Fife Health & Social Care Partnership

Home First Strategy

2023–2026

NHS Fife

Fife Council

Scottish Care
Voice of the independent care sector

fife voluntary action

Fife Carers Centre

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Foreword

Ensuring we care and support the people of Fife to live their best lives possible, it's important to look at different ways of delivering care and support to meet the best health and wellbeing outcomes for Fifers now and for the future. We've refreshed our Fife Health and Social Care Partnership (HSCP) Strategic Plan for the next three years (2023-2026) which shows the vision and aspirations of what we want to achieve here in Fife for our communities and how we will do this. There are nine strategies included in the HSCP Strategic Plan that will support us on this journey, one of those strategies is this document - the Home First Strategy 2023-2026.

We know how important it is for people who have been admitted to hospital that they are discharged when medically fit without unnecessary delays; that we help prevent hospital admissions, where possible, by intervening at an earlier stage, and for people to be able to access community services when these are needed seamlessly through a single point of access. These are major areas of work that the Home First Strategy will focus on, and I want to thank everyone involved in developing the Strategy to date and the continued ongoing work to progress this.

There has been an amazing 'Team Fife' approach with input from staff, partners, colleagues from the independent and third sectors and the communities and people we support. It is by working together and looking at how we can improve on what we do that does make the difference, and by using our collective resources to provide the best care and services that we can. It is exciting to see everyone working together to make improvements in these areas and building on our vision for 'Fifers' to live healthier and independent lives at home or in a homely setting'.

Nicky Connor
Director of Fife Health and Social Care Partnership

Executive Summary

The Home First Strategy outlines Fife's commitment to transform the discharge process and our vision is that:
"everyone in Fife is able to live longer, healthier lives at home, or in a homely setting."

The Home First Strategy aims to guide change projects that:

- Improve integration between NHS Fife, Fife Council, third and voluntary services and the Fife Health and Social Care Partnership (HSCP), to ensure the flow of patients from a hospital environment to a homely setting is safe, faster, with the person at the centre of all decisions.
- Help prevent hospital admissions by anticipating need and supporting self-management.
- Ensures data will lead the planning and commissioning of services.

The Home First Strategy focuses on integrated health and social care and how we maximise the excellent collaborative working that exists in Fife. It also strongly focuses on prevention, anticipation and supported self-management.

Person-centred care is fundamental in ensuring the highest standards of quality and safety is at the forefront of all decisions. Families, carers and people are at the heart of everything we do and this Home First Strategy has been informed by the people of Fife.

A key objective of the Home First Strategy is to have a single point of access, across all community settings. This will be transformational. People in Fife who require community support will be referred to a single point of access and we will build capacity in communities to embed a new model of care.

This Home First Strategy is pivotal and describes ambitious new ways of working which will be fundamental to creating the conditions to achieve our ambition in Fife:

Lynne Garvey
Head of Community Care Services
Fife Health and Social Care Partnership

Introduction

Like many areas across Scotland, delayed discharges remains an issue in Fife. Delayed discharges means that patients remain in hospital for a period of time after they are medically fit for discharge, due to various reasons, and ultimately is not in the best interest of the patients. It adds to the significant pressures on hospital beds during periods of peak demand, and detrimentally affects patient flow through the health and social care system.

The Home First Strategy has been developed in Fife with the aim of transforming the hospital discharge process and ensuring that people are enabled to live longer healthier lives at home or in a homely setting. This Home First Strategy is being led by Fife Health and Social Care Partnership with the support of NHS Fife, Fife Council, and local partner agencies.

A key objective is to have a single point of access in the community across Fife's seven locality areas, this will improve access to services and provide benefits for individuals, their families and carers. This Home First Strategy provides direction for a Home First Programme of transformational change projects that will:

1. Improve integration between the Health and Social Care Partnership, NHS Fife, Fife Council and third/independent sector providers to ensure that the flow of patients from a hospital environment to a homely setting is safe, faster, with the person at the centre of all decisions.
2. Help reduce and prevent hospital admissions by anticipating need and supporting self-management.
3. Ensure that robust and relevant data leads the planning and commissioning of services.

Home First Vision

The vision of the Home First Strategy is that:

"Everyone in Fife is able to live longer, healthier lives at home, or in a homely setting."

We are developing a future model of community care which is delivered in an integrated manner, with an emphasis on prevention, anticipation, and supported self-management to realise this vision. When people do require hospital care, we are focused on ensuring that people can return safely to their home or community environment as soon as medically fit with minimal risk of re-admission to hospital. Moving forward, the services that we provide will continue to evolve so they are flexible to growing and changing demands, as well as being person-centred, inclusive, and sustainable.

Diagram 1 below describes the Home First vision.

National Home First – Ten Actions to Transform Discharge

In 2018 the Joint Improvement Team (JIT) – which is a strategic improvement partnership between the Scottish Government, NHS Scotland, COSLA (Convention of Scottish Local Authorities), the third sector, the Independent Sector and Housing Sector - provided national guidance to Scottish health boards to transform discharges from hospital. These 10 actions are listed below:

1. Use data to know how you are doing
2. Scale up coordinated and anticipatory care
3. Develop intermediate care
4. Screen and assess for frailty
5. Integrate discharge planning
6. Build capacity for care and support at home
7. Assertive management of risk
8. Support people moving on to long term care
9. Understand Adults With Incapacity issues (AWI)
10. Joint commissioning and resourcing

For further details, Home First - Ten Actions to Transform Discharge: Joint Improvement Team report can be found on the Scottish Government website.

Home first - ten actions to transform discharge: Joint Improvement Team report - gov.scot (www.gov.scot)

Fife's Home First Programme has been structured to reflect this national direction, incorporating the ten actions identified above, and operates as the mechanism for the delivery of Home First.

National Outcomes and Strategic Priorities

Fife Health and Social Care Partnership has a three-year 'Strategic Plan for Fife 2023 to 2026' that sets out the future direction of all health and social care services across Fife. This includes how the nine National Health and Wellbeing Outcomes for Health and Social Care will be delivered locally, along with the six Public Health Priorities for Scotland.

The Partnership's Strategic Plan for Fife 2023 to 2026 is available in the publications section of our website: www.fifehealthandsocialcare.org/publications

The Home First Strategy is closely aligned to all of the National Health and Wellbeing Outcomes for Health and Social Care, which are:

1. People are able to look after and improve their own health and wellbeing 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 wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.
7. People who use 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.

Furthermore, there are clear links to some of the Public Health Priorities for Scotland e.g.:

1. A Scotland where we live in vibrant, healthy and safe places and communities.
2. A Scotland where we have good mental health.
3. A Scotland where we have a sustainable, inclusive economy with equality of outcomes for all.

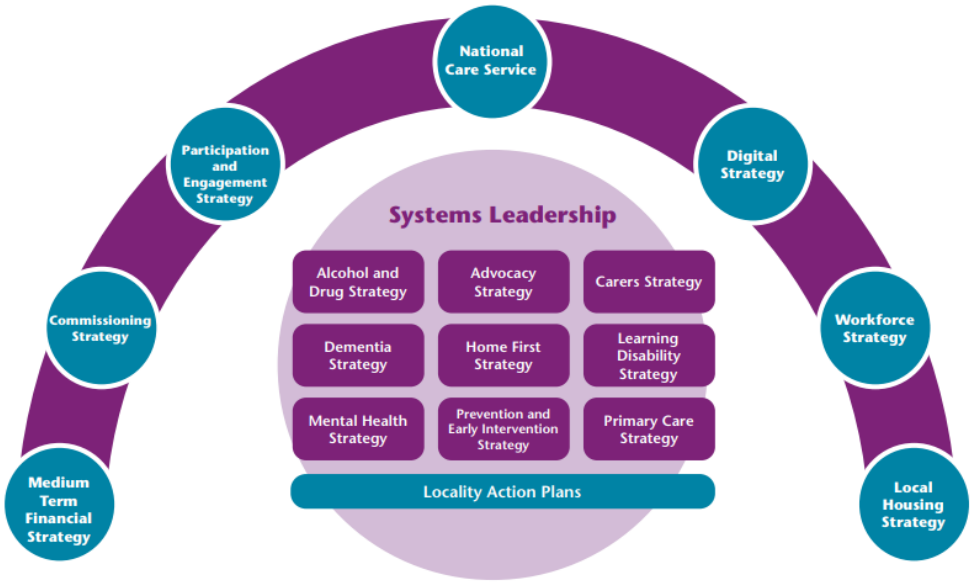
Fife Health and Social Care Strategic Priorities and Local Context

The Partnership's Strategic Plan for Fife 2023 to 2026 sets out the health and social care vision for Fife and includes these five strategic priorities as per diagram 2.

Diagram 2: Fife Health and Social Care Strategic Priorities

The Home First Strategy is one of the transformational strategies that supports the implementation of the Partnership's Strategic Plan for Fife 2023 to 2026. Diagram 3 below identifies all strategies under the Fife Health and Social Care Partnership Strategic Plan.

Diagram 3: Systems Leadership



Prevention and Early Intervention

All of the work being undertaken to transform the way we deliver our services has a strong emphasis on Prevention and Early Intervention throughout the Home First priorities.

Factors which influence our health and wellbeing can be complex. Some cannot be changed, such as our age or genetics. Others can be modified by prevention and early intervention approaches, such as healthy eating, smoking cessation or other health behaviours such as exercise.

Prevention and early intervention can positively influence our health and wellbeing by preventing or delaying health and other problems arising or getting worse. There are many interventions which aim to improve public health by preventing or limiting impact of disease. These interventions may be aimed at the whole population (universal) to influence health behaviours or address the social determinants of health. They can also be targeted to groups with particular needs, or that are particularly likely to benefit.

In Fife we will consider prevention and early intervention more broadly by considering health and other contributing factors, such as homelessness, social isolation or functional decline with age.

