www.fifehealthandsocialcare.org

Fife Health & Social Care Partnership

Annual Performance Report 2021-22

NHS Fife

Supporting the people of Fife together

Fife Council

Contents

A message from our Chair

I am proud to be introducing Fife Health and Social Care Partnership 5th Annual Performance Report which covers the financial year 2021/22 and is also our final annual performance report for the current strategic plan which covered the period of 2019 to 2022.

We have made good progress, none of which would have been possible without the skilled and dedicated staff working in Health and Social Care. Thank you to all staff, working across all services and sectors, you are at the heart of Health and Social Care, and we value all you do.

I am reflective that our current strategic plan was approved only a matter of months before the coronavirus pandemic commenced resulting in the largest global public health response. The pandemic has had a significant impact on everyone's lives and in many areas, we have worked flexibly to refocus our priorities to adapt to the needs of the rapidly changing environment. Periods of lockdown, the requirement to reprioritise services and the impact of ongoing waves and coronavirus outbreaks has undoubtedly impacted on our plans over the past two and half years. Responding to the pandemic has necessitated a whole system response and we have seen growth and momentum in relation to enabling a "Team Fife" approach working closely with partners in NHS Fife, Fife Council, third and independent sectors. It has been by working together that we have continued to move forwards towards the common goal within our Strategic Plan for 2019 to 2022 to enable the people of Fife to live independent and healthier lives.

The Integration Joint Board has experienced change in membership and roles over the past year. I extend my thanks to all members of the Integration Joint Board, past and present, for their leadership and commitment to integration and delivering improved outcomes for the people of Fife. Together over the last year the board has agreed and published a refreshed Integration Scheme, reviewed our governance committees, approved new policy and strategies, invested in growth across a range of services and carers support and continued to deliver financial balance. We have sustained regular Integration Joint Board meetings and Development Sessions and supported the restructure within the Health and Social Care Partnership.

Within this year's Annual Performance Report, we will not only highlight the outcomes, opportunities and challenges for the past year, but will also describe the progress that has been made on outcomes we had strived to achieve within our current strategic plan which provides an excellent platform from which to launch the Fife Strategic Plan for 2022 to 2025 later this year.

Christina Cooper
Chair, Fife Integration Joint Board

Foreword

During financial year 2021/2022 Fife Health and Social Care Partnership has continued on an improvement journey supporting a range of priorities, quality improvement actions and tangible outcomes which are highlighted below and described in fuller detail within our 5th Annual Report. My sincere thanks are extended to all staff working in the health and social care partnership, our partners and the Integration Joint Board – together we are Team Fife. We are ambitious for our Partnership and for integration in Fife, supporting our working and enabling improved services and outcomes for the people of Fife.

Leadership	Organisational Change	Staff Wellbeing
Refreshed Senior Leadership Team and created an extended Leadership Team which is now well established which enables and reflects our commitment to integrated leadership.	Through Organisational Change we have restructured to enable our services that need to work together most regularly to be a team together working towards common pathways and purpose.	Supporting our workforce is a priority. The Local Partnership Forum has met more frequently. We have invested in staff health and wellbeing and sustained regular communications and engagment.

Performance Improvement	Whole System Working	Performance Priorities for 2022/23
This year we have supported performance improvements as detailed in the Annual Internal Audit Report 2021/2022. Moving forward we will continue to address the requirements highlighted in the Fife IJB Governance Statement.	Ensuring people flow from hospital to a home or homely setting is a priority and by the end of this year we hope to have embedded home first principles into practice and continue to reduce standard delays in Fife.	Over the next year we will focus on improving post diagnostic dementia support, CAMHs and psychological therapy.

Integration Joint Board	Finance	Coronavirus pandemic
The Board has approved the Integration Scheme, reviewed governance structures and improved on their induction programme.	Savings for 21/22 were £14.207m which included savings brought forward from previous years. 73% of this was met (£10.413m). The unmet amount of £3.794 was brought forward to the 22/23 budget model, no further new savings were required to balance the 22/23 budget.	The HSCP continued to support remobilisation and recovery and sustaining service delivery whilst responding to the ongoing impact of the pandemic.

The outcomes highlighted above demonstrate good progress towards the outcomes of integration, despite the challenges we have faced due to the ongoing impact of the coronavirus pandemic. This is a strong platform from which to launch our refreshed Strategic Plan later this year which will lead to our priorities between now and 2025.

Nicky Connor
Director of Fife Health and Social Care Partnership
Chief Officer, Fife Integration Joint Board

Introduction and Background

Welcome to the fifth Annual Performance Report from Fife Health and Social Care Partnership.

This Report provides an update on progress in accordance with our Strategic Plan 2019 to 2022 which was published in August 2019, and is available on our website - **www.fifehealthandsocialcare.org/publications**

The purpose of the Strategic Plan is to set out the vision and future direction of health and social care services in 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. Details of the National Outcomes and Priorities are included in Appendix 1.

The Strategic Plan for Fife (2019 to 2022) defines five key priorities.

1. Working with local people and communities to address inequalities and improve health and wellbeing outcomes across Fife

We are committed to ensuring that people are empowered to make their own informed choices about how they will live their lives and what outcomes they want to achieve. Planning for preventative action can have a positive impact on improving health and reducing inequalities and can reduce the demands for health and social care services.

2. Promoting mental health and wellbeing

We are committed to ensuring that the people of Fife can get the right help at the right time, expect recovery and fully enjoy their rights, free from discrimination and stigma. The commitments of Fife's Mental Health Strategy will require creative thinking and innovation to ensure services are fit for the future, supporting positive mental health and wellbeing for all. To succeed will require co-production across all parts of the service, with communities, with our partners in the voluntary sector, with people who use our services, their families and carers.

3. Working with communities, partners and our workforce to effectively transform, integrate and improve our services

Delivery of effective and lasting transformation of health and social care services is central to the vision of Fife Integration Joint Board. Significant change on how services are planned and delivered with a range of stakeholders which includes carers, patients/service users who experience services is paramount to delivering changes.

4. Living well with long term conditions

We are committed to building on the work already started in Fife to support adults and older people with complex care needs, who are accessing both primary and secondary care services most frequently. We are developing and supporting a more integrated and earlier approach focussing support pro-actively with patients who would benefit from this which includes early identification and comprehensive assessment in case co-ordination.

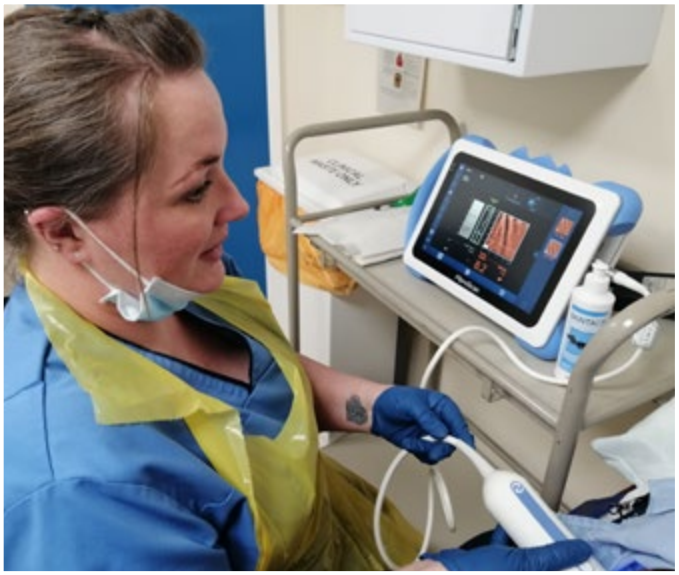
5. Managing resources effectively while delivering quality outcomes

The financial position for public services continues to be challenging and the Integration Joint Board must operate within significant budget restraints and pressures. It is therefore important that resources are targeted at the delivery of the priorities within the strategic plan.

Strategic Plan for Fife 2022 to 2025

The Public Bodies (Joint Working) (Scotland) Act 2014 requires Fife Health and Social Care Partnership to review and update the Strategic Plan at least every three years. This process is already underway, and a new Strategic Plan for Fife will be produced later this year covering the next three years, 2022 to 2025.

Further information about the strategic planning process, including opportunities to get involved in consultations or other engagement events, is available on our website: **www.fifehealthandsocialcare.org**.



Coronavirus Pandemic

Over the last two years, the coronavirus pandemic has had a substantial impact on the health and wellbeing of individuals and their communities. It has also increased the demand for social care services, highlighted high levels of inequalities in the health of the population, and changed the way that we all live our lives.

Across Scotland, at the start of the pandemic, coronavirus was the second leading cause of death and disability, lower than heart disease but higher than all other leading causes such as dementias, lung cancer, and drug use disorders, with deaths occurring most frequently in the elderly, vulnerable, and frail. Despite the success of the vaccination programme in reducing significant illness and death, the pandemic has starkly demonstrated the importance of health to the normal functioning of society. While all groups of people faced considerable impact from this, not all social groups and communities experienced the same level of impact. Older people, those with underlying health issues, and people from black and minority ethnic groups are the most vulnerable to the disease itself. Those with disabilities are more disadvantaged by coronavirus and are at increased clinical risk as they have higher rates of illness compared to the general population. The pandemic continues to have a disproportionate impact on health outcomes, with those living in deprived areas suffering the worst outcomes.

The past year has been incredibly difficult for the people that we care for, and for the employees and other individuals involved in delivering that care. The ongoing impact of the pandemic, and unprecedented demand over the winter period, has created increased demand for health and social care services and reduced options through both ward and care home closures, and challenges in community care capacity. These factors have produced unprecedented pressures on our workforce.

We recognise that the impact of these pressures will continue moving forward and we are working hard to reduce inequalities and improve outcomes for individuals and their communities, and to ensure that our employees are fully supported, both professionally and personally, in the work that they do.

Fife Health and Social Care Partnership, the individuals who access our services, and society in general, owes a huge debt of gratitude to the work carried out by the health and social care workforce, which includes those working formally in these sectors and those volunteering to provide care and support for loved ones and neighbours.

Thank you to all Health and Social Care Staff across all sectors who despite the challenges faced every day, demonstrate kindness, care, compassion and commitment to the people they care for and their colleagues, really supporting a "Team Fife" approach.

Many staff have experienced re-deployment and worked in different roles to support delivery of critical services for the people of Fife, and we have continued to see the need to work differently using technology, and through agile and remote working. The flexibility shown by staff is humbling and we are very lucky to have such a skilled, flexible and willing workforce in Fife. You are all indeed at the heart of Health, Social Work and Social Care and the great work you do every day is highly valued.

Fife's Population

Fife has a population of

374,000

(National Records of Scotland, 2020),
this is an increase of 11,500 people (3.2%) since 2010.

64,152
children aged 0-15 years (17%)

231,809
adults aged 16-64 years (62%)

78,169
older people aged 65 and over (21%)

By 2043 Fife's population is expected to decrease to 364,164. However, only younger age groups are expected to decrease, older age groups will see an increase in numbers.

2020

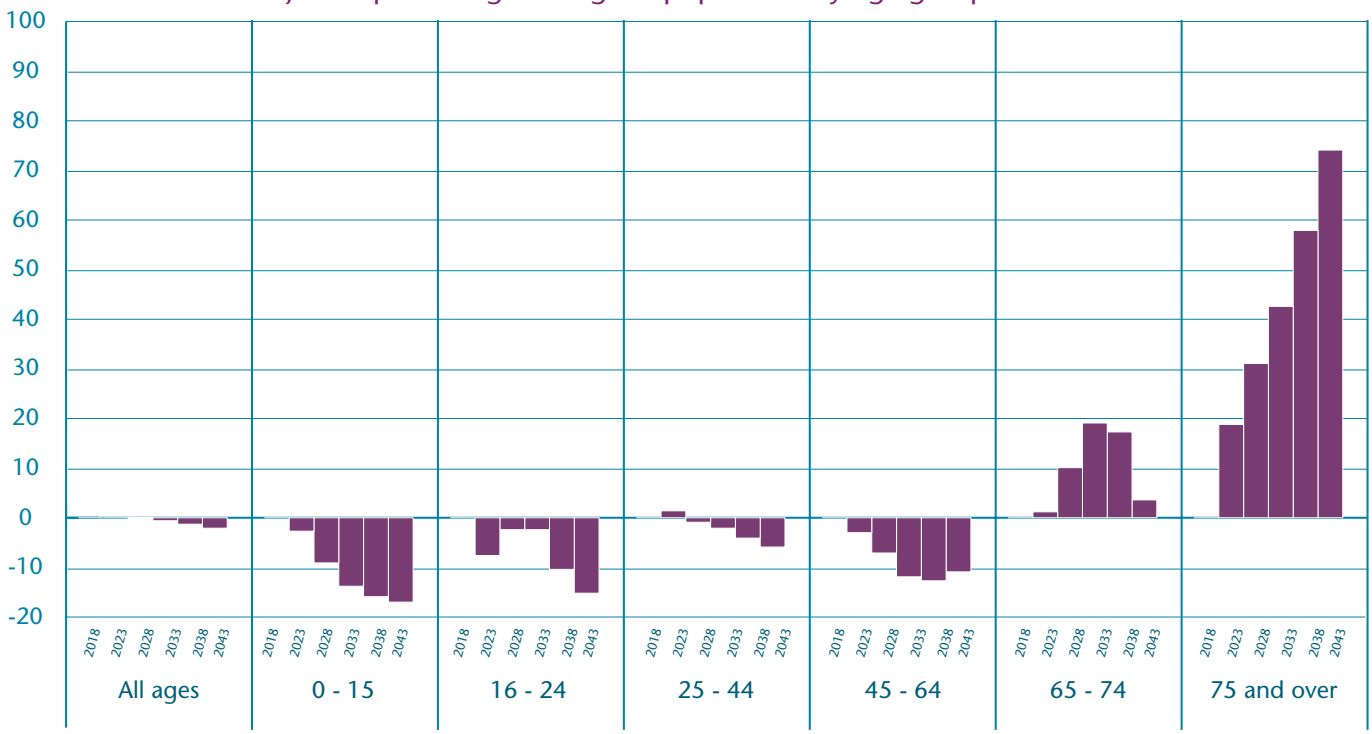
374,000 people

	2020	2043	
0-15	64,152	53,522	-17%
16-64	231,809	209,218	-10%
65+	78,169	101,424	+30%

2043

364,164 people

Projected percentage change in population by age group until 2043



Strategic Direction

To deliver reform, transformation, and sustainability, Fife Health and Social Care Partnership was restructured in 2021 to create clearer, more service user aligned care pathways, that enable the people that need to work together to be a team together. This seeks to create the conditions for a collaborative, systems approach to service design and delivery through operational delivery, professional standards, and business enabling and support services.

These portfolios include:

- Primary and Preventative Care: service delivery across primary care and early intervention and prevention.
- Community Care: a range of services across community hospitals, care homes and peoples' own homes, promoting independence and enabling people to stay well at home and in a homely setting.
- Complex and Critical Care: including the delivery of mental health, learning disability and adult and older peoples social work services.
- Professional Quality Standards and Regulation: this is integrated professional leadership in support of the delivery of nursing, medicine and social work working collaboratively with leads in allied health professions, pharmacy, and psychology.
- Business Enabling: services that support our delivery including finance, strategic planning, performance, commissioning, organisational development and culture.

Primary & Preventative Care Services

- Children's Services
- Urgent Care
- Sexual Health
- Rheumatology
- Speech & Language Therapy
- Primary Care
- Podiatry
- Dietetics
- Occupational Therapy
- Dental
- Health Improvement/ Promotion
- Locality Workers
- Local Area Co-ordinators

Community Care Services

- Home Care
- Community Hospitals
- Residential Care Homes
- Day Care
- Palliative Care
- District Nursing
- Integrated Discharge Hub
- Integrated Community Assessment & Support Services
- Hospital at Home
- Specialist Long-Term Conditions Management
- Rehabilitation & Re-ablement

Complex & Critical Care Services

- Mental Health
- Addictions
- Children & Adolescent Mental Health Services
- Learning Disability Services
- Psychology
- Adult Protection
- Adult and Older Adult Social Work
- Adult Commissioning & Resources
- Mental Health Officers

Business Enabling & Support Services

- Business Support
- Commissioning
- Corporate Functions
- Finance, Change & Transformation
- Information Compliance
- Organisational Development & Culture
- Performance & Assurance
- Resilience
- Risk

Professional & Quality Services

- SLT Lead for Quality Safety Experience
- Clinical & Care Governance
- Professional Regulation
- Professional Standards

Senior Leadership Team

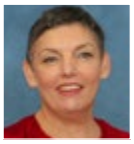
Nicky Connor
Chief Officer and Director of Health & Social Care

Operational Service Delivery

SLT leads for orperational management delivery and business outcoes for a portfolio of services

Bryan Davies
Head of Integrated Primary & Preventive Care Services

Lynne Garvey
Head of Integrated Community Care Services



Rona Laskowski
Head of Integrated Complex & Critical Care Services

Business Enabling

SLT leads for Corporate Services and functions inc. financial governance, strategic planning, performance, transformational change and organisational development

Audrey Valente
Chief Finance Officer and Head of Transformation & Corporate Services

Fiona Mckay
Head of Strategic Planning, Performancee & Commissioning

Roy Lawrence
Principal Lead Organisational Development & Culture

Professional & Quality Services

SLT leads for quality, safety, experience, clinical and care governancee, professional regulation and standards

Lynn Barker
Associate Director for Nursing

Helen Hellewell
Associate Medical Director

Jane Brown
Principal Social Work Officer

As a Senior Leadership Team (SLT), we are committed to being systems leaders. This means helping to create the conditions where people willingly work together towards a common vision and give their best by focusing on relationships, building trust and putting people at the centre. We believe in collective leadership to achieve improved outcomes across the whole organisation not just our part of it, and serve others so they also work in this way, celebrating when they do and learning about self, team and system along the way. Working in ways that promote integrity, courage, authenticity, curiosity, humility, kindness, compassion and empowerment.

Organisational Development and Culture

Over 2021/22 the Partnership implemented a revised organisational structure to deliver clearer, more service user aligned care pathways that enable the people that need to work together to be a team together. This also has the aim of creating the conditions for a collaborative, systems approach to service design and delivery through operational delivery, professional standards and business enabling and support services.

As part of this restructure, a Principal Lead for Organisational Development and Culture was recruited into the Senior Leadership Team to work alongside operational portfolios to drive a whole system leadership approach and a 'TeamFife - one voice, one Partnership' culture that underpins our ambition to be one of the best performing Partnerships in Scotland by 2025, which we've described as our 'Mission 25'.

We've undertaken a range of initiatives focused on improving our organisational capacity and capability for leadership across the Partnership. The restructured Senior Leadership Team have collaborated to ensure that the operational portfolios, professional standards, and business enabling services are working collectively to focus on a strong 'Golden Thread':

- **Setting Direction:** Our vision, purpose and strategy and our organisational leadership and culture.
- **Delivery:** Engaging stakeholders, creating sustainable value and driving transformation.
- **Outcomes:** Including our strategic and operational delivery and performance and stakeholder perceptions.

As part of this approach, we brought together the Extended Leadership Team (ELT), our group of senior leaders who represent the whole of our services across the partners. This group have worked to improve our integrated approach to service delivery and systems leadership through a range of approaches that has included developing our 'Success Statements' as a way of describing, 'What will success look like for our Partnership if we improve…'

- Our leadership ability and organisational culture.
- Our opportunities for our workforce to thrive.
- Our ability to transform our services.
- Our standards of practice excellence and quality.
- Our reputation with our citizens and our staff.
- Our ability to empower our local places to influence the service they receive.
- Our performance in affecting people's lives earlier to prevent the need for hospital and reduce the need for health and social care services.
- Our ability to get the best value from our financial resources and sustain our services.

The ELT have also worked to improve and innovate around key areas for the Partnership including iMatter, staff support and wellbeing, our Strategic Plan for 2022-25, our Workforce Strategy & Plan for 2022-25 and our Medium-Term Financial Strategy 2022-25. We have also used the forum to look at future developments such as the National Care Service, which will have a big impact on how we deliver services.

Feedback from the ELT Group around the work done:

"I have found all the sessions very informative and useful. In particular the sessions have helped me understand the mission, vision, strategy and objectives we are collectively working towards to ensure the success of the HSCP"

"I feel part of the leadership of the HSCP - more than ever before. We have covered some weighty topics and it is clear that we are listened to, and our views are valued"

"Working collaboratively across all services to co-design and agree HSCP wide strategies provides me with the ability to share first-hand, consistent messages with my team. It has provided a framework for systems thinking and working, which has broadened my own approach to solving problems within my services, which often have system wide solution"

We delivered the Workforce Strategy & Plan for 2022-25, which was endorsed by the Integration Joint Board and submitted to the Scottish Government in July. The Workforce Strategy Group has representation from across the system which has ensured the Strategy has been co-produced and a clear focus on integrated, collaborative working. This Group will continue to oversee the implementation of the Action Plan and report to the Integration Joint Board on an annual basis.

We have an ambition to work across organisational boundaries to better understand the collective challenges we face. This will help create an environment which supports people to take part in co-designing services and enables our workforce to deliver those services. All of this will be underpinned by a commitment to continuous quality improvement to keep learning, adapting to what we find, and improving our services, experience, and culture.

Our Performance

This Annual Performance Report summarises Fife Health and Social Care Partnership's performance and progress against the national outcomes and our strategic priorities and commissioning intentions.

