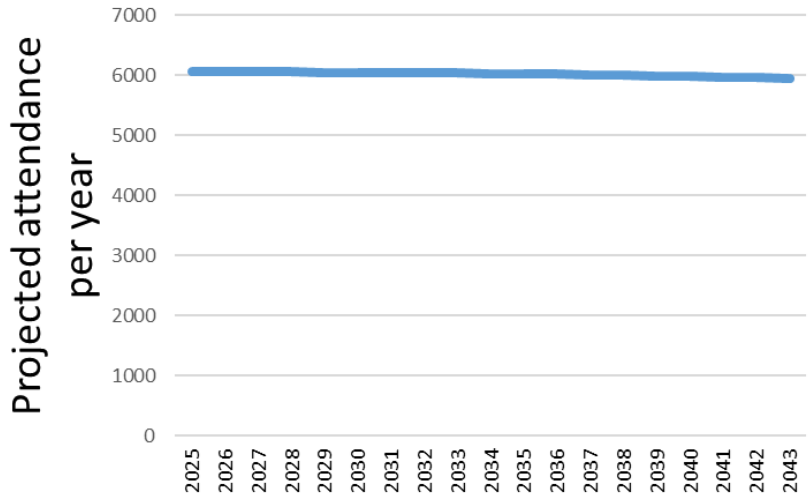

Figure 5. Projected total NEF MIU attendance until 2043

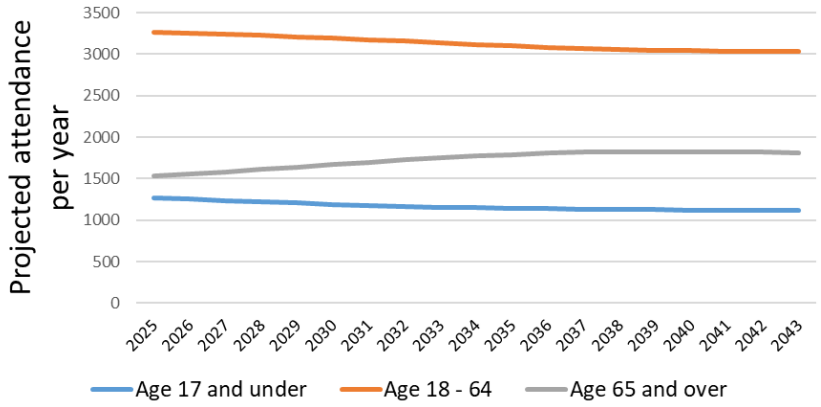

Figure 6. Projected attendance by age group at NEF MIU until 2043

In terms of choosing an appropriate single location, a rapid analysis considering detrimental impact of travel time to units at district level was undertaken. This suggests little difference between the locations in this regard where slightly more (5%) of people would travel further to Cupar, mainly because this is skewed by the higher numbers of people attending St Andrews. It should be noted that travel time is only one of a number of important criteria being considered.

attendances	Single Unit in -	
	St Andrews	Cupar
Broadly further	2116	2226
Broadly closer	111	488

Table 9. Simplified analysis by districts of travel implications of location of a single unit in North East Fife by change in distance for attendances (2024 data).

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**2 May 2025**
Title:	**Integrated Performance & Quality Report**
Responsible Executive:	**Ben Hannan, Director of Planning & Transformation**
Report Author:	**Susan Fraser, Deputy Director of Planning & Transformation**

Executive Summary:

There are 16 metrics reported via the IPQR relating to Quality and Care, of which, 3 (relating to Adverse Events, SAERs Report Approved, HSMR) have no defined trajectory/target.

- For all metrics utilising SPC methodology, 13 are 'within control limits'.
- SAER median days to report approval is high, but against no target. Major/Extreme adverse Events were at lowest level in 24-month reporting period.
- Inpatient Falls with Harm rate remains high but is within control limits.
- For Mental Health Quality Indicators, all rates were above target for Feb-25: the Self-Harm rate sits as an outlier outwith control limits.
- For Healthcare Associated Infections, targets were not achieved for Feb-25.
- Stage 2 Complaints are below local trajectory for Mar-25.

This report provides a Moderate Level of Assurance.

1 Purpose

This report is presented to the Clinical Governance Committee for:

- Assurance

This report relates to:

- Annual Delivery Plan

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

- Safe
- Effective
- Person Centred
- NHS Board Strategic Priorities:
  - To Improve Health & Wellbeing
  - To Improve Quality of Health & Care Services
  - To Improve Staff Experience & Wellbeing
  - To Deliver Value & Sustainability

2 Report summary

2.1 Situation

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

The period covered by the performance data is generally up to the end of Feb-25, although there are some measures with a significant time lag and two which are available up to the end of Mar-25.

2.2 Background

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

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

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

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

2.3 Assessment

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

Highlights of March 2025 IPQR

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

Quality & Care	Current Position	Reporting Period	Planned Trajectory	Target
Adverse Events	22	Feb-25	-	-
SAER – Median days to Report Approved	342	QE Feb-25	-	-
HSMR	0.95	YE Sep-24	-	-
Stroke Care Bundle	70.3%	Feb-25	-	80%
Inpatient Falls	8.59	Feb-25	-	6.95
Inpatient Falls with Harm	1.88	Feb-25	-	1.44
Pressure Ulcers	1.31	Feb-25	-	0.89
Ligature Incidents (MH)	2.76	Feb-25	-	0.76
Incidents of Restraint (MH)	15.17	Feb-25	-	6.44
Incidents of Physical Violence (MH)	13.98	Feb-25	-	7.04
Incidents of Self Harm (MH)	3.74	Feb-25	-	0.78
SAB (HAI/HCAI)	21.7	Feb-25	-	18.8
C Diff (HAI/HCAI)	21.7	Feb-25	-	6.5
ECB (HAI/HCAI)	65.0	Feb-25	-	33.0
Complaints (S1)	66.7%	Mar-25	-	80%
Complaints (S2)	13.8%	Mar-25	30%	60%

This report provides the following Level of Assurance:

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

2.3.1 Quality, Patient and Value-Based Health & Care

The Quality and Care section of the IPQR includes comprehensive reporting on quality measures to ensure continuous oversight and enhancement of patient care standards across NHS Fife. This section focuses on a broad range of indicators designed to monitor patient safety, clinical effectiveness, patient experience, and value-based care delivery. Regular assessment of these metrics facilitates timely identification of potential risks or variations in care quality, enabling proactive measures and improvement initiatives. By systematically evaluating these quality indicators, NHS Fife promotes optimal patient outcomes, improved care experiences, and effective utilisation of resources in line with national healthcare priorities.

2.3.2 Workforce

The Workforce section of the IPQR provides detailed reporting on workforce measures, ensuring robust oversight and management of staffing resources within NHS Fife. This section evaluates key indicators including staff sickness absence, vacancies, and Personal

Development and Performance Review (PDPR) compliance. Monitoring these metrics enables identification of workforce pressures, informs targeted interventions, and supports effective workforce planning and engagement strategies. Through continuous analysis of workforce data, NHS Fife aims to enhance staff wellbeing, optimise performance, and maintain sustainable staffing levels to deliver safe, high-quality patient care.

2.3.3 Financial

The Finance section of the IPQR summarises key financial performance measures, providing high-level assurance and highlighting areas that require ongoing attention. This section ensures the Board remains informed of overarching financial risks, trends, and pressures affecting NHS Fife. It should be noted that comprehensive financial reporting, including detailed analysis and performance evaluation, is presented separately to the Board in a dedicated Financial Performance Report. This separate report enables deeper scrutiny and detailed discussion on financial matters, supporting informed decision-making and effective financial governance.

2.3.4 Risk Assessment / Management

The IPQR includes a detailed mapping of key corporate risks aligned to performance measures, presented through the Risk Summary Table and supported by narrative within the Executive Summary of the IPQR. This structured approach enables NHS Fife to systematically identify, evaluate, and manage risks that may impact organisational objectives, patient care, operational delivery, and overall performance. Regular assessment ensures that risks are effectively monitored, mitigated, and escalated as appropriate, strengthening governance processes and supporting informed strategic decision-making.

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

The IPQR contributes to NHS Fife's commitment to addressing equality, human rights, children's rights, and reducing health inequalities. Through ongoing review and analysis of relevant performance metrics, NHS Fife identifies disparities in patient outcomes, and patient experience. This supports targeted improvement efforts aligned to statutory obligations and strategic ambitions as an Anchor Institution, promoting equitable healthcare delivery, enhancing community wellbeing, and fostering social value across the region.

2.3.6 Climate Emergency & Sustainability Impact

The IPQR will be enhanced to support NHS Fife's response to the climate emergency and sustainability commitments through targeted performance monitoring. By highlighting relevant measures, the report will enable assessment of progress toward reducing environmental impacts, such as carbon emissions and sustainable resource utilisation. This alignment encourages environmentally responsible healthcare practices, promoting sustainability objectives that contribute to NHS Scotland's wider climate ambitions and statutory responsibilities.

2.3.7 Communication, involvement, engagement and consultation

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

The Clinical Governance extract of the Position at March IPQR has been made available for discussion at the meeting on 02 May 2025.

2.3.8 Route to the Meeting

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

- **Executive Leadership Team**, 17 April 2025

2.4 Recommendation

This paper is provided to Clinical Governance Committee members for:

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

3 List of appendices

The following appendices are included with this report:

- Appendix No. 1, IPQR Position at March 2025 CG v1.0

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

Position (where applicable) at March 2025
Produced in April 2025

Introduction

The purpose of the Integrated Performance and Quality Report (IPQR) is to provide assurance on NHS Fife's performance relating to National Standards and local Key Performance Indicators (KPI). At each meeting, the Governance Committees of the NHS Fife Board is presented with an extract of the overall report which is relevant to their area of Governance. The complete report is presented to the NHS Fife Board.

The IPQR comprises the following sections:

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

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

C. Assessment & Performance Exception Reports
More detailed Indicator Summary for each area of Governance including (where appropriate) benchmarking, 'sparkline' trend, comparison with 'previous year' performance. There is also a column indicating performance 'special cause variation' based on SPC methodology. All charts with SPC applied will be formatted consistently based on the following;

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

Also incorporated into this section is an assessment for indicators of continual focus or concern. Content includes data analysis, service narrative and additional data presented in charts, incorporating SPC methodology, where applicable.

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

Ben Hannan
Director of Planning & Transformation
14 April 2024

Prepared by:
SUSAN FRASER
Associate Director of Planning & Performance

A. Corporate Risk Summary

Strategic Priority	Total Risks	Current Strategic Risk Profile				Risk Movement	Risk Appetite
To improve health and wellbeing	5	3	2	-	-	◀ ▶	Hungry
To improve the quality of health and care services	7	5	2	-	-	◀ ▶	Open
To improve staff experience and wellbeing	2	2	-	-	-	◀ ▶	Open
To deliver value and sustainability	6	5	1	-	-	◀ ▶	Open
Total	**20**	**15**	**5**	**0**	**0**		

Risk Key

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

Movement Key

▲ Improved - Risk Decreased

◀ ▶ No Change

▼ Deteriorated - Risk Increased

There are currently 20 risks on the Corporate Risk Register. This includes two new risks under consideration: **Drug Related Morbidity and Mortality** and **Hospital Acquired Harm**. These have been through the March Committees and will go through the Board in May before final adoption.

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

Risk Appetite	**Hungry**	Eager to be innovative and choose options offering potentially higher business rewards, despite greater inherent risk.
	Open	Willing to consider all potential delivery options and choose the one that is most likely to result in successful delivery while also providing an acceptable level of reward (and value for money etc).
	Cautious	Preference for safe delivery options that have a low degree of residual risk and may only have limited potential for reward.
	Averse	Avoidance of risk and uncertainty is a key organisational objective.

B. Indicator Summary

Quality & Care	Current	Previous	Change
SAER - Median Working Days to Report Approved	342	260	▼
Inpatient Falls	8.59	8.32	◆
Incidents of Restraint (Mental Health)	15.17	9.95	▼
SAB HAI	21.7	6.4	▼
S1 Complaints Closed in Month on Time	66.7%	57.1%	▲
HSMR	0.96	0.96	—
Tissue Viability	1.31	1.38	◆
Incidents of Physical Violence (Mental Health)	13.98	14.12	◆
C Diff HAI	21.7	9.7	▼
S2 Complaints Closed in Month on Time	13.8%	29.0%	▼
Stroke Care Bundle	70.3%	69.0%	◆
Ligature Incidents (Mental Health)	2.76	0.54	▼
Incidents of Self Harm (Mental Health)	3.74	0.72	▼
ECB HAI	65.0	12.9	▼

Operational Performance		Current	Previous	Change
Emergency Access	A&E	71.2%	71.5%	◆
	ED	61.4%	61.5%	◆
Patient TTG	% <=12weeks	43.1%	44.5%	▼
	>52 weeks	648	687	▲
Delayed Discharges (Standard)	Acute/Comm	58.2	54.0	▼
	MH/LD	10.7	17.0	▲
New Outpatients	% <=12weeks	37.6%	37.0%	▲
	>52 weeks	5320	5268	◆
Cancer	31-day DTT	92.9%	94.5%	▼
	62-Day RTT	68.9%	67.1%	◆
Diagnostics	% <=6weeks	88.2%	86.6%	◆
	>26 weeks	29	32	◆

Finance	Current	Change
Revenue Resource Limit Performance	Breakeven	
Capital Resource Limit Performance	Breakeven	

Workforce		Current	Previous	Change
Sickness Absence		6.84%	7.99%	▲
Personal Development Plan & Review		44.6%	44.6%	◆
Vacancies	Medical & Dental	5.2%	3.3%	▼
	Nursing & Midwifery	2.4%	2.7%	◆
	AHPs	2.6%	4.0%	▲

Public Health & Wellbeing		Current	Previous	Change
Smoking Cessation	40% Most Deprived	208	195	—
CAMHS		100.0%	98.8%	◆
Breast Screening		73.4%		—
Infant Feeding		32.3%	32.0%	◆
Child Development		16.7%	17.1%	◆
Alcohol Brief Interventions		103%	96%	—
Psychological Therapies		78.0%	74.8%	▲
Bowel Screening		65.8%	66.2%	▼
Childhood Immunisation	6-in-1 @ 12 months	93.5%	94.0%	▼
	MMR2 @ 5 years	86.8%	85.7%	▲
Drugs & Alcohol		92.3%	94.5%	▼
Mental Health Readmissions within 28 days		4.8%	5.6%	▲
AAA Screening		86.6%	87.3%	▼
Winter Vaccination	Influenza	40.6%		—
	Covid	39.2%		—

Key

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

C1. Quality & Care

To improve the quality of health and care services	7	5	2	-	-	◀ ▶	Open

Indicator	Current Position	Reporting Period		Planned Trajectory	Target	SPC	Vs Previous	Vs Year Previous	Trend	Benchmarking	
Major/Extreme Adverse Events	**22**	Month	Feb-25			○	◆	▲			
SAER - Median Working Days to Report Approved	**342**	Quarter	Feb-25			●	▼	–			
HSMR	**0.95**	Year to	Sep-24			○	–	–			
Stroke Care Bundle	**70.3%**	Month	Feb-25		80%	●	◆	▲			
Inpatient Falls	**8.59**	Month	Feb-25		6.95	○	◆	▼			
Inpatient Falls with Harm	**1.88**	Month	Feb-25		1.44	○	▲	▼			
Tissue Viability (Pressure Ulcers)	**1.31**	Month	Feb-25		0.89	○	◆	▲			
Ligature Incidents (Mental Health)	**2.76**	Month	Feb-25		0.76	○	▼	▲			
Incidents of Restraint (Mental Health)	**15.17**	Month	Feb-25		6.44	○	▼	◆			
Incidents of Physical Violence (Mental Health)	**13.98**	Month	Feb-25		7.04	○	◆	▼			
Incidents of Self Harm (Mental Health)	**3.74**	Month	Feb-25		0.78	○	▼	▼			
SAB - Healthcare associated infection	**21.7**	Month	Feb-25		18.8	○	▼	▼		●	YE Sep-24
C Diff - Healthcare associated infection	**21.7**	Month	Feb-25		6.5	○	▼	▼		●	YE Sep-24
ECB - Healthcare associated infection	**65.0**	Month	Feb-25		33.0	○	▼	▼		●	YE Sep-24
S1 Complaints Closed in Month on Time	**66.7%**	Month	Mar-25		80%	○	▲	▲		●	2023/24
S2 Complaints Closed in Month on Time	**13.8%**	Month	Mar-25	30%	60%	○	▼	◆		●	2023/24

Performance Key

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

SPC Key

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

Change Key

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

Benchmarking Key

- ● Upper Quartile
- ● Mid Range
- ● Lower Quartile

Median working days from Commissioned Date to Report Approval

Median 342 days

C1. Quality & Care

Data Analysis

There were 22 **Major/Extreme adverse events** reported in Feb-25 out of a total of 1,383 incidents. 68% of all incidents were reported as 'No Harm'. For Year Ending (YE) Feb-25, 'Tissue Viability on ward' was the most reported Major/Extreme incident at 207 incidents compared with 202 reported incidents for YE Feb-24.

There were 7 **SAERs commissioned** in Feb-25 and 62 in total for YE Feb-24: an average of 5.2 per month. In comparison, there were 56 SAERs commissioned in YE Feb-24: average of 5.0 per month.

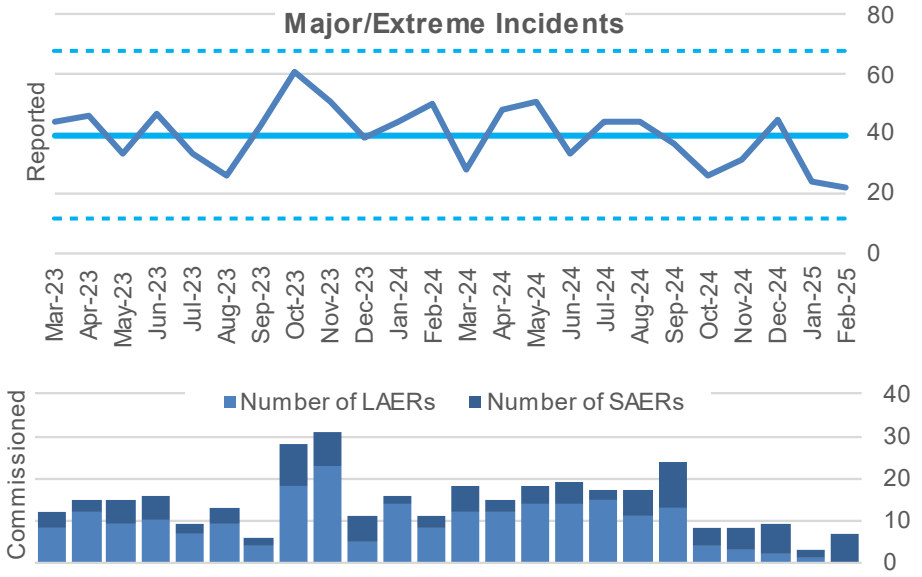
For the latest 3 months ending Feb-25, there were 7 reports approved with median days, from commissioned date, of 342 days: this is an increase of 31.8% on QE Jan-25 (median days 260) and a 48% increase since QE Sep-24 (17 SAER reports approved; median days 231).

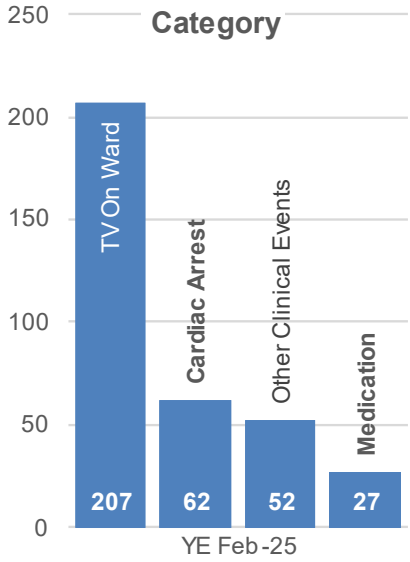
In terms of **SAER review outcomes**, those reported as 'Significant care or service delivery issues identified' in the 12 months to Feb-25 accounted for 23% of total reviews; an increase from 20% in the 12 months to Jan-25.

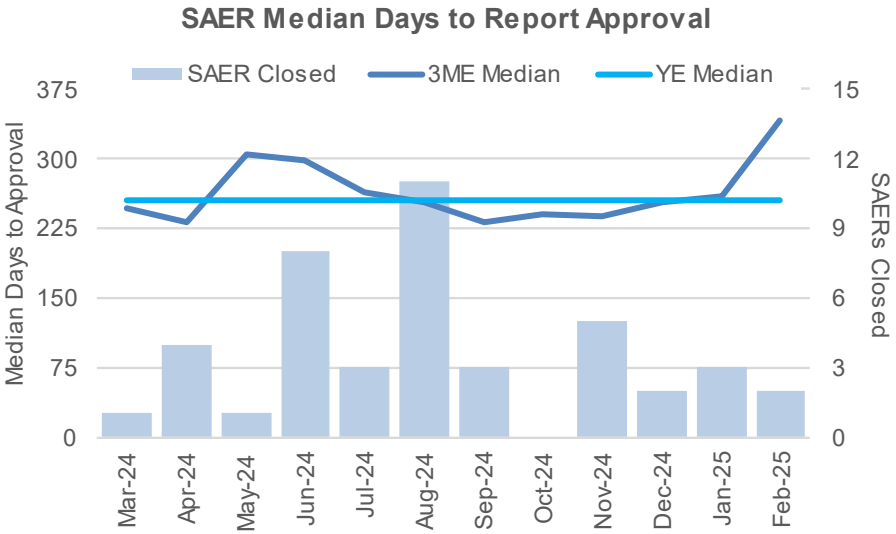
Achievements & Challenges

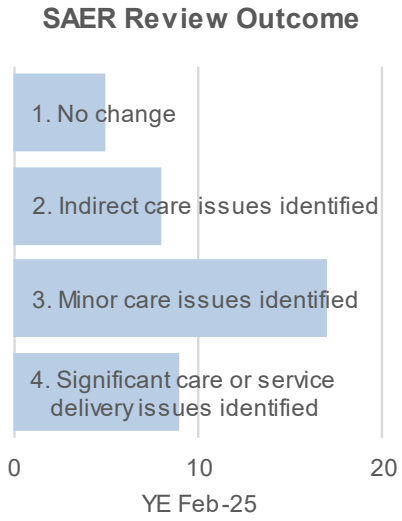
The refresh of the Major/Extreme adverse events trigger list, launched in January 2025, is a decision-making guidance tool: increasing consistence in consideration of events that require a SAER or other review type. An aim of the trigger list is to reduce the number of SAERs commissioned, whilst maintaining a robust focus on events that have resulted in major/extreme harm through a process of event type specific cluster reviews. This approach aligned to the 'National Framework for Reviewing and Learning from Adverse Events' creates greater opportunity to learn from thematics, allowing improvements to be organisationally focused and reviews completed timely.

The SAER Caseload Group has developed an improvement plan outlining improvement actions and corresponding targets which will be shared with the Executive Leadership Team in April. Greater understanding of our data around all steps in the SAER process, understanding delays and blockages and working collaboratively with senior leadership and clinical teams undertaking reviews has enabled steady progress towards reducing the median time to completion on SAER's.









HSMR
Hospital Standardised Mortality Ratio

Number of observed deaths within 30 days of admission divided by the number of deaths that were predicted.

0.95

C1. Quality & Care

Data Analysis

HSMR is the number of observed deaths within 30 days of admission divided by the number of deaths that were predicted for a particular hospital.

Value less than one, means the number of deaths is fewer than predicted. Greater than one means the number of deaths is more than predicted.

For the Year Ending Sep-24 there were 1,902 predicted deaths with 1,826 observed deaths from 39,456 patients. This gives a crude rate of 4.6% and an HSMR of 0.95, which is within observed limits and below the rate of 1.00 for Scotland.

Looking at Quarterly crude mortality rates within 30 days of admission data Fife tends to be above the figure for Scotland.

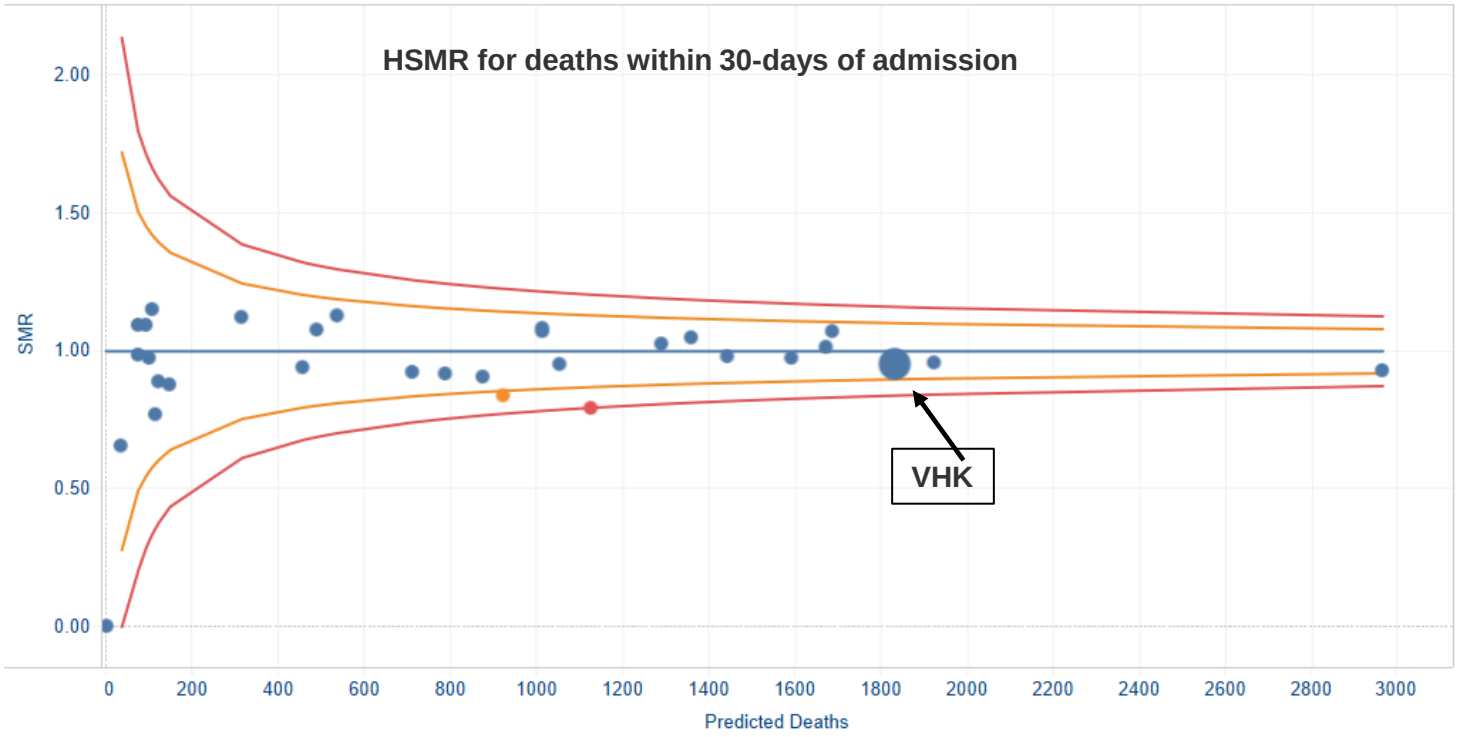
The rate for the last quarter Jul – Sep-24 has increased to 3.5% from 3.3% (Apr – Jun-24).

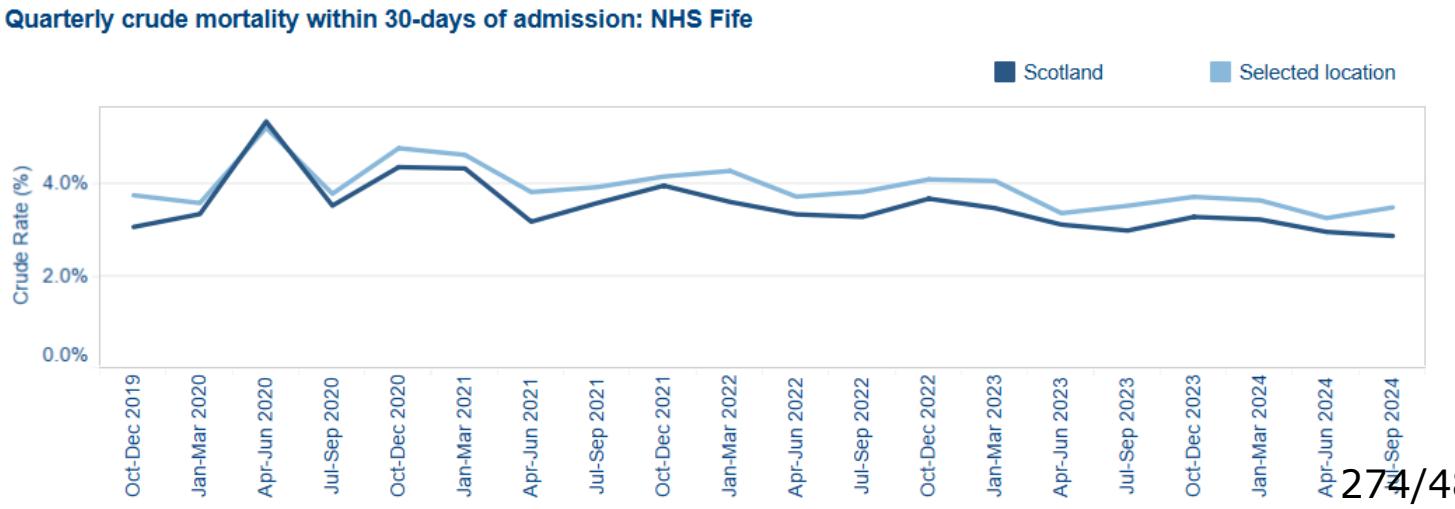
Challenges & Achievements

Proactive review of HSMR data combined with other clinical governance quality performance indicators is fundamental to ensuring the assessment and monitoring of quality and safety.

NHS Fife has a well-established and systematic process in place to review every cardiac arrest, meaning that every unexpected death is reviewed. Learning and themes from reviews are collated and an improvement plan is implemented. This is evidenced in the quarterly Deteriorating Patient Report.

Avoidable deaths are a very small fraction of all the deaths that occur in hospital. So, although extremely important to ensure measures are in place to stop avoidable deaths, reducing any avoidable deaths will not necessarily change the HSMR significantly.





Stroke Bundle

National Standard 80% of patients to receive appropriate Stroke Care Bundle

70.3%

7 patients to achieve target

C1. Quality & Care

Data Analysis

Care bundle performance increased from 69.0% in Jan-25 to 70.3% in Feb-25, this is higher than the same month in previous year (56.2%) but has remained below the 80% target for the last 4 months. Performance for QE Feb-25 was 69.3% down from 72.2% previous QE Dec-24.

Aspirin – 97.6% of patients met this standard, It has remained above the 95% standard for the last 10 months. Performance for QE Feb-25 was 97.5% up from 97.3% previous QE Dec-24.

Brain Imaging – 98.4% of patients met standard and has remained unchanged in last 3 months. It has remained above the 90% standard for the last 12 months. Performance for QE Feb-25 was 97.0% up from 94.5% previous QE Dec-24.

Swallow Screening – 78.1% of patients met standard the lowest level since Mar-24. It has not met the 100% standard for the last 12 months. Performance for QE Feb-25 was 80.2% down from 83.0% previous QE Dec-24.

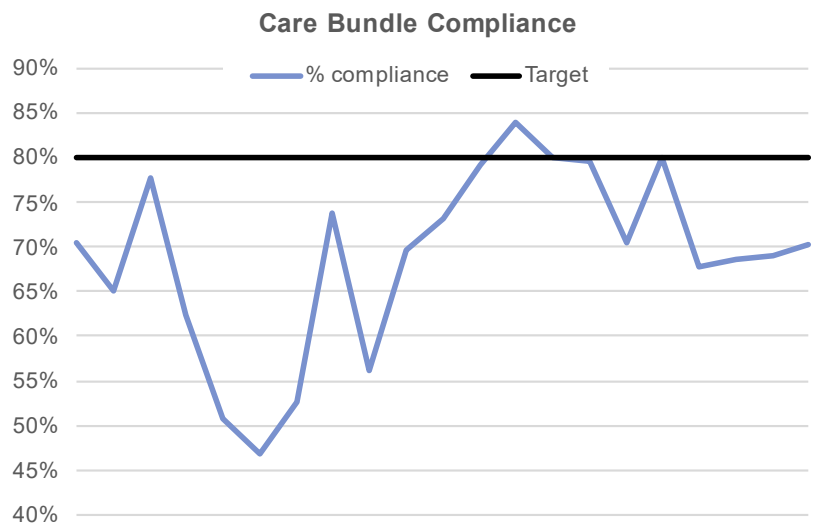
Admitted to a stroke unit within 1 day of admission – 91.8% of patients met standard the highest level since Oct-24. It is above the 90% standard. Performance for QE Feb-25 was 86.3% down from 87.9% previous QE Dec-24.

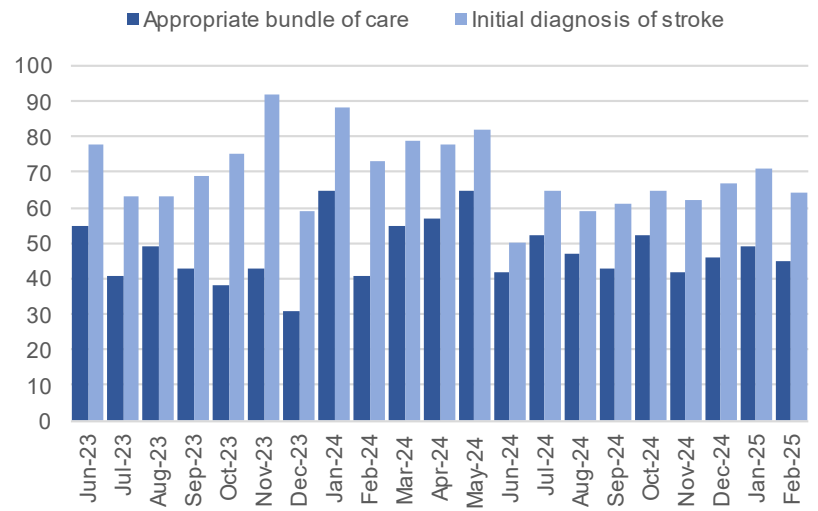
Achievements & Challenges

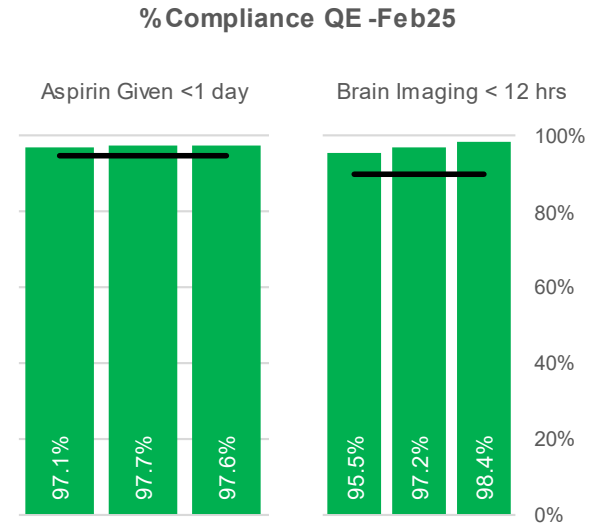
Targets are being reviewed nationally with a move to RedCap for capturing data. Rehab and MT data to be collected with data linked to SAS to be captured. RAG chart for each NHS Board self-reporting against SIP.

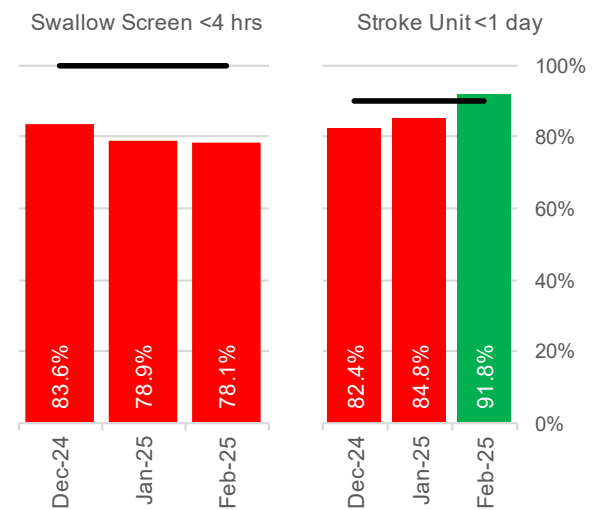
There is a real concern amongst PT/OT about covering Wards 6 and 9 within Victoria Hospital and other areas. This is already impacting upon therapy time, but more likely to be captured under new audits. Similar concerns in community.

Similarly, SLT feel they don't have enough time to do communication work as the focus is dysphagia and this covers the whole of VHK.









Inpatient Falls

Reduce Inpatient Falls rate by 15% to **6.95** per 1,000 Occupied Bed Days compared to baseline (YE Sep-21)	**8.59**	44 ↓ falls to achieve target
Reduce Inpatient Falls with Harm rate by 10% to **1.44** per 1,000 Occupied Bed Days compared to baseline (YE Sep-21)	**1.88**	12 ↓ falls to achieve target

Data Analysis

In Feb-25 there were 227 Inpatient Falls in total: an average of 8.1 falls per day (more than month previous; more than year previous). This equates to a rate of 8.59 falls per 1,000 Occupied Bed Days (OBD): an increase on the 8.32 seen the month previous. Performance has therefore not achieved the target of < 6.95; is above the 24M average; but is within control limits.

The number of Inpatient Falls 'with Harm' was 50 in Feb-25 (less than month previous; 24M average of 45). This equates to a rate of 1.88 falls per 1,000 OBD: a decrease on the 1.99 seen the month previous. Performance has therefore not achieved the target of < 1.44; is above the 24M average; but is within control limits.

Average total rate was 1.60 for YE Feb-25 compared to 1.54 for YE Feb-24.

HSCP saw a decrease in All Falls rate from a high of 10.13 in Dec-24 to 8.13 in Jan-25 followed by an increase to 8.97 in Feb-25 (12M average rate is 7.69).

For QE Feb-25, Falls classified as 'Major/Extreme Harm' accounted for 3.1% of Falls with Harm, compared to 5.1% for QE Nov-24.

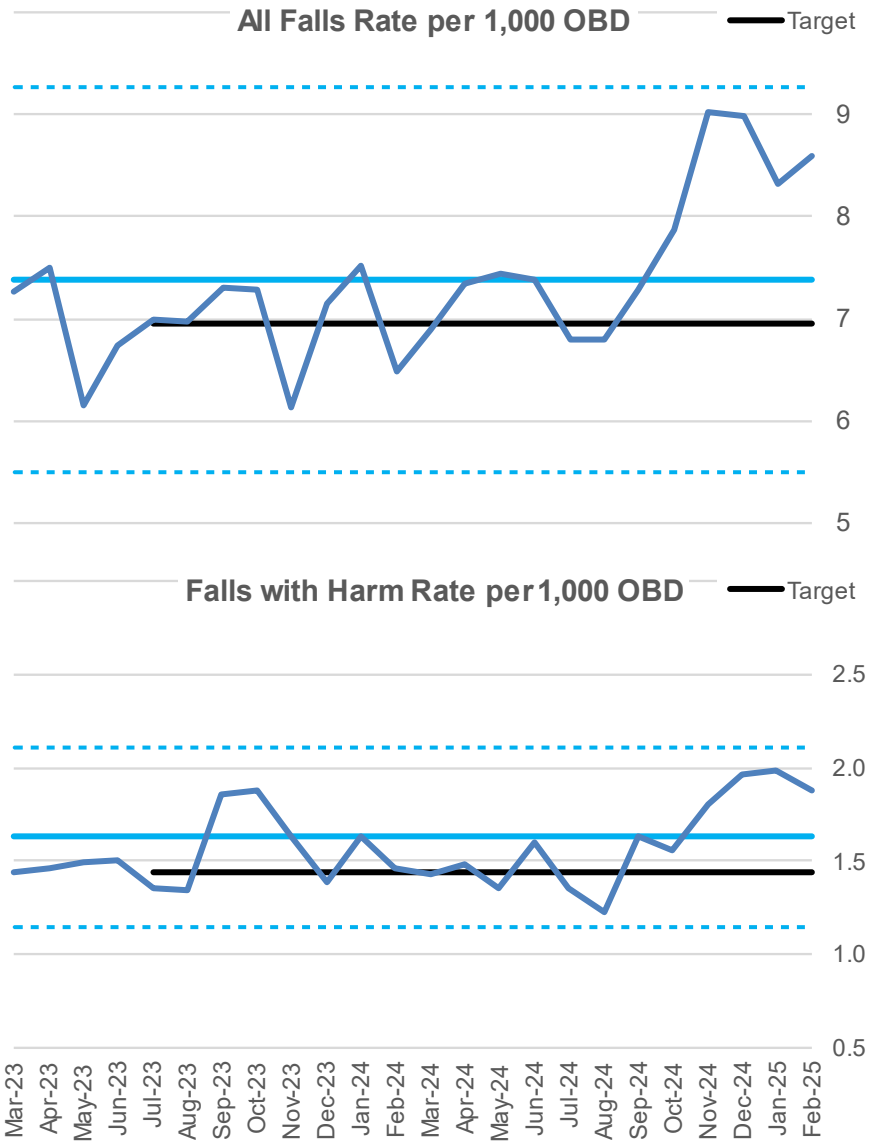
Achievements & Challenges

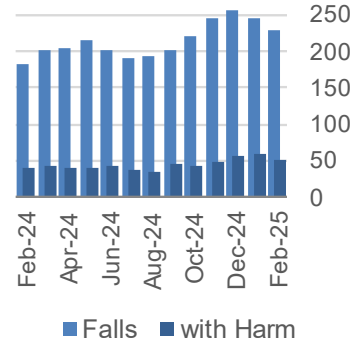
Falls Link Practitioner day was held on 17th March 2025, with 18 attendances from across Acute & HSCP. The event focussed on the risk of falls associated with Dementia & Delirium. There was also a session led by Therapy colleagues focussing on shared competencies and patient assessment all aimed at reducing falls.

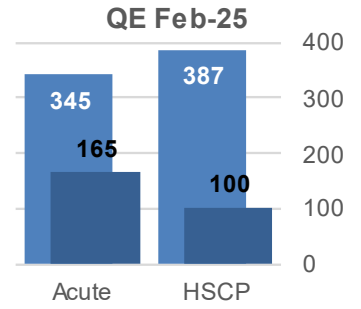
The Acute Falls group have re-introduced monthly falls audits: data and reporting will be supported by Clinical Effectiveness colleagues for improvement and learning.

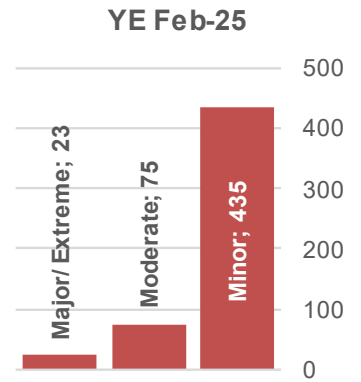
The increase in all falls in Acute has been attributed in part to a change in environment in Ward 43 and a SLWG has been convened to address the ward environment, safe staffing for both the medical and nursing cohorts. In response to an increase in Ward 54, Senior Nurses undertook a QI project looking in detail at location and time of falls again, for learning & improvement.

The new trigger list for Adverse Events including falls has been adopted with a focus on patient outcomes which may account for the reduction in Major/Extreme harm events. This will be monitored through the Safer Mobility & Falls Reduction Oversight Group.









Tissue Viability

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

1.31

12 Incidents to achieve target

C1. Quality & Care

Data Analysis

The total number of Tissue Viability (TV) incidents in Feb-25 was 35, an improvement on the month previous (41). This equates to a rate of 1.31 per 1,000 Occupied Bed Days (OBD). 12 fewer incidents would have resulted in performance for Feb-25 having achieved the target of < 0.89 per OBD.

The number of TV incidents in Acute Services in Feb-25 was 30, 4 fewer than in Jan-25 (rate decreased from 2.32 to 2.30). For YE Feb-25, the average number of TV incidents was 28 (rate 2.06); whilst the average number in YE Feb-24 was 25 (rate 1.89).

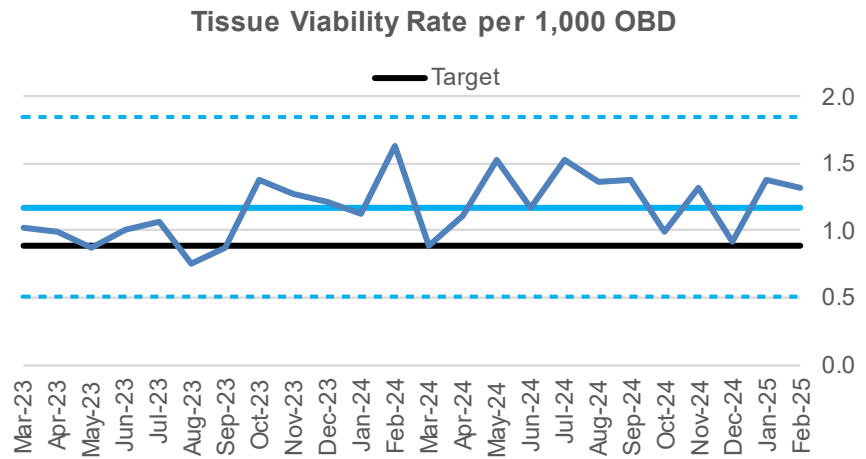
Within HSCP the prevalence of TV incidence was 5 for February, a reduction of 2 since January 2025; 3 of these were grade 2 and the remaining 2 were SDTI. The average number of TV incidents in HSCP for YE Feb-25 was 7 (rate 0.47); the same as the average for YE Feb-24 (rate 0.43).

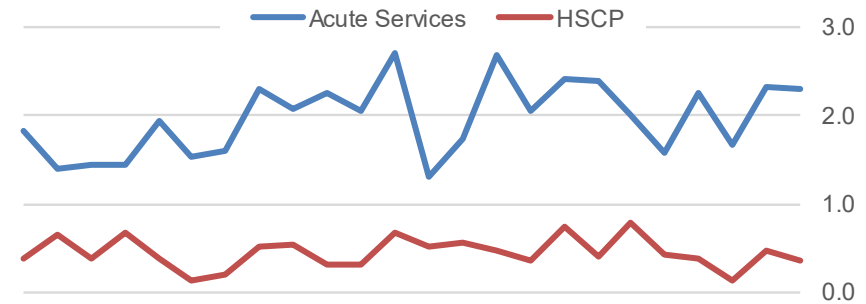
Most incidents of TV continue to be in Acute Services with 88 recorded in QE Feb-25; there were 14 recorded in HSCP in the same period. Of all TV incidents recorded in QE Feb-25, Grade 2 accounted for 42% of the total; with Grades 3 & 4 accounting for 8%.

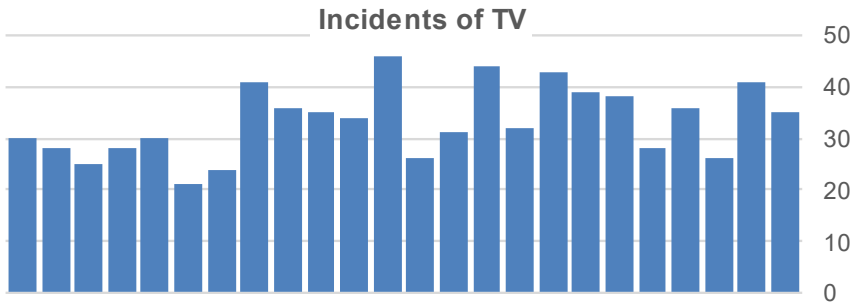
Achievements & Challenges

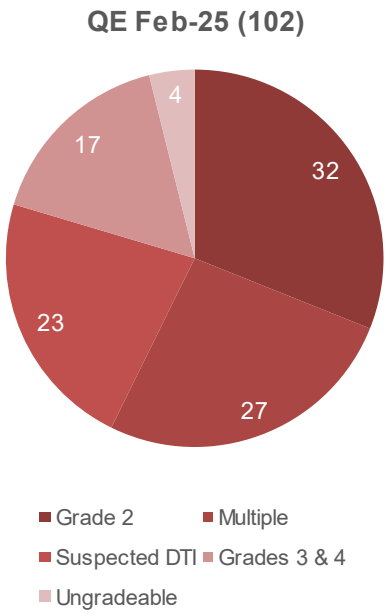
Average year-end rates in 2025 so far, have been higher than equivalent year-end rates in 2024. To address these issues, each directorate in Acute Services is implementing a 10-point improvement plan, which includes audit and learning feedback. Investment in skin care education programmes, funded by the Acute TVN team, is being rolled out to enhance practitioner knowledge and improve skills. These initiatives are designed to reduce TV incidents by improving clinical practice across the board.. The focus on education and structured improvement plans aims to drive further reductions in TV incidents.

