Dumfries and Galloway
Integration Joint Board

20th January 2022

This Report relates to
Item 5 on the Agenda

Response to Health and Social Care System Pressures

(Paper presented by Julie White)

For Approval

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List of Background Papers:	n/a
Appendices:	n/a

Direction Required to Council, Health Board or Both			
	Title	**Reference Number**	
	Direction to:		
	1. No Direction Required		*x*

	2. Dumfries and Galloway Council	
	3. NHS Dumfries and Galloway	
	4. Dumfries and Galloway Council and NHS Dumfries and Galloway	

1. Introduction

1.1 Over the years, the Health and Social Care Partnership have recognised that there is a requirement to redesign our services to ensure that we continue to meet the needs of our local population and respond to increasing demands due to changes in need and demography whilst also addressing workforce challenges and financial pressures.

1.2 The Strategic Commissioning Plan sets out the vision for the Integration Joint Board taking account of these pressures. Recently, the Strategic Commissioning Plan has been redeveloped to set out a range of Strategic Commissioning Intentions and is currently undergoing a period of Consultation before being presented back to the IJB in March 2022.

1.3 The challenges facing Dumfries and Galloway are not unique to this region as current pressures are mirrored elsewhere in Scotland. We are continuing to work with our National Networks to ensure we are capturing lessons learned and to ensure we are working together and sharing learning across the Partnerships.

1.4 With that said, Dumfries and Galloway's Health and Social Care System is currently experiencing an extreme surge in demand for Services as it responds to increased demand, the current phase of the COVID Pandemic and Winter Pressures.

1.5 There is no single reason for the current situation, but a multitude of complex factors across the whole Health and Social Care System. In many areas we are seeing the highest level of demand combined with restricted capacity and increasing patient and service user need culminating in significant system pressures.

1.6 The demography in the region has been evidenced through various strategies and health intelligence reporting where we anticipated we would see demand grow notwithstanding the impacts of the pandemic on the health and care system. Together with pressures on the working age population in the region which is reflected in the regional economic strategy which highlights the demand increase on need and supply constraints on staff.

1.7 In October 2021, all NHS Boards and Health and Social Care Parnterships received a letter from John Burns, Chief Operating officer, outlining a range of measures and new investment being put into place nationally to help protect health and social care services over the winter period and to provide longer term improvement in service capacity across our health and social care systems.

1.8 Our Health and Social Care Partners have aligned the Scottish Government measures to outline the local investment required to address the significant system pressures currently being faced. All of our winter planning preparations are predicated on four key principles:

- Maximising capacity – through investment in new staffing, resources, facilities and services.

- Ensuring staff wellbeing – ensuring that they can continue to work safely and effectively with appropriate guidance and line-management and access to timely physical, practical and emotional wellbeing support.

- Ensuring system flow – through taking specific interventions now to improve planned discharge from hospital, social work assessment, provide intermediary care and increase access to care in a range of community settings to ensure that people are cared for as close to home as possible.

- Improving outcomes – through our collective investment in people, capacity and systems to deliver the right care in the right setting.

The key areas of investments are described in the main body of this report.

2. Recommendations

2.1 **The Integration Joint Board is asked to:**

- Recognise the whole system pressures that Dumfries and Galloway's Health and Social Care System is experiencing.
- Approve the local investment needs required to support the system over the winter period together with the longer term improvement in service capacity.
- Approval to engage with all stakeholders regarding the report content and the further development of solutions.

3. Current System Pressures

The majority of our services across the Health and Social Care Partnership, be that in primary care, social work and social care, hospital services or community based provision, are experiencing an increase in the both the level and complexity of demand. This was the case pre-Covid but has been exacerbated by the ongoing Pandemic and the impact of the virus on capacity to respond to ongoing increased demands. Importantly, the challenges the Partnership is facing have absolutely been augmented by COVID but were in effect already in the system.

3.1 **COVID-19** is continuing to impact on capacity to support our community. The need for ongoing infection prevention and control (IPC) measures within NHS sites and social care settings has become part of daily business, reducing the number of patients and service users that can safely be treated each day, both because of time and physical capacity needed to maintain social distancing. For example, emergency response teams are required to complete additional procedures, including wearing extra personal protective equipment, impacting the speed at which they can respond to a call.

