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Fife Health & Social Care Partnership

Annual Report 2016-17

NHS Fife

Supporting the people of Fife together

Fife Council

Contents

A message from our Chair

Simon Little
Chair, Fife Health and Social Care Partnership Board

As I step into my first year as Chair of the Partnership's Board, I look forward to maintaining the progress that has been achieved over the past year.

I thank my two predecessors, Rona Laing and Cllr Andrew Rodger who each held the post as Chair over the course 2016/17. Their contribution, along with those who were long standing members of the Board, helped build the foundation for integration from the earliest days. Their vast knowledge, skills and experience has been invaluable in shaping the ambitious change agenda, one which we continue with today.

Most recently the Partnership's Board has welcomed new members from Fife Council and NHS Fife as well as representatives for the public and partners. We are grateful and excited to have this new diverse group of individuals who bring their unique talents, expertise and perspectives to the work of the Partnership in order to further our mission to improve the lives of those living in Fife.

Foreword

Putting people at the heart of all we do. This is the constant as we undertake the biggest transformation of health and social care services in a generation. Fife's Health and Social Care Partnership brings together a wide range of services. From primary care to District Nursing, social work to occupational therapy and many others in between, our services touch the lives of every person living in Fife.

In this, our first Annual Performance Report (April 2016-March 2017), we set out what's been achieved and what we need to focus on in the future. Where we have been successful, sits one common ingredient – trust. Trust in our staff, trust between our staff and those they serve and the trust generated by having honest, open and meaningful conversations at both a Fife wide and local community level. This is how we improve lives, tackle inequalities and remain sustainable.

Our frontline, grassroots up approach has people actively debating and shaping the future of Fife's health and social care services on a community by community basis. From Inverkeithing to Tayport, Levenmouth to Kincardine, members of the community are getting around the table with professionals such as nurses, social workers, housing officers, community planners, pharmacists, doctors, the Third Sector and Independent Sector to ask – 'how can we make services better?' I'm grateful to every person involved.

Change of this complexity and scale is vital if we are to fulfil our joint ambitions. There is still much to be done but we have made a strong start to our journey. Many examples are featured in this report. With a budget of around £495m, a proven history of partnership working and strong connections with communities, the opportunity to think differently and develop health and social care services which are high quality, seamless, responsive and offer more choice and control for generations to come is ours to take.

I truly believe, that in partnership, we can move forward with passion, professionalism and commitment to deliver the aspirations of Fife people – to live active, healthy and independent lives for longer.

Michael Kellet
Director, Fife Health
& Social Care Partnership

1. Introduction & Background

The 1 April 2016 triggered one of the biggest transformations of health and social care services in Scotland. The national drive is to have health and social care services delivered jointly, locally and as effectively as possible. Across Scotland, Partnerships have been set up to meet this aim and support people to live healthy and independent lives for as long as possible.

In Fife, a vast range of services from NHS Fife and Fife Council's Social Work Services transferred over to Fife's Health and Social Care Partnership. Services we are responsible for include:

- all adult and older people Social Work Services
- community health services
- nursing, physiotherapy and mental health services
- children's community health services
- housing services which provide support to vulnerable adults and disability adaptations; and
- planning of some services provided in hospital e.g. medical care of the elderly.

In Fife we work with around 300 organisations across the Third Sector and Independent Sector. They are a vital part of the Partnership in delivering services.

Next to Edinburgh and Glasgow, Fife is one of the largest Health and Social Care Partnerships in Scotland with around 5,000 staff, a joint budget of around £495 million, and an acute set aside budget of £34m.

Our Board, often referred to as the Integration Joint Board (IJB), are fully responsible for:

- Overseeing the development and preparation of the Strategic Plan for services delegated to it
- Allocating resources in accordance with the Strategic Plan
- Ensuring that the national and local Health and Well-being Outcomes are met.

Our Vision

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

Our Mission

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

Our Values

- Person-focused
- Integrity
- Caring
- Respectful
- Inclusive
- Empowering

The case for change

In 2014, Fife was home to an estimated 367,250 people. By 2039 this is expected to increase by 5% to 386,963. There is a projected 27% (from 77,700 to 99,034) increase in those of pensionable age, and 91% (from 30,809 to 58,903) amongst the 75 and over age group.

2014

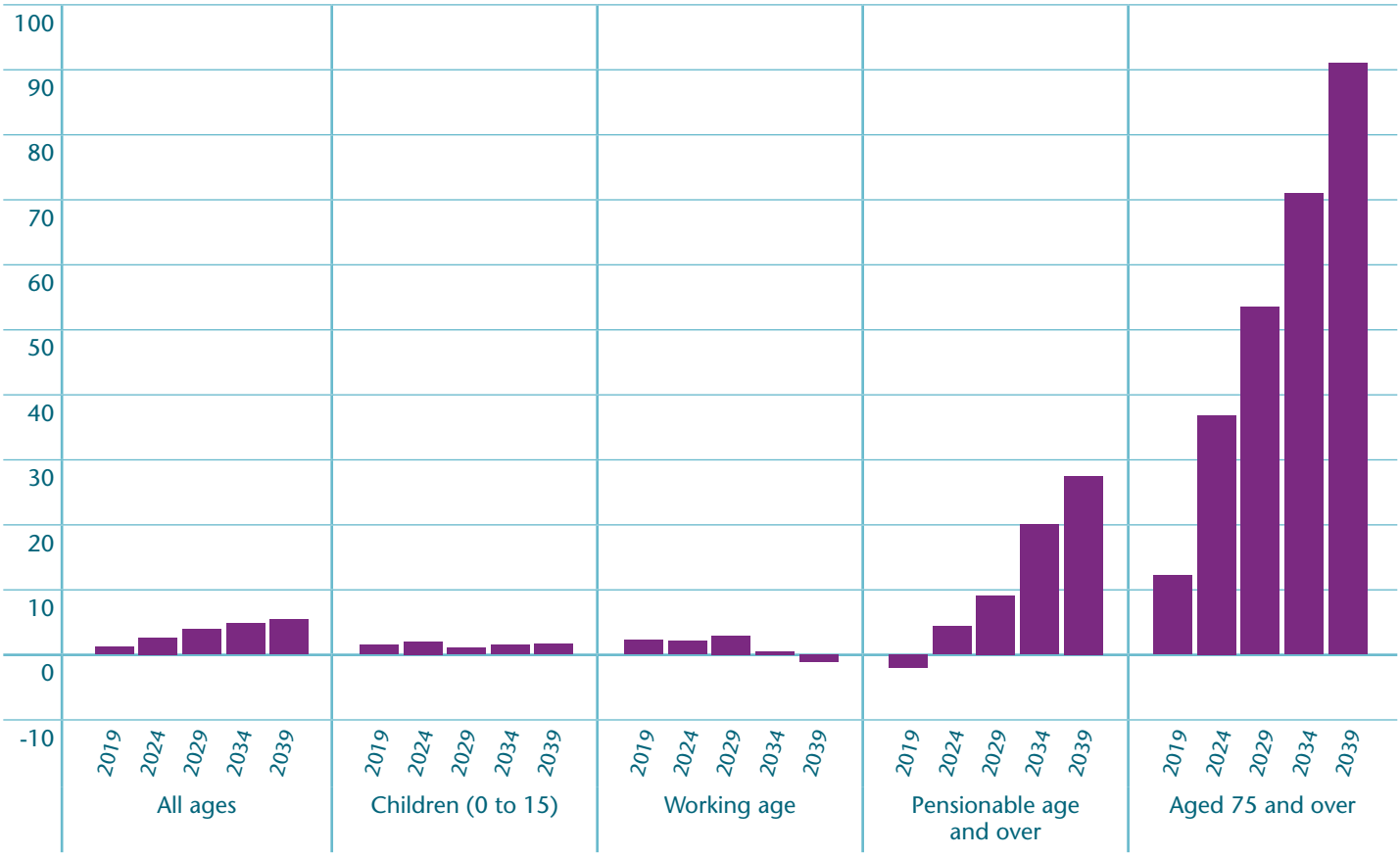
367,250 persons

	2014	2039	
0-15	64,070	65,089	+2%
Working age	225,480	222,840	-1%
Pensionable age & over	77,700	99,034	+27%
75+	30,809	58,903	+91%

2039

386,963 persons

Projected percentage change in population by age group until 2039



Source: National Records of Scotland, Projected percentage change in population (2014-based), by age structure and Scottish area, selected years. Pensionable age presented takes into account the changes to the pension age in the future.

How we prepared for integration

In readiness for integration the following three consultations were held and are the pillars of transformation:

Strategic Plan for Fife (2016-19) Consultation

(7 October 2015 until the 6 January 2016)

NHS Fife and Fife Council sought the public's view on the Strategic Plan for Fife (2016-19). The Plan sets out a vision for the transformation of health and social care. This includes widening the skills of teams, changing the way we commission services, strengthening relationships and making use of new technology.

The Strategic Plan was approved on the 10 February 2016 by Members of the Integration Joint Board (IJB) and is the blueprint for change.

Integration Scheme Consultation

(10 December 2014 to 31 January 2015)

The Integration Scheme is a legal document. It sets out how NHS Fife and Fife Council establish integrated partnership arrangements in line with the Scottish Government's Public Bodies (Joint Working) Scotland Act 2014. The Integration Scheme was approved by the Scottish Government in 2015. The Fife Health and Social Care Partnership Board has legal status and is legally known as the Integration Joint Board (IJB).

Localities Consultation

(11 August 2014 to 3 November 2014)

It was agreed that the Partnership in Fife will have 7 locality areas. These match the existing boundaries of the Fife Local Community Planning Groups as follows:

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

2. A grassroots approach

Fife has a strong history of working in communities and with local people. We value the rich wealth of knowledge, skill and expertise of staff and partners. The Partnership will build on this rich foundation with ambition.

