

Your Views Matter



**Fife Health
& Social Care
Partnership**



Joining Up Care Consultation Summary

For consultation

- **Community Health & Wellbeing Hubs**
- **Out of Hours Urgent Care Redesign**
- **Community Hospital and Intermediate Care Bed Redesign**

Thank you to all the staff and members of the public who have been involved in developing these proposals.

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.

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Foreword

This consultation document sets out some realistic, practical options for change.

From the youngest to the oldest, the fittest to the frailest we want people to live well in Fife.

The aim is to join up services to provide better experiences of care, especially for people with long-term conditions and disabilities, many of whom are older people.

We've already developed many new ways to support independence, improve wellbeing and care. We've listened and responded to the feedback from patients, service users, partner services and staff.

We know you value your local services and may be concerned about change, but we believe that doing nothing to change our service isn't safe, sustainable or responsible.

So it's time for us to change.

This is the beginning of a conversation. We're asking for your views on how we can work with you, your families and your representatives to develop new ways of working so people get the right care, at the right time, in the right place.

Our focus for change is how Fife's community health and social care services work together and also with:

- Doctors, hospitals, the independent sector (for example home care organisations), community and voluntary sectors
- Service users, patients, carers and the public of Fife

Before we were set up, Fife Council and NHS Fife consulted widely with the people of Fife to help us to put together our first Strategic Plan (available online at www.fifehealthandsocialcare.org). This consultation continues that approach to understand your views about how we deliver support for you and the communities of Fife.

We want to encourage as many voices as possible to be heard. You can help shape the future of care in Fife now and for generations to come.

Thank you.



Michael Kellet
Director, Fife Health
& Social Care
Partnership



Simon Little
Chair, Fife Health
and Social Care
Partnership Board

Why we are consulting

What this booklet is about and why it's important

We are the Fife Health and Social Care Partnership. Set up in April 2016 we bring together a wide range of services from NHS Fife and Fife Council's Social Work Services (Adults & Older People). More information can be found online at www.fifehealthandsocialcare.org.

We need to change the way we provide health and social care services in Fife. We need to do this because people's needs are changing, and we must change to make sure we meet their needs.

To help us decide what will work best here in Fife, we've produced a new proposal for how we deliver services. This is called our Joining Up Care proposal, and it has three parts.

This booklet describes these three parts and the benefits we think they'll bring. It summarises a more detailed document that we've produced, available from www.fifehealthandsocialcare.org/joiningupcare or by calling 01383 565 199 or 01592 226859 or emailing fife-uhb.joiningupcare@nhs.net.

Why we need to change the way we provide services

Here in Fife, like the rest of Scotland, the systems of health and social care have evolved over the decades.

People are living longer and this means we now have more very old people, some of whom have more complex health and social care needs.

To meet these demands, we need to adapt how we do things and change our ways of working.

We simply can't stay the same.

We need to join care across communities and hospital services. This will allow us to continue to respond to people's physical, emotional and social needs – day and night. This includes people's wish to stay independent and at home for as long as they can.

We know that what will work for some people may not be ideal for others. So we know we don't have an easy job in front of us.

But our job is to make sure you get the right care, from the right person at the right time, in the right place. Whether your child is sick and you need some medical advice after the GP practice has closed, or you, or someone you care for, is ill or recovering from an injury and needs round the clock care.

We must also listen and respond to our own members of staff and the increasing pressures they face. We're fully aware that different communities have different needs.

The future of Fife's integrated care involves all of us.

What we need from you

We now want your views on the three parts:

- 1. Community Health and Wellbeing Hubs** (pages 11 to 14): a more joined up approach to your care
- 2. Out of Hours Urgent Care Redesign** (pages 15 to 22): a more sustainable way of responding out of hours
- 3. Community Hospital and Intermediate Care Bed Redesign** (pages 23 to 26): Helping people stay independent for longer and avoid hospital admissions

We outline and explain these three parts in this booklet. Once you know more about our proposals, we're asking you to complete a questionnaire to tell us your views.

You can find out more about all the ways you can tell us your views at the end of this booklet. And we can provide this summary document in another format or language if you need us to.

**You can tell us your views from
2nd July to 8th October 2018.**

What happens once we've consulted?

We'll gather all the feedback we receive and review it at our meeting towards the end of 2018.

We'll take your views into account before we make any final decisions about how we provide health and social care in Fife.

Your views will help us make the right decisions for you, the community where you live, and for people across Fife.

If you'd like a copy of this booklet, the easy read version or our full proposal:

- call us on **01383 565 199** or **01592 226 859**
- email us at **fife-uhb.joiningupcare@nhs.net**
- go to our website at **www.fifehelthandsocialcare.org/joiningupcare** (where you will also find videos which help describe this proposal)

Thank you for helping us join up care in Fife

Why we need to change the way we provide health and social care services

People's needs change over time. Figure 1 shows how this happens.

Our goal is to:

- Support people as much as possible to stay well and live at home, at the lower level needs end of the scale
- Know people and how their needs are changing so we can support them earlier, before they need care at the complex needs end of the scale

But to do this we need to change how we work. There are many benefits of working in new ways. Here are just some of them:

- Provide care so that services look after and focus on people in their community
- Provide support earlier to keep you and your family well for longer
- Reduce the need for hospital or social work support unless it's absolutely necessary
- If your needs are more complicated and need a quick response, speed up access to specialist care by working in a different way to reduce the risk of things getting worse
- Make it easier for people to access the right support at the right time



Figure 1

<p>Prevention</p>	<ul style="list-style-type: none"> • Where you eat and drink sensibly • Increase exercise and reduce smoking • Take part in health screening programmes • Have a community alarm
<p>Self Care</p>	<ul style="list-style-type: none"> • When you manage your own care for example a personal asthma plan drawn up with your Practice Nurse or GP. • Have regular check-ups with Community Opticians, Dentists or seek advice from the Pharmacist for medicines you can buy.
<p>Support to access community</p>	<ul style="list-style-type: none"> • When you speak to a worker in your community, for example a Local Area Co-ordinator or Sheltered Housing Officer to find out about local groups and services
<p>Support at home</p>	<ul style="list-style-type: none"> • When you are supported by family carers, District Nurse, Homecare, etc to stay independent at home.
<p>Intermediate care at home</p>	<ul style="list-style-type: none"> • Where you need a bit more support for some time, for example from a Physiotherapist or Homecare, following an illness or injury.
<p>Intermediate bed based care</p>	<ul style="list-style-type: none"> • When you need support 24/7 for a short period, from a range of health and social care professionals to recover your independence or to consider your long term care needs. This could be provided in a care home.
<p>Hospital level care at home</p>	<ul style="list-style-type: none"> • When you need 2-3 days of intensive nursing and medical care to allow you to recover from a period of illness or injury without needing to go to hospital.
<p>Community hospitals and hospices</p>	<ul style="list-style-type: none"> • When you need round the clock nursing care and medical treatment for an illness or injury.

