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Health &
Social Care
Integration in Fife

Full Draft Strategic Plan for Fife (2016-2019)

Consultation Draft

7 October 2015 – 6 January 2016

NHS Fife

Supporting the people of Fife together

Fife Council

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FOREWORD

NHS Fife and Fife Council are working together in a new Integrated Health and Social Care Partnership in line with Scottish Government policy. The aim of this policy is that the Partnership will work together to deliver positive outcomes for the people of Fife.

We are fully committed to working with individuals, local communities, staff and our community planning and other partners to make effective use of all of our resources. To do this, the expertise, knowledge and skills of colleagues, along with input from service users, providers and other stakeholders, will all help to drive new and more innovative ways of working at a local level.

We are keenly aware that we are working in a period of significant change. This change creates uncertainty for all stakeholders and, perhaps most acutely, for the people of Fife who need access to care and support on a day to day basis.

Over the next decade, we face together enormous challenges and opportunities. Fife's population is getting older. By 2024, the number of people, aged over 75 years, is predicted to increase by 44.6%. Many more people will be living with more than one long term condition (a 50% increase in the next ten years) and there are increasing demands on public services. The introduction and the impact of the Public Bodies (Joint Working) (Scotland) Act 2014 will drive the change.

This agenda heralds a fantastic opportunity for all of us to ensure that across Fife pockets of innovation are spread and that best practice is shared between teams so that we can tap into and benefit from some of the existing creativity and expertise.

We are clear that in order for us to meet these challenges head on:

- We must change the way in which we commission services;
- We must change the way in which services are provided; and
- Above all, we must change to achieve better outcomes for the people of Fife .

Sandy Riddell
Director of Health and Social Care

Councillor Andrew Rodger
Chairman, (Shadow) Integration Joint Board

DRAFT STRATEGIC PLAN FOR FIFE 2016 - 2019: PART 1

1. INTRODUCTION

1.1 This is the first Fife Health and Social Care Integration Strategic Plan to be developed. It covers the period from 2016 to 2019. This Draft Strategic Plan describes how the Fife Health and Social Care Partnership, an integrated partnership between Fife Council and NHS Fife, will develop health and social care services for adults over the coming three years and will build upon a foundation of many years of strong partnership working in Fife.

1.2 We are working within an environment where there are increasing demands for services and public expectations are growing at a time of significant financial and other resource challenges and constraints e.g. work force availability and recruitment difficulties in some areas.

1.3 The recent and forecast demographic changes, alongside the short to medium term investment position, means that we cannot continue as we are. If we do nothing, our system will not be able to retain our staff; recruit to our services; continue to deliver the quality services which we want to deliver for the people of Fife; and fulfil our intentions to improve outcomes for the people who use our services.

1.4 Therefore, we need to make the best use of what we have. This means ensuring that social care, primary care, community health and acute hospital services work well together in a more integrated way with all our partners including Housing and the Third and Independent Sectors. It means, also, growing a new culture of care and support which works with people, their families and the wider community to create effective and sustainable solutions.

1.5 The creation of this new Partnership will mean changes in our work practices and this will create challenges. In order to meet these challenges, we will work together to create a culture of co-operation, co-production and coordination across all partners including the Public so that we deliver quality services which achieve the best outcomes for the people of Fife.

1.6 This is a three year strategic plan. It is not an operational plan. The operational plans, i.e. the detail of how our strategic plan will be delivered, will be developed and co-produced within our localities (see Section 2). The operational locality plans will support this strategic plan.

2. BACKGROUND

What is the Partnership?

2.1 The Fife Integrated Health and Social Care Partnership has been established as a Body Corporate. This means that it is a separate legal entity from either Fife Council or NHS Fife. Responsibility for its governance rests with an Integration Joint Board (IJB).

2.2 The IJB comprises eight voting members appointed from Fife Council's Elected Members and eight voting Board members from NHS Fife. Representatives from other sectors are non-voting members of the IJB. The arrangements for the IJB's operation, remit and governance are set out in the Integration Scheme (Partnership Agreement) which has been prepared and approved by Fife Council and NHS Fife.

2.3 Once the IJB approves this Strategic Plan, Fife Council and NHS Fife will delegate the functions included within the Integration Scheme to the new Fife Health and Social Care Partnership. This will be achieved by 31st March 2016.

What is the Strategic Plan?

2.4 The Strategic Plan outlines our vision for health and social care services for the people of Fife; what our priorities are for the next 3 years and beyond; how we determine those priorities; and how we will work in partnership to deliver them.

2.5 We know that there are already a number of national and local strategies in place and these have informed this strategic plan. **Appendix A** provides an overview of our main local strategies.

Locality Planning

2.6 This plan covers the whole geographical area of Fife. However, the Scottish Government's Act requires each local area to identify and define the 'localities' across which joint services will be planned. The Public Bodies (Joint Working) (Scotland) Act 2014 (hereinafter referred to as The Act) states that each local area must have at least two 'localities'. Consequently, a three month consultation exercise was undertaken to identify the most appropriate localities for Fife.

2.7 We used a range of methods to ensure that as many people as possible were able to contribute their views. We promoted the Localities Consultation document through websites, social media, sent it to targeted groups and made sure that translated and transcribed versions were available. In addition, there was a series of open meetings and an Equalities Impact Assessment was also undertaken. The period of active consultation was from 11th August to 3rd November 2014.

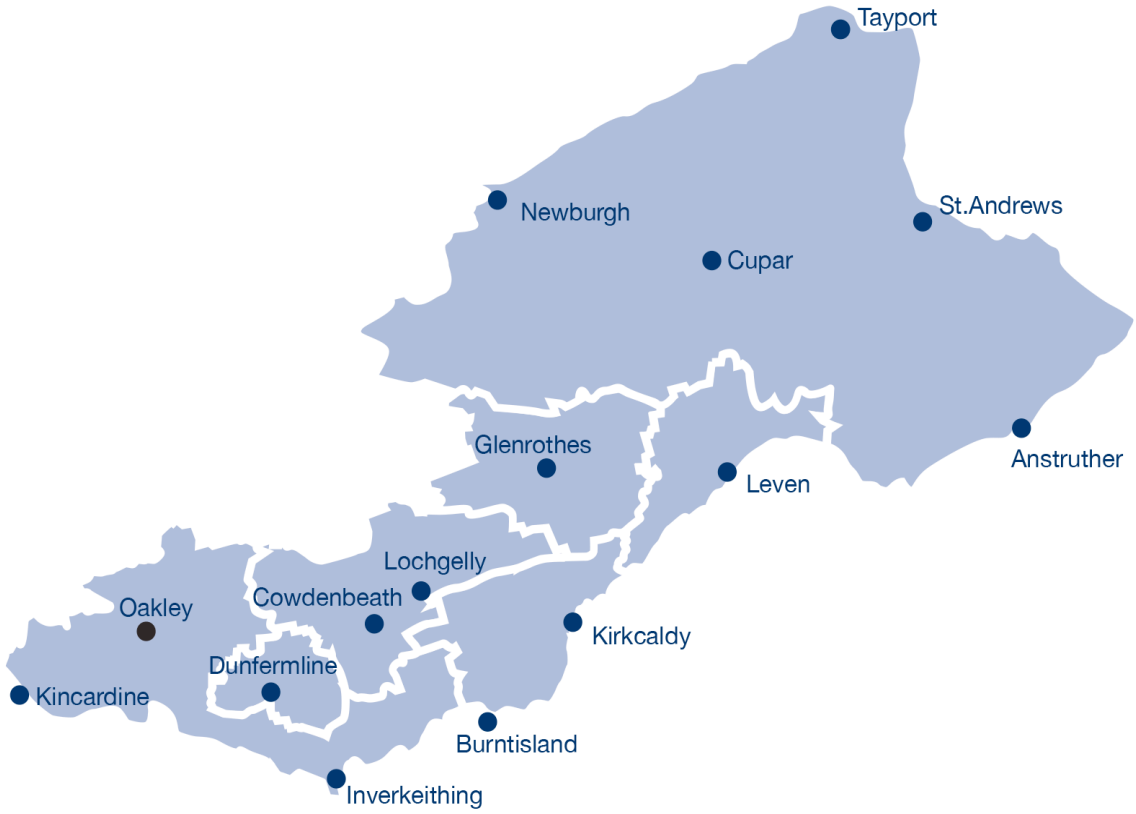
2.8 Following this three month consultation, the Shadow Board agreed to use the seven localities based on Local Community Planning areas which match Fife Council Area Committee boundaries. They agreed, also, that Fife's joint health and social care services would be managed in three divisions (East, West and Fife-wide) with a number of localities being managed within these divisions.

2.9 The consultation results indicated support for seven local areas as the best way to plan the delivery of local, flexible and easily accessible health and social care services. However, the consulation feedback noted, also, that, in terms of General Practice population registrations, there were issues across the localities which would impact on developing integrated models around GP practices or clusters of practices as well as localities.

2.10 Therefore, the local agreement is to work with locality boundaries in a way that supports primary care populations. As illustrated in Figure 1 below, the seven locality areas are:

- North East Fife (takes in Auchtermuchty, Cupar, Taybridgehead, St Andrews, Crail and Anstruther)
- Glenrothes (includes Thornton, Kinglassie and Leslie)
- Kirkcaldy (includes Burntisland and Kinghorn)
- Levenmouth (includes West Wemyss, Buckhaven, Methil, Methilhill, Kennoway and Leven)
- City of Dunfermline
- South West Fife (includes Inverkeithing, Dalgety Bay, Rosyth, Kincardine, Oakley and Saline)
- Cowdenbeath (includes Lochgelly, Kelty and Cardenden)

Figure 1: Fife Localities



2.11 We know that the needs of people vary across Fife and, once this Strategic Plan is approved, more work will be done by each locality to develop its own local implementation and delivery plan. The relevant Divisional General Manager will be responsible for developing these plans fully with the communities in each locality, as well as staff and all partners. In addition, the relevant Divisional General Manager will be responsible for ensuring that these plans align with the Community Plans for that locality.

2.12 The profiles of each locality are shown at **Appendix B**. These illustrate the key differences across the seven localities and the links to the existing community plans. This information will inform the further development of the locality plans.

2.13 The development of locality planning is at an early stage in Fife in terms of the composition of locality planning teams and how resources will be allocated. However, all the localities are currenty mapping community assets and the support for setting up social enterprises.

What services will the strategic plan cover?

2.14 The Act establishes the legal framework for integrating health and social care in Scotland. It requires each Health Board and Local Authority to delegate some of its functions to new Integrated Health and Social Care Partnerships. The objective is to create a single system for local joint planning and delivery of health and social care services built around the needs of patients and service users and which supports service redesign with a focus on preventative and anticipatory care in communities.

2.15 The Strategic Plan will cover all services delegated to the IJB as set out in the Integration Scheme. The budget for these services amounts to over £470m involving a workforce of around 5,500 staff. Those services, for which budgets will be delegated and services managed by the Integrated Health and Social Care Partnership, are:

Fife Council

- Social work services for people aged 16 and over
- Services and support for adults with physical disabilities and learning disabilities
- Mental health services
- Drug and alcohol services
- Adult protection and domestic abuse services
- Carers support services
- Community care assessment teams
- Support services
- Care home services
- Adult placement services
- Health improvement services
- Aspects of housing support, including aids and adaptations
- Day services
- Local area co-ordination
- Respite provision
- Occupational therapy services
- Re-ablement services, equipment and telecare

Housing

2.16 The interface with housing is crucial to the success of the integration agenda. The housing functions, which are being delegated to the new Integrated Health and Social Care Partnership are described fully in the draft Housing Contribution Statement (**Appendix C**). These include:-

- Housing support services
- Housing adaptations

NHS Fife

Community Services

- District nursing services
- Substance misuse services
- Services provided by allied health professionals in an outpatient department, clinic, or outwith a hospital
- The Public Dental Service
- Primary Medical Services
- General Dental Services
- General Ophthalmic Services
- General Pharmaceutical Services
- Community geriatric medicine services
- Community palliative care services
- Community learning disability services
- Community mental health services
- Community continence services
- Services provided by health professionals that promote public health
- Community children's services
- Sexual Health Service
- Rheumatology Service

Hospital Inpatient Services

- Community hospital inpatient facilities
- Palliative Care inpatient services
- Psychiatry of learning disability
- Mental Health including Forensic

2.17 New Integrated Partnerships will be responsible, also, for strategic planning of those aspects of acute hospital care which are most commonly associated with emergency care i.e. specialties where most of the unplanned hospital admissions are for adults. These are areas where there may be potential to design and deliver services to prevent admission. The operational management remains the responsibility of the Acute Services Division of NHS Fife. These services include:-

- Accident and Emergency services provided in a hospital
- Inpatient hospital services relating to:
  - general medicine
  - geriatric medicine
  - rehabilitation medicine
  - respiratory medicine

How will the plan be developed and agreed?

2.18 The IJB has been meeting as a Shadow Board since June 2013. The Shadow Board established a number of work streams, one of which is the Strategic Planning Group (SPG) which has developed this draft on behalf of the Shadow Board.

2.19 The IJB is responsible for leading the co-production of the Strategic Plan with the hospital sector and other stakeholders and for performance (see Section 13) in terms of outcomes delivered via the Strategic Plan. In order to achieve this, the SPG has representation from Fife Council, NHS Fife, general practice, acute clinicians and managers, and representatives of users, carers and the Housing, Third and Independent Sectors. **Appendix D** illustrates the composition of the SPG.

2.20 The SPG has developed our strategic priorities and commissioning intentions through reviewing our epidemiology and demographics assessment and the health needs and life circumstances of our population. In addition, the SPG reviewed current service delivery, available performance reports, recent developments and investment decisions and held a series of workshops and visioning events to find out the views of our staff and the public.

2.21 We will consult more widely on this first consultation draft of the Strategic Plan and, thereafter, we will review and finalise the plan. Once agreed we will continuously review and update the plan with annual reports to the IJB.

3. STRATEGIC VISION, MISSION AND OUTCOMES

Our Vision

Accessible, seamless, quality services and support that are personalised and responsive to the changing needs of individuals, designed with and for the people of Fife.

3.1 Providing integrated care that crosses the boundaries between primary, community, hospital and social care is a goal of health systems worldwide. We want to help people fulfil their personal aspirations to live life as they want. In order to do this, we must work in a much more coordinated and joined up way. Key to this vision is harnessing the experience and skills of professionals on the frontline along with that of our partners and colleagues from across the statutory, third and Independent Sectors .

3.2 Put simply, it means that, over the coming years, GPs, hospitals, health workers, social workers, social care staff and others will work together as one system. This more co-ordinated approach will help people avoid having to navigate their way through what can be a bewildering maze of specialist services.

Our Mission

We will work with people in their own communities, using our collective resources wisely. We will transform how we deliver services to ensure these are safe, effective and high quality and based on achieving personal outcomes.

3.3 We will 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.

Our Values

Our guiding values in the planning and delivery of services are person focused, integrity, caring, respectful, inclusive and empowering.

3.4 The way in which we will plan and deliver services is in line with The Act's principles. This means that our services will:-

- Take account of the particular strengths and assets of people who use our services whilst fostering a sense of shared responsibility for achieving good outcomes in terms of health and wellbeing;
- Take account of the diversity of people in Fife and of the particular relationships which they have and the local circumstances in which they live;
- Treat people with dignity and in a caring and compassionate way, listening carefully to what they aspire to in their lives and valuing continuity in relationships;
- Work as partners with service users in the wider range of communities in which they live;
- Co-design our services with the community including people who use our services, those who look after service-users, and those who are involved in the provision of health or social care; and
- Put the person at the hub of our created system recognising that quality relationships are a pre-requisite for good health and wellbeing.

3.5 The above are the Partnership's agreed vision, mission and values. Sitting alongside this are Fife Council's Plan 2017 and NHS Fife's Strategic Framework and Clinical Direction.

Fife Council's Plan 2017 sets out its direction for policy and commitment to reform over the term of the Plan. The overall strategic intention is to strengthen Fife's future and to make Fife a great place to live, work, visit and invest. Fife Council's challenge is to meet the growing needs and demands being made on its services with an ever reducing budget. In order to meet this challenge by 2017, we have set ourselves five aims:namely, Growing a vibrant economy; Increasing opportunities and reducing poverty and inequality; Improving quality of life in local communities; Promoting a sustainable society; and Reforming Fife's public services.

NHS Fife's Strategic Framework and Clinical Direction are founded upon the Scottish Government's direction as set out in its 20:20 vision for sustainable quality in Scotland's healthcare where everyone is able to live longer healthier lives at home or in a homely setting.

3.6 In addition to our vision, mission and values, our ways of working will focus on delivering outcomes at both a national and a personal level.

National Outcomes for Integration

3.7 We have developed and designed our draft Strategic Plan to deliver the national health and wellbeing outcomes for Integration. These are defined as:-

Outcome 1 - People are able to look after and improve their own health and wellbeing and live in good health for longer.

Outcome 2 - People, including those with disabilities or long term conditions or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

Outcome 3 - People, who use health and social care services, have positive experiences of those services and have their dignity respected.

Outcome 4 - Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

Outcome 5 - Health and social care services contribute to reducing health inequalities.

Outcome 6 - People, who provide unpaid care, are supported to look after their own health and wellbeing; this includes the reduction of any negative impact of their caring role on their own health and wellbeing.

Outcome 7 - People, using health and social care services, are safe from harm.

Outcome 8 - People, who work in health and social care services, feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

Outcome 9 - Resources are used effectively in the provision of health and social care.

Personal Outcomes Based Approach

3.8 We will adopt a Personal Outcomes Based Approach in the future delivery of our services. This means that our services will put service users and their carers at the heart of our support. This approach involves a conversation with the individual service user or unpaid carer that seeks to understand the extent to which they are achieving the outcomes important to them in their lives.

4. NATIONAL AND LOCAL CONTEXT

National Context

4.1 The Kerr Report (Building an NHS Fit for the Future 2005) stated that all the partners in the system needed to realise that they were inter-dependant and that we all needed to change. The report summarised the required nature of change as:-

Now		The Future
Geared towards acute conditions	→	**Geared towards long-term conditions**
Hospital centred	→	**Embedded in communities**
Doctor dependent	→	**Team based**
Episodic care	→	**Continuous care**
Disjointed care	→	**Integrated care**
Reactive care	→	**Preventative care**
Patient as passive recipient	→	**Patient as partner**
Self care infrequent	→	**Self care encouraged and facilitated**
Carers undervalued	→	**Carers supported as partners**
Low tech	→	**High tech**

4.2 The 2011 Christie Commission Report (Commission on the Future Delivery of Public Services) specified that,

"Public Services must be required to work much more closely in partnership, to integrate service provision and thus improve the outcomes they achieve. We must prioritise expenditure on public services which prevent negative outcomes from arising. And our whole system of public services – public, third and Independent Sectors – must become more efficient by reducing duplication and sharing services where possible".

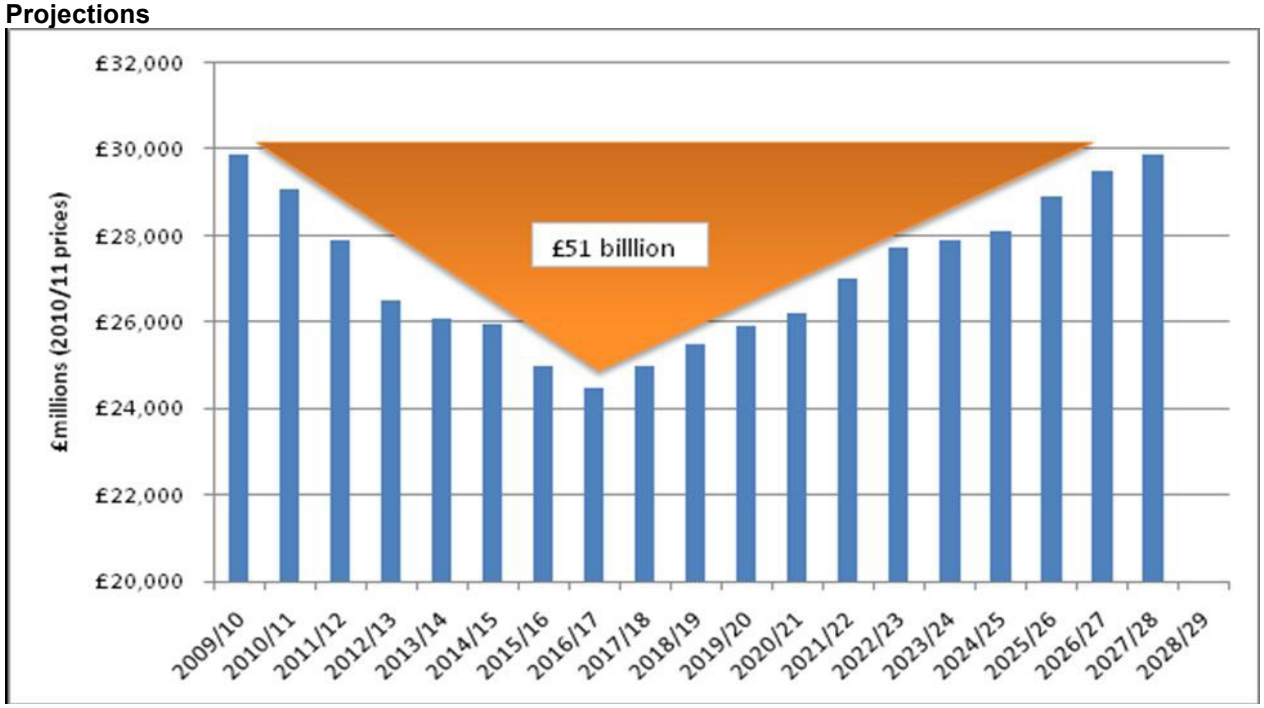
4.3 A Route Map to the 2020 Vision for Health and Social Care stated that,

"We will have a care system where we have integrated health and social care, a focus on prevention, anticipation and supported self-management. When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm. Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions. There will be a focus on ensuring people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission". (The Route Map was published in 2013 and, currently, is under review at national level.)

Public Sector Funding

4.4 The short to medium term public funding estimates show a challenging position (Chart 1). If no changes are made, it is anticipated that there will be a significant gap in funding for public services. Our current approach to service delivery is unsustainable in financial terms. Whilst we continue to improve efficiency, it is unlikely that any resource gap can be addressed fully through service efficiency measures. Therefore, we need to change, also, the way we work together to deliver services.

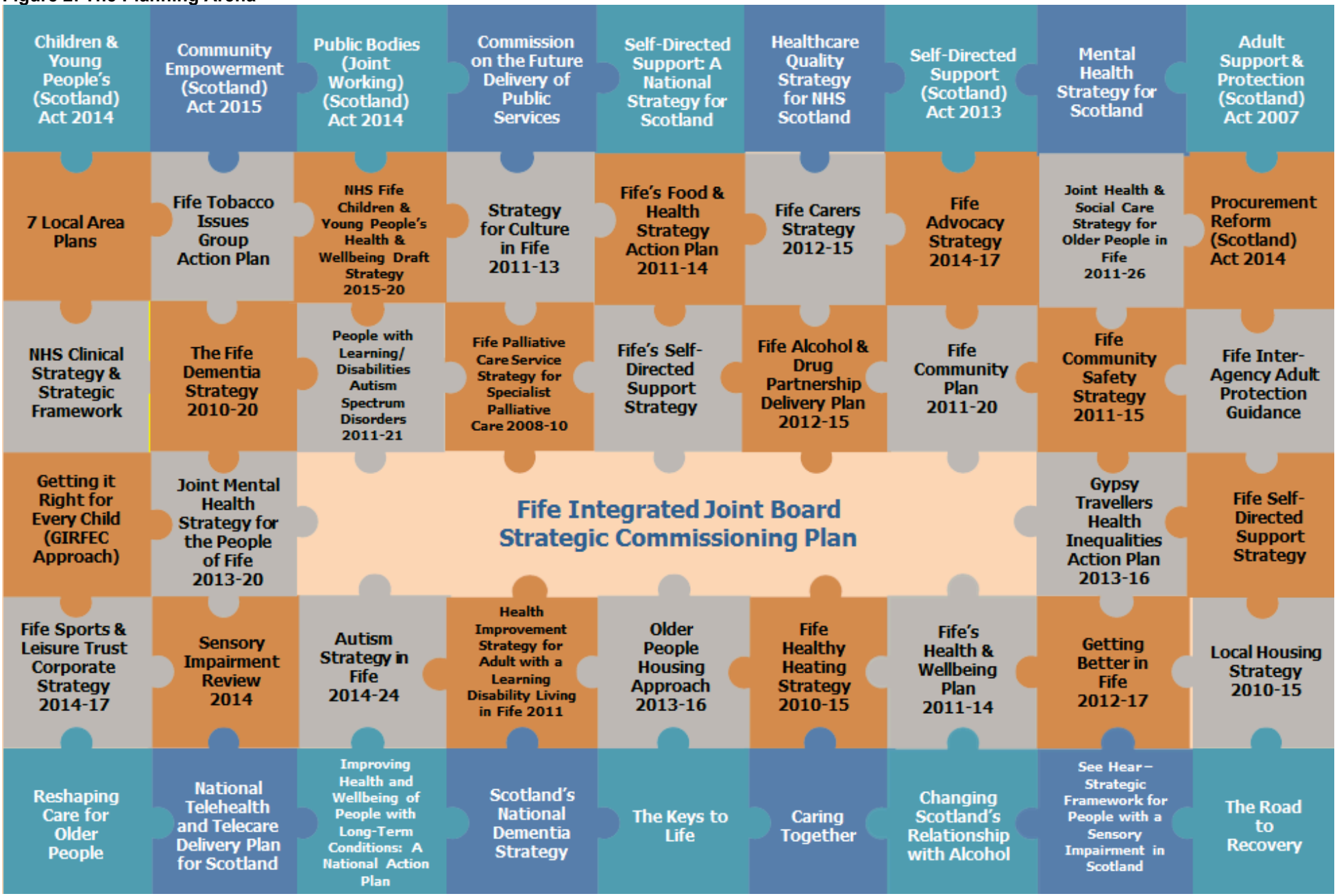
Chart 1: Medium Term Outlook for Scottish Funding – Autumn Statement 2011 illustrative Projections



Local Context

4.5 As illustrated in Figure 2 below, the planning arena is complex in terms of the number and range of strategic and policy documents which inform and direct how we develop and deliver services.

Figure 2: The Planning Arena



4.6 **Strategic Planning** - the Community Plan 2011-20 is Fife's overarching partnership plan. This brings together the public (Fife Council, NHS Fife, Police Scotland, Higher Education and Fire and Rescue services) and Fife's Third and Independent Sectors and channels their resources in order to strengthen Fife's future and make this a great place to live, work, visit and invest.

4.7 All the partners have their own services to deliver and business to run. All these services play important roles in building a strong and diverse economy; educating and skilling Fifers; improving health and wellbeing, sustaining and improving our environment; and making Fife's communities safer. However, we also must work also across service boundaries and focus on opportunities and risks which cannot be addressed by an individual partner on their own. In addition, in order to be efficient and effective, we must avoid all unnecessary duplication. Therefore, Fife's Community Plan 2011 – 2020 sets out three high level outcomes which are:-

- Reducing inequalities;
- Increasing employment; and
- Tackling climate change.

4.8 Each of these has a number of more detailed longer term outcomes. Those most pertinent to and to which this Plan contributes are:-

- Improving the health of Fifers and narrowing the health inequality gap; and
- Increasing the capability of Fifers to take action and make a difference to their communities.

4.9 The delivery of Fife's Community Plan and the contribution, which the Fife Partnership makes to the delivery of the Scottish Government's National Outcomes, are detailed in the Single Outcome Agreement for Fife. The delivery of the Community Plan and the Single Outcome Agreement is underpinned by:

- Partnership strategies;
- Partners' organisational strategies and plans; and
- Local community planning

4.10 Our Strategic Plan builds upon joint planning foundations established through our Community Planning and Health & Social Care Partnerships under which joint strategies and plans have been developed already and are being implemented for a range of services and client groups.

What our strategies and plans have told us

4.11 Our historic planning approach has been to plan on a care group basis with individual joint strategies for Older People, Mental Health Services, Learning Disability, Drugs and Alcohol and Children's Services. Other local plans and strategies are on a themed basis and have a bearing on the health and wellbeing of all care groups e.g. Housing, Tobacco Issues, Food and Health.

4.12 **The Joint Health and Social Care Strategy for Older People in Fife 2011 to 2026** places an emphasis on integrated services which focus on prevention and anticipatory care; reducing unplanned hospital admissions; and services which promote rehabilitation and reablement. Significant progress has been made already in establishing integrated teams within the community and work continues to develop this further.

4.13 **The Joint Mental Health Strategy for the People of Fife 2013 to 2020** has a number of key priorities including Anti-Stigma, Recovery, Physical Health and Holistic Care, and Suicide and Adult Protection. Workstreams have been established to progress actions supporting each of these areas.

4.14 Successful service redesign in previous years has seen a significant move from long term inpatient mental health care to community based teams supporting people at home.

4.15 **The "Keys to Life" is the current key policy for Learning Disability Services.** This and the preceding policy documents focus on a rights based approach which supports people and allows them to retain independence and control. Significant progress has been made already in establishing integrated working in the community and provides a strong foundation for the future.

4.16 Alcohol and Drug services are planned and commissioned by the multi-agency Alcohol and Drug Parternship (ADP) in Fife. **The Fife Alcohol and Drug Partnership Delivery Plan's** priorities include prevention, early intervention and recovery and treatment choices in community settings.

4.17 **Fife's Children's Services Plan 2014 to 2017** is the responsibility of the collective partnership, represented by the Children in Fife Group. This partnership brings together in common purpose Fife Council, the Third Sector, Police Scotland, Scottish Children's Reporter Administration and NHS Fife. The Children in Fife Group reports to the Fife Partnership. The Partnership between services for children in Fife is mature at both strategic level and in each of its areas and communities.

4.18 This plan is nested within Fife's Community Plan and the 4 particular outcomes are:-

- Improving early years development of children in Fife;
- Raising educational attainment and reducing educational inequality;
- Improving the health of Fifers and narrowing the health inequality gap; and
- Making Fife's communities safer.

4.19 Only community health services relating to children such as School Nursing and Health Visiting are included in the scope of the IJB.

4.20 Appendix A provides further details of the main areas of joint working and provides an overview of the main priority areas and the objectives for each. There is much commonality between and across this strategic planning work and across the national and local strategies and plans referred to throughout this plan.

4.21 This draft strategic plan does not revise or replace any of the joint strategies and plans already in place and being implemented now. In this draft strategic plan, our focus is the first phase of high level priority actions for Health & Social Care Integration which have been informed by exisiting strategies and plans.

4.22 This relationship will change as we go forward with this plan informing and directing the future development of the plans and strategies for services which come under the scope of Health & Social Care Integration.

5. UNDERSTANDING THE NEEDS OF OUR POPULATION

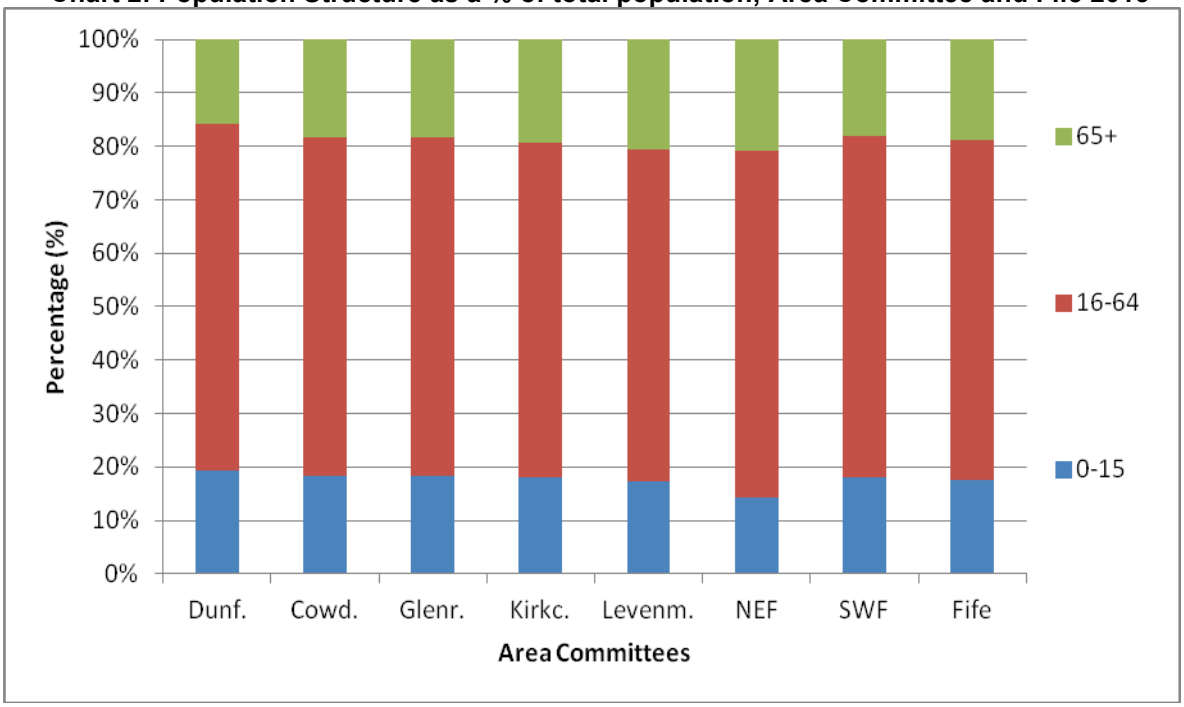
5.1 The full report on the epidemiological overview of the demographics, life circumstances, health related behaviours and health status of the population of Fife is a at **Appendix E**. Some key points are summarised below:

Fife's Population

5.2 As of 2013, Fife had a population of 366,910. Of this, 17.5% were children (0-15 years), 63.7% were aged 16-64 years and 18.8% were aged 65 years and over.

5.3 According to 2013 population estimates, the City of Dunfermline had the largest proportion of children (19.4%) and the smallest proportion of older people (15.7%) whilst North East Fife had the greatest proportion of population aged 65 and over (20.9%). Fife had slightly higher proportions of children and older people than Scotland overall but a lower proportion of working age adults.

Chart 2: Population Structure as a % of total population; Area Committee and Fife 2013



Source: KnowFife Dataset

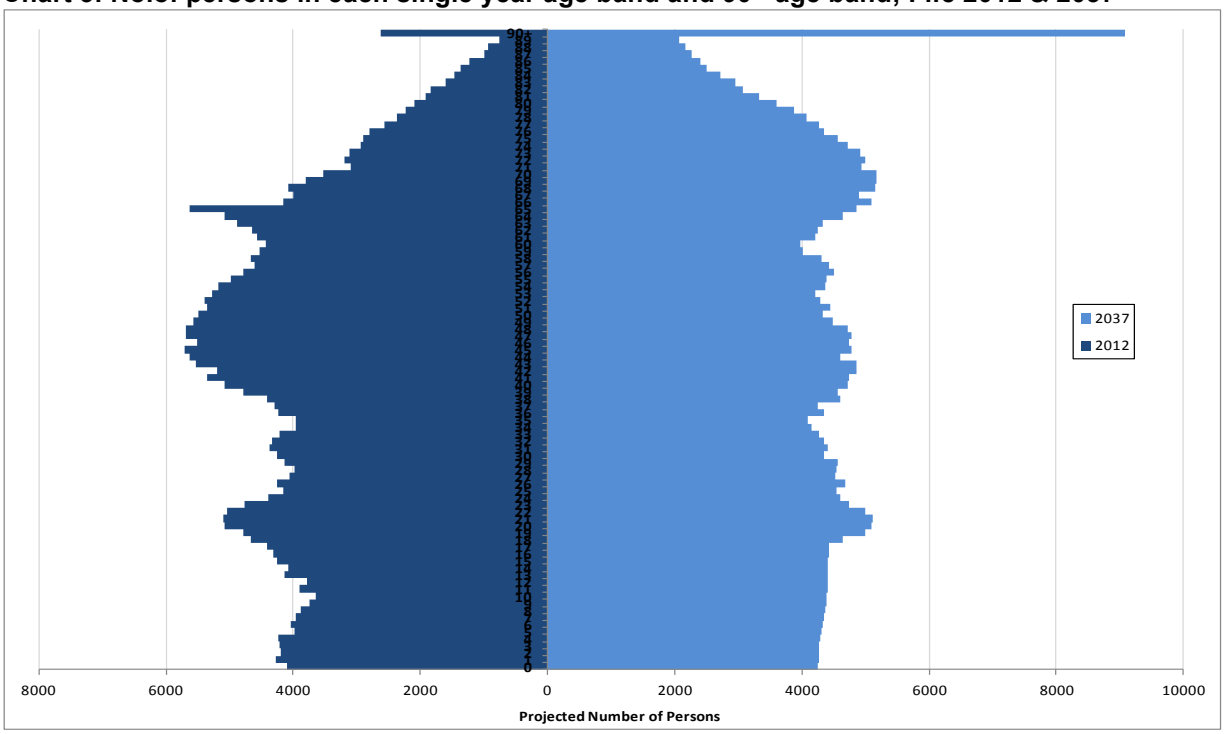
Fife's Population is changing

5.4 It is estimated that Fife's overall population will increase by 31,769 (9%), from 366,220 in 2012 to 397,989 in 2037. However, increases will not be seen across all age groups - in the next 25 years it is estimated that there will be an overall net reduction of 16,207 persons (9%) aged 30-64, the mid to older working age group whilst there will be increases in the number of younger Fife residents aged both 0 to 15 (8%) and 16 to 29 (4%).

5.5 The largest increases will be seen in persons aged 65-74 and those aged 75 and over. By 2037, the number of persons aged 65-74 is expected to be 12,000 more than in 2012, a rise of 33% whilst the number of persons aged 75 and over is estimated to increase by 93% from 29,632 in 2012 to 57,327 in 2037.

5.6 The structure of Fife's population is predicted, also, to change over the coming 25 years with, between 2012 and 2037, the bulk of the population moving upwards towards the older age bands (Chart 3). This means that, compared to 18% in 2012, by 2037 persons aged 65 and over will account for 27% of Fife's total population. Also, the proportion of children will remain fairly stable but the proportion of the population, who are of working age, will decline from 64% in 2012 to 56% in 2037.

Chart 3: No.of persons in each single year age band and 90+ age band; Fife 2012 & 2037



The people of Fife are living longer.

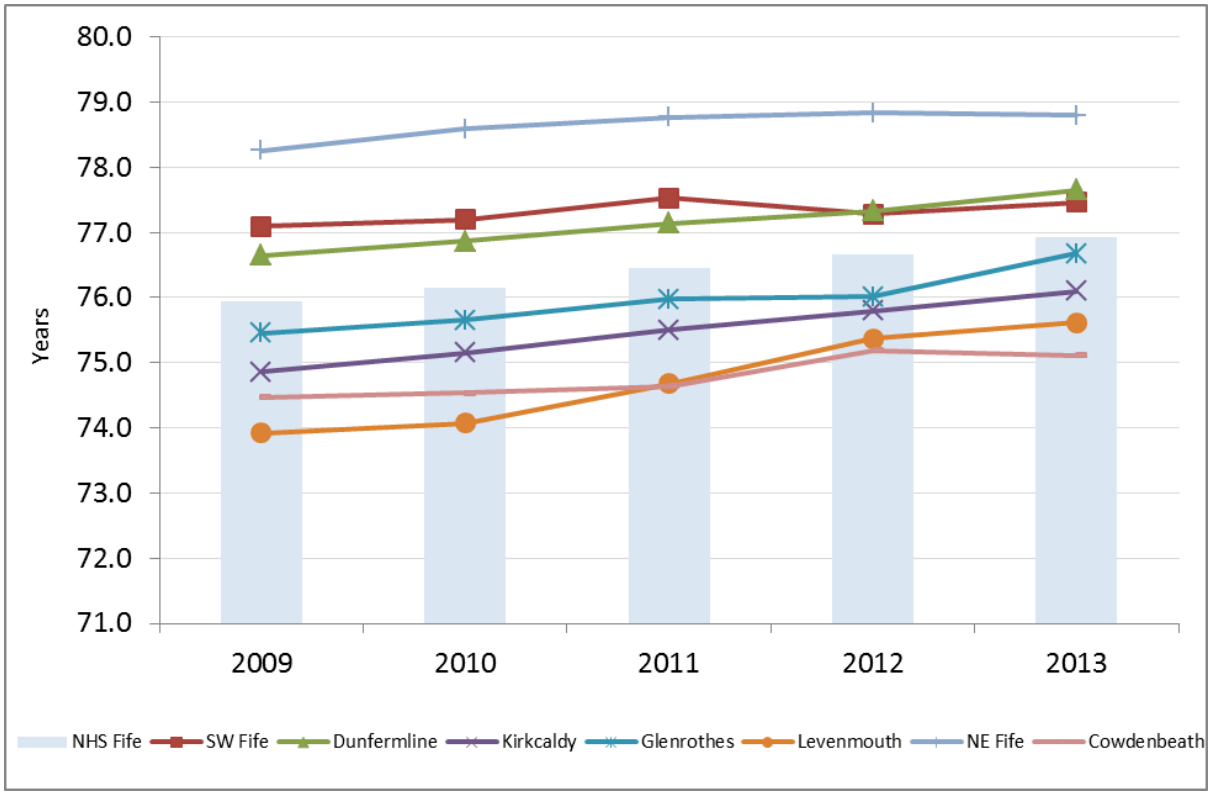
5.7 Life expectancy at birth has increased among both males and females in the last 10 years with latest figures showing that babies born in Fife during 2011-13 can expect to live 77.2 years for males and 81.2 years for females. At age 65, females can expect to live for 19.7 years whilst males can expect to live for 17.4 years.

5.8 There are differences in life expectancy within Fife with North East Fife having the highest values of life expectancy at both birth (78.8 years for males and 82.4 years for females) and at age 65 (18.2 years for males and 20.9 years for females).

5.9 Cowdenbeath has the lowest levels of life expectancy at both birth (75.1 years for males and 79.5 years for females) and at age 65 (16 years for males and 18.6 years for females). The life expectancy at birth for females in Levenmouth was, also, 79.5 years.

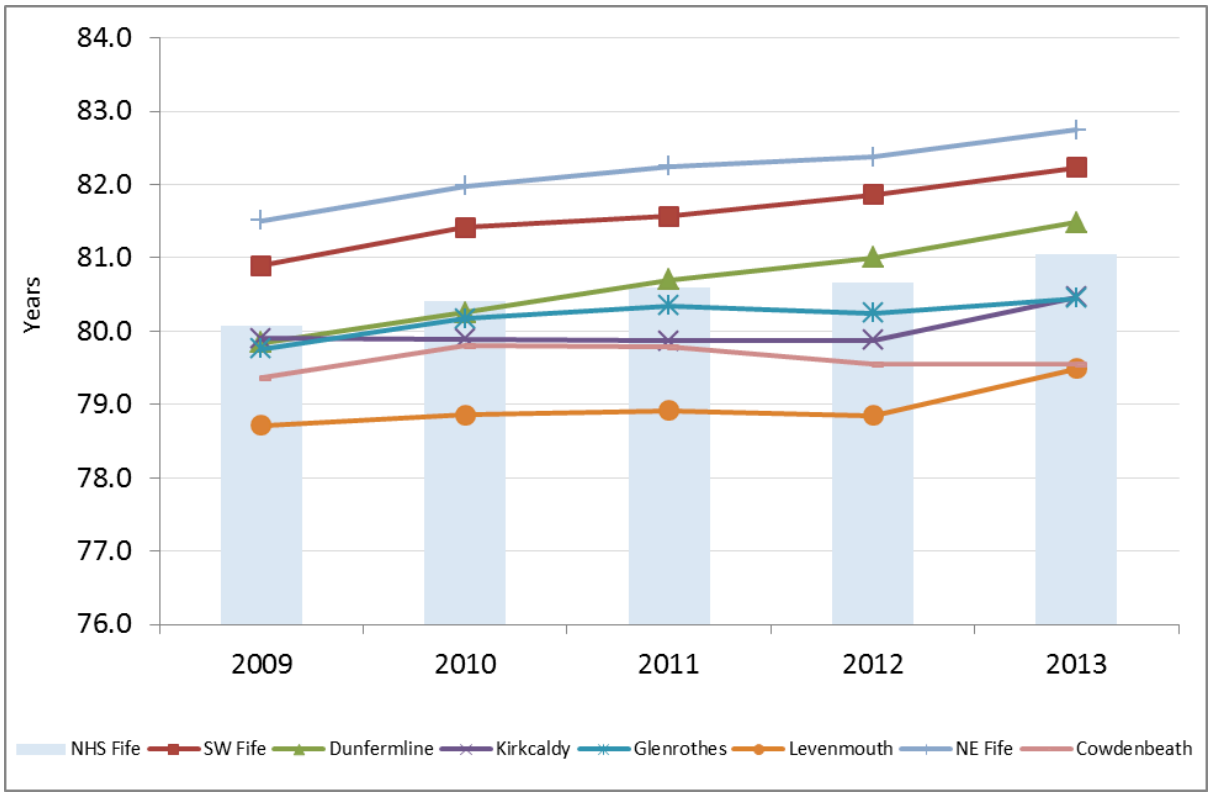
5.10 Thus, babies born in 2013 in North East Fife can expect to live longer than those born in the same year in Cowdenbeath – 3.7 years for males and 2.9 years for females (Charts 4 and 5).

Chart 4: Life Expectancy from Birth – Males - Fife NHS Board of Residence, 5 Year Ending; 2009 to 2013



Source; NRS Death Records and Population Estimates

Chart 5: Life Expectancy from Birth – Females - Fife NHS Board of Residence, 5 Year Ending; 2009 to 2013



Source; NRS Death Records and Population Estimates

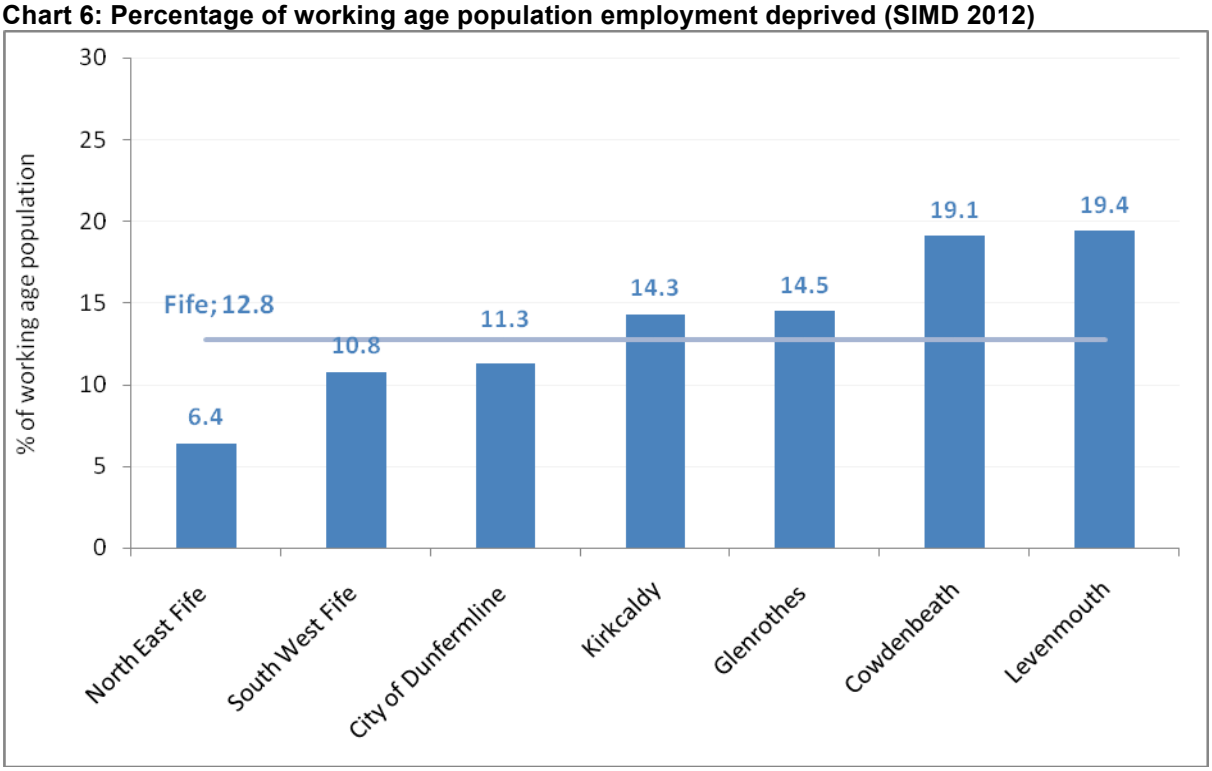
Life Circumstances

5.11 **The majority of Fife's population is economically active but deprivation is still a concern**. At the 2011 Census, 75% of the population of Fife aged 16-64 were economically active. Also, just over 4000 people aged 65 and over (7.4%) were economically active. Within Fife, the Dunfermline area had the highest proportion of its population aged 16-64 economically active whilst North East Fife had the highest proportion of over 65s who were economically active at almost 10%. Defined as persons who were in employment or currently actively seeking employment (including students).

