www.fifehealthandsocialcare.org

Fife Health & Social Care Partnership

Annual Report 2018-19

NHS Fife

Supporting the people of Fife together

Fife Council

Contents

A message from our Chair

Rosemary Liewald
Chair, Fife Health & Social Care Partnership Board

This year has been one of the busiest years in Fife for the Health & Social Care Partnership. We have seen one of the largest and most detailed public consultations of the health and care of the people of Fife that has ever been undertaken. The overall aim of the Joining-Up Care consultation has been to listen to your views, your opinions and establish a fully integrated 24/7 community health and social care system that ensures sustainable, safe, person-centred care for every citizen in Fife. By introducing this new approach, we're confident we will identify and support people earlier, put services in place that can respond day and night so you don't always need to go to hospital, help local professionals share appropriate information more easily and safely, while making the best use of local skills, knowledge and experience this will allow us to link people with local support networks and services such as befrienders.

This will reduce waiting times, frustration, and duplication. We want services to come together, locally, to match support to people's needs. At present, people are often referred to a number of services. We want to use local information to help identify needs sooner, to improve people's health and wellbeing. At present, people often access services too late. We want to focus on what matters to people when we organise support and communication for them. At present, people often feel that their care is not co-ordinated, and services repeat the same questions.

Easily accessible, seamless, quality services that are personalised and responsive to the changing needs of individuals, designed with and for the people of Fife. This is what you told us you want, and we are delivering this by working with people in their own communities, using our collective resources wisely. We are transforming how we provide services to ensure these are safe, timely, effective and high quality and based on achieving personal outcomes. The values we aim to work within are person-focused and embedded with integrity, care, respect and exclusivity

Foreword

I'm pleased to introduce our third Annual Performance Report. Fife's Health & Social Care Partnership has 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 over the last year and what our priorities are for the future. We focus on the work our staff do day to day to support the health and wellbeing of everyone across Fife. However, we also focus on how we are improving and redesigning those services. We need to do both to tackle inequalities and remain sustainable. I'm particularly proud of the work we have done this year – working with communities and organisations across Fife – to ensure Fife is Dementia Friendly. We've also made important progress on redesigning Out of Hours GP services. The work we are doing with Macmillan on Improving the Cancer Journey for those diagnosed with cancer is also important and innovative. We are ensuring that we support the whole person – emotionally and financially as well as medically.

There are many other successes too – including effective prescribing and implementation of the new GP contract – but there is still much to be done. With a budget of around £0.5bn, a proven history of partnership working and strong connections with communities, we are determined to support the health and wellbeing of the people of Fife that we serve.

Michael Kellet
Director, Fife Health & Social Care Partnership

Introduction & Background

Welcome to the third annual report from Fife Health & Social Care Partnership. Our Strategic Plan for health and social care (Strategic Plan 2016- 2019) was first published in 2016. In this plan we indicated several 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 significant challenges we have an opportunity to consider changes to services that will:

- Change the way we deliver services;
- Change to achieve better outcomes for people; and
- Change the way we commission services

Since our last annual report, we have made progress in a number of areas, where we 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 change in Fife's population

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 people aged 75 and over.

2016

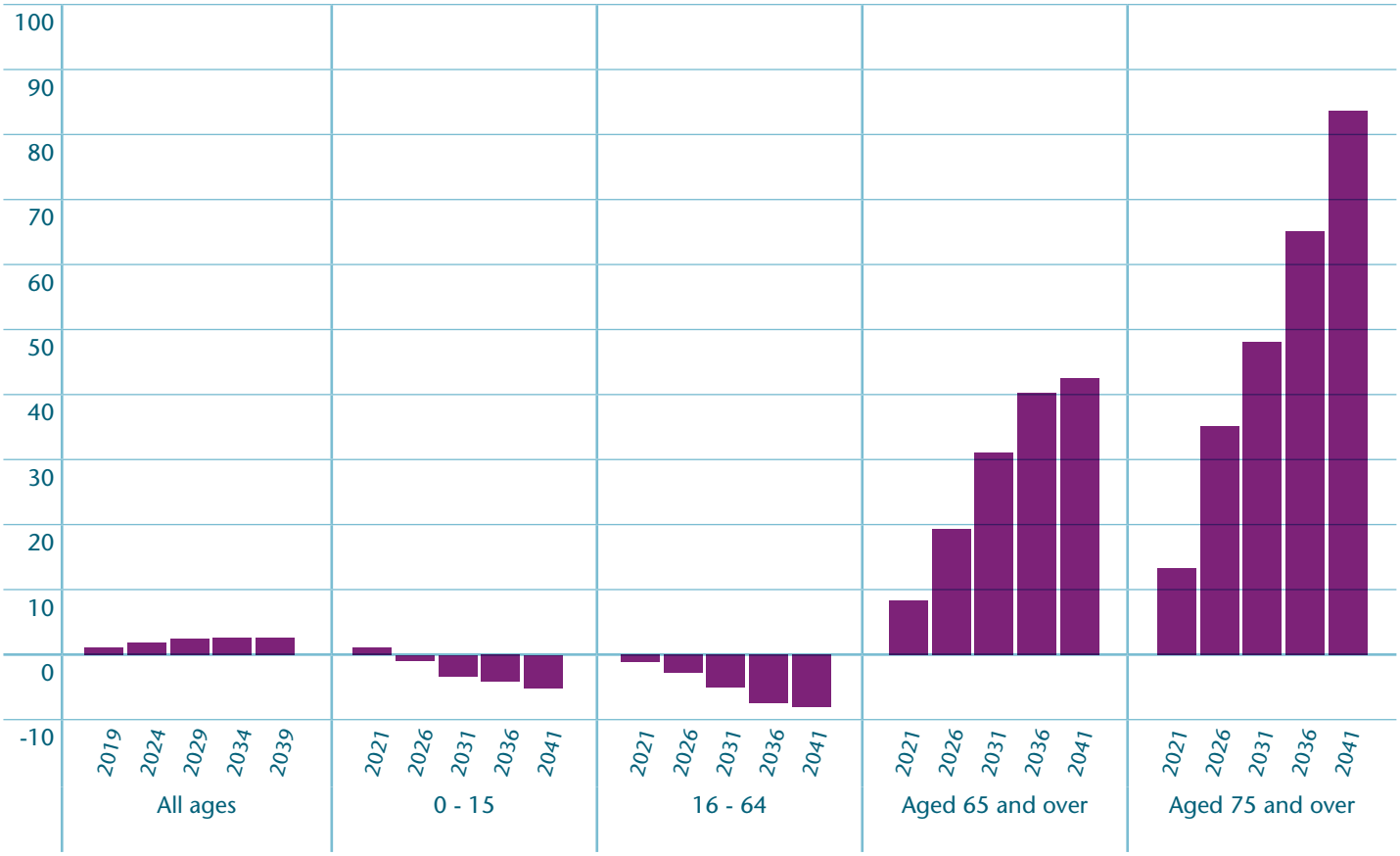
370,330 people

	2016	2041	
0-15	64,372	61,076	-5%
16-64	232,300	213,758	-8%
65+	73,658	104,956	+42%
75+	31,543	57,895	+84%

2041

379,788 people

Projected percentage change in population by age group until 2041



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 Co-ordinated Care, Improving Mental Health Services and Reducing Inequalities link directly to the nine National Health and Social Care Health and Well-being Outcomes (below). These provide the 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 & Social Care Partnership's performance and progress against these outcomes and our strategic commissioning intentions. The indicators we can report on are presented in Appendix 1.

Please note there are a few of the 23 indicators not available for 2018-19 period owing to the way in which these are collected, verified and released. The data reported are against core indicators and are for the period the most recent data is available. Some indicators may be provisional and subject to change.

