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‘Change is constant’ is rapidly becoming a modern cliché. However I can think of no better topic for this year’s introductory remarks. Even the most cursory reading of this annual report illustrates just how much change is impacting on the experience of service users, carers and staff. Many of the changes described arise from improvements in our knowledge and practice, but others are driven by the need to respond to unwanted challenges; such as staff shortages and financial pressures. One thing is clear, constant change will be with us for the foreseeable future and so it is incumbent upon The Health and Social Care Partnership to engage meaningfully with all concerned to negotiate the best outcomes.

To highlight a few examples, last year significant improvements were made in respect of Hospital Delayed Discharges, but this could not have been achieved without a ‘whole system’ approach. By enhancing the scale and range of community-based services, (e.g. Assessment and STAR beds and the START team) The Partnership has not only cut delays in hospital discharges but also enhanced opportunities for rehabilitation and living longer in communities. And as I write this, we are consulting with Fife residents on our proposals for Community Health and Wellbeing hubs; I hope these will be endorsed as I believe they will achieve much in preventing hospital admissions in the first place.

In other areas change may be less obvious but equally important. More and more of The Partnership’s work is being led by ‘Good Conversations’ where we seek to understand and respond to what is most important to the individual service users and carers we are there to serve.

And of course, there is technological change. Information Technology is being used to make best use of our staff and financial resources; for example, with the introduction of Totalmobile software across homecare services. But it won’t be long before mobile phone technology will allow remote monitoring of many conditions; providing much improved information for clinicians and reducing waits and journeys for service users.

But of course, not all change is easy and not everyone will always agree that changes proposed are necessary or an improvement. Add to this the fact that the needs of individual communities are not the same across Fife and the conditions are ripe for tensions and disputes. There’s no easy answer to this, but respectful dialogue and negotiation will be important. Here The Partnership’s Locality Planning initiative means there are increasing opportunities for individuals and interest groups to influence service priorities and delivery at a local level.

These are challenging and exciting times.
Foreword

I’m delighted to introduce our second Annual Performance Report. I’m also grateful that there is an increasing understanding of the important role of Fife’s Health and Social Care Partnership and that we have responsibility for a wide range of vital 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 report, we set out what’s been achieved and what we need to focus on in the future. We focus on the important day to day operation of vital services that support the health and wellbeing of everyone across Fife. However, we also focus on progress on improving and redesigning those services. Only, by doing both will we improve lives, tackle inequalities and remain sustainable.

I’m very pleased to be able to report that our bottom up locality based approach to improving health and wellbeing has really progressed over the last year. In all seven of our localities members of the community are getting around the table with professionals such as nurses, social workers, housing officers, community planners, pharmacists, doctors and the Third Sector and Independent Sector to ask, ‘How can we make services better?’ I’m grateful to every person involved.

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 £0.5bn, a proven history of partnership working and strong connections with communities, we are determined to develop health and social care services which are high quality, seamless, responsive and offer more choice and control for generations to come.

Michael Kellet
Director, Fife Health & Social Care Partnership
Welcome to the 2nd annual report from the Health and Social Care Partnership. The Strategic Plan for Fife was first published in 2016. In this plan we indicated a number of areas that the joined up services would want to achieve in the first three years.

On reviewing our statement in the strategic plan we indicated that although there would be enormous challenges we have an opportunity to consider changes to services that will:

• Change the way we commission services
• Change the way we deliver services
• Change to improve better outcomes for people.

Since the last annual report we have made significant progress in a number of areas and continue to redesign and consult on new ways of working.

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 2016, Fife was home to an estimated 370,330 people. By 2041 this is expected to increase by 3% to 379,788. There is a projected 42% (73,658 to 104,956) increase in those aged 65 and over, and an 84% (31,543 to 57,895) increase amongst the 75 and over.

![Projected percentage change in population by age group until 2041](chart.png)

Source: National Records of Scotland, Projected percentage change in population (2016-based), by age structure and Scottish area, selected years. Pensionable age presented takes into account the changes to the pension age in the future.

It is recognised that demographic changes present major challenges, especially the growing number of people aged 75 and over, and the declining ratio of working age people who help support the wider population.
Our performance

Our four key Strategic Plan themes: Prevention and Early Intervention, Integrated and Coordinated Care, Improving Mental Health Services and Reducing Inequalities 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 Health and Social Care Partnership’s performance and progress against these outcomes and our strategic commissioning intentions. The indicators we are able to report on is presented in Appendix 1. Please note there are a number of the 23 indicators not available for 2016/17 period due to the way in which these are collected. 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.
Strategic Plan – Theme 1
Prevention and Early Intervention

Strategic Plan Aim

• 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.

• Reduce the reliance on hospital beds and other health and care services; increase the focus on prevention, self-management and shared decision making; and increase the capacity of primary and community care services.

Connecting with Communities through Locality Planning

National outcomes 1 2 3 4 5 9

Early Intervention and Prevention in promoting health and wellbeing and how we are joining up health and social care across our communities is at the heart of our Locality Planning arrangements. We are working with all of our partners through Integrated Health and Social Care arrangements to tackle the challenges in respect of health and wellbeing across seven localities in Fife.

1 South West Fife
2 Dunfermline Area
3 Cowdenbeath / Lochgelly Area
4 Kirkcaldy Area
5 Glenrothes Area
6 Levenmouth Area
7 North East Fife
Health & Social Care Locality Planning 2017-18

Empowering staff at the frontline to develop integrated models which improve the lives of people who use services.

March 2018 saw the completion of the first round of wider Locality stakeholder events and the identification of initial priorities for each Locality. Seven wider Locality Stakeholder groups which are representative of all key stakeholders have been established and contributed to the development of agreed priorities for each locality.

Work is underway to address some of the priorities in some of the localities in partnership with communities, professionals and individuals.

Our understanding of our seven localities is taken from

• (Area Profiles) Both national and local data and statistics
• Experience and knowledge of people who use services and staff working in the localities who attended engagement and subsequent locality meeting/events across the seven localities

Following significant engagement exercises across the seven localities we have achieved:

• Development of draft locality action plans for the seven localities with initial priorities identified
• Draft Terms of Reference agreed by Strategic Planning Group
• Draft Governance Structure agreed
• In some localities GP Cluster Leads have agreed to chair the locality group in their locality
• In some localities the formation of working groups is taking place to take forward actions in relation to identified priorities
The National Development Team for Inclusion (NDTI) Community Led Support Programme (CLS) has been commissioned by the partnership to support and build on the localities agenda and identified as a priority.

NDTI CLS started working with the Health and Social Care Partnership in September 2017. During November/December 2017 a further series of 16 public engagement events took place. A steering group was established in February 2018 and a local working group set up to plan and ‘test’ the first Community Led Support model in Fife.

A Fife Wide priority will be to build community capacity with a focus on early intervention and prevention supporting self-management across all of our localities. This will be achieved by implementing Community Led Support (CLS) concept throughout the seven localities

South West Fife Priorities

1. Improve the accessibility of rural services in the locality by working with Community Planning partners to develop transport links and potential solutions for the adult population. This will improve access to existing community based resources and health and social care services within the community.

2. Improve integrated joined up working across partners to explore developing a range of self-help support and community based resources to enable people to make positive lifestyle choices impacting on preventable long term conditions.

Dunfermline Priorities

1. Link in with work already underway relating to Queen Margaret Hospital ‘Huddle’ and High Health Gain developing carer support in Queen Margaret Hospital.

2. Investigate the role of the Health and Social Care Partnership in supporting a consultation undertaken with Young Carers to implement the Carers Act. Consider a service based on individual needs as a potential to support young carers achieve their own identified outcomes.

Cowdenbeath Priorities

1. For some elderly people hospital admission can result from gaps in care processes in the community. We will investigate GP rapid access to social care provision. This triage model will look at supporting people and local GPs to keep people at home with services around them, if needed. This project will link with the new care village in the locality.

2. We will work collaboratively with the new care village and local community to consider building community capacity that reflects the needs of care village community.
Kirkcaldy Priorities

1. Coordination of care facilities by reviewing what they are doing in line with local area provision to support options to enable people to stay at home. Although hospital admission can provide timely access to expert lifesaving treatment, for some elderly people admission can result from gaps in care processes in the community.

2. Set up an Integrated Team in the locality, based in an inclusive living centre to deliver joined up adaptations service.

3. There is a perception that there are many people living with anxiety and depression and low mood within the community. There are a number of support options available to people in the locality. We will, in partnership with Community Planning partners, investigate integrated joined up working to improve the availability and pathways of care for those people who need access to mental health services. Action to be taken: ‘A scoping and feasibility exercise to determine need in the locality for a mental health or social connections support project and appropriate response’.