5.12 However, Scottish Index of Multiple Deprivation (SIMD) 2012 data shows that 12.8% of Fife's working age population are employment deprived. Defined as proportion of people from the resident working age population who are unemployed or who are not in the labout market due to ill health or disability. Within Fife, Levenmouth has the highest proportion of working age population employment deprived (19.4%) whilst North East Fife has the lowest (6.4%). Chart 6 provides further details.

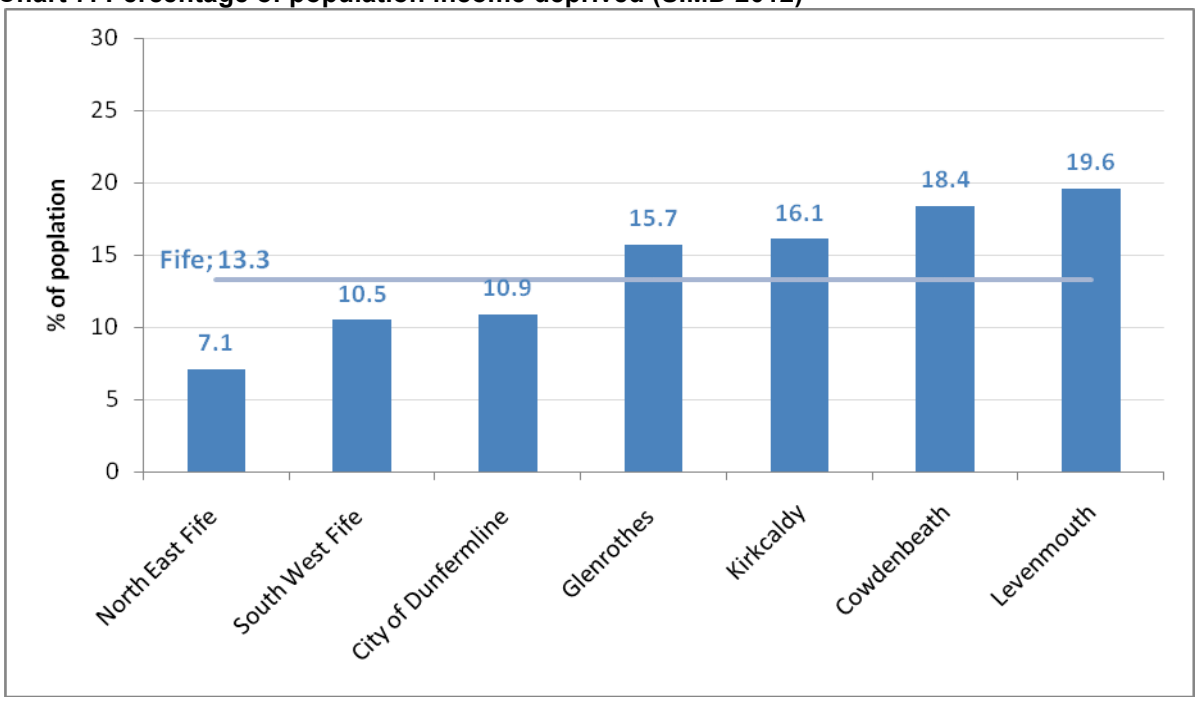
5.13 SIMD (2012) data shows, also, that 13.3% of the Fife population are income deprived. Defined as the number of people, both adults and children, who are receiving, or are dependent on, benefits related to income or tax credits. Within Fife, Levenmouth has the highest proportion of population income deprived (19.6%) whilst North East Fife has the lowest (7.1%). Chart 7 provides further details.

Chart 6: Percentage of working age population employment deprived (SIMD 2012)



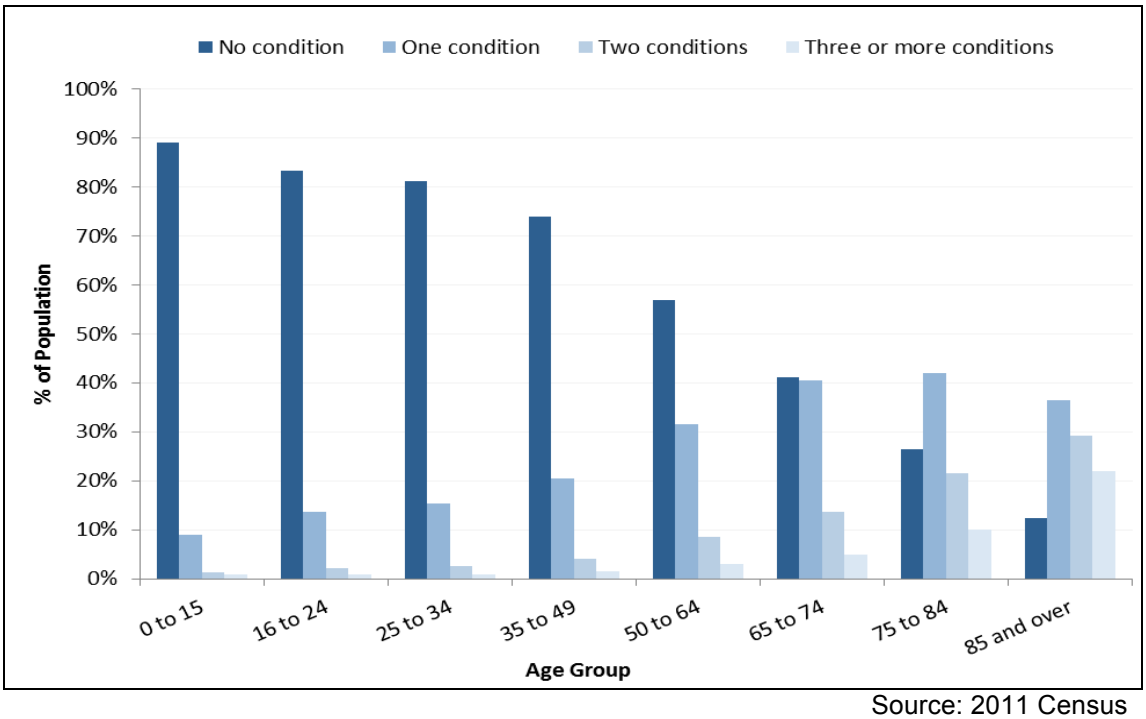
Source; SIMD (2012)

Chart 7: Percentage of population income deprived (SIMD 2012)



5.14 **Almost one third of people in Fife report living with one or more long term health conditions.** At the 2011 Census, the majority (82%) of Fife's population rated their general health as 'very good' or 'good'. However, almost a third (32%) reported that they had one or more long term health conditions. The presence of one or more health conditions increased significantly with age, with 20% of people aged 85 and over reporting they had three or more long term health conditions and only 12% reporting they had no long term health conditions (Chart 8). A long term condition is any condition(s) which has lasted, or is expected to last at least 12 months.

Chart 8: Self reported presence of health conditions by age group



Source: 2011 Census

5.15 Of those, who had reported one or more health conditions, 63% stated that their activities were limited by these conditions. Reports of activities being limited by a long term health problem or disability were more common amongst older age groups. 88% of those aged 75 and over reported their activities were limited as compared to 42% of those aged 16-24.

5.16 11% of the Fife Census population reported that their day to day activities were limited "a little" or "a lot" (9%) by a long-term health problem or disability (including problems related to old age) that had lasted or was expected to last at least 12 months.

5.17 **Fife's carers are providing more care.** Just under ten percent of the Fife Census population living in households reported that they provided unpaid care to someone either within or outwith their household due to the person's long term ill health or disability or problems relating to old age. This was similar to the national average of 9.3% and had not changed since the 2001 Census.

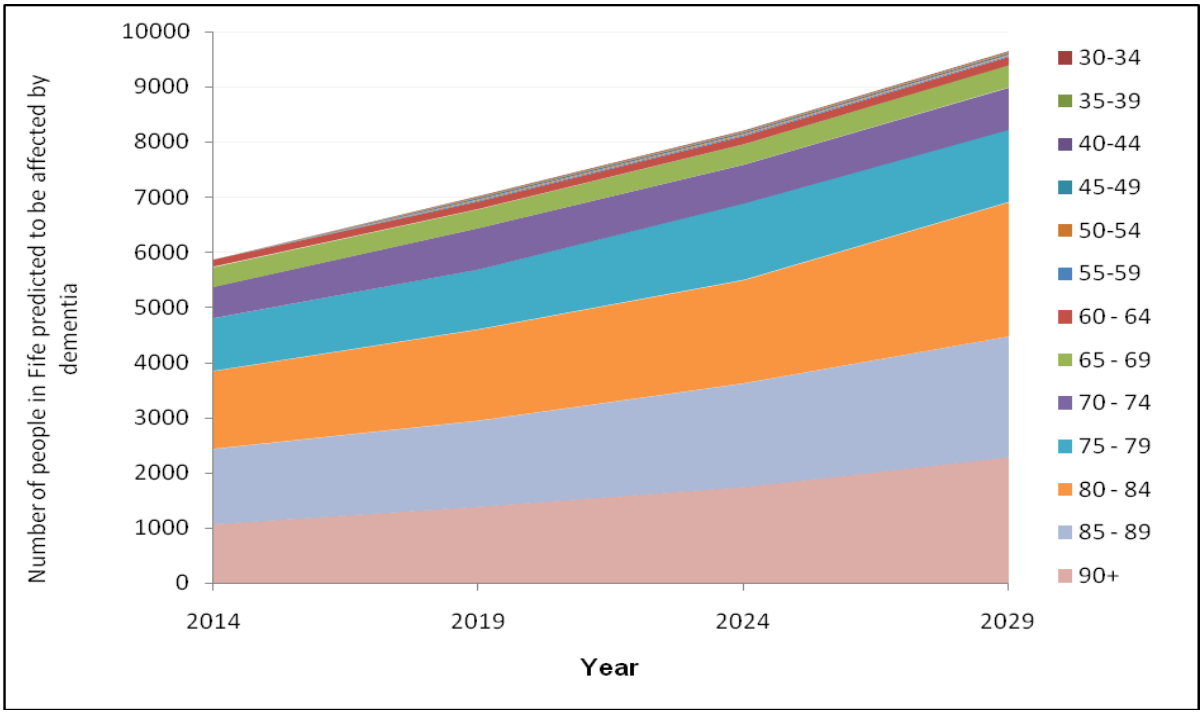
5.18 Although the overall proportion of the population providing care remained the same, there was an increase in the number of hours in which care was provided . Between 2001 and 2011, both the proportions of carers providing between 20-49 hours per week and 50 hours or more per week had increased from 12% to 17% and from 22% to 26% respectively.

5.19 The increasing hours of providing unpaid care was associated with poorer ratings of self assessed health - only 60% of carers who provided 50 or more hours of care a week rated their health as good or very good compared to 71% of those providing 20-34 hours and 83% of those who provided no care.

5.20 **More people will be affected by Dementia in future**. The World Health Organisation (WHO) stateds that, “dementia is one of the major causes of disability and dependency among older people worldwide” and that “dementia has physical, psychological, social and economical impact on caregivers, families and society”.

5.21 In Fife, it is estimated that, currently, 5,961 people are affected by dementia. With more people living longer, this figure is predicted to increase over the next 15 years by approximately 3,600 (Chart 9). The impact of this increase in the number of people affected by dementia, on the people themselves, their carers and families and on services providing care and support cannot be underestimated.

Chart 9: Number of people by age group in Fife predicted to be affected by dementia, 2014 – 2029



Source: Eurocode, Harvey, NRS

Summary

5.22 Our analysis shows that, in line with the rest of Scotland, people in Fife are living longer. However, whilst this is good news, it provides challenges in terms of an ageing population and the incidence of frailty including dementia.

5.23 In addition, our analysis shows that there are differences in life expectancy and deprivation factors across our localities which can impact on health and wellbeing.

6. UNDERSTANDING OUR SYSTEM

6.1 There are many component parts which are crucial to delivering health and social care in Fife. This section aims to describe these parts and the importance they play in an integrated health and social care system for the people of Fife. This plan will build on the successful innovations that have achieved both positive impacts for people who use our services and have contributed to meeting the National Outcomes.

6.2 This draft plan has been developed by our Partnership. Colleagues from general practice, acute and community health services, staff and the general public, Fife Council social work, housing and community planning officers and the Third and Independent Sectors have been involved in a range of events and workshops and through membership on the SPG.

Our Services

6.3 Section 2 summarises the services included in Fife's Integrated Health & Social Care Partnership. As part of developing this draft strategic plan, we issued a template to service managers seeking information on current activity, capacity and demand and views on current challenges and future priorities.

6.4 There is a lack of capacity and demand information on community health and social care services. This is due in part to national data collection requirements, which focus attention on particular services, and, consequently, has formed the basis of collecting local data.

6.5 There is national recognition that community health data is underdeveloped in comparison to acute and hospital based data and, similarly, social care data requires to be developed. In order to address this matter, two national project boards have been established; one to develop community health activity and a separate one to develop social care data with core data sets being identified for both. Data from this work will not be available in time to inform this plan.

6.6 In terms of current challenges and future priorities for Fife, the common themes, fed back by service managers, are:-

Current challenges:

- Demand for services is increasing due to a variety of reasons (changing demographics, improved life expectancy, public expectations).
- We are set up generally to be reactive.
- There is a lack of coordination and a client can receive multiple visits in one day from a series of health and social care services.
- Because of this, it is difficult for people to have quality relationships with staff working with them.
- Hours of service operation do not always match the person's needs and often their carer(s) and services are unaware what else is available in the local area which might be of value and assistance for the person needing help.
- Emergency hospital admission is seen often as the only option available.
- Due to increasing demand, the services' natural response is to concentrate on those with higher level needs. This works in the short-term but is not a long-term solution to the changing patterns of disabilty and frailty in the population.
- Because of the focus on high level need, there are areas of unmet need and waiting lists for some services.
- Alongside the service delivery challenges, we have the challenge of bringing together organisations with different cultures and histories.

Future Priorities:

- We need to reframe our thinking and recognise that the future will be radically different from the past if we are to meet these challenges.
- We need to review the skill mix and support staff structures.
- Better use should be made of assistive technology.
- We need to improve and streamline referral processes.
- We need to reduce duplication.
- Services should focus more on prevention and anticipatory care.
- There is a need for extended hours and/or overnight service provision.
- There is a need to support and develop staff so that they develop a new common culture and work collaboaratively to deliver new models of care based on personal outcomes.

Views of Our Staff and Public

6.7 A series of staff engagement events took place over the past year aimed at Health and Social Care staff with responsibility for delivering or supporting the delivery of front line services. The common themes from staff, who attended and contributed to these events and the development of this plan, are:

- Demand is increasing;
- Public expectations are rising;
- Complexity of presenting cases is increasing;
- We have recruitment difficulties in some professions and/or in specific geographical areas;
- We need to continue to review and develop skills and the skill mix;
- We need career progression frameworks for generic care assistants;
- We need to take the opportunities, which integration can offer, to work differently, and more flexibly than ever before. We would do this by utilising skills and experience available within our communities and our partner structures and organisations.
- This is a major culture shift and will take time to embed. Using a "One system, one budget" approach will help facilitate this shift as will a leadership style which is willing to share power and learn with us.

6.8 A range of methods and arrangements are in place to continuously seek the views of both the public and staff as Integration moves forward. This includes engaging with the Public Partnership Forum and Public Reference Group; involving service users and carers in service planning; and holding organised public engagement events.

6.9 Common themes, raised by our public through these mechanisms, are that they want to:

- Be in control and treated with dignity and respect;
- Feel part of a tight-knit team that works with them in tacking obstacles to enable them to get the right support they need;
- Be able to tell their story once;
- Get support at the right time and not have to wait for a crisis;
- Know that their community, family and carers have the support and information to help them;
- Go into hospital only when they need to and have access to quality support in their local community; and
- Play an active role in managing their own health and wellbeing.

Our Joint Workforce

6.10 Delivering health and social care services involves a large workforce across all sectors.There are a number of future challenges but, also, opportunities facing our own and partner organisations in terms of workforce planning and development. This requires us to take into account:

- The changing philosophy and culture of care, building quality relationships between staff and people using services;
- The changing philosophy and culture requires a re-alignment of skills and staff to working differently;
- The profile of our workforce e.g some professions have an ageing workforce profile which may result in significant numbers reaching retirement age around the same time;
- The future workforce e.g. younger people may not be as highly qualified and may require supported entry routes and younger generations may seek different working patterns from those traditionally found in the health and social care sectors e.g. part time or less weekly variations;
- Differences in terms and conditions including remuneration for staff of similar levels between organisations;
- Competition from other sectors and industries or other local authority and NHS areas; and
- Recruitment and appointments in one part of our system can be to the detriment of another part i.e. we are competing for the same workforce.

6.11 Solutions put forward by our staff include:

- Making our employment opportunities attractive to the potential workforce;
- Ensuring clear structures that offer career progression;
- Aligning, matching, developing and coordinating our skills and workforce across the Partnership;
- Setting up a Health and Social Care Academy through which to develop a more generic care assistant role across the Partnership with transferable skills; and
- Exploring the benefits of the housing contribution to the Partnership.

Our Partners - General Practice

6.12 By its nature General practice is patient focussed with an emphasis on positive outcomes for the individual. GPs and practice staff play an essential role in anticipatory care; preventing hospital admission; and maintaining people with complex needs at home for as long as possible. Health & Social Integration offers the opportunity for a renewed focus on the central role of primary care teams and how we develop and commission services around localities.

6.13 Our localities and local planning arrangements are established around natural communities made up of a number of primary care populations. GP practices have started to come together to discuss how they might organise themselves into collectives or clusters to support the development of new models and deliver services and care plans in partnership with local statutory and non statutory providers in care and local communities.

6.14 The collectives will help to build a different relationship with local communities and a joint and realistic understanding and agreement of the local care priorities. Funding of £80,000 from the Integrated Care Fund has been made available to support this development work in primary care.

Our Partners - Independent Sector

6.15 The Independent Sector in Fife provides a range of services e.g. Residential/Nursing Care Homes, Care at Home Services and 24/7 support for people with complex care needs.

6.16 Scottish Care has currently a development role within Fife, supported by the Older People's Change Fund and now the Integrated Care Fund. The Development Officer has a remit of supporting the work of the Independent Sector to build on existing relationships and to consider models of care which support the strategic plan.

6.17 Scottish Care is represented on the Shadow Integration Joint Board and the Strategic Planning Group. It has an essential role in ensuring that the views and interests of the Independent Sector are represented and reflected in this plan.

6.18 Our plan is founded on the principle of improving outcomes for people whilst recognising the need to make the best possible use of public funds. Scottish Care is committed to supporting a quality orientated, Independent Sector which offers real choice and value for money. Its aim is to create an environment in which care providers can continue to deliver and develop the high quality care that communities require and deserve.

6.19 Scottish Care has been involved in developing and testing new models of care in the care home sector; these include the provision of Short Term Assessment and Rehabilitation (STAR) beds.

Our Partners – The Third Sector

6.20 The Third Sector makes a key contribution to our current system and, in future, will play a greater part. Currently, we commission services from a number of Third Sector organisations. Funding in 2014/15 amounted to over £7m. **Appendix F** provides details of those organisations with a description of the services provided.

6.21 The Third Sector supports the strategic direction of Health & Social Care Integration through a range of means including, for example, joining up and activating diverse parts of the Third Sector and volunteers to support health and social care outcomes; developing a strong Third Sector engagement strategy to support strategic planning; and joint commissioning and supporting the exploration of the development of the Third Sector role in enhancing prevention, self-management and co-production.

6.22 There are a number of initiatives which demonstrate this support. These include supporting people to volunteer in local shops and charities; assisting people to manage their own care through the Self Directed Support (SDS) agenda; and supporting people to access social activities in their communities.

6.23 There is an evidence base which demonstrates that volunteers are making a significant contribution towards service delivery in Scotland. Close ties between Third Sector organisations, communities and volunteers have facilitated the initiation and organisation of this informal service provision.

6.24 In some ways, the Third Sector is better equipped to overcome the challenges facing public sector health and social care services. It is important to note, also, that many of the pressures facing the public sector are affecting the Third Sector too.

6.25 The Third Sector continues to demonstrate a strong commitment to working in partnership through H&SCI. This is evident in the number of strategy groups that the sector contributes towards, supports, operates and promotes. These include its involvement in the SDS agenda, the Keys to Life Strategy and the Public Social Partnership (PSP).

6.26 We need to continue our collaborative working and community involvement to drive progress; to improve sharing of technology; to develop a work force trained to work in any community service; and to ensure parity of remuneration and terms and conditions.

Developing Communities and Community Resilience

6.27 The physical, mental and social wellbeing of the local population is influenced by the wider determinants of health; these include material deprivation, employment/unemployment, education, housing and the environment.

6.28 Not everyone experiencing health inequalities lives in the most deprived areas. A range of issues can have an impact including income, work conditions, education and skills, living conditions, as well as individual characteristics and experiences such as age, gender, disability and ethnicity.

6.29 However, building individual and community resilience can mitigate the impact of inequalities. Building resilience to cope with everyday challenges and support improved health and wellbeing is most likely to attain the greatest benefit. The starting point is to identify the assets that exist in both individuals and communities.

6.30 There is increasing evidence that using an asset based approach can enhance the quality of collected information by focusing on the perceptions held by local people. This leads to the development of support for what people themselves say they need. This approach encourages a partnership approach which involves local people in decision making about service delivery and empowers them and increases independence rather than being passive recipients of services.

6.31 Engaging the population is fundamental to building resilient individuals and communities. Effective involvement helps to ensure that services are responsive to need and are developed in a way which ensures that they are accessible and acceptable and, thereby, reduces non-attendance and subsequent costs. Involving people in decisions about them and having control can boost self-confidence and self-efficacy as well as improving decision making.

6.32 There is a wealth of evidence that demonstrates how the use of low level community and social support can increase greatly a person's potential to better manage their health and wellbeing so that they stay and live well in their homes and communities for longer.

6.33 There is a real willingness and enthusiasm within communities and the Third Sector to develop, build on and release capacity to ensure that the support is available to people who need it. We recognise that to work and engage effectively and meaningfully with communities:

- Takes a significant investment of time and resources;
- Must be maintained over the longer term to be effective; and
- Requires a specific skill set to undertake this effectively.

6.34 However, there are many mutual benefits to be gained since engagement, inclusion and participation are key to the development of our local plans as is an ethos of openness and transparency.

6.35 A key priority for localities is the enhancement of the capacity and release of the existing potential of individuals and communities to maintain and improve their health and wellbeing. There is a focus on working with people to identify what really matters to them and to help them to set goals and find their own solutions.

Future Relationships and Direction

6.36 **Our Partners:** We will continue to develop stronger links and share learning with the wider Fife Partnership so that we are able to better collaborate and align appropriate resources to the health and well-being needs of our communities.

6.37 **People who use our Services**- We will offer choice and control and develop self-management approaches locally in order to increase the confidence, independence and resilience of people within our communities.

6.38 **Our Communities** - We see our communities as environments filled with potential assets (people and places) that can be linked, empowered and supported to address the local priorities of their communities. We will aim to enhance and grow these assets to build the resilience that is essential within our communities.

6.39 We will work together to build capacity among individuals, community groups and organisations within their local areas for the benefit of their communities. Thereby, we will increase the knowledge, self-confidence and capacity of individuals to develop safely and support the well-being of their communities.

6.40 **Service Providers** - We will continue to work with all our partners by involving them in the planning, design and delivery of the new models of care. We will produce a full market facilitation plan which will inform providers of what our support and care plans look like.

6.41 A first draft market position statement has been produced (Appendix G). It provides a starting point for discussion between Fife's Health & Social Care Integrated Joint Board, local providers and other commissioning organisations. It contains information on:

- What Fife looks like in terms of current and future demography and service provision;
- The IJB's commissioning intentions; and
- The vision for how future services might respond to the changing needs for care and support .

6.42 This first draft statement will then be subject to further development and amendment once this draft plan is finalised. Our full Market Facilitation Plan will then be developed and will allow current and future providers to adapt to new models of care and the Plan will complement their business plans.

6.43 Our Partnership recognises the importance of its individual component parts to the delivery of this strategic plan and to the achievement of better outcomes for people who use our services. We know that the interdependencies and robust relationships are key to our success.

7. WHAT OUR PERFORMANCE DATA TELLS US

7.1 One of the main aims of Health and Social Care Integration is to ensure people, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community for as long as possible. There are several key measures which can be used to illustrate whether Fife is achieving these or not or how it is achieving compared to Scotland as a whole.

Supporting People at Home

7.2 Our aim is to support people to live independently at home for as long as possible and to shift the balance of care from institutional care to care at home or as close to home as possible in a community setting. The Local Government Benchmarking Framework shows that in 2013/14:-

- Fife supported 30% of people with intensive care needs so that they can remain at home compared to 35% for Scotland;
- 23% of older people with intensive care needs were supported at home compared to 35% for Scotland; and
- 2% of people needing social work support got to choose how their needs were supported compared to 6% for Scotland.

7.3 The latest homecare census figures (2014) show that 3,820 people were receiving home care services in Fife – approximately 28% were under 65 and 72% aged over 65. The tables below provide further detail in terms of client groups and distribution of hours.

Table 1: Client Group Breakdown

Client Group	2010	2011	2012	*2013	2014
People with dementia	138	151	100	78	400
People with mental health problems	243	206	218	210	270
People with learning disabilities	458	543	575	399	560
People with physical disabilities	1,116	990	829	2,101	850
Older people (2010 onwards)	2,613	2,355	2,411	1,238	1580
People in other groups	266	194	156	172	-
Total	**4,834**	**4,439**	**4,289**	**4,198**	**3,820**

Source: Social Care Survey 2014, Home Care Census

*Note: * Table 1, Charts 12 and 13 - In 2013, local authorities were asked not to include clients getting 24/7 care (168 hours) as Home Care clients, but rather as Housing Support clients. This has resulted in a drop in the overall hours of care provided in 2013.*

Table 2: Distribution of Hours Per Week Across All Client Groups 2014

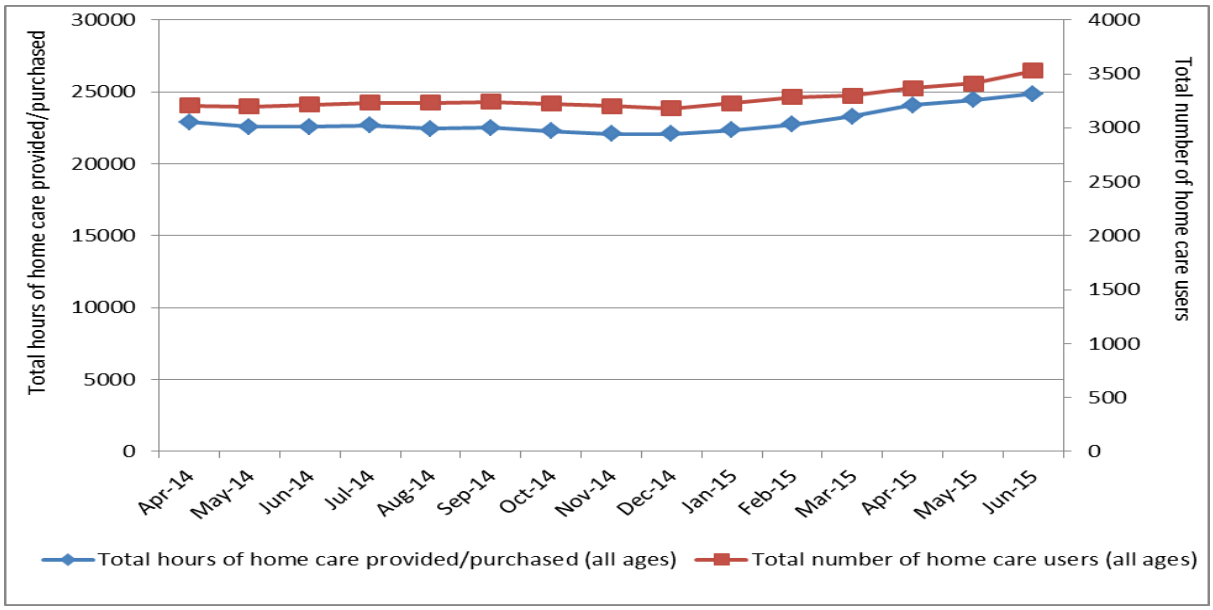
Local Authority	2 hours or less		Between 2 and 4 hours		Between 4 and 10 hours		10 hours or more		Total clients
	No. of Clients	% of total	No. of Clients	% of total	No. of Clients	% of total	No. of Clients	% of total	
Fife	590	15%	830	22%	1,240	32%	1,160	30%	3,820
Scotland	**9,640**	**16%**	**10,940**	**18%**	**19,460**	**32%**	**21,700**	**35%**	**61,740**

Source: Social Care Survey 2014, Home Care Census

7.4 The data in Tables 1 and 2 respectively, indicate that home care services are targeted to those with physical disabilities and older people and that over 60% of support provided is at a fairly intensive level of 4 hours or more. There are marked differences in the level of care package between the under and over 65s with someone aged under 65 more likely to receive a more intensive package to be supported at home.

7.5 Local data (Chart 10 below) shows that in recent months the total number of home care users (all ages) increased by approximately 400 in the first 6 months of 2015, whilst the number of home care hours provided/purchased increased by approximately 2,800 in the same time frame.

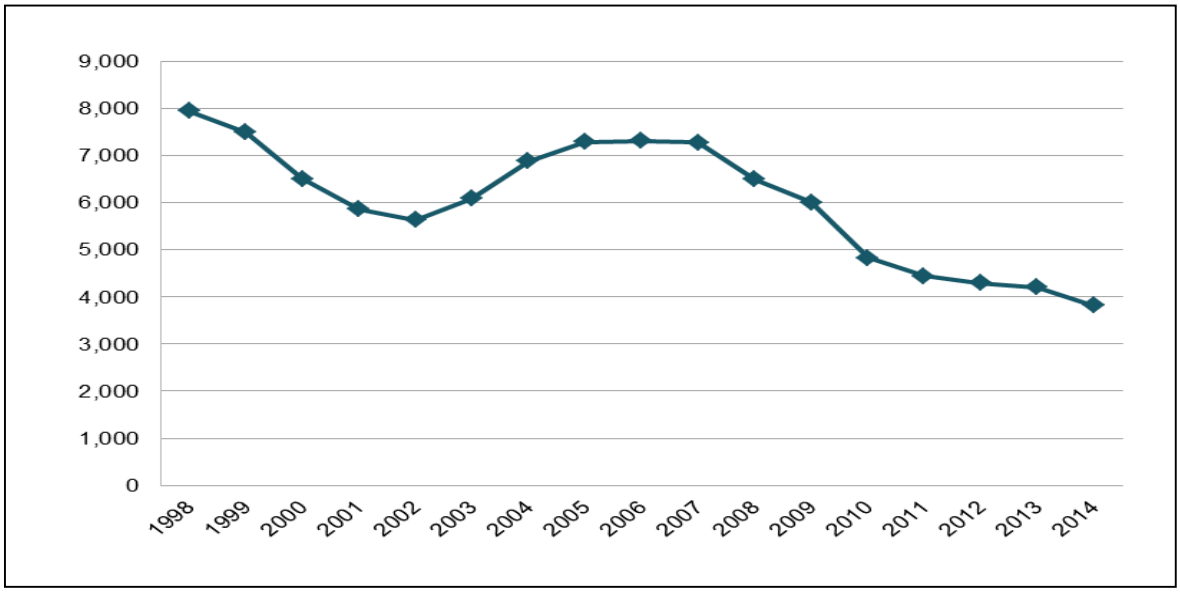
Chart 10: Home Care Users and Hours Provided



Source: Local Data

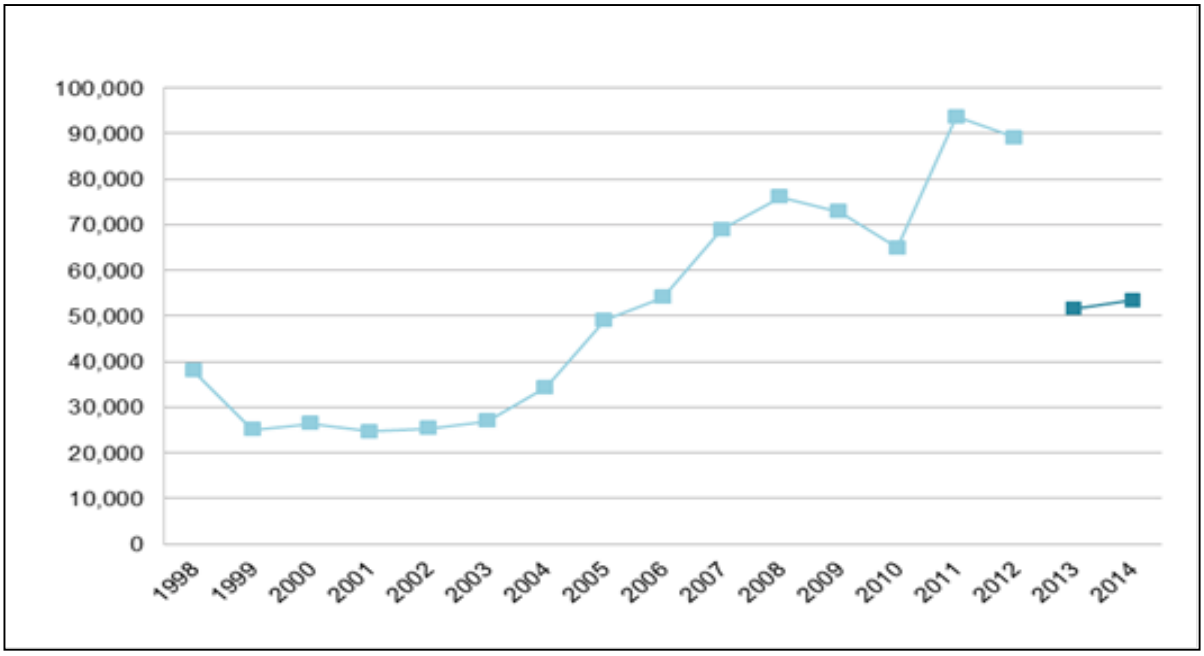
7.6 The charts below are taken from data from Social Care Survey 2014 (Home Care Census prior to 2013) and the key points from these are noted below each chart.

Chart 11: Number of home care clients (all ages) in Fife, 1998-2014



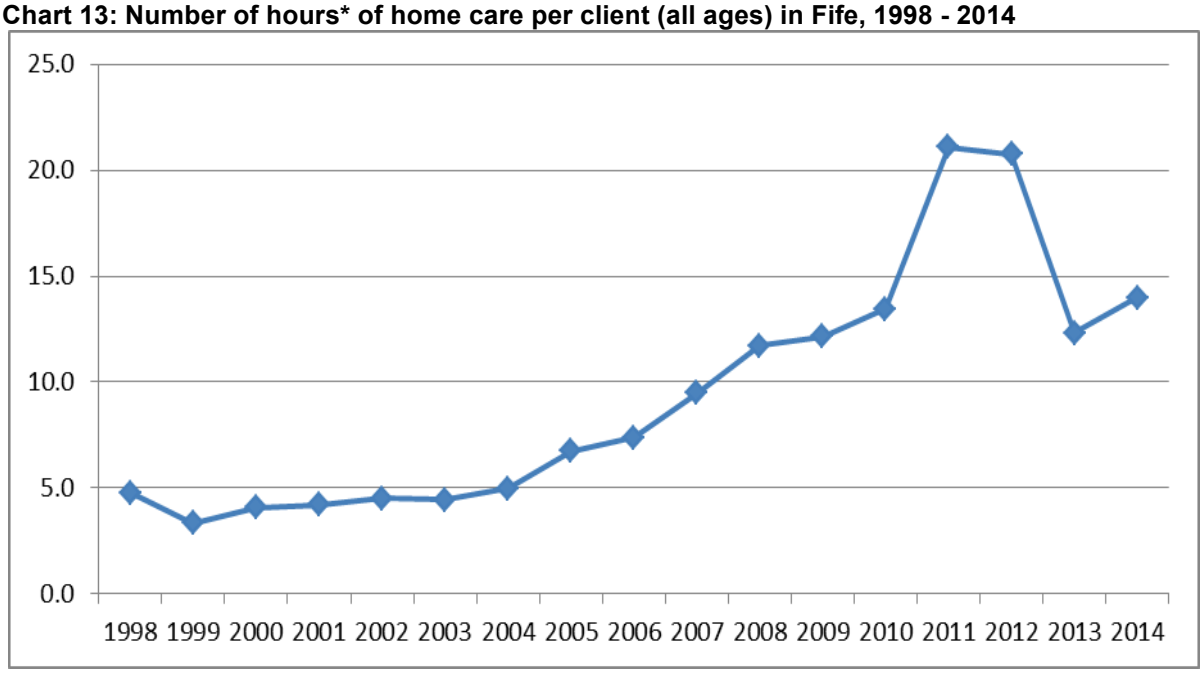
Key Point: *The number of people receiving home care (all ages) in Fife has decreased over time.*

Chart 12: Number of home care hours* provided/purchased in Fife, 1998-2014



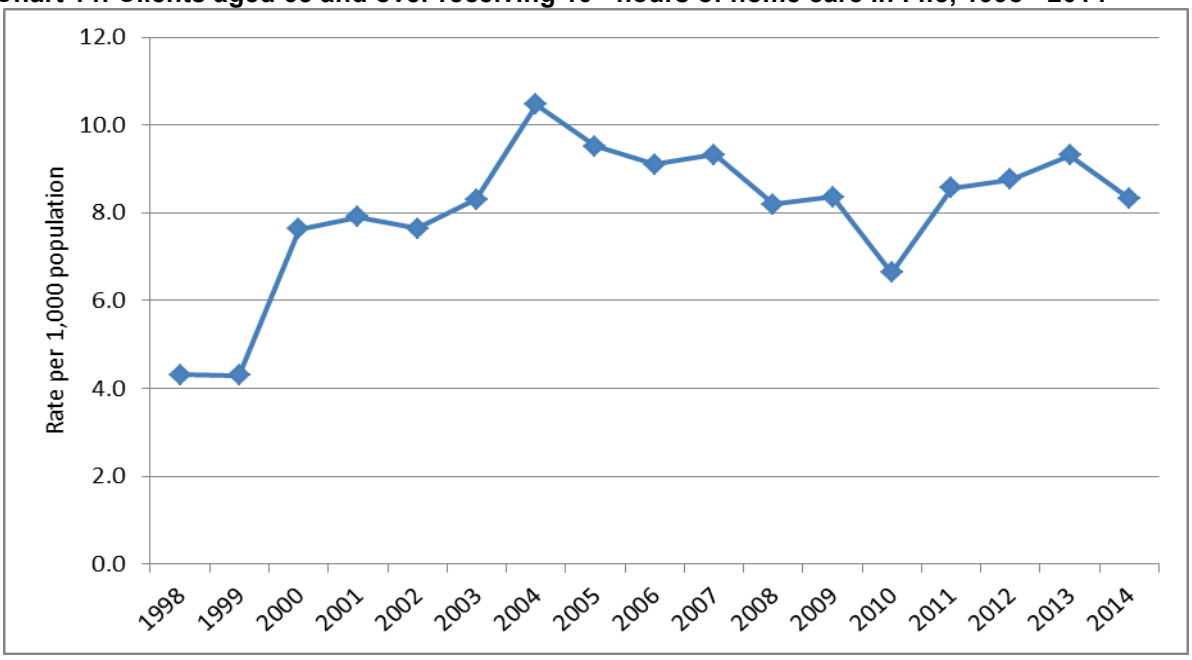
Key Point: *The number of home care hours provided/purchased has increased over time i.e. less people are receiving more home care hours.*

Chart 13: Number of hours* of home care per client (all ages) in Fife, 1998 - 2014



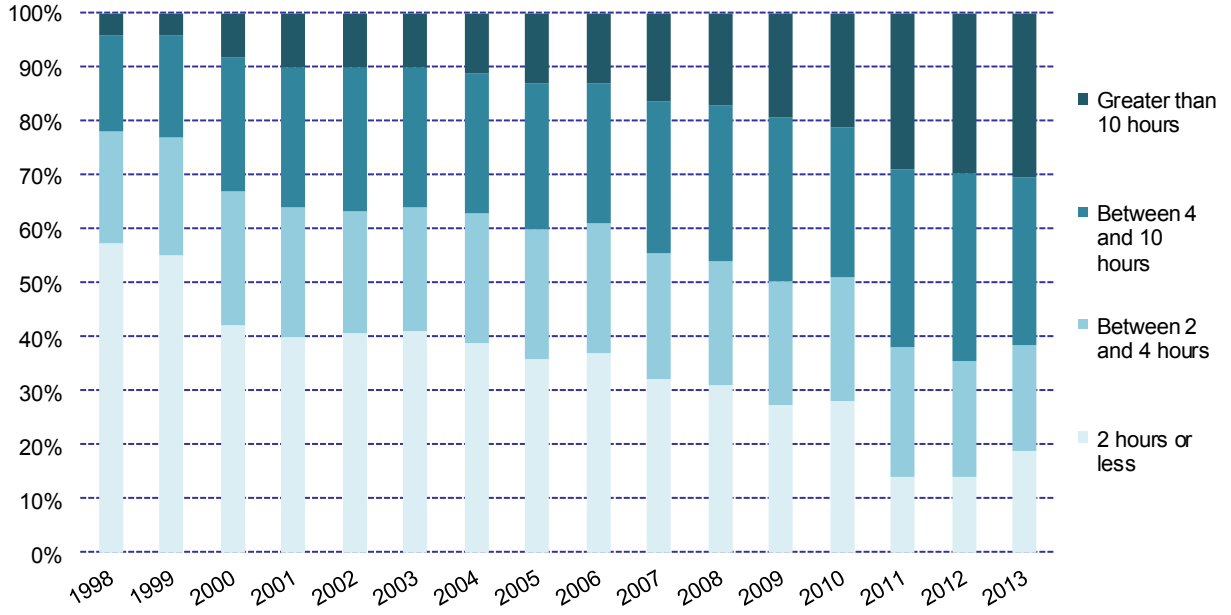
Key Point: *The number of hours of home care provided per client (all ages) has increased over time.*

Chart 14: Clients aged 65 and over receiving 10+ hours of home care in Fife, 1998 - 2014



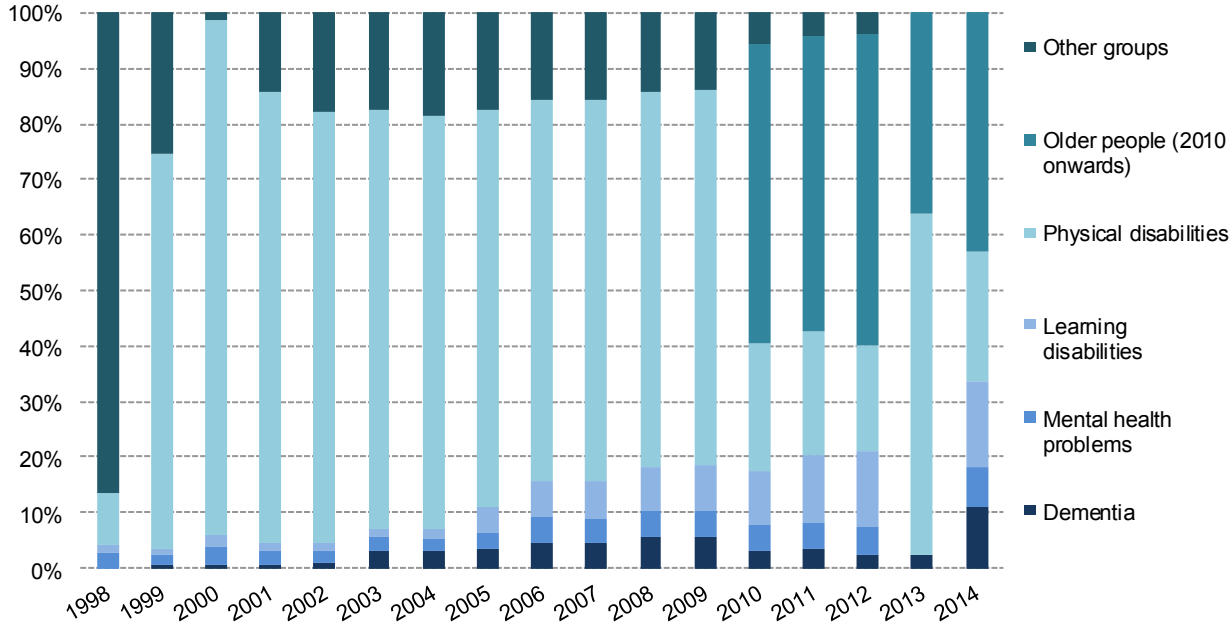
Key Point: *The number of clients aged 65 and over who receive 10 hours or more of home care has fluctuated between 8 and 9 clients per 1,000 population over the last ten years*

Chart 15: Distribution of home care hours received for all clients in Fife, 1998-2014