3.2 **Workforce** - we are currently reporting higher sickness levels as well as covid related absences. The three highest causes of sickness relate to 1 - cold, cough, influenza, anxiety 2 - Anxiety/stress/depression/other psychiatric illnesses closely followed by 3 - Gastro-intestinal problems.

The COVID related isolation guidance has had a significant impact on staffing levels across health and social care settings. The recent changes to isolation timelines is welcomed by the Partnership.

3.3 **Hospital Occupancy**

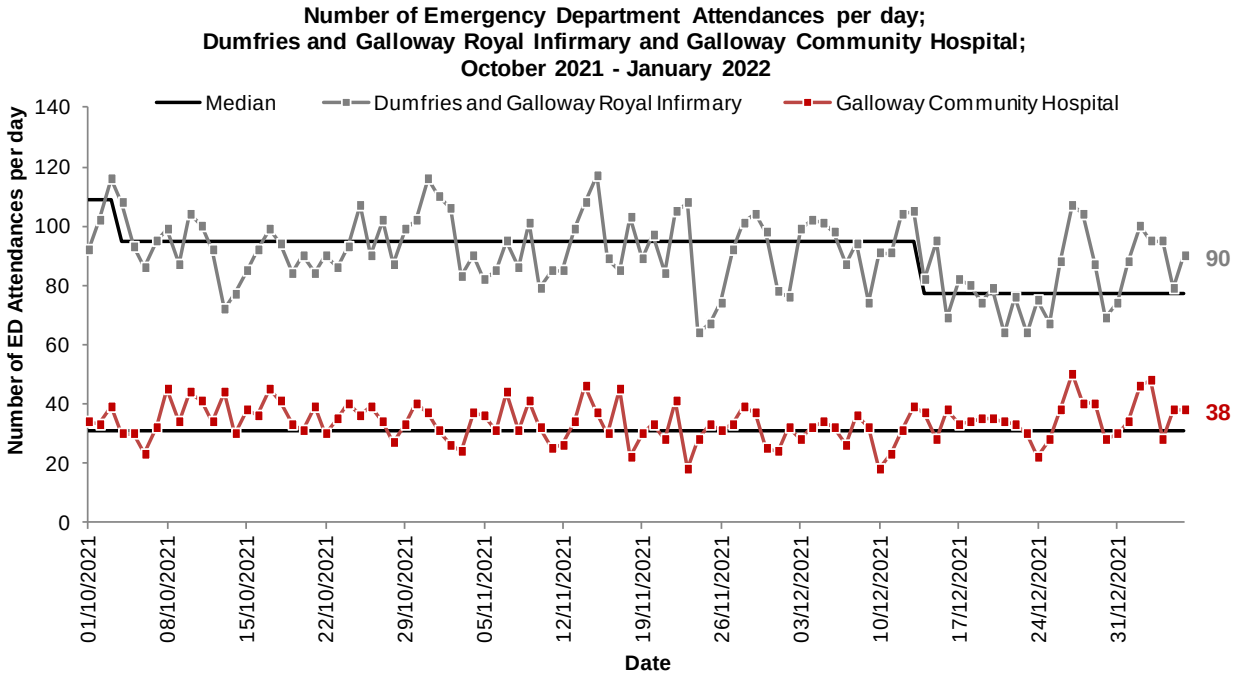
Across all Hospital sites we are consistently experiencing 95% - 100% occupancy across all the hospitals. Dumfries and Galloway Royal Infirmary has been operating at 100% occupancy for a number of months, additionally Midpark Hospital has been operating at 100% - 110% over the last few months where we have seen a peak of 112% occupancy in December 2021.

3.4 **COVID Admissions**

We are seeing a gradual increase in COVID admissions across hospitals at this time (as at 10th January 2022) which equates to 31 patients.

