DUMFRIES AND GALLOWAY
INTEGRATION JOINT BOARD

HEALTH AND SOCIAL CARE
NITHSDALE LOCALITY REPORT

DUMFRIES AND GALLOWAY
Health and Social Care

April 2020

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Contents

This report has been produced by:

Nithsdale Locality Team and the
Strategic Planning, Commissioning and Performance Team,
Dumfries and Galloway Health and Social Care Partnership

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Foreword

Welcome to the latest report from Nithsdale locality covering the period July 2019 to December 2019. In this report we have given a flavour of the work being undertaken across both core locality services and some of the eight diverse regional services managed within the locality including, Multi Agency Safeguarding Hub (MASH), NHS Police Custody and Out of Hours. These are important regional services supported within the locality resource and often overlooked when considering the work within the locality. In addition, we have been leading a review of Community Health and Wellbeing services across the region and a review of the regional Out of Hours Services; challenging ourselves to develop models of support that are fit for the future while being flexible and responsive to people's needs and the challenges ahead.

As a locality we are heartened by the recent commitment to adopting a Home Team model across Dumfries and Galloway. This will be a significant change to the way Health and Social Care is provided in the community. The foundations for this are already in place in Nithsdale:

- Rapid Response is the first team (of many) to change from being a team to a community function and, with the recent introduction of an Advanced Nurse Practitioner (ANP), has established a Virtual Community Ward which allows us to care and support our people safely at home;
- Single Point of Contact (SPoC) is now established in Nithsdale locality with nearly all region wide services operating within the locality involved in the SPoC. With SPoC being integral to the development of Home Teams, work has started to find out what is needed for SPoC to expand across Dumfries and Galloway. We are delighted that the region wide rollout is looking to the work started in Nithsdale as a sound basis for development.

As in past reports this period has not been without its particular challenges in terms of deploying our limited resources to meet the many demands within community health and social care. The tenacity and resilience of staff across all locality services can not be underestimated and goes a vast way towards continuing to ensure that we do our very best to support the people who use our services and for this I thank them.

A huge of amount of the work we have included in this report is done in partnership with other statutory agencies and with charities and volunteers. This is demonstrated in many of the examples given, which are only a small indication of the range of partners on whom we depend for the delivery of services. We will continue to enhance these relationships as we move forward into 2020 and beyond.

Alison Solley
Locality Manager - Nithsdale
April 2020

Introduction

The Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) (here) set a legal framework for integrating (combining) health and social care in Scotland. This legislation says that each health board and council must delegate (transfer) some of its functions to new integration authorities. By doing this, a single system for planning and delivering health and social care services is created locally.

The integration authority in this area came into existence in the form of Dumfries and Galloway Integration Joint Board (IJB) on 1 April 2016. The responsibility for the planning and delivery of the majority of adult health and social care services are delegated from the Local Authority and NHS to this new body.

The Scottish Government has set out 9 National Health and Wellbeing Outcomes. These outcomes set the direction for health and social care partnerships and their localities, and are the benchmark against which progress is measured. These outcomes have been adopted by the IJB in its Strategic Plan.

The Act requires each integration authority to establish localities. The 4 localities in Dumfries and Galloway follow the traditional boundaries of Annandale and Eskdale, Nithsdale, Stewartry and Wigtownshire. Each locality has developed its own Locality Plan.

In Dumfries and Galloway the Local Authority and NHS have agreed, through their Scheme of Integration, that “Health and social care services in each locality will be accountable to their local community through Area Committees and to the IJB”. It was also agreed that “Area Committees will scrutinise the delivery of Locality Plans against the planned outcomes established within the Strategic Plan.”

In November 2018 the IJB agreed the revised performance framework for the Partnership. This framework requires each locality to report to their respective Area Committee every 6 months. Each locality report focuses on either 4 or 5 of the 9 National Health and Wellbeing Outcomes so that, over the course of a year, progress towards each outcome is reported once to Area Committees.

Public Bodies (Joint Working) (Scotland) Act 2014
www.legislation.gov.uk/asp/2014/9/contents/enacted (last access 23 May 2017)

Dumfries and Galloway Scheme of Integration
http://www.dg-change.org.uk/wp-content/uploads/2015/07/Dumfries-and-Galloway-Integration-Scheme.pdf (last access 30 January 2019)

Strategic Plan 2018- 2021
dghscp.co.uk/wp-content/uploads/2018/12/Strategic-Plan-2018-2021.pdf (last accessed 20 June 2019)

Dumfries and Galloway Health and Social Care Performance Reports
www.dghscp.co.uk/performance-and-data/our-performance (last accessed 8 May 2019)

The symbols we use

i) How we are addressing this outcome in our locality

The Locality Plan for Nithsdale details our commitments that support the National Health and Wellbeing Outcomes and Dumfries and Galloway's Strategic Plan. These are repeated here, under their respective outcome, together with a Red, Amber, Green (RAG) Status that indicates our assessment of progress.

Red - Progress in implementing the commitment is significantly behind schedule or work has not started when it was due to start.

Amber - Early warning that progress in implementing the commitment is slightly behind schedule.

Green - Progress in implementing the commitment is on or ahead of schedule or the work has been completed.

Grey - work to implement the commitment is not yet due to start.

ii) How we are getting on

Next to each infographic in this report there are 2 circles, like this: A1

The first circle shows the indicator number. Information about why and how each indicator is measured can be found in the Performance Handbook, which is available on the Dumfries and Galloway Health and Social Care Partnership website (www.dghscp.co.uk/performance-and-data/our-performance/). Where there is a + instead of a number, the figures are not standard indicators, but additional information thought to be helpful.

The second circle shows red, amber or green colour (RAG status) and an arrow to indicate the direction the numbers are going in. We have used these definitions to set the colour and arrows:

- We are meeting or exceeding the target or number we compare against
- We are within 3% of meeting the target or number we compare against
- We are more than 3% away from meeting the target or number we compare against
- Statistical tests suggest the number has increased over time
- Statistical tests suggest there is no change over time
- Statistical tests suggest the number has decreased over time

The 9 National Health and Wellbeing Outcomes

The Scottish Government has set out 9 national health and wellbeing outcomes for people.

People are able to look after and improve their own health and wellbeing and live in good health for longer

People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community

People who use health and social care services have positive experiences of those services, and have their dignity respected

Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services

Health and social care services contribute to reducing health inequalities

People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing

People using health and social care services are safe from harm

People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide

Resources are used effectively and efficiently in the provision of health and social care services

The 9 national health and wellbeing outcomes set the direction of travel for services in the health and social care partnership and are the benchmark against which progress is measured. The Scottish Government has not numbered these outcomes to reflect that they are all equally important. However, locally we have added numbers solely for the purpose of tracking progress through our performance framework.

1. Outcome 1

People are able to look after and improve their own health and wellbeing and live in good health for longer

1.1 How we support this in our locality

Making the most of and maintaining health and wellbeing is better than treating illness. The aim is to promote good health and prevent ill health or, where health and social care needs are identified, to make sure there are appropriate levels of planning and support to maximise health and wellbeing.

In our locality the following examples demonstrate how we work towards this aim through:

- Healthy Connections
- CoH-Sync Programme
- Massive Outpouring of Love (MOOL) Yoga
- Providing Community Based Health and Wellbeing Support Training
- Mindfulness
- Reclaim Your Life
- Let's Prevent: Type 2 Diabetes

1.2 How we are addressing this outcome in our locality

Our We Will commitments which support this outcome and their current Red, Amber, Green (RAG) status:

1. Develop community link approaches within Nithsdale locality which enable people to have the information, motivation and opportunity to live a healthy life for as long as possible.
2. Support people to participate and engage in their communities as they choose to access day opportunities and activities which they feel are important to them, to stay as independent as possible, happy, safe and well.
3. Work with staff groups within health and social care, enabling them to motivate, educate and support people to improve their health and wellbeing.
4. Roll out programmes such as Mindfulness, Living Life To The Full and Ten Keys To Happier Living.

