NHS FIFE

LOCAL DELIVERY PLAN 2017-2018: A TRANSFORMATIONAL APPROACH for HEALTH & SOCIAL CARE DELIVERY

1. Context

Demands on health and care services are changing. Demographic shift, increasing complexity of need and public expectation are driving these changes within a context of a challenging financial position and difficulties in the recruitment and retention of staff. These challenges contribute to the significant pressures being experienced across the health and care system.

Services must continue to evolve to meet ongoing demand, deliver new models of care and treatments and to fully utilise the opportunities that technology and innovation present. Radical thinking to ensure best use of shared resources (people, buildings and information) is needed.

Ambitious and successful strategic planning, service transformation and delivery will require colleagues from NHS Fife, Fife’s Health and Social Care Partnership (H&SCP) and other key partners to work together to implement joint strategic objectives.

2. Policy/Strategic Drivers

Building on the national Clinical Strategy (Feb 2016), the Health & Social Care Delivery Plan (Dec 2016) sets out the high level aspirations of the plan:

- Focus on prevention, early intervention and supported self-management with minimal hospital stay
- Enhance integration to help people live better for longer at home or in a homely setting
- Evolve models of care incorporating new approaches, treatments and technologies
- With investment there must also be reform so there must be a bringing together of work
- Develop collaborative models at pace
- Ensure quality, safety and person centred care are maintained

It also outlines out the ways in which the plans will be delivered as follows:

- Better Care – working with people to provide the care they need at the right time and place with their input. Help people to anticipate their needs and plan accordingly and develop capacity in our community to support the changing needs of the population.
- Better Health – we need to move away from a ‘fix and treat’ model to one based on anticipation, prevention and self-management. Join with social care, education and others to tackle the issues that lead to ill health.
- Better Value – our approach must shift to one of seeking value – i.e. the best outcomes for our investment. A critical factor in this is developing community resource to reduce demand in hospitals and therefore beds. By reducing demand for beds we will be able to use the resource more effectively in our communities. We need to use data and a quality improvement approach to ensure we get and maintain value in terms of outcomes.
• Health & Social Care Integration – through more integrated working create capacity in the community which will reduce hospital demand and in turn delayed discharges and improve the adult social care sector.

• National Clinical Strategy - This provides strong themes around strengthening community care and capacity, reducing avoidable secondary care demand and ensuring services are delivered in the most appropriate and effective place in terms of experience, outcomes and value. Of equal significance is the concept of ‘realistic medicine’ – a more pragmatic approach which helps people make more informed choices based on outcomes and what matters to them.

• Public Health Improvement - Scotland has significant issues with social – cultural factors from lifestyle behaviours which we need to influence through comprehensive and sustained initiatives.

• NHS Board Reform – there needs to be a focus of National (Once for Scotland) and Regional Collaboration and Service delivery. A key opportunity is in the development and evolution of regional planning to find more effective and sustainable services at lower costs.

• Cross Cutting actions – in addition there are a number of other initiatives such as ‘Getting it Right for Every Child’ which looks to capitalise on early life interventions having the greatest impact for health, education and economic issues. Other cross cutting issues includes digital transformation and application, resilient workforce planning and a robust approach to public and staff engagement and communication.

3. Transformation of Services

NHS Fife Board and the Integration Joint Board have acknowledged these ambitious planning goals and have committed to a local and regional transformational approach to enable clinical and financial sustainability. The local infrastructure in conjunction with support from National Services Scotland (NSS) provides a unique opportunity for an accelerated, co-ordinated, focused approach which will support and drive corporate objectives.

The imperative for service transformation has been universally agreed and supported. New service models delivered by effective partnerships will ensure seamless, integrated and sustainable services for the people of Fife.

The goal of this work is to enable the development of a needs and value based approach to service development and provision with a focus on supporting people to remain well at home whenever possible. This can also be considered to be the right care being provided in the right place, by the right person, at the right time. This will require people to be assessed, treated and supported in the community wherever possible and only admitted into hospital when clinically necessary. If admitted, discharge will be as soon as possible to home or a homely setting, with appropriate support when required.

3.1. Transformation Programme

The joint strategic priorities from Fife’s Health and Social Care Strategic Plan and NHS Fife’s Clinical Strategy are in line with the National Clinical Strategy, the Health & Social Care Delivery Plan and are underpinned by the principles of person-centeredness.

We have therefore established a Joint Strategic Planning approach which will oversee our transformation plans (appendix 1). The programme incorporates service transformation to support changing needs and demographics of our population, the skill and age of our workforce and potential for new ways of addressing need through the use of digital solutions. Pulling together
the challenges and opportunities across the health and social care landscape, the following priorities (in line with the H&SC Delivery Plan) are considered to be the key areas for initial focus:

Key Joint Strategic Areas of Focus:

- Prevention, Early Intervention, Health Promotion and Improvement
- Integrated and Co-ordinated Care
- Improving Mental Health and Wellbeing
- Reducing Inequalities
- Acute Service Redesign
- Community Service Redesign

Cross cutting issues include the need to redesign our workforce and estate, the role of the 3rd sector, public engagement and education, out of area placements and consideration of the regional, national and political dimensions including key strategic documents such as the Ritchie Report and other national work due to report in 2017, for example, the Review of Maternity and Neonatal Services and the National Health and Social Care Workforce Plan.

There is therefore the potential for real benefit through a collaborative approach to achieve our joint transformational objectives, at pace, while maintaining safe, effective, person-centred care. This therefore requires a new structure and approach which brings these challenges together into a collaborative programme (appendix 2).

3.2. Approach - IMPACT (IMprovement, Planning And Change Team)

NHS Fife has established IMPACT - a small internal business unit which provides focused, co-ordinated, ‘client’ tailored support in terms of project management, data analytics, quality improvement, clinical governance, planning, communications and organisational development.

IMPACT will be pivotal in supporting and accelerating the delivery of transformational change to enable sustainability. The focus for the team, along with Finance and eHealth, is the delivery of the strategic objectives and joint strategic priorities alongside the financial efficiencies agreed within the Local Delivery Plan (LDP) and the relevant parts of the developing Regional LDP.

3.3. NSS/ISD

NHS Fife is undertaking work with NSS and ISD as part of a tailored support package to accelerate the management capacity and systems to provide a structured approach including commissionable resource allocation and audit trails. Data Analytics are being used to identify variation and opportunity and to monitor progress.

4. Strategic Transformational Plans

4.1. Local Transformation Plans

The work falls broadly into three categories:

- Community Redesign
  - Including the development of Localities and GP Clusters
  - Community Hospital Redesign
  - Out of Hours Redesign
  - Mental Health Services redesign
  - Community Hubs; Development
4.2. Developing Regional Transformation Plans

The changing demographics of Scotland in conjunction with workforce and economic pressures create a significant challenge for the sustainability of a safe and effective healthcare system for NHS Scotland.

In parallel with each Boards LDP plans for 2017/18, it is recognised that there is a need to develop a joint regional Sustainability and Transformation Plan/ Regional DP focused on areas where there are critical issues requiring regional collaboration and redesign which will enable service sustainability, quality and safety at lower cost.

The direction of travel outlined in the Clinical Strategy and the actions contained in the Health and Social Care (H&SC) Delivery Plan in conjunction with the financial and service sustainability challenges requires the current regional model of working to evolve. The new East of Scotland Regional Planning Group must become more transformational, agile and collaborative in approach with clear authority, scope, objectives and governance.

There is a need to design the new regional approach to service planning and delivery to achieve this outcome within the required timescale and to create an infrastructure which will drive and deliver its objectives. A clear principle underpinning this work should be to ensure equity of access to services across the region. A proposal for purpose, output, strategic oversight and project delivery, describing a fresh strategic methodology focused on sustainable performance, transformation and variance reduction as a vehicle for clinical and economic sustainability is currently being developed by SEAT.

This proposed change will:
- Provide an infrastructure which enables the development of regional transformation and sustainability at pace
- Ensure appropriate connections between planning, performance, finance and outcomes
- Develop a Regional LDP for East Scotland by August 2017
- Establish an infrastructure to monitor and drive program delivery
Local and Regional Delivery Plans recognise the work of the National Clinical Strategy, the Health and Social Care Delivery Plan and Realising Realistic Medicine.