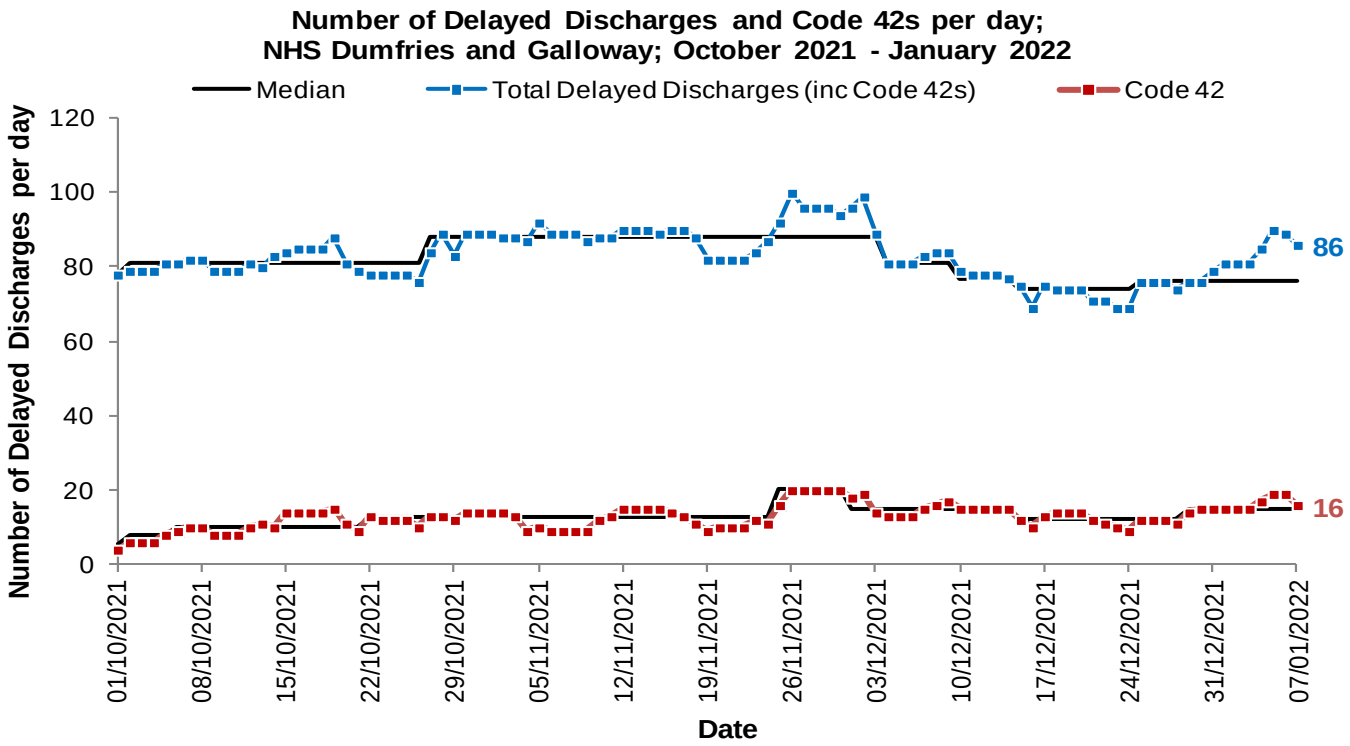
3.5 **Urgent and Emergency Care Attendances**

Daily emergency attendances continue to be above the median across both DGRI and GCH Emergency departments.



3.6 **Delayed Discharges**

We have seen a significant increase in delayed discharges over the last few months.



