NHS Fife Public Health & Wellbeing Committee

Mon 16 May 2022, 10:00 - 12:00

MS Teams

Agenda

10:00 - 10:00
0 min

1. Apologies for Absence

Tricia Marwick

10:00 - 10:00
0 min

2. Declaration of Members' Interests

Tricia Marwick

10:00 - 10:00
0 min

3. Minutes of Previous Meeting held on Tuesday 8 March 2022

Enclosed *Tricia Marwick*

- Item 03 - Public Health Wellbeing Committee Minutes (unconfirmed) - 20220308.pdf (8 pages)

10:00 - 10:10
10 min

4. Matters Arising / Action List

Enclosed *Tricia Marwick*

- Item 04 - Public Health & Wellbeing Action List - 20220516.pdf (1 pages)

4.1. Primary Care Governance and Oversight

Enclosed *Chris McKenna*

- Item 04.1 - SBAR Primary Care Governance and Oversight .pdf (5 pages)

10:10 - 10:30
20 min

5. GOVERNANCE MATTERS

5.1. Public Health & Wellbeing Committee Annual Statement of Assurance 2021/2022

Enclosed *Gillian MacIntosh*

- Item 05.1 - SBAR Public Health & Wellbeing Committee Annual Statement of Assurance 2021-2022.pdf (3 pages)
- Item 05.1 - Appendix 1 Draft Public Health Wellbeing Annual Assurance Statement 2021-2022.pdf (6 pages)

5.2. Risk Management Improvement Programme Progress Report

Enclosed *Gemma Couser*

- Item 05.2 - SBAR Risk Management Improvement Programme Progress Report.pdf (12 pages)

5.3. Board Assurance Framework – Strategic Planning

Enclosed *Margo Mcgurk*

- Item 05.3 - SBAR Board Assurance Framework – Strategic Planning.pdf (3 pages)
- Item 05.3 - Appendix 1 Board Assurance Framework – Strategic Planning.pdf (1 pages)

5.4. Review of Annual Workplan

Enclosed *Joy Tomlinson*

- Item 05.4 - SBAR Review of Annual Workplan.pdf (6 pages)

10:30 - 11:10
40 min

6. STRATEGY / PLANNING

6.1. Population Health & Wellbeing Strategy

Enclosed *Margo Mcgurk*

- Item 06.1 - SBAR Population Health & Wellbeing Strategy - Public and Staff Engagement.pdf (9 pages)
- Item 06.1 - Appendix 1 Draft EQIA.pdf (18 pages)

6.2. Corporate Objectives 2022/2023

Enclosed *Margo Mcgurk*

- Item 06.2 - SBAR Corporate Objectives 2022-2023.pdf (4 pages)

6.3. Anchor Institution Programme Board and Community Benefit Gateway

Enclosed *Joy Tomlinson*

- Item 06.3 - SBAR Anchor Institution Programme Board and Community Benefit Gateway.pdf (6 pages)

6.4. Mental Health Estate Re-Design Programme

Enclosed *Chris McKenna*

- Item 06.4 - SBAR Mental Health Estate Re-Design Programme.pdf (7 pages)

6.5. Implementation of the Immunisation Strategic Framework/Governance Assurance

Enclosed *Lisa Cooper*

- Item 06.5 - SBAR Implementation of the Immunisation Strategic Framework Governance Assurance.pdf (9 pages)
- Item 06.5 - Annex A Fife Immunisation Strategic Framework.pdf (19 pages)
- Item 06.5 - Annex B Fife Community Immunisation Service Terms of Reference.pdf (7 pages)
- Item 06.5 - Annex C Fife Community Immunisation Service Governance Structure.pdf (1 pages)
- Item 06.5 - Annex D Fife Community Immunisation Service Leadership & Management Structure.pdf (1 pages)

6.6. Briefing Paper on NHS Scotland Policy for Climate Emergency and Sustainable Development

Enclosed *Neil McCormick*

- Item 06.6 - SBAR Briefing Paper on NHS Scotland Policy for Climate Emergency and Sustainable Development.pdf (9 pages)

6.7. Kincardine & Lochgelly Health Centres – Outline Business Cases

Enclosed *Joy Tomlinson/Ben Johnston*

- Item 06.7 - SBAR Kincardine & Lochgelly Health Centres – Outline Business Cases.pdf (7 pages)
- Item 06.7 - Appendix 1 Kincardine Outline Business Case.pdf (92 pages)
- Item 06.7 - Appendix 2 Lochgelly Outline Business Case.pdf (101 pages)

11:10 - 11:30
20 min

7. QUALITY / PERFORMANCE

7.1. Integrated Performance & Quality Report

Enclosed *Margo McGurk/Susan Fraser*

- Item 07.1 - SBAR Integrated Performance & Quality Report .pdf (3 pages)
- Item 07.1 - Integrated Performance & Quality Report .pdf (44 pages)

7.2. Test & Protect Update

Enclosed *Joy Tomlinson*

- Item 07.2 - SBAR Test & Protect Update.pdf (5 pages)

7.3. Flu Vaccine & Covid Vaccine (FVCV) Programme

Enclosed *Joy Tomlinson/Nicky Connor*

- Item 07.3 - SBAR FVCV Programme Delivery Update.pdf (8 pages)
- Item 07.3 - Appendix A and Appendix B.pdf (9 pages)

7.4. Progress of Annual Delivery Plan (RMP4) 2021/22

Enclosed *Susan Fraser*

- Item 07.4 - SBAR Progress of Annual Delivery Plan (RMP4) 2021-22 + Appendix 1.pdf (9 pages)
- Item 07.4 - Appendix 2 Review of National Response to Winter 2021-22.pdf (21 pages)
- Item 07.4 - Appendix 3 Winter Report 2021-22 – Data to March 2022.pdf (5 pages)

11:30 - 11:50
20 min

8. ANNUAL REPORTS

8.1. Director of Public Health Annual Report 2020/2021

Enclosed *Joy Tomlinson*

- Item 08.1 - SBAR Director of Public Health Annual Report 2020-2021.pdf (3 pages)
- Item 08.1 - Appendix 1 Director of Public Health Annual report 2020-2021 - Health and Wellbeing in Fife.pdf (76 pages)

8.2. Health Promotion Service Annual Report 2021/2022

Enclosed *Nicky Connor*

- Item 08.2 - SBAR Health Promotion Service Annual Report 2021-2022.pdf (3 pages)
- Item 08.2 - Appendix 1 Health Promotion Service Annual Report 2021-2022.pdf (19 pages)

11:50 - 11:55
5 min

9. LINKED COMMITTEE MINUTES

9.1. Minutes of the Population Health & Wellbeing Portfolio Board held on 17 March 2022 (unconfirmed)

Enclosed

- Item 09.1 - Minutes of the Population Health & Wellbeing Portfolio Board held on 20220317 .pdf (4 pages)

9.2. Minutes of the Public Health Assurance Committee held on 9 February 2022 (unconfirmed) & 6 April 2022 (unconfirmed)

- Item 09.2i - Minutes of the Public Health Assurance Committee held on 20220209.pdf (5 pages)
- Item 09.2ii - Minutes of the Public Health Assurance Committee held on 20220406.pdf (6 pages)

11:55 - 12:00
5 min

10. ESCALATION OF ISSUES TO NHS FIFE BOARD

10.1. To the Board in the IPQR Summary

Tricia Marwick

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

Tricia Marwick

12:00 - 12:00
0 min

11. ANY OTHER BUSINESS

12:00 - 12:00
0 min

12. DATE OF NEXT MEETING - MONDAY 4 JULY 2022 AT 10AM

Fife NHS Board

Unconfirmed

MINUTE OF THE NHS FIFE PUBLIC HEALTH & WELLBEING COMMITTEE MEETING HELD ON TUESDAY 8 MARCH 2022 AT 10AM VIA MS TEAMS

Present:
R Laing, Non-Executive Director (Vice Chair)
M Black, Non-Executive Director
C Cooper, Non-Executive Director
M McGurk, Director of Finance & Strategy
C McKenna, Medical Director
J Owens, Director of Nursing
C Potter, Chief Executive
J Tomlinson, Director of Public Health

In Attendance:
N Connor, Director of Health & Social Care
G MacIntosh, Head of Corporate Governance & Board Secretary
F Richmond, Executive Officer to the Chief Executive & Board Chair
H Thomson, Board Committee Support Officer (Minutes)

Vice Chair's Opening Remarks

The Vice Chair welcomed everyone to the meeting, noting that she would be chairing today's meeting due to the Chair being on leave.

The Vice Chair advised that the Cabinet Secretary for Health and Social Care, Humza Yousaf MSP, visited the Victoria Hospital in Kirkcaldy on Monday 7th March 2022 to personally welcome a group of new international nursing recruits to Fife. The Vice Chair and Chief Executive joined the Cabinet Secretary for the visit. The Vice Chair expressed how humbled she was by the positive feedback received from the new international nursing recruits on the welcome they had received, and from the wider staff they met across the various sites during the visit, despite the ongoing challenges of coping with the pandemic.

The Vice Chair expressed deep sympathy for the people of Ukraine, those local people in Fife who have family in Ukraine and for all affected by the suffering caused by the recent invasion. The potential health impact of what we are all seeing in the media's daily coverage of the conflict was also recognised.

The NHS Fife MS Teams Meeting Protocol was set out and a reminder given that the notes are being recorded with the Echo Pen to aid production of the minutes.

1. Apologies for Absence

Apologies were received from T Marwick (Chair) and W Brown (Employee Director), and from attendee S Fraser (Associate Director of Planning & Performance).

2. Declaration of Members' Interests

There were no declarations of interest made by members.

3. Minutes of Previous Meeting held on Monday 10 January 2022

The minutes from the previous meeting was **agreed** as an accurate record.

4. Matters Arising / Action List

The Committee **noted** the updates and the closed items on the Action List.

4.1 Progress Update on Primary Care Pressures

The Medical Director provided a verbal update, providing assurance to the Committee on the plans in place to eliminate primary care pressures.

It was noted that General Practices (GPs) have been affected in the same way as other primary care services during the pandemic. However, there is good resilience within GPs, who are supporting each other and working in clusters. GPs are seeing members of the public who need to be seen on a face-to-face basis, with remote consultations in place where appropriate. It was noted that the operation of GP services was planned to change with the roll-out of the new contract. Due to the pandemic, this work has accelerated, and members of the public have been largely unaware of the impact of these changes. It was also noted that concern and negativity continue within the media around access to GP services, due to changed models of care. M Black, Non-Executive Member, noted inconsistences with GPs' provision of face-to-face appointments, and suggested listening to concerns from communities to understand what may need to be changed. It was also important to improve communication to members of the public on the role of GPs and what sort of service they can expect, across primary care, when they require access to community-based services.

The Medical Director and Director of Health & Social Care have established a Primary Care Governance and Strategy Oversight Group, which will include all independent contractors. A focus for the group will be sustainability, beyond the implementation of the new contracts and governance arrangements. The first meeting for the group has been scheduled and a draft Terms of Reference (ToR) has been prepared. The ToR will be brought to this Committee, once finalised.

Action: Medical Director/ Director of Health & Social Care

Positive developments were reported through work with the University of St Andrews' Medical School, including enhancing the ScotGEM programme which will support primary care resilience in future.

The type of reporting and information to be provided on primary care for this Committee to consider was considered by the Vice Chair, as it was noted that there are other reporting lines already in place through the Integrated Joint Board and Clinical Governance Committee. The Medical Director, Director of Public Health and Director of Health & Social Care will provide a written report outlining what sort of reporting would be brought forward. Timeline for submission will be agreed outwith the meeting, and will be dependent on the cycle of meetings, as discussed under item 5.1.

Action: Medical Director / Director of Public Health / Director of Health & Social Care

The Director of Public Health advised that she recently joined a Community Managers' meeting, which considered a range of feedback received during the pandemic. The group noted public irritation about a broad range of service provision. It is clear services cannot return to the way they were delivered previously, as pandemic restrictions ease,

and communication to the public around the impact of these changes needs to be clear and unambiguous.

The Committee **noted** the progress update on primary care pressures.

5. GOVERNANCE MATTERS

5.1 Proposed Annual Public Health & Wellbeing Committee Workplan 2022/23

The Director of Public Health provided an update on the proposed annual Public Health & Wellbeing Committee workplan for 2022/23.

The elements of potential changes to be incorporated into the workplan for 2022/23 were outlined, as detailed in the paper: these include adding reporting from the Primary Care Governance and Strategy Group; the National Place & Wellbeing Programmes (including a change to have 'inequalities' as a separate heading within the workplan); and the proposal to change to a bi-monthly meeting cycle.

The Director of Nursing advised that discussions have been taking place around reshaping the Patients Relations & Equality & Diversity Team, along with having a focus on the Equality Framework and the underlying principles. This would help support the inequalities section of the workplan.

It was advised that feedback had been received in relation to the preparation of papers coming to the Committee, given the pace of a monthly meeting. There would be benefit to those reporting regularly to have a longer interval between meetings to allow time for preparing papers. The draft workplan provided illustrates what a change to the meeting cycle (from monthly to bi-monthly) would look like and how agenda items could be aligned.

The Chief Executive advised that the strengthening the Place and Wellbeing section within the workplan links into conversations that have been taking place with the Board Chief Executives' Group and the Scottish Government. The Care and Wellbeing portfolio, at Scotland-wide level, is focussed on the role of the NHS in improving population health and reducing inequalities. Development of our strategy needs to consider being aligned to the direction of travel directed by the Scottish Government. The Chief Executive stated it would also be beneficial to have more time for detailed consideration of papers within the Executive Team, and that she would welcome the proposed meeting cycle changing so that timing of meetings for this Committee would be the same as the other Standing Board Committees., This would help fit into the Executive preparatory review and approval cycle in place for other Board committees.

The Chief Executive also noted Covid updates and Flu Vaccine & Covid Vaccine (FVCV) programme updates and Testing updates will become part of business as usual and be covered within the Integrated Performance & Quality Report (IPQR), as we go through 2022/23. These will cease as stand-alone reports.

M Black, Non-Executive Director, highlighted the effects on health due to inflationary increases in the price of food and heating and queried how this would be reflected in the work of the Committee. It was advised that this will be incorporated into more detailed discussions at the Board Development Sessions.

The Board Secretary advised that the workplan reflects a recent discussion that took place with the Chairs and Executive Leads for the Public Health & Wellbeing Committee, Clinical Governance Committee and Finance, Performance & Resource Committee. They looked at identifying potential duplication and clarifying where responsibilities sit. A small number of items will go to both the Public Health & Wellbeing Committee and the Clinical Governance Committee, though covering SBARs will clearly define discussion points for each Committee relevant to their own specific remit.

The Committee **considered** and **agreed** the items within the workplan. The Committee deferred making, a decision on the proposed change to the monthly cycle of meetings. A decision on the cycle of meetings will be agreed outwith the meeting. The Board Secretary agreed to arrange a meeting including the Chair, Vice Chair, Non-Executive members of the Committee and the Director of Public Health (*post-meeting note, this has now been scheduled for 29 March*).

5.2 Review of Committee's Terms of Reference

The Head of Corporate Governance & Board Secretary outlined the proposed changes to the Committee's current Terms of Reference. These are:

- Under point 5.1: bullet point 5, 'Portfolio Board' replaces 'Population Health & Wellbeing Portfolio Board';
- Under point 5.1: bullet point 6, new clause added: 'To support the work of the Primary Care Governance & Oversight Group, in its development of the Primary Care Strategy'.

If a change to the cycle of meetings is agreed, this will be subsequently reflected within the Terms of Reference, prior to submission to the Board.

The Committee **approved** a final version for further consideration by the Board, subject to agreement of the cycle of meetings.

6. STRATEGY / PLANNING

6.1 NHS Fife Population Health & Wellbeing Strategy Development Proposal

The Director of Finance & Strategy provided background information on the proposal and explained in further detail the phased approach that is being proposed for the strategy and development work, as detailed in the paper.

Dedicated time, with specific Committee discussions, is provided in the proposed milestone plan. Each activity will generate specific themes or issues for discussion. It was noted some discussions at Board level will be in Development or private sessions. The Chief Executive advised that subjects will be reviewed at the Board Development Sessions, which will be aligned and linked into the development of the strategy. Committee workplans will be updated accordingly.

The agenda item 'Reviewing the Community & Staff Engagement Survey', proposed for May 2022, was highlighted by the Vice Chair, given the timeline for changes being proposed around the Equality & Diversity Lead role. The Director of Nursing advised it

is anticipated the new role-holder will commence in May 2022. However, work on the engagement strategy will commence sooner.

The Committee **approved** the proposal to phase the development of the strategy.

6.2 Strategic Planning & Resource Allocation (SPRA) process (RMP 2022/23)

The Director of Finance & Strategy provided a verbal update and noted the SPRA proposal is nearing its final draft. The Executive Directors' Group will discuss the financials in the SPRA, and a report is being provided to the Committees in March who have not yet met, with a full report to go to the March Board meeting.

The Committee **noted** the update on the Strategic Planning & Resource Allocation process (RMP 2022/23).

7. QUALITY / PERFORMANCE

7.1 Integrated Performance & Quality Report (IPQR)

The Director of Finance & Strategy highlighted the ongoing challenges on all our services, with staff availability remaining one of the key factors. Our performance, however, remains in the upper quartile/medium range, which includes CAHMS & Psychological Therapies. It was reported NHS Fife is not an outlier compared to other NHS Scotland Health Boards, and that we strive for continuous improvement.

Within the report, there is a section directly relevant to the Public Health & Wellbeing Committee, which covers measures agreed to date, and these will be considered and monitored on an ongoing basis by the Committee.

As part of the IPQR review process, the immunisation programme will be incorporated into the Public Health & Wellbeing Committee section of the IPQR, and this activity will be worked through over the coming months.

M Black, Non-Executive Director, highlighted there were no specific targets for Post Diagnostic Support (PDS) for dementia. The Director of Health & Social Care agreed to provide further clarity in the next iteration of the IPQR.

Action: Director of Health & Social Care

The Vice Chair highlighted the indicator summary on page 3 of the IPQR and noted there is no section for the Public Health & Wellbeing Committee, given it remains in its original format. It was noted this will be added going forward.

The Committee took **assurance** from the performance reporting within the IPQR.

7.2 Integrated Performance & Quality Report (IPQR) Review Process

The Director of Finance & Strategy provided background on the IPQR review process and noted that the review had started from a positive position, given that the IPQR format demonstrated best practice in many areas. Key points from the paper were highlighted.

An overview on the assessment section in the paper was provided, which sets out areas of short-term and medium-term improvement.

The team involved in the review process are currently working on what can be enhanced within the IPQR, in terms of metrics covering Patient Feedback, Information Governance and Workforce. The IPQR is being developed to be more specific to each Committee, and a full executive summary will be provided and offer an opportunity for in-depth discussions.

The Vice Chair indicated that involving Non-Executive Directors in the review process would add value, ensuring that the final document meets the requirements of Non-Executives. Following suggestions, it was agreed that when the IPQR review group are developing the next iteration of the IPQR, each of the Committee Chairs, respective Executive Lead and the relevant persons within the Planning & Performance department would be involved.

Action: Director of Finance & Strategy

The Committee took **assurance** from the report and the proposed changes to the IPQR as part of the IPQR Review.

7.3 Testing & Tracing Update

The Director of Public Health highlighted the Scottish Government intention to publish their transition plan in mid-March. It is anticipated that this will impact on future testing delivery.

It was noted within the summary paper that the reduction in testing is a consequence of policy changes that were made in January 2022.

M Black, Non-Executive member, queried if there was any correlation between the number of tests and increase in positive cases. The Director of Public Health advised this detail is analysed on a weekly basis, and if there is a mismatch between positive case numbers and testing then additional capacity is provided. The current position in Fife overall is steady with alignment between testing and case numbers.

The Committee **took assurance** from the update on Testing & Tracing.

7.4 Flu Vaccine & Covid Vaccine (FVCV) Programme Update

The Director of Health & Social Care provided assurance that the programme continues to be successful in Fife in terms of fully delivering national directions. The key points from the paper were highlighted.

There was significant activity before 1 January 2022 with the 'Boosted by the Bells' campaign. A higher 'Did Not Attend' (DNA) rate has been recorded since 1 January 2022, and significant communication campaigns have been brought forward, to include an offer of unscheduled appointments. Targeted outreach work has been carried out, which also links to our inclusivity work.

The Spring vaccination programme was explained, and it was noted we are on track for delivery.

The Flu Vaccine & Covid Vaccine (FVCV) Programme update will transition into the IPQR, as mentioned previously in the meeting.

The Committee **took assurance** from the update on the FVCV Programme.

7.5 Update on CAMHS & Psychological Therapies

CAHMS

The Director of Health & Social Care provided an update on CAHMS in terms of the improvement work that has been carried out, as detailed in the paper.

It was noted the CAHMS performance continues to match the national average. It was also noted there has been an increase in the level of acuity of patients.

Assurance was provided that improvements continue on the developments of the CAHMS service in Fife, and the backlog in referrals is being worked through.

Psychological Therapies

The Director of Health & Social Care provided an update on Psychological Therapies, as detailed in the paper, and advised significant work is ongoing and actions are being monitored closely. Assurance was provided we are on track to achieve delivery targets by March 2023.

It was reported that those with the most complex needs are waiting too long for treatment. The challenge is within specialised areas. Work is ongoing with NHS Education for Scotland (NES) in relation to both national and international recruitment to fill vacancies in these specialist areas. Support for individuals is sought through the Community Mental Health teams in Community Care and other areas.

The improvement actions taken in recent years was highlighted, as detailed in table 1 of the paper.

M Black, Non-Executive member, noted concern for those on the longest waiting lists, particularly for those waiting over one or two years for treatment. The Director of Health & Social Care explained the support available for those on the waiting list and noted that all individuals are clinically assessed. Approximately 50% of those on the waiting lists are in the physical health group and Clinical Psychologists are being recruited specifically for this area. For others, there are complexities in relation to trauma. Detail on early intervention support and the range of services supporting individuals was provided.

C Cooper, Non-Executive member, requested more context around the patient experience and the carer experience in relation to CAHMS and the wider Psychological Therapies services.

The Vice Chair emphasised the importance of having sight of the detail on the waiting list backlog so that it was possible to understand the patient flow into and out of waiting lists. A higher level of detail will be provided going forward.

Action: Director of Health & Social Care

The Vice Chair welcomed the table, which summarises the improvement actions taken in recent years, and questioned if the referrals and Care pathways facilities defer people being referred or removed from waiting list. The Director of Health & Social Care advised for some people the services are a supplementary support whilst on the waiting list. For others, it is for early intervention, to support outcomes and their own wellbeing, and reduce dependency, potentially, on the more specialised services.

The Committee **took assurance** from the update on CAMHS and Psychological Services.

8. LINKED COMMITTEE MINUTES

The Committee **noted** the linked Committee minutes.

8.1 Public Health Assurance Committee dated 14 December 2021 (unconfirmed)

9. ESCALATION OF ISSUES TO NHS FIFE BOARD

There were no issues from this meeting to escalate to NHS Fife Board.

10. ANY OTHER BUSINESS

There was no other business.

11. DATE OF NEXT MEETING

Tuesday 12 April 2022 at 10am – to be confirmed, following discussions regarding the cycle of meetings.

KEY:	Deadline passed / urgent
	In progress / on hold
	Closed

PUBLIC HEALTH & WELLBEING COMMITTEE – ACTION LIST
Meeting Date: Monday 16 May 2022

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	TIMESCALE	COMMENTS / PROGRESS	RAG
1.	08/03/22	**Integrated Performance & Quality Report (IPQR)**	Further clarity to be provided on post Diagnostic Support (PDS) for dementia in the next iteration of the IPQR.	**NC**	04/07/22	06/05/22 - Report currently coming through management approval routes and will follow next IPQR	In progress
2.	08/03/22	**Integrated Performance & Quality Report (IPQR) Review Process**	Each of the Committee Chairs, respective Executive Lead and the relevant persons within the Planning & Performance (P&P) department to be involved when the IPQR review group are developing the next iteration of the IPQR.	**MM**	Review date - 22 July 2022		In progress
3.	08/03/22	**Psychological Therapies (PT) – Waiting List Backlog**	A higher level of detail to be provided going forward on the waiting list backlog so that it is possible to understand the patient flow into and out of waiting lists.	**NC**	To be added to the PT reporting for this Committee.	Complete	Closed
4.	08/03/22	**Primary Care Governance and Strategy Oversight Group – Terms of Reference**	The Terms of Reference (ToR) for the Primary Care Governance and Strategy Oversight Group to be brought to this Committee, once finalised.	**CMcK/ NC**	Once the ToR is finalised.	On agenda	Closed
5.	08/03/22	**Primary Care**	A written report to be provided outlining what sort of reporting would be brought forward on primary care.	**CMcK/ JT/NC**	05/05/22	On agenda	Closed

NHS Fife

Meeting:	**Public Health and Wellbeing Committee**
Meeting date:	**16 May 2022**
Title:	**Primary Care Governance and Oversight**
Responsible Executive:	**Dr Chris McKenna, Medical Director,**
	Nicky Connor Director of Health and Social Care
Report Author:	**Dr Helen Hellewell Associate Medical Director**
	HSCP Bryan Davies Head of Primary and
	Preventative Care Services HSCP

1 Purpose

This is presented to the Public Health and Wellbeing Committee for:

- Assurance
- Decision
- Discussion

This report relates to a:

- NHS Board/Integration Joint Board Strategy or Direction
- National Health & Well-Being Outcomes

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

2.2 Background

Historically there has not been a group that unites and considers the governance or strategic oversight of the four independent contracting areas of Primary Care that have contracts with Fife Health Board. Moving forward given the interdependences, increased demand and complexity of need within primary care it is vital that a group which achieves this objective is established.

2.3 Assessment

This paper proposes that a Primary Care Governance and Strategy Oversight Group is established. The group will bring together both the transformation and sustainability initiatives for all four of the independent primary care contractors, whilst also overseeing any critical aspects of governance. It will be co-chaired by the NHS Fife Medical Director and the Director of Health and Social Care ensuring. The group will provide assurance to NHS Fife Board and the Integration Joint board through the appropriate sub committees. Financial and service delivery considerations will continue to be taken through existing managerial routes. Fundamental contractual issues will continue to be considered through existing structures such as Primary Medical Services Committee and Pharmacy Practice Committee, which will provide update to the oversight group. The terms of reference are attached as Appendix 1

The Primary Care Governance and Strategic Oversight Group will provide the vision and support to the development of a Primary Care Strategy for Fife. This will include all four independent contractors and will be supported by a Primary Care Premises Strategy and a Primary Care Communications Strategy.

2.3.1 Quality/ Patient Care

The establishment of this group will allow governance and scrutiny of all aspects of primary care delivery and to provide a focus for improving patient care for the population of Fife.

2.3.2 Workforce

There are no workforce requirements with setting up this group. However, we will continue to bring forward updates on the workforce requirements for the areas of transformation and sustainability.

2.3.3 Financial

There is no financial impact of the establishment of this group and we will continue to bring forward papers detailing the financial risks of any transformation and sustainability proposals.

2.3.4 Risk Assessment/Management

There is a risk if an oversight and governance group is not established then the sustainability and transformation work for the four primary care independent contractors will be conducted in isolation without taking into account the considerable interdependences. There is also a risk that this work would not take account of the interfaces with secondary care and the wider redesign work such as the Redesign of Urgent Care leading to a less coherent and effective model.

2.3.5 Equality and Diversity, including health inequalities

An EQIA is not required for the establishment of this group. However much of the government guidance that this group will be considering will include consideration of health inequalities in the transformational redesign undertaken.

2.3.6 Other impact

There is an opportunity to improve further interface between Primary and Secondary Care Services by having a more comprehensive overview and whole system approach to Primary Care Provision.

Communication, involvement, engagement and consultation

This proposal have been tabled at various primary care stakeholder groups.

Route to the Meeting

A further meeting of the Executive co-chairs and senior representatives of the primary care areas was held in order to further develop the terms of reference.

This paper has been shared at Health & Social Care Partnership Senior Leadership Lead Team Meeting.

This paper was supported at EDG.

Recommendation

The Public Health and Wellbeing Committee are recommended to:

Note the proposal for the establishment of a Primary Care Governance and Strategic Oversight Group

2 List of appendices

Appendix 1 Terms of Reference

Report Contact(s)

Dr Helen Hellewell
Associate Medical Director HSCP
Helen.Hellewell@nhs.scot

Bryan Davies
Head of Primary and Preventative Care
Bryan.davies@nhs.scot

Appendix 1

Primary Care Governance and Strategy Oversight Group

Draft Terms of Reference and Remit

Purpose

The Primary Care Governance and Strategy Oversight Group will oversee Primary Care Governance and Strategy providing high-level strategic leadership, scrutiny and review of Primary Care delivery and transformation covering all of the 4 primary care groups and independent contractors. This will include the 4 areas of Primary Care: General Medical Services, Community Pharmacy, General Ophthalmic Services and General Dental Services. The Primary Care Governance and Strategy Oversight Group will report, provide assurance and make recommendations to the Fife Health Board and the Fife Integration Joint Board via appropriate sub-committees.

Role & Remit

- Define the vision and provide strategic leadership to oversee the development of a Primary Care Strategy in Fife, through the engagement of stakeholders (patients, staff, public and partner organisations)
- Ensure governance and scrutiny across all aspects of the Primary Care delivery.
- Ensure consistency between the four Primary strategic priorities and areas for change for both NHS Fife and Fife H&SCP.
- Oversee the implementation of the 2018 GMS Services Contract
- Oversee the recovery and reform of dental services in Fife.
- Ensure the continued development and delivery of Community Pharmacy within Fife
- Ensure the continued development of Primary Care Eye services within Fife and the alignment between Ophthalmology and General Ophthalmic Services.
- Provide oversight of implementation of primary care regulations/legislation.
- Champion the significant contribution of primary care services to support the health and wellbeing of the people of Fife
- Ensure the Estates Strategy is aligned to future models of care taking into account digital innovation and public health needs within the localities of Fife.

Membership

Medical Director (co-chair)
Director of Health and Social Care/Chief officer IJB (co-chair)
Director of Pharmacy and Medicines
Director of Public Health
Director of Finance
Director of Property and Asset Management
Associate Medical Director HSCP
Chief Finance Officer HSCP
Associate Director of Nursing HSCP
Head of Strategic Planning & Commissioning
Director of Dentistry
Head of Primary & Preventative Care Services
Chair of GP Subcommittee
Community Pharmacy Rep TBC

Community Dental Rep TBC
Community Optometry Rep TBC
Partnership Forum Representative

Timescale

The Primary Care Governance and Strategy Oversight Group will meet on a bi-monthly basis though the frequency may be varied subject to agreement with the Chair. A schedule of meetings will be set out in advance

Reporting Arrangements

Regular updates for assurance to EDG Portfolio Board, IJB and Fife Health Board via appropriate sub committees.

Group Administration

The Oversight Group is supported by the appropriate Business Support function. Key activities of the administrative support are:

- Work closely with the Chair;
- Advise on the content of agendas, accompanying papers, minutes and actions;
- Provide administrative support to ensure that appropriate information is communicated to all oversight group members or other affiliated groups.

The agenda & papers will normally be circulated one week in advance of the meeting. Urgent or late papers may be circulated by email prior to the meeting but tabled papers will be avoided except in extraordinary circumstances.

Minutes of the meetings will go to the NHS Fife Portfolio Board and Assurance Senior Leadership Team Meetings to discuss.

NHS Fife

Meeting:	**Public Health & Wellbeing Committee**
Meeting date:	**16 May 2022**
Title:	**Draft Public Health & Wellbeing Committee Annual Statement of Assurance 2021-22**
Responsible Executive:	**Dr Joy Tomlinson, Director of Public Health**
Report Author:	**Gillian MacIntosh, Board Secretary**

1 Purpose

This is presented to the Public Health & Wellbeing Committee for:

- Assurance

This report relates to a:

- Legal requirement
- Local policy

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

- Effective

2 Report summary

2.1 Situation

All formal Committees of the NHS Board are required to provide an Annual Statement of Assurance for the NHS Board, which is consider initially by the Audit & Risk Committee. The requirement for these statements is set out in the Code of Corporate Governance. The Public Health & Wellbeing Committee is invited to review the draft of the enclosed part-year report and comment on its content, with a view to approving a final paper for onward submission.

2.2 Background

Each Committee must consider its proposed Annual Statement at the first Committee meeting of the new financial year, as per the Committee's workplan. The current draft takes account of initial comments received from the Committee Chair and Director of Public Health.

2.3 Assessment

In addition to recording practical details such as membership and rates of attendance, the format of the report includes a more reflective and detailed section (Section 4) on agenda business covered in the course of 2021-22, with a view to improving the level of assurance given to the NHS Board.

2.3.1 Quality/ Patient Care

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

2.3.2 Workforce

N/A.

2.3.3 Financial

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

2.3.4 Risk Assessment/Management

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

2.3.5 Equality and Diversity, including health inequalities

This paper does not relate to the planning and development of specific health services, nor any decisions that would significantly affect groups of people. Consequently, an EQIA is not required.

2.3.6 Other impact

N/A.

2.3.7 Communication, involvement, engagement and consultation

N/A.

2.3.8 Route to the Meeting

This paper has been considered in draft by the Committee Chair and Executive Lead and has been reviewed by EDG at its meeting on 5 May.

2.4 Recommendation

The paper is provided for:

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

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

ANNUAL STATEMENT OF ASSURANCE FOR NHS FIFE PUBLIC HEALTH & WELLBEING COMMITTEE 2021/22

1. Purpose

To provide the Board with assurance that NHS Fife is fully engaged in supporting wider population health and wellbeing for the local population, including overseeing the implementation of the population health and wellbeing actions defined in the Board's strategic plans and ensuring effective contribution to population health and wellbeing related activities.

2. Membership

2.1 From its establishment in October 2021 and during the remainder of financial year to 31 March 2022, membership of the Population Health & Wellbeing Committee comprised: -

Tricia Marwick	Committee Chair / Chair of the Board
Martin Black	Non-Executive Member
Christina Cooper	Non-Executive Member
Rona Laing	Non-Executive Member
Margo McGurk	Director of Finance & Strategy
Dr Christopher McKenna	Medical Director
Janette Owens	Director of Nursing
Carol Potter	Chief Executive
Dr Joy Tomlinson	Director of Public Health

2.2 The Committee may invite individuals to attend the Committee meetings for particular agenda items, but the Director of Health & Social Care, Associate Director of Planning & Performance and Board Secretary will normally be in attendance at Committee meetings. Other attendees, deputies and guests are recorded in the individual minutes of each Committee meeting.

3. Meetings

3.1 Following its establishment in October 2021, the Committee met on four occasions during the financial year to 31 March 2022, on the undernoted dates:

- 15 October 2021
- 15 November 2021
- 10 January 2022
- 8 March 2022

3.2 The attendance schedule is attached at Appendix 1.

4. Business

4.1 In July 2021, the Board approved a proposal to establish a new Standing governance committee of the Board. The principle behind the establishment of the Public Health & Wellbeing Committee has been to give greater focus in the Board governance structure to wellbeing and preventative / proactive care (in line with Scottish Government's direction of travel) and to consider placement of the public health aspects currently within the remit of the Clinical Governance Committee and Finance, Performance & Resources Committee, to allow for enhanced input by the Board. In establishing the committee, it was agreed the first

meeting thereof would be an opportunity for members to directly discuss and agree the proposed Terms of Reference for the group, for formal approval of the Board thereafter.

4.2 The Committee met for its first meeting on 15 October 2021, with the sole agenda item being a draft remit for members to discuss. The remit has been influenced by Public Health Scotland's areas of focus and the Public Health Priorities for Scotland, including those around Covid. It also seeks to bring together into the one committee scrutiny of performance-related measures related to the planning and delivery of delegated services for which the Integration Joint Board sets the overall strategic direction. Prior to the Committee's meeting, discussion on the draft took place with the Chair, Vice-Chair and Chief Executive, with earlier input by the Directors of Health & Social Care and Public Health respectively. Members actively discussed the tabled draft and made a number of amendments, prior to a final version being agreed for the Board's endorsement at its November 2021 meeting.

4.3 On completion of the Committee's Terms of Reference, a comprehensive review of its workplan has also taken place, to help define the cycle of business that will be considered by the Committee annually. As part of this exercise, a parallel review of both Clinical Governance and Finance, Performance & Resources remits and workplans have been completed, to limit the potential for any unnecessary duplication of effort and help clarify each committee's responsibilities over agenda items that might be tabled to more than one standing committee, as part of reporting through the governance structure. At the time of writing, this remains a work-in-progress and is expected to be completed after a full annual cycle of business has been undertaken. The Committee has considered drafts of its annual workplan at its January and March 2022 meetings, refining this to ensure appropriate coverage of business throughout the year. As a result of discussion at the latter, meetings of the Committee have now been scheduled on a bi-monthly basis, to allow time for the adequate preparation of agenda items between meetings.

4.4 The Public Health & Wellbeing Committee's remit seeks to link explicitly to the local strategic priority proposed in the new strategy of 'improving health and wellbeing' of the population served by NHS Fife. It aims to have coverage over relevant elements of the national care and wellbeing programmes as these become established, as well as the Public Health Priorities for Scotland. It is also the intention that the Committee takes the governance lead in oversight and implementation of the new Population Health & Wellbeing Strategy and thereafter its delivery progress.

4.5 At its initial meetings, the Committee has focused on gaining assurance from the Board's ongoing work on Covid Test & Protect measures and vaccination (including the seasonal flu and Covid vaccine delivery for the 2021 Winter Period). The Committee has gained assurance that planning and workforce were in place to deal with anticipated demand over the busy Winter season, made more acute with the heightened pressures caused by the Omicron wave of Covid infection. The response of the Board continued to be agile, with local teams working closely with national colleagues both to implement the contact tracing programme and deliver new tranches of the Covid booster and seasonal flu vaccines as these came on-stream.

4.6 In January 2022, members received a detailed update on testing and tracing performance over the busy festive period, which coincided with a large number of positive Covid infections in Fife due to the spread of the Omicron variant. Resilience and response rates remained high, despite the pressures caused by the considerable increase in cases. In relation to vaccine delivery, the Committee were assured by the Board's performance in the 'Boosted by the Bells' campaign, with Fife data showing the number of booster doses delivered being above the Scottish Government target and higher than the Scottish average. Progress with the programme overall remained on track, with longer-term planning nearing completion for the stabilisation of the workforce, supported by permanent recruitment measures. Further updates on both testing and progress in the delivery of the vaccination programme were given to the Committee in March 2022. However, as Covid

updates transition into business-as-usual activities for the Board, performance tracking for these areas will move to being situated within the monthly performance reporting within the IPQR, rather than via stand-alone updates to the Committee.

4.7 At the meeting in November 2021, members took assurance from the process described for managing any vaccine incidents and how lessons learned from any local adverse events review are immediately implemented. Ongoing proactive audit undertaken locally helps to identify any incidents and feedback is provided promptly to the national team, to ensure a robust mitigation strategy is in place.

4.8 The Committee has received a series of updates on Child and Adolescent Mental Health Services (CAMHS) and Psychological Therapies (PT), the first report being considered in November 2021. Assurance was given on the Board's ongoing progress to eradicate the waiting list for CAMHS by December 2022. Support has been received from Scottish Government and a number of new posts are being recruited to. For Psychological Therapies, new roles and different roles in relation to supporting workforce pressures and challenges are being brought forward. The focus is also on access to the service and addressing the backlog of the longest waits. Recruitment challenges have a direct impact on meeting waiting list trajectories and the Committee requested further information on what is being done in the interim to support those on waiting lists in the interim, particularly those waiting the longest for treatment. A detailed update was given in January 2022 on the means by which those waiting the longest for specialist treatment were being supported. New models of care are important, particularly community mental health teams working in an outreach manner, to reach those most in need, some of whom are within Fife's most deprived communities. Changes to the recruitment of staff, and methods for upskilling the current workforce, will help address the workforce challenges that have impacted upon the timeliness of treatment for some patients. In March 2022, the Committee received a further update on the performance of both CAMHS and PT, taking assurance from the fact that both services are on track to achieve delivery targets by the stated deadlines. Challenges remain in eradicating the historic backlog of referrals for both services, but members recognised the impact of a series of improvement actions, that combined have helped address the numbers of patients waiting.

4.9 In March 2022, members considered an update on Primary Care pressures, including an outline of changes to delivery of GP services due to the pandemic and as a result of the new GP contract. Assurance was provided that a plan was in place to eliminate these pressures, assisted by the establishment of the new Primary Care Governance & Strategy Oversight Group. An early focus of the group's work will be enhancing sustainability of services, and building upon recent initiatives such as ScotGEM to support primary care resilience in the future. The Committee will receive regular reports and outputs from this group going forward.

4.10 The Committee, at its November 2021 meeting, has also received a report on progress in implementing the Mental Health Strategy. Examples of transformation, particularly around models of care, were described, in addition to details on the remobilisation of services and innovations in the recruitment and design of supporting staff roles, given ongoing workforce challenges. The Committee gained assurance that the service continues to deliver on the main strategic ambitions and that a refresh of the Mental Health Strategy for Fife will be undertaken, in line with learning post-pandemic and new national requirements.

4.11 The Committee has had input into initial discussions for the development of the Board's Population Health & Wellbeing Strategy, including review of the first stage of the survey process, to help capture public and staff feedback, and consideration of the Population Health Needs Assessment, which has also been reviewed at length by the Board. In January 2022, members discussed how participation of external stakeholders can best be enhanced, in a follow-up engagement exercise, particularly via outreach to Fife's most deprived groups and communities. Members recognise the importance of ensuring the

diversity of Fife's population is appropriately reflected and addressed in the organisational strategy.

4.12 In March 2022, members considered a detailed proposal outlining the phased approach to the Population Health & Wellbeing Strategy development. A milestone plan, outlining dedicated time for each Committee and thence the Board to consider key aspects of the strategy, was endorsed by the Committee. This work will be a significant part of the Committee's business over the remainder of this calendar year.

4.13 A Board-wide review of the Integrated Performance & Quality Report (IPQR) is expected to help define a set of performance-related metrics specific to the Committee, to allow for appropriate regular scrutiny of these at each meeting. As mentioned above, consideration of CAMHS and PT performance (specifically those metrics linked to the improvement trajectory for both services) has transitioned over to the Committee and is expected to be fully complete over the early part of the new Financial Year. Consideration is also being given to identifying a number of other metrics relevant to the Committee's remit, for inclusion in a new dedicated Public Health & Wellbeing section of the revised IPQR. It is recognised there is an opportunity to identify areas which are currently not reviewed and include them in the IPQR, such as the Covid Vaccination Programme, screening programmes, self-management of long-term conditions and the Mental Health Strategy Programme, dependent on the regularity of data reporting.

4.14 During the year, the Committee has received reports on: i) the work of the East of Scotland Regional Health Protection service; ii) the Anchor Institution Programme Board; iii) Fife Child Protection Annual Report; and iv) Adult Support and Protection Biennial Report. Members have welcomed the comprehensive detail provided in each.

5. Risk Management

5.1 A Board-wide review of risk reporting is currently underway and, when concluded, this will make recommendations for the reporting of relevant risks to the new Public Health & Wellbeing Committee. It is likely that stand-alone Board Assurance Frameworks (BAFs) in use at present will be replaced by a refreshed Corporate Risk Register, with sections pertinent to each standing committee. This will help the Committee define and monitor risks relevant to its remit as it becomes fully established.

6. Self-Assessment

6.1 Given its establishment part-way through the 2021-22 financial year and recognising the limited number of meetings thus far, the Committee has not as yet undertaken a formal self-assessment utilising the standard Board Committee format. This will be undertaken next year, as part of that regular schedule in use across all standing committees.

7. Conclusion

7.1 As Chair of the Public Health & Wellbeing Committee, I am satisfied that thus far, after its initial establishment, the integrated approach, the frequency of meetings, the breadth of the business undertaken and the range of attendees at meetings of the Committee has allowed us to fulfil our remit as detailed in the Code of Corporate Governance. As a result of the work undertaken during the meetings held through this year, I can confirm that adequate and effective governance arrangements were in place throughout NHS Fife during the year.

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

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

and attended meetings of the Committee as it has become established, particularly in another most challenging year, set against the ongoing backdrop of the Coronavirus pandemic.

Signed: Tricia Marwick   Date: 16 May 2022

Tricia Marwick, Chair
On behalf of the Public Health & Wellbeing Committee

Appendix 1 – Attendance Schedule

NHS Fife Public Health & Wellbeing Committee Attendance Record 1 April 2021 to 31 March 2022

	15.10.21	15.11.21	10.01.22	08.03.22
Members				
T Marwick, Non-Executive Member **(Chair)**	✓	✓	✓	x
M Black, Non-Executive Member	✓	✓	✓	✓
C Cooper, Non-Executive Member	✓	x	x	✓
R Laing, Non-Executive Member	✓	✓	✓	✓
W Brown, Employee Director	x	✓	x	x
M McGurk, Director of Finance & Strategy	✓	✓	✓	✓
C McKenna, Medical Director	✓	✓	✓	✓
J Owens, Director of Nursing	x	✓	✓	✓
C Potter, Chief Executive	✓	✓	✓	✓
J Tomlinson, Director of Public Health **(Exec.Lead)**	✓	✓	✓	✓
In Attendance				
O Adeyemi, Consultant in Public Health	✓			
N Connor, Director of H&SC	x	✓	✓	✓
L Cooper, Immunisation Programme Director		✓ Item 5.2		
P Donnelly, University of St Andrews		✓ Item 6.2		
S Fraser, Associate Director of Planning & Performance	✓	✓	✓	x
G MacIntosh, Head of Corporate Governance & Board Secretary	✓	✓	✓	✓
J McLean, Director of Regional Planning		✓ Item 6.2		
F Richmond, Executive Officer to the Chief Executive & Board Chair	✓	✓	✓	✓
N Robertson, Associate Director of Nursing	✓			

NHS Fife

Meeting:	**Public Health & Wellbeing Committee**
Meeting date:	**16 May 2022**
Title:	**Risk Management Improvement Programme Progress Report**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Gemma Couser, Associate Director of Quality and Clinical Governance and Pauline Cumming, Risk Manager**

1 Purpose

This is presented to the Public Health & Wellbeing Committee for:

- Assurance

This report relates to a:

- Annual Operational Plan
- Government policy/directive
- Local policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This paper sets out a record of the progress made since the risk management improvement programme was approved by the NHS Fife Board in March 2022.

2.2 Background

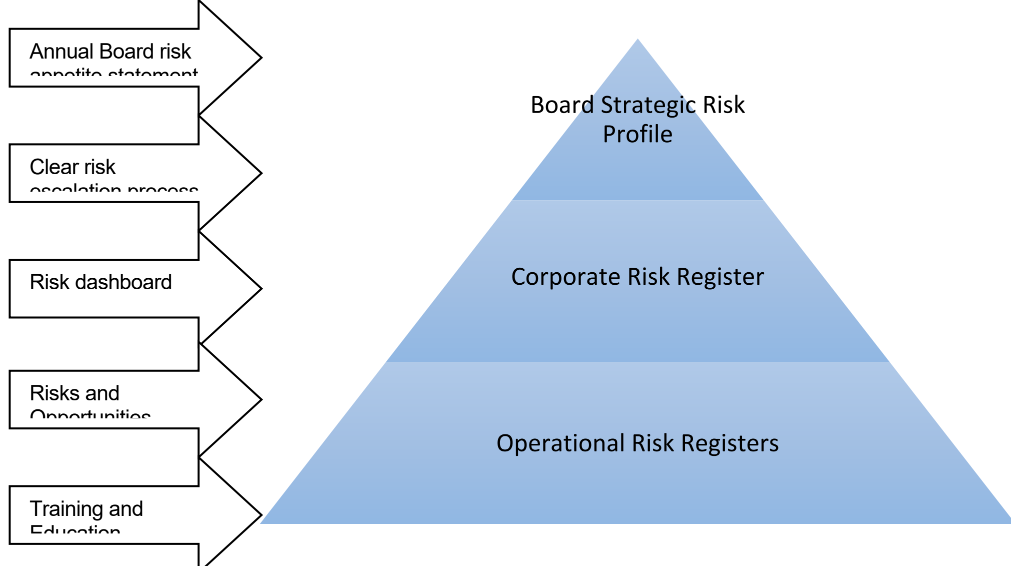
NHS Fife is committed to delivering this agreed improvement programme in relation to risk management.

2.3 Assessment

Strategic and operational risks are an inherent part of healthcare delivery. An effective risk management structure and approach is paramount in supporting the organisation to achieve strategic priorities. The objective is to deliver:

- A structured approach where risks are reviewed, addressed and controlled through governance structures of the Board
- Alignment of the organisational risk profile to the strategic planning agenda
- Promotion of a just culture to encourage the proactive identification and mitigation of risks from ward to Board
- Development of an annual Board risk appetite statement; stating the nature/ level of risks to be accepted/tolerated and the balance of risk versus reward

The current Risk Management Framework will be replaced with the following structure:



A summary of the Risk Management Improvement plan is summarised below:

	Workstream	Description/ Actions	Status update	By when
1	Board Strategic Risk Profile	Development of a risk profile against our strategic priorities: 1. To improve health and wellbeing 2. To improve the quality of health and care services 3. To improve staff experience and wellbeing 4. To deliver value and sustainability	Initial feedback has indicated the requirement to include environmental sustainability and inequality risks. Work is underway to develop these risks.	Draft complete (see Appendix 1)
2	Corporate Risk Register to replace Board Assurance Framework	A Corporate Risk Register (CRR) - contains the highest scoring risks from across the organisation that have the potential to affect the whole organisation, or operational risks which have been escalated e.g. can no longer be managed by a service or require senior ownership and support to mitigate*. The register will be routinely reviewed and monitored by Executive Directors. The CRR will be comprised of the following components: 1. Clinical Quality and Safety 2. Property and Infrastructure (including Digital and Information) 3. Workforce 4. Finance There will be a containment of number of risks on the CRR to ensure focus and impact Engagement sessions will be held in April and May with Senior Leadership Teams (SLT) for Acute Services, Health & Social Care Partnership, Workforce, Finance, Pharmacy, Medical Director's Directorate (including	Risks for inclusion in CRR are being identified through discussions with SLTs; review of existing risks; and identification of new risks which meet criteria*. Engagement sessions planned. Meetings are underway.	June 2022

		Digital and Information and Research & Development), Property and Asset Management , Public Health and the Nursing Directorate. Sessions will include the review of risks to clarify strategic risks v corporate risks v operational risks. A FORMS questionnaire to be issued to EDG members to complete on behalf of their SLTs. Questions cover the focus of team discussions about risk, their use of risk information e.g.to inform decision making or plan services, and the support that teams need to effectively manage risk including education and training. Feedback will be used to develop an effective and visible framework that connects with and is used by staff from ward to board.	FORMS questionnaire issued March 2022.	
3	Risk Dashboard	This will support a proactive risk management culture that is integral to performance and quality management. The dashboard will align to the refreshed Integrated Performance & Quality Report (IPQR) and will include metrics related to corporate risks. Purpose: • Enable oversight of risk level of corporate risks • Provide assurance that adequate controls are in place to proactively manage risks • Align to improvement actions contained within the IPQR • Integrate with Key Performance Indicators (KPIs) & Quality Performance Indicators (QPIs) • Risk is linked to an assurance committee Principles:	An outline of proposed risk content for the IPQR is in development and will be submitted to EDG as part of an update paper on the IPQR review.	May 2022

		• Provide simple, visual high level overview for assurance • Weave risk management into business as usual (BAU) • Corporate risks will be contained and regularly scrutinised The dashboard will capture current and target risk levels, related improvement or deterioration, and consider risk mitigation and anticipated timescales to achieve risk reduction. For risks which are deteriorating, it is proposed a 'deep dive' summary profile will be provided. It is proposed that risk content is integrated as follows: • The dashboard features at the start of the IPQR before the Indicator Summary • Narrative related to the risks is woven into respective components of IPQR		
4	Escalation Process	All staff throughout the organisation have a responsibility for identifying risk. To ensure that risks are managed effectively, they must be escalated to the appropriate levels in the organisation and to external stakeholders where necessary. Directors will have overall responsibility for establishing effective risk escalation procedures supported by: • Risk reviews • Governance group risk reviews; and Risk Leads who chair the Management Groups and provide advice on risk under the following broad categories :Clinical Quality and Safety, Property and Infrastructure	Being developed for submission to EDG in May 2022	June 2022

		(including Digital and Information), Workforce and Finance • EDG review risks and escalate to the Board any strategic risks **ESCALATION PROCESS** This will include consideration of the following: EDG • Discuss risk at EDG or proposed Risk & Opportunities Group • Develop action plan • Manage through risk register and Directorate or equivalent Management Group Executive Risk Owner • Can this risk be managed with directorate? • Does the risk impact on the wider organisation? • Share with EDG Line Manager, Risk Owners, Portfolio, Project and Programme leads • Can this risk be managed locally? • Is the risk on the register? • Who is the risk owner? Other directorate? Escalate to appropriate Directorate senior manager • Escalate to Executive risk owner All Staff • Can the risk be managed as part of Business As Usual (BAU)?		

		• What is the impact and likelihood of the risk? • Escalate to line manager		
5	Risks and Opportunities Group	A Risks and Opportunities Group will be established. This will be chaired by the Associate Director of Quality and Clinical Governance, with membership likely to include the Risk Manager and Associate and Deputy Directors. Governance lines are to be confirmed but the group is likely to report into EDG. The Group's broad remit is expected to: • Provide leadership to ensure the organisation gives risk management the appropriate priority; and facilitates and delivers effective risk management arrangements • Promote effective risk management and seek opportunity for the organisation • Link risks and opportunities to the strategic objectives of the organisation • Review aggregation of risk across the organisation to determine the most appropriate response on behalf of the whole organisation • Based on changing risk levels, provide beneficial direction / focus to the assurance functions • Horizon scan for future opportunities, threats and risks aligned to the strategic priorities • Ensure continuous improvement of the internal control environment	Terms of Reference are being drafted and will be presented to EDG in May 2022	August 2022

2.3.1 Quality/ Patient Care

Elevating the risk management framework in NHS Fife will support the further development of the quality and patient safety agenda through improved operational governance and strategic planning.

2.3.2 Workforce

There is a requirement to ensure that the appropriate workforce is in place to support the changes to the framework including updates to the Datix system. Arrangements for this are currently being explored.

The refresh of the Risk Management Framework will also include a training needs analysis to design an effective training and education strategy to support this change.

2.3.3 Financial

Once the workforce arrangements to support this change are confirmed an update to summarise the financial impact will be provided.

2.3.4 Risk Assessment/Management

This paper summarises actions to enable NHS Fife to progress an effective risk management framework and culture to support the achievement of the strategic priorities.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment has not been conducted.

2.3.6 Other impact

None

2.3.7 Communication, involvement, engagement and consultation

This paper has been developed in discussion with key stakeholders.

2.3.8 Route to the Meeting

An earlier version of this paper was considered and supported by:

- EDG, 17 February 2022
- Audit & Risk Committee, 17 March 2022
- Fife NHS Board, 29 March 2022

2.4 Recommendation

The Committee is asked to take **assurance** from this update on the plan to refresh and improve the Risk Management Framework.

Report Contact
Gemma Couser
Associate Director of Quality and Clinical Governance
Email gemma.couser2@nhs.scot

Appendix 1

DRAFT STRATEGIC PRIORITIES AND RISKS

STRATEGIC PRIORITY	Comments
To Improve Health and Wellbeing	
RISKS	
1.There is a risk that after more than 2 years of reduced levels of healthcare service as a consequence of the COVID -19 pandemic, and foreseeable continuation into the future compounded by the challenges of emerging variants and other respiratory pathogens, population health and wellbeing will be adversely affected which could result in: • increased population morbidity and mortality • increased pressure on healthcare and support services affecting service delivery • reduced capacity for non urgent services • high levels of employee absence due to personal illness and caring responsibilities • limited capacity to develop, transform and sustain services • non delivery on key quality performance measures	
2. There is a risk that the development and the delivery of the NHS Fife Population Health and Wellbeing Strategy is not adequately supported by the required planning and programme management capacity, capability and governance arrangements, resulting in delays to progression and implementation of this critical component of Fife's strategic approach to delivering the 4 national Care Programmes: Integrated Unscheduled Care; Integrated Planned Care; Place and Wellbeing; and Preventative and Proactive Care.	
3. There is a risk that if the Population Health & Wellbeing Strategy does not incorporate learning from the COVID-19 pandemic and align with the motivations, aspirations and expectations of the people of Fife, the Board's vision, corporate objectives and key priorities will not be achieved, resulting in services that are neither transformational nor sustainable in the long term.	
STRATEGIC PRIORITY	
To Improve the Quality of Health and Care Services	
RISKS	

1. There is a risk that due to failure of clinical governance, performance and management systems (including information governance & information security), NHS Fife may be unable to provide safe, effective, person centred care. Additionally, there is a risk that the effects of the COVID - 19 pandemic, including restricted capacity, reduced elective & non urgent services, and workforce pressures, will impact on the quality & safety of patient care and service delivery.	
2. There is a risk that sustained whole system pressures due to factors including COVID -19, and demand outstripping capacity within acute, primary and social care services will result in: • inability to timeously discharge medically fit patients, thus increasing their length of stay resulting in: o increased clinical risk including healthcare associated infection and deconditioning o reduced number of downstream beds o delayed patient pathways and negative impacts on safe capacity and patient flow o financial and workforce impacts due to the need to open and staff additional beds o increased Emergency Department (ED) attendances o unmet performance targets including those relating to: • 4 hour ED access • patients in delay • waiting times • treatment times • Remobilisation Plan • sub optimal patient experience and outcomes • reputational harm	
3.There is a risk that if we do not implement effective strategic workforce planning (including aligning funding requirements), we will not have the right size of workforce, with the right skills and competencies, organised appropriately within an affordable budget, to deliver business as usual services, respond to the ongoing challenges of COVID-19, and implement necessary transformation, resulting in sub optimal delivery, reputational harm, and further impacts on staff wellbeing and recruitment / retention rates.	
4. There is a risk that failure to invest appropriately in D&I resilience including the D&I Strategy and current operational lifecycle commitment, may result in an inablity to make essential transformation across Health and Social care to	

deliver sustainable and integrated services that are safe, secure and compliant with governance frameworks and associated legislation including Cyber Essentials and Network & Informations Systems Regulations, and future proofed as far as reasonable and practicable.	
STRATEGIC PRIORITY	
To Improve Staff Experience and Wellbeing	
RISKS	
1. There is a risk that because of current pressures and capacity challenges, staff may be unable to fully engage with the development of the Population Health and Wellbeing Strategy which underpins our aspiration to be an Anchor Institution i.e. one that positively influences the health and wellbeing of our communities. This may result in a strategy which does not: • recognise staff opinions and experiences • reflect staff values and motivations • reinforce the vital contribution of staff to creating a listening and learning organisation • relate to staff understanding of how we will achieve our ambition to develop and deliver a person-centred health and care system that reduces health inequalities and improves health and wellbeing for all citizens across Fife	
2. There is a risk that operating under restrictions including social distancing and working from home through subsequent waves of the pandemic whilst trying to recover / maintain services and manage increased public need, expectations and tensions, may result in result in: • sub optimal working relationships • staff feeling isolated • reduced staff resilience • increased staff absence • impact on safety and quality of patient care and services	
3. There is a risk that at a time of significant pace and scale of change, we are unable to meet our obligations in relation to required staff training and development, resulting in: • staff feeling unsupported and vulnerable due to not having the correct competencies • reduced staff resilience • reduced job satisfaction	

• negative impacts on role performance and the safety and quality of patient care and services • reputational damage • impacts on retention and recruitment rates	
STRATEGIC PRIORITY	
To Deliver Value and Sustainability	
RISKS	
1.There is a risk that the funding required to deliver the current and anticipated future service models, particularly in the context of the EU exit and the COVID - 19 pandemic, and associated supply chain issues and increased prices, will not match costs incurred, which may result in an inability to maintain and develop services and meet legislative requirements.	
2.There is a risk that failure to implement, monitor and review an effective financial planning, management and performance framework, including fully identifying the level of savings required to achieve recurring financial balance, may result in the Board being unable to deliver on its required financial targets.	
3.There is a risk that failure to assess our property and assets, and secure resources to support improvements to the condition, capacity and resilience of the estate and infrastructure may: • affect compliance with statutory obligations in relation to environmental & sustainability legislation • limit our ability to redesign and accommodate reconfigured services and different models of care to meet clinical demand • impede delivery of the Population Health and Wellbeing Strategy	

NHS Fife

Meeting:	**Public Health and Wellbeing Committee**
Meeting date:	**16 May 2022**
Title:	**NHS Fife Board Assurance Framework (BAF) Strategic Planning**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Susan Fraser, Associate Director of Planning and Performance**

1 Purpose

This is presented to the Public Health and Wellbeing Committee for:

- Assurance

This report relates to a:

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Board Assurance Framework (BAF) is intended to provide accurate and timely assurances to the Committee and ultimately to the Board that the organisation is delivering on its strategic objectives in line with the following:

- NHS Fife Strategic Framework
- NHS Fife Clinical Strategy
- Fife Health & Social Care Integration Strategic Plan

The Committee has a vital role in scrutinising the risk and where indicated, the Committee will seek further information from risk owners.

This report provides the Committee with the next version of the NHS Fife BAF 5 on 10.5
22.

2.2 Background

This BAF brings together pertinent information on the above risk, integrating objectives, risks, controls, assurances and additional mitigating actions.

- Identifies and describes the key controls and actions in place to reduce or manage the risk

- Provides assurances based on relevant, reliable and sufficient evidence that controls are in place and are having the desired effect

- Links to performance reporting to the Board and associated risks, legislation & standing orders or opportunities

The Committee is invited to consider the following:

- Does the risk score feel right?
- Do the current controls match the stated risk?
- Will the mitigating actions bring the risk down to its target level?
- If the mitigating actions are fully implemented would the outcome be achieved?
- Does the assurance provided describe how the controls are performing?
- Do the assurances come from more than one source including independent sources?
- Are limited resources being allocated appropriately i.e., on uncontrolled high risks or in otherwise well controlled areas of risk?

2.3 Assessment

This BAF reflects the changes that have happened over the COVID period and included the strategic planning for the new Population Health and Wellbeing Strategy for NHS Fife. The current risk level is assessed as Moderate, the expectation is that as we progress through the milestone plan activity in terms of the new strategy development and, as the recently recruited additional PMO capacity embeds, that this risk level should reduce.

Following discussion at previous committees, previous risks have remained on the BAF until the new Strategy is produced. The risks have been reviewed and updated. The BAF and risk also describes how:

- the Strategic Priorities form the focus of strategic planning direction going forward for NHS Fife.

- Work is progressing in the development of the Population Health and Wellbeing Strategy with revised timescales. The analysis from the public and staff survey will inform the production of a broader engagement proposal for consideration at the Portfolio Board and the Public Health and Wellbeing Committee in May 2022. Engagement planning is ongoing and will continue over the next few months. Milestone plan to December 2022 has been produced.

- The process for SPRA for 2022/23 has concluded with the production of a transitional organisational 1-year plan and financial plan. Corporate objectives are due to be signed off by the Board in May 2022. The actions from SPRA will form the basis of the Annual Delivery Plan 2022/23.

- An update on RMP4 has been submitted at the end of April for the year 2021/22. Any undelivered actioned will be carried over to the Annual Delivery Plan 22/23. This will be reported separately.

The committee are asked to note the current risk level against progress made in the development of the Population Health and Wellbeing Strategy and the robust planning through SPRA.

2.3.1 Quality/ Patient Care

Quality of Patient Care underpins the work undertaken by Strategic Planning and the development of the Population Health and Wellbeing Strategy.

2.3.2 Workforce

Workforce planning is aligned to the work undertaken by Strategic Planning through SPRA and the development of the Population Health and Wellbeing Strategy.

2.3.3 Financial

Financial planning is aligned to the work undertaken by Strategic Planning.

2.3.4 Risk Assessment/Management

Risk Assessment and Management is an integral part of the work undertaken by Strategic Planning.

2.3.5 Equality and Diversity, including health inequalities

Equality and Diversity is part of the work undertaken by Strategic Planning.

2.3.6 Other impact

n/a

2.3.7 Route to the Meeting

This paper was presented to EDG on 21 April 2022 in advance of discussion at other committees.

2.4 Recommendation

The Public Health and Wellbeing Committee is invited to:

- **Approve** the current position in relation to the Strategic Planning risk of Moderate.

Report Contact
Susan Fraser
Associate Director of Planning and Performance
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NHS Fife Board Assurance Framework (BAF)

					Initial Score				Current Score														Target Score				
Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Likelihood (Initial)	Consequence (Initial)	Rating (Initial)	Level (Initial)	Likelihood (Current)	Consequence (Current)	Rating (Current)	Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Likelihood (Target)	Consequence (Target)	Rating (Target)	Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Strategic Planning																											
1675	Clinically Excellent, Exemplar Employer, Person Centred, Sustainable	30/03/2022	25 May 2022	There is a risk that the development and the delivery of the new NHS Fife Population Health and Wellbeing strategy is not adequately supported by the required planning and programme management capacity, capability and governance arrangements. Key Risks from previous BAFs will remain until committees are content they are covered in renewed PHW Strategy. 1. Community/Mental Health redesign is the responsibility of the H&SCP/IJB 2. Governance remains between IJB and NHS Fife. 3. Regional Planning - risks around alignment with regional plans 4. Clinical Strategy does not reflect that the strategic direction of the organisation following the COVID-19 pandemic.	4 – Likely – Strong possibility this could occur	4 – Major	16	High Risk	3 – Possible – May occur occasionally – reasonable chance	4 – Major	12	3 – Moderate	Following period of COVID-19, portfolio management is being put in place. Programme management approach being refreshed through Strategic Planning Resource Allocation (SPRA) process.	Margo McGurk Director of Finance and Strategy	Clinical Governance. Christina Cooper.	*Ongoing actions designed to mitigate the risk including:* 30/03/22 1. PHW Portfolio Board meeting regularly and working well 2. Plan for delivery of PHW strategy to be agreed including analysis of Public and Staff Survey that will be used to inform strategy and public engagement work going forward. 3. SPRA 22/23 almost complete with draft Corporate Objectives for 22/23 still to be finalised	EDG Portfolio Board will provide the required leadership and executive support to enable strategy development - now in place.	PHW Portfolio Board is now meeting monthly. TOR signed off. Governance route will be Public Health and Wellbeing Committee Time period for Strategy has been amended to start from 23/24 rather than 22/23. Annual Delivery Plan for 22/23 providing interim strategic direction. Work will continue during 2022 to ensure delivery of Strategy for 23/24. Responsible Person: Director of Finance Timescale: 31/03/2022	1. Minutes of meetings record attendance, agenda and outcomes. 2. Reporting of key priorities to governance groups from the SPRA process. .	1. Internal Audit Report on Strategic Planning (no. B10/17) 2. Governance committee scrutiny and reporting. .	Governance of new arrangements will be agreed to deliver the required assurance. This gap have now been closed..	Corporate Objectives in draft for 22/23. SPRA 2022/23 will inform the Annual Delivery Plan due in July 22 and corporate objectives for 22/23. RMP4 Q3 update on deliverables was submitted in February 22 with Q4 update due in April 22.	2 – Unlikely – Not expected to happen – potential exists	4 – Major	8	3 – Moderate	Position is improving as Portfolio Board and Public Health and Wellbeing Committee is in place.

Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
	Nil currently identified				

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
	Nil applicable				

NHS Fife

Meeting:	**Public Health & Wellbeing Committee**
Meeting date:	**16 May 2022**
Title:	**Review of Annual Workplan**
Responsible Executive:	**Joy Tomlinson, Director of Public Health**
Report Author:	**Hazel Thomson, Board Committee Support Officer**

1 Purpose

This is presented to the Public Health & Wellbeing Committee for:
- Approval

This report relates to a:
- Local policy

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

2 Report summary

2.1 Situation

The Public Health & Wellbeing Committee approved the Annual Workplan at the March 2022 meeting. For assurance, the Annual Workplan, presented as a tracked version, will go to each future Committee meeting to enable the Committee to clearly monitor items that have been covered, carried forward to a future meeting, or removed.

2.2 Background

The Public Health & Wellbeing Committee sets out the planned work for the financial year in its annual workplan, which is used to inform the content of individual meeting agendas.

2.3 Assessment

The Workplan attached sets out the key plans, reports, business cases and proposals which the Committee will receive and be asked to consider, endorse or take assurance from during 2022/23.

2.3.1 Quality/ Patient Care

Delivering robust governance across the organisation supports sustaining and improving patient care and quality standards.

2.3.2 Workforce

Workforce considerations are included as appropriate in proposals considered by the Committee.

2.3.3 Financial

Ensuring appropriate scrutiny of the NHS Fife financial planning and financial performance is a core part of the Committee's remit.

2.3.4 Risk Assessment/Management

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

2.3.5 Equality and Diversity, including health inequalities

This paper does not relate to the planning and development of specific health services, nor any decisions that would significantly affect groups of people. Consequently, an EQIA is not required.

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

N/A

2.3.8 Route to the Meeting

N/A

2.4 Recommendation

The paper is provided for:

- **Approval**

3 List of appendices

- Public Health & Wellbeing Committee Annual Workplan 2022/23

Report Author
Hazel Thomson
Board Committee Support Officer
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Appendix 1

PUBLIC HEALTH & WELLBEING COMMITTEE

ANNUAL WORKPLAN 2022/23

Governance - General							
	Lead	**16/05/22**	**04/07/22**	**29/08/22**	**07/11/22**	**11/01/23**	**01/03/23**
Minutes of Previous Meeting	**Chair**	✓	✓	✓	✓	✓	✓
Action list	**Chair**	✓	✓	✓	✓	✓	✓
Escalation of Issues to Fife NHS Board	**Chair**	✓	✓	✓	✓	✓	✓
Governance Matters							
	Lead	**16/05/22**	**04/07/22**	**29/08/22**	**07/11/22**	**11/01/23**	**01/03/23**
Committee Self-Assessment Report	**Board Secretary**		✓				
Corporate Calendar / Committee Dates	**Board Secretary**			✓			
Review of Annual Workplan	**Associate Director of Quality & Clinical Governance**	✓	✓	✓	✓	✓	✓ Approval
Review of Terms of Reference	**Board Secretary**						✓ Approval
Annual Committee Assurance Statement (inc. best value report)	**Board Secretary**	✓					
Annual Internal Audit Report	**Director of Finance & Strategy**		✓				
Strategy / Planning							
	Lead	**16/05/22**	**04/07/22**	**29/08/22**	**07/11/22**	**11/01/23**	**01/03/23**
Population Health & Wellbeing Strategy	**Director of Finance & Strategy**	✓	✓	✓	✓	✓	✓
Anchor Institution Programme Board / Portfolio Board	**Director of Public Health**	✓		✓		✓	
Corporate Objectives	**Director of Finance & Strategy**	✓			✓		
Strategic Planning Resource Allocation (RMP 2022/23)	**Director of Finance & Strategy / Associate Director of Planning & Performance**	**Postponed (awaiting national guidance)**	✓ **TBC**	✓			
Briefing Paper on NHS Scotland Policy for Climate Emergency and Sustainable Development	**Director of Property & Asset Management**	✓					
Mental Health Strategy Implementation	**Director of Health & Social Care**	**Deferred to next mtg**	✓			✓	

Strategy / Planning (cont.)

	Lead	16/05/22	04/07/22	29/08/22	07/11/22	11/01/23	01/03/23
Primary Care Governance & Strategy Group *(timing tbc)*	**Director of Health & Social Care**						

Quality / Performance

	Lead	16/05/22	04/07/22	29/08/22	07/11/22	11/01/23	01/03/23
Covid Testing Programme	**Director of Public Health**	✓	**(General population testing ending at end of April '22)**				
Flu Vaccine / Covid Vaccine (FVCV) Programme	**Director of Public Health / Director of Health & Social Care**	✓	**(Will become part of business as usual)**				
Children Services	**Director of Health & Social Care**			✓			
Health Promoting Health Service	**Director of Public Health**			✓			
Health Weight **timing tbc*	**Director of Public Health**						
Integrated Performance & Quality Report	**Director of Finance & Strategy / Associate Director of Planning & Performance**	✓	✓	✓	✓	✓	✓
Joint Health Protection Plan	**Director of Public Health**		✓			✓	
Oral Health Reporting	**Director of Public Health**					✓	
Sexual Health and Blood Borne Virus Framework	**Director of Health & Social Care**				✓ **TBC**		
Smoking Cessation	**Director of Health & Social Care**				✓		

Inequalities

	Lead	16/05/22	04/07/22	29/08/22	07/11/22	11/01/23	01/03/23
Equalities Outcome Report *(also goes to CGC)*	**Director of Nursing**						✓
Participation & Engagement Report *(also goes to CGC)*	**Director of Nursing**				✓		
Inclusivity Overview	**TBC**		✓				
Child Poverty Action Plan	**Director of Public Health**			✓			
Addiction Services **timing tbc*							

Annual Reports							
	Lead	**16/05/22**	**04/07/22**	**29/08/22**	**07/11/22**	**11/01/23**	**01/03/23**
Adult Support & Protection Annual Report *(also goes to CGC)*	**Director of Nursing**					✓	
Alcohol & Drugs Partnership Annual Report **timing tbc*	**Director of Health & Social Care**						
Director of Public Health Annual Report *(and additional updates, based on agreed priorities) (also goes to CGC)*	**Director of Public Health**	✓					
Fife Child Protection Annual Report	**Director of Nursing**					✓	
Health Promotion Service Annual Report *(and additional updates, based on agreed priorities)*	**Director of Health & Social Care**			✓			
Health Promoting Health Service Report	**Director of Health & Social Care**			✓			
Immunisation Annual Report *(also goes to CGC)*	**Director of Public Health**		✓				
Integrated Screening Annual Report *(also goes to CGC)*	**Director of Public Health**			✓			
Linked Committee Minutes							
	Lead	**16/05/22**	**04/07/22**	**29/08/22**	**07/11/22**	**11/01/23**	**01/03/23**
Minutes of Fife Partnership Board *(meeting dates will be confirmed after the elections in May)*	**Director of Public Health**						
Minutes of Population Health & Wellbeing Portfolio Board	**Director of Finance & Strategy**	✓ 17/05	✓ 12/05 & 09/06	✓ 14/07 & 11/08	✓ 15/09 & 13/10	✓ 10/11 & 08/12	✓ TBC
Minutes of Public Health Assurance Committee	**Director of Public Health**	✓ 09/02 & 06/04	✓ 01/06	✓ 03/08	✓ 05/10	✓ 07/12	TBC 01/02
Ad Hoc Items							
	Lead	**16/05/22**	**04/07/22**	**29/08/22**	**07/11/22**	**11/01/23**	**01/03/23**
Mental Health Estate Re-Design Programme	**Medical Director**	✓					

Ad Hoc Items (cont.)							
	Lead	**16/05/22**	**04/07/22**	**29/08/22**	**07/11/22**	**11/01/23**	**01/03/23**
Implementation of the Immunisation Strategic Framework	**Director of Public Health**	✓					
Flu Vaccination Covid Vaccination (FVCV) Local Governance Arrangements	**Director of Public Health**	✓					
Additional Agenda Items (Not on the Workplan e.g. Actions from Committee)							
	Lead	**16/05/22**	**04/07/22**	**29/08/22**	**07/11/22**	**11/01/23**	**01/03/23**

NHS Fife

Meeting:	**Public Health and Wellbeing Committee**
Meeting date:	**16 May 2022**
Title:	**Population Health and Wellbeing Strategy - Public and Staff Engagement**
Responsible Executive:	**Janette Owens, Director of Nursing**
Report Author:	**Susan Fraser Associate Director of Planning and Performance** **Kirsty MacGregor, Head of Communications** **Fay Richmond, Executive Officer**

1 Purpose

This is presented to the Public Health & Wellbeing Committee for:

- Approval

This report relates to a:

- NHS Board/Integration Joint Board Strategy or Direction

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

A key part of the development of the NHS Fife Population Health and Wellbeing Strategy is having as wide engagement with the citizens of Fife, our workforce, and partners as is possible, whilst recognising that in some cases they are one and the same.

The start of our engagement process started in December 2021, with our “Community Conversation” and “Colleague Conversation” surveys. The results of this initial engagement phase have been used to inform the plan for the next phase of more in-depth and focused conversations, based on the emerging themes identified in the survey results.

We are now planning to deliver a second phase of focussed conversations over a 12-week period from July – September 2022 with evaluation in October 2022.

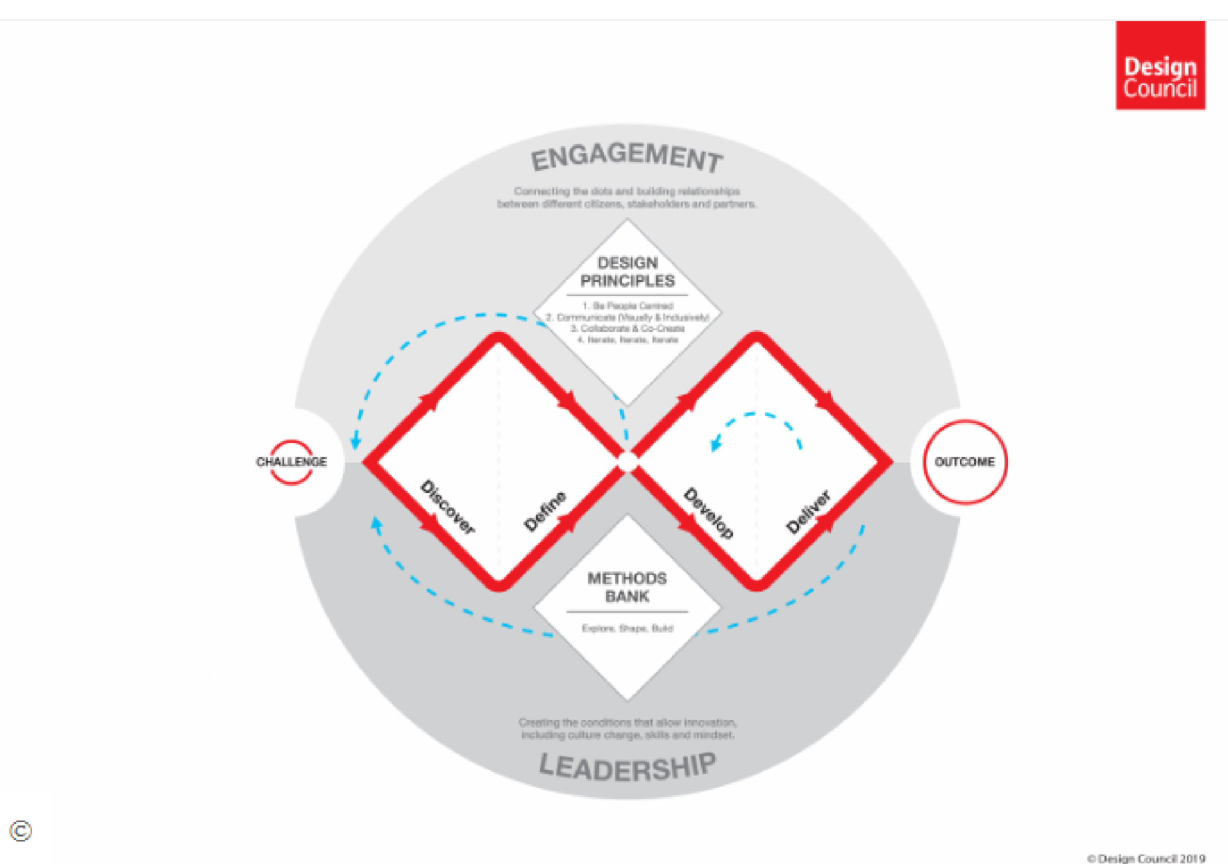
2.2 Background

NHS Fife recognises that quality and meaningful engagement is a key component of the development of strategy. Healthcare Improvement Scotland (HIS) published the draft *The Quality Framework for Community Engagement and Participation* (HIS Framework), to support NHS Boards, local authorities and IJBs to carry out effective community engagement. The framework also allows for self-evaluation, allowing bodies to demonstrate how they are meeting their statutory duties for public involvement.

HIS have a number of other tools that support appropriate and meaningful engagement, supporting teams and Boards in these activities. We have examined and considered the following:

- VOICE toolkit- (https://www.voicescotland.org.uk/voice/): an online resource to support planning, delivery, and review of engagement.
- HIS Engage- Engaging People and Communities: (https://www.hisengage.scot/equipping-professionals/how-to-engage/)

NHS Fife recognises that a framework and tools on their own can't deliver quality and meaningful engagement. There are multiple models for strategic development, and we have adopted the Double Diamond (The Scottish Approach to Service Design SAtSD) (Scottish approach to Service Design) approach that is thread throughout the work to date and outlined in this paper.



The five stages are:

1. Discover/ Research – gaining insight into themes and recurring issues
2. Define/ Synthesis – the area/s to focus on and prioritise
3. Develop/ Identify – potential solutions
4. Deliver/ Implementation – solutions that work
5. Refine/Review – with regular progress updates

The public and staff engagement in NHS Fife has been planned using the 5 stages in the Double Diamond model – currently we are going into Phase 2.

Phase 1: Discover (October 2021-March 2022)

Phase one of our approach, discover/ research, was the community conversations held in the later part of 2021. A questionnaire approach was used, and the results are informing the second phase (define/ synthesis) allowing us to both gain additional information but also test our understanding (develop/ identify) and potential solutions. Together this will allow us to deliver, implement and refine the Population Health and Wellbeing Strategy over its lifetime

COMPLETED

Phase 2: Define (March-May 2022)

More in depth conversations with Fife citizens and staff based on the analysis from the Community and Staff conversation.

Phase 3: Develop

We will be working to develop the conversation questions and the model for the conversations e.g. existing groups, workplaces, etc.

Phase 4: Deliver (July 2022-Sept 2022)

We will have the conversations with staff and citizens. We will be refining as we go, from the feedback we get

Phase 5: Refine (January 2023 onwards)

We will use the knowledge and feedback we have gained to write the strategy and associated workplan.

2.3 Assessment

NHS Fife worked with Progressive Partnership (a market research company) for phase one of the Community and Colleague surveys. Progressive developed, co-ordinated, and independently evaluated the surveys, with **587** citizen and **368** staff responses received. Analysis showed that the number of responses received were not from a representative sample of the local Fife population and NHS Fife workforce, but the response rate was not statistically significant. However, the responses and feedback along with recurring themes provided valuable insight to inform the second phase of our more in-depth engagement conversations

In developing stage *Define* more focused conversations will be required with citizens and colleagues. In order to develop this next phase of engagement, NHS Fife has sought advice from the following groups and bodies to ensure best practice and to provide a benchmark for this stage 2 planning and evaluation:

- Public Engagement Network (PEN)
- Healthcare Improvement Scotland (HIS) – Community Engagement Planning with People guidance document and tool kit and regular liaison with Rachel Lee HIS Engagement Officer for Fife
- Other Boards undertaking similar work – NHS Lothian and NHS Grampian
- NHS Fife workforce and staff side via EDG

Stage 2 - Engagement Plan

Using the HIS framework of Preparation, Inform, Engage and Review, a draft plan for phase two – focussed conversations is outlined for approval in this paper.

As in stage 1 we will continue with the two parallel streams of activity – Community and Colleague acknowledging that there will be synergy across the core themes explored as part of these facilitated focus group discussions.

It is proposed that independently facilitated focus groups for our local communities and colleagues will run for a period of 3 months from 1st July – 30th September.

A range of facilitated focus groups sessions will be run online and in person over a range of times and dates – including evenings and some weekends to maximise reach and opportunities for participation. We anticipate these focus groups being run for a maximum of 20-25 participants and lasting around 1 hour.

These groups will be based around the 7 Fife Localities and include representation from a range of community groups operating in the following localities as well as individual citizens:

- Cardenden (including Lochgelly, Kelty and Cardenden)
- City of Dunfermline
- Glenrothes (includes Thornton, Kinglassie and Leslie)
- Kirkcaldy (includes Burntisland and Kinghorn)
- Levenmouth (includes West Wemyss, Buckhaven, Methil, Methilhaven, Kennoway and Leven)
- North East Fife (takes in Auchtermuchty, Cupar, Taybridgehead, Crail and Anstruther)

Individuals or representatives of groups will self-select and complete an online booking form. Booking and session information will be shared as widely as possible, making use of local media, social media, PEN, elected members and other contacts to encourage sign-up and participation.

Initially 2 sessions per locality will be offered, depending on take-up and engagement or any identified potential gaps, additional sessions will be offered.

Planning and delivering an engagement programme of this scale is resource intensive. There is a need for skilled facilitation, both in planning and delivering the sessions, admin support pre, during and post sessions. There is no identified resource within NHS Fife staff with the skills and capacity to undertake these roles.

On this basis we are recommending that NHS Fife appoints independent facilitators to run the community and larger staff focus group sessions, ensuring no unconscious bias in relation to how the questions are posed, discussion is stimulated, captured, and reported. We are actively procuring these services.

Smaller team specific, ad hoc staff groups would be facilitated by internal colleagues.

We intend to pose 6 key questions to both the community and colleague focus groups with 4 general questions/topic areas and the 2 questions specific to either community or colleague attendees.

These proposed questions have been developed from:

- Stage 1 survey feedback
- Other NHS Fife engagement work (National Treatment Centre and Lochgelly/Kincardine Health Centres),
- i-Matter staff survey
- Patient Relations feedback
- NHS Fife Director of Public Health Annual Report 2022/23
- Experience of other boards in engagement work
- NHSScotland strategy

Proposed Questions

Staying Healthy and Well

1. When asked about maintaining good mental health, our survey results, were varied with around 1/3 of respondents finding it quite or very easy but 1/3 saying it was quite or very difficult. What do you see as the barriers to maintain good mental and physical health?

Proactive and Preventative Care

2. The responses to the survey question were inconclusive. We are still keen to hear about your experience of using NHS services to support you staying well, and how you rate them.

3. Following the survey, the majority of respondents agreed that proactive and preventative care should be a key focus for NHS Fife. Do you agree and how should we do this?

Improving Quality of Health Services

4. We want to know about your experience with NHS appointments. How easy have you found it to access appointments and how did you find the appointment (s) experience. (This will include both Mental Health and physical health)

5. The majority of survey respondents agreed that getting a quick appointment was more important than being able to access the care locally. Do you agree?

Delivering Value and Sustainability

6. The results from our survey indicated that many residents limited information about how NHS Fife uses their allocated resources and funding. How can we make this information more accessible?

Staff Wellbeing

7. From our survey results around 4 in 10 respondents said staying healthy or well was quite or very easy. Our staff were more likely than residents to describe it as quite difficult. What do you feel are the current barriers to staying healthy and well?

8. When we asked about support for your health and wellbeing, we had a very mixed response. We would like to ask again about what we can do to support you to maintain good health and wellbeing.

Community Conversation - Citizens

We recognise that we have a duty to ensure that we make every reasonable effort to include seldom heard groups and those with protected characteristics (age, disability, sex, sexual orientation, gender reassignment, race, gypsies and travellers, religion or belief, marriage and civil partnership) in our planned engagement. An EQIA Stage 1 assessment was completed for stage 1 and stage 2 is being completed in tandem with this next phase of engagement planning.

It is important that we aim to have engagement with groups and individuals that are as representative of communities and citizens of Fife as possible. To meet this aim, we will have to plan more active target approaches for some groups or individuals. We will co-ordinate with colleagues in the Health and Social Care Partnership (HSCP) who are also planning consultation on their Strategic Plan as part of their statutory duty.

We have had clear guidance from HIS community Engagement that we should make use of existing groups, places and people. We propose focus sessions with the community is delivered through virtual and in person sessions recognising limitations of citizens to online resources.

Staff Conversations

We recognise that many staff are also resident in Fife and may choose to engage through those mechanisms. We also understand that staff will also be members of seldom heard groups and have protected characteristics and will consider them when finalising plans.

However, we do want to continue our conversation with our workforce through staff focus groups. These are proposed to be delivered through virtual and in person sessions recognising that not all staff groups have access to virtual platforms like Teams. These sessions will be limited delivered over 60 minutes recognising the reality of releasing staff from their posts. Again, we would ask staff to register to allow us to be sure that we have

both representation from all areas of the Board, as well as all job families. If required, we would have additional sessions for staff groups or geographic areas.

It is our intention to have sessions at all the main hospital bases in Fife, trying to minimise travel and time away from work for staff. These are: Queen Margaret Hospital: Lynebank Hospital: Victoria Hospital, Kirkcaldy: Whyteman's Brae Hospital: Glenrothes Hospital: Cameron Hospital: Randolph Wemyss Hospital: Adamson Hospital: St Andrews Community Hospital.

EQIA

In developing the plan for engagement, a key activity has been the completing of the full Equality Impact Assessment (EQIA) which is attached as a draft in Appendix A. Using the expertise of our colleagues in HIS Community Engagement, NHS Fife key staff and reviewing other completed EQIAs, we have completed the paperwork. We will move onto the stage once the draft EQIA has been signed off by the Senior Responsible Officer. The next stage will be to share the draft with the PEN Advisory Group, seeking their input. In particular we will be looking to their collective expertise to ensure we have identified proportionate plans to engage with all the citizens of Fife, having particularly considered those whose protected characteristics could be impacted by the Strategy, and those from seldom heard groups. We are aware that for many if they have no underlying conditions or need to access health services, there will be little incentive to engage.

In completing the EQIA (stage 2), a strong message from others with experience in this field, was that we should make efforts to go to pre-existing groups or areas that individuals routinely visit.

2.3.1 Quality/ Patient Care

The Population Health and Wellbeing Strategy will have an impact on all care and services that NHS Fife delivers. It is anticipated that by engaging with citizens and staff we develop a strategy that positively impacts on health and wellbeing.

2.3.2 Workforce

Engagement with our workforce and actively listening as we develop the strategy is positive for all. In recognising and asking specifically for their ideas on how we deliver within our resources and against the known pressures.

2.3.3 Financial

There will be a cost for external, independent facilitation but funding has been identified to support the strategy development. Long term there could be savings to be made from implementing the strategy and how we deliver future care/ services.

The Portfolio Board will have oversight of all financial matters.

2.3.4 Risk Assessment/Management

A risk register will be developed for the engagement plan. This will be overseen by the Portfolio Board. The Engagement Plan will also use the national "Voice Tool" based around the 7 national standards for engagement to help plan, review and evaluate our engagement activity in support of our strategy development.

2.3.5 Equality and Diversity, including health inequalities

In developing the plan, cognisance has been given to both protected characteristics and seldom heard groups.

An Impact assessment is in draft form.

2.3.6 Communication, involvement, engagement and consultation

This plan has been discussed with the Healthcare Improvement Scotland- Community Engagement local engagement officer and their guidance used.

2.3.7 Route to the Meeting

- Portfolio Board 12 May 2022

2.4 Recommendation

State the action being requested. Use one of the following directions for the meeting. No other terminology should be used.

- **Approval** – Note the public and staff engagement plan for the Population Health and Wellbeing Strategy and progress made.
- **Approval** – Support is requested to engage an external facilitators to deliver the engagement plan

3 List of appendices

The following appendices are included with this report:

- Appendix No 1 Draft EQIA

Report Contact
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Associate Director of Planning and Performance
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Equality Impact Assessment
Full Impact Assessment
(Form 2)

EQIA Document Control

Date started	Feb 2022
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EQIA approved	

Full Equality Impact Assessment Form 2

You have by this stage identified an adverse impact for a protected characteristic group including any cross cutting issues or where a potential impact for those affected by economic disadvantage or poverty is apparent.

The Equality Impact Assessment (full) picks up from the Standard Impact Assessment (Stage 1) process, where the proposal has been identified or highlighted as having a potential negative impact.

It is now that you need to move onto a full Equality Impact Assessment.

This is more of a **detailed examination** of what you have identified at stage 1-Form 1.

Included here – see below- is the EQIA template to complete with your service, group, participation and engagement forum/involvement and partners etc. This will help to set you to set out who is affected, what the impacts are and what we are going to do about them.

The EQIA can be as part of your overall document (policies always have these attached) or you can keep this separately (i.e. if you are using it to work on as part of your bigger plans) as long as it evidences your ongoing actions to remedy the concerns, and remains linked to the plan etc so we can see that you are reducing the negative impacts.

The aims of an EQIA are to support your thinking in all your processes, so we ensure we are not being discriminatory towards any group. It is our legal duty to do this and to ensure we make a reasonable adjustment.

The EQIA must also demonstrate and record where we have eliminated discrimination, advanced opportunity or fostered good relations between those with a protected characteristic and those who haven't.

NHS Fife is mindful of these three needs of the Public Sector Equality Duty (PSED) - eliminate unlawful discrimination, harassment and victimisation, advance equality of opportunity between people who share a protected characteristic and those who do not, and foster good relations between people who share a protected characteristic and those who do not - and recognises while the measures may positively impact on one or more of the protected characteristics, also recognises that the introduction of the measures may have a disproportionate negative impact on one or more of the protected characteristics. Where any negative impacts have been identified, we have sought to mitigate/eliminate these. We are also mindful that the equality duty is not just about negating or mitigating negative impacts, as we also have

a positive duty to promote equality. This can be documented as you go along-some things you will highlight may be helping us to do one or all three of these duties, not all the content of an EQIA is negative, as our plans and developments are aimed to improve our services.

The EQIA must be published in full along with your plan or policy etc and signed off by the lead officer responsible. A copy should be then sent to Equality and Human Rights lead officer to publish and to quality assure.

1. Rational and aims

The last two years of the Covid – 19 pandemic has impacted significantly on individuals and the delivery of health and social care. In parallel with the direct harms, death and serious long-term sequalae, there have been the unintentional harms. These unintentional harms have affected in a multitude of ways but include, individual health and wellbeing, delays in treatment for existing conditions, delays in screening.

Prior to the pandemic NHS Fife had a Clinical Strategy 2016-2021 and the Board have recognised that a different approach would be needed. We are currently undertaking the work to develop a Population Health and Wellbeing Strategy.

2. Who will be affected by this?

All existing and future patients of NHS Fife services, staff and the general population. This includes those who access services across primary and secondary care, independent practitioners e.g., dentists and screening.

3. What do we know from our evidence base?

4. Who is present at this EQIA?

Name

5. Consulted at Stage 1 standard impact Assessment

Population groups and factors contributing to poorer health/health inequality	Potential Impacts and explanation why	Recommendations to reduce or enhance such impacts
Issues that apply to everyone Transport Income Air quality Transmission of infection Education Community space and leisure Housing Low pay Unemployment	Access to good health and wellbeing is impacted by all of the factors/ issues noted. In order to have good health individuals, families and communities need to be able to access and use the "building blocks" of good health. Money is a key determinant – affecting the ability to: • have good, sound, accessible housing • access their local community and families for support • access to nutritious food • know what to do with fresh produce (cooking) but also what to buy, storage and reduction in food waste • ability to buy fuel to heat homes and cook nutritious fresh produce • access transport to move between communities and access work Air quality affects health both as a risk factor to lung and other disease but also impacts general wellbeing and mental health. During the pandemic and as we recover and redesign services there has been and will remain an increasing digital access footprint. Not all citizens have access to hardware to facilitate this methodology and there is recognised data poverty in some. This includes health literacy as well as comprehension and language difficulties.	Actions taken NHS Fife is an Anchor Institution within Fife both as an employer and as a procurer of services and goods. Using initiatives such as Kickstart, NHS Fife is supporting young people to access employment and gain valuable experience in the workplace preparing them for lifelong employment not unemployment Applying fair work/ pay principles allows NHS fife to support individuals and communities in the widest sense. As a planning partner, and through wider Public Health role, NHS Fife can support the planning of communities and services e.g., health and wellbeing hubs, transport links, etc. Work with partners to explore appropriate delivery models e.g., health hubs with secure and private access for video calls Ensure that models of care reflect that not all patients/ service users can

Digital access. Communication and understanding Access to Interpreting and Translations		access a non- patient facing model. There is access to 24/7 interpreting and translation services using a suite of options including language line, mobile interpreting on iPads, etc. Health information can be translated into all community languages and easy read.
Issues that apply to all the population groups mentioned in the table below that are linked to the COVID-19 pandemic BAME staff and population. Older people and those who care for them at home	This proposed strategy will specifically work to lessen the consequences of the pandemic on all and in doing so will identify and address the specific issues of groups and individuals. Recognising that our BAME population (staff and patients) have been more affected by Covid- 19 at times. Many have become carers during the pandemic because of changes in their or their cared for persons circumstances. The strategy will support them to manage their own health as well as the cared for persons.	Actions taken/ planned Awareness when planning services and care models within the strategy that there have been specific health risks and consequences for our BAME population and that these are still a "live" issue. E.g, screening uptake low in some populations before the pandemic and targeted action will be needed to increase these levels post pandemic The strategy focus is health and wellbeing, supporting individuals to identify their own health needs and use skills to manage these

Care Homes residents and staff People vulnerable to this virus such as those with additional or lifelong conditions, such as those with a learning disability.	Care homes are the home setting for the individuals living in them. All identified actions will apply to this population and their carers, paid and family, kin and friends. People with an existing medical condition were identified as at greater risk from Covid. They were collectively known as "shielders". This has had an impact on their general health and considerations. Managing risk may well have been a part of their daily life, and for many there will an ongoing need to be aware of risks. The strategy will support individuals, regardless of their needs to identify need, manage their health needs and risks.	effectively. This is supported by the knowledge of how to be healthy and maintain good health and wellbeing This is the same for all citizens regardless of their home setting. With a focus on health and wellbeing the strategy will support these individuals to have the knowledge to both manage their personal circumstance but understand the range of supports e.g., peer support groups
Population groups and factors contributing to poorer health	**Potential Impacts and explanation why** **THINK Access to services, health differences or inequality, communication barriers, trust, knowledge, cost, social norms and attitudes, cultures.**	**Recommendations to reduce or enhance such impacts**
Age: older people; middle years; early years; children and young people.	This strategy will be relevant to all of the population of Fife directly and indirectly. The expectation is that this will be positive as individuals are encouraged and supported to manage their own health and wellbeing as well as have access when needed, to services. This will be a range of services and not those traditionally used. E.g., minor ailments support from a local, community pharmacy, different members of the multi-disciplinary team in a GP Practice, community-based peer support. Clarity about the exact changes and impacts cannot be realised at this time.	Actions taken/ planned Engaging with a range of groups and individuals across the age continuum will ensure that individual impacts are identified, and appropriate/ reasonable mitigations considered. We will work with our partners in this. We will be actively ensuring that we have representation from all age groups and if necessary, will arrange specific sessions for some age groups. We will be using existing groups and some of these will be age based.

	It is a clear objective of the strategy development team that we ensure we engage with younger people as they begin their life journey and develop good foundations of health, wellbeing, and self-care. We are also cognisant of the different health and wellbeing needs of different age and stage groups and will work to ensure we have representation from all.	
Children and Young People's rights and wellbeing is available- see under LAC looked after children and seek support from Children's services to complete this.	To be completed will need support/ advice from Public Health Lead	Actions taken/ planned
Disability: physical, sensory and learning impairment; mental health conditions; long-term medical conditions.	A key aim/ objective of the strategy is to support individuals to have access to services, supports and skills to allow them to manage their own health and wellbeing. In delivering the strategy cognisance will be made of the need to reach those with all disabilities including those that are hidden and ensure all materials are accessible in the necessary formats. Using existing networks and supports will also allow us to access these individuals/ groups.	Actions taken/ planned When undertaken the next stage of engagement there will be care taken to ensure that individuals from multiple disability groups including hidden disability are considered and able to engage. Care and any additional actions will be taken to liaise with partner and speciality staff and groups We will be actively ensuring that we have representation from across a range of disabilities including hidden, and if necessary will arrange specific sessions for some groups.

Gender Reassignment: people undergoing gender reassignment	In supporting individuals with a range of health and wellbeing needs, individuals in this group will have/ learn skills to manage their own needs as well as an understanding of wider service provision that is available to meet their individual health and wellbeing needs.	Actions taken/ planned Covered by the over arching approach of engagement and using the PEN Advisory as expert group.
Marriage & Civil Partnership: people who are married, unmarried or in a civil partnership.	It is not anticipated that an individual's marital status will be impacted by or have an impact on the strategy.	Actions taken/ planned Covered by the overarching approach of engagement and using the PEN Advisory as expert group.
Pregnancy and Maternity: women before and after childbirth; breastfeeding.	The strategy will support women to identify and manage their individual health and wellbeing needs during before, during and after pregnancy in the widest sense.	Actions taken/ planned We will be engaging with appropriate groups/ services including our staff within this group We will be actively ensuring that we have representation from all groups and if necessary, will arrange specific sessions for groups.
Patients/staff who return to work	With a focus on health and wellbeing the strategy will support individuals returning to work after any period of absence for whatever reason. This will include periods of ill health, caring responsibilities, etc. By identifying, and managing their individual health and wellbeing needs they can be supported to return to the most appropriate work for them. This applies to all citizens, and NHS Fife staff. There are individuals who have been impacted by long Covid and they will continue to be supported to be as healthy as possible, including their mental health and wellbeing.	Actions taken/ planned We have identified mental and physical health groups to engage with as well as specific disability groups We will be actively ensuring that we have representation from all staff groups and if necessary, will arrange specific sessions for some staff groups.
Race and ethnicity: minority ethnic people; speakers of community languages; Gypsy/Travellers; migrant workers.	With a focus on health and wellbeing the strategy will support all individuals. Materials will be available in different formats. There is access to interpretation services 24/7 via our interpreting apps. Face to face interpreters can be arranged for specific appointments/ consultations.	Actions taken/ planned These groups have been identified as part of the engagement strategy. We recognise that we will need to seek specialist input to support us to engage meaningfully. We will be actively ensuring that we have representation from all race and

		ethnicity groups that are representative of our staff and citizens and if necessary, will arrange specific sessions for groups. Interpretation will be available as required.
Religion and belief: people with a religion or belief, or none. Spiritual consideration.	There is not expected to be any impact from the strategy	Actions taken/ planned Covered by the overarching approach of engagement and using the PEN Advisory as expert group.
Sex: men; women; experience of gender-based violence. Sex workers	The strategy aims to support individuals to have access to services and skills to support their own health and wellbeing. In delivering the strategy cognisance will be made of the particular needs of the different groups	Actions taken/ planned We will be actively ensuring that we have representation from all groups and if necessary, will arrange specific sessions for groups.
Sexual orientation: lesbian; gay; bisexual; homosexual, transgender, heterosexual	The strategy aims to support individuals to have access to services and skills to support their own health and wellbeing. Sexual orientation will not have a negative impact.	Actions taken/ planned We will be actively ensuring that we have representation from all groups and if necessary, will arrange specific sessions for groups.
Looked after (incl. accommodated) children and young people	To be completed will need support/ advice from Public Health Lead	

Carers: paid/unpaid, family members.	In supporting individuals with a range of health and wellbeing needs, this group will have access to skills to manage their own needs and an understanding of wider service provision to meet their health and wellbeing needs and those of the individuals they provide care to. (We recognise that this can be direct and indirect care and will vary overtime.)	Actions taken/ planned Some carers will themselves have health conditions and all will be part of the general community giving multiple opportunities for engagement. We will be actively ensuring that we have representation from all groups and if necessary, will arrange specific sessions for groups.
Homelessness: people living on the street; staying temporarily with friends/family; in hostels, B&Bs. Do they have a permanent address or temporary address? Is their address recognised by our systems for data collection?	It is recognised that this population have less access to routine healthcare for a number of reasons. This includes individuals who are couch surfing, in insecure accommodation, etc.	Actions taken/ planned In planning for the strategy to be meaningful and engagement fruitful we will liaise with services to gain support to engage. We will be actively ensuring that we have representation from all groups and if necessary, will arrange specific sessions for groups.

Involvement in the criminal justice system: offenders in prison/on probation, ex-offenders. Those released and locating back into Fife.	It is recognised that this population have less access to routine healthcare for a number of reasons.	Actions taken/ planned In planning for the strategy to be meaningful and engagement fruitful we will liaise with services / experts in this field to gain support to engage.
Those affected by addictions substance misuse; alcohol, drugs, gambling, food/eating disorders	It is recognised that this population have less access to routine healthcare for a number of reasons.	Actions taken/ planned In planning for the strategy to be meaningful and engagement fruitful we will liaise with services to gain support to engage.

		We will be actively ensuring that we have representation from all groups and if necessary, will arrange specific sessions for groups.
Staff: full/part time; voluntary;	Staff are also potential patients for the services provided in and by NHS Fife.	Actions taken/ planned Staff have been identified as a target group within the engagement plan. Some staff, will themselves have health conditions, some will be carers, and all will be part of the general community giving multiple opportunities for engagement. We will be actively ensuring that we have representation from all groups and if necessary, will arrange specific sessions for groups. This may be due to job family or location. A mixed model of sessions will also be offered.
Low income/poverty/Low pay/benefits/	These all have an impact on an individual's health and wellbeing. This affects their opportunities and abilities to follow healthy lifestyle guidance e.g., cost of fresh food as well as being a risk factor for the development of diseases e.g., Type 2 diabetes. In developing the strategy in partnership consideration, we are looking from both the service and individual viewpoint	Actions taken/ planned Engagement activity is planned for both general community and focussed in our recognised areas of deprivation, etc. We will be actively ensuring that we have representation from all groups and if necessary, will arrange specific sessions for groups.
Low literacy / Health Literacy: Includes poor understanding of health and health services as well as written language skills.	Both of these can reduce the ability of individuals to understand and use effectively, the messages that they are given. This impacts on general and condition specific health information and also the ability to understand and use general health messages	Actions taken/ planned We will be actively ensuring that we have representation from all groups and if necessary, will arrange specific sessions for groups.

	including screening information	We will be using mixed mediums to advertise the sessions and will be guided by the PEN Advisory Group.
Living in deprived areas	Living in an area of deprivation can have a negative impact on an individual's health (physical and mental) and wellbeing. This impacts opportunities to follow healthy lifestyle guidance e.g., cost and access to cheap, healthy food. In developing the strategy in partnership consideration, we are looking from both the service and individual viewpoint	Actions taken/ planned Engagement activity is planned for both general community and focussed in our recognised areas of deprivation, etc. We will be actively ensuring that we have representation from all areas and if necessary, will arrange specific sessions for areas.
Living in remote or rural areas West and NEF	Living in an area of remoteness or rurality can have a negative impact on an individual's health (physical and mental) and wellbeing. Limited access to public transport, community services e.g., bank, library, alongside access to goods e.g., healthy food. In developing the strategy in partnership consideration, we are looking from both the service and individual viewpoint	Actions taken/ planned Engagement activity is planned for both general community and based on the seven localities. These recognise and identify areas of remoteness and rurality. We will be actively ensuring that we have representation from all areas and if necessary, will arrange specific sessions for areas.
Discrimination/stigma Mental Health	This is a complex and large group. Many of our citizens and staff have seen a deterioration in their mental health or have developed new mental health needs as a result of the recent pandemic.	Actions taken/ planned We will be actively ensuring that we have representation from all protected characteristics and identified seldom heard groups. If necessary, will arrange specific sessions to meet the needs.

Disability Hidden disability Impairment Speech impairment Neurological condition	A number of people have been left with ongoing, significant disability and impairment post Covid infection. This is known as long Covid. As a new disorder there is limited knowledge or understanding of treatments and support needs. Much of this is hidden disability e.g., fatigue – physical and mental, breathlessness, etc. Our strategy is focussing on not just the delivery of services but on ensuring that individuals, the population, have the skills or access to support, to be able to manage their own health and wellbeing regardless of the level of their need through disease, disability, age or impairment.	
Age Cognitive impairment	Our strategy is focussing on not just the delivery of services but on ensuring that individuals, the population, have the skills or access to support, to be able to manage their own health and wellbeing regardless of the level of their need through age or impairment.	Actions taken/ planned We will be actively ensuring that we have representation from all protected characteristics and identified seldom heard groups. If necessary, will arrange specific sessions to meet the needs
Refugees and asylum seekers All refugee resettlement programmes e.g, Syrian, Afghan and Ukraine	Our strategy is focussing on not just the delivery of services but on ensuring that individuals, the population, have the skills or access to support, to be able to manage their own health and wellbeing regardless of their previous country of residence.	Actions taken/ planned We will be actively ensuring that we have representation from all protected characteristics and identified seldom heard groups. If necessary, will arrange specific sessions to meet the needs

NHS Fife considers Human Rights in all our actions and evidence what we do to ensure we improve our Human rights focus and outcomes.

Children and Young People Rights impact assessment must be completed when children and young people are affected by change- this may occur when the policy is aimed at adults but will indirectly affect CYP.

Articles	Potential impacts and any particular groups affected	Recommendations to reduce or enhance such impacts
The right to life (absolute right)	The planned strategy and engagement does not negatively impact on this right. Giving individuals the skills and knowledge to manage their individual health and wellbeing will enhance this. We aim for people to live the best life they can regardless of circumstance.	By the planned focussed conversations, we will be addressing any impacts
The right not to be tortured or treated in an inhuman or degrading way (absolute right)	The planned strategy and engagement does not negatively impact on this right. Giving individuals the skills and knowledge to manage their individual health and wellbeing will enhance this. By giving them the skills and knowledge, they will be able to have realistic, good conversations about their health and treatment plan with clinicians. NHS Fife in providing safe, quality driven services ensures our service users are not treated negatively.	Our continued support of patient education programmes e.g,. diabetes, Step on stress, etc equip individuals with the necessary skills. Our ongoing CPD programme supports our staff to both give patients the information they need but also engage in realistic conversations about health care options.
The right to liberty (limited right)	NHS Fife does not limit the liberty of individuals except when they are subject to a court order e.g., section	
The right to a fair trial (limited right)	NHS Fife undertakes its legal duty in both providing information for courts and supporting legal requests. This is co-ordinated by the legal services department.	

The right to respect for private and family life, home and correspondence (qualified right)	NHS Fife takes it responsibilities under data protection and Caldicott legislation seriously and has appointed responsible officers. Many of our staff undertake their care in an individuals' home or homely setting. All staff are respectful of a patient's home circumstance/ life, their home and any correspondence. Within NHS Fife premises these are also respected.	
The right to freedom of thought, belief and religion (qualified right)	NHS Fife recognises that individuals have the right to freedom of thought, belief and religion. Individuals are actively invited to make their preferences known and our Spiritual Care support and liaise with all faiths and beliefs.	
The right to freedom of expression (qualified right)	NHS Fife recognises that individuals have the right to freedom of freedom of expression. However, we will support staff not to be verbally abused and ask that differing points of view are respected.	
The right not to be discriminated against	By ensuring that we consider citizens as individual and actively identify potential discrimination because of a protected characteristic, NHS Fife supports this right.	
Any other rights relevant to this policy.		

Will there be any cumulative impacts as a result of the relationship between this policy/plan and others? Are there any overlapping or cross cutting services etc that may be affected?

This strategy will cut across all work that NHS Fife delivers. There will be a need to consider how the policies and procedures in place are aligned to the strategy.

What sources of evidence have informed your impact assessment? Evidence can be local enquiry, research, evaluation or data etc and can come from patient feedback or complaints.

We have considered other EQIA's completed recently, local knowledge and expertise from individuals e.g, PEN. The knowledge from the health assessment completed for the strategy has also been used.

Discussions with HiS- Community Engagement and offer for local officer to be a critical friend during this process.

Summary of key impacts, research questions and evidence sources-please bullet point the key findings such as i.e,, communication /transport/

National policies and toolkits have also helped inform/ been used as evidence sources:

VOICE toolkit- https://www.voicescotland.org.uk/voice/

HIS Engage – Participation Toolkit (https://www.hisengage.scot/equipping-professionals/participation-toolkit/)

HIS Engage – Engaging people and communities (https://www.hisengage.scot/equipping-professionals/how-to-engage/)

The Promise – The Promise

Scottish Government Children's Rights Policy - Children's Rights

Document Control

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Signed
Date

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NHS Fife

Meeting:	**Public Health & Wellbeing Committee**
Meeting date:	**16 May 2022**
Title:	**Corporate Objectives**
Responsible Executive:	**Carol Potter, Chief Executive**
Report Authors:	**Margo McGurk, Director of Finance & Strategy,** **Linda Douglas, Director of Workforce**

1 Purpose

This paper sets out the proposed corporate objectives for 2022/23.

This is presented to the Public Health & Wellbeing Committee for:
- Endorsement and Assurance

This report relates to:
- Annual Operational Plan
- Government policy/directive
- National Health & Well-Being Outcomes

This aligns to the following NHSScotland quality ambition(s):
- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The committee requires to consider the corporate objectives annually, these objectives have been derived from the SPRA process and will inform the Annual Operational Plan or RMP for 2022/23.

2.2 Background

This is the second year of the SPRA process and the joint consideration of corporate objectives across the organisation and directorate functional areas.

2.3 Assessment

The corporate objectives of any organisation normally reflect the in-year, highest level actions which will inform the objectives of the Chief Executive. In that context, this paper proposes a refinement of the SPRA generated objectives to reflect those at that corporate level. This is our second year of generating our corporate objectives in this way and we continue to develop and embed this process.

The corporate objectives are linked to one of the 4 NHS Fife agreed strategic priorities, there may be a number which span more than one however they have been initially linked to what is considered to be the "primary" strategic priority.

In setting corporate objectives it is important to ensure individual director role clarity within the executive team. The lead roles have been confirmed through EDG discussion. Directors will determine the allocation of the other roles and confirm this by the end of April. The table below sets out the categories of involvement proposed (LSCI).

Lead - Executive Lead, accountable for delivery of objective
Critical - critical role in supporting the delivery of objective
Supporter - actively engaged in supporting those with executive lead and others with critical roles
Informed - not actively involved in delivery of objective but informed and supportive.

Annex 1 presents 25 corporate objectives for Committee consideration.

2.3.1 Quality/ Patient Care

NHS Fife corporate objectives link directly to the strategic priorities to either "Improve Health and Wellbeing" or "Improve the Quality of Health and Care Services".

2.3.2 Workforce

NHS Fife corporate objectives link directly to the strategic priority to "Improve Staff Experience and Wellbeing".

2.3.3 Financial

NHS Fife corporate objectives link directly to the strategic priority to "Deliver Value and Sustainability".

2.3.4 Risk Assessment/Management

Each corporate objective has an appropriate risk and opportunities assessment as detailed through the SPRA process.

2.3.5 Equality and Diversity, including health inequalities

Each corporate objective either has a completed Impact Assessment or is in the process of completing one.

2.3.6 Other impact

Each corporate objective has a range of impacts which are documented through the SPRA process.

2.3.7 Communication, involvement, engagement and consultation

Directors have been involved in the SPRA process which has generated this initial proposal.

2.3.8 Route to the Meeting

EDG reviewed and approved the corporate objectives on 21 April 2022.

2.4 Recommendation

The committee is asked to **consider** and **endorse** the corporate objectives.

3 List of appendices

The following appendices are included with this report:

- Annex 1, Draft Corporate Objectives.

Report Contacts

Margo McGurk Director of Finance & Strategy Email margo.mcgurk@nhs.scot	Linda Douglas Director of Workforce

Annex 1 : Proposed Corporate Objectives

	NHS FIFE STRATEGIC PRIORITIES - *(Objectives are linked to a primary strategic priority but will contribute directly and indirectly to others)*									
	To Improve Health and Wellbeing	Medical Director	Director of Nursing	Director of Public Health	Director of Finance & Strategy	Director of Workforce	Director of Pharmacy & Medicines	Director of Property & Asset Mgt	Director of Acute Services	Director of Health and Social Care
1	Develop the Population Health and Wellbeing Strategy				L					
2	Develop the strategic plan to secure teaching Health Board Status with the University of St Andrews	L								
3	Develop and deliver the Fife COVID Recovery and Rehabilitation Framework		L							
4	Deliver the OBC for the Mental Health Services Programme	L								
5	Refreshed mental health strategic plan informed through collaborative working with people with lived experience and trauma informed practice									L
6	Deliver the OBC and progress to FBC for both the Kincardine and Lochgelly Health Centres			L						
	Improve the Quality of Health and Care Services	Medical Director	Director of Nursing	Director of Public Health	Director of Finance & Strategy	Director of Workforce	Director of Pharmacy & Medicines	Director of Property & Asset Mgt	Director of Acute Services	Director of Health and Social Care
7	Deliver the National Treatment Centre Fife and ensure operational readiness for opening		L							
8	Develop and implement a system wide medicines safety programme with initial focus on high-risk pain medicines						L			
9	Develop and deliver an enhanced model of care in the Emergency Department								L	
10	Develop and deliver an augmented ambulatory, interface care model (RUC) supporting early and appropriate discharge Integrated Unscheduled Care Programme								L	
11	Develop and implement an integrated planned care programme to address waiting list backlog, including the optimisation of day surgery at QMH								L	
12	Oversight of NHS Fife Anchor Institution delivery plan for 2022/23			L						
13	Deliver Home First to enabling Prevention of admission, person centred transfers of care and a responsive integrated system									L
14	Deliver an approved Integrated Primary and Preventative Care Strategy to set the strategic direction supporting early intervention									L
15	Increase the pace of delivery in the localities of Fife in line with in line with the Plan for Fife.									L
16	Develop and implement an NMAHP Care Assurance Framework		L							
	Improve Staff Experience and Wellbeing	Medical Director	Director of Nursing	Director of Public Health	Director of Finance & Strategy	Director of Workforce	Director of Pharmacy & Medicines	Director of Property & Asset Mgt	Director of Acute Services	Director of Health and Social Care
17	Deliver high quality systems to support staff health and wellbeing					L				
18	Deliver corporate and system leadership that contributes to system wide activities including Plan 4 Fife					L				
19	Develop and deliver the Faculty for Excellence in NMAHP education, training and professional development		L							
20	Develop and deliver strategic and career frameworks for NMAHP Bands 2 - 4		L							
	Deliver Value & Sustainability	Medical Director	Director of Nursing	Director of Public Health	Director of Finance & Strategy	Director of Workforce	Director of Pharmacy & Medicines	Director of Property & Asset Mgt	Director of Acute Services	Director of Health and Social Care
21	Develop and deliver the medium-term financial plan including the implementation of the Financial Improvement and Sustainability Programme				L					
22	Develop the Workforce Strategy to support Population Health & Wellbeing Strategy					L				
23	Implement the Climate Emergency and Sustainable Development Policy including agreed Net Zero commitments							L		
24	Develop the business case and commence implementation of Paper lite systems across NHS Fife	L								
25	Develop the Initial agreement (IA) and Outline Business Case (OBC) for Robotics in Pharmacy						L			

NHS Fife

Meeting:	**Public Health and Wellbeing Committee**
Meeting date:	**16 May 2022**
Title:	**Anchor Institution Programme Board and Community Benefit Gateway**
Responsible Executive:	**Dr Joy Tomlinson, Director of Public Health**
Report Author:	**Jo-Anne Valentine, Public Health Manager (Health Improvement)**

1 Purpose

This is presented to the Public Health and Wellbeing Committee for:
- Discussion

This report relates to:
- Annual Operational Plan
- Emerging issue
- Local policy
- NHS Board/Integration Joint Board Strategy or Direction

This aligns to the following NHSScotland quality ambition(s):
- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

As an Anchor Institution NHS Fife can have a direct impact on reducing health inequalities locally. Key areas in which this can be achieved are employability, procurement and spend, estates, property and land and finances.

In April 2021, NHS Fife established an Anchor Institution Programme Board, chaired by the Chief Executive, with the aim of providing strategic leadership to the development of NHS

Fife as a recognised Anchor Institution in order to support NHS Fife's key objective to continue to work to reduce poverty and inequality.

In February 2022 EDG agreed that NHS Fife should become part of the Community Benefit Gateway. National Services Scotland (NSS) has developed an online portal which allows community benefits, which are procured as part of any NHS Scotland contracts, to be matched with potential beneficiaries. The Community Benefit Scheme links closely with NHS Fife's role as an Anchor Institution and to the community wealth building priority of Plan4Fife.

The Public Health and Wellbeing Committee is asked to note the progress in development of NHS Fife as an Anchor Institution and in establishing NHS Fife within the national Community Benefit Gateway.

2.2 Background

Anchor institutions have been described by The Health Foundation as organisations that have an important presence in a place, usually through a combination of being large scale employers, the largest purchasers of goods and services in the locality, controlling large areas of land and/or having relatively fixed assets[1]. In addition anchor institutions are tied to a particular place by their mission, histories, physical assets and local relationships.

As a community planning partner one of our key objectives is to continue to work to address poverty and inequality through ensuring the prioritisation of income, housing, education and employment programmes as part of the Plan 4 Fife. As part of the Plan 4 Fife, Fife Partnership has agreed its new priorities as being community wealth building, economic recovery, tackling poverty and climate change[4].

The NHS Fife Anchor Institution Programme Board has agreed to follow the themes set out by the Health Foundation: purchasing more locally for social benefit, widening access to quality work, using buildings and spaces to support communities, reducing environmental impact, working more closely with local partners. Executive Directors have undertaken a self assessment for the areas on which they lead.

In February 2022 EDG agreed that NHS Fife should become part of the Community Benefit Gateway. The portal allows organisations and community groups to submit 'needs' so that any contractor who is considering supplying a good or service to the NHS can also consider which community benefits they may also be able to supply. This is being asked for all contracts as part of the Sustainable Procurement Duty. These can be local initiatives that support the social or environmental wellbeing of a local area and any third sector organisation (community groups, voluntary organisations, charities, social enterprises, co-operatives that exist wholly or mainly to provide benefits for society or the environment) can upload a list of 'needs.'

The portal allows suppliers to 'bid' against identified needs. Once the portal is populated with information from third sector organisations/ community groups the supplier can offer a match against an identified need moving on to agree the process with the requester and delivery of the goods/services. NHS Scotland national procurement will check that the benefits are delivered and detail outcomes in their annual procurement report.

There is no restriction to identified 'needs' entered into the portal. Notably, this is not a funding platform; although some suppliers may choose to offer funding as a type of community benefit opposed to a good/service.

NHS Boards are being asked to help enable the national process of securing community benefits in the following ways:

1) Boards are asked to give clarity around what would be considered in scope as a useful community benefit. 'Needs' posted should be linked (themed) according to local health and wellbeing needs or priorities.
2) Boards are asked to review submissions to the portal. If a local Fife organisation/group submit a 'need' we must have in place a structure that supports timely review and assesses the 'need' in line with the local themes/priorities i.e. Does this needs seem appropriate, will it have impact etc. Boards are not expected to be prescriptive in what constitutes a 'need' since these should be led by third sector organisations/community groups, as long as it seems appropriate to improvement in the local community.
3) It is suggested that this review process is completed by a group from Public Health and from Procurement.
4) Encourage local suppliers, through procurement processes to offer community benefits, and use the portal to 'bid' against identified needs. Suppliers do not have to offer the benefits within their own area, they can 'bid' across Scotland to deliver benefits.
5) Annually review local health and wellbeing needs/priorities to ensure that any benefits realised are aligned to the improvements in health and wellbeing in Fife.

2.3 Assessment

There are existing and emerging areas of Anchor Institution work. Kickstarter and No-one Left Behind are examples of programmes where by reviewing our employability processes we are widening access to quality work and offering career opportunities to local people from deprived or excluded communities (such as care leavers).

Although much of our procurement is conducted through nationally agreed contracts, we are exploring the proportion of spend and which areas of spend from procurement can go into the local economy. Our procurement team are having conversations with National Procurement about how we can make progress with this.

In terms of how we use our estates and buildings and how we reduce our environmental impact we have greenspace audits for all of our facilities and have developed sustainability plans.

For the local Community Benefit Gateway, our next steps are to:

- establish a small group, including public health, health promotion and procurement as well as input from Fife Voluntary Action and Fife Council, to agree our priority themes (suggested themes are 1. Reducing health inequalities, 2.Contributing to anti-poverty work, 3. Improving health and wellbeing and 4. Responding to Climate Emergency), to review submissions to ensure 'needs' are listed in a timely and appropriate way and to ensure overall governance of the process.

- raise awareness of the portal to all third sector organisations/community groups in Fife, provide a brief synopsis of the aims of the portal and share nationally developed guidance/instructions for use. Information will also be provided about the themes/priorities so that 'needs' listed as likely to be accepted when reviewed internally within NHS Fife.

- develop a process whereby community benefits can be realised from local contracts which can be listed or matched against 'needs' on the national portal. NHS Fife's Procurement Strategy template and tender documents could be modified to facilitate a link to the Community Benefits Gateway for local tenderers to access.

As our understanding of what it means to be an Anchor Institution develops we have an emerging ambition to have Anchors themes threaded through the work of NHS Fife and to embed the themes within the Health and Wellbeing Strategy. This may however take a little while to achieve.

Over time as work is embedded within the organization the aim would be to include for example within SBARs information on meeting Anchors themes, and to report annually on progress to the Portfolio Board and to Health and Wellbeing Committee.

In the meantime in order to progress our action plan our next steps will include:
- Establishing a small operational group to meet regularly to ensure progress of our action plan
- Executive Directors to identify two priority areas with a named lead and timescales for actions as well as links to the assessment framework.

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2.3.1 Quality/ Patient Care

The quality of some of our support services may be improved by being more directly linked to local businesses and organizations. No direct impacts on quality or patient care have been identified.

2.3.2 Workforce

Widening access to employment will have a positive impact on reducing health inequalities of the local population. Staff health and wellbeing may be improved by having more direct links into for example the local food economy, and by improving our impact on the environment.

2.3.3 Financial

No additional financial costs have been identified.

2.3.4 Risk Assessment/Management

The development of an action plan to progress aspects of being an Anchor Institution can include identification and management of risks.

2.3.5 Equality and Diversity, including health inequalities

Operating as an Anchor Institution and contributing to community wealth building will impact positively on reducing health inequalities. An EQiA will be completed once identified areas of action have been agreed.

2.3.6 Other impact

The core of recognizing ourselves as an Anchor Institution is impacting in a positive way on our local economy and environment.