5. **Safety and Person-Centredness**

5.1. **Safety**

The NHS Fife Strategic Framework outlines that at the heart of everything we do is the value *Safety First*. There are a number of specific objectives which support the delivery of clinical excellence and safer care within the Strategic Framework. They are:

1. Ensure there is no avoidable harm
2. Achieve and maintain recognised quality standards
3. Embed patient safety consistently across all aspects of healthcare provision

The priority areas for improvement activity for the Board in 2017/18 and for the Health and Social Care Partnership align directly to the national Scottish Patient Safety Programme (SPSP) core themes and have been identified as:

- Medicines Reconciliation
- High Risk Medicines
- Deteriorating Patient
- Falls
- Pressure Ulcer Care
- Healthcare Associated Infection
- Clearly identified system enablers – Supporting patient infrastructure, use of data, co-ordinated education, learning and training sessions across staff groups

5.2. **System Enablers**

5.2.1 **Patient Safety Infrastructure**

We will continually and systematically review our working processes to prevent and reduce harm. In order to achieve this, an SPSP Stakeholder Group has recently been established to ensure the SPSP programmes are implemented across Fife. The purpose of this group is:

- To provide governance to the programme strands of the Scottish Patient Safety Programme
- To ensure that key performance indicators are reached within the expected timeframes
- To ensure that each SPSP strand has clear reporting and escalation processes
- To provide a forum for the sharing of best practice

This group will meet bi-monthly and is chaired by the Board Medical Director. Each programme or priority area will have a team/group to progress implementation.
This stakeholder group will:

- Deliver a comprehensive report for each programme strand and priority improvement area. The report will contain the following information:
  - Performance and progress against the aim of the programme
  - Spread plan for each programme
  - Highlight areas of improvement activity and interventions
  - Areas where any tests of change or prototyping may be taking place whether that is local or participation in national work
  - Reasons for current performance and any actions to be taken to improve or share good practice

- Report to the Clinical Governance Committee and Clinical & Care Governance Committee through a Quality Report and to the Health Board and Integration Joint Board through a Performance Report.

5.2.2 Performance Management

Effective use of data and robust local assurance systems for the SPSP programmes to inform improvement monitoring and reporting will remain at the core of our activity. In addition to the Priority Actions outlined above, relevant measures will be used at appropriate levels to monitor and assess progress.

Regular monitoring will take place at a range of levels from front line, through Directorate and Divisional Performance Reviews to Clinical and Clinical and Care Governance Groups and Committees. This will be achieved through use of dashboards and by ensuring data is core within all reports and activities.

5.2.3 Training and Education

A co-ordinated approach will be taken to combine training and education sessions across programmes and staff groups. This will ensure that patient safety is approached from a broader perspective and not just by individual Programme. The development of skills in Quality Improvement methodologies, using these and other available data and the application of these to the provision of safe care, will be supported through the work of IMPACT (Improvement, Planning and Change Team).

We remain committed to providing the highest quality care to our patients and believe that patients should be cared for in environments which minimise risk and therefore our commitment is to build upon some of the successes achieved to date through the implementation of the Scottish Patient Safety Programme.

For 2017-18 we will continue to:
- Maintain the improvements made in HSMR within acute hospitals through co-ordinated implementation of the actions known to reduce harm to ensure the delivery of safe care consistently. This will include a focus on the management of the deteriorating patient. We will continue to embed the technology platform, Patientrack, to enhance the safety of care and reduce cardiac arrest.
• Spread the learning from the acute workstream and in light of the changes to the HSMR calculation, spread this work to community hospitals. Discussion has already taken place with NHS National Service colleagues to explore making data on community inpatient areas available to our Health & Social Care Partnership in order for numbers of deaths to be monitored. HSMR will be reported through the Partnership Clinical and Care Governance structures to drive improvements within the system.
• Learn when outcomes are not always as anticipated or planned and refine and improve the management of adverse events ensuring this is fully integrated with other work to improve patient safety.
• Ensure safe use of medicines becomes a core strand of work commencing with review of current policy and procedures. This will be accompanied by communication, training and education for staff to support implementation. A complete audit programme will be developed to ensure continual improvement and compliance.

5.3 Person Centredness

The NHS Fife Strategic Framework is explicit in outlining person centred as a foundation to providing safe and effective care. The ‘Must Do with Me’ principles form the basis of the universal tool used in NHS Fife to capture patient experience, “Your Care Experience”. In 2017/18 the focus will be on the spread plan to ensure the Board has statistically robust data to demonstrate patient experience data. Hand in hand with this will be a focus on related improvement activity. The Excellence in Care programme of work will support this.

Patient Opinion is recognised as a valuable method of capturing the experience of people accessing Health Services in Fife. Patient Opinion is embedded in daily business in a number of Services and there is robust evidence to demonstrate an increase in the number of stories posted and an increase in the number of clinical staff responding directly. In 2017/18 the plan is to promote the spread to areas not actively promoting Patient Opinion. The shift from Patient Opinion to Care opinion in May 2017 will provide an opportunity to capture stories across Health and Social Care and support more collaborative working.

A Participation and Engagement Strategy has been developed across Health and Social Care, in collaboration with a wide range of stakeholders, including members of the public. The Strategy outlines the Board’s approach to actively seeking involvement of patients/carers/members of the public in all aspects of business. The Participation Standard will be used as a measure to determine the effectiveness of the approach being taken by the Board. The Strategy has been developed in tandem with Our Voice to support the national approach.

NHS Fife is committed to providing a person centred complaint handling process which is flexible to meet the needs of individuals. By using the What Matters to Me approach and promoting early dialogue with people it is possible to identify what is important to the individual raising the complaint and to work towards meaningful resolution. NHS Fife was one of two pilot sites testing the new model complaint handling procedure in advance of implementation in April 2017 and has developed a questionnaire to seek feedback from those using the complaints procedure. In 2017/18 work will be undertaken to integrate complaints and complaint handling practice across health and social care.
6.1 Acute Services Division

6.1.1 Planned Care

The local delivery planning guidance sets out a number of standards which relate to scheduled care for 2017/18. During 2017/18, Boards will need to assess activity requirements locally and regionally, to ensure the best possible performance against elective waiting time standards as well as ensuring the optimal design, configuration and availability of services in the context of an ageing and growing population.

In 2016/17 NHS Fife focused on sustaining improvements in diagnostic, outpatient and inpatient/day case waiting times, all of which have a significant impact on supporting waiting times standards, particularly 18 weeks RTT and cancer. A demand and capacity plan was developed, indicating that there was a projected gap of 9% in new outpatient and 8% gap in inpatient/day case activity within the current service configuration.

**During 2016/17**

- There has been a continued focus on complying with TTG which is a legally binding guarantee. Whilst performance against this standard improved in Quarter one it has proved challenging to maintain this due to vacancies in key clinical posts and availability of beds over the winter period.
- NHS Fife maintained zero patients waiting over 6 weeks for endoscopy; however performance for the key radiological tests has varied throughout the year due to increasing demand and vacancies in key clinical posts.
- The number of outpatients waiting over 12 weeks improved significantly to a position of under 500 in Quarter one from a position of over 3000 in September 2015 and has been sustained under 900 with the majority of patients waiting over 12 weeks being in Neurology.
- Cancer performance against the 62 day standard has remained variable throughout the year. The standard pathways are being reviewed to identify improvements. Performance for 31 days has been met with the exception of Quarter two.

**2017/18**

NHS Fife’s Clinical Strategy has described a future model for integrated healthcare delivery and made recommendations for future service provision. The outputs from the Clinical Strategy are informing the ongoing scheduled care and cancer service planning and delivery.

The capacity and demand plan has been updated for 2017/18. It shows a gap of 3% in New Outpatient, a 10% gap in Inpatient / Day case and a 13% gap in Radiology diagnostic activity within the current configuration of services.

The NHS Fife Scheduled Care Board oversees the NHS Fife projects/work streams which aim to manage and improve scheduled care and cancer activity and services. These are outlined in the diagram below.
Scheduled Care Board Projects/Workstreams

This structure provides a focus to ensure that the key elements are aligned to the delivery of improved performance against the standards, sustainability of services into the future and that there is appropriate governance around delivery of improvements.

**Key Priorities for 2017/18**

- Review the Demand and Capacity tables to identify activity required in 2017/18 to support the delivery of outpatient, diagnostic, TTG and cancer standards in the context of the requirement to make significant savings
- Use the output from detailed Demand and Capacity and align this with regional elective work to enable improved day to day operational management and longer term strategic plans for at risk elective, diagnostic and cancer services
- Identify optimal design of at risk elective, diagnostic and cancer services including options for reconfiguration at local and regional level
- Undertake a robust bed modeling exercise for the Victoria Hospital, Kirkcaldy
- Deliver recommendations for improvement from the optimising surgical efficiency project. This will be monitored through discussion of theatre performance metrics at monthly Theatre Advisory Group meetings. Pre-assessment review and redesign will be a key area of work
- Focus on delivery of improvements identified in the national Modern Outpatient: A Collaborative Approach programme and local benchmarking work to reduce duplication and variability.
6.1.2 Emergency Care

Overview

The LDP Emergency Access standard is for 95% patients to wait less than 4 hours from arrival to admission, discharge or transfer for accident and emergency and as a stretch target we should move towards 98%.

The performance overall against this for NHS Fife in 2016 (Acute Hospitals and for VHK only) is shown below:

![ED Attendances/4 Hr Performance Graph]

6.1.2.1 National Unscheduled Care Programme: Preparing for Winter 2016/17

This national guidance DL (2016)18 continued to focus on integration, improving delayed discharge and the six essential actions Improvement Programme.

Boards were asked to take a balanced approach to the effective planning and scheduling of elective and unscheduled care activity.

