AGENDA

A MEETING OF KIRKCALDY & LEVENMOUTH CHP COMMITTEE WILL BE HELD ON TUESDAY 12TH JULY 2011 AT 2:00 PM WITHIN THE TOWN HOUSE, KIRKCALDY

| 1. | Welcome and Introduction |
| 2. | Apologies for Absence |
| 3. | Declaration of interest – Committee members are asked to declare an interest in any of the Agenda items at this point and state what form that interest takes. |
| 4. | Minutes of Previous Meeting held on 10th May 2011 |
| 5. | Matters Arising |
| 5.1 | Review of Community Health Partnerships |
| 6. | Improving Health |
| 6.1 | Visit from Sir Harry Burns |
| 7. | Patient/Staff Experience |
| 7.1 | Strengthening Carer Involvement in Community Health Partnerships |
| 7.2 | Staff Absence Report |
| 7.3 | PPF Annual Report |
| 8. | Planning for Service Improvement |
| 8.1 | ADP – Drugs and Alcohol |
| 8.2 | Reshaping Care for Older People |
| 8.3 | Joint CHP Committee Development Session |
| 9. | Delivery & Efficiency |
| 9.1 | Financial Governance |
| 9.2 | Efficiency Savings 2011/12 |
| 9.3 | CHP Workplan 2010/11 |
| 9.4 | CHP Workplan 2011/12 |
| 10. | Items for Information: |
| (a) | Local Partnership Forum – 23rd March 2011 |
| (b) | PPF Reference Group – 27th May 2011 |
| (c) | CHP Clinical Governance Group – 17th March 2011 |
| (d) | Fife Health & Wellbeing Alliance – 9th March 2011 |
| 11. | A.O.C.B. |
| 12. | Dates for Diary: |

Next CHP Committee Meeting: 13th September 2011 at 2pm within Thomson House, Methil

Next Development Session: 11th October 2011 at 1pm, VTBC
Kirkcaldy & Levenmouth CHP Committee Meeting

12th July 2011
Agenda Item No 4

UNCONFIRMED MINUTE OF THE KIRKCALDY AND LEVENMOUTH CHP COMMITTEE MEETING HELD ON TUESDAY 10TH MAY 2011 AT 2:00PM WITHIN THOMSON HOUSE, METHIL

PRESENT:
Mr Alastair Robertson, Chair of Kirkcaldy & Levenmouth CHP
Mr George Cunningham, General Manager
Dr Les Bisset, Clinical Director
Mr Jim Bett, Voluntary Sector Representative
Mrs Mary Porter, Head of Nursing
Councillor Andrew Rodger, Council Representative
Mr Peter Adams, Non Executive Board Member
Mr Harry Blyth, Non Executive Board Member
Dr Brian Wilson, GP Representative
Mrs Samantha Allen, Nurse Representative
Mrs Moira Dunsire, Allied Health Professional Representative
Mr Ron Parsons, Public Partnership Forum Representative
Mrs Fiona Purdon, NHS Fife Non Executive Board Member
Councillor David Ross, Council Representative

IN ATTENDANCE:
Mr Andrew McCreadie, Assistant Director of Finance
Mrs Barbara Anne Boyter, Deputy Director of HR
Ms Rona Laing, Fife Council Officer Rep
Mrs Heather Fernie, Business Manager
Miss Claire Reid, Secretary (Minute)

18/11 WELCOME AND OPENING REMARKS FROM THE CHAIR
Mr Robertson opened the meeting and welcomed the Committee members.
Mr Robertson informed the Committee of some events he has attended recently.

19/11 APOLOGIES FOR ABSENCE
Apologies for absence were received from Prof Ian Campbell, Mr Gordon Penman, Dr Stephen Rodgers and Mr Nick Barber.

20/11 DECLARATION OF INTEREST
There are no declarations of interest.

21/11 MINUTES OF THE PREVIOUS MEETING HELD ON 8TH FEBRUARY 2011
The Minutes of the previous meeting held on 8th February 2011 were agreed as a true and accurate record of the meeting.
Mr Robertson advised that the CHP’s Annual Report, once ratified, will be presented to the Audit Committee in June together with other Committee Annual Reports. Mr Robertson requested confirmation from the CHP Committee that they were happy the report reflected the CHP’s work throughout 2010/11 in order that he may proceed with signing off the report.

The Committee **Approved** the Kirkcaldy & Levenmouth CHP Annual Report.

**23/11 MATTERS ARISING**

**Delayed Discharges (Deaths)**
There was discussion at the Committee Meeting in February regarding Deaths and Delay. Mr Cunningham advised this has now been discussed at two Board Meetings and the Board’s Clinical Governance Committee will receive the report on Deaths and Delay. Mr Cunningham also advised that there was an inaccuracy in the number of deaths which were detailed in the FOI, in that, less people had died than originally reported. Mr Cunningham added that there were no significant issues with any of the individuals at the time of their death.

Mr Cunningham confirmed a report will go to the Clinical Governance Committee and then to the CHP Committee, in an effort to answer the questions previously raised.

Councillor Rodger suggested that nursing staff are being put under pressure to release patients from hospital and enquired as to whether Clinical Manager’s meetings, in relation to hospital beds, are recorded. Councillor Rodger added that he understands consultants are responsible for discharging patients, however, there are major pressures being put on nursing staff to make sure patients are discharged from hospital, in order to release beds and he requires assurance that this is not the case.

Mrs Porter advised this issue had been raised previously and once investigated it was confirmed that, of all of the transfers within a year, only one patient required to be transferred back within 24 hours. Mrs Porter added that no patients were transferred after 8:00pm.

Mr Parsons enquired if the CHP had considered the number of transfers per patient. Mrs Porter advised that she understands this issue had been considered at the same time, unfortunately, information relating to a patient’s transfer to a community hospital is not available.

Mr Cunningham advised that NHS Fife apply a stringent approach in relation to Delayed Discharge coding. Not all Boards code in the same way and, therefore, other areas have less people with deaths in delay. Mr Cunningham added that there is no evidence that people prematurely died because they were held in hospital and that this had accelerated their death.

**Review of Community Health Partnerships**
Dr Bisset reminded members that he had updated the Committee at the last meeting on the review of Community Health Partnerships which was carried out at the end of May last year. Dr Bisset had intended producing a paper on the governance roles of the CHP but as this will not be published until June. Dr Bisset will report back at the next Committee meeting.
24/11  IMPROVING HEALTH

Rehab Discharge Programme, Stratheden Hospital
Mr Cunningham advised this work is underway under the assurances of the Health and Social Care Partnership. Mr Cunningham added that there is a gap in the funding for the discharge of the 45 patients from Stratheden Hospital and that a group has now been established, to consider the requirements of each individual patient and to try, as far as possible, to meet the aspirations of each patient. This group will report back to the Health and Social Care Partnership but will be managed through this CHP, therefore, regular updates will be provided to the CHP Committee.

Mr Parsons enquired if suitable accommodation for the patients is now being sourced and Mr Cunningham advised that the patients fall into three/four different groups and that all patients will be accommodated depending on their needs. Some patients will be easier to accommodate than others as some patients needs are complex.

It is planned to progress this in such a way as to allow the release of costs in line with the discharge of the patients and the group are currently working on a programme on how to do this efficiently.

Councillor Rodger enquired as to the timescale involved, whether this is linked into the Change Fund and whether the Voluntary Sector were involved. Mr Cunningham advised that the Change Fund is not a significant factor as not many patients were over aged 65 years of age. It was noted, however, that the Advocacy Service are involved in relation to the views of the patients and that each decision taken requires to be clinically appropriate and we must endeavour, as far as possible, to meet each of the patient’s needs.

The Committee Noted the Rehab Discharge Programme Paper

CHP Health & Wellbeing Profile 2010
Dr Bisset advised that a similar document to this had been produced in 2008. It has proved difficult to compare the 2010 profile to the 2008 document as some indicators have changed. Dr Bisset confirmed that the CHP has improved their position compared to the rest of Scotland, however, there are some areas where the CHP are performing below the Scottish average particularly in Asthma and Diabetes. Dr Bisset added that the number of deaths by suicide has increased, however, this reads as if we have improved as the rate is higher within the rest of Scotland. The document has been discussed with the Improving Health Team and they have been asked to identify key areas which the CHP will focus on. Dr Bisset will provide a further report at a future meeting.

Councillor Rodger suggested a Register be introduced for people who may wish to exchange houses, as he believes people’s health conditions may improve if they are living in the right environment to suit their health needs.

Ms Laing advised that a high number of Care Packages are provided by Fife Council to people in Fife to try to keep people living within their own home. It was agreed by the Committee that it would be helpful if Ms Laing could provide a presentation at a future Development Session.

The Committee Noted the CHP Health & Wellbeing Profile 2010 Paper.
Development Session – 7th June 2011
Mr Cunningham advised that the Development Session will be carried out in two parts. The CHP Committee members only, are invited to the first part of the session where Loughborough Road will be discussed. Both the Committee and the NHS Board members will be invited to the second part where representatives from the Addictions Service will provide a presentation.

The Committee Noted the Development Session Verbal Report.

Staff Survey Results
Mrs Boyter informed the Committee that information has been provided on comparisons between NHS Scotland and NHS Fife and between the CHP and the remainder of NHS Fife.

It is noted that, within the CHP, 274 staff completed the survey; this represents 17% of staff. In comparison to the survey carried out in 2008 there has been a reduction in the level of response.

Anecdotally the reduction may be linked to staff concerns about using an email address to access the survey and the issue of the staff survey close to that for the Healthy Working Lives programme. Mrs Boyter explained that there are lessons to be learned from this to assist in increasing the response rate for future Staff Surveys.

Mrs Boyter referred, in particular to section 4 i.e., comparison between the CHP and NHS Fife outcomes. Negative or positive differences of 10%+ were highlighted. It was noted it has been difficult to draw comparisons between the 2008 and 2010 surveys as some of the questions had changed. More detailed analysis is being carried out.

Mrs Boyter explained that the results of the survey will be communicated to staff using a variety of different formats and the views of the staff will used to implement appropriate actions to improve in the relevant areas. Local Partnership Forums will be responsible for including specific actions within the local Staff Governance Action Plans for 2011/12.

It was acknowledged that the survey completion rate, for both NHS Fife and the CHP, was poor and that this is disappointing. There was some discussion in relation to cultures within NHS Fife and Mr Cunningham advised that the CHP have various ways to give staff the opportunity to put forward their ideas and concerns including the Clinical Forum, Staff Briefing Sessions, Executive Walkabouts, Staff Side representing the staff, Team Meetings and e’mailing the Chief Executive direct.

The Committee Noted the Staff Survey Results Paper

Annual Complaints Report
Mrs Porter confirmed that this report relates to period 1st April 2010 to 31st March 2011. It should be noted that achieving 100% compliance to the response time target was missed by one patient only. Mrs Porter added that the two outstanding complaints were dealt with, within the identified timeframe.

Graph 5 identifies that the majority of complaints received were from the Mental Health client group (17). The outcome for 23 of the total complaints received was not upheld and the majority of complaints received were around
communication issues.

It is intended to share lessons learned across the senior Charge Nurses to ensure real staff engagement.

The Committee Noted the Annual Complaints Report Paper

26/11 PLANNING FOR SERVICE IMPROVEMENT

Reshaping Care for Older People
This programme was produced by the Scottish Government and the main goal is to optimise independence and wellbeing for older people at home or in a homely setting and help them be independent for as long as possible.

Dr Bisset highlighted the following points in the paper

2.1.1 outlines the Health Boards targets in relation to this and 2.2.1 outlines the main local authority targets.

The intention is for a local plan to be drawn up for Fife to take forward the key components of the programme and a consultation document entitled ‘Joint Health Care Strategy for Older Peoples Services in Fife 2011-2026’ has already been circulated and comments received back.

4.2.1 refers to the agreement of a Reshaping Care Local Transformation Plan which will show how the Change Fund will be used to continue to deliver Shifting the Balance of Care.

Mr Parsons enquired as to whether this strategy will operate within the three CHPs and Dr Bisset confirmed the strategy will apply across NHS Fife i.e., the three CHPs and the Operating Division.

Mr Rodger raised several questions in relation to the reduction of emergency care; involvement to date with NHS 24 and GPs and the CHP’s status in relation to the Dementia Strategy?

In answer to the questions Dr Bisset advised there are Intermediate Care Teams, Enhanced Healthcare Teams, Integrated Response Teams and Home Carers who all assist in the care of the patient. Dr Bisset also advised there had been no direct discussions with NHS 24, however, discussions have taken place with PCES. A group is taking forward the Dementia Strategy which will ensure best practice is shared.

The Committee Noted the Reshaping Care for Older People Paper Report

BBV Service
Mr Cunningham advised there are national targets which the BBV Service are expected to meet in relation to patients receiving treatment for HEP C. Mr Cunningham added that, although he is the Executive Lead for BBV he is not the lead for Sexual Health. The key issue being highlighted is for closer alignment of the BBV Service and Sexual Health due to the potential for overlap.

Therefore, it has been agreed to transfer the management of the BBV Service from the Operational Division to Kirkcaldy and Levenmouth CHP to sit within the remit of the Sexual Health Service. The testing, treatment and care of aspect of the BBV Service is provided by two nurses and this change will provide improved management support to these staff and appropriate management of the BBV Service to ensure that the targets are delivered.
Mr Cunningham advised that there has been an improvement in the service delivered and it is hoped to have 2,000 patients in treatment by this time next year.

The Committee **Noted** the BBV Service Paper.

**27/11 DELIVERY & EFFICIENCY**

**Financial Governance**
Mr McCreadie advised the paper provided is a year end report for 2010/11. The Report shows an underspend of £49k against Managed Clinical Services and on overspend of £310k on Prescribing. This information is summarised in the table on page 57 of the agenda.

With regards to efficiency savings full delivery has been achieved within 10/11, including the carry forward gap from the previous year.

The Capital allocation is shown in appendix 1. There is a small overspend on allocation, however, this is managed in conjunction with capital schemes across CHPs.

There are a number of issues for year 2011/12 including addressing the ongoing drugs issues within Rheumatology. Efficiency programmes are being established to ensure targets are met

The Committee **Noted** the Financial Governance Paper

**CHP Workplan/Balanced Scorecard 2010/11**
Mr Cunningham explained that Appendix 1 identifies the CHP’s position as at February 2011 whilst Appendix 2 provides a comparison between the CHP’s position, to that of NHS Fife, at different times throughout the year.

Table 1 in section 2.3 outlines where the CHP are performing slightly better than NHS Fife, however, Table 2 within section 2.4 identifies two targets where the CHP’s performance is in an adverse position to that of NHS Fife.

The Committee **Noted** the CHP Workplan/Balanced Scorecard 2010/11 Paper

**28/11 FOR INFORMATION**
The Committee **Noted** the following papers:
- Local Partnership Forum Minutes - 23rd November 2010
  - 20th January 2011
- PPF Reference Group Minutes - 14th January 2011
- CHP Clinical Governance Minutes - 17th November 2010
- SMT Risk Report - 26th January 2011

**29/11 DATES FOR DIARY**
**Next CHP Development Session:** 7th June 2011, 13.00 – 15.00, The Cottage, Cawdor Crescent, Templehall, Kirkcaldy
**Next CHP Committee Meeting:** 12th July 2011, 14.00 – 16.30, Town House, Kirkcaldy
Kirkcaldy & Levenmouth CHP Committee Meeting

12 July 2011
Agenda Item No 5.1

REVIEW OF COMMUNITY HEALTH PARTNERSHIPS

1. INTRODUCTION

1.1 In 2010 the Scottish Government published an independent study which had been carried out of Community Health Partnerships (CHPs) which assessed the CHPs progress in Scotland since their establishment in 2005.

Later that year they also published a document “Delivering Better Outcomes and the Use of Joint Resources” which summarised the findings of the above study and also outlined how the Scottish Government proposed to work with its partners to support the further development of CHPs.

This latter document was discussed at the February 2011 meeting of the CHP Committee.

The Scottish Government also at that time announced its intention to commission Audit Scotland to carry out a further study of CHPs to focus on the following areas:

- The Governance & Accountability Arrangements
- The Contribution to Shifting the Balance of Care
- The Use of Devolved Resources and their Effectiveness in Improving the Health & Quality of Life of Local People

The Audit Scotland report “Review of Community Health Partnerships” presents the outcome of that study and is attached separately.

The CHP Committee now has the opportunity to discuss this review document and contribute to the NHS Fife response.

2. DRAFT NHS FIFE RESPONSE

2.1 Attached as Appendix 1 is the draft response to the Audit Scotland document.

This identifies the most relevant key messages and recommendations for Fife with an initial response to each of the issues raised.

The Audit Scotland report and the final draft response from NHS Fife will be considered in due course by NHS Fife Board.

6. RECOMMENDATIONS

6.1 The Committee is asked to:

- consider the Audit Scotland document “Review of Community Health Partnerships” and;
- contribute to the draft response to that document

Report by: Dr Les Bisset
Clinical Director
Kirkcaldy & Levenmouth CHP
Introduction

The Review of Community Health Partnerships was published by Audit Scotland in June. This paper identifies the most relevant key messages and recommendations for Fife with an initial response to the issues raised. Only those issues most relevant to Fife have been highlighted as there are many messages and recommendations which are already covered in our joint working arrangements. This paper focuses on what we can learn and take forward in a local context.

The aim is to use this as a discussion document for CHP committees, the Area Clinical Forum, the Area Partnership Forum, the Partnership Management Group and the Strategic Management team before a final document with recommendations is produced for NHS Fife Board.

Background

The aim of the audit was to examine whether CHPs are achieving what they were set up to deliver, including their contribution to moving care from hospital settings to the community and improving the health and quality of life for local people. It assessed governance and accountability arrangements and if CHPs are using resources effectively. The report also emphasises the move to integration and highlights issues for Boards.

To put this into context, the Blake Stevenson report commissioned by the Scottish Government and published in May 2010, noted the significant variation between CHPs across Scotland and was clear in its conclusion that there is no one preferred model, each operate in the context of local circumstance. However, the conclusions of the Audit Scotland report do suggest that the same criteria for measurement have been used across the various models. It is no wonder they noted significant variations in their findings.

Many of the recommendations refer to progress against health and social care targets when CHPs were set up as NHS bodies. The report questions whether the responsibilities came with the necessary authority required to implement the changes required.

The report is critical of CHPs impact on health inequalities. This seems a tall order for one element of NHS provision in a complex environment but locally in Fife, the leadership for addressing inequalities come from the Health and Wellbeing Alliance reflecting the strategic sign up to this significant agenda across the partners. As CHPs we play a crucial role and have made an impact on health improvement
targets but whether we have successfully dealt alone with the huge issues around health inequalities is another matter.

NHS Fife was one of six areas which were singled out by Audit Scotland for more detailed analysis. The basis of this was the configuration of three CHPs to one Council area.

The relevant recommendations and associated issues have been categorised in the same way as that used by Audit Scotland. Not all recommendations have been highlighted, we have picked out those we consider to be most relevant to Fife.

**Governance and accountability**

**Messages and Recommendations**

The report emphasises that good governance and clarity of accountability is essential. Not all Boards have comprehensive partnership arrangements in place. Partners need to improve arrangements for managing staff in joint teams.

Audit Scotland recommends that the Government should review partnership arrangements for health and social care. Set up measures for Councils and Boards to measure the performance of joint arrangements. Update guidance on joint planning and resourcing for partnership activities.

Audit Scotland recommends that Boards and Councils should streamline existing partnerships, clarify governance arrangements if that is seen to be an issue and update schemes of establishment if required. In line with national guidance more work should be done to define success criteria and performance measures for CHPs.

**Local issues**

- The Fife Partnership has robust partnership arrangements with clear lines of accountability for the partnership groups. Under the circumstances it would be prudent to review our partnership arrangements formally to ensure there is clarity and restate strengths and identify gaps.

- We should specifically review existing management arrangements for our front line teams looking at existing and potential for expanding the number of joint posts.

- Ensure mechanisms are in place to look at the detail of workforce arrangements at the front line with the aim of increasing as much flexibility as possible.

**How resources are used**

**Messages and recommendations**

The Audit Scotland Report made a number of statements critical of CHPs success regarding GP involvement and influence. Much has been achieved in NHS Fife and there is evidence of sound GP clinical leadership and involvement. It has to be recognised that the establishment of CHPs commenced at the same time as the
significant contract changes with primary care. This necessitated GPs to focus on their practice development and operational arrangements in a different contractual environment.

CHPs manage 26% of total spending and have limited influence on the allocation of resources across the whole system. The Audit Scotland report commented that this lack of influence is a barrier to GPs engaging with CHPs and should be addressed as GPs influence a large percentage of the NHS budget driven by their clinical decisions including referrals, prescribing etc.

Audit Scotland recommended that the Government should improve systems to collate date for community health and social care activity and cost data. Progress care.

It was also recommended that Boards and Councils should collect data on costs, staff and activity data at a local level, including current and future staffing levels. They suggest we should maintain the work to develop the IRF to help plan how resources can be more effectively spent, share staff buildings, equipment and IT, involve GPs and address variation in referral rates and prescribing.

**Local issues:-**

- The CHP influence over the whole health system is a national issue and GPs locally would agree with and recognise the narrative in the Report. GPs feeling of influence over the whole system is a crucial but if they don’t perceive the CHPs as being the holder of influence they will not participate.

- The issue of who influences what and how may become clearer if there is a national move to joint commissioning arrangements but if there is to be a change in Fife as it stands, we would need to look at where the drivers for change are and ask questions locally about who does have the influence for change across acute and community services, what part do CHP’s play in that change and how we can then bring the GPs into the debate.

- As CHPs we need to work with the Area committees, building on our already significant involvement in Local Community Planning arrangements, beyond Social Work, to address some of the practicalities in relation to information services, finance and joint use of local assets.

**Impact on the health and quality of life of local people**

**Messages and recommendations**

As highlighted in the introduction, Audit Scotland were concerned that it was not possible to identify CHP role in reducing health inequalities. In relation to partnership working they noted variation in their successes in relation to specific performance indicators such as delayed discharges and reduction in multiple admissions.
Local issues:-

- The plans for delayed discharges locally are well rehearsed and the development of the services under the auspices of reshaping care will help that debate.