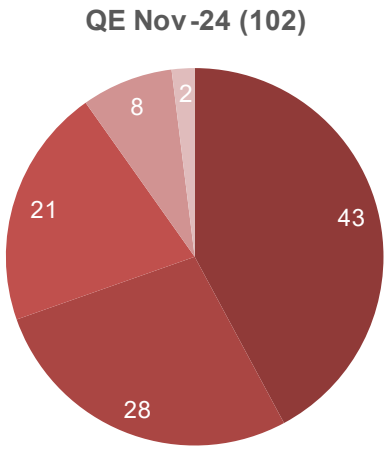
Within the HSCP we continue to focus on education delivery and our link nurses. We have noted a reduction in incidence of TV in areas where targeted training has occurred. We continue to work collaboratively with our acute colleagues and our Tissue Viability Improvement group now has mental health representation.











Mental Health Quality Indicators

Reduce **Ligature** Incidents (rate per 1,000 Occupied Bed Days) - 10% reduction by Mar-25	2.76	11	incidents to achieve target
Reduce incidents of **Self Harm** (rate per 1,000 Occupied Bed Days) - 10% reduction by Mar-25	3.74	16	incidents to achieve target
Reduce Incidents of **Restraint** (rate per 1,000 Occupied Bed Days) - 20% reduction by Mar-25	15.17	45	incidents to achieve target
Reduce Incidents of **Physical Violence** (rate per 1,000 Occupied Bed Days) – 20% reduction by Mar-25	10.61	36	incidents to achieve target

Data Analysis

There were 298 incidents reported in relation to Mental Health wards in Feb-25, a decrease from 309 previous month and remains above 24-month average of 260 per month. There were 14 Ligature incidents reported in Feb-25, with rate above 24-month average. The number of incidents of self-harm was 19 in Jan-25 an increase from previous month, rate above 24-month.

Rate of Restraint has increased to 15.17 per 1,000 Occupied Bed Days in Feb-25 (9.95 previous month), above 24-month. 62 incidents of Physical Violence were reported in Feb-25, with an increase from month prior, equating to a rate of 9.61 per 1,000 Occupied Bed Days above the 24-month average.

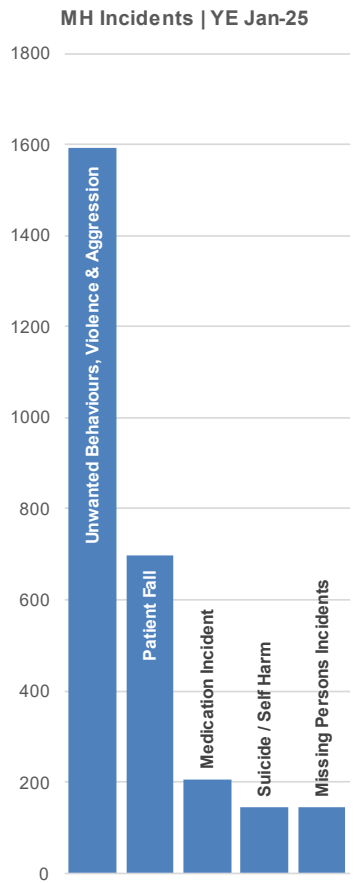
Achievements & Challenges

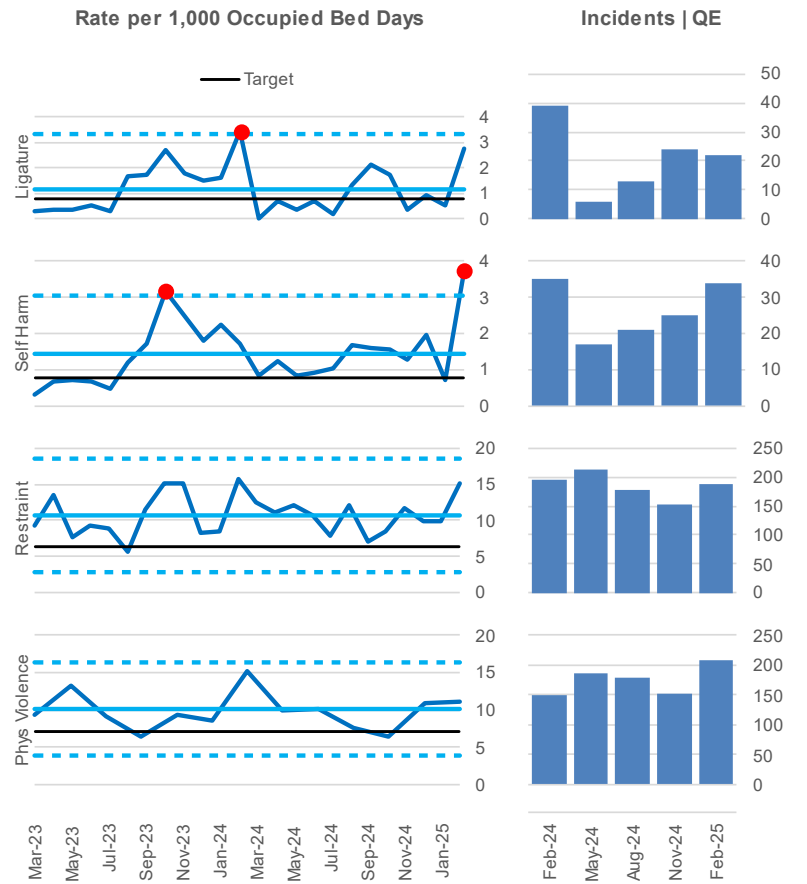
Ligature: The Ward 3 QMH project is ongoing and remains on target. The development and decant of wards continue to provide an improved anti-ligature environment. The design of the ward is being developed with clinical input and reported to the ligature board. While this work is ongoing, all staff within inpatient areas remain vigilant for any ligature concerns, managing individual patients based on need and risk assessments.

The ligature operational group is actively meeting and reviewing ligature assessments, providing assurance to the ligature project board. The group is up to date with all Health & Safety Environmental Ligature Risk Assessments and mitigation plans, with appropriate escalations to the ligature board. The Ligature policy for NHS Fife and Fife HSCP has been completed and approved at the Fife Policy and Procedure group.

Self-Harm Incidents: Incidents of self-harm have risen recently: a group is being stood up to implement actions to support work/QI work to reduce self-harm with all key contributors. Data continues to be monitored real time and via HSCP assurance processes. The risk of self-harm continues to be managed with all staff being vigilant and aware of individual needs, risk, care planning and appropriate interventions.

Restraint, Violence and Aggression: The Reducing Restrictive Practice Group (RRPG) is being stepped down and reviewed, with the view to include wider work such as self-harm. The group has moved to a new focus around seclusion, the Scottish Patient Safety Programme, and observation and intervention. Subgroups for each of these areas have been developed and are looking to identify key strategies to progress these workstreams.





Healthcare Associated Infections

CDI: Achieve and maintain rate of 6.5 per 100,000 Total Occupied Bed Days	**21.7**	**5** ↓ infection to achieve target
ECB: Achieve and maintain rate of 33.0 per 100,000 Total Occupied Bed Days	**65.0**	**9** ↓ infection to achieve target
SAB: Achieve and maintain rate of 18.8 per 100,000 Total Occupied Bed Days	**21.7**	**1** ↓ infection to achieve target

C1. Quality & Care

The **CDI HAI/HCAI** rate increased to 21.7 in Feb-25. The cumulative total of HCAI infections over the past 12 months (41) is significantly higher compared to the same period the previous year (28). Furthermore, the number of recurring infections has risen.

Quarterly comparison shows a decrease from 19 cases in QE Nov-24 to 14 in QE Feb-25.

The YE-Feb-25 highlighted a 55% increase in total cases compared to previous year.

The rise in cases over the past 12 months reflects national trends. Comprehensive reviews of cases have identified key risk factors: antibiotic usage within preceding 12 weeks (70% of cases) and PPI usage (51% of cases). Notably, 38% of patients had been exposed to both antibiotics and PPIs. This suggests a potential compounded risk in such cases. Two CDI triggers are currently under investigation by the IPC Team to determine root causes and possible links between cases. Moving forward, ongoing targeted interventions focusing on antibiotic stewardship and PPI prescribing practices are recommended to mitigate these risks.

The **ECB HAI/HCAI** rate rose to 65.0 in Feb-25, with healthcare-associated infections increasing from 4 in Jan-25 to 18 in Feb-25. The cumulative 12-month total (136) exceeded the figure for the same period the previous year (127).

Quarterly comparison shows a reduction form 76 cases in QE Nov-24 to 55 in QE Feb-25.

The YE Feb-25 revealed a 7% overall increase in ECB cases compared to previous year.

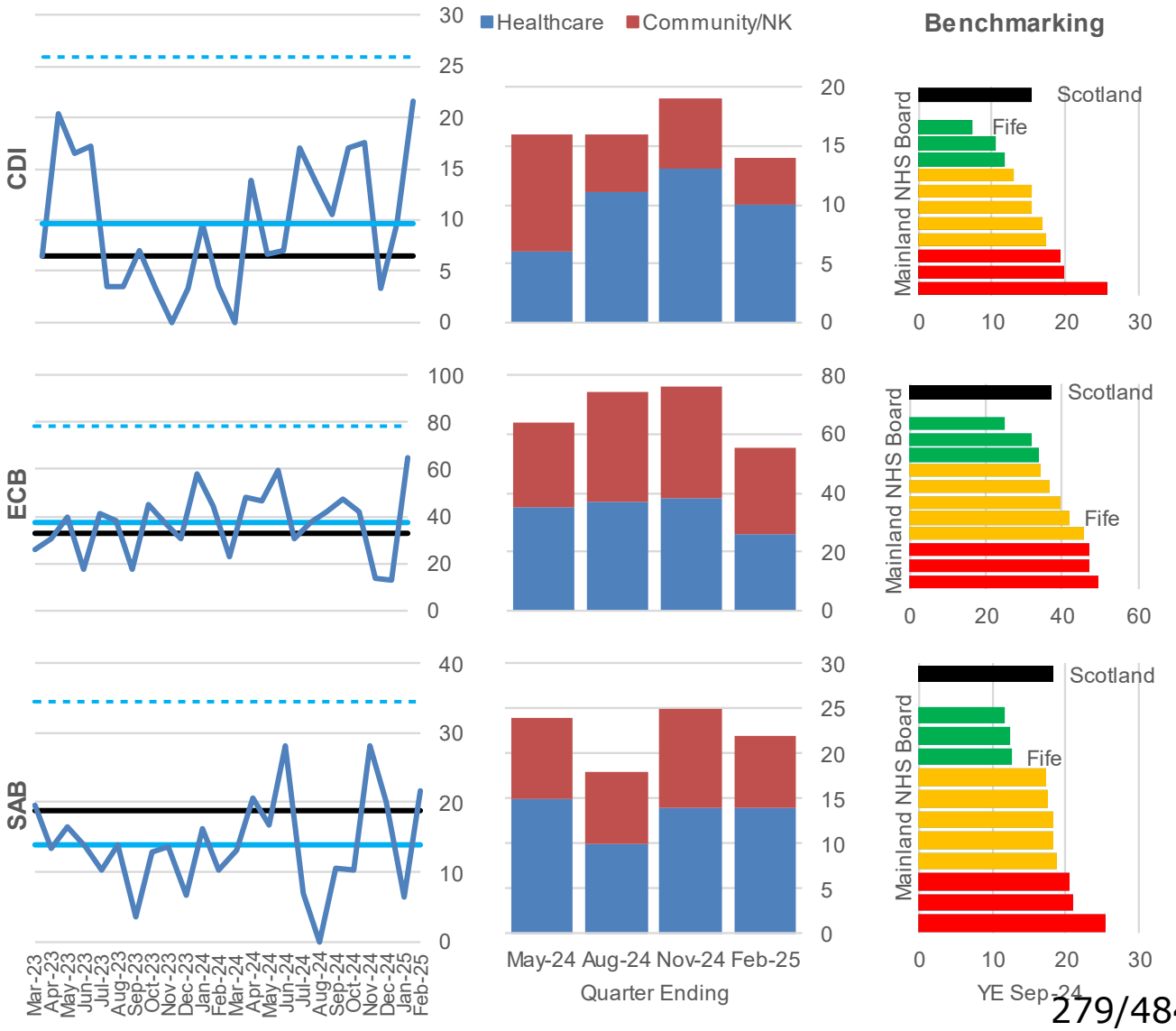
Fife observed a rise in total ECB infections over the last 12 months. The most frequent infection sources are renal tract (40%) and hepatobiliary-related (25%), which align with previous trends (YE Feb-24: 39% and 20% respectively). The majority of infections are community in origin. However, there has been a reduction in CAUTI-related infections (YE Feb-25: 18, compared to YE Feb-24: 31). This development may be linked to actionable insights from monthly CCR meetings & improvement initiatives led by UCIG group. Continued focus on these interventions is critical to sustaining reductions.

The **SAB HAI/HCAI** rate in Feb-25 was 21.7. Of the 53 HCAI cases reported in the last 12 months, the breakdown included 16 categorised as “Vascular Access Devices (VAD)” associated and 5 each under “Other/Not Known” and “Device Other Than VAD” associated. The cumulative 12-month total of HCAI cases (53) exceeded the previous year (45).

Quarterly comparisons showed a decrease from 25 cases in QE Nov-24 to 22 in QE Feb-25.

The YE Feb-25 noted a 4% decrease in overall SAB cases compared to the prior year.

Despite a 4% reduction in total cases, the number of HCAI cases increased. Specifically, VAD associated infections. PVC-related cases rose from 2 (YE Feb-24) to 8 (YE Feb-25), each case is Datix`d and a CCR undertaken to identify learning opportunities. CVC/PICC line related cases have also risen in the past year (from 0 cases YE Feb-24 to 3 cases YE Feb-25). However, encouragingly the number of tunnelled dialysis line related cases have halved in number during this time period (YE Feb-24 6 cases, to YE Feb-25, 3). Strengthening compliance with VAD insertion and maintenance protocols, combined with training initiatives, will be vital to reversing these trends.



Complaints

At least 80% of Stage 1 complaints will be completed within 5 working days by March 2025

61.9%

3 closed on time to achieve target

At least 60% of Stage 2 complaints will be completed within 20 working days by March 2025

13.8%

5 closed on time to achieve target

Data Analysis

There were 29 Stage 1 complaints received in Mar-25, with 21 closed. Of those closed 14 (66.7%) were within timescales. 61.9% of 21 complaints that were due in the month, were closed on time.

There were 33 Stage 2 complaints received in Mar-25, 33 acknowledged within timescales, with 29 closed. 21.2% of 33 complaints that were due in the month, were closed on time. The performance for Stage 2 complaints fell below trajectory.

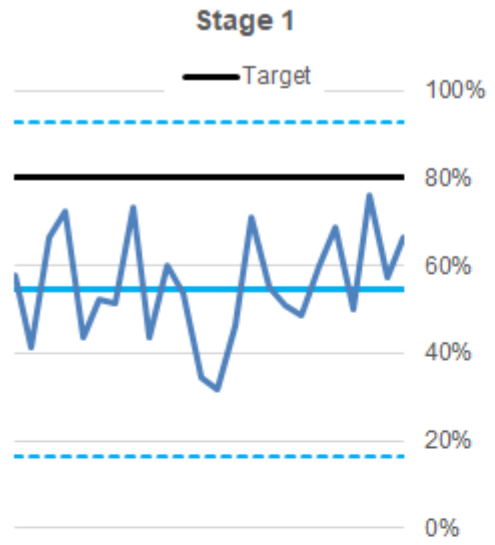
At the end of Mar-25, the average number of days to close a Stage 2 complaint was 58 days, the highest level in the last 12 months however lower than the same month last year.

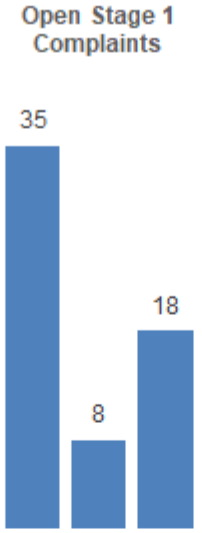
There are currently 3 Stage 2 complaints over 100 days with 17 between 50 and 100 days. Most (32/42.1%) are awaiting action from the Service with 7 (9.2%) with PET ready for draft.

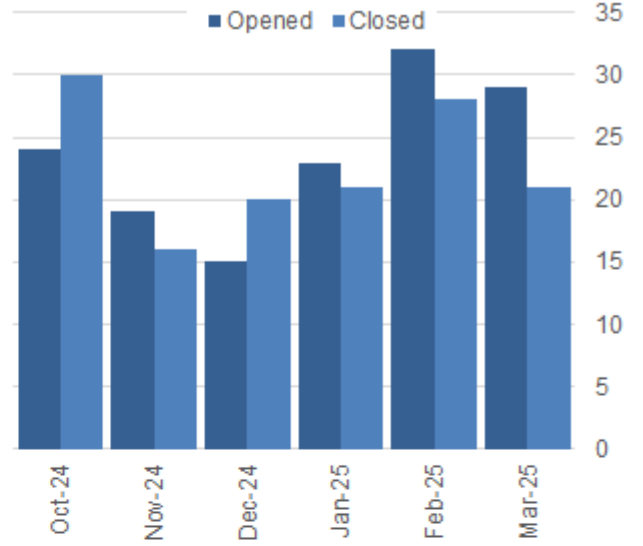
Achievements & Challenges

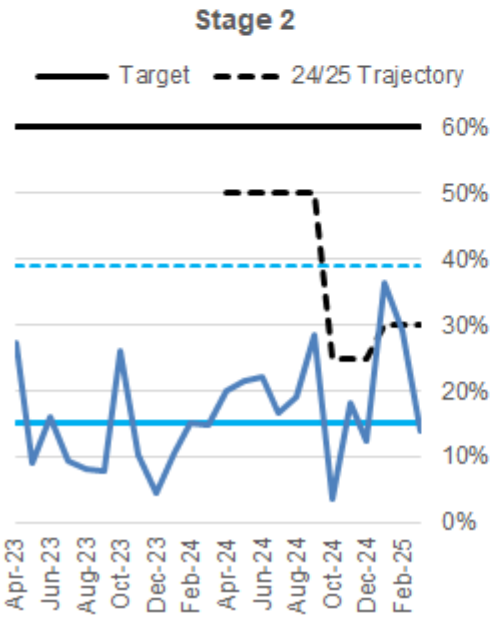
The target for 80% of Stage 1 complaints to be closed in time has not been met for the 5th month; this is due to various factors including staff absence, capacity and service pressures. However, there has been a noted improvement in Stage 1 complaint compliance and an increase in verbal resolution in recent months. Additionally, the introduction of standard letter templates for common complaint themes, e.g. car parking / wait times / immunisation clinic locations, has improved both the quality and speed of responses.

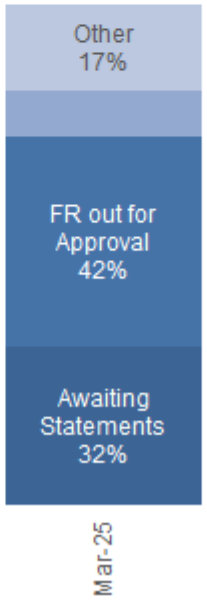
The target for 60% for Stage 2 complaints to be closed in time has not been met; this is due to various factors including staff absence, capacity and service pressures. However, there has been significant progress in the reduction of Stage 2 complaints over 100 days (currently 3), with prioritisation of Stage 2 drafting to prevent delays in the progression; all cases over 80 days are subsequently with the clinical services for approval. Additionally, we are working closely with Community Care Services to streamline their complaint handling process, as well as carrying out a review of our own internal admin processes to remove waste and improve workflow and response times.

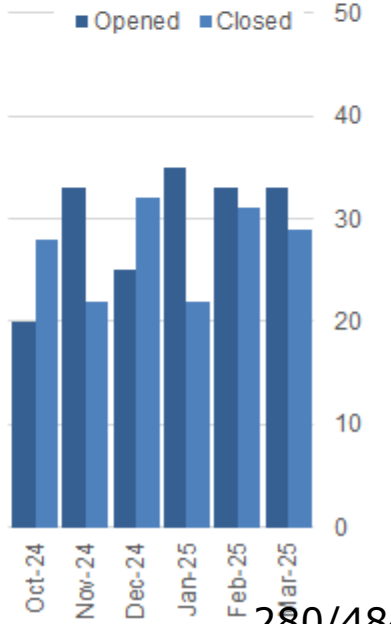












NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**2 May 2025**
Title:	**Healthcare Associated Infection Report**
Responsible Executive:	**Janette Keenan, Director of Nursing, HAI Executive Lead**
Report Author:	**Julia Cook, Infection Control Manager**

Executive Summary:

Staphylococcus aureus Bacteraemia (SABs):

- During Q3 2025 (July - September), NHS Fife was below the national rate for healthcare associated infections (HCAI)
- The total number of HCAI SABs for year ending Feb 2025 has risen from previous year
- Vascular access devices (VAD) remain the greatest challenge for hospital acquired SABs

Clostridioides difficile infections (CDIs):

- During Q3 2024 (July - September), NHS Fife was below national rate for HCAI and community acquired infections (CAI)
- The total number of CDI cases for year ending Feb 2025 has risen from the same time period the previous year
- There are currently 2 CDI triggers under investigation

Escherichia coli Bacteraemias (ECBs):

- During Q3 2024 (July - September), NHS Fife was below the national rate for HCAI
- Healthcare associated ECBs remain a challenge, with higher infection rates for year ending Feb 2025, than the previous year
- A lower rate of CAUTI associated ECBs recorded for year ending Feb 2025, than the previous year

MRSA and CPE Clinical Risk Assessments (CRA) Screening

- Following a noted reduction in compliance with both MRSA and CPE CRA screening in Quarter 3 (July- September 2024), targeted support has seen a noted improvement for Quarter 4 2024

Hospital Inspection

- Healthcare Improvement Scotland (HIS): NHS Safe delivery of care inspection - Unannounced follow up inspection to Victoria Hospital, NHS Fife, 03/12/2024 – 05/12/2024
- HIS NHS Safe Delivery of Care Mental Health Inspection - Unannounced Inspection to Queen Margaret Hospital, NHS Fife, 18/02/2024

National Cleaning Services Specification and Estates Monitoring

- Quarter 3 (October - December 2024) shows NHS Fife achieving Green status
- Quarter 3 (October - December 2024) NHS Fife achieving Green status

Outbreaks/Incidents/Data Exceedance NHS Fife reporting period (November and December 2024)

- Norovirus**:** 2 new ward or bay closures due to a Norovirus
- COVID-19: 1 new outbreaks/incidents of COVID-19
- 2 CDI triggers under investigation
- There are 4 ongoing environmental investigations
- Single case of endophthalmitis following IVI investigated

1 Purpose

This report is presented for:

- Assurance

This report relates to:

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

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

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

Update on Infection Prevention and Control for May 2025 Clinical Governance Committee to provide assurance that all IP&C priorities are being and will be delivered. This report is for information for the Committee based on the most recent HAIRT circulated to the Infection Prevention and Control Committee April 2025.

2.2 Background

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

Standards on Reduction of Healthcare Associated Infections:
The publication of **Further Update on Standards on Healthcare Associated Infections DL (2025) 05** in April 2025, sets out the local delivery plan standards for year 2025/2026.
The agreed standard should be no increase in the incidence (number of cases) of *Clostridioides difficile* infection (CDI), *Escherichia coli* bacteraemia (ECB), and *Staphylococcus aureus* bacteraemia (SAB) in the period between April 2025 and March 2026, from the 2023/2024 case numbers baseline.

In accordance with this ARHAI has provided NHS Boards with their 2023/2024 baseline number of healthcare associated CDI, ECB and SAB cases to enable local monitoring. This number reflects the number of cases that should not be exceeded in 2025/26 to meet the new standard.

Table 1. Healthcare associated case numbers of CDI, ECB and SAB, NHS Fife.

	2023/2024 case numbers
CDI	26
ECB	126
SAB	43

2.3 Assessment

SAB

- During Q3 2025 (July - September), NHS Fife was below the national rate for healthcare associated infections (HCAI)
- During Q3 2024 (July - September), NHS Fife was above the national rate for community acquired infection (CAI)
- There were 2 PWID related SABs in January 2025
- The total number of SAB cases year ending Feb 2025 (n=88*) was lower than during year ending Feb 2024 (n=93)
- However, the number of HCAI cases has risen during year ending Feb 2025 (n=52), compared to Feb 2024 (n=45).
- Vascular access devices (VAD) remain the greatest challenge for hospital acquired SABs:
  - The total number of PVC related SABs in 2024 was 8. This is in contrast to just 1 case for 2023. There was a PVC related SAB in January 2025
- There was a PICC line related SAB in February 2025.

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 2024 (July - September), NHS Fife was below national rate for HCAI and community acquired infections (CAI).
- The total number of CDIs year ending Feb 2025 (n=65) was higher than during the same time period the previous year, when there were 42 cases.
- This increase was also reflected in the number of HCAI cases (year ending Feb 25, n=41, Feb 24, n=28).
- There are currently 2 CDI triggers under investigation.

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

ECB

- During Q3 2024 (July - September), NHS Fife was below the national rate for HCAI.
- During Q3 2024 (July - September), NHS Fife was above the national rate for CAI.
- The cumulative total for year-end Feb 2025 (n=269)* was higher than year-end Feb 2024 (n=252)
- This increase is also reflected in the number of HCAI cases
- A reduction in the number of CAUTI related ECBs during the period year ending Feb 2025 (n=18), compared to the previous year, when there were 31 cases

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.

MRSA and CPR CRA Screening

- Following a noted reduction in compliance with both MRSA and CPE CRA screening in Quarter 3 (July- September 2024) below the Scottish national average, a deep dive identified some patient admission screening being undertaken on paper forms rather than the electronic Patientrak record used by both IPC Team and Excellence in Care, CAIR dashboard. Targeted support and collaboration between IPCT and clinical teams has seen a noted improvement in screening compliance rates for Quarter 4 2024.

Outbreaks (January – February 2025)

Norovirus

- There have been 2 new ward or bay closures due to a Norovirus outbreak during this time period.

Seasonal Influenza

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

COVID-19

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

Incidents/Data exceedance

- There are 4 ongoing environmental investigations.
- Single case of endophthalmitis following IVI investigated.

Hospital Inspection Team

There has been 1 new inspections during this reporting period (January – February 2025).
HIS NHS Safe Delivery of Care Mental Health Inspection 18/02/2024 Unannounced Inspection to Queen Margaret Hospital, NHS Fife

- Report expected to be published May 2025.

Healthcare Improvement Scotland (HIS): NHS Safe delivery of care inspection - Unannounced follow up inspection to Victoria Hospital, NHS Fife, 03/12/2024 – 05/12/2024.

- 9 areas of good practice
- 1 recommendation
- 5 previous requirements carried over
- 12 new requirements

Please note these are not all IPC related

Hand Hygiene

- ASD have introduced electronic recording system for reporting HH compliance from clinical areas and reported via the PAN IPC Group. Some areas continue to utilise LanQIP. Aim for one reporting system for all of NHS Fife, InPhase currently being explored.

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 2024) was **96.1%**.

National Cleaning Services Specification

The National Cleaning Services Specification – quarterly compliance report result for Quarter 3 (October - December 2024) shows NHS Fife achieving **Green** status.

Estates Monitoring

The National Cleaning Services Specification – quarterly compliance report result for shows Quarter 3 (October - December 2024) NHS Fife achieving **Green** status.

This report provides the following Level of Assurance:

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

2.3.1 Quality, Patient and Value-Based Health & Care

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

2.3.2 Workforce

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

2.3.3 Financial

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

2.3.4 Risk Assessment / Management

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

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

This report does not relate to the planning and development of specific health services, nor does it include any decisions that would significantly affect particular groups of people. As such, a full Equality Impact Assessment (EQIA) is not required for this paper. However, NHS Fife remains committed to ensuring that all Infection Prevention and Control policies and procedures are inclusive and equitable. Routine monitoring and review processes include the requirement for at least a Stage 1 EQIA to be completed for each relevant policy or guideline to assess potential impacts on equality and human rights. This approach will help ensure that infection prevention measures do not inadvertently create or exacerbate inequalities in access, experience, or outcomes of care.

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

This paper has been considered by the Infection Control Manager and Executive Director of Nursing based on the HAIRT that was presented to the Infection Control Committee

2.3.8 Route to the Meeting

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

This is a summary of the HAIRT submitted to the Infection Prevention and Control Committee 2 April 2025

2.4 Recommendation

This paper is provided to members for:

- **Assurance** – This report provides a "Moderate" Level of Assurance

3 List of appendices

The following appendices are included with this report:

- Appendix No. 1, 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 Prevention & Control Committee on 2nd April 2025

(Validated Data up to end of February 2025)

April 2025

Published Month Year

www.nhsfife.org

Contents

Board Wide Issues

Key Healthcare Associated Infection Headlines

1.1 Achievements:

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

During Q3 2025 (July-Sep), NHS Fife was below the national rate for healthcare associated infections (HCAI)

The total number of SAB cases YE Feb 25 (n=88*) was lower than during YE Feb 24 (n=93).

There was a lower number of dialysis line related SABs YE Feb 25 (n=5) than YE Feb 24, when there were 6 cases. At the time of reporting (01/03/2025), 95 days had been achieved since the last dialysis line related SAB. Each case undergoes a Complex Care Review (CCR) to ascertain any learning. IPCT continues to support the renal team.

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

During Q3 2024 (July-Sep), NHS Fife was below national rate for HCAI and community acquired infections (CAI).

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

During Q3 2024 (July-Sep), NHS Fife was below the national rate for HCAI.

There has been a reduction in the number of CAUTI related ECBs during the period YE Feb 25 (n=18), compared to the previous year, when there were 31 cases.

1.2 Challenges:

SABs

During Q3 2024 (July-Sep), NHS Fife was above the national rate for CAI

The number of HCAI cases has risen during YE Feb 25 (n=52), compared to YE Feb 24 (n=45).

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

- The total number of PVC related SABs in 2024 was 8. This is in contrast to just 1 case for the whole of 2023 and 2 for 2022. Unfortunately, there was a PVC related SAB in January 2025
- There was a PICC line related SAB in February 2025. Prior to this case, 260 days has been achieved since last infection.

There were 2 PWID related SABs in January 2025.

CDI

The total number of CDIs YE Feb 25 (n=65) was higher than during the same time period the previous year, when there were 42 cases. This increase was also reflected in the number of HCAI cases (YE Feb 25, n=41 v Jan-Feb 24, n=28).

There are currently 2 CDI triggers under investigation.

ECBs

During Q3 2024 (July-Sep), NHS Fife was above the national rate for CAI.

The cumulative total for YE Feb 25 (n=269)* was higher than YE Feb 24 (n=252). This increase is also reflected in the number of HCAI cases YE Feb 25 (n=136) compared to YE Feb 24 (n=127).

*Please note that ARHAI, National Services Scotland, now notify boards, retrospectively, of CAI cases reassigned to Fife (Cases detected in another board but reassigned to Fife due to person being a Fife resident), therefore numbers may be subject to slight change.

HCAI targets for 2024/25

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

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

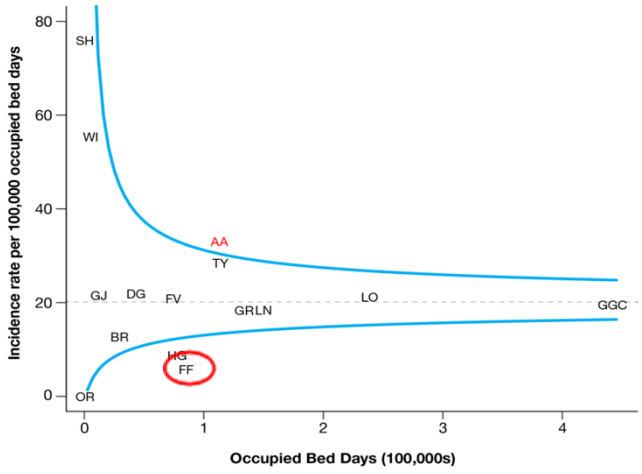
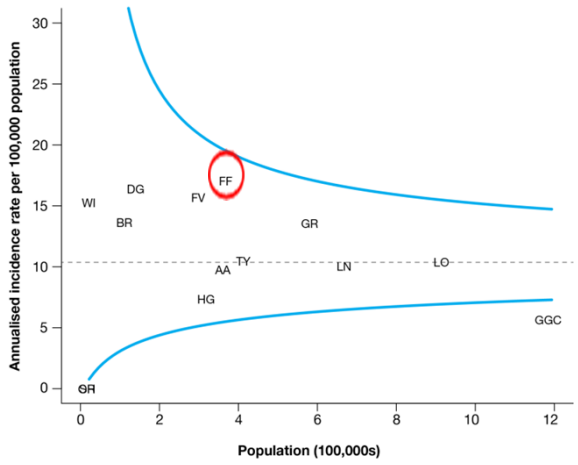
National surveillance programme for SSI has been paused due to the COVID-19 pandemic. DL (2023) 06 published February 2023 advises surgical site infection (SSI) remains paused for the time being.

Surveillance

2. Staphylococcus aureus incorporating MRSA/CPE screening compliance

2.1 Trends – Quarterly

Staphylococcus aureus Bacteraemias (SABs)				
Local Data: Q4 2024 (Oct-Dec) **(Q3 2024 National comparison awaited)**				
In Q4 2024 NHS Fife had:	23 SABs	17 HCAI/HAI 6 CAI	This is **UP** from:	18 Cases in Q3 2024

Q3 2024 (Jul-Sep) - ARHAI Validated data with commentary			
Healthcare associated SABs		**Community associated SABs infection**	
HCAI SAB rate: **5.7**	Per 100,000 bed days	CAI SABs rate: **17.1**	Per 100,000 Pop
No of HCAI SABs: 5		No of CAI SABs: 16	
This is **BELOW** National rate of 20.2		This is **ABOVE** National rate of 10.4	
			
NHS Fife was not an outlier for SABs in Q3 2024.			

New standards for reducing all Healthcare Associated SAB by 10% by 2024 (from 2018/2019 baseline). This standard will be locally extended for a further year to 2025		
Standards application for Fife:	**SAB Rate Baseline 2018/2019**	**SAB 10% reduction target by 2025**
SAB by rate 100,000 Total bed days	**20.9** per 100,000 TBDs	**18.8** 100,000 TBDs
SAB by Number of HCAI cases	**76**	**68**
Current 12 Monthly HCAI SAB rates for Year ending September 2024 (ARHAI)		
SAB by rate 100,000 Total bed days	**12.6** per 100,000 TBDs	
SAB by Number of HCAI cases	**45**	

Local Device related SAB surveillance

- Localised enhanced surveillance focuses on high-risk clinical areas and vascular line SABs.
- PVC & CVC related SABs will continue to be Datix'd by Dr Morris and undergo a SAER.
- There were 5 dialysis line (tunnelled) related SABs during 2024. The cases undergo a Complex Care Review, to ascertain learning

As of **01/03/2025** the number of days since the last confirmed SAB is as follows:	
CVC SABs	18 Days
PWID (IVDU)	30 Days
Renal Services Dialysis Line SABs	95 Days
Acute services PVC (Peripheral venous cannula) SABs	49 Days

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

2.2 Current SAB Initiatives

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

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

2.3 National MRSA & CPE screening programme

MRSA

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

NHS Fife achieved **93%** compliance with the **MRSA** CRA in Q4 2024 (Oct-Dec)

This was **ABOVE** Q3 2024 (78%), and **ABOVE** the compliance target of 90%.

This was **ABOVE** the national rate for Q4 2024

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

Quarter	Q3 2022 Jul-Sep	Q4 2022 Oct-Dec	Q1 2023 Jan-Mar	Q2 2023 Apr- Jun	Q3 2023 Jul-Sep	Q4 2023 Oct-Dec	Q1 2024 Jan-Mar	Q2 2024 Apr-Jun	Q3 2024 Jul-Sep	Q4 2024 Oct-Dec
Fife	98%	100%	100%	98%	93%	100%	95%	90%	78%	93%
Scotland	78%	74%	78%	81%	80%	74%	79%	80.5%	80.7%	81.4%

CPE (Carbapenemase Producing Enterobacteriaceae)

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

NHS Fife achieved **90%** compliance with the **CPE** CRA for Q4 2024 (Oct-Dec)

This was **ABOVE** the rate in Q3 2024 (73%)

This was **ABOVE** the national rate for Q4 2024

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

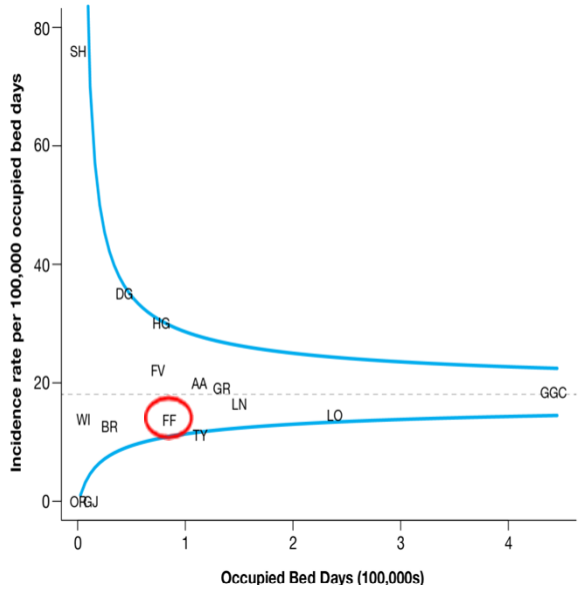
Quarter	Q3 2022 Jul-Sep	Q4 2022 Oct-Dec	Q1 2023 Jan-Mar	Q2 2023 Apr-Jun	Q3 2023 Jul-Sep	Q4 2023 Oct-Dec	Q1 2024 Jan-Mar	Q2 2024 Apr-Jun	Q3 2024 Jul-Sep	Q4 2024 Oct-Dec
Fife	100%	100%	100%	100%	100%	100%	98%	80%	73%	90%
Scotland	78%	76%	77%	80%	81%	76%	78%	81.3%	82%	83.3%

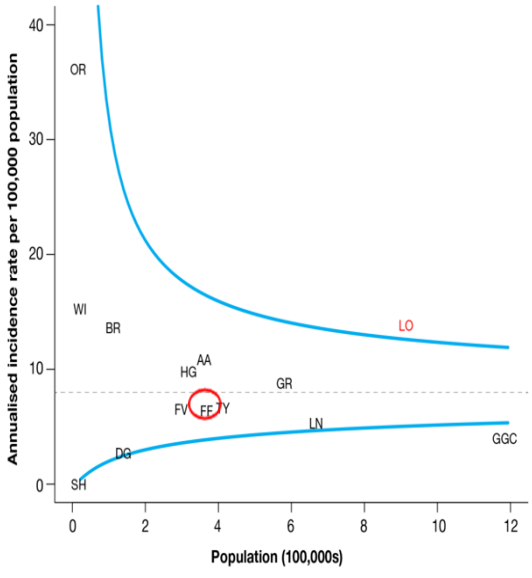
3. Clostridioides difficile Infection (CDI)

3.1 Trends

Clostridioides difficile Infection (CDI)				
Local Data: Q4 Oct-Dec 2024 **(Q4 2024 HPS National comparison awaited)**				
In Q4 2024 NHS Fife had:	15 CDIs	12 HCAI/HAI/Unknown 3 CAI	This is **DOWN** from	18 Cases in Q3 2024
Q3 (Jul-Sep) 2024 ARHAI validated data with commentary				
With ARHAI Quarterly epidemiological data Commentary *Please note for ARHAI reporting- the CDI denominator may vary from locally reported denominators. This is due to some Fife resident Community onset CDIs allocated back to NHS Fife, even though they were treated at other Health boards.				

Healthcare associated CDIs		Community associated CDIs infection	
HCAI CDI rate: **13.8**	Per 100,000 bed days	CAI CDIs rate: **6.4**	Per 100,000 Pop
No of HCAI CDIs: 12		No of CAI CDIs: 6	
This is **BELOW** National rate of 18.0		This is **BELOW** National rate of 8.0	





NHS Fife was not an outlier for CDIs in Q3 2024.

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

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** 12	Low Risk 6

3.3 Current CDI initiatives

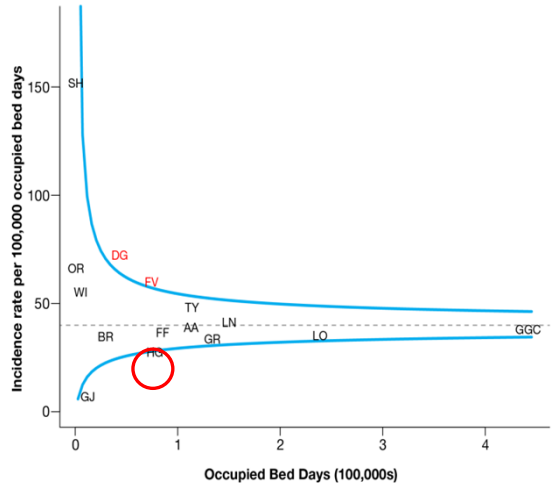
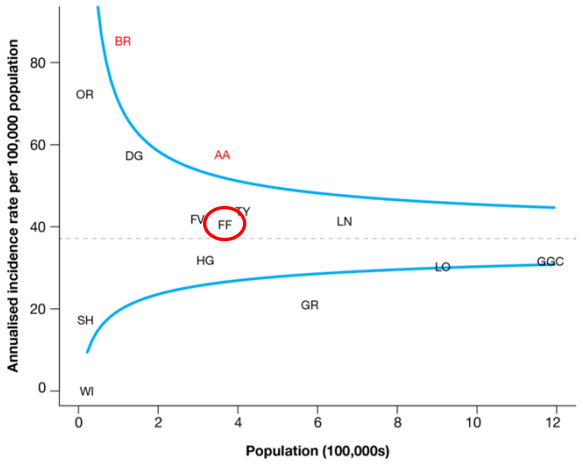
Follow up of all hospital and community cases continues to establish risk factors for CDI

- 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

4.0 Escherichia coli Bacteraemias (ECB)

4.1 Trends:

Escherichia coli Bacteraemias (ECB)				
Local Data: Q4 (Oct-Dec) 2024 **(Q4 2024) ARHAI National comparison awaited)**				
In Q4 2024 NHS Fife had:	61 ECBs	30 HAI/HCAIs 31 CAIs	This is **DOWN** from	71 Cases in Q3 2024
Q4 2024 There were **3** Urinary catheter associated ECBs, which was higher than during Q3 2024, when there were 2 CAUTIs.				

Q3 (Jul-Sep) 2024			
ARHA Validated data ECBs with HPS commentary *Please note for ARHAI reporting- the ECB denominator may vary from locally reported denominators. Due to some Fife resident Community onset ECB allocated back to NHS Fife, even though they were treated at other Health boards.			
Healthcare associated ECBs		Community associated ECBs infection	
HCAI ECB rate: **36.7**	Per 100,000 bed days	CAI ECBs rate: **40.5**	Per 100,000 Pop
No of HCAI ECBs: 32		No of CAI ECBs: 38	
This is **BELOW** National rate of 39.9		This is **ABOVE** National rate of 37.1	
			
For HCAI & CAI ECBs: NHS Fife was **WITHIN** the 95% confidence interval in the funnel plot analysis			

New standards for reducing all Healthcare Associated ECBs by 25% by 2024 (from 2018/2019 baseline). This standard will be extended locally for a further year to 2025		
New standards for reducing all Healthcare Associated ECB by 25% by 2025 (from 2018/2019 baseline).		
Standards application for Fife:	**ECB Rate Baseline 2018/2019**	**ECB** **25% reduction target by 2025**
ECB by rate 100,000 Total bed days	**44.0** per 100,000 TBDs	**33.0** per 100,000 TBDs
ECB by Number of HCAI cases	**160**	**120**
Current 12 Monthly HCAI ECB rates for Year ending September 2024 (HPS)		
ECB by rate 100,000 Total bed days	**41.8** per 100,000 TBDs	
ECB by Number of HCAI cases	**149**	

Hospital Acquired Infections (HAI) (Acute & HSCP Hospitals) CATHETER Device related *E.coli* Bacteraemia Count of Device- Catheter over Total Fife **HAI** ECBs			
	NHS Scotland	**NHS Fife**	Rate calculation
2024 Q4	N/K	***8.3%**	
2024 Q3	19.1%	**11.1 %**	
2024 Q2	21.1 %	**10.5 %**	
2024 Q1	19.5 %	**6.3 %**	
2023 Q4	21.2 %	**35.7 %**	
2023 Q3	18.5 %	**27.3 %**	
2023 Q2	18.1 %	**12.5 %**	
2023 Q1	18.9 %	**22.2 %**	
2022 TOTAL	17.0 %	**21.4 %**	
2021 TOTAL	16.0 %	**15.4 %**	
2020 TOTAL	16.4 %	**27.5 %**	* Locally calculated data- TBC by ARHAI when Q4 2024 data published on Discovery
2019 TOTAL	16.1 %	**24.5 %**	
Data from NSS Discovery ARHAI Indicators			
Healthcare Associated Infections (HCAI) CATHETER Device related *E. coli* Bacteraemia Count of Device- Catheter over Total Fife **HCAI** ECBs			

	NHS Scotland	**NHS Fife**	Rate calculation
2024 Q4	N/K	***11.1%**	
2024 Q3	23.6%	**4.3 %**	
2024 Q2	20.9 %	**23.1 %**	
2024 Q1	21.5 %	**18.2 %**	
2023 Q4	27.1 %	**30.0 %**	
2023 Q3	21.3 %	**35.3 %**	
2023 Q2	22.6 %	**22.2 %**	
2023 Q1	26.5 %	**12.5 %**	
2022 TOTAL	22.7 %	**30.9 %**	*Locally calculated data- TBC by ARHAI when Q4 2024 data published on Discovery
2021 TOTAL	27.0 %	**36.0 %**	
2020 TOTAL	24.1 %	**23.0 %**	
2019 TOTAL	22.8 %	**28.0 %**	
Data from NSS Discovery ARHAI Indicators			

4.2 Current Risk Register Rating

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

4.3 Current ECB Initiatives

The Urinary Catheter Improvement Group (UCIG) work was commissioned in 2018 to address the issues associated with ECB CAUTI incidence and reduce the CAUI incidence. This group developed from a previous Traumatic Catheter group in 2017 which aimed to reduce the incidence of Catheters associated with trauma. The IPCT continue to attend and contribute towards the UCIG last held on **11th March 2025.** This group aims to minimise urinary catheters to prevent catheter associated healthcare infections and trauma associated with urinary catheter insertion/maintenance/removal and self-removal, furthermore, to establish catheter improvement work in Fife.

Monthly ECB reports and graphs are distributed within HSCP and Acute services to update on the incidence of ECBs, ECB -CAUTIS (Urinary Catheters & Supra-pubic catheters) & associated trauma. During Jan-Feb 25, there were 5 CAUTI ECBs, of which three cases were associated with trauma.