Priorities

Service models in Fife continue to be developed within this Framework. The work undertaken in the 6 Essentials Programme in Fife during 2016/17 is:

**Essential 1 – Clinically Focussed and Empowered Hospital Management**

- Designated site management now in place for Victoria Hospital and Queen Margaret Hospital
- On-Call Senior Manager scheme is in situ (7 day support)
- 24/7 Clinical Co-ordination in place on the Victoria Hospital with embedded escalation processes
• Daily contact with colleagues in Health & Social Care to ensure efficient flow and weekly monitoring of action plans

**Essential 2 – Hospital Capacity and Patient Flow (Emergency and Elective Realignment)**

• An exemplar Safety Huddle continues on both acute sites. The main focus is on patient safety, safe staffing levels and a plan for capacity for the forthcoming 24 hour period

**Essential 3 – Patient Rather than Bed Management – Operational Performance Management of Patient Flow**

• A developing model of “pull through” to downstream wards
• Additional Acute Physician support in the Admission area and in ED when necessary
• Morning discharges are encouraged with timely transfer of patients to the Discharge Lounge
• A Transport Hub is currently being put in place

**Essential 4 – Medical and Surgical Processes arranged to improve patient flow through the Unscheduled Care Pathway**

• A “decision tree” has been developed with GP colleagues to clarify advice available and services that can be referred to or seek clinical advice from
• Assessment area within the Acute Admissions Unit (AU1) to provide timely assessment and triage of patients. The Assessment Unit continues discharging 30% of patients on the day of admission
• The Ambulatory Care Service has been enhanced to accommodate a wider range of interventions and provide an alternative to hospital admission

**Essential 5 – Seven Day Services appropriately targeted to reduce variation in weekend out of hours working**

• Additional Acute Physician support at weekend
• Frailty Team on site 7 days
• Additional Pharmacy support at weekends

**Essential 6 – Ensuring patients are optimally cared for in their own homes or homely setting**

• New homecare models being developed at front door and ward level
• Direct access to acute wards for “restart” homecare packages
• Hospital at Home services is optimised to prevent admission to hospital and support early discharge for patients to ensure that they are cared for in their own homes
Moving forward into 2017/18 and following a detailed evaluation of our Unscheduled Care performance during 2016/17, further redesign and augmentation of key services are expected to focus on the following:

- Review of AHP support in the acute setting to focus on a ‘Discharge to Assess’ model
- Development of an urgent care model that works in tandem with “minors” in our Emergency Department
- Improving flow by maximising our “pull through model” and by focussing on a reduced length of stay across all our specialties
- To support the above working directly with clinicians to discuss variability in practice in each specialty, working with both local and national data

5.4 Health and Social Care Partnership

5.4.1 Increasing Healthy Life Expectancy

Latest information (2009-2013) shows women in Fife have a Healthy Life Expectancy (HLE) of 65.4 years, very similar to that for women across Scotland (65.3 years). For men, the figure is slightly lower at 63.2 years but again is similar to that for the whole of Scotland (63.1 years).

We know there are marked differences between those living in our most and least deprived communities, those experiencing difficult life circumstances and vulnerable population groups such as those who are homeless, having caring responsibilities and are geographically or socially isolated. Additional factors include not being in education, training or employment, claiming out of work benefits or experiencing in-work poverty, being a lone parent, suffering from gender based violence or abuse, being a ‘looked-after’ young person or care leaver, experiencing mental health problems or having substance misuse and addiction issues.

NHS Fife is working with its own staff and those in Fife’s Health and Social Care Partnership, Fife Council, in Voluntary sector organisations and with the population as a whole to improve healthy life expectancy of the people of Fife.

5.4.2 Improvement actions for 2017-18

NHS Fife will continue its commitment to achieve the 6 outcomes of Fife’s Health Inequalities Strategy, Fairer Health for Fife and support implementation of priority recommendations identified within Fife’s anti-poverty report Fairness Matters. This will include working with Opportunities Fife to rebalance employability programmes to primarily focus on those with mental health problems and to develop a clear focus on health and employment, to increase employability capacity and sustain employment for these people.

Because of its impact on improving Healthy Life Expectancy, NHS Fife will continue its commitment to being a Health Promoting Health Service (HPHS) focusing on smoking cessation, active travel, prevention of harmful drinking, promotion of breastfeeding and physical activity. The HPHS framework is firmly aligned to NHS Fife’s Clinical Strategy and the Fife Health and Social Care Partnership’s Strategic Plan where early intervention and prevention feature significantly. Staff
health is closely aligned with this HPHS work to fulfil the ambitions set out in Fife’s Well at Work (Healthy Working Lives) programme.

**Approach to Ensuring Fife Alcohol and Drug Partnership delivers agreed service levels**

Fife’s ADP Committee funds a number of partner organisations. Each organisation has a service brief and a service level agreement which details expectations of service delivery and outcomes. These are monitored via the H&SC Partnership's Quality Assurance Unit.

In 2016/17 all services were reviewed by Fife's ADP commissioning group, with focus on performance, outcomes and efficiencies in 2017/18. Some reshaping was identified together with efficiencies realised as a result.

Fife's ADP Committee reports annually to the Integration Joint Board and Community Planning Partnership. The 2015/16 report received very positive feedback from the Scottish Government particularly in relation to successful alcohol brief interventions delivery, increasing the reach of the naloxone programme and well defined governance and accountability routes.

**5.4.2.1 How will improvements be measured?**

There are a range of indicators that are proxy measures for improving health and wellbeing and reducing health inequalities which are linked to *Fairer Health for Fife*. These include long term indicators taken from the national indicators for health inequalities and a range of intermediate indicators that measure health and wellbeing over the life course, by SIMD quintile annually. Progress is reported annually to the Fife NHS Board, the Integrated Joint Board (IJB), Fife’s Health and Wellbeing Alliance and Fife’s Partnership.

**5.4.3 Prevention in Early Years**

Fife has a multi-agency *Early Years Strategy* which outlines key actions to improve outcomes in the early years. In Fife, the IJB leads on services for children and young people’s health and manages community child health services. This is facilitating better Fife wide planning and management of services whilst NHS Fife is linked strategically to the partnership’s Children in Fife Group. The Early Years Strategy sits within this structure.

The Women and Children’s workstream of the NHS Fife Clinical Strategy has identified areas for prevention and early intervention starting with pre-conception. Specific preventive programmes include Vulnerability in Pregnancy for substance misusing women, Family Health Midwives for those in vulnerable social circumstances and Family Nurse Partnership nurses for first time mothers under the age of 20. The Family Nurture Approach provides centres in areas of greater need where enhanced family support is offered to vulnerable families. Other preventive programmes include Childsmile for dental health.

The Fife Child Protection Committee oversees processes for children in need of additional protection.
5.4.3.1 Current challenges

The Children and Young people Act 2014 and the Getting it Right for Every Child (GiRFEC) approach are in the process of being implemented including further work to clarify information sharing provisions for the ‘named person’.

There are workforce challenges in key services such as midwifery, health visiting and community paediatrics and service redesign is required moving forward. New Health Visitor posts have been created and the new pathway will be implemented in the coming months.

Smoking at booking in Fife is 20.9%, the highest in Scotland and maternal obesity is also high. These increase the risk of stillbirth, infant mortality and maternal health problems. Anti smoking messages need to be targeted at 13 -15 year olds in line with the Tobacco Free Generation commitment made by NHS Fife. Further information on smoking is provided below.

Inequalities and poverty affect children’s health and life opportunities. Progress is being made to streamline the health assessment process for looked after children and improve processes for adoption or permanent placements where relevant.

Breastfeeding rates have been relatively static and further work is needed to better support women to make this choice and to re-introduce breastfeeding as a cultural norm in some areas.

5.4.3.2 Improvement actions for 2017-18

NHS Fife is a contributing partner in the development of a new Children’s Services Plan, which will include elements of Prevention in Early Years. The Children’s Services Plan contains domains relevant to health which includes healthy weight, breastfeeding and mental and emotional wellbeing, smoking and harmful substance use, as areas for improvement.

The previous plan contained an indicator to reduce pregnancy in the under 16 year olds. The target has been met.

5.4.3.3 How will improvements be measured?

Indicators in the Children’s Services Plan health domain are likely to include:

- Increasing the proportion of children in P1 categorised as being of healthy weight
- Increase the percentage of children exclusively breastfed
- An indicator relevant to Children and Adolescent Mental Health (CAMH)
- An indicators on substance use and smoking at age 13-15

6.2.4 Smoking Cessation

The main focus of NHS Fife’s Smoking Cessation is on the 40% most deprived communities where smoking prevalence is highest. The LDP standard is to sustain and embed successful quits, at 12 weeks post quit, in the 40% most deprived areas. The national target is to achieve at least 9400 successful quits per annum, at 12 weeks post quit. To date Fife has recorded779.

For the second quarter data period (April to September 2016) Fife’s overall performance against the annual target was 28% (Scottish average is 37%). Our outcome data based on self reported 3 month successful quits is 23% (Scottish Average is 19%). Service reach in the most deprived areas
is 58% (Scottish average 61%).

