Kirkcaldy & Levenmouth CHP Committee Meeting

TUESDAY 8th MAY 2012 AT 2:00PM
THOMSON HOUSE, METHIL

1. Welcome and Introduction
   - Mr John Wilson, Chief Executive, NHS Fife, in attendance

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 13th March 2012 PAGE 3 - 9

5. Kirkcaldy and Levenmouth CHP Annual Report Appendices 1, 2 & 3 PAGE 11 - 22

6. Matters Arising PAGE 23

7. Planning For Service Improvement
   7.1 Reshaping Care for Older People – Community Bed Model for Central Fife PAGE 25 - 26
   7.2 Mental Health Service – Forensic Low Secure Unit PAGE 27 - 28

8. Improving Health
   8.1 Teenage Pregnancy PAGE 29 - 32

9. Patient/Staff Experience
   9.1 Fife Rehabilitation Service – CARF Visit PAGE 33 - 34
   9.2 Family Nurse Partnership Programme PAGE 35 - 37
   9.3 Committee Development Sessions 2012 (Verbal Report) PAGE 39

10. Delivery & Efficiency
    10.1 Financial Governance PAGE 41 - 45
    10.2 CHP Workplan/Balanced Scorecard Comparison 2011/12 PAGE 47 - 55
    10.3 CHP Workplan 2012/13 PAGE 57 - 62
    10.4 HEAT Target – Smoking Cessation PAGE 63 - 66
    10.5 Workforce Modernisation And Development Revised Workforce Planning Guidance / Strategic Plan 2012-13 PAGE 67 - 68

11. Items for Information:
    (a) Local Partnership Forum – Thursday 15 December 2011 PAGE 69 - 73
    (b) CHP Clinical Governance Group – Wednesday 18th January 2012 PAGE 75 – 79
    (c) Pharmaceutical Care Services in NHS Fife 2012/13 PAGE 81

12. Dates for Diary PAGE 83

MR ALASTAIR ROBERTSON
CHAIR
KIRKCALDY & LEVENMOUTH CHP
Kirkcaldy & Levenmouth CHP Committee Meeting

Tuesday 8th May 2012
Agenda Item No 4.

MINUTES OF PREVIOUS MEETING HELD ON TUESDAY 13TH MARCH 2012

UNCONFIRMED MINUTE OF THE KIRKCALDY AND LEVENMOUTH CHP COMMITTEE MEETING HELD ON TUESDAY 13TH MARCH 2012 AT 2:00PM WITHIN THE TOWN HOUSE, KIRKCALDY

PRESENT:
Mr Alastair Robertson, Chair of Kirkcaldy and Levenmouth CHP
Dr Les Bisset, Clinical Director
Mrs Mary Porter, Associate Nurse Director
Professor Campbell, Education Representative
Mr Harry Blyth, Non Executive Board Member
Councillor Andrew Rodger, Council Representative
Mrs Moira Dunsire, Registered Allied Health Professional Representative
Mr George Sime, Public Partnership Forum Representative
Mr Peter Adams, Non-Executive Board Member
Dr Stephen Rogers, Registered Medical Practitioner (non-primary care) Representative
Dr Brian Wilson, Registered GP Representative
Mrs Samantha Allen, Registered Nurse Representative
Mr Simon Fevre, Area Partnership Forum Representative
Mr Simon Little, NHS Fife Non-Executive Board Member
Mr Jim Bett, Voluntary Sector Representative
Mr Allan Shields, Pharmacy Representative

IN ATTENDANCE
Dr Lynda Anderson, Deputy Clinical Director
Mr Andrew McCreadie, Assistant Director of Finance
Ms Rona Laing, Fife Council Officer Representative
Mrs Brenda Ward, Corporate Services Administrator (Minute)

ACTION

76/11 WELCOME AND INTRODUCTION

Mr Robertson opened the meeting and welcomed the Committee members. A special welcome was given to Mr Simon Little who is the new Non Executive Member on the K&L CHP Committee.

Mr Robertson spoke on a sad note about the tragic death of Mrs Kelly Dutiaume, who worked within the Prescribing Support Team at Whytemans Brae. Mr Robertson added that the Prescribing Team are devastated by the turn of events and the CHP has written to Mr Dutiaume offering condolences for the very sad loss of his wife.

Mr Robertson updated the Committee on some news relating to NHS Fife Board, as follows;

- Moira Adams has been appointed Chair of Dunfermline & West Fife CHP.
- Arthur Morrison has been appointed Chair of Glenrothes & North East Fife CHP.
• Peter Adams has been appointed Chair of the Finance Resources Committee.
• John Wilson has been appointed Chief Executive with effect from 1st April 2012.
• George Cunningham has been appointed Acting Director of Acute Division with effect from 1st April 2012.
• Mary Porter has been appointed Acting K&L CHP General Manager with effect from 1st April 2012.

A paper was distributed listing events Mr Robertson had attended, since the last Committee Meeting.

77/11 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mr George Cunningham, Mr Ron Parsons, Mr Gordon Penman and Councillor David Ross.

78/11 DECLARATION OF INTEREST

There were no declarations of interest.

79/11 MINUTES OF THE PREVIOUS MEETING HELD ON 17th JANUARY 2012

The minutes of the previous meeting held on Tuesday 17th January 2012 were accepted as correct except for the following changes;

• In Attendance - Dr Lynda Anderson’s title should read Deputy Clinical Director
• Item 71/11 - The heading should read CHP Annual Conference.

80/11 MATTERS ARISING

Mr Robertson advised that the Sexual Health Service relocation into Whytemans Brae Hospital had taken place and Professor McGoldrick and Mr Robertson had visited recently. The Service has settled in well and are beginning to see the benefits of co-location.

Councillor Rodger asked how the Committee intend to take Delayed Discharges forward as he is continually receiving letters from patients and these have been forwarded to the Health Service. In addition, a census was published in January 2012 by ISD Scotland and it reported that only one other place is higher on Delayed Discharges than Fife and that is Orkney. Mr Robertson advised that the next topic on the Agenda was Re-shaping Care and this may address Councillor Rodger’s concerns.

NEXT PHASE OF RE-SHAPING CARE (VERBAL REPORT)

Dr Bisset advised that Re-shaping Care was discussed at the January Committee Meeting and details on page 7 of the report show the process the CHP will use for the next phase of reshaping care.

Dr Bisset reminded the Committee that a Project Board and Team were set up to discuss the model of care required within Central Fife for future delivery of Integrated Community Assessment of Support Service (ICASS) and in particular hospital at home. This is a model that will provide a facility in Fife and respond to ICASS facility with reassessment, etc. For assessment of patients the CHP will also take into account continued care within Central Fife, re-alignment of Dr Lance Sloan’s area and other Clinical Services provided within the CHP including Addiction Services.
The Project Board and team are tracking this work and details of the model will be agreed and brought to the Committee in May 2012.

A subsequent piece of work is taking place to deliver the model against a criteria that was agreed, at the joint meeting, with G&NEF in December 2011.

The draft criteria, was set aside and a benefit and cost analysis will be carried out to provide a new model. A public consultation exercise will also be carried out and the paper which will be brought to the Committee in May 2012 will outline the timetable for this.

Dr Bisset added the he appreciates this report may not cover Councillor Rodger’s questions on Delayed Discharges; however he would take these concerns back to the General Manager for comment.

Councillor Rodger added that as the CHP discuss the model for Re-shaping Care on the Cameron Site, would discussions also consider whether Sir George Sharp unit transfer to an Acute Setting and asked for the CHP’s comments. Mr Robertson added that the Committee cannot speculate where Services will be based. Dr Bisset agreed with the Chair and stated that the CHP have a set of criteria that was agreed at the Joint meeting in August 2011 with G&NEF & K&L CHP Committees. Dr Bisset stated that exact details of where Services are located will be brought to the Committee at a future date. The Rehabilitation Service is not guaranteed to stay at Cameron Hospital as the Service is required to be aligned with the new model and located within Central Fife. The CARF Accreditation will take place in April 2012 and the quality of the Sir George Sharp building is always discussed. The service is required to be aligned with Stroke Services, and where this is will be included in future papers to Committee.

Professor Campbell re-iterated that the Rehabilitation Service is an excellent facility and the Service is required to keep its quality.

Mr Little asked if he could receive a copy of the criteria that was set out by both CHP’s at the Joint August 2011 meeting. Dr Bisset agreed that this would be forwarded to Mr Little.

The Committee noted the Next Phase Of Re-Shaping Care Verbal Report.
Heart Failure Team have carried out PLT Sessions and work has been carried out in numerous practices in Fife to raise awareness. In addition a bid was also submitted to promote this application and it is hopeful this will be taken forward.

The Committee noted the MCN Priorities Report.

It was noted that Councillor Rodger left the Committee meeting.

82/11 PATIENT STAFF EXPERIENCE

SCOTTISH PATIENT SAFETY PROGRAMME – MENTAL HEALTH (SPSP-MH)
Dr Bisset reported that the Committee Members are already aware of the Scottish Patient Safety Programme as it has already been rolled out to the Acute Division and General Practitioners. The specific programme for Mental Health is now being rolled out and will be led by Healthcare Improvement Scotland (HIS) with the aim of reducing harm to patients in Mental Health settings relating to a number of key themes.

The HIS programme is being taken forward in two phases. The first phase (May 2012 – May 2013), when participation is voluntary, will focus on scoping work and testing interventions. The second phase (May 2013 onwards) will see the mandatory introduction of the programme across Scotland. NHS Fife Board has notified the preference to participate from the outset at phase 1. If participation in phase 1 is confirmed, then NHS Fife will be required to identify a clinical area to participate, with identified senior leadership. The participating area will focus on a single piece of work relating to one of the key themes. The purpose of the paper is to bring this to the attention of the Committee and work will start in May 2012, if NHS Fife are selected for phase 1.


83/11 PLANNING FOR SERVICE IMPROVEMENT

CHP CLINICAL STRATEGY 2012 - 2014
Dr Bisset reported that Committee members have received a copy of the final draft of the Clinical Strategy 2012-2014. The paper outlines were discussed at an informal meeting and at the Clinical Forum with PPF and Heads of Service in attendance.

In Dr Bisset’s opinion, the two main issues are; addressing the CHP’s population, which is not unique to NHS Fife with greater elderly and young people. Secondly, how the CHP care for the older people and focusing on ICASS. This will form part of the workplan for the next 2 years and will be delivered through the CHP within the current resources.

It was noted that the Clinical Strategy was not attached to the Report and agreed this would be sent out to the Committee members.


RECONFIGURATION OF THE PRIMARY CARE, OUT OF HOURS, TREATMENT CENTRES IN FIFE (PCES)
Dr Bisset advised that PCES is managed by Dunfermline & West Fife (D&WF) CHP for all Services across Fife. The CHP have recently been
carrying out a review of the Services and taking into account National and Local Priorities. The paper (Item 8.2 - Appendix A) highlights D&WF Reconfiguration of the Service. The interest to K&L Committee is the proposal to close Glenrothes Treatment Centre and provide all PCES Services from Victoria Hospital in Kirkcaldy. Around 30% of the Glenrothes Treatment Centre admissions are from Levenmouth, Kirkcaldy/Burntisland and that was part of the reason for closing the Glenrothes Treatment Centre. In addition Section 1 of the Appendix A states that it is nationally accepted that wherever possible PCES should be co-located within an A&E Department or Minor Injuries Unit.

Dr Wilson added that after reviewing Appendix A it appears to show that PCES Service at Victoria Hospital was showing one General Practitioner less. Mr Fevre asked that the Committee be reassured that patients will not receive an inferior service in light of recent media attention. Dr Bisset reiterated that the correct accommodation and staffing will be provided for PCES at Victoria Hospital.

The Committee noted the PCES Report

PRESCRIBING

Dr Anderson advised that addressing cost effective prescribing is a high priority for NHS Fife. For the first time Kirkcaldy & Levenmouth spend on prescribing in GP Practices is outwith budget. Heart Disease and Diabetes MCNs have considered prescribing as a priority with the coming year and Kirkcaldy & Levenmouth have included prescribing in the Clinical Strategy for 2012-2014. NHS Fife prescribing budget for 2011-2012 is £72.445M and is heading for a £3M overspend.

Dr Anderson advised that the Prescribing Support Team in the CHP are committed to providing support to the 18 practices but have recently decided to concentrate resource on a smaller number of practices whose spending is significantly above their allocated budget. NHS Fife has been reviewing prescribing for many years and a lot of work has been carried out to keep prescribing within budget. Kirkcaldy & Levenmouth CHP has been successful in the last few years and it is only recently that prescribing has been reported as overspent. Dr Anderson added that the pharmacy support to practices is limited due to lack of resource. Dr Anderson gave an example where the Pathhouse Practice had been particularly overspent and now that the GPs are engaging the costs have decreased. In addition Muiredge Practice have expressed an interest in working on prescribing which may release additional savings.

Dr Anderson gave an update on the areas within the CHP that are reviewing prescribing; In Dietetics, a prescribing Dietician has been appointed to analyse the recommendation and prescription of nutritional supplements and guidelines have been implemented. Within the Addiction Services prescribing of methadone exerts cost pressures to the CHP and practice has been encouraging a dose reduction programme instead of maintenance. This has reduced the methadone costs. In Rheumatology early identification and diagnosis may reduce the length of time patients are on medications. The Sexual Health Service are increasing the focus on educational sessions to reduce teenage pregnancies and the Fife Vascular MCN Service have agreed to making it priority to reduce the cost of prescribing.

The Committee noted the Prescribing Report
84/11 DELIVERY & EFFICIENCY

FINANCIAL GOVERNANCE
Mr McCreadie advised that the Financial report for the CHP for the ten months to the end of January 2012 is showing an underspend of £6K against Managed Clinical Services, compared with a £105K overspend in December. In addition Prescribing is showing an overspend of £470K to January 2012.

The key overspend within Managed Clinical Services relate to two areas; Fife Wide Services and Mental Health. Fife Wide Services are overspent against drugs in particular due to a growth within Rheumatology activity. In relation to Mental Health both Pay and Supplies are overspent, mainly within nursing at QMH as well as issues relating to the procurement of services for CAMHS outside Fife, and the cost of Methadone, even though costs have come down. Areas of underspend are mainly management pay lines, vacancy management and an underspend in supplies lines.

Mr McCreadie added that at the year end the CHP is expecting to deliver a break even position on the Managed Clinical services.

Mr McCreadie advised that the total efficiency savings target identified for the CHP is £1.405M for 11/12, but the target based on the submission of the financial framework is £903k. For the year-to-date the trajectory of delivery is £713k, and the CHP has achieved savings of £803k, an over-achievement of £90k. The CHP is expected to over-deliver against the reduced target this year, however it will not achieve it’s original target. Any recurring shortfall on the initial target will return to the CHP to be achieved from 12/13.

The specific Capital allocation for Kirkcaldy & Levenmouth as at 31st January 2012 is £302k. Other CHP general allocations bring the total capital allocation to £770k. The expenditure against the specific allocation to date is £270k. The CHP currently estimates a small overspend against the specific allocation by the year-end, which will be managed as part of the total capital programme across Fife.

Mr McCreadie gave an update on the draft financial framework that is to be submitted to the Finance & Resources Committee. Within the framework there will be a requirement for further efficiency savings and NHS Fife is working to develop a new model of efficiency savings delivery and management.

Mr Robertson added that achieving the CHPs financial balance and protecting patient effectiveness is a significant task and thanks were passed to all.

The Committee noted the Financial Governance Report

CHP WORKPLAN 2011/12 – COMPARATIVE REPORT
Dr Bisset advised that this report is a comparative report between NHS Fife Balanced Scorecard and the CHP Workplan as at December 2011. The Appendix 1 comparative report identifies 22 key priority targets for NHS Fife which related to K&L CHP for 2011/12.
Dr Bisset advised that 14 of the 22 key priority targets were currently on track, 2 are completed and the others are delayed and are being worked on by managed services.

The Committee noted the CHP Workplan 2011/12 – Comparative Report

85/11 AOCB
Mr Robertson added that this was the last K&L CHP Committee Meeting Dr Bisset, would be attending before he retires on 31st March 2012. Mr Robertson stated that this could not go by without recognising the enormous contribution Dr Bisset had made, not just to the CHP but to NHS Fife also. Mr Robertson expressed that the CHP had benefited enormously from Dr Bisset's development of a robust clinical strategy which has provided a solid foundation for service developments such as ICASS.