We are bringing together healthcare professionals, partners and the public closer together in new ways. This includes working closely with existing Community Planning Partners, such as Fife Council, schools, colleges, police, fire, transport and more.

This joined up approach will help to develop services that are right for each locality as well as Fife-wide, and ensure we use every pound from the public purse wisely.

Ultimately, this approach which will improve people's experience of health and social care and help people to live long and healthy lives in their own home for as long as possible.

Beyond 2017 we will continue to:

- **Connect with Communities**
- **Put people at the heart of transformation**

Connect with Communities

People from different communities experience life in different ways, with a wide range of contrasting health needs. Connecting with communities to hear their views on how we can reshape and transform services to benefit them and future generations remains at the centre of change. In early 2017 we held a 'Creating Healthy Communities' engagement event in each of our seven localities.

Stakeholders

- People using and accessing health & social care services
- GP's who have a key role in providing and coordinating care in local communities
- Primary and Secondary care teams
- Social care colleagues and Third Sector providers
- Community Planning Partners, including schools, colleges, police, fire, roads, transport and waste collection
- Housing sector representatives

600 people attended in total. We sought views and opinions on how services can be improved in each local area and how people can get involved to inform and shape change. In the future, there will be seven Locality & Cluster Planning Groups, one for each area. These will provide the forum for communities, professionals and individuals to work together to identify the key issues in their locality and develop a Locality Plan to address these. This will inform service redesign and improvement in each local area and across Fife as a whole.

"Need to make it real for communities and people working on the ground."

Event attendee

"There needs to be a 'localised' point of contact where people can speak to someone face to face and access the right service at the right time."

Event attendee

Put people at the heart of transformation

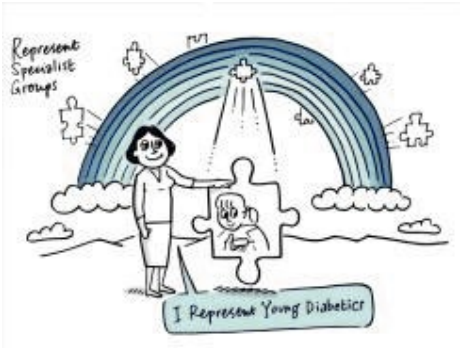
The Public Reference Group (PRG) was set up as early as 2012 with membership including users of services, carers, individuals, staff representatives and partners. The members played a central role when it came to consulting and engaging on the Integration Scheme, Localities Plan and the Strategic Plan.

This group has evolved to form the Participation & Engagement Network (P&EN), bringing together a wide range of patient and service user representatives and professionals. The Participation and Engagement Strategy is central to our approach, with members of the P&EN getting involved in transformational work at the earliest stage.

They are helping the Partnership reach out to the hundreds of patient and individual representatives and partner agencies to glean views and to ensure the voices of Fife are heard.

"I and the Participation and Engagement Network members help represent the voice of the public and of carers. We are the eyes and ears of the community and by being involved, we hope to help shape and reform services so people get the right care, at the right time, by the right people."

Ian Dall, Chair,
Participation and Engagement Network



3. Transforming Services in Fife

Although much work has been done over the first year of our journey, there is much more we need to do. With increasing pressure on finances and resources, the challenges are not to be under-estimated. Change of this scale and nature has never been seen before.

Our Strategic Plan is the blueprint for change and sets out our priorities for 2016-19. The Plan is driven by law and national and local policy. It aims to meet the needs of people now and in the future through better use of new technology and working within available financial and workforce resources to tackle inequalities and offer early interventions.

The move to join up health and social care will help to ensure seamless services and a better experience of care, especially for people with long term conditions and disabilities, many of whom are older people.

Over the past year Fife has made significant progress to improve collaborative working and the pathways for people accessing services. Some of the information presented in this report has been taken from national and local sources, such as the Social Care Survey and the Fife Council Annual Performance Report.

Fife Health & Social Care Partnership's four key strategic themes:

- **Prevention and Early Intervention**
- **Integrated and Coordinated Care**
- **Improving Mental Health Services**
- **Reducing Inequalities**

Our performance

Our four key Strategic Plan themes link directly to the nine Health & Social Care National Health and Well-being Outcomes (below). These provide a useful framework, against which we must demonstrate progress.

National Health and Well-being Outcomes

1	People are able to look after and improve their own health and well-being and live in good health for longer
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
3	People who use health and social care services have positive experiences of those services, and have their dignity respected
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
5	Health and social care services contribute to reducing health inequalities
6	People who provide unpaid care are supported to look after their own health and well-being, including to reduce any negative impact of their caring role on their own health and well-being
7	People using health and social care services are safe from harm
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
9	Resources are used effectively and efficiently in the provision of health and social care services

The following sections outline the Partnership's performance and progress against these outcomes and our strategic commissioning intentions. A full list of 23 indicators is presented in Appendix 1. Please note there are a number of the 23 indicators not available for the 2016/17 period due to the way in which these are reported. The data reported is against core indicators and are for the period the most recent data is available. Some indicators are provisional and subject to change.

Bringing care closer to home
Hospital to Home Pathway

There has been significant work undertaken within Fife to reduce both the number of delays and the number of bed days lost in hospital. In 2016/17 we developed a robust Hospital-to-Home pathway (Figure 1) to support people to get back home quickly and reduce the number of delayed in hospital unnecessarily.

The Scottish Government provided targeted funding for Health & Social Care Partnership to tackle people delayed in hospital. In 2016/17 we invested in improving delayed discharge levels. With this investment we implemented a range of programmes and projects as part of the Hospital-to-Home pathway.

These include "new models of care" such as:

- Short Term Assessment and Reablement (STAR)
- Front Door Discharge Support Service (Front Door)
- Short Term Assessment and Reablement Team (START)
- Assessment Beds (Community Assessment)

Fife's performance against delayed discharge targets has been a long-standing challenge. The introduction of these new interventions, as part of the Hospital-to-Home pathway, has improved performance during 2016/17 (see Figures 2 & 3).