- There are plans to increase flexibility for local managers but this will have to be backed up by ensuring flexibility on decision making and the whole system working to support the front line decisions. This may be superseded by the development of a national plan for joint commissioning and provision.

Conclusions

This work on integration should be taken forward by the existing partnership groups now rather than wait for any expected pronouncements from the Scottish Government on what should happen nationally. We have sound partnership structures in Fife so we should use this and our coterminosity to devise an improved integrated framework which allows us to address where we need to improve to strengthen frontline integration and improve services for the population. Reshaping care will help but that will be predicated on robust operational arrangements which will be able to deliver more joined up care.

Members are asked to note this initial response to the Report and comment on the issues raised. The comments will be taken into the next iteration of the report with specific recommendations being taken to the Partnership Management Group and the Strategic Management Group.

George Cunningham
Vicky Irons
Susan Manion

29/06/2011
STRENGTHENING CARER INVOLVEMENT IN COMMUNITY HEALTH PARTNERSHIPS

1. INTRODUCTION
1.1 In July 2010 the Scottish Government together with the Convention of Scottish Local Authorities published the Carers Strategy “Caring Together”, which outlined a 5 year strategy on the vision for the future of carer recognition and support in Scotland.

There were a number of Headline Actions contained within that Report including one stating that the Government will ensure carer representation on Community Health Partnerships.

2. BACKGROUND
2.1 This CHP has already carried out much good work in relation to the involvement of carers in terms of service development and planning e.g. redesign of services formerly at Montrave Ward and involvement in the Mental Health Acute Inpatient Forum.

Carers have also been involved through discussions with the CHP Public Partnership Forum.

However, there is a need to ensure that routine mechanisms are in place to ensure that carers are seen as equal partners in the planning, shaping and delivery of patient centred care services and support. This should ensure that the best quality services are available locally to address the needs of carers and those for whom they care.

3. BENEFITS
3.1 There are significant benefits not only to patients and carers but to the CHP and through it to NHS Fife in the meaningful involvement of carers in service planning.

The benefits of carer support and involvement include:-

- More informed decision making around planning for service change.
- Advice on Carer Information Strategies.
- Advice on specific changes to local services e.g. pharmacy provision.
- Advice on health inequalities as they specifically relate to carers locally.
- Advice on the need to inform and support carers in relation to hospital discharge arrangements.
- Advice on development of anticipatory care plans for patients supported by carers.
- Gaining a better understanding of the needs of young carers.

4. REPRESENTATION ON THE CHP
4.1 One of the action points in the Carers Strategy was that the Scottish Government would ensure carer representation on CHP Committees.

NHS Fife has been in discussion with the Fife Carers Centre in order to identify suitable representatives for the CHP.

This will be a demanding role requiring the representative to have a wide ranging
knowledge of the position within this area in terms of carers needs and support and in order to fulfil this will require good communication channels to be in place to support that individual in fulfilling their role.

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<td>5.1</td>
<td>The CHP Committee is asked to:-</td>
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<td>• note the actions being taken to strengthen carer involvement in the CHP Committee.</td>
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Report by: DR. LES BISSET  
CLINICAL DIRECTOR  
KIRKCALDY & LEVENMOUTH CHP
KIRKCALDY AND LEVENMOUTH CHP ABSENCE REPORT

1. INTRODUCTION

This report follows the same format as previous absence reports, with narrative on the current activity and statistical information.

As reported in December 2010, work has continued to date to reduce sickness absence within NHS Fife. From April 2009, the HEAT target became a HEAT standard of 4% on an on-going basis.

2. CHP ABSENCE POSITION

Details of the CHP’s percentage absence position for the 12 month period from 1 April 2010 to 31 March 2011 are provided below. As in previous reports, the position reflects a variable pattern. The CHP average for the period is 5.36%, with July being the best month so far in relation to attendance, when the percentage was 4.61% and the peak to date was in December when the percentage recorded was 6.11%.

Over the 12 months from April 2010 to March 2011, the following comparisons can be drawn between the CHP performance 2010/11, CHP performance 2009/10 and NHS Fife performance 2010/11.

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<td>CHP 2009/10</td>
<td>5.52%</td>
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<td>CHP 2010/11</td>
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<td>NHS Fife 2010/11</td>
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<td>CHP 2009/10</td>
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<td>CHP 2010/11</td>
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<td>NHS Fife 2010/11</td>
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There are a variety of reasons for this absence rate with the main issues being staff with long term health problems and localized issues in relation to staff absence.

The two areas of concern previously highlighted to the Committee, In-patient Nursing within Local Services and Mental Health have again had fluctuating rates. Additional details in respect of these areas is provided below:
Local Services

Inpatient Nursing

All services continue to fully implement the Absence Management Policy; however, in this period In-patient Nursing has experienced higher absence rates than anticipated. It should be noted that from April to March 2011 the figure has reduced by 1.41%, but this still leaves a March 2011 figure of 5.76% absence being experienced within this area. Further investigation will require to be undertaken to target appropriate action to support the reduction of the absence levels within the current year.

Disappointing levels remain due to long term absence. Rigorous application of the Policy continues in Partnership with proactive planning regarding long term absence and use of the Capability Policy for frequent short term absence. Focused action will be necessary to further reduce this level of absence.

Mental Health

The Mental Health Services have again experienced high sickness absence levels, a pattern which follows on from the end of the previous reporting year. There was an improvement in June and August 2010, with a rate of 4.90% and 4.78% respectively. As previously reported, the difficulties are focussed on the in-patient areas. Local management continue to manage attendance in Partnership applying all relevant policies, as appropriate.

3. CHP ABSENCE RATES

<table>
<thead>
<tr>
<th>Month</th>
<th>Local Services</th>
<th>Fife Wide Services</th>
<th>Improving Health Team</th>
<th>LTC &amp; MCN</th>
<th>Pharmacy Services</th>
<th>A&amp;C Services</th>
<th>Mental Health Service</th>
<th>KL CHP Total 2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2010</td>
<td>4.99%</td>
<td>1.55%</td>
<td>26.22%</td>
<td>10.28%</td>
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<td>3.26%</td>
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<td>5.52%</td>
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<tr>
<td>May 2010</td>
<td>4.21%</td>
<td>1.39%</td>
<td>11.78%</td>
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<td>4.20%</td>
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<td>June 2010</td>
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<td>August 2010</td>
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<td>Sept 2010</td>
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<td>3.15%</td>
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<td>October 2010</td>
<td>4.65%</td>
<td>4.04%</td>
<td>0.00%</td>
<td>0.88%</td>
<td>22.80%</td>
<td>4.11%</td>
<td>6.37%</td>
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<td>November 2010</td>
<td>5.15%</td>
<td>3.56%</td>
<td>0.00%</td>
<td>0.46%</td>
<td>4.97%</td>
<td>3.46%</td>
<td>6.78%</td>
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<td>December 2010</td>
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<td>0.00%</td>
<td>1.91%</td>
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<td>3.59%</td>
<td>6.95%</td>
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<td>January 2011</td>
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<td>2.33%</td>
<td>0.00%</td>
<td>2.48%</td>
<td>0.00%</td>
<td>2.68%</td>
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<td>February 2011</td>
<td>6.04%</td>
<td>2.07%</td>
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<td>0.00%</td>
<td>0.00%</td>
<td>3.91%</td>
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<tr>
<td>March 2011</td>
<td>4.44%</td>
<td>1.66%</td>
<td>2.70%</td>
<td>2.75%</td>
<td>2.97%</td>
<td>4.97%</td>
<td>5.59%</td>
<td>4.89%</td>
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</tbody>
</table>

4. ATTENDANCE MANAGEMENT ACTIVITY / TRAINING

As reported previously to the Committee, Managers and HR staff within the CHP are continuing to review areas of concern and to build on training previously undertaken. The HR Absence Management Tool is being used routinely to identify hot spots and ensure that the NHS Fife Management of Ill Health and Capability Policies are used appropriately. All of the initiatives previously reported to the Committee continue to be progressed and monitoring of the monthly absence figures will continue.
In conclusion, there is room for improvement and the CHP General Manager and the Management Team are committed to ensuring that an improvement is achieved in the next financial year.

The CHP Committee is asked to:

- **note** the content of this report and the activity which is continuing in relation to attendance management.

Report by: BARBARA ANNE NELSON
DEPUTY DIRECTOR OF HUMAN RESOURCES
Kirkcaldy & Levenmouth CHP Committee Meeting

12th July 2011
Agenda Item No 7.3

PATIENT/STAFF EXPERIENCE: PPF Annual Report

1. INTRODUCTION

When CHPs were established in 2005 they were required to set up Public Partnership Forums (PPFs) through which they would engage, communicate with and maintain a meaningful dialogue with the population within their area.

Within Kirkcaldy & Levenmouth we established a PPF Reference Group to guide the CHP in relation to advice on the best mechanisms to engage with public, patients and other interested groups on specific issues.

The attached Appendix 1 outlines the activity of the Public Partnership Forum and its Reference Group over the past year.

2. ACTIVITY

The Reference Group and through it the wider Public Partnership Forum have been extremely busy over the last year.

The main areas of work for the Forum members have been to attend and contribute to various national, local and Fife-wide events, to represent the CHP on other groups and to receive presentations on a number of topics to keep them abreast of developments within the CHP.

The breadth and depth of their engagement in these different areas is outlined in the attached Appendix.

3. RECOMMENDATION

The CHP Committee is asked to:

- note the Annual Report of the PPF

Report by: Dr Les Bisset, Clinical Director
Mr R Parsons, Chair, PPF
1. FOREWORD

We have been busy since our last report. Our main work is threefold. Members have attended and have contributed to events such as: NHS Fife Annual Review, Pharmacy Services Update, CHP Annual Conference and involvement in the cleanliness audits.

It is important to maintain involvement with events of this kind, for as new members join the group, they will wish to widen their horizons.

Then again, we are represented on other groups by several of our members. They are worth listing:

- CHP Committee
- CHP Clinical Governance Group
- Mental Health QIS Steering Group
- Mental Health Collaborative Steering Group
- NHS Fife Disabilities Group
- NHS Fife Patient Focus Public Involvement (PFPI) Standing Committee
- NHS Fife Wheelchair Users Group
- Pain Management Clinical Pathways Group
- Spiritual Care Committee

To these groups our members can contribute not only as Reference Group members, but because of the special knowledge imparted by their professional background.

The PPF Reference Group has also received presentations on a number of topics. These have included:

- In Our Shoes: Self Identified Health Needs of Young People
- Integrated Care Pathways in Mental Health
- Fife Rehabilitation Service
- Future Service Delivery Strategy
- Fife Sexual Health Service
- PFPI Research Study

This represents an important facet of our work, which is to advise on the methodology of communication. We believe that we are in a position to give help because of the variety of age, experience and disability which the Group represents. In that connection when it comes to fine-tuning a presentation or an initiative, the earlier we are involved in the process the better.

Nick Barber
Chairman
2. INTRODUCTION

The NHS Fife Scheme of Establishment for Community Health Partnerships (CHP) published in December 2004 outlined the statutory requirement for CHPs to develop Public Partnership Forums. A forum is described as a “meeting for the open discussion of subjects of public interest”. It is anticipated that the PPF will remain true to this definition supporting the open discussion of issues relating to health and health services in Kirkcaldy & Levenmouth.

The PPF is an important part of the work of the CHP and of wider health service planning and delivery. As such it should be involved as appropriate in all aspects of the CHP.

The PPF is the main mechanism by which the CHP engages, communicates and maintains a meaningful dialogue with the people of Kirkcaldy & Levenmouth.

The development of the PPF has been based on the following principles:

- Openness;
- Honesty; transparency;
- Learning from patients’ experience; tackling health inequalities and promoting health improvement; developing a meaningful ongoing dialogue with individuals and communities;
- Engaging with people;
- Respecting and promoting equality and diversity;
- Respecting and valuing the individual;
- Listening to, hearing and acting upon what people say;
- Giving and receiving feedback;
- Inclusion; and
- Learning from each other.

The PPF acts in all respects as an equal opportunity organisation, ensuring that all barriers to involvement and inclusion are overcome as far as is feasible.

The PPF is committed to the equality and diversity approach which addresses the needs of all individuals. The PPF must also consider the needs of people who are affected by a range of cross cutting issues: for example poverty and homelessness, mental ill health, involvement in the criminal justice system.
3. PUBLIC PARTNERSHIP FORUM INVOLVEMENT

3.1 Membership

Recruitment

At present we have 89 groups and 40 individuals on our Register of Interest.

The PPF Banner and Leaflets have also been taken to various events across Fife to try and recruit new members. This is a picture of the stand we developed and manned at the CHP Annual Conference in November.

3.2 Projects

The CHP PPF was involved in 115 projects from the 1st April 2010 until 31 March 2011 an increase of 31 projects on last year. A full list is attached at Appendix 1.

The breakdown is as follows:

<table>
<thead>
<tr>
<th>Project Involvement</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Consultations</td>
<td>21</td>
</tr>
<tr>
<td>NHS Fife Consultations</td>
<td>19</td>
</tr>
<tr>
<td>CHP Consultations</td>
<td>30</td>
</tr>
<tr>
<td>Invitations to Events</td>
<td>17</td>
</tr>
<tr>
<td>Invitations to join working groups/project team</td>
<td>17</td>
</tr>
<tr>
<td>Items for information only</td>
<td>11</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>115</strong></td>
</tr>
</tbody>
</table>
3.3 PPF Evaluation

As part of the ongoing review and development of the PPF outlined in the CHP Patient Focused Public Involvement (PFPI) Work Plan we have been looking at ways to demonstrate how the PPF has made a difference.

In the evaluation we looked at two key areas:

- PPF members who attend various groups or committees
- Staff attendance at PPF Reference Group meetings

The six monthly report prepared on the evaluation was discussed at our PPF Reference Group meeting. A number of comments were received from members of staff:

- They came up with valid comments and a few good suggestions.
- Feels a supportive meeting if there are different opinions.
- I think they were complimentary and felt we were doing what they would like other services to do.
- I hope we can involve the PPF in the future.

How have they contributed?

- Made further amendments to the volunteer handbook.
- Support re process of stakeholder involvement gives confidence to the group responsible for this project.
- Members also reinforced the importance of patient centred care.

3.4 PPF Involvement in Staff Training

The Vice Chairman of the PPF recently carried out a presentation at the CHP Annual Conference for Staff. The session was around ‘Creating a Mutual NHS’. The Vice Chairman’s presentation covered

- Why are we necessary?
- Where do we fit in the organisation?
- Who are we?
- What do we do?
- How do we do it?
- What about the future?

Initial feedback about the session was very positive.

3.5 Better Together: Inpatient Survey

Following the results of the Inpatient Survey the CHP set up a Short Life Working Group to develop a CHP Improvement Plan, a member of the PPF sits on this Group. The Improvement Plan will be monitored by the CHP PPF Reference Group.
3.6 CHP Service User Information Procedure

The CHP Clinical Governance Group has agreed that all patient information developed within the CHP must be processed through the Public Partnership Forum for comment. Therefore at the CHP Clinical Governance Group meeting in March 2011 the CHP Service User Information Procedure was approved. The procedure has been developed to outline the process for any patient information that is developed within the CHP.

4. PPF DEVELOPMENT TOOL

Kirkcaldy and Levenmouth CHP in partnership with the Scottish Health Council (SHC) agreed to undertake a review on the progress of the CHP Public Partnership Forum and to identify key development opportunities that may exist using their PPF Development Tool.

A Focus Group was organised in Kirkcaldy and Levenmouth in February 2010 and the aims of this event were to:

- Enable Public Partnership Forum participants, the Scottish Health Council, and the Community Health Partnership to consider what progress they have made so far and what areas they wish to develop and improve.
- Ask the Community Health Partnership and the Public Partnership Forum to agree key actions that can be developed over the forthcoming year.
- To ensure the right foundations are in place to help the Public Partnership Forum to broaden the range of people they include.

The information from this event was discussed at a joint session with PPF members, staff and representatives from the SHC held in April 2010 and a number of actions were agreed, these were included within the CHP PFPI Work Plan.

- It was agreed that a copy of the Working Agreement would be issued to all PPF members to increase their understanding of how the PPF works within the CHP.
- A copy of the minutes of the PPF Reference Group would be sent to all PPF members for information.
- A ‘Buddy’ System to be introduced for new members of the PPF Reference Group.
- A procedure on how the PPF members can raise issues with the CHP Management Team to be developed.
- Consideration to be given to holding PPF Reference Group meetings in public, to include wider PPF members.
4.1 PPF Reference Group: Public Meeting

The PPF Reference Group held its first ‘public’ meeting on 14th January 2011 where all PPF members on the Register of Interest were invited to the second part of their meeting. This second session is for Clinical Service Managers to discuss changes or developments within their service. At this first ‘public’ session the Clinical Service Manager from Fife Sexual Health Service carried out a presentation on how the service was working towards achieving the NHS Quality Improvement Standards for Sexual Health.

4.2 NHS Fife Board Elections

The Health Board (Membership and Elections) (Scotland) Act 2009 was passed by the Scottish Parliament on 12th March 2009. The Act introduced powers to: conduct pilot elections to Health Boards; carry out an evaluation of those pilots; report back to the Scottish Parliament on the outcome of the pilots; and for the Scottish Parliament decide whether this process should be rolled out across Scotland.

The aim of the Act is to

- improve public engagement and participation in the development of health services,
- ensuring that the public has a say in the decision making process.

Pilot elections to Health Boards were held in two NHS Boards areas: Fife and Dumfries & Galloway in June 2010. The elections ensure that elected members and councillor members (from a local authority within the Health Board area) form the majority of those two Health Boards. The majority will therefore have been democratically elected either through the Health Board elections process or through a local government election process.

One member of our PPF Reference Group was elected to NHS Fife Board.

5. SCOTTISH HEALTH COUNCIL : PARTICIPATION STANDARD

In August 2010 the Scottish Health Council published and launched the Participation Standard.

**Standard 1 Patient Focus**
Care and services are provided in partnership with patients, treating individuals with dignity and respect, and are responsive to age, disability, gender, race, religion or belief, sexual orientation, and transgender status.

**Standard 2 Involving people in service planning, improvement and change**
There is supported and effective involvement of people in service planning and improvement.

**Standard 3 Corporate Governance of Participation**
Robust corporate governance arrangements are in place for involving people, founded on mutuality, equality, diversity and human rights principles
As part of Standard 2 Boards were asked to draw up a short list of around six service changes (non-major service change) carried out in their Board area. The service change to be assessed was to be chosen in partnership between the NHS Board, community groups or Public Partnership Forum and the Scottish Health Council.

Each CHP and the Operational Division worked with their Public Partnership Forum or Patients Forum to select two service changes to be considered by NHS Fife.

The Kirkcaldy & Levenmouth PPF Reference Group discussed the selection of areas for reporting at their meeting on 8th October 2010. They selected:

- Relocation of Services from Barrie Street Clinic to Randolph Wemyss Memorial Hospital
- Relocation of Podiatry patients from Thornton Clinic to Pitteuchar Health Centre

The final projects selected from the 3 CHPs and Operational Division within NHS Fife were discussed at meeting in November 2010, where members of each of the PPFs and Patients Forum were asked to score and select one project for submission as part of Standard 2. The final project selected was the General Hospital & Maternity Service development.

6. PhD RESEARCH ON PFPI IN KIRKCALDY

A PhD Student from Edinburgh University has been working on a research project on the implementation of patient involvement policies in Scotland and England. The focus for her part of the research has been looking into patient focus public involvement within the Kirkcaldy & Levenmouth area. Initially the research student contacted the PFPI Lead to attend a meeting of the PPF Reference Group to outline her research. At this meeting it was agreed that she could attend all future PPF Reference Group meetings and also hold one to one interviews with the PPF Reference Group members.

The research student has provided an update to the PPF Reference Group on the two parts of her research. Once the research is complete a full report will be made available.

6.1 Part 1: 14 interviews were conducted with 18-25 year olds, focusing attention on slightly different aspects of health services.

Although this was a small number of self-selecting patients it gave an insight into experiences of services. There is clear difference between surgeries; but the problems are not waiting times or building facilities, but interpersonal between staff and patients.

- Experience was mostly confined to GP surgeries, very occasional use of A&E.
- Those with children had broader experience.
- Many were happy they didn’t need much from services: occasional prescription or absence line.
- Problems largely arising from diagnosis in primary care and not treatment or organisational aspects.
- Trying to be taken seriously and listened to by doctors.
By far the most common reaction to being unhappy was to avoid the individual GP and find one you liked and trusted.
Some had come close to complaining but had been put off by having to write a letter instead of filling in a form. Little belief that it would make a difference.
Also some stories where you get labelled as a ‘problem patient’
Everyone liked the idea of Forum but nobody could imagine themselves going. Many doubted their expertise/knowledge. Most would be willing to fill in a questionnaire or survey.

6.2 Part 2: Interviews with PPF Reference Group members

The findings identified three ‘modes’ of members, three different ways that people might see and do PPF membership; volunteering, consultancy, and challenging.

All members moved between modes at different times. All modes are invented ‘ideal types’, which means that they don’t correspond with any real person.

Volunteering: This was probably the most common type of activity within the PPF Reference Group. Members in a volunteering mode had signed up because they were very grateful to the NHS, or because they had been invited to join. They didn’t necessarily have strong views about what should change about local health services, and were often happy to wait for requests for help from staff.

Consultancy: Consultancy type membership also attracted people who wanted to help, but often people who had a stronger orientation towards changing things about the local NHS. Members in this mode were clear that they had specific expertise to offer from their experience, over and above a common-sense patient’s view. While, like volunteers, they were happy to respond to requests for help from NHS staff, they were more likely to raise issues of their own as well.

Challenging: Challenging members had clear priorities for things they would like to be better in the NHS. They saw the PPF as an opportunity for constructive criticism, and were keen to be pro-active in identifying problems or opportunities for change which were relevant to their interests or priorities.