1.2.1 Healthy Connections - Nithsdale Health and Wellbeing Team

Healthy Connections is a non clinical, structured support that enables people and communities to take more control of their health and wellbeing. This approach supports the development of knowledge, skills, social connections and the resilience of people and communities to improve health and wellbeing and work towards reducing health inequalities. Healthy Connections is delivered at home and in the community, including GP practices where it is a key feature in the transformation of primary care.

Fostering positive links with statutory, third and independent sector services and organisations is an essential part of Healthy Connections. Partnership working helps identify people in the community who may benefit from Healthy Connections support and prevent them requiring more intensive support in the future. For example, Healthy Connections might support someone who has had a number of falls to access a low level physical activity group to improve mobility.

Healthy Weight sessions are held in 4 GP practices. These sessions focus on achieving and maintaining a healthy weight to help prevent type 2 diabetes, heart disease and depression. An optional weigh in is available at the sessions as well as discussion on topics including healthy eating, keeping active and stress reduction.

305 people were referred to Healthy Connections between July and December 2019

23% of people referred to Healthy Connections are from communities considered nationally to be deprived. This is more than proportion in the wider Nithsdale population (15%) and suggests that Healthy Connections is successfully engaging with people experiencing deprivation

What people tell us: Jenny's story

Jenny was linked to Healthy Connections Service by her Psychiatrist. Through motivational interviewing techniques, it was found that Jenny was feeling socially isolated and unhappy with her weight. This was impacting on her confidence and her motivation to get out.

Through further guided conversation Jenny decided that aqua aerobics would be a good activity that would enable social contact and support her desire to lose weight.

Jenny was supported to create a plan of action by breaking down the steps into smaller manageable chunks. This boosted Jenny's confidence to start aqua aerobics.

With her improved confidence Jenny has since gone on to secure employment and get out more regularly.

1.2.2 CoH-Sync Programme

The Nithsdale Health and Wellbeing Team have continued to work in partnership with Cooperation and Working Together to deliver the Community Health Synchronisation (CoH-Sync) project. The project is supported by the European Union's INTERREG VA programme and aims to implement a cross border, collaborative, community based approach to promoting healthier lifestyles which target the risk factors associated with long term health conditions.

In 2019, the team worked with 195 people to support them to develop health and wellbeing plans. These plans help people to identify and make changes in their lives to improve their health and wellbeing.

The majority of people chose to focus on improving mental wellbeing and were linked with a wide range of opportunities and further support including the Food Train, Relationships Scotland, Dumfries Day Centre, Gamblers Anonymous and the Men's Shed.

People found CoH-Sync staff 'helpful and easy to talk to' and told us that it was 'helpful to make a plan to think of changes to make'. One person, who was linked with the Hen's Shed, commented that they enjoyed socialising with other people in the group and having a laugh. They have since gained the confidence to apply for multiple jobs, which has opened up new opportunities for them.

What people tell us: a CoH-Sync story

The CoH-Sync team worked with an elderly gentleman who lives alone. This gentleman has seen a decline in his mobility and has suffered falls as a consequence. This has affected his confidence to go out alone. He had previously used a taxi to get out to complete daily tasks and socialise. Being housebound has caused this gentleman to experience feelings of loneliness and social isolation.

The CoH-Sync team linked him with a local day centre for senior citizens which included his travel there and back. He very much enjoys the social aspect of the centre and in particular the meals. He describes "feeling looked after" at the centre, which he attends weekly.

The CoH-Sync team also linked this gentleman to a local befriending service. He has been matched to a befriender and is now accepting visits on a weekly basis. Their shared interest in gardening has given him the confidence to get out into the garden.

1.2.3 Massive Outpouring Of Love (MOOL) Yoga

This is a new, women only yoga class for asylum seeker and refugee women who are living in the Dumfries area. It was set up in the summer of 2019 and was initially funded by Nithsdale Health and Wellbeing Partnership's Day Opportunities Fund.

1.2.4 Providing Community Based Health and Wellbeing Support Training

The Nithsdale Team are now directly supporting the delivery of the training course 'Providing Community Based Health and Wellbeing Support'. The course has been developed to support staff across the partnership who provide community based support. The aim of the course is to provide a clear psychological framework to deliver health and wellbeing support, to ensure safe, effective and outcome focussed practice and to consider how we work with complexity to encourage positive change.

1.2.5 Mindfulness

This is a life skill development process that can provide long term personal development and health and wellbeing benefits. It is an integrative, mind and body based approach that helps people change the way they think and feel about their experiences, especially stressful experiences. Mindfulness involves paying attention to our thoughts and feelings so that become more aware of them, less enmeshed in them, and better able to manage them.

There is evidence to show mindfulness can improve;

- Work place stress and work satisfaction
- Communication
- Quality of life for staff.

1.2.6 Reclaim Your Life

This supports people to live well with a long term condition. Healthy Connections staff use motivational interviewing techniques to increase the likelihood that people will make the changes that are important to them. One of these is the ability to live well and live life to the full, despite often having more than one long term condition. People are given the Reclaim Your Life resource, which supports them to apply cognitive behavioural therapy self help techniques.

1.2.7 Let's Prevent – Type 2 Diabetes

Let's Prevent is a new group education programme which aims to support people identified at high risk of Type 2 diabetes by working with them to prevent or delay the condition. The programme follows a structured approach to target lifestyle modification and behaviour change. Each group can have up to 10 participants who can each bring along a family member or friend for support.

"It was good to learn that even making small changes can make a difference."

The programme is supported by the diabetes specialist teams, Public Health, Patient Safety and Improvement Team and Primary Care to promote consistency of practice and person centred approaches. Let's Prevent sessions are taking place monthly until the end of the year and are delivered in a variety of different community settings.

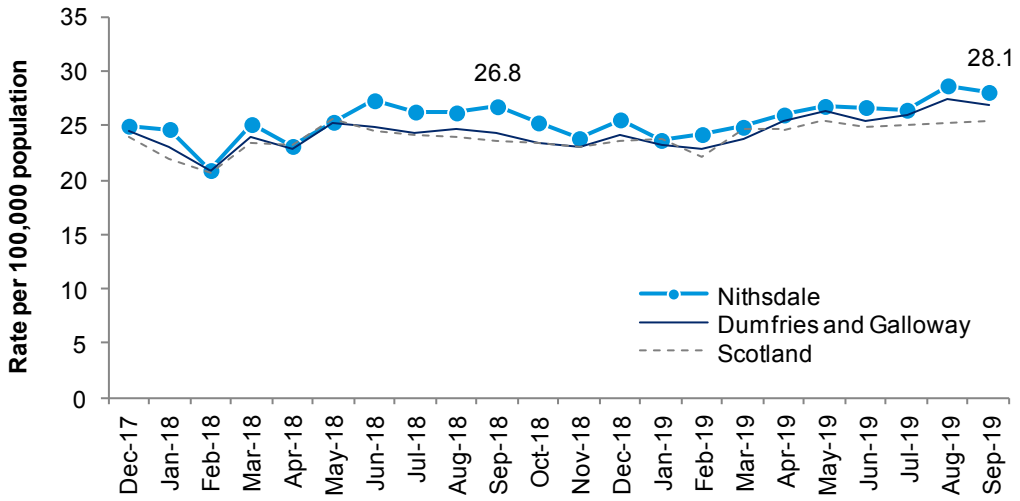
"The course helped motivate me to continue with the changes I had already made and reassured me that those changes could help prevent type 2 diabetes."