Figure 1
- Hospital to Home Pathway

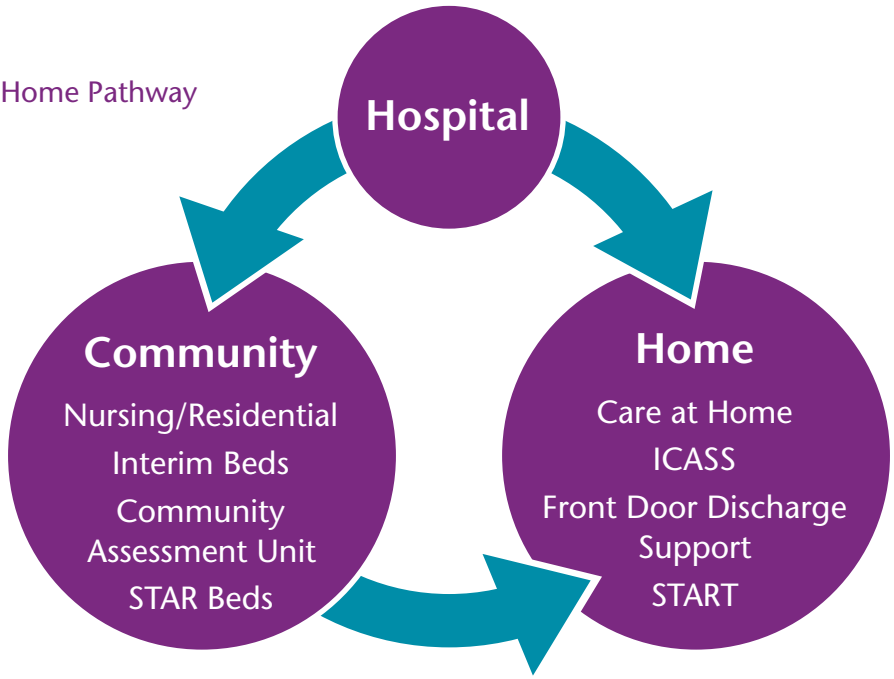
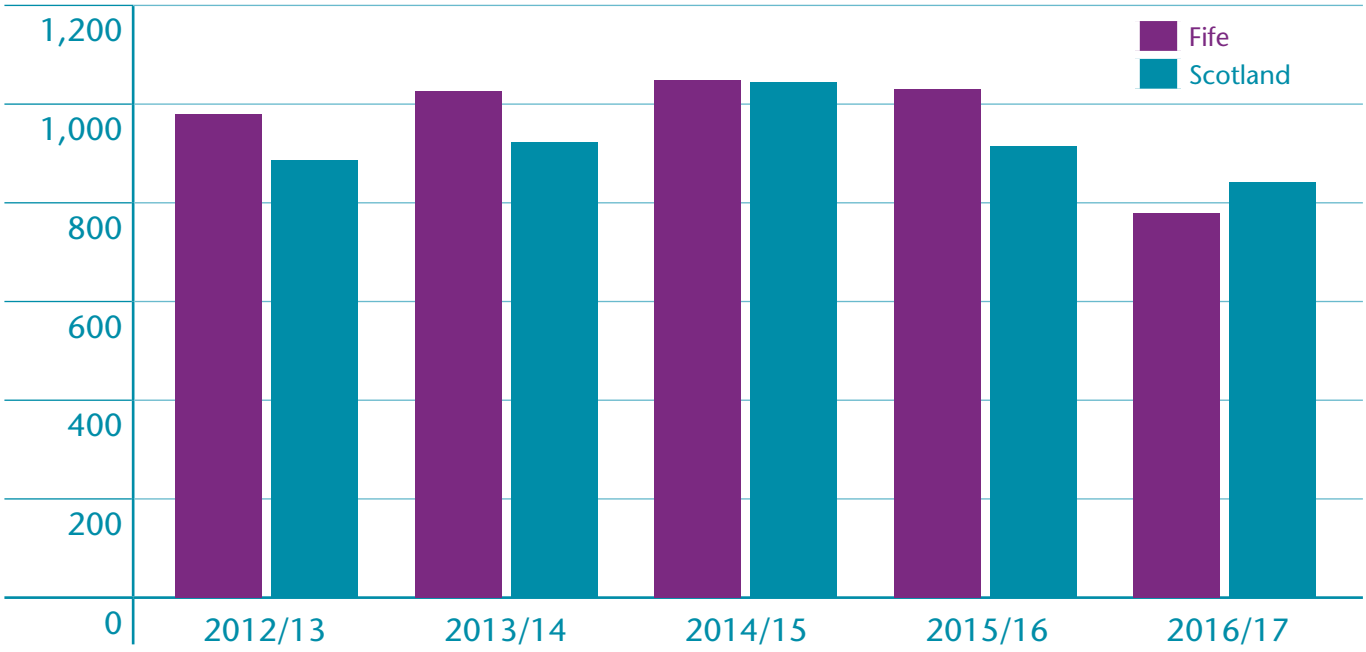
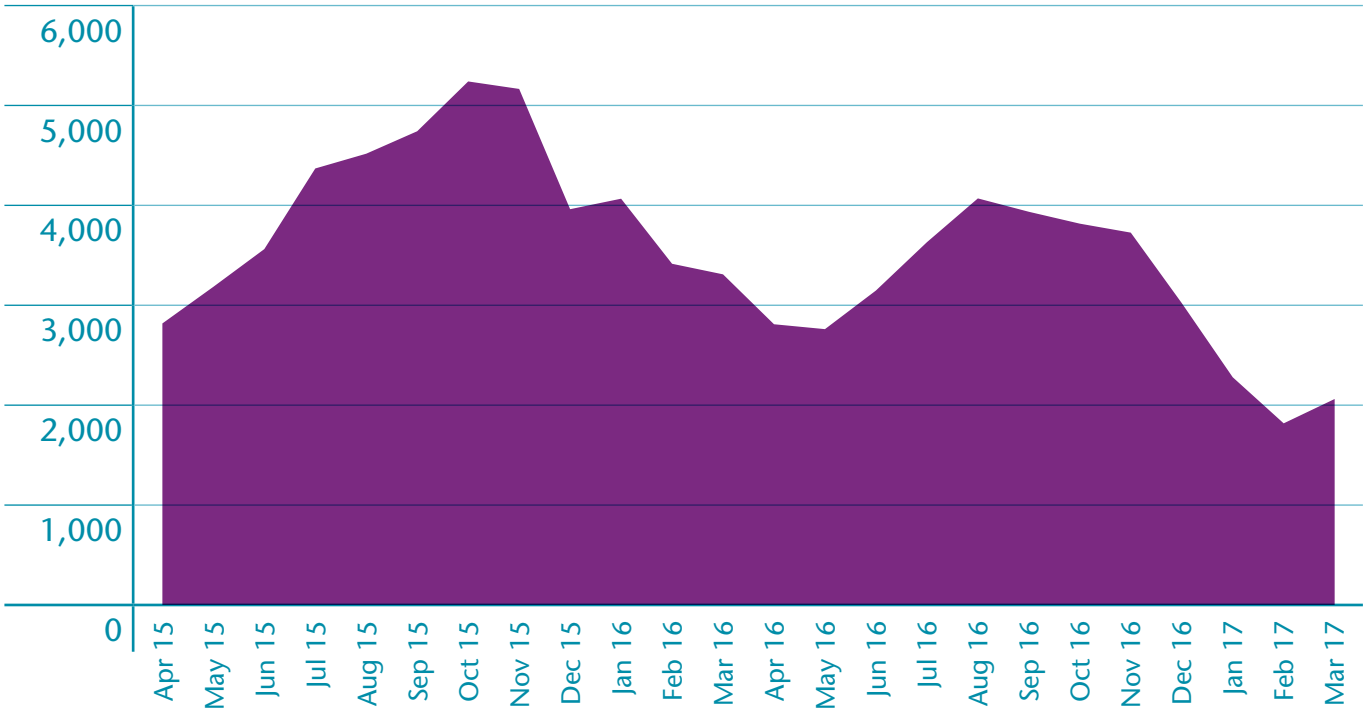


Figure 2 - Number of days people aged 75+ spend in hospital when they are ready to be discharged, per 1,000 population (National Indicator 19)



The chart below shows the number of bed days lost to delayed discharge over the previous two financial years for Fife H & SC partnership residents.

Figure 3 - Delayed Discharge Bed Days Lost (Fife) Source ISD Delayed Discharges May 2017



Commissioning Intention

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.

Front Door Discharge Support Service

National outcome 2

The Front Door Discharge Support Service was set up in July 2016 and is available for individuals presenting to the Acute Medical Unit and the Accident & Emergency Department at Victoria Hospital, Kirkcaldy. This is a short term support delivered by Avenue Care Services to help someone recover from an acute illness in their own home rather than in a hospital. The aim is to support them back to levels of health prior to illness. For the period from July 2016 to March 2017, 184 individuals accessed the service, removing the need for unnecessary hospital admission.

Commissioning Intention

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.

Community Assessment Units

National outcomes 1 2

This intermediate care model supports individuals to be discharged from hospital to a registered care home. This allows their care assessment to be finalised and care pathway planned. Individuals can be placed within this service for up to 28 days. In 2016/17 100 individuals used this service, with 84% having their Care Assessment completed and then supported to move on to an appropriate care service.

Short Term Assessment and Reablement Team (START)

National outcomes 1 2 3 4

This project supports people to return home from hospital, as quickly and as safely as possible with a Care At Home service tailored to individual needs. The initial pilot took place in Kirkcaldy and saw a small group of front-line home carers bring people home quickly from the Victoria Hospital, Kirkcaldy. START is now Fife wide. Not only are we getting people home quickly but we are getting the right support for people in place, adjusting care packages to suit individual needs.

STAR Beds

National outcomes 1 2 4

This service supports individuals to regain skills and independence with a view to returning home safely within six weeks. During 2016/17, 190 people accessed the service and 61% were supported to return home.

Commissioning Intention

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.

Emily came to the STAR Unit from hospital where she had been admitted with some dizziness, risk of falling and nutritional issues. She is in her nineties, lives alone at home, supported by her two daughters and had no services other than a wrist-worn falls detector. Emily's daughters noted that they had potentially been 'taking over' and that their mum was capable of more than they had thought. After a short stay in the STAR unit Emily returned home with a support plan in place as independently as possible in her own home.

Emily Brown (anonymised)
- STAR Unit Alan McLure House

Commissioning Intention

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.

Modernising Care At Home

National outcomes 1 2 3 4 9

There is a significant shift in the way home care is provided in Fife, with more Independent providers supporting the delivery (Figure 4) and a greater number of people needing more than 10 hours Care at Home support (Figure 5). Those receiving two hours or less in 1998 equated to 58% of overall service delivered, and in 2016 this substantially decreased to 13%. The Care at Home service is a large and complex service, delivering care to over 3,000 people across Fife. The service needs to be transformed to support the increasing shift to care closer to home and facilitate the higher demand from individuals who need 10+ hours home care.

It's one year since our Care at Home services went live with a new mobile phone scheduling system, Total Mobile. The approach is using digital technology alongside the skills and experience of staff to meet people's needs at home as well as work more efficiently with the resources available. Over 900 home carers are now using the new system and over 570,000 visits been delivered across the Kingdom in this new way.

Figure 4 - Distribution of Home Care hours by sector (Fife 1998-2016)

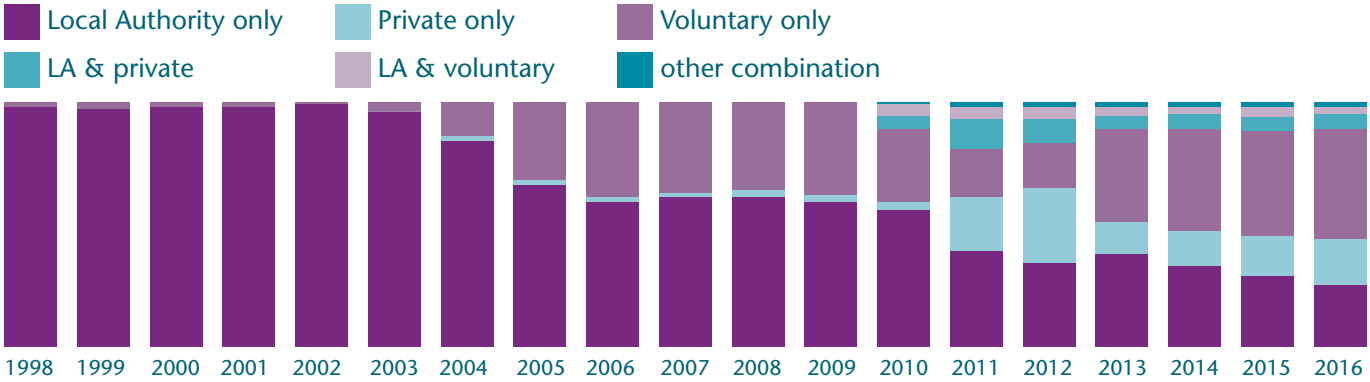
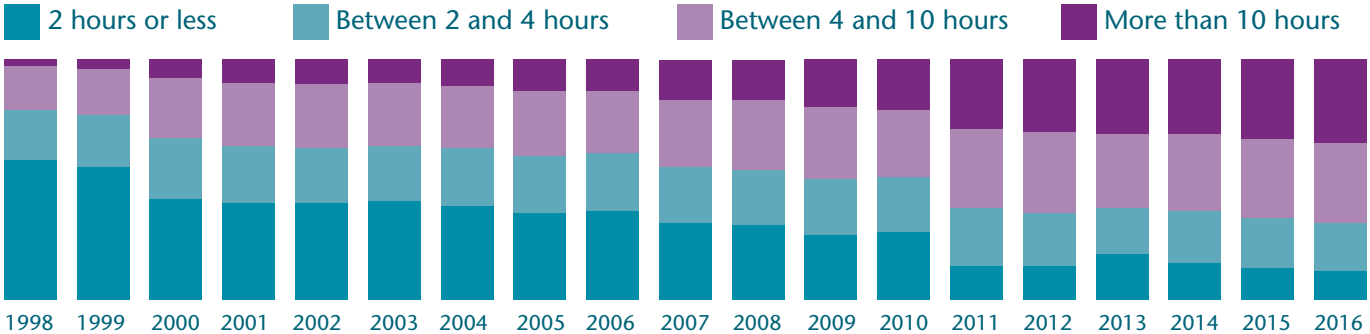