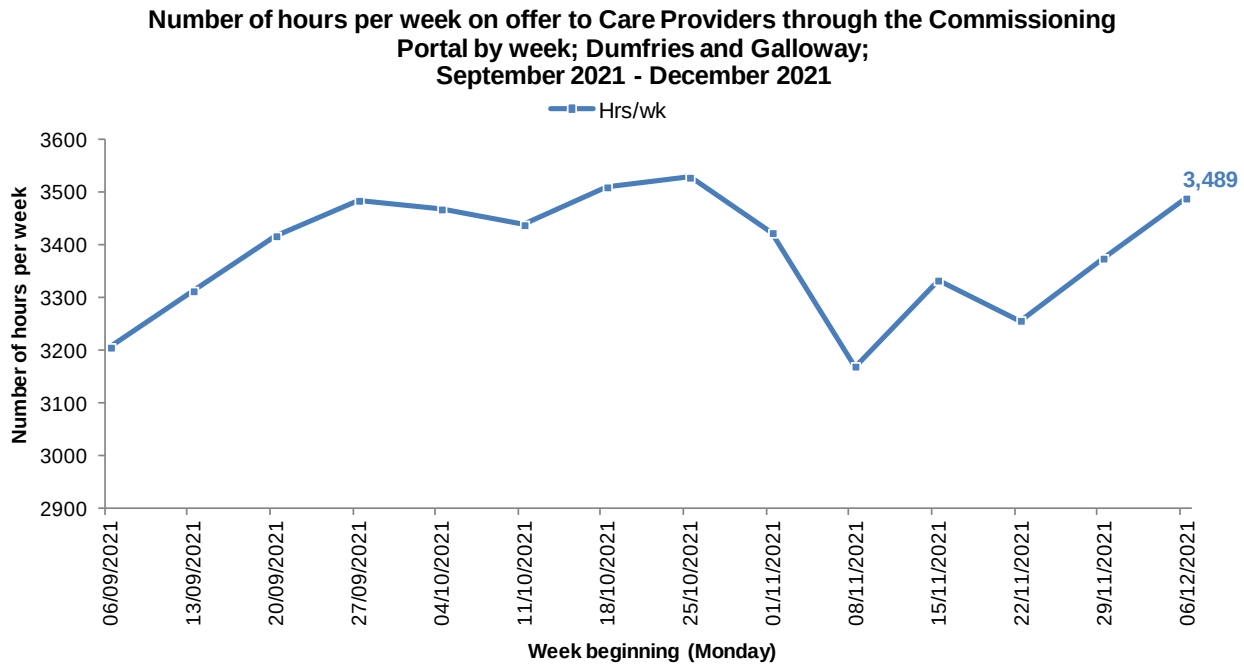
3.7 **Social Care** – people awaiting for Care and Support at Home

The Health and Social Care Partnership continues to work with both the Council's inhouse Care and Support Service alongside our Third and Independent Sector providers to identify ways of increasing capacity to address the identified gap in social care provision.

The approximately 3,500 hours a week of care that requires to be filled equates to approximately 330-350 individuals across the community and the hospital setting. The range of measures being implemented to address this are set out in section 4 of the report.

Whilst we have been able to successfully recruit into the Council's in house service, staffing retention challenges across all Providers have impacted on our abilities to sustain a reduction in unmet hours of need.

NB (ref: chart below): the drop in activity in November 2021 was due to the data unable to be processed



3.8 **Vacant Care Home Placement**

At this time, of the 31 Care Homes within our region 8 of these are closed to admissions due to COVID which has impacted on the ability to transfer of patients / residents to care home or use interim care placements. Furthermore, there are 2 Care Homes which have Care Inspectorate requirements which has resulted in improvement plans therefore Moratoria is in place.

There is limited bed availability across the region due to the COVID pressures, and staffing levels at this time.

3.9 Availability of staffing continues to be a significant factor for both Care Homes and Care at Home providers.

3.10 The Health and Social Care Partnership recognises the huge contribution that unpaid Carers make in ensuring that care and support needs are met across the region. Families, friends and local communities have continued to respond in a very effective manner and this support is even more vital at this time of significant service pressure. However, it is fully recognised that Carers have themselves been affected by the impact of the Pandemic and there is a need for further support to be provided to ensure that Carers are able to continue to provide this much needed input within the Partnership. More detail on the work being undertaken to support Carers is provided in section 4.

4. Response to System Pressures

Throughout the Pandemic, the Health and Social Care Partnership has developed a range of plans to respond to changes in need and demands on resources including Surge Plans, Pandemic Control Plans, Scaling back plans and Workforce plans alongside our remobilisation and recovery plan. .

The plan outlined below outlines the local investment to support the system over the winter period and the response to the ongoing surge together with the longer term improvement in service capacity.

4.1 **Workforce Absence**

We have set thresholds to allow careful monitoring of sickness and covid absence levels. This alongside a number of other winter measures enables the identification of any potential surge. In addition to surge plans, we have produced operational / corporate teams scaling back plans to support any extremis service pressures.

4.2 **Multi-agency Working**

Multi-agency working through our Tactical Local Resilience Partnership has been integral to working together as a Partnership in terms of shared learning, preparedness, resilience and response to the Partnership pressures.

4.3 **Social Care Staffing**

Support for social care is to be intensified as a national priority alongside the NHS and emergency services, as staffing pressures and increased demand reflect the extent and nature of the spread and effect of Omicron.

