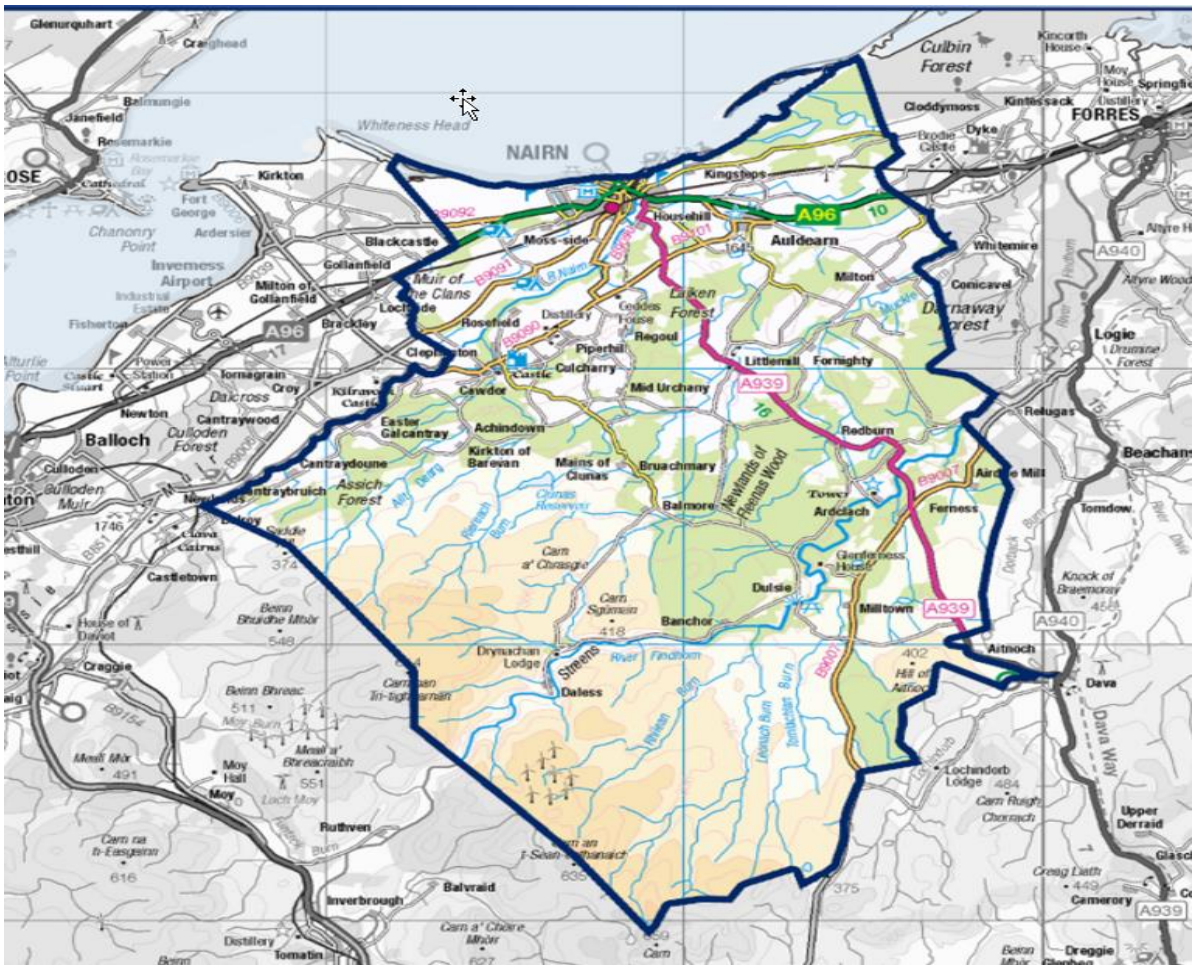
District Profile

District: Nairn

Manager: Ros Philip

Locality Demographics

As of 2021 the National Records of Scotland show that Nairn and Nairnshire had a population of 13,670 people as detailed below. However the boundary used to formulate the reports for Nairn & Nairnshire (as per below map) reflects the Council boundary which does not include our entire health and social care boundary which reaches out to the new Tornagrain area and Arderseir. Each of the demograph graphs within this document therefore are not a full representation of the population we deliver services to.