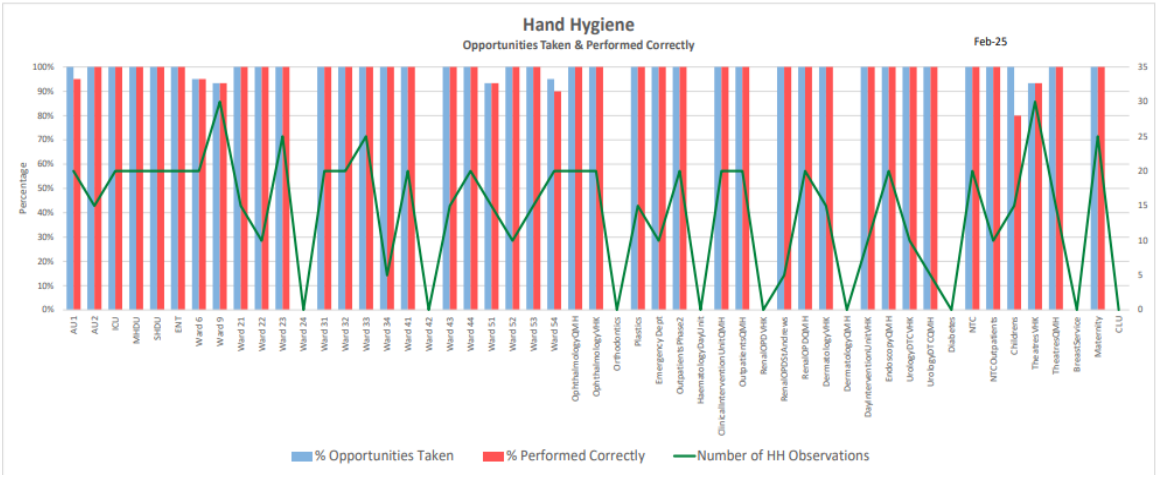
Infection control surveillance alert the patients care team Manager by Datix when an ECB is a urinary catheter associated infection, to then undergo a CCR, to provide further learning from all ECB CAUTIs.

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

The eCatheter bundle group met on 12th March 2025 to finalise the pathways for the catheter insertion & maintenance systems for both the acute & HSCP. IPC continue to work with D&I to fully integrate these updated bundles onto Patientrack.

5. Hand Hygiene

- Good hand hygiene by staff, patients and visitors is a key way to prevent the spread of infections and to minimise risk.
- NHS Boards should monitor hand hygiene (HH) and ensure a zero-tolerance approach to non-compliance, to provide assurance of optimum practice.
- A minimum of 20 observations are required to be audited, per month, per ward/unit.
- Reporting of Hand Hygiene performance was based on data submitted by each ward via LanQIP, which displayed the results on its dashboard.
- ASD have introduced electronic recording system for reporting HH compliance from clinical areas and reported via the PAN IPC Group. Some areas continue to utilise LanQIP. Aim for one reporting system for all of NHS Fife, InPhase currently being explored.



5.1 Trends

- Unable to report

6. Cleaning and the Healthcare Environment

- Keeping the healthcare environment clean is essential to prevent the spread of infections.
- NHS Boards monitor the cleanliness of hospitals and there is a national target to maintain compliance with standards above 90%.
- The Overall Cleaning Compliance for NHS Fife for Quarter 3 (Oct-Dec 24) was **96.1%**.
- 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 24	Q2 Jul-Sep 24
Fife	96.1%↑	95.8%
Scotland	95.3%	95.3%

- The National Cleaning Services Specification – quarterly compliance report results for Quarter 3 (Oct-Dec) 24 shows NHS Fife achieving **GREEN** status.

- **Estates Monitoring**

Estates Location	Q3 Oct-Dec 24	Q2 Jul-Sep 24
Fife	96.6%↓	96.8%
Scotland	96.2%	96.3%

- The Estates Monitoring – quarterly compliance report results for Quarter 3 (Oct-Dec) 24 shows NHS Fife achieving **GREEN** status.

6.2 Current Initiatives

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

7.1 Outbreaks

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

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

A summary of all outbreaks since the last report will be within Section 5.1 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.

January – end of February 2025

Norovirus

There have been 2 ward/bay closure due to GI outbreak.

Seasonal Influenza

There have been no new outbreaks due to confirmed Influenza since the last reporting period.

COVID-19

There has been 1 new COVID-19 outbreak/incident reportable to ARHAI Scotland during this reporting period.

Hospital	Ward	Ist Case	Total no. deaths	Total no. patients	Total no. staff
QMH	Ward 5	Feb 2025	0	3	0

7.2 Incidents/Data exceedance

January – end of February

There are 4 ongoing environmental investigations.

Endophthalmitis

Single case of endophthalmitis following IVI investigated.

8. Surgical Site Infection Surveillance Programme

A letter on 25 March 2020 from the Chief Nursing Officer revised HAI surveillance requirements with temporary changes to routine surveillance:

- All mandatory and voluntary Surgical Site Infection (SSI) surveillance should be paused until further notice

However, a further DL (2022) 13 was issued in May 2022, stating the planned resumption of SSI surveillance in Q4 2022. This has since been postponed, DL (2023) 06 published February 2023 and a subsequent DL (2024) 01 advises surgical site infection (SSI) surveillance reporting remains paused for the time being.

8 a) Caesarean section SSI

All Caesarean Section surveillance has been postponed due to the COVID19 pandemic until further notice

8 b) Hip Arthroplasty SSI

All Orthopaedic surveillance has been postponed due to the COVID19 pandemic until further notice

8 c) Hemi arthroplasty SSI

All Orthopaedic surveillance has been postponed due to the COVID19 pandemic until further notice

8 d) Knees SSI

All Orthopaedic surveillance has been postponed due to the COVID19 pandemic until further notice

8 e) Large Bowel SSI

All large bowel surveillance has been postponed due to the COVID19 pandemic until further notice

9. Hospital Inspection Team

There have been 1 new inspection during this reporting period (January – end of February 2025).

- HIS NHS Safe Delivery of Care Mental Health Inspection 18/02/2024 Unannounced Inspection to Queen Margaret Hospital, NHS Fife

  Report expected to be published May 2025.

- Healthcare Improvement Scotland (HIS):NHS Safe delivery of care inspection - Unannounced follow up inspection to Victoria Hospital, NHS Fife, 03/12/2024 – 05/12/2024.
  - 9 areas of good practice
  - 1 recommendation
  - 5 previous requirements carried over
  - 12 new requirements

    Please note these are not all IPC related.

10. Assessment

- **CDIs**: There has been an increase seen in the number of *Clostridioides difficile* cases, so far, (Jan-Feb) during 2025 (n=12), compared to the same time period the previous year (2023, n=7). However, the number of total cases and HCAI was the same as during Jan-Feb 2023.The number of CAI cases, Jan-Feb 25 was the same as during that timeframe the previous 2 years
- **SABs**: The Acute Services Division continues to see intermittent blood stream infections related to vascular access device infections
- Interventions to reduce peripheral vascular device infections have been effective but remains a challenge, with local surveillance continuing
- Ongoing monitoring of dialysis line related SABs. IPCT will support Renal service in investigating cases and any subsequent improvement strategies.
- IPCT will continue to carry out MDRO screening compliance and, highlight and support areas of non-compliance.
- Communication channels between IPCT and Addictions Service remain in place, with the offer of further support, if required.
- **ECBs**: Healthcare associated (HAI/HCAI) ECBs remain a challenge
- Addressing CAUTI related ECBs through the Urinary Catheter Improvement Group
- **SSIs surveillance** currently suspended nationally for C-sections, Large bowel surgery and Orthopaedic procedure surgeries (Total hip replacements, Knee replacements & Repair fractured neck of femurs). Awaiting further instruction regarding resumption of surveillance. Increased resources and months of preparing will be required prior to recommencing.

Summary

Healthcare Associated Infection Reporting Template (HAIRT)

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

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

ECBs, CDIs & SABs are categorised as:

Healthcare Associated (HCAI & HAI) or **Community** Onset (Community or Not known).

Please see HPS definition of Healthcare Associated & Community infections in 'References & Links'

The 2019 Scottish Government's new standards aim to reduce the Healthcare Associated Infections.

The information provided is local data, and may differ from the national surveillance reports carried out by Health Protection Scotland. This is due to some Fife residents who are treated at other health boards being allocated back to Fife's data. However, these reports aim to provide more detailed and up to date local information on HAI activities than is possible to provide through the national statistics.

Cleaning and Estates compliances are shown by Total Fife, VHK & QMH.

Report Cards

	NHS Fife								
	SAB			C Diff			ECB		
Month	HAI & HCAI	Community / Not Known	SAB Total	HAI/HCAI / UnKnown	Community	CD Total	HAI & HCAI	Community / Not Known	ECB Total
Apr-24	6	3	9	4	6	10	14	8	22
May-24	5	4	9	2	3	5	14	12	26
Jun-24	8	2	10	2	2	4	17	11	28
Jul-24	2	5	7	5	3	8	9	10	19
Aug-24	0	1	1	4	0	4	11	16	27
Sep-24	3	7	10	3	3	6	12	13	25
Oct-24	3	2	5	5	3	8	14	8	22
Nov-24	8	2	10	5	0	5	12	17	29
Dec-24	6	2	8	2	0	2	4	6	10
Jan-25	2	6	8	3	2	5	4	13	17
Feb-25	6	0	6	6	1	7	18	10	28

Cleaning Compliance (%) TOTAL FIFE												
	Feb 24	Mar 24	Apr 24	May 24	Jun24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25
Overall	95.9	96.3	96.5	96.3	96.1	96.0	95.6	95.8	96.0	96.0	96.4	96.4

Estates Monitoring Compliance (%) TOTAL FIFE												
	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25
Overall	96.6	96.3	96.9	96.9	96.7	96.4	96.7	97.2	96.7	96.8	96.4	96.6

Victoria Hospital

	VHK		
	SAB >48hrs admx	CDI >48hrs admx	ECB >48hrs admx
Month	HAI	**HAI**	HAI
Apr-24	3	3	5
May-24	4	1	6
Jun-24	6	2	6
Jul-24	2	2	1
Aug-24	0	1	3
Sep-24	1	1	4
Oct-24	2	3	5
Nov-24	7	1	4
Dec-24	3	0	3
Jan-25	1	0	2
Feb-25	4	0	5

Cleaning Compliance (%) Victoria Hospital												
	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25
Overall	94.9	95.9	96.2	95.3	95.8	95.1	95.0	95.4	96.2	95.1	96.4	95.4

	Estates Monitoring Compliance (%) Victoria Hospital											
	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25
Overall	97.3	97.2	97.6	97.6	97.3	97.2	97.1	97.9	97.5	97.3	97.1	97.1

Queen Margaret Hospital

	QMH		
	SAB >48hrs admx	CDI >48hrs admx	ECB >48hrs admx
Month	HAI	HAI	HAI
Apr-24	1	0	0
May-24	0	0	0
Jun-24	1	0	1
Jul-24	0	0	1
Aug-24	0	0	0
Sep-24	0	0	0
Oct-24	0	0	0
Nov-24	0	0	0
Dec-24	0	0	0
Jan-25	0	0	0
Feb-25	0	0	0

Cleaning Compliance (%) Queen Margaret's hospital												
	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25
Overall	97.5	96.7	97.7	97.4	96.5	97.0	96.4	96.6	96.5	97.4	96.9	97.3

Estates Monitoring Compliance (%)Queen Margaret's hospital												
	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25
Overall	95.6	95.7	95.6	95.9	95.9	95.7	96.3	96.2	95.5	96.3	96.0	96.3

Community Hospitals

	COMMUNITY HOSPITALS		
	SAB >48hrs admx	CDI >48hrs admx	ECB >48hrs admx
Month	HAI	HAI	HAI
Apr-24	0	0	1
May-24	0	0	0
Jun-24	0	0	0
Jul-24	0	1	0
Aug-24	0	2	0
Sep-24	0	0	0
Oct-24	0	1	0
Nov-24	0	2	0
Dec-24	0	0	0
Jan-25	0	1	0
Feb-25	0	3	0

Out of Hospital

	OUT OF HOSPITAL					
	SAB <48hrs admx		CDI <48hrs admx		ECB <48hrs admx	
Month	HCAI	Community / Not Known	HCAI / UnKnown	Community	HCAI	Community / Not Known
Apr-24	2	3	1	6	8	8
May-24	1	4	1	3	8	12
Jun-24	1	2	0	2	10	11
Jul-24	0	5	2	3	7	10
Aug-24	0	1	1	0	8	16
Sep-24	2	7	2	3	8	13
Oct-24	1	2	1	3	9	8
Nov-24	1	2	2	0	8	17
Dec-24	3	2	2	0	1	6
Jan-25	1	6	2	2	2	13
Feb-25	2	0	3	1	13	10

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:	**2 May 2025**
Title:	**Public Protection Accountability & Assurance Framework**
Responsible Executive:	**Janette Keenan, Executive Director of Nursing**
Report Author:	**Tanya Lonergan, Associate Director of Nursing – Mental Health**

Executive Summary:

- NHS Fife has completed a self-assessment against the Public Protection Accountability and Assurance Framework (PPAAF) using the national toolkit.
- Child Protection (CP) services are well-developed, with strong leadership, governance, training, and interagency collaboration.
- Adult Support and Protection (ASP) health services show significant gaps in leadership, workforce capacity and governance.
- An internal ASP review has been conducted to assess current arrangements and propose a more sustainable and equitable model.
- A multi-agency review is running concurrently and will inform final recommendations for improvement.
- A formal report will be considered by the Chief Executive and Director of Health and Social Care Partnership in May 2025.
- The findings highlight the need for investment in ASP infrastructure to ensure safe, consistent, and rights-based protection for all adults at risk in Fife.

1 Purpose

This report is presented for:

- Discussion

This report relates to:

- Emerging issue
- Government policy / directive
- Legal requirement

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The NHS Public Protection Accountability and Assurance Framework (PPAAF), (Appendix 1), was published by Scottish Government in October 2022. The Framework was developed to guide health boards in assessing the adequacy and effectiveness of their public protection arrangements at both strategic and operational levels and informs existing health board and shared multi-agency governance and assurance arrangements.

This report has been prepared to highlight to the group that work has being taken forward to quality assess the adequacy and effectiveness of public protection arrangements in NHS Fife. A self-assessment has been undertaken using the PPAAF Toolkit (Appendix 2) and was approved for use by the Scottish Executive Nurse Directors (SEND) in 2024.

The completion of the self-assessment indicates that Child Protection Services (CP) within NHS Fife can provide assurance that the recommendations from the Framework are being met, in the main. However, the self-assessment has highlighted significant shortcomings in the attainment of the Framework recommendations within Adult Protection Services (ASP).

2.2 Background

The aim of the PPAAF is to ensure greater consistency in what children, adults at risk of harm, and families can expect in terms of support and protection from health services in all parts of Scotland. Public protection requires effective joint working between statutory and non-statutory agencies, as well as with staff with different roles and expertise. A Gap Analysis against the PPAAF, in anticipation of the launch of the self-assessment toolkit, was taken to Executive Director Group and the Clinical Governance Committee in May 2023.

Health Boards have structural and organisational responsibilities in respect of child and adult protection. These include use of appropriate policies to keep children and vulnerable adults safe, safe recruitment practices, staff induction and provision of adequate training, procedures for whistleblowing and complaints, robust information sharing agreements, and the promotion of a workplace culture that listens to children, young people, and adults and considers their views and wishes.

Child Protection and Adult Protection Committees are the multi-agency partnerships responsible for monitoring and advising on procedures and practice, ensuring appropriate cooperation between agencies, and improving the skills and knowledge of those with a responsibility for the protection of children and adults at risk. It is crucial that health representation on Committees has sufficient seniority to represent the Health Board in discussions and decisions about policy, resources, and strategy. It is also important that

the Health Board is a key contributor to local, multi-agency analyses of child and adult protection data (for example the Minimum Dataset for Child Protection Committees) to ensure that data and intelligence held by health is shared with multi-agency partners and helps build a shared understanding of local needs and service responses.

2.3 Assessment

The PPAAF sets out exemplar evidence of high-quality, safe, and effective services that promote the protection of children and adults for territorial Health Boards. The Framework states that Chief Executives should consider whether this evidence is reflective of the public protection arrangements in their Health Board, and where further focus is required as part of ongoing development and quality assurance processes.

A self-assessment using the PPAAF Toolkit (Appendix 2) has been completed, assessing NHS Fife's current position against each of the eight Public Protection Standards. The findings highlight a disparity in service provision between Child Protection (CP) and Adult Support and Protection (ASP), with significant risks and gaps identified in ASP service provision. The table below summarises the findings aligned to each standard, drawing directly from the self-evaluation evidence.

PPAAF Standards	Fife Position (as per Self-Evaluation Toolkit)
1. An executive Health Board lead has overall responsibility for child protection, adult protection, and MAPPA and champions public protection across the Health Board and contracted services.	The Executive Director of Nursing is appropriately trained and actively involved in key groups (COPS, ASPC, CPC). However, gaps exist in the ASP workforce and weakened ASP governance due to limited capacity.
2. Lead clinicians are resourced and supported to provide advice, expertise, and professional leadership across the Health Board and contracted services.	Strong leadership exists in CP through the Lead Nurse and Lead Paediatrician. In ASP, there is no Lead Nurse or equivalent, and the Training Coordinator (Band 6) does not have a role reflective of current expectations. There is an acknowledgement of the workload and gaps in service and the need for increased capacity including seniority of staff for the ASP service.
3. All NHS employees, GP practices, and independent contracted practitioners are supported and directed to the actions they need to take when a child or adult is at risk of harm.	CP processes are well established with updated training and accessible guidance. In ASP, a review is underway, with no current audit tool or consistent oversight mechanisms.
4. The Health Board promotes a children's rights-based approach and a culture of listening to children and young people and taking account of their wishes and feelings, both in individual decisions and in the	CP demonstrates commitment to listening to children, with clear engagement mechanisms. A child-friendly complaints procedure is under development as part of UNCRC work, but advocacy signposting is inconsistent.

development of services	
5. Robust governance, accountability, assurance, and reporting arrangements for public protection are in place across Health Board services.	CP governance is robust, but ASP governance is evolving. The IJB's risk register includes a high-level risk regarding ASP. Monitoring and audit tools are under development Within ASP, assurance for the IJB and Health Board is evolving from the Portfolio Quality Matters Assurance Groups (QMAG) through QMAG to Senior Leadership Team (SLT) Assurance Group and Quality and Communities Committee (Q&CC). The ASP Health Steering Group is being refreshed and will oversee and monitor arrangements to strengthen governance and accountability.
6. Education, learning, and development arrangements support all NHS employees, GP practices, and independent contracted practitioners in their public protection roles and responsibilities	CP has a coordinated L&D structure. ASP lacks a formal training plan and adequate capacity to support a learning framework.
7. Strategic and operational arrangements between the Health Board and its multi-agency partners support effective joint working and communication.	CP is well represented in interagency forums, with clear reporting structures. ASP health representation is improving but lacks consistent processes for learning dissemination and risk reporting.
8. The Health Board provides an effective medical response for children and adults in need of assessment and care.	Medical response arrangements for CP are defined and SLA-based. For ASP, pathways and oversight of medical responses are unclear and require formalisation.

The completion of the PPAAF self-evaluation toolkit has enabled NHS Fife to identify both strengths and key areas for improvement in public protection arrangements. The self-assessment confirms that while Child Protection services can provide significant assurance aligned to the PPAAF Standards, Adult Support and Protection arrangements are not currently meeting the expected standards in several areas, particularly in relation to leadership, governance, workforce capacity, training and audit.

The findings from the self-evaluation underlined the need for investment in ASP structures, including a workforce review, development of a formal ASP training strategy, and implementation of mechanisms for data collection, monitoring, and governance. These changes are necessary to ensure NHS Fife meets national expectations and delivers safe, equitable, and rights-based protection services for all at-risk adults and children.

Strengthening Adult Support and Protection Governance

An internal exercise has been undertaken to explore the current structure, resourcing, and governance arrangements for Adult Support and Protection (ASP) within the organisation. The review was designed to identify strengths, risks, and areas for development in support of a cohesive and sustainable public protection model.

This work considered national expectations and local context, including capacity, leadership, training, and integration with wider governance arrangements. A report and set of recommendations have now been developed, with a view to informing strategic decision-making. These proposals will be discussed with the Chief Executive and Director of the Health and Social Care Partnership in May 2025.

Concurrently, a multi-agency review of public protection arrangements is also underway. This collaborative work, led by the Chair of the Child and Adult Protection Committees, will provide additional insights into shared challenges and opportunities for improvement. The findings of the multi-agency review will be considered alongside NHS Fife's internal exercise and will inform the final report and any proposed changes to ASP governance and resourcing.

2.3.1 Quality / Patient Care

The disparity in resourcing and infrastructure between Child Protection and Adult Support and Protection services presents a risk to the delivery of safe, high-quality, person-centred care for adults at risk of harm.

By undertaking both an internal and multi-agency review of ASP arrangements, NHS Fife is actively seeking to strengthen the quality of its adult protection response. The recommendations arising from these reviews will inform the development of a more sustainable model of public protection, aligned to the principles of equity, safety, and continuous improvement.

2.3.2 Workforce

There is a recognised inequity in workforce infrastructure between Child Protection and ASP within NHS Fife. The current ASP service is supported by a single Band 6 Training Coordinator (0.8WTE) whose job description does not fully reflect the breadth of leadership, governance, and operational responsibilities expected of the role. In contrast, CP is supported by a multi-tiered team with strategic, clinical, and educational leadership capacity. The recent internal review has recommended a workforce model and roadmap for ASP.

2.3.3 Financial

Addressing the identified gaps in Adult Support and Protection (ASP) will require some investment. While Child Protection benefits from a defined structure, ASP currently lacks equitable resourcing, relying on a single Band 6 post with limited scope. Financial planning discussions will be required to identify sustainable funding solutions. Any investment will align with NHS Fife's statutory duties and long-term commitment to safe, equitable public protection.

2.3.4 Risk Assessment / Management

The PPAAF self-evaluation process has reinforced the significance of the existing high-level risk recorded on the Integration Joint Board (IJB) risk register. This risk states that insufficient assurance and oversight in adult and child protection may lead to harm to individuals, diminished multi-agency confidence, and reputational damage to NHS Fife and its partners. The risk is actively reviewed, with the PPAAF process contributing to strengthened mitigation measures including the establishment of a refreshed ASP Health Steering Group, proposed changes to workforce and governance, and increased visibility at strategic forums.

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

Public protection is fundamentally a matter of equality and human rights. NHS Fife recognises its responsibilities under the Equality Act 2010, Human Rights Act 1998, and the European Convention on Human Rights, to ensure that all individuals, particularly those who are most vulnerable, are safeguarded and supported to live free from harm.

The gaps in ASP provision pose a risk to delivering equitable protection across age, gender, disability, and other protected characteristics. Adults with complex needs, mental health issues, learning disabilities, or communication challenges are especially at risk of under-identification or lack of follow-up. The proposed improvement actions will ensure that ASP services are planned, including robust equality impact assessments (EQIAs) on any service changes.

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

Initial work undertaken by a short-life working group supported the collation of baseline information in preparation for NHS Fife's self-assessment against the Public Protection Accountability and Assurance Framework (PPAAF). Verbal progress updates have been provided to the Executive Director of Nursing and the Director of the Health and Social Care Partnership throughout the process.

2.3.8 Route to the Meeting

- PPAAF SLWG
- ELT 24 April 2025

2.4 Recommendation

- **Discussion** – For examining and considering the implications of the matter.

3 List of appendices

The following appendices are included with this report:

- Appendix No. 1, NHS Public Protection Accountability and Assurance Framework nhs-public-protection-accountability-assurance-framework.pdf
- Appendix No. 2, PPAAF Self-Evaluation Toolkit

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NHS Public Protection Accountability and Assurance Framework Toolkit

Public Protection Standard 1: An executive Health Board lead has overall responsibility for child protection, adult protection, and MAPPA and champions public protection across our Health Board and contracted services (page 8)							
Applicable Care Inspectorate Quality Indicators Joint Inspection Children's Services:	**Applicable Care Inspectorate Quality Indicators Adult Support and Protection:**	**United Nation's Convention of the Rights of the Child (UNCRC)**	**Achieved**				
7.2, 9.3	**QI. 2.1, 2.2,**	**Articles: 1-3,6,9,12,16,18,19,23-25,24,25,27,34-36,39,40,42**	**In Full**	**In Part**	**Not At All**	**Not applicable**	**Key data and evidence that provides assurance around this standard**
Evidence							
1.1 This lead is up to date with their public protection training, has public protection responsibilities reflected in their job description, and participates in relevant Chief Officer and Committee meetings.							**TRAINING:** The lead is the Executive Director of Nursing. The lead is up to date with TURAS learn modules: • Adult Protection • Gender Based Violence • Human Trafficking • Protecting our Children • MAPPA Completed the Chief Officers' Public Protection Induction resource. **JOB DESCRIPTION**: Extract from job description: The Executive Director of Nursing, Midwifery and Allied Health Professions will provide energy, drive, leadership and strategic direction, in partnership with Director colleagues, in the delivery of continuous improvement in the clinical performance of NHS Fife, with a specific focus on: Patient and Public Protection of vulnerable adults and children. **PARTICIPATION IN MEETINGS:** The Executive Director of Nursing is a member of

					Chief Officers Public Safety Group (COPS), Adult Support and Protection Committee (ASPC), Child Protection Committee. ASP is delegated from and integrated with Fife Council. Child Protection is delegated from NHS Fife. The Director of Fife Health and Social Care Partnership (FHSCP) is accountable to the Integrated Joint Board (IJB) and NHS Fife Board for their role in relation to child and adult protection.
1.2 This lead ensures that local governance arrangements for public protection in their area support Chief Officers of Health and Social Care Partnerships.					Robust governance frameworks and regular reporting is required through Child Protection and Adult Protection Committees. Within NHS Board: Clinical Governance Committee, Public Health and Wellbeing Committee and FHSCP Quality Matters Assurance Groups (QMAG). Governance and assurance of ASP and CP is currently on the IJB risk register, as High (15) with the following risk identified. There is a risk that the IJB does not receive sufficient assurance to enable it to fulfil its statutory duty for Adult and Child protection, leading to negative impacts for individuals and for multi-agency working and damage to the reputation of the partner organisations and the IJB. Within ASP there is a need to explore further the reporting and monitoring on KPI's, data, risk management, policy and procedures development, training and development, audit and evaluation.
1.3 It can be shown that the executive lead promotes a strong culture of collective leadership across public protection.					Robust governance arrangements facilitate collective leadership across the board for public protection, delegating responsibilities to the FHSCP. However, due to changes within the management team and limited resources within ASP, there is a weaker culture of meetings and emphasis on ASP. This has been identified as a gap. The ASP Health Steering Group is being refreshed. Health representation on ASP Committee sub-groups is being strengthened. There is no head of Public Protection within the current structure.

Please provide an overall summary assessment on the extent to which our Public Protection Standard 1 has been implemented, identifying areas of strength and key barriers.

Strengths

- Executive level commitment and involvement in COPS, ASP and CPC Committees
- Strong child protection arrangements in place
- Commitment to strengthen adult protection arrangements in health

Barriers

- There is no Head of Public Protection in post at present and this causes vulnerability within the service.
- High level risk identified on the IJB risk register, which requires robust actions to reduce this risk.
- Due to capacity, and lack of team resources there is a weaker culture in respect of governance arrangements and leadership in ASP.

Please cite any planned self-improvement work

- SBAR produced to highlight requirement for a Head of Public Protection and further resource in ASP
- Re-evaluation of staff needs between ASP and CP
- Internal audit recommendations and actions identified on the risk register are to be taken forward
- Evaluation of governance and leadership arrangements for ASP.
- Refresh of Adult Protection Steering group underway

Public Protection Standard 2: Lead clinicians are resourced and supported to provide advice, expertise, and professional leadership across our Health Board and contracted services (page 8).							
Applicable Care Inspectorate Quality Indicators Joint Inspection Children's Services:	**Applicable Care Inspectorate Quality Indicators, Adult Support and Protection:**	**United Nation's Convention of the Rights of the Child (UNCRC)**	**Achieved**				
3.1, 6.4, 6.5, 7.2, 9.1, 9.2, 9.3. 9.4	**QI. 2.3,**	**Articles: 1-3,6,9,12,13,16,19,20, 23,24,27,34-36,39,40,42**	**In Full**	**In Part**	**Not At All**	**Not applicable**	**Key data and evidence that provides assurance around this standard**
Evidence							
2.1 There is a Chief/Lead Nurse or Nurse Consultant (or equivalent) for Public Protection.							There is no chief nurse/Nurse Consultant for Public Protection. There is a Lead Nurse, Band 8A for Child Protection (LNCP) who works according to the CP LN job description. For Adult Support and Protection (ASP) there is no Chief Nurse or Lead role.
2.2 The aforesaid position takes the professional lead on all aspects of our health contribution to safeguarding and is central to our Health Board's clinical and care governance processes for public protection.							The LNCP is a member of the Child Protection Committee (CPC) and participates in its subgroups, including CP Guidance Implementation Working Group, Quality Assurance & data group, the case review working group and the L&D group. Additionally, the LNCP is deputy chair to the NHS Fife Acute CP group and contributes to the Child Protection Health Steering group (CPHSG). The LNCP represents NHS Fife at the Scottish Nursing Leadership Child Protection group and associated working groups and the East Region MCN. For ASP, the ASP Training Coordinator, attends the Case Review working group, Learning & Development working group (where

					they serve as Deputy Chair), Self Evaluation working group, Hoarding & Self Neglect working group, NHS Fife ASP leads working group and the NHS Scotland ASP leads network. Health representation on working groups has been reviewed and strengthened
2.3 In our Health Board, if we are providing care to children, there is a Lead Paediatrician for child protection directly employed or contracted through a Service Level Agreement to provide expertise to our Board.					There is a Lead Paediatrician for Child Protection (LPCP)
2.4 The Lead Paediatrician and Chief/Lead Nurse or Nurse Consultant (or equivalent) have job descriptions which clearly define their roles, responsibilities, and expectations and have sufficient protected time and support to carry out their duties and responsibilities					Job descriptions within CP for Lead Nurse and Lead Paediatrician clearly define their roles. The LNCP does not have full-time strategic role responsibilities in line with the framework and as such does not have protected time allocation required for the role. LPCP has protected time but faces competing priorities with their acute general Paediatric role. The LPCP role is not included on current organisational charts. The LNCP professional development was compromised as a result of operational and strategic demand, resulting in very limited protected time to undertake training and learning to ensure competencies, skills, and knowledge appropriate to the role are attained and maintained at expert level. A team leader, reporting into and supporting the LNCP has been appointed to help address the issue of protected time.There is limited means for LNCP and LPCP to obtain the required Level 5 CP training and appropriate CP supervision. In ASP, there is no lead nurse. The current Job description for the Training Coordinator does not accurately reflect the responsibilities and expectations of the band 6 role, which includes leading and supporting Adult Protection efforts.

2.5 There is a clearly designated Lead Clinician within Forensic Mental Health services who has an overall responsibility for NHS MAPPA Responsible Authority duties and Restricted Patients. [If the Board does not have a forensic mental health service, there is clear evidence of formal and appropriate links and lines of communication to the boards that provide Forensic Mental Health services on their behalf].					The current Forensic Consultant Psychiatrist is identified as the lead clinician for MAPPA.
2.6 There is a designated Trauma Champion who supports the development of trauma-informed practice (role may sit out with Public Protection team)					There are Health board trauma champions in place. The LNCP/deputy, GBV Coordinator, CAMHS, Psychology and addiction services are core members of the multiagency Fife trauma steering group. Children's Services governance arrangements oversees mandatory trauma-informed training across the Children's Service workforce. The LP has progressed trauma-informed training in collaboration with psychology for paediatric services. This structure is not present in ASP.
2.7 There is a process in place to monitor the workload capacity of the Chief/Lead Nurse(s) or Nurse Consultant(s) and Lead Paediatricians with a clear reporting mechanism to the executive Health Board lead (may be exception reporting)					There is no robust process in place to monitor the workload of the LNCP. Through governance structures and annual reports, wider CP team workload is monitored and reported to executive lead. LPCP has protected time but faces competing priorities with their acute general Paediatric role. The LPCP undertakes regular job planning with senior management to support protected time for CP responsibilities. The LNCP and LPCP are accessible across NHS Fife and FHSCP. The LNCP has visibility across children's and midwifery services and has membership to CHMT, however, there are limitations on wider visibility across Health Board and contracted services in line with the framework.

					In AP there is no lead nurse; there is an acknowledgement of the workload and gaps in service and the need for increased capacity to address it effectively.
2.8 The Chief/Lead Nurse(s) or Nurse Consultant(s) and Lead Paediatrician are responsible for preparing a public protection annual report to provide assurance that our Board is meeting its obligations in respect of public protection in line with national guidance which highlights areas for improvement.					The LNCP's produces an annual CP report. The GBV service produces an annual report. The LNCP and LPCP are members of GIWDG and health GIWDG and associated sub groups to implement the new national CP guidance and contribute to any subsequent reporting to CPC. The Head of Complex and Critical Care Services is responsible for providing the ASP annual report, bi-ennial report and MAPPA however there has been delays in the MAPPA report being provided on an annual basis.
2.9 The Chief/Lead Nurse(s) or Nurse Consultant(s) and Lead Paediatrician have access to regular supervision appropriate to their role					There is limited means for LNCP and LPCP to obtain appropriate CP supervision relevant to the role. The Scottish Nursing Leadership Child Protection group are exploring an identified national gap. The CPLP attends MCN physical and CSA peer review, with access to peer supervision with CP Paediatrician colleagues. LNCP capacity to attend the monthly MCN peer review sessions is limited to a couple of times a year due to capacity. The LNCP has regular managerial supervision and professional supervision from HON (neither within a CP role) and annual TURAS PDP. The LNCP & CPLP have progressed joint case CP reflective supervision sessions, this

					included a session with the Sexual health team inc GBV. The CPLP reestablished 6 monthly multiagency case supervision for staff in 2023. In AP this is an identified gap. With managerial supervision to the Band 6 Training Coordinator provided by line manager (not within an AP role) and as required by Director of Nursing (Corporate) for advice however there is no formal arrangement in place.
2.10 The Chief/Lead Nurse(s) or Nurse Consultant(s) and Lead Paediatrician (or equivalent) for public protection has access to relevant resources and support, including national networks					There is currently no lead Nurse for Public Protection. For ASP the ADON within FHSCP attends the Health AP leads network.
2.11 The Lead clinician for MAPPA Responsible Authority duties and restricted patients has access to relevant resources and support, including National Forensic Network					The forensic consultant psychiatrist has access to resources, support and supervision from peers, the MAPPA coordinator as well as from the forensic network.
2.12 MAPPA Strategic Lead /Single Point of Contact (SPOC) responsible for Duty to Co Operate/ Health Liaison function attends local MAPPA Strategic Oversight Group and reports to Executive Leads as required					There are identified leads for MAPPA level 1,2 and 3 however the membership of SOG and MOG is being reviewed, to also ensure consistent health representation at all MAPPA national meetings. The reporting of the outcomes of the meetings requires be strengthening and evidencing through the annual report.
2.13 It is considered good practice to have a MAPPA Health Manager					The Head of Service for Complex and Critical Care Services is the MAPPA Health Manager

Please provide an overall summary assessment on the extent to which our Public Protection Standard 2 has been implemented, identifying areas of strength and key barriers.

Strengths

- There is key data and evidence to provide assurance in all quality indicators in respect of CP
- In CP Lead Nurse or Lead Paediatrician take the professional lead on all aspects of the health contribution to safeguarding and are central to the Health Board's clinical and care governance processes for public protection.

Barriers

- There is no identifies Lead Nurse or resource for ASP, except training coordinator (0.8WTE)
- There is inconsistent leadership and representation on ASP and MAPPA national meetings
- In ASP the current job description for the Training Coordinator does not reflect the responsibilities and expectations required.
- There is no HB Trauma Champion structure within ASP.

- The ASP training coordinator is accessible via email and telephone; however this is single person dependant, with an identified gap when on leave or unplanned absence.
- There is a gap in provision of regular supervision appropriate to the ASP role.
- These are identified gaps in providing assurance reports for MAPPA

Please cite any planned self-improvement work

- Progress the LPCP role on the appropriate organisational chart
- LNCP to progress any supervision progressing from The Scottish Nursing Leadership Child Protection group as part of the identified national gap.
- Review of capacity and work plan, job description of the one current member of staff in ASP as well as ensuring SBAR is progressed for equitable resources for ASP

Public Protection Standard 3: All our NHS employees, GP practices, and independent contracted practitioners are supported and directed to the actions they need to take when a child or adult is at risk of harm (page 9).							
Applicable Care Inspectorate Quality Indicators Joint Inspection Children's Services:	**Applicable Care Inspectorate Quality Indicators**	**United Nation's Convention of the Rights of the Child (UNCRC)**	**Achieved**				
3.1, 5.1, 5.2, 7.2,	**QI. 1.1, 1.1.2, 1.1.3, 1.3, 1.3.1, 1.3.2**	**Articles: 1-3,5,6,8,12,16,18,19,23,24,34-36,39,40,42**	**In Full**	**In Part**	**Not At All**	**Not applicable**	**Key data and evidence that provides assurance around this standard Evidence**
Evidence							
3.1 The role of our Public Protection Service is communicated throughout our Board and contracted services so all employees, GP practices, and independent contracted practitioners should know where and when to seek advice, support, and supervision at an appropriate level for their role.							For CP and ASP, guidance is available on Blink which all health professionals in NHS Fife have access to. CP are currently reviewing and updating CP Blink pages to ensure streamlined accessibility with current, up to date information. Including multiagency and single agency policies, protocols, guidance and leaflets. A CP advice line is accessible to all NHS staff. CP and ASP are mandatory courses for completion on Turas for all health board staff. CP and ASP moved to the NES online training for Level 1 and Level 2 in 2023. CP induction

					training was updated in 2023. CP team updates are provided as a standing agenda item at CPHSG. GP representative is included on the CPHSG. A GP CP Training Needs Analysis was carried out in 2024. An outcome from this is to hold a GP CP Update during designated PLT time later in 2024 organised by the LP CP and GP Lead. A SCPNA from the CP team is allocated the GBV portfolio. The ASP training coordinator is accessible via email and telephone; however this is single person dependant, with an identified gap when on leave or unplanned absence.
3.2 Public protection protocols and guidance are aligned with national guidance, and accessible to all employees, GP practices, and independent contractors.					CP Multiagency policies and protocols all required review and updating in line with the new CP guidance, this is ongoing work of the GIWDG. Multiagency and single agency policies, protocols, guidance and leaflets are available on Blink. A CP advice line is accessible to all NHS staff. ASP Multiagency procedures are in place and updated, while single agency protocols including health require review and updating in accordance with updated code of conduct and governance. The ASP coordinator ensures that Blink is regularly updated with current information, training materials, protocols, and a link to Fife.gov multiagency information. There is currently information and training provided for GBV and this is also accessed through Blink
3.3 Our Health Board has clear information sharing guidance, which practitioners can access, which sets out the process and principles					The existing Child Protection Committee (CPC) Information sharing protocol review and update has been delayed for a significant

for sharing information, relevant to safeguarding and promoting the wellbeing of children and vulnerable adults. This includes guidance on handling and storage of information and records, including responding to requests made under Section 10 of the Adult Support and Protection Act 2007. It also includes clear guidance/procedures regarding the sharing of health information under MAPPA arrangements via Section 10 and 11 of the Management of Offenders etc. (Scotland) Act 2005					period of time due to a national conflict with Police Scotland. A health information governance representative supported a review from a health perspective in November 2022. The GIWDG and CWP group have produced a draft Partnership Guidance on Information Sharing, Confidentiality, and Consent. Single agencies are working on their own single agency guidance to compliment and sit behind this document. Health progress is in the very early stages. The Caldicott Guardian Memorandum of Understanding was updated in 2023 in relation to new CP guidance to include pre-birth information sharing. This will require further updating in respect of 16 and 17 year olds at the appropriate implementation point of the new CP guidance and consideration of adult information sharing in CP cases as identified as best practice from National IRD training. The Scottish Accord on the Sharing of Personal Information and the Information Sharing Protocol for Fife ASP are currently under review since 2016. The legal framework for sharing information primarily relies on the Adult Support & Protection Act (Scotland) 2007, supplemented by the updated Code of Conduct July 2022. A CP advice line is accessible to all NHS staff. There are available information sharing protocols available for NHS Fife and FHCSP, including access to the data protection team. There are MAPPA information sharing protocols and procedures.

3.4 There is an identified Caldicott Guardian within our board.					NHS Fife Caldicott Guardian is Dr Chris McKenna, Medical Director. The NHS Fife Caldicott Guardian has responsibility at Board level for protecting patient identifiable data. Appropriate arrangements and communication are in place during periods of leave.
3.5 There is a mechanism to monitor awareness and understanding of public protection responsibilities and duties including the duty to refer; and the MAPPA specific duties related to Responsible Authority and the Duty to Cooperate agencies.					A CP advice line is accessible to all NHS staff. A new database was developed in 2023 to capture themes to inform training needs of the workforce. There is oversight of CS CP training at the monthly CS governance meeting. The CP team reports on the number of training sessions offered. Children's services have piloted a database to capture more robust information regarding additional CP training and hours, however this requires further review. There is a gap in oversight of CP training attendance across wider services. It is proposed that services report via CPHSG as part of evidence gathering for the PP&AAF. A CP Training Needs Analysis was carried out in 2023 to identify gaps in CP learning and repeated in 2024. A CP L&D coordinator was appointed in August 2023, this post moved under the CS QI team in January with a wider CS remit. A Child Protection Training Program was developed by the L&D coordinator and launched in 2024. The L&D coordinator represents NHS Fife at the CPC L&D working group. A 2023–2024 Child protection Committee (CPC) workforce survey was circulated to all practitioners within Health Visiting, Family Nursing, Vulnerable in Pregnancy (VIP) Midwives, Child Protection Paediatricians and

					a sample of GPs to monitor awareness and understanding and results incorporated into the CP annual report. Gap in progression and reporting of Workforce audit findings to provide assurance that staff have a good knowledge and understanding of public protection and what to do if they identify harm. CS SLWG progressed with wide CS representation to produce draft audit tool which meets requirements of new electronic child health record. Proposed audit findings to subsequently be reported by services via CPHSG as part of evidence gathering for the PP&AAF. Gap in Regular CP quality assurance/self-evaluation activity undertaken by services. . Proposed audit findings reported by services via CPHSG as part of evidence gathering for the PP&AAF. LNCP takes a lead on coordinating public protection concerns regarding health care workers identified at IRD. LNCP contributes to national work identified due to a gap in a consistent approach. Within ASP, there is a requirement to develop an audit tool to annually address this issue, there is no identified resource or capacity for Training coordinator in post to address this gap, however the refreshed ASP Health Steering Group will take this work forward.
3.6 There is a clear reporting mechanism on public protection performance to our executive Health Board lead.					The CP annual report and any appropriate CP updates progress at regular intervals via agreed governance routes. CP adverse event reporting has been under review, to support more robust reporting, monitoring and oversight. Action plans and thematic learning is progressed via CS governance routes. LNCP attends the new

					national group in relation to national adverse event reporting and datasets. The ASP process is currently under review, and efforts are underway to integrate developments with DATIX to facilitate reporting, monitoring and oversight. Progress may be constrained by the lack of adequate resources to effectively track and manage this but will be overseen by ASP health steering group. Annual assurance reports are required through governance groups CP has provided annual reports and an ASP bi-ennial interagency ASP report. However, the annual MAPPA report has been delayed.
3.7 There is evidence that transitions between age and services, including the Scottish Ambulance Service and NHS 24, particularly where there are multiple and/or complex health needs, are planned and co-ordinated.					A CP NHS24 PPR1 form process is in place within CS. Whilst there is senior NHS24 and SAS representation on CP national groups which the CPLN attends, local links within Fife between SAS and NHS24 could be improved. The review of 16-18 year olds progressing via CP pathways is under review of the GIWDG in collaboration with ASP colleagues. A new HV/SN transition process is being launched in August 2024. ASP, while NHS 24 is represented on the ASP leads network, clear links within Fife are lacking. However, a SAS representative attends the ASP NHS Fife Leads steering group. Additionally, the review of support for young people aged 16-18 years old is underway. The Scottish Ambulance Service (SAS) have a process for identifying High Intensity Users (HIU) and flagging this to local social work teams by submitting a request for assistance - 5 calls in a 12-week period (adults). Not all HIU will meet the criteria for ASP or CP and

					local SW teams can determine this from the information provided to them from SAS. Information sharing with SAS and NHS Boards is in its infancy and will develop more over time. A pilot is being progressed with a territorial board currently and if successful, learning can be used in other board areas

Please provide an overall summary assessment on the extent to which our Public Protection Standard 3 has been implemented, identifying areas of strength and key barriers.

Strengths

- CP, ASP and GBV guidance and multi-agency protocols are available on Blink and are regularly updated to take account of current information, training materials and protocols.
- Mandatory training on CP and ASP is available on Turas for all staff
- There is a GP representative on the CPHSG.
- There is an identified Caldicott Guardian and Data protection team who offer support.

Barriers

- There is a gap in monitoring and awareness of the public protection responsibilities for ASP
- There is no GP representative on the ASPHSG.
- Information Sharing Protocols for both CP and ASP require to be reviewed..
- There is a gap in oversight of CP and ASP training.
- CP IRD information is not consistently reported and in ASP progress of a review of the IRD process may be constrained by the lack of adequate resources.
- Clear links with NHS 24 in ASP are lacking.

Please cite any planned self-improvement work

- CP are currently reviewing and updating CP Blink pages to ensure streamlined accessibility with current, up to date information. Including multiagency and single agency policies, protocols, guidance and leaflets.
- Repeat 2023 CP Training Needs Analysis in 2024.
- GP CP Update organised by the LP CP and GP Lead. during designated PLT time
- new HV/SN transition process was launched in August 2024
- CP adverse event reporting under review
- CS SLWG progressed with wide CS representation to produce draft audit tool which meets requirements of new electronic child health record.
- audit findings and self-evaluation activity to be reported by services via CPHSG as part of evidence gathering for the PP&AAF.
- oversight of CP training attendance across wider services via CPHSG as part of evidence gathering for the PP&AAF.
- Progress single agency information sharing guidance to incorporate CWP & CP
- Consideration of adult information sharing in CP cases as identified as best practice from National IRD training – requires Caldicott Guardian approval and capacity within CP team.
- Review of Children's services CP training database pilot
- Within ASP, there is a work in progress to establish a SLWG aimed at developing an audit tool to establish a baseline for improvement in ASP awareness and annually address this matter.
- The ASP process in respect of IRDs, etc., is currently under review, with efforts to integrate developments with DATIX to facilitate reporting, monitoring and oversight.