2.3.7 Communication, involvement, engagement and consultation

Our Anchors Institution work has been discussed at a Board Development meeting, and at meetings of EDG as well as with the Health and Wellbeing Committee. It has also been discussed at Fife Partnership Board. An introductory presentation has been given at the Area Clinical Forum and to the extended acute service Senior Leadership Team. The Anchor Institution Programme Board recognises the importance of engagement and consultation particularly with our own staff groups, and this will form part of the programme's action plan.

As we establish NHS Fife within the national Community Benefits Gateway engagement and communication with community and voluntary sector organisations will form part of our action plan.

2.3.8 Route to the Meeting

An updated paper on NHS Fife as an Anchor Institution was presented to the Portfolio Board in March 2021. On 17 February 2022 an SBAR on the Community Benefits Gateway was presented to EDG.

2.4 Recommendation

- **Discussion** – Public Health and Wellbeing Committee members are asked to consider and discuss the contents of this paper and those areas of business included in development as an Anchor Institution.

3 List of Appendices

The following appendices are included with this report: None attached, but links included as references below:

References

1. Health Foundation

   https://www.health.org.uk/news-and-comment/charts-and-infographics/the-nhs-as-an-anchor-institution

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NHS Fife

Meeting:	**Public Health & Wellbeing Committee**
Meeting date:	**16 May 2022**
Title:	**Mental Health Estate Re-Design Programme**
Responsible Executive:	**Dr Christopher McKenna, Medical Director**
Report Author:	**Ben Johnston, Head of Capital Planning & Project Director** **Rona Laskowski, Head of Complex Care & Critical Services**

1 Purpose

This is presented to the Public Health & Wellbeing Committee for:

- Assurance

This report relates to a:

- Project update

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this paper is to provide an update on the current position regarding the Mental Health Estate Re-Design Programme.

2.2 Background

The Fife Mental Health Strategy 2020 to 2024 provides the strategic context for this programme. The refreshed Strategy takes full account of the recommendations of the Scottish Government's National Mental Health Strategy (2017 – 2027), which emphasises the need to build capacity within our local communities, increase access at the earliest point

in the patients' journey to proportionate advice and support and treatment, and reduce the reliance on hospital beds.

The Fife Mental Health Strategy is currently under review with the refreshed position expected by March 2022. The spirit of the strategy will remain the same with updates required to provide clear direction and tangible objectives that can be delivered upon, measured and reported.

Currently NHS Fife's mental health inpatient establishment is spread across several sites including Stratheden Hospital, Queen Margaret Hospital, Whytemans Brae Hospital and Lynebank Hospital.

We know that the current configuration of services and beds across multiple sites is sub-optimal, affecting patient flow and staffing efficiencies. The condition and configuration of the facilities are also of concern in respect to patient/staff safety and in promoting therapeutic interventions and reducing lengths of stay. The Mental Welfare Commission, Health & Safety Executive and Scottish Government are all actively involved seeking reassurances around positive changes to the estate.

The current situation and strategic/political context are helping to enable consideration of positive and bold changes regarding the mental health inpatient estate. This is an attractive opportunity to design sustainable long-term mental health inpatient services in Fife. It will support the overall strategy of offering patient centred care locally and appropriate inpatient services where these are necessary.

To enable these changes, a dedicated In-patient Re-design Project Board has been established to initially support completion of the Initial Agreement Document in accordance with the Scottish Capital Investment Manual. The current trajectory is to complete the Initial Agreement by May 2022 in readiness for internal governance consideration.

Following approval of the Initial Agreement, the Outline and Full Business Case components of the business case will require to be completed. Taking this into account, it could be several years before substantial reconfiguration works commence. As such there will be an ongoing requirement meantime to maintain and improve the existing inpatient estate so that patient and staff safety can be protected.

2.3 Assessment

2.3.1 Status Update

The Initial Agreement is continuing to be developed with the current target for completion being May. Key elements of work facilitating completion of the document include:

- Service Option Appraisal – 4 workshops planned to start from 25th March

- Updated projected bed numbers – complete
- Initial description of the community model to support the projected bed model – planned for March.
- Revenue cost development including staffing – planned for April
- Existing service performance data – planned for April
- Communication, participation and engagement strategy – planned for April

2.3.2 Needs for Change

This programme and business case is supported by the needs for change which are set out in the table below:

Effect of the need for change on the organisation:	**What has to be achieved to deliver the necessary change? (Investment Objectives)**
The current arrangements do not support national and local drivers for change which focus on rebalancing care through wider care in the community and appropriate inpatient support where required.	IO.1 – Provide the correct ratio of inpatient beds to support the wider mental health care model in Fife.
Inpatient beds are not in the right places affecting staff and patient efficiencies.	IO.2 – Provide services in the best locations to improve the quality of patient care. IO.3 – Provide services in the best locations for patient, visitor and staff access.
Current inpatient provision compromises patient dignity and respect.	IO.4 – Provide modern healthcare environments to optimise patient dignity and respect.
The existing facilities do not comply with national guidelines to provide safe and therapeutic environments.	IO.05 – Provide environments that support patient, staff and visitor safety. IO.06 – Provide environments that support therapeutic care.

2.3.3 Quality/Patient Care

Much of this programme and business case is concentrated on improving the quality of patient care. The key benefits to patients and the service will be compliance and achievement of the Health and Social Care Standards:

- I experience high quality care and support that is right for me
- I am fully involved in all decisions about my care and support
- I have confidence in the people who support and care for me
- I have confidence in the organisation providing my care and support
- I experience a high quality environment if the organisation provides the premises

In addition to the above:

- Patients will be supported to live independently within their local community
- Patients will receive appropriate and proportionate care
- Patient's dignity and respect can be optimised
- A reduction in adverse events
- Patients, Staff and Visitors feel safe and supported
- The service will deliver Improved treatment, care options and outcomes for patients

Key stakeholders including staff, patients, family members, advocacy, 3rd sector providers and other interested parties will be encouraged to get involved in the business case process and re-design of the facilities, ensuring a collaborative approach within the emerging programme of work.

A full communication, participation and engagement strategy is in development.

2.3.4 Workforce

Workforce is also central to this programme and business case. Key benefits to staff are likely to be:

- Support safe staffing in line with legislation
- Co-location of clinical specialties, providing a multi-disciplinary learning environment
- Efficacy and improved safety for staff in the management of acute mental health episodes with patients
- Better opportunities for staff training and development
- Clinical staff are better able to utilise their skills and knowledge
- Ability to provide appropriate and high quality patient care in fit for future environments
- Staff enjoy and value a better work environment

- Improve staff wellbeing and support staff attendance through an improved working environment which will promote better staff engagement, motivation and resilience
- Patients, Staff and Visitors feel like they are safe and supported

From an organisational perspective revised service locations and modern healthcare environments may also allow staff to be recruited and retained more successfully than the current situation.

As indicated above, staff representation will be encouraged all the way through the process to ensure that the proposals are reflective and considerate of the staff viewpoint.

2.3.5 Financial

The option costs for the Initial Agreement are currently in development but are likely to be quite considerable for the viable options (£90-150m). At a recent meeting with SG we received positive buy-in to identify the best service option based on cost/benefit analysis.

Once the preferred service option is identified, the staffing complement will be developed to align with this. Based on a historical under provision of staff within the mental health service in Fife, it is considered that the future projection of staffing may represent a cost pressure for the organisations – not necessarily as a consequence of the project but to balance the historic deficit. An initial indication around the staffing complement and cost will be set out within the Initial Agreement.

2.3.6 Risk Assessment/Management

A risk register has been prepared for the programme (available upon request). The current key risks and issues to note are outlined below. It should be noted that these are project risks and not existing operational risks.

Risk / Issue	**Mitigation Action / Note**
Client doesn't have the capacity or capability to deliver the project a.) staff resources may be unable to offer the required time to the IA process as a consequence of other priorities including COVID-19. b.) number of recent retirements within the MH Service. New appointed resources may not have the necessary immediate	This is a current issue with resources within the mental health service struggling to support to the process including Option Appraisal. The recently appointed Head of Service is however working to resolve this matter.

experience/knowledge to support the programme.	
Active interest from Mental Welfare Commission and SG. Risk that pace of programme may not meet their expectations.	This is a reputational risk. There is ongoing regular discussion and engagement between the service and bodies noted to align expectations and understanding. Active interest also acts as an opportunity to support this important work.
The project becomes unaffordable.	Affordability will be influenced by the scope and bed numbers which are currently being refined. Discussions regarding finances and affordability are also being held with the Scottish Capital Investment Group.
Inflation costs rise above those projected.	This is a current issue given market conditions and may have an impact on affordability. Inflation will be factored into the option costs presented within the Initial Agreement.

2.3.7 Equality and Diversity, including health inequalities

The first stage of the Equality Impact Assessment has been completed for the programme.

2.3.8 Other impact

Not used.

2.3.9 Communication, involvement, engagement and consultation

A communication engagement plan has been substantially developed for this first phase taking the project to Option Appraisal. This will be expanded by Apri to encompass future stages and will be appended to the Initial Agreement Document.

Within the Initial Agreement stage, involvement and engagement will largely be connected to the Service Option Appraisal exercise. A mix of around 100 volunteers from the public directory, patients/family/support and staff have expressed an interest in being included in the Service Option Appraisal. These workshops are currently in the process of being organised.

The service options to be presented for consideration within the option appraisal include:

- Do nothing
- Do minimum
- Multi-site option (>2)
- Two site option with split services across the two sites
- Two site option with centralised services across two sites
- A single site option

An external facilitator has been procured to assist with the option appraisal exercise and associated neutral reporting.

2.3.10 Route to the Meeting

Information contained in this SBAR has been discussed within the established Project Board meetings.

2.4 Recommendation

This paper seeks to provide a project update and provide assurance.

3 List of appendices

None

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NHS Fife

Meeting:	**Public Health and Wellbeing Committee**
Meeting date:	**16 May 2022**
Title:	**Implementation of the Immunisation Strategic Framework / Governance Assurance**
Responsible Executive:	**Nicky Connor, Director of Health and Social Care**
Report Author:	**Lisa Cooper, Immunisation Programme Director** **Emma Strachan, Project Manager**

1 Purpose

This is presented to the Public Health and Wellbeing Committee for:

- Assurance

This report relates to a:

- Government policy/directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This paper is designed to provide both an update for assurance to the Committee regarding progress of implementation of the Fife Immunisation Strategic Framework 2021-24 and assurance in regards to operational delivery of the Covid vaccination programme in regard to the issues communicated from the national team to all boards.

2.2 Background

<u>Progress of Fife Immunisation Strategic Framework:</u>

The Community Immunisation Services is now formed and being delivered as a delegated service within the Fife Health and Social Care Partnership (HSCP). A governance structure has been reviewed, refined and implemented to enhance and support effective oversight, reporting, escalation and assurance of delivery of all

Community Immunisation Programmes in collaboration with NHS Fife Public Health colleagues to achieve the vision of the Fife Immunisation Strategic Framework 2021-2024.

In parallel with this work being progressed locally, an urgent request was made by the National Flu and Covid Vaccination (FVCV) delivery team to all NHS boards to submit a formal paper regarding local governance structures to assure the effective operational delivery vaccination programmes.

Subsequent annexes were requested to detail the governance structure showing lines of accountability and decision making including:

- How assurance of local performance is provided to Chief Officer and Chief Executive levels.
- If there are devolved duties and responsibilities to HSCP delivery.
- How that all ties in and is safely and effectively linked in the overarching Board system.

On the 11th April 2022 the newly convened Community Immunisation Service Programme Board were presented with this paper and asked to consider the detail of the report and support progress of the paper to the National team via agreed governance structures. The paper was then presented to the HSCP business Senior Leadership Team 20th April 2022 and Executive Directors Group (EDG) 21st April 2022 for discussion and support.

EDG recommended the paper also be presented to the Public Health and Wellbeing Committee for assurance.

National Incidents

Communication received from the National team has highlighted a number of issues / challenges experienced across the national FVCV programme within April, which are highlighted within the assessment section, with a detailed response for each.

The National team advised that the scope per incident ranges from 300 to 7000, with 18000 apology letters having been issued to those individuals within the 3 largest presented incidents.

Root-cause analysis was completed by the National team suggesting a number of issues with recurring themes: governance and oversight; dedicated scheduling and operational management of teams; and expertise required locally in the functionality of the national scheduling system.

A number of national actions around system training and guides have been progressed. Due to the public interest on vaccinations remaining high and the resulting ongoing media and parliamentary scrutiny, an urgent action across

Scotland was suggested as necessary to enable the National team to assure a shared action plan in response to these issues.

2.3 Assessment

Progress of Fife Immunisation Strategic Framework:

Extensive work has recently taken place within Fife to robustly review governance structures, align strong professional leadership and implement the Fife Immunisation Strategic Framework (Annex A).

The Fife Immunisation Strategic Framework 2021 – 24 was drafted in July 2021 and following collaboration and co-production was progressed for decision and supported by the Executive Directors Group (EDG), NHS Fife Board and the Integrated Joint Board (IJB) in October 2021.

The vision of the framework is clear:

A Fife where everyone, everywhere, has confidence in and equitable access to high quality, safe, sustainable immunisation services throughout their life course

To achieve the vision, the framework details specific aims, core principles and 4 key priorities essential to enable the vision to be achieved as follows:

1) *optimise immunisation coverage ensuring equitable access for all eligible groups*
2) *enhance monitoring and evaluation of immunisation programmes*
3) *support and empower a sustainable skilled workforce to deliver safe and effective immunisation services*
4) *ensure community engagement and promotion*

It’s important to note that the 4 priorities are interdependent in their delivery and the framework details the critical leads and other roles essential to ensure collaboration for success.

Following the development and move to implementation of the Fife Immunisation Strategic Framework, a robust review of the overall governance structure to support this has taken place. A resulting recommendation from this review proposed a merger of both FVCV and VTP Programme Boards to form the new Community Immunisation Services Programme Board. Annex B includes the Terms of Reference for this, defining overall purpose, remit and membership. The overall Governance structure advising how the Community Immunisation Services Programme Board will report and the essential links to key services and groups across NHS Fife can be found within Annex C. This includes the following groups which will be critical in delivering the key priorities,

- Community Immunisation Implementation Group: led by Immunisation Clinical Services Manager (HSCP)
- Community Immunisation Workforce Strategic Group: led by Associate Director of Nursing (HSCP)
- Community Immunisation Quality and Clinical Care Assurance Group: led by Head of Nursing (Primary and Preventative Care Services, HSCP) and Immunisation Coordinator – NHS Fife
- Community Immunisation Inclusivity Group: led by Immunisation Coordinator

Community engagement and participation will be led by the Head of Strategic Planning and Performance within Fife HSCP to achieve key priority 4 but will closely link with each of the other priorities and groups above.

In addition to the 4 key strategic groups outlined above, there was also a weekly Bronze Vaccination/Scheduling meeting which took place, focusing on operational delivery ensuring that any risks and issues raised were locally mitigated where possible or escalated appropriately via the established governance structure. The Bronze meeting has now evolved to become the Implementation group as referenced above.

The Immunisation Coordinator chairs the Area Immunisation Steering Group (AISG) which meets three times a year. The purpose of the AISG is to provide assurance to the NHS Fife Board that the Fife population is protected from vaccine preventable disease. It reports to the Director of Public Health via the Public Health Assurance Committee and through reporting to the Public Health and Wellbeing Committee. In addition, throughout the planning and delivery phases of the COVID vaccination programme (since Autumn 2019) there have been weekly update calls scheduled involving the Director of Public Health (Executive Lead), the Director of the Health and Social Care Partnership (SRO), the Immunisation Programme Director and the Immunisation Coordinator. These have provided regular check-in opportunities to facilitate rapid problem solving, discussion and escalation of emerging issues.

As highlighted above, to ensure effective leadership and management is in place to drive and support a sustainable workforce within the Community Immunisation Service, a robust review of the leadership and management structure has taken place via an options appraisal process in alignment with priority 3. Annex D details the leadership and management structure which has been approved by the FVCV Programme Board in early March 2022.

A 6-month transition period for the FVCV and VTP Programmes to fully integrate and merge into the Community Immunisation Service has now launched commencing April 2022. This will result in planned completion by end of September 2022 however ongoing evaluation and a formal review at that point is proposed to determine the future plan for assurance for delivery of the Vision for Community Immunisation Service by 2024.

Fife local review of National incidents

To provide assurance in Fife's local governance and scheduling management, the incidents highlighted by the National team have been reviewed by programme leads with key detail on local processes for each outlined below.

Some 75+ year olds being actively scheduled ahead of 24 weeks (before the changes agreed in flexibility for tail or people turning up before 24 weeks)

The identification and schedule planning process in Fife only identifies citizens eligible at a particular point in time. This local measure, which calculates eligibility based on JCVI guidance and vaccination history, mitigates the lack of functionality within the national appointment system to prevent citizens being appointed before they become eligible.

Not all Health Boards had taken this approach, which appears to have led to this issue being raised. When raising scheduling/appointment tickets with the national team, Fife also provides confirmation of this check being carried out, to support collaborative working with national scheduling colleagues.

5–11-year old's parents calling to reschedule universal children beyond the 12-week post Covid infection period – and National Contact Centre (NCC) not being able to reschedule them as clinics not open that far in advance by HBs

This was the case across all Health Boards. When raised with Health Boards at the end of March 2022, Fife highlighted that the national appointment system was built/defaulted to only allow booking 8 weeks ahead. Following identification by Fife, this was rectified on the national appointment system at the start of April. Fife opened children's clinics 12 weeks in advance, up to end of June 2022. This has now been extended further to 16 weeks.

Local scheduling and quality check processes in Fife also helped identify an issue with the national appointment process for all 5-11 year old children - where NVSS had scheduled 2 appointments for 50% of Fife children, with the other 50% not being appointed at all. Working collaboratively with national scheduling colleagues, this was identified early in the process and a significant scheduling error averted.

74 year olds (with 75th birthdays beyond 30th June 22) were included in error in the spring cohort and sent invitation letters – needing to be contacted to apologise and cancel as they are not eligible within the scope of the Spring programme

This was not an issue for Fife due to the identification and schedule planning process which only identifies citizens eligible at a particular point in time.

The Scheduling and Business Analyst team in partnership with professional leads, CMO direction and JCVI guidance , agree on which cohort is to be scheduled, when this will take place and then undertake a data exercise to identify the total number in scope for that particular scheduling file. This is repeated for every scheduling exercise.

This mitigates the lack of functionality within the national appointment system to prevent citizens being appointed before they become eligible.

Over 75's appointed too far from their home for spring booster in some rural and remote parts of Scotland

The algorithm used by the national appointment system to identify the nearest clinic for citizens, does occasionally send citizens to clinics that would not be considered the closest to them, either in time or travel distance.

Fife has developed local processes to mitigate against this risk. Whilst a review of every individual appointment is not realistic or efficient, local process supports identification of clear errors with individual contact made if local issues are identified as a result from national scheduling.

It is also important to note at this point, that to date, there have been no complaints received via patient relations or elected members regarding this particular issue.

Universal 5-11's received underlying health conditions mop-up letter instead of universal 1st invite letter

This issue is not relevant to Fife, as all 5-11s with underlying health condition were appointed locally and the team are not aware of any issues where an incorrect letter was issued to children within the universal cohort by the national team. All 5-11 year olds received the correct invite letter within Fife.

Adults appearing at weekend clinics not running/or at special 5-11 clinics – as open to self-reschedules/NCC rebooking as clinic admin not correct re clinic locks etc.

A very small number of adults were able to book online/via National Call Centre, to one of Fife's closed local adult clinics, for a short period of time whilst the clinic schedule was being built on the system. This was identified the same day and local action taken to contact these citizens to reschedule.

As a further update to the above, a National incident occurred week commencing 18th April, where circa 2000 Fife residents received the incorrect vaccination invite letter. A National Problem Assessment Group (PAG) was convened urgently chaired by the national programme director to address this, with input from NHS Fife's Director of Public Health, Immunisation Programme Director, Immunisation Clinical

Services Manager and Communications Lead. The issue was escalated to HSCP SLT and EDG for awareness and a local action plan was implemented with all local actions identified having now been completed. There was no clinical harm indentified and those people lettered were due to be invited and offered a Spring booster vaccination regardless. As of 26/04/22, there are no further issues to report on with a local incident debrief group convened 28/04/22 and a follow up meeting 06/05/22 chaired by the Immunisation Coordinator.

2.3.1 Quality/ Patient Care

NHS Fife will continue to respond to new developments as guided nationally to provide a safe and effective service to all citizens in Fife.

The Quality and Clinical Care Assurance Group as can be viewed in appendix C meets regularly to provide assurance to the boards regarding safe clinical and care delivery of the Immunisation programme.

Based on the local review of National incidents raised, high levels of competency in the scheduling management and approach and the recent progression of the governance structure, Fife are in a strong position in responding to these issues and in ensuring that the strategic vision is achieved.

2.3.2 Workforce

Currently, there are no immediate concerns or pressures regarding workforce in relation to the issues raised. Workforce continues to be closely monitored with regular strategic and operational meetings in place to facilitate workforce strategic discussions, modelling and planning. There is representation from all key work stream leads which ensures that close collaboration is achieved and vaccination delivery is safely and effectively managed.

2.3.3 Financial

Baseline and core historic budgets for immunisation activity for non covid-19 vaccination are in place. SG funding of £6.5m has been confirmed for the 2022/23 financial year, and we have signposted the requirement for additional funding resource required for Covid-19 vaccination venue costs; plus additional extended flu vaccine costs through the SG financial planning process.

There are currently no financial issues or risks presented in relation to the National incidents raised. The Community Immunisation Service works closely with Finance colleagues as key members and critical partners in service delivery and assurance to track and report on expenditure accordingly.

2.3.4 Risk Assessment/Management

There have been no risks currently raised in relation to the National incidents communicated however a risk has been raised via the Scheduling group in that members of the population may be allowed to book spring booster appointments via the National system (NVSS) who may not be eligible. NVSS currently allows any individual with an online username and password to book a spring booster appointment even though they may not meet the eligibility criteria.

This therefore, may result in individuals presenting at clinics for spring booster vaccinations even though they are not eligible to receive one.

We can assure that this has been raised locally to National colleagues and all clinical staff across vaccination venues within Fife has been made aware of this issue. Local actions are agreed to support and manage any person who does present reducing risk of decreased confidence in programme and programme reputation.

2.3.5 Equality and Diversity, including health inequalities

The established Inclusivity Group continues to lead delivery of EQIA actions and direct specific outreach activities to ensure access for all eligible individuals.

Local scheduling processes identified above to support individuals within rural locations are in place and utilised where possible to provide an equitable service.

2.3.6 Communication, involvement, engagement and consultation

Communications are directly linked with the national direction applying national toolkits provided with adaption locally across an established range of channels to ensure effective, timely and targeted communications.

This provides support to both National and local Scheduling activity enabling a consistent and cohesive approach to overall public communications.

2.4 Recommendation

The Public Health and Wellbeing Committee are asked to consider this report for:

- **Assurance** regarding the implementation of the strategic framework and the plans being progressed to ensure the 4 priorities are achieved with assurance of an effective governance structure and commitment to an ongoing evaluation and review within the transition period agreed.
- **Assurance** regarding safe and effective delivery supported by effective governance arrangements in line with the national issues communicated.

3 List of appendices

Annex A: Fife Immunisation Strategic Framework
Annex B: Fife Community Immunisation Service Terms of Reference
Annex C: Fife Community Immunisation Service Governance Structure
Annex D: Fife Community Immunisation Service Leadership & Management Structure

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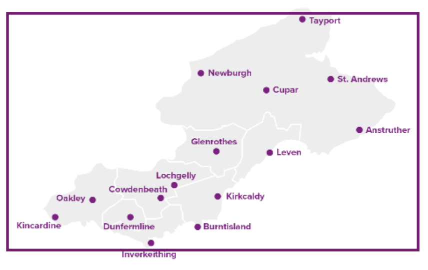
Fife Immunisation Strategic Framework 2021-2024



Contents

Fife Immunisation Strategic Framework 2021-2024 ... 1
Executive Summary ... 3
Introduction ... 4
National and Local Context ... 5
Vaccine Preventable Disease ... 7
Snapshot of Immunisations in Fife ... 8
Children's Immunisations At 24 Months ... 8
Teenage Routine Immunisations ... 8
Influenza ... 8
Selective Immunisation Programmes ... 9
Bacillus Calmette-Guerin (BCG) Vaccine ... 9
Hepatitis ... 9
Sexual Health ... 9
Pertussis (Whooping Cough) ... 9
Occupational Vaccination for Health Care Workers ... 9
COVID-19 ... 10
Equity and Inclusion ... 11
Our Vision ... 12
Our Aims and Priorities ... 12
Core Principles ... 12
Enablers ... 13
Governance ... 14
Monitoring, Reporting and Evaluation ... 15
Strategic Action Plan ... 16

Fife Immunisation Strategic Framework 2021-24

A Fife where everyone, everywhere, has confidence in and equitable access to high-quality, safe, sustainable immunisation services throughout their life course.

Our Core Principles: Person Centred | Inclusive | Integrated | Evidence Based | Timely | Quality & Safety Focused

Our Aims

- To protect the people of Fife from vaccine preventable disease by maximising uptake across all immunisation programmes
- To contribute towards improved well being and reducing health inequalities
- To ensure immunisation services across Fife are safe, effective and of a consistent high quality
- To raise peoples' awareness of the public health benefits of vaccination and raise peoples' trust in vaccinations.

Enablers

- Service Models: Design; Delivery; Access; Evaluation
- Workforce: Recruitment; Training; Skill Mix; Safe Staffing
- Logistics:- Venues; Cold Chain; Supplies; 4G/Wi-Fi
- Scheduling: Systems; Booking; Times & Days
- Data: Systems; Recording; Uptake Rates

Our Priorities

- Optimise immunisation coverage ensuring equitable access for all eligible groups
- Enhance the monitoring & evaluation of immunisation programmes
- Support & empower a sustainable skilled workforce to deliver safe and effective immunisation services
- Community engagement & promotion

What we need to consider

- Vaccination needs of population across the lifespan
- Large geography & diversity of urban & rural settings
- Accessibility
- Best Use of Resources

Introduction

Immunisation programmes have been an integral part of health services and public health for over 200 years since the ground-breaking discovery by Edward Jenner of the small pox vaccine. They are considered one of the greatest public health interventions in terms of measurable impact on population morbidity and mortality.[1]

Immunisation is a safe and effective way to help protect the population from serious vaccine-preventable diseases. Since the initial focus on six childhood vaccine-preventable diseases over four decades ago, they have evolved rapidly and expansively in a relatively short space of time. The addition of new vaccines has increased the breadth of protection provided by immunisation, to include vaccinations for protection of older children, adolescents and adults. Immunisation not only provides protection for the individual, but also offers important benefits for the long-term health of the community. For immunisation to provide the greatest benefit a sufficient proportion of the population need to be vaccinated to stop the spread of bacteria and viruses that cause disease – this is known as herd immunity. The success of established vaccination programmes mean that most vaccine preventable diseases of childhood are now rarely seen however there remains a need to ensure the population understand the importance of protection across all age groups.

Equality in immunisation is an important way to address health inequalities. Ensuring that coverage is not only high overall, but also within underserved communities is essential for disease control and elimination strategies. Immunisation uptake has been shown to be lowest in poorer families, those from minority ethnic backgrounds and those who may find it more challenging to access services[2].

Our recent experience of the COVID-19 pandemic demonstrates how outbreaks can overwhelm and profoundly disrupt public health programmes, clinical services and health and social care systems and has emphasised the critical importance of vaccines in the battle against emerging and re-emerging infections to protect people and save lives[3].

Providing cohesive immunisation services is paramount for success. Services must be safe and easily accessible, reflect the needs and demands of the population and will require the right workforce to deliver the right immunisations in the right place at the right time.

As we modernise immunisation service provision over the next three years it will be essential that inequalities are addressed in the new models of delivery, close monitoring of uptake rates continues and that immunisation services are recognised as an integral part of a well-functioning healthcare system.

[1] World Health Organisation: Strategic Advisory Group of Experts (SAGE) on Immunization Assessment Report of the Global Vaccine Action plan. 2018

[2] PHE Immunisation Inequalities Strategy, February 2021

[3] UK COVID-19 Vaccines Delivery Plan, January 2021, Department of Health & Social Care

National and Local Context

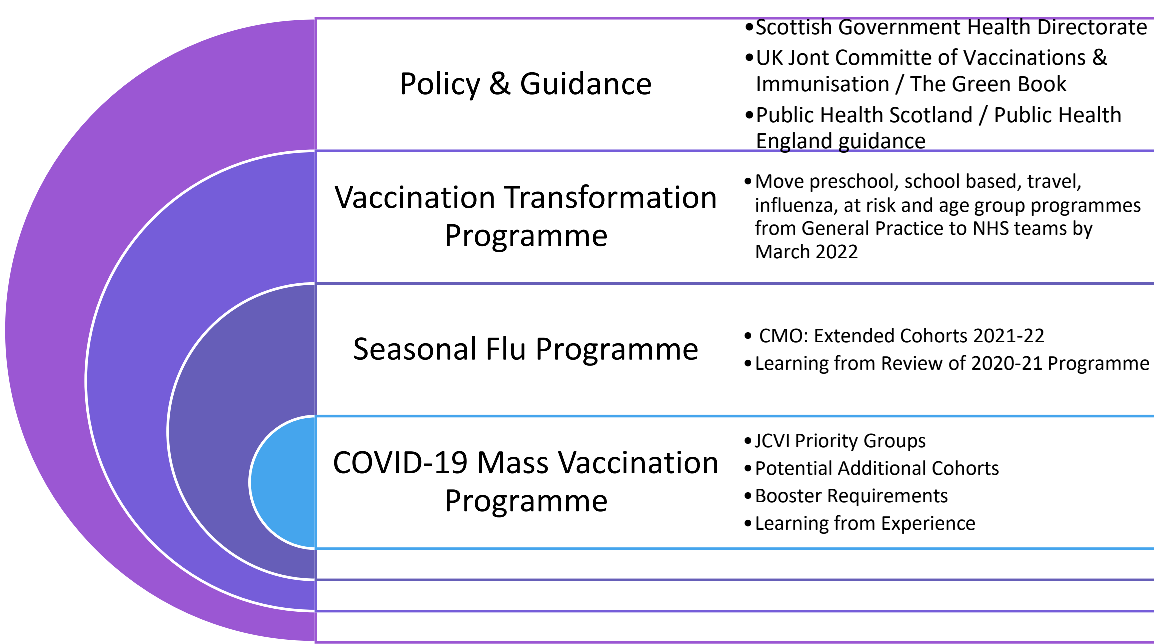


Fig 1: National and Local Context for Immunisation

Immunisation policy in Scotland is set by the Scottish Government Health Directorate who take advice from the UK Joint Committee of Vaccinations and Immunisation (JCVI). The JCVI provide advice on immunisations for the prevention of infections and/or disease following due consideration of the evidence on the burden of disease, on vaccine safety and efficacy and on the impact and cost effectiveness of immunisation strategies[4]. The UK immunisation schedule is continually reviewed and updated[5]. *Immunisation against infectious disease (*commonly known as the *Green Book)* reflects the current policies and procedures as advised by the JCVI and provides essential guidance on vaccines and vaccination procedures for all vaccine preventable diseases that may occur in the UK[6].

December 2019 saw the emergence of a new coronavirus, COVID-19, which led to a global pandemic being declared by the World Health Organisation in March 2020. Thousands of people in Scotland have died as a direct result of COVID-19. The indirect impact of COVID-19 on Scotland's health, economy and society will affect thousands more[7]. Mass vaccination of the population with COVID-19 vaccine is the single largest Public Health intervention in modern times. The priorities for this programme have been set out by the JVCI and vaccination remains a vital component for recovery and prevention of future outbreaks.

The 2018 Scottish General Medical Services (GMS) Contract[8] set out a new direction for general practice in Scotland which aims to improve access for patients, address health inequalities and improve population health. One of the priorities for implementation of the new contract is to reduce workload pressure on general practice and it has been agreed nationally that the delivery of

[4] Joint Committee on Vaccination and Immunisation Code of Practice, June 2013
[5] Complete schedule (children & adults) available here: https://www.gov.uk/government/publications/the-complete-routine-immunisation-schedule
[6] Immunisation Against Infectious Disease, Immunisation against infectious disease - GOV.UK (www.gov.uk)
[7] Public Health Scotland Strategic Plan 2020-23
[8] GMS contract: 2018 - gov.scot (www.gov.scot)

vaccination programmes will transfer from GP practice staff to dedicated NHS teams under the Vaccination Transformation Programme (VTP). The VTP is divided into different work streams[9]: -

- Pre-school programme
- School based programme
- Travel vaccinations and travel health advice
- Influenza programme
- At risk and age group programmes (shingles, pneumococcal, hepatitis B).

Transfer of all routine infant, pre-school booster and school age vaccinations had already been completed in Fife prior to 2020. Transfer of 2–5-year flu vaccine delivery was completed in autumn 2020 but other transfer plans were delayed due to the pandemic and some adult programmes were temporarily suspended. The national programme has been extended by a year with completion due by end of March 2022. This timeline remains challenging and the backlog of unvaccinated adults in eligible groups for example, for pneumococcal and shingles, has grown.

The seasonal flu programme is a strategic and Ministerial priority as well as a key clinical priority for NHS Fife and Fife Health & Social Care Partnership (HSCP). The Chief Medical Officer[10] has set out the priorities for the 2021-22 flu programme which aims to protect those most at risk from flu and to ensure that the impact of potential co-circulation of flu and COVID-19 is kept to an absolute minimum. There has been a significant extension to the eligible groups and a key focus of the programme will be to promote and increase flu vaccine uptake. Delivery of the programme will be challenging due of the ongoing impact of COVID-19 on our health and social care sector.

Independent reviews of the Seasonal Flu Programme 2020-21 and of the structure, governance, planning and resourcing requirements for immunisation in Fife together with learning from the roll out of the COVID-19 programme have identified key considerations for the development and delivery of all immunisation programmes (figure 2).

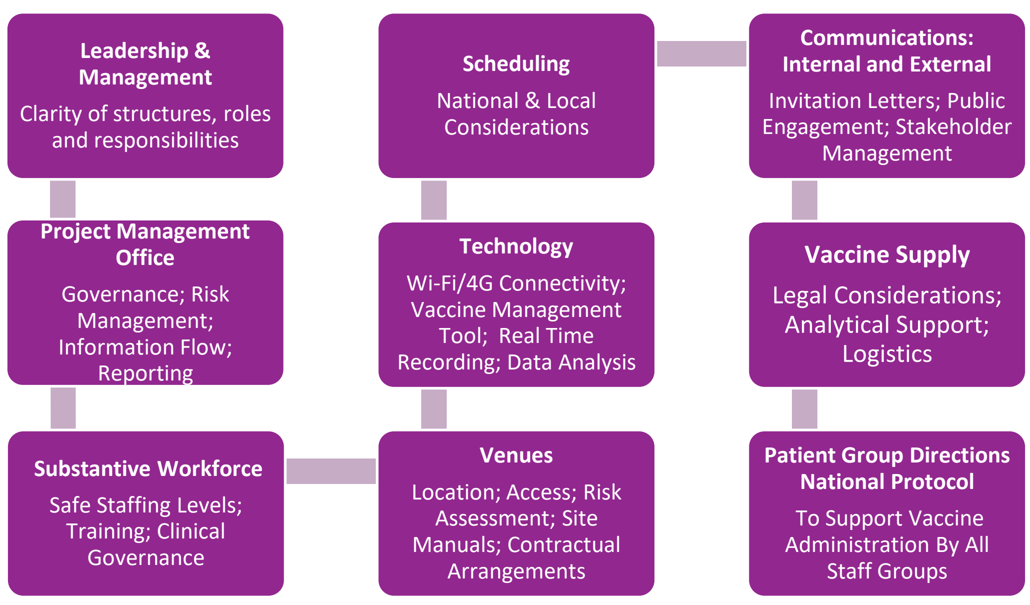


Figure 2: Key considerations for development and delivery of immunisation programmes

[9] www.healthscotland.scot/health-topics/immunisation/vaccination-transformation-programme
[10] SGHD/CMO(2021)7

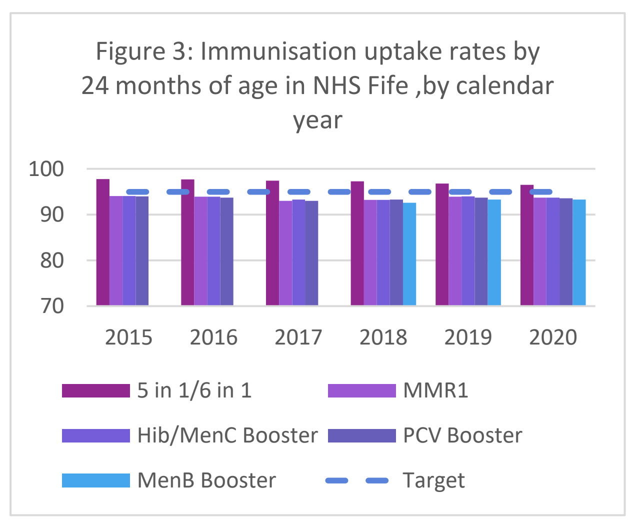
Vaccine Preventable Disease

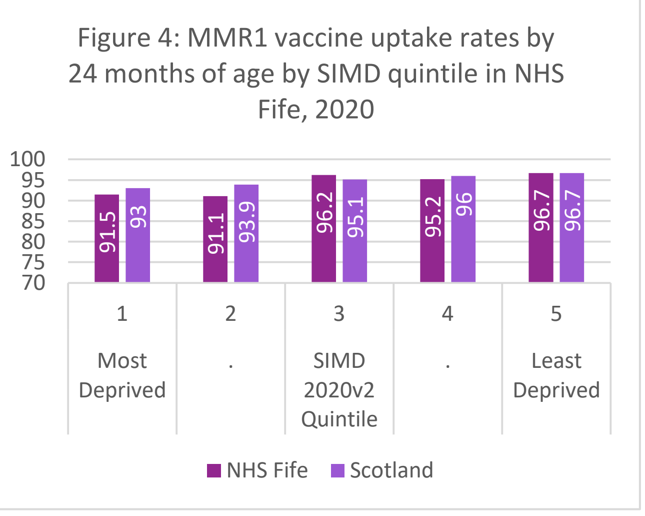
Vaccine-preventable diseases are those that are notifiable for surveillance purposes and for which a vaccine is available. In Fife and across Scotland the level of vaccine preventable disease is low (Table 1). All vaccine preventable disease under surveillance have shown a notable reduction in the past 12 months which is most likely due to the social distancing measures and restrictions implemented in response to the COVID-19 pandemic[11]. It is noted that the circulation of influenza was very limited in the UK in the 2020-21 season; therefore a lower level of population immunity is expected. 2021-22 will be the first winter when COVID-19 will co-circulate with seasonal influenza. This has the potential to add substantially to the usual winter pressures faced by the NHS, particularly if infection waves from both viruses coincide[12].

Table 1: Vaccine Preventable Disease	
Haemophilus influenzae	There have been less than 5 cases of invasive *H. influenzae* type b infection in Fife since 2009
Measles	In 2019 there were a small number of confirmed cases (less than 5) with limited secondary transmission. There were no confirmed cases in 2020
Meningococcal disease	There were less than 5 cases in 2019 (age range 5 to 75 years) and 5 cases in 2020 (age range 3 to 84 years)
Invasive Pneumococcal disease	Across both Scotland and Fife there has been a much lower number of cases in 2020 than in the previous four years: less than 5 in Fife
Pertussis (whooping cough)	Across Scotland there were 198 confirmed cases in 2020 with less than 5 in Fife. The majority of cases occurred in first quarter of 2020 and since lockdown the numbers have been very low.
Human Papilloma Virus (HPV)	Surveillance has shown that the HPV vaccine has reduced the highest grade of cervical pre-cancer at age 20 by almost 90% in Scotland
Mumps	There was a high number of laboratory-confirmed mumps cases in the first quarter of 2020 (853) across Scotland with 14 cases in Fife in 2020, all of which were in the first quarter. The incidence reduced after April 2020 most likely due to social distancing measures but also reduced attendance in Primary Care to diagnose.
Rotavirus	Following the introduction of the immunisation programme in 2013 there has been a reduction in numbers of hospital admissions in children under 5 years, and numbers of GP consultations for gastrointestinal illness in infants under 1 year in Scotland. The number of reports of confirmed rotavirus in 2020 remained low.
Rubella	The last reported case of laboratory-confirmed rubella in Scotland was in 2017.
Shingles	Rates of admissions and GP consultations for shingles remained fairly static during the period 2010 to 2017 in Scotland, with higher rates in the more susceptible older age groups; more recent surveillance data has not yet been published.
Tetanus	There have been no confirmed cases of tetanus in Fife since 2009.
Tuberculosis (TB)	Incidence of TB in Fife is lower than the Scottish average which has shown a consistent downward trend during the period 2010 to 2019. An increasing proportion of those with TB are born outside the UK and more than a third of cases live in the most deprived SIMD quintile.
Influenza	In the 2019 to 2020 season, low levels of influenza activity were observed in the community. Influenza activity in 2020/21 has remained at baseline.

[11] Immunisation and Vaccine Preventable Diseases Quarterly Update June 2021, Public Health Scotland
[12] JCVI interim advice: potential COVID-19 booster vaccine programme winter 2021 to 2022 - GOV.UK (www.gov.uk)

Snapshot of Immunisations in Fife





Children's Immunisations At 24 Months

Uptake rates in 2020 by 24 months of age are above 95% for the 6-in-1 vaccine and below 95% for first dose of MMR vaccine, Hib/MenC, PCV boosters, and Men B booster (Figure 3). The Scottish Index of Multiple Deprivation (SIMD) data shows that the 95% target is met for first dose MMR, Hib/MenB, PCV booster and MenB booster within the least deprived quintiles (3-5) but not in the most deprived quintiles 1 and 2 (figure 4). The drop-off in vaccination rates in quintiles 1 and 2 is more pronounced in Fife than is seen in the rest of Scotland.

Teenage Routine Immunisations

The teenage immunisation schedule includes booster immunisation for tetanus, diphtheria and polio (Td/IPV, given around 14 years of age); an immunisation protecting against four strains of meningococcal bacteria (MenACWY) and two doses of human papilloma virus vaccine. The teenage booster programme in Fife demonstrates a clear socioeconomic difference in vaccination uptake (Figure 5). Whilst this is similar to that seen in the rest of Scotland it indicates a need to develop targeted interventions.

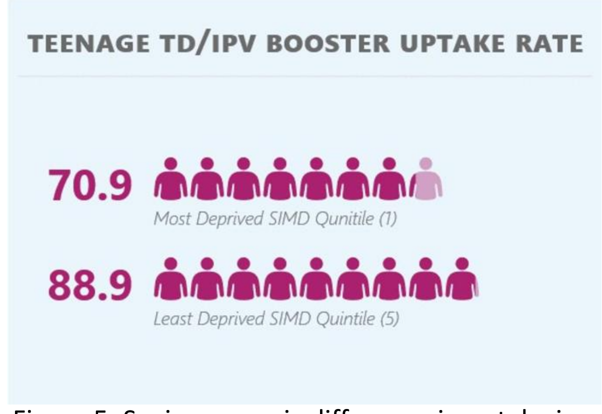


Figure 5: Socioeconomic difference in uptake in

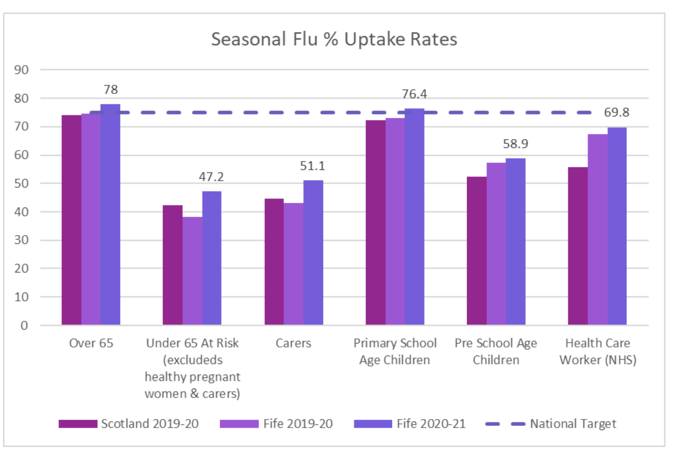


Figure 6: Seasonal Flu Uptake 2019-2021

Influenza

Influenza is associated with significant morbidity and mortality during the winter months, particularly in those at risk of complications. There is a 75% uptake rate target for each of the eligible cohorts. Data indicate that the overall vaccine uptake for Fife was higher in 2020-21 than in the previous season (figure 6). Increases were also seen in Scotland across these cohorts in 2020/21'[13].

[13] Weekly national seasonal respiratory report (publichealthscotland.scot)

Selective Immunisation Programmes

Immunisation programmes are also available for certain populations who are especially vulnerable to or at increased risk of vaccine preventable diseases. This includes healthcare workers, pregnant women, older people, prisoners, men who have sex with men and people with predisposing medical conditions.

Bacillus Calmette-Guerin (BCG) Vaccine

The aim of the UK selective BCG programme is to immunise those at increased risk of developing severe disease and / or exposure to Tuberculosis (TB) Infection. The BCG vaccine is offered to babies who are more likely than the general population to come into contact with someone with TB. The vaccine is usually offered soon after birth[14]. The neonatal BCG vaccination pathway is under review and the outcome of this will inform the future delivery of the programme in Fife.

Hepatitis

Both hepatitis A and B can be prevented with vaccination. In Fife, babies born to mothers who have hepatitis B or live in a house where someone is infected with the virus are offered hepatitis B vaccination within 24 hours of birth to reduce the risk of chronic infection and avoidable harm. This is in addition to the routine immunisation offered to all babies in the 6-in-1 vaccine.

Sexual Health

Hepatitis vaccine A&B is recommended for men who have sex with men (MSM), anyone having sex with people from countries where hepatitis B is more common and those with multiple sexual partners[15]. MSM are also considered to have higher risk of Human Papilloma Virus (HPV) infection which can cause genital warts and certain types of cancer. Both HPV and hepatitis vaccines are freely available through sexual health clinics. Data on uptake is affected by a number of factors and requires further scrutiny. An audit of data systems and processes in Fife in collaboration with National Sexual Health System (NaSH) would enable more reliable datasets to be developed.

Pertussis (Whooping Cough)

Since 2012 pertussis vaccination has been offered to all pregnant women with uptake during 2019 in Fife at 66.7% (Scotland 67.2%), data for 2020 is not currently available. The uptake data is reported by NHS Board of delivery and therefore excludes those who choose to receive their maternity care in other Board areas.

Occupational Vaccination for Health Care Workers

The objective of occupational immunisation of healthcare and laboratory staff is to protect workers at high risk of exposure and their families; to protect patients and other staff from exposure to infected workers; and to sustain the workforce. Vaccinations are offered to staff dependent on where they work in accordance with the guidance in the Green Book[17] (Table 2).

Vaccination	Health Care Workers
Up to date with routine immunisations e.g., Tetanus, MMR, Polio	All staff
BCG	Those who may have close contact with TB infectious patients.
Hepatitis B	Those who may have direct contact with blood or blood-stained body fluids.
Influenza (annual)	Those directly involved in patient care
Pertussis[16]	Those who have regular contact with pregnant women or young infants

Table 2 Vaccination Offered to Health Care Workers

[14] BCG vaccine - Immunisations in Scotland | NHS inform
[15] https://www.sexualhealthscotland.co.uk/the-clinic/stis/hepatitis
[16] https://www.gov.uk/government/publications/pertussis-occupational-vaccination-of-healthcare-workers/pertussis-occupational-vaccination-of-healthcare-workers
[17] https://www.gov.uk/government/publications/immunisation-of-healthcare-and-laboratory-staff-the-green-book-chapter-12

COVID-19

COVID-19 is a highly infectious respiratory infection which can spread quickly and cause serious illness, hospitalisation and death. COVID-19 vaccines have been approved for use by the Medicines and Healthcare products Regulatory Agency (MHRA) and mass vaccination of the population is well underway and is being delivered in Fife in accordance with JCVI guidance, prioritising those most at risk based on age and clinical condition. The vaccine is given in two doses and offers good protection within two to three weeks of the first dose.

As of 18th July 2021, 96.5% of people aged 40+years in Fife have received their first dose and 91.9% have received their second dose. The uptake by age group in is shown in figure 7[18].

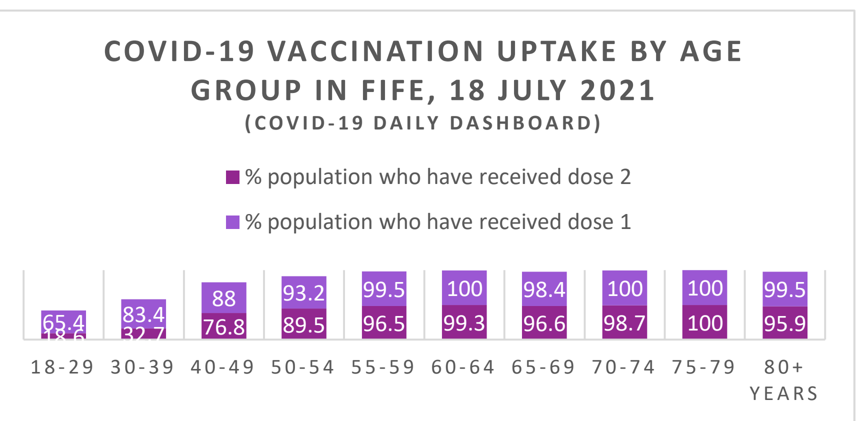


Fig 7: COVID-19 Vaccination Uptake Rates in Fife

The JCVI have released interim advice on a potential COVID-19 booster vaccination programme for winter 2021 to 2022[19] with the intention that this will ensure the protection built up in the population does not decline through the winter months and that immunity is maximised to provide additional resilience against variants. The planning assumption is that the booster programme will begin in September 2021 and is to be offered in 2 stages as outlined in figure 8. Early evidence supports the delivery of both COVID-19 and influenza vaccines at the same time and where possible, a synergistic approach to the delivery will be taken to maximise uptake of both vaccines.

Stage 1	Stage 2
Offer third dose COVID-19 booster vaccine & annual influenza vaccine from September 2021 to: • Adults aged 16 years and over who are immunosuppressed • Those living in residential care homes for older adults • All adults aged 70 years or over • Adults aged 16 years and over who are considered clinically extremely vulnerable • Frontline health and social care workers	Offer third dose COVID-19 booster vaccine as soon as practicable after stage 1, with influenza vaccine where eligible to: • All adults aged 50 years and over • Adults aged 16 to 49 years who are in an influenza or COVID-19 at-risk group. (As set out in the Green Book) • Adult household contacts of immunosuppressed individuals

Figure 8: Two Stage Potential COVID-19 Booster Programme

The JCVI have also advised that children and young people aged 12 years and over with specific underlying health conditions that put them at risk of serious COVID-19, and those who are household contacts of persons (adults or children) who are immunosuppressed should be offered COVID-19 vaccination[20].

The JCVI will continually review the evidence and finalise advice as more data becomes available. Delivery of the COVID-19 programme in Fife will be adapted to respond to any advised changes.

[18] COVID-19 Daily Dashboard | Tableau Public

[19] JCVI interim advice: potential COVID-19 booster vaccine programme winter 2021 to 2022 - GOV.UK (www.gov.uk)

[20] JCVI statement on COVID-19 vaccination of children and young people aged 12 to 17 years: 15 July 2021 - GOV.UK (www.gov.uk)

Equity and Inclusion

Equality in immunisation is an important way to address health inequalities. Ensuring that coverage is not only high overall, but also within underserved communities is essential for disease control and elimination strategies[21]. Immunisation uptake has been shown to be lowest in poorer families, those from minority ethnic backgrounds and those who may find it more challenging to access services. Low coverage patterns risk exacerbating health inequalities further through a rise in incidence in preventable diseases at both an individual and population level due to loss of benefits associated with herd immunity.

Although Scotland continues to perform strongly for vaccination uptake rates of the childhood programme compared to the rest of the UK[22] there have been recent concerns that completion rates in the childhood programme are showing a gradual decline. In Fife, performance on many of the routine childhood immunisations is slightly below the Scottish average, and uptake in the most deprived quintiles is a particular concern. The data demonstrates substantial socioeconomic inequalities across the childhood and teenage immunisation programme and that these increase with age. Further work is needed to explore and understand these areas of inequality.

To promote equity and inclusion in the COVID-19 vaccination programme a comprehensive Equality Impact Assessment (EQIA)[23]was undertaken which focussed not only on the differential impacts certain population groups may face in their ability to take up the offer of vaccination but also the need to make the mass vaccination programme as inclusive and accessible to the population as possible. Further work is required to apply this learning across all immunisation programmes.

Vaccine hesitancy is increasing and failure to vaccinate is well-recognised in Europe as a contributing factor to outbreaks of infectious diseases. Whilst public perception of vaccination is good and thought to have value in protecting people from specific disease this may not necessarily translate into the belief that a specific vaccine is worth having at an individual level due to misinformation, lack of confidence in vaccines, an underestimation of risk or difficulties in access[24].

Cultural norms, beliefs and behaviours shape how people navigate the health system and vaccination programmes. Low vaccine uptake has been seen in migrant communities. Recent research in Lothian identified trust in the national vaccination policy, health professionals and in individual vaccines together with language and communication issues affected the uptake within Polish communities[25].

It is recognised that where there are unmet information needs people may not be making truly informed choices about vaccination. There is a need for community engagement and promotion based around improved communication strategies, effective clinical and political leadership and public health messaging to help address the issues, constructively challenge the vaccine hesitant and improve the dialogue around immunisation.

[21] PHE Immunisation Inequalities Strategy, February 2021
[22] https://www.gov.uk/government/statistics/cover-of-vaccination-evaluated-rapidly-cover-programme-2020-to-2021-quarterly-data
[23] https://www.nhsfife.org/media/34517/covid-vaccine-programme-eqia.pdf
[24] Exploring public views of vaccination service delivery - Publications - Public Health Scotland
[25] A qualitative study of vaccination behaviour amongst female Polish migrants in Edinburgh, Scotland - ScienceDirect

Our Vision

A Fife where everyone, everywhere, has confidence in and equitable access to high-quality, safe, sustainable immunisation services throughout their life course.

Our strategic approach integrates national, regional and local policy objectives to ensure we take a collaborative whole-systems approach to improving immunisation and delivering the transformational change required. The following aims, priorities and core principles have been informed from our learning from the seasonal flu and COVID-19 programmes, independent review of immunisation services in Fife and the draft planning and policy principles for development of future vaccinations in Scotland.

Our Aims and Priorities

Our Aims	To protect the people of Fife from vaccine preventable disease by maximising uptake across all immunisation programmes
	To contribute towards improved wellbeing and reducing health inequalities in Fife
	To ensure immunisation services across Fife are safe, effective and of a consistent high quality
	To raise people's awareness of the public health benefits and raise people's trust in vaccinations
Our Priorities	Optimise immunisation coverage ensuring equitable access for all eligible groups
	Enhance the monitoring and evaluation of immunisation programmes
	Support and empower a sustainable and skilled workforce to deliver safe and effective immunisation services
	Community engagement and promotion

Core Principles

The core principles underpinning transformation of immunisation services are that they should be:

- Person centred- The design of services is primarily led by the perspective of the person who will use the service and is responsive to individual preferences, needs and value
- Inclusive- Care does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location or socioeconomic status and immunisation services are designed and delivered to be as accessible and inclusive as possible.

- Integrated- Immunisation policy and delivery are closely integrated with a clear connection between objectives and delivery outcomes.
- Evidence based- Vaccination delivery is informed by independent scientific and clinical evidence and advice. Local data is used to identify trends and inform targeted interventions to improve coverage.
- Timely- Vaccinations are delivered at the appropriate pace to reduce risk to people and the population.
- Quality and safety focused: People experience consistent, high quality, safe, effective and efficient services.

Enablers

Transformation of immunisation services presents an opportunity for NHS Fife and Fife HSCP to work in partnership to find different ways to deliver safe and sustainable immunisation services to suit the needs of the population taking account of the resources required and geography to be covered.

From our recent experience key enablers which will deliver a robust infrastructure have been identified to ensure successful and sustainable delivery of immunisation services (figure 9).

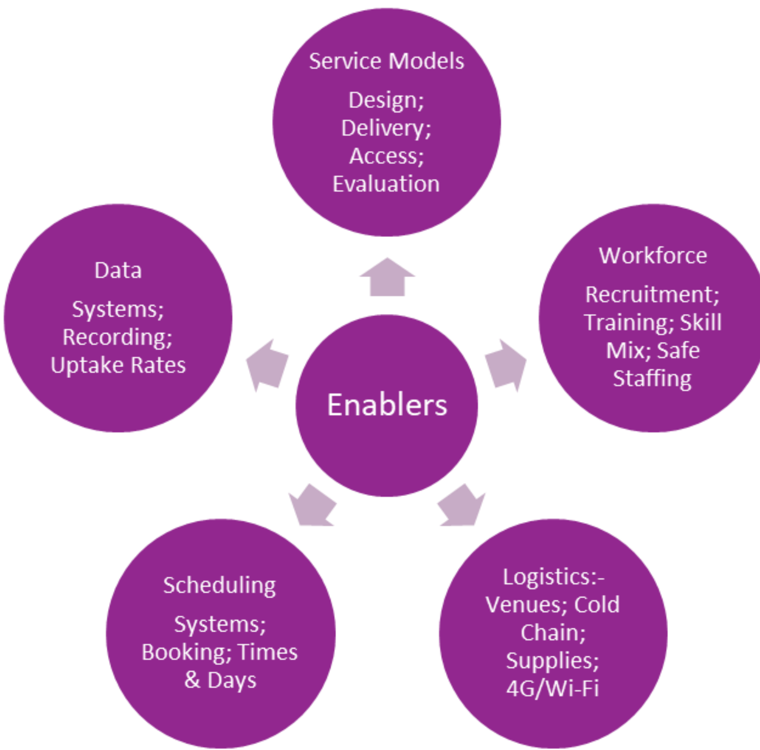


Figure 9: Key enablers for successful delivery of immunisation services

For all programmes to be successful the service delivery model needs to support access for all, utilising tailored communications and engagement, outreach and targeted models, where required, to support access for under-served groups. Development of a dedicated vaccination workforce will be prioritised to minimise impact on other NHS services and ensure sustainability of provision. As service delivery moves away from general practice to NHS dedicated teams, and building on our experience in delivering the COVID-19 programme, suitable venues and vaccination locations will be identified which are accessible and suitable for clinical activity. Digital systems will be developed to support scheduling of appointments and recording of clinical activity in partnership with the national teams. Over the next three years it will be essential to ensure close monitoring of uptake rates continues, immunisation services are as accessible and flexible as possible, and that inequalities are addressed in the new models of delivery.

Governance

The planning and governance of immunisation is shared across Fife NHS Board, Fife Integration Joint Board (IJB) and Fife HSCP with overlapping responsibilities as shown in figure 10.

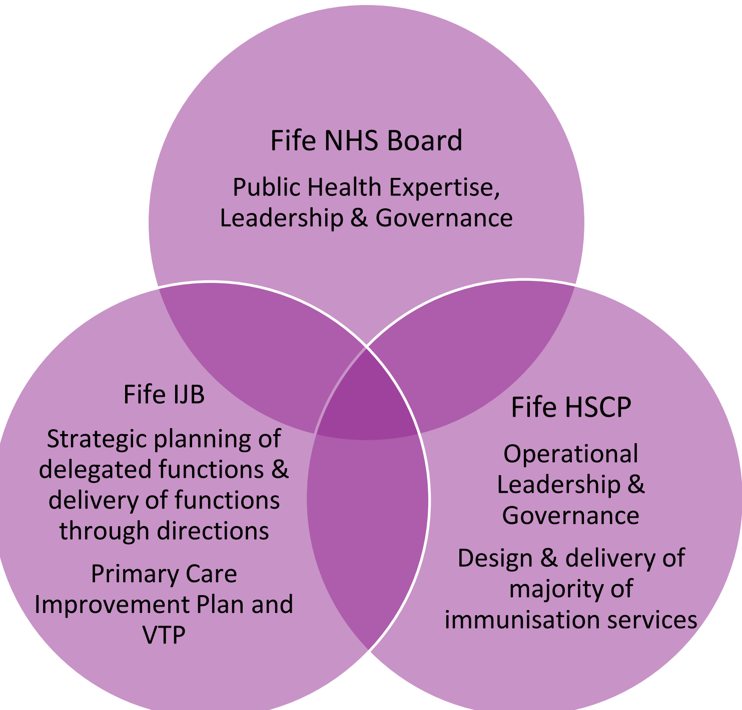


Figure 10: Planning and Governance Responsibilities

The implementation and governance of this strategy will be jointly led by the Director of Public Health (Executive Lead) and the Director of the Health and Social Care Partnership (Senior Responsible Officer). This integrated approach ensures that there is appropriate accountability and governance oversight of immunisation at Board level and that the immunisation programmes meet their objectives, deliver the required outcomes and realise the anticipated benefits for the population of Fife.

A Flu Vaccine and COVID Vaccine (FVCV) Programme Board has been established to provide multidisciplinary oversight and governance for all activities relating to seasonal flu and COVID-19. This will enable the synergies across these two large population-based programmes to be maximised and aligns with the direction of the national FVCV programme.

A Vaccination Transformation Board has been established to drive forward the changes required to move all other vaccination provision away from general practice delivery to dedicated NHS teams.

The programme boards will ensure rigorous oversight and direct the identification and management of risk as a critically important factor in delivering and assuring safe delivery of immunisation services.

Governance of the strategy will be addressed through the routine quality, safety and governance processes within Fife NHS Board, Fife IJB and Fife HSCP.

Monitoring, Reporting and Evaluation

Implementation of the strategy will be monitored through the Area Immunisation Steering Group (AISG) under the leadership of the Public Health Immunisation Coordinator and supported by a core senior management group to enable responsive decision making and to identify any necessary remedial actions, where required, to improve outcomes.

Nationally available immunisation data will be monitored to determine progress and areas for improvement. It is recognised that there are some inconsistencies in data collection methods and we will work with national teams to improve the quality and completeness to enable more accurate reporting.

A programme of audit will be agreed through the AISG for both routine and selective immunisation programmes to inform targeted interventions to improve overall performance.

Regular updates on progress will be reported to the Executive Director Group and onto the appropriate public health and clinical governance committees of NHS Fife Board, Fife IJB and Fife HSCP.

Monitoring and reporting over the life of the strategy, together with an evaluation of the strategy in the final year of implementation, will inform future direction and the development of future strategic plans.

Strategic Action Plan

To realise our vision, the following plan outlines the key actions to support continuous improvement in the planning and delivery of immunisation programmes with a focus on improving access and increasing uptake while reducing inequalities.

Priority 1	Key Actions	Performance Measures	Responsibility
Optimise immunisation coverage ensuring equitable access for all eligible groups	• Standardise the Equality Impact Assessment process and share learning across programmes to inform targeted interventions • Develop and implement Inclusivity Plan noting co-dependencies and ensuring coproduction with Priority 4 where relevant • Prioritise equity of access in design of programmes to ensure underserved populations can access • Implement and evaluate innovative, culturally-appropriate projects to increase and maintain immunisation coverage rates and improve timeliness of vaccinations • Implement and evaluate innovative projects to increase participation, including opportunistic vaccination, to ensure completion of the vaccination schedule. • Ensure gaps in delivery are followed up by the appropriate service.	• Achieve childhood immunisation coverage rates of 95% or higher across all SIMD quintiles • Achieve HPV immunisation coverage of 80% for both females and males by end S3 across all SIMD quintiles • Achieve MenACWY coverage of 95% by end S4 across all SIMD quintiles • Achieve Td/IPV booster coverage of 95% by end S4 across all SIMD quintiles • Achieve 85% BCG uptake rates for eligible children by 12 months for those at risk of Tuberculosis • Achieve 100% uptake of Hepatitis B for babies at risk within the recommended schedule for this cohort • Achieve Pertussis coverage of 75% for pregnant women • Achieve HPV coverage of 80% for men who have sex with men up to and including age 45 years attending sexual health services • Establish Hepatitis A&B uptake rates within sexual health services • Achieve seasonal flu coverage as set out in annual CMO letter • Local target for Shingle's programme to be confirmed • Local Target for Pneumococcal programme to be confirmed • Achieve national COVID-19 targets as they emerge across JCVI priority groups	**Lead:** • Immunisation Coordinator **Critical:** • Immunisation Programme Director • Associate Medical Director HSCP • Associate Nurse Director HSCP • Associate Director of Midwifery • Lead Pharmacist Public Health • Head of Strategic Planning & Performance

Priority 2	Key Actions	Performance Measures	Responsibility
Enhance the monitoring & evaluation of immunisation programmes	• Review Annual Immunisation Report to identify trends and areas for improvement • Monitor the collection and quality of Fife's immunisation data and work with local and national teams to identify improvements to support development of more reliable datasets. • Maintain oversight of the quality and effectiveness of immunisation programmes • Identify priorities and undertake audits of routine and selective programmes • Implement more formal, regular and consistent approach to immunisation Adverse Event Review to identify trends, patterns and learning to inform improvement. • Work with Datix team to ensure all adverse events are coded and notified to the Immunisation Coordinator and appropriate Senior Leadership Team • Ensure PHE Vaccine Incident Guidance is implemented to respond appropriately to errors in vaccine storage, handling and administration • Raise community and health professional awareness of vaccine safety surveillance systems to improve confidence in immunisation and the reporting of adverse events	• Annual Immunisation report presented to Clinical Governance Committee by end of June each year • Immunisation data completeness and verification of data quality • Quarterly Immunisation performance reports • Quality report on immunisation is considered by the Area Immunisation Steering Group (AISG) 3 times a year • Schedule of audit and audit outcomes are reported to AISG and appropriate services. Where appropriate, improvement plans are developed and implemented with progress reported to AISG. • Quarterly Datix reports of adverse events are reviewed by AISG and Senior Leadership Team • Investigation of adverse events are completed timeously in line with local and national policies with outcome reports included in quality reports to AISG • Vaccine wastage is quantified and reduction target agreed • Vaccine related incidents logged on Datix within 24 hours are measured, audited and reported	**Lead:** • Immunisation Coordinator **Critical:** • Immunisation Programme Director • Head of Strategic Planning and Performance • Associate Director of Nursing HSCP • Associate Director of Medicine HSCP • Head of Pharmacy – Medicine Supply and Quality • Lead Pharmacist – Public Health • Senior Public Health Practitioner

Priority 3	Key Actions	Performance Measures	Responsibility
Support & empower a sustainable skilled workforce to deliver safe and effective immunisation services	• Enhance the leadership and management of immunisation services within HSCP and Public Health • Develop comprehensive and sustainable immunisation workforce plan taking account of skill mix requirements and safe staffing levels to meet the demands of all aspects of immunisation services • To ensure strategies to support effective health and wellbeing of the workforce • Ensure a dynamic workforce with career pathways and succession planning evident in line with national and local workforce strategies • Provide a framework to support immuniser training and skill maintenance. • Facilitate online training for health providers and other key stakeholders. • Ensure effective communication strategies designed in partnership enabling an engaged and informed workforce	• Recruitment and appointment to key posts completed by October 2021 • Workforce plan is developed and approved by end October 2021 • Training programme is established, evaluated and audited with regular reporting via established governance and assurance framework • Statutory and Mandatory learning completion in line with targets with according reporting • Imatter and according action plans established with ongoing review in line with agreed processes • Percentage completion of personal development plans in line with staff governance standards • Absence rates monitored and achieved as per national targets • Recruitment and retention monitoring , ensuring scrutiny and reporting	**Lead:** Associate Director of Nursing HSCP **Critical:** • Immunisation Programme Director • Immunisation Clinical Services Manager • Immunisation Coordinator • Senior Public Health Practitioner • Human Resource Lead • Staff Side Representative Lead • Finance Lead

Priority 4	Key Actions	Performance measures	Responsibility
Community engagement and promotion	• Develop and implement community engagement plan, noting co dependencies and ensuring coproduction with output from priority 1 where relevant • Implement anchor practices in the design and delivery of the immunisation programme to invest in and work with others locally and responsibly to optimise use of buildings and spaces that support communities and accessibility • Work closely with partners and stakeholders to learn from them, share ideas and develop trust relationships as the foundation for promotion of immunisation • Design and implement communications protocols that will guide response to vaccine misinformation with aim to promote uptake • Implement and adapt national communication toolkits to ensure they meet the needs of the diversity of the local population • Develop digital first approaches to engagement drawing on pandemic experience • Ensure recommendations from national work on public views on vaccine delivery within the VTP is taken forward locally • Develop appropriate resources for culturally and linguistically diverse populations to insure people are able to make informed choices on vaccination. • Promote use of Care Opinion to build up reports and narrative of people's views of services • In year 2 undertake public consultation to inform future models of delivery	• Community engagement plan is established with oversight and timelines agreed at programme board • Establish and monitor accessibility measures • Evidence that partners and stakeholders have promoted the importance of immunisation for the health of the Fife community. • Auditing and reporting of immunisation uptake rates for routine and selective programmes • Monitor uptake response rates from target audiences • Quarterly report regarding public feedback via according governance routes • Measures within P1 are considered to evidence delivery of P4 key action	**Lead**: Head of Strategic Planning & Performance **Critical:** • Head of Communications NHS Fife • Communications Officers • Senior Public Health Practitioner • Lead Pharmacist - Public Health • Head of Person Centred Care • Head of Facilities • Immunisation Clinical Services Manager

Fife Health and Social Care Partnership
Community Immunisation Services Programme Board

TERMS OF REFERENCE

1. PURPOSE

The Fife Health & Social Care Partnership (HSCP) Community Immunisation Services Programme Board will ensure multidisciplinary senior leadership, strategic oversight, assurance and governance for all activities related to the effective delivery of a high quality, safe and sustainable vaccination and immunisation service for the population of Fife.

2. REMIT

The Board will:

2.1 Provide assurance and ensure strategic oversight of operational delivery of all immunisation programmes in Fife in alignment with the Fife Immunisation Strategic Framework 2021-2024.

2.2 Ensure oversight of implementation of national immunisation schedules as directed by the Scottish Chief Medical Officer (CMO) which are based on guidance issued by the JCVI, in collaboration with the Area Immunisation Steering Group (AISG). This will include oversight of changes to and/or new vaccine introductions to the Scottish Vaccination & Immunisation Programme ensuring these are introduced into local delivery in a safe, effective and sustainable manner in accordance with the UK Joint Committee on Vaccination and Immunisation (JCVI) guidance and Scottish Government Health Department direction.

2.3 Provide oversight and assurance of system wide collaboration and co production in line with national and local strategic drivers, policy, planning and direction.

2.4 Provide assurance via submission of performance information for the IPQR (Integrated Performance and Quality Report) on a monthly / quarterly basis to the assurance meeting of the HSCP Senior Leadership Team (SLT) and onwards through Executive Directors Group to the Public Health & Wellbeing Committee.

2.5 Review uptakes rates for all programmes directing delivery in collaboration with the Area Immunisation Steering Group (AISG), escalating by exception through agreed HSCP performance and reporting governance arrangements.

2.6 Enable scrutiny and monitoring of areas identified for improvement by the AISG and/or at board level or internally via the Immunisation Quality and Clinical Care Assurance Group

Version V2.0
Author: L Cooper / Dr E Curnock
Drafted 23/02/2022
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Ratified: 04/04/22
Review date: 04/07/22

which may require additional focus, recognising and managing any risk and directing further action where necessary.

2.7 Ensure scrutiny of planning and engagement activities to design service delivery, assuring inclusive, person-centred and accessible high-quality care regardless of personal characteristics such as gender, age, ethnicity, disability, geographic location or social status.

2.8 Scrutinise progress of critical milestones against the agreed priorities within the Immunisation Strategic Framework delivery plan for each work stream/subgroup agreed.

2.9 Ensure a multi-professional forum to support escalation of key challenges for delivery supporting operational decision making.

2.10 Assure a system-wide approach, linking across other programmes to ensure coproduction, integration and joint decision making to maintain alignment of the Programme with the other strategic objectives of the Health and Social Care Partnership and NHS Fife.

2.11 Provide oversight and assurance of effective communication and engagement strategies which encompass both workforce and public engagement, and are reflective of overall key priorities for the implementation of the strategic framework.

2.12 Ensure the strategic vision for Community Immunisation Services is achieved without adverse impact on safety or sustainability across all portfolios of immunisation service delivery.

2.13 Maintain and ensure oversight and rigour for a robust governance framework to support immunisation activities, including:

- Quality assurance of operating policies and standards
- Workforce planning and resourcing
- Education & training activity
- Venues and logistics
- Scheduling
- Financial management
- Risk identification, mitigation and escalation processes
- Adverse event reporting & oversight via the Clinical Assurance & Governance Group
- Safe, effective evidence based delivery

2.14 Confirm successful delivery and sign-off at the closure of programme work streams, including lessons learned.

2.15 Ensure models of delivery are sufficiently resourced and that the necessary systems and infrastructure are in place to support ongoing delivery in line with the priorities for delivery of the Fife Immunisation Strategic Framework from April 2022 - 2024.

3. MEMBERSHIP

Version V2.0
Author: L Cooper / Dr E Curnock
Drafted 23/02/2022
Reviewed: 30/03/22
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3.1 The core Community Immunisation Services Programme Board membership will be made up of:

Director of HSCP (Chair)
Associate Medical Director
Head of Primary Care and Prevention Services HSCP (Co-Chair)
Immunisation Programme Director (Co-Chair)
Public Health Consultant - Immunisation Coordinator
Associate Director of Nursing – HSCP
Clinical Services Manager – Immunisation Services
Estates and Facilities Lead
Communication Lead
Staff Side Representative
Human Resources Manager
Finance Representative
Digital & Information Head of Strategy
Associate Director of Midwifery NHS Fife
Quality, Clinical & Care Governance Lead (HSCP)
Deputy Director of Pharmacy & Medicines
Head of Strategic Planning and Performance
GP Representation
Head of Nursing

3.2 The following members will attend to report on workstreams and stakeholder engagement:

- Senior Manager Children's Services
- Scottish Care Representative
- Head of Education
- Associate Director of Nursing (Acute)
- Occupational Health Representative
- Public Health Pharmacist
- Programme Manager

3.3 Other persons can be invited as required for professional advice and/or to ensure appropriate representation, or for work-streams/sub groups commissioned to support projects related to the programme e.g. EQIA Lead. This list is not exhaustive and can be agreed by the group and ratified by the chair.

3.4 Quorum
There must be 6 members as a minimum to ensure quorate decision making. If a member is unable to attend they should nominate their agreed depute advising the chair in advance.

4. REPORTING ARRANGEMENTS

4.1 For assurance, progress will be reported to the HSCP Senior Leadership Team Assurance Group by the programme board chair/co-chair utilising presentation of a SitRep on a monthly basis.

4.2 Decisions required will be presented to the HSCP Senior Leadership Team Business Group from the programme board chair/co-chair via a written SBAR to enable constructive dialogue in support of critical decision making.

4.3 The Board reporting structure to NHS Fife board will include submission of performance information through the IPQR (Integrated Performance and Quality Report) on a monthly / quarterly basis to the assurance meeting of the HSCP Senior Leadership Team (SLT) and onwards through the Executive Directors Group to the Public Health & Wellbeing Committee of NHS Fife.

4.4 The Board will report to Fife Integrated Joint Board (IJB) for oversight of delivery via the Qualities and Communities Committee and the Finance and Performance Committee with reports from the HSCP Senior Leadership Team.

4.5 The Board will request minutes, formal action logs, verbal updates and other relevant papers as appropriate in line with the cycle of meetings from the Community Immunisation Quality and Clinical Care Assurance Group, Community Immunisation Services Implementation Group, Community Immunisation Strategic Workforce Group and Community Immunisation Services Inclusivity group in line with their agreed cycles for meeting. These groups will be expected to escalate or report by exception if necessary out with this cycle.

5. MEETINGS

5.1 Meetings of the Board will be held monthly via Teams with ongoing review to agree frequency, with additional sub-groups being established as required.

5.2 The Chair may convene an extraordinary meeting of the group as necessary.

5.3 Members are asked that in any instance where they may be unable to attend that a depute is nominated.

5.4 Administrative support will be provided by the PA to the Immunisation Programme Director.

5.5 Programme Management support will be provided following the appropriate approval process, based on assessed requirements from relevant teams.

5.6 A request will be made for agenda items with the agenda and all related papers circulated 1 week prior to the monthly meeting. It is expected all members will review papers to ensure meaningful, informed discussions.

5.7 An action log will be collated, reviewed and agreed at each meeting and circulated prior to each meeting to ensure ongoing ownership and progress of actions.

5.8 To ensure the Community Immunisation Service progresses in line with the high level planning required for implementation of the ongoing delivery of the NHS Fife Immunisation Strategic Framework 2021-2024, this group will regularly review its aim, purpose, function and membership to ensure this group remains relevant and current.

Version V2.0
Author: L Cooper / Dr E Curnock
Drafted 23/02/2022
Reviewed: 30/03/22
Ratified: 04/04/22
Review date: 04/07/22

6. Review

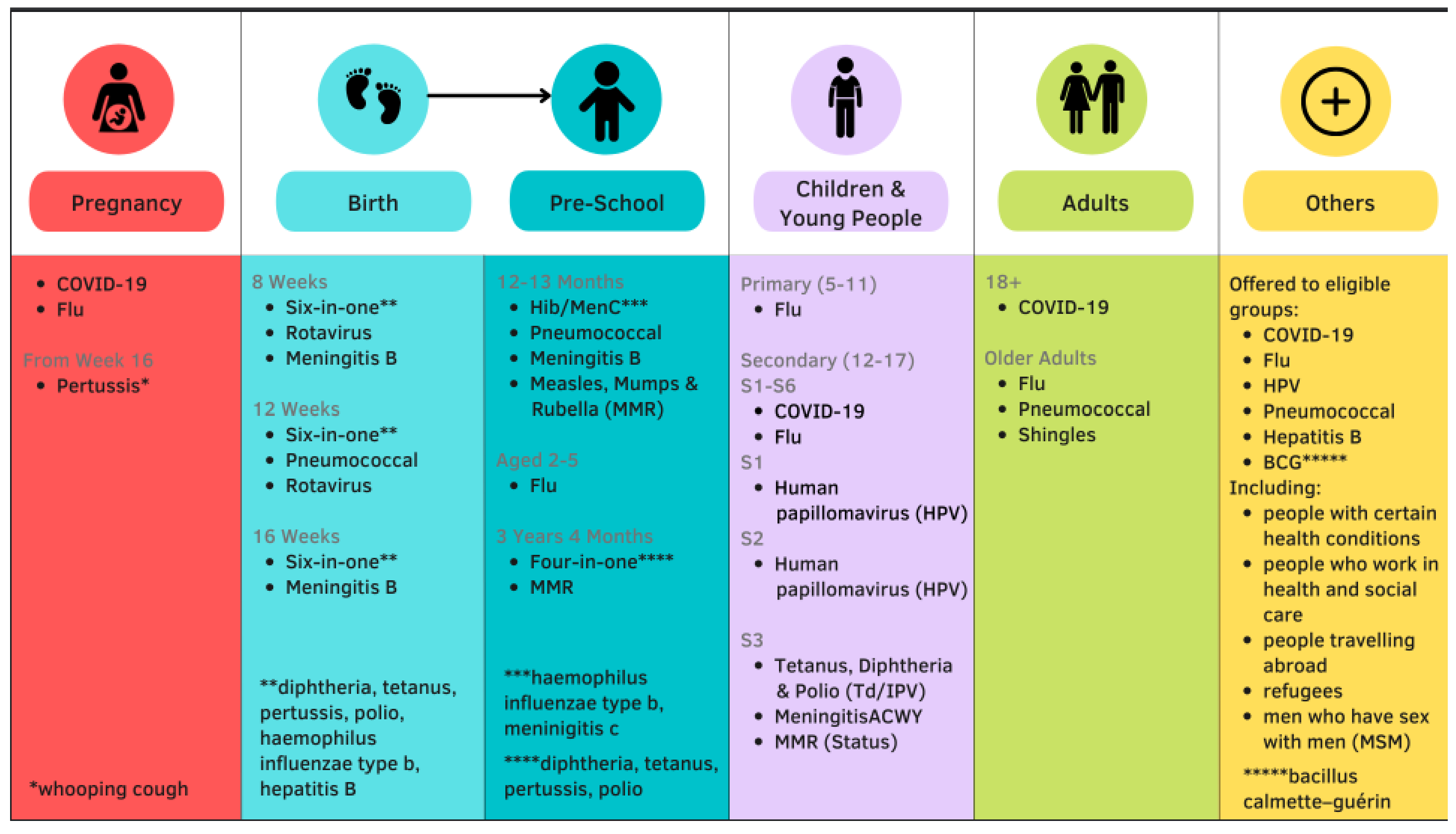
6.1 This is suggested as a 3 month review cycle initial from date of agreement but can be changed in consultation with chair and members.

Date Agreed: 04/04/22
Review Date: 04/07/22

Appendix 1- Full programme of NHS Fife & HSCP Vaccination & Immunisation Programme

Appendix 2 - Community Immunisation Services Governance Structure

Appendix 1 – Full programme of NHS Fife & HSCP Vaccination & Immunisation Programme, NB this is not exhaustive



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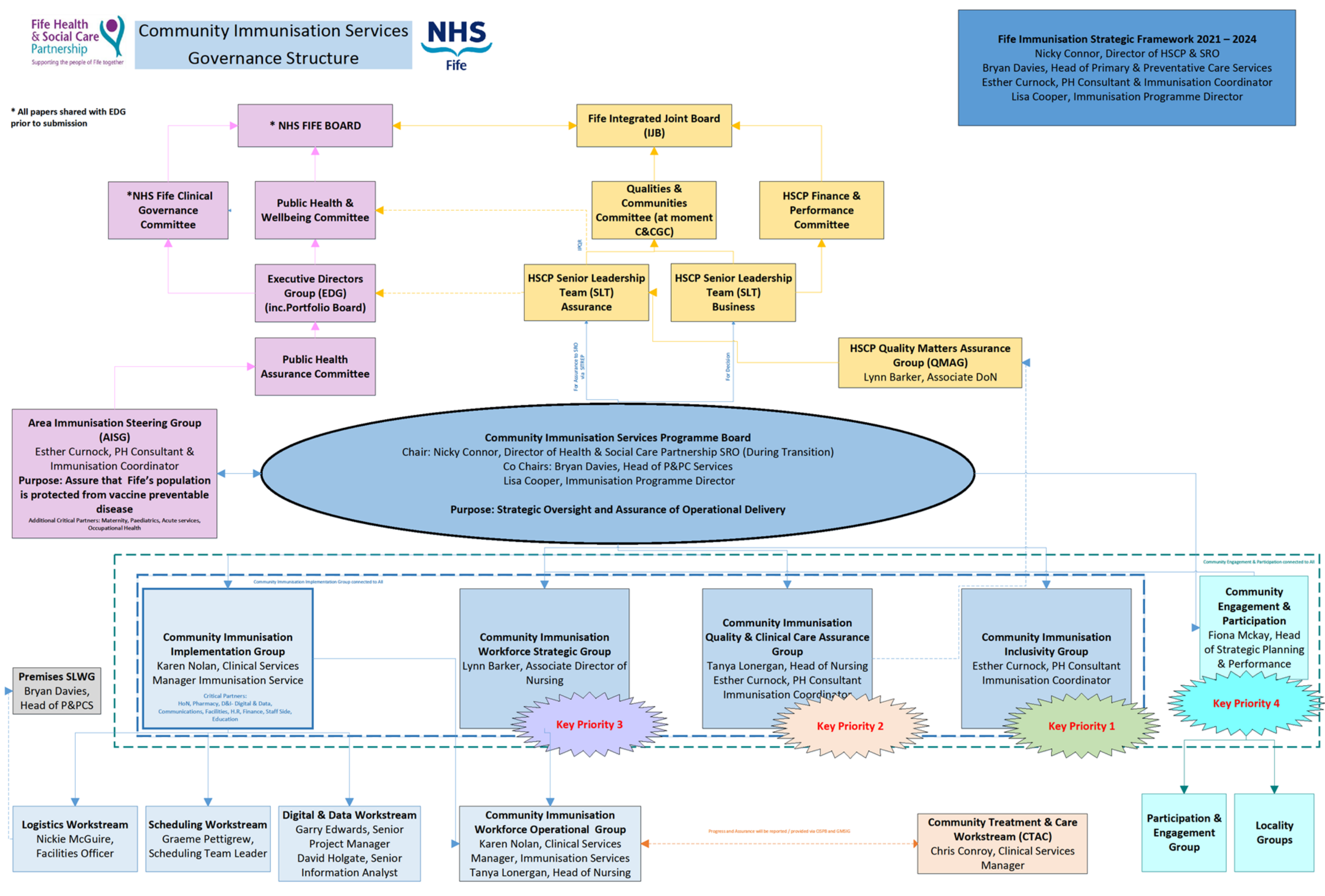
Appendix 2 - Community Immunisation Services Governance Structure



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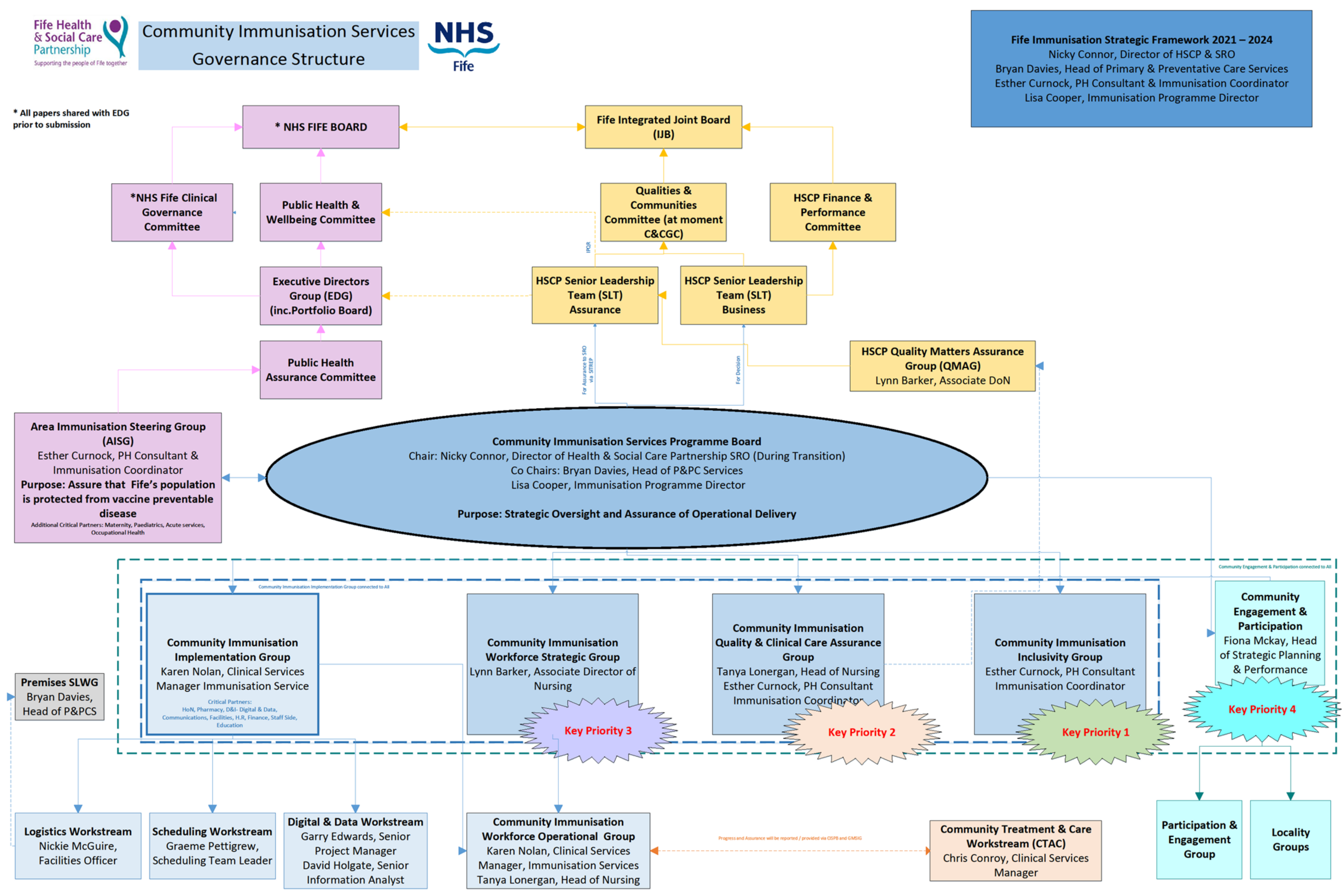
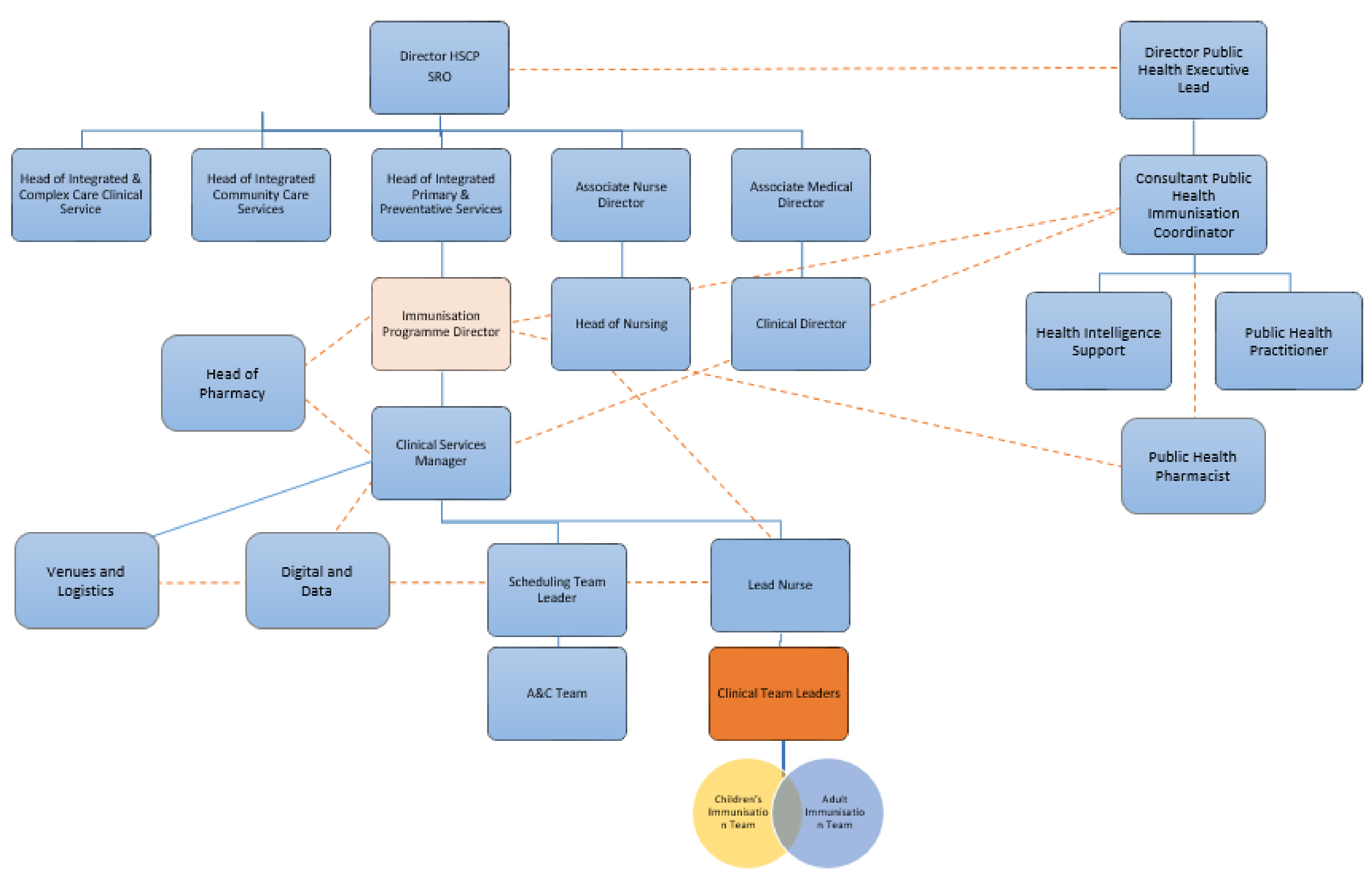
Annex C: Fife Community Immunisation Service Governance Structure



Annex D Fife Community Immunisation Service Leadership & Management Structure



NHS Fife

Meeting:	**Public Health & Wellbeing Committee**
Meeting Date:	**16 May 2022**
Title:	**Briefing Paper on NHS Scotland Policy for Climate Emergency and Sustainable Development**
Responsible Executive:	**Neil McCormick, Director of Property & Asset Management**
Report Author:	**Neil McCormick, Director of Property & Asset Management**

1 Purpose

This is presented to the Public Health & Wellbeing Committee for:

- Assurance
- Discussion
- Decision

This report relates to:

- National Health & Wellbeing Outcomes

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

- Effective

2 Report Summary

2.1 Situation

The revised policy for NHS Scotland on the Climate Emergency and Sustainable Development DL (2021) 38 is now extant. This sets out mandatory requirements for all NHS bodies and its scope extends to all of their activities. It also states that NHS Scotland bodies must co-operate with each other with a view to achieving the aims of the policy.

The supporting Draft NHS Scotland Climate Emergency and Sustainability Strategy 2022-2026 is out for consultation (see Appendix 1 for structure of the draft Strategy). The draft Strategy implements a national Climate Emergency and Sustainability Board, to be chaired by the CMO. The membership of the Board includes a representative from each of the 3 Regions and from the National Boards.

The paper is circulated for member awareness, discussion and approval of the governance arrangements and approach to resourcing to support the formulation of a plan to develop NHS Fife's approach to the Policy and Strategy.

2.2 Background

The key National Policy developments to highlight are listed below:

- The NHS target on net-zero carbon has been amended from 2045 to 2040.
- All Health Service owned buildings to be heated by renewable sources by 2038 at the latest. Scottish Government to invest £250m in this parliament term to support the transition.
- Policy for NHS Scotland on the Global Climate Emergency and Sustainable Development DL(2021)38 launched. This Policy Statement supersedes CEL 2 (2012) 'A Policy on Sustainable Development for NHS Scotland 2012'.
- The supporting 'draft NHS Scotland Climate Emergency and Sustainability Strategy 2022 to 2026' consultation was launched which sets out the aims, targets and actions to be undertaken across the Health Service. Consultation is now open with responses due 10 February.
- Scottish Government has requested annual reports on Sustainability, additional to the current requirements to report in relation to Climate Change (Carbon Emissions reports) and the National Sustainability Assessment Tool (NSAT). New reporting requirements are expected to commence October 2022, to update on progress against the NHS Scotland Climate Emergency and Sustainability Strategy.
- The draft Strategy includes an NHS Scotland Climate Emergency and Sustainability Board to be chaired by Dr Gregor Smith, Chief Medical Officer and John Burns, NHSS COO. The Board will oversee implementation of the Strategy, detailed in letter of 10 November to NHS Chairs and Chief Executives.
- Membership of the Board includes the Chairs of the Regional Climate Emergency and Sustainability Groups supporting Health Facilities Scotland National Environment and Sustainability Group (NESG).

Appendix 2 details the proposed Governance Arrangements for NHS Fife.

2.3 Assessment

The Policy and draft Strategy are a significant and welcome step forward for NHS Scotland. They contain a clear list of action areas. These actions are related to the UN Sustainable Development Goals.

The draft Strategy is more comprehensive than previous NHS Scotland Sustainability Strategies. It includes a section on Sustainable Care as a specific area and a much stronger emphasis on Climate Adaptation and resilience with resilience being a cross cutting theme of all action areas.

The proposed draft Strategy sets out actions across the whole of the NHS carbon footprint and includes wider environmental impacts.

The Policy specifies the following requirements for NHS Boards.

- Each NHS Scotland body must appoint an Environmental Management Representative (EMR) with the responsibility, resources and authority to implement this policy in respect of environmental management.
- Each NHS Scotland body must appoint a Waste Management Officer with the responsibility, resources and authority to implement this Policy in respect of waste. The Waste Management Officer must have responsibility for all aspects of waste management within the organisation consistent with the Scottish Government's commitments towards zero-waste and a circular economy.
- Each NHS Scotland body must appoint an officer with the responsibility, resources and authority to implement this Policy in respect of green space and bio-diversity.
- Each NHS Scotland body must appoint an officer with the responsibility, resources and authority to implement this Policy in respect of travel.
- Each NHS Scotland body who provide clinical services must include a Sustainable Care Medical Planning team as part of its Climate Emergency and Sustainability Team.

There is recognition that within these overall requirements, there will be variation in implementation reflecting difference in the size and scale of NHS Boards.

Notwithstanding the need to develop core capacity and expertise within each NHS Board as above, there is an opportunity for shared learning and shared development of expertise across the East Region. In order to support this collaboration, an East Region Climate Emergency and Sustainability Group is proposed with membership from the executive leads in each Board and other relevant colleagues. Board leads met in January to discuss the opportunities for collaborative working and contributing to and influencing the national work. The proposed Terms of Reference are attached at Appendix 2.

The initial priorities for sharing capacity and expertise have been identified as follows:

- Climate Change Adaptation and Risk Assessment
- Green space and Biodiversity
- Sustainable Travel Planning
- Environmental Management System requirements

An immediate action for the Regional Group is to carry out a gap analysis of current resources and progress against the actions in the draft Strategy.

There is also a need to identify the Climate Change and Sustainability priorities within the East Region Planning Programme as a whole.

2.3.1 Quality/Patient Care

The improvement of primary care premises could bring benefits to the quality and sustainability of patient care and access to services.

2.3.2 Workforce

An increase in our dedicated and specialist workforce will be required to implement the Climate Emergency and Sustainability Policy, specifically in respect of the roles required by the Policy set out above.

As indicated above, sharing skills and technical expertise in relation to Climate Change and Sustainability presents a key opportunity for a regional approach.

There will be requirements to develop the roles, knowledge and skills of staff across the NHS to support the delivery and development of the Strategy.

Interest and commitment of staff to a Greener NHS continues to grow and there are clear synergies and opportunities in relation to staff health and wellbeing, for example in relation to active travel, access to green space and positive staff engagement.

The expectation is that Directors be kept updated and engaged through the delivery of key parts of the Strategy as identified below. This approach will encourage collective ownership and system leadership and will enhance discussions and decision making.

<table>
<tr><th>Executive Director</th><th>Executive Input to Objective</th><th>Role (to be further developed)</th></tr>
<tr><td>Director of Property & Asset Management</td><td>Lead</td><td>Proposed Role is lead Executive and will create management time and capacity to co-ordinate the strategy on a day-to-day basis. In addition will take responsibility for sustainable buildings and land, sustainable travel and reporting progress.</td></tr>
<tr><td>Director of Public Health</td><td>Contributor</td><td>Proposed role is Board Champion and will ensure that the Board is aware of the key priorities and responsibilities within the strategy.
Also lead for the development of sustainable communities and adapting to climate change impacts.</td></tr>
<tr><td>Medical Director</td><td>Contributor</td><td rowspan="5">Leading and developing the thinking and models around Sustainable Care for the future including:

• Sustainable Care Pathways
• Reducing harm and waste
• Medicines
• Green theatres
• Supporting Primary Care</td></tr>
<tr><td>Director of Nursing</td><td>Contributor</td></tr>
<tr><td>Director of Acute Services</td><td>Contributor</td></tr>
<tr><td>Director of Health & Social Care Services</td><td>Contributor</td></tr>
<tr><td>Director of Pharmacy & Medicines</td><td>Contributor</td></tr>
<tr><td>Director of Finance & Strategy</td><td>Contributor</td><td>Lead for Sustainable Goods and Services (circular economy) and consideration for PMO support for the programme and reporting regime.</td></tr>
<tr><td>Director of Workforce</td><td>Contributor</td><td rowspan="2">Lead for engaging NHS Fife staff and ensuring that Climate Emergency and Sustainability are at the heart of all that we do including staff training, awareness and communication.</td></tr>
<tr><td>Employee Director</td><td>Contributor</td></tr>
</table>

2.3.3 Financial

Additional posts will be required in line with the Policy and to support the delivery of the strategy.

All NHS Boards were asked by NESG to submit their resource requirements for posts required for implementation of the Strategy. Funding for delivery of the Policy and Strategy in relation to these requirements is being considered by NHS Scotland SG Health Infrastructure, Investment and PPE Division.

The following additional resources are required by the Policy:

Environmental Management Representative (EMR)	To be identified once role further understood.
Waste Management Officer (WMO)	NHS Fife has a WMO in place.
Greenspace and Biodiversity Officer	A Student Internship is proposed over the summer to take forward some key work in this area (cost c£8k to be managed within existing budgets). NHS Fife has identified a Consultant to support in this area who has been involved with Fife Council in creating Greener Kirkcaldy and Greener Dunfermline projects.
Green Travel Officer	NHS Fife has a part-time Transport/Fleet Manager. This will be replaced by a single post following the impending retirement of the current incumbent. A Student Internship is proposed over the summer to take forward some key work in this area (cost c£8k to be managed within existing budgets). NHS Fife is also planning on setting up a separate SLWG with a view to looking at an EV Charging Strategy for Fife for staff and patients and to investigate funding routes to support this.
Sustainable Care Planning Team	To be identified once the role is further understood.

In addition, the following posts already exist within NHS Fife and will have changed priorities:

Estates Manager - Compliance	This role will be extended to allow further management time for managing the programme.
Estates Officer - Sustainability	This role will be focused on Carbon Reduction and Energy Management. Capacity will be created through the use of a Bill Management Service to free up management time (cost c£10k per year).

2.3.4 Risk Assessment/Management

The key risks to NHS Fife are currently:

- Compliance with existing and new legislation across the spectrum of sustainability, in particular 2040 and interim carbon reduction targets.
- Public/staff/political perception if we are not able to accurately outline our journey to net zero and our relative progression year on year.

2.3.5 Equality and Diversity, including Health Inequalities

An impact assessment has not been completed.

2.3.6 Other Impact

Global population, health and environment.

2.3.7 Communication, Involvement, Engagement and Consultation

Discussions continue with Fife Council and at an East Region level with NHS Lothian and NHS Borders to identify areas of sharing, learning and collaboration to support NHS Fife in taking this agenda forwards.

It is proposed that an initial Communication Plan will be developed to include internal and external stakeholders as part of the Addressing Climate Emergency Board work with Fife Council. Our own Communications team will be part of that work.

2.3.8 Route to the Meeting

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

- Portfolio Board on 17 March 2021

2.4 Recommendation

The paper is circulated for member assurance, discussion and approval of the governance arrangements and approach to resourcing in order to support the formulation of a plan to develop NHS Fife’s approach to the Policy and Strategy.

3 List of Appendices

The following appendices are included with this report:

- Appendix 1 - Structure of the NHS Scotland Climate Emergency and Sustainability Draft Strategy

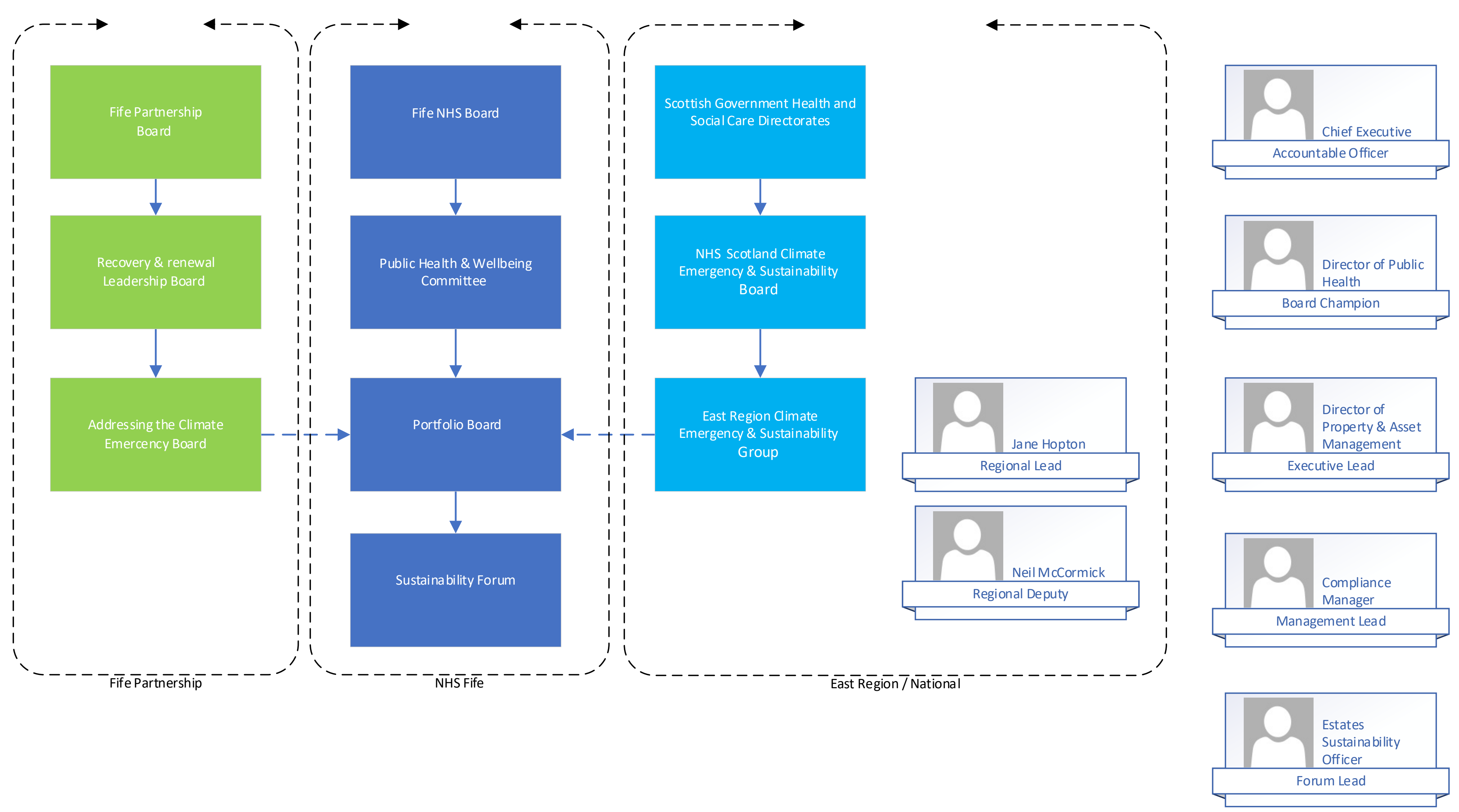
- Appendix 2 - Proposed Governance Arrangements

Report Contact
Neil McCormick
Director of Property & Asset Management
Email neil.mccormick@nhs.scot

Appendix 1: Structure of the NHS Scotland Climate Emergency and Sustainability draft Strategy: Action Areas and Themes

Sustainable Buildings and Land		Actions
	Reducing our building emissions	7
	Adapting to climate change impacts	14
	Environmental Stewardship (includes waste management)	14
	Valuing protecting and managing our green space	8
	Sustainable Development of the NHS estate	9
Sustainable Travel		
	Reducing the need to travel	6
	Promoting active travel	4
	Promoting public and community transport	3
	Decarbonising our fleet and business travel	8
	Climate change and access (transport resilience)	2
Sustainable Goods and Services (circular economy)		
	Embedding circularity within our supply chains	5
	Reducing the impact of our supply chains	16
	Supply chain resilience	4
	Minimising our waste	2
Sustainable Care		
	Sustainable care pathways	6
	Reducing harm and waste	3
	Medicines	8
	Green theatres	7
	Supporting primary care	5
Sustainable Communities		
	Supporting health and well-being	8
	Building community resilience	6
	Engaging our communities	5
Reporting Progress		

Appendix 2: Proposed NHS Fife Governance Arrangements



Meeting:	**Public Health & Wellbeing Committee**
Meeting date:	**16 May 2022**
Title:	**Kincardine and Lochgelly Health and Wellbeing Centre – Outline Business Cases**
Responsible Executive:	**Joy Tomlinson, Director of Public Health**
Report Author:	**Ben Johnston, Head of Capital Planning**

1 Purpose

This is presented to the Public Health & Wellbeing Committee for:

- Approval

This report relates to a:

- Business Case

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

- Safe
- Effective
- Person Centred
- Sustainability

2 Report summary

2.1 Situation

The purpose of this paper is to present the Outline Business Cases for the Kincardine and Lochgelly Health and Wellbeing Centres.

2.2 Background

The Initial Agreements for these projects were approved by the Scottish Government in January 2020. The project development process was then paused due to the global pandemic and the Outline Business Case stage commenced in earnest with associated project governance around March 2021.

The projects were initiated to tackle the following key needs for change:

- Restricted access to local clinical services
- Constrained ability to provide integrated care models
- Inability to increase accommodation to offer capacity to meet demand
- Current accommodation does not meet modern standards
- Safety and operational issues resulting from ongoing maintenance requirements

These needs for change are recognised by the Scottish Government's Place Based Needs Planning tool which places Kincardine and Lochgelly within the "top 3" primary care facilities requiring investment and improvement within Fife's portfolio.

The vision for primary care and community services in NHS Fife and Fife Health and Social Care Partnership is to enable the people of Fife to live independent and healthier lives. We will deliver this by working with people to transform services to ensure these are safe, timely, effective and high quality, focused on achieving personal outcomes. This requires access to the right professional at the right time in the right place; where services can be provided within a community setting, closer to where service users live. Care should be provided in an environment that supports staff to provide an excellent experience and has modern facilities that meet the needs and expectations of service users, carers and staff well into the late 21st century.

2.3 Assessment

Within the Outline Business Case stage the following key activities have taken place.

- Development of the services and requirements taking account of General Medical Services (GMS) contract obligations
- Initial work around tests of change and service re-design based on the patient's perspective (ongoing)
- Development of the schedule of accommodation to align with the updated service requirements
- Public engagement to capture end-user views and expectations on what the facilities might deliver
- Development of the outline design proposals
- Development of the associated costs

2.3.1 Quality/Patient Care

Quality and patient care are at the forefront of this important work as we are fundamentally seeking to deliver an appropriate compliment of integrated services locally within modern facilities. This has and will continue to progressively be delivered though two key workstreams.

Service

The service will concentrate on maximising the benefits of new accommodation through exploring service re-designs, integration opportunities and new ways of working to support the patient's needs. The Project Team will work with stakeholders including the public, local community and services to define operating models for the new facilities. These operating models will create a blueprint of how the facilities should function and form a basis for the change, improvement, integration and test of change work. This process will make use of a variety of strategic change and improvement methodologies (e.g. Systems Thinking principles, Service design, Process Improvement/Lean) as we as use the Patient Personas & Pathways work already undertaken. This will ensure service business perspectives, as well as patient/service user perceptions and journeys, both inform the service redesign process. This workstream has commenced but will continue through the Full Business Case and construction stages of the projects.

Design & Construction

The facilities to date have been designed around briefing from the services in respect to their needs and around the design statement which was generated at the initiation of the project.

Furthermore, the facilities will be designed in accordance with all statutory regulations and relevant healthcare guidance. Critical friend key stage reviews will take place by NHS Scotland Design Assessment Process (NDAP) and NHS Assure ensuring that the facilities are compliant and fit for operational use.

2.3.2 Workforce

The expected staff environment was briefed as part of the design statement process. Taking account of these requirements and embedding them into the design, it can be said that the facilities will offer excellent places to work, develop and rest.

There is likely to be changes to the working culture with a more agile environment being offered for office spaces. This will allow space within the asset to maximised and used flexibly by multiple services. This cultural change will be worked through as part to the re-design work.

Operational (FM) workforce requirements and costs have been estimated within the Outline Business Case.

The clinical/business support workforce and costs have been established and set out within the Outline Business Case. These will be further refined and tuned during the Full Business Case stage as the detailed service re-design work progresses and operating

models are agreed upon. This element will be responsibility of the HSCP via the Project Team.

2.3.3 Financial

Capital

The project costs have increased significantly since the Initial Agreement where initial budget costs were established. The key reasons for this are:

- More maturity around GMS requirements leading to an increase in building area.
- Volatile market conditions with an excessive inflationary impact
- More stringent sustainability/energy requirements.
- Site survey/investigation information being incorporated into the design

The capital cost position for each project is summarised in the table below (inclusive of VAT):

	IA Budget	**Current (OBC) Budget**	**Difference**
Kincardine	£4,656,975	£7,817,528	£3,160,553
Lochgelly	£8,155,615	£13,031,178	£4,875,563

Despite the increases in capital cost, given the mitigating circumstances the projects are considered to represent value for money in the current market place and this view has been upheld by our independent Lead Advisors who have helped us to interrogate and understand the cost movements.

Revenue

The estimated revenue costs are noted in the table below for each project.

Kincardine			
Description	**Baseline**	**Preferred Option**	**Difference**
Property pays (NHSF)	£12,605	£33,474	£20,869
Property non-pays (NHSF)	£16,612	£76,550	£59,938
Property non-pays – GP offset (NHSF)	-£16,584	-£27,142	-£10,558
Net Increase (NHSF)	**£12,633**	**£82,882**	**£70,249**
Service model		£31,500	-

(FHSCP)			

Lochgelly			
Description	**Baseline**	**Preferred Option**	**Difference**
Property pays (NHSF)	£24,467	£75,566	£51,099
Property non-pays (NHSF)	£61,920	£178,330	£116,409
Property non-pays – GP offset (NHSF)	-£37,718	-£83,165	-£45,448
Net Increase (NHSF)	**£48,670**	**£170,731**	**£122,061**
Service model (FHSCP)		£724,500	-

- NHS Fife's revenue costs have increased from the baseline primarily due to the increase in the size of the facilities.
- The revenue costs relating to the service model continues to be developed in consultation with the Scottish Government around MOU1/2 for urgent care and what Multi-Disciplinary Teams (MDT) means for Fife. The service model costs will have a nil impact on the revenue outturn position as funding sources have been identified.

2.3.4 Risk Assessment/Management

A risk register has been prepared for the projects and is appended to the Initial Agreement itself.

For each project, to cover risk from a financial position at this stage, Hubco have retained 5% to cover further inflation and some design development. At the end of the Full Business Case stage their risk provision is capped at 1%.

From NHS Fife's perspective, for each project, 13% has been retained at this stage in the process. An optimism bias matrix has been completed to substantiate the maturity of the projects and this resulting allocation.

Two key risks arising should be highlighted and noted – these are:

1. NHS Key Stage Review: the key stage review has been undertaken however the draft report from NHS Assure is delayed. The comments may have an impact on cost/programme depending on the findings.
2. Sustainability: the project briefing in respect to sustainability was established using the Building Research Establishment Evaluation Assessment Method (BREEAM) 2018 tool (current at the time of project implementation), however Scottish Government and Health Facilities Scotland have recently stated that the projects must be assessed during Full Business Case against SHTN 02-01 Sustainable Design and Construction Guide (SDaC). This guidance incorporates a new sustainability tool that is untested so the possible effects on the projects are difficult to quantify. That's said, Scottish Government are mandating the use of the tool so will need to be aware and accept any associated cost escalation through it's use.

2.3.5 Equality and Diversity, including health inequalities

Stage 1 of the Equality Impact Assessment (EQIA) has been completed. Stage 2 will be developed during the Full Business Case stage.

2.3.6 Other impact

Not applicable.

2.3.7 Communication, involvement, engagement and consultation

A communication engagement plan has been prepared for the projects – this is a live document and will be updated progressively as the projects develop.

During the Outline Business Case stage the following key pieces of engagement have taken place.

- Public engagement survey
- GP's integrated into design process
- Public representation during design process
- Public representation groups established
- Service communication and engagement meeting established
- Attendance at Councillor ward meetings
- Staff and public attendance at Achieving Excellence Design Evaluation Toolkit (AEDET) workshops

2.3.8 Route to the Meeting

The governance route for the IJB has been affected by the political process and Purdah. The H&SCP and IJB governance routes are outlined below. Discussions about the Lochgelly and Kincardine developments have taken place with the IJB members at IJB

meetings. An event being planned for June 2022 will form part of on-going engagement around the model as it is refined.

Governance milestones noted below:

Project Board – complete
H&SCP Transformation Board updates January and March 2022 – complete
NHS Fife, FCIG: 27 January 2022 – complete
H&SCP SLT Business 21st February 2022 – complete
NHS Fife, Portfolio Board: 17 March 2022 – complete
NHS Fife, FP&R: 10 May 2022
NHS Fife Public Health & Wellbeing Committee – 16 May 2022
NHS Fife, Board: 31 May 2022
SCIG Submission: 18 May 2022
SCIG Meeting: 29 June 2022
IJB Briefing Session to be held in June 2022

2.4 Recommendation

This case for change remains. The health centres are required to offer a full range of integrated health services locally within an appropriate environment.

In addition, these two initial health centres will act as exemplar facilities on which to establish a wider primary care premises strategy in Fife. Work regarding this strategy is also underway separately.

The capital costs for the health centres have increased since the Initial Agreement stage. There are key reasons for these increases, but importantly, in today's marketplace, the facilities represent value for money.

For these reasons we recommend that the Outline Business Cases are supported to allow swift development of the Full Business Cases in advance of construction delivery.

3 List of appendices

- Kincardine Outline Business Case
- Lochgelly Outline Business Case

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Kincardine Health and Wellbeing Centre

Outline Business Case

20 April 2022, Rev. 5

VERSION CONTROL

Draft R.0	29.09.21	First OBC Draft
Draft R.1	03.12.21	Updated Draft
Draft R.2	11.01.22	Updated Draft – Ben Johnston
Draft R.3	16.02.22	Updated Draft to incorporate FCIG comments – Ben Johnston
Draft R.4	28.03.22	Updated Section 4.4.14 – Ben Johnston
Draft R.5	20.04.22	Updated risks Section 1.4 and 4.5.2 – Ben Johnston

Contents

1 Executive Summary 8
1.1 Introduction 8
1.2 Strategic Case 8
1.3 The Economic Case 11
1.4 The Commercial Case 12
1.5 Financial Case 13
1.6 Management Case 15
2 Strategic Case 16
2.1 Introduction 16
2.2 Revisiting the Strategic Case 16
2.3 Current Arrangements 16
2.4 Strategic Context 25
3 Economic Case 39
3.1 Introduction 39
3.2 Revisiting the Economic Case 39
3.3 The Do Nothing/Do Minimum Option 39
3.4 Stakeholder Engagement 40
3.5 Service Change Proposals 44
4 Commercial Case 53
4.1 Introduction 53
4.2 Revisiting the Commercial Case 53
4.3 Procurement Strategy 53
4.4 Scope and Content of Proposed Commercial Arrangements 54
4.5 Risk Allocation 62
4.6 Payment Structure 64
4.7 Contractual Arrangements 65
5 Financial Case 67
5.1 Introduction 67
5.2 Revisiting the Financial Case 67
5.3 Financial Model (costs and associated funding for the project) 67
5.4 Accounting Treatment 72
5.5 Financial Situation and Statement of Affordability 72
5.6 Stakeholder Support 73
5.7 Resources 73
5.8 Capital and Revenue Constraints 73
5.9 Financial Contributions 73
6 Management Case 74
6.1 Introduction 74

6.2 Revisiting the Management Case 74
6.3 Reporting Structure and Governance Arrangements 74
6.4 Project Board 75
6.5 Project Team 79
6.6 Project Plan and Key Milestones 80
6.7 Change Management Arrangements 80
6.8 Benefits Realisation 80
6.9 Risk Management 82
6.10 Commissioning 83
6.11 Post Project Evaluation 83
Appendix A - Strategic Assessment 85
Appendix B – Design Statement 86
Appendix C – Design Pack 87
Appendix D – Benefits Register 88
Appendix E – Benefits Realisation Plan 89
Appendix F – Risk Register 90
Appendix G – Stakeholder Engagement & Communication Plan 91
Appendix H – The Patient Perspective 92

Glossary of Terms

ADAPT	Alcohol and Drug Abuse Prevention & Treatment
ADB	Activity Data Base
AEDET	Achieving Excellence Design Evaluation Toolkit
A&DS	Architecture & Design Scotland
BEP	Building Information Modelling Execution Plan
BIM	Building Information Modelling
BPC	Benefit Point Cost
BREEAM	Building Research Establishment Environmental Assessment Method
BRUKL	Building Regulations UK Part L
BSL	British Sign Language
CAB	Change Advisory Board
CDM	Construction (Design and Management)
CHaWS	Community Health and Wellbeing Sub-group
CHD	Coronary Heart Disease
CLD	Community Learning & Development
COPD	Chronic Obstructive Pulmonary Disease
CTAC	Community Treatment & Care
DBDA	Design and Build Development Agreement
DSM	Dynamic Simulation Model
DVLA	Driver and Vehicle Licensing Agency
EIR	Employers Information Requirements
FASS	Fife Alcohol Support Service
FBC	Full Business Case
FHSCP	Fife Health & Social Care Partnership
FVA	Fife Voluntary Action
GIFA	Gross Internal Floor Area
GMS	General Medical Services
GP	General Practitioner
HAI	Healthcare Associated Infection
HAI SCRIBE	HAI System for Controlling Risk in the Built Environment
HFS	Health Facilities Scotland
HHG	High Health Gain

HIS	Healthcare Improvement Scotland
HV	Health Visiting
IA(D)	Initial Agreement (Document)
IJB	Integration Joint Board
ISD	Information Services Division
LAC	Local and Community
L&D	Learning & Development
M&E	Mechanical and Electrical
MDT	Multi Disciplinary Team
MOU	Memorandum of Understanding
NCM	National Calculation Methodology
NDAP	NHSScotland Design Assessment Process
NPC	Net Present Cost
NSS	National Services Scotland
OBC	Outline Business Case
PA	Per Annum
PBA	Project Bank Account
PPD	Practice & Professional Development
PPE	Post Project Evaluation
PSCP	Principal Supply Chain Partners
QOF	Quality Outcome Framework
RAG	Red Amber Green
RIBA	Royal Institute of British Architects
SA	Strategic Assessment
SCIM	Scottish Capital Investment Manual
SFT	Scottish Futures Trust
SIMD	Scottish Index of Multiple Deprivation
SoA	Schedule of Accommodation
SPARRA	Scottish Patients at Risk of Readmission and Admission
SRO	Senior Responsible Officer
STAND	Dementia Friendly Fife
STAR	Stop Think Assess Respond/Report/Refer Method
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 1981
VfM	Value for Money

WBP	Weighted Benefit Points
WLC	Whole Life Cost
WFVF	West Fife Villages Forum
WTE	Whole Time Equivalent

1 Executive Summary

1.1 Introduction

Fife Health and Social Care Partnership is working with local communities, teams and stakeholders to support the delivery of a fully integrated 24/7 community health and social care model that ensures sustainable, safe, individual partnerships of care. The purpose of this outline business case (OBC) is to seek approval to develop the full business case (FBC) to re-provide Kincardine Health Centre in purpose designed facilities whilst making provision for a holistic offer of local health and wellbeing services to fulfil the General Medical Services (GMS) contract[1] requirements.

The OBC establishes the need for investment, building on the NHS Fife and Fife Health and Social Care Partnership (FHSCP) strategic goals to deliver a model of local care, focused on individual outcomes, supported by health and social care delivered by the right person in the right place at the right time. It describes the appraisal of a long list of options, identifies the short list, and recommends a preferred way forward to enable the delivery of Fife's Community Health and Wellbeing Hub model within the Kincardine community. The OBC's commercial, financial and management cases have been developed further to identify how the project can be practically delivered.

The vision for primary care and community services in NHS Fife and Fife Health and Social Care Partnership is to enable the people of Fife to live independent and healthier lives. We will deliver this by working with people to transform services to ensure these are safe, timely, effective and high quality, focused on achieving personal outcomes. This requires access to the right professional at the right time in the right place; where services can be provided within a community setting, closer to where service users live. Care should be provided in an environment that supports staff to provide an excellent experience and has modern facilities that meet the needs and expectations of service users, carers and staff well into the late 21st century.

1.2 Strategic Case

1.2.1 Current Arrangements

Kincardine Health Centre, located on the edge of the village, provides General Medical Services through Clackmannan and Kincardine Medical Practice who are contracted by NHS Forth Valley, as part of a two centre practice arrangement. Community services are provided by both NHS Fife (including District Nursing, Health Visiting and Podiatry) and NHS Forth Valley (the majority) for Kincardine residents. Services are working to deliver high quality person-centred health and social care services in a way which promotes and enhances the health and wellbeing of the people of Fife.

The Kincardine Health Centre Practice population is circa 3,200, the locality population is predicted to grow by 9% in the 25 years. However, the population in the older age group is projected to increase by 52%, this will see the proportion of the practice population who are frail, whom our local care model has demonstrated benefit from integrated holistic care management, grow from 4% to 5%.

[1] GMS contract: 2018 - gov.scot (www.gov.scot)

The current facility is a 1930's construction, originally built as a police station. Models of care have changed over time with the building considerably modified and extended throughout its lifetime. Our new model of working requires accommodation that is fit for purpose, which enables multi-disciplinary and group working, which supports the community and partners to deliver collaboratively. The current building and configuration is not fit for purpose, the building does not work for modern health and social care delivery, with corridors and treatment rooms which do not meet minimum standards, areas which do not enable disabled access and no storage.

The development of the health and wellbeing model and delivery of the new GMS contract is constrained by structural and layout constraints. All possible reasonable changes have been made to the existing building. Kincardine Health Centre fails to meet the spatial, organisation and design standards for Primary and Community Health Care premises and has no capacity for further growth. Major improvements to address maintenance and statutory standards will not facilitate significant improvements in space utilisation to meet patient quality, staff standards and efficiency objectives.