The non-pharmacy service (an evidence based model) has reported 3 month outcomes of 38% and 15% respectively, better than the pharmacy model. This demonstrates an alternative model of delivery from the Fife wide team.

A doubling of client throughput is required to achieve the performance target. Around 5800 of our smoking population from the most deprived areas would be required to set a quit date.

There are a number of key challenges in evidencing achievement of this standard. More quitters are presenting at community pharmacy, the use of E-cigarettes have changed the smoking cessation landscape and continued high levels of GP prescribing without referral to stop smoking services is lost data.

In order to overcome these challenges and increase the quit rate we will work more closely with pharmacy colleagues. All community pharmacies can deliver brief stop smoking support to their clients as part of national contract and a recent development has seen pharmacies participating in a Patient Group Directive (PGD) allowing clients direct access to pharmacotherapy (Varenicline) in addition to Nicotine Replacement Therapy (NRT).

We support the pharmacy smoking cessation service in a variety of ways, in particular, support has been provided to aid the introduction of the Patient Care Record (PCR) system. Ongoing support is being given to ensure the capture of robust data, to reduce blank records within the system and to support improvements with service delivery. This work will contribute to achieving the LDP target.

Fife has an integrated delivery model involving specialist services, the pharmacy model and a dedicated midwifery model, ‘Quit for Life’. We have also developed, after testing, a ‘Quit Teen’ model which supports young people to stop smoking.

Non-pharmacy smoking cessation provision is delivered in a variety of locations across Fife. Clinics are sited within GP practices and health centres using a shared care model of support. The shared care service also engages with clients in the community delivering sessions in non-traditional settings, e.g. food banks, nurseries, job centres, family centres and the workplace. In addition, a dedicated community resource is in place within our acute hospitals (in-reach service) to support patients and staff to stop smoking.

Support is predominately provided on a 1:1 basis with a few group support sessions provided in the workplace. Specific programmes of support have been developed for pregnant women and young people with another programme highlighting the benefits of exercise during a quit attempt.

6.2.4.1 Continued Evaluation, Development and Delivery of Existing Services

- The Quit 4 Life programme offers dedicated midwives to support pregnant smokers and their partners to stop smoking and has implemented routine CO monitoring for all pregnant women.
- QUIT Teen is a specialist programme aimed at supporting young people to stop smoking. The programme has been developed and piloted in a Fife secondary school with referral pathways and guidance having been established.
• The QUIT FIT programme was delivered predominately in the Cowdenbeath area with further sessions rolled out to other areas. Clients who attend the non-pharmacy smoking cessation service (from most deprived areas) are offered a gym pass as an incentive to maintain their quit attempt
• A suite of tobacco training opportunities is offered to NHS staff and community partners. In particular bespoke training is offered within the Acute hospital to promote Health Behaviour Change brief advice (a pilot project conducted with physiotherapists which evaluated well)
• We are supporting St Andrews University to develop a new mobile phone application (Map My Smoke) using integrated geo-positioning technology within primary care to help people quit smoking.

6.2.4.2 Future developments
• Consideration will be given on how to increase the use of Varenicline in line with the recommendations from the national service review as this has been shown to have improved outcomes for users
• Increase referral and access to services by maintaining a freephone number, an online referral option via a webpage, the use of a dedicated email address and access via SCI gateway
• Continue to support and promote National No Smoking Day at a local level to sign post and encourage clients to access services
• Continue to promote services using a variety of mediums e.g. radio, internet, intranet, leaflets, posters
• A development session with those directly involved in providing smoking cessation services in Fife has been planned for March 2017 with Scottish Government involvement
• Engage with GP clusters to discuss smoking cessation prescribing practices and to promote the smoking cessation service and identify ways of capturing data on patients prescribed NRT without support
• Explore potentials for service development as part of strategic planning with the seven locality cluster groups

6.2.5 Mental Health

6.2.5.1 Child and Adolescent Mental Health Service (CAMHS) Waiting Times

Target: At least 90% of clients will wait no longer than 18 weeks from referral to treatment for specialist Child and Adolescent Mental Health Services

Performance against the CAMHS standard fell for the fifth month in succession, with the percentage of patients starting treatment within 18 weeks of referral decreasing to 76.0% in the final quarter of 2016.

The recovery plan initially improved the position for referral to treatment as we focused on the general flow of referrals to treatment; however this resulted in a number of longer- wait outliers which are now being addressed. This has resulted in a fall over recent months in the percentage of
patients receiving treatment within 18 weeks but has been a necessary next step to achieving a sustainable performance of 90%.

The positive outcome of this is that as of December 2016, Fife only had 40 children and young people waiting longer than 18 weeks, all of whom have been offered a clinical appointment (excluding ASD assessment). The average wait for children and young people referred to Fife CAMHS is 7 weeks.

A continuation of the current approach to delivering treatment and the use of additional Scottish Government finance aims to achieve and maintain the standard in 2017.

6.2.5.1.1 Service Developments

- Fife CAMHS continues to engage in an active programme of review and redesign to improve access for children and young people with mental ill health.
- Fife CAMHS continues to work with Mental Health Access Improvement Support Team (MHAIST) to address quality improvement issues and processes aimed at improving access to the service.
- Fife CAMHS is working with ISD Scotland to ensure data collection processes are accurate and responsive.
- In collaboration with MHAIST, Fife CAMHS is hosting a development day specifically around the move from three geographical teams to two. This will ensure improved equity of access, screening, therapeutic provision and will build capacity within each team to absorb any changes to the staffing complement.
- Fife CAMHS is undertaking a wholesale review of its referral procedure and protocol. This will establish a clear threshold for referrers, provide better screening capacity, improve signposting for referrers and widen access of referral to all professionals working with children and young people in line with GIRFEC principles.
- Fife CAMHS is engaged in the commissioning process for third sector agencies to fulfill the commitments within the ‘Our Minds Matter’ framework.
- Fife CAMHS, in collaboration with the Local Authority’s Education and Children’s Services is developing a joint resource that maps the available emotional and mental wellbeing services and resources for children and young people across Fife. This will provide a joint signposting and reference facility.

6.2.5.2 CAMHS Looked After Children Service: The Beeches Project

- The Beeches Project will launch on 6th March 2017.
- Promotional materials have been developed to assist the launch specific to the needs of Partner agencies.
- The Beeches Project will complement the existing Springfield Project to provide therapeutic services to children & young people in Fife who are Looked After, extricating them from traditional CAMHS referral process.

6.2.5.3 CAMHS Primary Mental Health Workers (PMHW)

- Additional Scottish Government finance has supported the appointments of PMHW team leader and 3x PMHWs. The aim is for these staff to be in post by mid April 2017.
- The CAMHS PMHW service will place specialist CAMHS staff within universal and additional support areas.
- CAMHS PMHW’s will provide training, consultation, supervision, 1:1 and group therapies alongside partner agencies.
- Focus of the CAMHS PMHW service is to ensure children and young people have access to earlier intervention for emotional and mental health issues within the universal and additional support settings whilst building the capacity of this workforce.
- The CAMHS PMHW service is integrated in the Joint Framework for Emotional and Mental Wellbeing, “Our Minds Matter”.

6.2.6 Psychological Therapies

6.2.6.1 Improving Access and Reducing Waiting Times

Fife’s performance against the RTT 18 week target for Psychological Therapies (PT) fell from 74.1% in December 2015 to 66% in December 2016 within the context of an increase in referrals of 14% compared with the previous year. In the last quarter of 2016 Fife’s rate of accepted referrals for PT per 1,000 people, reached 5.7 against a Scottish average of 4.9; only one other Board can evidence a higher rate. Increasing reach in relation to the PT LDP Standard remains a Scottish Government priority. New monies released by the Scottish Government in the latter part of 2016 are intended to support the Standard by assisting Boards to reduce waiting times while also increasing access to PTs, including access by hard to reach groups.

Service development and service redesign to increase access to PT continued during 2016-17 and is expected to demonstrate a significant impact on waiting times in 2017-18. Investment in additional psychological therapists, primary care mental health workers and support staff, funded by new monies from Scottish Government will enable us to run waiting list initiatives to address the existing queue while implementing more extensive redesign across both primary and secondary care. This additional staff resource will join the workforce by April 2017. All service redesign will require continued development of models of shared care and patient pathways with partners across health, local authority and the third sector.

Redesign at secondary care level, focussed on the further development of Community Mental Health Teams and patient pathways, will yield a more integrated and efficient approach to meeting the needs of adults with complex and/or long term mental health needs. This will assist optimal utilisation of the available staff resource to deliver highly specialist and more intensive psychological therapies.

Within primary care the redesign will provide faster access to brief psychological interventions for adults with transient/mild mental health difficulties and will relieve some pressure in general practice by:

- Increasing the number and range of options for brief psychological therapies, both in groups and one-to-one interventions
- Increasing the availability of options that can be accessed through self-referral, removing the need to seek referral by a GP
- Continuing to encourage referral to Cognitive Behavioural Therapy (CBT) and self-referral to NHS 24 telephone for CBT where appropriate
• Within primary care the existing provision of psychological therapies for children and young people will be enhanced by a team of primary care mental health workers who will provide early stage mental health interventions through liaison, consultation, supervision and training to primary care professionals.