The information from this report will be used to review the PPF Reference Group and look at ways to ensure we have a broad range of activities to meet the preferences of different members.

7. CHALLENGES

- Seek evidence to show the PPF has made a difference.
- Seek evidence to show the PPF influenced the CHP and its services.
- Develop a broader range of activities to meet the preferences of different members.
<table>
<thead>
<tr>
<th>Date Received</th>
<th>Project Title</th>
<th>Request</th>
</tr>
</thead>
<tbody>
<tr>
<td>06/04/2010</td>
<td>In our Shoes</td>
<td>Request to come along to a meeting to discuss In our Shoes Report</td>
</tr>
<tr>
<td>13/04/2010</td>
<td>Bereavement Co-ordinating Group</td>
<td>Request for PPF member to join Bereavement Group.</td>
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<td>16/04/2010</td>
<td>K&amp;L CHP Newsletter</td>
<td>For Information Only</td>
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<tr>
<td>19/04/2010</td>
<td>External Audit Work - NHS Fife's Approach to Community Engagement</td>
<td>Request for PPF Chair to participate in telephone meeting.</td>
</tr>
<tr>
<td>19/04/2010</td>
<td>Project Argus Health Event</td>
<td>Invitation to attend events.</td>
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<td>20/04/2010</td>
<td>Royal College of Anaesthetists</td>
<td>Request for PPF member to join Patient Liaison group</td>
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<td>27/04/2010</td>
<td>Patient Agenda Cards</td>
<td>Request for PPF members to comment on Patient Agenda Cards.</td>
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<td>Point of Care Testing (POCT) Committee</td>
<td>Request for PPF members to join POCT Committee.</td>
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<td>Public Partnership Forum Information Leaflet</td>
<td>Request for comments.</td>
</tr>
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<td>14/05/2010</td>
<td>General Optical Council - Seeks Volunteers</td>
<td>Request for PPF members to join Stakeholder Reference Groups.</td>
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<td>Application for Inclusion in NHS Fife's Pharmaceutical List</td>
<td>Request for PPF members to comment on application.</td>
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<td>NHS Fife Safety Improvement in Primary Care (SIPC) Working Group</td>
<td>Request for PPF members to join Working Group.</td>
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<td>PPF Annual Report 2009-2010</td>
<td>For Information Only</td>
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<td>09/06/2010</td>
<td>NHS Fife Annual Review 2009-2010</td>
<td>Request for PPF members to participate to review the material for the NHS Fife Annual Review.</td>
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<tr>
<td>09/06/2010</td>
<td>NHS Fife Annual Review Material Meeting</td>
<td>Request for PPF members to participate to review the material for the NHS Fife Annual Review.</td>
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<td>10/06/2010</td>
<td>Fife Elderly Forum - Advocacy Leaflet</td>
<td>For Information Only</td>
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<td>10/06/2010</td>
<td>IHM Scotland's Top Healthcare Manager Award 2010</td>
<td>Request for PPF members to nominate a Manager for award.</td>
</tr>
<tr>
<td>11/06/2010</td>
<td>Mental Health Services</td>
<td>Request to come along to a future meeting to discuss Mental Health Services.</td>
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<tr>
<td>Date Received</td>
<td>Project Title</td>
<td>Request</td>
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<td>14/06/2010</td>
<td>Stoma Care Forum</td>
<td>Request for PPF members to join group.</td>
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<td>01/07/2010</td>
<td>PPF Event - 13th September, 2010</td>
<td>Invitation to attend event.</td>
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<td>08/07/2010</td>
<td>Blue Badge Reform Consultation</td>
<td>Consultation document for comments.</td>
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<td>08/07/2010</td>
<td>Ombudsman Consultation</td>
<td>Consultation document for comments.</td>
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<td>13/07/2010</td>
<td>Application for Inclusion in NHS Fife's Pharmaceutical List: Unit 5 Peploe Drive, Glenrothes</td>
<td>For Information Only</td>
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<td>19/07/2010</td>
<td>Consultation on Regulation of Independent Healthcare in Scotland</td>
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<td>Right for Fife Implementation - Consultation</td>
<td>Request for PPF members to join group.</td>
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<td>British Sign Language Consultation Bill</td>
<td>Consultation document for comments.</td>
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<td>Long Term Conditions Website</td>
<td>Invitation to attend open days.</td>
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<td>27/07/2010</td>
<td>Summary of the Care 21 Survey Findings for Fife</td>
<td>For Information Only</td>
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<td>11/08/2010</td>
<td>Spiritual Care Committee Social Programme and Lunch - 22/9/10</td>
<td>Invite to attend the Social Programme and Lunch on 22nd September, 2010. Members to advise by 8th September.</td>
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<td>K&amp;L CHP Development Session - 15/9/10</td>
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<td>Date for diary.</td>
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<td>National Standards for Community Engagement Workshop for Champions and others</td>
<td>Invitation to attend events.</td>
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<td>30/08/2010</td>
<td>Telehealth Event</td>
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<td>31/08/2010</td>
<td>GH &amp; MS - Departmental Names</td>
<td>Request for PPF members to complete survey.</td>
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<td>Date Received</td>
<td>Project Title</td>
<td>Request</td>
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<td>09/09/2010</td>
<td>Ward Information Leaflet - Wellesley Unit</td>
<td>Ward Information Leaflet for comments.</td>
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<td>20/09/2010</td>
<td>Future Service Delivery Strategy</td>
<td>Request to come along to a future meeting to discuss Future Service Delivery Strategy</td>
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<td>23/09/2010</td>
<td>Application for Inclusion in NHS Fife’s Pharmaceutical List: Moray Way North, Dalgety Bay</td>
<td>For Information Only</td>
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<tr>
<td>29/09/2010</td>
<td>PCES Stakeholder Group</td>
<td>Request for PPF members to join Group.</td>
</tr>
<tr>
<td>29/09/2010</td>
<td>Pharmacy Practices Committee</td>
<td>Request for PPF members to join Committee.</td>
</tr>
<tr>
<td>29/09/2010</td>
<td>Operational Division Clinical Governance Committee</td>
<td>Request for a PPF member to join Committee.</td>
</tr>
<tr>
<td>30/09/2010</td>
<td>PPF Networking Event 14/10/10</td>
<td>Invite to attend Networking Event on 14th October, 2010.</td>
</tr>
<tr>
<td>01/10/2010</td>
<td>Fife Carers Centre - Information Sessions</td>
<td>Invitation to attend events.</td>
</tr>
<tr>
<td>05/10/2010</td>
<td>Participation Toolkit Launch</td>
<td>Invite to attend Participation Toolkit Launch on 4th November, 2010.</td>
</tr>
<tr>
<td>05/10/2010</td>
<td>Shaping Bereavement Care</td>
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<td>08/10/2010</td>
<td>CHP PFPI Procedure and Guidance</td>
<td>Draft Procedure and Guidance</td>
</tr>
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<td>08/10/2010</td>
<td>Laboratory/Radiology Joint User Group</td>
<td>Request for PPF member to join Joint User Group.</td>
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<td>08/10/2010</td>
<td>CHP Clinical Strategy</td>
<td>For Information Only</td>
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<td>11/10/2010</td>
<td>PPF Community of Practice</td>
<td>Request for PPF members to consider 5 questions re Community of Practice.</td>
</tr>
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<td>11/10/2010</td>
<td>Scottish Medicines Consortium (SMC): Recruitment advert for public partners</td>
<td>Request for new Public Partners to join SMC.</td>
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<tr>
<td>15/10/2010</td>
<td>NHS QIS HIV Consultation</td>
<td>Request for PPF members to comment on draft standards.</td>
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<tr>
<td>20/10/2010</td>
<td>SMART Wheelchair and Seating Services</td>
<td>Request to send Newsletter Issue 2 to PPF members.</td>
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<td>The Healthcare Quality Strategy for NHS Scotland</td>
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<td>Fife Sexual Health Services</td>
<td>Request to come along to a meeting to discuss Sexual Health Services.</td>
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<tr>
<td>22/10/2010</td>
<td>Victoria Hospital Travel Planning Group</td>
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<tr>
<td>Date Received</td>
<td>Project Title</td>
<td>Request</td>
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<tr>
<td>--------------</td>
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</tr>
<tr>
<td>05/11/2010</td>
<td>Joint Health Improvement Plan - Workshops</td>
<td>Invite to attend Workshops on 18, 23rd or 25th November, 2010</td>
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<tr>
<td>08/11/2010</td>
<td>SCAN Patient Involvement Strategy</td>
<td>Request for PPF members to comment on draft Strategy.</td>
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<tr>
<td>17/11/2010</td>
<td>D&amp;WF CHP Let's Have a Blether Event - Newsletter</td>
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<tr>
<td>02/12/2010</td>
<td>RCGP Scotland's Patient Partnership in Practice (P3) Is Recruiting</td>
<td>Request for PPF members to apply for lay member on the P3.</td>
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<tr>
<td>02/12/2010</td>
<td>Patient Information Leaflet: Gemini</td>
<td>Request for PPF to comment on leaflet.</td>
</tr>
<tr>
<td>02/12/2010</td>
<td>Patient Information Leaflet: Community Psychiatric Nursing Service</td>
<td>Request for PPF to comment on leaflet.</td>
</tr>
<tr>
<td>07/12/2010</td>
<td>South Network Telesstroke Programme Board</td>
<td>Request for PPF members to join Programme Board.</td>
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<tr>
<td>09/12/2010</td>
<td>Information for People with Asthma</td>
<td>Request to come along to a future meeting.</td>
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<tr>
<td>10/12/2010</td>
<td>Patient Information: Hillview Day Hospital</td>
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<td>EQIA Arrangements for the PPF</td>
<td>Draft EQIA sent to PPF Chairman for comments.</td>
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<td>Participation Network: Scottish Health Council</td>
<td>Survey to be completed by PPF Chairman and Vice Chairman</td>
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<td>CHP Newsletter - December Edition</td>
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<td>Consultation Event - Dementia</td>
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<td>Pharmacy Application - East Wemyss</td>
<td>Pharmacy Application issued for comments.</td>
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<td>Healthcare Improvement Scotland - Complaints Procedure Consultation</td>
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<td>CPA Carers &amp; Users Booklet</td>
<td>Patient Information submitted for comments.</td>
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<td>Request</td>
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<td>---------</td>
</tr>
<tr>
<td>12/01/2011</td>
<td>Schizophrenia Pack</td>
<td>Patient Information submitted for comments</td>
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<tr>
<td>18/01/2011</td>
<td>GMC - handling concerns re Doctors</td>
<td>Submitted for comments.</td>
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<td>Research: K&amp;L PFPI</td>
<td>Attend future PPF meeting to discuss findings.</td>
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<td>20/01/2011</td>
<td>GHMS Workshop - 17 February 2011</td>
<td>Invite to attend Workshop on 17 February 2011</td>
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<tr>
<td>24/01/2011</td>
<td>PPF Event on 16th March 2011</td>
<td>Invite to attend joint PPF Development Session.</td>
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<td>Inspiring Breaks - Unpaid Carers</td>
<td>Event being held in Dunfermline</td>
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<td>27/01/2011</td>
<td>Spiritual &amp; Social Care Programme - 23rd March 2011</td>
<td>Invite to attend event on 23rd March 2011</td>
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<td>CHP Service User Information Procedure</td>
<td>Draft CHP Procedure for comments.</td>
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<td>01/02/2011</td>
<td>SGSU: Patient Information</td>
<td>Patient Information submitted for comments</td>
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<td>A&amp;E Service Reconfiguration</td>
<td>One member of PPF to join planning meeting.</td>
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<td>Fife Respiratory MCN Asthma Sub Group</td>
<td>Request Child or Young Person and their parent to join local sub group.</td>
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<td>07/02/2011</td>
<td>NHS Fife Dental Quality Improvement Committee</td>
<td>Request for public member to join this Committee</td>
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<tr>
<td>09/07/2011</td>
<td>Radernie Patient Information Leaflet</td>
<td>Patient Information submitted for comments</td>
</tr>
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<td>14/02/2011</td>
<td>Chest Heart &amp; Stroke Two Day Workshop</td>
<td>Two day workshop open to members of the public.</td>
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<tr>
<td>15/02/2011</td>
<td>Joint Health &amp; Social Care Strategy for Older People</td>
<td>Draft Strategy for Consultation.</td>
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<tr>
<td>17/02/2011</td>
<td>Advocacy Strategy Stakeholder Planning Group</td>
<td>To attend a Stakeholder Event on 30 March 2011</td>
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<td>21/02/2011</td>
<td>Physical &amp; Sensory Impairment Strategic Implementation Group</td>
<td>To be involve in Task Groups relating to physical and sensory impairment</td>
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<td>22/02/2011</td>
<td>Information for people with Asthma</td>
<td>Attend future PPF meeting to discuss launch of new guidance.</td>
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<td>24/02/2011</td>
<td>Business Continuity</td>
<td>Attend future PPF meeting to discuss Business Continuity Management arrangements for NHS Fife.</td>
</tr>
<tr>
<td>Date Received</td>
<td>Project Title</td>
<td>Request</td>
</tr>
<tr>
<td>---------------</td>
<td>---------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
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<tr>
<td>02/03/2011</td>
<td>DNR CPR Policy</td>
<td>Attend future PPF meeting to discuss DNR CPR Policy</td>
</tr>
<tr>
<td>07/03/2011</td>
<td>PCES Stakeholder Group</td>
<td>Requesting PPF member to join Group.</td>
</tr>
<tr>
<td>11/03/2011</td>
<td>Dementia Standards</td>
<td>Draft standards for comment.</td>
</tr>
<tr>
<td>14/03/2011</td>
<td>OD Patient Experience Review Group</td>
<td>Requesting PPF member to join Group.</td>
</tr>
<tr>
<td>14/03/2011</td>
<td>Fife Integrated Pain Service</td>
<td>Attend future PPF meeting to discuss Fife Integrated Pain Service</td>
</tr>
<tr>
<td>21/03/2011</td>
<td>HAI Task Force: National Policy Group</td>
<td>Requesting PPF member to join Group.</td>
</tr>
<tr>
<td>29/03/2011</td>
<td>ANNITT - Patient Information (6 items)</td>
<td>Sent to PPF Reference Group for comments by 15th April 2011</td>
</tr>
<tr>
<td>30/03/2011</td>
<td>Addictions - Patient Information</td>
<td>Sent to PPF Reference Group for comments by 15th April 2011</td>
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</table>
1. INTRODUCTION

1.1 Older people are entitled to the best quality of care and support that can be provided for them, with the objective of sustaining people for as long as practicable in their own homes. As the numbers of elderly people grow, and in particular the number of frail elderly, we need to find new ways of meeting needs.

The emergence of more appropriate models of care both to support elderly patients in their communities as an alternative to hospital admission helps with this goal and also helps older people maintain their maximum potential.

The overarching aim will be to deliver a model of care in line with the Quality Strategy which is patient centred – Safe, Effective, Efficient, Equitable and Timely.

Parallel pieces of work have been ongoing within the Health Board and the Council to develop service redesign plans to address this issue.

This paper describes how that will now be brought together in order to deliver a new community based Model of Care for the elderly.

2. VISION

2.1 The aim of this partnership working will be to improve quality and outcomes for older people with the intention of allowing them to remain independent within their own homes or communities. This will result in a shift away from institutional care, whether in hospital or in care homes through a significant increase in sustainable community services.

The initial focus of this work will be on the prevention of emergency hospital admissions for older people but will progress to also reduce the number of people requiring long term institutional care including those with dementia.

For those patients who require hospital admission a reduction in the length of stay will also be facilitated by the introduction of the Model described within this paper.

For those maintained at home we will ensure that services enable them to achieve and sustain their maximum potential.

3. PROPOSED MODEL OF CARE

3.1 The primary driver for change is to define a new model of care in Fife that aims to deliver improved health care for older people. By augmenting the level of clinical input in the community, the model would improve the care and wellbeing of the older population. By doing so it would bring about a reduction in emergency admission numbers and reduce lengths of stay.
The model seeks to augment clinical and social care input within the community thereby delivering all levels of the stratified community clinical care pyramid. (Fig 1) resulting in the improved patient pathway as shown in Diagram 1.

Figure 1: Stratified community clinical care pyramid.
Diagram 1 Improved Patient Pathway

The community clinical assessment and care model would have a direct impact on the admission and discharge process for older people in Fife in addition to providing a new service of specialist geriatric medicine care at community level.

The introduction of this Model will be facilitated through the concurrent introduction of the organisational redesign proposals relating to the Home Care Change Management Project of the Council. There needs to be a symbiotic relationship here in order to ensure the overall vision for the elderly is delivered.

4. INTERVENTIONAL THEMES

4.1 There are various interventions already underway or in development to contribute to models of care for elderly patients.

These can be applied at different sites along the care pathway but need to be co-ordinated and consistent both in terms of the individual care provider as well as cross-agency working.

These interventions would include:

- Anticipatory Care
- Self Care
- Tele-medicine
- Tele-care
- Respite Care
- Support for Carers
- Intensive Home Care
- Supported in Care Homes
- Intermediate Care Teams
- Hospital at Home
None of these are mutually exclusive and indeed in a truly integrated model there would be several elements if not all of these within a potential patient pathway. It would be important in developing this that there is equity of access to services across Fife although the mode of delivery may vary in different areas.

5. COMPLEMENTARY WORK

5.1 Discussions have been ongoing for some time within the CHP in relation to redesign of services for elderly patients.

One piece of work related to the patient groups being cared for in Montrave Ward at Cameron Hospital.

Through a consultation process several areas were identified as contributing to the poor experience and length of stay of these patients and following a full review a Model was agreed and constructed to address these areas.

The ongoing work relating to this will include the following steps:-

- Community support through increased hours for Bield Flexicare and Alzheimers Scotland.
- Anticipatory Care/staff continuity/person centred through introduction of “exclusive” Care Management and Coordination roles integrated within P’ Care and as part of the evolving Intermediate Care system. (Ref PRISMA model).
- Staff and carer support and Risk management through dedicated Clinical Psychology.

5.2 Also at Carlyle Ward at Whyteman’s Brae Hospital there has been a consistently low number of continuing care patients within this ward, although the remaining beds have tended to be occupied by patients in delay.

Discussions are underway around the most appropriate way of providing services to the continuing care patients there in line with the Model of Care described in this paper.

6. WORKFORCE RECONFIGURATION

6.1 Health Services

6.1.1 The introduction of this new model will result in a significant shift in human resource.

Work is ongoing to establish exactly the configuration of the teams required within the community. These could be populated by a mixture of current community staff, staff working in various ward settings and selected staff who either have, or can relatively easily acquire, the additional skills required to work in these teams. This latter requirement will be especially important in relation to the senior nurse practitioners leading the teams.

The changing roles of AHPs and GPs working to support patients in community beds at present will also need to be reviewed in the light of the new model.
It is important to also remember that this model envisages a reduction in acute beds in Fife which will have an impact on the future role of the staff within the Operational Division.

6.2 Council

6.2.1 Work is already underway within the Council in relation to addressing workforce remodelling in order to deliver the Home Care Change Management Project.

7. BED MODELLING

7.1 On the basis of the Model described in Section 4 above a bed modelling exercise has been carried out to consider what impact the proposed changes would have in terms of bed based services in Fife including Acute and Community Hospital beds and Care Home requirements.

The work so far suggests that this will be a reduction in the region of 300 beds across the Partnership, of which up to 95 might be within this CHP.

8 FINANCE

8.1 Integrated Resource Framework

8.1.1 The Integrated Resource Framework has been developed by the Scottish Government, NHS Scotland and COSLA. It is intended that this should achieve more effective integration of the resources across partnerships being used to support elderly people, thereby improving their experience of services and enabling better models of care to be provided without necessarily incurring additional costs.

8.2 Change Fund

8.2.1 The Scottish Government has established a Change Fund within each NHS area which will be created through ring fencing a proportion of the NHS uplift from the Scottish Government.

The fund will be used to influence decision making around the totality of spend on older people’s care, to facilitate change in the use of partnership budgets, enable investment in anticipatory care to reduce demand on reactive and institutional care and focus more on care within community settings.

Fife Health & Social Care Partnership have indicated a commitment to accelerate the pace of change in partnership with all interested parties including the Voluntary and Independent Sector organisations.

The approach being taken by the Health & Social Care Partnership is outlined in Appendix A.

9. IMPLEMENTATION

9.1 Engagement and Involvement

9.1.1 Such radical change to service delivery will require wide engagement and involvement.

It is proposed that this should be carried out as part of the already planned

This plan incorporates within it the principles of the model described in this paper and outlines a consultation period from mid-June to mid-August 2011.

In view however of the significant changes to bed provision which will result from the introduction of the new model it will be necessary to have a wider and extended period of engagement with the public through the Scottish Health Council.

Whilst of course individual members of staff affected by this will need to be kept fully involved and informed in the change process it will also be necessary to engage with the wider body of staff through the Local Partnership Forum at an early stage.

The model sees General Practitioners and Primary Care Teams having a pivotal role within the oversight of patients in this model and it will also therefore be necessary for early discussions to take place with the GP Sub-Committee of the Area Medical Committee.

### 9.2 Communication

#### 9.2.1
With such a far-reaching change in service delivery affecting such a wide audience including patients, carers and staff a robust communication strategy will clearly be required and will need to be developed and put into place in the near future.

### 9.3 Partnership Project Group

#### 9.3.1
Whilst the operational implementation and management of the service throughout Fife will be the responsibility of the CHPs through their LMUs it is essential that a Fife-wide oversight is kept in relation to the delivery of this new model.

It would be inappropriate for there to be inequity of service across Fife, either in terms of access or service delivery. Also in order to assist the manageability of the introduction of this model – across Primary and Secondary Care, the Local Authority, the Voluntary Sector and the Private Sector it will be essential that one group maintains an overview of the vision and is used as a central point to resolve common issues.

It will be essential that this group is supported at a high level both within the Council and Health in relation to services such as Redesign/Improvement Support, HR, Finance and IT.

It is proposed that the membership of this group is kept as small as possible in order to allow it to function efficiently.

The Group should be clinically led and its membership be such that it is able to be a decision making body rather than one consisting of representatives from all of the agencies involved which would probably result in it being unmanageable.