Strategic Plan – Theme 1
Prevention and Early Intervention

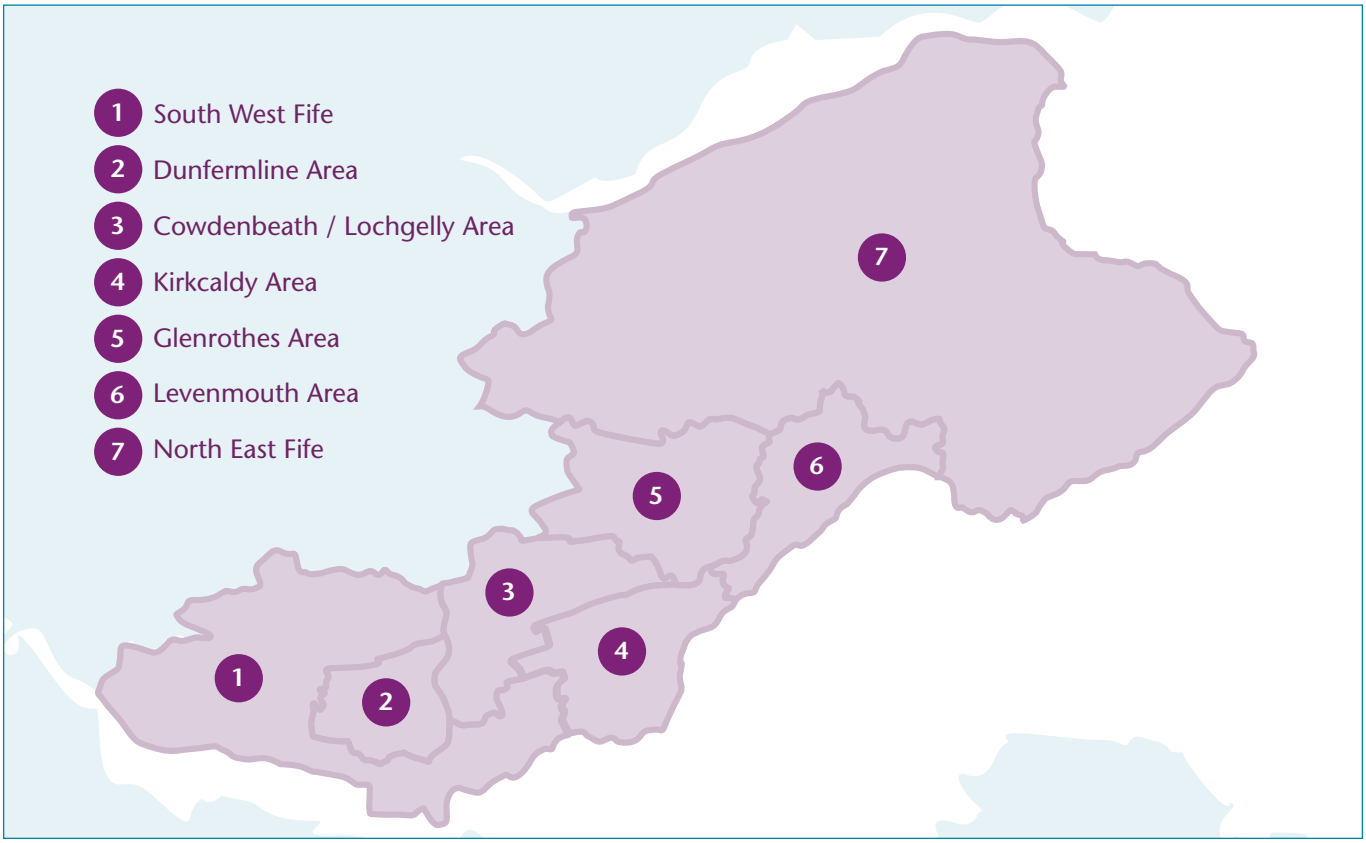
Strategic Plan Aim

- Work with stakeholders to improve access to information, advice and support to enable people and their carers to lead healthier lifestyles 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 our partners through Integrated Health and Social Care arrangements to tackle the challenges in respect of health and wellbeing across seven localities in Fife.



Fife Health & Social Care – Locality Planning Core Groups

Our seven Health and Social Care Locality Planning Core Groups are now established. The Core Groups mirror the existing GP Cluster, Area Committees and Local Community Planning areas of Fife.

The Core Groups will plan, take action at a local level and aim to improve people's health and wellbeing outcomes as a result.

The Core Groups meet 4 times per year. All seven areas have met for their first meeting of 2019 and are developing and getting to know each other as a group. The Core Group is responsible for ensuring that the agreed priority actions identified by the Health and Social Care Wider Stakeholder events are delivered for their area.

The agreed priority plans are available on the www.fifehealthandsocialcare.org/publications page or on each locality page within the www.fifehealthandsocialcare.org/your-community pages and the Core Groups are now planning on linking back with their Wider Stakeholder Groups to feedback on progress to date.

Fife Wide Priorities

Our local community Wells are connecting local people with local support and we now have seven Wells up and running in each of our seven localities. By working in partnership with our local communities and partners across Fife, we are building and supporting individual and community capacity, cohesion and resilience by changing from a service delivery approach that can only help people once they are in crisis, to a model where people are supported earlier to focus on the outcomes important to them and the promotion of wellbeing.

During 2018-19, we continued to work with the National Development Team for Inclusion Community Led Support Programme (NDTI CLS) to develop and embed the Wells Fife-wide across our seven locality planning areas.

Our partnership between social work, housing and the third sector, as equal partners, and with each local community, designs and delivers support through the Well, tailored to meet the needs that local people and staff have said are valuable to them in each area, but with some common principles that govern the work.

Evidence is emerging that this innovative and genuine partnership is supporting local people earlier. It has also improved staff morale, joined up working and understanding of each other's roles.

THE WELL

"I am Pauline and I am a carer for my adult son. I have been supporting and working as a carer representative with local staff in my community to help design a Well which suits my local community. For me, as volunteer and carer I believe the Wells give the community an informal place to chat with a range of people in one place, people who have the knowledge and expertise, where we can chat openly and in a relaxed manner. I work alongside staff in the Wells to support other people who are carers and struggle to know who to turn to for information and support. With the support of staff, I have helped other carers to access the right information and support. Seeing the relief on the lady's face when she realised she was not alone out there gave me the most rewarding feeling as being able to help even one person is one less person struggling".

Pauline Gear, Well Volunteer and Carer Representative

Meal Makers comes to Fife

Meal Makers is a community food sharing project delivered by Food Train, a national voluntary organisation supporting older people to live independently at home. Meal Makers uses a digital platform to connect volunteers (cooks) of any age who have a passion for cooking and want to be active in their communities, with older neighbours (diners) over the age of 55 who would benefit from the provision of home cooked meals and company.

The project aims to reduce food poverty and malnutrition, improve diets and combat social isolation by breaking down the barriers that lead to loneliness. By turning an everyday activity into a volunteering opportunity, Meal Makers strengthens connections within communities and provides a flexible way for people to volunteer their time and skills locally in a way that suits them.

We have listened to our communities across Fife and the Food Train will now be working with Fife Health & Social Care Partnership to roll out Meal Makers Fife-wide.

Involving Carers in Locality Planning

Fife has seven localities and we are supporting carers to be actively involved in discussions at these localities. This includes taking a place on the locality planning core groups. In order to make sure this is successful, we have asked Fife Voluntary Action to support carers on these groups. This independent support includes specific training to become involved in an effective way, as well as ongoing support to participate. We continue to look for carers who want to take a role on their Locality Planning Core Group.

The Warrior Academy for Rehabilitation - WAR

WAR is a local fitness based mental health charity for veterans to improve their physical health and wellbeing developed by Ben Donnachie, based on his personal veteran experience, trauma experienced on tour and his journey back into civilian life. WAR is funded by First Port.

Local veterans from both the British Forces as well as the emergency services who are suffering from debilitating issues such as post-traumatic stress, traumatic brain injury and in future, limbless veterans, can be referred to WAR and attend a 6-month fitness programme, along with receiving support from existing psychological services. Upon completion of the 6-month programme, veterans will have the option to then take part in the various competitions and events being run from CrossFit Regionals, Invictus Games, bodybuilding shows and powerlifting.

Once this is complete veterans will be offered the chance to retrain as a personal trainer and continue running classes for other veterans as well as the public.

Ben approached the Locality Planning team to discuss his idea to support other veterans with their physical and mental wellbeing after leaving duty. We thought this was a great idea and because the partnership supports veterans, we wanted to help Ben to develop this initiative further. We linked Ben to other partners within Fife, Fife Fire & Rescue Service, BRAG and Fife Voluntary Action. Ben has been working hard to develop his business plan and is now ready to form his Board of Directors and run his first test of change programme.

"Without the help from the Locality Planning Team, Health & Social Care Partnership, BRAG and other sectors from across the board, none of this would be possible. Although I am starting this programme alone, there is room for many groups to be involved."

Ben is keen to hear from any veterans who may benefit from this program.

Further information can be found at https://www.thewar.org.uk/

Facebook: @WarriorAcademyforRehabilitation.

Fife Sports and Leisure Trust

Fife Sports & Leisure Trust (FSLT) are passionate about working with local communities and partners to create opportunities for everyone to become active, stay active and live well. FSLT and Fife Health & Social Care Partnership are working closely with GPs in the Cowdenbeath, Lochgelly and Leven areas to promote physical activity opportunities for local people. FSLT will provide the GP's with information on how to signpost their patients to their local leisure centre and will also be able to offer free activity passes for them to issue to patients who would like an opportunity to get more active.

Magic Moments Coffee Club

Fife Health & Social Care Partnership in partnership with Alzheimer Scotland are delighted to launch Magic Moments Coffee Club, a social group for people living with dementia or memory problems in the Kirkcaldy area. This is a drop-in coffee club being held every Thursday 10am-12noon at the Stance Café, Kirkcaldy Bus Station.

Community Groups are there to be enjoyed by anyone living with dementia or experiencing difficulties with their memory, including their families and friends. All are welcome: people who can attend independently and/or for those unable to do so should come with a companion who can provide any support for them.

Health and Wellbeing in Pregnancy

… working with pregnant women and new mums to find out what is important to them!

There is a clear link between a baby's health and their mother's health during pregnancy. Healthy women are more likely to have healthy babies who grow into healthy children. Some women may feel more vulnerable during pregnancy and experience a range of concerns about their health at this time.

Exciting new work is being carried out in Levenmouth to find out what is important to mums before during and after birth.

To truly understand their concerns Health Promotion will be consulting with pregnant women and recent mothers to gather their thoughts, feelings and identify what gaps the mums feel there are for them. Exploring what information mums need, want and have at hand and what sources of advice they value to improve their health.

We are keen to find out what factors contribute to pregnant women not accessing the support available and to look at ways to make information and advice easier to access in their local community.

Mindfulness Project

Levenmouth has been leading the way in new ways to manage mental health problems. Since August 2018, patients with mild to moderate anxiety and depression have been offered sessions to be taught mindfulness techniques. This is a pilot project funded from NHS Fife's Patient Endowment Fund.

The project is sponsored by the Endowment Fund for one year, to offer up to 40 people the chance to self-manage their mental health problems. Each client is offered 8 sessions with a trained mindfulness nurse, Tracey Whitton, and a trainee, Fiona Shaw, where they are taken through the techniques. So far 20 people have taken part and there are 2 further courses to run before the end of the year. Initial evaluation is positive with mental health significantly improving at the end of the course and sustained at the 3 month follow up.

Feedback from the clients has been extremely positive, some evaluating it as 'life changing'. It is hoped that after learning the techniques, many will be able to stop antidepressant medication and self-manage their condition.