Public Protection Standard 4: Our Health Board promotes a child and adult's rights-based approach and a culture of listening to children, young people and adults and taking account of their wishes and feelings, both in individual decisions and in the development of services (page 10).							
Applicable Care Inspectorate Quality Indicators Joint Inspection Children's Services:	**Applicable Care Inspectorate Quality Indicators**	**United Nation's Convention of the Rights of the Child (UNCRC)**	**Achieved**				
2.1, 4.1, 5.4, 6.1, 6.2, 6.3, 8.2,	**QI. 2.4.2**	**Articles: 1-3,8,12,13,14,16, 18-20,24,27,39,40,42**	**In Full**	**In Part**	**Not At All**	**Not applicable**	**Key data and evidence that provides assurance around this standard**
Evidence							
4.1 Our Health Board can evidence how it meets its statutory duties (including safeguarding and promoting the welfare of children and adults) under the Children (Scotland) Act 1995 and Adult Support and Protection Scotland Act 2007							Service / staff compliance with mandatory and core training, child protection, neglect (pending GCP2 training) , disability, children's rights, trauma informed & responsive, child wellbeing pathway, wellbeing meeting, child plans). Assurance via clinical governance, supervision and peer review. Clinical decision making uses care aims which assesses risk and impact (psychological, physical & functional). Training spreadsheet available and details data regarding mandatory training compliance. Case reflection questions used in supervision and peer review. Some Children's Services areas have trauma and young carers champions. All staff are aware this training is mandatory and essential for role therefore training undertaken by all staff. Progression of National guidance for CP In Scotland via multiagency and single agency working groups. There is no clear formal process or a structure in place for collating assurance of the health information for ASP. This is being taken forward by ASPHSG

4.2 Our Health Board can evidence how it satisfies its duties under Part 1 of the Children and Young People (Scotland) Act 2014 and can demonstrate how they have secured the better or further effect within its areas of responsibility of the UNCRC requirements.					New CS QI team progressed in 2024 with focused remit for participation & engagement, The Promise/UNCRC and its implications for both children's and adult services. Progression of services incorporating the UNCRC into their policies or measures. Ongoing efforts by Children's services groups to exploring ways to enhance awareness of The Promise and children's rights across the partnership, including updates to CP guidance and GIRFEC principles. Equality and diversity statements are included in all locally developed policies and guidance using the NHS Fife - Equality Impact Assessment Toolkit, Section 6 – Children's Rights and Wellbeing Impact Assessment (CRWIA) since 15/08/2022. The Interim equality Outcomes Plan 2025 – 2029 includes an outcome related to UNCRC
4.3 Our Service planning and delivery reflects an understanding of the evolving capacities of our children and young people in relation to decisions that affect them.					There is significant progression within CS in this area over the past year which will be taken forward further via the CS QI team. There are likely gaps remaining that require exploration by individual services. Some service improvement examples below; CS Occupational Therapy - CYP involved in recruitment (interview panels). Talking Mat's routinely used to elicit thoughts, feelings and opinions of CYP. CRWIA considered and undertaken when required. Engagement and participation survey completed as part of new inclusive design for play park. Drive deck now available in a number of educational establishments following feedback from CYP & Families. CYP central to goal setting. Evidence of flexibility and accessibility to Occupational Therapy service in response to service user feedback. Planned work includes; future community projects and inclusive environments, accessible communication and resource. School Nursing - Children and their families are consulted regarding their care at every contact

					and this is recorded in their records. The service advocate for children and young people to support their attendance at LAC reviews. Any change of service a full CRWIA is undertaken CPYCNS - team are responsible for participation and engagement with CYPF and take a rights based approach to this work. Team use the P&E framework agreed by the HSCP and are leading the way in implementing the UNCRC in Fife
4.4 Feedback from our children and young people is sought in line with Article 12 of the UNCRC					There is significant progression within CS in this area over the past year or so which will be taken forward further via the CS QI team and UNCRC SLWG. There are likely gaps remaining that require exploration by individual services. For example, embedding CRWIA within Adult services. The CPLP is collating user feedback from children and young people who are in the CP process to inform service planning and delivery. Results reported to CPC. Parent and child's views are taken into consideration throughout CS, some examples below; OT - Service has extensive evidence using a variety of tools to ensure CYP remain central to decisions that affect them and 'what matters' (Talking Mats) School Nursing - Feedback is frequently sought and analysed from CYP and families to inform service improvements. Audits held regularly. CYPCNS - Our children in CYPCNS are non verbal and have complex difficulties with communication. Consultation with parents and communication methods of gaining the YPs voice are used routinely.

4.5 Complaint procedures are accessible including being child friendly and adapted according to age, level of maturity, and understanding.					National child complaint procedure was being developed however not currently used within Services. Work has recently significantly progressed in relation to complaints procedure for children via UNCRC SLWG.
4.6 Support and advocacy are available for our children, young people and adults who do not feel their full range of rights are being fulfilled.					Advocacy is available; however there are no robust means of assurance in this area. A potential gap exists in some services being aware of their role and responsibility in signposting to third sector advocacy support however, ongoing work of UNCRC in Fife is bridging gap.
4.7 Health Boards Public Protection, policy and processes are underpinned by a human rights approach enshrined within the Human Rights Act 1998 and the Scotland Act 1998 and ensure practice is compatible with European Convention on Human Rights (ECHR). Scotland Act 1998 (legislation.gov.uk) European-convention-human-rights Human Rights Act 1998 (legislation.gov.uk)					All relevant CP policies and legislation are considered when developing policies and training for staff, or services for children, alongside information and opinions from service users. There is a gap identified in ASP policies and procedures requiring review.
4.8 Ensure compliance with United Nations Convention of the Rights of Persons with Disabilities (UNCRPD), which promotes non-discriminatory, inclusive participation for all, with respect for the individual's dignity and differences, reinforcing equal rights of people with disabilities, whilst demonstrating actions taken to remove barriers and support disabled people to fully participate in society. Convention on the Rights of Persons with Disabilities (CRPD) | United Nations Enable					Equality and diversity statements are included in all locally developed policies and guidance using the NHS Fife - Equality Impact Assessment Toolkit, Section 6 – Children's Rights and Wellbeing Impact Assessment (CRWIA) since 15/08/2022. Equality and diversity statements are included in all locally governance documents.
4.9 Our Health Board can evidence a culture and shared vision in which 'we respect, protect and fulfil human rights and live free from discrimination' in line with Scotland's National Performance Framework and overarching human rights National Outcome Measuring progress | National Performance Framework					Health board values are promoted and included within all job adverts and descriptions.

Please provide an overall summary assessment on the extent to which our Public Protection Standard 4 has been implemented, identifying areas of strength and key barriers.

Strengths

- Progress is being made in CP, especially in the awareness of the need for advocacy for children in LAC reviews.
- Parent and child views are being taken into consideration in decision-making and development of services.

Barriers

- There are gaps in awareness of The Promise/UNRC and the implications for child and adult services.
- Not all services consider Children's Rights and Wellbeing Impact Assessments.
- There are gaps in services planning and delivery with individual services.
- There is no complaints procedure for children and the National procedure is not currently used within services.
- Only some services are aware of their role and responsibility in signposting to advocacy services.

Please cite any planned self-improvement work

- Increase awareness of the Promise/UNCRC and its implications for adult services.
- Progression with child's complaints processes for NHS Fife
- Embedding CRWIA within Adult services.

Public Protection Standard 5: Governance, accountability, quality assurance and reporting arrangements for protecting people are in place across the organisation (page 11).							
Applicable Care Inspectorate Quality Indicators Joint Inspection Children's Services:	**Applicable Care Inspectorate Quality Indicators**	**United Nation's Convention of the Rights of the Child (UNCRC)**	**Achieved**				
1.1, 6.4, 6.5, 7.1, 9.2, 9.4	**QI 2.4**	**Articles: 1,2,3,6,12,19,24,25, 34-36,39,40,42**	**In Full**	**In Part**	**Not At All**	**Not applicable**	**Key data and evidence that provides assurance around this standard**
Evidence							
5.1 Our Health Board has clear written governance, accountability, and assurance frameworks for public protection that apply to all services, both provided and contracted.							Assurance for the IJB and Health Board is evolving from the Portfolio QMAGs through QMAG to SLT Assurance Group and Q&CC. This is to be documented in the Clinical and Care Governance Strategic Framework which is almost complete. This is further supported by the recent clinical and care governance internal audit findings which recognised the risks and gaps in service provision and further recommendations for actions and improvements have been made.
5.2 Public protection governance processes and systems apply to our IJBs and are embedded in our wider Health Board governance arrangements.							There is a high level risk identified that the IJB does not receive sufficient assurance to enable it to fulfill its statutory duty for Adult and Child

					protection, leading to negative impacts for individuals and for multi-agency working and damage to the reputation of the partner organisations and the IJB. This risk is reviewed regularly with actions and recommendations being implemented to reduce this risk by March 2025.
5.3 There are arrangements to monitor compliance with safer recruitment procedures and selection procedures in relation to our children and adults, including Protecting Vulnerable Groups (PVG) scheme membership.					There are robust Once for Scotland policies which include compliance with the PVG scheme membership for all recruitment.
5.4 Audit shows that employees, GP practices, and independent contractors are aware of available guidance and support and policy and procedures are adhered to.					A 2023–2024 Child protection Committee (CPC) workforce survey was circulated to all practitioners within Health Visiting, Family Nursing, Vulnerable in Pregnancy (VIP) Midwives, Child Protection Paediatricians and a sample of GPs to monitor awareness and understanding and results incorporated into the CP annual report and are considered in CP training strategies. There is a gap in standardised health CP audit process as the Children's Services CP Quality Assurance framework does not aligning with the new electronic system, Morse. CS SLWG progressed with wide CS representation to produce draft audit tool which meets requirements of new electronic child health record. Proposed audit findings to subsequently be reported by services via CPHSG as part of evidence gathering for the PP&AAF. Health CP team participates in the annual CPC multiagency audit with any learning incorporated into multiagency and single agency CP training.ASP, a learning review of current ASP training framework is underway, along with development of a competency framework to enable assurance in training. The ASP Protocol requires review and an audit tool needs to be developed. This is an identified gap which will be taken forward by the ASPHSG.

5.5 There are clear governance arrangements and processes in place to determine the appropriate review process when our Board is notified about the death of a child or adult who was subject to formal child/adult protection measures or death was due to an individual subject to MAPPA arrangements					An Escalation process in established through exception reporting. There is a Child Death hub review group and a further oversight group for child deaths, ensuring robust governance is in place. There is a process through A&E and CP where the Board are notified of a death of a child. This process involves also notifying all relevant agencies or bodies. This may involve the Care Inspectorate and MWC. CP adverse event reporting has been under review, to support more robust reporting, monitoring and oversight. Action plans and thematic learning is progressed via CS governance routes. LNCP attends the new national group in relation to national adverse event reporting and datasets. Learning reviews are carried out in line with national guidance. It's important to consider the involvement of GPs and dentistry, especially with a GP joining the commissioning group. A communication plan is needed to address these changes. Additionally, a 7-minute briefing has been produced for GPs. Board-led reviews with wider relevant learning would be shared at CP and shared across Leads groups. Within ASP, health representatives on the Case Review Working Group are notified in accordance with Learning Review guidance. There is participation from the relevant health teams and the ASP training coordinator, however there is an identified gap in the learning being shared with no clear structure in place for disseminating this information. ASP reports are completed by services and submitted, with a Datix report also being

					generated. However, there is no established structure for reviewing these reports, ensuring consistency and standardisation, or closing the feedback loop. Again, this will be addressed by ASPHSG.
5.6 There are clear whistleblowing procedures and a policy for dealing with complaints against employees and contractors.					There is a whistleblowing procedure, with champions in these areas. Whistleblowing training is mandatory for all staff and there is regular communication and promotion of this procedure across blink and weekly newsletter communications.

Please provide an overall summary assessment on the extent to which our Public Protection Standard 5 has been implemented, identifying areas of strength and key barriers.

Strengths

- Robust CP governance arrangements are in place, including an escalation process through exception reporting and a Child Death Hub Review Group.
- The CP Lead Nurse if the NHS24 link as part of the CP LN role.
- CP and ASP are mandatory – both for induction and as ongoing training.
- Once for Scotland policies require PVG compliance for all recruitment.
- IJB risk is currently on the risk register with an action plan for improvement

Barriers

- There are gaps in representation of the CP and ASP HSGs.
- The ASP protocol needs to be reviewed and an audit tool developed.
- Individual services need to conduct CP audits and there is a gap in audit process reporting to the CPHSG.
- There is limited capacity to address the governance gaps evidenced in ASP

Please cite any planned self-improvement work

- CS SLWG progressed with wide CS representation to produce draft audit tool which meets requirements of new electronic child health record
- CP adverse event reporting under review
- Appointment of permanent CP Learning & Development Coordinator.
- A learning review of ASP training and development of a competency framework is underway.

Public Protection Standard 6: Education, learning, and development arrangements support all NHS employees, GP practices, and independent contracted practitioners in their public protection roles and responsibilities (page11).							
Applicable Care Inspectorate Quality Indicators Joint Inspection Children's Services:	**Applicable Care Inspectorate Quality Indicators**	**United Nation's Convention of the Rights of the Child (UNCRC)**	**Achieved**				
3.1, 5.1, 5.2, 5.3, 7.2, 9.3		**Articles: 1,2,3,6,12,19,23,24,25,32, 34-36,39,40,42,**	**In Full**	**In Part**	**Not At All**	**Not applicable**	**Key data and evidence that provides assurance around this standard**
Evidence							
6.1 Our Health Board has an organisational training strategy that ensures all our employees and contractors are competent to carry out their public protection responsibilities in line with national child protection guidance and Adult Support and Protection Code of Practice and reporting arrangements are in place to secure organisational assurance around this							A CP L&D coordinator was appointed in August 2023, this post moved under the CS QI team in January 2024 with a wider CS remit. The L&D coordinator represents NHS Fife at the CPC L&D working group. A CP training strategy is in development. There is oversight of CS CP training at the monthly CS governance meeting. The CP team reports on the number of training sessions offered. Children's services have piloted a database to capture more robust information regarding additional CP training and hours, however this requires further review. A CP Training Needs Analysis was carried out in 2023 to identify gaps in CP learning and repeated in 2024. A GP CP Training Needs Analysis was carried out in 2024. An outcome from this is to hold a GP CP Update during designated PLT time in 2024 organised by the LP CP and GP Lead. There is currently no explicit training plan in place for ASP with one staff member responsible for managing the training needs of

					NHS Fife/H&SCP. We are reviewing all available training options. there is Multi-agency training available; however there is no clear pathway for health staff. Training is mandatory on TURAS and is compliance is reported through the Staff Governance Committee.
6.2 Public protection is a mandatory aspect of induction for all our employees, GP practices, and contractors. Public Protection training is available on a single and multi-agency basis and senior managers monitor attendance and non-attendance at training.					CP and ASP are mandatory courses for completion on Turas for all health board staff. CP and ASP moved to the NES online training for Level 1 and Level 2 in February 2023. CP induction training was updated in 2023. A Child Protection Training Program was developed by the L&D Co-ordinator and launched in 2024. Multiagency CP training programme was launched in 2023 to which there is wide health service contribution. ASP, NES e-learning modules at both level 1 and level 2 are available on TURAS. Discussion regarding core and mandatory training are ongoing. There is a gap in oversight of CP training attendance across wider services. It is proposed that services report via CPHSG as part of evidence gathering for the PP&AAF.
6.3 All relevant staff have access to child and adult protection supervision at an appropriate level for their role to support continuous professional development.					Robust CP supervision is provided to VIP W team and FN as per licence. Regular group supervision is provided for Health Visiting, HV and SN TLs. Other CS and Addictions Services receive supervision via their portfolio holder although this has been limited for several years due to capacity. On request 1 to 1 supervision and group supervision across services is available on request. The LNCP is seeking funding from HV services to support HV supervision. The LNCP & CPLP have progressed joint case CP reflective supervision sessions in 2023, this included a session with the Sexual health team inc GBV. The CPLP reestablished 6 monthly multiagency case supervision for staff in 2023.

					There is limited means for LNCP and LPCP to obtain appropriate CP supervision relevant to the role. The Scottish Nursing Leadership Child Protection group are exploring an identified national gap. The CPLP attends MCN physical and CSA peer review, with access to peer supervision with CP Paediatrician colleagues. There is an identified gap within ASP due to capacity.
6.4 Our organisational assurance reflects NHS employees and contractors are trained to the appropriate level, dependant on their role, in line with the Transforming Psychological Trauma Knowledge and Skills Framework, using guidance in the Scottish Psychological Trauma Training Plan.					The LNCP/deputy, GBV Coordinator, CAMHS, Psychology and addiction services are core members of the multiagency Fife trauma steering group. Children's Services governance arrangements oversees mandatory trauma-informed training across the Children's Service workforce. The LP has progressed trauma-informed training in collaboration with psychology for paediatric services There is no clear governance process around this out with children services, therefore a gap identified.

Please provide an overall summary assessment on the extent to which Public Protection Standard 6 has been implemented, identifying areas of strength and key barriers.

Strengths

- Appointment of CP L&D Coordinator to help with training backlog.
- NES ASP training is available on Turas and CP is using the NES e-learning modules level 2.
- ASP multiagency training is available but scaled back from 2020.
- Vulnerability is covered in CP training.

Barriers

- There is a backlog in CP and ASP training with minimal single agency training provided due to staffing constraints.
- No multiagency training in CP is available.
- There is no ASP training plan in place – this will be reviewed by ASPHSG
- There is a limited capacity to review a learning framework in ASP and build confidence and competency within the workforce.

- It is unclear whether all NHS employees and contractors are trained in CP or ASP to an appropriate level due to a lack of agreement.
- No audit is in place

Please cite any planned self-improvement work

- CP training strategy in development
- CP Training Needs Analysis in 2024.
- CS SLWG progressed with wide CS representation to produce draft audit tool which meets requirements of new electronic child health record.
- audit findings and self-evaluation activity to be reported by services via CPHSG as part of evidence gathering for the PP&AAF.
- oversight of CP training attendance across wider services via CPHSG as part of evidence gathering for the PP&AAF.
- Review of Children's services CP training database pilot
- Scoping of a CP supervision model
- Progress a SCPNA 0.3WTE funding from HV services to support HV supervision model
- LNCP to progress any supervision progressing from The Scottish Nursing Leadership Child Protection group as part of the identified national gap.

Public Protection Standard 7: Strategic and operational arrangements between the Health Board and its multi-agency partners support effective joint working and communication (page12).							
Applicable Care Inspectorate Quality Indicators Joint Inspection Children's Services:	**Applicable Care Inspectorate Quality Indicators/ Adult Support and Protection:**	**United Nation's Convention of the Rights of the Child (UNCRC)**	**Achieved**				
3.1, 5.2, 6.1, 6.2, 6.5, 7.2, 9.2, 9.3	**QI. 2.3, 1.4, 1.5, 1.6, 1.7, 1.8 Theme 1, 2, 3, 4 and 8**	**Articles: 1,2,3,5,6,7,9,12,13,16,18,19,20, 22-25, 27,34-36,39,40,42**	**In Full**	**In Part**	**Not At All**	**Not applicable**	**Key data and evidence that provides assurance around this standard**
Evidence							
7.1 There is appropriate and consistent Health Board representation on our Chief Officer Groups and Child Protection/Adult Protection Committees / MAPPA Strategic Oversight Group (SOG) with specified reporting mechanisms to our Health Board.							Executive Lead and Lead Officer attends Public Protection Committees, CPLN attends Lead meetings, ADON attends Health ASP leads group. Reports are taken through Clinical Governance and Public health and Wellbeing Committees. MAPPA SOG is attended by Senior Manager within Mental Health, however there is a gap identified for the reporting mechanism to the board.

7.2 There is appropriate health representation in our Inter-agency Referral Discussions (IRDs), Child Protection Planning Meetings, Adult Protection Case Conferences, Learning Review meetings, and MAPPA Level 1-3 meetings and case review meetings, in line with national guidance.					There is a KPI of 100% for health attendance at CP IRDs. Feedback from Social Workers indicates that health professionals regularly participate in CPPMs. There is no governance process to give oversight and assurance across wider services, proposed progression via CPHSG as part of evidence gathering for the PP&AAF. The CPLN, LPCP and CS Senior manager are members of the CPC case review working group. ASP IRD's involve appropriate health representation. Senior staff from the MH forensic services attends MAPPA meetings, being members at the self evaluation and training groups.
7.3 There are systems in place to allow our clinicians including, for example, midwives, paediatricians, health visitors, mental health and addiction staff and GPs etc. to attend when appropriate. Support and guidance are provided to our Board representatives attending these meetings.					GIWDG are updating all policy and procedures in line with the new CP guidance. Health IRD operating model has been reviewed as a PDSA pilot in 2024 with associated named person and SN IRD training. NHS Fife participated in pilot of national IRD training in 2023. There is new MA training in relation to CPPM for 2024. CP advice line and on request supervision in relation to CP meetings is available to all NHS staff. There are no formal processes or structures in place for ASP to provide guidance and support for staff attending these meetings.
7.4 There is a process in place for learning from reviews and from inspection findings. Learning is shared across our Health Board, contracted services, and acted on.					Learning from reviews for CP, whatever the source, is shared widely across services and when relevant, single service, single agency and multi-agency improvement plans are put in place.

					CP learning reviews are progressed in line with national guidance. Work is being taken forward by the ASPHSG for sharing and disseminating learning from ASP learning reviews. Within FHSCP there are discussions at service QMAGs, however work is required to ensure this standardised approach across all areas. There would also require to be a similar and agreed approach with all other areas of the board.
7.5 Health engagement in all risk assessment processes i.e. identifying, analysing, evaluating, and controlling risk is monitored and reviewed with a clear reporting mechanism to our executive Health Board lead.					Health staff routinely contribute to key CP processes including risk assessment. Risk assessment and analysis training has been reviewed and incorporated into CP training program for 2024. This is mandatory for all health named persons. Datix risks involving children are reviewed by LNCP with wider service oversight and action plans taken to CS governance and CPHSG/joint acute group to mitigate risk. Organisation risks are captured via Datix. Within ASP, the Senior Manager attend the Case review working group, which reviews cases on a multi-agency platform. Processes are needed to ensure that required learning and risks are shared and upheld throughout the wider health board.
7.6 Our Health Board ICT systems allow sharing of information about our children and adults for whom there are concerns, and ICT systems allow flagging where there is a concern. children and adults for whom there are concerns					A SOP exists for flagging children and families involved in the CP process as part of CP messaging, which undergoes regular reviews. There is no process for LAC alerts. A gap is identified in relation to a digital platform to support integrated chronologies and sharing of information and this should be identified as a risk.

7.7 Our Health Board is a key contributor to local, multi-agency analyses of child and adult protection data (for example the Minimum Dataset for Child Protection Committees to ensure that data and intelligence held by health is shared with multi-agency partners and helps build a shared understanding of our local needs and service responses.					Health CP datasets are reported via the CPC Quality assurance and data group. Consideration has been given to any additional health data to further support the minimum dataset. CP team have progressed databases for all 4 core functions in 2023. Information within health ASP is minimal, with a requirement to mature and progress this dataset for further sharing with multi-agency partners.

Please provide an overall summary assessment on the extent to which Public Protection Standard 7 has been implemented, identifying areas of strength and key barriers.

Strengths

- Appropriate Lead Officers attend Chief Officers' Groups.
- Health professionals regularly participate in IRDs and case conferences and attend MAPPA meetings.
- There are clear whistleblowing procedures and champions.
- Board-led reviews are shared with both CP and ASP.

Barriers

- There is an inconsistency with the attendees at senior group meetings
- Information-sharing protocols need to be reviewed.
- There is no monitoring system in place for risk assessment processes.
- Information shared within ASP is ad hoc.

Please cite any planned self-improvement work

- Oversight of CPPM via CPHSG as part of evidence gathering for the PP&AAF.
- Datix risk re digital platform for CS for integrated health chronologies
- Review of new CP datasets to ensure meaningful data capture
- Processes to learn from CP and ASP reviews are being developed.

Public Protection Standard 8: The Health Board provides an effective medical response for children and adults in need of assessment and care							
Applicable Care Inspectorate Quality Indicators Joint Inspection Children's Services:	**Applicable Care Inspectorate Quality Indicators**	**United Nation's Convention of the Rights of the Child (UNCRC)**	**Achieved**				
1.1, 2.1, 2.2, 5.1, 5.2,5.3, 6.1, 8.1,		**Articles 1,2,3,5,6,12,13,16,18,19,20,23,24,25,27,34 -36, 39, 42**	**In Full**	**In Part**	**Not At All**	**Not applicable**	**Key data and evidence that provides assurance around this standard**
Evidence							
8.1 Arrangements are in place to provide assessment for child abuse and neglect, including joint paediatric/forensic medical assessment examinations (JPFE) when required. This also includes FME arrangements for adults following rape and sexual assault							Guidelines are present for consenting children and young people for medicals, with further guidelines on joint approach to assessment and report writing. There are guidelines, protocols and SLA managed by GBV re adult forensic services.
8.2 Medical assessments are conducted in line with sections 9 and/or 11 of the Adult Support and Protection (Scotland) Act 2007 where a Council Officer knows or believes a person is an adult at risk of harm. The assessment may be conducted under an assessment order, if the court has granted an order for a health professional nominated by the council to conduct a private medical examination of the specified person							No Assessment orders have been applied for in Fife. Medical assessments would be carried out in line with Section 9 and/or 11 of the Act.
8.3 Assessment and care arrangements draw on best practice contained in the Child Protection Scottish National Clinical Guidelines.							National Proforma's used in assessing Children and Young People in Child protection medical examinations. Use of GIRFEC tools and neglect toolkits to enable holistic assessments.
8.4 There are clear assessment pathways for accessing assessments of capacity to contribute to protection decisions, including decisions relating to the use of Adult Support and Protection, Adults with Incapacity, and/or Mental Health (Care and Treatment) (Scotland) Act 2003 legislation.							Guidance is available on BLINK or referral pathways for vulnerable adults. There are clear assessment pathways to access Mental Health Services though an individual's GP, Mental Health Nurses in Primary Care and Urgent Care Assessment and Treatment Services (UCAT), this can involve the use of MHA legislation.

					However currently accessing assessment for capacity is limited, with this being known and discussed at the national leads meetings and is under review.
8.5 There is access to appropriately trained medical staff during out of hours periods when there is a requirement for paediatric examination, medical assessment, or a JPFE.					There is a service level agreement with Lothian in place for out of hours medical assessment, QMH has a medical assessment suite, with staff being appropriately trained.
8.6 Processes are in place within Emergency Departments and acute receiving units to respond to suspected abuse and neglect of children and vulnerable adults, with appropriate information sharing mechanisms to support clinical staff and named persons to work in line with Getting it right for every child/everyone.					Guidelines are available on BLINK with induction training to ED staff with lead CP clinician in ED. There are good links with Child wellbeing liaison nurse to ED to pick up any well being concerns and escalate concerns to child protection if necessary. There are quarterly reports within the governance reporting structure to evidence this. Health raised IRDs progressed in 2024 as part of the new national guidance for CP and to fill the gap from SW discontinuation of NOCC, to be replaced by SW referral form. The Graded Care, evidenced based neglect assessment tool is in use across Health Visiting and is now progressing wider within Children's Services
8.7 Medical assessment and care responses are monitored and reviewed with a clear reporting mechanism to the executive Health Board lead.					There is a requirement for national reporting mechanism for those undergoing CSA examinations in keeping with HIS standards. Data on individuals undergoing all CP examinations is collated and reported to executive health board lead; this includes the annual injuries in under 2's audit. There is an identified gap with ASP adult health medical assessments (other than rape/sexual assault) with there being no structure to currently collate this information or report on this to the lead.

Please provide an overall summary assessment on the extent to which Public Protection Standard 8 has been implemented, identifying areas of strength and key barriers.

Strengths:

- There are guidelines for a joint approach to CP assessment and report writing.
- Graded Care (evidence-based neglect tool) is in place across Health Visiting and Children's Services.
- National proformas are used in assessing children and young people in CP medical examinations.
- GIRFEC enables holistic assessment.
- Guidance is available on Blink for ASP referral pathways.
- There are clear assessment pathways to access Mental Health Services.
- There is a service-level agreement with NHS Lothian for out of hours medical assessment and staff are appropriately trained.
- There are CP guidelines on Blink for ED staff and a lead CP clinician in ED.
- Good links exist between the Child Wellbeing Liaison Nurse and ED to pick up and escalate concerns to CO if necessary.
- Medical assessments are carried out in line with ASP legislation (there have been no Assessments Orders applied for in Fife to date).
- Data on all CP examinations are collated and reported to the Executive Health Board lead.

Barriers:

- No structure to currently collate information for ASP on medical assessments and evaluation or report on this to the board – again will be taken through ASPHSG.

Please cite any planned self-improvement work

- Progression of health raised IRDs pathway
- Comms and training program to compliment the change to SW referral form from CWP refresh and discontinuation of NOCC

NHS Fife

Meeting:	**Clinical Governance Committee**
Meeting date:	**2 May 2025**
Title:	**Patient Experience and Feedback Report**
Responsible Executive:	**Janette Keenan, Executive Director of Nursing**
Report Author:	**Siobhan McIlroy, Head of Patient Experience (HoPE)**

Executive Summary:

Stage 1 Complaint:

- Average days to close a stage 1 complaint decreased from 8 days in Q3 to 3 days in Q4
- 6% increase in Stage 1 complaints closed in Q4 compared to Q3
- Increase in the number of Stage 1 complaints closed on time from 39 in Q3 to 46 in Q4, with an 18% improvement

Stage 2:

- 29% increase in Stage 2 complaints opened in Q4 (101) compared to Q3 (78).
- Total number of Stage 2 cases closed remained the same in Q3 and Q4 (82 cases).
- Significant delays in obtaining final responses and statements.
- There were 7 stage 2's over 100 days open in January decreasing to 3 in March, indicating efforts to resolve long-standing cases.
- Increase in the average number of days to close a stage 2 complaint, January (37), February (48) and March (58). Indicating the impact of delays and significant pressures withing PET and Services.

SPSO:

Implementation of Objective Connect System to securely transfer files to SPSO.

Care Opinion:

- 420 stories received
- 428 responses provided
- Stories viewed 36,686 times.
- 85% of stories were completely positive, above the 75% average.

1 Purpose

The purpose of this paper is to provide an update on patient experience and feedback, and to describe work being taken forward to present a more rounded picture of patient experience, ensuring improvements are made and are featured in future reports.

This report is presented for:

- Assurance
- Discussion

This report relates to:

- Emerging issue
- Government policy / directive
- Local policy
- NHS Board Strategic Priority/ies – To Improve Quality of Health & Care Services

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

- Person Centred

2 Report summary

2.1 Situation

Patient complaints are reported monthly through the Fife Integrated Performance and Quality Report (IPQR). The indicators are identified as:

- Stage 1 Closure rate (target 80%)
- Stage 2 Closure rate (target 60% by 31st March 2025)

Whilst concern has been raised about the level of performance, these indicators do not adequately capture patient experience and a review is underway to ensure that the quality of patient experience is described, and to improve the complaint handling performance in line with national timeframe standards.

2.2 Background

Person centred care is about ensuring the people who use our services are at the centre of everything we do. It is delivered when health and social care professionals work together with people, to tailor services to support what matters to them. It is about:

- respect for patients' values, expressed needs and preferences
- coordination and integration of care
- communication, information, education,

- physical comfort
- emotional support
- involvement of family and friends

How do we know we are getting it right?

DEFINING THE PATIENT EXPERIENCE

Patient experience is based partly on the patients' and family's *expectations* of what is about to happen and the *cumulative evaluation* of their journey through our system.

- We have opportunities to delight or disappoint based on their clinical and emotional interactions with us, and their interactions with our staff, our processes, and the environment

MEASURING THE EXPERIENCE

Currently, 'patient experience and feedback' is captured through:

- Care Opinion
- Compliments and comments
- Complaints
- Initiatives, such as the Care Experience Improvement Model
- MS Forms Questionnaires / Surveys

Moving forward, we will also make use of:

- Surveys e.g. Your Care Experience
- Focus groups / Lived Experience groups
- Post discharge / appointment phone calls
- Warm welcome / fond farewell
- Care Assurance processes, for example:
    - Shadowing / observation
    - Walkarounds
    - 15 step challenge

IMPROVING THE EXPERIENCE

It is important to analyse the data, identifying themes and any issues:

- Develop and share goals and targets based on data
- Assess processes
- Create an enabling infrastructure:
    - Framework
    - Leadership
    - Education and training
- Engage staff, patients, families, and carers in improvement work

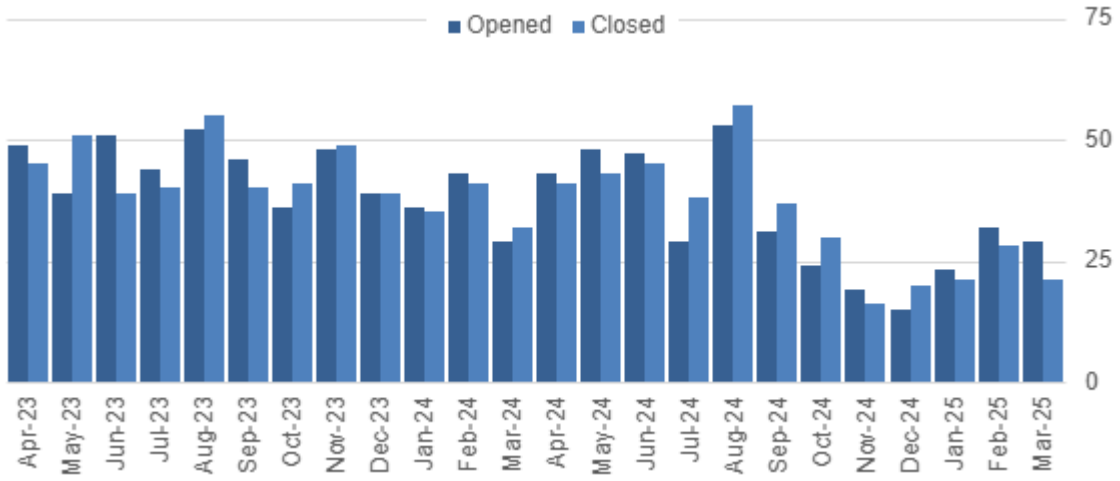
2.3 Assessment

Stage 1 Complaints, Concerns and Enquiries

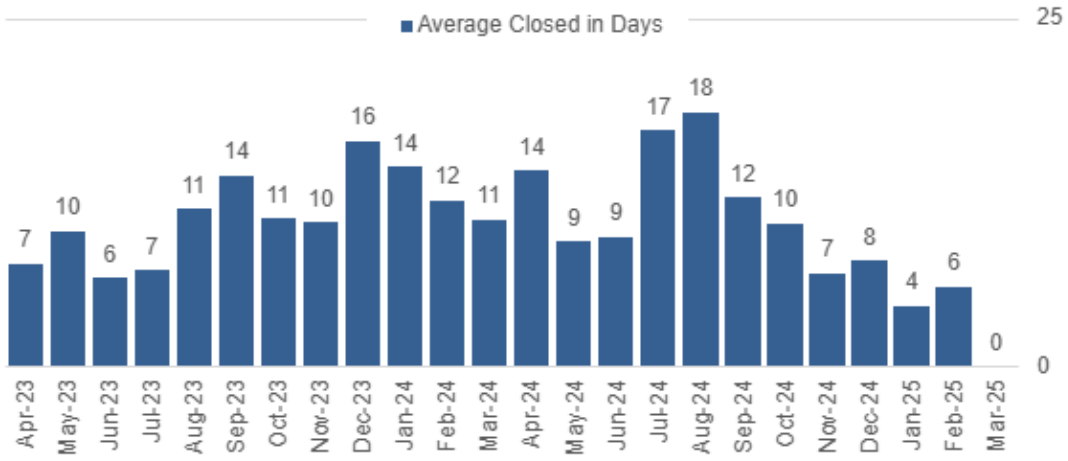
There has been a continued focus within the Patient Experience Team and the Service regarding early complaint resolution. All Services are aware and reminded of the importance of resolving Stage 1 complaints locally within the five working days. Direct

dialogue between the Services and the Complainant is crucial for maintaining a high level of patient experience and satisfaction. This proactive approach to complaint resolution will help to achieve the 80% target timeframe. Local resolution also eliminates the need for a written response from the Patient Experience Team, which can add extra steps and potential delays to the process.

In Q4 there were 84 Stage 1 complaints opened compared to 58 opened in Q3 which is a 45% increase. Additionally, the number of stage 1's closed saw a 6% increase, 66 closed in Q3 compared to 70 closed in Q4.



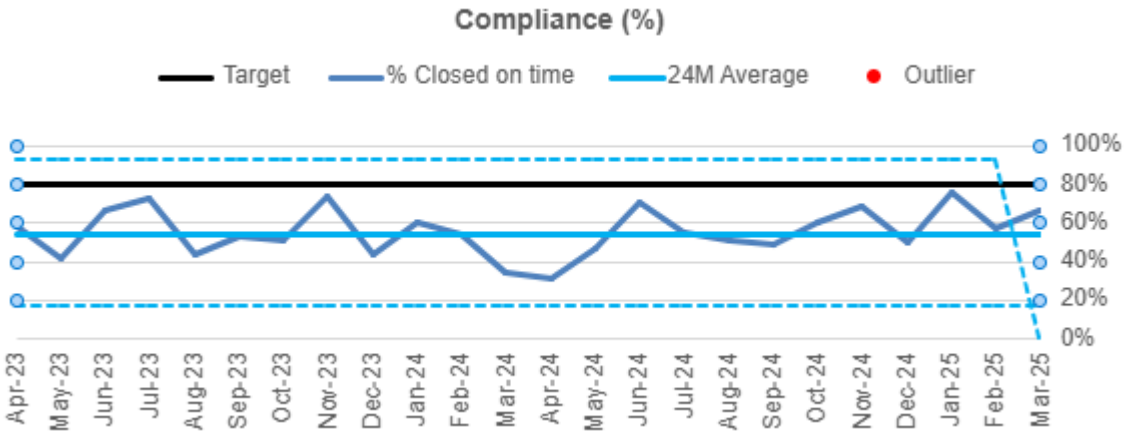
In Q3, the average number of days to close Stage 1's was 8.33 days. In Q4, this significantly decreased to 3.33 days. Representing a 60.00% decrease in the average number of days to close Stage 1's from Q3 to Q4. The significant reduction in the average closure time indicates an improvement in efficiency and effectiveness in managing stage 1 cases during Q4 compared to Q3.



The target timeframe for Stage 1 complaints is 80%. In Q3, the total number of stage 1s closed on time was 39, while in Q$, it was 46. This represents an improvement in the number of stage 1s closed on time in Q4 compared to Q3.

The percentage of cases closed on time changed from an average of 59.60% in Q3 to an average of 66.67% in Q4. This indicates an improvement of 11.86% in stage 1s closed on time in Q4 compared to Q3.

The data for January (76%), February (57%), and March 2025 (67%) indicates that the target of 80.0% closed on time was not met in any of these months, although there were improvements compared to the previous year's performance.

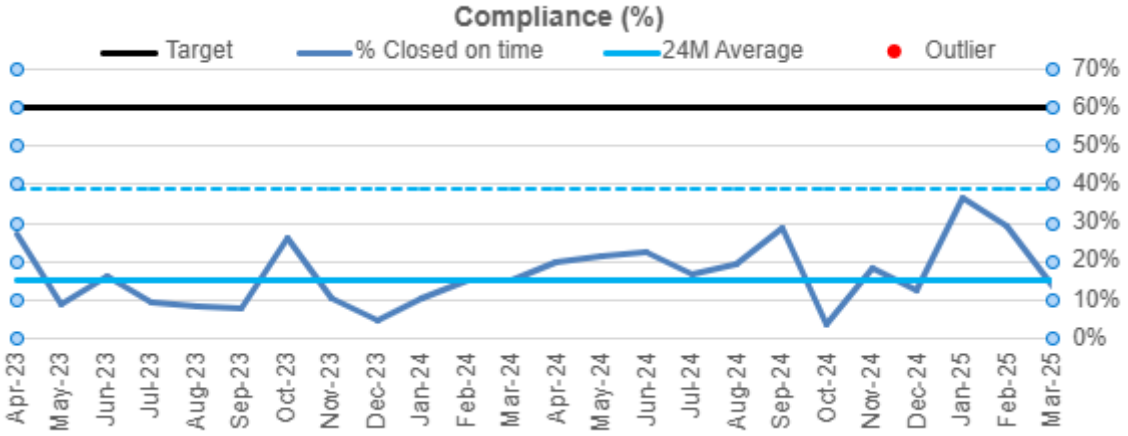


Stage 2's Complaints

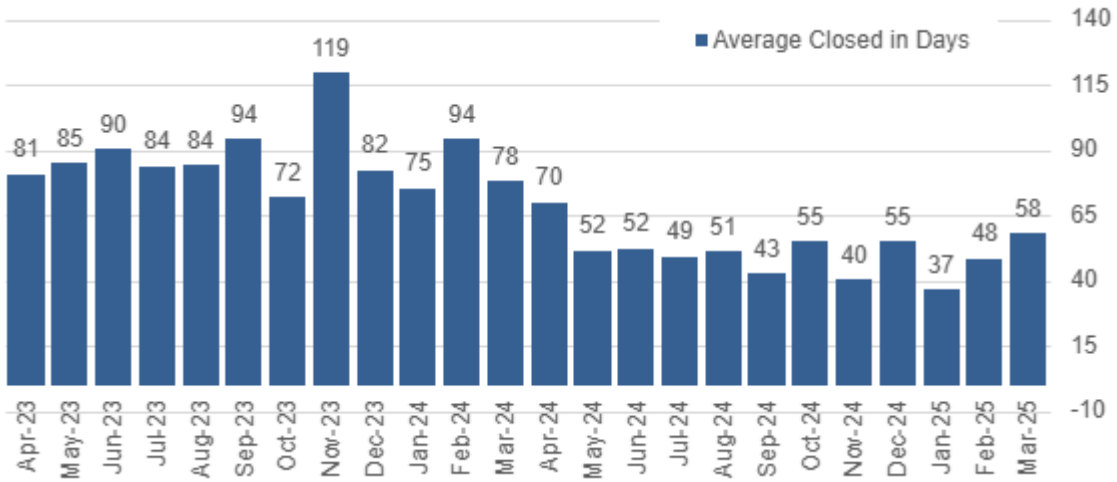
The Patient Experience Team are also collaborating with the Datix team to implement a feature that automatically calculates the number of days taken for the Patient Experience Team to draft a response. Currently, this calculation is done manually making it inefficient and time-consuming. Automating this process will enable the Patient Experience Team to assess the average time taken to draft a complaint response and identify areas for improvement.

Q4, demonstrates consistent performance in acknowledging stage 2 complaints on time: In January 2025, all 35 complaints opened were acknowledged on time (within 3-working days), achieving a 100.0%. In February 2025, out of 33 complaints opened, 32 were acknowledged on time, resulting in a 97.0% acknowledgment rate. In March 2025, all 33 complaints opened were acknowledged on time, again achieving a 100.0% acknowledgment rate.

The percentage increase in the number of stage 2 cases opened from Q3 (78 cases) to Q4 (101 cases) is 29.49%. This indicates a significant rise in the number of cases opened in Q4 compared to Q3. The total number of stage 2 cases closed remained the same, with 82 cases closed in both Q3 and Q4.



In January the average number of days to close a stage 2 complaint was 37 days, 48 days in February and 58 days in March 2025. Highlighting the ongoing challenges faced in maintaining timely resolutions as the quarter progressed.



The percentage closed on time for Q4 is as follows:

	2024	2025	Difference
January	10.5%	36.4%	25.9
February	15.2%	29.0%	13.8
March	15.0%	13.8%	-1.2

Overall, the data indicates significant improvements in January and February 2025 compared to the previous year, with notable increases in the percentage of cases closed on time. However, March 2025 saw a slight decline, suggesting potential areas for further improvement.

The distribution of open cases across different timeframes in Q4. The number of cases open for <=20 days fluctuated throughout the quarter, with January having the highest number at 33 cases. The number of cases open for >101 days decreased from January (7) to March (3), indicating continued efforts to resolve long-standing cases.

Still experiencing significant delays with obtaining final responses and statements. As of the end of March 2025, 42% of stage 2 complaints were awaiting final approval and

32% awaiting statements with 17% of stage 2 complaints with the PET for drafting and further processing.

Scottish Public Services Ombudsmen (SPSO)

In Q3, there were 4 new SPSO cases were received, 3 decision, 3 cases were upheld, zero cases not upheld, and two cases not taken forward.

At the end of March 2025 there are 12 SPSO cases at investigation and 4 at final decision. Nine are with the SPSO for review, 5 are with the service for review and comment, 2 are with PET.

The SPSO have implemented a Support Intervention Policy (SIP) for cases that are delayed. In Q4 there was 1 case with a SIP-1, 2 cases with a SIP-2, and zero cases with a SIP-3-5. The Head of Patient Experience, Patient Experience Lead and Senior Administrator meet weekly to review and escalate cases.

Objective Connect system is now in place and supports healthcare records and complaint files to be transferred securely and electronically to the SPSO.

Additional fields have been added to Datix to provide data regarding SPSO status of complaints. Discussion continues regarding this information being added to the Complaint Dashboard.

Care Opinion

The promotion of Care Opinion within the Organisation continues with the Patient Experience Team regularly visiting clinical areas to offer support, training, and guidance, along with sharing good practices from other regions. Responders are encouraged to add the photograph to their profile page to help those telling their story on Care Opinion feel like they are conversing with a real person and that staff are reaching out to them from one human being to another. A profile picture makes staff more visible and more human, bringing comfort and ease to the person reading it and removing any confusion about who is responding.

The Patient Experience Team are in the process of recruiting a Volunteer to support the promotion and gathering of patient stories. The plan will be to focus on hearing patients' stories from those that are currently not being heard, specifically targeting, and engaging with minority communities, children and adolescents, and individuals facing mental health challenges. In addition, the Patient Experience Team will support and promote Care Opinion within services that have not yet engaged with it.

The Quarter 3 report was extremely positive. From January to March 2025, NHS Fife received 420 stories, which received 428 responses and were viewed 36,686 times. A total of 85% of the stories were completely positive, above the 75% average with the remaining having some level of criticality ranging from minimal 5% (17), mildly 9% (31) to moderate 2% (8).

This report provides the following Level of Assurance:

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

2.3.1 Quality, Patient and Value-Based Health & Care

Analysing data will lay the foundation for quality improvement work. More work is required by PET and Services to review themes, trends and lessons learned from complaints and adverse events, which can be triangulated with activity and staffing resources.

Analysing data from patient experience feedback offers significant insights into improving the quality of care and services. This process, when combined with regularly reviewing themes, trends, and lessons learned, can help the services and wider organisation identify critical areas for improvement and help develop strategies to enhance patient experience, safety, and outcomes.

2.3.2 Workforce

Workforce planning

Currently, the team establishment consists of a 1.0 WTE Band 7 interim team leader, 2.6 WTE Band 6 Patient Experience Officers, 1.0 WTE Band 4 Patient Experience Support Officers, 2.07 WTE Band 3 Patient Experience Administrators, and 1 Band 4 Senior Patient Experience Administrator. A Band 6 Bank (retired) Patient Experience Officer (0.27 WTE) continues to support drafting complaint responses. 1.0 TWE Band 7 and 0.8 WTE Band 4 are currently deployed out with PET which is challenging.

Discussions have taken place with the Volunteering Lead, to recruit Volunteers to support in gathering patient feedback in the form of Care Opinion and Lived Experiences. There is one candidate who has now competed the recruitment process and is currently undertaking training.

2.3.3 Financial

n/a

2.3.4 Risk Assessment / Management

Complaints handling and learning from complaints are vitally important in reducing reputational risk as it enables the organisation to address issues proactively, improve

services, communicate transparently, build trust, comply with regulations, fostering a culture of continuous improvement. Actively contributing to a positive reputation and a stronger more resilient organisation.

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

People can expect to experience integrated care and support services that are underpinned by a Human Rights Based Approach, in which:

- People's rights are respected, protected and fulfilled.
- Providers of care clearly inform people of their rights and entitlements.
- People are supported to be fully involved in decisions that affect them.
- Providers of care and support respect, protect and fulfil people's rights and are accountable for doing this.
- People do not experience discrimination in any form.
- People are clear about how they can seek redress if they believe their rights are being infringed or denied.

2.3.6 Climate Emergency & Sustainability Impact

n/a

2.3.7 Communication, involvement, engagement, and consultation

NMAHP leadership group has been involved in discussions and improvement action planning.

2.3.8 Route to the Meeting

Update from Patient Experience Team
Direct report to Executive Nurse Director

2.4 Recommendation

Members are asked to take a **"moderate" level of assurance** from the report.

3 List of appendices

- Appendix 1 - PEaF Quarterly Report (Q4) for Clinical Governance Committee

Report Contact
Siobhan McIlroy
Head of Patient Experience
Email: Siobhan.mcilroy@nhs.scot

Patient Experience and Feedback

PEaF Quarterly Report (Q4) for Clinical Governance Committee

January - March 2025

CONTENTS

Introduction

Person-centred Care

Person-centred care is about ensuring the people who use our services are at the centre of everything we do. It is delivered when health and social care professionals work together with people, to tailor services to support what matters to them. It is about:

- respect for patients' values, expressed needs and preferences
- coordination and integration of care
- communication, information, education,
- physical comfort
- emotional support
- involvement of family and friends

Measuring the Experience

Care Opinion highlights the 25 organisations across the UK, with the highest number of staff listening, learning, and making changes. NHS Fife is one of the top performing NHS Boards in Scotland.