Linking across the other transformational strategies and the Getting it Right for Everyone (GIRFE) will support new collaborations across health, social care, council and third sector. People themselves will be included as active partners in care by supporting them to be involved in co-designing care. Prevention and early intervention is relevant to everyone including people with no current care or support needs; people with current care and/or support needs; and to carers themselves.

People of all ages across Fife will interact, in some way, with health and social care staff and other agencies throughout their lives. Every health and care interaction provides an opportunity to inform, influence and support prevention and early intervention to help people live healthier independent lives. A life course approach looks at prevention and early intervention at any point in a person's life from before birth, through childhood, to adulthood and into our older years. Preventing problems or intervening at an early age can have a positive impact across their lifespan. We want to make every interaction count so we encourage people, communities and those providing information, care, or services to consider - are there problems now; what might become a future problem; what can we do to prevent, reduce or delay any health issues.

The Home First Strategy has clear links with prevention and early intervention approaches and as such is interlinked with the Prevention and Early Intervention Strategy. Any reference to prevention and early intervention within this Home First Strategy will be in the context of preventing admissions to hospital for those living with long term conditions and/or frailty.

NHS Fife's Population Health and Wellbeing Strategy

The Home First Strategy also supports the NHS Fife's Population Health and Wellbeing Strategy by delivering value and sustainability and improving health and wellbeing. The pledge to use NHS Fife's buildings and land to support communities to improve health and wellbeing and in particular, make our buildings and land more accessible to support third/ voluntary sector activities is an area of joint work that fulfils our collective ambitions. The NHS Fife Population Health and Wellbeing Strategy also recognises that we must identify new ways of working to manage the increasing demand for services including those 65+ years who are more likely to have medical conditions and/or be frailer. The Home First Strategy outlines key areas of work that will go a long way to address this demand.

The Strategic Plan for Fife supports community led services, communities and service users by putting them at the heart of how we design services, and building on the strengths and assets we have in our workforce and in our communities in order to deliver valued services.

The Home First Strategy recognises the need to build capacity within our communities and there will be a real focus on community growth and planning services based on what the people of Fife need. We will commit to ensuring people and place feature highly in our Home First transformation workstreams.

The table below describes the Home First strategic priorities included in the Strategic Plan for Fife.

Priority number	The changes we need to make	What will success look like?	Where we want to be in 2026
Priority 1	We will continue to build a model that utilises multi-agency Teams who can prevent admissions and support people to manage their long-term condition(s) at home	Teams will have access to relevant records and information that highlights those who may be at risk of admission to hospital and supports those who require intense case management	People living at home with long-term conditions will be enabled and supported to effectively manage their condition at home, and to live longer, healthier lives at home, or in a homely setting
Priority 2	We will utilise digital systems and applications to enable relevant multi-agency access to a single Anticipatory Care Plan	An increase in the number of patients and service users with an agreed Anticipatory Care Plan, and the number of agencies that can access the Plans	All patients and service users will be offered the opportunity to develop an appropriate Anticipatory Care Plan
Priority 3	We will utilise digital systems and applications to create a single point of access and build capacity in communities to embed a new model of care	Access to community care services will be streamlined, there will be less footfall in people's houses and care coordination within localities will result in people being cared for at the right time at the right place	People in Fife will be able to live longer healthier lives at home or in a homely setting
Priority 4	We will ensure that people who present at the Victoria Hospital, Kirkcaldy and do not need an acute admission, are redirected and supported to be cared for in the right place	A Front Door Team will fully function on-site at the VHK and will be integrated with Acute Services to ensure joined-up decision making, resulting in appropriate redirection of patients who do not require hospital admission	Only individuals who require acute care and whose needs cannot be met at home, or in a homely setting, are admitted to the Victoria Hospital
Priority 5	We will transform the hospital discharge process, ensuring that discharge planning and discussion begins as soon as possible	A reduction in the number of patients who are required to remain in hospital after they are medically well enough to be discharged home	Individuals require less hospital admissions, and when they do require hospitalisation are able to return to their home environment as soon as they are medically well enough

Locality Planning

The Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) puts in place the legislative framework to integrate health and social care services in Scotland. Section 29(3)(a) of the Act requires integration authorities to work within localities and in Fife we have established seven locality groups which are aligned to the Fife Council Local Area Committees. Health and Social Care Local Action Plans are currently based on improving joined up working across local teams and informed by the staff who have the insight and knowledge regarding delivery of health and social care services within the local community. The Locality Planning Groups will focus on changing the way we work to improve health and wellbeing outcomes.

The overarching aims of localities are to:

- promote healthy lifestyle choices and self-management of long-term conditions.
- support people to live healthy independent lives while living in their own home, or homely setting, for as long as possible.
- reduce the number of avoidable emergency admissions to hospital and minimise the time people are delayed in hospital.
- efficiently and effectively manage resources available to deliver Best Value.
- support staff to continuously improve information, support and care that they deliver.
- support unpaid carers, to reduce the impact of their caring role on their own health and wellbeing.

To achieve these aims the Locality Planning Groups take a systematic approach to gathering and analysing data in order to provide an accurate and timely evidence base that will influence locality priorities relating to the Home First Strategy. When reflecting on all the evidence across the seven localities, it is key that in order to make a positive impact in regard to the Home First Strategy, Locality Planning Groups ensure that people who use health and social care services get the right care and support, at the right time and in the right setting, with a focus on community-based and preventative care.

Medium-Term Financial Strategy

The financial position for public services continues to be challenging and the Integration Joint Board (IJB) must operate within significant budget restraints and pressures. It is therefore critical that our resources are targeted at the delivery of the strategic priorities identified in the HSCP Strategic Plan for Fife 2023 to 2026. To support this the IJB have developed the Medium-Term Financial Strategy (MTFS) which sets out the resources available and ensures that they are directed effectively to help deliver the outcomes identified in the HSCP Strategic Plan for Fife 2023 to 2026. The MTFS will inform decision making and actions required to support financial sustainability in the medium term. This includes transforming how we provide services to ensure these are safe, timely, effective, high quality and based on achieving personal outcomes.

Our Home First Strategy will be delivered in accordance with the MTFS and the funds that are made available to meet our statutory obligations in relation to service provision, and our performance targets in accordance with the National Health and Wellbeing Outcomes for Health and Social Care.

The MTFS acknowledges the financial challenges ahead, estimates any financial gap between resources available and those required to meet our strategic ambitions for the people of Fife and identifies measures required to address these challenges effectively. In order to ensure best value and transform our services, three key transformational projects, to support the delivery of the Home First Strategy, have been agreed by the IJB as follows:

A Bed Base Fit for the Future

By delivering our Home First Programme we will create an optimised, sustainable bed base that is fit for the future ensuring that there are the right numbers of community inpatient beds in Fife to deliver high quality, excellent care. The long-term ambition is to offer care and support to as many people as possible at home or in a homely setting and delivering initiatives that support achievement of that goal. The intention is to create a bed base that improves outcomes for people, is person-centred and enables people to be supported and cared for at home or in a homely setting for as long as possible.

In doing this we will:

- Reduce the amount of people that have been assessed as needing critical care in the community.
- Reduce delayed discharges through enhanced flow and appropriate community-based support being available.
- Optimise use of resources, workforce, and buildings to achieve best value.

Centralising Scheduling in Fife

Efficient scheduling can support capacity planning across many teams including releasing crucial clinical and caring time. We will ensure more efficient working by creating a centre of excellence whereby all staff providing scheduling support to services are co-located. This will allow standardised practices and sharing of knowledge and skills, with a view to exploring where there are opportunities to increase capacity across the integrated services.

Care at Home Commissioning for the People of Fife

The vision of the Home First Strategy is that everyone in Fife will live longer healthier lives at home or in a homely setting. This means investment in services that deliver care and support in the community is fundamental to realising this vision. We currently have a hybrid model whereby our care at home is delivered collaboratively by our in-house teams and our partners in both the third and independent sector. Through our Home First programme we will ensure there are efficient and equitable processes in place that maximise the available resource and collaborative relationships we have in Fife. In doing so there will be a focus on models of care in localities and the needs of the local communities, recognising that the needs in one community may be different to others. We will develop a fit for purpose, tailored, operating model that best suits the person who is at heart of everything we do.

The Home First Strategy is aligned with all of the Partnership's supporting strategies (see page 9), including the Commissioning Strategy 2023 to 2026 and our commissioning vision:

"To commission high quality, local, sustainable, and collaborative services that are person-centred and outcome-focussed, that support the delivery of care provision at the right time and in the right place, and enable people to live independent and healthier lives in their own home, and within their own community".

The Medium-Term Financial Strategy can be seen under the publications section of our website: www.fifehealthandsocialcare.org/publications.

Carers Strategy

The Carers Strategy gives the direction for support for all carers - young and adult -and will further increase the investment in some of the key supports for young and adult carers which they have told us would help them the most, such as respite breaks from caring to rest, play, and enjoying life's other pleasures are among the highest identified priorities carers have.

The planned introduction of a new National Care Service includes a commitment to give more opportunities to carers to take a break from their caring roles.

Additionally, the Scottish Government's new Carers Strategy outlines the approach to supporting unpaid carers at a national level; the national and local strategies complement each other, and together will ensure carers needs are once again at the forefront of our actions. For those reasons, the focus in the Carers Strategy is on what we will do in Fife to expand the range and types of support that will be available to carers, including short break support.

Fife Health and Social Care Partnership adopted a statement of intent of support for unpaid carers. This statement laid out our commitment to "ensuring that unpaid carers are fully supported to have a life alongside caring, in order to protect their health and wellbeing and better sustain caring roles."

There are clear linkages with community care provision and the unpaid care availability that the Carers Strategy is aiming to enhance, ensuring that carers are supported well and enabled to continue their caring role for as long as they are willing to.

National Care Service

The vision for the proposed National Care Service is that everyone has access to consistently high-quality social care support across Scotland, whenever they might need it.

The National Care Service aims to promote local responsibility for the design and responsiveness of care and support to the needs of our communities. It proposes to champion quality and embrace improvement across all aspects of the system.