• Ensuring hard to reach groups remains a priority for service development. The Fife Veteran’s First Point (V1P) service established in 2016 provides peer support and PT for individuals who may not engage with mainstream mental health services. V1P has been very successful and will continue if further funding is agreed. Pathways including local area coordination, self-referral options and brief 1:2:1/group PTs are being trialled in community locations with particular focus on areas of high deprivation.

6.2.6.1.1 Workforce Development Plans

Work to increase capacity to deliver evidence-based PT across the Partnership continues:

• Keeping ‘Trauma in Mind’ cascade training programme funded by the Mental Health Innovation Fund completed its first cycle in October 2016 and has trained 15 trainers from the NHS, Women’s Aid, Social Work and other 3rd sector agencies. The programme is ongoing

• Additional clinical staff recruited with new monies from Scottish Government will provide training and clinical supervision to NHS, local authority and third sector staff working with older adults, adults, children and young people to increase the range and accessibility of psychological interventions. This builds on current initiatives such as group PT programmes for survivors of sexual abuse run jointly by NHS and third sector partners.

6.2.6.1.2 Outcomes

Performance against the PT standard will continue to be measured through monthly reports to ISD, the IJB and NHS Fife Board. Local scrutiny involves assessment against a recovery plan and monitoring through Clinical and Care Governance Committees.

Since mid 2016, input from the HIS/ISD Mental Health Access Improvement Support Team has been invaluable in assisting us to develop our e-health infrastructure to facilitate further Demand, Capacity, Activity, Queue (DCAQ) and related service improvement.

6.2.6.2 Dementia Post-Diagnostic Support (PDS)

Performance against the LDP standard will be reported in two parts each addressing a separate element to the Standard

Target: To deliver expected rates of dementia diagnosis

6.2.6.2.1 Performance - Diagnosis

Since May 2016, the average number of dementia diagnoses per month has been around 85. This is approximately 85% of the number expected according to ISD predictions.
Supporting GP’s to diagnose dementia in primary care setting remains a priority. A suite/bundle of diagnostic support tools have been developed to guide and support GP’s with diagnosing.

Target: All people newly diagnosed with dementia will have a minimum of one year’s post-diagnostic support coordinated by a link worker including the building of a person-centred support plan.

6.2.6.2.2 Background

The offer of Dementia Post-Diagnostic Support (DPDS) which meets the Alzheimer’s Scotland (5 Pillars) standard is in direct response to the national standard having been set in 2015-16. This approach is in addition to other support, care and treatment taking place as a matter of routine work.

The workforce identified for the task comprises a mixture of mental health, psychology, Alzheimer’s Scotland and other resources operating from three geographically based hubs. There has been success in clearly articulating and streamlining pathways to diagnosis and to DPDS support. The success of the pathway to diagnosis has resulted in the challenge of managing high volume referrals to DPDS.

6.2.6.2.3 Performance - DPDS

Although ISD have stated that there is no target to be attained as yet and while DPDS is in its infancy, its January report (which covered FY 2014-15 only) highlighted some key points:
- The rate of dementia diagnosis will have to increase by 17.9% between 2014 and 2020 in order to meet predicted growth in sufferers
- NHS Fife referred 374 patients to the DPDS during 2014-15, 31.3% of the estimated new cases in that period
- Of the 374 patients referred to the DPDS during 2014-15, 286 (75.6%) were deemed to have completed a full year of PDS

The low referral figure is a result of the service in Fife not starting until September 2014. Management information indicates that there were 749 referrals in FY 2015-16 and 515 in FY 2016-17 (to the start of December).

6.2.6.2.4 Key Concerns Risks and Challenges

The main challenges to achieving this target (whenever it is formally defined) are:
- Achieving the expected rate of diagnosis
- Managing demand and capacity

6.2.6.2.5 Recovery Trajectory

We are unable to provide recovery trajectories covering diagnosis and support until formal targets are specified.
The management arrangements now in place enabled a review of existing provision and implementation of systems and processes ensuring a more flexible and efficient use of the existing resource and the waiting time has continued to reduce across Fife.

The PDS has no one waiting more than 4 weeks from referral to an appointment with a link worker; however we recognise that it is important to avoid complacency and continue to monitor demand and capacity. In our experience, a significant number of newly diagnosed clients wish a few weeks to come to terms with their diagnosis before they are ready to meet and talk through the implications of this with a link worker and start planning for their future.

The timeliness and quality of the DPD support provided to those diagnosed with dementia is very important to the team and this is assured by:

- The DPD service and staff are now all hosted and managed by one service (Mental Health), which provides a robust reporting, monitoring and governance structure for the service to work within
- The appointment of a Team Leader with the authority to address inconsistencies across the 3 Hubs in areas including clarity of the DPDS model being delivered, monitoring of all team members activity levels, waiting times and the skill mix and experience of staff

Actions for 2016/17 include:

- Capturing patient and carer experience of the service by continuing to encourage patient feedback and having built in flexibility of service delivery in response to the feedback
- Identification of an appropriate quality assessment tool
- Await the publication of the new Dementia strategy and its recommendations for delivering support to those in a more advanced stage of dementia. The DPDS service has the capacity to assess and support those individuals referred in a more advanced stage of the illness and who may have more complex needs; these individuals would be seen by a care manager and not a link worker.

The team will continue to work in close collaboration with partner services that can and do deliver aspects of the 5 Pillar Support such as the Carers Centre, Alzheimer’s Scotland, Community Mental Health services and others.

Fife’s rate of referral for post diagnostic support is approximately twice the Scottish average, and yet our waiting times for DPDS are by far the best in Scotland with figures of 3% waiting greater than 3 months for DPDS in Fife, compared to the national average of 73%. Since spring 2016, the number of Fife residents waiting DPDS for longer than 3 months, has reduced from 161 to 60 to 3.

6.2.7 Delayed Discharge 2017/18:

A delayed discharge is defined as a hospital in-patient who is judged clinically ready for discharge but who continues to occupy a bed beyond the ready for discharge date.

Fife’s performance against delayed discharge targets has been a long-standing challenge, however performance is improving. For the 12 months from January 2016 to January 2017 an improvement of 44% has been achieved in terms of the reduction in the number of people in delay. However, we recognize that there is still much to do to ensure that people should only be
in hospital when they cannot be treated in the community and that people should not stay in hospital longer than necessary.

To further reduce delayed discharges in Fife, improvement work in 2017/18 will focus on:

- Reducing the number of bed days lost due to patients waiting in hospital for the appointment of a Welfare Guardian
- Delivery of the 72-hour discharge target for intermediate care, discharge to assess and re-ablement
- Reducing admissions and delays for people who are homeless
- Listening to patients and carers through consultation to understand their experiences of delayed discharge and discharge from hospital
- Providing more support to carers by increasing awareness of the Carers Centres and increase the number of carers assessments completed

Good quality community care should mean less unscheduled care in hospitals. In Fife, work is underway to develop and consolidate models of community based care. This involves a range of approaches including Hospital at Home, rapid response models providing assessment and support at home as well as intermediate care models within care home settings. A priority for 2017/18 is to develop a greater understanding of the interfaces and relationships between the various models of care to maximise our ability to reduce inappropriate referrals, attendance and admission to hospital.

7 Workforce Planning

7.1 Delivering Everyone Matters: 2020 Workforce Vision

In 2015, NHS Fife’s Strategic Framework was published following extensive consultation with staff and patients. This document outlined the vision, mission and values we believe will enable us to continue delivering good quality, person centred care based on the approach that ‘what matters to you, matters to us’.

To meet these challenges the Strategic Programme 2015-2018 prioritises a series of projects to support the delivery of sustainable healthcare services. Previously underpinned by a programme management structure, the structure evolved in 2016 into the Strategic Improvement Planning and Change Team (IMPACT) whose aim is to support the delivery of a range of key corporate objectives.

IMPACT’s initial focus is to support the delivery of the NHS Fife Clinical Strategy, the Health and Social Care Partnership Strategic Plan and the financial efficiencies outlined within this Local Delivery Plan. These documents recognise that ensuring sustainable healthcare services will require altering the way we work by modernising our systems, our processes and our workforce.

The vision within Fife involves multidisciplinary community teams including nursing and midwifery staff, pharmacists and allied health professionals working alongside our GPs and social care colleagues to quickly assess people’s needs and to support them to remain at home, wherever possible. This involves the further development of diagnostic services to allow more diagnostic tests to be carried out in the community or even in the patient’s own home. The use of technology will provide new opportunities to help individuals take greater responsibility for managing their own health and well being. Where hospital treatment is required and cannot be provided in a community setting, day case treatment will be the norm.
This vision will have a direct impact on our workforce as they are developed and managed in a way that optimises use of their existing skills and experience. As roles evolve, new roles emerge and service delivery and models of care change, to ensure staff are enabled to work at the top of their capability they must be supported to acquire new knowledge, skills and behaviours.

