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Improvement Action Plan

Healthcare Improvement Scotland:

Unannounced Mental Health Services Safe Delivery of Care Inspection

Queen Margaret Hospital, NHS Fife

18 February 2025

Improvement Action Plan Declaration

It is the responsibility of the NHS board Chief Executive and NHS board Chair to ensure the improvement action plan is accurate and complete and that the actions are measurable, timely and will deliver sustained improvement. Actions should be implemented across the NHS board, and not just at the hospital inspected. By signing this document, the NHS board Chief Executive and NHS board Chair are agreeing to the points above. A representative from Patient/Public Involvement within the NHS should be involved in developing the improvement action plan.

NHS board Chair

Signature: 

Full Name: Pat Kilpatrick

NHS board Chief Executive

Signature: 

Full Name: Carol Potter

Date: 14.10.25

Date: 14.10.25

File Name: 20250509 Improvement Action Plan – Queen Margaret Hospital, NHS Fife v0.1	Version: 0.1	Date: 14/10/2025
Produced by: HIS/NHS Fife	Page: Page 1 of 12	Review Date: -
Circulation type (internal/external): Internal and external		

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Ref:	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
Requirement 1 NHS Fife must ensure there are effective risk management systems and processes in place to ensure the safe delivery of care where additional beds are in use (see page 10). This will support compliance with: Health and social care standards (2017) criteria 4, 4.11					
1	Risk assessment for the use of surge beds within Under 65 General Adult Admission wards will be developed.	30th June 2025	Senior Manager, Mental Health Service Clinical Service Manager, General Adult Mental Health Service Lead Nurse, General Adult Mental Health Service.	The risk assessment for the use of surge beds within Under 65 General Adult Admission wards has been developed.	
Requirement 2 NHS Fife must ensure that all staff complete the necessary training to safely carry out their roles. This includes but is not limited to life support, adult support and protection, child support and protection and fire safety training (see pages 12 & 17). This will support compliance with: Health Care (Staffing (Scotland) Act 2019 Criteria 12II & Core Mental Health Standards (2023) Criteria 4.1 & 4.5 and relevant codes of practice of regulated healthcare professions.					

2.1	Each ward will ensure that a Staff Training Action plan is in place which will be reviewed and updated through local area Quality Matters Assurance Groups (QMAG) and reported through MH & LD QMAG, with onward assurance to the Chief Executive	31st August 2025	Senior Manager, Mental Health Service Clinical Service Managers Lead Nurses	Staff training action plans have been developed for each ward within Mental Health Services. Development of robust action plans continued beyond the	

	via the Executive Leadership Team			target timescale and are now fully implemented and overseen by the Lead Nurse and Clinical Service Manager, with regular updates provided through local service and wider portfolio QMAG structures. Training compliance figures are collated monthly and shared with Senior Managers and Health & Safety groups. Individual training records are maintained at a local level with a HSCP spreadsheet available on the T drive to support a service-wide overview. A report is provided at each QMAG. Action plans include rostering in Protected Learning Time, implementation of a new training record alongside care assurance recording and ensuring SCN's have leadership time outside of ward staffing numbers. Training compliance continues to improve with ongoing	

				progress and assurance provided through regular	

				oversight by Lead Nurses and Clinical Service Managers. Implementation of Action plans have been supported through the provision of supplementary rostering and protected time to ensure that services maintain a balance of safe and effective staffing rosters and the capacity to support individual learning time with Lead Nurse and Clinical Service Manager oversight. Onward assurance is provided through IPQR to Exec team.	

2.2	Mental Health Service will implement a Training Calendar with monthly focus on specific areas of training supported by the Core Skills Training Diary and the required Protected Learning Time to achieve each priority.	31st July 2025	Senior Manager, Mental Health, Learning Disability & Addictions Service Mental Health Business Manager	Several initiatives have been introduced to reinforce training engagement and compliance; the 'Policy of the Month' initiative was launched ahead of schedule and is now embedded as a recurring monthly feature and is shared across the whole of the HSCP, via the Directors brief and via emails. Evidence is gathered to confirm that staff have shared and read the policy. Managers continue to promote Protected Learning Time with agreement to capture compliance with this in the SSTS system, ensuring visibility and accountability. In addition to shared communication around the Policy of the Month, the service also includes the 3 areas of training that require the most focus for staff awareness and uptake where the promoted training for that month has already been achieved.	