Current estimated population by age group,2021

Age Band	Nairn and Nairnshire	Highland	Scotland
All ages	13,670	238,060	5,479,900
Under 1 year old	88	1,842	46,782
1-4 years	418	8,321	208,655
5-15 years	1,511	27,967	656,085
16-39 years	3,223	61,405	1,671,841
40-64 years	4,879	83,301	1,822,676
65-74 years	1,958	30,598	595,578
75+ years	1,593	24,626	478,283
85+ years	452	6,691	131,309
0-15 years	2,017	38,130	911,522
16-64 years	8,102	144,706	3,494,517
65+ years	3,551	55,224	1,073,861

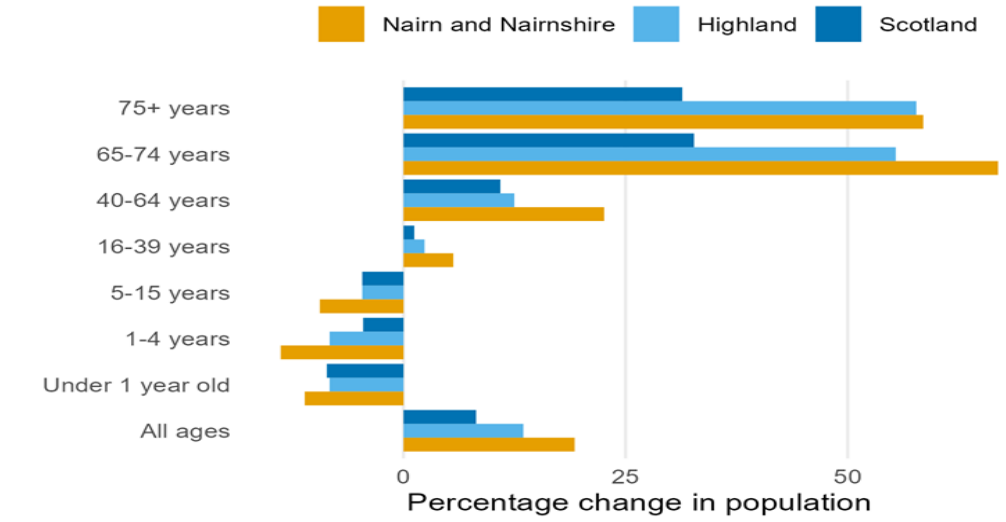
Source: National Records of Scotland, Small Area Population Estimates 2021

The patient demography of those registered with Nairn Healthcare Group as at 1 October 2022 are detailed below. Due to the boundaries between general practice and the NHS, and NHS and the Council being different, in addition to the provision of care for all of the Nairn registered patients, our local services also encompasses provision for patients who are registered with Inverness practices, and for whom we don't have the demographic data. The over 65 population as at October 2022 registered with Nairn Healthcare Group alone is 26% of their overall list size.

Age Group	0-4	May-14	15-24	25-44	45-64	65-74	75-84	85+	TOTAL
Male	291	812	761	1664	2284	1055	621	190	7678
Female	269	758	657	1622	2412	1121	770	298	7907
TOTAL	560	1570	1418	3286	4696	2176	1391	488	15585

The National Records of Scotland data as at 2021 shows of the Nairn & Nairnshire population of 13,670, 14.8% were children aged 0-15 years, 59.3% were people aged 16-64 years and 26.0% were people aged 65 years and over. There is a greater percentage decrease in the population aged 0-15 years compared to Highland or Scotland.

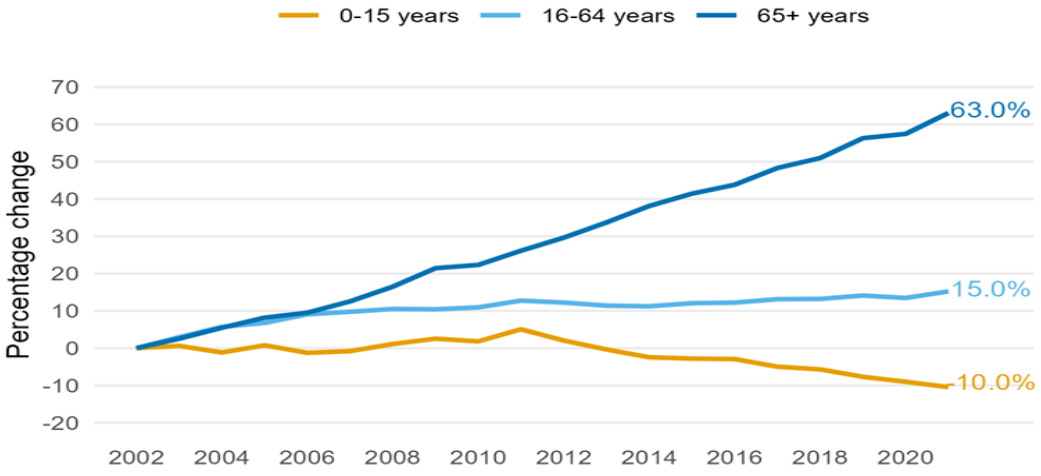
Percentage change in population by age group, 2002 to 2021



Source: National Records of Scotland, Small Area Population Estimates 2021

The National Records of Scotland shows population has increased by 19% in the period 2002 to 2021 with a difference between age groups with regard to population change. There was a 63% increase in the 65+ age group, which occurred year on year since 2002. We have seen a greater percentage decrease in the population aged 0-15 years compared to Highland or Scotland.

