Fife Health and Social Care Partnership Service Delivery Plan 2008-2011

Foreword

We are delighted to present the Health and Social Care Partnership's Service Delivery Plan. It sets out the strategic direction of health and social care services in Fife for the next three years. The plan is designed to be a map for staff and managers as they provide and develop services over this period. We also hope that this plan will inform the people of Fife of our goals and help them to hold us to account.

We are grateful for the wealth of feedback we received during the consultation on the draft plan and would like to thank everyone who contributed for their interest and input. This detailed feedback has been passed to operational groups enabling them to incorporate this information into their work

It is not the purpose of this plan to go into the detail of how we will meet our priorities. Detailed action planning takes place on an annual basis to reflect our annual budget allocation from the Scottish Government. These plans will however be developed with the involvement of carer and service user representatives.

We recognise that the open and trusting relationships which have developed within the Partnership will help us to meet the challenges of joint working. This will enable us to further empower staff at all levels to make a difference in peoples' lives. The benefits of better partnership working will be apparent in making more efficient and effective use of partnership resources, and higher quality, more responsive services for our service users. Everything that we do will be guided by the evidenced needs and aspirations of Fife's public.

The Partnership will ensure that the services we provide are appropriately staffed and quality assured. We will work with staff to ensure that the highest standards are maintained and public funding is used in the most effective manner.

Doreen Bell. Tim Brett

Mrs Doreen Bell
Chair
Fife Health and Social Care Partnership

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1 Introduction

1.1 Fife Health and Social Care Partnership is a joint Fife Council and NHS Fife group which is responsible for the management and strategic development of health and social care services (role and remit attached at Appendix 1). This plan sets out how the Partnership will deliver services, over the next 3 years for:

- Older people;
- People with a learning disability;
- People with and affected by drug and alcohol dependency;
- People with and affected by mental ill health;
- People with a sensory impairment;
- People with a physical impairment.

1.2 This plan sets out the common Fife-wide priorities for the care groups, giving guidance for the staff who manage and deliver these services on how services will develop within the joint resource allocation, ensuring best value from our combined resources.

1.3 This plan is the overarching plan for health and social care services provided in the community. It is supported by more detailed, annual, action plans for each care group. This plan follows on from the previous Joint Community Care Plan and Health and Social Care Partnership's Extended Local Partnership Agreement.

2 Background of the Health and Social Care Partnership

2.1 Fife Health and Social Care Partnership (the Partnership hereafter) is committed to:

- providing better outcomes for service users;
- providing appropriate services, i.e. Social, Housing and Health Care, which are delivered through Fife Council and the NHS Fife to meet the needs of individual communities;
- building and strengthening existing joint working relationships across Council, Health and Voluntary Sector to deliver unified services;
- re-designing services to be people-centred, inclusive, accessible and to provide best value within the agreed financial framework.

2.2 The Partnership has an aligned budget and management model which is supported by an agreed set of Joint Governance Arrangements. This means that each of the two Partner Organisations (Fife Council and NHS Fife) keeps its own management and accountability structure, and the Partnership has a joint reporting structure for the joint services. The two organisations come together through different arrangements at both strategic and operational level to agree priorities and joint working arrangements. However, each remains individually accountable for the use made of public funds under their control.

2.3 The Partnership forms part of the wider Fife Community Planning Partnership (FCPP) and is represented by members on the FCPP.

3 The national legislative and policy context

3.1 The broad national policy guidance shaping the future of health and social care is contained in:

- A Shared Approach to Building a Better Scotland (http://www.scotland.gov.uk/Resource/Doc/115423/0028606.pdf);
- Delivering for Health (http://www.deliveringforhealth.scot.nhs.uk/pages/Reports.htm);
- Changing Lives: 21st Century Social Work Review (http://www.scotland.gov.uk/Resource/Doc/91931/0021949.pdf).

3.2 'A Shared Approach' highlights the need for all public agencies to re-shape the way in which they provide services to improve access and ensure they are as cohesive as possible.

3.3 'Delivering for Health' requires the NHS to undertake a fundamental shift in how it works, which for joint health and social care services will mean "providing care which is quicker, more personal and delivered closer to home"[1]. 'Delivering for Health' also seeks to "support greater integration within the health service and with other social services and seek continuous improvements in productivity and the quality of health care"[2]

3.4 Likewise, for Social Work, 'Changing Lives' acknowledges the need to find new ways of working in partnership and "to harness all our resources and expertise to design services around the needs of people, delivering the right outcomes for the people who use them"[3]. As with 'Delivering for Health' there is an emphasis on shifting the balance of resource allocation towards preventing problems and early intervention.

[1] Delivering for Health, SEHD, November 2005 (introduction)
[2] ibid
[3] Changing Lives, Scottish Government 2006 (foreword)

3.5 The policy context therefore is one which seeks efficient, streamlined services, delivered as locally as possible, with a focus on prevention. It seeks services which are provided in a manner that is seamless to the service user, no matter how many provider agencies are involved, and is delivered in a personalised way.

3.6 In August 2007, the Cabinet Secretary for Health and Wellbeing published "Better Health, Better Care". This began the consultation process that will lead to the development of the Scottish Government's Health Action Plan, to be published in December 2007. The Plan will support the Scottish Government's strategic objective for a "Healthier Scotland". "Better Health, Better Care" is intended to build on the work of "Building a Health Service Fit for the Future" (the David Kerr Report).

3.7 The national legislation and policy framework for the Partnership also includes:

- Mental Health (Care and Treatment) (Scotland) Act 2003 (www.opsi.gov.uk/legislation/scotland/acts2003/asp_20030013_en_1);
- Adults with Incapacity (Scotland) Act 2000 (www.opsi.gov.uk/legislation/scotland/acts2000/asp_20000004_en_1);
- Adult Support and Protection (Scotland) Act 2007 (www.opsi.gov.uk/legislation/scotland/acts2007/asp_20070010_en_1) ;
- Housing (Scotland) Acts 2001 and 2006 and Homelessness Etc. (Scotland) Act 2003 (www.opsi.gov.uk/legislation/scotland/acts2001/asp_20010010_en_1, www.opsi.gov.uk/legislation/scotland/acts2006/asp_20060001_en_1, www.opsi.gov.uk/legislation/scotland/acts2003/asp_20030010_en_1);
- Building a Health Service Fit for the Future /Kerr Report (www.scotland.gov.uk/Publications/2005/05/23141307/13348);
- Better Outcomes for Older People: a National Framework for joint services Scottish Executive 2005 (www.scotland.gov.uk/Publications/2005/05/13101338/13397):
- Same As You? 2000 (www.scotland.gov.uk/ldsr/docs/tsay-00.asp);

- Scottish Governments Response to Care 21: The future of unpaid care in Scotland (www.scotland.gov.uk/Publications/2006/04/20103316/0);
- Equality of Opportunity Duties and Policy: Race, Gender and Disability Public Sector Duties, Fife Council & NHS Fife Equal Opportunities Policies (www.scotland.gov.uk/Topics/People/Equality/PublicEqualityDuties, www.nhsfife.scot.nhs.uk/about_us/corporatedocuments/policies/HR8.pdf, www.fifedirect.org/topics/index.cfm?fuseaction=subject.display&subjectid=10779EC8-E471-441C-BBF2834A6950E4D1);
- Management of Offenders (Scot) Act 2005 (www.opsi.gov.uk/legislation/scotland/acts2005/asp_20050014_en_1).

3.8 The Scottish Government is developing National Outcome Measures to assess how well Partnerships' performance is improving (full details of these measures at www.scotland.gov.uk/Topics/Health/care/JointFuture/DetailedMeasures). These have 4 themes:

- Improved health;
- Improved wellbeing;
- Improved social inclusion;
- Improved independence and responsibility.

3.9 The new Measures are included at appendix 2. The majority of these will start being measured from April 2008, four will be measured in 2007/08.

3.10 Partnerships are also asked to set their own Local Improvement Targets; as steps towards achieving the national outcomes. In Fife these are designed to support staff to improve:

- Opportunities to support people to stay in their own home for longer as an alternative to residential or nursing care
- Access to services;
- Support to carers;
- The time to set up care to enable people to leave hospital;
- Support to people with long term conditions;
- Early identification of support needs;
- Assessment and paperwork for people.

3.11 The Local Improvement Targets will be reported publicly on Fife Direct and NHS Fife websites.

3.12 Local policy, studies and joint strategy development which impact on health and social care services are detailed in:

- Carers' Strategy 2004-7 (new strategy imminent) (www.fifedirect.org/atoz/index.cfm?fuseaction=advice.display&adviceid=C850FDC7-E7FE-C7EA-06C6BE19815BC44A);
- Community Plan (www.fifedirect.org/publications/index.cfm?fuseaction=publication.pop&pubid=0D5C1A0B-E7FE-C7EA-05AF34E68C351A41);
- Local Housing Strategy (includes Homelessness, Supporting People, Special Housing Needs and Private Sector Strategies (both the latter are currently under development))(www.fifedirect.org/publications/index.cfm?fuseaction=publication.pop&pubid=15076A6D-E7FE-C7EA-0A94B7D558D06049);
- NHS Fife Response – Delivering for Health (www.nhsfife.scot.nhs.uk/Papers/2006/Nhs%20Fife%20Board/Item%209.1a.doc);
- The Drug and Alcohol Action Team Corporate Action Plan;
- Mental Health Joint Local Implementation Plan (JLIP) ;
- Social Work Service Improvement Plan (www.fifedirect.org/atoz/index.cfm?fuseaction=advice.display&adviceid=C1F5D8FC-E7FE-C7EA-054290FC93DE8930);
- NHS Continuing Care Needs Assessment for Fife 2006 (www.nhsfife.scot.nhs.uk/about_us/corporatedocuments/NHS%20Continuing%20Care%20Final%20Report.doc);
- NHS Carers Information Strategy (www.nhsfife.scot.nhs.uk/about_us/corporatedocuments/Carer%20Info%20Str%20update%20nov07.doc);
- Fife's Framework for Older People 2007 (www.fife.gov.uk/publications/index.cfm?fuseaction=publication.pop&pubid=4F68A195-EC6D-85B6-6003504B7B2F464D);
- Joint Health Improvement Plan 2007-2010 (www.fiferights.org/healthyfife.html).

4 The Partnership's vision

4.1 The Health and Social Care Partnership's vision for health and social care services in Fife 2008-2011, is:

> Accessible, seamless, quality services, personalised and responsive to the changing needs of individuals, designed by and for the people of Fife.

5 The Partnership's principles

5.1 The Health and Social Care Partnership has defined its principles as:

- Choice: Choice for individuals, with clear information on what services and resources are available to support choice;
- Accountability: The Partnership will engage with communities about what is achievable within available resources and ensure best value from its resources, so that key targets and key priorities are delivered for the people of Fife;
- Personal Control: Care and support are provided in a manner that enables people to maximise control over their own life and environment;
- Respectful and responsive: People and their carers will be involved in decisions that affect them and encouraged to play an active role in their communities;
- Partnership: By working in partnership with service users, carers, staff from all agencies and communities, better services will be delivered;
- Prevention: Supporting people at home for longer through early access to support, care and health promotion.