Mr Robertson spoke on behalf of all the Committee to say that it had been a pleasure and wished Dr Bisset a long and happy retirement. Dr Bisset added that he had enjoyed the meetings and they had been very productive. Dr Bisset asked that the Committee support Dr Anderson in her role as Clinical Director.

86/11 ITEMS FOR INFORMATION
PPF Reference Group – 2nd December 2011
CHP Clinical Governance Group – 24th November 2011
FHWA – 7th December 2011
H&SCP Service Delivery Plan 2012 - 2015

87/11 DATES FOR DIARY

Next CHP Committee Meeting:
Tuesday 8th May 2012 at 2:00pm - 4:30pm within Thomson House, Methil

Next Development Session:
Tuesday 12th June 2012 at 1:00pm – 3:00pm within Meeting Room 1, Cameron House
1. INTRODUCTION

1.1 As part of the Code of Corporate Governance and its Constitution and Terms of Reference, Kirkcaldy & Levenmouth CHP Committee is required to produce an Annual Report reviewing it's activities for the previous year.

1.2 The attached paper is the Kirkcaldy & Levenmouth CHP Committee Annual Report for the year 2011/12.

2. RECOMMENDATION

2.1 The Kirkcaldy & Levenmouth CHP Committee is asked to:

- Approve the attached paper for submission to NHS Fife.

REPORT BY: ALASTAIR ROBERTSON
CHAIR OF KIRKCALDY AND LEVENMOUTH CHP
1. BACKGROUND

1.1 Kirkcaldy & Levenmouth Community Health Partnership (CHP) has a geographical population of approximately 97,000. Clinical Services managed and provided locally to this population include all aspects of Community Nursing, Long Term Conditions, Podiatry, Physiotherapy and In-Patient/Day Care Services for Older People.

1.2 Clinical Services managed and provided across Fife include Mental Health Services, Rehabilitation Medicine Services, Rheumatology Services, Nutrition and Dietetics Service, Integrated Reproductive Health Service and Managed Clinical Networks.

1.3 There are two Local Management Units within the CHP area.

2. DEVELOPMENT OF GOVERNANCE ARRANGEMENTS

2.1 Kirkcaldy & Levenmouth CHP Committee was first constituted in July 2005 and operated in “Shadow” form until membership was ratified by Fife NHS Board on 26th July 2005.

3. PURPOSE

3.1 The purpose of the Committee is to ensure that the Board’s strategic and operational objectives in relation to all services provided by the Kirkcaldy and Levenmouth CHP are implemented in accordance with Board policies and governance arrangements.

3.2 The CHP will engage with its local communities to improve health, deliver more integrated health and social care and tackle health inequalities. Clinicians, professionals and other disciplines involved in health care will work together to deliver tangible benefits to their communities. This will be done in partnership with all parts of NHS Fife, Fife Council other Community Planning partners, members of staff, the public and the voluntary sector. The CHP Committee will also give consideration as to how it engages with the private sector.

4. MEMBERSHIP

4.1 The membership of the Committee for the year ending 31 March 2012 comprised:

- Alastair Robertson, CHP Chair and NHS Fife Non Executive Director
- George Cunningham, General Manager
- Dr Les Bisset, Clinical Director
- Professor Ian Campbell, Education Representative
- George Sime, Public Partnership Forum Representative
- Ron Parsons, Public Partnership Forum Representative
- Jim Bett, Voluntary Sector Representative
- Councillor Andrew Rodger, Councillor, Fife Council Representative
- Councillor David Ross, Councillor, Fife Council Representative
- Dr Brian Wilson, General Practitioner Representative
- Gordon Penman, Dental Representative
- Mary Porter, Associate Nurse Director
- Mr Simon Fevre, Area Partnership Forum Representative
- Moira Dunsire, Registered Allied Health Professional
- Dr Stephen Rogers, Registered Medical Practitioner (Non Primary Care) Representative
• Mr Peter Adams, NHS Fife Non-Executive Board Member
• Mrs Samantha Allen, Registered Mental Health Service Representative
• Mr Harry Blyth, NHS Fife Non-Executive Board Member
• Mr Simon Little, NHS Fife Non-Executive Board Member
• Mr Allan Shields, Pharmacist Representative

4.2 The Committee membership consisted of twenty members at the end of March, 2012.

Three new members have been welcomed to the Committee during the year i.e.
Mr Simon Little, NHS Fife Non-Executive Board Member replacing Ms Fiona Purdon,
Mr George Sime, Public Partnership Forum Representative replaced Mr Nick Barber and
Mr Allan Shields, Pharmacist Representative replaced Mrs Sarah Donaldson.

4.3 The Director of Finance, Director of Human Resources, the Director of Operations (or
their nominated deputies) and an Officer of Fife Council have the right of attendance at
Committee meetings.

5. MEETINGS

5.1 The Committee Meetings have been held in public and the Committee have met on six
occasions during 2011/12. Dates of the meetings together with a Schedule of
Attendance is provided in Appendix 1.

6. BUSINESS

6.1 Details of items considered during 2011/12 are provided in Appendix 2.

6.2 Minutes of the Committee are presented, on a timely basis, to Fife NHS Board by the
Committee Chair, who provides a report, on an exception basis, on any particular issue
which the Committee wishes to draw to the Board’s attention.

6.3 Kirkcaldy & Levenmouth CHP continues to demonstrate its commitment to build on the
previous year’s achievements and make a measurable improvement in local population
health and provide higher quality, equitable, accessible, joined up services to local
communities.

7. BEST VALUE

7.1 For 2011/12 and future years the Board is required to provide overt assurance on Best
Value. The Best Value Framework was approved at the Audit committee on 22nd
September 2011 and Appendix 3 provides evidence of where and when the Committee
considered the relevant characteristics during 2011/12.
8. CONCLUSION

8.1 As Chair of the Kirkcaldy & Levenmouth CHP Committee during financial year 2011/12, I am satisfied that the integrated approach, the frequency of meetings, the breadth of the business undertaken and the range of attendees at meetings of the CHP Committee has allowed us to fulfil our remit as detailed in the Code of Corporate Governance.

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

................................................
ALASTAIR ROBERTSON
Chair of Kirkcaldy & Levenmouth CHP
## KIRKCALDY & LEVENMOUTH CHP COMMITTEE
## SCHEDULE OF ATTENDANCE
### 2011/12

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KIRKCALDY & LEVENMOUTH CHP COMMITTEE

ITEMS OF BUSINESS CONSIDERED BETWEEN
1 April 2011– 31 March 2012

1. Partnership Working

2. Clinical Governance arrangements

3. Financial Governance arrangements

4. Staff Governance arrangements

5. Mental Health Service
   - Reconfiguration of Old Age Psychiatry Admission Wards
   - Scottish Patient Safety Programme – Mental Health Service

6. Public Partnership Forum Progress

7. Service Development and Redesign

8. CHP Workplan/Performance

9. CHP Annual Conference

10. Development Sessions – Presentations:-
    - Addictions Services
    - Social Work Home Care Service
    - Health & Homelessness
    - Muiredge Project
    - Re-Shaping Care
<table>
<thead>
<tr>
<th>REQUIREMENT</th>
<th>POTENTIAL EVIDENCE SOURCES</th>
<th>RESPONSIBILITY</th>
<th>TIMESCALE</th>
<th>EVIDENCE RECEIVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive and Non-Executive leadership ensure accountability and transparency through effective performance reporting for both internal and external stakeholders and that there is a willingness to be open to external scrutiny, for example, through formal external accreditation tools.</td>
<td>Consideration of relevant external reports included within remit and workplans of relevant committees. Formal consideration/mapping by Committees and Board of independent sources of assurance Audit Scotland Best Value Toolkits External review reports i.e. HIS, HEI etc.</td>
<td>Board/Committees</td>
<td>Annual</td>
<td>Audit Scotland – Review of Community Health Partnerships - July 2011.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Ongoing</td>
<td>Reshaping Care for Older People – Qualitative Appraisal Criteria - November 2011.</td>
</tr>
<tr>
<td>Statements, strategies and plans clearly show a systematic approach by the organisation towards risk management.</td>
<td>Risk Management included in all relevant Board/Committee reports</td>
<td>Board/Committees</td>
<td>Ongoing</td>
<td>CHP Clinical Governance Group Minutes included with Committee papers - May, July, September, November 2011 and January and March 2012.</td>
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</tbody>
</table>
There is an explicit and systematic approach to integrating continuous improvement into everyday working practices and involving all staff in developing the organisation’s approach to Best Value.

<table>
<thead>
<tr>
<th>Best Value Toolkits</th>
<th>Relevant Committee</th>
<th>Ongoing</th>
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<tbody>
<tr>
<td></td>
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<td>CHP Workplan 2011/12 (local priority) - July 2011.</td>
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<tr>
<td></td>
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<td>Loughborough Road - September 2011.</td>
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<td>Reconfiguration of Old Age Psychiatry Admission Wards - September 2011.</td>
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<td></td>
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<td>Carlyle Ward - September 2011.</td>
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<td></td>
<td>Podiatry Service - November 2011.</td>
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<tr>
<td></td>
<td></td>
<td>Sexual Health Service move to Whytemans Brae Hospital - January 2012.</td>
</tr>
<tr>
<td>Leaders and senior managers actively encourage opportunities for formal and informal partnerships, including through joint use of resources and joint funding options, where this will offer scope for improvement in outcomes, as well as continuous improvement in organisational performance.</td>
<td>Reference to appropriate partner input/consultation in relevant business cases, strategies etc.</td>
<td>Board /Operational Division/CHPs/F&amp;R</td>
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<td>The organisation is clear about the intended outcomes and likely impacts of partnership working and that it has identified, and is sensitive to, the needs of the potentially different communities it and its partners serve.</td>
<td>Fife HSCP minutes</td>
<td>Board/CHPs</td>
</tr>
</tbody>
</table>

Social Work Home Care Service (Dev. Session) - October 2011.
Health & Homelessness (Dev. Session) - December 2011.
Reshaping Care/ICASS Team (Dev. Session) - August and December 2011 and February 2012.
Muiredge Project (Dev. Session) - December 2011.

Reshaping Care for Older People - July and November 2011, January and March 2012.
Rehab Discharge Programme, Stratheden Hospital - May 2011.
ADP – Drugs and Alcohol - July, September and November 2011.
Partnership plans have agreed a set of measures and targets to track progress and can clearly demonstrate (and regularly reports on) the impact of, and the outcomes from, any partnership working.

<table>
<thead>
<tr>
<th>Performance reports on Partnership working</th>
<th>CHPs</th>
<th>Bi-annual</th>
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<tbody>
<tr>
<td>Muiredge Project – January 2012.</td>
<td></td>
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<tr>
<td>Reshaping Care/ICASS Team - July, November 2011 and January and March 2012.</td>
<td></td>
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<tr>
<td>Clinical Strategy – March 2012</td>
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<tr>
<td>PPF Minutes are included with CHP Committee papers - May, July, September, November 2011 and January and March 2012.</td>
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</table>

Where appropriate, the organisation participates effectively in Community Planning Partnerships and other joint working initiatives, working openly to agreed objectives, performance management and reporting mechanisms and integrating these into local planning mechanisms to deliver outcomes.

<table>
<thead>
<tr>
<th>Fife HSCP Annual Report</th>
<th>Board/CHPs</th>
<th>Annual</th>
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<tbody>
<tr>
<td>Clinical Strategy – March 2012</td>
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<tr>
<td>Reshaping Care/ICASS Team - July, November 2011 and January and March 2012.</td>
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<tr>
<td>Leaders address impediments and barriers which inhibit integrated approaches to joint funding and joint management of activities with internal and external partners and undertake appropriate engagement (including with the Scottish Government) where this would help promote more effective use of resources and better value for money.</td>
<td>Reference to consideration of joint working in relevant business cases, strategies etc.</td>
<td>Board /Operational Division/CHPs/F&amp;R</td>
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<tr>
<td>The organisation has a framework for planning and budgeting that includes detailed and realistic plans linked to available resources together with an effective system for financial stewardship and reporting in order to achieve the organisation’s goals, ensure appropriate financial governance, deliver high-quality and efficient services and ensuring continuous improvement in both performance and delivery of outcomes.</td>
<td>Regular review of Corporate Finance and Corporate Monitoring Reports</td>
<td>Board/F&amp;R/CHPs/ Operational Division</td>
</tr>
<tr>
<td>The organisation is aware of the need to conduct its business in a manner which demonstrates appropriate competitive practice.</td>
<td>Consideration of Initial Agreements, Outline Business Cases, Full Business Cases etc.</td>
<td>F&amp;R/CHPs/ Operational Division / Board appropriate.</td>
</tr>
<tr>
<td>Leaders champion the use of performance management (including self assessment) as a key means for achieving improvement. Leaders lead by example in proactively managing performance and talking publicly about improving performance.</td>
<td>Balanced Scorecard</td>
<td>Board/Committees</td>
</tr>
<tr>
<td>Performance is systematically measured across all key areas of activity and that a performance management framework for the organisation extends throughout the structures of delivery in order to ensure effective governance and accountability and enable public performance mechanisms which track delivery outputs and outcomes through to high level objectives.</td>
<td>Balanced Scorecard</td>
<td>Board/Committees</td>
</tr>
</tbody>
</table>

Reference to consideration of joint working in relevant business cases, strategies etc. | Board /Operational Division/CHPs/F&R | Ongoing | Reshaping Care/ ICASS Team - July, November 2011 and January and March 2012. |

Balanced Scorecard | Board/Committees | Ongoing | Balanced Scorecard/ CHP Workplan update - May, July, September, November 2011 and January and March 2012. |
| The organisation meets the requirements of equality legislation, has a culture which encourages equal opportunities and is working towards the elimination of discrimination. | Equality and Diversity Impact Assessments included as relevant | Board/Committees | Ongoing |
Kirkcaldy & Levenmouth CHP Committee Meeting

Tuesday 8th May 2012
Agenda Item No 6.

MATTERS ARISING

REPORT BY: ALASTAIR ROBERTSON
CHAIR OF KIRKCALDY AND LEVENMOUTH CHP

Page 23 of 83
1. INTRODUCTION

1.1 The Workplan of the Project Team, reviewing the in-patient community bed model to support ICASS, falls into a number of sections covering:-

- The establishment of project arrangements;
- Communications;
- Developing the new model of care for in-patient community beds to support ICASS; and
- The options appraisal and consultation.

2. PROJECT ARRANGEMENTS

2.1 The Project Initiation Document was drafted and the Project Team and Board established. The Project focuses on the future model of care for community in-patient beds in central Fife.

2.2 A recent review of reshaping care change plans across Fife has highlighted that the plans for in-patient facilities should be brought together under a common project plan. Work is currently underway to expand the scope of the work undertaken to date, to take into account the configuration of services across Fife. This would be under the direction of the Partnership Project Group.

2.3 Vicky Irons, General Manager, Glenrothes North East Fife CHP (GNEF) has recently taken on the Executive Lead for the Partnership Project Group, which will oversee the delivery of the work stream on in-patient facilities and also the delivery of ICASS plans across Fife.

3. COMMUNICATIONS

3.1 The Scottish Health Council Self Assessment was completed and sent to SHC. SHC concluded they could not advise, at this stage, whether this constituted a major service change and suggested early discussion with the Scottish Government Health Department. As a consequence, the Work plan assumes a three month consultation period.

3.2 Information on the project has been drafted and it has been agreed that this will be co-ordinated on a pan-Fife basis, in order to avoid duplication and confusion.

4. REFINING THE NEW MODEL OF CARE

4.1 A workshop was held in early March with a range of organisations and professions represented. This covered the clinical model, the care environment and links with other partners.
4.2 Further actions to complete the model are being pursued by project members with a deadline of mid May for completion. After which, the draft model will be circulated wider for comment/further contributions.

5. OTHER ISSUES

5.1 In association with the Fife wide work on emergency care and flow, work has been commissioned to look at patient flow from acute settings through to community hospitals. The focus initially is on improving our utilisation of community hospital resources but it will also provide a detailed insight into current arrangements. It is felt this work will further inform discussion and decision on future community in-patient bed requirements across Fife.