As a result of staffing availability due to Covid, the Scottish Government and COSLA, working with local partners across the public services in Scotland, have agreed a joint approach to maximise social care support to ensure people receive the care they need, dignity and human rights are upheld, and to avoid further pressure falling on the NHS.

Pressure on social care staffing is very significant with some teams being asked to prioritise capacity and identify staff who can be deployed to sustain and maintain support for some of the most vulnerable people in society. This may mean some other services are temporarily paused or reduced to redeploy capacity and expertise. Work is being undertaken locally via our Local Resilience Partnership networks to ensure that requests for additional capacity and support are fed through to Partner organisations to consider appropriate responses. Throughout the Pandemic, Partner organisations have shown a willingness and ability to contribute to the wider response within the HSCP to support vulnerable people in our communities e.g. via the shielding work.

4.4 **Mountainhall Treatment Centre (support flow)**

Currently, opened 15 of 18 beds to support flow from DGRI. It is anticipated that we will be able to open the 3 remaining beds mid January 2022. The team is now testing an MDT assessment approach – where we are seeing reductions of care packages as a result of this. This approach will become standard practice for any delays within a cottage hospital setting

4.5 **Health Care Support Workers to support Care at Home / Discharge to Assess Model**

Recruitment to 21 WTE Health Care Support Workers to support care at home and Discharge to assess model. 14 WTE have been recruited and are part of Home Teams supporting Care at Home which currently equates to 108 people (602 hours of care).

Recruitment of 6 WTE is underway to support the discharge to assess model to support early intervention / discharge and reduction in long term support requirement.

CASS Recruitment – recently recruited to 22WTE (778 hours of care) to our commissioned Care at Home Service.

4.6 **Community Waiting Times Model (support flow / waiting times)**

Investment to monitor community waiting times for care homes / care at home with agreed escalation points similar to that of the Cancer Tracking Model. It has been agreed to recruit to a 1WTE lead for Community waiting times with 2WTE trackers supporting the flow team and social work team. This will enable us to report in real time of current waiting times and the reasons for the waits. This will support all part of a person journey and mitigate any unnecessary delays.

Job descriptions are under development with a view to recruitment in Mid January 2022.

4.7 **Discharge Planning / Inreach Hub to Hospital (MDT Model**)

The discharge process can be complex and there is a requirement to ensure this is managed efficiently and effectively. A discharge process action plan has been developed with the implementation of a community in reach model which comnprises a multi disciplinary team that meets on a daily basis to support early discharge and ensure the appropriate prescribed care is in place with linkage to the Home Teams / Home from Hospital service.

4.8 **MDT Review Team (unmet need)**

In response to the identified gap in social care provision within the care at home sector, the Partnership has re-established a review team to assess outstanding packages of care on the portal = 341 packages. This approach adopted an MDT model of review which will become standard practice and aligned to the Community In-reach Model for lessons learned / impact assessment.

Importantly, the review team has implemented a prioritisation process to those who are awaiting care packages across the region to assess the level of need with involvement of third sector, public health, pharmacy, home teams and also any alternatives to care through the use of assistive and inclusive technology. The Team are also working closely with Providers to identify packages that can be reduced to release capacity. This ensures that limited resources are directed at those in greatest need.

4.9 **Day Care Services**

Work has started with providers to expand day care services as an alternative to Care at Home.

4.10 **Digital Care Planning (Care Providers)**

Investment to support digital care planning, therefore a shift from a paper based system to an electronic system for Care Providers to support person centred care / better outcome for individuals. Enables staff to record information in real time which can inform care and support needs.

4.11 **Support Supervisors / Schedulers**

Investment in an electronic scheduled planner to efficiently and effectively schedule Health Care Assistants in order to maximise the care at home resource.

Recruitment to 4WTE to support the scheduling is planned for recruitment in Mid January 2022.

4.12 **Good Conversations Documentation (planning for discharge)**

Documentation has been developed by a multiagency/multiprofessional team; to support conversations with patients, relatives and carers.

A leaflet will be made available for all in-patients, their relatives and their Carers.

This will be given to people on admission and discussed with them at the earliest opportunity in terms of discharge planning, as well as at regular points during the patients admission. To help staff start those conversations, and to ensure important issues are discussed and relevant information gathered and considered, a 'Discharge Planning Prompt Card' has also been produced for distribution to staff.