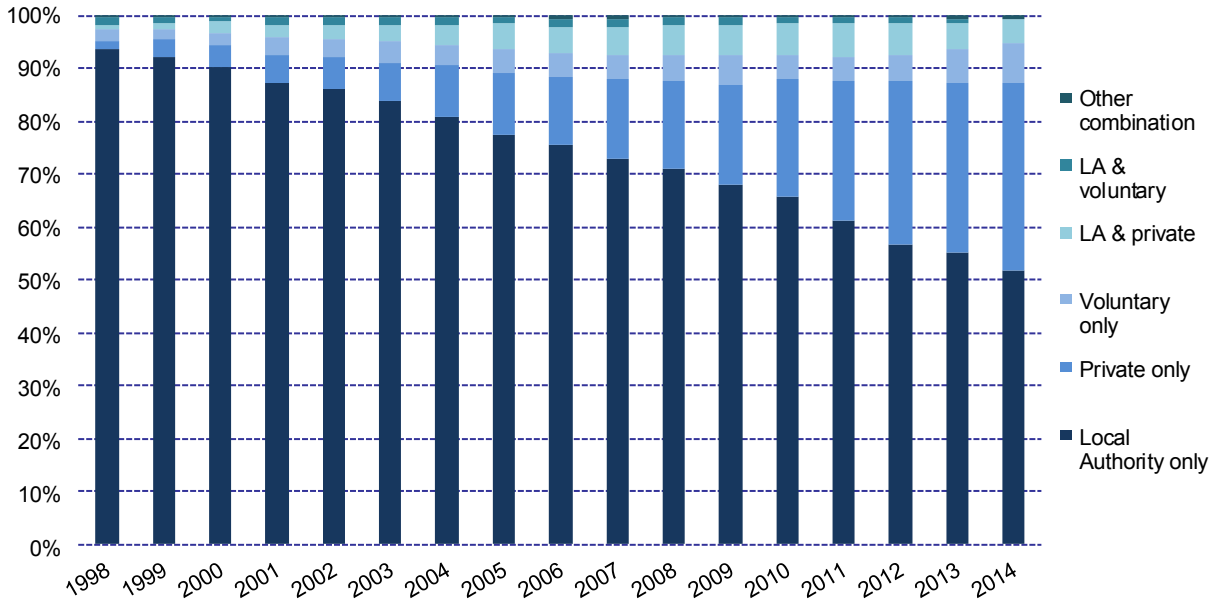
Key Point: *The proportion of people receiving 4 hours or more of home care has increased over the last ten years.*

Chart 16: Client group breakdown of all clients receiving Home Care, 1998-2014



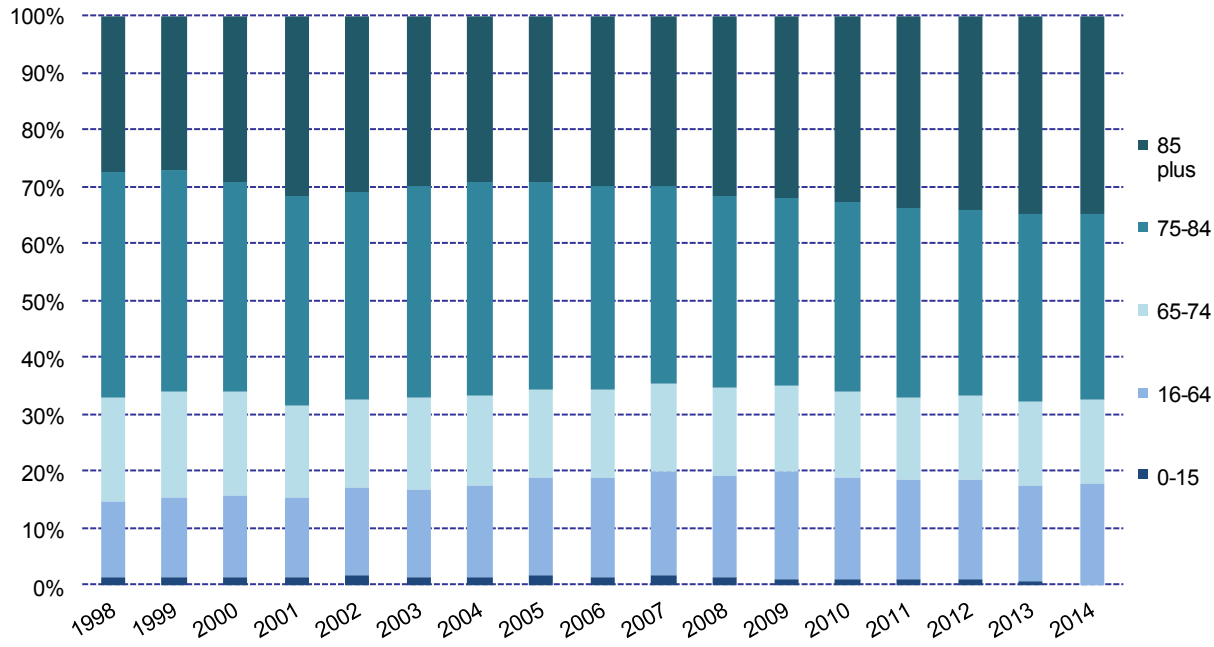
Key Point: *Data only started to be split appropriately in 2010 to show older people, but they are main recipients of home care followed by people with physical disabilities (although this seemed to switch in 2013 with only 30% of home care clients being older people and 50% of clients having physical disabilities).*

Chart 17: Number of home care clients by sector of provider, 1998-2014



Key Point: *There has been a shift towards externally provided home care over the last ten years.*

Chart 18: Age breakdown of all clients receiving home care in Fife, 1998-2014



Key Point: *Older people have been, and remain, the main client group receiving home care in Fife.*

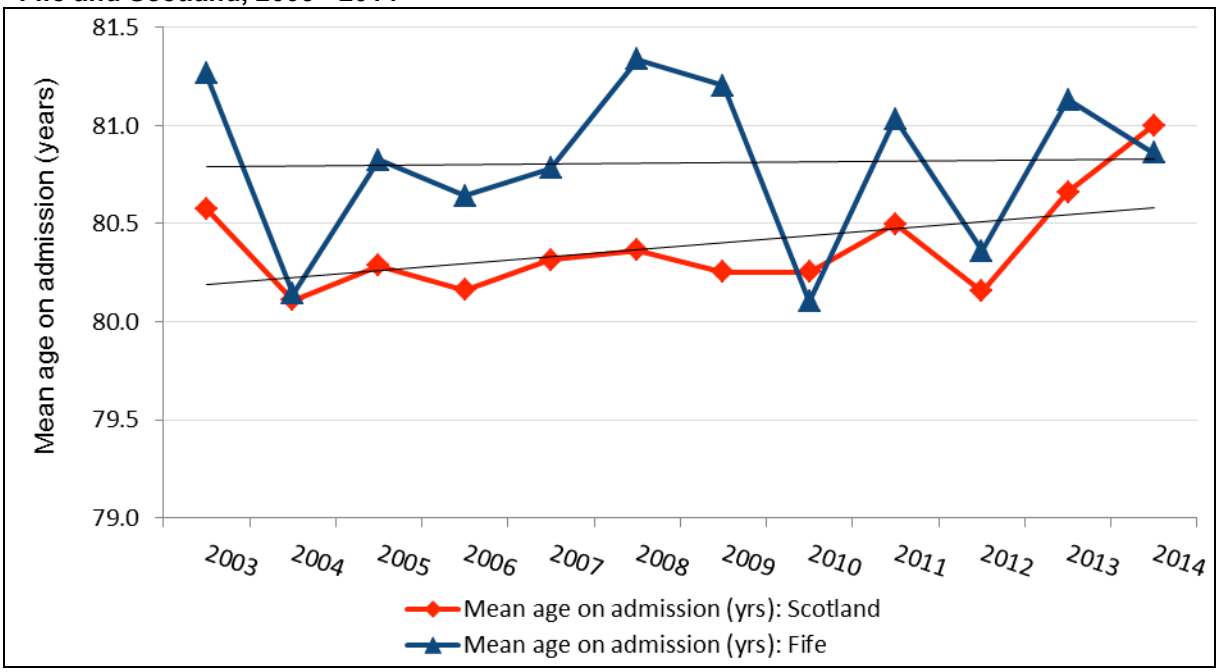
Living in a Care Home

7.6 Whilst our aim is to support people to live independently at home for as long as possible, we recognise that for some people a care home will be the most appropriate place to provide the necessary care and support.

7.7 Data from the Scottish Care Home Census 2014 shows that:

- In 2014, the mean age of older people on admission to a care home was 80.9 years (Chart 15) and was similar to that for Scotland (81 years);
- The total numbers of short stay and respite care residents (older people) increased from 68 at March 2003 to 116 at March 2014, an increase of 70%;
- 51% of long stay residents in care homes for older people had a formal diagnosis of dementia. This is an increase of 50% since the March 2005 census; and
- Over the same time period, the percentage of residents, who have been identified as having dementia but not formally diagnosed, has reduced from 13 per cent to 7 per cent.

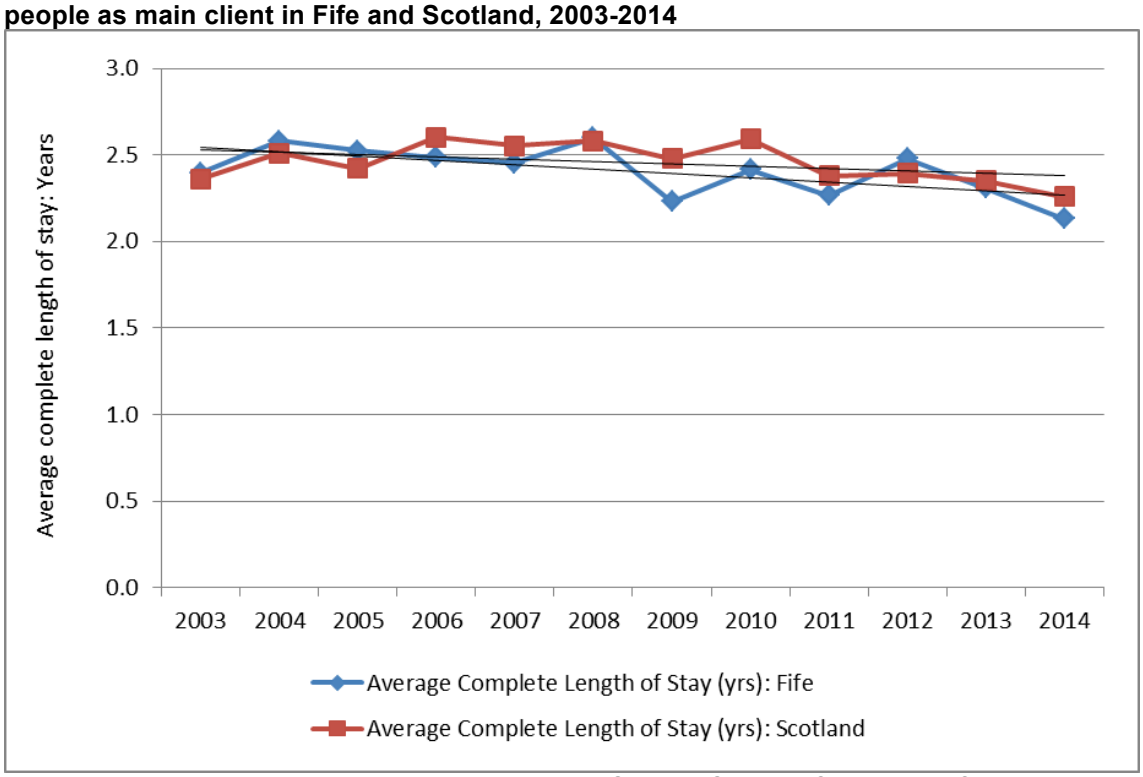
Chart 19: Mean age of people admitted to care home (main client of older people) in Fife and Scotland, 2003 - 2014



Source: Scottish Care Home Census 2014

7.8 When looking at the average length a person stays in a care home as a long stay resident, this reduced slightly between 2003 and 2014 from 2.4 years to 2.1 years in Fife as compared to 2.4 years to 2.3 years in Scotland as a whole (Chart 17).

Chart 20: Average length of stay for long stay residents in care homes with older people as main client in Fife and Scotland, 2003-2014



Source: Scottish Care Home Census 2014

7.9 Anecdotal evidence suggests also that people, who are admitted to a long term care setting, are more dependent and frailer. Unfortunately, at the present time, there is no quantative evidence to support this theory. However, work led by JIT using the Augmented IORN (Indicators of Relative Need) in a care home setting is currently underway to determine whether or not the relative dependency of care home residents has increased over the last few years. Results from this work are anticipated in the near future.

7.10 **Care Homes for Other Main Client Groups –** In March 2014**,** 32 adults with learning disabilities were long stay residents in care homes whilst there were 30 adults with physical disabilities who were long stay residents in care homes .

Preventing Unnecessary Hospital Admission

7.11 Another key aim of H&SCI is to prevent unnecessary admission to hospital. However, when an admission cannot be avoided, integrated patient flow and pathways should ensure that there are no unnecessary delays to discharge.

7.12 Day of care audits in 2014 concluded that up to 25% of patients in the acute hospitals and up to 50% of patients in community hospitals did not require to be in a hospital setting. For these patients, the length of stay in hospital was prolonged frequently. In the acute hospital, 70% of those patients had a length of stay longer than 7 days and in community hospitals, 55% of patients had a length of stay of over 50 days.

7.13 Extended lengths of stay can have a detrimental effect on the individual by leading to reduced confidence and independence as well as an increased risk of falls or acquiring an Healthcare Associated Infection. Such delays also impact, also, on the ability of the facilities to provide timely treatment to those who need an inpatient episode.

7.14 Work has commenced to reduce lengths of stay in community hospitals. There is a specific focus on health and social care discharge processes through using community capacity differently to enable people to return home as soon as they are ready and through reviewing how community hospitals are used.

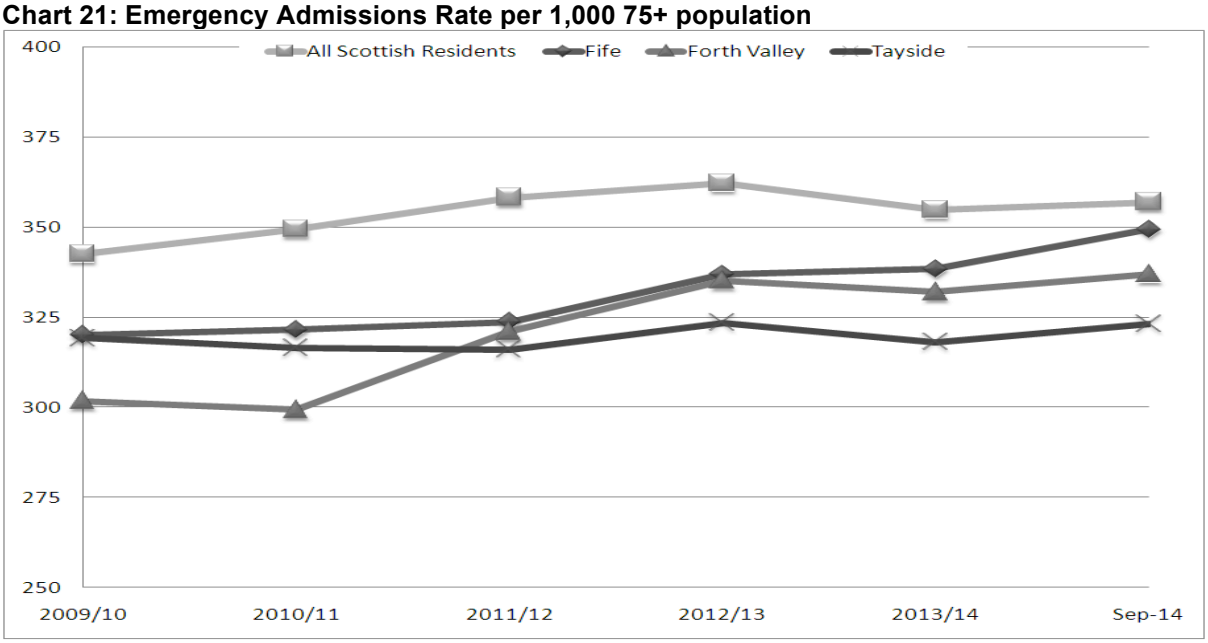
7.15 **Health, Equality, Access and Treatment Targets (HEAT) -** NHS Fife has a number of standards and targets against which it is monitored by the Scottish Government. These include emergency admissions for those aged 75 and over and delayed discharges.

Emergency Admissions 75+

7.16 An emergency admission to hospital can be a time of stress and anxiety both for the patient and for relatives and friends. Evidence shows that older people, who are admitted to hospital as an emergency, are more likely to stay longer than is clinically necessary once their treatment is completed. In turn, this is particularly bad for their health and independence.

7.17 Although consistently below the Scottish average, the Fife rate of emergency admissions for people aged 75 and over increased by 9.2% from 2009/10 to the 12 months ending September 2014 whilst the rate for Scotland as a whole increased by 4.2%.

Chart 21: Emergency Admissions Rate per 1,000 75+ population



Source: ISD Scotland Linked SMR01

7.18 In terms of emergency bed day rates for people aged 75 and over, local analysis shows that there a 9,9% reduction in the rate between 2009/10 and September 2014 and this decline was similar to that for Scotland as a whole.

Delayed Discharges

7.19 After hospital treatment is complete, patients should not wait in hospital for care and services to be available. Waiting unnecessarily in hospital may lead to poor outcomes for the person; is an ineffective use of scarce resources; and potentially denies an NHS bed for someone else who might need it.

7.20 Being in hospital disconnects people from their family, friends and social network and can result in a sense of isolation, loss of confidence and depression. Visiting hospital for a long period may heighten an already stressful situation for family carers.

7.21 Older people experience functional decline as early as 72 hours after admission and are more likely to have an episode of delirium or infection. The risk of a poor outcome increases every time a frail patient is moved from ward to ward.

7.22 There were 86 people recorded as having their discharge from hospital delayed in June 2015. Of these, 13 people were delayed between 2 and 4 weeks and 22 people were delayed for 4 weeks or more.

7.23 Fife had the highest number of delayed discharges in Scotland over the 3 month period from May to July 2014 and, with the exception of February 2015, was higher than the monthly Scottish average.

7.24 The are various reasons for people's discharge from hospital being delayed and include waiting for assessment of need; awaiting the sourcing of a care package; or undergoing legal guardianship processes. When exploring the impact of delayed discharges on NHS Services, recording the number of bed days lost to delayed discharges is seen as a more accurate whole system measure. In June 2015 , Fife's 86 delayed discharge patients accounted for 2,299 bed days.

7.25 Reliably achieving safe, timely and person centred discharge from hospital to home is an important indicator of quality and a measure of effective and integrated care. Fife Health & Social Care Partnership has made significant efforts to reduce the number of people whose discharge from hospital has been delayed and will continue to prioritise this work.

Last 6 Months of Life

7.26 Percentage of the last 6 months of life spent at home or in a community setting focuses on measuring the impact of "Living and Dying Well: A National Action Plan for Palliative and End of Life Care in Scotland". It focuses, in particular, on its objective to "produce achievable and measurable changes which will ensure quality improvement and enhance patient and carer experience".

7.27 National statistics show that for people of Fife who died in 2012/13, approximately 91% spent the last 6 months of life either at home or in a community setting. This figure has remained constant since 2008/9 and is similar to the national average.

Conclusion

7.28 Our performance data tells us that we can do more to improve outcomes for people and that hospital care is being used too frequently for people who would be better cared for either at home or in a community setting. This needs to change because hospital care can be a risk to the likelihood of people's long-term recovery and it is not what people want.

DRAFT STRATEGIC PLAN FOR FIFE 2016-19: PART 2

8. TRANSFORMING SERVICES – MAKING IT REAL

Context and the Case for Change

8.1 The previous sections presented the variety of reasons why we need to change the way in which we deliver services. Despite progress towards a more joined up service approach, some inefficiencies remain in terms of integrated working. By integrating services, there will be opportunities to improve personal outcomes; provide care at home or in a homely setting; and, ultimately, enhance the experience of the people who use services and their carers.

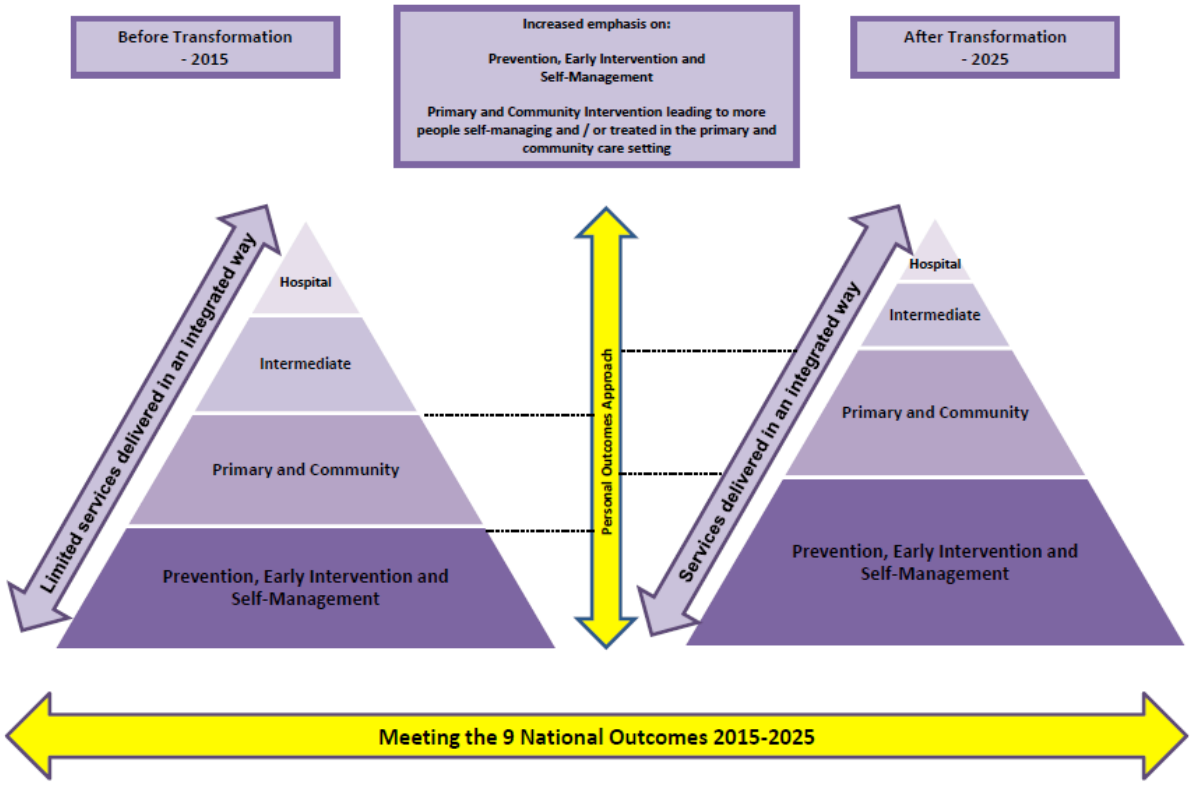
In summary, we know that:
• We have more to do to shift the balance of care and service provision towards more community based services; • We need to reduce the reliance on admissions to nursing and residential care; • When people do become ill and their mobility or functioning is reduced, they should be supported to regain their health and independence as far as possible using personally-defined outcomes as the goals around which support is configured; • Some people, including those at the end of their lives , end up in hospital when they could be supported at home if a range of community based integrated services were available; • Some people experience delays in discharge arrangements and, consequently, lengthy stays in hospital can result in reduced confidence and less likelihood of independent living; • We have stark differences in health inequalities in relation to healthy life expectancies across our localities and communities of interest; • We need to provide information, advice and support (preventative and anticipatory) to enable people to lead healthier life styles and to remain as independent as possible; • Demand for services is increasing and we have waiting times for some services; and • The short to medium term public funding position is challenging.

8.2 Transforming the way in which we deliver services is expected to reduce reliance on hospital services; lead to improvements in achieving the Nine National Outcomes for Integration; and empower people to manage their own conditions through the increased provision of advice, support and care in primary and community settings.

8.3 We have considered national strategy and policy and have reviewed and assessed local information, including taking into account the views of our staff and the public, in order to agree our long term Strategic Priorities. In turn, these allow us to identify our Commissioning Intentions for 2016-2019.

8.4 The first period of this plan (2016/19) will start the process of change and transformation. Figure 3 below illustrates the model and direction of travel. This is directly in line with national policy and reflects what the people and staff in Fife have said throughout the development phase of this plan. All the proposed changes to achieve what is expected in 2016-19 will contribute to the transformation of our service delivery model below.

Figure 3 – Model Direction of Travel



8.5 The Strategic Priorities and Commissioning Intentions, set out for the period of this plan, are based on best available information, both local and national. This learning continues to emerge and it is recognised that there is often limited published evidence to support decision making at this time. However, the overall direction of travel is clear from the policy, the staff and the people who use services. All the proposed changes will be evaluated on an ongoing basis in order to assess their impact on outcomes for people and their contribution to the whole system.

8.6 In order to ensure that there is more choice and support available to people so that they achieve their personal outcomes, many changes reflecting national and local strategies have been agreed already. These are set out in Section 4. In the future, the Strategic Plan will inform all other plans for the services delegated to the IJB.

8.7 In addition to the programmed changes set out in existing strategies, it is recognised that our overall approach needs to change through further development. Looking to the future, the strategies need to reflect what service users have said matters to them as outlined in Section 6.

Strategic Priorities

8.8 Our Strategic Priorities are informed by what staff and service users have told us will make a difference. The 2020 vision for Health and Social Care and the Christie Commission on Public Sector Reform (2011) highlighted, also, the need for change and identified the characteristics of future services (Section 4). They both emphasised the need for communities to be involved; to empower people; and that, wherever possible, services should be provided in the person's own home. They remind us, also, that prevention of ill health should be given a greater priority.

8.9 In order to achieve the priorities set out below, Fife's Integrated Heath and Social Care Partnership is committed to the following approach:

- Using a variety of activities, as agreed with the public, to involve people within local communities to describe the assets within communities and to identify enablers and barriers to inform improvements;

- Involving a wide range of partners within local communities, organisations, local groups and businesses to develop opportunities within communities so that these can support people to achieve personal outcomes;

- Developing staff skills to ensure that they can use feedback from service users' experiences to improve these services.

8.10 Bearing in mind our vision is for the people of Fife to make the most of their lives; to remain as independent as possible; to be connected with others; and to make active contributions to their families and communities; our Strategic Priorities for the period 2016 to 2019 are as set out below.

Strategic Priority - One Prevention and Early Intervention
• We will continue to work with all stakeholders to improve access to information, advice and support to enable people and their carers to lead healthier life styles and to remain as independent as possible and make active contributions to their families and communities; • We will develop our capacity to support people at home through new models that provide greater choice and control including timely provision of aids and adaptations and technology to enable care; • We will focus our activities on supporting people to manage their own conditions and to stay healthy and more independent for longer; • We will increase access to services, including anticipatory care planning, which promote early intervention and recovery and reduce the risk of deterioration in health and wellbeing; and • When people become ill and experience difficulties with everyday tasks, we will support people to recover and regain as much independence as possible to remain at home.

Strategic Priority - Two Integrated and Co-ordinated Care
• We will redesign our services to provide more integrated services and coordinated care at home so that the experiences of service users and their carers will be enhanced; • We will work together to ensure those, who are at risk of harm, receive the shared response necessary to keep them safe; • We will work to bring together health and social care teams and the third and Independent Sectors to provide the right level of support at the right time; to meet individual needs; and to reduce avoidable emergency admissions to hospital; • We will work to provide coordinated health and social care services to better meet the needs of people, requiring care at the end of their lives, and their families and carers; • We will work with General Practice and the Out of Hours services to deliver more joined up responses and we will ensure that there is a named person for GPs to contact with queries about patients who are receiving care commissioned by social work; and • We will create a structured, coordinated and strategic approach to community support for people with frailty including dementia and their carers to ensure that they remain in the community for as long as possible.

Strategic Priority - Three Improving Mental Health and Wellbeing
• Shifting the balance of care - support people who experience mental ill health to remain as long as possible in their own homes and communities rather than in hospital settings; • Challenging stigma; • Developing the outcomes based approach to include personal, social and clinical outcomes based on what matters to individuals; and • The promotion of more effective partnership working resulting in clearer pathways which facilitate the right support at the right time based on the needs of the individual.

Strategic Priority - Four Tackling Inequalities
• We will work with people across the different localities in Fife to improve their experiences of health and wellbeing and making a positive contribution to reducing inequalities; • We will work with our Community Planning Partners to improve equity of access and provision of services to maximise opportunities for people experiencing inequality; • We will ensure that people have access to appropriate housing and housing adaptations to enable independent living; and • We will work with partners to offer financial advice to service users to ensure that they are in receipt of full entitlement of benefits.

8.11 In order to support the Strategic Priorities of the Integrated Health and Social Care Partnership, it was agreed that a number of key actions relating to ***Information Management and Technology*** be taken forward. These are:-

1. We will continue to explore the use of technologies to enable our staff, working within services, to work together efficiently and effectively across the whole system;

2. We will work toward an integrated system that will allow staff, working within services, to share appropriate information (where consent has been given) and, thus, recognising the need for service users to tell their stories only once;

3. We will continue to explore and maximise opportunities to develop technology enabled care which supports our priorities and improves outcomes for people e.g. those affected by dementia;

4. We will share and use data across our systems to understand needs and to demonstrate the impact of change; and

5. We will continue to explore technologies that improve homes at all stages of housing development.

Our Commissioning Intentions: 2016 to 2019

8.12 The following principles will underpin the Fife approach to commissioning to ensure that the services, which we provide, are flexible to meet different levels of demand and changing levels of need. They will enable us, also, to meet the planning principles (paragraph 3.4) outlined in The Act:

- ***Community*** – working alongside service users to develop and design services that meet local needs and grow local assets and solutions.
- ***Innovation*** – engaging with emerging delivery models and best practice to implement new ways of working that better serve the people of Fife.
- ***Commissioning*** – working actively with local providers to make best use of resources and prioritize services where there is evidence of positive impacts in terms of outcomes and,consequently, reducing demand elsewhere.

8.13 Our Commissioning Intentions are described in four areas of activity, and all contribute to the intended change to the model of care as described at section 8.4 above . They build on the shared investment of the Integrated Care Fund to develop integrated models of care and support which are person - centered. Our Commissioning Intentions are focused on the four Strategic priority areas mentioned above. Thes are, namely:

1. Prevention and Early Intervention;
2. Integrated and Coordinated Care;
3. Mental Health and Wellbeing; and
4. Tackling Inequalities.

Commissioning Intention - One	**Prevention and Early Intervention**

8.14 Currently, there are a significant number of projects across Fife, supporting the Third Sector and other community groups which create opportunities for preventative initiatives and lifestyle education. Throughout the period of the plan a number of reviews will be carried out. These will ensure that projects will be aligned to the Strategic Priorities, so that they make best use of the existing investment. Using the Integrated Care Fund a range of services will be put in place. These include:

- The development of a Fife directory of services and local community groups to support choice and control for individuals;
- Faster access to equipment and information through an on-line self-assessment tool;
- A review of the current Fife Community Equipment Partnership;
- Extending the Local Area Co-ordination service to link people with the right service and support the development of community assets;
- The development of the Shared Lives project to explore an alternative way in supporting Older People to remain at home or in a homely setting. This is an opportunity to provide greater choice of personalised shared care and support for cost effective respite, day care and residential care .
- The further development of Befriending services to reduce social isolation;
- Redesigning care and clinical pathways to have fewer steps resulting in speedier decision making and earlier service provision through proactive anticipatory care planning;
- Systematically identifying and treating frail people within community settings through a planned screening process which links General Practices closely with medical consultants and other specialist staff;
- To expand wellness services tailored to older people such as physical activity and cooking for one; and
- To undertake a review of our approach and investment in technology enabled care

Impact:-
Reduced reliance on hospital beds and other health and care services;
Increased focus on prevention, self-management and shared decision making; and
Increased capacity in primary and community care.

Commissioning Intention - Two	**Integrated and Coordinated Care**

8.15 By integrating services further, there will be significant opportunities to improve outcomes and to provide more care in people's own homes. The main activities will include the following:

- Further development of an urgent response service for acute care within the community and, whenever possible, provision of ongoing support for people to recover in their own homes following an acute illness:-
  - Care and support will be redesigned to provide a more joined up service at a local level and will work with communities to integrate care around clusters of GP practices and other community providers;
  - Care will be more coordinated, particularly to support those at risk of harm, deterioration or hospital admission. The new model will have someone to coordinate care with the carers and all the staff from across the sectors who may be involved;
  - GPs can request an urgent response that could include Hospital at Home as well as wider Intermediate Care services. This would be developed to include extending into the traditional out of hours period and, if this is supported by evidence, moving towards availability up to a 24 hour basis;
  - Work towards improved information and technology applications to support integrated working;
  - People being cared for at home by a range of staff with key services being available over 7 days. All sectors working more closely together in order to provide an enabling approach to support recovery in line with personal outcomes; and
  - To meet the needs of those who do not require hospital care but are initially unable to go home to recover, provision of a bed based intermediate care will be developed further. This will include exploring if the new housing and care home facilities, planned for Kirkcaldy, Glenrothes and Lumphinnans, can offer different options for the local population.

8.16 In addition to the above,we will work to foster greater openness across society about death, dying and bereavement. This will also facilitate greater use of Power of Attorneys, Wills and Advance Directives where appropriate.

8.17 The Commissioning Intentions, as set out in this section of the plan, will result in a higher proportion of care being provided in the community. This includes early clinical and care assessments which will reduce the number of avoidable admissions as well as delays in discharge.

8.18 The reduced inpatient activity and greater integration and coordination will release resources to be realigned to community based services and build sustainability for the future. The predicted demographic changes will provide challenges and it is intended that the new community model will be enhanced to meet any increasing demand.

8.19 The Day of Care Audits (paragraph 7.12) tell us that up to 50% of community hospital beds are occupied by people whose care needs can be met either at home or in another community setting. Therefore, when community alternatives are put in place, it should be possible to reduce the number of community beds.

Impact:-
Reduced use of acute resources;
Reduced need for community hospital inpatient care;
Increased primary and community care capacity through integrating with intermediate care services;
Improved coordination across the whole system; and
Potential to reduce inpatient capacity.

Commissioning Intention - Three	**Mental Health and Wellbeing**

8.20 The agreed Strategic Priorities are set out in the Joint Mental Health Strategy for the People of Fife 2013-20. While this activity applies predominantly to mental health services, many of the actions are applicable across other areas. Key activities will include:

- Shifting the balance of care - continue the redesign work started already at Stratheden Hospital to create additional alternative models of care and crisis response in the community;

- Training, education and local campaign strategies to ensure that fewer people experience stigma, discrimination and lack of understanding;
- Maximises the participation and inclusion of the people with whom we work together along with their carers; and
- The promotion of more effective partnership working which should result in clearer pathways which facilitate the right support at the right time based on the needs of the individual.

Impact:-
Reduced requirement for inpatient care;
Increased Community Care provision;
Potential to reduce inpatient capacity;
Increased choice and control for individuals; and
Increased knowledge and skills of staff to develop the personal outcomes approach within all services.

Commissioning Intention - Four	Tackling Inequalities

8.21 We will work to ensure that services are responsive and sensitive to people who are covered by equalities legislation. Under the Equality Act 2010, the protected characteristics are Age, Disability, Gender, Gender Reassignment, Marriage and Civil Partnership, Pregnancy and Maternity, Race, Religion and Belief, Sexual Orientation. The key areas of activity include:

- Ensuring that our approaches to engaging people within our localities reflect equality and diversity within each community;
- Developing joint working with community planning partners across the seven localities to ensure that locality plans for the partnership are aligned to the Community Plans;
- Actively supporting the priorities set out in the Health and Wellbeing Plan for Fife; and
- Working to make the necessary changes to meet the requirements of the Local Housing Strategy.

Impact:-
Increased focus on prevention, self-management and shared decision making to improve general health and wellbeing in the population and to reduce health inequalities; and

Better quality relationships between service users and those providing them.

8.22 The above mentioned Commissioning Intentions enhance the activity agreed already within existing strategies and being taken forward throughout the services. The Table below shows the overall direction of travel looking forward to 2025 ; this which is beyond the period covered in this plan. The intention of this plan is to support the transition to the future model detailed below in Table 32 Stepping Stones for Change .

8.23 The commissioning intentions do not all require additional resources; many will be provided by the redesign of current service provision within the community services resource. However, it is essential that resources are released from the reduction of inpatient care to sustain new models of care in the community. (See Section 9: Financial Framework).

Table 3 – Stepping Stones for Change

AT PRESENT 2015	TRANSITIONAL 2015-2018	THE FUTURE BY 2025
Focus on hospital services for specialist needs and acute care. Contributing to people's discharge from hospital being delayed.	Increasingly specialist and acute care will be provided in the community. These will be high quality, safe and effective.	Use acute hospitals only for acute care which cannot be provided in other settings.
Continued issues of episodic care model, duplication, multiple referrals, multiple professionals, many visits and repetition of information, separate assessments leading to confusing and complex arrangements.	Health and social care services are redesigned to improve experience and achieve better outcomes through more integrated and coordinated models making best use of resources.	Multi-disciplinary input to shared assessment, co-ordinated person-centred outcome focussed support. Ensuring effective sharing of relevant information and an emphasis on prevention and early intervention.
Limited out of hours options where urgent health or social care is required, leading to unnecessary presentations at hospital.	The model of provision, developed in partnership with Third and Independent Sectors, will aim to increase availability of 24/7 working to support people either at home or in homely settings.	A range of safe and effective community services available 24/7 to support people either at home or in homely settings.
NHS Fife and Fife Council lead prioritisation and allocation of resources.	Health and social care will work more closely together with all partners to allocate resources. Staff, across sectors, and public are participating in co- designing solutions.	Localities and communities will drive and deliver change accessing resources accordingly. The focus will be on relationships and personal outcomes solutions based on local assets.
People are supported to manage their own health and wellbeing but only in some services. Technology playing a limited role.	Increasing numbers of people are encouraged to manage their own health and wellbeing using personal outcomes focussed approach. Increasing emphasis will be placed on anticipatory and preventative approaches including more effective use of technology.	Localities and communities facilitate and support their own health and wellbeing. Technology fully maximised.
Carers have limited support in their caring role	Health and Social Care Partners develop the support available and value the contribution of their caring role.	Carers can access support in their own communities and localities. People, who provide unpaid care, are supported to reduce the potential impact of their caring role on their own health and wellbeing.

8.24 The Table below summarises our commissioning priorities, intentions and the linkages to the national outcomes.

Table 4 STRATEGIC PRIORITIES	COMMISSIONING INTENTIONS	MEASURES (Core indicators 1-23 as shown on Page 72)	NATIONAL OUTCOMES
1. Prevention and Early Intervention	A directory of local services and community groups to be developed	1,2,3,7,8,12,13,14,15	1 – Support looking after own health and well-being 6 – Support to carers
	An on-line self-assessment tool to be put in place to enable faster access to equipment and information	1,2,3, 5, 7,8,9,10, 16,	1 – Support looking after own health and well-being 2 – Living independently at home or homely community setting
	A review of the current Fife Community Equipment Partnership	1,2,3, 5, 7,8,9,10, 16,19,21,22,23	1 – Support looking after own health and well-being 2 – Living independently at home or homely community setting 6 – Support to carers
	Local Area Co-ordination Service to be extended to link people with the right service and support the development of community assets	1,2,3,4,5,6,7,8,9,10,12,13,14,15, 16,18,19,20,21,22,23	1 – Support looking after own health and well-being 2 – Living independently at home or homely community setting 3 – Positive experience of services 4 – Improving quality of live
	Develop shared lives project to explore on alternative way to support adults to remain at home or in a homely setting	3,4,5,7,8,9	1 – Support looking after own health and well-being
	Befriending services to be developed to reduce social isolation	1,2,3,7,8,	2 – Living independently at home or homely community setting
	Redesigning care and clinical pathways to have fewer steps resulting in speedier decision making and earlier service provision through proactive anticipatory care planning	1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16 18,19,20,21,22,23	1 – Support looking after own health and well-being 4 – Improving quality of live 9 – Effective use of resources
	Systematically identify and treat people who are frail within community settings through a planned screening process, closely linking to GPs with medical consultants and specialist nurses	1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16 18,19,20,21,22,23	1 - Support looking after own health and well-being 4 – Improving quality of live 6 - Support to carers

2. Integrated & Co-ordinated Care	Further develop an urgent response service for acute care within the community	2,3,4,5,6,7,8,9,10,11,12,13,14,15,16 18,19,20,21,22,23	2 – Living independently at home or homely community setting 4 – Improving quality of live
	Care and support will be redesigned to provide more joined up care at a local level	1,2,3,4,5,6,7,8,9,10,12,13,14,15,16 18,19,20,21,22,23	2 – Living independently at home or homely community setting
	Care will be co-ordinated, particularly to support those at risk of harm, deterioration or hospital admission	1,2,3,4,5,6,7,8,9,10,12,13,14,15,16 18,19,20,21,22,23	3 – Positive experience of services 8 – Workforce feel engaged and supported 9 – Effective use of resources
	GPs to enable to request an urgent response that could include hospital at home as well as wider intermediate care services	2,3,4,5,6,7,8,9,10,11,12,13,14,15,16 18,19,20,21,22,23	4 - Improving quality of live 7 – Safe from harm 8 - Workforce feel engaged and supported
	Work towards availability of key services being available over 7 days	1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,1 6 18,19,20,21,22,23	2 - Living independently at home or homely community setting 4 - Improving quality of live 8 - Workforce feel engaged and supported 9 - Effective use of resources
	Work towards improved information and technology applications to support integrated working	4,5,8,9,10,12,13,14,15,16,18,19, 20,21,22,23	8 - Workforce feel engaged and supported 9 - Effective use of resources
	People being cared for at home by a range of staff from all sectors working more closely together, will experience an enabling approach to support recovery and personal outcomes	1,2,3,4,5,6,7,8,9,10,12,13,14,15,16 18,19,20,21,22,23	2 - Living independently at home or homely community setting 3 – Positive experience of services 4 - Improving quality of live 8 - Workforce feel engaged and supported
	To meet the needs of those who do not require hospital care, but are initially unable to go home to recover, a bed based intermediate care provision will be further developed. This will include exploring if the new housing and care home facilities planned for Kirkcaldy, Glenrothes and Lumphinnans, can offer	1,2,4,5,7,8,9,10,12,13,14,15, 16,18,19,20,21,22,23	2 - Living independently at home or homely community setting 6 – Support to carers 8 - Workforce feel engaged and supported 9 - Effective use of resources

	different options for the local population		

3. Improving Mental Health and Wellbeing	Shifting the balance of care continue the redesign work already started at Stratheden Hospital to create additional alternative models of care and crisis response in the community	2,3,4,7,15,18	2 - Living independently at home or homely community setting 3 – Positive experience of services 4 - Improving quality of live 9 - Effective use of resources
	Training, education and local campaign strategies to ensure that fewer people experience stigma, discrimination and lack of understanding.	1,7	3 – Positive experience of services 4 - Improving quality of live 5 – Reducing inequalities
	Maximises the participation and inclusion of the people we work with together with their carers.	1,7,8	2 - Living independently at home or homely community setting 3 – Positive experience of services 4 - Improving quality of live 5 – Reducing inequalities 9 - Effective use of resources
	The promotion of more effective partnership working resulting in clearer pathways facilitating the right support at the right time based on the needs of the individual.	1,2,3,4,5,7,8,9,10, 18,20,21,22	1 - Support looking after own health and well-being 2 - Living independently at home or homely community setting 3 – Positive experience of services 6 – Support to carers 8 - Workforce feel engaged and supported 9 - Effective use of resources

4. Tackling Inequalities	We will ensure that our approaches to engaging people within our localities reflect equality and diversity within each community	1,2,3,4,5,6,7,8,9,10,11,12,13,14,15, 16,17,18,19,20,21,22,23	1 - Support looking after own health and well-being 3 – Positive experience of services 4 - Improving quality of live
	We will develop the joint working with community planning partners across the seven localities to ensure that locality plans for the partnership are aligned to the Community Plans	1,2,3,4,5,6,7,8,9,10,11,12,13,14,15, 16,17,18,19,20,21,22,23	5 – Reducing inequalities 8 - Workforce feel engaged and supported 9 - Effective use of resources
	We will actively support the priorities set out in the Health and Wellbeing Plan for Fife	1,2,5,7,8,11	1 - Support looking after own health and well-being 5 – Reducing inequalities 8 - Workforce feel engaged and supported 9 - Effective use of resources
	We will work to make the changes necessary to meet the requirements of the Local Housing Strategy	1,2,4,5,7,8,9,10,13,14,15, 16,19,20,21,22	1 - Support looking after own health and well-being 2 - Living independently at home or homely community setting 5 – Reducing inequalities

9. FINANCIAL FRAMEWORK

Context

9.1 The draft Strategic Plan is intended to be viewed as a continuum of work with further development required to make the vision a reality. The plan provides the strategic framework for the development of health and social care services over the next few years and lays the foundation for the integration of the plan into the core work of NHS Fife, Fife Council and partners with priorities and proposals reflected in each organisation's business plan .

9.2 Therefore, there is a requirement to identify and develop an aligned resource strategy including a clear financial framework which will support delivery of the plan. There is clear recognition by NHS Fife and Fife Council and partners that, whilst our aims and aspirations are extensive, the Strategic Plan and its associated programmes will have to be delivered within the finite resources available to the partner organisations.

Partnership Budget

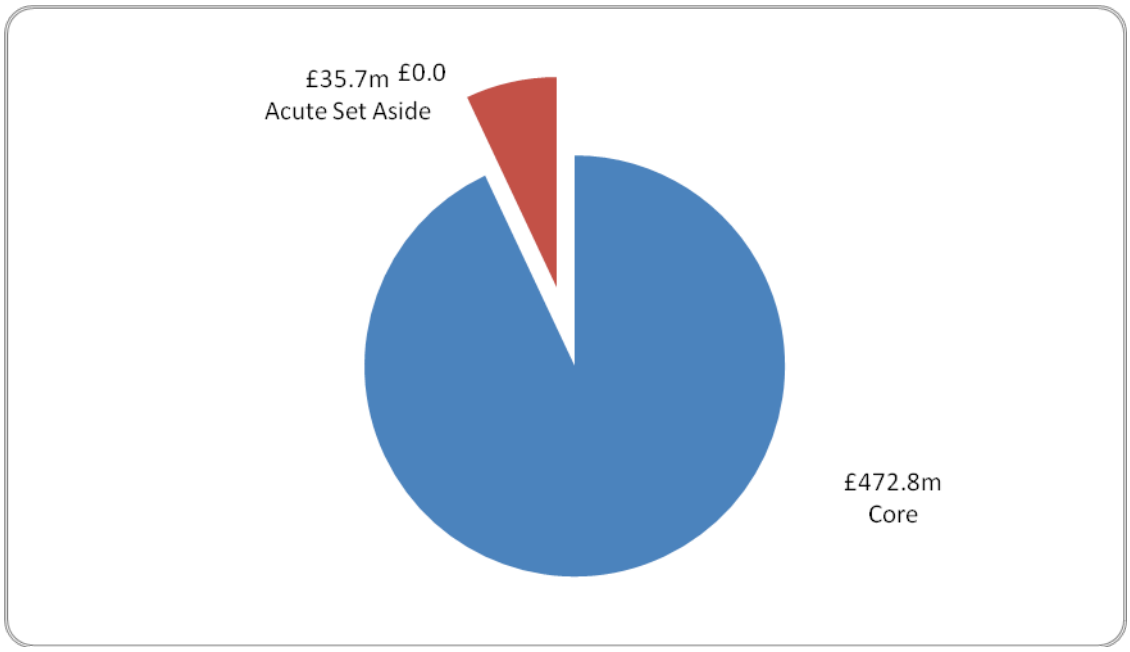
9.3 The Partnership Budget has been agreed in line with legislation to support the integration of health and social care. Services and resources are identified in the following three categories:

1. Delegated Community Health and Social Care Resource; this includes Community Hospitals. This is within the scope of the Strategic Plan with the Director of Health and Social Care responsible for operational management;

2. Hospital resource used by the Integrated Authority (IA) population for delegated large hospital services. This is within the scope of the Strategic Plan with the Health Board (Set Aside) responsible for operational management; and

3. Non Integrated Health & Social Care Resource used by the IA population. However, although visible to the IA, this is not in the scope of the Strategic Plan.