2.3	Implement a supportive programme co-designed	31st July 2025			
	with SCNs/TLs to help balance clinical and non-clinical responsibilities, including training, peer support, and protected time, with feedback gathered quarterly to assess impact.		Head of Nursing - Nursing Directorate Senior Manager Mental Health, LD & Addictions Services	A supportive action plan has been developed to support SCN's in balancing the clinical and non-clinical demands of their roles. The plan includes a review of SCN responsibilities and job planning to ensure appropriate time allocation across both areas. Development of the supportive plan has continued beyond the identified timeframe to ensure full engagement with the SCN workforce and complexity of supporting the SCN's to effectively balance role responsibilities whilst providing additional direct support to achieve safe and effective staffing rosters and non-clinical functions. Development of SCN work plans in progress, supported by Lead Nurses to support SCN's to review and balance the demands of role and prioritisation of key tasks.	

Requirement 3

NHS Fife must ensure effective and appropriate governance approval and oversight of policies and procedures are in place (see page 13). This will support compliance with: Health and Social Care Standards (2017) Criteria 1.24 & Quality assurance framework criteria 2.6

3.1	Mental Health Services will adopt the new NHS Fife Policy and Procedure framework and review 100% of all current documentation to ensure policies and procedures are compliant and align with the framework standards.	31st August 2025	Head of Service, Complex Critical Care Services Associate Director of Nursing Change and Improvement Manager	The Mental Health Services Procedure Group process has been updated to ensure appropriate governance and oversight of policies and procedures and is now aligned with the NHS Fife Policy and Procedure framework. While the action to adopt the new framework was completed within the agreed timescale, full review and updating of all policies is ongoing. Currently 77% of policies and procedures have been reviewed and updated. The remaining 11 policies have been allocated to individuals or groups for review, with ongoing work to bring these up to date. The service has set a target date for completion for the remaining policies and procedures by 31st January 2026 due to the complexity of the documents and the need to ensure multi professional	

				and multi-agency engagement and review.	

3.2	Action plan to be reviewed, a policy tracker will be introduced to monitor progress for policies and procedures and for all to be reviewed and submitted to the group for governance and robustness	31st July 2025	Head of Service, Complex Critical Care Services Associate Director of Nursing Change and Improvement Manager	A policy/procedure tracker, action plan and workplan are in place and shared as part of the agenda for each meeting.	
3.3	Allocate out of date procedures for review and ensure support to review within the policies and procedures group within 3 months to ensure policies and procedures remain current and compliant.	30th September 2025	Associate Director of Nursing – Nursing Directorate	A policy/procedure tracker, action plan and workplan are in place and shared as part of the agenda at each meeting. Issues in relation to delayed completion are escalated to Senior Manager, ADoN and AMD for additional action.	

3.4	Paper to be submitted 2 monthly to the Quality Matters Assurance Group (QMAG) and provided to the Mental Health Oversight group on progress and assurance around policies and procedures.	31st August 2025	Associate Director of Nursing Change and Improvement Manager	Policy, Procedure and Guidance updates are circulated via email to a wide distribution list of staff across services for further dissemination. A flash report was submitted to C&CCS QMAG on 5.9.25 and this is now a standing item on the agenda reflected in the QMAG work plan.	
Requirement 4 NHS Fife must ensure effective oversight of ligature risk assessments and any identified risks to ensure these are effectively mitigated (see page 14). This will support compliance with: Health and Social Care Standards (2017) Criteria 5.19 & 4.19 and Quality Assurance Framework (2022) Indicator 2.6.and 4.1.					
4.1	NHS Fife will ensure that all areas are reminded who should be in attendance at the Ligature Risk Assessment meeting.	26th May 2025	Head of Complex & Critical Care/Chair of Ligature Oversight Board	The Ligature Management Policy has been approved, signed and launched across all services and teams. Agreement on the core team attending the Ligature Risk Assessment meetings has been reached, with an email reminder circulated to all teams.	