1.2.2 The Patient Perspective

It has been recognised for many years, service providers across Scotland and the UK have planned care separately in different parts of the system including primary, community, acute care and mental health. Services have often been planned around buildings, individual service providers or even clinicians.

What is now proposed is a shift toward an overarching whole systems model which focuses on the needs of people who use the different health and social care services within the Kincardine Practice. This is described as a more holistic community health and wellbeing approach.

The central underlying principle of the development of the new centre is to focus on the patient outcomes, their journey and experience. This will help to identify where service improvements are necessary and involve a wide range of service users and providers in analysing and redesigning improved patient pathways to positively impact on outcomes.

The agreed way forward was to develop patient personas and pathways to enable the patient perspective and journey to be captured. We have identified seven people (personas) who typify patients or people who use the Kincardine Practice and whose care represents key requirements and challenges for NHS Fife, FHSCP and partners. The personas and pathways in this document were developed in using local profile and practice data as well as in collaboration with a range of clinical services, community and voluntary sector partners.

We have used the personas to illustrate pathways and through mapping their care needs - we can agree how they can be met more effectively and efficiently. A designed and managed process of patient and service provider engagement including wider public involvement has taken place and is expected to shape development of the new centre – moving from the traditional medical model to a more holistic community health wellbeing service model of delivery.

The Health & Wellbeing Model was developed by change and improvement colleagues in NHS Fife and FHSCP. This is illustrated below.

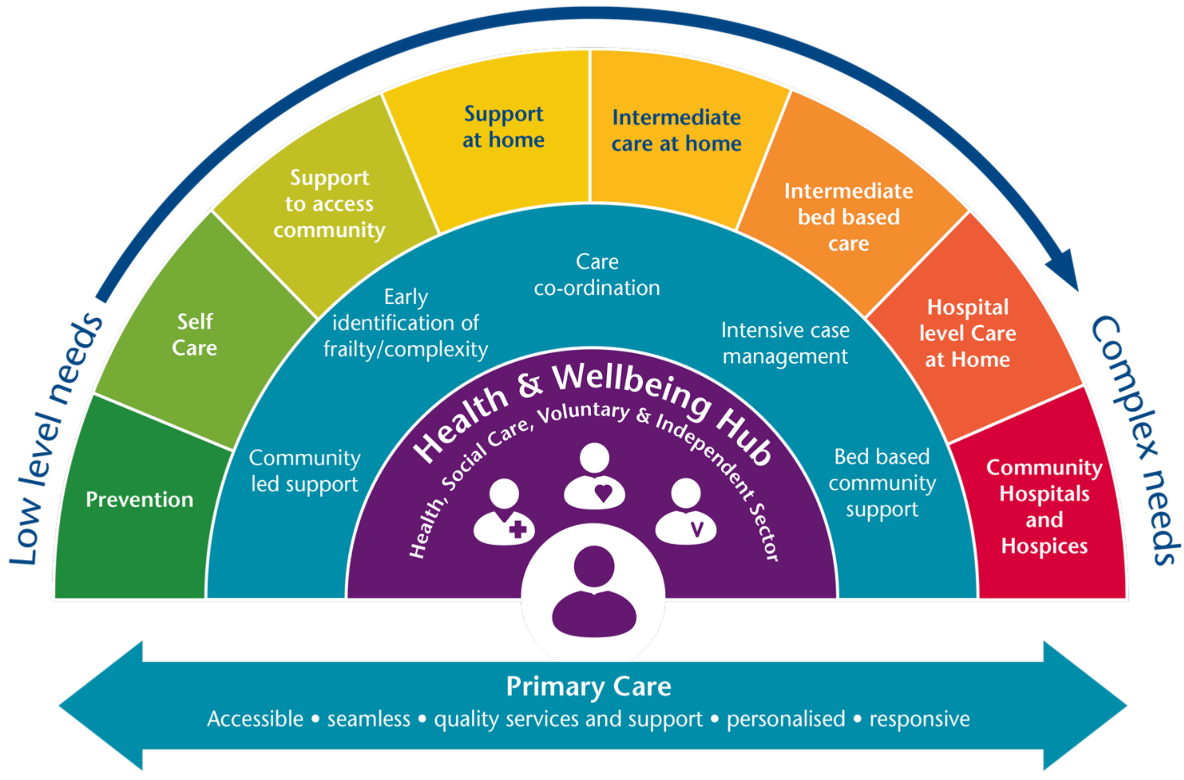

Figure 1 - Health and Wellbeing Model

The Project Team is using the Patient Personas & Pathways to look at possible improvements through a number of tests of change. This workstream has commenced but will continue through the FBC and construction stages of the project.

1.2.3 The Need for Change and Investment Objectives

The drivers for change and developed Investment Objectives to enable this change are set out in the table below. Associated benefits are set out in Section 2.4.4.

Effect of the need for change on the organisation:	Investment Objectives
Existing service arrangements are affected by lack of clinical support service facilities.	Ensure equal access to a patient centred approach by enabling delivery of and access to local anticipatory and preventative care for patients.
Implementation of integrated models of care is undeliverable locally in the current environment	Ensure equal access to modern integrated care with provision driven by patient need rather than limitations in physical capacity.
Pressure on existing staff, accommodation and services will inevitably increase.	Ensure the right staff skill mix and service capacity are available to deliver and strengthen local capacity to manage people's health within the local community.
The facilities available, 100% occupancy, combined with significant population change, restrict the ability of	Enable earlier access to proactive and anticipatory care through local delivery via

the parties to deliver the full range of integrated services locally.	integrated seamless service across health and social care.
Existing configuration, as a result of a 1930's building, being modified and extended with a 'best fit' approach. Current facilities have treatment rooms below minimum acceptable standards.	Delivery of safe and effective care with dignity –by providing facilities which comply with all legal standards and regulatory requirements and gives equality of access for all.
Increased safety risk from outstanding maintenance and inefficient service performance.	Improve safety and effectiveness of accommodation by improving the physical condition, quality and functional suitability of the healthcare estate.

Table 1 - Needs for Change and Investment Objectives

1.2.4 Fife Place Based Planning Tool

NHS Fife have recently been engaging with Scottish Government around their proposal to develop a longer-term primary care strategy. Scottish Government have recently developed a Place Based Needs Planning tool which helps Boards to understand their investment priorities based on community health, demographics, supporting infrastructure and the condition of the estate. Analysing the data for Fife in totality, Kincardine Health Centre has an Estate Need Score of 83 (top primary care priority), bolstering the case for change and intervention.

Property	Postcode	Intermediate Zone	Floor Area	Age	Estate Need Score
Kincardine Health Centre	FK10 4QX	Kincardine	254	91	83
Oakley Health Centre	KY12 9QH	Oakley Comrie and Blairhall	918	71	73
Lochgelly Health Centre	KY5 9QZ	Lochgelly West and Lumphinnans	822	81	70
Valleyfield Health Centre	KY12 8SJ	Valleyfield Culross and Torryburn	1,012	51	65
Path House Medical Practice	KY1 2PG	Kirkcaldy Pathhead	612	329	56
Strathmiglo Auchtermuchty Practice	KY14 7QA	Auchtermuchty and Gateside	50	59	55
Leven Health Centre	KY8 4ET	Leven East	1,624	56	53
Rosyth Health Centre	KY11 2SE	Rosyth East	946	39	47
Kelty Health Centre	KY4 0AE	Kelty East	754	60	44
Lundin Links Scoonie Medical Practice	KY8 6DB	Largo	48	59	43

Table 2 - Priority Order of Estate Need

1.3 The Economic Case

A wide range of options were developed and considered. These were then consolidated into a shortlist of options which were scored via a wide range of stakeholders. The option scores are presented below.

Investment Objective	Option 1: Status Quo	Option 2: Feregait	Option 3: Station Road	Option 4: Tuliallan School
Net present cost (NPC) - £m	723,705	6,307,702	6,368,662	6,368,662
Weighted benefit points (WBP)	221	539	509	739
BPC per WBP - £000	3,275	11,703	12,512	8,618
	Rejected	Possible	Possible	Preferred

Table 3 - Short-listed Option Scores

Option 4 scored highest in respect to benefit points. Once the net present costs were factored in, option 1 is highlighted at the lowest cost per benefits point – this is purely because of low net present cost owing to the limited capital that could be invested in the existing facility. As option 1 does nothing to tackle the needs for change as demonstrated, it is not a legitimate option but included for comparative purposes.

Given the balance of legitimate options, option 4 offers the highest benefits score and the lowest cost per benefits point, indicating that it is the strongest option. Option 4 is therefore the preferred option.

1.4 The Commercial Case

The Commercial Case has been developed significantly since IA. Key aspects contained within the commercial case are summarised below.

- The project is community focussed and more than £750k, therefore the Scottish Futures Trust hub initiative has been selected as the most appropriate route to deliver the project. The East Central hubCo have been appointed to deliver this public funded project under the design and build option.
- Currie & Brown have been appointed through the Frameworks Scotland Lead Advisor lot to support the Board with multiple services including Project Management, Cost Advisor, Technical Advisor and Clerk of Works.
- The design has been fully developed in conjunction with the Project Team and Stakeholders. With exception to the NHS NSS Design Quality Assurance and NDAP processes which are ongoing, the design has been well received through the HAI, AEDET and focussed design workshops.
- Discussions with Fife Council in respect to leasing the required land are advanced appropriately for the stage in the project. These will continue during the FBC stage with a view to concluding arrangements at the point of completing the FBC.
- The current key risks/issues facing the project are summarised in the table below:

Risk/issue	Mitigation
Brief inadequate/unreliable This issue relates to developments around the GMS contract and effect this has had on the area requirements for the building.	The required area increase from IA to OBC has been factored into the current design and corresponding cost plan.
Stop/start nature of the programme – keep people engaged through these periods.	Updates are being provided to community groups via newsletters and the public via press releases. NHS Fife's communication team are supporting this effort.
Project cost increases due to: ▪ Change in requirements ▪ Inflation / market conditions	This is a current issue where the cost increases have rose beyond the IA budget projection. Refer to Financial Case for further substantiation.
Programme delay The OBC programme has been affected because of COVID which has impacted resources, engagement activity and costs.	Potential to commence FBC activity in parallel with the OBC governance approval process. The project now has a full complement of resources to help drive the project forward.
Change of policy – NHS Assure Key Stage reviews Programme delays / cost increases arising	Key stage review process was implemented half-way through OBC and is required to achieve capital funding. Risk had to be accepted, but impact can be mitigated through collaboration.
Change of policy – SHTN 02-01 Sustainable Design and Construction Guide (SDaC) Programme delays / cost increases arising	Informed by HFS at OBC NDAP review that new guidance must be followed at FBC. Guidance is untested to impact is difficult to quantify. As such this risk has not currently been factored into OBC cost estimates.

Table 4 - Key Risk Summary

1.5 Financial Case

1.5.1 Capital Costs

A capital cost summary is provided in the table below demonstrating the total OBC estimated cost for the project, together with the movement in cost since IA.

IA	OBC	Movement
£4,656,975	£7,817,528	£3,160,553

Table 5 - Capital Cost Summary

The key reasons for the movement in cost since IA, are set out below:

- Building area increase to take account of service and GMS contract evolving requirements – accounts for circa 35% of the construction cost increase
- Inflation and extraordinary market conditions considered to driven by the COVID-19 pandemic and the resulting global effect on supply chains – accounts for circa 20% of the construction cost increase
- Site and design abnormals: this relates to site conditions, more onerous energy requirements and creating a building that satisfies the conditions of the brief and design statement – accounts for circa 45% of the construction cost increase
- Associated percentage mark-ups based on an increased construction cost
- Some further adjustments to the IA budget allowances, notably equipment and internal direct labour costs

A number of value engineering / cost saving opportunities have been identified and these have already been accounted for in the presented OBC figures above.

Notwithstanding the cost increases noted, given the current project environment, the costs are considered to represent value for money in the current marketplace and this view has been endorsed by our consultant Cost Advisor.

1.5.2 Revenue Costs

A summary of the revenue costs is provided in the table below.

Description	Baseline	Preferred Option	Difference
Property pays (NHSF)	£12,605	£33,474	£20,869
Property non-pays (NHSF)	£16,612	£76,550	£59,938
Property non-pays – GP offset (NHSF)	-£16,584	-£27,142	-£10,558
Net Increase (NHSF)	**£12,633**	**£82,882**	**£70,249**
Service model (FHSCP)	In development	£31,500	-

Table 6 - Revenue Cost Summary

The increase in cost from an NHS Fife perspective is largely associated with the increase in building area.

The revenue costs relating to the service model continues to be developed in consultation with the Scottish Government around MOU1/2 for urgent care and what MDT means for

Fife. The service model costs will have a nil impact on the revenue outturn position as funding sources have been identified.

1.6 Management Case

The Management Case identifies the actions that will be required to ensure the successful delivery of the scheme. The management case has been significantly updated for this the IA stage and demonstrates that the Board and Partnership are well prepared to deliver the project successfully during the construction phase and beyond. Key milestones for the project are identified in the table below:

Description / activity	Date
Full Business Case	
Commencement	February 2022
Completion	January 2022
Governance Approvals	April 2023
Construction & Handover	
Commencement	May 2023
Completion	June 2024
Operational	August 2024

Table 7 - Key Milestone Summary

2 Strategic Case

2.1 Introduction

The main purpose of the Strategic Case is to confirm the background and drivers for change for the proposition. It also sets out the key investment objectives and associated benefits.

2.2 Revisiting the Strategic Case

The Initial Agreement Document (IAD) was approved by Scottish Government in January 2020. The next phase involved undertaking a widespread engagement exercise with key stakeholders and the people of Kincardine. This process was paused as a result of the global pandemic and was eventually reinstated in November to December 2020. The outcome of the engagement exercise can be reviewed within the Economic Case. The recovery plan in relation to the pandemic also caused delay to timescales for the Outline Business Case and design process. However, these have since resumed at pace. There are new sections added which were not previously in the IAD including:

- The patient perspective and service integration in Section 2.4.1.2
- A summary of services (existing versus proposed) in Section 2.3.2
- A description of associated buildings and assets in Section 2.3.3

The critical success factors have been retained although are not reflected in the current Scottish Capital Investment Manual (SCIM) guidance. The residual balance of the Strategic Case has been retained and updated where necessary.

2.3 Current Arrangements

2.3.1 Service Arrangements

The holistic multi-disciplinary primary and community care services in Kincardine are currently delivered from the existing Kincardine Health Centre, a 1930's constructed facility – originally built as a residential property and then utilised as a police station - that has been considerably modified and extended throughout its lifetime. The building is owned by NHS Fife.

GP services in Kincardine are delivered as part of a two-centre practice, along with Clackmannan Health Centre, with each operational unit given equal standing and operating full time to meet their respective local needs. The GP Practice is contracted to NHS Forth Valley to provide General Medical Services.

The services delivered from the existing Kincardine Health Centre are primarily provided in support of the population needs of the people of Kincardine and surrounding areas, with 98% of the resident population registered (see figure 2 - map of Kincardine interzone) with the practice. In accordance with NHS Fife's statutory obligation to provide access to Primary Medical Services there is a requirement to continue provision of these services within this geographic area.

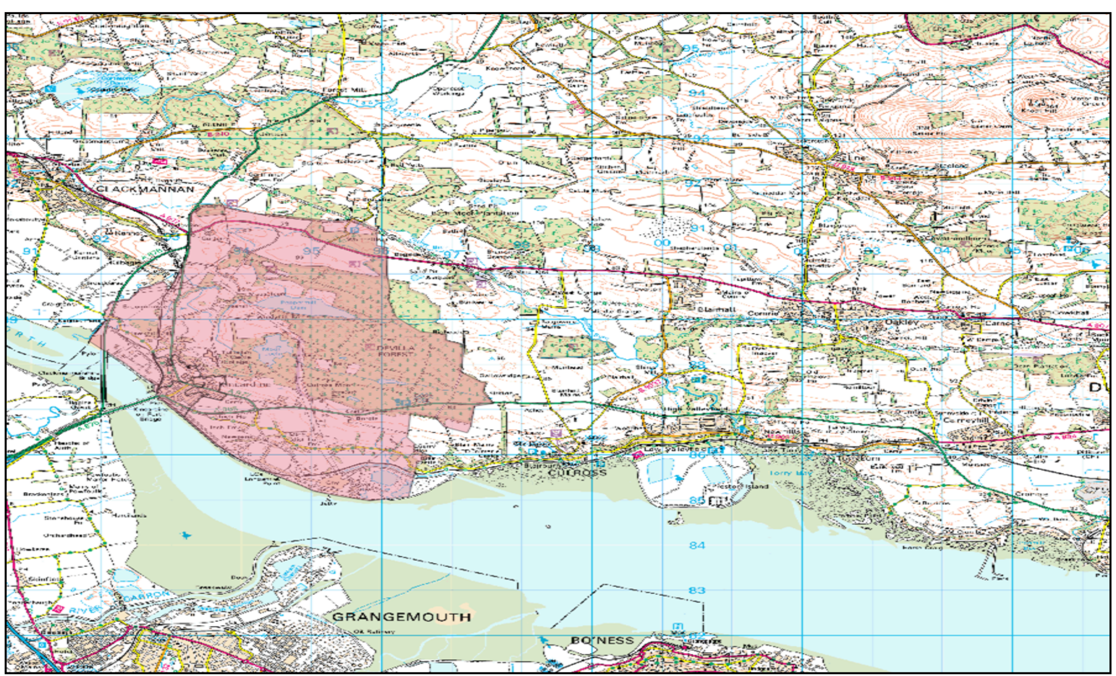

Figure 2 - Map of Kincardine Interzone

Aligned to the Practice there are a range of community health services provided from the current facility including District Nursing, Health Visiting, Midwifery and Podiatry. In addition, there are services working with the Practice and wider community team who cannot access accommodation locally, requiring patients to travel to them. This includes Mental Health Nursing and Physiotherapy. There are dependencies with the District General Hospital at Forth Valley Royal Hospital Larbert and Local General Hospital at Queen Margaret Hospital, Dunfermline, and other hospitals in the East Region for provision of diagnostic services, consultant advice, elective and unscheduled inpatient care and outpatients for a variety of specialties to meet the health care needs of their local population. The Forth Valley Primary Care Out of Hours Service and Fife's Primary Care Emergency Service provide out of hours care from other facilities.

The GPs together with the multi-disciplinary team manage the widest range of health problems; providing both systematic and opportunistic health promotion, diagnoses and risk assessments; dealing with multi-morbidity; coordinating long-term care; and addressing the physical, social and psychological aspects of patients' wellbeing throughout their lives.

The GPs and multidisciplinary team are integrally involved in deciding how health and social services should be organised to deliver safe, effective and accessible care to patients in their community. Practice based multi-disciplinary team working is identifying people who could benefit from a case management approach and supporting people to access the right support where there is:

- Complexity in their care and support arrangements through locality multi-disciplinary teams, or
- Clinical complexity rapid access to assessment through the locality community health and wellbeing hub teams

Kincardine Health Centre has a current practice population of 3285 (July 2021), which has grown by 3% over the past 18 months. The current demographic of the population are[2]:

- 50.7% female: 49.3% male
- 24% are over the age of 65 and 13.4% are 0-15 years
- 9.1% of the population are income deprived, 10.8% of the population are employment deprived and 14.4% of children (under 16) live in poverty
- 0.1% of the practice population live in the most deprived quintile and 0% on the least deprived
- 25.9% of patients of the practice have at least one long term condition

Since long-term condition data was previously not available in the IAD and the Quality Outcome Framework (QOF) is no longer in use, up-to-date long-term condition data was sourced from the Practices and Public Health Scotland using the SPARRA[3] (Scottish Patients at Risk of Readmission and Admission) tool.

Local Profile & Practice Data - Kincardine

Long Term Condition Rates	Kincardine	Fife
Arterial Fibrillation	1.78%[1]	1.92%[1]
Asthma	6.34%[1]	4.61%[1]
Cancer	2.22%[1]	4.25%[1]
CHD	3.61%[1]	3.97%[1]
COPD	1.61%[1]	1.7%[1]
Dementia	0.88%[1]	0.81%[1]
Depression	6.53%[1]	9.54%[2]
Diabetes	4.71%[1]	2.94%[1]
Hypertension	13.47%[1]	15.43%[1]
Mental Health	0.65%[1]	0.87%[1]
Psychiatric Admissions	n/a	24.5 per 1,000[2]

Data sourced from:

1. Public Health Scotland (PHS), SPARRA at 1 December 2020 - the percentage of people with each Long Term Condition are calculated by dividing the number of people with each Long Term Condition by the number of people registered at the GP practices (i.e. the "Population Register") then multiplying by 100.
2. Initial Agreement Documents, approved by Scottish Government in January 2020 data via QOF calculator 1 April 2019.

Figure 3 - Local Profile and Practice Data - Kincardine

Mental health conditions including addictions have been exacerbated and impacted during the global pandemic. Therefore, the need for mental health and related services has significantly increased during this period.

Projections for future demand for primary care and community services with Kincardine are driven by the population projections which see the older population growing by 52% by 2041. This would therefore see the practice population who have severe and moderate frailty grow significantly. It is this group whom Community Nursing are seeking to work with to maintain and improve their position on the life curve through the care management intervention and the wider hub programme is seeking to support through local delivery of rehabilitation programmes.

[2] Based on 2011 census, 2016 SIMD datazone data and ISD Practice data 2019
[3] https://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/SPARRA/SPARRA-Model/

The current workforce delivering services is outlined below along with potential future workforce required to deliver primary care and community services. Recent and continuing changes to the workforce are being phased in line with population growth and service model developments which take into account the requirements to implement the GMS (2018) contract[4] and enhance the primary healthcare team, community health and social care teams and Health Visitor pathway. The Practice is also a training practice with a GP trainee and provides training placements for 5th year medical students.

	Existing Provision (WTE)	**Recent Change (WTE)**	**Future provision * Incl. new roles**
General Practitioners (7)	2.35	0.25	
Advanced Nurse Practitioner (2)	0.6	0.6	
Practice Nursing (2)	0.78	0.05	
Practice Phlebotomist	0.1		
Practice Manager (shared with Clack)	1		
Admin staff (10)	4.1	1.46	
District Nursing Team (3 shared with High Valleyfield)	2.2		Treatment room service extension Hosiery / Doppler follow up clinics Extending the range of treatment for patients who could attend the centre
Community Phlebotomist (2)	0.12	12 sessions per month	
Community Teams Admin Staff	0.2		
GP Trainee	(1)		
Visiting teams	WTE	Sessions	Future provision * Incl. new roles
Primary Care Pharmacist	Circa 0.5 WTE		
Midwifery Team	(0.1)	2 per month	

[4] https://www.gov.scot/publications/gms-contract-scotland/

Health Visiting clinic Baby weighing	0.05 0.05	1 per month HV also arrange ad hoc appointments	Opportunity to hold child wellbeing meetings locally
Physiotherapy		4 per month	
Podiatry	0.3	12 per month	
Mental Health Nursing (Primary Care)		4 per month	
Smoking Cessation specialist	(0.13)	See patients in Clacks.	Opportunity to deliver locally
Child immunisation clinic		4 per month	Potential future flu clinic
Social Workers / Social Care Workers	0		MDT time
Continence Nurse		4 per month	
Dermatology Nurse		4 per month	

Table 8 - Kincardine Staffing

2.3.2 Service Details

The accommodation in Kincardine is provided over one level with a total floor area of 237m^2, supports:

- GP activity associated with the Kincardine Health Centre (circa. 13,000 appts PA and a practice population of circa. 3,200)
- Nurse activity associated with the Kincardine Health Centre (circa. 6,400 appts PA)
- Practice employed Phlebotomist activity associated with the Kincardine Health Centre(circa. 2260 appts PA)
- Community nursing treatment room activity (circa. 1,500 episodes[5] PA)
- Community Phlebotomy services (circa. 1,325 episodes PA)
- Midwifery ante-natal clinic activity (circa. 200 appts PA)
- Podiatry services (circa 410 appts. PA)
- Health Visiting
- Stop Smoking sessions (circa. 200 appts PA)

[5] Episode refers to inpatient, outpatient or Allied Heathcare Profession treatment as defined by https://www.ndc.scot.nhs.uk/Dictionary-A-Z/Definitions/index.asp?ID=241&Title=Episode%20of%20Care

- Mental Health
- Health Visiting Clinic
- Physiotherapist

The primary care and community services have been developed as far as possible however the development of the clinical (Health & Wellbeing) model and increasing demand for services has exacerbated the issues of an inefficient layout, internal and external envelope deterioration. Whilst the GP Practice and Health and Social Care Partnership are working collaboratively to modernise and expand services to improve outcomes and support the population growth, development is severely constrained by the existing premises.

Services delivered from the existing Kincardine Health Centre amount to a total of circa 25,000 attendances per annum, 96 attendances per day or around 23 patients / clinical room activity per day.

Patients initial experience is very poor with one small reception hatch and reception area of 10m^2 (NB no separate records area now exists as all GP records are held electronically). There is one waiting area (total 22m^2) with no age-specific provision. Local Politicians have indicated their concern about the fabric of the building and the constraints it places on the local delivery of integrated health and social care.

Clinical care is delivered through five poorly configured consulting rooms which also support administrative activity. These are distributed throughout the current facility and, for the most part, used very flexibly. With 100% utilisation of the available capacity it is clear that a lack of available space is impacting upon the provision of local care. Mixed function means sub optimal use of clinical space. The AEDET review exercise confirmed that the layout and fabric of the building place considerable limitations on effective and safe service delivery (Section 2.3.3).

The office accommodation available for the administrative functions is well below the minimum standards and staff facilities are insufficient for the 21 staff working in the building on a daily basis as well as the wide range of visiting colleagues.

Although all possible reasonable changes have been made to the building Kincardine Health Centre fails to meet the spatial, organisation and design standards for Primary Health Care Premises and has no capacity for further growth. It has reached the end of its economic life as a clinical facility. Major improvements to address maintenance and statutory standards are not feasible due to structural and layout constraints.

A number of services are only available from the Clackmannan Health Centre because of capacity constraints. Resulting in patients from Kincardine travelling to Clackmannan to see a health professional, with best estimates indicating that this may be as many as 2,000 times per annum. People may be asked to attend Clackmannan for stop smoking support, CTAC, physiotherapy, mental health nurse consultation, coil insertion/removal, implant insertion/removal and joint injections as well as medicals such as fostering or DVLA medicals. It is extremely difficult to put an actual figure on this, as the baseline number has not been recorded historically and there is good anecdotal evidence to suggest that Kincardine patients would rather cancel / delay an appointment rather than travel to Clackmannan – further masking the true extent of the problem.

Local and proactive care is further confounded by problematic public transport to Clackmannan from Kincardine; there are no direct public transport (bus) routes. One appointment may take up to three hours out of a patient's day.

Where services are not/cannot be delivered locally in Kincardine, patients are referred to different locations – mostly within the NHS Forth Valley Board area - that include:

- Clackmannan Health Centre (GP overflow activity)
- Forth Valley Royal (Out-patient activity) (unless specifically requested by patient to be referred to a Fife hospital)
- NHS Fife provided services e.g. Physiotherapy provided in other Fife locations
- Community Nursing provide home based support for people who are not housebound, meaning that fewer patients are being seen than could be seen within a clinic setting, with wider MDT input potential

Out of Hours Primary Care is delivered from Urgent Care Centres in Forth Valley. Both Health Boards do not have current plans to extend the number of Urgent Care Centres. Kincardine Health Centre does not routinely deliver out of hours services, but offers a small number of clinics over an extended period. It is not feasible to deliver evening services including extended hours from the health centre.

The model of care is developing in line with the new GP Contract, with the Primary Care Development implementation plan progressing along with the Business Planning process. Historical re-development of the facility has meant that many areas originally designed to provide essential support functions have been lost in a drive to maximise clinical consultation space. This means that the facility no longer has any meaningful storage (with a consequential impact on consulting rooms, staff morale and patient experience); does not have: a utility room; a disposal hold; cleaner's room/facilities; a quiet/interview room; or an effective disabled WC.

This is effectively demonstrated by comparing the baseline Schedule of Accommodation of the current Kincardine Health Centre with that proposed for a replacement facility that has been developed based on the current and developing clinical model, future capacity requirements and relevant health planning guidance. Such a comparison shows that, even although the number of consulting rooms has only increased by three from the baseline, the actual area now required is 1,013m^2 compared to the existing area of 237m^2.

The table below summarises the services using the current facility and also a list of services that could be provided from the new as a result of a lager functional facility.

No:	Name of Service	Currently in Health Centre	Will be based in (or using) the new CH&W Centre
1	Fife Young Carers		X
2	Community Nursing		X
3	The Well		X
4	Complex Care Team		X
5	Clinical Psychology		X
6	Speech & Language Therapy		X
7	Health Promotion		X
8	Children's Services		X
9	Community Nurse Respiratory Team		X
10	Nursing	X	X
11	Occupational Therapy		X
12	Pharmacy		X
13	ADAPT/FASS (Addictions Services)		X
14	NHS Addictions Service		X
15	Local Area Coordinators (Locality Planning)		X
16	Frailty & Older People's Service		X
17	Immunisations Service		X
18	Podiatry Service	X	X
19	Mental Health Services		X
20	MSK Physiotherapy	X	X
21	Nutrition & Dietetics		X
22	Obstetrics and Gynaecology		X
23	Fife Carers Centre		X
24	Mental Health Nursing		X
25	Dementia Friendly Fife		X
26	Diabetes MCN		X
27	Midwifery	X	X
28	Diabetic Retinopathy		X
29	Physiotherapy		X
30	Orthoptics		X
31	Coalfields Regeneration Trust & Fife Voluntary Action services		X
32	Social Work		X
33	Multi-Disciplinary Team meetings		X

Table 9 - Kincardine Services

Approximately 35+ services were engaged prior to lockdown in March 2020 and all re-engaged in September and again in November 2020, to develop a service schedule and see if anything had changed or additional requirements were needed due to Covid-19: requirement of space in the centres, days of use and frequency, any special requirements etc. An exact number has not been provided as there are numerous services which sit under

single or multiple providers. This data has however been collated into a spreadsheet that has informed an updated schedule of accommodation.

2.3.3 Associated Buildings and Assets

The current facility is based centrally in the village of Kincardine. Established in 1930 and previously used originally as a residential property and then utilised as a police station. As a health facility the property has been considerably modified and extended throughout its lifetime. The accommodation in Kincardine is provided over one level with a total floor area of 237m^2. The building is owned by NHS Fife.

Figure 4 - Kincardine Practice

The building block condition is category C and the risk adjusted back-log cost is £85,000.

Condition, space and functionality of the facility are best summarised within the AEDET benchmark assessment which is outlined below.

Category	Benchmark
Use	1.0
Access	1.1
Space	2.0
Performance	1.3
Engineering	1.4
Construction	0.0
Character & Innovation	1.3
Form & Materials	2.1
Staff & Patient Environment	1.3
Urban & Social Integration	2.6

1 = virtually no agreement / poor 6 = virtually total agreement / excellent

Table 10 - AEDET Benchmark Score - Kincardine

2.4 Strategic Context

2.4.1 Drivers for Change

2.4.1.1 Local Context

NHS Fife Clinical Strategy[6] sets the strategic direction with Fife Health & Social Care Partnership (FHSCP) that is focused on local early, preventative care. In working with partners to improve the health of local people and the services they receive, while ensuring that national clinical and service standards are delivered across the NHS system we will strengthen primary care and community services.

Our vision requires a flexible and responsive model that works with people to define the outcomes they want to achieve, enabling people to maximise their health and wellbeing by utilising their own and community assets, adding and adapting services responsively to meet and sustain outcomes.

Our development of community health and wellbeing hubs is designed to flexibly and responsively layer services where required, adjusting support and care incrementally. In light of the changing demography this has focused on supporting people to minimise and modify the impact of frailty (including younger people frail because of long term conditions, addictions etc). Providing holistic assessment and care management, focused on individual outcomes, anticipatory planning and supporting a reduction in unscheduled care. Fife has a population of 371,910[7], (midyear estimate 2018), with slightly above the Scottish average for the over 65's age group described in Table 11.

	Total Population	65+	75+	85+
Fife	371,910	20%	9%	2%
Scotland	5,438,100	19%	8%	2%

Table 11 - Population Demographic Summary

Fife H&SCP has seven localities. Kincardine is in the South West Fife locality. The South West Fife locality sits within the West Division of the H&SCP. The H&SCP is developing a locality clinical model with GP Clusters focused on the needs of the locality population. Table 12 demonstrates the percentage of locality populations over 75.

	Population >75	
City of Dunfermline	3928	7%
Cowdenbeath	3360	8%
Glenrothes	4109	8%

[6] https://www.nhsfife.org/media/32112/c64_cs-finalforintranet.pdf
[7] Mid-Year Population Estimates Scotland, Mid-2018, National Records of Scotland. Publication (nrscotland.gov.uk)

Kirkcaldy	5549	9%
Levenmouth	3560	10%
North East Fife	7192	10%
South West Fife	3845	8%

Table 12 - Locality Demographic Summary

Over the next 25 years the total population within South West Fife is projected to increase by 9% by just around 4,600 by the year 2041. Most of the areas' population growth is expected to take place in the older people age group, an increase of circa 52% which will place and increasing demand on health and social care.

Population Projections		
	2016	2041
Overall	49,777	54,400
0-15 years	17.1%	17.5%
16-64 years	63%	55%
>65 years	19.7%	27.5%

Table 13 - Population Projections

The Local Development Plan indicates that housing developments will see circa 317 new homes built by 2032 (potentially an additional 790 people). The local development plan includes potential for the development of a further 259 homes within the Kincardine Health Centre catchment area.

The local and national goal, supported by NHS Fife's Clinical Strategy (2016-21)[8], NHS Forth Valley Healthcare Strategy (2016-21)[9] and the Fife Health and Social Care Partnership's Strategic Plan for Fife 2019-2022[10] is to provide safe, effective and sustainable care at home or as close to home whenever possible. The model being implemented will support robust, integrated health (primary and community), social care and third sector services with a strong focus on early intervention, prevention, anticipatory care and supported self-management.

The proposal for investment into fit for purpose health and social care facilities in Kincardine will not only address the current restrictions upon local delivery of clinical services and deficiencies in facilities at the existing Kincardine Health Centre but also enable the delivery of the above key areas within the Kincardine area.

The well-rehearsed pressures in General Practice in Scotland can be illustrated by the following indicators:

- 10% of the population consults with a GP practice clinician every week
- 34% of all GPs are aged 50 and over in 2015, compared with 29% in 2005

[8] https://www.nhsfife.org/media/32112/c64_cs-finalforintranet.pdf
[9] NHS-Forth-Valley-Healthcare-Strategy-2016-21.pdf (nhsforthvalley.com)
[10] https://www.fifehealthandsocialcare.org/__data/assets/pdf_file/0028/188263/HSCP_Strategic_Plan_2019-2022.pdf

- 37% increase in female GPs and 15% decrease in male GPs over the ten-year period to 2015
- 2015 – 1 in 5 GP training posts unfilled

Fife's Primary Care Improvement Plan sets out how primary care and General Practice are reshaping to implement the new GMS 2018 Contract. This is facilitating the development of GPs as expert medical generalists within expanded Primary Health Care Teams, by implementing new roles and ways of working. This is underpinned by the guiding principles of:

- Contact: accessible care for individuals and communities
- Comprehensiveness: holistic care of people – physical and mental health
- Continuity: long term continuity of care enabling an effective therapeutic relationship
- Co-ordination: overseeing care from a range of service providers

Care pathways are patient (not disease) centred to meet the challenge of shifting the balance of care, realising Realistic Medicine and enabling people to remain at or near home wherever possible. Local accessibility and the need to provide a wider range of services to people in their local communities and to develop greater local integration is being hampered by the accommodation available within the Kincardine area. The effect of which is evidenced in the continued reliance upon the traditional medical model of relatively high acute hospital attendance and admission rates. Section 2.4.1.2 below highlights the patient journey using personas.

Local accessibility and improved joint working with other Health and Social Care Partners as part of wider whole system will facilitate integration of health and social care and enable more effective delivery of health and wellbeing outcomes. This will be underpinned by practice multi-disciplinary team working, supported by responsive wider locality teams in reaching to deliver local care. This is further illustrated in Section 2.4.1.3 below.

2.4.1.2 The Patient Perspective

It has been recognised for many years, service providers across Scotland and the UK have planned care separately in different parts of the system including primary, community, acute care and mental health. Services have often been planned around buildings, individual service providers or even clinicians.

What is now proposed is a shift toward an overarching whole systems model which focuses on the needs of people who use the different health and social care services within the Kincardine Practice. This is described as a more holistic community health and wellbeing approach.

The central underlying principle of the development of the new centre is to focus on the patient outcomes, their journey and experience. This will help to identify where service improvements are necessary and involve a wide range of service users and providers in analysing and redesigning improved patient pathways to positively impact on outcomes. To support this work seven patient personas have been developed which serve to inform key considerations when designing new pathways and the integration of services. Full details of

this work is contained in the supplementary document, “The Patient perspective” (Appendix J).

2.4.1.3 Sustainable Workforce and Staff – Health & Wellbeing

Since the launch of Everyone Matters 2018-2020[11], key priorities and actions have been identified which are contributing greatly to achieving a healthy organisational culture. Everyone Matters Implementation Plan actions will be integrated into the new centre where appropriate – initial considerations include:

- Health & Wellbeing and Healthy Organisational Culture – take action to promote the health, wellbeing and resilience of the workforce. Create an environment which supports working across teams, open office space, bookable quiet space and hot-desks, collaborative spaces, wellbeing space, access to support services – these are considered vital to staff wellbeing and morale. Wellbeing Hubs have been established in various sites to support staff, particularly during the global pandemic. Bookable peaceful indoor and outdoor spaces could be established within the centre for both (practice-based and visiting) staff and community use. Providing opportunities for staff to take part in wellbeing-related sessions as appropriate including mindfulness, kindness, resilience and self-care related activities. Sessions are planned with the local Health Psychologist to provide some of these activities within GP clusters, Lunchtime Bytes, Community Health & Wellbeing Services (CHaWS) Subgroup and with practice staff. Other elements will include Staff Cycle to Work Scheme, bike racks, outdoor gym, community garden with covered area, showers and changing facilities etc.

- Sustainable workforce: over 35 clinical and non-clinical services engaged in relation to: requirement of space in the new centre, days of use, frequency, special requirements etc. A service schedule was developed from the feedback which formed the Schedules of Accommodation and this information was used to start the early design of the new building. This will ensure that local services can be planned, coordinated and delivered within the new centre as close to home for people as possible. The new centre will have the space to accommodate a wider range of services as per GMS (General Medical Services) contract and aforementioned drivers for change. There is ongoing engagement with the Kincardine Practice and services throughout the process including via the CHaWS Subgroup, the Design Team meetings etc.

- Capable workforce:
    - NHS Fife and FHSCP offer a suite of development opportunities for their workforce. Educational support services include: Health Promotion, Organisational Development, Learning & Development and Practice & Professional Development (PPD). The PDD is embedded below and includes: managerial coaching, observational visits to support recruitment, clinical skills,

[11] Everyone matters: 2020 workforce vision implementation plan 2018-2020 - gov.scot (www.gov.scot)

leadership, dementia awareness, palliative and end of life care. PPD provision and training is offered to all staff including those working in residential, nursing and care homes in Fife. HR, Patient Relations, Infection Prevention & Control, Pastoral, Resuscitation and Manual Handling all offer training to NHS staff.

  - Work across organisational and professional boundaries (i.e. between primary and secondary care, across sectors etc) to share good practice in Learning & Development (L&D), evidence-informed practice and organisational development. Facility available regarding L&D space e.g. face to face training or a computer room where staff can participate in virtual training, update their core skills, LearnPro, Turas etc. Engaging with the staff regarding what they would like and to ensure they feel included as part of the process in relation to the new building.

- Workforce to deliver integrated services: Working with partners to develop workforce planning capacity and capability in the integrated setting including ways of working – exploring opportunities to work differently before the building completion e.g. using the Patient Personas & Pathways in order to establish a service coordination approach and tests of change.

- Change management – ensuring change is managed appropriately and providing opportunities to keep all key staff and stakeholders informed, involved and engaged in the process where possible. The Staffside representative also attends Project Team meetings and has had input into these sections of the OBC. This will be organised through a range of methods such as Subgroup meetings, staff updates, Blink, websites, newsletters and ongoing communications with key stakeholders etc. It is important to give staff ownership particularly if the new building is to be their main base. How and when to ask staff for views is important - all views need to have equal importance.

- Longer opening hours – these will be considered as part of the new building where designated areas could potentially be 'locked-down' for out-of-hour use as a community asset.

- Health & Social Care and Design & Construction Career Pathways – work with L&D to ensure links with local schools and education providers are established to showcase Health & Social Care and Design & Construction as career pathways including options for apprenticeships, internships, student placements and work experience etc.

2.4.1.4 National and Local Strategies

Key national and local documents have influenced the development of our health and care model and thereby this proposal, although this is not an exhaustive list. It should be noted that along with Caithness and Ayrshire Fife's Community Health and Wellbeing Hub programme has been selected as a national pathfinder site to support a Once for Scotland approach to delivering the shift in the balance of care from hospital to community.

National

- Commission on the Future Delivery of Public Services (The Christie Report) (June 2011)
- 2020 Vision for Health and Social Care (September 2011)
- Healthcare Quality Strategy (2012)
- A National Clinical Strategy for Scotland (February 2016)
- Health and Social Care Delivery Plan (December 2016)
- Property Asset Management Strategy (2017)
- NHS in Scotland 2016 – Audit Scotland Report (October 2016)
- Achieving Excellence in Pharmaceutical Care: A Strategy for Scotland (August 2017)
- General Medical Services Contract (2018)
- Health and Social Care Integration – Audit Scotland (November 2018)
- Nursing 2030 Vision: Promoting Confident, Competent and Collaborative Nursing for Scotland's Future (2017)

Local

- Health and Social Care Partnership Strategic Plan for Fife Plan (2019-2022)
- NHS Fife Clinical Strategy (2016-21)
- NHS Fife Property and Asset Management Strategy (2022)
- NHS Fife Operational Delivery Plan (2018/19)
- Let's really raise the bar: Fife Mental Health Strategy (2019-2023)

This proposal interacts with these key local and national strategies in terms of:

Quality Strategy ambitions in relation to:

- Person centred care - through improving access to Primary Care and providing more care closer to home
- Safe – reducing risk of infection through provision of modern fit for purpose accommodation
- Effective – bringing together a wider range of health and care services to make more effective use of resources

2020 Vision aspirations are that everyone can live longer healthier lives at home, or in a homely setting with focus on improving quality of care, improving the health of the population and providing better value and sustainability.

Technology Enabled Care projects are being tested within the current service model to modernise primary care, support earlier identification and self-management.

NHS Fife's Clinical Strategy and **Operational Delivery Plan** are focused on delivering person centred care, closer to home where possible. The proposed development will support the local provision of health and social care services within Kincardine, facilitating person centred care and support.

The **2018 General Medical Services Contract** refocuses the role of General Practitioners as expert medical generalists and recognises that general Practice requires collaborative working, with enhanced multidisciplinary teams that are required to deliver effective care, joint working between GP Practices in clusters and as part of the wider integrated health and social care landscape. Better care for patients will be achieved through:

- Maintaining and improving access
- Introducing a wider range of health professionals to support the expert medical generalist
- Enabling more time with the GP for patients when it is really needed
- Providing more information and support to patients

The **Public Bodies (Joint Working) (Scotland)** Act 2014[12] aims to improve outcomes for people by creating services that allow people to stay safely at home for longer with a focus on prevention, anticipation and supported self-management, and provide opportunities to co-locate health and care services working together for the local population. Fife's local Health and Social Care Strategy describes how the nine National Outcomes for Integration can be met through prevention, local earlier integrated working focused on peoples own outcomes.

Promoting the wellbeing of children is central to the work of Health Visitors and this is supported by the new **Universal Health Visiting Pathway**[13] and the Named Person role conferred by the **Children and Young People (Scotland) Act** (2014)[14]. The Universal Health Visiting Pathway sets the standard for health visiting and the minimum core visits that families with children aged 0-5 years can expect from their Health Visitor, regardless of where they live. This will require an increase in the Health Visiting establishment and new ways of working for full implementation.

The Scottish Government's **Nursing 2030 Vision: Promoting Confident, Competent and Collaborative Nursing for Scotland's Future** (2017)[15] sets the direction for nursing in Scotland through to 2030 and focuses on personalising care, preparing nurses for future needs and roles, and supporting nurses. Within this framework redesign in community nursing is supporting the implementation of the Chief Nursing Officer Directorates paper on

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[12] Public Bodies (Joint Working) (Scotland) Act 2014 (legislation.gov.uk)
[13] Universal Health Visiting Pathway in Scotland: pre-birth to pre-school - gov.scot (www.gov.scot)
[14] Children and Young People (Scotland) Act 2014: National Guidance on Part 12: Services in relation to Children at Risk of Becoming Looked After, etc - gov.scot (www.gov.scot)
[15] Nursing 2030 vision - gov.scot (www.gov.scot)

Practice and Community Nursing to integrate locally to support prevention and early intervention.

Fife Health and Social Care Partnership, established on 1 April 2016, is refreshing its strategic plan, this includes revised Vision, Mission and Values. The plan is focused on delivering proactive, integrated support and therefore will seek to secure an outcome focused model delivered locally aimed at securing improved outcomes through early identification and intervention:

- ***The Vision is*** To enable the people of Fife to live independent and healthier lives.
- **The Mission is** "We will deliver this (vision) by working with individuals and communities, using our collective resources effectively. We will transform how we provide services to ensure these are safe, timely, effective and high quality and based on achieving personal outcomes."
- Our **Values** are: Person-focused - Integrity – Caring - Respectful - Inclusive - Empowering

2.4.2 Need for Change Summary

The following is a full list of the main drivers causing the need for change, the effect that these issues are having on the current service provision and an assessment of why it is believed action is required now.

Driver for change:	What effect is it having, or likely to have, on the organisation?	Why action now:
The clinical and social care model have developed and implementation is being circumscribed.	Primary, Community and Voluntary sector services cannot provide the integrated model of care they and the community recognise is required now and for the future.	The model of care is being undermined now: preventing locally based, integrated proactive care. Time from Initial Agreement to occupation of a new facility could take circa 4 years.
	Services cannot be delivered locally for local patient need; instead are based where it is possible to deliver services.	NHS Fife/Fife H&SCP will fail to deliver the GMS (2018) and community health and wellbeing hub model within Kincardine unless this is planned for.
	Pressure on existing staff, accommodation and services will inevitably increase.	Sustainability of primary care is a key priority for the IJB and NHS Fife. There is a need to plan to provide a sustainable service for the future.
Poor clinical and non-clinical	Existing facilities fall far below the required standards in terms	Existing facility configuration and layout presents unacceptable risks,

Driver for change:	What effect is it having, or likely to have, on the organisation?	Why action now:
functionality and space restrictions in existing accommodation (configuration)	of how they are configured and laid out. The Equalities Act 2010 compliance within the building is poor.	as well as poor local performance, functional in-efficiency and suboptimal patient experience.
	Premises are functionally inadequate and compromise pro-active, integrated care.	No scope exists to re-organise parts of the service to improve the experience.
	Some consulting rooms are very small and do not meet current standards. These are very restrictive / unsuitable for patients and staff.	Poor patient and staff experience. Does not meet current recommended standards.
Clinical and social care functionality (capacity) issues	Capacity is unable to cope with current, let alone future projections of need. Patients are required to make repeated appointment to meet with different members of their multi disciplinary team and to access healthcare out-with the local area.	Service sustainability and development is at risk and an increasing number of patients will travel from Kincardine to Clackmannan for basic Primary Care.
	Facilities lack the number and range of support areas necessary to deliver modern, integrated, safe and effective services	A lack of essential support areas represents a real and unacceptable risk to the Board in key areas such as HAI and patient safety.
Building issues (Including statutory compliance and backlog maintenance)	Increased safety risk from outstanding maintenance and inefficient service performance	Building condition and associated risks will continue to deteriorate if action is not taken now, affecting performance. Redesign of building will allow for improved care, staff experience and financial performance.

Table 14 - Need for Change

2.4.3 Investment Objectives

This section identified the ‘business need’ in relation to the current arrangements described in Section 2.1. These were discussed at the Architecture & Design Scotland (A&DS)

facilitated workshop to develop the project design statement. A wide range of stakeholders including clinical and managerial staff along with community representatives were involved in a workshop to describe the difference between 'where we are now' and 'where we want to be'.

Effect of the need for change on the organisation:	Investment Objectives
Existing service arrangements are affected by lack of clinical support service facilities.	Ensure equal access to a patient centred approach by enabling delivery of and access to local anticipatory and preventative care for patients.
Implementation of integrated models of care is undeliverable locally in the current environment	Ensure equal access to modern integrated care with provision driven by patient need rather than limitations in physical capacity.
Pressure on existing staff, accommodation and services will inevitably increase.	Ensure the right staff skill mix and service capacity are available to deliver and strengthen local capacity to manage people's health within the local community.
The facilities available, 100% occupancy, combined with significant population change, restrict the ability of the parties to deliver the full range of integrated services locally.	Enable earlier access to proactive and anticipatory care through local delivery via integrated seamless service across health and social care.
Existing configuration, as a result of a 1930's building, being modified and extended with a 'best fit' approach. Current facilities have treatment rooms below minimum acceptable standards.	Delivery of safe and effective care with dignity –by providing facilities which comply with all legal standards and regulatory requirements and gives equality of access for all.
Increased safety risk from outstanding maintenance and inefficient service performance.	Improve safety and effectiveness of accommodation by improving the physical condition, quality and functional suitability of the healthcare estate.

Table 15 - Investment Objectives

2.4.4 Proposed Benefits

There is a clear emphasis on General Practice provision and the development of the community health and wellbeing hub model within the IJBs' Strategic Plans and NHS Fife and Forth Valley's Clinical Strategies. The proposed investment in infrastructure will enable the Kincardine Medical Practice to fully participate in the required programmes of care, enable full access to the Primary Care Improvement Plan and thereby improve outcomes for individuals, experience for staff and the reputation of the organisation.

Benefits for each of the investment objectives described in Section 2.4.3 above are mapped to the expected benefits in the context of the Scottish Government's five Strategic Investment Priorities (Safe; Person-Centred; Effective Quality of Care; Health of Population; Efficient: Value and Sustainability).

To ensure that resources are effectively exploited and that any investment made provides agreed benefits a register has been developed. The benefits register (see Appendix E) identifies the expected benefits, indicates a baseline and target measurement and also gives a priority level to each benefit. The Benefits Realisation Plan demonstrating how the benefits can be secured is included at Appendix F.

Investment Objective	Benefit	Investment Priority
Ensure equal access to a patient centred approach by enabling delivery of and access to local anticipatory and preventative care for patients.	GP Practice Multi Disciplinary Team and wider community hub team have access to accommodation to meet population needs locally	Person Centred Health of Population Integrated Care Quality of Care
Ensure equal access to modern integrated care with provision driven by patient need rather than limitations in capacity.	Services delivered locally based on need	Person Centred Efficient Effective Integrated Care
Ensure the right staff skill mix and service capacity are available to deliver and strengthen local capacity to manage people's health within the local community.	Higher staff retention levels Higher staff morale/lower absence rates Increased flexibility of roles Career progression Improved workforce planning across the health and social care pathway Supports training, education and development	Person Centred Efficient Effective Value and Sustainability Integrated Care
Enable earlier access to proactive and anticipatory care through local delivery via integrated seamless service across health and social care.	Access to wider staff skills and experience on one site Reduces unnecessary hospital referrals / multiple appointments Reduces patient risk	Effective Quality of Care Person Centred Integrated Care

Investment Objective	Benefit	Investment Priority
Delivery of safe and effective care with dignity – by providing facilities which comply with all legal standards and regulatory requirements and gives equality of access for all.	Improves patient experience addressing privacy and dignity issues Improves staff safety through provision of primary care & community services on one site allowing for available support for patients and staff. Ease of compliance with standards e.g. Equalities Act 2010[16], HAI Fit for purpose flexible accommodation meeting all guidelines e.g. room sizes	Safe Person Centred Quality of Care Integrated Care
Improve safety and effectiveness of accommodation by improving the physical condition, quality and functional suitability of the healthcare estate.	Increased local provision and access to treatment making best use of available resources by having the infrastructure to deliver more proactive prevention and early intervention focused support, maximising MDT working to facilitate access for people and thereby reducing the call upon unscheduled care.	Effective Quality of Care Efficient: Value and Sustainability

Table 16 - Benefits

2.4.5 Risks

Risk is now covered within the Commercial Case (Section 4) and Management Case (Section 6). The project's Risk Register can be found at Appendix G.

2.4.6 Constraints and Dependencies

2.4.6.1 Constraints

Constraints are limitations on the investment proposal. Key constraints relating to this particular investment proposal are noted below:

- Financial – given the current climate it is recognised that the project is likely to be constrained financially. Once the project budget it is set, the project will require to be delivered within this.

- Programme – given the needs for change relating to the current arrangements, there is a need to deliver the project as quickly as possible.

[16] https://www.gov.uk/guidance/equality-act-2010-guidance

- Quality – the project will require to comply with all applicable healthcare guidance and achieve the AEDET pre-defined target criteria across all categories. The project will also be subject to NDAP and Design Assure key stage reviews.
- Sustainability – as the preferred option is a new-build there will be a requirement to achieve and agreed BREEAM rating.
- Site – site constraints have been investigated during the OBC and factored into the OBC cost projections. Planning constraints will be investigated during the FBC stage.

2.4.6.2 Dependencies

Dependencies are where action from others is required to ensure success of the investment proposal. Key dependencies include:

- Acquisition of the site for development. Discussions with Fife Council are ongoing in this regard, although initial indications are that Fife Council are supportive of the proposals. Engagement will continue through the FBC stage with a view to concluding a long lease arrangement at the end of this stage.
- Service re-design to maximise the opportunities of bookable spaces, agile working and service integration.
- E-health initiatives as outlined at Section 4.4.14.

2.4.6.3 Critical Success Factors

In addition to the Investment Objectives set out in Section 2.4.3, the stakeholders have identified several factors which, while not direct objectives of the investment, will be critical for the success of the project.

Requirement	**Description**	**Critical Success Factor**

Strategic fit	Meets agreed clinical and investment objectives, related business needs and service requirements	• Promotes sustainability of Primary Care provision and delivery of 2018 GMS Contract
		• Consistent with NHS Board's Clinical Strategy
		• Supports delivery of NHS Scotland Quality Strategy
		• Facilitates integration of health and social care services, delivered locally
		• From Patient perspective:
		  • a facility that is easily accessible, bright, friendly and airy.
		  • designed so that patients can be treated with dignity particularly in terms of confidentiality.

Value for money	Maximise the return on the required investment and minimise risks	• Service model maintains or reduces revenue costs in the longer term through earlier intervention • Service model enables effective decision making in allocation of resources • Building design maximises efficiency and sustainability
Potential achievability	Is likely to be delivered in relation to the required level of change Matches the available skills required for successful delivery	• The skills and resources are available to implement new ways of working • The H&SCP and the Practice are able to embed new ways of working • NHS Fife are able to deliver the programme to agreed budget and timescales • Technology enablers are available and utilised
Supply side capacity and capability	Matches the ability of service providers to deliver required services	• Service providers are available with skills, materials and knowledge • The project is likely to attract market interest from credible developers

Potential affordability	Available capital and revenue resources are sufficient to support the successful delivery of the proposed facility and services	• Solution is affordable to all stakeholders

Table 17 - Critical Success Factors

3 Economic Case

3.1 Introduction

The purpose of the Economic Case is to undertake a detailed analysis of the costs and benefits of a short list of options, including a do nothing and/or do minimum option, for implementing the preferred strategic / service solution(s) identified within the IA.

The objective is to demonstrate the relative value for money of the chosen option in delivering the required outcomes and services.

3.2 Revisiting the Economic Case

Since the IA, the Economic Case has been updated to provide details of stakeholder engagement activity undertaken during the stage.

3.3 The Do Nothing/Do Minimum Option

It is not feasible to continue with the existing arrangements ('Do Nothing'), because the building is not fit for purpose. The backlog maintenance required while supporting minimum safety and the building to be water-tight will not make it fit for purpose. The do nothing option scored lowest throughout the option appraisal process. The building and footprint likewise mean that a do minimum option is not feasible.

Strategic Scope	Do Nothing / Do Minimum
Service Provision:	Primary Care services in Kincardine are delivered from the existing Kincardine Health Centre. This former Police Station has been considerably modified and extended throughout its lifetime. Continue with existing service provision with no changes to service provided as outlined in Section 2.11. This will result in insufficient capacity to meet future demand for treatment, restrict proactive integrated care and maintain inequity of access.
Service Arrangements:	The service arrangements will continue as existing with Kincardine Medical Practice; Primary General Medical Services being provided alongside Community, District Nursing and Children's Services. There will be the risk of being unable to implement GMS (2018) and community health and wellbeing hub model and potential requirement for patients to register with practices outwith their catchment area.

Strategic Scope	Do Nothing / Do Minimum
Service Provider and workforce arrangements (at the time of the Option Appraisal):	Workforce arrangements will continue as the existing situation with GP services Community, District Nursing and Children's Services delivered in the building. The developing integrated Mutli disciplinary mode will be circumscribed with inequity of access and travel implications for both patients and staff. Poor accommodation will continue to be managed as a risk in terms of staff health and safety. Areas originally designed to provide essential support functions have been lost in a drive to maximise clinical consultation space. The facility no longer has any meaningful storage (impacting on consulting rooms); does not have the following: a clean utility room; a dirty utility room; a disposal hold; any cleaner's room/facilities; a quiet/interview room; or an effective disabled toilet.
Supporting assets:	The building presently does not meet the required standards (particularly around spacing and access). The condition of the building will continue to deteriorate. Decant of community services may be required to support practice provision and reducing access for community services.
Public & service user expectations:	Public consultation indicates a strong desire for the delivery of effective GP & Primary Care/Community Care services in Kincardine from one building in a good central location which is all on one level. Services delivered by a wide range of professionals. Strong desire to increase targeted delivery to address inequalities. Single shared staff room. Suitable space for patients who become unwell and need transfer to acute services. This option will not deliver this in the future and will perpetuate a poor environment with limited facilities and also reduce access to primary and community care services for local residents. It will also continue to impact negatively on confidentiality and dignity, and the organisations reputation.

Table 18 - Do Nothing Option Summary

3.4 Stakeholder Engagement

3.4.1 Initial Agreement

It was important to have the support of key stakeholders from health and social care staff and leaders from the local community to define the change required and create the vision for change.

Stakeholders supported this through their participation in the Option Appraisal Exercises and Design Statement workshops. This ensured that the vision was shared and communicated to all who will be impacted by the change. It also encouraged support from those who have an emotional commitment to the services provided in their community.

3.4.2 **Outline Business Case**

This section focuses on the outcome of the subsequent OBC engagement exercise undertaken with the people of Kincardine. In light of the restrictions, all engagement activities were planned mostly online or with appropriate measures such as social distancing in place. Key stakeholders were involved in developing a Covid-19 safe engagement approach including the Kincardine Practice, Fife Young Carers, The Coalfields Regeneration Trust (CRT), Equality & Diversity, Participation & Engagement Team and their related networks.

The communication and engagement framework was approved by the Partnership and Engagement Network: Advisory Group in October 2020. This plan sought to maximise engagement with local stakeholders via a range of networks to gather the citizen voice to inform the development of the business case. Online materials were hosted by the NHS Fife website.

3.4.2.1 Key Communication and Engagement Activities

The main communication and engagement methods included: websites and social media; press release and posters; cascading via local health care providers, schools, services and politician colleagues; Peoples Panel; Public Directory; patient texting service; online discussion forums; online and paper surveys.

Activities included:

- A press release was issued to initiate the engagement process through local newspapers and then an update partway through the engagement process
- December Localities Newsletter was sent across the 7 Localities (800+ members), SW Fife and Cowdenbeath Localities (189 members)
- Cowdenbeath Area Cluster
- Peoples Panel (1700 members)
- Public Directory (62 members)
- FVA Health & Social Care e-bulletin was sent to 653 members
- All communications included a link to the online survey and paper versions were made available in local sites
- Additional to this, the survey link and information was also sent out numerous times over the engagement period via social media by the NHS Fife and Fife Health & Social Care Partnership (FHSCP) Communication Teams as well as via local groups and organisations including twitter, Facebook etc
- The patient texting service was utilised by the practices on a number of occasions and this proved to be the most successful method
-

3.4.2.2 Stakeholder Engagement and Surveys

Approximately 70 local groups and organisations were successfully engaged. This included:

- 1 school in Kincardine

- Public Directory
- Fife Young Carers
- FVA
- NHS Fife and Equality Groups
- Cowdenbeath Cluster
- Centre for Equalities
- Carers Link
- Fife Carers Centre
- Dementia Friendly Fife (STAND Fife)
- HIS Community Engagement
- Disabled Persons Housing Association
- Saje Scotland
- Community Teams
- Community Learning & Development
- Scottish Stammering Network
- The Coalfields Regeneration Trust
- Go Forth
- Gala Committee
- West Fife Villages Forum (WFVF)

3.4.2.3 Survey Design

The survey was developed to provide participants with ample opportunity to share their thoughts and views in relation to their new Community Health & Wellbeing Centres. The following question ranges were outlined in the survey:

- health and wellbeing related services people would like to see in their new centre
- changes introduced since the pandemic would people like to keep
- changes introduced since the pandemic would people not like to keep
- order of importance e.g. support services, wellbeing services, increased opening times, outdoor gym, community spaces etc
- environmental factors to consider e.g. recycling, solar panels, electric car-charging points
- anything additional requirements or information not previously mentioned

- biographical information

This survey has been fully analysed and the information received from the engagement exercise has helped to support the OBC process, inform the options appraisal and building design processes, as well as help shape future service delivery in the new Kincardine Community Health and Wellbeing Centre. Full details of the approach taken to the survey and this analysis are detailed in the supporting document Kincardine Community Health and Wellbeing Centre Engagement Feedback Summary Report (available upon request).

3.4.2.4 Quick Wins

Using the thoughts, comments and ideas shared in the engagement feedback above, considerable work has taken place with the Kincardine practice and other service providers to identify potential changes or improvements that can be put in place with immediate effect. Other longer term or more complex changes will be considered as the programme progresses with the development of the new centre.

These changes or improvements include:

- Ensuring a wide range of health and wellbeing services – the Clinical Services Subgroup was expanded further to include non-clinical services and renamed as the Community Health & Wellbeing Services (CHaWS) Subgroup

- Coordination and collaborative approach – working with the CHaWS Subgroup to test a coordination approach to improve patient pathways by ensuring people are accessing the most appropriate services when they need them most

- Mental Health Services – the engagement exercise highlighted a real need for mental health services, particularly during the pandemic. People will be better supported and enabled to access their local mental health services e.g. counselling, befriending, The Well etc

- Access to Carers Support – raising awareness of the needs of Carers of all ages and the appropriate support to access key services such as Fife Young Carers or Fife Carers Centre e.g. including benefits, short breaks (respite)

- Use of technology:

    - Encouraging or enabling people to access clinical and/or non-clinical appointments using technology where appropriate e.g. video calls/Whatsapp
    - Development and better use of practice websites where this isn't already available
    - Development and better use of the patient texting service
- Volunteering opportunities - public participation groups have been established to provide community representation to help shape the new centre

- Improved repeat prescription process – working with patients, carers and families, local pharmacists, doctors and administration staff are committed to ensuring easier access to safe, high quality repeat prescription systems

- Improved appointment systems – all the practices are considering how to best provide appointments, improve access and reduce waiting times for patients and will be taking the engagement feedback into consideration

3.4.3 Ongoing Stakeholder Engagement

The Project Team worked closely with practices and local organisations to identify members of the community who were interested in being involved in the development of their new centre. Local participation groups are set up and members of these groups feed into project meetings to share a representative view and feedback to the main group. There are also engagement events and activities being planned. Other options to increase community involvement and ownership will include the community/sensory garden and art work for the new centre.

The Stakeholder Engagement and Communication Plan is located at Appendix H.

3.5 Service Change Proposals

The initial scope for the Kincardine Health Centre project was to explore design and scope options to provide a suitable health and social care facility in Kincardine which was of a suitable size and condition to meet with the growing needs of the existing practice and community health and social care team.

3.5.1 Long List of Options

The theoretical long list of options was initially generated by the NHS and Local Authority teams with the support of hubCo and its advisers and was reviewed throughout the process. This long-list was based on the cross-referencing of strategic theoretical service options available with local site / facility considerations.

Strategic theoretical option themes included:

Strategic Scope	Summary
1 Service Provision	• Do nothing (The status quo) • Centralise (currently separate) health care facilities in Fife (Kincardine), Forth Valley (Clackmannan) or somewhere in-between recognising that these sites are staffed by the same practice • Build entirely new and minimise any use of existing buildings (full build)
2 Service Arrangements	• Don’t have any specific GP / health facilities locally
3 Service provider/ workforce	• Utilise only ‘operational’ solutions to address existing problems
4 Supporting Assets	• Build new but also make use of existing facilities to support the overall model (reduced build)

	• Combine a new build or refurbishment proposal with other new / existing developments across the public sector
5 User Expectations	• The expectations of the public and service users

Table 19 – Strategic Theoretical Service Options

The following core long-list of options, in addition to Option 1 do nothing/minimum described above at Section 3.3, was agreed:

Option	Description	Commentary
2	Don't have any Health Centre building – use existing available public sector estate.	This option was not short-listed as it was completely incapable of delivering the preferred service model, would not deliver the community health and wellbeing hub required and result in an even more fragmented service than at present. It was also reliant upon finding existing spaces that do not exist.
3a	An operational solution utilising only the existing Health Centre	Whilst a number of operational solutions are being considered by the Board to address acute short-term crises – and this option is not 'mutually exclusive' – it is not capable of addressing anything other than capacity concerns in the very short-term and certainly not any of the physical/facility issues identified. It was consequently not short-listed.
3b	An operational solution utilising the existing Health Centre plus space in other local facilities.	This option was assessed as a variation on option 3a), that also sought to access space in other local facilities. It was not short-listed for the same reasons.
4a	Refurbish & extend the existing Health Centre facility	This option was not deemed feasible as the current Health Centre building covers the entire curtilage meaning no options for extension or adequate refurbishment exist. It was consequently proven unfeasible and not short-listed.
4b	Refurbish other existing facilities.	This option acknowledged the possibility of identifying and refurbishing another local facility however, in the event, no such facility could be found. It was consequently proven unfeasible and not short-listed.

Option	Description	Commentary
5a	Reduced new build on existing Health Centre site (plus use of space in other facilities to be confirmed).	This option involved building a reduced new facility on the existing site that made use of space in other local buildings. It was rejected as not feasible for a number of reasons including the cost/disruption associated with decant and lack of facilities to support either the reduced new build element or decant. The option was consequently not short-listed.
5b	Reduced new build on land at Feregait (plus use of space in other (?) facilities)	This option was rejected as no additional suitable facilities could be identified.
5c	Reduced new build on land at Station Road (plus use of space in other (?) facilities)	This option was rejected as no additional suitable facilities could be identified.
5d	Reduced new build on land at Tulliallan Primary School (plus use of space in other (?) facilities)	This option was rejected as no additional suitable facilities could be identified and no way could be found to link into the existing school facility.
6a	Full new build on existing site for Kincardine services only	This option involved a full new build on the existing site that was entirely self-contained and intended to deliver Kincardine services only. It was not short-listed as the site is too small for the required area as well as having significant cost, disruption and operational challenges associated with decant to support demolition and re-building.
6b	Full new build on the Feregait site for Kincardine services only	This option involved a full (self-contained) new build on the Local Authority owned Feregait site. It was deemed feasible and consequently short-listed.
6c	Full new build on the Station Road site for Kincardine services only	This option involved a full (self-contained) new build on the Local Authority owned Station Road site. It was deemed feasible and consequently short-listed.

Option	Description	Commentary
6d	Full new build on the Tulliallan School site for Kincardine services only	This option involved a full (self-contained) new build on part of the Local Authority owned Tulliallan Primary School site. It was deemed feasible and consequently short-listed.
7a	Full (combined) new build on existing site for Kincardine & Clackmannan services	This option involved a full new build on the existing site that was entirely self-contained and intended to deliver the combined services currently delivered separately in Kincardine and Clackmannan by the same GP practice. It was not short-listed as any option that involved centralising existing services in any single location was not deemed acceptable by any of the stakeholders involved. This included NHS Fife and NHS Forth Valley in recognition of the fact that the practice and its delivery locations straddle both Board areas.
7b	Full (combined) new build at Feregait site	This option was not short-listed as any option that involved centralising existing services in any single location was not deemed acceptable by any of the stakeholders involved.
7c	Full (combined) new build at Station Road site	This option was not short-listed as any option that involved centralising existing services in any single location was not deemed acceptable by any of the stakeholders involved.
7d	Full (combined) new build at another site in Kincardine	This option was not short-listed as any option that involved centralising existing services in any single location was not deemed acceptable by any of the stakeholders involved.
7e	Full (combined) new build at ANOther site in Clackmannan.	This option was not short-listed as any option that involved centralising existing services in any single location was not deemed acceptable by any of the stakeholders involved.

Option	Description	Commentary
7f	Full (combined) new build at ANOther site "between" Kincardine & Clackmannan.	This option was not short-listed as any option that involved centralising existing services in any single location was not deemed acceptable by any of the stakeholders involved.

Table 20 - Long-list of Options

The benefits criteria against which the long list were assessed were initially drafted by the wider planning team in light of the strictures placed upon the clinical model by the facility associated challenges identified. These were refined during the option appraisal events into an agreed list based on global stakeholder opinion.

Importantly, this list was also developed with the support of the stakeholder group reviewing options related to a similar business case being developed for Lochgelly in order to ensure that both projects, which have similar objectives and timescales, were able to benefit from each other's work through the development of an agreed list of benefits criteria that were weighted independently.

In summary, the benefits criteria reflected the ability of each identified option to, noted in order of highest to lowest weighting:

- Deliver an optimal physical environment
- Be readily accessible
- Support flexibility and sustainability
- Support local and national service strategies
- Deliver wider community & public benefits

The Partnership is committed to delivering services that are integrated and maximise opportunities for local delivery. It has been formally confirmed that there is an on-going requirement to continue to deliver GP, primary care and local clinical services separately from Kincardine and Clackmannan in recognition of population, local clinical needs and geographical considerations. Consequently all option 7s, were not taken forward to the short-list.

Specific site/facility considerations included:

- The existing NHS owned Health Centre site in Kincardine
- A Local Authority owned site at Feregait
- A Local Authority owned site at Station Road
- Part of the Local Authority owned Tulliallan Primary School site

Whilst a number of other potential sites were raised and considered, they were all excluded at this stage as they were either demonstrably too small and / or not in public sector ownership. On this latter point it was noted that a site that was not currently in the ownership

of the public sector would only be considered if none of the public sector sites was deemed appropriate based on the appraisal process.

It was acknowledged by all concerned at the outset and throughout the appraisal process that sites are extremely limited in the Kincardine area and that this would inevitably present a significant challenge to the project.

3.5.2 Short List of Options

The short-list was largely shaped by:

- A complete lack of suitability/options regarding the current site
- A complete lack of facilities in the Kincardine area to present refurbishment opportunities or additional supportive capacity for the integrated health and social care model
- A very limited range of additional sites/opportunities

The short list consequently included four options:

Option	Description
1	1 - Do Nothing (The Status Quo)
2	6b - New build at Feregait site in Kincardine (for Kincardine services only)
3	6c - New build at Station Road site in Kincardine (for Kincardine services only)
4	6d - New build at Tulliallan Primary School in Kincardine (for Kincardine services only)

Table 21 – Short-list of Options

3.5.3 Indicative Costs

Indicative costs for each of the options on the Short List have been prepared as per guidance in the Scottish Capital Investment Manual by hubCo. The non-preferred options are based on BCIS Tender Price Indices – updated to 4th quarter 2020. The preferred option is based on elemental cost/m^2 from other recent health centre projects and the current Schedules of Accommodation (updated to 4th quarter 2020). Figures are calculated over a 60 year period.

	Description	Capital Costs (£) *	Whole Life Capital Costs (£)	Whole Life Operating Costs (£)	Est. NPV (£)	Est. EUV (£)
1	**Do Nothing/Base**	-	-	1,749,291	723,705	28,520
2	**(6b) Feregait**	3,846,621	758,689	10,220,763	6,307,702	248,577
3	**(6c) Station Road**	3,903,627	769,948	10,293,636	6,368,662	250,979
4	**(6d) Tulliallan School**	3,903,627	769,948	10,293,636	6,368,662	250,979

Table 22 - Option Costs

3.5.4 Option Advantages and Disadvantages

The following table outlines how the advantages and disadvantages of the short list were assessed against the benefits criteria. This was undertaken through a process of discussion / debate within groups with the intention of seeking consensus agreement around the relative merits of each option and scores to be applied.

	Option1: Status Quo	**Option 2: Feregait**	**Option 3: Station Road**	**Option 4: Tuliallan School**
Advantages (Strengths & Opportunities)	Established location.	Purpose built facility. Good central location. Good pedestrian and vehicle access. Secure location. Good service access. Good parking.	Relatively close to town centre. Relatively flat site, for 1 level building. Good pedestrians and vehicle access. Secure location. Good community setting. Flexibility – with potential expansion options. Ease of segregated access.	Central location. Good physical site. Good local and physical access. Community Campus opportunity. High visibility. Increased flexibility. Ability to segregate access for staff/patients/ servicing. Access from A977.
Disadvantages (Weaknesses & Threats)	Building and curtilage not suitable for further development	Potential flood risk. Site investigation required (mining?). Ground conditions make development expensive. Infrastructure issues.	Potentially too overlooked. Impacts on village green. Potential flood risk. Site investigation required (mining?). Ground conditions make development expensive. Infrastructure issues. Public transport – slight walk.	Loss of school / community amenity space. Potentially contentious road issues. Potential flood risk. Site investigation required (mining?) Ground conditions make development expensive. Infrastructure issues.

			Access road may not be suitable for construction traffic.	

3.5.5 Does the Option meet the Investment Objectives?

The table below summarises the extent to which the shortlisted options meet the Investment Objectives.

Table 23 - Option Advantages and Disadvantages

Investment Objective	Option 1: Status Quo	Option 2: Feregait	Option 3: Station Road	Option 4: Tuliallan School
Ensure equal access to a patient centred approach by enabling delivery of and access to local anticipatory and preventative care for patients.	No	Yes	Yes	Yes
Ensure equal access to modern integrated care with provision driven by patient need rather than limitations in physical capacity.	No	Yes	Yes	Yes
Ensure the right staff skill mix and service capacity are available to deliver and strengthen local capacity to manage people's health within the local community.	No	Yes	Yes	Yes
Enable earlier access to proactive and anticipatory care through local delivery via integrated seamless service across health and social care.	No	Yes	Yes	Yes
Delivery of safe and effective care with dignity –by providing facilities which comply with all legal standards and regulatory requirements and gives equality of access for all.	No	Yes	Yes	Yes
Improve safety and effectiveness of accommodation by improving the physical	No	Yes	Yes	Yes

Investment Objective	Option 1: Status Quo	Option 2: Feregait	Option 3: Station Road	Option 4: Tuliallan School
condition, quality and functional suitability of the healthcare estate.				

Table 24 - Does the Option Meet the Investment Objectives?

3.5.6 Cost / Benefit

This section presents the case for the selection of the preferred option. In line with HM Treasury guidance, the NPC is divided by the weighted benefits (WBP) score to determine the cost per benefit point for each option. The lowest cost per benefit point is considered to be the most attractive option.

	Option 1: Status Quo	Option 2: Feregait	Option 3: Station Road	Option 4: Tuliallan School
Net present cost (NPC) - £m	723,705	6,307,702	6,368,662	6,368,662
Weighted benefit points (WBP)	221	539	509	739
BPC per WBP - £000	3,275	11,703	12,512	8,618
	Rejected	Possible	Possible	Preferred

Table 25 - Option Benefit Scores

3.5.7 Preferred Option

From table 25 it can be seen that option 4 scores highest in respect to benefit points. Once the net present costs are factored in, option 1 is highlighted at the lowest cost per benefits point – this is purely because of low net present cost owing to the limited capital that could be invested in the existing facility. As option 1 does nothing to tackle the needs for change as demonstrated within the strategic case and benefits appraisal, it is not a legitimate option.

Given the balance of legitimate options, option 4 offers the highest benefits score and the lowest cost per benefits point, indicating that it is the strongest option. Option 4 is therefore the preferred option as favoured by all stakeholders (consensus), with little to choose between options 2 and 3 for second place.

The proposal has the support of representative service users, carers, staff, the GP Practice and all other key stakeholders.

Through further dialogue with Fife Council during the OBC the site location was selected to the North of the playing fields. This allowed future expansion for the School, whilst protecting the primary football pitch.

4 Commercial Case

4.1 Introduction

This section outlines the commercial arrangements and implications for the Project. This is done by responding to the following points:

- The procurement strategy and appropriate procurement route for the Project
- The scope and content of the proposed commercial arrangement
- Risk allocation and apportionment between public and private sector
- The payment structure and how this will be made over the lifetime of the Project
- The contractual arrangements for the Project

4.2 Revisiting the Commercial Case

The commercial case has generally been updated and expanded since IA in accordance with SCIM OBC guidance. In particular, the design of the preferred option has been progressed allowing for a detailed overview on the status of the design to be provided.

4.3 Procurement Strategy

4.3.1 Procurement Route

NHS Fife will lead on the procurement whilst being supported by the Fife Health and Social Care Partnership.

The project is community focussed and more than £750k, therefore the Scottish Futures Trust hub initiative has been selected as the most appropriate route to deliver the project. The East Central hubCo have been appointed to deliver this public funded project under the design and build option.

The following further procurements have been undertaken to support the Board and these will be procured through Frameworks Scotland Lead Advisor lot.

Lead Advisor

- Project Manager services
- Cost Advisor services
- Technical Advisor services (M&E)
- Authority's Representative (for contract purposes)
- Clerk of Works

4.3.2 Procurement Rules and Regulations

As the proposed procurements have already been tendered they are in compliance with the procurement rules and regulations.

4.3.3 Procurement Plan

The summary table below provides an overview in respect to procurements to date:

Service	Appointment	Status
Contractor, Designers and Principal Designer	East Central hubCo	New Project Request (NPR) agreed. Stage 1 Approved.
Lead Advisor	Currie & Brown	Appointed

Table 26 - Procurements

4.4 Scope and Content of Proposed Commercial Arrangements

4.4.1 Overview

The project involves providing a new health and wellbeing centre within Kincardine at the preferred Tulliallan site. The new centre will replace the existing facility and will be developed further to accommodate future growth within the local area whilst taking cognisance of the Scottish General Medical Services (GMS) contract. The new facility will focus on providing core GP and other health services whilst offering broader flexibility for the promotion of interconnected health and wellbeing opportunities within the local community – this is in-keeping with NHS Fife's ambition to become an anchor institution within Fife.

4.4.2 Project Brief

The project brief is reflected within the following documents which can be provided upon request:

Document	Date	Revision
New Project request (including appendices)		4
Authority's Construction Requirements (ACR)	12.08.21	1

Table 27 - Project Brief

The brief for the design process is that the proposal must conform to all statutory requirements. In addition, the design proposals must meet all relevant Healthcare Guidance as published by HFS on their website.

The PSCP is required to schedule all relevant healthcare guidance and identify any associated derogations against that guidance. This process is ongoing in parallel with the development of the design and will be concluded and presented during the FBC stage of the project.

In respect to governance, the Project Team will be charged with reviewing and agreeing proposed derogations. Thereafter the Project Board have assumed responsibility for sanctioning any proposed derogations. This will be an iterative process culminating in formal acceptance of derogations in advance of contract execution. The Project Team will liaise with Health Facilities Scotland for support and guidance where necessary when contemplating derogations.

4.4.3 Current Design Status

The design has been completed to RIBA Stage 2 which aligns with OBC and NDAP requirements. The table referenced below provides an overview of how the project is performing against predefined OBC requirements.

OBC Design Requirements	Project Status
Concept Design incl. Arch, M&E, C&S, Fire, Landscape	Complete
Outline drawings (≥1:200, key ≥1: 50) & specifications	Complete
Outline sustainability strategy	BREEAM Pre-assessment completed
Outline construction strategy incl. HAI, CDM H&S Plan	Ongoing and will be continued into FBC
3D sketches of key Design Statement spaces	Complete
Completed Design Statement OBC self-assessment	Complete – assessed through AEDET workshop
Completed AEDET OBC self-assessment	Complete
Photographs of site showing broader context	Complete
Evidence of Local Authority Planning consultation and/or alignment with Local Development Plan.	Pre-planning engagement has been sought from Fife Council via a formal application and fee. Consultation and feedback will be received early within the FBC period.

OBC Design Requirements	Project Status
Extract of draft OBC detailing benefits & risks analysis	Provided within this OBC.
Evidence of HAI & CDM consultation	HAI SCRIBE Stage 1 has been completed
Evidence Sustainability commitments will be met. e.g. accurate & NCM models (DSM). BREEAM, .CAB files and BRUKL; show how design will be optimised	Design development ongoing but briefing requirements set out in NPR and ACR
Evidence Equality & access commitments will be met	EQIA Stage 1 complete
Evidence of VfM e.g. WLC on key design options	Ongoing process through design workshops
Evidence Activity Data Base (ADB) use optimised	Will be used at FBC. Standard HFS repeatable layouts will be utilised where appropriate
Evidence NHS guidance & technical standards will be met; list any derogations, with their technical reasons	Ongoing – to be evidenced and concluded within the FBC stage
OBC design report evidencing all above & IA brief met ≥1:500, ≥1:200, key ≥1: 50; diagrams, sections plans, 3Ds, specs, comfort & energy DSMs, to RIBA Stage 2 Concept plus key elements developed to Stage 3	Complete – NDAP submission made on 23 December 2021

Table 28 - Design Status

4.4.4 Schedule of Accommodation (SoA) Development

A SoA was developed at the IA stage of the project. Whilst the schedule was tested with stakeholders at this stage to inform budgetary costings it was very much a working draft. The status of the SoA was offset by the optimism bias allocation factored into the Financial Case at IA.

The SoA was developed further at commencement of the OBC stage following a detailed review of health services to be accommodated within the building. When the IA was first developed, the GMS contract was in its infancy. Changes to the SoA largely relate to emerging requirements from the GMS contract.

The table below compares the IA SoA to the OBC “as drawn” outturn. As it can be seen there is an increase of 180m^2 overall.

IA SoA (m^2)	OBC "as drawn" (m^2)	FBC "as drawn" (m^2)	Difference (m^2)
833	1,013		180

Table 29 - Area (m^2) Summary

4.4.5 Flexible Space

Given the order of investment, it is important that use of the asset is maximised with rooms being utilised to their full potential. It is also important for the asset to be used successfully at the outset whilst being capable of withstanding future change with minimal disruption and cost. For these reasons the following themes and workstreams are being progressed.

- HFS standardised rooms are being incorporated wherever practicable
- The building configuration is being designed to withstand future changes in GP practice arrangements – i.e. consolidation of GP practices
- A bookable room system is being developed to support transient services
- The building layout and landscape is being designed to afford and promote "out of hours" use for health and wellbeing initiatives and community use
- An agile working policy is being developed to support agile workstations within open plan office areas
- The building design is being considerate to possible constraints caused by pandemics and how the building may cope with these temporary situations

4.4.6 Community Engagement

In December 2020 a community engagement exercise was undertaken to reach out to the local community to establish what was important for them within their new health and wellbeing centre over and beyond core requirements. Aspects relating to the physical building are listed below together with detail on how these themes will be taken forward and where applicable incorporated into the design. Feedback in respect to the community engagement exercise has been undertaken with the community separately.

Theme	Project Action
Flexible spaces to allow the provision of services and for community use out of hours	Carried forward into design proposals
Near-me booths to support accessibility and digital poverty	Being carried forward into design proposals
Community gym	No space allowance for an internal gym currently. External space is being incorporated for community use which could include provision for gym related equipment. Space allocation only at OBC.

Theme	Project Action
Needle exchange	Being considered within design proposals
Community garden	External space is being incorporated for community use which may include provision for a community garden. Space allocation only at OBC
Accessibility - space for external mobility scooter parking plus space for wheelchair and pram storage/parking internally	Being carried forward into design proposals
Covered external area	Being considered and where possible incorporated, but needs to be balanced with anti-social behaviour which covered areas can often attract
Community café	It is considered that the health centre is too small to benefit from a community café. This amenity is already provided locally
Community fridge	This amenity could/is be provided by the local community centre

Table 30 - Engagement Feedback

4.4.7 NHSScotland Design Assessment Process (NDAP)

The purpose of NDAP is to promote design quality and service. It does this by mapping design standards to the key investment deliverables, including Scottish Government objectives and expectations for public investment, then demonstrating their delivery via self, and independent assessments. NDAP is made up of personnel from Health Facilities Scotland (HFS) and Architecture Design Scotland (A&DS).

During the IA Stage, A&DS helped to facilitate a Design Statement workshop. This document forms part of the Project Brief, setting out design objectives for the Project Team. The project's design statement is located at Appendix B.

At commencement of OBC shortly after hubCo appointment, the Project Team met with HFS to discuss the project, principles and expectations. This helped to provide a framework for development of the design during the OBC Stage.

The OBC NDAP submission was issued on 23 December 2021. The review process is ongoing at the time of concluding this OBC for governance approvals, although it is anticipated that the NDAP report will be available in advance of the project being considered by the Scottish Capital Investment Group.

4.4.8 NHS Assure

NHS Assure is a technical key stage review process set up and administered by NHS NSS. Their remit is to provide knowledge and expertise through the lifecycle of projects to provide confidence within the public sector that projects are being procured, designed and delivered in a compliant manner ensuring operational safety for building users.

NHS Fife submitted their OBC key stage review pack to NHS Assure on 23 December 2021.The review process is ongoing at the time of concluding this OBC for governance approvals, although it is anticipated that the NDAP report will be available in advance of the project being considered by the Scottish Capital Investment Group.

4.4.9 Achieving Excellence Design Evaluation Toolkit (AEDET)

In accordance with SCIM guidance and the investment objectives, AEDET will be used throughout the development of the Project to help NHS Fife manage the design from initial proposals through to detailed design and will continue to do so through to Project Evaluation.

The AEDET toolkit has three key dimensions (functionality, build quality and impact) and outlines 10 assessment criteria. Each of the 10 areas is assessed using a series of questions which are scored on a scale of 1 - 6.

AEDET assessments are to be undertaken at predefined stages throughout the project's lifecycle. The stages are outlined in the table below together project progress against these to date.

Stage	Project Progress
Benchmark – assessment of current asset(s)	Completed at IA
Target – aspiration for project	Completed at IA
OBC – assessment of design proposals	Complete
FBC – assessment of design proposals	To be completed at FBC

Table 31 - AEDET Progress

On 8 September 2021, an AEDET workshop was held to review the OBC stage design against the agreed target scores. This workshop involved a wide range of participants including staff, service users and hubCo. The OBC AEDET scores are included in the table below together with the benchmark and target scores. Whilst some of the scores are lower than the target, this is mostly connected to the maturity of the design and it is envisaged the scoring will be improved further during the FBC AEDET workshop.

Category	Benchmark	Target	OBC	FBC
Use	1.0	4.3	4.1	
Access	1.1	4.4	3.1	
Space	2.0	4.2	3.7	
Performance	1.3	4.4	2.7	
Engineering	1.4	3.4	3.4	
Construction	0.0	4.0	0.0	
Character & Innovation	1.3	4.4	3.9	
Form & Materials	2.1	4.4	3.6	
Staff & Patient Environment	1.3	4.5	4.3	
Urban & Social Integration	2.6	4.3	3.6	

Table 32 - AEDET Scores

4.4.10 BREEAM

Projects requiring capital investment through the Scottish Government are required to demonstrate sustainable credentials to contribute towards the development of a sustainable NHS estate.

The project has been assessed using BREEAM UK New Construction 2018, sub-group healthcare. A target score of 45% was set at the briefing stage which equates to a BREEAM “good” rating. The project is currently targeting credits equating to 52.21% which is beyond the briefing target.

Note: the project commenced in advance of new sustainability guide being mandated / published so proceeded on the basis of mandated guidance at that point in time

4.4.11 Energy

Following a meeting with HFS, project specific energy targets were agreed. The energy targets took cognisance of project budgetary constraints set at IA (pre zero carbon policy) whilst still aiming to ensure that the facility will be very energy efficient. The following criteria was agreed:

- >59% emissions reduction against 2015 benchmarking to be sought
- Electricity target not more than 60 kWh/m^2 pa; and max demand not to exceed 20 Watts/m^2
- Thermal target not more than 120 kWh/m^2 pa

The criteria will be achieved through the development of the design.

4.4.12 Healthcare Associated Infection System for Controlling Risk in the Built Environment (HAI SCRIBE)

HAI SCRIBE is a risk management process aiding the identification and mitigation of design and construction related infection risks within the built environment. There are four stages within the process – these are identified in the table below together with project progress against these stages to date.

Stage	Project Progress
Stage 1 – Site Selection	Complete
Stage 2 – Design	To be completed at FBC stage.
Stage 3 – Construction	To be completed at FBC stage.
Stage 4 – Occupation	To be completed post completion.

Table 33 - HAI SCRIBE Summary

4.4.13 Building Information Modelling (BIM)

BIM describes the process of designing and constructing a building collaboratively using one coherent system of digital models and linked non graphical data, as opposed to separate sets of drawings and documents. These models and data also incorporate information which will be carried over and used in the operational phase.

NHSScotland is supporting the adoption of Level 2 BIM maturity following the SG mandate in support of the recommendations of the "Review of Scottish Public Sector Procurement in Construction" which endorsed that "BIM will be introduced in central government with a view to encouraging adoption across the public sector. The objective states that, where appropriate, projects across the public sector adopt BIM level 2 by April 2017."

The NHSScotland BIM strategy is intended to ensure the creation of a digitised information management process which all Boards and teams working on NHSScotland programmes should follow to maintain consistency and facilitate collaborative working, which will in turn reduce waste and non-conformances.

The Project will use BIM as a key design tool during the design and construction phases of the project helping to facilitate coordination and mitigate risks. Another benefit of BIM is that NHS Fife will have true "as built" records along with the project specific asset tagging that will assist with the operation, maintenance and replacement of components.

An NHS Fife Employers Information Requirements (EIR) has been developed and offered hubCo as part of the Project Brief. The EIR in turn has helped to inform the BIM Execution Plan (BEP) which has been developed by the hubCo. These two documents control how BIM will be utilised on the project.

4.4.14 E-health

Consultation has been ongoing with eHealth during the OBC phase of the project. Initial efforts have focussed on ensuring the IT infrastructure meets e-health's standard requirements. E-health systems will be provided in line the department's wider strategy for GP premises. E-health suggestions flowing from the stakeholder consultation are as follows

and these will be considered by the project team in further detail at the next stage of the process (**subject to separate funding and business cases where appropriate**).

- A patient appointment system
- A consultant room with near me facilities
- A GP text messaging system
- A self check-in facility
- Subject to security considerations, public access to IT equipment to combat digital poverty
- A room booking system

4.5 Risk Allocation

4.5.1 Key Principles

At conclusion of the FBC NHS Fife will enter a contract with hubCo to deliver the facility. The contract will be based on the Hub standard form Project Agreement (Design Build Direct Agreement) and will be subject to amendment through agreement between Legal Advisers.

Having worked through the pre-construction stage and mitigated the construction risks through surveys and investigations most of the residual construction risk is taken by hubCo.

The risk allocation table below is driven by the Design Build and Direct procurement methodology described above. Note: the percentage allocations are indicative of a project of this nature.

	Allocation of risk		
Risk Category	**Public**	**Private**	**Notes**
Title	100%	0%	
Design	0%	100%	
Development and Construction	5%	95%	√
Ground conditions below existing structures that could not be surveyed	100%	0%	There are no existing buildings on the proposed site.
Transition and implementation	100%	0%	Commissioning and migration Board responsibility
Operation of the facility	100%	0%	
Revenue	100%	0%	
Termination of Project	40%	60%	

	Allocation of risk		
Risk Category	**Public**	**Private**	**Notes**
Technology and obsolescence	100%	0%	√
Financing	100%	0%	Capital funding
Legislative	100%	0%	

Table 34 - Risk Allocation Summary

4.5.2 Key Risks

The key risks/issues currently encountered on the project are outlined in the table below. The risk register can be located at Appendix G.

Risk/issue	Mitigation
Brief inadequate/unreliable This issue relates to developments around the GMS contract and effect this has had on the area requirements for the building.	The required area increase from IA to OBC has been factored into the current design and corresponding cost plan.
Stop/start nature of the programme – keep people engaged through these periods.	Updates are being provided to community groups via newsletters and the public via press releases. NHS Fife's communication team are supporting this effort.
Project cost increases due to: ▪ Change in requirements ▪ Inflation / market conditions	This is a current issue where the cost increases have rose beyond the IA budget projection. Refer to Financial Case for further substantiation.
Programme delay The OBC programme has been affected because of COVID which has impacted resources, engagement activity and costs.	Potential to commence FBC activity in parallel with the OBC governance approval process. The project now has a full complement of resources to help drive the project forward.
Change of policy – NHS Assure Key Stage reviews Programme delays / cost increases arising	Key stage review process was implemented half-way through OBC and is required to achieve capital funding. Risk had to be accepted, but impact can be mitigated through collaboration.

Risk/issue	Mitigation
Change of policy – SHTN 02-01 Sustainable Design and Construction Guide (SDaC) Programme delays / cost increases arising	Informed by HFS at OBC NDAP review that new guidance must be followed at FBC. Guidance is untested to impact is difficult to quantify. As such this risk has not currently been factored into OBC cost estimates.

Table 35 - Key Risk Summary

4.6 Payment Structure

During the pre-construction stage hubCo are paid on a monthly lump sum basis in line with an agreed drawdown schedule. At construction the Board will be obliged to pay hubCo a lump sum one-off Development Fee for their services. Thereafter applications for payment will be processed and settled monthly in accordance with the form of contract.

Directly appointed consultants will be paid on a monthly basis in accordance with their agreed NEC4 Option A activity schedules.

4.6.1 Project Bank Account

The Project will operate a Project Bank Account (PBA), consistent with Scottish Government Guidance for public sector construction projects. A Project Bank Account is a ring-fenced bank account from which prompt payments are made directly and simultaneously to hubCo, the lead contractor and members of the supply chain. PBA's improve subcontractors' cashflow and ring-fence it from upstream insolvency.

The PBA will become operational during the construction stage of the project. The documentation and contractual arrangements associated with setting up the PBA will be developed during the FBC stage. Recent board experience in setting up a project bank account for a separate capital project will be beneficial for this project.

4.6.2 Risk Contingency Management

A project risk register was created at IA and this has since been developed further during OBC. It is used as an active management tool to identify and mitigate risks progressively as the design is developed. The risks have been fairly allocated to the party best able to manage them.

The risk register will continue to be used through FBC and the construction stage to enable risks to be identified and managed. From a commercial perspective hubCo risk is capped at 1% prior to entering the construction stage. Variations are managed in accordance with the terms of the contract. Although the opportunity for risk and variations is restricted during the construction stage, it is prudent for the NHS Fife to retain a reasonable contingency provision to cover this risk. The contingency provision will be developed and informed by the risk register during FBC but is likely to be in the order of 3-5%.

4.6.3 Contract Variations

Variations will be managed in accordance with the terms of the contract. The contract will be based on the standard SFT DBDA template with agreed amendments.

4.6.4 Disputed Payments

Disputed payments will be managed in accordance with the terms of the contract. The contract will be based on the standard SFT DBDA template with agreed amendments.

4.6.5 Inflation

Inflation will be taken account of when developing the price using the BCIS indices. HubCo and NHS Fife's Lead Advisor will ensure that the correct indices are utilised to identify the correct inflation to be applied to the project. Any deviation to the agreed inflation allowance rest with hubCo as an opportunity/risk.

4.6.6 Utilities and Service Connection Charges

Responsibility for utility and service connections charges will be identified and confirmed at Stage 2 (FBC).

4.6.7 Performance Incentives

No performance incentives will be utilised.

4.7 Contractual Arrangements

4.7.1 Type of Contract

The contract will be based on the standard SFT DBDA template with agreed amendments.

4.7.2 Key Contractual Issues

No key contractual issues have been identified at this stage, however should any arise through development and completion of the contract documentation, then these will be presented within the FBC.

4.7.3 Dispute Resolution and Termination

Procedures for contract administration, dispute resolution and termination are clearly set out within the proposed contract form.

4.7.4 Asset Ownership

In respect to asset ownership, the project is being procured using traditional capital funding. hubCo will be responsible for delivering the facilities. At Completion, NHS Fife will take possession of the building and will be responsible for the ongoing operation and maintenance of the facilities.

4.7.5 Land Ownership

The land is likely to be leased on a long-terms basis (100 years) from Fife Council. This is a similar arrangement to many of Fife's existing health centres and comparably demonstrates far greater value for money than purchasing the land outright. Initial discussions have already taken place with Fife Council and these will be advanced during the FBC stage of the project.

4.7.6 Personnel Implications

There are no employees who are wholly or substantially employed on services that will be transferred to the private sector under the proposals for this Project, and therefore the Transfer of Undertakings (Protection of Employment) Regulations 1981[17] (TUPE) will not apply.

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[17] https://www.legislation.gov.uk/uksi/2006/246/contents/made

5 Financial Case

5.1 Introduction

The Financial Case considers the affordability of the scheme. This section sets out all associated capital and revenue costs, assesses the affordability of the preferred option and considers the impact on NHS Fife's and the FHSCP's finances. The affordability model assessment has been developed to cover all aspects of projected costs including estimates for:

- Capital costs for the option considered (including construction and equipment)
- Non-recurring revenue costs associated with the project
- Recurring revenue costs (pay and non-pay) for current model i.e. baseline
- Recurring revenue costs (pay and non-pay) for the preferred option

For clarity it should be noted that NHS Fife will take ownership and financial responsibility for all property related costs (capital and revenue). The FHSCP will be financial responsible for all service-related costs – i.e. costs to provide the required clinical services.

5.2 Revisiting the Financial Case

The IA was approved by Scottish Government Health and Social Care Department (SGHSCD) in November 2019 and no specific conditions were outlined in the approval letter in relation to the Financial Case.

NHS Fife have considered the affordability of this proposal by undertaking a review of the financial implications of investment, both capital and revenue.

5.3 Financial Model (costs and associated funding for the project)

5.3.1 Capital Costs

5.3.1.1 Capital Cost Summary

Capital costs have been produced by East Central hubCo and have been summarised in Table 36 below.

Description	IA Costs	OBC Costs	Difference
Design Fees	£322,666	£473,265	£150,599
Construction Price	£2,370,203	£4,400,070	£2,029,867
Surveys/Investigations	£20,000	£50,000	£30,000
Statutory Fees	£20,000	£75,000	£55,000
Contingency	£151,739	£212,970	£61,231
Inflation	£68,073	£119,574	£51,501
Optimism Bias	£708,643	£703,676	-£4,967
Client Consultants	£136,888	£139,788	£2,900
Equipment	£82,209	£266,544	£184,335
Decant	£14,643	£14,643	£0
BIM Fees	£0	£0	£0
E-health	£8,563	£0	-£8,563
Direct Labour Costs	£0	£98,848	£98,848

Description	IA Costs	OBC Costs	Difference
Total ex. VAT	**£3,903,627**	**£6,554,380**	**£2,650,753**
VAT	**£753,348**	**£1,263,149**	**£509,801**
Total	**£4,656,975**	**£7,817,528**	**£3,160,553**

Table 36 - Capital Costs

The total updated cost of the preferred option, which is to develop Kincardine Health Centre for NHS Fife is £7,817,528.

It is important to recognise that whilst the capital cost has increased since Initial Agreement, the other feasible options presented within the Economic Case would have increased in the same way given that the underlying factors driving cost would have been the same. This means that the preferred option, despite being subject to significant cost increase, remains the preferred option in respect to benefit realisation and cost.

5.3.1.2 Capital Cost Key Movements

Table 37 below provides a summary of key project cost adjustments. The adjustments are described further beneath the table from a budgetary perspective.

Description	IA Cost	OBC Cost	Difference	Notes
Hubco	£2,884,607	£5,211,306	£2,326,699	Area increase: 180m^2 Inflation: extraordinary conditions Site & design abnormals
Inflation	£68,073	£119,574	£51,501	Based on BCIS indices to construction
Optimism bias	£708,643	£703,676	-£4,967	Updated for OBC based on project maturity at this stage (13%)
Consultants	£136,888	£139,788	£2,900	Contract now awarded – firm cost
Decant	£14,643	£14,643	-	
Equipment	£82,209	£266,544	£184,335	Equipment allowance too low at IA – increased in consultation with HFS (5%)
E-health	£8,563	-	-£8,563	Included in equipment line
Direct costs	-	£98,848	£98,848	None allowed for at IA
Total ex. VAT	**£3,888,983**	**£6,539,736**	**£2,650,753**	
VAT	**£753,348**	**£1,263,149**	**£509,801**	
Total	**£4,656,975**	**£7,817,529**	**£3,160,555**	

Table 37 - Key Capital Cost Movements

In respect to the OBC cost plan, there is a difference amounting to £3,160,553 when compared to the agreed IA allocation (£4,656,975). This difference is primary attributed to the construction costs where increases have been realised through:

- Building area increase to take account of service and GMS contract evolving requirements – accounts for circa 35% of the construction cost increase
- Inflation and extraordinary market conditions considered to driven by the COVID-19 pandemic and the resulting global effect on supply chains – accounts for circa 20% of the construction cost increase
- Site and design abnormals: this relates to specific site conditions, more onerous energy requirements and creating a building that satisfies the conditions of the brief and design statement – accounts for circa 45% of the construction cost increase

It should be noted and acknowledged that the construction costs figures provided make allowance for realistic value engineering targets/savings within the FBC stage of the project – without this, the construction cost element and associated overall OBC budget cost estimate would have been higher.

Whilst our Lead Advisors have yet to formally report on hubCo's Stage 1 (OBC) report, they have been working hand in hand with hubCo and their Tier 1 contractor in recent weeks to agree the OBC costs. They concur with hubCo that given the current nature of the market and evolving more onerous briefing requirements the costs represent value for money.

The other costs movements are either percentage mark-ups based on the increased construction cost or adjusted/new provisions (equipment and direct costs) to take the opportunity to make the overall budget more deliverable and realistic.

In the OBC cost plan the inflation assumptions have been rebased to ensure they are as current as possible, and inflation relating to the period between IA and OBC is now historical, and therefore now included in the current construction costs. There is a forecast inflation allowance built in from the period January 2022 to construction. Inflationary forecasting is difficult during these current times so there is an inherent risk in respect to project inflation – that said, whilst inflation increases are still forecast from 2022 to 2023, consultancy Cost Advisors generally believe that there should be some stabilisation given the significant movement in 2021.

5.3.1.3 Capital Clarification and Assumptions

The OBC capital cost estimate noted under Section 5.3.1.1 should be read with reference to the following assumptions.

Description	Note
Professional Fees	Professional services contract for Lead Advisor has been awarded
Equipment	Estimated 5% cost based on HFS advice. Transferable equipment will be moved to the new unit. Equipment budget only allows for items of equipment to be identified on the room layouts (conventional arrangement) and does not take account of any specialist equipment to be provided by the GP's or others

Contingency	Optimism bias at OBC stage has been calculated using a standard build template
Inflation	Based on Qtr 1 2022 Indices to construction
VAT	VAT has been applied where applicable. No VAT recovery estimates have been built into the cost plan for construction – this will to be confirmed with VAT Advisors and HMRC after contract is awarded
E-health	The project will cover the cost of e-health infrastructure within the building and key items of equipment as referenced on the room layouts. The budget does not allow for capital/revenue funded e-health projects.
Enhancements	Landscaping treatments around the health centre are currently quite standard. Any community garden, community gym or enhanced scheme is likely to require additional financial support.
Peppercorn Lease	The lease for the land is currently in discussion with Fife Council with the likely outcome that it will be considered a peppercorn rent. This will have an impact on leased depreciation figures under IFRS16 for right of use assets.

Table 38 - Capital Assumptions

5.3.2 Revenue Costs

5.3.2.1 Revenue Cost Summary

In order to confirm the revenue implications of the project the baseline costs (do nothing/minimum option) have been thoroughly reviewed and then compared to the projected costs of the preferred option to assess the financial implications. A summary of the revenue costs is provided in the table below.

Description	Baseline	Preferred Option	Difference
Property pays (NHSF)	£12,605	£33,474	£20,869
Property non-pays (NHSF)	£16,612	£76,550	£59,938
Property non-pays – GP offset (NHSF)	-£16,584	-£27,142	-£10,558
Net Increase (NHSF)	**£12,633**	**£82,882**	**£70,249**
Service model (FHSCP)		£31,500	-

Table 39 - Revenue Cost Summary

NHS Fife Revenue Costs

The OBC identifies overall net recurring revenue impact of £0.07m (excluding depreciation) for the preferred option against the baseline costs. Total revenue costs have been adjusted to reflect the GP rechargeable revenue costs associated with the health centre.

There are staff costs associated with this development - staffing, non-pay and consumable costs will continue to be reviewed as the FBC develops.

FHSCP Revenue Costs

The table below provides a breakdown of the FHSCP's anticipated revenue costs at OBC. The service model will evolve once decisions are received from Scottish Government on what the full implementation of MOU1/2 for urgent care and what MDT means for Fife.

All these costs will have a nil impact on the revenue outturn position as funding sources have been identified.

Staff group	WTE	Cost	Funding Source	Additional Information
Band 7 (Primary Care Pharmacist	0.50	£31,500	Funded through Primary Care Investment Fund	Per OBC
Total	**0.50**	**£31,500**		

Table 40 – FHSCP Service Model Costs

5.3.2.2 Property non-pays breakdown

A breakdown of the property non-pays is provided in the table below for information.

Property Cost	Baseline	Preferred Option	Increase
Equipment	£40	£2,172	£2,132
Heating Fuel & Power	£5,385	£29,016	£23,631
Property Maintenance	£1,131	£5,175	£4,044
Property Rates	£5,439	£28,140	£22,700
Water Charges	£711	£3,065	£2,354
Bedding & Linen	£128	£550	£422
Cleaning	£21	£647	£626
General Services	£135	£1,556	£1,421
Surgical sundries	£77	£332	£255
GP Clinical Waste	£3,545	£5,897	£2,352
Net Cost Increase	**£16,612**	**£76,550**	**£59,938**

Table 41 - Property Non-pays Breakdown

5.3.2.3 Depreciation

An outline of the changes in both running costs and depreciation is summarised below:

Depreciation	Life	Value £000's	Proposed Dprchg £000's	Baseline Dprchg £000's	Net Increase Dprchg £000's
Buildings	60	£7,497,676	£124,961	£9,111	£115,851
Equipment	10	£319,853	£31,985	£0	£31,985
Total		**£7,817,529**	**£156,947**	**£9,111**	**£147,836**

Table 42 - Depreciation

The depreciation for the preferred option is £0.157m based on an asset building life of 60yrs and 10yrs for equipment on an overall capital cost of £7.818m. The overall increase in depreciation is £0.148m based on 21/22 full depreciation charges - which will be met from the current ring-fenced NHS Fife non-core depreciation budget. The buildings depreciation charge is pre any Valuation Office valuation being done after completion – there is an expectation that any non-value works will reduce the value held in the balance sheet once the valuation is carried out and therefore reduce the depreciation charge going forward.

5.3.2.4 Revenue Clarification and Assumptions

A number of assumptions have been made at the OBC stage which will be further evaluated and revised throughout the development of the FBC. These assumptions are as detailed in the table below.

Description	Note
Costs	Costs are calculated using 2020/21 prices and using 2020/21 budgetary information.
Pays (NHSF)	The support costs for the existing Kincardine Health Centre have been calculated as the baseline and then used as a benchmark against which any changes are considered. Estimated costs for the preferred option reflect forecast demand from 2024/25. Calculations include allowances for on-costs, enhancements, sick leave, public holidays and annual leave. Workforce increases are based on increased health centre sqm increase.
Non-Pay (NHSF)	Non-pay costs assumed to increase in line with increased health centre sqm.
Depreciation	Building – 60 years and equipment 10yrs.

Table 43 - Revenue Assumptions

5.4 Accounting Treatment

The traditional funding route for the project will impact on NHS Fife's Balance Sheet - both the capital cost of the development and the associated capital equipment will be added as non-current assets to the balance sheet and depreciated over the life of the assets in line with accounting policies.

5.5 Financial Situation and Statement of Affordability

NHS Fife confirm that this project remains affordable in both revenue and capital terms. The capital costs of the investment will be met through a capital contribution from the Scottish Government Health and Social Care Division capital budget.

Additional recurring revenue costs for Kincardine Health Centre will be incorporated into NHS Fife's Annual Operational Plan for future years.

FHSCP funding in respect to their service model is ongoing and will be articulated within the FBC stage.

5.6 Stakeholder Support

As the project will be delivered by NHS Fife for Fife, written agreement of Stakeholder support from other NHS Scotland / public sector organisations is not required in this instance.

5.7 Resources

The project is fully resourced from both NHS Fife and the FHSCP's perspective. Any associated costs have been built into the updated OBC budget. Further clarity on resourcing and project structure can be found at Section 6.3.

5.8 Capital and Revenue Constraints

NHS Fife's capital funding commitments mean that the project cannot exceed the available budget. Any additional revenue costs will be met within NHS Fife's overall revenue resource envelope.

FHSCP?

5.9 Financial Contributions

Other than capital funding from the Scottish Government, there will be no financial contributions from external partners in respect to this project.

6 Management Case

6.1 Introduction

The main purpose of the Management Case is to demonstrate that NHS Fife is ready and capable of delivering the project successfully.

6.2 Revisiting the Management Case

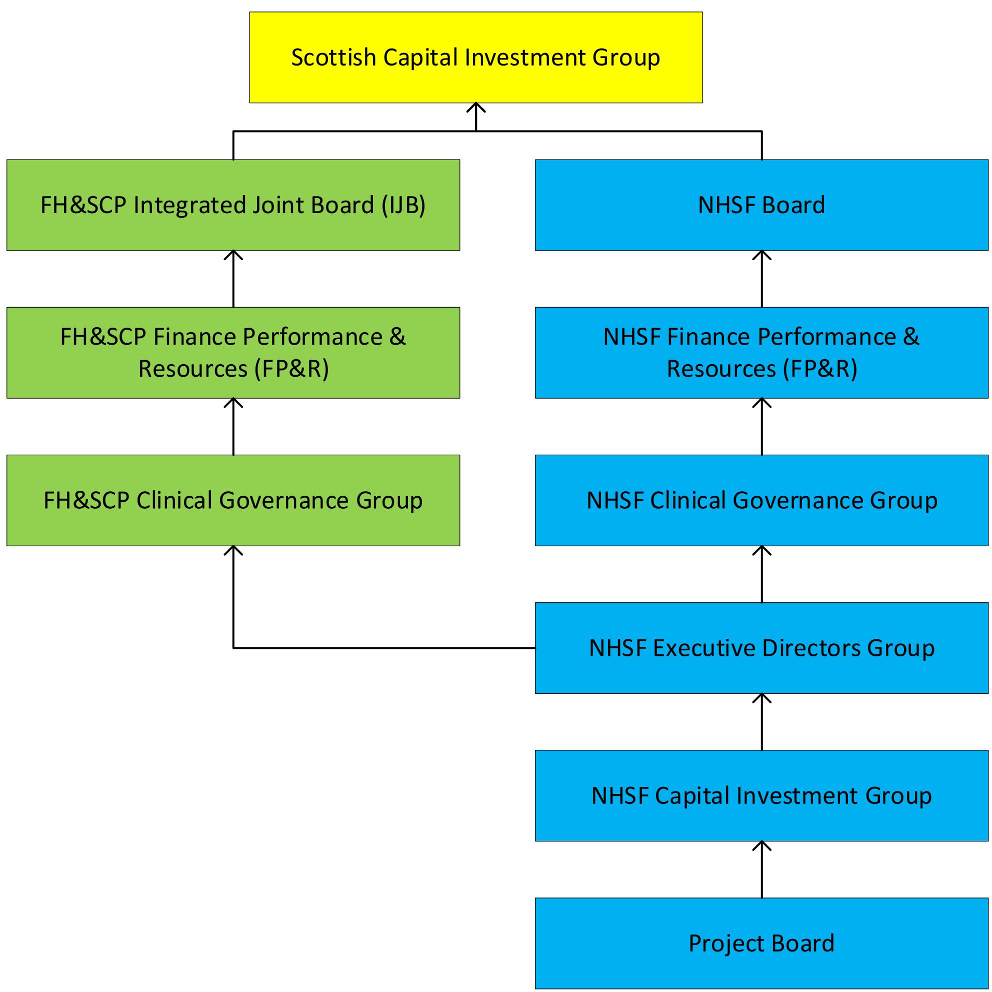
The management case has generally been updated and expanded since OBC in accordance with SCIM FBC guidance. The main sections remain the same and text has been updated where appropriate to reflect the current status of the project.

6.3 Reporting Structure and Governance Arrangements

To deliver the project successfully, good governance is required to monitor and direct it. An understanding of the structure and mechanisms for escalation and reporting is set out on the organograms below.

6.3.1 Governance

The strategic and business case governance controlling the project is set out below.



6.3.2 Project Structure

The project structure taking account of the Project Board, FHSCP and Capital Planning functions is set out below. NHS Fife are responsible to delivering the facilities whilst FHSCP are responsible for delivery of the services from the facilities.

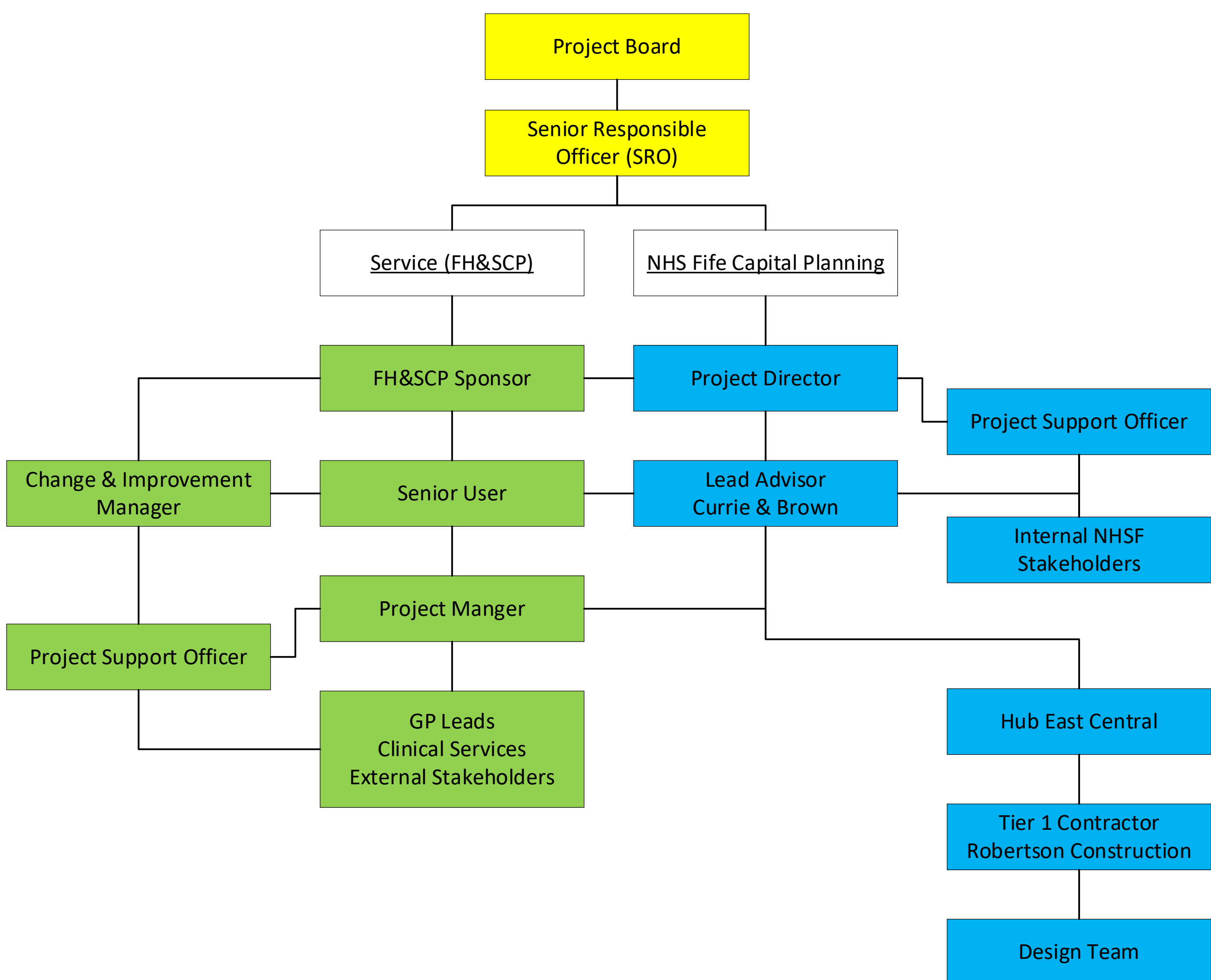


Figure 5 - Project Organisation

6.4 Project Board

A Project Board has been established to oversee the project. The Project Board was set up at commencement of the OBC and Terms of Reference have been agreed. The Project Board meets monthly where they receive a regular project update report from the FHSCP Sponsor and the Capital Planning Project Director. Necessary matters are escalated as required whilst the Project Board offers direction to the Project Team.

Project Board membership and experience is outlined in the table below:

Name/Role	Experience
Joy Tomlinson Director of Public Health Project role: Senior Responsible Officer (SRO) with overall responsibility and accountability for the project	Joy joined NHS Fife in May 2021, having worked within the NHS for 27 years. She has a clinical background, having trained in General Practice prior to working in Public Health. Prior to joining NHS Fife, she was joint Interim Director of Public Health in Ayrshire & Arran and has experience of departmental budgetary management with the additional complexities of rapid workforce and service development during the pandemic. She chairs the national 'place and wellbeing collaborative' which has developed Place & Wellbeing principles to support the refreshed National Planning Framework (NPF4).

Name/Role	Experience
Neil McCormick Director of Property and Asset Management Project role: responsible for contributing towards general governance.	Neil joins NHS Fife with over 30 years' experience of working at a senior level across the public and private sector. Neil's previous role was with Robertson Capital Projects, where he was Managing Director with specific responsibility for delivering infrastructure projects and joint ventures with the public sector including NHS Frameworks. Prior to this, Neil was Director of Strategic Projects & Property at NHS Forth Valley and Project Director for the £300m Forth Valley Royal Hospital.
Margo McGurk Director of Finance Project role: responsible for contributing towards general governance.	Margo joined NHS Fife as Director of Finance in February 2020. She is a CCAB qualified accountant, with a broad range of experience across the public sector but particularly within the NHS in Scotland. She has significant experience of decision-making at strategic and operational levels and has a strong personal focus on developing strategy, supporting culture, delivering sound financial control and best value from the allocation of resources. Very experienced in delivering professional leadership to the finance function, she has held a number of senior roles across a number of NHS Boards. She is particularly interested in working in partnership across organisations and leading on the development and delivery of financial strategies to support delivery against agreed priorities.
Nicky Conner Director of Health and Social Care Project role: responsible for contributing towards general governance.	Nicky has been Chief Officer and Director of Health and Social Care since 2019. Nicky offers 25 years' experience covering a diversity of public service roles including nursing, acute, specialist and community roles along with professional and clinical leadership to services within Fife's communities and leading on regional and national work. In her current role Nicky leads Health and Social Care Services for all of Fife including Community Care, Complex and Critical Care and Primary and Preventative Care. Nicky champions Integration, Partnership Working to deliver high quality services for the people of Fife.
Simon Fevre Staff Side Representation Project role: responsible for contributing towards general governance.	Simon is the NHS Trade Union Co-Chair of the HSCP Local Partnership Forum. Simon was NHS Fife's Employee Director for 7 years and has worked on the Board's Staff Governance agenda for 20 years. He was a clinician working in the Nutrition and Dietetic Department as Clinical lead for Older Peoples Services.

Name/Role	Experience
Ben Johnston Head of Capital Planning Project role: Capital Planning Project Director	Ben joined NHS Fife in January 2021 with over 15 years construction consultancy experience having worked in a diverse range of sectors. Working predominantly as a Project Manager, Ben has been responsible for delivering multiple projects diligently from inception to completion. Over recent years, Ben has spent most of time operating specifically within the healthcare sector, helping to positively contribute towards creating a sustainable healthcare estate for current and future generations. Ben has helped to deliver several projects for NHS Fife including Muirview and Hollyview at Stratheden Hospital and is currently helping to deliver the Fife Elective Orthopaedic Centre Project at Victoria Hospital.
Bryan Davies Head of Primary and Preventative Care Services Project role: FHSCP Project Sponsor	Bryan has worked within health and social care for over 25 years with experience in local area co-ordination, planning, performance, change management, commissioning, mental health, addictions, learning disability and advocacy. Bryan feels very passionate about health and social care integration and is excited to be working with colleagues and stakeholders to make a positive difference for individuals, families and communities in what are currently very challenging times.
Audrey Valente FHSCP Chief Financial Officer Project role: responsible for contributing towards general governance	Audrey has more than 30 years' experience working in local government holding senior finance positions. As a local lass, raised in Kirkcaldy, she went on to study accountancy at Napier University following her high school years at Kirkcaldy High. Audrey's experiences have combined strategic and operational financial management along with significant change management.
Helen Hellewell Associate Medical Director Project role: responsible for contributing towards general governance	Helen originated from Motherwell and moved to Fife after marrying. She finished her medical training at the Victoria in Kirkcaldy and took up a GP position in a local practice in Kirkcaldy. She then joined the Markinch medical practice, and currently still works one and half days per week there. Helen has been involved with the Partnership for a number of years having been the cluster lead for Glenrothes, working on a number of initiatives including quality improvement and integrated working and was the

Name/Role	Experience
	clinical lead on a leadership programme for integration with GP Scotland.
Benjamin Hannan Deputy Director of Pharmacy & Medicines Project role: represents the Area Clinical Forum as well as contributing to towards general governance.	Benjamin is an experienced pharmacy leader, with broad professional, managerial and leadership experience. Benjamin is a Fellow of the Institute of Leadership and Management and is currently Vice-Chair of Fife's Area Clinical Forum and represents this forum on the Project Board. The Area Clinical Forum allows NHS Fife to draw on the full range of professional skills and expertise that exists in all parts of the NHS system for advice on clinical and other professional matters. Benjamin's current role of Deputy Director of Pharmacy & Medicines is integrated across Health and Social Care, and all sectors and settings of care delivery. Prior to his current role, Benjamin was a GP Federation Director, responsible for 31 GP practices in the North East of England. This broad experience of primary care and community working will enable Benjamin to provide valuable insight to this project.
Tracy Gardiner Capital Accountant Project role: Capital Planning Accountant	Tracy has worked within NHS Fife for 26 years within the capital branch of the finance department. Tracy has a wide range of knowledge and experience in the delivery of capital projects within NHS Fife.
Ruth Lonie Communications Manager Project role: responsible for project communications	Ruth joined NHS Fife as Communications Manager in 2009. She has been involved in the communications aspects of a number of similar projects within NHS Fife.
Eugene Clark Non-executive Member *Dec. 20 – Jul. 21* Project role: responsible for contributing towards general governance	Eugene has spent the last 14 years working as a self-employed consultant helping businesses and public sector organisations in the fields of internal communication and employee engagement. Eugene's community interests have included being a former member of Largo Community Council and being involved in several action groups relating to sports in the Levenmouth area, most recently having helped establish the Fifers for the Community charity. Eugene is an active member of the Fife Children's Panel. He is also currently the Chair of the Levenmouth Rail Campaign, which seeks to regenerate the local community through the restoration of the direct rail link to Edinburgh.

Name/Role	Experience
Alistair Grant Non-executive Member *From Jan. 22* Project role: responsible for contributing towards general governance	Alastair Grant is a qualified accountant with more than 30 years' experience working both in Scotland and the Middle East. Most recently Alastair worked for Sodexo Justice Services, until his recent retirement. Alastair brings to the Board proven commercial acumen, combined with good people management, team building, development, and mentoring skills.

Table 44 - Project Board Experience

6.5 Project Team

The project team sits below the Project Board and are responsible for delivering the project on a day-to-day basis. Responsibilities include:

- Facility design development
- Service change re-design
- Business case development
- Stakeholder communications and engagement
- Management of risks and issues
- Management of cost
- Construction and handover of the facilities

To discharge these responsibilities, there are a wide range of roles. These are outlined within the Project's Project Execution Plan.

6.5.1 External Advisors

Where necessary independent consultants have been procured by the Board to help with the management of the project. Consultants procured to date include:

Project Role	Organisation
Lead Advisor	Currie & Brown
▪ Project Manager	Currie & Brown
▪ Cost Advisor	Currie & Brown
▪ M&E Technical Advisor	Hulley & Kirkwood (sub-consulted)
▪ Clerk of Works	Currie & Brown + Hulley & Kirkwood
▪ Authority's Representative (contract)	Currie & Brown

Table 45 - External Advisors

6.5.2 Project Recruitment Needs

No additional recruitment needs are envisaged at this time, however this will be re-considered during the FBC phase of the project.

6.6 Project Plan and Key Milestones

The project plan and key milestones are set out in the table below.