6. TIMESCALES

6.1 The original Workplan estimated:

<table>
<thead>
<tr>
<th>Topic/Action</th>
<th>Deadline</th>
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<tbody>
<tr>
<td>Establish Project Arrangements</td>
<td>January 2012</td>
</tr>
<tr>
<td>Work Plan Developed</td>
<td>February 2012</td>
</tr>
<tr>
<td>Develop New Model of Care for Community In-patient Beds in Central Fife</td>
<td>End May 2012</td>
</tr>
<tr>
<td>Identify Options for Future Provision</td>
<td>End June 2012</td>
</tr>
<tr>
<td>Option Appraisal</td>
<td>End July 2012</td>
</tr>
<tr>
<td>Identify Preferred Option</td>
<td>End August 2012</td>
</tr>
<tr>
<td>Consultation</td>
<td>Sept-Nov 2012</td>
</tr>
<tr>
<td>Joint Committee Session</td>
<td>Nov/Dec 2012</td>
</tr>
<tr>
<td>Recommendation to Committees and Board</td>
<td>December 2012</td>
</tr>
</tbody>
</table>

6.2 The scope, role and remit of the group will need to be revised to take into account the expansion from a central Fife to a Fife-wide project. The work plan and timescales may also need to be reviewed in line with the expanded remit and the intelligence gained from commissioned work associated with the work on emergency care in Fife.

7. RECOMMENDATION

The Committee is asked to:-

**Note** the progress to date and the plans to extend programme arrangements, to assume a Fife-wide role and remit for the review of community in-patient beds, under the direction of the Partnership Project Group. A further update will be prepared for consider at the next CHP Committee meeting in July 2012.

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**REPORT PRESENTED BY:** FIONA MACKENZIE, LOCAL CLINICAL SERVICE MANAGER

**REPORT PREPARED BY:** TERESA BRIGGS, ASSISTANT DIRECTOR CLINICAL DELIVERY, GLENROTHES AND NORTH EAST FIFE CHP
Kirkcaldy & Levenmouth CHP Committee Meeting

Tuesday 8th May 2012
Agenda Item No 7.2

PLANNING FOR SERVICE IMPROVEMENT: MENTAL HEALTH SERVICE – FORENSIC LOW SECURE UNIT

1. INTRODUCTION
1.1 Committee members have been advised previously on the position in NHS Fife regarding mental health patients who require care and treatment in conditions of low security. This paper informs the Committee of plans to address the issue this year with a local solution.

2. BACKGROUND AND CONTEXT
2.1 Review of the Forensic estate in Scotland and measures introduced in the Mental Health (Care and Treatment) (Scotland) Act 2003 led to changes in the care arrangements for patients requiring conditions of high, medium and low security. The State Hospital provides conditions of high security. Regional units in Glasgow, Edinburgh and Perth provide conditions of medium security. Conditions of low security must be provided locally by Health Boards.

2.2 NHS Fife currently has no accommodation suitable to provide an appropriate low secure facility. As a result, NHS Fife has had to utilise a private facility in Ayr to accommodate Fife patients with low secure needs, at significant revenue cost. The annual cost of an inpatient stay in the Ayr Clinic is £170,000. Fife currently has 10 patients placed there at a cost of circa £1.7 million per annum. The nature of the patients means that extended periods of care are the norm.

2.3 The mental health service has been exploring various options to deliver a service locally. The advantages of a local service are both financial and qualitative. A local service can be provided at a significantly lower cost. It will enhance the Forensic service currently being provided and will offer an improved and far more satisfactory service for the patients concerned. To date, the major barrier to a solution has been the availability of capital funding.

2.4 The following plan has been approved by the CHP and Strategic Management teams

3. SERVICE PLAN
3.1 A ward has been identified on the Stratheden hospital site for conversion to a low secure unit. Radernie ward is currently an old age psychiatry ward and it is planned to move that patient group to Cairnie ward, which is now vacant due to the return of Adamson hospital patients to their refurbished hospital accommodation.

3.2 NHS Fife has committed up to £700,000 capital funding to enable the refurbishment of the ward and meet the requirements necessary for a low secure facility. The Estates department is in the process of finalising the redesign plans for review by the clinical management team. It is anticipated that the refurbished ward will be able to accommodate between 10 to 13 patients.

3.3 NHS Fife has also committed revenue funding of £995,500 to operate the unit. This will fund the nursing staff and other clinical staff required to run the unit, including the appointment of an additional Consultant Forensic Psychiatrist, a Forensic Psychologist and a Clinical Pharmacist which will generally enhance the current forensic service.
3.4 It is anticipated that the Low Secure Unit may be operational as early as September 2012.

4. SUMMARY
4.1 The CHP and mental health service has secured a plan for the local provision of an appropriate and suitable low secure unit. The unit will meet NHS Fife’s requirement to provide local care and treatment for this patient group.

4.2 The repatriation of patients from the Ayr Clinic will generate expenditure savings of circa £750,000 per year. This saving will be credited to the CHP/Mental Health Service efficiency targets.

4.3 The plan will deliver an improved service for this patient group, improve the service options in mental health, and enhance the capacity and function of the forensic mental health team.

5. RECOMMENDATION
5.1 The Committee is asked to:-

- **Note** the content of the paper
- **Endorse** the plan

REPORT BY:  BOB MCLEAN, GENERAL MANAGER, MENTAL HEALTH SERVICES
KIRKCALDY & LEVENMOUTH CHP
IMPROVING HEALTH: TEENAGE PREGNANCY

1. INTRODUCTION
Teenage Pregnancy falls under the remit of the Fife Multi-agency Sexual Health Strategy Group which brings together NHS personnel, Fife Council and other services. The Strategy Group reports to the Fife Health and Wellbeing Alliance, and is aligned to outcomes in the Fife Health and Wellbeing Plan 2012-15.

The approach to teenage sexual health falls within the Government Framework for Bloodborne Viruses and Sexual Health 2012-15, the Getting it Right for Every Child approach to meeting children’s needs, Curriculum for Excellence within schools and National Guidance on Underage Sexual Activity in relation to relevant laws.

Outcomes such as teenage pregnancy show clear deprivation gradients, and targeted work to reduce inequalities underpins the approach taken in Fife.

2. DEFINITION
Teenage pregnancy refers to conceptions i.e. deliveries plus abortions. Generally there are more abortions than deliveries in the under 16s. Nationally, the target for those aged under 16 is to reduce to 6.8/1000 by 2010.

Due to the nature of the data, the most recent results may be two year old i.e. the latest rate for Fife was 10.5/1000 (67 events) for 2009 against the Scottish average of 7.0/1000.

The Children's Services Plan and Early Years Strategy are signed up to reducing under 16 teenage pregnancy.

3. BACKGROUND
Sexual intercourse is reported by up to a third of young people under the age of 16. In a high proportion this is later regretted. While against the law, a proportionate response is expected in services in those aged 13-16 and staff must conduct risk assessments to determine whether child protection referral is appropriate under existing NHS guidance. Sexual activity below the age of 13 would always be a child protection matter.

Teenage pregnancies can be associated with adverse social outcomes or “cycles of deprivation”. While many are unplanned, they may be wanted and some are intended. It is important not to stigmatise mothers or children in this situation. The Young Mother’s initiative supports young people to remain in education after birth of a child, and the area of parenting support is an important one. It is also important to address issues for boys or fathers in both prevention and parenting.

4. LOCAL SERVICE CONTEXT
The role of the Local Authority is key with Education delivering Relationships and Sexual Health Education appropriate for all pupils, Community Services working to address sexual health in its contacts with young people, and Social Work in its contact with looked after and other vulnerable young people.
Within NHS Fife, Executive Leadership is provided via the Director of Public Health. Each of the three CHPs has the responsibility for local sexual health services and assessing the needs of their populations. Kirkcaldy/Levenmouth CHP has lead responsibility for the specialist sexual health services, Sexual Health Fife, encompassing Reproductive Health, Genito-urinary Medicine and specialist health promotion across Fife.

5. EVIDENCE BASED APPROACH
The known risk factors for teenage pregnancy are shown in the box:

<table>
<thead>
<tr>
<th>Behaviour:</th>
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<tbody>
<tr>
<td>Early sexual activity</td>
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<tr>
<td>Poor contraceptive use</td>
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<tr>
<td>Mental Health/Conduct Disorder/Crime</td>
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<tr>
<td>Alcohol/Substance Misuse</td>
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<tr>
<th>Education – related:</th>
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<tbody>
<tr>
<td>Low educational attainment</td>
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<td>Disengagement from school</td>
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<tr>
<th>Family /Background:</th>
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<tbody>
<tr>
<td>Looked after children</td>
</tr>
<tr>
<td>Daughter of a teenage mother</td>
</tr>
<tr>
<td>Low parental aspiration</td>
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</tbody>
</table>

Health improvement work in this area involves addressing issues of self-esteem and self-worth, as well as negotiation skills in addition to other factors.

Evidence from research suggests these are the key areas to reduce a high teenage pregnancy rate:
- Senior local sponsorship from all key partners:
- Health, Education, Social Services, Youth Support Services, Voluntary Sector
- Young people’s sexual health services
- Sex education given high priority
- Youth & Community Services
- Target those at most risk especially looked after children

6. RECENT RATES IN FIFE
Across Scotland rates have been relatively stable over the last ten years and a small change in numbers can significantly affect rates from year to year. Fife rates for <16 teenage pregnancies are usually higher than the Scottish average and in 2009 were highest of any NHS Board in Scotland. 2010 data will be released in June 2012. Kirkcaldy & Levenmouth CHP rates are consistently higher than other CHPs.
7 RESPONSE
These rates have been broken down to the smallest possible level for local NHS staff to identify key areas to target.

Using Sexual Health HIF funding, £10K was allocated for targeted secondary schools to take forward actions to reduce the rates in partnership with local agencies. The target schools are Buckhaven High School, Kirkcaldy High School, Lochgelly High School and Auchmuty High School.

As an example of good practice, health improvement staff working with Kirkcaldy High School staff and public health nurses are piloting new methods of delivering Sex and Relationship Education based on pupils’ identified needs. The school guidance team and nursing team are working well together. The nursing team are planning to pilot a specific drop in for sexual health concerns and will link with specialist services to fast track any pupils who need further medical input. The aim is to streamline the referral process to make it easier for young people to access these services.

In response to the high rate in 2009, to gather more information a focus group approach was considered but the circumstances of current schoolgirl mums made this inappropriate at this time. A detailed literature review of interventions and qualitative research on the topic has been conducted and disseminated to local areas.

8. SELECTED EXISTING INITIATIVES
The aim of all Relationships and Sexual Health Education is to encourage young people not to engage in early regretted sex. Staff from Fife have been recently trained in a specific innovative programme ‘Only when I'm ready’, or ‘Delay’ and elements of this will be incorporated into local practice.

The Hubs are a network of young people’s drop-ins run by each CHP in Fife. They are run under a service level agreement with Community Services and address sexual health and other health issues for young people. Sustaining and developing these in or near schools in target areas is very important and continual development takes place to meet young people’s needs.

A needs assessment for supporting parent and carers in approaching this topic with young people was completed in 2011 and actions from this will be taken forward.

The website www.urhealthfife.org.uk was jointly developed to give young people access to appropriate health information. It is available within schools in Fife.

Primary care staff provide contraception services and initiatives are in place to promote training and uptake of more reliable methods such as implants. Emergency Hormonal Contraception (“morning after pill”) is available in pharmacies throughout Fife.

Sexual Health Fife has introduced additional priority measures for under 16s, and outreach work has taken place with vulnerable groups and drug and alcohol services.

Training was delivered in 2011 to 21 staff working with vulnerable young people who do not usually receive sexual health input; employability workers, social workers, youth justice, SACRO and staff who deal with missing children. This was in addition to the existing multi-agency training programme and condom distribution scheme training.

A DVD has been developed by Dunfermline/West Fife CHP for use with vulnerable young people linking sexual health risks and alcohol use.

The Health Psychology for Looked after children project offers 1:1 support for those who are looked after, and consultancy for worked and carers, on sexual health and a range of other health behaviours.
The last two projects have received national awards for good practice.

9. **FURTHER PLANS**
   Leadership across all agencies is key to addressing high teenage pregnancy rates. The new Fife Sexual Health Strategy 2012-15 will emphasise this. It will be important to maintain momentum in targeted schools, on a partnership basis, linking to drug and alcohol issues.

   Using health psychology expertise, Implementation Intentions will be explored to reduce unwanted pregnancy. This involves a checklist of ‘what if’ scenarios for effective use of contraception and has been shown in a randomised trial to reduce unwanted pregnancy.

10. **RECOMMENDATION**
    The CHP committee is asked to **Note** this report on reducing teenage pregnancy in Fife.

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**REPORT PRESENTED BY:** HEATHER BETT, CLINICAL SERVICES MANAGER
KIRKCALDY & LEVENMOUTH CHP

**REPORT PREPARED BY:** DR LORNA WATSON, CONSULTANT IN PUBLIC HEALTH
1. INTRODUCTION

1.1 The Sir George Sharp Unit which houses the Fife Rehabilitation Service for people with acquired brain injury, completed the accreditation process for the fourth time in April 2012. CARF (Commission for the Accreditation of Rehabilitation Facilities) is an international board based in the United States. The Unit was the first in Britain to obtain this accreditation 12 years ago and has now become a point of contact for advice, by other centres, seeking to go through the process in Britain.

1.2 Accreditation is normally gained for 3 three years and, at each visit, the Unit has successfully gained accreditation for this period of time.

2. STANDARDS

2.1 The process looks at three standards of the rehabilitation programme:-

- ASPIRE to Excellence which assesses the business practices and performance management.

- The Rehabilitation and Service process for the person served which assesses the programme and service structure.

- Programme Standards which assesses the scope and practice of the rehabilitation process.

The programme standards can covers a wide range of rehabilitation programmes and the Fife Rehabilitation Service is assessed on their in-patient programme.

2.2 ASPIRE to Excellence looks at the leadership of the programme at all levels and strategic planning for the Unit. It also looks for evidence of input from patients and other stakeholders. With regards to implementing the plan, areas assessed include legal requirements, financial planning and management, risk management and health and safety, human resources, technology, accessibility of the service and upholding the rights of the person served. Information measures and performance improvement are also covered in this section.

Programme/Service Structure looks for evidence that the programme is able to effect positive change in the functional ability, independence and self-reliance while protecting and promoting the rights of the person served. The importance on communication on all levels is vital here and clear standards are required to be met to ensure delivery of the objectives of the programme.

The Programme standards is the specific standard for the Comprehensive Integrated In-patient Rehabilitation Programme which is followed in the Unit. It looks for an integrated team approach to be reflected in all activities and clear indications of achieved outcomes across the programme.
2.3 The Unit works hard to achieve the standards set out by CARF and a great deal of preparation is involved in pulling together all of the required evidence.

2.4 The assessors visit the unit for two days and meet with patients, staff and relatives to assess compliance with the standards set. An exit conference is held where verbal feedback is provided on the visit and recommendations or suggestions made for improvement. A written report as to whether accreditation is achieved, is normally received within four weeks of the visit and the outcome from the visit, will be reported to the Committee at the next Committee meeting. The CHP Committee at that time will be asked to support (wherever possible) the recommendations made during the assessment process.

3. RECOMMENDATION

The CHP Committee is asked to:-

• Note the content of this paper.

REPORT BY: DR LYNDA ANDERSON, CLINICAL DIRECTOR
KIRKCALDY AND LEVENMOUTH CHP
### 1. INTRODUCTION

1.1 In January 2012 the Scottish Government FNP National Implementation Team delivered a presentation to the Strategic Nursing Team and a cohort of senior nurses within NHS Fife which highlighted the core elements of this programme. This allowed participants to gain an understanding of what it means to become a Family Nurse Partnership site.

1.2 Following this presentation and an initial discussion at SMT it was agreed that NHS Fife would submit an Expression of Interest to the Scottish Government to become a Family Nurse Partnership site in 2012.

1.3 This bid was submitted in February 2012 and on 9 March 2012 the Nurse Director NHS Fife was informed that, after careful consideration by the Scottish Government Expert Panel, it had been decided to accept the application from NHS Fife to proceed to Phase 1 with the FNP Programme.

1.4 Further information was subsequently provided regarding the requirements for participation and management of the Programme. NHS Fife were requested to progress this initiative immediately and achieve an early implementation date of May 2012.