Chart 22: Fife Health and Social Care Funding - 2015/16



9.4 Core and set aside services have been identified per the regulations with the addition of NHS Community Children's Services and NHS Mental Health Forensic Services to core services as agreed by the Shadow Board. (Section 2). The Fife Health and Social Care Partnership is coterminous and, therefore, all set aside acute services are identifiable as delivered to the whole population of Fife .

Table 5: Revenue Budgets 2015/16 to 2017/18

Health and Social Care Integration **Revenue Budgets**	Budget 2015/16	Indicative Budget 2016/17	Indicative Budget 2017/18
DELEGATED AND MANAGED			
SOCIAL WORK			
Adults Services	**67,719**	**64,786**	**65,030**
Older People Services	**80,480**	**74,124**	**75,727**
TOTAL Social Work	**148,199**	**138,909**	**140,757**
Housing Services	**1,910**	**1,998**	**1,878**
TOTAL FIFE COUNCIL	**150,109**	**140,908**	**142,635**
NHS Fife			
Community Services	141,606	141,606	141,606
Family Health Services	156,162	156,162	156,162
Resource Transfer & Other	24,968	24,968	24,968
Total NHS Fife in scope	**322,736**	**322,736**	**322,736**
TOTAL H & SCI Delegated & Managed	**472,845**	**463,644**	**465,371**
Acute Services-Set Aside Delegated but managed by Health Board	**35,664**	**35,664**	**35,664**

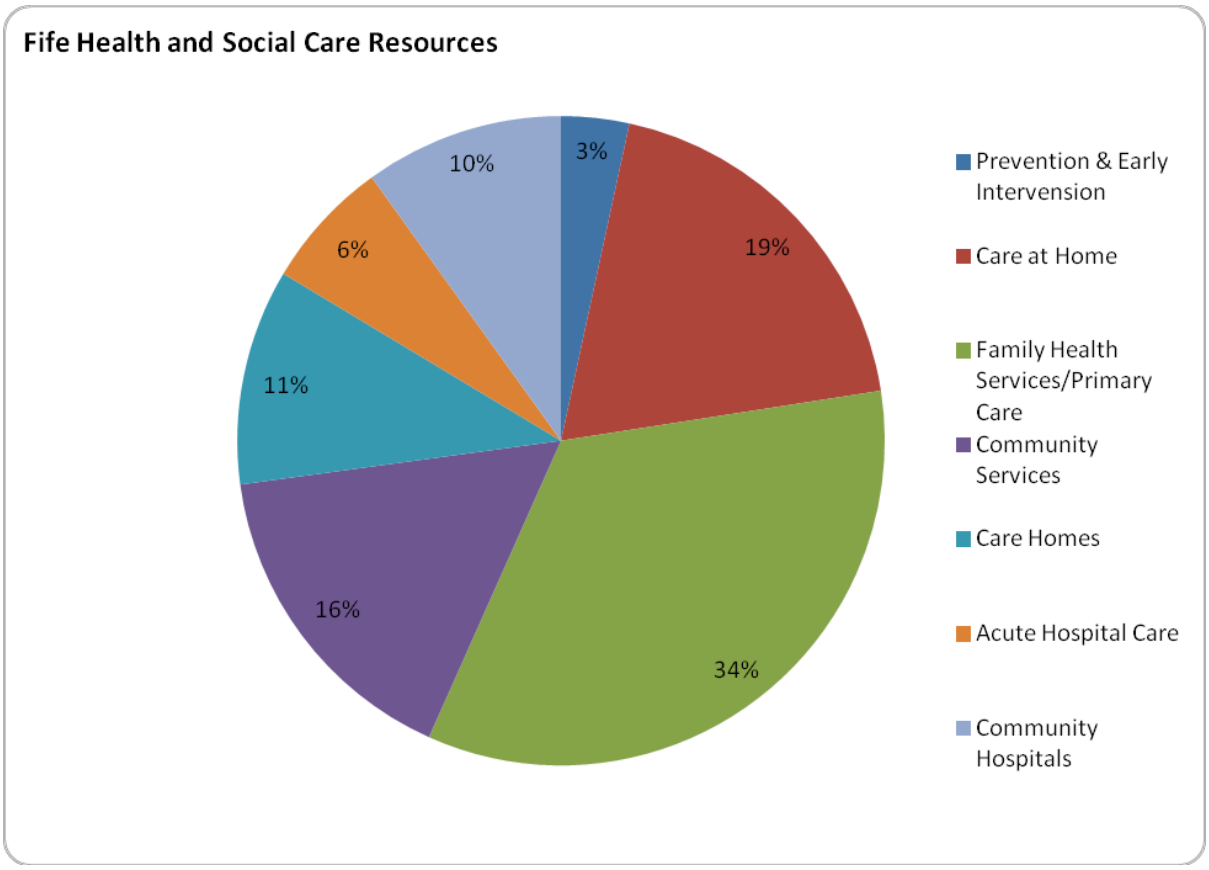
9.5 Some explanatory notes associated with the above Table are as follows:

- The Table is based on the current resource structure. There is ongoing realignment of resources to the East, West and Fife Wide Divisions and, when complete, this Table will be replaced;
- The financial planning process will consider the impact of efficiency, uplift and any other changes.
- The Fife Council indicative budgets exclude funding which, as yet, is not built into the recurring base line;
- Also, there is no reflection of the shifts in the balance of care during the period of the Strategic Plan; and
- Resources will be subject to change.

How we currently use our funding

9.6 The Fife Health and Social Care current resources can be identified within care groups as illustrated in the Chart below.

Chart 23: Current Profile



Services Delegated and Managed by the IJB	
Prevention & Early Intervention	Public Health Nursing for Children and Adults
Care at Home	Local Authority Services
Family Health Services/Primary Care	General Practice, Prescribing, Pharmacy, Dental & Ophthalmic
Community Services	Community Health Services, LA Respite and Day Care
Care Homes	Local Authority Services
Community Hospitals	Community Hospitals and associated services
Services Delegated but not Managed by the IJB (Operational Management and Budgetary Control Remain with NHS Fife)	
Acute Hospital Care	Acute Services providing unplanned care e.g. general medical wards and Accident & Emergency

How we plan to use our funding in future

9.7 As a Health & Social Care Partnership, we must embrace new ways of working which, where clinically safe and appropriate, will divert significant financial resources from expensive bed based models into community based services.

9.8 The establishment of Health & Social Care Partnerships has the potential to improve the experience of the current and potential users of health and social care services. Moving resources away from hospital based treatments into prevention and early intervention will be crucial to achieving this objective. This is referred to sometimes as “shifting the balance of care”.

9.9 As functions, strategies and services are reviewed and integrated the pattern of spend will alter as the Partnership seeks to operate in accordance with the commissioning intentions to shift the balance of care from institutional to community settings.

How will we fund our strategic commissioning intentions?

9.10 The Integrated Care Fund is being utilised to fund priorities for change during the period of the Strategic Plan; these will be monitored and evaluated to ensure that the invested resources have delivered the agreed intentions.

Integrated Care Fund Investment 2015/16

Strategic Intention	ICF funding £000’s
Prevention and early intervention	630
Integrated Care	230
Health & Care in Primary Care and Community Settings	5,872
	6,732

9.11 Detailed implementation plans will be developed to support the strategic intentions. These will include fully costed models to ensure that all plans are sustainable within the finite resources available to the IJB.

10. WORKFORCE STRATEGY

Development of the Workforce Strategy

10.1 The Workforce Group is one of the main work streams established by the Shadow Board. This Group will be responsible for the development of a supporting workforce strategy.

10.2 In addition,there has been established a sub group with Divisional General Manager, Human Resources and employee representative membership to deliver on operational elements of the work plan .

Workforce Engagement

10.3 The Health and Social Care Partnership brings together around 5,500 employees from both local authority and NHS backgrounds. As a Partnership, we wish to engage with our staff in developing our approach and in ensuring that we have the knowledge, skills, experience and support within the organisation to deliver on our priorities now and in the future.

10.4 The Health and Social Care Partnership is made up not only of NHS and local authority employees but, also, our partners in the Third and Independent Sectors need to be engaged with our change journey.

10.5 The clear intention is to work across sectors and disciplines to develop our workforce and organisation in line with our vision, values and priorities. Our parent bodies have in place organisational development and workforce development plans. Complementing these plans, the Health and Social Care Partnership will develop coordinated plans in line with the requirements of an integrated workforce.

10.6 Partnership working with employees is an effective and essential vehicle to supporting the workforce and delivering services. We are committed to continuing to build and develop relationships with trade unions and professional organisations in Fife to enable the partnership to deliver the best services and to achieve the best outcomes for people that require our support.

10.7 We will do this through programmes of engagement in the partnership, workforce planning and organisational development within the partnership. There has been considerable engagement in developing and sharing our vision through key workstreams during our shadow year. In the first full year of the Health and Social Care Partnership, engagement will be deepened and focused on collaboration across sectors and disciplines. A programme of engagement will be put in place to take this forward.

What will our Strategic Plan mean for our workforce?

10.8 As this Strategic Plan is implemented, our workforce will work in a more integrated way. Workforce integration is about changing the way people work so that work is organised around enabling people who need care and support to live as independently as possible.

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

10.10 Workforce planning and development underpins the Health and Social Care Partnership's effectiveness in delivering on all the national and local outcomes. As we transform the way we deliver services, our teams will need to deliver care which offers:

- Choice and control to the person receiving services;
- An outcomes based approach;
- Self Directed Support; and
- More support in the community for people with complex needs.

10.11 As part of the Strategic Plan, it is crucial to recognise the relationships beyond traditional local authority and NHS providers to extend to Third, Independent Sectors and to local Social Enterprises.

Principles of Workforce Development

10.12 Staff governance, clinical and care governance and financial impact all require to be addressed within the integrated workforce plan. The Health and Social Partnership's overarching aim is the 2020 Vision of "safe, effective and person centred care which supports people to live as long as possible at home or in a homely setting".

10.13 In addition, Skills for Care and Skills for Health (2014) developed the following principles to support organisations, managers and practitioners to think through what is meant by integration and, in particular, how workforce development can contribute to its introduction, implementation and sustainability.

Principle 1:	Successful workforce integration focuses on better outcomes for people with care and support needs
Principle 2:	Workforce integration involves the whole system
Principle 3:	To achieve genuine workforce integration, people need to acknowledge and overcome resistance to change and transition. There needs to be an acknowledgement of how integration will affect people's roles and professional identities
Principle 4:	A confident, engaged, motivated, knowledgeable and properly skilled workforce supporting active and engaged communities is at the heart of workforce integration
Principle 5:	Process matters—it gives messages, creates opportunities and demonstrates the way in which the workforce is valued
Principle 6:	Successful workforce integration creates new relationships, networks and ways of working. Integrated workforce commissioning strategies pay attention to each of these , creating the circumstances in which all can thrive

10.14 Each of these principles will taken into account when developing the workforce strategy for the Fife Partnership.

11. CONSULTATION STRATEGY

Context

11.1 The Act requires partnerships to engage fully with a defined group of stakeholders in the development of the Strategic Plan.

11.2 The SPG was established in 2014 and includes all the stakeholders defined in the Regulations. This Group is responsible for ensuring that the Strategic Plan is developed in partnership. In addition to the formal SPG, a wide range of events have been held to engage staff and the public in the development of the Strategic Plan. When the Shadow Board approves the Strategic Plan consultation, the full consultation will follow. The outcomes of this consultation will inform the final Strategic Plan submitted to the IJB for approval.

11.3 Fife Council and NHS Fife are committed to the National Standards for Community Engagement and follow Fife Council's Standards for Excellence in Communication, Scottish Government Planning Advice Note 2010 and CEL 4(2010) 'Informing, engaging and consulting people in developing health and community care services' and, in line with the Equality Act 2010, any guides to best practice.

Staff

11.4 A range of staff events have taken place across Fife - held under the heading of "Together we can". These events informed the early development of the Plan. A total of ten events, involving over 800 staff across all sectors, were held in May 2014 and in November 2014. These events asked staff about where Integration was working well and what a good integrated system would look like.

11.5 A senior staff visioning event was held in January 2015 in order to agree the design principles of an integrated system based on what staff had said. These principles and the proposal to support early implementation sites were agreed and taken to the locality events held in February and March 2015. These were held in the seven localitiesand, in addition, there was an event specifically for managers. Over 300 staff and public members participated.

11.6 The SPG held two workshops to consider the key areas within the Strategic Plan and to identify priorities. These were shared and supported by GPs at a Primary Care Strategy event held, also, in January 2015. This work is being developed within primary care through a series of local workshops ensuring that GPs and primary care staff are involved fully and engaged in the planning processes.

Clinical / Professional groups

11.7 The existing advisory group members have been involved throughout the above mentioned process and at formal advisory group meetings.

The Public/ Carers and Service Users

11.8 Members of the public participation network, including the People's Panel, were invited to the seven locality events. Public members participated fully and are helping to shape actions at a local level as well as giving input to the strategic planning priorities.

11.9 Service user/ carers' events were held throughout 2014 where the emerging model of care was shared. This model and the under pinning principles were supported by this group. They helped, also to define what would be priorities for them.

11.10 A British Sign Language users event was held where Health & Social Care Integration and the emerging plans were shared and discussed.

11.11 The existing public participation networks have been brought together to expore how we approach future participation and engagement within the partnership. This early work has provided, also, some direction as to what is important to service users and how they would wish to become involved in the future.

Strategic Planning Group

11.12 The Strategic Planning Group organised a number of workshop style events. Invitations to participate were issued to a wide range of staff including clinicians, GPs, staff, managers and colleagues from the independent and voluntary sectors.

Future Plans

11.13 Full involvement of all stakeholders will be central to the further development and implementation of the Strategic Plan. Full engagement plans will be developed at each stage and, in relation to each priority area, defined in the plan.

SECTION 12 – GOVERNANCE ARRANGEMENTS

Local Governance Arrangements

12.1 Fife Council will appoint 8 Councillors and NHS Fife will appoint 8 Board members. The Board members will hold office for a maximum period of 3 years. Board members will cease to be members of the Board in the event that they cease to be a Board member of NHS Fife or a Fife Councillor.

12.2 The Integration Joint Board will appoint non-voting members in accordance with the regulations.

Local Operational Delivery Arrangements

12.3 The IJB will be responsible for:

- The planning of services through this Strategic Plan;
- The operational oversight of Integrated Services;
- The operational management of Integrated Services through the Director of Health and Social Care; and
- The planning of some Acute Services.

Clinical and Care Governance

12.4 NHS Fife's Medical Director, the Director of Public Health and the Nurse Director remain accountable for quality of care and professional governance in relation to the NHS functions delegated to the Integration Joint Board.

12.5 Fife Council's Chief Social Work Officer will be accountable for ensuring the maintenance of proper standards and values in respect of the Social Work Services delegated to the IJB.

12.6 Both organisations will continue to monitor and report on clinical, care and professional governance matters through their existing mechanisms in order to comply with legislative and policy requirements.

12.7 Fife Council's Chief Social Work Officer and NHS Fife's Nursing and Medical Directors will be members of the IJB providing oversight and advice at that level.

12.8 Professional oversight, advice and accountability in respect of care and clinical governance will be provided throughout divisions and localities by the Associate Medical Director, Associate Nurse Directors, Director of Pharmacy, Clinical Directors for Healthcare and Professional Lead Social Workers.

12.9 Professional advice will be provided to the Integration Joint Board, the Strategic Planning Group and Localities through an Integrated Professional Advisory Group comprising of health and social care professionals. The existing advisory groups will be linked to the Integrated Professional Advisory

Group and will provide advice, as required, and be involved fully in Strategic Planning processes.

12.10 All professional staff across the Partnership will continue to be professionally accountable to their Senior Officers and respective regulatory bodies.

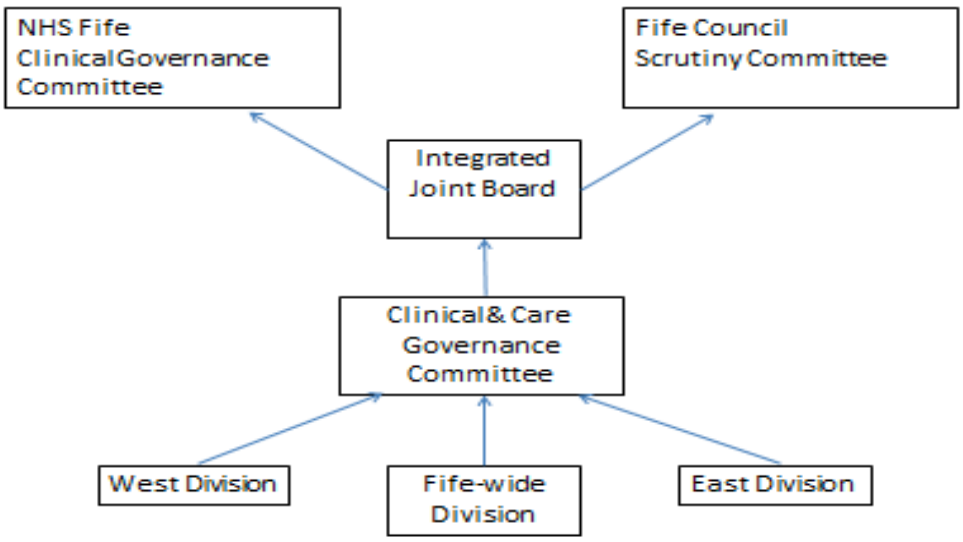
12.11 The quality and safety of health and care, delivered by the IJB, will be overseen by a Clinical and Care Governance Committee. This Committee will report directly and provide assurance to the IJB, to the NHS Fife Clinical Governance Committee and to the relevant Scrutiny Committee of Fife Council for Social Work and Social Care.

12.12 It will provide assurance to the Integration Joint Board, to the Senior Leadership Team, who are responsible for locality planning and delivery, and to the Strategic Planning Team that appropriate governance systems and processes are in place to assure the quality of care being delivered

12.13 The Chief Social Work Officer will provide specific reports including the annual report and assurance to the relevant Committee of Fife Council.

12.14 The model shown in Figure 4 below identifies the structure for care and clinical governance within the Integrated Health and Social Care Partnership.

Figure 4: Clinical Care and Goverance Arrangements



12.15 Each of the three Divisions of the Partnership will have an operational Clinical and Care Governance Group reporting to the Clinical and Care Governance Committee for their respective service areas.

12.16 Senior professionals within the locality structure will ensure that the values, set out in the Clinical and Care Governance Framework, are embedded in all strategic planning processes and service delivery. These senior staff will provide assurance about the quality of care provision within their localities.

Director of Health and Social Care

12.17 The Director of Health and Social Care is directly line managed by both Fife Council's Chief Executive, and NHS Fife's Chief Executive and will be a member of the respective senior management teams. Joint performance review meetings involving both Chief Executives and the Director of Health and Social Care will take place on a regular basis in accordance with each organisation's normal performance management arrangements.

SECTION 13 – MONITORING PERFORMANCE

Context

13.1 The IJB will be responsible for monitoring and reporting in relation to the operational delivery of the integrated services on behalf of NHS Fife and Fife Council.

13.2 It will be responsible, also, for the continuous review of progress of the implementation of this Strategic Plan, measured against the statutory outcomes for health and wellbeing and associated indicators.

13.3 The National Health and Wellbeing Outcomes provide a strategic framework for the planning and delivery of health and social care services in Fife. They are high-level statements of what health and social care partners, both in Fife and nationally, are attempting to achieve through integration; through the pursuit of quality improvement across health and social care; and through focussing on the experiences and quality of services for service users, carers and their families.

13.4 Integration authorities will be required to publish an annual performance report setting out how they are achieving these outcomes. The report will include information in relation to a suite of core indicators which underpin the outcomes. In addition, there will be local measures and contextualising data to provide a broader picture of local performance.

13.5 The core indicators have been developed in consultation and in partnership with NHS Scotland, COSLA, the third and Independent Sectors. The core indicators draw together measures that are appropriate for the whole system under integration.

13.6 The indicators remain to be tested in practice with partnerships requiring to understand their usefulness both for reporting progress and identifying areas for improvement to help with strategic planning. The Scottish Government has advised that the indicators will develop and improve over time and that some of them still require data development.

13.7 Core indicators which are shown at table 6 are grouped into 2 types of complementary measures:

- Personal outcomes and quality measures; and
- Indicators derived from organisational / system data primarily collected for other reasons.

13.8 The Integration Joint Board will receive a performance report at each meeting. The Shadow Board have received regular reports since April 2015. The report acknowledged the requirement to develop a partnership performance framework and to design a performance report for the Shadow Joint Board and, subsequently, the IJB.

13.9 This report focuses on the following key measures:

- Hospital at Home activity
- A&E Attendances and 4 Hour Performance
- Emergency Admission and Bed Days - Age 75+
- Number of delayed discharges
- Number of delayed discharges 2+ weeks
- Bed Days lost to Delayed Discharge
- Delayed Discharge Rate per 100,000 population (mainland Boards)
- STAR Facilities Placements and Vacancies
- Key Performance Information on Homecare and Long term care

A variety of other data is provided on a once only basis to give an indication of the range of information available.

13.10 The Shadow Joint Board recognised that this is an Interim Performance Report since the local and national reporting requirements are still being defined.

13.11 The Schedule below details the progress with developing local information to enable reporting on the core indicators. In order to accelerate this work, the National Services Local Intelligence Support Team has made available resource and a senior analyst will be working with local planning and performance staff to develop our performance framework.

13.12 In addition to the above, once our strategic commissioning intentions have been finalised, there will be a need to review and potentially develop further the emerging performance report for the IJB. This will ensure that we have the most appropriate means to allow progress against our commissioning intentions to be measured.

Table 6: Core Indicators for National Health and Wellbeing Outcomes - Local Health & Social Care Reporting Matrix

Not currently possible to report on	Data available but not currently reported
Already reported	Under development

	Core National Indicators	Local Availability	Source	
Personal outcomes and quality measures	1	Percentage of adults able to look after their health very well or quite well		SW
	2	Percentage of adults supported at home who agree that they are supported to live as independently as possible		SW
	3	Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided		SW
	4	Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated		SW
	5	Percentage of adults receiving any care or support who rate it as excellent or good		SW
	6	Percentage of people with positive experience of care at their GP practice		SG
	7	Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life		SW
	8	Percentage of carers who feel supported to continue in their caring role		SW
	9	Percentage of adults supported at home who agree they felt safe		SW
	10	Percentage of staff who say they would recommend their workplace as a good place to work*		SW
Indicators derived from organisational system data primarily collected for other reasons	11	Premature mortality rate		NRS
	12	Rate of emergency admissions for adults *		SMR01
	13	Rate of emergency bed days for adults *		SMR01
	14	Readmissions to hospital within 28 days of discharge *		SMR01
	15	Proportion of last 6 months of life spent at home or in community setting.		SMR01
	16	Falls rate per 1,000 population in over 65s *		SMR01
	17	Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections	**Partial**	SW
	18	Percentage of adults with intensive needs receiving care at home	**Partial**	SW
	19	Number of days people spend in hospital when they are ready to be discharged		EDISON
	20	Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency.		SMR01/SWIFT
	21	Percentage of people admitted from home to hospital during the year, who are discharged to a care home *		SMR01
	22	Percentage of people who are discharged from hospital within 72 hours of being ready *		EDISON
	23	Expenditure on end of life care *		SMR01/SWIFT

13.13 The Performance Framework will continue to evolve and will be reviewed regularly to ensure that the contained improvement measures continue to be relevant and reflective of the National Outcomes and local indicators (once developed) to which they are aligned. Our performance framework will be aligned to the requirements of the Health Improvement, Efficiency, Access and Treatment (HEAT) standards and targets as well as the Community Plan and Single Outcome Agreement.

13.14 The three divisions will develop implementation plans in order to ensure that this strategy is delivered. These implementation plans will include details of how progress and success will be measured. The Integration Joint Board will receive regular updates from Divisional General Managers.

14. FIRST DRAFT CONSULTATION PROCESS

14.1 This is the first consultation draft of the Fife Health and Social Care Integration Strategic Plan. We are embarking upon a three month consultation programme over the period 5th October 2015 to 4th January 2016.

14.2 To take part in the consultation which seek the views on the Draft Strategic Plan proposals please visit www.fifedirect.org.uk/integration or call 03451 555555 ext 444230.

www.fifedirect.org.uk/integration

Health & Social Care Integration in Fife

Full Draft Strategic Plan for Fife (2016-2019)

Consultation Draft
Supporting Appendices

NHS Fife

Supporting the people of Fife together

Fife Council

APPENDIX A

Overview of Fife's Strategic Objectives as stated in existing strategic documents, updated February 2015

Introduction

Efforts are currently underway in Fife to develop a Strategic Commissioning Plan to progress Health & Social Care Integration. As part of this work, current strategic priorities (as detailed in existing strategic documents) have been captured and are reported here.

The list of current strategic priorities has been arranged in alphabetical order by area of interest in order to facilitate easier navigation of this document. It is acknowledged that some areas of interest will cover various care groups.

In some areas of interest, there are several strategic documents detailing the strategic direction - this document details what is stated in each document and does not attempt to combine areas of strategic direction from the various documents.

It should also be noted that some documents do not use the terminology "Strategic Priorities". In these instances, an attempt has been made to extract what these Strategic Priorities are using the terminology as detailed in the relevant document.

Previous work

Previous documents such as the Joint Health & Social Care Strategy for Older People in Fife, 2011 – 2026, the Joint Commissioning Strategy Analysis Group Report (version 0.6) or the Health & Social Care Partnership Service Delivery Plan have already provided high level summaries of strategic intent relating to specific care groups. This document does not attempt to replicate that work but instead has looked at the existing strategies which might be relevant to the Strategic Plan for the new Integrated Joint Board for Fife and extracted the stated strategic priorities.

Strategic Priorities of Current Areas of Interest

Advocacy 3
Alcohol and Drugs 3
Carers 4
Children's Services 5
Community Planning 5
Community Safety 6
Culture 7
Dementia 7
Food & Health 8
Gypsy/Traveller Population 8
Health & Wellbeing 10
Housing 11
Learning Disabilities/Autism Spectrum Disorder 14
Mental Health 17
Older People 18
Palliative Care 19
Physical Disabilities or Sensory Impairments 20
Self Directed Support 21
Sports & Leisure 23
Tobacco Control 24

Advocacy

Fife's Advocacy Strategy, 2014-2017

Aims:

1. A wider range of people are eligible to receive advocacy;
2. People can access a wider range of advocacy services;
3. More people are aware of what advocacy is, how it can benefit them, what advocacy services are available in Fife, and know how to access them, and;
4. Local advocacy services are provided with appropriate support in order to help them develop their services.

Alcohol and Drugs

Fife Alcohol & Drug Partnership Delivery Plan 2012 - 2015

Key strategic changes planned:

1. Raising awareness and understanding of the risks and consequences of substance misuse;
2. Promoting healthy lifestyle choices and opportunities;
3. Identifying high-risk groups and promoting early intervention;
4. Identifying and protecting those most at risk from the substance misuse of other;
5. Tackling problems associated with the supply and availability of substances;
6. Tackling substance-related violence, crime and anti-social behaviour;
7. Promoting effective access to substance misuse recovery services;
8. Providing an effective range of treatment services in Fife;
9. Supporting the longer-term rehabilitation of those recovering from substance misuse.

Carers

Fife Carers Strategy, 2012-2015

Vision:

1. Carers are regarded as equal partners in the care of the people they care for.
2. Carers are offered timely, effective and appropriate help both to sustain their caring role and to enjoy life outside it.
3. Carers across Fife will be supported to access information, services and personalised support, which meets their needs and enables them to manage their caring role with confidence.
4. Carers will not be disadvantaged or discriminated against in relation to gender, age, ethnicity, religious beliefs, location and including financial hardship as a result of caring.
5. Carers will be involved in the planning and shaping of the provision of care for the service user and the support for themselves.
6. Young carers will be seen as children first and carers second.

Outcomes for carers:

1. Be well informed with easy access to good information.
2. Have access to simple Carers Assessments.
3. Be recognised and valued by public bodies as equal partners in care.
4. Be supported and empowered to manage their caring responsibilities with confidence and to have a life outside caring.
5. Remain in good health.
6. Have the opportunity of short and respite breaks.
7. Be trained to look after the cared for person safely.
8. Not be disadvantaged or discriminated against.
9. Be fully engaged in the planning and development of their own personalised support.

Children's Services

NHS Fife Children and Young People's Health and Wellbeing Draft Strategy for Consultation 2015-2020 *NB: Draft Strategy document due to be circulated as part of formal Consultation process*

High Level Strategic Priorities

- Promote health and wellbeing
- Develop children's and young people's services
- Work in partnership with other services to support improved outcomes

Priority areas – 2015

- Embedding GIRFEC and preparation for Children and Young People's Act (Scotland (2014)
- Develop nursing pathways
- Looked after children and young people
- Reshape service provision to ensure focus on reducing health inequalities
- Mental Health
- H&SCP Integration

Community Planning

Fife Community Plan, 2011 - 2020

High level outcomes:

1. **Reducing inequalities:**
    a. Making Fife's communities safer
    b. Meeting the need for suitable housing choices
    c. Reducing low income households
    d. Increasing the capability of Fifers to take action and make a difference to their communities.
    e. Strengthening communities through regeneration
    f. Raising educational attainment and reducing educational inequality
    g. Improving early years development of children in Fife.
    h. Improving the health of Fifers and narrowing the health inequality gap

i. Improving the health and wellbeing of older people in Fife and maintaining their involvement in their local communities

2. **Increasing employment:**
    a. Extending employment and skills opportunities
    b. More dynamic businesses
    c. Developing a modern business infrastructure
    d. Improving the knowledge and research base
    e. Growing businesses and employment in key sectors (including investment in renewables and tourism)
3. **Tackling climate change:**
    a. Adapting to climate change
    b. Reducing carbon emissions (including reducing energy use, more sustainable transport and less waste)

Community Safety

Fife Community Safety Strategy, 2011 – 2015

Strategy Outcomes:

1. People feel safer
2. Better support for victims
3. Reduce crime and antisocial behaviour
4. Reduce re-offending
5. Less risk from injury in the home
6. Less risk from fire
7. Fewer people killed or seriously injured on the road

Culture *(Include?)*

Strategy for Culture in Fife 2011-2013

Strategic Objectives:

1. Make creativity and heritage more accessible to all in Fife's communities
2. Increase cultural participation and engagement
3. Raise awareness of the wellbeing outcomes of cultural activity
4. Support communities to increase their cultural capacity
5. Support creative learning for all ages
6. Maximise the economic benefits of cultural activity in Fife

Dementia

Fife Dementia Strategy, 2010 – 2020

Strategy Outcomes:

- Increased collaborative working across all sectors and services who work with people affected by dementia.
- Improved access to services
- Increased flexibility of services
- Services which are responsive to individual need
- Improved continuity in care
- Providing high-quality sustainable services
- Increased staff knowledge and skill surrounding dementia
- Increased awareness of dementia in the general public
- Increased number of opportunities for carers and people with dementia to be involved in service development and provision

Food & Health

Fife's Food and Health Strategy Action Plan, 2011-2014

Key Outcomes

1. People have the personal skills, strengths, knowledge and opportunity to improve their health and wellbeing. (Outcome 5 of Health & Wellbeing Plan)
    a. Key target groups have a better knowledge and skills around healthy eating
    b. Communities have the opportunity to influence food and health issues
2. Local community networks are built and community participation increased around sourcing, preparing and eating a healthy diet (Outcome 7/8 of Health & Wellbeing Plan)
    a. Young people and children have access to affordable healthy food around schools and community use venues
    b. Communities in disadvantaged areas are involved in developing local community Food Projects
    c. More communities in disadvantaged areas make use of available outdoor space for growing projects and community gardens
    d. More people living in disadvantaged areas are involved in opportunities to improve their health
3. Workforces have increased confidence and competence to improve health and wellbeing and tackle health inequalities (Outcome 10 of Health & Wellbeing Plan)
    a. Workers supporting target groups have the necessary skills and knowledge in food and health related issues
    b. More workplaces support healthy eating
    c. Staff working with key target groups have access to resources and training

Gypsy/Traveller Population

Gypsy Travellers Health Inequalities Action Plan 2013-2016

Strategic Priorities:

- Improving nutrition
    - To improve nutrition and diet for gypsy/ travellers of all ages and in particular during pregnancy and infant years.
- Improve access and experience of health services ; primary, secondary and tertiary
    - To improve access to and equity of general medical services.

    - To improve access and equity within secondary care services.
    - To monitor and ascertain the patient experience and satisfaction levels.
    - Improve access to national Health screening programmes and local health programs and initiatives.
- Improving access and provision of general dental services
    - To improve knowledge of & access to general dental services and oral health improvement.
- Improving access and provision of mental health services
    - To ensure equity of access to, and service contact continuity with, Adult Mental Health Services.
- Improve collection of data and information on health needs
    - To improve understanding of the Fife population and including those moving through Fife.
    - To improve data recording and reporting of ethnicity.
    - To improve monitoring of the effect of policies.
    - Provide a baseline of information; work with SG Strategy group to provide an input to the data and baseline information required.
    - Improve information sharing processes between agencies with regard to improving timeous interventions and information giving
- Awareness raising, information and training
    - Increase staff awareness and training on the relationship between health and gypsy/ travellers.
    - Provide cultural awareness training and opportunities to staff.
    - Provide a range of resources to staff to support cultural awareness.
- Domestic and Gender based health issues
    - To promote positive relationships between services and population.
    - To improve information and awareness of domestic violence and support services, not only for refuge but for outreach, counselling and support services.
- Addictions
    - Improve access and information about addiction services including prevention, testing and treatment programs.

Health & Wellbeing

Getting Better in Fife, 2012 – 2017

Strategic Priorities:

- Improving Flow and Emergency Access
- Improving Elective Flow
- Reshaping Older People's Services
- Safe and Accessible Mental Health Services
- Safe and Effective Medicines Management

Fife's Health & Wellbeing Plan, 2011 - 2014

Overarching Aim:

1. Reducing Health Inequalities

Key Themes:

- Supporting healthier lifestyles for individuals and families
- Creating and sustaining healthier places and communities
- Changing the way organisations work

Outcomes

1. People have opportunities and effective support to access and sustain education, training and employment
2. People have increased skills, knowledge and opportunities to manage and improve their financial situation
3. Vulnerable pregnant women, children, young people and families have reduced risk of poor health outcomes
4. Target groups have a choice of suitable housing and support
5. People have the personal skills, strengths, knowledge and opportunity to improve their health and wellbeing
6. Older people have increased opportunities and support to improve their health and wellbeing and to engage in their local communities
7. Communities develop and lead local health and wellbeing initiatives which create supportive social networks and increase participation

in community activity

8. Communities develop and use safe outdoor and community spaces in ways that enhance their health and wellbeing
9. Services and support are delivered in flexible ways which meet the health and wellbeing needs of different communities, neighbourhoods and equality groups
10. Workforces have increased confidence and competence to improve health and wellbeing and tackle health inequalities

Housing

Local Housing Strategy 2010-2015 (update 2011)

High level aim: Provide housing choices for people in Fife

Priorities:

1. Address homelessness

1.1. People are prevented from becoming homeless
1.2. People are provided with temporary accommodation for the duration of their homelessness
1.3. All unintentionally homeless applicants are entitled to settled housing

2. Improve access to housing

2.1. People are provided with suitable and sustainable housing allocations
2.2. People are provided with quality-assured housing information and advice
2.3. People benefit from improved availability and best use of existing housing supply

3. Support sustainable living

3.1. People are offered appropriate housing support services to sustain their choice of living arrangements

4. Increase the supply of housing

4.1. People are provided with new housing appropriate to their need and demand
4.2. People are provided with construction training and employment opportunities

5. Improve the sustainability of housing

5.1. People live in energy efficient housing
5.2. People live in well designed homes and a better quality housing environment
5.3. Sustainable communities are built through partnership and engagement

6. Reduce fuel poverty

6.1. As far as reasonably practicable, people do not live in fuel poverty

7. Improve the condition and suitability of housing

7.1. People live in homes of good quality and condition
7.2. People are provided with housing adaptations to enable independent living

8. Raise standards in the private rented sector

8.1. Private rented sector tenants live in good quality housing

Fife Healthy Heating Strategy, 2010 – 2015

Strategy Aim: Fife Council and its partners will seek to eradicate fuel poverty as far as is reasonably practicable in Fife by 2016

Strategy objectives:

1. To identify fuel poor households in Fife
2. To target advice and support to the fuel poor households in Fife with a view to removing them from fuel poverty as far as reasonably practicable
3. To encourage all landlords to recognise households that are in fuel poverty and take actions to assist them in coming out of fuel poverty
4. To encourage private owners to take actions which will assist in removing them from fuel poverty

Older People Housing Approach 2013 – 2016

Key areas for strategic development:

1. **Responding to National Strategic Changes:** Closer joint working arrangements will be developed between health, social work and housing.
2. **Information and Advice:** The provision (and communication of the availability) of advice and support should be improved to ensure points of information are clear to households from all tenures.
3. **Preventative Support Services:** The research undertaken by North Star and the University of York clearly indicates that older people would prefer to retain their independence and live in their own home for as long as possible.
4. **New Developments:** Future housing developments, including affordable housing, must be of a high standard with provision of desired facilities and support services.
5. **Retirement Housing Model:** The Fife Housing Partnership will work with landlords who are converting existing models of sheltered housing to retirement models to ensure continued access to services for older people. Fife Council will explore the model of retirement housing within its own Sheltered Housing stock and potentially test this in a couple of agreed locations over the next two years.
6. **Sheltered Housing:** The policy to review current low demand and obsolete sheltered housing should continue.
7. **Dementia Services:** The provision of dementia services (particularly in Kirkcaldy and Glenrothes) will be further explored and, where appropriate, highlighted as a priority in new build models and future strategy development.
8. **Extra Care Housing:** Research has identified the need to develop Extra Care Housing across Fife.
9. **Intermediate Care:** Development is required to bridge the gap between home and a care setting both to allow rehabilitation but also to prevent hospital admissions. It is proposed that this be developed within Extra Care complexes.
10. **Review of Existing Charging Framework:** Covering Housing Support Charges for older people in amenity, sheltered and very sheltered housing. There will be a full consultation on charging options.

Learning Disabilities/Autism Spectrum Disorder

Health Improvement Strategy for Adults with a Learning Disability Living In Fife, 2011

Key recommendations:

Health Surveillance:

1. Establish learning disability registers at local level to identify health needs. This would support and improve strategic planning.

National Screening Programmes:

2. Make health screening programmes more accessible though better local information on breast screening; cervical screening; bowel screening; osteoporosis screening.

Health Improvement:

3. Ensure there is proactive coordination of current and future health initiatives for people with a learning disability especially around sexual health, parenting, healthy eating; general health needs (*Keep Well* Checks), smoking, alcohol and substance use.

Nutrition (Food and Health):

4. Develop and implement appropriate nutritional standards for residential supported living and day support services.

Training:

5. Improve workforce competencies across all agencies around health needs for people with a learning disability.

Communication:

6. Provide accurate, up to date and accessible information on services available to people with a learning disability for all staff, carers, and the community.
7. Improve communication between agencies and services in order to provide a holistic health care approach.
8. Build on existing forums to ensure that health improvement is a focus for all key stakeholders. This will allow sharing, learning and developing of expertise.
9. Build on existing practice to proactively identify patients with a learning disability who enter the acute sector so that suitable adjustments can be put in place to meet their health needs.

Active Citizenship:

10. Develop in partnership with other statutory and voluntary organisations:

- more opportunity for social and physical activities, employment opportunities and a greater breadth of educational opportunities for people with a learning disability;
- an active citizen charter for people with a learning disability which describes individuals' rights and responsibilities in relation to actively managing their health needs;
- improve access to transportation services that assist people with a learning disability especially in relation to access for social and educational opportunities to maintain and improve their health.

11. Ensure that when a person is in transition from child to adult services or from adult to older people services there is sufficient attention given to their ongoing and future health needs.

Strategy/Policy:

12. Develop further integration of services and pathways to ensure a holistic approach to the health needs of people with a learning disability.
13. Review, develop and influence partnership strategies and action plans to ensure planning and commissioning of health issues is being carried out.
14. Ensure Equality and Diversity is a priority in all health improvement activity intended for those with a learning disability.
15. Ensure the Patient Focus Public Involvement Strategy includes a focus on service users' and families' input to improving their health outcomes.

Joint Commissioning Strategy For People With Learning Disabilities/ Autism Spectrum Disorders and Complex Need, 2011 - 2021

No strategic level priorities/aims listed – lists the principles of Joint Commissioning:

1. Person Centred Approach – Family and Carer Involvement
2. Promoting appropriate, cost effective models of Community Living and care
3. Self Directed Support
4. Quality Assurance and Review
5. Care Within Fife
6. Using Evidence Based practice to meet Health and Social Care needs

7. Taking account of all service users and the Equality duty
8. Assessing and Managing Risk
9. Purchasing within Framework Agreements

Autism Strategy in Fife 2014-2024

Key aspiration: getting the right service at the right time to promote the independence and resilience of people with autism and their carers

Strategic Priorities: Document does not list Fife's strategic priorities but details Fife's position in relation to the indicators of current best practice according to the National Strategy –

1. A local Autism Strategy developed in co-operation with people across the autism spectrum, carers and professionals, ensuring that the needs of people with ASD and carers are reflected and incorporated within local policies and plans.
2. Access to training and development to inform staff and improve the understanding amongst professionals about ASD.
3. A process for ensuring a means of easy access to useful and practical information about ASD, and local action, for stakeholders to improve communication.
4. An ASD Training Plan to improve the knowledge and skills of those who work with people who have ASD, to ensure that people with ASD are properly supported by trained staff.
5. A process for data collection which improves the reporting of how many people with ASD are receiving services and informs the planning of these services.
6. A multi-agency care pathway for assessment, diagnosis and intervention to improve the support for people with ASD and remove barriers.
7. A framework and process for seeking stakeholder feedback to inform service improvement and encourage engagement.
8. Services that can demonstrate that service delivery is multi-agency in focus and co-ordinated effectively to target meeting the needs of people with ASD.
9. Clear multi-agency procedures and plans which are in place to support individuals through major transitions at each important life-stage.
10. A self-evaluation framework to ensure best practice implementation and monitoring.

Also provides details of Fife Council's "Education Service, Autism Spectrum Disorder Improvement Plan, 2011 – 2014" which aims to:

1. continuously improve the educational experience of all our children and young people with autism by:
    a. building the capacity of schools by extending, challenging and supporting schools in the self-evaluation process,
    b. providing high quality robust information to support the self-evaluation process,
    c. identifying, developing and promoting good practice in supporting children and young people with autism

Adult services:

Future outcome: removal of short-term barriers such as unaddressed diagnoses and delayed intervention and access to appropriate post-diagnostic support for families and individuals (particularly when there is a late diagnosis).

Mental Health

What matters to You? Joint mental health strategy for the people of Fife, 2013-2020

Outcomes:

1. More people will have good mental health
2. More people with mental health problems will recover
3. More people with mental health problems will have good physical health
4. More people will have a positive experience of care and support
5. Fewer people will suffer avoidable harm
6. Fewer people will experience stigma and discrimination

Older People

Joint Health & Social Care Strategy for Older People in Fife, 2011 – 2026

Areas of Strategic Intent:

1. Preventative/Anticipatory Care: We will identify and support, in a planned way, people with long term conditions and their carers enabling home based care to be provided wherever possible and taking account of the wishes of the person and their carer.
2. Unplanned Care: We will reduce level of unplanned care episodes, but where these occur, ensure return to their usual place of residence as soon as possible and ensure that life changing decisions are not made at the point of crisis.
3. Hospital Based Care: Hospital-based care will provide specialist diagnostic and treatment services that cannot be provided within the community
4. Home Based Care: We will refocus services to actively support people to feel safe while living at home whilst reducing reliance on care, where this is in accordance with the person's needs and wishes. The important role of the carer will be recognised in this and appropriate support provided.
5. Recovery & Rehabilitation: Everyone will have the opportunity to remain independent in their daily lives, and when indicated be actively supported to regain quality of life as defined by them
6. Carers: With the agreement of the person being cared for, we will keep carers at the centre of care provision – working together as true partners
7. Community: We will actively nurture and develop communities to support and utilise older people as full participants within those communities
8. Housing: We will actively ensure older people have access to information, advice and housing support services to enable independent living of their choice
9. Integrated Care: Integrated care provision should be put in place to support improved outcomes

Fife's Health & Social Care Partnership Service Delivery Plan 2012 – 2015 states the current strategy focus for Older People as being the areas of strategic intent detailed above.

Palliative Care

Fife Palliative Care Service Strategy for Specialist Palliative Care, 2008 – 2010 *(NB: No updated strategy available)*

Areas of strategic recommendations:

Delivery of Clinical Care

- Fife Palliative Care Service should review and define the referral criteria for the Service and provide clear guidance to all referrers.
- The Service needs to review the model for clinical care taking into consideration "Living and Dying Well", "Shifting the Balance of Care" and the inclusion of patients with non-malignant disease. The model for inpatient beds, hospital and community support should reflect an efficient and effective use of resources.
- The Service should continue to develop and support proactive care planning and management, including anticipatory prescribing across all areas.
-

Specialist Palliative Care as a Resource

- The Service should be available as an advisory and support service for generalists and other specialist disease services.
- Information on the Service for patient, carers and professionals should be readily available and easy to access.
- The Service should help support the development and implementation of *triggers* for identification, assessment and review of palliative care and end of life needs.
- The Service should consider how access to 24 hour information and support for patients and carers can be provided.
- The Service will continue to support the use of recognised assessment tools, e.g. Gold Standards Framework and encourage roll out across Primary Care in Fife to improve communication and quality of care for palliative care patients and their carers.
-

Collaboration (Joint Working) and Partnership

- There is a need to develop links working with other services caring for patients with non-malignant diseases to help support the adoption of palliative care principles into the patient's care pathway.
- The Service should ensure there is patient and carer involvement in developing services which reflects the diversity of population.
- The Service should explore opportunities created by technology and telemedicine to support and enhance palliative and end of life care (electronic palliative care summary).
- The Service will continue to develop partnership working in collaboration with Voluntary Sector Providers , Health and Statutory Services

Education

- In order for high quality general and specialist palliative care to be provided to patients and their carers there needs to be mutual sharing of knowledge and skills between generalists, specialists in non-malignant conditions and palliative care specialists. Specialist Palliative Care input into planning and delivery of training and education for health and social care providers needs to be further developed and increased to improve access and quality of general palliative care for the increasing number of patients with cancer and for those suffering from progressive non-malignant conditions.
- The Service should be involved in supporting the implementation of the rollout of The Liverpool Care Pathway across Fife incorporating specialist knowledge and experience in education and training programmes.
- Education for the Fife Palliative Care Service workforce should be reviewed and developed to be able to respond to the changes in referral criteria and patients accessing the Service.
- The Service should work in collaboration with general palliative care Educators to review the model for the delivery of education to help raise awareness and increase palliative care knowledge and skills of the general workforce across Fife.