6 The Partnership's priorities

6.1 The overarching priorities of the Health and Social Care Partnership are:

- Support: Recognise the increasing demand upon services and shape the use of available resources to maximise the support to the most vulnerable, whilst maintaining the focus on prevention in a sustainable way within an integrated and evidence-based framework;
- Best Value: Achieve best value from available resources by developing joint commissioning and budgetary arrangements, maximising opportunities for joint facilities and support services;
- Involve: Involve the citizens of Fife in shaping the way services develop and in agreeing how resources are used;
- Independence: Support a shift in people's expectations of services from one of dependence upon them, to supporting and maximising independence, by encouraging acceptable risk taking and personal responsibility. This will require giving people the support to make real choices through individual decision-making, assisted by the development of single shared assessment and personalisation of services;
- Access: Streamline access to services through closer integration and partnership-working with health, council, voluntary and private services;
- Equip: Equip and empower staff to develop local and individual solutions within a Fife-wide framework;
- At home: Where possible, and within available resources, support people within their own homes;
- Streamline: Continually review systems and processes to reduce bureaucracy and maximise the use of resources for service provision.

6.2 Each care group section of the plan clearly demonstrates how these priorities are being addressed.

7 The Partnership's resources

7.1 The Joint Resourcing budget is the aligned budget for the provision of community based health and social care services for which the Partnership is responsible. It includes the resources for those services where Fife Council and NHS Fife will often be providing support to the same people.

7.2 Each agency retains responsibility for their own budgets; however the Partnership's role is to monitor the expenditure against the Joint Resourcing Budgets, to provide joint accountability. There are a number of budgets within this overall financial framework which are for joint services, but require to be held by one agency. For example the mental health funding includes monies for the Joint Local Implementation Plan which is held by Fife Council, and NHS Fife holds funding for Delayed Discharges which supports both agencies meeting the Delayed Discharge Targets.

7.3 Each agency is required to work within the resources it is given. This will mean that choices have to be made about where the funding is used. Through the Partnership and its supporting groups the views of the people of Fife are represented in this decision making.

7.4 The level of funding available in 2008/09 and future years will be dependent upon confirmation of the final budget settlements for Fife Council and NHS Fife; likewise consideration may require to be given to the financial consequences of changes to the ring fencing of monies within local authority settlements.

7.5 The Joint Resourcing budget does not include all services for these client groups. For example NHS Fife services such as ENT (Ear, Nose and Throat) and Fife Rehabilitation Service are vital components of the services provided for people with sensory or physical impairment, but they are not part of the Joint Resourcing Budget. (See also paragraph 13.2).

7.6 Contributions to Voluntary Organisations support the provision of services to all care groups.

7.7 Table 1 details the funding within the Joint Resourcing budget for community based services for the year 2007/08. Details of how this breaks down into services is contained in each of the care group sections of the plan.

Table 1

Care Group	**NHS Fife £000's**	**Fife Council £000's**	**Total £000's**
Older People's Services	19,471	71,489	90,960
Mental Health Services	10,362	5,597	15,959
Learning Disabilities	3,288	27,666	30,954
Physical / Sensory Impairment		9,992	9,992
Voluntary Organisations	1,319	1,374	2,693
DAAT	Included in MH	519	519
TOTAL	**34,440**	**116,637**	**151,077**

Resource Transfer from NHS Fife to Fife Council – included within Fife Council Services

Older People	3,688
Mental Health	656
Learning Disabilities	10,594
	14,938

Source: H&SCP JOINT RESOURCING BUDGET 2007/08 – Sept. 2007
Equipment & Adaptations included in figures for older people services

8 What are the issues facing health and social care services?

8.1 The Partnership recognises the need to develop its services to meet the changing needs of the people of Fife. People within Fife have highlighted a number of ways in which they would like services to develop. These include: to be seen as partners; being involved and listened to; having increased control and participation; the opportunity to stay within their own home as long as possible; and to have better information about services and resources.

8.2 The Partnership has identified a number of issues common to all community health and social care services. These are:

- People often find it difficult to access information about or physically access services;
- Processes to arrange and provide care can be long and complicated;
- There will always be more requests for services than there are resources available;
- More support is required to enable people with long-term conditions or disabilities to fully participate in the community;
- Resources need to be rebalanced to both help people to avoid illness where this is possible, and provide support earlier to prevent crises;
- When people move from services designed for children to adults or from adult services to services for older people they often find it hard to find out about or access services and find the change itself difficult.

8.3 The budgets for Fife Council and NHS Fife will be formally agreed in early 2008 for 2008/09. It is expected that there will be resource pressures in relation to Adults with Learning Disabilities placements, Homecare and Residential Nursing care.

8.4 Both Fife Council and NHS Fife are implementing workforce pay modernisation. While these programmes have the goal of ensuring meaningful reward and supporting knowledge and skills development, there will be a period of stabilisation required to enable the joint implementation of the arrangements outlined in this Plan.

9 How will the partnership address these issues?

9.1 Work is ongoing within each joint Strategy Implementation Group, the Fife Drug and Alcohol Action Team and Local Management Units, to simplify routes into health and social care services and improve outcomes for service users. By continuing to develop joint working at both strategic and operational levels, local solutions will be developed to meet the above issues.

9.2 Control is a key issue for many service users. Fife will seek to develop a self assessment system based on Single Share Assessment.

9.3 Over the past few years Fife has met its delayed discharge targets. The processes put in place for this have enhanced partnership working and systems. This has supported people to return home more quickly with the right level of support and care. This work will continue.

9.4 The "Review of Nursing in the Community"[4] also provides opportunities to reshape services. It asks us to consider how services are arranged around people's needs, facilitating local access to services through partnership working.

9.5 As social housing only provides accommodation for about 25% of Fife's residents, it is expected that the introduction and further development of the Fife Housing Register will

[4] Visible, Accessible and Integrated Care: report of the Review of Nursing in the Community In Scotland, Scottish Government, May 2007 http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/nursing/communitynursing/08125906/4

enable better targeting of resources to those with particular requirements, including the care groups of this Plan. The facility of the Register to accomplish this in relation to joint health and social care interests will be enhanced by the development of specialist shared assessment for housing, allied to Single Shared Assessment.

9.6 The Partnership will continue to work with Carers to implement and develop Fife Carers' Strategy.

9.7 The developments in this plan will take place in the context of the health improvement work outlined in the Joint Health Improvement Plan 2007-2010 (www.fiferights.org/healthyfife.html) and Fife's Framework For Older People 2007 (www.fife.gov.uk/publications/index.cfm?fuseaction=publication.pop&pubid=4F68A195-EC6D-85B6-6003504B7B2F464D)

9.8 Each of the care group sections within the plan draws out how these issues affect the different care groups and how the Partnership proposes to address them.

10 Housing

10.1 Housing organisations support a range of client groups through a variety of housing types and support arrangements. The funding arrangements in place include both revenue and capital elements and apply to services provided to both the social and private housing sectors.

10.2 Separate business management arrangements are applied by each housing provider (of which Fife Council is one), to managing their own housing stock and any support services provided; although this might be directed at stock improvement rather than being directed at particular client groups. For example; although general benefit is derived by all Fife Council tenants from circa £40m annual investment on regeneration and housing quality standards programmes, a number of those tenants will be represented within the care groups of this Plan.

10.3 In addition, the Fife Housing Partnership has put in place a strategic framework that governs the way in which wider external capital investment is applied across Fife.

10.4 It remains the case that there is scope for at least modest alignment of housing financial investment to better serve joint service arrangements for the priority client populations. The nature of these resources, and the activities to which they could be applied, would have to be subject to discussion and clarification which will be based on: assessed need; the application of agreed criteria; and monitoring and review of outcomes to justify and guide further housing investment.

11 Reporting structures and monitoring arrangements

11.1 The Strategy Implementation Groups, Drug and Alcohol Action Team and Local Management Units report twice a year to the Partnership Management Group, who inform the Health and Social Care Partnership of progress.

11.2 These groups have annual action plans which explain the detail of how the Partnerships' objectives will be met. These plans are drawn together following the annual financial allocation to the agencies. The action plans therefore reflect the decisions made in partnership about how to make best use of available resources.

11.3 These action plans also have detailed targets which enable progress to be measured.

11.4 The Finance and Performance Management Group will ensure that relevant systems provide robust performance management measurements and regular Finance & Performance Management reports to meet the requirements of the Partnership Management Group and the Health and Social Care Partnership Group.

Care Groups

12 Older People

12.1 The Health and Social Care Partnership is responsible for services provided in the community and for the links from these to acute services. A more detailed description of all the issues and challenges impacting on services for older people is contained in Fife's Framework for Services for Older People 2007. (www.fife.gov.uk/publications/index.cfm?fuseaction=publication.pop&pubid=4F68A195-EC6D-85B6-6003504B7B2F464D).

12.2 Services for people with dementia are discussed in the Mental Health section of this plan (section 14). However services work closely together to ensure that people with dementia receive the care they need in a co-ordinated manner.

12.3 A Joint Commissioning Strategy for older peoples services

12.3.1 The Partnership will produce a Joint Commissioning Strategy for Older Peoples Services in 2008. The work on this to date has involved gathering information on existing services and resources, about population changes and needs, and asking people for their feedback on services. With this information, services and service users have considered what needs to be changed to provide the services sought and needed for the future, and develop a 'strategy' to work towards achieving these.

12.3.2 This process has taken account of all the issues, challenges, pressures and gaps noted below and agreed outcome targets that we will work to achieve. The Older Peoples Strategy Implementation Group will report to the Partnership Management Group on progress against these targets.

12.3.3 The Partnership believes that by meeting these targets services will be able to show that they are providing the support and care that the people of Fife would like.