Appendix B shows in diagrammatic form how the Partnership Project Group will relate to other strategic and operational groups in Fife that contribute to service provision for older people.
In respect of the introduction and planning of this model the LMUs would report to the group to ensure the consistency and equity mentioned above across Fife.

9.4 **Phasing**

9.4.1 Whilst this model is of course new to Fife it has been in place in similar forms in other parts of the United Kingdom for the past few years, including areas where the demography is similar to Fife.

There will of course nevertheless be challenges but it is not anticipated that any major new issues will arise through the implementation of this plan in Fife.

It is proposed that following the engagement period teams can be established and put in place over about a 2 month period.

Work is ongoing in relation to the consequences of the introduction of this model in different parts of Fife. In general terms however it is planned that the new model should be introduced rapidly with the consequent reduction in bed usage and therefore closures happening over a relatively short period of time.

Furthermore the savings achieved will clearly be greater if whole wards are closed at one time rather than only a few beds at various locations and similarly even greater savings made, should a single site be vacated.

10. **NATIONAL AND LOCAL TARGETS**

10.1 **NHS Targets**

10.1.1 In line with the NHS Scotland Quality Strategy this new model of care will deliver the Quality Ambitions based on services which are person centred, safe and effective.

10.1.2 NHS Boards are required through their Local Delivery Plan to deliver national targets in relation to health, efficiency, access and treatment (HEAT).

The main health related targets in relation to this are:-

- Increase the level of older people with complex care needs receiving care at home.
- Achieve agreed improvements in the early diagnosis and management of patients with dementia by March 2011.
- Reduce the need for emergency hospital care through a reduction in emergency bed day rates for people aged 75 and over.

10.2 **Local Authority Targets**

10.2.1 These are focused on Community Care Outcomes Framework (CCOF) which are intended to ensure that partnerships understand their performance locally and share information with other partnerships in Scotland.

The main themes within this are:-

- Satisfaction.
- Faster access.
- Support for carers.
- Quality of assessment and care planning.
• Identifying those at risk.
• Moving services closer to users

11. OUTCOMES

11.1 The introduction of a more appropriate model of care will lead to a reduction in length of stay for older people in both acute and community hospital beds and also a reduction in admissions to hospital.

It is noted that the Joint Improvement Team have circulated a draft document with potential improvement measures contained within it and these will clearly need to be incorporated when finally agreed.

12. RECOMMENDATION

12.1 The Committee is asked to:-

• **Agree** the Model of Care for the Elderly.
• **Note** the complementary work ongoing within the CHP.
• **Note** the proposed implementation process.

Report by: DR LES BISSET
CLINICAL DIRECTOR
KIRKCALDY AND LEVENMOUTH CHP
Appendix A

Change Plan

1. **Name of Partnership**

   Fife Partnership

2. **Partner Organisations**

   Fife Council
   NHS Fife
   CVS Fife
   Scottish Care (Fife Branch)

3. **Finance – use of Change Fund and additional resources**

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<th>From</th>
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<tr>
<td>Initial central allocation</td>
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<tr>
<td>Added by NHS Board – total LMU budget covers all care groups</td>
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<tr>
<td>Added by local authority (already included in Partnership Budget below)</td>
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<td>Other Voluntary Orgs support from NHS Fife and Fife Council</td>
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4. **Summary of current partnership budget for older people**

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<th>Health and Social Care Partnership</th>
<th>Partnership Budget</th>
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<th>LENGTH OF SERVICE</th>
<th>NHS FIFE</th>
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<td><strong>Total Older People</strong></td>
<td>21,591</td>
<td>82,979</td>
<td>104,570</td>
</tr>
</tbody>
</table>
A key piece of work for the Joint Finance Group over the coming year will be to identify and include all resources that contribute to the care for older people; including any further health or social work resource, housing, leisure, transport and other groups where care of the elderly is not the primary function as well as third and independent sector organisations. Further work will be undertaken through the Finance group using the Integrated Resource Framework to identify other relevant resources. This will also include exploration of local community capability and assets, to expand the definition of resources.

The Joint Finance Group will review current initiatives/spend, including that on the third and independent sectors, during 2011/12 with a view to identifying improvements/alternatives. The Change Plan will involve alternative models of service delivery emerge shifting the focus from statutory services to more informal community based approaches.

5.0 Vision and Principles

5.1 The Partnership’s Vision

The Health and Social Care Partnership’s vision for health and social care services for older people in Fife is:

Accessible, seamless, quality services, personalised and responsive to the changing needs of individuals, designed by and for the older people of Fife, focussing on people’s assets rather than their deficits.

The aim of the partnership overall is to improve quality and outcomes and enable Older People to remain independent at home. We will achieve this by shifting funding for institutional beds both in hospital and in care homes and allow the transfer of resources currently locked into those beds into community services in a sustainable manner post change fund transition.

5.2 The Partnership’s Principles

The Health and Social Care Partnership has defined its principles as:

- **Choice:** Choice for individuals, with clear information on what services and resources are available to support choice;
- **Accountability:** The Partnership will engage with communities about what is achievable within available resources and ensure best value from its resources, so that key targets and key priorities are delivered for the people of Fife;
- **Personal Control:** Care and support are provided in a manner that enables people to maximise control over their own life and environment;
- **Respectful and responsive:** Older people and their carers will be involved in decisions that affect them and encouraged to play an active role in their communities;
- **Partnership:** By working in partnership with service users, carers, staff from all agencies, including General Practice, and communities, better services will be delivered;
- **Prevention:** Supporting older people at home for longer through early access to support, care and health promotion and appropriate information and advice.
6. Use of Change Fund and Outcomes Anticipated

6.1 The Change Fund investment will support a whole system approach to shifting older people’s health and social care to non-institutional, community based settings and promoting independent and fulfilled lives.

6.2 This is rooted in the existing strategy and plan but we are seeking to accelerate the pace of change within all parts of the response to the local demographic challenge.

6.3 Fundamental to addressing the ‘demand’ within the health/social care system is an emphasis on community well-being and utilising universal services. This approach will be founded upon community development and asset based principles and will involve investment in community capacity building, supporting volunteering, developing a range of lower ‘tier’ community services, supporting the third sector/community infrastructure, providing information and support and supporting carers.

6.4 Fife Health & Social Care Partnership will pursue the Re-shaping Care programme in partnership with all sectors and interests and will ensure that third and independent sector organisations are equipped and resourced to participate fully as partners.

6.5 The National Programme on Reshaping Care for Older People provides an opportunity for the Fife Partnership and wider stakeholders including people who use services, carers, providers and the public to take forward an engagement and delivery programme which builds on work already underway in Fife including :-

- Achieving consistency around care partnership and outcome for older people in Fife regardless of where they live and ensuring that service provision is sustainable.
- Ensuring a person centred and integrated focus on dementia and physical health care needs.
- Ensuring real alternatives to hospital admission in particular focussing on avoidable emergency admissions with effective preventative and anticipatory care services and responses.
- Developing a re-ablement approach in care at home services focusing on independence rather than dependence and empowering older people through support and encouragement to achieve a good quality of life living at home.

6.6 The Key Changes for the Next Five Years

6.6.1 We will develop initiatives which address issues impacting on the quality of life and well-being of older people, including early intervention measures. This will include scaling up current preventative activity which promotes healthy life expectancy and builds on the assets of older people themselves, e.g. our planned changes to the provision of day care support through the third sector. This links with priority outcomes in Fife’s new Joint Health and Wellbeing Plan.
6.6.2 The existing hospital based assessment services and discharge arrangements into the community will be streamlined such that all patients, when clinically ready, will be discharged within a maximum of 3 days into a community setting. As a result more community care assessments will be undertaken in the persons home environment (or place of previous residence). This will introduce a shift in cultures and behaviours as well as a significant shift in the balance of care. Our priority will be no direct admission to long term care from acute hospitals. The streamlining of the hospital discharge process, assessment of patients needs and appropriate levels of ongoing treatment and care will be augmented by a range of alternatives to hospital care.

6.6.3 As a result of these changes there will be a significant reduction in bed based services, with a reduction over the life of the change fund of 300 beds across the partnership. The H&SCP will lead the involvement and consultation on these changes as appropriate.

7. Summary of Key Outcomes/Outputs Achieved Through Current Resources

7.1 Improvement and Performance Management

We will develop an integrated improvement and resource framework around Reshaping Care which measures outcomes for older people and their carers and evidences a shift in the balance of care and associated resource utilisation. As a first step to this, we will agree baseline data re current hospital and residential bed base complements and associated funding. We will also undertake initial capacity and demand processes in order to measure the efficacy of each of the change processes described below.

We will agree the range of risks associated with each of the change areas. We will identify and provide training and development opportunities across the Partnership in support of the significant change agenda.

Additional targets are being considered for the following performance measures.

**Qualitative Measures**

- Improve health and wellbeing
- Deliver person centred care – outcome focus
- Invest in carers as partners
- Provide good assessment and access to services
- Customer satisfaction
- Reducing people’s dependence on formal care and support

**Quantitative Measures**

- Shift the balance of care
- Reduction in length of stay in care homes
- Increased proportion of last 6 months of life spent at home
- Reduction in direct admissions to long stay care homes from hospital
- Reduction in beds (NHS Continuing Care, Assessment and Rehabilitation and Care Home)
Crucial to the process is the recognition of making the various initiatives self-funding during the course of the four year funding period of the Change Fund. Accordingly, we will establish mechanisms which also measure financial performance linked with ‘shifting the balance of care’ such that we have the ability to withdraw surplus residential capacity to fund community services in the longer term.

7.2 The Community Care Outcomes Framework (see appendix 1) is used to measure performance and in this section the data is structured around the CCOF themes and the Partnership Balanced Scorecard.

The analysis of the data is used to inform the changes required.

7.3 Delayed Discharge

Bed day rates per 100,000 population of All Emergency Admissions for patients aged 65+ with 2+ admissions

Delayed Discharges that are out with the six week discharge planning period - January 2007 to January 2011

Source: ISD Delayed Discharges
What is the data telling us?

The position in Fife is that despite lower than Scottish average emergency admissions the total number of people who are classified as in delay is consistently above the Scottish average and as a consequence the performance in sustaining over 6 weeks standard is variable.

What is the current position?

The number of people delayed over 6 weeks rose sharply in December 2010 and January 2011 as the number of people who could not be discharged without a change in service provision overwhelmed the system and put pressure on available resources. A one-off additional investment by NHS Fife and Fife Council eased the position and as a result of this and micro management of discharge planning arrangements the position improved in February and March resulting in zero over 6 weeks at the April Census.

What will we do in the future?

The Partnership is undertaking a route and branch review of all processes related to admission and discharge arrangements including strengthening local management arrangements and accountability through a Lead Manager model within the current aligned management structure.

Service Redesign through the opportunities presented by the Change Fund will shift the balance of care from hospital and institutional care to care in the community.

7.4 Community Care Outcome Theme: Quality of Assessment and Care Planning

Care Home Placements, From Hospital and Other Sources, Relative Numbers

<table>
<thead>
<tr>
<th>Periods</th>
<th>Month</th>
<th>Total Placed</th>
<th>From Hospital</th>
<th>From Elsewhere</th>
</tr>
</thead>
<tbody>
<tr>
<td>16 Feb - 15 Mar 2009</td>
<td>Mar-09</td>
<td>81</td>
<td>34</td>
<td>44%</td>
</tr>
<tr>
<td>16 Mar - 15 Apr 2009</td>
<td>Apr-09</td>
<td>92</td>
<td>42</td>
<td>46%</td>
</tr>
<tr>
<td>16 Apr - 15 May 2009</td>
<td>May-09</td>
<td>94</td>
<td>45</td>
<td>48%</td>
</tr>
<tr>
<td>16 May - 15 Jun 2009</td>
<td>Jun-09</td>
<td>98</td>
<td>49</td>
<td>47%</td>
</tr>
<tr>
<td>16 Jun - 15 Jul 2009</td>
<td>Jul-09</td>
<td>94</td>
<td>49</td>
<td>47%</td>
</tr>
<tr>
<td>16 Jul - 15 Aug 2009</td>
<td>Aug-09</td>
<td>105</td>
<td>50</td>
<td>47%</td>
</tr>
<tr>
<td>16 Aug - 15 Sep 2009</td>
<td>Sep-09</td>
<td>99</td>
<td>49</td>
<td>47%</td>
</tr>
<tr>
<td>16 Sep - 15 Oct 2009</td>
<td>Oct-09</td>
<td>97</td>
<td>50</td>
<td>51%</td>
</tr>
<tr>
<td>16 Oct - 15 Nov 2009</td>
<td>Nov-09</td>
<td>103</td>
<td>50</td>
<td>49%</td>
</tr>
<tr>
<td>16 Nov - 15 Dec 2009</td>
<td>Dec-09</td>
<td>109</td>
<td>51</td>
<td>48%</td>
</tr>
<tr>
<td>16 Dec - 15 Jan 2010</td>
<td>Jan-10</td>
<td>106</td>
<td>52</td>
<td>48%</td>
</tr>
<tr>
<td>16 Jan - 15 Feb 2010</td>
<td>Feb-10</td>
<td>77</td>
<td>35</td>
<td>47%</td>
</tr>
<tr>
<td>16 Feb - 15 Mar 2010</td>
<td>Mar-10</td>
<td>55</td>
<td>35</td>
<td>61%</td>
</tr>
<tr>
<td>16 Mar - 15 Apr 2010</td>
<td>Apr-10</td>
<td>48</td>
<td>31</td>
<td>65%</td>
</tr>
<tr>
<td>16 Apr - 15 May 2010</td>
<td>May-10</td>
<td>69</td>
<td>39</td>
<td>56%</td>
</tr>
<tr>
<td>16 May - 15 Jun 2010</td>
<td>Jun-10</td>
<td>71</td>
<td>36</td>
<td>51%</td>
</tr>
<tr>
<td>16 Jun - 15 Jul 2010</td>
<td>Jul-10</td>
<td>69</td>
<td>37</td>
<td>55%</td>
</tr>
<tr>
<td>16 Jul - 15 Aug 2010</td>
<td>Aug-10</td>
<td>85</td>
<td>41</td>
<td>48%</td>
</tr>
<tr>
<td>16 Aug - 15 Sep 2010</td>
<td>Sep-10</td>
<td>99</td>
<td>44</td>
<td>44%</td>
</tr>
<tr>
<td>16 Sep - 15 Oct 2010</td>
<td>Oct-10</td>
<td>93</td>
<td>45</td>
<td>48%</td>
</tr>
<tr>
<td>16 Oct - 15 Nov 2010</td>
<td>Nov-10</td>
<td>95</td>
<td>48</td>
<td>51%</td>
</tr>
<tr>
<td>16 Nov - 15 Dec 2010</td>
<td>Dec-10</td>
<td>93</td>
<td>50</td>
<td>53%</td>
</tr>
<tr>
<td>16 Dec - 15 Jan 2011</td>
<td>Jan-11</td>
<td>93</td>
<td>46</td>
<td>50%</td>
</tr>
<tr>
<td>Rolling 12 months</td>
<td></td>
<td>935</td>
<td>454</td>
<td>48%</td>
</tr>
</tbody>
</table>
What is the data telling us?

Care assessments for people in hospital are undertaken within the hospital setting by hospital based social workers or community based staff linked to hospital wards.

What is the current position?

In view of this the assessment often focuses on the areas of need and support required as presented in a ward setting without account being taken of the person’s home situation and the areas of accepted risk and ‘coping levels’ for the person and their family.

This leads to a high number of people being admitted to care homes straight from hospital.

What will we do in the future?

Community Care Assessments and future care needs identification in hospital needs to be minimised and discharge home or to an alternative homely setting while future plans are formulated should be the norm.

Intermediate care and home care re-ablement will be developed. This will reduce the length of hospital stay and readmissions.

7.5 Community Care Outcomes Theme: Support for Carers

Provision of Respite in Weeks 06/07 – 09/10 for people over 65 years

<table>
<thead>
<tr>
<th>Year</th>
<th>Overnight Respite</th>
<th>Daytime Respite</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006/07</td>
<td>4,000</td>
<td>6,000</td>
</tr>
<tr>
<td>2007/08</td>
<td>5,000</td>
<td>5,000</td>
</tr>
<tr>
<td>2008/09 C</td>
<td>6,000</td>
<td>4,000</td>
</tr>
<tr>
<td>2008/09 N</td>
<td>7,000</td>
<td>3,000</td>
</tr>
<tr>
<td>2009/10</td>
<td>8,000</td>
<td>2,000</td>
</tr>
</tbody>
</table>

Source: Scottish Government Respite publication

Same methodology used as in 2007/08 making the figure comparable to 2007/08 New methodology used making the figure incomparable to 2007/08 but comparable with 2009/10.
Rate of Respite provision per 1000 population, 06/07 – 09/10

Source: Scottish Government Respite publication

Same methodology used as in 2007/08 making the figure comparable to 2007/08
New methodology used making the figure incomparable to 2007/08 but comparable with 2009/10

What is the data telling us?

In 08/09 it was identified that for a number of years we had not been counting all day time respite, column N 08/09 onwards reflects more accurately our respite provision. On this basis it is clear that daytime respite is heavily accessed by Older People in Fife, this is in line with An Overview of Short Break (respite), a report by Reid Howie Associates for Shared Care Scotland 2010 which outlines that the “short break options for older people should be more personalised and less “risk averse” and not always in residential care. Our total rate of respite provision per 1000 population decreased slightly in 09/10, however our level of provision remained greater than the Scottish average, evidencing our work to shift the balance of care towards preventative support.

What is the current position?

As stated above improvement work concerning the reporting of respite provision uncovered late in 09/10 significant levels of under recording of grant funded provision. This will be included in our 10/11 return and will enable us to fully demonstrate our delivery of extra respite week in line with the commitment of the Concordat.

What will we do in the future?

We are conducting a Review of Direct Payments, Self Directed Care and commissioning models to make sure that we get the best possible range of services for the money, are all progressing. This includes redesign of the process for commissioning care and support. A project manager has been appointed to take forward a joint Council/ NHS Fife pilot project on Self-Directed Support.
Community Care Outcomes Theme: Moving Services Closer to Service Users / Patients

Scotland: A Report by Reid Howie Associates for Shared Care Scotland, November 2010

It’s About Time: An Overview of Short Break (Respite) Planning and Provision in Scotland: A Report by Reid Howie Associates for Shared Care Scotland, November 2010

7.6 Community Care Outcomes Theme: Moving Services Closer to Service Users / Patients

Older people receiving intensive home care (10+ hours per week)

Figures from quarterly monitoring return

Source: Scottish Government Quarterly Monitoring, Home Care Census and ISD, Continuing Care Census

Balance of Care, 2010

Scottenish Government & ISD, Scottish Care Homes Census

Figures from quarterly monitoring return

Source: Scottish Government Quarterly Monitoring, Home Care Census and ISD, Continuing Care Census

Rate per 1,000 population aged 65+
Scottish Government Health and Community Care Datasets

Figures from quarterly monitoring return

Older People Supported in Care Homes - 2009/10

Sources: Scottish Government Quarterly Monitoring, Home Care Census & ISD, Continuing Care Census

Figures from quarterly monitoring return

Scottish Government Quarterly Monitoring, Home Care Census
**What is the data telling us?**

The data shows that the balance of institutional and care at home reflects a high % of low level home care hours provided.

This is because Fife has a long history of providing high volume and low level support under 10 hours which is the proxy for intensive support.

**What is the current position?**

The number of people supported in Care Homes is below the Scottish average however the Partnership’s priority is to reduce this to shift the balance of care to more intensive care at home to 50/50 split.

The Social Work Home Care Service has plans in place to move to a Home Care Re-ablement Service which provide intensive support in initially reducing as appropriate.

**What will we do in the future?**

We will use the Change Fund to implement the Home Care Re-ablement service more quickly and use the Fund to bridge the new service starting and the current service changing focus.

We will develop an intermediate care service and we will ensure closer integration of the range of community teams under one system. We will work with third sector and private sector parties to develop a range pf preventative services which serve grater choice for Older People and more opportunities to review levels at home with the appropriate levels of support as and when needed.

This will be achieved through a Lead Manager role at a local level to enhance the existing joint management arrangements.

**8. Summary of how Change Fund will enable shifts in core budgets and impact on the totality of spend by the partnership over the next 5 years**

**8.1** We will develop the Integrated Resource Framework work to enable us to more fully understand the cost consequences of existing spend and from modelling emerging changes we will also factor in demographics to current levels of activity to fully understand the impacts on the likely levels of demand

**8.2** We will use the Change Fund to bridge service developments to achieve a shift in the balance of care from institutional and bed-based models to community and day case models.

**8.3** We expect use of the Change Fund to release three times the investment from current models of service delivery into alternative models of care and support. The Change Fund Plan and Indicative Spend are in appendix 2.

**8.4** We will explore opportunities for closer alignment between health, housing and social care, including greater integration and management. We will also work together to build on the vital contribution of carers, families and communities at the local level.
8.5 We will monitor the percentage shift of budgets from existing service models to new community-based approaches as developed via the Change Fund.

8.6 We will review our own resources before seeking support, but initial proposals are that assistance with modelling tools will be required.

9. **Indicate the Financial Mechanism and Governance Framework**

<table>
<thead>
<tr>
<th>Group</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older People’s Strategy Implementation Group (OPSIG) and technical subgroup</td>
<td>Develop Joint Health &amp; Social Care Strategy for Older People’s Services and the evidence base around alternative models</td>
</tr>
<tr>
<td>Joint Finance Group</td>
<td>Agree financial modelling for plan</td>
</tr>
<tr>
<td>Partnership Management Group (PMG)</td>
<td>Sign off plan, monitor performance and submission to Health &amp; Social Care Partnership</td>
</tr>
<tr>
<td>Health &amp; Social Care Partnership</td>
<td>Accountable Committee</td>
</tr>
<tr>
<td>Community Planning Partnership/Fife Partnership Executive Group</td>
<td>Final sign off and oversight of plan, including links with wider community capacity and planning issues</td>
</tr>
</tbody>
</table>

This plan has been prepared and agreed by the NHS, Council, Third Sector and Independent Sector interests.