National Health and Social Care Health and Wellbeing 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 national indicators that we report on are presented in Appendix 2.

Please note that data for some of the national indicators is not available for the period 2021 to 2022 due to the way in which this information is collected, verified and released. We have provided the most complete and robust data that is currently available. Figures presented may not fully reflect activity during 2021/22 due to the varying impact on services at different points of the coronavirus pandemic.

Thank you to all of the colleagues and other individuals who have contributed to the production of this Annual Performance Report.

Priority 1

Working with local people and communities to address inequalities and improve health and wellbeing outcomes across Fife.

We are committed to ensuring that people are empowered to make their own informed choices about how they will live their lives and what outcomes they want to achieve. Planning for preventative action can have a positive impact on improving health and reducing inequalities and can reduce the demands for health and social care services.

What we set out to do

- The Wells (Community Led Support) will be rolled out across Fife's seven localities and will be embedded across the whole system.
- People with sensory and communication impairment can expect the same access to information and support as everyone else.
- Improve the ease of access to support planning services by investing in voluntary sector partners to increase our capacity to assess the need for support for carers and prepare an outcome based Adult and Young Carer Support Plan for more carers.
- The needs of households that are homeless and in vulnerable housing circumstances can be addressed.
- Further improve the person with a learning disability's experience of acute hospital admission.

Where are we now

The Wells

The Wells are part of the Partnership's Community Led Support Service and are for anyone 16+ looking for advice and support. The Well enables people to speak directly to health and social care professionals and discuss enquiries in relation to their health and wellbeing. Our friendly staff empower people to find solutions to problems quickly and easily, giving them the right information at the right time and by providing support, information and guidance on topics such as social care, carer support, social isolation, housing, benefits, bereavement, or anything related to health and wellbeing.

During 2021 The Wells predominantly operated virtually with a few sessions for the Kirkcaldy physical Well. For the majority of the year, the Wells operated for five sessions a week with a total of 10 hours per week. During 2022 the Wells have returned to a full face-to-face service in all seven localities.

In 2021, the average number of people contacting The Wells each month was 18.
In 2022, this increased to an average of 74 contacts each month.

Feedback from visitors has been very positive (4.7/5).

This map shows the range of locations for people visiting/ contacting The Well.

The top five reasons for visiting The Well related to:

- Mental Health
- Community Support
- Financial Support
- Housing Support
- Carer Support

47% of all visitors had more than one enquiry.

The Well is staffed from a core group of staff from Link Life Fife (Community Connectors), Social Work Teams (Adults & Older People) and Third Sector (Fife Forum) as well as additional staff joining on regular basis from other services and third sector organisations such Welfare Support Assistants, Fife Migrants Forum, Fife Carer sector and others. This allows an opportunity for shared learning between staff, and minimises the risk of the person being referred to multiple organisations.

Case Study (The Well)

Issue: Sarah cares for her elderly mum Mary. They both live in the same town but a distance apart. Since the coronavirus lockdown in March 2020 Sarah has been struggling to see her mum due to lack of transport and fear of passing on the virus. As a result, Mary has been feeling lonely and isolated.

Action: Sarah heard The Well Near Me radio advert and decided to get in contact. Sarah found contacting the Well virtually very easy and quick from her phone by following the simple instructions available. At the Well, Sarah spoke to Hannah, one of the social workers. After having a conversation with Hannah who supported Sarah through a 'good conversation approach' to come to her own conclusions about what might help her mum at this time given the challenges they are both experiencing, Sarah decided on contacting a local befriending project which her mum could access over the phone.

Outcome: Mary is now enjoying the friendly support she is receiving from her befriender over the phone and Sarah is feeling less stressed about her mum.

Deaf Communication Service

The Deaf Communication Service (DCS) consists of a small team of workers with many years of experience supporting individuals who are D/deaf, Deaf Sign Language users, hard of hearing, deafened, deafblind and for people newly diagnosed with a hearing loss. The team work to remove barriers to communication to the deaf community. They support families, carers, friends, the public, employers, service providers/organisations who may need advice and support in relation to hearing loss. They also work closely with local communities across Fife. There are no age barriers to support, as the team provide support from birth to end of life.

DCS also provide a range of direct provision of advice and support in relation to Deafness. For example:

- Specialist Social Work support.
- Workplace assessment (for anyone who employs or is about to employ a person with a hearing loss).
- Empowering Deaf people to access services.
- Advice and information about specialist equipment.
- Loan of equipment and hire of loop systems.
- Produce written materials in British Sign Language.
- Providing appropriate communication support.
- Providing Deaf Awareness, BSL and bespoke training.

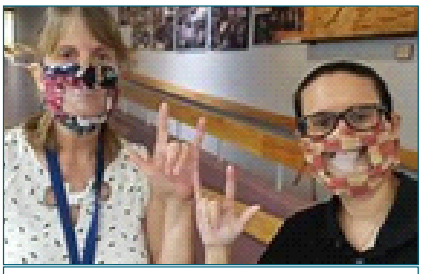
DCS work closely with a vast range of local voluntary and community groups including:

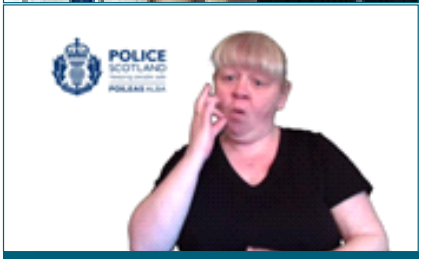
- Police Scotland
- Scottish Fire & Rescue Service
- Job Centre Plus
- Citizens Advice Scotland

The Deaf Communication Service provide a drop-in service for members of the community to gain assistance to translate letters and make phone calls and support where necessary. During the coronavirus pandemic this was cancelled, but has recently restarted, with reduced days/hours. Service users can travel from all areas of Fife to request assistance.

DCS staff worked alongside Police colleagues, Adult Support and Protection, and Care at Home to ensure that any individual in the Deaf Community or those with a hearing loss and additional needs were keeping themselves safe from harm.

This meant on many occasions, visiting the person, and explaining in person, the guidance around coronavirus safety measures, self-isolation, wearing of Personal Protective Equipment (PPE) and to ensure safety and continued access to health and wellbeing services.





Provision of Equipment

Over 110 referrals were received in the last year to DCS for assessment of alert equipment at home to improve an individual's quality of life. For example, the provision of a flashing doorbell, and baby alarms.

Examples of support provided over the year is the delivery of food parcels, supporting communication at end-of-life care for a British Sign Language (BSL) user and supporting individuals with mental health.

Service User Feedback - Anna

"I've been a service user of Deaf Communication Service for around 13 years.

As my confidence slowly began to be rebuilt, DCS was always there when I needed them - helping me from the point I was at, to move forward.

I'm a long-term member of both the Kirkcaldy and Cupar Hearing Support related groups - so I've seen DCS in action at both of these groups - and I know they support the Dunfermline group as well. I observe how they support without taking over, we all know DCS will do whatever they can, within their packed schedule, when we approach them for all sorts of reasons.

I could go on! Suffice to say, I simply don't know how such a small team, with so many skills, knowledge and understanding, can cover such a wide remit and still keep that personal touch, leaving people like me feeling they're there if I need them."

Case Study (Support for Syrian Family relocated to Scotland)

Issue: One member of the family uses Arabic sign language. BSL is different to Arabic sign language. Most Syrian families are encouraged to enrol in learning English to support their new life in Scotland where this family member had to learn BSL as a third language. DCS had to find out how we could support his communication needs

Outcome: DCS arranged a BSL tutor, now working with this family weekly which means he has improved access to services with a BSL interpreter. DCS continue to work with this family to improve their quality of life.

Supporting those with Diabetes

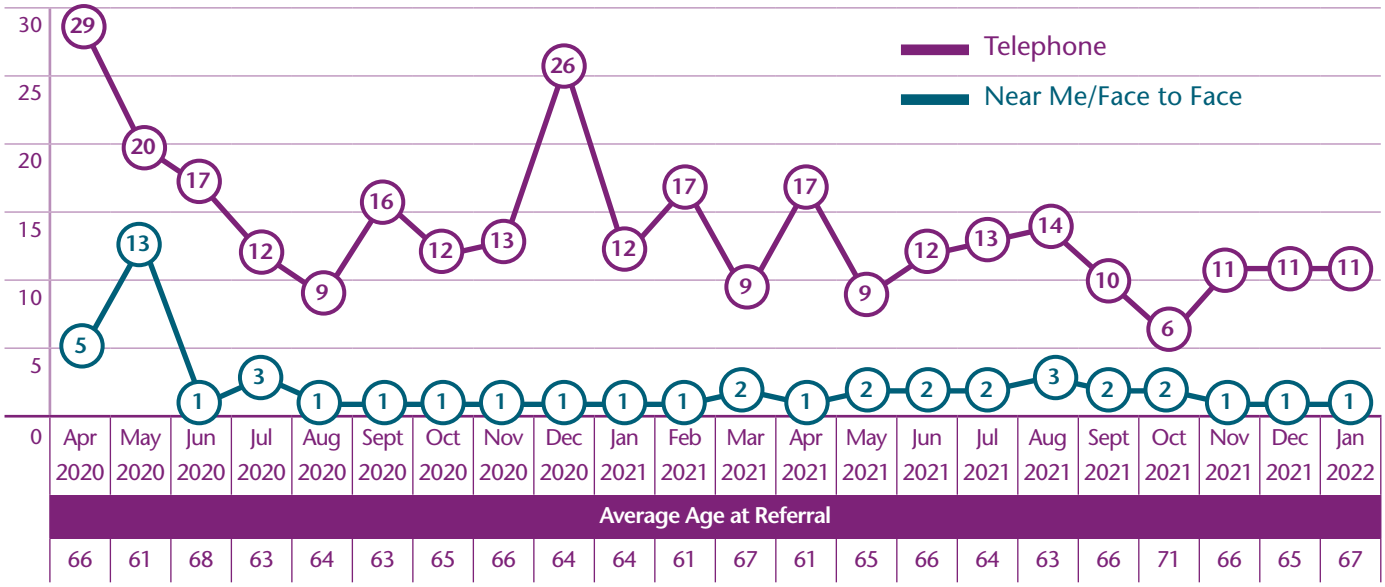
The Fife Community Diabetes Specialist Nursing Service (FCDSNS) is an interface service between primary and secondary care. Its aims are to:

1. support patients with complex type 2 diabetes;
2. provide supported hospital discharge; and
3. offer professional support and education.

Immediately prior to the coronavirus pandemic, waiting times for the service were more than 11-12 weeks due to staffing, service design, referral rates, inequity in the allocation of caseloads and inconsistencies in how care was delivered. The pandemic provided access to new tools and encouraged a reconfiguration of the service in order to offer a more equitable service with lower wait time. We have achieved the following outcomes over the past 2 years:

- Triage assessment offered and conducted in the majority of patients within 24 hours of the initial referral.
- Patient wait times for appointment, (video consultation or face to face) significantly reduced from an average of 90 days to 13 days.
- Majority of patients managed remotely allowing us to see elderly or vulnerable patients face to face in locality clinics or at home visit more quickly.
- Patient and Professional satisfaction increased.
- Professional advice email averages 120 requests per month and we are able to use this data to determine professional education needs in our locality and plan education delivery.

Community Diabetes Specialist Nursing Service - Average Patient Waiting Times (days)



Carers

We continued to support unpaid carers through the challenges of the coronavirus pandemic and invested in additional support to promote carers health and wellbeing including:

- Creation of a Team dedicated to supporting carer involvement to promote the participation and engagement of unpaid carers and others.
- Introduction of a new commissioned support service in partnership with Circles Advocacy to help the carers of people without capacity to secure the necessary legal instruments for the longer term.
- Additional investment to support unpaid carers who meet the eligibility criteria with a dedicated budget for self-directed support, including resources to manage this new support opportunity.
- Ringfencing additional resources for carers of people living with autism spectrum disorder.
- Recruitment of a Project Officer to coordinate the review and reimagining of the commissioned voluntary sector support for carers and others.

Introduction of significant additional support for young carers through the commissioned partnership with Fife Young Carers including a new holistic support for carers and their family members together with additional support to assist young carers transition into adulthood.

As well as the new support we have made available during the year we have continued to deliver the support needed to carers in their localities and have strengthened our support for the carers of people being discharged from hospital.

Again, this year we recognised carer contributions during Carers Week which, because of the pandemic, was an enhanced social media campaign with our commissioned partners playing a key role.

Finally, through our partnership with Fife Carers Centre we have continued to support carers' access to Personal Protective Equipment (PPE) during the pandemic and ensured they have ready access to the necessary protections to enable them to continue in their caring roles.

Shared Lives Fife

This initiative provides family-based care in the homes of carers across Fife to adults with disabilities and mental health difficulties. It aims to match families or individuals who are willing to share their homes, lives, interests, experience, and skills with adults who need support to live their lives to the full.

The initiative is supported by a small team consisting of three social workers and one social work assistant who provide vital input to the recruitment and on-going support for approved carers across Fife. This includes regular communication and engagement with those involved with the service through newsletters and developing networking opportunities. The team actively include carers and service users in the development of policies, procedures and guidance (including the Shared Lives Fife Charter and Participation Strategy). The team also ensure that carers can access and complete required training

Being a Shared Lives Carer allows the carer to build close connections with the people they support, by welcoming them into the carers home and family life, the carer is self-employed so can offer their support to work flexibly around their needs.

There are currently 61 carers working from their own homes to provide placements to 76 individuals (day care, short breaks or long-term live-in arrangements).

Housing

Preventing homelessness and supporting those who are homeless or vulnerable

We have made progress in the Rapid Rehousing Transition Programme against the key areas highlighted below, despite some delays with projects due to pressures still placed on homelessness statutory duty and the use of all homelessness services especially temporary accommodation. There has also been less housing opportunity and allocations made due to the slow return to the new build programme, and delays in voids work due to material/supply delays.

Housing First - For those with multiple and complex needs.

- Creation of a Housing First for Youth programme in partnership with Rock Trust started March 2021, capacity for 21 places for young people aged between 16 and 25.
- Housing First providing wraparound support for as long as is needed or wanted, choice of support with the young person's own aims and goals in life, a Scottish Secure Tenancy to settle into as their home, with no conditions to being 'tenancy ready.
- 51 Referrals made for Housing First.
- 21 live HF4Y cases, two referrals pending assessment, 28 referrals unsuitable, four on waiting list.
- 13 HF young people in permanent tenancies with seven awaiting offers of housing, one in prison.
- Ongoing discussion to scale up youth programme and introduce further Housing First partnerships.

Prevention of Homelessness & Housing Advice

- Enabling Officers to provide up to date advice on tenancy rights across all tenure types and full Housing Options information.
- All Housing Options Officers and Lead Officers/Managers have undergone refresher training on Housing Advice provided by Shelter.
- Managing Change completed for Housing Options Officers, this is an ongoing exercise where the role of Housing Allocation Officers and Homeless Persons Officers has been combined.
- 4DX (4 disciplines of execution) mythology used to help prevent homelessness for single under 35-year-olds. Leading to 'insights' being gathered, to share good practice and innovative prevention and tenancy sustainment

Innovation Fund – to help with tenancy set up and sustainment

- 153 essential starter packs (white goods, beds, etc)
- 147k spend between RRTP and Temporary Accommodation funding two staff posts funded through RRTP to Scottish Welfare Fund team to fast-track applications for Community Care Grant assessments for those leaving TA.

Housing Access Hubs – provided Housing & Homelessness Advice and Support Services to community members locally.

- Segal House offices refurbishment completed, awaiting further advice on blended working to offer one stop shop for Housing Advice.
- Virtual Housing Advice Hub – ongoing sessions with Customer Programme Team and part of the 4DX approach.

Hostel Reprovision – redesign of Fife Council hostels to accommodation with support.

- Increase in support staff group and development of support and risk assessments to ensure support needs are met
- Increase in Temporary Accommodation Management Team to enable move on from Fife Council Hostels to appropriate accommodation to meet individual needs.

Scatter flat conversions – where there is a need for Temporary Accommodation, placements that meet the customers' needs and choice, converting the TA to permanent tenancy to help reduce the trauma of multiple moves.

- 100 scatter flats converted to permanent tenancies

PSP Review – working through a redesign of commissioned services. Enabling better outcomes for customers, identifying gaps in services or redesigning or decommissioning outdated services.

- Assertive Outreach Programme started in September 2021, with collaboration between Frontline Fife, The Richmond Fellowship and Kingdom Support and Care, to work with repeat homeless cases and prevention of homelessness were possible and linking back into available services where appropriate.
- Increase in members to Commissioning Staff Team to ensure customers' needs are met and appropriate services to support homeless households including preventing homelessness occurring.

Developing New Approaches to Specialised Housing

There have been several improvements in relation to the supply of specialised housing this financial year including:

- Older Persons Housing – Work is on-going in Methil to complete the Care Village there. There will be 40 bungalows for Older People in the development and these will offer a Very Sheltered Housing service. Further developments are on-going with work at Care Villages at Cupar and Anstruther at the planning stage. Housing only sites are being developed at Aberdour Road in Dunfermline, Bellyeoman Road, Dunfermline, and on the site of the former Jenny Gray Care Home in Lochgelly. There is an on-going programme of Affordable Housing across Fife.
- Specific Needs Housing – Additional Group Homes have been purchased this year (nine in total) from other Registered Social Landlords to meet the needs of adults with complex needs.
- Young Care Leavers - We have been working closely with the National House Project. This is joint initiative between Children's Services and Housing. A cohort of 10 young people at a time apply to go through the project. They undertake a full set of support modules tailored around their independent living needs. At the end of these independent living modules the young person is guaranteed an offer of housing. Support continues for the young person once they have been rehoused and can be accessed at any time they need it. All young people housed by the project are still sustaining their tenancies.
- Geographic spread of services – We have undertaken the geographic mapping of where we have specialised housing. This has been input on the WEB GIS system to allow us to see where we have gaps in provision.

Service utilisation

45 new units of Older Persons Housing started

9 new Group Homes purchased

17 Care Experienced Young People housed via the National House Project

Improving Aids and Adaptations

We have made several improvements in the aids and adaptations process this year:

- The Adaptations One Stop Shop at Rosewell Clinic opened in the last year to provide advice on adaptations to service users. We have installed three room pods here to assess service users in un-adapted kitchens/bathrooms and adapted kitchen/bathrooms.
- We have been promoting the use of Smart Life in Fife across the service, to encourage people to access independent living advice at the earliest possible stage. We are training all Older Persons Housing staff to use the system and we are promoting this across our tenant base.
- We reviewed the research findings from the Shelter Hospital Advice project in Accident & Emergency Departments. Information from this has been utilised in developing the actions for our Home First Housing Sub-Group. As a result, we are looking at introducing housing advice at the earliest possible point of service users going into hospital. We have also introduced a single point of contact for hospital staff with queries around housing delayed discharge reasons.

Adaptations 2021-22

360 people accessed advice regarding adaptations

246 Fife Council permanent adaptation jobs completed

Learning Disabilities Service

The Learning Disability Service is developing an additional support team to create a life span resource. We continue to work with the Multi-Disciplinary Team and our partners in social work and the third sector using Positive Behavioural Support Planning to maintain care within the patient's home. Should individuals be admitted to hospital, the Learning Disability Liaison Service operates within our acute hospitals to support patients and staff, by providing advice and guidance to ensure positive outcomes, and works collaboratively with the Community Learning Disability Nursing Team and social care partners to ensure development of a clear and concise discharge plan, which supports effective communication to ensure care delivery is optimised to prevent the readmission.

Staffing the service has been challenging due to difficulties replacing staff as they retire. Competition from neighbouring health boards negatively impacts recruitment and has resulted in skills shortages. The Lead Nurse for the Learning Disability Service has worked hard to build relationships with universities to actively participate and engage with student nurses to build a positive picture of employment in Fife.

Priority 2
Promoting mental health and wellbeing

We are committed to ensuring that the people of Fife can get the right help at the right time, expect recovery and fully enjoy their rights, free from discrimination and stigma. The commitments of Fife's Mental Health Strategy will require creative thinking and innovation to ensure services are fit for the future, supporting positive mental health and wellbeing for all. To succeed will require co-production across all parts of the service, with communities, with our partners in the voluntary sector, with people who use our services, their families and carers.

What we set out to do

- Reduce the waiting times for children and young people to access the right mental health support at the right time.
- Support for all people to have an understanding of how to promote their own mental health and how to care for and recover from mental health problems and mental illness.
- Establish flexible, joined up services and supports that are accessible for all.
- Information about supports and services should be easily accessible and available in a format suitable for the person.
- Increase the use and application of technology enabled care to radically transform the way people of all ages experience their health and care.

Where are we now

Child & Adolescent Mental Health Services (CAMHS)

As a result of investment through the Scottish Government's Recovery & Renewal Fund, Fife CAMHS has embarked on a number of service developments in order to improve waiting times, reduce waiting lists, achieve the standards set within the National CAMHS Service Specification and deliver services that are quality and evidence focused. As part of this, Fife CAMHS is in the process of increasing its multi-disciplinary workforce through the introduction of additional staff across Mental Health Nursing, Consultant Psychiatry, Family Therapy, Clinical Psychology and Allied Health Professionals. Referrals to Fife CAMHS continue to increase with the impact of the coronavirus pandemic contributing to the ongoing trend. An increase in the number of children and young people presenting with urgent or priority mental health needs has meant that the service has had to respond to changing demand in order to ensure those with the most significant need receive prompt and effective interventions.

