Dumfries and Galloway Integration Joint Board

Health and Social Care

STEWARTRY

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

2.1 Home Teams

Stewartry began working as one of the 4 early adopter sites for Home Teams in August 2020. Across Dumfries and Galloway there are now 8 Home Teams established. We continue to develop and refine how the Home Teams work and support people to access the right support at the right time in the right place. These teams use their collective experience and professional judgement to offer advice and support people to manage their own health and wellbeing. The Home Teams also assess, plan, treat, care for and support people in their own homes or in a homely setting.

2.2 Community Nursing

The Community Adult General Nursing (CAGN) team is helping to ensure more care and support can be delivered at home or in the community. This care and support can prevent the need for people to be admitted to hospital and is helping to reduce the number of different people visiting a person's home.

The Community Nursing service is now provided 24 hours a day, 7 days a week across all localities in Dumfries and Galloway and has also taken on additional roles such as:-

- Care home support in the event of an outbreak of COVID-19
- Roll out of the COVID-19 vaccination programme – All people living in a care home in Stewartry and their staff had their first dose vaccination in December 2020. All second doses were completed in March 2021. Plans have been developed for the roll out of a COVID-19 booster vaccination pending approval from the Scottish Government.
- Home Team early adopter sites – Community Nursing staff are part of the 'core' Home Team in Stewartry

2.3 Adult Social Work

The service continues to deliver on adult social work statutory duties including Adult Support and Protection (ASP). As lockdown and social restrictions have eased there has been an increase in people seeking care and support.

Between February 2021 to July 2021 there were 210 ASP referrals, 78 ASP duty to inquire, 12 ASP investigations, 4 ASP case conferences and 10 ASP case conference reviews. A total of 1,211 referrals were received with the highest monthly total of 242 referrals in July 2021.

Social work staff have been involved in a number of other key areas of work such as:

- **Surveillance testing in care homes** – The social work team has continued to review information on people living in residential care homes to ensure that accurate information was in place and to enable consent for COVID-19 testing, by the person themselves or by a power of attorney or guardian.
- **Activity and Resource Centre reviews** – The adult social work team have been working in partnership with local Activity and Resource Centres (ARCs) to carry out reviews to identify

alternative supports to those people unable to attend ARCs due to the current COVID-19 situation and the associated risks.

- **Adult Support and Protection (ASP) audits** – the team have continued to support the valuable work of ASP audits to review practice and support further learning opportunities. This has consisted of localities carrying out 2 reviews per month.
- **ASP Inspection** - the team have been involved in the preparatory work required for the forthcoming inspection in September 2021
- **Home Teams** – some social work staff are part of the 'core' Home Team in Stewartry.

2.4 Pharmacy

The Stewartry Pharmacy Team have continued to provide pharmacotherapy services to GP practices, the people registered at the practices, and the wider healthcare team throughout the COVID-19 pandemic. This is despite the challenges of staff shortages due to long term illness and movement of staff to new posts elsewhere in the region. We are currently recruiting to fill outstanding vacancies within the team and ensuring that all pharmacy staff team are being supported to ensure they receive the right training and professional development.

We continue to use technology and new ways of remote working to provide GP surgeries with input, when physically having staff on premises has not been possible.

The Stewartry Pharmacy Hub aims to provide a more robust and efficient pharmacotherapy service to our GP colleagues and their patients. This is similar to the hub set up in Wigtownshire.

A member of the pharmacy team provides daily input to the Stewartry Home Team.

2.5 Health and Wellbeing

Stewartry Health and Wellbeing Team continue to deliver Community Link services across Stewartry. Referrals are received through social work, Home Teams, GP practices and from people themselves.

Innovative ways to support people from across our communities were developed in response to COVID-19. One example of this is a virtual café, 'Café Connections', which is accessed via a NHS digital platform.

The launch of Café Connections has offered people the opportunity to connect socially to help reduce isolation. The Café, in partnership with Dumfries and Galloway Council Leisure and Sport, also offers low level exercises and social support.

Community development staff are continuing with deployment to DG Support to provide support to food providers and work alongside ward officers and third sector colleagues.

We are working with Loch Ken Trust and D&G Council to increase access to and awareness of Community Publicly Accessible Defibrillators with an outcome of increasing survival of out of hospital cardiac arrest around Loch Ken. A £9,000 grant from Awards for All was received.

2.6 mPower Programme

ARMED trial continues to be delivered to beneficiaries in four service areas with 61 individuals having signed up and making use of the technology to date. The Pulmonary Rehab team began making use of the equipment for some of their COPD patients with their first sign up taking place in May.

An evaluation report was produced for people who had been on the system for 12 weeks (up to end March) and the findings showed positive outcomes. Key findings reported that risk levels were maintained or increased for 85% of participants with 91% maintaining or improving their IoRN score, and 96% maintained or improved Rockwood Frailty score; 52% of participants saw an increase in their step count with 52% reporting a decrease in periods of inactivity during the day.