Percentage change in population by broad age group, 2002 to 2021

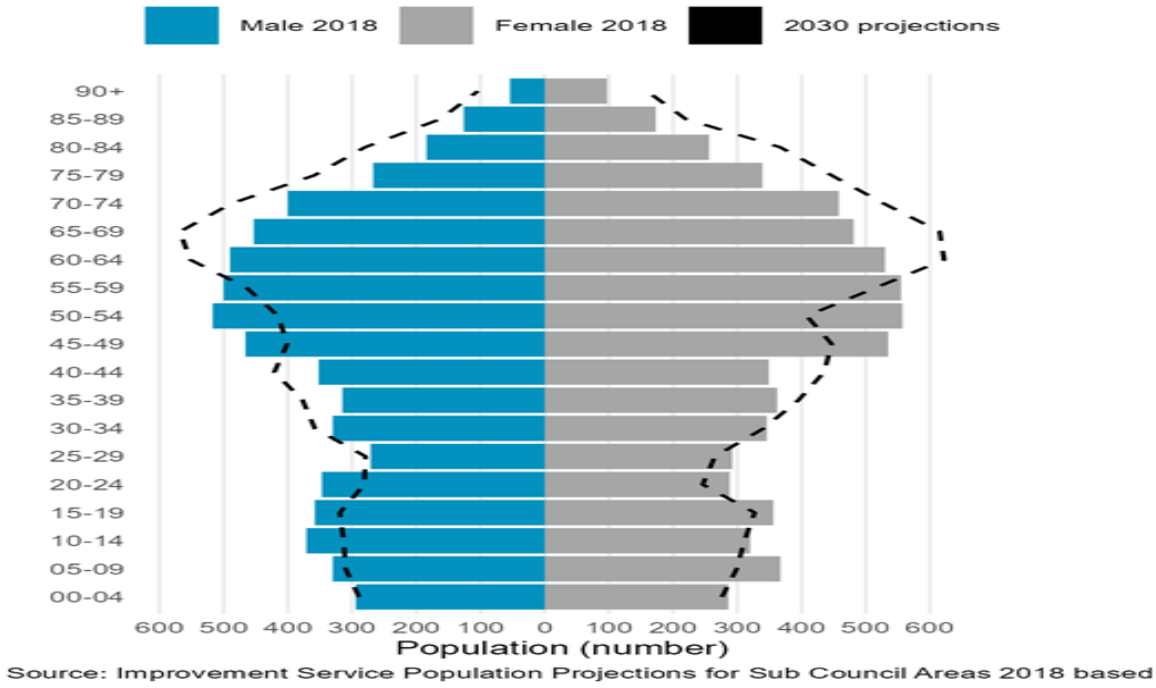


Source: National Records of Scotland, Small Area Population Estimates 2021

It is estimate that the overall population will increase between 2018 and 2030 and that the population will continue to age. The number and proportion of people in the 65-74,

75-84 and 85+ age groups are projected to increase, whereas the population aged 0-15 years and 45-64 years are projected to decrease.

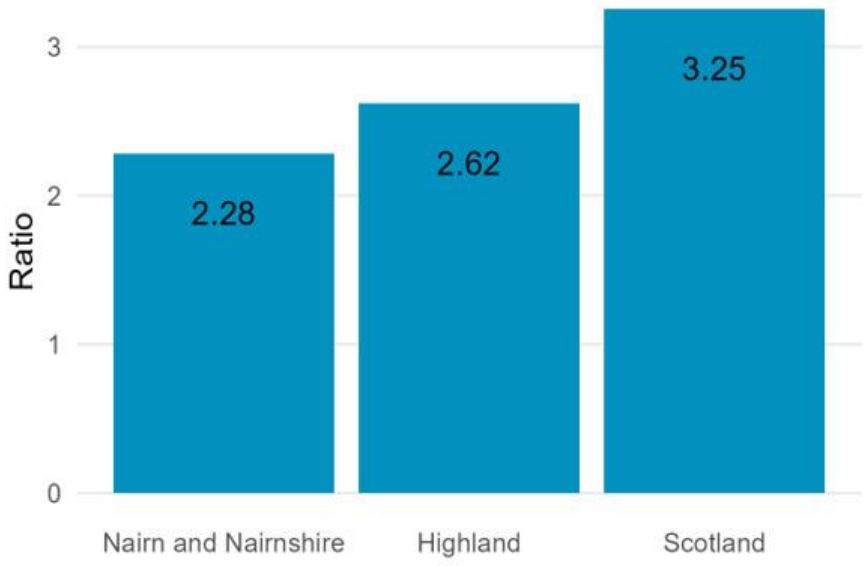
Estimated population in 2018 and projected population in 2030



Source: Improvement Service Population Projections for Sub Council Areas 2018 based

The ratio of people of working age (16-64 years) to older people (age 65 years and over) is lower compared to Scotland overall.