Whilst working to maintain and reduce the number of children and young people waiting to receive support from Fife CAMHS, the service has also maintained its focus on providing early intervention and positive signposting to partner agencies through the CAMHS Early Intervention Service.

The Primary Mental Health Workers continue to provide initial assessment of need within three weeks of referral which contributes to the overall response from CAMHS and an average waiting time of 10 weeks. Due to the increased acuity of presentation, 60% of all children and young people have been seen within eight weeks however this has a negative effect on the longest waits and as staffing resource has been focused on the priority and urgent referrals, those who were already waiting were required to wait slightly longer.

Reduced staffing capacity during December 2021 and January 2022 due to coronavirus-related absence, patient cancelled appointments, core staff redeployed into CAMHS Tier 4 services to ensure adequate capacity to respond to increasing prevalence of high-risk patients and redeployment into General Surge Wards as part of Fife Partnership's contingency measures, resulted in approximately 480 lost appointments during that timeframe within core services. The impact of re-booking lost appointments resulted in less 'New Appointments' than predicted through February and March 2022 and a subsequent negative impact against the Fife CAMHS improvement trajectory.

Recruitment processes are ongoing to enhance the wider CAMHS provision however specific challenges persist in recruiting into core CAMHS provision for nursing and psychology staff due to national staff shortages.

Developments are ongoing to ensure that Fife CAMHS service provision aligns with the National CAMHS Service Specifications. Recruitment processes and the development of specific roles and teams to enhance service delivery include innovations such as CAMHS Transition Coordinator, CAMHS Kinship Team and a review of the CAMHS urgent care provision. Regional developments are underway as part of the East Regional Planning Group which will incorporate the revision of pathways into specialist regional services such as Intensive Psychiatric Care for young people, National Secure Unit and Regional Out of Hours provision. Workforce review and assessment of demand and capacity continues with support from Scottish Government CAMHS Advisory Team and waiting times initiatives have been instigated to ensure that the CAMHS Waiting Times and Waiting List Objectives are achieved by the Scottish Government target of March 2023.

Supporting Children and Families

The Child and Adolescent Mental Health Service continue to support children, parents and carers through a range of groups through Access Therapies Fife including:

- **Understanding teens**, designed for parents of teenagers who are experiencing emotional distress.
- **Shine**, an online group to help 12-17 year olds learn about anxiety and coping strategies.
- **Glow**, an anxiety management resource for primary school age children.

A new group **Embracing Difference** has been developed to meet the needs of parents with primary aged children with suspected neurodiversity.

A helpline for families awaiting neurodevelopmental assessment for their child was introduced to provide support while they wait for assessment.

Psychology Support

Improving the accessibility of services via self-referral, online options and provision of individualised therapies and psychological interventions is a core aspect of Psychology service delivery. The service continues to build upon recent innovations to improve our digital delivery of mental health care.

- The **Access Therapies Fife website** (**www.accesstherapiesfife.scot.nhs.uk**) was launched in 2018 to provide improved access to online psychological therapies, including numerous self-referral options. The website has grown considerably in the past year, with the introduction of additional online groups (for all ages) and additional self-referral to wellbeing modules. The website is reviewed regularly.
- The **Moodcafe website** (**www.moodcafe.co.uk**) was introduced in 2006 to promote mental health by providing information and resources to help people in Fife understand and improve mental health and wellbeing. During 2021/2022 it has undergone an extensive upgrade to provide easier navigation and increased content. The site was relaunched early in 2022. Work is ongoing to provide a facility that can be used on both desktop/laptop and mobile devices
- The **Psychology Service Digital Working Group** was set up in response to the coronavirus pandemic, initially looking at best digital practice in providing online groups, videos and one-to-one consultations. Over, the last year, work has included testing to introduce a different platform (Near Me Beta Platform) which offers improved functionality in the delivery of psychoeducational and therapeutic groups and the investigation of possibilities for transfer of the whole Psychology Service to paperless functionality using the Morse system.

Telephone Triage

In September 2021, in response to increasing referrals and consequent need for more initial assessments, a telephone triage system was established. This was provided as an alternative to Near Me computer assessments and has allowed us to streamline and shorten the assessment process, increase patient choice as to the type of assessment they preferred, reduce patient waiting times for assessment, and ensure that patients are allocated to the appropriate part of the service, or for onward referral/signposting, more quickly.

New approaches in Psychology

The Adult Mental Health psychology service introduced **Interpersonal Psychotherapy** as an alternative to Cognitive Behavioural Therapy, particularly for those experiencing depression or eating disorders. This now increases choice of intervention for people with mild/moderate conditions and reduces the need for onward referral to secondary care mental health services where waits for treatment can be lengthy.

Increasing Functional Neurological Disorder (FND) Support

Reducing waiting times remains a key driver to service improvement. Capacity modelling work identified issues within the Clinical Health Psychology Service. These issues were impacting the Service's ability to meet the 18-week referral to treatment waiting time standard. The Partnership agreed to fund additional new posts in the Psychology Service, including Clinical Health Psychology. It was identified that a significant number of referrals (40%) come from Neurology for patients with Functional Neurological disorder (FND) with this patient group making up the majority of those with the longest wait. It was agreed that some of the funding should be used to create a Specialist Clinical Psychology post working in FND. This post will work more closely with Neurology to shape referrer behaviour and provide specialist clinical expertise to this complex patient group in a more patient-centred, timely and accessible way. The post holder will also represent Clinical Health Psychology in a Fife Multidisciplinary FND patient pathway which has been developed in recent years.

Design and development of the Fife-wide MACH (Mental Health After Coronavirus Hospitalisation) Service for patients who have been hospitalised by severe symptoms of coronavirus

Following the announcement of funding from the Scottish Government for the establishment of MACH services nationally across Scotland a business case for the development of the service in Fife was approved by the Executive Directors' Group and recruitment of staff started in May 2021. The team consists of Clinical Psychologists, Assistant Psychologist, Liaison Psychiatry, ICU Nurse (Recovery Coordinator).

Clinical Governance and E-Health have assisted with identifying all patients who were hospitalised earlier in the pandemic and a database has been designed for the collation of this information and recording of outcomes. The service is retrospectively contacting patients by letter to screen for mental health problems. Direct referrals to the service are also being received from primary and secondary care and 1:1 and group clinical work is underway.

The MACH service is closely linked to the InSPIRE Post Intensive Care Rehabilitation Service, which also has psychology input and there is a direct pathway for referral into MACH from InSPIRE where additional support is required. Most patients are offered treatment on an outpatient basis, but there is also an inpatient recovery coordinator based at Victoria Hospital, Kirkcaldy, who offers support to patients currently in hospital with coronavirus, with onward referral to receive additional support after discharge if required.

Increasing Support for those with Complex Respiratory Disease

In March 2021, funding was secured from the Scottish Government Modernising Patient Pathways Project (MPPP) to improve service provision for patients with complex respiratory disease by piloting a new part-time integrated Clinical Psychologist post over a 12-month period. The aims of the project are to study the added value psychology can bring in several aspects of care including, but not limited to, the following:

- pulmonary rehabilitation
- adherence to treatment
- generalised anxiety and depression
- self-efficacy
- patient avoidance
- emergency healthcare utilisation
- staff knowledge and understanding of the psychological impact of respiratory conditions

Asthma and chronic obstructive pulmonary disease (COPD) impair not only the physical functioning of patients, but also affect their psychological state. Mood disorders and cognitive impairment are more prevalent in this group than in the general population. In addition, it has been proven that co-existence of physical and psychological dysfunction worsens the functioning of patients (work, family and social lives) and has an impact on the course of the treatment of the illness. Recent systematic reviews have found that patients with COPD have significant unmet psychological needs, which if met, could lead to an improvement in their care.

The psychologist has been embedded within the Respiratory Team on a four session (two day) per week basis, from May 2021 to May 2022, and attends ward rounds and receives referrals from the Respiratory Team. The psychologist reviews patients with complex respiratory needs, with an emphasis on severe asthma, COPD and interstitial lung disease. The overall aim is that the psychological aspects of the patient's disease become part of routine care and a focus for intervention.

Introduction of Maternity & Neonatal Psychology Service

In 2021, a Fife Maternity & Neonatal Psychological Interventions (MNPI) service was introduced, with additional clinical psychology staff recruited to support this service to help:

4. Parents with complex needs arising from pregnancy and birth complications, or birth trauma affecting mental health;
5. Parents with significant difficulties that directly affect maternity care, and who are likely to benefit from psychological therapies for these difficulties;
6. Parents whose infant's health is significantly compromised requiring care from the Special Care Baby Unit (SCBU) or Neonatal Intensive Care Unit (NICU);
7. Maternity and neonatal staff who care for patients struggling to adjust to pregnancy and infant care.

Developments during the past year have included:

- Establishment of the MNPI service, with clinical psychology staff embedded in hospital clinical teams.
- Training of 130 NHS staff to raise awareness of perinatal and infant mental health and introduce the new services.
- Focus on birth trauma webinar (April 22) and planned workshops (Autumn 2022) with 139 registered participants; and
- Development of maternity & neonatal care pathways.

Supporting the mental health and wellbeing of veterans

The Veterans First Point (V1P) Fife service was established in 2015, as part of a Scottish Government commitment to veterans to meet responsibilities linked to the Armed Services Covenant. The initiative is now 50% funded by Fife Health and Social Care Partnership.

The V1P Fife service moved to newly refurbished premises at Rosewell Centre in Lochgelly and was officially opened by Keith Brown, Cabinet Secretary for Justice and Minister for Veterans, in July 2021.

The V1P service model takes a holistic psychosocial perspective to mental health and wellbeing, working with a range of community partners to address wider determinants of poor mental health and wellbeing. One example is our partnership with the Fife Employment Action Trust on the 'Grow Your Mind' project, through which veterans develop their horticultural knowledge and skills and their more general cognitive skills. This programme has been well received by veterans.

The V1P Fife service has committed to developing and growing a trauma-informed service, systems and relationships. Work to achieve this has included staff carrying out a trauma-informed walk through of the new Rosewell Centre to identify aspects of the environment that, for staff, fit with trauma-informed values and aims.

In-person V1P social drop-ins, run by V1P peer support workers and offering a space for veterans to connect and offer mutual support, were reinstated in 2022. We are grateful to Lochore Meadows Park Manager for granting the pro-bono use of a meeting space in the Willie Clarke Visitors' Centre.

One of the V1P peer support workers has investigated the barriers to homeless veterans accessing V1P Fife, to find ways to extend service reach to this group. A few areas for development and improvement have been identified for future activities.

V1P service facts

There are six V1P services in Scotland.

The V1P Fife service offers mental health and wellbeing support for veterans and their families through a combination of remote and in-person supports and therapy.

At March 2022:

462 veterans were registered with the service

125 were being actively supported.

Link Life Fife (Action 15)

Link Life Fife is a project which is funded by the Scottish Government's Mental Health Strategy. The aim of the project is to reduce pressures on GP practices whilst supporting individuals to meet their outcomes and reduce dependence upon GPs, where appropriate. The project criteria are for anyone aged 18 and over living in Fife who is engaging with their GP or other health professional in Primary Care for support to manage stress, anxiety, or feelings of being overwhelmed, that are affecting their mental health or general well-being.

A team of local area co-ordinators and seven community connectors were recruited between June and September 2021 and are now receiving referrals from Fife GPs and Primary Care Teams.

Link Life Fife Referrals (September 2021 - June 2022)

Case Study (Link Life Fife)

Referral: GP Practice referral by mental health triage nurse.

Individual: A woman in her 50s, with history of low mood, chronic pain, and traumatic events in her life.

Issue: Little benefit from anti-depressants. Lacking motivation to leave the house resulting in social isolation, withdrawn from friends and family.

Conversation: Community Connector (CC) identified through a good conversation that the woman wanted to establish a routine, improve her mobility and connect with others in order to improve her day-to-day life and reduce her feelings of isolation. She also wanted to work through some of her emotional trauma and find a way to move on from past events.

Actions: Referrals to Occupational Therapy Service (OT) to help with mobility, which was a priority, as well as physiotherapy and Active Options at Fife Sports and Leisure Centre.

CC and the woman explored a number of social and mental health support groups within her community.

Outcomes: The individual now feels it is easier to get up in the morning, and keep on top of her self-care, having more energy and motivation to go out more. She has consistently attended the Active Options class, despite how she may be feeling on the day. Also attends a local social group, has reconnected with family (not seen in over a year) and sees her grandchildren regularly.

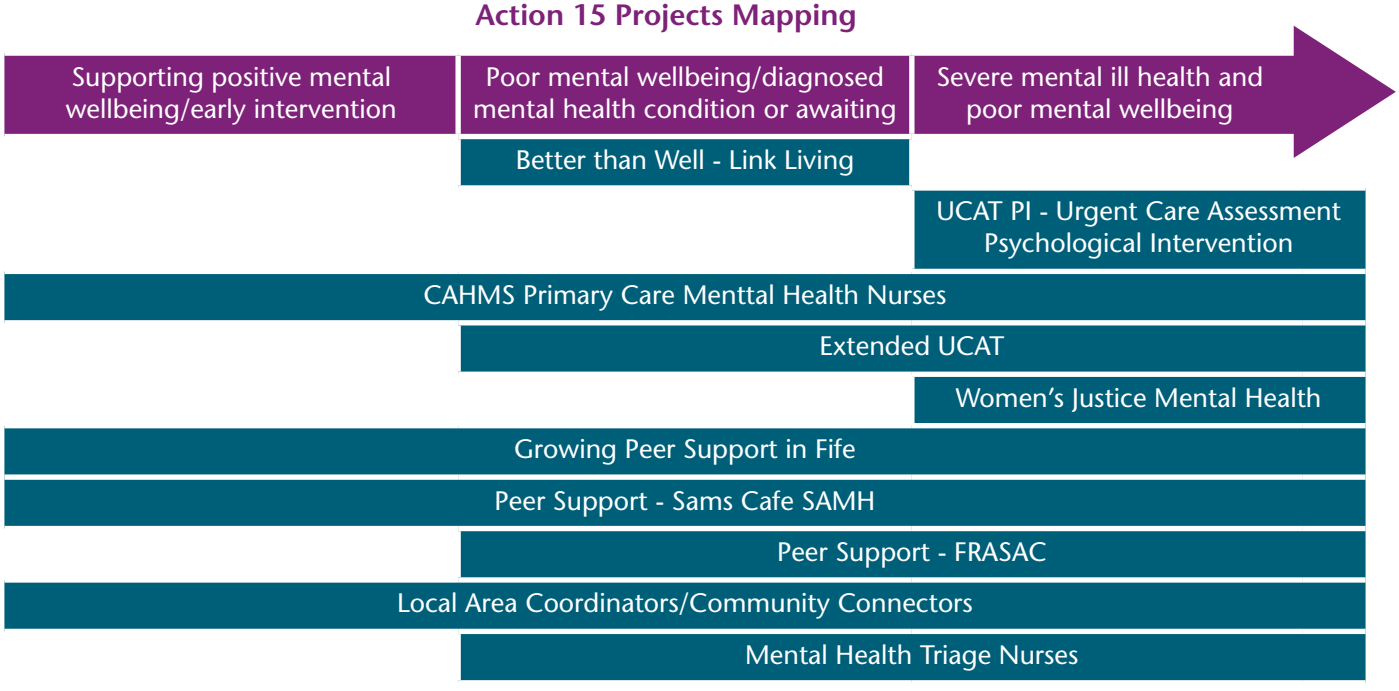
'I thank you for everything you've done. The support for mental health is so much better than it used to be.'

The Action 15 Oversight Group identified communications needed to be strengthened to support the new Mental Health projects and services developed through Action 15 funding. The Health Promotion Service received Action 15 Funding to develop and deliver a communication plan to directly support the Action 15 mental health projects and services. The aim is to increase frontline staff, partner organisations and the general public's understanding and awareness of the range of mental health services and support available and how to access support and services. The support and services information spans prevention and early intervention through to acute service provision.

Progress so far includes:

- The creation of a Fife Multiagency Mental Health Information and Communication working group with representation from Fife Health and Social Care Partnership, NHS Fife, Fife Council and five third sector organisations. The Group members all have responsibility for updating mental health and wellbeing information within their roles and remits and some of their services and organisations have received Action 15 funding. Members represent a wide variety of services across Fife including Moodcafe, Fife Voluntary Action, On your doorstep Fife, Fife Centre for Equalities, The Well and Fife Forum. The remit of the group is to develop and deliver information and communication strategies to ensure frontline staff and members of the public are aware of, and are able to navigate the range of support and services available.
- A mapping exercise of all ten Action 15 funded projects in Fife has been developed, allowing Action 15 members to be aware of how their service fits into a pathway from Early Intervention/ Prevention to Crisis (see attached graphic).
- A patient leaflet is currently being developed for the Unscheduled Care Assessment Team – Psychological Intervention (UCAT PI) Brief Intervention service, ensuring it is in an easy read format and accessible to a wide audience to be printed and available digitally.
- Links with key Health Promotion Service resources such as the Keeping Connected leaflet suite have been added to service web pages such as Fife Rape and Sexual Assault Centre (FRASAC), alongside internal promotion of new services such as the Women's Justice Health Team on Blink and increased promotion of the Better than Well self-referral service with a new patient leaflet.
- Evaluation of the impact and outcomes of the Information and Communications Group action plan is being progressed.

Action 15 Projects Mapping



Feed Your Mind

During the coronavirus pandemic the importance of alternative ways to access reliable evidence-based information, in relation to Food, Wellbeing and Mental Health, became apparent. Mental health is integral to living a healthy and balanced life and is not limited to therapy and counselling. Over the course of the year, we developed and introduced a podcast series called 'Feed your Mind' hosted on the NHS Fife website **www.nhsfife.org/feedyourmind** and shared on the NHS Fife Facebook page, NHS Fife Nutrition and Clinical Dietetics Facebook page, Twitter and Instagram.

The aim of the podcast series being to provide 'little bursts' of information on topics addressing food as a contributor in individuals overall Wellbeing and Mental Health. The Nutrition and Clinical Dietetic Service used a small working group of Dietitians and Nutritionists to develop the podcasts to provide reliable digital information to the public and other health professionals on nutrition for holistic health.

A funding application to NHS Fife Small Grants Endowment Funds was successful to enable the purchase of the necessary recording equipment to produce podcasts. A Department Sub-Group was created to achieve the objectives of the Endowment Fund application, which was to produce ten podcasts around Nutrition and Mental Health. So far, the podcasts have covered:

Episode 1: Holistic Health

Episode 2: Diet Culture

Episode 3: Caffeine

Podcast stats

13,306 post impressions

393 page views on www.nhsfife.org/feedyourmind

Priority 3

Working with communities, partners and our workforce to effectively transform, integrate and improve our services

Delivery of effective and lasting transformation of health and social care services is central to the vision of Fife Integration Joint Board. Significant change on how services are planned and delivered with a range of stakeholders which includes carers, patients/service users who experience services is paramount to delivering changes.

What we set out to do

- To support more integrated and earlier approaches for adults and older people who are at highest risk of decline in their health and wellbeing.
- As part of the GP contract and primary care transformation, vaccination programmes will be transferred from delivery by GP practice to NHS Fife. This includes the infant, child and teenage programmes, adult programmes (for example, seasonal flu, shingles and pneumococcal vaccines) as well as travel health provision.
- Realign alcohol and drug services to improve the physical and mental health of people with a dependency.
- Redevelopment of our residential care homes and where practical, developing care villages that co-locate care homes, particular needs housing, day services and early years facilities.
- Increase the number of technological solutions offered in Housing to support independent living.

Where are we now

Adult Services Resources

Fife Community Support Service (FCSS)

This Service provides flexible, community-based support during the daytime, evenings and weekends to suit the identified needs of individuals Fife-Wide. The service enables adults aged 16 to 65+ years old, with a range of disabilities (including learning disabilities, physical disabilities, sensory impairments, autistic spectrum disorders and other related issues) to lead full and meaningful lives and be valued citizens within their own communities. Service users can be supported in a variety of settings, determined by themselves and the outcomes they want to achieve. These personal outcomes are reviewed through regular review meetings and new goals identified. Support allows access to leisure, social, and recreational opportunities enabling individuals to maintain and develop life skills to enhance their self-esteem, confidence, and independence. We have four hubs across Fife, some of which contain PAMIS care suites (where personal care can be provided), multi-sensory areas to stimulate senses, relaxation areas and accessible gardens which all individuals in receipt of support have use of.

In accordance with the Health and Social Care Standards, FCSS promote individualised support with communication. For those individuals requiring enhanced support with their communication needs, FCSS continue to be invested in the PAACT initiative, partnership working with Speech and Language Therapy, and Education Services.

There was a significant impact on FCSS during the pandemic, with restrictions to how, when and where we could deliver services. The four hubs primarily remained closed, thus preventing us offering any building-based support, except for our Care Suites. In addition, many community-based activities formerly used by us were also closed or very restricted. We had to significantly change the way we provide services/support during the pandemic and for the team of staff retained within FCSS, infection control measures were reviewed and updated, strict protocols implemented, and guidance issued. New Interim Support Plans were developed to ensure the needs of the person receiving support were accurate, up-to-date and relevant to ensure safe, high-quality support was achieved. We re-assessed all 336 service users who formerly accessed FCSS to ensure they continue to meet the eligibility criteria to receive a funded service provided by the Partnership.