Glenrothes Priorities

1. Rates of alcohol related deaths have been increasing in the locality. For example in the 5 years between 2011 and 2015 there were an average 0.28 deaths per 1,000 population in each year, so for Glenrothes this is an average of about 14 individuals a year. Between 2012 and 2016 this average comes down to 0.26 per 1,000 population, which is around 13 individuals a year. We will work with relevant partners to understand more about the drivers behind this statistic and work to develop interventions to reduce the number of people admitted to hospital with alcohol related issues.

2. Although hospital admission can provide timely access to expert lifesaving treatment, for some elderly people admission can result from gaps in care processes in the community. We will implement improved joint interdisciplinary meetings for frail, elderly people who are not currently in receipt of any social care. This will include primary care, social work and third sector staff to develop robust Anticipatory Care Planning for those identified.

3. Rise in unnecessary hospital admissions and people delayed in hospital discharge can result from gaps in care processes in the community. We will develop a test of change around GP Rapid access to the Health and Social Care Partnerships Short Term Assessment and Review (STAR) Service; develop local capacity to support older people stay at home through models that provide choice and control.

4. Promote community resources to support people living with mental health issues particularly veterans by supporting and encouraging small social enterprise.

5. Increase options to support older people to remain active and connected to their community.
Levenmouth Priorities
1. We will develop interventions to promote ante and post-natal health and wellbeing in this locality due to the number of mothers who present as smokers during pregnancy and promote breast feeding.
2. Increasing number of the adult population have one or more long term health conditions. We will promote health and wellbeing interventions in the locality in order to manage these conditions. The aim of this will be to increase capacity of individuals to self-manage their conditions and utilise community-based resources that promote self-help and wellbeing programmes.
3. Explore potential to support older people who may be isolated by working to promote and establish ‘meal makers’ in the locality.
4. Local GP Cluster group report a high number of people who are accessing their support to manage anxiety, low mood, and depression within the community. The GP Cluster are looking to access funding to support the use of mindfulness based cognitive behavioural therapies for patients with low to moderate mental health issues.

North East Fife Priorities
1. The main challenges in the North East Fife Locality relate to the ageing population and fewer people to care for them. We will develop an efficient model of care providers from in-house and external funded care provision to improve integrated team working. This project will link with St Andrews Hospital to support reduction in unnecessary hospital admissions.
2. There are challenges due to the rurality for the locality which can impact on both the ability to deliver services and also on the demand and need for services. By developing links with the existing community led ‘Hub’ in St Andrews this will establish an opportunity for local people experiencing depression, anxiety and loneliness to support social connections for people experience low level mental wellbeing challenges.
3. We will actively support the Day Services Redesign with locality input to Increase options to support older people to remain active and connected with their community.

Stay Tuned
Throughout 2018 we will continue to develop and establish the seven locality core groups and provide input needed to make them effective. We have adopted a ‘test and learn’ methodology to allow everyone involved to contribute and identify what works and what might need to be done differently as we continue to roll out the Locality Planning arrangements across the seven Localities.
In July 2018 the work undertaken in 2017-18 will see the launch of the first Community Led Support test site in our Levenmouth Locality. This is in partnership with local communities and voluntary community groups.
We also plan to invite carers’ representatives on to Locality groups and develop the processes to make sure this is effective and engaging for carers.
The Public Engagement Network (PEN) has evolved from the Public Reference Group and local health partnership members. It also includes service users, carers and their representative. The PEN Chair and Carers’ Representative are non-voting members on the Integration Joint Board. These two members also attend several committees including the Strategic Planning Group, Clinical Governance Committee and Carers Strategy Group.

In the past year individual members have been involved in a range of projects and working groups across the Health and Social Care Partnership making a significant contribution to the following projects:

- Carers Act
- Localities Planning
- Out of Hours Care
- Care At Home Review
- Community Led Support
- Dementia Friendly Glenrothes

Engagement and consultation has provided a valuable insight and provided vital information ensuring that process reviews necessary for the development of services will fully meet the needs of service users. In recognition of this the Health and Social Care Partnership has approved a new post with responsibility for the future expansion and scope of Consultation and Engagement.

Ian Dall, Chairperson, PEN  
Morna Fleming, PEN Carer Representative
Delayed Discharges

A delayed discharge is when someone is clinically ready for discharge from a hospital setting and where their care could be provided elsewhere but they cannot leave hospital for various reasons. This is detrimental for the person, their family and for the service as the hospital resource cannot then be used by someone who more urgently requires medical support.

Within Fife we have taken a whole system approach to reducing delayed discharges and over the past year we have seen a reduction in the number of patients waiting to be cared for within their own home or a more homely setting. Figures 1 & 2 demonstrate April 2017 – March 2018 data. A number of actions have contributed to this which include a re design of our home care model, better links with the Acute Hospital and the Health and Social Care Partnership through the multi-agency Discharge HUB and collaborative working with the Third Sector including earlier direct support for carers, veterans and homeless individuals.

Figure 1 - Bed days occupied by delayed discharge

Figure 2 - Average number of beds occupied per day
Figure 3 - Number of days people aged 75+ spend in hospital when they are ready to be discharged, per 1,000 population (National Indicator 19)

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</table>
Short Term Assessment and Reablement Team (START)

National outcomes 1 2 3 4 9

Since the pilot project, less than 2 years ago, the Short Term Assessment and Review Team (START) provided by the Health and Social Care Partnership has continued to grow. This reactive Care at Home service is designed to support a person’s discharge from hospital and significantly improves discharge planning for people with assessed needs. Residents of Fife with care needs, who wish to return home, are referred to the service from any hospital. The service has further expanded in 2017-18 to take referrals for people not in hospital which includes referrals from STAR beds, and other models of care and support for people in crisis at home by delivering the right care at the right time in the right place.

Over the coming year Fife Health and Social Care Partnership will continue to review this service to ensure that it delivers care to those who are most in need and can be supported to remain at home independently.

Community Assessment Beds

National outcomes 1 2 4 8

During 2017-18, the community assessment bed model continued to be developed and more services were made available. At the start of 2017, there were 39 placements available within 7 care homes and by the end of March 2018 the available placements had increased to 48 being delivered in 8 care homes.

The development of the service during 2017-18 considered options to allow assessment beds to be available throughout Fife so that individuals accessing this service could move into a care home in or near their own community.

In 2017-18, 177 individuals used this service allowing staff an extended time for the completion of their care assessment and to identify appropriate levels of support to achieve personal outcomes.

Whilst available services increased during 2017-18, there are some areas in Fife where assessment beds are needed to enhance the service further and give greater choice to those individuals accessing this service. The Health and Social Care Partnership will work with our independent care home providers and partners to look at the continued expansion and development of this service.
Short Term Assessment and Review service (STAR)

National outcomes 1 2 4 7 9

The Short Term Assessment and Review service supports people to return home following a period in hospital and to regain confidence and skills to remain at home. The service is available to those who are over 65 years of age and will be provided for up to six weeks. STAR beds are located within the Partnership’s care homes across Fife. Over 150 people have accessed the service during 2017-2018.

During 2017-18 we have linked Short Term Assessment and Re-ablement service and Short Term Assessment and Review Team which has enabled those requiring the support of one carer to return home without unnecessary delays.

The addition of a Pharmacy Technician to the multi-disciplinary team has enabled medication reviews to be undertaken while individuals are in a STAR bed and this has resulted in a reduction of prescribed medication or a revision of the time medication should be taken, which can sometimes positively impact on the need for a care package.

An additional Senior Social Care Worker in the care homes offering STAR beds has enabled a more effective response to referrals for admission.

We have developed direct access arrangements for GPs in Glenrothes area to STAR beds at Napier House, Glenrothes to avoid inappropriate hospital admissions.

Throughout the next year we will continue to identify opportunities for further development of the STAR bed model within Local Authority care homes. Rapid access referral pathways will be developed to support an emergency admission, thus reducing demand on using respite resources. We will, subject to investment, increase staffing capacity for STAR services to deal with more complex needs i.e. those requiring two staff for manual handling. Along with growing the service we will also explore working in partnership with external resources to develop the service where possible.
Modernising Care At Home

Totalmobile has effectively transformed Care at Home through the use of mobile technology for everyday services which make a real difference to people’s lives. Through dynamic resource scheduling, Totalmobile has improved visibility in all areas of Care at Home service delivery and offers robust evidence for continuous improvement. Totalmobile has been fully operational for all of this year across all internal care at home teams. On average the system schedules 22,000 internal care at home visits per week which are delivered by Fife Health and Social Care frontline care workers. Introducing Totalmobile has not only increased staff satisfaction within a challenging and sometimes difficult role; it has also demonstrated that Fife Health and Social Care Partnership can positively tackle complex problems effectively.

