Joining Up Care
Consultation Summary

- Community Health & Wellbeing Hubs
- Out of Hours Urgent Care Re-design
- Community Hospital bed based care

This booklet sets out our suggestions of how Health and Social Care services could be improved for you and the communities of Fife. We want your views on these ideas and will listen to them before deciding how changes are made. Information on how to get this document in another format and contact details are on the back page.

NHS Fife
Supporting the people of Fife together
From the youngest to the oldest, the fittest to the frailest we want people to live well in Fife. Ensuring the right care, from the right person at the right time, in the right place is vital. Whether this is responding to a poorly child after the GP practice has closed, or providing complex round the clock, clinical care to those who are ill or are recovering from an injury.

We know people value their local services highly, but the challenges we will describe mean that doing nothing is not a safe, sustainable or responsible option.

Here in Fife, like the rest of Scotland, the systems of health and social care have evolved over the decades. Sometimes together, but often independently. Over this time the ageing population has grown significantly, people’s needs have become far more complex and the health care requirements of a modern society have shifted dramatically.

To meet these demands, we need to adapt how we do things and change ways of working that have been in place for decades. We need to join care across communities and hospital services so we can continue to respond to peoples’ physical, emotional and social needs – day and night. This includes peoples’ desire to stay independent and at home for as long as they can. We must also think of frontline staff and the increasing pressures they face and respond to this. All whilst being fully aware that different communities have different needs. The future of Fife’s integrated care involves all of us.

Since its launch in 2016, Fife’s Health and Social Care Partnership has developed many new initiatives to support independence, improve wellbeing and the care experience.

This has been as a result of listening and responding to the feedback from patients, service users, partners and staff.

By bringing together the review of out of hours urgent care, the development of community health and wellbeing hubs and community hospital re-design under one ‘Joining Up Care’ proposal, we will continue to work together to develop a comprehensive and steady approach to service development.

In this proposal we talk about ‘we’. The focus is on Fife’s community health and social care services and how they work together with:

- colleagues in acute, independent and voluntary sectors
- service users, patients, carers and the public of Fife

Before the Health and Social Care Partnership was established, we consulted extensively with the people of Fife to help us to put together our first Strategic Plan. This consultation continues that conversation about how we deliver support for you and the communities of Fife. We encourage as many voices as possible to be heard. You will help inform and shape the future of care in Fife now and for generations to come.

Thank you.
People’s needs vary and can increase or decrease over time, as shown in the diagram above.

New ways of working and re-arranging services means that:

- we can provide place based care so that services look after and focus on people in their community, rather than at a distance in a particular building.
- we can provide more proactive and earlier intervention to keep you and your family well for longer.
- we can reduce the need for hospital or social work support unless absolutely necessary.
- where needs are more complex and clinically time sensitive, we can respond more quickly to reduce deterioration and speed up access to specialist care.

The proposal in this document is set in three parts and the consultation period will take place from June – September 2018.
Part 1: Community Health and Wellbeing Hubs

Introduce more joined up ways of working between professionals to co-ordinate care and appointments, help reduce waiting times and improve the care experience through proactive support, working locally in communities.

Part 2: Out of Hours Urgent Care Redesign

When the GP surgery is closed, these are the services that see members of the public who need a GP or a nurse (advice, treatment centre care and home visits). As well as minor injury services and the evening and night District Nursing service. It is important to state, that this is not Accident and Emergency at the hospital.

There are two options being proposed for the future of out of hours urgent care and these are discussed in Part 2.

Part 3: Community Hospital redesign

At this stage, we are asking for your feedback on the idea of developing a ‘pool’ of beds across Fife that can be used to support early intervention and wellbeing. For example after a fall at home, or a stay in hospital you may need a little help to return home. To do this you could spend some time in a care home setting where a team will work with you to re-gain your skills, confidence and strength. The aim is to:

• Support you to safely return home earlier
• Support you at home or in a homely setting (care home) near to your home
• Focus the use of Community Hospital beds on people with very complex health conditions who need round the clock nursing and medical care.

Your feedback during this stage of the Joining Up Care Consultation will inform future decisions on the type, number and location of community beds in future. This will be developed into a detailed proposal for public consultation later this year.

For more information visit www.fifehealthandsocialcare.org
For sustainable, safe and seamless journeys of care to be achieved, all three parts must work together.