1.3 How we are getting on

An important measure of how well people are able to manage their health and wellbeing in the community setting is how often their healthcare occurs as an emergency. There will always be the need for urgent and emergency care, but where possible the aim is to support people in the community and prevent crisis events.

In Nithsdale the rate of Emergency Department attendances is typically higher than for Dumfries and Galloway, which reflects the close proximity of a sizeable population to an emergency centre.

Rate of emergency department attendance per 1,000 population, Nithsdale



Source: NSS Discovery, from National A&E Datamart

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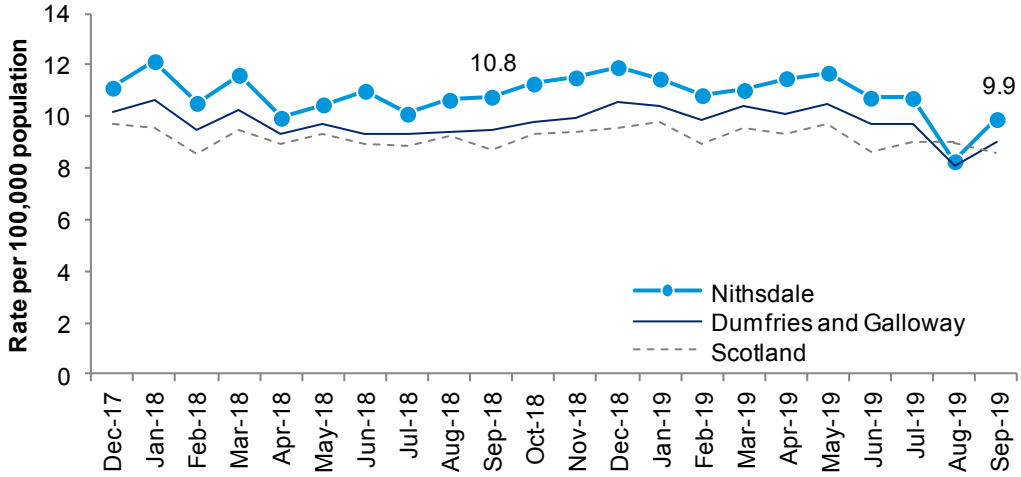
Rate of emergency admissions to hospital per 1,000 population, Nithsdale



Source: NSS Discovery, GP Cluster Activity, from Scottish Morbidity Records (SMR01)

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4. Outcome 4

Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services

4.1 How we support this in our locality

The way that we work with people, designing and delivering their care and support, fundamentally focuses on maintaining quality of life.

In our locality, a good example of this is

- Lymphoedema Service
- Modernising the roles of District Nurses
- Developments at Thornhill Hospital
- Care Home Support
- 4Max Group
- Hen's Shed
- Housing Development

4.2 How we are addressing this outcome in our locality

Our We Will commitments which support this outcome and their current Red, Amber, Green (RAG) status:

13 Work in partnership to promote consistency of practice and person centred approaches.

4.2.1 Lymphoedema Service

This is a regional service managed within Nithsdale locality. Lymphoedema occurs when lymphatic vessels or lymph nodes that are missing, damaged, removed or otherwise, become impaired. There are two types of lymphoedema:

Primary Lymphoedema - Occurs when the lymphatic system is damaged due to a developmental defect. Primary lymphoedema can be classified according to age of onset.

Secondary Lymphoedema - Occurs due to an outside factor damaging or impairing the lymphatic system. Causes of secondary lymphoedema include:

- Tumours (all types) that grow and press on the lymphatic vessels, blocking them
- Cancer treatment
- Trauma and injury

Over the past 23 months a lymphoedema specialist nurse has been trained. Permanent funding for this post has now been secured. The specialist nurse will work across Dumfries and Galloway to provide professional advice to other practitioners and to see people either at home or in clinics across the region.

There are currently approximately 140 people receiving active treatment. Following feedback from people, future plans include setting up a self help support group.

4.2.3 District Nurse Development

There are currently 5 charge nurses leading our teams across Community Adult General Nursing (CAGN) in Nithsdale Locality. Over the next 2 years, all 5 charge nurses will undertake Advanced Clinical Assessment and V300 Non Medical Prescribing training. They will then move onto the new national job description of District Nurse Senior Practitioner. This will enhance their scope of practice, broaden their ability to fully assess people and have the ability to prescribe a greater range of treatments. This is expected to reduce the need for some people to be seen by a GP.

"Care has been spot on."

"The attitude of all the nurses who have visited for a while is kind, caring and have made my life a lot easier. They listen to what you say, I can't say how much I have appreciated their care and understanding."

"Very happy with the care the DN team provided, they have managed to improve a very difficult wound by visiting daily, nothing was too much trouble."

4.2.4 Thornhill Hospital

Activity within the hospital remains high with an average 95% occupancy across the 13 beds.

Recent investment in Thornhill hospital has included the installation of:

- a new nurse call system
- wall mounted televisions
- public wi-fi

4.2.5 Care Home Support

Senior staff in the locality are currently providing support to 2 of our care homes in relation to pharmacy support and nursing interventions. District nurse teams are working with one care home to improve the way people are supported. The traditional model of district nurse teams looking after people belonging to 'their' GP practice has proved inefficient, with different staff visiting the same care home. In Nithsdale, a new approach has been developed, moving towards having one district nurse team for the care home. Care home managers have welcomed this change.

4.2.6 4Max Group

The Healthy Connections Service, in partnership with Kaleidoscope, has set up the 4Max Group for adults who have mild autism as well as severe anxiety. This was requested by community members who had highlighted that there were no suitable social opportunities for them in Dumfries. This small group meets weekly in one of the quiet rooms at Kaleidoscope providing the opportunity to socialise in a quiet safe space.

4.2.7 Hen's Shed

"We feel safe rather than hanging out on the streets."

The Hen's Shed continues to support vulnerable women by providing a safe space to meet, chat, obtain support and advice and get involved with low level activities. A key benefit of the provision of this time and space is the opportunity to develop relationships and gain insight into the issues that are prevalent for the women attending. This has resulted in the identification of a number of issues of concern where we have been able to work in close partnership with our colleagues to protect individuals and families deemed at risk.

"It gets me out of the house."

The value of the Hen's Shed and the networks and support it offers were detailed in a presentation at the IJB celebration event in Dumfries this year. Over a number of weeks staff worked with the women to identify what makes the Shed work for them and then support them to develop a presentation which they were able to deliver themselves. This illustrated the confidence they had developed and was a significant achievement as they have never spoken in public before or engaged with large groups of people.

"This is our safe space."

"I was so proud of the Hen's Shed speaker. It takes a lot of courage to stand up and speak, and the audience really connected with her story. Brilliant"

- IJB event organiser

4.2.8 Housing Development

The partnership is working towards a new housing development that will look at merging three existing properties into one new build. This will allow each resident to have their own individual, purpose built home with the same care provider in a core and cluster model. This is expected to give each of the residents more independence with the onsite support of the care provider. This is expected to be completed by 2021.