Physical Disabilities or Sensory Impairments

Sensory Impairment Review, 2014

Pre-cursor to a strategy being developed hence no strategic priorities listed. Does, however, list recommendations from National Strategy:

1. **Audit of spend–**
   An audit should be undertaken of all current spend on sensory impairment, including that relating to carers, across statutory Health and Social Care and third sector agencies, in relation to specialist provision and also to those elements of other service provision that impact on people with a sensory impairment. In the light of the findings, consideration should be given to options for realignment of spend as appropriate.

2. **Basic sensory screening –**
   Local partnerships should consider options for the introduction of basic screening, for example, for people of a certain age, and at agreed times in their care pathway.

3. **Sensory awareness training –**
   There should be mandatory training in sensory awareness and assessing for non-complex needs across staff in health and social care settings, targeted in the first instance on older people's services.

4. **Local partnership work –**
   Local partnerships (statutory health and social care and third sector) should be able to evidence that their service planning reflects the need in their area.

   Local partnerships should develop care pathways for people with a sensory impairment, which confirm the component parts of the individual's journey. In so doing they should assess performance against the care pathway and the key factors for effective pathways outlined earlier, and use this as the basis for service improvement, and identify the relevant possibilities across agencies for the delivery of this.

   Accessible local information strategies should be developed to include preventative measures and good self- care in retaining sensory health, but also providing information on how to access services.

   These matters should be subject to regular reporting and review by local partnerships. The Scottish Government will provide funding to local partnerships for 2013/14 and 2014/15 to assist with the work that will be required to implement this group of recommendations. Partnerships should ensure that attention be given to ensuring maximum sustainability once this funding ceases.

5. **Local information –**
   There should be robust systems for maintaining information locally, and sharing this between agencies, in relation to people who have received a diagnosis of a sensory impairment at any time from birth onwards.

6. **The Equality Act –**
   Compliance with the Equality Act 2010 should be scrutinised in relation to sensory impairment, particularly in relation to communication, and consideration given as to what future action may be required.

Self Directed Support	
Fife's Self Directed Support Strategy	
Strategic Action Plan	
Action 1:	SDS Act implementation preparation Develop SDS Strategy, Strategic Action Plan and FC Operational Priority Report to ensure readiness for the proposed new SDS duties in line with the national regulations and guidance when published. Prepare report when SG finalise

draft regulations and guidance.

- Action 2: Fife Council SDS Readiness for New Assessment Referrals

  Undertake phased programme of SDS awareness raising and assessor training with all SW Locality Teams. SW Teams to implement SDS pathway for all new assessment referrals by April 14.

- Action 3: SDS Training Strategy

  Preparation and implementation of staff training strategy to underpin effective implementation of all actions within strategic action plan.

- Action 4: SDS Test Site Development

  Led by the SDS Team, develop project plans and implement these for each test site

- Action 5: Development of Resource Allocation System (RAS)

  Continuing to investigate and develop a resource allocation system

- Action 6: Monitoring and Evaluation Framework

  Develop a monitoring and evaluation framework then implement recommendations on an ongoing basis

  Within framework, develop model SDS pathway for individuals.

- Action 7: Develop and Implement Communication Strategy

  Develop SDS Communication Plan

- Action 8: Provision of accessible information

  Providing accessible and relevant information, advice and guidance to all stakeholders

- Action 9: Develop a Market Shaping Strategy with Providers : In-House (A) and External (B)

  Work with providers in all sectors, including in-house services, to draft a market shaping strategy

- Action 10: Joint SDS working between NHS Fife and Fife Council

  Strengthening working links on SDS with NHS Fife

- Action 11: Develop Strategy Review Framework

  Developing and reviewing this strategy and action plan for taking SDS forward in the future.

Fife Sports & Leisure Trust Corporate Strategy 2014-2017

Strategic Priorities:

- Health Opportunities
- Partnership working
- Increased Participation in Sport and Physical Activity
- Resources
- Grow the Business

Overarching Aim:

"Providing opportunities for clients to enjoy regular participation in sport and physical activity as part of a physically active lifestyle"

Key Themes:

- Growing the business – seek new opportunities
- Improving the client experience – increase the numbers of people taking part in physical activity
- Make a Difference – promote "feeling good in body and mind"

Outcomes

1. Aid reduction of health inequalities by providing concessionary programmes for disadvantaged groups within the community
2. Older people have increased opportunities and support to improve their health and wellbeing to engage in physical activity
3. Demonstrate the impact of the contribution physical activity makes to improving the quality of life of the local community
4. Physical activity is delivered in flexible ways which meet the health and wellbeing needs of different communities, neighbourhoods and equality groups
5. Work in partnership with NHS Fife to develop and support physical activity programmes
6. FSLT Workforce have increased confidence and competence to improve health and wellbeing and tackle health inequalities

Tobacco Control

Fife Tobacco Issues Group Action Plan: aims to promote the health of people living and working in Fife by reducing the health impact of tobacco, particularly targeting areas and populations of greatest need

OBJECTIVES

- To support the achievement of the aim the Action Plan has the following objectives:
  - **Enforcement:** to implement locally legislation relating to the sale and supply of tobacco;
  - **Smoking Prevention:** to reduce initiation and uptake of smoking in young people
  - **Stop Smoking services:** to reduce rates and frequency of active smoking in adults and young people
  - **Health Protection:** to reduce exposure to second-hand smoke and the wider harm associated with smoking

Enforcement: to implement locally legislation relating to the sale and supply of tobacco

- Includes action to maintain and improve traders knowledge of age related sales and relevant laws, to ensure compliance of smoking in public place legislation and maintain a strong enforcement presence.

Smoking Prevention: reduce initiation and uptake of smoking in young people

- Includes action to reduce youth access to tobacco, reduce promotion of tobacco, and discourage young people from starting to smoke through effective programmes in schools and colleges to encourage young people to quit smoking

Stop Smoking Services: reduce rates and frequency of active smoking in adults and young people

- Includes action to increase uptake, enhance performance and improve monitoring of the stop smoking services, to enhance referrals to the service via health professionals, to encourage the development of services accessible and sympathetic to the most disadvantages in Fife.

Health protection: reducing exposure to second-hand smoke and the wider harm associated with smoking

- Includes action to raise awareness of the impact of second-hand smoke on health, to ensure the effective implementation of workplace tobacco policies (in particular NHS Smokefree Sites) and to reduce the wider harm associated with smoking including measures to reduce fires in the home.

Health & Social Care
Integration in Fife

Key Locality Information

Data sourced from KnowFife Dataset (accessed 20th August 2015) and Linked SMR01 data provided by NHS Fife Information Services (20th April 2015)

UNDERSTANDING THE LOCALITY OF COWDENBEATH

Population
(Fife 366,910)

Total	40,498
Children	7431 (18.3%)
Working age adults	25642 (63.3%)
Pensionable age adults	7425 (18.3%)

Employment Deprived
% of working age population

19.1%	Cowdenbeath
12.8%	Fife

Income Deprived
% of population

18.4%	Cowdenbeath
13.3%	Fife

Multiple Admissions to Hospital for People Aged 75+

71.4	Cowdenbeath
71.8	Fife

Rate per 1,000 population aged 75 and over with two or more emergency admissions to hospital

Life Expectancy at Birth

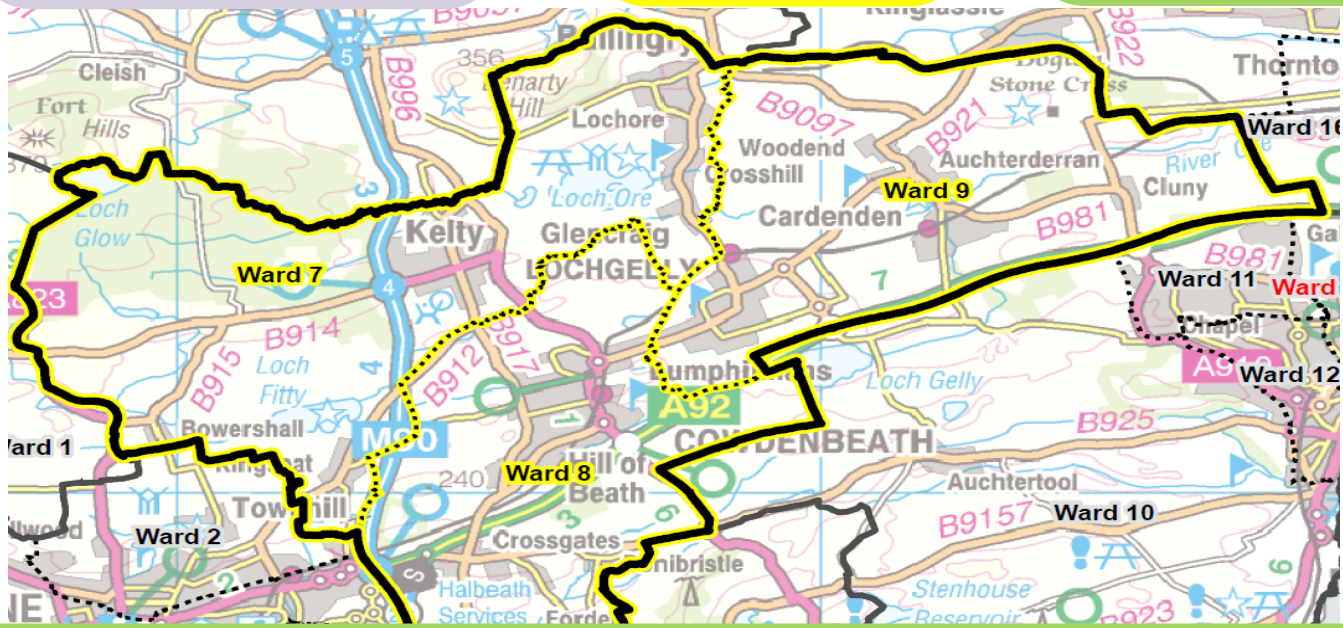
	Cowdenbeath	Fife
Males	75.1	76.9
Females	79.5	81

Children in Poverty
% of all children under 16

25.6%	Cowdenbeath
19.1%	Fife

Affordable Decent Housing
% satisfaction

77%	Cowdenbeath
77.4%	Fife



Additional Information - 8 GP Practices plus 2 practices in Kinross that provide services for Fife citizens.

Community Planning Priorities and Action Areas

Social prescribing model is being piloted in Lochgelly Health Centre to promote physical activity.

Mental health – social prescribing project through the mental health strategy.

Reduce child poverty – increase use of healthy start vouchers for families on low incomes.

Increase membership on credit unions. Develop foodbank provision.

UNDERSTANDING THE LOCALITY OF DUNFERMLINE

Population (Fife 366,910)

Total	54,712
Children	10632 (19.4%)
Working age adults	35514 (64.9%)
Pensionable age adults	8566 (15.7%)

Employment Deprived
% of working age population

11.3%	Dunfermline
12.8%	Fife

Low Income
% of population

10.9%	Dunfermline
13.3%	Fife

Multiple Admissions to Hospital for People Aged 75+

85.8	Dunfermline
71.8	Fife

Rate per 1,000 population aged 75 and over with two or more emergency admissions to hospital

Life Expectancy at Birth

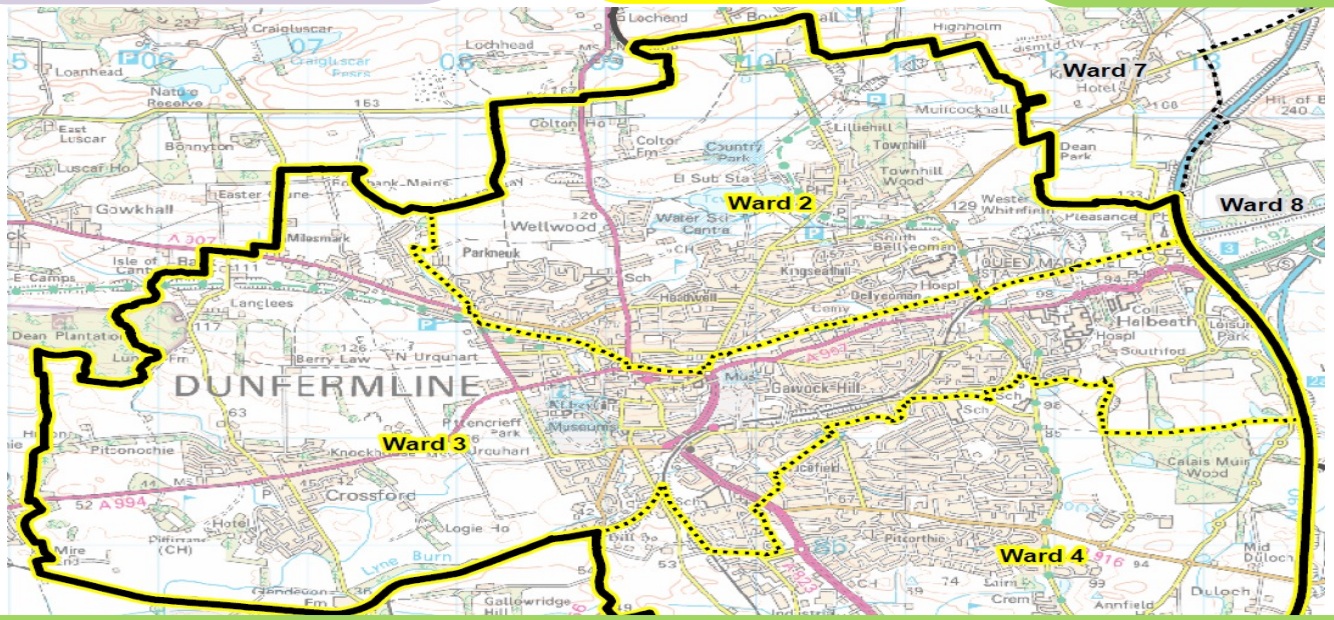
	Dunfermline	Fife
Males	77.7	76.9
Females	81.5	81

Children in Poverty
% of all children under 16

13.2%	Dunfermline
19.1%	Fife

Affordable Decent Housing
% satisfaction

84.1%	Dunfermline
77.4%	Fife



Additional Information - 6 GP Practices.

Community Planning Priorities and Action Areas

Active Lifestyle – increased opportunity for older people, people with long-term condition and people with physical disability to engage in physical activities while addressing social isolation.

Increased opportunities to access support for people affected by welfare reforms e.g. Frontline Fife, Furniture Plus, Foodbanks.

UNDERSTANDING THE LOCALITY OF GLENROTHES

Population
(Fife 366,910)

Total	50,701
Children	9306 (18.4%)
Working age adults	32135 (63.4%)
Pensionable age adults	9260 (18.3%)

Life Expectancy at Birth

	Glenrothes	Fife
Males	76.7	76.6
Females	80.4	81.3

Children in Poverty
% of all children under 16

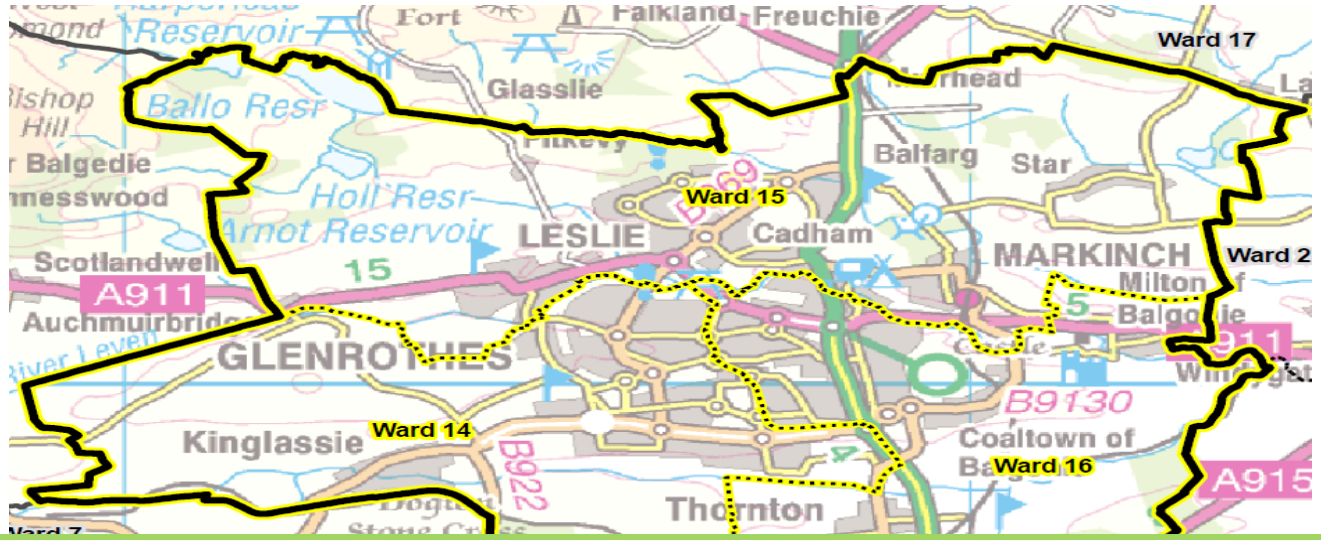
23%	Glenrothes
19.1%	Fife

Affordable Decent Housing
% satisfaction

78.3%	Glenrothes
77.4%	Fife

Employment Deprived
% of working age population

14.5%	Glenrothes
12.8%	Fife



Low Income
% of population

15.7%	Glenrothes
13.3%	Fife

Multiple Admissions to Hospital for People Aged 75+

79.6	Glenrothes
71.8	Fife

Rate per 1,000 population aged 75 and over with two or more emergency admissions to hospital

Additional Information - 7 GP Practices.

Community Planning Priorities and Action Areas

Active Lifestyle – target difficult to reach groups, improving health through increased update in opportunities for the development of sports and community hubs.

Healthy Lives – making best use of community assets.

Develop foodbank provision.

Regeneration – town centre and business infra-structure.

UNDERSTANDING THE LOCALITY OF KIRKCALDY

Population
(Fife 366,910)

Total	59,795
Children	10768 (18%)
Working age adults	37417 (62.6%)
Pensionable age adults	11610 (19.4%)

Employment Deprived
% of working age population

14.3%	Kirkcaldy
12.8%	Fife

Low Income
% of population

16.1%	Kirkcaldy
13.3%	Fife

Multiple Admissions to Hospital for People Aged 75+

75.3	Kirkcaldy
71.8	Fife

Rate per 1,000 population aged 75 and over with two or more emergency admissions to hospital

Life Expectancy at Birth

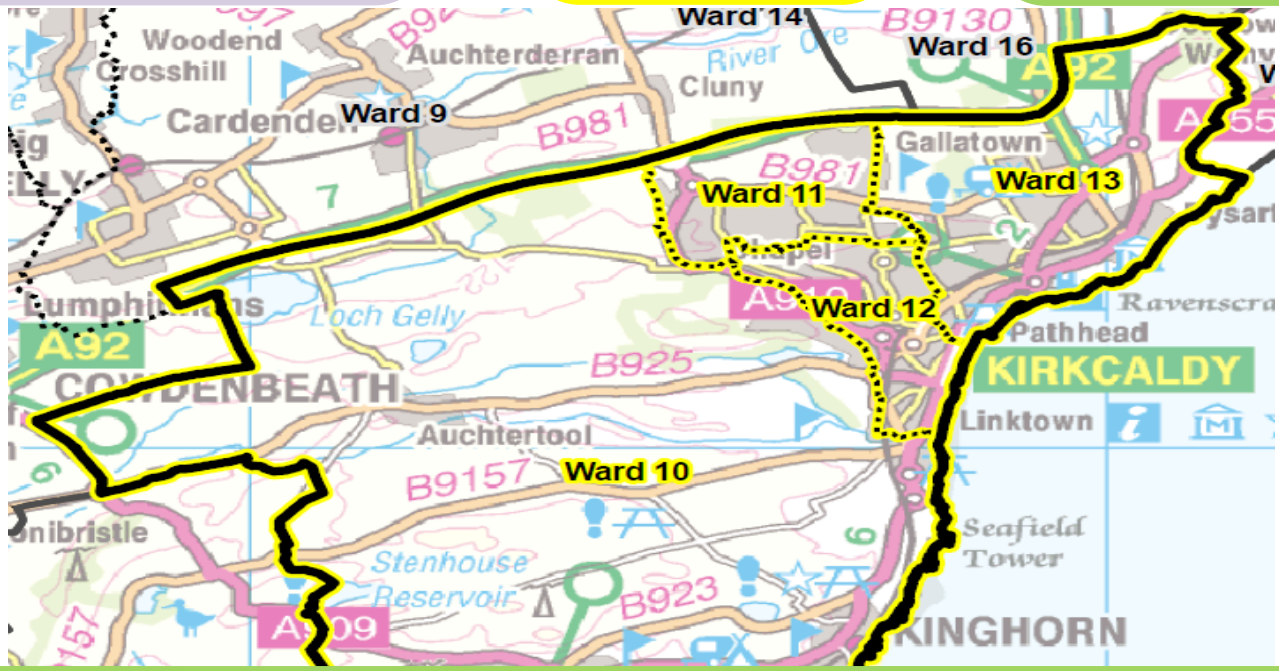
	Kirkcaldy	Fife
Males	76.1	76.9
Females	80.5	81.0

Children in Poverty
% of all children under 16

22%	Kirkcaldy
19%	Fife

Affordable Decent Housing
% satisfaction

96.3%	Kirkcaldy
77.4%	Fife



Additional Information - 11 GP Practices.

Community Planning Priorities and Action Areas

Promoting and developing early year's activities informed by the community.

Redevelopment of Gallatown in the context of a community regeneration approach.

Promote a multi-agency approach to supporting Kirkcaldy tenants with poverty issues.

UNDERSTANDING THE LOCALITY OF LEVENMOUTH

Population
(Fife 366,910)

Total	37,695
Children	6467 (17.2%)
Working age adults	23487 (62.3%)
Pensionable age adults	7741 (20.5%)

Life Expectancy at Birth

	Levenmouth	Fife
Males	75.6	76.9
Females	79.5	81

Children in Poverty
% of all children under 16

26.9%	Levenmouth
19.1%	Fife

Affordable Decent Housing
% satisfaction

91.0%	Levenmouth
77.4%	Fife

Employment Deprived
% of working age population

19.4%	Levenmouth
12.8%	Fife

Low Income
% of population

19.6%	Levenmouth
13.3%	Fife

Multiple Admissions to Hospital for People Aged 75+

76.1	Levenmouth
71.8	Fife

Rate per 1,000 population aged 75 and over with two or more emergency admissions to hospital

Additional Information - 7 GP Practices.

Community Planning Priorities and Action Areas

Active lifestyle – The incorporation of Green Gym equipment for intergenerational use and to promote physical activity.

Redevelopment of Silverburn in the context of a community regeneration approach.

Continued work to address suitability of Levenmouth transport infrastructure to enable increased access to jobs and training.

UNDERSTANDING THE LOCALITY OF NORTH EAST FIFE

Population
(Fife 366,910)

Total	73,461
Children	10581 (14.4%)
Working age adults	47508 (64.7%)
Pensionable age adults	15372 (20.9%)

Life Expectancy at Birth

	North East Fife	Fife
Males	78.8	76.9
Females	82.7	81

Children in Poverty
% of all children under 16

10.2%	North East Fife
19.1%	Fife

Affordable Decent Housing
% satisfaction

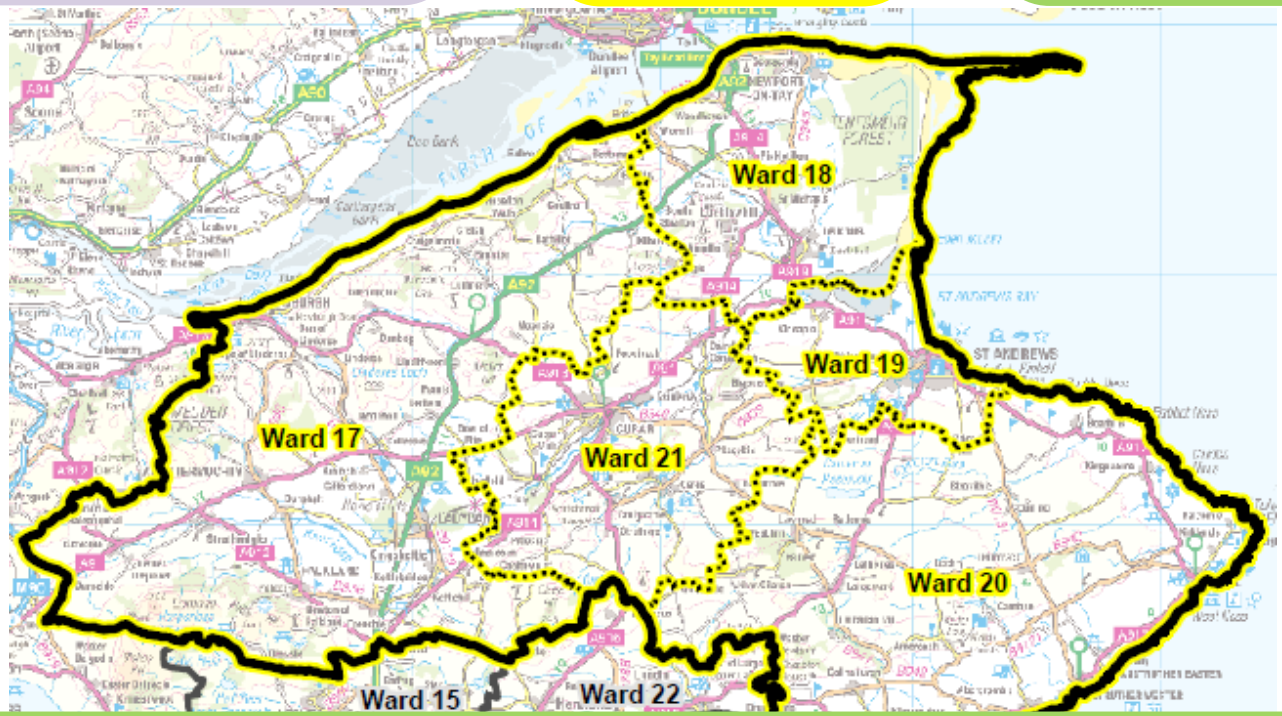
45.8%	North East Fife
77.4%	Fife

Employment Deprived
% of working age population

6.4%	North East Fife
12.8%	Fife

Low Income
% of population

7.1%	North East Fife
13.3%	Fife



Multiple Admissions to Hospital for People Aged 75+

56.3	North East Fife
71.8	Fife

Rate per 1,000 population aged 75 and over with two or more emergency admissions to hospital

Additional Information - 12 GP Practices plus 1 practice in Bridge of Earn that provide services for Fife citizens.

Community Planning Priorities and Action Areas

Supporting the elderly population through a range of community initiatives.

Connectivity – reducing the impact of reduced transport options.

UNDERSTANDING THE LOCALITY OF SOUTH WEST FIFE

Population
(Fife 366,910)

Total	50,048
Children	9008 (18.0%)
Working age adults	31998 (63.9%)
Pensionable age adults	9042 (18.1%)

Employment Deprived
% of working age population

10.8%	South West Fife
12.8%	Fife

Low Income
% of population

10.5%	South West Fife
13.3%	Fife

Multiple Admissions to Hospital for People Aged 75+

65.7	South West Fife
71.8	Fife

Rate per 1,000 population aged 75 and over with two or more emergency admissions to hospital

Life Expectancy at Birth

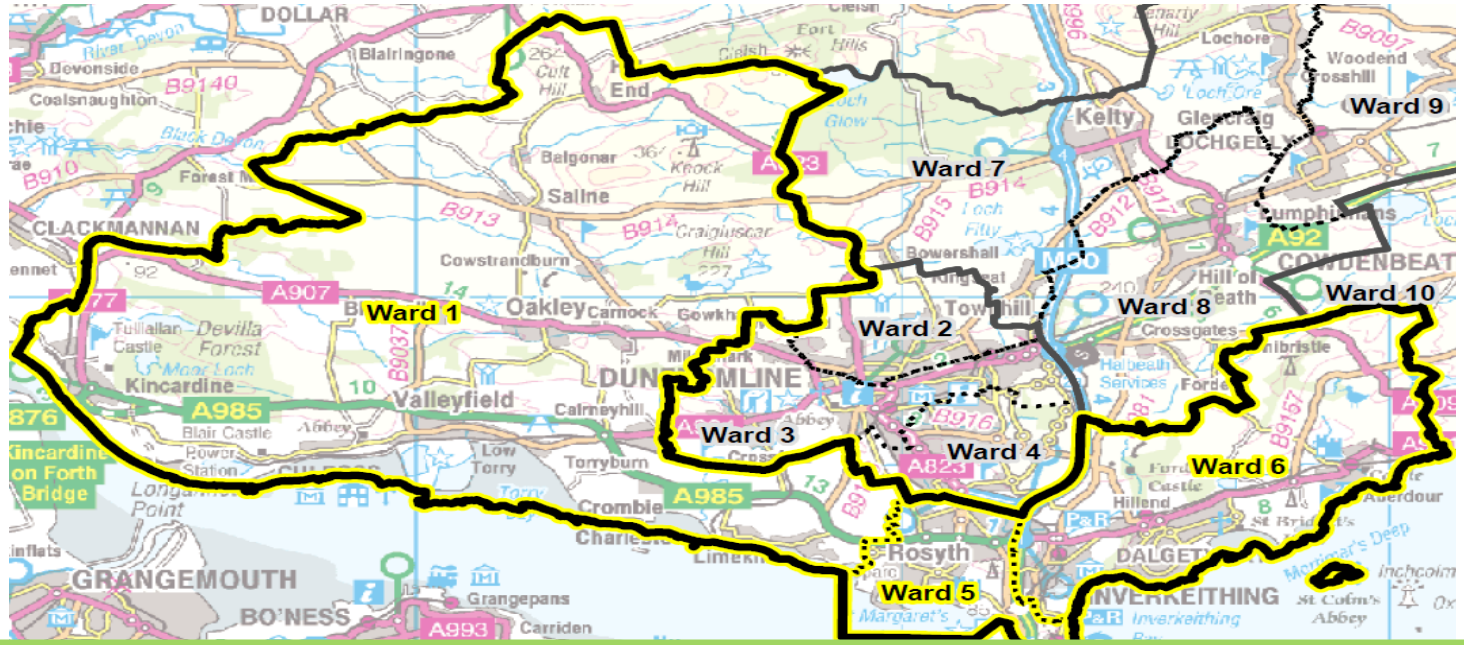
	South West Fife	Fife
Males	77.5	76.9
Females	82.2	81.0

Children in Poverty
% of all children under 16

14.7%	South West Fife
19.1%	Fife

Affordable Decent Housing
% satisfaction

72.6%	South West Fife
77.4%	Fife



Additional Information - 7 GP Practices plus 1 practice in Clackmannan that provide services for Fife citizens.

Community Planning Priorities and Action Areas

Priorities for active lifestyle have been identified as: building on early years the understanding of behaviours affecting health, mental health, older citizens.

Redevelopment of Fraser Avenue in the context of a community regeneration approach.

Appendix C
Housing Contribution Statement

Draft for Consultation

Sept 2015

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1. Introduction

1.1 The Housing Contribution Statement sets out the role of social housing providers in Fife to achieving outcomes for health and social care. It strengthens the proposals provided in Fife's first contribution statement agreed by the Health and Social Care Shadow Board in January 2014.

1.2 The revised Housing Contribution Statement will become an integral part of Fife Health & Social Care Partnership's Strategic Plan. It has been developed from work undertaken by the Fife Housing Partnership to provide Fife's Local Housing Strategy (LHS) 2015-2020. The Housing Contribution Statement mirrors the content of the LHS 2015-2020, but is provided as a 'stand-alone' publication for those focusing on housing, health and social care.

2. Housing Partnerships

2.1 The Fife Housing Partnership has responsibility delegated by Fife Council to take forward the strategic housing agenda for Fife. Its membership comprises:

The Fife Housing Partnership

2.2 The Fife Housing Partnership is underpinned by a working group structure designed to ensure effective implementation of a strategic housing plans for Fife. Outcomes for housing, health and social care are managed by the LHS Implementation and Performance Group and delivered through the LHS Social

Inclusion Group.

2.3 In 2013, a Housing Sector Reference Group was formed by Fife Council, registered social landlords and third sector organisations to help promote joint-housing, health and social care working in Fife. This group agreed a 'Fife model', outlining how Fife's housing sector could best contribute to health and social care. This model underpinned Fife's first Housing Contribution Statement and, following a process of public consultation, was incorporated into the LHS 2015-2020.

3. Health and Social Care Partnership

3.1 The Public Bodies (Joint Working) (Scotland) Act 2014 establishes the legal framework for integrating health and social care to ensure joined-up, seamless services. In 2015, the Health and Social Care Partnership will be established as a separate legal entity governed by an Integration Joint Board. The Board comprises voting members from the Council and NHS Fife Board, supported by other non-voting members.

3.2 The Integration Joint Board has responsibility for providing a Strategic Plan by April 2016, outlining the vision for health and social care services, key strategic priorities and the commissioning outcomes to be achieved. Services will become fully delegated when the Board approves the Strategic Plan.

3.3 Fife Council's Chief Housing Officer is represented on the Strategic Planning Group, actively promoting the housing sector's role in health and social care integration. Officers with strategic housing, health and social care responsibilities are in regular liaison around strategic needs assessment and planning. This Housing Contribution Statement will form part of the agreed Strategic Plan.

4. National Outcomes

4.1 The national health and wellbeing outcomes to be delivered through integration are defined as:

Outcome 1 - People are able to look after and improve their own health and wellbeing and live in good health for longer.

Outcome 2 - People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

Outcome 3 - People who use health and social care services have positive experiences of those services, and have their dignity respected.

Outcome 4 - Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

Outcome 5 - Health and social care services contribute to reducing health inequalities.

Outcome 6 - People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.

Outcome 7 - People using health and social care services are safe from harm.

Outcome 8 - People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

Outcome 9 - Resources are used effectively in the provision of health and social care.

4.2 Outcome 2 is of particular importance in defining the housing contribution though the provision of good quality housing to support a range of needs. A

contribution will also be made to other national outcomes such as Outcome 9, the effective use of resources where effective housing solutions can prevent costly health and social care responses.

5. Locality Planning

5.1 It has been determined through consultation that health and social care services will be managed through three divisions (East, West and Fife-wide) and delivered through seven local areas to match the local community planning boundaries of: City of Dunfermline, Cowdenbeath Glenrothes, Kirkcaldy, Levenmouth, North East Fife and South West Fife.

5.2 Once the Strategic Plan is approved, more work will be undertaken within each locality to develop a local implementation plan. This will provide the opportunity to link to area housing plans already being implemented within each locality. The experience of the housing sector in area planning will contribute to the successful delivery of health and social care outcomes, offering the opportunity for joint local responses to meet local needs.

6. Integration of Functions

6.1 By the 31st March 2016, the Integration Joint Board will have approved the Strategic Plan, and Fife Council and NHS Fife will have delegated functions to the new Fife Health and Social Care Partnership. The Act sets out a range of health and social care functions, including functions under housing legislation, which 'must' or 'may' be delegated to an integration authority. In Fife, the delegated functions are contained within the Health and Social Care Partnership Integration Scheme agreed in September 2015.

6.2 The housing functions that are being delegated by Fife Council to the Fife Health and Social Care Partnership are:

- Older person's housing support (General Fund Housing Account) – housing support is defined in housing legislation as any service which provides support, assistance, advice and counselling to an individual with particular needs to help that person live as independently as possible in their own home or other residential

accommodation such as sheltered housing. The prescribed housing support services are defined in Appendix 1.

- Housing adaptations (General Fund Housing Account and Housing Revenue Account) – an adaptation is defined in housing legislation as an alteration or addition to the home to support the accommodation, welfare or employment of a disabled person or older person, and their independent living. Common examples in Fife include ramps, level access showers and kitchen conversions. This also includes the commended Care and Repair Services provided through Kingdom Housing Association offering advice and assistance to elderly and disabled householders in the repair, improvement or adaptation of their home.

- Improved housing, health and social care working in adaptations has commenced through the Fife Demonstrator Project. This is one of five national housing adaptations demonstrators operating to December 2016, involving the Scottish Government, the Joint Improvement Team, housing, health and social care partners in redesigning the end-to-end adaptations process from a customer perspective.

- Garden Care Services (Housing Revenue Account) – this being a programme of works provided for older or vulnerable Fife Council tenants to help with the grass, hedges and other garden maintenance.

6.3 In 2015-16 the following housing activity will be closely aligned to health and social care:

- Housing support services for homeless people – a Public Social Partnership is in place from April 2015 between Fife Council and 13 third sector organisations for the commissioning of housing support services for homeless people and those at risk of homelessness.
- Other housing services – a range of wider functions will be closely aligned to health and social care including the provision of extra care housing,

retirement housing, housing options information and advice, services to address fuel poverty and other poverty reduction measures.

6.4 The LHS 2015-2020 highlights how the delivery of its eight key housing priorities can influence the success of the Health and Social Care Partnership (and vice-versa), including for example:

- Prevention of homelessness – there is successful joint working to address the specific health needs of homeless people through the Fife Health and Homelessness Plan.
- Access to housing – the Fife Housing Register partners allocate specific needs housing and providing a range of housing allocations protocols for vulnerable adults.
- Healthy heating and poverty – partnership approaches to reducing fuel poverty and addressing poverty in housing are linked to the health and social care improvement of residents.
- New housing supply – 27% of the 2,700 target for new affordable homes are meeting specific housing needs through amenity and wheelchair provision.
- Private sector – actions to improve the condition and management in private rented housing are benefitting older people and vulnerable adults who are over-represented in the sector.
- Sustainable places – inequality and disadvantage is being addressed through prioritising housing issues in the most deprived communities.
- Home energy – providing warm, energy efficient homes and energy innovation is benefitting households' health and financial well-being.

7. Housing Profile

7.1 An overall profile of housing in Fife, taken from local housing market analysis to inform the LHS 2015-2020, indicates:

Housing Profile

Population	•Population of 367,260 persons (mid-2014) •93,662 persons (26%) aged over 60 years
Households	•163,958 households (mid-2014) •6.6% increase 2004-2014 •Average household size 2.19 persons
Household Composition	•37% single adult households (2013) •49% small family households •15% large family households
Dwellings	•163,958 residential dwellings (mid-2014) •6.6% increase 2004-2014 •80% urban / 20% rural locations
Completions	•Annual average 954 new homes (2010-14) •Target of 2,700 affordable homes 2012-17 (540 pa) including 27% specific needs housing
Occupancy	•96% occupancy rate •3% vacancy rate •1% second homes
Tenure	•64% owner occupation (2013) / 68% (2003) •23% social rented (2013) / 27% (2003) •12% private rented (2013) / 4% (2003)
Specific needs housing	•21% homes with adaptations (all tenures) •1,563 sheltered (social sector) •466 very sheltered/extra care (social sector)
Non-permanent accommodation	•50 Council-provided Gypsy Traveller places on 3 sites •540 temporary homes provided for homeless people

8. Housing Need and Demand

8.1 Revised guidance for housing need and demand assessment was provided by the Scottish Government in 2014, supporting the production of cross-boundary assessments for the TAYplan area (Angus, Dundee City, Fife, Perth & Kinross) and the SESplan area (City of Edinburgh, East Lothian, Fife, Midlothian, West Lothian and Scottish Borders). A purpose of these assessments is to inform regional and local housing strategies.

8.2 The guidance emphasises the need for housing practitioners to engage with health and social care planners in developing a Joint Strategic Needs Assessment, to share evidence, identify needs and plan for solutions across health, social care and housing.

8.3 The LHS 2015-2020 summarises the overall housing requirements taken from the TAYplan and SESplan housing need and demand assessments:

- An estimated **19,361 households** were assessed as being in housing need in Fife (31st March 2013) comprising a requirement for adaptations (47%); households living in poor housing conditions (36%); homeless households (7%); overcrowded households (4%); concealed households (3%); and households requiring specialist housing (3%).
- Fuel poverty affecting **56,000** (34%) households (although there is potential for cross-over with some of the above categories).

8.4 The LHS 2015-2020 also summarises the housing needs of a range of equality groups and other vulnerable stakeholder groups, in most cases based on more detailed research undertaken in Fife. These groups are likely to require a housing contribution to either improve health and well-being or to prevent a health and social care issue arising in the future. The summary is provided as follows:

Stakeholder Groups	Summary of Housing Needs / Health and Well-Being Concerns
Age	Older people - households headed by people over 75 years / specialist and adapted housing requirements; and over-representation of 'pensioner' households in fuel poverty. Complexity of housing support requirements / links to physical disability, mental ill-health and substance misuse Young people - 16-17 year olds presenting as homeless; and homelessness in people formerly living in LA residential care. Complexity of housing support requirements / links to mental ill-health, learning disability and substance misuse Children – living in homelessness and in households affected by domestic abuse
Disability	Physical disability – increasing requirement for housing adaptations, specialist forms of housing, hospital discharge. Complexity of housing support requirements with links to mental ill-health, issues of age, learning disability and substance misuse Mental ill-health - complexity of housing support requirements / links to physical disability, issues of age and substance misuse
Gender	Males - over-representation in homelessess Females - over-representation in issues of domestic abuse. Complexity of housing support requirements with links to homelessness, issues of age, mental ill-health, learning disability and substance misuse
Gender reassignment	No significant strategic issues identified
Sexual orientation	Complexity of housing support requirements / links to issues of age, mental ill-health, physical disability and learning disability
Race	Gypsy Travellers - identified need for seasonal sites, site improvements Migrant Workers – issues of housing quality on agricultural holdings BME households – over-representation in homelessness and poverty. Complexity of housing support requirements / links between issues of race, age, mental ill-health and domestic violence
Religion & belief	No significant strategic issues identified
Income / employment deprived	Households within SIMD areas / impacts of poverty linked to ability to access and sustain housing; impacts of Welfare Benefit Reform; fuel poverty
Single people	Over-representation of single people presenting as homeless
Families	Families – high number affected by fuel poverty / links to income and employment deprivation and poverty
Students	Demand for good quality student housing / particular pressure in St Andrews
Ex -offenders / managed offenders	Over-representation in homelessness. Complexity of housing support requirements / links to mental ill-health and substance misuse

9. LHS 2015-2020 Priority - Housing, Health and Social Care

9.1 The LHS 2015-2020 contains a priority for housing, health and social care, providing two outcomes for the delegated functions of housing support and housing adaptations. Section 6.4 previously outlined how other parts of the LHS 2015-2020 will contribute to health and social care outcomes. Activities around the delegated function of garden care are delivered according to criteria for the scheme and budget availability.

9.2 The LHS 2015-2020 outcome plan for housing, health and social care as provided in Appendix 2. Overall success of the LHS priority for housing, health and social care will be measured in 2020 by an increase in the number of independent living solutions provided. This will be achieved through general and specific milestones relating to each outcome, as follows:

- Mapping current housing provision for older people and vulnerable adults to identify what is being provided within the health and social care localities.
- Developing and implementing a training plan for front-line housing staff around housing, health and social care integration.
- Reviewing opportunities for single shared assessments across housing, health and social care services, and introducing a housing options approach for information and advice provision to older people.
- Regularly reporting the client groups receiving housing support and adaptations services against the equality profile of the general population.
- Reviewing the priorities and budget for the Fife Council garden care scheme to ensure that assistance continues to be targeted at those in most need of the service.

Outcome 1: People are offered appropriate housing options and support services to enable independent living

- Considering a consortium approach between Fife Council and registered social landlords to develop new housing models for older people and other vulnerable adults.
- Moving away from the models of sheltered and very sheltered housing to retirement and extra care housing.
- Integrating housing, health and social care services within care village settings.
- Providing visiting support services to older people, vulnerable adults and other priority groups.
- Implementing a plan for direct support to improve choice in service provision.
- Supporting a review of services for people with a physical disability through the Health and Social Care Partnership.

Outcome 2: People are provided with housing adaptations to enable independent living

- Delivering the Fife Demonstrator Project to redesign the end-to-end housing adaptations process, increasing the number of adaptations and reducing the time taken to receive an adaptation.
- Reviewing the opportunities for 'telehealthcare', using technology in homes to maintain independent lives.
- Investigating the provision of drop-in clinics for minor adaptations, information and advice.
- Reviewing the potential for extending the adaptations process to include the Council, registered social landlord and private housing sectors.

- Increasing the number of households accommodated through the specific needs housing process, supported by the Disabled Persons' Housing Service.
- Considering options for 'healthy-homes' health checks to help prevent hospital admissions and help with hospital discharge.
- Providing options for earlier notification of the housing requirements of people awaiting hospital discharge.

10. Resources

10.1 The Fife Council budget identified as making a direct contribution to health and social care through delivery of the delegated functions is £4.599 million in 2015-16, a reduction on the £4.739 million of 2014-15. The identified budget for services that will be closely aligned is £5.764 million, an increase of around £2 million on the previous year. There are no plans for staff with housing responsibilities to be transferred to the Health and Social Care Partnership.

Health & Social Care / Identified Housing Contribution 2014-15 to 2015-16

	2014-15 Outturn £000	Current Budget £000
1. Housing Services - Delegated		
Commissioned Housing Support		
General Fund Housing (GFH)	708	709
Housing Adaptations		
General Fund Housing (GFH) - Revenue	1,233	1,201
General Fund Housing (GFH) - Capital	1,404	1,232
Housing Revenue Account (HRA) - Revenue	1,046	1,120
Garden Care		
Housing Revenue Account (HRA) - Revenue	348	337
TOTAL	**4,739**	**4,599**
2. Housing Services - Closely Aligned		
Commissioned Housing Support		
Public Social Partnership (PSP) - Voluntary Sector	3,723	5,764
TOTAL	**3,723**	**5,764**

10.2 The extent of the resources that could be influenced by the health and social care agenda is less clear. Section 6.4 provides examples of housing activities that can be influenced by health and social care (and vice versa). This includes £million budgets across the housing sector for new-build housing, housing improvement across tenures, actions to address poverty and reduce disadvantage.

10.3 The opportunities that are presented through improved joint-working principally focus on the ability to apply housing resources to prevent costly health and social care crisis responses. The direct influence of health and social care on these housing activities requires on-going dialogue between the Fife Housing Partnership and the Health and Social Care Partnership as part of the closer links between the LHS 2015-2020 and the Strategic Plan.

11. Monitoring and Review

The outcomes, milestones and timescales of the LHS 2015-2020, specifically the housing contribution to health and social care, will be subject to:

- Scottish Government assessment including peer review by other Scottish local authorities.
- Quarterly monitoring through the LHS Social Inclusion theme.
- Quarterly reporting of progress to the LHS Implementation and Performance Group.
- Annual reporting of progress to the Fife Housing Partnership and Fife Council.
- Annual reporting of progress to the Fife Partnership Board, leading in the implementation of the Fife Community Plan / Single Outcome Agreement.
- Reporting of specific outcomes within wider partnership frameworks, including to the Health and Social Care Partnership at a frequency still to be determined.