Multi-agency team working will mean people can work together to get you and your family the right care, at the right time, in the right place – day or night.

Initially the work to develop community health and wellbeing hubs will target people who are frail or have age related conditions and are at most risk of decline. Through prevention and early intervention our aim is to improve their health and wellbeing, keeping people independent for longer.

Now you have an overview, the remainder of this document explains these proposals and the reasons for change in more detail. Please read this before completing the questionnaire.

The full Joining Up Care Proposal is broken into chapters of detailed information which you many find useful and is available online at www.fifehealthandsocialcare.org/joiningupcare

To request a copy of this summary or the full proposal, please call 01383 565 199 (calls to this number are charged at local rate) or email fife-uhb.joiningupcare@nhs.net
Local and national challenges

Like all other Partnerships nationally, Fife has to deal with:

- Fewer GPs and nurses to deliver services
- Rapidly increasing demand for services
- A population who are living longer but who have multiple conditions.
- Outdated ways of working
- Finite resources

These are having an impact on our current health and social care system in Fife which is in need of modernisation to meet demand.

Life expectancy at 65 in Fife

- 17.7 years
- 20.1 years

Number of Long term conditions by age in Fife

- 65-84 years old: 36%
- 1-2: 58%
- 3+: 66%
- 85+ years old: 12%
- 0: 12%
- 3+: 22%

The vision

We want our health and social care system to be:

- Easy to access and use
- Clinically effective
- Joined up
- Fit for the future

For more information visit www.fifehealthandsocialcare.org
1. Community Health and Wellbeing Hubs – let’s make it local

Current Challenges

At the moment if you need support in the community you may be referred to one team, they may work with you for some time and then suggest that another team could help you. We want to stop this disjointed way of working and work with people earlier to promote wellbeing and independence for longer.

How can we change?

To manage care across the Kingdom, Fife is organised into seven locality areas. The Partnership is proposing to develop seven Community Health and Wellbeing Assessment Hubs, one for each area:

- Dunfermline
- West Fife
- Levenmouth
- Glenrothes
- North East Fife
- Cowdenbeath/Lochgelly
- Kirkcaldy

Community Health and Wellbeing Hubs will be centres of activity where teams gather and work from. Some of the larger hubs will provide access to complex assessment and diagnostic services. No one-size fits all, so each will be developed with local teams in response to local needs. For example, a hub could be in a local community facility or it could be in a local hospital if there is a requirement to co-ordinate more complex care needs.

For the West and North East Fife areas, we would respond to the rural and local needs by having a mobile model where the teams travel around and provide the hub from different places on different days.

How can teams work differently within each locality?

To improve communication and co-ordination, professionals working within each local area will get together to jointly review what the best clinical or social care options for you are. These multi-agency meetings, known as huddles could include local health and social care professionals such as nurses, social workers, GPs, mental health staff or Occupational Therapists.

Round the table the team will consider what support is available locally, including in the voluntary and independent sectors. Importantly, everything will be discussed and agreed with you to ensure your goals and what matters to you remains the focus.

Huddle is a common term across industry and care. Huddles enable teams to have frequent but short briefings so that they can stay informed, review work, make plans, and move ahead rapidly.
What if my needs are more complex?

The goal is a health and social care model that works in partnership with you. The aim will be to understand what matters to you, agree what your goals are and who will work with you to meet these.

If you have significant health and social care needs or there are a number of professionals involved, one of the team will agree to act as the ‘lead professional’. This means they will work in partnership with you to co-ordinate your care and support you to ensure that the outcomes that you have agreed are being met.

The aim is to:
- Identify and support people earlier
- Put in place services that can respond more effectively day and night
- Help local professionals share appropriate information more easily and safely
- Make best use of local skills, knowledge and experience
- Link people with local support networks and services
- Reduce waiting times, frustration, and duplication.

Locality huddle
Includes a variety of professionals including Social Work, Community Nursing, GP, Mental Health and the Voluntary & Independent Sector with meeting frequency agreed by local teams

Care Partnership
May agree a case manager
Agrees who will take forward any actions agreed and who will liaise with you
Agrees support suggestions for you
Identifies if you may need assessment and diagnosis at the Community Hub

For more information visit www.fifehealthandsocialcare.org
How do you know this approach could work?