The system has allowed an increase of service users with delivery of care internally increasing by 19.5%. It was therefore extremely satisfying for all concerned to be presented when the project was chosen as the Award Winner at Fife Business Awards ceremony in the Success through Innovation field.

As Phase 3 of the Care at Home restructure continues within the service will move to its main business being the START team with our internal mainstream service focussing on the more high level care needs which have a higher degree of risk including protection of people.
Resilience Planning

National Outcomes 4 9

The ferocity and intensity of the weather conditions experienced during February and March which the media nicknamed ‘The Beast from the East’ was exceptional. Clearly this was no match for the people of Fife as colleagues, partners, businesses, communities and the public gave untiringly and continually throughout this most difficult time.

The heroic efforts of everyone involved ensured that services were able to reach those most in need. The response, resilience and sheer determination of hundreds of people has been unprecedented. Across Fife, people walked miles through blizzard conditions, offered their 4 by 4 vehicles, worked very long hours, stayed overnight in care facilities right across Fife, volunteered to come in on their days off to cover shifts and much, much more.

Phenomenal levels of kindness, comradeship and putting the needs of service users and patients above all else have been shown, epitomising the dedication which sits at the heart of care services and workers each and every day. These extreme circumstances just brings it to the fore.

Social media channels were flooded with updates on the difficulties experienced by those trying to deliver essential services along with the many expressions of thanks and gratitude to those who worked tirelessly. Their invaluable contribution made a huge difference and kept vital services going. Michael Kellet said “I am immensely proud of everyone who has contributed. You are a credit to the Partnership and to Fife. Thank you very much indeed”.

For more information visit www.fifehealthandsocialcare.org
Improving Services for people living with Dementia

National outcomes 1  3  5  9

During 2017-18 we have invested in developing a range of support services for people with dementia and their carers through Dementia Investment Monies (£500,000). This has been done in partnership with the Third Sector, Fife Sports & Leisure, Fife Cultural Trust, Shared Lives, Fife Carers Centre.

Dementia Friendly Glenrothes

In the second phase of activity the Project continued to focus on working with organisations and businesses to award the window sticker signifying they were dementia friendly. To date 17 awards have been made including to a local Funeral Parlour, a GP Practice, The Royal Bank of Scotland and the Nationwide Building Society.

A key priority for the Project was to establish a reference group of people with recent and current lived experience of dementia to steer the direction and identify issues. The first meeting of this group took place on 18th March 2018. The attendance at that meeting was small and it is anticipated this will continue to grow and develop in the coming months as regular groups have been set up. Their most practical outcome has been to create an information leaflet identifying support services for people with dementia in and around Glenrothes and across Fife.

Volunteers have also been recruited to the Project and they are involved in extending the reach of the work beyond Glenrothes into Leslie, Thornton and Markinch.

When informed of the project one of the Partners at the GP Practice stated:

“It seemed obvious that a doctor’s surgery should make the small but targeted changes necessary to allow those living with dementia to find their way into and around the building with confidence. As the changes relate mainly to signage they were inexpensive and easy to do. I would encourage other surgeries to do the same.”
Technology

National outcomes 1 2 4 7

Fife Health and Social Care Partnership will provide technology, support or practical help, to people who require additional support to enable them to live at home independently. Technological support such as Community Alarms and Telecare offer an effective means of support to people, from a distance. As technology continues to improve the range of equipment and aids has grown.

Community Alarms

When a person needs help, a single press of a pendant button will connect them with a specialist call handler at our Alarm Receiving Centre available 24/7. This is a Fife wide service.

Telecare

Offers people support round the clock. It is a non-intrusive, safe and highly effective method of supporting people and enabling them to live as independently as they can. Telecare equipment can be used to support people to continue to live in their own homes by reducing risks, offering carers and service users reassurance and ensures that resources are directed to those most in need.

Examples of telecare available are:
- personal alarms
- fall detector
- pressure mats for beds and doors/exits
- heat and smoke detectors
- medication dispensers

Fife Health and Social Care Partnership strive to support people be as independent as they can be and to live in their own homes safely.

Lifestyle Monitoring (also known as Quietcare)

Quietcare can help ascertain a person’s care needs by installing Lifestyle Monitoring technology in their home to provide greater insight to activities of daily living (ADL). This is appropriate when a person is unable to articulate any difficulties they may be having due to their cognitive impairment or learning disability. Discreet, unobtrusive motion detectors, installed with their or their family’s consent, display ADLs in chart/graph form on a secure website.

In some cases the wider community can also be indirectly supported by Telecare.
A personal story

Sadie* was identified by the Fire Service as a great fire risk. Sadie’s habit of setting fires deliberately was putting herself and neighbours at risk. Sadie was being supported under Adult Support and Protection procedures. The property did not have an active telephone line and lack of finances prevented Sadie from installing one. By using alternative equipment, an Auto Dialler, until a BT phone line can be installed a Community Alarm could be fitted along with smoke and heat detectors.

The Community Alarm team monitored daily to check for any activations and carried out weekly tests on equipment until BT line was fitted. The sensitivity of the equipment in picking up a fire and then sending a message to the control centre to activate a 999 call to the Fire Service made the environment for Sadie and the neighbours much safer.

*Anonymised.
Small Sparks

National outcomes 3 5 9

The second round of Small Sparks in 2017-18 was undertaken across the Levenmouth locality. The project provides a £250 grant to promote community connections through creative projects and at the same time helps to bring communities together in ways which are meaningful to them. Drawing on the learning and success of the previous year in North East Fife, the project has had eleven applications approved, which range from the community Connect group in Methilhill, Parkhill Wild Planting and the Kennoway Community Shed. Small Sparks continues to work positively and to include everyone in the community. Keeping the Small Sparks application process and projects simple and achievable means that it is easier for people to get involved, including citizens who have never done anything in their neighbourhood before. Feedback at the first celebration event confirmed that applicants appreciate the fact that Small Sparks is free from bureaucracy and simple to administer.

On Your Doorstep

National outcomes 1 5 6

The Partnership’s community website “On Your Doorstep Fife” continues to evolve as 2017-18 saw the first information review on the site. Contact was made with all registered organisations requesting that they check and review their entries to ensure information is as accurate and up to date as possible. Staff and the public continue to have access to information about services, resources, activities and groups that are available within their local community. On Your Doorstep includes a specific section about Self-Directed Support which provides information and guidance on ways in which people can have more choice and control over their care needs. A new section has been added in 2017-18 – Short Breaks. This Short Breaks section provides information on a wide range of resources that can be accessed for short breaks/respite to maximise choice. The website continues to 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 just over 1700 organisations and groups listed on the website and the diversity of the information continues to appeal to people of all ages and interests.
Befriending Grants to Voluntary Organisations

The Partnership continues to work with partners in the Third Sector with our Befriending Service continuing to make 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. The services were established and became productive very quickly considering the new and diverse concept.

- In 2017-18 the Health and Social Care Partnership supported 11 organisations to deliver the service.
- The target for the Befriending Service as a whole was to provide Befriending services within the different models to 332 Individuals.
- Actual service delivery was to 470 Individuals which is 140% of the target.

The organisations contributed along with the Health and Social Care Partnership in 2017-18 to finalise work with Evaluation Support Scotland through the ‘Threading the Needle’ programme to devise a way within the existing parameters of the council’s monitoring and evaluation framework to consistently measure the achievement of the specific desired outcomes to Befriending. Work with Evaluation Support Scotland allowed new revised Service Level Agreements to be introduced and Monitored in 2017-18.

The services overall have developed during the financial year and have been further embedded as an integral part of the core services being provided by the individual organisations which gives greater sustainability. The general overall challenge for all organisations providing Befriending Services has been around the need for a continual availability and recruitment of volunteer befrienders and the logistics of matching them with the individuals requiring a befriender.
The Befriending service was sent a referral for Helen*, a 77 year old with a visual impairment and experiencing low mood due to isolation. A Local Area Coordinator undertook an assessment which resulted in a volunteer visiting on a weekly basis. Helen was supported to connect back into her community and enjoyed the social interaction and was able to reminisce with her befriender. Helen experienced improved mood, less isolation and improved wellbeing. The biggest change is Helen is getting out and enjoying life more and feels happier.

“Before I wouldn’t go out of the house I was scared that I would fall or get lost now I feel like I can go anywhere with my befriender, now I enjoy going to the local cafe and visiting the park and the shops, so much has changed around me I feel like I can keep up now and it’s something to look forward to, its precious. We don’t stop laughing we have the same sense of humour and can talk for hours it’s like we have known each other for years”

*Anonymised
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.