1.5 This paper provides an overview of the FNP Programme and highlights the implications of becoming a Partnership site.

### 2. BACKGROUND

2.1 The FNP is an evidence based, preventative programme offered to young mothers having their first baby. It begins in early pregnancy and is orientated to the future health and well-being of the child. It is a nurse-led, intensive, home visiting programme and supports universal services in supporting teenage families.

2.2 FNP is a licensed programme with structured inputs and well tested theories and methodologies. Creating the right environment to deliver the FNP is important and challenging. The aims are achieved by maintaining fidelity to the programme license which is essential if the benefits identified in the research are to be realised.

2.3 The FNP team needs to be part of an organisation that appreciates and values the skills of practitioners, supports them in their work and is ready to learn with them. The FNP brings particular challenges to the organisation as it sits across different systems, organisations, services, settings, stakeholders and policies.

2.4 The Scottish Government has established an FNP National Implementation Unit and NHS Education for Scotland (NES) assist organisations to develop the best conditions in which to successfully deliver this programme.
3. MEASURES FOR IMPROVEMENT

3.1 Specific measures for improvement will be determined and agreed with the Scottish Government. These will be consistent with improvement measures in place in other UK test sites.

3.2 These measures are likely to focus on:
- Improving the outcome of pregnancy by supporting women to improve their prenatal health;
- Improving child health and development by supporting parents to provide more competent care of their children in the first 2 years of life;
- Improving families’ economic self-sufficiency by supporting parents to develop a vision of the future, accomplish goals by planning timing of pregnancies and staying in school/finding work.

4. IMPLICATIONS FOR HEALTH

4.1 The FNP Programme is underpinned by a strong and vigorous US evidence base and from early feedback from test sites in England and NHS Scotland (Lothian and Tayside).

4.2 Consistent results across three trials in the US demonstrated:
- Improvements in women's ante-natal health;
- Reduction in children’s injuries;
- Fewer subsequent pregnancies;
- Greater intervals between births;
- Increased father involvement;
- Reductions in welfare dependency;
- Reductions in substance misuse initiation and later problems;
- Improvements in school readiness;
- At 15 years follow up, 48% fewer verified incidents of child abuse and neglect.

5. RESOURCE IMPLICATIONS

5.1 All staffing and training costs will be met by the Scottish Government for three full years.

5.2 Sustainability of the Programme (following satisfactory evaluation) requires to be achieved via the redesign of current mainstream provision.

5.3 NHS Fife will contribute through the input of senior staff time to initiate implementation and monitor achievement. Accommodation and equipment for FNP team members will also be provided.

6. RISK ASSESSMENT

6.1 Risks in relation to the health and wellbeing of vulnerable children and families are well documented locally, nationally and internationally.

6.2 Risk assessment and a risk management plan will be required as part of the implementation process.
7. PROGRESS TO DATE

7.1 The Executive Project Sponsor for NHS Fife is the Nurse Director who is responsible for the programme in entirety and for ensuring that the NHS Board meets the licensing requirements. The specific details relating to the licensing requirements have been received from the Scottish Government and are now being followed within NHS Fife.

7.2 The Associate Nurse Director, Dunfermline and West Fife CHP, has been identified as the FNP Lead for NHS Fife and consideration is currently being given to identifying an Implementation Manager to drive the set up locally and ensure that NHS Fife meets the specified milestones, on time and within budget.

7.3 There is a requirement to set up an FNP Advisory Board which will be Chaired by the Executive Project Sponsor. Consideration is currently being given to membership and the first meeting of the group will take place in the near future.

7.4 Membership of the FNP Advisory Board will include senior decision makers from children and young people’s services within NHS Fife and the local authority.

7.5 Work has been undertaken to develop job descriptions for the Family Nurse Partnership Supervisor post and four Family Nurses. These posts have currently been advertised and dates set for interview. Initial training for those appointed to the post will take place in May 2012. Further training is scheduled for June and November 2012.

7.6 Communication plans for the project are being developed and this will include engagement with stakeholders.

8.0 GOVERNANCE AND ACCOUNTABILITY

8.1 The FNP Programme should be incorporated into local governance arrangements with the FNP team being integrated into Children’s Services and Primary Care, whilst maintaining integrity of the programme.

9. RECOMMENDATION

9.1 The Committee is asked to:-

- **Note** the successful application by NHS Fife to proceed to Phase 1 with the FNP Programme;

- **Note** progress to date with implementation within NHS Fife

REPORT BY:  NICKY CONNOR, ACTING ASSOCIATE NURSE DIRECTOR
KIRKCALDY AND LEVENMOUTH CHP
Kirkcaldy & Levenmouth CHP Committee Meeting

Tuesday 8th May 2012
Agenda Item No 9.3

PLANNING FOR SERVICE IMPROVEMENT: COMMITTEE DEVELOPMENT SESSIONS 2012 (Verbal Report)

12th June 2012 at 1:00pm –3.00pm within Meeting Room 1, Cameron House

9th October 2012 at 1:00pm –3.00pm within Activities Room, Playfield House

11th December 2012 at 1:00pm –3.00pm within Meeting Room 1, Cameron House

REPORT BY: MARY PORTER, ACTING GENERAL MANAGER
KIRKCALDY AND LEVENMOUTH CHP
NHS FIFE
REPORT TO KIRKCALDY AND LEVENMOUTH CHP
FINANCIAL REPORT FOR THE 12 MONTHS TO 31ST MARCH 2012

Income and Expenditure

The Income and Expenditure position for the CHP for the twelve months to 31st March 2012 is showing an underspend of £168k against Managed Clinical Services and a £473k overspend on Prescribing. Note that this outturn position is subject to review by External Audit as part of the annual accounts process.

This information is summarised in the following table:-

<table>
<thead>
<tr>
<th></th>
<th>Budget for Year</th>
<th>Budget for Period</th>
<th>Expenditure for Period</th>
<th>Over/ (under)</th>
<th>February over / (under)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Fife Wide Services</td>
<td>9,278</td>
<td>9,278</td>
<td>9,340</td>
<td>62</td>
<td>46</td>
</tr>
<tr>
<td>Local Services</td>
<td>13,741</td>
<td>13,741</td>
<td>13,428</td>
<td>(313)</td>
<td>(225)</td>
</tr>
<tr>
<td>Management, Admin &amp; Other</td>
<td>4,013</td>
<td>4,013</td>
<td>3,792</td>
<td>(221)</td>
<td>(190)</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>35,436</td>
<td>35,436</td>
<td>35,740</td>
<td>304</td>
<td>271</td>
</tr>
<tr>
<td>Voluntary Organisations</td>
<td>681</td>
<td>681</td>
<td>681</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Clinical Services</strong></td>
<td><strong>63,149</strong></td>
<td><strong>63,149</strong></td>
<td><strong>62,981</strong></td>
<td><strong>(168)</strong></td>
<td><strong>(98)</strong></td>
</tr>
<tr>
<td>Prescribing</td>
<td>21,423</td>
<td>21,423</td>
<td>21,896</td>
<td>473</td>
<td>469</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>84,572</strong></td>
<td><strong>84,572</strong></td>
<td><strong>84,877</strong></td>
<td><strong>305</strong></td>
<td><strong>371</strong></td>
</tr>
</tbody>
</table>

**Memorandum:**
Fife Wide - PMS Service and FHS

<table>
<thead>
<tr>
<th></th>
<th>Budget for Year</th>
<th>Budget for Period</th>
<th>Expenditure for Period</th>
<th>Over/ (under)</th>
<th>February over / (under)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PMS</td>
<td>45,406</td>
<td>45,406</td>
<td>45,427</td>
<td>(159)</td>
<td>(158)</td>
</tr>
<tr>
<td>Dental</td>
<td>22,835</td>
<td>22,835</td>
<td>22,835</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Ophthalmic</td>
<td>6,613</td>
<td>6,613</td>
<td>6,613</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>11,578</td>
<td>11,578</td>
<td>11,578</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

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 are made to the individual budgets in line with the available funding.
A total budget of £63,149k is available for Clinical Services at this stage, an increase of £18k on the Period 11 position, largely due to following adjustments:

<table>
<thead>
<tr>
<th>Description</th>
<th>(£000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transfer for Hepatitis C</td>
<td>(49)</td>
</tr>
<tr>
<td>Westfield upgrade</td>
<td>28</td>
</tr>
<tr>
<td>Insulin projects</td>
<td>28</td>
</tr>
<tr>
<td>Adult support &amp; protection</td>
<td>15</td>
</tr>
</tbody>
</table>

**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 the individual budgetary areas. More detailed reports behind the individual service areas are provided to the relevant managers via the CHP Management Accountants.

The main variances are:

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Pay Variance</th>
<th>Supplies Variance</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fife Wide Services</td>
<td>(£170k)</td>
<td>£233k</td>
<td>Vacancies within the Sexual Health service and within Dietetics is partially offset by an overspend within the Fife Rehab Service and Rheumatology.</td>
</tr>
<tr>
<td>Local Services</td>
<td>(£232k)</td>
<td>(£81k)</td>
<td>An underspend in community and hospital nursing arising from vacancies is partially offset by an overspend within AHPs in the Physio Service.</td>
</tr>
<tr>
<td>Management, Admin &amp; Other</td>
<td>(£167k)</td>
<td>(£55k)</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>Mental Health</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The overspend is mainly within QMH Nursing and Medical Staffing across sites. The overspend is partly within drugs, driven in part by an overspend of £27k against Methadone. The Methadone costs for the year total £406k against a budget of £379k. In addition, recharges from external facilities have significantly contributed to the overspend, in respect of CAMHS and IPCU.

| Voluntary Organisations Pay and Supplies | £0k | - | This is at break-even. |
| Prescribing | £473k | 2.2% | The prescribing position is based on 10 months of actual data and 2 months accruals. |

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.
Management Actions to Control Spend

The key area of overspend within the CHP is the Mental Health Service. In order to reduce the level of expenditure the following actions have been implemented: An Eating Disorders Intensive Treatment Team has been introduced to reduce the length of hospital stay in other units out-with Fife and plans are being developed to provide these services locally; Consultants have been recruited to remove the requirement for locums; Methadone prescribing continues to be closely monitored – a price reduction is in place from January 1st 2012 and the average level of Methadone dispensed in Fife has been reduced.

In addition to Mental Health, Fife-wide Services is also overspent. The key action here is to address the overspend in drugs. A new contract for a lower cost anti-TNF was agreed this year, and patients are being moved over to this where appropriate. This continues to be a challenge for the service as activity is currently 10% higher than last year.

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. 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 12 months.

<table>
<thead>
<tr>
<th>Carry Forward gap from 2010/11 (£000)</th>
<th>New target for 11/12 (£000)</th>
<th>Total target for 11/12 (£000)</th>
<th>Plans identified per the financial framework (£000)</th>
<th>Planned Delivery to P12 (£)</th>
<th>Delivered at Period 12 (£)</th>
<th>Surplus/ (Shortfall) (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>K&amp;LM</td>
<td>169</td>
<td>1,405</td>
<td>1,574</td>
<td>903</td>
<td>903</td>
<td>1,032</td>
</tr>
</tbody>
</table>

Capital

The Capital allocation for the CHP as at 31st March 2012 is shown in the attached appendix.

The specific allocation for Kirkcaldy & Levenmouth at this time is £312k. Other CHP general allocations bring the total capital allocation to £779k.

The expenditure against the specific allocation to date is £733k. The CHP has underspent against its total allocation, although this is managed in conjunction with divisional capital budgets across NHS Fife.

Summary

The position as at 31st March 2012 is showing an underspend of £168k on revenue budgets for Clinical Services, and a £473k overspend against Prescribing. The capital programme is showing an underspend of £46k.

Recommendation

The CHP Committee is asked to:

-  **Note** the contents of this report.
# Appendix 1

## FOR FINANCIAL YEAR 2011/12

<table>
<thead>
<tr>
<th>Project</th>
<th>CRL New Funding</th>
<th>Total Expenditure to Date</th>
<th>Projected Expenditure 2011/12</th>
<th>Projected Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£</td>
<td>£</td>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td>Stratheden - Asbestos Removal</td>
<td>34,000</td>
<td></td>
<td></td>
<td>(34,000)</td>
</tr>
<tr>
<td>Cameron - Electrical Distribution System Improvements</td>
<td>5,000</td>
<td></td>
<td></td>
<td>(5,000)</td>
</tr>
<tr>
<td>Cameron - Legionella Works</td>
<td>5,000</td>
<td></td>
<td>5,000</td>
<td>5,000</td>
</tr>
<tr>
<td>Cameron - Neopost Folder Insertor</td>
<td>198,000</td>
<td>193,906</td>
<td>193,906</td>
<td>(4,094)</td>
</tr>
<tr>
<td>S.H.S. Accommodation</td>
<td>9,834</td>
<td>9,087</td>
<td>9,087</td>
<td>(747)</td>
</tr>
<tr>
<td>Cameron - Pipework Repairs</td>
<td>31,574</td>
<td>27,099</td>
<td>27,099</td>
<td>(4,475)</td>
</tr>
<tr>
<td>Whytemans Brae - Lampost Replacement</td>
<td>18,592</td>
<td>21,179</td>
<td>21,179</td>
<td>2,587</td>
</tr>
<tr>
<td>Kirkcaldy Health Centre - Sanitary Works</td>
<td>10,000</td>
<td>9,537</td>
<td>9,537</td>
<td>(463)</td>
</tr>
<tr>
<td><strong>Total K &amp; LM CHP</strong></td>
<td><strong>312,000</strong></td>
<td><strong>265,809</strong></td>
<td><strong>265,809</strong></td>
<td><strong>(46,191)</strong></td>
</tr>
<tr>
<td><strong>Vehicle Replacement</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hyster Fork Lift Truck</td>
<td>14,343</td>
<td>14,343</td>
<td>14,343</td>
<td></td>
</tr>
<tr>
<td>Citroen Relay with supertruck conversion</td>
<td>25,032</td>
<td>25,032</td>
<td>25,032</td>
<td></td>
</tr>
<tr>
<td><strong>Total Vehicle Replacement</strong></td>
<td><strong>39,375</strong></td>
<td><strong>39,375</strong></td>
<td><strong>39,375</strong></td>
<td></td>
</tr>
<tr>
<td>Dental Service Centres</td>
<td>428,000</td>
<td>428,000</td>
<td>428,000</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL ALLOCATION FOR 2011/12</strong></td>
<td><strong>779,375</strong></td>
<td><strong>733,184</strong></td>
<td><strong>733,184</strong></td>
<td><strong>(46,191)</strong></td>
</tr>
</tbody>
</table>
1. **INTRODUCTION**

1.1 Kirkcaldy and Levenmouth CHP Workplan is based on the NHS Fife’s Balanced Scorecard approach. As identified in the CHP Workplan paper presented to the Committee on 12th July 2011, this report set out the priorities for the CHP during 2011/12.

1.2 The CHP Workplan (Appendix 1) identifies 22 key priority targets for NHS Fife which specifically relate to Kirkcaldy and Levenmouth CHP for 2011/12. The additional 19 objectives highlighted in the Workplan are local priorities which the CHP Management Team had agreed as objectives for 2011/12.

2. **PERFORMANCE**

2.1 NHS Fife’s performance is assessed by the Strategic Management Team and Kirkcaldy and Levenmouth’s performance is self assessed by the CHP Management Team, against criteria agreed with performance monitoring colleagues.

2.2 For monitoring purposes, NHS Fife and the CHP continue to use the “traffic lights” system. 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.

2.3 Table 1 highlights the CHP’s overall performance for the last quarter of the year (as at 31st March 2012).

<table>
<thead>
<tr>
<th>Status at March 2012</th>
<th>No of Targets</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue</td>
<td>6</td>
<td>14.5</td>
</tr>
<tr>
<td>Green</td>
<td>25</td>
<td>61</td>
</tr>
<tr>
<td>Amber</td>
<td>6</td>
<td>14.5</td>
</tr>
<tr>
<td>Red</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>100</td>
</tr>
</tbody>
</table>

*NB: This includes both NHS Fife targets which relate to Kirkcaldy and Levenmouth and the CHP’s local targets.*
Table 2 provides a comparison between NHS Fife and the CHP’s performance as at 31st March 2012.