The Home First Strategy is aligned to the principles of the National Care Service by working to remove barriers, tackle inequalities and allow people to flourish and live their lives as they want to.

Getting it Right for Everyone (GIRFE)

GIRFE is a national initiative that is aimed at developing a multi-agency approach of support and service from young adulthood to end of life care. This will help define the person's journey through individualised support and services and will respect the role that everyone has in providing support planning. This approach aims to provide a more personalised way to access help and support, placing the person at the centre of decisions that affect them in order to achieve the best outcomes, with a joined-up, coherent and consistent multi-agency approach through all stages of life.

Social Work Statutory Duty

The Social Work (Scotland) Act 1968 places a duty on the HSCP to assess and make provision for the welfare and protection needs of the residents in its local area. The social work and social care workforce in the Partnership carry forward this function to enable our approach to locality provision through each individual and family we support. Keeping the person at the centre of our work and ensuring that they have access to the information they need to make an informed decision regarding their right to direct their social care support, as set out within the Social Care (Self Directed Support) (Scotland) Act 2013, remains a commitment for the HSCP. Where an individual has an unpaid carer involved with their support, the HSCP will offer a carer support plan and provide signposting to local carer organisations to explore how the carer can be supported to remain able and well as they carry out their caring role.

Our processes are set out to enable these conversations and to ensure that the individual, their family, and carer are provided with the information and time they require to make informed decisions. This may mean that they are provided interim options out-with the hospital setting to afford the time such conversations and considerations require. The HSCPs models of service and support will be informed by these discussions and our ongoing relationships with our third, independent and voluntary providers as we work together to ensure the services offered in Fife are sustainable and meet the needs and demand of our residents.

Currently, all referrals for Social Work assessment are made through our contact centre. A screening process determines risk, and individuals are prioritised for assessment depending on their circumstances. Following allocation, if an outcomes focused assessment identifies need and extra support required, care packages will be allocated in line with current eligibility criteria and in accordance with the Social Care (Self Directed Support) (Scotland) Act 2013.

The task of assessment, care planning and review is encompassed within the term 'care management'. Social Work staff will often work closely with commissioning colleagues to access traditional services such as home care, day care or respite from providers in both the independent and public sector. They are also creative with self-directed support options to maximise an individual's independence. A key challenge in social work is to weigh up the promotion of independence, self-determination and individual rights against the need to provide sensitive protection to individuals facing risk.

Home First Strategy

Top Five Priorities

The Home First Strategy identifies these five key priorities.

Home First Standards

The Home First Standards have been developed to define and measure quality in the way that we deliver services to enable a Home First approach. The Home First Standards in Fife set out the actions that will enable us to deliver the Home First vision: *"Everyone in Fife is able to live longer, healthier lives at home, or in a homely setting."*

The Home First Standards are relevant to all the work that we do across the Home First Programme; they are particularly relevant to the key priorities shown in the table below and within the Home First Strategy Delivery Plan and accompanying Key Performance Indicators (KPIs), SMART (Specific, Measurable, Achievable, Relevant, Time-bound) improvement actions are described to ensure progress on delivery of these Standards. Further information on Fife's Home First Standards is also included in Appendix A.

The table below identifies the Strategic priorities mapped across the Home First Standards.

Priority 1 **Prevention and Early Intervention** We will continue to build a model that utilises multi-agency Teams who can prevent admissions and support people to manage their long-term condition(s) at home	**Priority 2** **Prevention and Early Intervention** We will utilise digital systems and applications to enable relevant multi-agency access to a single anticipatory care plan	**Priority 3** **Digital** We will utilise digital systems and applications to create a single point of access and build capacity in communities to embed a new model of care	**Priority 4** **Prevention of Admission** We will ensure that people who present at the Victoria Hospital, Kirkcaldy and do not need an acute admission, are redirected and supported to be cared for in the right place	**Priority 5** **Hospital Discharge** We will transform the hospital discharge process, ensuring that discharge planning and discussion begins as soon as possible
STANDARD 1: Adults in fife will have timely access to a community-based team intervention in order to prevent hospital admissions and by intervening early will be managed at home or in a homely setting.				
✓		✓	✓	
STANDARD 2: adults in care homes across fife will all have anticipatory care plan in place with supportive community- based services managing care in order to reduce unnecessary acute hospital admissions and ensure care is delivered in a homely setting.				
✓	✓	✓	✓	
STANDARD 3: 'at risk' individuals in fife should have timely access to community based services in order to reduce unnecessary acute hospital admissions.				
✓		✓	✓	✓
STANDARD 4: adults in fife hospital settings will be discharged to a suitable community setting without unnecessary delay.				
✓			✓	✓
STANDARD 5: adults in fife hospital settings will be discharged with reduced requirement for interim solutions.				
		✓	✓	✓

Participation and Engagement

There is a strong legislative and policy context for participation and engagement across health and social care that demands and promotes participation and engagement with individuals, their carers and families, communities, and our partners.

Fife Health and Social Care Partnership recognises the range of national standards, guidance, and principles to aid with the planning and organisation of participation and engagement activities to ensure they are meaningful, accessible, and flexible to encourage and increase participation. The Participation and Engagement Strategy was refreshed in 2022 and has strengthened the need for these principles to be integral to all other strategies, including Home First. The Participation and Engagement Strategy is available in the publications section of our website: www.fifehealthandsocialcare.org/publications.

The principles of participation and engagement call for, and underline, the need to engage with, and listen to, individuals directly impacted by the changes brought about by the development and delivery of the Home First Strategy. As part of the development of the Strategy three stages were identified:

1. **Listening to people who have recently used Health and Social Care Services**

   A number of participation and engagement approaches were taken to gather individual experiences and stories of using Health and Social Care Partnership services to understand the patient journey. This was through a number of engagement events and an electronic survey.

2. **Hearing the views of people who deliver the services**

   A series of on-line stakeholder engagement events were run and staff working across the wide range of services contributed experiences, views and thoughts on the Home First vision.

   The key themes identified from this engagement work are:

   - Home is the right place to be.
     - We should be enabling people to get home where we can.
     - Delayed discharges should be prevented.
     - Person-centred care and support should be our focus.
   - The vision has a person-centred focus.
     - The focus is on the patient and their family and their needs – this is what it should be and what we should be working towards
     - Making the person's journey smoother should be a priority.
     - Offering person-centred/tailored care will improve people's health.
   - IT systems that will work with one another.
     - Ensure those who need access to patients notes can do so without having to call various people across what is meant to be an integrated system.
     - Will avoid patients having to tell the same story multiple times.

- Streamlining services
  - No longer working in silos.
  - Holistic view and approach are positive and how we should be working.
  - Overall improved communication across services
  - Improved access to information – knowing where to go.
  - Having clearer pathways for referrals

3. **Building participation and engagement processes into the Home First Programme transformational workstreams**

   There is recognition and commitment to the need for ongoing participation and engagement processes for the successful delivery of the Home First Vision and Strategy. This has been reflected in each of the Home First workstreams with a range of participation and engagement approaches being used.

Home First Programme

The Home First Programme is the primary method to deliver this Home First Strategy and, in line with the national directive, is composed of working subgroups/workstreams that each focus on key transformational areas of the Home First model. These are:

- Anticipatory Care
- Screen and Assess for Frailty
- Integrated Discharge Planning
- Joint Commissioning and Resourcing
- Intermediate Care
- Housing, Community Support and Technology Enabled Care
- Co-ordinated Case Management (creating a Single Point of Access - SPOAs)
- Information and Data
- Communication and Engagement

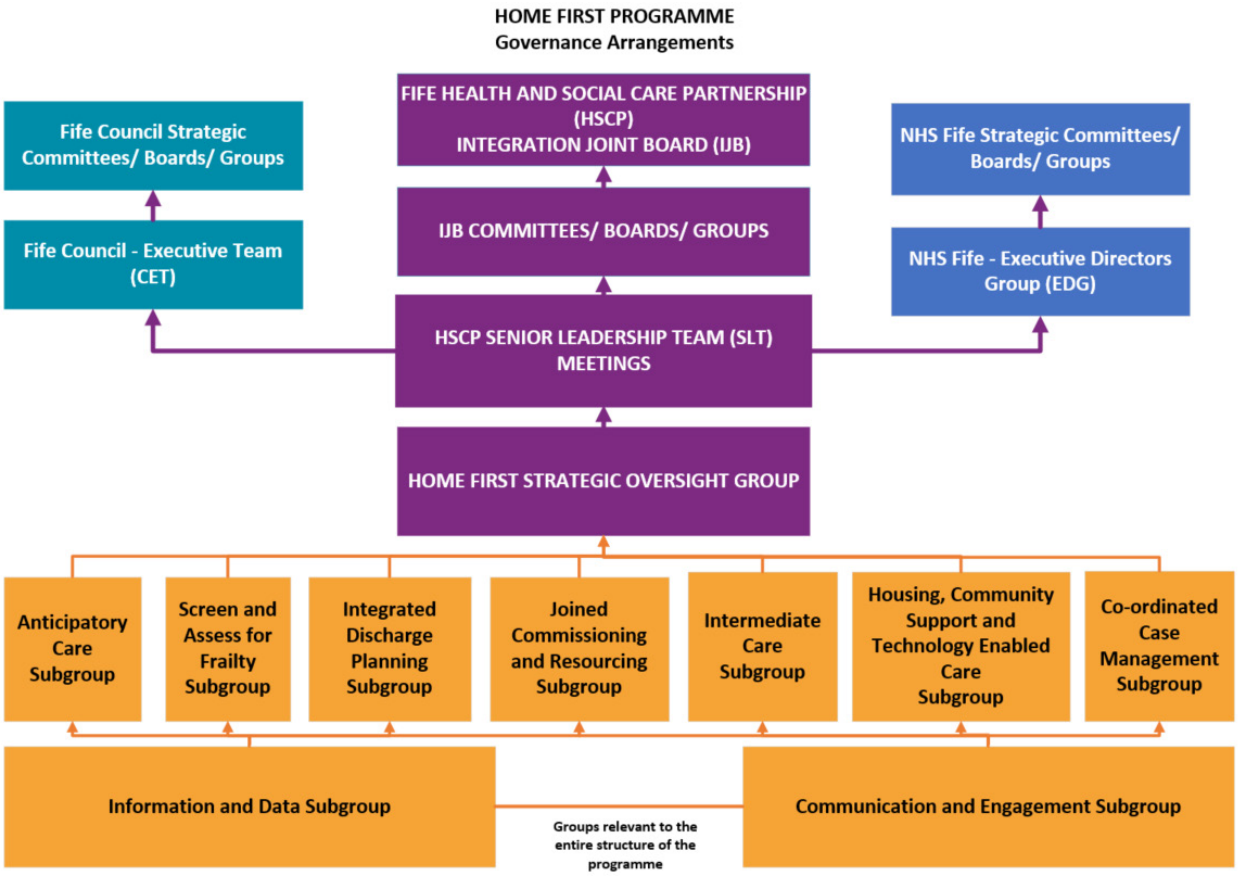
Subgroups have been established, with agreed terms of reference, for their area of strategy delivery and aligned to the transformational areas. Progress and performance is formally reported through the Home First Strategic Oversight Group and on to the Partnership's Committees/ Boards/Strategic Groups.