Description / activity	Date
Full Business Case	
Commencement	February 2022
Completion	January 2022
Governance Approvals	April 2023
Construction & Handover	
Commencement	May 2023
Completion	June 2024
Operational	August 2024

Table 46 - Key Milestone Summary

6.7 Change Management Arrangements

6.7.1 Operational and Service Change Plan

The operational and service change plan proposals are outlined under Section 2.4.1.3. This work will continue through FBC and Construction in parallel with the soft landings process to ensure that the services are prepared to adopt new ways of working in advance of the facilities being made available for use. The FHSCP will ultimately assume responsibility for progressing this dependant workstream.

6.7.2 Facilities Change Plan

The new facility will be serviced by NHS Fife's in-house Facilities and Estates team in a similar way to the existing arrangements. Costs relating to the increase in area have been factored into the GP allocations. NHS Fife resource projections to maintain and upkeep the building have been taken account of in revenue projections (see the Financial Case).

6.7.3 Stakeholder Engagement and Communication Plan

A Stakeholder Engagement and Communication Plan has been developed and endorsed by the Project Board. The plan will continue to be developed and updated as the project progresses. A copy of the plan can be located at Appendix H.

In addition, an update in respect to stakeholder engagement during the OBC stage is outlined at Section 3.4.2.

6.8 Benefits Realisation

6.8.1 Benefits Register

The rationale for an investment needs to be reflected in the realisation of demonstrable benefits, as this will provide the evidence base that the proposal is worthwhile and that a successful outcome is achievable. The benefits to be achieved are discussed in the Strategic Case and have resulted in the creation of a Benefits Register and Benefit Realisation Plan for the Project. The Benefits Register is located at Appendix E.

The Benefits Register includes a range of benefits to be realised by the development. Each benefit includes a target that will be used to indicate the measure of success during the Post Project Evaluation (PPE).

Benefits are either assessed in a quantitative or qualitative manner.

For the quantitative benefits, the register indicates the baseline (current position) at the start of the project including the source. This will be compared with the same data source when the PPE is completed.

For benefits that are qualitative in nature, questionnaires will be developed, and a mix of patient and staff surveys/interviews will be undertaken to outline the baseline for these benefits. The same survey tools will be used during the PPE to examine to what degree the improvements sought were achieved.

Additionally, a Red, Amber, Green (RAG) score highlighting the relative importance of each benefit is indicated using the scale outlined below in the table below.

Scale / RAG	Relative importance
1	Fairly insignificant
2	↕
3	Moderately important
4	↕
5	Vital

Table 47 - Benefit Importance

6.8.2 Benefits Realisation Plan

A Benefits Realisation Plan has been produced to support the achievement of the benefits outlined in the Benefits Register, and it is included as Appendix F.

The benefits realisation process is a planned and systematic process consisting of four defined stages outlined below. The implementation of this plan will be reviewed regularly by the Project Board.

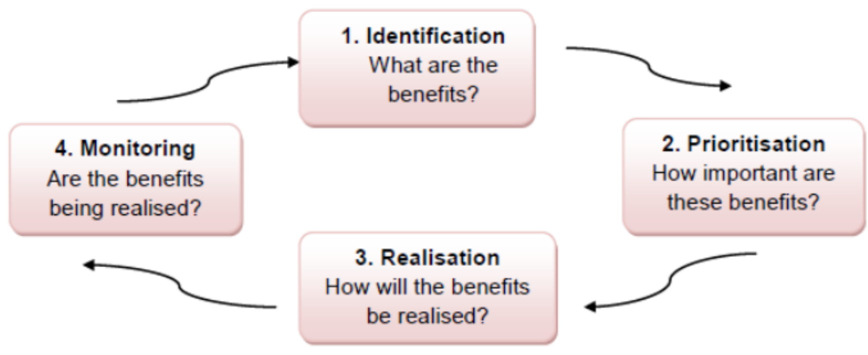


Figure 6 - Benefit Realisation Process

The Benefits Realisation Plan outlines:

- Which Investment Objective the benefit addresses
- Who will receive the benefit
- Who is responsible for delivering the benefit
- Any dependencies that could affect delivery of the benefit
- Any support needed from other agencies etc. to realise the benefit

Benefits monitoring will be ongoing over the life of the Project through the planning, procurement and implementation phases. Progress will be reported to the Project Board at regular intervals and will culminate in the Project Evaluation Report.

6.9 Risk Management

Risk management is a structured approach to identifying, assessing and controlling risks that emerge during the project lifecycle. It is a critical and continuous process throughout the planning, procurement and implementation journey of a project.

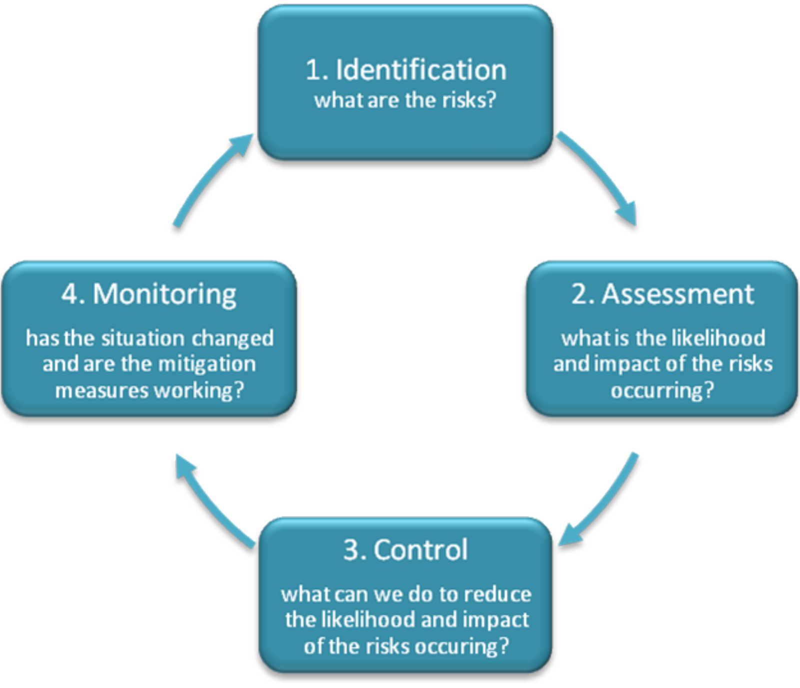


Figure 7 - Risk Management Process

6.9.1 Updated Risk Register

The Project Team have continued to develop the Risk Register provided at IA. The current FBC risk register can be located at Appendix G. The Risk Register is up to date and representative of the residual risks that may be encountered during the balance of the project. The headline items noted below, demonstrate how the risk register has been developed since IA.

- New risks have been identified and added to the register, whilst other risk have been closed
- Probability, impact and risk ratings have been updated progressively at risk workshops

- Mitigation measures have been agreed and updated
- Risk owners and managers have been allocated (a risk owner has overall responsibility for the risk, whilst a manager is responsible for helping to mitigate the risk)

The commercial arrangements associated with the Risk Register are set out within the Commercial Case.

6.9.2 Governance

The Project Board will assume overall responsibility for the risk register, however the Capital Planning Project Director will be responsible for ensuring it is maintained and updated regularly in line with the agreed project controls.

The risk register is updated and provided to the Project Board on a monthly basis as an appendix to the Capital Planning Project Manager's monthly progress report. Key risks are extracted from the risk register and highlighted within the Project Manager's monthly report for ease of reference. The Project Board provide direction to the Project Director and capital Planning Project Manager on risk matters as necessary.

6.10 Commissioning

The importance of the commissioning process cannot be underestimated, as failure to adequately consider this process is likely to cause increases to project costs and failure to deliver agreed service benefits and project outcomes. The Project Board and Capital Planning Director are fully committed to implementing a robust commissioning process, ensuring that the facilities are safe to use and operate from the outset.

The commissioning process will be treated as a distinct workstream, but fully integrated into the overall project to enable a smooth transition to the new working arrangements and realisation of the anticipated benefits. Workstreams will include Technical Commissioning and Operational Commissioning and these will be supported by BIM and Soft Landing processes.

Technical Commissioning concentrates on the readiness of the facility to support operational activity. As such the mechanical and electrical systems all need to be operating satisfactorily at handover of the facility and beyond. Operational Commissioning on the other hand is involved with getting the clinical services transferred into the facility with minimal disruption to business continuity. Given these separate requirements requiring different expertise, it is considered that there is value in assigning these roles to separate individuals with the necessary knowledge and expertise – these roles will be confirmed during the FBC stage.

The Commissioning Managers will report to the Capital Planning Project Manager on a day to day basis but will maintain lines of communication with the wider team to deliver against the agreed plans.

A Commissioning Strategy and detailed commissioning programme will be developed during the FBC stage of the project.

6.11 Post Project Evaluation

The arrangements for post implementation review and project evaluation reviews have been established in accordance with best practice. These reviews will determine whether the

anticipated benefits identified at the outset have been delivered. The project will be evaluated in stages:

Stage 1 – Procurement Process Evaluation

An evaluation of the procurement process will be undertaken following the signing of the contract to assess the effectiveness of the procurement process in meeting the project objectives. This will identify any issues and lessons to be learned that will benefit future projects. This evaluation can take place shortly after commencement of the construction phase.

Stage 2 – Monitoring Construction

During the construction period progress will be monitored to ensure delivery of the project to time, cost, and quality to identify issues and actions arising. On completion of the construction phase the actual project outputs achieved will be reviewed and assessed against requirements, to ensure these match the project's intended outputs and deliver its objectives.

Following completion, the Project Manager's and Supervisor's monthly reports will be reviewed and summarised to represent a holistic view of how the project performed during the construction period.

Stage 3 – Initial Project Evaluation of the Service Outcomes

This will be undertaken 6 to 12 months after the new facility has been commissioned. The objective is to determine the success of the commissioning phase and the transfer of services into the new facilities and what lessons may be learned from the process.

Stage 4 – Follow-up Project Evaluation

This will be undertaken 2 years into the operational phase by the Evaluation Team to assess the longer-term service outcomes and ensure that the project's objectives continue to be delivered.

The following questions will be asked at each stage:

- Have relevant project objectives been achieved?
- Has the project progressed as planned?
- If the plan was not followed, why did this occur?
- If appropriate, how should plans for future projects be amended?

The process will be led by evaluators, independent of the delivery team, who will meet with representatives of the user groups and other key stakeholders. The Project Sponsor, on behalf of the Project Board, will receive reports at each stage of the evaluation process.

Appendix A - Strategic Assessment

Appendix B – Design Statement

Appendix C – Design Pack

Appendix D – Benefits Register

Appendix E – Benefits Realisation Plan

Appendix F – Risk Register

Appendix G – Stakeholder Engagement & Communication Plan

Appendix H – The Patient Perspective

Lochgelly Health and Wellbeing Centre

Outline Business Case

20 April 2022, Rev. 5

VERSION CONTROL

Draft R.0	29.09.21	First OBC Draft
Draft R.1	03.12.21	Updated Draft
Draft R.2	17.01.22	Updated Draft – Ben Johnston
Draft R.3	16.02.22	Updated Draft to incorporate FCIG comments – Ben Johnston
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Draft R.5	20.04.22	Updated risk Section 1.4 and 4.5.2 – Ben Johnston

Contents

1 Executive Summary 8
1.1 Introduction 8
1.2 Strategic Case 8
1.3 The Economic Case 12
1.4 The Commercial Case 12
1.5 Financial Case 14
1.6 Management Case 14
2 Strategic Case 15
2.1 Introduction 15
2.2 Revisiting the Strategic Case 15
2.3 Current Arrangements 15
2.4 Strategic Context 27
3 Economic Case 41
3.1 Introduction 41
3.2 Revisiting the Economic Case 41
3.3 The Do Nothing/Do Minimum Option 41
3.4 Stakeholder Engagement 43
3.5 Service Change Proposals 47
4 Commercial Case 58
4.1 Introduction 58
4.2 Revisiting the Commercial Case 58
4.3 Procurement Strategy 58
4.4 Scope and Content of Proposed Commercial Arrangements 59
4.5 Risk Allocation 67
4.6 Payment Structure 68
4.7 Contractual Arrangements 69
5 Financial Case 71
5.1 Introduction 71
5.2 Revisiting the Financial Case 71
5.3 Financial Model (costs and associated funding for the project) 71
5.4 Accounting Treatment 71
5.5 Statement of Affordability 71
5.6 Stakeholder Support 71
5.7 Financial Situation 71
5.8 Resources 71
5.9 Capital and Revenue Constraints 71
5.10 Signed Statement from Project Board Members 71
6 Management Case 72

6.1 Introduction 72
6.2 Revisiting the Management Case 72
6.3 Reporting Structure and Governance Arrangements 72
6.4 Project Board 73
6.5 Project Team 76
6.6 Project Plan and Key Milestones 77
6.7 Change Management Arrangements 77
6.8 Benefits Realisation 78
6.9 Risk Management 79
6.10 Commissioning 81
6.11 Post Project Evaluation 81
Appendix A - Strategic Assessment 83
Appendix B – Design Statement 84
Appendix C – Design Pack 85
Appendix D – Benefits Register 86
Appendix E – Benefits Realisation Plan 87
Appendix F – Risk Register 88
Appendix G – Stakeholder Engagement & Communication Plan 89
Appendix H – The Patient Perspective 90

Glossary of Terms

ADAPT	Alcohol and Drug Abuse Prevention & Treatment
ADB	Activity Data Base
AEDET	Achieving Excellence Design Evaluation Toolkit
A&DS	Architecture & Design Scotland
BEP	Building Information Modelling Execution Plan
BIM	Building Information Modelling
BPC	Benefit Point Cost
BREEAM	Building Research Establishment Environmental Assessment Method
BRUKL	Building Regulations UK Part L
BSL	British Sign Language
CAB	Change Advisory Board
CDM	Construction (Design and Management)
CHaWS	Community Health and Wellbeing Sub-group
CHD	Coronary Heart Disease
CLD	Community Learning & Development
COPD	Chronic Obstructive Pulmonary Disease
CTAC	Community Treatment & Care
DBDA	Design and Build Development Agreement
DSM	Dynamic Simulation Model
DSR	Domestic Services Room
DVLA	Driver and Vehicle Licensing Agency
EIR	Employers Information Requirements
FASS	Fife Alcohol Support Service
FBC	Full Business Case
FHSCP	Fife Health & Social Care Partnership
FVA	Fife Voluntary Action
GMS	General Medical Services
GP	General Practitioner
HAI	Healthcare Associated Infection
HAI SCRIBE	HAI System for Controlling Risk in the Built Environment
HFS	Health Facilities Scotland
HHG	High Health Gain

HIS	Healthcare Improvement Scotland
HR	Human Resources
HV	Health Visiting
IA(D)	Initial Agreement (Document)
IJB	Integration Joint Board
ISD	Information Services Division
LAC	Local and Community
L&D	Learning & Development
M&E	Mechanical and Electrical
MDT	Multi Disciplinary Team
MOU	Memorandum of Understanding
MDT	Multi-disciplinary Teams
NCM	National Calculation Methodology
NDAP	NHSScotland Design Assessment Process
NPC	Net Present Cost
NSS	National Services Scotland
OBC	Outline Business Case
PA	Per Annum
PBA	Project Bank Account
PPD	Practice & Professional Development
PPE	Post Project Evaluation
PSCP	Principal Supply Chain Partners
QOF	Quality Outcome Framework
RAG	Red Amber Green
RIBA	Royal Institute of British Architects
SA	Strategic Assessment
SCIM	Scottish Capital Investment Manual
SCOTPHO	Scottish Public Health Observatory
SFT	Scottish Futures Trust
SIMD	Scottish Index of Multiple Deprivation
SoA	Schedule of Accommodation
SPARRA	Scottish Patients at Risk of Readmission and Admission
SRO	Senior Responsible Officer
STAND	Dementia Friendly Fife

STAR	Stop Think Assess Respond/Report/Refer Method
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 1981
VfM	Value for Money
WBP	Weighted Benefit Points
WLC	Whole Life Cost
WTE	Whole Time Equivalent

1 Executive Summary

1.1 Introduction

Fife Health and Social Care Partnership is working with local communities, teams and stakeholders to support the delivery of a fully integrated 24/7 community health and social care model that ensures sustainable, safe, individual partnerships of care. The purpose of this outline business case (OBC) is to seek approval to develop the full business case (FBC) to re-provide Lochgelly Health Centre in purpose designed facilities whilst making provision for a holistic offer of local health and wellbeing services to fulfil the General Medical Services (GMS) contract[1] requirements.

The OBC establishes the need for investment, building on the NHS Fife and Fife Health and Social Care Partnership (FHSCP) strategic goals to deliver a model of local care, focused on individual outcomes, supported by health and social care delivered by the right person in the right place at the right time. It describes the appraisal of a long list of options, identifies the short list, and recommends a preferred way forward to enable the delivery of Fife's Community Health and Wellbeing Hub model within the Lochgelly community. The OBC's commercial, financial and management cases have been developed further to identify how the project can be practically delivered.

The vision for primary care and community services in NHS Fife and Fife Health and Social Care Partnership is to enable the people of Fife to live independent and healthier lives. We will deliver this by working with people to transform services to ensure these are safe, timely, effective and high quality, focused on achieving personal outcomes. This requires access to the right professional at the right time in the right place; where services can be provided within a community setting, closer to where service users live. Care should be provided in an environment that supports staff to provide an excellent experience and has modern facilities that meet the needs and expectations of service users, carers and staff well into the late 21st century.

1.2 Strategic Case

1.2.1 Current Arrangements

Lochgelly Health Centre, located in the heart of the town, provides General Medical Services to 79% of the resident population of Lochgelly and the surrounding areas of Lochgelly East, Lochgelly West & Lumphinnans, Ballingry, Cardenden and Lochore & Crosshill, through three Medical Practices based within the Health Centre. Community services are provided by NHS Fife including for example Community Nursing, Health Visiting, Mental Health, Sexual Health and Podiatry. Services work together to deliver high quality person-centred health and social care in a way which promotes and enhances the health and wellbeing of the people of the area.

The three practice populations total circa 10,728 people. The practice area is in the highest income deprived deciles of Scotland and therefore faces significant health inequalities. The locality population is predicted to grow by 5% in the next 25 years. Most of this population growth is anticipated to be in the older people age group, circa 45%, with both children and working age populations predicted to decrease. These changes will significantly increase

[1] GMS contract: 2018 - gov.scot (www.gov.scot)

the level of frailty the practices are supporting within a community which has a significantly higher disease burden associated with intergenerational income inequalities.

The current facility is a 1970's construction, with every effort made to modify the building to support the delivery of modern integrated health and social care. However, it is no longer fit for purpose, our new model of working requires accommodation that enables the delivery of our vision of multi-disciplinary and group working, which supports the community and partners to deliver collaboratively. A model which is being delivered in other communities which have access to modern facilities which do not have the same complexity of intergenerational inequalities and disease burden of the Lochgelly Community. Healthcare has been identified through local community planning as one of the major issues for the area.

The development of the community health and wellbeing model and delivery of the new GMS contact is being held back by structural and layout constraints. All possible reasonable changes have been made to the existing building and alternative premises accessed. Lochgelly Health Centre fails to meet the spatial, organisation and design standards for Primary and Community Health Care premises and has no capacity for further growth. Major improvements to address maintenance and statutory standards will not facilitate significant improvements in space utilisation to enable local integrated care to meet patient quality, staff standards and efficiency objectives.

1.2.2 The Patient Perspective

It has been recognised for many years, service providers across Scotland and the UK have planned care separately in different parts of the system including primary, community, acute care and mental health. Services have often been planned around buildings, individual service providers or even clinicians.

What is now proposed is a shift toward an overarching whole systems model which focuses on the needs of people who use the different health and social care services within the Lochgelly facility. This is described as a more holistic community health and wellbeing approach.

The central underlying principle of the development of the new centre is to focus on the patient outcomes, their journey and experience. This will help to identify where service improvements are necessary and involve a wide range of service users and providers in analysing and redesigning improved patient pathways to positively impact on outcomes.

The agreed way forward was to develop patient personas and pathways to enable the patient perspective and journey to be captured. We have identified seven people (personas) who typify patients or people who use the Lochgelly Health Centre and whose care represents key requirements and challenges for NHS Fife, FHSCP and partners. The personas and pathways in this document were developed in using local profile and practice data as well as in collaboration with a range of clinical services, community and voluntary sector partners.

We have used the personas to illustrate pathways and through mapping their care needs - we can agree how they can be met more effectively and efficiently. A designed and managed process of patient and service provider engagement including wider public involvement has taken place and is expected to shape development of the new centre – moving from the

traditional medical model to a more holistic community health wellbeing service model of delivery.

The Health & Wellbeing Model was developed by change and improvement colleagues in NHS Fife and FHSCP. This is illustrated below.

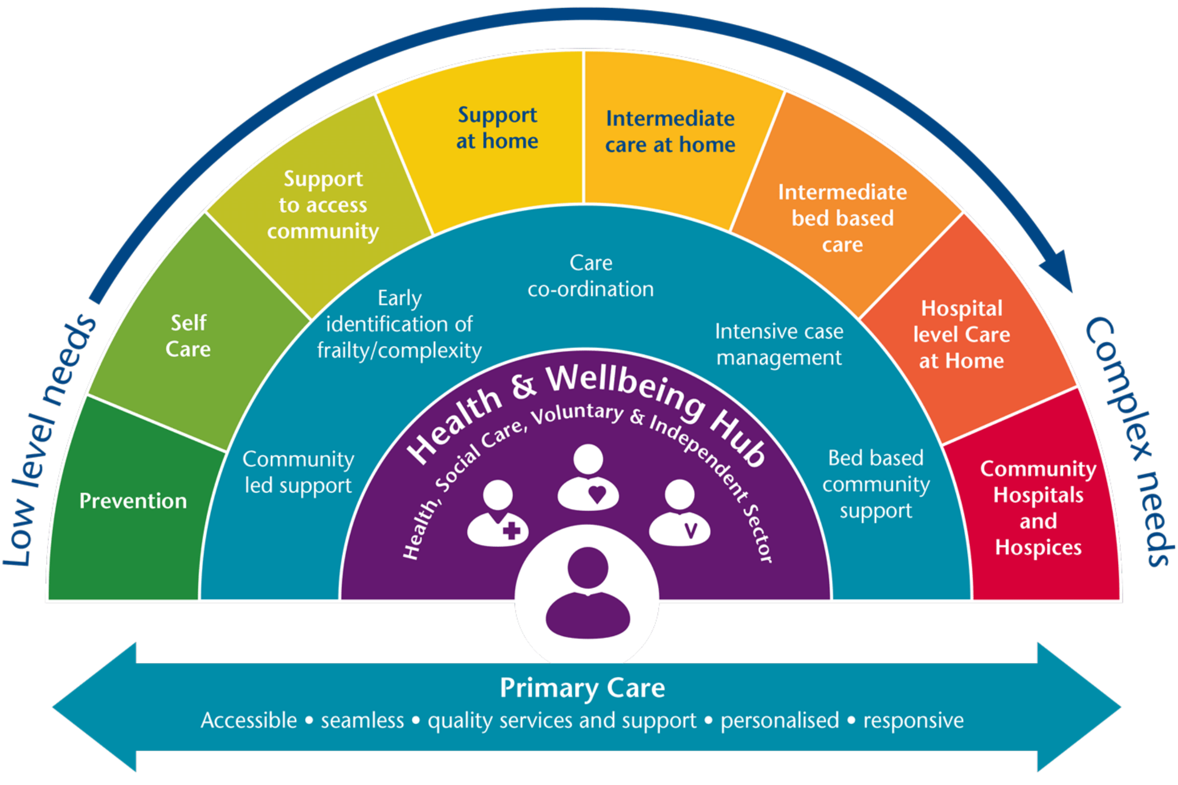


Figure 1 - Health and Wellbeing Model

The Project Team is using the Patient Personas & Pathways to look at possible improvements through a number of tests of change. This workstream has commenced but will continue through the FBC and construction stages of the project.

1.2.3 The Need for Change and Investment Objectives

The drivers for change and developed Investment Objectives to enable this change are set out in the table below. Associated benefits are set out in Section 2.4.4.

Effect of the need for change on the organisation:	Investment Objectives
Existing service arrangements are affected by lack of clinical support service facilities.	Ensure equal access to a patient centred approach by enabling delivery of and access to local integrated anticipatory and preventative care for patients. Secure accommodation to deliver required group based activities.
Implementation of integrated models of care is undeliverable locally in the current environment	Ensure equal access to modern integrated care with provision driven by patient need rather than limitations in capacity.

Effect of the need for change on the organisation:	Investment Objectives
Pressure on existing staff, accommodation and services will inevitably increase.	Ensure the right staff skill mix and service capacity are available to deliver and strengthen local capacity to manage people's health within the local community.
The facilities available, 100% occupancy, combined with significant population change, restrict the ability of the parties to deliver the full range of integrated services locally.	Enable earlier access to proactive and anticipatory care through local delivery via integrated seamless service across health and social care. This will reduce referrals to other services. Care will be driven by patient need rather than limitations on capacity.
Existing configuration, as a result of a 1970's building, being modified and extended with a 'best fit' approach means poor accommodation e.g. service users who rely on wheelchair access or have a mobility problem have extreme difficulty in both accessing and traversing the facility.	Delivery of safe and effective care with dignity by providing facilities which comply with all legal standards and regulatory requirements and gives equality of access for all. Improved staff wellbeing.
Increased safety risk from outstanding maintenance and inefficient service performance.	Improve safety and effectiveness of accommodation by improving the physical condition, quality and functional suitability of the healthcare estate.

Table 1 - Needs for Change and Investment Objectives

1.2.4 Fife Place Based Planning Tool

NHS Fife have recently been engaging with Scottish Government around their proposal to develop a longer-term primary care strategy. Scottish Government have recently developed a Place Based Needs Planning tool which helps Boards to understand their investment priorities based on community health, demographics, supporting infrastructure and the condition of the estate. Analysing the data for Fife in totality, Lochgelly Health Centre has an Estate Need Score of 70 (3rd highest priority), bolstering the case for change and intervention.

Property	Postcode	Intermediate Zone	Floor Area	Age	Estate Need Score
Kincardine Health Centre	FK10 4QX	Kincardine	254	91	83
Oakley Health Centre	KY12 9QH	Oakley Comrie and Blairhall	918	71	73
Lochgelly Health Centre	KY5 9QZ	Lochgelly West and Lumphinnans	822	81	70
Valleyfield Health Centre	KY12 8SJ	Valleyfield Culross and Torryburn	1,012	51	65
Path House Medical Practice	KY1 2PG	Kirkcaldy Pathhead	612	329	56
Strathmiglo Auchtermuchty Practice	KY14 7QA	Auchtermuchty and Gateside	50	59	55
Leven Health Centre	KY8 4ET	Leven East	1,624	56	53
Rosyth Health Centre	KY11 2SE	Rosyth East	946	39	47
Kelty Health Centre	KY4 0AE	Kelty East	754	60	44
Lundin Links Scoonie Medical Practice	KY8 6DB	Largo	48	59	43

Table 2 - Fife Priority of Estate Need

1.3 The Economic Case

A wide range of options were developed and considered. These were then consolidated into a shortlist of options which were scored via a wide range of stakeholders. The option scores are presented below.

	1 Do Nothing/ Base	2 (5c) Car park	3 (4b) Jenny Grey Refurb	4 (6d) Jenny Grey New Build	5 (5d) Lochgelly School New Build	6 (6e) Francis Street New Build
Net present cost (NPC) - £m	2,311,661	11,871,118	-	11,799,393	12,763,618	11,666,192
Weighted benefit points (WBP)	256	431	435	632	431	879
BPC per WBP - £000	9,029	27,543	-	18,669	29,613	13,272
	Reject	Possible	NA	Possible	Possible	Preferred

Table 3 - Short-listed Option Scores

Option 6 scored highest in respect to benefit points. Once the net present costs were factored in, option 1 is highlighted at the lowest cost per benefits point – this is purely because of low net present cost owing to the limited capital that could be invested in the existing facility. As option 1 does nothing to tackle the needs for change as demonstrated, it is not a legitimate option but included for comparative purposes.

Given the balance of legitimate options, option 6 offers the highest benefits score and the lowest cost per benefits point, indicating that it is the strongest option. Option 6 is therefore the preferred option.

1.4 The Commercial Case

The Commercial Case has been developed significantly since IA. Key aspects contained within the commercial case are summarised below.

- The project is community focussed and more than £750k, therefore the Scottish Futures Trust hub initiative has been selected as the most appropriate route to deliver the project. The East Central hubCo have been appointed to deliver this public funded project under the design and build option.

- Currie & Brown have been appointed through the Frameworks Scotland Lead Advisor lot to support the Board with multiple services including Project Management, Cost Advisor, Technical Advisor and Clerk of Works.

- The design has been fully developed in conjunction with the Project Team and Stakeholders. With exception to the NHS NSS Design Quality Assurance and NDAP processes which are ongoing, the design has been well received through the HAI, AEDET and focussed design workshops.

- Discussions with Fife Council in respect to leasing the required land are advanced appropriately for the stage in the project. These will continue during the FBC stage with a view to concluding arrangements at the point of completing the FBC.

- The current key risks/issues facing the project are summarised in the table below:

Risk/issue	**Mitigation**
Brief inadequate/unreliable This issue relates to developments around the GMS contract and effect this has had on the area requirements for the building.	The required area increase from IA to OBC has been factored into the current design and corresponding cost plan.
Stop/start nature of the programme – keep people engaged through these periods.	Updates are being provided to community groups via newsletters and the public via press releases. NHS Fife's communication team are supporting this effort.
Project cost increases due to: ▪ Change in requirements ▪ Inflation / market conditions	This is a current issue where the cost increases have rose beyond the IA budget projection. Refer to Financial Case for further substantiation.
Programme delay The OBC programme has been affected because of COVID which has impacted resources, engagement activity and costs.	Potential to commence FBC activity in parallel with the OBC governance approval process. The project now has a full complement of resources to help drive the project forward.
Change of policy – NHS Assure Key Stage reviews	Key stage review process was implemented half-way through OBC and is required to achieve capital

Risk/issue	Mitigation
Programme delays / cost increases arising	funding. Risk had to be accepted, but impact can be mitigated through collaboration.
Change of policy – SHTN 02-01 Sustainable Design and Construction Guide (SDaC) Programme delays / cost increases arising	Informed by HFS at OBC NDAP review that new guidance must be followed at FBC. Guidance is untested to impact is difficult to quantify. As such this risk has not currently been factored into OBC cost estimates.

Table 4 - Key Risk Summary

1.5 Financial Case

1.5.1 Capital Costs

A capital cost summary is provided in the table below demonstrating the total OBC estimated cost for the project, together with the movement in cost since IA.

IA	OBC	Movement
£8,155,615	£13,031,178	£4,875,563

Table 5 - Capital Cost Summary

The key reasons for the movement in cost since IA, are set out below:

- Building area increase to take account of service and GMS contract evolving requirements – accounts for circa 41% of the construction cost increase
- Inflation and extraordinary market conditions considered to driven by the COVID-19 pandemic and the resulting global effect on supply chains – accounts for circa 20% of the construction cost increase
- Site and design abnormals: this relates to site conditions, more onerous energy requirements and creating a building that satisfies the conditions of the brief and design statement – accounts for circa 39% of the construction cost increase
- Associated percentage mark-ups based on an increased construction cost
- Some further adjustments to the IA budget allowances, notably equipment and internal direct labour costs

A number of value engineering / cost saving opportunities have been identified and these have already been accounted for in the presented OBC figures above.

Notwithstanding the cost increases noted, given the current project environment, the costs are considered to represent value for money in the current marketplace and this view has been endorsed by our consultant Cost Advisor.

1.5.2 Revenue Costs

A summary of the revenue costs is provided in the table below.

Description	Baseline	Preferred Option	Difference
Property pays (NHSF)	£24,467	£75,566	£51,099
Property non-pays (NHSF)	£61,920	£178,330	£116,409
Property non-pays – GP offset (NHSF)	-£37,718	-£83,165	-£45,448
Net Increase (NHSF)	**£48,670**	**£170,731**	**£122,061**
Service model (FHSCP)		£724,500	

Table 6 - Revenue Cost Summary

The increase in cost from an NHS Fife perspective is largely associated with the increase in building area.

The revenue costs relating to the service model continues to be developed in consultation with the Scottish Government around MOU1/2 for urgent care and what MDT means for Fife. The service model costs will have a nil impact on the revenue outturn position as funding sources have been identified.

1.6 Management Case

The Management Case identifies the actions that will be required to ensure the successful delivery of the scheme. The management case has been significantly updated for this the IA stage and demonstrates that the Board and Partnership are well prepared to deliver the project successfully during the construction phase and beyond. Key milestones for the project are identified in the table below:

Description / activity	Date
Full Business Case	
Commencement	February 2022
Completion	January 2022
Governance Approvals	April 2023
Construction & Handover	
Commencement	May 2023
Completion	June 2024
Operational	August 2024

Table 7 - Key Milestone Summary

2 Strategic Case

2.1 Introduction

The main purpose of the Strategic Case is to confirm the background and drivers for change for the proposition. It also sets out the key investment objectives and associated benefits.

2.2 Revisiting the Strategic Case

The Initial Agreement Document (IAD) was approved by Scottish Government in January 2020. The next phase involved undertaking a widespread engagement exercise with key stakeholders and the people of Lochgelly. This process was paused as a result of the global pandemic and was eventually reinstated in November to December 2020. The outcome of the engagement exercise can be reviewed within the Economic Case. The recovery plan in relation to the pandemic also caused delay to timescales for the Outline Business Case and design process. However, these have since resumed at pace. There are new sections added which were not previously in the IAD including

- The patient perspective and journey using personas in Section 2.4.1.2
- A summary of services (existing versus proposed) in Section 2.3.2
- A description of associated buildings and assets in Section 2.3.3

The critical success factors have been retained although are not reflected in the current Scottish Capital Investment Manual (SCIM) guidance. The residual balance of the Strategic Case has been retained and updated where necessary.

2.3 Current Arrangements

2.3.1 Service Arrangements

The holistic multi-disciplinary primary and community care services in Lochgelly are currently delivered from the existing Lochgelly Health Centre, a 1970's constructed facility, which has been considerably modified and extended throughout its lifetime. The building is owned by NHS Fife.

General Practitioner (GP) services in Lochgelly and the surrounding area are delivered by three Practices operating full time to meet their respective Practice population needs. The Practices are contracted to NHS Fife to provide General Medical Services:

- Lochgelly Meadows Practice (Primary care services) General Medical Services
- Lochgelly Medical Practice (Primary care services) General Medical Services
- Lochgelly (Dr Thomson) Medical Practice (Primary care services) General Medical Services

Aligned to the Practices there are a wide range of permanent and visiting community health services provided from the current facility. Fife Health & Social Care Partnership (FHSCP) and NHS Fife are responsible for the provision of Community Nursing, and managed services (treatment room support, Primary Care Nurse, Health Visiting, Clinical Psychology, Sexual Health, Pharmacy, Allied Health Professionals, Child Health, Stop Smoking, Community Midwifery, Mental Health & Addictions, Out-Patient Services and Facility Management).

A constrained range of Voluntary Sector activity is delivered from the Health Centre, including drug and alcohol support services (supporting clinic activity etc) and the Local Area Coordinator. The constraining factor is accommodation availability.

The local Community Council supported by Councillors and Members of the Scottish and UK Parliament have a local campaign group to support the realisation of a new health centre. The campaign notes the need for modern infrastructure to enable the local delivery of an integrated model to meet the significant health and wellbeing needs of the community.

The services provided from the existing three Practices are primarily provided in support of the population needs of the people of Lochgelly and surrounding areas, with 79% of the resident population registered with the Practices (see figure 2 - interzone map). In accordance with NHS Fife's statutory obligation to provide access to Primary Medical Services there is a formal requirement to continue provision of these services within this geographic area.

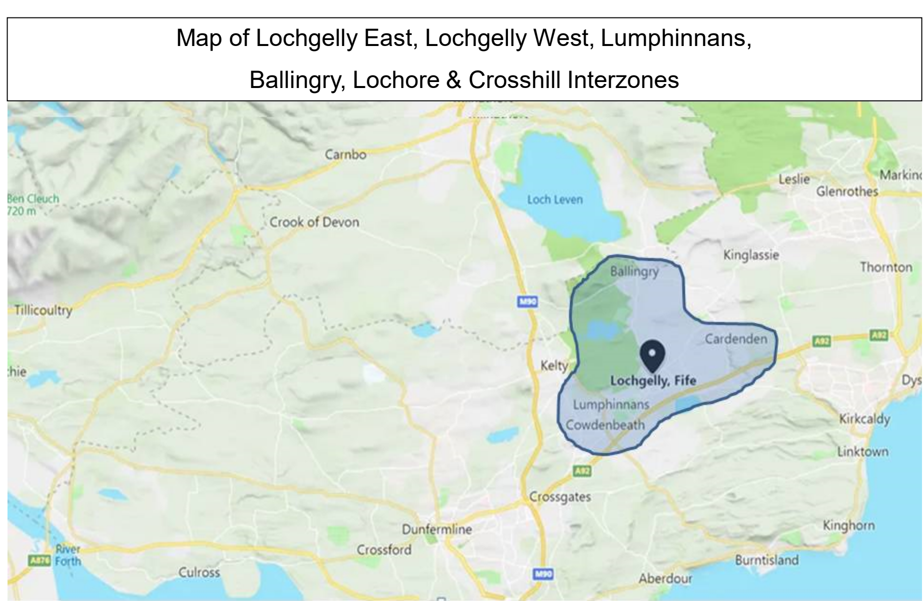


Figure 2 - Map of Lochgelly Interzone

The General Practitioners together with the multi-disciplinary team manage the widest range of health problems; providing both systematic and opportunistic health promotion, diagnoses and risk assessments; dealing with multi-morbidity; coordinating long-term care; and addressing the physical, social and psychological aspects of patients' wellbeing throughout their lives.

The General Practitioners and multidisciplinary team working in the hub model are integrally involved in deciding how health and social services should be organised to deliver safe, effective and accessible care to patients in their community. Practice based multi-disciplinary team working is identifying people who could benefit from a case management approach and supporting people to access the right support where there is:

- Complexity in their care and support arrangements through locality multi-disciplinary teams, or
- Clinical complexity providing rapid access to assessment through the locality community health and wellbeing hub teams

The combined Practice population of 10,728 (April 2019), has grown by 1.6% over the past 18 months. The current demographics of the population are[2]:

- 50.9% female: 49.1% male
- 18.0% are over the age of 65 and 18.2% are 0-15 years (slightly higher than the average for Fife)
- 45.4% of patients live in the most deprived quintile, with 0.9% living in the least deprived quintile
- 20.9% of the wider locality population are income deprived, compared to the Fife average of 12.4%, 24.3% of children (under 16) live in poverty compared to the Fife average of 17.9%
- 27.6% of the Practice's patients have one or more long term condition compared to Fife rate of 7.16%
- Fife has the highest rate of under 18 and under 20 pregnancy rates in Scotland. The Cowdenbeath locality has the second highest rate of teenage pregnancy under 18 (three year aggregates to 2017) within Fife

Since the QOF (Quality Outcome Framework) is no longer in use, up-to-date long-term condition data was sourced from the Practices and Public Health Scotland using the SPARRA[3] (Scottish Patients at Risk of Readmission and Admission) tool.

Local Profile & Practice Data - Lochgelly

Long Term Condition Rates	Lochgelly	Fife
Arterial Fibrillation	1.87%[1]	1.92%[1]
Asthma	6.22%[1]	4.61%[1]
Cancer	4.58%[1]	4.25%[1]
CHD	4.87[1]	3.97%[1]
Chronic Liver Disease	1.15%[1]	0.88%[1]
COPD	2.48%[1]	1.70%
Dementia	0.67%[1]	0.81%[1]
Depression	13.50%[2]	9.54%[2]
Diabetes	3.72%[1]	2.94%[1]
Hypertension	18.53%[2]	15.43%[1]
Mental Health	1.03%[2]	0.87%[1]
Psychiatric Admissions	29.7 per 1,000[2]	24.5 per 1,000[2]

Data sourced from:

1. Public Health Scotland (PHS), SPARRA at 1 December 2020 - the percentage of people with each Long Term Condition are calculated by dividing the number of people with each Long Term Condition by the number of people registered at the GP practices (i.e. the "Population Register") then multiplying by 100.
2. Initial Agreement Documents, approved by Scottish Government in January 2020 data via QOF calculator 1 April 2019.

Figure 3 - Local Profile and Practice Data - Lochgelly

Previous QOF data has been incorporated from the IAD in this section including to provide a fuller picture and a pre-pandemic comparison where possible. Table 8 below notes a range of health indicators for the Lochgelly practice population (where available, or the wider locality where not available) compared to seven localities in Fife. This demonstrates the relative poor health of the population. The health outcomes for the people supported by the

[2] Based on 2011 census, 2016 SIMD datazone data and ISD Practice data 2019
[3] https://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/SPARRA/SPARRA-Model/

Lochgelly practices are consistently lower than the rates for Fife. In a number of instances of these are the highest rates / poorest outcomes in Fife.

The Lochgelly area populations experience higher rates of emergency hospital and multiple admissions. Along with higher rates of admission related to COPD, coronary heart disease and alcohol related hospital stays.

In Scottish Public Health Observatory (SCOTPHO) analysis of QOF data 2017/18 the Lochgelly area comes out in the top three in 12 of 17 measures when compared with the seven Fife localities.

Mental Health is the fourth highest of the health impacts on the population of Fife (after Cancer, Cardiovascular disease and Neurological conditions); those who are socially disadvantaged have an increased probability of experiencing mental ill health. For example, in 2010/2011, there were twice as many GP consultations for anxiety in areas of deprivation than in more affluent areas in Scotland (62 consultations vs. 28 per 1,000 patients). The impact of mental health difficulties in the Lochgelly community is evidenced in the data below and the current range of services seeking to access accommodation in the health centre (detailed in Table 10).

Mental health conditions including addictions have been exacerbated and impacted during the global pandemic. Therefore, the need for mental health and related services has significantly increased during this period.

Indicator	Lochgelly Area	Wider Locality	Fife	Comparative Notes
Premature mortality		337 per 100,000		(5th of 7)
Cancer related		180 per 100,000		(2nd of 7)
CHD related		70 per 100,000		(2nd of 7)
Patients (65+) with multiple emergency admissions		6,087 per 100,000		(1st of 7)
New and unplanned repeat A&E attends	297.4 per 1,000		264 per 1,000	
Potentially avoidable admissions		20.2 per 100,000		(2nd of 7)
Median 11/15-5/19 Falls		2.5 per 1,000	2.05 per 1,000	(1st of 7)

Indicator	Lochgelly Area	Wider Locality	Fife	Comparative Notes
related admissions (65+)				
Cancer rate (QOF)	3.06	2.85	2.85	(Lochgelly has the 3rd highest compared to the 7 localities)
CHD rate (QOF)	4.65	4.67	3.94	(Lochgelly has the 3rd highest compared to the 7 localities)
Hypertension rate (QOF)	18.45	17.54	15.36	(Lochgelly has the highest compared to the 7 localities)
Asthma Rate (QOF)	7.17	7.58 (2nd of 7)	6.94	(Lochgelly has the 3rd highest compared to the 7 localities)
COPD rate (QOF)	3.4	3.61 (2nd of 7)	2.58	(Lochgelly has the 3rd highest compared to the 7 localities)
COPD admissions (standardised rate)	Prac. 1 - 2.7			
Prac. 2 - 7.2				
Prac. 3 - 5.6				
	5.3	3.1	Two of the three practices are above Fife levels (Crude & standardised rates).	
Diabetes rate (QOF)	7.11	6.51 (2nd of 7)	5.56	(Lochgelly has the highest

Indicator	Lochgelly Area	Wider Locality	Fife	Comparative Notes
				compared to the 7 localities)
Alcohol related mortality		17.1 per 100,000		(3rd of 7)
Mental Health rate (QOF)	0.96	0.85	0.86	(Lochgelly has the highest compared to the 7 localities)
Mental Health Prevalence		5,132 per 100,000 (1st of 7)		
Psychiatric Admissions (episodes[4])	29.7 per 1,000 (2018)	25.7 per 1,000 (2018)	24.5 per 1,000 (2018)	Lochgelly levels are above all Fife localities for both patients and episodes
Depression rate (QOF)	12.47	11.57	8.93	(Lochgelly has the highest compared to the 7 localities)
Dementia rate (QOF)	1.00	1.09	0.81	(Lochgelly has the 2nd highest compared to the 7 localities)
Stroke and TIA rate (QOF)	2.81	2.7	2.46	(Lochgelly has the 2nd highest compared to the 7 localities)
Developmental disorders		856 per 100,000 (2nd of 7)		

Table 8 - Local Indicators

Projections for future demand for primary care and community services within Lochgelly are driven by the population increase, which see the older population growing by 45% by 2041 and by the known negative impact on health of the relative socio economic deprivation the

[4] Episode refers to inpatient, outpatient or Allied Heathcare Profession treatment as defined by https://www.ndc.scot.nhs.uk/Dictionary-A-Z/Definitions/index.asp?ID=241&Title=Episode%20of%20Care

community experiences. Housing developments are seeing the construction of circa 420 new homes by 2025 (potentially an additional 1,050 people). The local development plan includes potential for the development of a further 4070 homes within the catchment area of the Practices. The infrastructure is therefore required to enable services to develop the community health and wellbeing model, to support the anticipated increase in the needs detailed in table 8 rather than seeking to continue to do more of the same.

The current workforce delivering services, health, social and voluntary sector activity is outlined below at table 9 along with potential future workforce required to deliver integrated primary care and community services. Recent and continuing changes to the workforce are being phased in line with population growth and service model developments and are taking into account the requirements to implement the GMS (2018) contract[5] and enhance the primary healthcare team, community health and social care teams and health visitor pathway. The Meadows Practice provides training placements for medical students.

	Existing Provision (WTE)	**Recent Change (WTE)**	**Future provision * Incl. new roles**
General Practitioners (5)	4.5	-1	
Advanced Nurse Practitioner (2) + trainee	2	1	
Nurse Practitioner (1)	0.8	0.8	
Practice Nursing (3)	1.7	-1.05	
Primary Care Mental Health Nurse	1	1	
Practice Phlebotomist (1)	0.39		
Practice Manager (3)	2.9		
Admin staff (11)	9.6	-0.27	
Community Nursing Team (9 + 2 student/rotational intermediate care team colleague)	6.87 (+2)		Redesign of Community Nursing + caseload weighting necessitate change
Community Phlebotomist (2)	0.5	12 sessions per month	
Community Teams Admin Staff	0.2		
Primary Care Pharmacist	1		+4 requiring an office and access to

[5] https://www.gov.scot/publications/gms-contract-scotland/

			consultation accommodation
Visiting teams	**WTE**	**Sessions**	**Future provision * Incl. new roles**
Addiction Services	12		
Clinical Psychology	33		
Fife Intensive Rehabilitation and Substance Misuse Team	16		
Phlebotomy (Bloods)	16		
Respiratory Nurse Base + Clinic	1 WTE + 3 clinics		
Paediatric Clinic	6		
Asthma Clinic	4		
Fife Forum	8		
Continence Clinic	4		
ADAPT (Alcohol and drug triage service)	4		
Stop Smoking	4		
Psychiatry	8		
Health Visitors Baby Clinic	4		
Health Visitor Review Clinic	12 + Wellbeing meetings when required		13 staff and the full range of centre based Health Visiting activity: majority currently delivered from an adjacent smaller village
Immunisation Team	8		Potentially evening Flu clinics
Midwife Clinic	12		
Safe Space	4		
Dietician	2		

Orthoptic Clinic	4		
Podiatry	16		
Diabetic Foot Check (DAR's)	6		
Dermatology	4		
Minor Surgery Clinic	As required circa 2 per week		
Depot Clinic (QMH Nurses)	1 hr per week		
Treatment Room	20		
Fife Alcohol Advisory Service	4		
Social Workers / Social Care Workers			MDT time Child Protection meetings
Mental Health Nursing	8		
Contraception and Sexual Health	4		
Alcohol and Drug Drop in	4 (evenings)		
Wider voluntary sector			A wider range of voluntary sector services e.g. citizens advice supporting income maximisation
First Contact Physiotherapist			0.55 WTE

Table 9 - Lochgelly Staffing

2.3.2 Service Details

The accommodation in Lochgelly is provided over one level with a total floor area of 760m^2, supports:

- GP activity associated with the Lochgelly Meadows Practice (Circa. 19,000 appts PA and a Practice population of circa. 5,011)
- Nurse activity associated with the Lochgelly Meadows Practice (Circa. 4,000 appts PA)
- GP activity associated with the Lochgelly Medical Practice (Circa. 10,000 appts PA and a Practice population of circa. 3,511)
- Nurse activity associated with the Lochgelly Medical Practice (Circa. 7,000 appts PA)

- GP activity associated with the Lochgelly (Dr Thomson) Practice (Circa. 5,400 appts PA and a Practice population of circa. 2,206)
- Nurse activity associated with the Lochgelly (Dr Thomson) Practice (Circa. 900 appts PA)
- Community nursing “treatment room” activity (16 appts per day, 22 at busiest times, Circa. 4,100 appts PA), Phlebotomy provide 37 appts 4 days per week, Circa 6,500 PA) with the team visiting about 30 people at home per day
- Primary Care nursing activity (Average 30 appts per week - 1560 PA)
- Minor surgical procedures undertaken by a specialist GP (Circa. 100 episodes PA)
- Practice Phlebotomy services (Circa. 5,500 episodes PA)
- Midwifery ante-natal clinic activity (Circa. 750-800 appts PA)
- Psychology out-patient services (Circa. 1000 appts PA)
- Targeted sexual health services for younger people (Circa. 300 appts PA)
- Dietetic consultations (Circa. 204 episodes PA)
- Podiatry services (Circa. 1010 appts PA)
- Stop Smoking sessions (Circa. 470 appts PA)
- Paediatric consultation activity (Circa. 170 appts PA)
- Mental Health: Nursing Psychiatry and Psychology
    - West Fife Community Outreach Team (Circa. 200 appts PA)
    - Addictions – sessions outlined above
    - Psychiatry – sessions outlined above
- Voluntary Sector services – sessions outlined above

The Practices have access to a known number of consulting rooms/areas on a daily basis, with visiting services scheduled ahead as far as possible, based on room availability. Often, rooms are booked in advance for services. However, due to lack of attendance etc, they are then not utilised and the bookings are not cancelled so rooms are unoccupied.

Whilst the Practices and FHSCP are working collaboratively to modernise, integrate and expand services to improve outcomes and support the population growth, development is severely constrained by the existing premises. For example the respiratory nurse would be able to see circa three times more patients if clinic space was available, supporting more proactive case management with medical colleagues, and thereby reduce emergency admissions further.

In summary, baseline data indicates that services delivered from the existing Lochgelly Health Centre amount to a total of circa 70,000 attendances per annum; circa 270 attendances per day or around 15 patients / clinical room activity per day. Whilst this is considerably less than the theoretical capacity associated with these clinical spaces, this situation occurs as a result of an overall lack of administrative / support areas within the building and the resultant extensive use of consulting space for administrative and clinical support activities. For example GPs use their consulting rooms also as office space, meaning the rooms cannot be used by another clinician outwith their clinical sessions.

As the Health Centre runs at 100% capacity services often double book rooms in case cancellations arise – this includes clinical services, voluntary sector support groups, teams seeking to deliver mandatory staff training and centre based teams seeking to meet together. The AEDET review exercise confirmed that the layout and fabric of the building place considerable limitations on effective and safe service delivery (Section 2.3.3).

Where services are not / cannot be delivered locally in Lochgelly, patients are referred to different locations that include: Queen Margaret Hospital, Dunfermline; Victoria Hospital, Kirkcaldy; Rosewell Clinic, Lochore. For example the majority of Health Visiting activity including Wellbeing Meetings is delivered from Rosewell Clinic; impacting on access inequities.

Out of Hours Primary Care is delivered from four Urgent Care Centres in Fife. The Partnership does not have plans to extend the number of Urgent Care Centres. The Community Teams offer a small number of clinics / sessions into the evening. The restrictions of the building do not lend themselves to safe and simple access in the evening.

The model of care is developing in line with the new GP Contract, with the Primary Care Development implementation plan progressing along with the Business Planning process. Accommodation is not available to support the local delivery of physiotherapy, mental health nursing, primary care pharmacists, social prescribing, etc. For example the Local Area Co-ordinator (voluntary sector member of the team sign posting people to local community provision) is not able to work from Lochgelly as frequently as required. To meet the areas needs within the GMS (2018) there will be three levels of pharmacotherapy input, this will see the resource based in Lochgelly grow from 1 whole time equivalent to 5.

Nationally, a re-provisioning exercise is in process to replace existing GP IT systems, with suppliers having until February 2020 to complete development of their respective systems in line with NHS National Services Scotland requirements. After this, a transition exercise will commence across all boards, with Fife's transition scheduled to commence summer 2020. This will facilitate the Lochgelly practices to be paperlite.

The table below summarises the services using the current facility and also a list of services that could be provided from the new as a result of a lager functional facility.

No:	Name of Service	Currently in Health Centre	Will be based in (or using) the new CH&W Centre
1	Fife Young Carers		X
2	Community Nursing	X	X
3	The Well		X
4	Complex Care Team		X
5	Clinical Psychology		X
6	Speech & Language Therapy		X
7	Health Promotion		X
8	Children's Services		X
9	Community Nurse Respiratory Team		X
10	Nursing	X	X
11	Occupational Therapy		X
12	Pharmacy	X	X
13	ADAPT/FASS (Addictions Services)	X	X
14	NHS Addictions Service	X	X
15	Local Area Coordinators (Locality Planning)	X	X
16	Frailty & Older People's Service		X
17	Immunisations Service	X	X
18	Podiatry Service	X	X
19	Mental Health Services		X
20	MSK Physiotherapy	X	X
21	Nutrition & Dietetics		X
22	Obstetrics and Gynaecology		X
23	Fife Carers Centre		X
24	Mental Health Nursing	X	X
25	Dementia Friendly Fife		X
26	Diabetes MCN		X
27	Midwifery	X	X
28	Diabetic Retinopathy		X
29	Physiotherapy	X	X
30	Orthoptics	X	X
31	Fife Voluntary Action		X
32	Social Work		X
33	Multi-Disciplinary Team meetings		X

Table 10 - Lochgelly Services

Approximately 35+ services were engaged prior to lockdown in March 2020 and all re-engaged in September and again in November 2020, to develop a service schedule and see if anything had changed or additional requirements were needed due to Covid-19: requirement of space in the centres, days of use and frequency, any special requirements etc. An exact number has not been provided as there are numerous services which sit under single or multiple providers. This data has been collated into a spreadsheet that will inform the design and construction of the new building to ensure that all services can be

accommodated appropriately. NHS Facilities contacted all services again to reaffirm requirements and develop a Schedule of Accommodation – this information has since been extrapolated to develop the early building design.

2.3.3 Associated Buildings and Assets

The current facility is based centrally in the village of Lochgelly and was established in the 1970s. The property has been considerably modified and extended throughout its lifetime. The accommodation in Lochgelly is provided over one level with a total floor area of 760m^2. The building is owned by NHS Fife.

Figure 4 – Lochgelly Health Centre

The building block condition is category B and the risk adjusted back-log cost is £247,000.

Condition, space and functionality of the facility are best summarised within the AEDET benchmark assessment which is outlined below.

Category	Benchmark
Use	1.4
Access	1.1
Space	1.0
Performance	1.4
Engineering	1.3
Construction	0.0
Character & Innovation	1.0

Form & Materials	1.3
Staff & Patient Environment	1.1
Urban & Social Integration	1.3
1 = virtually no agreement / poor *6 = virtually total agreement / excellent*	

Table 11 - AEDET Benchmark Score – Lochgelly

2.4 Strategic Context

2.4.1 Drivers for Change

2.4.1.1 Local Context

NHS Fife Clinical Strategy[6] sets the strategic direction with Fife Health & Social Care Partnership (FHSCP) that is focused on local early, preventative care. In working with partners to improve the health of local people and the services they receive, while ensuring that national clinical and service standards are delivered across the NHS system we will strengthen primary care and community services.

Our vision requires a flexible and responsive model that works with people to define the outcomes they want to achieve, enabling people to maximise their health and wellbeing by utilising their own and community assets, adding and adapting services responsively to meet and sustain outcomes.

Our development of community health and wellbeing hubs is designed to flexibly and responsively layer services where required, adjusting support and care incrementally. In light of the changing demography this has focused on supporting people to minimise and modify the impact of frailty (including younger people frail because of long term conditions, addictions etc). Providing holistic assessment and care management, focused on individual outcomes, anticipatory planning and supporting a reduction in unscheduled care. Fife has a population of 371,910[7] (midyear estimate 2018), with slightly above the Scottish average for the over 65's age group described in Table 12.

	Total Population	65+	75+	85+
Fife	371,910	20%	9%	2%
Scotland	5,438,100	19%	8%	2%

Table 12 - Population Demographic Summary

Fife H&SCP has seven localities. Lochgelly is within the Cowdenbeath locality. The Cowdenbeath locality sits within the West Division of the H&SCP. The H&SCP is developing a locality clinical model with GPClusters focused on the needs of the locality population. Table 13 demonstrates the percentage of locality populations over 75.

	Population >75

[6] https://www.nhsfife.org/media/32112/c64_cs-finalforintranet.pdf
[7] Mid-Year Population Estimates Scotland, Mid-2018, National Records of Scotland. Publication (nrscotland.gov.uk)

City of Dunfermline	3928	7%
Cowdenbeath	3360	8%
Glenrothes	4109	8%
Kirkcaldy	5549	9%
Levenmouth	3560	10%
North East Fife	7192	10%
South West Fife	3845	8%

Table 13 - Locality Demographic Summary

Table 14 notes the anticipated change in the localities population over the next 25 years. The total population within Cowdenbeath Locality is projected to increase by 5% by just around 2,000 by the year 2041. Most of the areas' population growth is expected to take place in the older people age group, an increase of circa 45% which will place an increasing demand on health and social care.

Population Projections		
	2016	2041
Overall	41,228	43,300
0-15 years		(600) -8%
16-64 years		(1000) -4%
>65 years		(3,600) +45%

Table 14 - Population Projections

The local and national goal, supported by NHS Fife's Clinical Strategy (2016-21)[8], and the Fife Health and Social Care Partnership's Strategic Plan for Fife 2019-2022[9] is to provide safe, effective and sustainable care at home or as close to home whenever possible. The integrated model being implemented will support robust, holistic health (primary and community) and social care, with third sector services having a strong focus on early intervention, prevention, anticipatory care and supported self management.

The proposal for investment into fit for purpose health and social care facilities in Lochgelly will not only address the current restrictions upon local delivery of clinical, community and third sector services and deficiencies in facilities at the existing Lochgelly Health Centre, but also enable the delivery of the above integrated model within the Lochgelly area.

The well rehearsed pressures in General Practice in Scotland can be illustrated by the following indicators:

- 10% of the population consults with a GP Practice clinician every week
- 34% of all GPs are aged 50 and over in 2015, compared with 29% in 2005

[8] https://www.nhsfife.org/media/32112/c64_cs-finalforintranet.pdf
[9] https://www.fifehealthandsocialcare.org/__data/assets/pdf_file/0028/188263/HSCP_Strategic_Plan_2019-2022.pdf

- 37% increase in female General Practitioners and 15% decrease in male GPs over the ten-year period to 2015
- 2015 – 1 in 5 GP training posts unfilled

Fife's Primary Care Improvement Plan sets out the ambitions for reshaping primary care and General Practice in implementing the new GMS 2018 Contract. This is facilitating the development of General Practitioners as expert medical generalists within expanded Primary Health Care Teams, by implementing new roles and ways of working. This is underpinned by the guiding principles of:

- Contact: accessible care for individuals and communities
- Comprehensiveness: holistic care of people – physical and mental health
- Continuity: long term continuity of care enabling an effective therapeutic relationship
- Co-ordination: overseeing care from a range of service providers

Care pathways are patient (not disease) centred to meet the challenge of shifting the balance of care, realising Realistic Medicine and enabling people to remain at or near home wherever possible. Local accessibility and the need to provide a wider range of services to people in their local communities and to develop greater local integration is being hampered by the accommodation available within the Lochgelly area. The effect of which is evidenced in the continued reliance upon the traditional medical model of relatively high acute hospital attendance and admission rates. Section 2.4.1.2 below highlights the patient journey using personas.

Local accessibility and improved joint working with other health and social care partners as part of a wider whole system will facilitate integration of health and social care and enable more effective delivery of health and wellbeing outcomes. This will be underpinned by Practice multi-disciplinary team working, supported by responsive wider locality teams in reaching to deliver local care. This is further illustrated through the patient pathways in Section 2.4.1.3 below.

2.4.1.2 The Patient Perspective

It has been recognised for many years, service providers across Scotland and the UK have planned care separately in different parts of the system including primary, community, acute care and mental health. Services have often been planned around buildings, individual service providers or even clinicians.

What is now proposed is a shift toward an overarching whole systems model which focuses on the needs of people who use the different health and social care services within the Lochgelly Practice. This is described as a more holistic community health and wellbeing approach.

The central underlying principle of the development of the new centre is to focus on the patient outcomes, their journey and experience. This will help to identify where service improvements are necessary and involve a wide range of service users and providers in analysing and redesigning improved patient pathways to positively impact on outcomes. To support this work seven patient personas have been developed which serve to inform key

considerations when designing new pathways and the integration of services. Full details of this work is contained in the supplementary document, “The Patient perspective” (Appendix J).

2.4.1.3 Sustainable Workforce and Staff – Health & Wellbeing

Since the launch of Everyone Matters 2018-2020[10], key priorities and actions have been identified which are contributing greatly to achieving a healthy organisational culture. Everyone Matters Implementation Plan actions will be integrated into the new centre where appropriate – initial considerations include:

- Health & Wellbeing and Healthy Organisational Culture – take action to promote the health, wellbeing and resilience of the workforce. Create an environment which supports working across teams, open office space, bookable quiet space and hot-desks, collaborative spaces, wellbeing space, access to support services – these are considered vital to staff wellbeing and morale. Wellbeing Hubs have been established in various sites to support staff, particularly during the global pandemic. Bookable peaceful indoor and outdoor spaces could be established within the centre for both (practice-based and visiting) staff and community use. Providing opportunities for staff to take part in wellbeing-related sessions as appropriate including mindfulness, kindness, resilience and self-care related activities. Sessions are planned with the local Health Psychologist to provide some of these activities within GP clusters, Lunchtime Bytes, Community Health & Wellbeing Services (CHaWS) Subgroup and with practice staff. Other elements will include Staff Cycle to Work Scheme, bike racks, outdoor gym, community garden with covered area, showers and changing facilities etc.

- Sustainable workforce: over 35 clinical and non-clinical services engaged in relation to: requirement of space in the new centre, days of use, frequency, special requirements etc. A service schedule was developed from the feedback which formed the Schedules of Accommodation and this information was used to start the early design of the new building. This will ensure that local services can be planned, coordinated and delivered within the new centre as close to home for people as possible. The new centre will have the space to accommodate a wider range of services as per GMS (General Medical Services) contract and aforementioned drivers for change. There is ongoing engagement with the Lochgelly Practice and services throughout the process including via the CHaWS Subgroup, the Design Team meetings etc.

- Capable workforce:

    - NHS Fife and FHSCP offer a suite of development opportunities for their workforce. Educational support services include: Health Promotion, Organisational Development, Learning & Development and Practice & Professional Development (PPD). The PDD is embedded below and includes: managerial coaching, observational visits to support recruitment, clinical skills, leadership, dementia awareness, palliative and end of life care. PPD provision and training is offered to all staff including those working in residential, nursing

[10] Everyone matters: 2020 workforce vision implementation plan 2018-2020 - gov.scot (www.gov.scot)

and care homes in Fife. HR, Patient Relations, Infection Prevention & Control, Pastoral, Resuscitation and Manual Handling all offer training to NHS staff.

  - Work across organisational and professional boundaries (i.e. between primary and secondary care, across sectors etc) to share good practice in Learning & Development (L&D), evidence-informed practice and organisational development. Facility available regarding L&D space e.g. face to face training or a computer room where staff can participate in virtual training, update their core skills, LearnPro, Turas etc. Engaging with the staff regarding what they would like and to ensure they feel included as part of the process in relation to the new building.

- Workforce to deliver integrated services: Working with partners to develop workforce planning capacity and capability in the integrated setting including ways of working – exploring opportunities to work differently before the building completion e.g. using the Patient Personas & Pathways in order to establish a service coordination approach and tests of change.

- Change management – ensuring change is managed appropriately and providing opportunities to keep all key staff and stakeholders informed, involved and engaged in the process where possible. The Staffside representative also attends Project Team meetings and has had input into these sections of the OBC. This will be organised through a range of methods such as Subgroup meetings, staff updates, Blink, websites, newsletters and ongoing communications with key stakeholders etc. It is important to give staff ownership particularly if the new building is to be their main base. How and when to ask staff for views is important - all views need to have equal importance.

- Longer opening hours – these will be considered as part of the new building where designated areas could potentially be 'locked-down' for out-of-hour use as a community asset.

- Health & Social Care and Design & Construction Career Pathways – work with L&D to ensure links with local schools and education providers are established to showcase Health & Social Care and Design & Construction as career pathways including options for apprenticeships, internships, student placements and work experience etc.

2.4.1.4 National and Local Strategies

Key national and local documents have influenced the development of our health and care model and thereby this proposal, although this is not an exhaustive list. It should be noted that along with Caithness and Ayrshire Fife's Community Health and Wellbeing Hub programme has been selected as a national pathfinder site to support a Once for Scotland approach to delivering the shift in the balance of care from hospital to community.

<u>National</u>

- Commission on the Future Delivery of Public Services (The Christie Report) (June 2011)

- 2020 Vision for Health and Social Care (September 2011)

- Healthcare Quality Strategy (2012)
- A National Clinical Strategy for Scotland (February 2016)
- Health and Social Care Delivery Plan (December 2016)
- Property Asset Management Strategy (2017)
- NHS in Scotland 2016 – Audit Scotland Report (October 2016)
- Achieving Excellence in Pharmaceutical Care: A Strategy for Scotland (August 2017)
- General Medical Services Contract (2018)
- Health and Social Care Integration – Audit Scotland (November 2018)
- Nursing 2030 Vision: Promoting Confident, Competent and Collaborative Nursing for Scotland's Future (2017)

Local

- Health and Social Care Partnership Strategic Plan for Fife Plan (draft 2019-2022)
- NHS Fife Clinical Strategy (2016-21)
- NHS Fife Property and Asset Management Strategy (2022)
- NHS Fife Operational Delivery Plan (2018/19)
- Let's really raise the bar: Fife Mental Health Strategy (draft) (2019-2023)

This proposal interacts with these key local and national strategies in terms of:

Quality Strategy ambitions in relation to:

- Person centred care - through improving access to Primary Care and providing more care closer to home
- Safe – reducing risk of infection through provision of modern fit for purpose accommodation
- Effective – bringing together a wider range of health and care services to make more effective use of resources

2020 Vision aspirations are that everyone can live longer healthier lives at home, or in a homely setting with focus on improving quality of care, improving the health of the population and providing better value and sustainability.

Technology Enabled Care projects are being tested within the current service model to modernise primary care, support earlier identification and self management.

NHS Fife's Clinical Strategy and Operational Delivery Plan are focused on delivering person centred care, closer to home where possible. The proposed development will support the local provision of health and social care services within Lochgelly, facilitating person centred care and support.

The **2018 General Medical Services Contract** refocuses the role of General Practitioners as expert medical generalists and recognises that general Practice requires collaborative working, with enhanced multidisciplinary teams that are required to deliver effective care, joint working between GP Practices in clusters and as part of the wider integrated health and social care landscape. Better care for patients will be achieved through:

- Maintaining and improving access
- Introducing a wider range of health professionals to support the expert medical generalist
- Enabling more time with the GP for patients when it is really needed
- Providing more information and support to patients

The **Public Bodies (Joint Working) (Scotland**) Act 2014[11] aims to improve outcomes for people by creating services that allow people to stay safely at home for longer with a focus on prevention, anticipation and supported self-management, and provide opportunities to co-locate health and care services working together for the local population. Fife's local Health and Social Care Strategy describes how the nine National Outcomes for Integration can be met through prevention, local earlier integrated working focused on peoples own outcomes.

Promoting the wellbeing of children is central to the work of Health Visitors and this is supported by the new **Universal Health Visiting Pathway**[12] and the Named Person role conferred by the Children **and Young People (Scotland) Act** (2014)[13]. The Universal Health Visiting Pathway sets the standard for health visiting and the minimum core visits that families with children aged 0-5 years can expect from their Health Visitor, regardless of where they live. This will require an increase in the Health Visiting establishment and new ways of working for full implementation.

The Scottish Government's **Nursing 2030 Vision: Promoting Confident, Competent and Collaborative Nursing for Scotland's Future** (2017)[14] sets the direction for nursing in Scotland through to 2030 and focuses on personalising care, preparing nurses for future needs and roles, and supporting nurses. Within this framework redesign in community nursing is supporting the implementation of the Chief Nursing Officer Directorates paper on Practice and Community Nursing to integrate locally to support prevention and early intervention.

Fife Health and Social Care Partnership, established on 1 April 2016, is refreshing its strategic plan, this includes revised Vision, Mission and Values. The plan is focused on delivering proactive, integrated support and therefore will seek to secure an outcome focused model delivered locally aimed at securing improved outcomes through early identification and intervention:

[11] Public Bodies (Joint Working) (Scotland) Act 2014 (legislation.gov.uk)
[12] Universal Health Visiting Pathway in Scotland: pre-birth to pre-school - gov.scot (www.gov.scot)
[13] Children and Young People (Scotland) Act 2014: National Guidance on Part 12: Services in relation to Children at Risk of Becoming Looked After, etc - gov.scot (www.gov.scot)
[14] Nursing 2030 vision - gov.scot (www.gov.scot)

- ***The Vision is*** To enable the people of Fife to live independent and healthier lives.
- **The Mission is** "We will deliver this (vision) by working with individuals and communities, using our collective resources effectively. We will transform how we provide services to ensure these are safe, timely, effective and high quality and based on achieving personal outcomes."
- Our **Values** are: Person-focused - Integrity – Caring - Respectful - Inclusive - Empowering

2.4.2 Need for Change Summary

The following is a full list of the main drivers causing the need for change, the effect that these issues are having on the current service provision and an assessment of why it is believed action is required now.

Driver for change:	What effect is it having, or likely to have, on the organisation?	Why action now:
The clinical and social care model have developed and implementation is being circumscribed.	Primary, Community and Voluntary sector services cannot provide the integrated model of care they and the community recognise is required now and for the future. Existing facilities lack the number and range of support areas necessary to deliver safe and effective services, the physical capacity of the building is 100% utilised and oversubscribed.	The model of integrated care is being undermined now: preventing locally based, proactive care. Lack of essential support areas (e.g. clean and dirty utility areas) represents a real and unacceptable risk to the Board in key areas such as Healthcare Associated Infections and patient safety that can only be addressed through significant investment. Time from Initial Agreement to occupation of a new facility could take circa 4 years.
	Services cannot be delivered locally for local patient need; existing physical capacity is unable to deliver essential baseline change and re-design.	Local health inequality issues will continue to be difficult to support. NHS Fife/Fife H&SCP will fail to deliver the GMS (2018) and the community health and wellbeing hub model within Lochgelly unless this is planned for.
	Pressure on existing staff, accommodation and services will inevitably increase.	Sustainability of primary care is a key priority for the Partnership and NHS Fife.

Driver for change:	What effect is it having, or likely to have, on the organisation?	Why action now:
		There is a need to plan to provide a sustainable service for the future
Poor clinical and non-clinical functionality and space restrictions in existing accommodation (configuration)	Existing facilities fall far below the required standards in terms of how they are configured and laid out. The Equalities Act 2010 compliance within the building is poor.	Existing facility configuration and layout presents unacceptable risks, as well as poor local performance, functional in-efficiency and suboptimal patient experience. Wheelchairs, mobility scooters and double buggies cannot access parts of the building, including the waiting area. The waiting areas are too small.
	Premises are functionally inadequate and compromise pro-active, integrated care.	No scope exists to re-organise parts of the service to improve the experience.
	Some consulting rooms are very small and do not meet current standards. These are very restrictive / unsuitable for patients and staff.	Poor patient and staff experience. Does not meet current recommended standards.
Clinical and social care functionality (capacity) issues	Capacity is unable to cope with current, let alone future projections of need. Patients are required to make repeated appointment to meet with different members of their multi disciplinary team and to access healthcare out-with the local area.	Service sustainability and development is at risk and an increasing number of patients will travel to other venues for appointments.
	Facilities lack the number and range of support areas necessary to deliver modern, integrated, safe and effective services	There are no rooms available to deliver training, accommodate local multi disciplinary team meetings, etc. There is no accommodation to support local access to a wider range of visiting community services to support for example income maximisation.

Driver for change:	What effect is it having, or likely to have, on the organisation?	Why action now:
Building issues (Including statutory compliance and backlog maintenance)	Existing facilities fall far below the required standards in terms of how they are configured and laid out. Physical characteristics of the building prevent safe and effective patient care: small treatment rooms below minimum standards. Increased safety risk from outstanding maintenance and inefficient service performance.	Building configuration and layout present unacceptable risks as well as poor performance and functional inefficiency. Redesign of building will allow for improved care, staff experience and financial performance. Building condition, performance and associated risks will continue to deteriorate if action is not taken now.

Table 15 - Need for Change

2.4.3 Investment Objectives

This section identified the ‘business need’ in relation to the current arrangements described in Section 2.1. These were discussed at the Architecture & Design Scotland (A&DS) facilitated workshop to develop the project design statement. A wide range of stakeholders including clinical and managerial staff along with community representatives were involved in a workshop to describe the difference between ‘where we are now’ and ‘where we want to be’.

Effect of the need for change on the organisation:	Investment Objectives
Existing service arrangements are affected by lack of clinical support service facilities.	Ensure equal access to a patient centred approach by enabling delivery of and access to local integrated anticipatory and preventative care for patients. Secure accommodation to deliver required group based activities.
Implementation of integrated models of care is undeliverable locally in the current environment	Ensure equal access to modern integrated care with provision driven by patient need rather than limitations in capacity.
Pressure on existing staff, accommodation and services will inevitably increase.	Ensure the right staff skill mix and service capacity are available to deliver and strengthen local capacity to manage people’s health within the local community.
The facilities available, 100% occupancy, combined with significant population change, restrict the ability of	Enable earlier access to proactive and anticipatory care through local delivery via integrated seamless service across health

the parties to deliver the full range of integrated services locally.	and social care. This will reduce referrals to other services. Care will be driven by patient need rather than limitations on capacity.
Existing configuration, as a result of a circa 1970's building, which has been modified and extended with a 'best fit' approach means poor accommodation e.g. service users who rely on wheelchair access or have a mobility problem have extreme difficulty in both accessing and traversing the facility.	Delivery of safe and effective care with dignity by providing facilities which comply with all legal standards and regulatory requirements and gives equality of access for all. Improved staff wellbeing.
Increased safety risk from outstanding maintenance and inefficient service performance.	Improve safety and effectiveness of accommodation by improving the physical condition, quality and functional suitability of the healthcare estate.

Table 16 - Investment Objectives

2.4.4 Proposed Benefits

There is a clear emphasis on General Practice provision and the development of the community health and wellbeing hub model within the Partnership's Strategic Plan and NHS Fife Clinical Strategy. The proposed investment in infrastructure will enable the Lochgelly Medical Practices to fully participate in the required programmes of care, enable full access to the Primary Care Improvement Plan and thereby improve outcomes for individuals, experience for staff and the reputation of the organisation.

Benefits for each of the investment objectives described in Section 2.4.3 above are mapped to the expected benefits in the context of the Scottish Government's five Strategic Investment Priorities (Safe; Person-Centred; Effective Quality of Care; Health of Population; Efficient: Value and Sustainability).

To ensure that resources are effectively utilised and that any investment made provides agreed benefits a register has been developed. The benefits register (see Appendix E) identifies the expected benefits, indicates a baseline and target measurement and also gives a priority level to each benefit. The Benefits Realisation Plan demonstrating how the benefits can be secured is included at Appendix F.

Investment Objective	Benefit	Investment Priority
Ensure equal access to a patient centred approach by enabling delivery of and access to local integrated anticipatory and preventative care for patients. Secure accommodation to deliver required group based activities.	GP Practice Multi-Disciplinary Team, wider community hub team and voluntary sector have access to accommodation to meet population needs locally.	Person-Centred Health of Population Integrated Care

Investment Objective	Benefit	Investment Priority
Ensure equal access to modern integrated care with provision driven by patient need rather than limitations in capacity.	Services delivered locally based on need.	Person Centred Efficient Effective Integrated Care
Ensure the right staff skill mix and service capacity are available to deliver and strengthen local capacity to maximise and improve people's health and wellbeing within the local community.	Higher staff retention levels. Higher staff morale/lower absence rates. Increased flexibility of roles. Career progression. Improved workforce planning across the health and social care pathway. Supports training, education and development. Improved patient centred communication within the wider team.	Person Centred Efficient Effective Value and Sustainability Integrated Care
Enable earlier access to proactive and anticipatory care through local delivery via integrated, seamless services across health and social care. This will reduce referrals to other services. Care will be driven by patient need rather than limitations on capacity.	Access to wider staff skills, support and experience on one site. Reduces unnecessary hospital referrals and admissions. Reduces patient risk. Cost effectiveness of service provision – ensuring patients can access services as close to home as possible	Effective Quality of Care Person Centred Integrated Care
Delivery of safe and effective care with dignity – by providing facilities which comply with all legal standards and regulatory requirements and gives equality of access for all. This will improve the patient and staff experience.	Improves patient experience addressing privacy and dignity issues. Improves staff safety through provision of primary care and community services on one site allowing for available support for patients and staff.	Safe Person Centred Quality of Care Integrated Care

Investment Objective	Benefit	Investment Priority
	Ease of compliance with standards e.g. Equality Act (2010)[15], HAI Fit For Purpose, flexible accommodation meeting all guidelines e.g. room sizes.	
Improve safety and effectiveness of accommodation by improving the physical condition, quality and functional suitability of the healthcare estate.	Increased local provision and access to treatment making best use of available resources by having the infrastructure to deliver more proactive, prevention and early intervention focused support; maximising MDT working to facilitate access for people and thereby reducing the call upon unscheduled care.	Effective Quality of Care Efficient: Value and Sustainability

Table 17 - Benefits

2.4.5 Risks

Risk is now covered within the Commercial Case (Section 4) and Management Case (Section 6). The project's Risk Register can be found at Appendix G.

2.4.6 Constraints and Dependencies

2.4.6.1 Constraints

Constraints are limitations on the investment proposal. Key constraints relating to this particular investment proposal are noted below:

- Financial – given the current climate it is recognised that the project is likely to be constrained financially. Once the project budget it is set, the project will require to be delivered within this.
- Programme – given the needs for change relating to the current arrangements, there is a need to deliver the project as quickly as possible.
- Quality – the project will require to comply with all applicable healthcare guidance and achieve the AEDET pre-defined target criteria across all categories. The project will also be subject to NDAP and Design Assure key stage reviews.
- Sustainability – as the preferred option is a new-build there will be a requirement to achieve and agreed BREEAM rating.

[15] https://www.gov.uk/guidance/equality-act-2010-guidance

- Site – site constraints have been investigated during the OBC and factored into the OBC cost projections. Planning constraints will be investigated during the FBC stage.

2.4.6.2 Dependencies

Dependencies are where action from others is required to ensure success of the investment proposal. Key dependencies include:

- Acquisition of the site for development. Discussions with Fife Council are ongoing in this regard, although initial indications are that Fife Council are supportive of the proposals. Engagement will continue through the FBC stage with a view to concluding a long lease arrangement at the end of this stage.
- Service re-design to maximise the opportunities of bookable spaces, agile working and service integration.
- E-health initiatives as outlined at Section 4.4.14.

2.4.6.3 Critical Success Factors

In addition to the Investment Objectives set out in Section 2.4.3, the stakeholders have identified several factors which, while not direct objectives of the investment, will be critical for the success of the project.

Requirement	Description	Critical Success Factor

Strategic fit	Meets agreed clinical and investment objectives, related business needs and service requirements	• Promotes sustainability of Primary Care provision and delivery of 2018 GMS Contract
		• Consistent with NHS Board's Clinical Strategy
		• Supports delivery of NHS Scotland Quality Strategy
		• Facilitates integration of health and social care services, delivered locally
		• From Patient perspective:
		  • a facility that is easily accessible, bright, friendly and airy.
		  • designed so that patients can be treated with dignity particularly in terms of confidentiality.

Value for money	Maximise the return on the required investment and minimise risks	• Service model maintains or reduces revenue costs in the longer term through earlier intervention • Service model enables effective decision making in allocation of resources • Building design maximises efficiency and sustainability
Potential achievability	Is likely to be delivered in relation to the required level of change Matches the available skills required for successful delivery	• The skills and resources are available to implement new ways of working • The H&SCP and the Practice are able to embed new ways of working • NHS Fife are able to deliver the programme to agreed budget and timescales • Technology enablers are available and utilised
Supply side capacity and capability	Matches the ability of service providers to deliver required services	• Service providers are available with skills, materials and knowledge • The project is likely to attract market interest from credible developers
Potential affordability	Available capital and revenue resources are sufficient to support the successful delivery of the proposed facility and services	• Solution is affordable to all stakeholders

Table 18 - Critical Success Factors

3 Economic Case

3.1 Introduction

The purpose of the Economic Case is to undertake a detailed analysis of the costs and benefits of a short list of options, including a do nothing and/or do minimum option, for implementing the preferred strategic / service solution(s) identified within the IA.

The objective is to demonstrate the relative value for money of the chosen option in delivering the required outcomes and services.

3.2 Revisiting the Economic Case

Since the IA, the Economic Case has been updated to provide details of stakeholder engagement activity undertaken during the stage.

3.3 The Do Nothing/Do Minimum Option

It is not feasible to continue with the existing arrangements ('Do Nothing'), because the building is not fit for purpose. The backlog maintenance required while supporting minimum safety and the building to be water-tight will not make it fit for purpose. The do nothing option scored lowest throughout the option appraisal process. The building and footprint likewise mean that a do minimum option is not feasible.

Strategic Scope	Do Nothing / Do Minimum
Service Provision:	Primary Care services in Lochgelly are delivered from the existing Lochgelly Health Centre. The facility has previously been considerably modified and extended.
Service Arrangements:	Three separate Primary General Medical Services practices, Community Health and Voluntary Sector services
Service Provider and workforce arrangements (at the time of the Option Appraisal):	For the services detailed above at section 2 the workforce arrangements will continue with General Practitioner services Community Health and Social Care and Voluntary Sector services delivered in the building. The developing integrated multi disciplinary model will be circumscribed with inequity of access and travel implications for patients. Poor accommodation will continue to be managed as a risk in terms of staff health and safety.
Supporting assets:	The existing Lochgelly Health Centre has a baseline area of 760m^2 and features a mixture of traditional General Practitioner/consulting spaces that includes:4 x restricted separate reception and records areas at a total of 100m^2 (Associated with the 3 x separate Practices and NHS consulting elements) 2 x waiting areas (total 26 m^2) with inadequate space to meet even baseline needs and no age-specific provision 17 x (reasonably sized but poorly configured) consultant/treatment rooms located throughout the facility with little/no functional relationship to each other or the different patient groups they relate to 1 x interview room 1 x group room, although this is in effect a former waiting area with no windows that is far from fit for purpose and can consequently only be used for very short periods, therefore this has virtually no capacity for e.g. staff meetings, staff training and group work (e.g. breastfeeding support) 5 x small and disparate offices (total 74 m^2) 1 x staff room (23m m^2) servicing the whole facility and all staff groups

Strategic Scope	Do Nothing / Do Minimum
	Clinical Functionality Capacity issues have been identified as those problems associated with a lack of local space (area) that is essential to safe, effective and appropriately compliant service delivery. Areas originally designed to provide essential support functions have been lost in a drive to maximise clinical consultation space. Whilst the facility technically has sufficient space to support baseline clinical activity, in reality it is unable to do this as a consequence of a chronic lack of storage, waiting, quiet / interview, phlebotomy, administrative and office space. In addition, the existing facility lacks any form of clean utility room, dirty utility room, disposal hold, Domestic Services Room (DSR) or clinical storage facilities. There is no dedicated teaching, group space nor consulting rooms capable of supporting a GP training function. There are no administration areas capable of supporting wider staff teaching and learning or undertaking on-line training and assessment packages. The facility has nowhere that a patient can be managed should their visit become protracted; they become unwell; and / or they require acute management prior to transfer out to another facility by ambulance. This results in delays to clinical activity as it means consultations being delayed or suspended and is compounded due to the extremely poor access to all existing clinical areas. (None of these can be accessed by a trolley through the main entrance should this be required, with the only other entrance – at the rear – only being accessible by a number of steps. This impacts poorly on patient dignity and confidentiality). The building configuration is poor from access, service configuration, safety and security perspectives.
Public & service user expectations:	Delivery of effective General Practitioner and Primary Care, physical and mental health services in Lochgelly from one building in a good central location which is all on one level. Services delivered by a wide range of professionals. Strong desire to increase ‘targeted’ delivery to address inequalities. Single shared staff room Access to adjacent car parking spaces in a free Council car park.

Table 19 - Do Nothing Option Summary

3.4 Stakeholder Engagement

3.4.1 **Initial Agreement**

It was important to have the support of key stakeholders from health and social care staff and leaders from the local community to define the change required and create the vision for change.

Stakeholders supported this through their participation in the Option Appraisal Exercises and Design Statement workshops. This ensured that the vision was shared and communicated to all who will be impacted by the change. It also encouraged support from those who have an emotional commitment to the services provided in their community.

3.4.2 **Outline Business Case**

This section focuses on the outcome of the initial engagement exercise undertaken with the people of Lochgelly in November to December 2020. In light of the restrictions, all engagement activities were planned mostly online or with appropriate measures such as social distancing in place. Key stakeholders were involved in developing a Covid-19 safe engagement approach including the Lochgelly Practices, Fife Young Carers, Fife Voluntary Action (FVA), Equality & Diversity, Participation & Engagement Team and their related networks.

The communication and engagement framework was approved by the Fife Partnership and Engagement Network: Advisory Group in October 2020. This plan sought to maximise engagement with local stakeholders via a range of networks to gather the citizen voice to inform the development of the Outline Business Case (OBC). Online materials were hosted by the NHS Fife website.

3.4.2.1 Key Communication and Engagement Activities

The main communication and engagement methods included:

- websites and social media
- press releases and posters
- cascading via local health care providers, schools, services and politician colleagues
- Peoples Panel
- Public Directory
- patient texting service
- online discussion forums, online and paper surveys

Activities included:

- Press releases were issued to initiate the engagement process through local newspapers and then an update partway through the engagement process
- The Localities Newsletter (December 2020) was sent across the seven localities (800+ members), SW Fife and Cowdenbeath Localities (189 members)
- Cowdenbeath Area Cluster

- Peoples Panel (1700 members)
- Public Directory (62 members)
- FVA Health & Social Care e-bulletin was sent to 653 members
- All communications included a link to the online survey and paper versions were made available in local sites
- Additional to this, the survey link and information was also sent out numerous times over the engagement period via social media by the NHS Fife and FHSCP Communication Teams as well as via local groups and organisations including Twitter, Facebook etc
- The patient texting service was utilised by the practices on a number of occasions and this proved to be the most successful method

3.4.2.2 Stakeholder Engagement and Surveys

Approximately 70 local groups and organisations were successfully engaged. This included:

- 12 schools in Cowdenbeath and Lochgelly
- Public Directory
- Fife Young Carers
- FVA
- Lochgelly Community Council
- NHS Fife and Equality Groups
- Cowdenbeath Cluster
- Centre for Equalities
- Carers Link
- Fife Carers Centre
- Dementia Friendly Fife (STAND Fife)
- HIS Community Engagement
- Disabled Persons Housing Association
- Benarty Response Team
- Lochgelly Beat Corona
- Lochgelly Community Development Forum
- Lochgelly Lunches
- Benarty Group

- Saje Scotland
- Community Teams
- Community Learning & Development
- Scottish Stammering Network

3.4.2.3 Survey Design

The survey was developed to provide participants with ample opportunity to share their thoughts and views in relation to their new Community Health & Wellbeing Centres. The following question ranges were outlined in the survey:

- health and wellbeing related services people would like to see in their new centre
- changes introduced since the pandemic would people like to keep
- changes introduced since the pandemic would people not like to keep
- order of importance e.g. support services, wellbeing services, increased opening times, outdoor gym, community spaces etc
- environmental factors to consider e.g. recycling, solar panels, electric car-charging points
- anything additional requirements or information not previously mentioned
- biographical information

This survey has been fully analysed and the information received from the engagement exercise has helped to support the OBC process, inform the options appraisal and building design processes, as well as help shape future service delivery in the new Lochgelly Community Health and Wellbeing Centre. Full details of the approach taken to the survey and this analysis are detailed in the supporting document Lochgelly Community Health and Wellbeing Centre Engagement Feedback Summary Report (available upon request).

3.4.2.4 Quick Wins

Using the thoughts, comments and ideas shared in the engagement feedback above, considerable work has taken place with the Lochgelly practice and other service providers to identify potential changes or improvements that can be put in place with immediate effect. Other longer term or more complex changes will be considered as the programme progresses with the development of the new centre.

These changes or improvements include:

- Ensuring a wide range of health and wellbeing services – the Clinical Services Subgroup was expanded further to include non-clinical services and renamed as the Community Health & Wellbeing Services (CHaWS) Subgroup
- Coordination and collaborative approach – working with the CHaWS Subgroup to test a coordination approach to improve patient pathways by ensuring people are accessing the most appropriate services when they need them most

- Mental Health Services – the engagement exercise highlighted a real need for mental health services, particularly during the pandemic. People will be better supported and enabled to access their local mental health services e.g. counselling, befriending, The Well etc

- Access to Carers Support – raising awareness of the needs of Carers of all ages and the appropriate support to access key services such as Fife Young Carers or Fife Carers Centre e.g. including benefits, short breaks (respite)

- Use of technology:

  - Encouraging or enabling people to access clinical and/or non-clinical appointments using technology where appropriate e.g. video calls/Whatsapp
  - Development and better use of practice websites where this isn't already available
  - Development and better use of the patient texting service
- Volunteering opportunities - public participation groups have been established to provide community representation to help shape the new centre

- Improved repeat prescription process – working with patients, carers and families, local pharmacists, doctors and administration staff are committed to ensuring easier access to safe, high quality repeat prescription systems

- Improved appointment systems – all the practices are considering how to best provide appointments, improve access and reduce waiting times for patients and will be taking the engagement feedback into consideration

3.4.3 Ongoing Stakeholder Engagement

The Project Team worked closely with practices and local organisations to identify members of the community who were interested in being involved in the development of their new centre. Local participation groups are set up and members of these groups feed into project meetings to share a representative view and feedback to the main group. There are also engagement events and activities being planned. Other options to increase community involvement and ownership will include the community/sensory garden and art work for the new centre.

The Stakeholder Engagement and Communication Plan is located at Appendix H.

3.5 Service Change Proposals

The initial scope for the Lochgelly Health Centre project was to explore design and scope options to provide a suitable health and social care facility in Lochgelly which was of a suitable size and condition to meet with the growing needs of the existing Practices, community health and social care team and voluntary sector services.

3.5.1 Long List of Options

The theoretical long list of options was initially generated by the NHS and Local Authority teams with the support of hubCo and its advisers and was reviewed throughout the process. This long-list was based on the cross-referencing of strategic theoretical service options available with local site / facility considerations.

Strategic theoretical option themes included:

Strategic Scope	Summary
1 Service Provision	• Do nothing (The status quo) • Build entirely new, minimise any use of existing buildings (full build)
2 Service Arrangements	• Don't have any specific GP / health facilities locally
3 Service provider/ workforce	• Utilise only 'operational' solutions to address existing problems
4 Supporting Assets	• Build new but also make use of existing facilities to support the overall model (reduced build) • Combine a new build or refurbishment proposal with other new / existing developments across the public sector • Use and/or refurbish one or more existing local buildings/facilities
5 User Expectations	• The expectations of the public and service users

Table 20 – Strategic Theoretical Service Options

The following core long-list of options, in addition to Option 1 do nothing/minimum described above at Section 3.3, was agreed:

Option	Description	Commentary
2	Don't have any Health Centre building – use existing available public sector estate.	This option was not short-listed as it was completely incapable of delivering the preferred service model, would not deliver the health & social care hub required and result in an even more fragmented service than at present. It was also reliant upon making use of existing spaces that lack both the capacity and functionality to deliver any of the services being delivered now and in the future.
3a	An operational solution utilising only the existing Health Centre	Whilst a number of operational solutions are being considered by the Board to address acute short-term crises – and this option is not mutually exclusive – it is not capable of addressing anything other than capacity concerns in the very short-term and certainly not any of the

Option	Description	Commentary
		physical/facility issues identified. It was consequently not short-listed.
3a	An operational solution utilising only the existing Health Centre	Whilst a number of operational solutions are being considered by the Board to address acute short-term crises – and this option is not mutually exclusive – it is not capable of addressing anything other than capacity concerns in the very short-term and certainly not any of the physical/facility issues identified. It was consequently not short-listed.
3b	An operational solution utilising the existing Health Centre plus space in the adjacent Lochgelly Centre	This option was assessed as a variation on option 3a), with space in the Lochgelly Centre providing potential additional scope to improve capacity concerns in the short-term. It was not short-listed for the same reasons.
4a	Refurbish & extend the existing Health Centre facility	This option was originally agreed for short-listing and was subsequently developed into drawings. Unfortunately this work-up highlighted that there was insufficient space to support the required extension (which would have to be on a single level on the adjacent car park site). It was consequently proven unfeasible and not short-listed.
4b	Refurbish the existing Jenny Grey facility	In contrast to the previous option, refurbishment of the Jenny Grey facility was not initially thought feasible, however architect work up developed a scheme that appeared credible with good use of space and only minimal compromise. This option was consequently short-listed.
5a	Reduced new build on existing Health Centre site (plus use of space in the existing health centre facility)	This option involved building a reduced new facility on the existing site that retained the existing facility. It was a theoretical option only and clearly not feasible as the existing Health Centre occupies its entire curtilage. The option was consequently not short-listed.

Option	Description	Commentary
5b	Reduced new build on existing Health Centre site (plus use of space in Lochgelly Centre)	This option involved building a reduced new facility on the existing site that also made use of space in the adjacent Lochgelly Centre. The option was not short-listed as it offered no benefits over a reduced new build on the adjacent car park site but introduced significant cost, disruption and operational challenges associated with de-cant to support demolition and re-building. The option was consequently not short-listed.
5c	Reduced new build on adjacent (car park) site (plus use of space in Lochgelly Centre)	This option involved a reduced new build on the adjacent car park site that made use of space (primarily group rooms) in the adjacent Lochgelly Centre. It was deemed feasible and consequently short-listed.
5d	Reduced new build on Lochgelly North School site (plus use of space in shared new development)	This option involved a reduced new build on the existing (disused) Lochgelly North School site that would be aligned to potential (very early stage) local authority proposals relating to the construction of a pre-school nursery on the site. It was deemed feasible and consequently short-listed.
5e	Reduced new build on Jenny Grey site (plus use of space in other facilities TBC)	This option involved building a reduced new facility on the existing Jenny Grey site that also made use of space in appropriate existing local facilities. In the event, no such facilities could be found and consequently the option was not short-listed.
6a	Full new build on existing site	This option involved a full new build on the existing site that was entirely self-contained. It was not short-listed as it offered no benefits over a full new build on the adjacent car park site but introduced significant cost, disruption and operational challenges associated with de-cant to support demolition and re-building.

Option	Description	Commentary
6b	Full new build on adjacent car park site	This option involved a full (self-contained) new build on the adjacent car park site. It was deemed feasible and consequently short-listed.
6c	Full new build at Lochgelly North School site	This option involved a full (self-contained) new build on the Lochgelly North School site. It was deemed feasible and consequently short-listed.
6d	Full new build at Jenny Grey	This option involved a full (self-contained) new build on the existing Jenny Grey site. It was deemed feasible and consequently short-listed.
6e	Full new build at Francis Street	This option involved a full (self-contained) new build on the Francis Street site. It was deemed feasible and consequently short-listed.

Table 21 - Long-list of Options

The benefits criteria against which the long list were assessed were initially drafted by the wider planning team in light of the strictures placed upon the clinical model by the facility associated challenges identified. These were refined during the option appraisal events into an agreed list based on global stakeholder opinion.

Importantly, this list was also developed with the support of the stakeholder group reviewing options related to a similar business case being developed for Kincardine in order to ensure that both projects, which have similar objectives and timescales, were able to benefit from each other's work through the development of an agreed list of benefits criteria that were weighted independently.

In summary, the benefits criteria reflected the ability of each identified option to, noted in order of highest to lowest weighting:

- Deliver an optimal physical environment
- Be readily accessible
- Support flexibility and sustainability
- Support local and national service strategies
- Deliver wider community & public benefits

The Partnership is committed to delivering services that are integrated and maximise opportunities for local delivery. It has been formally confirmed that there is an on-going requirement to continue to deliver GP, primary care and local clinical services from Lochgelly.

Specific site/facility considerations included:

- The existing NHS owned Health Centre site in Lochgelly
- The adjacent Local Authority owned (car park) site in Lochgelly
- A site at the Local Authority owned Lochgelly North School
- The Jenny Grey site (A Local Authority care home recently reprovided)
- A Local Authority owned site at Francis Street

Whilst a number of other potential sites were raised and considered, they were all excluded at this stage as they were either demonstrably too small and / or not in public sector ownership. On this latter point it was noted that a site that was not currently in the ownership of the public sector would only be considered if none of the public sector sites was deemed appropriate based on the appraisal process.

3.5.2 **Short List of Options**

The short list initially included Options 1, 4b, 5c, 5d, 6b, 6c, 6d and 6e. 4. In reflection of the complexity of the process and relatively early stage in the development it was however agreed to combine a number of these options. Specifically:

- Option 6b was combined with option 5c for evaluation purposes, with the amended option 5c becoming new build on adjacent (car park) site plus/minus use of space in Lochgelly Centre. This combined option referenced the fact that the required land take for both options was the same, with only the volume of accommodation required on a second floor different, whilst acknowledging the significant additional work still required to understand the actual opportunities and threats associated with potentially accessing the Lochgelly Centre.
- Option 6c was combined with option 5d for evaluation purposes, with the amended option 5d becoming new build on the Lochgelly North Schools site that 'had the potential to make use of space in a shared new development' if this is taken forward by the Local Authority. This combined option referenced the fact that the area available was capable of delivering both options whilst acknowledging that the nursery proposal was still only embryonic.

The short list options finally agreed and short-listed for scoring (by location) were:

Option	**Description**
1	1 – Current: Do Nothing (The Status Quo)
2	5c – Site/Adjacent Car Park Area: Build a new Health Centre on the adjacent (car park) site (plus/minus make use of space in Lochgelly Centre)
3	4b – Jenny Grey Site: Create a new Health Centre by refurbishing the existing Jenny Grey facility *Option no longer available as demolished*

4	6d – Jenny Grey Site: Build a new Health Centre on the Jenny Grey site by demolishing the existing facility
5	5d – Lochgelly North School Site: Build a new Health Centre on the Lochgelly North School site (with potential to make use of space in a shared new nursery development)
6	6e – Francis Street Site: Build a new Health Centre on the Francis Street site

Table 22 – Short-list of Options

3.5.3 Indicative Costs

Indicative costs for each of the options on the Short List have been prepared as per guidance in the Scottish Capital Investment Manual by hubCo. The non-preferred options are based on BCIS Tender Price Indices – updated to 4th quarter 2020. The preferred option is based on elemental cost/m^2 from other recent health centre projects and the current Schedules of Accommodation (updated to 4th quarter 2020). Figures are calculated over a 60 year period.

	Description	Capital Costs (£) *	Whole Life Capital Costs (£)	Whole Life Operating Costs (£)	Est. NPV (£)	Est. EUV (£)
1	**Do Nothing/Base**	-	-	5,465,940	2,311,661	91,099
2	**(5c) Car park**	7,025,717	1,639,332	19,613,953	11,871,118	467,823
3	**(4b) Jenny Grey Refurb**	-	-	-	-	-
4	**(6d) Jenny Grey New Build**	6,959,207	1,623,802	19,526,538	11,799,393	464,996
5	**(5d) Lochgelly School New Build**	7,244,244	1,690,358	21,488,830	12,763,618	502,995
6	**(6e) Francis Street New Build**	6,835,692	1,594,962	19,364,198	11,666,192	459,747

Table 23 - Option Costs

3.5.4 Option Advantages and Disadvantages

The following table outlines how the advantages and disadvantages of the short list were assessed against the benefits criteria. This was undertaken through a process of discussion / debate within groups with the intention of seeking consensus agreement around the relative merits of each option and scores to be applied.

Option	Advantages: Strengths and Opportunities	Disadvantages: Weaknesses and Threats
1 Do Nothing/Base	Established location	Building and curtilage no longer fit for purpose Not suitable for further development
2 (5c) Car park	Central, established location Accessible site. Overlooked- supports security Visible site Community setting Improves town landscape Community setting	Two storey Further site investigations required due to mining Constrained town centre site Loss of car parking during construction Reduced car parking Access roads may be unsuitable for construction traffic Site ground conditions make development very expensive Infrastructure issues – sewers do not support new development /network issues
3 (4b) Jenny Grey Refurb	Relatively close to town centre Reuse of existing public sector estate Space for optimum parking / site servicing Good access Overlooked- supports security Potential capital savings Community setting Flexibility of expansion options on site Potential complimentary use of site	Decant costs Possibly too overlooked. Further site investigations required due to mining Access roads may be unsuitable for construction traffic Does not meet more detailed briefing requirements due to restrictions of existing structure

	Potential to have segregated staff access	
4 (6d) Jenny Grey New Build	Relatively close to town centre Large flat site, optimum parking/site servicing Good access. Overlooked- supports security Adjacent to open amenity site Community setting Flexibility of expansion options on site Potential complimentary use of site Potential to have segregated staff access	Overlooking could impact on patient privacy Further site investigations required due to mining Access roads may be unsuitable for construction traffic Perceived impact on local amenity space
5 (5d) Lochgelly School New Build	Relatively close to town centre Large flat site, optimum parking/site servicing Good access. Overlooked - supports security. Potential complimentary use of site Uses a site with established community function Uses infrastructure of potentially suitable capacity of site	Access roads may be unsuitable for construction traffic Site ground conditions make development very expensive Infrastructure issues – sewers do not support new development /network issues Hidden from primary routes Demolitions required on site Potential impact on programme/approvals from adjacent developments
6 (6e) Francis Street New Build	Central location Accessible, ample site Overlooked- supports security Visible site Community setting Increased flexibility	Possibly too overlooked Further site investigations required due to mining Access roads may be unsuitable for construction traffic Site ground conditions make development very expensive

	Enables segregated access	Infrastructure issues – sewers do not support new development /network issues

3.5.5 Does the Option meet the Investment Objectives?

The table below summarises the extent to which the shortlisted options meet the Investment Objectives.

Table 24 - Option Advantages and Disadvantages

Investment Objective	1 Do Nothing /Base	2 (5c) Car park	3 (4b) Jenny Grey Refurb	4 (6d) Jenny Grey New Build	5 (5d) Lochgelly School New Build	6 (6e) Francis Street New Build
Ensure equal access to modern integrated care with provision driven by patient need rather than limitations in capacity.	No	Yes	No	Yes	Yes	Yes
Ensure the right staff skill mix and service capacity are available to deliver and strengthen local capacity to maximise and improve people's health and wellbeing within the local community.	No	Yes	No	Yes	Yes	Yes
Enable earlier access to proactive and anticipatory care through local delivery via integrated, seamless services across health and social care. This will reduce referrals to other services. Care will be driven by patient need rather than limitations on capacity.	No	Yes	No	Yes	Yes	Yes
Delivery of safe and effective care with dignity – by providing facilities which comply	No	Yes	No	Yes	Yes	Yes

Investment Objective	1 Do Nothing /Base	2 (5c) Car park	3 (4b) Jenny Grey Refurb	4 (6d) Jenny Grey New Build	5 (5d) Lochgelly School New Build	6 (6e) Francis Street New Build
with all legal standards and regulatory requirements and gives equality of access for all. This will improve the patient and staff experience.						
Improve safety and effectiveness of accommodation by improving the physical condition, quality and functional suitability of the healthcare estate.	No	Yes	No	Yes	Yes	Yes
Ensure equal access to modern integrated care with provision driven by patient need rather than limitations in capacity.	No	Yes	No	Yes	Yes	Yes

Table 25 - Does the Option Meet the Investment Objectives?

3.5.6 Cost / Benefit

This section presents the case for the selection of the preferred option. In line with HM Treasury guidance, the NPC is divided by the WBP score to determine the cost per benefit point for each option. The lowest cost per benefit point is considered to be the most attractive option.

	1 Do Nothing/ Base	2 (5c) Car park	3 (4b) Jenny Grey Refurb	4 (6d) Jenny Grey New Build	5 (5d) Lochgelly School New Build	6 (6e) Francis Street New Build
Net present cost (NPC) - £m	2,311,661	11,871,118	-	11,799,393	12,763,618	11,666,192
Weighted benefit points (WBP)	256	431	435	632	431	879
BPC per WBP - £000	9,029	27,543	-	18,669	29,613	13,272

	1 Do Nothing/ Base	2 (5c) Car park	3 (4b) Jenny Grey Refurb	4 (6d) Jenny Grey New Build	5 (5d) Lochgelly School New Build	6 (6e) Francis Street New Build
	Reject	Possible	NA	Possible	Possible	Preferred

Table 26 - Option Benefit Scores

3.5.7 Preferred Option

From table 26 it can be seen that option 6 scores highest in respect to benefit points. Once the net present costs are factored in, option 1 is highlighted at the lowest cost per benefits point – this is purely because of low net present cost owing to the limited capital that could be invested in the existing facility. As option 1 does nothing to tackle the needs for change as demonstrated within the strategic case and benefits appraisal, it is not a legitimate option.

Given the balance of legitimate options, option 6 offers the highest benefits score and the lowest cost per benefits point, indicating that it is the strongest option. Option 6 is therefore the preferred option as favoured by all stakeholders (consensus).

The proposal has the support of representative service users, carers, staff, the GP Practice and all other key stakeholders.

4 Commercial Case

4.1 Introduction

This section outlines the commercial arrangements and implications for the Project. This is done by responding to the following points:

- The procurement strategy and appropriate procurement route for the Project
- The scope and content of the proposed commercial arrangement
- Risk allocation and apportionment between public and private sector
- The payment structure and how this will be made over the lifetime of the Project
- The contractual arrangements for the Project

4.2 Revisiting the Commercial Case

The commercial case has generally been updated and expanded since IA in accordance with SCIM OBC guidance. In particular, the design of the preferred option has been progressed allowing for a detailed overview on the status of the design to be provided.

4.3 Procurement Strategy

4.3.1 Procurement Route

NHS Fife will lead on the procurement whilst being supported by the Fife Health and Social Care Partnership.

The project is community focussed and more than £750k, therefore the Scottish Futures Trust hub initiative has been selected as the most appropriate route to deliver the project. The East Central hubCo have been appointed to deliver this public funded project under the design and build option.

The following further procurements have been undertaken to support the Board and these will be procured through Frameworks Scotland Lead Advisor lot.

Lead Advisor

- Project Manager services
- Cost Advisor services
- Technical Advisor services (M&E)
- Authority’s Representative (for contract purposes)
- Clerk of Works

4.3.2 Procurement Rules and Regulations

As the proposed procurements have already been tendered they are in compliance with the procurement rules and regulations.

4.3.3 Procurement Plan

The summary table below provides an overview in respect to procurements to date:

Service	Appointment	Status
Contractor, Designers and Principal Designer	East Central hubCo	New Project Request (NPR) agreed. Stage 1 Approved.
Lead Advisor	Currie & Brown	Appointed

Table 27 - Procurements

4.4 Scope and Content of Proposed Commercial Arrangements

4.4.1 Overview

The project involves providing a new health and wellbeing centre within Lochgelly at the preferred Francis Street site. The new centre will replace the existing facility and will be developed further to accommodate future growth within the local area whilst taking cognisance of the Scottish General Medical Services (GMS) contract. The new facility will focus on providing core GP and other health services whilst offering broader flexibility for the promotion of interconnected health and wellbeing opportunities within the local community – this is in-keeping with NHS Fife's ambition to become an anchor institution within Fife.

4.4.2 Project Brief

The project brief is reflected within the following documents which can be provided upon request:

Document	Date	Revision
New Project request (including appendices)		4
Authority's Construction Requirements (ACR)	12.08.21	1

Table 28 - Project Brief

The brief for the design process is that the proposal must conform to all statutory requirements. In addition, the design proposals must meet all relevant Healthcare Guidance as published by HFS on their website.

The PSCP is required to schedule all relevant healthcare guidance and identify any associated derogations against that guidance. This process is ongoing in parallel with the development of the design and will be concluded and presented during the FBC stage of the project.

In respect to governance, the Project Team will be charged with reviewing and agreeing proposed derogations. Thereafter the Project Board have assumed responsibility for sanctioning any proposed derogations. This will be an iterative process culminating in formal acceptance of derogations in advance of contract execution. The Project Team will liaise with Health Facilities Scotland for support and guidance where necessary when contemplating derogations.

4.4.3 Current Design Status

The design has been completed to RIBA Stage 2 which aligns with OBC and NDAP requirements. The table referenced below provides an overview of how the project is performing against predefined OBC requirements.

OBC Design Requirements	**Project Status**
Concept Design incl. Arch, M&E, C&S, Fire, Landscape	Complete
Outline drawings (≥1:200, key ≥1: 50) & specifications	Complete
Outline sustainability strategy	BREEAM Pre-assessment completed
Outline construction strategy incl. HAI, CDM H&S Plan	Ongoing and will be continued into FBC
3D sketches of key Design Statement spaces	Complete
Completed Design Statement OBC self-assessment	Complete – assessed through AEDET workshop
Completed AEDET OBC self-assessment	Complete
Photographs of site showing broader context	Complete
Evidence of Local Authority Planning consultation and/or alignment with Local Development Plan.	Pre-planning engagement has been sought from Fife Council via a formal application and fee. Consultation and feedback will be received early within the FBC period.
Extract of draft OBC detailing benefits & risks analysis	Provided within this OBC.

OBC Design Requirements	Project Status
Evidence of HAI & CDM consultation	HAI SCRIBE Stage 1 has been completed
Evidence Sustainability commitments will be met. e.g. accurate & NCM models (DSM). BREEAM, .CAB files and BRUKL; show how design will be optimised	
Evidence Equality & access commitments will be met	Design development ongoing but briefing requirements set out in NPR and ACR
Evidence of VfM e.g. WLC on key design options	EQIA Stage 1 complete
Evidence Activity Data Base (ADB) use optimised	Ongoing process through design workshops
Evidence NHS guidance & technical standards will be met; list any derogations, with their technical reasons	Will be used at FBC. Standard HFS repeatable layouts will be utilised where appropriate
OBC design report evidencing all above & IA brief met ≥1:500, ≥1:200, key ≥1: 50; diagrams, sections plans, 3Ds, specs, comfort & energy DSMs, to RIBA Stage 2 Concept plus key elements developed to Stage 3	Ongoing – to be evidenced and concluded within the FBC stage

Table 29 - Design Status

4.4.4 Schedule of Accommodation (SoA) Development

A SoA was developed at the IA stage of the project. Whilst the schedule was tested with stakeholders at this stage to inform budgetary costings it was very much a working draft. The status of the SoA was offset by the optimism bias allocation factored into the Financial Case at IA.

The SoA was developed further at commencement of the OBC stage following a detailed review of health services to be accommodated within the building. When the IA was first developed, the GMS contract was in its infancy. Changes to the SoA largely relate to emerging requirements from the GMS contract.

The table below compares the IA SoA to the OBC “as drawn” outturn. As it can be seen there is an increase of 339m^2 overall.

IA SoA (m^2)	OBC "as drawn" (m^2)	FBC "as drawn" (m^2)	Difference (m^2)
1,478	1,817		339

Table 30 - Area (m^2) Summary

4.4.5 Flexible Space

Given the order of investment, it is important that use of the asset is maximised with rooms being utilised to their full potential. It is also important for the asset to be used successfully at the outset whilst being capable of withstanding future change with minimal disruption and cost. For these reasons the following themes and workstreams are being progressed.

- HFS standardised rooms are being incorporated wherever practicable
- The building configuration is being designed to withstand future changes in GP practice arrangements – i.e. consolidation of GP practices
- A bookable room system is being developed to support transient services
- The building layout and landscape is being designed to afford and promote "out of hours" use for health and wellbeing initiatives and community use
- An agile working policy is being developed to support agile workstations within open plan office areas
- The building design is being considerate to possible constraints caused by pandemics and how the building may cope with these temporary situations

4.4.6 Community Engagement

In December 2020 a community engagement exercise was undertaken to reach out to the local community to establish what was important for them within their new health and wellbeing centre over and beyond core requirements. Aspects relating to the physical building are listed below together with detail on how these themes will be taken forward and where applicable incorporated into the design. Feedback in respect to the community engagement exercise has been undertaken with the community separately.

Theme	Project Action
Flexible spaces to allow the provision of services and for community use out of hours	Carried forward into design proposals
Near-me booths to support accessibility and digital poverty	Being carried forward into design proposals
Community gym	No space allowance for an internal gym currently. External space is being incorporated for community use which could include provision for gym related equipment. Space allocation only at OBC.

Theme	Project Action
Needle exchange	Being considered within design proposals
Community garden	External space is being incorporated for community use which may include provision for a community garden. Space allocation only at OBC
Accessibility - space for external mobility scooter parking plus space for wheelchair and pram storage/parking internally	Being carried forward into design proposals
Covered external area	Being considered and where possible incorporated, but needs to be balanced with anti-social behaviour which covered areas can often attract
Community café	It is considered that the health centre is too small to benefit from a community café. This amenity is already provided locally
Community fridge	This amenity could/is be provided by the local community centre

Table 31 - Engagement Feedback

4.4.7 NHSScotland Design Assessment Process (NDAP)

The purpose of NDAP is to promote design quality and service. It does this by mapping design standards to the key investment deliverables, including Scottish Government objectives and expectations for public investment, then demonstrating their delivery via self, and independent assessments. NDAP is made up of personnel from Health Facilities Scotland (HFS) and Architecture Design Scotland (A&DS).

During the IA Stage, A&DS helped to facilitate a Design Statement workshop. This document forms part of the Project Brief, setting out design objectives for the Project Team. The project's design statement is located at Appendix B.

At commencement of OBC shortly after hubCo appointment, the Project Team met with HFS to discuss the project, principles and expectations. This helped to provide a framework for development of the design during the OBC Stage.

The OBC NDAP submission was issued on 23 December 2021. The review process is ongoing at the time of concluding this OBC for governance approvals, although it is anticipated that the NDAP report will be available in advance of the project being considered by the Scottish Capital Investment Group.

4.4.8 NHS Assure

NHS Assure is a technical key stage review process set up and administered by NHS NSS. Their remit is to provide knowledge and expertise through the lifecycle of projects to provide confidence within the public sector that projects are being procured, designed and delivered in a compliant manner ensuring operational safety for building users.

NHS Fife submitted their OBC key stage review pack to NHS Assure on 23 December 2021.The review process is ongoing at the time of concluding this OBC for governance approvals, although it is anticipated that the NDAP report will be available in advance of the project being considered by the Scottish Capital Investment Group.

4.4.9 Achieving Excellence Design Evaluation Toolkit (AEDET)

In accordance with SCIM guidance and the investment objectives, AEDET will be used throughout the development of the Project to help NHS Fife manage the design from initial proposals through to detailed design and will continue to do so through to Project Evaluation.

The AEDET toolkit has three key dimensions (functionality, build quality and impact) and outlines 10 assessment criteria. Each of the 10 areas is assessed using a series of questions which are scored on a scale of 1 - 6.

AEDET assessments are to be undertaken at predefined stages throughout the project's lifecycle. The stages are outlined in the table below together project progress against these to date.

Stage	Project Progress
Benchmark – assessment of current asset(s)	Completed at IA
Target – aspiration for project	Completed at IA
OBC – assessment of design proposals	Complete
FBC – assessment of design proposals	To be completed at FBC

Table 32 - AEDET Progress

On 8 December 2021, an AEDET workshop was held to review the OBC stage design against the agreed target scores. This workshop involved a wide range of participants including staff, service users and hubCo. The OBC AEDET scores are included in the table below together with the benchmark and target scores.

Category	Benchmark	Target	OBC	FBC
Use	1.4	4.5	3.8	
Access	1.1	4.4	3.1	
Space	1.0	4.2	3.1	
Performance	1.4	4.4	2.7	
Engineering	1.3	3.4	3.4	

Construction	0.0	4.0	0.0	
Character & Innovation	1.0	4.4	3.4	
Form & Materials	1.3	4.4	3.0	
Staff & Patient Environment	1.1	4.3	3.5	
Urban & Social Integration	1.3	4.5	3.4	

Table 33 - AEDET Scores

4.4.10 BREEAM

Projects requiring capital investment through the Scottish Government are required to demonstrate sustainable credentials to contribute towards the development of a sustainable NHS estate.

The project has been assessed using BREEAM UK New Construction 2018, sub-group healthcare. A target score of 45% was set at the briefing stage which equates to a BREEAM "good" rating. The project is currently targeting credits equating to 53.71% which is beyond the briefing target.

Note: the project commenced in advance of new sustainability guide being mandated / published so proceeded on the basis of mandated guidance at that point in time

4.4.11 Energy

Following a meeting with HFS, project specific energy targets were agreed. The energy targets took cognisance of project budgetary constraints set at IA (pre zero carbon policy) whilst still aiming to ensure that the facility will be very energy efficient. The following criteria was agreed:

- >59% emissions reduction against 2015 benchmarking to be sought
- Electricity target not more than 60 kWh/ m^2 pa; and max demand not to exceed 20 Watts/ m^2
- Thermal target not more than 120 kWh/ m^2 pa

The criteria will be achieved through the development of the design.

4.4.12 Healthcare Associated Infection System for Controlling Risk in the Built Environment (HAI SCRIBE)

HAI SCRIBE is a risk management process aiding the identification and mitigation of design and construction related infection risks within the built environment. There are four stages within the process – these are identified in the table below together with project progress against these stages to date.

Stage	Project Progress
Stage 1 – Site Selection	Complete

Stage	Project Progress
Stage 2 – Design	To be completed at FBC stage.
Stage 3 – Construction	To be completed at FBC stage.
Stage 4 – Occupation	To be completed post completion.

Table 34 - HAI SCRIBE Summary

4.4.13 Building Information Modelling (BIM)

BIM describes the process of designing and constructing a building collaboratively using one coherent system of digital models and linked non graphical data, as opposed to separate sets of drawings and documents. These models and data also incorporate information which will be carried over and used in the operational phase.

NHSScotland is supporting the adoption of Level 2 BIM maturity following the SG mandate in support of the recommendations of the "Review of Scottish Public Sector Procurement in Construction" which endorsed that "BIM will be introduced in central government with a view to encouraging adoption across the public sector. The objective states that, where appropriate, projects across the public sector adopt BIM level 2 by April 2017."

The NHSScotland BIM strategy is intended to ensure the creation of a digitised information management process which all Boards and teams working on NHSScotland programmes should follow to maintain consistency and facilitate collaborative working, which will in turn reduce waste and non-conformances.

The Project will use BIM as a key design tool during the design and construction phases of the project helping to facilitate coordination and mitigate risks. Another benefit of BIM is that NHS Fife will have true "as built" records along with the project specific asset tagging that will assist with the operation, maintenance and replacement of components.

An NHS Fife Employers Information Requirements (EIR) has been developed and offered hubCo as part of the Project Brief. The EIR in turn has helped to inform the BIM Execution Plan (BEP) which has been developed by the hubCo. These two documents control how BIM will be utilised on the project.

4.4.14 E-health

Consultation has been ongoing with eHealth during the OBC phase of the project. Initial efforts have focussed on ensuring the IT infrastructure meets e-health's standard requirements. E-health systems will be provided in line the department's wider strategy for GP premises. E-health suggestions flowing from the stakeholder consultation are as follows and these will be considered by the project team in further detail at the next stage of the process (**subject to separate funding and business cases where appropriate**).

- A patient appointment system
- A consultant room with near me facilities
- A GP text messaging system
- A self check-in facility

- Subject to security considerations, public access to IT equipment to combat digital poverty
- A room booking system

4.5 Risk Allocation

4.5.1 Key Principles

At conclusion of the FBC NHS Fife will enter a contract with hubCo to deliver the facility. The contract will be based on the Hub standard form Project Agreement (Design Build Direct Agreement) and will be subject to amendment through agreement between Legal Advisers.

Having worked through the pre-construction stage and mitigated the construction risks through surveys and investigations most of the residual construction risk is taken by hubCo.

The risk allocation table below is driven by the Design Build and Direct procurement methodology described above. Note: the percentage allocations are indicative of a project of this nature.

	Allocation of risk		
Risk Category	**Public**	**Private**	**Notes**
Title	100%	0%	
Design	0%	100%	
Development and Construction	5%	95%	√
Ground conditions below existing structures that could not be surveyed	100%	0%	There are no existing buildings on the proposed site.
Transition and implementation	100%	0%	Commissioning and migration Board responsibility
Operation of the facility	100%	0%	
Revenue	100%	0%	
Termination of Project	40%	60%	
Technology and obsolescence	100%	0%	√
Financing	100%	0%	Capital funding
Legislative	100%	0%	

Table 35 - Risk Allocation Summary

4.5.2 Key Risks

The key risks/issues currently encountered on the project are outlined in the table below. The risk register can be located at Appendix G.

Risk/issue	Mitigation
Brief inadequate/unreliable This issue relates to developments around the GMS contract and effect this has had on the area requirements for the building.	The required area increase from IA to OBC has been factored into the current design and corresponding cost plan.
Stop/start nature of the programme – keep people engaged through these periods.	Updates are being provided to community groups via newsletters and the public via press releases. NHS Fife's communication team are supporting this effort.
Project cost increases due to: ▪ Change in requirements ▪ Inflation / market conditions	This is a current issue where the cost increases have rose beyond the IA budget projection. Refer to Financial Case for further substantiation.
Programme delay The OBC programme has been affected because of COVID which has impacted resources, engagement activity and costs.	Potential to commence FBC activity in parallel with the OBC governance approval process. The project now has a full complement of resources to help drive the project forward.
Change of policy – NHS Assure Key Stage reviews Programme delays / cost increases arising	Key stage review process was implemented half-way through OBC and is required to achieve capital funding. Risk had to be accepted, but impact can be mitigated through collaboration.
Change of policy – SHTN 02-01 Sustainable Design and Construction Guide (SDaC) Programme delays / cost increases arising	Informed by HFS at OBC NDAP review that new guidance must be followed at FBC. Guidance is untested to impact is difficult to quantify. As such this risk has not currently been factored into OBC cost estimates.

Table 36 - Key Risk Summary

4.6 Payment Structure

During the pre-construction stage hubCo are paid on a monthly lump sum basis in line with an agreed drawdown schedule. At construction the Board will be obliged to pay hubCo a

lump sum one-off Development Fee for their services. Thereafter applications for payment will be processed and settled monthly in accordance with the form of contract.

Directly appointed consultants will be paid on a monthly basis in accordance with their agreed NEC4 Option A activity schedules.

4.6.1 Project Bank Account

The Project will operate a Project Bank Account (PBA), consistent with Scottish Government Guidance for public sector construction projects. A Project Bank Account is a ring-fenced bank account from which prompt payments are made directly and simultaneously to hubCo, the lead contractor and members of the supply chain. PBA's improve subcontractors' cashflow and ring-fence it from upstream insolvency.

The PBA will become operational during the construction stage of the project. The documentation and contractual arrangements associated with setting up the PBA will be developed during the FBC stage. Recent board experience in setting up a project bank account for a separate capital project will be beneficial for this project.

4.6.2 Risk Contingency Management

A project risk register was created at IA and this has since been developed further during OBC. It is used as an active management tool to identify and mitigate risks progressively as the design is developed. The risks have been fairly allocated to the party best able to manage them.

The risk register will continue to be used through FBC and the construction stage to enable risks to be identified and managed. From a commercial perspective hubCo risk is capped at 1% prior to entering the construction stage. Variations are managed in accordance with the terms of the contract. Although the opportunity for risk and variations is restricted during the construction stage, it is prudent for the NHS Fife to retain a reasonable contingency provision to cover this risk. The contingency provision will be developed and informed by the risk register during FBC but is likely to be in the order of 3-5%.

4.6.3 Contract Variations

Variations will be managed in accordance with the terms of the contract. The contract will be based on the standard SFT DBDA template with agreed amendments.

4.6.4 Disputed Payments

Disputed payments will be managed in accordance with the terms of the contract. The contract will be based on the standard SFT DBDA template with agreed amendments.

4.6.5 Inflation

Inflation will be taken account of when developing the price using the BCIS indices. HubCo and NHS Fife's Lead Advisor will ensure that the correct indices are utilised to identify the correct inflation to be applied to the project. Any deviation to the agreed inflation allowance rest with hubCo as an opportunity/risk.

4.6.6 Utilities and Service Connection Charges

Responsibility for utility and service connections charges will be identified and confirmed at Stage 2 (FBC).

4.6.7 Performance Incentives

No performance incentives will be utilised.

4.7 Contractual Arrangements

4.7.1 Type of Contract

The contract will be based on the standard SFT DBDA template with agreed amendments.

4.7.2 Key Contractual Issues

No key contractual issues have been identified at this stage, however should any arise through development and completion of the contract documentation, then these will be presented within the FBC.

4.7.3 Dispute Resolution and Termination

Procedures for contract administration, dispute resolution and termination are clearly set out within the proposed contract form.