<table>
<thead>
<tr>
<th></th>
<th>NHS Fife Balanced Scorecard</th>
<th>CHP Workplan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Green</td>
<td>15</td>
<td>12</td>
</tr>
<tr>
<td>Amber</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Red</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>22</td>
<td>22</td>
</tr>
</tbody>
</table>

NB: This relates to the 22 NHS Fife key priorities which also specifically relate to Kirkcaldy and Levenmouth CHP.

3. OVERALL ANALYSIS OF PERFORMANCE
3.1 Table 1 identifies that Kirkcaldy & Levenmouth CHP, at the end of the last quarter, are either on track or have completed 76% of all their priorities. Six targets have been delayed (15%), one target relating to NHS Fife and five local priority targets. All of these targets have been carried forward into 2012/13 CHP Workplan and action is ongoing to address and improve these targets’ performance.

The four targets the CHP have not met, as at 31st March 2012, (10%) have also been carried forward into the 2012/13 CHP Workplan and again the CHP will focus their attention on how these targets’ status may be improved.

The data in table 2 provides a comparison between NHS Fife and the CHP’s performance for the same targets. The CHP are, as at 31st March 2012, identifying 77% in the Blue or Green quadrant (on track or complete) as opposed to NHS Fife which is 73%.

4. RECOMMENDATION
4.1 The CHP Committee is asked to:

- **Note** the position as at March 2012 on the 2011/12 CHP Workplan
- **Note** the comparative report between the NHS Fife Balanced Scorecard and the CHP Workplan as at 31st March 2012.

REPORT BY: MARY PORTER, ACTING GENERAL MANAGER
KIRKCALDY AND LEVENMOUTH CHP
Kirkcaldy and Levenmouth
Community Health Partnership

CHP Workplan 2011/12

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
## BSC Objectives

<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>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.02</td>
<td>Disease Prevention</td>
<td>Alcohol brief interventions - we will aim to deliver 4,505</td>
<td>NT</td>
<td>Mar-12</td>
<td>Achieve agreed number of screenings using the setting-appropriate screening tool and appropriate alcohol brief intervention, in line with SIGN 74 guidelines during 2011/12.</td>
<td>Complete</td>
<td>BMcL</td>
</tr>
<tr>
<td>1.03</td>
<td>Disease Prevention</td>
<td>Smoking Cessation - we will aim to deliver 3,550 1-month smoking quits in the 40% most-deprived areas of Fife.</td>
<td>NT</td>
<td>Mar-14</td>
<td>Achieve agreed number of successful 1-month smoking quits in deprived areas of CHP.</td>
<td>On Track</td>
<td>MP</td>
</tr>
<tr>
<td>1.06</td>
<td>Early Years, Children &amp; Teenage Transition</td>
<td>Child Healthy Weight interventions - we will aim to deliver 1,060 interventions</td>
<td>NT</td>
<td>Mar-14</td>
<td>Achieve agreed completion rates for child healthy weight intervention programme over the three years ending March 2014</td>
<td>On Track</td>
<td>LB</td>
</tr>
<tr>
<td>1.09</td>
<td>Early Years, Children &amp; Teenage Transition</td>
<td>Childhood Immunisation - Ensure that all childhood immunisation targets are met.</td>
<td>LP</td>
<td>Mar-12</td>
<td>CHP continues to have a low uptake of 90.2 for MMR at less than 24 months. For &gt; 24 months Kirkcaldy and Leven are in line with the national average. All other immunisation rates are satisfactory.</td>
<td>Delayed</td>
<td>MP</td>
</tr>
<tr>
<td>K/L 1.10</td>
<td>Disease Prevention</td>
<td>-</td>
<td>LP</td>
<td>Mar-12</td>
<td>Vascular MCNs (Stroke) - Evaluate the future role of the Vascular MCNs.</td>
<td>On Track</td>
<td>MP</td>
</tr>
<tr>
<td>K/L 1.11</td>
<td>Disease Prevention</td>
<td>-</td>
<td>LP</td>
<td>Mar-12</td>
<td>Diabetes MCN - Evaluate the future role of the MCN</td>
<td>On Track</td>
<td>MP</td>
</tr>
<tr>
<td>K/L 1.12</td>
<td>Disease Prevention</td>
<td>-</td>
<td>LP</td>
<td>Mar-12</td>
<td>Heart Disease - Evaluate the future role of the MCN</td>
<td>On Track</td>
<td>MP</td>
</tr>
<tr>
<td>K/L 1.13</td>
<td>Early Years Children &amp; Teenage Transition</td>
<td>Breastfeeding - We will aim to increase the proportion of newborn children exclusively breastfed to 34.8%.</td>
<td>LP</td>
<td>Mar-12</td>
<td>Increase the proportion of newborn children exclusively breastfed.</td>
<td>Delayed</td>
<td>MP</td>
</tr>
<tr>
<td>K/L 1.14</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>Mar-12</td>
<td>Work with available data and put in place appropriate strategies to meet this target.</td>
<td>Delayed</td>
<td>MP</td>
</tr>
<tr>
<td>BSC No.</td>
<td>BSC Objective</td>
<td>NHS Fife Target</td>
<td>Target Origin</td>
<td>Target Date</td>
<td>CHP Target</td>
<td>Target Status</td>
<td>Lead</td>
</tr>
<tr>
<td>-------</td>
<td>-------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------</td>
<td>---------------</td>
<td>-------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------</td>
<td>------</td>
</tr>
<tr>
<td>2.01</td>
<td>Balance of Care</td>
<td>Delayed Discharges - We will aim to achieve no waits over 6 weeks.</td>
<td>NS</td>
<td>Mar-12</td>
<td>We will aim to achieve no waits over 6 weeks.</td>
<td>Not Met</td>
<td>GC</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>LP</td>
<td>Mar-12</td>
<td>Ensure NHS Fife Equality and Diversity legislative requirements are embedded into CHP.</td>
<td>On Track</td>
<td>FMcK</td>
</tr>
<tr>
<td>2.03</td>
<td>HAI</td>
<td>HAI - We will aim to reduce the rate of staphylococcus aureus bacteraemia (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>NT</td>
<td>Mar-13</td>
<td>Further reduce healthcare associated infections so that by 2012/13 NHS Board’s staphylococcus aureus bacteremia (including MRSA) cases are 0.26 or less per 1000 acute occupied bed days; and the rate of Clostridium difficile infections in patients aged 65 and over is 0.39 cases or less per 1,000 total occupied bed days.</td>
<td>On Track</td>
<td>MP</td>
</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>LP</td>
<td>Mar-12</td>
<td>Implement local Action Plan and Workplan for Health and Safety.</td>
<td>Complete</td>
<td>LB</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>NS</td>
<td>Mar-12</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>Not Met</td>
<td>GC</td>
</tr>
<tr>
<td>2.07</td>
<td>New Dcal/GWTD</td>
<td>New Deal/EWTD - We will comply with the requirements of New Deal and European Working Time Directive (EWTD)</td>
<td>LP</td>
<td>Mar-12</td>
<td>We will comply with the requirements of New Deal and EWTD within CHP.</td>
<td>Complete</td>
<td>BMcL</td>
</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>LP</td>
<td>Mar-12</td>
<td>To continue to develop, implement, monitor and evaluate the CHP SGAP, based on Local Partnership Forum development needs.</td>
<td>On Track</td>
<td>HF</td>
</tr>
<tr>
<td>K/L 2.09</td>
<td>Staff and Patient Welfare</td>
<td>-</td>
<td>LP</td>
<td>Mar-12</td>
<td>Deliver the vision for re-Shaping Care for Older People in Fife.</td>
<td>On Track</td>
<td>FMcK</td>
</tr>
<tr>
<td>K/L 2.10</td>
<td>Staff and Patient Welfare</td>
<td>-</td>
<td>LP</td>
<td>Mar-12</td>
<td>File Rehabilitation Service - Develop and Agree Neuro-Rehab Pathway</td>
<td>On Track</td>
<td>HF</td>
</tr>
<tr>
<td>K/L 2.11</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>
<td>On Track</td>
<td>BMcL</td>
</tr>
<tr>
<td>K/L 2.12</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>On Track</td>
<td>FMcK</td>
</tr>
<tr>
<td>K/L 2.13</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>On Track</td>
<td>FMcK</td>
</tr>
<tr>
<td>BSC No.</td>
<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>Lead</td>
</tr>
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<td>---------</td>
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</tr>
<tr>
<td>3.01</td>
<td><strong>Balance of Care</strong></td>
<td>Reduction in Emergency Bed Day Rates for Patients Aged 75+ - we will aim to reduce the bed days rate for people aged 75 and over to 3,750.</td>
<td>NT</td>
<td>Mar-12</td>
<td>Reducing the need for emergency hospital care. CHP will support NHS Fife to achieve agreed reductions in emergency inpatient bed day rates for people aged 75 and over between 2009/10 and 2011/12 through improved partnership working between the acute, primary and community care sectors.</td>
<td>Not Met</td>
<td>GC</td>
</tr>
<tr>
<td>3.08</td>
<td><strong>Resilience Planning</strong></td>
<td>Resilience Planning. We will continually review and refine our emergency planning arrangements. A - Business Continuity. B - Flu Pandemic.</td>
<td>LP</td>
<td>Mar-12</td>
<td>To review and amend CHP emergency plans annually and link into NHS Fife’s emergency plan.</td>
<td>On Track</td>
<td>HF</td>
</tr>
<tr>
<td>3.09</td>
<td><strong>Stroke Services</strong></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>To work with colleagues in the Operational Division and CHP to meet NHS Fife target.</td>
<td>Not Met</td>
<td>LB</td>
</tr>
<tr>
<td>3.10</td>
<td><strong>Clinical Redesign</strong></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>Deliver the Kirkcaldy &amp; Levenmouth CHP Clinical Strategy 2010-2012 and develop the Clinical Strategy for 2012-2014.</td>
<td>On Track</td>
<td>LB</td>
</tr>
<tr>
<td>K/L 3.11</td>
<td>Clinical Redesign</td>
<td>-</td>
<td>LP</td>
<td>Mar-12</td>
<td>Deliver the Community Nursing Framework</td>
<td>Complete</td>
<td>FMcK</td>
</tr>
<tr>
<td>K/L 3.12</td>
<td><strong>Balance of Care</strong></td>
<td>Complex Care for Older People - we will aim to increase the level receiving care at home to 27%.</td>
<td>LP</td>
<td>Mar-12</td>
<td>Increase the level of older people with complex care needs receiving care at home.</td>
<td>On Track</td>
<td>FMcK</td>
</tr>
<tr>
<td>K/L 3.13</td>
<td><strong>Balance of Care</strong></td>
<td>Long Term Conditions - we will aim to reduce the rates of hospital bed days of patients with a LTC.</td>
<td>LP</td>
<td>Mar-12</td>
<td>To work with available data and put in place appropriate strategies to meet this target.</td>
<td>Delayed</td>
<td>MP</td>
</tr>
<tr>
<td>BSC No.</td>
<td>BSC Objective</td>
<td>NHS Fife Target</td>
<td>Target Origin</td>
<td>Target Date</td>
<td>CHP Target</td>
<td>Target Status</td>
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</tr>
<tr>
<td>4.03</td>
<td>Child Protection</td>
<td>We will comply with Child Protection Standards set for HMIE inspection.</td>
<td>LP</td>
<td>Mar-12</td>
<td>We will comply with Child Protection Standards set for HMIE inspection within CHP.</td>
<td>On Track</td>
<td>MP</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-12</td>
<td>Investigate solutions and implement systems to ensure improved and safer patient care within CHP.</td>
<td>On Track</td>
<td>HF</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-12</td>
<td>Ensure CHP achieves financial balance in 2011/2012 and meets cash requirement.</td>
<td>Complete</td>
<td>GC</td>
</tr>
<tr>
<td>4.08</td>
<td>Finance</td>
<td>Cash Efficiencies - We will aim to achieve £1.5m cash efficiency savings.</td>
<td>E6</td>
<td>Mar-12</td>
<td>Ensure CHP contributes to Government Efficiency Targets.</td>
<td>Complete</td>
<td>GC</td>
</tr>
<tr>
<td>4.13</td>
<td>18 weeks RTT Collaborative</td>
<td>18 weeks Waiting Time - We will aim to deliver a maximum 18 weeks Referral to treatment timescale.</td>
<td>NT</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>HF</td>
</tr>
<tr>
<td>4.14</td>
<td>Joint Service Delivery</td>
<td>Drug and Alcohol Waiting Times - we will aim to have 90% of clients wait no longer than 3 weeks from referral to treatment.</td>
<td>NT</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.</td>
<td>On Track</td>
<td>BMcL</td>
</tr>
<tr>
<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>NT</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>BMcL</td>
</tr>
<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>Delayed</td>
<td>GC</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>On Track</td>
<td>HB</td>
</tr>
<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>On Track</td>
<td>FMcK</td>
</tr>
<tr>
<td>K/L 4.20</td>
<td>Finance</td>
<td>-</td>
<td>LP</td>
<td>Mar-12</td>
<td>Pharmacy Service - Deliver wound care prescribing efficiency savings.</td>
<td>On Track</td>
<td>LB</td>
</tr>
<tr>
<td>K/L 4.21</td>
<td>Capacity</td>
<td>Efficiencies - we will aim to deliver improved efficiencies or sustain standards i) N:R Out-patient attendance at 2.21; ii) New OP attendance DNA at 7.8%.</td>
<td>LP</td>
<td>Mar-12</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>HF</td>
</tr>
<tr>
<td>K/L 4.22</td>
<td>Corporate Governance</td>
<td>Best Value - Develop a framework during 2011/12 to provide assurance on Best Value.</td>
<td>LP</td>
<td>Mar-12</td>
<td>Best Value - Ensure CHP are providing overt assurance to the Accountable Officer on Best Value as required by the guidance on the Statement of Internal Control.</td>
<td>On Track</td>
<td>HF</td>
</tr>
</tbody>
</table>
## PERFORMANCE AT A GLANCE
### COMPARISON – BALANCED SCORECARD/CHP WORKPLAN 2011/12