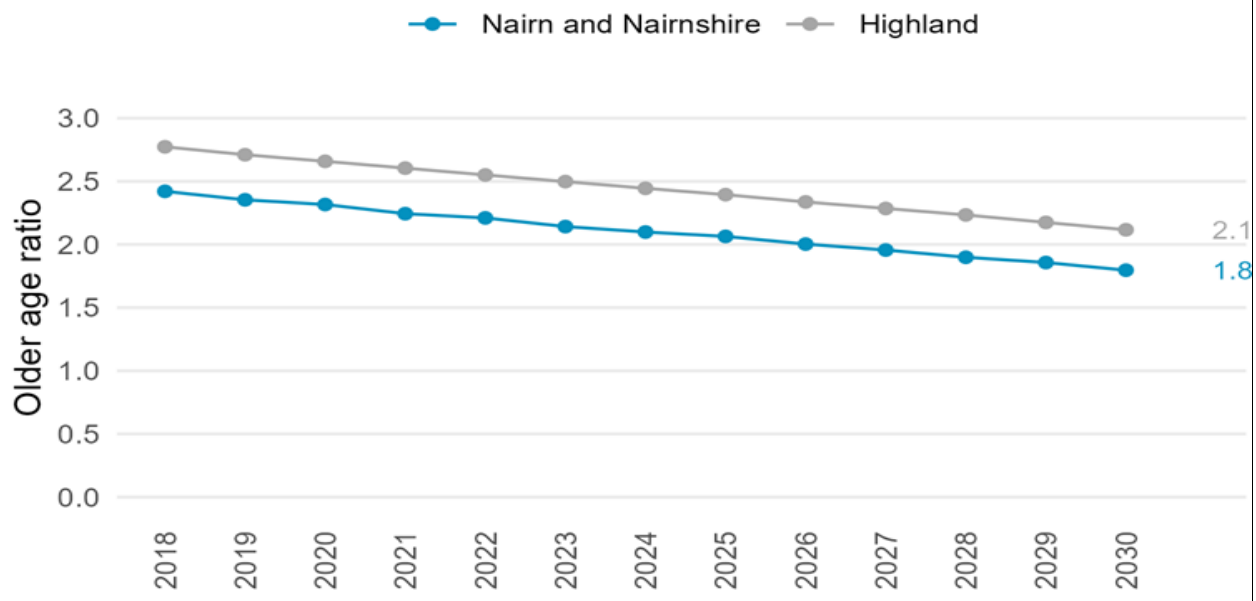
People of working age (16-64 years) for every person 65 years and older in 2022