The Home First Oversight Group has delegated authority from the Sponsoring Group (Health and Social Care Partnership Senior Leadership Team) to:

- Support the implementation of an integrated Home First delivery model for Fife.
- Co-ordinate the workstreams in line with the agreed priorities.
- Act as a governance body to ensure the delivery plan is progressing and the standards are being met.
- Act as a forum for collaboration to support services in the operational delivery of the Home First model.
- Set direction for services in relation to actions from the Home First Strategy.
- Escalate issues for support and direction to the Health and Social Care Partnership Senior Leadership Team.
- Ensure accurate and timely communications in line with the agreed Home First Strategy.
- Align with and promote the delivery of digital solutions, which will support the implementation of the aims and objectives of the Home First Strategy.

Rigourous governance arrangements are in place, as per diagram 4 below, to ensure appropriate scrutiny. Any decisions that are required and all improvement projects that are implemented in accordance with the Strategy, are progressed through the governance structure, enabling us to continue to deliver positive and transformational change for individuals, families and carers, and communities across Fife. The Home First Oversight Group ensures robust governance and oversight of the entire programme.

Diagram 4: Governance Arrangements



Further to the robust reporting and governance arrangements, diagram 5 identifies the connections between the Home First Vision, Home First strategic priorities, and the national direction and how they link to deliver the transformational change initiatives required to implement the Home First Strategy.

Diagram 5: The table describes the Home First strategic priorities included in the Strategic Plan for Fife

Strategic Direction

This section of the Home First Strategy describes Fife's high level strategic direction linked to the 10 actions that the Scottish Government outline Health and Social Care Partnership's take to transform discharge from hospitals.

Screen and Assess for Frailty

Relevant to Home First Strategic Priority 1 - We will continue to build a model that utilises multi-agency teams who can prevent admissions and support people to manage their long-term condition(s) at home.

Relevant to Home First Standards 1, 2, 3 and 4.

Prioritising effective communication and joint working across health and social care and third sector organisations to maximise service delivery and engagement with staff in relation to the Screening and Assessment for Frailty for patients across Fife is a key component of Home First to prevent hospital admissions.

Lack of understanding of the complexity of frailty, timely identification and appropriate holistic interventions leads to poorer outcomes for patients when presenting to the acute or community hospitals.

If patients with frailty are not identified at the earliest opportunity during a hospital presentation, they are at increased risk of being exposed to harm associated with hospitalisation such as falls, delirium and malnutrition. These patients would also not have the opportunity to benefit from a comprehensive geriatric assessment, which has been shown to improve outcomes through reduction in hospital length of stay and offering an increased likelihood of living in their own homes following a hospital admission. Comprehensive geriatric assessments (Diagram 6) should be undertaken by professionals who are appropriately trained to understand the complexity of frailty and able to assess the person in a holistic way, taking into consideration their physical and cognitive function, social circumstances, environmental issues and their medical condition, including their presenting complaint and their past medical history.

Diagram 6: British Geriatric Society definition of a Comprehensive Geriatric Assessment

To facilitate early identification of frailty at the front door it is essential that a robust screening tool is used. There are various tools available, and a local tool has been developed to support early identification of frailty also allowing a rapid cognitive assessment and falls assessment which are key elements of the Older People in Acute Hospital Standards (Health Improvement Scotland 2015) and the Scottish Patient Safety Falls programme. The scale below is a globally recognised scale which is used within the acute hospital and the community to identify a person's level of frailty and can support effective pathways of care for people living with frailty.

The NHS Fife Inpatient Frailty Screening Tool is shown in diagram 7.

Diagram 7: Frailty Screening Tool

Frailty Screening Tool

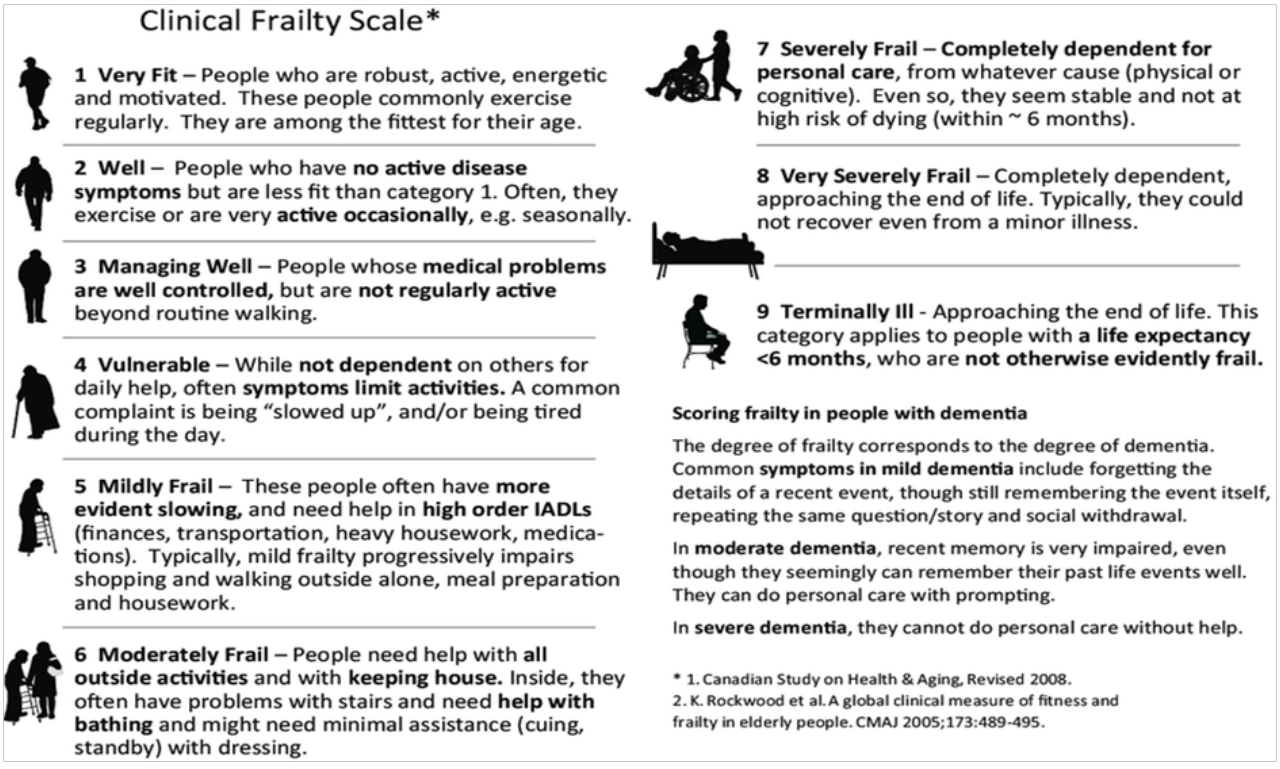
Would this person benefit from Comprehensive Geriatric Assessment? If answered "Yes" to any of the following questions please refer to the Integrated Assessment Team

Practitioner Signature: …… Date: …… Time: ……..

1. Has the patient been admitted from a nursing or residential home?	YES ☐ NO ☐
2. Does the patient have **NEW functional** decline?	YES ☐ NO ☐
3. Dementia diagnosis or are there any concerns about memory/cognition?	YES ☐ NO ☐
4. Is the patient acutely confused, more confused than usual or more sleepy/drowsy than usual?	YES ☐ NO ☐
5. Has the patient fallen in the past 3 months or is a fall the reason for admission?	YES ☐ NO ☐
6. Does the patient attempt to walk alone although unsteady or unsafe?	YES ☐ NO ☐
7. Does the patient or their relatives have fear or anxiety re falling?	YES ☐ NO ☐
If YES to Question 3, 4 or 5: Complete 4AT below. THINK DELIRIUM **Initiate FALLS PATHWAY if FALLS OR COGNITIVE questions positive**	
FALLS PATHWAY initiated	☐ **YES** ☐ **NO**

Rockwood Clinical Frailty Scale is described in diagram 8 below.

Diagram 8: Clinical Frailty Scale



Anticipatory Care

Relevant to Home First Strategic Priority 2 - We will utilise digital systems and applications to enable relevant multi-agency access to a single Anticipatory Care Plan.

Relevant to Home First Standard 2.

The Home First Anticipatory Care Planning adopts an inter-agency and multi-disciplinary approach to embedding Anticipatory Care Plans in Fife to support individuals to have greater control and choice through recording their wishes and care preferences in the event of a future deterioration of health, or sudden change in circumstances, for themselves or their carer(s).