<table>
<thead>
<tr>
<th>ID No</th>
<th>Target</th>
<th>Target Origin</th>
<th>CHP Lead</th>
<th>NHS Fife Balanced Scorecard March 2012</th>
<th>CHP Workplan March 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.02</td>
<td>Alcohol Brief interventions – we will aim to deliver 4,505</td>
<td>NT</td>
<td>BMcL</td>
<td>Complete</td>
<td>Complete</td>
</tr>
<tr>
<td>1.03</td>
<td>Smoking Cessation – we will aim to deliver 3,550 – 1 month smoking quits in the 40% most deprived areas of Fife.</td>
<td>NT</td>
<td>MP</td>
<td>On Track</td>
<td>On Track</td>
</tr>
<tr>
<td>1.06</td>
<td>Child Health Weight interventions – we will aim to deliver 1,060 interventions.</td>
<td>NT</td>
<td>LB</td>
<td>On Track</td>
<td>On Track</td>
</tr>
<tr>
<td>1.09</td>
<td>Childhood Immunisation – Ensure that all childhood immunisation targets are met.</td>
<td>LP</td>
<td>MP</td>
<td>Not Met</td>
<td>Delayed</td>
</tr>
<tr>
<td>2.01</td>
<td>Delayed Discharges – We will aim to achieve no waits over 6 weeks</td>
<td>NS</td>
<td>GC</td>
<td>Not Met</td>
<td>Not Met</td>
</tr>
<tr>
<td>2.02</td>
<td>Equality and Diversity legislative requirements to be embedded into NHS Fife.</td>
<td>LP</td>
<td>FMcK</td>
<td>On Track</td>
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</tr>
<tr>
<td>2.03</td>
<td>HAI – We will aim to reduce the rate of staphylococcus aureus bacteraemia (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>NT</td>
<td>MP</td>
<td>On Track</td>
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<tr>
<td>2.05</td>
<td>Health &amp; Safety – We will develop and implement the annual local action plans for Health and Safety.</td>
<td>LP</td>
<td>LB</td>
<td>On Track</td>
<td>Complete</td>
</tr>
<tr>
<td>2.06</td>
<td>Sickness Absence – We will aim to achieve and sustain a sickness absence rate of no more than 4%.</td>
<td>NS</td>
<td>GC</td>
<td>Not Met</td>
<td>Not Met</td>
</tr>
<tr>
<td>2.07</td>
<td>New Deal/EWTD – We will comply with the requirements of New Deal and European Working Time Directive (EWTD)</td>
<td>LP</td>
<td>BMcL</td>
<td>Delayed</td>
<td>Complete</td>
</tr>
<tr>
<td>2.08</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>HF</td>
<td>On Track</td>
<td>On Track</td>
</tr>
<tr>
<td>3.01</td>
<td>Reduction in Emergency Bed Day Rates for Patients Aged 75+ - we will aim to reduce the bed days for people aged 75 and over to 3,750.</td>
<td>NT</td>
<td>GC</td>
<td>Not Met</td>
<td>Not Met</td>
</tr>
<tr>
<td>3.08</td>
<td>Resilience Planning – We will continually review and refine our emergency planning arrangements A – Business Continuity, B – Flu Pandemic.</td>
<td>LP</td>
<td>HF</td>
<td>On Track</td>
<td>On Track</td>
</tr>
<tr>
<td>ID No</td>
<td>Target</td>
<td>Target Origin</td>
<td>CHP Lead</td>
<td>NHS Fife Balanced Scorecard March 2012</td>
<td>CHP Workplan March 2012</td>
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<tr>
<td>3.09</td>
<td>Stroke Services - 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>LB</td>
<td>Not Met</td>
<td>Not Met</td>
</tr>
<tr>
<td>3.10</td>
<td>Clinical Redesign - 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>LB</td>
<td>On Track</td>
<td>On Track</td>
</tr>
<tr>
<td>4.03</td>
<td>Child Protection - We will comply with Child Protection Standards set for HMIE inspection.</td>
<td>LP</td>
<td>MP</td>
<td>On Track</td>
<td>On Track</td>
</tr>
<tr>
<td>4.06</td>
<td>E’Health – We will identify and implement solutions to support improved and safer patient care.</td>
<td>LP</td>
<td>HF</td>
<td>On Track</td>
<td>On Track</td>
</tr>
<tr>
<td>4.07</td>
<td>Financial Performance – We will aim to operate within our revenue and capital resource limit.</td>
<td>E5</td>
<td>GC</td>
<td>On Track</td>
<td>Complete</td>
</tr>
<tr>
<td>4.08</td>
<td>Cash efficiencies – We will aim to achieve £1.5 m cash efficiency savings.</td>
<td>E6</td>
<td>GC</td>
<td>On Track</td>
<td>Complete</td>
</tr>
<tr>
<td>4.13</td>
<td>18 weeks Waiting Time – We will aim to deliver a maximum 18 weeks RTT timescale.</td>
<td>NT</td>
<td>HF</td>
<td>On Track</td>
<td>On Track</td>
</tr>
<tr>
<td>4.14</td>
<td>Drug and Alcohol Waiting Times – 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>NT</td>
<td>BMcL</td>
<td>On Track</td>
<td>On Track</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 CAMH Services.</td>
<td>NT</td>
<td>BMcL</td>
<td>On Track</td>
<td>On Track</td>
</tr>
</tbody>
</table>
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 2012/13 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 at regular intervals throughout the year.

2. PERFORMANCE: 2012/13

2.1 The CHP Workplan (Appendix 1) sets out the objectives of Kirkcaldy and Levenmouth CHP, based on NHS Fife’s key priorities and the CHP’s local priorities for 2012/13. The CHP Workplan aims to articulate the CHP’s objectives 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 2012/13 CHP Workplan.
Kirkcaldy and Levenmouth
Community Health Partnership

CHP Workplan 2012/13

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>Quality Ambition</th>
<th>National Target/Standard</th>
<th>NHS Fife Target</th>
<th>Target Origin</th>
<th>Target Date</th>
<th>CHP Target</th>
<th>Target Status</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.02</td>
<td>Clinically Effective</td>
<td>National Standard NHS Boards and Alcohol and Drug Partnerships (ADPs) will sustain and embed alcohol brief interventions (ABI) in the three priority settings (Primary Care, A&amp;E, Antenatal) in accordance with the SIGN 74 Guideline. In addition, they will continue to develop delivery of alcohol brief interventions in wider settings.</td>
<td>Alcohol Brief Interventions - We will aim to deliver 4,505.</td>
<td>National HEAT Standard</td>
<td>Mar-13</td>
<td>Achieve agreed number of screenings using the setting appropriate screening tool and appropriate alcohol brief interventions, in line with SIGN 74 guideline during 2012/13.</td>
<td>BMcL</td>
<td></td>
</tr>
<tr>
<td>1.03</td>
<td>Clinically Effective</td>
<td>National Target: NHS Scotland to deliver universal smoking cessation services to achieve at least 80,000 successful quits (at one month post quit) including 48,000 in the 40% most-deprived within-Board (SIMD) areas over the three years ending March 2014.</td>
<td>Smoking Cessation (SIMD) - We will aim to deliver 3,550 1-month smoking quits in the 40% most deprived areas of Fife.</td>
<td>National HEAT Target</td>
<td>Mar-14</td>
<td>Achieve agreed number of successful 1-month smoking quits in deprived areas of CHP.</td>
<td>NC</td>
<td></td>
</tr>
<tr>
<td>1.06</td>
<td>Clinically Effective</td>
<td>National Target: To achieve 14,910 completed child healthy weight interventions over the three years ending March 2014.</td>
<td>Child Healthy Weight Interventions - We will aim to deliver 1,060 interventions.</td>
<td>National HEAT Target</td>
<td>Mar-14</td>
<td>Achieve agreed completion rates for child healthy weight intervention programme over the three years ending March 2014.</td>
<td>LA</td>
<td></td>
</tr>
<tr>
<td>1.09</td>
<td>Clinically Effective</td>
<td>Local Priority: NHS Fife will take action to ensure that the uptake of the MMR1 vaccine by children aged 2 and 5 improves against the national standard.</td>
<td>Childhood Immunisation - We will improve the NHS Fife uptake of MMR1 at Age 2 and Age 5, against the standard of 95%.</td>
<td>NHS Fife Local Priority</td>
<td>Mar-13</td>
<td>CHP will support NHS Fife in improving the NHS Fife uptake of MMR1 vaccine.</td>
<td>NC</td>
<td></td>
</tr>
<tr>
<td>1.10</td>
<td>Improving Health</td>
<td>National Target: Reduce suicide rate between 2002 and 2013 by 20%.</td>
<td>Suicide Rate - We will achieve a 20% reduction in suicide rate based on 2002 figures.</td>
<td>National HEAT Target</td>
<td>Dec-13</td>
<td>CHP will aim to achieve a 20% reduction in suicide rate, based on 2002 figures.</td>
<td>BMcL</td>
<td></td>
</tr>
<tr>
<td></td>
<td>K/L Disease Prevention -</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>1.11</td>
<td></td>
<td>Vascular MCNs (Stroke) - Evaluate the future role of the Vascular MCNs.</td>
<td>Chp Local Priority</td>
<td>Mar-13</td>
<td>Vascular MCNs (Stroke) - Evaluate the future role of the Vascular MCNs.</td>
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<td>1.12</td>
<td></td>
<td>Diabetes MCN - Evaluate the future role of the MCN</td>
<td>Chp Local Priority</td>
<td>Mar-13</td>
<td>Diabetes MCN - Evaluate the future role of the MCN</td>
<td>NC</td>
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<tr>
<td>1.13</td>
<td></td>
<td>Heart Disease - Evaluate the future role of the MCN</td>
<td>Chp Local Priority</td>
<td>Mar-13</td>
<td>Heart Disease - Evaluate the future role of the MCN</td>
<td>NC</td>
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<tr>
<td>1.14</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>Chp Local Priority</td>
<td>Mar-13</td>
<td>CHP will support NHS Fife to increase the proportion of new-born children exclusively breastfed to 34.8%.</td>
<td>NC</td>
<td></td>
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<tr>
<td>1.15</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>Chp Local Priority</td>
<td>Mar-13</td>
<td>To support NHS Fife to reduce teenage pregnancies to 7.2 per 1,000 population.</td>
<td>NC</td>
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<tr>
<td>1.16</td>
<td>Clinically Effective</td>
<td>Chp Local Priority</td>
<td>Chp Local Priority</td>
<td>Mar-13</td>
<td>To meet the target for the number of patients receiving treatment for HCV - national target 43 patients in treatment 2012/13.</td>
<td>HB</td>
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<tr>
<td>BSC No.</td>
<td>Quality</td>
<td>Ambition</td>
<td>National Target/Standard</td>
<td>NHS Fife Target</td>
<td>Target Origin</td>
<td>Target Date</td>
<td>CHP Target</td>
<td>Target Status</td>
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<tr>
<td>2.01</td>
<td>Person Centred</td>
<td>National Target: No people will wait more than 28 days to be discharged from hospital into a more appropriate care setting, once treatment is complete from April 2013, followed by a 14 day maximum wait from April 2015.</td>
<td>Delayed Discharges - We will aim to achieve no waits over 4 weeks.</td>
<td>National HEAT Target</td>
<td>Apr-13</td>
<td>We will aim to achieve no people waiting more than 4 weeks to be discharged from hospital into a more appropriate care setting.</td>
<td></td>
<td>MP</td>
</tr>
<tr>
<td>2.03</td>
<td>Safe</td>
<td>National Target: Further reduce healthcare associated infections so that by 2012/13 NHS Boards’ staphylococcus aureus bacteriemia (including MRSA) cases are 0.26 or less per 1000 acute occupied bed days; and the rate of Clostridium difficile infections in patients aged 65 and over is 0.39 cases or less per 1000 total occupied bed days.</td>
<td>HAI - We will aim to reduce the rate of staphylococcus aureus bacteriemia (including MRSA) to 0.26 and maintain a rate of C diff infection in the over 65s of less than 0.39.</td>
<td>National HEAT Target</td>
<td>Mar-13</td>
<td>CHP will aim to reduce the rate of healthcare associated infections to 0.26 or less per 1000 acute occupied bed days and maintain a rate of c diff infection in the over 65s of less than 0.39.</td>
<td></td>
<td>NC</td>
</tr>
<tr>
<td>2.06</td>
<td>Clinically Effective</td>
<td>National Standard: We will aim to achieve and sustain a sickness absence rate of no more than 4%.</td>
<td>Sick Absence - We will aim to achieve and sustain a sickness absence rate of no more than 4%.</td>
<td>National HEAT Standard</td>
<td>Mar-13</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>
<td>MP</td>
</tr>
<tr>
<td>2.08</td>
<td>Person Centred</td>
<td>Local Priority: We will aim to ensure staff governance strategy setting and action planning processes are in place.</td>
<td>Staff Governance - We will aim to ensure staff governance strategy setting and action planning processes are in place.</td>
<td>NHS Fife Local Priority</td>
<td>Mar-13</td>
<td>To continue to develop, implement, monitor and evaluate the CHP SGAP, based on local partnership forum development needs.</td>
<td></td>
<td>HF</td>
</tr>
<tr>
<td>2.13</td>
<td>Person Centred</td>
<td>National Target: NHS Boards and partners will reduce the rate of emergency inpatient bed days for people aged 75 and over per 1,000 population, by at least 12% between 2009/10 and 2014/15.</td>
<td>Reduction in Emergency Bed Day Rates for Patients Aged 75+ by 2014/15, we will aim to reduce the bed days rate to 3,556.</td>
<td>National HEAT Target</td>
<td>Mar-15</td>
<td>CHP will support NHS Fife to achieve agreed reductions in emergency inpatient bed day rates for people aged 75 and over between 2009/10 and 2014/15 through improved partnership working between the acute, primary and community care sectors.</td>
<td></td>
<td>MP</td>
</tr>
<tr>
<td>K/L</td>
<td>Staff and Patient Welfare</td>
<td>Reshaping Care for Older People linked to reduction in bed days and to the 4 hour A&amp;E standard, the whole system measure.</td>
<td>To implement across Fife the full ICASS to include Hospital @ Home in all areas.</td>
<td>CHP Local Priority</td>
<td>Mar-13</td>
<td>• To implement in Kirkcaldy &amp; Levenmouth full ICASS, including Hospital @ Home. • To contribute to the delivery of the Clinical Strategy.</td>
<td></td>
<td>FM</td>
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<tr>
<td>K/L</td>
<td>Staff and Patient Welfare</td>
<td>-</td>
<td>-</td>
<td>CHP Local Priority</td>
<td>Mar-13</td>
<td>Mental Health Service - Develop and implement Psychiatry Liaison Services.</td>
<td></td>
<td>BMcL</td>
</tr>
<tr>
<td>K/L</td>
<td>Person Centred</td>
<td>-</td>
<td>-</td>
<td>CHP Local Priority</td>
<td>Mar-13</td>
<td>Continue with the integration of Sexual Health Service by relocating the service currently located at Carnegie Clinic to QMH to allow a fully integrated service to be offered in West Fife</td>
<td></td>
<td>HB</td>
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<tr>
<td>K/L</td>
<td>Clinically Effective</td>
<td>-</td>
<td>-</td>
<td>CHP Local Priority</td>
<td>Mar-13</td>
<td>To improve the pathway for patients referred for female sterilisation counselling with the aim of reducing the number of women undergoing sterilisation procedures</td>
<td></td>
<td>HB</td>
</tr>
</tbody>
</table>
## BSC No. 3.04 Effective Efficient and Timely

**National Standard:** Maintain the proportion of people with a diagnosis of dementia on the Quality and Outcome Framework (QOF) dementia register and other equivalent sources.

**Target:** Dementia - We will aim to have 2908 diagnosed patients registered on the Quality Outcome Framework.

**Target Origin:** National HEAT Standard

**Target Date:** Mar-13

**CHP Target:** CHP will support NHS Fife to have 2908 diagnosed patients registered on the QOF.

**Status:** BMcL

## BSC No. 3.05 Safe

**Local Priority:** Voluntary implementation of the first phase of the Scottish Patient safety programme - mental health

**Patient Safety:** one clinical area will be identified and participate in the scoping phase of the programme.

**Target Origin:** NHS Fife Local Priority

**Target Date:** Mar-13

**CHP Target:** Patient Safety - one clinical area will be identified and participate in the scoping phase of the programme.

**Lead:** BMcL

## BSC No. 3.09 Clinically Effective

**National Target:** To improve stroke care, 90% of all patients admitted with a diagnosis of stroke will be admitted to a stroke unit on the day of admission, or the day following presentation by March 2013.

**Stroke Services:** 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.

**Target Origin:** National HEAT Target

**Target Date:** Mar-13

**CHP Target:** To review bed numbers required within the CHP across Central and East Fife in collaboration with Glenrothes & North East Fife CHP. The enablers and measures of progress develop discussion paper across the 2 CHP areas in order that demand is understood in the context of the national and local targets/care. Maximise the use of ICASS in relation to early supported discharge for stroke patients.

**Lead:** FMcK

## K/L 3.10 Balance of Care

**Long Term Conditions:** we will aim to reduce the rates of hospital bed days of patients with a LTC.

**Target Origin:** CHP Local Priority

**Target Date:** Mar-13

**CHP Target:** To work with available data and put in place appropriate strategies to meet this target.

**Lead:** NC

## K/L 3.11 Clinical Redesign

**Forensic mental health statutory requirement:** NHS Boards to provide local low secure care.

**Local priority:** Implement a local solution to accommodate mental health low secure inpatients in Fife.

**Target Origin:** CHP Local Priority

**Target Date:** Sep-12

**CHP Target:** Develop and establish a mental health low secure inpatient facility on the Stratheden site.

**Lead:** BMcL

## K/L 3.12 Clinical Redesign

**Shifting the balance of care:** Mental Health Partnership: Improve the outcomes for individuals whose assessed needs indicate they are able to move from inpatient care to the community.

**Target Origin:** CHP Local Priority

**Target Date:** Mar-14

**CHP Target:** In conjunction with Social Work, implement a rehabilitation redesign programme enabling up to 45 patients to be discharged.