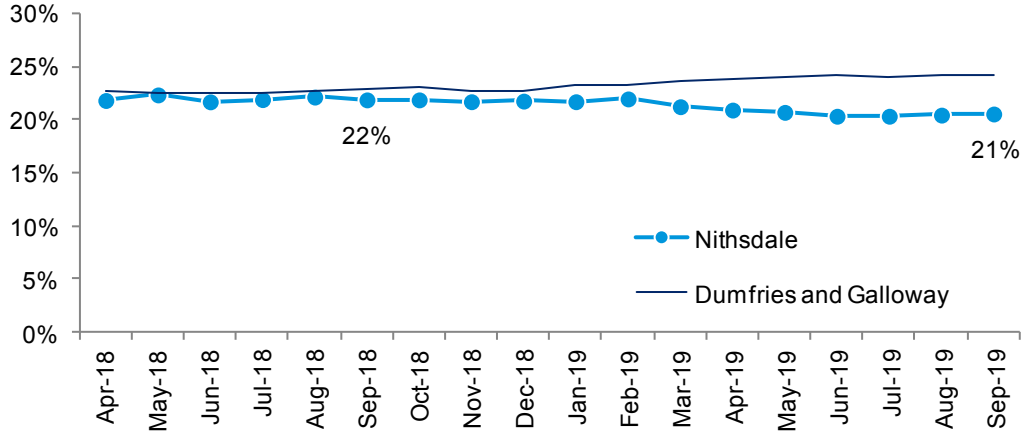
There is ongoing work with colleagues in commissioning looking at how to upgrade current properties to make them more sustainable for the future. This work is in the early stages and we are in discussion with a number of care providers looking at supporting them with modernisation and upgrading to ensure the people they support have a more independent life.

4.3 How we are getting on

The proportion of people in Nithsdale receiving support through Self Directed Support Options 1 or 2, which have the largest levels of personal responsibility has remained stable for the past two years. Whilst we support people to have the confidence to choose Options 1 and 2 for themselves, many people continue to prefer to choose Option 3.

Around one in five people aged under 65 have chosen Options 1 and 2, whilst for people aged 65 or older, it is around one person in twenty. In September 2019 there were 79 people aged under 65 receiving care through SDS and 34 people aged 65 or older. It is not clear why the proportion of people electing for Options 1 and 2 might be lower in Nithsdale compared to Dumfries and Galloway.

Percentage of people under 65 years with SDS accessing options 1 and 2; Nithsdale



Source: Dumfries and Galloway Council, local figures

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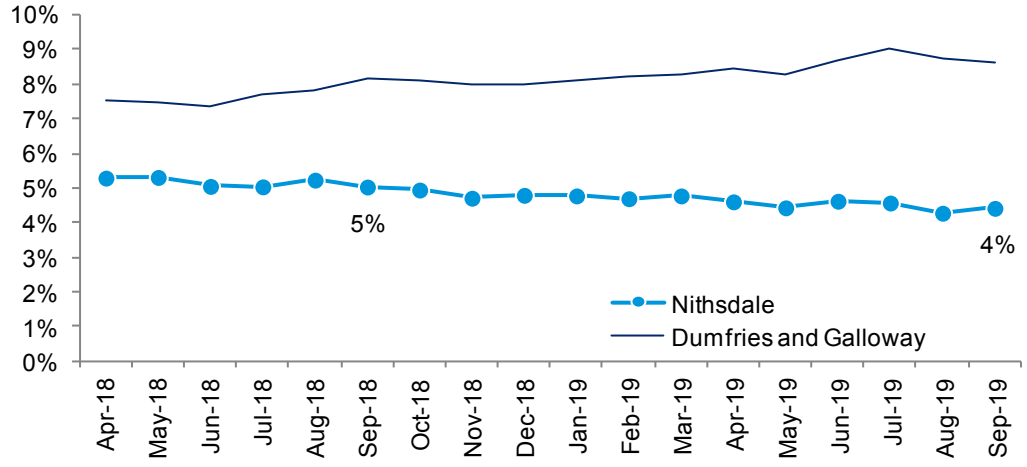
Percentage of people 65 and over with SDS accessing options 1 and 2; Nithsdale



Source: Dumfries and Galloway Council, local figures

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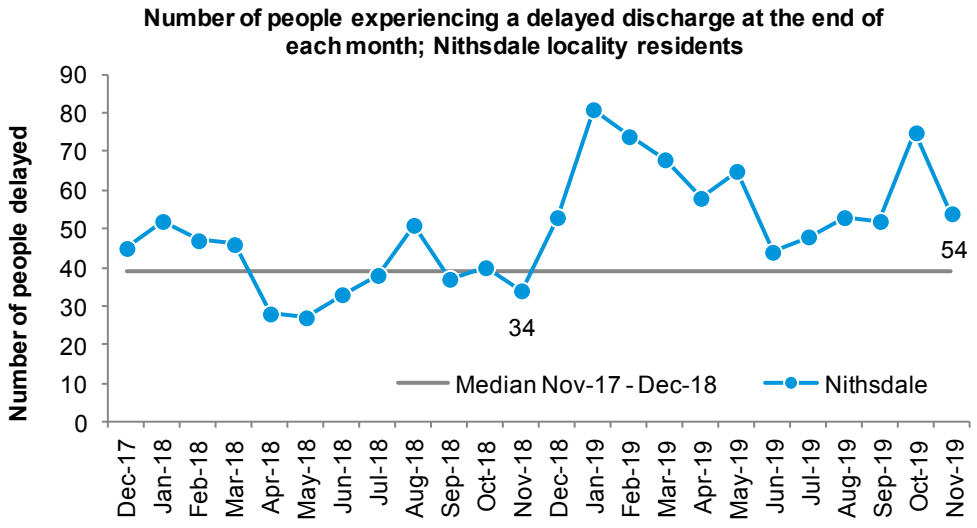
One measure of the successful coordination of people's journey of care, is the amount of time spent in hospital settings when people were ready to be discharged to a less acute setting or into the community. When people are not in the most appropriate place for their care we refer to this as a delayed discharge.

In Nithsdale, and across Dumfries and Galloway over the last year, the number of people experiencing a delayed discharge (in acute, community or cottage hospital setting) has risen on average. Reasons for this include recruitment challenges across both health and social care sectors and complex legal arrangements including guardianship. A dedicated flow coordinator works with the multidisciplinary team to enable smooth transitions from one setting to another.



Source: NHS Dumfries and Galloway, local figures

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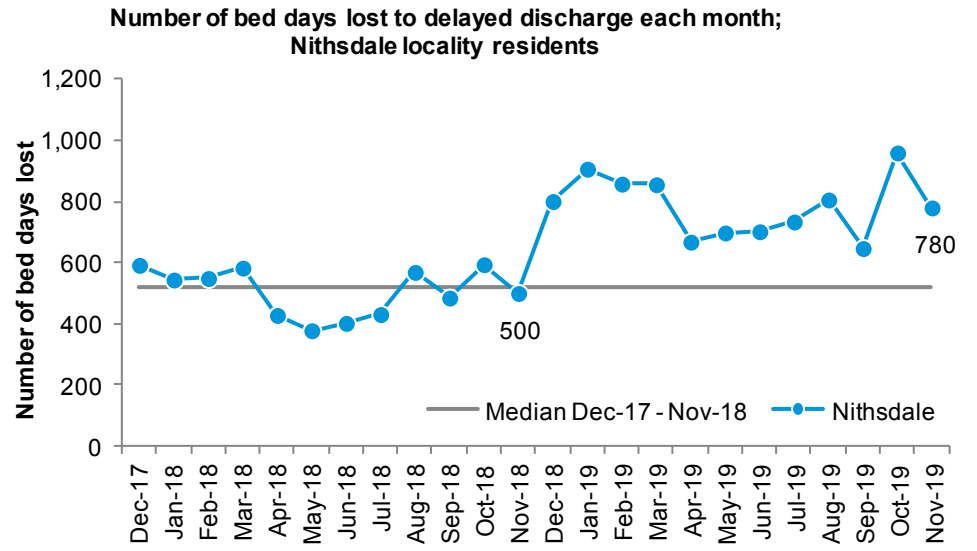

Source: NHS Dumfries and Galloway, local figures

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7. Outcome 7

People using health and social care services are safe from harm

7.1 How we support this in our locality

Making sure people are safe from harm is about maintaining safe, high quality care and protecting vulnerable people. In some instances activities focus on protecting people already identified as vulnerable. Other activities are focussed on improving the safety of services, aiming to reduce the risk of harm to all people.