Figure 5 - Distribution of home care hours received (Fife 1998 - 2016)



Strategic Plan – Theme 1
Prevention and Early Intervention

Strategic Plan Aim 2016/17

- Work with stakeholders to improve access to information, advice and support to enable people and their carers to lead healthier lifestyles and to remain as independent as possible and make active contributions to their families and communities.
- Reducing the reliance on hospital beds and other health and care services; increasing the focus on prevention, self-management and shared decision making; and increasing the capacity of primary and community care services.

Improving Services for people living with Dementia

National outcome 1

Across Fife, we have been working with partners to offer care and support to people with dementia and their carers in a way which promotes well-being and quality of life. This is helping to improve the experience, care, treatment and outcomes for people with dementia. An additional worker from Fife Carers Centre has been funded to support carers of those with dementia and offer a carer support plan.

The Dementia Ambassadors programme in care homes and Dementia Champions Programme in hospitals settings are supporting staff to improve the experience, care, treatment and outcomes for people with dementia.

"I found all the information about carers and patients help good. The visits from them are always welcome and a big help with this strange illness."

Carer

Commissioning Intention

Shifting the balance of care

Dementia Friendly Glenrothes

National outcome 1

In 2016, Glenrothes became the first Dementia Friendly Community in Fife. A total of 21 organisations across Glenrothes including the Michael Woods Sports and Leisure Centre, Active Fife, the Kingdom Shopping Centre, Rothes Halls, libraries and other local businesses and services have all shown their support to this. Part of the success has seen two new dementia friendly walking paths with new signage in Riverside Park, Glenrothes through Active Fife, Bums of Seats Programme and the Kingdom Shopping Centre has been the designated the first 'Dementia Friendly' business in Glenrothes.

"Michael Woods Sports & Leisure Centre is a very popular facility with the local community and we want to ensure we are doing all we can to make it friendly and welcoming for people with dementia."

Health & Physical Activity Manager, Fife Sports & Leisure Trust.

Commissioning intention

To undertake a review of our approach and investment in technology enabled care.

Telecare

National outcomes 1 2 4 7

Telecare is the use of technology to support people to live in their own homes independently and prevent admission to care or hospital. In October 2016 the Telecare team along with Scottish Fire and Rescue received funding to work on fire safety initiatives and to trial new equipment. 499 additional pieces of Telecare equipment have been installed since October 2016.

Mr Allan* lives himself in a privately owned house. He came to our attention when accidentally setting his paper bin on fire. Mr Allan did not need Care at Home and Assessors recommended a Community Alarm and Pendant to enable Mr Allan to contact assistance should he have a fall. Telecare smoke detectors were fitted in his home. The Fire Service provided Fire Retardant bedding to ensure the risk was minimised as much as possible. This equipment is allowing Mr Allan to live independently with the risk of accidents reduced.

**anonymised*

Commissioning intention

We will develop joint working with Community Planning in Fife and with a range of other services and organisations to tackle the root causes of poor health and well-being and inequality in Fife

Small Sparks

National outcome 5

Small Sparks was set up to help individuals and communities to take control and make a difference in their community. It was launched in East Fife in June 2016 and provides grants up to £250 for local people who wish to come together to make new connections, to do something they enjoy and to make a difference in their local community. 16 projects have benefited. Projects include Sensory Garden with Story Stones in Newburgh, an Oor Wellie Boot Garden in Kirkcaldy and Health Baking project in Auchtermuchty. The Partnership plans to offer a second round of Small Sparks grants during 2017/18.

"Small Sparks provides a fun platform for engaging with the community and helps reduce social isolation."

Local Area Co-ordinator

Commissioning intention

The development of a Fife directory of services and local community groups to support choice and control for individuals.

On Your Doorstep

National outcome 1

The Partnership has developed a community website called On Your Doorstep Fife. Here staff and the public have access to information about what services, resources, activities and groups are available within their local community. Information also includes guidance on ways in which they can take more choice and control over their care needs, such as Self Directed Support as well how they can get involved in groups to improve their well-being, activities such as the Bums Off Seats walking programme. This hub of information can help people make choices about their lives, to help improve their health and well-being and a sense of "belonging" to their local community. There are currently 1700 organisations and groups listed on the website and the diversity of the information makes it appealing to people of all ages and interests.

"This site is so easy to use. We can tell people with confidence that they will find what they are looking for here."

Vivienne McNiven, Bums off Seats Programme Co-ordinator

Befriending Grants to Voluntary Organisations

National outcome 5

The Partnership monitors, evaluates and supports voluntary organisations as part of Fife Council's Monitoring and Evaluation Framework. Working with partners in the Voluntary Sector our Befriending Service is making a difference to people experiencing loneliness. Befriending works with individuals needing support to increase their self-confidence, their trust in other people and their involvement in their local community. In 2016/17 we awarded £330,991 to 12 organisations to deliver the service.

"Being in a befriending relationship is really rewarding."

Service user

Commissioning intention

The further development of Befriending services to reduce social isolation.

Independent Living Equipment Recycling Campaign

National outcome 9

The initiative encourages people to return items such as zimmer's, support chairs, bath aids and trolleys that are no longer needed so that they can be re-used, re-cycled or turned into cash for re-investment. Between August 2016 and March 2017 over 1,645 items were returned via nine recycling centres across Fife. The equipment collected in the first seven months has an approximate new purchase value of £50,000.

Commissioning Intention

To undertake a review of our approach and investment in technology enabled care.

Strategic Plan – Theme 2
Integrated and Coordinated Care

Strategic Plan Aim

- Work to redesign our services to provide more integrated services and coordinated care at home so that the experience of service users and their carers is enhanced.
- Further develop an urgent response service for acute care within the community and provide ongoing support for people to recover in their own homes, wherever possible following an acute illness.

Commissioning intention

All sectors working more closely together in order to provide an enabling approach to support recovery in line with personal outcomes.

Self Directed Support (SDS)

National outcome 4

Self Directed Support (SDS) is helping people, families and carers have more choice and flexibility over their care. People who are eligible, are offered four ways in which they can take control, manage their independence and fulfil their life aspirations.

Option 1 - Direct Payment - self managed

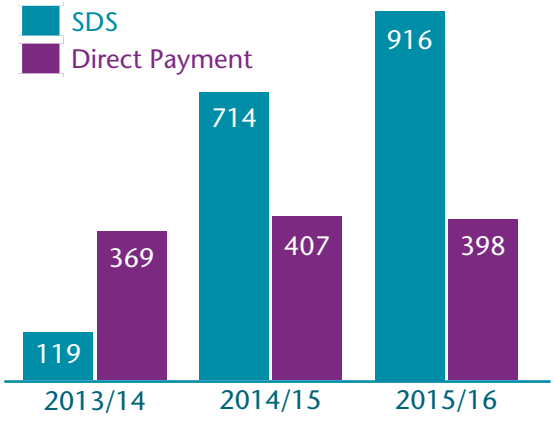
Option 2 - Direct their available support through a third party

Option 3 - After talking with client, Local Authority arranges support

Option 4 - A mix of options 1, 2 & 3

This tailored approach is helping to improve people's quality of life and the Partnership will continue to roll out SDS in line with the principles and values underpinned by the legislation. There has been a recorded year-on-year increase in the number of individuals opting for Self Directed Support in Fife, increasing by 202 between 2014/15 and 2015/16.

Number of SDS and Direct Payment Services Provided



Comparison of SDS options selected

SDS Options	2014/15	2015/16
SDS option 1	403	378
SDS option 2	0	5
SDS option 3	307	513
SDS option 4	4	20
Total	**714**	**916**

Lindsey's New Lease of Life

When Lindsey moved from Biggar to Fife she left behind a very strong support network of family and friends. This left her without daily personal care and help with her medication. Her health is very precarious and she faces hospitalisation when it is not managed properly. The SDS approach has helped Lindsey manage this.

"I now have a quality of life. I go out, do my own food shopping, pay my own bills and do so many things other people take for granted. It is so important for me to be able to go out, be independent and in control. My support is now centred on my needs. I wish other people could experience the difference that SDS has made to me."

Personal Outcomes Support Assessment (POSA)

National outcome 4

A new Personal Outcomes Support Assessment, Support Plan and Review has been developed for Adults and Older Peoples Services, replacing the Single Shared Assessment. The new assessment is based on a conversational approach, and focusses on what matters to the individual and helps to identify the person's goals and outcomes. The review also gives the person the opportunity to discuss whether they have been involved in developing their support provision, one of the general principles of the Self Directed Support legislation.