4.7.4 Asset Ownership

In respect to asset ownership, the project is being procured using traditional capital funding. hubCo will be responsible for delivering the facilities. At Completion, NHS Fife will take possession of the building and will be responsible for the ongoing operation and maintenance of the facilities.

4.7.5 Land Ownership

The land is likely to be leased on a long-terms basis (100 years) from Fife Council. This is a similar arrangement to many of Fife's existing health centres and comparably demonstrates far greater value for money than purchasing the land outright. Initial discussions have already taken place with Fife Council and these will be advanced during the FBC stage of the project.

4.7.6 Personnel Implications

There are no employees who are wholly or substantially employed on services that will be transferred to the private sector under the proposals for this Project, and therefore the Transfer of Undertakings (Protection of Employment) Regulations 1981[16] (TUPE) will not apply.

[16] https://www.legislation.gov.uk/uksi/2006/246/contents/made

5 Financial Case

5.1 Introduction

The Financial Case considers the affordability of the scheme. This section sets out all associated capital and revenue costs, assesses the affordability of the preferred option and considers the impact on NHS Fife's and the FHSCP's finances. The affordability model assessment has been developed to cover all aspects of projected costs including estimates for:

- Capital costs for the option considered (including construction and equipment)
- Non-recurring revenue costs associated with the project
- Recurring revenue costs (pay and non-pay) for current model i.e. baseline
- Recurring revenue costs (pay and non-pay) for the preferred option

For clarity it should be noted that NHS Fife will take ownership and financial responsibility for all property related costs (capital and revenue). The FHSCP will be financial responsible for all service-related costs – i.e. costs to provide the required clinical services.

5.2 Revisiting the Financial Case

The IA was approved by Scottish Government Health and Social Care Department (SGHSCD) in November 2019 and no specific conditions were outlined in the approval letter in relation to the Financial Case.

NHS Fife have considered the affordability of this proposal by undertaking a review of the financial implications of investment, both capital and revenue.

5.3 Financial Model (costs and associated funding for the project)

5.3.1 Capital Costs

5.3.1.1 Capital Cost Summary

Capital costs have been produced by East Central hubCo and have been summarised in Table 37 below.

Description	IA Costs	OBC Costs	Difference
Design Fees	£285,522	£802,972	£517,450
Construction Price	£4,464,850	£7,496,286	£3,031,436
Surveys/Investigations	£20,000	£50,000	£30,000
Statutory Fees	£16,000	£75,000	£59,000
Contingency	£267,677	£363,124	£95,447
Inflation	£119,270	£209,907	£90,637
Optimism Bias	£1,241,597	£1,187,642	-£53,955
Client Consultants	£236,078	£139,788	-£96,290
Equipment	£144,037	£449,864	£305,827
Decant	£25,657	£25,657	£0
BIM Fees	£0	£0	£0
E-health	£15,004	£0	-£15,004
Direct Labour Costs	£0	£98,848	£98,848

Description	IA Costs	OBC Costs	Difference
Total ex. VAT	**£6,835,692**	**£10,899,088**	**£4,063,396**
VAT	**£1,319,923**	**£2,132,090**	**£812,168**
Total	**£8,155,615**	**£13,031,178**	**£4,875,563**

Table 37 - Capital Costs

The total updated cost of the preferred option, which is to develop Lochgelly Health Centre for NHS Fife is £13,031,178.

It is important to recognise that whilst the capital cost has increased since Initial Agreement, the other feasible options presented within the Economic Case would have increased in the same way given that the underlying factors driving cost would have been the same. This means that the preferred option, despite being subject to significant cost increase, remains the preferred option in respect to benefit realisation and cost.

5.3.1.2 Capital Cost Key Movements

Table 37 below provides a summary of key project cost adjustments. The adjustments are described further beneath the table from a budgetary perspective.

Description	IA Cost	OBC Cost	Difference	Notes
HubCo	£5,054,049	£8,787,381	£3,733,332	Area increase: 339m^2 Inflation: extraordinary conditions Site & design abnormals
Inflation	£119,270	£209,907	£90,637	Based on BCIS indices to construction
Optimism bias	£1,241,597	£1,187,642	-£53,955	Updated for OBC based on project maturity at this stage (13%)
Consultants	£236,078	£139,788	-£96,290	Contract now awarded – firm cost
Equipment	£144,037	£449,864	£305,827	Equipment allowance too low at IA – increased in consultation with HFS (5%)
Decant	£25,657	£25,657	£0	
E-health	£15,004	£0	-£15,004	Included in equipment line
Direct costs	£0	£98,848	£98,848	None allowed for at IA
Total ex. VAT	**£6,835,692**	**£10,899,088**	**£4,063,396**	
VAT	**£1,319,923**	**£2,132,090**	**£812,168**	
Total	**£8,155,615**	**£13,031,178**	**£4,875,563**	

Table 38 - Key Capital Cost Movements

In respect to the OBC cost plan, there is a difference amounting to £4,875,563 when compared to the agreed IA allocation (£8,155,615). This difference is primary attributed to the construction costs where increases have been realised through:

- Building area increase to take account of service and GMS contract evolving requirements – accounts for circa 41% of the construction cost increase
- Inflation and extraordinary market conditions considered to driven by the COVID-19 pandemic and the resulting global effect on supply chains – accounts for circa 20% of the construction cost increase
- Site and design abnormals: this relates to specific site conditions, more onerous energy requirements and creating a building that satisfies the conditions of the brief and design statement – accounts for circa 39% of the construction cost increase

It should be noted and acknowledged that the construction costs figures provided make allowance for realistic value engineering targets/savings within the FBC stage of the project – without this, the construction cost element and associated overall OBC budget cost estimate would have been higher.

Whilst our Lead Advisors have yet to formally report on hubCo's Stage 1 (OBC) report, they have been working hand in hand with hubCo and their Tier 1 contractor in recent weeks to agree the OBC costs. They concur with hubCo that given the current nature of the market and evolving more onerous briefing requirements the costs represent value for money.

The other costs movements are either percentage mark-ups based on the increased construction cost or adjusted/new provisions (equipment and direct costs) to take the opportunity to make the overall budget more deliverable and realistic.

In the OBC cost plan the inflation assumptions have been rebased to ensure they are as current as possible, and inflation relating to the period between IA and OBC is now historical, and therefore now included in the current construction costs. There is a forecast inflation allowance built in from the period January 2022 to construction. Inflationary forecasting is difficult during these current times so there is an inherent risk in respect to project inflation – that said, whilst inflation increases are still forecasts from 2022 to 2023, consultancy Cost Advisors generally believe that there should be some stabilisation given the significant movement in 2021.

5.3.1.3 Capital Clarification and Assumptions

The OBC capital cost estimate noted under Section 5.3.1.1 should be read with reference to the following assumptions.

Description	Note
Professional Fees	Professional services contract for Lead Advisor has been awarded
Equipment	Estimated 5% cost based on HFS advice. Transferable equipment will be moved to the new unit. Equipment budget only allows for items of equipment to be identified on the room layouts (conventional arrangement) and does not take account of any specialist equipment to be provided by the GP's or others

Contingency	Optimism bias at OBC stage has been calculated using a standard build template
Inflation	Based on Qtr 1 2022 Indices to construction
VAT	VAT has been applied where applicable. No VAT recovery estimates have been built into the cost plan for construction – this will to be confirmed with VAT Advisors and HMRC after contract is awarded
E-health	The project will cover the cost of e-health infrastructure within the building and key items of equipment as referenced on the room layouts. The budget does not allow for capital/revenue funded e-health projects.
Enhancements	Landscaping treatments around the health centre are currently quite standard. Any community garden, community gym or enhanced scheme is likely to require additional financial support.
Peppercorn Lease	The lease for the land is currently in discussion with Fife Council with the likely outcome that it will be considered a peppercorn rent. This will have an impact on leased depreciation figures under IFRS16 for right of use assets.

Table 39 - Capital Assumptions

5.3.2 Revenue Costs

5.3.2.1 Revenue Cost Summary

In order to confirm the revenue implications of the project the baseline costs (do nothing/minimum option) have been thoroughly reviewed and then compared to the projected costs of the preferred option to assess the financial implications. A summary of the revenue costs is provided in the table below.

Description	Baseline	Preferred Option	Difference
Property pays (NHSF)	£24,467	£75,566	£51,099
Property non-pays (NHSF)	£61,920	£178,330	£116,409
Property non-pays – GP offset (NHSF)	-£37,718	-£83,165	-£45,448
Net Increase (NHSF)	**£48,670**	**£170,731**	**£122,061**
Service model (FHSCP)		£724,500	-

Table 40 - Revenue Cost Summary

NHS Fife Revenue Costs

The OBC identifies overall net recurring revenue impact of £0.122m (excluding depreciation) for the preferred option against the baseline costs. Total revenue costs have been adjusted to reflect the GP rechargeable revenue costs associated with the health centre.

There are staff costs associated with this development - staffing, non-pay and consumable costs will continue to be reviewed as the FBC develops.

FHSCP Revenue Costs

The table below provides a breakdown of the FHSCP's anticipated revenue costs at OBC. The service model will evolve once decisions are received from Scottish Government on what the full implementation of MOU1/2 for urgent care and what MDT means for Fife.

All these costs will have a nil impact on the revenue outturn position as funding sources have been identified.

Staff group	WTE	Cost	Funding Source	Additional Information
Band 5	2.00	£86,000	This resource would be provided from the core vaccination workforce.	Rota across both Lochgelly and Kincardine HC
Band 3	4.00	£122,000	This resource would be provided from the core vaccination workforce.	Rota across both Lochgelly and Kincardine HC
Band 5 (Nurse)	3.00	£129,000	CTAC - funded through Primary Care Investment Fund	
Band 2 (phlebotomy)	1.70	£47,000	CTAC - funded through Primary Care Investment Fund	
Band 6 (Health Visitor)	1.00	£53,500	Funded through Primary Care Investment Fund	Per OBC
Band 7 (Primary Care Pharmacist	4.00	£252,000	Funded through Primary Care Investment Fund	Per OBC
Band 7 (First Contact Physiotherapist)	0.55	£35,000	Funded through Primary Care Investment Fund	Per OBC
Total	**16.25**	**£724,500**		

Table 41 - FHSCP Service Model Costs

5.3.2.2 Property non-pays breakdown

A breakdown of the property non-pays is provided in the table below for information.

Property Cost	Baseline	Preferred Option	Increase
Equipment	£309	£4,400	£4,091
Heating Fuel & Power	£18,019	£52,536	£34,517
Property Maintenance	£5,198	£27,562	£22,364
Property Rates	£27,278	£65,293	£38,015
Water Charges	£1,577	£6,209	£4,632
Bedding & Linen	£650	£1,516	£866
Cleaning	£57	£1,124	£1,067
General Services	£1,237	£2,125	£888
Surgical sundries	£504	£1,176	£672
GP Clinical Waste	£7,092	£16,389	£9,297
Net Cost Increase	**£61,920**	**£178,330**	**£116,409**

Table 42 - Property Non-pays Breakdown

5.3.2.3 Depreciation

An outline of the changes in both running costs and depreciation is summarised below:

Depreciation	Life	Value £000's	Proposed Dprchg £000's	Baseline Dprchg £000's	Net Increase Dprchg £000's
Buildings	60	£12,491,341	£208,189	£39,251	£168,938
Equipment	10	£539,837	£53,984	£0	£53,918
Total		**£13,031,178**	**£262,173**	**£39,251**	**£222,922**

Table 43 - Depreciation

The depreciation for the preferred option is £0.262m based on an asset building life of 60yrs and 10yrs for equipment on an overall capital cost of £13.031m. The overall increase in depreciation is £0.223m based on 21/22 full depreciation charges - which will be met from the current ring-fenced NHS Fife non-core depreciation budget. The buildings depreciation charge is pre any Valuation Office valuation being done after completion – there is an expectation that any non-value works will reduce the value held in the balance sheet once the valuation is carried out and therefore reduce the depreciation charge going forward.

5.3.2.4 Revenue Clarification and Assumptions

A number of assumptions have been made at the OBC stage which will be further evaluated and revised throughout the development of the FBC. These assumptions are as detailed in the table below.

Description	Note
Costs	Costs are calculated using 2020/21 prices and using 2020/21 budgetary information.
Pays (NHSF)	The support costs for the existing Kincardine Health Centre have been calculated as the baseline and then used as a benchmark against which any changes are considered. Estimated costs for the preferred option reflect forecast demand from 2024/25. Calculations include allowances for on-costs, enhancements, sick leave, public holidays and annual leave. Workforce increases are based on increased health centre sqm increase.
Non-Pay (NHSF)	Non-pay costs assumed to increase in line with increased health centre sqm.
Depreciation	Building – 60 years and equipment 10yrs.

Table 44 - Revenue Assumptions

5.4 Accounting Treatment

The traditional funding route for the project will impact on NHS Fife's Balance Sheet - both the capital cost of the development and the associated capital equipment will be added as non-current assets to the balance sheet and depreciated over the life of the assets in line with accounting policies.

5.5 Financial Situation and Statement of Affordability

NHS Fife confirm that this project remains affordable in both revenue and capital terms. The capital costs of the investment will be met through a capital contribution from the Scottish Government Health and Social Care Division capital budget.

Additional recurring revenue costs for Kincardine Health Centre will be incorporated into NHS Fife's Annual Operational Plan for future years.

FHSCP funding in respect to their service model is ongoing and will be articulated within the FBC stage.

5.6 Stakeholder Support

As the project will be delivered by NHS Fife for Fife, written agreement of Stakeholder support from other NHS Scotland / public sector organisations is not required in this instance.

5.7 Resources

The project is fully resourced from both NHS Fife and the FHSCP's perspective. Any associated costs have been built into the updated OBC budget. Further clarity on resourcing and project structure can be found at Section 6.3.

5.8 Capital and Revenue Constraints

NHS Fife's capital funding commitments mean that the project cannot exceed the available budget. Any additional revenue costs will be met within NHS Fife's overall revenue resource envelope.

FHSCP?

5.9 Financial Contributions

Other than capital funding from the Scottish Government, there will be no financial contributions from external partners in respect to this project.

6 Management Case

6.1 Introduction

The main purpose of the Management Case is to demonstrate that NHS Fife is ready and capable of delivering the project successfully.

6.2 Revisiting the Management Case

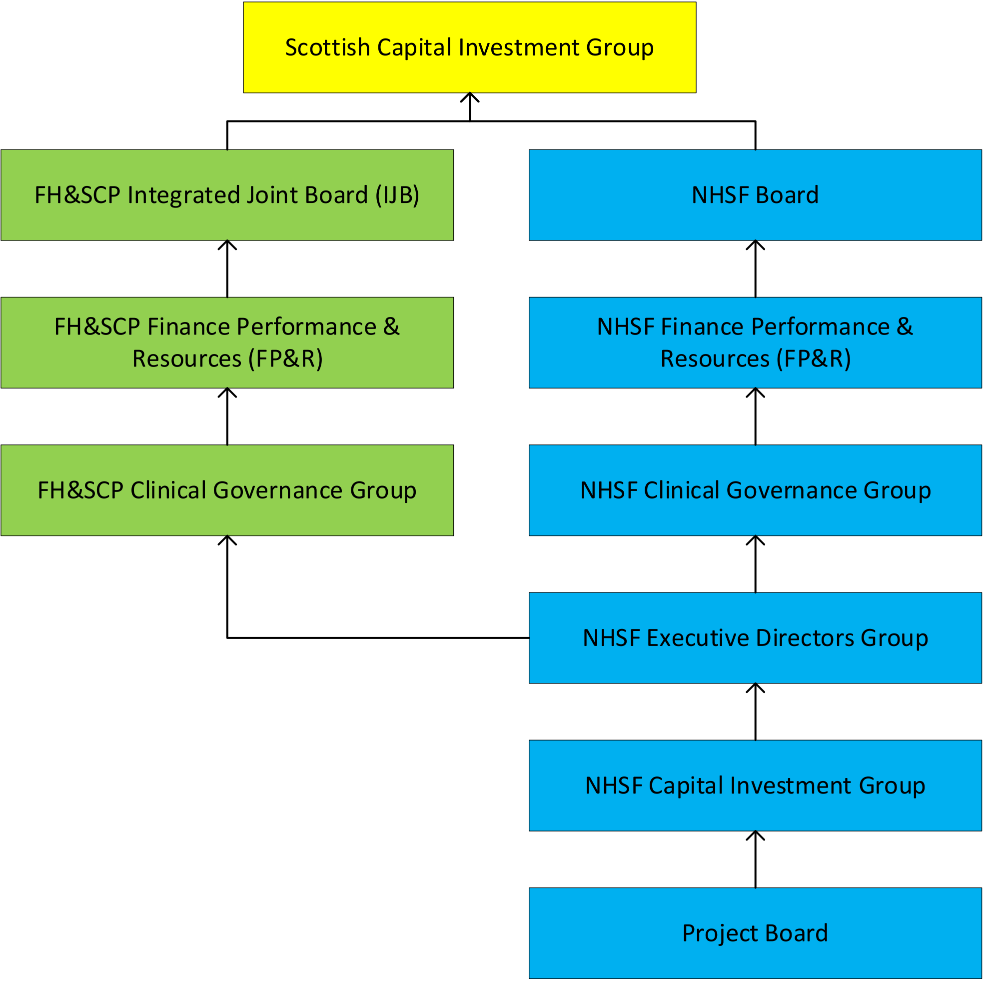
The management case has generally been updated and expanded since OBC in accordance with SCIM FBC guidance. The main sections remain the same and text has been updated where appropriate to reflect the current status of the project.

6.3 Reporting Structure and Governance Arrangements

To deliver the project successfully, good governance is required to monitor and direct it. An understanding of the structure and mechanisms for escalation and reporting is set out on the organograms below.

6.3.1 Governance

The strategic and business case governance controlling the project is set out below.



6.3.2 Project Structure

The project structure taking account of the Project Board, FHSCP and Capital Planning functions is set out below. NHS Fife are responsible to delivering the facilities whilst FHSCP are responsible for delivery of the services from the facilities.

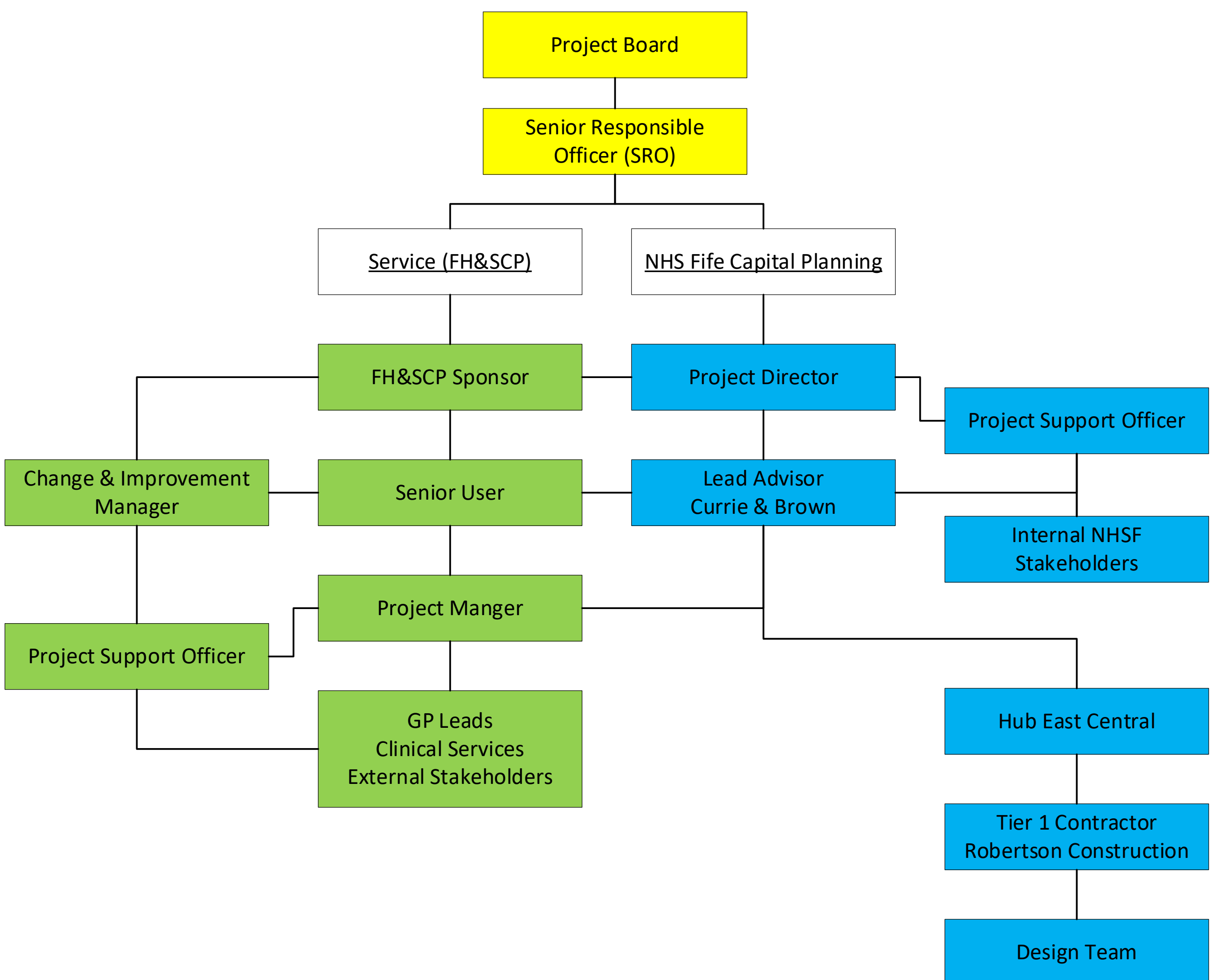


Figure 5 - Project Organisation

6.4 Project Board

A Project Board has been established to oversee the project. The Project Board was set up at commencement of the OBC and Terms of Reference have been agreed. The Project Board meets monthly where they receive a regular project update report from the FHSCP Sponsor and the Capital Planning Project Director. Necessary matters are escalated as required whilst the Project Board offers direction to the Project Team.

Project Board membership and experience is outlined in the table below:

Name/Role	Experience
Joy Tomlinson Director of Public Health Project role: Senior Responsible Officer (SRO) with overall responsibility and accountability for the project	Joy joined NHS Fife in May 2021, having worked within the NHS for 27 years. She has a clinical background, having trained in General Practice prior to working in Public Health. Prior to joining NHS Fife, she was joint Interim Director of Public Health in Ayrshire & Arran and has experience of departmental budgetary management with the additional complexities of rapid workforce and service development during the pandemic. She chairs the national 'place and wellbeing collaborative' which has

Name/Role	Experience
	developed Place & Wellbeing principles to support the refreshed National Planning Framework (NPF4).
Neil McCormick Director of Property and Asset Management Project role: responsible for contributing towards general governance.	Neil joins NHS Fife with over 30 years' experience of working at a senior level across the public and private sector. Neil's previous role was with Robertson Capital Projects, where he was Managing Director with specific responsibility for delivering infrastructure projects and joint ventures with the public sector including NHS Frameworks. Prior to this, Neil was Director of Strategic Projects & Property at NHS Forth Valley and Project Director for the £300m Forth Valley Royal Hospital.
Margo McGurk Director of Finance Project role: responsible for contributing towards general governance.	Margo joined NHS Fife as Director of Finance in February 2020. She is a CCAB qualified accountant, with a broad range of experience across the public sector but particularly within the NHS in Scotland. She has significant experience of decision-making at strategic and operational levels and has a strong personal focus on developing strategy, supporting culture, delivering sound financial control and best value from the allocation of resources. Very experienced in delivering professional leadership to the finance function, she has held a number of senior roles across a number of NHS Boards. She is particularly interested in working in partnership across organisations and leading on the development and delivery of financial strategies to support delivery against agreed priorities.
Nicky Conner Director of Health and Social Care Project role: responsible for contributing towards general governance.	Nicky has been Chief Officer and Director of Health and Social Care since 2019. Nicky offers 25 years' experience covering a diversity of public service roles including nursing, acute, specialist and community roles along with professional and clinical leadership to services within Fife's communities and leading on regional and national work. In her current role Nicky leads Health and Social Care Services for all of Fife including Community Care, Complex and Critical Care and Primary and Preventative Care. Nicky champions Integration, Partnership Working to deliver high quality services for the people of Fife.
Simon Fevre Staff Side Representation	Simon is the NHS Trade Union Co-Chair of the HSCP Local Partnership Forum. Simon was NHS Fife's Employee Director for 7 years and has worked on the

Name/Role	Experience
Project role: responsible for contributing towards general governance.	Board's Staff Governance agenda for 20 years. He was a clinician working in the Nutrition and Dietetic Department as Clinical lead for Older Peoples Services.
Ben Johnston Head of Capital Planning Project role: Capital Planning Project Director	Ben joined NHS Fife in January 2021 with over 15 years construction consultancy experience having worked in a diverse range of sectors. Working predominantly as a Project Manager, Ben has been responsible for delivering multiple projects diligently from inception to completion. Over recent years, Ben has spent most of time operating specifically within the healthcare sector, helping to positively contribute towards creating a sustainable healthcare estate for current and future generations. Ben has helped to deliver several projects for NHS Fife including Muirview and Hollyview at Stratheden Hospital and is currently helping to deliver the Fife Elective Orthopaedic Centre Project at Victoria Hospital.
Bryan Davies Head of Primary and Preventative Care Services Project role: FHSCP Project Sponsor	Bryan has worked within health and social care for over 25 years with experience in local area co-ordination, planning, performance, change management, commissioning, mental health, addictions, learning disability and advocacy. Bryan feels very passionate about health and social care integration and is excited to be working with colleagues and stakeholders to make a positive difference for individuals, families and communities in what are currently very challenging times.
Audrey Valente FHSCP Chief Financial Officer Project role: responsible for contributing towards general governance	Audrey has more than 30 years' experience working in local government holding senior finance positions. As a local lass, raised in Kirkcaldy, she went on to study accountancy at Napier University following her high school years at Kirkcaldy High. Audrey's experiences have combined strategic and operational financial management along with significant change management.
Helen Hellewell Associate Medical Director Project role: responsible for contributing towards general governance	Helen originated from Motherwell and moved to Fife after marrying. She finished her medical training at the Victoria in Kirkcaldy and took up a GP position in a local practice in Kirkcaldy. She then joined the Markinch medical practice, and currently still works one and half days per week there. Helen has been involved with the Partnership for a number of years

Name/Role	Experience
	having been the cluster lead for Glenrothes, working on a number of initiatives including quality improvement and integrated working and was the clinical lead on a leadership programme for integration with GP Scotland.
Benjamin Hannan Deputy Director of Pharmacy & Medicines Project role: represents the Area Clinical Forum as well as contributing to towards general governance.	Benjamin is an experienced pharmacy leader, with broad professional, managerial and leadership experience. Benjamin is a Fellow of the Institute of Leadership and Management and is currently Vice-Chair of Fife's Area Clinical Forum and represents this forum on the Project Board. The Area Clinical Forum allows NHS Fife to draw on the full range of professional skills and expertise that exists in all parts of the NHS system for advice on clinical and other professional matters. Benjamin's current role of Deputy Director of Pharmacy & Medicines is integrated across Health and Social Care, and all sectors and settings of care delivery. Prior to his current role, Benjamin was a GP Federation Director, responsible for 31 GP practices in the North East of England. This broad experience of primary care and community working will enable Benjamin to provide valuable insight to this project.
Tracy Gardiner Capital Accountant Project role: Capital Planning Accountant	Tracy has worked within NHS Fife for 26 years within the capital branch of the finance department. Tracy has a wide range of knowledge and experience in the delivery of capital projects within NHS Fife.
Ruth Lonie Communications Manager Project role: responsible for project communications	Ruth joined NHS Fife as Communications Manager in 2009. She has been involved in the communications aspects of a number of similar projects within NHS Fife.
Eugene Clark Non-executive Member *Dec. 20 – Jul. 21* Project role: responsible for contributing towards general governance	Eugene has spent the last 14 years working as a self-employed consultant helping businesses and public sector organisations in the fields of internal communication and employee engagement. Eugene's community interests have included being a former member of Largo Community Council and being involved in several action groups relating to sports in the Levenmouth area, most recently having helped establish the Fifers for the Community charity. Eugene is an active member of the Fife Children's Panel. He is also currently the Chair of the Levenmouth Rail Campaign, which seeks to

Name/Role	Experience
	regenerate the local community through the restoration of the direct rail link to Edinburgh.
Alistair Grant Non-executive Member *From Jan. 22* Project role: responsible for contributing towards general governance	Alastair Grant is a qualified accountant with more than 30 years' experience working both in Scotland and the Middle East. Most recently Alastair worked for Sodexo Justice Services, until his recent retirement. Alastair brings to the Board proven commercial acumen, combined with good people management, team building, development, and mentoring skills.

Table 45 - Project Board Experience

6.5 Project Team

The project team sits below the Project Board and are responsible for delivering the project on a day-to-day basis. Responsibilities include:

- Facility design development
- Service change re-design
- Business case development
- Stakeholder communications and engagement
- Management of risks and issues
- Management of cost
- Construction and handover of the facilities

To discharge these responsibilities, there are a wide range of roles. These are outlined within the Project's Project Execution Plan.

6.5.1 External Advisors

Where necessary independent consultants have been procured by the Board to help with the management of the project. Consultants procured to date include:

Project Role	Organisation
Lead Advisor	Currie & Brown
▪ Project Manager	Currie & Brown
▪ Cost Advisor	Currie & Brown
▪ M&E Technical Advisor	Hulley & Kirkwood (sub-consulted)
▪ Clerk of Works	Currie & Brown + Hulley & Kirkwood
▪ Authority's Representative (contract)	Currie & Brown

Table 46 - External Advisors

6.5.2 Project Recruitment Needs

No additional recruitment needs are envisaged at this time, however this will be re-considered during the FBC phase of the project.

6.6 Project Plan and Key Milestones

The project plan and key milestones are set out in the table below.

Description / activity	Date
Full Business Case	
Commencement	February 2022
Completion	January 2022
Governance Approvals	April 2023
Construction & Handover	
Commencement	May 2023
Completion	June 2024
Operational	August 2024

Table 47 - Key Milestone Summary

6.7 Change Management Arrangements

6.7.1 Operational and Service Change Plan

The operational and service change plan proposals are outlined under Section 2.4.1.3. This work will continue through FBC and Construction in parallel with the soft landings process to ensure that the services are prepared to adopt new ways of working in advance of the facilities being made available for use. The FHSCP will ultimately assume responsibility for progressing this dependant workstream.

6.7.2 Facilities Change Plan

The new facility will be serviced by NHS Fife's in-house Facilities and Estates team in a similar way to the existing arrangements. Costs relating to the increase in area have been factored into the GP allocations. NHS Fife resource projections to maintain and upkeep the building have been taken account of in revenue projections (see the Financial Case).

6.7.3 Stakeholder Engagement and Communication Plan

A Stakeholder Engagement and Communication Plan has been developed and endorsed by the Project Board. The plan will continue to be developed and updated as the project progresses. A copy of the plan can be located at Appendix H.

In addition, an update in respect to stakeholder engagement during the OBC stage is outlined at Section 3.4.2.

6.8 Benefits Realisation

6.8.1 Benefits Register

The rationale for an investment needs to be reflected in the realisation of demonstrable benefits, as this will provide the evidence base that the proposal is worthwhile and that a successful outcome is achievable. The benefits to be achieved are discussed in the Strategic Case and have resulted in the creation of a Benefits Register and Benefit Realisation Plan for the Project. The Benefits Register is located at Appendix E.

The Benefits Register includes a range of benefits to be realised by the development. Each benefit includes a target that will be used to indicate the measure of success during the Post Project Evaluation (PPE).

Benefits are either assessed in a quantitative or qualitative manner.

For the quantitative benefits, the register indicates the baseline (current position) at the start of the project including the source. This will be compared with the same data source when the PPE is completed.

For benefits that are qualitative in nature, questionnaires will be developed, and a mix of patient and staff surveys/interviews will be undertaken to outline the baseline for these benefits. The same survey tools will be used during the PPE to examine to what degree the improvements sought were achieved.

Additionally, a Red, Amber, Green (RAG) score highlighting the relative importance of each benefit is indicated using the scale outlined below in the table below.

Scale / RAG	Relative importance
1	Fairly insignificant
2	↕
3	Moderately important
4	↕
5	Vital

Table 48 - Benefit Importance

6.8.2 Benefits Realisation Plan

A Benefits Realisation Plan has been produced to support the achievement of the benefits outlined in the Benefits Register, and it is included as Appendix F.

The benefits realisation process is a planned and systematic process consisting of four defined stages outlined below. The implementation of this plan will be reviewed regularly by the Project Board.

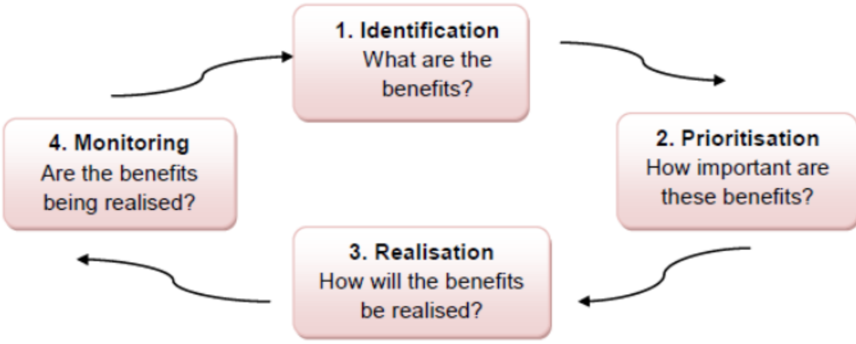


Figure 6 - Benefit Realisation Process

The Benefits Realisation Plan outlines:

- Which Investment Objective the benefit addresses
- Who will receive the benefit
- Who is responsible for delivering the benefit
- Any dependencies that could affect delivery of the benefit
- Any support needed from other agencies etc. to realise the benefit

Benefits monitoring will be ongoing over the life of the Project through the planning, procurement and implementation phases. Progress will be reported to the Project Board at regular intervals and will culminate in the Project Evaluation Report.

6.9 Risk Management

Risk management is a structured approach to identifying, assessing and controlling risks that emerge during the project lifecycle. It is a critical and continuous process throughout the planning, procurement and implementation journey of a project.

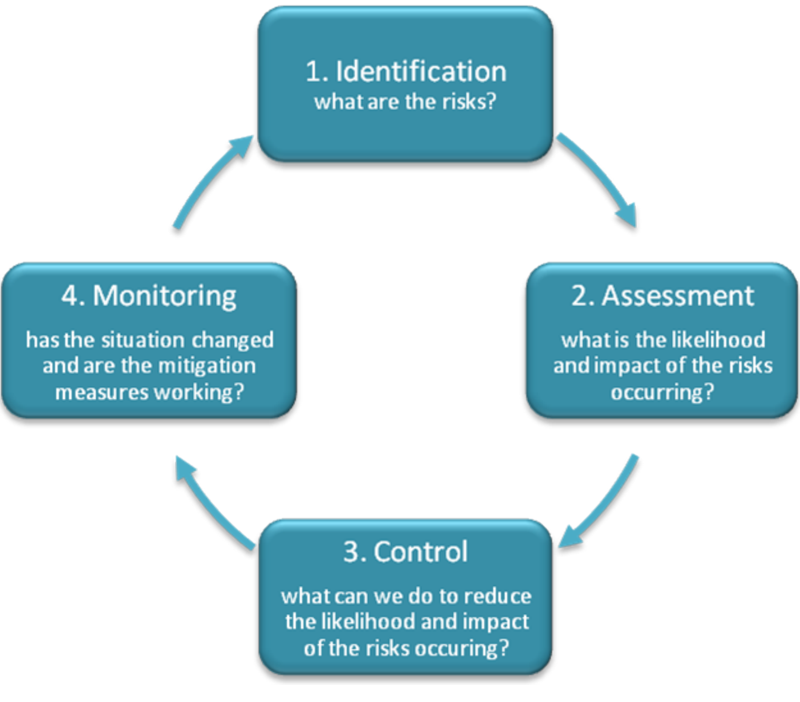


Figure 7 - Risk Management Process

6.9.1 Updated Risk Register

The Project Team have continued to develop the Risk Register provided at IA. The current FBC risk register can be located at Appendix G. The Risk Register is up to date and representative of the residual risks that may be encountered during the balance of the project. The headline items noted below, demonstrate how the risk register has been developed since IA.

- New risks have been identified and added to the register, whilst other risk have been closed
- Probability, impact and risk ratings have been updated progressively at risk workshops
- Mitigation measures have been agreed and updated
- Risk owners and managers have been allocated (a risk owner has overall responsibility for the risk, whilst a manager is responsible for helping to mitigate the risk)

The commercial arrangements associated with the Risk Register are set out within the Commercial Case.

6.9.2 Governance

The Project Board will assume overall responsibility for the risk register, however the Capital Planning Project Director will be responsible for ensuring it is maintained and updated regularly in line with the agreed project controls.

The risk register is updated and provided to the Project Board on a monthly basis as an appendix to the Capital Planning Project Manager's monthly progress report. Key risks are extracted from the risk register and highlighted within the Project Manager's monthly report for ease of reference. The Project Board provide direction to the Project Director and capital Planning Project Manager on risk matters as necessary.

6.10 Commissioning

The importance of the commissioning process cannot be underestimated, as failure to adequately consider this process is likely to cause increases to project costs and failure to deliver agreed service benefits and project outcomes. The Project Board and Capital Planning Director are fully committed to implementing a robust commissioning process, ensuring that the facilities are safe to use and operate from the outset.

The commissioning process will be treated as a distinct workstream, but fully integrated into the overall project to enable a smooth transition to the new working arrangements and realisation of the anticipated benefits. Workstreams will include Technical Commissioning and Operational Commissioning and these will be supported by BIM and Soft Landing processes.

Technical Commissioning concentrates on the readiness of the facility to support operational activity. As such the mechanical and electrical systems all need to be operating satisfactorily at handover of the facility and beyond. Operational Commissioning on the other hand is involved with getting the clinical services transferred into the facility with minimal disruption to business continuity. Given these separate requirements requiring different expertise, it is

considered that there is value in assigning these roles to separate individuals with the necessary knowledge and expertise – these roles will be confirmed during the FBC stage.

The Commissioning Managers will report to the Capital Planning Project Manager on a day to day basis but will maintain lines of communication with the wider team to deliver against the agreed plans.

A Commissioning Strategy and detailed commissioning programme will be developed during the FBC stage of the project.

6.11 Post Project Evaluation

The arrangements for post implementation review and project evaluation reviews have been established in accordance with best practice. These reviews will determine whether the anticipated benefits identified at the outset have been delivered. The project will be evaluated in stages:

Stage 1 – Procurement Process Evaluation

An evaluation of the procurement process will be undertaken following the signing of the contract to assess the effectiveness of the procurement process in meeting the project objectives. This will identify any issues and lessons to be learned that will benefit future projects. This evaluation can take place shortly after commencement of the construction phase.

Stage 2 – Monitoring Construction

During the construction period progress will be monitored to ensure delivery of the project to time, cost, and quality to identify issues and actions arising. On completion of the construction phase the actual project outputs achieved will be reviewed and assessed against requirements, to ensure these match the project's intended outputs and deliver its objectives.

Following completion, the Project Manager's and Supervisor's monthly reports will be reviewed and summarised to represent a holistic view of how the project performed during the construction period.

Stage 3 – Initial Project Evaluation of the Service Outcomes

This will be undertaken 6 to 12 months after the new facility has been commissioned. The objective is to determine the success of the commissioning phase and the transfer of services into the new facilities and what lessons may be learned from the process.

Stage 4 – Follow-up Project Evaluation

This will be undertaken 2 years into the operational phase by the Evaluation Team to assess the longer-term service outcomes and ensure that the project's objectives continue to be delivered.

The following questions will be asked at each stage:

- Have relevant project objectives been achieved?
- Has the project progressed as planned?

- If the plan was not followed, why did this occur?
- If appropriate, how should plans for future projects be amended?

The process will be led by evaluators, independent of the delivery team, who will meet with representatives of the user groups and other key stakeholders. The Project Sponsor, on behalf of the Project Board, will receive reports at each stage of the evaluation process.

Appendix A - Strategic Assessment

Appendix B – Design Statement

Appendix C – Design Pack

Appendix D – Benefits Register

Appendix E – Benefits Realisation Plan

Appendix F – Risk Register

Appendix G – Stakeholder Engagement & Communication Plan

Appendix H – The Patient Perspective

NHS Fife

Meeting:	**Public Health & Wellbeing Committee**
Meeting date:	**16 May 2022**
Title:	**Integrated Performance & Quality Report**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Bryan Archibald, Head of Performance**

1 Purpose

This is presented to the Public Health & Wellbeing Committee for:

- Assurance

This report relates to the:

- Joint Fife Remobilisation Plan for 2021/22 (RMP4)

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

- Safe
- Effective
- Person Centred

2 Report Summary

2.1 Situation

The Population, Health & Wellbeing Committee is a new body set up to monitor progress in this area of the NHS Fife services. This report informs the committee of performance in NHS Fife and the Health & Social Care Partnership against a range of key measures (as defined by Scottish Government 'Standards' and local targets). The period covered by the performance data is (with certain exceptions due to a lag in data availability) up to the end of February 2022.

2.2 Background

The Integrated Performance & Quality Report (IPQR) is the main corporate reporting tool for the NHS Fife Board. It is produced monthly and made available to Board Members via Admin Control.

The report is presented at the meetings of the Clinical Governance, Staff Governance, Finance, Performance & Resources and Public Health & Wellbeing Committees, and an 'Executive Summary' IPQR (ESIPQR) is then produced as a formal NHS Fife Board paper.

2.3 Assessment

Performance, particularly in relation to Waiting Times across Acute Services and the Health & Social Care Partnership has been hugely affected during the pandemic. NHS Fife is working according to the Joint Fife Remobilisation Plan for 2021/22 (RMP4), and the IPQR provides a high-level activity summary on Page 4. This will be updated monthly until the end of the FY.

The Public Health & Wellbeing aspects of the report cover measures listed in the table below.

Measure	Update	Target	Current Status
DD (Bed Days Lost)	Monthly	5%	Not achieving
Antenatal Access	Monthly	80%	Achieving
Smoking Cessation	Monthly	100%	Not achieving
CAMHS WT	Monthly	90%	Not achieving
Psy Ther WT	Monthly	90%	Not achieving
Drugs & Alcohol WT	Monthly	90%	Not achieving
Dementia PDS [1]	Quarterly	N/A	N/A

[1] There are no formal targets for either of the Dementia PDS measures (referrals and 1-year support).The guidance to Health Boards is to aim for a year-on-year improvement.

2.3.1 Quality/ Patient Care

IPQR contains quality measures.

2.3.2 Workforce

IPQR contains workforce measures.

2.3.3 Financial

Financial aspects are covered by the specific sections of the IPQR.

2.3.4 Risk Assessment/Management

Not applicable.

2.3.5 Equality and Diversity, including health inequalities

Not applicable.

2.3.6 Other impact

None.

2.3.7 Communication, involvement, engagement and consultation

The NHS Fife Board Members and existing Standing Committees are aware of the approach to the production of the IPQR and the performance framework in which it resides.

The April IPQR will be available for discussion at the round of April/May Standing Committee meetings.

2.3.8 Route to the Meeting

The IPQR was ratified by EDG and approved for release by the Director of Finance & Strategy.

2.4 Recommendation

The Public Health & Wellbeing Committee is requested to discuss and take assurance from this report.

3 List of appendices

- Integrated Performance & Quality Report

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Fife Integrated Performance & Quality Report

Produced in April 2022

Introduction

The purpose of the Integrated Performance and Quality Report (IPQR) is to provide assurance on NHS Fife's performance relating to National LDP Standards and local Key Performance Indicators (KPI).

A summary report of the IPQR, the Executive Summary IPQR (ESIPQR), is presented at each NHS Fife Board Meeting.

The IPQR comprises of the following sections:

I. Executive Summary

a. LDP Standards & Local Key Performance Indicators (KPI)

b. National Benchmarking

c. Indicatory Summary

d. Remobilisation Summary

e. Assessment

II. Performance Assessment Reports

a. Clinical Governance

b. Finance, Performance & Resources
   Operational Performance
   Finance

c. Staff Governance

d. Public Health & Wellbeing

Section II provides further detail for indicators of continual focus or those that are currently experiencing significant challenge. Each 'drill-down' contains data, displaying trends and highlighting key problem areas, as well as information on current issues with corresponding improvement actions.

MARGO MCGURK
Director of Finance & Strategy
19th April 2022

Prepared by:
SUSAN FRASER
Associated Director of Planning & Performance

I. Executive Summary

At each meeting, the Standing Committees of the NHS Fife Board consider targets and Standards specific to their area of remit. This section of the IPQR provides a summary of performance against LDP Standards and local Key Performance Indicators (KPI). These indicators are listed within the Indicator Summary, which shows current, previous and (where appropriate) 'Year Previous' performance as well as benchmarking against other mainland NHS Boards.

Health Boards are planning the recovery of services following the first and second waves of the COVID-19 Pandemic. NHS Fife agreed its Joint Remobilisation (RMP3) for 2021/22 at the start of 2021, and this effectively replaced the previous 1-year or 3-year Annual Operational Plans. It has now been superseded by RMP4, addressing the status and forecasts for the second half of the FY. Both RMP3 and RMP4 include forecasts for activity across key outpatient and inpatient services, and progress against these forecasts is included in this document by two methods:

- Update of monthly activity (Remobilisation Summary)
- Enhancement of drill-downs to illustrate actual v forecast activity

The RMP provides a detailed, strategic view of how NHS Fife will approach the recovery, while the IPQR drills down to a level where specific Improvement Actions are identified and tracked. In order to provide continuity between the IPQR from version to version (year to year), Improvement Actions carry a '20', '21' or '22' prefix, to identify their year of origin. They are shaded in **BLUE** if they are assessed as being complete or no longer relevant.

Action completion dates appear in **RED** text if they have slipped, but will revert to BLACK text in the next issue of the report, provided no further slips have been reported.

a. LDP Standards & Key Performance Indicators

The current performance status of the 29 indicators within this report is 12 (41%) classified as **GREEN**, 2 (7%) **AMBER** and 15 (52%) **RED**. This is based on whether current performance is exceeding standard/trajectory, within specified limits (mostly 5%) of standard/trajectory or considerably below standard/trajectory.

There were notable improvements in the following areas in February:

- Rate of Falls and Falls with Harm both reducing to be below their targets for FY 2021/22
- Closure of FOI requests above the local target after several challenging months
- % bed days lost due to patients in delay continuing a downward trend towards target

Additionally, it has now been 22 months since the Cancer-31 DTT performance fell below the 95% Standard, with 7 months out of 11 this FY reporting no breaches.

b. National Benchmarking

National Benchmarking is based on whether NHS Fife performance is in the upper quartile of the 11 mainland Health Boards (●), lower quartile (●) or mid-range (●). This benchmarking information indicates that whilst a number of areas continue to experience significant levels of challenge, in over 85% where we are able to compare our performance nationally we are delivering performance within either the upper quartile or the mid-range.

c. Indicator Summary

Performance
meets / exceeds the required Standard / on schedule to meet its annual Target
behind (but within 5% of) the Standard / Delivery Trajectory
more than 5% behind the Standard / Delivery Trajectory

Benchmarking	
🟢	Upper Quartile
🟡	Mid Range
🔴	Lower Quartile

Section	Measure	Target 2021/22	Reporting Period	Year Previous		Previous		Current			Trend	Reporting Period	Fife		Scotland
Clinical Governance	Major & Extreme Adverse Events	N/A	Month	Feb-21	24	Jan-22	23	Feb-22	36	↓		N/A			
	HSMR	N/A	Year Ending	Sep-20	1.01	Jun-21	1.03	Sep-21	1.04	↓		YE Sep-21	1.04	🔴	1.00
	Inpatient Falls	7.68	Month	Feb-21	9.51	Jan-22	8.33	Feb-22	7.30	↑		N/A			
	Inpatient Falls with Harm	1.65	Month	Feb-21	1.87	Jan-22	2.02	Feb-22	1.59	↑		N/A			
	Pressure Ulcers	0.42	Month	Feb-21	1.44	Jan-22	1.32	Feb-22	1.23	↑		N/A			
	Caesarean Section SSI	2.5%	Quarter Ending	Sep-20	2.2%	Jun-21	3.6%	Sep-21	2.5%	↑		QE Dec-19	2.3%	🔴	0.9%
	SAB - HAI/HCAI	18.8	Quarter Ending	Feb-21	19.4	Jan-22	15.0	Feb-22	15.4	↓		QE Dec-21	12.8	🟡	17.3
	SAB - Community	N/A	Quarter Ending	Feb-21	10.8	Jan-22	9.6	Feb-22	8.7	↑		QE Dec-21	8.5	🟡	9.9
	C Diff - HAI/HCAI	6.5	Quarter Ending	Feb-21	5.2	Jan-22	5.8	Feb-22	4.7	↑		QE Dec-21	4.6	🟢	13.3
	C Diff - Community	N/A	Quarter Ending	Feb-21	5.4	Jan-22	1.1	Feb-22	1.1	↔		QE Dec-21	1.1	🟢	5.0
	ECB - HAI/HCAI	33.0	Quarter Ending	Feb-21	33.6	Jan-22	28.9	Feb-22	27.3	↑		QE Dec-21	33.6	🟡	34.1
	ECB - Community	N/A	Quarter Ending	Feb-21	29.3	Jan-22	37.3	Feb-22	39.3	↓		QE Dec-21	39.2	🟡	39.8
	Complaints (Stage 1 Closure Rate)	80%	Quarter Ending	Feb-21	88.5%	Jan-22	61.2%	Feb-22	69.2%	↑		2020/21	80.2%	🟡	79.5%
	Complaints (Stage 2 Closure Rate)	65%	Quarter Ending	Feb-21	31.1%	Jan-22	12.2%	Feb-22	12.8%	↑		2020/21	32.8%	🟡	57.8%
Operational Performance	IVF Treatment Waiting Times	90%	Month	Feb-21	100.0%	Jan-22	100.0%	Feb-22	100.0%	↔		N/A			
	4-Hour Emergency Access	95%	Month	Feb-21	91.1%	Jan-22	76.1%	Feb-22	83.0%	↑		Feb-22	83.0%	🟢	74.2%
	Patient TTG (% of Total Waits <= 12 Weeks)	100.0%	Month	Feb-21	48.6%	Jan-22	56.6%	Feb-22	52.7%	↓		Dec-21	64.5%	🟢	34.6%
	New Outpatients (% of Total Waits <= 12 Weeks)	95%	Month	Feb-21	48.0%	Jan-22	50.1%	Feb-22	48.8%	↓		Dec-21	53.7%	🟢	46.5%
	Diagnostics (% of Total Waits <= 6 Weeks)	100%	Month	Feb-21	76.2%	Jan-22	52.7%	Feb-22	61.2%	↑		Dec-21	57.9%	🟡	49.6%
	18 Weeks RTT	90%	Month	Feb-21	73.6%	Jan-22	77.3%	Feb-22	71.4%	↓		QE Dec-21	71.2%	🟡	74.2%
	Cancer 31-Day DTT	95%	Month	Feb-21	97.5%	Jan-22	100.0%	Feb-22	100.0%	↔		QE Dec-21	100.0%	🟢	97.1%
	Cancer 62-Day RTT	95%	Month	Feb-21	80.7%	Jan-22	71.2%	Feb-22	83.6%	↑		QE Dec-21	82.3%	🟡	79.0%
	Detect Cancer Early	29%	Year Ending	Jun-20	22.0%	Mar-21	19.6%	Jun-21	21.4%	↑		2019, 2020	22.5%	🟡	24.1%
	Freedom of Information Requests	85%	Quarter Ending	Feb-21	85.8%	Jan-22	84.3%	Feb-22	86.9%	↑		N/A			
	Delayed Discharge (% Bed Days Lost)	5%	Month	Feb-21	6.2%	Jan-22	5.6%	Feb-22	7.0%	↓		QE Sep-21	10.4%	🔴	6.7%
	Delayed Discharge (# Standard Delays)	N/A	Month	Feb-21	54	Jan-22	50	Feb-22	55	↓		Feb-22	18.20	🟢	26.85
	Antenatal Access	80%	Month	Dec-20	85.7%	Nov-21	88.4%	Dec-21	90.0%	↑		2021	90.1%	🟡	88.5%
Finance	Revenue Resource Limit Performance	(£13.7m)	Month	Feb-21	N/A	Jan-22	(£13.7m)	Feb-22	Breakeven	↑		N/A			
	Capital Resource Limit Performance	£33.9m	Month	Feb-21	N/A	Jan-22	£13.8m	Feb-22	£19.2m	↑		N/A			
Staff Governance	Sickness Absence	3.89%	Month	Feb-21	5.03%	Jan-22	5.93%	Feb-22	5.63%	↑		YE Mar-21	4.77%	🟡	4.67%
Public Health & Wellbeing	Smoking Cessation	473	YTD	Dec-20	48.6%	Nov-21	57.1%	Dec-21	52.5%	↓		QE Sep-21	58.9%	🔴	82.0%
	CAMHS Waiting Times	90%	Month	Feb-21	88.1%	Jan-22	69.4%	Feb-22	68.0%	↓		QE Dec-21	71.9%	🟡	70.3%
	Psychological Therapies Waiting Times	90%	Month	Feb-21	84.0%	Jan-22	81.8%	Feb-22	79.2%	↓		QE Dec-21	80.6%	🟡	84.4%
	Alcohol Brief Interventions (Priority Settings)	80%	YTD	Mar-19	60.2%	Dec-19	75.7%	Mar-20	79.2%	↑		FY 2019/20	79.2%	🟡	83.2%
	Drugs & Alcohol Treatment Waiting Times	90%	Month	Dec-20	96.5%	Nov-21	88.4%	Dec-21	87.9%	↓		QE Dec-21	93.4%	🟡	93.1%
	Dementia Post-Diagnostic Support	N/A	Annual	2018/19	93.4%	2019/20	93.2%	2020/21	94.6%	↑		2019/20	93.2%	🟢	81.3%
	Dementia Referrals	N/A	Annual	2018/19	61.0%	2019/20	58.5%	2020/21	50.6%	↓		2019/20	58.5%	🟢	42.9%

d. NHS Fife Remobilisation Summary – Position at end of March 2022

Better than Projected | Worse than Projected | No Assessment (NOTE: Better/Worse may be higher or lower, depending on context)		Quarter End	Quarter End	Quarter End	Month End			Quarter End
		Jun-21	Sep-21	Dec-21	Jan-22	Feb-22	Mar-22	Mar-22
TTG Inpatient/Daycase Activity (Definitions as per Waiting Times Datamart)	Projected	2,981	3,120	3,400	1,203	1,269	1,268	3,740
	Actual	3,260	2,953	2,792	756	1,012	1,169	2,937
	Variance	279	-167	-608	-447	-257	-99	-803
New OP Activity (F2F, NearMe, Telephone, Virtual) (Definitions as per Waiting Times Datamart)	Projected	17,100	19,125	20,905	7,286	7,287	7,288	21,861
	Actual	19,488	20,161	19,600	5,073	6,358	7,501	18,932
	Variance	2,388	1,036	-1,305	-2,213	-929	213	-2,929
Elective Scope Activity (Definitions as per Diagnostic Monthly Management Information)	Projected	1,801	1,833	1,840	613	613	614	1,840
	Actual	1,406	1,511	1,381	446	433	497	1,376
	Variance	-395	-322	-459	-167	-180	-117	-464
Elective Imaging Activity (Definitions as per Diagnostic Monthly Management Information)	Projected	10,850	11,250	13,642	4,480	4,605	4,607	13,692
	Actual	12,971	12,629	11,733	3,962	4,149	4,569	12,680
	Variance	2,121	1,379	-1,909	-518	-456	-38	-1,012
A&E Attendance (Definitions as per Scottish Government Unscheduled Care Datamart)	Projected	17,110	19,110	20,620	7,110	6,450	6,780	20,340
	Actual	20,729	20,814	18,554	5,883	5,997	7,326	19,206
	Variance	3,619	1,704	-2,066	-1,227	-453	546	-1,134
A&E 4-Hour Performance (%) : ALL A&E and MIU (Definitions as per Core Sites, unplanned attendances only)	Projected			80.0%	85.0%	86.0%	87.0%	83.0%
	Actual			77.4%	77.1%	83.0%	79.6%	79.9%
	Variance			-2.6%	-7.9%	-3.0%	-7.4%	-3.1%
Emergency Admissions (Definitions as per Scottish Government Unscheduled Care Datamart)	Projected	8,040	8,320	10,680	3,520	3,190	3,410	10,120
	Actual	10,085	10,001	9,975	3,275	2,923		6,198
	Variance	2,045	1,681	-705	-245	-267		-3,922
Total Emergency Admission Mean Length of Stay (Definitions as per Discovery indicator attached)	Projected	5.82	5.85	5.63				5.73
	Actual	5.55	6.17	6.34				
	Variance	-0.27	0.32	0.71				
Urgent Suspicion of Cancer - Referrals Received (SG Management Information)	Projected	2,450	2,610	2,610	870	870	870	2,610
	Actual	2,885	3,047	2,820	973	928	1,044	2,945
	Variance	435	437	210	103	58	174	335
31 Day Cancer – Decision to treat to first treatment (Definitions as per published statistics)	Projected	415	435	384	128	128	128	384
	Actual	305	337	306	84	93		177
	Variance	-110	-98	-78	-44	-35		-207
62 Day Cancer - Referral to First treatment (Definitions as per published statistics)	Projected			200	70	70	70	210
	Actual			215	66	67		133
	Variance			15	-4	-3		-77
CAMHS - First Treatment Appointments (patients treated within 52 weeks of referral)(Definitions as per published statistics)	Projected			405	130	143	120	393
	Actual			350	126	150	152	428
	Variance			-55	-4	7	32	35
CAMHS - Backlog First Treatment Appointments (patients treated after waiting 52+ weeks, if applicable) (Definitions as per published statistics)	Projected			68	20	10	0	30
	Actual			13	8	6	11	25
	Variance			-55	-12	-4	11	-5
CAMHS - Performance against the 18 week standard (%) (Definitions as per published statistics)	Projected			69.3%	70.0%	75.0%	80.0%	75.0%
	Actual			71.9%	69.4%	68.0%	70.6%	69.4%
	Variance			2.6%	-0.6%	-7.0%	-9.4%	-5.6%
Psychological Therapies - First Treatment Appointments (patients treated within 52 weeks of referral) (Definitions as per published statistics)	Projected			1,941	768	799	630	2,197
	Actual			1,750	600	559		1,159
	Variance			-191	-168	-240		-1,038
Psychological Therapies - Backlog First Treatment Appointments (patients treated after waiting 52+ weeks, if applicable) (Definitions as per published statistics)	Projected			234	85	70	55	210
	Actual			113	22	29		51
	Variance			-121	-63	-41		-159
Psychological Therapies - Performance against the 18 week standard (%) (Definitions as per published statistics)	Projected			73.2%	67.5%	65.9%	70.9%	67.9%
	Actual			80.1%	81.8%	82.1%		80.1%
	Variance			6.9%	14.3%	16.2%		12.2%

		Month End	Month End	Month End	Month End			Month End
		Jun-21	Sep-21	Dec-21	Jan-22	Feb-22	Mar-22	Mar-22
Delayed Discharges at Month End (Any Reason or Duration, per the Definition for Published Statistics) [1]	Projected	65	63	84	81	73	66	66
	Actual	127	112	69	79	91	91	91
	Variance	62	49	-15	-2	18	25	25
Code 9 Delayed Discharges at Month End (Any Duration, per the Definition for Published Statistics) [1]	Projected	28	27	23	21	21	20	20
	Actual	47	29	26	29	36	45	45
	Variance	19	2	3	8	15	25	25
Standard Delayed Discharges at Month End (Any Duration, per the Definition for Published Statistics) [1]	Projected	37	36	61	60	52	46	46
	Actual	80	83	43	50	55	46	46
	Variance	43	47	-18	-10	3	0	0

[1] The data required is the estimated number of people delayed at each census point (the snapshot figure). Baseline figures used are the census point figures as at the end of each month

e. Assessment

CLINICAL GOVERNANCE		Target	Current
HSMR		**1.00**	**1.04**

Hospital Standardised Mortality Ratio (HMSR) is not intended for use in a pandemic situation. However, the increased HSMR will be closely monitored over the coming months, and appropriate action including target audit will be commenced if required.

Inpatient Falls (with Harm)	*Reduce falls with harm rate by 10% in FY 2021/22 compared to rate in FY 2020/21*	**1.65**	**1.59**

Falls data/trends are reviewed continuously, and currently show a broadly static picture in the number of falls with harm over the last year, with a small decrease since December. As noted in the position paper at last CG committee a range of improvement work is ongoing in the continued challenges that the current pandemic presents and as previously described. Data continues to be reviewed with supported improvement action in focussed areas as required.

Pressure Ulcers	*50% reduction by December 2020, continued for FY 2021/22*	**0.42**	**1.23**

Acute: Over the past year hospital acquired pressure ulcer rate has shown a random pattern, with no signs of improvement or deterioration to the process. Data over time continues to be monitored by senior nursing team and shared with clinical teams for discussion at a variety of forums, in order to drive improvement. Access to the newly developed Data and Insight Hub is being arranged for senior nurses, to assist with triangulation of data in order to develop a comprehensive understanding of the system. Clinical Teams continue to follow the process for Major and Extreme Adverse Events for shared learning.

HSCP: The rate of hospital acquired pressure ulcers has increased from the last quarter. Data continues to be monitored weekly via the Quality Matters Assurance Safety Huddle, allowing for early identification of emerging themes. This is shared with services and teams across the partnership to inform change and improvement. Actions from LAERs also support key learning in relation to hospital and community acquired pressure ulcers.

Caesarean Section SSI	*We will reduce the % of post-operation surgical site infections to 2.5%*	**2.5%**	**2.5%**

Mandatory SSI surveillance has been paused since the start of the Covid-19 pandemic. This remains the case until further instruction from the Scottish Government. Maternity services continue to monitor the SSI cases locally, and, where necessary (i.e Deep or Organ space infection), carry out Clinical Reviews. The performance data provided should be interpreted with caution as it is non-validated and does not follow the NHS Fife Methodology. There has been no national comparison data published since Q4 2019.

SAB (MRSA/MSSA)	*We will reduce the rate of HAI/HCAI by 10% between March 2019 and March 2022*	**18.8**	**15.4**

NHS Fife continues to be on target to achieve the 10% reduction. There have been no Renal haemodialysis line SABs since October and no PVC SABs since August. There have been 2 PWID SABs in 2022 to date.

C Diff	*We will reduce the rate of HAI/HCAI by 10% between March 2019 and March 2022*	**6.5**	**4.7**

NHS Fife is on target to achieve the 10% reduction. There have been only 3 health care associated CDI in 2022 to date. Reducing the incidence of CDI recurrence is pivotal to achieving the HCAI reduction target, and continues to be addressed. There has not been a recurrence of infection since August.

ECB	*We will reduce the rate of HAI/HCAI by 25% between March 2019 and March 2022*	**33.0**	**27.3**

The target for NHS Fife is to achieve an initial 25% reduction of HCAI ECBs by March, and we are currently on target to achieve this. There were 17 ECBs in total for February, of which only 7 were HCAI and with no CAUTIs. Reducing CAUTI incidence remains the quality improvement focus to achieve a further 25% reduction of HCAI SABs, required by March 2024.

CLINICAL GOVERNANCE		Target	Current
Complaints – Stage 2	*At least 65% of Stage 2 complaints are completed within 20 working days (50% by October 2021)*	**65%**	**12.8%**

There continues to be an ongoing challenge to investigate and respond to Stage 2 complaints within the national timescales due to the ongoing response to COVID-19 and current service pressures. There is an increase in the complexity and number of complaints received and numbers received continue to be high. PRD have seen a significant decrease in the number of concerns and Stage 1 complaints relating to COVID-19 vaccination appointments and/or booster vaccinations; however, the overall delays caused by managing the pandemic continues to feature within complaints.

OPERATIONAL PERFORMANCE		Target	Current
4-Hour Emergency Access	*95% of patients to wait less than 4 hours from arrival to admission, discharge or transfer*	**95%**	**83.0%**

Attendance has continued to be high, impacting on the 4-hour access target. Escalation actions include additional support through the Flow and Navigation Centre with additional primary care triage. Assessment pathways in AU1 continue to see high numbers compounding whole site high occupancy and demand for bed capacity. The emergency department continue with plans for remodelling to allow for expanded assessment provision.

Patient TTG (Waiting)	*All patients should be treated (inpatient or day case setting) within 12 weeks of decision to treat*	**100%**	**52.7%**

Performance in February has deteriorated further. Elective activity has been significantly less than projected with inpatient surgery in particular being restricted to urgent and cancer patients only in response to significant pressures in unscheduled care and the emergence of the Omicron variant. The waiting list continues to rise with 4,283 patients on list in February, 27% greater than in March 2021. There is a continued focus on clinical priorities whilst reviewing long waiting patients. A new recovery plan has been submitted to the Scottish Government and discussions are live around the additional resources needed to deliver additional capacity in the plan. It is anticipated that there will be a gradual resumption in non-urgent core activity in April, but this is heavily dependent on our ability to maintain access to beds for elective activity.

New Outpatients	*95% of patients to wait no longer than 12 weeks from referral to a first outpatient appointment*	**95%**	**48.8%**

Performance continued to deteriorate in February following the decision to cancel routine outpatients to support the response to the emergence of the Omicron variant and significant pressures in unscheduled care. The waiting list has increased with 21,654 on the outpatient waiting list which is 10% higher than in March 2021. There is a continued focus on urgent and urgent suspicion of cancer referrals along with those who have been waiting more than 52 weeks. The number waiting over 52 weeks has risen to 444 in February but has reduced by 55% since March 2021. Due to the ongoing need for physical distancing and the pressures of unscheduled care our outpatient capacity and therefore activity continues to be restricted. A new recovery plan has been submitted to the Scottish Government and discussions are live around the additional resources needed to deliver additional capacity in the plan. There has been a gradual resumption in routine activity and it is anticipated that this will continue, but this is heavily dependent on the demands on staff from unscheduled care activity and the impact on staffing from the Omicron variant.

Diagnostics	*100% of patients to wait no longer than 6 weeks from referral to key diagnostic test*	**100%**	**61.2%**

Performance improved slightly in February. The improvement has been in Radiology with 63.9% waiting less than 6 weeks whilst the performance in endoscopy has deteriorated to 44% of patients waiting less than 6 weeks. Activity continues to be restricted in Endoscopy due to the need for social distancing and enhanced infection control procedures. The overall waiting list for diagnostics has stabilised at 6,607 in February although the number waiting for an Endoscopy and Ultrasound has increased whilst the number waiting in CT and MRI has decreased. There is a continued focus on urgent and urgent suspicion of cancer referrals along with those routine patients who have been experiencing long waits. A new recovery plan has been submitted to the Scottish Government and discussions are live around the additional resources needed to deliver the additional capacity in the plan. It is anticipated that performance will continue to be challenged due to the demand for urgent diagnostics and the pressure from unscheduled care along with continued restrictions in activity due to enhanced infection control measures and staff absence due to COVID.

Cancer 62-Day RTT	*95% of those referred urgently with a suspicion of cancer to begin treatment within 62 days of receipt of referral*	**95%**	**83.6%**

February continued to see challenges in the 62-day performance. The number of USC referrals remains high, consistently exceeding pre pandemic numbers. Breaches are attributed to staffing issues in relation to COVID-19 and lack of resources, particularly radiology capacity over the festive period. Breast, Oncology and Urology (Prostate) are our current most challenged pathways. The majority of breaches continue to be seen in Prostate. The range of breaches was 4 to 55 days (average 18 days).

OPERATIONAL PERFORMANCE		Target	Current
FOI Requests	*At least 85% of Freedom of Information Requests are completed within 20 working days*	**85%**	**86.9%**

There were 62 FOI requests closed in February, 5 of which were late, a monthly closure performance of 91.8%.

The performance figure above reflects the performance for the 3-month period from December 2021 to February 2022 and is the highest 3-month figure since the period from April to June 2021. Provisional figures for March show a further improvement.

Delayed Discharges	*The % of Bed Days 'lost' due to Patients in Delay is to reduce*	**5%**	**7.0%**

The number of bed days lost due to patients in delay in the last 3 months has reduced significantly from the previous quarter, but has remained above the target of 5%. Increased hospital activity over the recent months has resulted in more people requiring social care; this demand has been unable to be met due to social care services experiencing significant workforce pressures. H&SCP have surged 65 downstream beds over the last 6 months to mitigate against the lack of care at home, care home and ward closures, and continue to recruit for care at home and commission additional interim beds. At the February census, approximately half of delays were coded as 51X (Adults With Incapacity) or 100 (Commissioning/Reprovisioning).

FINANCE		Forecast	Current
Revenue Expenditure	*Work within the revenue resource limits set by the SG Health & Social Care Directorates*	**Breakeven**	**Breakeven**

At the end of February the board's reported financial position is a **B**reak **E**ven position which is in line with the projected outturn for the financial year end. The position comprises an adverse variance for Acute Services Division of £17.4m and £2.2m for External Health Care Providers, offset by favourable variances across Corporate Functions of £6m and, of note this month, is the receipt of non recurring Scottish Government funding support of £13.7m to enable the Board to break even. The exceptional demand on unscheduled care capacity within Acute Services continues to be a challenge to available financial resources coupled with increased costs of External Health Care Providers. The savings target of £8.2m the board committed to delivering in year was delivered in full at the end of December with additional savings of £1.4m secured in January taking total savings secured to £9.6m.

Capital Expenditure	*Work within the capital resource limits set by the SG Health & Social Care Directorates*	**£33.9m**	**£19.2m**

The overall anticipated capital budget for 2021/22 is £33.9m. The capital position for the period to February records spend of £19.2m. The full capital budget is on track to be delivered in full by 31 March 2022.

STAFF GOVERNANCE		Target	Current
Sickness Absence	*To achieve a sickness absence rate of 4% or less*	**3.89%**	**5.63%**

The sickness absence rate in February was 5.63%, a reduction of 0.30% from the rate in January 2022. The average rate for COVID-19 related special leave, as a percentage of available contracted hours for the financial year to date was 1.71%.

Given on-going workforce pressures and service challenges, the March 2022 target set in relation to NHS Circular PCS (AfC) 2019/2 will not be achieved and we anticipate further NHSScotland guidance on sickness absence targets, which will reflect the circumstances of the last two years.

PUBLIC HEALTH & WELLBEING		Target	Current
Smoking Cessation	*Sustain and embed successful smoking quits at 12 weeks post quit, in the 40% most deprived SIMD areas*	**473**	**186**

Service provision continues to be delivered remotely by phone, Near Me appointments and use of translation service. We are regularly in contact with all the GP practices where we previously delivered a service. It has been a fluid situation over the last 3 months with practices keeping in touch with updates on clinic space, and we have two practices which are keen to have us start delivering a service starting in the first week of May. We are continuing to support pregnant mums as both midwives have retired. In March we tested some outreach work to assess community appetite to engage in community activity; both sessions were successful so plans to increase community outreach activity have been progressed. No Smoking Day activity saw a small uptake of interest and engagement in the service.

CAMHS Waiting Times	*90% of young people to commence treatment for specialist CAMH services within 18 weeks of referral*	**90%**	**68.0%**

Work on the CAMHS Referral to Treatment (RTT) continues with a lowered RTT as work on the longest waits increases. The amount of activity is increased as new staff capacity improves however is lower than projected due to ongoing vacancies, persistent levels of staff absence and patient cancellations as a result of Covid-19. Urgent and priority referrals remain high with an increased proportion of staff activity allocated to this client group. The process to fill vacant posts continues with a total of 21 posts either in development or out to advert.

Psychological Therapies	*90% of patients to commence Psychological Therapy based treatment within 18 weeks of referral*	**90%**	**79.2%**

The demand for PTs increased significantly in the latter half of 2021 compared to the first 6 months of the year and this remains the case in the first 2 months of 2022. This has resulted in an increase in numbers on the waiting list including, in February, an increase in the number of people waiting over 53 weeks. Issues of workforce availability have negatively impacted the increase in activity that was anticipated from October onwards.

II. Performance Exception Reports

Clinical Governance

Adverse Events (Major & Extreme) 11
HSMR 12
Inpatient Falls (With Harm) 13
Pressure Ulcers 14
Caesarean Section SSI 15
SAB (HAI/HCAI) 16
C Diff (HAI/HCAI) 17
ECB (HAI/HCAI) 18
Complaints (Stage 2) 19

Finance, Performance & Resources: Operational Performance

4-Hour Emergency Access 20
Patient Treatment Time Guarantee (TTG) 21
New Outpatients 22
Diagnostics 23
Cancer 62-day Referral to Treatment 24
Freedom of Information (FOI) Requests 25
Delayed Discharges 26

Finance, Performance & Resources: Finance

Revenue Expenditure 27
Capital Expenditure 36

Staff Governance

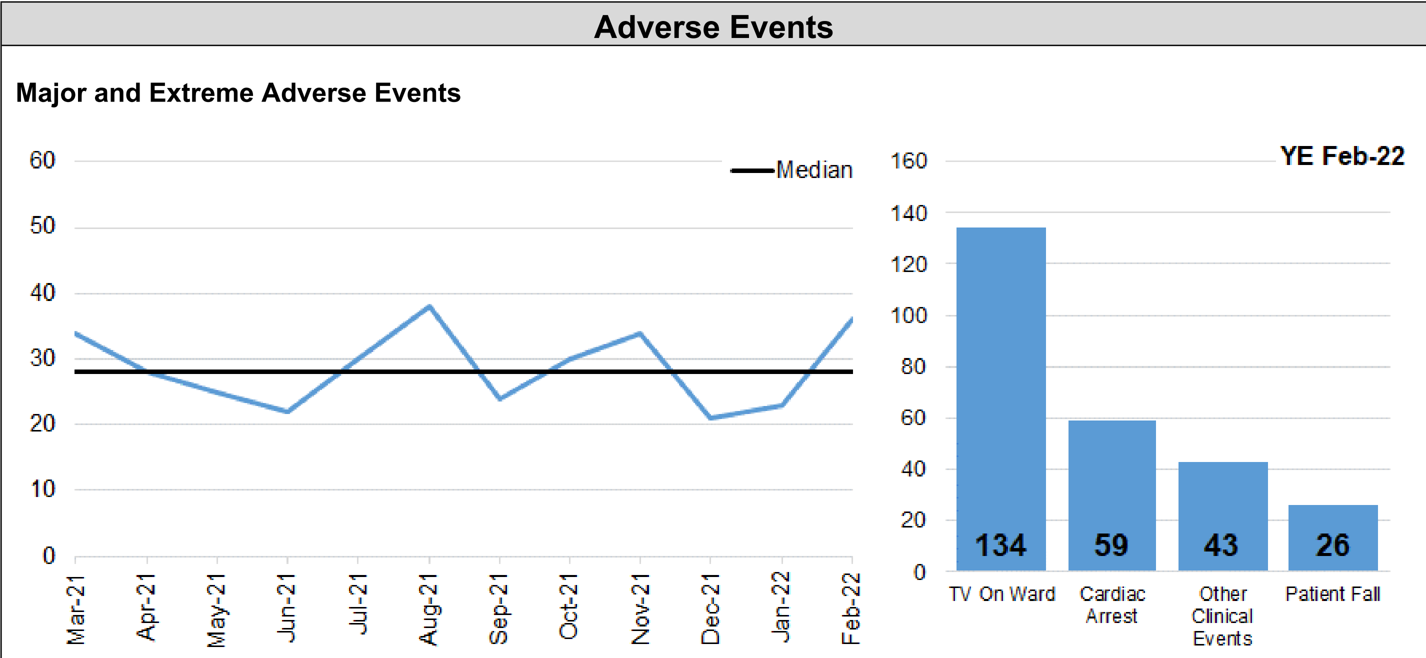
Sickness Absence 40

Public Health & Wellbeing

Smoking Cessation 41
CAMHS 18 Weeks Referral to Treatment 42
Psychological Therapies 18 Weeks Referral to Treatment 43

Adverse Events

Major and Extreme Adverse Events



All Adverse Events

	Month	2020/21	2021/22										
		Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
ALL	NHS Fife	1365	1358	1373	1351	1420	1453	1397	1392	1437	1492	1495	1230
	Acute Services	630	594	649	606	629	616	609	646	632	596	611	491
	HSCP	708	725	682	694	741	799	746	690	746	834	851	698
	Corporate	27	39	42	51	50	38	42	56	59	62	33	41
CLINICAL	NHS Fife	954	937	1012	936	1009	956	964	948	1015	974	938	842
	Acute Services	588	547	600	547	568	551	536	567	581	536	564	439
	HSCP	353	372	388	365	412	384	401	351	405	399	360	383
	Corporate	13	18	24	24	29	21	27	30	29	39	14	20

Commentary

Incident numbers in January were in keeping with normal variation, but although there was a significant overall decrease in February the number of incidents reported as Major or Extreme in this month increased.

The main categories of events showing decreases were:

- Other Clinical events – the most notable reduction is in 'Hypoglycaemia (BM<4)' which have seen a consistent reduction from 50 in March 2021 to 19 in February 2022
- Medication incidents decreased to <100 per month for the first time in this 12-month period, however the number of Major/Extremes in this category increased

Focused improvement work continues in relation to falls, pressure ulcers and deteriorating patient. Adverse Events improvement work is ongoing. A dedicated Adverse Events resource folder has been created within Blink, and this holds resources to facilitate adverse events incident management as well as including links to human factors training. Collaborative work on the adverse events improvement plan is ongoing.

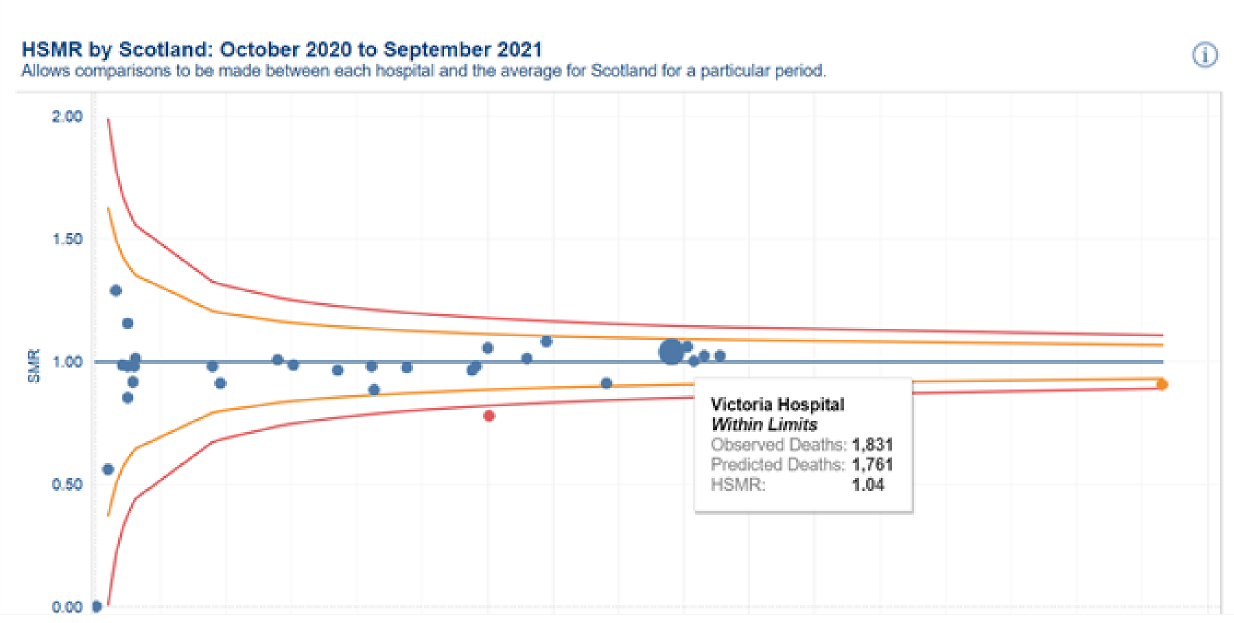
HSMR

Value is less than one, the number of deaths within 30 days of admission for this hospital is fewer than predicted. If value is greater than one, number of deaths is more than predicted.

Reporting Period; October 2020 to September 2021p

Please note that as of August 2019, HSMR is presented using a 12-month reporting period when making comparisons against the national average. This will be advanced by three months with each quarterly update.

The rate for Victoria Hospital is shown within the Funnel Plot.



Commentary

Hospital Standardised Mortality Ratio (HMSR) is not intended for use in a pandemic situation. However, the increased HSMR will be closely monitored over the coming months, and appropriate action including target audit will be commenced if required.

Inpatient Falls with Harm

Reduce Inpatient Falls with Harm rate per 1,000 Occupied Bed Days (OBD)
Target Rate (by end March 2022) = 1.65 per 1,000 OBD

Local Performance

Performance by Service Area

	2020/21	2021/22										
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
NHS Fife	1.68	0.98	1.68	0.82	1.45	1.50	1.50	1.66	1.33	1.52	2.02	1.59
Acute Services	0.98	0.35	0.88	0.33	0.79	1.26	0.81	1.44	1.11	0.64	1.80	1.14
HSCP	2.29	1.54	2.40	1.27	2.03	1.72	2.11	1.84	1.52	2.27	2.21	1.95
Target		1.65	1.65	1.65	1.65	1.65	1.65	1.65	1.65	1.65	1.65	1.65

KEY CHALLENGE(S) IN 2021/22

- Continued challenges in in-patient settings with patient placement, social distancing - the falls toolkit is continuing to be used to support assessment and local plans on care delivery and this will be reviewed in line with the national work expected later this year
- Ongoing combined challenges of the dynamic nature of provision of care while ensuring COVID measures are firmly in place, and remobilisation of services
- Re-establishing the Falls Champion Network across all in-patient areas to support local work and support how to address the challenges noted

IMPROVEMENT ACTIONS

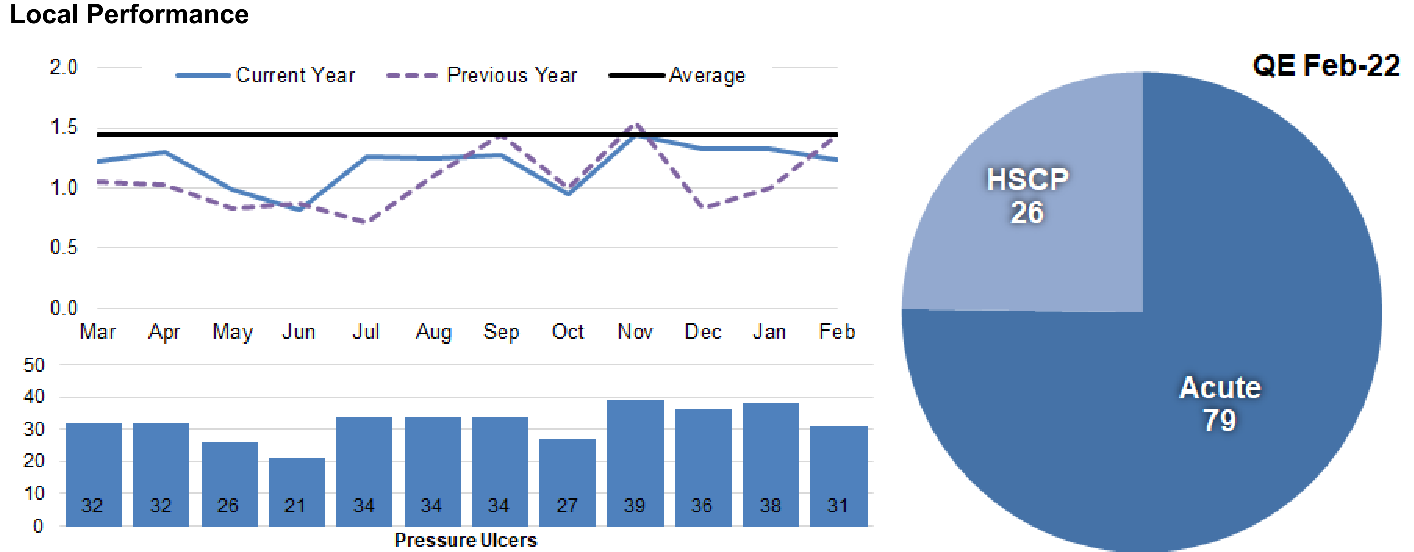
20.3 Falls Audit	***By Aug-22***
As previously noted the expected new national driver diagram and measurement package are not yet finalised and the local audit programme will be fully developed following receipt of this; if further delayed, an interim audit programme will be commenced. This will be reviewed again in the Summer.	
20.5 Improve effectiveness of Falls Champion Network	***By Aug-22***
This work remains on hold due to staffing challenges, with contact being maintained with existing champions	
21.2 Falls Reduction Initiative	***Complete Nov-21***
21.3 Integrated Improvement Collaborative	***Complete Jan-22***

Pressure Ulcers

Reduce pressure ulcers (grades 2 to 4) developed in a healthcare setting

Target Rate (by end March 2022) = 0.42 per 1,000 OBD

Local Performance



Performance by Service Area

		2020/21	2021/22										
		Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Grade 2 to 4	NHS Fife	1.22	1.30	0.99	0.82	1.26	1.25	1.28	0.95	1.44	1.33	1.32	1.23
	Acute Services	2.12	2.51	1.60	1.58	2.13	2.36	2.18	1.44	2.54	2.24	2.25	1.84
	HSCP	0.43	0.23	0.44	0.15	0.49	0.27	0.49	0.53	0.49	0.55	0.52	0.72

KEY CHALLENGE(S) IN 2021/22

Analysing impact of COVID-19 on clinical pathway for handling Pressure Ulcers, and taking appropriate action to improve performance – this continues to require an agile response

IMPROVEMENT ACTIONS

Action	Status
21.2 Integrated Improvement Collaborative	**Complete Jun-21**
21.3 Implementation of robust audit programme for audit of documentation	**Complete Jun-21**
22.1 Improvement Collaboratives - HSCP	**Complete Mar-22**

The Tissue Viability Steering Group are reviewing the reporting framework. This involves forming an operational sub-group that will report directly into the Tissue Viability Steering group on developments and progress against key quality indicators, standards, relevant guidance and policies and quality improvement programmes.

A number of improvement ideas have been identified, to be discussed and developed further at the next Tissue Viability Group meeting.

Action	Status
22.2 Community Nursing QI Work	**Complete Mar-22**

One of the community nursing teams has implemented a focused piece of improvement work to ensure that all relevant skin and risk assessments are completed. This is having a positive impact on patient outcomes.

Joint adverse event reviews and sharing learning have increased between services, including working collaboratively with care homes.

Action	Status
22.3 ASD Pressure Ulcer Improvement Programme	**Complete Mar-22**

Due to the continued and significant workforce pressures and therefore inability to use a collaborative model for continuous quality improvement, a decision has been taken to terminate this programme and for clinical teams to own their own improvement activity.

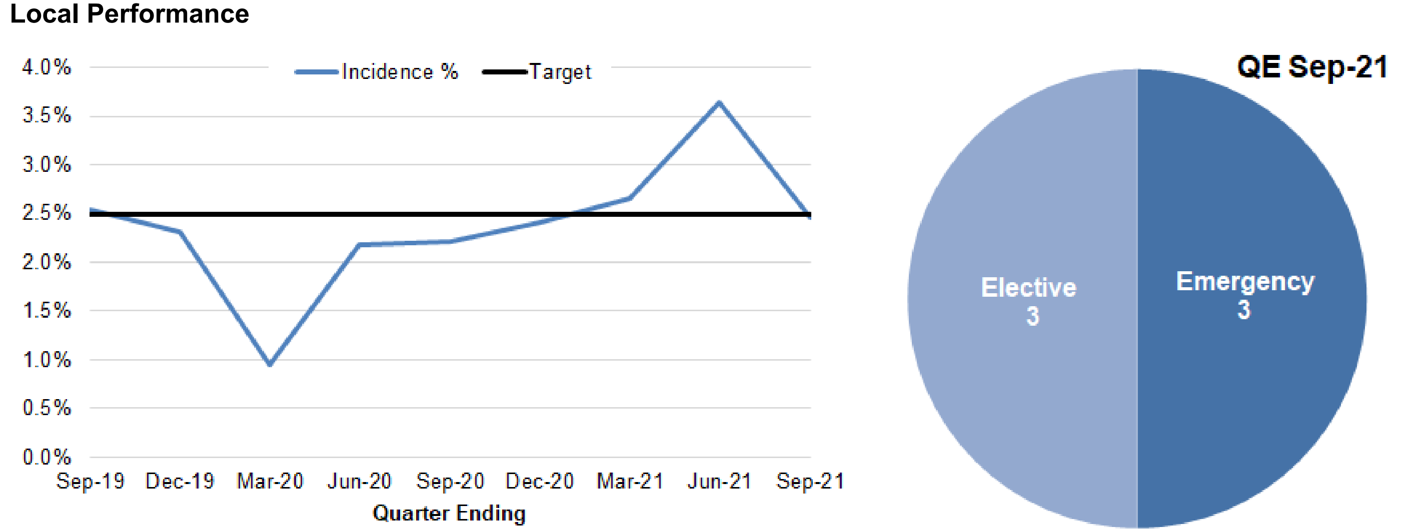
Action	Status
22.4 Implementation of Focused Improvement Activities	**Complete Mar-22**

ICU continue to test change ideas to prevent Medical Devise Related Pressure Ulcers, including prophylactic use of barrier creams and the development of a poster depicting preventative techniques. All mattresses have been replaced with specialist mattresses that have the technology to deflate individual cells under targeted areas of the body at particular risk. Ward 31 and ED continue to discuss pressure ulcer incidences at the Hip Fracture Meeting.

Caesarean Section SSI

Sustain C-Section SSI incidence for inpatients and post discharge surveillance (day 10) below 2.5% during FY 2021/22

Local Performance



National Benchmarking

Quarter Ending	2018/19				2019/20		
	Jun-18	Sep-18	Dec-18	Mar-19	Jun-19	Sep-19	Dec-19
NHS Fife	3.1%	2.3%	1.7%	6.5%	2.0%	2.5%	2.3%
Scotland	1.5%	1.5%	1.4%	1.6%	1.0%	1.2%	0.9%

KEY CHALLENGE(S) IN 2021/22

Resumption of SSI surveillance (when instructed/agreed) will require a review of the previously established methodology (adopted in Q4 2019 and paused during Q1 2020 due to the pandemic response), with regards to possible subsequent changes both nationally and locally. Then training of staff in the definitions of C-section SSI and the surveillance programme, areas include; Maternity Assessment, Maternity Ward, Observation Ward and the Community Midwives.

IMPROVEMENT ACTIONS

20.1 Address ongoing and outstanding actions as set out in the SSI Implementation Group Improvement Plan	**Complete Mar-22**

The SSI Implementation Group de-mobilised in August 2020 as there were no outstanding actions, infection rates had improved and there was a robust system in place for reviewing (LAER/SAER) any Deep or Organ Space SSI cases. The group will re-establish if any future concerns develop.

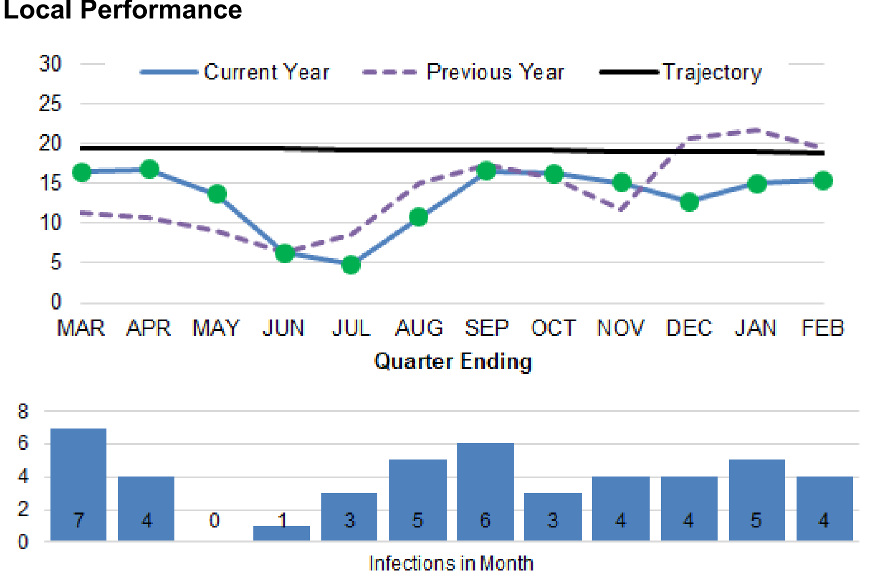
Due to the ongoing Covid-19 pandemic, there is currently no date (set by ARHAI) for resumption of SSI surveillance. Until such time, Maternity services will continue to monitor infection rates locally and will maintain links with the Infection Control Surveillance Team, for support and guidance.

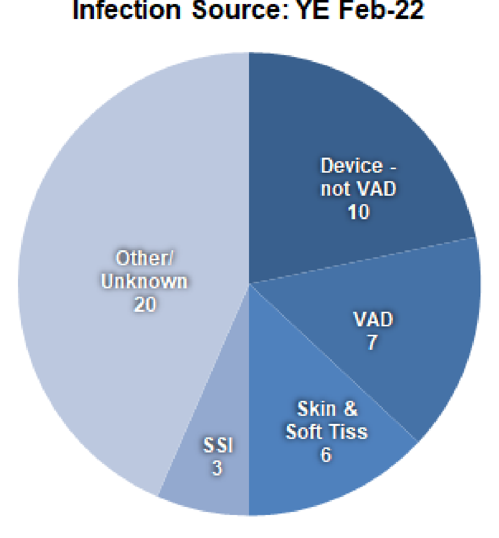
On resumption of the C-section SSI surveillance programme, the IPCT will review the surveillance methodology to capture any practice/patient pathway changes due to the pandemic response and/or any alterations to the case definition. This will ensure that the surveillance methodology remains the most effective means of capturing SSI cases.

SAB (HAI/HCAI)

Reduce Hospital Infection Rate by 10% (in comparison to FY 2018/19 rate) by the end of FY 2021/22

Local Performance





National Benchmarking

Quarter Ending	2020/21				2021/22		
	Jun	Sep	Dec	Mar	Jun	Sep	Dec
NHS Fife	6.3	18.7	20.6	17.8	6.3	16.6	12.8
Scotland	20.3	17.3	18.9	18.4	18.6	18.3	17.3

KEY CHALLENGE(S) IN 2021/22

Vascular access devices and medical devices such as urinary catheters are risk factors identified for SAB, and infections in these areas need to be minimised in order to achieve the 10% reduction by March 2022

IMPROVEMENT ACTIONS

20.1 Reduce the number of SAB in PWIDs	***Complete Mar-22***

The incidence of SABs in PWIDs has continued to reduce although there has been 2 cases identified in 2022 up to February. IPC will continue to support Addiction Services with their QI work to reduce the rate further.

20.2 Ongoing surveillance of all VAD-related infections	***Complete Mar-22***

Monthly charts are distributed to clinical teams to inform of incidence of VAD SABs - these demonstrate progress and promote quality improvement as well as raising triggers and areas of concern

20.3 Ongoing surveillance of all CAUTI	***Complete Mar-22***

Bi-monthly meetings of the Urinary Catheter Improvement Group (UCIG) identify key issues and initiate appropriate corrective actions in regard to catheter and urinary care with ECB data presented to indicate CAUTI incidence and trends. The UCIG Driver Diagram continues to be reviewed. eCatheter insertion & maintenance bundles on Patientrack are currently being trialled within Urology services, before being rolled out across the whole AS & HSCP, to ensure optimum catheter care delivery.

20.4 Optimise comms with all clinical teams in ASD & the HSCP	***Complete Mar-22***

Monthly SAB reports are distributed with Microbiology comments, to gain better understanding of disease process and those most at risk. This allows local resources to be focused on high-risk groups/areas and improve patient outcomes. 'Days since last SAB' data is emailed out to each directorate monthly for wards to display for public assurance

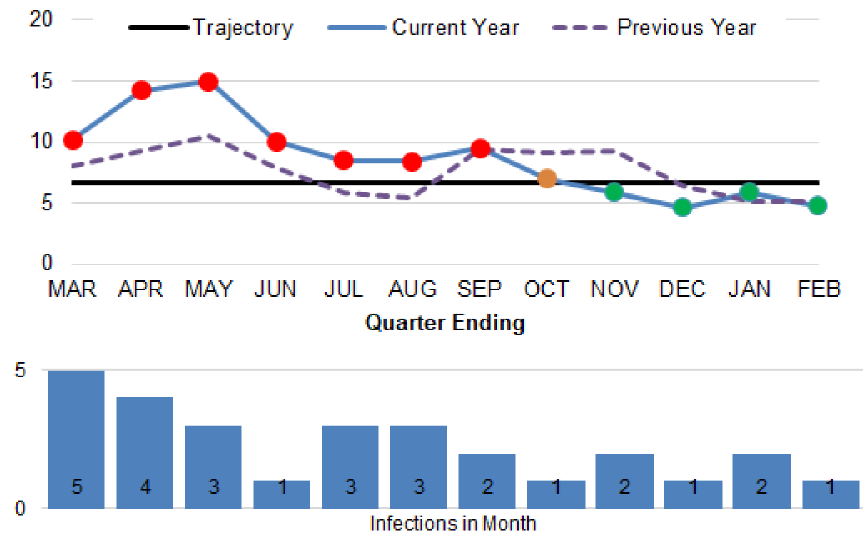
22.1 Use Electronic insertion and maintenance bundles for PVC, CVC, urinary catheters	***Complete Mar-22***

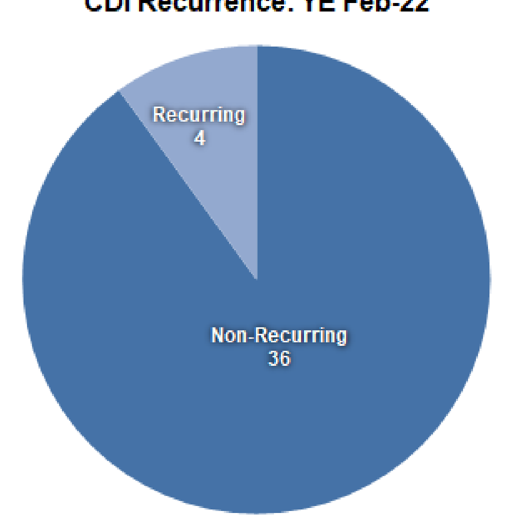
Electronic insertion and maintenance bundles for PVCs are completed on Patientrack to support best practice. Compliance is reported weekly to ward Senior Charge Nurses if the ward failed to achieve 90% of all PVC being removed prior to the 72hr breach. Similar electronic insertion and maintenance bundles are being trialled currently for in-dwelling urinary catheters and planned for CVCs to promote and support best practice, reduce avoidable harm and improve quality of care.

C Diff (HAI/HCAI)

Reduce Hospital Infection Rate by 10% (in comparison to FY 2018/19 rate) by the end of FY 2021/22

Local Performance





National Benchmarking

Quarter Ending	2020/21				2021/22		
	Jun	Sep	Dec	Mar	Jun	Sep	Dec
NHS Fife	7.9	9.3	7.7	14.0	10.0	9.5	4.6
Scotland	15.4	17.4	16.4	15.8	14.6	16.8	13.3

KEY CHALLENGE(S) IN 2021/22

Sustain and further reduce healthcare-associated CDI and recurrent CDI in order to achieve the 10% reduction target by March 2022

IMPROVEMENT ACTIONS

20.1 Reducing recurrence of CDI	***Complete Mar-22***

Each CDI occurrence is reviewed by a consultant microbiologist. The patient's clinician is then advised regarding patient treatment and management to optimize recovery and prevent recurrence of infection.

To reduce recurrence of CDI Infection for patients at high risk of recurrent infection, two treatments are utilised in Fife, Fidaxomicin and Bezlotoxumab. The latter can be prescribed whilst faecal microbiota transplantation is unavailable during the COVID-19 pandemic.

20.2 Reduce overall prescribing of antibiotics	***Complete Mar-22***

NHS Fife utilises National antimicrobial prescribing targets by NHS Fife microbiologists, working continuously alongside Pharmacists and GPs to improve antibiotic usage.

Empirical antibiotic guidance and the revised Microguide app has been circulated to all GP practices.

20.3 Optimise communications with all clinical teams in ASD & the HSCP	***Complete Mar-22***

Monthly CDI reports are distributed, to enable staff to gain a clearer understanding of the disease process, recurrences and rates.

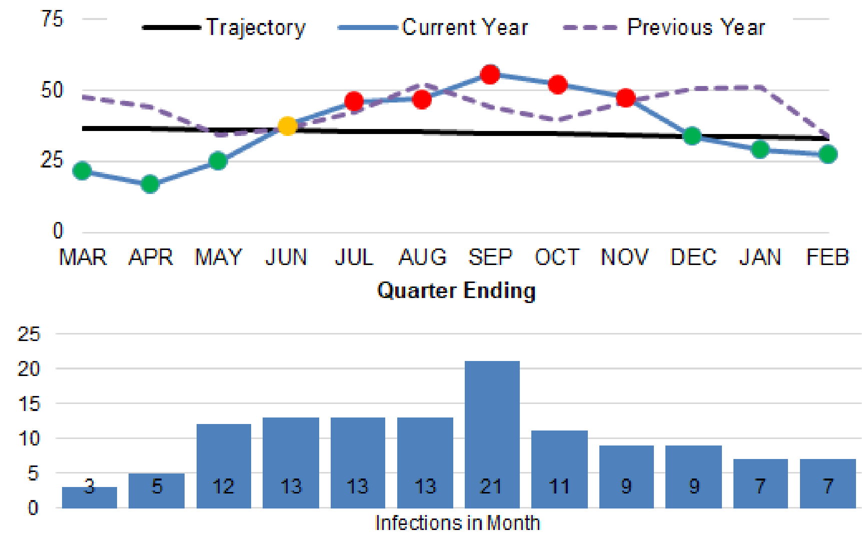
IPCN ward visits reinforce SICPs and transmission-based precautions, provide education to staff to promote optimum CDI management and daily Medical Management form completion.

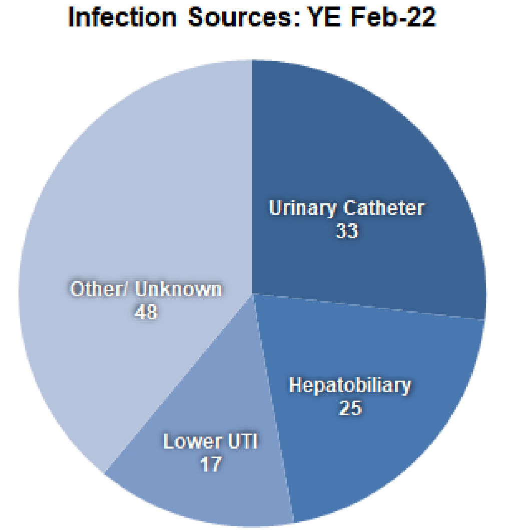
'Days since last CDI' data is emailed monthly by IPC surveillance to each directorate for all wards to display for public assurance

ECB (HAI/HCAI)

Reduce Hospital Infection Rate by 25% (in comparison to FY 2018/19 rate) by the end of FY 2021/22

Local Performance





National Benchmarking

Quarter Ending	2020/21				2021/22		
	Jun	Sep	Dec	Mar	Jun	Sep	Dec
NHS Fife	36.4	45.3	50.3	21.6	37.6	60.3	33.6
Scotland	39.7	42.0	40.9	34.7	38.2	41.4	34.1

KEY CHALLENGE(S) IN 2021/22

Lower Urinary tract Infections (UTIs) and Catheter associated UTIs (CAUTI) remain the prevalent source of ECBs and are therefore the areas to address to reduce the healthcare-associated inflection ECB rate

IMPROVEMENT ACTIONS

20.1 Optimise communications with all clinical teams in ASD & the HSCP — ***By Mar-24***

Monthly ECB reports and charts are distributed to key clinical staff across the HSCP and ASD. Each CAUTI associated ECB undergoes IPC surveillance and a DATIX is submitted for all catheter associated ECBs, prompting an LAER by the patient`s clinical team. ECB rates reduced in Q4 of 2021 following NHS Fife receiving an exception report for HCAI & CAI rates in Q3, for which an Action Plan was submitted to ARHAI.
NHS Fife is currently on target for achieving the 25% target reduction by the end of March; a further 25% reduction of HCAI ECBs is to be achieved by March 2024.

20.3 Ongoing work of Urinary Catheter Improvement Group (UCIG) — ***By Mar-24***

The UCIG meeting last met in November, two further meetings having been cancelled. Initiatives to promote hydration and provide optimum urinary catheter care (including continence care) across Fife continue. They cover analysis and update of process, training/education/promotion and quality improvement work.

A new eCatheter insertion & Maintenance bundle on Patientrack is currently being trialled by Urology before being rolled out across the AS & HSCP to ensure optimum catheter care is delivered across NHS Fife.

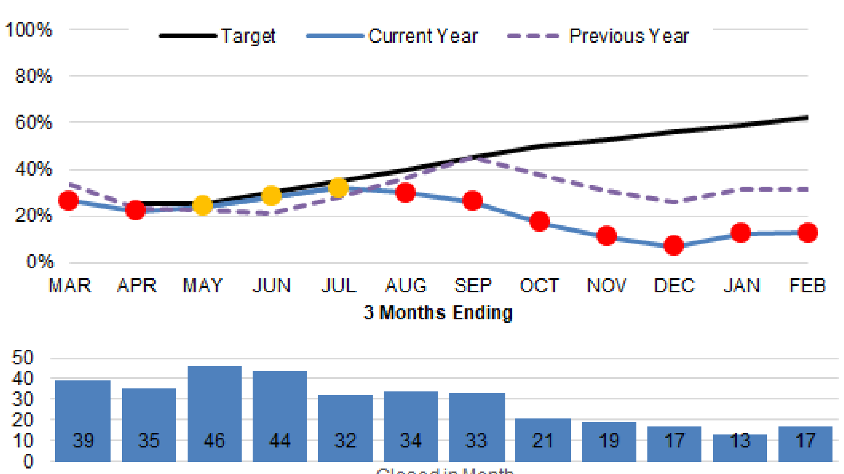
22.1 Develop ECB Strategy — ***Complete Mar-22***

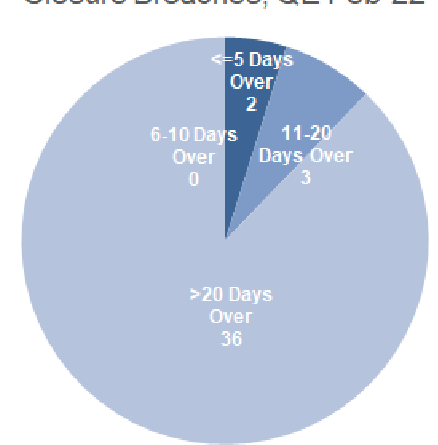
NHS Fife are collaborating with NHS Shetland and NHS Grampian to pioneer an enhanced ECB CAUTI surveillance tool. The aim is to gather data on all CAUTIs, identify risk factors and, where appropriate, make subsequent improvements to practice.

Complaints | Stage 2

At least 65% of Stage 2 complaints are completed within 20 working days (50% by October 2021)

Local Performance





Performance by Service Area

3-Month Ending	2020/21	2021/22										
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
NHS Fife	26.3%	21.9%	24.2%	28.0%	32.0%	30.0%	26.3%	17.0%	11.0%	7.0%	12.2%	12.8%
Ack <= 3 Days (Monthly)	94.9%	100.0%	93.5%	100.0%	96.9%	100.0%	100.0%	100.0%	100.0%	94.1%	100.0%	100.0%
ASD	19.3%	15.9%	15.7%	22.5%	23.5%	25.7%	26.2%	19.3%	14.0%	7.5%	17.1%	17.6%
HSCP	50.0%	38.1%	48.3%	31.4%	38.7%	23.3%	20.8%	13.0%	5.9%	8.3%	0.0%	0.0%

KEY CHALLENGE(S) IN 2021/22

- Service recovery following Covid-19 pandemic
- Improve the quality of complaint handling
- Complex complaints / Multi-Directorate Complaints

IMPROVEMENT ACTIONS

22.1 Review complaint handling process and agree measures to ensure quality — **By Sep-22**

Patient Relations have yet to recommence in-house QA checks on draft final responses; however, it is hoped we will be in a position to recommence this in the near future.

Review of the current complaint handling process by Clinical Governance and Patient Relations also continues to be on hold due to the ongoing response to COVID-19 and current capacity issues. This will be recommenced in the future.

In March, there was a focus within the Patient Relations team to work on the backlog of complaint response, which had been created due to the pressures on clinical services whilst managing Covid-19 measures. Over the course of 14 days, the team were able to clear the backlog of responses that were ready to draft and move these cases onward through the complaint's procedure.

22.2 Improve education of complaint handling — **By Sep-22**

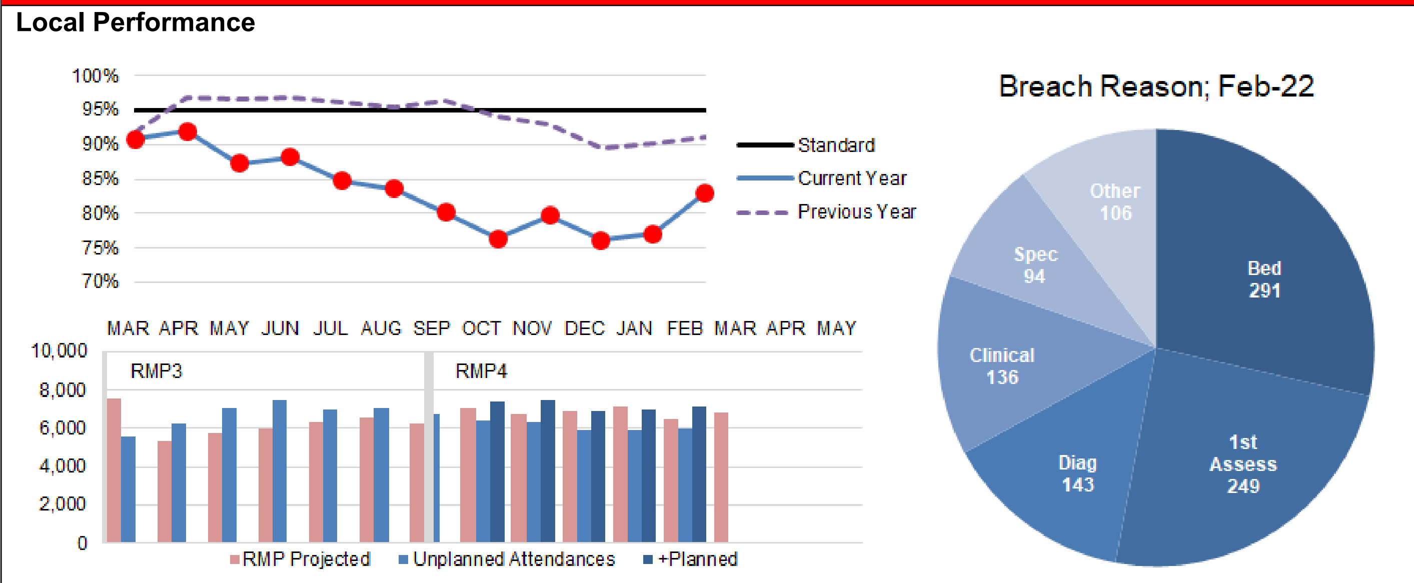
This action aims to improve overall quality by delivering education programmes at induction and bespoke training sessions across the Clinical Services. Unfortunately, training remains on hold due to the ongoing response to COVID-19 and current capacity issues; however, there have been some training sessions delivered virtually during the pandemic. It is hoped to recommence training once the picture in regard to Covid-19 settles somewhat and face-to-face training in large groups can be accommodated once again.

Although bespoke training sessions were due to be undertaken with Fife Wide & Fife East in May in 2021, this has not been possible to achieve for the reasons above. It is hoped there will be capacity to recommence this soon.

4-Hour Emergency Access

At least 95% of patients will wait less than 4 hours from arrival to admission, discharge or transfer for Accident & Emergency treatment

Local Performance



National Benchmarking

Month	2020/21	2021/22										
	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB
NHS Fife	90.8%	91.9%	87.2%	88.2%	84.7%	83.6%	80.1%	76.3%	79.7%	76.1%	77.0%	83.0%
Scotland	88.5%	88.7%	87.2%	85.0%	81.5%	77.8%	76.1%	73.5%	75.9%	75.7%	76.0%	

KEY CHALLENGE(S) IN 2021/22

- Achievement of 4-hour access Standard
- Delivery of an integrated Flow and Navigation HUB
- Increased patient demand for urgent care

IMPROVEMENT ACTIONS

21.2 Integration of the Redesign of Urgent Care model and the Flow & Navigation Hub	**Complete Mar-22**

Virtual Flow and Navigation appointments to ED are now in place and the Hub has expanded to handle GP calls previously taken by ANPs into AU1. Early indication shows decreased number of referrals with a re-direction rate of 26%. Expansion for 24/7 handling is in planning and the Clinical Director for Planned Care is reviewing surgical pathways through FNC with a focus on a more streamlined urology pathway.

This will be picked up again in the refreshed IPQR.

22.1 Co-produce (with NHS 24) patient criteria for access to ED via 1-hr and 4-hr pathways	**Complete Nov-21**
22.2 Reduce number of patients breaching at 4 hrs, 8 hrs, and waits for beds	**Complete Mar-22**

February saw an improvement in performance, however bed waits continue to be the principal reason for breaches with the knock on effect of holding patients within the department further impacting time to first assessment due to lack of space. Flow to downstream wards impacted on high acuity of patients and the impact that COVID staff absence has had on ward staffing numbers and management of workload to enable discharges. OPEL escalation tool now in daily use with actions in place for escalation and formal action cards under development.

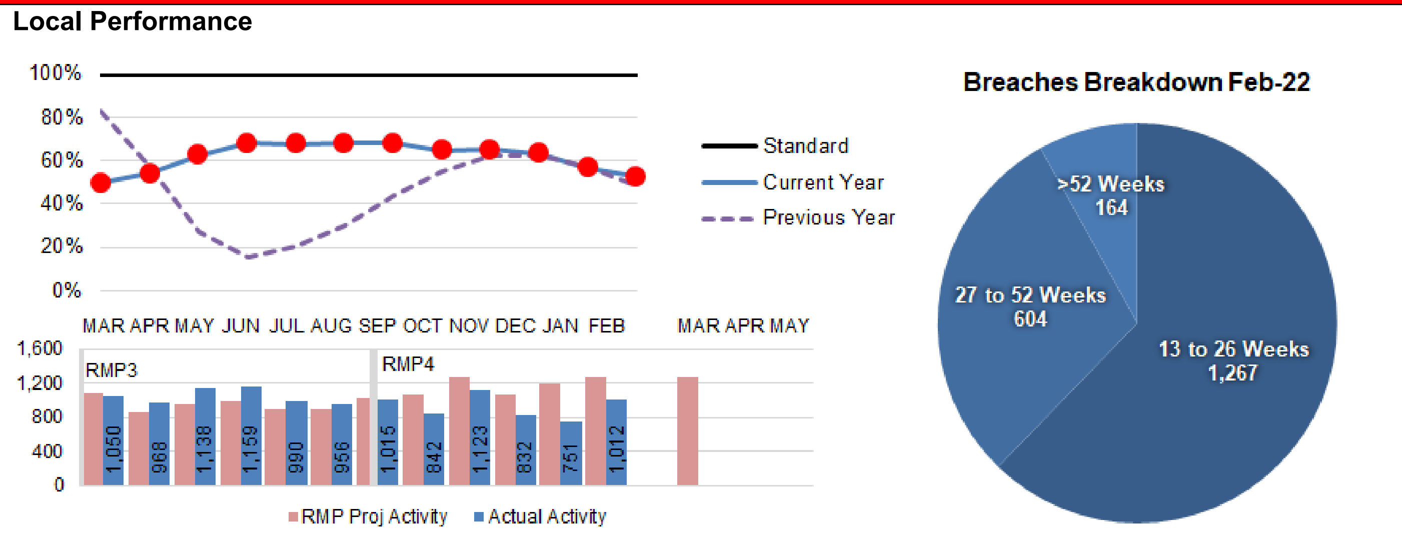
This will be picked up again in the refreshed IPQR.

22.3 Develop re-direction policy for ED	**Complete Dec-21**

Patient TTG

We will ensure that all eligible patients receive Inpatient or Daycase treatment within 12 weeks of such treatment being agreed

Local Performance



National Benchmarking

	2020/21	2021/22										
	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB
NHS Fife	49.7%	54.1%	62.7%	67.9%	67.6%	68.2%	68.2%	64.9%	65.1%	63.1%	56.6%	52.7%
Scotland	34.7%	35.5%	37.2%	38.6%	36.7%	36.5%	34.0%	37.5%	37.3%	34.6%		

KEY CHALLENGE(S) IN 2021/22

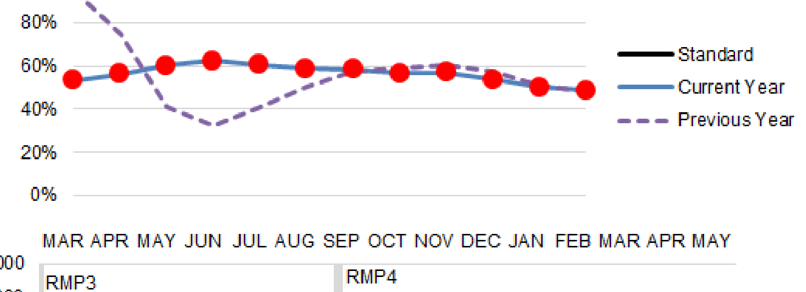
- Reduced Theatre Capacity due to current infection control and social distancing measures
- Clinical Prioritisation leading to long waits for lower priority patients
- Increased demand as a result of backlog in outpatients and change in case mix
- Increased unscheduled workload
- Staff vacancies, absence and fatigue

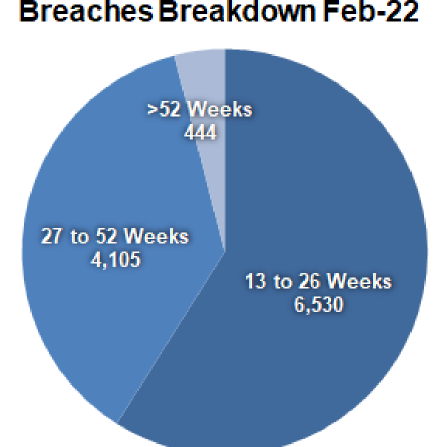
IMPROVEMENT ACTIONS	
22.1 Monitor and review DCAQ against waiting times improvement plan, secure additional funding from SG and amend plan prior to formal review in September	**Complete Sep-21**
22.2 Redesign Pre-assessment to increase capacity and flexibility around theatre scheduling	**By Sep-22**
Business case delayed awaiting decision on suitable IT system	
22.3 Undertake waiting list validation against agreed criteria	**Complete Mar-22**
Clinical teams continue to review lists and prioritise patients, Clinical Prioritisation Group meets regularly. This work will continue as clinical prioritisation remains essential when elective capacity is restricted due bed capacity and unscheduled care demand.	
22.4 Develop and deliver improvement actions in line with CFSD priority projects overseen by Integrated Planned Care Programme Board	**Complete Mar-22**
ACRT in place for 3 specialities and PIR in place for 6 specialities. The work for this year is complete. A new programme of improvements for 2022/23 will be agreed by the Integrated Planned Care Programme Board.	

New Outpatients

95% of patients to wait no longer than 12 weeks from referral to a first outpatient appointment

Local Performance





National Benchmarking

	2020/21	2021/22										
	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB
NHS Fife	53.4%	56.4%	60.3%	62.4%	60.7%	58.6%	58.3%	56.5%	57.1%	53.8%	50.1%	48.8%
Scotland	48.3%	50.5%	52.3%	53.4%	51.6%	49.7%	48.1%	48.0%	48.4%	46.5%		

KEY CHALLENGE(S) IN 2021/22

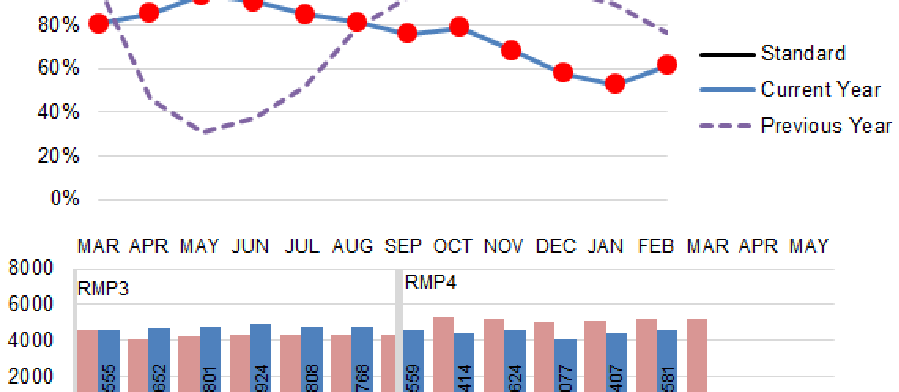
- Reduced Clinic capacity due to current infection control and social distancing measures
- Clinical Prioritisation leading to long waits for lower priority patients
- Increased demand as a result of unmet need and change in case mix of referrals
- Increased unscheduled workload
- Staff vacancies, absence and fatigue

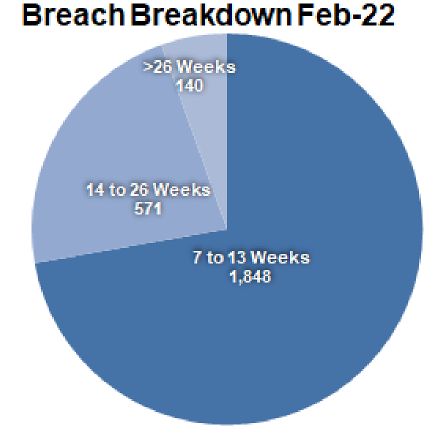
IMPROVEMENT ACTIONS	
22.1 Monitor and review DCAQ against waiting times improvement plan, secure additional funding from SG and amend plan prior to formal review in September	**Complete Sep-21**
22.2 Deliver appropriate elements of Modernising outpatients and unscheduled care redesign to reduce and manage demand and sustain capacity	**Complete Mar-22**
The work for this year is complete. A new programme of improvements for 2022/23 will be agreed by the Integrated Planned Care Programme Board.	
22.3 Actively promote and support staff wellbeing initiatives within the acute division	**Complete Mar-22**
Directorates promoting and supporting initiatives	
22.4 Understand impact of potential changes to guidance on social distancing and actions needed to implement	**Complete Dec-21**

Diagnostics Waiting Times

No patient will wait more than 6 weeks to receive one of the 8 Key Diagnostics Tests appointment

Local Performance





National Benchmarking

	2020/21	2021/22										
	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB
NHS Fife	80.6%	85.3%	93.5%	90.6%	84.9%	81.2%	75.7%	78.7%	68.3%	57.8%	52.7%	61.2%
Scotland	61.4%	61.8%	64.1%	62.6%	57.2%	56.5%	57.8%	55.2%	56.9%	49.6%		

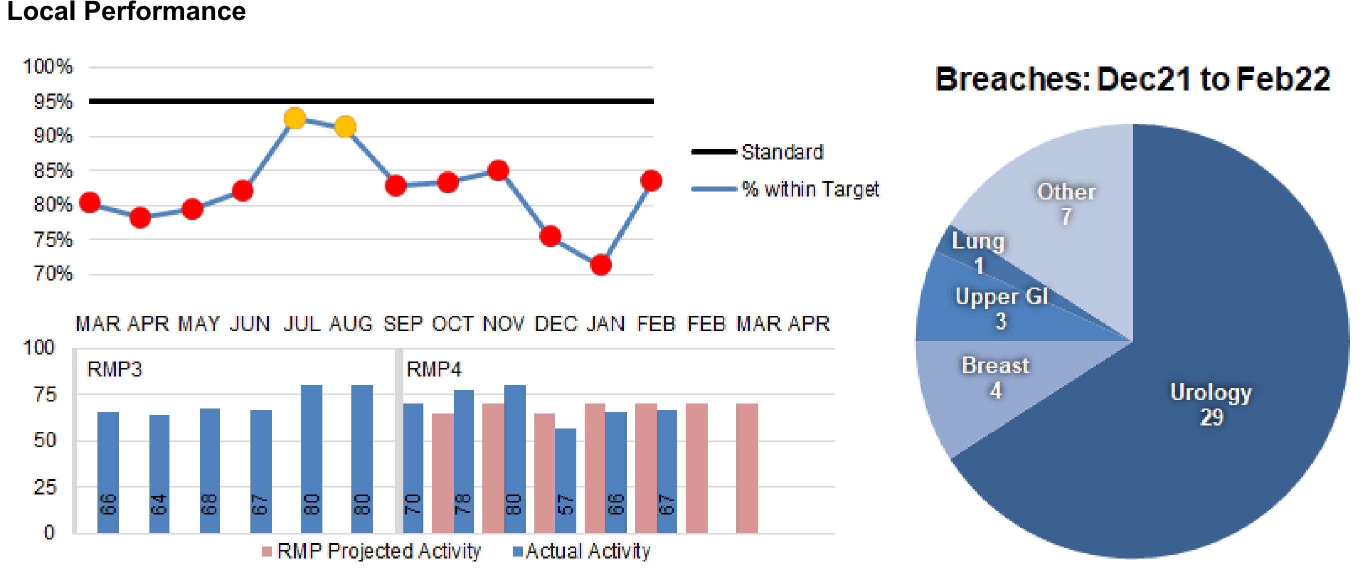
KEY CHALLENGE(S) IN 2021/22

- Reduced diagnostic capacity due to current infection control and social distancing measures
- Clinical Prioritisation leading to long waits for lower priority patients
- Increased demand as a result of unmet need, backlog in outpatients and change in case mix of referrals
- Staff vacancies, absence and fatigue

IMPROVEMENT ACTIONS	
22.1 Monitor and review DCAQ against waiting times improvement plan, secure additional funding from SG and amend plan prior to formal review in September	**Complete Sep-21**
22.2 Explore implementation of point of care testing in endoscopy	**Complete Mar-22**
System implemented	
22.3 Actively promote and support staff wellbeing initiatives within the acute division	**Complete Mar-22**
Directorates promoting and supporting initiatives	
22.4 Actively seek alternative sources of additional CT capacity to manage increasing waiting times for routine patients	**Complete Jan-22**

At least 95% of patients urgently referred with a suspicion of cancer will start treatment within 62 days

Local Performance



National Benchmarking

Month	2020/21	2021/22										
	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB
NHS Fife	80.3%	78.1%	79.4%	82.1%	92.5%	91.3%	82.9%	83.3%	85.0%	75.4%	71.2%	83.6%
Scotland	83.0%	84.5%	83.0%	83.6%	82.8%	83.5%	83.1%	78.8%	78.1%	78.3%	76.3%	77.4%

KEY CHALLENGE(S) IN 2021/22

- Prostate cancer pathway (remains the most challenged pathway in NHS Fife)
- Increased number of referrals into the breast service, converting to cancers
- Catch up with the paused screening services (which will increase the number of patients requiring to be seen)
- Introduction of the robot may impact on waits to surgical treatment due to training requirements

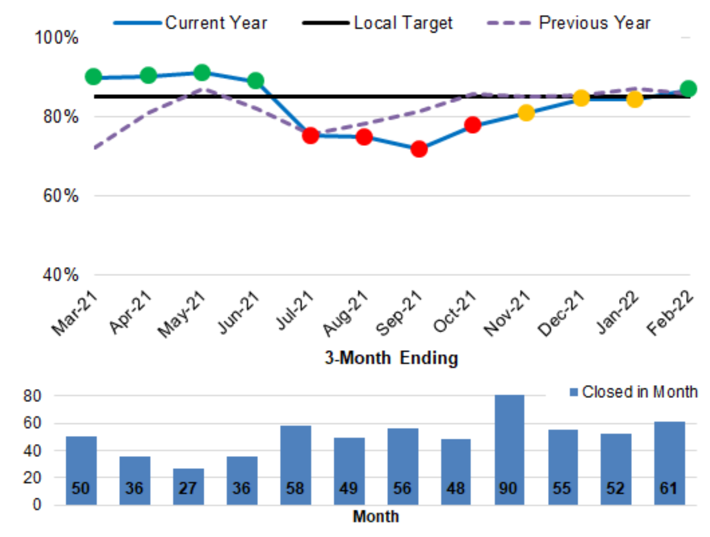
IMPROVEMENT ACTIONS

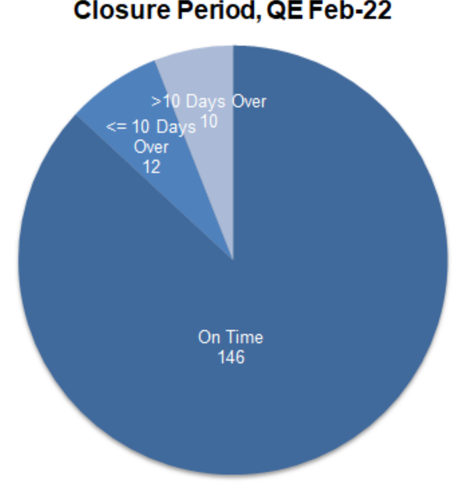
20.3 Robust review of timed cancer pathways to ensure up to date and with clear escalation points	**By Mar-23**
This will be addressed as part of the overall recovery work and in line with priorities set within the Cancer Recovery Plan and by the leadership team. Priority will be given to the most challenging pathways.	
20.4 Prostate Improvement Group to continue to review prostate pathway	**By Mar-23**
This is ongoing work related to Action 20.3, with the specific aim being to improve the delays within the whole pathway. A national review of the prostate pathway will be undertaken as part of the Recovery Plan.	
21.2 Cancer Strategy Group to take forward the National Cancer Recovery Plan	**By May-22**
The National Cancer Recovery Plan was published in December 2020. A Strategic & Governance Cancer Group has been established with a Cancer Framework Core Group to develop and take forward the NHS Fife Cancer Framework and annual delivery plan for cancer services in Fife. Engagement sessions have been completed and the Framework and delivery plan is currently being drafted. The Framework is out for consultation.	
22.1 Effective Cancer Management Review	**By May-22**
The Scottish Government Effective Cancer Management Framework review to improve cancer waiting times performance is underway. The recommendations from the review will be addressed as part of the improvement process. The Scottish Government will be visiting NHS Fife to introduce the reviewed Framework. An action plan has been drafted and is to be sent to the relevant groups for ratification.	