Self Directed Support (SDS)

Self-Directed Support offers choice and flexibility to those assessed as being eligible over their care and support. Following assessment people are offered four ways in which they can take control, manage their independence and meet their personal outcomes.
• Option 1 - Direct Payment – people choose and direct their own support and manage their own budget.
• Option 2 - Individual Service Fund – people choose and direct their own support with either the local authority or a third party managing the budget
• Option 3 – The local authority selects, arranges and manages the service provision on the person’s behalf.
• Option 4 - A mix of options 1, 2 and/or 3.

Access to independent information, advice and support is a key part of the ongoing implementation of Self Directed Support. In 2017-18 the Health and Social Care Partnership engaged an independent advice and support service – SDS Options Fife. Their role is to provide independent information, advice and support to people, particularly those who have chosen Option 1 (Direct Payment) and who choose to become employ their own support staff.

The ongoing development of recording self-directed support in 2017 has allowed the Health and Social Care Partnership can now measure the ongoing delivery of choice, control and flexibility as evidenced below, which reflects a significant increase.

The Health and Social Care Partnership continues to work to the priorities agreed in Fife’s Self Directed Support (SDS) Strategy to ensure supported people and their families/carers are involved as much as they choose to be in their assessment and support planning. In 2017-18 the Health and Social Care Partnership will continue to develop the performance reports to evidence supported people’s experience of accessing social work support.
Carers Act and Carer’s Strategy

In Fife there are approximately 35,000 self-identified unpaid adult carers not including the considerable number of hidden carers. This number is set to increase. In 2017 we made significant investments to support carers and prepare for the Carers (Scotland) Act 2016. The Act comes into effect on 1st April 2018.

We reintroduced the Carers’ Strategy Group to help shape our work for the future. We assessed our position as strong with a range of assets in place which were delivering well for carers.

We consulted Fife’s carers. We recognise there is further opportunity to do more and have started this work. Over 300 commented on the priorities for our strategy. We started to refresh our strategy with new investments to support carers.

In 2017 we tried a new approach to supporting carers in decision making before the people they care for are discharged from hospital. With Fife Carers Centre, we supported 252 carers in the first year. In 2018 we will expand this support across Fife.

In preparation for the Carers Act we refreshed our carer assessment and support planning approach through our strong partnership working with voluntary organisations. We will now build on this strength.

The Carers Strategy for Fife is in development. It will include the outcomes and key improvement actions required over the three year period of the strategy to implement the Act fully and benefit local carers.

Community Hospitals redesign

Community Hospital redesign is part of the Joining up Care proposal which aims to join up services to provide better experiences of care, especially for people with long-term conditions and disabilities. Clinical care has changed over time and more care can now be provided at home or in homely settings such as care homes. By developing our community models so that more people can be safely cared for in their own homes and communities, far fewer will need to be admitted to hospital.

We have been testing new ways of working and are analysing all our data as well as undertaking audits to understand where we can make improvements. We continue to engage with our workforce and stakeholders from across health and social care and the people who use our services to identify the best models to support transformation. We are holding a number of events specifically for community hospital redesign and as part of the wider consultation in August and September. These will support us to develop detailed proposed models of care for you to consider later in 2018.

Future developments will focus on 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 and Day Hospital for Older People

National outcomes 2 9

During 2017 the day service previously offered at Rosyth Resource Centre was re-provisioned offering more choice and flexibility to individuals and their carers requiring day support.

Day Service Redesign has offered alternative day supports for individuals based on a good conversation approach. The result has been a decline in demand for traditional day services and we continue to work with partners in the Third Sector to redesign services to meet future needs and demand.

The new care home builds offer a significantly improved environment for residents. However dependency levels are increasing due to demographics and individuals who have complex health/care and support needs requiring increasing staffing levels to meet need, and joint working with health colleagues to ensure holistic approach to care and support.

Locality Huddles have been developed to bring together Health and Social Care practitioners to discuss and agree possible outcomes very complex cases. These huddles include a range of services - Social Work, psychiatry and mental health services, community nursing, GPs, ICASS and Community Occupational Therapy. It is planned that these will be one of the foundations for the Community Hub model.

One of the challenges around these new developments is achieving equity across Fife and making sure that people are able to access these Community Health and Wellbeing Hubs wherever they live in Fife.
Fife Macmillan Improving Cancer Journey

Fife Macmillan Improving the Cancer Journey is a service of change intended to support people affected by cancer. The success of the Integrated Community Cancer Care Project has contributed to the decision by Macmillan Cancer Support to invest further in Fife, providing funding for an additional 3 years to enable Fife Health and Social Care Partnership to develop the “Improving Cancer Journey” service.

The overall aim of the Fife Macmillan Improving the Cancer Journey service is to develop and deliver clear and accessible pathways of care and support for people affected by cancer.

Fife Improving the Cancer Journey team carried out a scoping exercise from October 2017 to March 2018 to inform the test sites and identify any gaps in service provision. The overarching themes from the people affected by cancer engagement events and survey included:

- The need for emotional support – both for the person with a cancer diagnosis, and their family. This support needs to be available at any stage in the journey.
- Lack of communication between doctors, nurses, consultants, hospitals, across health boards – patients assume a medical professional will understand their situation, and often they don’t.
- Honesty and respect for patients is hugely important, and not something everyone experiences.

The Improving the Cancer Journey Service has established a process for co-production whereby people affected by cancer, carers and partners agree on actions and innovations to improve integrated care pathways for the future, making sure people have the best chance of living well independently, and are part of resilient communities.
Veteran Support in Fife

National Outcomes  1  5  9

The Veterans’ First Point (V1P) service has been funded temporarily through LIBOR funds distributed by the Scottish Government up until 30 June 2017. The Scottish Government asked all Health and Social Care Partnerships that host V1P services in their areas to agree a plan to secure funding for V1P services from 1 July 2017 onwards. The investment for Fife Health and Social Care Partnership is £0.100m.

Veteran’s First Point enables peer support workers to register all veterans, assess their needs, and provide a variety of support options. Those who need specialist psychological intervention are referred internally to the clinical team. Access to the service can either be self referral or via another support agency. Fife V1P run regular drop in sessions in Dunfermline and Kirkcaldy and have noticed that veterans have started to informally drop-in without any appointment or prior contact. We will continue to work with V1P to enable the service to operate a single point of access for its operation in Fife.
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;
• 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.
Mental Health Strategy Update

National outcomes 1 2 3 4 5 8 9

The Scottish Government published the national Mental Health Strategy (2017–2027) which provides a 10 year plan for the delivery of mental health services across Scotland. The key aims within the strategy seek to improve:

- Prevention, early intervention and physical wellbeing;
- Access to treatment and joined up accessible services;
- Rights, information use and planning.

There is emphasis within the new strategy on supporting children and young people and on early service delivery to adults of all ages, in addition to a clear intention to align mental and physical health service delivery. The strategy recognises the impact of structural inequalities on mental health and identifies poor mental health as a barrier to accessing physical health services. This is the first mental health strategy since the integration of health and social care. The strategy therefore promotes the need for an innovative whole systems approach to service redesign to meet local priorities. The priorities set out within the strategy are scheduled to run for 3-4 years with the subsequent phase of national strategic planning focused on secondary care (inpatient and community services). Fife’s Mental Health Strategic Implementation Group has a short life Mental Health Strategy Review working group which is mapping the national strategy with Fife’s current mental health strategy, which runs to 2020. Work to date suggests that Fife’s mental health services across the Health and Social Care Partnership are addressing the national strategic actions.

Fife continues to deliver on the local mental health strategy through the implementation group, which has seen an increase of subgroups to implement Fife’s wider Rebalancing Care agenda which also aligns with the national strategy. Significant improvements are projected across the field of mental health in Fife informed by both local and national strategic drivers.
Anti-stigma campaign

National outcomes 2 3 4 5 9

The Partnership’s commitment to challenging stigma and discrimination continued throughout 2017-18, with the ‘Power of Okay’ campaign, which seeks to challenge societal attitudes on an individual level to promote that ‘it’s okay’ for people to feel able to talk freely about their mental health. In Fife, during the month of October 2017 (World Mental Health day was 10th October) the Mental Health Strategic Implementation Group sub group widely publicised the ‘It’s Okay’ campaign through online media via internal Health and Social Care Partnership and external partner agencies. The success of the 2017 inaugural walk informed the commitment from the Mental Health Strategic Implementation Group to increase Fife’s miles and challenge stigma through a planned event in 2018. The third strand of Fife’s anti stigma campaign is the ‘Pass the Badge’ campaign, was launched during 2017 in partnership with See Me, the national organisation committed to challenging mental health related stigma and discrimination. The campaign requires a person to wear a badge for 24 hours and subsequently pass it to another person and invite them to ‘Pass the Badge’ whilst highlighting the stigma attached to mental Health.