NHS Fife's **Care Opinion** highlights for Q4 include:

- **420** stories, viewed **36,686** times in all:
    - January 139 stories (147responses) (Read, 7,372)
    - February 114 stories (107 responses) (Read, 6,602)
    - March 167 stories (181 Reponses) (Read 9,318)

In Q4, Care Opinion moderators rated the stories as:

- Not critical 85% (307)
- Minimally critical 5% (17)
- Mildly critical 9% (31)
- Moderately critical 2% (8)

An important aspect of Care Opinion is the ability to feedback information to patients on changes which have been made. Three Care Opinion stories where published where a change within a service was identified.

Positive and Negative Themes

What was good?

What could be improved?

Compliments:

'Compliments', another vital component of patient feedback, is not routinely reported on. There is a 'compliments' section in the Datix Complaints module, which is not widely used, and the following table only provides a small glimpse of positive patient feedback. Many Services collect their own feedback; MS Forms questionnaires, paper feedback forms etc.

It is hoped that the 'compliments' module will become more widely used as staff are encouraged to record compliments, celebrating, and learning from success.

Compliments	24/25 Q1	24/25 Q2	24/25 Q3	24/25 Q4	Total
Compliment	302	306	321	165	1094
Learning from Excellence	0	0	0	0	0
Comments and Feedback	3	3	2	5	13
Total	305	309	323	170	1107

Compliments	24/25 Q1	24/25 Q2	24/25 Q3	24/25 Q4	Total
Acute Services Division - Planned Care & Surgery	133	150	146	82	511
Acute Services Division - Emergency Care & Medicine	45	50	43	35	173
Acute Services Division - Women, Children and Clinical Services	23	6	22	8	59
Community Care Services	37	35	75	14	161
Primary and Preventative Care Services	29	28	20	12	89
Complex and Critical Care Services	7	8	7	5	27
Corporate Directorates	0	1	1	0	2
No value - Miscellaneous	28	28	7	9	72
Total	302	306	321	165	1094

Comments:

TO WARD 31(Orthopaedic) thank you all so much for making me feel so welcome and part of your team. you have all shown me so much kindness which has made my experience on the ward amazing.

Thank you for all your hard work I could not get through it without you all. Urology - Surgical

Hi, I presented to victoria hospital kirkaldy on monday 3rd march. From the moment i arrived i recevied exceptional care and support. Your staff where outstanding and very efficant under a very busy enviroment. I just want to say they are all valued and thank all staff in a&e and assesment ward 2. Thank you NHS Fife

Words cannot express how much we as a family appreciate the love and care "pt" received whilst in your care at the Hospice. It is such a welcoming caring environment that is felt as soon as you walk through the doors. It takes a special type of person to work in a Hospice. You are all amazing. Palliative Care Inpatient

For the love, care and attention displayed towards our mother- Lilian. We know that you all took her to your hearts and that assisted greatly in our coming to terms with her passing- you are all indeed a group of angels and we salute you.' Medicine for the Elderly

Physiotherapy Department, Whyteman's Brae Hospital. Physiotherapist was very encouraging and the exercises and walking aids got me back on my feet and walking again. Thank you to NHS. I am most grateful.

The care that they received on the ward in the days after operation was also excellent, particularly the time spent by staff teaching how to breast feed. Patient hopes that all those who work in these services remember the fantastic work they do, despite the often unfair media reports about maternity services. Their skills have resulted in a healthy baby family are eternally grateful for this. Maternity

We just wanted to say a huge thank you to all the doctors and nurses and staff that looked after our dad, he wads in and out of ward 54 a few times over the years and all took the time to chat and have a laugh with him. Dad sadly passed away I your ward and will sorely missed

Complaints:

There are two stages to the NHS complaints procedure:

1. Early resolution
2. Investigation

Stage 1: Early resolution

The focus is on finding a solution quickly and locally if possible. If the complaint cannot be resolved at stage 1, or if the complainant is not happy with the outcome of stage 1, the complaint should be moved on to stage 2.

Most complaints should be resolved within five working days of the date the complaint is received. In some circumstances, this can be up to ten working days.

Stage 2: Investigation

Complaints might be handled at stage 2 because:

- They are complex, serious or high-risk issues and are not suitable for early resolution
- early resolution has failed
- the complainant was unhappy with the outcome of stage 1 and asked for an investigation.

The complainant should receive a written response within 20 working days.

This table presents the total number of Enquiries, Concerns, Stage 1, and Stage 2 complaints received each quarter:

Records logged in Datix Complaints module – 01/10/2024 - 31/12/2024	24/25 Q1	24/25 Q2	24/25 Q3	24/25 4	Total
Stage 1 Complaint	142	116	63	81	**402**
Stage 2 Complaint	79	82	75	96	**332**
Concern	162	175	177	156	**670**
Enquiry	111	103	78	91	**383**
Total	**494**	**476**	**393**	**424**	**1787**

Stage 2 closed complaints and % closed within the 20-day standard timescale.

CLOSED COMPLAINTS	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Total	30	14	27	42	26	28	28	22	32	22	31	29
Average Closed in Days	70	52	52	49	51	43	55	40	55	37	48	58
Closed within timescales	6	3	6	7	5	8	1	4	4	8	9	4
% Closed within timescales	20.0%	21.4%	22.2%	16.7%	19.2%	28.6%	3.6%	18.2%	12.5%	36.4%	29.0%	13.8%

Themes

The quarterly ranking of each theme is highlighted in brackets.

	23/24 Q1	24/25 Q2	24/25 Q3	24/25 Q4
1	Disagreement with treatment / care plan (41)	F5133 Disagreement with treatment / care plan (51)	Co-ordination of clinical treatment (38)	F5115 Co-ordination of clinical treatment, 38
2	Co-ordination of clinical treatment (38)	F5115 Co-ordination of clinical treatment (35)	Disagreement with treatment / care plan (32)	F5133 Disagreement with treatment / care plan, 34
3	Staff attitude (9)	A0502 Face to face (10)	Staff attitude (12)	A0502 Face to face, 11
4	Face to face (5)	A0103 Staff attitude (7)	Telephone (6)	A0504 Lack of a clear explanation, 9
5	Accuracy of records (5)	A0504 Lack of a clear explanation (7)	Face to Face (5)	A0103 Staff attitude, 7

These complaint issues have been addressed at a local level, but Organisational learning must take place to improve practice and the patient experience.

Locations receiving most complaints:

1. Obstetrics & Paediatrics (12)
2. General Medicine (7)
3. Gynaecology (7)
4. Orthopaedics (7)
5. Front Door (5)

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.

'Care Assurance Walkarounds' these have commenced and planned for 2024/25 across NHS Fife Acute and H&SCP.

'Service Specific Questionnaires' Many Services within NHS Fife us questionnaires to capture feedback. NHS Fife Mental Health and Learning Disabilities Services is one of these areas, using MS Forms to within the following areas:

- ***Older Adult Inpatient***
  The QR code and link to the electronic feedback forms are displayed in all inpatient ward areas, are in the patient admission leaflets and will be available on website when they move to fully developed.
- ***Older Adult Community Teams***
  All three community teams have the QR codes available and have them displayed on their work badges and are moving to include this in their clinic letters.
- ***Post Diagnostic Support (Dementia)***
  The team use QR codes on their work badges and will routinely source feedback at a patients 6 month point of service and end of service. (Post diagnostic support is a 1y service). This format of feedback gathering has gained national recognition with Health Improvement Scotland Post Diagnostic Support Programme and is being spread to other boards due to its success
- ***General Adult Inpatient***
  The QR code and link to the electronic feedback forms are displayed in all inpatient ward areas, and will be available on website when they move to fully developed

Feedback process

The MS forms follow a standardised approach, with ward/service drop downs influencing which questions you are asked. The forms facilitate anonymous feedback, but a free text question has been added which allows individuals to leave name and contact details should they wish someone to discuss their feedback with them.

The forms are set up in such a way that an automated email is sent to the following people

- Clinical Service manager
- Lead Nurse(s)
- Mental Health Change and Improvement Manager
- Quality Improvement Practitioner

A monthly report is issued to service areas with details of all responses, but service management do check responses when alerted via email for any requiring immediate response.

The process was initially set up to have QI practitioner for each area using the information and including this in Monthly Service update reports, identifying any key trends and actioning any QI work that was required. However, the lack of QI support currently available has impacted this process.

Service areas are now predominantly responsible for identifying and reporting their own responses, with MH Change and Improvement Manager having oversight and generating reports where necessary.

Services are including the spreadsheet of response information within their Service QMAG (Quality Matters Assurance Group) templates for reference.

Future Developments

The service is currently working to ensure that the MS Form/QR code is utilised in the remaining areas of service. This includes General Adult Community Mental Health Teams, Specialist inpatient and community teams, Addictions and Learning Disability Services.

The service is also working with Head of Patient Experience to ensure the feedback received through service specific means is included in wider reporting. A test of change for this is being discussed and is likely to focus on the Older Adult Mental Health Service as they have fully implemented the process.

Scottish Public Services Ombudsman

The SPSO is the final stage for complaints about public service organisations in Scotland and offers an independent view on whether the Board has reasonably responded to a complaint. A complainant has the right to contact the SPSO if they are unhappy with the response received from the Board.

The number of SPSO cases, decisions and outcome by quarter:

	Apr to Jun 2023	Jul to Sep 2023	Oct to Dec 2023	Jan to Mar 2024	2022/ 2023	Apr to Jun 2024	Jul to Sep 2024	Oct to Dec 2024	Jan to Mar 2025	2024/ 2025
New SPSO cases	8	7	8	7	30	7	7	6	4	24
SPSO decisions	5	0	3	1	9	3	5	1	3	12
SPSO cases upheld	1	0	2	1	4	1	1	1	3	6
SPSO cases not upheld	1	0	1	0	2	0	0	0	0	0
Cases not taken forward	3	0	1	6	10	2	4	0	2	8

New SPSO cases this quarter

This quarter, 4 new information requests have been received. These relate to the following services:

- Woman & Children's Services: 1
- Primary & Preventative Care: 1
- Complex and Critical Care Services: 2

Support and intervention Policy (SIP) - SIPLeaflet.pdf

- This quarter, 3 SPSO complaints had a Support and Intervention Policy applied:
- SIP Level 1 - 1
- SIP Level 2 – 2
- SIP Level 3 – 0
- SIP Level 4 – 0
- SIP Level 5 - 0

NHS Scotland Model Complaints Handling Procedure

Introduction

Empowering people to be at the centre of their care and listening to them, their carers' and families about what is, and is not, working well in healthcare services is a shared priority for everyone involved with healthcare in Scotland. Scottish Ministers want to facilitate cultural change and to create an environment that uses knowledge to inform continuous improvement to services in a culture of openness without censure. The NHS Scotland Model Complaints Handling Procedures (CHP) forms an integral part of that vision.

The CHP was introduced across Scotland from 1 April 2017. The key aims are:

- to take a consistently person-centred approach to complaints handling across NHS Scotland
- to implement a standard process
- to ensure that NHS staff and people using NHS services have confidence in complaints handling
- encourage NHS organisations to learn from complaints to continuously improve services.

Complaints Performance Indicators

The CHP introduced nine key performance indicators by which NHS Boards and their service providers should measure and report performance. These indicators, together with reports on actions taken to improve services as a result of feedback, comments and concerns will provide valuable performance information about the effectiveness of the process, the quality of decision-making, learning opportunities and continuous improvement.

This section of the report is structured around the nine Key Performance Indicators.

Indicator One: Learning from complaints

A statement outlining changes or improvements to services or procedures as a result of consideration of complaints including matters arising under the duty of candour. This should be reported on quarterly to senior management and the appropriate sub-committees, and include:

The Ombudsman expects all organisation's to learn from complaints, and the findings from this report should be shared throughout the organisation. The learning should be shared with those responsible for the operational delivery of the service as well as the relevant internal and external decision-makers who make up the governance arrangements for the organisation, for example elected members, audit or quality assurance committee or clinical governance team.

Learning Identified

Under complaint a)

- *A was not provided with an adequate supply of steroids on discharge which could have had serious consequences.*
- *an Occupational Therapy assessment was not considered necessary, or arranged, on the ward;*
- *Occupational Therapy were not invited to establish home set up before A was discharged home;*
- *A's anticipatory needs were not considered.*

Under complaint b):

- *there was a failure to communicate with A and their family about the appropriate assessments, A's diagnosis and discharge which fell below a level they could reasonably expect.*
- *There was an unreasonable failure to oversee and expedite appropriate support for A's discharge home which took into account their prognosis and involved palliative care.*
- *There was an unreasonable delay in issuing the letter to A's GP following the clinic appointment on 4 October 2022.*
- *Under complaints handling we found that there were some shortcomings in the standard of the investigation and commitments to A's family which had not been met*
- *The Board failed to complete a Significant Adverse Event Review or other appropriate mechanism for learning from what happened.*

Outcome Needed

- *Patients should be discharged with appropriate supplies of medication.*
- *Consideration should be given to a patient's anticipatory needs as well as their needs during admission.*
- *Patients and carers / family should be involved with, and know what the plan is post discharge.*
- *Consideration before discharge should be given to how patients will cope once home and in the community.*
- *Communications should be clearly documented, including with regard to prognosis and recognising end of life.*
- *Healthcare services should plan for the deterioration of people with palliative care needs, enabling them to remain in their preferred place of care for as long as possible.*
- *The Board should ensure that immediate discharge and clinic information reaches the GP as soon as is practicable in every case, ideally on the same day, in order that GPs receive essential information that enables continuity of care.*
- *When a relevant adverse event occurs, the Board should carry out a formal review to investigate the cause and identify any potential learning*

Learning Identified

Under complaint a)
the Board failed to provide a reasonable standard of care and treatment to Mr A during the admission of May 2023. Specifically, we found that:

- *the Board unreasonably managed Mr A's nutritional needs;*
- *the nursing documentation and the absence of the AWI certificate was unreasonable; the*

communication with Mr C and Mrs A was unreasonable.

- *the Board's communication with Mr C and Mrs A was unreasonable.*
- *the Board's communication with Mr C and Mrs A was unreasonable.*

Outcome Needed

- *The Board should ensure effective communication with family members, particularly in circumstances where AWI is in place.*
- *The Board's complaint investigation has identified issues with documentation including in relation to administration of medication and fluid balance charts. In response, audits were being carried out to monitor record keeping on the ward.*

Indicator Two: Complaint Process Experience

A statement to report the person making the complaint's experience in relation to the complaints service provided. NHS bodies should seek feedback from the person making the complaint of their experience of the process. Understandably, sometimes the person making the complaint will not wish to engage in such a process of feedback. However, a brief survey delivered in easy response formats, which take account of any reasonable adjustments, may elicit some response.

- *The Patient Experience Team are holding quarterly meeting to review feedback data more frequently and effectively. During these meetings, thematic analysis of the feedback received will be conducted, allowing the identification of recurring issues and trends. This structured approach will enable the Patient Experience Team to implement targeted quality improvement initiatives aimed at enhancing the complaint handling procedure. With the ultimate goal to improve the patient experience, ensuring that individuals feel heard and supported throughout the complaints process. Report of themes and improvement initiatives will feature in future reports.*

  Q4 quarterly prompted a review of KPI's and questions within survey.

Indicator Three: Staff Awareness and Training

Subject Title		No. of staff			Notes
		NHS	SWFC	VOL	
Good conversations (Gc) (3 day course)	Q1	0	55	0	Figures provided for NHS, Social work / Fife Council, Voluntary Sector –
	Q2	0	0	0	
	Q3	0	0	0	Good Conversations training did not take place in Q2 and Q3 due to vacancy in post.
	Q4	0	0	0	
Gc half- day intro course	Q1	16	0	0	Good Conversations training did not take place in Q2 and Q3 due to vacancy in post.
	Q2	0	0	0	
	Q3	0	0	0	
	Q4	0	0	0	
Gc Foundation Management		0			
Human Factors	0				NES offer a range of training and information resources on this topic – Learning page sites, presentations, Guidance, webinars and posters.

			We are unable to report on engagement in these resources.
Duty of Candour Training	Q1	125	
	Q2	127	
	Q3	133	
	Q4	99	

Indicator Four: The total number of complaints received

	Q1-24/25	Q2-24/25	Q3-24/25	Q3-24/25	Total
4a. Number of complaints received by the NHS Fife Board (STG1/STG2)	221	198	155	177	**751**
4b. Number of complaints received by NHS Primary Care Service Contractors	N/A	N/A	N/A	N/A	N/A
4c. Total number of complaints received in the NHS Board area	**221**	**198**	**155**	**177**	**751**

Records logged in Datix Complaints module – 01/10/2024 - 31/12A/2024	24/25 Q1	24/25 Q2	24/25 Q3	24/25 Q4	Total
Stage 1 Complaint	142	116	63	81	**402**
Stage 2 Complaint	79	82	75	96	**332**
Concern	162	175	177	156	**670**
Enquiry	111	103	78	91	**383**
Total	**494**	**476**	**393**	**424**	**1787**

NHS Fife Board - sub-groups of complaints received -

Stage 1 and Stage 2 (classed as complaints/no concerns or enquiries)	Q1	Q2	Q3	Q4	Total
4d. General Practitioner (GP/Medical)	1	3	1	2	**7**
4e. Dental	1	0	0	0	**1**
4f. Ophthalmic	0	0	0	0	**0**
4g. Pharmacy	0	0	0	0	**0**
Total - Board managed Primary Care services	**2**	**3**	**1**	**2**	**8**

	Q1	Q2	Q3	Q4	Total
4h. General Practitioner (independent GPs)	104	133	146	0	**383**
4i. Dental	3	17	5	0	**25**
4j. Ophthalmic	0	5	0	0	**5**
4k. Pharmacy	26	3	11	0	**40**
Total – Independent Contractors	**133**	**158**	**162**	**0**	**453**
4l. Combined total of Primary Care Service complaints	**135**	**161**	**163**	**2**	**461**

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).5a until 9c*	**Number**				**As a % of all NHS Fife complaints closed (not contractors)**			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
5a. Stage One	129	132	68	61	65%	57%	44%	67%
5b. Stage two – non escalated	58	69	62	25	29%	30%	40%	27%
5c. Stage two - escalated	13	29	25	5	6%	13%	16%	5%
5d. Total complaints closed by NHS Board	**200**	**230**	**155**	**91**	**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**			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
6a. Number of complaints upheld at stage one	27	37	36	27	21%	28%	53%	44%
6b. Number of complaints not upheld at stage one	69	50	22	22	53%	38%	32%	36%
6c. Number of complaints partially upheld at stage one	33	36	10	12	26%	27%	15%	20%
6d. Total stage one complaints outcomes	**129**	**132**	**68**	**61**	**100%**	**93%**	**100%**	**100%**
Stage two complaints **Non-escalated complaints**	**Number**				**As a % of all non-escalated complaints closed by NHS Fife at stage two**			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
6e. Number of non-escalated complaints **upheld** at stage two	24	23	18	4	34%	23%	21%	13%
6f. Number of non-escalated complaints **not upheld** at stage two	20	26	26	12	28%	27%	30%	40%
6g. Number of non-escalated complaints **partially upheld** at stage two	14	16	18	9	20%	16%	21%	30%
6h. Total stage two, non-escalated complaints outcomes	**58**	**69**	**62**	**25**	**82%**	**66%**	**66%**	**83%**
Stage two escalated complaints **Escalated complaints**	**Number**				**As a % of all escalated complaints closed by NHS Fife at stage two**			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
6i. Number of escalated complaints **upheld** at stage two	4	5	2	2	31%	17%	8%	40%
6j. Number of escalated complaints **not upheld** at stage two	7	16	13	2	54%	55%	52%	40%
6k. Number of escalated complaints **partially upheld** at stage two	2	6	10	1	15%	21%	40%	20%

6l. Total stage two escalated complaints outcomes	**13**	**27**	**25**	**5**	**100%**	**93%**	**100%**	**100%**

Indicator Seven: Average times -

	Q1	Q2	Q3	Q4
7a. the average time in working days to respond to complaints at stage one	13	18	9	7
7b. the average time in working days to respond to complaints at stage two	67	50	54	30
7c. the average time in working days to respond to complaints after escalation	36	44	36	14

Indicator Eight: Complaints closed in full within the timescales -

	Number				**As a % of complaints closed by NHS Fife at each stage**			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
8a. Number of complaints closed at stage one within 5 working days.	49	54	30	35	38%	41%	45%	57%
8b. Number of non-escalated complaints closed at stage two within 20 working days	10	13	8	8	17%	19%	13%	32%
8c. Number of escalated complaints closed at stage two within 20 working days	5	7	5	4	38%	24%	20%	80%
8d. Total number of complaints closed within timescales (total STG2/total Q1,2,3,4)	**64**	**74**	**43**	**47**	**93%**	**84%**	**28%**	**28%**

Indicator Nine: Number of cases where an extension is authorised-

	Number				**As a % of complaints closed by NHS Fife at each stage**			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
9a. Number of complaints closed at stage one where extension was authorised	14	11	15	4	11%	8%	22%	7%
9b. Number of complaints closed at stage two where extension was authorised (this includes both escalated and non-escalated complaints)	17	13	30	6	24%	13%	34%	24%
9c. Total number of extensions authorised	**31**	**24**	**35**	**1**	**16%**	**10%**	**23%**	**20%**

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who require Easy Read versions, who speak BSL, read Braille or use
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Area Clinical Forum

AREA CLINICAL FORUM

(Meeting on 3 April 2025)

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 3 APRIL 2025 AT 2PM VIA MS TEAMS

Present:
Nicola Robertson (Chair)
Aileen Boags, Lead Pharmacist
Lorna Brocklesby, Occupational Therapy Manager
Jackie Fearn, Consultant Clinical Psychologist
Robyn Gunn, Head of Laboratory Services
Janette Keenan, Director of Nursing
Dr Chris McKenna, Medical Director
Nicola Robertson, Director of Nursing, Corporate
Amanda Wong, Director of Allied Health Professions

In Attendance:
Ben Hannan, Director of Planning & Transformation *(items 1 – 5.1 only)*
Hazel Thomson, Board Committee Support Officer (Minutes)

1. Introduction/Apologies for Absence

The Chair welcomed everyone to the meeting. A welcome was extended to Aileen Lawrie, who has re-joined the Forum as the Nursing & Midwifery Workforce Planning Group representative, however, is unable to join today's meeting. A welcome was further extended to Lynn Barker, who will join the Forum to represent the Integrated Professional Advisory Group, and was also unable to join today's meeting.

Discussion took place on the importance of representatives at the Area Clinical Forum. It was agreed to invite the Director of Pharmacy & Medicines and Deputy Medical Directors to join, or ask a representative to join the Forum to represent their respective areas. It was confirmed Dr McKenna is the lead for the Area Medical Committee.

Apologies were received from members Emma O'Keefe (Consultant in Dental Public Health), Steven Halstead (Specialist Optometrist) and Dr Susannah Mitchell (General Practitioner).

2. Declarations of Members Interests

There were no declarations of interest from those present.

3. Minutes of the Previous Meeting held on 5 December 2024

The minutes of the previous meeting were **agreed** as an accurate record.

4. Matters Arising and Action List

There were no matters arising.

The action list was discussed and updated accordingly.

5. PRESENTATIONS

5.1 RTP - Shaping our Future Together and our Transformation Framework

The Director of Planning & Transformation presented an update on the transformation framework and advised that the framework will be circulated to the Forum.

It was reported that significant progress has been made in relation to new government directives, reform agendas, and collaborative initiatives. An overview was provided on achieved savings from 2024/25 and for the year ahead. It was advised that the Scottish Government's plans include reducing outpatient waits to under 52 weeks and achieving 92% accident & emergency performance by March 2026. It was noted that there are rapidly developing proposals and transformation plans to meet these goals, focusing on system-wide improvement and that NHS Fife's efforts include planned and unscheduled care innovations, enhancing clinical services design, and redesigning business services with technology-driven efficiency. An overview was also provided on the reduction of administrative job families and workforce.

Extensive discussion followed and the challenges of recruiting were highlighted, particularly for graduates of nursing, health professionals, midwifery and clinical services. An emphasis on redesign and transformation was raised, and the challenges of transformation thinking. Digital technology was raised as an important aspect and the challenges were outlined. The importance of communication and engagement was also highlighted.

6. GOVERNANCE MATTERS

6.1 Election of the Vice Chair of the Area Clinical Forum

The Forum elected the Director of Allied Health Professions as the Vice Chair.

6.3 Delivery of Annual Workplan 2025/26

The Chair highlight that arrangements are ongoing in relation to presenters joining the Forum, as detailed within the workplan. It was noted that there were no deferred items.

The Forum took **assurance** from the annual workplan.

7. INTERNAL / EXTERNAL UPDATES

Concerns were highlighted in relation to the Morse system, electronic patient records and the introduction of future technology systems, and it was agreed to invite a digital representative to present at the Allied Health Professional Clinical

Group, with learnings to be shared with the Forum in advance of the June 2025 meeting.

Action: Director of Allied Health Professions

8. LINKED MINUTES

The Forum **noted** the linked minutes:

8.1 Allied Health Professions Clinical Advisory Forum held on 5 March 2025 (Action Log)

8.2 GP Subcommittee held on 17 September 2024 (confirmed), 15 October 2024 (confirmed), 19 November 2024 (confirmed), 17 December 2024 (confirmed), 21 January 2025 (confirmed) & 18 February 2025 (unconfirmed)

8.3 Area Medical Committee held on 8 October 2024 (confirmed) & 10 December 2024 (unconfirmed)

8.4 Area Pharmaceutical Committee held on 25 November 2024 (unconfirmed)

9. ESCALATION OF ISSUES TO THE CLINICAL GOVERNANCE COMMITTEE

There were no escalations to the Clinical Governance Committee

10. ANY OTHER BUSINESS

10.1 Terms of Reference

The Chair agreed to update the membership section of the Forum's Terms of Reference, to reflect the election of the new Vice Chair.

Action: Chair

11. DATE OF NEXT MEETING

The next meeting will take place on Thursday 5 June 2025 from 2 – 3.30pm via MS Teams.

CANCER GOVERNANCE & STRATEGY GROUP (Meeting on 19 February 2025)
No issues were raised for escalation to the Clinical Governance Committee.

Cancer Governance & Strategy Group

NHS FIFE CANCER GOVERNANCE & STRATEGY GROUP (CGSG)

Confirmed Note of the Meeting Held at 09:00 on Wednesday 19th February 2025 via Microsoft Teams

Present:	**Designation:**
Izzy Corbin (IC)	Patient Representative
Claire Dobson (CD)	Director of Acute Services
Susan Fraser (SF)	Associate Director of Planning & Performance
Alistair Graham (AG)	Associate Director Digital and Information
Murdina MacDonald (MM)	Lead Cancer Nurse
Chris McKenna (CM) Chair	Medical Director
Kathy Nicoll (KN)	Cancer Transformation Manager
Frances Quirk (FQ)	Assistant Director Research, Development & Innovation
Alison Robertson (AR)	Cancer Audit & Performance Manager
Shirley-Anne Savage (SAS)	Associate Director for Risk and Professional Standards
Amanda Wong (AW)	Associate Director of Allied Health Professions
Apologies:	**Designation:**
David Astill (DA)	Patient Representative
Paul Bishop (PB)	Head of Estates
Fiona Forrest (FF)	Acting Director of Pharmacy and Medicines
Nick Haldane (NH)	Lead Cancer GP
Janette Keenan (JK)	Director of Nursing
Rishma Maini (RM)	Consultant - Public Health
Neil McCormick (NM)	Director of Property and Asset Management
Linda McGourty (LM)	GP
Margo McGurk (MMcG)	Director of Finance and Strategy
Emma O'Keefe (EO'K)	Consultant – Dental Public Health
John Robertson (JR)	Lead Cancer Clinician - Surgery
Nicola Robertson (NR)	Director of Nursing, Corporate
Sarah Scobie (SS)	Consultant – Clinical Oncologist
Fiona Towns (FT)	Patient Representative
In Attendance:	**Designation**
Rebecca Hands (RH)	Clinical Governance Administrator (minute taker)

		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 31 October 2024 via Microsoft Teams**	
	The Unconfirmed Note of 31 October 2024 was **accepted** as an accurate record.	
3.	**Action Log**	

		Action
	140824#1 – MM is currently working on a paper for this. 140824#2 – MM shared a summary paper with the group on the review of new cancers post pathway discharge. CM to have a meeting with MM, SAS, the cancer leads and Neil Cruickshank to discuss RCDS and where it is going and what we are doing. CM advised he wishes to discuss where they are going to take some of this data next.	
4.	**GOVERNANCE**	
4.1	**Acute Cancer Services Delivery Group Update**	
	CD noted the Acute Cancer Services Delivery Group reconvened in the latter part of last year. They have refreshed the membership of the group. NH and JR are now in attendance along with service managers from areas who were seeing particular challenges. CD advised Louise Noble is now attending and is providing regular updates in relation to the prostate pathway. It was noted that they have a specific action around the prostate pathway, and they have had colleagues that have attended the national meetings on the work that's taking place in Lanarkshire. CM noted it is important for this group to have a rundown of what we have learned from Lanarkshire and if there are any particular actions that we are going to take away from what they have done.	**CD**
4.2	**Cancer Risks**	
	Papers were shared with the group on cancer risks. It was noted that since the last report to the group, the overall number of agreed risks on the Cancer Risk Register has remained the same at 11. It was advised in summary: • **Closed Risks:** No risks have been closed. • **New Risks:** No risks to delivery of the Cancer Framework have been opened in Datix. • **Risk Level breakdown:** 2 High and 9 Moderate • **Risk Rating and Level:** 1 risk has reduced from High (rating 16) to Moderate (rating 9) • **Risk Target:** No risk has achieved its target. SAS to update the description on risk 2297. CM asked if pharmacy can look at risk 2515 as it is not really written as a risk, it is more a statement of fact. CM noted there needs to be clarity on what the risk is. SAS to take this action away.	**SAS** **SAS**
5.	**STRATEGY/PLANNING**	
5.1	**Cancer Framework Refresh**	

		Action
	KN met with all stakeholders to refresh, review and update the commitments. It was agreed that the existing content was still relevant and up to date and that it aligned with both the cancer strategy for Scotland and the public health and wellbeing strategy. KN stripped back the content to focus on the commitments. Action plans should still be agreed on an annual basis to ensure delivery of the framework. A very draft document is in development for 2025-26. The draft Framework has been sent to the communications team for an overhaul of the look. CM noted this can go through SLTs for ASD and HSCP before it is then taken through EDG then the Clinical Governance Committee.	
5.2	**Project Updates**	
5.2.1	**Single Point of Contact Hub Progress Report April 24 – Sept 24**	
	KN provided an update on Single Point of Contact Hub (SPOCH): • Progress reports are submitted to Scottish Government on a quarterly basis. • They are asked to provide as much information as possible regarding impact/progress against objectives for example, the impact on patient experience, DNA rates and capacity. • There have been significant staffing challenges within SPOCH due to long term sickness and vacancy. • The progress report shows continued expansion and improvement within the service with increased support provided to both patients and services despite the significant staffing challenges. • Queuebuster has been adopted. • A brief overview of activity shows the incoming and outgoing calls to CNSs are reduced in comparison to pre SPOCH. • DNA rate is higher than previous reporting at 4.9% however still below the DNA target of 5%. • During this period, they have introduced two new pathways: management of negative qFIT and initiation of the lung cancer pathway. • They have also supported the pilot of the CRUK prostate Rapid Access Diagnostic Centre. CM asked if there is anything written down somewhere about the negative qFIT pathway. KN advised they have a process noted. KN to forward this to CM.	**KN**
6.	**FUNDING**	
6.1	**Funding Update**	

		Action
	KN advised Cancer Waiting Times (CWT) funding is now allocated on a recurring basis and it sits alongside the planned care funding for NHS Fife and not separately. Recurring CWT funding was not fully allocated and has been used to support additional activity, staffing and some training. Bids for consideration of recurring CWT funding for 2025-26: • 1.0wte MDT Coordinator for the cancer audit team • 2.0wte Pathway Navigators for GI services • Pelvic floor physiotherapy service for post RALP patients • Uplift CNS for professional leadership for cancer nurses KN provided an update to the group and advised of the following funding streams for 2024-25: • CWT Funding (recurring) - £776,00 • CWT Funding (non-recurring) - £323,198 • AO/SACT (recurring) - £317,565 • RCDS/RCDS Dec 23 – Sept 24 (non-recurring) - £160,549 • RCDS/RCDS Oct 24 – Mar 25 (non-recurring) - £167,917 • SPOCH (recurring) - £107,354 • CRUK TET funding to support Prostate Pathway (non-recurring) - £213,000 • Detect Cancer Early – Optimal Pathways (Head & Neck) (non-recurring) - £53,000 • Detect Cancer Early – Optimal Pathways (Lung) (non-recurring) - £8.382	
7.	**QUALITY/PERFORMANCE**	
7.1	**Cancer Waiting Times Q3 2024**	
	CD provided a summary on the Cancer Waiting Times: • The **62 Day Standard** states that 95% of patients urgently referred with a suspicion of cancer will wait a maximum of 62 days from referral to first cancer treatment. • In Scotland **72.1%** of patients started treatment within the 62-day standard compared with **73.2**% in the previous quarter and **83.7%** for quarter ending 31 December 2019. • The 62-day standard was met by NHS Lanarkshire (95.4%). • In NHS Fife **75%** of patients started treatment within the 62-day standard [previous quarter **73.1%**]. SCAN **76.2%** and NHS Scotland **72.1%.** • The **31-Day Standard** applies to all eligible referrals, regardless of route of referral and states that 95% of all patients will wait no more than 31 days from decision to treat to first cancer treatment.	

		Action
	• In Scotland **95.5%** of patients started treatment within the 31-day standard, compared with 94.1% in the previous quarter, and **96.5**% in the quarter ending December 2019. • The 31-day standard was met by 13 of the 15 NHS Boards, including NHS Fife. • In NHS Fife **95.7%** (**95.9**% previous quarter) of patients met the 31-day standard. SCAN **95.0%** and NHS Scotland **94.3%.**	
8.	**CANCER RESEARCH**	
8.1	**Cancer Research Update**	
	FQ advised following on from the figures provided at the last meeting, they have 25 new participants across a range of studies. 1 new study started which is a behavioural science mixed method study. 2 studies are in set up: 1 in neurology and 1 in behavioural science. FQ noted there is a small cell lung cancer study in feasibility.	
9.	**REALISTIC MEDICINE**	
9.1	**Realistic Medicine Update**	
	Item to be carried forward to the next meeting.	
10.	**LINKED COMMITTEE MINUTES**	
10.1	**Cancer Leadership Team (19/11/2024 & 17/12/2024)**	
	This was noted by the group.	
10.2	**Acute Cancer Services Delivery Group (05/12/2025)**	
	This was noted by the group.	
10.3	**Earlier Cancer Diagnosis Programme Board (13/12/2024)**	
	This was noted by the group.	
10.4	**National Cancer Managers' Forum (31/01/2025)**	
	This was noted by the group.	
11.	**ITEMS TO NOTE**	
	No items were to note.	
12.	**ISSUES TO BE ESCALATED TO EDG/CLINICAL GOVERNANCE COMMITTEE**	
	No issues to be escalated.	
13.	**ANY OTHER BUSINESS**	
13.1	**Terms of Reference**	
	Terms of Reference to be updated. Terms of Reference to be sent around the group for comment.	
13.2	CM advised the group that today's meeting is KN last meeting as she is now retiring. CM noted the amazing pieces of work that KN has worked on over the years. CM thanked KN for all of her work with this group and	

		Action
	acknowledged that KN has been instrumental in pulling us all together and keeping us all right.	
14.	**Date of Next Meeting**	
	Tuesday 1st April 2025, 09:00-11:00 via MS Teams	

CLINICAL GOVERNANCE OVERSIGHT GROUP

(Meeting on 8 April 2025)

No issues were raised for escalation to the Clinical Governance Committee.

Clinical Governance Oversight Group

Date : 08/04/2025
Enquiries to: April Robertson
Telephone Microsoft Teams
Ext:

UNCONFIRMED MEETING NOTE OF THE NHS FIFE CLINICAL GOVERNANCE OVERSIGHT GROUP HELD ON TUESDAY 8th APRIL 2025 via MICROSOFT TEAMS

Attendees

Jane Anderson (JA)	Interim General Manager, Women & Children's Services
Norma Beveridge (NB)	Director of Nursing, Acute Services Division
Gemma Couser (GC)	Associate Director of Quality & Clinical Governance
Dr Stephen Fenning (SF)	Associate Director of Medical Education
Fiona Forrest (FF)	Acting Director of Pharmacy & Medicines
Claire Fulton (CF)	Lead for Adverse Events
Catherine Gilvear (CG)	Fife HSCP Quality, Clinical Care & Governance Lead
Robyn Gunn (RG)	Lead Healthcare Scientist
Dr Helen Hellewell (HH)	Deputy Medical Director, Health & Social Care Partnership
Janette Keenan (JK)	Director of Nursing, NHS Fife
Aylene Kelman (AK)	Associate Medical Director, Health & Social Care Partnership
Aileen Lawrie (AL)	Director of Midwifery
Dr Chris McKenna (CMcK) (Chair)	Medical Director, NHS Fife
Elizabeth Muir (EM)	Clinical Effectiveness Manager
Marie Richmond (MR)	Head of Digital Strategic Delivery
Nicola Robertson (NR)	Director of Nursing, Corporate
Shirley-Anne Savage (SAS)	Associate Director for Risk & Professional Standards
Gavin Simpson (GS)	Consultant Anaesthetics, Deteriorating Patient Lead
Jillian Torrens (JT)	Head of Complex & Critical Care, H&SCP

In Attendance

Tanya Lonergan (TL)	Associate Director of Nursing, Health & Social Care Partnership
April Robertson (AR)	Clinical Governance Administrator (Minute Taker)

Apologies

Lynn Barker (LB)	Director of Nursing, Health & Social Care Partnership
Dr Sue Blair (SB)	Consultant in Occupational Medicine
Andy Durden (AD)	Chief Registrar, Obstetrics & Gynaecology
Dr Iain MacLeod (IM)	Deputy Medical Director, Acute Services Division
Dr Sally McCormack (SMcC)	Associate Medical Director for Medical & Surgical Directorate
Siobhan Mcilroy (SM)	Head of Patient Experience
Dr John Morrice (JM)	Associate Medical Director of Women & Children's Services
Joy Reid (JR)	Nurse Consultant, Acute Services Division
Amanda Wong (AW)	Director of Allied Health Professions

	Items	Action
1	**Apologies for Absence**	
	Apologies for absence were noted from the above members.	
2	**Minutes of the last meeting held on 11th February 2025**	
	The group confirmed that the note from the meeting held on the 11th February 2025 was an accurate record.	

3	**Matters Arising/Action List**	
3.1	NHS Fife Complaints Escalation Process	
	In SM's absence NR informed the group that the escalation matrix and the standard operating procedure are currently being finalised. She gave assurance that while these were being written / updated there were still escalations in process. Ultimately the key is to move complaints through the systems as quickly as possible. SM will bring a full assurance update to the next meeting.	**SM**
3.2	SBAR NHS Fife Deep Dive Review - Hospital Acquired Harm	
	SAS stated this deep dive was here for noting after going through Risks & Opportunities Group, Clinical Governance as well as the Audit & Risk Committee. CMcK concluded this is an important risk which should be monitored carefully. We need to be very clear, if there's increasing evidence of harm, for example, falls, we know this is being tracked, what our interventions are and how we update this risk in relation to the interventions required.	
4	**ACTIVE OR EMERGING ISSUES / EVENTS**	
4.1	NHS Fife Healthcare Improvement Scotland Inspection of 5th December 2025	
	NB gave an overview of the visit and will bring a paper reflecting the action plan to the next meeting. She shared the following highlights from the inspection; • 9 areas of good practice, one recommendation and 13 requirements. • Staff recommended the hospital as a good place to work. • Patients and relatives were complimentary. • Safety huddles were well structured, inclusive and informative.	**NB**
4.2	NHS Fife Orthopaedic Scottish National Audit Programme - Hip Fracture & Arthroplasty	
	NB gave the following update from IM; The committee are aware that we have not made the 'time to arthroplasty' standard for five years now and that we fall below the Scottish average. Hip fractures are a surrogate marker for trauma in general and as predicted a significant rise in the number of patients presented to the hospital with fractures. The team have been working hard at looking at local improvements in theatres but have been unable to significantly improve performance. Executive Leadership Team (ELT) have been able to provide additional resource for additional theatre capacity and a trauma co-ordinator role to improve pathways and patient experience. This additional resource and time in theatre will hopefully improve the trauma performance and allow NHS Fife to meet the standards set. A full paper will come to the next meeting. CMcK concluded that this investment should be monitored / measured very closely to ensure improvement.	**IM**
4.3	NHS Fife Organisational Learning Leadership Group Update	
	GC reminded the group that tomorrow, 9th April 2025 will see the launch of the Clinical Organisation Learning Event (COLE) which aims to compliment the Grand Round.	

	The difference being that COLE is seeking to extrapolate matters of learning that are of organisational significance. The events are going to be comprised of three themes. • Celebrating success and learning from appositive change or quality improvement. • A micro learning element • Learning from adverse events Routes into this group are still evolving. We would envisage in time, referrals from Serious Adverse Event Review (SAER) panel meetings and Clinical Governance meetings across the divisions. As well as encouraging individuals to come forward and share their learning. A page has been created on Stafflink by Blink, where items presented at these meetings will be shared.	
5	**QUALITY / PERFORMANCE**	
5.1	NHS Fife Quarterly Deteriorating Patient Report - Quarter 3 (Q3)	
	GS spoke to the report and highlighted; • There is 70% mortality of patients who experience cardiac arrest • Average acuity over the last 5 years is creeping up • 46 cardiac arrests in quarter 3 giving a rate for quarter per 1000 admissions of 0.77 • 400 peri-arrest plus 239 other 2222 calls across all NHS Fife sites. This demonstrates the amount of time an emergency team has been called out for Q3 • Outcome of cardiac arrests: 38 cardiac arrests, 15 deceased and 23 alive • Status at discharge: 11 deceased, 11 survived to hospital discharge 1 still in hospital • Overall survival rate 29% GS pointed out that this figure has crept up. This is a function of us being more proactive, anticipating patients who are sick and doing something about it, including putting Do Not Attempt Cardio Pulmonary Resuscitation's (DNA CPR) in place. It could also be a signal that we might be getting better at triaging, which is what the deteriorating patient work is all about. The current definition for observations on time gives the result that VHK is complying 70% and Health & Social Care Partnership (HSCP) 50%. There is a lot of scope for improvement and we will be doing a lot of work over the next two years to try and improve our compliance. Treatment escalation planning is what we do when someone has a DNA CPR in place. This figure is currently 25% but should be around 95%. Making improvements here could mean we structure and communicate better for our sick patients, the deteriorating patient group will focus on this over the next 12 to 18 months. In conclusion, one of the big elements, is that we're not triaging patients that should be DNA CPR, it's still around 30%. There is an opportunity to put DNA CPR's in place for a significant number of patients who go on to have cardiac arrest, which would make us more efficient, use less resource in the hospital, but it would also mean much better clinical care for these patients that are dying, and that's a large	

	proportion of patients.	
5.2	NHS Fife Deteriorating Patient Flash Report July - December 2024	
	GS informed the group that the Flash Report has now been condensed into a one-page report to allow it to be shared with our clinical teams for them to digest in a meaningful way, which includes the improvement and learning points. GS highlighted; NEWS2 - a Deteriorating Patient Oversight Group has been established. The functionality of this group is to provide oversight for implementation of NEWS2, which by virtue of doing that, will also oversee a number of the improvement actions that we know we need to take forward as a board. NHS Fife is on target for NEWS2 to be implemented on Tuesday 30th September 2025. GC commented that an implementation plan for NEWS2 will be brought to the next 17th June 2025 CGOG meeting. This will clarity the various steps that need to be delivered by when to reach the implementation date. An insightful discussion followed around the difficulties of DNA CPR conversations clinicians are required to have with patients and their families, especially around the timings of these. There was an agreement among the members of the group that this conversation if not done at the correct time and place could cause catastrophic barriers which were not previously there.	
5.3	NHS Fife Integrated Performance Quality Report	
	GC spoke to the Integrated Performance Quality Report (IPQR) informing the group it had been brought for assurance as well as discussion. How are we going to seek assurance and understanding for improvement across the system? There was some discussion around the data, particularly falls with harm and how these figures rise in the winter months and the reasons behind this. CMcK concluded that the organisation needs to start looking at what we do in terms of planning from a different perspective. The data shows that action is required. This is not an easy thing to do however we should keep in mind that the frame of reference is patient safety.	
6	**ADVERSE EVENTS**	
6.1	NHS Fife NHS Fife Adverse Events Incidents Flash Card	
	This was noted by the group. CF pointed out to the group that this flash card has already been viewed by 1498 people on Stafflink.	
6.2	NHS Fife Adverse Events Themes & Trends	
	CF explained to the group, the format in which the data was displayed had changed to encompass an approach of looking at the data over time. Work is ongoing with Digital & Information Services (D&I) to see how this data can be made more visual going forward.	

	The charts breakdown every single category reported across 24 months of data over time to understand where there are any themes and trends and any signals in our system, we need to be mindful of an increase or decrease as well as where we can celebrate success in the events. Next steps are to share this report with Senior Leadership Teams in advance of CGOG to inform and generate discussion at divisional and service level clinical governance meetings. This process will enable feedback from the SLT's on shifts in data and opportunity to escalation any emerging issues relating to data at CGOG . CF highlighted from 1500 incidents reported each month over 38 categories on Datix; • Medication Incidents increase in the medium from 133 to 147 • Missing Persons increased from 17 to 21 • Specimen management decreased from 16 to 11 • Clinical Nutrition 10 points consistently above the median GC gave an update on the progress of the SAER Update Group which gives an opportunity to understand where the blockages are in our SAER process.	
6.3	NHS Fife Adverse Events Key Performance Indicators (KPI's)	
	CF informed the group this paper was for noting. There is still work to be done around the 90-day target which was not currently providing the assurance it should be within the KPI's. CMcK reminded everyone that where a SAER has been commissioned, even if the service is no longer appropriate, there is an expectation that review process is brought back to SAER panel to be completed.	
6.4	Healthcare Improvement Scotland (HIS) Learning from Adverse Events National Framework	
	• CF shared with the group the launch of the new National Framework for Reviewing and Learning from Adverse Events in NHS Scotland. This was published by Health Care Improvement Scotland in February 2025. A SWOT analysis (strengths, weakness, opportunities, threats) methodology was applied to assess NHS Fife alignment with the new framework. • NHS Fife current approach and processed for reporting and reviewing significant adverse events align with the framework: ○ Strengths were identified in process, approach and support for staff in adverse event reviews. ○ Weakness was identified in the level of engagement with patients/family and staff involved in the review, the process for management of events that has impacted on multiple patients and the implementation of improvement plans. ○ Opportunities in the expansion of human factors knowledge and training for staff involved in adverse events reviews was identified and increased prospect for shared learning both locally and nationally. ○ Threats were identified in additional training and education for staff in human factors both in the provision and attendance of training and the process for quality checking all stages of the adverse event cycle.	