4.2	NHS Fife will ensure that all Ligature Risk Assessments have a second line of scrutiny through Ligature Risk Oversight Group.	26th May 2025	Head of Complex & Critical Care/Chair of Ligature Oversight Board	Ligature Risk Assessments are signed off by the Clinical Service Manager and Head of Nursing to ensure accuracy and appropriate scrutiny. Assessments are shared with the Ligature Risk Oversight Group and form part of the standing agenda, with minutes and actions circulated to the Ligature Risk Programme Board.	
4.3	NHS Fife will ensure that the Ligature procedure is updated to identify the process to update risk assessments if there are clinical reasons that specific rooms/areas can't be assessed at the time.	30th September 2025	Head of Complex & Critical Care/Chair of Ligature Oversight Board	The Policy has been updated and now includes a requirement for re-assessment if areas/rooms are unable to be accessed at the time of the assessment.	
Requirement 5 NHS Fife must use data on incidents and identify themes to inform and drive quality and improvement and safe delivery of care in the Queen Margaret Hospital mental health wards (see page 15). This will support compliance with: Health and Social Care Standards (2017) Criteria 4.27.					

5.1	Using the Quality Matters Assurance and Safety Huddle data and IPQR data, NHS Fife will ensure actions are agreed and taken forward for focused areas of improvement where this is required. This will include collaboration with other key stakeholders to ensure PDSA cycles, development of action plans and a robust process for monitoring, reporting and escalation.	31st August 2025	Clinical Care Governance/Head of Nursing	The Quality Matters Assurance and Safety Huddle (QMASH) alongside IPQR data, continues to inform targeted improvement work across the partnership. This intelligence has led to the prioritisation of several key initiatives, the formation of sub-groups,	

				commissioned reports and policy reviews. Areas of focus include falls, ligature risks, missing persons, and incident management. Harm data is routinely shared with services to highlight areas for action or improvement. Representation from each portfolio is sought at QMASH where pareto and run chart data support focused responses. Several subgroups and workstreams have emerged directly from this intelligence eg missing person data led to the formation of a group and the review of a supporting policy. Within the partnership performance data is now reported monthly to the Senior Leadership Team, strengthening oversight and accountability. Additionally, a driver diagram and improvement charter is a new quality improvement initiative within mental health using triangulated data to guide focus and inform intervention planning. A member of the CCGT has recently joined the SCIL course and will	

				collaborate with the service to support this work.	
5.2	Register of agreed quality improvement initiatives to be gathered to ensure compliance with quality improvement initiatives and the impact of interventions.	31st August 2025	Clinical Care Governance/Head of Nursing/Change and Improvement manager	A register of quality improvements for the organisation is already in place. A customised RAG status overview spreadsheet for Mental Health and Learning Disabilities (MH/LD) has been drafted to support local monitoring of MHLD QI initiatives and will align with the launch of the new SPSP in November. These initiatives will be tracked at QMAG level, with appropriate escalation where concerns arise.	

Requirement 6
NHS Fife must take steps to understand and reduce the high number of falls within the mental health wards in Queen Margaret Hospital (see page 16). This will support compliance with: Health and Social Care Standards (2017) criteria 4.11, 4.14

6	NHS Fife will ensure targeted falls quality improvement is underway with a new group arranged and meetings in place to identify specific improvement work within mental health wards at Queen Margaret Hospital.	31st July 2025	Clinical Service Manager, Older Adult Psychiatry. Lead Nurses	The HSCP Falls group continues to meet two monthly and has agreed key quality improvement work in relation to falls, particularly within Ward 4 Queen Margaret Hospital. Learning from this work is intended to be shared with Ward 1 and other ward areas. Ward 4 has reinstated MDT weekly falls meeting to review patient with frequent falls. A project charter has been developed, with the Clinical Care Governance (CCG) Team, working collaboratively with ward staff on quality improvement initiatives; this has included been observational audits, a deep dive into falls data, and the commencement of PDSA cycles. A monthly falls newsletter has been created and shared widely, and a development session was held on 1st October which falls link practitioners attended by falls	

