Nithsdale in Partnership: A "One Team" Approach to Meeting the 20:20 Vision

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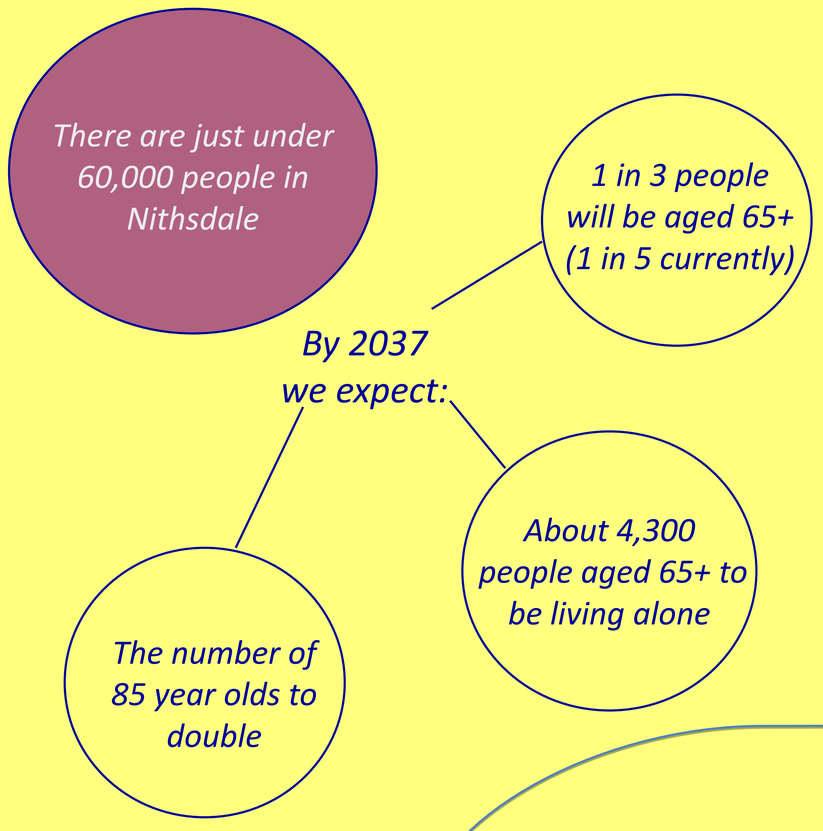
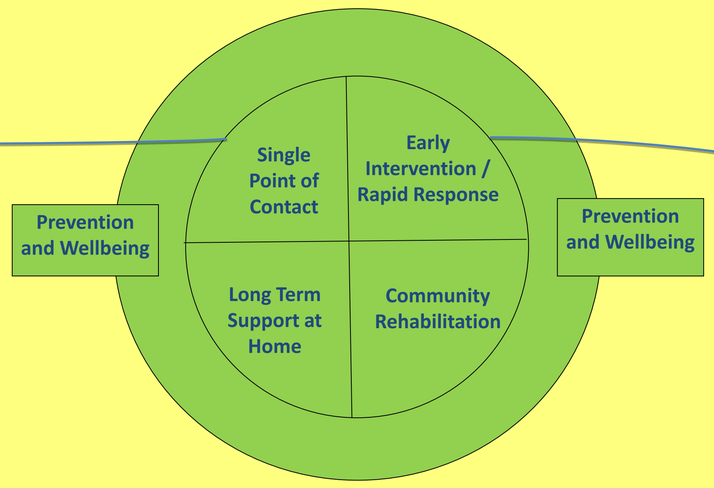


Our ageing population is placing an increased demand on acute and community services. In Nithsdale (DG1/DG2 postcodes) this is exacerbated because there's no community bed provision. In line with the 20:20 Vision and the Nithsdale Locality Strategic Plan, Nithsdale in Partnership (NiP) is a One Team approach where all the services in the locality work together. The wider aim is to support people to live at home safer for longer and reduce pressure on acute and community services by maintaining patient flow and reducing admission where possible.



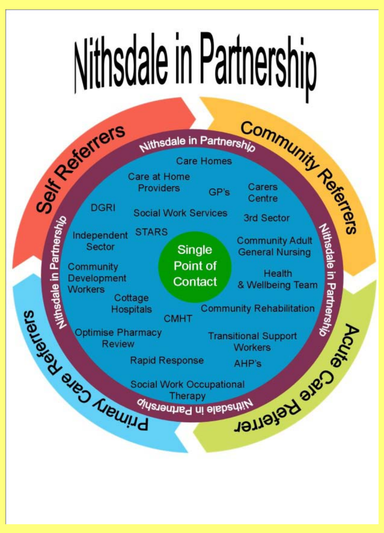
Single Point of Contact

Working with key stakeholders, we launched the Single Point of Contact (SPoC) in October 2018. The aim of this is to streamline non-emergency Health and Social Care referrals for anyone living in the DG1 and DG2 postcode areas who is aged 16+.

People can self refer to SPoC, thereby encouraging self-management and relieving GP pressure.

Referrals can be made by calling 030 33 33 30001 or via SCI-Gateway.

SPoC provides a central hub where referrals are robustly triaged and transitioned to appropriate services.



A daily huddle takes place with representation from a number of disciplines to discuss more complex referrals, reducing duplication and improving team working and communication.

Between 17th October 2018 and 31st March 2019, SPoC received a total of 856 referrals, an average of 143 a month. Work continues to develop SPoC; it is key to the success of NiP, ensuring a truly integrated One Team approach for the locality.

Rapid Response

The multi-disciplinary Rapid Response Team was set up in 2017, comprising of two Occupational Therapists, a Physiotherapist, Community Adult General Nurse, Care Co-ordinator and a Trainee Advanced Practitioner Physiotherapist. We tested with two GP Practices during August 2017, followed by a staged roll out to the remaining five Practices, other community teams and acute hospital. The team responds to community referrals within 2 hours and also supports hospital flow. A holistic assessment is undertaken, working closely with statutory and third sector partners, creating a "one-stop shop" for the service user.

Now fully established the Rapid Response Team continues to raise its profile. In 2018, the team received a total of 614 referrals, an average of 51 a month. Since SPoC launched the average referrals have increased to 61 per month. On average 70% of the service users remained out of acute facility 4 weeks post discharge from the service.

Conclusions / Next Steps

Rapid Response and SPoC were challenging to roll out within the current Health and Social Care climate. However, persistence, belief and buy-in from all stakeholders resulted in us seeing a steady and consistent embracement of these services.

We succeeded to get buy-in from stakeholders for SPoC in 2018 as a result of our learning from rolling out Rapid Response the previous year. We are therefore more confident in moving forward with the other two quadrants of the model: Community Rehabilitation and Long Term Support at Home and expanding the services to the rest of the Nithsdale Locality.

References:
Health and Social Care Locality Plan, Nithsdale 2016-2019
The 2020 Vision, Scottish Government 2010