In October 2017, the Health and Social Care Partnership was again involved and participated in the Scottish Association Mental Health (SAMH) anti-stigma football tournament which also launched a Poetry Exhibition by people with lived experience. The day was highly successful and promoted its key aim of sending a powerful message in relation to the ways in which poor mental health adversely impacts on the emotional, social and physical wellbeing of people affected by poor mental health.

Improvements, challenges and sustainability

The Partnership remains committed to widely promoting the challenge of stigma and discrimination in relation to mental health and expects the ongoing campaigns to continue to build momentum during 2018-19.
Stratheden Hospital Redesign

National outcomes 2 3 4 9

Fife Health and Social Care Partnership Board’s commitment to improving Mental Health across Fife is evidenced through investment of £660k in 2016-17 on a recurring basis. The fund was agreed to be invested in social care packages to support people who have the potential for discharge after a lengthy stay in hospital. This redesign programme aims to facilitate discharge (as appropriate) and support people to live in their communities and experience life in the same way, as far as practicable, as people not so affected by mental ill health. To date, a project team are working alongside 11 people now living in the community with the right supports for their circumstances while a further 9 people are supported to live in new build residential properties in the North East Fife area.

The Stratheden Redesign Project will complete during 2018-19 and is part of Fife’s commitment to rebalance care across mental health services in Fife.

*Peter’s story*

Peter had been in hospital for five years and when discharged and moved into a community home, he found the move very scary. He says, “I thought my past would come back to haunt me thinking someone would come after me and find me.” Scottish Mental Health Association supported Peter to move into his new home.

Peter settled in within a few months, but initially needed staff support to even go over to the local shops at first. Eventually, Peter gradually went out on his own a little at a time and ventured further on his own. Peter can now go shopping on his own and even volunteers at a local charity for the elderly. Peter spent a total of four years in supported accommodation and in 2018 moved into a lovely bungalow which he says he feels very safe in. Peter still has outreach support and gets 21 hours per week to support him with day to day living tasks and cooking which he says he appreciates.

Peter has great plans for his new home and is already planning new carpets throughout his house and showed staff where he is intending to put up his pictures and says he is very happy to be there.

*Anonymised.*
*Heather’s story*

I have been living in the community for four years now. I was in hospital for over 14 years, and my only privacy was a curtain around the bed. I shared a bay in a ward with four other female patients; it was noisy and peace and quiet was something I did not have much of. When I first heard I was being discharged and would be living in a flat on my own, I was delighted, a little nervous but not scared.

Scottish Mental Health Association staff were introduced to me and came to see on the ward, and also took me to see the flat I would be living in. Staff supported me to get a grant for furniture. When I was first taken to see my flat in the community, I cried when I saw the furniture and was told it was all mine. For the past three years I have lived in my little flat, it was small but cosy and easy to heat.

I really look up to the staff, their hearts are in the right place, and they certainly know their stuff around mental health.

Having the staff in the same building gave me peace of mind, they were just next door if I needed them. Any support I needed was always there, and sometimes I would just knock on the manager’s door, and he would make me a cup of tea. I had friends living in the block as well, and we had music and art groups to look forward to. I am now in a much bigger flat just down the road from where I first lived, and I get outreach support from the staff. The staff know me, I have support to live independently, I have good neighbours, and I am in contact with my family. And better still, I have all the peace and quiet I want. I am just waiting to hear about a befriender.

*Anonymised.*
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.

Shared Lives
National outcomes 4 5 6

Shared Lives Fife continued to provide crucial support to adults and older people with long term support, short breaks and day support across Fife. Shared Lives Fife developed and expanded carer numbers and increased support provision to people aged over 65 years. A key aspect of Shared Lives Fife is the recruitment and assessment of carers from a wide range of backgrounds, which continued in 2017 across Fife. The service closely involves carers and supported people in the ongoing development of the service through the carer consultation group, which has increased engagement in 2017. In addition to the supported person consultation group ‘Speak UR Mind’. 2017 saw the celebration of 30 years of Shared Lives with a celebration event which saw over 50 carers and supported people in attendance, with some new and seasoned carers sharing their experiences of Shared Lives in Fife. As a Care Inspectorate regulated service, Shared Lives Fife was assessed as excellent in the delivery of care and support in 2017.

The development of the Shared Lives project explores an alternative way to support 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.

Extracts from Carer Consultation feedback 2017

“I would like to thank everyone for their support and the ease of arranging this service for my daughter. I feel absolutely sure that she is in good hands and taken care of.”

“I like the laughing, friends and meeting new people.”

Continuous improvement for the service will see ongoing expansion of carer recruitment for all adult ages and increased support availability for over 65 years, in addition to developing opportunities for dementia-specific training for carers. Shared Lives Fife will continue to ensure that the matching process remains at the heart of the service which can be a challenge as referrals continue to increase across all areas.
New Build Housing & Housing Adaptations

National outcomes 1 2 5

During the past year we have worked hard to deliver performance improvement in relation to adaptations. We have taken an average of 24 days to complete approved medical adaptations (in 2016-17 this was 30.27).

90% of approved medical adaptations have been completed.

The Care Village programme has moved on significantly – the Housing contribution to this has been a 30 flat Extra Care Housing complex at Lumphinnans located at the adjoining site to the new Care Home and Day Services facility of Lindsay House. The Extra Care properties are a mix of one and two bedroom properties and along with two onsite Very Sheltered Housing Support Officers, offers tenants communal facilities and an on-site café.

New Care Villages

National outcomes 2 5 9

Napier House, Glenrothes, the second of three new 60 bedded care homes opened in August 2017. The care home provides 48 permanent residential care beds and 12 short term assessment and reablement (STAR) beds that support timely hospital discharge or prevent unnecessary admissions to hospital, as well as day service facilities. Work is also underway to develop extra care housing on the site to form a care village. Lindsay House, Lumphinnans Care Home and Day Service based on a similar model to both Ostlers House, Kirkcaldy and Napier House, is well on the way to completion by June 2018.

In February 2017, Fife Council allocated £18.3 million, as part of its Capital Investment programme, to support the continued development of the Care Homes replacement programme. Work is underway to develop proposals for an intergenerational facility incorporating a new 36 bed care home, nursery provision and extra care housing at Methil which will replace Methilhaven Care Home. Work is also underway to identify options to locate replacement care homes for Northeden, Cupar and Ladywalk, Anstruther.

To enhance these resources further we are planning to develop an Adaptations One Stop Shop this year for the provision of advice.
The Intervention Project is patient centred and proactively makes contact with those patients who are homeless or at risk of being homeless. The project aims to identify the underlying causes of people’s attendance at hospital, working with them to explore what support services are available to prevent or reduce the likelihood of further attendances and admissions.

The project started in March 2018 and supported 30 patients. Of these 27 patients experienced an addiction or a mental health issue. One of the aims is to reduce the length of stay for patients and provide more community based care with ongoing and faster access to housing support. The average length of stay for patients admitted to hospital who are known to the service is currently 3.5 days. Although the data is limited from previous patient journeys we have examples of a patient’s length of stay being 180 days.

Following discharge 16 patients transferred to temporary accommodation, 9 to a secure tenancy, 2 moved into a private let and 3 moved in with family members. From that point forward project staff act as an advocate for the patient, guiding them through the complex journey and multi-faceted approach aiming to make sure that there is an appropriate use of scheduled and unscheduled care services.

We are fully committed to ensure that access to services best meets those who require additional support and will explore and develop referral pathways between mental health, addiction services and third sector providers to make sure patients are supported quickly in their own community.

By working alongside the discharge hub there is a developing multi-professional focus to discharge planning and appropriate service support. Going forward when space allows it would be good if the service was more accessible from the hub.

We will continue to work in partnership with local authority around the development of a safe discharge protocol for homeless patients along with ongoing discussions with regard to GP services for those patients who are homeless and provide better access to health services. As part of this we are developing a mini locality huddle for people who are homeless where a multi-disciplinary team discussion can be facilitated to support a joined-up case management approach.
Child Well-Being Pathway

Lochore Meadows Project (National outcome 2)

Fife Health and Social Care, Fife Council, Third Sector partners PAMIS ‘promoting a more inclusive society’ who work with people with profound and multiple learning disabilities and local families are working together to provide a facility in an accessible park in Fife where children with significant motor difficulties can play outside alongside their siblings and peers using powered mobility.