Local and national challenges we must take into account

Like all other Health and Social Care Partnerships in Scotland, Fife has to deal with:

- Fewer GP and nurses hours to deliver services
- More demand for services such as services for older people
- A population which is living longer but which has more than one health condition (figure 2)
- Traditional ways of working in a changing world
- Financial challenges due to growing demand to provide services within a limited budget

All these factors impact on our health and social care system in Fife.

Life expectancy in Fife



Number of health conditions by age in Fife

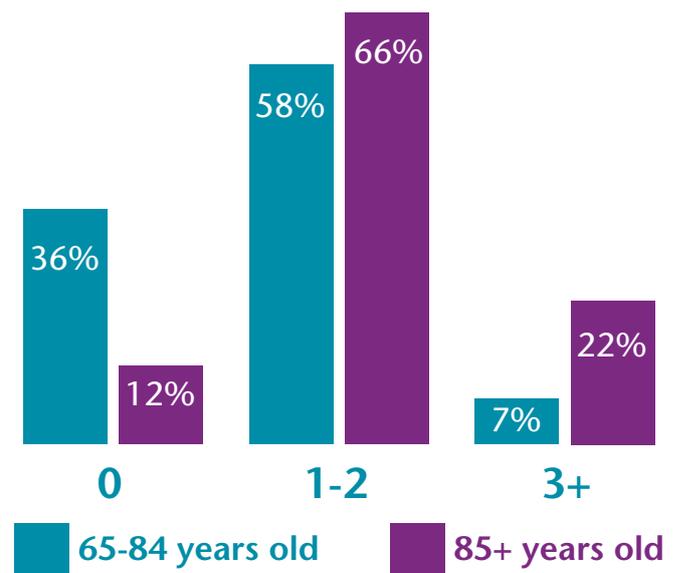


Figure 2

What we are proposing to change

Part 1: Community Health and Wellbeing Hubs



A more joined up approach to your care.

Community Health and Wellbeing Hubs will bring the professionals involved in your care together. This will help us identify people who are becoming more frail to offer professional support earlier.

Teams will work locally in communities. By working together in this way, we can make sure we co-ordinate your care and appointments better and faster.

At first Community Health and Wellbeing Hubs will first of all support people who are frail or have age-related problems. By promoting healthy lifestyles and supporting people earlier, we aim to improve people's health and wellbeing and help keep them independent for longer.

Part 2: Out of Hours Urgent Care Redesign



A more sustainable way of responding out of hours.

By Out of Hours Urgent Care services, we mean care for people who need a GP or a nurse when their GP surgery is closed. We don't mean an emergency which needs to be seen at Accident and Emergency (A&E) at the hospital.

Our out of hours urgent care services include:

- Appointments, telephone advice or visits at home from the out of hours GP service (like the care you would get from your GP during the day)
- Being treated for a minor injury
- Evening, night and weekend District Nursing Services

This also includes how we work with NHS 24 and the Scottish Ambulance Service.

We describe the current service and the two new options we're proposing in Part 2 of this document (page 15).

Part 3: Community Hospital and Intermediate Care Bed Redesign



Helping people stay independent for longer and avoiding hospital admissions.

At this stage, we are asking for your views on changing the role of community hospitals and developing our existing intermediate care beds across Fife:

- Community hospitals care for people who need round the clock care from health professionals such as doctors and nurses
- Intermediate care beds provide round the clock care for people in care homes with visits from health and social care professionals as part of their care

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 where a team helps you re-gain your skills, confidence and strength, rather than having to stay in a community hospital. These are called intermediate care beds. We have also developed the range of services which provide rehabilitation and reablement to support you to recover after an illness or injury at home.

By having these in place across Fife, we're confident that we can:

- Allow people to safely return home earlier
- Support you in a homely setting (care home) near to your home
- Use community hospital beds for people with very complex health conditions who need round-the-clock nursing and medical care

We want to know your views on expanding our intermediate care beds and changing the way we use community hospitals in the future. Your views will help us decide on their type, number and location. We will then develop a more detailed proposal for public consultation later this year.

To make sure that care is sustainable, safe and joined up all three parts of the proposal must work together.

Working as a team across health and social care, professionals can act together to get you and your family the right care, at the right time, in the right place – day or night.

The rest of this booklet explains our proposals and the reasons for change in more detail. Please read this before completing the questionnaire.

You may want to read about our proposals in more detail. If you do, you can find our full Joining Up Care Proposal online at www.fifehealthandsocialcare.org/joiningupcare.

1. Community Health and Wellbeing Hubs

A more joined up approach to your care

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

Why we need to change

At the moment our community health and social care services are not joined up enough. We need to work with people earlier to promote their wellbeing and independence for longer.



How can we change?

We propose to change the way health and social care services work together locally.

Our teams have already been trying new ways of working. They started by looking at the needs of frail and older people.

To make sure they offered the right support, staff focused on understanding people's goals better and improved how they work together across different areas. These simple changes have led to quicker and better care. We have found that this has helped people to stay at home for longer (please see Mary's story later in the booklet).

We now want to build on this great work by our teams and introduce this right across Fife.

We propose setting up seven Community Health and Wellbeing Hubs, based on this way of working. There will be one for each local area (figure 3):

These hub teams may see you in a local community centre or in a local hospital. This means that we'll bring more services to your local area and local teams will arrange your appointments together all in one place, where possible.

For the South West and North East Fife areas, we would respond to the rural and local needs in a different way. Our hub teams would travel around to work from different places on different days. As we develop this way of working we will spread out to support a wider range of needs, for example for younger people with long term conditions.