In our locality, good examples of this are:

- Forensic health for adults who have experienced rape, sexual assault
- Care Assurance audits in Thornhill Hospital
- Helpline card
- Virtual community ward
- Multi Agency Safeguarding Hub (MASH)

7.2 How we are addressing this outcome in our locality

Our We Will commitments which support this outcome and their current Red, Amber, Green (RAG) status:

19 Keep people at the centre of what we do, working with all partners to improve the way we identify, support and protect adults who are vulnerable to physical, psychological or financial harm.

7.2.1 Forensic health for adults who have experienced rape, sexual assault

Forensic health is a hosted service within Nithsdale locality. Previously all forensic examinations for victims of rape and sexual assault were carried out in a police setting. We opened the new forensic health examination facility at Mountain Hall Treatment Centre in July 2019.

The service provides forensic examinations for adults and trauma informed care, whilst meeting all the evidence guidelines to satisfy the needs of Police Scotland and Procurator Fiscal. The site was developed in partnership with Clinical Lead Forensic Medical Examiner, Police Scotland, Sexual Health, Public Protection, Scottish Government Taskforce and our local Rape Crisis team, who were able to bring the survivors voice and views into the design.

> “It does 'feel' very much better doing these examinations away from the police station - I'm not certain why that is, I think it is possibly that extra confidence knowing that all the kit and stuff is going to be there and that we now have a better (NHS) structure for looking after the unit and dealing with these kinds of cases?” - Forensic Medical Examiner

7.2.2 Care Assurance

This is a quality of care tool used in cottage hospitals which monitors the quality of care we deliver to our inpatients. It audits the care delivered across 9 separate standards, ranging from food, fluid and nutrition, medicines, falls, and pressure area care. Nursing staff in Thornhill Hospital carry out level 1 weekly, a nurse manager carries out level 2 monthly and an external team audit each standard every 3 months. From this, action plans are compiled to take forward any improvements highlighted.

How we are getting on: Care Assurance

The results from most recent Care Assurance audits carried out at Thornhill Hospital were:

Standard	Percentage Compliance	Standard	Percentage Compliance
Falls	90%	Medicine	99%
Pressure Area Care	100%	Discharge and Transfers	100%
Food, Fluid and Nutrition	92%	Staff and skill mix	70%
Relationship Centred Care	82%	Infection Control	95%
Cognition	83%		

Bronze - at least 75% compliance

Silver - at least 85% compliance

Gold - at least 95% compliance

Exemplary - 3 consecutive gold assessments

7.2.3 The Single Point of Contact (SPoC)

A robust triage process and daily huddles enhance patient safety, as more time is spent gathering accurate background, ensuring the people are seen by the right service at the right time and place, every time. Information is shared with the wider Multi Disciplinary Team (MDT) to ensure people's safety and minimise risk.

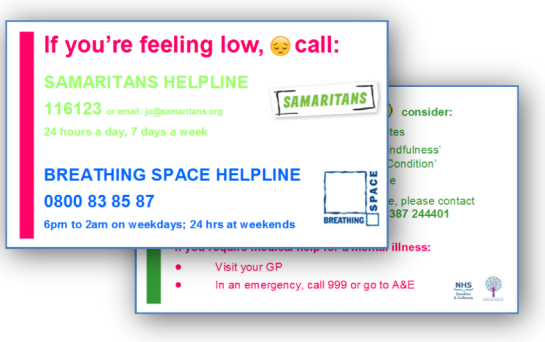
Daily multi disciplinary huddles support identifying people in Nithsdale who are vulnerable and identifying appropriate protective support to reduce the risk of harm.

7.2.4 The SPoC Virtual Community Ward (VCW)

This initiative allows people to remain at home safely as they are cared for and supported. Evidence robustly demonstrates that hospital admissions can increase the of risk of harm to people. The virtual community ward has made it possible to safely treat people in their home, reducing the risks associated with hospital admission.

7.2.5 Helpline Card

Nithsdale Health and Wellbeing Team developed this card. It has been used extensively by the Healthy Connections service and has been shared with health and social care colleagues. A trial at Charlotte Medical Practice in the autumn 2019 proved very successful with the number of cards being taken surpassing expectations. It will be offered to all Nithsdale GP practices early in 2020.



7.2.6 Multi Agency Safeguarding Hub (MASH)

The Adult Social Work Team within MASH continues to be hosted by Nithsdale locality. There have been developments in this service in the past 12 months, with the additional appointment of a Senior Social Worker. Nithsdale locality has also added a social worker for a trial period to support the volume of regional work within the MASH and to provide a more detailed analysis of the work undertaken.

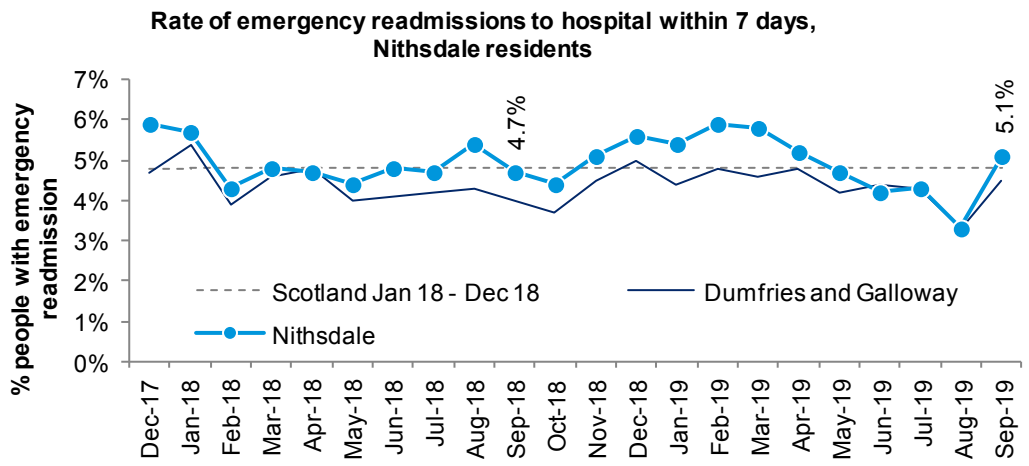
MASH social workers now complete all Adult Support and Protection (ASP) 'Duty to Inquires' for the region and provide oversight of the ASP work across all localities. This is working well with support provided to all localities.

MASH screens all potential ASP referrals to decide if further action is required. If this is the case then the Duty to Inquire will be started and background checks and assessment will be completed to determine what further supports, if any, are required for the person. If ongoing or complex support is needed, the referral will pass to the locality social work team.

Since this new process began the increase in ASP Duty to Inquire numbers has risen by almost 50% in Nithsdale. This reflects the increased scrutiny of the referrals and the work being done in MASH. A rolling audit of Adult Support and Protection work has started, to ensure a consistent high standard across localities. This has highlighted good practice that is being shared with other workers.