Source: National Records of Scotland, Small Area Population Estimates 2021

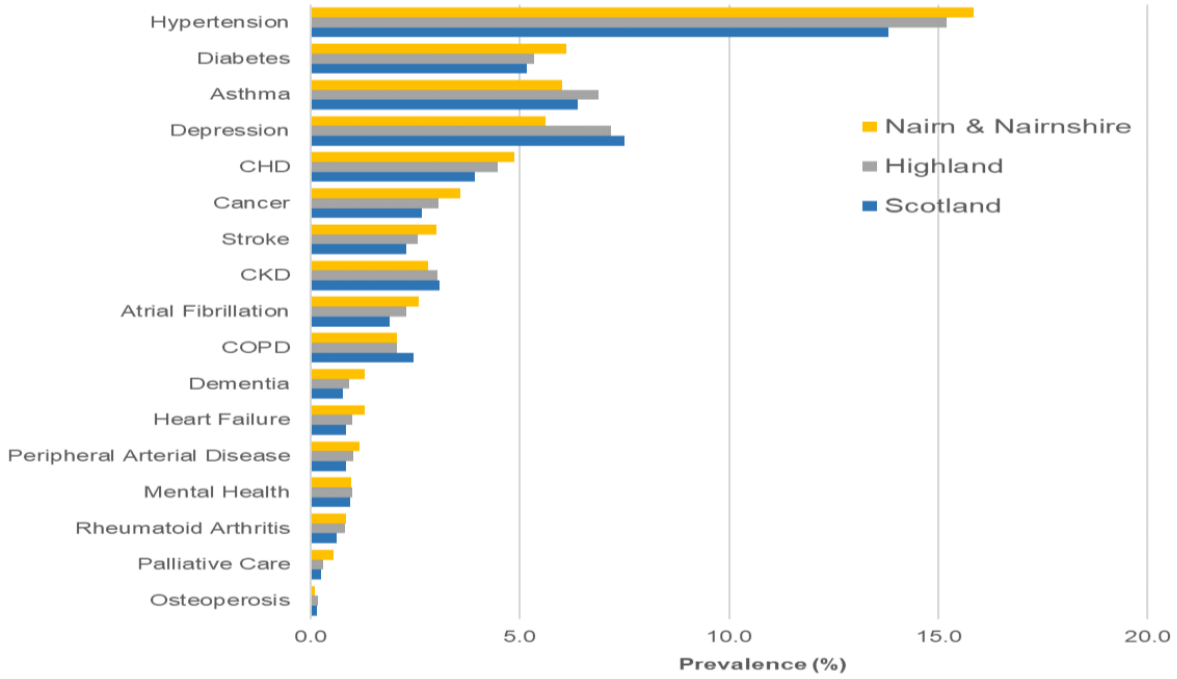
The impact of long-term demographic changes will mean that the ratio of people of working age to people aged 65 years and older will further decrease. **This pattern has implications for staffing and recruitment.**

Projected ratio of people of working age (16-64 years) for every person 65 years and older



Source: Improvement Service Population Projections for Sub Council Areas 2018 based

Number of people with health conditions: prevalence of chronic diseases (%)



Aggregation of General Practice disease **registries to Community Partnership areas for 17 chronic conditions**

The graphic is based on data published from QoF (Quality and Outcomes Framework) disease registers. Data was extracted by ISD (now Public Health Scotland(PHS)) from QoF and is available here:The data is based on Read codes entered by practice staff in the GP practice system.
Rates per 100 population are based on the populations included in the data and so can be considered as broadly accurate.

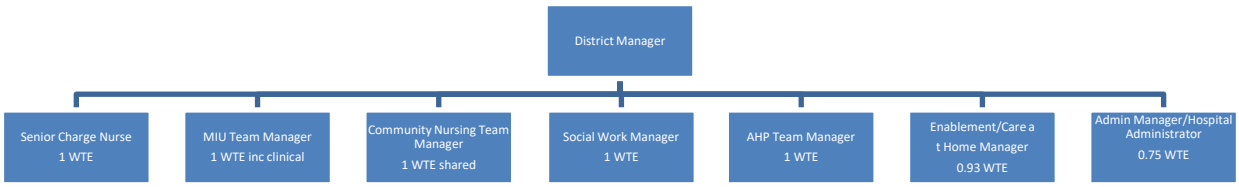
Services provided and current workforce

Nairn Town & County Hospital houses various services/agencies with the staff and services within the district manager area of responsibility being:

Community Nursing
16 bed Inpatient Ward
Physiotherapy
Social Work
Enablement/Care at Home
Minor Injury Unit/PCEC
Occupational Therapy
Support Services

Children's services (including child social work), podiatry, X-ray, CMHT, SAS, pharmacy, dental, midwifery and the general practice, whilst also based in the hospital are managed outwith the district management structure.

The District manager directly line manages the Integrated and Hospital Team with a Team Lead in place for each service (1 for AHP). All services are situated within the same building allowing effective multi-disciplinary working which proves effective.



The teams within the District are small with any absences/vacancies causing significant impact. Of particular challenge are within the below teams as a result of vacancy/LTS/maternity along with any short term sickness combined with the level of complexity of work within the community.

	Mon-Fri	Sat/Sun	Team Establishment		Issues
			Qualified WTE	Unqualified WTE	
Ward	24 hour	24 hour	14.21	10.71	1.53 WTE qualified maternity leaves only partial cover picked up.
Minor Injury Unit	24 hour	24 hour	6.07		Unsuccessful in WFP 0.71WTE. Career break imminent with no applicants.