How our teams could work differently to benefit you

Importantly, we will discuss and agree all your care needs with you to ensure we focus on what matters to you. To help us do this, professionals in each local area will get together to jointly agree what the best clinical or social care options are for you. These meetings, known as huddles* could include local health and social care professionals such as Nurses, Social Workers, GPs, Mental Health staff or Occupational Therapists.

The team will consider what support is available to you locally, including in the voluntary and independent sectors.

* Huddles are frequent but short briefings for teams so that they can keep up to date, review work, make plans, and move ahead.

If you have more complex needs

If you have complex health and/or social care needs or there are a number of professionals involved in your care, one of the team will agree to act as your Care Co-ordinator (figure 4). This will be the professional most involved in your support. They'll work with you to focus on the things that matter to you, for example being able to walk to the local shop for your paper after an illness which had made you unsteady on your feet.

By introducing this new approach, we're confident we can:

- Identify and support people earlier
- Put services in place that can respond day and night so you don't always need to go to hospital
- Help local professionals share appropriate information more easily and safely
- Make the best use of local skills, knowledge and experience
- Link people with local support networks and services such as befrienders
- Reduce waiting times, frustration, and duplication

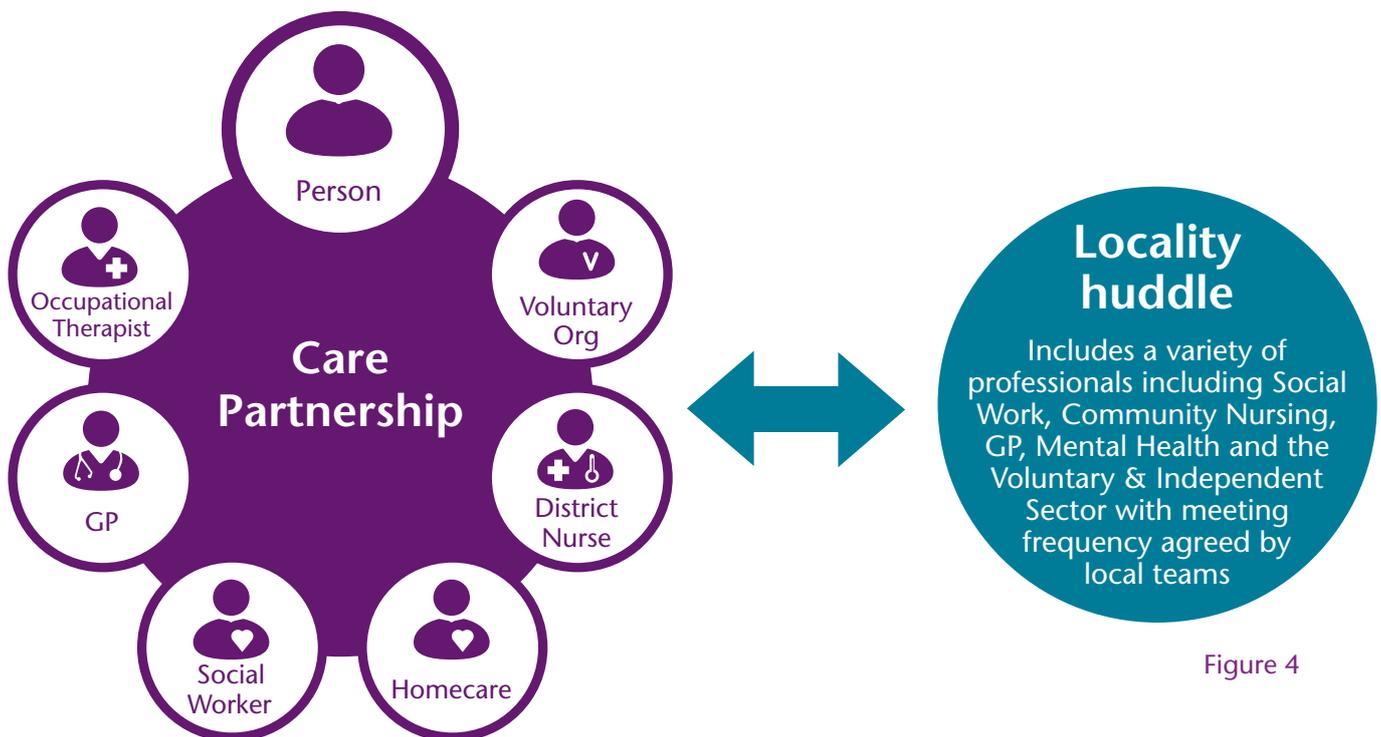


Figure 4

How do we know this approach could work?

We asked our teams to try it, and it worked! Here's *Mary's story (*not her real name)

Mary

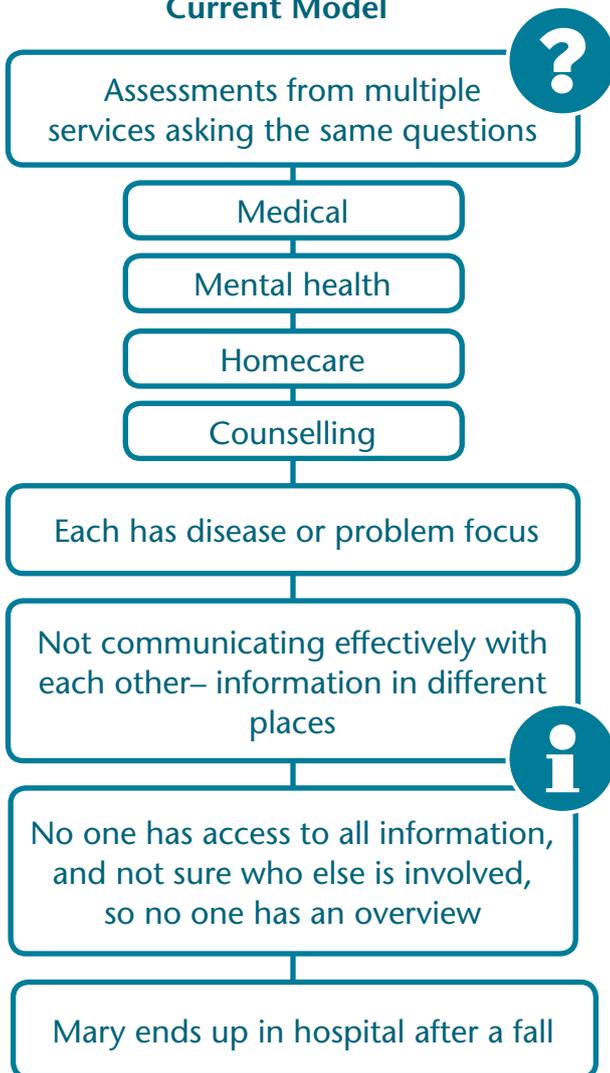
85 years old • Number of health conditions • Regular contact with District Nurse