7.2 A Healthy Organisational Culture

A healthier, safer place to work is an integral part of our culture. Having achieved the Gold Healthy Working Lives Award in 2016 through demonstration of our commitment to improving the health, safety and wellbeing of our staff, we will be working to sustain the positive changes into 2017-18. We will continue our commitment to being a Health Promoting Health Service, promoting the benefits of physical health and will continue to support the mental health and wellbeing of our staff by ensuring this is an integral part of staff support and related policies. This work will be overseen by the Well at Work Project Steering Group and is an integral part of the Health and Wellbeing Strategic Implementation Plan for 2015-2018.

NHS Fife is now in the final year of a three year roll-out programme for the iMatter employee engagement tool. To date, 4884 staff have had the opportunity to participate in the process, allowing them an opportunity to shape how their team functions and develop and to improve their experience of work. The Board employee engagement index score for 2016 was a positive 71% reflecting the views of 66% of the staff participating.

The Health and Social Care Partnership staff will participate in the process for the first time in 2017 ensuring all staff in the Board have been included in at least one cycle of the iMatter tool by the end of 2017.

7.3 Sustainable Workforce

NHS Fife published its Clinical Strategy in 2016. This strategy will shape the delivery of healthcare in Fife over the next five years and is our response to the changing needs of a growing and ageing population. The strategy recognises Health and Social Care services are facing many challenges, however it also identifies an opportunity to support the people of Fife to live long and healthy lives by moving more care into our communities and closer to people’s homes, designing ‘joined up services’ that respond to individuals’ needs and embracing the opportunities afforded by technology.

A Workforce Strategy, to support the Clinical Strategy, will be published in 2017. It recognises the workforce of the future will comprise many of the current workforce and how we require an appropriate mix of generalist and specialist skills; the ability to work effectively in multi-disciplinary teams; have excellent generic skills and flexibility and adaptability to changing technology and patient need.

The implementation plan for the Workforce Strategy will identify and address any risks to ensuring a sustainable workforce, such as the age of the workforce and will consider how best to adapt HR policies and processes, learning and development activity and recruitment and retention efforts to ensure the ambitions of the Clinical Strategy are realised.

7.4 Capable Workforce
NHS Fife recognises that to provide sustainable services our skilled workforce needs to be developed and managed in a way that optimises use of their existing skills and experience with staff working at the top of their capability and supports the acquisition of new knowledge, skills and behaviours as roles evolve, new roles emerge, and service delivery and models of care change.

An NHS Fife Learning and Development Strategy Framework has been developed as an integral component of our Workforce Strategy to provide a clear direction for the future development of our workforce. This framework sets out four strategic objectives:

1. Plan effectively for our future needs
2. Maintain the ‘core’ competencies of our workforce;
3. Build on and develop the skills and capability of our workforce
4. Develop and promote effective leadership and management

We recognise we are starting with an experienced and competent workforce and a strong track record of driving and supporting multi-disciplinary and professional learning and development to underpin service provision. In 2017-18 we will continue to build on our well established record of collaborative staff development with a range of partners and stakeholders.

7.5 **A Workforce to Deliver Integrated Services**

Fife’s Health and Social Care Partnership is committed to developing a workforce where GPs, hospitals, health workers, social workers, social care staff and others work together as one system. This co-ordinated approach will help people avoid having to navigate their way through what can be a bewildering maze of specialist services. During 2017-18, workforce integration will focus on changing the way people work, so that work is organised around this one system approach, enabling individuals who need care and support to live as independently as possible.

Staff with the right skills and who are enthusiastic and motivated are key to the successful delivery of this plan. We need to ensure that our workforce, those who are directly employed by us and those who provide services voluntarily or under contractual arrangements, have the skills, knowledge, experience and qualifications to match the changes and ambitions outlined in NHS Fife Clinical Strategy and the Health and Social Care Partnership Strategic Plan.

A Workforce and Organisational Development Strategy has been created, aligned to the Partnership’s Strategic Plan 2016-19, to support the development of locality plans following the set of principles developed by Skills for Care and Skills for Health (2014), which help organisations, managers and practitioners think through what is meant by integration and how workforce development can contribute to induction, implementation and sustainability. These principles will guide the prioritisation of workforce development activity, and the delivery of integrated services, within each of the localities throughout 2017-18.

7.6 **Effective Leadership and Management**

Effective leadership and management at all levels is recognised as essential for ensuring high quality, safe and effective care and will be critical to the delivery of the NHS Fife Clinical Strategy and the Health & Social Care Integration Strategic Plan.

The Implementation Plan for Everyone Matters 2020 Workforce Vision has identified leadership development as a priority for action. The NHS Fife Strategic Framework in the “Exemplar Employer” domain sets out our commitment “to equip people to be the best leaders” and the Fife Health & Social Care Partnership Workforce and Organisational Development Strategy
emphasises collaborative leadership as a core requirement for successful implementation and delivery.

NHS Fife will continue to review and refresh its approach to leadership and management development to ensure alignment to strategic and operational priorities and will continue to work collaboratively with our partners nationally and locally to ensure a wide range of provision and opportunities supporting leaders and managers at all levels. Locally, we will continue to provide leadership and management development programmes and tailored support to individuals and teams using internal expertise and targeted at leaders at all levels across NHS Fife.

7.7 Key Workforce Challenges

The NHS Fife Nursing and Midwifery Workforce Group (NMWG) was reconstituted in 2016. The remit of the group is to develop recruitment strategies to reduce the number of vacancies, monitor bank and agency usage and to oversee the utilisation of the Nursing & Midwifery Workload and Workforce (NMWWPP) tools and subsequent workforce reviews.

Analysing the challenges in delivering a sustainable workforce is fundamental to this group and the group has undertaken a number of age profiling exercises in certain key disciplines by utilisation of the national working longer toolkit. The results from this will be mapped against the findings from the NMWWPP tools with workforce reviews taking cognisance of a range of factors including our ability to retain and recruit staff, strengthening links with educational providers and considering our ability to create or enhance roles.

The initiatives implemented to date include:

- Coordination of recruitment activity to coincide with the graduation of student nurses from local Universities, ensuring potential candidates can seamlessly finish their studies and commence employment within NHS Fife. This work resulted in the appointment of approximately 90 Nursing, Midwifery and Allied Health Professional graduates in September 2016 and this will form a key component of our recruitment strategy in 2017-18
- The development of a common Advanced Nurse Practitioner (ANPs) role and remit, recognising ANP’s will play a key part in developing and sustaining the capacity and capability of the health and care workforce of the future. We will continue to monitor the increase in this role in line with the national commitment for the creation of 500 ANP’s throughout Scotland over the next 5 years.
- As part of the application of the NMWWPP tools, continue to explore whether the development of new and/or evolving roles should be progressed to relieve the recruitment difficulties being experienced in certain specialties

Within Medical and Dental professions, steps have been taken locally to maximise recruitment opportunities. This has been in response to a number of vacancies being experienced in Fife, within a context of national recruitment difficulties across certain specialties. Recruitment sources have been analysed to target job adverts and NHS Fife has participated in both Scottish Government and European initiatives with varying success.

Alternative approaches are also being explored with the implementation of the new Community Physician Fellowships in conjunction with NES and the Scottish Government and the recruitment of non medical staff (e.g. Healthcare Scientists) to support the medical workforce. The Clinical Strategy offers the opportunity to explore how this work can be extended in 2017-18, with the introduction of GP Community Fellows, introducing GPs with specialist skills to support practices and aid the retention of GPs who are looking for ‘portfolio’ careers.
8 Financial Planning

8.1 Financial Context

In October 2016, the Auditor General recognised in her annual overview report that NHS funding is not keeping pace with increasing demand and the needs of an ageing population, with NHS Boards facing an extremely challenging financial position. Boards were asked to consider their forward planning within the context of a number of recommendations including:

- Work to reduce over investigation and variation in treatment;
- Take ownership of changing and improving services;
- Develop long term workforce plans;
- Work with the public about the need for change
- Work with the public so they take more responsibility for their own health

The past 12 months has seen a significant financial challenge for NHS Fife, with delivery of a balanced position in the longer term being predicated on major redesign and significant transformation of services. The findings of the Auditor General’s annual overview report reflect the national, regional and local context / policy drivers set out earlier within this document and are addressed in our joint strategic planning approach across health and social care in Fife.

Development of the Board’s Clinical Strategy was a key achievement during 2016/17 and the local Transformation Programme and IMPACT approach established to support our emergent priority actions are essential components of future financial sustainability. The budget for 2016/17 was approved within the context of this approach and the Board subsequently agreed a package of tailored support with Scottish Government comprising additional skills, capacity and resources. This approach has provided a solid footing for our financial strategy for 2017/18 and beyond, of delivering safe and effective care at lower cost, themed around transformation, variation and efficiency.