Abigail's Story…

Abigail is a young adult from St Andrews who volunteers at NEF Community Hub. Through a chance encounter with the Health & Social Care Locality Planning team and a discussion about The Well due to open in St Andrews, Abigail shared that she had always had a passion and interest in becoming a general practitioner.

So what is the best way to find out if this is something you want to pursue further? By heading to Airlie Medical Practice in Methil and having the opportunity to shadow a GP and staff in their surgery setting for the day.

Abigail had a unique opportunity to gain first-hand knowledge of what a day in the life of a GP was like and during her day was involved in sitting on our busy reception area seeing the requests from patients as soon as the doors open! Therefore, having a proper view of the patient's journey from making the appointment to attending and then leaving.

We actively encourage young people into Primary Care. As a practice we are very much involved in providing day release to students from St Andrews University and have encouraged other students to come in day release from school to see what a day in the life of a GP entails. Airlie Medical Practice is always looking at ways to encourage young people to look at a future career within general practice and as such giving young people like Abigail the opportunity to see exactly what it's like. It is very exciting and rewarding to know we are part or have been part of the future generation of GPs.

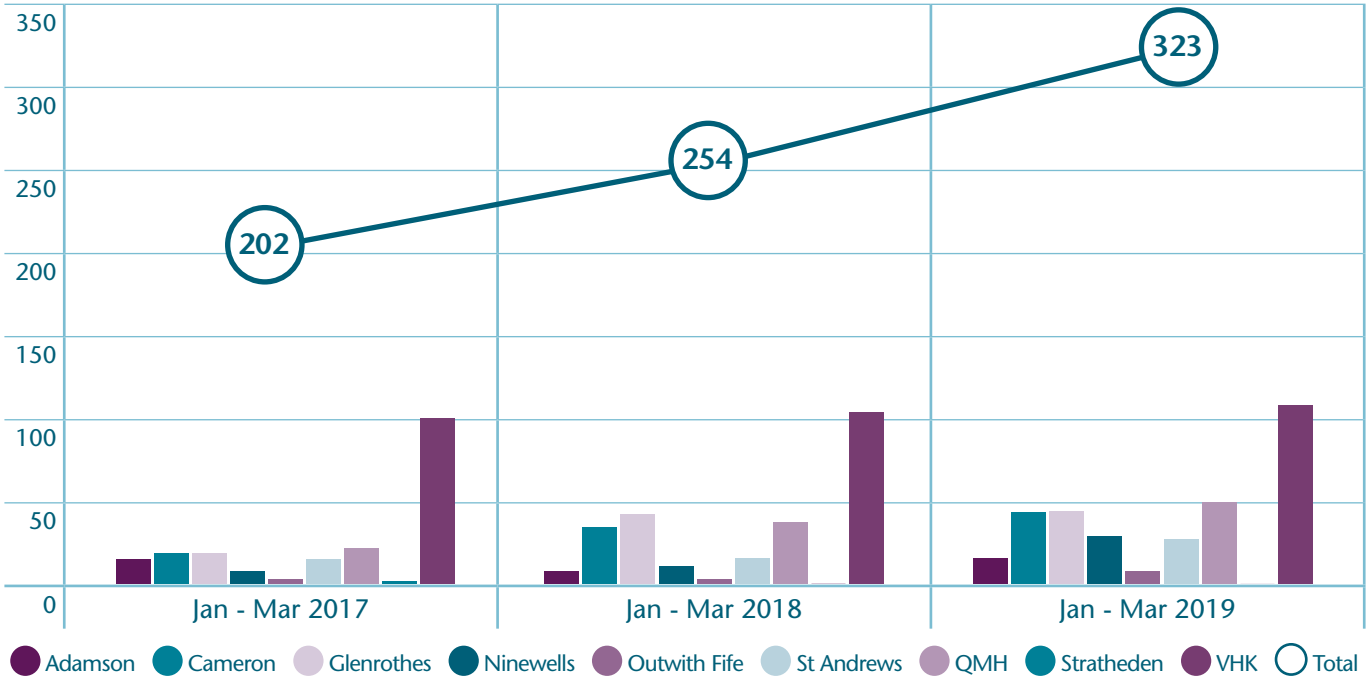
Abigail found the experience beneficial and has now applied for a scheme (Medic Insight), which takes place over the summer at Ninewells Hospital, giving her the opportunity to shadow various specialities over the period of one week. She is awaiting a reply to see if she has been accepted.

Short Term Assessment and Reablement Team (START)

National outcomes 1 2 3 4 9

The Short-Term Assessment and Review Team (START) is provided by the Health & Social Care Partnership's Care at Home Service. 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. Referrals from hospital continues to rise.

Figure 1 - Referrals by Month/Year



The service also takes referrals for people in crisis at home and other models of care to deliver the right care, at the right time, in the right place.

In 2018-19 the START service continued to grow. The number of people who received a START service was 1,115 compared to 942 from the previous year.

- 776 people required an ongoing service after enablement;
- 35.1% of service users had a reduction to their care following their START service;
- 3.4% of service users required an increase to their service; and
- the average hours at the commencement of the service was 10.25 hours per week and by the end of their START service, this reduced to 5.25 hours per week, a reduction of 51%.

Over the coming year, Fife Health & Social Care Partnership will recruit more Enablement Support Workers to grow this service and will continue to monitor 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

Community Assessment Beds support individuals to leave hospital, to continue their care and assessment out of hospital, where it is anticipated they may require residential or nursing home placement.

In 2018-19, the community assessment bed model continued to be developed and more services were made available. At the start of 2018, there were 48 placements available within 8 care homes and by the end of March 2019 the available placements had increased slightly to 51 and was available within 9 independent sector care homes.

In 2018-19, 243 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 slightly, 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 & Social Care Partnership is looking at options and is working 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 (STAR) 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 3 of the Partnership's care homes.

In 2018-19, 146 people accessed a STAR bed.

GP Direct Access to STAR Beds

A successful pilot has taken place in Napier House in Glenrothes, which was one of the agreed locality priorities, to support older people who may become ill and need care and support to get better and removes the need for an admission to hospital.

The aim of the project is to help people get well and regain the skills and confidence to live more independently in their local community and ensure a safe return home as soon as possible.

It is an integrated approach between the local GP's and linking them with the Short-Term Assessment and Review (STAR) Unit at Napier House, enabling people to continue to live in their own homes as independently as possible, preventing unnecessary admission to hospital or long-term care. The Health & Social Care Partnership are now looking at rolling out this pilot across some of their other GP practices across Fife.

Other developments for STAR beds

Towards the end of 2018-19, a test of change commenced at Lindsay House in Lumphinnans to provide direct referral to a geriatrician. Part of this test of change included a joint medication review with the geriatrician, pharmacist and pharmacy technician to optimise the residents' medication. This has proved beneficial for individuals and the sustainability of this model through the health and wellbeing hub is being explored.

The Health & Social Care Partnership is looking at additional STAR beds in the west of Fife as part of the community hospital re-design.

Improving Services for people living with Dementia

National outcomes 1 3 5 9

During 2018-19 we have invested in developing a range of support services for people with dementia and their carers through Dementia Investment Monies. This has been done in partnership with the Third Sector, Fife Sports & Leisure, Fife Cultural Trust, Shared Lives and Fife Carers Centre.

A full time Project Manager has been appointed for 2 years to roll out the development of Dementia Friendly Communities across Fife. A dementia friendly community is made up of the whole community; people who are committed to working together and helping people with dementia to remain a part of their community.

The project has aimed to deliver Glenrothes as the first Dementia Friendly Community in Fife. The objectives of the Dementia Friendly Glenrothes Project have been:

- To deliver a Dementia-Friendly community that will make it easier for people living with dementia to be understood, valued and continue to be able to contribute to their community.
- To support businesses and services in Glenrothes including shops, banks, leisure and cultural services (e.g. swimming pools, theatres, libraries) and transport providers to understand what they can do to assist their customers living with dementia.
- The creation of safe, public open spaces for people with dementia so that they can enjoy walking and other active leisure pursuits. Physical activity and access to safe open space is key to maintaining the health, wellbeing and social inclusion of people with dementia.

To date 150 businesses or services have achieved Dementia Friendly status and there are 4,500 registered Dementia Friends.

The Project is now in the process of working with people in Burntisland, Lochgelly, Ballingry, St Andrews, Cupar and Newburgh to take the same approach forward in these areas. It is anticipated that by the end of the Project all these villages, and hopefully many more, will have achieved Dementia Friendly status and be delivering dementia friendly activities. Through the engagement of local people who are taking ownership of this agenda in their local communities we hope to have rolled out Dementia Friendly Communities across Fife by October 2020.

Small Sparks

National outcomes 1 4

The Small Sparks 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

2018-19 saw another successful year for the project with 13 projects being supported, across all age ranges (see below for list of projects in Levenmouth). The celebration event was a vibrant success, with clear evidence of increasing confidence and community connections. A celebration event for the 13 Levenmouth Projects took place in October 2018. Some people spoke in public for the very first time which was a great achievement. The atmosphere was one of genuine support and encouragement.

Feedback from the project participants was very positive:

"Bringing people together. Companionship among people. Gets people out of their house and connecting with other people, and everyone here is doing a FANTASTIC job."

"Funding from small sparks inspires people in the community to try new things for the benefit of all and bring people together."

"That people appreciate community involvement and socialising more than an activity. It is the coming together that counts."

"Brilliant! Great to see the project come to life and the great work people have been doing. Excited for their future."

"Fantastic! The passion, enthusiasm and confidence was great to witness."

On Your Doorstep

National outcomes 1 5 6

During 2018-19, On Your Doorstep saw the addition of 135 new groups or organisations registered on the website. There were 5,291 users during the period, 86% of whom were return visitors, which evidences a year on year increase in both organisations and people seeking additional support in their local communities and confidence in the resource.