Commissioning intention

All sectors working more closely together in order to provide an enabling approach to support recovery in line with personal outcomes.

Transforming Services
Integrated and Coordinated Care

Commissioning intention

Redesigning care and clinical pathways to have fewer steps resulting in speedier decision making and earlier service provision through proactive anticipatory care planning.

Community Hospitals redesign

National outcomes 1 2 4

Community Hospitals have a key role in achieving Fife's ambitions to move care closer to home. At any given time up to 70 people are in Community Hospitals who would be better supported at home or in their community. More community services are being developed to support the care at home approach. It is very early days but our commitment to shift care from hospital to more local settings continues. We've held 24 staff engagement events with community hospital colleagues and held a visioning event with over 100 staff, ranging from nurses, team leaders, service, patient managers and GPs from across Fife.

"It's great to hear all the different view points in one room, from right across the service system, including the Third Sector and other partners. There is an interesting blend of challenges and interestingly finance did not dominate. I sense that staff really want to connect and make change happen."

Charlie Chung, Rehabilitation Manager, Queen Margaret Hospital

Commissioning intention

Redesigning care and clinical pathways to have fewer steps resulting in speedier decision making and earlier service provision through proactive anticipatory care planning.

Redesign of Day Services for Older People

National outcome 2

By working with the Third Sector, Independent Sector, Trusts and local community facilities such leisure centres, cafés and community groups we are beginning to offer a wider choice of experiences and activities as alternatives to traditional day care provided within a day centre building. Where it is appropriate and safe to do so, options can include, swimming, fitness classes, cycling or book groups. These alternatives will help connect older people back into their community and fulfil their personal aspirations. It will also help to make best use of our existing buildings and resources as we re-design the service.

Mr A* is an 86-year old widower. He has led a very active life and although frailer than he used to be, Mr A wanted to be able to go cycling, bowling and swimming again. Mr A has been taking part in a health programme offered through Fife Sports & Leisure Trust and both Mr A and his daughter are very happy with the support which sees him pursue his chosen activities rather than attending day services.

**anonymised*

Commissioning intention

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.

Redesign of Day Hospitals

National outcome 2

There are 3 Day Hospitals for older people in Fife – Whitefield Day Hospital in Dunfermline, Glenrothes Day Hospital and Randolph Wemyss Memorial Hospital in Buckhaven. Services they provide include tests, therapies, treatments and on-going support. Staff across the Partnership are now looking at how Day Hospitals can work more closely with traditional social care Day Services and other partners to ensure equal access for all older people across Fife.

"Ostlers House has a very special quality, the staff are kind and the décor and atmosphere make it feel welcoming."

Ostlers House Resident

New Care Villages

National outcome 2

We are replacing six care homes with three new build 60 bedded care homes in Kirkcaldy, Glenrothes & Lumphinnans. This will provide 48 permanent residential care beds and 12 short term assessment & reablement beds to facilitate hospital discharge or prevent admission to long term care. The new build resources are offering hairdressing facilities, drop in café and day services. The first new build care home, Ostlers House, opened in 2015. The Glenrothes & Lumphinnans new build care homes will open late 2017 and will offer the same model of care as Kirkcaldy. Extra Care Housing will be available at Lumphinnans late 2017 and Glenrothes 2018.

Commissioning intention

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.

Redesigning Care Together

National outcome 1 3 7 9

A 'Re-designing Care Together' event in March 2017 saw senior figures from the Independent Sector, Third Sector and Fife's Health & Social Care Partnership come together to look at how we can collectively continue to improve people's experience of care in the Kingdom. By working closer together, the aim is to reduce the number of people entering hospital, by providing early intervention and prevention services, and for those that are in hospital, by making sure the transition back home is as positive and smooth as possible.

"In celebrating the fact that people in Fife are living longer we know that what matters to us all is that for ourselves or our family members that we get the support and help we need, when we need it and where we are. The Independent Care Sector whether in care homes or home care services is committed to working in partnership with others to ensure that the best quality of care is delivered in Fife. We hope this event will be yet another step in building services and supports which respect the dignity and needs of all."

Dr Donald Macaskill, Chief Executive of Scottish Care

Commissioning Intention

Redesigning care and clinical pathways to have fewer steps resulting in speedier decision making and earlier service provision through proactive anticipatory care planning.

Strategic Plan – Theme 3
Improving Mental Health Services

Strategic Plan Aim

- Work to help ensure a shift in the balance of care – by supporting people who experience mental ill health to remain as long as possible in their own homes and communities rather than in hospital settings.
- Work will focus on: reducing the need for inpatient care and increasing care provision in the community; increasing choice and control for individuals; and developing the knowledge and skills of staff, to support an improved personal outcomes approach across all services.

The multi-agency Mental Health Strategic Implementation Group took forward four key strands of work: Anti-Stigma and Early Intervention, Participation and Engagement, Voluntary Organisations and the Stratheden Redesign. The group can actively shape and influence the redesign of mental health services to support people's aspirations, inform our approach to campaigns and identify initiatives to increase access to mental health services.

For example, a review of mental health specific Third Sector organisations across Fife has identified opportunities to raise awareness of which services are available, where and steps that can be taken to ensure equal access to services for all. The Group are also working closely with staff from Stratheden Hospital to help support people who have been patients to return to their communities to live safe and active lives.

Children from the Frappy Friday Night Project in Anstruther celebrate positive mental health before the SAHM football match.

Anti-stigma campaign

National outcomes 2 3 4 5 9

In March 2017 we supported the launch of the 'Walk A Mile' campaign. This was the third in a series of three mental health anti-stigma campaigns which include 'Power of OK' and 'Pass the Badge' all of which are run in association with See Me, Scotland's programme to tackle mental health stigma and discrimination and Fife Council's Bums Off Seats initiative.

Fife's first 'Walk a Mile' event consisted of two simultaneously coordinated walks which took place at Stratheden Hospital and Silverburn Park, Leven with a total of 84 miles walked by people living with mental health conditions, carers, mental health professionals and members of the public.

The 'Pass the Badge' campaign will continue to be passed throughout Fife and the Power of Okay will continue to promote on a very personal level that it is 'okay' to ask someone how they are and that showing that you care can change someone's life.

The links between physical activity and positive mental health are well known. The annual anti-stigma football match led by the Scottish Association for Mental Health (SAMH) was launched in 2016 as part of the drive to support children and young people's mental health and well-being.

"We all have mental health and this is a message that young people need to hear and understand in Fife. Young people will be better placed to deal with mental health issues with an increased understanding and information available at an earlier stage of their lives. We hope this football tournament will encourage young people in Fife to open up about their mental health."

Ross Reilly, SAMH Community Peer practitioner

Commissioning intention

Training, Education and local Campaign strategies to ensure fewer people experience stigma, discrimination and lack of understanding.

Commissioning intention

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.

Stratheden Hospital

National outcomes 3 4 9

A purpose-built psychiatric care facility caring for some of Fife's most vulnerable individuals was officially opened in July 2016 by the Minister for Mental Health, Maureen Watt MSP. The new Hollyview Ward at Stratheden Hospital caters for those experiencing acute episodes of mental illness, providing specialist care and treatment at a time when patients are at their most vulnerable. The eight-bed facility sits on the north-eastern part of the hospital grounds and replaces the Intensive Psychiatric Care Unit (IPCU) which was previously housed in one of the Victorian buildings on the hospital site. Patients past and present played a pivotal role in the design of the new unit, identifying many of the key features which made their way into the finished build. It is line with the Scottish Government's new Mental Health Strategy 2017-2027 which was launched in March 2017.

"Mental health is an absolute priority for this government and the £4.4 million allocated for this project is just one illustration of our commitment to improving mental health services across Scotland. Purpose-built, specialist facilities like this provide an invaluable service for some of our most vulnerable individuals."

Minister for Mental Health, Maureen Watt MSP.

New Hollyview Ward, Stratheden Hospital

Strategic Plan – Theme 4
Reducing Inequalities

Strategic Plan Aim

- Work to ensure that health and social care services contribute to reducing the inequalities in health currently experienced by a range of disadvantaged groups and in a number of local communities.
- Increased focus on prevention, self-management and shared decision-making to improve general health and well-being in the population and reduce health inequalities; and achieving better quality relationships between people using services and those providing them.

Carers Outreach Service, Victoria Hospital

National outcomes 5 6

This service was introduced as a direct result of engaging with 50 carers and individuals. The service is available for anyone, where the person they care for is currently in Victoria Hospital, Kirkcaldy. The service can be accessed at any point during a hospital admission and no appointment is necessary. Help includes advice and assistance with welfare benefits, information on what other services may be available for the carer or the person they care for, or just to provide a listening ear.

Commissioning intention

Maximise the participation and inclusion of the people with whom we work together along with their carers;

"Having Sandra from the Carers Service at the Victoria Hospital step into my life was like a light bulb going on in a very dark tunnel. The difference, even in the first few weeks is immeasurable. It's like a balloon deflating as she navigated the forms, found out my entitlement to allowances, and helped arrange carers and importantly she said "I hear you". This is powerful and goes way beyond just support. It's personal. I realised that I too was entitled to have 'me' time. I urge anyone who is in a carers' role to take up the help available. It's the difference between struggling and having a life to live."

Jacqui Towers, Carer

Commissioning intention

The development of the Shared Lives project explores 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.