We empowered teams to try it. Here’s *Mary’s story:

Mary is an 85 year old lady with progressive lung disease. Mary has regular contact with the district nurse who observed that her mood was low and that she was declining her family’s offer to take her out at the weekends to visit family, claiming that “it feels just too much of an effort”.

Mary also reported that her personal care activities were becoming too difficult and asked about homecare. The District Nurse presented Mary’s situation at the local multi-agency team huddle. After discussion, it was agreed to try a social care approach rather than a traditional medical approach to Mary’s situation.

Although Mary was not keen on a “stranger coming into her home”, she agreed to try a befriender. This was positive and Mary found that she enjoyed the regular contact and her mood improved considerably. Four weeks later, she agreed to think about going out to a local community facility.

*not her real name

Through this consultation our aim is to develop this approach across Fife

Importantly, the Community Health and Wellbeing Hubs approach could work to serve local need not only during the day but, will help to improve the response to urgent care situations in the evening, weekends and public holidays, supporting Fife’s Out of Hours Urgent Care.

How can this happen?

We want to develop the Single Point of Access (SPOA) for teams, so they can better co-ordinate your access to services day and night. For example your GP can make one call and know that the right people to support your needs will be contacted and arrangements followed up, whether the information is passed during the day or overnight. Health and social care teams will be able to share appropriate information more easily. This will help to identify when people need support earlier.
Out of Hours Urgent Care is care in the community that needs a response before the next routine care service (e.g. GP, District Nurse) is available.

It is not emergency care requiring an immediate response.

The services providing out of hours urgent care are:

• The Primary Care Emergency Service (PCES) - GP and nursing care when your own GP is closed (6pm to 8am during the week, 24hours at weekends and public holidays). This service includes advice, treatment centre care and home visits. It is accessed via NHS 24 with NHS Fife’s Dispatch Hub in Glenrothes directing where patients, both children and adults, should be seen so they get the right care, by the right person, at the right time.

• Minor Injury services delivered in the out of hours period (evening, overnight and weekends)

• Evening, night and weekend district nursing.

Current Challenges

• Activity levels vary greatly across centres but all are staffed in the same way

• Lack of flexibility for staff to move across and within centres to meet need

• People presenting who need to see a specialist and have to be moved to an acute hospital

• Our working arrangements are complex and inefficient

• Out of hours home visits cannot be sustained in the face of anticipated demand for over 75s to be treated to home

• Clinicians recommend that children, who may become very unwell quickly, are seen in a centre with direct access to specialist support. While 95% of children’s contacts are centre appointments, overnight this is not beside specialist support. The reason for this is that the PCES centre at the Victoria Hospital is not open overnight.

2. Out of Hours Urgent Care Redesign – responding to needs round the clock

Evening 6pm - midnight • Overnight midnight - 8am • Weekend Day 8am - midnight • Weekend 24 Fri 6pm - Mon 8am

Public holidays as per weekend arrangements
In common with other parts of Scotland, our services are under constant pressure. This is having an impact on our out of hours services where the current system is experiencing:

- Reducing numbers of GPs and Nurses available to work evenings, holidays and weekends. In April 2018, 51% of overnight GP sessions were vacant
- Increases in people attending at some centres with very low attendance at others
- Clinical and professional skills being spread across four centres meaning team working is not being maximised and is an inefficient use of resources
- Inability to ensure a safe level of response for the public if the model continues in its current shape

Our priority is to provide the people of Fife with a safe, person-centred and effective Urgent Care out-of-hours service that best meets their needs. It is simply no longer possible to do that without making changes to the existing service model.

How can this change?

There are two options being proposed, each taking into account clinical safety, transport and workforce challenges.

The quickest appointment anyone would be offered for an out of hours GP appointment is one hour. 94% of people currently drive or are driven to centres.

The urgent care centre options proposed are all within a one hour drive for all Fife communities. We will develop a procedure to support people to have equal access in line with other areas of Scotland.

Each proposal consists of the following:

- **The Urgent Care Resource Hub** will be an area where staff from a number of health and social care urgent services work together to coordinate service delivery. It will direct how services work in the out of hours period to make best use of resources according to need.
- **Urgent Care Centre(s)** will deliver the range of urgent clinical care to their communities. They will be a safe venue that can be accessed by the public, located to make the best use of available staffing.