12.4 What has the Partnership done to improve services for older people?

12.4.1 In the 2004/07 Joint Community Care Plan and Extended Local Partnership Agreement, the Partnership committed to a number of actions. Here are details of some of them:

Commitment	Action
• Provide free personal care	• Now available
• Develop out of hours services	• As part of the development of out of hours service, Fife Falls response service has been set up to help people over 65 who are unable to get up after a fall at home. People are then put in touch with a health service team to work with them to identify any underlying health reasons for the fall and arrange any support this suggests
• Reduce the number of older people who are in hospital whose discharge has been delayed due to non-medical reasons	• Fife has consistently met its targets to reduce delayed discharges. • Fife has developed a joint Choice Policy
• Develop a Joint Hospital Discharge Protocol	• This protocol is in place, and is being updated in 2007

Commitment	Action
• Develop rapid response systems to deal with emergency situations where a person's ability to remain at home is jeopardised	• A number of services have been developed, e.g. integrated response teams, intermediate care beds, occupational therapy and homecare expertise in A&E
• Ensure the provision of shopping and domestic services	• These are provided on the basis of need, as part of a wider care package that also includes provision of personal care
• Provide four weeks Free Home Care following discharge from hospital (excluding Meals on Wheels)	• This is now provided (prior to introduction of free personal care as a national objective)

12.5 What resources are involved?

12.5.1 As the table below shows, there is a wide variety of services working to support older people. The financial resources committed to these in 2007/08 are detailed within table 2:

Table 2

OLDER PEOPLE	NHS Fife £000's	Fife Council £000's	Total £000's
Integrated Response Teams	575	892	1,467
Equipment & Adaptations	404	895	1,299
District Nurses	6,427		6,427
Community Evening Services	859		859
Community Podiatry Services	2,157		2,157
Home Care Services		21,235	21,235
Occupational Therapy Service		1,280	1,280
Meals on Wheels		602	602
Shopping Delivery & Pension		605	605
Community Alarms/CSESL		615	615
Continuing Care	7,881		7,881
Care Packages/Contracts		1,677	1,677
Capacity Planning	1,168		1,168
Direct Payments		711	711
Respite Care		635	635
Nursing Home/Residential Care		26,443	26,443
Residential/Respite & Day Care		11,638	11,638
Older People Fieldwork Teams		4,261	4,261
(Fife Council spending on Sheltered Housing is about £2,100,000 each year.)			
TOTAL	**19,471**	**71,489**	**90,960**

Source: H&SCP JOINT RESOURCING BUDGET 2007/08 – Sept. 2007

12.6 Issues facing services for older people. **How will the Partnership address these?**

Issues facing services for older people	How will the Partnership address these?
Support	
It is well known that the proportion of older people in Scotland is expected to rise while the number of people of working age will fall. Forecasts suggest that between 2004 and 2031 the number of people of working age will fall by 7%, and the number of people of pensionable age will rise by 35%. In Fife, between 2004 and 2024, the number of people aged 60 and over will grow by 45%. From 2005 to 2010 the number of people aged 75 and over is projected to rise by 8.3%. Currently 12% of people aged 65 and over are services users, whilst 26% of people over 75 are service users. These population factors will challenge the Partnership. For example; based on current service use, there will be an additional 150 people aged 75 and over who will access services for older people by 2010. On the basis of these population projections, to keep services at their current level, the Partnership will see a 2.5% increase in demand each year.	The Partnership, through the commissioning strategy, will consider how best to restructure existing services to equip them to meet increasing demand. Fife Council has implemented the recommendations of the 2006/07 review of Homecare.
Involve	
While a lot of progress has been made, there is a need to continue to improve planning with people when they need to go into hospital, and also for coming home.	The Partnership will continue to improve the experience of people being discharged from hospital who require health and social care.
The Partnership recognises that there is not enough advocacy provision for older people in Fife.	The Partnership will support the ongoing development of Citizen Advocacy in Fife and work with Partners to raise awareness and understanding of the valuable role of advocacy.
At home	
Carers are a vital part of health and social care. The Partnership recognises the need to further develop its involvement with carers to support them in their role.	Fife Carers Strategy (www.fifedirect.org/atoz/index.cfm?fuseaction=advice.display&adviceid=C850FDC7-E7FE-C7EA-06C6BE19815BC44A) highlights the service measures being developed to support Carers.

Issues facing services for older people.	How will the Partnership address these?
Independence	
"Better Outcomes for Older People" notes that older people wish to be helped to be more independent, to have choice and control over how they manage their lives, with customised support, preferably in their own home[5]. "Delivering for Health" builds on these principles and seeks to change the way the NHS works, from a hospital driven service to one that is community based, with a concentration on preventing ill health and treating people faster and closer to their homes.	There are a number of targets which encourage services to work with people earlier, to help maintain their independence and where possible avoid going into hospital. Funding is being invested in supporting people in the community who have Long Term Conditions and to develop the SPARRA (Scottish Patients At Risk of Re-Admission) risk predictor database. Locally, services are working together to ensure information gathered through Single Shared Assessment, which identifies people who need additional care management / support, is acted upon as quickly as possible. These developments will, however, initially put pressure on resources to support prevention, and it will take time to reduce the resources needed for treatment. Services will work with staff to support these changes. The developing use of Person Centred Planning techniques and investment to support people with Long Term Conditions and Care Management, will enable people to have greater control over their care and maximise the opportunities for individualised care. Likewise developments in Telecare (electronic equipment that provides monitoring, alert support, etc) will provide more support for people in their own homes. Through the Joint Telecare project the Partnership is also working to bring together services that work outwith office hours, to improve communication and make best use of resources.

The developing Commissioning Strategy for Older People's Services, in taking a close look at existing resources, projections and care developments, will provide detail of how the Partnership will address these issues. The outcome will be a joint commissioning strategy for the design and delivery of the Partnership's resources for Older People. The detailed actions and outcome targets stemming from the Commissioning Strategy and others that are already underway are outlined in the Older Peoples Strategic Implementation Group Action Plan. This action is reviewed every six months by the Partnership Management Group.

[5] Better Outcomes for Older People: Framework for Joint Service, Scottish Government/CoSLA/ NHS Scotland, May 2005

13 Services for people with a learning disability

13.1 This plan sets out the way that services will develop and informs the Fife Partnership in Practice agreement (PiP). The PiP sets out in detail the actions that will be put in place to achieve the priorities.

13.2 The first PiP was published in 2000 and based its goals on the findings of the Same As You review. The 2007 PiP will be the third PiP; it highlights the steady progress that has been made against the original goals.

13.3 The Partnership is committed to continue developing services that are person-centred and support people to fulfil their potential, being as involved as possible in their own community. This will be achieved in partnership with service users and carers.

13.4 What has the Partnership done to improve services for people with a learning disability?

13.4.1 Since 2004 there have been significant developments in services for people with Learning Disabilities in Fife.

13.4.2 Services have become more and more focused on the needs of individuals and in supporting people to be involved in their local community. For example a number of people now live in the community who would formally have lived in a hospital: 41 beds have closed and the funding is now used to provide community services.

13.4.3 In the 2004/07 Joint Community Care Plan, Partnership in Practice Agreement (2004/07) and Extended Local Partnership Agreement, the Partnership committed to a number of actions.

13.4.4 Here are details on some of them:

Commitment	Action
• Based on user consultation, develop day services	• Services continually seek to support people to increase their circles of support • A variety of transport options are now in place to support access to day activities • Increasingly, community resources are being used for day support
• Ensure citizen advocacy is available throughout Fife	• A development worker has been appointed to develop Citizens' Advocacy in North East Fife to close that gap
• Develop a Joint Forensic Team	• The team is in place
• Local Area Co-ordination staff would be piloted	• Two Local Area Co-ordinators posts created
• Achieve the discharge of the existing residents of Lynebank Hospital, providing housing and support	• The discharge programme is nearing the end of the fourth phase (this is the final phase)
• Improve transitions from children to adult services	• A nurse has been appointed to scope and develop the arrangements for people moving from children to adult services

Commitment	Action
• Develop community support arrangements	• Three local community learning disability healthcare teams, along with colleagues, have worked hard to improve awareness of additional health needs and access to healthcare • A nurse specialist in challenging behaviour and applying best practice guidance for multidisciplinary assessment and intervention, is being recruited • To improve services, close working with midwives and health visitors has been developed

13.5 The 2007 /2010 Partnership in Practice Agreement provides more detailed feedback.

13.6 What resources are involved?

13.6.1 The financial resources committed to services for people who have a learning disability in 2007/08 are detailed at table 3.

13.6.2 These are the resources in the H&SCP aligned budget, which is the funding that provides the joint community based services. NHS Fife also spends £2.4million each year on services for people with a learning disability who have forensic needs or who have challenging behaviours (this is the direct clinical costs and does not include the cost of buildings etc).

Table 3

LEARNING DISABILITIES	**NHS Fife £000's**	**Fife Council £000's**	**Totals £000's**
Admission/Assessment/Day Care	1,444		1,444
Care Packages		13,170	13,170
Day Care		4,987	4,987
Direct Payments		549	549
Community Teams	1,844		1,844
Respite Care		993	993
Accommodation Services		5,457	5,457
Residential and Nursing Care		1,597	1,597
Adults Fieldwork Teams		913	913
TOTAL	**3,288**	**27,666**	**30,954**

Source: H&SCP JOINT RESOURCING BUDGET 2007/08 – Sept. 2007

13.7 Issues facing services for people with a learning disability. How will the Partnership address these?

Support

Advances in medical science have seen more children with disabilities surviving into adulthood and people now have increased life expectancy at all ages and ability levels. In 2000 the Scottish Government estimated that there has been, and will continue to be until 2010, a 1% growth each year in the number of people with severe and moderate learning disabilities since 1965[6]. Approximately 8800 people living in Fife have a learning disability:

Table 4: Estimates of people who require care and support from Fife Council and NHS Fife and 2010

Care level	2006 estimate	2010 projection
Regular care and support	2200 people	2288 people
Added to the above, a lot of assistance to cope with daily living	1100-1500 people	1144-1560 people

These demographic changes have "resulted in a growing number of older adults with learning disabilities and also a growing number of persons with severe and profound learning disabilities in all cohorts"[7].

The Partnership will ensure that the resources available to deliver support to people with learning disabilities are used as effectively and efficiently as possible. This will include targeting those in greatest need and developing new ways of working which can deliver the support required cost-effectively and meet the expectations of service users and carers.

Measures to support carers, and to recognise and make use of their expertise within service provision, are detailed in Fife's Carers Strategy[8].

The Partnership will seek to enhance access to respite/short break services across the range of disabilities.

The Partnership will support the development of better co-ordination between services for older people and services for people with a learning disability, through its joint management groups.

Streamline

The National Government has recognised a need to develop services for women with a learning disability who come into contact with the criminal justice system.

Fife will consider the local impact of the guidelines and work to implement any required changes.

[6] People with Learning Disabilities in Scotland: NHS Scotland Health Needs Assessment Report 2004.
[7] People with Learning Disabilities in Scotland: NHS Scotland Health Needs Assessment Report 2004.
[8] Fife Carers Strategy 2004-07, fifedirect - Publications - Fife Carers Strategy 2004-2007

Issues facing services for people with a learning disability.	How will the Partnership address these?
S u p p o r t	
"People who have a learning disability and / or who have a mental health problem are more likely to die younger of preventable causes."[9] As the Disability Rights Commission quotation indicates, some people with learning disabilities will be affected more by chronic physical illnesses.	To address the physical health needs of people with a learning disability, the Partnership will continue to develop and support better access to health promotion, primary care and hospital based services.
A need has been identified for an assessment and admissions unit for people who have a learning disability and mental health problem or challenging behaviours.	The Partnership is setting up an admissions and assessment unit for people with learning disability who also have a mental illness or challenging behaviour
There is a need to further develop the range of services that support people who have a learning disability who also have forensic needs.	The Partnership is working with regional partners in setting up a low secure service for people who would otherwise have to stay in the state hospital. The Partnership will continue to develop and consolidate the Fife Forensic Learning Disability Service; working to deliver care and support and ensure public safety in relation to individuals who have forensic needs.

A t H o m e	
Supporting older people with learning disabilities in a community setting is an increasing priority.	The Partnership will work with service users and carers, bearing in mind national guidance, to define how this can best be achieved in Fife. The Partnership will feed into the national assessment of the need for supported accommodation and supported living services for people with learning disabilities. The Partnership will continue to work closely with service providers and the voluntary sector to ensure the delivery of person centred support for people to live as independently as possible, whether this is living in single tenancies or in shared accommodation.