12. Contact

12.1 For more information on the housing contribution to health and social care contact:

Lynn Leitch

Team Manager Health, Social Care and Children Team

Fife Council Housing Services

Lynn.leitch@fife.gov.uk

03451555555 x 402191

Appendix 1 - Prescribed Housing Support Functions

1. General counselling and support including befriending, advising on food preparation, reminding and non-specialist counselling where this does not overlap with similar services provided as personal care or personal support.

2. Assisting with the security of the dwelling required because of the needs of the service user.

3. Assisting with the maintenance of the safety of the dwelling.

4. Advising and supervising service users on the use of domestic equipment and appliances.

5. Assisting with arranging minor repairs to and servicing of a service user's own domestic equipment and appliances.

6. Providing life skills training in maintaining the dwelling and curtilage in appropriate condition.

7. Assisting the service user to engage with individuals, professionals and other bodies with an interest in the welfare of the service user.

8. Arranging adaptations to enable the service user to cope with disability.

9. Advising or assisting the service user with personal budgeting and debt counselling.

10. Advising or assisting the service user in dealing with relationships and disputes with neighbours.

11. Advising or assisting the service user in dealing with benefit claims and other official correspondence relevant to sustaining occupancy of the dwelling.

12. Advising or assisting with resettlement of the service user.

13. Advising or assisting the service user to enable him or her to move on to accommodation where less intense support is required.

14. Assisting with shopping and errands where this does not overlap with similar services provided as personal care or personal support.

15. Providing and maintaining emergency alarm and call systems in accommodation designed or adapted for and occupied by elderly, sick or disabled people.

16. Responding to emergency alarm calls, where such calls relate to any of the housing support services prescribed in other paragraphs of this Schedule, in accommodation designed or adapted for and occupied by elderly, sick or disabled people.

17. Controlling access to individual service users' rooms.

18. Cleaning of service users' own rooms and windows.

19. Providing for the costs of resettlement services.

20. Encouraging social intercourse and welfare checks for residents of accommodation supported by either a resident warden or a non-resident warden with a system for calling that warden where this does not overlap with similar services provided as personal care or personal support.

21. Arranging social events for residents of accommodation supported by either a resident warden or a non-resident warden with a system for calling that warden.

Appendix 2

LHS Priority Housing, Health and Social Care

Outcome Plan

LHS Priority Housing, Health and Social Care					
Action	**Baseline**	**Indicators**	**Target / Milestone**	**Timescale**	**Lead**
LHS 2020 Success Indicator **Number of independent living solutions to maintain people in their homes 12 months and more is increased** **Measured by:** **Number of housing support interventions - baseline 2,574 service users 2013-2014 Fife Council commissions** **Housing adaptations provided – baseline 20.8% of homes 2011-2013 Scottish House Conditions Survey**					
Outcome 4.1: People are offered appropriate housing options and support services to enable independent living					
Provide housing for older people and other vulnerable adults	3,901 comprising: 1,563 sheltered 367 very sheltered 558 medium dependency 280 wheelchair 1,133 ambulant disabled March 2013	Scottish Government housing statistics / social sector housing tables for Fife Council and RSLs SHIP 2015-17	Increase of 439 new build comprising: 81 extra care 195 wheelchair 184 amenity (or ambulant disabled)	May 2017	FC / RSLs
		Conversion of existing housing into new models of provision	969 sheltered to retirement homes 233 very sheltered to extra care (where care packages available)	Mar 2016	FC
Provide visiting support to older people and vulnerable adults	153,866 hours for older people	Fife Council	213,707 commissioned hours	Mar 2016	FC / RSLs

LHS Priority Housing, Health and Social Care					
Action	**Baseline**	**Indicators**	**Target / Milestone**	**Timescale**	**Lead**
(excluding homeless shown under Priority 1)	76,752 hours for vulnerable adults 2013-2014				
Outcome 4.2: People are provided with housing adaptations to enable independent living					
Enhance the end to end customer journey for those requiring adaptations	N/A	N/A	Deliver Housing Adaptations Demonstrator Project (including review of Telehealthcare)	Mar 2017	FC / H&SCP
Increase the number of major adaptations delivered	242 Private 269 Fife Council	Fife Council	267 Private 296 Fife Council	Mar 2016	FC
Reduce the time taken to provide a major adaptations	157 days Private 247 days Fife Council	Fife Council	120 days Private 160 days Fife Council	Mar 2016	FC
Reduce requirement for housing adaptations	3.7% of homes Fife 2.67% of homes Scotland 2011-2013	Scottish House Conditions Survey / dwellings where adaptations required	Reduce to or below Scottish average	Mar 2020	FC / RSLs

LHS Priority Housing, Health and Social Care					
Action	**Baseline**	**Indicators**	**Target / Milestone**	**Timescale**	**Lead**
Increase the number of households accommodated through the specific needs housing process	102 allocations 2013-2014	Fife Council	Provide target following review of specific needs housing process	Mar 2016	FC / RSLs
Housing, Health and Social Care Review Areas					
Develop locality mapping of housing provision and services to older people and vulnerable adults aligned to Locality Health and Social Care Group				Mar 2016	FC
Provide staff training plan on health and social care / housing impacts				Jun 2015	FC / RSLs
Review opportunities for shared assessment tools across the housing sector				Dec 2016	FC / RSLs
Support a review of services to people with a physical disability through the Health and Social Care Partnership				Sep 2015	H&SCP
Review potential for consortium approach to provide specific needs housing (prioritising Older People, Dementia, People with Alcohol and Drug issues, Veterans)				Mar 2017	FC / RSLs
Review capacity to convert Sheltered and Very Sheltered housing to Retirement and Extra Care housing models across the social sector				Mar 2016	FC / RSLs
Establish governance and reporting framework for Fife Public Social Partnership / mechanisms for prioritising housing support by client type				Mar 2016	FC / PSP

LHS Priority Housing, Health and Social Care					
Action	**Baseline**	**Indicators**	**Target / Milestone**	**Timescale**	**Lead**
Contribute to the implementation plan for self-directed support				Sep 2015	H&SCP
Investigate provision of drop in clinics for minor adaptations and information and advice				Mar 2016	H&SCP
Complete a review of the Specific Needs Housing List				Mar 2016	FC
Review the process to deliver extensions to specific needs households				Mar 2016	FC
Consider options for 'healthy-homes' health checks to help prevent hospital admissions and help with hospital discharge				Mar 2016	FC
Provide options for earlier notification of hospital discharge / housing requirements				Mar 2016	FC
Provide reporting of the client groups receiving support and adaptations services against the equality profile of the general population				Mar 2016	FC / KHA
Provide a review of the priorities and budget of the Fife Council garden care scheme				Mar 2016	FC
Resources					
Health and Social Care Partnership resources Fife Council Housing Revenue Account / General Fund Housing Account RSL Stage 3 resources					

Health & Social Care
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MEMBERSHIP – STRATEGIC PLANNING GROUP

Supporting the people of Fife together

STRATEGIC PLANNING GROUP MEMBERSHIP

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Bryan Archibald	Information Services, NHS Fife
Teresa Briggs	Head of Planning
Gerald Burnett	LMC GP Sub Committee
Pam Butter	Richmond Fellowship
Janice Cameron	Scottish Care
Jan Carter	Chief Finance Officer, H&SCI
Tina Chapman	Public Reference Group
Katherine Cheshire	Head of Psychology Services, NHS Fife
Rona King (replaced David Christie)	Chair, Workforce Workstream
Joanna Clark	Fife Voluntary Action
Hugh Elliott	Finance, Fife Council
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Evelyn McPhail	Director, Pharmacy Services
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Susannah Mitchell	GP/GP Sub Committee
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Sandy Riddell	Director, H&SCI
Debbie Thompson	Joint Trade Unions Secretary (Fife Council)
Paul Vaughan	Head of Community & Corporate Development
Angela Wilkinson	Consultant, Care of the Elderly

APPENDIX E

NHS Fife

Fife Council

Health & Social Care
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Health & Social Care Integration in Fife

Epidemiological and Demographic Overview of Fife's Population

Supporting the people of Fife together

A brief epidemiological assessment of the demography, life circumstances, health related behaviours and health status of the population of Fife

Clare Campbell

Chris Brown

Mhairi Gilmour

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January 2015

Key Points

Fife's total population based upon the 2013 mid-year estimates was 366,910.

18.8% of the total population in 2013 were aged 65 years and over, 63.7% aged 16-64 years and 17.5% were children (0-15years).

Fife has a greater proportion of those aged 65 and over than Scotland (17.8%).

Fife's population is predicted to continue to grow and to age for at least the next 20 years with an estimated increase of 31,769 (9%) in Fife's overall population from 366,220 in 2012 to 397,989 in 2037.

The largest increases will be seen in persons aged 65-74 and those aged 75 and over. By 2037 the number of persons aged 65-74 is expected to rise by 33% and the number of persons aged 75 and over is estimated to increase by 93% from 29,632 in 2012 to 57,327 in 2037.

There were 3,872 live births to Fife residents during 2013. Fife continues to have higher rates than Scotland, 55.9 per 1000 women compared to 53.7 per 1000 women in 2013 within Fife birth rates were highest in the Kirkcaldy area.

Life expectancy at birth in 2011-13 in Fife was 77.2 years for males and 81.2 years for females.

13% of the population of Fife live in income deprived households.

75% of the 2011 Census population aged 16-64 reported they were economically active as did 7% of those aged 65 and over.

14% of people aged 16-64 lived in single person households rising to a quarter of people aged 65-74 live alone rising to almost half of all those aged 75 and over.

34% of all households in Fife are fuel poor as are 52% of pensioner households.

10% of the population of Fife provided unpaid care with more than a quarter of carers providing 50 or more hours of care a week.

32% of the Fife population reported they had a long term condition with the proportion increasing with age.

More than 1,000 people were admitted to hospital for the first time in 2012/13 with Coronary Heart Disease, the majority of whom were over 65 years old.

Dementia is currently estimated to affect almost 6,000 people in Fife with prevalence highest amongst females and oldest age groups.

Adults aged 65 and over were less likely to smoke and drink to excess and slightly more likely to eat healthily than younger adults but they had low levels of physical activity and high levels of overweight/obesity.

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1. Introduction

The purpose of this report is to provide information to contribute to the establishment of a baseline position and identification of potential future need relating to the work of the Joint Commissioning Strategy. The report has used as it structure the report published by ScotPHN in 2013 of the epidemiological assessment of health and social care needs of older people in Scotland.[1]

This report provides an overview of the current and future population structure of Fife and areas within Fife. It also provides information relating to the life circumstances of people in Fife, their health status and health behaviours collected and used regularly by Public Health. Where appropriate and possible the report has used data for the age groups 0-15 (children), 16-64 (working age adults), 65-74, 75-84 and 85+ (older adults). All data has been presented for Fife and where possible geographies within Fife with comparisons to Scotland. Sub Fife geographies have been presented where possible for the seven area committee structures but where data is not easily available at this level sub Fife breakdowns have been shown for the three Community Health Partnerships.

This report does not provide information on the use or provision of primary, secondary or social care services which may be provided by other partnership colleagues in Fife.

[1] http://www.scotphn.net/pdf/2013_10_01_FINAL_MASTER_ScotPHN_OPHSCNA_epid_report.pdf

2. Demography

This section includes data on the population structure of Fife, with a specific focus on the Child Population aged 0-15 years, Adult Population aged 16-64 years and the Older Years populations aged, 65-74, 75-84 and 85 and over, as at June 30th 2013[2]. It also looks at the differences within Fife and the projected future increase in the population of older people in Fife.

2.1. Fife Population: Age & Sex

Fife's total population based upon the 2013 mid-year estimates was 366,910.
Of this, 18.8% is accounted for by the older years population (65 years and over), 63.7% by the adult population (16-64 years) and 17.5% by the child population (0-15years)

Older Years

The population of Fife's 65+ year olds was 69,016 accounting for 18.8% of Fife's total population (Table 1). This is 1.0 percentage points higher than the Scottish figure, 17.8%. Among the different older year's age groups, Fife also has a slightly higher population compared to Scotland, as follows:

- Among the 65+ age group, Fife's figure 18.8% is higher than Scotland's 17.8%.
- Fife has 10.6% aged 65-74 compared to Scotland's 9.8%;
- The 75-84 year olds are nearly the same with Fife and Scotland at 6.0% and 5.9% respectively;
- With the 85+ age group, Fife and Scotland's figures are similar at 2.2% and 2.1% respectively.

Table 1: Older Year's Populations as a % of total population; Fife and Scotland

	65+		65-74		75-84		85+	
	number	**%**	**number**	**%**	**number**	**%**	**number**	**%**
Fife	69,016	18.8	39,001	10.6	22,056	6.0	7,959	2.2
Scotland	946,862	17.8	522,236	9.8	313,899	5.9	110,727	2.1

Source: KnowFife Dataset

Of Fife's total male and female populations, 65+ year olds account for 17.3% and 20.2% respectively (Table 2). These are slightly higher than the comparative male and female Scottish figures of 16.1% and 19.4%.

[2] http://www.nrscotland.gov.uk/files//statistics/population-estimates/mid-2013/mid-2013-pop-est.pdf

Table 2: Male and Female Older Year's Populations as a % of Fife's male and female total populations; Fife and Scotland 2013

	65+		65-74		75-84		85+	
	Male	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Fife	17.3	20.2	10.5	10.8	5.4	6.6	1.5	2.8
Scotland	16.1	19.4	9.5	10.0	5.1	6.6	1.4	2.7

Source: National Records for Scotland (NRS)

Among the 65+ population in Fife, 44.7% are males and 55.3% female (Table 3). Within each of the older year's age groups there are, as expected, more females than males, particularly among those aged 75 and over. This is very apparent among the 85+ year olds where females account for 66.8%.

Table 3: Male and Female Older Years populations as a % of total older year populations: Fife and Scotland 2013

	65+		65-74		75-84		85+	
	Male	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Fife	44.7	55.3	47.8	52.2	43.3	56.7	33.2	66.8
Scotland	43.9	56.1	47.3	52.7	42.2	57.8	32.3	67.7

Source: National Records for Scotland (NRS)

Working Age Adults

Fife's total adult population, aged 16-64, based upon the 2013 mid-year estimates was 233,701 (Table 4). This accounted for 63.7% of Fife's total population. This is 1.4 percentage points lower than the Scottish figure of 65.1%.

Table 4: Adult Population as a % of total population; Fife and Scotland

	16-64	
	number	**%**
Fife	233,701	63.7
Scotland	3,469,159	65.1

Source: Know Fife Dataset

Of Fife's total male and female populations, 16-64 year olds account for 64.1% and 63.3% respectively (Table 5). These are both slightly lower than the comparative male and female Scottish figures of 65.9% and 64.4%.

Table 5: Male and Female Adult Population as a % of Fife's male and female total populations; Fife and Scotland 2013

	16-64	
	Male	**Female**
Fife	**64.1**	**63.3**
Scotland	**65.9**	**64.4**

Source: National Records for Scotland (NRS)

Among the 16-64 population in Fife, 48.8% are males and 51.2% female (Table 6). In comparison the male and females figures are 49.2% and 50.8% respectively.

Table 6: Male and Female Adult population as a % of total working age populations: Fife and Scotland 2013

	16-64	
	Male	**Female**
Fife	48.8	51.2
Scotland	49.2	50.8

Source**:** National Records for Scotland (NRS)

Children

Fife's total child population, aged 0-15, based upon the 2013 mid-year estimates was 64,193 (Table 7). This accounted for 17.5% of Fife's total population. This is 0.4 percentage points higher than the Scottish figure of 17.1%.

Table 7: Child Population as a % of total population; Fife and Scotland

	0-15	
	Number	**%**
Fife	64,193	17.5
Scotland	911,679	17.1

Source: KnowFife Dataset

Of Fife's total male and female populations, 0-15 year olds account for 18.5% and 16.5% respectively (Table 8). These are both slightly higher than the comparative male and female Scottish figures of 18.0% and 16.3%.

Table 8: Male and Female Child Population as a % of Fife's male and female total populations; Fife and Scotland 2013

	0-15	
	Male	**Female**
Fife	18.5	16.5
Scotland	18.0	16.3

Source: National Records for Scotland (NRS)

Among the 0-15 population in Fife, 51.4% are males and 48.6% female. In comparison the male and females figures for Scotland are 51.1% and 48.9% respectively.

Table 9: Male and Female Child population as a % of 0-15 populations: Fife and Scotland 2013.

	0-15	
	Male	**Female**
Fife	51.4	48.6
Scotland	51.1	48.9

Source: National Records for Scotland (NRS)

2.2. Sub Fife Populations: Community Health Partnerships (CHP)

Glenrothes and North East Fife (GNEF) CHP and Kirkcaldy and Levenmouth (K&L) CHP both have relatively higher older year's populations than Fife. 19.9% and 19.8% of their populations are aged 65+ compared to Fife's 18.8% (Table 10). This is perhaps most apparent among the 75-84 year olds where GNEF CHP has 6.5% and K&L CHP has 6.6%, compared to Fife's 6.0%.

Dunfermline and West Fife (DWF) CHP's older years population is markedly lower than the two other CHPs and Fife, particularly among the 75-84 and 85 and over age groups. This is largely attributed to Dunfermline City, as can be seen in Table 13 below showing the population by Area Committee.

Table 10: Older Year's Populations as a % of total population; CHP and Fife 2013

	65+	**65-74**	**75-84**	**85+**
	%	**%**	**%**	**%**
Dunfermline and West Fife	17.2	10.1	5.3	1.8
Glenrothes and North East Fife	19.9	11.2	6.5	2.3
Kirkcaldy and Levenmouth	19.8	10.7	6.6	2.5
Fife	18.8	10.6	6.0	2.2

Source: KnowFife Dataset

Among the adult population aged 16-64, DWF and GNEF CHPs both account for 64.1% of their populations, higher than the Fife figure of 63.7% (Table 11). In the K&L CHP, the adult population accounts for a slightly smaller 62.5%.

Table 11: Adult Population as a % of total population; CHP and Fife 2013

	16-64
	%
Dunfermline and West Fife	64.1
Glenrothes and North East Fife	64.1
Kirkcaldy and Levenmouth	62.5
Fife	63.7

Source: KnowFife Dataset

Among the child population aged 0-15, DWF CHP has a markedly higher rate compared to the other two CHPs and Fife (Table 12). 18.7% of its population is aged 0-15, whereas GNEF has 16.0%, K&L has 17.7%, compared to Fife's 17.7%. Again, this can be explained by Dunfermline City, as shown in Table 15 below for Fife's Area Committees.

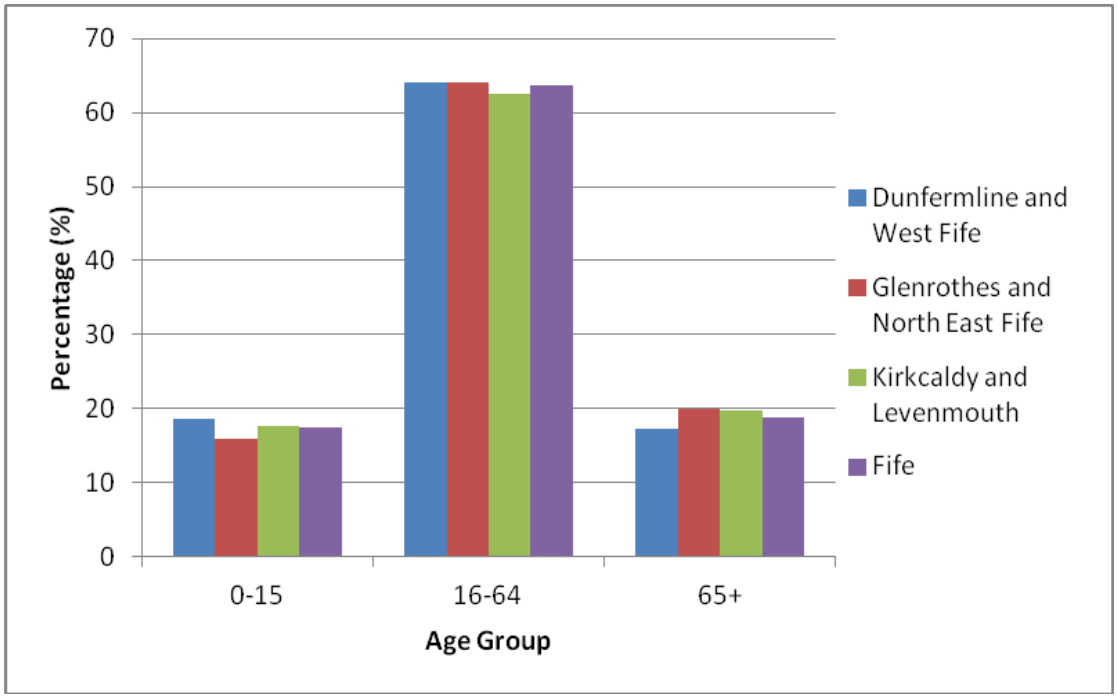
Table 12: Child Population as a % of total population; CHP and Fife 2013

	0-15
	%
Dunfermline and West Fife	18.7
Glenrothes and North East Fife	16.0
Kirkcaldy and Levenmouth	17.7
Fife	17.5

Source: KnowFife Dataset

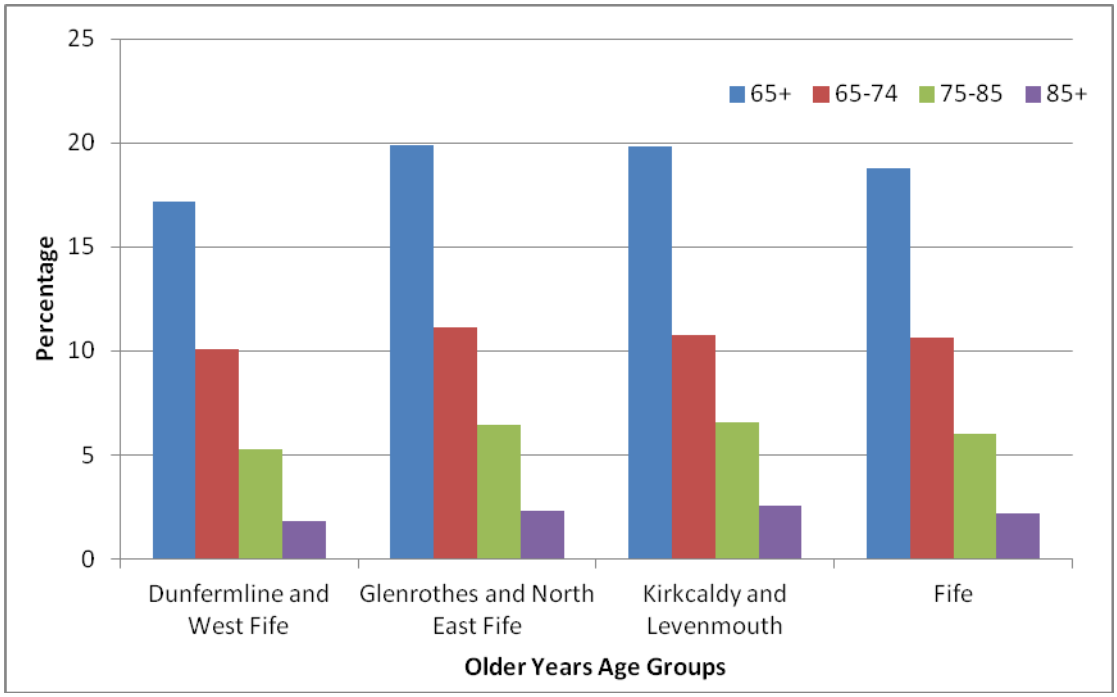
Summaries of both the population structure and the older years populations, as a % of total population at CHP and Fife level are provided in Chart 1 and Chart 2 respectively.

Chart 1: Population Structure as a % of total population; CHP and Fife 2013



Source: KnowFife Dataset

Chart 2: Older Years Populations as a % of total population; CHP and Fife 2013



Source: KnowFife Dataset

2.3. Sub-Fife Populations: Fife Area Committees

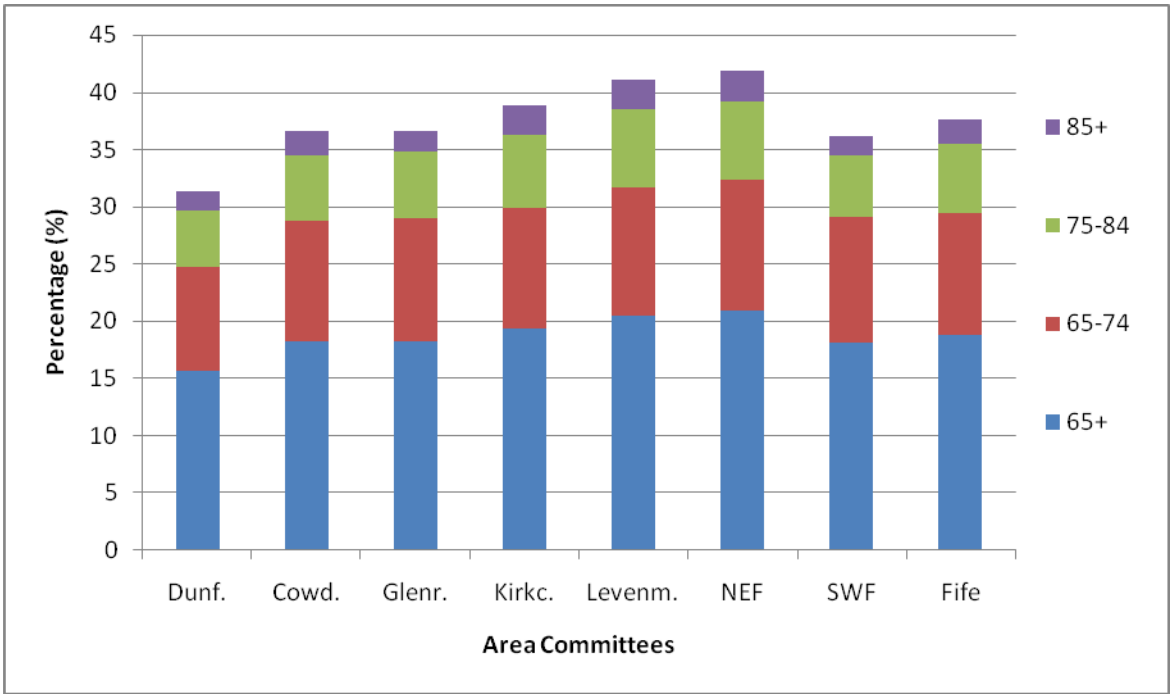
Three of Fife's seven Area Committees (AC) have higher proportions of the population aged 65+ compared to Fife's 18.8%; Kirkcaldy (19.4%), Levenmouth (20.5%) and North East Fife with 20.9% (Table 13 and Chart 3).These three areas also have higher proportions of 75-84 year olds and 85+ year olds. In contrast, Dunfermline Area Committee's population is consistently lower than Fife, highlighted in particular by the 65+ population of just 15.7%. This is likely attributable to the new housing developments over the past decade.

Table 13: Older Year Population as a % of Total Population: Area Committee and Fife

	65+	65-74	75-84	85+
	%	%	%	%
City of Dunfermline Area Committee	15.7	9.1	4.8	1.7
Cowdenbeath Area Committee	18.3	10.5	5.7	2.1
Glenrothes Area Committee	18.3	10.6	5.9	1.8
Kirkcaldy Area Committee	19.4	10.5	6.4	2.5
Levenmouth Area Committee	20.5	11.1	6.8	2.6
North East Fife Area Committee	20.9	11.5	6.8	2.6
South West Fife Area Committee	18.1	11.0	5.4	1.7
Fife	18.8	10.6	6.0	2.2

Source: KnowFife Dataset

Chart 3: Older Years Populations as a % of total population; Area Committee and Fife 2013



Source: KnowFife Dataset

When looking the adult population aged 16-64 among Fife's Area Committees, there is a certain amount of variation among them and in comparison to the Fife figure of 63.7% (Table

14). Three Areas have higher adult populations - City of Dunfermline with 64.9%, North East Fife with 64.7% and South West Fife with 63.9%. The remaining for have lower adult populations –Glenrothes with 63.4%, Cowdenbeath with 63.3%, Kirkcaldy with 62.6% and Levenmouth with 62.3%.

Table 14: Adult Population as a % of Total Population: Area Committee and Fife

	16-64
	%
City of Dunfermline Area Committee	64.9
Cowdenbeath Area Committee	63.3
Glenrothes Area Committee	63.4
Kirkcaldy Area Committee	62.6
Levenmouth Area Committee	62.3
North East Fife Area Committee	64.7
South West Fife Area Committee	63.9
Fife	63.7

Source: KnowFife Dataset

Of Fife's Child Population, two Area Committees have populations lower than the Fife figure of 17.5% (Table 15). Levenmouth has slightly less with 17.2% but North East Fife has markedly lower child population with 14.4%. Each of the other five Areas has relatively higher child populations than Fife. Dunfermline has 19.4%, Cowdenbeath has 18.3%, Glenrothes 18.4%, and Kirkcaldy and South West Fife both have 18.0%.

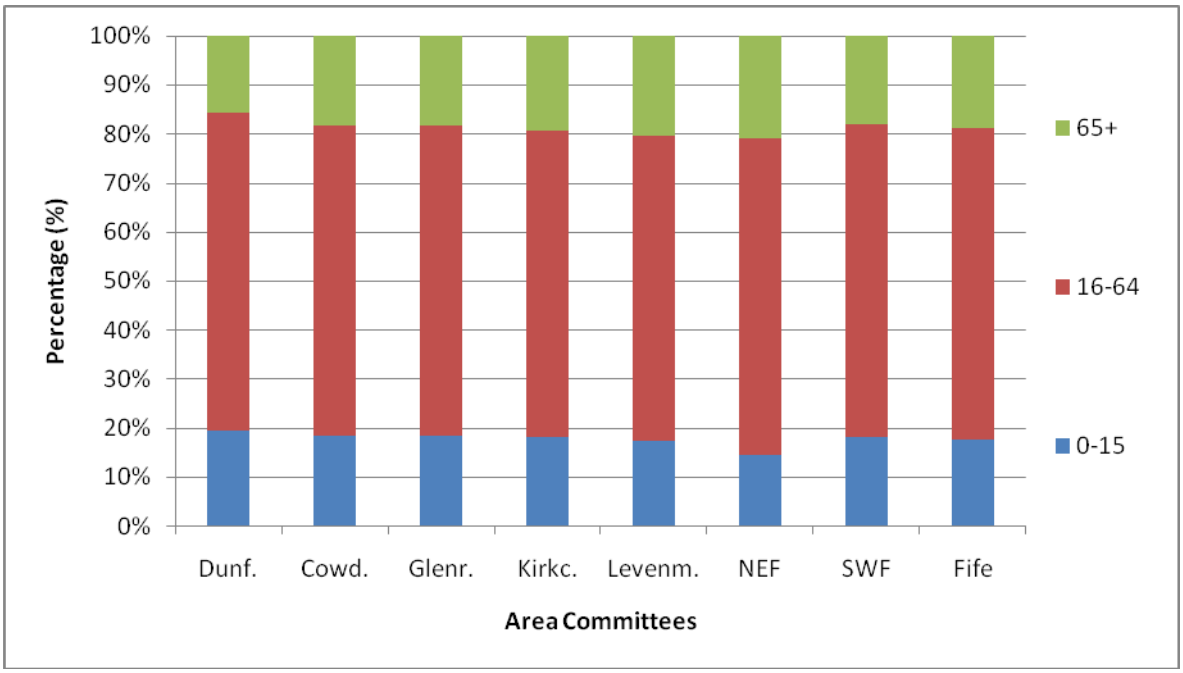
Table 15: Child Population as a % of Total Population: Area Committee and Fife

	0-15
	%
City of Dunfermline Area Committee	19.4
Cowdenbeath Area Committee	18.3
Glenrothes Area Committee	18.4
Kirkcaldy Area Committee	18.0
Levenmouth Area Committee	17.2
North East Fife Area Committee	14.4
South West Fife Area Committee	18.0
Fife	17.5

Source: KnowFife Dataset

The population structure as a % of total population for each Area Committee and Fife is summarised in Chart 4.

Chart 4: Population Structure as a % of total population; Area Committee and Fife 2013



Source: KnowFife Dataset

2.4. Deprived Areas

If we look at the population structures of the five Fife deprivation quintiles we can see that the most deprived quintile had the lowest proportion of older people, 16.7% of the population were aged 65 and over compared to 20% aged 0-15, as defined by the Scottish Index of Multiple Deprivation 2012 (Table 16 and Chart 5).[3]

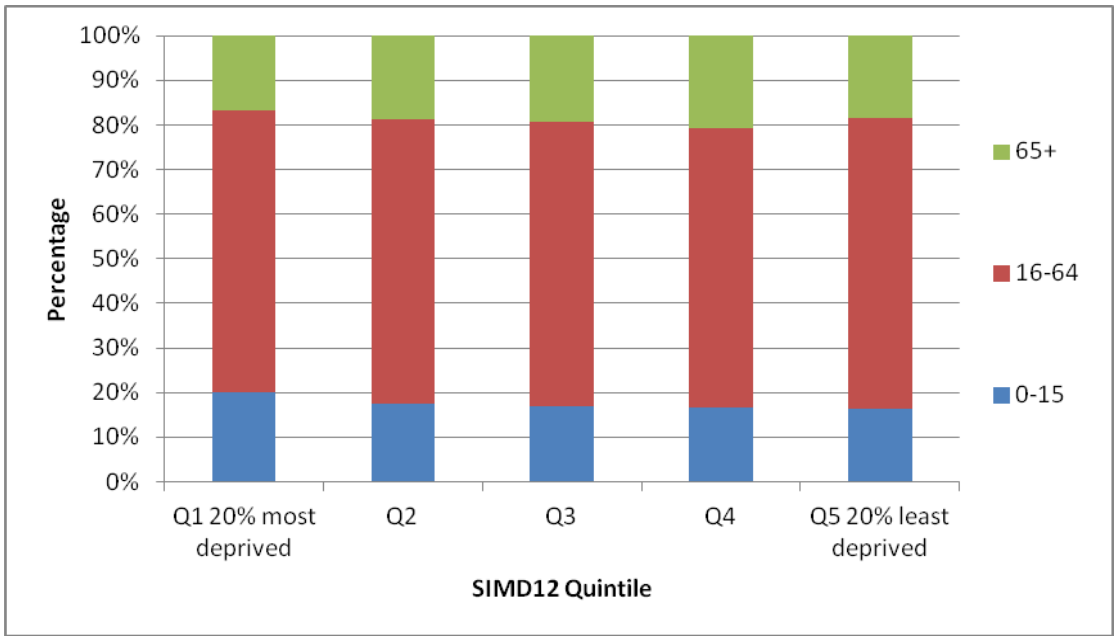
Table 16: Population by broad Age Group: Fife and SIMD12 Quintiles 2013

	Children (0-15)	Working Age (16-64)	Pensionable Age (65+)
	%	%	%
Q1 20% most deprived	20.0	63.3	16.7
Q2	17.6	63.7	18.7
Q3	16.8	63.9	19.3
Q4	16.7	62.5	20.8
Q5 20% least deprived	16.4	65.1	18.5

Source: KnowFife Dataset

[3] Deprived areas (quintiles) are created by ranking the Fife population in each data zone by the SIMD 2012 index and creating five groups from most to least deprived each containing approximately 20% of the population.

Chart 5: Population Structure as a % of total population; SIMD12 Quintiles 2013



Source: KnowFife Dataset

Of the 69,016 persons aged 65 and over estimated to be living in Fife in 2012, 16.7% were living within the 20% most deprived areas in Fife and 18.5% within the 20% least deprived areas (Table 17 and Chart 6).

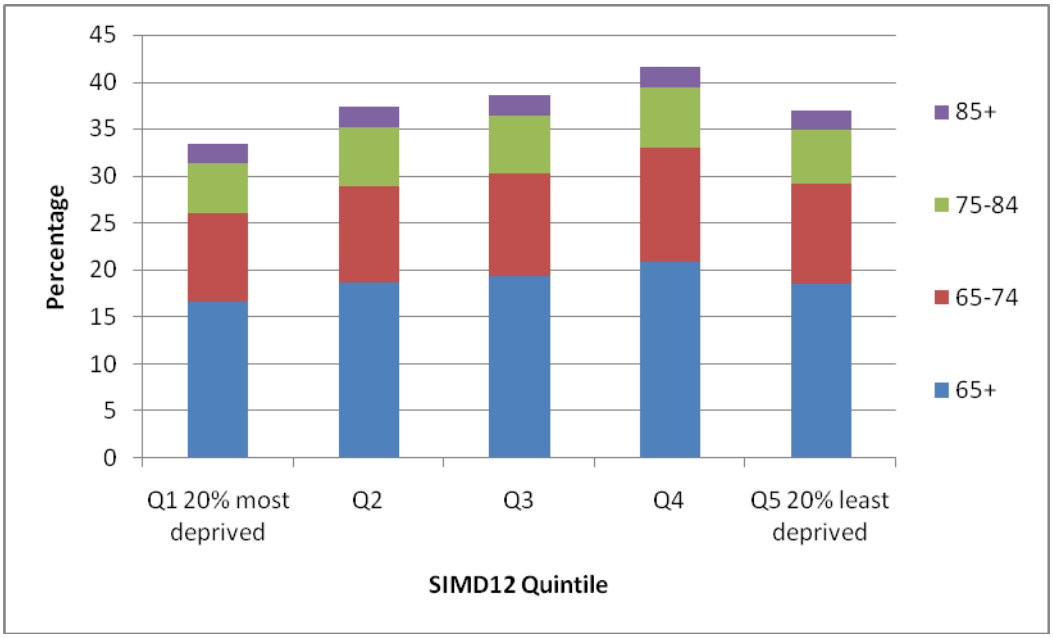
The most deprived quintile had the smallest proportions of persons aged 65-74 and 75-84 but there were few differences between the quintiles in terms of the oldest age group with each of the quintiles having between 2.0 and 2.3% of their population aged 85 and over.

Table 17: % of older years population in each age group: Fife and SIMD12 Quintiles 2013

	65+	**65-74**	**75-84**	**85+**
	%	**%**	**%**	**%**
Q1 20% most deprived	16.7	9.3	5.4	2.0
Q2	18.7	10.2	6.3	2.3
Q3	19.3	11.0	6.1	2.2
Q4	20.8	12.1	6.4	2.2
Q5 20% least deprived	18.5	10.6	5.8	2.2

Source: KnowFife Dataset

Chart 6: Older Years Populations as a % of total population; SIMD12 Quintiles 2013



Source: KnowFife Dataset

2.5. Ethnic Group

In the 2011 Census, 97.6% of the population of Fife described their ethnicity as 'White', a decrease of approximately 1% on the 98.7% reported in 2001 (Table 18).[4] Within this grouping the most commonly reported category was 'White Scottish' stated by 85.7% of the Fife population followed by 'White Other British' stated by 8.6%. A new category for the 2011 Census showed that there were just over 3,000 persons living in Fife who stated they were 'White Polish', 0.8% of the total population.

A separate 'White Gypsy/Traveller' response category was also added to the Census in 2011. 316 people in Fife recorded their ethnic group within this category corresponding to 0.1% of the population of Fife (Table 18). This proportion was the same as that recorded nationally but compared to other council areas Fife had the fourth (of 32) largest number of people who identified themselves as 'White Gypsy/Traveller'.

[4] Scotland's Census 2011 Data Explorer; Standard Outputs available from: http://www.scotlandscensus.gov.uk/ods-web/standard-outputs.html

Table 18: Population of Fife by broad ethnic group; 2001 and 2011 Census

	White	White: Scottish	White: Gypsy/ Traveller	White: Polish	Asian	African, Caribbean or Black
2001 – No.	345,003	308,371	-	-	2,734	490
2001 - %	98.7	88.3%	-	-	0.8	0.1
2011 – No.	356,550	312,957	316	3,058	5,748	1,126
2011 - %	97.6	85.7	0.1	0.8	1.6	0.3

Source: Scroll and Census Data Explorer

There have been increases in all of the minority ethnic groups in Fife in the last ten years with the largest increase seen in the proportion of people in Fife who stated they were of 'Asian' ethnicity (a grouping which includes Indian, Pakistani, Bangladeshi and Chinese). In the 2011 Census this was 1.6%, double the 0.8% reported in 2001 (Table 18). There was also an increase from 0.1% to 0.3% in people classifying themselves as 'African, Caribbean or Black'.

There were differences in the proportions of ethnic groups within the age groups of the Fife population. Almost 98% of the population aged 75 and over in Fife described themselves as 'White Scottish or British' compared to 89% of those aged both 16-24 and 25-34. Table 19 shows that 3.1% of the population aged 25-34 recorded their ethnicity as 'White Polish' which was almost four times the proportion across the total population. This age group also had the second highest proportion of people who identified themselves as 'Asian' (2.9%) with the highest being among those aged 16-24. Both of these age groups had the highest proportion of people who identified themselves as 'African, Caribbean or Black', 0.5% respectively.

Among children in Fife 95% were part of 'White Scottish or British' group with a further 1.7% of 'Asian' ethnicity and 1% 'White Polish'. Older people in Fife were the least ethnically diverse with 98% of those aged 65 and over describing themselves as 'White Scottish or British' whilst only 0.4% were of 'Asian' ethnicity and a further 0.2% were 'White Polish'

Table 19: Ethnic group by age; Fife 2011 Census

	White Scottish or British	White Gypsy/ Traveller	White Polish	White Other	Mixed or multiple ethnic groups	Asian, Asian Scottish or Asian British	African	Caribbean or Black	Other ethnic groups
Total	94.3	0.1	0.8	2.4	0.3	1.6	0.2	0.1	0.1
0-15	94.5	0.1	1.0	1.3	0.8	1.7	0.3	0.2	0.1
16-24	89.0	0.1	0.9	5.1	0.7	3.5	0.3	0.2	0.3
25-34	88.7	0.1	3.1	4.1	0.3	2.9	0.4	0.1	0.2
35-44	93.8	0.1	0.8	2.8	0.3	1.6	0.3	0.2	0.2
45-54	96.3	0.1	0.3	1.9	0.1	1.1	0.1	0.1	0.1
55-64	97.3	0.1	0.2	1.5	0.1	0.7	0.1	0.1	0.1
65-74	97.7	0.0	0.1	1.5	0.1	0.5	0.0	0.0	0.0
75+	97.8	0.0	0.2	1.5	0.0	0.4	0.0	0.0	0.0

Source: 2011 Census

Glenrothes and North East Fife CHP had the lowest proportion of people classifying themselves as 'White' and the highest stating they were 'Asian'. 1.5% of the population of Kirkcaldy and Levenmouth stated they were 'White Polish' which was more than double the proportions in the other two CHPs and almost double the proportion in Fife (Table 20).

Table 20: Fife 2011 Census Results; ethnic group by CHP

	White	White: Scottish	White: Polish	Asian	African, Caribbean or Black
GNEF	97.0%	80.1%	0.7%	2.1%	0.32%
DWF	98.2%	87.9%	0.5%	1.2%	0.30%
K&L	97.7%	89.4%	1.5%	1.5%	0.32%
Fife	97.6%	85.7%	0.8%	1.6%	0.31%

Source: Census Data Explorer

In line with Fife all three CHPs have seen a decrease in the proportion of their populations stating they were 'White' and an increase in proportion from other ethnic groups between the 2001 and 2011 Census.

2.6. Population Projections

Population projections make use of past population trends to make predictions about future population growth and structure.[5] Projections are based on assumptions about births, deaths and migration but do not take into account changes relating to policy or unexpected events. Population projections are a useful and established means of considering future demand on services.

Fife in common with Scotland has a growing and ageing population. The 2012-based population projections, based on the 2011 Census results, estimate that Fife's overall population will increase by 31,769 (9%), from 366,220 in 2012 to 397,989 in 2037. Increases however will not be seen across all age groups (Tables 21 and 22). In the next 25 years it is estimated that there will be an overall net reduction of 16,207 persons (9%) aged 30-64, the mid to older working age group, in Fife.

Increases will be seen in the number of younger Fife residents aged both 0 to 15 (8%) and 16 to 29 (4%). The largest increases will be seen in persons aged 65-74 and those aged 75 and over. By 2037 the number of persons aged 65-74 is expected to be more than 12,000 more than in 2012, a rise of 33%. However the number of persons aged 75 and over is estimated to increase by 93% from 29,632 in 2012 to 57,327 in 2037. From 2027 the number of persons aged 75 and over in Fife is estimated to exceed the number of persons aged 65-74 (Table 21 and 22).

Table 21: Fife 2012 based population projections by age group

	2012	**2017**	**2022**	**2027**	**2032**	**2037**
All Ages	**366,220**	**372,742**	**380,385**	**387,569**	**393,468**	**397,989**
0-15	64,374	65,355	67,855	68,696	69,494	69,484
16-29	63,118	63,843	62,281	62,247	63,828	65,905
30-64	171,575	168,225	167,554	164,778	159,303	155,368
65-74	37,521	42,530	43,147	45,653	49,587	49,903
75+	29,632	32,789	39,548	46,195	51,256	57,329

Source: NRS

Between 2012 and 2037 both the Fife and national population is projected to grow by 9% however Fife will see a greater increase among children and those aged 16-29 and 75 and over than Scotland.

[5] http://www.gro-scotland.gov.uk/statistics/theme/population/projections/sub-national/index.html

Table 22: % increase in population from 2012 to 2037; Fife and Scotland

	All ages	0-15	16-29	30-64	65-74	75+
Fife	9	8	4	-9	33	93
Scotland	9	5	-4	-4	37	86

Source: NRS

By 2037 persons aged 65 and over will account for 27% of the total population of Fife compared to 18% in 2012 (Table 23). The proportion of children in the Fife population will remain fairly stable over the next 25 years but the proportion of the population who are of working age will decrease to 56% from 64% in 2012. Fife will have a smaller proportion of adults of working age than Scotland as a whole but a larger proportion aged 75 and over.