The technology proves to be challenging for some people on the trial and the wellbeing calls that are provided on a bi weekly basis are a major contributing factor to successful outcomes. Restrictions on face to face visits create difficulties in supporting people to develop their digital skills, and therefore the reliance on the calls has intensified.

Additional funding has been secured to extend the trial until March 31st 2022 and this will enable the outcomes to be evaluated for people who have made use of the equipment for 12 months. It will also provide the opportunity to introduce monitoring in other areas of interest. Data is being gathered to produce a six month evaluation report and it will be published end of September 2021.

mPower Community Fund of 25,000 Euros has been awarded to Third Sector DG to distribute to local third sector organizations. The funding will be used to increase digital capacity and is part of the wider Connecting DG strategy.

A successful request to mPower Programme Board for additional funding will provide the opportunity to trial Help My Street, a platform that manages volunteers and their availability and matches them to people in need. A steering group will be formed in partnership with the Wigtownshire Health and Wellbeing Partnership to develop plans for implementation.

Funding was sourced to recruit expertise to trial the idea of a Trusted Assessor role to support the Home Teams. The role will be available for 30hrs per week for 47 weeks.

2.7 Quit Your Way Service

The Quit Your Way Service continues to provide cessation support across the region primarily with the virtual support model, offering regular phone contact or Attend Anywhere video consultations alongside the motivational text messaging service Florence, for those that want to use it. The demand for cessation support has been high and although in line with previous years, there has been an increase in successful 12 week quits in this financial year.

The Scottish Government target remains the same as it was in 2019/20 – for Dumfries and Galloway this was set for 161 successful 12 week quits from areas of deprivation only.

The Quit Your Way and Community Pharmacy service met the target by 115% with 185 successful 12 week quits from SIMD 1 and 2 areas in 2019/20. We were one of only 5 boards to meet the target and one of only 4 boards to exceed it.

At the end of June 2021 we submitted data for this current financial year and our successful quits are up to 246 from areas of deprivation. We expect the data comparison of the health boards to be released in October 2021.

We have recently refreshed and updated our opt-out referral pathway with Midwifery and plan to do some further joint training sessions around this in the coming months; one session delivered with the Stewartry team at the start of the year.

We are due to start some Community Pharmacy training following a successful updating of the Varenicline Patient Group Directive in July 2021. We continue to support quit rates in Community Pharmacy and have adopted a process of 'nudge calls' as reminders to staff when follow-up calls are required to patients. There still remains some flexibility from PHS for specialist QYW teams to support pharmacies in this way and during the lockdowns when pharmacies were under extreme pressure we completed follow-up calls for all community pharmacies successfully.

Currently we are working on establishing a seamless referral pathway from DGRI and the Galloway Community Hospital into QYW. Our ward visits and clinics running alongside Cardiac, Rehab and Vascular outpatients stopped with the onset of Covid-19 and we are looking to develop a new way of supporting smokers prior to hospital admission, within the hospital setting and on discharge.

Some future areas of focus will be training around Smoking and Mental Health and aligning some of our work with drugs and alcohol across the region.

Stephanie Mottram
Locality Manager
September 2021

Summary of Locality Indicators

Outcome	Indicator	Description	Previous value: Time Period	Previous value: Dumfries and Galloway	Previous value: Stewartry	Current value: Time Period	Current value: Dumfries and Galloway	Current value: Stewartry
Outcome 1	D23	Rate of ED attendance by locality of residence per 1,000	Dec-20	18.7	13.6	Jun-21	23.1	17.0
	D24	Rate of emergency admission by locality of residence per 1,000	Sep-20	9.3	8.8	May-21	9.5	8.2
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	401.9	Mar-21	572.1	370.2
	A15/E5	Proportion of last 6 months of life spent at home or in a community setting	2019/20	88%	89%	2020/21	91%	91%
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%	29%	Mar-21	25%	32%
	C11	% of people supported by SDS option 1 or 2 65 years and older	Sep-20	8%	23%	Mar-21	10%	28%
	D25	Number of people with delayed discharge in all hospitals	Jul-19 to Jun-20	517	109	Jul-20 to Jun-21	514	101
	D26	Number of bed days lost to delayed discharge by locality of residence	Jul-19 to Jun-20	17,316	2,764	Jul-20 to Jun-21	13,425	2,180
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	22.8	Apr-20 to Mar-21	32.3	15.6

Outcome	Indicator	Description	Previous value			Current value		
			Time Period	Dumfries and Galloway	Stewartry	Time Period	Dumfries and Galloway	Stewartry
Outcome 6	C5	Number of adult carer support plans developed within the locality	2019/20	173	34	2020/21	147	39
Outcome 7	D27	% rate of emergency readmission to hospital within 7 days	Sep-20	4.3%	3.2%	May-21	3.8%	3.2%
	C9	% of referrals to MASH acknowledged within 5 days	Dec-20	33%	10%	Mar-21	16%	12%
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	£50.46	Jan-Mar 2021	£51.38	£47.75
	C1	% of people with SDS option 3 supported with telecare	Dec-20	75%	78%	Mar-21	75%	77%

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