[9] Equal Treatment: Closing the Gap, A formal investigation into physical health inequalities experienced by people with learning disabilities and/or mental health problems. DRC 18/9/06

Issues facing services for people with a learning disability.	How will the Partnership address these?
Independence	
Policy has developed in very positive ways to ensure personalised, individually-tailored services which promote social integration, choice and independence, so that people can lead a full life within their local community. All long stay hospital beds for people with learning disabilities are being closed within Scotland by the end of 2007, ensuring the move towards community based care and support. These policy developments have led to an increase in the cost of service provision well in excess of available budgets. The average annual cost of a learning disability community care package in Fife is currently £55,000. If every adult with learning disabilities requiring a lot of assistance had their needs met by the Council rather than through informal care, the potential annual cost to the Council would be much higher, with the cost of associated health needs falling to NHS Fife.	We will continue to develop personalisation by developing the Local Area Co-ordination model, implementing the In-Control model and reviewing direct payments. Underpinning this, we will put in place better information systems to ensure that people, their carers and support staff, have access to good information about what services are available and how to access resources. Early planning is essential to ensure that we develop our services to meet needs within available resources. The Partnership will develop a joint commissioning approach to services for people with a learning disability. This will support the development of services to effectively meet people's needs into the future. At the same time Local Government, through CoSLA, is seeking to ensure that the Scottish Government recognises the scale of the challenges and makes increased financial resources available to Local Authorities and NHS Boards. This will support the effective implementation of positive policy developments to meet the needs of a growing population.

Equip	
To provide services which continually improve and meet people's needs, staff need to continually develop their skills and knowledge. Carers want to increase their knowledge and skills to support them in their role.	The Partnership will support staff and carers to gain the skills and knowledge they need, drawing on the knowledge and experience of service users and carers. The Partnership will also seek to learn from developments in other areas.
The Adult Support and Protection (Scotland) Bill was implemented in 2007.	The Partnership will ensure that staff are trained and that our procedures keep up to date with any further changes. The Joint Vulnerable Adult Guidelines and Procedures will be reviewed every year.

Issues facing services for people with a learning disability.	How will the Partnership address these?
I n v o l v e	
Estimates suggest that 42% of people with a learning disability are living with older carers: 30% of these carers are above the pension age. A substantial amount of daily care and support is provided informally, with limited impact on public finances at the present time. As older carers become unable to provide informal care, a significant cost burden will fall on Fife Council and NHS Fife for care and support to be provided, to enable people to live safely in the community.	The Partnership recognises the need to further develop involvement with carers. The Partnership will continue to involve service users and carers in service and policy development, providing information to support involvement in the formats people prefer.
It is recognised that the needs of people with autistic spectrum disorders are not being fully met.	The Partnership will work with service users and voluntary sector groups to clearly identify these needs and develop proposals to address them. An Autism Co-ordinator will be appointed jointly to develop services for adults with Autistic Spectrum Disorders and the Partnership will support the development of a regional clinical network.

A c c e s s	
It is recognised that Citizen Advocacy is not accessible for everyone who may need this support and there is a need to increase understanding and awareness of the role advocacy has to play.	The Partnership will support the ongoing development of Citizen Advocacy in Fife and work with Partners to raise awareness and understanding of the valuable role of advocacy.
People with a learning disability want to participate in their own community, develop their skills and have meaningful relationships.	Building on developments to date such as Fife in College Support Services and Fife Employability, the Partnership will continue to ensure people with learning disabilities have the opportunity to access meaningful day activities, further education and employment, and reach their full potential as contributing members of their community.

The PiP details the actions required to take this forward and outcomes that we are aiming for. The PiP will be reviewed and monitored at the Learning Disability Strategy Implementation Group meetings.

14 Services for people with and affected by mental ill health

14.1 This section of the plan sets out the strategic direction for community mental health services in Fife; of more personalised services and a recovery based model of care. This plan informs our local joint Mental Health Delivery Plan which defines how Fife will address the issues outlined in this section and meet the national policy objectives for mental health services. Fife's Area Partnership is responsible for taking this work forward and will report twice a year to the Partnership Management Group.

14.2 NHS Fife Mental Health Services also report twice a year on the joint Mental Health Delivery Plan to the Scottish Government.

14.3 Fife's Area Mental Health Strategy Implementation Group (SIG) / Partnership includes service user and carer representatives. This ensures that within the SIG / Partnership the views of service users and carers are continually reflected in service provision, development and in holding services to account. The Area Mental Health SIG / Partnership continually seeks to enhance communication with service users, carers and their representatives.

14.4 The Area Mental Health SIG / Partnership has only recently been established and has concentrated on revising the membership and ensuring appropriate representation from the local partnerships and other relevant parties. The Partnership approach is committed to supporting the development of local services and solutions thus investing resources as locally as possible.

14.5 The Area Mental Health SIG / Partnership, with the three Locality Mental Health Partnerships, will draw up a detailed action plan to define and monitor work to meet the objectives of the H&SCP Service Delivery Plan. The Locality Mental Health Partnerships are joint groups of operational managers working with local service users and carers to meet local needs.

14.6 People want easy access to all the support and care they require. To support integration of community health and social care services the Locality Mental Health Partnerships work with the Local Management Units.

14.7 There are a variety of treatments available. The Partnership will seek to ensure that people have choice of treatments appropriate to their needs.

14.8 What has the Partnership done to improve services for people with and affected by mental ill health?

14.8.1 The Mental Health Delivery Plan continues the commitment to shifting the balance of care for people with mental health problems from hospital to the community. There has been a steady shift in the focus of services and the development of new services to community centred approaches. This is aimed at avoiding admission to hospital and maintaining people at home or in an appropriate setting in their community, therefore targeting the care of particularly vulnerable groups such as the elderly and the homeless.

14.8.2 Some of the developments since the Extended Local Partnership Agreement 2005 and Joint Community Care Plan 2004-07 are noted below:

Commitment	Action
• Develop the strategic vision for mental health services • Develop local mental health services	• All four tiers of service are now in place, with continuing development to support people to move between the levels • Progress has been achieved in older people's services • Within Adult services, Locality Mental Health Teams are operating successfully in each locality.

Commitment	Action
• Implement the Mental Health (Care and Treatment) Act (Scotland) (2003)	• A Mental Health Officer Team was established to implement the legislative requirements of the Act.
• Implement Right for Fife	• The Mental Health Inpatients project is taking forward the decision to move inpatient services from 3 to 2 sites, (relocation of inpatient services at Whyteman's Brae hospital to Stratheden hospital and Queen Margaret/Lynebank hospitals)
• Review services for people with an eating disorder	• The Anorexia Nervosa Intensive Treatment team has been appointed
• Develop Dementia and services for older people	• The following have been developed: >Core funding for a memory clinic >Early onset dementia support worker being appointed >Change & Innovation funding rolled out to the EAST Project across North East Fife >Flexible day care developed >Locality mental health teams for older adults
• Implement locally "Choose Life", the Scottish Government 10 year strategy and action plan to reduce suicides in Scotland by 20% by 2013	• In Fife, "Choose Life" supports a total of 9 projects, employs a programme evaluator within the NHS Fife Public Health Department and is running a training programme. (www.chooselife.net has the annual report and more details)
• Develop Advocacy Services	• Services have been developed to meet the requirements of the new Code of Practice for the provision of Independent Advocacy and Mental Health & Treatment Act 2003

14.9 What resources are involved?

14.9.1 The financial resources committed to community services for people who have or are affected by mental ill health in 2007/08 are detailed at table 5.

14.9.2 Other resources for people who have or are affected by mental ill health, such as in-patient services, are not included in the aligned joint budget.

Table 5

Mental Health	NHS Fife £000's	Fife Council £000's	Total £000's
Addiction Services	2,733		2,733
Community Teams	2,452		2,452
Care Packages		1,429	1,429
Direct Payments		54	54
Joint Commissioning	319		319
ART	100		100
Day Hospitals	2,107		2,107
Psychology	2,651		2,651
Respite Care		132	132
Residential & Nursing Care		827	827
Mental Health Fieldwork Teams		1,733	1,733
Specific Grant Projects		1,422	1,422
TOTAL	**10,362**	**5,597**	**15,959**

Source: H&SCP JOINT RESOURCING BUDGET 2007/08 – Sept. 2007

14.10 Issues facing services for people with and affected by mental ill health. **How will the Partnership address these?**

Support	
Rebalancing care from acute to a social model of recovery has significant resource implications. These include housing, adequate advocacy provision and training to ensure the promotion of individual choice, growth and development	The Partnership will ensure that there is an appropriate range of accommodation models to support people effectively within their own local community. The Partnership will continue to review the provision of advocacy services to ensure accessible, responsive and appropriate support is available. The Partnership will seek to deliver services as locally as possible.
The Partnership recognises carers' important role in care provision and their need for effective support and appropriate information to help them in their role.	The Partnership will work more closely with carers and implement the Joint Carers Strategy and NHS Fife Carers Information Strategy. The Partnership will also work to improve the support provided to carers.
The sustainability of voluntary sector services to ensure the ongoing provision of services across the spectrum of care.	The Partnership will work with the voluntary sector to shape the use of available resources, maximising the support to the most vulnerable, while maintaining the focus on prevention in a sustainable way within an integrated and evidence-based framework.
Effective communication between agencies, across sectors and with individuals is crucial.	The Partnership will work with all partners to improve communication between agencies and professions, with service users and their carers.
Mental health problems can affect people of all ages. The Partnership is increasingly aware of the needs of young adults with mental health problems. People often find it difficult to find out about or access services and also find the change itself difficult when they move from services for children to adults, or from adult services to services for older people.	Within available resources, the Partnership will develop person-centred services, which are appropriate to the individuals needs. This will provide more effective support for people in the community. The Partnership will ensure that services communicate and work together effectively, so that people do not feel that there is a lack of support.

Issues facing services for people with and affected by mental ill health.	How will the Partnership address these?
Support	
The Scottish Government has proactively promoted better mental health (National Programme for Mental Health and Wellbeing).	Locally there is a wide range of services and activities which reflect the National Programme. As far as possible these link with the mental health services' agenda.
The funding for the "Choose Life" programme ceases at the end of 2007/08.	The Partnership will seek to ensure that these services are retained where feasible.
There has been closer scrutiny of patient care through NHS Quality Improvement Scotland (NHS QIS). NHS QIS has made recommendations on specific service developments e.g. for the management and treatment of eating disorders.	The partnership will continue to work with NHS Quality Improvement Scotland to support ongoing learning and development.
The Partnership recognises that 24 hour access to support and crisis support need be more responsive and accessible.	There has been an increase in Mental Health Officers to ensure a better response out of hours. The Partnership will explore how to use existing resources more flexibly and proactively.
Projections suggest that the number of people with dementia will more than double by 2040[10]. There is therefore a need to consider how best to deliver services jointly into the future.	The Partnership, with Stirling University, has secured funding for a Knowledge Transfer Partnership to support the development of a joint Dementia Strategy.