During April 2021 to March 2022, the number of people accessing our support has risen from 54 to 132 through being assessed as in critical need. We have been restricted to offering mainly 1-to-1 support to keep people safe as the pandemic continued to cause difficulties. From the service users who previously received support from FCSS, those assessed as eligible to receive funded support has risen with 204 expected to return to the service. FCSS has continued to provide a vital lifeline to those receiving our support and their families.

Accommodation with Care and Housing Support

This Service provides a combined housing support/care at home service to 140 adults with learning disabilities, physical disabilities and mental health issues living across Fife.

With a staff team of 625, support is provided over 64 services, in single tenancies, group homes and core and cluster services. Support can range from a few hours per week to 24 hours support each day.

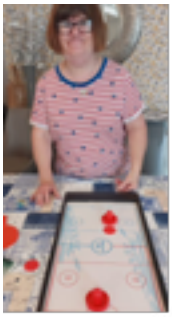
The service delivers a person-centred provision of care and support with people's "rights" at the forefront. We promote independence with an active support approach that focuses on making sure that people are engaged and participating in all areas of their life, to maintain and increase their skills and abilities.

Feedback from relative, Care Inspection December 2021

"I know my relative is happy and content and feel their voice will be heard and views taken on board."

People are supported to get the most out of life, by accessing a wide, varied range of social and leisure opportunities and have a valued role in their local community.

We promote health and wellbeing through healthy eating, exercise, relaxation and wellness. We golf, walk, keep fit, football, swim, bowl, snooker and learned how to play Boccia! We encourage rest and relaxation with sensory sessions and mindfulness.




We had an Active August Challenge in 2021 where people were encouraged to be active every day for the month of August, with Union Street Service winning the gold medal with a whopping 86 points!

We celebrated International Day of Happiness inspiring people to spread positivity and prioritise being happy!

Staff are committed to supporting people to maintain relationships with friends and family and build new positive relationships. This supports people's sense of security and belonging.

Sensory Garden

Residents at Watt Crescent enjoyed creating their very own sensory garden using lots of different lights, ornaments, foils, wind chimes, bird feeder, plants and a custom-made water feature that they built themselves.

Since the creation of this space the residents have a regular little visitor, in the shape of a baby bird who comes to the kitchen window and knocks to say hello, the service users think this is wonderful and find so much joy in this.

Learning Disability Week 2021 – Relationships

We celebrated Learning Disability Week 2021 with a whole range of activities despite lockdown. From the key “Relationships” theme, we focused on three areas, friendship, challenges, and social life.

We held Teams Bingo, competed in Bake Off Competitions and had an online Social Event with our very own Playlist for Life!

Vaccination Transformation Programme

Strategic Framework

The direction and shape of the new Community Immunisation Service has been defined through the development of the Fife Immunisation Strategic Framework 2021 to 2024.

The Framework aims to:

- Protect the people of Fife from vaccine preventable disease by maximising uptake across all immunisation programmes.
- Contribute towards improved well-being and reducing health inequalities.
- Ensure immunisation services across Fife are safe, effective and of a consistent high quality.
- Raise peoples' awareness of the public health benefits of vaccination and raise peoples trust in vaccinations.

This has four key priorities:

- Optimise Immunisation coverage ensuring equitable access for all eligible groups.
- Enhance the monitoring and evaluation of immunisation programmes.
- Support and empower a sustainable skilled workforce to deliver safe and effective immunisation services.
- Community engagement and promotion.

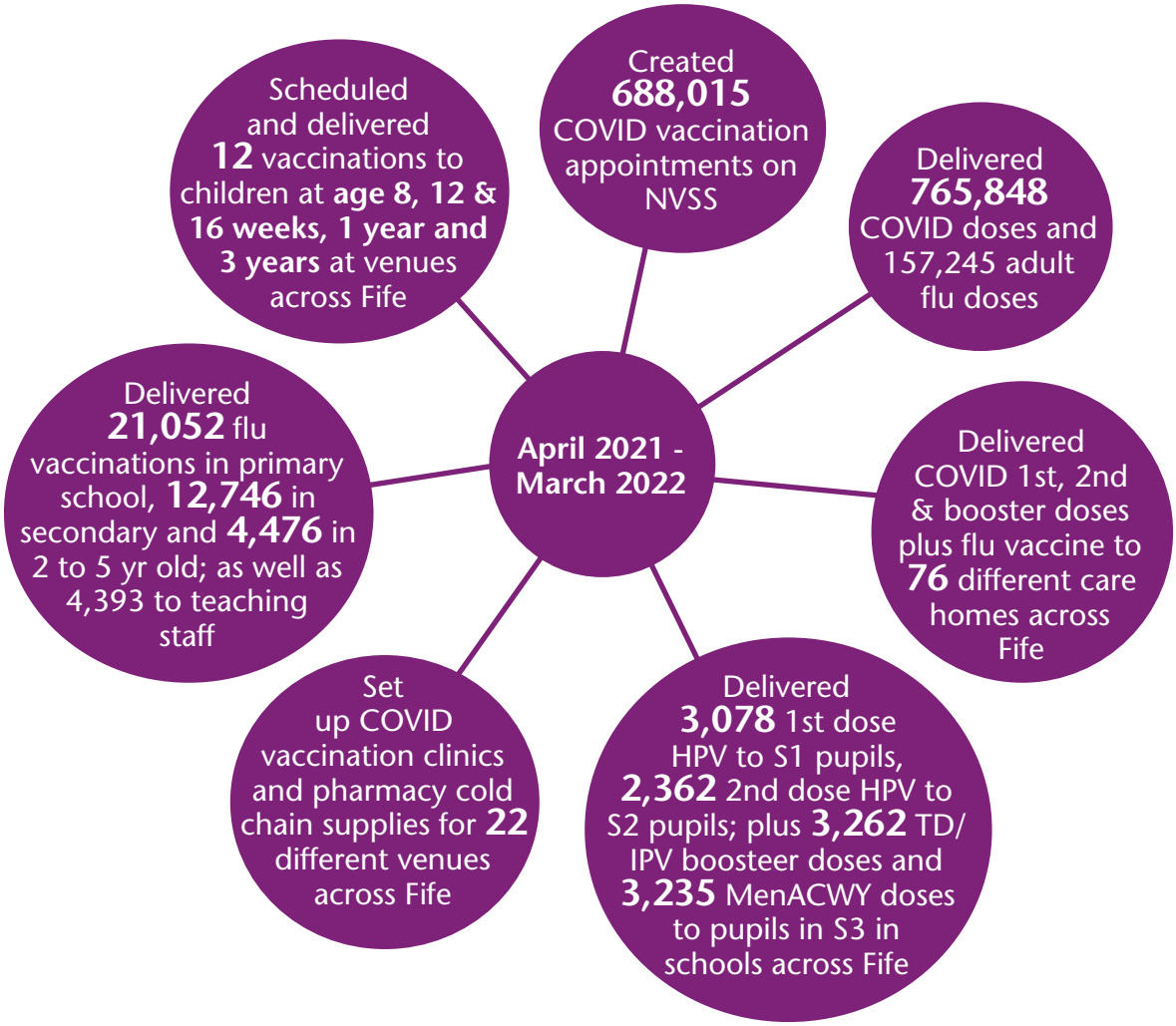
Implementation of the Fife Immunisation Strategic Framework is progressing at pace with the establishment and implementation of the overall governance and leadership structures to support safe and effective care delivery.

Covid Immunisation Progress

As of March 2022:

- 860k doses have now been administered in Fife, 236k individuals having received their full course + booster or 3rd dose.
- 8,682 2nd doses have been administered to the 12-15 cohort (52% uptake)
- 5028 2nd doses have been administered to the 16-17 cohort (64% uptake)
- 7205 1st doses have been administered to the 5-11 cohort
- We continue to review opportunities to target cohorts who have not taken up the vaccination. Community outreach is ongoing to assess areas with low vaccine uptake, promotional activities are in place to encourage drop-ins and pop-up activity is also continuing across Fife.
- Spring booster progress:
- 5-11 cohort commenced 19th March. Uptake within Fife currently positioned at 24%, higher than the national average of 15%.
- Residents in older peoples care homes commenced from 14th March with Phase 1 completed. Phase 2 mop up sessions commenced week of 11th April.
- Over 75s and those who are housebound commenced 4th April with 19,319 boosters administered to those over 75, an uptake of 85%
- Immunosuppressed/severely immunosuppressed cohort, 557 boosters administered, an uptake of 61%
- 18,473 Spring boosters (booster 2) have now been administered

The diagram summarises vaccination performance over the past year.



Transfer of Travel Vaccinations

The transfer of Travel Health Vaccinations Levels 1 to 3 was successfully delivered from GPs to the Health Board via a Community Pharmacy model on 1st April 2022. 22 local Fife Community Pharmacies are delivering Travel Health Vaccinations, with the spread of pharmacies across Fife providing equitable access to all areas within the Kingdom. Collaborative working with the Acute Infectious Diseases Consultant and successful recruitment of a GP with Specialist Interest supports complex Level 4 Travel Health Vaccinations.

The Fifefitfortravel webpage (**www.nhsfife.org/fifefitfortravel**) with links to NHS Inform and the national Fitfortravel website detailing the 23 Fife Community Pharmacies providing Travel Health Vaccinations was successfully launched on 1st April 2022 with both a national and local communications campaign promoting and supporting the launch.

The successful transfer of VTP was supported with a new electronic request form and process communicated widely to GPs, Acute Consultants, Urgent Care Services Fife (UCSF), NHS24 for adhoc and selected vaccination requests via the Immunisation Team from Monday to Friday 9am – 4pm. This has been successfully provided online via the Fife Referral Organisation Guidance (FROG) system and widely used from April 2022.

Fife Alcohol and Drug Partnership

Since January 2021, Fife ADP has recognised and renewed its commitment to addressing the national Drug Related Death crisis and has worked closed with the national Drug Death Taskforce and Scottish Government Drug Mission Policy Unit to align provision to the new evidence-based recommendations. This regalvanised the approach across Fife for 2021 to 2022 to focus on its strategic priorities through the lens of delivering interventions with a focus on addressing the drug related deaths crisis. Whilst DRDs have reduced by 20% in Fife from 2019 to 2020, rolling averages show 70 deaths per annum and an increase of 86% in Fife over the last ten years. Alcohol specific deaths have remained static over the last two years and increases in hospital stays also indicate unmet need.

In response, the ADP Partnership has reconfigured their structure to concentrate on these priorities, with three sub-groups (Multiple-agency Drug Related Death Review Group, Medication Assisted Treatment (MAT) Standards 1 to 5 Oversight Group, and the Addressing Alcohol Specific Deaths (ASD) Group) focused on addressing harm caused by alcohol and drugs including prevention of alcohol specific and drug related deaths. These groups work across partnerships and directorates within HSCP, Fife Council and NHS Fife and include relevant representation from the voluntary and independent sectors. These subgroups have clear remits with a focus on analysing and reviewing our current position, assessing options and opportunities to deliver improvements across the whole system and reporting back to the ADP Committee.

Fife ADP were awarded a £1.3 million per annum across six new priorities and took the view that given the high number of alcohol specific deaths in the area, any additional investment would consider this local priority too. Additional funding for MAT Standards implementation has also been awarded following the development of a project specification plan. Below is a summary of improvement work funded from these additional investments:

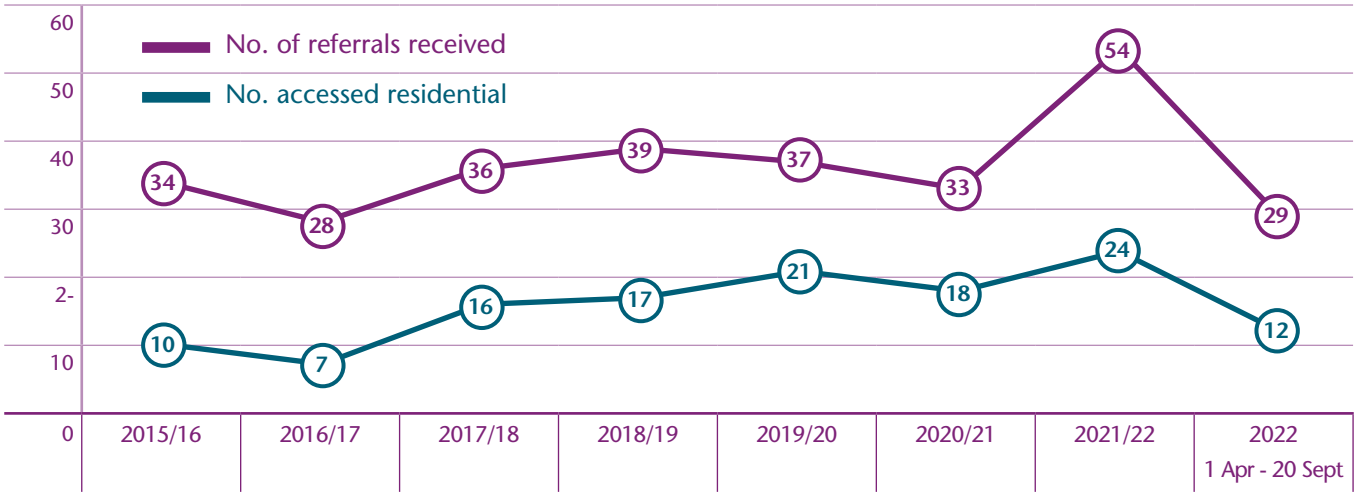
Children, Young People, Whole Family and Adult Family Members Carers Support

- Joint strategic planning and commissioning as part of Children Services Planning to create the Whole Family Support and Young Person's Service. Barnardo's and Clued Up will provide whole family support at additional level for other referrers – out-with the ICSP - and provision for YP up to the age of 26.
- Adult family support provision across Fife co-located with Tier 3 alcohol and drug services but mainly NHS Addictions to provide key working, CRAFT based support and group working to any adult family member affected by another's substance use. The service was commissioned by ADP and will be provided by Scottish Families Affected by Alcohol & Drugs and will take a carers'-based approach with an aim of providing support to carers to improve their own wellbeing. A further aim is to improve access to services for the member of the family using alcohol or drugs by providing family members with knowledge, tools and techniques to improve motivation and support recovery. Take Home Naloxone/overdose awareness training and general harm reduction advice for alcohol are also provided as part of the approach for the prevention of substance use deaths
- Additional capacity created by ADP funding allocated to Kinship Care Social Work Team for two social work positions to focus on family intervention/support and management and prevention of trauma within the family.

Increase Access to Residential Rehabilitation

- New budget placed with FIRST who provide thorough and robust preparation support, placements in any rehabilitation centre within Scotland thus allowing the service user choice of intervention, location and length of stay. Family support whilst the placement is ongoing and referral into community-based rehabilitation on return. Work is underway to improve the referral pathway to focus on priority groups - women, people with dual diagnosis, young people, veterans - outlined by the Scottish Government.

Referrrals for Residential Rehabilitation



Medication Assisted Treatment Improvement Plan & Increase of Assertive Outreach, Non-Fatal Overdose Response and Harm Reduction

- Non-Fatal overdose assertive outreach, information shared from Scottish Ambulance Service to third sector and a 48-hour response occurs to support the individual and prevent further overdoses which may result in deaths. The ADAPT service with support of the ADP has received additional funding to respond to non-fatal overdoses occurring out-with of this pathway.
- Annual budget provided by Public Health Scotland to services to deliver MAT Improvement Plan developed by the ADP and its delivery partners. This is a rights-based approach for safe delivery of OST medication (methadone, buprenorphine, buvidal) and psychosocial support and is underpinned by a requirement to increase the percentage of people (9%, n=154) in the system of care by end of March 2024. The main deliverables of the plan are:
  - To provide same day prescribing across the full service building on the success of the same day prescribing clinic based in Kirkcaldy. This approach reduces attrition rates at start of treatment thus increases the likelihood of good outcomes for the service user, their family and community.
  - To increase the provision of buvidal (long-acting injectable buprenorphine) prescribing where it is safe to do so thus respecting the choice of those within the treatment system and allowing for a recovery-based approach to this aspect of the model of care.
  - All services have adopted an assertive outreach-based retention policy especially when people are in crisis or lapsing/relapsing as maintaining people in support preventing further harm and protecting people's recovery. In addition to this, ADAPT provide a separate retention service when some services do not have the capacity to provide outreach and follow up. This is focused on both those experiencing alcohol and drug problems.

- Harm reduction (needle exchange, take home naloxone, wound care, testing for Blood Borne Viruses (BBV) provided by services at point of need. Additionally, planned and funded by the ADP, the pharmacy network has increased HR reach to remote communities, family members and those that need out of hours access. This prevents BBV exposure and contraction decreasing risks of Drug Related Deaths.
- Hospital Liaison Service – The ADP will continue to redevelop this inreach and outreach partnership – provided by NHS Fife Addiction Service, We are With You and ADAPT – to support people whose alcohol and drug use has reached crisis point and who are not getting a service or the service provided has not yet been beneficial.
- COMPASS Social Work Service – This project is due to be operational in the summer of 2022 and will provide support to adults affected by alcohol or drug use who have complex, severe additional needs which make it difficult to access and engage in treatment and support and/or be retained in services. This will provide additionality to people supported through the Hospital Liaison Service whose needs include social care and support.
- Increased assertive outreach approaches for those in custody and in prison, delivering harm reduction and providing active linkage into universal and specialised alcohol and drug supports.

Lived Experience Panel & Advocacy

- Fife ADP has developed an autonomous Lived Experience Panel recognised as a subgroup of the ADP with the same rights and responsibilities as other subgroups to develop policy, strategic direction and contribute to improvements of service delivery. This group is afforded latitude to set its own remit and focus.
- Commissioning of an independent advocacy service, delivered by Circles Network to work with adults with alcohol and drug problems.
- Completion of a lived experience led evaluation of women's experience of alcohol and drug services in Fife in partnership with Fife Violence Against Women Partnership. This should form the basis of an improvement approach across Fife Violence Against Women Partnership, Social Work Services, NHS Scotland, Fife Health & Social Care Partnership and ADP to engage more women in support and treatment earlier and retain in provision use and a co-production approach will be undertaken with women with lived experience to deliver the recommendations.

Care Home Replacement

Methil Care Village

The project has progressed well over the past year despite ongoing issues with materials/supplies and global price increases. Internal works within the care home/nursery building is on track and we anticipate handover of the building in October 2022. There is an 8-week allowance for fit-out of the building including furnishings and fittings, and staff training on new systems.

Methilhaven residents will be helping the Project Team to choose colour schemes, furniture and fabrics for their new home in May 2022.

Throughout the project, they have been shown monthly photographs of their new home as well as drone footage and they are excited to see it progressing and hoping to be in their new home by Christmas this year.

Cupar Care Community

Planning approval was granted on 15th December 2021 for the replacement care home and supported housing building in Cupar and work has been progressing well on the detailed design of the building. The building design has been shown to perform very well in terms of carbon emissions and likely to achieve an 'A' Energy Performance Certificate (EPC) rating which is good news in terms of energy costs.

There has been some slippage due to emergent issues such as the need now for a Sub-Station on site, however, early enabling works on site are anticipated to commence before the end of 2022.

Anstruther Care Village

Work on the design for Anstruther has been ongoing and complicated in nature due to the size and sloping nature of the site, leading to a re-design that is over three storeys on the care home side of the building. This has led to slippage due to extended discussion with experts in, for example, Fife Council Transportation Services and the Care Inspectorate. It is anticipated we can submit the Planning Application for Anstruther by September 2022.

Using Technology in Housing to Support Independent Living

Our Housing Plus project is the key mechanism that we use to deliver new technological solutions across Housing. Key Achievements this financial year have been:

- Connecting Scotland – we worked with the Scottish Government scheme to provide access to 80 I-Pads and Mi-Fi personal wi-fi hotspots. We ensured that people that took part in the scheme were paired with one of our Digital Champions who provided them with training and support.
- CHARM2 – We provided 20 people within our Older Persons Housing with active health and wellbeing monitoring equipment. People have been given a health monitoring watch, they participate in U-Checks which involves weight, grip and strength monitoring. This is fed into an AI programme which predicts the potential to have a fall. Actions can then be discussed with the individual that should help prevent this.
- Smart Life in Fife – we have been promoting the Smart Life in Fife website across our Older Persons Housing staff and tenants. The aim of doing this is to encourage people to use the site to get independent living advice and improve their health and wellbeing.
- TEC Demonstrator House – we have identified a property in Woodside, Glenrothes which will act as a TEC Demonstrator House for staff and service users. At this point in time, we are working through identifying Technology Enabled Care equipment to be installed within the property. The aim is to demonstrate how this can help people live independently.

Service utilisation

Connecting Scotland scheme – 80 people

Supporting Adults to live independently through Self-Directed Support

The implementation of self-directed support (SDS) continues in Fife, ensuring that people we support, along with their families and carers, are offered choice and flexibility when planning their support ensuring that everyone can live their life as independently as they choose.