Anticipatory Care Planning will create and support a spectrum of support for individuals and their carer(s) to have increased choice and control of care preferences in advance of future deterioration of health. Service users and carers will have Anticipatory Care Plans and linked Key Information Summaries to increase the resilience of both individuals, families, carers, and local communities, reduce dependency on services, and reduce emergency admissions to hospital through encouraging and enabling people to access community care resources through self-management.

One such resource is the Life Curve App, which supports individuals to monitor their own abilities in order that they can gauge their own levels of need and dependency based on movements and activities that they start to find difficult. The intention is that the Life Curve App will be widely promoted across Fife and that services will support service users to use it and link individuals to services and supports across Fife that can support the service user to undertake activities or join groups. This part of the Home First Strategy is linked to Intermediate Care as well as Anticipatory Care and as such, both subgroups will continue to work together to support the roll out and implementation of Life Curve across Fife.

Information and Data

Relevant to Home First Strategic Priority 3 - We will utilise digital systems and applications to create a single point of access and build capacity in communities to embed a new model of care.

Relevant to Home First Standards 1, 2, 3 and 5.

As part of the Home First Programme a digital dashboard has been developed as the measurement and reporting tool for the successful implementation of the Home First Strategy and its vision.

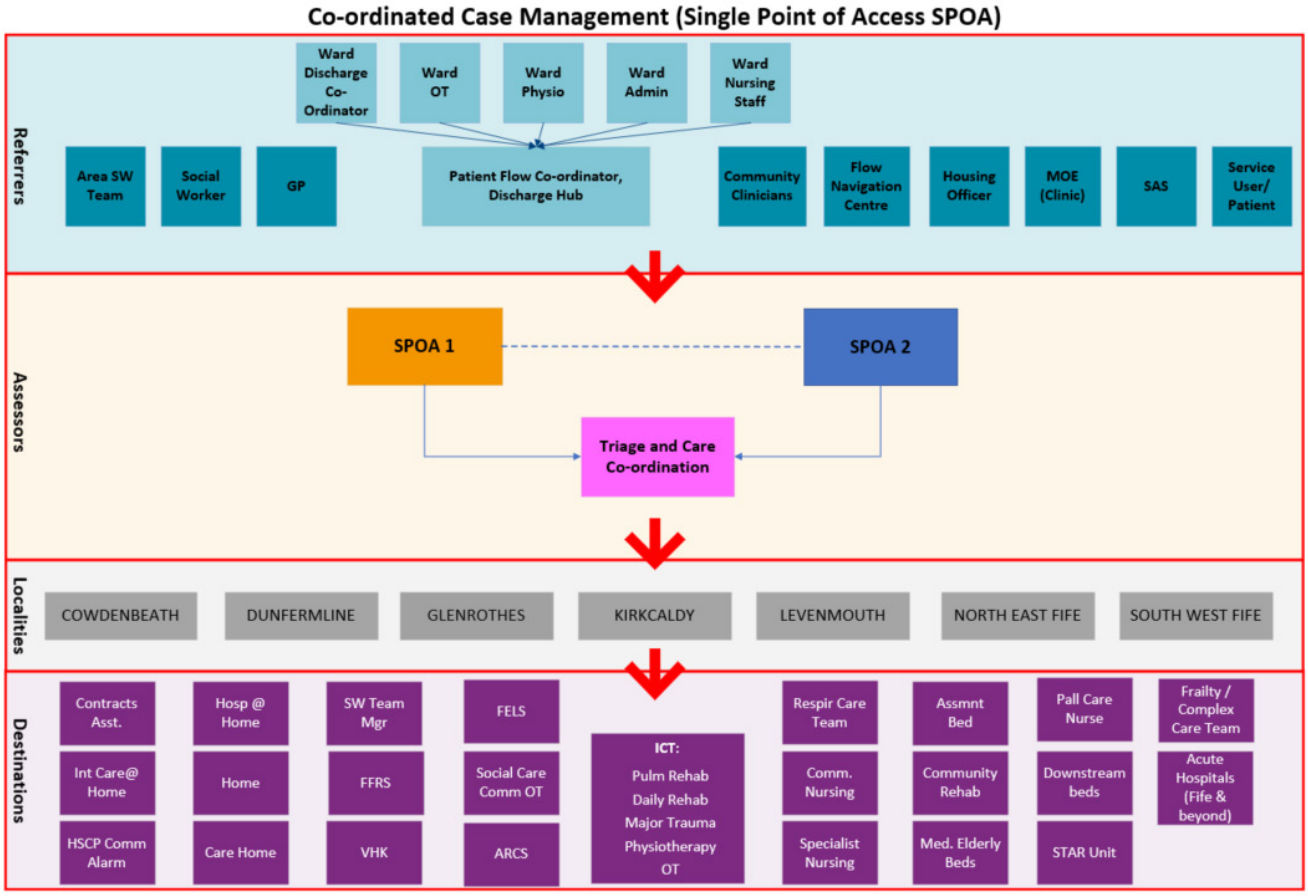
Co-ordinated Case Management/Single Point of Access

Relevant to Home First Strategic Priority 3 - We will utilise digital systems and applications to create a single point of access and build capacity in communities to embed a new model of care.

Relevant to Home First Standards 1, 2, 3 and 5.

The co-ordinated case management project will create a single point of access to integrate systems across the partners. This will achieve the aim of the Home First vision to streamline the referral pathways to support timely discharge through the creation of a single point of access to manage the flow of referrals as per diagram 9 below.

Diagram 9: Co-ordinated Case Management (Single Point of Access)



Joint Commissioning and Resourcing

Relevant to Home First Strategic Priority 4 - We will ensure that people who present at the Victoria Hospital, Kirkcaldy (VHK) and do not need an acute admission, are redirected and supported to be cared for in the right place.

Relevant to ALL Home First Standards.

The Joint Commissioning and Resourcing guiding principle is to consider the aspects of commissioning that support the Home First model working with providers, Scottish Care, and inhouse provision to redesign a health and social care system that is fit for the future.

Intermediate Care

Relevant to Home First Strategic Priority 5 - We will transform the hospital discharge process, ensuring that discharge planning and discussion begins as soon as possible.

Relevant to Home First Standards 3, 4 and 5.

Intermediate Care Services play a vital role in health and social care systems. Whilst Intermediate Care Services are available to all aged 18 years and over, the significant majority of those supported are primarily older people living with frailty and other health and social care challenges. A range of skilled professionals support this group with short-term escalations of need with the intent of helping people to return to optimal heath, their own home, living independently and with strengths-based support as needed.

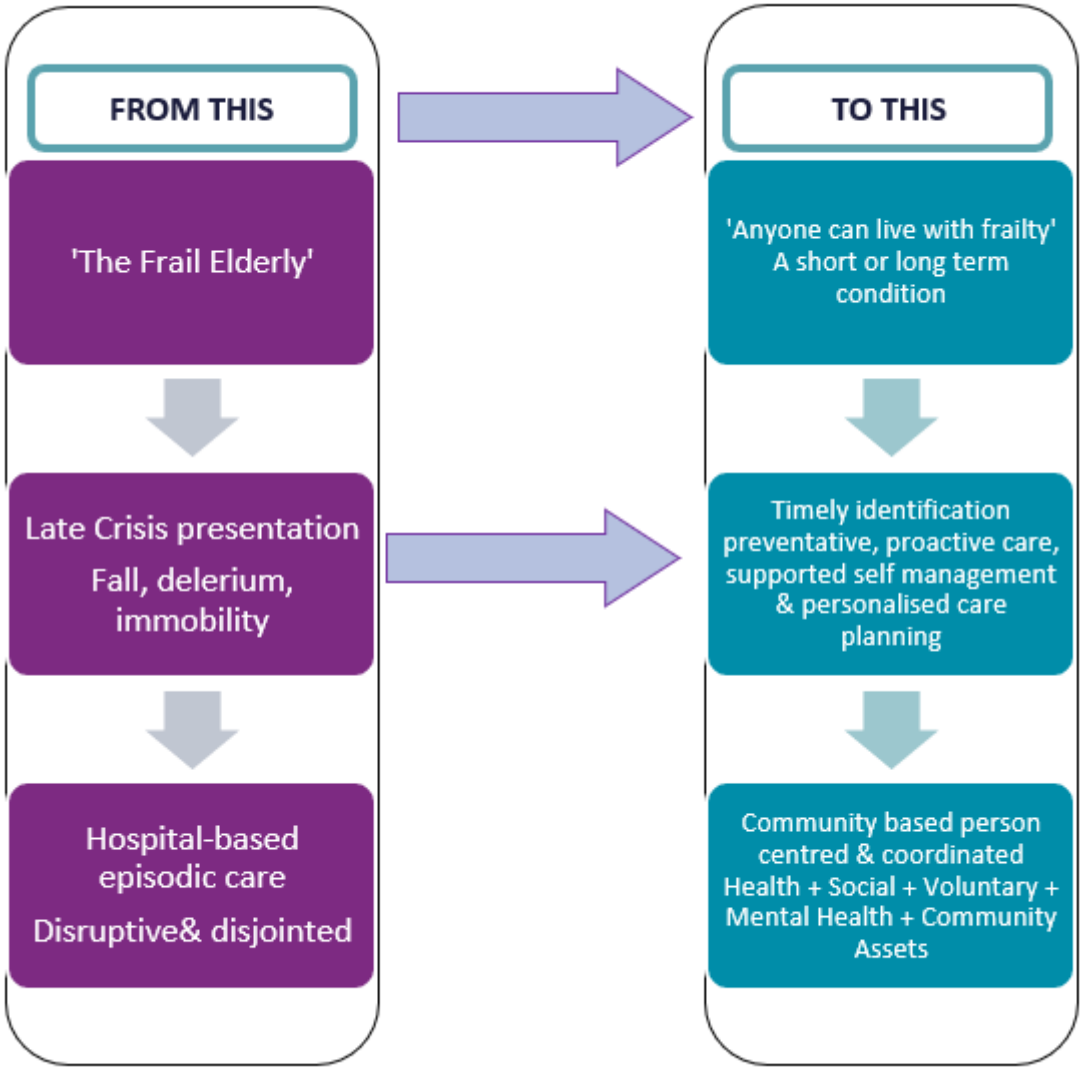
Intermediate Care is a short-term, focused intervention, for adults who are able to be looked after in their home environment, maximising recovery and promoting independence. It supports the ethos of delivering rehabilitation and re-ablement to the right person, at the right time, in the right place with the right intensity. Care is delivered by a spectrum of multi-professional services, working collaboratively with the patient/carer in a responsive, co-ordinated, and flexible way.