Best Value	
Establish Mental Health Partnerships as an integral part of the development of Community Health Partnerships.	Planning structures have been revised to align with the formation of Community Health Partnerships. The Mental Strategy Implementation Group has incorporated Area Mental Health Partnership function into its role, and three CHP Locality Mental Health Partnerships have been established and include the functions previously undertaken by the Area Redesign Teams. Work is ongoing to consolidate these structures.

[10] Delivering for Mental Health, Plan for Scotland (December 2006)

Issues facing services for people with and affected by mental ill health.	How will the Partnership address these?
I n v o l v e	
While close working is in place across agencies, the Partnership recognises that more user-involvement is needed.	The Partnership has been working with the Scottish Development Centre for Mental Health to capture users' and carers' views on issues and challenges. The report will be available shortly.
Locally, there are important changes in how the mental health agenda is viewed. This takes into account the requirements set out in legislation and national policy, but also includes a range of local perspectives, including local community planning, the views of users and carers, clinical advice, service constraints and the wider public. In addition, it reflects the increasing recognition that many mental health problems are preventable and, even if they develop, the majority of people with mental health problems recover.	Scenario planning has the potential to support the transformation of mental health services in Fife. It will allow consideration of a wide range of information and models, and bring together all the stakeholders involved to discuss the implications of potential future scenarios. This work will help to set the direction of travel for local service developments. It takes time to bring all these perspectives together and develop an understanding to set a new joint direction for mental health services. Over the period of this plan the Partnership intends to undertake scenario planning exercises informed by local needs analysis and service mapping to create an integrated and effective working plan for future service development. The scenarios will reflect the aspirations of service users, carers and national policy.

E q u i p	
Along with these broad policy objectives, there has been a huge growth in evidence for what works in mental health services. This in turn requires that staff continually update their skills and knowledge base.	NHS Education Scotland has been working with staff to set up better training opportunities. A joint project between Fife and Tayside has been developing care pathways to respond better to people with mental health problems in crisis.
The Mental Health Nursing Review (published in April 2006) embraces this new evidence and philosophy.	Work is taking place in Fife to help nursing staff develop recovery based models of care and treatment, supporting a dignified approach to dementia care where recovery is often unrealistic.

Issues facing services for people with and affected by mental ill health.	How will the Partnership address these?
Access	
The results of national research suggest that the needs of people with depression, anxiety and stress could be met in different and more effective ways[11]. This is particularly the case for people aged 45-65 living in deprived communities, where long-term unemployment is often linked to depression, anxiety and stress.	Fife's "Keep Well" pilot project will assist in supporting the identification of mental health incidence within deprived communities and in sign-posting people to appropriate services for support.
The need for psychological therapies is high. This is demonstrated in a 7% increase in people waiting for psychology services between 2006/07 and 2007/08.	NHS Education Scotland is working closely with local services to provide training for staff within the area of mental health to support this aspect of care. To ensure waiting times are tackled effectively, monitoring will continue.
There are pockets of good practice, and the learning from such initiatives needs to be shared across the whole service.	This learning, combined with the high levels of commitment of staff to provide good quality and effective services, will enable services to develop more of a social recovery model allowing for personal choice and development.

Streamline	
An Integrated Care Pathway for Postnatal Mental Health has been developed.	Services are considering how best to implement this and what training is needed. Inpatient beds have been commissioned at the regional centre based in St John's Hospital in Livingston.
Better discharge planning and risk management is required for patients subject to the Management of Offenders (Scot) Act 2005 (MAPPA arrangements, Care Programme Approach used for restricted patients).	A multi-agency Significant Risk Advisory Group has been set up to underwrite risk management plans.

[11] Delivering for Mental Health, Plan for Scotland (December 2006)

Issues facing services for people with and affected by mental ill health.	How will the Partnership address these?
S t r e a m l i n e	
The Partnership has noted that service users have highlighted the need for better discharge planning (particularly regarding communication and information) to ease the return to the community.	The Partnership will work with services to update and maintain information and enhance links between services and professions. The Joint Discharge Protocol has been revised and will be comprehensively re-launched with staff.

Issues facing services for people with and affected by mental ill health.	How will the Partnership address these?
I n d e p e n d e n c e	
The Section 26 (Mental Health (Care and Treatment)(Scotland) Act (2003)) gives a commitment to the right to leisure and recreation, employment, education and vocational training, community provision and the availability of transport to enable access will have an impact on resources. It is recognised that enabling social inclusion is important to supporting people effectively and to aiding recovery.	Services are continuing to develop a personalised approach to meeting these needs. The Partnership will work to enhance peer support and models of care which enable people to develop their informal support networks. The Partnership will continue to work with employers and partners, for example through Fife Employability, in raising awareness and encouraging supported employment.
It is also recognised that maintaining people in the least restrictive environment will support their recovery.	A process of risk assessment and risk management will be implemented which supports positive risk taking, allowing the promotion of personal independence alongside individual and community safety.
Stigma continues to be a barrier to full community involvement and can reduce the opportunities people have.	Fife Partnership signed a “See Me” pledge in 2006 and local work is progressing from this to reduce stigma. The Partnership will also continue its work to reassure communities.

Issues facing services for people with and affected by mental ill health.	How will the Partnership address these?
National objectives – local solutions	
The major policy driver in mental health services in Scotland is Delivering for Mental Health, Plan for Scotland (December 2006). This identifies a range of challenges and issues for mental health services. A further policy driver has been the Mental Health (Care and Treatment) (Scotland) Act 2003, which was put into place in 2005. A Joint Local Implementation Plan ensures local agencies are equipped to meet their statutory duties. These issues and policy drivers have significant resource and training implications. However, funding beyond 2007/08 has not been clarified and there are likely to be continued funding challenges.	To take these forward the Partnership will: ▪ ensure equitable access and treatment, focusing on health promotion and a range of prevention services (e.g. smoking cessation, immunisations); ▪ support quality improvement and communication by enhancing peer support and developing in-patient forums; ▪ support the roll-out of the standardised assessment tool for GP practices for people presenting with depression, and seek to ensure that appropriate therapy is available to meet assessed need; ▪ implement the treatment models that are currently being developed for people with depression and anxiety who also have coronary heart disease and/or diabetes; ▪ become accredited for the new Integrated Care Pathways for Schizophrenia, bi-polar disorder, depression and dementia from the end of 2007. (supporting better co-ordination and outcomes; help people access other services in a way that encourages a more holistic approach to support and care); ▪ support a focus on the physical health of people with severe and enduring mental illness; ▪ increase the capacity within the current mental health workforce to provide psychological therapies; ▪ concentrate efforts on those most at risk of suicide, enhancing training for frontline mental health staff in suicide prevention and assessment tools; ▪ meet the crisis standards by 2009 to ensure that people are managed and cared for more effectively within the community, reducing the number of inappropriate admissions; ▪ meet the statutory guidance on the Care Programme Approach for all patients subject to the Management of Offenders (Scot) Act 2005 by 2008. This guidance will be available shortly;

Issues facing services for people with and affected by mental ill health.	How will the Partnership address these?
National objectives – local solutions (continued)	
	To take these forward the Partnership will (continued): ▪ consider fully which steps will be required to meet the Scottish Government guidance on practical measures to implement Mind the Gap[12] and Fuller Life[13] when these are published at the end of 2007; ▪ learn from the findings of the Forth Valley pilot study on improving dementia services, and develop in a way that meets the needs of local people and their carers; ▪ review advocacy services to ensure that they are in line with the new code.

The action that results from this plan will be contained in the Area Mental Health SIG / Partnership Action Plan. The Area Mental Health SIG / Partnership reports to the Partnership Management Group twice a year on progress against this.

[12] Mind the Gap - Meeting the needs of people with co-occurring substance misuse and mental health problems http://www.scotland.gov.uk/Publications/2003/11/18567/29477
[13] A Fuller Life www.alcoholinformation.isdscotland.org/alcohol_misuse/files/ARBD_afullerlife.pdf:

15 Services for people with a sensory impairment

15.1 This Plan sets the strategic framework for the Action Plan of the Fife Sensory Impairment Steering Group. This group reports into the Partnership via senior operational managers.

15.2 The Sensory Impairment Steering Group has valued the opportunity to work in partnership across the voluntary and statutory sectors. The group has supported involvement in service planning, improvement and development; as well as increasing awareness and information cross over into a wider range of groups and planning structures.

15.3 Agencies working with people with sensory impairment continue to seek to provide services that are as personalised and local as possible.

15.4 What has the Partnership done to improve services for people with sensory impairment?

15.4.1 Some of the developments since the Extended Local Partnership Agreement 2005 and Joint Community Care Plan 2004-07 are:

Commitment	Action
• Ensure that communication support is available so that people with a sensory impairment can be involved in planning for services and be involved in their own communities	• The SPIN pack (Senses, Plan, Involve & Nurture) has been developed. It is a guide to support service user representation and consultation • Fife Sensory Impairment Centre is now a registered Learn Direct Centre – this offers the potential to provide a wider range of training for people who have, or are working with, those who are deaf or have a sensory impairment
• Raise awareness of the fact that sight loss can be a consequence of strokes. Look at putting together a proposal for early intervention	• As part of the Stroke Managed Clinical Network, an assessment and neurological vision training service for people who have had a stroke was developed to help people maximise the use of their remaining vision (only the second such service in the world, with 118 referrals in first year)

15.5 Resources

15.5.1 The 2007/08 financial resources committed to services for people who have a physical or sensory impairment are detailed at table 6. Adult service budgets in general do not record sensory and physical impairment expenditure separately, which is why the budgets are shown together.

15.5.2 As noted in paragraph 7.5 there are a number of NHS services which are vital components of the services provided for people with sensory or physical impairment which do not come within the Joint Resourcing Budget. The Partnership resources also include contributions to Voluntary sector organisations, for example Fife Society for the Blind.

Table 6

Physical / Sensory Impairment	NHS Fife £000's	Fife Council £000's	Total £000's
Care Packages	NHS resources in this area are not part of the Resourcing Budget	3,957	3,957
Deaf Communications Unit		183	183
Day Care		1,656	1,656
Direct Payments		1,328	1,328
Respite Care		960	960
Residential & Nursing Care		1,166	1,166
Adults Fieldwork Teams		742	742
TOTAL		**9,992**	**9,992**

Source: H&SCP JOINT RESOURCING BUDGET 2007/08 – Sept. 2007

15.6 Issues facing services for people with a sensory impairment. How will the Partnership address these?

<table>
<tr><th colspan="2">Independence</th></tr>
<tr><td>The Disability Rights Commission notes that people with a disability are:
twice as likely to be unemployed
twice as likely to have no qualifications[14]
only 25% of working age people who are blind or partially sighted are in employment
In 2006 there were 1,804 people registered as blind or partially sighted in Fife, over 73% of blind and partially sighted people are of pensionable age. Fife Society for the Blind is increasingly working with the people over 75 (between 1980 and 2006 they had a 10% increase in the number of people over 75 they worked with).

Predictions estimate that the number of people over 65 with sight loss will double in the next 20 years.