Declining mood – looking after herself is becoming too much of an effort

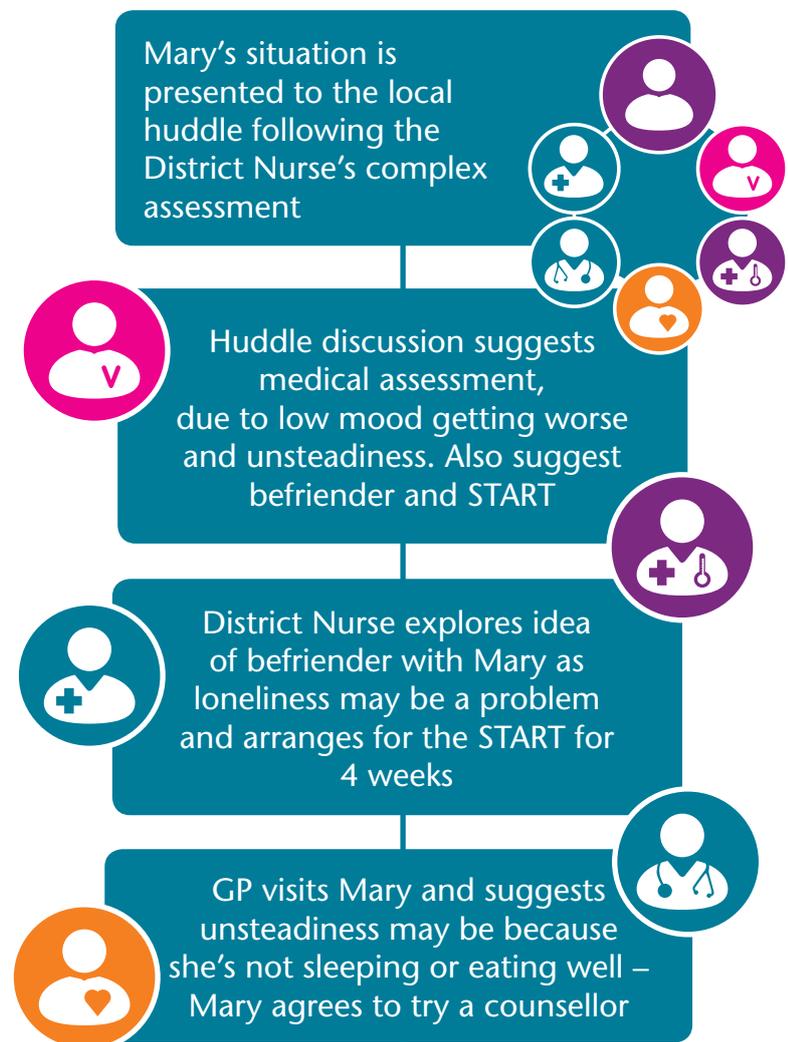
Her family noticed that she wasn't taking care of herself and was becoming more unsteady on her feet and they were frightened that she might fall

The District Nurse had also noticed she was losing weight

Current Model



New Model



After 4 weeks the regular contact has helped improve her mood, she agrees to try the befriender service and she no longer requires START
Mary agreed to think about going to a local community facility and to get a community alarm fitted in her home.

Health and Social Care staff working and talking together as a team can reduce time and duplication and also provide more options through local community support services.

2. Out of Hours Urgent Care Redesign

A more sustainable way of responding out of hours

Out of Hours Urgent Care is care in the community that needs a response before the next routine care service is available, for example, a GP or District Nurse. It is not 999 emergency care.

These are the services providing out of hours urgent care just now:

- The Primary Care Emergency Service (PCES). This is GP and nursing care when your own GP is closed (6pm to 8am during the week, 24 hours at weekends and public holidays). This service is for Fife and Kinross. It provides advice, appointments and visits to people at home

You can access it through NHS 24. A local dispatch team in Glenrothes co-ordinates where people should be seen and who will visit or call to give advice

The quickest appointment anyone would be offered for an out of hours GP appointment is one hour (because this is for urgent care - not an emergency)

- Minor injury services are delivered in the out of hours periods, that is, evening, overnight and weekends
- Evening, night and weekend District Nursing

Like all other parts of Scotland, our services are under constant pressure. This is also having an impact on out of hours' urgent care. The current system is experiencing the following:

- A national shortage of GPs and nurses available to work evenings, holidays and weekends. This means we struggle to cover the service and ensure that it is safe for patients
- Clinical and professional skills being spread across four centres. This is not the best use of professional resources and reduces team working
- The challenge of ensuring a safe level of staff available for the public

Our priority is to provide the people of Fife with a safe and effective out-of-hours service that best meets their needs. It is simply no longer possible to do that without changing the way we currently provide services.

Why we need to change

These are some of the challenges we are facing for urgent care:

- It's getting much harder, nationally, to recruit GPs and nurses for urgent care. We're finding it difficult to make sure we have enough staff to provide a clinically safe service. In all areas of Fife we're short of GPs and Nurses
- Our staff are based in one place all the time. This means they're not able to move between centres to meet patients' needs, even though some centres are busier than others

- People who come for an appointment overnight who then need to see a specialist have to be moved to an acute hospital, sometimes by ambulance
- Doctors and Nurses recommend that children, who can become very unwell quickly, are seen in a centre with direct access to specialist support. Overnight PCES centres are currently at Glenrothes, Dunfermline and St Andrews, not beside children's services, which are based at Victoria Hospital
- We have just enough home visits available at the moment. We know we will need more as the number of very old people increases
- With a lot of different services providing urgent care, we are not as joined up as we could be and this makes how we work more complicated and less efficient.