Online analytics indicates that On Your Doorstep is accessible and being used via various means, with 61% of people using a PC and 39% accessing the local information via mobile phone or tablet. In line with health and social care priorities, the top searches on the website includes mental health, care, befriending, dementia and autism in addition to social activities including dance, social, youth activities, music, art, and lunch clubs.

With On Your Doorstep information including a wide range of resources, people are seeking information in relation to Adults and Older People Eligibility Criteria, Self Directed Support leaflets, local groups, with a significant number accessing the self-directed support animation.

The 2018-19 On Your Doorstep information indicates that the site is increasingly been used positively, across age ranges and health conditions and searches are aligned with the priority areas within the Health & Social Care Partnership's Strategic Plan.

A refreshed publicity campaign is planned for 2019/20 to maintain the profile of the website across local communities and GP practices and to encourage new groups to register.

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.

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 to 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 manage delayed discharges so that patients can be cared for within their own home or a homelier setting. Several actions have contributed to the managing delayed discharges to improve hospital discharge and better support people to transfer from acute care to community and has included:

- further re-design and development of our care at home model;
- better links with the Acute Hospital and the Health & Social Care Partnership;
- collaborative working with the Third Sector including earlier direct support for carers, veterans and homeless individuals; and
- continued robust performance management of delays.

2018-19 has been a challenging year due to several factors, including capacity within care at home services and access to intermediate care services. There has been an increase in delayed discharges and associated bed days lost for health and social care reasons, rising to 3,033 (March 2019) from 1,227 (April 2018).

Figure 2 - Average number of beds occupied per day

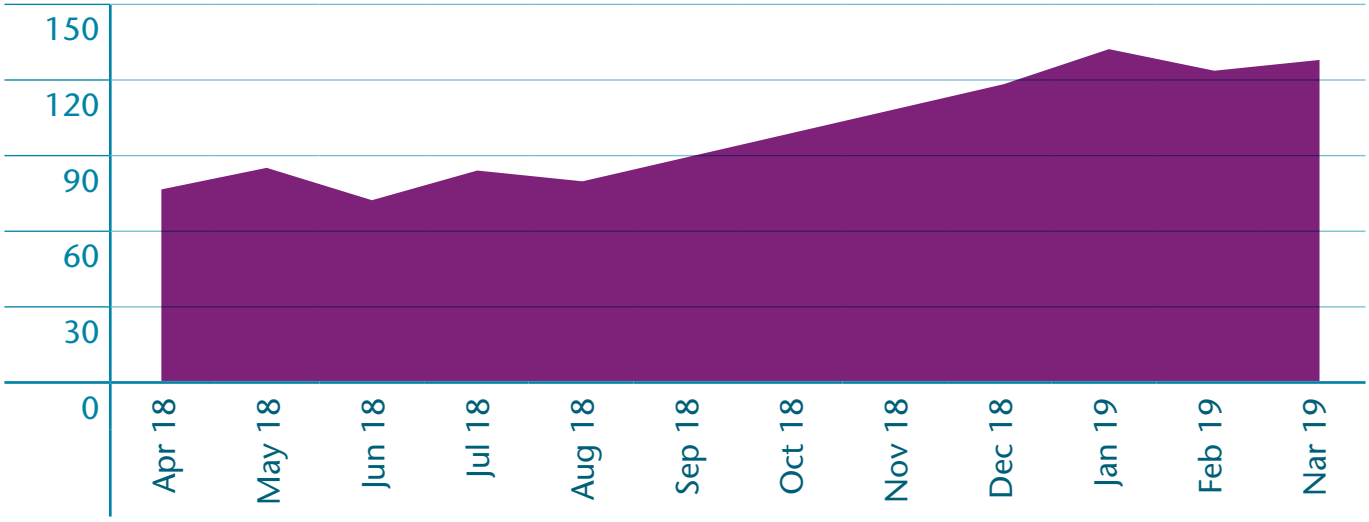


Figure 3 - Total number of bed days occupied by delayed discharge by type of delay

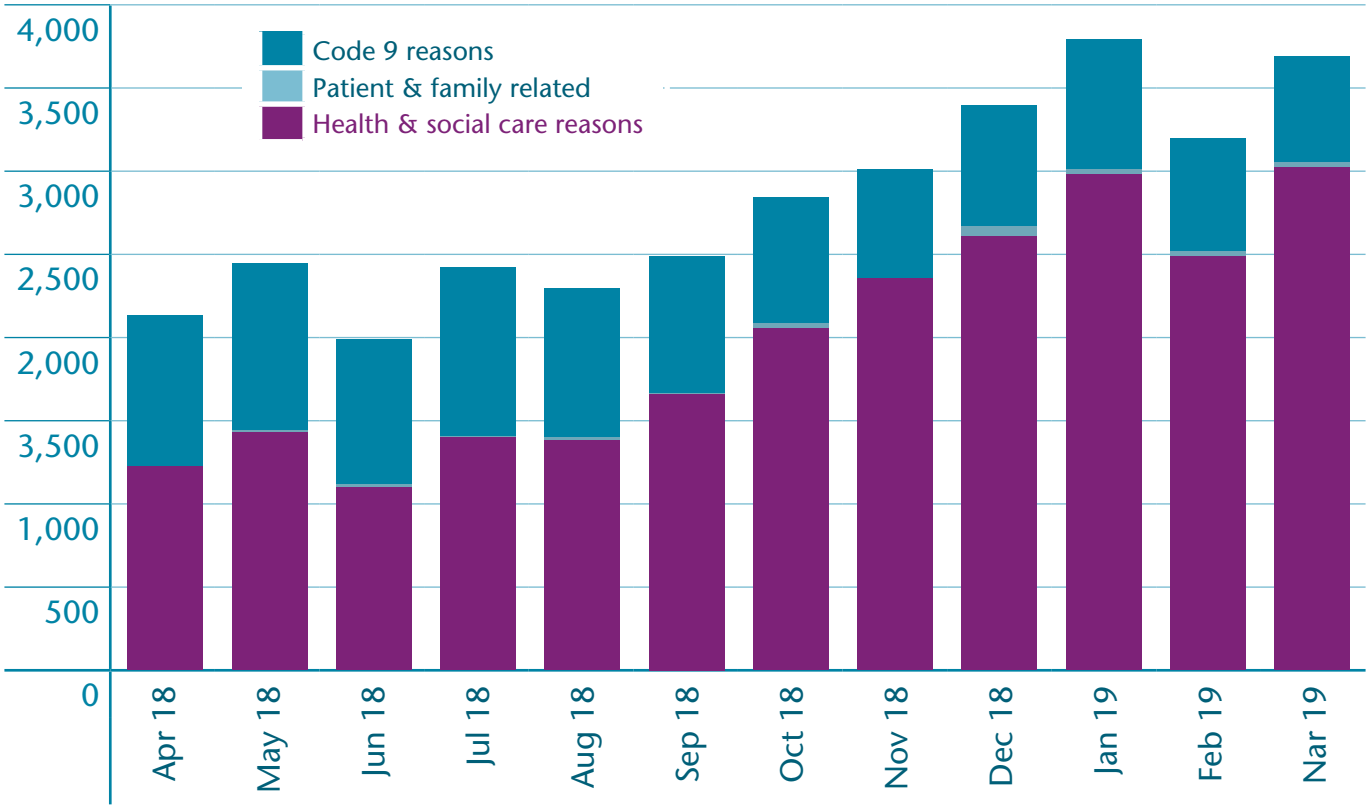
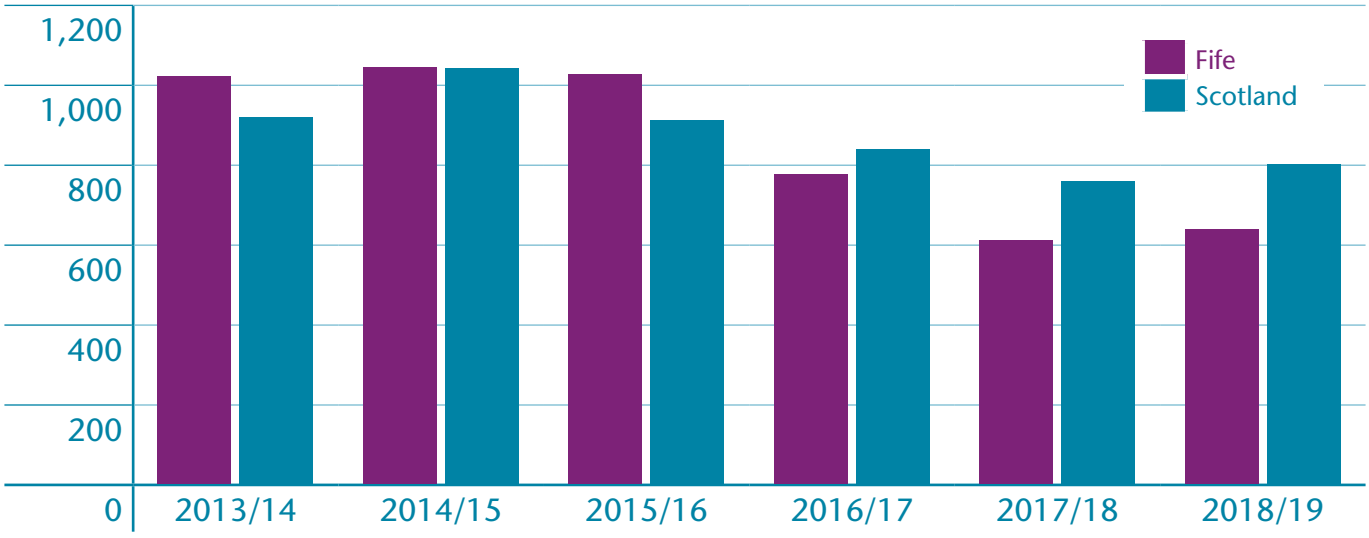


Figure 4 - Number of days people aged 75+ spend in hospital when they are ready to be discharged, per 1,000 population (National Indicator 19)



Modernising Care at Home

National outcomes 1 2 3 4 9

Totalmobile has effectively transformed Care at Home using 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 is now fully imbedded within the Partnership's Care at Home Service. The service delivers care to around 1,300 service users across Fife, providing approximately 20,000 visits per week.