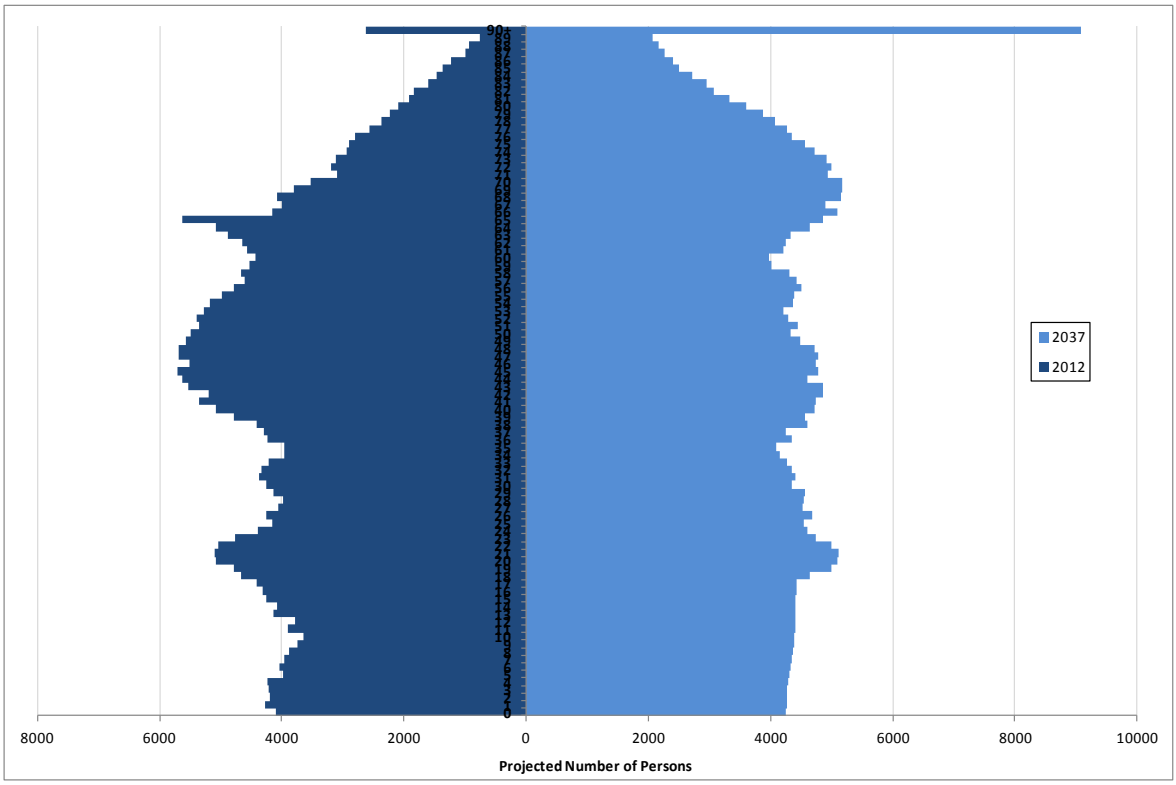
Table 23: % of total population within each age band; Fife and Scotland 2012 and 2037

	Fife		Scotland	
	2012	**2037**	**2012**	**2037**
0-15	17.6	17.5	17.2	16.7
16-29	17.2	16.6	18.4	16.2
30-64	46.9	39.0	47.0	41.6
65-74	10.2	12.5	9.5	12.0
75+	8.1	14.4	7.9	13.5

Source: NRS

Chart 7 shows the population structure based on the number of people in each single year of age band (with the exception of the 90+ age group) in 2012 compared to that projected for 2037. Chart 7 shows that the bulk of the population has moved upwards towards the older age bands between 2102 to 2037.

Chart 7: Number of persons in each single year age band and 90+ band; Fife 2012 & 2037



Source: NRS

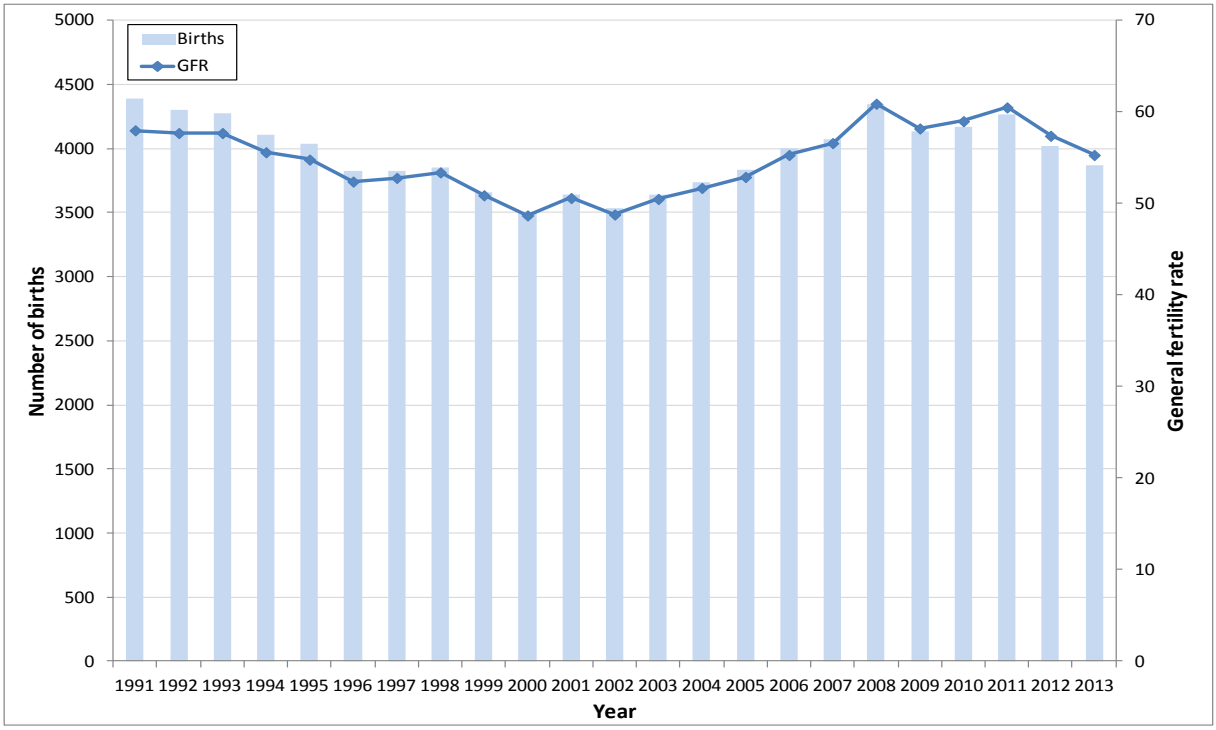
2.7. Births

There were 3,872 live births to Fife residents during 2013.[6] This was a decrease of 147 on the 4,019 babies born in the previous year. This was the lowest number of births in Fife since 2006 and 11% fewer births than the peak in 2008 which saw 4,349 births.

Chart 8 below shows that between 1991 and 2002 birth rates fell in Fife from 58.0 per 1000 women to 48.8 before increasing annually between 2002 and 2008. Since 2008 birth rates have fluctuated in Fife but the current rate is the lowest since 2006.

Despite the recent fall in the number of births and General Fertility Rates seen both in Fife and nationally, Fife continues to have higher rates than Scotland, 55.9 per 1000 women compared to 53.7 per 1000 women in 2013, and has had higher rates each year since 2001. Within Fife birth rates were highest in the Kirkcaldy area at 63.7 per 1000 women closely followed by rates in the Cowdenbeath area of 62.2 per 1000 women. Birth rates were lowest in North East Fife at 40.4 per 1000 women in 2013.[7]

Chart 8: Number of births and general fertility rate; Fife 1991 – 2013



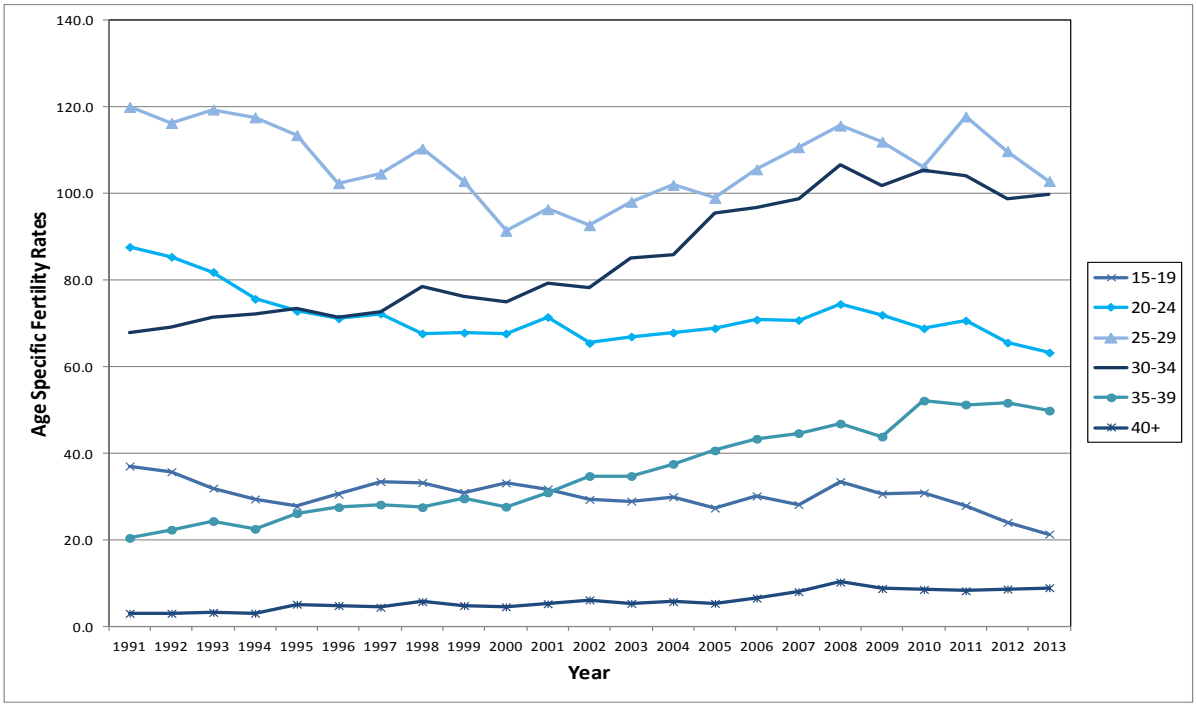
Source: NRS/Information Services NHS Fife

[6] National Records of Scotland Vital Events Reference Tables; Births Available from:http://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/general-publications/vital-events-reference-tables/2013/section-3-births

[7] NHS Fife (2014) SMR02 Births in Hospitals; Fife extract, Information Services, NHS Fife

Age Specific Fertility Rates, calculated for five-year age groups of mother's age, show that women in Fife are now choosing to have babies later in life. Fertility rates for women in the three age groups beyond 30 years have all increased since 1991, with rates among women aged 35-39 and 40-44 increasing by 143% and 190% between 1991 and 2013 (Chart 9).

Chart 9: Age specific fertility rates by age group; Fife 1991-2012



Source: NRS

During the same time period rates among women aged 30-34 have almost doubled whilst rates among women aged 15-19 and 20-24 have decreased by more than a quarter. Women aged 25-29 have had the highest fertility rates in Fife in the period shown below however rates among this age group have also decreased since 1991 and in 2013 fewer babies were born to mothers aged 25-29 (1,093) than aged 30-34 (1,108).

3. Life Circumstances

3.1. Rurality

The size and geographical distribution of the population in Fife means that we have only three of the six urban-rural classifications within our boundary.[8] These are:

- Other urban areas - settlements of between 10,000 and 125,000 persons;
- Accessible small towns - settlements of between 3,000 and 10,000 persons and within a 30 minute drive of a settlement of 10,000 persons or more;
- Accessible rural – areas with a population of less than 3,000 people and within a 30 minute drive of a settlement of 10,000 persons or more.

[8] http://www.scotland.gov.uk/Topics/Statistics/About/Methodology/UrbanRuralClassification

•

Across Fife the majority of people live in 'other urban areas', 67% of the total population. Of those aged 65 and over the majority (63%) also live in 'other urban areas' but a higher proportion of older people live in 'accessible rural' areas and 'accessible small towns' than the population as a whole (Table 24).

Table 24: Population of Fife by age group and urban rural classification; 2013

	0-15	16-64	65-74	75-84	85+	65+	All ages
Accessible Rural	15.4	16.0	20.6	19.5	17.9	19.9	16.6
Accessible Small Towns	17.3	16.5	17.1	17.5	18.9	17.5	16.8
Other Urban Areas	67.3	67.5	62.3	63.0	63.2	62.6	66.5

Source: KnowFife Dataset

3.2. Income

Guarantee Pension Credits

As at the end of December 2012 there were 5,100 persons in Fife aged 60 and over in receipt of the guarantee element of pension credit, a benefit that provides financial help for people aged 60 or over whose income is below a certain level set by the law.[9] Fife had a lower proportion than Scotland of adults aged 60 and over in receipt of this benefit whilst within Fife Kirkcaldy and Levenmouth CHP had the highest proportion (Table 25).

Table 25: Guarantee Pension Credit Claimants; CHP, Fife and Scotland

	Number	% of population
Dunfermline & West Fife	1,765	11.1%
Glenrothes & NE Fife	1,570	10.3%
Kirkcaldy & Levenmouth	1,865	15.1%
Fife	5,100	11.9%
Scotland	86,150	15.4%

Source: SNS

Income Deprived Households

13% of the population in Fife were living in income deprived households in 2012**,** defined as the number of children and adults living in households in receipt of one or more of a range of benefits. The area covered by Levenmouth area committee had the highest proportion of income deprived people at 19.7% of the population and North East Fife the lowest at 7.4% (Table 26).

Children Living in Poverty

Across Fife 19% of children were living in poverty in 2012, defined as living in households with less than 60% of median household income. This figure ranged from 10.2% of children in living in the area covered by North East Fife area committee to 26.9% in the Levenmouth area (Table 26).

[9] https://www.gov.uk/government/publications/pension-credit-technical-guidance

Table 26: % of population living in income deprived households

	% of population income deprived	% of children living in poverty
City of Dunfermline Area Committee	10.5	13.2
Cowdenbeath Area Committee	18.0	25.6
Glenrothes Area Committee	15.6	23.0
Kirkcaldy Area Committee	16.0	22.0
Levenmouth Area Committee	19.7	26.9
North East Fife Area Committee	7.4	10.2
South West Fife Area Committee	10.5	14.7
Fife	13.3	19.1

Source: SIMD12/KnowFife Dataset

3.3 Economic Activity

At the 2011 Census 75% of the population Fife aged 16-64 were economically active, defined as persons who were in employment or currently actively seeking employment (including students).[4] 7.4% (4,181 persons) of the population aged 65 and over were also economically active. Dunfermline area had the highest proportion of its population aged 16-64 economically active whilst North East Fife had the highest proportion of over 65s who were economically active at almost 10% (Table 27).

Table 27: Proportion of population economically active; Fife and Area Committees 2011

	16-64	65+
City of Dunfermline Area Committee	80.8	7.2
Cowdenbeath Area Committee	74.9	6.4
Glenrothes Area Committee	77.4	6.4
Kirkcaldy Area Committee	77.6	6.4
Levenmouth Area Committee	74	5.8
North East Fife Area Committee	69.6	9.7
South West Fife Area Committee	78.8	8.2
Fife	75.1	7.4

Source: Census Data Explorer

Figures derived from the Annual Population Survey suggest that there could be 5,500 persons aged 65 and over who are economically active in Fife, 8.4% of the population in this age group.[10] The majority (73%) of those in this age group who are economically active are men, approximately 4,000 men and 1,500 women. The rate of economic activity among older adults has been increasing from an estimated 5.8% in 2004/5 to the current figure 8.4% in 2012/13.

[10] http://www.nomisweb.co.uk/articles/804.aspx

Of those aged 16-64 who reported being economically active in the 2011 Census 92% were in employment rising to 98% of those aged 65-74 who were economically active. The older age group were more likely to report working part-time than those aged 16-64, 49% compared to 28%. This equates to just over 1,900 persons aged 65-74 working up to 30 hours a week and a further 2,000 persons aged 65-74 working 31 or more hours a week in Fife.[4]

The most common industries to be employed within in Fife were 'human health and social work activities' which employed 15% of those aged 16-64 and 13% of those aged 65-74 closely followed by the 'wholesale and retail trade' employing 14% and 16% respectively. 'Manufacturing' employed 10% of those aged 16-64 and 9% of those aged 65-74 with 9% of each age group being employed within 'education'.[4]

3.4 Housing

At the 2011 Census there were 357,440 people (98% of population) living in 160,952 households in Fife, an increase of 7% in the number of households since 2001. The average household size in Fife has decreased in the last 10 years from 2.28 persons to 2.22. As such two person households account for the largest proportion (37%) of households followed by one person households (32%), both of which have increased since the 2001 Census. The majority of people (77%) in Fife lived within 'one family' households.[4]

The most common type of which was 'married or cohabitating couple with two or more dependent children' accounting for the living arrangements for 20% of the Fife population followed by 'married or cohabiting couple no children' (17%). 12% of the population (adults and children) lived in a lone parent family household. Two percent of the Fife population, 7,758 people, lived in communal establishments, a rise of more than 1000 persons living in such accommodation since 2001 when 6,442 lived in communal establishments. In 2011 the most common type of communal establishments were care homes and educational establishments. Almost half of all persons living in communal establishments lived in educational establishments (48%) and a further 38% lived in medical and care establishments. Of those living in communal establishments one third were aged over 65 years, 2622 persons which represented 4% of the population aged 65 and over in Fife.[4]

More than 50,000 people in Fife, 14.3% of the household population, lived alone in 2011 (Table 28). This total included 8,647 persons aged 65-74 and 12,560 persons aged 75 and over, 25% and 47% of persons in that age group living in households in Fife.

Table 28: Single Person Household Composition by Age; Fife 2001

	Fife							
	16-24		25-64		65-74		75+	
	No	%	No	%	No	%	No	%
All persons in households	38,774		192,985		34,848		26,601	
Single person household	1,459	4%	28,573	15%	8,647	24.8%	12,560	47%

Source: 2011 Census Data Explorer

Ninety-nine percent of households in Fife had some form of central heating, the most common form being gas central heating found in 87% of households. Whilst nearly all homes are equipped with central heating additional information shows that 34% of all households in Fife are fuel poor, required to spend more than 10% of their income on fuel to satisfactorily heat their home and 11% of households are in extreme fuel poverty, spending more than 20% of income.[11] Pensioner households are more likely to be fuel poor with more than half of all pensioner households (52%) living in fuel poverty compared to 25% of both family and adult only households.

Seventy-four percent of all households in Fife had access to a car or van, with 30% of households reporting having access to two or more.[4] This is higher than the 69.5% reported for Scotland as a whole. Single person households where the resident is aged 65 and over were the least likely to have access to a car with 38% reporting access to at least one car. Similarly of all people living in all household types in Fife, 84% aged of those 16-64 stated they had access to at least one car compared to 69% of the population aged 65 and over.

3.5 Carers

The provision of unpaid care is a key indicator of care needs and is important for the planning and delivery of health and social care services both for the carer and the persons being cared for. It can also be used to identify local needs and inequalities within Fife.

Just under ten percent of the Fife Census population living in households reported that they provided unpaid care to someone either within or outwith their household due to the person's long term ill health or disability or problems relating to old age.[4] This is similar to the national average of 9.3% and has not changed since the 2001 Census. The provision of care was reported by a greater proportion of the population aged 50 and over than among those aged under 50 years (Table 29).

Table 29: Number of carers and caring hours provided by age; Fife 2011 Census

	Carers		**Hours of unpaid care provided**			
	Number	**% of population**	**1-19**	**20-34**	**35 to 49**	**50+**
Total	34,717	9.7%	56.2%	9.4%	8.1%	26.4%
0 to 24	2,355	2.3%	66.5%	11.4%	11.1%	10.9%
25 to 49	12,494	10.5%	56.7%	9.7%	10.1%	23.5%
50 to 64	12,962	17.6%	62.1%	8.8%	6.6%	22.5%
65+	6,906	11.2%	40.5%	9.2%	6.1%	44.2%

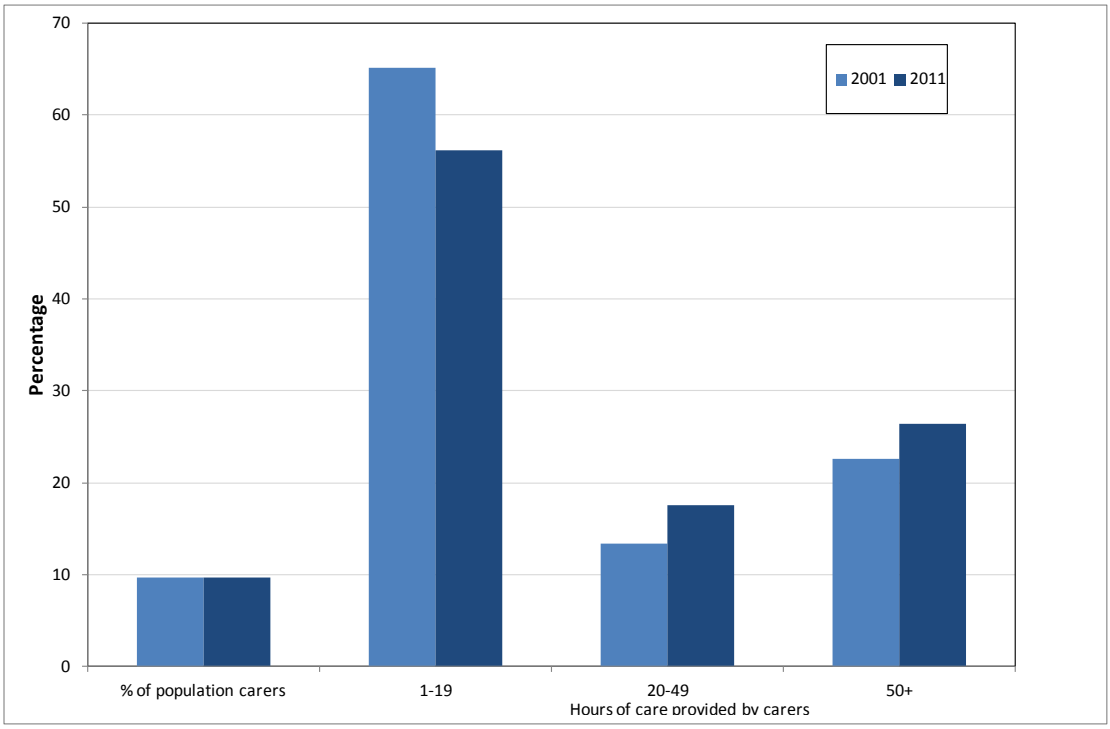
Source: Census Data Explorer

Although the overall proportion of the population providing care has remained the same the number of hours care is provided has increased. In 2001 65% of carers reported providing

[11] http://www.scotland.gov.uk/Topics/Statistics/SHCS/keyanalyses/LAtables2013.

between 1-19 hours per week unpaid care which had fallen to 56% in 2011 (Chart 10). The proportion of carers providing between 20-49 hours per week and 50 hours or more have both increased from 12% to 17% and from 22% to 26% between 2001 and 2011.

Chart 10: Carers and hours of care provided; Fife 2001 & 2011 Census



Source: Scroll/Census Data Explorer

58% of carers reported they were economically active slightly less than the adult population average of 61%. Carers who provided greater hours of unpaid care (35 or more a week) were more likely to be economically inactive (63%) than those who provided no care (38%) or less care (30% of those providing 1-19 hours). Of carers who were inactive the majority were retired (62%) followed by those looking after home and family (19%).

Increasing hours of providing unpaid care as associated with poorer ratings of self assessed health. 60% of carers who provided 50 or more care a week rated their health as good or very good compared to 71% of those providing 20-34 hours and 83% of those who provided no care.

4. Health Status

This section provides information on the prevalence of specific diseases among the older population in Fife including dementia and coronary heart disease. It also looks at life expectancy, long term conditions and mental wellbeing.

4.1 Life Expectancy

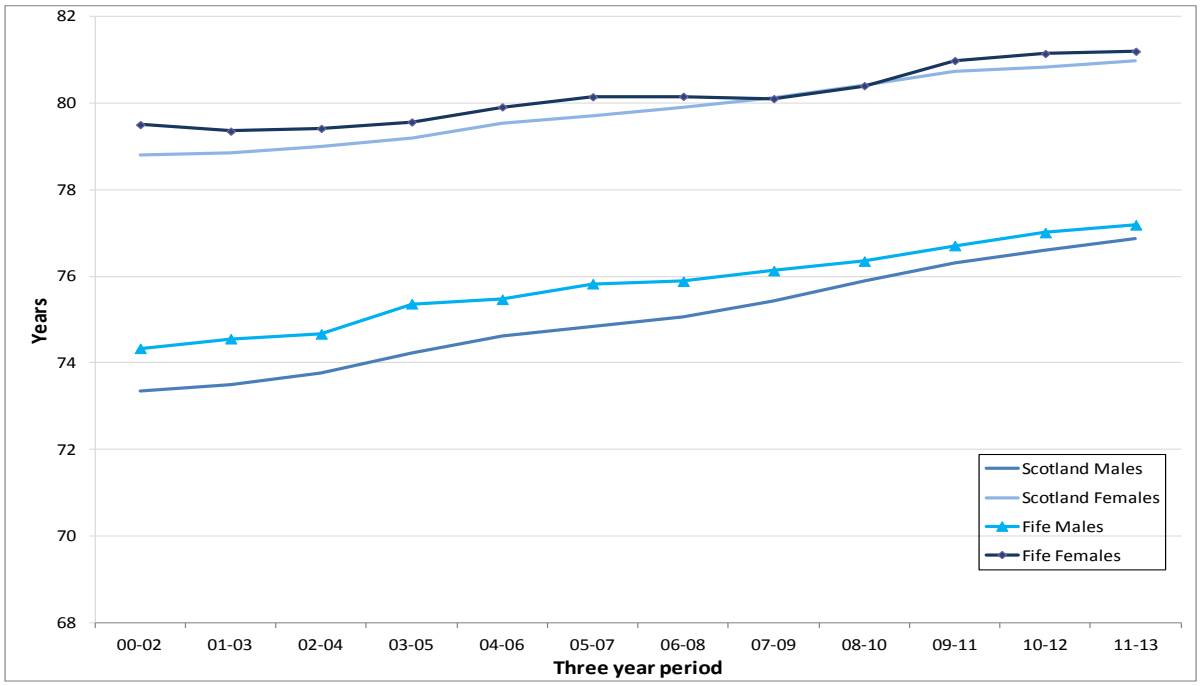
The latest figures available for life expectancy show that babies born during 2011-13 in Fife could expect to live 77.2 years for males and 81.2 years for females (Table 30).[12] Life expectancy at birth has increased among both males and females in the last 10 years. Although male life expectancy is still significantly lower than female it has increased more in the last 10 years, 2.9 years compared to 1.7 years for females. This means the gap between male and female life expectancy has reduced from 5.2 years in 2000-02 to 4.0 years in 2011-13. Fife has higher values for both male and female life expectancy than Scotland but Scotland has seen greater increases in the last 10 years, 3.3 years among males and 2.0 years among females (Chart 11).

Table 30: Life expectancy at birth and age 65: Fife and Scotland 2011-13

	Fife		Scotland	
	Males	**Females**	**Males**	**Females**
Life Expectancy at birth	77.2	81.2	76.9	80.97
Life Expectancy at age 65	17.4	19.7	17.3	19.6

Source: NRS

Chart 11: Male and female life expectancy; Fife and Scotland 2000-02 to 2011-13



NB: Vertical axis starts at 68 years

Source: National Records of Scotland

There are differences in life expectancy values within Fife with Glenrothes and North East Fife having higher values of life expectancy at birth and age 65 than the other two Fife CHPs (Table 31).

[12] National Records of Scotland: Life Expectancy Estimates. Available from:http://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/life-expectancy/life-expectancy-in-scottish-areas/life-expectancy-for-administrative-areas-within-scotland-2011-2013

Table 31: Life expectancy at birth and age 65: CHPs 2011-13

	Life Expectancy at birth		Life Expectancy at age 65	
	Males	**Females**	**Males**	**Females**
Dunfermline & West Fife	76.8	81.3	16.96	19.6
Glenrothes & NE Fife	78.3	81.7	17.94	20.01
Kirkcaldy & Levenmouth	76.2	80.4	17.3	19.5

Source: NRS

4.2 Self-Reported Health

The 2011 Census asked people to rate their health on a five point scale from very good to very bad. Self-reported health has been shown to be a useful measure of overall health status and to be related to the presence of disease and predictive of hospital admissions, perceived poor health is a strong indicator of future use of the health service.

82% of the Fife Census population rated their general health as 'very good' or 'good', 14% rated their health as 'fair' and 5% as 'bad' or 'very bad'. Ratings of health as bad or very bad increased with increasing age, 10% of those aged 65-69 selected these categories compared to 1% of those aged 30-34.[4]

The question asked in the 2001 Census was not directly comparable to the information collected in 2011 with 67% rating their health in the previous 12 months as 'good' and 23% as 'fairly good'.

4.3 Long term health conditions

Long-term health problems can be a strong predictor of higher use of health service resources and as such a question about the presence, and types, of long term conditions were asked in the 2011 Census. Fife residents (of all ages) were asked if they had any of eight conditions (or enter other conditions) listed that had lasted or was expected to last at least 12 months.[4]

32% of Fife residents reported they had one or more long term health conditions compared to 30% nationally (Table 32). The presence of one or more health conditions increased significantly with age, 19% of those aged 25-34 reported having one or more health conditions compared to 59% of those aged 65-74 and 88% of those aged 85 and over.

Table 32: Self reported presence of health conditions by age group; Fife 2011 Census

	Population	No Conditions		One or more conditions	
		No	%	No	%
Total	365,198	247,857	68%	117,341	32%
0 to 15	64,397	57,394	89%	7,003	11%
16 to 24	42,525	35,471	83%	7,054	17%
25 to 34	41,589	33,733	81%	7,856	19%
35 to 49	78,487	58,108	74%	20,379	26%
50 to 64	74,129	42,157	57%	31,972	43%
65 to 74	35,181	14,436	41%	20,745	59%
75 to 84	21,155	5,598	26%	15,557	74%
85 and over	7,735	960	12%	6,775	88%

Source: Census Data Explorer

The most frequently reported health conditions from those listed were 'deafness or partial hearing loss' and 'physical disability' which were both reported by 7% of the Fife population. 'Mental health conditions' were reported by 4% of the population and 'blindness and partial sight loss' by 2.5%. 20% of the Fife population reported they had 'other' health conditions as did 19% of population of Scotland.

Reports of 'deafness or partial hearing loss', 'blindness or partial sight loss' and physical disability were much more common among the older population in Fife. More than a quarter of residents aged 65 and over reported 'deafness or partial hearing loss' rising to half of all those aged 85 and over (Table 33). A fifth of the 65 and over age group reported a physical disability compared to just 4% of those aged 35-49. The oldest old were most likely to report mental health conditions (11%) but proportions reporting this among the other age groups were more similar, 3% of those aged 16-24 and 5% of those aged 50-64 (Table 33).[4]

Residents were also asked in the 2011 Census if their day to day activities were limited by a long-term health problem or disability (including problems related to old age) that had lasted or was expected to last at least 12 months. 80% of the Census population reported that their activities were not limited by a health problem. 11% reported that their activities were limited 'a little' and 9% said their activities were limited 'a lot'. This (20%) was the same proportion who reported a limiting long-term health problem 2001, and is consistent with the Scottish average of 19.6% reported in 2011.

Table 33: Four most common condition categories by age; Fife 2011 Census

	Deafness or partial hearing loss	Blindness or partial sight loss	Physical disability	Mental health condition
Total	7%	3%	7%	4%
0 to 15	1%	0%	1%	0%
16 to 24	1%	1%	1%	3%
25 to 34	1%	1%	2%	5%
35 to 49	3%	1%	4%	6%
50 to 64	8%	2%	10%	5%
65 to 74	18%	4%	16%	3%
75 to 84	31%	11%	24%	5%
85 and over	50%	27%	37%	11%

Source: Census Data Explorer

Of those who had reported one or more health conditions 63% stated that their activities were limited by these conditions. Reports of activities being limited by a long term health problem or disability were more common among older age groups. 88% of those aged 75 and over reported their activities were limited compared to 42% of those aged 16-24.

4.4 Mental Wellbeing and Life Satisfaction

Mental wellbeing is measured in the Scottish Health Survey using the WEMWBS questionnaire.[13] It is a 14 item scale designed to assess positive effect, satisfying interpersonal relationships and positive functioning. WEMWBS produces a possible score of 14 to 70 with a higher score indicating more positive wellbeing. Older adults in Fife had higher average WEMWBS scores than young adults and a slightly higher average score than older adults in Scotland as a whole (Table 34).

Table 34: Average Mental Wellbeing and Life Satisfaction scores by age; Fife and Scotland

	Fife				Scotland
	16+	**16-44**	**45-64**	**65+**	**65+**
Average WEMWBS	49.9	49.3	50.2	50.5	50.2
Av Life Satisfaction	7.61	7.58	7.48	7.86	7.8

Source: SHeS 08-11

Ratings of life satisfaction given in response to the question 'on a scale of zero (extremely dissatisfied) and 10 (extremely satisfied) how satisfied are you with your life as whole nowadays?' increased in Fife with increasing age. Older adults in Fife had slightly higher average life satisfaction scores than older adults in Scotland (Table 34).

4.5 Overweight and Obesity

74% of adults aged 65 and over in Fife had a body mass index (weight/height^2) which placed them in the category of overweight (including obese). 35% of adults in this age group were obese (including severely obese) compared to 26% of adults aged 16-44 and 35% of adults aged 45-64. Fife had higher levels of obesity in older adults than Scotland (Table 35).

Table 35: Prevalence of overweight and obesity by age; Fife and Scotland

	Fife				Scotland
	16+	**16-44**	**45-64**	**65+**	**65+**
Overweight (incl obese)	67%	55%	77%	75%	74%
Obese (incl severely obese)	31%	26%	35%	35%	32%

Source: SHeS 08-11

4.6 Dental Health

As at 30th June 2013, 25,277 Fife residents aged 65-74 and a further 18,571 aged 75 and over were registered with a dentist (table 36). This corresponds to 67% and 63% of all persons aged 65-74 and 75 and over in Fife slightly lower proportions than reported nationally and lower than the 76% of all adults registered in Fife.

[13] NHS Fife (2014) Fife Scottish Health Survey Results 2008-11 Information Services, NHS Fife

Table 36: Dental registrations (number and percentage) by age group; Fife and Scotland

	Fife		Scotland	
	65-74	**75+**	**65-74**	**75+**
Number	25,277	18,571	365,065	276,794
% of age group population	67%	63%	72%	66%

Source: http://www.isdscotland.org/Health-Topics/Dental-Care/Publications/data-tables.asp?id=1183#1183

The Scottish Health Survey collects information on the prevalence of natural teeth. 12.5% of Fife adults reported that they had no natural teeth with the proportions reporting this increasing with increasing age from just 2% of those aged 16-44 to 38% of those aged 65 and over (Table 37).

Table 37: Prevalence of no natural teeth by age; Fife and Scotland

	Fife				Scotland
	16+	**16-44**	**45-64**	**65+**	**65+**
No natural teeth	12.5%	2%	11%	38%	43%

Source: SHeS 08-11

4.7 Coronary Heart Disease

ISD provides information on the incidence of Coronary Heart Disease (CHD) at a Fife and Scotland level. Incidence is presented as the number of people with a first hospital admission for CHD or death from CHD without a prior admission to hospital.

Latest published data (January 2014) shows that during 2012/13 a total of 1,242 persons in Fife (all ages) were either admitted to hospital with CHD for the first time or died from CHD without a prior admission to hospital. The incidence rate increases with age with the 75+ age group having the highest incidence rate of 1625.9 per 100,000 population (Table 38).

Fife had similar incidence rates to Scotland for those aged 65 and under but slightly lower incidence rates for both the 65-74 and 75+ age groups.

Table 38: CHD incidence rates by age; Fife and Scotland

	Fife				
Age group	**0-44**	**45-64**	**65-74**	**75+**	**All Ages**
Incidence	55	406	315	466	1242
% of age group population[14]	0.03	0.4	0.8	1.6	0.3
Standardised rate per 100,000 population[15]	24.8	395.2	851.2	1625.9	239.3
	Scotland				
Age group	0-44	45-64	65-74	75+	All Ages
Incidence	711	6267	4866	7459	19303
% of age group population	0.02	0.4	0.9	1.8	0.4
Standardised rate per 100,000 population	21.7	429.5	976.4	1829.2	262.8

Source: http://www.isdscotland.org/Health-Topics/Heart-Disease/Topic-Areas/Incidence/

4.8 Cerebrovascular Disease

Latest published data (January 2014) shows that during 2012/13 there were 707 new hospital admissions or deaths (with no prior hospital admission in last 10 years) relating to cerebrovascular disease among those aged 65 and over in Fife. The majority of these cases occurred among the adults aged 75 and over with 1.7% of the population in this age group experiencing a cerebrovascular incident in 2012/13 (Table 39). The proportions of the older adult populations experiencing stroke in Fife and Scotland were similar but standardised incident rates (taking into account the different age and sex population structures) were higher in Fife.

Table 39: Incidence of cerebrovascular disease by age group: Fife and Scotland

	Fife				
Age Group	0-44	45-64	65-74	75+	All Ages
Incidence	33	176	203	504	916
% of age group population	0.02	0.2	0.5	1.7	0.2
Standardised rate per 100,000 population[15]	15.5	168.9	546.9	1592.7	154.1
	Scotland				
Age Group	0-44	45-64	65-74	75+	All Ages
Incidence	497	2621	2639	6765	12522
% of age group population[14]	0.02	0.2	0.5	1.6	0.2
Standardised rate per 100,000 population[15]	15.5	178.1	522.9	1566.6	153.7

Source: http://www.isdscotland.org/Health-Topics/Stroke/Topic-Areas/Incidence/

[14] Calculated using the 2013 mid-year population estimates as provided by National Records of Scotland (NRS) http://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/population/population-estimates/mid-year-population-estimates/mid-2013

[15] The age-sex standardised rates were calculated using the direct method, standardised to the 1976 European Standard Population. NRS Population Estimates were used in the calculation of the crude and standardised rates.

4.9 Diabetes

Data extracted from the SCI-DC[16] dataset in October 2014 showed that there were a total of 20,081 (5.5%) people resident in the NHS Fife Board area affected by diabetes (either Type 1 or Type 2) with the majority (15.8%) of these being in the 65+ age group. This prevalence rate is higher than that for Scotland as a whole (5.05%). Further details are provided in Table 40.

Table 40: Prevalence of diabetes (Types 1 and 2) in NHS Fife Board area of residence

	All ages		Age group		
	Scotland[17]	**NHS Fife**	**<16**	**16 - 64**	**65+**
Number	268,154	20,081	145	9,001	10,935
% of Population[14]	5.05%	5.5%	0.2%	3.9%	15.8%

Source: SCI-DC, Scottish Diabetes Survey 2013

Prevalence levels of diabetes (for all ages) differs across Fife with North East Fife having the lowest prevalence rate (4.6% of total population) and Cowdenbeath having the highest prevalence rate of 7.5% of the total population. Further details are provided in Table 41.

Table 41: Prevalence rates of Types 1 and 2 diabetes (All ages) across Fife

	SW Fife	**Dunfermline**	**Kirkcaldy**	**Glenrothes**	**Levenmouth**	**NE Fife**	**Cowdenbeath**
Number	2,938	2,681	3,281	2,549	2,169	3,396	3,041
% of Population[14]	5.9%	4.9%	5.5%	5.0%	5.8%	4.6%	7.5%

Source: SCI-DC

4.10 Dementia

It is estimated that 5,961 people are affected by dementia in Fife at the present time, with more females than males being affected. The number of people in Fife who are estimated to be currently affected by dementia was calculated by applying the prevalence rates of dementia (%) detailed in the EuroCoDe[18] and Harvey[19] studies to 2013 mid-year population estimates as provided by NRS[14]. Details are provided in Table 42.

As per the methodology used by Alzheimer Scotland[20], EuroCoDe prevalence rates were applied to ages 60+ whilst the prevalence rates quoted by Harvey were applied to the under 60 age group. In order to calculate the number of people aged 90+ affected by dementia, the prevalence rates of 29.2 and 44.4 were used for males and females respectively, as per the Fife Dementia Strategy, 2010 .

[16] Scottish Care Information – Diabetes Collaboration

[17] Taken from the Scottish Diabetes Survey 2013 http://www.diabetesinscotland.org.uk/Publications/SDS2013.pdf

[18] Alzheimer Europe (2009) *EuroCoDe: prevalence of dementia in Europe* http://www.alzheimer-europe.org/index.php?lm3=CEE66BE91B37

[19] Harvey R (1998) *Young onset dementia: epidemiology, clinical symptoms, family burden, support and outcome* Imperial College London

[20] http://www.alzscot.org/assets/0001/0676/2014_stats.pdf

[21] http://admin.1fife.org.uk/weborgs/nhs/uploadfiles/publications/DEMENTIA%20STRATEGY.pdf

Table 42: Estimated number of people living with dementia in Fife

Age group	Males	Females	Total
30-59	48	51	99
60 - 64	22	107	129
65 - 69	198	164	362
70 - 74	245	329	574
75 - 79	406	550	956
80 - 84	543	865	1409
85 - 89	395	972	1366
90+	221	845	1066
Total	2078	3883	5961

Source: EuroCoDe, Harvey, NRS

The estimated number of people affected by dementia is predicted to increase over the next 15 years by approximately 3600. Full details of the predicted number of people affected by dementia in Fife in the coming years are provided in Table 43 and Chart 12.

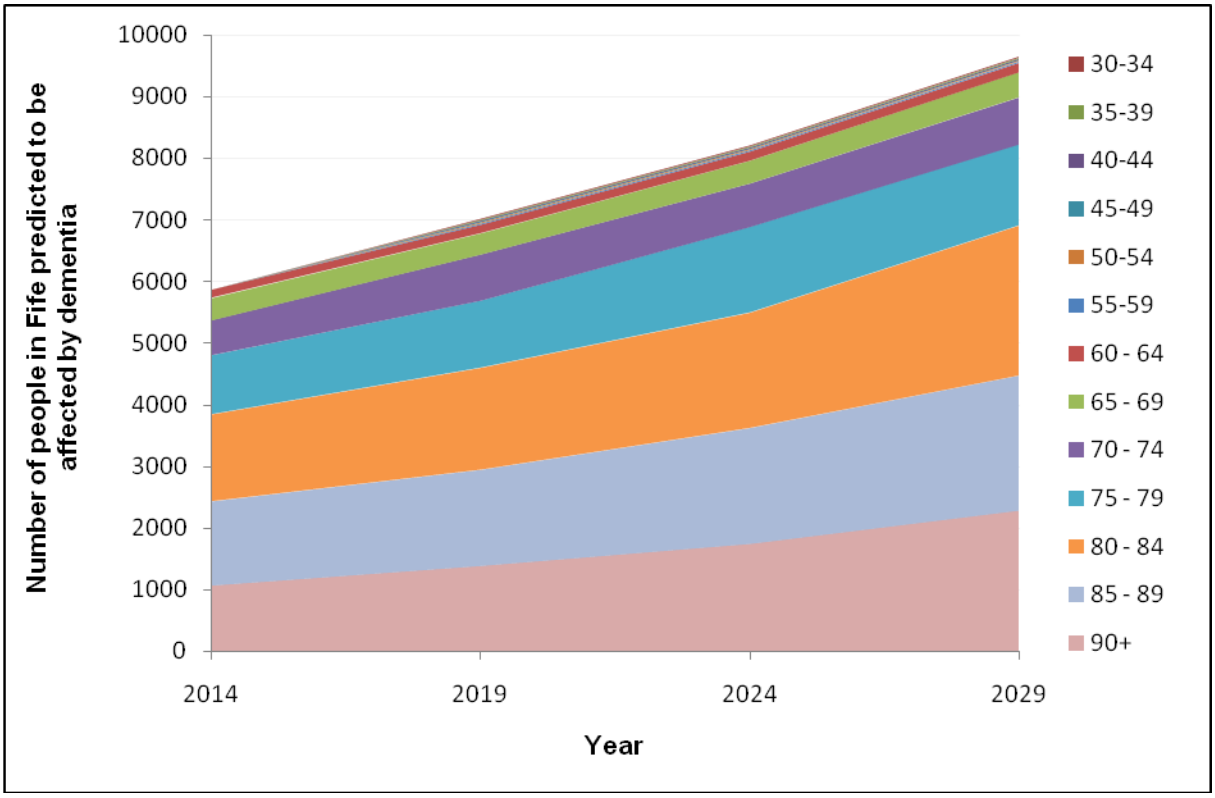
Data on predicted numbers of people affected by dementia in Fife over the next fifteen years were calculated using 2012 based NRS population projections for health board areas and applying the appropriate EuroCoDe or Harvey prevalence rate, as per previous calculations.

Table 43: Predicted numbers of males and females by age group affected by dementia in Fife, 2019 – 2029

	Year								
	2019			2024			2029		
Age group	Males	Females	Total	Males	Females	Total	Males	Females	Total
<60	47	51	98	46	50	96	45	48	93
60 - 64	23	112	135	25	123	148	26	127	153
65 - 69	187	158	345	201	169	370	221	187	408
70 - 74	330	425	755	307	403	710	332	435	767
75 - 79	474	612	1,086	625	765	1,390	588	732	1,320
80 - 84	660	992	1,652	766	1104	1,870	1,034	1399	2,433
85 - 89	492	1,070	1,562	620	1261	1,881	747	1445	2,192
90+	317	1,067	1,384	436	1306	1,742	609	1673	2,282
TOTAL	2,530	4,485	7,015	3,026	5181	8,207	3,602	6046	9,648

Source: Source: EuroCoDe, Harvey, NRS

Chart 12: Number of people by age group in Fife predicted to be affected by dementia, 2019 – 2029



Source: Eurocode, Harvey, NRS

5 Health Related Behaviours

In Fife we can use data from the Scottish Health Survey 2008-11, a national survey of health conditions and health related behaviours, to provide information on smoking, alcohol use, diet and physical activity. Due to the sample size of Fife respondents this information can only be presented for those aged 65 and over and not other older age groups.[13]

Smoking

In Fife 26% of adults describe themselves as a current smoker. The prevalence of smoking decreased with age from a high of 33% of those aged 16-44 to 11% of those aged 65 and over (Table 44). The proportion of smokers among those aged 65 and over in Fife was lower than the 14% reported nationally. Conversely the proportion aged 65 and over classifying themselves as ex-smokers was much greater than in other age groups, 42% compared to 14% in the 16-44 age group and 26% among those aged 45-64.

Alcohol Consumption

Guidelines for levels of alcohol consumption state weekly consumption should be not be greater than 14 units per week for women and 21 units per week for men. 23% of adults in Fife drank beyond these weekly levels which included 16% of those aged 65 and over (Table 44). The Fife figure of 16% was slightly greater than the Scottish figure of 14% reported in the ScotPHN report which also showed that men aged 65 and over were much more likely

than women to exceed weekly drinking limits. Average weekly consumption among those aged 65 and over was 8.2 units which was lower than among other age groups and the 12.3 units reported for all adults.

Table 44: Health Related Behaviours by age; Fife and Scotland

	Fife				Scotland
	16+	**16-44**	**45-64**	**65+**	**65+**
Current Smoker	26%	33%	28%	11%	14%
Ex Smoker	24%	14%	26%	42%	43%
Exceeds weekly alcohol limits	23%	24%	26%	16%	14%
Meets physical activity guideline	37%	47%	38%	15%	14%
Av hours active per week	7.2	8.4	8.9	3.4	3.4
Eats 5+ portions fruit/veg daily	23%	19%	28%	27%	23%
Av portions eaten in week	3.3	3.0	3.5	3.7	3.4
No risks	2.8%	3.3%	2.9%	1.9%	N/A
Three risks	37%	33%	39%	45%	N/A
Five risks	2.6%	2.4%	3.6%	1.2%	N/A

Source: Scottish Health Survey 2008-11

Physical Activity

Age specific guidelines for physical activity were published in 2012 and the Scottish Health Survey will provide information to monitor progress towards all of these in future surveys. Data from the 2008-11 surveys provided information to show how many older adults are moderately active (in periods of 10 minutes or more) for at least 2½ hours or 30 minutes five days a week (Guideline 2).