We use a personal outcomes and Good Conversations approach to ensure people feel involved and listened to in decisions which impact their lives, ensuring they are given information and advice, including sign posting to external sources of support and/or advocacy, where required or requested, when discussing the four SDS Options. Staff continue to ensure that both personal and community assets are considered when discussing potential support options.

The graph below shows the increasing numbers of people over the past three years in receipt of either a Direct Payment (Option 1, which offers maximum choice, control and flexibility for people to select, arrange and manage their own support) or Individual Service Fund (Option 2 which offers clients a high degree of control in selecting and directing their own support arrangements but the responsibility of financial management rests with the local authority or third-party organisation(s)). Referrals for Option 1 or 2 continue to increase due to the demand for care at home packages and it is anticipated that Option 1 will continue to rise as the cultural shifts towards people feeling confident and comfortable to manage their own support arrangements and budgets, which is one of the key aims of both national and local SDS policy.

We continue to have a dedicated Self-Directed Support (SDS) team who provide advice, information and support to colleagues in the wider service.

Over the past year we have:

- Refreshed SDS training with a new training module focused on the personal outcomes approach to assessment and support planning, using case studies and examples. The training provides an opportunity for participants to reflect that their practice addresses the SDS statutory values and principles.
- Had our Self-Directed Support Processes and Procedures approved in April 2021. These provide an excellent guide for staff. As well as an overview of self-directed support and the four options, it includes a guide to the new National SDS Framework for Scotland, links to external information, the legislation, some Frequently Asked Questions and the link to our website, On Your Doorstep Fife, which includes our SDS animation.
- Restarted our work on the implementation of prepaid cards. This will replace our current system of paying individual social care budgets via SDS Option 1 (direct payments). This piece of work was significantly impacted by the pandemic however is now a priority for the SDS team, working alongside colleagues in Contracts/Quality Assurance.
- Continued to work closely with SDS Options (Fife), our external partner offering advice and support to people choosing to take their social care budget as a direct payment. Meetings are held quarterly to share information and discuss issues. This ensures consistency of approach and information.
- Participated in the quarterly SDS network (a subgroup of Social Work Scotland) which provides an excellent source of information and allows for significant shared learning, and Independent Living Fund (ILF) Scotland meetings to ensure we are kept up to date with developments relating to ILF payments and budgets.

Priority 4
Living well with long term conditions

We are committed to building on the work already started in Fife to support adults and older people with complex care needs, who are accessing both primary and secondary care services most frequently. We are developing and supporting a more integrated and earlier approach focussing support pro-actively with patients who would benefit from this which includes early identification and comprehensive assessment in case co-ordination.

What we set out to do

- Develop a short breaks service to build on the respite and short breaks opportunities that already exist, including developing a market shaping strategy to enhance short break opportunities for all carers.
- Early supported discharge for all palliative care patients and people who are at the end of life avoiding unnecessary hospital waits and choice of end-of-life care to people's own homes or a homely setting.
- Continue to enhance the investment in support for carers of people with dementia to reach all parts of Fife, recognising that carers of people with dementia are often older and may experience a high level of burden from their caring situation and role which can adversely affect their own health and well-being.
- Support and improve the health and wellbeing needs for all people who have long term conditions. This includes respiratory, cardiac, diabetes, renal and obesity related conditions.
- Results delivered through the Fife Macmillan Improving Cancer Journey service will build a foundation for service redesign for other long term health conditions in Fife.

Where are we now

Short Breaks Service

Choice and flexibility remain the key themes as we continue to try and support individuals and their families and carers to access suitable short breaks. Through a personal outcomes approach, our dedicated team works with families to facilitate short breaks for adults under 65 years of age, to give both individuals and their unpaid carers a break.

The Short Break Team provide information to supported individuals and their families/carers to assist them to access creative and innovative short break provisions or, where this is their choice (and depending on availability), building based resources, using their individual short break budget and chosen option through self-directed support.

The previous two years have been extremely challenging for many families who provide unpaid care and support. Coronavirus restrictions resulted in many building-based resources being closed and the requirement to "stay at home" meant that many other facilities were not an option. As restrictions eased, many resources were limited due to ongoing social distancing and staffing issues, with one facility closing permanently.

2021/22 brought about some degree of normality for services and as facilities began to welcome back visitors, options began to open up again for many families.

Due to the reduction in building based support, the Short Breaks Team have been working extremely hard to source creative ways in which breaks can be achieved, within budgets. Some examples of breaks taken during the last year are:

- Accessible Lodges and holiday cottages.
- Air BnB properties.
- Caravans with or without support staff.
- Supported holidays booked through external partners who source the break as well as the support – including one at the beginning of the year to Tenerife (see below).

The individual took a friend as her carer and gave the following feedback to the team "just back from a break using Enable Holidays …. it was fab. Both the hotel and the location are completely disabled friendly"

Palliative and End of Life Care

Inpatient hospice care 2021/2022

Over the last 12 months the inpatient hospice unit has continued to deliver high quality of care to those with complex care needs in the context of a palliative diagnosis. This year the hospice on the Victoria Hospital, Kirkcaldy site commenced its refurbishment which involved a lot of planning and logistics to ensure seamless care for the patients. Since January 2022 our inpatient beds have been based on the Queen Margaret Hospital site. It has been important to understand the impact of the changes in bed base and location on patient experience and flow and the data below has provided significant reassurance.

- There has been a sustained reduction in demand for hospice beds and an improved ability to admit to the hospice with a 25% reduction in the average number of monthly referrals (25 per month in 2019, compared to 19 per month in 2020) and an increased proportion of patients being admitted to hospice in 2020 (14/19, 75%) versus 14/25 (55%) in 2019.
- Admissions to hospice beds have been facilitated more quickly with the average (mean) number of days spent on the hospice waiting list for patients reducing from 3.4 to 1.4 days and the percentage of patients who have died in another care location whilst on the hospice waiting list has reduced by half, from 12% (three patients per month on average) in 2019 to 6% (one patient per month on average) in 2021.
- Consistent, active and dynamic use of the hospice beds from April 2020 to March 2022. In March 2022: the inpatient hospice had 15 admissions, 17 discharges and average length of stay of 20.6 days. Occupancy in March 2022 95%.
- The hospice has developed closer working relationships with the discharge hub to ensure optimal flow through the hospice. The hospice continues to admit individuals seven days a week from all care and residential settings including the acute hospital.

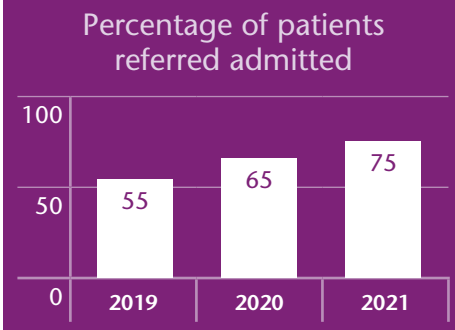
In-Patient Hospice Bed Occupancy (Av. Occupancy)

April 21 – March 22	82%
April 20 – March 21	84%

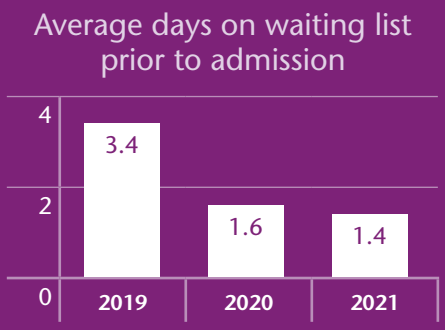
Right Care. Right Place. Right time.

Following the temporary reduction in in-patient hospice beds in response to changing clinical demands:

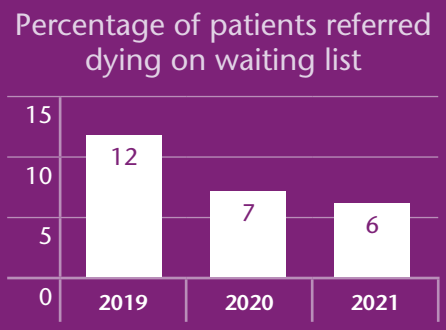
The proportion of people on the waiting list for hospice care who were admitted has risen from 55% in 2019 to 75% in 2021



The average (mean) number of days spent on the hospice waiting list for patients has fallen from 3.4 to 1.4 days



The percentage of patients who have died in another care location whilst on the hospice waiting list has fallen by half, from 12% in 2019 to 6% in 2021



Outreach clinical care provision

The outreach team incorporates both the community and hospital parts of the service, with regular flexing of resource across these sites. This is particularly important at weekends when staffing numbers are lower and clinical demand less predictable. Over the past 12 months several core staff members have developed skills and confidence to work across both settings on any given day. This has greatly improved the team's ability to respond to clinical need and to flex when colleagues are absent (as has been particularly common during the coronavirus pandemic). In 2021 there was a several month period when the Social Care End of Life Care Team were reallocated away from end-of-life care to more mainstream social care demand, in order to facilitate more discharges from hospital. For the duration of this period, Fife Specialist Palliative Care took on responsibility for the non-specialist caseload, receiving referrals, coordinating care and ensuring that people who wished to die at home had adequate care and support in the community. This was a major undertaking and involved significant changes in practice and pathways within the service, as well as management of regular bank staff, many of whom did not have experience of end-of-life care delivery.

The core work of the Outreach Team is direct clinical care for patients and families with complex needs, whose usual care teams require additional support and input to ensure that needs are met. Since the start of the coronavirus pandemic, and sustained over the last 12 months, we have been able to support many patients with highly complex needs in both inpatient and community settings. It has been particularly striking how many patients with intractable, distressing physical conditions such as bowel obstruction, bleeding and seizures have been able to be cared for at home, with many of them able to die there with the care and support they have required. This would not have been possible under our previous model of community care and has required a very high level of collaboration with District Nurse and GP Teams in the community, as well as with Marie Curie and other delivery partners.

Counselling Services

The counselling services have continued to use a blended approach using telephone, Near Me video conferencing and face to face visits to support the psychosocial/emotional needs of each family. This has enabled more people to be seen as it has dramatically cut down travel time around Fife. However, sensitivity to the needs of the person is considered and face to face appointments are offered if required.

There has been another step towards restabilising the bereavement groups with small socially distanced bereavement groups running again helping to reduce social isolation.

Children and Families Service

Using a blend of virtual clinics and meetings, 'drive by', garden visits and home visits, the children and families service has continued to provide support to parents and carers supporting children facing and coping with parental death. Microsoft Teams meetings have enabled full liaison with education and social work colleagues and ad hoc teaching as required. Families have been surprisingly appreciative of the option to have very painful and intimate conversations remotely, though digital poverty remains an issue for a minority. Parents Groups, a Family Resilience Group and Remembering Days have been held in the therapeutic space at Falkland Estate and have been well received by children and families. A partnership with 'Roots and Resilience' has allowed safe, therapeutically informed support and education to be offered to families with the added benefits of outdoor activity, known to enhance mental health.

Several seminars and education sessions have been delivered by the service this year, as well as more tailored training for specific situations.

Dementia Friendly Fife

The Dementia Friendly Fife Project has become closely connected with the local peer support group called STAND (Striving Towards a New Day) over the past year. STAND supports anyone with a diagnosis of dementia and their families and friends.

With the support of the Dementia Friendly Fife Project Manager, STAND has secured £160,000 of income to develop seven Meeting Centre spaces across Fife to ensure every weekday in Fife there will be a space where people who are affected by dementia can go for information, peer support, physical activity and creative opportunities. It has also supported the 1st phase of the consultation on the Fife Dementia Strategy.

Dementia Friendly progress in 2021-22

8 more local businesses have achieved dementia friendly status.

Creating 100 more individual dementia friends.

Access to 2 schools means that 293 children (and their teachers) are now dementia friends.

2 new weekly peer support groups have been established, in Kennoway and Kinghorn, enabling people to access support and information on their doorstep and get involved in meaningful and creative activities that ensure they can live well with dementia.

7 individuals, recently diagnosed with dementia, were able to benefit from the 6 week self-management course called a Good Life With Dementia. These individuals, their families and friends who supported them to attend are now linked up with weekly groups.

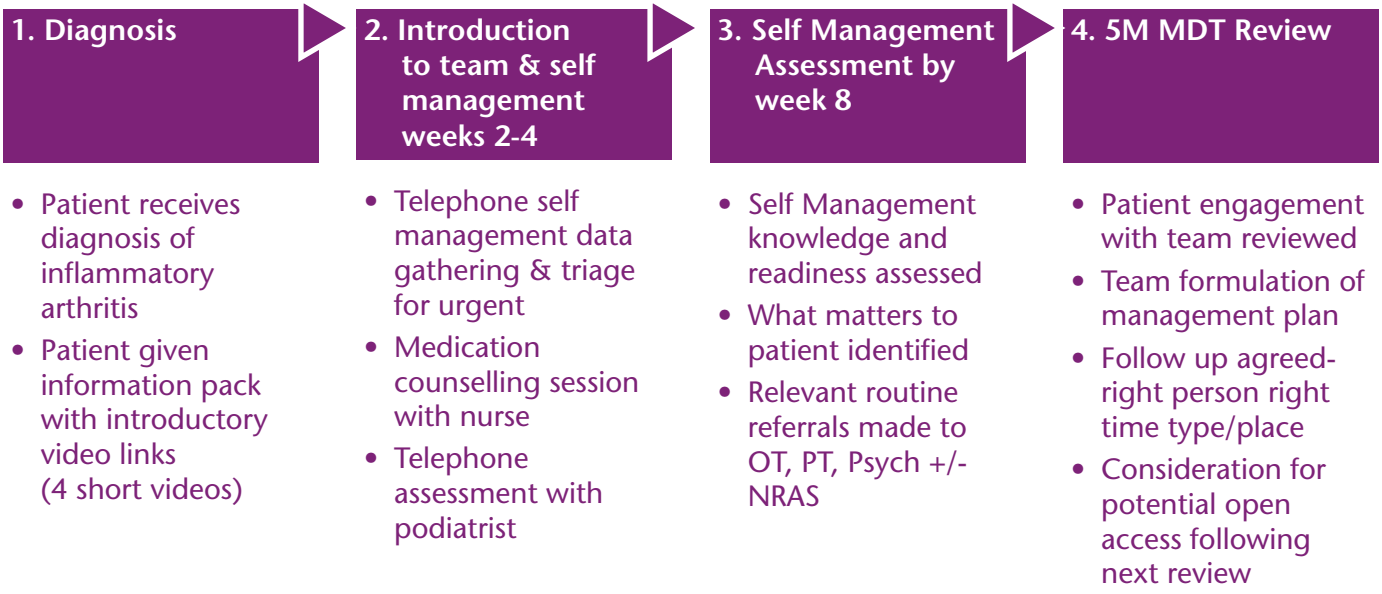
Redesigning Rheumatology Support

Taking account of national and local drivers we introduced a new self-management patient pathway for newly diagnosed inflammatory arthritis patients in Fife. This was based around the seven principles of self-management.

7 Principles of Self Management - patients capacity to

1. **Have knowledge of their condition**
2. **Follow a treatment plan (care plan) agreed with their health professionals**
3. **Actively share in decision making with health professionals**
4. **Monitor and manage signs and symptoms of their condition**
5. **Manage the impact of the condition on their physical, emotional and social life**
6. **Adopt lifestyles that promote health**
7. **Have confidence, access and the ability to use support services.**

The pathway is shown in the following diagram. Results have been improved efficiency, better use of limited staffing resources, a more patient-centred approach through the multidisciplinary service, resulting in improved patient satisfaction.



Improving the Cancer Journey

Building on the developments of last year the service has continued to be delivered via telephone and virtual appointments with staff adopting a hybrid model of working at home, face-to-face, and in the office.

Data capture and reporting has improved using the Client Relationship Management System developed last year. Strategic and operational reports are in development to support improvements in the service.

There were more than 1,100 referrals into the service (an increase of 35% on the previous year) evidencing that the opt out approach and marketing with various clinical teams begun last year has been very successful.

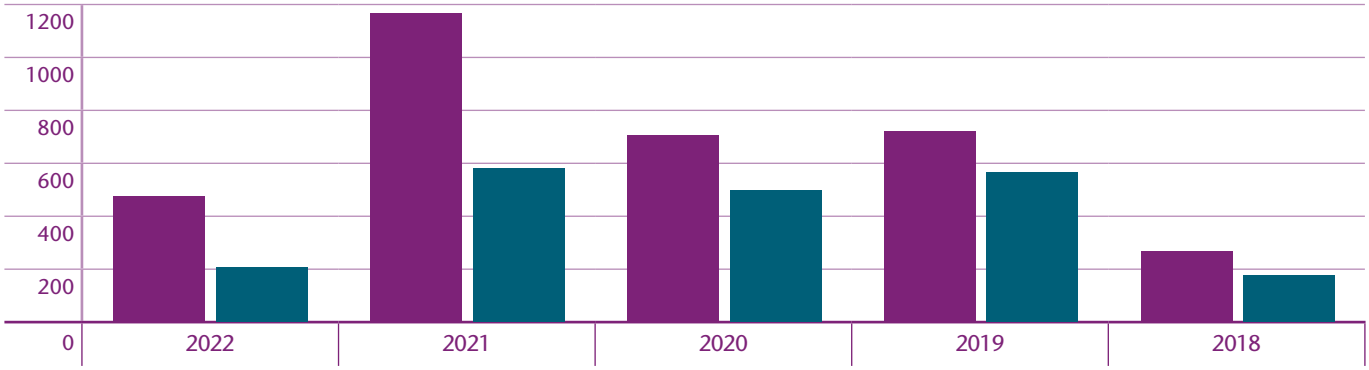
Progress was made in Key Performance Indicators for processing referrals, arranging appointments with Local Area Co-ordinators/Link Workers and sharing Care Plans.

The Test of Change using the Holistic Needs Assessment (HNA) approach for other long-term conditions (chronic obstructive pulmonary disease, heart failure and diabetes) went live in August 2021. Working in partnership with third sector providers it aims to build an evidence base for integration of care and support. It will continue for 12 months.

A new Service Manager was recruited into post in July 2021, and development is ongoing. Following the retirement of the Business Administrator, a re-evaluation of team roles took place, and a new role of Project Support Officer was created to better reflect the needs of the service and team.

Number of referrals into the service and number of HNAs completed

The service began in mid-2018 and the target of offering support to people affected by cancer has improved over time, with the first year of the pandemic impacting capacity as staff were initially redeployed to support provision of Personal Protective Equipment (PPE), and capacity issues towards the end of 2021 and beginning of 2022, impacting completion of HNAs.



Referral sources

Evidence of year-on-year improvement in referrals into the service from clinical colleagues – seen as an integral part of the care pathway and people with a cancer diagnosis are offered the service.

Priority 5

Managing resources effectively while delivering quality outcomes

The financial position for public services continues to be challenging and the Integration Joint Board must operate within significant budget restraints and pressures. It is therefore important that resources are targeted at the delivery of the priorities within the strategic plan.

What we set out to do

- Develop a transformational change programme to deliver financial balance for HSCP over a 3-year period.
- Reduce reliance on high-cost residential care and nursing placements.
- Invest in working with local people and communities to address inequalities and improve health and wellbeing outcomes across Fife.
- Develop a safe, equitable, accessible and sustainable model for care delivery in the out of hours period.
- Improve the use of existing resources and release efficiencies through service redesign.

Where are we now

Musculoskeletal Physiotherapy Clinical Education Lead (CEL) Role in NHS Fife

The introduction of the innovative NHS Fife Physiotherapy Clinical Education Lead (CEL) role (a physiotherapist with a designated role and responsibility for student education) has increased student placement offers, provided sustainable and evidence-based placement models and enhanced practice educator support.

Working in collaboration with the Higher Education Institutions (HEIs) who provide physiotherapy training, our CELs have had significant impact on the Physiotherapy Service:

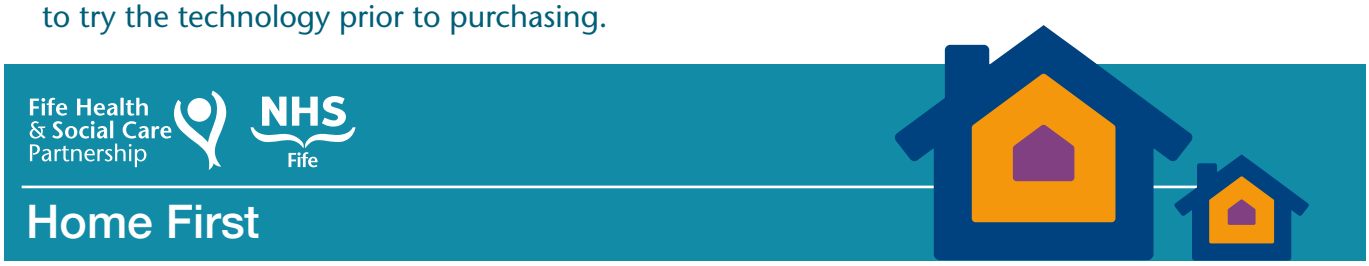
- Band 5 training and whole staff training on 'facilitation of learning' was delivered by the CELs. Feedback on all sessions was positive.
- The CELs led and supported placement provision across the entire service - developing a robust infrastructure and resources to support practice educators and students and has resulted in Increased numbers of educational placements for Physiotherapy students.
- Musculoskeletal (MSK) Physiotherapy placement offers within NHS Fife increased from 16 to 23 students during 2020-2021, with positive student evaluations. Several students went on to secure Band 5 physiotherapist posts in NHS Fife in 2021. Increased conversion rate of students to employees within NHS Fife supports research highlighting that positive student placements influence graduates' selection of their first employment. This recruitment has been a valuable asset in managing the national recruitment and physiotherapist shortage.