### In 2016/17 people accessed PCES as follows (excluding 7,000+ advice calls)

<table>
<thead>
<tr>
<th></th>
<th>Daytime 8am to 6pm</th>
<th>Evening 6pm to Midnight</th>
<th>Overnight Midnight to 8am</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Treatment Centres</strong></td>
<td>4 centres 147.1 (range 92-226)</td>
<td>4 centres 44.2 (range 22-71)</td>
<td>3 centres 10.6 (range 1-32)</td>
</tr>
<tr>
<td><strong>Home Visits</strong></td>
<td>3-6cars 46.3 (range 10-85)</td>
<td>3-4cars 11.7 (range 3-28)</td>
<td>3 cars 5.4 (range 0-19)</td>
</tr>
</tbody>
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For more information visit [www.fifehealthandsocialcare.org](http://www.fifehealthandsocialcare.org)
Option 1

• A clinically led Urgent Care Resource Hub which will link with the day time Community Health and Wellbeing Hubs’ Single Point of Access (SPOA)

• Two Urgent Care Centres open in the evenings, weekends and public holidays based at the Victoria and the Queen Margaret Hospitals

• One Urgent Care Centre open overnight based at the Victoria Hospital

• Home visits by staff based in cars, with capacity to provide additional support from centre based teams – with 2 car based clinicians overnight

This option would:

• Make the treatment centres work more efficiently to provide flexibility to meet demand at busiest periods

• Provide capacity for:

<table>
<thead>
<tr>
<th></th>
<th>Evenings, Weekends and Public Holidays</th>
<th>Overnight</th>
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<tbody>
<tr>
<td>Treatment Centre appointments</td>
<td>138,580</td>
<td>29,120</td>
</tr>
<tr>
<td>Home visits</td>
<td>13,689</td>
<td>6,552</td>
</tr>
<tr>
<td>Advice calls</td>
<td>10,176</td>
<td>4,368</td>
</tr>
</tbody>
</table>

Compared to the current model this would mean capacity for:

• 9% more home visits at weekends, evenings and public holidays

• 300% more home visits overnight

• 12% more advice calls at weekends, evenings and public holidays and 33% more overnight.
Option 2

- A clinically led Urgent Care Resource Hub which will link with the day time Community Health and Wellbeing Hubs’ Single Point of Access (SPOA)

- Two Urgent Care Centres open in the evenings, weekends, public holidays based at the Victoria and the Queen Margaret Hospitals

- Two Urgent Care Centres open overnight based at the Victoria and Queen Margaret Hospitals

- Home visits by staff based in cars, with capacity to provide additional support from centre based teams. Overnight this option would have a mix of 1 car based clinician and another clinician covering both a centre and home visits.

This option would:

- Make the treatment centres work more efficiently to provide flexibility to meet demand at busiest periods

- This option would provide capacity for:

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</tr>
<tr>
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<td>10,176</td>
<td>3,276</td>
</tr>
</tbody>
</table>

Compared to the current model this would mean capacity for:

- 9% more home visits at weekends, evenings and public holidays
- 200% more home visits overnight
- 12% more advice calls at weekends, evenings and public holidays, with no additional capacity overnight.
We are continually developing and improving our services. This has included testing new specialist roles such as Advanced Nurse and Specialist Paramedic Practitioners.

We know that by working from fewer centres we will be able to use these and other roles to better support people in the out of hours period.

Although we would have fewer centres our workforce would be more flexible and have the support of a wider team, with simpler access to specialist services.

What could this mean for you?

Both options will simplify care pathways.

With each of the options the aim is to:

• ensure that if you need to attend for an appointment you can access an urgent care centre within a maximum of a one hour drive from anywhere in Fife
• get access to advice more quickly
• ensure we can meet the expected increase in demand for home visits required for the ageing population
• give you access to a team that has more specialist resources within it and improved pathways with other specialist teams, for example hospital specialist, mental health and district nursing.
3. Community Hospital bed based care

What happens at the moment?

In 2017, 2804 people were cared for in community hospitals across Fife:

- St Andrew’s Community Hospital
- Adamson Community Hospital
- Cameron Community Hospital
- Randolph Wemyss Community Hospital
- Glenrothes Community Hospital
- Queen Margaret, Community Hospital

Their average age was 82 years.