It is well known that early discharge planning involving patients and unpaid family carers will facilitate an early discharge. These 2 documents are aimed at communicating that to everyone to ensure conversations, information gathering and actions are undertaken from the point of admission to ensure a safe, timely and well-planned discharge. It is everyone's responsibility to start these discharge conversations and develop those discharge plans, however, in the current situation/crisis, it is essential that everyone makes this responsibility one of their priorities.

4.13 **Interim Care Placements**

Following the Cabinet Secretary's letter supporting the use of Care Home beds for Interim Care, a local letter has been developed and shared with appropriate teams. It has been agreed regardless of the size of package people are waiting for, they should be considered for interim placement if Home Teams cannot provide short-term support. Communication has been circulated to Home Team huddles and the impact of this will be monitored across the Partnership in terms of numbers of placements made, duration of placement, outcomes for individuals.

We have committed to develop a longer term model of Intermediate Care which is currently being developed with all relevant stakeholders and forms part of the review of community beds across the region.

4.14 **HR Support (Care Providers)**

Investment in a service model to commission a third party professional HR consultancy (Realise HR) to provide a package of bespoke coaching and consultancy to all Registered Provider Partner managers working in Care Homes and Care and Support at Home Services in Dumfries and Galloway; focussed around strengthening Managers' ability to maximise recruitment and retention of front line staff.

4.15 **Single Assess Point (Care Call)**

Within Dumfries and Galloway, a key development over the last year has been the introduction of a Single Access Point for all of our community based health and social care provision. As part of our response to increased levels of demand, Investment is being made in the Single Assess Point for additional care calls advisors to support early intervention for admission avoidance.

4.16 **Payment on Planned (Care Providers)**

The Partnership has agreed to undertake a test of change investment to make changes to the current payment systems for care at home providers which is intended to increase capacity of Care Providers. This test is based on shifting from 'payment on actual' care delivered to 'payment on planned' for care providers. This test of change will run until 31st March 2022.

This temporary change in payment arrangements will allow monitoring to take place during quarter four of the current financial year. Provider partners will agree processes to measure the impacts of the temporary change and work together to develop longer term proposals that will enable more people to be supported at

home flexibly, efficiently and cost effectively. It is noted that the temporary payment arrangement may become permanent in some form, although there is much process detail and complexity to be worked through first.

4.17 **Meal Provision**

Investment in a cooked meal delivery option rather than a food parcel to help reduce the number of packages on the portal where the individual only requires a cooked meal.

A test of change will proceed with the providers who supported this during the early stages of Covid.

This Service is being designed to release capacity so other people will benefit from personal care and therefore reduce the unmet need of people across the region.

Providers will be paid £6.50 minimum per meal and a cost modelling is completed so that travel costs are agreed for both urban, rural and very rural settings.

A project officer is appointed for 6 months to progress this work with the meal planning group, at a cost of around £40k plus 20% on costs.

4.18 **Food Train**

Investment in Food Train which commenced as a test of change for the Health and Social Care Partnership called “home from hospital”. The test of change will run from Monday 20th December 2021 till 31st March 2022.

The service will be available to everyone living in Dumfries and Galloway. The objective of the Service is to provide any / all of the following

- food parcel for up to 72 hours
- pop in checks / phone calls once a day for 72 hours and escalate any concerns such as Adult Support and Protection or deterioration in health through the Single Access Point
- transport home from hospital for those not assessed as requiring Patient Transport

4.19 **Assistive and Inclusive Technology**

Investment in AIT bundle which includes investment in a SMART LIFE front facing portal for the population to use as an online self assessment tool which promotes individuals on self management.

Digital ARMED – to procure a wearable digital device with a range of sensors which can be worn at home to monitor activities of daily living e.g. heart rates, falls risk, fluid intake – to name a few.

Help my Street – investment in an online community portal supported by the Third Sector.

4.20 **Trusted Assessor Training**

Investment to purchase training modules to support the development of the trusted assessor role in terms of accessing the right assistive and inclusive technology. There are 200 places available for staff across the Partnership; plans are in place to implement this work.

4.21 **Supporting Carers** is a key area of priority for the Dumfries and Galloway Integration Joint Board (IJB) within their Strategic Commissioning Plan (SCP).