The aim is to prevent unnecessary admission to acute hospital/long term residential care, promote faster recovery from illness, support timely discharge from hospital to optimise a return of confidence and independence, and avoid making premature decisions about future long-term care.

Intermediate Care guiding principles are to ensure that people who are able to be looked after in their home environment are supported to do so. Short term focused intervention with clear outcomes agreed with the service user is fundamental to achieving good outcomes. Intermediate care is delivered in a co-ordinated way by multi-professional and multi-agency services and is responsive and flexible. Fife's Intermediate Care Model involves a spectrum of intervention that maximises recovery and promotes independence including services that provide rehabilitation and re-ablement from both statutory and third sector organisations.

Diagram 10 below illustrates a stepped change approach to move from the current state to the desired future, outlining the shifts required to deliver improved outcomes linked to frailty.

Diagram 10: Future outcomes of frailty



Functional Independence Levels

Acknowledgement to Alex Robertson, Director, AJ Robertson Consulting for providing the diagrams.

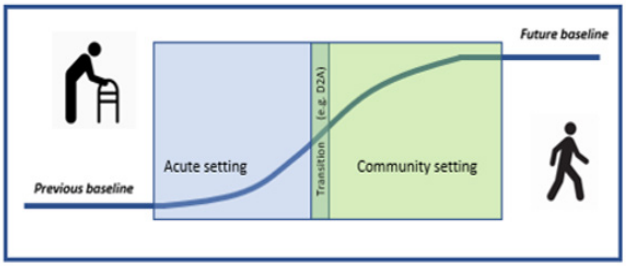
Diagram 11 below demonstrates a visual representation of functional independence pathways which are key to ensuring people's personal outcomes remain a focus for services.

Diagram 11: Functional Independence Levels

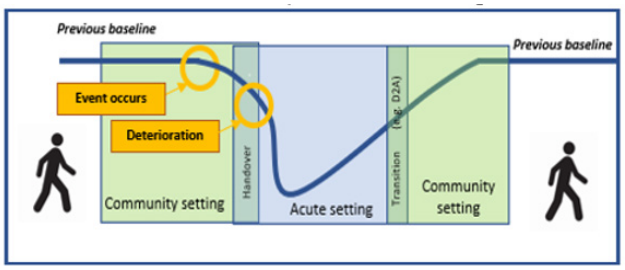
Functional Independence Levels

Understanding which functional independence pathway and individual is on at the outset, helps ensure the system remains focused on the desired outcome for the individual at every stage

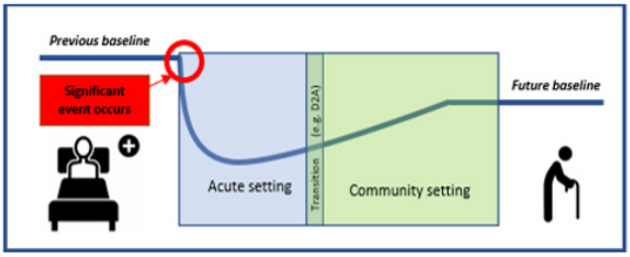
A person who has a chronic issue (e.g. requires a hip replacement) and is admitted to hospital to improve their functioning.



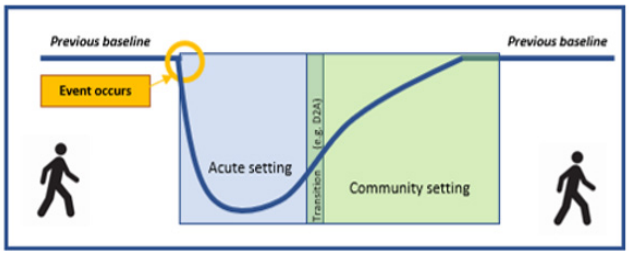
A person who has ongoing community-managed condition / issue which deteriorates and is admitted to hospital to return to their previous functioning.



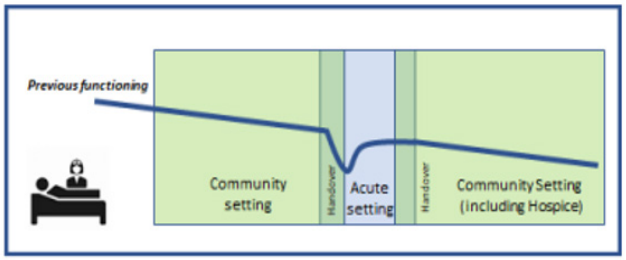
A person who has had a significant life event (e.g. stroke, MI), who may not re-attain their previous functioning.



A person who has a life event (e.g. compound leg fracture), who is admitted to hospital to return to their previous functioning.



A patient who is receiving palliative care, in the nest place for them, at the right time, and in accordance with their wishes.



The role of Intermediate Care Services is to work with other services as needed to support the person effectively.

Hospital at Home

As well as preventing hospital admissions and accepting patients who require step down acute care, Hospital at Home (H@H) also accept referrals from the Scottish Ambulance Service (SAS), with support from the Flow and Navigation Centre, during the out of hours period for people living within care homes. This has supported a reduction in unnecessary transfers from care homes to acute services. H@H are also developing an in-reach model to acute services with Nurse Practitioners to promote prevention of admission, timely discharge and support increased flow.

Intermediate Care Team

The Intermediate Care Teams (ICT) have worked with Fife Voluntary Action (FVA) on an initiative which developed and implemented a protocol for undertaking the delivery of equipment when a home is empty, and no-one is available to accept the delivery. This integrated work supports timely discharges from community hospitals by facilitating prompt delivery of equipment. ICT have also collaborated with social care colleagues and our independent partners to facilitate people moving from hospital to a more homely setting by creating Assistant Practitioner (AP) posts to support the interim bed model. The APs work independently within care homes linking closely with care home staff and Assessment and Review Practitioners (ARPs). These posts assist individuals by providing ongoing general rehabilitation intervention programmes to prevent deconditioning whilst people await preparations for discharge home.

Care Home Beds

In Fife there are many beds available to support early discharge, such as:

- Residential/nursing emergency placement – to support individuals from the community who can no longer remain in their own home without support or may now require long term care support in a care home, or where a carer break is required.
- Interim beds – to support individuals who require a limited period within a care home setting for 6-8 weeks, until their Care at Home service has been sourced and to support enablement and confidence to maintain daily living skills, to support a return to their own home.
- See YouTube video on Care Home choices on the link below: My home from home
- Short Term Assessment and Reablement (STAR) beds - to support enablement and confidence to regain and maintain daily living skills, for anyone over the age of 65 for a period of up to 6 weeks. The service is delivered by the Short Term Assessment and Reablement Team (START).

  Assessment beds – to support individuals who are over the age of 65 years where it is anticipated that their care pathway will be long term care and where an extended period up to 6 weeks of assessment is required to make this decision. In addition, to support individuals who require a longer time to make care home choices once a care assessment has been concluded.

- Temporary resident - to support individuals who require a limited period (not exceeding 52 weeks) within a Care Home setting, for example, due to housing issues where their own home is flooded, fire damaged, requires adaptation etc.
- Long term residential/nursing care – to support individuals who require either residential or nursing care.

Integrated Discharge Planning

Relevant to Home First Strategic Priority 5 - We will transform the hospital discharge process, ensuring that discharge planning and discussion begins as soon as possible.

Relevant to Home First Standards 3, 4 and 5.

The term delayed discharge is used in situations where a patient in hospital has been assessed as being medically ready for discharge but continues to occupy a hospital bed.

The Home First Integrated Discharge Planning ethos is to ensure that a cohesive approach is adopted with regards to timely, safe, and appropriate discharge planning. Integrated Discharge Planning involves reducing those in hospital experiencing a delay in discharge which can be harmful and debilitating and may result in an inability to return to living independently at home. Part of this Integrated Discharge Planning ensures that equipment or adaptations are accessed online at www.smartlifeinfife.org. This is a web-based assessment system which may suggest equipment to resolve issues. Minor equipment will be loaned through the Fife Equipment Loan Store. Achieving timely discharges is important and demonstrates a person-centred, effective, and integrated approach to the individual's health and social needs. Integrated Discharge Planning will ensure people are supported to make decisions about longer term care in a care home environment. Individuals who lack capacity to consent to the proposed care package will be discharged within an appropriate legal framework.

Local guidance has been established to support decision making to ensure timely discharges and makes operational the Scottish Government CEL (Chief Executive Letter) 32 (2013) "Guidance on Choosing a Care Home on Discharge from Hospital", in particular the following statement has influenced the work of the Home First Strategy:

"Clear local protocols, that are robustly and consistently implemented with the support of all staff including senior managers, clinicians, ward and social work staff are essential to improve discharge planning and improve outcomes for patients".

Fife's Moving On policy goes wider and sets out the arrangements to manage 'Moving On' and discharge to the appropriate care and support settings. It also provides a clear and consistent local process for staff, individuals in hospital, their families/guardian and/or proxy decision makers to arrange a timely discharge from hospital and ensures Health and Social Care staff and NHS Fife staff are aware of their responsibilities.

Integrated Discharge Planning takes a whole systems approach to ensuring that patient moving on from inpatient admissions to a supported community setting happens in a safe and timely manner. This approach has enabled efficient discharge planning for the benefit of people living in Fife requiring any type of social or health support in the community to return home or to a homely setting.