				link practitioners. The falls awareness and prevention week of the 15th of September was celebrated across all services, with information stalls within Queen Margaret Hospital and information shared with patients, relatives, carers and staff on raising awareness of falls and falls prevention.	
Requirement 7 NHS Fife must ensure staff comply with the locked-door policy and that the necessary ward specific signage and risk assessments are in place (see page 17). This will support compliance with: Health and Social Care Standards (2017) Criteria 2.7.					
7.1	The locked door procedure will be reviewed, finalised and approved at the procedures group and uploaded to NHS Blink	31st July 2025	Associate Director of Nursing – Nursing Directorate Change and Improvement Manager	The procedure has undergone several reviews to ensure it is appropriate for all areas within the Mental Health setting. It has received initial approval and is now awaiting final approval.	

7.2	Appropriate signage for the locked door procedure will be designed, approved and displayed at the entrance of each ward area,	31st August 2025	Lead Nurses	Signage has been standardised and shared across all areas and is now displayed at ward entrances. To ensure signage remains in place, an agreed process for weekly checks has been developed and implemented.	
7.3	Information about the locked door procedure will be added to all ward information packs and distributed to patients and families on admission.	31st August 2025	Lead Nurses	An information pack has been developed, with an initial draft available that includes details on then on the locked door procedure. Further work is underway to add a QR code to the booklet allowing patients and families to access digital information, including any relevant policies.	

7.4	Staff will be expected to discuss the locked door procedure with patients and relatives during admission, with documentation of the discussion recorded in the patient's notes.	31st July 2025	Lead Nurses Senior Charge Nurses	Staff are reminded through emails and safety huddles to document conversations with patients and relatives regarding the locked doors. All new staff to the ward, including bank and agency staff, are introduced to the locked door policy via the orientation checklist. Discussion of the locked door policy forms part of the 1:1 admission discussion. A standardised Admission Assessment questionnaire has been developed, which includes the specific question "has locked door policy been discussed?", this is currently awaiting approval (October) and will be added. An audit will be undertaken to measure compliance with this action.	

Requirement 8 NHS Fife must ensure that all fire risk assessments are accurately completed (see page 17). This will support compliance with: Fire Safety (Scotland) Regulations (2006), The Fire (Scotland) Act (2005) Part 3 & NHS Scotland 'Firecode' Scottish Health Technical Memorandum SHTM 83 (2017)					
8	NHS Fife will ensure that fire risk assessments are sent to SCN, LN and CSM on completion to check for accuracy and agreement.	28th May 2025	Fire Officer Clinical Service Manager	There is now service agreement that Fire Risk Assessments will be sent by the Fire Officer to Clinical Service Managers, Lead Nurse and SCN for sign off; this was previously limited to SCN's. All ward level Fire Risk Assessments have been reviewed to ensure accuracy and that actions are taken forward collaboratively to provide assurance. Future Risk Assessments will be subject to increased scrutiny by SCN, LN and CSM with the development of Fire Risk Assessment Action plans to provide assurance on actions taken.	
Requirement 9 NHS Fife must ensure that wards adhere to the audit schedule, and these are planned and organised in a way that provides assurance that high quality care is being delivered (see page 19). This will support compliance with: Health and social care standards (2017) criteria 4.11 and relevant codes of practice of regulated healthcare professions.					

9.1	NHS Fife will ensure the electronic audit assurance tool tested within Older Adult wards is standardised	30th June 2025	Lead Nurses and Change and Improvement Manager	Care Assurance audit spreadsheet has been standardised and tested within ward 2 prior to roll out across the rest of service.	
	and used in all ward areas.				
9.2	There will be a dashboard/tracker of audit completion and a robust process to monitor compliance and escalation if required.	30th Jun 2025	Lead Nurses and Change and Improvement Manager	A Care Assurance audit spreadsheet containing dashboard/tracker has been standardised and tested within ward 2 ahead of a planned rollout across the wider service.	
9.3	6 monthly thematic reports on the audit findings to be provided through the existing governance meeting structures on the themes, risks and improvements.	30th September 2025	Lead Nurses and Head of Nursing	Service QMAG assurance reports are provided at each QMAG detailing audits undertaken and providing assurance on actions completed. The QMAG work plan identifies when papers are required including papers on audit and themes. A Planned Day of Care audit has been completed, with a medication audit currently underway. Findings from these audits are then shared with themes and actions agreed.	