**Sources**

- Draft Joint Health & Social care Strategy for Older People’s Services in Fife 2010-2025
- Fife Framework for Older People
- Revenue Budget – Projected Out-turn 2010/11 (Report to 31 December 2010)
- 2009/10 Community Care Outcomes Framework Performance report to H&SCP November 2010
Appendix 1

Satisfaction
• % of community care service users feeling safe.
• % of users and carers satisfied with their involvement in the design of care package.
• % of users satisfied with opportunities for social interaction.

Faster Access
• No. of patients waiting in short stay settings, or for more than 6 weeks elsewhere for discharge to appropriate setting.
• No. of people waiting longer than target for assessment, per 000 population.
• No. of people waiting longer than target time for service, per 000 population.

Support for carers
• % of carers who feel supported and capable to continue in their role as a carer.

Quality of assessment and care planning
• % of user assessments completed to national standard (e.g. SSA).
• % of carers’ assessments completed to national standard.
• % of care plans reviewed within agreed timescale.

Identifying those at risk
• No. of emergency bed days in acute specialties for people 75+, per 100,000 pop.
• No. of people 75+ admitted as an emergency twice or more to acute specialties, per 100,000 pop.
• Percentage of people 75+ admitted twice or more as an emergency who have not had an assessment.

Moving services closer to users/patients
• Shift in balance of care from institutional to 'home based' care.
• % of people 65+ with intensive needs receiving care at home
• % of people 65+ receiving personal care at home.
Telecare

- No. of new service users
- No. of delayed discharges prevented and bed days saved
- No. of unplanned hospital admission avoided and bed days saved
- No. of admissions to care homes avoided and bed days saved
- No. of Council tenancies sustained

Very Sheltered Housing Services

- Number of designated complexes
- No. of unplanned hospital admission avoided and bed days saved
- No. of admissions to care homes avoided and bed days saved
- No. of Council tenancies sustained
## Appendix 2

### Reshaping Care for Older People in Fife – Local Plan

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Areas of Service Development</th>
<th>Indicative Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 All care and support will provide personalised care based on outcomes and goals agreed with the older person, and their unpaid carer. These will be based on assessments that focus on personal outcomes.</td>
<td>We will develop a personal outcome based assessment and care planning process which focus on strengths not deficits and reduces dependency on formal support.</td>
<td>No cost identified.</td>
</tr>
<tr>
<td>Integration of physical and mental health needs to ensure optimum wellbeing.</td>
<td>Clear pathways for people with dementia and physical health needs that include integrated care provision at all stages.</td>
<td>No cost identified.</td>
</tr>
<tr>
<td>2 Services will be focussed on anticipatory care needs and coordination. Supporting people to stay at home with minimal time in hospital or care home setting.</td>
<td>We will improve care management for older people with complex needs fully involving and aligned to Community Health and Social Care Teams including GP’s. Systematic use of recognised predictor data sources e.g SPARRA.</td>
<td>No cost identified.</td>
</tr>
<tr>
<td>3 Services that focus on promoting independence and recovery will be widely available.</td>
<td>We will implement home care re-ablement and intermediate care models of support.</td>
<td>£2 million.</td>
</tr>
<tr>
<td>4 More older people will live in housing suited to their needs and helps maintain independence.</td>
<td>We will introduce extra care housing and telecare. Linked to Specific Needs Housing Strategy.</td>
<td>£350k (Telecare).</td>
</tr>
<tr>
<td>5 Community will actively support older people to participate (as providers and recipients) in volunteering, community enterprises and care cooperatives.</td>
<td>We will engage community and third sector in supporting Older People to live safely at home, maximise independence and preventing decline.</td>
<td>£500k.</td>
</tr>
<tr>
<td>Outcome</td>
<td>Areas of Service Development</td>
<td>Indicative Cost</td>
</tr>
<tr>
<td>---------</td>
<td>-----------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>6</td>
<td>Comprehensive information, advice and support resources will be a readily accessible for all older people to help make decisions about life choices.</td>
<td>We will develop direct access to services supported by clear information in variety of formats.</td>
</tr>
<tr>
<td>7</td>
<td>Personal budgets will be available for care and housing choice.</td>
<td>Person centred solution will be developed including a range of provision across all sectors inc independent, charitable and micro enterprise to suit wide range of need.</td>
</tr>
<tr>
<td>8</td>
<td>Public sector resources from all sources (NHS, Council and Benefits) will be available to jointly fund any agreed aspect of care.</td>
<td>We will reduce institutional bed models by 300 across the partnership.</td>
</tr>
<tr>
<td>9</td>
<td>Clear, agreed pathways for all older people, in particular those with complex care and support needs will be in place. This will enable timely access to effective health and community care as required, and to move smoothly through the system.</td>
<td>We will develop a comprehensive specialist medical assessment and treatment in the community.</td>
</tr>
<tr>
<td>10</td>
<td>Community based support for end of life care will be in place to increase the proportion of older people who will be able to die at home or in their preferred place of care.</td>
<td>We will introduce a dedicated home care team for end of life care, including continuous education and support for staff, able to work across all care settings where required.</td>
</tr>
<tr>
<td>11</td>
<td>An infrastructure designed to facilitate and sustain the co-produced changes and outcomes agreed through the Reshaping Care programme.</td>
<td>We will move to a joint leadership posts with levels of delegated authority appropriate to expectations. Clear metrics/data to monitor activity and service improvement.</td>
</tr>
</tbody>
</table>
FINANCIAL REPORT FOR THE 2 MONTHS TO 31\textsuperscript{ST} MAY 2011

Income and Expenditure

The Income and Expenditure position for the CHP for the two months to 31\textsuperscript{ST} May 2011 is showing an overspend of £97k against Managed Clinical Services.

This information is summarised in the following table:-

<table>
<thead>
<tr>
<th></th>
<th>Budget for Year £'000</th>
<th>Budget for Period £'000</th>
<th>Expenditure for Period £'000</th>
<th>over/ (under) £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fife Wide Services</td>
<td>8,900</td>
<td>1,515</td>
<td>1,512</td>
<td>(3)</td>
</tr>
<tr>
<td>Local Services</td>
<td>13,796</td>
<td>2,250</td>
<td>2,265</td>
<td>15</td>
</tr>
<tr>
<td>Management, Admin &amp; Other</td>
<td>3,563</td>
<td>626</td>
<td>616</td>
<td>(10)</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>34,509</td>
<td>5,943</td>
<td>6,038</td>
<td>95</td>
</tr>
<tr>
<td>Voluntary Organisations</td>
<td>628</td>
<td>161</td>
<td>161</td>
<td>0</td>
</tr>
<tr>
<td>Efficiency Savings to be allocated</td>
<td>(1,202)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Clinical Services</strong></td>
<td><strong>60,194</strong></td>
<td><strong>10,495</strong></td>
<td><strong>10,592</strong></td>
<td><strong>97</strong></td>
</tr>
</tbody>
</table>

Memorandum: Fife Wide - PMS Service and FHS

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>PMS</td>
<td>43,957</td>
<td>7,552</td>
<td>7,527</td>
<td>(25)</td>
</tr>
<tr>
<td>Dental</td>
<td>19,780</td>
<td>3,640</td>
<td>3,640</td>
<td>0</td>
</tr>
<tr>
<td>Ophthalmic</td>
<td>6,315</td>
<td>1,112</td>
<td>1,112</td>
<td>0</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>12,702</td>
<td>2,100</td>
<td>2,100</td>
<td>0</td>
</tr>
</tbody>
</table>

Information on Prescribing at CHP level is not shown to Period 2 as data is not currently available due to the time lag in collation. This will be available from next month.

Income Analysis

The Financial Framework and budgets for 2011/12 were approved by the Board at their meeting in May 2011. As further allocations are received adjustments will be made to the individual budgets in line with the available funding.

A total budget of £60,194k is available for Clinical Services at this stage.
Expenditure Commentary

In line with previous years, expenditure will be monitored against budgets throughout the financial year and the following table summarises variances being reported against any of the individual budgetary areas. More detailed reports behind the individual service areas are provided to the individual responsible managers via the CHP Management Accountants.

The main variances are:-

<table>
<thead>
<tr>
<th></th>
<th>Pays</th>
<th>Supplies</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fife Wide Services</strong></td>
<td>(£17k) (1.9%)</td>
<td>£14k 2.2%</td>
<td>Vacancies within the Sexual Health service and within Dietetics is partially offset by an overspend within the Fife Rehab Service and Rheumatology. The overspend is largely due to increased anti-TNF costs within Rheumatology. This continues to be closely monitored.</td>
</tr>
<tr>
<td><strong>Local Services</strong></td>
<td>£20k 0.9%</td>
<td>(£5k) 2.2%</td>
<td>Overspends within Nursing at Cameron Hospital due to staff absence, and within AHPs in the Physio Service. Underspend on single use items within Podiatry.</td>
</tr>
<tr>
<td><strong>Management, Admin &amp; Other</strong></td>
<td>(£5k) (0.9%)</td>
<td>(£5k) (6.9%)</td>
<td>An underspend within Business Management and the Long Term Conditions team, partially offset by an overspend within CASH &amp; GUM. The underspend is prevalent across lines.</td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td>£66k 1.2%</td>
<td>£29k 5.7%</td>
<td>The overspend is within Medical staffing at Whyteman’s Brae and Stratheden and QMH Nursing. The overspend is largely within drugs, driven in part by an overspend of £11k against Methadone. Methadone costs for the first two months total £74k</td>
</tr>
</tbody>
</table>
against a budget of £63k. The costs of Methadone are provided
two months in arrears and this is
an estimate at this stage.

In addition, recharges from external facilities have
contributed to the overspend.

| • Voluntary Organisations Pays and Supplies | £0k | - |
|                                             |     | This is at break-even. |

A memorandum note has also been included in the main table to show the overall position on PMS Services and FHS Services across the whole of Fife.

Graphs are included for the CHP to show the movement in year for both Pays and Supplies expenditure against budget.
Efficiency Savings

Across NHS Fife, sufficient schemes have been identified within the Financial Plan to meet this year’s savings target, with shortfalls against targets within delivery units expected to be recovered from corporate schemes identified. Whilst the CHP remains short of identifying savings to meet its local target, it will continue to work towards achievement of this throughout the year. The table below sets out the CHP savings target for this year, the value of plans identified in support of the financial plan and the progress against this after 2 months.

<table>
<thead>
<tr>
<th></th>
<th>Carry Forward Gap from 10/11 (£000)</th>
<th>New target for 11/12 (£000)</th>
<th>Total target for 11/12 (£000)</th>
<th>Plans identified per financial framework (£000)</th>
<th>Planned Delivery to P2 (£000)</th>
<th>Delivered to P2 (£000)</th>
<th>Surplus/ (Shortfall) (£000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>K+LM CHP</td>
<td>169</td>
<td>1,405</td>
<td>1,574</td>
<td>903</td>
<td>60</td>
<td>60</td>
<td>0</td>
</tr>
</tbody>
</table>

Capital

The Capital allocation for the CHP as at 31st May 2011 is shown in the attached appendix.

The specific allocation for Kirkcaldy & Levenmouth at this time is £12k. Other CHP general allocations bring the total Capital allocation to £642k.

The total expenditure against the specific allocation to date is £155k, of which £152k relates to Dental Service Centres.

Summary

The position as at 31st May 2011 is showing an overspend of £97k on revenue budgets for Clinical Services.

Recommendations

The CHP Committee is asked to
• Note the contents of this paper.

Report by: ANDREW McCREADIE
ASSISTANT DIRECTOR OF FINANCE
<table>
<thead>
<tr>
<th>Project</th>
<th>CRL New Funding</th>
<th>Total Expenditure to Date</th>
<th>Projected Expenditure 2010/11</th>
<th>Projected Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>14 Stratheden - Dry Good Store Floor</td>
<td>12,000</td>
<td>12,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>49 Total K &amp; LM CHP</td>
<td>12,000</td>
<td>12,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>51 CHP Statutory Compliance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>72 Total CHP Statutory Compliance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>76 Vehicle Replacement</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>77 Vehicle Balance</td>
<td>37,221</td>
<td>37,221</td>
<td></td>
<td></td>
</tr>
<tr>
<td>85 Total Vehicle Replacement</td>
<td>40,000</td>
<td>2,779</td>
<td>40,000</td>
<td></td>
</tr>
<tr>
<td>87 CHP Capital Minor Works</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>88 Minor Works Balance</td>
<td>36,000</td>
<td>88,000</td>
<td>50,000</td>
<td></td>
</tr>
<tr>
<td>90 Total CHP Capital Equipment</td>
<td>36,000</td>
<td>88,000</td>
<td>50,000</td>
<td></td>
</tr>
<tr>
<td>96 CHP Capital Equipment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>97 Equipment Balance</td>
<td>71,500</td>
<td>21,500</td>
<td>50,000</td>
<td></td>
</tr>
<tr>
<td>102 Total CHP Capital Equipment</td>
<td>71,500</td>
<td>21,500</td>
<td>50,000</td>
<td></td>
</tr>
<tr>
<td>104 Dental Service Centre 1 &amp; 2 - Primary Care Modernisation</td>
<td>400,000</td>
<td>152,000</td>
<td>400,000</td>
<td></td>
</tr>
<tr>
<td>113 TOTAL ALLOCATION FOR 2011/12</td>
<td>641,500</td>
<td>155,650</td>
<td>641,500</td>
<td></td>
</tr>
</tbody>
</table>
Kirkcaldy & Levenmouth CHP Committee Meeting

12th July 2011
Agenda Item No 9.2

DELIVERY AND EFFICIENCY: Efficiency Savings 2011/12

1. INTRODUCTION

NHS Fife is expected to deliver £13,547,000 efficiency savings in 2011/12 plus any remaining carry forward gap from 2010/11. The CHP’s contribution towards these efficiency savings is £1,574,000. Work is ongoing within the CHP to address and meet this savings target as detailed in section 2 below.

Efficiency savings are invested back into the NHS. NHS Fife have recently been successful with the new build St Andrews Memorial Hospital and, more locally to the CHP, two new wards at Stratheden Hospital, modernisation of Kirkcaldy Health Centre, together with refurbishment of Seaview and Pentland areas within Whyteman’s Brae Hospital. NHS Fife is also looking forward to the handover of the new build Victoria Hospital later this year.

2. PROPOSALS TO ACHIEVE EFFICIENCY TARGETS 2011/12

The undenoted provides details of how the CHP’s efficiency savings will be achieved during this financial year. All of these reductions can be made without any impact on the quality of service delivered due to service redesign and modified models of care.

- Mental Health Service

The Mental Health Service has an efficiency savings target of circa. £800,000, almost half of the total CHP target and allocated on a pro-rata basis. The plans include, reviewing the optimum occupancy and use of old age psychiatry admission beds with a view to a reduction of beds, similar to the exercise implemented successfully with adult psychiatry admission beds last year. Not replacing two management posts created by the impending retirement of the post holders followed by a restructuring of management arrangements will make a further contribution to the overall target. Savings arising from reductions in the cost of drug prescribing and medical supplies are also anticipated. Savings across a range of administrative budgets including travel, training and administrative support will further contribute to the overall savings target.

- Sexual Health Service

Due to the retirement of two members of staff and review of activity and clinic scheduling, the Sexual Health Service will meet part of its efficiency savings through the reduction of 1.0 wte. The balance will be achieved through in year efficiencies due to the delay in recruiting to the Lead Nurse post and the commencement of a speciality grade doctor.
• Nutrition and Dietetic Service

The Nutrition and Dietetic Service’ efficiency savings for the current financial year is £67,500 which includes the carry forward element from savings delivered non-recurrently in the previous year.

These efficiency savings will be found from the Borderline Substances budget as a result of improved contract prices, recently negotiated as part of the National Contract Specification.

Efficiency savings will also be accrued within the Community Prescribing Budget; again due to the Nutrition and Dietetic Department’s negotiations for Borderline Substances as part of the National Contract. It is anticipated that this saving may be as much as £100k.

The balance of the Dietetic efficiency savings will be met through the implementation of skill mix changes from staff turnover; where appropriate changes to staff bandings should release some funds.

• Continuous Professional Development

As part of the efficiency savings for 2011/12 the spending against the Education budget held by Kirkcaldy and Levenmouth CHP and administered by the Head of Nursing will be reduced.

It is planned to reduce the expenditure by £100k. This will be achieved by reducing the number of staff who are supported to undertake the DN/SPQ programme at Queen Margaret University.

The initiative has been discussed and agreed by the General Managers. The Nurse Director has been informed and is supportive of the initiative. The funding can be removed from the budget as of 1st April 2011.

• Long Term Conditions

Due to various factors, the Long Term Conditions budget was underspent in 2010/11. The situation will remain the same for this financial year. It has, therefore, been agreed to take £40,000 out as part of the contribution to the efficiency savings. Once again, this funding is available as of 1st April 2011.

• Pharmacy/Managed Clinical Networks

It is intended to work towards achievement of efficiency savings of 2.6% in respect of the Pharmacy Budget and the budget for the Managed Clinical Networks. Investigations continue to identify any other areas where efficiency savings may be possible e.g., Working Groups.

• Administrative and Business Management Service

The Administration Service has an efficiency target of £31,000 for 2011/12. The contribution to achieve this target is divided into recurring and non-recurring savings during this financial year.

The recurring savings is achieved by one member of staff voluntarily reducing their hours, by not recruiting to a secretarial vacancy and reducing the supplies budget by £2,300.
The non-recurring savings is achieved by retaining a vacancy, whilst the postholder is on secondment.

3. Future Efficiency Savings

Throughout the next few years NHS Fife and the CHP will be required to meet efficiency savings targets. The CHP acknowledges staff’s contribution in continuing to deliver high quality healthcare to the population of Kirkcaldy and Levenmouth, during these challenging times both at present and continuing into the future.

This item will remain high on the CHP Management Team’s agenda and investigations will continue as to how further efficiency savings may be achieved in future years.

4. RECOMMENDATION

The CHP Committee is asked to:-

• note the report on CHP Efficiency Savings 2011/12.

Report by: GEORGE CUNNINGHAM
GENERAL MANAGER
1. INTRODUCTION

1.1 At its meeting on 8th June 2010, The CHP Committee agreed the CHP Workplan for 2010/11 and, as indicated at the same meeting, the reporting frequency of the CHP Workplan to the Committee has changed, mirroring that of the Balanced Scorecard progress reports to the Board.

2. PURPOSE OF THE REPORT

The purpose of the CHP Workplan is to advise the Committee, at regular intervals, of the CHP’s performance in relation to each of the CHP’s priorities.

3. PERFORMANCE: 2010/11

3.1 The CHP Workplan (Appendix A) sets out the objectives for Kirkcaldy and Levenmouth CHP, based on NHS Fife’s key priorities for 2010/11. Performance is self assessed by the Management Team against criteria agreed with performance monitoring colleagues.

3.2 The CHP intends to continue to use the “traffic lights” system as adopted by NHS Board. The four traffic lights are:

- Blue - Target achieved early
- Green - On track to complete by agreed date
- Amber - Not on track but within agreed tolerance levels
- Red - Not on track and not within agreed tolerance levels

3.3 The CHP Workplan as at 31st March 2011 highlights the following results:

<table>
<thead>
<tr>
<th>Status as at 31st March 2011</th>
<th>No of Targets</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue - Complete</td>
<td>10</td>
<td>36</td>
</tr>
<tr>
<td>Green – On Track</td>
<td>7</td>
<td>25</td>
</tr>
<tr>
<td>Amber - Not on Track but Within Agreed Tolerance Levels</td>
<td>7</td>
<td>25</td>
</tr>
<tr>
<td>Red – Not on Track and not Within Agreed Tolerance Levels</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td>28</td>
<td>100</td>
</tr>
</tbody>
</table>
4. OVERALL ANALYSIS OF PERFORMANCE

4.1 When the four quadrants of the Workplan are placed alongside each other, the undernoted overarching observation can be made:-

4.2 Table 2 shows the percentage of Blue and Green scores in each quadrant at 31\textsuperscript{st} March 2011:

Table 2

<table>
<thead>
<tr>
<th>Quadrant</th>
<th>March 2011 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving Health</td>
<td>38</td>
</tr>
<tr>
<td>Patient and Staff Experience</td>
<td>71</td>
</tr>
<tr>
<td>Planning for Service Improvement</td>
<td>50</td>
</tr>
<tr>
<td>Delivery and Efficiency</td>
<td>78</td>
</tr>
<tr>
<td>Overall</td>
<td>61</td>
</tr>
</tbody>
</table>

Overall 17 targets out of 28 were deemed Blue or Green which equates to 61% as at March 2011.

5. RECOMMENDATION

The Committee is asked to:-

- Note the progress on the 2010/11 CHP Workplan to 31\textsuperscript{st} March 2011.