How we currently provide out of hours services

The diagram below (Figure 5) shows the service arrangements. PCES works from:

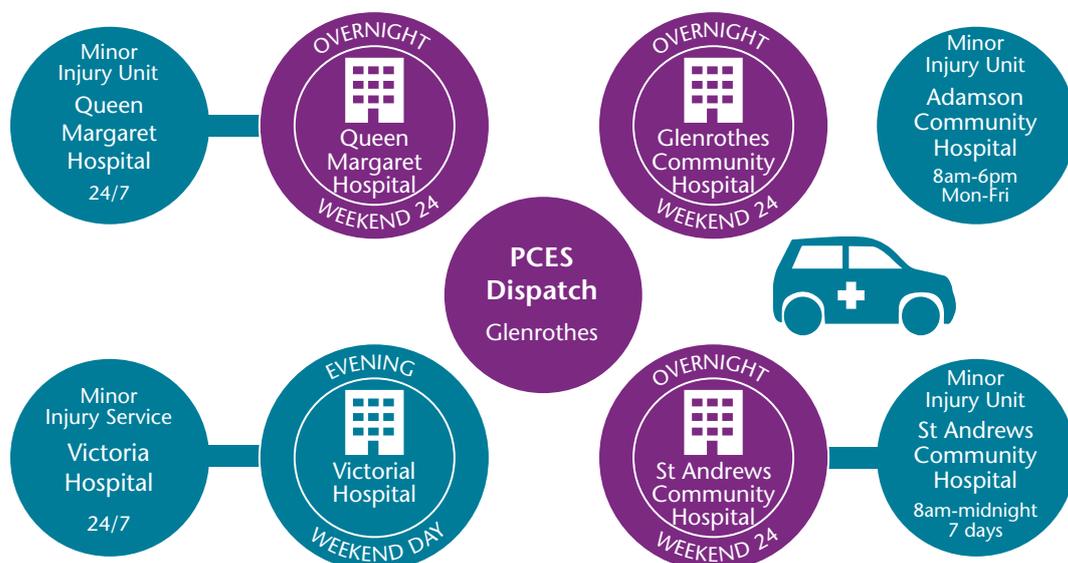
- Queen Margaret, Glenrothes, Victoria and St Andrews Community Hospitals in the evenings, at weekends and on public holidays
- Queen Margaret, Glenrothes and St Andrews Community Hospitals through the night

Minor injuries services are delivered from:

- Queen Margaret and Victoria Hospital 24 hours a day, seven days a week
- St Andrews Hospital 8am-6pm then 6pm-midnight by appointment through NHS 24 (111)
- Adamson Hospital, Monday to Friday from 8am-6pm

The District Nursing Service provides appointments during the evening, and weekends and an on-call service overnight.

Figure 5



Evening 6pm - midnight • Overnight midnight - 8am • Weekend Day 8am - midnight • Weekend 24 Fri 6pm - Mon 8am
Public holidays as per weekend arrangements

How do people use the current service?

The way people use minor injuries services has not changed much over the years.

Figure 6 below illustrates how people used PCES in 2016/17. PCES also provided over 7,000 advice calls.

Use of Minor Injury Services from midnight to 8am is very low. In 2016/17, an average of eight people across Fife used the service each night. At Queen Margaret Hospital, there were three or fewer patients on 77% of nights and 21% of nights at Victoria Hospital.

Calls to the Evening and Night District Nursing Service went up by 40% between 2010/11 and 2016/17. This is because we're treating more people at home. District Nurses provide support at home for people with complex illnesses and for people who are terminally ill.

How can we change?

We've considered a wide range of options and focused on those which we think:

- Offer the best possible clinical care
- Are possible in terms of the available workforce and will attract people to work in the service
- Are possible in terms of the money we have available
- Bring the different services together

We're proposing two new options, alongside the current model. These two new options take account of the clinical safety, transport and workforce problems we have with the current system as described in this section.

- Do nothing option (staying the same)
- Option 1 – two centres (Dunfermline and Kirkcaldy), with only Kirkcaldy open overnight
- Option 2 – two centres (Dunfermline and Kirkcaldy), both open overnight

In 2016/17 on average the following number of people accessed PCES (excluding 7,000+ advice calls)

	 Daytime Weekends & Public Holidays 8am to 6pm	 Evening 6pm to Midnight	 Overnight Midnight to 8am
 Treatment Centres	4 centres 147.1 (average per day)	4 centres 44.2 (average per evening)	3 centres 10.6 (average overnight)
 Home Visits	3-6cars 46.3 (average per day)	3-4cars 11.7 (average per evening)	3 cars 5.4 (average overnight)

Figure 6

The urgent care centres described in options 1 and 2 are both within a one-hour drive for everyone in Fife. When we surveyed people in September 2017 and asked them how they got to their GP out of hours appointment or minor injuries centre 94% of people drove or were driven.

People who live in North East Fife or West Fife can choose to use out of hours services in NHS Tayside and Forth Valley. To ensure people have equal access to urgent care we will develop a procedure to support people who have difficulties getting to an appointment. This will be in line with other areas of Scotland.

Options 1 and 2 both have the following:

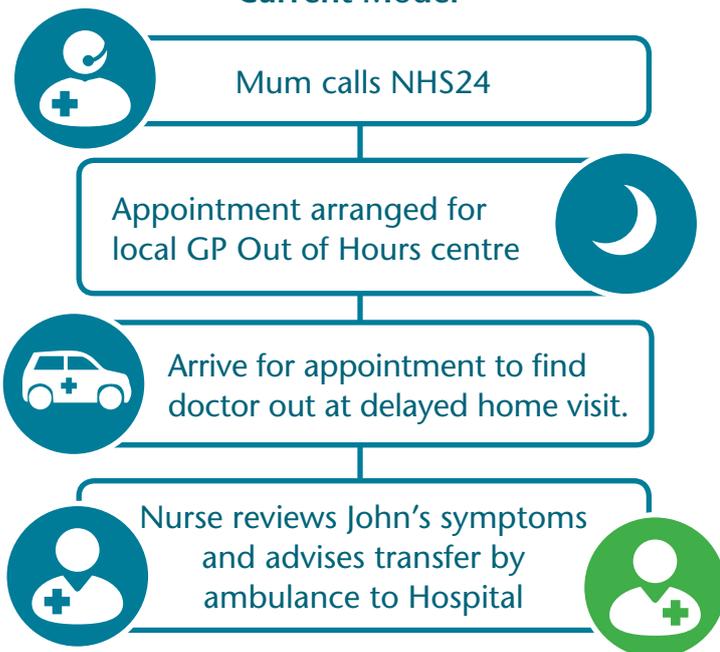
- **Urgent Care Centres** that would deliver the full range of urgent clinical care locally. They will be based at a safe venue that the public can access, which makes the best use of available staffing
- **An Urgent Care Dispatch** that staff from a number of health and social urgent care services (including clinical staff) would work together from to coordinate services according to need. It would direct how services work in the out-of-hours period to make best use of our workforce and skills according to need. This team would not consult with patients there.

How do we know this approach could work? Here's *John's story

John

6 years old • Asthmatic
Asthma attack during the night

Current Model



New Model



Directing people to large centres removes the risk of lack of staff and provides access to greater range of support. Also provides more back up for staff members.

Do Nothing Option: How we deliver the services now

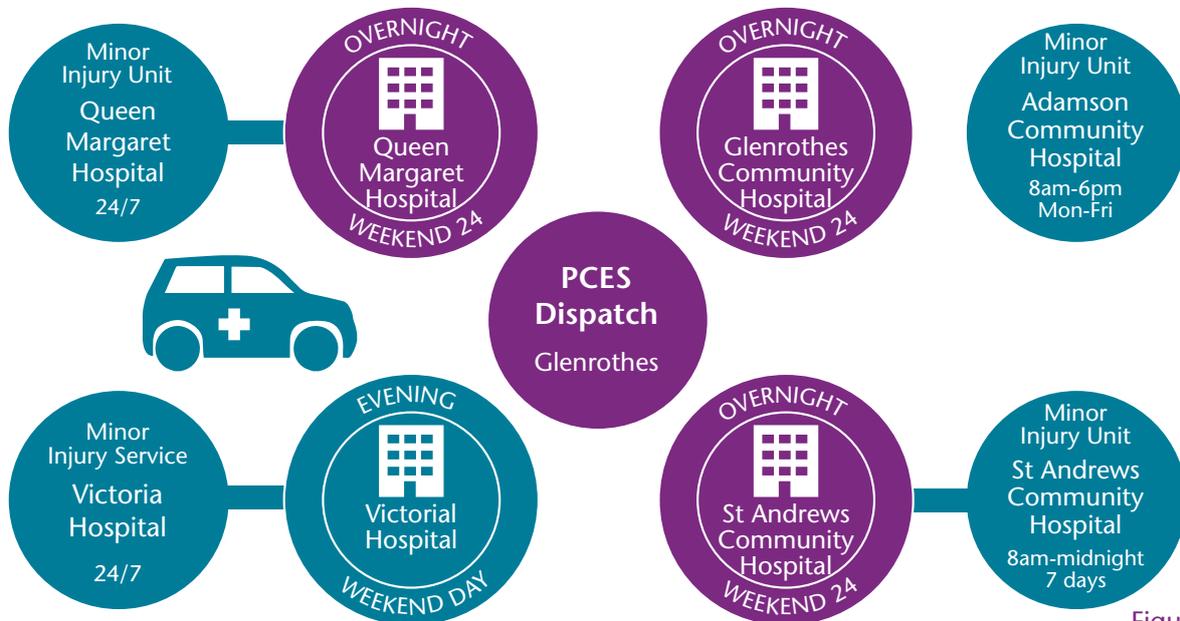


Figure 7

- Appointments and calls are organised by PCES Dispatch (administrative team).
- Four Urgent Care Centres open in the evenings, at weekends, and on public holidays based at the Glenrothes, St Andrews Community, Victoria and the Queen Margaret Hospitals. Three of these centres are beside minor injuries services
- Three Urgent Care Centres are open overnight based at the Glenrothes, St Andrews Community and Queen Margaret Hospitals. One of these centres is beside a minor injury service
- Home visits by car-based doctors until midnight. After midnight, the doctor from each centre covers both the centre and home visits

This option would:

- Not have enough GPs or nurses to staff all centres with the current shortages of staff we have in all areas of Fife
- Continue to be inflexible
- Make it hard to meet demand at the busiest times in busier centres and have centres which see very few people
- Not support new ways of working
- Not support the workforce to work as a co-ordinated team
- Not have an overnight centre beside specialist services
- Provide too many appointments in centres and not enough home visits for the future
- Allow us to provide:

This option is not recommended as it is not sustainable

	Evenings, Weekends and Public Holidays	Overnight
Available Appointments	168,456	67,017
Home visits	12,609	1,638
Advice calls	9,072	3,276

Option 1: How we could deliver services



Figure 8

- Appointments and calls are organised by a clinically led Urgent Care Dispatch. This team would link with the day time Community Health and Wellbeing Hubs
- Two Urgent Care Centres open in the evenings, at weekends and on public holidays based at the Victoria and the Queen Margaret Hospitals
- One Urgent Care Centre open overnight, based at the Victoria Hospital
- Home visits provided by staff based in cars, who can help the teams based in the centres and also get support from the centre team – with 2 car based staff overnight

This option would:

- Make the centres work more efficiently and be flexible enough to meet demand at busiest periods
- Allow us to provide:

	Evenings, Weekends and Public Holidays	Overnight
Available Appointments	138,580	29,120
Home visits	13,689	6,552
Advice calls	10,176	4,368

Compared to the way we deliver services just now, this option would mean:

- 29% reduction in unneeded appointments
- 9% more home visits at weekends, evenings and on public holidays
- 300% more home visits overnight
- 12% more advice calls at weekends, evenings and on public holidays and 33% more overnight

Option 2: How we could deliver services



Figure 9

- Appointments and calls are organised by a clinically led Urgent Care Dispatch that would link with the day time Community Health and Wellbeing Hubs.
- Two Urgent Care Centres open in the evenings, at weekends, and on 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 provided by staff based in cars, who can help the teams based in the centres and also get support from the centre teams. Overnight this option would have 1 car based clinician and another clinician covering both a centre and home visits

This option would:

- Make the centres work more efficiently to provide flexibility to meet demand at busiest periods
- Continue to have more overnight appointments than needed
- Allow us to provide:

	Evenings, Weekends and Public Holidays	Overnight
Available Appointments	138,580	55,328
Home visits	13,689	4,914
Advice calls	10,176	3,276

Compared to the way we deliver services just now, this option would mean:

- 18% reduction in unneeded appointments
- 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 know that working from fewer centres can help us develop staff roles and provide a more efficient service. This would mean we can better support people in the out-of-hours periods.