Fife Health and Social Care Children and Young People’s Occupational Therapy patient endowment has funded the purchase and installation of permanent outdoor track and SMILE Smart Technology. This is in response to feedback from families about the limited access to leisure and the impact of this. There is a Drive Deck (which is currently on loan) which allows children and young people with physical disabilities to mobilise independently, access leisure opportunities and play in their local community. The smart technology enables the child to move the Drivedeck independently using a basic button switch. Initially at Lochore Meadows the child will be able to drive along a track to feed the ducks and play on the wheelchair accessible roundabout. In the future there are opportunities to extend the track giving more play experiences for children and young people.

Home visits making life easier for youngsters in Fife

A unique service aimed at ensuring children and young people spend less time in hospital is being extended to seven days a week.

Leading innovation in health and social care Fife’s Paediatric Home Visiting Service is the first of its kind in Scotland and supports young people and their families from the comfort of their own home.

When a young person comes in to hospital, sometimes their stay can be prolonged as they wait for a number of arrangements to be put in place to support their discharge. The Paediatric Home Visiting Service helps ensure they are able to leave hospital at the earliest opportunity by arranging a home visit within the first 48 hours of leaving, ensuring patients and their carers have the medical and social support that they need.

Uniquely, Community Nurses from the Service can also provide intravenous antibiotics to young people in their homes or at school.

We will strive to redesign 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)

A Managed Clinical and Care Network brings professionals, public representatives and organisations together to promote consistency and quality of service throughout a person’s experience of care. The Frailty Managed Clinical and Care Network is focused on supporting healthy aging, reducing people’s 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 Managed Clinical and Care Network is collaborating with colleagues across health and social care. In 2017-18 effective links were established which have seen:

- Managed Clinical and Care Network establish a clear action plan;
- Early development of a resource for practitioners to support the frailty pathway;
- Expansion of early recognition and recording of frailty through the GP frailty register, with links from this for people with moderate frailty to the case management element of the Community Health and Wellbeing Hub development programme;
- Continued development of the inpatient falls pathway – maintaining the reduction in falls and falls with harm;
- Development and testing of a falls pathway with the Scottish Ambulance Service to share information to be able to support people sooner;
- Development of a supported self-assessment with testing planned with Third Sector and statutory agencies, to help people identify their falls risks and sign post people to support;
- Route to a medicines review has been simplified for people identified as having risks because they have a large number of medicines;
- Development of Fife falls strategy for 2018-2022 for launch in June;
- Commitment to develop a comprehensive programme to support healthy ageing.

Managed Clinical and Care Network hosted an initial multi agency frailty event, with 140 people attending from primary care, community services, the Third Sector and social work.

Advocacy Strategy

An extensive engagement and consultation exercise was undertaken to inform the refresh of the Fife Advocacy Strategy.

The updated Fife Advocacy Strategy includes advocacy support for Carers. Additional investment has been identified to implement advocacy for carers through the Carers (Scotland) Act 2016 funding received from Scottish Government.

We are exploring the implementation of an eLearning module for staff to continue to raise awareness of advocacy.

Due to Fife’s changing demographic profile we expect there to be a continuing increase in demand for advocacy services.
High Health Gains

National outcomes 1 5 8 9

What is High Health Gain

We have increasing numbers of adults and older people with complex care needs in Fife, who are accessing both primary and secondary care services more frequently. To support a more integrated and earlier approaches we have developed a model of locality focussed support which identifies pro-actively patients who could benefit from this approach.

The approach involves:
- Targeted approach early identification using High Health Gain data set and clinical override;
- Comprehensive assessment – holistic lens;
- Person-centred actions providing a seamless anticipatory plan;
- Case co-ordination – a lead professional simplifying communication and access

Within Fife we are using a dataset developed by NHS Scotland’s Information Services Division (ISD) to identify and potentially predict where people are at risk of unnecessary admission to hospital due to deteriorating health as a result of complex health and social care needs. We are testing a case management approach whereby District Nurses will act as the care navigator through the system and ensure care is seamless and person centred. A holistic assessment is carried out which includes mental health and wellbeing, physical health and carer status using a combination of validated and project specific tools.

To support our model of joined-up seamless care we are removing traditional access barriers to services and ensuring the whole system from hospital, community and GPs is integrated. Within this district nurses now have direct access to:
- Care at Home;
- Polypharmacy reviews;
- Local area co-ordination and befriending support;
- Monthly huddles with a full Multi-Disciplinary Team (MDT) model;
- Day Hospital services – transforming into community HUBS.

Since commencement we have seen 150 individuals and from a random sample 60% have seen a significant reduction in admissions.
Case Study

Chris* is a 63 year old with a past medical history of Asthma, Hypertension, and COPD. Identified via discharge planning from the Discharge Hub in Victoria Hospital, Kirkcaldy as had 7 admissions to an acute setting between July 2017 and November 2017. Chris lived with his wife and was housebound and had become unable to mobilise in the home. Chris had been previously been self-employed and his wife worked with the business as well so there were significant financial stresses. Care needs were met by the spouse and they were both impacted by the patient’s significant anxiety, dyspnoea and inability to recover his breathing pattern. Chris had significant weight loss in last few months and now weighed 46kgs. Occupational Therapy and Pulmonary Rehabilitation services were already involved at this point.

Actions from involvement with HHG included:
- Medication review (included reducing paracetamol dose for weight)
- Inhaler review (was unable to activate the device that they had)
- Dyspnoea management (including fan therapy, opioid therapy, and pacing)
- Carer Stress managed via support from carers centre and homecare support
- Anxiety management
- Personal care supported by START (double carers)

Positive outcomes from the intervention has resulted in no new unplanned admissions.

*Anonymised.
Improvements in Prescribing

National outcome

The NHS Fife Medicines Efficiency programme, led by the pharmacy service, has delivered £6M medicines efficiencies in the Fife Health and Social Care Partnership and £1.9M efficiencies in the Acute Division, NHS Fife, during 2017-18. This has seen Fife move to the 5th lowest cost per patient for GP prescribing in Scotland, and moving closer to Scottish average.

The programme has delivered the following specific outcomes:

1. Improvements in safe, quality and cost effective prescribing;
2. Increase in compliance with the Fife formulary (list of medicines);
3. Increased use of patients’ own medicines in hospital to reduce medicines waste and ensure continuity of supply of medicines for patients;
4. Reduction in costs of dressings by using a different ordering system;
5. Reduction in medicines waste by empowering patients to order their own prescriptions (instead of community pharmacies ordering on their behalf);
6. Pharmacists undertaking medication reviews with patients to ensure that patients are having the best benefit from their medicines.
Celebrating Success in Fife

Investing in our people

In recognition of the commitment and contribution of social work staff across the Health and Social Care Partnership, in addition to celebrating the 50th Anniversary of the Social work (Scotland) Act, a celebration event was held at the Rothes Halls which accommodated around 200 staff members. With presentations from Scotland’s Chief Social Work Advisor, the Scottish Social Services Council (SSSC) workforce development team, cutting edge research around Professional Identity in social work from Maura Daly (Glasgow Caledonian University) and a Mindfulness session from Wendy Simpson (Health Psychologist, Playfield Institute), the day was a resounding success. A key highlight of the day was a drama presentation from the creative and talented Delivering Differently Theatre Group, who delivered key messages in relation to the importance of listening and taking time with people. The event was facilitated by Julie Paterson, Divisional General Manager, Fife wide, with recognition and thanks from Michael Kellet, Director Health and Social Care Partnership, with the Chief Social Work Officer for Fife, Dougie Dunlop, summing up the day. The event feedback from the delegates reflects the day was informative, interactive and insightful in relation to local and national challenges and developments.

“It has been a great morning and was really lovely to hear from all of the other services today. What is current in legislation, what is important or going to be important in the near future and to hear how great Fife is to work in.”

Delegate quote
Primary Care Emergency Services

In July 2017 Fife Primary Care Emergency Services (PCES) launched a new nurse training programme to support training experienced nurses at band 5 level to transition to autonomous band 6 Urgent Care Practitioners.

This involved academic study at Napier University and practice-based development with the support of nurse mentors at band 6 and ANP level; GPs were also involved in providing mentorship and support. There were agreed competencies to achieve in line with the knowledge and skills framework and clinical competencies.

The trainee Urgent Care Practitioners were supported through a staged approach moving from direct to indirect supervision and placements were undertaken in other specialities to support skills and knowledge development to the level required.

Both are expected to complete their training early in the summer and if successful will be expanded further.

This supports the nursing vision for 2030 and a great success for the service and is wholly due to the commitment of the trainees and the support of their mentors in guaranteeing the success of this programme.