Report by: George Cunningham, General Manager

1\textsuperscript{st} July 201
Kirkcaldy and Levenmouth
Community Health Partnership

CHP Workplan 2010/11
Version 1.3 - 31st March 2011

Status Assessment to be used:-

- Target achieved early
- On track to complete by agreed date
- Not on track but within agreed tolerance levels
- Not on track and not within agreed tolerance levels
<table>
<thead>
<tr>
<th>BSC No.</th>
<th>BSC Objective</th>
<th>NHS Fife Target</th>
<th>Target Origin</th>
<th>Target Date</th>
<th>CHP Target</th>
<th>Target Status</th>
<th>Enablers (Measures of Progress)</th>
<th>KPI's (Evidence of Progress)</th>
<th>Accountable Executive</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.01</td>
<td>Disease Prevention</td>
<td>Cardiovascular Health Checks - we will aim to deliver 2,100</td>
<td>H8</td>
<td>Mar-11</td>
<td>Achieve agreed number of inequalities targeted Cardiovascular Health checks during 2010/11</td>
<td>Complete</td>
<td>Local Lead: Mary Porter</td>
<td>Number of Checks</td>
<td>Susan Manion</td>
</tr>
<tr>
<td>1.02</td>
<td>Disease Prevention</td>
<td>Alcohol brief interventions - we will aim to deliver 10,452</td>
<td>H4</td>
<td>Mar-11</td>
<td>Achieve agreed number of screenings using the setting-appropriate screening tool and appropriate alcohol brief intervention, in line with SIGN 74 guidelines by 2010/11.</td>
<td>Delayed</td>
<td>Local Lead: Bob McLean</td>
<td>Number of Interventions</td>
<td>George Cunningham</td>
</tr>
<tr>
<td>1.03</td>
<td>Disease Prevention</td>
<td>Smoking Cessation - we will aim to deliver 6,168 1-month smoking quits.</td>
<td>H6</td>
<td>Mar-11</td>
<td>Through smoking cessation services, support 8% of your Board’s smoking population in successfully quitting (at one month post quit) over the period 2008/09 - 2010/11.</td>
<td>Delayed</td>
<td>Local Lead: Mary Porter</td>
<td>Number of Quits</td>
<td>Eddie Coyle</td>
</tr>
<tr>
<td>1.04</td>
<td>Early Years, Children &amp; Teenage Transition</td>
<td>Child fluoride varnish applications - we will aim to give 60% of 3 and 4 year old children two applications of fluoride varnish per year.</td>
<td>H9</td>
<td>Mar-14</td>
<td>60% of 3 and 4 year old children receiving two applications of fluoride varnish per year.</td>
<td>Complete</td>
<td>Local Lead: Mary Porter</td>
<td>% of 3 and 4 year olds receiving two applications of fluoride varnish</td>
<td>Eddie Coyle</td>
</tr>
<tr>
<td>1.05</td>
<td>Early Years, Children &amp; Teenage Transition</td>
<td>Child Healthy Weight interventions - we will aim to deliver 414 interventions</td>
<td>H3</td>
<td>Mar-11</td>
<td>Support the Fife Healthy Weight Strategy. The recommendations for childhood obesity are: Fife referral criteria for obese children should be reviewed. Consider how to offer family based weight management for obese children in Fife.</td>
<td>On Track</td>
<td>Local Lead: Dr L Bisset</td>
<td>Number of Interventions</td>
<td>Annie Buchanan</td>
</tr>
<tr>
<td>1.06</td>
<td>Early Years, Children &amp; Teenage Transition</td>
<td>Breastfeeding - we will aim to increase the proportion of new-born children exclusively breastfed to 34.8%</td>
<td>H7</td>
<td>Mar-11</td>
<td>Increase the proportion of new-born children exclusively breastfed at 6 - 8 weeks from 25.6% to 33.3% in 2010/11.</td>
<td>Not Met</td>
<td>Local Lead: Mary Porter</td>
<td>% Exclusively Breastfed</td>
<td>Annie Buchanan</td>
</tr>
<tr>
<td>1.07</td>
<td>Early Years, Children &amp; Teenage Transition</td>
<td>Teenage pregnancy - we will aim to reduce teenage pregnancies to 7.2 per 1,000 population.</td>
<td>LP</td>
<td>Dec-11</td>
<td>Reduce teenage pregnancies for 13 - 15 year olds to 7.2 per 1,000 by March 2011.</td>
<td>Delayed</td>
<td>Local Lead: Mary Porter</td>
<td>Rate per 1,000 population</td>
<td>Eddie Coyle</td>
</tr>
<tr>
<td>1.08</td>
<td>Early Years, Children &amp; Teenage Transition</td>
<td>Childhood Immunisation - we will aim to achieve an MMR1 uptake rate of 95%</td>
<td>S</td>
<td>S</td>
<td>HEAT Standard (HS&amp;.1 &amp; 7.2) at 2 and 5 years of age.</td>
<td>Delayed</td>
<td>Local Lead: Mary Porter</td>
<td>% Uptake Rate</td>
<td>Eddie Coyle</td>
</tr>
<tr>
<td>BSC Objective</td>
<td>NHS Fife Target</td>
<td>Target Orgin</td>
<td>Target Date</td>
<td>CHP Target</td>
<td>Target Status</td>
<td>Enablers (Measures of Progress)</td>
<td>KPI's (Evidence of Progress)</td>
<td>Accountable Executive</td>
<td></td>
</tr>
<tr>
<td>---------------</td>
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<td>--------------</td>
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<td>---------------</td>
<td>---------------------------------</td>
<td>-----------------------------</td>
<td>-----------------------</td>
<td></td>
</tr>
<tr>
<td>Balance of Care</td>
<td>Delayed Discharges - We will aim to achieve no waits over 6 weeks and to have no delays in short stay specialties</td>
<td>S</td>
<td>S</td>
<td>To reduce Delayed Discharges to Nil.</td>
<td><strong>Not Met</strong></td>
<td>Local Lead: Fiona Mackenzie</td>
<td>Number DD &gt; 6 weeks Number of SSS</td>
<td>George Cunningham</td>
<td></td>
</tr>
<tr>
<td>A Mutual NHS</td>
<td>A Mutual NHS - we will comply with the requirements of being a mutual NHS.</td>
<td>LP</td>
<td>Mar-11</td>
<td>Work in partnership with staff, patients and members of the public, to create a mutual NHS.</td>
<td><strong>On Track</strong></td>
<td>Local Lead: Dr L Bisset</td>
<td></td>
<td>Annie Buchanan</td>
<td></td>
</tr>
<tr>
<td>Staff and Patient Welfare</td>
<td>Health &amp; Safety - we will develop and implement the annual local action plans for Health &amp; Safety.</td>
<td>LP</td>
<td>Mar-11</td>
<td>Implement local Action Plan and Workplan for Health and Safety</td>
<td><strong>On Track</strong></td>
<td>Local Lead: Dr L Bisset</td>
<td></td>
<td>Rona King</td>
<td></td>
</tr>
<tr>
<td>Staff and Patient Welfare</td>
<td>Sickness Absence - We will aim to achieve and sustain a sickness absence rate of no more than 4%.</td>
<td>S</td>
<td>S</td>
<td>To contribute to NHS Fife in achieving and sustaining a 4% sickness absence rate, by reducing sickness absence within the CHP.</td>
<td><strong>Delayed</strong></td>
<td>Local Lead: George Cunningham</td>
<td>% Sickness Absence Rate</td>
<td>Rona King</td>
<td></td>
</tr>
<tr>
<td>Staff Governance</td>
<td>Staff Governance - We will aim to ensure staff governance strategy setting and action planning processes are in place.</td>
<td>LP</td>
<td>Mar-11</td>
<td>To continue to develop, implement, monitor and evaluate the CHP SGAP, based on Local Partnership Forum development needs.</td>
<td><strong>Complete</strong></td>
<td>Local Lead: Heather Fernie</td>
<td></td>
<td>Rona King</td>
<td></td>
</tr>
<tr>
<td>Staff Governance</td>
<td>Suicide Prevention Training - we will aim to train 50% of key frontline staff in using suicide assessment tools/suicide prevention training.</td>
<td>HS</td>
<td>Dec-10</td>
<td>Reduce suicide rate between 2002 and 2013 by 20% supported by 50% of key frontline staff in mental health and substance misuse services, primary care and accident and emergency being educated and trained in using suicide assessment tools/suicide prevention training programmes by 2010.</td>
<td><strong>Complete</strong></td>
<td>Local Lead: Mary Porter</td>
<td>Number of Staff Trained</td>
<td>David Christie</td>
<td></td>
</tr>
<tr>
<td>Staff Governance</td>
<td>Personal Development Plans - We will aim to ensure at least 80% of staff will have their annual PDP review completed and recorded on eKSF.</td>
<td>E10</td>
<td>Mar-11</td>
<td>To contribute to NHS Fife achieving target i.e., 80% of staff to have annual PDP and recorded on eKSF.</td>
<td><strong>Complete</strong></td>
<td>Local Lead: Mary Porter</td>
<td>% recorded on eKSF</td>
<td>David Christie</td>
<td></td>
</tr>
<tr>
<td>BSC No.</td>
<td>BSC Objective</td>
<td>NHS Fife Target</td>
<td>Target Origin</td>
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</tr>
<tr>
<td>---------</td>
<td>---------------------</td>
<td>---------------------------------------------------------------------------------</td>
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<td>-----------------------------------------------------------------------------</td>
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<td>--------------------------------</td>
<td>------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>3.01</td>
<td>Balance of Care</td>
<td>Bed Days for Emergency Patients - we will aim to reduce the bed days for people aged 65 and over to 2,555.</td>
<td>T12</td>
<td>Mar-11</td>
<td>By 2010/11, we will reduce the emergency in-patient bed days for people aged 65 and over, by 10% compared with 2004/05.</td>
<td>Delayed</td>
<td>Local Lead: George Cunningham</td>
<td>Bed Days (rate per 1,000 population)</td>
<td>Vicky Irons</td>
</tr>
<tr>
<td>3.02</td>
<td>Balance of Care</td>
<td>Complex Care for Older People - we will aim to increase the level receiving care at home to 27%.</td>
<td>T8</td>
<td>Mar-11</td>
<td>Increase the level of older people with complex care needs receiving care at home.</td>
<td>Not Met</td>
<td>Local Lead: Fiona Mackenzie</td>
<td>% Receiving Care at Home</td>
<td>George Cunningham</td>
</tr>
<tr>
<td>3.03</td>
<td>Balance of Care</td>
<td>Long Term Conditions - we will aim to reduce the rates of hospital bed days of patients with a LTC.</td>
<td>T6</td>
<td>Mar-11</td>
<td>To work with available data and put in place appropriate strategies to meet this target.</td>
<td>Complete</td>
<td>Local Lead: Mary Porter</td>
<td>rate per 100,000</td>
<td>Vicky Irons</td>
</tr>
<tr>
<td>3.08</td>
<td>Sustaining Fife</td>
<td>Emergency Planning We will continually review and refine our emergency planning arrangements.</td>
<td>LP</td>
<td>Mar-11</td>
<td>To review and amend CHP emergency plans annually and link into NHS Fife's emergency plan.</td>
<td>Complete</td>
<td>Local Lead: Heather Fernie</td>
<td></td>
<td>John Wilson</td>
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<td>KPI's (Evidence of Progress)</td>
<td>Accountable Executive</td>
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<td>E4</td>
<td>Mar-11</td>
<td>Deliver improved efficiencies for rheumatology for first out-patient attendance for DNAs and N:R out-patient attendance ratio.</td>
<td>Delayed</td>
<td>Local Lead: Heather Fernie</td>
<td>% DNA N:R</td>
<td>John Wilson</td>
</tr>
<tr>
<td>4.02</td>
<td>Capacity</td>
<td>Electronic Referrals - We will aim to increase the percentage of referrals that are managed electronically to 90%.</td>
<td>E7</td>
<td>Dec-10</td>
<td>Increase the percentage of new GP outpatient electronic referrals to 90%.</td>
<td>On Track</td>
<td>Local Lead: Dr L Bisset</td>
<td>% of Electronic Referrals</td>
<td>Chris Bowring</td>
</tr>
<tr>
<td>4.06</td>
<td>E’Health</td>
<td>E’Health - Identify and implement solutions to support improved and safer patient care.</td>
<td>LP</td>
<td>Mar-11</td>
<td>Continue to ensure plans are being met for the implementation of NaSH to Sexual Health Service and all staff within CHP migrated to NHS Mail e’mail system.</td>
<td>Complete</td>
<td>Local Lead: Heather Bett/Heather Fernie</td>
<td></td>
<td>Chris Bowring</td>
</tr>
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<td>4.08</td>
<td>Finance</td>
<td>Cash Efficiencies - We will aim to achieve £19.5m cash eﬃciency savings.</td>
<td>E6</td>
<td>Mar-11</td>
<td>Ensure CHP contributes to Government Efficiency Targets.</td>
<td>Complete</td>
<td>Local Lead: George Cunningham</td>
<td>Cash Eﬃciency Savings Made</td>
<td>Chris Bowring</td>
</tr>
<tr>
<td>4.09</td>
<td>Balance of Care</td>
<td>A&amp;E attendances - We will aim to reduce rates of attendance to 1,819.</td>
<td>T10</td>
<td>Mar-11</td>
<td>To support shifting BoC, aim to reduce rates of A &amp; E attendances to 1,819.</td>
<td>Not Met</td>
<td>Local Lead: George Cunningham</td>
<td>A &amp; E Attendance Rate</td>
<td>Susan Manion</td>
</tr>
<tr>
<td>4.13</td>
<td>18 weeks Waiting Time - We will aim to deliver a maximum 18 weeks Referral to treatment timescale.</td>
<td>A10</td>
<td>Dec-11</td>
<td>Ensure appropriate planning for and compliance with all waiting time targets including 18 week referral to Treatment target for Rheumatology.</td>
<td>On Track</td>
<td>Local Lead: Heather Fermie</td>
<td>Number waiting over 18 weeks</td>
<td>John Wilson</td>
<td></td>
</tr>
<tr>
<td>4.14</td>
<td>Drug and Alcohol Mis-users - we will aim to have 90% of clients wait no longer than 3 weeks from referral to treatment.</td>
<td>A11</td>
<td>Mar-13</td>
<td>By March 2013, 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery. By December 2010, 90% of clients referred to drug treatment will receive a date for assessment that falls within 4 weeks of referral received and 90% of clients will receive a date for treatment that falls within 4 weeks of their care plan being agreed.</td>
<td>On Track</td>
<td>Local Lead: Bob McLean</td>
<td>% of clients &gt; 3 weeks</td>
<td>George Cunningham</td>
<td></td>
</tr>
<tr>
<td>4.15</td>
<td>Child and Adolescent Mental Health Services - We will aim to have no one waiting longer than 26 weeks from referral to treatment for specialist CAMHS services.</td>
<td>A12</td>
<td>Mar-13</td>
<td>Child and Adolescent Mental Health Services - We will aim to have no one waiting longer than 26 weeks from referral to treatment for specialist CAMHS services.</td>
<td>On Track</td>
<td>Local Lead: Bob McLean</td>
<td>Number waiting &gt; 26 weeks</td>
<td>George Cunningham</td>
<td></td>
</tr>
</tbody>
</table>
DEVELOPMENT AND EFFICIENCY: CHP Workplan 2011/12

1. INTRODUCTION

1.1 Kirkcaldy and Levenmouth CHP Workplan is based on NHS Fife’s Balanced Scorecard approach.

1.2 The Workplan outlines the priorities for the CHP during 2011/12 and, as stated at previous CHP Committee meetings, the reporting of the CHP Workplan to the Committee has changed to mirror that of the CHP Balanced Scorecard reports to the Board. Comparative reports, to that of the NHS Fife Balanced Scorecard, will be reported to the Committee four times per year.

2. PERFORMANCE: 2011/12

2.1 The CHP Workplan (Appendix A) sets out the objectives of Kirkcaldy and Levenmouth CHP, based on NHS Fife’s key priorities and the CHP’s local priorities for 2011/12. The CHP Workplan aims to articulate the CHP’s objectives which includes process measures (enablers) and is a ‘live’ performance tool, with refinement and improvement continuing throughout the year. Performance is self-assessed by the Management Team against criteria agreed with performance monitoring colleagues.

2.2 The CHP Workplan considers performance across four domains. These are:-

- Improving Health
- Patient and Staff Experience
- Planning for Service Improvement
- Delivery and Efficiency

2.3 The CHP intends to continue to use the “traffic lights” system as adopted by NHS Board. The four traffic lights are:-

- Blue - Target achieved early
- Green - On track to complete by agreed date
- Amber - Not on track but within agreed tolerance levels
- Red - Not on track and not within agreed tolerance levels

3. RECOMMENDATION

3.1 The Committee is asked to:

- agree the 2011/12 CHP Workplan.

Report by: George Cunningham, General Manager
Status Assessment to be used:-

- Target achieved early
- On track to complete by agreed date
- Not on track but within agreed tolerance levels
- Not on track and not within agreed tolerance levels
<table>
<thead>
<tr>
<th>NHS Fife Target</th>
<th>Target Origin</th>
<th>Target Date</th>
<th>CHP Target</th>
<th>Target Status</th>
<th>Enablers (Measures of Progress)</th>
<th>KPI’s (Evidence of Progress)</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol brief interventions - we will aim to deliver 10,452</td>
<td>H4</td>
<td>Mar-11</td>
<td>Achieve agreed number of screenings using the setting-appropriate screening tool and appropriate alcohol brief intervention, in line with SIGN 74 guidelines by 2010/11.</td>
<td></td>
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<td>BMcL</td>
</tr>
<tr>
<td>Smoking Cessation - we will aim to deliver 6,168 1-month smoking quits.</td>
<td>H6</td>
<td>Mar-11</td>
<td>Through smoking cessation services, support 8% of your Board's smoking population in successfully quitting (at one month post quit) over the period 2008/09 - 2010/11</td>
<td></td>
<td></td>
<td></td>
<td>MP</td>
</tr>
<tr>
<td>Child Healthy Weight interventions - we will aim to deliver 414 interventions</td>
<td>H3</td>
<td>Mar-11</td>
<td>Support the Fife Healthy Weight Strategy. The recommendations for childhood obesity are: Fife referral criteria for obese children should be reviewed. Consider how to offer family based weight management for obese children in Fife.</td>
<td></td>
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<td>LB</td>
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<tr>
<td>Breastfeeding - we will aim to increase the proportion of new-born children exclusively breastfed to 34.8%</td>
<td>H7</td>
<td>Mar-11</td>
<td>Increase the proportion of new-born children exclusively breastfed at 6 - 8 weeks from 26.6% to 33.3% in 2010/11.</td>
<td></td>
<td></td>
<td></td>
<td>MP</td>
</tr>
<tr>
<td>Teenage pregnancy - we will aim to reduce teenage pregnancies to 7.2 per 1,000 population.</td>
<td>LP</td>
<td>Dec-11</td>
<td>Reduce teenage pregnancies for 13 - 15 year olds to 7.2 per 1,000 by March 2011.</td>
<td></td>
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<td></td>
<td>MP</td>
</tr>
<tr>
<td>Childhood Immunisation - we will aim to achieve an MMR1 uptake rate of 95%</td>
<td>S</td>
<td>S</td>
<td>HEAT Standard (HS&amp;.1 &amp; 7.2) at 2 and 5 years of age.</td>
<td></td>
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<td>MP</td>
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<td></td>
<td>-</td>
<td>Mar-12</td>
<td>Vascular MCNs (Stroke) - Evaluate the future role of the Vascular MCNs.</td>
<td></td>
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<td></td>
<td>MP</td>
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<tr>
<td></td>
<td>-</td>
<td>Mar-12</td>
<td>Diabetes MCN - Evaluate the future role of the MCN</td>
<td></td>
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<td>MP</td>
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<tr>
<td></td>
<td>-</td>
<td>Mar-12</td>
<td>Heart Disease - Evaluate the future role of the MCN</td>
<td></td>
<td></td>
<td></td>
<td>MP</td>
</tr>
<tr>
<td>BSC No.</td>
<td>BSC Objective</td>
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<tr>
<td>2.01</td>
<td>Balance of Care</td>
<td>Delayed Discharges - We will aim to achieve no waits over 6 weeks and to have no delays in short stay specialties</td>
<td><strong>S</strong></td>
<td><strong>S</strong></td>
<td>To reduce Delayed Discharges to Nil.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.02</td>
<td>Equality and Diversity</td>
<td>Equality and Diversity legislative requirements to be embedded into NHS Fife.</td>
<td><strong>LP</strong></td>
<td>Mar-12</td>
<td>Ensure NHS Fife Equality and Diversity legislative requirements are embedded into CHP.</td>
<td></td>
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</tr>
<tr>
<td>2.03</td>
<td>HAI</td>
<td>HAI - We will aim to reduce the rate of staphylococcus aureus bacteremia (including MRSA) to 0.26 and maintain a rate of C Diff infection in the over 65's of less than 0.39.</td>
<td><strong>NT</strong></td>
<td>Mar-13</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2.05</td>
<td>Staff and Patient Welfare</td>
<td>Health &amp; Safety - we will develop and implement the annual local action plans for Health &amp; Safety.</td>
<td><strong>LP</strong></td>
<td>Mar-11</td>
<td>Implement local Action Plan and Workplan for Health and Safety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.06</td>
<td>Staff and Patient Welfare</td>
<td>Sickness Absence - We will aim to achieve and sustain a sickness absence rate of no more than 4%.</td>
<td><strong>S</strong></td>
<td><strong>S</strong></td>
<td>To contribute to NHS Fife in achieving and sustaining a 4% sickness absence rate, by reducing sickness absence within the CHP.</td>
<td></td>
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</tr>
<tr>
<td>2.07</td>
<td>New Deal/GWTD</td>
<td>New Deal/EWTD - We will comply with the requirements of New Deal and European Working Time Directive (EWTD)</td>
<td><strong>LP</strong></td>
<td>Mar-12</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2.08</td>
<td>Staff Governance</td>
<td>Staff Governance - We will aim to ensure staff governance strategy setting and action planning processes are in place.</td>
<td><strong>LP</strong></td>
<td>Mar-11</td>
<td>To continue to develop, implement, monitor and evaluate the CHP SGAP, based on Local Partnership Forum development needs.</td>
<td></td>
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</tr>
<tr>
<td>K/L 2.09</td>
<td>Staff and Patient Welfare</td>
<td>-</td>
<td><strong>LP</strong></td>
<td>Mar-12</td>
<td>Deliver the vision for re-Shaping Care for Older People in Fife.</td>
<td></td>
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</tr>
<tr>
<td>K/L2.10</td>
<td>Staff and Patient Welfare</td>
<td>-</td>
<td><strong>LP</strong></td>
<td>Mar-12</td>
<td>Fife Rehabilitation Service - Develop and Agree Neuro-Rehab Pathway</td>
<td></td>
<td></td>
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<tr>
<td>K/L2.11</td>
<td>Staff and Patient Welfare</td>
<td>-</td>
<td>LP</td>
<td>Mar-12</td>
<td>Mental Health Service - Develop and implement Psychiatry Liaison Services.</td>
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<tr>
<td>K/L2.12</td>
<td>Staff and Patient Welfare</td>
<td>-</td>
<td>LP</td>
<td>Nov-11</td>
<td>Occupational Therapy (Older People) - Streamline care of stroke patients out of hospital</td>
<td>FMcK</td>
<td></td>
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<tr>
<td>K/L2.13</td>
<td>Staff and Patient Welfare</td>
<td>-</td>
<td>LP</td>
<td>Mar-12</td>
<td>Physiotherapy Service - Develop a referral pathway that generates equity of provision</td>
<td>FMcK</td>
<td></td>
</tr>
<tr>
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<td>Complex Care for Older People - we will aim to increase the level receiving care at home to 27%.</td>
<td>T8</td>
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<td>3.03</td>
<td>Balance of Care</td>
<td>Long Term Conditions - we will aim to reduce the rates of hospital bed days of patients with a LTC.</td>
<td>T6</td>
<td>Mar-11</td>
<td>To work with available data and put in place appropriate strategies to meet this target.</td>
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<td>3.08</td>
<td>Sustaining Fife</td>
<td>Emergency Planning We will continually review and refine our emergency planning arrangements.</td>
<td>LP</td>
<td>Mar-11</td>
<td>To review and amend CHP emergency plans annually and link into NHS Fife's emergency plan.</td>
<td></td>
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</tr>
<tr>
<td>3.09</td>
<td>Stroke Services</td>
<td>We will aim for 90% of all patients admitted with a diagnosis of stroke to be admitted to a stroke unit on the day of admission, or the day following presentation.</td>
<td>NT</td>
<td>Mar-13</td>
<td></td>
<td></td>
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<tr>
<td>3.10</td>
<td>Clinical Redesign</td>
<td>We will deliver sustainable health and healthcare services which support improvements in the care, treatment and health of our population.</td>
<td>LP</td>
<td>Mar-12</td>
<td></td>
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<tr>
<td>K/L3.11</td>
<td>Clinical Redesign</td>
<td>-</td>
<td>LP</td>
<td>Mar-12</td>
<td>Deliver the Community Nursing Framework</td>
<td></td>
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</tr>
<tr>
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<td>BSC Objective</td>
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<td>E4</td>
<td>Mar-11</td>
<td>Deliver improved efficiencies for rheumatology for first out-patient attendance for DNA's and N:R out-patient attendance ratio.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.03</td>
<td>Child Protection</td>
<td>We will comply with Child Protection Standardsset for Hfie inspection.</td>
<td>LP</td>
<td>Mar-12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.06</td>
<td>E'Health</td>
<td>E'Health - Identify and implement solutions to support improved and safer patient care.</td>
<td>LP</td>
<td>Mar-11</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>4.07</td>
<td>Finance</td>
<td>Financial Performance - we will aim to: i) Operate within our revenue resource limit. ii) Operate within our Capital resource limit. iii) Meet our cash requirement.</td>
<td>E5</td>
<td>Mar-11</td>
<td>Ensure CHP achieves financial balance in 2010/2011 and meets cash requirement.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.08</td>
<td>Finance</td>
<td>Cash Efficiencies - We will aim to achieve £19.5m cash efficiency savings.</td>
<td>E6</td>
<td>Mar-11</td>
<td>Ensure CHP contributes to Government Efficiency Targets.</td>
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<tr>
<td>4.13</td>
<td>18 weeks RIT</td>
<td>18 weeks Waiting Time - We will aim to deliver a maximum 18 weeks Referral to treatment timescale.</td>
<td>A10</td>
<td>Dec-11</td>
<td>Ensure appropriate planning for and compliance with all waiting time targets including 18 week referral to Treatment target for Rheumatology.</td>
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<td>4.14</td>
<td>Joint Service</td>
<td>Drug and Alcohol Mis-users - we will aim to have 90% of clients wait no longer than 3 weeks from referral to treatment.</td>
<td>A11</td>
<td>Mar-13</td>
<td>By March 2013, 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery. By December 2010, 90% of clients referred to drug treatment will receive a date for assessment that falls within 4 weeks of referral received and 90% of clients will receive a date for treatment that falls within 4 weeks of their care plan being agreed.</td>
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<td>4.15</td>
<td>Delivering for Mental Health</td>
<td>Child and Adolescent Mental Health Services - We will aim to have no one waiting longer than 26 weeks from referral to treatment for specialist CAMHS services.</td>
<td>A12</td>
<td>Mar-13</td>
<td>Child and Adolescent Mental Health Services - We will aim to have no one waiting longer than 26 weeks from referral to treatment for specialist CAMHS services.</td>
<td>BMcL</td>
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<tr>
<td>K/L 4.16</td>
<td>Capacity</td>
<td>-</td>
<td>LP</td>
<td>Jun-11</td>
<td>Review of Dietetic Department Service</td>
<td>GC</td>
<td></td>
</tr>
<tr>
<td>K/L 4.17</td>
<td>Capacity</td>
<td>-</td>
<td>LP</td>
<td>Aug-12</td>
<td>Sexual Health Services - Undertake Workforce Planning exercise.</td>
<td>HB</td>
<td></td>
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<tr>
<td>K/L 4.18</td>
<td>Capacity</td>
<td>-</td>
<td>LP</td>
<td>Mar-12</td>
<td>Podiatry Service - Rationalisation of Service</td>
<td>FMcK</td>
<td></td>
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<td>K/L4.20</td>
<td>Finance</td>
<td>-</td>
<td>LP</td>
<td>Mar-12</td>
<td>Pharmacy Service - Deliver wound care prescribing efficiency savings.</td>
<td>LB</td>
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Kirkcaldy & Levenmouth CHP Committee Meeting