There are circa 49,000 people with hearing impairment in Fife and approximately 300 people who are Deaf sign language users. 1 in 5 people over 16 have some form of hearing loss, and about 30% of people aged 61-70 and 75% of people over 70 have a significant hearing loss.</td><td>These factors will influence the nature of the support and services provided by the Partnership.

The Partnership will continue to work to improve communication and access for all service users, via training for staff and developing systems and materials with users, carers and specialist services.

Work will continue to provide personalised services based on the needs of the individual.

To address the difficulties people who are blind or partially sighted face in accessing employment, Fife Society for the Blind has started a Social Enterprise Company, FSB Enterprises, with a view to creating real jobs. The Partnership will work to ensure that full use is made of these services.</td></tr>
<tr><td>The Disability Equality Duty has implications for the services provided by the Partnership[15].</td><td>The Partnership will continue to examine the implications of the Disability Equality Duty, which will provide a framework for improving access to health and social care and promoting independent living for people.</td></tr>
</table>

[14] Disability Rights Commission; DED Launch 4/12/6

[15] Gerry Zarb: Using the Disability Equality Duty to tackle inequalities in health and social care, September 2006

Issues facing services for people with a sensory impairment.	How will the Partnership address these?
Independence	
Funding for the Health Living Centre (sensory impairment) will cease in 2008. This development has put in place a well received programme of training for independent living skills and health improvement, as well as a number of training initiatives for staff.	The work the Centre has undertaken has established effective links between agencies. The Partnership sees the services the Centre has provided as valuable resources. Some of the services it has been providing will be incorporated into the provision of some partner agencies as appropriate and as capacity allows.

Streamline	
As with other care groups, when people move from children to adult services and from adult to services for older people, there can be difficulties.	The Partnership will support services to simplify the move for people between services.

At Home	
As services develop, people with more complex needs are now able to be supported at home. This has meant that more complex equipment is required to support people. The joint Fife Community Equipment Service is finding its targets for delivery times increasingly challenging because of: increased demand; and a greater proportion of orders include larger pieces of equipment that need two people to deliver and take longer to install. Timely provision of equipment makes a significant impact on being able to support people at home.	The Community Equipment Service has appointed a member of staff to clinically prioritise referrals to ensure timely delivery that will help people remain at home. An additional van and driver are also in place. Staff and managers continue to review systems and process, and consider funding implications. Information technology has huge potential to support people with sensory impairment. The Partnership will work with agencies to grasp this potential.

Issues facing services for people with a sensory impairment.	How will the Partnership address these?
S u p p o r t	
As discussed above, an increase in the number of older people may increase the number of people with sensory loss. In addition, models of rehabilitation for people who acquire a sensory impairment have largely developed to meet the needs of younger people; there is a need to develop services to meet the needs of older people who acquire a sensory impairment.	Work is ongoing to develop rehabilitation models that meet the needs of older people with a sensory impairment. The Partnership will work with voluntary organisations as they seek to develop resources to enable people to retain and regain their involvement with mainstream social provision. Work will be progressed to raise awareness of sensory loss, identify the level of need in Fife and provide support to people in care homes and their support staff.
People who acquire a sensory loss may find value in receiving counselling support. Likewise it is important that people receive information quickly to enable them to access the support and services they need.	Counselling along with appropriate information and support for people who become deaf or blind or deafblind, will be enhanced. Links between agencies and general publicity will be enhanced to increase awareness of the supports that are available.

I n v o l v e m e n t	
Awareness of sensory impairment issues is required in all service planning. It is vital that service users and carers are involved in planning at all levels.	The Fife Sensory Impairment Steering Group includes service users, carers and voluntary sector organisations. It will continue to promote fuller involvement in all aspects of service and capital planning. All Partner agencies involve service users and carers in service planning and capital developments. Processes are constantly being developed to ensure effective representation in planning. Fife Independent Disability Network is invited to comment on every new plan for a public building by Fife Council. Within NHS Fife the Disability Working Group support the Disability Equality Schemes and Action Plan.

Issues facing services for people with a sensory impairment.	How will the Partnership address these?
A c c e s s	
Access to services continues to be a problem for people. Awareness training has been developed and enhanced over recent years but more staff need to know about it and attend. Also, information, whether it is about services, health promotion or advice is often not available in all formats.	Access to services will be improved; this requires tailored resources and information to be developed with service users. The Partnership will continue to support staff to attend awareness training Communication is vital to enable access to assessment, diagnosis and appropriate support. The Partnership will continue to ensure that communication support is available to enable equal access. Insight has identified priority areas (Taybridge/Kirkcaldy East/Lochgelly) where local partnerships will be developed to raise awareness and improve locality-based work for people who have sight loss.
It is recognised that experience and new technology can highlight ways to improve how people access services.	Services will continue to review their processes to ensure that people are able to access the appropriate assessment and services as quickly as possible.
Related to this, there are gaps in the awareness of health and social care staff of the communication needs of people with a sensory loss and the services they can work with to aid communication. This can have a very positive impact on the support people receive when they are ill. Similarly there is a need for staff to be aware of the wider impact and implications of someone's sensory impairment on their health and involvement in the community.	The Partnership will work with staff to raise awareness of sensory loss and how to support independence and ongoing community involvement. This may also mean developing skills and ensuring staff are aware that an interpreter needs to be arranged for any health consultation. A number of developments are anticipated regarding remote access to interpretation services making use of new technology.
Services highlight a gap in provision for people with dual diagnosis. Where someone has dual sensory loss or a sensory loss and a physical health problem or disability, there are significant problems in getting appropriate support to enable them to fully access services.	The Single Shared Assessment looks at all the needs of the person and enables the assessor to work with colleagues across agencies to put all support and care arrangements in place. The Partnership will ensure that this continues to develop.

Issues facing services for people with a sensory impairment.	How will the Partnership address these?
Access	
A particular example relates to the high levels of sight loss amongst people who have a learning disability. Around 80% of people with a learning disability who have been assessed by the Royal National Institute for the Blind have some degree of sight loss. Many people with a learning disability live with undetected sight loss and may not have had an eye test due to various difficulties when attending a local optician, or lack of awareness about the prevalence of sight loss and the need for specialist assessment. However, if sight loss is identified and appropriately supported it can make a significant difference in day to day living.	The Partnership funds free assessments via Visual Impairment Learning Disability service; we will continue pursue the development of a routine referral route for assessment when a single shared assessment takes. Sensory impairment services work together to provide holistic assessment and support across the range of sensory impairments and communication difficulties.
In addition, there are concerns that there are a significant number of people who are not involved with services who could benefit from additional care along with social and economic support.	Multi agency networks are helping to develop links and enhance access across services. Likewise services and agencies will continually advertise to raise awareness of the issues and services that are available, through the likes of www.fifedirect.org, www.fiferights.org.uk, and www.nhsfife.scot.nhs.uk The Partnership is committed to increasing social inclusion.
The number of people with acquired dual sensory loss is not fully understood and there is a need to consider what resources would meet their needs effectively.	The review of Eyecare in Fife is examining the day to day support that is available, identifying any gaps and will consider how these can be addressed, to enable people to live independently and fully participate in their community.

The Fife Sensory Impairment Steering Group Action Plan for Services for people with sensory impairment includes the detailed planning for these measures, the Group reports into the Partnership Management Group via senior Operational Managers.

16 Services for people with a physical impairment

16.1 Services for people with a physical impairment are continuing to develop and provide personalised services based on the needs of the individual.

16.2 This section of the plan will be monitored and reviewed by the Partnership Management Group via senior operational managers.

16.3 The Special Needs Housing Strategy details the actions that will be carried forward to support advice and develop clear pathways for people requiring support and adapted accommodation. This strategy will be monitored and reviewed by the Housing and Communities Committee of Fife Council.

16.4 Medical advances and changes in lifestyle mean that people are living for longer with serious physical impairments and enjoying a higher quality of life. There is a large range of causes and types of physical impairment, for example in 2006 806 people in Fife had a stroke[16], this continues a downward trend, and the number of people who will survive a stroke continues to increase (7% increase in survival rates December 2005- Dec 2006). About 180 people in Fife have had a spinal cord injury[17] and 32 people in every 100,000 in Fife have had a major amputation[18].

16.5 What has the Partnership done to improve services for people with a physical impairment?

16.5.1 Some of the developments since the Extended Local Partnership Agreement 2005 and Joint Community Care Plan 2004-07 are:

Commitment	Action
• To improve services, improving access and opportunities for people with a physical impairment	• Housing Occupational Therapists now involved with medical student education to raise awareness of physical disabilities • Enhanced Occupational Therapy input to support access to adapted council housing • Partnership with Disabled Persons Housing Service and ownership options to promote Homestake grants enabling people to purchase appropriate housing via shared ownership • Fife Housing Register supports joint working and improves access to general health assessment including specailist functions

16.6 What resources are involved?

16.6.1 The 2007/08 financial resources committed to services for people who have a physical or sensory impairment are detailed at table 7. Adult service budgets in general do not record sensory and physical impairment expenditure separately which is why the budgets are shown together.

16.6.2 As noted in paragraph 7.5 there are a number of NHS Fife services which are vital components of the services provided for people with sensory or physical impairment which do not come within the Joint Resourcing Budget. The Partnership resources also include contributions to Voluntary sector organisations, for example Fife Society for the Blind.

[16] ISD: Stroke Incidence and Mortality 30/10/07
[17] Fife Non-Cancer Palliative Care Needs Assessment, May 2006
[18] Fife Public Health Dataset

Table 7

Physical / Sensory Impairment	NHS Fife £000's	Fife Council £000's	Total £000's
Care Packages	NHS resources in this area are not part of the Resourcing Budget	3,957	3,957
Deaf Communications Unit		183	183
Day Care		1,656	1,656
Direct Payments		1,328	1,328
Respite Care		960	960
Residential & Nursing Care		1,166	1,166
Adults Fieldwork Teams		742	742
TOTAL		**9,992**	**9,992**

Source: H&SCP JOINT RESOURCING BUDGET 2007/08 – Sept. 2007

16.6.3 In addition to the funding above homeowners who have a physical disability can access grants via Private Sector Housing Grant. The Partnership of Care and Repair/Social Work/Housing can assist people to access these funds.

16.7 Issues facing services for people with a physical impairment.

How will the Partnership address these?

Support	
The Partnership recognises that end of life support which gives people choice and control is important. The May 2006 Fife Non-Cancer Palliative Care Needs Assessment highlighted that 20% of people who die from non-malignant disease (about 550 people each year) have unmet needs for: symptom control; psychological support; family care; and communication with health professionals. Most people[19] would prefer to die at home, but 60% die in hospital (similar statistics for cancer and non-cancer patients).	The Partnership will work towards the provision of community based palliative care services for all diagnoses at the same level as is available for people with cancer.