Freedom of Information Requests

We will respond to a minimum of 85% of FOI Requests within 20 working days

Local Performance





Performance by Service Area

Monthly	2020/21	2021/22										
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Health Board	93.5%	93.5%	79.2%	88.6%	58.0%	83.3%	74.5%	78.0%	84.1%	85.4%	85.7%	94.2%
IJB	100.0%	100.0%	100.0%	100.0%	100.0%	42.9%	77.8%	100.0%	87.5%	100.0%	60.0%	77.8%

KEY CHALLENGE(S) IN 2021/22

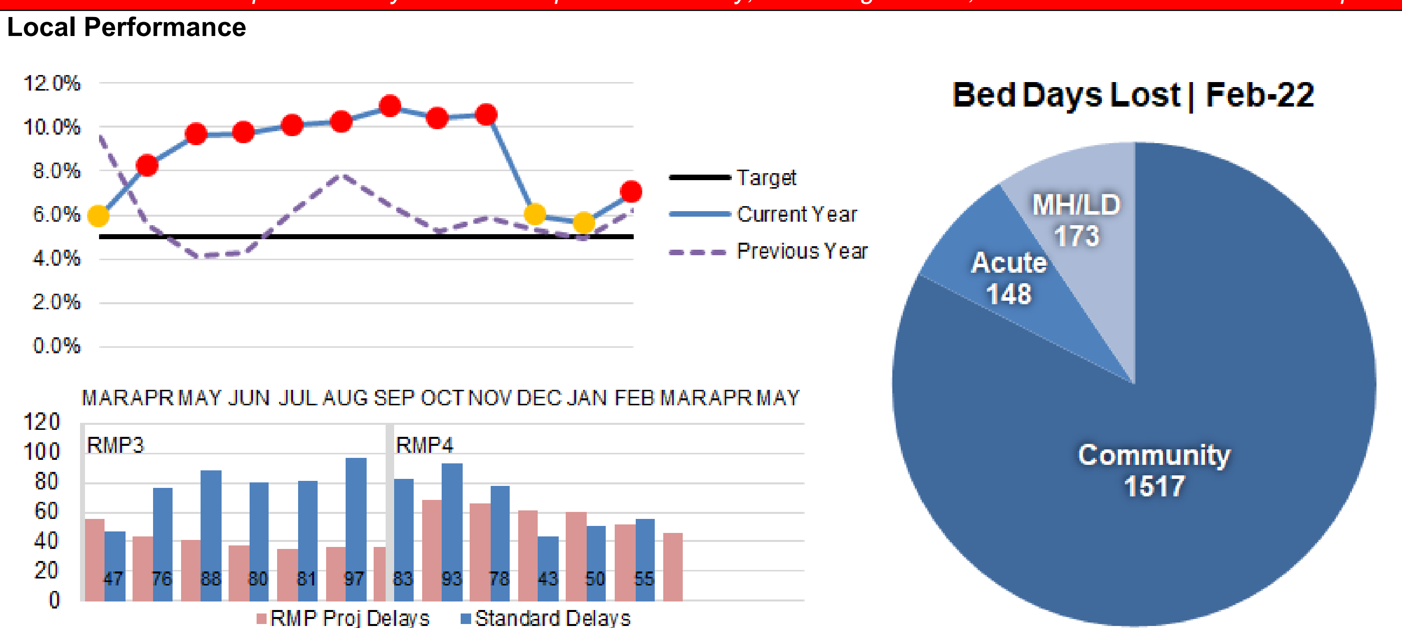
Establishment of a permanent resource level for all Information Governance and Security activities. Within the area of Freedom of Information, the temporary appointment has left the organisation and an Information Governance and Security Advisor is overseeing FOI administration. The route to a permanent post is still going through Human Resources and it is hoped that this will be ready for advertisement soon.

IMPROVEMENT ACTIONS	
21.1 Organisation-wide Publication Scheme to be introduced	**Complete Jun-21**
21.2 Improve communications relating to FOISA work	**Complete Dec-21**

Delayed Discharges (Bed Days Lost)

We will limit the hospital bed days lost due to patients in delay, excluding Code 9, to 5% of the overall beds occupied

Local Performance



National Benchmarking

Quarter Ending	2019/20			2020/21				2021/22	
	Sep	Dec	Mar	Jun	Sep	Dec	Mar	Jun	Sep
NHS Fife	8.0%	7.2%	8.3%	4.6%	6.8%	5.4%	5.7%	9.2%	10.4%
Scotland	7.2%	7.1%	7.3%	3.8%	5.1%	4.8%	4.6%	5.0%	6.7%

KEY CHALLENGE(S) IN 2021/22

- Capacity in the community – demand for complex packages of care has increased significantly
- Information sharing – H&SC workforce having access to a shared IT, for example Trak, Clinical Portal
- Workforce – Ensuring adequate and safe staffing levels to cover the additional demand to facilitate discharge from the acute setting to the community hospitals and social care provision

IMPROVEMENT ACTIONS	
21.1 Progress HomeFirst model / Develop a 'Home First' Strategy	**By Dec-22**
The Oversight "Home First" group continue to meet on a regular basis, and Project Management Office (PMO) support is in place. Seven subgroups are taking forward the operational actions to bring together the "Home First" strategy for Fife. Monthly meetings take place, and this action will continue for the remainder of 2022.	
22.1 Fully implement the "Moving On" Policy in Acute and Community Hospitals	**Complete Jul-21**
22.2 Test of Change – Trusted Assessor Model (or similar) to support more timely discharges to STAR/Assessment placements in the community	**By Sep-22**
The test of change is ongoing, however, the number of STAR beds available has been limited due to care home closures (COVID). This has resulted in a slip to the initial target completion date.	
22.3 Reduce number of delays due to awaiting the appointment of a Welfare Guardian	**Complete Mar-22**
A review of the guardianship paperwork and templates is complete, and the refreshed document has been approved by H&SC and NHS Fife (Acute). It will be held within patient notes to provide an overview and audit trail.	
22.4 Develop capacity within START plus additional investment to develop a programme of planning with the private agencies supported by Scottish Care	**Complete Mar-22**
Development of Care at Home Collaborative, supported by Scottish Care, started in late 2021, bringing together 10-12 Care at Home providers to work together, to maximise resources and capacity to help service user return to their own home, following a period in a care home interim placement. Commissioning of this resource is now complete.	
22.5 Surge capacity established to support admission demand	**Complete Mar-22**
Surge capacity has been established in QMH (Ward 3/8/8A), Glenrothes (Ward 1/2/3), Cameron (Balgonie/Balcurvie/Letham) and VHK (Ward 6/9)	

Revenue Expenditure

NHS Boards are required to work within the revenue resource limits set by the Scottish Government Health & Social Care Directorates (SGHSCD)

1. Executive Summary

At the end of February the board's reported financial position is a balanced position which is in line with the projected outturn for the financial year end. The position comprises an adverse variance for Acute Services Division of £17.433m and £2.224m for External Health Care Providers, offset by favourable variances across Corporate Functions and, of note this month, is the receipt of non recurring Scottish Government funding support of £13.7m to enable the Board to break even. Included in the Acute Services overspend is an adverse variance for Set Aside budgets of £5.8m and, as NHS Fife have current responsibility for the set aside budgets, this places additional financial pressure on the board and non-IJB health care services. The health services delegated to the Health & Social Care Partnership (H&SCP) report an underspend of £2.980m for the 11 months to February (following a non-recurring budget realignment payment made from Health Board to Fife Council of £3.734m in December).

Revenue Financial Position as at 28th February 2022

Budget Area	Annual Budget £'000	YTD Budget £'000	YTD Spend £'000	YTD Variance £'000
NHS Services (incl Set Aside)				
Clinical Services				
Acute Services Division	240,598	221,877	239,310	-17,433
IJB Non-Delegated	9,474	8,691	8,520	171
Non-Fife & Other Healthcare Providers	90,611	83,066	85,290	-2,224
Non Clinical Services				
Estates & Facilities	78,041	70,914	68,000	2,914
Board Admin & Other Services	91,789	84,474	83,129	1,345
Other				
Financial Flexibility & Allocations	30,077	15,153	0	15,153
Income	-39,132	-36,408	-36,482	74
SUB TOTAL	**501,458**	**447,767**	**447,767**	**0**
Health & Social Care Partnership				
Fife H & SCP	433,869	345,485	342,505	2,980
SUB TOTAL	**433,869**	**345,485**	**342,505**	**2,980**
TOTAL	**935,327**	**793,252**	**790,272**	**2,980**

1.2 Cost pressures within Acute Services continue to increase reflecting the exceptional demand on unscheduled care capacity and challenges with delayed discharges. The many actions being taken to manage demand pressures have increased the requirement for temporary staffing. Increasing expenditure across medicines budgets continues to add to the significant cost pressures within clinical directorates particularly with Haematology/Oncology drugs budgets and Biologics.

1.3 The financial impact of COVID-19, including direct additional costs for vaccination, testing and remobilisation plus indirect costs associated with the managing the wider impact and recovery measures continues to be regularly updated and shared through established reporting mechanisms through quarterly reporting returns. Details are contained within Appendix 1. A Scottish Government letter received in February 2022 set out details of a further tranche of Covid-19 funding available to Boards and Integrated Authorities. The available balance of funding remaining at year end, which is expected to total £34m subject to final review, will be carried forward

into 2022/23 as an earmarked Covid recovery reserve within Integration Joint Boards. Further guidance is expected on how the funding will require to be deployed in 2022/23 against key priorities in supporting Covid-19 recovery.

1.4 The February allocation letter was issued on 9 March 2022 and included ADP Task force funding of £0.409m, out of hours additional urgent support £0.168m and CSO support for Covid research infrastructure. We also received notification of further Covid funding of £64.908m on 25 February 2022 for both Health Board and HSCP additional costs. Anticipated core allocations total -£0.712m and, as is often the case as we near year end, reflects additional top slicing for services to NSD. Further allocation details are contained within Appendix 2.

1.5 At the beginning of the financial year the board was committed to delivering cost improvements in year of £8.181m which are now confirmed as delivered in full. Despite the challenges the pandemic has created in the delivery of cost improvement plans, the board has delivered savings totalling £9.618m at the end of February. Appendix 3 sets out the savings achieved including an analysis of recurring and non-recurring sources, and forms the basis of our additional monthly reporting to Scottish Government.

1.6 The overall anticipated capital budget for 2021/22 is £33.942m. The capital position for the period to February records spend of £19.233m. Therefore, 56.66% of the anticipated total capital allocation has been spent to month 11. The full capital programme is expected to deliver in full with significant activity in the final month of the year and a balanced capital position is expected.

2. Health Board Retained Services

Clinical Services financial performance at 28 February 2022

Budget Area	Annual Budget £'000	YTD Budget £'000	YTD Spend £'000	YTD Variance £'000
Acute Services Division	240,598	221,877	239,310	-17,433
IJB Non-Delegated	9,474	8,691	8,520	171
Non-Fife & Other Healthcare Providers	90,611	83,066	85,290	-2,224
Income	-39,132	-36,408	-36,482	74
SUB TOTAL	**301,551**	**277,226**	**296,638**	**-19,412**

2.1 Costs directly attributable to Covid-19 have been identified and matched with budget, on a non-recurring basis and work continues to develop the projected covid impact into the new financial year. The Quarter 3 financial return and projections included an update on the financial impact of Covid 19 and informed Scottish Government further funding allocations per 1.5 above.

2.2 The Acute Services Division reports an **overspend of £17.433m.** Acute Services are experiencing particularly challenging capacity pressures at the front door and downstream wards on top of existing historic cost pressures. Measures are underway to ease the pressures including increasing temporary over recruitment to unregistered nursing posts, admin posts and international recruitment. A significant proportion of the reported overspend to February relates to unachieved savings of £11.489m. As reported in other sections of this report, non repayable funding has been received from Scottish Government which is included within financial flexibility. The decision not to attribute to individual budget areas was made to retain focus on delivery of savings targets. The remainder of the reported overspend continues across Nursing, Senior and Junior Medical Pay budgets, non-pay pressures within Haematology/Oncology medicines budgets and growth demand on diabetic pumps. Growth in spend on Acute medicines has accelerated beyond available funding significantly and is an issue being reported across boards in Scotland. In preparation for next year, cost improvement programmes are being identified and documented which will help to close the financial gap.

2.3 The IJB Non-Delegated budget reports an **underspend of £0.171m.** This is mostly being driven by a pay underspend in the Daleview Regional Unit, resulting from occupational therapy and learning disabilities nursing vacancies.

2.4 The budget for healthcare services provided out-with NHS Fife is **overspent by £2.224m** and is broadly in line with the position reported last month. Further detail is contained in Appendix 4.

Corporate Functions and Other Financial performance at 28 February 2022

Budget Area	Annual Budget £'000	YTD Budget £'000	YTD Spend £'000	YTD Variance £'000
Non Clinical Services				
Estates & Facilities	78,041	70,914	68,000	2,914
Board Admin & Other Services	91,789	84,474	83,129	1,345
Other				
Financial Flexibility & Allocations	30,077	15,153	0	15,153
SUB TOTAL	**199,907**	**170,541**	**151,129**	**19,412**

2.5 The Estates and Facilities budgets report an **underspend of £2.914m.** This comprises an underspend in pay of £0.809m which is continuing the trend of previous months across several departments including estates services, catering, and portering. Non-pay costs continue to perform well except for property maintenance. The ongoing increases in energy prices will continue to be monitored, as will general price inflation and its resulting impact.

2.6 Within the Board's corporate services there is **an underspend of £1.345m**. The main driver for this underspend is the level of vacancies across the Finance Directorate (£0.296m), the Nursing Director budget (£0.297m), Medical Director (£0.211m) and Other (£0.351m). The latter covers areas such as legal, early retirements and injury benefits - which in the main are financial transactions.

2.7 As part of the financial planning process, expenditure uplifts including supplies, medical supplies and drugs uplifts were allocated to budget holders from the outset of the financial year as part of the respective devolved budgets. A number of residual uplifts and cost pressure/developments and new in-year allocations are held in a central budget; with allocations released on a monthly basis. The **financial flexibility of £15.153m** has been released at month 11, and includes receipt of non-repayable support received from SG. Further detail shown in Appendix 5.

3. Health & Social Care Partnership

3.1 Health services in scope for the Health and Social Care Partnership report an **underspend of £2.980m.** This underspend is net of a non-recurring payment on account of the Health Delegated in-year underspend to Social Care made in December.

Budget Area	Annual Budget £'000	YTD Budget £'000	YTD Spend £'000	YTD Variance £'000
Health & Social Care Partnership				
Fife H & SCP	433,869	345,485	342,505	2,980
SUB TOTAL	**433,869**	**345,485**	**342,505**	**2,980**

The Health and Social Care Partnership budget detailed above are Health budgets designated as in scope for HSCP integration, excluding services defined as Set Aside. The financial pressure related to 'Set Aside' services is currently held within the NHS Fife financial position. These services are currently captured within the Clinical Services areas of this report (Acute set aside £5.8m overspend to month 11 per 1.1 above).

4. Forecast

4.1 Our forecast outturn to the year end is a balanced position following receipt of non recurring funding support of £13.7m for Health Board retained services (representing our in-year deficit in our opening financial plan of £13.656m unachieved). Our forecast position assumes ADEL (Additional Departmental Expenditure Limit) funding of £0.950m re the replacement of obsolete equipment; and property and vehicle repair expenditure which we expect to receive in our final allocation letter this year.

4.2 The Health delegated underspend position is forecast at £3.748m following the non-recurring budget realignment transfer of £3.734m to Fife Council in December. It is anticipated the final year end underspend will be transferred as a non-recurring payment later in March. The H&SCP projected year end position is an underspend of c£0.573m as confirmed by the Chief Finance Officer following the roll out of the recovery plan and receipt of further funding.

4.3 Whilst details of funds held within Delegated Health Earmarked Reserves (created last financial year) are noted at Appendix 6; work is ongoing to finalise an additional significant Health Delegated earmarked reserve for the current financial year.

4.4 The projected NHS Fife forecast does not include any risk share with the Health and Social Care Partnership given Integration Authorities will also be provided with Scottish Government support to a balanced position. A cash transfer has been actioned in December from Health to Council to allow both organisations to report a balanced position; with a further transfer planned towards the end of the financial year.

5. Recommendation

5.1 Members are invited to approach the Director of Finance and Strategy for any points of clarity on the position reported and are asked to:

- **Note** the reported core breakeven position for the 11 months to date for Health Board retained;
- **Note** the forecast balanced position for Health Board retained, following non recurring, non repayable funding SG funding support;
- **Note** the Health delegated forecast core underspend position (net of a cash transfer made to Fife Council of £3.7m in December) of a further £3.7m which will be transferred to Fife Council as we approach the financial year end.

Appendix 1: Covid-19 Funding

COVID funding	Health Board	Health delegated	Social Care delegated	Total	Capital
	£000's	£000's	£000's	£000's	£000's
Allocations Q1	8,702	2,878		11,580	
Allocations Q2	6,815	6,831	192	13,838	
Final allocation in January	20,947	9,945		30,892	
HSCP ear marked reserve		3,399		3,399	
Additional		34,017		34,017	
Total funding	**36,464**	**57,070**	**192**	**93,726**	**0**
Allocations made for April to February					
Planned Care & Surgery	1,393			1,393	
Emergency Care & Medicine	8,144			8,144	
Women, Children & Clinical Services	2,838			2,838	
Acute Nursing	0			0	
Estates & Facilities	1,321			1,321	
Board Admin & Other Services	1,860			1,860	
Public Health Scale Up	957			957	
Test and Protect	4,881			4,881	
Primary Care & Prevention Serv		635		635	
Community Care Services		1,672		1,672	
Complex & Critical Care Serv		286		286	
Professional/Business Enabling		182		182	
Covid Vaccine/Flu		11,640		11,640	
Social Care			192	192	
Non-repayable support	13,656				
Exclude additional		34,017			
Total allocations made to M11	**35,050**	**48,432**	**192**	**36,001**	**0**
Balance In Reserves	**1,414**	**8,638**	**0**	**57,725**	**0**
Remaining funding c/fwd to 2022/23	**34,017**				

Appendix 2: Revenue Resource Limit

		Baseline Recurring £'000	Earmarked Recurring £'000	Non-Recurring £'000	Total £'000	Narrative
	Initial Baseline Allocation	712,534			712,534	
	June Letter	9,264	12,244	20,964	42,472	
	July Letter			8,002	8,002	
	August Letter	141	230	1,522	1,893	
	September Letter	-135	59,994	-1,931	57,928	
	October Letter		3,390	14,908	18,298	
	November Letter	2,042	1,704	4,333	8,079	
	December letter		23	3,126	3,149	
	January Letter reported at month 10	-178	6,274	2,995	9,091	
25 Feb 2022	Amendment to January letter					
	PPE			130	130	As per SG Correspondence
	Further Covid Funding 2021-22			61,147	61,147	As per SG Correspondence
	Covid & Extended Flu Vaccinations			3,979	3,979	As per SG Correspondence
	Test & Protect			-347	-347	As per SG Correspondence
Letter 9 March 2022	Task Force Funding to ADPs			409	409	As per SG Correspondence
	Distinction Awards for NHS Consultants		139		139	Annual Allocation
	CSO support for Covid research infrastructure			60	60	Additional Allocation
	Improvements to forensic medical services			2	2	Additional Allocation to previous allocation
	Afghan refugee healthcare provision			62	62	As per specific allocation letter
	Audiology Equipment			12	12	Specific Allocation
	Remote blood pressure monitoring (InHealthCare)			15	15	Specific Allocation
	Out of Hours additional Urgent Support 2021-22			168	168	As per specific allocation letter
	ScotSTAR Topslice	-345			-345	Annual Adjustment
	Purchase of audiology equipment			5	5	Specific Allocation
	GJNH - Top slice adjustment - Boards			-11	-11	Annual Adjustment
	National Distribution Centre - Top-slice		-780		-780	Annual Adjustment
	Total Core RRL Allocations	**723,323**	**83,218**	**119,550**	**926,091**	
Anticipated	Capital to Revenue			277	277	
Anticipated	NSD Adjustments		-989		-989	
		0	**-989**	**277**	**-712**	
Anticipated	IFRS			8,900	**8,900**	
Anticipated	Donated Asset Depreciation			115	**115**	
Anticipated	Impairment			1,333	**1,333**	
Anticipated	AME Provisions			-400	**-400**	
	Total Anticipated Non-Core RRL Allocations	**0**	**0**	**9,948**	**9,948**	
	Grand Total	**723,323**	**82,229**	**129,775**	**935,327**	

Appendix 3: Savings Position at 28 February 2022

Total Savings	Total Savings Target £'000	Forecast Achievement (Core) £'000	Forecast unmet savings (Covid-19) £'000	Identified & Achieved Recurring £'000	Identified & Achieved Non-Recurring £'000	Identified & Achieved to February £'000	Unachieved to March £'000
Health Board	21,837	8,181	13,656	5,779	3,839	9,618	0
					0		0
Total Savings	**21,837**	**8,181**	**13,656**	**5,779**	**3,839**	**9,618**	**0**

NHS Fife Potential Savings Summary	£000's	Risk level		Identified CY	Outstanding Balance		Identified FY	Outstanding Balance
Workforce Capacity and Utilisation Review	1,000	High		-607	393		-41	959
Pay Vacancy Factor (1%)	3,015	Medium		-3,015	0		-3,015	0
Repatriation of Services	500	Low		-500	0		-500	0
External Commissioning Cost Review	1,000	Medium		-1,000	0		-1,000	0
Medicine Utilisation	500	Medium		-640	-140		-595	-95
Contracts	1,500	Low		-284	1,216		0	1,500
Procurement - Non pay	500	Medium		0	500		0	500
Other	166	Low		-3,572	-3,406		-628	-462
	8,181			**-9,618**	**-1,437**		**-5,779**	**2,402**

Appendix 4: Service Agreements

	CY Budget £'000	YTD Budget £'000	YTD Actuals £'000	YTD Variance £'000
Health Board				
Ayrshire & Arran	99	91	88	3
Borders	45	42	52	-10
Dumfries & Galloway	25	23	52	-29
Forth Valley	3,227	2,958	3,365	-407
Grampian	365	334	259	75
Greater Glasgow & Clyde	1,680	1,540	1,534	6
Highland	137	126	187	-61
Lanarkshire	117	107	198	-91
Lothian	31,991	29,327	30,859	-1,532
Scottish Ambulance Service	103	94	92	2
Tayside	40,084	36,741	38,167	-1,426
Savings				0
	77,873	**71,383**	**74,853**	**-3,470**
UNPACS				
Health Boards	10,801	9,900	8,679	1,221
Private Sector	1,151	1,057	1,293	-236
	11,952	**10,957**	**9,972**	**985**
OATS	721	661	400	261
Grants	65	65	65	0
Total	**90,611**	**83,066**	**85,290**	**-2,224**

Appendix 5: Financial Flexibility & Allocations

	£'000	Flexibility Released to Feb-22 £'000
Financial Plan		
Junior Doctor Travel	17	14
Consultant Increments	232	213
Cost Pressures	3,656	2,035
Developments	2,054	1,240
Sub Total Financial Plan	**5,959**	**3,502**
Allocations		
Waiting List	1,300	0
AME: Impairment	73	0
AME: Provisions	126	0
Pay Award:AfC	1,664	1,522
Test & Protect	784	0
Covid General	629	0
Winter	661	0
Cancer Waiting Time	225	92
Distinction Award	3	3
Unscheduled Care Summer	180	0
Support to build recruitment capacity	27	0
Building Capacity for international recruitment	11	0
Young Patients Family Fund	38	29
Emergency Cancer Diagnostic Centre	196	0
Pregnancy Anaemia Management	28	0
Workforce Wellbeing	200	0
Discharge Without Delay Pathfinders	256	0
Interface Care Programme	480	0
Nurse Director Support	403	0
Fleet Decarbonisation	54	0
R&D	12	11
2020/21 Surplus	340	312
Chronic Pain	9	0
Additional CT & MRI Capacity	44	0
Mental Health Pharmacy recruitment	64	0
Additional Band 2-4	845	0
Capital to Revenue	355	0
International Recruitment	378	0
Diabetic Technologies	999	0
Audiology Equipmet	18	0
Funding Support	13,656	9,682
CSO Covid Research	60	0
Sub Total Allocations	**24,118**	**11,651**
Total	**30,077**	**15,153**

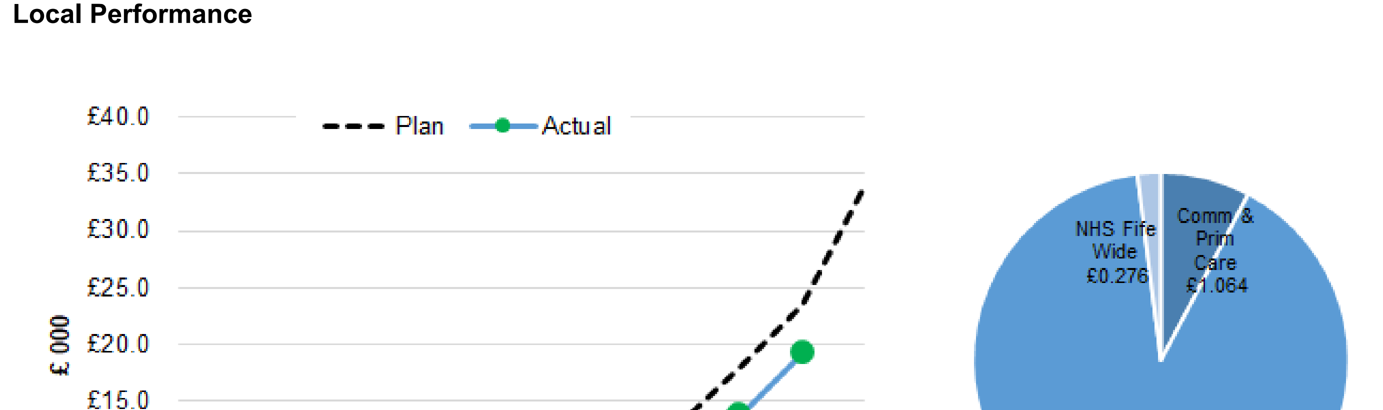
Appendix 6: Anticipated Funding from Health Delegated Earmarked Reserve

Health Delegated Earmarked Reserve	Total £000's	Health Delegated Budgets To M11 £000's	Health Delegated Budgets Anticipated £000's	Balance £000's
Vaccine	740	740		0
Care homes	526	82		444
Urgent Care Redesign	935	408		527
Flu	203	203	0	0
Primary Care Improvement Fund	2,524	1,011		1,513
Action 15	1,315	505		810
RT Funding	1,500			1,500
FSL	500	500		0
District Nurses	30			30
Fluenz	18			18
Core run rate	1,767	1,206	0	561
Core (covid offsets)	1,250	1,250		0
Total	**11,308**	**5,905**	**0**	**5,403**

Capital Expenditure

NHS Boards are required to work within the capital resource limits set by the Scottish Government Health & Social Care Directorates (SGHSCD)

Local Performance



Commentary

The overall anticipated capital budget for 2021/22 is £33.942m. The capital position for the period to January records spend of £19.233m. Therefore, 56.66% of the anticipated total capital allocation has been spent to month 11; with significant activity underway in the final month of the year which will inform a balanced capital position.

1. Annual Operational Plan

The capital plan for 2021/22 was approved by the FP&R Committee in July and was subsequently tabled at the NHS Fife Board. NHS Fife has assumed a programme of £33.942m detailed in the table below.

Capital Plan	£'000
Initial Capital Allocation	7,394
National Equipping Funding	1,537
Elective Orthopaedic Centre	15,907
Mental Health Review	22
Lochgelly Health Centre	348
Kincardine Health Centre	207
Energy Scheme Funding	1,457
Pre Capital Fund Grant	50
Covid Capital	1,878
QMH Theatre	1,000
CT Scanner	700
Louisa Jordan Equipment	22
Laundry Equipment	655
2nd Tranche NIB Equipment	1,176
National Eyecare Workstream	228
Capital to Revenue Transfer	- 277
SG Extra Funding Request	591
Decontamination Room	350
Colposcope	12
Extra National Eyecare Workstream	51
Audiology Equipment	97
Additional Equipment Funding	136
Decontamination Equipment	241
Additional Equipment Funding PH2	160
Total	**33,942**

There has been a reduction in the expected funding to be allocated for the Energy Grant this year. Originally, expenditure was planned to be £1.8m, however, this has now been reduced to £1.457m, and the remaining balance of £0.343m will be provided for next financial year.

Despite being a challenging year in terms of supply chain issues, availability of materials and price increases on materials the capital plan and achievement of the capital resource limit remains on target.

Capital Receipts

1.1 Work continues into the new financial year on asset sales re disposals:

- Lynebank Hospital Land (Plot 1) (North) – discussions are ongoing as to whether to remarket, there are also discussions ongoing around the potential possibility of HFS constructing a new sterilising unit for East Scotland on the site.
- Skeith Land – an offer has been accepted subject to conditions for planning and access - however the GP's have now put in an objection to the planning department. The Developers have provided other plans in order to move forward, however, the GP's are still objecting.

2. Expenditure / Major Scheme Progress

2.1 The summary expenditure position across all projects is set out in the dashboard summary above. The expenditure to date amounts to £19.233m, this equates to 56.66% of the total capital allocation, as illustrated in the spend profile graph above.

2.2 The main areas of spend to date include:

Statutory Compliance	£3.851m
Equipment	£3.241m
Digital	£0.343m
Elective Orthopaedic Centre	£10.658m
Health Centres	£0.424m
Clinical Prioritisation	£0.711m

3. Recommendation

3.1 Members are invited to approach the Director of Finance and Strategy for any points of clarity on the position reported and are asked to:

note the capital expenditure position to 28 Febuary 2022 of £19.233m and the year-end spend of the total anticipated capital resource allocation of £33.942m.

Appendix 1: Capital Expenditure Breakdown

Project	CRL Confirmed Funding £'000	Total Expenditure to Date £'000	Projected Expenditure 2021/22 £'000
COMMUNITY & PRIMARY CARE			
Clinical Prioritisation	218	158	218
Statutory Compliance	364	303	364
Capital Equipment	151	147	151
Condemned Equipment	23	23	23
National Infrastructure Equipment Funding	6	0	6
Kincardine Health Centre	207	173	207
Lochgelly Health Centre	348	250	348
Decontamination Room	350	0	350
Total Community & Primary Care	1,666	1,055	1,666
ACUTE SERVICES DIVISION			
Statutory Compliance	2,953	2,301	2,953
Capital Equipment	1,981	1,639	1,981
Clinical Prioritisation	763	292	763
Condemned Equipment	88	63	88
National Infrastructure Equipment Funding	3,407	1,288	3,407
Elective Orthopaedic Centre	15,907	10,658	15,907
Laundry Equipment	655	0	655
National Eyecare Workstream	279	0	279
Colposcope	12	0	12
QMH Theatre	1,000	242	1,000
Extra SG Funding Request	591	82	591
Audiology Equipment	97	0	97
Total Acute Services Division	27,734	16,565	27,734
NHS FIFE WIDE SCHEMES			
Equipment Balance	3	0	3
Information Technology	1,200	343	1,200
Clinical Prioritisation	0	0	0
Statutory Compliance	0	0	0
Condemned Equipment	1	0	1
Fire Safety	60	60	60
Scheme Development	0	0	0
Vehicles	142	0	142
Covid Capital	1,325	260	1,325
Mental Health Review	22	5	22
Total NHS Fife Wide Schemes	2,753	667	2,753
TOTAL CAPITAL ALLOCATION FOR 2021/22	**32,154**	**18,288**	**32,154**

Project	CRL Confirmed Funding £'000	Total Expenditure to Date £'000	Projected Expenditure 2021/22 £'000
ANTICIPATED ALLOCATIONS 2021/22			
Energy Funding Grant	1,457	945	1,457
Pre Capital Grant Funding	50	0	50
ECG Machines - Louisa Jordan Equipment	22	0	22
Capital to Revenue Transfer	-277	0	-277
Additional Equipment Funding	136	0	136
Decontamination Equipment	241	0	241
Additional Equipment Funding PH2	160	0	160
Anticipated Allocations for 2021/22	**1,788**	**945**	**1,789**
Total Anticipated Allocation for 2021/22	**33,942**	**19,233**	**33,942**

Appendix 2: Capital Plan - Changes to Planned Expenditure

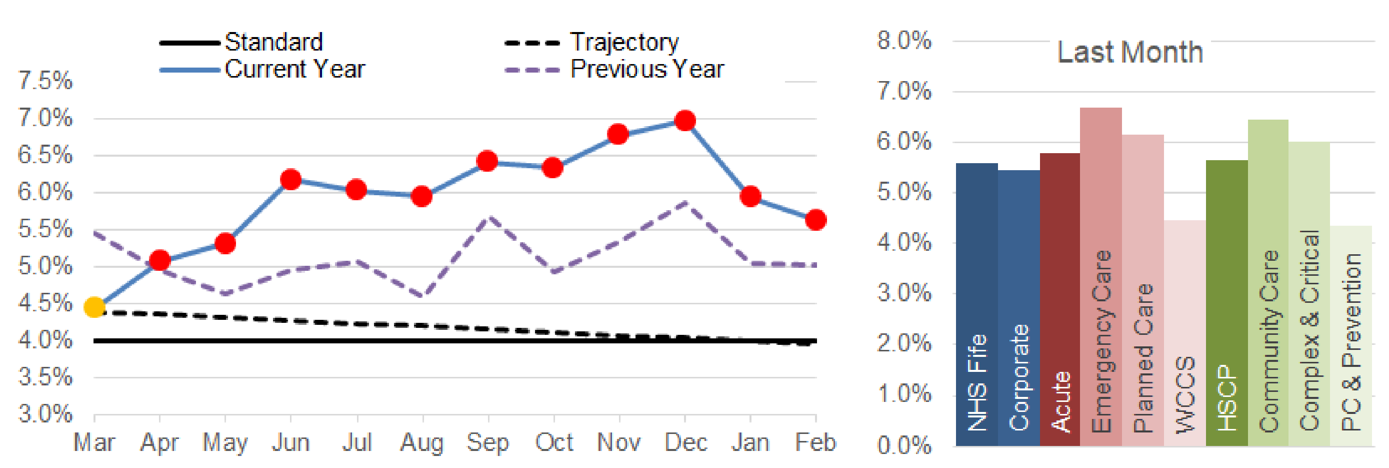
Capital Expenditure Proposals 2021/22 Routine Expenditure	Pending Board Approval £'000	Cumulative Adjustment to January £'000	February Adjustment £'000	Total February £'000
Community & Primary Care				
Capital Equipment	0	151	0	151
Condemned Equipment	0	24	-1	23
Clinical Prioritisation	0	252	-34	218
Statutory Compliance	0	329	35	364
Lochgelly Health Centre	0	0	207	207
Kincardine Health Centre	0	0	348	348
National Infrastructure Equipment Funding	0	6	0	6
Decontamination Room	0	0	350	350
Total Community & Primary Care	**0**	**762**	**905**	**1,666**
Acute Services Division				
Capital Equipment	0	1,971	10	1,981
Condemned Equipment	0	88	0	88
Clinical Prioritisation	0	727	36	763
Statutory Compliance	0	2,945	8	2,953
National Infrastructure Equipment Funding	0	3,407	0	3,407
Elective Orthopaedic Centre	0	15,907	0	15,907
National Eyecare Workstream	0	228	51	279
Laundry Support	0	600	55	655
Colposcope	0	0	12	12
Audiology Equipment	0	0	97	97
Extra SG Funding Request	0	0	591	591
QMH Theatre	0	0	1,000	1,000
	0	**25,874**	**1,860**	**27,734**
Fife Wide				
Backlog Maintenance / Statutory Compliance	3,500	-3,476	-43	-18
Fife Wide Equipment	1,805	-1,792	-10	3
Digital & Information	1,000	200	0	1,200
Clinical Prioritisation	500	-480	-2	18
Condemned Equipment	90	-90	1	1
Fife Wide Asbestos Management	0	0	0	0
Fife Wide Fire Safety	0	60	0	60
General Reserve Equipment	94	-94	0	0
Pharmacy Equipment	205	-205	0	0
Fife Wide Vehicles	0	142	0	142
Covid Capital	0	1,325	0	1,325
Mental Health Review	0	0	22	22
Total Fife Wide	**7,194**	**-4,409**	**-31**	**2,753**
Total Capital Resource 2021/22	**7,194**	**22,226**	**2,733**	**32,153**

ANTICIPATED ALLOCATIONS 2021/22				
Energy Funding Grant	1,457	0	0	1,457
Pre Capital Grant Funding	50	0	0	50
ECG Machines - Louisa Jordan Equipment	22	0	0	22
Capital to Revenue Transfer	-277	0	0	-277
Additional Equipment Funding	136	0	0	136
Decontamination Equipment	241	0	0	241
Additional Equipment Funding PH2	160	0	0	160
Anticipated Allocations for 2021/22	**1,788**	**0**	**0**	**1,788**
Total Planned Expenditure for 2021/22	**8,982**	**22,226**	**2,733**	**33,942**

Sickness Absence

*To achieve a sickness absence rate of 4% or less (Improvement Target for 2021/22 = **3.89%**)*

Local Performance



National Benchmarking

Month	2020/21	2021/22										
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
NHS Fife	4.43%	5.07%	5.31%	6.17%	6.03%	5.95%	6.42%	6.34%	6.79%	6.98%	5.93%	5.63%
Scotland	4.56%	4.59%	5.04%	5.52%	5.62%	5.76%	6.12%	6.30%	6.37%	6.23%	5.37%	4.96%

KEY CHALLENGE(S) IN 2021/22

To secure an ongoing reduction in the current levels of sickness absence performance, as services remobilise, working towards the third-year trajectory for the Board of 3.89% in with NHS Circular PCS (AfC) 2019/2

IMPROVEMENT ACTIONS

22.1 Work towards improvement in long term sickness absence relating to mental health, using Occupational Health and other support services and interventions — **By Mar-23**

The additional OH Physician is providing specific support for staff affected by Mental Health and training is available for managers. This is in addition to the individual case work being progressed by local managers and HR staff, with input when necessary from the specialist OH Mental Health Nurse. The new OH Occupational Therapist is providing support to staff resuming work following diagnoses of long COVID, and this will continue into 2022/2023.

Additional staff support is being provided via a variety of services and initiatives, alongside the introduction of new eLearning Modules on resilience and wellbeing and access to the National PROMiS resources. This is complemented by a range of supporting materials, including a new “Benefits of Being Outdoors” poster and desktop campaign.

Additional monies to support staff during the winter months have been allocated and include improved access to meals out of hours, additional resources for Spiritual Care, Values Based Reflective practice, Psychology Staff support and Health Psychology, alongside bespoke wellbeing sessions for specific staff groups (e.g. H&S, ICU).

On line Fuel Poverty sessions took place in March, with additional on site sessions being arranged for April. Plans have been completed in terms of the use of the extra Scottish Government funding allocation for Staff Health and Wellbeing with a range of staff support activities during 2022/2023.

22.2 Continue existing managerial actions in support of achieving the trajectory for the Board and the national standard of 4% for sickness absence — **By Mar-23**

In addition to routine activities, a questionnaire is being circulated to managers in advance of the Promoting Attendance training sessions to identify areas for provision of support, both within and outwith the training sessions. The new Once for Scotland eLearning module is being promoted to complement our internal training and to assist managers and staff with their understanding of the policy.

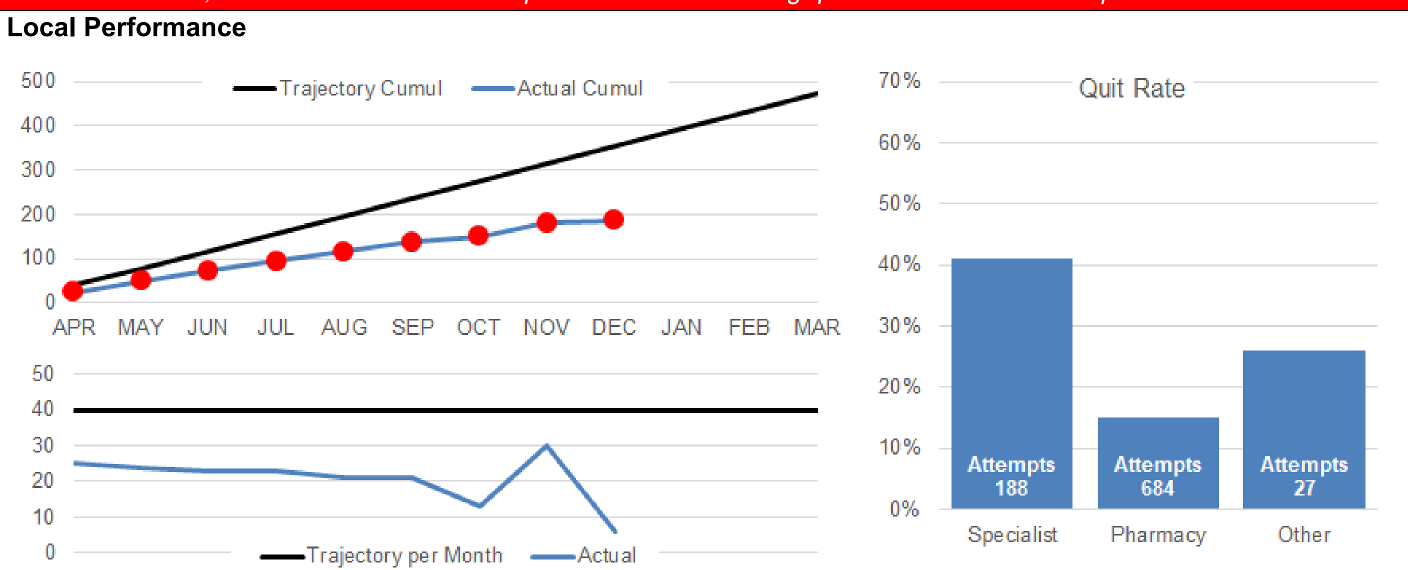
Feedback received following a programme to reinforce attendance management processes undertaken between May and July 2021 was discussed in partnership at the Attendance Management Workforce Review Group held in December, with a series of actions being progressed by key stakeholders. Promoting attendance at work is a regular agenda item at LPF and APF meetings ensuring regular discussion and suggestions/actions for consideration.

22.3 Consider refinements to COVID-19 absence reporting, including short-term manual data capture from SSTS and eESS in preparation for any change to self-isolation guidance and to support ongoing workforce resourcing actions, acknowledging that systems development is required to support MI reporting — **Complete Nov-21**

Smoking Cessation

In 2021/22, deliver a minimum of 473 post 12 weeks smoking quits in the 40% most deprived areas of Fife

Local Performance



National Benchmarking

		2021/22											
		APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
NHS Fife	Actual	25	24	23	23	21	21	13	30	6			
	Actual Cumul	25	49	72	95	116	137	150	180	186			
	Trajectory Cumul	40	79	118	158	197	236	276	315	354	394	434	473
	Achieved	62.5%	62.0%	61.0%	60.1%	58.9%	58.1%	54.3%	57.1%	52.5%			
Scotland	Achieved			92.4%			82.0%						

KEY CHALLENGE(S) IN 2021/22

- Remobilising face to face delivery in a variety of settings due to venue availability and capacity
- Moving from remote delivery to face to face provision, patients having confidence in returning to a medical setting
- Potential for slower recovery for services as they may require to rebuild trust in the brand
- Re-establishment of outreach work

IMPROVEMENT ACTIONS	
20.2 Test Champix prescribing at point of contact within hospital respiratory clinic	**Complete Oct-21**
20.3 'Better Beginnings' class for pregnant women	**Complete Oct-21**
20.4 Enable staff access to medication whilst at work	**Closed Mar-22**
This action has been paused due to the pandemic, but may be revisited in FY 2022/23. Action closed at this stage.	
21.1 Assess use of Near Me to train staff	**Complete Jul-21**
21.2 Support Colorectal Urology Prehabilitation Test of Change Initiative	**Complete Sep-21**
22.1 Test face to face provision in two GP practices and one community venue	**Complete Mar-22**

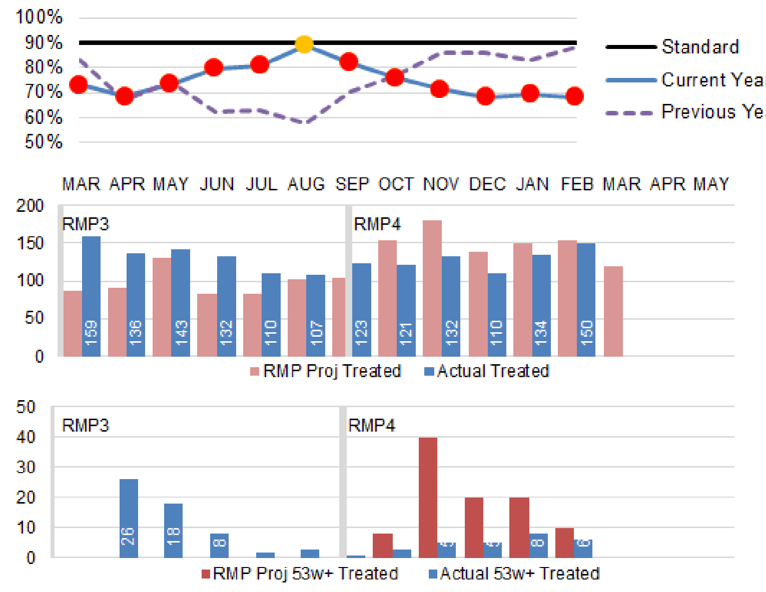
Assess and engage with two GP practices and one community venue to re-establish face to face provision in the most deprived communities. Risk assessments, PPE, equipment and patient flow to be considered and included in plans.

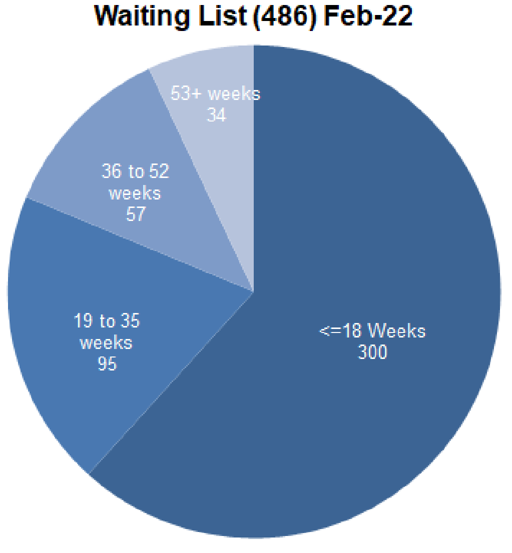
Early discussions with 2 GP practices were due to restart in the second week of January, while the remobilisation plan was scheduled to go to the remobilisation committee on 9th December. However, both activities were paused due to the impact of the COVID Omicron strain. Ongoing discussions with GP practices have taken place, and we have an agreed start date of week beginning 2nd April.

CAMHS 18 weeks RTT

At least 90% of clients will wait no longer than 18 weeks from referral to treatment

Local Performance





National Benchmarking

Month	2020/21	2021/22										
	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB
NHS Fife	73.0%	68.4%	73.4%	79.5%	80.9%	88.8%	82.1%	76.0%	71.2%	68.2%	69.4%	68.0%
Scotland	67.5%	71.3%	71.8%	74.8%	75.9%	77.4%	82.1%	71.5%	70.5%	68.9%		

KEY CHALLENGE(S) IN 2021/22

- Implementation of additional resources to meet demand; development of workforce to meet National CAMHS Service Specification
- COVID-19: relaxation on referrals and delivery of 'models' to reflect social distancing

IMPROVEMENT ACTIONS

21.1 Re-design of Group Therapy Programme	Complete Jul-21
21.3 Build CAMHS Urgent Response Team (CURT)	**By Jun-22**

The CURT model is in place. Responsiveness to A&E and Paediatric inpatient unit has been extended with same day assessments available if young people are considered fit for assessment. Presentations to Emergency department due to self harm/suicidal ideation remain high with a 180% increase through 2022. Recruitment is underway to increase the existing CURT staffing capacity from 2.8 wte to 6.6 wte to address the increasing referral trend for urgent presentations. Review of activity and effectiveness of the model is ongoing utilising improvement methodology.

22.1 Recruitment of Additional Workforce	By Jun-22

Recruitment is ongoing across multiple service areas to improve RTT, Longest waits and CAMHS service provision. From the 12 staff identified to address immediate capacity issues, 9 have been appointed with remaining posts re-advertised at lower banding to improve uptake. All new staff have worked through induction programme to ensure they are competent to take on caseloads and are incrementally increasing clinical activity towards full capacity. This is balanced against staff departures and retirements which have created 6 additional posts for recruitment.

Phase 1 and Phase 2 recruitment as part of the SG Recovery & Renewal fund is underway. Currently Fife CAMHS has 21 wte posts either out to recruitment or in development with additional roles in admin (5.0 wte) and AHP (3.0 wte) working through the recruitment process.

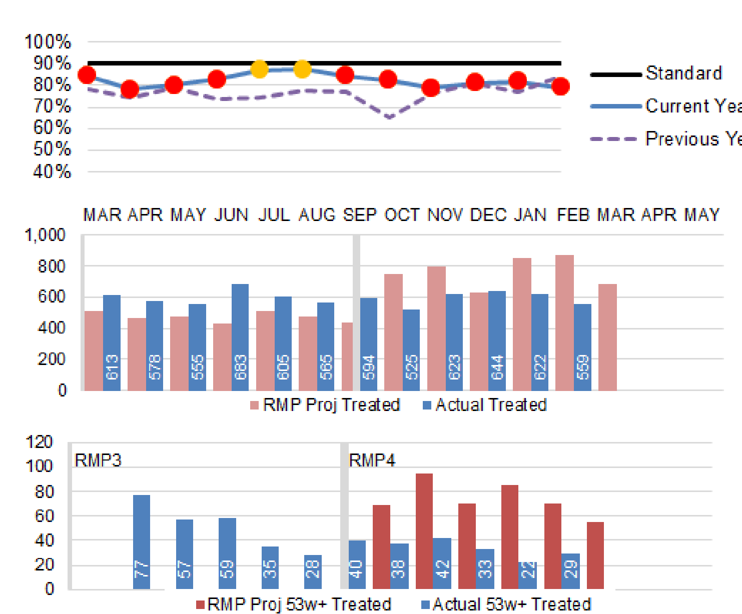
22.2 Workforce Development	Complete Mar-22

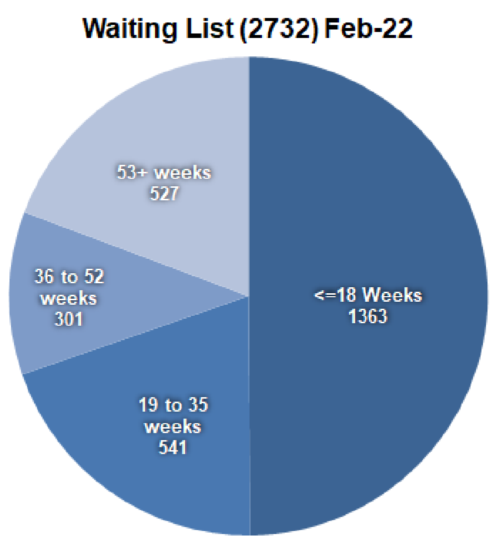
A revised development and training programme, which was originally postponed in January due to high Covid-19 absences, is now underway. Three Programmes have been developed to suit different levels of CAMHS experience. A Training needs analysis has been completed to ensure the right skills and competencies exist across the range of teams in CAMHS.

Psychological Therapies 18 weeks RTT

At least 90% of clients will wait no longer than 18 weeks from referral to treatment

Local Performance





National Benchmarking

Month	2020/21	2021/22										
	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB
NHS Fife	84.3%	78.2%	80.0%	82.6%	86.9%	87.4%	84.5%	82.3%	78.8%	81.1%	81.8%	79.2%
Scotland	80.9%	81.3%	82.5%	84.3%	88.5%	87.0%	86.1%	85.5%	83.0%	85.1%		

KEY CHALLENGE(S) IN 2021/22

- Recruitment of staff required to achieve waiting times standard at a time of national workforce pressures
- Progressing vision for PTs within the timeframe required to sustain improved performance

IMPROVEMENT ACTIONS

Action	Status
20.5 Trial of new group-based PT options	**Complete Sep-21**
22.1 Increase access via Guided self-help service	**Complete Sep-21**
22.2 Expansion of skill mix model to increase delivery of low intensity interventions	**Complete Jan-22**
22.3 Recruit new staff as per Psychological Therapies Recovery Plan	**By Jun-22**

There remain significant national issues with workforce availability for staff who can provide highly specialised PTs - required to address our WL backlog. The service has been successful in recruiting other grades of staff to increase delivery of PTs for people with less complex problems and free some capacity amongst staff qualified to work with the more complex presentations. The NHS Education for Scotland national recruitment campaign has been less successful than hoped but we do have some applicants for highly specialist posts, with interview dates for end of April. However, we shall not be able to recruit to all of the posts that were identified as required within the PT Recovery Plan.

Action	Status
22.4 Waiting list management within General Medical Service in Clinical Health	**By May-22**

Staff are undertaking a focused piece of work to clear the backlog on the assessment waiting list. A key driver is the need to differentiate patients with functional neurological disorder from those with other needs in order to inform development of appropriate clinical pathways. The work will ensure that only those for whom psychological therapy is the best option remain on the waiting list. It will also inform next steps in development of clinical pathways.

Action	Status
22.5 Programme of training to increase capacity for work with more complex patients	**Complete Mar-22**

The AMH psychology service have implemented a structured programme of training and supervision to increase the skills of the Clinical Associates in Applied Psychology. This will reduce the demand upon the Clinical Psychologists in the service who are able to work with people with more complex presentations.

Meeting:	**Public Health & Wellbeing Committee**
Meeting date:	**16 May 2022**
Title:	**Test and Protect Update**
Responsible Executive:	**Joy Tomlinson, Director of Public Health**
Report Author:	**Clare Campbell, Public Health Intelligence Manager; Sharon Crabb, Public Health Service Manager**

1 Purpose

This is presented to the Public Health & Wellbeing Committee for:
- Assurance

This report relates to a:
- Emerging issue
- Government policy/directive

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

2 Report summary

2.1 Situation

This overview report has been provided to inform committee members of the ongoing delivery and future direction of testing and contact tracing for COVID-19 across Fife.

Although Test & Protect was previously expected to substantially continue until September 2022, a more rapid transition has been agreed at policy level for local implementation.

Asymptomatic testing for most people ended on the 17th April. From this date LFD tests were no longer able to be undertaken at, or distributed from, tests sites across Fife. LFD testing continues to be available for specific groups; through health and social care staff testing programmes and through the UK Government for home delivery for certain circumstances including visiting a hospital or a care home or ending self-isolation early.
Symptomatic PCR testing ended on the 30th April.

From the 1st May all fixed and mobile testing sites in Fife are closed, and contact tracing stopped.

2.2 Background

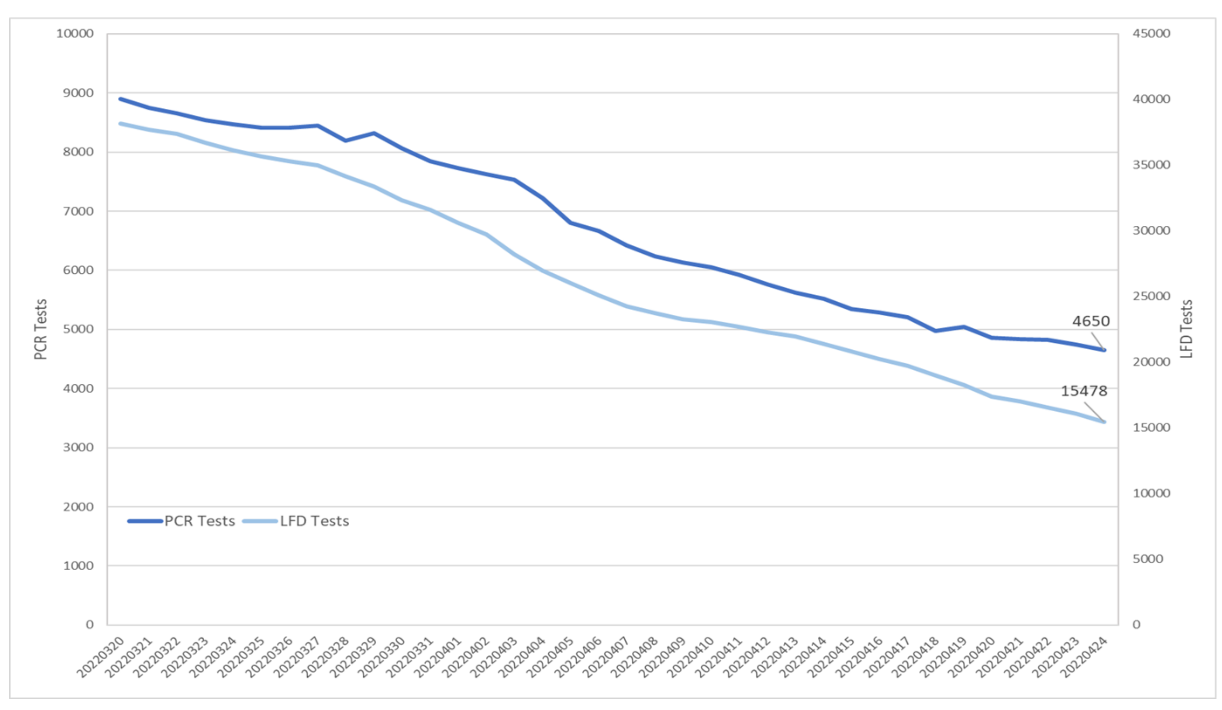
Updates to national Covid-19 strategic frameworks made in February and March by the UK and Scottish Governments have had an impact on the demand for PCR and LFD testing. The implications of, and actions arising from, the Test and Protect Transition Plan for Scotland for testing and contact tracing in Fife continue to be progressed. Further guidance is expected on the future of COVID-19 testing and the reporting of COVID-19 cases.

2.3 Assessment

Demand for PCR testing has fallen since the middle of March. In the seven days up to and including the 20th March a 7-day total of 8,903 PCR tests were undertaken by Fife residents has fallen to 4,650 on the 24th April.

A steeper fall has been observed in the reporting of LFD results with a 7-day total of 38,159 results recorded on the 20th March falling to 15,478 on the 24th April.

Chart 1: Fife Resident PCR and LFD Test Results; 7-day rolling total number
20th March to 24th April 2022



[1]https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/coronaviruscovid19infectionsurveypilot/22april2022 Source: PHS

Reported Covid-19 positive cases in Fife are decreasing. In the seven days up to and including the 28th March there were 4,708 positive cases compared with the 7-day total on the 24th April of 1,638 positive cases.

ONS estimates of Covid-19 infection prevalence have reduced across Scotland in the last four weeks, with an estimated 1 in 19 people having COVID-19 in the week ending 16th April.[1]

2.3.1 Quality/ Patient Care

Test & Protect has provided protection for the population and vulnerable settings which has reduced the risk of transmission from COVID 19 in our communities, and protected the most vulnerable groups. This has benefitted individuals from avoidance of illness and benefitted healthcare services. Symptomatic PCR testing continues for priority groups, those residing in Care homes through whole home testing and areas of essential workers e.g. Health and Social Care. PCR testing also continues meantime for pre-assessment and pre-operative patients. PCR testing of the general population ceased on 30/04/2022.

A contact tracing transitional workforce has been initiated for the month of May in order to support the Health Protection Team to provide covid-related advice to partners in high-risk settings.

Review of internal processes is via the Test & Protect Oversight Group, working in alignment with national guidelines and expectations.

2.3.2 Workforce

NHS Fife Test & Protect workforces include a Contact Tracing team, a Community Asymptomatic Testing team, and a small Community Testing Team for healthcare and care home staff and patient/resident testing.

	Contact Tracing	Team	
	Secondees / redeployment	Fixed Term <2yrs NHS Service	Fixed Term >2 yrs NHS Service
Band 5	21	37	6
Band 6	6	4	1
Band 7	1	0	0

	Asymptomatic	Testing Team
	Secondees	Fixed Term
Band 2	3	58
Band 4	0	1
Band 6	3	6
Band 7	1	0

	Symptomatic	Testing Team
	Secondees	Fixed Term
Band 2	1	13
Band 5	0	1
Band 6	1	0

Contractual cohort meetings are being hosted with representation from HR and Staff Side to provide staff assurance in local policy and processes. 1:1 meetings have been arranged where appropriate.

Transition and change support sessions have been offered to the Test & Protect workforce during this turbulent time and be delivered though staff wellbeing initiatives funded by Fife Health Charity.

In alignment with the guiding principles, seconded staff have commenced transition conversations with substantive line managers and making plans to return to substantive posts.

Asymptomatic Testing Team 4-week dismissal notice letter was issued on 16th April 2022. Redeployment process and opportunities are being explored for this workforce, working in collaboration with various departments within the organisation, Fife Council and Fife Social Care Partnership.

Temporary Public Health representation on redeployment meetings captures the live situation and helps to distribute information at pace. This process will not disadvantage staff already on the redeployment register.

A contact tracing transitional workforce has been initiated for May 2022 to build resilience around our management of Covid-19 in supported areas. This workforce is made up of staff on fixed term contracts with >2yrs continuous NHS service.

Interim working opportunities are being explored to provide meaningful work to staff with of staff fixed term contracts <2yrs continuous NHS service.

2.3.3 Financial

Scottish Government has provided funding for the Test and Protect workforce throughout the pandemic.

Asymptomatic Testing team will continue to be paid at fixed term terms & conditions during notice and redeployment period.

Interim working arrangements for contact tracing team will continue to be funded by Scottish Government in the meantime.

Staff returning to substantive posts will be paid at seconded terms & conditions for the 4-week notice/transition period before returning to substantive terms & conditions.

2.3.4 Risk Assessment/Management

Testing is fully integrated within Public Health Governance and management systems. Symptomatic testing intentions are awaited.

Transition model for contact tracing intentions are not fully known past 31/05/2022.

An assurance paper was presented to EDG. Contact Tracing contract extension, financial risk assessment and organisational acceptance has been agreed by EDG for those with contracts exceeding 24 months continuous NHS service.

2.3.5 Equality and Diversity, including health inequalities

Withdrawal of covid testing and contact tracing for most people may widen health inequalities and increase risks of infection and adverse outcomes for the most vulnerable population groups.

For the workforce during this transition, all employment opportunities are provided in alignment with contract type local policy. Opportunities are fair and equal to all, adhering to existing policies and protocols.

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

This paper has been developed in consultation with Public Health Intelligence.

2.3.8 Route to the Meeting

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

- Public Health and Wellbeing Committee

2.4 Recommendation

- **Assurance** – For Members' information only.

3 List of appendices

N/A

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NHS Fife

Meeting:	**Public Health & Wellbeing Committee**
Meeting date:	**16 May 2022**
Title:	**FVCV Programme Delivery Update**
Responsible Executive:	**Nicky Connor, Director of Health and Social Care**
Report Author:	**Lisa Cooper, Immunisation Programme Director** **Emma Strachan, Project Manager**

1 Purpose

This is presented to the Public Health & Wellbeing Committee for:
- Assurance

This report relates to a:
- Government policy/directive

This aligns to the following NHSScotland quality ambition(s):
- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this report is to provide an update of the progress of delivery regarding the Flu vaccine and Covid-19 vaccine (FVCV) programme within NHS Fife.

The Public Health and Wellbeing Committee are asked to consider this report for assurance and note the progress and updated information regarding the delivery of the programme. This paper will progress to the NHS Fife Community Immunisation Services Programme Board for information purposes.

2.2 Background

The FVCV programme continues to successfully progress with the local delivery of the nationally directed immunisation programme for all cohorts eligible, while responding to National direction in alignment with evolving JCVI guidance.

Following national direction received in January from the Chief Medical Officer (CMO) Letter (3), further guidance has since been received (CMO) Letter (6) (appendix 1) and supporting documentation received, advising boards to operationalise the JCVI advice and action the following:

- the spring dose programmes for those eligible
- the universal offer of COVID-19 vaccination for children aged 5 to 11 years

In line with national direction the 21/22 Flu vaccination completed 31/03/2022.

Additional national instruction has since been received 31/03/22, confirming operational flexibility for the following,

- **Eligible individuals who turn up at clinics for a spring booster before 24 weeks** (and before their scheduled appointment by blue envelope), but who have an interval of at least 12 weeks since their previous booster dose **should be vaccinated and not turned away**.
- Eligible individuals who reach their 24-week dose interval from 1 July onwards **should be brought forward for scheduling to June (as long as they are at 12 weeks for June appointments).** This has been named nationally as 'the tail'.

2.3 Assessment

At time of writing (29/04/2022) 861K doses have been administered in Fife with 236, 414 individuals having received their full course + booster(s) or 3rd dose.

24,109 Spring boosters (booster 2) have now been administered for those eligible.

The programme has continued to progress with vaccinations of primary course doses for tranche 1 and tranche 2 cohorts while reviewing opportunities for targeted work for those who have not taken up the vaccination to date. These bespoke models continue to run alongside all other planned activity with drop-in clinics continuing to be scheduled where possible across venues in Fife to ensure all individuals who have not received first, second or booster dose vaccinations so far can access vaccination when eligible.

Tranche 1 Delivery

5–11year olds

The official CMO letter (6) (appendix 2) providing guidance on a universal offer for this cohort has now been received and activity commenced 19th March on the universal 5-11 vaccinations. There are approximately 30k individuals eligible with a 50% DNA rate factored into planning assumptions. Bespoke clinics have been scheduled across evenings and weekends and to date 7,054 1st doses have been administered to this cohort, an uptake of **24%** in Fife, higher than the national average of **15.1%.** Fife will continue to take a proactive approach by continuing to promote uptake within this cohort through scheduled appointments and via drop-ins at bespoke children's clinics.

12–15 year olds

To date 8,617 2nd doses have been administered to this cohort (52% uptake) with work continuing within the programme to identify approaches to increase uptake. Those 12-15 year olds who are clinically at risk, severely immunosuppressed or household contacts of someone who is severely immunosuppressed continue to be scheduled by NHS Scotland for booster vaccination appointments.

16 and 17 year olds

Primary and Booster doses for 16–17-year-olds continue to progress with appointments offered via the national booking system and drop-in clinics in alignment to eligibility at a 12-week interval. To date 5,378 2nd doses have been administered to this cohort equating to 64% uptake and 1784 booster doses have been administered.

Outreach Work

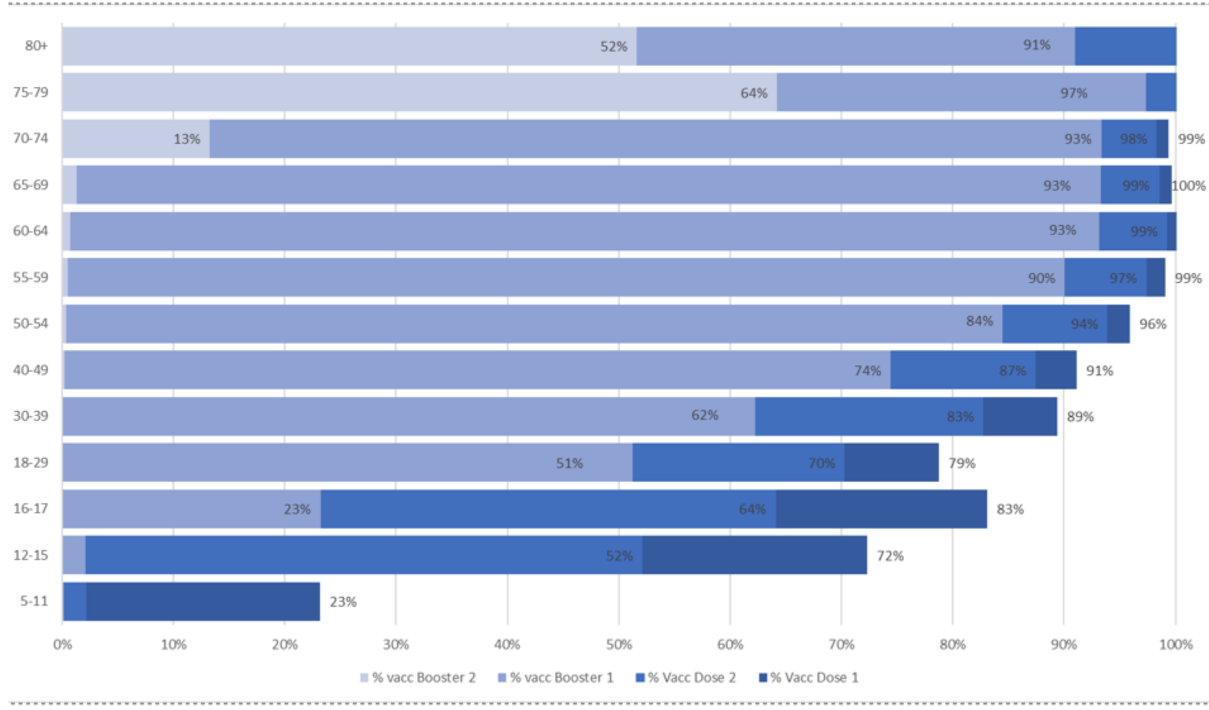
Community outreach and pop up activity had continued throughout March and early April however work in these areas have currently been paused to focus on the Spring Booster programme for those with increased clinical risk from Covid. It is planned for outreach and pop up activity to continue following this.

Community outreach ties in closely with the Inclusivity Group who continues to lead on activity via specialised sub groups such as encouraging uptake among those with a history of Substance Use and Ethnic minority groups with lower uptake rates. Recent SIMD data reviewed within the Inclusivity Group evidences positive results of outreach activity with a 9% increase in uptake between 2nd doses and booster uptake for the 18-29 age group within SIMD decile 1 (most deprived) since beginning of February 2022.

Tranche 2 Delivery

Over 18 Public Programme

The summary table below shows progress to date across each of the age group cohorts as off 27/04/2022 by JCVI age group.



Source: Vaccination Universe, Fife Extract, NRS Midyear population estimates 2020

Spring Vaccination Programme

In response to the recent CMO guidance received, the programme has progressed planning for the universal vaccination offer to the 5-11 cohort and the spring boosters. Around 6 months after the last vaccine dose, the 'spring booster' is now offered to:

- adults aged 75 years and over (commenced week beginning 19/04/22)
- residents in a care home for older adults (commenced 04/04/22)
- individuals aged 12 years and over who are immunosuppressed, as defined in the Green Book (commenced 23/04/22))

The aim is to vaccinate these groups at 24 weeks and no later than 28 weeks, from their last booster dose. Please see appendix 2 for further detail on current planning assumptions.

Nationally directed 'operational flexibility' guidance received allows teams to vaccinate 12 weeks from previous dose. This will allow programme to align cohorts accordingly in anticipation of the Autumn/Winter delivery.

‘Mop up’ activity will be required for all cohorts due to the level of circulating virus and those who are positive having to be vaccinated at a later date in line with JCVI guidance.

2.3.1 Quality/ Patient Care

NHS Fife will continue to respond to new developments as guided nationally to provide a safe and effective service to all citizens in Fife. A clinical oversight and assurance group meets regularly to provide assurance to the boards regarding safe delivery of the Immunisation programme.

2.3.2 Workforce

Fife has now completed the initial substantive recruitment phase to ensure a resilient and sustainable immunisation workforce in line with national funding.

Workforce requirements are closely monitored and where possible staff are being mobilised to aid outreach models as well as supporting other services within NHS Fife such as inpatient areas.

Effective workforce communication and engagement remains a critical priority with an established strategic workforce group providing oversight and assurance for this lead by the HSCP Associate Director of Nursing.

2.3.3 Financial

The programme continues to work closely with Finance colleagues as critical partners in service delivery to provide assurance regarding funding and expenditure. Additional costs and any risks identified throughout the planning stages of the FVCV programme are being managed, mitigated and reported accordingly.

2.3.4 Risk Assessment/Management

A robust risk review process is in place where risks are reviewed frequently across key work streams of the programme. There have recently been a number of risks closed with the current total now equating to 14, all which are either moderate or low-level risks.

2.3.5 Equality and Diversity, including health inequalities

The established inclusivity group will continue to lead delivery of EQIA actions and direct specific outreach activities to ensure access for all people eligible. As the service transitions in pursuit of the vision of the Immunisation strategic framework, the current EQIA will be reviewed to ensure it remains relevant and fit for purpose with wide stakeholder engagement to facilitate this lead by the Deputy Director of Public Health.

2.3.6 Other impact

No other relevant impact.

2.3.7 Communication, involvement, engagement and consultation

Communications are directly linked with the national direction applying national toolkits provided with adaption locally and the team have established a range of channels, with lessons learned from the COVID programme to ensure effective, timely and targeted communications.

Tailored comms packages have been issued to groups such as: Youth first, Active Schools, Youth Employment Network and others.

Weekly communications continue to be issued to elected members and monthly communications are issued to NHS Fife staff. Communications pathways have been established and documented within the programme and work is underway to assess these pathways, ensuring strong relationships are maintained and continue to work effectively within the FVCV programme.

2.3.8 Route to the Meeting

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

- HSCP SLT Assurance, 4 May 2022
- Executive Directors Group, 5 May 2022

2.4 Recommendation

The Public Health and Wellbeing Committee is asked to:

- Note the content for **assurance** of the progress achieved and updated information regarding the programme and ongoing developments in the approach.

3 List of appendices

The following appendices are included with this report:

- Appendix 1, CMO Letter SGHD/CMO (2022)6 (Also available online: https://www.sehd.scot.nhs.uk/cmo/CMO(2022)06.pdf)

- Appendix 2, Spring/Summer Vaccination Planning

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Chief Medical Officer Directorate

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From the Chief Medical Officer
Chief Pharmaceutical Officer

Professor Sir Gregor Smith
Professor Alison Strath

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28 February 2022

SGHD/CMO(2022)6

Addresses

For action
Chief Executives, NHS Boards
Medical Directors, NHS Boards
Primary Care Leads, NHS Boards
Directors of Nursing & Midwifery, NHS Boards
Chief Officers of Integration Authorities
Chief Executives, Local Authorities
Directors of Pharmacy
Directors of Public Health
General Practitioners
Practice Nurses
Immunisation Co-ordinators
Operational Leads

For information
Chairs NHS Boards,
Infectious Disease Consultants,
Consultant Physicians,
Chief Executive, Public Health Scotland, NHS 24

Further Enquiries

Policy Issues
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Medical Issues
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Pharmaceutical and Vaccine Supply Issues
NHS NSS National Procurement:
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Dear Colleague(s)

COVID-19 VACCINATION PROGRAMME:

- **SPRING DOSE PROGRAMME**

- **UNIVERSAL OFFER FOR 5 TO 11 YEAR OLDS**

KEY OBJECTIVES

1. To provide an update and clarify operational guidance on the JCVI advice regarding:

    - Spring dose vaccinations

    - Universal offer of COVID-19 vaccinations for children aged 5 to 11 years old.
      JCVI statement on vaccination of children aged 5 to 11 years old - GOV.UK (www.gov.uk)

BACKGROUND

2. The JCVI continues to advise on the COVID-19 vaccination programme.

3. The Scottish Government is guided by the clinical and scientific advice on vaccination as provided by the JCVI.

4. The Scottish Government remains fully committed to ensuring that everyone who is eligible has access to a COVID-19 vaccine.

SPRING DOSE

5. In its advice of 21 February 2022, the JCVI advised that the primary aim of the COVID-19 vaccination programme continues to be the prevention of severe disease, hospitalisation and mortality arising from COVID-19.

6. Many of the oldest adults, and therefore most vulnerable, will have received their most recent COVID-19 vaccine dose in autumn 2021. Therefore, as a precautionary strategy for 2022, the JCVI has advised a COVID-19 spring dose for these individuals, around 6 months after their last vaccine dose.

7. This will be offered to:

   - Adults aged 75 years and over;
   - Residents in a care home for older adults; and
   - Individuals aged 12 years and over who are immunosuppressed, as defined in tables 3 and 4 of the Green Book.

8. These individuals are at a higher risk of severe COVID-19, and with the lapse of time, their immunity derived from vaccination may wane substantially before autumn this year.

9. Eligible persons aged 18 years and over may be offered booster vaccination with Pfizer-BioNTech COVID-19 (Comirnaty®) 30mcg vaccine or Moderna (Spikevax®) 50mcg vaccine.

10. Eligible persons aged between 12 and 18 years may be offered booster vaccination with Pfizer-BioNTech COVID-19 (Comirnaty®) 30mcg vaccine.

11. Cohorts will become eligible for a spring dose at 24 weeks (6 months) since their previous vaccine dose. There are, however, circumstances where this gap can be reduced to 3 months as detailed in the updated Green Book chapter.

12. The Green Book states that someone in an eligible group who has received a full course of primary vaccination (two or three doses depending upon eligibility group) but has not received their first booster by March 2022, may be given the spring dose in the campaign provided there is at least three months from the previous dose. An additional dose is not then recommended before the autumn. The vaccines offered should follow the age-appropriate advice as for other reinforcing doses.

UNIVERSAL OFFER FOR CHILDREN AGED 5-11 YEARS OLD

13. In its advice of 16 February 2022, the JCVI advised that a non-urgent offer of two doses of the Pfizer-BioNTech COVID-19 (Comirnaty®) 10mcg vaccine be offered to children aged 5 to 11 years of age who are not in a clinical risk group. The two doses should be offered with an interval of at least 12 weeks between doses.

14. When considering the deployment of its advice, the JCVI noted that:

   - The offer of COVID-19 vaccination to 5 to 11 year olds who are not in a clinical risk group should not displace the delivery of other paediatric non-COVID-19 or COVID-19 immunisation programmes;
   - Delivery of paediatric non-COVID-19 immunisation programmes across all ages should receive due attention, particularly where vaccine coverage has fallen behind due to the COVID-19 pandemic and where there is evidence of health inequalities;
   - Use of the Pfizer-BioNTech COVID-19 (Comirnaty®) 10mcg paediatric formulation vaccine should be encouraged for all pupils in the relevant academic year for children aged 11/12 years to reduce complexity in programme delivery and expected reactogenic events for individuals.

15. This advice on the offer of vaccination to 5 to 11 year olds, who are not in a clinical risk group, is considered by the JCVI as a one-off pandemic response programme. This one-off programme applies to those currently aged 5 to 11 years, including those who will turn 5 years of age by the end of August 2022.

16. As the COVID-19 pandemic moves further towards endemicity in the UK, the JCVI will review whether, in the longer term, an offer of vaccination to this, and other paediatric age groups, continues to be advised.

17. The total cohort size for children in Scotland aged 5 to 11 years is estimated to be approximately 419,000. Of this, approximately 32,000 are considered to be in a clinical risk group or a household contact of someone who is immunosuppressed and are already eligible for vaccination under the JCVI's previous advice of 22 December 2021.

18. This leaves an estimated cohort size of approximately 387,000 children aged 5 to 11 years old who will be eligible for vaccination under this universal offer.

INFORMED CONSENT

19. In all instances, the offer of vaccination must be accompanied by appropriate information to enable children (where appropriate), and those with parental responsibility, to provide informed consent prior to vaccination. Teams responsible for the implementation and deployment of COVID-19 vaccination for persons aged 5 to 11 years should be appropriately trained and confident regarding the information relevant to the vaccination of these persons.

20. We already have a suite of resources relating to COVID-19 vaccines available that enable children and young people and those with parental responsibility to give informed consent, and dedicated leaflets including easy-read versions of these resources have been developed. In addition, training resources for vaccinators have been updated to enable them to provide information in a child-appropriate manner during vaccination visits.

21. Vaccinators will be required to undertake knowledge acquisition and achieve clinical competency sign off prior to administering the paediatric formulation to this age cohort. Specific education materials have been prepared by NHS Education Scotland (NES) and Public Health Scotland (PHS).

OPERATIONAL DEPLOYMENT

22. Health Boards are asked to ensure that their planning, operational, scheduling and clinical teams are fully appraised of the recent JCVI advice regarding this phase of vaccine delivery, the national delivery plan and the timescales.

23. Annexes A and B are attached and illustrate a tabular oversight of the spring expectations. Annex 2 is designed to be a simple guide clearly explaining the vaccine dose for each individual, how and where it will be offered and the interval between doses.

Older adult care home residents

24. Care home residents (older adults) who received their booster in September 2021 as part of the Autumn/Winter Vaccination Programme will have been amongst the earliest individuals to receive their booster vaccination. To ensure that these individuals receive

their next dose as close to 24 weeks as possible, Health Boards are asked to schedule these as a priority from the week commencing 7 March 2022 at the earliest.

25. Some operational flexibility around the timing of the spring dose in relation to the last vaccine dose is considered acceptable as detailed in the Green Book. For example, individuals in care homes may be offered the spring dose alongside other residents providing there is at least 3 months from the previous dose. In addition, if the care home is for older people and there is a small number of individuals aged under 65 years in this setting, then they can also be vaccinated as part of this offer.

Individuals aged 75 years and over and Individuals aged 12 years and over who are immunosuppressed

26. Individuals who are 75 years and over will generally be scheduled by Health Boards through the National Vaccine Scheduling System (NVSS) as they become eligible and will receive an appointment inviting them to attend; this is likely to be from the 2nd or 3rd week in March onwards. These individuals will be invited to community clinics (unless a home visit is required) for their vaccinations. If they should need to reschedule they can use the online portal or the National Contact Centre (NCC) by telephone and schedule a more suitable time.

27. The aim is to vaccinate these citizens at 24 weeks, and no later than 28 weeks, from their last booster dose (the latter week limit is an operational aim for the national programme and local delivery).

28. The Green Book again supports some operational flexibility; for example, if a domiciliary visit is taking place to an elderly couple they may be offered their vaccinations at the same time providing there is at least 3 months from their previous dose.

29. The cohort for the general 75 years and over population will be extracted by Public Health Scotland (PHS) and placed on the SEER platform for Health Boards to extract and organise their files for sending for rescheduling. As this is a specific spring offer this extract will contain people who are or who turn 75 years up to 30th June 2022.

30. Individuals aged 12 years and over who are immunosuppressed will also be invited for a spring dose. This file is being planned at present and will be extracted from the same variety of sources as previously for the programme, that is to say an Albasoft extract. This file will also be uploaded onto the SEER platform for Health Boards to review and organise scheduling.

Children aged 5 to 11 years

31. We will continue to prioritise 5 to 11 year olds who are in a clinical risk group, or who are a household contact of someone who is immunosuppressed as they (or their household contacts) have higher risk factors for COVID-19 related ill-health. At present we have seen only an 18% uptake for first doses from children aged 5 to 11 years old with at risk medical conditions. All parents were contacted previously (either by a national letter inviting them to call to book an appointment, a local letter or local phone call) and Health Boards will now also be asked to de-dupulicate and proactively schedule the remaining children. This will allow this group another opportunity to be vaccinated ahead of their universal age-matched peers.

32. Appointments will be scheduled via NVSS for the universal offer of vaccination of children aged 5 to 11 years. This is a non-urgent offer as per the JCVI's advice, and therefore the amount of scheduling per month will be at a proportionate level alongside the higher priority adult and 12-plus spring dose programme. This may be approximately a 2:1 ratio of appointments (adult spring dose/higher risk children spring dose: universal 5 to 11 year olds).

33. Health Boards will be asked to accommodate family appointments where possible for siblings and family members attending together, so the numbers of families requiring multiple visits are minimised.

34. Whilst spring booster doses should take priority over the universal offer for 5 to 11 year olds, there is still a need to pragmatically maximise uptake potential by using capacity for appointments for the 5 to 11 year old cohort during evenings, weekends and the Easter holidays. Therefore, a parallel offer is expected, with options like spring doses Monday to Friday with 5 to 11 year olds at evenings and weekends considered in local planning.

35. Boards are asked to implement a range of community clinic locations that can accommodate spring dose needs and child friendly sections for the 5 to 11 year olds. PHS and the National COVID Vaccination Team have been working on a range of branding and child friendly material that can support Health Boards in their local planning to make sections of clinics welcoming to children and their families. This will be supplemented by materials for those with parental responsibility via leaflets, videos and material on NHS Inform. Health Boards need to ensure sufficient access in suitable locations and settings to ensure maximum uptake in both the spring doses and the 5 to 11 universal offer.

36. Scheduled appointments in blue envelopes will be sent to those who have parental responsibility for 5 to 11 year olds. The online booking portal is not set up to rebook children's appointments, so the NCC will be used instead to reschedule any unsuitable appointments. It is proposed that scheduling will permit appointments to commence from 19th March 2022. This will enable first and second doses to largely be offered prior to schools returning in August 2022 after the summer holidays.

COMMUNICATIONS

37. Some interim messaging has already been shared with Health Boards to clarify the recent JCVI announcements. Further updates and materials will be provided to Health Boards to communicate via their local channels and networks in due course. We are also working with stakeholders to deploy appropriate messages via their channels and networks. NHS Inform has been updated. The ongoing analysis of experience and evidence will continue to inform our approach to communications and engagement – this is particularly important for children and their parents.

ACTIONS

38. Health Boards are asked to note and operationalise the JCVI advice regarding:

- the spring dose programmes for those eligible;
- the universal offer of COVID-19 vaccination for children aged 5 to 11 years.

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disability confident LEADER

We remain very grateful for your continued support and ongoing efforts in relation to the national COVID vaccination programme.

Yours sincerely

Gregor Smith	*Alison Strath*
Professor Sir Gregor Smith	Professor Alison Strath
Chief Medical Officer	Chief Pharmaceutical Officer

Annex A

SUMMARY OF ONGOING AND NEW FVCV: MARCH – AUGUST 2022 (2 pages)

Who	Vaccine & Gap Period	When in Delivery Year	How - Invite	Where
• Adults 18+ **(universal) (Autumn/Winter Booster 1 mop up)**	• Covid-19 vaccine mRNA booster (>12 wk gap since primary course and 4 weeks post infection)	• Ongoing through Jan - March – to reach people not yet boosted in the pre New Year period	• All remaining adults had a reminder and new appointment issued. • Only remaining route (for people that did not take up any booster offer to date) is via self book or drop in. • Hesitant audience national media campaign currently running	• Local vaccination clinics • Some bespoke pregnancy clinics
• **Autumn/Winter Flu mop** up offer to: any remaining 16-64 **at risk groups**; 65+; pregnant	• Flu vaccine only	• Ongoing Jan - March	• Any remaining high risk Flu people that have not taken up offer to date can have a flu vaccine via their HB route up to end of march and then flu vaccination season closes for the past Autumn/Winter period	• If pregnant, via your midwife. • A local vaccination centre
• 16/17 year olds **(universal) Covid** • **16/17 at risk** were part of initial JCVI 1-9 as part of CEV or underlying health conditions for tranche 1 and also for initial booster 1 – so should be ahead of their age peer group for primary and booster dosing)	• 2nd primary dose Pfizer 30 mcgs - 12 weeks from 1st dose or 12 weeks from confirmed positive Covid infection (whatever comes last) • Booster Pfizer dose 30 mcgs (12 weeks post primary course or 12 weeks post infection)	• Early November onwards. Many of this group are outstanding for 2nd dose (over 42% currently) • Early February onwards (for those with prompt primary courses)	• All were initially asked to self reg or self book and have subsequently been contacted via dedup letters/texts to remind them of outstanding second doses. o HBs should continue to do local promotions of the need to complete primary course and be boosted also (linking this into positive needs for vaccination such as summer vacations) • People can attend drop ins; phone and book via NCC; book via portal o HBs should use national comms and local comms to promote self booking or drop in for 16/17 boosters o HBs can submit cohort files for NVSS invite for people they know to be eligible (but need to co-ordinate this with the number of files they are sending in via the national team and NSS)	• A local vaccination clinic
• 12-15 year olds **(clinically at risk; and household contacts of immunosuppressed) Continued Mop Up/completion Phase**	• 3rd dose for those who are themselves **SIS** – Pfizer 30 mcgs - (8 weeks after last dose; or 4 weeks post infection) • Booster Doses Pfizer 30 mcgs - Pfizer 30 mcgs - (12 weeks after primary course completion; or 4 weeks post infection)	• offered early December 2021 onwards • offered early December 2021 onwards (at risk but non SIS) OR; early Feb onwards if SIS 4th/booster dose	• NVSS scheduling o HBs should check that they are complete on all their scheduling of these 3rd dose and booster offers	• A local vaccination clinic
• 12-15 year **(Universal)**	• 1st doses Pfizer 30 mcgs • 2nd doses Pfizer 30 mcgs - (12 weeks post 1ST dose or 12 weeks post infection)	• 1st scheduled offer was late Sept 21 onwards via lettered appointment • 2nd dose offers commenced from 3rd January onwards (12 weeks from 2nd dose) via drop ins and appointments through January 22	• All outstanding 1st and 2nd dose people were lettered as mop up advising to phone book or drop in to complete primary course. Currently at 70% 1st does uptake and 41% at 2nd dose uptake o HBs should continue to promote uptake via drops in and also explore mops ups in various settings (e.g. if in schools doing other childhood programmes)	• A local vaccination clinic
• 5-11 year olds – at risk **(clinically at risk; and household contacts if IS)**	1st Dose – Paediatric Pfizer 10 mcgs (and 4 weeks post infection if recently infected) • 2nd Dose – Paediatric Pfizer 10 mcgs (8 weeks after 1st dose; or 4 weeks post infection) • 3rd Dose (ONLY for those with SIS) – Paediatric Pfizer 10 mcgs - (8 weeks after 2nd dose; or 4 weeks post infection)	• From around 27th January onwards • From late March onwards (at least 8 weeks after 1st dose) • From late May onwards (at least 8 weeks after 2nd dose)	• All were lettered or locally phoned asking them to either self book via NCC: or offered locally • From the National cohort created for those with specific medical conditions – uptake currently at 18% o Hbs should depup and looks at ways to engage further with these families to encourage uptake prior to the wider universal offer o HBs should consider a wider range of locations for parent to come with their child now that 5-11 universals are also commencing o National and local child friendly branding and spaces should be created (e.g. sections for main centres) • For second appointments 8 weeks later (unless the child has Covid infection and subject to the 12 week wait gap): o HBs need to organise the 2nd appointment for individuals via their chosen route – local appointing or NVSS. • For children who are SIS and requiring a 3rd dose o HBs need to organise the 3rd appointment for individuals via their chosen route – local appointing or NVSS.	• A local vaccination clinic (set clinic area with Paed Pfizer and suitably trained staff)
• **5-11 – Non urgent Universal Offer** (up to those who turn 5 up to 31st August – offer won't extend for any child turning 5 after this – BUT to note – children CANNOT have until they ARE 5 – so we will vaccinate this group into Sept)	• 1st Dose – Paediatric Pfizer 10 mcgs (12 weeks post infection) • 2nd Dose – Paediatric Pfizer 10 mcgs (12 weeks after 1st dose, or 12 weeks post infection)	• From Mid-March onwards • From Mid-June onwards	• NVSS appointment – o PHS will do file creation and load to SEER for HBs to do files for appointments and send into NSS o NVSS appointment – HBs send in files for appointing	• A local vaccination clinic (set clinic area with Paed Pfizer and suitably trained staff)

Key: National co-ordinated actions (National team = SG/NHS National Team)
HB actions

SUMMARY OF ONGOING AND NEW FVCV: MARCH – AUGUST 2022 (2 pages)

Who	Vaccine & Gap Period	When in Delivery Year	How - Invite	Where
• **Spring Booster – Adults 75 years plus**	• Covid-19 vaccine mRNA booster (>24 weeks since last dose and/or 4 weeks post infection). • Aim not later than 28 weeks for operational target • Green book offers operational flexibility – e.g. in housebound if visiting a couple and one under the 24 weeks – as long as 3 months gap – they can have at same time	• From Mid-March onwards	• NVSS appointment – ○ PHS will do file creation and load to SEER for HBs to do files for appointments and send into NSS	• Local vaccination clinics • Domiciliary visits
• **Spring booster – residents older adult care homes** (assumption of 65 years plus)	• Covid-19 vaccine mRNA booster (>24 weeks since last dose and/or 4 weeks post infection). • Aim not later than 28 weeks for operational target • Green book offers operational flexibility – e.g. for care homes – as long as 3 months gap – the residents can be done in a collective visit, even if some under 24 weeks. As long as they have a 3 month gap.	• From w/c 7th March onwards	• Via care home visits organised by HB	• Care home/ setting
• **Spring Booster – people age 12+ who are immunosuppressed**	• Covid-19 vaccine mRNA booster (>24 weeks since last dose and/or 4 weeks post infection). • Aim not later than 28 weeks for operational target • Green book offers operational flexibility –Severely Immunosuppressed individuals who have received an additional primary dose may have received the booster (fourth) dose more recently and should also be offered the booster during the spring campaign providing there is at least three months from the previous dose.	• From Mid-March onwards as individuals become eligible	• NVSS appointment – ○ PHS will do file creation and load to SEER for HBs to do files for appointments and send into NSS	• A local vaccination clinic • Domiciliary visits

Key: National co-ordinated actions (National team = SG/NHS National Team)
HB actions

Annex B

	Primary Course Doses			Booster Doses		Interval Between Doses* (There is a minimum time you need to wait after a Covid Infection to have a vaccine, even if you are due another dose)	How & When
	1st	2nd	3rd	1st	2nd		
Over 75	✓	✓	✗	✓	✓	8 weeks between primary doses; 12 weeks from primary course to booster dose; 24 weeks between booster doses; (4 weeks from first symptoms or positive test)	Invited by NHS – Spring (booster 2) invite will come out via post from mid-March onwards
Elderly Care Home Residents	✓	✓	✗	✓	✓	8 weeks between primary doses; 12 weeks from primary course to booster dose; 24 weeks between booster doses with flexibility; (4 weeks from first symptoms or positive test)	Delivered through care home - Spring (booster 2) will be offered from mid-march onwards
Over 18: Except those who are immunosuppressed	✓	✓	✗	✓	✗	8 weeks between primary doses; 12 weeks from primary course to booster dose; (4 weeks from first symptoms or positive test)	If not completed the primary course or had booster 1 yet - Book by phone or online or attend a drop in.
Over 12: Severely Immunosuppressed	✓	✓	✓	✓	✓	8 weeks between primary doses; 12 weeks from primary course to booster dose 12 weeks between booster doses (4 weeks from first symptoms or positive test)	Invited by NHS – Spring (booster 2) invite will come out via post from mid-March onwards
Over 12: Immunosuppressed (but not severely immunosuppressed)	✓	✓	✗	✓	✓	8 weeks between primary doses; 12 weeks from primary course to booster dose; 24 weeks between booster doses; (4 weeks from first symptoms or positive test)	Invited by NHS – Spring (booster 2) invite will come out via post from mid-March onwards
16/17: no additional risk factors	✓	✓	✗	✓	✗	12 weeks between all doses ; (12 weeks from first symptoms or positive test)	Book by phone or online or attend drop-in
16/17: At risk for specific medical conditions (not those immunosuppressed)	✓	✓	✗	✓	✗	8 weeks between primary doses; 12 weeks from primary course to booster; (4 weeks from first symptoms or positive test)	Book by phone or online or attend drop-in
12 to 15: No additional risk factors	✓	✓	✗	✗	✗	12 weeks between primary doses; (12 weeks from first symptoms or positive test)	Invited by NHS - can attend a drop-in or book if overdue
12 to 15: Specific medical conditions or household contacts of a person with immunosuppression	✓	✓	✗	✓	✗	8 weeks between primary doses; 12 weeks from primary course to booster; (4 weeks from first symptoms or positive test)	Invited by NHS - can attend a drop-in or book if overdue
5 to 11: No additional risk factors	✓	✓	✗	✗	✗	12 weeks between primary doses; (12 weeks from first symptoms or positive test)	Invited by NHS and can reschedule using helpline (From mid-March 2022)
5 to 11: Specific medical conditions or household contact of a person with immunosuppression	✓	✓	✗	✗	✗	8 weeks between primary doses; (4 weeks from first symptoms or positive test)	Invited by NHS - can book or reschedule using helpline
5 to 11: Severely Immunosuppressed	✓	✓	✓	✗	✗	8 weeks between primary doses; (4 weeks from first symptoms or positive test)	Invited by NHS - can book or reschedule using helpline

*To support operational delivery, the Green Book sets out additional flexibility for this time to be reduced in some instances – e.g. the time between the first and Spring booster can be reduced from 24 weeks, to a minimum of 12 weeks, where people are co-residents in older adult care homes, living together and having a domiciliary visit, or where an Immunosuppressed individual has had an additional primary dose followed by booster 1 at a later date.

NHS Fife

Meeting:	**Public Health and Wellbeing Committee**
Meeting date:	**16 May 2022**
Title:	**Progress of Annual Delivery Plan (RMP4) 2021/22**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
	Janette Owens, Director of Nursing
Report Author:	**Susan Fraser, Associate Director of Planning & Performance**

1 Purpose

This is presented to the Public Health and Wellbeing Committee for:
- Assurance

This report relates to the:
- Remobilisation Plan 4 2021/22 – Update to end of March 2022
- Review of National Response to Winter 2021/22
- Winter Report 2021/22 – Data to March 2022

This aligns to the following NHS Scotland quality ambition(s):
- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The fourth Joint Remobilisation Plan (RMP4) for Health and Care services delivered by NHS Fife and Fife Health and Social Care Partnership (HSCP) was submitted to Scottish Government on 30th September. This plan is considered as a review of the Remobilisation Plan 3, reflecting on progress and set out what is expected to be delivered over the remainder of 2020/21.

This paper reports on the actions of the Remobilisation Plan 4 and has been renamed as NHS Fife's Annual Delivery Plan (including the winter actions) 2021/22.

2.2 Background

The Scottish Government letter dated 20th July 2021 titled *Remobilisation Plans 2021/22: Mid-Year Update (RMP4)* commissioned the next iteration from NHS Boards of the Remobilisation Plan.

The feedback letter from Mr John Burns, Chief Operating Officer, Scottish Government was received on 19th November 2021 confirming that the RMP4 for the second half of 2021/22 can be taken through NHS Fife's governance process.

Progress against deliverables is to be reported to the Scottish Government on a quarterly basis. This paper focusses on status at end of March (to be submitted by 29th April).

This paper also covers the submission following the letter received 14th February from Scottish Government titled *Review of National Response to Winter 2021/22* which asked Boards for their winter lessons and reflections on collective planning and response arrangements.

2.3 Assessment

This assessment reports on three aspect of strategic planning and covers: update to the Remobilisation Plan 4, Review of national response to Winter 2021/22 and Winter Report (data).

Remobilisation Plan 4 2021/22 – Update to end of March 2022
The guidance document issued in July 2021 described a different approach and requirements for RMP4 since the submission of RMP3. We were required to provide a shorter strategic organisational overview with specific delivery action plans to be delivered by March 2022.

Action Status (31/3/2022)	
Unlikely to complete on time/meet target	12
At risk - requires action	20
On Track	61
Complete/ Target met	52

The summary status above shows that the majority of the action for 2021/22 are completed or on track to be completed by the target date. The key themes of actions that are unlikely to be completed are: delivery of elective care and diagnostics and improvements in cancer performance and early diagnosis.

The full delivery action plan of the Remobilisation Plan 4 can be found in Appendix 1 and is being monitored and documented quarterly. Any incomplete actions will be carried over into next year's Annual Delivery Plan 2022/23.

Review of National Response to Winter 2021/22
Following the request from Scottish Government, NHS Fife submitted the Review of the National Response to Winter 2021/22 on 18 March 2022 – the full response can be found in Appendix 2.

The pressure on the health and care system intensified over the winter period but has not subsided in terms of capacity and flow since 2020. NHS Fife and Fife Health and Social Care Partnership (HSCP) continues to prioritise the needs of our vulnerable and ill patients by providing timely and effective care, despite increases in demand on services or a mismatch between demand and supply of services.

Reflections of the health and care services over the winter period has been considered and the key actions taken by NHS Fife and Fife HSCP to lead and manage the health and care system are described in this section.

Emergency Command Structure
NHS Fife managed the emerging Covid-19 position through the Emergency Command structure that was already well embedded throughout the organisation and Fife Health and Social Care Partnership. The framework of the command structure of Gold, Silver and Bronze was implemented for operational teams, winter, capacity and flow and workforce.

Development of Escalation Framework
The development of the OPEL (Operational Pressure Escalation Levels) Tool at the end of 2021 enables the whole system to manage and respond to current challenges in capacity in a systematic and planned way. Each operational team now have an accurate overview of the pressures on their systems to be able to focus and plan to release or maintain capacity and flow in the system.

Informed Decision Making
A winter scorecard has been used on a weekly basis to discuss and plan in an integrated way with the operational teams. This scorecard follows the patients journey starting with Urgent Care, through Emergency Care and acute to community ward stays and onwards to social care capacity.

Impact on HAI standards
Constant pressures on the health and care system have impacted on the bed capacity in ward bays. The number of beds was reduced in ward bays to meet the HAI standards; however, additional beds were reintroduced in wards in acute and community settings. The demand for beds is such that these have remained open longer than expected.

Workforce
Workforce continues to be challenging across health and social care with a significant impact on the care and treatment that can be provided. We established a Workforce Resilience Silver Group last year as part of our command structure and the group has overseen workstreams on Resilience Planning, Resourcing, Education & Training and Employee Wellbeing.

Some of the key workstreams have involved the identification and deployment of a 'Workforce Resilience Layer' which has included non-frontline staff trained and redeployed for short term support in an operational support capacity.

Fife has experienced daily staffing challenges, so processes have been put in place to support the daily management of workforce, ensuring patient safety is maintained.

A number of initiatives have been introduced or enhanced to support staff wellbeing including wellbeing hubs, pastoral care, peer support and psychological support. These will continue to be in place to support our workforce.

Themes
Lessons learned have continued to be gathered and discussed by our staff throughout the winter period. Feedback from operational services were gathered and a detailed list of the responses received can be found in table below, which summarises the high-level themes. A further winter review workshop in April has been arranged with the wider clinical and

operational teams where the lessons learned will be discussed and proposed plans for 2022/23 will be described.

Theme	What went well	What did not go well?	What could be done differently?
Business Continuity/ Emergency Planning	Working of Local Resilience Partnership	Limitations on workforce and equipment	More robust BCPs and transport plans
Whole System Working	Agile and flexible teams Cross system working	Uptake of serial prescribing across all teams	Better deployment of Point of care testing (POCT)
Demand and Capacity	Pathway redesigned Staff Commitment Available information	Capacity challenges and delays Restricted GP access	Development of Front Door Model Improved discharge process
Escalation and Surge Plans	Command structure in place Development and Implementation of OPEL framework Agility of workforce	-	Earlier agreement of plans
Staffing Levels	Dedicated consultant cover Recruitment of temporary and redeployment of staff Wellbeing resources for staff	Staffing levels despite recruitment drive Patient care affected due the available staff	Ability to flex staff across the system Debrief for staff
Elective Activity	Maintenance of P1 and P2 activity Use of QMH	Stopping of electives, in particular orthopaedic	-
Infection Prevention and Control	Implementation of ARHAI Respiratory Pathway Care home huddles	Late publication of guidance	Time to implementation guidance Earlier MRSA screening
Test and Protect	Clear protocols for contact tracers Protocol to manage care home admissions	Managing the changes in isolation and testing requirements Timings of staff testing	Workforce model required going forward that can rapidly respond to demands
Communications	Regular engagement with all staff	Changing position with care home closures difficult to manage	Better national communications with public Revised visitors' policy

Winter Report 2021/22 – Data to March 2022

The Winter Report highlights the following key indicators for Winter – the full report can be found in Appendix 3:

A&E

The 95% Standard has not been met in the last 26 weeks. The Redesign of Urgent Care Program has had an impact on performance, and this affects all boards across Scotland. The board average has maintained within 5% of the Scotland average for the majority of the Winter Period.

Covid-19

The number of Covid-19 positive patients in Acute setting has risen increasingly since early March and are now at the highest levels seen throughout the Pandemic.

During the same period within Community settings Covid positive numbers have also risen increasing with the highest level seen causing many wards/bays to close during this period.

Occupancy
VHK occupancy was high late January then dipped in February till mid-March but has since been extremely high (98-99%).

The non-respiratory pathway has almost mirrored the overall occupancy and ending March with 98%.

Occupancy in Community Hospitals has maintained well above 100% for the whole of Winter and hitting 123% in January, and consistently 113% or above this year. Many wards throughout the period have had to close due to Covid which has contributed to pressure throughout. The occupancy this winter is trending higher than any other due to the number of surge beds opened to try and maintain flow within the acute hospital.

Delayed Discharges
The number of Delayed Discharge Bed Days in VHK was steady during February until the end of the month where numbers climbed and continued into March, these have since decreased again. There has been an average of 26 Delayed Discharge Bed Days lost over the last 2 months.

There has been an average of just above 446 bed days lost to delayed discharges within the community hospital throughout February and March. The standard delays have remained fairly static around the 230-240 mark, whereas code 9's have fluctuated a little more.

Health & Social Care Placements
The number of referrals to H&SCP for Health and Social Care Placement is on average 66 patients per week, with the number of discharges over this period over at an average of 69.3 per week.

The waiting list peaked at 57 for the week ending 23rd January and has gradually declined since thanks to the high levels of discharges achieved.

2.3.1 Quality/ Patient Care

Quality of patient care and safety are at the heart of the Remobilisation Plan. The Remobilisation Plan (RMP4) was endorsed by NHS Fife Board on 30 November 2021.

2.3.2 Workforce

Oversight to workforce implications during remobilisation have been considered and form part of the Strategic Planning and Resource Allocation process. The Remobilisation Plan (RMP4) was endorsed by NHS Fife Board on 30 November 2021.

2.3.3 Financial

Oversight to financial implications during remobilisation have been considered and form part of the Strategic Planning and Resource Allocation process. The Remobilisation Plan (RMP4) was endorsed by NHS Fife Board on 30 November 2021.

2.3.4 Risk Assessment/Management

A Risk Assessment is contained within the Remobilisation Plan.

2.3.5 Equality and Diversity, including health inequalities

Remobilisation Plan included the appropriate equality and diversity impact assessment as part of the restart process.

2.3.6 Other impact

N/A.

2.3.7 Communication, involvement, engagement and consultation

Appropriate communication, involvement, engagement and consultation within the organisation and with key external stakeholders is integral to the implementation of the Remobilisation Plan.

2.3.8 Route to the Meeting

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

- Executive Directors' Group by email, 22 April 2022
- Clinical Governance Committee, 29 April 2022
- Finance, Performance and Resources Committee, 10 May 2022
- Staff Governance Committee, 12 May 2022

2.4 Recommendation

The Committee is asked to:

- **Note** progress of deliverables within Joint Remobilisation Plan 4 (RMP4)
- Take **assurance** from the lessons learned from Review of National Response to Winter 2021/22
- **Note** the performance in the Winter Report 2021/22 – Data to March 2022

3 List of appendices

- Appendix 1: Highlight Report of Actions from RMP4 Delivery Action Plan 2021/22
- Appendix 2: Review of National Response to Winter 2021/22
- Appendix 3: Winter Report 2021/22 – Data to March 2022

Report Contact
Susan Fraser
Associate Director of Planning & Performance

Appendix 1: Highlight Report of Actions from RMP4 Delivery Action Plan 2021/22

Complete Actions (those in **bold** since previous update)

Pandemic Response

- ✓ ICU capacity

Primary, Community and Social Care

- ✓ Development of a Specialist Respiratory team to support a wide range of respiratory conditions to work collaboratively with the wider Community Teams to support patients, both acutely and long term with COVID.
- ✓ Develop a new Fife laryngectomy service in collaboration with Acute Services.
- ✓ Working towards reinstatement of the diagnostic pathway for Children and Young People, subject to restrictions and guidance.
- ✓ **Phase 3 (return to majority of previous service provision) will be implemented when safety measures such as social distancing can be relaxed.**

Mental Health

- ✓ Resumption of activity in AMH Day Hospitals.
- ✓ Re-development of the Moodcafe website to facilitate information-giving and support self-help across the life span and for people with long term health conditions.
- ✓ **Increasing the delivery of group PTs.**

Cancer Performance and Early Diagnosis

- ✓ Continue implementation of 'Framework for Recovery of Cancer Surgery' and 'National Approach to Clinical Prioritisation'.

Planned Care, Electives and Diagnostics

- ✓ Introduce PIR (Patient Initiated Review) within Medical Paediatrics.
- ✓ Continue to increase the number of Nurse Endoscopist posts which is one of the priorities to creating a future sustainable workforce.
- ✓ Review the model of collection for issuing repeat prescriptions for patients on ADHD/sleep medication.
- ✓ Introduction of home spirometry.
- ✓ Developmental assessments for Global Developmental Delay to be re-established.
- ✓ **Near Me Phase 2 - Further develop communication and stakeholder engagement strategy.**

Workforce

- ✓ **Harness the benefits of the latest NHS Education and Public Health Scotland (PHS) developments on workforce modelling to support our service planning arrangements and delivery of workforce plans.**
- ✓ Potential long term COVID-19 health issues for staff to be addressed through incorporating national guidance from developing evidence into our policy, practice, and service delivery arrangements.
- ✓ **Consolidation of our Staffing Bank management arrangements.**
- ✓ Continue to ensure Workforce Mobilisation Hubs are robust and flexible to adapt to future challenges.
- ✓ Workforce Planning & Mobilisation Silver Group to continue into 2021/2022 and review workforce deployment mechanisms to address the changing workforce needs across the year.
- ✓ Adapt our onboarding and development delivery approach through the use of e-enabled fast-track induction and other training.
- ✓ **Staff personal/professional development needs that have been delayed or restricted due to COVID-19 response to be prioritised as restrictions are eased through Directorate development delivery plans.**
- ✓ **Provision of staff support and wellbeing initiatives which meet staff needs and contribute to workforce sustainability.**

Digital

- ✓ ServiceNow - Migration to joint South-East activity to modernise the IT Service Management suite offering improved automation and slicker processes for activities such as 'Joiners, movers and leavers' consistent SLA/OLA's and much improved self-help solutions.
- ✓ ITIL Process Maturity Improvement - Assess and benchmark our maturity against the 5 lifecycles and 27 processes of ITIL.
- ✓ Digital Business Continuity and Disaster Recovery (BC/DR) Plan.
- ✓ Infrastructure and Network Connectivity - Initiate an architectural review of our infrastructure to support remobilisation including a review of licensing to ensure we have sufficient capacity to support the increase in digital usage.
- ✓ Paperlite - Subject to agreed funding, the ambition is to accelerate the Paperlite programme. Reducing paper to the patient and clinician.

Corporate Services

- ✓ **Deliver the NHS Fife Prevention and Control of Infection Annual Work Programme for 2021-2022. Provide a structured delivery programme with priorities for nursing staff, clinical support staff, clinicians and managers to minimise the spread of infection, support the reduction of HCAI and to meet the NHS Healthcare Improvement Scotland (NHS HIS) Standards (2015).**
- ✓ **Develop a framework for Innovation adoption, generation, development, monitoring and evaluation.**
- ✓ **Investment secured for Programme Management Office (PMO) and embedded as part of the strategic planning arrangements to ensure corporate focus on progressing the service redesign required to release both cash savings and productive opportunities over the medium-term.**

Unscheduled Care

- ✓ Seamless GP Admission Pathways
- ✓ Increased scheduling for patients accessing ED
- ✓ Increased capacity within ED Resus
- ✓ Safe and timely discharges – COVID STATUS
- ✓ Lack of physical capacity in Admissions Unit 1
- ✓ Effective HALO resource to support front and back-door flow
- ✓ Minimise delays across the in-patient bed base through the systematic use of the Moving on Policy.
- ✓ HSCP Escalation to support daily decision making at HSCP huddles aligned to joint escalation plan with Acute services.
- ✓ Review current clients who have packages of care and require a renewed assessment.
- ✓ Community ANPs will return to General Practice from the COVID Hub and Assessment Centre to support workload
- ✓ **Public Engagement to ensure people are enabled to access the right care at the right time**
- ✓ Pharmacy support to safely manage discharge and transfer medications within the SUMPP parameters
- ✓ **Public facing information - Public messaging on right place right care, and how / when to access ED distributed through a wide range of established communications platforms including; NHS Fife Website, NHS Fife Social Media Channels, Local Press and Media, Partner organisation communications channels – these will be issued on a regular basis to reflect demand on ED, urgent and primary care services.**
- ✓ NHS 24 – 4-hour pathways for minor illness triaged via FNH from 13/5/21
- ✓ Urgent Care Services and ED have revisited the OOH redirection policy and reviewed pathways between ED and OOH
- ✓ **Identify and establish resources to support new pathways.**
- ✓ An urgent need for Paediatric escalation planning which cannot wait until Autumn/Winter.
- ✓ Review of red pathway into acute paediatrics that ensures that all referrals have been assessed by another health care professional (GP, ED, Unscheduled Care) which will filter out the patients currently being seen with mild symptoms.
- ✓ Increase in HDU/ITU Paediatric Demand
- ✓ Protecting the most vulnerable babies
- ✓ **Delivery of the adult seasonal influenza vaccination programme.**

Actions at risk (those in **bold** since previous update)

Primary, Community and Social Care

- Review the arrangements to Primary Care 'Care Home Local Enhanced Service' during 2021-22 including strengthening good quality anticipatory care planning.
- **Podiatry Services to be made available in all community and hospital sites including domiciliary and care homes**
- Working towards a return to this routine therapeutic support as soon as restrictions allow e.g. securing of IPC compliant clear masks, vaccination of staff.
- Redesign by recruiting Advanced Nurse Practitioners who can support the Consultant Rheumatologists in the delivery of the service. This will reduce the reliance on agency medical locum staffing.
- **Review of GIRFEC practices and wellbeing pathway to increase effectiveness and impact**

Planned Care, Electives and Diagnostics

- ACRT and PIR - Continue rollout throughout 2021/22 to all appropriate services.
- Patient Self- Booking - Support Patient Self-Booking across acute and community services. Linked to the Digital Hub is also the emerging capability for pathways to be enhanced by Remote Health Pathways, with COVID discharge and Pre-operative Assessment being identified as high impact areas for consideration.
- **Digital Pathology - Support creation of a business case, which if approved will lead to the Introduction of digital pathology to support a more resilient and sustainable service by improving efficiency, patient safety and delivering value for money.**

Unscheduled / Elective Care

- Review of Business Continuity/Resilience
- Workforce planning - planning for surge capacity to include a robust Medical, Nursing & AHP model.
- Sustainable Workforce – ED & AU1
- Maximise discharges from inpatient wards within VHK before 12 noon and move discharge profile to earlier in the day. Improve weekend discharge profile for Emergency Care Directorate.
- Capacity available for pre-assessment and pre-admission for front door areas of the hospital.
- Develop appropriate alternatives to attendance at A&E, minimise the need for admission, and reduce length of stay and increase options and processes for timely and appropriate discharge
- Develop a Home First Strategy
- Reduce hand offs in discharge processes
- Promote interim care home moves for people waiting on PoC.
- **Additional coordinating role in social care to ensure transfer of patients from hospitals. Test the trusted assessor model.**
- Ensure timely access to UCAT and addiction services for patients within the Acute Services Division in crisis's

Actions unlikely to meet target (those in **bold** since previous update)

Public Health

- Improve the health of the Black and Minority Ethnic Community.
- Take forward the recommendations from the Independent Expert Reference Group on COVID-19 and Ethnicity on behalf of NHS Fife.

Unscheduled / Elective Care

- Reducing length of stay on CAMHS
- The development of an app to support the Moving on Policy and help with decision making of moving on patients. This will include care home videos, staff messages.
- Winter elective plan to minimise the impact on elective activity as far as possible.
- Optimise digital healthcare where possible.

Mental Health

- Community Wellbeing Hubs across Fife to support delivery of mental health interventions and integrated care

Pharmacy

- **Implementation and roll out of HEPMA.**

Planned Care, Electives and Diagnostics

- Secure additional Waiting Times funding to increase capacity and enable waiting list reduction.
- T&O to achieve 100% of pre covid activity with progression to 110% by March 2022 in line with national commitment.
- **Exploring Locum Consultant recruitment options.**
- Remobilisation of Elective pathway in a phased manner with the need to maintain adequate red and amber capacity.

Winter Lessons and Reflections 2021/22

18 March 2022

1 Introduction

Winter 2021/22 came with significant challenges due to the impact of COVID on the past 2 years as well as running efficient vaccination and test and protect programmes.

The pressure on the health and care system intensified over the winter period but has not subsided in terms of capacity and flow since 2020. NHS Fife and Fife Health and Social Care Partnership (HSPC) continues to prioritise the needs of our vulnerable and ill patients by providing timely and effective care, despite increases in demand on services or a mismatch between demand and supply of services.

Leadership is the key to the successful whole system collaboration in place over this time.

2 Winter 2021/22

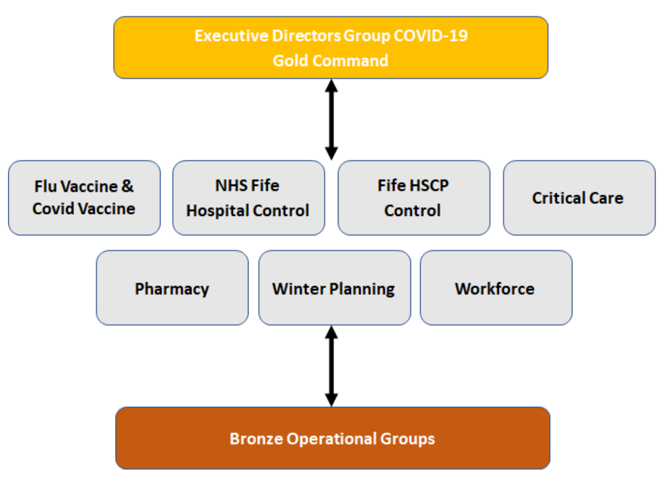
Reflections of the health and care services over the winter period has been considered and the key actions taken by NHS Fife and Fife HSPC to lead and manage the health and care system are described in this section.

2.1 Emergency Command Structure

As emergency planning measures were still in place, NHS Fife managed the emerging COVID position through the Emergency Command structure that was already well embedded throughout the organisation and Fife Health and Social Care Partnership.

The framework of the command structure of Gold, Silver and Bronze was implemented for operational teams, winter, capacity and flow and workforce. The reporting structure went to Gold Command that met at least twice a week and was made up of the Executive Directors' Group – the Chief Executive, Executive Directors and strategic senior managers.

The reporting and escalation structure provided clear lines of responsibility and decision making as shown below.



Chair: NHS Fife Chief Executive

- *Receive briefings from the Silver Command groups*
- *Approve operational acute health and social care service delivery priorities*
- *Approve NHS Fife Communications*

Chair: Executive Director

- *Receive briefings from the Bronze Command groups*
- *Escalate issues and challenges to Gold Command*

Chair: Senior Manager

- *Set up by each Silver Command group on an 'on demand' basis*
- *Aligned to specific workstreams*
- *Stood down when no longer required*
- *Reporting to Silver Command Groups*

2.2 Development of Escalation Framework

The development of the OPEL (Operational Pressure Escalation Levels) Tool at the end of 2021 enables the whole system to manage and respond to current challenges in capacity in a systematic and planned way. Initially development to manage early decision making and support to Acute's demand and capacity, it was then adapted to reflect the challenges in the HSPC. Each operational team now have an accurate overview of the pressures on their systems at least daily to be able to focus and plan to release or maintain capacity and flow in the system.

Testing has been a critical part of the implementation process. Multiple testing of the tool over daily cycles for the past 5 weeks has ensured the tool is reliable and sensitive to changes in pressure across the site to enable pro-active cross site and whole system actions to be undertaken to ensure a timeous de-escalation.

The OPEL tool has been demonstrated at the Executive Directors' Group and the Board and has been praised as being very positive and innovative. The operational and clinical teams have welcomed its introduction and is now part of their daily business. An example of the OPEL tool can be found in Appendix 1.

2.3 Informed Decision Making

Historically, during the winter period but over the last 3 years, a winter scorecard has been used on a weekly basis to discuss and plan in an integrated way with the operational teams. This scorecard follows the patients journey starting with Urgent Care, through Emergency Care and acute and community ward stays and onwards to social care capacity.

The scorecard is discussed at the Winter Capacity and Flow Bronze group with escalations, where appropriate, to Winter Silver Group. This provides the operation teams to discuss changes and monitor their impact on the whole system. An example of this can be found in Appendix 2.

The OPEL escalation framework works at an operational level, the Winter scorecard is used at a tactical level and at a strategic level, the Executive Directors' Group (Gold) received COVID report weekly and over the winter period, this was refined to a whole system monitoring report. The report provided an overview of COVID admissions and projections, planned and unplanned activity and delayed discharges. An example of this report can be found in Appendix 3.

2.4 Impact on HAI standards

The constant pressures on the health and care system have impacted on the bed capacity in ward bays. Previous work undertaken reduced the number of beds in ward bays to meet the HAI standards, however, there was such a strain on the system that additional beds were reintroduced in wards in acute and community settings. Although the situation is reviewed on a daily basis, the demand for beds is such that these additional beds have remained open longer than expected.