12th July 2011
Agenda Item No 10 (a)

CONFIRMED MINUTE OF THE MEETING OF THE LOCAL PARTNERSHIP FORUM HELD AT 2.00 PM ON WEDNESDAY 23RD MARCH 2011 IN THE TRAINING ROOM CAMERON HOSPITAL, WINDYGATES

CHP Representation:
George Cunningham, General Manager, K&L CHP GC
Bob McLean, General Manager, Mental Health Directorate BM
Heather Bett, Clinical Service Manager, Sexual Health Service HB
Karen Laird, HR Officer KL
Heather Fernie, Business Manager HF
Mary Porter, Head of Nursing MP

Staff Side Representation:
Simon Fevre, Staff Side Representative - Chair SF
Marie Innes, RCN Representative MI

In Attendance
Claire Reid, Secretary (Minutes) CR

ACTION

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Dr Les Bisset, Fiona MacKenzie, Brian Gilmour, Lynne Parsons and Dave Reid

GC welcomed everyone and opened the meeting

2. MINUTES OF THE PREVIOUS MEETING

The Minutes from the meeting held on 20th January 2011 were agreed as a true and accurate record.

3. MATTERS ARISING

3.1 Montrave Ward

GC advised that the resource transfer for funding has been agreed by NHS Fife and Fife Council and will be available from the 1st April 2011. The funding available is just over £400,000 and is expected to be held by Fife Council with expenditure reports being available via the LMU, CHP MT and CHP Committee.

KL advised that 9 employees from Montrave Ward have been re-deployed (not including the Admin & Clerical Staff).
3.2 e-KSF

SF advised that NHS Fife are currently sitting at 74% complete and it is hoped by the end of March this will be 80%. Breakdown figures by CHP are not yet available.

3.3 Car Park, Kirkcaldy Health Centre

SF advised there has been some concerns raised by staff who are aware that the parking at Victoria Hospital will change considerably and they have queried if the barrier is getting fixed or whether there will be a security guard present.

GC advised that it is his understanding that there will be a security guard present, however, this may not be the case when Interserve more off site.

SF raised the issue of the lights in the back car park of Whyteman’s Brae Hospital and advised that no action has taken place. GC agreed to chase up.

There was discussion in relation to the bollards put in place to discourage people parking, however, GC clarified this is part of a Health & Safety programme with regard to visibility and maintaining safe access which is linked to an incident at the Western General Hospital.

3.4 Staff Survey Results

KL informed the LPF that, at the moment, only NHS Fife data is available and further, breakdown by CHP is to follow.

The LPF members agreed that it would be useful to know the number of percentage of our staff that completed the survey. KL to speak to Bruce Anderson about this.

HF advised that this topic is on the agenda for the CHP Committee in May 2011.

4. TEMPORARY CONTRACTS

SF raised the question of whether the CHP are allowed to have temporary contract staff for longer than 21 months and whether this includes having all paperwork processed by then.

GC advised that for all temporary/fixed term contracts the CHP are working to 21 months including all paperwork completed. Only exception to this is, if the GMs direct reports, advise there is another substantial reason for 21 months not being adhered to.

5. COMMUNITY NURSING FRAMEWORK

MP advised that this was looked at some time ago and discussion was held on how this should be established.

The documents are driven by Lead Nurses in the CHP and are linked to National Drivers HEAT Targets and Delivery Plans.
We are currently looking at output measures and working with Information Services regarding how we are gathering this information and will have the opportunity to review the skill mix in the future.

The LPF need to think about whether the responsibilities in the framework can be met.

6. RAISING & ESCALATING CONCERNS/NMC GUIDANCE

MP advised that the NMC Guidance was raised at the Management Team and it was highlighted that we have a responsibility to ensure staff have access to this leaflet.

7. SOCIAL NETWORK/RCN GUIDANCE

MP advised that during disciplinary hearing's regarding social network issues we should refer to the RCN Guidance.

8. FEEDBACK FROM CHP COMMITTEE & MANAGEMENT TEAM

GC advised that the last Committee Meeting was held on the 8th February 2011 and several issues were discussed including the Delayed Discharges (The FOI from Richard Simpson in particular), the Change Fund, Finance and Sickness Absence.

The last Management Team Meeting was held on the 15th March 2011 and Finance, Estates and Facilities, Human Resources and Voluntary Organisations were discussed.

9. FINANCE

GC advised that the CHP are heading for £25,000 underspend by the end of the year.

10. STAFF BRIEFINGS

The LPF discussed this and agreed that we will hold staff briefing sessions in May and November this year and the topics will be as follows:

- Finance
- Temporary Contracts
- Social Networking Sites
- Staff Governance Action Plan

11. STAFF GOVERNANCE ACTION PLAN 2010/11

The Staff Governance Action Plan was issued to LPF members for comments/amendments and responses have been received from BM and SF. HF will now finalise and send to Bruce Anderson.

HF
12. **SICKNESS ABSENCE**

KL advised that sickness figures have been increasing slightly over the last 4 - 5 months, however, February figure has decreased slightly.

13. **FOR INFORMATION**

13.1 **Healthy Working Lives**

GC advised that Janie Gordon is the CHP’s Lead for Healthy Working Lives. GC asked if the LPF thought it would be a good idea to have Janie come along to another meeting to discuss this. The LPF members agreed this would be helpful, GC to contact Janie.

14. **AOCB**

14.1 SF asked what progress has been made regarding the risk assessment survey and visit at Loughborough Road Clinic. It was advised this is still with Barrie Higgins and will be brought back to the next meeting.

14.2 MI advised she is still trying to gather information on the Incident Reporting Forms and will report back at the next meeting.

14.3 HF informed the LPF that Cameron Hospital Centenary is this year and an email will be issued to all staff requesting help to celebrate this event.

15. **DATE OF NEXT MEETING**

The next LPF will take place on Thursday 19th May 2011 at 2.00pm within the Seminar Room, Whytemans Brae Hospital, Kirkcaldy

1:00pm Staff Side
2:00pm Local Partnership Forum
1. WELCOME AND INTRODUCTION

Ron welcomed everyone to this additional meeting to discuss the Podiatry Service Redesign Consultation.

PRESENTATION BY:

Cheryl Easton, Podiatry Professional Head of Service
Karen Baxter, Podiatry Manager, (D&W Fife CHP)

Cheryl gave an introduction to why both herself and Karen were attending the PPF Reference Group meeting.

The main challenge with the redesign of this service is how we can provide the best level of service appropriate for the people who need it most and reduce costs.

At the end of the presentation Cheryl asked the PPF to consider two questions:

How we should be consulting?
Who should we be consulting with?
<table>
<thead>
<tr>
<th><strong>Question</strong></th>
<th>What do you mean by self referral?</th>
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<tbody>
<tr>
<td><strong>Answer</strong></td>
<td>This is currently a service offered in Dunfermline &amp; West Fife where patients can refer themselves for treatment. It is hoped that this can be rolled out across the other areas of Fife.</td>
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<table>
<thead>
<tr>
<th><strong>Question</strong></th>
<th>Map on the presentation outlining the number of clinics, high population areas – high number of clinics – will there be enough clinics to cope with the increasing population expected for the Kirkcaldy area?</th>
</tr>
</thead>
</table>
| **Answer**   | Most clinics are part-time and some operate only a half mile from each other, this is why we need to look at where we provide clinics at the moment, to make better use of staff time. Staff are travelling to all these clinics and therefore losing patient contact time. 

To improve the patient journey we need to look at buildings, review locality of clinics, looking at where we are sending patients. |

<table>
<thead>
<tr>
<th><strong>Statement</strong></th>
<th>If your main objective is to reduce costs you have to look at clinical placements, reduce the travelling for staff, create a centre of excellence but when you do all this you need to keep people informed, let them know what is happening and why.</th>
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<tr>
<td><strong>Question</strong></td>
<td>Have you mapped out the main areas of requirement; we did this recently for the pain management service?</td>
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</table>
| **Answer**   | Yes, we have been looking at this as part of redesign process but any review always comes down to buildings and their suitability. 

We currently have 41 clinics which operate across Fife, each clinic requires equipment, therefore if we were to reduce the number of clinics we would not only save on staff time but on the purchase of new equipment for all clinics. 

The infrastructure is another area we have been reviewing and it is not good in Fife so we need to look at different ways to deliver the service. 

We need to look at the public transport and identify where the transport links are, e.g. a bus service to Kincardine only operates hourly therefore you can have all patients for that clinic (16) turning up at the same time if they were relying on public transport. 

One of the main advantages for our service is that patients are only required to come for a review approximately 3 times per year. |
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<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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<tbody>
<tr>
<td>Are these appointments planned well in advance?</td>
<td>Yes</td>
</tr>
<tr>
<td>Have you got the facilities to make these centres of excellence?</td>
<td>Yes – if we highlight the facilities available we may be able to go higher up the order of allocation. It would also be better for us to integrate with other services.</td>
</tr>
<tr>
<td>Have you already outgrown the facilities at Seaview?</td>
<td>Yes, we would like to incorporate the clinics currently provided at Loughborough Road Clinic, but we will need to do a consultation with the public on what they want.</td>
</tr>
</tbody>
</table>
| Can you describe your current patient base?       | 70% of our patients are over 60  
Of the 70% - 50% are over 75  
10% of our patients are children  
The late 40 – 60 year olds are our high risk diabetic group who require regular care. |
<p>| The cost of travel to another facility will this be significant? | No, our regular patients due to their condition have access to other incomes to support travel costs. |
| You have to do a survey on your patient base. Outlining what is the objective, build your case around improved quality | |
| Over the next 20 years our caseload is estimated to rise by 23,000 patients’ so we need to change the delivery of the service. | |
| Looking at the service currently provided at Loughborough Road Clinic there would need to be considerable maintenance to this clinic to bring it up to standards we need to provide a quality service. | |
| I would suggest you link with the pain management service who are having similar problems to yourselves, looking at central referral and accommodation issues. | |
| Can you indicate the level of home visits in your current caseload? | Up to 20% is on home visits. |</p>
<table>
<thead>
<tr>
<th><strong>Question</strong></th>
<th>Wouldn’t it be more effective to bear the cost of transport rather than see patients in their own homes?</th>
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<tr>
<td><strong>Answer</strong></td>
<td>Yes we do that already. We currently provide transport to the clinic for patients who are not housebound but who cannot travel on public transport, but this is currently under review as not all patients accessing the service meet our access criteria.</td>
</tr>
<tr>
<td><strong>Question</strong></td>
<td>Who currently provides your transport?</td>
</tr>
<tr>
<td><strong>Answer</strong></td>
<td>The Facilities Department.</td>
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</tbody>
</table>
| **Question** | A question to the PPF:  
Currently within the service we have fully qualified staff, with no staff working at assistant level – how do you think the public would feel if we were to change posts to include some assistant grade posts within this service? |
| **Answer**   | The public like to see someone who is professional and as long as they have been trained for the service they are providing.  
At the end of the day if the patient is treated appropriately.  
As long as your professional body is comfortable with it. |
| **Question** | Who will provide the training for the assistant grades? |
| **Answer**   | Queen Margaret University have developed a programme for us. Lothian, Lanarkshire and Forth Valley are waiting to see if it is successful and they hope to participate in the scheme.  
A one year programme to the equivalent of HNC level – Assistant Practitioner – the caseload would be defined by the Podiatrist. |
| **Question** | Would this give them access to a degree programme? |
| **Answer**   | Yes – but our worry would be that they would then leave and this is a risk that the service needs to manage.  
The staff would be employed by us but trained for 30 weeks at Queen Margaret University and complete 22 week work placement. If they sign on for the programme they would be required to sign a contract to say that they would stay with us for two years and we are looking at adding into this contract if they don’t possibly paying back their training costs and the time involved in training them.  
We currently have everything in place apart from the funding required to train them. |
<table>
<thead>
<tr>
<th>Question</th>
<th>How many qualified podiatrists would you be replacing?</th>
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<tbody>
<tr>
<td>Answer</td>
<td>In the first instance it would be 3 – one per CHP.</td>
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<tr>
<td></td>
<td>20% of the current caseload can be carried out by assistant grades.</td>
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<tr>
<td></td>
<td>When a podiatry posts becomes vacant it was hoped that it would be replaced by two assistant grades to help manage expected rise in demand but with the cost pressure we would only replace with 1 assistant grade.</td>
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<table>
<thead>
<tr>
<th>Question</th>
<th>How many self referrals have you in your current caseload?</th>
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<tr>
<td>Answer</td>
<td>Self referral is only available in Dunfermline &amp; West Fife and at present this stands at approximately 70% (20% of which are electronic referrals). This has been in place for 10 years and it has shown that we also get a better referral straight from the patient. It reduces GP appointment time as they are not required to see the patient in order to make the referral</td>
</tr>
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<table>
<thead>
<tr>
<th>Statement</th>
<th>A survey needs to be completed for the current patient base and we need to learn from the experience of conducting this type of survey on the Barrie Street Clinic review.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statement</td>
<td>One CHP is given Fife-wide responsibility for Podiatry across Fife as per Mental Health Service. There are pros and cons to this – its easier to ensure equity but sometimes it difficult to get engagement from other CHPs.</td>
</tr>
<tr>
<td>Statement</td>
<td>I would prefer to attend a centre of excellence. There is a downside to this, members of the public also look for a community service, people in that local community think it is a loss of service to them.</td>
</tr>
<tr>
<td>Statement</td>
<td>There is also the issue for our staff working in undesirable facilities, isolation, not a pleasant environment it is difficult to recruit, e.g. Abbeyview Clinic – couldn’t recruit to this vacant post but when they moved to the new Lyneburn Clinic recruited instantly to this post.</td>
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<thead>
<tr>
<th>Question</th>
<th>What do you currently offer at St Andrews?</th>
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<tr>
<td>Answer</td>
<td>3 chairs but possibly could expand this service.</td>
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<td></td>
<td>In the past we have moved like for like service in new accommodation but in the future we would consider requesting additional space.</td>
</tr>
<tr>
<td>Statement</td>
<td>We are currently working with Estates and Dentistry to look at sharing accommodation. We have similar requirements and issues with access</td>
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</table>
to appropriate chairs, lighting and meeting infection control requirements.

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<tr>
<th>Statement</th>
<th>We are also looking at reviewing our working hours – starting earlier and finishing later. Our older patients not happy about coming in the evening but our working population would not have to lose time from work.</th>
</tr>
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<tbody>
<tr>
<td>Question</td>
<td>Are there clinics at Fair Isle?</td>
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<tr>
<td>Answer</td>
<td>Yes, but would prefer to move into Seaview as the accommodation at Fair Isle is not ideal.</td>
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</tbody>
</table>

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<thead>
<tr>
<th>Statement</th>
<th>We have seen the benefits of moving into one area, e.g. office accommodation we have 7 desks but these are accessed by 17 part-time members of staff.</th>
</tr>
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<tbody>
<tr>
<td>Question</td>
<td>Do you have similar issues in Glenrothes?</td>
</tr>
</tbody>
</table>
| Answer    | Kirkcaldy & Levenmouth CHP manages the service in Glenrothes, dates back to the times of the LHCC.  
We have a number of clinics in this area at Glenwood, Cos Lane, Pitteuchar, Leslie, Glenrothes Hospital and Thornton.  
But it has its own issues with incoming workers to this area everyone is reaching retirement at the one time. |

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<tr>
<th>Statement</th>
<th>We have more clinics in the Fife area than the whole of Edinburgh.(42 in Fife 20 in Edinburgh)</th>
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<tr>
<td>Statement</td>
<td>We need to show the benefits to any change – that is the key. We need to evidence that the quality will be better.</td>
</tr>
<tr>
<td>Statement</td>
<td>The whole of the NHS is driven by cost – its difficult - but the general public know we are under hard times.</td>
</tr>
<tr>
<td>Question</td>
<td>When you have thought about your questionnaire and have something in draft can we look at it for you?</td>
</tr>
<tr>
<td>Answer</td>
<td>Yes</td>
</tr>
</tbody>
</table>
| Question  | Question to PPF:  
Do you think it should be structured questionnaire or focus groups? |
| Answer    | Suggest you might want to do both – asking patients who complete questionnaire if they would interested in joining focus group. |

On behalf of the PPF Ron thanked Karen and Cheryl for the opportunity to discuss the proposals for the Podiatry Service.  
Cheryl and Karen thanked the PPF for their valued input to this consultation.
3. **PPF MEMBER RESIGNATION**

Ron read out a letter received from Graham Garvie tendering his resignation.

4. **ELECTION OF VICE CHAIRMAN**

Ron advised the Group that George Sime had indicated that he would be interested in becoming the Vice Chairman of the PPF.

David Balfour nominated George and it was seconded by Wilma Phillips. The Group unanimously agreed to the appointment of George Sime as Vice Chairman.