The Carers Programme Board has continued to provide oversight and scrutiny on the delivery of the Carers (Scotland) Act in Dumfries and Galloway and the development and delivery of the Dumfries and Galloway Carers Strategy, ensuring that progress in made against outcome 6 of the Nine National Outcomes

The Carers Interest Network Group has supported inclusive and collaborative partnership working.

The Short Breaks Working Group has worked to identify opportunities for Carers to be able to access Short Breaks including residential short breaks but also alternative types of Short Breaks through the Short Break Grant scheme. This has supplied IT and other equipment which has allowed Carers to take a break in another way.

A Carers Task Force has been established to take forward a number of initiatives which will support Carers across the region. This includes Carer Awareness which also involves the training of Carer Ambassadors, improved Carer Identification and referral of Carers to local Carer Support Services.

Carers Act Funding has been allocated locally to support initiatives such as Respitality, training for Carers, animal therapy visits, access to online classes and wellbeing vouchers. It is recognised that there is an increased need to fund the development of preventative and early intervention models of care and support to help reduce pressure and demand, over the longer term, on more downstream supports.

5. Finance

In October 2022, the Cabinet Secretary for Health and Social Care set out the new investment of more than £300 million in funding, as a direct response to the intense winter planning and systems pressures work that has taken place over recent weeks with stakeholders, including with health boards, local authorities, integration authorities, trade unions and non-affiliated staff-side representatives.

For Dumfries and Galloway this translates into approximately £7m of additional funding for 2021/22, with the recurrent resources associated with this being confirmed through the Scottish Government budget process for 2022/23. Plans for use of this funding and affordability of proposals on an ongoing basis will be brought forward as part of the three year Financial Plan development.

All of our winter planning preparations are predicated on four key principles:
1. Maximising capacity – through investment in new staffing, resources, facilities and services.
2. Ensuring staff wellbeing – ensuring that they can continue to work safely and effectively with appropriate guidance and line-management and access to timely physical, practical and emotional wellbeing support.
3. Ensuring system flow – through taking specific interventions now to improve planned discharge from hospital, social work assessment, provide intermediary care and increase access to care in a range of community settings to ensure that people are cared for as close to home as possible.
4. Improving outcomes – through our collective investment in people, capacity and systems to deliver the right care in the right setting.

6. Governance / Evaluation of the Impact of local Investment

6.1 The Programme Board Structure will ensure that all investment needs required to support the system over the winter period together with the longer term improvement in service capacity will be brought forward to the Health and Social Care Governance and Performance Group are subject to scrutiny, with appropriate assurance offered as follows:

6.1.1 The Financial Recovery Board will confirm that proposals are affordable and / or contribute to the delivery of the Financial Recovery Plan;

6.1.2 The Digital Assurance Board will confirm that all technological opportunities to support the modernisation and transformation of any given service have been explored and that those proposed will optimise benefits; and

6.1.3 The Workforce Assurance Board will confirm that the skills, expertise, capacity and capabilities required to support delivery of the modernisation and transformation plans have been specified and can be secured within the overall context of the Workforce Plan.

6.2 Importantly, it is recognised that we require to assess the impact of these interventions in the round. These are our suggested criteria of success:

- Sustained reduction in the number of people awaiting long term care and support
- Interim Care Placement Waiting Times
- Sustained reduction in delayed discharges
- Sustained reduction in Length of Stay
- Sustained reduction in hospital occupancy levels
- No rise in readmission rates
- Sustained improvement in ED 4 hour waiting standard
- People involved in service improvement / changes have positive outcomes

We are committed to the measurement and reporting on the impact of these investments.

7. Impact on Integration Joint Board Outcomes, Priorities and Policy

7.1 The content of this report is in line with the National Health and Wellbeing Outcomes for Health and Social Care.

8. Legal and Risk Implications

8.1 There are no legal issues or risk that may arise, relating to the integration authority or the constituent partners.

9. Consultation

9.1 The following Groups have been consulted with in the development of this Report - Health and Social Care Senior Management Team and Community Health and Social Care Directorate Leads

10. Equality and Human Rights Impact Assessment

10.1 An Equality and Human Rights Impact Assessment will be carried out as part of the transformation programme / project it is associated with.

11. Glossary

SCI1	**Strategic Commissioning Intention 1**
SCI13	**Strategic Commissioning Intention 13**