[19] Fife Non-Cancer Palliative Care Needs Assessment, May 2006 (www.nhsfife.scot.nhs.uk/about_us/corporatedocuments.html)

Issues facing services for people with a physical impairment.	How will the Partnership address these?
Support	
The Delivery Framework for Adult Rehabilitation in Scotland[20] highlights some challenges for services. Particular challenges are noted in supporting those with multiple-long term conditions who wish to live independently in their own home. The consultation for this framework noted the need to improve access, availability, communication and co-ordination when the support / care people receive moves from hospital to community based services.	The Partnership will continue to work to improve communication and access for all service users, via training for staff and developing systems and materials with users, carers and specialist services. Services will, in partnership, consider the Framework for Adult Rehabilitation with service users and carers. There is a multi-agency steering group to support the implementation of the Framework, it will oversee the: ▪ appointment of the Fife Rehabilitation Co-ordinator; ▪ mapping of existing rehabilitation services within Fife; ▪ consideration of where these need to be improved and redesigned; ▪ collation of learning from Fife's existing good pathways to inform further developments and ensure a co-ordinated 'whole system' approach; ▪ discussion about developing the key worker / rehabilitation co-ordinator role, to enhance co-ordination of services for people not in hospital and promote the use of case management within the rehabilitation team; ▪ consideration of how to maximise the opportunities of anticipatory care and rehabilitation to avoid unnecessary admissions and institutional care; ▪ maximisation of opportunities for people to participate in community activities and employment.
There are concerns that there are a significant number of people who are not involved with services who could benefit from additional care, social and economic support.	The Partnership will undertake a needs assessment to identify people's needs, to support planning of services into the future.

[20] Co-ordinated, integrated and fir for purpose: A delivery framework for adult rehabilitation in Scotland. NHS Scotland Feb. 2007. http://www.scotland.gov.uk/Resource/Doc/166617/0045435.pdf

Issues facing services for people with a physical impairment.	**How will the Partnership address these?**
I n d e p e n d e n c e	
There are concerns that many people with ongoing needs do not access the support they could to help them regain both skills and functioning, and participate as fully as possible in their community.	The Consultant to Fife Rehabilitation Service is a member of the Managed Clinical Network for Acquired Brain Injury. The Partnership will consider the potential this has to ensure holistic support for people.
Early social support and advice can help prevent longer term problems, but there are few day support options for people who do not feel they need a day centre. This may lead to them losing contact with services. People want to be supported to lead as full a life as possible. This can include access to work and assisted programmes e.g. Job Centres+ pilots.	The Partnership is developing the services provided by Day Centres, moving towards individualised support that assists people to use mainstream community services.

A c c e s s	
People who have a physical disability may experience psychological problems which may include behavioural problems. Appropriate resources, including psychiatric support, for this aspect of people's care are required.	The Partnership will work with mental health services to support effective access to services.
Supporting carers and families is an important aspect of health and social care. The Partnership recognises that there are insufficient respite resources for people with a physical disability.	The Partnership will seek to identify the level of demand and the nature of resources required more effectively, then consider how to use available resources creatively to meet the needs of individuals.
Good discharge planning is important and the Partnership recognises the need to continually seek to improve discharge planning for people with a physical disability.	The Partnership will continue to work towards zero delayed discharges and to improve discharge planning.
Access to health promotion, routine health screening and Council services could be improved for people with physical impairment.	The Partnership will support services to work together to ensure equal access. For example; the Wellwoman service is reviewing how it can improve access and Fife Council's Access Strategy Group is considering how best to support access to Council Services.

Issues facing services for people with a physical impairment.	How will the Partnership address these?
Involvement	
Awareness of physical impairment issues is required in all service and capital planning. It is vital that service users and carers are involved in planning at all levels.	The Partnership will involve service users and carers in service planning. Processes are constantly being developed to ensure effective representation in planning. Fife Council invite Fife Independent Disability Network to comment on all plans for new public buildings; NHS Fife's Disability Working Group support the Disability Equality Schemes and Action Plan.
At home	
All services need to work together to ensure that people can quickly and easily access the support and adaptations they require to stay at home.	The Special Needs Housing Strategy will define how Fife will improve the way it offers advice, how people access assessment and support, to ensure that individuals have a sustainable housing solution.
As services develop people with more complex needs are able to be supported at home and more complex equipment is required. The joint Fife Community Equipment Service is finding its targets for delivery times increasingly challenging because of: increased demand; and a greater proportion of orders include larger pieces of equipment that need two people to deliver and take longer to install. Timely provision of equipment makes a significant impact on being able to support people at home.	The Community Equipment Service has appointed a member of staff to clinically prioritise referrals to ensure timely delivery that will help people remain at home. An additional van and driver are also in place. Staff and managers continue to review systems and process and consider funding implications.
Best Value	
Where longer term support is required, providing ongoing rehabilitation for people with a disability will have an inevitable impact on the case-loads of service providers, affecting the ability of services to respond within the resources available to them.	Work with the Community Health Partnerships to develop support for people with a long term condition will help services to consider: who requires their support; who would benefit from education to support their self care; and who could be better supported by other services.

The Action Plans of the Rehabilitation Framework Group, the Special Needs Housing Strategy and the Local Improvement Targets will contain the detailed action required to take forward this section of the plan these will be reviewed and monitored by NHS Fife Redesign Board, the Housing and Communities and the Partnership Management Group respectively.

17 Services for people with and affected by drug and alcohol dependency

17.1 The Fife Drug and Alcohol Action Team (DAAT) is a strategic partnership set up to deliver the Scottish Government's priorities in Fife related to the National Drug Strategy and National Plan for Action on Alcohol Problems, while taking local need into account. It also contributes to the achievement of the Fife Community Plan, particularly under the Healthier Fife and Stronger, Safer Communities themes. It co-ordinates the planning and commissioning of substance misuse services and encourages partnership working to provide accessible, equitable services across Fife.

17.2 DAAT reports through the Health and Social Care Partnership to Fife Council and NHS Fife and reports directly to the Scottish Government.

17.3 What has the Partnership done to improve services for people with and affected by drug and alcohol dependency?

17.4 Some of the developments since the Extended Local Partnership Agreement 2005 and Joint Community Care Plan 2004-07 are:

Commitment	Action
• Reduce the harm to children affected by parental substance misuse	• Development of joint Child Protection Committee (CPC)/DAAT Action Plan • DAAT Represented at CPC and its two sub committees • Established Specialist Community Midwife and Public Health Nurse post • Time 4 U works with children under 12
• Improve the integration of treatment and rehabilitation services	• Development of a Fife wide, community based rehabilitation service • A pathway for alcohol is being developed. Drugs services are working along this continuum already • Development of a Fife wide service for people who are homeless and experiencing substance misuse problems • Development of a new Prescribing and Rehabilitation Service • Appointment of Integration Manager
• Work to reduce binge drinking among young people	• Boozebusters and Blue Light discos in place • Investment to expand DELTA Fife wide and deliver substance misuse education to all primary and secondary schools.
• Develop alcohol treatment services	• Investment to expand NHS Community Alcohol Team Fife wide, and enhance work of specialist voluntary sector services • A new development has seen the appointment of two liaison nurses, one at each acute hospital site

17.5 What resources are involved?

17.5.1 The current committed resources for substance misuse are noted at table 8. These are the resources within the joint resourcing budget, other reported funding (including the funding in the table below) on Drugs and Alcohol services is circa £7.5million; of this £2.5million is influenced by the DAAT.

Table 8

Substance Misuse	**NHS Fife £000's**	**Fife Council £000's**	**Total £000's**
Mental Health: Addiction Services (*included in MH services above*)	*(2,733)*		
Substance misuse		519	519
Total		**519**	**519**

Source: H&SCP JOINT RESOURCING BUDGET 2007/08 – Sept. 2007

17.6 Issues facing services for people with and affected by drug and alcohol dependency.

Issues facing services for people with and affected by drug and alcohol dependency.	How will the Partnership address these?
Independence	
DAAT recognises the need for a continuum of services that start with prevention.	DAAT will continue to seek resources to support the development of prevention and deliver local elements of national programmes.

Involvement	
DAAT is seeking to identify an effective model for Service User involvement although much has been learned from a previous partnership arrangement with the Scottish Drugs Forum, a national organisation, which delivered user involvement in Fife. DAAT is actively working with partner agencies to identify and implement a model that would give service users a role in shaping future services.	Work to implement National Quality Standards is underway. This will involve consultation with all specialist services and users of services.

Issues facing services for people with and affected by drug and alcohol dependency.	How will the Partnership address these?
Support	
As table 9 below highlights, the number of new people accessing services because they have a substance misuse problem is growing year on year, with alcohol being a significant factor. Such increases are seen as a factor of success with more people being reached and finding it easier to access support. A Glasgow University study in 2004[21] found that the hidden population had decreased by 7% in the preceding two years. Services are now seeking to retain people's engagement and move away from a pattern of "chronic relapsing". This too has an impact on resources with people receiving support for longer periods. The range and variety of services has vastly improved in the preceding years, with a number of community-based services being developed and communication and referral between professionals/agencies improving. However, the resulting increase in demand means that waiting times for assessment and treatment have fluctuated and at times increased, although much effort has been expended to keep these to a minimum. A key achievement during 2006-07 saw increased accessibility to services with the target set to reduce waiting times being exceeded. DAAT, therefore, anticipates that the increasing demand on services will continue. This means that with greater demand on resources, maintaining recent reductions in waiting times will present a challenge to all partners.	NHS Fife is reviewing addiction services with a view to improving access. As part of this process NHS Addiction Services have been redesigned, with changes starting to take place in April 2007. This has already helped reduce waiting times and increased the number of people attending for initial assessment. The Scottish Government carried out a stock taking exercise of all DAATs early in 2007. Once available the national recommendations will be implemented locally. Internally Fife DAAT is reviewing services to gain a clearer picture of how effectively it is meeting the needs of those affected by substance misuse. This will help to define appropriate outcome measures and set strategic priorities for the next three years Similarly, the Scottish Government Updated Plan for Action on Alcohol Problems (February 2007) will inform Fife DAAT's review of the Fife Alcohol Strategy. The Scottish Government is developing new strategies for Drugs and Alcohol. These will be reflected in the DAAT Action Plan's over the period of this plan.

