**Dumfries and Galloway Integration Joint Board**

# Health and Social Care

# NITHSDALE

# LOCALITY REPORT

# September 2021

Version: Final

September 2021

# 1. General Manager's Introduction

### 1.1 The COVID-19 Pandemic

Health and social care across Dumfries and Galloway continues to face extraordinary challenges as a result of the COVID-19 pandemic.

Dumfries and Galloway is experiencing a third wave of the COVID-19 pandemic. In the week ending 24 August 2021 there were 918 cases identified by Test and Protect. This is the highest number of cases identified in Dumfries and Galloway in 1 week since the pandemic started. As a result there are substantial demands on the Test and Protect service for contact tracing and on laboratory services for carrying out PCR COVID-19 testing. However, compared to the second pandemic wave, there have been fewer people requiring care and treatment in hospital for COVID-19. This is a direct consequence of older people and people in vulnerable groups being prioritised for first and second doses of COVID-19 vaccine earlier this year.

COVID-19 mass vaccination has continued at pace across the region. At the time of writing, over 215,000 doses of vaccine have been delivered to people from Dumfries and Galloway and 94.4% of people aged 18 and over in the region have had at least one dose. This compares to the rate for Scotland at 90.1%. In early July 2021 drop-in clinics were introduced to increase flexibility and access for people who have not so far been able to get their jab. Also, pop-up vaccination clinics have been held at Morrison's supermarkets in Dumfries and Stranraer.

Health and social care services across the partnership are experiencing an increase in demand for non COVID-19 related reasons. In some services, this demand is markedly higher than it was before the pandemic started. The full extent the COVID pandemic and lockdown has impacted on the deterioration of people's health in not yet known, but there are early signs that many people accessing services are frailer than before. For example, amongst older people, who have been one of the most restricted groups, there has been an increase in people being treated for hip fractures. Also, amongst people who already receive care and support at home, there has been a sizeable group who have needed increases in their care provision.

Another re-emerging challenge across the partnership is recruiting and keeping staff. As restrictions have eased and different economic sectors remobilise, there is increased competition for the available workforce in Dumfries and Galloway.

Many services across health and social care that were reduced during the pandemic waves have remobilised and have started to address backlogs built up during their suspension. All services continue to implement the necessary additional COVID-19 infection prevention and control measures. At times, these measures can add extra steps to people's experience of treatment, care and support, and mean that people may be seen at a slower pace than happened before the pandemic. It is anticipated this will be the situation for the foreseeable future.

The complexity and impact of the COVID-19 pandemic is still being experienced by our population and this has affected people in different ways. Currently there is minimal evidence of how this will

impact on health and wellbeing and demand on health and social care services. As evidence emerges, this will inform the partnership's planning.

### 1.2 Delivering a modernisation programme to sustain local services

The Sustainability and Modernisation Programme (SAM) was established in 2019 in response to the significant financial challenges faced by the Partnership. The initial priorities identified for modernisation by the SAM programme are:

- Community health and social care
- Urgent Care
- Planned care

Between January and March 2021, work was undertaken to identify priorities for sustainability. It was agreed that, while there is a need to support staff recovery from the COVID-19 pandemic, the current focus for sustainability would be on:

- Prescribing improvement
- Workforce efficiency and productivity

#### 1.2.1 Prescribing Improvement

The Prescribing Improvement project is one of 2 priorities for addressing the sustainability of services and supporting the Partnership to meet its financial challenges. There are 4 areas this project will seek to address:

- To minimize unwarranted variation in prescribing across all areas of the Partnership
- To maximize compliance with the drug formulary across all areas of the Partnership
- To minimize medicines wastage in all health and social care settings
- To maximize the opportunities available to the Partnership to modernize prescribing

Plans are being developed in each of the Partnership's directorates to deliver improvements in prescribing.

#### 1.2.2 Workforce Efficiency and Productivity

The Workforce Efficiency and Productivity project has identified 4 key goals:

- Ensure staff across the Partnership are deployed and managed effectively, efficiently and productively
- Ensure lessons are learned when the implementation of policies result in additional costs
- Ensure every vacancy approved for recruitment, or extension to a fixed term contract, is critical to the delivery of services locally
- Ensure best value is being delivered when using bank or agency staff

A project plan is currently being developed.

### 1.2.3 Community Health and Social Care

**Single Access Point**

In May 2021 the Care Call team moved from Monreith House to Irish Street. This completed the co-location of all aspects of the Single Access Point, including the Social Work Access Team and Professional Health Advisors.