Shared Lives

National outcome 5

Shared Lives Fife provides family-based care for adults with disabilities and mental health difficulties. It matches adults with families or individuals who are willing to share their homes, lives, interests, experience and skills. The length of stay can be either on a long or short term basis. The approach also helps to support the main carers have a break whilst giving the person with support needs a new and positive experience within a family setting.

One person who has benefited said: "I am 20 years old. I am blind and lost my sight when I was nine. My Shared Lives family treat me almost like their own son. I feel relaxed and that their home is like my own home. This means I'm not a stranger and feel very much part of the community."

Service user

Commissioning intention

Spread and embed poverty reduction initiatives within housing, social and health care settings relating to financial inclusion, digital inclusion, fuel poverty, employability, volunteering and befriending.

Poverty Awareness Training Programme

National outcome 5

We commissioned and delivered a multi-agency Poverty Awareness Training Programme for front-line staff across Fife during 2016-2017. The training programme took forward the Fairer Fife Commission's recommendation that 'Fife Partnership should rapidly implement poverty-training and workforce development for Fife Council staff and those in partner organisations.' The programme enabled staff to increase their understanding of poverty issues in Fife, its causes and consequences and link to inequalities. A total of 544 people accessed workshops and training courses, with 61 from our Partnership, and a further 206 completed the e-learning module. Many participants stated that the workshops increased their awareness of the implications of living in poverty within Fife and associated stigma and discrimination.

'I understand more about the implications of poverty within a family'

Worker Attending

New Build Housing and Housing Adaptations

National outcomes 1 2 5

Our New Build Housing Programme aims to support both individuals and families. House types include bungalows and flats, all of which are fully accessible. This supports our ambition for people to live independently in their local community regardless of age or ability.

In a separate programme of work we are fitting equipment to help support independence. This includes fitted grab rails, equipment to help get in and out the bath, creating a wet floor bathroom and installing a ramps and fitting specialist equipment to people's homes to improve their quality of life. The service has made 1025 disability adaptations in 2016/2017.

"I am just writing to thank you for the great job, bathing is much easier as I was having trouble getting out of the bath. Workers were very efficient, polite and did a great job."

Tenant

Commissioning intention

Working to make the necessary changes to meet the requirements of the Local Housing Strategy.

Commissioning intention

Early Years/Children and Young People's work will continue to have a focus on resilience, parenting and well-being aimed at supporting improved mental health and well-being throughout the life course.

Child Well-Being Pathway

National outcomes 1 3 7 9

Our staff have worked with key partners to develop the Child Well-being Pathway (CWP). The CWP is based on the principles of Getting it Right for Every Child (GIRFEC) and promotes the use of the Well-being indicators during assessments of well-being. It provides staff with a tool to guide a coordinated approach to the assessment of, and planning for, every child and young person's well-being. The CWP is the agreed assessment, intervention and planning pathway for children/young people in Fife.

Commissioning intention

Redesigning care and clinical pathways to have fewer steps resulting in speedier decision making and earlier service provision through proactive anticipatory care planning;

Falls & Frailty Managed Clinical and Care Network (MCCN)

National outcomes 1 2 4 7

A Managed Clinical and Care Network (MCCN) enables professionals, public representatives and organisations to work together to promote consistency and quality of service throughout a person's experience of care. The Frailty MCCN is focused on supporting people in healthy ageing, reducing their risks associated with frailty through early intervention and where people do require care and support we will work together to simplify access to integrated support. The MCCN is collaborating with the different parts of health and social care to make their best contribution to frailty at its different levels of severity. For example general practice and primary care can work on continuity, appointment length, drug rationalisation and elderly medicine can help us care for the most frail. Partners are learning and working together with community groups and social care to maximize people's well-being by supporting the increasingly recognised reversible aspects of frailty.

Transforming Services
Reducing Inequalities

Improvements in Prescribing

National outcome 9

An ambitious plan to enhance and promote cost-effective prescribing aims to deliver £5m efficiencies. In April 2016 Fife had the highest GP prescribing cost per individual of all Health Boards in Scotland. The plan involved a review and identified a wide range of projects, including one to reduce medicines waste in care homes and another to encourage individuals to only order the medicines needed. Up to the end of March 2017, the project delivered £4.27m of prescribing efficiencies. Through this improvement work Fife has seen the largest decrease in cost per individual patient of all Health Boards from April 2016 to April 2017.

Commissioning intention

Shifting the balance of care

Commissioning Intention

Redesigning care and clinical pathways to have fewer steps resulting in speedier decision making and earlier service provision through proactive anticipatory care planning.

Cancer Care – Transforming Care after Treatment (TCAT)

National outcome 2

The overall aim is to help people play a more active role in managing their health and well-being, provide services which are more co-ordinated, tailored and responsive to need, and help people deal with the physical, emotional and financial impact of cancer treatment. Over the course of 2016/17 funding from Macmillan Cancer Support has been invested to focus on the initial three areas:

1. **Best supportive care for lung cancer patients**
   The model delivered high quality palliative care, earlier and more consistently, to all individuals with lung cancer who were unfit for treatment.

2. **Skin Cancer (Melanoma)**
   The Melanoma TCAT Project in Fife has developed a support programme for Melanoma Skin Cancer Patients.

3. **Integrated Community Cancer Support - Local Area Co-ordinators**
   The Local Area Co-ordinators (LACs) role is to visit people at home, to discuss hopes and concerns, provide support by linking into community services and to help with a personalised care plan.

"I was diagnosed with breast cancer last year. After treatment finished I felt very alone and vulnerable and didn't like or recognise myself. I had lost all my hair and confidence…as we talked she made me realise I was not alone and was there for me…..it is very important to me as I wanted to help myself get back to everyday living….I am doing a lot better now, slowly getting my confidence back and take each day at a time….I'm in a better place right now thanks to the help of the TCAT Project".

Individual using the TCAT service

Transforming Urgent Care

National outcomes 1 2 4 5 7

Pressure is growing as public demand for medical appointments after GP closing time rises. Knowing where to go to get the right help in the evenings, overnight, at weekends or on public holidays can be confusing, with people often going to A&E as their first port of call. A review of Out Of Hours urgent care services is underway to improve people's experience of care, reduce the risk of harm or hospital admission and help support staff working in A&E who need to treat people with critical, life threatening conditions such as heart attacks or road traffic injuries. Our aim is to ensure people get the right treatment from the right professional, in the right place, at the right time.

Developing new ways of working is already taking place on a partnership approach basis. These range from 10 Community Pharmacies testing quicker access to medication for women with Urinary Tract Infections, resulting in 230 women accessing the service with over 60% receiving treatment. Four new Scottish Ambulance Service Specialist Paramedic Practitioners were trained to advanced level in minor injury and illness, who then attended 502 calls between November 2016 and March 2017.

Commissioning Intention

Redesigning care and clinical pathways to have fewer steps resulting in speedier decision making and earlier service provision through proactive anticipatory care planning.

4. Investing in our people

Local Partnership Forum

National outcome 8

Fife was the first to set up a joint Union and staff representative body of its kind. In February 2016 representatives from NHS Fife and Fife Council's Trade Unions and Staff representatives groups along with senior management signed a new joint agreement which saw the creation of a forum to forge closer partnership working. Known as the Local Partnership Forum (LPF), the group focuses on the key issues facing the workforce in delivering health and social care services.

Workforce Strategy

National outcome 8

The Partnership's Workforce and Organisational Development Strategy was approved by the Partnership's Board at their meeting in February 2016. The Strategy was developed in partnership with staff representatives from Fife Council and NHS Fife as well as managers from Human Resources, Organisational Development, Learning and the Senior Leadership Team of the Partnership.

Clinical Strategy

National outcome 8

Health and Social Care Staff had the opportunity to participate in the Clinical Strategy consultation led by NHS Fife's Medical Director. The strategy serves as a blueprint for the provision of healthcare services, help the NHS Fife Board to meet the evolving needs of the population and has synergy with the Partnership's Strategic Plan (2016-19) to transform services and ways of working.

Lets Connect

National outcome 8

A range of tools and channels are well established to engage, inform and involve colleagues within the Fife Partnership. These include monthly newsletters, video clips, project specific bulletins, use of web platforms, team meetings and workshops. We've established marketing materials, tools and templates to support management to engage and listen to colleagues across Fife. These are being constantly reviewed and use public and staff representative panels to test and develop and improve our communications approach in line with transformation, changing staff needs and make use of new technology and resources available .

5. Inspection of services

Inspections of Integrated Children's Services

(Care Inspectorate 2016)

National outcome 7

A joint inspection of services for children & young people in the Fife Community Planning Partnership was undertaken and the findings published in 2016. It covered the full range of partners in Fife who have a role in providing services for children, young people and families, including Children's Services within the Fife Health and Social Care Partnership.

The inspection highlighted a number of key strengths:

- The Family Nurture Approach, which was embedded across the area and was having a positive impact on families.
- Participation and engagement of wide groups of children, young people and families, which was making a difference to how services were being delivered.

The inspection also identified areas for further improvement:

- Ensuring that the quality of planning for children and young people is focused on both risk and need, that all partners fulfil their responsibilities in meeting need as outlined in the child's plan, and that the processes to support planning are effective.

Healthcare Environment Inspectorate - St Andrews Community Hospital

(Healthcare Improvement Scotland July 2016)

National outcome 7

The inspection consisted of the following areas:

- minor injuries unit
- outpatients department
- renal dialysis unit
- ward 1 (GP/rehabilitation), and
- ward 2 (elderly care/palliative care

The inspection highlighted:

The wards and departments and majority of individual equipment inspected were clean. On the wards inspected, inspectors saw good staff compliance with hand hygiene, linen, waste and sharps management, and individual placement and isolation procedures. They observed good compliance by nursing staff with the use of personal protective equipment.