[21] Centre for Drug Misuse Research, University of Glasgow, Scottish Centre for Infection & Environmental Health Estimating the National & Local Prevalence of Problem Drug Misuse in Scotland, 11- 2004

Table 9: **People attending drug treatment services reporting alcohol as a problem drug: Fife 2001/02-2004/05**

	01/02	**02/03**	**03/04**	**04/05**
New individuals reporting illicit drug use	617	822	996	1025
Reporting alcohol as problem drug	53	76	135	149
Percent reporting alcohol locally	8.6	9.2	13.6	14.5
Percent reporting alcohol nationally	7.7	9.0	9.9	10.3

Source: Scottish Drug Misuse Database Alcohol Profile: Fife, ISD Scotland 2006

Issues facing services for people with and affected by drug and alcohol dependency.	**How will the Partnership address these?**
Access	
Given the higher risks for people with drug and alcohol problems; there is a need to fully understand the level of blood borne viruses in Fife and to work in partnership to provide effective support.	The DAAT will seek to work more closely with the range of partners who have lead responsibility for the blood borne virus work to meet the needs of those affected by blood borne viruses.
A number of geographical factors affect substance misuse services. Some teams work within defined geographical areas, leading to inequitable service provision and service users can find Fife wide services difficult to access where they need to travel to the service.	Many services are now providing locality based drop-in facilities. A "one stop shop"; where a number of services come together to deliver support from a base in Glenrothes, is being piloted. FIRST (Fife Intensive Rehabilitation Substance Misuse Team) provides community rehabilitation from 38 locations.
It is recognised that packages of care need to be more integrated.	Work is underway to develop care pathways in partnership.
Between 1999/00 and 2004/05 Fife saw a 6% increase in the number of alcohol related hospital discharges, (compared to a Scottish increase of 21%)[22]. While the rate for men remained static, the figure for women increased by 20%. As the number of people with alcohol problems increases, ensuring a range of services with enough capacity may become a challenge. Attitudes towards alcohol are very different from those related to illicit drugs. This has implications for services working with adults where there are children/vulnerable adults within the family in terms of greater assessment requirements, the need to act upon these and connections with other services.	Alcohol care pathways are being developed. A pilot scheme to make access to services easier is being undertaken. Clearer information for referrers and potential service users is being developed. The DAAT is refreshing the local alcohol strategy. The potential to agree a common specialist substance misuse assessment tool, to complement the Single Shared Assessment, is being explored. This will support access through onward referral to the most appropriate service following a single assessment.

[22] Alcohol Profile – Fife, ISD Scotland 2006

Issues facing services for people with and affected by drug and alcohol dependency.	How will the Partnership address these?
Streamline	
Communication between the DAAT and Community Health Partnerships (CHPs) is a challenge. This stems from organisational restructuring which all parties are aware of and seeking to address in terms of understanding, integration and data sharing.	The operational and strategic relationship between the DAAT and CHPs will be refined to continue to deliver improved joint services to the community.
A further challenge for services is that of gathering consistently reliable data on outcome measures, performance indicators and community based incidence and prevalence. Data collection and analysis is critical to the establishment of a robust and effective joint commissioning process.	DAAT will work with partners to identify local, available and robust data to inform the development of strategic direction and priorities.

At Home	
It has been recognised that a significant number of people with substance misuse problems can have a number of other difficulties, such as homelessness. This particular issue can lead to difficulties in accessing and maintaining contact with treatment services.	A specialist homeless service, to support service users with substance misuse problems has been developed. The new service aims to see 300 people each year and ensure rapid access to treatment services.

The DAAT Corporate Action Plan (www.drugmisuse.isdscotland.org) details the targets and related activities which will take forward these key actions. Action will be reviewed constantly by the DAAT, twice a year by the Partnership Management Group and annually by the Scottish Government.

Appendix 1: Fife's Health and Social Care Partnership role and remit

1 Role

1.1 The Fife Health & Social Care Partnership's responsibilities are:

- overview of strategy development
- overall responsibility for governance accountability for those resources contained within the joint resourcing arrangements.
- connecting the developing partnership strategy within the wider strategic contexts, e.g. Community Planning

1.2 The Fife Health & Social Care Partnership has delegated authority from both Fife Council and NHS Fife for the strategic management of those Community Care resources in the joint resourcing arrangements.

2 Remit

2.1 The remit of the Group is to:

- consider policy, strategy and resource issues, and make recommendations to the Partners
- approve the relevant joint resourcing arrangements and Joint Management Plans with associated financial frameworks and agreed timescales
- scrutinise these joint plans to ensure that they are integrated and reflect the policies and priorities of each of the partners
- monitor and review plans within agreed financial frameworks
- ensure that proper public consultation/involvement mechanisms are in place to support the joint governance arrangements
- receive and approve reports and agree those parts of the development and business plans for the Partners relating to the service
- give direction to the work of the Local Management Units through the agreed scheme of delegation for each partner organisation
- agree an Annual Report which will be scrutinised by Fife Council, NHS Fife and the Scottish Government
- ensure the delivery of best value
- agree the joint resourcing arrangements on an annual basis

3 Overarching Principles

3.1 Consistent with both the Extended Local Partnership Agreement (ELPA) and the Scheme of Establishment for Community Health Partnerships (CHPs), the key principles are:

- Aligned budget and management arrangements, working within a single system to jointly agreed objectives and priorities.
- Clear accountability to each of the two organisations for budget, staffing and operational matters.
- Locally responsive delivery arrangements within a consistent, Fife-wide framework.
- Governance arrangements aligned with the multi-agency Children's Services framework.

4 Membership

4.1 The Group operates on a concurrent committee basis with representation from seven Fife Council Councillors and seven NHS Fife Board members. In addition, the Staff Side Chair of the Joint Staff Partnership Forum attends these meetings. Changes in members within each of the current committees are agreed by the Accountable Organisation and do not constitute a change in the Minute of Agreement.

4.2 The membership of the Group is:

Fife Council

SNP: Two members
Lib. Democrats: Chair of Social Work & Health Committee
One further member
Labour: Two members
Independent: One member

NHS Fife

Chief Executive, NHS Fife
Chairs of CHPs
Director of Nursing Services, Fife Operational Division
Two CHP General Managers

Joint Staff Partnership Forum

Staff Side Chair

5 Chair

5.1 Chair of the Fife Health and Social Care Partnership will be rotated between Council and Health on an annual basis.

6 Frequency of Meetings

6.1 The Fife Health & Social Care Partnership will meet at least four times each year but may, when necessary, call an extraordinary meeting with the proviso that ten working days notice of such meetings will be given.

7 Minutes

7.1 Minutes are noted at the meetings of NHS Fife Board and Social Work and Health Committee, Fife Council.

Appendix 2: New National Outcome Measures

- % of users of community care services feeling safe
- % of users of community care services & carers satisfied with involvement in their health and social care packages
- % of users of community care services reporting satisfaction with the opportunities provided for meaningful social interaction
- % of user assessments of needs completed in accordance with agreed national standards
- % of carer assessments of needs completed in accordance with agreed national standards
- % of all adults with higher level of community care needs living in their own home (For 2007-08, target that by 2008 30% of older people with intensive care needs will receive those services at home)
- % of carers who feel supported and capable to continue in their role as a carer
- Shift in balance of care from 'institutional' to 'home based' care (Final measure to be determined)
- Reduce number of patients who's discharge is delayed by over six weeks to zero by April 2008
- Reduce number of patients, in short stay beds, whose discharge is delayed to zero by April 2008
- % of care plan reviews carried out within agreed timescale
- Number of people waiting for more than targeted time from referral to completion of assessment per 1,000 population
- Number of people waiting more than the targeted time for the delivery of community care services following an assessment per 1,000 population
- Reduce emergency in-patient days for older patients aged 65+ by 10% by 2008, compared with 2004/05
- Reduce number of older people aged 65+ admitted as an emergency two or more times in a year by 20% by 2008, compared with 2004/05
- Number of older people aged 65+ per 100,000 population with two or more emergency admissions in a year who have not had an assessment of their health and social care needs

Full details of the measures, the related targets and how they will demonstrate improved performance can be found at www.scotland.gov.uk/Topics/Health/care/JointFuture/NationalOutcomes.

Glossary

Advocacy	A support system for helping people to say what they need, to make choices and to make their own decisions.
Aligned budget and management model	Each partner is still responsible for setting its own budget, managing and reporting it, but we come together to agree how resources are used and managed.
CHPs	Community Health Partnerships (CHPs) were established in April 2005 and are responsible for the delivery of health services in local communities. CHPs are partnerships made up of health, local authority, voluntary sector organisations and members of the public. There are three within the Fife area - Glenrothes & North East Fife, Kirkcaldy & Levenmouth and Dunfermline & West Fife. Each CHP is also responsible for some Fife-wide services including Health Promotion, Mental Health, Well Woman and Family Planning Service.
Commissioning	Making the decision on what services are needed and then contracting with a statutory or voluntary organisation to provide them.
Delayed discharge.	A delayed discharge is experienced by a person in hospital who is clinically ready to move to the next stage of care but is prevented from doing so by one or more reasons for delay in discharge
Fife Community Planning Partnership	The Fife Partnership has lead responsibility for community planning in Fife, directs action and monitors progress toward achieving the Fife Community Plan. For more information click on link Community Planning Partnerships I Overview

Joint Governance Arrangements	An aligned budgetary model has been developed in Fife and a joint governance and accountability framework which includes Health, Social Work, Housing and Local Office Network. The framework is detailed in a 'Minute of Agreement' between Fife Council and Fife Health Board.
LMUs	Local Management Units manage jointly the community care services that are in the Joint Resourcing budget as well as others which would benefit from a joint approach. The LMU are also responsible for the co-ordination, planning and redesign of services and the development of these processes. There are 6 LMU's in Fife, 2 within each CHP area, reflecting the local geography and population needs.
Local Area Co-ordination	This is a model of service provision for people with a learning disability. Co-ordinators help people: access information, be involved in their community and support people to improve the quality of their life.
LTCs	Long Term Conditions. This is a health condition that a person will have for a long time, such as Asthma, Chronic Obstructive Pulmonary Disease, Diabetes, etc. People with an LTC may need different levels of support and this may vary over time.

Managed Clinical Network	MCNs fulfil a key role in bringing together patients and health professionals from all disciplines to plan services locally, based on local needs and priorities, but to nationally agreed standards. They also ensure traditional boundaries - primarily between GP-based and hospital services, are broken down so that patients receive integrated treatment and care based on their individual requirements - not based on buildings or organisations.
Neurological Vision Training	As a result of stroke or another Acquired Brain Injury (ABI) people may have neurological vision deficits. The programme objectives are to assess and train a person with Neurological Vision Impairment to maximise the use of their remaining vision and to become as independent as possible.
Palliative care	Holistic care for someone who is not going to get better.
Resources	The financial resources are the direct cost of service delivery – they do not include capital costs such as buildings.
Respite care	Respite care is available in health and social care settings and at home so that the patient and the carer can have a short break.
Section 26	Section 25-31 of the Mental Health (Care and Treatment)(Scotland) Act (2003) places duties on the Local Authorities with respect to the care, support, and the promotion of well-being and social development. It is often abbreviated to "section 26". Anyone who has, or has had a mental illness, personality disorder or learning disability, should be assisted by their local authority to lead lives as normal as possible. This means helping them to fulfil their ambitions in relation to their personal life, leisure, training and employment.
SPARRA	Scottish Patients At Risk of Re-Admission. This is a database that uses patient information to work out the risk that a person may be admitted to hospital again.
SSA	Single Shared Assessment. An assessment of a person's health and social care needs which is carried out by the first health or social care professional involved. Re-assessments will be undertaken as needs change.
Whole Systems	Whole systems means: • recognising the benefit of the wider picture of community planning that understands and knows the needs of the local community • recognising and maximising the contribution that can be made by partners through providing a range of services, both within and beyond the traditional boundaries of health, housing and social care • looking at things that impact, one upon the other

Contact details

You can find the plan, its summary and easy read version at:

http://www.fifedirect.org.uk/hscpplan

or

http://www.nhsfife.scot.nhs.uk/about_us/corporatedocuments.html

or

call 08451 55 55 55 extension 443 884.

Contact us to get copies in other formats or languages:

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