**Lead:** BMcL
<table>
<thead>
<tr>
<th>BSC No.</th>
<th>Quality</th>
<th>National Target/Standard</th>
<th>NHS Fife Target</th>
<th>Target Origin</th>
<th>Target Date</th>
<th>CHP Target</th>
<th>Target Status</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.03</td>
<td>Safe</td>
<td>Local Priority:</td>
<td>Child Protection - We will ensure information is shared appropriately to support Child Protection.</td>
<td>NHS Fife Local Priority</td>
<td>Mar-13</td>
<td>Within the CHP we will ensure information is shared appropriately to support Child Protection.</td>
<td>NC</td>
<td></td>
</tr>
<tr>
<td>4.07</td>
<td>Clinically Effective</td>
<td>National Target: Boards to operate within their agreed revenue resource limit; operate within their capital resource limit; meet their cash requirement.</td>
<td>Financial performance - We will aim to: i) operate within our RRL ii) operate within our CRL iii) meet our cash requirement</td>
<td>National HEAT Target</td>
<td>Mar-13</td>
<td>Ensure CHP achieves financial balance in 2012/13 and meets cash requirement.</td>
<td>MP</td>
<td></td>
</tr>
<tr>
<td>4.13</td>
<td>Clinically Effective</td>
<td>National Standard: 90% of planned/elective patients to commence treatment within 18 weeks of referral.</td>
<td>18 weeks RTT - We will aim to deliver a maximum 18 weeks referral to treatment</td>
<td>National HEAT Standard</td>
<td>Mar-13</td>
<td>Ensure appropriate planning for and compliance with, all waiting time targets including 18 week referral to treatment target for Rheumatology.</td>
<td>HF</td>
<td></td>
</tr>
<tr>
<td>4.14</td>
<td>Clinically Effective</td>
<td>National Target: By March 2013, 90% of clients will wait no longer that 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery.</td>
<td>Drug and Alcohol Waiting Times - We will aim to have 90% of clients wait no longer than 3 weeks from referral to treatment.</td>
<td>National HEAT Target</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.</td>
<td>BMcL</td>
<td></td>
</tr>
<tr>
<td>4.15</td>
<td>Clinically Effective</td>
<td>National Target: Deliver faster access to mental health services by delivering 26 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (CAMHS) from March 2013, reducing to 18 weeks by December 2014.</td>
<td>CAMHS Waiting Times - We will aim to have no-one waiting longer than 26 weeks from referral to treatment for specialist CAMHS services.</td>
<td>National HEAT Target</td>
<td>Mar-13</td>
<td>By March 2013, we will aim to have no-one wait longer than 26 weeks from referral to treatment for specialist CAMHS services.</td>
<td>BMcL</td>
<td></td>
</tr>
<tr>
<td>4.17</td>
<td>Clinically Effective</td>
<td>National Target: Deliver faster access to mental health services by delivering 18 weeks referral to treatment for Psychological Therapies from December 2014.</td>
<td>Faster Access to Mental Health Services - We will aim to have no-one waiting longer than 18 weeks from referral to treatment for Psychological Therapies.</td>
<td>National HEAT Target</td>
<td>Dec-14</td>
<td>By December 2014, we will aim to have no-one wait longer than 18 wks from referral to treatment for Psychological Therapies.</td>
<td>BMcL</td>
<td></td>
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<tr>
<td>K/L</td>
<td>Capacity</td>
<td>-</td>
<td>CHP Local Priority</td>
<td>Mar-13</td>
<td>Review of Dietetic Department Service</td>
<td>MP</td>
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<tr>
<td>K/L</td>
<td>Finance</td>
<td>-</td>
<td>CHP Local Priority</td>
<td>Mar-13</td>
<td>Reduce overspend in CHP Prescribing Budget</td>
<td>LA</td>
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<tr>
<td>K/L</td>
<td>Capacity</td>
<td>Efficiencies - we will aim to deliver improved efficiencies or sustain standards i) N/R Out-patient attendance at 2.21 ii) New OP attendance DNA at 7.8%.</td>
<td>CHP Local Priority</td>
<td>Mar-13</td>
<td>Deliver improved efficiencies for rheumatology for first out-patient attendance for DNAs and N/R out-patient attendance ratio.</td>
<td>HF</td>
<td></td>
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<tr>
<td>K/L</td>
<td>Corporate Governance</td>
<td>Best Value - Develop a framework during 2012/13 to provide assurance on Best Value.</td>
<td>CHP Local Priority</td>
<td>Mar-13</td>
<td>Best Value - Ensure CHP are providing overt assurance to the Accountable Officer on Best Value as required by the guidance on the Statement of Internal Control.</td>
<td>HF</td>
<td></td>
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</tr>
<tr>
<td>K/L</td>
<td>Clinical Strategy</td>
<td>-</td>
<td>CHP Local Priority</td>
<td>Mar-13</td>
<td>•Increase capacity and review support to Primary Care and General Medical Practice to reflect increasing demand. •Release GPs from unnecessary gatekeeper roles and unnecessary onward referral to secondary care</td>
<td>LA</td>
<td></td>
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</table>
1. INTRODUCTION

1.1 In 2011 NHS Scotland outlined an aim to deliver universal smoking cessation services to achieve at least 7.5% (80,000) successful quit (at one month post quit) including 48,000 in the 40% most deprived within board SMD areas over the three years ending in March 2014.

This translates to 3,550 one month quit rates in 40% of the most deprived areas in Fife. Within Kirkcaldy and Levenmouth we are required to achieve 1872 successful one month quit rates with 1461 of these people residing in the 40% most deprived areas.

This paper provides a summary of Kirkcaldy and Levenmouth Community Health Partnerships progress towards the HEAT target.

2. BACKGROUND

2.1 Within Kirkcaldy and Levenmouth CHP people can have access to the main types of smoking cessation support:

- Specialist Support: A 7 week programme of group (1 hour per week) or individual support (20-30 minutes per week) delivered within NHS and community venues. Support is delivered by specialist smoking cessation workers and vascular nurses. In addition to the planned groups and clinics there are “drop in” sessions available to people that wish to discuss stopping smoking or if they require additional support or to help sustain their quit. Domiciliary support is also available should this be required.

- Pharmacy Support: There are 21 community pharmacies providing smoking cessation support within Kirkcaldy and Levenmouth offering up to 8 weeks of smoking cessation support and 12 weeks of nicotine replacement therapy. Appointments last for approximately 10 minutes and are available at flexible times. Smoking cessation is also included as part of the national pharmacy contact which was introduced in 2008.

3. SUMMARY OF SERVICE ACCESS AND OUTCOME DATA

3.1 Detailed information regarding the service will be included in future annual reports however the development of the service can be demonstrated in the following charts regarding access to the service, the number of clients setting a quit date and quit rates at 4 weeks.

Chart 1: Access to service
Access to the service has increased significantly over the past 3 years from 1046 clients in 2009 to 2112 in 2011.

Chart 2: Clients Setting a quit date

![Clients Setting a Quit Date](chart2)

The service has sustained that over 90% of people that access the service go on to set a quit date.

Chart 3: Successful Quit Rates at 1 month

![Clients with Successful Quit at 1 Month](chart3)

Within Kirkcaldy and Levenmouth CHP 42% of people achieve a quit at 4 weeks. This is above the national average of a 39% quit rate at 4 weeks. There is also evidence that the service is supporting people to sustain a successful quit with 15% of people achieving a 12 month quit rate compared with a national average of 7%.

4. PROGRESSION TOWARDS THE HEAT TARGET

4.1 H6 target 2011/2014 requires each health board area to support 7.5% of their smoking population to quit at 4 weeks with a percentage of these quits (60% for NHS Fife) from 40% of the most deprived areas.

Following NHS Fife Senior Management Team’s decision to split the deprivation target using a population based approach, Kirkcaldy & Levenmouth Stop Smoking Service requires 1872 clients quit at 4 weeks with 1461 (78%) of these quits residing in the 40% most deprived areas.

In order to achieve the target, approximately 1758 clients are required to access support from March 2012 to March 2014, equating to 70 clients per month. These figures are an approximation based on an average quit rate of 48% over the past 5 years and allows for clients not setting a quit date, approximately 8% of those accessing the service.

As demonstrated in the graph below, Kirkcaldy & Levenmouth has achieved 745 quits in relation to the required 624 target quits for year 1, and has achieved 540 SIMD quits in relation to the required 487 quits for year 1. This is 129% above the target that has been set for the CHP.
5. **Work Planned**

Considerable work has been undertaken and is planned in the coming months to make the service accessible and to raise awareness and referrals to enable people to access support to stop smoking. Some examples include:

- **Service Provision**: Within Pharmacies, GP practices and community venues. Also exploring alternative support options should people be unable to attend a session e.g. telephone, email.

- **Promotion/Marketing**: The service is actively involved in: No Smoking Day; marketing campaigns targeting community venues e.g. community centres, leisure centres; media coverage of peoples' stories; participating in Fife wide marketing; advertising on pay and display parking tickets.

- **Engagement with other services**: links are developed and being enhanced with other service providers to raise awareness and encourage referral to the service e.g. nursing staff, GP practices, optometrists

- **Continual Review**: Mapping exercise performed with information analyst end January to highlight postcodes/areas of low access/quit rates to guide service provision and marketing. Updated maps produced by analyst end March (data Apr 11-Dec11), no change noted to access/quit rates

- **Solution Focused approach**: The service actively monitors various sources of data to identify if there are any areas/issues that may be impacting on outcomes and works positively in partnership with others as relevant to support improvement. Some examples include: prescribing data to identify practices with high prescribing of Nicotine Replacement Therapy to raise awareness and promote referral; introducing a Champix request letter to reduce potential barriers in accessing treatment; monitoring return of paperwork and data.

6. **Summary**

6.1 Both the specialist and pharmacy aspects of the smoking cessation service are demonstrating significant improvements on a year on year basis in terms of access to service and quit rates. Whilst full year data for Year 1 of the HEAT target is not currently available, the data thus far demonstrates that we are exceeding the target for 1 month quit rates both in terms of the total number of people and also people living within deprived areas. The service is also demonstrating a very proactive approach to: raising awareness; promoting referral; delivering flexible treatment and support options; managing data; identifying areas for improvement and targeting resource to meet identified need.
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<th>7.</th>
<th>RECOMMENDATION</th>
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<tbody>
<tr>
<td>7.1</td>
<td>The Committee is asked to:—</td>
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</table>

- **Note** the progress being made within Kirkcaldy and Levenmouth CHP towards delivery against the HEAT target for smoking cessation.

REPORT BY:  
NICKY CONNOR, ACTING ASSOCIATE NURSE DIRECTOR  
KIRKCALDY AND LEVENMOUTH CHP
DELIVERY & EFFICIENCY: WORKFORCE MODERNISATION AND DEVELOPMENT
REVISED WORKFORCE PLANNING GUIDANCE / STRATEGIC PLAN 2012-13

1. INTRODUCTION

1.1 This paper outlines for Committee members an overview of the revised Workforce Planning Guidance issued by the Scottish Government in December 2011. It also describes for members’ information the framework which is in place to develop the Kirkcaldy & Levenmouth CHP Workforce Plan and how this fits in with the development of the NHS Fife strategic plan.

1.2 Workforce planning is a statutory requirement and was established in NHS Scotland (NHSS) in 2005 when Boards were provided with a base for establishing workforce planning as a key element of the wider planning systems within NHSS. There has since been discussion for some time about the need to refresh the workforce planning guidance and ensure that the methodology can be used by other areas of planning, most notably within financial and service planning. The revised guidance issued under CEL 32(2011) provided Boards with a consistent framework to support evidence based workforce planning. It also emphasises the importance of using the available workforce planning tools to underpin any projections.

1.3 The Workforce Plan is an integral element of the Quality Strategy and enables the organisation to demonstrate how better quality of care and outcomes for patients can be delivered.

2. CEL 32(2011) – REVISED WORKFORCE PLANNING GUIDANCE 2011

2.1 The guidance reflects the 6 Step Methodology to integrated Workforce Planning and includes workforce projections which for most staff groups will cover a period of 3 years.

2.2 The 6 step methodology components are as follows:

**Step 1: Defining the Plan**
To describe the purpose of the plan and how it will support the achievement of wider Corporate goals and objectives and define the purpose, scope and ownership of the Workforce plan.

**Step 2: Service Change**
To indicate the goals and benefits of change, the future context for how services will be delivered, identify the options for future service delivery, the drivers for and / or Constraints against future changes and what any preferred option(s) might look like.

**Step3: Defining the Workforce Required**
To outline the workforce required to meet the predicted service needs and requires all of the key issues local and national which will impact upon workforce design and deployment to be taken into account.

**Step4: Workforce Capability**
To describe the characteristics of the current workforce (i.e. baseline data), how any supply data can inform workforce forecasting and to identify what options can be implemented in managing future supply.
Step 5: **Action Plan**
To develop an action plan which identifies short, medium or long term actions and how these will be progressed and managed.

**Step 6: Implementation and Monitoring**
To implement a monitoring process which allows for reflection on actions and the ability to take into account any new drivers and any unintended consequences of developments.

2.2 The guidance also is seen as providing a tool to:
- Ensure closer integration between NHS Boards and Social Care providers in planning the wider workforce.
- Identify the key learning and educational needs of the existing and future workforce, the evidence of which will inform national education and training requirements.
- Reference the evidence and material that will support the wider planning agenda (including financial and service planning).
- Ensure that in developing workforce plans they support corporate goals and objectives.
- Take account of the guiding principles of workforce planning.

2.3 The timetable within the guidance seeks to have workforce plans approved by the Board and published by 30 June 2012.

3. **CHP FRAMEWORK**

3.1 The CHP has taken the above guidance into account and has implemented local arrangements which identify those key individuals who have been given responsibility for taking forward workforce planning for all staff groups and identified services within the CHP. These arrangements also include the timetable for the completion and submission of the relevant information.

3.2 Appropriate templates based upon the guidance have been issued to these individuals with a requirement that these be completed and submitted to senior management for review and to ensure that any projections support the service delivery objectives of the CHP going forward.

3.3 It is important that any workforce planning exercise is iterative in nature and is not viewed as a one-off annual event. The ability to revisit and review projections on an ongoing basis is absolutely necessary to make any workforce plan meaningful and inextricably linked to the CHP strategic plans outlining the way in which services will be delivered in the future.

4. **RECOMMENDATION**

4.1 The Committee is asked to:-

- **Note** receipt of the revised guidance and the steps taken within the CHP to ensure that a robust framework is in place to underpin the development of the workforce plan.
ITEMS FOR INFORMATION: LOCAL PARTNERSHIP FORUM

THE MINUTES REMAIN UNCONFIRMED AS THE LAST TWO LPF MEETINGS WERE NOT QUORATE

UNCONFIRMED MINUTES OF THE MEETING OF LOCAL PARTNERSHIP FORUM HELD AT 2.30 P.M. ON THURSDAY 15 DECEMBER 2011 IN THE BOARD ROOM, CAMERON HOSPITAL .DEP

Present:

<table>
<thead>
<tr>
<th>Management</th>
<th>Staff Side</th>
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<tbody>
<tr>
<td>George Cunningham</td>
<td>Simon Fevre</td>
</tr>
<tr>
<td>Mary Porter</td>
<td>Marie Innes (until Item 8)</td>
</tr>
<tr>
<td>Les Bisset</td>
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<tr>
<td>Bob McLean</td>
<td></td>
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<td>Karen Laird</td>
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<td>Heather Bett</td>
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<td>Heather Fernie</td>
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In Attendance: Dorothy Guthrie (minutes)

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<thead>
<tr>
<th></th>
<th>ACTION</th>
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<tbody>
<tr>
<td>1.</td>
<td><strong>Apologies</strong>: received from Lynn Parsons</td>
</tr>
<tr>
<td>2.</td>
<td><strong>Minutes of Meeting held 15th September 2011</strong></td>
</tr>
<tr>
<td>3.3</td>
<td><strong>LPF Constitution</strong></td>
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<tr>
<td></td>
<td>Addendum to go out with minutes</td>
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</table>

“The APF constitution was written in partnership with the Director of Human Resources and the Employee Director. Following on from this the LPF agendas were drawn up, on the basis of the APF, and also done in partnership.

HR are more content with the wording of the new version however it still needs to be discussed with the Employee Director to ensure consistency across the three CHPs.