The current estate in Fife is such that in the older hospitals, the conditions are not optimal with investment into the older estate required to upgrade wards and improve ventilation.

2.5 Workforce

Workforce continues to be challenging across health and social care with a significant impact on the care and treatment that can be provided. Workforce continues to be challenging across health and social care with a significant impact on the care and treatment that can be provided. We established a Workforce Resilience Silver Group last year as part of our command structure which has coordinated a range of activity to support short, medium and longer term workforce supply and demand solutions and escalate workforce issues to our Gold group as required. The combination of operational, corporate, support and staff side representatives has allowed us to remain as responsive as possible during the changing context. The group has overseen workstreams on Resilience Planning, Resourcing, Education & Training and Employee Wellbeing.

Some of the key workstreams have involved the identification and deployment of a 'Workforce Resilience Layer' which has included non-frontline staff trained and redeployed for short term support in an operational support capacity; additional ward administration support; rapid recruitment to Healthcare Support Worker roles and bank utilisation and deployment of volunteers. Lessons learned have included reviewing how we improve workforce data, faster deployment of staff, better definition for support roles and enhancing communication methods and channels.

NHS Fife and Fife Health and Social Care Partnership have taken a number of actions to support workforce supply and these include:

- Accelerated recruitment to Nurse Staff Bank, including recruitment of medical, nursing and AHP students; returners (to support vaccination programme
- Early recruitment of nursing students who are graduating, employing them at Band 4 level as they await their registration from the NMC, in areas where they have secured permanent registered posts
- Accelerated recruitment processes supported by Workforce Directorate
- International recruitment: supported by the Centre for Workforce Supply and in collaboration with Yeovil Trust; 40 registered nurses and 3 radiographers will join our workforce over the coming months, with the first nursing recruits taking up posts in February 2022
- Participation in national recruitment campaign, although recognising that it is unlikely to attract a significant number of staff to work in Scotland

Fife has experienced staffing challenges on a daily basis so processes have been put in place to support the daily management of workforce, ensuring patient safety is maintained:

- Establishment of workforce hubs, monitoring staffing levels on shift by shift, on occasion hour by hour, basis
- Daily staffing huddles, led by senior nurses

- Development of 'Safe to Start Guidance' which forms part of the OPEL framework
- Development of Guiding Principles to support registered staff working in extremely challenging times
- Deployment of staff utilising Community Guidance in relation to Children's Services, Community Nursing and AHP
- Training modules adapted, which can be accessed online, rather than face to face sessions

Staff wellbeing continues to be vitally important and there has been a focus on staff wellbeing throughout the pandemic. A number of initiatives have been introduced including wellbeing hubs, pastoral care, peer support and psychological support and these will continue to be in place to support our workforce.

2.6 Winter Review themes

Lessons learned have continued to be gathered and discussed by our staff throughout the winter period. Feedback from operational services including Public Health were gathered and a detailed list of the responses received can be found in Appendix 4 – the table below summarises the high level themes with examples of positive and negative feedback and suggestions for next year. Lessons learned from the Vaccination Programme have not been included as they have been submitted separately.

A further winter review workshop in April has been arranged with the wider clinical and operational teams where the lessons learned will be discussed and proposed plans for 2022/23 will be described. As in previous years, this will bring together teams from across health and social care as well as partner agencies to gather multi agency feedback.

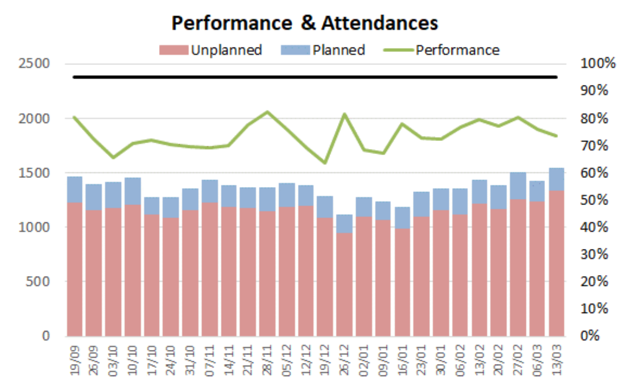
Theme	What went well	What did not go well?	What could be done differently?
Business Continuity/ Emergency Planning	Working of Local Resilience Partnership	Limitations on workforce and equipment	More robust BCPs and transport plans
Whole System Working	Agile and flexible teams Cross system working	Uptake of serial prescribing across all teams	Better deployment of Point of care testing (POCT)
Demand and Capacity	Pathway redesigned Staff Commitment Available information	Capacity challenges and delays Restricted GP access	Development of Front Door Model Improved discharge process

Theme	What went well	What did not go well?	What could be done differently?
Escalation and Surge Plans	Command structure in place Development of OPLE framework Agility of workforce	-	Earlier agreement of plans
Staffing Levels	Dedicated consultant cover Temporary and redeployment of staff Wellbeing resources for staff	Staffing levels despite recruitment drive Patient care affected due the available staff	Ability to flex staff across the system Debrief for staff
Elective Activity	Maintenance of P1 and P2 activity Use of QMH	Stopping of electives, in particular orthopaedic	-
Infection Prevention and Control	Implementation of ARHAI Respiratory Pathway Care home huddles	Late publication of guidance	Time to implementation guidance Earlier MRSA screening
Test and Protect	Clear protocols for contact tracers Protocol to manage care home admissions	Managing the changes in isolation and testing requirements Timings of staff testing	Workforce model required going forward that can rapidly respond to demands
Communications	Regular engagement with all staff	Changing position with care home closures difficult to manage	Better national communications with public Revised visitors' policy

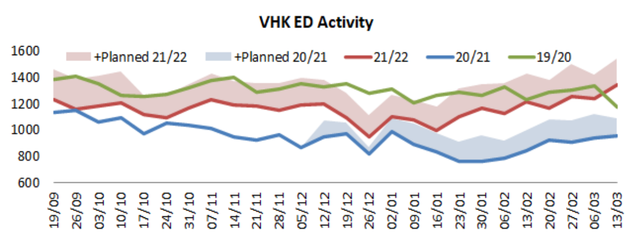
3 Analysis of Key Metrics

3.1 Emergency Department

Performance within Victoria Hospital against 4-hour standard averaged below 75% for the 26-week period to 13th March, achieving excess of 80% on four occasions. There was 1177 unplanned attendance on average per week up until festive period and have been rising since mid-January with last 8-week average over 1200. Week of 13th March exceeded 1300 unplanned attendances. Planned activity averaged just below 200 per week over the same time period.

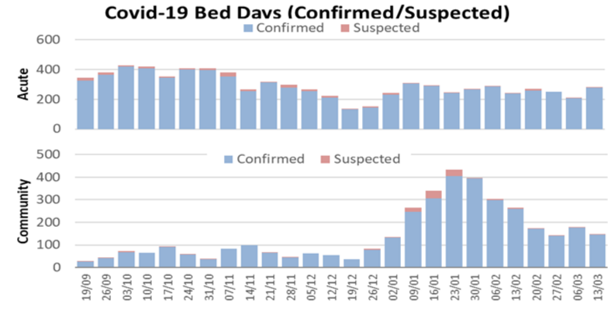


Unplanned attendances for this winter were below 2020 levels every week apart from the latest. However, when including planned activity, totals were similar up to mid-December and have been above since mid-January. Latest week was also higher than weekly average for winter 2020.



3.2 COVID-19 Hospital Activity

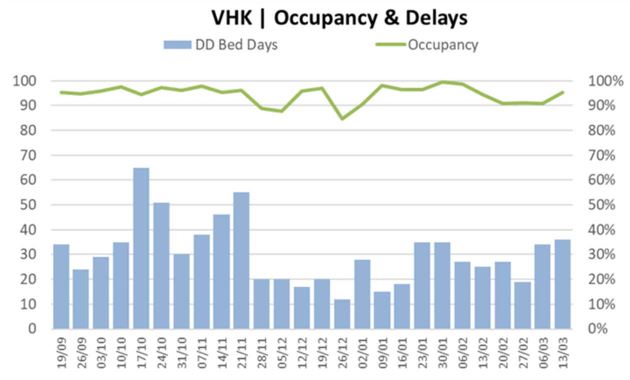
Bed days attributed to COVID-19 within Victoria Hospital peaked at 422 in early October. Steady decrease from then until Christmas period to below 150. This has risen since and has fluctuated between 250 and 300.



Bed days within Community and Mental Health Hospitals had been below 100 throughout winter until week ending 2nd January. Outbreaks within these settings led to an increase to 400 by mid-January leading to ward closures that placed significant pressure on the whole system.

3.3 Acute Occupancy and Delays

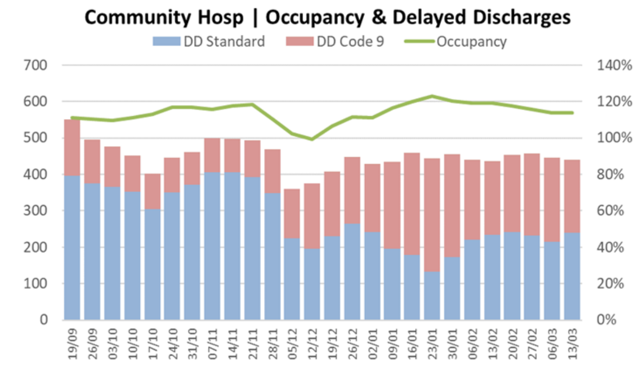
Occupancy pressures have been extreme, driven by significant increases in admission demand leading to the requirement for the use of contingency inpatient capacity, over and above surge capacity to accommodate demand. This significantly disrupted the urgent elective programme, particularly Orthopaedics, with occupancy levels continuing to impact activity.



Delayed discharge bed days have come down because of the discharge profile to HSCP with enough flex in the system to accommodate additional flow during times of significant pressure.

Site pressures have been compounded by staffing challenges, with high absence rates eroding staff ratios and placing additional strain across teams. Pre-emptive service retraction, based on clinical priority, enabled staffing resource to be consolidated based on greatest need.

Occupancy across HSCP MoE wards is higher than what it has ever been due to number of beds open over and above the MoE normal covid bed base.



Bed days for standard delays has significantly dropped. We are seeing a sustained discharge profile to care at home and interim beds which has attributed to this reduction. Increase in Code 9 delays in early 2022 was due to ward closures due to COVID-19.

4 Financial Position

Winter monies made available to the Health Board and Integrated Joint Board in November 2021 have been used to support the delivery of key winter priorities. All the funding allocated has been utilised in full with additional costs underwritten by the Health Board and the Integrated Board. Monies received into Fife has been used by the board and the H&SCP to fund additional delayed discharge coordinators, medical locum cover, discharge vehicles and multiple reviews of packages of care, all monies spent with the focus being to take discharges out of Fife hospitals and support increasing demand.

In addition, further winter monies announced in October 2021 to support the board and the H&SCP with a focus to improved delayed discharges have enabled NHS Fife

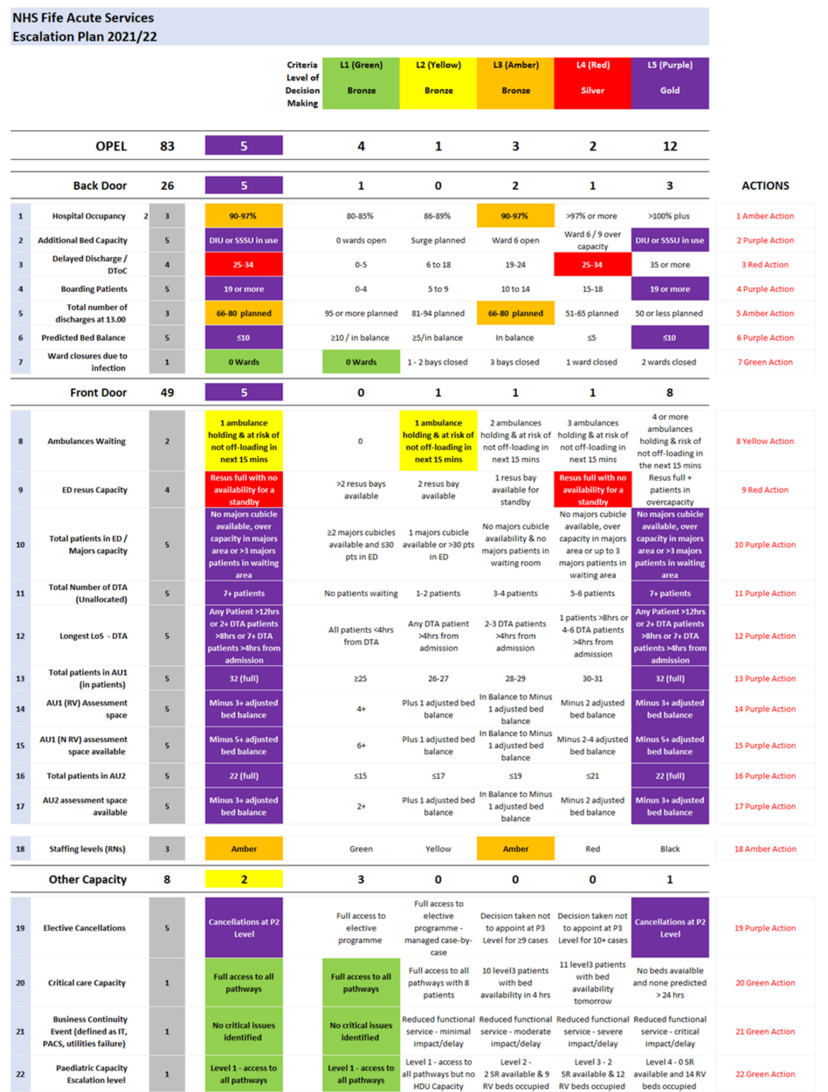
to move forward with a successful International recruitment programme with the first members of staff recruiting from overseas joining NHS Fife in February 2022 with other new recruits expected in the coming months. A successful recruitment campaign has also enabled to board to recruit the minimum 68 new band 2-3 support staff roles to support delayed discharges. Several staff are already in post with others to join the board in the next couple of months. Monies allocated for staff wellbeing measures have also been spent in full providing much needed support to staff.

Despite significant ongoing recruitment challenges other winter monies have been utilised by the H&SCP to enhance service provision with a firm focus on improvement in delayed discharges.

5 Summary

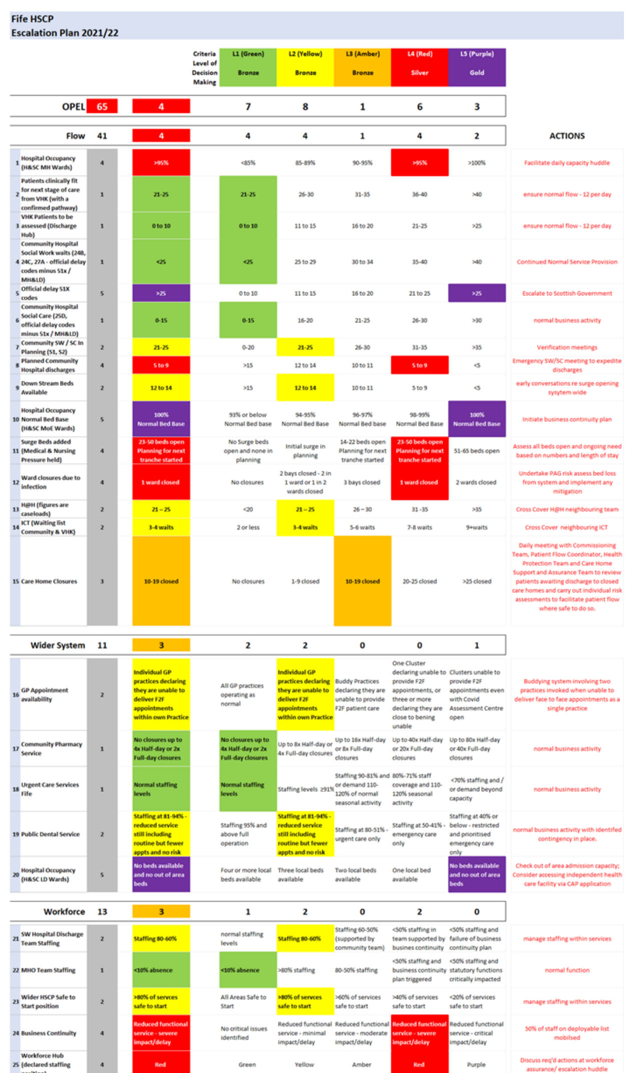
NHS Fife and Fife HSPC have shown leadership and collaborative working over this period and the integrated actions described have demonstrated the benefits of whole system working with the patient at the centre. The challenges continue to be felt across the system and we will continue to work together across agencies.

Appendix 1: Example of OPEL reporting



NHS Fife Acute Services
Escalation Plan 2021/22

#	Criteria	Score	Level of Decision Making	L1 (Green) Bronze	L2 (Yellow) Bronze	L3 (Amber) Bronze	L4 (Red) Silver	L5 (Purple) Gold	ACTIONS
	OPEL	83	5	4	1	3	2	12	
	Back Door	26	5	1	0	2	1	3	
1	Hospital Occupancy 2	3	90-97%	80-85%	86-89%	90-97%	>97% or more	>100% plus	1 Amber Action
2	Additional Bed Capacity	5	DIU or SSSU in use	0 wards open	Surge planned	Ward 6 open	Ward 6 / 9 over capacity	DIU or SSSU in use	2 Purple Action
3	Delayed Discharge / DToC	4	25-34	0-5	6 to 18	19-24	25-34	35 or more	3 Red Action
4	Boarding Patients	5	19 or more	0-4	5 to 9	10 to 14	15-18	19 or more	4 Purple Action
5	Total number of discharges at 13.00	3	66-80 planned	95 or more planned	81-94 planned	66-80 planned	51-65 planned	50 or less planned	5 Amber Action
6	Predicted Bed Balance	5	≤10	≥10 / in balance	≥5/in balance	In balance	≤5	≤10	6 Purple Action
7	Ward closures due to infection	1	0 Wards	0 Wards	1 - 2 bays closed	3 bays closed	1 ward closed	2 wards closed	7 Green Action
	Front Door	49	5	0	1	1	1	8	
8	Ambulances Waiting	2	1 ambulance holding & at risk of not off-loading in next 15 mins	0	1 ambulance holding & at risk of not off-loading in next 15 mins	2 ambulances holding & at risk of not off-loading in next 15 mins	3 ambulances holding & at risk of not off-loading in next 15 mins	4 or more ambulances holding & risk of not off-loading in the next 15 mins	8 Yellow Action
9	ED resus Capacity	4	Resus full with no availability for a standby	>2 resus bays available	2 resus bay available	1 resus bay available for standby	Resus full with no availability for a standby	Resus full + patients in overcapacity	9 Red Action
10	Total patients in ED / Majors capacity	5	No majors cubicle available, over capacity in majors area or >3 majors patients in waiting area	≥2 majors cubicles available and ≤30 pts in ED	1 majors cubicle available or >30 pts in ED	No majors cubicle availability & no majors patients in waiting room	No majors cubicle available, over capacity in majors area or up to 3 majors patients in waiting area	No majors cubicle available, over capacity in majors area or >3 majors patients in waiting area	10 Purple Action
11	Total Number of DTA (Unallocated)	5	7+ patients	No patients waiting	1-2 patients	3-4 patients	5-6 patients	7+ patients	11 Purple Action
12	Longest LoS - DTA	5	Any Patient >12hrs or 2+ DTA patients >8hrs or 7+ DTA patients >4hrs from admission	All patients <4hrs from DTA	Any DTA patient >4hrs from admission	2-3 DTA patients >4hrs from admission	1 patients >8hrs or 4-6 DTA patients >4hrs from admission	Any Patient >12hrs or 2+ DTA patients >8hrs or 7+ DTA patients >4hrs from admission	12 Purple Action
13	Total patients in AU1 (in patients)	5	32 (full)	≥25	26-27	28-29	30-31	32 (full)	13 Purple Action
14	AU1 (RV) Assessment space	5	Minus 3+ adjusted bed balance	4+	Plus 1 adjusted bed balance	In Balance to Minus 1 adjusted bed balance	Minus 2 adjusted bed balance	Minus 3+ adjusted bed balance	14 Purple Action
15	AU1 (N RV) assessment space available	5	Minus 5+ adjusted bed balance	6+	Plus 1 adjusted bed balance	In Balance to Minus 1 adjusted bed balance	Minus 2-4 adjusted bed balance	Minus 5+ adjusted bed balance	15 Purple Action
16	Total patients in AU2	5	22 (full)	≤15	≤17	≤19	≤21	22 (full)	16 Purple Action
17	AU2 assessment space available	5	Minus 3+ adjusted bed balance	2+	Plus 1 adjusted bed balance	In Balance to Minus 1 adjusted bed balance	Minus 2 adjusted bed balance	Minus 3+ adjusted bed balance	17 Purple Action
18	Staffing levels (RNs)	3	Amber	Green	Yellow	Amber	Red	Black	18 Amber Action
	Other Capacity	8	2	3	0	0	0	1	
19	Elective Cancellations	5	Cancellations at P2 Level	Full access to elective programme	Full access to elective programme - managed case-by-case	Decision taken not to appoint at P3 Level for ≥9 cases	Decision taken not to appoint at P3 Level for 10+ cases	Cancellations at P2 Level	19 Purple Action
20	Critical care Capacity	1	Full access to all pathways	Full access to all pathways	Full access to all pathways with 8 patients	10 level3 patients with bed availability in 4 hrs	11 level3 patients with bed availability tomorrow	No beds avaialble and none predicted > 24 hrs	20 Green Action
21	Business Continuity Event (defined as IT, PACS, utilities failure)	1	No critical issues identified	No critical issues identified	Reduced functional service - minimal impact/delay	Reduced functional service - moderate impact/delay	Reduced functional service - severe impact/delay	Reduced functional service - critical impact/delay	21 Green Action
22	Paediatric Capacity Escalation level	1	Level 1 - access to all pathways	Level 1 - access to all pathways	Level 1 - access to all pathways but no HDU Capacity	Level 2 - 2 SR available & 9 RV beds occupied	Level 3 - 2 SR available & 12 RV beds occupied	Level 4 - 0 SR available and 14 RV beds occupied	22 Green Action



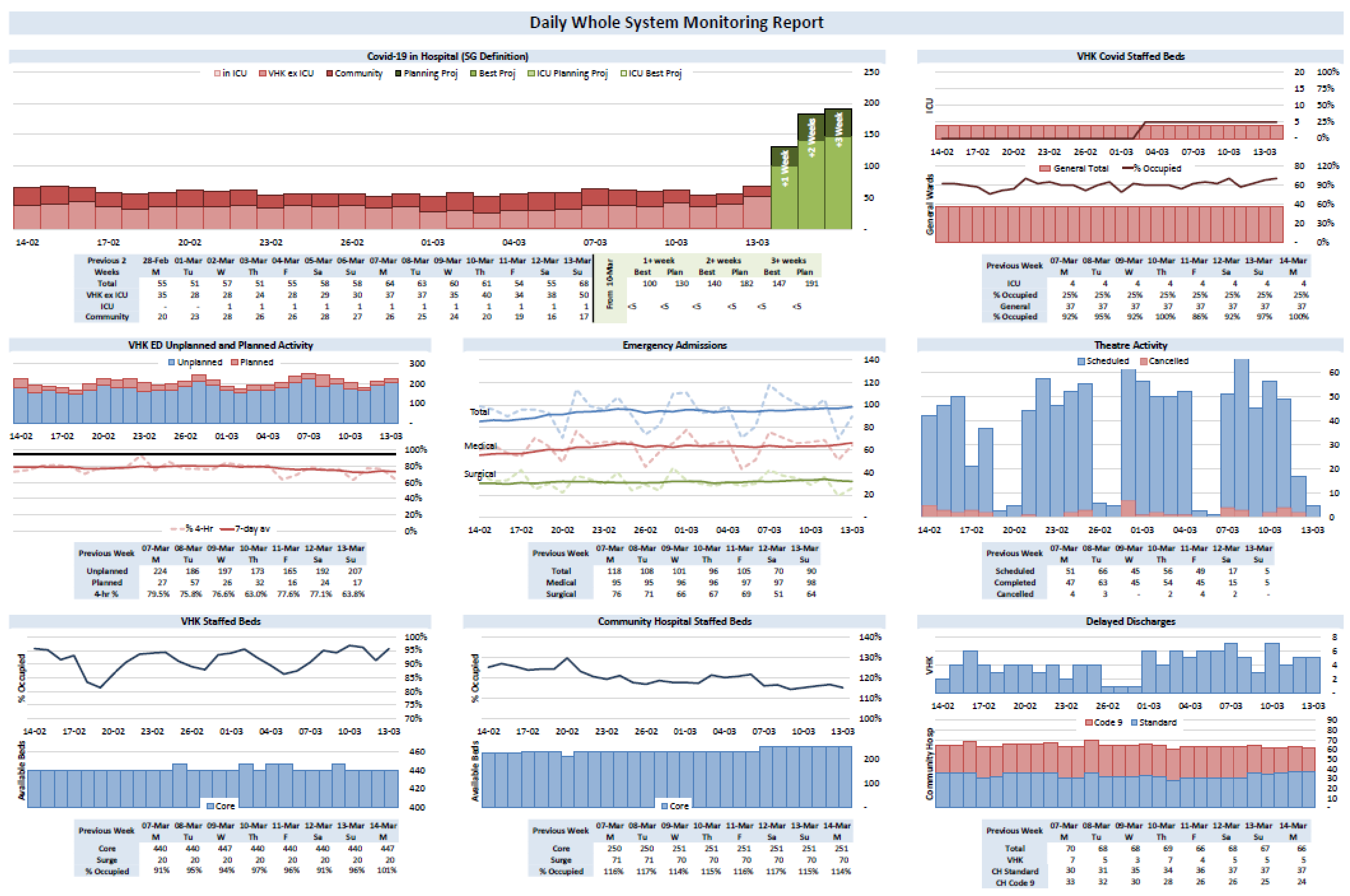
Fife HSCP
Escalation Plan 2021/22

#	Criteria	Score	Level of Decision Making	L1 (Green) Bronze	L2 (Yellow) Bronze	L3 (Amber) Bronze	L4 (Red) Silver	L5 (Purple) Gold	ACTIONS
	OPEL	65	4	7	8	1	6	3	
	Flow	41	4	4	4	1	4	2	
1	Hospital Occupancy (H&SC MH Wards)	4	>95%	<85%	85-89%	90-95%	>95%	>100%	Facilitate daily capacity huddle
2	Patients clinically fit for next stage of care from VHK (with a confirmed pathway)	1	21-25	21-25	26-30	31-35	36-40	>40	ensure normal flow - 12 per day
3	VHK Patients to be assessed (Discharge Hub)	1	0 to 10	0 to 10	11 to 15	16 to 20	21-25	>25	ensure normal flow - 12 per day
4	Community Hospital Social Work waits (24B, 24C, 27A - official delay codes minus 51x / MH&LD)	1	<25	<25	25 to 29	30 to 34	35-40	>40	Continued Normal Service Provision
5	Official delay 51X codes	5	>25	0 to 10	11 to 15	16 to 20	21 to 25	>25	Escalate to Scottish Government
6	Community Hospital Social Care (25D, official delay codes minus 51x / MH&LD)	1	0-15	0-15	16-20	21-25	26-30	>30	normal business activity
7	Community SW / SC In Planning (51, 52)	2	21-25	0-20	21-25	26-30	31-35	>35	Verification meetings
8	Planned Community Hospital discharges	4	5 to 9	>15	12 to 14	10 to 11	5 to 9	<5	Emergency SW/SC meeting to expedite discharges
9	Down Stream Beds Available	2	12 to 14	>15	12 to 14	10 to 11	5 to 9	<5	early conversations re surge opening sysytem wide
10	Hospital Occupancy Normal Bed Base (H&SC MoE Wards)	5	100% Normal Bed Base	93% or below Normal Bed base	94-95% Normal Bed Base	96-97% Normal Bed base	98-99% Normal Bed Base	100% Normal Bed Base	Initiate business continuity plan
11	Surge Beds added (Medical & Nursing Pressure held)	4	23-50 beds open Planning for next tranche started	No Surge beds open and none in planning	Initial surge in planning	14-22 beds open Planning for next tranche started	23-50 beds open Planning for next tranche started	51-65 beds open	Assess all beds open and ongoing need based on numbers and length of stay
12	Ward closures due to infection	4	1 ward closed	No closures	2 bays closed - 2 in 1 ward or 1 in 2 wards closed	3 bays closed	1 ward closed	2 wards closed	Undertake PAG risk assess bed loss from system and implement any mitigation
13	H@H (figures are caseloads)	2	21 – 25	<20	21 – 25	26 – 30	31 -35	>35	Cross Cover H@H neighbouring team
14	ICT (Waiting list Community & VHK)	2	3-4 waits	2 or less	3-4 waits	5-6 waits	7-8 waits	9+waits	Cross Cover neighbouring ICT
15	Care Home Closures	3	10-19 closed	No closures	1-9 closed	10-19 closed	20-25 closed	>25 closed	Daily meeting with Commissioning Team, Patient Flow Coordinator, Health Protection Team and Care Home Support and Assurance Team to review patients awaiting discharge to closed care homes and carry out individual risk assessments to facilitate patient flow where safe to do so.
	Wider System	11	3	2	2	0	0	1	
16	GP Appointment availability	2	Individual GP practices declaring they are unable to deliver F2F appointments within own Practice	All GP practices operating as normal	Individual GP practices declaring they are unable to deliver F2F appointments within own Practice	Buddy Practices declaring they are unable to provide F2F patient care	One Cluster declaring unable to provide F2F appointments, or three or more declaring they are close to bening unable	Clusters unable to provide F2F appointments even with Covid Assessment Centre open	Buddying system involving two practices invoked when unable to deliver face to face appointments as a single practice
17	Community Pharmacy Service	1	No closures up to 4x Half-day or 2x Full-day closures	No closures up to 4x Half-day or 2x Full-day closures	Up to 8x Half-day or 4x Full-day closures	Up to 16x Half-day or 8x Full-day closures	Up to 40x Half-day or 20x Full-day closures	Up to 80x Half-day or 40x Full-day closures	normal business activity
18	Urgent Care Services Fife	1	Normal staffing levels	Normal staffing levels	Staffing levels ≥91%	Staffing 90-81% and or demand 110-120% of normal seasonal activity	80%-71% staff coverage and 110-120% seasonal activity	<70% staffing and / or demand beyond capacity	normal business activity
19	Public Dental Service	2	Staffing at 81-94% - reduced service still including routine but fewer appts and no risk	Staffing 95% and above full operation	Staffing at 81-94% - reduced service still including routine but fewer appts and no risk	Staffing at 80-51% - urgent care only	Staffing at 50-41% - emergency care only	Staffing at 40% or below - restricted and prioritised emergency care only	normal business activity with identifed contingency in place.
20	Hospital Occupancy (H&SC LD Wards)	5	No beds available and no out of area beds	Four or more local beds available	Three local beds available	Two local beds available	One local bed available	No beds available and no out of area beds	Check out of area admission capacity; Consider accessing independent health care facility via CAP application
	Workforce	13	3	1	2	0	2	0	
21	SW Hospital Discharge Team Staffing	2	Staffing 80-60%	normal staffing levels	Staffing 80-60%	Staffing 60-50% (supported by community team)	<50% staffing in team supported by busines continuity	<50% staffing and failure of business continuity plan	manage staffing within services
22	MHO Team Staffing	1	<10% absence	<10% absence	>80% staffing	80-50% staffing	<50% staffing and business continuity plan triggered	<50% staffing and statutory functions critically impacted	normal function
23	Wider HSCP Safe to Start position	2	>80% of servces safe to start	All Areas Safe to Start	>80% of servces safe to start	>60% of services safe to start	>40% of services safe to start	<20% of services safe to start	manage staffing within services
24	Business Continuity	4	Reduced functional service - severe impact/delay	No critical issues identified	Reduced functional service - minimal impact/delay	Reduced functional service - moderate impact/delay	Reduced functional service - severe impact/delay	Reduced functional service - critical impact/delay	50% of staff on deployable list mobilsed
25	Workforce Hub (declared staffing position)	4	Red	Green	Yellow	Amber	Red	Purple	Discuss req'd actions at workforce assurance/ escalation huddle

Appendix 2: Whole System Scorecard

Area	Indicator	Trend	19-Sep	26-Sep	03-Oct	10-Oct	17-Oct	24-Oct	31-Oct	07-Nov	14-Nov	21-Nov	28-Nov	05-Dec	12-Dec	19-Dec	26-Dec	02-Jan	09-Jan	16-Jan	23-Jan	30-Jan	06-Feb	13-Feb	20-Feb	27-Feb	06-Mar	13-Mar
Urgent Care	Contacts		2312	2243	2339	2823	1993	2138	2218	2190	2257	2360	2223	2352	2312	2354	1920	3117	2897	2252	2341	2245	2174	2139	2229	2133	2134	2206
	Home Visits		101	124	120	152	107	125	134	104	98	108	116	118	107	83	98	247	179	124	124	131	108	120	121	112	114	121
	COVID Outcome		426	396	383	530	370	391	308	385	411	431	369	398	358	422	359	666	556	337	308	289	291	315	296	299	304	324
	NHS24 Outcome		326	338	344	414	323	351	376	365	359	351	369	398	399	342	308	522	440	367	383	396	359	362	397	358	342	368
VHK ED	All		1462	1392	1411	1450	1268	1267	1350	1434	1377	1357	1359	1398	1380	1283	1114	1267	1227	1177	1319	1348	1355	1433	1385	1504	1424	1543
	Planned		228	235	231	242	148	176	185	201	181	171	211	209	181	189	163	161	150	180	214	184	230	213	216	244	187	199
	Unplanned		1234	1157	1180	1208	1120	1091	1165	1233	1196	1186	1148	1189	1199	1094	951	1106	1077	997	1105	1164	1125	1220	1169	1260	1237	1344
	Performance		80.4%	72.5%	65.6%	70.8%	72.1%	70.4%	69.6%	69.3%	69.9%	77.4%	82.1%	75.9%	69.0%	63.7%	81.5%	68.4%	67.1%	78.0%	72.9%	72.4%	76.8%	79.3%	77.0%	80.5%	76.0%	73.5%
MIU	Total		484	414	419	377	361	339	347	353	375	374	370	305	352	295	197	204	199	320	367	325	382	347	317	403	383	436
	Unplanned		405	348	346	322	311	290	299	293	308	315	304	250	292	242	146	179	158	267	306	271	317	291	267	332	325	372
VHK	Admissions		696	730	729	709	705	703	683	714	702	689	705	767	716	750	649	715	639	667	730	737	693	677	707	730	743	770
	Emergency		589	640	636	628	624	650	611	626	621	601	619	674	628	658	586	687	611	616	657	653	617	597	641	657	651	686
	Medical		355	356	351	360	358	407	355	351	378	355	357	402	366	387	363	424	364	367	366	370	347	335	354	371	362	405
	Surgical		234	284	285	268	266	243	256	275	243	246	262	272	262	271	223	263	247	249	291	283	270	262	287	286	289	281
	Discharges		615	678	648	648	644	649	630	659	660	636	686	679	616	726	653	561	605	637	653	668	684	644	693	674	697	661
Theatre Activity	Scheduled		224	255	258	245	217	213	207	244	280	225	267	265	242	273	141	51	96	182	200	227	260	257	218	272	293	303
	Cancelled		14	16	16	15	14	16	15	16	15	11	11	13	15	19	4	1	11	7	7	20	19	7	15	7	12	15
	Hospital Cancelled		0	1	3	3	8	1	0	3	4	1	0	1	3	2	0	0	3	0	0	0	6	0	3	2	0	1
VHK Bed Utilisation	Occupancy		95%	95%	96%	98%	95%	97%	96%	98%	95%	96%	89%	88%	96%	97%	85%	91%	98%	96%	97%	99%	99%	95%	91%	91%	91%	95%
	COVID Bed Days		346	380	430	420	352	408	408	379	268	318	297	265	224	138	152	241	308	292	245	270	291	242	271	252	208	279
	DD Bed Days		34	24	29	35	65	51	30	38	46	55	20	20	17	20	12	28	15	18	35	35	27	25	27	19	34	36
Community Hospital	Admissions		54	51	52	52	53	42	52	59	59	50	65	52	40	59	57	55	46	71	34	55	73	53	56	50	50	52
	Discharges		55	52	55	46	45	36	68	53	48	48	78	53	41	55	57	51	33	60	37	57	69	55	51	60	45	57
	Occupancy		111%	110%	110%	111%	113%	117%	117%	116%	118%	118%	110%	102%	99%	107%	111%	111%	117%	120%	123%	120%	119%	119%	118%	116%	114%	114%
	COVID Bed Days		28	45	73	65	95	60	37	84	98	67	48	64	54	37	84	136	264	340	433	397	303	265	173	143	180	149
	DD Bed Days		551	496	476	452	401	445	462	499	498	493	469	359	376	408	448	428	434	459	443	456	440	436	454	458	446	440
	DD Standard		397	376	365	352	305	351	372	405	405	392	349	225	195	231	265	242	196	179	132	173	220	234	241	233	215	240
	DD Code 9		154	120	111	100	96	94	90	94	93	101	120	134	181	177	183	186	238	280	311	283	220	202	213	225	231	200

Appendix 3: Whole System Monitoring Report



Previous 2 Weeks	28-Feb M	01-Mar Tu	02-Mar W	03-Mar Th	04-Mar F	05-Mar Sa	06-Mar Su	07-Mar M	08-Mar Tu	09-Mar W	10-Mar Th	11-Mar F	12-Mar Sa	13-Mar Su
Total	55	51	57	51	55	58	58	64	63	60	61	54	55	68
VHK ex ICU	35	28	28	24	28	29	30	37	37	35	40	34	38	50
ICU	-	-	1	1	1	1	1	1	1	1	1	1	1	1
Community	20	23	28	26	26	28	27	26	25	24	20	19	16	17

From 10-Mar	1+ week Best	1+ week Plan	2+ weeks Best	2+ weeks Plan	3+ weeks Best	3+ weeks Plan
Total	100	130	140	182	147	191
ICU	<5	<5	<5	<5	<5	<5

Previous Week	07-Mar M	08-Mar Tu	09-Mar W	10-Mar Th	11-Mar F	12-Mar Sa	13-Mar Su	14-Mar M
ICU	4	4	4	4	4	4	4	4
% Occupied	25%	25%	25%	25%	25%	25%	25%	25%
General	37	37	37	37	37	37	37	37
% Occupied	92%	95%	92%	100%	86%	92%	97%	100%

Previous Week	07-Mar M	08-Mar Tu	09-Mar W	10-Mar Th	11-Mar F	12-Mar Sa	13-Mar Su
Unplanned	224	186	197	173	165	192	207
Planned	27	57	26	32	16	24	17
4-hr %	79.5%	75.8%	76.6%	63.0%	77.6%	77.1%	63.8%

Previous Week	07-Mar M	08-Mar Tu	09-Mar W	10-Mar Th	11-Mar F	12-Mar Sa	13-Mar Su
Total	118	108	101	96	105	70	90
Medical	95	95	96	96	97	97	98
Surgical	76	71	66	67	69	51	64

Previous Week	07-Mar M	08-Mar Tu	09-Mar W	10-Mar Th	11-Mar F	12-Mar Sa	13-Mar Su
Scheduled	51	66	45	56	49	17	5
Completed	47	63	45	54	45	15	5
Cancelled	4	3	-	2	4	2	-

Previous Week	07-Mar M	08-Mar Tu	09-Mar W	10-Mar Th	11-Mar F	12-Mar Sa	13-Mar Su	14-Mar M
Core	440	440	447	440	440	440	440	447
Surge	20	20	20	20	20	20	20	20
% Occupied	91%	95%	94%	97%	96%	91%	96%	101%

Previous Week	07-Mar M	08-Mar Tu	09-Mar W	10-Mar Th	11-Mar F	12-Mar Sa	13-Mar Su	14-Mar M
Core	250	250	251	251	251	251	251	251
Surge	71	71	70	70	70	70	70	70
% Occupied	116%	117%	114%	115%	116%	117%	115%	114%

Previous Week	07-Mar M	08-Mar Tu	09-Mar W	10-Mar Th	11-Mar F	12-Mar Sa	13-Mar Su	14-Mar M
Total	70	68	68	69	66	68	67	66
VHK	7	5	3	7	4	5	5	5
CH Standard	30	31	35	34	36	37	37	37
CH Code 9	33	32	30	28	26	26	25	24

Appendix 4: Themed responses

Business Continuity/Emergency Planning

What went well?

- Resilience in primary care in relation to Covid assessment.
- Local Resilience Partnership arrangements were rapidly put in place in response to Storm Arwen 'red' warning
- Local Resilience Partnership activated to consider social care pressures and concurrent risks and coordinated offers of assistance.

What did not go well?

- The Fife Equipment Loan Store has also had to deal with other external factors: Covid, Brexit which has led to a lack of supply of equipment.
- Consideration needs to be taken for the additional staffing and equipment needs for an increased number of community beds (Surge).
- Availability of 4 x 4
- Partner agencies were only able to offer limited support when additional social care was requested.

What should be done differently/changed?

- Could transport department take a role in providing 4 x 4 transport for all community services if required in severe weather?
- Strong contingency plans- Identified Winter surge capacity (winter wards that provide appropriate accommodation in line with national guidance) with HCWs recruited to staff these areas.

Whole System Working

What went well?

- Command structure (Bronze/Silver/Gold) in place for operational teams in Acute, HSCP and system wide. Clear actions and accountability relating to decisions
- Cross system working and flexibility in use of clinical space
- Launch of nMAB treatment for clinically vulnerable outpatient treatments

- Transition of Medical Admissions Controller GP function to Flow and Navigation Hub
- System wide working through huddles to manage flow through pathways for both care at home and care homes. Ensuring collaborative commissioning with providers to meet the needs of patients.
- Commitment of all teams to manage workforces across all sectors to work in an agile way has been very apparent – not only via deployment but also through prioritisation of work, responding to tight time scales and rapidly changing circumstances as well as being solutions focused. Staffing BRAG scoring and whole system approach to site safety including critical care bronze/silver daily reviews
- Increased integration and collaborative working between teams
- Multi-disciplinary approach to working under significant pressure to support hospital discharges and appropriate care placements. Regular multi-disciplinary meetings to ensure management oversight of service users' journey in as timely a way as is possible.
- Agile working from **all teams** clinical and support teams (domestics, facilities, portering and volunteers etc)
- Community Pharmacy remained open as a frontline clinical service to all patients. Use of Pharmacy First was significantly above previous years, allowing patients to access treatment quickly and flexibly.
- COVID POCT ability for clinical assessment and patient placement
- Staff rapid COVID testing for business-critical areas

What did not go well?

- While Board wide uptake of serial prescribing has been a success, there are a limited number of teams who have not engaged with this important service which is of benefit to workload management and clinical care.

What should be done differently/changed?

- Need to feed lessons learned from whole system working into workforce strategy and development as well as work on service re-design
- Consolidation of platforms for respiratory testing
- Improved route for COVID-19 reporting to deliver better TAT.
- Better deployment and management of the poct team.
- Increased availability of point of care testing (POCT) for **<u>all</u>** admissions (As NHS Fife is not 100% single room occupancy, this would support patient placement, and reduce number of hospital bay contacts from asymptomatic patients)

Demand and Capacity Planning

What went well?

- Use of Live Discharge tool for wards and hub whiteboard patient discharges
- Integrated HALO within front door
- Use of elective orthopaedic ward for screened trauma overflow
- Use of data intelligence and modelling to anticipate and plan acute service delivery
- Remodelling of ED resus area to allow for increased capacity whilst meeting IPCT requirements for COVID
- Commitment by all staff to provide the best service they possibly could during a period of working under extreme pressures with, at times limited resources available to them.
- Quick responses by most providers to ensure assessments were undertaken as quickly as possible and discharges arranged.
- Constant review of delayed discharges for up-to-date position.
- Use of interim/assessment/STAR bed placements to await the completion of care assessments/decision on pathway of care.
- Good dissemination of information about ward status.
- Daily care home huddle to address challenges and ensure optimal discharges
- Existing Pharmacy service core priorities provided an effective framework for targeting of resource. This supported the wider system appropriately and staff responded with flexibility and professionalism to the revised ask.
- Pathways for new COVID treatments were developed and deployed rapidly following exemplary multi-professional response. New pathways through Flow and Navigation Hub for Acute Admissions and nMAB Treatment.
- Rapid development of urgent COVID-19 pathways such as staff testing, discharge and surgery in spite of resource restrictions.
- Board-wide uptake of serial prescribing has improved across the last six months – this is important as a government priority supporting management of workload pressures in Community Pharmacies and General Practice.
- Public Health teams managed the pressures of Omicron through supportive practices established during earlier stages of the pandemic

What did not go well?

- Capacity challenges resulting in ambulance queues for ED
- Delays in transfers of care through Downstream Beds and Social Work pathways
- Use of planned care beds for emergency care patients with significant impact on patients requiring urgent surgery

- The daily request for sitrep reports to Senior Management and Scottish Government left staff feeling overwhelmed with providing data. This included for the first time the Social Work Hospital Discharge Team.
- Opportunity to reflect on transfers of care to support good relationship and safe optimal hand over. Interim beds – high numbers and length of stay due to lack of capacity in Care. More evidence to be gathered on this going forwards in respect of Service User outcomes.
- Restricted access to appointments at GP Practices
- Management of discharge pathways placed additional pressure on Microbiology and were too reactive.
- Challenges with adequate surge capacity (and staff for these areas) leading to increased number of patients in bays, which increases the risk of transmission of COVID-19
- An Increase in waiting times for support services (e.g. Fife Council Community OT Service) despite staff working to capacity.

What should be done differently/changed?

- Need to link Demand and Capacity Planning to transformation programme as demand outstripped the capacity available
- The Moving on Policy brought to the attention of the families/representatives as soon as possible rather than waiting until their family member has been delayed in hospital for a number of days without any decision made on care home choices/pathway agreed.
- Ensure families/representatives understand and are in agreement that staying in hospital is not an option or in the best interest of the patient while care home choices are made.
- Front door model is being developed – this will be in place for next winter, again, time needed to develop this model in light of what we know and what we need the model to achieve.
- Indicative guidance regarding policy would be helpful when Boards are required to rapidly stand-up new services or pathways. A proactive approach to planning for most likely scenarios would be beneficial, managed both locally and nationally – this would resolve concerns linked to reactive responses where there are time constraints.
- A review of use of resources such as surge wards and proactively planning for likely scenarios, allowing for proactive identification of staff and required processes etc. Review of data around organisation status may reveal patterns in demand levels across the system. More broadly, a proactive review of surge planning and assurance that all relevant areas, including clinical support teams, have visibility of them is important.
- Adequate Roll out time for New Processes i.e. training and system updates.
- System data reporting for specific services.
- Improved process and control on discharge across the hospital.

Escalation and Surge Plans

What went well?

- Development of OPEL escalation tools and live working for early warning and operational actions. Use of OPEL to have a shared language and understanding of operational pressures across Acute and HSCP
- Agility in retracting from services in Omicron wave
- Daily SLT meeting to provide a forum for escalation
- Authorisation for funding to increase GP resource.
- Continual assessment and redesign of the Urgent Care Service

What did not go well?

What should be done differently/changed?

- Earlier agreement of escalation plans before the start of Winter.

Staffing Levels

What went well?

- Unwavering passion and commitment from all teams across all services – inspiring!
- Dedicated consultant cover for additional capacity at VHK removing ‘boarding’ culture as per previous years
- Availability of up-to-date data through the workforce dashboard
- Staffing inpatient surge wards was achieved through the whole MDT approach which allowed sourcing of staff to cover the wards from Agency, Bank, extra hours OT/PT.
- Additional temporary staff through Health Improvement Scotland for Hospital at Home. This gave us the opportunity to secure permanent funding.
- Securing continuous permanent funding for OT/PT across ICASS and Nursing for Hospital at Home will have a significant positive impact for the future.
- Teams working across disciplines to support Care Homes have added huge value and support to struggling staff teams within care homes
- A lot of admin staff now have laptops and can work from home

- Team leads supported implementation of changes at pace and kept morale of staff high despite escalating numbers
- Based on previous year's activity we were able to forecast projections to put adequate staffing levels in place.
- Re-deployment staff from Partnership into Flow and Navigation Hub between January 2022 - April 2022.
- Recruitment to enhance Nursing and Admin Establishment.
- Availability of wellbeing resources for all staff.
- Re-deployment of 3 x Band 5 TUCP's to QMH to support Ward 8 at Queen Margaret Hospital Dunfermline.

What did not go well?

- Despite an ongoing recruitment drive, challenges remained with staffing (COVID related whether additional resources required for the vaccination programme, new streams of work such as the monoclonal antibody treatments as well as COVID related sickness/absenteeism)
- It is notable that staff across the service are feeling increasingly fatigued following pressure over the last two years.
- Plans for staff to rest over Christmas and New Year were not fully realised and we had to ask staff to work extra hours.
- Extended redeployment of staff to support Omicron response and impact of staff morale
- Temporary staff with a quick turnaround, as the availability of OT/PT staff is very difficult to access even through agency.
- Staff being redeployed to surge wards which meant teams were continuously working at critical function. This inevitably means there is a backlog of work to pick up when staff return e.g. CDM reviews
- Time taken to extend contracts for fixed term staff caused uncertainty and increased turnover
- Patient Conveyancing issues – due to staffing levels

What should be done differently/changed?

- Cultural changes in the way teams respond and commit to ensuring staffing as a whole system is safe and responsive to need i.e. flexing up capacity and staff movement
- To consider the positive impact that adequate staffing on wards will have on reducing length of stay and reducing level of dependency to decrease the demand on care services required on discharge
- Increased staffing resource to accommodate increased care of patients who are palliative or have complex health conditions and wishing to remain at home
- Debriefing for clinical teams to allow reflections over the last few months.
- There is a need to ensure staff have sufficient capacity to undertake the core parts of their jobs to a high standard and reviewing activities which do not add appropriate value.

- Funding for winter assurance should be released earlier to allow for recruitment processes to be followed ahead of winter, rather than reacting to it. A review of winter spends incurred across departments would allow for flexible use of resource across the organisation, focussing on key areas affected by winter.

Elective Activity

What went well?

- Maintenance of P1 and P2 surgery
- Use of QMH facilities to maintain activity

What did not go well?

- Cessation of all planned orthopaedic elective surgery in ward 10 due to demand for emergency patients.

Infection Prevention and Control

What went well?

- Adaptability with ARHAI guidance to improve flexibility of ward areas and minimise ward closures
- Good availability of PPE (supported by excellent collaboration with H&S, procurement and IPCT)
- Stepping up of HCT, Bronze, Silver meetings over winter months
- NHS Fife went live with the new ARHAI Scotland Winter 2021/22 Respiratory Infections in Health and Care Settings Infection Prevention and Control (IPC) Addendum, in line with the revised dates
- Local pathways and implementation of the above guidance supported by excellent leadership from Deputy COO, ADoN, clinical teams and IPCT.
- IPC training on new guidance and outbreak management available over the winter months
- Care home hub/care home safety huddle/care home oversight group (a multidisciplinary group to support best practice in care homes)- service found to be supportive.

What did not go well?

- Very late publication of the ARHAI Scotland Winter 2021/22 Respiratory pathway guidance (with revised launch/implementation dates as guidance was incomplete)

What should be done differently/changed?

- A full comprehensive National IPC winter guidance published with sufficient time for boards to develop and implement pathways locally
- Earlier MRSA screening for trauma patients anticipating ward 10 usage next year, but this won't be available as we will be in the FEOC by then.

Test and Protect

What went well?

- Agreed national protocols for Contact Tracing were implemented and there was clear focus on more vulnerable settings
- Local protocol developed to manage admissions into Care Homes with COVID19 outbreaks

What did not go well?

- Impact of changing isolation and testing requirements for staff and subsequent staffing pressures
- Lack of OH support over weekends to allow for use of Cameron for staff testing
- Lack of available resources due to care staff being unable to work due to contracting covid or waiting for test results – both of these being unavoidable.
- OH resources did not match demand for TAT of urgent staff testing.
- IT connectivity caused delays due to high demand for new interfaces and extended pathways developed to feed information back to T&P teams

What should be done differently/changed?

- A rapid response workforce for T&P needs to be retained to manage pressures given the likelihood of winter pressures next year. We recognise this may look different for winter 22/23 but there does need to be careful thought put to the retention of an agile emergency response for future COVID19 pressures and other infectious diseases.

Communications

What went well?

- Command structure in place (Bronze, Silver, Gold) which ensures optimal communication and clear lines of decision making.
- Staff engagement in recognising clinical need for redeployment
- Strong communications at a local, organisational and national level
- Regular communication to all staff regarding developments has been valuable.

What did not go well?

- Changing position with regards to care home closures due to Covid outbreaks – this led to delays in discharges taking place or alternative providers being sourced.

What should be done differently/changed?

- Improved national communications to the general public that the guidance is different in healthcare premises.
- Consider national policy for visitors- will requirements continue to be for LFD tests to be performed prior to visiting? Will these continue to be free? If not will boards have to provide the tests and an area for these to be performed?

Winter Planning

Monthly Report

Week Ending 31st January to 3rd April 2022

Contents

Introduction..2

Section A: Executive Summary 3

Section B: Performance Summary to Wk Ending 30th January 2022 6

Introduction

The purpose of this report is to assure the Chief Executive, IJB and EDG that the Winter Plan is being delivered in accordance with the submission to Scottish Government and against agreed performance targets.

In 2021/22, the Winter Plan is integrated in the Remobilisation Plan and describes the actions that will be taken forward by NHS Fife and the Health and Social Care Partnership to optimise service resilience during the winter months and beyond in a COVID-19 sensitive environment. Executive leadership sits with the Director of Nursing and delivery lies with both the Directors of Acute Services in NHS Fife and the Health and Social Care Partnership.

A Silver Command has been established for winter planning which meets weekly and agrees actions, supported by the Winter Planning Bronze Command that monitors the dashboard weekly and escalates issues to Silver Command where appropriate. A bi-monthly report is provided to the board for assurance. The weekly reporting will cease at the end of March with the monthly report going to the NHS Fife Board in May 2022. Weekly reporting has commenced in October 2021 as part of the Winter Plan 2021/22.

The Winter Planning Performance Review Summary will be considered by the Finance, Performance and Resources and Clinical Governance Committees and for performance measures relating to the HSCP via Finance and Performance and Clinical and Care Governance Committees.

Section A: Executive Summary

This is the third bi-monthly report summarising performance against key indicators and actions for Winter 2021/22. The key points to note this month are as listed below.

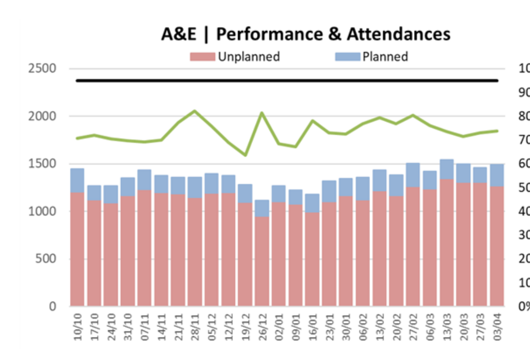
A&E

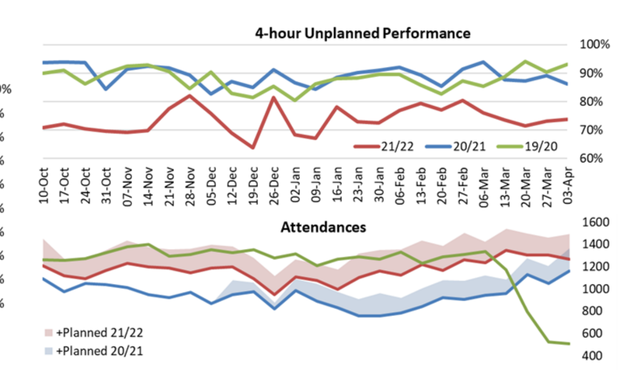
Narrative

The 95% Standard has not been met in the last 26 weeks. The board average has maintained above the Scotland average since w/e 6th February, and within 5% of the Scotland average throughout the Winter period with only week ending 19th December as the exception.

Planned attendances are not included within the numbers used to calculate the emergency access 4-hour target. The Redesign of Urgent Care (RUC) programme will transfer a portion of what previously would have been unplanned (minor) attendances into planned attendances. These patients would have been less likely to breach the 4-hour target, removing them has caused a negative effect on the performance.

Attendances including planned since the ed of January are now at the highest levels they have ever been and are trending much higher than pre pandemic levels now.



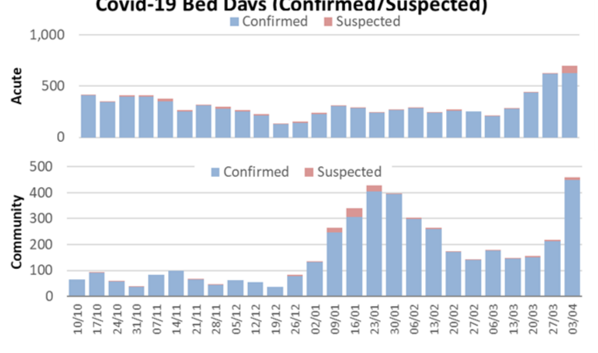


Covid-19 Bed Days

Narrative

The number of Covid-19 positive patients in Acute has risen increasingly since early March and are now at the highest levels seen throughout the Pandemic.

During the same period within a community setting the numbers have also risen increasing with the highest level seen causing many wards to close during this period.



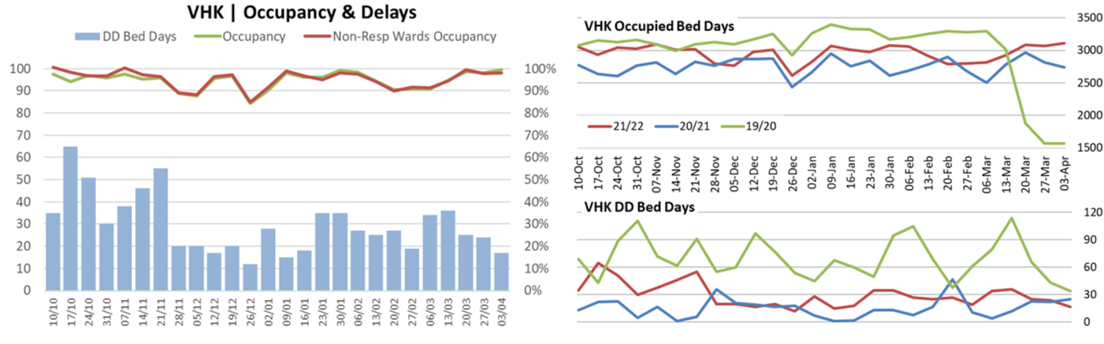
Acute Occupancy & Delays

Narrative

VHK occupancy was high late January then dipped in February till mid-March but has since been extremely high (98-99%), this coincides with the high covid numbers which will put a squeeze on beds available.

The non-respiratory pathway has almost mirrored the overall occupancy and ending March with 98%.

The number of Delayed Discharge Bed Days in VHK was steady during February until the end of the month where numbers climbed and continued into March, these have since decreased again. There has been an average of 26 Delayed Discharge Bed Days lost over the last 2 months.



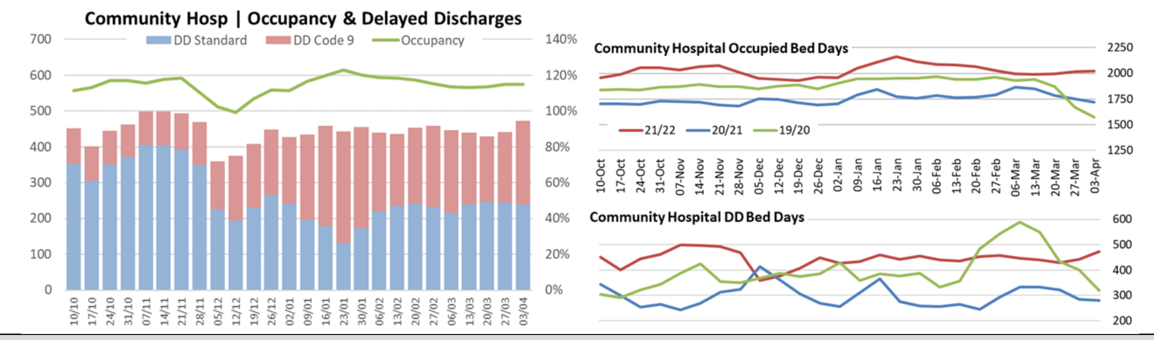
Community Occupancy & Delays

Narrative

Occupancy has maintained well above 100% for the whole of Winter and hitting 123% in January, and consistently 113% or above this year. Many wards throughout the period have had to close due to Covid which has contributed to pressure throughout.

The occupancy this winter is trending higher than any other due to the number of surge beds opened to try and maintain flow within the acute hospital.

There has been an average of just above 446 bed days lost to delayed discharges within the community hospital throughout February and March. The standard delays have remained fairly static around the 230-240 mark, whereas code 9's have fluctuated a little more.

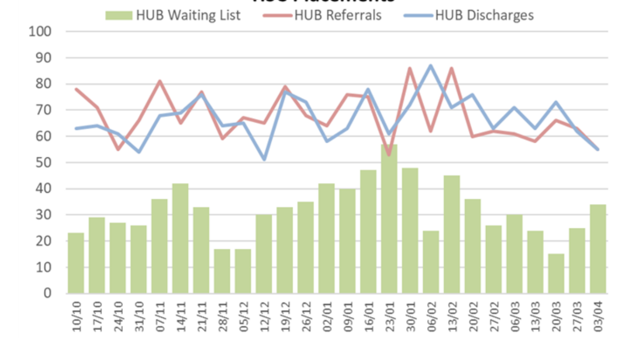


H&SCP Placements

Narrative

The number of referrals to H&SCP is on average 66 patients per week, with the number of discharges over this period over at an average of 69.3 per week.

The waiting list peaked at 57 week ending 23rd January and has gradually declined since thanks to the high discharges.



Section B: Performance Summary to Wk Ending 3rd April 2022

Weekly Unscheduled Care Monitoring Report

Area	Indicator	Trend	06-Feb	13-Feb	20-Feb	27-Feb	06-Mar	13-Mar	20-Mar	27-Mar	03-Apr
Urgent Care	Contacts		2174	2139	2229	2133	2134	2206	2150	2111	2296
	Home Visits		108	120	121	112	114	121	112	92	136
	COVID Outcome		291	315	296	299	304	324	336	357	277
	NHS24 Outcome		359	362	397	358	342	368	351	292	335
VHK ED	All		1355	1433	1385	1504	1424	1543	1501	1459	1493
	Planned		230	213	216	244	187	196	194	153	223
	Unplanned		1125	1220	1169	1260	1237	1347	1307	1306	1270
	Performance		76.8%	79.3%	77.0%	80.5%	76.0%	73.6%	71.5%	73.1%	73.9%
MIU	Total		382	347	317	403	383	436	371	440	385
	Unplanned		317	291	267	332	325	373	311	381	325
VHK	Admissions		696	687	709	731	745	769	722	718	724
	Emergency		617	595	639	651	651	684	639	650	647
	Medical		348	333	355	369	363	404	368	354	350
	Surgical		269	262	284	282	288	280	271	296	297
	Discharges		683	646	692	670	697	663	683	667	661
Theatre Activity	Scheduled		260	257	218	272	294	304	277	274	231
	Cancelled		19	7	15	7	12	15	25	14	16
	Hospital Cancelled		6	0	3	2	0	1	3	0	4
VHK Bed Utilisation	Occupancy		98%	95%	91%	91%	91%	95%	99%	98%	99%
	COVID Bed Days		291	242	271	252	208	279	441	621	698
	DD Bed Days		27	25	27	19	34	36	25	24	17
Community Hospital	Admissions		72	54	57	49	50	51	57	45	39
	Discharges		70	55	51	59	45	56	55	35	36
	Occupancy		119%	118%	117%	115%	114%	113%	113%	115%	115%
	COVID Bed Days		303	265	173	143	180	149	155	218	458
	DD Bed Days		440	436	454	458	446	440	429	442	472
	DD Standard		220	234	241	233	215	240	247	244	239
	DD Code 9		220	202	213	225	231	200	182	198	233

NHS Fife

Meeting:	**Public Health and Wellbeing Committee**
Meeting date:	**16 May 2022**
Title:	**Director of Public Health Annual Report 2020/2021**
Responsible Executive:	**Director of Public Health**
Report Main Authors:	**Catherine Jeffery Chudleigh CPH, Mhairi Gilmour, Clare Campbell**

1 Purpose

This is presented to the Public Health and Wellbeing Committee for:

- Discussion

This report relates to a:

- Legal requirement
- NHS Board/Integration Joint Board Strategy or Direction
- National Health & Well-Being Outcomes

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Director of Public Health annual report provides a mechanism to present the key issues relating to health and wellbeing for local areas and enable more targeted local responses to be developed. The most recently published DPH annual report for Fife covered the time period 2018/2019. This new report covers a longer time period, the calendar years 2020 and 2021 as the normal cycle of reporting was interrupted by the pandemic.

2.2 Background

This Director of Public Health Annual report is structured around the six Public Health priorities for Scotland. The Public Health Priorities for Scotland were first published in 2018 as part of the Public Health reform process which also established the new national body, Public Health Scotland. The priorities were jointly supported by Scottish Government and COSLA and have a 10 year lifespan.

They were created to help focus effort around key areas of population health following an extensive consultation process. The priorities were created in recognition that the health of the population in Scotland was lagging behind the health of similar countries in Europe. The aim of setting these nationally agreed priorities was to build momentum addressing the risk factors which result in poor health in the population.

The Fife Director of Public Health annual report published in 2018/19 was structured around the six priority areas, setting out the key issues for the population of Fife. This new report, follows the same outline approach as in 2018/19 and builds into the report data relating to COVID19 where this is available.

2.3 Assessment

The report provides an overview of the demographic changes across the population of Fife along with updates across each of the six public health priority areas.

Key findings include:

Demographic changes

The total population grew during 2020, one of only 12 local authority areas in Scotland to do so. There was very little change in published life-expectancy data for Fife during the time period 2018-2020 in contrast with Scotland, which saw a measurable fall in life-expectancy. Inequalities are detectable across Fife. There is a difference of 10 years in life-expectancy between men from communities most affected by deprivation and those least affected. For women a difference of 8 years was found.

COVID in brief

The pandemic saw collaboration across agencies and within communities to provide support. Figures up to and including 30th April 2022 show there has been a cumulative total of 127,094 confirmed positive COVID-19 cases among Fife residents since the first positive case in March 2020. Although case-rates of infection were lower among those aged >65yrs, those who were older than 65 experienced higher death rates and more severe illness. There were inequalities in COVID-19 mortality observed between the most and least deprived areas of Fife. Dedicated COVID19 services were established including contact tracing, testing and vaccination. Since the start of the vaccination campaign more than 830,000 vaccinations have been carried out (as at 7th April 2022).

Public Health Priorities

For each of the Public Health Priorities, the report provides an overview of the key issues and areas of progress. At the end of each chapter are listed our ambitions and future opportunities, which includes opportunities for public health, NHS and other partners.

2.3.1 Quality/ Patient Care

The Director of Public Health report provides a focus on areas of population health and wellbeing would benefit from strengthening. The Health and Wellbeing review which was completed to support the DPH report will also support the development of the Population Health and Wellbeing strategy.

2.3.2 Workforce

There is no direct impact on workforce from this report. However, it could only be produced through collaboration and support from staff working in Public health, Health Promotion, Fife Council and wider partners. It is a tribute to their commitment that the report has been produced during the pandemic.

2.3.3 Financial

There are no direct financial impacts from this report.

2.3.4 Risk Assessment/Management

The risks to health which are described within this report are part of existing programmes of work and services.

2.3.5 Equality and Diversity, including health inequalities

This report considers the health of the population of Fife overall. It therefore contributes towards NHS Fife's duty to the Public Sector Equality Duty, Fairer Scotland Duty, and the Board's Equalities Outcomes. An impact assessment has not been completed because this is a descriptive report, covering the whole of the population.

2.3.6 Communication, involvement, engagement and consultation

The report has been developed in collaboration with a range of partners including NHS Fife Public Health, Fife Health and Social Care Partnership, Fife Council and other partners. The key points will be embedded in the wider engagement work carried out in advance of the NHS Fife Health and Wellbeing strategy.

2.3.7 Route to the Meeting

The paper has been shared with EDG in advance of coming to this meeting.

2.4 Recommendation

The Committee are asked to consider the emerging issues set out within the Director of Public Health annual report and to endorse the future opportunities listed for each priority.

- **Discussion** – Examine and consider the implications of a matter.

2 List of appendices

The following appendices are included with this report:

- **Appendix No 1.** DPH Annual report 2020/2021: Health and Wellbeing in Fife

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Director of Public Health Annual Report

Health and Wellbeing in Fife

2020 - 2021

Acknowledgments

I am grateful to my colleagues within our Public Health Department and from our colleagues and partners within Health Promotion Service, Fife Health and Social Care Partnership, Fife Council and the third sector for their significant contributions to this report. We are all part of the Fife public health team, and it is good to see examples of this work throughout the report.

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Contents

Foreword 2

Public Health Priorities and Ambitions 3

Fife – In brief 5

Priority 1: A Fife where we live in vibrant, healthy and safe places and communities 15

Priority 2: A Fife where we flourish in our early years 25

Priority 3: A Fife where we have good mental wellbeing 32

Priority 4: A Fife where we reduce the use of and harm from alcohol, tobacco and drugs 37

Priority 5: A Fife where we have a sustainable inclusive economy with equality of outcomes for all 45

Priority 6: A Fife where we eat well, have a healthy weight and are physically active 54

Conclusions 62

Glossary 64

References 65

Foreword

Welcome to the 2020/21 Director of Public Health Annual Report for Fife. This is my first report since coming to Fife as Director of Public Health and the timing is significant. This report comes with an invitation to pause and reflect on the health and wellbeing of the population after two very difficult years of living through the COVID-19[i] pandemic. While it feels in some ways that everything changed during the pandemic, fundamentally many of the same underlying challenges to health and wellbeing remain. With that in mind, this report is set out with the same chapter structure as the 2018/19 Director of Public Health Annual report presented by my predecessor Dona Milne and is focused around the Public Health priorities for Scotland. The report captures the key issues impacting on health and wellbeing in Fife and highlights ambitions for the future and areas where there are concerns emerging.

It will be some years in the future before the legacy of the COVID-19 pandemic is fully understood and the data within this report does not cover the entirety of the pandemic. Some of the direct impacts on health are clear, and where this is the case, we have included comment within the report. Amongst very difficult times, the response of communities and agencies across Fife has been incredible. Some of that response is described within the report. The rapid establishment of support for people so they could isolate safely and protect the wider community demonstrates to all the importance of looking after each other. Entirely new services were established to test for the virus and take every opportunity to interrupt transmission as well as setting up a vaccination programme.

I would like to thank everyone who has contributed to the different chapters of this report, together these provide an updated perspective of progress across the different Public Health priorities. One of the recurring themes through the report is the widening in health inequalities which was apparent even before the onset of the pandemic. This can be seen in a number of statistics, including a widening of the gap in life-expectancy between those who are most affected by deprivation and those who are least affected. This is important because these differences are avoidable.

Dr Joy Tomlinson
Director of Public Health,
NHS Fife

i COVID-19: Coronavirus disease is an infectious disease caused by the SARS-CoV-2 virus

Public Health Priorities and Ambitions

In Fife we have adopted the Scottish Government Public Health priorities which reflect the most pressing health and wellbeing concerns for Fife, which we should focus on over the next decade to improve the health and wellbeing of the population[1]. They focus on the upstream determinants of health which are shared 'risk factors' for many of the leading causes of poor health and wellbeing in Fife.

We want to see:

1	A Fife where we live in vibrant, healthy and safe places and communities.
2	A Fife where we flourish in our early years.
3	A Fife where we have good mental wellbeing.
4	A Fife where we reduce the use of and harm from alcohol, tobacco and other drugs.
5	A Fife where we have a sustainable, inclusive economy with equality of outcomes for all.
6	A Fife where we eat well, have a healthy weight and are physically active.

Responding to and supporting recovery from the COVID-19 pandemic has since been identified as a clear additional priority for public health in Fife.

This report describes why each priority is important for Fife and sets out our ambitions for each priority[ii]. It also describes some of the wide-ranging activities undertaken across Fife focused on these priorities in 2020 and 2021 and discusses the impact of the COVID-19 pandemic on this work.

Population health in Fife is influenced by the actions and efforts of many organisations within the public and third sector as well as private sector organisations and community groups, and this is reflected across the report.

The Public Health priorities are clearly aligned with several national and local strategies and plans including the Plan for Fife Recovery and Renewal Priorities, Fife's Health and Social

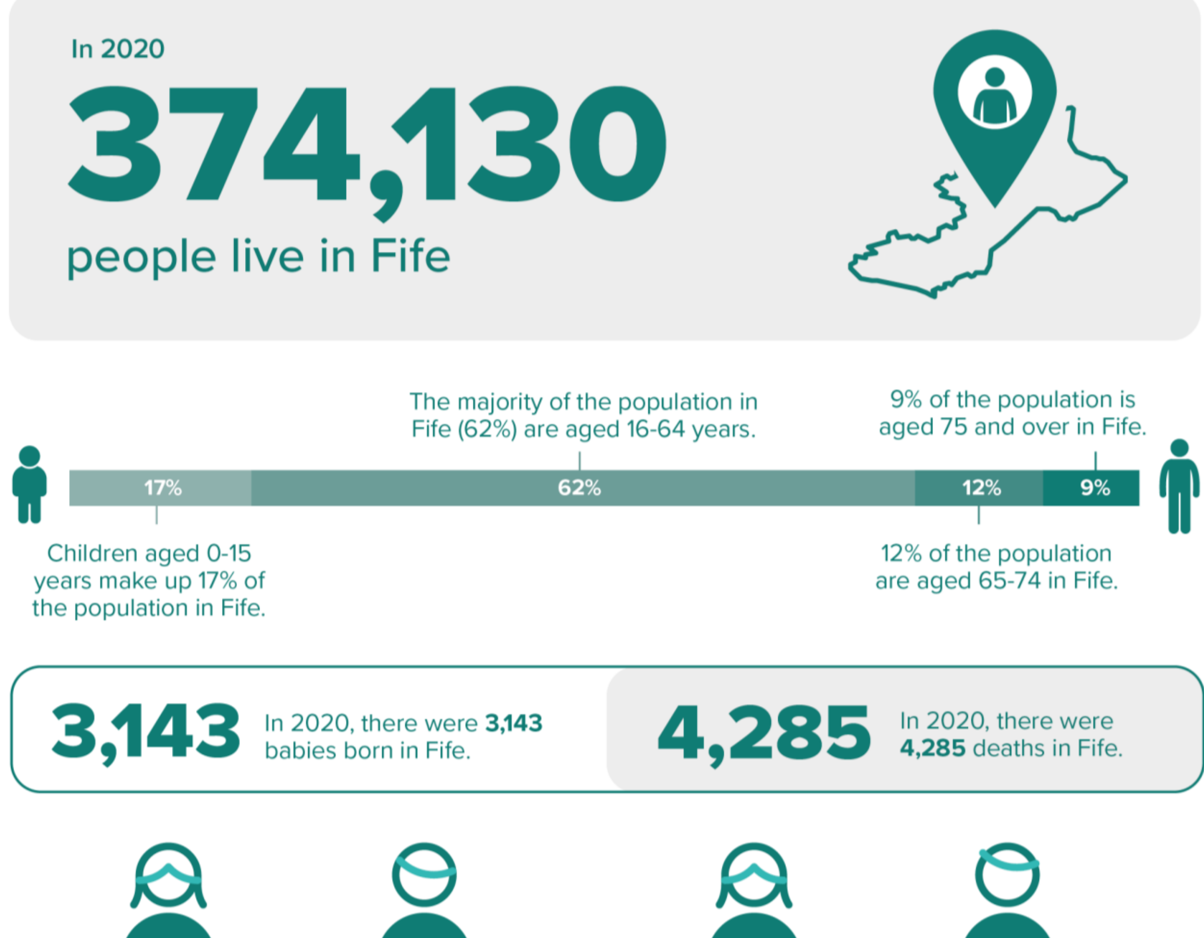
ii For each of our Public Health priorities, NHS Fife together with Health and Social Care Partnership (HSCP) have developed ambitions for improving the health and wellbeing of our population. These were developed in 2019, prior to the start of the COVID-19 pandemic

Care Partnership's (HSCP) Strategic Plan and Scottish Government's Coronavirus (COVID-19) Recovery Plan.[2,3,4] The report also therefore reflects on potential opportunities for public health and our partners for the coming years to contribute together to further improving the health and wellbeing of people in Fife.

Public health activities often intersect across multiple priorities. For the purposes of this report, we have attempted to avoid duplication by describing our activities under a single priority respectively.

Fife – In brief

In this chapter we look at the size and structure of the current population of Fife, births, deaths and diseases.



Why this is important

It is important that we regularly review what we know about the population of Fife, examine differences within Fife and look at changes in Fife over time. Understanding our population helps us understand their needs which helps us, together with our partners, prioritise actions and interventions that can improve population health and reduce inequalities and ensure existing and new services meet population needs.

In each Director of Public Health Report, we look at the size and structure of the current and future population of Fife, births, deaths and diseases, but also look at other factors that are important for creating and maintaining health and wellbeing, such as our education, employment, income, social networks, housing and broader socio-economic, cultural and environmental factors. These determinants are experienced unequally in our society with correspondingly worse health outcomes and life expectancy experienced by people living in the most deprived areas of Fife. People from other diverse or vulnerable groups also unjustly experience inequalities and can experience less good health and wellbeing as a consequence.

As such, although Fife is made up of different areas such as electoral wards, localities, or area committees, the main focus of this report is the health and wellbeing of the population of Fife and inequalities throughout Fife as a whole. In this chapter we provide an overview of the population of Fife and births, deaths and diseases of Fife residents using the most current figures available and drawing on national trends where appropriate.

The remaining chapters contain key information about the health and wellbeing and its determinants of the Fife population, relating to each of our public health priorities. Where known, we reflect upon the impact of COVID-19 on our population, however our understanding of the impact of COVID-19 upon population health is still developing.

Due to the pandemic, some data was not collected in 2020 and therefore some of the data used in this report predates the pandemic. Where we do have more recent data, much of this is for the early phase of the pandemic, limiting our impact to draw firm conclusions on the impact of COVID-19 for population health over the full course of the pandemic, and/or may not be from the usual routine health information sources which limits comparability with pre-pandemic data.

Further information about Fife and its residents, including those living in different areas, can be found from a number of sources including KnowFife (https://know.fife.scot), Our Fife (https://our.fife.scot) and ScotPHO Profiles (https://scotpho.org.uk).

Population

The population of Fife grew in 2020, one of only 12 council areas in Scotland to see growth. At June 2020, an estimated 374,130 persons lived in Fife, 580 more people than in 2019, resulting in an annual growth rate of 0.2%, higher than the national growth rate of 0.05%, which was the lowest growth since 2003.[5]

Children aged 0-15 years make up 17% of the population with 64,152 children living in Fife. The majority of the population in Fife (62%) are aged 16-64 years, whilst 12% of the population are aged 65-74 and 9% aged 75 and over. [5]

Current population projections estimate that by mid-2028, the population of Fife will be a similar size with a 0.1% decrease in the total population compared to 2018. Within the Fife population the number of people aged under 65 is estimated to fall by mid-2028, but the number of people aged 65-74 is estimated to increase by 10% and the number aged 75 and over by 31%.[6]

At the 2011 Census the population of Fife was predominantly of white ethnicity (97.6%), with 1.6% Asian ethnicity and 0.8% of people being from minority ethnic groups. [7] We know that there is diversity within the population of Fife (in terms of ethnic group, gender identity and sexual orientation) and findings from the recently held 2022 Census will provide us with a greater insight into this diversity to better understand the future needs of our communities and reduce inequalities in population health between groups.

Births

In 2020 there was a 6% reduction in the number of babies born in Fife compared to in 2019, with 3,143 babies born.[8] This continues a reducing trend of births in the last ten years and is the lowest annual number of births since 1991. Fertility rates in Fife, although falling, continue to be higher than the rates for Scotland, 47.1 per 1000 women aged 15-44 years compared with a national rate of 45.5.[8]

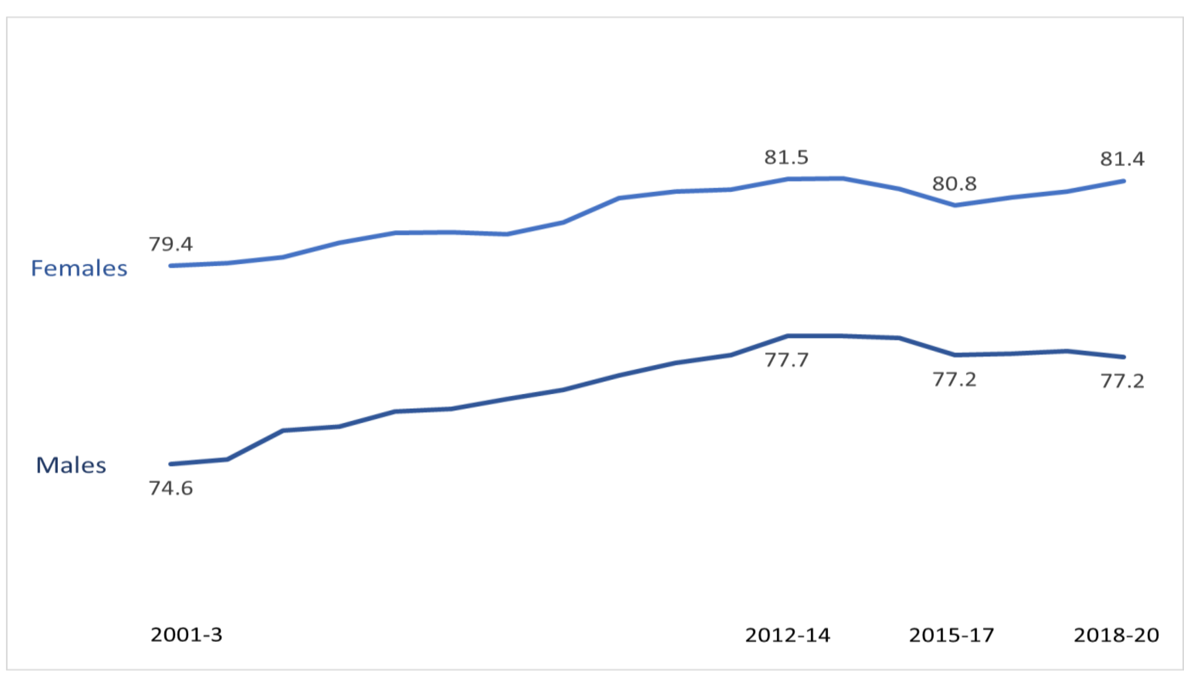
Of the 3,143 babies born in Fife over half (59%) were born to mothers aged 25-34 years, 5% to mothers aged 19 and under and 4% to mothers aged 40 and over. Since 2000 the number of births to mother aged 19 and under has decreased by 61% whilst births to mothers aged over 40 have more than doubled.[8]

Life expectancy

Life expectancy at birth in Fife was 77.2 years for males and 81.4 years for females in 2018-2020.[9] This was a small annual fall in life expectancy in males and a small rise in females since the last estimates of 77.3 and 81.2 years respectively in 2017-2019 (Figure 1). Nationally during the same time-period life expectancy fell by the largest annual amount since these statistics began, to 76.8 years for males and 81 years for females.[9]

This large annual fall was mainly driven by COVID-19 deaths, but drug-related deaths and deaths from external causes (including accidents and suicides) also contributed to the fall in male life expectancy. The full impact of COVID-19 on life expectancy will be clearer in future estimates that cover the whole period of the pandemic as current estimates only include 2020.[9]

Figure 1: Life Expectancy in Fife; Males and Females 2001-2003 to 2018-2020



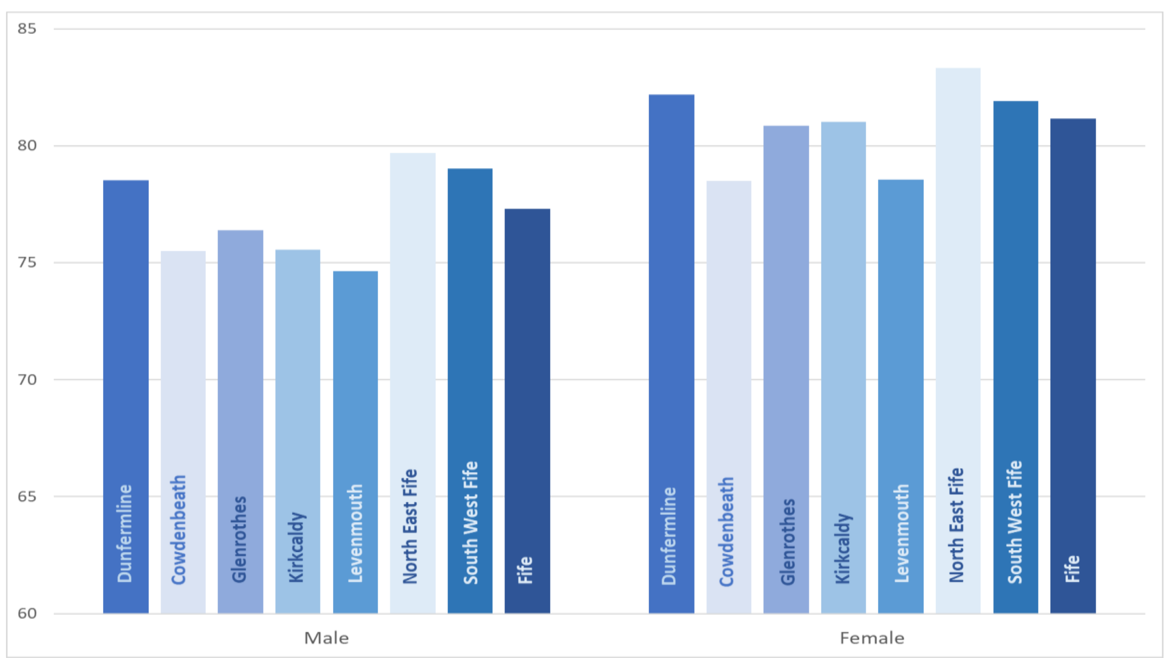
Source: NRS

Although recent changes in life expectancy in Fife have been small, more significant changes have been seen since 2012-14, the point at which Scotland and other countries experienced an unprecedented slowing of life expectancy growth. Female life expectancy fell in Fife from 2012-14 to 2015-17 but has increased a little each year since this point (Figure 1). This has resulted in a much lower rate of growth from 2012-14 to present compared to between 2001-3 and 2012-14. Among males in Fife life expectancy decreased between 2012-14 to present compared to growth from 2001-3 to 2012-14.[9]

The trends in life expectancy are of public health importance and a programme of work to understand the cause of these trends is being coordinated by Directors of Public Health, with findings expected to be published later in 2022.

There is variation in male and female life expectancy within Fife, which is illustrated by the 2016-20 figures for the seven HSCP localities/Area Committees in Figure 2.[10] Both male and female life expectancy were higher than the Fife average in Dunfermline, North East Fife and South West Fife areas and lower than average in the other four areas.

Figure 2: Male and Female Life Expectancy; HSCP Locality/Area Committee 2016-20



Source: PHS

However, the full extent of inequality in life expectancy across Fife is most apparent when you look at the differences between the life expectancies of the populations living in most and least deprived areas (quintiles) in Fife.[iii] In 2016-20 life expectancy in Fife was 10 years lower in the most deprived areas than the least deprived areas among males, and 8 years lower among females. Wide inequalities were seen across Scotland with life expectancy in the 10% most deprived areas 13.5 years lower among males and 10.5 years lower among females than in the 10% least deprived areas in 2018-20. These differences in national life expectancy have widened since 2013-15.[9]

iii Most and least deprived areas are used in the report to refer to the most deprived and least deprived Fife SIMD 2020 population quintiles as measured by the Scottish Index of Multiple Deprivation. These are derived by ranking the datazones in Fife based on their SIMD score from most to least deprived and then splitting them into five groups (quintiles) based on their level of deprivation with each group representing roughly a fifth (20%) of the population. This approach is also used nationally and can be split into ten groups (deciles or 10%) if appropriate.

Deaths

There were 4,285 deaths in Fife in 2020, an increase of 130 (3%) on 2019.[11] Rates of all-cause mortality in Fife in 2020 were below the Scottish average, 1118 per 100,000 population compared to 1212.[iv] 36% of these or 1,529 deaths were in people aged under 75s, which equates to a rate of 421.8 per 100,000 population. In line with deaths at all ages, mortality rates in the under 75s increased from 2019 but remain below the Scottish average of 457 per 100,000 population.

There are significant inequalities in mortality rates in the under 75s, which have persisted over the last 10 years. Over this period rates in the under 75s have been between 2 to 3 times higher in the most deprived areas than in the least deprived areas, and the current rate is currently sitting at 2.9 times higher.[10]

Even greater inequalities are seen in the rates of death among those aged 15-44 in Fife. Rates of death in this age group have risen for Fife as a whole since 2013-15, with rates rising from 98.2 per 100,000 population in 2013-15 to 115 in 2020, slightly below the Scottish average of 116 per 100,000 population.[10] During this time rates in the least deprived areas decreased whilst rates in the most deprived areas increased, widening the absolute gap between them. In 2013-15 rates in the most deprived areas were 3.9 times greater than rates in the least deprived areas which rose to 6.7 times greater in 2018-20.[10]

Causes of death

Grouped together cancers were the most common cause of death in Fife (and Scotland) with 1,112 deaths being attributed to malignant neoplasms in 2020, 26% of all deaths.[11] The most common cancer death was lung cancer which accounted for almost a quarter (23%) of all cancer deaths and 6% of all deaths.

Heart disease, the majority of which were ischaemic heart disease, was the next most common cause of death accounting for 13% of deaths followed by dementia and Alzheimer’s disease (11%) and cerebrovascular diseases (7%). Mortality rates among the under 75s for both cancer and heart disease have fallen in Fife in the last 10 years, but inequalities are evident in both these causes of death.[10] The most deprived areas experienced 44% more early deaths from cancer than the Fife average in 2017-19, and rates in the most deprived areas were twice those in the least deprived areas. There were greater inequalities in early deaths from ischaemic heart disease, with the most deprived areas experiencing 69% more early deaths than the Fife average and rates in these areas being 3.1 times greater than in the least deprived areas in 2018-20.[10]

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iv In the report where rates are provided, unless stated otherwise, they are standardised for age and sex. Age-standardised rates account for population size and age structure and provide more reliable comparisons between groups or over time. Fertility rates and crude rates are not age-standardised.

Up to the 31st March 2022 there have been 791 deaths recorded in Fife where confirmed or suspected COVID-19 was mentioned on the death certificate.[11] This equates to a rate of 98 per 100,000 population which was lower than the Scottish average of 127 per 100,000 population. Most COVID-19 deaths were to persons aged 75 and over. Latest data available at the time of writing showed that across Scotland, between February 2020 and August 2021, 72% of COVID-19 deaths were in this age group. During this time rates of death involving COVID-19 were 2.4 times higher in the most deprived areas than in the least deprived. This is wider than the gap (1.9 times) seen for all causes of death and has widened since the early stages of the pandemic.[12]

Healthy life expectancy

Healthy life expectancy (HLE) is an estimate of the number of years lived in 'very good' or 'good' general health derived from self-reports of general health and deaths and population data.[13] Healthy life expectancy used alongside life expectancy provides additional insight into the health of our population as well as their current years of life expectancy and can be expressed as the proportion of life spent in 'good' health.

Since 2016-18 estimates of healthy life expectancy have been published for health boards and councils together with national estimates.[v] Healthy life expectancy was 59.0 years for females and 57.4 years for males in Fife in 2018-2020 (Figure 3). Both estimates were lower than the estimates for Scotland which were 61.8 and 60.9 years respectively. Among males, current estimates for Fife were the lowest of all health board areas and third lowest among females.[9,10] The most recent Fife estimates are the lowest reported across the time series available for both males and females. Nationally longer time trends show that healthy life expectancy increased from 2009-11 to 2015-17 among males and to 2014-16 among females but has decreased since then and was lower in 2018-2020 than it was in 2009-2011 for both males and females.[13]

Expressing healthy life expectancy as a proportion of life expectancy, the proportion of life spent in 'good' health in Fife was estimated at 72% for females compared to 75% for males in 2018-20 (Figure 3). Both estimates were lower than the national averages of 76% and 79%.[13] In Fife and across Scotland females spend a greater proportion of life in 'poor' health than males. Nationally the proportion of life spent in 'good' health is lower for both males and females now compared to 2010-12, which means that a greater proportion of life is likely to be spent in 'poor' health now than in previous years.

v Due to the method of calculating HLE there can be uncertainty around the estimates which can impact on the ability to reliably compare over time and across areas. The figures for 2018-20 cover nine months of the COVID-19 pandemic which would be expected to have an impact on the estimates, however it is difficult to quantify this effect due to method of calculation.

Figure 3: Life and Healthy Life Expectancy in Fife; 2018-2020

	HLE	LE
Female	59	81.4
Male	57.4	77.2

Source: NRS

For both males and females, deprivation has a significant impact on healthy life expectancy. In the most deprived areas of Scotland healthy life expectancy was more than 24 years lower for both males and females than in the least deprived areas in 2018-20. This difference was much larger than the difference in life expectancy, resulting in people living in the most deprived areas having shorter life expectancy and spending a smaller proportion of life in 'good' health.[13]

The proportion of life estimated to be spent in 'good' health in the most deprived areas of Scotland was 65% for females and 66% for males compared to 85% for both males and females in the least deprived areas meaning that both males and females in the most deprived areas spend more than a third of their life in 'poor' health.[13]

Burden of Disease

Burden of Disease studies assess the years of health lost due to disease and injury, through living in ill-health and from early death, thus preventing populations from living longer lives in better health.[14] These studies can help us understand the disease and injury that causes the biggest health loss in our population, and how these may be experienced differently and change over time.

Figures from the 2019 Scottish Burden of Disease study showed that in Fife (and Scotland) the leading groups of causes of health loss were cancers followed by cardiovascular diseases, neurological disorders, mental health disorders and musculoskeletal disorders.[14] These five disease/injury groups accounted for almost two thirds of total burden of health loss across the whole Fife population.

Lower back and neck pain, depression and headache disorders were the top three leading individual causes of ill-health in Fife in 2019 and ischaemic heart disease, lung cancer and Alzheimer's disease and other dementias were the top three individual causes of early death.[14]

Figure 4: Top Ten Causes of Burden in Fife from Ill-Health and Early Death; 2019

	Ill health		Early death
1	Low back and neck pain	**1**	Ischaemic heart disease
2	Depression	**2**	Lung cancer
3	Headache disorders	**3**	Alzheimer's disease and other dementias
4	Anxiety disorders	**4**	Cerebrovascular disease
5	Osteoarthritis	**5**	Other cancers
6	Diabetes mellitus	**6**	Drug use disorders
7	Cerebrovascular disease	**7**	Chronic obstructive pulmonary disease
8	Other musculoskeletal disorders	**8**	Colorectal cancer
9	Alcohol use disorders	**9**	Self-harm and interpersonal violence
10	Age-related and other hearing loss	**10**	Lower respiratory infections

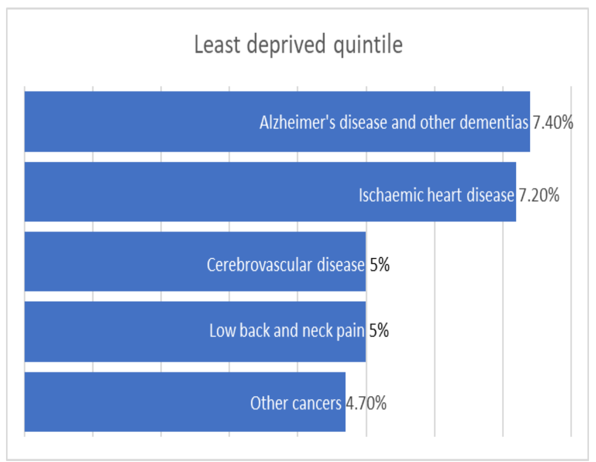
Source: PHS

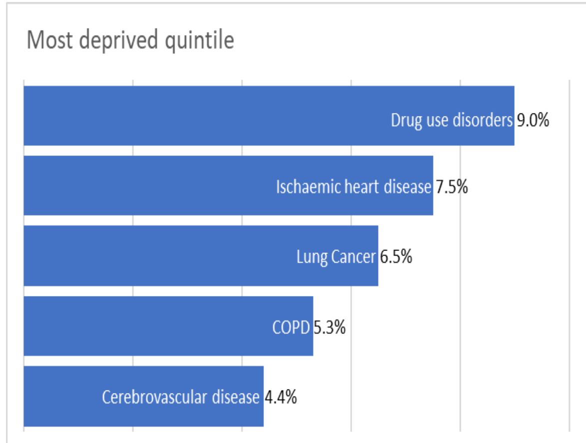
As our population ages the contribution to the overall total burden of health loss from ill-health and early death changes. For Fife as a whole, 64% of the burden is due to early death and 36% to ill-health in the population, however, in younger age groups contribution from early death is much lower, 28% in the age group of 15-24 years, and increases with age to 84% in the those aged 85 and over.[14]

Health loss from ill health and early death, is not experienced equally. 2019 figures (Figure 5) showed health loss in the most deprived areas was almost double the least deprived areas of the East Region of Scotland[vi] (Fife, Lothian and Borders Health Board areas). In the most deprived areas in the region drug use disorders, ischaemic heart disease and lung cancer were the three leading causes of health loss compared to Alzheimer's disease and other dementias, ischaemic heart disease and cerebrovascular disease in the least deprived areas.[14]

vi Regional analysis undertaken: not available at Fife level

Figure 5: Top 5 causes of health loss in 2019 by deprivation quintile; East Region of Scotland





Source: PHS

Priority 1: A Fife where we live in vibrant, healthy and safe places and communities

Where we live directly affects our health through the quality of our housing, our access to services, what we can do for work, our sense of community or isolation, experience of crime, and how able we are to participate in physical and enriching activities and to access opportunities.

60% of people reported that their neighbourhood was a very good place to live.

Around three quarters of the Fife population typically live within close proximity (5-minute walk) to usable green or blue space.

People living in the most deprived areas are less likely to report their neighbourhood was a very good place to live (32%).

24% of households are living in fuel poverty.

2,542

There were **2,542** homeless applications in 2020/21.

COVID-19 pandemic

There has been a total of **127,094** confirmed positive COVID-19 cases (as at 30 April 2022).

More than **830,000** vaccinations have been administered to Fife residents (as at 27 April 2022).

92% of the 12+ population in Fife have had at least one dose and **89%** of the 40+ population have received their primary and booster vaccinations (as at 27 April 2022).

Why Priority 1 is important

Where we live directly affects our health through the quality of our housing, our access to services, what we can do for work, our sense of community or isolation, experience of crime, and how able we are to participate in physical and enriching activities and to access opportunities.

Because of this the assets, resources and support available in our communities has a tremendous impact on our health and wellbeing and long-term life chances. Our environment also has the potential to directly affect our health through exposure to communicable disease; environmental hazards and the impact of climate change.

The following sections will consider a range of health impacts of 'where we live' and the Public Health actions to address these factors these, in terms of:

- Places and communities (including homes and housing)
- Public health care services (vaccination, screening and dental public health)
- Environmental and communicable disease exposures (including climate change)

Places and communities

Healthy places and communities should include affordable quality secure housing, safe open space and facilities for play, physical activity and recreation provision and public realm, healthy food environments, a sense of community and safety from crime. Healthy places should also limit access to harmful substances and gambling; ensure protection from environmental hazards; and safeguard against potentially negative impacts of unsustainable development and climate change.[vii]

60% of adults in Fife reported that their neighbourhood was a 'very good' place to live in 2019, slightly more than in Scotland (57%).[15] However, people living in the most deprived areas across Scotland are far less likely to report this (32%), compared to those living in the least deprived areas (77%). 30% of the population of Fife lived within 500m of a derelict site in 2019, compared to 28% across Scotland.[16] Around three quarters of the Fife population typically live within close proximity (5-minute walk) to usable green or blue space, and this is used by more than half of Fife residents at least once a week.[15]

vii A Placebased Approach, is concerned with the interconnection of people and their environment. Partners and communities collectively consider and address physical, social and economic aspects of an area to maximise its potential for being a resilient, sustainable, vibrant, healthy and safe place for everyone to live, work and play in.

The absence of affordable, safe, secure or warm housing affects health and wellbeing across the life course. Tackling homelessness is a crucial part of creating healthy places where everyone has access to a secure, good quality, affordable home. A person or family may be classed as homeless, or being threatened with homelessness, if they have nowhere to live or cannot stay where they live. Currently there is unprecedented pressure on housing in Fife. 2,542 homeless applications were made in Fife in 2020/21 and 708 households were living in temporary accommodation.[17] This will likely be further exacerbated as a result of the significant rise in energy bills putting households into fuel poverty and making it unsustainable for many to meet their budgets. In 2017-2019, 24% of households across Fife were living in fuel poverty.[18]

Environmental and communicable disease exposures

Healthy places offer protection from the impact of infectious disease and environmental, chemical and radiological threats.

Over the last two years our population has faced unprecedented exposure to a communicable disease through the COVID-19 pandemic. The first case in Scotland was confirmed on 1st March 2020.[19] COVID-19 was declared a pandemic by the World Health Organization (WHO) on 12 March 2020.[13]

Figures up to and including 30th April 2022 show there has been a cumulative total of 127,094 confirmed positive COVID-19 cases among Fife residents since the first positive case in March 2020.[viii,20] Figure 6 shows the course of the pandemic in Fife using rolling 7-day totals of positive cases as a crude rate per 100,000 population.[ix] The highest case rate for a 7-day period was seen on 5th January 2022, which equated to 8,293 cases.

Distribution of COVID-19 cases by age has changed over time and by variant. Across Scotland, for the cumulative number of cases up to 30th April 2022, the highest crude case rates were among those aged 20-24 years and 15-19 years.[x] Crude case rates were lower among those aged 65 and over. Crude case rates were highest in the most deprived areas in Scotland, but rates did not decrease in line with decreasing deprivation as the least deprived areas did not have the lowest case rates. [20] Conversely deaths associated with COVID-19 were higher in the older age groups and increased relative to increasing levels of deprivation.[21]

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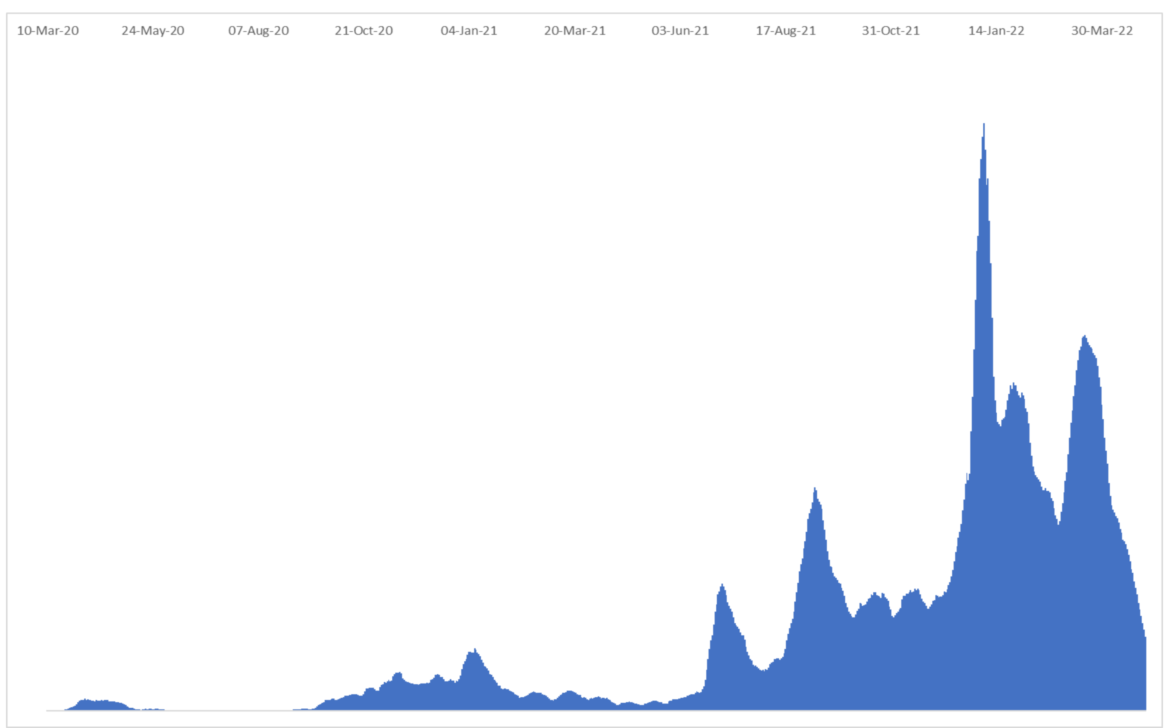
viii Positive cases are now determined from PCR or LFD positive test results and include new infections and possible reinfections (defined as individuals who test positive 90 days or more after their last positive test). This definition has been applied retrospectively. Snapshot was taken on 3rd May and may be subject to change.

ix It should be noted that testing for the general population was not available in the early stages of the pandemic and there have been changes to testing strategies over time. Figure 6 should be interpreted with this in mind.

x These rates will not account for any differences in the age structure of these areas.

Figure 6: Fife COVID-19 positive cases; 7-day total rate per 100,000 population up to 30th April 2022



Source: PHS

Long COVID is a commonly used term to describe signs and symptoms that continue or develop after acute COVID-19 infection. Long COVID is an emerging condition and we do not yet have a full understanding of the number of people experiencing long COVID or the determinants, distribution and natural course of it. Experimental statistics from the UK COVID-19 Infection Survey estimated that, in the four weeks to the 5th March 2022, 2.7% of the UK population were experiencing self-reported long COVID (defined as symptoms persisting for more than four weeks after the first suspected COVID-19 infection, that were not explained by something else).[22] 47% of those experiencing long COVID stated that it affected their ability to undertake day-to-day activities ‘a little’ and a further 20% ‘a lot’. More than two thirds (69%) of long COVID sufferers reported it was at least 12 weeks since they first had COVID-19.

Rates of many other communicable diseases had reduced greatly during the pandemic, responding to the same measures used to manage COVID-19. This is likely to be associated with disease control measures implemented during the pandemic disrupting normal routes of transmission for example widespread use of face coverings, social distancing and more frequent hand washing.

Public health care services

Ensuring that vaccination coverage is not only high overall across Fife, but also within underserved communities, is essential for disease control and elimination strategies, and equality. Uptake of vaccinations including COVID-19 has been lower in more deprived areas in Fife and in certain ethnic minority communities.

Screening Programmes aim to save lives or improve quality of life through the early identification of a condition, or by decreasing the chance of developing a serious condition or its complications. The Director of Public Health is the executive lead for the coordination and quality assurance of the national screening programmes delivered for the Fife population. Uptake of screening in Fife is generally similar to or exceeds uptake in Scotland. In general, across all the screening programmes, levels of participation in screening in Fife decrease as levels of deprivation increase.

Dental Public Health aims to protect and secure the oral health of communities and populations and reduce inequalities in oral health, including amongst the most vulnerable populations in Fife.

Our ambitions for Priority 1

- The places where people live, work and socialize are safe and have positive impacts on health, wellbeing and ecological restoration
- People are empowered and motivated to be involved in local decision-making and improving their communities
- Affordable and sustainable travel is accessible to all, including rural communities
- There is protection from environmental hazards, communicable disease and other health risks including pollution and climate change mitigation
- Safe, affordable, warm and secure housing is available to all
- There is equity of access to high quality and sustainable health and care services, including preventative and early intervention health services across the life course such as screening, immunisation, dental health, and reproductive and sexual health care

Focus of work for Priority 1 in 2020 and 2021

The focus of work has been to reduce the transmission and impact of COVID-19. We have also delivered routine vaccinations, including COVID-19 vaccinations to protect population health, alongside strategic projects to support improvements in vaccination delivery. We have strengthened partnership work to support places and communities during the COVID-19 pandemic, progressed work on planning and public health, and supported the review and implementation of the updated 'Plan for Fife'. Additionally, we have delivered and supported remobilisation of routine screening and dental health services.

Places and communities

COVID-19 pandemic

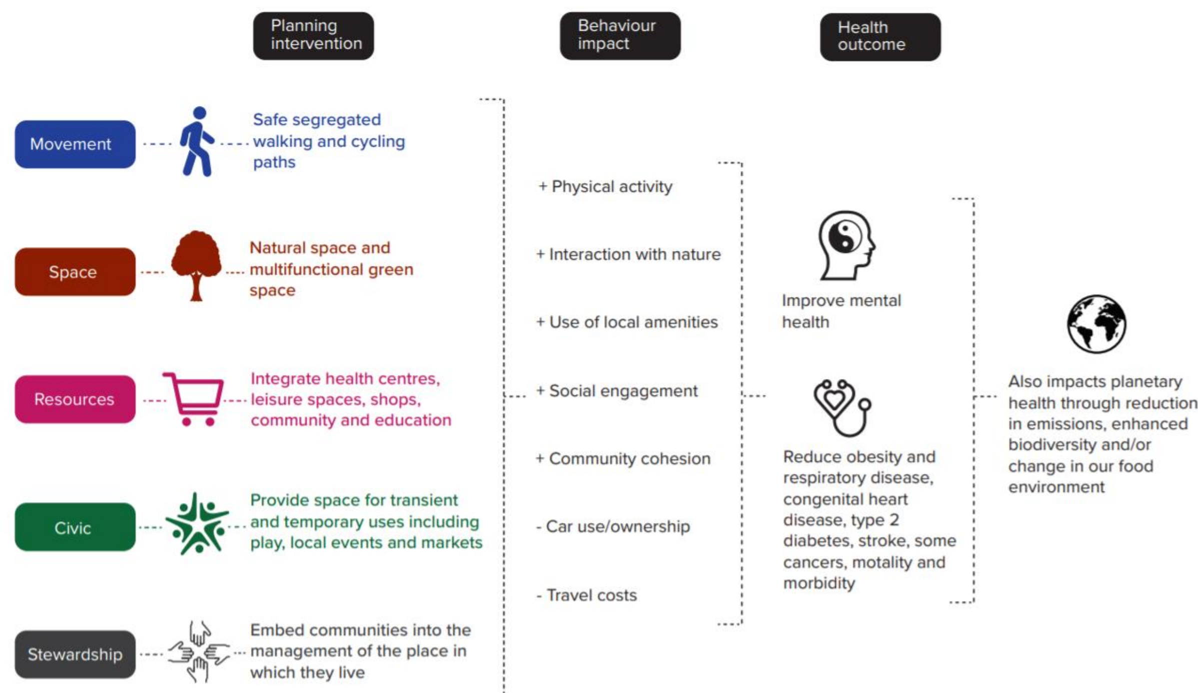
The COVID-19 pandemic has had a transformational effect on our places and communities, and already disadvantaged population groups and communities have suffered disproportionately across many areas of their lives. However, there has also been a positive transformation in how we work together as partners to support those most in need. During the pandemic, multi-agency partners across public and third sector organisations worked successfully together to establish community assistance hubs, responding to the needs of our most disadvantaged individuals and communities, including those who were shielding and self-isolating. Much was learnt from this and the willingness and adaptability of partners collaborating to implement testing and contact tracing, and supporting isolation and vaccination. This model of collaborative working has also now resulted in the establishment of longer-term People and Place locality groups in Fife.

Work was also taken forward to implement the 'Spaces for People' programme. Working with local communities and stakeholders, this allowed spatial modifications in town centres to facilitate pedestrian flow and social distancing. Some of the lessons learnt from this programme will help inform how health and spatial planning in Fife can work together to develop healthier and more sustainable places in the future.

Planning and public health

Recent local collaborations have signalled a shared ambition for transformation in spatial planning and public health to improve health and wellbeing and reduce inequalities across Scotland's communities, reflecting national policy developments. Figure 7 shows an example of how planning interventions can support and encourage behaviour change, which can result in health improvements. We are seeing the benefits of this approach through The River Leven Programme and the Whole Systems Approach to Obesity Prevention described in this report.

Figure 7: Planning and Wellbeing Process Diagram[23]



The Plan for Fife

In other key areas of work, Fife's Community Plan, The Plan for Fife, was reviewed in 2021 resulting in a set of Recovery and Renewal Priorities being identified along with a refresh of the partnership arrangements and delivery of the 12 Plan for Fife ambitions.[2] Many of the activities associated with this refreshed strategy will contribute to this public health priority, such as ambition 7: 'Every community has access to high quality outdoor, cultural and leisure opportunities'.

Environmental and communicable disease exposures

COVID-19 & emergency preparedness

Health protection provides expert advice and implements measures to prevent and mitigate the impact of infectious diseases, environmental and other threats. Over the last two years the overwhelming majority of the workload for the Health Protection Team (HPT) has been management of COVID-19. The HPT workforce has increased greatly, with additional specialist nurses and the establishment of Test and Protect teams. COVID-19 testing and contact tracing teams have been essential to understanding and responding to the virus, engaging directly with the public, and reducing risk to the most vulnerable groups.

Our response has required a multi-agency approach including, for example, a robust care home support process led by a directors group with representatives from relevant agencies. Maintaining these networks will be essential to effective working going forward.

Work is underway to evaluate the local response to the pandemic, and at a wider level to evaluate the national response, in order to share key learning and to inform our emergency preparedness plans for future pandemics.

Protection from climate change

New ways of working implemented during the COVID-19 response have brought forward the use of some technologies that will help to reduce avoidable car travel, such as online staff meetings and online clinical consultations. There has been a renewed public interest in outdoor physical exercise and access to our green and blue spaces. 2021 also saw international discussion and promotion of the need to mitigate climate change as Scotland hosted the UN climate change conference, COP26, and the launch of NHS Scotland's consultation on its sustainability strategy. We have contributed to the national discussion, as well as continuing to advocate for sustainable and climate protecting options in our local partnerships and plans.

Public health care services

Immunisation programmes

There has been a significant increase in vaccination activity over the last two years with the expanded flu vaccination programme from September 2020 and the introduction of the COVID-19 vaccination programme in December 2020. The COVID-19 vaccination programme has been an incredible collaborative effort and has been implemented in the context of a national programme to transform vaccination. [xi] Since the start of the vaccination programme more than 830,000 vaccinations have been administered to Fife residents (as at 27th April 2022).[xii] At this time 92% of the 12+ population in Fife have had at least one dose and 89% of the 40+ population have received their primary and booster vaccinations. Uptake is higher in older age groups for primary and booster vaccinations, with booster uptake in the under 40s being lower compared to those over 40 to date.[24]

The formation of an Immunisation Inclusion working group, with participation from local partners, has focused on taking action to enable marginalised and disadvantaged groups to access COVID-19 vaccination in Fife.

Importantly, throughout the pandemic the routine infant, childhood and teenage immunisation programmes have continued to be delivered and monitored. Where programmes were disrupted due to the pandemic (for example, the HPV programme in secondary schools), subsequent mop-up activity has taken place to minimise the impact on population health.

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xi The Vaccine Transformation Programme has since 2018 has been transitioning all vaccination delivery out of General Practice and will complete in March 2022.

xii Primary vaccinations include first and second doses. Snapshot was taken on 27th April and may be subject to change.

Screening programmes

At the end of March 2020, all screening programmes were temporarily paused in response to the COVID-19 outbreak. By mid-October 2020, routine screening had resumed across all programmes with some reduction in capacity due mainly to physical distancing and other infection prevention and control measures. Since restarting, efforts have focused on recovery from the backlog of participants waiting to be screened and the slippage in recommended screening intervals. The recovery has been challenging due to continued COVID-19-related infection and prevention control protocols including distancing and staff absences, shortages and recruitment challenges.

Dental Public Health

NHS Fife responded to the challenges faced by dental services during the pandemic by collaborating with wider colleagues including primary care, secondary care and dental public health colleagues. This collaborative approach ensured the maintenance of an Emergency and Urgent Dental Care Service in Fife at all times. The team have supported high street dentists to safely remobilise to provide more routine care where challenges continue.

A range of activity to support vulnerable groups has continued, including the distribution of tooth brushing equipment to children, foodbanks and locations supporting people experiencing homelessness.

Priority 1: Opportunities and areas of focus for public health and partners for the coming years

- **River Leven Programme** – The River Leven Programme is a regeneration project with people and the environment at its heart. The programme, which encompasses the Levenmouth Reconnected railway development, provides unprecedented scope for partners to come together and make sure opportunities to benefit individuals and communities are maximised. The River Leven Programme has a Health and Wellbeing theme, with Public Health and Health & Social Care Partnership (HSCP) Health Promotion Service providing leadership and input to this on aspects such as social referrals and community engagement.
- **Local area community assets and plans** – 'People and Place' groups will continue to develop their work to engage with communities, identify assets and gaps and review local area community plans. NHS Fife Public Health will support this work with interpretation of intelligence and data to inform assessment of local plans and priorities. HSCP Locality Planning Groups will be refreshed and reviewed with a view to further developing service integration and joint priorities with local community plans.

- **Spatial planning and local transport strategy** – NHS Fife Public Health will contribute to work to promote health and wellbeing through spatial planning in collaboration with Fife Council and other partners. Development of the Local Transport Strategy will provide another opportunity to improve health, wellbeing and sustainability for Fife's people and places.
- **Tackling homelessness** – Fife's Rapid Rehousing Transition Plan[25] is crucial to tackling homelessness and a priority will be to reinvigorate and refresh this work to prevent and address homelessness over the next five years.
- **Non-COVID-19 infections** – As pandemic measures ease, non-COVID-19 infections are likely to re-emerge in a population that may now be more vulnerable. Training and development of the HPT are priorities to ensure the team is fully prepared.
- **Pandemic preparedness** – We will need to ensure learning from the COVID-19 pandemic is built into future pandemic preparedness plans.
- **Reducing inequalities in screening** - Working to address inequalities in uptake of screening programmes within our population.
- **Recovery of oral health improvement programmes** - Support the national recovery of oral health within oral health improvement programmes focusing on the impact of the pandemic and also reducing inequalities.
- **Remobilisation and recovery of screening and dental services**
  - Whilst acknowledging that recovery from COVID-19 will remain a challenge for some of the screening programmes for the next few years, we will continue to work with and support the screening programmes in this recovery process.
  - Support the recovery of dental services across Fife to pre-pandemic levels
- **Fife Immunisation Strategic Framework 2021–2024** – We will provide public health expertise and leadership for the implementation of vision of the Fife Immunisation Strategic Framework 2021-2024. This will include:
  - Supporting the optimisation of immunisation coverage across the life-course, ensuring equitable access for all eligible groups and
  - Develop and implement an immunisation community engagement plan and
  - Enhancing the monitoring and evaluation of immunisation programmes within Fife.

Priority 2: A Fife where we flourish in our early years

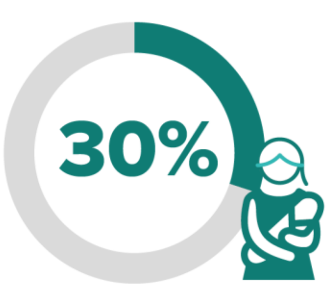
The effects of poor health and wellbeing, and inequalities in experience and opportunity, can accumulate over a person's life, starting in childhood, and result in poorer health and life chances as a person ages.

Around 1 in 5 children in Fife are estimated to live in relative poverty.

Most children living in poverty live in working households.

36% of school leavers in the most deprived areas of Fife achieve 1 or more SCQF at Level 6 compared to **75%** in the least deprived areas.

For all of these indicators of child health and wellbeing there are inequalities between the least and most deprived areas of Fife.



30% of babies in 2021 were exclusively breastfeeding at 6-8 weeks.

74% of Primary 1 children in 2020 had no obvious dental decay.

23% of Primary 1 children measured are at risk of overweight or obesity.

Around 25,000 adults in Fife are estimated to have experienced four or more Adverse Childhood Experiences (ACEs).

For example experiencing abuse, neglect, violence, homelessness or growing up in a household where adults are experiencing poor mental health or harmful use of alcohol and drugs; which are known to contribute to poorer health and wellbeing.

Why Priority 2 is important

Not only is good health and wellbeing of great importance for children in Fife, it is also a foundation for adult health and wellbeing. The effects of poor health and wellbeing, and inequalities in experience and opportunity, can accumulate over the life course of an individual and result in poorer health and life chances as a person ages. Children's health and wellbeing are influenced by a wide range of socio-economic factors and are closely linked to the other public health priorities detailed in this report. Unfair differences in the life chances of children growing up in the most deprived areas of Fife and those living in poverty will have a significant impact on their current and future health and wellbeing.

Poverty and inequalities

The health of children and young people is impacted by the economic stability of their families. Around 1 in 5 children in Fife are estimated to live in relative poverty, and for many families a single missed wage or delayed payment could signal crisis and poverty. [26] The proportion of children living in relative poverty across Scotland has gradually risen since 2011/12 to 26% in 2019/20.[27] More than two thirds (68%) of children living in relative poverty after housing costs were living in working households.[27] Almost 90% of families in poverty in Scotland are in the six priority groups: lone parent families; minority ethnic families; families with a disabled adult or child; larger families (with 3 or more children); families with a youngest child aged under 1; families with a younger mother (mothers aged under 25). [28]

The mechanisms by which poverty and disadvantage can interact with child, and subsequently adult, health and wellbeing outcomes, are complex and interconnected. For example, the effects of poverty can contribute to mental health, financial problems and substance misuse in parents which can affect parenting and children's wellbeing. In severe cases this can contribute to abuse, neglect or major adversity, which affect children's health and wellbeing in the immediate and longer term. Relative child poverty was rising pre-pandemic but the restrictions and economic impacts have increased hardship and crisis for many families.[29,30]

There are significant inequalities in indicators of child health and wellbeing between the most deprived and least deprived areas of Fife, reflecting in part the effect of poverty on child health and wellbeing. For example, breastfeeding rates, smoking in pregnancy and vaccine uptake is lower in the most deprived areas compared to the least deprived areas.[10]

Education

Education affects many outcomes including employment, future earnings, involvement in crime, and health and wellbeing. We know that poverty can unfairly limit the development and educational attainment of children and young people from low income families through, for example, affecting their access to learning opportunities.[31]

There were 50,078 children in school in Fife at the 2021 Pupil Census, with 44% in secondary school.[32] Across Scotland 63% of pupils leave school after S6, and in 2019/20 3,406 children left school in Fife, 92% went onto a positive destination. The top 3 positive destinations were higher education (38%), further education (36%) and training (4%). The majority of school leavers in 2019/20 (97.2%) achieved 1 or more SCQF Level 3 qualifications or higher, which is slightly higher than the figure for Scotland at 96.3%, with 95% of school leavers in the most deprived areas achieving this. However, social deprivation impacts on achievement as the level of qualification increases, with only 36% of school leavers in the most deprived areas achieving 1 or more SCQF at Level 6 in Fife compared to 75% in the least deprived areas. [32]

Mental health and wellbeing and experiencing adversity

Protecting the mental health of children and young people is important to ensure their wellbeing and future health, mental health and resilience. A wide range of socio-economic factors can have a significant impact on children's and young people's mental health, including poverty or chronic health problems. Mental wellbeing scores for 13- and 15-year-olds in Fife are similar to those reported for Scotland (2018). [33] Death by suicide in young people aged 11-25 has occurred at a similar rate as observed in Scotland (9.5 per 100,000; 2015-2019), with very few deaths occurring under the age of 15 at a Scotland level.[10]

Cumulative exposure to multiple sources of adversity in childhood are also known to be associated with increased risk of mental health problems, further adversity and health consequences in adults. People who have had multiple adverse childhood experiences (ACEs), for example experiencing abuse, neglect, violence, homelessness or growing up in a household where adults are experiencing poor mental health or harmful use of alcohol and drugs; are likely to have poorer health and wellbeing as adults, including increased risk of chronic conditions.[34] In 2019, just over one in seven adults reported having experienced four or more adverse childhood experiences in the Scottish Health Survey. [35]

The child protection register is a list of children who have been identified as being at risk of harm or further harm in Fife. There were 258 child protection registrations in Fife in 2020/21, a rate of 4 per 1000 children aged 0-15 which was similar to the rate in Scotland.[36] 817 children were looked after in Fife at July 2021, a crude rate of 11.4 per 1000 children aged 0-17, lower than the Scottish rate of 12.9.

Looked after children may experience further risk factors affecting their health and wellbeing, in addition to those facing all children.[37]

General health

Breastfeeding has long term benefits for babies, including reducing the likelihood of infections and obesity, it also has known health benefits for mothers. 30% of babies in Fife were exclusively breastfed at 6-8 weeks compared to 32% across Scotland in 2020/2021.[10]

Being overweight or obese can significantly affect a child's health, wellbeing and self-esteem, as well as have long-term consequences for their health. In the school year 2019/20, just over three quarters (76%) of children in primary 1 (approximately 5 years old) in Fife had a healthy weight and 23.3% were at risk of overweight or obesity. In the last ten years levels of overweight and obesity have remained relatively stable in children in Fife fluctuating between 21.1 and 23.5%.[38]

Monitoring of body mass index (BMI) for Primary 1 (P1) school children through school-based reviews has been significantly impacted by the COVID-19 pandemic with fewer children being reviewed and the most recent figures are not available at a Fife level. Public Health Scotland reported an increase in the proportion of children who were at risk of overweight and obesity from 22.7% in 2019/20 to 29.5% in 2020/21, with the biggest increase in the proportion of children at risk of obesity.[39] Having looked at the data in detail in terms of comparability with previous years, they have concluded that 'the scale and consistency of observed changes in 2020/21 suggest that there are true differences in the BMI distribution of P1 children and cannot be accounted for solely by differences in the size and composition of the dataset'.