Current Challenges

- At any one time, around a third of people in our community hospitals could be discharged from hospital care most of whom are waiting for a different type of care package at home or in a care facility.
- We need to shift focus from our hospitals to support people’s wish to stay at home or near to home.
- Some of our community hospital buildings are old and will not be fit for purpose in the longer term.
- We need to respond to the growing and ageing population now.
- Over the course of the last two years, new community-based services have been developed that are working with people who have not been well or have had an injury, to help them regain their skills and strength. This early support is being provided either at home, in a care home or in a community hospital bed depending on each person’s condition and needs.

This way of working is helping to avoid unnecessary admissions directly to the acute hospital in Kirkcaldy and is keeping people safe, well and independent for longer.
How could we change?

Looking at a map of the different beds with care across Fife, we are not always providing care in the right places to enable people to have equal access to the right type of beds that would meet their needs.

Our new models of bed based care include:

- **36 Short Term Assessment and Reablement (STAR) beds in three care homes located in Kirkcaldy, Cowdenbeath and Glenrothes.** STAR beds provide residents with encouragement, support, and the skills for independence needed to enable them to return home or stay in their own home by offering tailored support in a care home for a short period of time, usually around six weeks.

- **Eight care homes provide 49 assessment beds located in Cellardyke, Cowdenbeath, Kinglassie, Newburgh, Glenrothes, Kirkcaldy, Cluny and Kelty.** Assessment beds are a new concept designed to support people to leave hospital and finalise their long term care needs assessment with their families. These are set within care homes across Fife.
This proposal sets out the need to:

- move some of our resources from hospitals to community based teams.
- review the community hospital estate to ensure that it is sustainable and is fit for purpose to meet growing demand and changing population need.
- review how and where we deliver the different types of care within community hospitals. This could include facilities for those recovering from a stroke through to people who require long term hospital care.

Investing in care in people’s homes or near to home will enable us to reduce our bed-based care in community hospitals, to continue to develop the range of settings within which people can get the support of they need.

What if my care needs are more complex?

We know some people who are recovering from illness or injury will still need more care than we can safely provide at home or within a care facility. Under our proposal there will be sufficient community hospital beds for those people requiring:

- Specialist rehabilitation beds - hospital beds with nursing care, medical review and specialist therapy
- Neurological rehabilitation beds – hospital beds with nursing care, medical review and specialist therapy for people who have had a stroke, have a neurological condition or have suffered a brain injury
- People who require complex clinical care whose needs can only be met in a hospital (known as hospital based complex clinical care)

How do you know it could work?

Here’s *Emily’s story:

Emily came to the STAR Unit from hospital where she had been admitted with some dizziness, risk of falling and nutritional issues. She is in her nineties, lives alone at home, supported by her two daughters and had no services other than a wrist-worn falls detector. Emily’s daughters noted that they had potentially been ‘taking over’ and that their mum was capable of more than they had thought. After a short stay in the STAR unit Emily returned home with a support plan in place to continue to live as independently as possible in her own home.

*not her real name
This is the beginning of a conversation. We are asking you for your views on how we can work with you, families and your representatives to develop new ways of working so people get the right care, at the right time, in the right place.

Where can I get more information about this consultation?

To find out more information about the full proposal, please call 01383 565 199 (calls to this number are charged at local rate) or email fife-uhb.joiningupcare@nhs.net.

Or go to our website at www.healthandsocialcare.org/joiningupcare

How can I give my views?

1) Complete the on-line version of the consultation questionnaire at www.fifehealthandsocialcare.org/joiningupcare

2) Request a printed copy of the Joining Up Care consultation pack, which includes a FREEPOST envelope.

3) Share your views in person by attending one of our road shows/public meetings. These will be promoted through local press, social media (@joiningupcare) and online at www.fifehealthandsocialcare.org/joiningupcare

What happens next?

Following the consultation we will gather all the feedback received and the Partnership Board will consider this at its meeting in October 2018.
**Glossary**

**Acute Care** - Is a branch of health care where people receive active but short term treatment for a severe injury or episode or illness, an urgent medical condition or during recovery from surgery. Acute care is generally provided in a formal hospital setting.

**Anticipatory Care** - Anticipatory care encourages people to make positive choices about what they should do themselves, and from whom they should seek support, in the event of a flare up or deterioration in their condition, or in the event of a carer crisis.