Prior to the constitution being taken to APF it needs to be discussed at an organisational level".
<table>
<thead>
<tr>
<th>6.</th>
<th><strong>Carlyle Ward</strong></th>
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<tr>
<td>KL said that HR is arranging meetings with all staff. For interim working arrangements we would try to see where travel can be minimised, taking into account the organisation’s vacancies and hotspots. They are looking at posts that have been held in the recruitment suspension which may create opportunities. There are a number of opportunities for Band 2 staff and staff are keen to take these up. There is more of an issue for trained staff.</td>
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<tr>
<th>3.</th>
<th><strong>Matters Arising</strong></th>
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<tr>
<td>3.1</td>
<td><strong>LPF Constitution</strong></td>
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<tr>
<td>SF confirmed that the revised Role and Remit would not be going to the APF on 16(^{th}) December. GC asked if SF could provide a copy of the LPF agenda prior to the next APF for discussion at the CHPMT.</td>
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| 4. | **Feedback from CHP Committee and Management Team** - noted |

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<th>5.</th>
<th><strong>Reshaping Care</strong></th>
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<td>5.1</td>
<td><strong>Quantitive Appraisal</strong></td>
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<td>GC said that a meeting has been held with GNEF Managers where a draft project plan was discussed. The plan is not just for the appraisal but for the whole process around public engagement etc. He said that the Project Board is looking for a couple of staff side reps, one from each LPF, to populate the Project Team and these two groups will formulate what is to be appraised. GC said that, as we are hoping to have a first meeting in early January, it would be useful to get the names of staff side reps from both LPFs next week.</td>
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GC said that, rather than articulating the reduction in patient services we want to formulate a model of future inpatient services that is clear and positive about what we want to continue rather than concentrating on which facility it would be best to close. He said that, both from an operational and strategic point of view, it is better to focus on the positive in terms of what is continuing rather than just see it as a closure. This will be important from the staff side perspective as, once they see what we want to continue, it will become clear to them whether they have the skill set or if they can work towards that skill set. |

SF asked if there was a timeline. GC said that there is none as yet but it has been agreed that we will have one for the next Committee meeting. The date for the January committee meeting has been put back a week from the 10\(^{th}\) to the 17\(^{th}\) in the hope that this will enable us to provide a written paper. GC said that we still intend to do this in a relatively short space of time. LB said that some things are out of our control i.e. consultation. GC agreed and said that, in terms of timing, in the run up to the election it will be seen as a significant change. |
SF said that, at the annual review, staff side raised the whole issue of staff movements and the preference for staff to live close to their workplace. He said that, for a whole range of issues, closing a site close to where staff currently live, is not good from a carbon footprint point of view e.g. staff moving from QMH to VHK. There will also be more staff out in the community creating a huge issue of how they get about and how they do their work. SF said that staff’s lives will be mapped around where they work and he is not sure if this has been factored into the whole cost. LB agreed that there needs to be a balance between providing care close to the patient and ensuring cost effective staffing costs. He said that there has been some work done by ICASS in terms of staff travel and hopefully telecare will assist in reducing staff visits.

6. Estates and Facilities

6.1 Barrier Car Parking
There was a short discussion on the proposals. This will not be happening imminently and therefore will be discussed at the next meeting when Barrie Higgins is in attendance.

6.2 Lighting of Car Parks
GC said that he has seen recent correspondence saying that the situation has been rectified. SF to contact Barrie Higgins if there is still a problem.

6.3 Accommodation for Dietetic Department, VHK
Barrie Higgins is communicating with the dietetic department on this and Ward 16 VHK is being considered.

7. Staff Briefings
The latest round of briefings is complete. Cameron and Whyteman’s Brae sessions were well attended as was Stratheden.

FM is doing additional briefings for staff on a Wednesday and, once the Project Team is up and running we will use this as a weekly opportunity to keep staff up to date. SF said that he would be interested in hearing any questions posed by staff at these sessions.

The plan is to run staff briefings again in March/April. SF said it would be useful to avoid school holidays therefore it was decided to aim for the end of April 2012.

8. Staff Governance Action Plan
HF has now started work on next year’s CHP Workplan so we need to think about what we are incorporating staff governance into this. GC asked SF to discuss with staff side colleagues anything they would like to see in the CHP Workplan.
SF said there are no massive ideas coming out to be incorporated. BM suggested either something generic or, alternatively, within the enablers, there should be reference e.g. under Project Reshaping Care, Staff Governance Community should be a key enabler. Staff governance issues should be cross referred. SF to consider options.

SF feels that the committee needs to be more aware of staff governance as an issue and he would prefer that it is done robustly. BM agreed with this in light of the significant change in the next year.

LB said that he doesn’t think the committee is aware of staff governance and that it would be useful for someone to discuss it at a development session. GC said that he will look at taking it to a development session in the spring.

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9. **Healthy Working Lives**

SF said that there is a local group that is not very well populated and they have been unable to get a staff side rep. Janie Gordon is on the Fife-wide group and regularly distributes information. GC said that we need local intelligence to be fed into the CHP so that we can look at how we can apply health working lives initiatives.

It was tentatively suggested that Healthy Working Lives should be included in the next staff briefing in order to highlight to people things that are going on. Health Promotion are well positioned to provide relevant information that can be rolled out to staff.

10. **Finance**

GC said that the CHP is looking at an overspend of £600,000 at the year end and next year doesn’t look any better. We are continuing to see what we can do to improve the situation. For the February committee we will try to prepare them for the changes we think might come about in relation to savings.

11. **Sickness Absence**

The October figure was down from September however November has spiked and this is thought to be due to a virus.

MP attended the Attendance Group on behalf of BM. She said that the group is very proactive in its approach and has a lot of interesting ideas. MP has provided BM with an action list to be taken back to the next meeting on 25 January.

12. **Move of Sexual Health Service to Whyteman’s Brae**

HB explained that the service was required to move out of Forth Park by February 2012 and will be moving to Carlyle Ward, Whyteman’s Brae. Refurbishment of the ward will be completed in early January to allow the service to move by the 30th January. Safety concerns of staff remaining on the Forth Park site after Women and Children’s service has moved off site have been resolved and everything is going according to plan.

13. **Community Kitchen Research Proposal** - The research proposal for Fife’s Community Kitchen was noted.

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<td>SF</td>
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<td>14.</td>
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<tr>
<td><strong>14.1 Adverse Weather Policy</strong></td>
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<td>There was some discussion on NHS Fife’s response to the high winds of Thursday 8th December. It was generally felt that communication had been poor. The CHP fed back what was given from either George Brechin or the SMT but there was a feeling that there just wasn’t enough information or that instructions were wrong.</td>
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<td>GC said that there is a problem with the policy and he has a disagreement on this with senior HR colleagues. The policy states that a specific post decides whether the adverse weather policy should be enacted and, on the absence of that trigger, people are making local decisions. He said that the policy is out of date and he has already stated this fact as feedback from last year’s winter. This leads to matters being dealt with in an adhoc way and an inconsistency with communication.</td>
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<td>SF said that managers are left with no right to manage their own department in a way they see fit. He sent someone home at 11.30 a.m. and the official e-mail from SMT did not come out until 3.30 p.m.</td>
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<td>BM voiced some criticism around the timing of the SMT communication and the lack of clarity. He said that managers need to take individual circumstances into account e.g. travel to Edinburgh. He said that some departments, not necessarily managers but senior clinicians, need to take decisions to stop services and according to the current policy this can’t be done without the approval of the Chief Executive.</td>
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<td>GC said there is a difference between individual decisions and wholesale closing of departments. The default position is to stay.</td>
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<td><strong>15. Date of Next Meeting:</strong> Friday 3rd February 2012, 1.00 p.m., Seminar Room, Whyteman’s Brae</td>
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MINUTE OF THE KIRKCALDY & LEVENMOUTH CHP
CLINICAL GOVERNANCE GROUP HELD ON WEDNESDAY 15TH JANUARY 2012 IN MEETING ROOM 1, CAMERON HOUSE

Present:
Dr Les Bisset, Clinical Director, Kirkcaldy & Levenmouth CHP (Chair)
Avril Eardley, Quality Improvement Co-ordinator
Heather Fernie, Business Manager
Julie O’Neill, Risk Manager
Moira Dunsire, Podiatry Development Co-ordinator
Sally Tyson, Primary Care Development Pharmacist
Dr Lynda Anderson, Deputy Clinical Director

In Attendance:
Roslyn Blair, Addiction Services
Graham Buchanan, Acting Head of CAMHS Service
Karen Gibb, Clinical Nurse Specialist, Vascular Services
Dr Karin Piegsa, Consultant in Reproductive Health
Marion Sapcote, Business Development Officer

Yvonne McLaren, Administrator, K&L CHP

1. WELCOME

Dr Bisset welcomed everyone to the meeting. Dr Bisset informed the group that he would be retiring at the end of March and introduced Dr Lynda Anderson who has taken on the role as Deputy Clinical Director.

2. APOLOGIES FOR ABSENCE

Apologies were received from: Fiona MacKenzie, Heather Bett, Mhairi Leslie, Janie Gordon and Jill Dow.

3. PREVIOUS MINUTES (24th November 2011)

The minutes from 24/11/11 were accepted as a true reflection of the meeting and were confirmed.

4. MATTERS ARISING

There were no matters arising

5. CLINICAL GOVERNANCE

5.1 Annual Reports Due

5.1.1 The following reports were presented to the Group:
<table>
<thead>
<tr>
<th>Service</th>
<th>Presented by</th>
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<tbody>
<tr>
<td>Sexual Health Service</td>
<td>Dr Karin Piegsa</td>
</tr>
<tr>
<td>Addiction Service</td>
<td>Roslyn Blair</td>
</tr>
<tr>
<td>Administration Services</td>
<td>Heather Fernie</td>
</tr>
<tr>
<td>Nutrition &amp; Dietetics</td>
<td>Marion Sapcote</td>
</tr>
<tr>
<td>Pharmacy Services</td>
<td>Sally Tyson</td>
</tr>
<tr>
<td>Podiatry Service</td>
<td>Moira Dunsire</td>
</tr>
<tr>
<td>Rehabilitation Services</td>
<td>Marion Sapcote</td>
</tr>
<tr>
<td>Rheumatology Service</td>
<td>Marion Sapcote</td>
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After each presentation there was the opportunity for the Group to ask any questions of the presenter if they wished to do so.

The Group **noted** the reports.

Reports to be carried over to the meeting in March are:

<table>
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<tr>
<th>Service</th>
<th>To be presented by</th>
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<tbody>
<tr>
<td>Adult Mental Health</td>
<td>Graham Buchanan</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>Jill Dow</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>Jill Dow</td>
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</tbody>
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5.2 K&L Clinical Governance Management Arrangements

Dr Bisset gave an update of the Clinical Governance Management arrangements following the retiral of Isabel Easson. These had been outlined in a memo sent out to Group members in December 2011.

5.3 K&L Clinical Governance Role & Remit

Julie O'Neill introduced this paper and explained the need to look at membership of group and check that the most appropriate people are representing the CHP at meetings. It was agreed that Heather Fernie would enquire about a representation from Rheumatology, Dr Bisset would speak to the Chair of Staff-side and Julie O'Neill would contact the other two CHP to see if they have Public Health Practitioner representation on their groups.

The Group were asked to forward any other comments to Julie O'Neill within the next two weeks.

The Role & Remit was otherwise **approved**.

5.4 DNA – CPR – result of snapshot audit

Julie O'Neill spoke to this paper and reported that the results of the snapshot were positive. The only part which has some confusion is the review timeframe which is still not completed and will be taken on to the NHS Fife Clinical Governance Steering Group for advice.

Julie O'Neill asked the Group to look at the report, agree the recommendations and feedback to the next meeting.

A short life working group will be set up for DNA – CPR Communication with Community Team and Dr Anderson will be invited to sit on the group.
5.5 **MCN Accreditation Update**

Julie O’Neill gave a verbal update.

Dr Bisset will discuss this with Alastair Robertson before it is taken to the NHS Fife Clinical Governance Steering Group. **LB**

5.6 **Deaths whilst awaiting discharge**

Dr Bisset spoke to this paper. A further paper will be brought back to the next meeting in March. The report was **noted**.

5.7 **MCN Priorities**

Morag Maillie, the Vascular MCN Manager, introduced 3 papers relating to Heart Disease, Stroke and Diabetes and highlighted the main priorities identified by these 3 groups. Dr Bisset asked the Clinical Governance Group to recognise the considerable amount of work being carried by the MCNs and particularly in relation to agreeing their priorities for 2012-2013. He emphasised that he was happy to be involved in taking forward the issues highlighted and asked Morag Maillie to return to a future meeting of the Group to update them on progress with the priorities.

5.8 **Healthcare Improvement Scotland Status Report**

Julie O’Neill spoke to this report. Julie advised the Group that this report is discussed at the NHS Fife Clinical Governance Steering Group and we are required to provide an update on the areas our CHP is leading on. Julie will be writing to everyone requesting for an update. **JON**

6.0 **CLINICAL EFFECTIVENESS**

6.1 **K&L CHP CE Update – Jan 2012**

Avril Eardley spoke to this report. Avril Eardley advised that the work on the SIGN Guidelines for SIGN 119 had now been completed.

6.2 **CE Audit Update – Jan 2012**

Avril Eardley referred to the backlog that was reported at the last meeting and advised that she has compiled a list of the information on an Excel spreadsheet. There has been a problem adding this information to the National database. Avril advised that a review will be carried out later on in the year as Fife is a pilot site for the Quality Improvement Register. **AE**

6.3 **SIGN Guideline Update**

Avril Eardley introduced the 6 monthly report for update and this was **noted** by the Group.

7.0 **RISK MANAGEMENT**

7.1 **Risk Register – New Risks**
7.1.1 Diabetic retinopathy service – 2 new risks
Karen Gibb spoke to the new risks. It was agreed that both these risks should be included on the CHP Risk Register. Mary Porter to be the Risk Owner.

7.1.2 Pharmacy
Sally Tyson spoke to this report. Sally Tyson explained that this Risk had previously been de-escalated from the CHP Risk register to the Pharmacy Risk Register but now that the CHP is moving to an overspent position asked if this should now be escalated onto the CHP Risk register. It was agreed that it should go back on the Risk Register as a Moderate Risk and be reviewed again in June. The Risk Owner will be Lynda Anderson.

Dr Bisset advised the Group that a paper on Prescribing will be presented at the next CHP Committee meeting.

8.0 IM & T (eHealth)

8.1 eHealth Board Update
Julie O’Neill reported on the 6 monthly update and advised that this will be put on the agenda for the next Agenda Group.

8.2 CHP Website
Julie O’Neill informed the Group that the new website is now live, but the K&L pages have not been fully populated. This information will be uploaded within the next few weeks.

9.0 ORGANISATIONAL DEVELOPMENT

9.1 PLT Dates
Julie O’Neill confirmed that the final dates were confirmed this week.

10.0 PATIENT SAFETY PROGRAMME

Julie O’Neill advised that the report has been prepared for submission to the NHS Fife Patient Safety Implementation Group.

11.0 DEPARTMENTAL CLINICAL GOVERNANCE MINUTES

The updated database was presented to the Group. Dr Bisset issued a reminder to the services who have not updated their reports to the Group.

12. For Information/Noting

12.1 Ombudsman’s Reports for December 2011 – for noting
Departmental Clinical Governance Minutes

12.2 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.
12.3 **Areas to be covered:**

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

**Reports received as follows:**

**MCNs**
- Bone Health & Falls – minutes from meetings on 03/03/11, 07/09/11 – for noting
- CHD – minutes from meeting on 15/11/11 – for noting

14. **DATE OF NEXT MEETING:** Wednesday 14th March 2012 at 2.45 in Meeting Room 1, Cameron House.

**DISTRIBUTION**

Dr L Bisset, Clinical Director, Cameron House
Dr Lynda Anderson, Deputy Clinical Director, Kirkcaldy Health Centre
Ms Alyssa Bell, Clinical Effectiveness, Mental Health Service, Stratheden Hospital
Mrs. Heather Bett, Clinical Services Manager, CASH/GUM Forth Park
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
Ms Barbara Anne Nelson, Head of Human Resources, Hayfield 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
Mr Graham Buchanan, Acting Head of CAHMS Service

**GP, vacant**

**Copied for information to:**
Simon Fevre, Staff Side Representative
<table>
<thead>
<tr>
<th>ITEMS FOR INFORMATION:</th>
<th>PHARMACEUTICAL CARE SERVICES IN NHS FIFE 2012/13</th>
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The above report is attached separately for information.
Kirkcaldy & Levenmouth CHP Committee Meeting

Tuesday 8th May 2012
Agenda Item No 12

DATES FOR DIARY

CHP Committee Development Session:
Tuesday 12th June 2012 at 1:00pm - 3.00pm within Meeting Room 1, Cameron House

CHP Committee Meeting
Tuesday 10th July 2012 at 2:00pm - 4:30pm within Thomson House, Methil