**Home Teams**

In January 2021, 8 new Home Teams were established covering all of Dumfries and Galloway. Initially, the Home Teams are focused on supporting improvements in moving people from hospital to their own home or a homely setting. However, we are looking to rapidly develop the Home Teams into integrated, empowered teams that will assess, plan, treat, care for and support people in their own homes.

The development of Home Teams continues to progress. A process mapping workshop was held in May 2021 to help further our understanding of people's journeys of care and support. Following on from this workshop, a new communication and engagement group has been formed with the aim of ensuring that staff on the ground are engaged in the continued development of Home Teams.

Our Home Teams will work with others involved in a person's care to assess people in their own homes, identify changes in their health and wellbeing and rapidly respond accordingly. This will ensure that the collective skills and experience of the team are used to their best effect. The Home Teams will provide short and longer term care and support, rehabilitation, and reablement, as well as palliative and end of life care.

**Care at Home Capacity**

In April 2021 the Partnership approved a short term action plan for care and support at home in response to the challenges currently faced by the Partnership. A Care and Support at Home Oversight Group (CASHOG) has been established. This group will support the development and delivery of refined models of care and support at home.

The Partnership also approved the development of a longer term strategy for care and support at home. This plan will be underpinned by the voices of people with lived experience. This work is being led by the Strategic Planning and Commissioning Team

### 1.2.4 Urgent Care

**Flow Navigation Centre**

The Flow Navigation Centre was established in December 2020 to provide safe scheduled access to urgent care for people with non life threatening conditions. Dedicated resource from the SAM Team and from the Strategic Planning Team has been allocated to focus on improving the links between the Flow Navigation Centre and community based care and support.

**General Practice Out of Hours**

A new, multi disciplinary team model for General Practice Out of Hours has been delivered. This model includes increased contracted GP capacity.

### 1.2.5 Planned Care

Planned care typically refers to hospital based services such as inpatient and day case treatments and procedures, diagnostic tests and outpatient clinics. There are a number of improvement projects being undertaken to support the sustainability and modernisation of planned care:

- **Ophthalmology –** This project established a new shared care approach between NHS Dumfries and Galloway and optometrists in practices in people's local communities to support people with stable glaucoma. This new approach will offer 1,200 community based review appointments to ensure people receive the right treatment in a timely way and to minimise their clinical risk. An evaluation is currently being carried out and planning has started on how to sustain this shared care model on a longer term basis.

- **Orthopaedics –** The modernisation of orthopaedics will build on learning from other health board areas and focus on implementing Active Clinical Referral Triage (ACRT) and Patient Initiated Review (PIR) where people are enabled to decide if, and when, they require follow up outpatient appointments after having treatment.

- **Dementia Care** – We are creating a single point of contact that people with dementia, their families and Carers can refer themselves to. People will be supported to manage their own condition, access comprehensive assessments and, in a timely way, onward referrals for specialist care and support.

- **Virtual Consultations -** Building on the success of delivering virtual consultations during the Covid-19 pandemic, we are working to establish systems and processes to ensure this method of service delivery is embedded, sustained and used widely across our health and social care partnership. We are monitoring how many times NHS Near Me and telephone consultations are used in different areas of the Partnership.

- **Community Treatment and Care (CTAC) (previously referred to as Community Based Testing) –** We are working with our GP practices to develop a new approach to diagnostic tests so that people will be able to access blood and urine tests and electrocardiograms (ECGs) closer to home. The initial focus is on phlebotomy (blood) services. The proposed model for CTAC will be presented to the Contract Development Group in August 2021 for approval.

We remain incredibly grateful to our communities for working together with us during these challenging times, and are very mindful of the delicate balance between catching up to where we need to be and the health and wellbeing of our dedicated teams delivering health and social care.

**Nicole Hamlet, Interim Manager for Community Health and Social Care**
**September 2021**

# 2. Locality Manager's Report

The period January to June 2021 has continued to be a challenging time for everyone working in community health and social care. The impact of COVID-19 required a number of staff to be redeployed into different roles to support the local pandemic response. Many of these services, such as Community Nursing, would have struggled without this additional resource. More recently, some staff have been supporting the unmet care needs of people to enable their timely discharge from hospital.

Further examples can be seen in Community Rehab (Nithsdale), Bladder and Bowel Health, Community Health Development and Huntington's Specialist Practitioners. Due to lockdown, many routine clinics were cancelled and some work and community engagement was not possible. Many staff continued to be deployed into essential services, delivering direct support to people and communities across the region. As services struggled to provide support during the pandemic, and people who work in health and social care have been required to self isolate, this redeployed support was highly valued by all who received it. Also, routine clinical assessments in continence care for people who are housebound were temporarily passed from community nursing to bladder and bowel nurse specialists to create capacity for the COVID-19 vaccine programme.