We are looking to move the use of Totalmobile into the Mobile Emergency Care Service (MECS) which should allow us to increase our ability to respond to more calls across Fife.

Technology

National outcomes 1 2 4 7

Fife Health & 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.

In 2018-19, the number of people in Fife who live at home with technology (including community alarms) continued to rise with just under 9,000 individual pieces of telecare equipment or community alarms in service user own homes.

8,722 (March 2018) to 8,997 (March 2019), an increase of 3.15%

Self Directed Support (SDS) - Short Break Service

National outcomes 1 2 4 7 9

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.

The personal outcomes approach to assessment and supporting planning continues to be embedded across Health & Social Care. This has been evidenced this year with the launch of our new Short Breaks Service for Adults (65 years and under). Fife Health & Social Care Partnership established a small centralised team who provide information to supported individuals and their families/carers to assist them to access creative and innovative short break provisions, using their individual short break budget and their chosen option through self-directed support. The team has collated a bank of information ranging from an accessible travel agency registered with the Care Inspectorate, fully adapted buildings, accessible caravans and holiday lets as well as breaks that offer activity opportunities for individuals with additional needs. Details of all short break options gathered are available under the Short Breaks section on "On Your Doorstep Fife" (www.onyourdoorstepfife.org)

Below are examples where individuals have chosen an alternative short break recently:

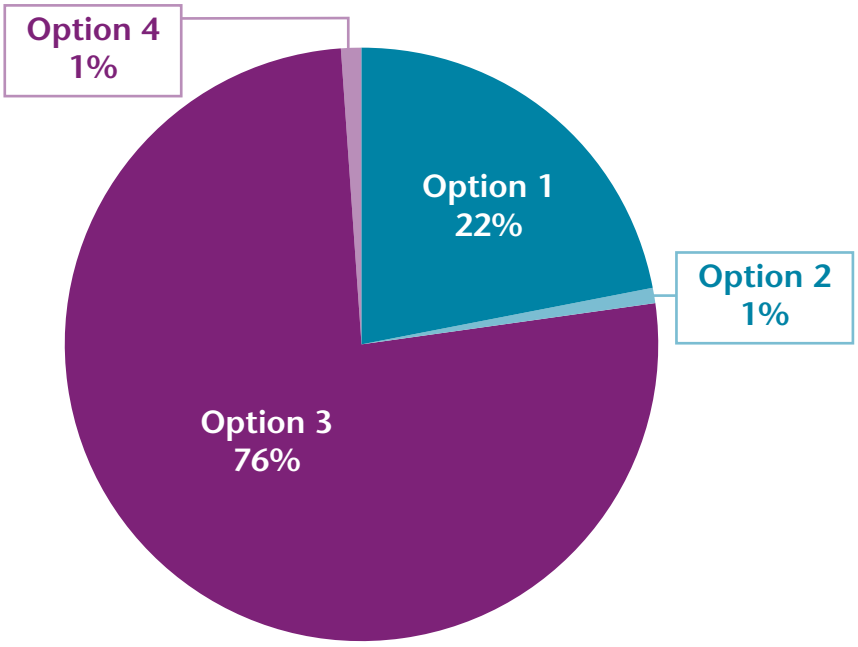
"A" has gone on city breaks, attended concerts staying away overnight and had caravan breaks. Mum directs his daily support using a support provider (SDS Option 2). This arrangement works well for all, it provides a break for mum from her caring role and allows A to experience opportunities which otherwise may not have been an option for him. This is a good example of a family and an agency working together to find alternatives to unit-based respite.

"R" and "G" are brothers with autism. They have chosen to use Shared Lives Fife for their short breaks. R has recently been away to Ireland with a member of staff from a local support provider who he knows and gets on very well with.

As evidenced below, whilst most individuals are continuing to choose resources they are familiar with, the short breaks team will work with them and their families/carers to ensure they are aware of the range of creative breaks and alternative options that are available, should people wish to try something new.

This will be monitored over the coming year to track any shift in short breaks being accessed.

Figure 5 - Short Breaks (Service)



Carers Act and Carers Strategy

National outcomes 1 4 6

Last year we reported that the Carers (Scotland) Act 2016 (Carers Act) would come into effect on 1st April 2018. This will increase our focus to support Fife's 34,828+ self-identified unpaid carers and many more carers who are 'hidden'.

During the year we completed our consultations and published the 'Carers Strategy for Fife 2018–21', and a separate 'Getting it Right for Young Carers in Fife Strategy 2018-21'. We also published our 'Fife Carers Short Breaks Service Statement'. These were key requirements within the Carers Act which were delivered ahead of time.

We identified supporting more carers as a key outcome from our investment to implement the Carers Act. Our Health & Social Care Social Workers supported 595 of the most critical need unpaid adult carers with an Adult Carer Support Plan during the year, an increase of 206 (53%) on the previous year. A further 380 non-critical carers were supported to develop their Adult Carer Support Plan through Fife Carers Centre, our commissioned partner, a significant increase of 51% on the previous year.

Our strategy focuses on providing all carers with access to appropriate support to help them avoid reaching crisis. This universal support is free to all and includes:

- Increasing the carers hospital discharge support at Victoria Hospital in Kirkcaldy where 379 carers were supported, up by 127 (50%) on the previous year. In October 2018 we extended this support to Queen Margaret Hospital in Dunfermline where 103 carers were supported in the first 6 months of this support being available. This support is offered though our partnership with Fife Carers Centre.
- In November 2018, launching a new independent advocacy support project for all carers in Fife delivered through a partnership between Fife Carers Centre and Fife Young Carers.
- The Young Carers Befriending Project, developed and agreed offering additional support to Fife's 6,000+ young carers through a partnership between Fife Young Carers and LEAD Scotland (LEAD Scotland supports young people and adults and carers across Scotland to access learning opportunities).
- Commissioning a new universal specialist income maximisation support offer for unpaid adult carers provided by Citizen's Advice and Rights Fife.
- A suite of information leaflets for carers, as well as a new carers information web-site developed, to help them understand their rights under the Carers Act. This is part of the ongoing awareness raising campaign.

Our investment will increase in 2019-20 to include more carers support workers through our main partners, and further expansion of the hospital discharge support into community hospitals.

- We will host the first Carers' Gathering to increase awareness of support for carers.
- We will launch new universal support through our web-site and access to Carers Scotland's digital carers' resource.
- We will support healthcare and teaching professionals to identify carers and make appropriate onward referrals for support.

Child Well-Being Pathway
Home visits making life easier for youngsters in Fife

National outcomes 2 4

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 into 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.

Community Hospitals redesign

National outcomes 2 4 7 8 9

In May 2018, the Health & Social Care Partnership Board approved the Joining-Up Care consultation proposal. This programme is designed to transform how we deliver community health and social care services in Fife. Part of this proposal was to undertake a review of the community hospitals and the intermediate bed care model.

This review has included stakeholder engagement with our workforce as well a comprehensive public consultation. The key themes from this engagement have informed an option appraisal process, undertaken between September and December 2018. This considered various options for community hospital and intermediate care bed redesign.

Since then work to test new ways of working and develop a detailed proposal for how the future community hospital and intermediate care bed model can be delivered has been underway. A business case is currently being refined and will be submitted to the Integration Joint Board for consideration

Improvements, sustainability and challenges

Redesigning care and clinical pathways to have fewer steps to ensure people are supported in the right place at the right time for their needs.

Day Services and Day Hospital for Older People

National outcomes 2 9

During 2018-19 the Health & Social Care Partnership continued to work collaboratively with the voluntary sector to re-design day services for older people. Day services now offer more flexibility and choice for individuals while continuing to offer support for carers.

There has been an uptake in individuals choosing SDS option to engage and tailor their own day supports to meet their personal outcomes.

We will continue to keep day services under review as demand and expectations change to ensure what is provided meets need and desired outcomes.

Fife Macmillan Improving Cancer Journey

National outcomes 1 3 4 8

Macmillan Cancer Support has invested £1.1m into the project, which will see the Health & Social Care Partnership and other third sector organisations working together to provide a seamless, accessible and personal support for people affected by cancer.

The new service will see every newly diagnosed person in Fife sent a letter offering a meeting with a dedicated one-to-one link worker. The worker will then help the person access a wide range of support, from benefits advice, emotional support and practical needs. Anyone currently living with cancer can also access the service by simply calling the team to arrange an appointment.

While it's good news that advances in treatment mean that more people than ever are surviving, it also means that people living with cancer are living longer, often with long-term effects of treatment or other health conditions that have a huge impact on health, wellbeing and independence. Many of them don't know where to go for help coping with the non-medical effects of the illness.

Since June 2018 to March 2019, over 250 people affected by cancer have requested the Improving Cancer Journey Service. The top three concerns identified by people engaging with the service are fatigue, moving around and finance.