8.2 Financial Planning & Budget Setting Methodology

The Board’s Financial Plan for 2017/8 has been developed using a revised approach which aims to strengthen the link between operational plans for Directorates and Departments and the delivery of financial balance, through the development of specific action plans at an operational level. The financial planning process has also sought to recognise the Board’s changing role in relation to the budget setting process for the Integrated Joint Board. The methodology applied for budget setting has been based around 4 key principles:

- We can only set budgets based on the funding envelope available;
- The requirement to deliver safe and effective care at lower cost will be recognised across all budget areas;
- Budget holders will be asked to identify opportunities to deliver this through a combination of transformation (supported by the system-wide programme and the IMPACT resource)

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1 Audit Scotland: NHS in Scotland 2016
and routine ‘housekeeping’ measures commonly referred to as CRES or Cash Releasing Efficiency Savings;

- Financial performance will therefore be monitored through in year run rate, with no centrally held negative reserve balance.

### 8.3 Financial Planning Assumptions

The Financial Plan for 2017/18 has been developed around a confirmed revenue resource allocation of £624.7m, which includes an uplift of £9.1m (1.5%) on the baseline allocation, of which £6.7m is to be used to support delivery of the living wage within social care services. This leaves a net uplift of £2.4m (0.3%) and additional NRAC funding of £8.5m to offset the impact of pay and prices increases; known developments; and unavoidable cost increases. Key assumptions are summarised below:

**Expenditure Assumptions**

<table>
<thead>
<tr>
<th>Item</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay</td>
<td>1% uplift and low pay adjustment</td>
</tr>
<tr>
<td>Direct Medical Supplies</td>
<td>4% uplift</td>
</tr>
<tr>
<td>Hospital Drugs (existing)</td>
<td>4% uplift (to cover growth and price increases)</td>
</tr>
<tr>
<td>Energy</td>
<td>2.5% uplift</td>
</tr>
<tr>
<td>Rates</td>
<td>2.5% plus £1.6m for Rates Review</td>
</tr>
<tr>
<td>NHS Board Service Level Agreements</td>
<td>1.5% uplift</td>
</tr>
<tr>
<td>Resource Transfer</td>
<td>1.5% uplift</td>
</tr>
<tr>
<td>GP Prescribing</td>
<td>4% uplift (to cover growth and price increases)</td>
</tr>
<tr>
<td>Depreciation (cost of capital assets)</td>
<td>2.5% uplift</td>
</tr>
<tr>
<td>Private Finance Initiative contractual commitments</td>
<td>2.5% uplift</td>
</tr>
<tr>
<td>Scottish Medicines Consortium (SMC) Approvals</td>
<td>£2.5m (pending horizon scanning analysis)</td>
</tr>
<tr>
<td>Apprenticeship Levy</td>
<td>£1.3m</td>
</tr>
<tr>
<td>Clinical Negligence &amp; Other Risks Scheme (CNORIS)</td>
<td>No assumed changes from 2016/17</td>
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<tr>
<td>Royal Hospital for Sick Children / Department of Clinical Neurosciences</td>
<td>£0.9m contribution</td>
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<tr>
<td>Local Developments</td>
<td>£0.4m GP Fellowships</td>
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<tr>
<td>Incremental Progressation</td>
<td>£0.6m Pharmacy posts</td>
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<tr>
<td></td>
<td>£1.0m</td>
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</tbody>
</table>

Taking account of the planning assumptions outlined above and the increase in funding available, the savings required to deliver a balanced financial plan are in the region of £29.2m for 2017/18, as summarised in the table below.
Summary Additional Income & Expenditure 2017/18

<table>
<thead>
<tr>
<th></th>
<th>£'000</th>
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<tbody>
<tr>
<td><strong>Estimated Additional Income</strong></td>
<td></td>
</tr>
<tr>
<td>Baseline uplift:</td>
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<tr>
<td>- Social Care</td>
<td>6,700</td>
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<tr>
<td>- Balance</td>
<td>2,335</td>
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<tr>
<td>NRAC</td>
<td>8,500</td>
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<tr>
<td>New Medicines Fund</td>
<td>251</td>
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<tr>
<td>Additional estimated DEL</td>
<td>2,500</td>
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<tr>
<td><strong>Increase in funding</strong></td>
<td>20,286</td>
</tr>
<tr>
<td><strong>Estimated Additional Expenditure</strong></td>
<td></td>
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<tr>
<td>Pay uplift</td>
<td>5,305</td>
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<tr>
<td>Supplies uplift</td>
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<td>PPP contractual</td>
<td>572</td>
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<tr>
<td>Prescribing uplift / new medicines</td>
<td>6,744</td>
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<tr>
<td>Infrastructure</td>
<td>1,734</td>
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<tr>
<td>Other healthcare providers</td>
<td>361</td>
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<tr>
<td>New local developments</td>
<td>677</td>
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<tr>
<td>National &amp; regional developments</td>
<td>1,441</td>
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<tr>
<td>Social care</td>
<td>6,700</td>
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<tr>
<td>Other</td>
<td>2,683</td>
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<tr>
<td><strong>Increase in expenditure</strong></td>
<td>27,529</td>
</tr>
<tr>
<td><strong>Savings required in year</strong></td>
<td>(7,243)</td>
</tr>
<tr>
<td>Recurring savings target b/f</td>
<td>21,958</td>
</tr>
<tr>
<td><strong>Net in year savings requirement</strong></td>
<td>(29,201)</td>
</tr>
</tbody>
</table>

The financial planning and budget setting model adopted for 2017/18 provides a mechanism to consider the impact of the position across the health aspects of the Integration Joint Board and the services that remain with the Health Board.

It is important to note that a range of system-wide costs including the Apprenticeship Levy, CNORIS, infrastructure costs, national developments and other healthcare providers are not allocated to a Division or Departmental level and that the NRAC funding received has been held centrally to offset these increases. A proportion of assumed DEL funding however has been allocated to both the retained HB budgets and the IJB in line with proportionate recurring budgets.

The table below provides a summary of the overall position on that basis:
Summary Additional Income & Expenditure 2017/18: 
Integration Joint Board & Health Board Analysis

<table>
<thead>
<tr>
<th></th>
<th>Total £’000</th>
<th>IJB £’000</th>
<th>HB £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>20,286</td>
<td>8,877</td>
<td>11,409</td>
</tr>
<tr>
<td>Expenditure</td>
<td>(27,529)</td>
<td>(13,100)</td>
<td>(14,429)</td>
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<tr>
<td>Prior year savings recurring shortfall</td>
<td>(21,958)</td>
<td>(9,150)</td>
<td>(12,808)</td>
</tr>
<tr>
<td><strong>Net position</strong></td>
<td>(29,201)</td>
<td>(13,373)</td>
<td>(15,828)</td>
</tr>
</tbody>
</table>

8.4 Delivering Safe & Effective Care at Lower Cost

Opportunities to address the estimated £13.4m financial challenge within the health budgets delegated to the IJB remain subject to scrutiny and discussion within the Health and Social Care Partnership, in parallel with the challenges flowing through from the local authority budget process. These discussions are being considered via the governance processes of the IJB.

The resultant gap (£15.9m) across the Health Board has been allocated across Directorates and sub departments taking into account a number of key assumptions: corporate departments are required to deliver at least a 10% reduction in recurring expenditure; the budgets for activity with other NHS providers are held at recurring funding levels pending further discussion on the regional planning and delivery model; and the residual efficiency target is shared on a pro-rata basis in relation to recurring budgets across acute services and estates & facilities.

Through Executive Directors, budget holders have identified indicative opportunities to reduce costs through a combination of transformation and routine ‘housekeeping’ measures commonly referred to as CRES.

The following chart illustrates the Health Board gap of £15.9m together with early indicative proposals to close the gap across the nationally defined workstream savings scheme types.
An initial desk top exercise has been undertaken to consider the associated risk assessment of these early proposals. This is summarised in the chart below using the following informed principles:

- Service Redesign savings have been categorised in the main as high risk given further work is required to explore granularity of detail and to impact assess the proposals.
- Medicines and Procurement savings have been assessed as medium risk and are supported by the respective ongoing workstream groups.
- Workforce initiatives have been assumed as medium risk as plans are in the process of being scoped.
- Cash releasing efficiency savings have been assessed as low risk given previous tested assumptions and outputs.
- Balances within Departments where there is ongoing consideration of options are shown as “in progress”.

### Delivery Risk Factor
**2017/18 Total Savings**

- **High**
  - £5.2m
  - 33%
- **Medium**
  - £3.4m
  - 22%
- **Low**
  - £6.5m
  - 41%
- **In Progress**
  - £0.7m
  - 4%
The totality of the savings requirement (£29.2m) will be reflected across all budgets with effect from 1 April 2017 and as an underpinning principle, this will be phased equally over the financial year, with financial performance monitored accordingly.

For the Health Board retained budgets the existing PID process will continue for individual proposals at Directorate level. The good governance and discipline of staff side engagement and impact assessment is essential. Responsibility for this is a component part of the delegated budget authority of individual Directors. An overarching “tracker” of specific projects will be maintained within the Finance Directorate, to ensure a consolidated summary is available for scrutiny and reporting purposes and to ensure robustness and integrity of budgets.