These examples demonstrate the commitment, flexibility and tenacity of staff working across Nithsdale locality. Myself and Nithsdale Management team are hugely appreciative of the efforts and commitment of all staff, especially during such unprecedented times.

### 2.1 Adult Social Work

Since November 2020 staff have dedicated time to completing Activity Resource Centre (ARC) reviews for people who use services. Throughout the pandemic this resource has been a huge loss to some families. Social work, along with ARC staff and families, were keen to look at how they could safely re-instate this while also exploring alternatives that would allow a more choice for people. The example below describes a young man who was able to explore alternatives to returning to the ARC and increase flexibility with his current plan.

**What people tell us:**

D is a man who has complex and profound learning disabilities. His mobility is deteriorating to the extent that he is more reliant on a wheelchair. He had supports from his family, an external care provider, ARC and an external facility that he used on other days.

The good conversations at the review meant that all options were discussed for D and the request from his Carers was that D had enjoyed using the alternatives to the ARC and other facilities. He had made friends. Flexibility to his current plan to give more variety to his days had been considered.

The families' views were very positive that his outcomes will be met with his new plan and that the worker was very inclusive throughout the review ensuring D's outcomes were at the centre of all discussions. "She is an excellent advocate for all concerned; it was a very positive experience for us due to her keeping us updated either by phone or email."

The social work team have also continued to support people to be discharged from cottage hospitals, with dedicated staff members working alongside the multidisciplinary team. They support the people from Nithsdale in Thomas Hope, Annan, Lochmaben, Castle Douglas cottage hospitals and, while it was open, the Mountainhall ward.

The team works closely with all agencies to promote the flow of people from the hospitals. This is a busy and demanding area of their work made more challenging due to the shortage of care at home provision. Nithsdale social work have been part of Home Team huddles in Upper Nithsdale and are now involved with the development of the North and South Home Teams in Nithsdale.

We continue to assess and consider all aspects of support for people requiring assistance to maintain independent living. This has been made more challenging throughout this period due to the decline in care agency staff.

### 2.2 Clinical pharmacy service in General Practices

We continue to offer pharmacotherapy services in GP practices in Dumfries and Nithsdale, as required by the national GP contract, working on medication reviews, medicines reconciliation and acute requests. During the pandemic this has meant using the pharmacy technicians more, ensuring that there is clear training, guidance and documentation so that the appropriate level of task is being undertaken by the appropriate personnel in the pharmacy team. All GP practice pharmacists in the team are being supported to ensure they receive the right training and professional development.

The volume of prescription requests remains at a high level across all the GP practices. A project has been undertaken to review and look at ways of reducing the volume of acute prescription requests in 2 of the GP practices. The pharmacy support workers aim to increase the number of people signing up to the Medicine Care and Review service (formerly known as the serial prescription service). This should help with managing the repeat prescription requests and ensuring that medication reviews are up to date.

### 2.3 Mid and Upper Nithsdale Home Team

The Mid and Upper Nithsdale Home Team has strong representation from all professions considered core to the Home Team. 29 regular staff support the daily huddles. In addition, the wider team involves members providing specialist input. This has included dietetics, pharmacy and palliative care nursing. In the 6 months between January and June 2021 there have been 77 referrals for people to be supported through the huddle. 216 referrals have been received in total since Home Team's inception in August 2020.

Staff involved in the Home Team have reflected that a key strength and valuable function of the huddle format has been the opportunity to discuss, negotiate and coordinate care delivery across nursing and care staff. This makes effective use of time and resources and enables timely support to prevent people's deterioration and potential hospital admission or readmission. The process has also highlighted however, the lack of provision in terms of guardian response in the area and the associated risks this carries.

A significant development during the last 6 months has been the testing of triage processes to support efficient use of resources at huddle. Mid and Upper Nithsdale Home Team staff team were

encouraged to feedback on the process and take an active part in a Test of Change process. A number of learning points were recorded and a paper presented to the Operational Reference Group for future consideration.

As part of the wider Home Team concept to reach out into the local community, health improvement staff have been working in partnership with staff and volunteers from a local third sector organization. The organization have been providing emergency food provision and social support during the pandemic, and together they have established a pathway, linking vulnerable people identified through the food support operations, into the Home Team.