Themes from the practice educator feedback highlighted positive aspects of practice education, including valuing support from CELs with placement organisation, support for students at risk of failing and assisting embedding alternative placement models.

Home First

Home First is a Scottish Government directive to transform discharge from hospital, translated into the Fife vision 'to enable people in Fife to live longer healthier lives at home or in a homely setting'. The focus of the work is to develop the future model of community care in an integrated manner, with a focus on prevention, anticipation and supported self-management to realise this vision, ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission to hospital. Services will be redesigned/developed so they are flexible to growing and changing demands, as well as being sustainable. A new Home First Strategy for Fife is currently in development, but many advances have been made in this area across a range of operational areas.

- **Care at Home Collaborative** - To support capacity and efficiency improvements from the independent sector, a Collaborative has been established where 15 independent care providers have a regular meeting with the Commissioning Team to assess capacity and to better co-ordinate plans/the undertaking of packages of care. Significant progress has been made in returning people from interim beds via the Collaborative. It is thought this way of working is a first in Scotland. Work is now focused on developing processes for issues and returns of care packages.
- **Planned Discharge Date** – Community Hospitals (Test of Change) Project has been started supported by a Senior Project Manager from the Partnership's Project Management Office. Lessons will be captured for sharing with the wider pathfinder initiatives. Linked to this work is a new project 'Front Door', which is being developed. This will seek to have Patient Flow Co-ordinators involved in the planning of discharge as the patient presents at the 'front door', to try and get work started earlier in the process on identifying suitable patient pathways.
- **New patient pathways** - To improve patient flow there is ongoing development of new patient pathways between hospital services and social care areas, as well as a discharge protocol linking with Fife Council Housing colleagues. STAR Intermediate bed models are also under review.
- **Prevention / Anticipatory Care** – The Anticipatory Care Sub-Group comprised of representatives from Social Work, Health (Occupational Therapy, Nursing, Scottish Ambulance Service, GP's, GP Practice Managers and Secondary Care Doctor), Fife Carers Centre, Fife Voluntary Action and Fife Leisure Trust have consulted and agreed on a single Anticipatory Care Plan Template (ACP) to be used Fife-wide and are working on plans to roll out training on the ACP across our localities. Significant work is being undertaken across primary and secondary care on a pilot approach to rolling out the new ACP format and link to local care homes. The Life Curve App will also support anticipatory care planning by helping map individual and community needs and has links with Smart Life in Fife, which is supported via Housing Services colleagues.
- **Housing Plus Programme** - Work is progressing with Fife Council Housing Services on the use of demonstrator properties and Technology Enabled Care (TEC) Homes, which is being co-ordinated via this Programme. These demonstrator properties show what is possible to the public and link to potential items people can purchase for themselves, for example based on a Life Curve App assessment that people will be able to self-service. We are working collaboratively with Housing Services to get best use of this capability for example, exploring the use of their property to try the technology prior to purchasing.



Hospital at Home

Fife Hospital at Home Service was successful in securing short term funding of £207,000 from Health Improvement Scotland for service development opportunities. This funding was to be used between August 2021 – March 2022, and Fife utilised that by increasing our nursing, pharmacy technician and administration workforce/resource with the aim of:

- Developing and progressing seven-day access to the Hospital at Home Service.
- Increasing capacity and resilience within the service to accept more referrals and increase caseloads.
- Reduce the number of occasions that Hospital at Home Teams reach maximum capacity and are unable to accept new referrals for a specified period.
- Scope the opportunity of accepting referrals from other Health and Social Care Partnership Boards (in particular Tayside).
- Scope the opportunity to work with and meet the needs of other patient groups.
- Improving patient flow and further develop collaborative working with the flow and navigation centre.
- Improving patient safety and medicine management.
- Purchase additional pieces of medical equipment to enhance consistency and continuation of patient care and increasing capacity across the system.

The temporary funding opportunity demonstrated the positive impacts and benefits of increasing our workforce and capacity across the teams and has consequently enabled the Service to secure permanent funding from Fife Health and Social Care Partnership to recruit additional multi-disciplinary staff across Fife.

During the year Hospital at Home have achieved the following:

- Developed and implemented a Fife Hospital at Home Acuity and Dependency tool. Completed for each patient admitted to Hospital at Home and reviewed daily, the tool supports our workforce, and the Hospital at Home Teams, in identifying the needs and requirements of individual patients and also contributes to understanding the overall level of acuity and dependency of each of the Hospital at Home Teams' caseloads.
- Developed a process to gather, report and monitor the interconnected factors and measures that contribute to determining Hospital at Home team and Fife wide Service capacity, to determine capacity at any given time and support decision making in regards to the Fife Hospital at Home Service reaching maximum capacity policy.
- Rolled out a Hospital at Home Live Capacity system to GP practices, with 62% of GP Practices opting in to using the system.
- In collaboration with the Learning Disabilities Service, we undertook an audit of acute admissions and discharges for patients with learning disabilities. The aim being to ascertain if any admissions to hospital could have been avoided and the care of the patient undertaken by a Hospital at Home Team. The audit demonstrated that in most cases referrals to hospital were necessary and/or appropriate, however it did highlight some instances where a referral could have been made to Hospital at Home and prevented an admission to hospital. As a result, the Fife Hospital at Home referral criteria was updated and enhanced to provided clearer guidance to referrers for Learning Disabilities Service patient pathway options. The Learning Disabilities Service has also adapted their patient centred care plans, to prompt staff to suggest Fife Hospital at Home Service as a possible pathway option, if admission to hospital is being considered. Records of Fife Hospital at Home interventions are now also clearly indicated on the care plans and will be included in anticipatory care plans that are being completed.

- Adopted Patientrack to enable use of the Fife Early Warning Score, and identify patients at risk of deterioration.
- Started training Hospital at Home team members in the insertion of midlines within the community to avoid service users from having to attend hospital for this procedure.
- Streamlined clinical pathways to facilitate a smoother step-down process for patients from wards and emergency department.

Performance Indicators

Total number of **all referrals received** since Hospital at Home Service inception (April 2012 - March 2022)	**16,982**
Total number of **all referrals accepted** between April 2021 and March 2022	**1,268**
Total number of **GP/Community referrals accepted** between April 2021 and March 2022	**794**
Total number of **Acute Step-down referrals accepted** between April 2021 and March 2022	**474**
Average number of **all referrals received per week** between April 2021 and March 2022	**24**
Average comparison of **Hospital at Home caseload** between April 2021 and March 2022	**GP/Community - 62%** **Acute step-down - 38%**

In April of 2022, Fife Hospital at Home Service celebrated its 10-year anniversary. Throughout the years of being operational, the Teams and our workforce have evolved and gone from strength to strength. The Service is very well established in relation to staffing, skill mix, protocols and procedures and has demonstrated the positive impacts we have on the patient's that we care for. The reputation that Fife Hospital at Home Service has nationally with other Health Boards reinforces this and as a result, Fife is involved in numerous webinar events to train/educate and support other teams across Scotland and beyond on a regular basis.

Recent feedback that Fife Hospital at Home Service has received from patients/families is:

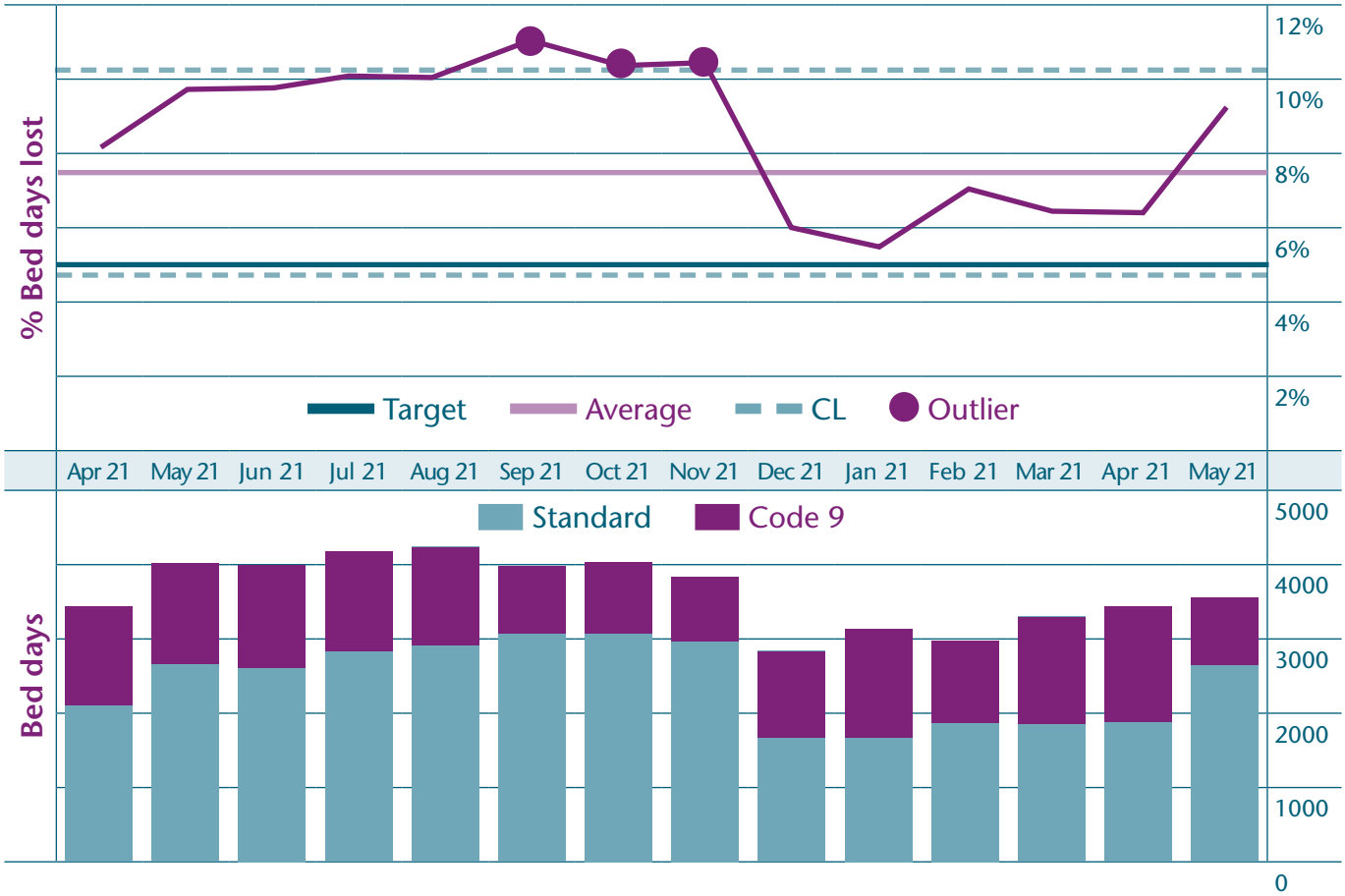
'thank you H@H team for all you did for mum in her final days -you treated her with dignity and listened to what she wanted as if she were your own mother. I cannot thank you enough'

'it gave me such self-confidence and assurance when the nurses came in to check on me. They are a magnificent team that couldn't have been more helpful and highly professional'

Community Hospital Flow & Discharge

Fife Health and Social Care Partnership continue to work hard to discharge medically fit patients from hospital into more homely settings.

The data from Public Health Scotland shows that whilst the national target of 5% 'Hospital Bed Days Lost to Standard Delays' has not been met it was below 8% in 5 of the last 6 months to May 2022. Bed Days Lost have also generally fallen in 2022, compared to 2021.

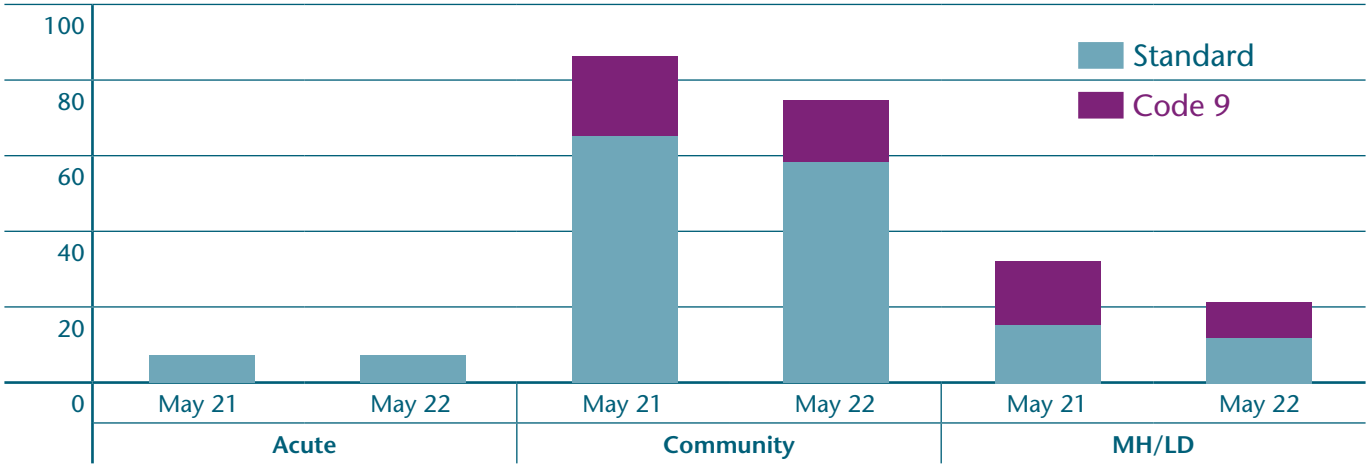


In benchmarking terms, NHS Fife lies in the middle ground of mainland Health Boards for the second 2 quarters of FY 2021-22, having been in the lowest quartile in the first two quarters. This is for both Standard Delays and All Delays.

% Bed Days Lost		Quarter Ending								
		2019/20	2020/21				2021/22			
		Mar	Jun	Sep	Dec	Mar	Jun	Sep	Dec	Mar
NHS Fife	Standard	8.3%	4.6%	6.8%	5.4%	5.7%	9.2%	10.4%	9.0%	6.4%
	All	12.4%	8.6%	10.1%	9.6%	10.9%	14.4%	14.8%	12.4%	11.1%
Scotland	Standard	7.3%	3.8%	5.1%	4.8%	4.6%	5.0%	6.8%	7.2%	7.2%
	All	9.3%	5.9%	7.1%	7.3%	7.3%	7.4%	9.4%	9.7%	10.4%

The bar chart below is a snapshot of the May 2021 and May 2022 census position and shows an overall reduction in patients this year. The May 2021 figure for all delays was 130, while it was 104 in May 2022.

Census



In terms of Standard delays per 100,000 Age 18+ population, NHS Fife has generally performed better than the Scottish average and periodically in the top quartile of mainland Health Boards. This is summarised in the table below.

Delayed Discharges

	Fife		Scotland		
Census month	Total patients in delay (xC9)	per 1,000 population	Total patients in delay (xC9)	per 1,000 population	NHS Fife ranking
Apr 21	78	25.74	737	16.54	9
May 21	88	29.04	791	17.76	10
Jun 21	81	26.73	916	20.56	8
Jul 21	81	26.73	995	22.33	8
Aug 21	99	32.67	1,101	24.71	8
Sep 21	83	27.39	1,211	27.18	5
Oct 21	93	30.69	1,195	26.82	5
Nov 21	82	27.06	1,169	26.24	5
Dec 21	44	14.52	1,058	23.75	3
Jan 22	56	18.48	1,294	29.05	2
Feb 22	55	18.15	1,192	26.76	2
Mar 22	46	15.18	1,232	27.65	1
Apr 22	63	20.79	1,264	28.37	2
May 22	78	25.74	1,210	27.16	5

Participation and Engagement

The Partnership's Participation and Engagement Team was established in 2021.The Team undertook the following consultations in 2021:

- National Care Service Review
- Fife Alcohol and Drugs Partnership
- Third Sector Re-Imagining Exercise (ongoing)
- Fife Integration Scheme

An updated Participation and Engagement Strategy will be published in 2022 to set out how the Partnership will support Fife Integration Joint Board to deliver on its vision, through participation and engagement activity, to enable the people of Fife to live independent and healthier lives.

Technology Enabled Care

As part of our Transformational Change programme, the Partnership has been working with an external partner, **Just Checking**, to introduce the use of technology into both our assessment and review process. This is currently being piloted in the assessment of support needs for older adults and the review of overnight support in our 24/7 supported accommodation services.

Assessment

Just Checking continues to be used by operational teams supporting adults aged 65 years and over to undertake initial assessments through the use of the discreet motion sensors. This, coupled with the social work practitioner assessment, provides an overview of support needs prior to packages of support being arranged. This ensures that resources are targeted appropriately to those individuals with the greatest need.

Overnight Reviews

Overnight reviews, using discreet motion sensors, have almost been completed in the Dunfermline and Glenrothes area and work is ongoing with providers to identify if and where alternative models of support can be provided.

In the Glenrothes area, the use of responsive technology, provided by Just Roaming, was introduced during 2021 and has been a huge success. Technology and waking staff have replaced the use of sleepover staff which now provides support for several nearby properties, since the waking night staff can be alerted to the needs of the individuals in the three neighbouring properties providing quick and responsive support, which is captured and evidenced on the handset. This allows greater independence for the individuals, whilst providing the security that support is nearby if required.

Work will continue with providers to explore options where this can be introduced whilst ensuring risks can be managed and individuals receive the support they require.

OP Services Assessment
(Sept 20 – Feb 22)

- 230 referrals
- 199 assessments using motion sensors.

Of the assessments concluded by social work practitioners:

£289,350 pa of care costs were avoided where following requests for support/ increased support, the use of sensors indicated that support was at an optimal level.

£6,570 pa was saved where an individual identified to require less support than was being provided, thus increasing their independence

Overnight Support/Reviews
(Sept 20 – Feb 22)

- 212 referrals
- 131 reviews

£84,656 pa of care costs were avoided where following requests for support/increased support, the use of sensors indicated that support was at an optimal level.

£125,129 pa was saved where individuals were identified as requiring less support than was being provided, thus increasing their independence

Podiatry Talking Mats

Working with the Social Enterprise Talking Mats, funded by Fife Charity Trust, the Podiatry Service was able to design and create a Talking Mats Podiatry Tool to support patients with cognitive impairment and help them engage with their decision making. The Talking Mats Podiatry Tool consists of three discussion topics – prevention, intervention and impact of foot health conditions.

The aim was to promote patient engagement in their care – both in preventative care and when specialised input is required. By creating the resource, we aimed to explore what really mattered to the person and what for them were acceptable goals and outcomes. By developing a specific Talking Mats resource, we were able to explore treatments options and impact of conditions and actively engage the person in expressing their views thus creating a person-centred care plan. Evidence shows us when people are involved in decision making, they are more satisfied with their care, which in turns improves their quality of life.

The tool was initially used in a trial phase in order to gather patient's views and make alternations as required. Following this period the completed Talking Mats Podiatry Tool is now in use and members of staff have been trained in its use.

By using this resource, we can help our patients explore their views and wishes, therefore enabling co-production in care. The resource promotes preventative care as well as specialist intervention. Going forward there are many other areas of foot health that could potentially be explored in developing further resources – such as paediatrics, nail surgery, musculoskeletal.

Talking Mats, Footcare and Podiatry Case Study

Find out about the benefits of Talking Mats and how it could support interactions with patients with a LD or dementia and empower people to be more involved with decisions around their care.

Visit: letstalkaboutdementia.wordpress.com/2021/11/04/talking-mats-footcare-and-podiatry

Investment in social work to increase capacity within the Mental Health Officer Service.