**Assessment beds**

**Avoidable admissions** - An admission to a bed that may be regarded as unnecessary had other more appropriate services available.

**Care pathways** - To improve the person-centred nature of care service planners now try to understand how patients experience their care from prevention, to diagnosis and assessment, to treatment and where appropriate, to palliative care. This normally involves mapping the journey and the experience using a range of techniques with patients, clinicians, and managers. They describe this journey as a care pathway. Their aim is to improve the flow of patients along this pathway by reducing inefficiencies and improving reliability.

**Clinically Led** - Decisions about resource allocation are taken by a clinician locally, who has knowledge of the resource available within each locality.

**Community Health and Wellbeing Hubs** - The vision for future includes the introduction of Community Health and Wellbeing Hubs – these will be centres of activity where teams gather and work from, with some larger hubs providing access to complex assessment and diagnostics. The Hub teams will work as part of a wider locality with their colleagues providing the right level of assessment and care in the right setting, including responding to urgent care situations in the evening, weekends and public holidays.

The hubs will support existing services such as General Practice but they will also offer enhanced services in the community. Examples of this might include diagnostics, Occupational Therapy and Physiotherapy. They will also link to social care and third sector services. This will make it possible to offer joined up services, agreeing tailored pathways of support, accessible via a single point of contact.

**Emergency Department (Accident and Emergency)** - The Emergency Department is open 24 hours a day, 7 days a week is based at the Victoria Hospital. The Emergency Department, formerly known as ‘Accident & Emergency (A&E)’, provide care for Adults and Children who show the symptoms of serious illness or are badly injured. Although technically A&E is not an urgent care service and is an emergency service it is important to look at the pressures A&E face and how urgent and emergency services work together to ensure people are seen by the right service.
**Hospital at Home (H@H)** - H@H is a consultant-led service provided for people predominantly over 75, to prevent acute hospital admission or enable earlier discharge where an acute hospital admission has taken place. If house-bound, under 75s may be accepted in certain circumstances, e.g., those with frailty due to long-term conditions.

**Hospital Based Complex Clinical Care** - Hospital Based Complex Clinical Care is based around a single eligibility question: ‘Can the individual’s care needs be properly met in any setting other than a hospital?’ A patient is defined as receiving HBCCC if they cannot have their care needs met in any setting other than hospital and require long-term complex clinical care.

**Huddle** - Huddles are short, regular meetings in which a ‘team’ reviews people’s care and support needs. They are short, enabling a team to anticipate care needs and special situations, so that members of the care team can work together to maximise support to the person. The most effective huddles involve some preparation in advance. Used in a range of health situations but also in a wide range of sectors.

**Integrated Joint Board** - The Partnership has an Integration Joint Board (IJB) with legal responsibility for services delegated to it. The Integration Joint Board is fully responsible for:

- Overseeing the development and preparation of the Strategic Plan for services delegated to it.
- Allocating resources in accordance with the Strategic Plan.
- Ensuring that the national and local Health and Wellbeing Outcomes are met.

**Intermediate Care** - Also known as step up, step down and transitional care – this is care for people who are medically stable but still need temporary care in a community bed or home-care for recovery and rehabilitation.

**Locality** - The legislation behind Health and Social Care Partnerships (the Public Bodies (Joint Working) (Scotland) Act 2014) requires each integration authority to establish at least two localities. This aims to provide an organisational mechanism for local leadership of service planning, to be fed upwards into the integration authority’s strategic commissioning plan. Localities are intended to have real influence on how resources are spent in their area.

Fife has agreed seven localities – these are Kirkcaldy, Levenmouth, Glenrothes, North East Fife, South West Fife, Cowdenbeath and Dunfermline.

**Minor Injuries Unit** - Minor Injury Units provide treatment for a range of minor or less serious injuries, such as joint or skin injuries, cuts and wounds which may need dressing and stitches, head and neck injuries in people who are fully conscious. Minor Injury Units do not treat illness a GP would normally see or illness/injury requiring an emergency response. – greater detail can be found at appendix 5 of the proposal.