**What people tell us:**

Mr and Mrs X were not known to the Home Team. English was not their first language and they had very limited knowledge of and contact with services. They had however, raised a number of worries and concerns to a local volunteer during a doorstep "check n' chat". Through the pathway, a request for support was placed with the Home Team. On assessment by occupational therapy and social work it was discovered that Mr X had very limited mobility and speech due to a stroke and his wife was providing all his personal care with great difficulty. This was impacting on her health and resulting in concerns for Mr X's safety and health. As a result of the team input mobility aids and an electric profile bed were put in place, the district nurses provided support to maintain skin integrity and the couple were linked to the Carer's Centre. A respite package was agreed to support Mrs X for when she has a planned admission to hospital and has enabled Mrs X to feel supported in her Caring role.

The development of Home Teams highlights the need to work more collaboratively between services to provide a fully integrated approach.

### 2.4 GP Practice Out of Hours Service

Historically we had 2 staff groups working in Out of Hours (OOH). They were GP Drivers and Health Care Support Workers. Out of Hours has recently gone through a redesign of services so that Health Care Support Workers are able to work both in and out of hours. The staff have all undergone their clinical educational training and will begin to work with colleagues in the community to gain confidence in the key skills to achieve competency sign-off.

Low volumes of calls through NHS24 for people with symptoms of COVID-19 in hours are responded to by GP practices, with the Out of Hours service managing any such calls from 6pm.

### 2.5 Single Access Point (SAP)

Collocation of the Single Access Point (SAP) has been successful, and the team of professional health advisors are working closely with colleagues in social work. Collocation of both groups of staff further supports joint working.

SAP continues to process requests for assistance for a number of regional services. SAP is supporting the development of Home Teams by providing checks across health and social care systems for when people have had previous contacts with services. SAP is also processing the new multi disciplinary team referrals and onwards transitions.

## 2.6 Thornhill Cottage Hospital

As a direct result of the COVID-19 pandemic it was necessary to create additional capacity to accommodate people with COVID-19 and without COVID-19 across Dumfries and Galloway. The Community Health and Social Care Directorate identified cottage hospitals and new facilities which were to be used for outbreak management purposes. In turn this has meant diversion of staff and resources to other cottage hospitals and community teams and temporary closure of some cottage hospitals, including Thornhill Hospital.

From April 2020, a total of 24 nursing and hotel services staff were initially deployed into areas of their preference including Community Nursing in Nithsdale, Dumfries and Galloway Royal Infirmary, Midpark Hospital, Castle Douglas Hospital and Single Access Point. Subsequently, some staff have been further deployed to support the opening of the cottage hospital ward at Mountainhall Treatment Centre. Hotel Services staff have been retrained as Health Care Support Workers, and the majority of these staff have chosen to remain within this role which is of mutual benefit to them and the Partnership.

Thornhill Hospital remains closed at the present time and one of the buildings on site has been utilised as a COVID-19 Vaccination Centre.

## 2.7 Mindfulness for Pain online course

Between February and March 2021 a Mindfulness for Pain course was provided online. Although only a small number of people took part, this provided an opportunity to test this format and gather feedback from people. It was received very positively and those that took part were pleasantly surprised at how well the technology and remote delivery worked for them. They felt able to get a lot out of the course to help manage their pain. A monthly follow up session continues to be offered online for all people who have previously attended.

## 2.8 Public Health Improvement

Healthy Connections is a service delivered by the Health and Wellbeing Team. This is a non clinical, structured support for psychosocial health which enables people and communities to take more control of their health and wellbeing. This holistic approach supports the development of knowledge, skills, social connections and resilience of people and communities to help improve health and wellbeing and work towards reducing health inequalities.

During the second wave of the COVID-19 pandemic, there continued to be a pivotal role for our Healthy Connections Service. From January to June 2021 Healthy Connections received 145 requests for support. 48% of people accessing support from the service live in areas considered nationally to be amongst the 40% most deprived areas of Scotland (Scottish Index of Multiple Deprivation 2020 Quintiles 1 and 2).

From January to June 2021, support was primarily delivered over the telephone or via ‘Near Me’, NHS Dumfries and Galloway’s video consulting service. Support was focused on welfare and screening for vulnerabilities that may contribute to increased challenges during the pandemic.

Loneliness and social isolation were prevalent themes across all requests for support received during this period. Many people were also experiencing multiple health and social care pressures such as poor mental health, low income, unemployment, inappropriate housing, bereavement and anxiety to go out of the house. This was further exacerbated by a limited number of community based opportunities to signpost people to. Many activities and groups had not yet resumed or are doing so in significantly smaller numbers which has led to waiting times for these opportunities.