In relation to the specific areas of work across the Transformation Programme to drive forward the early proposals, there are a number of points to note:

- **Service redesign** proposals will focus on changing the way we deliver services. These will largely be driven by the redesign of community services in order to reduce delayed discharges within community hospitals and thus facilitate the 72 hour turnaround within the acute hospitals. It will also allow the redesign of the bed footprint within Victoria Hospital. Other service change proposals include a mental health review and, in response to the Ritchie report, work is already underway to review urgent care services.

- Through the continuing joint work of the Chief Executives, Directors of Finance, and Scottish Government colleagues, there is a Sustainability & Value Programme Board in place to support Boards. This work includes potential productive opportunities relating to areas such as: reducing average lengths of stay; preventable admissions; procedures of low clinical value; and theatre utilisation. Within the variation workstream of our Transformation Programme, detailed work is underway to identify and better understand variance through benchmarking NHS Fife performance against other Scottish Boards. This work is being driven through a structured and systematic review of Discovery (the NHSiS web based information system).

- In relation to the national drive to reduce spend on agency and locum medical and nursing staff, NHS Fife is continuing to strive to demonstrate positive performance, as seen over the past year.

- Significant work continues to ensure effective and efficient prescribing across Fife, with the implementation and roll out of a new medicines formulary in both secondary and primary care in Fife.

- In addition, a procurement workstream has been established as part of our Transformation Programme to support “better buying; we are working within the East Coast Procurement Consortium to ensure we drive forward the recommendations of the recent Procurement Shared Services Strategy.

- Work has commenced in recent months on Regional Financial Planning with Boards who may potentially form a South East Scotland Region. In addition a Regional Planning Team will be established to enhance the Regional Planning capability and potential. The extent of any financial opportunities to flow from the regional planning and delivery model will be scoped over the coming months.
8.5 Operational Performance & Finance

In reaching the financial position described above, the Board has maintained its commitment to meet the requirements for patient treatment as mandated in the Patient’s Rights legislation, in relation to the delivery of Treatment Time Guarantees and both Outpatient and Diagnostic Standards. A detailed demand, capacity, access and performance modelling exercise has been undertaken for 2017/18; this indicates a demand / capacity gap of 4.5% in outpatient capacity; 9% for inpatient TTG and 12% in diagnostics. The resultant financial implication of sustaining the current (good) levels of performance has been quantified at £1.7m:

<table>
<thead>
<tr>
<th>Standard</th>
<th>No. of patients</th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatients</td>
<td>5,580</td>
<td>0.5</td>
</tr>
<tr>
<td>Inpatients (TTG)</td>
<td>2,020</td>
<td>1.1</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>5,240</td>
<td>0.1</td>
</tr>
</tbody>
</table>

The demand / capacity gap was supported in 2016/17 through internal funding of £0.7m coupled with an additional £1m from SGHSCD. Early discussions have taken place with SGHSCD Waiting Times team on securing additional resources for 2017/18.

8.6 Financial Planning 2018/19 – 2019/20

Planning assumptions beyond 2017/18 remain largely indicative; with an expectation that income is unlikely to grow beyond current levels.

Predicated on the delivery of the full 2017/18 efficiency challenge of £29.2m on a recurring basis, the indicative gap for 2018/19 would be £21.9m. Similarly on the premise that the 2018/19 position is addressed recurrently, then the gap in the 2019/20 financial year is estimated at £16.9m.

8.7 Infrastructure Investment Programme

In 2017/18, it is anticipated that NHS Fife will receive no project specific capital funding and formula funding will be broadly in line with the previous year’s allocation at £7.4m. In relation to capital receipts, it is assumed that the income received from any properties already in the process of being disposed will not be available to support the capital investment plan and as such the full formula funding will be required. This links to the use of infrastructure support funding in 2016/17, with the Board agreeing additional revenue funding from SGHSCD predicated on the future sale proceeds from these properties. It is assumed that no capital to revenue funding transfers will be allowable for backlog maintenance schemes.

The Board is managing key risks through its formula funding with rolling programmes which commit funding each year. These include medical equipment replacement, backlog maintenance and eHealth, all of which project spending requirements in excess of available funding and will require close management and understanding of associated risks.

For future years, it is assumed that the formula allocation will not increase and is likely to remain at 2017/18 levels for each year to 2021/22.

The capital programme for 2018/19 and beyond includes indicative investment for the East Central Territory Hub projects currently progressing for Kincardine Health Centre and Lochgelly.
Health Centre. These are being taken forward by the West Fife management team of the Health & Social Care Partnership, with formal consideration through both the Integration Joint Board (in relation to the clinical service model and revenue affordability) and the NHS Board (in relation to capital affordability and overall approval). The outline business cases for these projects are due for completion by Autumn 2017.

The Property & Asset Management Strategy (PAMS) for 2017/18 will be completed over the next few months. This will set out greater clarity on future projects which will require capital funding – either as acute projects to be supported by project specific funding or community / primary care projects which would require to be financed through the Design, Build, Finance and Maintenance (DBFM) Hub model. At this point in time, pending completion of the PAMS, an indicative sum of £55m has been included across the period to 2021/22 in relation to a number of proposed projects outlined in an earlier iteration of the PAMS. These have not yet been considered through any business case proposal and are based on previous advice from the Director of Estates, Facilities & Capital Services; linked to early work on the master planning for a number of sites and the strategic aspiration of moving toward a community hub model. Detailed work is required and will flow through the Joint Strategic Planning & Transformation Group.
Appendix 1: Governance and Leadership

Joint Strategic Transformation Map

*KEY PRIORITY PROGRAMMES*

- Strategic Community, Mental Health and Out of Hours Programme
  1. Community Hospital Redesign
  2. Out of Hours Redesign
  3. Mental Health Redesign
  4. Community Hub Development and Implementation
  5. Community Workforce and Infrastructure
  6. Locality Planning

- Strategic Acute Redesign Programme
  1. Scheduled Care Performance and Redesign
  2. Urgent Care Performance and Redesign
  3. Medicines Efficiency
  4. Variance
  5. Regional Working

- Other Strategic Transformations Programme
  1. Medicines Efficiency
  2. Estates Rationalisation
  3. Procurement
  4. Variance

Appendix 2: Delivery Structure/Outputs

<table>
<thead>
<tr>
<th>Strategy</th>
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<tbody>
<tr>
<td>Community Capacity and Infrastructure</td>
</tr>
<tr>
<td>Mental Health and Learning Disabilities Redesign</td>
</tr>
<tr>
<td>Prevention, Early Intervention &amp; Hospital Avoidance</td>
</tr>
<tr>
<td>Urgent Care, Out of Hours</td>
</tr>
<tr>
<td>Delayed Discharges, Frailty and Re-admissions</td>
</tr>
<tr>
<td>Women and Children’s Services</td>
</tr>
<tr>
<td>Scheduled Care</td>
</tr>
<tr>
<td>Cancer, Palliative Care and Care in the Last Days of Life</td>
</tr>
<tr>
<td>Transformation Projects</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key Priority Programmes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic Community, Mental Health and Out of Hours Redesign</td>
</tr>
<tr>
<td>SRO Michel Kellett</td>
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<tr>
<td>Strategic Acute Redesign</td>
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<tr>
<td>SRO Prof Scott McLean</td>
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<tr>
<td>Other Strategic Transformations</td>
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<tr>
<td>SRO: Joint</td>
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</table>

<table>
<thead>
<tr>
<th>Projects</th>
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</thead>
<tbody>
<tr>
<td>1. Community Hospital Redesign</td>
</tr>
<tr>
<td>2. Out of Hours Redesign</td>
</tr>
<tr>
<td>3. Mental Health Redesign</td>
</tr>
<tr>
<td>4. Community Hub Development and Implementation</td>
</tr>
<tr>
<td>5. Community Workforce and Infrastructure</td>
</tr>
<tr>
<td>6. Locality Planning</td>
</tr>
<tr>
<td>1. Scheduled Care Performance and Redesign</td>
</tr>
<tr>
<td>2. Urgent Care Performance and Redesign</td>
</tr>
<tr>
<td>3. Medicines Efficiency (Acute)</td>
</tr>
<tr>
<td>4. Variance</td>
</tr>
<tr>
<td>5. Regional Working</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce Community Hospital Beds</td>
</tr>
<tr>
<td>Implement Community Hubs</td>
</tr>
<tr>
<td>Improve Out of hours Efficiency</td>
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<tr>
<td>Reduce Mental Health Beds</td>
</tr>
<tr>
<td>Increase Mental Health Community Resource</td>
</tr>
<tr>
<td>Engage Communities</td>
</tr>
<tr>
<td>Achieve and Maintain Affordable Performance</td>
</tr>
<tr>
<td>Reduce Acute Medicines Costs</td>
</tr>
<tr>
<td>Reduce Acute Beds</td>
</tr>
<tr>
<td>Reduce Service Delivery</td>
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<tr>
<td>Reduce Variance and Waste</td>
</tr>
<tr>
<td>Reduce community Medicines costs</td>
</tr>
<tr>
<td>Reduce Estate and Facilities Costs</td>
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<tr>
<td>Reduce Procurement costs</td>
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<td>Reduce Variance and Waste</td>
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