7.3 How we are getting on

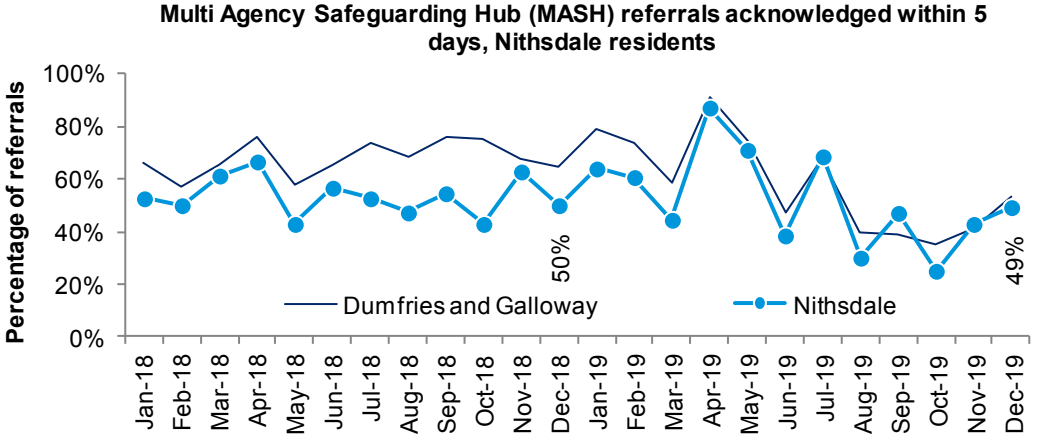
One aspect of keeping people safe is monitoring readmissions to hospital. Whilst a discharge quickly followed by an emergency admission may be entirely appropriate in many cases, it could mean in some cases that people were possibly discharged before they were ready. Readmission rates are typically around the Scottish rate of 4.7% for Nithsdale whereas Dumfries and Galloway is typically below the Scottish average. The figures for Nithsdale residents are more variable, which reflects the smaller number of people involved.



Source: NSS Discovery, GP Cluster Activity, from Scottish Morbidity Records (SMR01)

D27

Adult Support and Protection activity is scrutinised through the Public Protection Committee (PPC). The PPC Performance and Quality subcommittee is currently redesigning the analysis and reporting of performance figures for Adult Support and Protection. It is expected that when performance reporting has been agreed, an appropriate locality level measure will be reported here. In the interim, the previous indicator showing the percentage of people making referrals who receive feedback within 5 days of receipt of their referral, was 49% in December 2019.

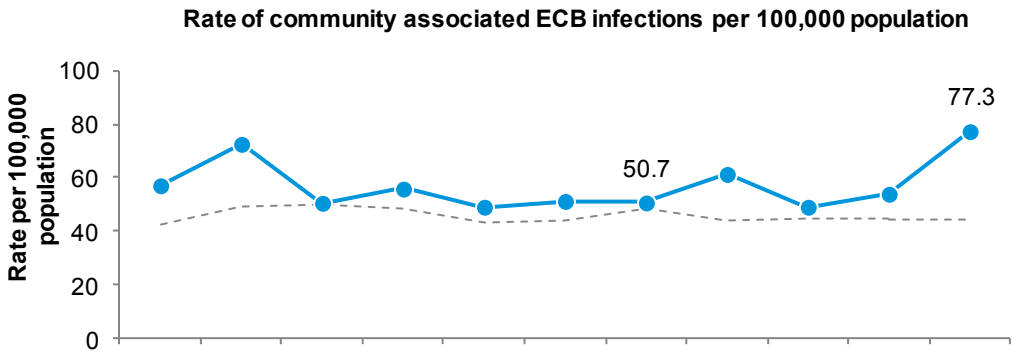


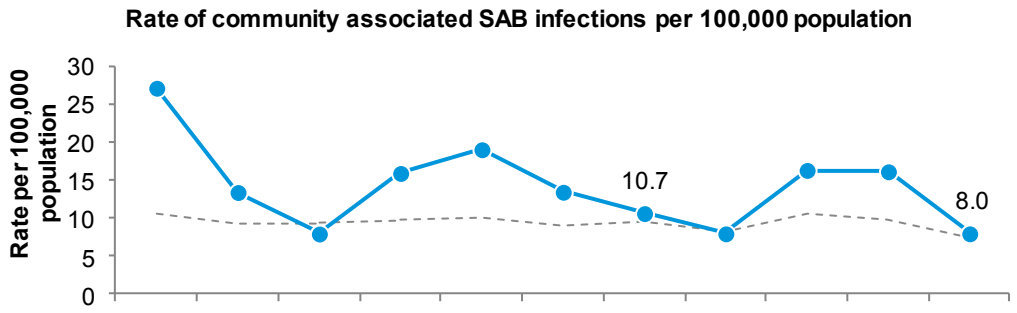
Source: Dumfries and Galloway Council, local figures

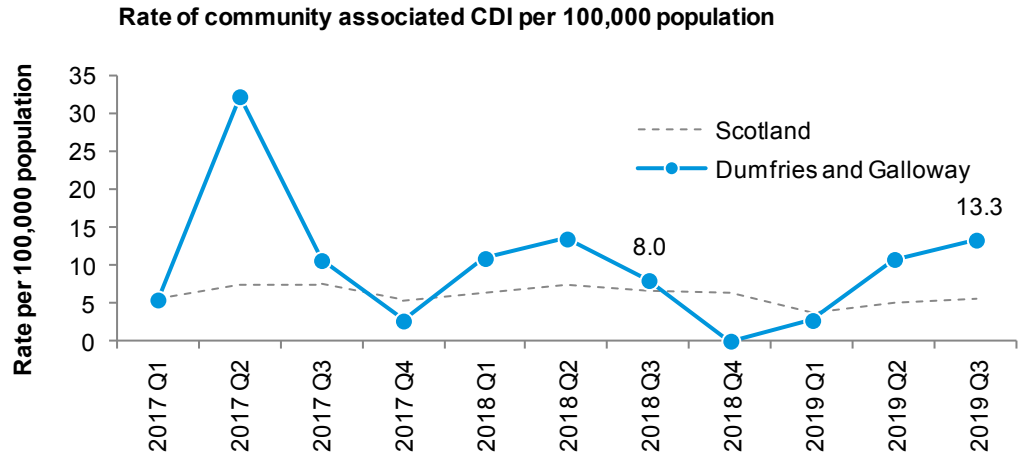
C9

Infections can be acquired in different environments: hospital, other health care settings, and in the community such as people's own home and care homes. The charts below show rates of infection associated with community settings for Dumfries and Galloway (locality rates not available) compared to Scotland for infections monitored by Health Protection Scotland.

The number of people from Dumfries and Galloway contracting these infections is small. Typically in the community across the region, during a 3 month period, fewer than 30 people are diagnosed with an Escheriachia coli (E Coli) infection, fewer than 5 people are diagnosed with a Staphylococcus aureus Bacteraemia (SAB) infection, and fewer than 5 people are diagnosed with a Clostridium Difficile (C Diff) infection. These small numbers mean that changes in infection rates over time can appear variable and erratic. However, these changes represent month to month differences of just 1 or 2 people. The small numbers also mean that it is not possible to report rates at a locality level.