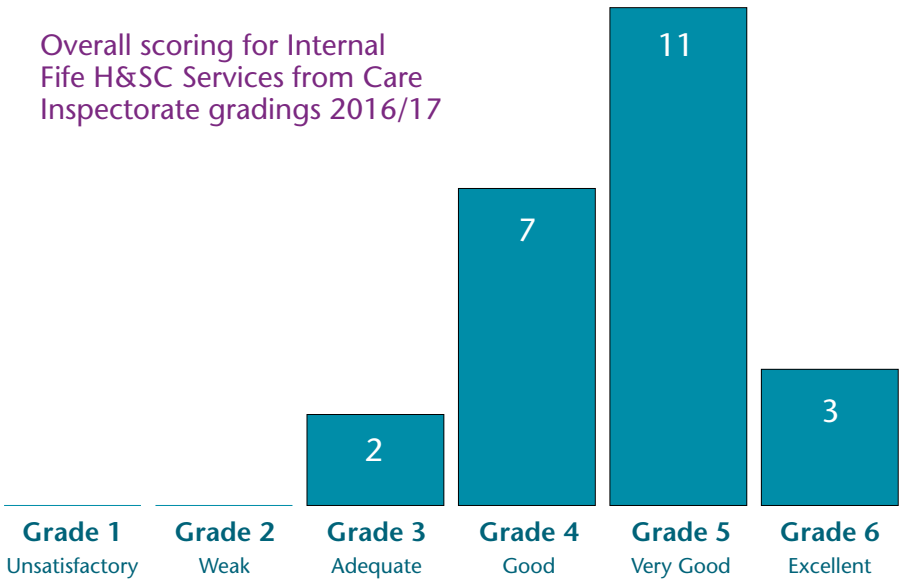
Inspection of Social Care Providers

(Care Inspectorate 2016/17)

National outcome 7

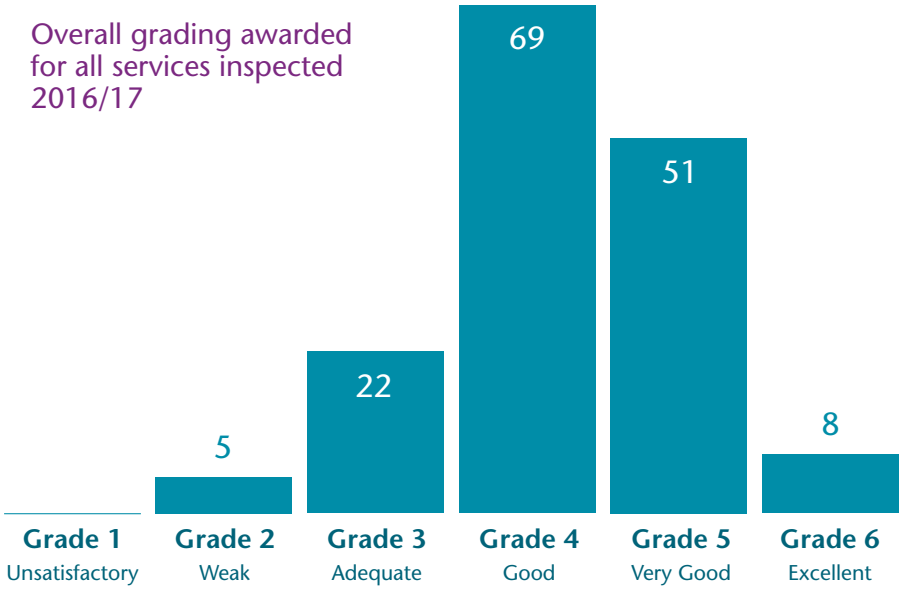
All registered Social Care services undergo inspection from the Care Inspectorate. 23 Fife Health & Social Care Partnership registered services were inspected in 2016/17. For both Adults and Older People, 21 of 23 services inspected, scored 4 or higher against this indicator.

Overall scoring for Internal Fife H&SC Services from Care Inspectorate gradings 2016/17



For all registered adult social care services (including Older People) within the Fife Health and Social Care Partnership, including those delivered by the Third Sector and Independent Sector, 155 Care Inspectorate inspections were carried out with 82.5% graded 'good' (4) or above in Care Inspection grades.

Overall grading awarded for all services inspected 2016/17



6. Financial Performance & Best Value

Revenue Expenditure 2016–17

The Partnership had a challenging financial position with a £15m budget gap. A savings and investments plan approved by the Integration Joint Board on 4th August 2016 partly addressed this gap. Primary Care prescribing cost pressures and increased demand for services placed additional pressure on the financial position. A financial recovery plan was implemented to address the position in year. The Provisional Outturn in respect of the Partnership delegated and managed services was a £9.263m overspend. The funding arrangements for the overspend are that NHS Fife made a further contribution of £6.669m and Fife Council made a further contribution of £2.594m. NHS Fife funded the overspend of £0.614m on acute set aside services. Table 3 details the financial position for 2016–17.

Financial position for 2016–17

Delegated and Managed Services	Budget £m	Provisional Outturn £m	Provisional Variance £m
Community Services	87.651	88.965	1.314
Hospital	52.055	52.617	0.562
Family Health Services and Prescribing	156.404	163.865	7.461
Children's Services	13.994	13.309	-0.685
Social Care	182.774	183.494	0.720
Housing Services	1.848	1.739	-0.109
TOTAL	**494.726**	**503.989**	**9.263**
Acute Set Aside	34.376	34.990	0.614

A number of services experienced significant pressures during 2016-17:

Community Healthcare — £1.314m overspend

This mainly relates to a delay in achieving service redesign savings and this is partly offset by budget underspends across a range of areas, including vacancies in community nursing, community and general dental services, and administrative posts; and underspends in Sexual Health and Rheumatology drugs costs.

Hospital — £0.562m overspend

The overspend within Hospital Services relates to the additional cost of complex care patients along with the use of bank and agency nursing to provide safe staffing levels. This is offset in part by a staffing cost underspend within Mental Health due to difficulties in staff recruitment.

Children Services — £0.685m underspend

The Children Services underspend represents the continuing difficulties in recruiting to Health Visiting and School Nursing posts.

Family Health Services and Prescribing — £7.461m overspend

This reflects the increase in the number of items and the additional cost of 17 drugs where costs have increased exponentially. The prescribing projected overspend equates to 81% of the total projected overspend.

Social Care — £0.720m overspend

This is mainly due to overspends on home care, residential placements within local authority homes, adult placements, older people direct payments and client transport. This is partly offset by underspends primarily due to intermediate care, staff vacancies and an underspend on investment for new models of care.

Housing Services — £0.109m underspend

Financial outlook

It is important that expenditure is managed within the financial resources available. There are significant challenges for the Partnership to achieve this. The funding for the Partnership in 2017/18 does not meet the budget required to deliver services. A number of proposals have been identified to address the budget gap. The most significant risks faced by the Partnership's Board over the medium to longer term can be summarised as follows:

- the increased demand for services alongside reducing resources
- the wider financial environment, which continues to be challenging
- the impact of demographic changes
- the cost pressures relating to primary care prescribing
- the impact of the Living Wage and other nationally agreed policies
- the Transformation Programme does not meet the desired timescales or achieve the costs associated

It is therefore crucial that we focus on early intervention and prevention if we are to work within the total 2017/18 Partnership budget of £475m. Moving into 2017–18, we are working to proactively address the funding challenges while, at the same time, providing high-quality services for the residents of Fife.

Delivering Best value

NHS Fife and Fife Council delegate budgets to the Integrated Joint Board (IJB). The IJB decides how to use these resources to achieve the objectives of the Strategic Plan. The IJB then directs the Partnership to deliver services in line with this plan. The governance framework is the rules and practices by which the IJB ensures that decision making is accountable, transparent and carried out with integrity. The IJB has legal responsibilities and obligations to its stakeholders, staff and residents of Fife.

The Partnership ensures proper administration of its financial affairs by having a Chief Financial Officer (section 95 of the Local Government (Scotland) Act 1973). To strengthen governance arrangements and oversee the IJB's significant transformation programme, the Joint Strategic Transformation Group was established. It is chaired by Michael Kellet, IJB Chief Officer with senior representation from the Partnership services and senior representation from NHS Fife and Fife Council.

Evidence of transformational change taking place at strategic and operational levels includes:

- Extension of START programme
- Home Care Redesign
- Front Door discharge programme
- Winter Planning
- Assessment unit bed model
- Expansion of Telecare & Nightlink

Financial reporting on Localities

The 2016–17 financial information is not split into localities as this level of financial reporting will be developed during 2017–18.

7. Moving forward

Michael Kellet
Director, Fife Health
& Social Care Partnership

As seen through this Annual Report, the depth and range of initiatives and transformation in Fife has been designed to support people at any point of their care journey, from the most complex care needs to those people who need just a little help to regain skills and confidence. Next year (2017/18), offers further opportunities to 'shift the balance of care' closer to home and continue to 'shift the balance of decision making' to local communities.

Using the Health & Social Care Integration, Core suite of 23 indicators (Appendix 1) to guide our progress, we recognise further work is required in the following three areas:

- **National Indicator 12.**
  The Number of Emergency Admissions, we have seen an upward trend which has risen above the Scottish average. The numbers provided for both Scotland and Fife are provisional. We have commissioned a number of projects and redesign work to counteract this, which should contribute towards a reduction in this figure in future periods.
- **National Indicator 16.**
  Falls rate per 1,000 aged 65+. Fife is ranked 6th out of 32 local partnerships. We are working together to simplify access to frailty support. We are building on existing work, such as acute and community hospitals working together to reduce falls in hospital. The Frailty Hub based at the Victoria Hospital, Kirkcaldy and targeted improvement work within Care Homes across Fife, should also contribute to a reduction in this figure moving forward.
- **National Indicator 18.**
  Proportion of those with intensive care needs receiving care at home, although this indicator was not reported in 2016/17; Fife was ranked 8th lowest out of 32 local authority areas. Work to redesign the Care @ Home service has been underway since May 2015. The final part of the redesign will move the service forward in 2017/18 to meet the changing needs of the people of Fife.