Despite these challenges, there have been positive outcomes for people accessing support through the Healthy Connections service. The service has provided a listening ear, supported people to break down stresses and worries into more manageable chunks, access services including the use of digital platforms, enabled people to find joy in previous or new hobbies and become more creative in their own home.

**What people tell us:**

Mrs A was linked to the Healthy Connections Service by her GP. Mrs A was shielding during the pandemic and described feeling like a prisoner in her own home. Mrs A was supported by the Community Link Work to explore opportunities to keep herself well and stimulated at home. Mrs A described the view from her window and the joy she experienced looking at nature and the people coming and going. Mrs A began scribbling down notes of what she saw each day and used this inspiration to develop short stories that she shared with her grandson over the phone. She described this new hobby as empowering and transporting her to a new place from the comfort and safety of her living room.

**Alison Solley**
**Locality Manager**
**September 2021**

## Summary of Locality Indicators

| Outcome | Indicator | Description | Previous value | | | Current value | | |
|---|---|---|---|---|---|---|---|---|
| | | | Time Period | Dumfries and Galloway | Nithsdale | Time Period | Dumfries and Galloway | Nithsdale |
| Outcome 1 | D23 | Rate of ED attendance by locality of residence per 1,000 | Dec-20 | 18.7 | 19.8 | Jun-21 | 23.1 | 24.5 |
| | D24 | Rate of emergency admission by locality of residence per 1,000 | Sep-20 | 9.3 | 10.8 | May-21 | 9.5 | 11.8 |
| Outcome 2 | C8 | Total number of care at home hours provided as a rate per 1,000 population 65 and over | Dec-20 | 599.2 | 769.4 | Mar-21 | 572.1 | 728.8 |
| | A15/E5 | Proportion of last 6 months of life spent at home or in a community setting | 2019/20 | 88% | 87% | 2020/21 | 91% | 90% |
| Outcome 3 | D2 | Number of complaints received by the locality team | Delayed due to staff deployment to support the COVID-19 response | | | | | |
| Outcome 4 | C10 | % of people supported by SDS option 1 or 2 under 65 years of age | Sep-20 | 24% | 21% | Mar-21 | 25% | 22% |
| | C11 | % of people supported by SDS option 1 or 2 65 years and older | Sep-20 | 8% | 4% | Mar-21 | 10% | 4% |
| | D25 | Number of people with delayed discharge in all hospitals | Jul-19 to Jun-20 | 517 | 202 | Jul-20 to Jun-21 | 514 | 213 |
| | D26 | Number of bed days lost to delayed discharge by locality of residence | Jul-19 to Jun-20 | 17,316 | 7,052 | Jul-20 to Jun-21 | 13,425 | 5,887 |
| Outcome 5 | D27 | Difference in the rate at which people attend hospital in an emergency between the most and least deprived communities in the locality | Apr-19 to Mar-20 | 36.3 | 49.1 | Apr-20 to Mar-21 | 32.3 | 49.0 |

| Outcome | Indicator | Description | Previous value | | | Current value | | |
|---|---|---|---|---|---|---|---|---|
| | | | Time Period | Dumfries and Galloway | Nithsdale | Time Period | Dumfries and Galloway | Nithsdale |
| Outcome 6 | C5 | Number of adult carer support plans developed within the locality | 2019/20 | 173 | 67 | 2020/21 | 147 | 56 |
| Outcome 7 | D27 | % rate of emergency readmission to hospital within 7 days | Sep-20 | 4.3% | 4.5% | May-21 | 3.8% | 5.1% |
| | C9 | % of referrals to MASH acknowledged within 5 days | Dec-20 | 33% | 30% | Mar-21 | 16% | 14% |
| Outcome 8 | D5 | Proportion of people who agree they have the information necessary to do their job | Delayed due to staff deployment to support the COVID-19 response | | | | | |
| | D21 | Proportion of people who agree that they are involved in decisions relating to their job | Delayed due to staff deployment to support the COVID-19 response | | | | | |
| | D22 | Proportion of people who would recommend their organisation as a good place to work | Delayed due to staff deployment to support the COVID-19 response | | | | | |
| Outcome 9 | D28 | Average prescribing costs per person for 3 months | Jul-Sep 2020 | £52.49 | £52.37 | Jan-Mar 2021 | £51.38 | £51.38 |
| | C1 | % of people with SDS option 3 supported with telecare | Dec-20 | 75% | 73% | Mar-21 | 75% | 73% |

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