In 2019/20 in Scotland, 27% of children living in the most deprived areas were at risk of overweight and obesity, compared with 17% of children living in the least deprived areas. Levels of overweight and obesity increased in both areas in 2020/21, but the increase was greater amongst children in the most deprived areas (increased to 35.7%), widening the gap between the most and least deprived areas.[31]

In terms of dental health, 74% of P1 children in Fife and across Scotland had no obvious dental decay in 2020.[40] This is a significant improvement on the 45% reported across Scotland in 2003 and the 67% reported in 2012. Inequalities are evident, 58% of P1 children in the most deprived areas of Scotland showed no obvious dental decay compared with 87% of P1 children in the least deprived areas in 2020, but the size of this difference has decreased since 2018.

Impact of COVID-19

All aspects of children and young people's lives have been affected by the pandemic, including critical windows of development socially and educationally, and access to leisure

activities and healthcare. Emerging evidence has highlighted the significant negative impacts of COVID-19 to mental health and wellbeing affecting children and young people. [41,42,43] These may have long lasting consequences for Fife. There have been particularly stark impacts on single-parent families, those living with children with a disability or serious illness, families affected by substance use, and those with a parent in jail, and others. The pandemic has occurred on top of an already concerning situation for child health and wellbeing, and the challenge is to recover, improve and change to better support families and children in Fife.

Our ambitions for Priority 2

- The drivers of child poverty (cost of living, income from employment, income from social security benefits) are tackled
- Children and young people enjoy high quality childcare, education and leisure opportunities, including use of the outdoor environment
- There is a whole-society approach to prevent, reduce and mitigate childhood adversity including violence, abuse and neglect
- There are high quality, effective early interventions to improve children and young people's physical and mental health and to build resilience
- Children and young people's rights are promoted and integrated within service delivery

Focus of work for Priority 2 in 2020 and 2021

Work to support a healthy start in the early years has focused on responsive, comprehensive actions to mitigate the impact of child poverty, improve mental health and wellbeing with a particular focus on early intervention and prevention, increase access to support and implement a whole family approach to substance use. A family focused Healthy Weight Service aims to support positive family friendly lifestyle changes, including eating well and physical activity.

Child poverty

Fife's third Child Poverty Action Plan was published in 2021 and details positive actions taken to mitigate the impact of poverty. [44] It recognises that actions need to go beyond those that target children specifically and need to be based on listening and responding to the experiences of those living in Fife.

Children in both primary and secondary education accessing free school meal provision has increased during the past 2 years and services in Fife have been working to ensure that those families who can access free school meals know how to do so.

Initiatives around personalised income maximisation advice and support to parents and carers of children in the school setting have also been put in place.

Supporting mental health and wellbeing

Work to develop Fife's Our Minds Matter Framework for supporting young people's emotional wellbeing continues to focus on the development of partnership approaches to staged intervention practices (a structured approach to identify the level of support required), with a particular focus on early intervention and prevention. [45] In 2021, work to increase access to mental wellbeing support took place with feedback from young people and families, and examination of data across partners leading to a key focus on the provision of supports which are available digitally, support available to young people without the need for a professional referral and investment in the provision of locality-centred offers. [46,47]

Besides these extended service-offers, themes for early intervention have also been identified. These have responded to the impacts of the COVID-19 pandemic and have included extension of supports for bereavement and loss, extension of strategies to support emotional literacy and listening and talking, and development of relationship supports. [48] In the next few years evaluation and development of these approaches will continue.

Whole family approach to substance use

Making it Work for Families was relaunched in October 2020 supporting lone parent, low income or out of work families affected by current, historic or at risk of substance use where there is a young person living at home who is in S1 or S2 at High School. [49] The project provides tailored holistic whole family support to families through a co-ordinated approach, offering a safe space for families to overcome barriers and progress at their own pace.

Child Healthy Weight and Healthy Families

The Child Healthy Weight Programme in Fife, Fife Loves Life supports positive family friendly lifestyle changes, including eating well and physical activity. [50] The programme can also signpost families to other services as required. Improvements have been made such as referral and care pathways being developed and implemented, running a marketing campaign to increase awareness of the service and to encourage self-referral and developing a toolkit to enable staff to signpost, refer or deliver first line key messages. The service was delivered online and via telephone due to COVID-19.

Early years funding has been secured for training the trainer on Healthy Families: Right from the start (known as HENRY). [51] HENRY Core Training builds the skills of early years practitioners to support families and children (0-5 years) to improve their health and wellbeing by changing behaviour and attitudes towards a healthy lifestyle.

Priority 2: Opportunities and areas of focus for public health and partners for the coming years

- **Income maximisation** - Support work to increase access to income maximisation programmes in the early years
- **Anchor institution** - work to support NHS Fife as an anchor institution in supporting those in low paid work, and access to work for child poverty priority groups
- **Children’s rights** - Raise awareness of and realise children's rights across mainstream services, including Article 24 (healthcare for children and young people should be as good as possible) and Article 26 (children and young people should get financial support from the government when their parents or guardians are unable to provide them with a good enough standard of living by themselves) of the United Nations Convention on the Rights of the Child (UNCRC)
- **Ongoing work** - Continue work to support breastfeeding, physical activity, good diet, oral health and healthy weight

Priority 3: A Fife where we have good mental wellbeing

Good mental health and wellbeing is imperative as it enhances quality of life and survival, and improved engagement with positive health behaviours, education, employment, family and community.

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38% of people report they are extremely satisfied with their life (2016/19).

10% of respondents to the Scottish Health Survey in 2019 reported that they felt lonely often or all of the time in the previous two weeks.

Depression was the second largest cause of ill health in 2019 and anxiety disorders were the 4th largest cause.

1 in 5 people were prescribed drugs for anxiety, depression or psychosis in 2019/20.

The most deprived areas have **36%** more prescriptions for anxiety, depression, psychosis than the overall average.

There was an annual average of **50** deaths from probable suicide between 2016/20.

For all these indicators of mental health and wellbeing, there are inequalities between the least and most deprived areas of Fife.

Why Priority 3 is important

Good mental health and wellbeing is imperative as it enhances quality of life and survival, and improved engagement with positive health behaviours, education, employment and community. Connections with others can help us cope with difficulties and adversity as well as improving our health and wellbeing. Poor mental health and wellbeing can have a considerable impact on individuals, their families and the wider community and often occurs alongside other health conditions. Inequalities are evident in both mental wellbeing and mental health problems.

Wellbeing and loneliness

Findings from the Scottish Health Survey in 2016-2019 reported that 38% of respondents in Fife were extremely satisfied with their life, slightly higher than the rate in Scotland, and a third of Fife respondents reported below average life satisfaction.[52] Mental wellbeing, as measured by Warwick-Edinburgh Mental Well-being Scale (WEMWBS) was 49.9, similar to a mean of 49.7 in Scotland.[xiii] Mental wellbeing, as measured by WEMWBS, increases with decreasing deprivation, with mean scores of 46.5 among respondents to the Scottish Health Survey 2019 in the most deprived areas in Scotland to 51.5 in the least deprived areas.

The effect of social isolation and loneliness on mortality is estimated to be similar to that of other health risk factors such as smoking, obesity and physical inactivity. [53] 10% of respondents to the Scottish Health Survey across Scotland in 2019, reported that they felt lonely often or all of the time in the two weeks prior to the survey and those who reported this had lower mental well-being than respondents who were rarely or never lonely.[54] Reports of feeling lonely ‘often or all of time’ increase with increasing deprivation from 6% of respondents in the least deprived areas to 17% in the most deprived.

Mental health problems

17% of Fife respondents to the Scottish Health Survey reported a General Health Questionnaire (GHQ)-12 score of four or more, an indicator of potential mental health problems, the same as in Scotland.[52] A trend of increasing prevalence of reports of two or more symptoms of depression and anxiety has been seen since 2012-13, with current figures for depression of 12% and for anxiety of 14% being the highest recorded in the time series of the survey.[54] Adults living in the most deprived quintile were more than twice as likely in 2018-2019 to report two or more symptoms of depression and twice as likely to report two or more symptoms of anxiety than those living in the least deprived quintile.[34]

xiii The Warwick-Edinburgh Mental Well-being Scale (WEMWBS) is a scale of 14 positively worded items for assessing a population's mental wellbeing, including both feeling and functioning aspects of mental wellbeing. The WEMWBS scale runs from 14 (the lowest level of wellbeing) to 70 (the highest).

1 in 5 people in Fife (20.8%) were prescribed drugs for anxiety/depression/psychosis in 2019/20, slightly higher than Scotland (19.7%). This trend has increased year on year since 2014/15. [10] The most deprived areas had 36% more people receiving prescribed drugs for anxiety/depression/ psychosis than the Fife average in 2019/20, with the proportion of the population in the most deprived areas (27%) almost double that in the least deprived (15%).[10]

Suicide

Between 2016 and 2020 there were a total of 250 deaths from probable suicide registered in Fife, an annual average of 50 deaths.[55] The rate of suicide mortality in Fife in 2016-20 was similar to Scotland, 13.9 per 100,000 population compared to 14.1 per 100,000 population. Across Scotland more than 70% of people dying from suicide were male, with the highest numbers in men aged 35-39 and highest numbers in women aged 45-49.[56] One in every five suicide deaths in Scotland in 2020 was to someone under the age of 30. The suicide rate in most deprived areas of Scotland was three times the rate in the least deprived areas in 2020.[10]

Impact of COVID-19

We are not yet able to quantify the full impact of COVID-19 pandemic on mental health and wellbeing with the data available to us. Studies and surveys, mainly from 2020 and early 2021, have shown a range of impacts on mental health and wellbeing across the population, with some groups being more adversely affected. The pandemic and in particular lock downs have been associated with increased loneliness, anxiety, depression and stress. [57,58]

Our ambitions for Priority 3

- There is promotion of mental health and wellbeing throughout society and a culture where stigma and discrimination is challenged
- Public spaces promote intergenerational social connections, people feel included in their community and social isolation is reduced
- There is widespread awareness of Adverse Childhood Experience (ACE) and trauma-informed practice
- There is access to timely and person-centered mental health advice and services across the life course

Focus of work for Priority 3 in 2020 and 2021

The focus of work for this priority has been on mental health improvement, suicide prevention, workforce development, building capacity for trauma informed working and workforce support during the pandemic. Work continued to deliver local activity in line with local and national strategies and plans.[59,60,61,62] Fife also continues to support national campaigns to promote their key mental health and wellbeing messages where possible.[63,64,65]

Mental health improvement

The #ItsEveryonesJob workplace campaign launched in 2021 and encouraged Fife's workforce and employers to have healthy conversations around mental wellbeing, mental health and suicide.[66] A range of materials were developed with employers and Fife Voluntary Action's Lived Experience Team including a digital toolkit, traumatic incident framework, lived experience case study and web based information.[67] Lived Experience Team volunteers have since gone on to support a number of strategic developments including the review of the MoodCafe website and work on improving pathways of care in mental health services in Fife, including for complex trauma.[xiv] Work to launch the Fife Mental Health Peer Support Network has also taken place with the aims of improving services and employment pathways for people who have experienced mental health challenges. There has also been mental health and wellbeing support for students attending Fife College through awareness raising, health information, advice, support and training.

Workforce development including building capacity for trauma informed practice

During the pandemic, workforce training moved to *'digital by default, face to face by exception*', with training relating to improving mental health and prevention of self-harm and suicide for adults, children and young people being provided to ensure our workforce have the tools and skills needed to support people in Fife's mental health and wellbeing. Good Conversations Training and support for staff to implement this has also continued. Training around trauma has also been implemented to develop knowledge and skills in psychological trauma across all public, private and voluntary sectors by ensuring the workforce receive the appropriate training to support the delivery of trauma-informed practice.

xiv Moodcafe. Promoting Mental Health from Fife. Available: https://www.moodcafe.co.uk/

Suicide prevention

Work continued throughout the pandemic particularly around identifying, gathering and analysing local and national data on suicides to inform timely responses to incidents and provide a basis to plan interventions in a more targeted way. A monthly e-newsletter kept stakeholders up to date on relevant activity around suicide prevention, including local and national updates, training, research and campaigns.

Workforce support during the pandemic

During the pandemic the increased importance of supporting staff across the health and social care system and wider partners to take care of their own mental well-being was recognised, including sleeping, eating well and exercising. A range of opportunities were promoted across the system with lots of collaborative working to support staff resilience such as:

- Creation of staff Health and Wellbeing Hubs
- Staff Listening Service
- Online peer support sessions
- Mindfulness and self-compassion drop in sessions
- Information sessions for managers to clarify range and types of support
- Inspiring Kindness online conference.

Priority 3: Opportunities and priorities for public health and partners for coming years

- **Improving professional awareness and navigation of available support** – Funding has been secured to undertake work to ensure frontline staff and members of the public are aware of, and able to navigate, the range of mental health and wellbeing support and services available in Fife.
- **Support for young people** – Support for young people attending Fife College will continue.
- **Workforce development** – We will continue to equip staff to support the mental health and wellbeing of people in Fife, as well as their own wellbeing, through a suite of training and development opportunities, including Good Conversations and strengthening trauma informed practice.

Priority 4: A Fife where we reduce the use of and harm from alcohol, tobacco and drugs

Smoking and alcohol consumption continue to be leading causes of illness and early death in Fife. Deaths associated with drug use have also increased significantly in recent years. There are persistent inequalities in harms caused by smoking, alcohol consumption and drug use.

Rates of smoking have decreased significantly since the early 2000s with less than **1 in 5** of the population over 16 reporting they smoke.

Around **one third** of the population over 16 in our most deprived populations currently smoke.

Smoking during pregnancy is high with **1 in 5** expectant mothers who smoke continuing to do so.

There are inequalities evident on smoking rates in the most and least deprived areas.

Over **1 in 4** people report they exceed the recommended **14 units** of alcohol per week.

There was an annual average of **71** alcohol-specific deaths between 2016/20.

87% more alcohol-specific deaths in the most deprived areas compared to the average.

Drug-related hospital admissions have increased in Fife and across Scotland in the last 10 years.

There was an annual average of **64** drug related deaths between 2016/20, more than double the five-year average of 30 deaths in 2006/10.

Drug related deaths were **15** times higher in the most deprived areas of Fife compared to the least deprived.

Why Priority 4 is important

Smoking and alcohol consumption continue to be leading causes of illness and early death in Fife. There are persistent inequalities in both smoking and alcohol consumption and the harm they cause. Deaths associated with drug use have increased significantly in recent years and also constitute a public health emergency, with much higher rates of drug related death occurring in the most deprived areas of Fife.

Smoking

Smoking is one of the leading causes of death, responsible for many cancers (the leading cause for lung cancer), cerebrovascular disease, respiratory conditions such as chronic obstructive pulmonary disease and pneumonia. In pregnancy it increases the risk of complications such as miscarriage, still birth and having a low birth weight baby.[68] Rates of smoking have decreased significantly since the early 2000s, with less than 1 in 5 of the population over 16 reporting that they smoked in Fife (18%) and Scotland (19%) in 2019.[69] Figures for smoking levels among adolescents have also decreased since 2006; the proportion of 13- and 15-year-olds who were regular smokers in 2018 was 2% and 8% compared to 6% and 16% in 2006.[70]

Despite the overall decrease in smoking levels in adults aged 16 and over, rates of smoking have continued to be higher in the more deprived areas across Scotland than the least deprived, currently at 32% and 6% compared to 45% and 17% in 2003.[52] A similar pattern is seen in reports of smoking in pregnancy, with an average of 35% of Fife expectant mothers reporting smoking in the three years to the end of 2020/21, which was almost nine times the rate in the least deprived areas (4%).[10] In line with other smoking indicators, smoking in pregnancy has decreased since 2003/4 in both Fife and Scotland to current levels of 20% and 14% respectively, but Fife levels have remained higher throughout this time.[10] The risks associated with smoking increase the longer a person continues smoking. However, these risks can reduce substantially when a person stops, adding further weight to the importance of cessation policies, interventions and initiatives. In 2019/20, there were almost 3,000 attempts to stop smoking made with the help of NHS Fife smoking cessation services.[71]

Drugs

Use of drugs can lead to a variety of health problems including transmission of communicable diseases including human immunodeficiency virus (HIV), hepatitis, injecting related injuries, mental health problems and overdose.[72] Due to the nature of drug use it is difficult to get a full understanding of the number of individuals with problematic drug use but the most recent estimates (2015/16) suggest this could be almost 1 in 60 (1.62%) of the

population aged between 15 and 64 in Scotland, and 1.19% in Fife[xv,73]. Drug-related hospital admissions have increased significantly in Fife and across Scotland in the last 10 years, although a fall was seen in 2020/21, which may have been expected due to impact of the COVID-19 pandemic.[74] Since 2012/13, rates in Fife have been consistently higher than the Scottish average and are currently 278 per 100,000 population, compared to 235 per 100,000 population nationally and may reflect differences in care pathways in different areas. Half of all patients with a drug-related hospital admission in 2020/21 lived in the most deprived areas in Fife, with admission rates in the most deprived areas being 18 times greater than those in least deprived areas.[74]

Use of drugs can also be associated with (or the consequence of) social problems which also have a long term impact on health and the health and wellbeing of families, for example crime, violence, unemployment, family breakdown and homelessness. Rates of Child Protection Case Conferences where parental drug misuse was recorded (with or without alcohol misuse) was higher in Fife than in Scotland with a crude rate of 11.8 per 100,000, compared to 7.8 per 100,000 in Scotland (2019/2020).[10]

In Fife, as in Scotland, an increase in drug-related deaths has been observed. The current (2016-20) five-year average in Fife of 64 deaths is more than double the five-year average of 30 deaths in 2006-10.[75] During this time Fife has had a lower drug-related death rate than Scotland which recorded the highest ever annual number of drug-related deaths in 2020. Males account for the majority of drug-related deaths in Fife and across Scotland. The average age of drug-related deaths in Scotland has increased over the last 20 years from 32 in 2000 to 43 in 2020, with the highest rates of death being among the 35-44 age group.[75] Stark inequalities are evident in drug-related deaths with rates of drug-related death 15 times higher (2015-19) in the least deprived areas compared to the most deprived areas in Fife.[10] The Drugs Deaths Taskforce was established in July 2019 to tackle the rising number of drug deaths in Scotland. [76]

It is increasingly understood that people with severe mental illness combined with problematic use of substances have significantly poorer health outcomes than average, and often have difficulty accessing effective treatment and support. [xvi] It is not clear how many people are affected by such a dual diagnosis, but estimates have included that this could affect up to a third of those in secondary mental health services and 6-15% in substance misuse settings. [77]

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xv More recent estimates are not available at the time of writing this report

xvi including schizophrenia, schizotypal and delusional disorders, bipolar affective disorder and severe depressive episodes with or without psychotic episodes

Alcohol

Drinking alcohol is a risk factor for many health conditions, including many cancers, high blood pressure, cerebrovascular disease, liver disease and mental health problem.[78] The harmful use of alcohol can also result in social and economic impacts for both individuals and wider society, including violence and accidents.

Self-reported alcohol consumption figures estimate that just over 1 in 4 people (22%) in Fife drank more than the weekly recommended level of 14 units per week with men more likely to report this than women in 2016-19.[52] Surveys consistently obtain lower consumption estimates than those derived from alcohol sales data. In 2019 the equivalent of 9.9 litres of pure alcohol for every person aged 16 years and over was sold in Scotland, which converts to 19.1 units per adult per week.[79] During the COVID-19 pandemic, alcohol sales (litres of pure alcohol per adult) were 9% lower in 2020 and 16% lower up to May 2021 than the average for the same time periods in 2017–19.[79] During both these times there was a noticeable increase in alcohol off-sales (shops and supermarkets) and a substantial fall in sales within licensed premises. This level of alcohol sales during the pandemic suggests that population-level consumption continued to be above recommended levels, at an average of 17 units per adult each week.[79]

There was a fall in alcohol-related hospital (acute) admissions in Fife in 2020/21 (584 per 100,000 population), compared to 2019/20 (701 per 100,000 population).[80] The COVID-19 pandemic and measures put in place to respond to the pandemic are likely to have contributed to this fall. Prior to this fall, rates in Fife had increased year on year since 2015/16 and have shown an upward trend since 2011/12, in contrast to the downward trend seen nationally during the same time period.[80]

Between 2016 and 2020, there were a total of 356 alcohol-specific deaths registered in Fife, an annual average of 71 deaths and a rate of 18.5 per 100,000 population.[81] This was the highest five-year rate since 2008-12 but was lower than the Scottish average, which has been a consistent trend since 2000-04. Men are more likely than women to die from an alcohol-specific death and be admitted to hospital for an alcohol-related condition.

There are large and persistent inequalities in both alcohol-related hospital admissions and alcohol-specific deaths which are both five times higher in the most deprived areas in Fife compared to the least deprived areas. The most deprived areas had double the admissions in 2020/21 and 87% more alcohol-specific deaths in 2016-20 than the Fife average.[10]

Our ambitions for Priority 4

- Cultural norms have changed and smoke-free, alcohol-free and drug-free facilities and events are widespread across Fife
- Decisions on the location and number of licensed premises are informed by public health intelligence
- There is a holistic and integrated approach to improving the health of those who have contact with police, criminal justice or homelessness services
- People are supported to make healthy life choices
- People are supported to access and remain in drug and alcohol treatment services
- A whole-family approach is taken to drugs and alcohol rehabilitation

Focus of work for Priority 4 in 2020 and 2021

The work to reduce harms related to alcohol and drugs in 2020 and 2021 included the establishment of a new system for the review of drug related deaths, and increased prevention activity. To address tobacco use and the wider harms associated with smoking and reduce associated health inequalities, work has centred on three priority areas: Prevention, Protection and Smoking Cessation.

Review of drug-related deaths

In 2020, the lead public health consultant and ADP (Alcohol and Drugs Partnership) colleagues established a process for reviewing all suspected drug related deaths in Fife to learn lessons to contribute to reducing the number of drug related deaths in Fife. To date, the group has learnt some very important lessons in relation to:

- Improving access to alcohol and drug services
- Improving communication and information sharing across multiple agencies and service users
- Need for a case management approach/lead agency, assertive outreach or additional support during high-risk times
- Adult Protection concerns not being identified or cases not meeting the criteria for protection
- Improving overdose awareness in people at risk and family members
- Making appropriate referrals following disclosure of physical/sexual assault
- The review also found a small number of cases where, due to COVID-19 restrictions, face to face meetings were not available and people found it difficult to engage via telephone or online.

Service changes implemented as a result of learning from the drug related deaths review process have included enabling nurses and navigators based in police custody suites to be able to make direct referrals to addiction services and training social work staff on the increased risk of overdose at significant anniversary dates. Community Pharmacies are now working to ensure missed doses of medication are reported quickly. Furthermore, a community pharmacy audit has been carried out on prescribing rates of certain high risk drugs and liaising with GP practices as appropriate.

Other work with ADP partners to increase prevention work

A Near Fatal Overdose project has implemented an 'assertive outreach' approach to engage people with services, advice and naloxone. Distribution of naloxone and injecting equipment has expanded, including peer naloxone and injecting equipment. A new anonymous reporting system has been developed to improve our capacity to quickly identify dangerous batches of drugs. There is now a Lived Experience Panel which has contributed strongly to ADP meetings.

Levenmouth locality work

Focused work with the Levenmouth locality group since 2020 has concentrated on increasing the presence and awareness of drug services embedded within the community and wide availability of injectable and nasal naloxone and injecting equipment, and support for family members. Educational opportunities on harm reduction and overdose have been available to individuals, families and friends, and key local professionals within the community.

Tobacco prevention

Fife looks to create an environment where individuals, particularly children and young people, choose not to smoke. Key pieces of work included delivering educational programmes, which encourage children and young people to consider how smoking sits alongside other risky behaviours such as drinking alcohol and drug taking. These were delivered in alternative formats as a result of the pandemic.

Tobacco protection

An important piece of work was completed to understand the issues and identifying opportunities to reduce smoking for people who are being cared for in NHS Fife's Mental Health sites, resulting in a new Temporary Abstinence Model in Mental Health sites to align with other areas of NHS Fife acute services and smoke free campaign. A challenge due to COVID-19 was the lack of access to members of the Mental Health workforce for training, particularly around medication interactions during the quitting process.

Smoking cessation

Prior to the pandemic, evidence-based smoking cessation support was available through the NHS Quit Your Way Specialist service and the midwife led service providing intensive one to one support over 12 weeks within GP Practices, Heath Centres, Hospitals and a variety of community venues. All Community Pharmacies also provided a brief stop smoking intervention. However, COVID-19 affected service availability due to staff redeployment and changes in the way people could access support, resulting in a shift to providing support remotely affecting rapport and access.

Across all three priority areas of prevention, protection and smoking cessation, the COVID-19 pandemic has impacted our ability to access community partners and conduct health promotion, awareness-raising opportunities and engagement activities at a local level.

Priority 4: Opportunities and priorities for public health and partners for coming years

- **Implementing recommendations for drug specialist services** – Improve the way drug specialist services are commissioned to address the deficits outlined in previous locally-commissioned reports such as the public health synthesis of recommendations from 2019.
- **Prevention focus for drugs and alcohol** – Make the case for more resources to be spent 'upstream' of the point at which overdoses or severe alcohol related complications occur, including an over-provision policy to support licensing decision making.
- **Mental health integration with substance misuse** – Find ways of providing better mental health provision and liaison for high risk individuals with both a mental health condition and substance misuse.
- **Strategic multiagency response to alcohol and drug misuse** – Some of the issues identified by the drug related deaths review process require a strategic and multi-agency response. Planning for this process is under way.
- **Implementing 'Medication Assisted Treatment (MAT) Standards'** – The ADP is in the process of establishing a 'Medication Assisted Treatment (MAT) Standards' sub-group to coordinate local action to improve rapid access to medically assisted treatment.
- **Smoking Prevention** – We will work collaboratively with key stakeholders to increase engagement on Tobacco Issues, adapting and delivering prevention and education activities with children and young people at the heart, with areas of work looking at the environment in and around the school gates and children's play parks.

- **Protection from second-hand smoke and the wider harms of smoking** – Leadership and further cultural change will be a focus in expanding smoke-free environments to ensure all are protected from second-hand smoke and the wider harms of smoking. NHS Fife can lead and manage change by refreshing our Smoking Policy to reduce smoking on our sites.
- **Smoking Cessation** – We will remobilise face to face smoking cessation services within health and community venues, and re-establish community outreach work, to improve accessibility and uptake of support that is sympathetic to people living in the most disadvantaged circumstances. We will build on opportunities to support patients to quit while in our care.

Priority 5: A Fife where we have a sustainable inclusive economy with equality of outcomes for all

The greatest opportunity to improve health and wellbeing in Fife lies in reducing differences in health and wellbeing outcomes associated with poverty and deprivation. The drivers of poverty and deprivation are closely associated with income, quality employment and social inclusion, as well as the nature of the places in which we live.

It is estimated that **19%** of Scotland's population were living in relative poverty after housing costs, in 2017/20. In Fife this would equate to **71,085** people.

12% of the population (adults and dependent children) are in receipt of key benefits in relation to being out of work or in receipt of low income.

71.3% of 16-64 year olds in Fife were in employment.

61% of the working age adults living in poverty in Scotland in 2017/20 lived in a household with at least one adult in paid work.

The median household monthly income was **£481** in 2017/20 (after housing costs).

Nearly **1 in 10** people were classed as employment deprived.

Why Priority 5 is important

The greatest opportunity to improve health and wellbeing in Fife lies in reducing differences in health and wellbeing outcomes associated with poverty and deprivation. The drivers of poverty and deprivation are closely associated with income, quality employment and social inclusion, as well as the nature of the places in which we live.

Relative Multiple Deprivation

The Scottish Index of Multiple Deprivation (SIMD) helps us to understand the extent to which parts of Fife are more or less deprived in relation to income, employment, education, health, access to services, crime and housing. Throughout this report we have seen that this measure can illustrate stark inequalities in life circumstances and across many health and wellbeing outcomes according to the level of multiple deprivation assigned to the area in which people live, which highlights the importance of addressing social determinants of health to improve health and wellbeing. [xvii]

Income and poverty

Income is a fundamental social determinant of health, and in turn impacts many other wider determinants of health, for example what we can eat, our access to transport and leisure activities, our experience of financial strain etc. Societies with greater income generally have better health and research indicates that this relationship is causal i.e. earning a higher income improves health. The greatest benefits of increasing income are derived by those with the lowest incomes. [82]

Across Scotland, median household weekly income before housing costs has seen a gradual rise since 2010-13 from £496 to £533 in 2017-20, with current weekly income after housing costs £481.[83] However, income inequality is evident across Scotland: in 2017-20, the top 10% of the population had 21% more income (before housing costs) than the bottom 40% combined. Across Fife, 12% of the population were categorised as income deprived in 2020, living in households in receipt of key benefits in relation to being out of work or having a low income. This varies significantly across neighbourhoods within Fife from 1.4% to 31.6%, with more deprived areas having significantly higher proportions of their population income deprived.[84]

xvii Having said this, we must also take care not to generalize too far in relation to the experiences of people and families living in the different SIMD areas, for example some people and families living in the 'least deprived' areas defined by SIMD, could also be experiencing poverty or inequality depending on their own circumstances; conversely others living in the 'most deprived' areas may experience a comfortable standard of living.

It is estimated that 19% of Scotland's population were living in relative poverty after housing costs, in 2017-20. In Fife this would equate to 71,085 people. Relative poverty, the most commonly used indicator of poverty, is a measure of whether the lowest-income households are keeping pace with middle income households across the UK.[59] Estimates suggest that 10% of the population could currently be living in persistent poverty, defined as living in relative poverty for three out of the last four years. The Fairer Scotland duty places a legal responsibility on certain public bodies, including the NHS, to actively consider how they can reduce inequalities associated with socio-economic disadvantage.

The full impact of the COVID-19 pandemic on income and poverty rates is not yet known, however, reports published covering 2020 and in particular the first lockdown, suggest that the economic effects fell disproportionately on those on low pay with little savings. [85]

Employment

Another important wider determinant of health is access to quality employment, which can provide income as well as meeting social and psychological needs. In 2020/21, 71.3% of those aged 16-64 years in Fife were in employment which was slightly lower than the rate for Scotland at 72.8%.[5] Employment rates in both Scotland and Fife fell from 2019/20, but the size of the fall in Fife was not significant, (0.1%) compared to the 1.7% fall nationally. Nearly 1 in 10 people in Fife (9.4%) were classed as employment deprived, which is the same as in Scotland. In January 2022, rates of people in Scotland claiming benefits due to being unemployed was 24% higher than the pre-pandemic level in February 2020. [86] Many of the impacts of COVID-19 such as longer term impacts of working from home, furlough and future employment opportunities remain unknown.

It is important to recognise, however, that access to employment is not guaranteed to lift families out of poverty if work is low paid or insecure; and low-quality employment can contribute to poorer health outcomes. The majority (61%) of the working age adults living in poverty in Scotland in 2017-20 lived in a household with at least one adult in paid work.[59]

Protected characteristics and vulnerable groups

Protected characteristics are aspects of a person's identity that makes them who they are[87]. Nine characteristics are outlined in the Equality Act 2010, they are:

1. Age
2. Gender
3. Race.
4. Disability
5. Religion or belief
6. Sexual orientation
7. Gender reassignment
8. Marriage or civil partnerships
9. Pregnancy and maternity

These characteristics may affect people's health and wellbeing and their use and experience of public services, including healthcare. The Public Sector Equality Duty includes a requirement to assess the impact of new or revised policies and practices in relation to the protected characteristics.[88]

Other groups also potentially face inequalities in health and wellbeing outcomes and may have a different experience of health services. For example people who experience homelessness; people who use substances; vulnerable migrants and victims of trafficking; Gypsy, Roma and traveller communities; people in contact with the justice system and many other diverse people. Whilst these people may have very different life experiences to one another they are more likely to be affected than the rest of the population to experience inequalities associated with their particular living and working conditions or social circumstances, and they may face different challenges in accessing and using health services[89].

Our ambitions for Priority 5

- The adverse impacts of welfare reforms are mitigated, income through social security benefits and income through employment are maximized
- People's physical and mental health needs including disabilities are recognized by employers and their capacity to engage with employment supported
- There are thriving locally-rooted businesses and social enterprises offering local employment opportunities that deliver within a wellbeing economic model: fundamental human needs are met (to be valued and respected, to have a sense of dignity and purpose); income and wealth are fairly distributed; and planetary boundaries are not breached
- Employers have an inclusive workforce that reflects the communities where they are based, including protected characteristics[xviii]

Focus of our work for Priority 5 in 2020 and 2021

The focus of work has been creating the groundwork for community wealth building; supporting the early stages of establishing NHS Fife as an anchor institution; building employability policy; supporting Fife workplaces to promote health and address inequalities; and promoting the health and wellbeing of vulnerable people and communities.

Community wealth building

The review of the Plan for Fife identified that "Our current ways of working are not preventing problems early enough or addressing the economic, environmental and other challenges we face quickly enough". In response to this, work to embed Community Wealth Building principles was taken forward. [90] Community wealth building is a people-centred approach to local economic development to improve communities and their wellbeing, redirecting wealth back into the local economy, placing control and benefits into the hands of local people. Examples of work identified to take forward include targeting interventions to address under-representation in Fife's workforce, promoting opportunities to join credit unions and increasing the number of organisations paying the Real Living Wage. [91]

xviii Age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation

Anchor institutions

NHS Fife aims to be an anchor institution within its population area. Anchor institutions have been described as organisations that have an important presence in a place, usually through a combination of being large scale employers, the largest purchasers of goods and services in the locality, controlling large areas of land and/or having relatively fixed assets. In addition, anchor institutions are tied to a particular place by their mission, histories, physical assets and local relationships. The Health Foundation 2019 report, "Building healthier communities: the role of the NHS as an anchor institution" highlighted how decision makers across the health care system can maximise the contribution the NHS makes to the social, economic and environmental conditions that shape good health. [92] The worsening of inequalities due to COVID-19 has brought the importance of this work into sharper focus. By working as an anchor institution, NHS Fife can have an impact on reducing health inequalities, particularly through our policies for employability, procurement and spend, estates, property and land.

In 2021 NHS Fife established an Anchor Institution Programme Board. Areas of work have included:

- Widening access to employment, working in partnership with Fife Council to establish the Kickstarter programme for young people
- Exploring the proportion of spend and which areas of spend from procurement can go into the local economy
- Conducting greenspace audits for all of our estates and buildings facilities and developing sustainability plans to reduce environmental impact

Financial inclusion and advice work

Work has continued to increase financial awareness, maximise incomes and improve health outcomes for people including: people attending maternity services, people with caring responsibilities and people who have received a cancer diagnosis. During 2021, new services included specialist advice services within foodbanks in Fife to support those who are living with food insecurity and the development of a financial advice service for NHS Fife staff.

Employability

Fife's employability partnership, Opportunities Fife, aims "to influence and drive innovative approaches to skills and employability services that reflect the current and future needs of individuals and employers". [xix] Work to 'refocus employability support more on those with multiple barriers to employment', led to the commissioning of new employability services in 2021/22 and 2022/25 under the banner of No One Left Behind Fife. [93] The consultation and ultimate commissioning process for No One Left Behind Fife was co-designed with people who currently use unemployment services, those from key equalities groups and key delivery partners. [94]

Supporting Fife's workplaces to promote health and wellbeing

Work has continued to support employers in Fife to identify workplace health and safety and wellbeing issues; develop and implement supportive policies and practices to protect and improve physical and mental health, and support employees to remain in and return to work. During the pandemic staff were directed to frontline health and social care services. However, workplaces still requested help and advice in relation to health, safety and wellbeing matters, particularly in relation to COIVD-19 risk assessment and control measures, both in the workplace and for those working at home. Latterly, requests have related to measures to be implemented in the recovery from the pandemic. Social media platforms were used to raise awareness of local and national campaigns and activities and to signpost to supporting services. Case studies were developed to identify and share good workplace practices on promoting health at work. [xx]

xix Opportunities Fife: Available: https://www.opportunitiesfife.org/

xx Frontline Fife, Police Scotland, Youth 1st

Inclusion health

Building on existing outreach work to address health inequalities in access to sexual health and blood-borne viruses (BBV) services, during the pandemic Sexual Health and BBV services staff in partnership with "We Are with You" workers maintained outreach harm reduction and support services to people across Fife most at risk, extending this to people experiencing homelessness.[xxi, 95,xxii] This included providing practical support like access to phones, food, medicines and other supports and maintaining capacity to continue HIV and Hepatitis C treatments through outreach. Innovative ways of working included the use of the NHS Fife Public Dental Service Childsmile bus, street work in town centres and liaison with homeless accommodation units. This extended to include roll out of LFD kits and promotion of immunisation in homeless units. [xxiii] This way of working is here to stay.

A new collaboration with the University of Dundee and the Scottish Drugs Forum focused on oral health improvement for people with experience of drugs. The collaboration has included capturing lived experience in a series of comics highlighting oral health issues that are pertinent to this population, and an oral health training programme for addiction workers supporting people in recovery. The next stages of development of the programme are currently being planned.

NHS Fife also formed part of the response for Afghan refugees including providing health screening, childhood immunisations, support to access health services and emergency dental care, and short courses of dental treatment where needed.

xxi We are with you is Fife's Specialist Harm Reduction Service, offering a range of services to help reduce drug related harm.

xxii This work uses the ACORN approach (Access Care Respond to Needs).

xxiii Childsmile is a national programme to improve the oral health of children in Scotland and reduce inequalities in dental health and access to dental services

Priority 5: Opportunities and priorities for public health and partners for coming years

- **Embedding the Anchor Institution principles:** Anchor Institution development work will continue. This will help NHS Fife and key partner organisations prioritise work on areas such as employability and procurement that will promote community wealth building in Fife. Employability and poverty initiatives such as the Kickstart programme and Living Wage Accreditation will be crucial elements of this. The focus of the work should include:
  - Widening access to quality work for the NHS with inclusive workforces reflecting their communities, including protected characteristics
  - Purchasing more locally and for social benefit including developing involvement in the NHS Community Benefit Gateway[96]
  - Using buildings and spaces to support communities
  - Reducing environmental impact
  - Working more closely with local partners

- **Anti-poverty measures:** Continue to work on interventions that are upstream and prevent crisis, including developing a plan for delivering a range of anti-poverty measures across a variety of settings such as GP practices, acute hospital settings and community venues.

Priority 6: A Fife where we eat well, have a healthy weight and are physically active

Poor diet and physical inactivity are major risk factors for many chronic diseases, as well as contributing to mild and moderate mental health, depression and anxiety and social isolation.

Around **two thirds** of adults are overweight (including obese).

Around **two thirds** of the adult population meet the recommended levels of physical activity.

Over a **quarter** of people report having low or very low activity levels.

in 5 people report eating the ecommended five portions of fruit or vegetables per day.

1 in 10 people report eating no fruit or vegetables.

It is estimated that more than **27,720** people in Fife are fooc insecure (**9%**).

Rates of obesity and Type 2 diabetes among adults are higher in older adults and the most deprived areas compared to the least deprived.

Why Priority 6 is important

Poor diet is a major risk factor for obesity and chronic diseases including cancer, heart disease and Type 2 diabetes, as well as contributing to mild and moderate mental health, depression and anxiety and social isolation. The social dimension of food is significant, including its potential to build connection and community, however, there are also clear links between food insecurity, diet and health inequalities. The COVID-19 pandemic has affected food security, cooking and eating habits and levels of physical activity.

Overweight and obesity

The circumstances and behaviours that contribute to obesity are influenced by a complex combination of biological, psychological, environmental and social factors. Many of the factors overlap and interact with each other, with deprivation increasing the risks. The bidirectional link between mental health and physical health cannot be ignored. Experiencing mental health problems, particularly depression, significantly increases a person's risk of being overweight, with those experiencing severe mental illness (SMI) at even more risk. Obesity and overweight are associated with a wide range of health complications and premature mortality, including emerging evidence indicating that excess weight is associated with a heightened risk of serious COVID-19 outcomes. [97]

Around two thirds of adults in Fife (68%) were overweight (including obese) and 31% of adults were obese in 2016-19, similar proportions to Scotland.[52] Across Scotland, gradual increases in overweight levels have been seen since 2011 and are currently (2019) at their highest levels since 2003. Scottish Health Survey data from a smaller telephone survey in 2020, reported that 39% of people in Scotland stated their weight had increased since March 2020.[98]

Males (69%) are more likely to be overweight (including obese) than females (67%) in Fife (2016-19) and in Scotland.[52] The levels of overweight (including obese) and obesity increases with age until the age group of 75 and over when levels decrease. Obesity rates among adults are higher in Scotland's most deprived areas compared to the least deprived, particularly for women amongst whom rates in 2019 were 40% in the most deprived areas compared to 18% in the least deprived.[54]

Type 2 diabetes

Rising obesity levels are contributing to increased rates of Type 2 diabetes, which is preventable. The most recent Scottish Diabetes Survey (2019) reported that there were 20,390 people with known Type 2 diabetes in Fife, a crude prevalence of 5.5%. Type 2 diabetes is more common in older people; 53% of all people with diabetes recorded in the survey were aged 65 years or older.[99] With an ageing population, the prevalence of Type 2 diabetes is expected to continue to rise. There are wide inequalities in Type 2 diabetes across Scotland with prevalence in the most deprived areas (12%) three times greater than in the least deprived areas (4%).[99]

Diet and eating well

Scotland has long faced significant challenges to improve its diet, and consumption of foods such as cakes, biscuits and sugary drinks remain at higher than recommended levels to maintain good health. [100]

Adults in Fife eat around three portions of fruit or vegetables a day, similar to the Scotland average. Only 1 in 5 people in Fife report eating the recommended five portions of fruit or vegetables per day (21% compared to 22% in Scotland), and around 1 in 10 people (11%) report eating no fruit or vegetables (10% in Scotland).[52]

Whilst the COVID-19 pandemic has seen increased purchases of fruit and vegetables there is also evidence that snacking, purchases of discretionary foods and takeaways have increased, however, this occurred alongside decreased eating out. Around a third (34%) of parents in Scotland reported their diet had become less healthy and 17% reported their children’s diets had also worsened.[92]

Food insecurity

Household food insecurity has significant implications for health and wellbeing including hunger. It is defined as “the inability of one or more members of a household to consume an adequate quality or sufficient quantity of food that is useful for health, in socially acceptable ways, or the uncertainty that they will be able to do so”.[101] While poverty is the major cause of food insecurity, there are other contributory factors, for example, the skills and knowledge to prepare healthy, nutritious food, or access to adequate equipment to do so.

In 2019, 9% of adults in Scotland were estimated to be food insecure, which equated to 27,720 people in Fife. Food insecurity was more common among younger adults (13% in 16-44 year olds) and among single parents (31%).[54] Adults (12%) and children (14%) living in relative poverty in Scotland were much more likely to live in very low food security households compared to the population as a whole (4%).

During the past 15 months, local partnership groups in Fife's seven areas have increasingly identified food insecurity as a significant issue. COVID-19 had knock on effects to community food providers and foodbanks, who had to find alternative ways of delivering services at a time when need was even greater. Increases in both food and fuel prices are expected to exacerbate these issues in the coming months.

Physical activity

Physical activity offers a protective effect against many chronic conditions, including coronary heart disease, obesity, Type 2 diabetes and mental health problems, and can increase social connectedness, reducing isolation. [102]

Around two thirds of the adult population in Fife meet the recommended levels of physical activity (67% compared to 65% Scotland, 2016-19). But over a quarter of people (27%) report having low or very low activity levels, similar to the rate in Scotland (25%).[52] The proportion of adults meeting recommended levels declines with age and in all age groups men are more likely to meet recommended levels than women. Across Scotland, 71% of children aged 2-15 met physical activity levels for their age group, with two thirds participating in sport in the week prior when interviewed, but participation in sports was lower in children aged 13-25.[54] 51.8% of school pupils in Fife surveyed in 2020 said they normally travel to school in an active way, without any form of motorised transport. Walking was the most popular mode of active travel to school (46%).

The COVID-19 pandemic appears to have changed our physical activity levels in different ways depending on individual circumstances.[91] In Scotland, whilst there are indications that recreational walking and cycling have increased, overall walking does not appear to have increased compared to previous years, whilst cycling has. [103] This reflects the changes in levels of routine exercise in daily life such as travel to work or shops, as a consequence of COVID-19 restrictions.

Our ambitions for Priority 6

- There are cultural and structural changes to support active travel, healthy eating and breastfeeding as norms
- We have consistent approaches to healthy eating and physical activity across multiple sectors - health, education, welfare, social care, workplaces and the voluntary sector
- Individuals and communities are empowered to access and participate in healthy eating and physical activity throughout the life course, including the ageing population and addressing food insecurity

Focus of our work for Priority 6 in 2020 and 2021

The focus of work has been partnership, working with a wide range of partners on a number of multi-pronged collaborative programmes focused on preventing Type 2 diabetes and obesity, and strengthening the food system in Fife. Physical activity interventions across the life course are being delivered and physical activity interventions are embedded in much of the broader partnership work.

East Region Type 2 Diabetes Prevention Partnership

The East Region Type 2 Diabetes Prevention Partnership was created in 2019, with work continuing throughout 2020 and 2021. [104] Health and social care providers have joined forces with partners from the public, third and private sectors to address the increasing rates of preventable diabetes across the whole system. The partnership focuses on four areas: adult weight management, children and young people, piloting a whole systems approach to diet and healthy weight, and an employer workstream. Activities have included research into outdoor advertising around schools, exploring and understanding the 27-30 month review of Health Visitor data, and working with education and early years colleagues to support sport and exercise extra-curricular activities.

The whole systems approach aspect of the work involves applying systems thinking to collectively better understand and address obesity, with pilot work in Dunfermline and Cowdenbeath areas. This work aims to encourage ownership and achieve change in prioritised actions to address inequalities. Collaboratively, a wide range of stakeholders mapped the causes of obesity and the activities already happening in Cowdenbeath and Dunfermline. From this, 10 themes were identified with many of these associated with the 'upstream factors' or wider conditions that affect health, however, of existing interventions in place many were more commonly linked to individual lifestyle factors (Figure 8). Three themes of Home Environment, Transport and Availability of Unhealthy Food emerged as priorities for action. Keeping wider upstream determinants of health in mind will be very important as plans to address and prevent obesity in our communities develop.

Figure 8: Current and Future Actions Mapped Against the Perceived Causes of Obesity

Feeding Fifers

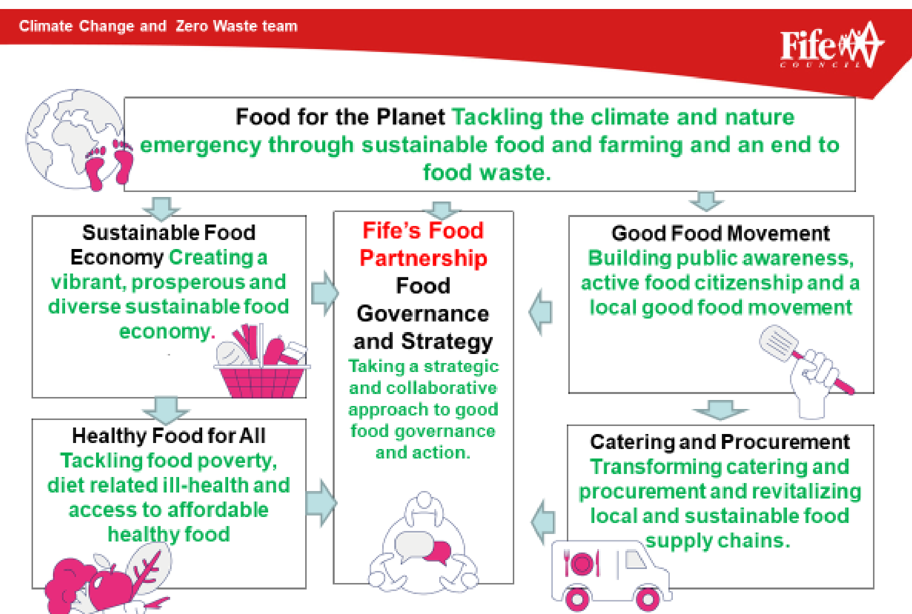
New initiatives such as the introduction of Feeding Fifers were made possible through online collaboration during the pandemic. [105] This joint initiative engaged with communities across Fife to share healthy eating tips, meal ideas and recipes using social media. Recipe cards were distributed across Fife via community assistance hubs and promoted across local food initiatives to ensure support and information were available to as many people as possible.

The Food4Fife Partnership

This partnership, established in 2021, is about people in Fife (individuals, communities and businesses) coming together to work across all aspects of the food system to help solve some of today's health, environmental and economic challenges, strongly aligned to all of Fife Partnership's Recovery and Renewal priorities. [xxiv] The Partnership's vision is to create a sustainable food culture for a healthy Fife via a strategy and action plan that will include '6-pillars' as described in Figure 9.

xxiv Fife Partnership's Recovery and Renewal priorities are: Community Wealth Building, Addressing the Climate Emergency, Tackling Poverty and Preventing Crisis and Leading Economic Recovery.

Figure 9: Creating a Sustainable Food Culture, for a Healthy Fife



Physical activity

During 2021, a Physical Activity and Sport Strategy was developed with the aim of realising 'An Active Fife where everyone has opportunities to be more active, with better physical and mental health and wellbeing'. [106] Recognising the impact COVID-19 has had on many people in Fife, actions from the strategy are themed around:

- Reducing inequalities in physical activity and sport across Fife
- Increasing and sustaining physical activity, physical confidence and sports participation
- Building resilient communities that are physically active and participate in sport
- Investing in facilities and infrastructure for physical activity and sport.

Partnership work continued in 2020 and 2021 to link physical activity to health outcomes such as improved mental health and in a variety of settings, including workplaces, care settings and with a variety of population groups, including incorporating physical activity within a new 'Be Well-Get Active' programme. Work has also taken place to link with the Older Adults Care Network to promote physical activity in care settings and to support care providers with physical activity ideas to enable their service users to maximise independence. Resources have also been developed specifically for people with dementia and work is underway to help support those living with chronic pain through instructor-led physical activity programmes.

With walking being a key recreational activity in the pandemic, walking challenges continued to be developed by creating virtual interactive maps enabling engagement within communities, as well as promoting walking for older people through linking with local history.

Priority 6: Opportunities and priorities for public health and partners for coming years

- **Focus on upstream determinants of health to prevent obesity**: Continue engagement with Fife Partnership agencies and emphasise the need to work upstream in order to achieve our goals. Progress Phase 2 of our Whole Systems Approach to obesity prevention within Cowdenbeath and Dunfermline and share learning on whole systems way of working with appropriate partnerships across Fife.
- **Diabetes prevention**: Continue to be part of the East of Scotland Type 2 Diabetes Prevention Partnership, implementing the recommendations from various evaluations, working both across the region and within Fife.
- **Physical activity pathway**: Implement the Physical Activity Pathway within NHS Fife and support the different developing approaches to increasing physical activity within Fife, as well as the Fife Physical Activity and Sport Strategy.
- **Implementation of a sustainable healthy food culture**: Continue to develop and implement the Food4Fife Partnership strategy action plan to realise the vision of creating a sustainable food culture for a healthy Fife.

Conclusions

The Fife population is ageing and is expected to continue to do so, whilst the proportion of years lived in good health is reducing. The difference between the life expectancy and healthy life expectancy of people living in the most deprived and in the least deprived parts of Fife is stark, and in younger age groups inequalities in the rates of early death are even more marked. Increasing healthy life expectancy and reducing the ingrained differences in health outcomes are fundamental to improved overall population health, but not straightforward.

Rates of obesity, levels of alcohol consumption, sedentary activity and smoking, and experience of childhood adversity, are higher in Fife than they should be for good health and there is a marked difference in the prevalence of these risk factors between the most and least deprived parts of the region. The effects of many of these health risk factors accumulate from an early age, highlighting a need for focus on these risk factors across the life course.

The burden of anxiety, depression and loneliness, and more severe mental health problems, also limit the wellbeing potential of the Fife population, including children and young people, and again there is a clear relationship between deprivation and poor mental health. We see the same distribution of inequalities with problematic drug use, on a background of increasing drug related deaths.

Whilst focus on preventing health conditions that have the greatest impact on health and wellbeing, and the direct risk factors for poor health is crucial, we must equally turn attention to the broader 'upstream' factors that have a more insidious effect on our health. These are the 'social determinants of health' that interact to shape our lives, influence our health behaviours and generate unfair differences in our society from a young age. By systematically addressing these root causes of poor health and wellbeing in Fife, we will have a far greater chance of creating change in health outcomes across our population in years to come. For example, by preventing, mitigating and undoing the impact of poverty on health and wellbeing; reducing inequalities in education attainment, and facilitating access to quality employment and safe and secure housing.

One approach to this is committing to work with communities and partners to foster healthy places in the areas of Fife most affected by multiple deprivation, building on the assets within those communities, such as the Levenmouth project and The River Leven Programme. Additional approaches include supporting and or collaborating with particular populations more vulnerable to poor health outcomes to improve their health and wellbeing. Working with the Fife homeless community during the COVID-19 pandemic, and the Alcohol and Drugs Partnership lived experience panel, are examples of good work in support and collaboration.

There remain opportunities to systematically consider and address the broader determinants driving specific public health challenges, in a similar way to how we are addressing obesity in Fife, working together as a whole system. Similarly, there are opportunities for Fife public sector institutions to consider their role in addressing social determinants of health through policy and even beyond their normal sphere of influence; for example through promoting financial inclusion pathways and becoming 'anchor institutions' for the benefit of our Fife communities.

The COVID-19 pandemic has generated an unprecedented challenge to population health in Fife and for the first time has contributed to a drop in life expectancy across Scotland. Our population have experienced both the direct impacts of the disease, and also wider harms associated with restrictions on life, including changes to employment, education, social isolation, travel and diet, which all affect health. At this stage we do not fully understand the effect of these changes on health, but early indications are that this has resulted in serious and potentially lasting impacts.

Whilst the pandemic has made it challenging to conduct the full range of public health work, this report reflects on a huge range of activities that have been undertaken despite this. The pandemic has resulted in innovative and collaborative efforts across Fife communities and partners, from which lessons have been learned to support improved ways of working for the future.

Improving the health and wellbeing of the population of Fife requires a concerted and collaborative effort including partnerships to address complex challenges, evidence of which is demonstrated throughout this report. Continuing and further developing such work and placing consideration of health at the centre of all policy making in all sectors, will enable us to further strengthen efforts towards improving health and wellbeing for the people of Fife.

Glossary

ACE	Adverse Childhood Experience
ADP	Alcohol & Drug Partnership
BBV	Blood Borne Virus
BMI	Body Mass Index
COP26	United Nations (UN) Climate Change Conference
GHQ-12	General Health Questionaire-12
GP	General Practitioner
HIV	Human Immunodeficiency Virus
HLE	Healthy Life Expectancy
HPT	Health Protection Team
HPV	Human Papillomavirus
HSCP	Health and Social Care Partnership
LFD	Lateral Flow Device
MAT	Medication Assisted Treatment
NHS	National Health Service
NRS	National Records of Scotland
P1	Primary 1
PCR	Polymerase Chain Reaction
PHS	Public Health Scotland
RNA	Ribonucleic Acid
S6	Sixth year in Scottish secondary schools
SALSUS	Schools Adolescent Lifestyle and Substance Abuse Survey
ScotPHO	Scottish Public Health Observatory
SCQF	Scottish Credit and Qualifications Framework Partnership
SIMD	Scottish Index of Multiple Deprivation
SMI	Severe Mental Illness
UN	United Nations
UNCRC	United Nations Convention on the Rights of the Child
WEMWBS	Warwick-Edinburgh Mental Wellbeing Scale
WHO	World Health Organisation

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NHS Fife

Meeting:	**Public Health & Wellbeing Committee**
Meeting date:	**16 May 2022**
Title:	**Health Promotion Service Annual Report 2021/22**
Responsible Executive:	**Nicky Connor, Director: Fife Health & Social Care Partnership**
Report Author:	**Ruth Bennett, Health Promotion Service Manager, H&SCP**

1 Purpose

This is presented to the Public Health & Wellbeing Committee for:
- Assurance.

This report relates to a:
- NHS Board/Integration Joint Board Strategy
- National Health & Well-Being Outcomes

This aligns to the following NHS Scotland quality ambition(s):
- Effective
- Person Centred

2 Report Summary

2.1 Situation

This report has been requested by NHS Fife Public Health and Wellbeing Committee (16th May) for assurance. To inform the committee of the role of the Health Promotion Service, strategic drivers, the range of work undertaken and services provided.

2.2 Background

The Fife Health Promotion Service annual report for 2021/22 provides information on the role of the service, the key national and local strategic drivers and commitments to early intervention and prevention with a focus on the upstream determinants of health. The report sets out the range of work undertaken and the services provided, with selected examples to illustrate the way Health Promotion Service work to achieve this. The report also provides examples to illustrate the response to COVID-19 and supporting recovery from the pandemic.

2.3 Assessment

The attached report provides the Public Health and Wellbeing Committee with update and assurance on:

- Health Promotion Service Strategic Framework
- Health Promotion Team
- Health Promotion Service Drivers
- Responding to the Challenges of COVID-19
- Capacity Building
- Partnership Working
- Digital Developments
- Priorities for 202/23
- Health Promotion Service Key Contacts

The Health Promotion Service is a delegated service within the Health and Social Care Partnership. The team have specialist knowledge, skills and experience in developing and delivering programmes of work, projects and services, which improve the health and wellbeing of people living and working in Fife. With a specific focus on working in ways to reduce health inequalities. As well as contributing to and working with services in Fife H&SCP we are closely aligned to NHS Fife Public Health Department which assures alignment to health improvement priorities within the evolving NHS Fife Health and Wellbeing Strategy.

Each section of the attached report clearly articulates the Integration Joint Board Strategic Priorities and National Public Health Priorities that are being delivered and the range of workstreams that are ongoing which evidences and assures that proactive work has continued over the past year, despite the challenges of the pandemic. Of particular note are the following prioritised examples:

- Our contribution to NHS Fife commitments as an Anchor Institution, for example, financial inclusion work for staff.
- Mental Health workstream as we recover from the pandemic.
- Child Poverty Agenda and our ongoing commitment to build on financial inclusion pathways and other initiatives which directly support families with children. This is an area for continued prioritisation and development.
- Ongoing commitment and development of specialist smoking cessation services to support people into the pathways.

2.3.1 Quality/ Patient Care

The Health Promotion approach of working upstream, considering social determinants of health and health inequalities contributes to improving the health and wellbeing of the Fife population, and improving the quality of patient care through including consideration in patient pathways; and improving access to services.

2.3.2 Workforce

No specific considerations.

2.3.3 Financial

No additional financial considerations.

2.3.4 Risk Assessment/Management
None

2.3.5 Equality and Diversity, including health inequalities
Prevention and early intervention and working to tackle health inequalities is central to Health Promotion Service provision. Health Promotion Service lead on approaches which improve health and wellbeing and mitigate, prevent or undo health inequalities. This supports the Public Sector Equality Duty, Fairer Scotland Duty, and the Board's Equalities Outcomes.

2.3.6 Other impact
No other impacts identified

2.3.7 Communication, involvement, engagement and consultation
This report was developed with involvement from Health Promotion staff group, HSCP Head of Primary and Preventative Services, and communicated to HSCP Director.

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

- Health Promotion staff group
- Health and Social Care Partnership Senior Leadership Team
- Executive Directors Group

2.4 Recommendation

Assurance to the Public Health and Wellbeing Committee on the work undertaken by Fife Health Promotion Service during 2021/22 to support delivery of strategic priorities and public health priorities for the people of Fife and the priorities for 2022/23.

3 List of appendices

The following appendices are included with this report:

Appendix No 1, Fife Health Promotion Service Annual Report 2021/22

Report Contact
Ruth Bennett
Health Promotion Service Manager
ruth.bennett@nhs.scot

Fife Health Promotion Service Annual Report 2021-22

Contents

Introduction 3
UK Public Health Registration 3
Health Promotion Service Strategic Framework 4
Health Promotion Team 5
Health Promotion Service Drivers 6
Responding to the Challenges of COVID-19 7
Capacity Building 9
Partnership Working 12
Digital Developments 15
Priorities for 2022-23 18
Health Promotion Service Key Contacts 19

Introduction

I am pleased to introduce the Fife Health Promotion Service (HPS) annual report for 2021/22.

The role of our service is to work at a population level to provide services and lead on approaches which maintain and improve health & wellbeing, reduce health inequalities and prevent ill-health for people of all ages who live and work in Fife.

Our strategic drivers are the set of National Public Health Priorities and Fife Health and Social Care Partnership (H&SCP) commitments to early intervention and prevention with a focus on the upstream determinants of health.

This report sets out the range of work undertaken and services we provide, with selected examples to illustrate the ways in which we work to achieve this. This includes capacity building and partnership working across H&SCP, NHS Fife, Fife Council, Fife Community Planning Partnerships, third sector organisations and businesses in Fife.

We have provided examples to illustrate the ways in which we have responded to and are supporting recovery from the COVID-19 pandemic and the challenges and new developments this presents. I hope you find the report engaging and informative.

Ruth Bennett
Health Promotion Service Manager
ruth.bennett@nhs.scot

April 2022

UK Public Health Registration (UKPHR) - Developing the specialist health promotion workforce

The UKPHR scheme provides a framework for practitioners working in the area of health improvement and public health. The structured programme highlights key competencies and standards that practitioners must evidence in order to achieve registered status.

The HPS is committed to developing progress with the UKPHR to ensure our specialist workforce are developing and evidencing relevant skills, knowledge and accreditation.

Over the last year the HPS has continued with our commitment to UKPHR, and progress has been made ensuring full participation at all levels in the registration scheme. This includes a local Fife scheme coordinator, a scheme verifier, 3 portfolio assessors who have all completed assessments in the last 5 months, and 2 individuals who have achieved practitioner registration this year.

Health Promotion Service Strategic Framework

Prevention and Early Intervention
“Supporting and encouraging people to achieve their full potential, stay resilient and take more responsibility for their own health and wellbeing; making choices that increase their chances of staying healthy as long as possible and where they experience ill health, promoting recovery and self-management

Tackling Inequalities
“Working with our partners to tackle the causes of inequality and health inequality by supporting those at greatest risk and focusing on:
- Mitigating the health and social consequences of inequalities
- Helping individuals and communities resist the effects of inequality on health and wellbeing”

OUR VISION
People in Fife reach their full potential

OUR PURPOSE
Lead health promotion approaches and improve health and wellbeing and mitigate, prevent or undo health inequalities

HOW WE DO IT
Promote health in policies, prioritise early intervention and drive prevention through five core functions:
1: Service delivery, programme and project management
2: Organisational and partnership development
3: Capacity building
4: Workforce development
5: Information and knowledge management

OUR PRIORITY
Giving children the best start in life
Supporting healthy choices and reducing harm
Strengthening and enabling sustainable communities to improve health

Health Promotion Team

The Health Promotion Service is part of Fife H&SCP Primary and Preventative Care. Our staff have specialist knowledge, skills and experience in developing and delivering programmes of work, projects and services, which improve the health and wellbeing of people living and working in Fife. With a specific focus on working in ways to reduce health inequalities.

As well as contributing to and working with services in Fife H&SCP we are closely aligned to NHS Fife Public Health Department.

Health Promotion Service Manager

Deputy Health Promotion Manager

Teams and Workstreams

Workplace Team
Food & Health Team
Localities and Communities Team
Tobacco Prevention and Protection Team

Alcohol
Gambling
Mental Health
Physical Activity
Suicide Prevention
NHS Acute
Poverty and Child Poverty

Services

Health Promotion Information and Resources Centre
Health Promotion Training Service
Stop Smoking Service

Administrative Staff and Graphic Design

Health Promotion Service Drivers

As a service all of our work is driven by H&SCP and public health priorities. Working upstream on prevention and early intervention means that there are many links across all of these priorities, but we can also clearly identify some priorities where our HPS work streams make a significant contribution.

Fife H&SCP Priorities	HPS workstreams	National Public Health Priorities
Priority 1 Working with local people and communities to address inequalities and improve health and wellbeing outcomes across Fife	**Acute services** H&SCP 1, 2, 3 PH 1, 3, 5	**Priority 1** A Scotland where we live in vibrant, healthy and safe places and communities
Priority 2 Promoting mental health and wellbeing	**Food & health and physical activity** H&SCP 1 PH 6	**Priority 2** A Scotland where we flourish in our early years
Priority 3 Working with communities, partners and our workforce to effectively transform, integrate and improve our services	**Information and resources** H&SCP 1, 2, 3, 4 PH 1, 2, 3, 4, 5, 6	**Priority 3** A Scotland where we have good mental wellbeing
Priority 4 Living well with long term conditions	**Locality and community** H&SCP 1, 2, 3, 4 PH 1, 3, 6	**Priority 4** A Scotland where we reduce the use of and harm from alcohol, tobacco and other drugs
Priority 5 Managing resources effectively while delivering quality outcomes	**Mental health and suicide prevention** H&SCP 1, 2 PH 3	**Priority 5** A Scotland where we have a sustainable, inclusive economy with equality of outcomes for all
	Tobacco, gambling and alcohol H&SCP 1, 2, 3 PH 1, 2, 3, 4	**Priority 6** A Scotland where we eat well, have a healthy weight and are physically active
	Training H&SCP 1, 2, 3, 5 PH 1, 2, 3, 4, 5, 6	
	Workplace H&SCP 1, 2, 3, 4 PH 3, 5	

*Strategic priorities are highlighted for each work example. H&SCP Public Health

Responding To The Challenges Of COVID-19

As with all services the pandemic posed us many challenges. Some staff were deployed to support other services, and we also worked in partnership to deliver services in different ways and add capacity across the Fife H&SCP and public health system. Although it wasn't business as usual we were able to develop services, knowledge and skills to prioritise the provision of some critical HPS services to support COVID-19 and COVID-19 recovery, and to mitigate the impact of the pandemic on health inequalities.

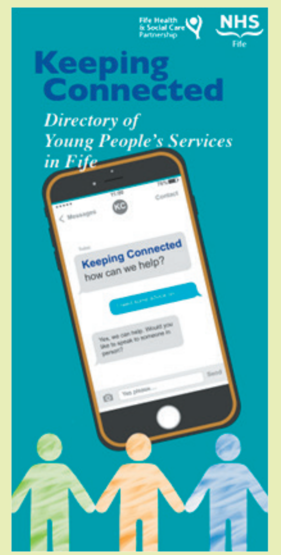
Postal condom scheme

During the pandemic Sexual Health Fife, in partnership with HPS, developed and extended the Free Condoms Fife Service to include a postal condom scheme. This scheme is run in partnership with HPS and offers a free and confidential service for people living in Fife. The scheme was promoted via NHS Fife Sexual Health Fife Facebook and social media channels. A poster was created and circulated to a number of key services and organisations such as Fife College. Over the past 12 months we processed 796 orders. This work has also included working with Pharmacies in Fife to participate in the Free Condoms Fife Service.

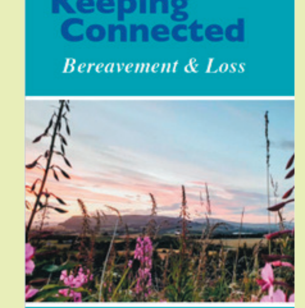
H&SCP
1, 3, 5

Public Health
1

Prioritisation of Mental Health work stream



In order to mitigate the impacts of the pandemic, priority was given to the mental health and suicide prevention workstreams. The use of virtual technology presented the opportunity to ensure the Multi-Agency Suicide Prevention Core Group and associated delivery groups continued to meet during the pandemic, as well as the ongoing delivery of key mental health courses (such as 'Mental Health Improvement & Prevention of Self-Harm & Suicide Ask Tell Workshop' and 'Positive Steps to Mental Health'). The Fife Suicide Prevention Network grew to over 150 members and work also continued in order to support national campaigns, such as Clear Your Head and #ConnectWithNature. Local initiatives, such as #ItsEveryonesJob Workplace campaign were developed and the suite of three Keeping Connected resources (generic adult, young persons, bereavement and loss) were updated and widely disseminated across Fife.



H&SCP
2

Public Health
3

Sharing capacity to support COVID-19 pressures

> *Thank you to everyone for being really kind and supportive as I was concerned about being judged for being a smoker when I am pregnant but I didn't feel that at all.*

Stop smoking services deliver direct individual interventions at a community level. Throughout COVID-19 efforts to encourage and support people to stop smoking continued. However, COVID-19 has impacted on services and as a result we have had to adjust our delivery models. Face to face delivery was replaced with remote telephone support to enable these crucial services to continue in light of the connection between lung health and increased COVID-19 risk.

The workforce was impacted in different ways; reduced capacity in the midwife led service was due to staff being deployed to support COVID-19 pressures and long term absence. Community Pharmacies had reduced ability to provide support due to increased pressures to ensure appropriate medicine management and limitations of available consultation space within their premises due to social distancing requirements.

Working with the lead midwife, we were able to offer additional capacity to continue to support pregnant mums to quit. We also managed to undertake 4 week and 12 week follow-ups on behalf of our community pharmacy colleagues while they were dealing with increased footfall.

> *I have felt powerless over the pandemic at times, but being able to quit smoking with the help of your [telephone support], has been empowering and great for my confidence.*

H&SCP
1, 3

Public Health
4

Long COVID-19 working group and training for workplaces

> *Really enjoyed the course on Long COVID-19. Will pass on all I've learned today to my work colleagues.*
> **Participant Feedback**

> *Very valuable in hearing about Long COVID-19 and how as the condition develops and has an impact on people's lives moving forward.*
> **Participant Feedback**

The world of work has changed as a result of the pandemic and Fife workplaces have been supported by the HPS Workplace Team in relation to the health, safety and wellbeing matters throughout the course of the pandemic, including the emerging aspects of new hybrid working arrangements. Post-COVID-19 syndrome, or Long COVID-19, is already a significant issue for employers and people of working age and information for all concerned will be crucial if rehabilitation, successful return to work and job retention are to be managed successfully. The Workplace Team provided information and links for the Returning to Work section of the current H&SCP Post COVID-19 Patient Information Pack and are contributing to ongoing work on the development of an NHS Fife Post COVID-19 Recovery & Rehabilitation Service.

The Fife Workplace Team, along with Allied Health Professionals, developed 'Long COVID-19, a training session for Fife's workplaces' to raise awareness of Long COVID-19 and the impact that it could have on the workforce. This session has been presented through HPS Training Programme and Fife Voluntary Action Lunchtime Learning series.

H&SCP
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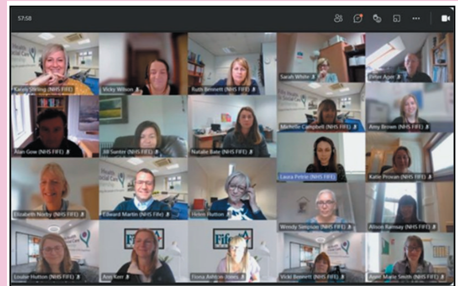
Public Health
5

Capacity Building

Building capacity is a core function of the HPS. Working to develop knowledge within the wider health improvement workforce enables us to build understanding around key health improvement topics, wider health determinants, and the causes of health inequalities. Working with and supporting partners is key to enabling us to meet our service aims.

Training to facilitate digital delivery

In response to the circumstances of the pandemic we had to quickly adapt to online delivery.



The HPS were instrumental in providing knowledge, skills and confidence to other colleagues, teams and services across all sectors on how to deliver online workshops. This involved how to set up and structure online delivery, inviting participants, sharing presentations/documents as well as how to use some of the key functions. We established an 'Introduction to Creative Digital Facilitation' workshop for those who wanted to develop their skills further. Utilising MS Teams and becoming confident with online delivery, enabled the HPS to be a key contributor at the hugely successful online Inspiring Kindness Conference in May 2021 by hosting the event and supporting workshops.

Superb event. Loved the warm tone of all those facilitating and how accessible it was.

The HPS training team organised their first Virtual Trainers Network with two workshops on offer – 'Making your digital session interactive' and 'Being Mindful of our own wellbeing' with 22 trainers in attendance. The network event offered trainers the opportunity to share experience, develop skills, feedback their views and ideas about the operation and development of the programme as well as taking time to reflect as a trainer and identify possible areas for improvement. Over 90% of trainers rated the event extremely/very valuable overall.

H&SCP
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Public Health
1, 2, 3, 4, 5, 6

Financial health checks for NHS staff - anti poverty workstream

Paid work has the potential to protect health, and contribute to reducing health inequalities, by increasing income through earnings and by meeting important social and psychological needs. Those who are in less well paid jobs however are more likely to feel the impact of poverty on their health and wellbeing.

The past year saw collaboration between HPS, Public Health, and Citizens Advice and Rights Fife (CARF) to establish financial health checks scheme for staff. The overall aim is to ensure that staff have access to financial supports and benefits to which they are entitled.

Maximising income can have a profound effect on people's lives and consequently on their health and wellbeing.

H&SCP
1

Public Health
5

Health literacy - empowering people to improve their own health

Health literacy is the ability to access, understand and use healthcare information. Meeting people's health literacy needs plays an important role in addressing health inequalities.

Really worthwhile - will be recommending to our Senior Leadership Team that this course is made available more widely.

Fife Health Promotion Information and Resources Centre (HPIRC) work with local and national partners to raise awareness of health literacy.

HPIRC and department colleagues developed a virtual workshop to raise awareness of the role health literacy plays in enabling people to maintain their health and to increase workforce knowledge and skills in communicating health messages clearly.

Workshops have been facilitated via the Health Improvement Training Programme and tailored sessions have been delivered to the Department for Work and Pensions (DWP). Workshops have received positive feedback.

HPIRC worked with National Education for Scotland colleagues during Health Literacy month to deliver a social media campaign - highlighting training opportunities for health & social care staff and Health Literacy Place resources.

Highlighted how widespread health literacy issues are in society and how simple steps to check understanding will improve levels of understanding and buy-in to services.

HPIRC were proud to be involved in the national pilot "Information for Wellbeing" which was funded by various stakeholders. The project is at evaluation stage and could be delivered nationally thereafter.

The information provided was really thought provoking and gave some great insight into the consequences of lack of health literacy.

H&SCP
1

Public Health
1, 2, 3, 4, 5, 6

Targeted Mental Health Improvement Training

Mental Health Improvement & Prevention of Self-Harm & Suicide Ask Tell... Adults, is a Public Health Scotland digital workshop which has been adapted for Fife. It has quickly established itself as one of our most oversubscribed workshops with 26 delivered to date and 195 participants in attendance. The ethos of the workshop is that 'suicide is everyone's business' and explores how to have a healthy conversation in relation to self-harm and suicide and in turn reduce the stigma and discrimination attached. We have built capacity by developing a pool of 17 trainers across all sectors to deliver this workshop; increasing the number we are able to offer.

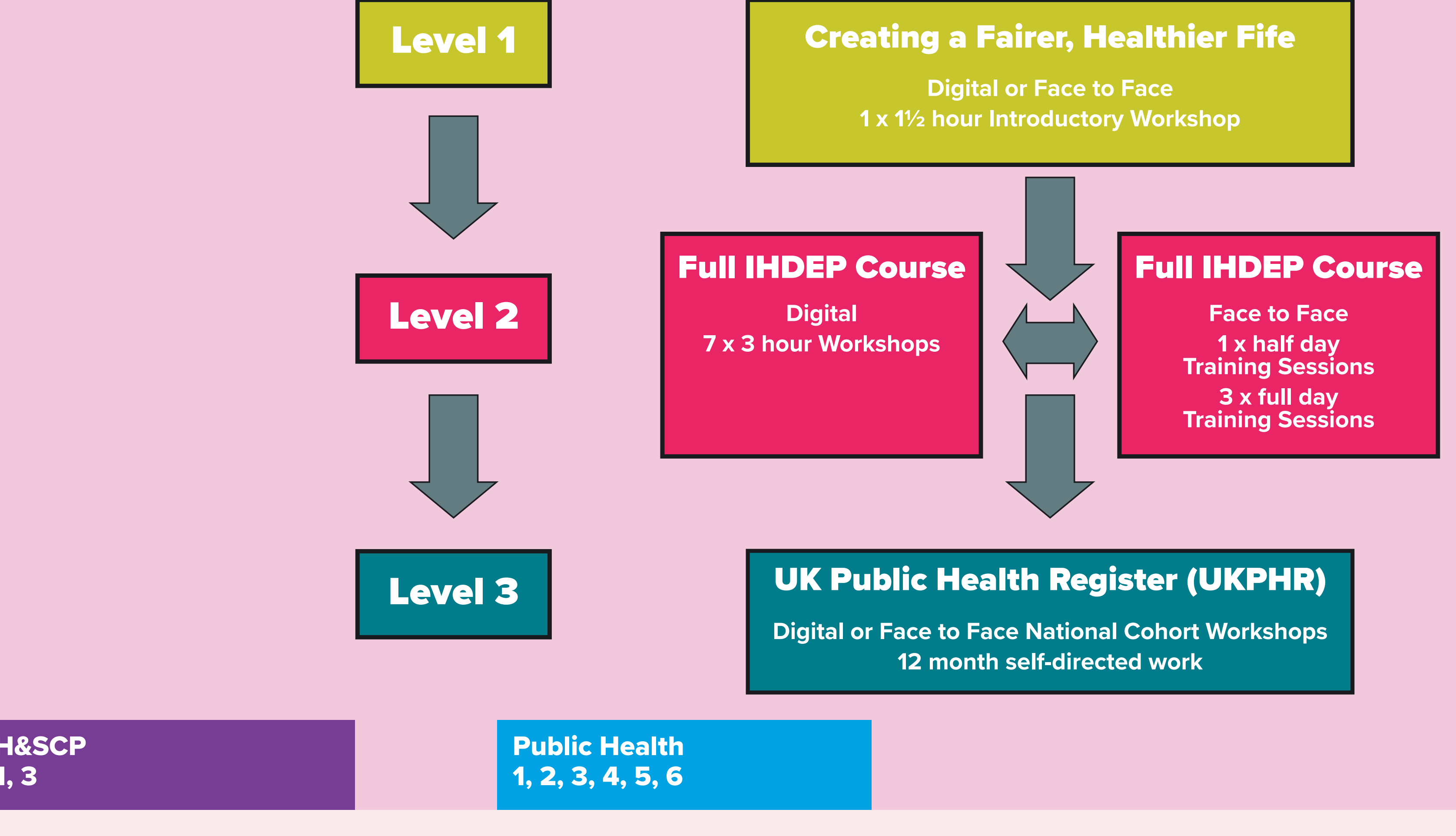
In response to a local need a multiagency group was established to look at what additional work could be undertaken to support staff working within the wider Cowdenbeath community so they would feel confident to support any individuals affected by a recent probable suicide. The aim was to have consistency in messages and support between the school community and the wider community. The HPS led on the delivery of the Ask, Tell... training, working collaboratively with the appropriate team managers within the Cowdenbeath area. Approximately 60 members of staff were identified from Community Learning & Development, Safer Communities and Youth Work teams. These staff either undertook the self-directed eLearning module or the virtual workshop.

H&SCP
2

Public Health
3

Improving Health: Developing Effective Practice - developing a health improvement workforce

Improving Health: Developing Effective Practice (IHDEP) is a blended course with face to face sessions and online modules which focus on theories, principles and practices of improving health and tackling health inequalities. It provides the necessary foundation knowledge and application for frontline staff on health improvement and public health, and is an accessible and essential key course for those wishing to undertake their UK Public Health Practitioner Registration. Due to COVID-19 the course was suspended. As a result we developed a virtual introductory workshop called Creating a Fairer Healthier Fife to ensure the aims, outcomes and values of the full IHDEP course continued to be shared with the Fife workforce. We participated in a national IHDEP trainers group to review and refresh the main course for virtual delivery. A Fife pilot is currently underway with participants from the HPS and Public Health. We aim to make the course available to practitioners across all sectors.



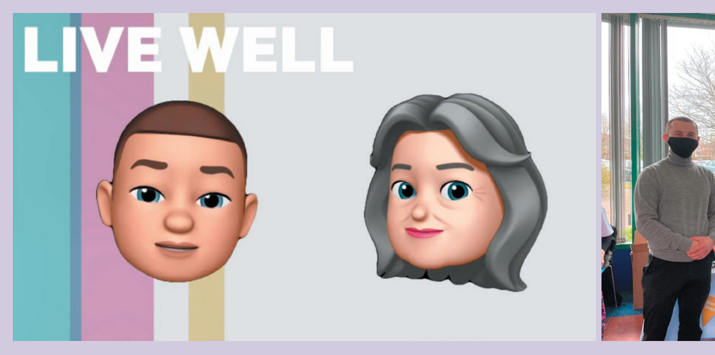
Partnership Working

Working across sectors and with a wide range of partners is an important role of the HPS. In order to make an impact on the complex nature of health inequalities working with partners to address upstream causes of inequalities in health is vital. This includes linking with local, national and Fife wide strategic groups and community planning partnerships, and working with a wide range of internal and external partners across H&SCP, Public Health, NHS acute services, and our 7 Fife locality areas, as well as working with workplaces and communities. The HPS has a specialist role to play in building and strengthening these partnerships.

Partnership working to support priority groups

In order to progress our prevention and early intervention agenda reaching the priority group of 16-24 year olds is vital. One of the ways we do this is through a partnership agreement between the HPS and Fife College. This approach enables us to work collaboratively to shape and support in-house health and wellbeing activities around tobacco, smoking cessation, substance misuse, alcohol, food and health and physical activity, and to provide pathways towards mental health support for College students.

During lockdown, our health and wellbeing advisor continued prevention activities remotely as well as delivering support through other mediums such as online events and classroom activities via MS Teams. Strategic work continued to create the infrastructure to plan and support Health and Wellbeing programmes and activity on an ongoing basis. Progress has also been made on the inclusion of health and wellbeing pathways to support the new Health and Wellbeing Dunfermline Learning Campus.



H&SCP
1, 2, 3

Public Health
3, 4, 6

#ItsEveryonesJob campaign

#ItsEveryonesJob, the mental wellbeing and suicide prevention campaign was a successful collaborative project designed with partners such as Samaritans and Fife Lived Experience Panel and tailored to Fife's workforce needs and priorities.

The workplace campaign encouraged Fife's workforce to have healthy conversations around mental wellbeing, mental health and suicide by raising awareness of the range of support which is available and encouraging those in need of help to access it. A range of materials were developed including a digital toolkit, traumatic incident framework, lived experience case study and web based information.

Highlights included:

- 453 campaign page views through NHS Fife web platform
- Over 70% of post campaign survey respondents felt the campaign was either very valuable or valuable to them.

H&SCP
1, 2

Public Health
3, 5

Partnership Working

Embedding Good Conversations in practice

The HPS has been working in partnership with Public Health to deliver Good Conversations personal outcomes training for a number of years. In 2020, due to the impact of COVID-19, the course was redesigned for virtual delivery to ensure continued development for the H&SCP workforce. This change allowed the course to be included in the HPS Virtual Training Programme.

The new H&SCP Link Life in Fife team received the Good Conversations training as part of their core induction training, which created the opportunity to work in partnership with them to help to develop peer support sessions. This will enable them to further embed the Good Conversation approach in their work.

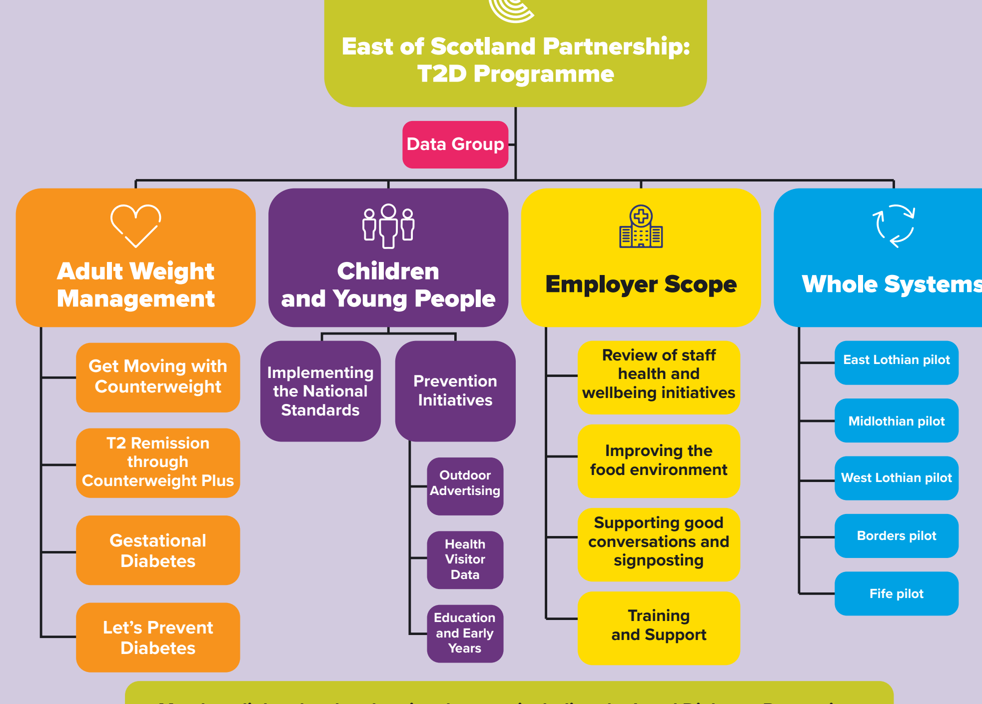
Can I spend some time with you to find out **what matters to you?**

H&SCP
12

Public Health
1, 2, 3, 4, 5, 6

Whole Systems Approach to obesity prevention

The East Region Type 2 Diabetes Prevention Partnership is a collaborative working to reduce Type 2 diabetes (T2D) across the East of Scotland. This includes Adult Weight Management and Child Healthy Weight services, and piloting a Whole Systems Approach (WSA) to diet and healthy weight.



The HPS has been a key partner in progressing this work in Fife as part of the Fife Diabetes Prevention Partnership. We have contributed to the new Adult Weight Management services by facilitating the Let's Prevent Diabetes group education programme, which aims to support people who have been identified as being at "high risk" of developing T2D, and work with them to prevent or delay the onset of this condition.

Recognising that T2D is driven by a multitude of factors a WSA to obesity prevention is being taken forward in Dunfermline and Cowdenbeath. Along with Public Health, HPS has led the development of this workstream. We have worked with local partners and stakeholders in these areas to understand the key causes of obesity locally, how this links to current interventions, and to identify collective actions.

H&SCP
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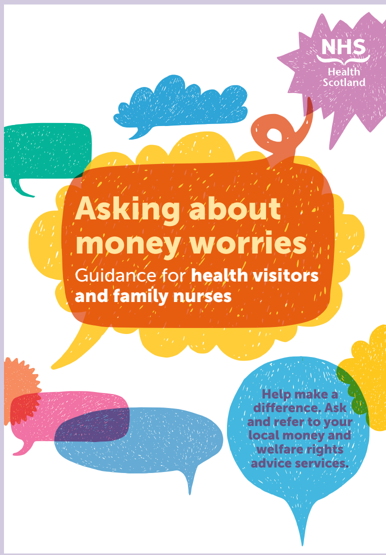
Public Health
6

Tackling child poverty - Financial Inclusion Referral Pathway

Delivery of a Financial Inclusion Referral Pathway is a key area which H&SCP and NHS Boards deliver as part of the Scottish Government Child Poverty agenda. The pathway ensures that all Midwives, Health Visitors and Family Nurse Partnership staff have the skills, knowledge, awareness and confidence to routinely ask all pregnant women and families with young children about financial concerns. It ensures that staff are confident with the referral pathway to the Fife Citizens Advice and Rights Fife Money Talk Team (CARF).

The HPS led on this work and developed training and a dedicated pathway in partnership with CARF. To date a total of 159 participants have attended the training. Most recently the training took place as a digital drop-in session and was extended to include other health professionals, with many from occupational therapy and nursing in attendance.



H&SCP
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Public Health
1, 2, 3, 4, 5, 6

Poverty Awareness Training Group

A multi-agency Poverty Awareness Training Group (funded through the Fife Partnership and led by the Health Promotion Training Team) was set up in response to the Fife Fairness Matters Report 2015 which highlighted the need to establish free training sessions to support public, private and third sector organisations in Fife. The courses are suitable for frontline staff and managers, increasing and updating their knowledge and skills, enabling increased support for service users. The group continue to steer this work and identify new and innovative training/workshops to be included in an annual Poverty Awareness Training Programme which reflects current issues around welfare reform and anti-poverty.

H&SCP
1, 2, 3, 5

Public Health
1, 2, 3, 4, 5, 6

Digital Developments

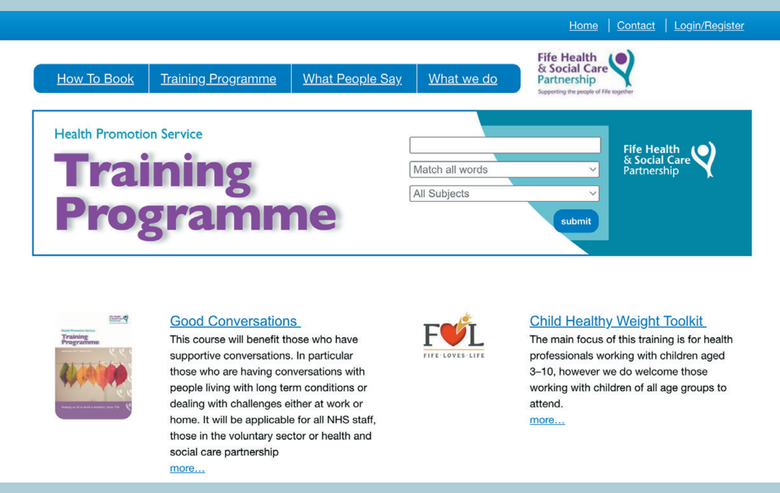
During the pandemic the HPS have successfully implemented innovative changes to how we work and made significant progress developing our digital offerings. This includes digital information campaigns and drop-in sessions, the use of social media to amplify messages with key communities and target groups, and the delivery of virtual training and workshops. This is in addition to maintaining service provisions through regular interactions and support through telephone conversations.

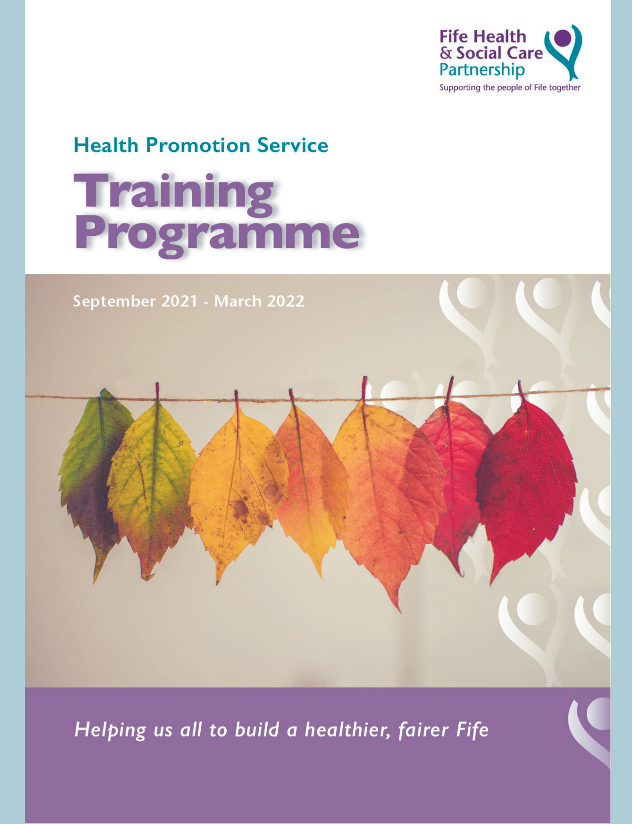
Health Promotion Training Programme and Website

In response to the pandemic there have been significant developments to our core training programme, with the launch of a new website, digital training programme, and a shift to deliver learning in a digital format. In addition to our core training programme, we offer bespoke, targeted and in-house training.

The HPS Training Team developed and produced a Virtual Training Programme to provide the Fife workforce with knowledge, skills and experience in relation to improving health outcomes and reducing health inequalities. Workshops covered topics such as Core Skills for Health Improvement; Groupwork and Facilitation; Working with Key Groups and Priority Health Improvement Topics such as trauma; poverty; workplace; mental health; tobacco and physical activity. A total of 58 online and virtual courses were offered. Virtual courses were delivered by trainers across all sectors at both local and national level.

To support the roll out of the programme a new training website was launched. Participants can sign up to browse and access workshops, get up to date information on key developments and are able to share good practice.





H&SCP
1, 2, 3, 5

Public Health
1, 2, 3, 4, 5, 6

Digital adaptations to progress tobacco prevention – Smoke Factor and Smoke Free Class

Tobacco Prevention contributes to reducing health inequalities. To ensure continued engagement with schools during the pandemic we adapted our tobacco education programmes to a digital format. This resulted in the first ever 'live streaming' of the interactive theatre performance of Smoke Factor directly into primary school classrooms.

In addition, we created online resources replicating our Smoke Free Class activities for secondary schools. This interactive digital resource guides pupils through individual sessions via talking heads with the aim of increasing engagement, prompting discussion and reflecting on tobacco issues. For inclusivity, worksheets were also provided for children without internet access.

Pupils reacted well to the sessions and commented on the uniqueness of the new resource. Working collaboratively with Fife Council resolved internet access issues and security considerations.

H&SCP
1

Public Health
4

Stop Smoking Service adoption of Near Me, IP communicator and digital translation service to support service users during COVID-19

It was recognised very early on in the pandemic that the stop smoking service had to adapt. Our provision moved to remote working to enable this crucial service to continue in light of the connection between lung health and increased COVID-19 risk.

We modified the model of service delivery to meet the needs of our clients by embracing digital adaptations such as Near Me, IP communicator and online translation tools. This ensured minority groups were not excluded and services were delivered equitably.

Near Me, the attend anywhere phone and video system, was set up and offered to everyone but with very little uptake. Barriers to uptake were lack of appropriate technology, internet connectivity and limited data availability. Conversely online translation tool has proved very successful and covered an un-met need.

These adaptations and service developments ensured we were able to continue with specialist service provision throughout the pandemic.

H&SCP
1, 3

Public Health
4

Digital Developments

Feeding Fifers

Feeding Fifers was developed in April 2020 as a joint initiative between Fife Council, Fife Community Food Team and the H&SCP Food and Health Team to engage with communities across Fife throughout the COVID-19 crisis. Feeding Fifers aimed to bring people together through sharing of healthy tips, meal ideas and recipes on social media, via Facebook, encouraging people to be creative with items they have available.

Initially posts were based on meals they had prepared in their kitchens at home, focusing on key store cupboard ingredients and recipes when there was limited access to shops, making meals from leftovers in an effort to reduce food waste and lunch ideas for returning to work or school. It became apparent that as the posts continued, regular interest and engagement was obtained on pages by some members of the public. Different formats of sharing information were trialled to find a format that appealed to a large audience.

The page currently has 688 followers and reaches a wide range of ages (18-65+ years) in all localities in Fife.

H&SCP
1

Public Health
6

Workplace health and wellbeing – digital engagement with employers

Workplace Team have for a number of years developed a range of innovative digital communication means to reach out to Fife workplaces, and during the course of the pandemic this became especially important. The team were able to deliver messages on a range of health, safety and wellbeing topics as well as local and national public health campaigns. The Workplace Team webpage on NHS Fife website was updated to provide service information, COVID-19 Business Recovery Advice, Case Studies and links to partner organisations. A service infomercial video was also developed. Workplace Team's digital engagement with employers included Twitter and LinkedIn, regular team newsletters and email communications to over 300 subscribed workplaces. Positive feedback from Fife workplaces continues to be received.

H&SCP
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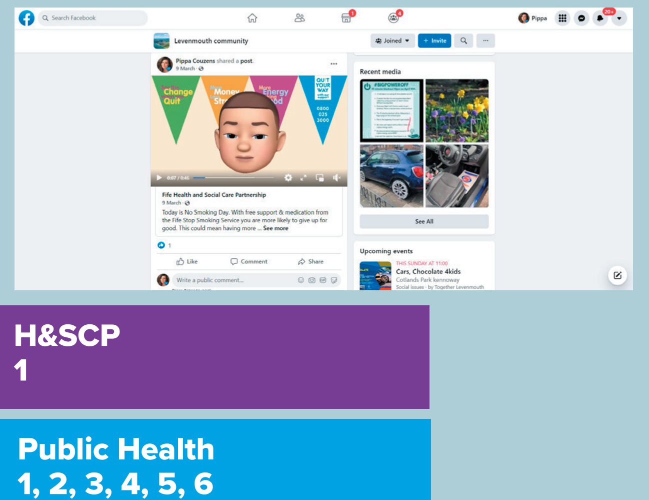
Public Health
5

Raising awareness of health messages using local social media

During the pandemic there has been an increase in local and national health campaigns, particularly from the Scottish Government. Many of these campaign messages have been distributed digitally and through various social media channels. This tends to be through national and Fife wide social media channels. However, there are many very active social media networks and groups used by partner organisations in local areas of Fife with a wide audience.

By developing links with these pages and groups we have begun to develop an effective means of sharing key messages and health information on these pages to ensure important messages reach a wider audience and that key groups can be targeted with appropriate and relevant health information.



H&SCP
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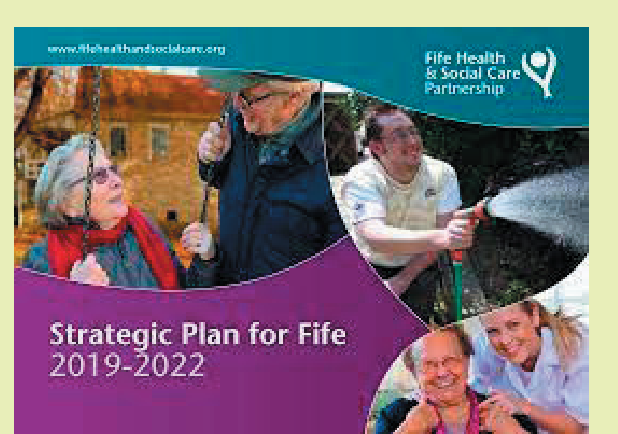
Public Health
1, 2, 3, 4, 5, 6

Priorities For 2022-23

The pandemic has had a major impact on health and wellbeing, and some groups have been impacted more severely than others. As part of COVID-19 recovery we must focus on those groups that have been most impacted by the pandemic. COVID-19 has challenged us to adapt service provision, and we will continue to develop and work innovatively to meet the challenges ahead.

- Over 2022/23 period our key strategic drivers will continue to be the national public health priorities and Fife's H&SCP commitments.
- We will contribute to the delivery of the Plan4Fife Recovery and Renewal priorities, taking a particular focus on reducing health inequalities and working in ways that strengthen and reinforce partnerships to address the wider determinants of health.
- Fife H&SCP Prevention and Early Intervention strategy will be developed over the next 12 months and the HPS will contribute to this work.
- We will contribute to the development and delivery of a number of key strategies, including Fife Mental Health Strategy, Fife Child Poverty Action Plan, Fife Tobacco Strategy, and NHS Fife Population Health and Wellbeing Strategy.
- We will work with partners in ways to build links across strategies, workstreams and service delivery plans, translating strategic plans into operational action.



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For further information on any of our work please visit our website, Twitter, or email fife.healthpromotion@nhs.scot

Fife NHS Board

MINUTE OF THE PORTFOLIO BOARD MEETING HELD ON 17 MARCH 2022 AT 9.00 AM TO 10.30 AM VIA MS TEAMS

Carol Potter
Chair

Present

Carol Potter (CP)	Chief Executive (Chairperson)
Margo McGurk (MMcG)	Director of Finance and Strategy and Deputy Chief Executive (deputy chair)
Dr Chris McKenna (CMcK)	Medical Director
Nicky Connor (NC)	Director of Health and Social Care
Jeanette Owens (JO)	Director of Nursing
Claire Dobson (CD) (arrvd 10.06am)	Director of Acute Services
Susan Fraser (SF)	Associate Director of Planning and Performance
Alistair Graham (AG)	Associate Director of Digital and Information
Ben Hannan (BH)	Director of Pharmacy & Medicines
Neil McCormick (NMcC)	Director of Property & Asset Management
Kirsty MacGregor (KMcG)	Head of Communications
Ben Johnston (BJ)	Head of Capital Planning and Project Director
Gillian MacIntosh (GMcI)	Head of Corporate Governance & Board Secretary
Joy Tomlinson (JT) (arrvd 9.39am)	Director of Public Health
Wilma Brown (WB)	Employee Director

In Attendance

Sharon Gilfillan (SG)	Project Support Officer (Minutes)
Maxine Michie (MM)	Deputy Director of Finance
Kevin Reith (KR)	Deputy Director of Workforce

Apologies

Linda Douglas (LD)	Director of Workforce

1.	**Unconfirmed Minute from meeting held 13 January 2022**
	The Minute from 13th January 2022 was accepted as an accurate record.
2.	**Actions Outstanding**
	Action 4 – MMcG commented Stephen McNamee had done a great job as Interim Portfolio Lead but advised the new PMO and Portfolio Leads were scheduled to start beginning of April. Action 5 – work ongoing
3.	**Climate Emergency & Sustainable Development**

UNCONFIRMED IN CONFIDENCE

	NMcC presented the paper to the PB advising the revised policy for NHS Scotland DL(2021) 38 sets out mandatory requirement that have non-negotiable actions required to be taken by Boards and will form part of the Ministerial Review. NMcC advised the policy requested a number of new appointments, however funding was currently on hold and NMcC was taking a pragmatic approach, recognising team members already in post and innovatively thinking how to use other resources. NMcC advised discussion were ongoing with St. Andrews University who were keen to have 3rd year students undertake an internship with NHS Fife looking at Travel Planning, Biodiversity and Green Space. NMcC added this tied in with Anchor Institution ethos. NMcC highlighted within the paper the proposed Directors roles encouraging collective ownership, Appendix 1 outlining the draft structure of the strategy and Appendix 2 illustrating a proposed governance structure. CP advised the paper had been presented to the Board CExecs and there was actively a lot of work going on, highlighting Highland were removing a particular Medical Gas. BH thanked NMcC for a considered approach, advising he was happy to report back from the SLWG formed to look at the holistic medical pharmacy review. CMcK asked if there was connection with Scot Gov ensuring the greener approach was being considered alongside the drive to save. NMcC advised it was not fully linked up but it was being considered. MMcG agreed required to be a pragmatic approach, at every stage assessing if financially viable, adding cannot do this at expense of financial sustainability. NC thanked NMcC for the paper and raised the issue of heading on the SBAR template to ensure everyone thinks about what the impact means on the global population health and environment. NC proposed Directors come back, as a contributor, what this means within a reasonable timescale. CP agreed require to review the SBAR template. **ACTION: GMacI advised in chat she was reviewing the SBAR template and would include this issue.** **The Portfolio Board were all content with the paper and in agreement with the recommendation.**
4.	**Mental Health Re-Design Project Board – Inpatient Update** CMcK and BJ presented the paper to PB for awareness and provide an update. CMcK advised they were making progress slowly and there were workshops scheduled after Easter and early May, with invites going out today to look at an option appraisal. BJ advised there were logistical challenges undertaking the options appraisal via teams but highlighted the timelines with the initial agreement completed around June 2022. NC agreed the complexity of this redesign and valued CMcK's leadership and BJ's support. CP requested BJ review 2.35 Financial statement highlighting the need to evidence historical under resourcing. CP was hugely supportive of this project and suggested BJ include photos of current accommodation to make a robust case to the Board and Scot. Gov. and proposed inviting Board members to visit Stratheden and QMH. NC advised she was in the process of re-establishing the IJB visits. **ACTION: NC and CP discuss Board member visits to MH** **The PB accepted the paper as an update and CP thanked CMcK and BJ.**

UNCONFIRMED IN CONFIDENCE

5.	**Kincardine & Lochgelly Project Board – OBCs**
	JT and BJ presented and SBAR to accompany the OBCs for Kincardine and Lochgelly highlighting the need for improvement and advising the challenging timescales, with the aim to submitted to Scot Gov in May /June ensuring enough time for the PB and other Committees to see the papers. JT highlighted the process that had been gone through, advising the MOU and GMS contractual obligations had defined the service model. JT explained the absence of Kincardine service model costs as these sit with Forth Valley. JT advised this was an opportunity for the PB to comment on the OBCs. BJ highlighted the work on the OBC started March last year but the need remains the same, integrated services in the right place. BJ highlighted the costs, noting significant increase in capital due to the evolving nature of GMS and impact of COVID and Brexit. CMcK advised he had visited and was concerned staff had waited so long they are not convinced this will happen. BJ agreed advising once OBC agreed by Scot. Gov will work on a communication piece to give assurance. **ACTION: CP agreed to raise this as positive progression at the MSP meeting scheduled on 18/3/22.** MM thanked JT and agreed need to ensure the OBC is what it needs to be for Scot. Gov to support, as it is an opportunity to showcase the difference this will make. BJ highlighted the cut off for BC will be £10m adding Kincardine is below this but need to submit for information as Capital is required. **CP agreed the PB were happy to support the recommendation to progress to FBC and agreed to look over the OBC over the coming weeks.**
6.	**Anchor Institution Programme Board**
	JT presented the SBAR for discussion highlighting there required to be an overview of the different areas of work progressing and how should Anchor be developed in a phased approach alongside the Strategy. CP proposed a smaller group, chaired by Jo-Anne with the Associates and Deputy Group. KR highlighted the Community Health and Organisation Change Group has requested NHS Fife sign up to their Anchor Charter but was unclear what they expected NHS to commit to and how this would embed in the Strategy. BH agreed happy to take the lead with the Deputy Associate Group (DAG). **ACTION: CP requested LD, MMcG, KR and BH formalise the DAG and look at including Anchor on their agenda.** **ACTION: CP requested Anchor be considered in SBARs and added to the template.**
7.	**ToR FI&SPB**
	MMcG advised the FISPB had signed off the ToR on Monday 14th March 2022 and were in the process of establishing the approach and determining the scope. SG to circulate the ToR.
8.	**ToR IPCPB**
	CD advised the IPCPB was scheduled 31/3/22, one meeting had been held in Dec 2021 and the ToR was in the process of being refined for sign off at the end of the month. CD advised the IPCPB would be reviewing QMH project. CP advised the June Board Development session would be look to be sighted on the QMH programme.
9.	**ToR IUSCPB**
	CMcK advised had met yesterday, 16/3/22 and had gone through the ToR, adding the IUSCPB would be focussing on 3 streams of RUC; redesign of UC; interface care; discharge without delay. CMcK acknowledged discharge without delay was being led by M Watts and L Garvey

UNCONFIRMED IN CONFIDENCE

	and was happy to pick up a conversation with NC regarding this.
10.	**AOCB**
	CP requested MMcG provided a visual of all the programmes brought back to the next meeting.
11.	**DATE OF NEXT MEETING**
	Thursday 14th April 2022 9.30am to 11.30am via Microsoft® TEAMS

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Fife NHS Board

MINUTES OF THE PUBLIC HEALTH ASSURANCE COMMITTEE MEETING (PHAC) HELD ON WEDNESDAY 9 FEBRUARY 2022 AT 2.00PM via MST

Present:

Joy Tomlinson (JT)	Director of Public Health (Chair)
Olukemi Oyedeji (formerly Adeyemi) (OO)	Consultant in Public Health
Lynn Barker (LB)	Associate Director of Nursing
Fiona Bellamy (FB)	Senior Health Protection Nurse Specialist
Lynn Burnett (LBu)	Consultant in Public Health
Hazel Close (HC)	Lead Pharmacist Public Health
Cathy Cooke (CC)	Public Health Scientist
Esther Curnock (EC)	Consultant in Public Health (joined 1506)
Lucy Denvir (LD)	Consultant in Public Health
Duncan Fortescue-Webb (DFW)	Consultant in Public Health
Emma O'Keefe (EO'K)	Consultant in Dental Public Health

In attendance: Fiona Currie (FC), Interim PA to Joy Tomlinson
Kaye Robertson (KR), Personal Assistant

PUBLIC HEALTH ASSURANCE

1. Welcome and Apologies

JT welcomed everyone to the meeting. Apologies were received from George Brown, Sharon Crabb and Esther Curnock.

2. Minute of Meeting Held on 14 December 2021 (Attached)

Minutes were accepted as an accurate record.

2.1 Actions from Last Meeting (Attached)

JT advised that the first two items 8.2 and 8.3 would be carried over to the next meeting as they are still ongoing. Since various issues are on the agenda and to avoid duplication nothing further from the action points were discussed.

3. Matters Arising

See separate Action Log

4. Testing Reports

DFW reported on the provision of monthly updates with the help of SC. Discussion on test and protect to be carried over to next meeting. The 1906 update is now up to date. DFW mentioned that we don't know what the future

of testing is and the implications it holds for us. There has been a huge increase in the demands for home test kits which is where the focus has shifted to and it is going well. HC commented that there has been a huge supply uplift over the past couple months. 18,000 kits were given out in November. December recorded 57,500 tests kits being given out with 50,000 in January.

5. Update No Cervix Exclusion Incident Lessons Learned Report — **OO**
(Verbal Report) OO hadn't had the chance to read letter from CMO and has no further update for the incident investigation

No cervix incident investigation lessons learnt report.
OO went on to share this document which has been sent out to the contributors for final verification. She spent time detailing the contents of the report. JT asked that the report be circulated along with the CMO letter. OO and JT went onto thank everyone involved in the incident investigation and the lessons learnt session.

6. PHAC TERMS OF REFERENCE — **EO'K**
EOK advised she had reached out to Paediatric ICU colleagues as they actually have a ToR and they have put a shout out to his excellent colleagues across the UK to see if they have got anything that we can use and build on. Action to be carried forward to next meeting.

6.1 Feedback from Small Group on Workstreams — **EO'K/EC/SC**

RISK MANAGEMENT

7. Identified Near Misses, Critical Incidents & Learning

7.1 Testing Samples Collected by Member of the Public (update on approach agreed at last meeting)
DFW reported that in light of the miscommunication situation where PCR samples were picked up by a member of the public and not the Red Cross, there is now a sign up form for samples and the volunteer needs to provide photographic ID in order to collect. The record of this is then uploaded onto the shared drive weekly. If it doesn't happen then the site leads are tasked with reviewing the record sheet and it has been made clear to the site leads if the Red Cross don't turn up then they need to take the samples to the labs themselves. That has been working well. In terms of the audit of the process there is a weekly review by site leads and then by Bev as they are collated. DFW would hope to provide a review from the audit. — **DFW**

8. New Prospective Risks

Consideration of New Risk: OO provided an overview of the proposed new overarching risk for the restart of the screening programmes (to follow) — **OO**

FC had recently circulated the new proposed risk. JT commented that this is something that has previously been discussed in the committee and that the screening programmes themselves all owned that individual risk register. However the pandemic has resulted in overarching risk for screening which is coming to public attention.

OO reported that there are five adult screening programmes which all had issues with Covid backlog. Different interventions have come up with different programmes and have variable rates of recovery across these programmes. We know that some of the programmes are still behind, so there remains a risk. Delayed screening can result in delayed identification and diagnosis and the potential adverse consequences. OO advised that without having to present a risk document for each programme it was difficult to pull it all together in one piece. OO summarized the background information and the key issues.

- Programs paused in March 2020 and resuming by October 2020.
- Infection Control Procedures
- Social Distancing requirements
- Location – some screening programs have had to relocate due to Covid.

There is backlog and slippage with risk of delayed screening across the programmes. We need to look at what happens when people are not screened within the recommended interval? There are consequences for the patient, for the screening program itself in terms of confidence and organization re reputation. It remains difficult to quantify.

JT commented that the screening team have produced a robust overarching risk and thanked OO for all the work that she has put into this and to the key points made. JT suggested further detail into the programmes specific actions and the management approach..

9. Review of Current Risks on Public Health Register (to follow)

9.1 518 Resilience **JT/GB**

Head of Resilience will start formally early March but they have begun to pick up some areas of work already. We have a preferred candidate for the fixed term Emergency Planning Officer post.

9.2 528 Pandemic Flu Planning **EC/GB**

In the absence of EC, JT advised there is no change in the situation at present because the progress hasn't continued at national level yet and we are still waiting on a bit more clarity.

CC/OA

9.3 1729 Suspicion of Malignancy (update not due until June 2022)

No update required although it is a continued update on the agenda.

CC/LW

9.4 1873 Pregnancy and Newborn Screening

JT advised this is a long standing issue with our lack of digital support for the

pregnancy newborn screening programme and quite a difficult area for individual boards. This will be carried forward to next meeting.

9.5 1904 Coronovirus Disease 2019 (Covid-19) Pandemic **JT**

Although the update isn't due until 17th February JT had done an update today as it was felt that there had been considerable change recently. JT suggested risk reduction from five to four for both consequence and likelihood. Discussion then took place regarding this and it was felt we were coming out of it although there are still a lot of unknowns but we are in a steady, predictable place at the moment and have learned how to monitor it – additional text suggested by HC regarding availability of therapies as mitigation against more severe outcomes from COVID19.

9.6 1905 Contact Tracing including TTIS Programme **JT**

Wider infection control procedures should help going forward. Wider availability of treatments for individuals at higher risk of severe outcomes from Covid.

9.7 1906 Testing including HCW **DFW**

Discussed within Care Homes

9.8 1907 Public Health Oversight of Covid-19 in Care Homes **FB**

FB reported a good uptake of vaccination in our population group. We have a good process in place for contact tracing to make sure that those who work in care homes are priority traced and we have processes in place to ensure they continue to be attempted to be called rather than just once a month. Infection prevention and control practices within the care homes in the wider support is available to them from infection control team. Due to this we're not seeing sizeable outbreaks that we had seen previously affecting residents and staff. Illness that we are seeing is mailed and the death added. We are not seeing an uptick in deaths due to Covid in these settings. Things are better than they were in December.

JT noted consequences remain at level five.

9.9 2132 Test & Protect (update not due until 25 March 2022) **DFW**

DFW reported case numbers are steady and may be declining slowly. The system is able to cope. Nationally they have boards which will handle it and that seems to be working as capacity becomes available or not. The process seems to be working well and as such we are consistently able to get nearly all of their cases within 48 hours. We have demonstrated that we are able to adapt. Propose risk level change from 4 x 4 to 3 x 3.

We still have the same avenues available but the demand for in person testing, testing sites and PCR uptake has fallen since the change in national guidance isolation requirements. We are carrying out 200 tests per week within the community settings but we are distributing between 7000 – 8000. The balance has completely changed. There are four fixed sites and five mobile units still doing this and they are being asked to distribute instead of offering people tests there and then. Charts were shared to show the changes in test numbers and tests which showed the radical change to the testing world. Funding is available until end March 2022 – asked for it to be

extended until end June 2022. Looking to get into food banks and homeless shelters to distribute to vulnerable groups.

9.10 2222 No cervix exclusion – cervical screening incident (update not due until April 2022) **CC/OA**

10. Any Issues to Escalate to Public Health & Wellbeing Committee

None noted

11. Any Other Competent Business

12. Meetings 2022

All meetings will be held at 2.30pm:

Wednesday 6 April
Wednesday 1 June
Wednesday 3 August
Wednesday 5 October

Department of Public Health
Cameron House, Cameron Bridge, Leven, KY8 5RG

DRAFT Minute of the PUBLIC HEALTH ASSURANCE COMMITTEE MEETING (PHAC) held on Wednesday 6 April 2022 at 2.30PM via Microsoft Teams

Present:

Joy Tomlinson (JT)	Director of Public Health (Chair)
Lynn Barker (LB)	Associate Director of Nursing
Fiona Bellamy (FB)	Senior Health Protection Nurse Specialist
Susan Cameron (SC)	Head of Resilience
Hazel Close (HC)	Lead Pharmacist Public Health
Cathy Cooke (CC)	Public Health Scientist
Esther Curnock (EC)	Consultant in Public Health (joined 1506)

In attendance: Dawn Mitchell (DM), Health Protection Support Secretary
Gemma Couser, Associate Director of Quality and Clinical Governance
Pauline Anne Cumming, Risk Manager

PUBLIC HEALTH ASSURANCE

ACTION

1. Welcome and Apologies

JT welcomed everyone to the meeting. Apologies were received from Duncan Fortescue-Webb, Olukemi Oyedeji, Emma O'Keefe and Sharon Crabb.

2. Minute of Meeting Held on 9 February 2022

Due to timescale in production – any changes to be made to these to be with DM by 12 April 2022. After that date minutes will be recorded as final version. Final version of minutes approved and circulated.

2.1 **Actions from Last Meeting**

A small update was made to Item 9.04 Risk 1904 from 09.02.2022 regarding the therapeutic benefits from the new treatments for COVID.

The following completed items can be greyed out. **DM**

Item 4 Testing Report to CGC/PH&WB from 20.10.2021

Item 6 No Cervix Cervical Screening Incident from 10.08.2021

2nd Risk 1904 from 09.02.2022

Item 8.2 Emerging Infections to be carried over to next meeting.

3. Matters Arising

CC reported that the No Cervix Exclusion report has been finalised and will be **CC**

circulated after the meeting to give members a chance to provide any comments prior to it being sent to the Clinical Governance Committee.

JT provided an update on the proposal to table a new risk for drug related deaths following discussion with Paul Madill. Discussions were initiated by addiction services late last year about creating an overarching risk for drug related deaths. This could link to a public health specific risk but this needs further clarification on risk ownership. The overarching risk discussion has not progressed, in part as there has been restructuring within the ADP and changes to individuals taking forward the discussion. To be carried over to next meeting.

4. PHAC ToR

4.1 **Feedback from Small Group on Workstreams** **EO'K/EC/SC**

RISK MANAGEMENT

5. Identified Near Misses, Critical Incidents & Learning

5.1 **Immunisation Incidents Yearly Overview** (Verbal) **EC**

EC recommended that this be incorporated into the annual report. EC chairs a monthly immunisation quality and clinic care assurance group which has a standing item to consider new Datix reports around adverse events. EC had extracted from the data that in 2021 there were 207 incidents recorded. EC noted that the coding wasn't completely accurate and has a meeting with Karen Nolan, Clinical Services Manager, lead nurse and Cathy Gilvear, Fife HSCP Quality, Clinical & Care Governance Lead to look at the coding in more depth. EC reported around half of the incidents are medication related. EC proposed this should be articulated in narrative within the annual report which will go through the Board this coming summer. The matter arising action in terms of the immunisation risk will need to come back to the next meeting. EC noted that the process for looking at organizational structure, the terms of reference for the new boards and the transfer of vaccines coming to completion at the end of the last financial year, has been completed. EC briefly shared a document 'Governance Structure - Community Immunisation Services'. This will be brought back as a further item on the next agenda.

6. Review of Current Risks on Public Health Register (to follow)

6.1 **518 Resilience** **JT/SC**

SC provided an overview of current risk profile and proposed risk level is increased. The rationale for increase is combination of issues highlighted by Scottish Government, Ukraine situation, ongoing COVID incident, continued pressure on the systems, ability to check and refresh plans, Avian Flu potentially running alongside COVID. SC also advised that in terms of business continuity resilience we could have significant implications on our ability to respond. SC recommended that our level be moved to high.

Detailed discussion followed regarding the assignment of likelihood and

consequence levels. It was agreed to support an increase in the likelihood up to four and with the consequence already being at four. PHAC endorsed the change and noted the need for review at the next meeting given the nature of the concurrent risks described.

6.2 **528 Pandemic Flu Planning** **EC/GB**
Due to be reviewed in June 2022

6.3 **1729 Suspicion of Malignancy** **CC/OA**
Due to be reviewed in June 2022

6.4 **1873 Pregnancy and Newborn Screening** **CC/LW**

6.5 **1904 Coronovirus Disease 2019 (COVID-19) Pandemic** **JT**
JT noted that this risk remains at the same high risk level. Over the course of March there has been steadily increasing community prevalence. Even though there is high prevalence, a much smaller proportion of people with infection require medical support. Of those who are admitted to hospital, national statistics suggest around one third are admitted directly because of COVID infection. Hospitals are not seeing an increase in patients needing ICU treatment. The number of deaths we are seeing is much lower than in earlier periods of the pandemic. Care Home residents have protective measures from vaccinations and also treatments as previously highlighted, however the cases remain high due to high community prevalence and the changing nature of the levels of protection and the community mixing.

6.6 **1905 Contact Tracing including TTIS Programme** **DFW**
JT talked through the risk proposal presented by DFW, who has suggested the risk be closed. The rationale is there is an agreement now that testing for the general public is going to stop during April and the will reduce the demand for contact tracing. JT asked PHAC to consider if the risk should be increased at this point because of the uncertainty and she noted that the Directors of Public Health are concerned about sustaining the current policy ambition of the programme because of workforce attrition. EC suggested a new risk is tabled around our ability to have surge capacity to contact trace at short notice. This may be preferable to altering the the risk description. After a short discussion amongst the members it was agreed that the recommendation would be accepted to close the current risk and request DFW present a new risk about the ability of the local system to provide surge capacity for new Variants and Mutations and outbreaks.
Action DFW to table new risk for June meeting

6.7 **1906 Testing including HCW** **DFW**
Update not required until 3 June 2022

6.8 **1907 Public Health Oversight of COVID-19 in Care Homes** **FB**
FB proposed that the risk be left at the current level. Community transmissions, case numbers in care home residents and staff remain high. Although the spring booster vaccination programme is underway the impact of this dose is difficult to predict, particularly given the levels of infection among Care Home residents may result in vaccination being deferred. Care homes are now an open community in that they have visitors, residents are able to

go out and socialize. This all increases and/or keeps the risk at a higher level. PAC accepted the update.

GC noted the active use of risk register by PHAC and the complimented the group on the detailed nature of the discussion.

6.9 **2132 Test & Protect** **DFW**

The proposed risk update was discussed. PHAC noted that there is a lot of uncertainty around the testing routes for elective care, of care home residents and higher risk individuals after the transitional period (April-June 2022). It is understood some PCR testing will continue but much will move to LFD use and further work remains to be done to understand the detailed pathway requirements. PHAC agreed that this emerging challenge should be captured within the risk update and proposed increasing risk level.
Action DFW to amend risk update

6.10 **2222 No cervix exclusion – cervical screening incident** **CC/OA**

CC advised that a brief update had been submitted and that she was waiting to hear from national team. The Head of General Practice Division at Scottish Government has written to all Chief Execs, GP's and Primary Care leads about further audit of all women who have been noted as having no cervix or further recall. As a result 134,000 records need to be updated. There has been national agreement that GP's will help initially with investigation. Fife have been advised there are approximately 19,000 records which may require review. A letter will be sent to GP's from Scottish Government with details about the support that is expected. The look-back exercise will be completed in a two-step approach. Firstly, admin staff will identify the relevant section within health records and then this summary information will be forwarded to the health boards multidisciplinary clinically led team. Discussions will be held with Helen Hellewell and Bryan Davies for their input. There have already been discussions with cervical screening committee and lead colposcopist. Earlier investigations have been completed. The first part of the look-back exercise was substantial but the numbers affected were smaller. In terms of risk level, although there is some activity it was agreed to leave the level unchanged.

CC to send further information about the context and how the update went. CC informed that funding is available for Boards if we need additional staff. There is also potential adverse impact on the other national screening programmes because there will be less specialist support available from public health while this incident is ongoing.

With the second stage of work due to commence early summer a new risk can be articulated at that point.

7. New Prospective Risks – screening programmes restart

JT thanked the screening team on capturing the risk clearly. CC noted that there was one minor change with some emphasis put on the risk being related to COVID related delays. The delay in screening for eligible participants as a result of COVID-19 could result in delayed diagnosis and poor clinical outcomes for participants. CC described how the East of

Scotland Breast Screening have completed a very detailed work plan to address the backlog. The team will aim to give very short line on management actions for each of the programme, indicating where plans are in place and timescales agreed.

JT advised that screening will be added to the Risks regularly reviewed by PHAC with the initial risk score being set at 12. The target to have it down to a 6. The review cycle will be agreed after the meeting. **JT/CC**

8. Risk Management Framework refresh (attached) **GC/PC**

PAC shared the slide set presentation regarding Refresh of Risk Management Framework. A question and answer session followed. PAC will share the NHS Fife Board Risk Appetite statement after the meeting and has agreed to come back at a later date to update us on progress with the Refresh and establishment of the Risk and Opportunities Group.

Details of the presentation can be found at R:\Risk Management Refresh Engagement Session V 1.0 PHAC 060422.pptx

GC invited PHAC to raise any matters of concern directly should we require assistance with any of our risks.

9. Any Issues to Escalate to Public Health & Wellbeing Committee

Nothing on note.

10. Any Other Competent Business

Immunisation risk will be carried to next meeting.

FB highlighted an emerging risk relating to the delivery of BCG immunisation. This may require a funded business case to be progressed. EC suggested that it is sent to the Area Immunisation Steering Group in the first instance. EC and FB to discuss after meeting.

SC noted there is an additional new organisational risk in terms of resilience. BT are pausing their digital voice, part of which was highlighted following Storm Arwen where people had power cuts in community and rural areas. They were unable phone for help because the digital platform failed. SC also advised on an update from Scottish Government about checking and refreshing business continuity and part of that includes cyber and IT resilience in terms of cyber attacks. It has been recognised and highlighted that all of the phone systems within hospital acute setting and community rely on a digital platform. In the event of a cyber incident, as our phones are digital, it's highly likely we would lose important lines of communications right throughout the hospital setting. SC feels this needs to go on as a visible risk. It needs to be shared with infrastructure to see exactly how we would get mitigation for the hospital site.

JT felt we can create and articulate the risk but that risk ownership of the actions needs to be taken forward to a more technical level. A joint paper

(prepared with input from Digital) need to be taken through one of the business EDG meetings as it is a potential risk for the wider system.

Permission was given for SC to progress conversations with telecoms colleagues and also to bring a new overarching risk that we will take forward but must make sure we share the risk with other and we don't own it. **SC**

11. Date of Next Meeting

Wednesday 1 June at 2.30pm