	CF ask of the group was to understand what the outcome of our SWOT analysis is and have a view on the changes we may need to make to our delivery plan for the coming year to allow focus on the work aligning within the framework. There was discussion in support of the paper and an offer from SF of assistance from Medical Education regarding training and education around human factors. CMcK agreed this was a helpful offer especially in terms educating our clinical teams to be aware of cognitive bias.	
7	**GOVERNANCE**	
7.1	SBAR NHS Fife Health & Social Care Partnership Clinical Governance Assurance Summary from 24th January 2025	
	TL informed the group the meeting was unfortunately cancelled due to 'Storm Eowyn'. However, three papers were agreed virtually to allow them to progress. CMcK asked for TL to share the papers so they could be circulated to the group.	**TL**
7.2	NHS Fife Acute Services Division Clinical Governance Assurance Summary from 22nd January 2025	
	NB shared the following highlights from the assurance summary; **Active Clinical Referral Triage and Patient Initiated Return Toolkit** This project has made excellent progress and is showing promising value in releasing capacity, clinical time, and providing patients ownership of their own health care, engagement has been challenging in particularly strained specialties. This has emphasised the importance of collaboration between service managers and clinical leads to progress implementation effectively with improvements such as ACRT and PIR The main aims in Q4 for the project are to prioritise releasing clinical capacity in Gastroenterology and Endocrinology for ACRT implementation. Vascular and Cardiology are also being supported to implement ACRT/PIR before the end of the project in March 2024. **IV Fluids Standard Adherence** NB informed the committee that NICE 174 Quality Standards on closer inspection most of the content is now business as usual for NHS Fife. NB advised that we are waiting on clarification regarding the Fluid Improvement Nurse being appointed as the IV Lead with support from a nominated Consultant. Work has started with renal to integrate electronic fluid balance charts with the lab system and AKI alerts on Patient Track which will hopefully improve prevention, detection and management of AKI. **Waiting Times Audit** The committee was provided with information regarding the management of outpatient / inpatient waiting times within NHS Fife. BM informed the committee for future awareness that there is a new national and corporate objective on the Annual Delivery Plan that there will be no new outpatient waits beyond 12 months, so there will be scrutiny on these cohorts of patients,	

	specifically the specialties that have long waits, and noted that this will require a focussed piece of work as currently we have over 7000 patients in this category. BM asked for it to be added onto the Divisional Risk Register if there is a likelihood that the targets will not be met. The objective was not to have any new outpatients beyond 12 months, and information is due to be returned to the Scottish Government by 31st January 2025 detailing how NHS Fife plan to achieve this. **Directorate Report Woman & Children** • Colposcopy waiting times routine is around 8 weeks for referrals, this is currently sitting at 19 weeks. Work is ongoing to open up a new outpatient area with Queen Margaret Hospital to support Colposcopy. The next hurdle will be to staff the additional facility. • SCOTSTAR have highlighted that they will adhering to the referral criteria of accepting children only with an unstable airway and retrieving to the Paediatric Intensive Care Unit. This may mean that Level 2 transfers may increasingly have to be done. The numbers are thought to be minimal, this will be audited over the next 6 months. • Obstetrics Consultant staffing, there is a significant dip in the number of Consultant Obstetricians, this has identified a risk to the service. Pamela Galloway, Head of Midwifery and Nursing Women & Children's Directorate, presented the high-level annual report noting the main point to the committee: • Increase in pressure ulcers within gynaecology due to patients not being transferred to the hospice. CMcK thanked NB and commented that a renewed focus around digital clinical safety is required within the year. He also asked NB to bring back more detail on the increase in pressure ulcers within gynaecology due to patients not being transferred to the hospice. This would allow the group to understand the reasoning behind the issue.	**NB**
7.3	NHS Fife Clinical Policy & Procedure Update 24th February 2025	
	EM advised at the 24th February 2025 meeting of the NHS Fife Clinical Policy & Procedure Co-ordination & Authorisation Group that; **Fife Wide Procedures** There is **one** Fife Wide Procedure past it's review date: **FWP-RDEOLK-01 - NHS Fife Wide Procedure for Rapid Discharge for End-of-Life Care in Normal Place of Residence (01/08/2024)** Due to staff capacity the review was not able to be completed, the aim is to have it to the group as soon as possible. **Acute Services Division** There is **one** procedure past their review date:	

	ASD-POPI-01 - Acute Services Division Pre-Operative Patient Identification: the identification and preparation of patients undergoing operative and invasive procedures (18/02/2025) An update on progress of the review will be brought to April meeting. **NHS Fife Policy & Procedure Framework** The approved NHS Fife Policy & Procedure Framework was presented to the group. This has been developed in order to set out the requirements for the production, approval, implementation and dissemination of Board-wide policies and procedures and local procedures in NHS Fife. The Group were given assurance that they have a 98% compliance rate for all clinical policies and procedures for NHS Fife. CMcK commented that he had noted a number out of date clinical procedures on Stafflink by Blink in relation to mental health & addictions. He has spoken with TL and these were already under review, however this should be noted at the Mental Health Oversight Group. TL replied that there has been work done in the background to address this and bring the procedures up to the current standard. They plan to mirror the framework and have the same processes as NHS Fife Clinical Policy & Procedure Co-ordination & Authorisation Group.	
7.4	NHS Fife Activity Tracker 2025 - 2026	
	EM shared the following with the group: One new Inspection has been issued: • Victoria Hospital - Safe delivery of care Two new Reports and Publications have been issued: • A National Framework for Reviewing and Learning from Adverse Events in NHS Scotland • Hospital at Home Q3 report One new standard has been issued • Cervical Screening	
7.5	SBAR NHS Fife Corporate Risk Register Aligned to Clinical Governance	
	Due to time constraints SAS could not present this item. It is within the papers for the group to note.	
7.6	DRAFT NHS Fife Clinical Governance Oversight Group Terms of Reference	
	This paper will be circulated by email with the Group with a request for any comments to be sent to GC.	

7.7	DRAFT NHS Fife Clinical Governance Oversight Group Assurance Statement	
	This was noted by the Group and any comments should be sent to GC by 18th April 2025.	
8	**STRATEGY / PLANNING**	
8.1	NHS Fife Clinical Governance Strategic Framework Annual Delivery Plan 2025 - 2026 Update	
	Due to time constraints, GC will circulate around the Group for feedback / comments.	
9	**LINKED COMMITTEE MINUTES**	
9.1	NHS Fife Clinical Policy & Procedure Co-ordination & Authorisation Group, unconfirmed - 24th February 2025	
	The minutes of the meeting were noted by the Group and no escalation is needed.	
9.2	NHS Fife Acute Services Division Clinical Governance Committee, unconfirmed – 22nd January 2025	
	The minutes of the meeting were noted by the Group and no escalation is needed.	
9.3	NHS Fife Safer Mobility and Falls Reduction Oversight Group - 6th February 2025	
	The minutes of the meeting were noted by the Group and no escalation is needed.	
9.4	NHS Fife Point of Care Testing Committee – unconfirmed, 4th December 2024	
	The minutes of the meeting were noted by the Group and no escalation is needed.	
9.5	NHS Fife Deteriorating Patient Oversight Group - 31st January & 27th February 2025	
	The minutes of the meetings were noted by the Group and no escalation is needed.	
9.6	Fife Partnership Reviews of Children & Young People Deaths' Governance Group, unconfirmed, 13th March 2025	
	The minutes of the meeting were noted by the Group and no escalation is needed.	
9.7	NHS Fife Organisational Learning Leadership Group - 11th February & unconfirmed, 11th March 2025	
	The minutes of the meetings were noted by the Group and no escalation is needed.	
9.8	NHS Fife Pressure Ulcer Oversight Group, 12th February 2025 & unconfirmed 12th March 2025	
	The minutes of the meetings were noted by the Group and no escalation is needed.	
10	**ITEMS TO NOTE / INFORMATION**	
10.1	NHS Fife Clinical Governance Oversight Group Assurance Summary 11th January 2025	

	This was noted by the Group.	
10.2	NHS Fife Clinical Governance Oversight Group Annual Workplan 2025/26 **(GC)**	
	This was noted by the Group.	
9	**ISSUES TO BE ESCALATED**	
	There were no issues for escalation.	
10	**ANY OTHER BUSINESS**	
	Date of Next Meeting 17th June 2025 10.00 via Microsoft Teams	

FIFE IJB QUALITY & COMMUNITIES COMMITTEE

(Meeting on 4 September 2024)

No issues were raised for escalation to the Clinical Governance Committee.

Fife IJB Quality & Communities Committee

Fife Health & Social Care Partnership

Supporting the people of Fife together

CONFIRMED MINUTE OF THE QUALITY & COMMUNITIES COMMITTEE WEDNESDAY 4TH SEPTEMBER 2024, 1000hrs - MS TEAMS

Present:	Sinead Braiden, NHS Board Member (Chair) (SB) Councillor Rosemary Liewald Morna Fleming, Carer's Representative (MF) Kenny Murphy, Third Sector Representative (KM) Colin Grieve, Non-Executive Board Member (CG) Alistair Grant, Non-Executive Board Member (AG) Amanda Wong, Director of Allied Health Professionals (AW)
Attending:	Dr Helen Hellewell, Deputy Medical Director (HH) Lynn Barker, Director of Nursing (LB) Lynne Garvey, Head of Community Care Services (LG) Lisa Cooper, Head of Primary Care and Preventative Care Services (LC) Fiona McKay, Interim Director of HSCP (FMcK) Jennifer Rezendes, Principal Social Work Officer (JR) Jillian Torrens, Head of Complex and Critical Care (JT) Vanessa Salmond, Head of Corporate Services (VS) Cathy Gilvear, Head of Quality, Clinical & Care Governance (CG) Gemma Reid, Fife HSCP and IJB Co-ordinator (GR) Leesa Radcliffe, Clinical Service Manager (LR)
In Attendance:	Jennifer Cushnie, PA to Deputy Medical Director (Minutes)
Apologies for Absence:	Councillor Sam Steele Councillor Margaret Kennedy Paul Dundas, Independent Sector Lead Ian Dall, Service User Rep, Chair of the PEN Roy Lawrence, Principal Lead for Organisational Development & Culture

No	Item	Action
1	**CHAIRPERSON'S WELCOME AND OPENING REMARKS** SB welcomed everyone to the 04 September HSCP Quality & Communities Committee meeting. Warm congratulations were offered to Lynne Garvey on her recent appointment to Director of HSCP.	

2	**ACTIVE OR EMERGING ISSUES**	
	No emerging issues were Reported.	
3	**DECLARATION OF MEMBERS' INTEREST** No declarations of interest were received.	
4	**APOLOGIES FOR ABSENCE** Apologies were noted as above.	
5	**MINUTES OF PREVIOUS MEETINGS HELD ON 05 JULY 2024** The previous minutes from the Q&CC meeting on **05 JULY 2024** were reviewed and no alterations or corrections were requested. The minutes were taken as an accurate record of the meeting.	
6	**ACTION LOG**	
	The Action Log from the meeting held on **05 July 2024** was reviewed. There was only one current item on the Action Log which related to the Q&CC ToR. This item was included on the Agenda.	
7	**GOVERNANCE & OUTCOMES**	
7.1	**Quality Matters Assurance** This Report was brought to Committee by Lynn Barker for **Assurance.** LB introduced the Report which was based on the QMAG meeting which took place on 12.07.24, Chaired by Jennifer Rezendes. LB stated there was one escalation which was considered and mitigated at SLT Assurance. The Quality Data information showed a slight rise in medication incidents, however, she spoke of a significant amount of work which is taking place, led by the Deputy Head of Pharmacy. JR added, the QMASH meeting on 12.07.24 was the first meeting where there has been an increase in data coming forward from the Social Work side of the Partnership, which she felt supported thorough discussion. JR will present Papers today which will reflect this. SB wished to thank CG for her work to modify the Report to allow easier reading. It was agreed, SB will attend the next QMAG meeting and will tie in with CG. Mental Health work being of particular interest. JT offered to speak off-line with SB regarding her possible involvement in various MH meetings taking place.	**SB / CG** **SB / JT**

	Cllr Liewald queried the Missing Person Update Assurance, she asked if these individuals are patients or does it refer to the public in general. JR stated this is only in-patients (not in community settings) as SW use different data-streams to Health, which she explained. JR referred to the SW and SC Professional Assurance Framework which she is presenting later in the Agenda. She felt the Report will help identify and target data and how it is reported. JR spoke of work which has taken place over the past year. The Committee were Assured by the Paper.	
7.2	**Deep Dive Review Report for IJB Risk 10 – Adult and Child Support and Protection** The Paper was brought to the meeting by JR. JR thanked Avril Sweeney for her assistance with the Paper. JR advised the Paper demonstrates the Committee can take reasonable confidence at the level of mitigations which are in place to address the risk around meeting the duties of Adult Support and Protection and Child Protection. She added there is a strong governance structure which exists within public protection at a multi-agency level. This covers the two strands of Child and Adult Protection delivered by NHS and FC staff. JR referred to the QMAG governance structure, connecting the IJB into the public protection structure, which she described in some detail. Questions were invited. No questions were asked. SB asked the Committee if they were happy to take Assurance from the Report, this was agreed.	
7. 3	**Q&CC Terms of Reference** HH brought the Terms of Reference to Committee for final approval. HH apologised, she had noted a couple of typos which will be corrected before going to IJB. Given the corrections being made, the Committee were content for the Terms of Reference to progress to the IJB.	
8	**STRATEGIC PLANNING & DELIVERY**	
8.1	**Prevention and Early Intervention Strategy** LC presented the Draft Prevention and Early Intervention Strategy to the Committee and advised the Report was brought to seek feedback. She commended the work of the multiple Stakeholders who have been involved in designing the Strategy. LC advised the Strategy is one of the nine key deliverable strategies which underpins the IJB Strategic Plan. She explained, it is one of the	

	key objectives of the NHS Fife's Population Health & Wellbeing Strategy and is one of the priority deliverables through Public Health Scotland around Reform of Public Health and Prevention. LC outlined the journey over the past year and a half, through the discovery phase and design of the Strategy. She stated a collaborative approach was taken with Communities, which can be seen within the report and she referred to the Appendices, which she felt are necessary to give the Assurance required. The definition of prevention and early intervention, along with the strategic priority, to improve and support people to lead a good life, is framed within the strategy. LC described in some detail, the delivery of the Strategy with stakeholder involvement and a multi-agency approach. Cllr Liewald was delighted with the Strategy and welcomed the Report. She referred to page 71, and felt the breakdown of terminology was extremely useful. MF thanked LC for the Report which she found very interesting. She felt the Strategy was exactly what the Partnership should be about. However, she was worried there may be scepticism from service users. The expression "care-giving" has been used through the Report. MF advised she has received feedback this phrase is not liked by Carers, they prefer simple 'caring'. Page 72 shows a graphic which is difficult to read due to the colours used. There was discussion relating to some of the wording within the Report and this will be given further consideration off-line, particularly around Carers. CG was very supportive of the Strategy and felt prevention is extremely important and early intervention as people go into crisis is key. He felt the challenge going forward will be to still be reactive to people and their needs as we move towards effectively embedding the Strategy. KM was supportive of the Strategy and was glad to see the work pulled together into a Report, however, acknowledged it was nothing new. He felt the challenge is how to measure effectiveness of the Strategy. He felt better understanding of how this will work in a very complex system. LC agreed, it is multi-factorial and measuring impact and demand is extremely challenging. She referred to Area 10 of Deliverables which evidences the impact and will be taken forward through Year 1, coming back through the Annual Report. SB stated the Committee was content with the direction of the Strategy and agreed Assurance could be taken from the Report.	

8.2	**Primary Care Strategy 2023-2026** This Report is brought to Committee by **Lisa Cooper**. It comes for **Assurance**. LC introduced the Annual Report for Year 1 of delivery of the Strategy. She explained, the ambition of the strategy is recovery, quality and sustainability. She stated, there were 41 separate actions which were agreed to be delivered upon and all actions have been either delivered or are on track. She drew attention to the achievements during Year 1, including completion of the governance and assurance review, sustainability priorities established and delivered upon and refreshment of the Primary Care Improvement Plan, which she gave detail around. LC confirmed the Strategy is a 3 Year Plan. 25 actions are completed and 16 are on track and will continue within Year 2 of the Plan. HH felt very good progress has been made with excellent collaborative work with independent contractors. She felt there is greater workforce stability, although there is still complex work to take place. She wished to highlight the work taking place around MDT within General Practice to further improve true parity across Fife. Cllr Liewald was supportive of the Strategy and thanked LC for the excellent work. She referred to the participation and engagement which has taken place, she queried communication with patients and the "campaign will largely be digitally focused" asking if this refers to reaching out to the public or to partners? She was concerned the public will not always be kept fully aware through digital correspondence. She stressed the importance of non-digital communication being included. LC gave assurance that there is a very robust Communication & Engagement Plan which is all-encompassing. She described and explained this in some detail. HH added, when signing off the Plan, there was a good deal of discussion around communication and she felt this could be more fully explained and welcomed feedback. MF felt the graph on page 179 was not clear. LC will take this back for a fuller description to be added. MF queried the HACE survey summary table where there is reference to caring responsibilities – she felt it was unclear. LC explained and advised further descriptors will be added to support the table. SB commented on the excellent work taking place. LC added, although it is very challenging within Primary Care at the moment, Teams are working hard to shift the balance locally through what can be influenced locally. The Committee took Assurance from the Strategy.	

8.3	**Community OT Waiting Times** This Report is brought to Committee by **Lynne Garvey**. It comes for **Assurance**. LG introduced Leesa Radcliffe, Clinical Service Manager to present the Report. LG explained the initial Paper came to Committee in Sept '23 where several actions were committed to and now comes back for Assurance. She highlighted the changes to the referrals seen by the Services within the 6 months from Sept '23, which shows a 26% increase in the number of Community OT Service referrals. Previously referrals were for those at substantial level of risk, this has now shifted to critical risk, therefore fewer people waiting at substantial and moderate level, however, are waiting longer. She stated, there have been a high number of vacancies and sickness levels have also been high. For Assurance, LR outlined the actions presented in the previous Paper, ie. working more closely with Housing, SW, and Third Sector, which are at various levels of implementation and tests of change. She highlighted these are not quick fixes and shall take time to embed. Further actions being considered are re-branding/launching Smart Life in Fife. Feedback received was people may not readily recognise Smart Life in Fife as a mechanism to obtain equipment to help their independence. Committee are asked to recognise COT do not consider the waiting times at present acceptable and are committed to reducing waiting times where possible. Members are asked to take assurance from the initiatives described within the Paper, once these are fully actioned and embedded and COT is targeting those at highest risk. SB recognised the difficulties being experienced and appreciated the efforts being made to mitigate the problems. MF appreciated the difficulties being experienced, however, was concerned the earlier intervention can happen, the greater the results will be and the less support required moving forward, thus effecting the work of Carers. She was fully supportive of changes to Smart Life in Fife which she felt was having widespread positive impact. Cllr Liewald was supportive of the Paper and acknowledged it was a difficult situation to improve and spoke of news from the Housing teams that waiting times are reflected in Housing OT staff as well. She asked if everything possible is being done regarding staffing and bringing employees back to work from sickness. She also gave congratulations to the changes in Smart Life in Fife. Rosewell Clinic is being used with a good percentage of referrals coming through and spoke of work with the pods being successful. LR gave details around the efforts being made to recruit new staff to the Service. SB asked if there was anything the Committee could do to support. LG asked the Committee to be patient as the changes being implemented bring improvement, whole-time equivalent staff increase and absence issues are addressed.	

	The Committee took Assurance from the Paper.	
8.4	**Self Directed Support** This Report is brought to Committee by **Jennifer Rezendes**. It comes for **Assurance**. JR thanked Alison Morrison, Self Directed Support Team Manager, for bringing together the Paper. JR wanted to bring to the Committee's attention, HSCP are meeting their duties around Self Directed Support. She explained the Social Care Self Directed Support (Scotland) Act is the mechanism through which social work assessments are undertaken, giving details. JR explained, Alison's team were asked to identify four different themes from the expectations of Scottish Government of how the National Self Directed Support Plan is to be embedded in practice. These have been identified, and connections made to the existing processes which are currently in place. JR advised the Report will come back to Committee for further Assurance, where the Professional Assurance Framework will be discussed, giving assurance to IJB the workforce is taking this Act forward. Questions were invited. No questions were raised. The Committee took Assurance from the Report.	
8.5	**Assessment Rehabilitation Centre (ARC) Transformation SBAR** This Report is brought to Committee by **Lynn Garvey**. It comes for **Decision**. LG asked the committee to acknowledge the redesign of ARC – Assessment Rehabilitation Centre, previously known as the Day Hospital Model. Leesa Radcliffe gave a summary of the Paper – she advised consideration has been given to the future needs and sustainability of the ARCs with the primary focus to be managing frailty. She outlined the current ARC model of care and gave some detail around the problems currently being encountered. The SBAR sets out the proposed redesign model of care for the Service with the aim to implement a locality based, enhanced model which is in a community setting, sustainable and responsive across Fife. She explained, the current service delivery of ARCs will cease and develop into the enhanced model supported by other teams and services which are already undertaking similar roles. She stated there will be some enhancement of roles, looking at shared competencies which works well within other teams in Fife. A Fife-wide approach will be taken with a shift from a clinical setting to a home-based	

	setting with redeployment of staff within the current ARCs, which will be managed through organisational change. Discussions with Staff Side and Professional Leads have taken place, with full support. It is asked Committee Members approve the proposed service redesign, the communication strategy, the organisational change process and approve commencement of the staff consultations in collaboration with HR and Staff Side. Questions were invited. LG asked Committee to recognise the ARC redesign is one of the savings which has been signed off by IJB and comes to Q&CC to ensure all quality aspects have been considered. She wanted to give assurance this change will make a difference in terms of the equitable service which is not currently seen and is in line with all HSCP Strategies, supporting home-based care. She stated she would value the Committee's view before she decides whether the Paper will go to IJB. MF asked if this is similar to the changes to Palliative Care, which she would be supportive of. She was pleased to hear staff have been consulted. HH advised, this is not exactly the same as Palliative Care, as the Palliative Care model involved in-patients, however, the non-centralisation, ensuring taking place in localities and communities, is the same. Cllr Liewald was fully supportive and agreed with care taking place in a home setting. She was reassured staff have, and are being consulted with, and was very interested to read the detail. AG suggested the Report does not need to go to IJB as the Committee appeared to be very supportive. He queried when the financial savings will be seen. LR confirmed It was expected part of the financial savings will come forward during this year. LG advised the Paper will be taken to the LPF Committee. SB confirmed the Committee were Assured by the Paper and were content to continue with the model.	
8.6	**Professional Assurance Framework** This Report is brought to Committee by **Jennifer Rezendes**. It comes for **Decision**. JR introduced the Paper and gave background. She outlined the work which has taken place with colleagues to develop the Framework over the past year. She explained what Professional Assurance means for Social Work and Social Care and how the Framework will evidence and give Assurance to the IJB through the practices being carried out.	

	JR outlined the governance journey the Framework has taken to date and the route it will follow moving forward. The 8 Domains used to capture Assurance across SW and SC services and practices were explained. In particular Service User and Carer Engagement and Feedback through Complaints and Compliments, will be used to identify improvements required and enable analysis of themes. JR spoke of Workforce engagement through various meetings and groups which have been established. LG and LB were very supportive of the Framework and thanked JR for developing, particularly in collaboration with the workforce. CG queried Duty of Candour which JR explained not only relates to Care Home Services but also extends into Children & Families and other Services. SB confirmed the Committee were content to submit the Framework to the IJB.	
8.7	**IJB/HSCP Resilience Assurance Group Annual Report** This Report is brought to Committee by **Lynne Garvey**. It comes for **Assurance** and **Discussion**. LG highlighted the main points from the report. In March 2021, the IJB became a Category One Responder, under the Civil Contingencies Act, meaning some work took place regarding IJB's preparedness to ensure they were ready to respond as such. LG spoke of the role of Resilience SLT Lead and the learning she has gained whilst in the position. She advised support from Avril Sweeney has been vital and will be important moving forward as the post is taken up by a new SLT member. LG drew on some of the actions from the Resilience Framework and described the work involved. Keeping the framework live and relevant is an important aspect and LG explained how this has been communicated to the workforce, also business continuity plans have been considered and updated to ensure they are relevant and robust. Internal Audit have taken assurance from the work undertaken, with one item identified as moderate risk, which has been addressed. LG asked that members are Assured and advised the report will go to the IJB Committee. Cllr Liewald was happy to support and wanted to congratulate the Teams on their handling of the incident which took place last year where there	

	was a terrible fire at a block of flats in Lochgelly. She stated the immediate response from SW teams ensuring every resident was taken care of overnight and continued over several weeks until every resident was relocated a safe and comfortable home. She felt this was an excellent example of Fife performing as a Category One Responder.	
8.8	**Equality, Diversity & Inclusion Action Plan 2024-27** This Report is brought to Committee by **Roy Lawrence**. It comes for **Discussion** and **Decision.** In RL's absence, JR introduced the Paper and thanked LR for her work on it. She advised there was an Equality, Diversity, and Inclusion Steering Group established to consider how HSCP will support a workforce to address EDI issues. The group will also collect workforce data to inform long-term strategies relating to EDI and there is a 3 year Action Plan. JR summarised the background to the report and gave an overview of the work which has taken place from June '23 to date. She spoke of engagement with the Equality Pathfinders Scheme which acknowledges efforts to make Fife fair and inclusive. The Bronze Level of the Scheme was achieved in August '24 demonstrating compliance with the Equality Act 2010. The next level of compliance is now being worked towards. JR outlined the overarching principles and gave detail around the objectives within the Plan. She stated, these will guide the implementation of EDI initiatives across HSCP, giving an organised and widespread approach. JR asked the Committee to consider and approve the 16 points of action which the Steering Group would like to take forward with the Workforce. SB acknowledged the degree of work which has taken place and was very supportive of the Paper MF found the paper an interesting read, she however found it disappointing some service users objected to certain members of staff coming into their homes. She asked if this has been addressed within the Partnership or if it was felt to be due to entrenched attitudes. JR gave a full explanation, advising the ethos and principles of the EDI work which has been taken forward is around "what kind of Fife do we want to live in". She acknowledged it is difficult for policies to impact cultural beliefs. However, she felt continuing to engage and having the difficult conversations, is the only way move forward, demonstrating HSCP value diversity and inclusivity.	

	Cllr Liewald was fully supportive of the Action Plan and spoke of discussions with her Councillor colleagues regarding recent prejudice attitudes shown towards Afghanistan refugees living in Leuchars. She also spoke of anti-racist marches which are taking place in Edinburgh and Glasgow, demonstrating Scottish people are not willing to tolerate racist views. SB asked if the Committee were happy to remit the Action Plan to the IJB. The Committee were supportive.	
9	**LEGISLATIVE REQUIREMENTS & ANNUAL REPORTS**	
9.1	**Primary Care Improvement Plan – MoU2 Annual Progress Update** The Report is brought to Committee by **Lisa Cooper**. It comes for **Assurance.** LC introduced the report which outlines the progress which has been made through 2023-24, towards delivery of the MoU2 Contract. She highlighted some of the achievements of Pharmacotherapy, Community Treatment in Care and the Vaccination Transfer Programme. LC stated VTP was completed at the end of 2022, Pharmacotherapy is still in absence of National Direction, however, good strides have been taken, of which she gave examples. The Community Treatment in Care has increased from 64% coverage (when paper last came to Committee) to 82% across Fife. She spoke of the changes which have occurred to aid this improvement. LC highlighted, within the Appendices, a Timeline, as agreed with the GMS Implementation Group, which shows an endpoint being worked towards – April 2026, which she gave details of. Through the GMS Group and Office Bearers, there has been successful negotiations around transitionary payments, which allows a positive place for finance moving forward. HH wished to add, careful consideration has been given to maximising skill mix, ensuring patients are being seen by the correct professional, ensuring best use of resources. She stated there has been particular consideration given relating to Pharmacotherapy and CTAC. Cllr Liewald commended the work of the Community Link Worker and had heard very positive feedback regarding this piece of work. She queried PC Mental Health Nursing Team – 67% of the intended service is being met, she asked how this is likely to improve and queried the Musculoskeletal physiotherapy teams with 54% of intended service, asking what can be done. LC thanked Cllr Liewald for her comment re Community Link Work and advised, although MH is not a priority within MoU2, explained the work being advanced with the same consideration	

	being given for MSK. HH supported LC's comments and gave further detail around maximising the systems currently in place. Cllr Liewald queried if there is potential to recruit further to these services. LC advised, capacity has been reach for the moment.	
10	**EXECUTIVE LEAD REPORTS & MINUTES FROM LINKED COMMITTEES**	
	10.1 Quality Matters Assurance Group Unconfirmed Minute from 12.07.24 **10.2 Clinical Governance Oversight Group** Unconfirmed Minute from 12.07.24 **10.3 Strategic Planning Group** Unconfirmed Minute from 09.07.24	
11	**ITEMS FOR ESCALATION** No items for escalation.	
12	**AOCB** No other business requested.	
13	**DATE OF NEXT MEETING** **Friday 08 November 2024, 1000hrs, MS Teams**	

FIFE IJB QUALITY & COMMUNITIES COMMITTEE

(Meeting on 8 November 2024)

No issues were raised for escalation to the Clinical Governance Committee.

Fife Health & Social Care Partnership

Supporting the people of Fife together

CONFIRMED MINUTE OF THE QUALITY & COMMUNITIES COMMITTEE
FRIDAY 8TH NOVEMBVER 2024, 1000hrs - MS TEAMS

Present:	Sinead Braiden, NHS Board Member (Chair) (SB) Councillor Rosemary Liewald Councillor Sam Steele Councillor Lynn Mowatt Paul Dundas, Independent Sector Lead (PD) Morna Fleming, Carer's Representative (MF) Colin Grieve, Non-Executive Board Member (CG) Amanda Wong, Director of Allied Health Professionals (AW)
Attending:	Dr Helen Hellewell, Deputy Medical Director (HH) Lynne Garvey, Head of Community Care Services (LG) Lisa Cooper, Head of Primary Care and Preventative Care Services (LC) Fiona McKay, Interim Director of HSCP (FMcK) Jennifer Rezendes, Principal Social Work Officer (JR) Jillian Torrens, Head of Complex and Critical Care (JT) Roy Lawrence, Principal Lead for Organisational Development & Culture (RL) Cathy Gilvear, Head of Quality, Clinical & Care Governance (CG) Vanessa Salmond, Head of Corporate Services (VS) Avril Sweeney, Risk Compliance Manager (AS) Dafydd McIntosh, Organisational Development & Culture Specialist (DMcI) Lesley Gauld, Team Manager Strategic Planning (LG) Lyndsey Dunn, Community Flow, Clinical Services Manager (LD) Jacquie Stringer, Service Manager (Locality/Community Led Support) (JS)
In Attendance:	Jennifer Cushnie, PA to Deputy Medical Director (Minutes)
Apologies for Absence:	Councillor Margaret Kennedy Ian Dall, Service User Rep, Chair of the PEN (ID) Kenny Murphy, Third Sector Representative (KM) Alistair Grant, Non-Executive Board Member (AG) Lynn Barker, Director of Nursing (LB) Hazel Close, Deputy Director of Pharmacy and Medicines (HC) James Ross, Chief Social Work Officer (JR)

No	Item	Action
1	**CHAIRPERSON'S WELCOME AND OPENING REMARKS** SB welcomed everyone to the 08 November HSCP Quality & Communities Committee meeting.	
2	**ACTIVE OR EMERGING ISSUES**	
	No emerging issues were Reported.	
3	**DECLARATION OF MEMBERS' INTEREST** No declarations of interest were received.	
4	**APOLOGIES FOR ABSENCE** Apologies were noted as above.	
5	**MINUTES OF PREVIOUS MEETINGS HELD ON 04 SEPTEMBER 2024** The previous minutes from the Q&CC meeting on **04 September 2024** were reviewed and no alterations or corrections were requested. The minutes were taken as an accurate record of the meeting.	
6	**ACTION LOG**	
	The Action Log from the meeting held on **04 September 2024** was reviewed. The Action Log is currently complete and up to date.	
7	**GOVERNANCE & OUTCOMES**	
7.1	**Quality Matters Assurance** This Report was brought to Committee by Helen Hellewell in Lynn Barker's absence. The report is brought for **Assurance and Discussion.** HH introduced the Report which was based on the QMAG meeting which took place on 31.10.24. She advised the Mental Welfare Commission is considered in further detail later on in the Agenda. HH wished to draw attention to further work taking place around drug and alcohol deaths and deaths due to suicide. The reports detail work understaken to improve matters for people and help prevent occurrences in the future. She spoke of discussions relating to the Mr E Report from the MWC, HSCP are looking to ensure such an occurrence will not happen within Fife. A relating report will be brought to Q&CC in the future. Good work taking place in Cowdenbeath relating to tissue viability was highlighted.	

	HH welcomed questions. SB thanked those involved for the work around QMAG. Cllr Liewald wished to add, the ADP Drop-In has relocated to new premises within Cowdenbeath. The move has demonstrated a good example of transitionary work with the relocation of all drop-in services, including triage & prescribing and tissue viability. The Committee was Assured by the Paper.	
7.2	**Quality and Communities Committee Strategic Risk Register** This report is brought to Committee by **Audrey Valente** and was presented by Avril Sweeney. The report comes for **Assurance and Discussion**. AS introduced the report and advised it sets out the IJB's Strategic Risks which may pose a threat to the Partnership in achieving it's objectives in relation to clinical and care governance and quality of care. She stated, the Risk Register last came to Q&CC in May 2024. The report comes 6-monthly and Deep Dive Risk reviews are presented on individual risks, in between. AS stated, the Risks were last reviewed in Oct '24 and continue to be managed by the Risk Owners. She explained the meaning of the Risk Scores and highlighted the increase in scores for Primary Care Services and Demographic Changing Landscapes. This is due to the current significant financial pressures. Both have been subject to a deep dive risk review during the last year. AV outlined the operational risks and advised they are regularly monitored at the QMAG and actively managed by Service Managers. Any concerns are escalated to SLT and to a Strategic level, if necessary. Questions were invited. MF commented she was finding the Paper difficult to read due to the small print. She was concerned though 'Demographic Changing Landscape' is being monitored closely, she was unsure what action is being taken. She asked what 'monitored closely' means. FMcK responded to MF's question by explaining 'Demographic Changing Landscapes' has been on the Register since 2017 and is a long-term plan around how strategic needs are assessed - how things come through the system. She advised how previous strategic plans and strategic needs assessments give information which is important to be on the radar. Strategies, such as the Prevention and Early Intervention Strategy, has influence and the Strategic Needs Assessment is reviewed regularly through the Strategic Plan Annual Report, identifying 'blips' is all part of an ongoing process. She added, it would be remiss for it not to be included and pointed out the Register focuses on Quality and Communities. CG advised, a quality report is in development to be at the newly convened meeting relating to the Recovery Plan. This will monitor	

	any unintended impact on quality of care by considering reported incidents. Cllr Liewald stated she felt confident the risks are monitored and there is flexibility to apply acceleration where appropriate. She has taken assurance and has confidence HSCP are doing what is required with flexibility and assurance behind it. CG agreed some of the risks have been in place for a long time and felt perhaps a SMART action is required, such as a monitoring group to consider financial matters going forward, giving further assurance. He agreed with Cllr Liewald and felt assured through feedback at Committee meetings. SB suggested AS take away for consideration. The Committee were Assured by the report.	**AS**
8	**STRATEGIC PLANNING & DELIVERY**	
8.1	**Winter Planning 2024/25** This report is brought to Committee by **Lynne Garvey**. It comes for **Discussion and Assurance**. **Lyndsey Dunn** joined the meeting to present. LD introduced herself as the Clinical Services Manager for the Integrated Discharge Teams, Community Nursing and Specialist Services, HSCP. LD spoke of the significant demand on Services with an unprecedented rise in referrals across all services. She explained, data shows considerable increase since the same timeframe 2023. LD outlined the key services such as the Red Cross Service, Home to Assess model, Discharge to Assess and the Enhanced Immediate ICT Team, which is currently being redesigned for those in need of extra support and assistance. The Integration of Services across community hubs was described, where people have quick access to services when required. LD advised a discharge profile was set last year at approximately 100/weekly discharges. This is lower than the Scottish average and places Fife within 25% of the best performing local authority areas. However, she acknowledged, current financial challenges may pose difficulties in maintaining the current level of performance, moving forward. She did, however, want to give assurance all services are operating well and are meeting the demands of this winter. LG thanked LD for an excellent overview. She highlighted the work is performed in collaboration with some of Urgent Care and support from external providers and Acute. She highlighted the huge improvement from several years ago when Fife was amongst the worst performing Boards and there have been great strides to turn this around, particularly relating to Care at Home. The immediate risk is the lack of funds to	

	commission and move people through the system as currently taking place. LG advised this Risk is considered in the Recovery Plan. PD gave thanks for the plan and report. He commented on the plan for ongoing recruitment of ANPs to increase the levels of ACP within Care Homes. He was pleased to note a growing number of ACPs at the weekly Verification meetings of the Optimisation of Care Home Pathways, into and out of hospital. He asked if 'what the starting point was and where was reached by the end of winter' could be included in the Winter Review for 2024/25. Also, the benefits brought to the whole system, once the system is reviewed. Cllr Liewald was very pleased to read the Paper and was particularly pleased to see the redesign of the Telecare Service and the Community Heart Failure Clinic and the Spiritual Service at Community level. She advised Early Discharge and the work with Red Cross, who have a very good reputation, is receiving excellent feedback. There was discussion around possible funding. MF gave thanks for the report and commended the glossary at the front of the report which makes for much easier reading. She queried the situation with unpaid carers under the age of 65yrs, receiving Covid vaccinations. LC advised the Vaccination Programme is delivered in line with Direction from GCVI and Chief Medical Officer, and she explained the under 65yrs carers would not be eligible. LC offered to link MF with the HSCP Immunisation Co-ordinator to discuss further off-line. LG stated she is delighted with the direction of Anticipatory Care Planning and wanted to highlight the focus on Prevention. She felt there has been great strides made, particularly with Care Home residents where emphasis is being placed upon the Rights of people and their carers. LG also informed the meeting of an initiative where an unpaid carer is working with the Front Door Team for a period of one year. The Committee took Assurance from the Paper.	
8.2	**Locality Planning – Community Chest Fund** This report is brought to Committee by **Fiona McKay** and comes for **Assurance**. FMcK advised of a Localities Event which had taken place earlier in the week with good attendance. FMcK advised the Community Chest Fund is a dedicated fund to support projects which can aid unpaid carers. The report gives an overview of how the Fund has functioned during its first and second term. FMcK introduced Jacquie Stringer, Service Manager (Locality/Community Led Support), who works closely with the project. JS offered assurance to the Committee the Community Chest Fund is being appropriately monitored and evaluated. She advised there has been 54 applications for financial assistance approved during the first	

	two rounds of funding. Each project has up to 2 years to spend their funding, but equally there has been some projects who have struggled to engage with unpaid Carers. These projects have been assisted by the Locality Planning Group, Fife Carers and Local Development Officers to have as far a reach as they possibly can. JS stated, projects have been innovative, ranging from very small projects, such as a group of unpaid carers asking for walking boots, up to supporting kinship carers and also schools for young carers. She advised MF has been Chair of the panel who have governed and overseen the applications to ensure a fair process is in use. The evaluation is not a big piece of work for these projects, as it is understood this may be a barrier, however, it is important to have appropriate evaluation in place. If a group has been unable to spend the funding within 2 years, the funding will be put back into the pot. JS felt the Community Chest Fund has been a good success and the meeting was opened up for questions. MF was very happy to see the report brought to Q&CC and was pleased to take part at the recent event and present re the CCF. She described her experience of being on the panel and stressed only projects which would benefit unpaid carers were supported. She was disappointed some very good ideas did not come to fruition due to failing to attract people to take up the option. She would like to continue to support and spoke, in particular, of kinship carers, the Young Carers Group and of the 'Supporting Memories' project. MF wished to commend the Partnership for allocating the funding to support the work. The Committee took Assurance from the report.	
8.3	**Smoking Cessation Deep Dive** This report is brought to Committee by **Lisa Cooper** which comes for **Assurance and Discussion**. LC welcomed the opportunity to bring the report forward to Committee. She advised, the project is led by Health Promotion, a delegated service within the Partnership. LC advised, a Deep Dive had recently been commissioned into the Smoking Cession Programme to understand delivery and numbers around uptake and successful quit rates. She outlined the 3 separate strands within the programme, which are Specialist Service (at hospital and community venues), Maternity Service and Community Pharmacy Service, involving all Community Pharmacies across Fife. Specific details around the improvement actions in place and the next steps were	

	described. The health implications and financial cost to individuals and NHS were discussed. LC advised, Scottish Government have published the Tobacco and Vaping Framework, with an aim to achieve 'Tobacco Free Scotland' by 2034. Priority groups are identified which will be used for Fife to be measured against. A plan is in place to enable Fife to achieve this goal. LC spoke of an Event planned for January '25 involving all stakeholders to assess the current situation in Fife and plan to reach a Tobacco Free Scotland by 2034. MF thanked LC for the report and had concern regarding vaping and the ability for children to obtain vapes. She referred to Fife being at the top of national scales for drug deaths, dental problems in children, etc. She queried what were the effects of people in poverty spending money on vapes and cigarettes. She asked why the relevant medication is not available and is there an alternative option. LC advised the Scottish Government Framework and Direction did not involve vaping as it is a relatively new problem, however, has now been amended to include vaping. LC spoke of evidence being gathered around the health consequences of vaping. A multi-agency event is to take place looking at the entire Framework, including vaping, along with smoking. She went on to say prevalence in SINDs, does not have answers but is very concerning, whole early intervention/prevention approach required, and will be encompassed within the Strategy, which has recently been signed off. LC queried medication not being available and she will endeavour to discover why, and what is the alternative. She spoke of the focus of the Improvement Plan. Cllr Liewald was supportive of the report. She also queried where young people are obtaining vapes/cigarettes. She stated, she has been advised, local corner shops are selling to underage. There was discussion around concerns of addiction and children being excused from class to vape under the pretence of using rest room. Cllr Liewald was curious around the data collected from the School Nurse Service who give children the opportunity to attend a referral pathway. She believed children go straight onto vapes, they are not used to wean off cigarettes. Discussed at some length where media is influencing trends young people follow. Agreed action required by Government to ban single use vapes. LC spoke of a multi-agency approach being required to set up measures for Strategy to prevent, support and aid stopping. SB asked to see the report back in 6 months. Will be added to workplan.	

9	**LEGISLATIVE REQUIREMENTS & ANNUAL REPORTS**	
9.1	**Workforce Strategy Action Plan Year 2 Report 2023-24** **Reports within the Appendices Include** Year 2 Report 2023-24 Summary Report of Medium-Term Actions 2023/24 Year 3 Workforce Action Plan 2024-25 Annual Whistleblowing Report April 23-March 24 This report is brought to Committee by **Roy Lawrence** and comes for **Assurance**, **Discussion and Decision.** RL introduced the report which was recently presented at the Strategic Planning Group. He summarised the collaborative activity which has taken place to reach the current position, detailed within the Year 2 Report 2023-24 and the Medium-Term summary of Actions. The Year 3 Workforce Action Plan, which has been designed by 50 people from across the systems, details the actions for the year ahead. RL acknowledged the very fast pace of change and advised the Y3 Action Plan will be a dynamic document. He introduced the Partnership's first Annual Whistleblowing Report which sets out the whistleblowing standards as previously discussed at IJB in early 2023. RL was confident all Internal Audit recommendations are met by the work and data in place and spoke of the various workstreams operating to ensure this happens. Cllr Liewald queried foundation apprenticeship feedback. RL gave an update advising, there had been little connection in the first year, thus there was work with schools taking a more local approach. RL introduced Dafydd McIntosh, Organisational Development & Culture Specialist to give further detail. DMcI told of connecting with both workplaces and pupils to explore if the workplace was not understanding the purpose of the courses or the pupils lacked information. Since then, work has taken place to create a database storing all information, ensuring every pupil always has a workplace and ensuring the workplace is in locality of the school attended. Approximately 50 pupils are signed up with mentors available to all pupils and events organised with current students to tell of their experience. There was a good deal of discussion around attracting employers into the project. Career events taking place were discussed and DMcI spoke of specific events which will be attended by pupils who have identified Health & Social Care as a career of choice. SB confirmed the Committee were content for the report to be submitted to IJB.	

9.2	**Pharmaceutical Care Services Report 2023-2024** This report is brought to Committee by **Aileen Boags** and comes for **Assurance.** AB introduced the report stating, in line with Pharmacy Regulations, Pharmacy are legally obliged to publish the Report, which is used to identify any unmet need within the Pharmaceutical Care Services. The Paper reports on Pharmaceutical Services provided by Community Pharmacy during 2023-2024 across 86 sites in Fife. AB described excellent assistance received from the HSCP Participation and Engagement Team to enable a very robust public engagement process to take place. Feedback was received through 270 responses, which supported the statements included within the report. This was very encouraging, and it is hoped, to develop the public engagement exercise to enrich the report as it moves forward. AB highlighted several areas of the report – the biggest change in the Pharmaceutical landscape was between Jun-Nov when one of the large multiples exited the UK market, all contracts in Fife were taken over by other contractors and service provision continued and actually increased. The demographics across Fife are covered in Section 1 and Section 2 describes all the CP services which AB summarised. Data relating to Pharmacy First was explained. She wished to highlighted data relating to Smoking Cessation 75% of quit attempts were within Pharmacy settings and 53% came from the 40% most deprived data zones. Moving forward, the report will transition into a plan which will both reflect and show what can be achieved in the future. Questions were invited. CG referred to his time as Chair of the Pharmacy Practice Committee for Fife where applications to open Pharmacies came through the Committee. He described the system used and felt it was very archaic and asked why the tender process used for General Practice is not used, which would be a fairer process. LC responded by stating Fife HSCP are duty bound by national legislation, she felt it was a fair question and agreed but currently does not have the power to influence. MF queried medicines care and review and was concerned public engagement suggests 52% are aware of this service. She asked what is being done to ensure people know about the service and have medicines reviewed on a regular basis. AB advised, the public engagement showed some work is required to ensure the public are aware of all CP services. She explained a full review of a person's medicines would lie with Pharmacotherapy or General Practice. A refresh of this specific part of the service is expected in the coming year, making it clearer what the service is as it is not a full review of people's medicines. SB confirmed the Committee were Assured by the report.	