What people are telling us

"I am coping much better and I am coming to terms with what has happened. It has been amazing for me and I really feel the benefit of being invoolved with the ICJ Service" - Service user

"Your support to me has been wonderful - no one else has ever gone the extra mile to help me like you have done" - Service User

"The Improving Cancer Journey Official Launch" at Carnegie Conference Centre in Dunfermline

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 is 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

During 2018-19 Fife continued to deliver on the local mental health strategy through the implementation group, whilst undertaking a significant public consultation across all localities and agencies to inform Fife's refreshed Mental Health Strategy, due for publication in summer 2019. The key themes identified are:

- **Challenge discrimination and stigma** through involvement in local and national campaigns.
- **Raise awareness** and **focus on prevention and early intervention** with the aim of promoting mentally healthy communities.
- Work closely with our partners to take a **collaborative, whole system approach** to ensure care and support is matched to the unique needs and outcomes of individuals who seek support.
- **Raise awareness** of the importance of **keeping good mental and physical health and wellbeing**; to ensure that the physical health of those with mental health conditions is improved and also that the mental health needs of those with physical health problems are fully considered.
- Ensure that all available **resources** are utilised in the most **efficient and effective** way, optimising opportunity for the right care in the right setting at the right time and ensuring best value for all.
- Ensure services are **informed** by, if not **grounded** in 'evidence-based practice'.

The above commitments will inform the planning and delivery of mental health and wellbeing support in Fife over the four-year strategy period (2019-2023).

Fife's Mental Health Strategic Implementation Group continue to proactively lead on Fife's Rebalancing Care agenda with positive progress being made in a range of key areas, for example, through the implementation of Community Mental Health Teams and the forging of closer and joined up links across agencies to create sustainable and accessible mental health services. The Stratheden Redesign (Phase II) Project has progressed significantly and is expected to be concluded during 2019, with 20 people supported out of long-term admissions to live independently in their communities, with the right support to sustain their recovery. There is significant progress across children's and young people's mental health services, delivered through the CAMHS service and Our Minds Matter framework.

A range of supports are available including stress management, counselling and specialist mental health training for professionals, parents, families and carers to promote the mental health and wellbeing of Fife's children and young people.

In 2018-19, the Scottish Government announced a commitment to increase mental health workers across Scotland - Fife's target is 54 workers which is in progress through creative and innovative projects.

The Better Than Well approach has been expanded across Fife, Access Therapies is available online as a complimentary resource to the existing Mood Café with Fife's refreshed Mental Health Strategy aiming to further develop a range of initiatives, including the development of Peer Support across settings.

Significant and continuing progress is projected across the field of mental health in Fife informed by the Fife wide consultations and local and national drivers to continually support people to access the right support at the right time and, live as mentally healthy lives as possible.

A significant challenge to the strategy implementation will be meeting an increasing demand for services and supports whilst continuing to manage available resources. Fife is committed to ensuring that our resources are used in the most effective and efficient way, allowing our strategy commitments to be delivered within existing budgets. This will require creative and innovative thinking to ensure services and supports are fit for the future. The Strategy implementation will be overseen by the Mental Health Strategic Implementation group (MHSIG).

Anti-stigma campaign

National outcomes 2 3 4 5 9

With each passing year, mental health is increasingly visible and discussed in terms of 'it's okay not to be okay', across all walks of life. However, stigma associated with mental health continues and the Partnership remains committed to tackling discrimination and stigma at every level.

2019-20 will see an increase in Walk A Mile venues, a refreshed Anti-Stigma campaign through the new mental health strategy and anti-stigma threaded through all areas and continued Partnership working with See Me supporting Fife with anti-stigma.

Stratheden Hospital Redesign

National outcomes 2 3 4 9

A multi-disciplinary team comprising of social work, OT, nursing staff, CPN staff and speech and language therapy staff have been working together to support the discharge of 20 long-stay patients from rehabilitation wards at Stratheden Hospital. The team have been working intensively with nine patients to assess and plan their transition from hospital. Work to date has included:

- Identifying a support provider to provide bespoke packages of care and the development of a core and cluster service allowing long-stay patients to live in their own home in the community
- Working closely with the support provider to develop comprehensive, person-centred, outcome focused support plans and risk assessments/management plans with input from all stakeholders

To date, six people have been discharged to core and cluster accommodation in North East Fife with the remaining three due to be discharged imminently. An evaluation of service user views has taken place throughout their journey. Informal feedback from those discharged has been extremely positive in terms of outcomes being met with one service user stating 'This is braw. I love being in my own house so much and never want to go back to hospital!'

The multi-disciplinary team has now evolved into a community rehabilitation team and will continue to work collaboratively with service users and providers. This ensures continuity for service users in terms of relationships that have been built and will hopefully ensure service users remain living within their own home, even in times of crisis, rather than having to be readmitted to hospital.

Going forward, it is clear that there is a need for additional models of support for those with enduring mental health difficulties throughout Fife. It has been identified that there is a gap in service provision in West Fife and consideration could be given to the development of a multi-disciplinary team to drive this forward.

The main challenges being faced are in relation to the complex legal and procedural issues regarding leasing of the properties.

The aim is for this to be a model of support with an 'exit-strategy' for service users to move on to independent living, if appropriate. This would ensure the sustainability of the resource allowing a flow of service users from hospital to community.

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

During 2018-19 Shared Lives Fife (SLF) continued to provide crucial support to adults of all ages with long term, short break and day support, across Fife's localities. The support is delivered both within carers own homes and in the community and has supported people to secure individual tenancies, gain employment and access voluntary opportunities in addition to supporting people affected by dementia.

Carer numbers expanded during this period with delivery of 287,671 support hours across Fife, an increase of over 11% from the previous year.

Shared Lives Fife also continued to increase the number of people over the age of 65 years accessing the service and continued to access Dementia specific training for carers and staff. Recruitment of carers from all backgrounds and robust assessment, approval and matching practices are fundamental to Shared Lives Fife success, which was recognised through the excellent grade provided by the Care Inspectorate for the care and support delivered in 2018-19. The service continues to promote maximum involvement of both carers and supported people through the Speak Ur Mind Group and Carer's Consultation Group, which has seen an expansion during the period of joined up meetings with all involved in the service.

Feedback from people accessing the service:

'I feel staff go that extra mile'

'It [SLF] provides a valuable alternative to traditional respite and offers people the opportunity to be part of their community'

'the service is flexible, and the support is second to none'

The ongoing challenge for Shared Lives Fife is carer recruitment, which through ongoing monitoring is most effective through 'word of mouth'. The service targets multiple sources to attract carer applicants, which although has seen an increase in carers, remains a challenge. The involvement of carers and people who access the service contribute significantly as ambassadors for the service, which supports continual carer recruitment. With increasing demand and the ongoing expansion to support people affected by dementia, the service will be recruiting an additional team member to support growth of the service and continue to strive for excellence with the people we support and work alongside.

New Build Housing and Housing Adaptations

National outcomes 1 2 5

We continue to work hard to deliver improved performance in relation to Housing Adaptations. This year we have taken 23 days on average to complete approved medical adaptations. (In 2016/ 17 this was 30.27 days and in 2017 /18 this was 24 days).

89% of approved medical adaptations were completed.

The Affordable Housing programme continues to make a significant contribution to Housing for older people within Fife. A 23-unit Retirement Housing Complex in Oakley has just been completed and we are on schedule to deliver a new Extra Care Housing Complex in Glenrothes. We have just completed a full modernisation of our Retirement Housing Complex at Den Court, Cardenden – this will deliver 13 new units of Retirement Housing.

Fife Council Housing Service has just completed a pilot using wearable technology to monitor tenants' health and wellbeing. We are looking to run potentially a further pilot of this technology in an Extra Care Housing Complex to test how this works with a frailer group of tenants.

New Care Villages

National outcomes 2 5 9

Lindsay House in Lumphinnans opened in May 2018 replacing Jenny Gray in Lochgelly and Valley House in Cowdenbeath. It offers 48 permanent beds, 12 STAR beds and day services. Fife Day Care services have dedicated accommodation within the building from which they provide voluntary day service.

Planning is well underway for the replacement of Methilhaven Care Home and this site will also host a nursery and extra care housing. Approval has also been given for replacement of Northeden House, Cupar on the current Dalgairn site and planning is currently underway for this new resource.

Homeless – Shelter

National outcomes 3 4

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 had 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, nine to a secure tenancy, two moved into a private let and three 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 colleagues around the development of a safe discharge protocol for homeless patients along with ongoing discussions with regard to GP services for those patients to 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

National outcomes 2

Lochore Meadows Project

Fife Health & Social Care Partnership, 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 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 Drive Deck 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.

This project was completed in 2018; the SMART computer technology is now installed and has enabled children with significant motor difficulties to safely and independently participate in play whatever their disability.

Falls and Frailty Managed Clinical and Care Network (MCCN)

National outcomes 1 2 4 7

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.

Work progressed in 2018-19 included:

- Agreement that the Scottish Ambulance Service Falls Pathway will be included in mandatory training for Scottish Ambulance Service personnel;
- Roll out of falls screening by the Fife Fire & Rescue Service across Fife;
- Implementation of realistic prescribing priorities which includes GPs and pharmacists jointly reviewing patients' medication in care homes.
- Discussions and agreement to develop a falls public awareness campaign. The aim of the campaign is to maximise public and practitioner's knowledge of falls prevention and risk. The campaign is planned to coincide with the National Falls Awareness week in September 2019.

Complex Case Management
(previously known as High Health Gain)

National outcomes 1 5 8 9

The goal of the Complex Case Management approach is to work proactively with adults and older people with complex care needs in Fife, who are accessing both primary and secondary care services more frequently. We initially called this approach 'High Health Gain' as the focus was on individuals who had the greatest potential to see a gain where a collaborative, proactive approach to planning was taken.

As part of our Community Health and Wellbeing Hub model, the Partnership is now embedding a model of complex case management, supporting earlier and more integrated working.