Source: ISD Scotland (Discovery)

9. Outcome 9

Resources are used effectively and efficiently in the provision of health and social care services

9.1 How we support this in our locality

There are various ways that the Partnership is seeking to ensure that resources are used effectively and efficiently. We are improving quality and efficiency by making the best use of technology and trying new ways of working to improve consistency and remove duplication. The Partnership is committed to using its buildings and land in the most efficient and effective way.

In our locality, good examples of this are:

- Locality Flow Meetings
- A Single Point of Contact
- Day of Care Survey
- Effective use of Resources in Prescribing
- Volunteering and Working in Partnership
- Sheltered Housing
- Assessments for Services

9.2 How we are addressing this outcome in our locality

Our We Will commitments which support this outcome and their current Red, Amber, Green (RAG) status:

24 Through effective use of resources, including those of the individual, support the redesign of integrated services.

25 Develop and promote a culture amongst staff and the people who use services that will support and engage with the redesign of services. These services will be sustainable, promote independence, support an ethos of reablement and deliver person centred outcomes.

23 Encourage and support recruitment in to the care sector.

24 Work with all partners to look at how we can make the best use of assets and resources.

25 Build on the existing initiatives in Nithsdale to ensure safe, appropriate, effective prescribing.

9.2.1 Locality Flow Meeting

Building on the success of the weekly locality flow meetings, this is now integral to the Single Point of Contact daily huddles and a daily communication is sent to Senior Management Team to provide them with an update. This ensures that flow is at the forefront of planning in Nithsdale community and in turn, resources are used effectively and efficiently. The daily flow meetings are attended by Social Work, Healthy Connections, Community Nursing, Occupational Therapy and Physiotherapy. This is a multi disciplinary discussion relating to delayed discharges and multi agency assessments, ensuring that people have their needs assessed by the right person.

9.2.2 A Single Point of Contact

A Single Point of Contact Virtual Community Ward (VCW) has been established for people who are acutely unwell, allowing them to remain in their own home safely as they receive care, support and treatments.

Single Point of Contact (SPoC) enables access for all as the general public can self refer to services that they once were only able to access via a GP. People can also be signposted to other services in the third and independent sectors. The robust triage process in place ensures that people are seen by the right service at the right time and place, every time, ensuring person centred care. Representatives from Nithsdale community services continue to attend daily multi disciplinary team huddles to discuss complex referrals and agree the best way forward for people and reducing duplication visits. Dietetics, podiatry, and speech and language therapy are now part of SPoC.

9.2.3 Day of Care Survey

Every month an assessment called a Day of Care Survey is done across all of the cottage hospitals. This assessment uses a set of criteria to determine if people are being cared for and supported in the most appropriate setting.

In November 2019 the results for Thornhill Hospital showed that 6 people out of 13 (46%) could have been supported in a more appropriate setting. Across all cottage hospitals in Dumfries and Galloway, 50% could have been supported in a more appropriate setting.

9.2.4 Effective use of Resources in Prescribing

The prescribing team has been expanded to include the implementation and delivery of a new pharmacotherapy service in every GP practice in Dumfries and Nithsdale. The focus of this is to provide access to specialist medicines advice. This includes medicines reconciliation, acute medication requests and general medicines queries.

To provide this service, additional team members have been recruited, including pharmacy support workers, trainee pharmacy technicians and GP practice Clinical Pharmacists. Training, including General Practice Clinical Pharmacist Advanced Framework, Independent Prescribing, Pharmacist Foundation Framework and the Pharmacy Technician programme, is underway to assist in the competent delivery of the service. This has required substantial guidance and support from the locality lead pharmacists, including assurance of competency in new tasks and making sure that tasks are assigned to the right member of the team.

Pharmacy technicians have been assisting with medicines reconciliation to check that medication records are accurate and complete. This happens when someone is discharged from hospital or attends an outpatient clinic appointment.

Specialist clinics run by experienced pharmacist independent prescribers have continued to develop, to ensure the safe and effective use of medication, to effectively treat conditions such as pain, asthma and hypertension.

Pharmacy Support Workers were a new addition to the prescribing support team and in Dumfries and Nithsdale have developed their role to include:

- working with care homes to look at medicines management and medicines waste
- working with GP practices to look at serial prescribing and increase the numbers of people subscribed to the repeat prescription management system
- assisting the pharmacy technicians with Cash Releasing Efficiency Scheme (CRES) and Local Enhanced Scheme (LES) audit work

With the expanded team there is now regular pharmacist input to the SpoC morning meetings. The majority of the pharmacy input to this is through the Optimise programme, which enables the pharmacy team linked with the person's GP practice to target and review their medication related needs.

The team continues to support Thornhill Hospital with regular input to MDT meetings. There has been a focus on service development, such as continuing the Mindfulness for Pain course. This complements the wider aspect of reviewing appropriate prescribing for those people with chronic pain and the specialist clinics offered for pain reviews.

Prescribing initiatives such as cost effectiveness audits and reviewing prescribing data on a monthly basis, has continued alongside this activity. This helps to ensure that prescribing is as appropriate and cost effective as possible.

9.2.5 Building Healthy Communities (BHC) Volunteers transition into the NHS

Building Healthy Communities Area Partnerships (BHCAPs) for Upper Nithsdale and Lower Nithsdale, identified three years ago it was time for change and members from both BHCAP decided that it was the right time for them to come together to work collectively to become one. This formed Nithsdale BHC Area Partnership.

BHCAP members have continued to be supported through this process by Health and Social Care staff. A key part of this process included Nithsdale BHCAP members working with the volunteers and the health and social care partnership to explore future options. As a result of this process BHC volunteers will join NHS Dumfries and Galloway volunteers in February 2020.

This new role will be as Nithsdale Community Health Development Volunteers (NCHDV). There will be two strands to this role:

NCHDV Activity Leaders and Facilitators - This role will provide targeted support to young people and vulnerable adults who may have long term conditions

NCHDV Active Citizens - This role will promote social inclusion, active citizenship; community led collective action, collaboration and influencing policy

9.2.6 Sheltered Housing

The sheltered housing complexes in Nithsdale now have one care provider associated with each of them and it is hoped that this will enable a more person centred and flexible service for each of the residents whilst maximising availability of the care and support available. This has been supported by the social work team in Dumfries.

In order to continue to create efficiencies and support providers to meet the increasing demands on services, Dumfries town centre is undergoing a 6 month pilot to look at current care provision in the town and how this can best be used to meet the needs of the people and the needs of the service. This is expected to start in February 2020 and will be supported by the social work team.

9.2.7 Assessments for Services

There is now a full time care coordinator based with the Short Term Assessment and Reablement Service (STARS) team who takes part in their reablement assessments. This enables quicker assessments for service users who require longer term care and allows a smoother transition from STARS to a care provider.

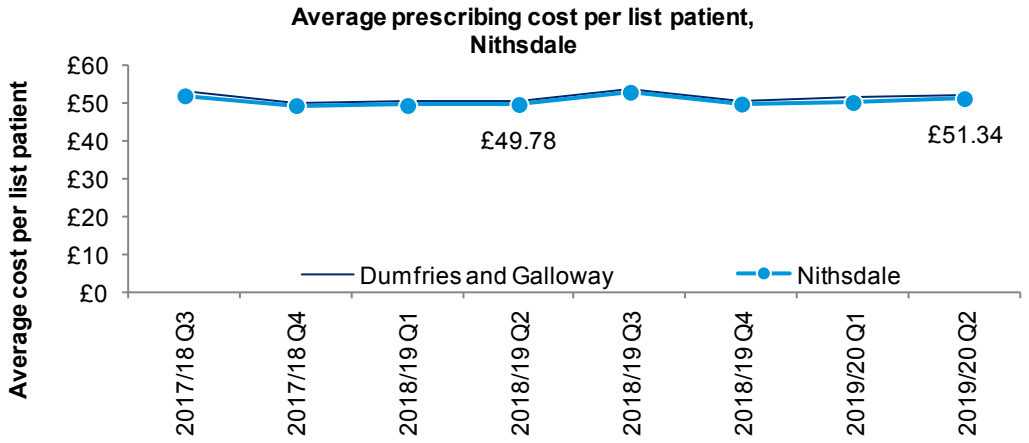
The care coordinators in Dumfries and Galloway Royal Infirmary are working with patients at the initial assessment while in the Combined Assessment Unit (CAU). This is supporting a quicker assessment and quicker discharge back home.