9.3	**MAPPA Report** This report is brought to Committee by **Jillian Torrens** for **Assurance.** JT introduced the MAPPA (Multi Agency Public Protection Arrangements) Report which is brought to Committee to give Assurance around the local MAPPA arrangements and the management of people subjected to MAPPA support. JT explained, MAPPA supports 3 categories of people – sex offenders, restricted patients and individuals who are assessed as a potential risk to cause serious harm. Under National Guidance, Fife HSCP is a responsible authority, with both Fife Council and NHS Fife included as responsible authorities. There is National Guidance which informs and supports practice locally and the report gives detail of the guidance set out nationally. JT advised there are 12 MAPPA regions across Scotland, 3 levels of management in terms of how people are supported, levels 1-3 with 3 being the highest, most risky level. JT advised there are 569 people in Fife supported via MAPPA arrangements, with 400 living within the community. 399 are managed at Level 1, deemed to be routine management and 1 individual managed at Level 2. The Management Oversight Group and the Strategic Oversight Group are reported into and oversee governance. A local MAPPA co-ordinator sits on all MAPPA groups with great knowledge and extensive expertise supporting practice locally. JT spoke of the APPA Co-ordinator passed away recently, being a huge loss to the Service. JT wished to thank Jackie Drummond, Associate Medical Director for compiling the report. Questions were invited. MF requested as a matter of general practice, all reports presented include a glossary of abbreviations and acronyms. JT stated this shall be included in future reports and was happy to pick up a call off line with MF if required. SB commented this is the first time the MAPPA report has come to Q&CC. She was interested to read the numbers and queried if Fife, because there is no prison, and people are managed in the community, there are no individuals at Level 3. JT stated the people are managed very well in the community. SB confirmed the Committee took Assurance from the report.	
9.4	**Adult Protection Report (Social Work/Social Care) 2023/24** This report is brought to Committee by **Jillian Torrens** and comes for **Assurance.**	

	JT introduced the report which is in relation to Adult Support and Protection activity within the past year. The report was compiled by Danielle Archibald who leads on Adult Support and Protection practice across the Partnership. JT wished to highlight the activity stats showing an increase of 57% in referrals. She outlined the various reasons and spoke of managing the demand in capacity, moving forward. JT advised, local procedures are set out in the report and she outlined key statistics. Audits carried out and the strengths identified were described and the areas for improvement were discussed, along with the improvement plan. JT spoke of the work which has taken place regarding promotion of ASP procedures and practice, training plans for health and for social work staff have been identified, with training being a standard agenda item at team meetings. Focus moving forward is use of a 2nd worker ensuring they are a health care worker and preferably known to the individual with good oversight of cases. The main risk is managing demand and capacity around the activity which is coming in from HSCP moving forward. PD thanked JT for the report and felt it is well laid out and demonstrates how the inter-agency partners work. PD, who is heavily involved in ASP, queried referral levels and what this will mean in terms of resource, avoiding duplication. He also felt very good interagency work is demonstrated within the report. JT spoke of the robust process in place where every new referral goes automatically to an inter-agency referral discussion at a very early stage, giving a higher level of scrutiny. Resource being targeted in the correct places is always consideration. Cllr Liewald mentioned the recent workshop at Cowdenbeath Locality Planning Group where Danielle presented the work taking place within ASP in a very detailed but easily understandable, organised format. JT advised Danielle has been attending all Locality Groups and the message is going out across the whole of Fife. Using examples is very powerful to demonstrate the work taking place and the impact on individuals, families and carers across Fife. SB confirmed the Committee took Assurance from the report.	
9.5	**Mental Welfare Commission Report and Action Plan** This report is brought to Committee by **Jillian Torrens** and comes for **Assurance.** JT advised the report comes for Assurance and gives an overview of MWC visits which have occurred in the past 12 months. She stated there has been 11 visits in total, predominately the visits are within Ward areas, however, within Fife there was the first visit in Scotland to a community	

	mental health team in Scotland. The Commission intends to increase these visits in the future. JT advised MWC have a very well-established visit programme where they engage with staff, patients, relatives and visitors. She spoke of repeated themes, such as quality of the environment, number of beds being operated in wards, activities or purposeful engagement for patients. Care planning raised some concern and more focus is to be placed on auditing of care plans. Visits will continue on a mainly monthly basis. When a visit has taken place there is a draft report submitted which HSCP have a chance to respond to and an action plan is submitted to the Commission which is to be taken forward in the coming months. SB spoke of a visit to Stratheden Hospital with Arlene Wood and JT. She felt it had been very helpful. She commented there had been improvements made in the ward areas, whilst capital funding is awaited. SB confirmed the Committee were content to take Assurance from the report.	
9.6	**Armed Forces Covenant Duty** The report is brought to Committee by **Fiona McKay** and comes for **Assurance and Decision.** FMcK introduced Lesley Gauld who has carried out the majority of the work on the Armed Forces Covenant Duty. FMcK will be passing responsibility to JT from 2025. FMcK advised there has been a good deal of work since the previous report in November 2023. She spoke of the Armed Forces Covenant Working Group which had been established, initially as a short term group, to support implementation of the Armed Forces Covenant across Fife Partner agencies. This group is now a permanent group who's remit includes reviewing services already in place, identifying actions to support compliance and overseeing work to promote compliance and monitor progress against the Duty across partner agencies. A Forces Connect App which is being used across other parts of the country has been introduced in Fife. The App provides details of local and national organisations that offer immediate help and support across a wide range of services for members of the Armed Forces Community. From crisis support, to searching for a GP or a dentist, starting a business to advice on housing.	

	The HSCP website now hosts a new area for the Armed Forces Community which offers support, information and supports the Armed Forces Covenant. LG wished to provide Assurance to the committee that the work is ongoing and improving compliance across the partnership. There is also a section added to EQIAs to ensure the armed forces community is considered in any decisions or policies and there are also questions added to the consultation process to identify the number of people who are part of the armed forces community across Fife. The Committee took Assurance from the report.	
10	**EXECUTIVE LEAD REPORTS & MINUTES FROM LINKED COMMITTEES**	
	10.1 Quality Matters Assurance Group Unconfirmed Minute from 06.09.24 **10.2 Clinical Governance Oversight Group** Unconfirmed Minute from 06.09.24 **10.3 Strategic Planning Group** Unconfirmed Minute from 05.09.24 **10.4 Fife Alcohol, Drugs and Therapeutics Committee** Unconfirmed Minutes 21.08.24 **10.5 Equality and Human Rights Strategy Group** Unconfirmed Minutes 24.08.24	
11	**ITEMS FOR ESCALATION** No items for escalation.	
12	**AOCB** No other business requested.	
13	**DATE OF NEXT MEETING** **Thursday 6th March, 1400hrs, MS Teams**	

FIFE IJB QUALITY & COMMUNITIES COMMITTEE

(Meeting on 10 January 2025)

No issues were raised for escalation to the Clinical Governance Committee.

Fife IJB Quality & Communities Committee

Fife Health & Social Care Partnership

Supporting the people of Fife together

UNCONFIRMED MINUTE OF THE QUALITY & COMMUNITIES COMMITTEE FRIDAY 10th JANUARY 2025, 1000hrs - MS TEAMS

Present:	Sinead Braiden, NHS Board Member (Chair) (SB) Councillor Rosemary Liewald Councillor Sam Steele Councillor Lynn Mowatt Councillor Margaret Kennedy Paul Dundas, Independent Sector Lead (PD) Morna Fleming, Carer's Representative (MF) Colin Grieve, Non-Executive Board Member (CG) Ian Dall, Service User Rep, Chair of the PEN (ID)
Attending:	Lynne Garvey, Head of Community Care Services (LG) Lisa Cooper, Head of Primary Care and Preventative Care Services (LC) Roy Lawrence, Principal Lead for Organisational Development & Culture (RL) Cathy Gilvear, Head of Quality, Clinical & Care Governance (CG) Avril Sweeney, Risk Compliance Manager (AS) Jacquie Stringer, Service Manager (Locality/Community Led Support) (JS) Chris Conroy, Head of Community Care Services (CC) Elizabeth Butters, Fife Alcohol and Drug Partnership Service Manager (EB) Emma O'Keefe, Consultant in Public Dental Public Health (EO'K) Fiona Forrest, Acting Director of Pharmacy (FF) Rachel Heagney, Head of Improvement, Transformation & PMO (RH) Tanya Lonergan, Associate Director of Nursing (TL) Audrey Valente, Chief Finance Officer (AV) Jacqueline Drummond, Associate Medical Director, MH and Complex and Critical Care Services (JD) Jillian Torrens, Head of Complex and Critical Care (JT)
In Attendance:	Jennifer Cushnie, PA to Deputy Medical Director (Minutes)
Apologies for Absence:	Dr Helen Hellewell, Deputy Medical Director (HH) Lynn Barker, Director of Nursing (LB) Vanessa Salmond, Head of Corporate Services (VS) Jillian Torrens, Head of Complex and Critical Care (JT)

No	Item	Action
1	**CHAIRPERSON'S WELCOME AND OPENING REMARKS** SB welcomed everyone to the 10 January 2025 HSCP Quality & Communities Committee meeting.	
2	**ACTIVE OR EMERGING ISSUES**	
	No emerging issues were Reported.	
3	**DECLARATION OF MEMBERS' INTEREST** No declarations of interest were received.	
4	**APOLOGIES FOR ABSENCE** Apologies were noted as above.	
5	**MINUTES OF PREVIOUS MEETINGS HELD ON 08 NOVEMBER 2024** The previous minutes from the Q&CC meeting on **08 November 2024** were reviewed and no alterations or corrections were requested. The minutes were taken as an accurate record of the meeting.	
6	**ACTION LOG**	
	The Action Log from the meeting held on **08 November 2024** was reviewed. The Action Log is currently complete and up to date.	
7	**GOVERNANCE & OUTCOMES**	
7.1	**Quality Matters Assurance** This Report was brought to Committee by Cathy Gilvear, in Lynn Barker's absence. The report is brought for **Assurance and Discussion.** CG introduced the report which relates to the QMAG meeting which took place on 01 November 2024 and the subsequent QMASH meetings. The report summarises the items which were presented, with no escalations. She stated, a small number of items were carried forward to the next meeting, as the meeting had to be adjourned early. CG advised, the Quality report presented showed an overall increase in adverse events reported over the year, this data will be reviewed and fed back to QMAG.	

	Challenges around SAER and LAER reviews relating to capacity were outlined and CG stated the pool of staff have increased to mitigate. Other items highlighted related to pressure ulcers, medication incidents and ligatures. Questions were invited. SB thanked CG and her team for the paper. SB intends to attend a QMAG meeting in the near future. The meeting was content to take Assurance from the QMAG Report.	
7.2	**Deep Dive Review Report for IJB Risk 20 – Transformation / Change** This report is brought to Committee by **Audrey Valente** and was presented by **Avril Sweeney**. The report comes for **Assurance and Discussion**. AS introduced the Deep Dive and explained the Risk Reporting Framework. She stated the Risk is assigned to both the Quality & Communities Committee and the Finance, Performance and Scrutiny Committee. The purpose of the Deep Dive is to ensure Committee members are assured risks are being effectively managed within the agreed risk appetite and at appropriate tolerance levels. AV outlined the risk description and explained scoring, the factors impacting on the risk and the assurances provided. The key mitigations were described and fully explained with appropriate Strategies referred to. Close scrutiny is being applied to delivery actions and performance is monitored. External factors out-with HSCP's sphere of influence, are also being closely monitored. She highlighted the point some of the programmes are at planning stage and may require consideration as part of the refresh of the Strategic Plan 2026 onwards, therefore the risk may require review or merge with other risks - something for members to bear in mind. Questions were invited. SB thanked AS for the comprehensive Paper. PD commented he found the Paper very helpful as it explained in detail the risks associated with Transformation. He also found the standards within the papers attached very helpful. MF felt the IJB and Committees have been talking about Transformation Change for years. She felt often it is reported change has not been able to occur for various reasons and there is a lack of reference to the people who are going to be affected by change, ie service users, patients and workforce. She felt the Paper refers to the management side of the business. She stated, the reason for being is lost, ie. helping the people of Fife lead better, healthier lives. LG welcomed MF's feedback and wished to address her comments. She explained the Transformation undertaken within the	

	Partnership is phenomenal and what is described in the Paper is the process for managers. She referred to the Participation & Engagement Team who have their own Strategy, and as with all Strategies, there is a strong connection to the public weaved throughout them. She stated the Paper is a structured PMO approach of how projects are delivered, ensuring consistency. LG offered to speak with MF offline to give further assurance. LG spoke of aspects of Transformation which have taken place and various items which have been delayed, giving reasons. She gave assurance of delivery of aspects of Transformation, which will be delivered in the coming financial year. AV supported LG's comments and spoke of delivery of projects, support for SRO's, and staff progressing the work to deliver within timescales with the resources available. She confirmed the people are of upmost importance and referred to multi-disciplinary teams to support completion of the Transformation work. CG referred to the GANT chart, showing significant delays and slippage, he queried if this was the original GANT chart shown at the start of the Transformation. RH felt CG made a point and agreed there had been significant delays. She advised the chart shows text which should help to explain reasons for delays. She outlined several changes in circumstances which have affected delivery dates. She acknowledged HSCP should be getting into delivery for all programmes and major projects by 31 March. If no other internal or external changes take place, she felt confident of delivery. She spoke of transparency and participating and engagement work which has been taking place. She was very happy to receive feedback and adapt the reporting if required. CG felt assured by RH's explanation. PD commented the paper purposefully contextualised the current position of the Transformational journey. LG had referred to a possible Development Session and he felt that would be advantageous. It was agreed, there would be an IJB Development Session on Transformation organised. LG would like to extend the invite to all those interested. It was agreed a Development Session will be arranged relating to Transformational Changes. SB confirmed the Committee took Assurance from the Paper.	**VS / LG**
8	**STRATEGIC PLANNING & DELIVERY**	
8.1	**Fife Dental and Oral Health Improvement Annual Report 2024** The report was brought to Committee by **Lisa Cooper** and **Emma O'Keefe**. It came for **Assurance**. LC introduced the report which outlines all activity overseen and led by Primary Care Contract Team in collaboration with the Dental	

	Leadership Team relating to Dental and Oral Health. She advised aspects of the report focus on oral health improvement, access and uptake to dental care services across Fife within the powers available to Fife HSCP. LC referred to the Primary Care Strategy which demonstrates and supports focus on recovery, quality and sustainability on Dental Services across Fife. EO'K introduced herself as Consultant in Dental Public Health in Fife. She stated a collaborative approach between PC, HSCP, the Senior Dental Leadership Team and the Partner Agency Sector. EO'K drew attention to the challenges of Dental Access across the UK. She gave assurance, all possible efforts are being made to improve access, although many aspects are out-with NHS Fife's control. She explained PC Dentistry mainly comprises of independent dental practitioners, who are independent business people. She advised, Scottish Government introduced a new Contact in 2023, and explained what is within control and what is out-with control, whilst further direction is awaited from Scottish Government. She acknowledged the difficulties being experienced and advised, people with urgent dental pain will be triaged by the Public Dental Service and seen at the nearest clinic possible. She explained the difference between general medical contracts and dental contracts. As an NHS Board, there is not the legal obligation to ensure every member of the public is able to register with an NHS Dentist. She wished to emphasise, if there is a member of the public in pain, they will be seen. EO'K referred to the new Annual Delivery Plan and explained the work which will be taken forward during 2025/26. This includes the Oral Health Improvement Programme, using opportunities to signpost to NHS Inform relating to self-care and prevention and encouraging good oral health. Child Smile National Initiative for children's oral health, starting with pregnant mums getting it right from an early stage was explained. A collaborative approach is taken to work with care homes, alcohol and drugs services and groups which are often without voices. EO'K explained the Scottish Dental Access Initiative where it is intended for new Dental Practices to be established in Glenrothes, Kirkcaldy and Dunfermline. Applications are currently being received. The year ahead plans were outlined, which will see continued collaborative working around recovery and improving access, strengthening of quality assurance and reducing inequalities. Questions were invited. Cllr Kenedy thanked EO'K and LC for the paper and wished to raise the following points – she felt stats around children were concerning, although was aware the Pandemic had a huge impact on education / ability to influence families, the work which goes through Public Health,	

etc. She was fearful of problems stored for the future. Also, she understood NHS Dental Care is not funded by Scottish Government at a rate to meet the cost of the treatment, contributing to the loss for NHS Dentists.

EO'K agreed the Child Oral Health information in the National Report is very concerning. She was aware there will be a rocky few years. Targeting resources appropriately will be important, she felt this was the benefit of the Public Dental Service, where there is the Child Smile Programme and National Dental Inspection Teams who are carrying out mapping to target resources appropriately.

There was discussion around the Dental Funding Contract and the problems it has brought. EO'K advised every effort is being made to stabilise NHS Dentistry to avoid moving to a purely private model. Primary Care are collecting data around de-registrations and will be working collaboratively to understand the situation.

Cllr Liewald appreciated the problems being experienced. She commented on de-registration and she, herself had experienced this. She advises her constituents to continue to check for dentists taking on NHS patients. She was supportive of the information going out to schools and the Child Smile Programme which is having a positive impact. She would welcome the additional funding coming from Scottish Government.

MF was glad to hear the reference to work with pregnant women. She stressed the importance of communication to the public. She felt a big impact on Dentistry has been Brexit and the Pandemic. Self-care must be communicated in a sensitive way. She felt access to dental treatment is definitely a public concern and is raised frequently.

PD spoke of the work which has been taking place on the Caring for Smiles Programme. Also, collaborative work on Test of Change around the Right Decision App in Care at Home, where work has taken place with Fife Council, Independent and Third Sector Organisations, to trial the App. He felt it was significant, in terms of both care planning and upskilling. Also for awareness of Oral Health and Oral Pain for people in Care Homes and being cared for at home. He added, evaluation of the work is underway and will be helpful to understand what this looks like at a local level.

ID asked if there was a list of dentists who are taking on NHS patients. EO'K advised the Public Dental Service has a dental advice line where you can leave an email address and a list will be emailed to you. The lists are checked monthly to ensure they are up to date. Mostly taking on children, quite a lot of waiting lists. ID agreed with MF and felt this information must be publicised.

CG queried statistics, particularly the P1, SIMD and the Scottish Dental Access Initiative mapping work. He asked why Fife have been 2nd worst

	for two years in a row and what actions are in place to improve the situation. EO'K advised, SIMD is generally reported at National Level because the numbers are small and agreed, local information would be useful, although per school level information is available. In terms of SDAI mapping – worked with data colleagues looking at SIMD and access, as part of the access initiative is distance to travel. Intelligence around depravation is key to ensuring equitable access to the service. She advised there are initiatives for dentists working in deprived areas and she is very keen to increase accessibility in these areas. LC was supportive of EO'K's response to CG's queries. She spoke of challenges seen locally of how data is reported. She advised locally, action is being taken to improve intelligence to drive what needs to be done and she will be seeking to see improvements next year. The Improvement actions being taken will be evidenced for assurance to members. LC commented she felt there is a significant level of assurance around the work the team are taking forward at a strategic and operational level. Teams are working to establish a Public Dental Service and an Emergency Dental Service which is operational 7 days a week ensuring access to care. The Committee took Assurance from the Paper.	
8.2	**Fife Immunisation Strategic Framework 2024 – 2027** This report is brought to Committee **Lisa Cooper.** It comes for **Assurance**. LC introduced the Fife Immunisation Strategic Framework 2024 – 2027, she advised the previous iteration of the Framework came to Committee in 2021. The Strategic Framework has since been reviewed to ensure it is contemporary and is what is needed now. LC outlined the main points from the review and gave assurance. She referred to improvement required within uptake and explained the quality improvement work taking place. Questions and comments were invited. Cllr Kennedy thanked LC for the report, she referred to stats relating to the Routine Childhood Programme (page 8). She commented a more rapid decline has been seen in the past 5 years. She queried if the 'Anti-Vacc' campaign during the Pandemic had an impact, also unproven links to autism. She also queried downward trends relating to older children. LC referred to a new phenomenon 'vaccine fatigue'. She agreed comms are vital to encourage uptake. Through IPQR, QI approach,	

	inclusivity group established, much work is being carried out to encourage uptake and improve confidence. LC advised, HPV vaccine is now proven to eradicate cervical cancer. Work is taking place with education, looking at data to target improvement actions. Cllr Kennedy, queried why S2, S3 as well as S1 for HPV? LC advised, a rolling programme is used to catch all youngsters. FF welcomed the excellent paper. She spoke of the vaccine supply chain, continuous review of model of delivery ensuring flexibility. Also guaranteeing alignment with the Cold Chain Supply Model to ensure vaccines are available at the right place at the right time. Including pharmacy colleagues in conversations relating to changes to models for service delivery is vital. FF was very supportive of the direction of travel. SB queried if vaccines can be wasted if people do not attend appointments. LC stated, processes are in place to minimise waste, although there is a tolerance for a minimum of waste. Always maximising reduction of waste as far as possible, working with Pharmacy colleagues. Cllr Liewald queried pre-school uptake, ie. playgroups. She suggested, if available, could staff drop in to give informal chats regarding uptake? Some parents choose not to take children, perhaps through lack of correct knowledge. LC thought that was a very good suggestion and will take it back to the team. Cllr Liewald will forward contact details of the groups. LC will take away to look at ensuring there is available resource. Cllr Kennedy felt it would be helpful to know the outcome of this idea as it could be a point of contact she could refer queries to. LC will progress through the Transformational Group, Quality Improvement and Increase of Uptake, and will feedback. SB commented she hears of mothers taking advice through social media, which she felt quite troubling. She felt a national concerted comms campaign is required. The Committee were content to take Assurance from the report.	**Cllr Liewald / LC**
9	**LEGISLATIVE REQUIREMENTS & ANNUAL REPORTS**	
9.1	**Learning from the Deaths of Fife's Children and Young People Annual Report 2023-2024** This report is brought to Committee by **Lisa Cooper** and comes for **Assurance**	

	LC acknowledged the sensitive nature of the report and from a statutory perspective, it is mandatory for Fife HSCP to ensure there is learning from any child death. She stated, the report stipulates the processes in place which fall under the responsibility of the Executive Director of Nursing. In Oct 21, Scottish Government mandated a National Process to ensure there is learning from Child Deaths and the Child Death Oversight Panel was convened, led by a Consultant Paediatrician. LC advised, this is the 2nd report to be brought forward and covers a 15 month period. Moving forward, will be an annual report, aligning with the fiscal year. Interventions and protections will be put in place as identified through the Oversight Panel. The age of the children are aged up to 18, and 26 for those in care experience. The report advises of 20 deaths within the reporting period, 2 out-with Fife. 70% of those deaths were males, and all those over the age of 14 were males. LC outlined various statistics from the report. She gave assurance learning is taken from the approach being taken. Cllr Kennedy agreed it was difficult conversations to have and acknowledge it could be sensitive to those involved on the call or group. She felt there was a good deal of positive information contained within the report. She referred to the most common cause – chronic medical conditions, she asked if families who do not take up support at the time of their child's death, are we confident there are follow up processes and if there is an ability to recognise where support is required. Trauma experienced years ago may come back to Services. LC did not have data but will come back to Cllr Kennedy. Families who choose not to engage in support at the time will be followed up. LC will check available data and come back to Cllr Kennedy. Support for staff was discussed and LC advised, debriefs and supporting staff is fundamental and ongoing. She gave an unspecified example where she has knowledge of support being provided. Assurance was taken from the report.	**LC**
9.2	**Mainstreaming the Equality Duty and Equality Outcomes Progress Report – January 2025** This report is brought to Committee by **Audrey Valente**. It comes for **Assurance, Discussion and Decision.** AV explained the report is an update on the progress relating to achieving quality outcomes, set by IJB in April 2023. AV introduced AS to speak to the report. AS advised the report is on route to the IJB via this committee and the Finance Performance and Scrutiny committee. The Equality Act 2010 places a number of duties on public bodies, including IJB. The duties are outlined in the Background section of the SBAR. Fife HSCP last published its mainstreaming Equality Duty and Equality Outcome	

	Progress Report in 2023, when it also set out new equality outcomes as part of the Strategic Plan. AV outlined the main points from the report relevant to Q&CC. MF thanked AV and AS for the report. She wished to highlight Carers are included in the Partnership's protected characters. She asked if there could be a specific reference to Human Rights relating to Carers. AS will look to adapt the report. The Committee were content for the report to be escalated to IJB.	**AS**
9.3	**Drug Related Deaths Deep Dive Risk Assessment – NHS Board Corporate Risk Register** This report is brought to Committee by **Elizabeth Butters**. It comes for **Assurance.** EB introduced the report and advised a Deep Dive Risk Assessment was carried out following a requested from NHS Fife to include Drug Related Deaths within their Corporate Risk Register. She stated NHS Tayside have also included DRD within their Risk Register, making Fife the second Board in Scotland to do so. EB highlighted the main points from the report, the importance of partnership working, the limitations of the NHS and the work of the ADP. She fully explained the content of Appendices. MF queried if it was known how individuals were obtaining prescription drugs. She also questioned if there is any evidence of grooming gangs operating in Fife, similar to Tayside. EB advised there is no doubt there are levels of diversion of prescription drugs. High risk pain medication work is being undertaken to understand the picture better, how this medication is prescribed, looking at warning people of mixing prescribed medication with illicit drugs. She pointed out not all elements can be controlled but able to warn people to be aware of dangers. She spoke of the Young Person's Rapid Action Group, warning young people of poly drug use, speaking to parents, raising the profile of risks within schools. A good deal of progression in this area. EB was unaware of grooming gangs operating in Fife exploiting vulnerable people. FF described the work being carried out over the past 2 years re high risk pain medication. She stated, Gabapentin is implicated in over half of drug deaths. If high levels are being prescribed, it gives greater chance of diversion. FF reported prescribing rates are starting to plateau with further work being put into understanding the rates of prescribing. It is important patients with long term pain have access to suitable medicines and other means to alleviate pain. As a priority, is being taken through the High Risk Pain Medicine Safety Group which feeds into the Medicine Safety and Policy Group across NHS Fife.	

	Looking to see what can be done differently. FF gave assurance is a high priority and the DRD Deep Dive will be taken through the HRPM Safety Group. LG referred to safe places to inject drugs offering proper equipment. Deaths may be caused by infection, although it is difficult to accept promoting illegal practice – in terms of reducing deaths may be helpful. Asked for EB's thoughts. EB felt it was a very innovative and interesting approach and has been quite effective, ie in the event of an overdose. She stated, Edinburgh have introduced a Safety Injecting Room. For Fife to introduce a site, a very extensive Needs Assessment would be required and she explained some of the considerations. She explained, in Glasgow and Edinburgh the sites are in City centres where there is a homeless population, which is not the case in Fife, so would be very different. It was agreed it would be wise to take learning from Edinburgh and Glasgow as trials progress and consider how it could work in Fife. LG was keen to investigate and unpick the reasons for death. JT advised the consulting room in Glasgow is on the verge of opening and it will be useful, through Fife's strong links with Glasgow, to learn from their experience. Also, she stated there is now more determination from Police Scotland targeting the supply of drugs, hoping this has impact and will effect the drug deaths in Fife. CG fully supports all recommendations within the report. Cllr Liewald referred to the KY work and the effectiveness of the programme can be seen on page 170. In Cowdenbeath area where there is the highest number of deaths, there has been a change of venue to the Maxwell Centre. She spoke of further work relating to 15-24 yo age group. She highlighted a change of attitude and perspective within the community – more empathy and understanding that drug addiction is an illness. She felt this was something which needed to happen and very glad to hear it, as this was not the situation previously. She would like to expand the work of the KY. She asked EB what she felt KY could do. EB and Cllr Liewald will chat offline. ID referred to the graph on deaths which peaks at 2019 and then a downward trend. He asked how deaths from overdose and deaths from long term use, how this will affect the rate of reduction, ie. if most people die from long term use, could this take longer to improve figures. EB advised the definition of what a DRD is, is decided by National Records Scotland. HSCP look at all drug-related deaths. She explained the treatment is the same for both and gave detail. SB thought it was absolutely correct the DRD be added to the NHS Fife Corporate Risk Register and was pleased to see the Equality and Human Rights Team embedded National Collaborative Rights for People Effected by Substance Use. She agreed with Cllr Liewald regarding stigma, as this prevented people coming forward for help. The possibility of Rehab facilities within Fife were discussed.	**EB / Cllr Liewald**

	CG commented, the focus is on 'Intervention' and 'treatment'. However, drug use is inextricably linked to prevention at early stages (often chaotic home lives) or environments being the cause. It is absolutely a multi-agency issue not just health. SB confirmed the Committee took Assurance from the report.	
10	**EXECUTIVE LEAD REPORTS & MINUTES FROM LINKED COMMITTEES**	
	10.1 Quality Matters Assurance Group Unconfirmed Minute from 01.11.24 **10.2 Clinical Governance Oversight Group** Unconfirmed Minute from 01.11.24 **10.3 Strategic Planning Group** Minutes Unavailable **10.4 Fife Alcohol, Drugs and Therapeutics Committee** Unconfirmed Minutes 23.10.24 **10.5 Equality and Human Rights Strategy Group** Unconfirmed Minutes 24.11.24	
11	**ITEMS FOR ESCALATION** No items for escalation.	
12	**AOCB** LG asked if SB could ask the meeting after each presentation if the paper should be escalated to IJB. If Assurance is taken, a report should not need to be escalated. All Committees will be asked to do the same. MF was supportive of LG's comment and would like to avoid duplication. LG plans to work towards minutes being shared at IJB will give Assurance to IJB. Also, avoidance of the same papers going to every committee. Moving forward, the intension is to create an SBAR template which is specific to each Committee, ie. considering a paper through a finance lens will be different from a quality lens, therefore a different narrative. A reviewed SBAR template will be developed. Cllr Kennedy asked the minutes in Item 10.3 have titles of those attending the meeting. JC will ask for titles to be recorded at future meetings.	**LG / VS**
13	**DATE OF NEXT MEETING** **Thursday 6th March, 1400hrs, MS Teams**	

HEALTH AND SAFETY SUBCOMMITTEE

(Meeting on 7 March 2025)

No issues were raised for escalation to the Clinical Governance Committee.

Health and Safety Subcommittee

Minute of the H&S Sub-Committee Meeting
Friday 7 March 2025 at 1 pm on Teams

Present
Neil McCormick, Director of Property & Asset Management (Chair) (NMcC)
Janette Keenan, Director of Nursing (JK)
David Miller, Director of Workforce (DM)
Jillian Torrens, Head of Complex & Critical Care, HSCP (JT)
Dr Chris McKenna, Medical Director (CMcK)

In Attendance
Billy Nixon, H&S Manager (BN)
Anne-Marie Marshall (Manual Handling Team Lead (A-MM)

The order of the minute may not reflect that of the discussion
The meeting was recorded on Teams

No.		Action
1	**Welcome & Apologies** NMcC welcomed members of the Sub-Committee to the meeting. Apologies were received from Paul Bishop and Iain MacLeod.	
2	**Minute/Matters Arising**: The Minute of 6 December 2024 was **approved** as an accurate record. Item 1 - Staff Side Representation Action - David Miller agreed to take forward to Staff Side the lack of representation at H&S Sub-Committee meetings. By way of an update, DM has been in touch with the Employee Director who is happy to have a conversation with Staff Side and provide him with an update. DM added that Lynn Parsons has agreed to cover attendance until a rep is in place. **Action now closed.** Item 4.1 - Self-Harm Ligature Risks Action - BN circulated a one-off summary document on self-harm incidents (use of personal items) to the Sub-Committee out with the meeting. **Action now closed**.	

	Item 4.2 - H&S Heads of Service Riddor Reporting Exercise Riddor Reportable information over the past 5 years was gathered from Scottish Boards identifying varying numbers of Riddor incidents across Scotland. It was agreed that the report be distributed to Sub-Committee members for information. Action - BN distributed a summary document to the Sub-Committee out with the meeting **Action now closed**.	
3	**Governance Arrangements** 3.1 Health & Safety Sub Committee Annual Statement of Assurance 2024-25 A 'draft' copy of the Health & Safety Sub-Committee Annual Statement of Assurance 2024-25 will be prepared and distributed to Sub-Committee members prior to the next meeting. Action - Andrea to take this forward. The Annual Statement of Assurance (draft) will be distributed for final approval prior to the next meeting on 6 June 2025. Following approval by the Sub-Committee, the Annual Statement of Assurance 2024-25 will be noted at the next Clinical Governance Committee when it meets on 2 May 2025. 3.2 H&S Sub-Committee Annual Workplan 2025-26 The H&S Sub-Committee Annual Workplan (draft) will be prepared by BN and distributed to the Sub-Committee in advance of the next meeting. Action - Andrea to take this forward. The Annual Workplan (draft) will be distributed to the Sub-Committee for final approval prior to the next meeting on 6 June 2025. 3.3 Health & Safety Sub-Committee Terms of Reference 2025-26 A 'draft' copy of the Health & Safety Terms of Reference (ToR) for 2025-26 was distributed to the Sub-Committee members prior to the meeting. The ToR (draft) was presented and **approved** at the meeting by the Sub-Committee members. Post Meeting Note - A copy of the approved Health & Safety Sub-Committee Terms of Reference 2025-26 was circulated to members of the Sub-Committee following the meeting.	**Andrea** **Andrea**
4	**Operational Updates** In relation to the quarterly publication of the H&S Incident Report, comments were received from the Auditors in relation to introducing a	

	dashboard and additional graphical images showing changes to incidents over time. BN actioned the request and has added yearly graphs which show trending data for each of the sub-sections in the report. This was presented to the Sub-Committee today. Comments are welcome. JT thanked BN for the content displayed in the report. She asked if the term 'unwanted behaviours' from the Self-Harm section could be changed in any way? A-MM advised that the term 'unwanted behaviours' is the way it is presented and worded on the Datix system drop down menu. Action - Moving forward, the wording on the Incident Report will be amended to '**Challenging Behaviours'** of which the Sub-Committee **agreed**. DM thanked BN and was fully supportive of the content from a Staff Governance point of view particularly around trends and how we action and make recommendations on the data collected. NMcC added that it is important to keep the Incident Report as factual as possible and minute any trends or significant data that peaks or stands out. He added that he was pleased to see that the collective data does not appear to be any worse as a result of the introduction of the yearly data adding that awareness and taking ownership of the data is key. The Incident Report, containing the new data and graphical images, will be discussed at the following meetings in terms of feedback: • Staff Governance Committee when it meets on 13 May 2025 • Area Partnership Forum when it meets on 21 May 2025 4.1 H&S Incident Report (December - February 2025) The H&S Incident Report for the period December 2024 - February 2025 was distributed and noted by the Sub-Committee. **Sharps** (staff) 32 reported incidents in the quarter, of which: 11 incidents - no harm 18 incidents - minor harm 3 incidents - moderate harm For the quarter, there were 19 sharps incidents recorded with no SBAR attached. BN advised the Sub-Committee that he had met with Lynn Barker, Director of Nursing and Cath Gilvear, Head of Quality & Clinical Care Governance, Fife HSCP had been in touch and it was agreed that Datix incidents with accompanying SBAR documents will be discussed and managed at local meetings moving forward. Action - BN agreed to distribute on Blink a message regarding the importance of an accompanying SBAR with each Sharps Datix report, adding that this arrangement applies to all sharps incidents and near misses and not just major or extreme incidents.	**BN** **BN**

Update - JK advised that the implementation of the InPhase app for adverse events has been delayed until April 2026.

Slips, Trips & Falls (staff)
13 reported incidents in the quarter, of which:

11 incidents - minor harm
2 incident - moderate harm

Violence & Aggression (staff)
323 reported incidents in the quarter, of which:

230 incidents - no harm
79 incidents - minor harm
14 incidents - moderate harm

- Incidents reported to Police = 24
- Incidents reported as sexual assault/harassment = 30
- Incidents reported as hate crimes = 24

Musculoskeletal (staff)
7 reported incidents in the quarter, of which:

1 incident - no harm
3 incidents - minor harm
3 incidents - moderate harm

- 3 load handing
- 4 patient handling

Self-Harm (patients)
72 reported incidents in the quarter, of which:

32 incidents - no harm
31 incidents - minor harm
7 incidents - moderate harm
1 incident - major harm
1 incident - extreme harm

Riddor (all)
8 reported incidents in the quarter, of which:

7 incidents - moderate harm
1 incident - major harm

4.2 Reinforced Autoclaved Aerated Concrete (RAAC) Update

NMcC advised that Phase 2 of the detailed surveys, which have been tendered nationally, have begun and we have mitigated several areas, particularly at Lynebank Hospital, in readiness. Point Cloud laser scanning surveys will identify whether there is any bowing or deflection of beams These surveys will identify whether there is any change to the condition of the buildings in question. These surveys will be funded nationally as a Project moving forward and can be carried out on a regular basis.

	In terms of our yearly RAAC inspections, as it stands at the moment, there has been no indication that RAAC in NHS Fife buildings has deteriorated or is any worse than it was from previous inspections. Once we move into more detailed inspections, then this will determine whether there are any remedial actions we have to take. A Scottish Government appointed Surveyor has also been conducting regular surveys on our sites. 4.3 Manual Handling and Other Training Updates • A-MM advised that the Moving and Handling Policy has now been published on Blink. • Moving and Handling task specific risk assessments have been re-written and are now accessible on Blink. • Training is going well, working closely with the HSCP on health and safety. • Investing in the purchase of Lateral Lifting equipment is being considered and discussions continue with teams in Acute and the HSCP. Funding is currently being sourced. • The new training for Portering staff has been a resounding success! 4.4 Sharps Incident Review Discussed in item 4.1 above.	
5	**HSE Enforcement Activity** There was no enforcement activity to report within NHS Fife. In terms of ligature risks, BN advised that his team were comfortable working with the ligature identification tool and added that they are working closely with the mental health team and other groups to look at specific ligature risks. NMcC mentioned the number of ligature points in the Accident and Emergency Department and suggested a Risk Assessment be carried out to identify these. Enforcement activity continues in several Boards throughout Scotland.	
6	**Policies & Procedures** 6.1 Glove Selection Procedure Review (GP/G1-1) BN advised the Sub-Committee that the Glove Selection Procedure Review (GP/G1-1) will be discussed at the next meeting on 6 June 2025. Action - Andrea to add as an Agenda item. Post Meeting Note - Action complete.	**Andrea**

	6.2 Health and Safety Policy BN advised that the Health and Safety Policy is due for renewal in the near future and will be discussed at the next meeting on 6 June 2025. Action - Andrea to add as an Agenda item. Post Meeting Note - Action complete.	**Andrea**
7	**Performance** 7.1 ASD&CD H&S Committee Update The ASD&CD H&S Committee Minute of 15 November 2024 was circulated in advance to members of the Sub-Committee for noting. 7.2 HSCP H&S Assurance Group Update The HSCP H&S Assurance Group minute of 29 October 2024 (unconfirmed) was circulated in advance to members of the Sub-Committee for noting. JT added that the on-going focus is around the ligature work, with a Ligature Programme Board meeting taking place on a monthly basis. The Sub-Committee agreed for the HSCP Ligature Programme Board minute to be distributed for noting at meetings moving forward. Action - JT to take this forward. Action - Andrea to add Ligature Programme Board Meeting Minutes as a standing item on the Agenda from the next meeting on 6 June 2025. Fixtures and Fittings - JT advised that the risks around replacement soap dispensers and curtain rails (around beds) remains outstanding since December 2024, in terms of an installation date. She added that the replacement items are on order. NMcC asked that JT contact Paul Bishop in order to address this as a priority. Action - NMcC to take this forward and speak to his colleagues and provide an update to the Sub-Committee when it next meets on 6 June 2025.	**JT** **Andrea** **NMcC**
8.	**Any Other Business** 8.1 New Violence and Aggression Trainer BN was pleased to advise that following a successful interview, Sonia O'Keefe has been appointed as Violence and Aggression Trainer. Sonia is experienced in violence and aggression and is knowledgeable in her field and she will work collaboratively with Bill Coyne, Violence and Aggression Advisor. 8.2 Moving and Handling Training Update	

	By way of an update in terms of training, JK added that work pressures and staffing issues, with the non-use of supplementary staff, during a particularly busy time contributed to the lack of attendance at training sessions in the past. She added that training attendance levels will continue to be monitored. 8.3 Update following a recent meeting with the Scottish Fire and Rescue Service NMcC advised that he and BN had had a helpful and supportive discussion with the local fire service, particularly around a recent inspection. As a result of this, a list of the 'top ten' improvements around the estate in terms of fire prevention has been drawn up. The Sub-Committee agreed for this item to be discussed at the next H&S Sub-Committee when it meets on 6 June 2025. Action - Item to be added to the agenda. Post Meeting Note - Action complete. Action - BN to present and discuss the 'top ten' fire prevention improvement list at the next meeting on 6 June 2025. JK added that following the Safe Delivery of Care Inspection, a fire related item had been added to every inspection so far. NMcC added that there were outstanding items raised around risk assessments and he is aware that an Action Plan has been drawn up by Norma Beveridge to respond to this. Fire risks include general ward house keeping issues in terms of storage, particularly in areas close to fire escapes. Compliance numbers in terms of mandatory fire training in Acute Services was also highlighted, which has been given priority in the Action Plan mentioned above. NMcC added that additional support following Risk Assessments may be required from BN and the Fire Advisors on Acute Wards to highlight and challenge some of the behaviours and correct them, several of which will require intervention from the Estates teams and several of which will be staff related in terms of behaviour and training in fire safety.	**Andrea** **BN**
9	**Date & Time of Next Meeting** Friday 6 June 2025 at 1 pm on Teams.	

Infection Control Committee

INFECTION CONTROL COMMITTEE (Meeting on 1 October 2024)
No issues were raised for escalation to the Clinical Governance Committee.

Fife Health & Social Care Partnership | NHS Fife

Infection Prevention and Control Team

Infection Control Committee Minutes (unconfirmed

1st October 2024 at 1400 via Teams

Item No	Subject	Actions
1	**Attendees** Nicola Robertson, Director of Nursing (Chair- deputising for Janette Keenan) **NR** Claire Connor, Dental Practice Co-Ordinator **CC** Amy Mbuli, Lead IPCN **AMb** Lynsey Delaney, Infection Control Surveillance Audit Midwifed **LD** Midge Rotheram, Support Services Manager **MR** Julia Cook, Infection Control Manager **JC** Catherine Gilvear, Head of Quality, Clinical & Care Governance **CG** Mirka Barclay, Senior IPCN **MB** William Nixon, H&S Manager **WN** Suzanne Watson, Senior IPCN Care Homes **SuW** Paul Bishop, Assoc. Director of Estates **PB** Fiona Bellamy, Senior HPNS **FB** Sharon McDonald (Minutes) **SM**	
	Apologies Janette Keenan, David Griffith, Steven Wilson, Keith Morris, Priya Venkatesh, Norma Beveridge, Iain McLeod, Neil McCormick, Aileen Lawrie, Lynn Barker, Elizabeth Dunstan, Jamie Gunn NOTE- meeting not quorate as no Consultant Microbiologist in attendance. Agreed to continue meeting but any decision making actions would be carried forward to next meeting	
2	**Minute of Previous Meeting** Minutes of previous meeting were approved.	
3	**Action List** • (Pt. 11) JC to email SB for update on meeting re staff immunisation screen, prior to next meeting. • (Pt. 10) AM – paper has gone to SLTs for escalation to EDG (re isolation period) following discussions re EDG / National Guidance regarding COVID. Contact part of paper is live. NR will take to EDG on 3 Oct. 24. • (Pt. 7) AM to take to Pharmacy - issues about linking in with communications re CDI increase due to PPI. • (Pt. 5) JC to meet with SMcG and RG – now waiting to get date fixed in diaries with lab managers. • (Pt. 4) JC has met with SP re pertussis boosters for staff every 5 years. Guidance has since been released. No OH representation at today's meeting. • CG raised issues with Lanquip and lack of InPhase or MEG system. NR added that InPhase should be in place by the end of the financial year. JC and NR to speak to Clin.Gov. colleagues re timeline for InPhase.	**JC** **AM** **AM** **JC** **JC/NR**
4	**Standing Items**	
4.1	**Risk Register** 3 high level 15 moderate level 1 low level	

	2 new risks from the HPT (3026 respiratory infections for vulnerable settings) & (3027 emergent infectious diseases) Reduction in 1 risk – water systems contamination Closed 3 risks – SAB LDP standard, ENT W5 complete, IPC workforce. 2 remain despite meeting targets – Legionella and Pseudomonas JC advised MORSE is yet to be added to the Risk Register.	**JC**
4.2	**HAIRT Board Report** LD gave overview of report. Up to end August 2024 Q1 ARHAI report • SAB – reduction in year ending totals. 5 PVC related SABs, CCR been done on each. No further dialysis line this year. 7 PWID related. • CDI – reduction in year ending totals. Slight increase in CA CDIs. PPI most common risk related. **MRSA & CPE** • NHS Fife compliance rates down for Q2. Met MRSA, CPE below target. A further review of the non-compliant cases identified a delay in submission to PatienTrak, but recorder on paper assessments. **ECB** Increase in total and HCAI. Reduction in CAUTIs. **UCIG** Group met in August. **Domestics & Estates Monitoring** Above targets- GREEN status. **Outbreaks** July & August 2024 • 3 GI • No flu outbreaks • 5 COVID-19 – no COVID related deaths. JC raised project bringing in electronic health records to be introduced in NHS Fife in Summer of 2025, will hopefully help with MDRO reporting. CG asked about trends/clusters that can be highlighted re CDI CO cases. Meeting to be arranged to discuss further.	**JC/PV/LD**
4.3	**Care Home Update SW** • Support following Care Inspectorate issues – walkabout and bespoke training. • Education – SCIPS, Winter Preparedness, Scabies protocol and awareness (192 staff and >16 homes) • Link Practitioner training 8 Care Homes completed, 1 to follow and 1 did not attend, which SW will follow up. • Working with Dermatology re scabies awareness and training with AMPs and GPs. • Routine visits – monthly contact, bi-monthly visits all on tract • Scabies Awareness training has been implemented in CH with very good uptake. MR raised cleaning spec to be updated at national level in CH – MR will chase.	**MR**
4.4	**NHSS National Cleaning Services Specification** • Report was discussed. • Results for NHS Fife remain stable. • Quarterly average is slightly higher for NHS Fife than NHS Scotland. • Peer and Public audits continue. • Annual Facilities Questionnaire Report was completed in June 2024 and been issued widely.	
4.5	**Learning Summary** Nothing to report. Discussion about how we want learning summaries presented at IPCC. Minutes from CCRs to be sent to IPCC. Themes being pulled from PAN Fife group. JC to have conversation with TL and JD. Anything to be shared with Organisational Learning Group.	**JC**
4.6	**National Guidance** AM reported updates: MPox Clade 1 review and update to national guidance.	

4.7	**Isolation & Risk Assessment** JC discussed SBAR around mental health and required Risk Assessment to be added to MORSE, as discussed earlier to be added to Risk Register as D&I have indicated likely not in place till next year.	
4.8	**Quality Improvement Programmes** **PWID & UCIG** CG – discussed MAT4 group meeting.	
4.9	**Education** AM reported: IPC Study days – went very well, received positive feedback. A further study day has been arranged to take place at QMH 31st October. Student Nurse training day in August 2024 in conjunction with University of Dundee and NHS Tayside. St Andrews year 3 medical student IPC/Wound Care module has commenced, in conjunction with tissue viability team. Increased HCID/PPE training in light of Mpox Clade 1 alerts. NQP sessions well attended. SCRIBE education provided at Glenrothes hospital with Estates, which has been requested further. JC raised AMR and IPC Specialist Career Development Frameworks are =being developed/under review by NES.	
4.10	**Infection Prevention & Control Audit Programme Update** JC reported: August 10 audits were carried out, with 5 re-audits. Discussion re collaborating with care assurance audit.	
4.11	**HAI-SCRIBE** AM highlighted: OOS location walkabouts continue. Refurb has started in renal dialysis at QMH. Pitcheucar HC refurb work starting in ~2 weeks.	
4.12	**Capital Planning** MB updated - MH project in QMH ward 3 refurb started August, will be mix of General Psychiatry and Older Adults Audiology booth work started in ENTHN. Phase 1 VHK, Cameron and RW work coming to an end.	
4.13	**HCAI Strategy** JC gave update. 2 year strategy, to provide foundations of the next 5 year IPC strategy 2025-2030. No updates, at present, from year 1. Will report further information following attendance at Working Together event at Golden Jubilee with CNOD on 2 October.	
4.14	**Infection Prevention and Control Annual Work Programme Update** JC reported ongoing challenges around AMR and AMR workforce. SSI Surveillance Programme remains paused. SLWG nationally.	
4.14	**Health Protection** Duncan F-W will attend the 4th December meeting, to receive SBAR update in advance.	**JC**
5	**New Business**	
5.1	**Incidents/Outbreaks/Triggers** AM reported, communication documented as positive experience between wards/units and IPC. A challenge noted around cleaning. HCW not always able to do their part to allow the domestic teams to do their work. Where concerns are raised, extra training has been given at the time and post closure. Pseudomonas – no further cases than initial 4. SCRIBE is completed, awaiting timeframe to start works to remove taps.	
5.2	**The IPC Workforce Strategy 2022-24** Nothing new to update.	
5.3	**PAN NHS Fife IPC Group** AM advised, new group combines acute and HSPC governance group to feed up into ICC any themes, trends and concerns for escalation.	
5.4	**ICNET AND LIMS** ICNET and LIMS integration still not fully functioning. Coding has not been mapped fully. PoC testing locations has not been resolved. Remains on the risk register.	

6	**Infection Control Committee's Sub Groups – Minutes/notes of meetings**	
6.1	**Infection Prevention & Control Team** Nil to raise.	
6.2	**NHS Fife Decontamination Steering Group** Nil to raise.	
6.3	**NHS Fife Antimicrobial Management Team** Nil to raise.	
6.4	**NHS Fife Water Safety Management Group** Nil to raise.	
6.5	**NHS Fife Ventilation Group** Nil to raise.	
6.6	**NHS Fife HAI Scribe Planning Group** As presented earlier.	
6.7	**Quality Reports** Nil to raise.	
7	**Any Other Business**	
	JC discussed the ARHAI Scotland TBP literature review – now expected Spring 2025. Chapter 4 – DL re water safety – SLWG will need to be arranged to have in place for 1st of January 2025 NHS Fife IPC won a silver IPS award for nurturing new IPC talent at the IPS Awards. CC added how useful she found the face to face training at the IPC study day.	
8	**Date of Next Meeting**	
	4th December 2024 at 2pm, via Teams.	