Advanced Nurse Practitioners

In July 2017 over 3000 patients had to be dispersed from a GP Practice in Kirkcaldy to the majority of the other local GP Practices. Part of the measures to support increased workload of these GP Practices was to establish 2 Advanced Nurse Practitioners (ANPs) to specifically support the work load from the Care Homes in the area which have over 600 beds.

Two ANPs started in late January 2018 and worked closely with the Practices to establish the model of care. This is a completely new model for NHS Fife.

The ANPs have two main strands of work; the regular planned “proactive” ward rounds and the unplanned “reactive” on the day calls. The ANPs can and do undertake many of the clinical activities common to GPs including: diagnosis, examinations, medication changes, taking bloods samples and referral to hospital services which will provide practical, measurable support for the local GPs.
Fife Health and Social Care Partnership

Achievements

Care at Home Service

Fife Health and Social Care Partnership’s Care at Home service won the Success Through Innovation Award at this year’s Fife Business Awards.

Their submission told the story of the roll out of Totalmobile across Fife, where the use of cutting-edge technology led to real improvements in the scheduling of home care appointments.

All 900 home carers have been issued with smart phones and can now see their daily rotas and respond to real time changes.

Innovative Technology Solutions Winners
– Fife Business Awards for Totalmobile

Adult Services: Resources

Scottish Award for the joint work they carried out with the Deaf Communication Service and RNIB to provide screening for adults with a learning disability to identify issues related to hearing loss and provide appropriate advice or equipment to help address these.

Dental Service

• Dawn Adams, Clinical Director, was awarded an OBE for her services to dentistry in Scotland.
• Barry Corkey, Paediatric Specialist, was presented with a Scottish Health Award for Dentistry. The award not only recognised Barry’s front line care, but also the efforts of all staff involved in Fife’s paedodontic dental service.
Queens Nurses

We are very proud that Gemma MacDonald, Health Visitor, graduated as a Queen’s Nurse in December 2017 as part of the refreshed Queen’s Nurse Programme. In 2018 an additional three Fife nurses have been selected to take part in this special professional development programme that will earn them the right to use the coveted Queen’s Nurse title. The Queen’s Nursing Institute Scotland (QNIS) was established by Queen Victoria in 1889 in honour of her Golden Jubilee. Historically, the Queen’s Nurse title was awarded to nurses who completed training that equipped them to work in the community. They provided healthcare and health promotion to people in their own homes, and were well respected in the communities in which they practised.

- Polly Buchanan, Dermatology Nurse Specialist based in West Fife
- Lyndsey Forsyth, ADHD Nurse Specialist based in Kirkcaldy.
- Gerrard Hastie, Community Psychiatric Nurse based in Leven.

They make up three of the twenty-one community-based nurses from across the country selected by the QNIS to join this year’s Queen’s Nurse Development Programme. The new Queen’s Nurses will take part in a nine-month programme, developing and honing their existing skills and capabilities, culminating in an Awards Ceremony in December. Once they have completed the QNIS development programme, the modern Queen’s Nurses will support new models of care to promote health improvement and local delivery of services.
Inspection of Services

Inspection of Social Care Providers
Care Inspectorate 2017-18

All registered Social Care services undergo inspection from the Care Inspectorate. 22 Fife Health & Social Care Partnership registered services were inspected in 2017-18. For both Adults and Older People, all 22 services inspected scored 4 or higher against this indicator.

For all registered adult social care services (including Older People) within the Fife Health and Social Care Partnership, including those delivered by the voluntary and Independent Sector, 127 Care Inspectorate inspections were carried out with 92% graded ‘good’ (4) or above in Care Inspection grades.

Overall scoring for Internal Fife H&SC Services from Care Inspectorate gradings 2017/18

- Grade 1: Unsatisfactory
- Grade 2: Weak
- Grade 3: Adequate
- Grade 4: Good
- Grade 5: Very Good
- Grade 6: Excellent

Overall grading awarded for all services inspected 2017/18

- Grade 1: Unsatisfactory
- Grade 2: Weak
- Grade 3: Adequate
- Grade 4: Good
- Grade 5: Very Good
- Grade 6: Excellent

For more information visit www.fifehealthandsocialcare.org
Financial Performance & Best Value

Revenue Expenditure 2017-18

The provisional 2017-18 outturn position is an £8.841m deficit prior to external annual audit sign off. The Partnership at inception had a challenging financial position with a £15m budget gap and the first full year of operating out turning a deficit of £9.263m in 2016-17. 2017-18 sees an improved position on 2016-17 with a reduced deficit outturn. The partnership implemented a savings plan of £16.9m and delivering £13.05m. £3.1m of the savings target was against the community redesign project which has been rolled into 2018-19. This is being taken forward as part of a large transformation programme - Joining Up Care.

The key contributors to the out-turn deficit was:

- The community redesign project roll forward into 2018-19 (£3.1m);
- The prescribing overspend of (£3.517m) despite £6m of efficiency savings being made in year - the overspend reflects the price impact of a national shortage in supply of some medicines, resulting in significant price increases of commonly prescribed medicines for which there is no suitable cost-effective alternative. Further detail is provided below
- Overspends in Social Care on adult packages and homecare as demand rises (£2.168m)

Financial position for 2017-18

Spend across the Health and Social Care Partnership in 2017-18 is represented below:

<table>
<thead>
<tr>
<th>Delegated Services (as at 31 March 2018)</th>
<th>Budget £m</th>
<th>Provisional Outturn £m</th>
<th>Variance £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Services</td>
<td>93.001</td>
<td>92.237</td>
<td>(0.764)</td>
</tr>
<tr>
<td>Hospitals and Long Term Care</td>
<td>49.256</td>
<td>54.510</td>
<td>5.254</td>
</tr>
<tr>
<td>GP Prescribing</td>
<td>72.227</td>
<td>75.744</td>
<td>3.517</td>
</tr>
<tr>
<td>Family Health Services</td>
<td>86.641</td>
<td>86.627</td>
<td>(0.014)</td>
</tr>
<tr>
<td>Children’s Services</td>
<td>15.035</td>
<td>13.715</td>
<td>(1.320)</td>
</tr>
<tr>
<td>Social Care</td>
<td>193.333</td>
<td>195.501</td>
<td>2.168</td>
</tr>
<tr>
<td>Housing</td>
<td>2.078</td>
<td>2.078</td>
<td>0.000</td>
</tr>
<tr>
<td><strong>Total Health &amp; Social Care</strong></td>
<td><strong>511.571</strong></td>
<td><strong>520.412</strong></td>
<td><strong>8.841</strong></td>
</tr>
</tbody>
</table>
### Community Healthcare

£0.764m underspend

This mainly relates to a delay in achieving savings targets and the cost of complex care packages in the community which is more than 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

£5.254 overspend

The provisional overspend within hospital services of £5.254m relates to roll forward of the Community Redesign project £3.1m as detailed above, the additional cost of complex care patients, along with the use of bank and agency nursing to provide safe staffing levels. There is a significant shortage of medical staffing due to recruitment difficulties within Mental Health and Older People services. This has resulted in high level usage of medical locum cover at significant cost.

### GP Prescribing and Family Health Services

£3.503M overspend

The majority of the overspend £3.517m reflects the price impact of a national shortage in supply of some medicines, resulting in significant price increases of commonly prescribed medicines for which there is no suitable cost-effective alternative. This is a budget issue being seen across Scotland.

### Children’s Services

£1.320 underspend

The Children’s Service shows a provisional underspend of £1.320m, comprising a number of over and underspends in Children’s services overall. The underspend is predominantly due to vacancies within Health Visiting/School Nursing as a direct result of difficulty in recruiting to Health Visiting posts (this is a national issue). School Nursing vacancies are under recruitment. The Children and Young Persons District Nursing Service (CYPDNS) is overspent due in the main to high cost emergency placement. The service also now has 1:1 overnight nursing need to address for child a discharged from Sick Kids.
Social Care

The draft outturn overspend position of £1.940m, is predominately due to client demand and complexity of care. There are overspends on home care primarily due to demand for care packages. Within the Older People fieldwork teams, purchased care has an overspend due to growth in the use of Self Directed Support (SDS) payments. There are overspends on adult placements due to increasing demand. Within the Adult Fieldwork teams continuing increased demand has resulted in overspends on respite and client transport.

The projected overspends are partly offset by underspends on Supported Living mostly due to staff vacancies and Local Authority Homes due to reduced employee costs and increased income. There are also underspends on Older People nursing and residential placements and intermediate care.

Housing Services

Spend on housing delegated to the Health and Social Care Partnership outturned on budget. Housing provided an additional £400k in budget in year increasing the budget from £1.7m to £2.1m.