Requirement 10 NHS Fife must ensure the care environment is in a good state of repair to support effective cleaning (see page 22). This will support compliance with: National Infection Prevention and Control Manual (2022) & Standard 8 of Healthcare Improvement Scotland's Infection Prevention and Control Standards (May 2022					
10.1	Continue monthly Care Assurance walkarounds and IPC scheduled and unscheduled visits, with finding documented and actioned within 4 weeks.	30th September 2025	Head Of Nursing Lead Nurses IPCT	Walkarounds continue within the ward areas, scheduled annually by the Head of Nursing. IPC audits are also carried out and have taken place within 2 of the 3 wards this year. Action plans are completed and returned within 4 weeks.	

10.2	Ensure robust MICAD reporting process for all staff, including a clear escalation pathway for unresolved or high risk issues, with monthly audits to ensure compliance.	30th September 2025	Clinical Service Manager Lead Nurses Senior Charge Nurses	All maintenance requests are submitted through MICAD. MICAD does not currently provide functionality to escalate outstanding jobs however to mitigate this the estates team will provide bimonthly Reactive Overall Job Reports to services which will be reviewed through local service QMAG meetings. Requests for escalation can be achieved through accessing the estates helpdesk to request update and through adding notes to outstanding	

				jobs on the MICAD Customer portal. The option to develop	

				an integrated escalation function is being reviewed by the estates manager and MICAD Software manager.	

10.3	Continue delivering planned environmental improvements for the Mental Health estate, with progress reviewed monthly at the Estates Group and the Mental Health Ligature Programme Board, and all updates documented in the meeting minutes.	30th September 2025	Senior Manager, – Mental Health, LD & Addiction Services Head of Service – Complex and Critical Care	Large scale estates improvement works are reviewed through the Mental Health Estates Group which are now minuted and action planned. Governance for MH estates group is through the mental health Redesign programme board. Time frame for large scale estates work developed by Capital Planning with approval through NHS Fife Board. Ligature improvement work is monitored, reviewed and minuted through the Ligature Management Project Board.	

10.4	NHS Fife staff within Domestic Services, Quality Assurance and ward staff will continue to report Estates defects as part of routine monitoring of the ward environment. Estates Manager will review defects as these are reported and prioritise repairs/replacement to allow for ease of cleaning and maintenance of a safe clean environment for the delivery of patient care.	30th June 2025	Support Services Manager Estates Manager IPCT Estates Manager – Review of outstanding repairs to flooring.	All maintenance requests are submitted through MICAD. Estates team will provide bimonthly Reactive Overall Job Reports to services which will be reviewed through local service QMAG meetings. Domestic services continue to track completion/escalation of required works through the Facilities Monitoring Tool	

Requirement 11 NHS Fife must ensure used linen is managed appropriately, in line with national guidelines (see page 22). This will support compliance with: National Infection Prevention and Control Manual (2022) & Standard 6.1 of Healthcare Improvement Scotland's Infection Prevention and Control Standards (May 2022)					
11.1	NHS Fife will ensure that there continues to be a focus on safe handling of used linen at ward level with a reminder of the correct process, procedure to follow and who to contact where linen hampers are not readily available.	30th June 2025	Linen Services Manager	Work has been undertaken to ensure sufficient linen hampers have been purchased, with all wards now adequately supplied. A new sign is displayed within ward areas to ensure teams are aware of contact numbers should a ward run out. This information has also been circulated via email to all teams. IPC audits confirm that hampers are in place and being used appropriately.	
Requirement 12 NHS Fife must ensure: • there are clear and consistent systems and processes in place for the monitoring and mitigation of any severe and/or recurring staffing risk to support longer term workforce planning. • there are clear, robust systems and processes in place to support the full and consistent application of the common staffing method (see pages 25 & 27). This will support compliance with: Health Care (Staffing (Scotland) Act 2019					
12.1	Review **all** safe staffing-related entries on the Health risk register and ensure that appropriate mitigation actions are documented,	31st July 2025	Senior Manager – Mental Health, LD & Addiction Services	The risk register has been reviewed and continues to be a standing item at QMAG meetings to ensure risks are	