Part of this work has involved bringing a range of professionals together in localities in a Multi-Disciplinary Team to collaborate in tailoring care and identify people who could benefit from this approach. The approach involves:

- A targeted approach – using data, evidence and local knowledge to identify people as early as possible;
- a comprehensive assessment - an assessment which involves looking at all aspects of an individual's health and care and what matters to them;
- person centred – working with people and their carers to develop a plan that looks ahead, focused on what matters to them. This helps people to think ahead and share how they would want things to happen in a range of circumstances (anticipatory care planning);
- case co-ordination –agreeing which of the professionals working with an individual will take the lead to simplify communication and access for people, their family, carers and for colleagues

During 2018-19, we have developed and refined a holistic assessment which includes mental health and wellbeing, physical health and carers status using a combination of validated and project specific tools. We are now embedding a model which sees:

- Locality Multi-Disciplinary Team discussion enabling professionals to collaborate more effectively and timeously to support people;
- District Nursing colleagues undertaking holistic complex assessment and providing a single point of contact for people;
- Complex Case Management Team – supporting the wider community nursing service and providing complex case management for people with the most complex needs;
- The Community Single Point of Access simplifying how people are referred for complex case management.

To support our model of joined-up seamless care, we are continuing to remove traditional access barriers to services and ensuring the whole system is integrated. For example, within the District Nurse service now have direct access to:

- Care at home;
- Polypharmacy review by a pharmacist;
- Local area co-ordination and befriending support;
- Monthly huddles with a full Multi-Disciplinary Team (MDT) model;
- Day Hospital services – transforming into locality Assessment and Rehabilitation Centres as part of the wider Community Health and Wellbeing Hub model.

Since commencement, the Complex Case Management approach has supported 468 individuals.

322 individuals were supported during 2018-19.

From a random sample, 60% saw a significant reduction in hospital admissions.

The Complex Case Management Team have a rolling caseload of approx. 50 individuals at any one time. Part of the team's role is supporting people to stay at home but where an individual does need to go in to hospital, the team continue to support the people they are working with to be discharged home as soon as possible.

Improvements in Prescribing

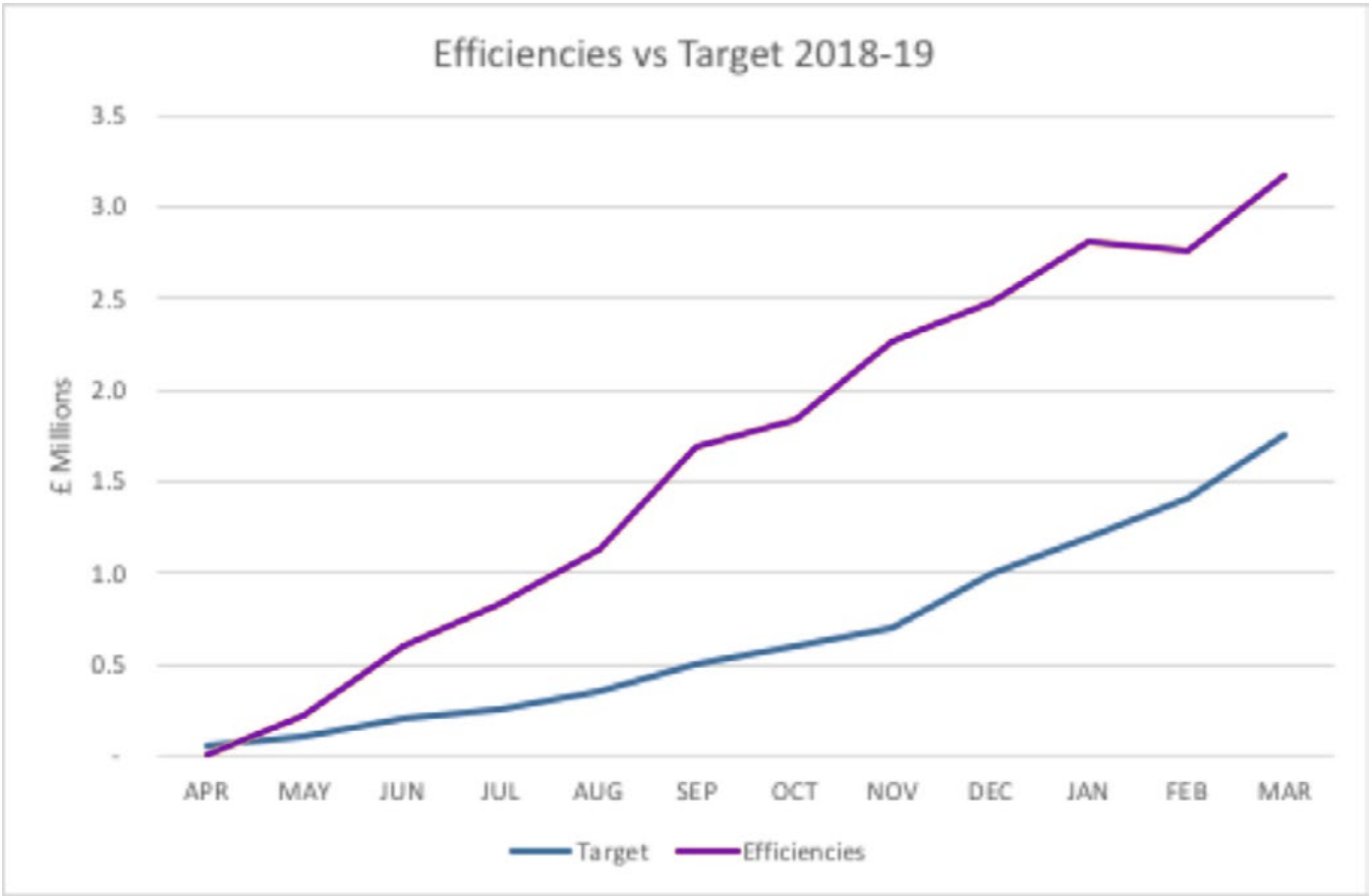
National outcome 1 2 3 4 5 6 7 8 9

In 2018-19, the Medicines Efficiency Programme delivered an efficiency target in the Health & Social Care Partnership of £1.75m. Within NHS Fife's Acute Services, and efficiency of £1.6m was achieved. Key performance indicators show that GP prescribing continues to improve on a monthly basis compared to other boards and is moving closer to Scottish average.

The medicines efficiency programme included the following prescribing improvements:

- Improved compliance with the Fife formulary (list of approved medicines);
- Reduction in medicines waste in care homes;
- Reduction in spend on wound care, stoma and catheter products; and
- Pharmacists and pharmacy technicians undertaking polypharmacy medication reviews in GP practices, care homes and patients' own homes.

Due to ongoing cost pressures outwith Fife's control, there was a projected overspend of approx. £2.2m at the year end, for GP prescribing budget.



Key successes in Pharmacy, Medicines Governance and Prescribing

Medicines Governance

- Safe and Secure Use of Medicines Policy & Procedures (SSUMPP) details the systems and processes in place to ensure safe and secure prescribing, administration, supply, storage and destruction of medicines. An audit programme was developed to provide assurance. The 'Medicines Administration Observational Audit: Controlled Drugs' - between Sept 2018 & and Jan 2019 in conjunction with 'Non-Controlled Drugs Administration Observational Audit'. Aim of Audits - to ensure all relevant clinical areas are adhering to the standards and practice expected for the safe and secure administration of medicines by achieving 100% compliance with Section 9 of the SSUMPP. This was the first of a rolling programme of audits, 5-year audit cycle for all NHS Fife, including HSCP Hospital wards and departments / GP Practices / Clinics and Health Centres. Our audits include Medical Gas / Medicines Fridges/ Medicines Storage. Controlled Drug Audits are carried out by Pharmacy every 6 months in all NHS Fife Hospital wards and departments.
- Pharmacy Services Medicines Administration training to Social Care Workers in residential settings e.g. Care of the Elderly, Looked after Children, Group Home settings. This work is now enhanced by the introduction of Pharmacy teams into Care home settings where the team work with staff to reduce waste, improve systems and enhance patient safety.
- Engagement to drive forward the high-risk agenda, specifically opioids safety agenda in Primary Care and encourage review of patients. Opportunity to provide training and support to GPs and GP Practice teams to identify and offer supported reduction to patients in highest risk groups if appropriate to reduce short and long-term risk.

GP practices

- Developing Pharmacotherapy service to all GP practices in Fife, in line with GMS contract Implementation.
- Challenges in development of the Pharmacotherapy Service as future funding is unclear, which will impact on General Practice sustainability.

Mental Health

- Recruitment to MH Team has enabled development of skill-mix triage for pharmacy review for newly admitted patients. Support clinicians via ward presence and attendance at MDT meetings. Implementation of the Fife Wide Prescription Chart in OAP and Rehabilitation wards. Support to Cameron Hospital to improve systems, contribute to patient reviews and discharge planning. Work to update the JIC service and progress the Palliative Care Network.

Unscheduled care

- Service developments have led to Community Pharmacists becoming an important route for patients to access care both in hours and out of hours and are reducing the number of patients who routinely use primary care or out of hours services. Developments include; NHS Minor Ailment Service and Pharmacy First service.

Pain Management Service

- Pharmacist clinical provision within Fife Pain Management Service has undergone pathway redesign pathway to ensure equitable access to pharmacist support within Pain service.