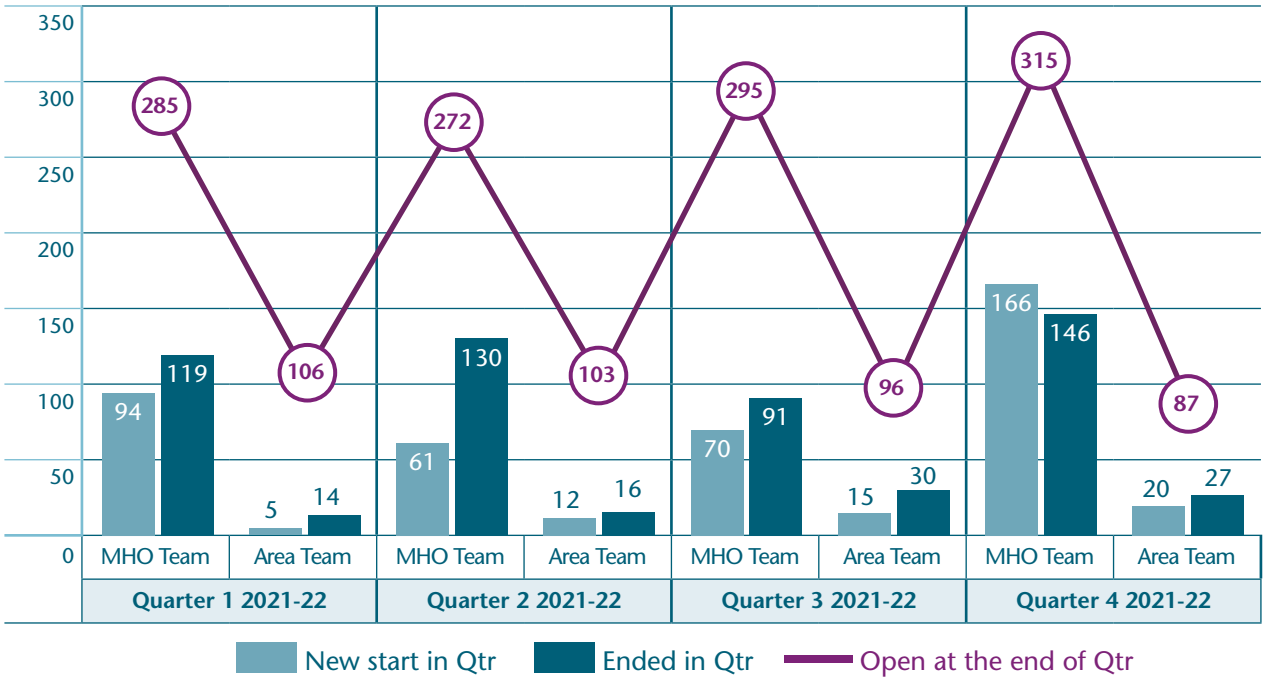
Fife Health and Social Care Partnership were successful in their funding bid to increase the number of complex assessments for people in hospital. This investment is being used to increase capacity within the Mental Health Officer (MHO) Service, which plays a crucial role in helping people who need support to make decisions to safeguard their welfare and/or finances, to leave hospital within an appropriate legal framework which upholds their rights. Many people are unable to leave hospital until a welfare guardian has been appointed to make decisions about their post discharge support needs and an MHO is required to write a report to the court to confirm the order is necessary and whether the proposed guardian is suitable. This report guides the Sheriff in determining whether to grant the guardianship order.

The Service is delivered via a service level agreement to ensure Fife Council meets its statutory obligations with a dedicated MHO Team that undertake all requests for emergency assessments under the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Criminal Procedures (Scotland) Act 1995. The Team remain involved if an application is being made for a short-term detention certificate and undertake the social circumstances report. They also undertake most reports to accompany an application for welfare guardianship, (both Local Authority and private). For those MHO not employed in the dedicated MHO Team, the service level agreement sets out the amount and type of work they are required to do.

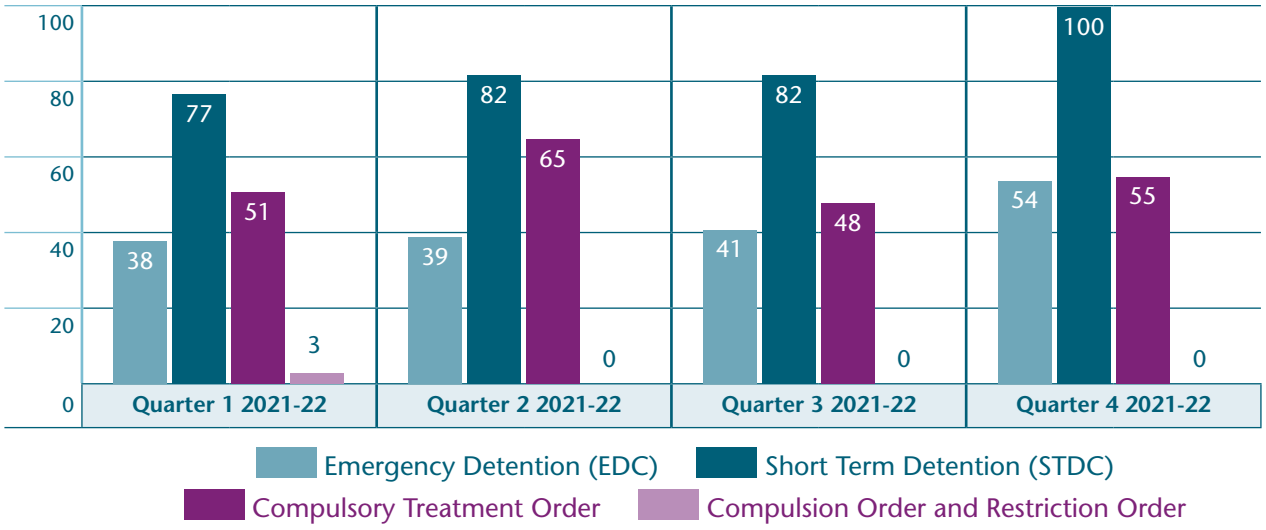
The investment is being used to employ an additional Team Manager and eight MHOs within the dedicated MHO Team. This increased capacity will allow more guardianship reports to be allocated which will reduce delays for people whose discharge planning cannot progress until a welfare guardian has been appointed. It will also enable the Partnership to progress integration between Fife Council MHO's and the NHS Mental Health Community Mental Health Teams.

Team involvement activity - New Mental Health cases starting during the quarter, number of cases closed during each quarter and the number of cases open to MHO Team and to the area teams during each quarter.

Involvement Activity during each Quarter



Legal orders granted during each quarter of the year



A Mental Health Officer is someone who:

- is a qualified social worker and with two years post qualifying experience
- has successfully completed an approved MHO training course and
- is employed by a Scottish local authority.

Mental Health Officers provide a service to individuals who are experiencing mental disorder and may require support to protect their health, safety, welfare finances and property. Mental Health Officers strive to balance the need for compulsory treatment or intervention while promoting the rights and needs of people who have mental illness or who lack capacity. This mainly involves using legal powers under three Acts –

- Mental Health (Care and Treatment) (Scotland) Act 2003.
- Adults with Incapacity (Scotland) Act 2000.
- Criminal Procedure (Scotland) Act 1995

Fife "in hours" MHO Service sits within the Health and Social Care Partnership and is managed within Adult Social Work Service. There are 50 MHO's employed either in the Dedicated MHO Team or in Adults, Older People, Children and Families and Criminal Justice Social Work services. All MHO's work to a Service Level Agreement, (SLA) in relation to the statutory requirements for a mental health officer within service hours. This SLA ensures Fife Council meets the demands for statutory MHO assessments.

There is a high demand for MHO Service and consequently Fife Health and Social Care Partnership has agreed investment to increase the size of the Dedicated MHO Team. The information provided below demonstrates the demand and activity which justifies this investment. Recruitment is ongoing and it is hoped all new posts will be filled by December 2022.

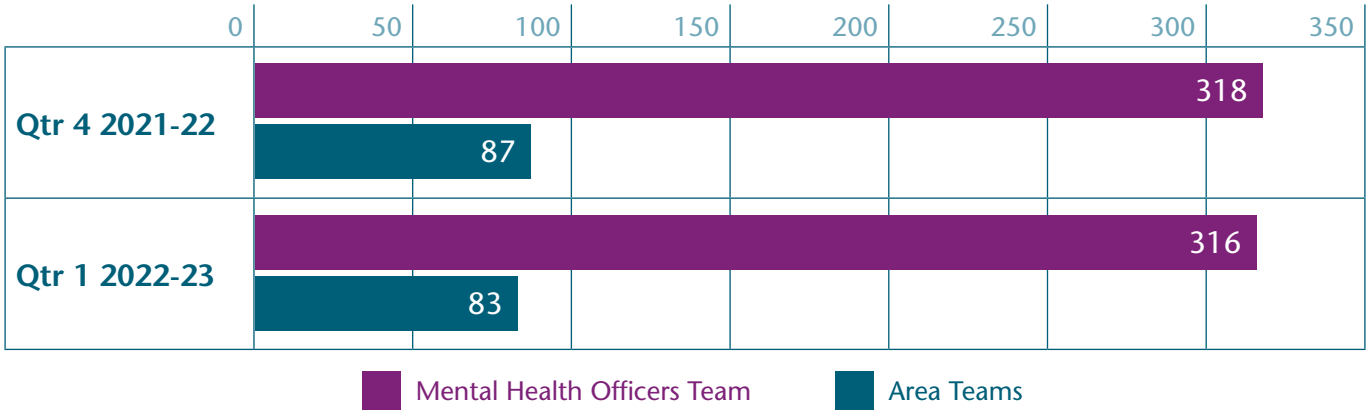
The below table shows the number and source of contacts for MHO involvement for both the Mental Health Care and Treatment Act or the Adults with Incapacity Act between January and March 2022 compared to 2021.

Contact SOURCE Type	Average 2021-22	Q1	%
Secondary Health	46	125	36%
Primary Health	6	8	2%
Legal (private solicitors)	2	79	23%
Internal SW or other FC Team	12	104	30%
Community	3	3	1%
Police	18	22	6%
Not recorded	3	10	3%
Total	**89**	**351**	**100%**

There is a large increase seen in the number of contacts received between Jan-Mar 2022. This is in part due to recognising that the way requests for MHO Team work are recorded by the different services who receive them was not being properly captured. A large workload coming to the MHO team was being discounted. The report parameters now reflect the accurate activity in relation to request for involvement.

The MHO work undertaken by the Dedicated Older People Team and MHO's employed in Adults and Older People teams is recorded on SWIFT/AIS and this allows us to pull reports showing activity and performance. However, work undertaken by MHO's in Criminal Justice and Children and Families Teams is not recorded consistently in the same way. The new social work system Liquid Logic will remedy this and allow us to show the full range of activity and performance. Therefore, the table below shows the number of Involvements which are related to the MHO functions associated with the Mental Health Care and Treatment Act and Adults with Incapacity Act, open to the Dedicated MHO team and Adults and Older People Social Work Service area teams, at the end of the quarter.

Open involvements at the end of the Qtr.



At the end of March 2022, there were 316 cases open to the Dedicated Mental Health Officers Team and 83 to the Area Teams. This is just 4 fewer cases compared to December 2021 so there is little change month to month.

Adults Social Work Service area teams hold the most cases because there has been more uptake by staff in those teams to compete the MHO award. The Team Managers of the Mental Health Dedicated Teams are working with Workforce Development to understand why this is and how this can be replicated in other Social Work Services.

Between January and March 2022, the Dedicated MHO Team completed 109 MHO assessments.

Additionally, the Mental Health (Care and Treatment) (Scotland) Act 2003 allows for people to be placed under different types of compulsory orders, depending on the circumstances. There are three main types of compulsory powers:

1. Emergency detention (EDC)
2. Short Term Detention (STDC)
3. Compulsory Treatment Order

Between January and March 2022, the Dedicated MHO Team completed 53 EDC's, 93 STDC's and 39 CTO's.

Our performance data tells us that there is a consistent increase in the number of EDCs issued over the last 12 months with a slight decrease in STDC and CTOs. We also know that 65% of CTOs were issued for service users under the age of 65 and 35% for Older Service Users.

In addition to this activity which is related to the Mental Health (Care and Treatment) (Scotland) Act 2003, MHOs also undertake reports to accompany applications for welfare guardianship in accordance with the Adults with Incapacity (Scotland) Act 2000.

The aim of the Adults with Incapacity Act is to protect people who lack capacity to make decisions, but also to support their involvement in making decisions about their own lives as far as they are able to do so.

If they are unable to do this, then the Sherriff Court may appoint a welfare guardian.

The welfare guardian might be a relative, friend or a carer. The court can also appoint the Chief Social Work Officer of a local authority to be a person's welfare guardian.

Local authorities have a duty under the Act to supervise all welfare guardians, and to visit the guardian and the adult at regular intervals. Local authorities also have a duty to make an application for welfare guardianship where it is needed and nobody else is doing so.

Requests for reports to accompany Local Authority applications are made by staff within Adult and Older People Social Work Services and private solicitors make the request if the application is being made by a spouse, relative or other.

Existing orders may need to be renewed and an MHO report is required for those and they are also agreed by the Sherriff Court.

As a result of court closures due to the coronavirus pandemic, Fife Health & Social Care Partnership currently have a significant waiting list for the preparation of MHO reports for both Private and Local Authority Guardianship Orders and renewal of existing orders.

Since the situation started to ease earlier this year, the MHO Team have received a significant number of new requests which have increased the numbers waiting. The higher the number of outstanding reports, the higher the volume of correspondence, (enquiries on progress, updates in relation to risks to the person in the absence of the guardianship order which helps the manager prioritise allocation of reports), which places pressure on the MHO Duty System.

The processing of reports can only go at a pace that can be supported by the finite number of MHO's, (who also have to undertake statutory duties in respect of the Mental Health Care and Treatment Act and the Criminal Procedures Act), as well as NHS and legal partners, and of course, the courts, (who are also dealing with a backlog of business including criminal procedures and child protection matters), so it is anticipated this issue will continue for some considerable time.

Between January and March 2022, 17 reports were completed. However, 59 new orders were issued by the courts, all of which had a report completed by the MHO Service. This shows the level of activity which is ongoing.

The additional MHO's appointed will help increase the volume of reports which can be allocated.

Total Number of report requests received in reporting quarters are shown in the table included in the Contacts Section along with the source of request. However, it is not possible to identify the requests received specifically to accompany LA application for Welfare Guardianship.

Referrals for reports to accompany applications for guardianship reports are made by private solicitors. In the current system we are unable to differentiate between the report requests to accompany a private application for welfare guardianship.

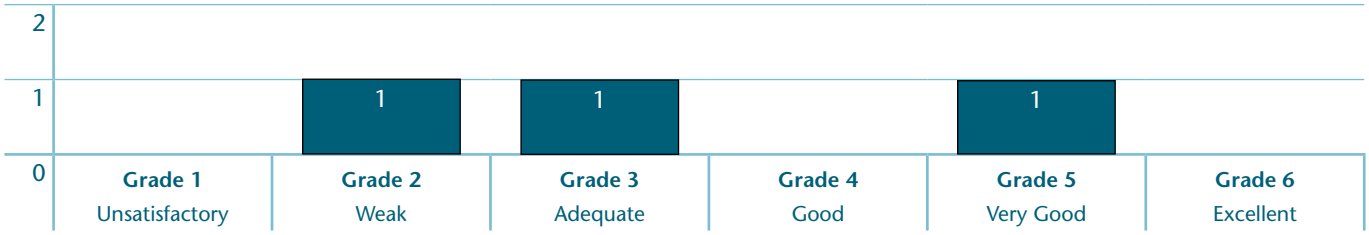
Inspection of Services

All registered Social Care services undergo inspection from the Care Inspectorate following their quality framework.

In order to robustly assess arrangements to respond to the coronavirus pandemic and meet the duties placed on them by the Coronavirus Scotland (No. 2) Act and subsequent guidance, the Care Inspectorate had to develop a new key question to augment their inspection framework placing a particular focus on infection prevention and control, wellbeing and staffing in care settings. As a result, they moved to carrying out shorter more targeted inspections on these particular issues rather than the standard inspections. The overall number of inspections since 2020 has been reduced due to the impact of the coronavirus pandemic and lockdowns.

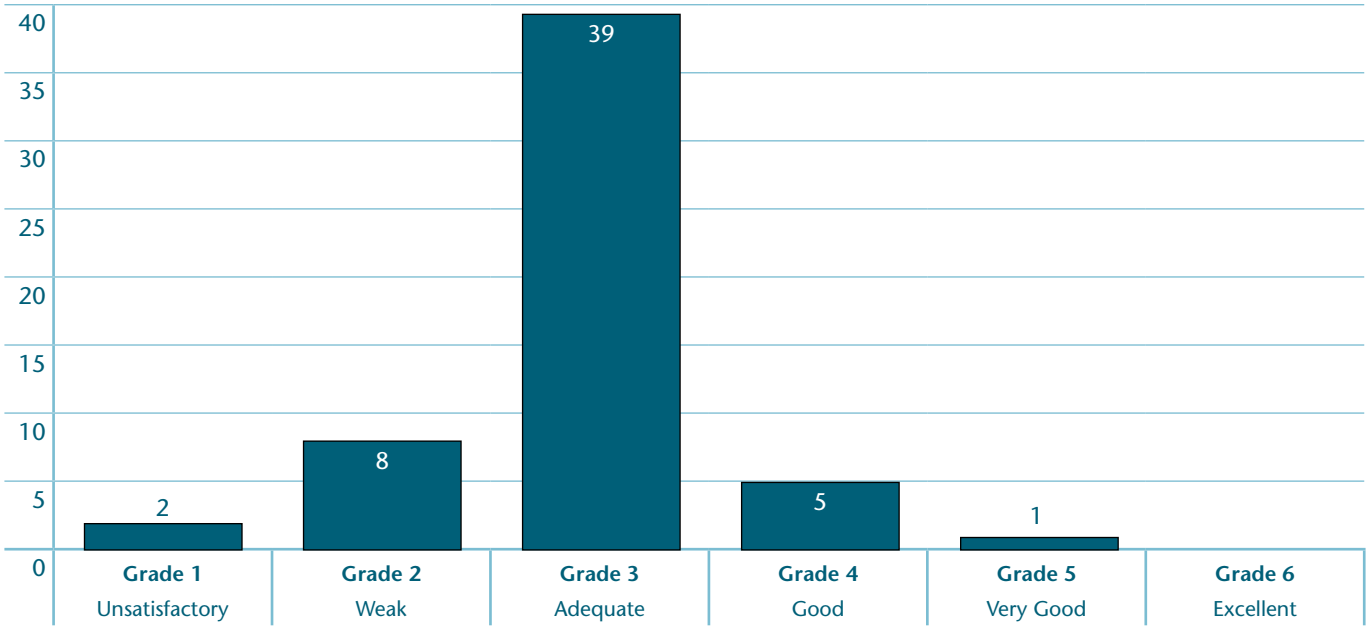
During 2021-2022 only three inspections of Health and Social Care Partnership (Local Authority) services were undertaken. Two care homes and one combined inspection of Accommodation with Care and Housing Support (which has two registered services one for Housing Support and one for Care at Home).

Fife Registered Services (Local Authority)
Inspections conducted during 2021/2022



For all registered adult social care services (including Older People) within the Fife Health and Social Care Partnership areas, delivered by the voluntary and independent sector, 55 Care Inspectorate inspections were carried out.

Fife Registered Services (Private/Voluntary)
Inspections conducted during 2020/21



Fife Joint Inspection of Adult Support and Protection

Summary of Key Strengths and Priorities for Improvement August 2021

Inspectors from the Care Inspectorate, Healthcare Improvement Scotland and Her Majesty's Inspectorate of Constabulary in Scotland carried out an inspection in Fife between May 2021 and August 2021. The purpose of this was to provide assurance to the Scottish Government about local partnership areas' effective operation of adult support and protection processes, and leadership for adult support and protection services. The Adult Support and Protection partnership refers to Social Work, Health and Police. In Fife, Housing and Scottish Fire and Rescue Services are included in our strategic leadership group but were not included for the purpose of this inspection.

The CI, HIS and HMICS took forward a full programme of activities in order to ensure thorough and robust scrutiny of Adult Support and Protection in Fife. This programme included the audit of 90 case files, the preparation of a Position Statement with supporting evidence and a staff survey and focus groups.

The report of the joint inspection of adult support and protection measures in Fife, published 10th August 2021, has found clear strengths in ensuring adults at risk of harm are safe, protected and supported and a small number of improvement areas identified. The inspection report concluded that Fife Adult Support and Protection Partnership's key processes for adult support and protection were effective with areas for improvement. There were clear strengths supporting positive experiences and outcomes for adults at risk of harm, which collectively outweighed the areas for improvement. The partnership's strategic leadership for adult support and protection was found to be very effective and demonstrated major strengths supporting positive experiences and outcomes for adults at risk of harm. Fife partnership carried out almost all aspects of adult support and protection well. Social work staff, health professionals, and police officers worked collaboratively to make sure adults at risk of harm were safe, supported, and protected.

Fife ASPC were the first Committee to be inspected following the coronavirus pandemic and period of lockdown. To enable the inspection to progress whilst adhering to Government guidance and staff safety advice, Fife HSCP required to work innovatively, flexibly and creatively to support a virtual inspection. Key tools to support the journey were Microsoft Teams and SharePoint sites. Feedback from the Care Inspectorate, HIS and HMICS indicated that this approach had been extremely successful and supported the smooth progression of the inspection activity. Support, advice and guidance has been offered to other HSCPs and ASPCs to support the organisation of virtual platforms to allow the continuance of inspections across Scotland.

Financial Performance and Best Value

The financial position for public services continues to be challenging and the Integration Joint Board must operate within significant budget restraints and pressures. It is therefore important that resources are targeted at the delivery of the priorities within the strategic plan.

Demand on services due to new variants emerging means we have had to respond to these challenges by looking at new ways of working and increased use of technology to ensure the health and social care needs of the most vulnerable people in our communities are met, whilst some services remain on pause.

Fife HSCP has undergone a period of significant change which became effective as of June 2021. The new structure for service provision is:

- Integrated Primary and Preventative Care Services
- Integrated Community Care Services
- Integrated Complex and Critical Services, and
- Professional and Business Enabling Services

We have learned a lot since March 2020 and the start of the pandemic, we have a strong, resilient workforce and their commitment to Team Fife has been admirable. Ways of working changed; mobile and home working have proven to be very efficient and will continue. A hybrid of home, office and mobile working affords our workforce a better work life balance, whilst still maintaining social care services to the people of Fife. We have shown how important integration is and what can be achieved by working together with a common goal of providing the best person-centred care and support we can for our communities.