	ænted, and reviewed monthly throug nce structures.		Associate Director of Nursing	captured and appropriate mitigation and controls are put in place.	
12.2	Continue supporting the rollout of the newly developed MHLD Workforce Tool across all relevant services.	31st December 2025	Head of Nursing Associate Director of Nursing	The MHLD Workforce Tool roll out training information has been shared with all Lead Nurses, Service Managers, Senior Charge Nurses and relevant staff. This is raised and discussed in staffing forums, including the supplementary staffing meetings, the Nursing and Midwifery staffing meeting and the HSCP workforce strategy meeting. "Safecare" continues to be rolled out and remains on target. The schedule for MHLD Workforce tool run has been shared.	
12.3	Sh 2025/2026 Workforce Tool run sc hedule targeted sng resources with all services, and rovide during each scheduled run ccurate o data input and engagement	30th June 2025	Head of Nursing Associate Director of Nursing	The tool schedule has been shared with staff and promoted through emails and SCN meetings. A local training presentation is	

				available and has been circulated, alongside promotion of the MHLD workforce tool training dates.	
12.4	Provide robust staffing reports in line with the MHLD Workforce Tool schedule, ensuring timely submission to governance and management structures, with clear outcomes and actions communicated back to all participating teams within 10 working days.	31st December 2025	Head of Nursing	This action is not complete as the first tool run following inspection is due to take place 19th January 2026. Plans are in place to ensure this action is completed within 10 working days. Workforce health check which uses common staffing method has been run.	

Requirement 13 NHS Fife must ensure clear real time staffing data is consistently recorded and any mitigations or inability to mitigate are recorded clearly and accurately (see page 26). This will support compliance with: Health Care (Staffing) (Scotland) Act 2019					
13.1	Implement eRostering and SafeCare across all Mental Health and Learning Disability service areas, ensuring all staff are trained and system actively used for shift planning and acuity-based staffing decisions.	30th September 2025	Head of Nursing Lead Nurses	eRostering continues to be a priority for NHS Fife. Mental health Services have just recently been fully on boarded with eRostering and about to undertake training in Safecare which is due to go live from mid-October 2025.	

13.2	Reinforce daily OPEL status reporting and Teams affing updates by issuing monthly s to all team leads, and develop a s ed process to record staffing-rela ed and actions taken, with documen ation n trally and reviewed monthly.	30th June 2025	Associate Director of Nursing Clinical Services Managers Lead Nurses	Implementation of eRostering and Safecare will mitigate the need for OPEL reporting, however huddles will continue to ensure that services are meeting safe staffing legislation. Evidence of staff moves is recorded within the 24hour report.	

Requirement 14 NHS Fife must demonstrate how it supports, monitors and reviews the provision of adequate time to lead and resource to clinical leaders (see page 27). This will support compliance with: Health Care (Staffing (Scotland) Act 2019					
14.1	Develop and implement a robust and standardised rocess for recording the time allocated to Senior harge Nurses and Team Leaders for leadership ctivities, ensuring consistent use across all MHLD ervices and monitored monthly.	31st July 2025	Associate Director of Nursing Senior Manager Mental Health, LD & Addictions Services	An agreed process is in place where SCN have allocated time for leadership activities documented within SSTS as 'management days. These are days that SCN's are not working clinically as part of the staffing numbers.	
14.2	Implement a supportive programme co-designed	31st July 2025			

	with SCNs/TLs to help balance clinical and non-clinical responsibilities, including training, peer support, and protected time, with feedback gathered quarterly to assess impact.		Head of Nursing Senior Manager Mental Health, LD & Addictions Services	A supportive action plan has been developed to support SCN's in balancing the clinical and non-clinical demands of their roles. The plan includes a review of SCN responsibilities and job planning to ensure appropriate time allocation across both areas. Development of the supportive plan has continued beyond the identified timeframe to ensure full engagement with the SCN workforce and complexity of supporting the SCN's to effectively balance role	

				responsibilities whilst providing additional direct support to achieve safe and effective staffing rosters and non-clinical functions. Development of SCN work plans in progress, supported by Lead Nurses to support SCN's to review and balance the demands of role and prioritisation of key tasks.	