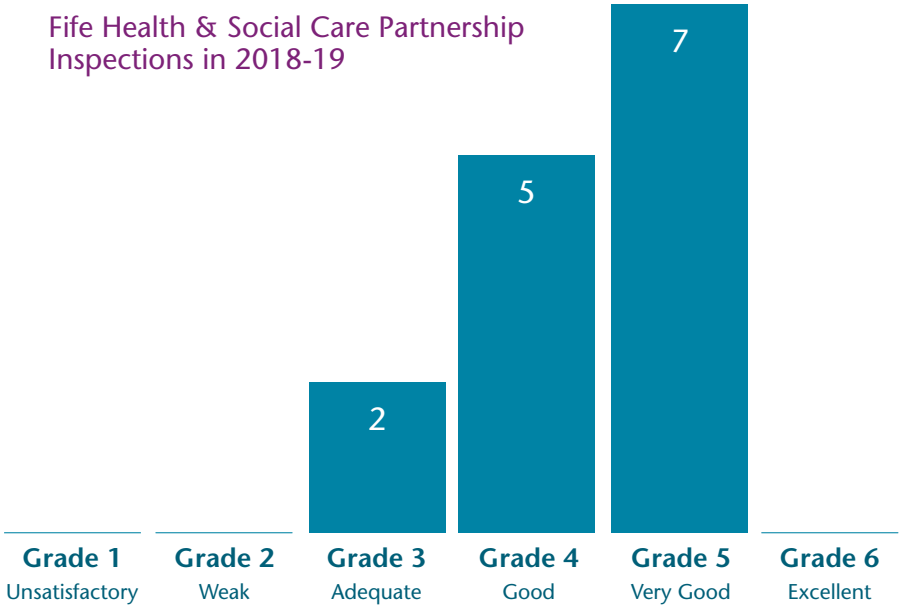
Inspection of Services

Inspection of Social Care Providers Care Inspectorate 2018-19

National outcomes 3 7

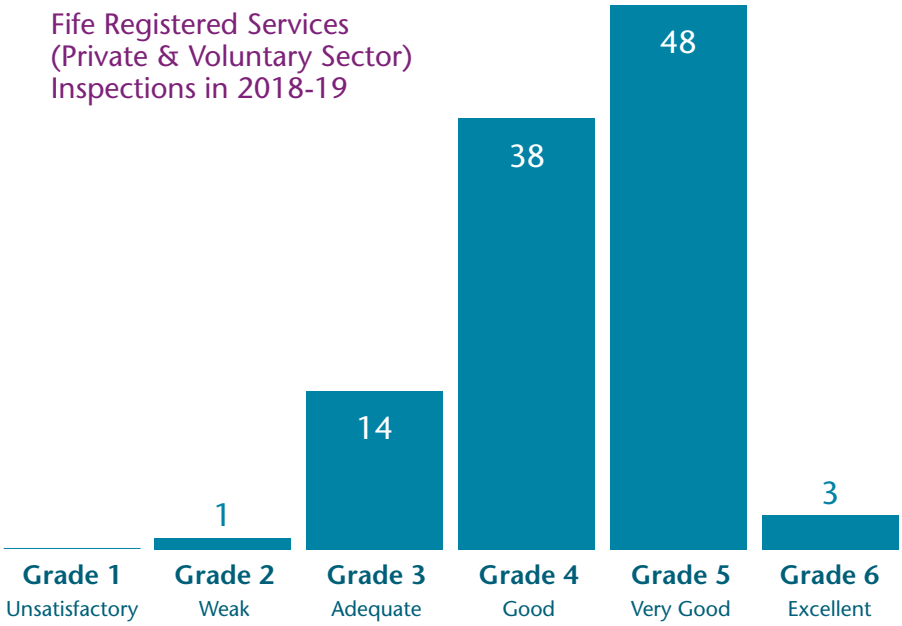
All registered Social Care services undergo inspection from the Care Inspectorate. 14 Fife Health & Social Care Partnership registered services were inspected during 2018-19. For both Adults and Older People, 12 of the 14 services (86%) that were inspected were graded 4 (Good) or above.

Fife Health & Social Care Partnership Inspections in 2018-19



For all registered adult social care services (including Older People) within the Fife Health & Social Care Partnership area, delivered by the Voluntary and Independent Sector, 104 Care Inspectorate inspections were carried out. 89 of the 104 services (86%) that were inspected were graded 4 (Good) or above.

Fife Registered Services (Private & Voluntary Sector) Inspections in 2018-19



Financial Performance & Best Value

Revenue Expenditure 2018-19

The provisional 2018-19 outturn position is an £9.236m deficit prior to external annual audit sign off. The Partnership at inception had a challenging financial position with a £15m budget gap and after the first full year of operating out turned a deficit of £9.263m (in 2016-17).

2018-19 sees a position similar to the previous 2 years, with overspends in the region of £9.0m. In 2018-19 the Partnership implemented a savings plan of £12.9m and delivered £8.2m against those agreed savings.

Financial position for 2018-19

Spend across the Health and Social Care Partnership in 2018-19 is represented below:

Delegated Services (as at 31 March 2019)	Budget	Provisional Outturn	Variance
Objective summary	£m	£m	£m
Community Services	97.812	93.586	(4.226)
Hospitals and Long-Term Care	52.867	55.259	2.392
GP Prescribing	72.293	74.448	2.155
Family Health Services	93.005	92.911	(0.094)
Children's Services	15.370	14.897	(0.473)
Social Care	196.627	206.252	9.625
Housing	1.574	1.432	(0.142)
Total Health & Social Care	**529.548**	**538.785**	**9.236**

Community Healthcare — £4.226m underspend

This mainly relates to budget underspends across a range of areas, including vacancies in Community Nursing, Community and General Dental Services, and administrative posts.

Hospital and Long-term Care — £2.392m overspend

The provisional overspend within hospital services relates to the additional cost of complex care patients, along with the use of bank and agency nursing to provide safe levels of staffing in line with current workforce tool numbers. 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 — £2.061m overspend

The majority of the overspend £2.061m reflects an increase in the average cost and volumes of medicines as well as the price impact of a national shortage in supply of some medicines.

Children's Services — £0.473m underspend

The Children's Service position comprises a number of over and underspends in Children's services, the main areas being within Health Visiting and School Nursing due to a difficulty in recruiting to Health Visiting (National Issue).

Social Care — £9.625m overspend

The draft outturn overspend position of £9.625m, is predominantly due to client demand and complexity of care. There are overspends on Home Care primarily due to demand for care packages. There are overspends on adult placements due to increasing demand, and within Social Care Other there are overspends of £3.629m predominantly as a result of non-achieved transformational and management savings.

Housing Services — £0.142m - underspend

Spend on housing delegated to the Health and Social Care Partnership out-turned with £0.142m underspend.

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 2019-20 does not meet the budget required to deliver services and the approved budget approved by the IJB has a budget gap of £6.553m which will 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 2019-20 to deliver long-term financial sustainability. The most significant risks faced by the Health & 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 impact of demographic changes leading to increased demand and increased complexity of demand for services alongside reducing resources;
- difficulties in recruitment leading to use of higher cost locums and agency staff;
- the cost pressures relating to primary care prescribing;
- the Joined-up Care Transformation Programme does not meet the desired timescales or achieve the associated benefits; and
- workforce sustainability both internally in health and social care and with our external care partners.

It is therefore crucial that the IJB focus on early intervention and prevention and changing the balance of care if we are to work within the available resources.

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 & 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 & 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 Redesign;
- Extension of START programme;
- Home Care Redesign;
- Winter Planning; and
- Assessment Unit bed model.

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.
The next update is due in 2019-20
Figures for indicators 10, 21, 22 and 23 are not currently available

National Indicator	Fife 2015/16	**Fife** 2017/18	Fife diff from 15/16	Scotland 2015/16	**Scotland** 2017/18	Fife 17/18 diff from Scotland
1 Percentage of adults able to look after their health very well or quite well	94%	**94%**	No diff	95%	**93%**	↑ 1%
2 I was supported to live as independently as possible	80%	**82%**	↑ 2%	83%	**81%**	↑ 1%
3 I had a say in how my help, care or support was provided	76%	**74%**	↓ 2%	79%	**76%**	↓ 2%
4 My health, support and care services seemed to be well coordinated	72%	**75%**	↑ 3%	75%	**74%**	↑ 1%
5 Overall, how would you rate your help, care or support services? Please exclude the care and help you get from friends and family.	78%	**81%**	↑ 3%	81%	**80%**	↑ 1%
6 The care provided by your GP practice?	83%	**81%**	↓ 2%	85%	**83%**	↓ 2%
7 The help, care or support improved or maintained my quality of life	84%	**80%**	↓ 4%	83%	**80%**	No diff
8 I feel supported to continue caring	39%	**32%**	↓ 7%	40%	**37%**	↓ 5%
9 I felt safe	82%	**84%**	↑ 2%	83%	**83%**	↑ 1%

Data for Indicators 11-20 updated December 2019

National Indicator	Fife 2017/18	**Fife 2018/19**	Fife diff from 17/18	Scotland 2017/18	**Scotland 2018/19**	Fife diff from Scotland
11 Premature mortality rate per 100,000 persons; by calendar year*	427	410	↓ 17	425	432	↓ 22
12 Emergency admission rate per 100,000 persons	13,447	13,295	↓ 152	12,208	12,259	↑ 1,036
13 Emergency bed day rate per 100,000 persons	124,677	120,561	↓ 4,116	122,923	118,462	↑ 2,099
14 Readmission to hospital within 28 days per 1,000 admissions	123	115	↓ 8	103	103	↑ 12
15 Proportion of last 6 months of life spent at home or in a community setting	88.7%	88.6%	↓ 0.09%	87.8%	88.1%	↑ 0.54%
16 Falls rate per 1,000 population aged 65+	25	27	↑ 1.36	22	22	↑ 4
17 Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	89%	86%	↓ 3%	85%	82%	↑ 4%
18 Percentage of adults with intensive care needs receiving care at home	50%	55%	↑ 5%	61%	62%	↓ 7%
19 Number of days people aged 75+ spend in hospital when they are ready to be discharged, per 1,000 population	612	628	↑ 16	762	793	↑ 165
20 Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	26%	25%	↓ 0.69%	24%	24%	↑ 2%

** Data measured in Calendar years - 17/18 is represented by 2017, 18/19 by 2018 data*

Alternative Formats

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

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

Fife Health & Social Care Partnership