The implications of the coronavirus pandemic are likely to affect life outcomes for people for some time after it ends. This will be seen through increased or changed demand for services and is expected to impact on health and poverty levels in Fife, and a move from crisis support to prevention.

Going forward it is extremely clear that we must respond to changing needs and wants and services must be modernised as we recover. We must continue to provide new and innovative methods of service delivery as we have proven we can 'get things done' and we must keep up this momentum.

Financial Performance

The IJB commenced 2021/22 with an ongoing, uncertain, and challenging financial position due to the continued pandemic. As we learn to live with the coronavirus pandemic and government restrictions are lifted, focus is now on recovery and reform.

The budget for 2021/22 was set predicated on implementing an approved saving plan to deliver £14.207m of savings. Savings of £10.413m were met by services and Scottish Government funded those which could not be achieved due to the coronavirus pandemic. £3.794m of unmet savings from prior years have been carried forward to 2022/23 and work is ongoing to ensure that plans are in place to progress the delivery of these savings.

Key pressures within the 2021/22 accounts have been:

- The significant increased demand for our services associated with an increasing population, in particular an increasing ageing population and increased complexity of care needs. Adult packages increased in year, due to Community Services, Day Care and Respite remaining on hold due to the pandemic.
- The significant increased demand to ensure the flow from hospital discharges was effective and timeous in moving service users to a home or homely setting, to free hospital beds for admissions. Care home beds were used as an interim measure to allow service users to free up hospital beds whilst waiting on care package availability.
- The inability to recruit staff to the Partnership which in some cases required higher cost recruitment for locum and agency staff to cover services.
- GP Practices were handed back to the Board therefore the partnership incurred the associated costs of staffing these and providing cover.
- Bad Debt for care invoices increased from previous years.

The outturn position as at 31 March 2022 for the services delegated to the IJB are:

	Budget £000	Actual £000	Variance £000	Variance %
Delegated and Managed Services	664,203	614,134	(50,069)	7.5
Set Aside Acute Services	40,227	40,227	0	0.0

The IJB reported total income of £704.430m for the financial year 2021/22, which was made up of £664.203m integrated budget and £40.227m relating to set aside.

The IJB reported total expenditure for the financial year 2021/22 of £654.361m, which comprised of £614.134m spend on integrated services and £40.227m on set aside.

As income to the IJB exceeded expenditure in year, a surplus of £50.069m was reported in the Comprehensive Income and Expenditure Statement as at 31 March 2022. This is mainly the result of specific funding received late in the year to be utilised to fund the continued costs of the coronavirus pandemic, and other earmarked carry forwards such as Primary Care Improvement Fund, Action 15, and Mental Health Recovery & Renewal. Because these funds were received late in the financial year, funding will be carried forward to 2022/23 as per Scottish Government guidance. Funding was also received in year to help provide additional interim care beds and care at home services; and any unspent balances have been carried forward to be utilised in 2022/23.

Within the favourable position of £50.069m, the core underspend is £5.847m. The main areas of underspend within the Delegated and Managed Services are Community Services £2.586m, GP Prescribing £0.805m, Children Services £1.118m, Older People Nursing & Residential £0.859m, Adults Fife Wide £0.279m, Adults Supported Living £1.158m, Social Care Fieldwork Teams £1.906m and Housing £0.644m. Underspends in core areas are mostly attributable to staffing vacancies, many of which continue to be difficult to recruit to, especially for specialist roles. Work is ongoing to review the skill mix in a bid to successfully recruit to vacant posts.

These underspends are partially negated by overspends on Hospital and Long-Term Care £0.660m, Family Health Services £0.374m, Older People Nursing and Residential £0.361m, Social Care Other £0.686m and Adult Placements £1.335m. The overspends in hospital and long-term care are mainly due to the use of agency staff to cover vacancies and Family Health Services overspend is due to GP practices being handed back to be managed by the NHS. An increase in bad debt within Older People Nursing and Residential, a backdated pay award in Social Care Other and an increase in the number of packages to meet demands results in an overspend in Adult Placements.

Actual spend on the coronavirus pandemic in 2021/22 was £33.052m. This was partially funded by reserves of £13.719m with further funding received in year. The balance of the funding received in year, £35.993m, has been carried forward as an earmarked reserve for the coronavirus pandemic expenditure in 2022/23. Work is ongoing to determine the recurring costs of the coronavirus pandemic.

The opening reserves balance at April 2021 was £29.643m. In year allocations of £16.473m were passed to services, mainly for the coronavirus pandemic related expenditure, with the balance of £13.170m remaining in reserve. Further to this, late funding received from Scottish Government for the coronavirus pandemic expenditure and for new commitments such as Mental Health Recovery and Renewal totalling £66.541m was received and carried forward to reserves, giving a total reserve of £79.712 at March 2022.

Financial Outlook

2021/22 has been another difficult year with the effects of the coronavirus pandemic continuing throughout the year, as we worked towards recovery from the pandemic as well as demand on services as restrictions were lifted. Moving forward there is significant financial uncertainty due to the global economic crisis and there is predicted to be a reduction in future contributions from Fife Council and NHS Fife along with an increase in costs across the economy on inflation, energy, supplies, pressure on pay costs and an ageing demographic. This uncertainty will be a significant challenge and will need to be dealt with in the immediate and longer term. Reserves held total £79.712m, however only £13.436m of this remains uncommitted as at March 2022. Use of reserves is not a sustainable solution, as it only provides a short-term one-off funding, any use of uncommitted reserves is agreed at Committee in line with the reserves policy.

Included within the total reserves figure of £79.712m, £35.993m has been carried forward into 2022/23 to fund the coronavirus pandemic related expenditure. No further funding is anticipated from Scottish Government during 2022/23 as we begin to move out of the pandemic. Work is ongoing to identify any recurring costs of the pandemic, such as increased care packages and ongoing use of PPE. Some services may have an increase in demand and our uncommitted reserves may be required to meet demands. We will continue to work with services to ensure costs are minimised, but where this is not possible, we will need to reflect any future cost pressures as part of our forward planning.

Services have shown they can adapt, work together, and get things done and the Transformation Team/PMO will be integral to progressing whole system change going forward. Finance will work closely with the Transformation Team to ensure savings, benefits and investments are captured and monitored.

It is expected that Mental Health Services will see a continued surge in requirements and a Public Health Scotland announced funding from the Mental Health Recovery and Renewal Fund, the fund is aimed at improving how people can manage their mental health with appropriate early support and be referred to additional support when required.

Older people requiring Care at Home and the use of interim beds to move people out of hospitals are also recognised as a priority area for 2022/23 with funding on a recurring basis. The unspent balances at March 2022 have also been earmarked and carried forward into reserves.

The budget for 2022/23 has been set and balanced. Previously agreed savings of £3.794m which have not been met have been brought forward. No new savings initiatives were required to balance the budget. Senior Leadership Team will provide updates during 2022/23 to provide assurance that these savings targets are on course to be met on a recurring basis.

It has become clear that the impact of the pandemic will remain for years to come and there will be pressure on services and core budgets. Work will progress at pace to assess future budget gaps, and finance will work with services and the Senior Leadership Team to progress change rather than cuts. We need to adapt the way we work to allow us to provide essential services to the most vulnerable people.

The Senior Leadership Team will need to consider all options, such as reconfiguring services, alternative operating models, opportunities to work with partners, and adapting current services to meet needs effectively to ensure we stay focused on key priorities and are providing the right services.

The Medium Term Financial Strategy will be refreshed in 2022/23 and it will address the various new and additional pressures that will face the Health and Social Care Partnership over next financial year and also into future years.

The most significant risks faced by the IJB over the medium to longer term can be summarised as follows:

- the economic crisis – the cost of inflation, energy and pay costs
- the ageing population leading to increased demand and increased complexity of demand for services alongside reducing resources
- the coronavirus pandemic lasting impact on the economy;
- continuing difficulties in recruitment leading to the use of higher cost locums and agency;
- the Transformation Programme does not meet the desired timescales or achieve the associated benefits;
- workforce sustainability both internally in health and social care and with our external care partners.

Value for Money

Value for money is a key priority for the Partnership and all service redesign, purchasing, procurement and commissioning must comply with the best value and procurement guidance of the relevant bodies. It is extremely important that expenditure is managed within the financial resources available to ensure that they align to the 3-year financial strategy and our long-term objective to achieve financial sustanbility.

An annual assessment of how the IJB demonstrated best value will be undertaken, highlighting the following key areas where we seek to demonstrate compliance with the principles of best value.

- Management of Resources - financial assurance and monitoring of IJB budget resources, medium term financial planning, workforce planning
- Effective Leadership and Strategic Direction - commitment to delivering integration among Board members and senior managers through IJB Strategic Plan
- Performance Management - regular reporting and scrutiny of IJB performance, achievement against Health and Social care outcomes and progressing integration
- Joint Working with Partners - demonstration of effective approach to joint working with partners to progress integration through Fife Health and Social Care Delivery plan
- Service Review / Continuous Improvement - regular reviews of service activity and scope for integration through projects such as Frailty Programme and Mental Health Redesign
- Governance and Accountability - demonstration through public performance information such as Annual Accounts, Governance Statement and Annual Performance report
- Engagement with Community - regular engagement and consultation with stakeholders through Locality Planning Groups and Strategic Plan consultation

The assessment for 2021-22 demonstrates our commitment to these principles as follows,

- **Management of Resources** - demonstrated through regular improved financial/budget reporting to committee, tri-partite meetings with partners to discuss funding and implications of funding assumptions including inflation pressures, a Finance Governance Group has been launched, an in-year Finance Recovery plan was actioned, regular monitoring and reporting of Ministerial Strategic Group Action Plan, a Project Management Office was set up and detailed Transformation Change Programme in place, Workforce Strategy and action plan in place. The Medium-term financial plan is being refreshed in 22-23 in line with the HSCP Strategic Plan.
- **Effective Leadership and Strategic Direction** – demonstrated by the approval of the Revised Integration Scheme in March 2022, Commissioning Strategy Approved, Regular Development sessions with IJB Board Members and Senior Officers. The HSCP have carried out a review of the structure of the organisation and redesigned the portfolios to ensure that any critical gaps have been identified. Looking forward to 2022, Governance training is planned for all new Members of the IJB and the Strategic Plan for 2022-25 will be reviewed.
- **Performance Management** – demonstrated by Regular Performance Reporting to IJB and Governance Committees, Revised Performance Framework approved by the IJB, The Head of Strategic Planning, Performance and Commissioning is a member of the IJB Strategic Commissioning and Improvement Network and links in with other areas to highlight work that would benefit Fife. Looking forward the HSCP are actively participating in networking communities and are a member of the NDTI Community Led Support programme and working with them we will redesign our pathways into services.

- **Joint Working with Partners** – demonstrated by setting up of Project Management Office and Transformation Board and detailed Transformation Change Programme in Place. Also, the HSCP have been working with Scottish Care, and a collaborative has been established with care at home providers to ensure closer working relationships linked directly with people currently in interim care home beds to ensure they return home as quickly as possible. The learning from this will be shared across other partnerships. Looking forward the Transformation Board will develop and explore the programme for change and the delivery of differing models of care identified in the strategic direction of the partnership including the strategic plan and the associated strategic plans within it. A voluntary sector review will be undertaken and reviews of models of care incorporating the learning from the pandemic for MOU2 (Pharmacotherapy, CTAC and Vaccine Programme)
- **Service Review/Continuous Improvement** – demonstrated by reviews such Mental Health Redesign, Frailty Programme and Day Care Review and Design and Implementation of Immunisation Strategic Framework 2021 – 2024
- **Governance and Accountability** - demonstration through having a Revised Integration Scheme in place from March 2022, revised Governance Framework, regular audit action monitoring, Directions Policy in place, Reserves Policy in place. The Partnership has developed a Quality Matters programme which is a governance board within the partnership, this board will ensure effective clinical and care governance with a dedicated terms of reference and workplan.
- **Engagement with Community** - regular engagement and consultation with stakeholders through Locality Planning Groups, there are 7 locality plans in place and looking forward 7 reviews of plans across Fife will be undertaken. Also in 2022, a new Qualities and Communities Committee will be established which will have a focus on Participation and engagement and membership will include non-voting members of the IJB.

Appendix 1
National Outcomes and Priorities

National Health and Social Care Health and Wellbeing Outcomes

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 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.

Public Health Priorities for Scotland

1. A Scotland where we live in vibrant, healthy and safe places and communities.
2. A Scotland where we flourish in our early years.
3. A Scotland where we have good mental wellbeing.
4. A Scotland where we reduce the use of and harm from alcohol, tobacco and other drugs.
5. A Scotland where we have a sustainable, inclusive economy with equality of outcomes for all.
6. A Scotland where we eat well, have a healthy weight and are physically active.

National Care Service Principles:

1. NCS services are an investment in society
2. Realisation of human rights
3. Enables people and communities to thrive
4. Services are financially sustainable
5. Promote early intervention
6. Services designed collaboratively
7. Continuous improvement
8. Promoting dignity, advancing equality and non-discrimination
9. Inclusive communication
10. Promoting Fair Work

Appendix 2
National Indicators

The National Integration Indicators are reported in the Scottish Health and Care Experience Survey commissioned by the Scottish Government. The Survey is run every two years and is sent out by post to a random sample of people who are registered with a GP in Scotland. It asks people about their experiences of accessing and using health and social care services. The information collected enables comparisons with different Health and Social Care Partnerships across Scotland, and across different years.

During the period 2021 to 2022 many of the services that we provide in Fife were impacted negatively by the coronavirus pandemic, for example by national lockdown restrictions (such as limiting face-to-face contact) or by staff redeployment to support critical services. These necessary changes have impacted on the services that we can provide and may have had a direct impact on people's experience.

Some areas have improved, these are highlighted in green, and we have included examples in the main section of the Report. For example, we have reduced the number of readmissions to hospital within 28 days of discharge (Indicator 14). This is linked to the 'Community Hospital Flow and Discharge' section on page 50 of the Report. Other indicators have dropped because of external factors, for example the proportion of care services rated good or better by the Care Inspectorate (Indicator 17). This indicator is linked to the 'Inspection of Services' section on page 58 which explains that the overall number of inspections since 2020 has reduced due to the impact of the coronavirus pandemic and lockdown restrictions. This is why the response for this indicator has dropped compared to previous years.

Moving forward we are focusing on remobilisation and recovery, being mindful of the learning gained during the pandemic as well as considering the impact from other external factors including the cost-of-living crisis, climate change, and issues with workforce recruitment. The Partnership will continue to actively monitor internal and external factors and incorporate any outstanding or new requirements into the new Strategic Plan for 2022 to 2025.

ID	Indicator	Previous period	Latest period	Previous period Figure Fife	Latest period Figure Fife	Comparison to Previous Period Fife	Latest period Figure Scotland	Fife - Latest Period Compared to Scotland
1	Percentage of adults able to look af-ter their health very well or quite well	2019/20	2021/22	92.60%	90.19%	↓ 2.41%	90.87%	↓ 0.68%
2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	2019/20	2021/22	77.57%	79.44%	↑ 1.87%	78.82%	↑ 0.62%
3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or sup-port was provided	2019/20	2021/22	73.38%	69.74%	↓ 3.64%	70.59%	↓ 0.85%
4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	2019/20	2021/22	72.99%	63.09%	↓ 9.90%	66.37%	↓ 3.28%
5	Total % of adults receiving any care or support who rated it as excellent or good	2019/20	2021/22	81.61%	70.62%	↓ 10.99%	75.34%	↓ 4.72%
6	Percentage of people with positive experience of the care provided by their GP practice	2019/20	2021/22	74.73%	62.83%	↓ 11.90%	66.52%	↓ 3.69%
7	Percentage of adults supported at home who agree that their services and support had an impact on im-proving or maintaining their quality of life	2019/20	2021/22	80.54%	75.23%	↓ 5.31%	78.12%	↓ 2.89%
8	Total combined % carers who feel supported to continue in their caring role	2019/20	2021/22	34.29%	27.56%	↓ 6.73%	29.69%	↓ 2.13%
9	Percentage of adults supported at home who agreed they felt safe	2019/20	2021/22	82.46%	79.85%	↓ 2.61%	79.70%	↑ 0.15%

ID	Indicator	Previous period	Latest period	Previous period Figure Fife	Latest period Figure Fife	Comparison to Previous Period Fife	Latest period Figure Scotland	Fife - Latest Period Compared to Scotland
11	Premature Mortality Rate per 100,000 population	2020	2021	422	446	↑ 24	466	↓ 20
12	Rate of emergency admissions per 100,000 population for adults	2020/21	2021	11,374	12,580	↑ 1,206	11,656	↑ 924
13	Rate of emergency bed day per 100,000 population for adults	2020/21	2021	95,747	104,455	↑ 8,707	110,718	↓ 6,263
14	Readmissions to hospital within 28 days of discharge per 1,000 dis-charges	2020/21	2021	115	114	↓ 1.11	110	↑ 4
15	Proportion of last 6 months of life spent at home or in a community setting	2020/21	2021	90.7%	90.6%	↓ 0.08%	89.9%	↑ 0.74%
16	Falls rate per 1,000 population (65+)	2020/21	2021	26.1	27.9	↑ 1.78	23.09	↑ 4.77
17	Proportion of care and care services rated good or better in Care Inspec-torate inspections	2020/21	2021/22	84.71%	73.28%	↓ 11%	75.80%	↓ 2.52%
18	Percentage of adults with intensive care needs receiving care at home	2020	2021	61.29%	60.27%	↓ 1.02%	64.92%	↓ 4.65%
19	Number of days people aged 75+ spend in hospital when they are ready to be discharged per 1,000 population	2020/21	2021/22	556	908	↑ 352	761	↑ 147
20	Percentage of health and care re-source spent on hospital stays where the patient was admitted in an emergency	2019	2019/20	25.92%	-	-	24.23%	-

National MSG Indicators (Ministerial Strategic Group for Health and Community Care)

ID	Indicator	Previous period	Latest period	Previous period Figure Fife	Latest period Figure Fife	Comparison to Previous Period Fife
MSG 1a	Emergency Admissions*	2020/21	2021	32,494	36,116	↑ 3,622
MSG 2a	Number of unscheduled hospital bed days; acute specialties*	2020/21	2021	213,723	235,025	↑ 21,302
MSG 3a	A&E Attendances	2020/21	2021/22	54,484	65,531	↑ 11,047
MSG 4	Delayed Discharge bed days	2020/21	2021/22	29,970	46,613	↑ 16,643
MSG 5a	Proportion of last 6 months of life spent at home or in a community set-ting*	2019/20	2020/21	88.37%	90.73%	↑ 2.36%

* Data completeness for emergency admissions and bed days for Fife is 99% as at Dec 2021
** 2021 deaths data not complete, previous financial years only
All figures are for ages 18+

Appendix 3
Financial Information 2018 to 2022

Delegated Services (as at 31 March)	2018			2019			2020			2021			2022		
	Budget	Provisional Outturn	Variance	Budget	Provisional Outturn	Variance	Budget	Provisional Outturn	Variance	Budget	Provisional Outturn	Variance	Budget	Provisional Outturn	Variance
Objective summary	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**
Community Services	93.001	92.237	-0.764	97.812	93.586	-4.226	107.695	102.295	-5.400	123.319	120.719	-2.603	163.319	160.733	-2.586
Hospitals and Long-Term Care	49.256	54.51	5.254	52.867	55.259	2.392	54.839	57.197	2.358	56.000	56.666	0.566	55.840	56.500	0.660
GP Prescribing	72.227	75.744	3.517	72.293	74.448	2.155	73.807	73.799	-0.008	70.979	70.955	-0.024	74.730	73.925	-0.805
Family Health Services	86.641	86.627	-0.014	93.005	92.911	-0.094	99.765	99.749	-0.016	103.878	104.367	0.489	107.679	108.053	0.374
Children's Services	15.035	13.715	-1.32	15.37	14.897	-0.473	17.544	17.077	-0.467	18.202	16.913	-1.289	18.614	17.496	-1.118
Social Care	193.333	195.501	2.168	196.627	206.252	9.625	204.635	214.814	10.179	243.682	239.459	-4.223	233.087	231.360	-1.727
Housing	2.078	2.078	0	1.574	1.432	-0.142	1.665	1.656	-0.009	1.324	1.324	0.000	1.529	0.885	-0.644
Total Health & Social Care	**511.571**	**520.412**	**8.841**	**529.548**	**538.785**	**9.236**	**559.95**	**566.589**	**6.639**	**617.384**	**610.300**	**-7.084**	**654.798**	**648.952**	**-5.846**

References

- National Health and Social Care Health and Wellbeing Outcomes
  https://www.gov.scot/publications/national-health-wellbeing-outcomes-framework/
- Public Health Priorities for Scotland
  https://www.gov.scot/publications/scotlands-public-health-priorities/pages/1/
- Public Bodies (Joint Working) (Scotland) Act 2014
  https://www.legislation.gov.uk/asp/2014/9/contents/enacted
- Fife Health and Social Care Partnership
  www.fifehealthandsocialcare.org

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.

Language lines
خط هاتف اللغة العربية: 03451 55 55 77
বাংলায় আলাপ করার জন্য টেলিফোন লাইন: 03451 55 55 99
中文語言熱線電話: 03451 55 55 88
Polskojęzyczna linia telefoniczna: 03451 55 55 44
اُردو زبان کے لیے ٹیلیفون نمبر 03451 55 55 66

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