5. **CARERS EVENT ON 16TH JUNE 2011**

Julie reminded everyone about the event being held on 16th June 2011 at Lynebank Hospital to showcase the work that is currently going on within Fife to support carers.

If anyone is interested in attending a booking form should be sent to Julie as soon as possible.

4. **DATE AND TIME OF NEXT MEETING**

The next meeting will be held on 10th June 2011 at 2.00pm in Meeting Room 1, Cameron House, Cameron Hospital, Windygates.

**Distribution:**

Those Present
Alistair Black
Bill Campbell
Senga McLeod

**For info:**

Dr L Bisset
Mr G Cunningham
Mr A Robertson
MINUTE OF THE KIRKCALDY & LEVENMOUTH CHP
CLINICAL GOVERNANCE GROUP HELD on THURSDAY 17TH MARCH 2011 IN THE
BOARD ROOM, STRATHEDEN HOSPITAL

Present
Dr Les Bisset, Clinical Director Kirkcaldy & Levenmouth CHP (Chair)
Heather Bett, Clinical Service Manager, Sexual Health Service Fife
Moira Dunsiure, Podiatry Development Co-ordinator
Avril Eardley, Clinical Effectiveness Facilitator
Isabel Easson, Clinical Governance Manager
Janie Gordon, Head of Service, Dietetics
Fiona MacKenzie, Local Clinical Services Manager
Julie O’Neill, Risk Manager K&L CHP
Sally Tyson, Primary Care Development Pharmacist

In Attendance:
Karen Gibb, Manager, Long Term Conditions
William John, Public Health Pharmacist
Heather Shearer, Quality & Clinical Governance Lead, NHS Fife
Maureen Sullivan, P/A to the K&L CHP Clinical Director

1. WELCOME
Dr Bisset welcomed everyone to the meeting.

2. APOLOGIES FOR ABSENCE
Apologies were received from: Anne Callaghan, Nicky Connor, Jill Dow,
Heather Fernie, Barrie Higgins, Mhairi Leslie, Wilma Phillips and Dr Skelton

3. PREVIOUS MINUTES (26TH JANUARY 2011)
There were no amendments received so the minutes were confirmed.

4. MATTERS ARISING
4.1 Suicide Prevention Training Performance
Isabel Easson advised that a programme has been put together for front line
training for Mental Health nurses and details will go to the Mental Health
Clinical Governance Group. Dr Bisset requested that the MH Group look at
how effective this training is and Isabel Easson said that the training would be
concentrating on risk management and she will bring details back to the CHP
CG group at a later date.
5. CLINICAL GOVERNANCE

5.1 Hot Topic – Varencline Patient Group Direction (PGD) for Smoking Cessation Specialists in Fife

5.1.1 William John, Public Health Pharmacist and Karen Gibb, Manager for Long Term Conditions gave a presentation outlining their proposal for a Varencline PGD for Smoking Cessation Specialists (SCS) in Fife. A meeting is scheduled with G&NEF CHP in a few weeks to also discuss this proposal.

William John advised that NHS Fife would almost certainly not meet its HEAT (HEAT 6) target related to smoking cessation. The 4 week post quit data capture can only be recorded by practitioners in a specialist service and it is estimated that a large number of scripts written by GPs are not captured for HEAT targets.

The proposals brought to the Group would lead to a decrease in the patient journey as it would streamline the service and would also allow a freeing up of GP time but there are cost implications and the suggestion was put forward that although it would be for the CHP to decide how to fund, that top slicing the NRT budget was an option.

Risk Assessments have been carried out for both clinical and financial risks and a cost benefit analysis has been carried out in respect of each of the 3 CHPs.

K&L CHP was asked to endorse the introduction of a service for SCS to supply varenicline via a PGD bearing in mind the clinical and financial risk which would then enable the following key priorities to be delivered:

- Streamlined patient journey
- Increased specialist support leading to increases in HEAT 6 numbers

Dr Bisset expressed concerns re problems around accessing patient records and Karen Gibb advised that NHS Forth Valley have devised a tick list that the patient signs off.

Fiona MacKenzie queried if there was confidence that this proposal would make a difference in successful quits and Karen Gibb said she was confident that it would in K&L CHP.

Sally Tyson thought it would be good to start off with the use of specialist services and consideration could be given to expanding to pharmacy services at a later date.

Dr Bisset said there were 2 issues:

- Cost (against the GP prescribing budget)
- Access to patient’s notes (permission would be required in all cases and a one week delay would need to be built into the service)

Dr Bisset queried the position in relation to the other 2 CHPs and it was confirmed that G&NEF was in a similar position to K&L CHP but that in D&W that most were prescribers so the proposal would have little impact there.

5.2 K&L CHP Quality Improvement Annual Reporting
A paper was submitted to the Group for consideration in advance of the meeting which outlined the changes to the K&L CHP Clinical Governance Summary Reporting System. Isabel Easson and Avril Eardley had also prepared a presentation detailing the reporting options for measuring quality improvement in line with the Quality Strategy.

Quality Improvement Reporting provides an assurance to the CHP Clinical Governance Group and can also be used to inform the NHS Fife Clinical Governance Committee on identified strategic issues.

In the past the previous reporting systems were a combination of:
- Summary Reports
- Annual Reports
- Clinical Strategy Monitoring Process

A Quality Improvement Annual Reporting Template for each of the Managed Services and Hosted Services within the CHP was proposed which would encompass the 3 QIS quality dimensions of clinical effectiveness, patient safety and patient experience. The annual report would require each service to consider the quality improvements for their individual Services and identify at least one priority action area for each of the 3 quality ambitions during the year.

There were 2 options for the Group to consider as to how to take the process forward:
- **Option 1** – to keep the existing K&L CHP Clinical Governance reporting schedule for 2011-2012 for each individual Service
- **Options 2** – to combine the Quality Improvement Annual Report for 2011-2012 with the mechanism and timetable for the K&L CHP Clinical Strategy Monitoring Process introduced in 2010

Heather Bett said that not everyone was represented today but that she felt that it was better to report at the same time as she would be reporting on the Clinical Strategy. Fiona MacKenzie stated that she would like to take the proposals back to her Clinical Management Team as they were in favour of an annual reporting format. Dr Bisset agreed to write to the Services who were not in attendance today to remind them to comment on the proposals.

**Annual Reports**

Annual reports were presented as follows:

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<tr>
<th>ANNUAL REPORTS</th>
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<tr>
<td>Service</td>
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</tr>
<tr>
<td>Long Term Conditions</td>
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<tr>
<td>Community Nursing</td>
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**5.3**

**5.3.1**

After each presentation there was the opportunity for the Group to ask any questions of the presenter if they wished to do so.

**5.3.2**

The Kirkcaldy & Levenmouth CHP Clinical Governance Group **noted** the reports.

**5.3.3**

**Food, Fluid & Nutrition Annual Report**

This report has not yet been finalised and will come to the Group at a later date.

**Clinical Governance Collaboration – reply to CHP General Managers**
5.4 Isabel Easson advised that this report has gone forward but there has been no response as yet.

5.4.1 Information Governance

Fiona MacKenzie stated that this report has been adopted for all the Local Services and has now been brought to the Clinical Governance Group for the other CHP Services to consider if they also want to use it. Isabel Easson will look at how best to adapt it for the CHP and will bring recommendations to the next meeting.

6. CLINICAL EFFECTIVENESS

6.1 K&L CHP Joint Audit Summary

6.1.1 Two projects have been added to the Mental Health Register and there are now 184 projects on the register. Three projects have been added to the CHP Register and there are now a total of 149 projects on this register.

Details are listed relating to completed Audit Summaries and Isabel Easson advised that if no review date is shown then this means that no review is required.

6.2 NHS Fife QIS Update

6.2.1 Avril Eardley advised that as from April 2011 NHS QIS will be replaced by Healthcare Improvement Scotland. This body will take over the current responsibilities of NHS QIS and will also have responsibility for the regulation of independent healthcare – part of the role currently carried out by the Care Commission.

It has been agreed by NHS Fife Clinical Governance Steering Committee that the QIS HD reports will come to the relevant hosting Clinical Governance Group and will then be followed by action plans to address any recommendations. The action plans will be monitored on a 6 monthly basis by the relevant CG Group until all the actions have been completed.

The QIS Review of Sexual Health Services took place on 16/03/11 and Dr Bisset said that he felt that the visit went well. Heather Bett advised that a group was being set up to review baseline HIV standards and reports from the group will come to the CHP Clinical Governance Group for information.

7. RISK MANAGEMENT

7.1 CHP Risk Register

7.1.1 Julie O’Neill led the discussion on the Risk Register.

Risk 2655 – Fiona MacKenzie advised that the risk level has lowered and the register has been updated to reflect this.

Risk 1125 – Dr Bisset advised that a meeting had taken place on 11/03/11 between Rehab and Stroke Services to look at re-aligning the Rehab Service and this will go on to the Co-ordinating Group to take forward.

Risk 1137 – the CHP is not able to influence this directly but it remains a high risk.

Risk 2356 – Julie O’Neill stated that there were only 2 Services who still had to reply but in view of the proposal to roll out the Information Governance Procedure (item 5.4 refers) she proposed that this risk be closed. The Group agreed to close the risk.
7.2 CHP Annual Risk Management Report to SMT (draft)

7.2.1 Julie O’Neill advised that this is the report that George Cunningham takes to SMT and the draft is currently out for comment. The report outlines the key actions for patient safety for the next 6 months and any comments should be submitted to Julie O’Neill within the next 2 weeks. Julie O’Neill will also speak to Heather Fernie regarding submitting the final report to the CHP Committee.

7.3 CHP Risk Management Work Plan for 2011-2012 (draft)

7.3.1 Julie O’Neill has prepared the Work Plan around standards and strategy. She will be looking at the quality of the Services’ Risk Registers. There are 32 Services and at present only 4 need support with their Risk Registers.

Julie O’Neill said that it is proposed to look at a mechanism for learning from incidents. Dr Bisset queried if there was a mechanism for feedback on incidents that cross primary and secondary care and Julie O’Neill confirmed that there was nothing in existence at present but that she was currently in discussion with Ann Barnes and Anne Wilson to look at Tissue Viability Incidents from secondary care to primary care. Dr Bisset felt that a meeting with Isabel Easson/Julie O’Neil and himself would be useful so that they could discuss how best to take this issue forward to the NHS Fife Clinical Governance Steering Group.

If there are any comments on the draft Work Plan then they should be submitted to Julie O’Neill within the next 2 weeks.

7.4 Medication Incident Report

7.4.1 This report was brought to the Clinical Governance group for information and will be uploaded on to the Clinical Governance Map.

8. IM & T (eHealth) (Capacity)

8.1 E-Health Update

8.1.1 Fiona MacKenzie advised that there was nothing new to report.

8.2 CHP Website

8.2.1 There have been no items submitted for approval in the current period.

9. ORGANISATIONAL DEVELOPMENT (Learning & Development)

9.1 eKSF Update

9.1.1 The latest update was prepared for the eKSF Steering Group on 08/02/11 and showed the picture as at 31/01/11. Details are shown in Item 12.5 of this agenda in the Report to the eKSF Leads/Steering Group. K&L CHP showed that 37% of reviews had been completed by 31/01/11 but a lot of work has gone on since that date.

Fiona MacKenzie wished to record the effort staff have made to complete PDPs despite the issues faced over the winter. It was not felt that this was a good system as it was difficult for staff to use. Isabel Easson advised that it was intended to hold further training sessions in May and June.

9.2 Healthcare Support Worker

9.2.1 Isabel Easson said that there is now a Healthcare Support Worker standard and all staff who come under Agenda for Change who are non-registered (non-
professionally registered staff such as Admin, Catering, Porters etc.) are classed as Healthcare Support Workers.

There is a Work Book available and HR will issue to new staff when they come into the service.

10. **PATIENT FOCUS PUBLIC INVOLVEMENT**

10.1 **Service User Information Procedure**

10.1.1 Julie O’Neill has incorporated comments received and the procedure has been brought back to the Group for agreement. The K&L CHP Clinical Governance group duly agreed the procedure.

11. **PATIENT SAFETY PROGRAMME**

11.1 **Tissue Viability: CHP Action Plan**

11.1.1 As Anne Callaghan was not able to be present today this item has been held over to the May meeting.

11.2 **CHP Patient Safety Report for Patient Safety Implementation Group (PSIG)**

11.2.1 This report is due to go to the PSIG on 01/04/11 and has been brought to the CG Group for information.

12. **For Information/Noting**

12.1 Ombudsman’s Report for February 2011 – for noting

12.2 CE National Standards & Guidelines Update March 2011 – for noting

12.3 Departmental Clinical Governance Minutes

Dr Bisset originally advised there was a need to ensure that this Group’s review of CHP Departmental minutes were recorded. A record is now being kept of all minutes received and Dr Bisset advised that he was looking for groups to be having discussions at least 3 times per year.

Areas to be covered:

- Clinical Effectiveness
- Risk Management
- IM & T (eHealth)
- Organisational Development
- Patient Focus Public Involvement

Reports received as follows:

- Mental Health Directorate
  Includes: Addictions/CAHMS/Mental Health Services – minutes from 13/01/11 – for noting
- Dietetics – extract from minutes of meeting on 17/11/10 – for noting
- Rheumatology – minutes of meeting on 04/03/11 – for noting
- e-KSF Steering Group Minutes from 18/01/11 – for noting.
  Report to eKSF Leads/Steering Group 08/02/11 – for noting

13. **ANY OTHER COMPETENT BUSINESS**

13.1 1. Julie O’Neill advised that the Participation Standard has now been submitted to the Scottish Health Council. The work next year will be around Carers and Complaints.
2. Maureen Sullivan said that due to a clash with the Clinical Governance Steering Group that the meeting originally arranged for 23/11/11 had now been rescheduled to 24/11/11.

3. Dr Bisset asked the Group for their views on the venue for future meetings and it was agreed that meeting Room 1 at Cameron House had proved suitable for the meeting in January and was preferable to the majority of members travelling to Stratheden. It was agreed therefore that the May meeting would take place in Cameron House.

14. **DATE OF NEXT MEETING: 2.45 PM ON WEDNESDAY 11TH MAY 2011 IN MR1, CAMERON HOUSE**

**DISTRIBUTION**

Dr L Bisset, Clinical Director, Cameron House  
Mrs Isabel Easson, Clinical Governance Manager Kirkcaldy & Levenmouth CHP  
Mrs. Heather Bett, Clinical Services Manager, CASH/GUM Forth Park  
Ms Barbara Anne Boyter, Head of Human Resources, Hayfield House  
Mrs. Anne Callaghan, Lead Nurse, Older People, Cameron Hospital  
Mrs. Nicky Connor, Lead Nurse Community Nursing  
Mr. George Cunningham, General Manager Kirkcaldy & Levenmouth CHP  
Mrs. Jill Dow, Head OT, Older People Services Cameron Hospital  
Mrs. Moira Dunsire, Podiatry Development Co-ordinator  
Mrs. Avril Eardley, Clinical Effectiveness Facilitator Kirkcaldy & Levenmouth CHP  
Mrs. Heather Fernie, Business Manager Cameron House  
Dr Harris, Consultant, Rheumatology Cameron Hospital  
Mr. Barrie Higgins, Facilities Manager  
Mrs. Janie Gordon, Dietetics & Nutrition Pentland House  
Ms. Mhairi Leslie, Physiotherapy Services  
Mrs Fiona MacKenzie, Local Clinical Service Manager Cameron House  
Mrs Julie O’Neill, Risk Manager, Kirkcaldy & Levenmouth CHP Cameron Hospital  
Mrs Wilma Phillips, PPF Representative  
Mrs. Mary Porter, Head of Nursing, Cameron House, Cameron Hospital  
Dr Carol Skelton, Fife Rehabilitation Service, Cameron Hospital  
Mrs. Sally Tyson, Primary Care Development Pharmacist, Loughborough Road Clinic

GP, vacant

Copied for information to:

Simon Fevre, Staff Side Representative
Fife Health & Wellbeing Alliance – Note of Meeting
9th March, 2011

Note of Meeting held on 9th March at 2.00 pm, Committee Room 3, Fife House

Present: Jim McGoldrick (Chair), Moira Adams, George Brechin, Tim Brett, Vivienne Brown, Fiona Grant, Steve Grimmond, Neil Hamlet (on behalf of Eddie Coyle), Bryan Kirkaldy, Bryan Poole, Fiona Purdon, Dave Stewart.

In Attendance: Carole Patrick, JHIP Funding Group
Fiona Scott (minutes).

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<tr>
<th>Agenda Item</th>
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<tr>
<td>1. APOLOGIES</td>
<td>Apologies were received from Kay Barton and Eddie Coyle.</td>
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<tr>
<td>2. CHANGES TO MEMBERSHIP OF FHWA</td>
<td>JMCG welcomed new members Moira Adams and Fiona Purdon who have recently been elected to Fife NHS Board.</td>
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### 3. MINUTES OF LAST MEETING

The minutes of the meeting held on 8th September were agreed. The December 2010 meeting was cancelled due to bad weather.

### 4. MATTERS ARISING

**Links with SDHI**  
No update

**Report on Obesity**  
The national action plan on obesity is still awaited. A local report will be provided to FHWA when this becomes available.

**Equally Well**  
Equally Well now has funding for a third year. There will be both a national evaluation of Equally Well and a local evaluation of the Fife test site.

An Equally Well update report will be provided to the Alliance in June.

**Health Works**  
NHS Fife has three named senior managers responsible for the different delivery elements of Health Works.

NHS Fife is continuing to work closely with colleagues working around employability. Future reports will be provided to both FHWA and the Opportunities Fife Partnership.

**Third Sector Strategy Group**  
VONEF, Volunteer Centre Fife and CVS Fife will come together as the Third Sector Interface in Fife. Work to progress this is on-going and it is hoped that the interface will be in place by September.

A Third Sector Strategy Group has also been set up and has met once.

### 5. HEALTH & WELLBEING PLAN 2011-14 – FINAL PLAN FOR APPROVAL

#### 5.1 Approval of content

Steve Grimmond presented the proposed Health & Wellbeing Plan 2011 – 14. It was noted that this version had incorporated comments from the seminar held with members of the Alliance in February.

Discussion followed and the following points were clarified.

- A list of relevant indicators linked to the 10 outcomes will be available on healthyfife.net. These are not all new indicators - most were used for the last JHIP and information has been collected over several years. Baseline information is therefore available for most, but not all indicators. Information will be updated healthyfife.net as it becomes available.
The outcomes in the plan are aligned with other partnership strategies and plans where applicable.

A list of all the main partnerships involved in implementing the plan will also be available on healthyfife.net, with a statement outlining their specific commitment to progressing the plan.

It is the responsibility of FHWA, through the Co-ordination Group and the JHIP Development Group, to ensure partnerships and partners work together to progress the outcomes of the Health and Wellbeing Plan.

FHWA members approved the content of the Fife Health & Wellbeing Plan 2011-14.

5.2 Proposals for next steps
There was discussion around launching and distributing the plan.

As the new Fife Community Plan 2011-21 is due to be launched within the next three months it was decided that a major launch event for the new Health & Wellbeing Plan would not be appropriate.

A variety of existing avenues, such as committee and partnership meetings and local forums- along with specific workshops will be used to disseminate the plan.

In line with this approach, a facilitated session - bringing together key partnerships with members of FHWA to discuss delivering the outcomes of the plan - will be arranged for the early summer.

FHWA members remitted to the Co-ordination Group and the JHIP Development Group to organise a facilitated session for FHWA and supporting groups and key partners.

Including a programme of ongoing connections or conversations with other partnerships should be incorporated into the Alliance work plan.

Jim McGoldrick thanked everybody involved in the development and writing of the new plan.

6. FHWA FUNDING ALLOCATIONS 2011-12
Carole Patrick outlined the key points from the paper on Funding Allocations 2011-12.

There is a 5.4% reduction of FSF and HIF funding available to FHWA for 2011/12.

Any proposed changes to project allocations have been discussed with the projects and strategy groups to ensure these will not impact on delivery over 2011/12.

The Community Food Project’s FSF allocation 2011/12 is reduced in
response to underspend two years running, mainly due to staffing vacancies.

Funding reserves will be used to progress activities in line with the outcomes of the Health and Wellbeing Plan 2011-14 and to commission evaluation of some of the current initiatives.

Members of FHWA agreed FSF allocations for 2011/12 as outlined in paper.

Members of FHWA agreed £100,000 of the HIF budget be returned to NHS Fife’s core budget to support smoking cessation work in Fife, with no future FHWA funding allocation for tobacco issues work in Fife.

HIF funding for 2011/12 as outlined in the paper was agreed.

The Choose Life allocation to NHS Health Promotion Fife for mental health training programmes was agreed, as outlined in the paper.

Members of FHWA remitted to the Co-ordination Group to allocate any 2011/12 reserve on behalf of the Alliance.

The issues outlined in section 6 of the report were noted:-

- the significant amount of FHWA funding currently being used for posts across sectors - some providing effective front-line services to vulnerable groups
- the need to balance future funding of these long-term projects with the need for FHWA to have resources to progress innovative approaches to achieving the outcomes of Fife Health and Wellbeing Plan 2011-14
- the need to strengthen links, improve communication and share information around funding with other key partnerships

It was noted that the amount of work required resolve these funding issues over the next year may be beyond the current capacity FHWA has to manage its funding. There is need to either prioritise the work load or find resources from another source.

The Co-ordination Group and its funding sub group were remitted to address these issues, including the issue of capacity around the level of work required during the transition year.

It was also noted that more clarification is required on the status of these funding streams beyond March 2012.

It was confirmed that HIF ring-fencing was withdrawn a number of years ago but NHS Fife retained this budget, managed by FHWA, for health improvement work. There is no proposal to change this situation.

The Funding Group will provide a Funding Report for 2010 – 11.
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<td></td>
<td>It was noted that Fife’s Community Plan 2011-21 has been signed off by Fife Partnership Board.</td>
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8. **Any Other Business**  
   None.

9. **Date of Next Meeting**  
The date of the next meeting is Wednesday 15th June 2011 at 2pm in Committee Room 1, Fife House.