14.3	NHS Fife will seek to enhance medical clinical leadership by progressing recruitment to a Clinical Director post.	30th September 2025	Associate Medical Director	Clinical Director post has been advertised and recruited to. The new Clinical Director took up post on the 15th of September 2025.	
Requirement 15 NHS Fife must ensure adequate staffing to enable meaningful activity to be provided to enhance recovery and promote wellbeing (see page 29). This will support compliance with: Health Care (Staffing) (Scotland) Act 2019 & Health and Social Care Standards (2017) Criteria 1.19 & 1.25 & Core Mental Health Standards criteria 4.6					
15.1	Each ward will undertake a review of current workforce establishment and skill mix in order to ensure that adequate resource is allocated to meaningful activity within the ward settings	31st August 2025	Clinical Service Managers Senior Manager Head of Nursing	A review of current AHP arrangements was undertaken by the Clinical Service Manager, with further meetings with finance to consider the current establishment and skill mix and utilising resources differently to ensure availability of staff to support	
				with meaningful activities. Meetings are due to take place over September and October 2025, with plans, papers and agreement of any resource changes to follow by November 2025.	
15.2					

	Mental Health Services will reprovision the skill mix of the Allied Health Professions workforce in order to recruit and embed staff with a specific focus on meaningful activity across each inpatient setting	30th September 2025	Clinical Service Managers Senior Manager	A review of current AHP arrangements has been undertaken by the Clinical Service Manager, with further meetings with finance to consider the current establishment and skill mix and utilising resources differently to ensure availability of staff to support with meaningful activities. Meetings are due to take place over September and October 2025, with plans, papers and agreement of any resource changes to follow by November 2025.	

Recommendation 1 - Domain 2
NHS Fife should ensure ward staff have an opportunity to participate in staff meetings to support team discussion and information sharing (see page 19)

16.1	NHS Fife will ensure that ward based team meetings are arranged and the record of these are shared with team.	31st August 2025	Clinical Services Managers Lead Nurses Senior Charge Nurses	Ward staff recognise the importance of regular staff meetings, and from September 2025 it was proposed that these be embedded into ward culture, with a minimum of two monthly meetings and minutes shared with the team. Work is ongoing to achieve the regular occurrence of Team meetings however this has not been achieved consistently due to the prioritisation of ensuring safe and effective staff rostering and the focus on staff training.	
16.2	NHS Fife will ensure further initiatives are trialled to ensure staff are well informed such as -Lead Nurse monthly service meetings attended by Senior Charge Nurses and Team Leads with minutes shared amongst teams. - Management team staff forums to allow the opportunity to ask questions sent in advance with subject's wider service.	31st August 2025	Clinical Services Managers Lead Nurses Senior Charge Nurses	Senior Charge Nurse meetings continue to be held monthly by Lead Nurses, with the Senior Manager attending in August. A management forum is in place within the service which allows ward staff the opportunity to submit questions in advance to the Lead Nurse and Clinical Service Manager. Planned engagement sessions for teams across MH and LD services during September and	

				October took place as scheduled and attended by staff side representatives. These were delivered by the Head of Service, Senior Manager, Associate Medical Director and the Associate Director of Nursing to share information on redesign and transformational plans. The service is considering making sessions a regular feature to keep people updated. Director of HSCP delivering road show and drop in sessions with attendance of teams encouraged. Implementation of initiatives to ensure staff are well informed through SCN Meeting and Management Forum were completed.	
Recommendation 2 - Domain 6 NHS Fife should consider improvement of the outdoor area for patients within Ward 2 in Queen Margaret Hospital to develop a more therapeutic space					

17.1	NHS Fife will ensure a better patient experience within the external area by linking with landscapers to consider opportunities to improve the current environment.	30th September 2025	Senior Manager Clinical Service Manager	Agreement has been made that ward 2's courtyard will be upgraded when the redesign programme progresses work on ward 1 and the shared	
				courtyard. Plans have been developed of the courtyard	
				within Queen Margaret Hospital, with funding secured to progress with the plans as part of the overall estates' improvement environmental work. This development creates a delay to providing an improved external area however the overall improvement will be better than would have been expected if developed earlier.	