Community Nursing	08.30-16.30	08.30-16.30 Reduced Staffing	8.72	0.96	Increasing complexity and caseload with up to 60 visits per day being undertaken by the nurses. Team also provide ITR clinic demand exceeds resourced capacity. Admin post vacancy unable to appoint to date impacting on Team as no capacity in district to provide admin outwith the admin heavy resource required to support ITR clinics. Post out to advert again.
Enablement Team	08.00-21.00	08.00-21.00 Reduced Staffing(no manager/scheduler)	15.4	0.8 WTE (2 posts)	1.68 WTE vacancies out to recruitment. Continuing to support ISP packages. Plans in place for contingencies.
Social Work	09.00-17.00	Unavailable	5	4.87	1 WTE qualified maternity leave and 1 WTE unqualified on long term leave. No HSCCs from 6/12/2022
Occupational Therapy	08.30-16.30	Unavailable	2.58	2.53	1.44 WTE qualified out to recruitment. (1 qualified reducing from January 2023 + utilising Band 5 hours as unable to fill B 5 post).
Physiotherapy	08.30-16.30	Unavailable	2.15	1.6	0.7 WTE qualified unable to recruit. Only 1 qualfied staff member available for rehabilitation service currently (who is the AHP Team Manager).
Admin/Portering	08.30-17.00	Reduced staffing		5.08 (6 are part time)	Supporting ITR clinics takes up significant resource.

Services Provided

Ward

The Ward is a 16 bed inpatient ward overseen by a Senior Charge Nurse. The ward play a key role in ensuring community flow with the beds full the majority of the time (graph highlighted further below). The service provides rehabilitation and end of life care. Two community access beds are allocated and admissions to these beds are utilised both for community admissions but also to transfer end of life care patients from Raigmore or directly from Raigmore A&E where appropriate. Medical cover is provided by the local general practice and Dr Andrew Jamieson Consultant Physician attends all MDT meetings. Qualified nursing staffing regularly runs below WFP requirements and B5 shifts filled where possible with a B2. It is a regular occurrence for the ward to be short of a B5 as a result of uncovered elements of maternity leave and short term sickness/COVID.

MIU

Nairn MIU is nurse led with a GP on call for support if required. In hours Mon-Fri the on call GP is available from the Practice via the emergence mobile. Out of hours the GP

is available on the emergency mobile from home although they are in attendance at weekends and several GPs stay in the hospital overnight when on shift. The MIU staff support the ward night shift 7 nights a week. This involves being present on the ward once all MIU work is complete (returning to MIU to see patients as required), covering breaks, assisting with patient care and being included in staffing numbers to ensure fire safety overnight.

This is a complex job requiring specialist skills and knowledge. The majority of the nurse shifts are worked alone. The nature of the job requires staff to make complex decisions in sometimes challenging and urgent situations. In order to carry out the job safely and avoid risk they require appropriate skills, training and support in terms of regular clinical supervision and personal development planning.

Workload can include falls/collapse, drug overdose, fractures/dislocations, burns, wound care, head injury, MSK injury, chest pain, infection/sepsis, breathing difficulties, assaults, mental health, Stroke, RTC, pregnancy complications. Consultation time can vary and can take up to 2 hours. With current pressures on SAS delays of 4+ hours are common with a lone working nurse juggling a busy MIU department and monitoring for a deteriorating patient awaiting onward transfer.

Community Nursing

The Community Nursing team provides preventative, reactive and maintenance clinical care to patients in the community. The elderly age profile and care homes in the area are above average. The team leads on End of life Care and are well above the national average supporting patients to die at home. There has been a real shift from secondary care to the community to provide high end complex clinical care. This impacts on team resource to provide care and also training to upskill on new procedures. Ongoing work force planning evidences the increased complexity and dependency of client group requiring the knowledge and skills of band 6 nurses. Services require to be reactive with minimal opportunity for any waiting lists. The aim is to avoid hospital admissions and expedite timely discharges.

We provide a community nurse lead clinic for complex care not provided by practice nurse services. Patients are seen close to home, avoiding the need to attend secondary care.

Investigation and **T**reatment **R**oom service (**ITR)** is covered by the community nursing team. It runs at over 125% of the resource allocated. Clinician AL, absence etc is not resourced leaving extra pressure on community team and there is no resource for the associated administration required for the ITR service.

We have been unable to recruit to the community nursing admin post which impacts on the team who are trying to cover this role. The post is out to advert again.

Physiotherapy

The Nairn physiotherapy service covers all aspects of clinical service delivery. This includes inpatient rehabilitation to the 16 bed unit, medical out patients, MSK, Pelvic dysfunction, Cardiac rehabilitation and Pulmonary rehabilitation, Falls and Frailty

intervention and Community rehabilitation. Service is currently provided by the AHP Lead, 2 part time qualified staff and 3 part time non registered staff.
Resource was taken from mainstream physiotherapy to fund the development of FCP service. Whilst this was a good opportunity for staff and service development, it led to a shortfall in funding for mainstream physiotherapy services. Patient flow into MSK services has reduced from GP referrers but all other referring sources have continued to grow. The Band 6 rehab staff member resigned at the end of August 2022. As this is a part-time post it has been difficult to recruit which has resulted in services having to stop including falls, cardiac and pulmonary rehabilitation and community rehabilitation will be severely reduced causing significant delays that will impact on admission prevention and discharge support. The WFP undertaken had recommended an additional 1.5 WTE B6 and 1 WTE Band 4, however this was not resourced.