Adults with Incapacity (AWI)

At times, patients may be unable to consent to the proposed arrangements to facilitate a safe and timely discharge from hospital. A refresh of the arrangements for the timeous discharge of patients unable to consent has been fundamental to realising our Home First Vision.

To further support the work described above, two Mental Health Officers now have a specific role to provide expert advice and support to social work staff undertaking assessments for people in hospital, who are deemed to lack capacity to consent to a support plan to enable their discharge. Their role includes supporting staff with consideration of 13ZA of the Social Work Scotland Act as timeously as possible.

Section 13ZA of the Social Work (Scotland) Act 1968 makes it explicit that following an assessment of an adult's needs and outcomes, if the adult requires a community care service but is not capable of making decisions about the service, the local authority may take any steps they consider necessary to help the adult benefit from the service.

Pharmacy and Medicines

Medicines are the most common intervention in healthcare. However, medicines also have the potential to cause adverse events and harm, particularly in frail and elderly patients commonly prescribed multiple medicines for multiple co-morbidities. Pharmacy plays a critical role in all aspects of the prescribing, dispensing, checking, monitoring and clinical governance of medicines in Fife and supports the Home First Strategy vision by reducing harm from medicines and improving patient care.

The pharmacy team works in collaboration with the patients and multi-disciplinary team colleagues to undertake medication reviews and contribute to ward rounds, in order to reduce unnecessary prescribing of medicines. Thus, reducing the potential harm from medicines and improving the person's health-related quality of life. Reviews of patients who take multiple medicines (polypharmacy) has a positive impact on patient care through medicines optimisation (starting or stopping medicines) reducing risk of falls, side effects of medicines and risk of hospital admissions. This contributes to the overall health of the patient and empowers them to live independently for as long as possible.

When patients in the hospital setting are medically fit for discharge, pharmacy teams contribute to discharge planning and help reduce delayed discharges by:

1. Improving access to information – Pharmacy teams have access to information regarding the flow of patients and therefore prioritise patients with a planned discharge date and support discharge planning and timely access to discharge medicines.
2. Medicines reconciliation - Pharmacy has an integral role in medicines reconciliation to support seamless care across the interface and reduce the risk of errors.
3. Prioritising patients - Pharmacy Technicians use toolkits to prioritise the patients that the Pharmacist reviews to identify patients with the greatest need or risk of harm from medicines.
4. Advising on all aspects of medicines - Pharmacy teams advise on medicine related queries, support discharge planning, early intervention, crisis prevention, anticipatory planning and advise on medicines supporting patients to maintain independence and remain at home or their place of care for as long as possible.
5. Timely access to discharge medicines - Pharmacy Team works in collaboration with Health and Social Care Staff to ensure timely access to discharge medicines to support patients being discharged from the Fife Hospitals on the planned discharge date.
6. Seamless care - Good communication is essential to ensure medicine safety across the transitions of care, including seamless transfer of medicines information across the interface. Following discharge from hospital, patients are supported by Pharmacy teams working in general practice and community pharmacy to ensure continued safe and effective use of medicines. Robust electronic systems are required to enable timely sharing of clinical and medicines information between different sectors of care. A new electronic immediate discharge document (eIDD) is being introduced in Autumn 2023 and it is expected that a new electronic prescribing system HEPMA (Hospital Electronic Prescribing and Medicines Administration) will be introduced in NHS Fife in 2024. Both of these will support the timely transfer of medicines information across the interface.

Housing, Community Support and Technology Enabled Care

Relevant to Home First Strategic Priority 5 - We will transform the hospital discharge process, ensuring that discharge planning and discussion begins as soon as possible.

Relevant to Home First Standards 3, 4 and 5.

Housing, Community Support & Technology Enabled Care (TEC) is fundamental to minimise delays where housing is the primary reason for a delayed discharge and ensure service users are rehoused or are given housing related supports to ensure that they can live independently.

There are various housing related issues which can lead to a delayed discharge from hospital as described below, such as the person's home being unsuitable based on current circumstances, the service user is homeless at the point that they enter hospital or made homeless during their time in hospital, the home is suitable but requires adaptations to be appropriate and conditions at home that need to be resolved e.g repairs, house cleanliness.

There are a range of actions that the Fife Housing Partnership are undertaking to support the Home First Strategy as described in diagram 12 below:

Diagram 12: Actions for the Fife Housing Partnership

To support people to live at home as independently as possible Technology Enabled Care is a key component of Home First. Diagram 13 describes what an optimal model would look like.

Diagram 13: Technology Enabled Care at Home

The aspiration of Fife is that individuals have a health monitoring device such as a smart watch and a range of other critical life signs monitoring tools which are sent to an app on a smartphone so that the individual has access to information about their health. Smart monitoring devices within the home also monitor the quality of the environment. This is all fed into the cloud where an Artificial Intelligence (AI) algorithm interprets this and produces alerts where required. A responsive team within a mix of Health and Social Care and Housing receives the data and takes action to assist the individual to manage the health situation avoiding an admission to hospital.

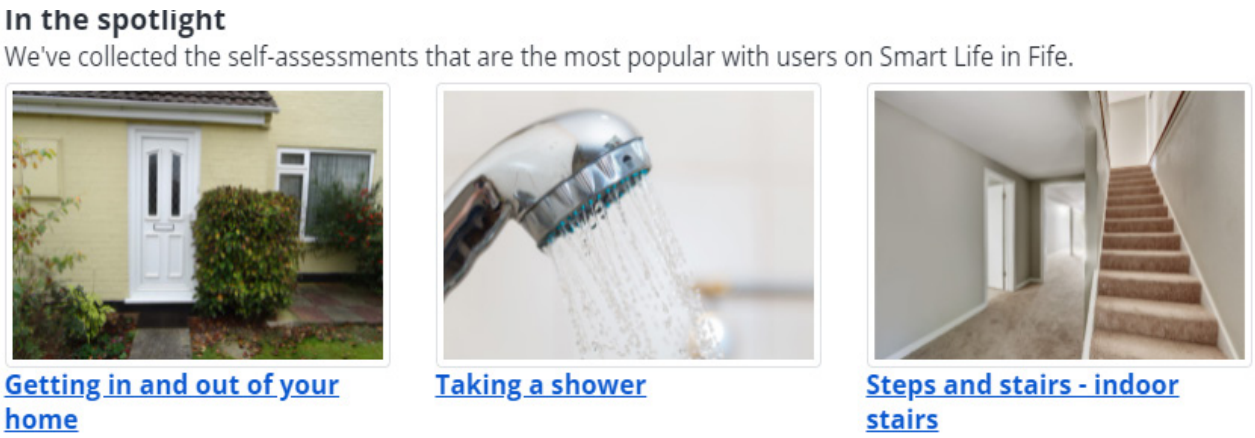
Through our Housing Plus programme we are exploring a range of projects which will assist Home First, for example;

- Independent living advice hubs to promote TEC products and offer advice on how they can be used
- TEC Demonstrator property – to show workers and members of the public how this can be used to remain independent
- Overnight TEC House – the aim of this TEC house will be to create a property where tenants can stay overnight and test out the use of TEC
- CHARM Project – active health monitoring project which could be expanded and used to assist with Hospital Discharge.
- Environmental sensors – a project is being tested to look at installing a range of environmental sensors within a property. This would allow us to monitor if the property is being heated and moisture levels within the property, therefore monitoring how healthy the environment within the property is.

Within the Housing Partnership there is a focus on promoting independent living as a means of helping individuals to maintain better health and independence. Housing and independent living advice is the key to keeping people living longer and more successfully within the community. Housing Officers visit a range of properties during their day-to-day work and the development of an assessment tool to assess levels of frailty will assist Housing Officers gather information around who needs support to remain in the community, see diagram 14.

In addition, there is a need for advice before going into hospital and when in hospital, to support a more seamless return to home. Leaflets and online information are being developed to support this.

Diagram 14: Examples of Self Assessments undertaken



Communication and Engagement

Relevant to all Home First Strategic Priorities and to all Home First Standards

A series of participation and engagement stakeholder events were delivered as part of developing the Home First Strategy. Key participation and engagement content has contributed to the Home First Strategy.

The co-ordination of all future communication and engagement activities relevant to Home First Strategy implementation will be managed by the Communication and Engagement subgroup and will report to the Home First Oversight Group on a regular basis.

Monitoring and Review

The Home First Strategy Delivery Plan provides details of specific projects which support the implementation of the Home First Strategy categorised by each of the Home First strategic priorities and identifies their relevance to the Home First Standards.

The delivery of the individual projects will be monitored by the Home First Oversight Group. The Home First Dashboard will measure the successful implementation of the Strategy through the regular reporting against the Key Performance Indicators (KPIs) relevant to each of the projects within the Delivery Plan.

The Home First Oversight Group, in managing the Delivery Plan implementation, is accountable to the Health and Social Care Partnership Strategic Planning Group who provide regular reports to Committees, and on to the Integration Joint Board. This will include quarterly Flash Reports (progress updates), Annual Reports, and the escalation of any potential issues or risks through the Home First Programme Risk Register.

The Home First programme undertook an Equality Impact Assessment (EqIA) Stage 1, and it aims to ensure that the health and social care support system is focused on equity, quality improvement and reducing health inequalities.

As part of the Equality Impact Assessment process consideration has been given to the good principles laid out in Healthcare Improvement Scotland Improvement Hub (IHUB), Equity, Health Inequality and Quality Improvement discussion document.

Conclusion

Fife's Home First Strategy delivers on the national guidance to improve the hospital discharge process for the residents of Fife and sets out the local initiatives relevant to the three critical elements of the Home First model: early intervention and prevention, person-centred at the heart of all care decisions and a whole system approach.

The vision of the Home First Strategy reflects the ambition of Team Fife to transform a community model of care, in an integrated way, to the highest standards ensuring that

"everyone in Fife is able to live longer, healthier lives at home, or in a homely setting".