MEDICAL DEVICE GROUP

(Meeting on 12 March 2025)

No issues were raised for escalation to the Clinical Governance Committee.

Medical Device Group

Minutes Medical Device Group
Wednesday 12 March 2025 at 2 pm on Teams

Present
Dr Chris McKenna, Medical Director **(Chair)** (CMcK)
Neil McCormick, Director of Property & Asset Management (NMcC)
Maxine Michie, Deputy Director of Finance (MM)
Rose Robertson, Assistant Director of Finance (RR)
Mike McAdams, Estates Compliance Manager (MMcA)

In Attendance
Allan Young, Head of Digital Operations for Alistair Graham (AY)
Julia Cook, Infection Control Manager (JC)
Paula Lee, Head of Procurement (PL)
Nicola Robertson, Director of Nursing - Corporate (NR)
Miriam Watts, General Manager, Directorate Office Planned Care (MW)
Robyn Gunn, Head of Laboratory Services (RG)
Dr Frances Quirk, Associate Director RIK, Research & Development (FQ)
Bryan Hynd, Head of Medical Physics, NHS Forth Valley (BH)

The meeting was recorded on Teams
The order of the minute does not necessarily reflect that of the discussion

		Action
1	**WELCOME & APOLOGIES** Members were welcomed to the meeting. Apologies were received from Alistair Graham (Allan Young), Kevin Booth (Paula Lee), Gemma Couser and Iain MacLeod. NMcC advised that he had extended an invitation to Bryan Hynd, Head of Medical Physics, NHS Forth Valley to join today's meeting. Bryan has provided NHS Fife with invaluable professional advice around medical physics and he continues to support MMcA. Following discussion the MDG agreed that an invitation be extended to BH to attend future meetings of the group. Post Meeting Note - Teams invites have been sent to Bryan for quarterly MDG meetings for the remainder of the year.	**Andrea**

2	**<u>MINUTE OF LAST MEETING/MATTERS ARISING</u>** The Minute of 11 December 2024 was approved by the Medical Device Group (MDG).	
3	**<u>ACTION LIST from 11 December 2024</u>**	
3.1	<u>MDG Terms of Reference</u> - On-going. Attendance list to be narrowed down to include one representative from each relevant sector.	**CMcK/NMcC**
3.2	<u>Medical Device Policy</u> - On-going. Awaiting further guidance.	**MMcA**
4	**<u>GOVERNANCE</u>**	
4.1	<u>Medical Device Group Terms of Reference (draft) v5</u> Overall, as it stands, the ToR is on-track except for the attendance list. CMcK and NMcC **agreed** to discuss and narrow down the list to include only necessary attendees/one representative from each sector. FQ added that in terms of clinical research, there is no reference to innovation in the MDG ToR. Clinical trials are mentioned however, innovation is where most discussions will feature. The MDG agreed that a section on innovation be added under the Responsibility Section of the ToR. NMcC **agreed** to take this forward. The ToR will then be sent out to the MDG via email for approval.	**CMcK/ NMcC** **NMcC** **Andrea**
4.2	<u>Medical Device Group Annual Statement of Assurance</u> (draft) NMcC advised that the MDG Annual Statement of Assurance (draft) will be updated over the next few weeks and will then be sent out to the MDG via email for any comments. The MDG Annual Statement of Assurance will be on the 11 June 2025 Agenda for final approval by the MDG.	**NMcC Andrea**
4.3	<u>Medical Device Policy</u> (revised) (draft) MMcA advised that he is awaiting further guidance in terms of the Medical Device Policy. NMcC added that the Scottish Government department are happy that our existing Medical Device Policy and Medical Equipment Policy meet the necessary requirements.	

	Effectively, we will move over to having an agreed style of Medical Device Policy that other boards are adopting including software as a service and research and innovation. In terms of the National work around the Medical Device Policy, BH advised that work is continuing the creation of a standard template by the Short Life Working Group in conjunction with the Board Chairs of Medical Device Committees on how the policy should look. The new Medical Device Regulations have still to be published and, therefore, everything remains in draft format for the time being. He added that ideally, the aim is to reach the point where the 14 boards across Scotland will follow the same format. The expectation now is that each board must have a Medical Device Policy in place and have it published on their website by the end of March 2025. Colleagues from NHS Assure are in the process of producing an Audit Checklist which will ensure that each policy encapsulates input from other areas eg digital, procurement, clinical teams and general management, in the form of appendices, where necessary. FQ mentioned that in terms of clinical research, there is no reference to innovation in the Medical Device Policy. Clinical trials are mentioned however, innovation is where most discussions will feature. MMcA advised that a section has been added to the Policy around Clinical Research, however, innovation can be included in this, if required? The process of controlling this equipment has been removed from the Policy, allowing Research and Development (R&D), to manage their own Policies and Procedures. <u>DL(2024)32 - Safety of Health, Social Care, Estates and Facilities Equipment: NHS Board and Local Authority Responsibilities</u>	
4.4	NMcC advised that the circular has requested: • A single point of contact in NHS Fife for issues relating to the safety of medical equipment across Scotland • An identifiable Alert Safety Officer for NHS Fife NMcC added that NHS Fife may be best served by appointing the Head of Health and Safety given this would be more of a health and safety issue and with the support of MMcA as co-ordinator. We could then focus our interventions with the people who are using the equipment on a day-to-day basis. Following consultation with BH, NMcC advised that he was supportive of the planned process and will respond to the Circular accordingly.	

	The MDG agreed that MMcA review the Medical Device Policy (draft) to ensure everything has been covered including the title and responsibilities.	**NMcC/Andrea** **MMcA**
5 5.1 5.2	**<u>FOR DISCUSSION</u>** <u>Scan for Safety Update</u> With the last Scan for Safety meeting having been cancelled, a new date of 20 March 2025 has been arranged and will be held on-site. CMcK provided an update on behalf of GC advising that there is a plan to implement Scan for Safety hopefully, by the end of the year. He added that an Implementation Group will be set up around April 2026. CMcK stressed the importance of Scan for Safety aligning with D&I implementations by ensuring that resources and time were made available, adding that a written update would be helpful for the next meeting. The MDG **agreed** for AY to take the preparation of a report forward for the next MDG meeting on 11 June 2025. Looking forward, NMcC added the importance of our D&I and Medical Physics teams working together around this in terms of looking at an interface link whereby a role that connects medical equipment and digital devices to the internet and the network. <u>Software as a Medical Device</u> CMcK added that it would be helpful to have a report specifically from D&I on how Scan for Safety and Software as a Medical Device fit together, detailing the guidance and governance around this. The report could take the form of an appendix to the main Medical Device Policy. BH advised that there was a National Shortlife Working Group set up to deal with software as a medical device with recommendations on how the governance etc should be provided. He added that it is key that Medical Physics will require to be part of the governance process by providing advice on whether a piece of software is actually a medical device or not, with D&I managing the process going forward. The MDG **agreed** for AY to take the preparation of a report forward for the next MDG meeting on 11 June 2025. <u>Replacement of T34 Syringe Driver Infusion Pumps - End of Life</u>	**AY** **AY**

5.3	RR confirmed that 199 T34 Syringe Driver Infusion Pumps have been replaced from this year's Capital Plan from additional capital monies secured. She added that in terms of planned equipment replacement, information held on the medical equipment database will be used to drive the planned equipment replacement programme. In order to apply the Medical Devices Policy into practise there will also have to be a separate process set up. Once these plans are in place, they will be shared with Medical Device Group colleagues to provide views and input to ensure that we have the standardisation, connectivity, procurement from the outset thus avoiding separate groups being set up for different pieces of equipment. NMcC added that the best practice around these infusion devices would be for them to be part of a programme of replacement. This will allow us to drive efficiency out of Procurement and in turn drive efficiency out of servicing. MMcA added that once the RFID System is up and running, we can then carry out an accurate inventory of what equipment we have across NHS Fife. Once this is in place, we will be able to predict what is going to come out of life within the next 10 to 15 years. <u>Replacement of Defibrillator Devices</u> RR confirmed that 155 defibrillators were replaced from additional capital monies secured. NR extended her thanks to Susan Fraser and the PMO team who assisted with the project plan. CMcK stressed the importance around the governance route and this way we can predict replacement plans. MMcA advised that when we add all our lifecycles to the National Medical Equipment Database eQuip, we can then start building capital plans for the future.	
5.4		
6	**<u>FOR INFORMATION</u>** There was no information to report.	
7	**<u>MINUTES FOR NOTING</u>**	
7.1	**<u>Capital Equipment Management Group</u>** (CEMG)	

(a) (b) (c) (d) 7.2 (a)	Copies of the Fife Capital Equipment Management Group minutes, noted below, were distributed to group members in advance of the meeting: CEMG Minute of 7 November 2024 CEMG Minute of 5 December 2024 CEMG Minute of 9 January 2025 (meeting stood down) CEMG Minute of 6 February 2025 There were no comments or questions raised by the group. **Point of Care Testing Committee** (PoCTC) A copy of the Point of Care Testing Committee minute of 4 December 2024 (unconfirmed) was distributed to group members in advance of the meeting. There were no comments or questions raised by the group.	
8 8.1	**ANY OTHER BUSINESS** CMcK extended his thanks on behalf of the MDG to Bryan Hynd for his attendance at today's meeting.	
9	**DATE & TIME OF NEXT MEETING** Wednesday 11 June 2025 at 2 pm on Teams	

MEDICAL & DENTAL PROFESSIONAL STANDARDS OVERSIGHT GROUP

(Meeting on 21 January 2025)

No issues were raised for escalation to the Clinical Governance Committee.

Medical & Dental Professional Standards Oversight Group

Medical and Dental Professional Standards Oversight Group
Draft Note of Meeting held at 3.00 pm on Tuesday, 21 February 2025 on Microsoft Teams

Present:	**Designation:**
Dr C McKenna	Executive Medical Director/Responsible Officer, NHS Fife (Chair)
Dr A Kelman	Associate Medical Director Fife Health & Social Care Partnership
Dr M Philp	GP Appraisal Lead
Mr E Dunstan	Secondary Care Appraisal Lead
Dr E O'Keefe	Director of Dentistry
Ms J Anderson	General Manager, Women, Children & Clinical Services
Dr S Savage	Associate Director for Risk and Professional Standards
Dr J Morrice	Associate Medical Director, Women and Children
Ms Lisa Cooper	Head of Primary and Preventative Care Services

Apologies:	
Dr I MacLeod	Deputy Medical Director – NHS Fife Acute
Prof M Wood	Director of Medical Education
Dr H Hellewell	Deputy Medical Director – Fife Health & Social Care Partnership
Dr J Tomlinson	Director of Public Health
Dr J Pickles	LNC Representative
Dr S McCormack	Associate Medical Director – Surgical and Medical Directorate
Mrs A Gracey	Medical Appraisal and Revalidation Co-ordinator
Mrs G Couser	Associate Director of Quality and Clinical Governance
Ms S Ali	Medical Education Manager

In Attendance:
Debbie McPherson

ACTION

1. Welcome/Apologies for absence
Apologies noted as above.

2. Draft Note of previous meeting (14/10/2024)
Minutes accepted by group as an accurate record.

3. Action Tracker

Action**:** Item 9 - Medical Workforce Planning - HSCP:
HH to bring the Portfolio Programme paper to the next meeting.

HH still to share portfolio careers document. AK to discuss with Jackie Drummond. — AK/JD

4. **Dental Education**

EO noted the difficulties of working within the regulations and ensuring the dentists we are enlisting into Primary Care are safe to practice, particularly overseas dentists. EU dental graduates are automatically listed with the General Dental Council (GDC) once they graduate from an EU university. They can then ask to join the list as an NHS dentist and all there is to go on is the GDC registration and a couple of references from university. A couple of situations have arisen recently within this and other health boards where they

have been dismissed within a matter of weeks or months from the practice. We are now trying to determine what other information we can get for new graduates. EO advised that Nicola Taylor is looking at what they do for GP listing here. EO asked if there is any learning from the GMC which would be helpful?

CM advised that overseas GPs need to do the NES equivalency programme before they get onto the Performers List. They will have also trained in General Practice so have post graduate training.

EO reported that the EU graduates come out as complete 'newbies' whereas the wider overseas dental graduates go through the equivalent process to the UK, so there is more of a safety mechanism for those. It is difficult to get relevant information for the EU graduates. CM thought this should be an issue for the Chief Dental Officer to look at.

EO moved on to report that the introduction of the core trainees within the salary dental service is going well and that there are specialty trainees in dental public health and orthodontics. Feedback is generally positive although cannot get a specific breakdown in specialty training feedback due to the small numbers.

5. **Medical Appraisal and Revalidation.**

SS noted that there is not a lot of change from last time. Priority areas are still to ensure all doctors have access to an appraiser when their appraisal is due and to support doctors through that. Recruitment of Secondary Care appraisers will still be a priority. To date we have had one applicant and two notes of interest for the role.

She also advised of the need to recruit to the Lead Appraisal Advisor post for Primary Care. SS and CM to finalise and send out paperwork. SS/CM

For period 1 October to 31 December there were 48 due to revalidate, 40 positive recommendations were made and 8 deferrals.

Challenges continue to be the recruitment of Secondary Care appraisers, currently 71 appraisees are unallocated. Our key achievement is managing to ensure each doctor has access to an appraiser when needed.

ED noted that it is not just about recruiting, it is about retention. He reported that in the past six months we have had two appraisers say they are stopping appraisal after a job planning session. Both were in the Women's, Children's and Clinical Services Directorate. ED is concerned that clinical or non clinical managers of that particular directorate may not understand the requirements for appraisals and to have adequate numbers of appraisers.

CM reported that he had spoken to JM about this and he is aware of the importance but that there are some workforce issues at the moment that are putting a lot of pressure on the teams but that this should hopefully resolve by around June. JM confirmed this and that he has been speaking to someone about becoming an appraiser.

CM referred to the MARQA report and noted that this had not been done since 2019. He noted that NHS Fife is 'middle of the road' with most of the statistics. He felt that the report reinforces that we have pretty good governance around appraisal and revalidation. There was some further general discussion around the report.

6. **Consultant and SAS Doctor Job Planning.**

CM reminded all that last year there were not many job plans signed off compared with this year where around 140 were currently signed off with a few more progressing towards having them signed off by the end of the month. Hopefully this coming year plans can be signed off earlier in the year so that we can work towards 100% completed job plans.

CM noted that having accurate job plans is essential for understanding how the service is provided with some specialties better than others at completing. He offered congratulations to everybody for the effort in getting this far. He believes that we can get to a point where everyone has a signed off job plan although some may need a bit of help and support to get their job plans onto the system.

CM suggested that an improvement action plan be pulled together to try and improve the trajectory and what actions need to be taken to do that. CM/SS to discuss. CM/SS

JM reported that the pathologists are all now job planned and signed off. He was not sure they had ever opened up an Allocate job plan before this year, noting that some specialties are starting from a different baseline. He also noted that there would be the incentive of not being able to apply for a discretionary point unless you have a signed off job plan coming this year.

CM advised that this has not been agreed with the LNC and that for now they must be engaged with the job planning process.

CM noted that it is a contractual obligation for consultants and SAS doctors to engage in job planning and that the process starts with them.

CM also mentions that EPAs are annualised contracts and need to be reviewed and signed off annually, which he noted is also a contractual obligation for job planning.

7. Medical Education.

CM reported that the biggest thing for medical education at the moment is the advent of the St. Andrew's MBCHB Programme; the first students will start their clinical placements a year from now. NHS Fife is lobbying the Scottish Government to change the legislation so that NHS Fife become one of five teaching Health Boards in Scotland, which should hopefully happen this year as we are now a Board with a co-delivered MBCHB programme.

CM advised that Deborah Williamson has been appointed as the new Dean of Medicine at St. Andrew's University. Originally from Dunfermline, she is a consultant in Public Health Microbiology and led the Covid pandemic as the Director of Laboratories in Melbourne and is a welcome addition.

CM reported that one of the old wards at Cameron has been turned into an education hub. There is a house with various rooms and a ward area which will be used as simulated environments that patients would be in. He noted the massive potential of the hub referring to teaching facilities, classrooms and scope for being a conference centre.

8. Medical Workforce Planning – Acute Services.

CM referred to the flash report sent by IM and noted that IM has been working with SS in bringing together a medical workforce strategy.

CM thought that the priority for the first part of the next financial year will be pulling a plan together; to include Acute and the Partnership as well. He noted that finance colleagues were pulling together a lot of the finance data. SS advised that she is going to a meeting to get the first rendition of that data.

JM added that at the SLT meeting they had discussed cost reductions but that he thinks these are precarious due to trainees still claiming they do not get breaks. Although there had been a reduction, he wouldn't be confident that this is going to be sustained consistently across all rotas.

JM also noted that there was inconsistency across various departments/ directorates as to what is available for study leave – what pots of money are being used, what should the rules be and how they should be communicated. CM advised that there is a policy agreed with the BMA and that a procedure to ensure the policy is implemented fairly and consistently across the Board is what needs developed. AK confirmed that there is no uniformity across departments regarding study leave and agreed that something needs to happen to provide consistency.

JM asked if finance for study leave is part of the finance when a new post is approved, or do we continued to employ new consultants and medical staff without allocating appropriate funds for study leave? CM agreed that this is probably the case and that admin and IT are also not considered when putting together a new post.

9. Medical Workforce Planning - HSCP

AK reported that Mental Health had progressed with job planning.

Rheumatology is one of the biggest challenges at the moment with only 1.5 WTE. There has been some progress with potential consultant recruitment and have made an offer to a candidate interviewed, which will take it up to 2.5 WTE. The goal is to get to 3 plus 1 Specialty Doctor in the next year, however, it is going to be a challenge. We are actively pursuing SLAs with Forth Valley, but they also have recruitment issues so not sure it will be successful.

The main development is that LC has formed a Rheumatology Oversight Group which meets fortnightly making sure that there is ownership within the clinical team to build a more robust system that maximises use of the MDT rather than using a very medically focused model.

There has been some positive recruitment in the Sir George Sharp unit. They still don't have a substantive consultant but have a locum consultant and a Specialty Doctor which is starting to help support the team. There is also a Clinical Fellow joining the team but is held up with Home Office issues.

AK also reported that there were no applicants for the MoE Rehab ScotCOM post. CM noted that there needs to be strategic thought around how ACT money is spent as we were £500,000 underspent this year and it is a missed opportunity to spend it on other things. With ScotCOM materialising the ACT budget will increase annually. By the third year of ScotCOM there will be near £5,000,000 annually of ACT money. He felt there is a need to make sure we are integrating into other budgets by trying to expand consultant recruitment.

10. Any Other Competent Business

CM confirmed that this would be MP's last meeting and thanked her for all of the years of hard work and dedication behind the scenes to keep Primary Care appraisal effective and to a high standard.

11. Date, Time and Venue of Next Meeting

The next meeting will be held on Tuesday, 15 April 2025 at 3.00pm via Microsoft Teams.

Distribution List:
Dr C McKenna, Medical Director – NHS Fife
Dr I MacLeod, Deputy Medical Director – NHS Fife Acute
Dr H Hellewell, Deputy Medical Director – Fife Health & Social Care Partnership
Dr J Tomlinson, Director of Public Health
Dr E O'Keefe, Director of Dentistry
Dr S Savage, Associate Director for Risk and Professional Standards
Ms G Couser, Associate Director of Quality and Clinical Governance
Dr S McCormack, Associate Medical Director – Surgical and Medical Directorate
Dr J Morrice, Associate Medical Director, Women & Children
Dr A Kelman, Associate Medical Director, Fife Health & Social Care Partnership
Ms J Anderson, General Manager, Women, Children & Clinical Services
Ms L Cooper, Head of Primary and Preventative Care Services
Mrs A Gracey, Medical Appraisal and Revalidation Co-ordinator
Dr M Philp, GP Appraisal Lead
Mr E Dunstan, SC Appraisal Lead
Prof Morwenna Wood, Director of Medical Education
Dr M Clark, Associate Director of Medical Education
Dr K Steel, Associate Director of Medical Education
Ms S Ali, Medical Education Manager
Mrs R Waugh, Head of Workforce Planning and Staff Wellbeing
Dr J Pickles, LNC Representative

MEDICAL & DENTAL PROFESSIONAL STANDARDS OVERSIGHT GROUP

(Meeting on 15 April 2025)

No issues were raised for escalation to the Clinical Governance Committee.

Medical & Dental Professional Standards Oversight Group

Medical and Dental Professional Standards Oversight Group
Draft Note of Meeting held at 3.00 pm on Tuesday 15th April 2025 on Microsoft Teams

Present:	**Designation:**
Dr C McKenna	Executive Medical Director/Responsible Officer, NHS Fife (Chair)
Dr A Kelman	Associate Medical Director Fife Health & Social Care Partnership
Dr H Hellewell	Deputy Medical Director – Fife Health & Social Care Partnership Associate
Dr E O'Keefe	Director of Dentistry
Prof M Wood	Director of Medical Education
Dr S Savage	Associate Director for Risk and Professional Standards
Mr E Dunstan	SC Appraisal Lead
Dr J Tomlinson	Head of Primary and Preventative Care Services
Dr J Morrice	Associate Medical Director, Women and Children
Dr J Pickles	LNC Representative
Ms G Couser	Head of Workforce Planning and Staff Wellbeing
Dr Jacqueline Drummond	Associate Medical Director of Psychiatry
Dr L Frew	GP Appraisal Lead
Ms A Gracey	Medical Appraisal and Revalidation Co-ordinator

Not in attendance:	
Dr I MacLeod	Deputy Medical Director – NHS Fife Acute
Prof M Wood	Director of Medical Education
Ms J Anderson	General Manager, Women, Children & Clinical Services
Dr Christopher Cartlidge	Associate Medical Director – Surgical and Medical Directorate
Dr I Banerjee	LNC Representative
Ms Lisa Cooper	Head of Primary and Preventative Care Services
Ms S Ali	Medical Education Manager
Mrs R Waugh	Head of Workforce Planning and Staff Wellbeing
Dr M Clark	Associate Director of Medical Education
Dr K Steel	Associate Director of Medical Education
Dr S McCormack	Associate Medical Director – Surgical and Medical Directorate

ACTION

1 Welcome/Apologies for absence

Apologies:
Dr Iain McLeod
Ms Lisa Cooper
Dr Sally McCormack
Ms Jane Anderson

2 Draft Note of previous meeting (21/01/2025)

The minutes accepted by group as an accurate record. **DMc**

3 Action Tracker

CM confirmed that all items on the action list have been completed. This included a paper on portfolio careers which links into today's paper given by JD and the appointment of the new Lead Appraisal Advisor for Primary Care, Dr Lindsey Frew replacing Maritta Philp.

4. **Medical Appraisal and Revalidation.**

AG presented the flash report, highlighting the ongoing challenge to recruit and retain appraisers. Despite this, two new appraisers have been recruited. One is ready to go and the other requires some further follow-up on concerns. During 2024/25, 181 of 211 doctors due for revalidation received positive recommendations. There were 24 deferrals (4 subsequently revalidated later).

There are currently 67 unallocated appraisees, currently being managed with the goodwill of the current appraisers.

CM acknowledged the ongoing challenges and thought that the number of positive recommendations was reassuring. JT asked CM if he was happy with the consistency and quality of the appraisers, CM confirmed the quality is generally good and feedback is provided to the appraisers, emphasising the importance of thorough Form 4 summaries.

Actions:

- **ED to follow up on concerns with new appraiser.**
- **Continued effort to recruit and retain appraisers.**

5. **Consultant and SAS Doctor Job Planning.**

CM introduced the year end job report for job planning celebrating the significant improvement in signed off job plans. There has been a a great improvement from small numbers signed off to 62% and should only improve going forward as many job plans will Only require tweaking for this current year.

HH acknowledged the hard work of the Clinical Leads in Primary and Community Care portfolios and the work done to get us to this stage in the Health and Social Care Partnership. Despite outcomes that weren't as good in Complex Care, substantial work has been done and the foundations laid this year will significantly improve next year's results

AK reported high completion rates (65%) in her portfolio areas and attributed this to a streamlined process that focuses on exception reporting and regular reviews. She noted that people are getting into the habit of reviewing their job plans and making necessary adjustments and asking themselves the question of 'is my job plan still fit for purpose?' AK pointed out that having smaller numbers of doctors in her portfolio made the process more manageable and highlighted there were discussions on keeping the list of doctors up to date.

CM picked up on AK points and congratulated her on her progress and approach and felt it was something for others to consider

ED raised concerns about whether all clinical leads and directors were ensuring that the importance of appraisals was being promoted in relation to job planning. He reported instances where appraisers had dropped their appraisal duties following job planning discussions which he found disappointing. CM acknowledged this and explained that in a struggling speciality area the focus sometimes shifts to clinical time over appraisal duties.

JM confirmed that there has been significant progress in getting jobplans signed off compared with the previous year, with approximately 60% of the Acute Consultants now having signed job plans. However, he raised concerns

that the remaining unsigned job plans were now the more complicated ones that were more challenging. JM said these more difficult ones were consultants who are doing more work than their stated PA's MW supported JM's point emphasising that she believes that around 30% were still in discussion and were the more 'challenging' ones. MW proposed that a report once a year to the board from this group may be beneficial. CM acknowledged the hardship JM and MW stated and pointed out that we do report to the board via the Staff Governance Committee. CM emphasised the importance of completed job plans for strategic planning, particularly for the medical workforce and having accurate job plans is crucial for identifying gaps in services, planning effectively and making informed cases for additional resources or service changes.

ED questioned why some specialities, like geriatric medicine, orthopaedics and anaesthetics were doing so well as they are specialities that are really under the cosh. AK explained that in geriatrics, they had a tenacious leader and constant conversations, there was a team understanding that they needed to articulate their challenges, write down who they were and what they do to secure support and resources. HH added that the job planning process is definitely useful data for looking at the bigger picture CM finished this with reiterating the positive progress we have made and the fact we have done so well this year and expressed a desire to maintain momentum.

6. Medical Education.

MW presented the flash report and added that as the department expands, they are aiming to become more professional, sending letters to the appointees and to the finance officer in that department and the clinical lead/director. However, it also made the department realise that attracting people to do a 1 or 1.5 session post is going to detract from clinical service delivery within an individual's job plan. MW stated they do plan to continue to send letters so there is a paper trail.

MW reported that there still hasn't been confirmation of ACT finances for the current financial year from NES, which is causing frustration. Delays by the Scottish Government, NES and internal systems within NES and Fife are making it difficult to appoint people quickly to posts needed for delivery of ScotCom.

CM confirmed that he has been trying every tactic to receive a timeline regarding ACT funding but no accurate timeline to date. The delays seem to maybe come from the cost pressures created by English Pathway students. It may be more appropriate that the funding is delayed due to the fact that some boards will lose funding as less students will be placed in, for example, Greater Glasgow and Clyde as they will be staying in NHS Fife. This means that a certain amount of ACT funding that GGC may have been expecting will no longer be received so the 'smoothing funding' process is intended to give boards time to adjust to having less money in the next budget. MW added that the smoothing funding is a good thing and NHS Fife actually benefited from this by around £300,000 last year due to an anomaly in the Edinburgh curriculum. However, she noted that NES indicated a hit this year to Fife although this has not been confirmed.

CM discussed the importance of accounting for where the ACT money is spent. Much of this money is allocated to directorates and is tied to clinicians

committed to medical education. CM emphasized that this funding is for time spent on undergraduates and is distinct from SPA time and not the same as appraisal or educational supervision.

MW confirmed that they do know where their ACT money sits. Initially it was separated by university (Edinburgh, Dundee, ScotGEM etc) but finance colleagues combined it into one large sum. They are now working on separating it again. MW asked the group if it would be helpful for her to provide a letter detailing the allocation of funds for each university/program and which jobs they think it should be in. Everyone agreed this would be useful.

Action**:**

- **MW to write to larger departments outlining ACT funding.**

7. Dental Education.

Emma O'Keefe raised the issue around annual appraisals for dental consultants in Fife which are currently not being conducted regularly despite being a requirement in their consultant contracts. Historically there were 2 Orthodontic colleagues but one has left and the other is currently not in clinical practice. The number of dental consultants is small compared with the GMC doctors. The GMC doctors are prioritised due to revalidation requirements which does not apply to GDC consultants. EO posed the question to the group on how we move forward with ensuring dental consultant appraisals. She suggested exploring the possibility of using the already trained employee as an appraiser or another suggestion was to include the two hospital orthodontic consultants in the current NHS Fife consultant appraisal system. She raised the longer term issue of building a sustainable model for dental consultant appraisal noting that Public Dental Service colleagues have undergone appraisal training and are almost self sufficient so could we use them?. EO also highlighted the need to be mindful of the fact that the oral and maxillofacial SAS doctors are GDC registered unlike Maxillo Facial Consultants who are GMC registered**.**

CM confirmed the priority for a solution for the two hospital orthodontic consultants who are employed as consultants under consultant contracts but are not doctors. They are the priority but are different from GMC as they don't require annual appraisal for revalidation but need it for contractual requirement. CM suggested it would be reasonable that one or two of the GMC doctor appraisers appraise these consultants. The appraisal would be the same but without the need for revalidation. Joy Tomlinson noted that some non-medical consultants in public health follow a similar approach, not requiring GMC sign-off for their appraisals. She inquired about the practice of other boards and what they were doing to combat this.

ED asked whether dental consultants use the SOAR website and EO confirmed they do. ED offered to talk to other appraisal leads of other boards to find out what they do.

CM stated that it would be reasonable for a doctor to appraise a dental consultant and also to train a dental consultant orthodontist as an appraiser but expressed uncertainty about whether a dental consultant would be allowed to appraise a doctor, noting the potential for creating a 'vice versa' situation. AG

confirmed that a consultant who was an orthodontist used to conduct appraisals, but the GMC, for revalidation purposes requires appraisals by GMC registered doctors. EO and CM to discuss further for plans to be put in place.

EO also stated than she has received an email from the deanery and they are keen to do a virtual review for core trainees and specialist trainees in orthodontics. She noted that she hasn't been involved in one before and CM has confirmed he hasn't either and suggested linking in with the General Manager in the Surgical Directorate to ensure there aren't any issues from a service perspective.

Actions:

- **ED to talk to other boards regarding dental appraisals.**
- **EO to touch base with Surgical Directorate General Manager.**
- **EO to develop a plan to address appraisals.**

8. **Medical Workforce Planning – Acute Services.**

The flash report is attached in the absence of Dr Iain McLeod. JM added that the Gateway Doctors continue to be a valuable resource in acute care and is working well. He noted that the management and coordination of this service had been a 'sticking point' but that Chris Cartlidge, the new AMD has taken this on.

9. **Medical Workforce Planning - HSCP**

HH advised that they had successfully recruited into Rheumatology, one of the more difficult specialties to recruit to. CM congratulated them.

JD presented a paper on international recruitment and stated she has had contact with IMG connect, an agency specialising in international medical recruitment due to the challenges in psychiatry recruitment which is expected to continue. This is an agency that Fife has not used before. They have provided some CV's of seemingly strong candidates and JD has submitted the paper of the agency's compliance procedures seeking the approval of the group to proceed with using this agency. In addition to paper JD has had a further meeting with them to see if they could support recruitment to the portfolio pathway posts. The agency has offered to provide pastoral care and assistance to doctors before their arrival in the UK and during their settling in period for the standard contract price. JD proposes a trial of the agency by filling a few posts initially and if successful expand to other specialities.

CM inquired about HR involvement and JD confirmed Mechelle Sinclair-Forrow has been involved in the portfolio pathway development. HR has also been involved in discussions about contracts for the portfolio pathway, with a decision made to issue 3-year contracts. CM stressed the importance of HR's full commitment to supporting JD and her team particularly with visas and related matters.

CM requested that an EQIA be completed on the international recruitment process, so that we are mindful of the potential inequalities faced by international recruits in an unfamiliar environment and even retrospectively for

Gateway doctors. CM advised that Isla Bumba, the equality lead, could provide assistance with the EQIA.

JM sought clarification on the agency fees. JD explained that the exact figures were in the paper but off the top of her head it is around £15000 for a consultant and a bit less for a Speciality Doctor. There would also be additional costs for double-running as they would be initially shadowing locums. However, there would be significant savings in the long term compared with the high costs of agency locums. JD also stated that she is going to do a finance write up detailing financial costs and savings with the portfolio pathway paper and international recruitment plans to be shared with the Partnership SLT and can also be shared with this group. MW suggested JD link in with Mohamed Elmoursi, the IMG lead in Medical Education who could offer his expertise and experience in supporting international doctors.

Actions:

- **JD to contact Isla Bumba and do EQIA**
- **JD to share the finance paper going to Partnership SLT**

Any Other Competent Business

10.

CM shared with the group the response letter to some concerns sent to the GMC regarding applications. Both CM and MW expressed significant concerns about delays and inefficiencies within the GMC's pathways. There is a possibility of contacting the Joint Royal Colleges beginning with Royal College of Physicians and Surgeons in Edinburgh to gain their perspective and initiate further dialogue. CM suggested he could reach out to Mike Jones, Chief Executive of the Federation.

The meeting concluded with recognition of the importance of supporting individuals through these professional pathways as part of a broader mental health support.

Actions:

- **CM to reach out to Mike Jones to discuss challenges.**

Date, Time and Venue of Next Meeting – Tuesday 15th July 2025, 3pm via Teams.

Distribution List:
Dr C McKenna, Medical Director – NHS Fife
Dr I MacLeod, Deputy Medical Director – NHS Fife Acute
Dr H Hellewell, Deputy Medical Director – Fife Health & Social Care Partnership
Dr J Tomlinson, Director of Public Health
Dr E O'Keefe, Director of Dentistry
Dr S Savage, Associate Director for Risk and Professional Standards
Ms G Couser, Associate Director of Quality and Clinical Governance
Dr S McCormack, Associate Medical Director – Surgical and Medical Directorate
Dr J Morrice, Associate Medical Director, Women & Children
Dr A Kelman, Associate Medical Director, Fife Health & Social Care Partnership
Ms J Anderson, General Manager, Women, Children & Clinical Services
Ms L Cooper, Head of Primary and Preventative Care Services

Mrs A Gracey, Medical Appraisal and Revalidation Co-ordinator
Dr M Philp, GP Appraisal Lead
Mr E Dunstan, SC Appraisal Lead
Prof Morwenna Wood, Director of Medical Education
Dr M Clark, Associate Director of Medical Education
Dr K Steel, Associate Director of Medical Education
Ms S Ali, Medical Education Manager
Mrs R Waugh, Head of Workforce Planning and Staff Wellbeing
Dr J Pickles, LNC Representative

RESILIENCE FORUM

(Meeting on Thursday 20 March 2025)

- Storm Eowyn was a red alert; NHS Fife enacted the severe weather framework incident response. Lessons identified in hot debrief, in permanent incident records.
- Nationally it was noted Occupational health screening guidance for powered respirator suit CBRN/HAZMAT will be circulated once received.
- CONTEST update National Cyber Security Centre threat remains high. New cyber security incident support contract set up nationally and locally.

Department of Public Health
Bankhead Central Office, Bankhead Park, Glenrothes, KY7 6GH

Minute of Resilience Forum meeting held on Thursday 20th March at 1430 via Microsoft TEAMs

Chair:
Joy Tomlinson, Director of Public Health, NHS Fife **(JT)**

Present:
Susan Cameron, Head of Resilience, NHS Fife **(SC)**
Aileen Boags, Lead Pharmacist - Public Health & Community Pharmacy, NHS Fife **(AB)**
Allan Young, Head of Digital Operations, D&I, NHS Fife **(AY)**
Christopher Conroy, Clinical Services Manager, H&SCP **(CC)**
Jeremy Stewart, Emergency Planning Officer, NHS Fife **(JS)**
Yasmine Morgan, Sustainability Officer, NHS Fife **(YM)**
Lynne Innes, Lead for Spiritual Care and Wellbeing, NHS Fife **(LI)**
Olivia Robertson, Senior Manager Community Children's Services, H&SCP **(OR)**
Kirsty McRae, Resilience Advisor, Scottish Ambulance Service **(KMcR)**
Rhona Waugh**,** Head of Workforce Planning and Staff Wellbeing **(RW)**
Neal Stevenson, Communications Manager, NHS Fife **(NS)**
Susan Fraser, Associate Director of Planning and Performance, NHS Fife **(SF)**

Minute prepared by Holly Jones **(HJ)**

Agenda Item

1. Welcome and Apologies
JT welcomed everyone to the meeting.

Apologies were noted from Craig Burns, Alison Henderson, David Miller, Jane Anderson, Janette Keenan, Neil McCormick, Nicola Robertson, Samantha McLaughlin, Sharon Doherty, and Susan Dunsmuir.

2. Minutes of Previous Meeting (17th December 2024)
Minutes from the previous meeting were reviewed and advised any comments to be forwarded to HJ by end of the week, this will be considered as accepted if no comments raised.

Action: 6.4 National Services Document to rollover to next meeting in June – SC

Terms of reference (TOR) update:
JT highlighted proposed change that Resilience Quarterly Updates will be tabled with EDG twice a year, subject to endorsement by Forum and EDG (Next EDG reporting to is July 3rd)

Action: Any comments re. terms of reference to be returned by Mid-April
Action: TOR update to be inputted in assurance statement

2.1 Action Tracker
2.1.1 Vulnerable persons PARD
Agreed to pause on action tracker as there is a national pause – to be resumed once a national update is known.
2.1.2 CBRN/HAZMAT

Update noted in attachment

2.1.3 NHS Fife Major Incident Framework

Verbal update given by SC
Key change in document is the psychological support cell has been inputted into the document.
Recommendation that once refreshed IMF is ratified the next review date will be more than a year.

3. Matters Arising

3.1 Critical National Infrastructure Review Scottish Government

Written overview provided by CB within meeting papers
Verbal update by SC

Action: Final input from Estates and Digital colleagues to be inputted on CB's return from annual leave

Requested additional week-extension for submission to SG.

Action: Draft to be sent to all Directors with responsibilities in CNI prior to submission.

4. Resilience Governance & Assurance

4.1 Q3 EPRR report

SC provided verbal update on key elements:

- The focus of this report is on EPRR, emergency planning and providing a position update
- Hospital Major Incident Management Medical Support (HMIMMS) training accreditation has commenced, provided, and sponsored by resilience team.
    - Important for whole hospital response
    - Internationally accredited training
- Inclusion of section covering Civil contingency responsibilities with our key stakeholders
    - Multi agency response exercises MIMC and interoperability, in alignment with HAZMAT regulations and COMAH sites
        - Safe hands 3 and Ex NIGHTSTAR
    - To have a rolling plan for testing and exercising for future
- Prevent Awareness, Home Office modules to launch on TURAS April 1st.
- Field-based learning student from Stirling University has provided us with insights of HAZMAT and CBRN response across East Fife.

Action: Any questions/feedback regarding any activities listed in the Q3 EPRR report to be forwarded onto resilience team by Mid-April

- CC endorsed the report and suggested sharing with partnership-wide resilience group
    - CC is due to attend HMIMMS training in April
    - Report is particularly useful in highlighting availability for training and work planning
- EPRR Prevent and business continuity is being added to induction of new NHS Fife staff

4.2 Business Continuity Dashboard - HJ

- Organised BC testing with JS as seen in the training plan
- HJ continuing to contact out of date and no-plan owners
- CB continuing Bitesize awareness sessions
- Number of no-plans are currently 7 (down from 9)
- In past 2 years there has been a significant increase in identification of areas which require a dedicated business continuity plan. The number of required business continuity plans has more than doubled from 75 to 153 active plans
  - Potentially 54 additional plans for GP practices to be added
- SC noted concern that some plans from 2017-2021 have not been updated and a number of areas still showing as no-plan being in place
  - JT noted escalation may be required through Acute and HSCP SLTs, asking for their assistance engaging and supporting areas with out-of-date plans and no-plans
  - Dashboard overview to be brought to Acute and HSCP SLTs
- CC to take to HSCP SLT as assurance report was sent to managers this week
- YM suggested a workshop regarding what is required within a plan (i.e. Grand Round)
- JT noted Storm Eowyn may have opened conversations for plan owners, highlighting the requirement for each service area .

4.3 NHS Fife BC Policy

JS gave verbal update
JS thanked all stakeholders for feedback on the document and has incorporated a lot of the feedback, noting the policy is now being worked on regarding formatting and final updates (aiming for about a week from now).
Next steps are that this document will be ratified and then have a review date set.
SC noted that the policy incorporates the contributions from the Resilience coordinator post (HJ's role).
SC noted the policy document has been through the Clinical Policy Group and is to be taken to the General policy group in due course.

5. Whole system Overview

5.1 SAS - KMcR

Verbal update given on SAS pressures.
National, regional and control rooms REAP level has gone down from REAP 4, which was reported at last meeting (December) to REAP 2.
There are still some pressure points in the service, primarily in the North, but there should be some improvement in the near future.

5.2 HSCP - CC

Verbal update given on HSCP activity.
Currently looking into the plan for the year regarding training and mapping across the partnership.
Review of the Resilience Framework to make sure that it is contemporary. After a discussion with CC and Craig Burns action cards or equivalent to
Tabletop exercise between council and health to be considered in a local level as a way of testing the local resilience (i.e. Ex. PEGASUS)
Gaps noted after Storm Eowyn in terms of knowledge and understanding of resilience which is to be addressed in the work plan this year.

JT noted Storm Eowyn also provided lessons identified for Gold Command, there were a lot of strengths in the response. Noting this is the first severe weather event which has happened since ratification of the severe weather framework, providing an opportunity to test the framework and learn from the system response.

5.3 Acute Services – Surge Capacity

Apologies were given and no update was available.

5.4 CCRA Team – YM

Verbal update given.
Publication of the mid-year Sustainability Report was sent to the board, which details the main areas of progress. Flooding and heat maps should soon be available on a national level, which will allow the making of a climate model to identify the high-risk sites, in terms of future climate events.
Overheating in wards trial to happen this summer due to anticipation of heat waves during summer which is a serious issue for staff and patients.

- Looking into possible nature-based solutions i.e. planting trees outside south facing windows
- Receiving data from energy management systems

Upgrades to the cycle infrastructure across multiple sites.
JT noted availability of funding from the Forth O2 project – YM noted there are applications in progress.
SC noted the opportunity to include heat threat within business continuity planning.
YM noted NHS inform is coming out with national heatwave guidance.
NS advised "Stay Summer Safe" is now available online

5.5 Digital & Information - AY

Verbal update provided on D&I activity and threats.
Cyber Security update:

- National Cyber Security Centre threat remains high (has been high since 2022)
- Averaging 19 cyber incidents/alerts per month
- Averaging 12 new vulnerabilities per month
- Cyber Security Operations Centre (CSOC) and Cyber Resilience Early Warning (CREW) alerts have been at normal levels
- New cyber security incident support contract set up nationally and locally, an expert cyber security firm able to give us immediate support in an incident at pre-determined rates.
    - Reducing incident response and recovery costing for NHS Fife
    - In June 2025 Network Information Systems (NIS) interim audit, will be supported in service level assurance by the above agreement.

SC noted, agenda item 10 is regarding counter terrorism in a CONTEST policy which is being organised, which includes the digital counter terrorism cyber element.

6. Emergency Planning

6.1 Storm Eowyn – SC

SC gave verbal update
Storm Eowyn resulted in a red weather alert across large parts of Scotland and Fife, and we enacted the severe weather framework document.
Incident Management Command and Control on a silver (tactical) and gold (strategic) level were established.

Lessons identified were captured through hot debrief workshop and recorded in permanent incident records. Key points will be shared
JT noted in terms of care homes that there will be separate learning to be taken from their experience in the storm, particularly relating to loss of power.
Action: CC highlighted the intention to pull a final report in regard to care homes in extended leadership team meetings
Action: Further call to be organised:

- Collating debrief information from storm meetings
- Information cascading procedures re. Met office alerts could also go to care homes.
- SC noting action cards for care homes could be discussed

AB noted debrief on April 8th for pharmacy

6.2 Fife 4x4 Volunteers Team Report – SC

Provided NHS Fife support during red alert, report has been included within papers for this meeting.
Formalising memorandum of understanding with NHS Fife to be organised.
A representative from 4x4 support is happy to join a future meeting to discuss an overview of what they can do to support.

7. Emergency Equipment

JT gave verbal update in response to the escalated risk raised by the Forum which has been discussed by EDG.
Our current CBRN tent has been in use for 20 years (no beyond the manufacturer's best before date).
SC and Paul Bishop have been in discussions, they have provided clear recommendations about replacing the tent with an all-encompassing air inflated tent with heating and lighting. This has been supported by representatives from Estates, Clinical lead, ED, and Public Health. Details will be shared in the next quarterly update. The gold standard solution would require alterations to the built environment; however, the costs of adaptations are currently prohibitive.

7.1 IBIS Airwave Radios

JS gave verbal update
Familiarisation briefing took place which JT and SC took part in.
This is a secure radio which is used by the emergency services nationally (only used for voice not data).
Future familiarisation exercises organised for July 31st and February 27th, for senior leaders.

- SC noted a formalised agreement is to be made with Police Scotland regarding access to the radios, a lesson identified from the airwave exercise was that out-of-hours access to the radios was difficult.

8. Training & Exercising

8.1 2025-26 Resilience Training & Exercising Plan

SC gave an overview of attached document; dates are still to be confirmed for some training opportunities.
Feedback is welcomed regarding any additional training anyone would like to see on this plan.
Action: Comments requested by Mid-April

8.2 NHS Fife EPRR Workforce Induction

SC gave verbal update.
Resilience team will be commencing face-to-face corporate induction with workforce, for all new staff in NHS Fife.

9. Fife Regional Resilience Events Brief

For information purposes only.
For HSCP and Acute colleagues to have an overview of the events across the region which if they have a large footfall, please consider staffing etc.

10. Counter Terrorism (Pursue, Prevent, Protect, and Prepare)

JS to lead SLWG for CONTEST policy to take place between May and August 2025, covering the four pillars of CONTEST; Prepare, Protect, Pursue and Protect.
SC advised NHS Fife have an existing framework documents that relate to CONTEST arrangements and emergency planning, these are NHS Fife Lockdown framework and suspect package and bomb threat (including buildings evacuation) framework guidance.

10.1 Martyn's Law NHS Assure – Regulator Update

JT gave verbal update.
This is a bill which is at UK level which is still in legislative process but has been cascaded through NHS security leads (Kenny Green).
Legislation is being developed in response to the Manchester Arena attack, which was an entertainment venue so currently unsure how it will impact healthcare settings. The legislation is being framed around large numbers of people congregating together.
Director of Estates is to be noted as the accountable executive for Martin's Law.
SC working with Kenny Green to articulate clearly the legislative responsibilities that we already have in place for CONTEST, and to see any gaps.
JT in her role as Executive lead for Resilience, is noted as NHS Fife CONTEST lead.
Security Industry Authority (SA Licencing) is the authorising party of the legislation.

10.2 Prevent TURAS Modules & NHS Fife staff induction

CB sent written update within forum papers
Pre-screening

10.3 UK CONTEST Threat Level

As discussed above.

11. National Updates:

Nationally there has been an update on PRPS suits

- There will now be an occupational health screening for anybody who is going to be CBRN/HAZMAT response.
- Once for Scotland approach is currently being organised by Mark Hilditch (NHS Highlands)
- This has been cascaded through occupational health, CBRN clinical leads and internal staff.

12. AOB

No noted AOB.

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13. Date of next meeting:
Wednesday 18th June 2025 1430-1630 via MS TEAMs

Action Log:

- Re. December forum - 6.4 National Services Document to rollover to next meeting in June
- Feedback on Mid-April
    - Terms of reference
    - Q3 EPRR report
    - Training and Exercising plan
- Terms of reference update to be inputted in assurance statement
- Re. Storm Eowyn; CC to pull a final report in regard to care homes in extended leadership team meetings
- Re. Storm Eowyn; further call to be organised:
    - Key themes
    - Collating debrief information from storm meetings
    - Information cascading procedures re. Met office alerts could also go to care homes.
    - SC noting action cards for care homes to be discussed
- Re. CNI: Final input from Estates and Digital colleagues to be inputted on CB's return from annual leave
    - CNI coming to relevant directors
- Re. National Updates; send PRPS suit users new occupational health guidance