Occupational Therapy
There are high levels of volume of referrals being received and with the ever increasing complexity in a high elderly population the team are having difficulty with an increasing waiting list for services. The team are aware of the OT staff levels within other similar areas appearing to be higher than this district which impacts on staff morale and raises concerns regarding staff's willingness to remain in post in this area. Currently there are qualified staff vacancies in the team and from 1 January 2023 unless we recruit we will have only 1.14 WTE qualified staff.

Enablement/Care at Home Team
The Team currently have 2 vacancies and the team continue to support ISP packages which have been handed back which brings challenges however solutions are detailed further below in the document. As in other districts we are seeing increasing elderly population with increase frailty and co-morbities which increases the need and level of care.

Social Work
The Social Work Team currently have 2 long term leaves and 2 vacancies which is impacting on the service. Due to the high number of elderly clients and complex learning disability/disability clusters they generally have a high number of Guardianship orders that require to be reviewed. At one stage they had 54 clients who were subject to a Guardianship Order and required a review or are subject to a member of the team (qualified Social Worker) being their legal guardian. It is anticipated this number will increase as the population continues to grow in the local area. High numbers of ASP inquiries are common. Nairn has 7 care homes housing 196 beds which is a high number within a small district.

The Team are cognisant of the SDS options available to support people and utilise Option 1 wherever possible, however within the Nairn area there are ongoing recruitment and retention difficulties in all sectors of adult social care including self directed support option 1, and housing support.

Independent sector care homes within Nairn housing 196 beds

No of Care Homes	Client Group	No of Beds

4	Older People	88
1	Older People/Learning Disability	42
1	Learning Disability/Physical Disability/Severe and Complex	43
1	Mental Illness	23

General Practice/s
Nairn has 1 general practice which provides care for all of the population in Nairn, along with patients registered who reside in Arderseir and Croy. The local GPs work closely alongside the hospital services linking in with the integrated team, inpatient ward, Minor Injury Unit/PCEC and all other services within the building.

Integrated Working/Complexity within the District
The teams provide integrated services to a population of approximately 16,000, the majority of whom, but not all, are registered with the Nairn general practice. An ever increasing complexity of care is required, and whilst we as far as possible aim to ensure the Home First principles are embedded, and implement the recommendations in the NHSH Enhancing Community Health and Care Model, this is challenging within our current resource and taking in to account our geography.

The Teams work closely together to ensure provision of services for the population are available utilising an integrated approach. Patients within hospitals are monitored daily with person centred wrap around care, with acute referrals from Raigmore directed to the ward senior charge nurse, and the integrated team linking in across all sectors.

Teams are linking to ensure our vulnerable people list is updated on an ongoing basis and that ACPs and personal contingency plans are in place for everyone included on the list.

We work very closely with our local GP colleagues linking in around palliative and end of life care along with routine core services. Dying at home remains the first choice for the majority of patients who are coming to the end of life. Nairn has a high proportion of elderly population, and the community caseload is complex with workload continuing to increase. Data shows the end of life care provided at home ratios are higher in Nairn in comparison to other areas (based on 2018/19 GP Cluster data).

We are fortunate in Nairn as the hospital provides the opportunity for co-location of staff groups in the building. This means that health, social work and care at home teams are sharing offices with the wider integrated team, which promotes and enhances integrated working, and allows strong relationships with the general practice, hospital, mental health and Children's Services colleagues.

The hospital also provides outpatient clinics as detailed below:

CMHT	Diabetic Retinopathy	Podiatry
Physiotherapy	X-ray	Alzheimers
Psychiatry	CAB	Cardiac/Heart Failure

Childrens Services	Paediatrics	SLT
Dietetics/Weight Management	Epilepsy	Learning Disability
Midwifery	Psychology	Parkinsons Disease
Viral Hepatitis		

With the rollout of the Primary Care Modernisation as detailed in the GP contract we are seeing pressure on availability of both clinic and administration space as we have the additional need for pharmacotherapy, First Contact Practitioner, Primary Care Mental Health Services and Community Link Worker being embedded.