Both options 1 and 2 would have fewer centres. But our staff would:

- Be more flexible
- Have the support of a wider team
- Be able to arrange simpler and quicker access to specialist services

We have identified Queen Margaret and Victoria hospitals for options 1 and 2. This would mean the appointments, calls and home visits would be spread almost equally across both centres.

More detail about other options we considered is available as part of the full proposal document.

The benefits of options 1 and 2 for you

We believe both these options do the following:

- Ensure that if you need to attend an appointment you can get to an urgent care centre within a maximum of a one-hour drive from anywhere in Fife
- Get you access to advice more quickly
- Make sure we can meet the increase we expect 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 access to other specialist teams, for example hospital specialists, Mental Health and District Nursing

3. Community Hospital and Intermediate Care Bed Redesign

Helping people stay independent for longer and avoiding hospital admissions

Medical care has changed over time and more care can now be provided at home or in homely settings such as care homes.

By developing the types of care based in local communities, we can care for more people safely in their own homes. This means far fewer people will need to be admitted to hospital.

Some of our buildings are no longer suitable to deliver our services, so we need to change how some of our services work.

We don't yet have firm proposals. But we'd like to begin gathering your views to help us develop this part of our proposal to change the way we use community hospitals and introduce intermediate care beds.

We've already started developing new community-based services. These services help people regain their skills and strength. We do this either in someone's home or in a care home, depending on their health condition and needs. This means that the community hospitals can then deliver support to people who have a high level of care and those who need 24-hour care.

We are proposing to continue to develop and extend these new services so that we can avoid unnecessary admissions directly to the acute hospital as well as keeping people safe, well and independent for longer.

What happens at the moment?

In 2017 we cared for 2,804 people 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.

We've been testing different types of bed-based care options to find out what works best.

Here are some of the different types of care we offer just now:

- **Short Term Assessment and Reablement (STAR) beds** – This type of care aims to help people return to their own homes in a short period of time, typically around six weeks. Our teams work to help people become independent and offer the specific skills and support they need to do this. There are currently a total of 36 STAR beds in three care homes in Kirkcaldy, Lumphinnans and Glenrothes
- **Assessment beds** – This type of care allows us to support people when they leave hospital, but are not able to go home. By moving out of hospital and into this type of care, we can assess exactly what someone needs in the long term and where that needs to be. There are eight care homes providing 49 assessment beds in Anstruther, Cowdenbeath, Kinglassie, Glenrothes, Kirkcaldy, Auchtertool and Kelty

People who had been unwell or injured used to be moved to a community hospital to get the support they needed to help them get home. People have told us that they want us to provide more care nearer to their homes.

Why we need to change

- At any one time, around a third of people in our community hospitals could be cared for in a different way and in a different place
- We need to support people's wish to stay at home or near to home rather than be in hospital - the map shows we do not have enough beds in some areas (figure 10)
- Some of our community hospital buildings are old and won't be suitable in years to come
- We need to respond to our growing and ageing population now

Developing care in people's homes or near to home will allow us to reduce the amount of time people spend in community hospitals. We want to continue to develop different ways to give people the support they need from us.

How can we change?

We know we are not always providing care in the right places so that everyone has access to the right type of beds to meet their needs. Figure 10 shows where we're providing care just now.

We propose to do the following:

- Move some of our workforce from hospitals to teams based more locally
- Make sure our community hospital buildings and grounds meet our needs for the future
- Consider how and where we would deliver the different types of care within community hospitals. This could include where we would deliver care for people recovering from a Stroke through to people who require long-term hospital care

If you have more complex care needs

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.

Our proposal would mean that there will be enough community hospital beds for people needing the following:

- Specialist rehabilitation beds - these are for people with specialist medical, nursing and therapist care needs
- Neurological rehabilitation beds - these are for people who need nursing care, medical review and specialist therapy for example people who have had a stroke, have a neurological condition or have suffered a brain injury
- Hospital based complex clinical care beds – these are for people who require complex clinical care whose needs can only be met in a hospital