Financial outlook

It is important that expenditure is managed within the financial resources available. There are significant challenges for the Health and Social Care Partnership to achieve this. The funding for the Health and Social Care Partnership in 2018-19 does not meet the budget required to deliver services and the approved budget by the IJB has a budget gap of £5.2m agreed to be funded by both partners based on the risk share agreement. The agreement is predicated on the partnership implementing a robust 3 year financial strategy in 2018-19 to deliver long-term financial sustainability. The most significant risks faced by the Health and Social Care Partnership’s Board over the medium to longer term can be summarised as follows:

- the wider financial environment, which continues to be challenging;
- the increased demand for services alongside reducing resources;
- the impact of demographic changes and the ageing population;
- 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;
- the ability to recruit permanent staffing across the service – impacting on increased use of locums and agency at a higher cost.

It is therefore crucial that we focus on early intervention and prevention if we are to work within the total Partnership budget. Moving into 2018-19, 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 Health and Social Care 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 Health and Social Care Partnership services and senior representation from NHS Fife and Fife Council.

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

- Joined Up care transformation programme;
- Mental Health H Redesign;
- Extension of START programme;
- Home Care Redesign;
- Winter Planning;
- Assessment Uunit bed model.

Financial reporting on Localities

The 2017-18 financial information is not split into localities as this level of financial reporting will be developed during 2018-19.
Moving forward

As we move into the last year of the Strategic Plan for Fife, we recognised that the landscape continues to change with redesign being a key priority both now and in the future years ahead.

Joining Up Care

The Partnership are currently consulting on “Joining Up Care in Fife” which will run from 2 July until 8 October 2018. To help us decide what will work best here in Fife, proposals have been produced about a new way of delivering services. In three parts the consultation covers:

1. Community Health and Wellbeing Hubs: a more joined up approach to your care
2. Out of Hours Urgent Care Redesign: a more sustainable way of responding out of hours.
3. Community Hospital and Intermediate Care Bed Redesign: helping people stay independent for longer and avoid hospital admissions.

The outcome of the consultation will be known in later this year.

Localities

We continue to develop the locality planning work across Fife, with future plans to roll out “The Well” across Fife, along with the priorities that support the prevention and early intervention agenda.

New Care Homes

We continue to replace care homes across Fife, in Levenmouth, Cupar and Anstruther. This will ensure that the care facilities across Fife will be fit for the future. Three 36 bed care homes will be completed by 2022.

Mental Health Redesign

The Mental Health Strategic Implementation Group will continue to provide the framework for planning and delivery of cohesive, responsive, quality mental health services. This will be informed by the ‘taking stock’ event held in May 2018, the purpose of which was to ensure that all stakeholders are informed of progress and to provide an opportunity to sense-check priorities in Fife.
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 Third 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** - Integration 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** - Supporting activities in daily living such as being able to get in and out of bed, prepare a meal, bathe, and 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.

**Telehealth 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.
Appendix 1  
National Indicators

*Please note National Indicators 1 – 9 are reported Bi-annually. Figures for indicators 10, 21, 22 and 23 are not currently available

<table>
<thead>
<tr>
<th>National Indicator</th>
<th>Fife 2015/16</th>
<th>Fife 2017/18</th>
<th>Fife diff from 15/16</th>
<th>Scotland 2015/16</th>
<th>Scotland 2017/18</th>
<th>Fife 17/18 diff from Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Percentage of adults able to look after their health very well or quite well</td>
<td>94%</td>
<td>94%</td>
<td>No diff</td>
<td>95%</td>
<td>93%</td>
<td>↑ 1%</td>
</tr>
<tr>
<td>2 I was supported to live as independently as possible</td>
<td>80%</td>
<td>82%</td>
<td>↑ 2%</td>
<td>83%</td>
<td>81%</td>
<td>↑ 1%</td>
</tr>
<tr>
<td>3 I had a say in how my help, care or support was provided</td>
<td>76%</td>
<td>74%</td>
<td>↓ 2%</td>
<td>79%</td>
<td>76%</td>
<td>↓ 2%</td>
</tr>
<tr>
<td>4 My health, support and care services seemed to be well coordinated</td>
<td>72%</td>
<td>75%</td>
<td>↑ 3%</td>
<td>75%</td>
<td>74%</td>
<td>↑ 1%</td>
</tr>
<tr>
<td>5 Overall, how would you rate your help, care or support services? Please exclude the care and help you get from friends and family.</td>
<td>78%</td>
<td>81%</td>
<td>↑ 3%</td>
<td>81%</td>
<td>80%</td>
<td>↑ 1%</td>
</tr>
<tr>
<td>6 The care provided by your GP practice?</td>
<td>83%</td>
<td>81%</td>
<td>↓ 2%</td>
<td>85%</td>
<td>83%</td>
<td>↓ 2%</td>
</tr>
<tr>
<td>7 The help, care or support improved or maintained my quality of life</td>
<td>84%</td>
<td>80%</td>
<td>↓ 4%</td>
<td>83%</td>
<td>80%</td>
<td>No diff</td>
</tr>
<tr>
<td>8 I feel supported to continue caring</td>
<td>39%</td>
<td>32%</td>
<td>↓ 7%</td>
<td>40%</td>
<td>37%</td>
<td>↓ 5%</td>
</tr>
<tr>
<td>9 I felt safe</td>
<td>82%</td>
<td>84%</td>
<td>↑ 2%</td>
<td>83%</td>
<td>83%</td>
<td>↑ 1%</td>
</tr>
<tr>
<td>National Indicator</td>
<td>Fife 2015/16</td>
<td>Fife 2017/18</td>
<td>Fife diff from 15/16</td>
<td>Scotland 2015/16</td>
<td>Scotland 2017/18</td>
<td>Fife 17/18 diff from Scotland</td>
</tr>
<tr>
<td>-------------------</td>
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<td>--------------</td>
<td>----------------------</td>
<td>------------------</td>
<td>------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>11 Premature mortality rate per 100,000 persons; by calendar year*</td>
<td>432</td>
<td>427</td>
<td>↓ 5.20</td>
<td>440</td>
<td>425</td>
<td>↑ 1.60</td>
</tr>
<tr>
<td>12 Emergency admission rate per 100,000 persons</td>
<td>12,727</td>
<td>13,152</td>
<td>↑ 424</td>
<td>12,297</td>
<td>11,959</td>
<td>↑ 1,193</td>
</tr>
<tr>
<td>13 Emergency bed day rate per 100,000 persons</td>
<td>123,757</td>
<td>118,628</td>
<td>↓ 5,129</td>
<td>126,302</td>
<td>115,518</td>
<td>↑ 3,110</td>
</tr>
<tr>
<td>14 Readmission to hospital within 28 days per 1,000 admissions</td>
<td>109</td>
<td>119</td>
<td>↑ 9.76</td>
<td>100</td>
<td>97</td>
<td>↓ 21.83</td>
</tr>
<tr>
<td>15 Proportion of last 6 months of life spent at home or in a community setting</td>
<td>87.50%</td>
<td>89.07%</td>
<td>↑ 1.57%</td>
<td>87.14%</td>
<td>88.26%</td>
<td>↑ 0.81%</td>
</tr>
<tr>
<td>16 Falls rate per 1,000 population aged 65+</td>
<td>24</td>
<td>25</td>
<td>↑ 0.94</td>
<td>21</td>
<td>22</td>
<td>↑ 3.11</td>
</tr>
<tr>
<td>17 Proportion of care services graded ‘good’ (4) or better in Care Inspectorate inspections</td>
<td>80%</td>
<td>89%</td>
<td>↑ 9.43%</td>
<td>84%</td>
<td>85%</td>
<td>↑ 3.55%</td>
</tr>
<tr>
<td>18 Percentage of adults with intensive care needs receiving care at home</td>
<td>50%</td>
<td>n/a**</td>
<td>n/a</td>
<td>61%</td>
<td>n/a**</td>
<td>n/a</td>
</tr>
<tr>
<td>19 Number of days people aged 75+ spend in hospital when they are ready to be discharged, per 1,000 population</td>
<td>779</td>
<td>623</td>
<td>↓ 157</td>
<td>842</td>
<td>772</td>
<td>↓ 149</td>
</tr>
<tr>
<td>20 Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency</td>
<td>26%</td>
<td>25%</td>
<td>↓ 0.90%</td>
<td>25%</td>
<td>23%</td>
<td>↓ 1.88%</td>
</tr>
</tbody>
</table>

* Data is published by NRS by calendar year - 2014 = 2014/15, 2015 = 2015/16...etc  
** Data is published by Census from Scottish Government - data not available yet
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