Nithsdale have a consistent number of people referred to and using telecare. Since recordings started in 2015 Nithsdale have maintained a consistent number of people with Self Directed Support accessing telecare, which is in the region of 74%.

9.3 How we are getting on

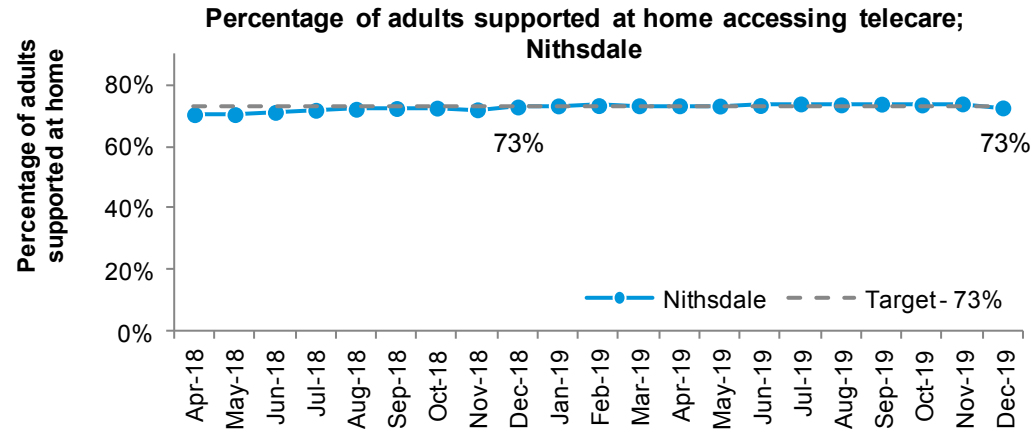
The Strategic Plan Adults Needs Assessment indicates that over 75% of the population receives a prescription at least once per year. In 2016/17 the annual cost per person ranged from £137 - £277 across the GP practices. This is partly because of the different mix of people they support. Nithsdale has a very similar cost per person to Dumfries and Galloway. The figure for July to September 2019 was higher than the same period in the previous year. Note that these figures are not adjusted for age profile. Also, the cost of medications is strongly influenced by market forces, not just the volume of medication dispensed.

Another measure of efficiency is how effectively the Partnership uses technology to support people, both to live independently and to access services equitably. An indicator is under development to demonstrate how Technology Enabled Care is being rolled out. This will include both the well established telecare support, and also Home and Mobile Health Monitoring (such as text message medication reminders) and video consultations. The current indicator shows the percentage of people with SDS Option 3 supported with telecare, was 73% in December 2019



Source: PRISM, LHP Average Prescribing Costs Per 1,000 People

D28



Source: Dumfries and Galloway Council, local data

C1

Appendix 1: Summary of Locality Indicators

Locality Indicator			Previous Value			Current Value		
			Time Period	Dumfries and Galloway	Nithsdale	Time Period	Dumfries and Galloway	Nithsdale
Outcome 1	D23	Rate of Emergency Department attendances by locality of residence per 1,000 population	Sep 2018	24.4	26.8	Sep 2019	26.8	28.1
	D24	Rate of emergency admission by locality of residence per 1,000 population	Sep 2018	9.6	10.8	Sep 2019	9.0	9.9
Outcome 2	C8	Total number of care at home hours provided as a rate per 1,000 population aged 65 and over	Dec 2018	566.2	657.8	Dec 2019	548.5	635.5
	A15 / E5	Proportion of last 6 months of life spent at home or in a community setting	2017/18	89%	88%	2018/19	89%	89%
Outcome 3	D2	Number of complaints received by the locality team (all stages)	-	-	-	2018/19	-	19

Source: ISD Scotland, HACE Dashboard, Dumfries and Galloway Council (p) - Provisional result

We are meeting or exceeding the target or number we compare against

We are within 3% of meeting the target or number we compare against

We are more than 3% away from meeting the target or number we compare against

	Locality Indicator		Previous Value			Current Value		
			Time Period	Dumfries and Galloway	Nithsdale	Time Period	Dumfries and Galloway	Nithsdale
Outcome 4	C10	Percentage of people supported by SDS Option 1 or Option 2, under 65 years of age	Sep 2018	25%	22%	Sep 2019	24%	21%
	C11	Percentage of people supported by SDS Option 1 or Option 2, 65 years and older	Sep 2018	8%	5%	Sep 2019	9%	4%
	D25	Number of people with delayed discharge in all hospitals (Dumfries and Galloway Royal Infirmary, Galloway Community Hospital and Cottage Hospitals) by locality of residence	Dec 2017 - Nov 2018	628	275	Dec 2018 - Nov 2019	968	433
	D26	Number of bed days lost to delayed discharge by locality of residence	Dec 2017 - Nov 2018	14,622	6,055	Dec 2018 - Nov 2019	22,527	9,417
Outcome 5	D13	Difference in the rate at which people attend hospital in an emergency between the most deprived and least deprived communities in the locality (per 1,000 population)	2016/17	38	57	2018/19	41	67
Outcome 6	C5	Number of Adult Carer Support Plans developed within the locality	2017/18	-	56	2018/19	-	64

Source: ISD Scotland, HACE Dashboard

We are meeting or exceeding the target or number we compare against

We are within 3% of meeting the target or number we compare against

We are more than 3% away from meeting the target or number we compare against

Locality Indicator			Previous Value			Current Value		
			Time Period	Dumfries and Galloway	Nithsdale	Time Period	Dumfries and Galloway	Nithsdale
Outcome 7	D27	Percentage rate of emergency re-admission to hospital within 7	Sep 2018	4.0%	4.7%	Sep 2019	4.5%	5.1%
	C9	Percentage rate of referrals to the Multi Agency Safeguarding Hub (MASH) acknowledged within 5 days	Oct – Dec 2018	69%	53%	Oct – Dec 2019	44%	40%
Outcome 8	D5	Proportion of people who agree that they have the information necessary to do their job	2017	80%	n/a	2019	79%	78%
	D21	Proportion of people who agree that they are involved in decisions relating to their job	2017	70%	n/a	2019	69%	68%
	D22	Proportion of people who would recommend their organisation as a good place to work	2017	74%	n/a	2019	74%	74%
Outcome 9	D28	Average prescribing costs per person for 3 months	Jul - Sep 2018	£50.60	£49.78	Jul - Sep 2019	£52.41	£51.31
	C1	Percentage of People With SDS Option 3,supported with Telecare	Dec 2018	73%	73%	Dec 2019	73%	73%

Source: ISD Scotland, HACE Dashboard

We are meeting or exceeding the target or number we compare against

We are within 3% of meeting the target or number we compare against

We are more than 3% away from meeting the target or number we compare against

If you would like some help understanding this or need it in another format or language please contact dg.ijbenquiries@nhs.net or telephone 01387 241346