Levels of moderate physical activity among those aged 65 and over were low with just 15% achieving the recommended weekly levels. This figure was more than half the proportions reported for the other age groups in Fife but similar to the 14% reported nationally (Table 44). Older adults reported being active for an average of 3.4 hours each week which was considerably lower than the number reported by younger age groups (Table 44).[13]

Diet

Consumption of five portions of fruit and vegetables a day is a long established dietary target which is measured via data collected within the Scottish Health Survey. Consumption of 5 portions a day was low in Fife with 23% of all adults reporting this. Proportions among those aged 65 and over were higher with 27% reporting they ate 5 or more portions a day, a figure higher than the 23% reported nationally. Older adults also reported higher than average daily consumption, 3.7 portions compared to 3.3 portions for all adults.

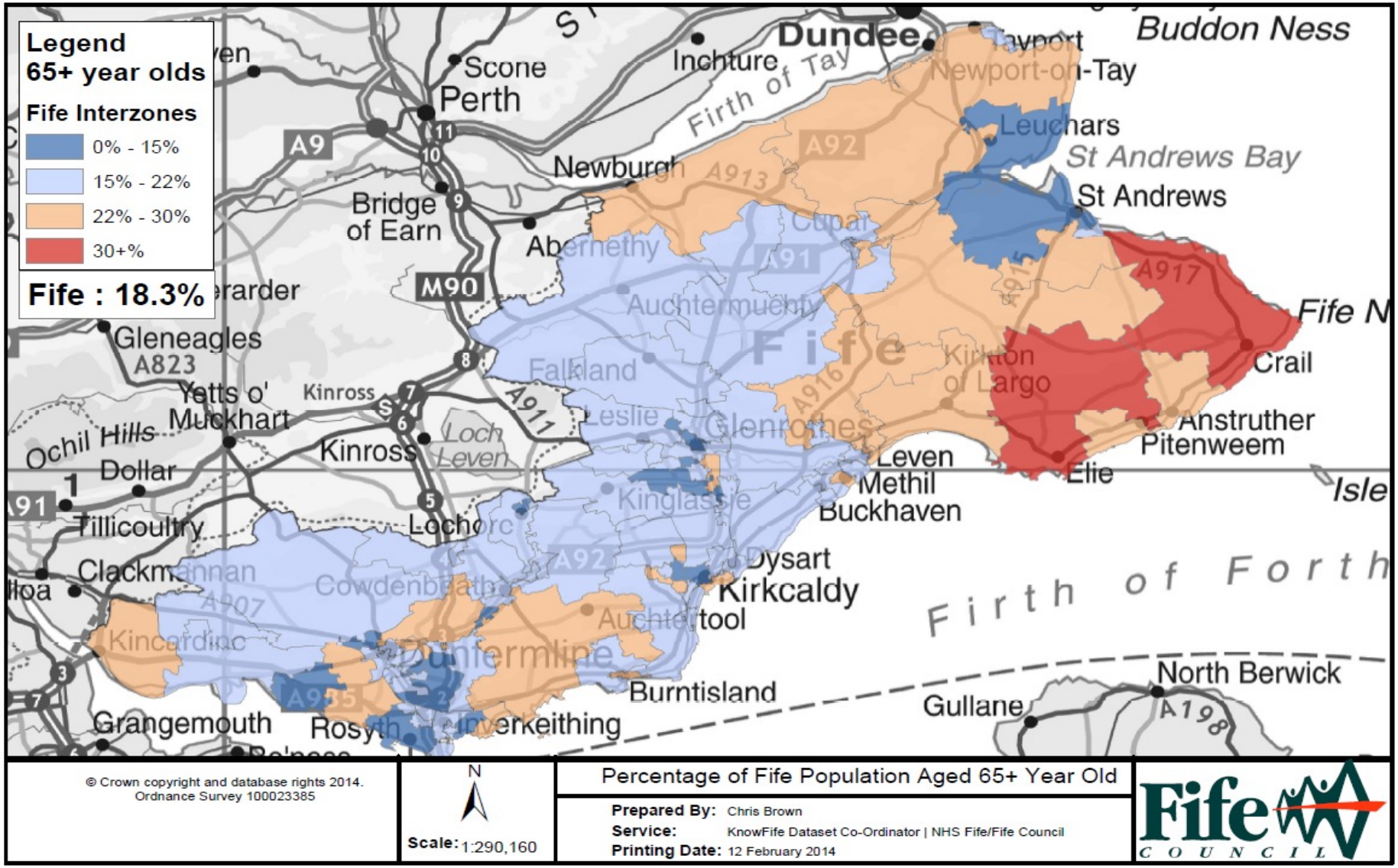
Multiple Risk Factors

Five risk factors have been identified as contributing approximately 90% of the total burden of disease in countries such as the United Kingdom. These factors are smoking, excess alcohol consumption, poor diet, physical inactivity and being overweight (incl. obesity). Data from the Scottish Health Survey linked to each of these factors has been analysed to presents estimates of the prevalence of multiple risk factors from none to having all five risk factors.

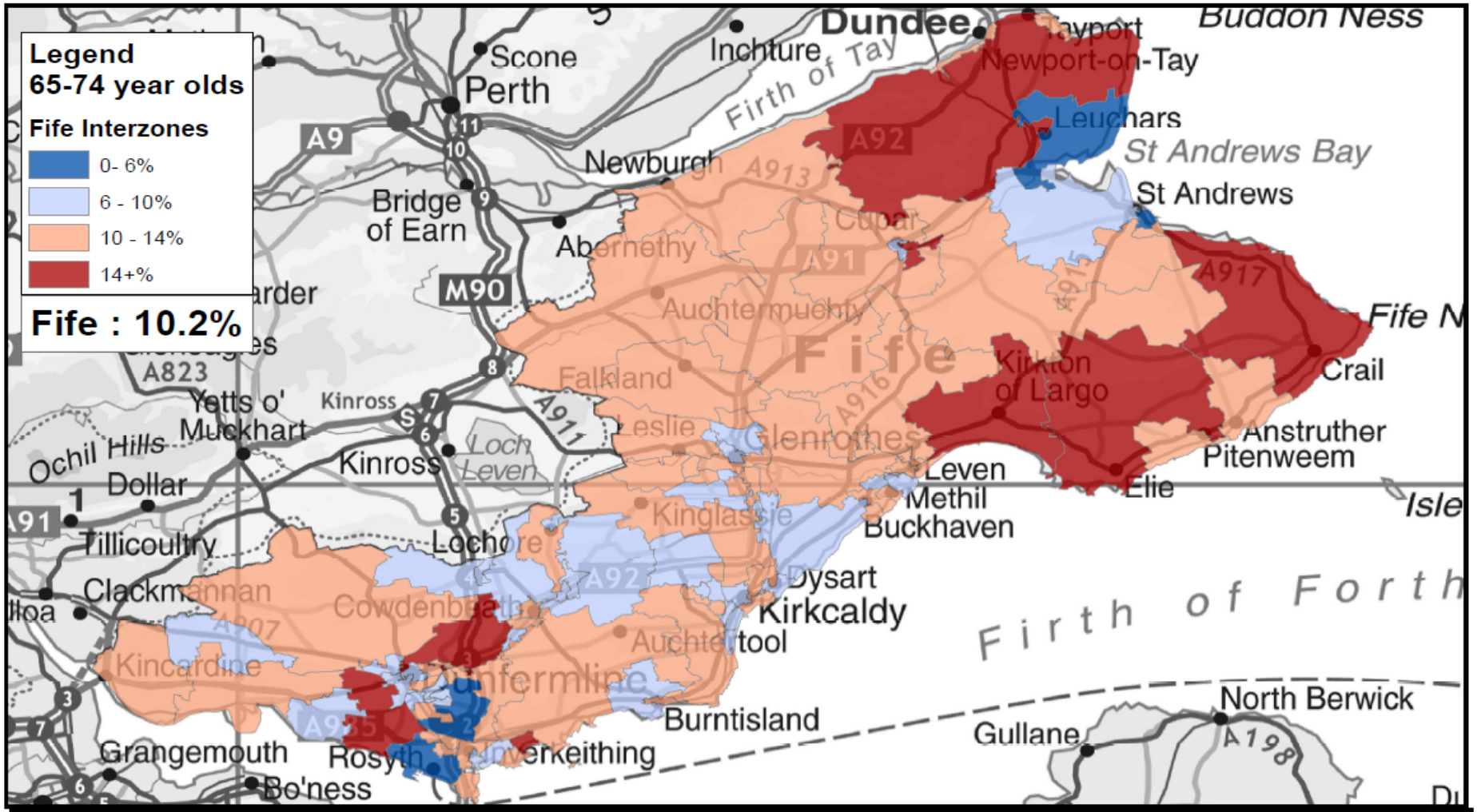
Less that 3% of all adults in Fife and 2% of those aged 65 and over had no risk factors (Table 44). Having all five risk factors present was as comparatively rare as reporting none with 2.6% of all adults found to have all five and 1.2% of those aged 65 and over. Adults aged 45-64 were most likely to report having all five risk factors and was reported by 3.6%.

The most common number of risk factors was three, reported by 45% of those aged 65 and over in Fife compared to 33% aged 16-44 and 39% aged 45-64. Among those aged 65 and over the most frequently reported combination of three risk factors was to be overweight or obese, be physically inactive (not achieving recommended levels) and not eat the recommended five portions of fruit and vegetables. This combination was reported by 34% of adults aged 65 and over compared to 14% of those aged 16-44 and 20% aged 45-64.

Appendix 1 – Map 1



Appendix 1 – Map 2



N

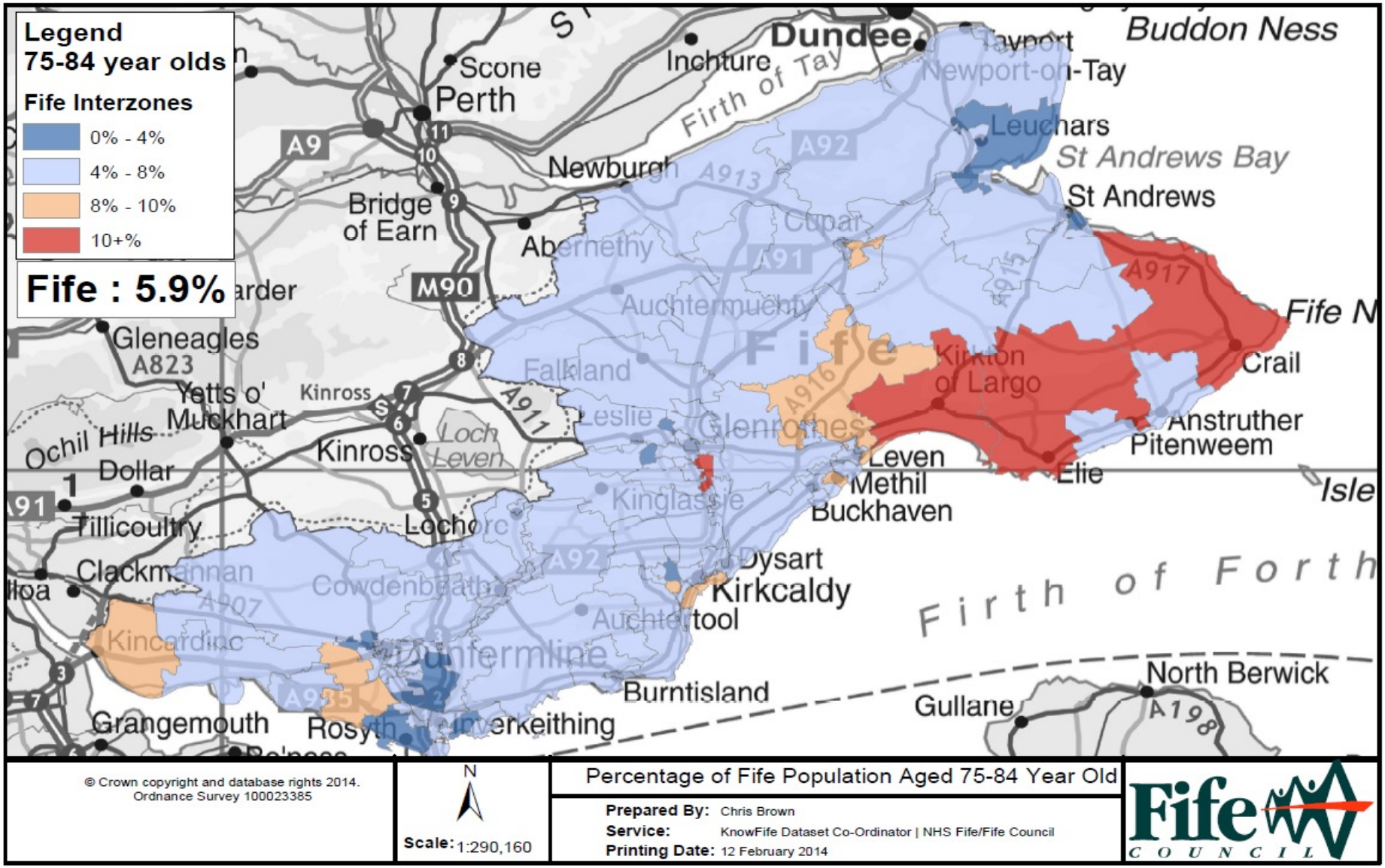
Scale: 1:290,160

Percentage of Fife Population Aged 65-74 Year Old

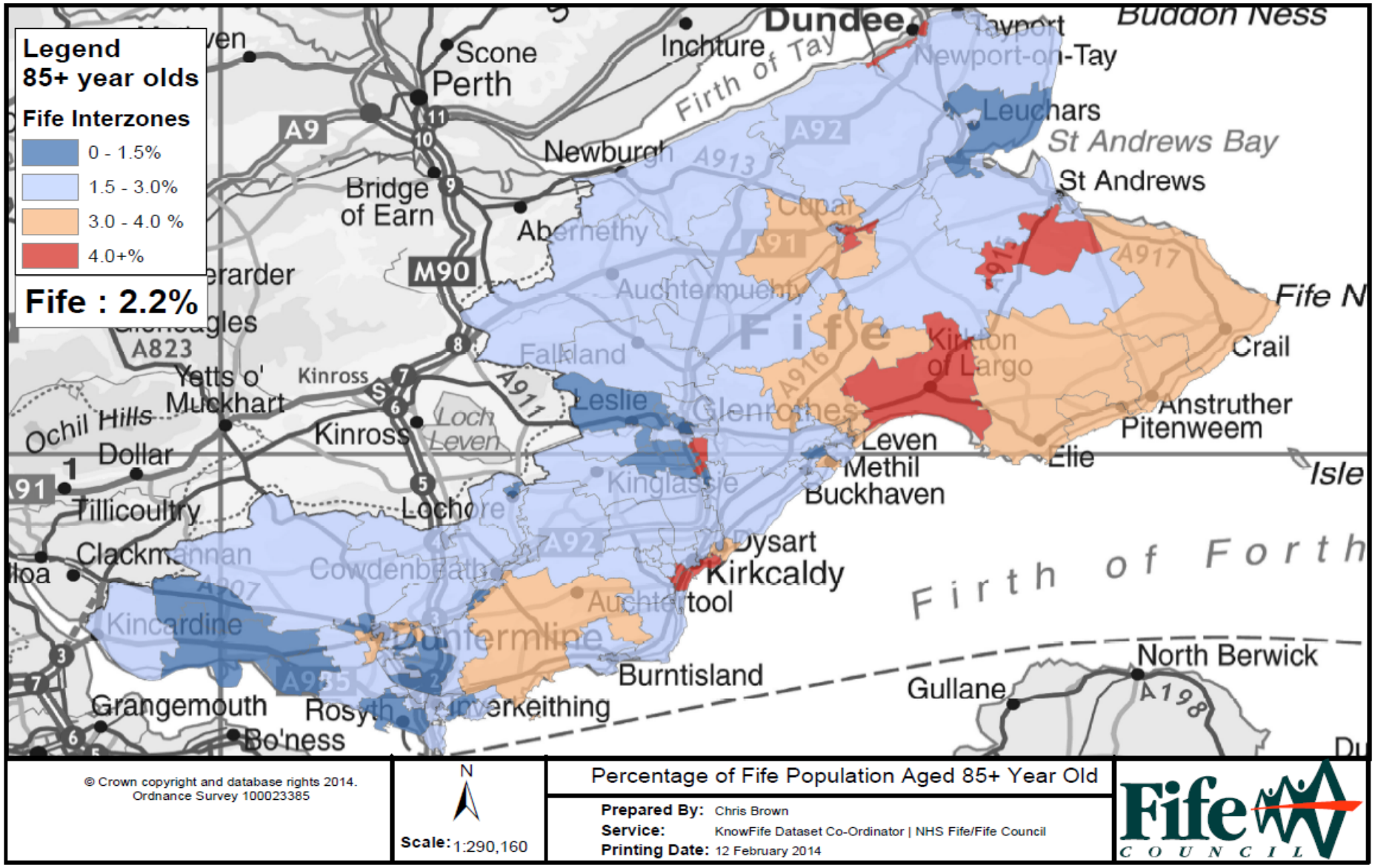
Prepared By: Chris Brown
Service: KnowFife Dataset Co-Ordinator | NHS Fife/Fife Council
Printing Date: 12 February 2014

Fife COUNCIL

Appendix 1 – Map 3



Appendix 1 – Map 4



N

Scale: 1:290,160

Percentage of Fife Population Aged 85+ Year Old

Prepared By: Chris Brown
Service: KnowFife Dataset Co-Ordinator | NHS Fife/Fife Council
Printing Date: 12 February 2014

Fife Council

Health & Social Care Integration in Fife

Health & Social Care Integration in Fife

OVERVIEW OF VOLUNTARY SECTOR FUNDING

Supporting the people of Fife together

Fife Council Social Work Service

Voluntary Sector Funding

Introduction

The following information gives details of the current funding arrangements with Voluntary Sector organisations that are either funded by the Social Work Service or NHS Fife.

NHS Fife agreed that Fife Council Social Work Service would monitor, evaluated and support voluntary sector organisations as part of the Council's Monitoring and Evaluation Framework. This has ensured that organisations receiving funding have a co-ordinated approach and a single Service Level Agreement.

Service Level Agreements detail the work the organisation will carry out linked to agreed outcomes and outputs; this is monitored by the dedicated Link Officers, who are also available to support organisations giving advice and guidance.

The information contained before has been linked to current strategies in place across partnerships which can link to the Strategic Plan for Health and Social Care Integration. Please note that due to Organisations receiving funding from different sources they may appear within different strategies.

Advocacy Strategy 2014 - 2017

Over the period 2014 – 2017, the Fife Advocacy Strategy aims to ensure that:

- A wider range of people are eligible to receive advocacy;
- People can access a wider range of advocacy services;
- More people are aware of what advocacy is, how it can benefit them, what advocacy services are available in Fife, and know how to access them, and;
- Local advocacy services are provided with appropriate support in order to help them develop their services in line with this strategy.

Name of Organisation	Service Details	Funding Amount
Circles Network	Circles Network in Fife provides advocacy for everyone who is eligible to access advocacy services in Fife.	£353,202
Fife Women's Aid	Fife Women's Aid provides professional advocacy (and other support services) to women, young people and children who are experiencing, or have experienced, domestic abuse.	£383,227
Fife Elderly Forum	Fife Elderly Forum provides professional advocacy for people over 65 who are in community hospitals or residential or nursing care homes within Fife.	£40,693 - Fife Council SW Service £40,248 - NHS Fife
Dunfermline Advocacy	Provide Citizen Advocacy in the Dunfermline Area	£27,641 – Fife Council SW Service £85,359 - NHS Fife

Equal Voice	Provide Citizen Advocacy in the Kirkcaldy and Central Fife Area	£33,962
Enable		£38,181
IncludeME	Provide Citizen Advocacy in North East Fife	£37,744
People First	Provide Group Support across Fife	£83,710

In March 2009 Audit Scotland published the document, 'Key messages: Drug and alcohol services in Scotland', which made several recommendations about services. These included ensuring that all drug and alcohol services should be based on an assessment of local need and that regular evaluation take place to measure best value. Another was that all commissioned services should have service specifications outlining expectations and monitoring requirements. The funding below complements the commissioned services agreed via the ADP.

Name of Organisation	Service Details	Funding Amount
DAPL (Drug & Alcohol Project)	Provide support to people with drug and alcohol misuse issues	£303,924 – Fife Council SW Service £21,450 - Fife Council SW Service £295,000 – ADP Funding
FASS (Fife Alcohol Support	Provide support for people	£71,361 - Fife Council SW

Services)	with Alcohol issues	Service £227,467 – NHS Fife *£262,000 - ADP Funding (Jointly funded ADAPT partnership with Fife Community Drugs Service)
FIRST	Provides recovery support for people who have had drug and alcohol issues	£391,698 - Fife Council SW Service £269,426 - ADP Funding
Fife Community Drugs Service	Provides support for people with drug issues.	£56,373 - Fife Council SW Service *£262,000 - ADP Funding (Jointly funded ADAPT partnership with FASS)

Fife Carers Strategy

2012 - 2015

Most carers accept their responsibilities as they wish to assist and support their family and friends to remain in their own homes. However, social isolation and financial hardship remain major issues for many carers. Becoming a carer can mean the end of employment and a reduction in the household income. Caring can exclude people from social activities and everyday life choices. The impact can be both immediate and long lasting and often affects the health of carers resulting in high levels of stress, depression and exhaustion. Many parents, husbands, wives, children, friends and relatives who care because of a relationship do not always recognise themselves as carers. Many carers care for more than one relative or friend and it is important to understand who is a carer. Without recognition carers' contributions will not be valued and they will not get the support they need and are entitled to.

Name of Organisation	Service Details	Amount
Fife Carers Centre	Provides direct support to carers including carrying out carers assessments. Also	£65,674 - Fife Council SW Service

	receive funding via Carers Information Strategy	£77,000 – NHS Fife £29,785 – NHS Carers Strategy Funding
Crossroads Central	Provides direct support to carers and service users by providing respite services Also receive funding via Carers Information Strategy	£142,978 - Fife Council SW Service £99,990 - NHS Fife £38,567 – NHS Carers Strategy Funding
Crossroads Dunfermline	Provides direct support to carers and service users by providing respite services	£43,240 - Fife Council SW Service £27,914 – NHS Fife
PAMIS	Family Support service to Children and Adults with PMLD. Additional funding via Carers Information Strategy – NHS Fife	£55,919 – Fife Council SW Service £41,279 – NHS Carers Strategy
Fife Action on Autism	Support to those affected by Autism, their families & care. Additional funding via Carers Information Strategy – NHS Fife	£15,325 – NHS Carers Strategy
Link Living	Real Living and Keep well carers projects. Additional Funding Funding via Carers Information Strategy – NHS Fife	£30,000 – NHS Fife £17,314 - NHS Carers Strategy £36,354 – NHS Fife
RNIB	Funding via Carers Information Strategy – NHS Fife	£23,385 - NHS Carers Strategy £4,925 - NHS Carers Information Strategy

Fife Dementia Strategy

2014 -

This Strategy is designed to improve the lives of people affected by dementia by promoting the provision of high quality services and support in Fife which meet and are responsive to their unique needs. It aims to bring formal services together with individuals, communities and voluntary organisations to work in partnership to support people with dementia in Fife. The services will be accessible to everyone affected by dementia in Fife, regardless of location, and enable them to live as independently as possible in the environment of their choice. It invites people with dementia and their carers to be partners in care, giving them real choice and the ability to impact the care they receive.

Name of Organisation	Service Details	Amount
Alzheimer's Scotland	Supports people with Alzheimer's to remain independent and in control of their lives wherever possible, also supports a peer group and one to one support.	£163,353 - Fife Council SW Service £328,370 - NHS Fife
Dementia Services Development Centre	Provides support and information to professionals from Dementia Development Unit.	£3,933

Mental Health Strategy

2013 - 2020

Our overall aim is to improve the mental health and wellbeing of the people of Fife and deliver prompt, safe and effective treatment, care and support for those with mental health problems and mental illness. We will use our strategy to help us develop specific areas of work identified locally as essential for the effective, efficient and sustainable delivery of current and future services and to support the key themes identified in the Mental Health Strategy for Scotland.

Name of Organisation	Service Details	Amount
Barony Housing	Provides day time activities and opportunities for social interaction to people experiencing mental health problems.	£186,452 - Fife Council SW Service £93,546 - NHS Fife
Castle Furniture	Provides work opportunities and therapeutic support for individuals with mental health problems	£57,200
ENERGI	Provides support to individuals and carers of people who are experiencing mental health issues in North East Fife	£38,525
Express Group	Provides support to individuals experiencing mental health issues.	£131,971
Fife Action on Autism	Provide adolescent clubs for young people with Autism, which includes support tailored to individual needs	£53,914
Fife Boomerang	Provides people with mental health issues to access a range of activities	£25,056
Fife Employment Access	Enable service users who	£20,033 - Fife Council SW

Trust (FEAT)	have mental health issues to access a range of employment opportunities and support them throughout that process.	Service £35,028 - NHS Fife
Fife Voluntary Action		£138,000
Talk Matters	Provides counselling service for people who are suicidal, depressed or stressed or experiencing bereavement.	£36,752
North East Fife Befriending (LINK)	Provides support to people with mental health problems in North East Fife.	£10,744
NSF Scotland	Provides a range of services across Fife such as gardening, music therapy and social interaction. Including people with hearing voices.	£174,168
Quarries' – Epilepsy Support	Provides support to people with epilepsy throughout Fife, which includes information and support to people of all ages, their family and carers.	£17,998 - Fife Council SW Service £16,561 - NHS Fife
SAMH	3 Mental Health Services, Core Club, Evergreen & Pantry offering various supports around rehabilitation, training, skills and work experience.	£213,161 – - Fife Council SW Service £20,766 - NHS Fife
Scottish Huntington's Association	Provides support to people affected by Huntington's Disease and supports carers.	£54,945
Cruse Bereavement Service	Provides one to one support service for all bereaved people in Fife.	£3,371

Fife Rape and Sexual Assault Strategy

The long term outcomes to be achieved within this strategic area are contained within the Fife Domestic and Sexual Abuse Logic model. These aim to reduce the impact of violence against women and reduce violence against women. Intermediate outcomes to be achieved within this are to meet the individual need of those affected by violence, to ensure perpetrators are less likely to reoffend, to reduce social tolerance of violence and to reduce acceptance of gender inequalities. There are also a number of Short term outcomes around Strategic Planning, provision/early intervention and prevention.

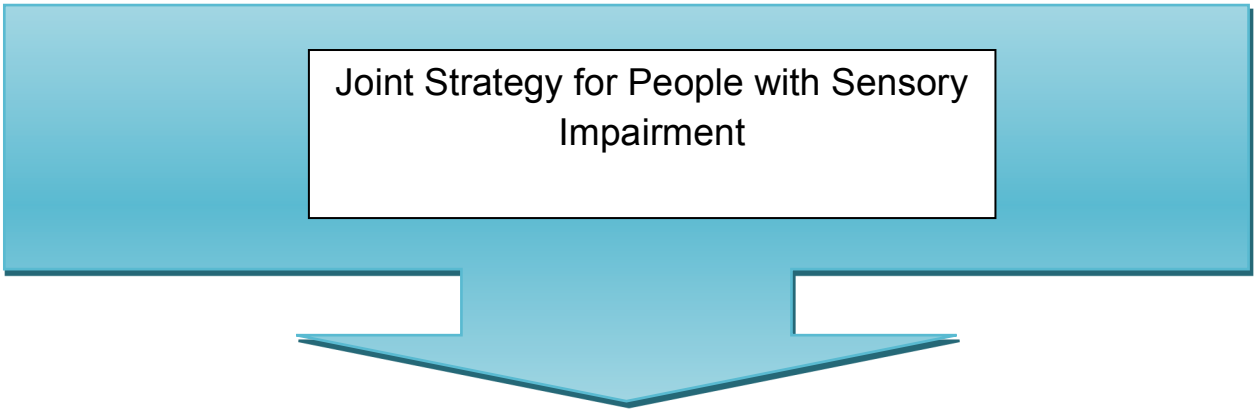
Name of Organisation	Service Details	Amount
Fife Rape and Sexual Abuse Centre	Offer complete and accessible support to anyone affected by sexual trauma in Fife.	£38,081
Kingdom Abuse Survivors Project	Enables adult survivors of childhood sexual abuse throughout Fife.	£98,580 - Fife Council SW Service £53,407 - NHS Fife
Safe Space	Provides a support service for survivors of sexual abuse	£124,014 - Fife Council SW Service £18,362 - NHS Fife

Older People Strategy

To meet the needs of the older population now and in the coming years, all Health and Social Care Services should have a primary aim of maintaining and supporting independent living and maintaining quality of life. The resources of local people and communities will be at the centre of social care provision. The purpose of the strategy is, therefore, to provide a clear direction for future developments of the NHS Fife Services within hospitals (acute and community) and in the community, and Fife Council's Services, acknowledging and building
on the contribution of the Voluntary and Independent sectors.

Name of Organisation	Service Details	Amount – Fife Council
Abbeyview Day Care	Provides a day centre for elderly people 5 days per week in the Dunfermline Area	£89,666
Aberdour Day Care	Provides a day centre for elderly people one day per week with approximately 20 people attending	£5,942
Age Concern Cupar	Provides a day centre for elderly people in the Cupar area 5 days per week.	£61,425
Age Concern Glenrothes	Provides a day centre for elderly people at 3 different locations in the Glenrothes area 5 days per week.	£99,886 - Fife Council SW Service £8,481 - NHS Fife
Arden House	Provides lunch and activities for people in the Leven Area 5 days per week.	£162,479 - Fife Council SW Service £19,464 - NHS Fife
Asian Older People	Provides support and advice to Asian Community in Dunfermline and West Fife.	£8,661
Auchtermuchty Older People	Provides a lunch and activities for 20 people every	£1,942

	Wednesday	
Auchtermuchty Day Centre	Provides a lunch and activities for 15 people every Tuesday	£2,426
Dalgety Bay Day Centre	Provides a day centre for elderly people	£20,680
Day Centre Services Ltd	Provides day centre for elderly people in Kirkcaldy area 5 days per week, also has specialist dementia unit.	£162,451
East Neuk Frail Elderly Project	Provides a day centre for people in the East Neuk area of Fife	£33,606
Falkland Lunch Club	Provides lunch and activities for 20 people once a week in Falkland	£1,124
Fife Chinese Older People	Provides support to elderly people in the Chinese community in Fife. Over 50 people attend monthly	£11,237
Inverkeithing Concern for the Aged	Provides lunch and activities for people in the Inverkeithing area 5 days per week.	£35,409
Fife Day Care Services Ltd	Provides day centre for elderly people in the Lochgelly area 5 days per week	£176,364
Strathmiglo Lunch Club	Provides lunch and activities for people in the village of Strathmiglo once a week.	£2,361
Tayport Lunch Club	Provides lunch and activities for people in Tayport once a week	£733



This strategy relates to people of all ages who have a sensory impairment. This covers people who have a sight or hearing loss or both. It recognises the health, social, educational and economic disadvantages these people face and the human rights issues inherent. It promotes a better quality of life, independence, better outcomes and preventative approaches. It sets out clear expectations for streamlining assessment, care and support through care pathway approaches.

Name of Organisation	Service Details	Amount
DeafBlind Association	Deafblind aims to help people live as rightful members of their own communities.	£2,967
Fife Society for the Blind	Provision of specialist Sensory Impairment assessments and supporting services.	£306,500 - Fife Council SW Service £68,609 - NHS Fife
LEAD Scotland	Enables disabled adults and carers to access guidance and learning opportunities as well as providing opportunities for volunteering.	£18,417
Mid Fife Newstape	Local News transferred to CD and Tape for 120 visually impaired service users.	£250
RNIB	A Day Service and Visual Assessment Service to people with visual impairment and multiple disabilities.	£171,254

Health & Social Care
Integration in Fife

Health & Social Care Integration in Fife

Draft Market Facilitation Statement

Supporting the people of Fife together

Fife Health and Social Care Integration

Market Position Statement

February 2015

Version 1 – Fiona McKay

1. Strategic Directions

Fife Health and Social Care Integrated Board wish to stimulate a diverse market which offers good quality care as standard and a real choice for the service user.

To achieve this

- We will focus on commissioning quality services which deliver value for money
- We want a balanced care market that offers the service user choice in how, where and from whom they receive their care and support
- We want to enable independence so that people avoid expensive specialist, residential and nursing care and health services for as long as possible
- We will only work with providers who can clearly demonstrate a commitment to delivering good quality care and who place dignity, compassion and respect at the heart of their services
- We will aim to work with the market to develop prevention and demand management to reduce harm and avoid hospital admissions

The Health and Social Care Integration agenda is progressing and will gather further pace in 2015/16 and we will need to ensure that the market is kept informed and aligned to any intentions to make strategic changes.

2. The Market Position Statement

A market position statement sets out to identify what the care and support market looks like. It provides a starting point for discussion between Fife's Health and Social Care Integrated Board, local providers and other commissioning organisations.

It contains information about:

- What Fife looks like in terms of current and future demography and service provision
- The Integrated Board's commissioning intentions

- The vision for how services might respond to the changing needs for care and support in the future

This is Fife's first market position statement, we know that there are areas which will need further work to improve the information we hold. It is our intention to continue to work with providers and commissioning organisations to improve our intelligence and data so we can consider business planning in future years.

3. Key Messages in the Statement

Fife Health and Social Care Integrated Board expects to see an increase in the number of

- Older people with multiple care and support needs
- People with mental health problems including a large increase with those with dementia
- Older people living alone
- People with caring responsibilities, and
- People who receive a direct payment via self-directed support in order to arrange their own care.

We also expect a small increase in the number of people with learning disabilities year on year via transitional planning.

With an ageing population we expect demand for social care services to rise year on year. In particular we expect there to be an increased demand for:

- Services which enable someone to remain independent for longer by support such as reablement and telecare
- Community based services such as homecare
- Nursing care services for older people particularly for people with dementia and enduring mental illness
- Self-Directed Support
- Day activities for younger adults
- Services for carers such as respite
- Overnight care services in a person's own home.
- Community living scheme for adults with learning difficulties

- Short Term support in times of crisis or following a period of hospital care

Generally the supply of care and support services in Fife is a mix of local authority, Nhs, voluntary sector and independent sector. The mix varies depending on the service.

- There is currently an adequate supply of residential care beds and there are developments in progress, which, when completed will Increase the overall supply.
- There is currently a minor gap in nursing care home beds for people with dementia
- There is currently adequate supply of 24 hour supported living tenancies for people with learning difficulties and mental health
- There is limited choice for people who require day time activities

Our commissioning activity reflects our strategic direction and responds to our changing picture of demand.

- We will work collaboratively with the Joint Commissioning Group to deliver effective integrated health and social care services
- We have a strong ambition to work closely with providers and ensure there is a level playing field regardless of the size and type of organisation.
- We will encourage providers to design services which provide the specialist support required for people with dementia.
- Our aim is to stimulate and assist providers in developing new models of care and support which deliver improved outcomes, quality and value for money.
- We want to encourage providers who can demonstrate a person centred focus and can evidence their achievements on outcomes, reablement and enhancing independence.
- We will work with providers to ensure that service users access better quality information particularly those providers that provide services for those with self-directed support payments.

Quality and Performance

Fife Health and Social Care Integrated Board is committed to commissioning quality services which are safe and deliver good outcomes for service users. To support this commitment, a Quality Assurance Unit has been established to put in place a consistent framework to help monitor provider performance, identify where providers are performing well and where improvements need to be made. We want to work with providers, service users and carers in developing our framework so that it is meaningful for all and adds value o the Care Inspectorate standards of care.

Growing Needs

It is expected that the demand for services will be driven by changes in the local demographic profile; this is detailed in the analysis already carried out.

4. Specific Commissioning Intentions

A "commissioning intention" is a brief statement that sets out the priorities of the commissioning authority in respect of se the services and market changes I wishes to deliver. The commissioning intentions below are an outline of the Health and Social Care priorities for Fife during 2015

Older People

Homecare

- To re-tender the Care at Home framework agreement by October 2015 and build in stronger requirements around provider quality assurance and effective management of service. Consider an alternative model for delivery of homecare including direct access from hospital.

- To consider models of homecare with Joint Commissioning Group and examine piloting different forms of care at home that will reduce hospital admissions and reduce the need for residential care.

- Develop "Nightlink" services to allow people to remain at home with overnight support.

Residential Care

- To reduce the frequency of residential care home placements

- To develop a quality framework for all care homes across the region in partnership with providers and the Care Inspectorate.

- To stimulate the market to increase the supply of provision specifically for those with dementia and in particular develop services for those with more challenging behaviour/complex needs.

- Consider "step up" and "step down" care home placements to support people who require higher support when in crisis or when discharged from hospital.

- Further develop the Short Term and Reablement (STAR) approach within dedicated units in residential care throughout Fife.

Hospital at Home

- Further develop hospital at home that treats appropriately identified patients at home or in a care home setting. It is an alternative to hospital admission and provides the same level of care expected had the person been admitted to hospital. This service would link to Step Up services.

Day Support and Activities

- To stimulate more community based and volunteer run models of services including exploring the use of befrienders in different settings.
- We will consider the review which is underway within older people's services within facility based day care.

Mental Health

We will work with the Mental Health Strategy Implication Group (SIG) to deliver their commissioning intentions to:

- To continue to review those services currently commissioned via contractual arrangements or service level agreements including considering qualitative and quantitative measure to ensure delivery of key national and local targets ensuring good outcomes for patients/service users.
- Ensure on-going improvements in quality of care for people who experience mental health issues in order to secure good mental wellbeing outcomes for the population of Fife.
- Continue to work collaboratively with all partner agencies to deliver Integrated Care.

Housing Support

- We will develop a self-assessment tool for people who have medium or low level need to purchase a piece of equipment or how to arrange for an adaptation to their home without requiring an assessment by an Occupational Therapist.
- We will develop a "Handy-man" service to support the above working with voluntary sector partners.

Prevention and early intervention

- We are seeking to refocus services on the reduction of harm and avoidance of hospital admissions.
- Consider the impact of the use of equipment including Telecare and Telehealth with a view to enabling more people to remain independent for longer.

Carers Support

- We will monitor providers of grant funded support and consider the delivery against the Carers Strategy Outcomes
- We will further develop short breaks for carers who require support to maintain their caring role.

5. Providers who we want to work

- Those that work proactively to quality assure their services and are able to evidence the positive outcomes for service users.
- Those that want to work in partnership with all agencies across the region to continuously improve service provision
- Those that are delivering improved value for money and added value whilst avoiding sacrificing quality of care
- Those that proactively listen to service users views when improving service delivery
- Those that work to develop and train their workforce to deliver the above
- Those embed a culture of dignity and respect into services.

6. Care for the Future

The things we will be engaged in over the next two to three years based on what we know about supply and demand and the level of resources:

- A model of quality assurance for care services which informs service users and other citizens of the quality level of service
- Further develop prevention such as early intervention service to help reduce future demand.
- Increase use of voluntary run services to complement existing statutory care
- Improve our intelligence on self-direct support recipients in order to stimulate specific service growth.
- Work with Housing service to develop a model of extra care housing to allow people to stay in their own homes for longer reducing the need for home adaptations and give greater choice to disabled people who cannot achieve independent living due to lack of suitable housing.

GLOSSARY OF TERMS AND ABBREVIATIONS

A	Definition
Acute	A severe condition which usually occurs suddenly.
Anticipatory	Proactive planning for expected change(s).
Aids and Adaptations	Changes to house or home to help people live independently e.g. hand rail.
Allied Health Professionals	A person registered with the Health Professions Council e.g. physiotherapists, dieticians, speech and language therapists etc.
Asset based approach	This approach values the capacities skills, knowledge and connections in individuals and communities. Focus on the positive capacity of individuals and communities rather than the needs, deficits and problems.

B	
Body Corporate	A legal entity such as a company or government agency.
Befriending	Provides companionship for isolated people and opportunities to participate in social activities.

C	
Care Home	An institution (residential or nursing home) providing accommodation and care for people who are unable to look after themselves.
Carer	A person who spends time providing unpaid support to a family member or a friend who is ill, frail, disabled or has a mental health or substance misuse problem.
Care Pathway	The route or journey a person takes into, through and out of health and social care services.
Census	The procedure of systematically acquiring and recording information about members of a given population.
Commissioning	A process of needs assessment, planning, agreeing, putting in place and monitoring services.

Community Planning	The process by which public agencies (Local Authority, NHS, Police, Further & Higher Education, Fife & Rescue Service) work together with the private and third sectors to plan and deliver better services.
Co-production	Professionals, service users and their families collaborating on an equal basis to deliver health and social care services. It involves service users and the community taking over some of the work done by practitioners.
Core Services	Those services that must be included.
Coterminous	Having the same border or covering the same area.

D	
Delayed Discharge	A hospital inpatient who has been judged clinically ready for discharge by the responsible clinician in consultation with all agencies involved in planning that patient's discharge, and who continues to occupy the bed beyond the ready for discharge date.
Delegated	Transfer of authority.
Dementia	Dementia is a syndrome (a group of related symptoms) associated with an ongoing decline of the brain and its abilities.
Demographic	Studies of population based on factors such as age, race, sex and economic status.

E	
Early Intervention	Help and support available when problem(s) start which can prevent the problem(s) becoming more serious and/or assist recovery.
Economically Active	Employed or actively seeking employment.
Efficiency	The ability to produce or deliver something without waste.

Emergency Admission	An unplanned admission to a hospital inpatient ward.
Employment Deprived	The proportion of people from the resident working age population who are unemployed or who are not in the labour market due to ill health or disability.
Epidemiology	The science that studies the patterns, causes and effects of health and disease conditions in a defined population.
Equality & Diversity Impact Assessment (EQIA)	A strategic process to be considered when planning or redesigning a policy or service to ensure the current equality and diversity legislative framework is reflected.
Extra Care Housing	Developments that comprise self-contained homes with design features and support services to enable self-care and independent living.

F	
Family Health Services	A term used to describe general practice, community dentists, pharmacists and opticians.
Forensic Mental Health Services	An alternative to prison for people who have a mental health problem and who have been arrested. They are usually secure units which means people are not free to come and go.
Frailty	Frailty is a common clinical syndrome that carries an increased risk for poor health outcomes including falls, incident disability, hospitalization, and mortality.

G	
Governance	Establishment of policies and continuous monitoring of their proper implementation by the members of a governing body.
GP	General Practitioner.

H	
Health Inequalities	Differences in health status or in the distribution of health determinants between different population groups. For example, differences in mobility between elderly people and younger populations or differences in mortality rates between people from different social classes.
Healthcare Associated Infection	Infections that are acquired as a result of health care.

I	
Income Deprived	People, both adults and children, who are receiving, or are dependent on, benefits related to income or tax credits.
Independent Sector	Employers and organisations partially or wholly independent of the public sector e.g. private care homes, private homecare providers.
Integration	Combining structures or people of different types to form a single effective unit or system.
Integration Joint Board	The governing body of the Integrated Health and Social Care Partnership.
Intermediate Care Bed	Allow patients to be discharged to a registered care home from hospital or admitted to a registered care home to prevent a hospital admission, as part of their journey of returning to their own home and community.

L	
Life Expectancy	An estimate of how long an individual is expected to live taking into account a number of factors e.g. sex, physical condition and occupation.
Long Term Condition	A health condition that lasts a year or longer which impacts on a person's life and could require ongoing care and support.

M	
Market Facilitation	A type of market intervention, agent or action, which works to stimulate markets while still remaining outside of the market.
Multidisciplinary	A group composed of members with varied but complimentary experience, qualifications, and skills.

O	
Operational Plan	A plan prepared by a component of an organisation that clearly defines actions it will take to support the strategic objectives and plans.

Ophthalmic Services	Opticians.
Over arching	Including or influencing everything.

P	
Palliative Care	Care that relieves pain, symptoms and stress caused by serious life-limiting illnesses, improving patients' quality of life.
Person Centred	Puts the individual at the heart of everything we do.
Personal Outcomes	The impact or end result of services/support on a person's life.
Preventative Care	Primary Prevention – promoting health and wellbeing with the purpose of preventing disease. Secondary Prevention – early detection of disease followed by appropriate intervention or treatment. Tertiary Prevention – to reduce the impact of the disease and promote quality of life through rehabilitation.
Primary Medical Services	The term used to describe the range of healthcare that is provided by General Practitioners (GPs or family doctors).
Principles	The ideals that guide our actions and behaviours.
Public Partnership Forum	A network of patients, carers, community groups, voluntary organisations and individuals who are interested in the development and design of local health and social care services.
The Public Reference Group (PRG)	This group includes a wide range of Fife residents and individuals as well as representatives from existing community organisations. Its role is to develop a two way dialogue for views gathered from personal experience and local networks and advise and assist in the development of communication materials in relation to Health and Social Care Integration.
Public Social Partnership	A partnership between Fife Council and a number of Third Sector organisations for provision of housing support services.

R	
Re-ablement	Services approach to help people learn or re-learn skills necessary for daily living.

S	
Scottish Index of Multiple Deprivation (SIMD)	The Scottish Government's official tool for identifying those areas in Scotland suffering from deprivation. It incorporates several different aspects of deprivation, combining them into a single index.
Screening	A way of finding out if people are at higher risk of a health problem with a view to treating early and providing information
Self Directed Support (SDS)	Legislation that is designed to improve the quality of life of people who require care and support through increased choice and control over the services they receive.
Service User	Anyone who requests or uses a service
Shadow Integrated Board	Takes on the role of the Integrated Joint Board to oversee the transition of responsibilities to the Partnership until the Integrated Joint Board is formally established.
Set Aside Services	The financial amounts to be made available for planning purposes by the NHS Board to the Integration Joint Board in respect of Acute Services.
Shared Lives Project	Shared Lives is where an approved carer shares their home and family life with a vulnerable person.
Shift the Balance of Care	A term used to describe changes in different levels of our care and support system usually entailing a shift from hospital or institutional based to care and support in the community.
Short Term Assessment and Rehabilitation Beds (STAR)	Intermediate care units enabling patients to be discharged to a registered care home from hospital or admitted into an intermediate care placement to prevent admission to hospital as part of a journey of returning to their own home and community. Once admitted to the registered care resource, intermediate care services can help to facilitate the return of an older person to their own home using a re-ablement approach.
Single Outcome Agreement	This sets out the shared aspirations and commitments of the Community Planning Partnership to improve the quality life for people living in Fife.
Stakeholder	Anyone who might be affected by an organisation, a strategy or a project including service users, their carers, staff and the general public.
Statutory Agencies	Public Sector organisations e.g. Local Council or NHS.

Step Down Bed	Patients transferred to Step Down beds typically come from hospital and are awaiting assessment, community service or funding to enable return home or to a care home. The purpose of Step Down beds is to create capacity for patients who are medically fit for discharge from hospital by freeing up hospital beds across the system thus enabling hospital capacity for acute unwell patients and those who require inpatient hospital rehabilitation.
Strategy/Strategic	High level plan of action to achieve longer term or overall aim(s).

T	
Telecare	Technology that can be used to help people live safely and independently at home.
Third Sector	A general title for non-public sector, non-profit making bodies e.g. charities, voluntary organisations, community groups, faith groups and social enterprises.

V	
Vision	What we would like to achieve or accomplish in the mid to longer term future.

W	
World Health Organisation (WHO)	An organisation whose primary role is to direct and coordinate international health within the United Nations' system.