Glossary of Terms

ACP	Anticipatory Care Plan
AHP	Allied Health Professionals
AI	Artificial Intelligence
ANP	Advanced Nurse Practitioner
AP	Assistant Practitioner
ARCS	Assessment and Rehab Centre Support
ARP	Assessment and Review Practitioner
AWI	Adults With Incapacity
BAU	Business As Usual
C&YP	Children And Young People
CCS	Community Care Services
CEL	Chief Executive Letter
CET	Council Executive Team
CFS	Chronic Fatigue Syndrome
CGA	Comprehensive Geriatric Assessment
COSLA	Convention of Scottish Local Authorities
D&I	Digital And Information
DN	District Nurse
DPIA	Data Protection Impact Assessment
DwD	Discharge without Delay
ED	Emergency Department
EDG	Executive Directors Group
eIDD	Electronic Immediate Discharge Document

EQIA	Equality Impact Assessment
FELS	Fife Equipment Loan Store
FFRS	Fife Fire and Rescue Service
FRS	Fife Rehabilitation Service
FTE	Full Time Equivalent
FVA	Fife Voluntary Action
GIRFE	Getting it Right for Everyone
GP	General Practitioners
H@H	Hospital at Home
HEPMA	Hospital Electronic Prescribing and Medicines Administration
HPW	Hours Per week
HR	Human Resources
HSCP	Health and Social Care Partnership
IAT	Immediate Assessment Team
ICASS	Integrated Community Assessment and Support Service
ICT	Intermediate Care Team, Community Car Services
iHUB	Improvement HUB, Health Improvement Scotland
IJB	Integration Joint Board
JIT	Joint Improvement Team (Scottish Government)
KPIs	Key Performance Indicators
LoS	Length of Stay
MDT	Multidisciplinary Team
ME	Myalgic Encephalomyelitis
MoE	Medicine of the Elderly
MORSE	Electronic Patient Record Platform

MSPS	Member Of Scottish Parliament
MTFS	Medium-Term Financial Strategy
NHS	National Health Service
OT	Occupational Therapy
P.A	Per Annum
PDD	Planned Discharge Date
PMO	Programme Management Office
POSA	Personal Outcomes Assessment
RAD	Rapid Assessment to Discharge
RADU	Rapid Assessment Discharge Unit
SAS	Scottish Ambulance Service
SG	Scottish Government
SGSU	Sir George Sharp Unit
SLT	Senior Leadership Team
SMART	Specific, Measurable, Achievable, Relevant, Time-bound
SPOA	Single Point of Access
SRO	Senior Responsible Officer
STAR	Short Term Assessment and Reablement
START	Short Term Assessment and Reablement Team
SW	Social Work
TBC	To Be Confirmed
TEC	Technology Enabled Care
VHK	Victoria Hospital Kirkcaldy
WTE	Whole Time Equivalent

Appendix 1: Fife's Home First Standards

Standard 1: Adults in Fife will have timely access to a community-based team intervention in order to reduce hospital admissions

Aligns with Home First Strategic Priorities 3, 4 and 5

Rationale

Intermediate Care is a short-term, focused intervention supporting medically stable people in maximising recovery and promoting independent living in their own home or home environment. It supports the ethos of delivering rehabilitation and re-ablement to the right person, at the right time, in the right place with the right intensity.

The aim is to prevent unnecessary admission to acute hospital/long term residential care, promote faster recovery from illness, support timely discharge from hospital to optimise a return of confidence and independence to avoid making premature decisions about future long-term care.

Measure of success

Prevent unnecessary admission to acute hospital/long term residential care, promote faster recovery from illness and support timely discharge from hospital to optimise a return of confidence and independence.

Quality indicator

1. Decrease in admissions
2. Number of community teams contacts

Key performance indicators

- 90% of discharges to ICT (Intermediate Care Teams) from all Fife hospitals will take place within 48 hours of referral.
- Hospital at Home will reach maximum capacity no more than 10 occasions per month.
- 20% Increase in ARC (Assessment & Rehabilitation Centre) "contacts" by the end of 2023.
- Reduce and sustain the average longest wait for COT (Community Occupational Therapy) waiting list to no more than 250 days.
- 80% of care home admissions for interim placements will take place within 4 days from receipt of referral to Commissioning Team.
- 90% of STAR (Short Term Assessment) beds admissions meet the Service criteria.
- 80% reduction in the percentage of people in an acute setting waiting for a package of car.

Standard 2: Adults in care homes across Fife will have timely access to community-based services in order to reduce unnecessary acute hospital admissions

Aligns with Home First Strategic Priorities 2, 3, 4 and 5

Rationale

Residents of Care Homes in Fife will have access to a community-based service that will provide the same quality of care expected in a person's own home. Provision of this level of community input will lead to a reduction in the overall admissions to acute hospital settings from a care home.

Quality indicator

1. Decrease in admissions
2. Number of community teams contacts

Key performance indicators

- 50% of Fife private Care Home residents are offered an Anticipatory Care Plan (ACP), and that family members are supported to contribute where possible.
- 100% of Fife Health and Social Care Partnership Care Home residents are offered an Anticipatory Care Plan and that family members are supported to contribute where possible.
- 100% of Fife Care Home residents and their family carers are offered an Anticipatory Care Plan that is shared with the linked GP practice(s) for the Care Home.
- 100% of Fife Care Home residents and their family carers are offered the opportunity to use the Life Curve App.
- 100% of Care Home residents in Fife have up to date Personal Outcomes Assessments in place, that the relevant Community Services have been contacted to meet any changes in respect of needs and that this is documented.
- 100% reduction in the percentage of residents who do not need acute care or admissions to hospitals from Fife Care Homes.
- 80% reduction in the number of complex community care patients admitted into Fife hospitals.
- 20% increase in the number of Smart Life in Fife assessments completed.
- 12-hour reduction in the time taken for the Front Door Assessment team to undertake an assessment in the Emergency Department, or in admitting wards.

Standard 3: 'at risk' individuals in fife should have timely access to community-based services in order to reduce unnecessary acute hospital admissions

Aligns with Home First Strategic Priorities 1, 3, 4 and 5

Rationale

'At risk' adults in Fife form a particularly vulnerable group with a greater likelihood of requiring acute hospital admissions. However, keeping people 'at-risk' in the safety of their own home and community is also recognised to be of significant benefit to the individual. Ensuring access to wide-ranging community health and social care expertise will help to ensure that unnecessary acute hospital admissions can be avoided.

Measure of success

- Reduction in hospital admissions following intervention of a community care team
- Numbers of patients referred to IAT within ED.
- Number of patients seen by IAT in ED.
- Numbers discharged home/to homely setting.
- Numbers admitted to RADU.
- Length of stay for patients in RADU as direct admissions from front door.
- Other measure could be numbers discharged and whether they need support at home or go home independently.

Quality indicator

3. Decrease in admissions
4. Number of community teams contacts

Key performance indicators

- 50% reduction in unnecessary hospital admissions following the intervention of a community care team.
- 50% increase in the number of patients referred to the Rapid Assessment and Discharge Unit (RADU-Ward 9) directly from the Emergency Department.
- 75% increase in the number of patients assessed by the rapid Assessment and Discharge Team (RAD Team) in the Emergency Department.
- 75% of increase in the number of patients assessed by the Rapid Discharge and Assessment Team (RAD Team/ Front Door frailty team) from Emergency Department
- 50% increase in the number of people discharged to home/ to a homely setting from RADU.
- 3 days reduction in length of stay in RADU for patients directly admitted from the Front Door.

Standard 4: Adults in Fife hospital settings will be discharged to a suitable community setting without unnecessary delay

Aligns with Home First Strategic Priorities 1, 4 and 5

Rationale

A delay to discharge from a hospital can be harmful and debilitating and may result in an inability to return to living independently at home. Achieving timely discharges is an important indicator for quality and demonstrates a person-centred, effective, and integrated approach to the individual's health and social needs. Individuals who lack capacity to consent to the proposed care package will be discharged within an appropriate legal framework.

Measure of success

Reduction in those in hospital experiencing a defined 'delayed discharge'.

Quality indicator

1. Number of delayed discharges.
2. Waits for beds.
3. Length of hospital stay.

Key performance indicators

- Increase of 30 patients per week discharged, whether they need support at home or go home independently.
- Number of patients in official delay in acute hospitals to be reduced and maintained at zero.
- 90% increase in the number of Planned Discharge Date (PDD) being met.
- Reduction to 1 day lost in the acute setting from referral to the Discharge Hub, to discharge to home/ homely setting/ downstream bed.

Standard 5: Adults in Fife hospital settings will be discharged with reduced requirement for interim solutions

Aligns with Home First Strategic Priorities 1, 3 and 4

Rationale

It is important for adults in Fife who are being treated in acute hospitals receive the optimal care and in the optimal environment.

When adults discharge from hospital the assessed need should be considered and an appropriate pathway for the adult should be the ultimate goal, when this is not available or requires significant planning the need for an interim solution to assist in their recovery in a care home should be considered.

However, there should be a reduction in the use of interim solutions by increasing the availability of care at home provision to ensure people do not have unnecessary steps in their pathway home.

Measure of success

The measure will be the weekly report on the number of people waiting on discharge from an interim bed this in our IJB performance report.

Quality indicator

- People, including those with disabilities or long-term conditions, or who are frail and able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
- People who use Health and Social Care services have a positive experience of those services, and have their dignity respected.

Key performance indicators

- A reduction from 10 to 3 people per month moving into an interim placement.
- A reduction from 7 to 3 days for people moving into assessment beds to make choices for long-term care.

We provide accessible communication in a variety of formats including for people who are speakers of community languages, who need Easy Read versions, who speak BSL, read Braille or use Audio formats.

To make a request for accessible formats contact **03451 55 55 00**

Fife Council and NHS Fife are supporting the people of Fife together through Fife's Health & Social Care Partnership.

To find out more visit **www.fifehealthandsocialcare.org**