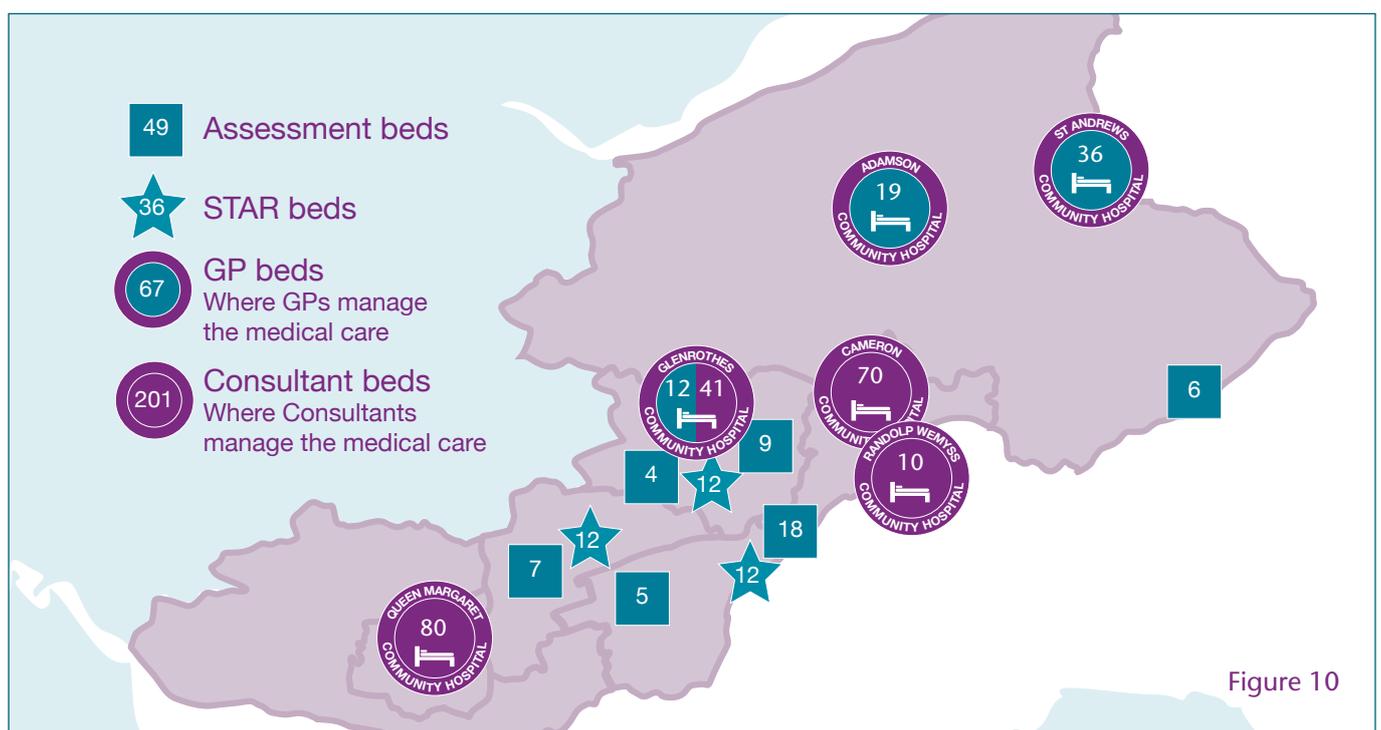


Figure 10

How do we know this approach could work?

Here's *Emily's story

Emily

93 years old

Lives at home with support from her daughters • Has a community alarm

Experiences dizziness, falls, difficulties with eating and drinking

Current Model



New Model



Moving Emily to a care home setting not only meant that she received more rehabilitation support in a homely place but also spent less time in hospital, freeing up the bed for someone with more complex medical conditions.

We now want to know what you think about our proposals

You can tell us your views in the following ways:

1. Complete the on-line version of the consultation questionnaire at www.fifehealthandsocialcare.org/joiningupcare.
2. Download the consultation questionnaire, complete it and post it to:
Joining Up Care Team,
Administrative Block,
Lynebank Hospital,
Halbeath Road,
Dunfermline, KY11 4UW
or hand in your envelope at any NHS facility.
3. Share your views in person by attending one of our road shows/consultation workshops where you'll be able to ask questions about the proposals. We will arrange a number of opportunities, going to each of the seven localities. The doors will open half an hour before the meeting starts. We will share the dates using posters in public venues, social media, radio and through networks such as the People's Panel. Keep an eye out for these.
4. Get involved on social media.

We will work with groups and carers to provide opportunities for children, young people and people with additional support needs to be involved in this consultation.

If you'd like a copy of this summary booklet, easy read booklet, consultation questionnaire, or full proposal, you can:

- call us on **01383 565 199** or **01592 226 859**
- email us at fife-uhb.joiningupcare@nhs.net.
- go to our website at www.fifehealthandsocialcare.org/joiningupcare.

Thank you for your interest in this consultation.

Glossary

Acute Care

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

Assessment beds

This is assessment and care in a care home that supports people over the age of 65 years who are likely to need long term care in a residential or nursing home care. It may take up to 6 weeks to make this assessment. In addition, to support people who require a longer time to make care home choices or where a bed is not available in their preferred care home, after a care assessment has been completed.

Clinically Led

Decisions about how appointments and staff time is used are taken by a clinician locally, who has knowledge of the resource available within each local area.

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 tests. The Hub teams will work as part of a wider local team 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 tests, 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 personal plans of support, with improved co-ordination between support services.

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 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 help a team to anticipate care needs and special situations, so that members of the care team can work together to support the person as soon as possible.

The most effective huddles involve some preparation in advance.

Integrated Joint Board

The Partnership has an Integration Joint Board (IJB) with legal responsibility for services it manages. The Integration Joint Board is fully responsible for:

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

Intermediate Care

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.

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. More detail can be found at appendix 5 of the proposal.

PCES 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 advice calls, appointments and home visits by local doctors, nurses and paramedics. 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 Wormit 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.

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.

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.

AHPs Allied Health Professionals

Includes **Arts Therapists** use art, dance, drama and music as a therapeutic intervention to assist people with physical, mental, social and emotional difficulties.

Diagnostic radiographer employ a range of imaging techniques to produce high quality images of injury or disease, often interpreting them so that correct treatment can be provided

Dietitians translate the science of nutrition to assess, diagnose and treat diet and nutrition problems at an individual and wider public health level. They work with people to promote nutritional wellbeing, prevent food-related problems and treat disease.

Occupational therapists enable services users to participate in activities of daily living by modifying the occupation or environment to better support their occupational engagement.

Orthoptists assess and manage a range of eye movement disorders and defects of binocular vision.

Orthotists design, manufacture and apply devices such as braces, splints and specialist footwear to help people with movement difficulties and to relieve discomfort

Physiotherapists help people affected by injury, illness or disability through movement and exercise, manual therapy, education and advice.

Podiatrists assess the vascular, neurological and orthopaedic status of the patient's lower limbs to diagnose and treat diseases and conditions of the feet

Speech and language therapists work with children and adults who have problems with speech, language, communication and swallowing difficulties

CHWH Community Health and Wellbeing Hub

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

GP General Practitioner

MIU Minor Injuries Unit

PCES Primary Care Emergency Service

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

Alternative Formats

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

Language lines

خط ہاتف اللغة العربية: 03451 55 55 77

বাংলায় আলাপ করার জন্য টেলিফোন لائن:

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Polskojęzyczna linia telefoniczna:

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اُردو زبان کے لیے ٹیلیفون نمبر 03451 55 55 66

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

**Fife Health
& Social Care
Partnership**