**Morbidity** - Morbidity refers to the level of illness of the individual or population.
Non clinical dispatch - Administrative staff are contacted when someone needs a local service after they have spoken to NHS 24. The team then make the arrangements for the local delivery of advice calls, treatment centre appointments and home visits by local clinicians. NHS 24 will put the call through to the NHS Board that will provide the service – e.g. people may request Tayside because they live in Taybridge Head and people on holiday in Fife from other areas would request Fife.

Out of Hours - This describes the period when general practice services are normally closed. By regulation, general medical (GP) services** are provided between 08.00 and 18.00, Monday to Friday, out of hours provision often starts at 18.00.

**As defined by the National Health Service: General Medical Services Contract Scotland Regulations, 2004.

Pathways - Care pathways, clinical pathways, critical pathways, care paths, integrated care pathways, case management plans, clinical care pathways or care maps, are used to systematically plan and follow up a focused patient or client care programme. They are a way of setting out a process of best practice to be followed in the treatment of a patient or client with a particular condition or with particular needs.

Point of Care - Is clinical diagnostic testing at or near the point of care. That is at the time and place of patient care

Primary Care - Primary care is the first point of contact with the NHS. This includes contact with community based services such as General Practitioners (GPs) or Community Nurses. It can also be with Allied Health Professionals such as Physiotherapists and Occupational Therapists, Midwives and Pharmacists. Primary care provides access to other care when it is required and links to ongoing care in the community and continuity of relationships, where this is required. Primary care services covers: primary care mental health, dental services, community pharmacies and optometrists.

Primary Care Emergency Service (PCES) - PCES provides out of hours (when your GP practice is closed) GP services. This includes Treatment centre appointments, advice calls and home visits. For example a child with severe ear ache over night, you would call NHS 24 on 111 and following a triage discussion PCES would be in touch to make arrangements with you.

PCES has a support office for the daily operational delivery of support services and during the out of hours period a control centre takes calls from NHS 24 and dispatch the call to the relevant profession/centre. There are 4 centres across Fife – greater detail can be found at appendix 5 of the proposal.

Reablement - Is about giving people the opportunity and the confidence to regain/relearn some of the skills they may have lost as a result of poor health, disability, impairment or entry into a hospital or residential care. As well as regaining skill, reablement supports service users to gain new skills to help them maintain their independence.
**Rehabilitation** - Is the process of helping a person to achieve the highest level of function through guidance and therapy after illness or injury.

**Workforce** - By workforce we mean all professions and roles within the health and social care system, including independent contractors e.g. GPs, Community Pharmacists, Care Home Providers etc. This encompasses homecare, social worker, ancillary staff, allied health professionals, nurses and doctors.

**ACP** - Anticipatory Care Planning is a voluntary process of discussion about future care between an individual and their care providers, irrespective of discipline. It is recommended that, with the individual’s agreement, this discussion is documented, regularly reviewed and updated, and communicated to key people involved in their care.

**ANP** - Advanced Nurse Practitioner – senior nurse trained in a speciality to work autonomously. The ANP’s role includes assessing the patient, making differential diagnosis and ordering relevant investigations, providing treatment (including prescribing) and admitting/discharging patients.

**CHWH** - Community Health and Wellbeing Hub

**CSW** - Clinical Support Worker – staff who carry out personal care duties for people in support of the registered staff where appropriate.

**ED** - Emergency Department (previously A&E – Accident & Emergency)

**eHealth** - Electronic enabled health care and advice

**ENP** - Emergency Nurse Practitioner – senior nurses trained in minor injury

**GP** - General Practitioner

**H@H** - Hospital at Home

**HHG** - High Health Gain – people with ‘high health gain’ potential, those who are most likely to benefit from a proactive, multidisciplinary approach and anticipatory care planning in primary care. A predictive tool has been developed by Information Services Division (ISD) of NHS, National Services Scotland, data is shared quarterly with GP practices.

**MIU** - Minor Injuries Unit

**PCES** - Primary Care Emergency Service

**SPOA** - Single Point of Access

**SPP** - Specialist Paramedic Practitioner – paramedic trained to advanced practice level, working autonomously trained in minor illness and minor injury

**STAR** - Short Term Assessment and Reablement - bed based care within care homes, medical overview from GPs

**START** - Short Term Assessment and Review Team - intensive enablement support

**UCP** - Urgent Care Practitioner – senior nurses trained in minor illness
Alternative Formats

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

Language lines

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