In 2017/18, we will review our Strategic Plan (2016-20) and take actions to integrate our commissioning intentions based on the need of each Locality and Cluster planning area. We will take steps to introduce and sustain localities budgeting and financial reporting. Our Localities and Cluster planning will continue to empower staff to come together with people who use services and communities to develop early intervention and preventative models which will improve the lives of people who use services.

We received notification in February 2017, from the Ministerial Strategic Group for Health and Community Care, that in 2017/18 we will be required to also track progress across the following areas:

1. Unplanned admissions
2. Occupied bed days for unscheduled care
3. A&E performance
4. Delayed discharges
5. End of life care – percentage of last six months of life by setting; occupied bed days during last six months of life
6. Balance of care/ spend – percentage of population in community or institutional settings.

With the increasing pressure and demand on Fife's Health & Social Care services, we will use this and all other national and local intelligence to enable the delivery of high quality and safe services. This will include reviewing the performance information and learning from the Hospital-to-Home pathway. This is vital to ensuring we are developing the necessary support so people move out of hospital quickly and safely.

I truly believe, that in partnership with our staff, partners and local communities, we can move forward with passion, professionalism and commitment to deliver the aspirations of Fife people – to live active, healthy and independent lives for longer.

Glossary of Terms (A-Z)

Care - Medical, mental, emotional or practical support that is given to groups or individuals including ill health, disability, physical frailty or a learning disability, so they can participate as fully as possible in society.

Carer - Someone who looks after family, partners or friends who are ill, frail or have a disability. The support they provide can be paid or unpaid.

Community Care - Care for people who are ill, elderly, or disabled, which is provided within the community rather than in hospitals or institutions. The preference is to support people in the community, especially in their own homes, where possible.

Community engagement - Community engagement refers to the process of getting communities involved in decisions that affect them. This includes the planning, development and management of services, as well as activities which aim to improve health or reduce health inequalities.

Day Care - Extra care at a day centre to help someone who normally lives at home, by providing care, social contact opportunities and, where applicable, respite.

Family Nurture Approach - brings together services from NHS Fife, Fife Council and the voluntary sector, to work in partnership to support families and give children the best start in life.

Financial Recovery Plan - Plan to bring expenditure in line with budget.

H&SCP - Health and Social Care Partnership.

Home Care - Home care (or home help) involves someone coming into your home to help you with personal care, like dressing or washing.

ICASS - Integrated Community Assessment and Support Service is a team of Healthcare Professionals and Support Workers who provide a range of integrated services in your own home, care home or community settings and is made up of two main parts that work very closely together.

IJB - Integrated Joint Board.

Independent Sector - private companies or organisations of varying sizes from single providers, small and medium sized groups to national providers.

Integration - Combining. In this case, it means health and social care services working closer together to help achieve better outcomes for individuals and communities in Fife.

ISD - Information Services Division is part of NHS National Services Scotland. ISD provides health information, health intelligence, statistical services and advice that supports the NHS in progressing quality improvement in health and care.

MCCN - A Managed Clinical and Care Network enables professionals, public representatives and organisations to work together to promote consistency and quality of service throughout a person's experience of care.

Partnership - Way of working where staff at all levels and their representatives are involved in developing and putting into practice the decisions and policies which affect their working lives.

Pathway - A way of achieving a specified result; a course of action.

PDS - Post Diagnostic Support.

Person Centred - Person Centred is an approach to working with people which respects and values the uniqueness of the individual and puts the individual's needs and aspirations firmly at the centre of the process.

Personal Care - Activities in daily living such as being able to get in and out of bed, prepare a meal, bathe, move safely around the home.

Provisional Outturn - The outturn is the actual net expenditure for the financial year, this is provisional until the external auditors have audited the annual accounts.

Reablement - Time-limited support services that aim to help people learn or re-learn the skills necessary for daily living. Can also be referred to as Intermediate care which is used to describe a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission, support timely discharge and maximise independent living.

Reduce risk - Take action to control the risk either by taking actions which lessen the likelihood of the risk occurring or the consequences of occurrence.

Resources - People, money, buildings and equipment.

Risk - The chance of something happening that will impact on the organisation's ability to achieve its objectives.

Self Directed Support - Self Directed Support describes an arrangement where the service user arranges some or all of their support instead of receiving directly provided services from local authority social work or services or equivalent. Self Directed Support allows people more flexibility, choice and control over their support so that they can live at home more independently.

STAR (Beds) - Short term Assessment and Reablement.

START Teams - Short Term Assessment and Reablement Team.

Strategic Plan Themes - What we intend to take forward and how well respond to the issues.

Teleheath care - Telehealth care is a term used to describe a range of equipment used to support people in their own homes such as a community alarm, movement sensors, smoke alarms.

Third Sector - comprising community groups, voluntary organisations, charities, social enterprises, co-operatives and individual volunteers.

Voluntary organisations - includes registered charities, housing associations, credit unions, community interest companies, trusts and local community groups.

Alternative Formats

The information included in this publication can be made available in large print, Braille, audio CD/tape and British Sign Language interpretation on request by calling 03451 55 55 00.

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Fife Council and NHS Fife are supporting the people of Fife together through Fife's Health and Social Care Partnership. To find out more visit **www.fifehealthandsocialcare.org**

Fife Health & Social Care Partnership

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Fife Health & Social Care Partnership

Annual Report 2016-17
Appendices 1 & 2

NHS Fife

Supporting the people of Fife together

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Appendix 1
Health & Social Care Integration: Core suite of 23 indicators

Indicator		National Outcomes	Latest Year	Fife	Scotland	Provisional
1	Percentage of adults able to look after their health very well or quite well	1	2015/16	94%	94%	
2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	2	2015/16	78%	84%	
3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	2, 3	2015/16	74%	79%	
4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	3, 9	2015/16	72%	75%	
5	Total % of adults receiving any care or support who rated it as excellent or good	3	2015/16	80%	81%	
6	Percentage of people with positive experience of the care provided by their GP practice	3	2015/16	85%	87%	
7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	4	2015/16	82%	84%	
8	Total combined % carers who feel supported to continue in their caring role	6	2015/16	39%	41%	
9	Percentage of adults supported at home who agreed they felt safe	7	2015/16	81%	84%	
10	Percentage of staff who say they would recommend their workplace as a good place to work	8	NA	NA	NA	
11	Premature mortality rate per 100,000 persons	1, 5	2015	423	441	

Indicator		National Outcomes	Latest Year	Fife	Scotland	Provisional
12	Emergency admission rate (per 100,000 population)	1, 2, 4, 5, 7	2016/17	12,262	12,037	X
13	Emergency bed day rate (per 100,000 population)	2, 4, 7	2016/17	116,005	119,649	X
14	Readmission to hospital within 28 days (per 1,000 population)	2, 3, 7, 9	2016/17	103	95	X
15	Proportion of last 6 months of life spent at home or in a community setting	2, 3, 9	2016/17	87%	87%	
16	Falls rate per 1,000 population aged 65+	2, 4, 7, 9	2016/17	23	21	X
17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	3, 4, 7	2015/16	82%	83%	
18	Percentage of adults with intensive care needs receiving care at home	2	2015/16	57%	62%	
19	Number of days people (aged 75+) spend in hospital when they are ready to be discharged (per 1,000 population)	2, 3, 4, 9	2016/17	779	842	
20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	2, 4, 7, 9	2016/17	23%	23%	X
21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home	2	NA	NA	NA	
22	Percentage of people who are discharged from hospital within 72 hours of being ready	2, 3, 9	NA	NA	NA	
23	Expenditure on end of life care, cost in last 6 months per death	2, 3, 9	NA	NA	NA	

Appendix 2

Social Care Inspections for Fife Health & Social Care Partnership Internal Services inspected by Care Inspectorate 2016/17

Services	Quality			
	Care & Support	Environment	Staffing	Management & Leadership
Kirkcaldy and Levenmouth Housing Support Services	3	4	3	3
Kirkcaldy and Levenmouth Care at Home Services	3	N/A	3	3
Jenny Gray Home	5	4	5	4
Ladywalk House	5	5	5	4
78 Broad Street	4	4	4	4
Valley House	4	4	4	4
Ostlers House	4	5	4	4
Leng Resource Centre	6	5	4	5
Rosyth Resource Centre	4	5	5	4
Shared Lives Fife	5	N/A	5	5
Alan McLure House	5	5	5	5
Matthew Fyfe Care Home	5	5	5	5
Jean Mackie Centre	5	5	5	5
Accommodation with Care and Housing Support (Fife)	6	N/A	6	5
Sheltered Housing Services	5	N/A	5	5
St. David's Resource Centre	5	5	5	5
Jean Mackie Centre	5	5	5	5
Matthew Fyfe Care Home - Day Care	5	5	5	5
Northeden Day Care	5	5	5	5
Methilhaven Day Care	5	5	5	5
Adult Services, Resources - Housing Support and Care At Home Service (Housing Support)	6	N/A	6	6
Adult Services, Resources –Housing Support and Care At Home Service (Support Services)	6	N/A	6	6
West Fife Community Support Service	6	6	6	6

Care Inspectorate grade definitions

1 – Unsatisfactory 2 – Weak 3 – Adequate 4 – Good 5 – Very good 6 – Excellent