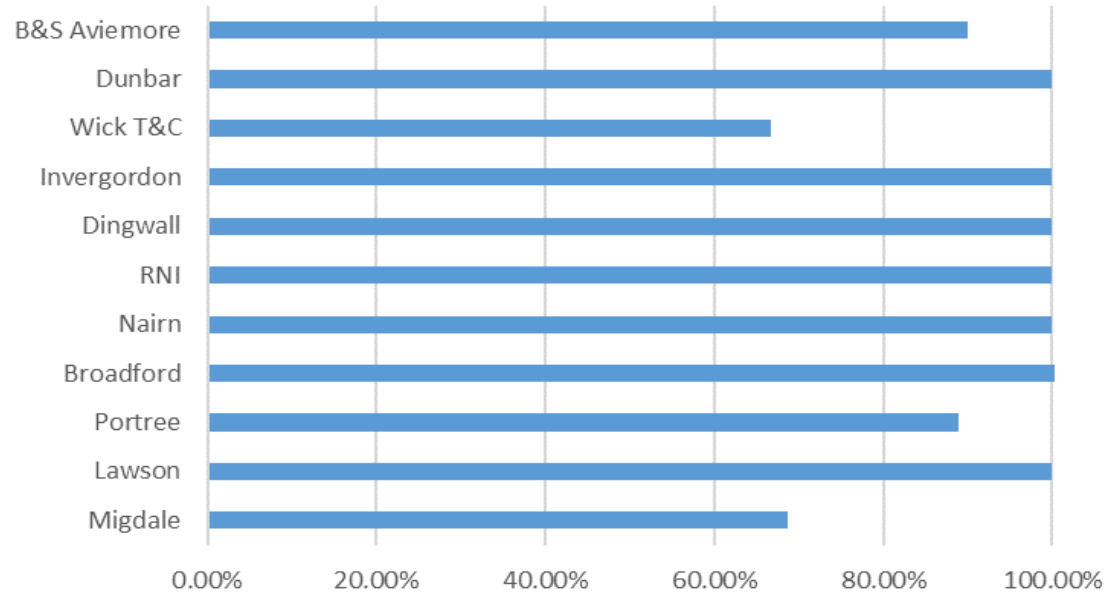
Finance & Performance

Finance

The budget for 22/23 for the District is £13.178m of which £0.045m relates to hospital and community services, and the balance of £0.865m being ASC. At the time of writing the projected year end is being forecasted at a £0.447m overspend. This overspend can be broken down into Health £0.119m and ASC £0.327m. The Health year end variance mainly relates to inflationary pressures of £0.082m due to rental costs and increased prices and the balance being mostly staffing pressures due to maternity and sickness. ASC overspend of £0.327m is due to ISC mainly in younger adult and LD packages where costs have increased post pandemic.

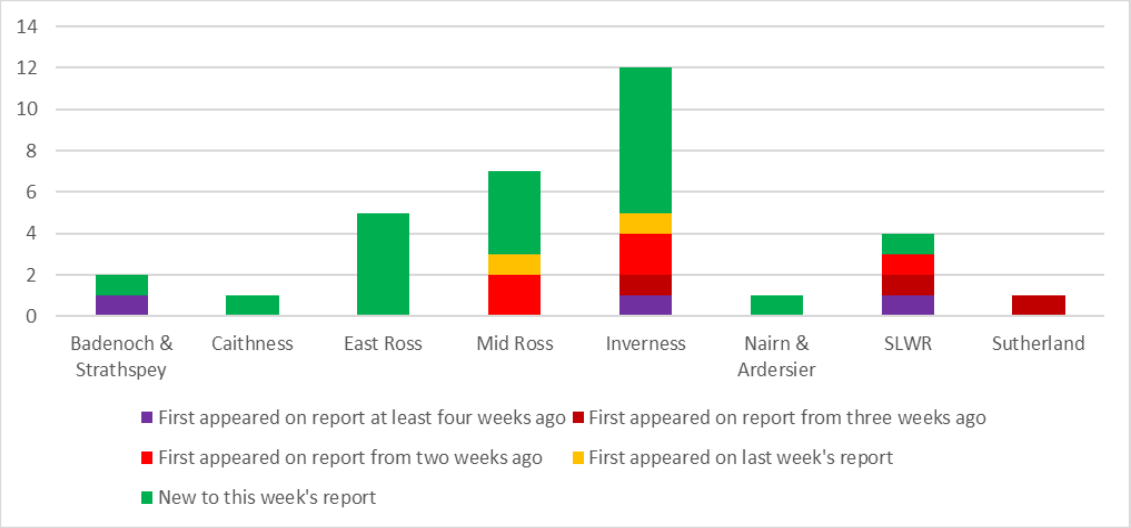
We understand the Board is undertaking a baseline review of resources per district and it will be interesting to establish our position with regard to the share of budget vs activity.

Nairn Hospital Bed Occupancy (systems pressure report 21/11/2022)



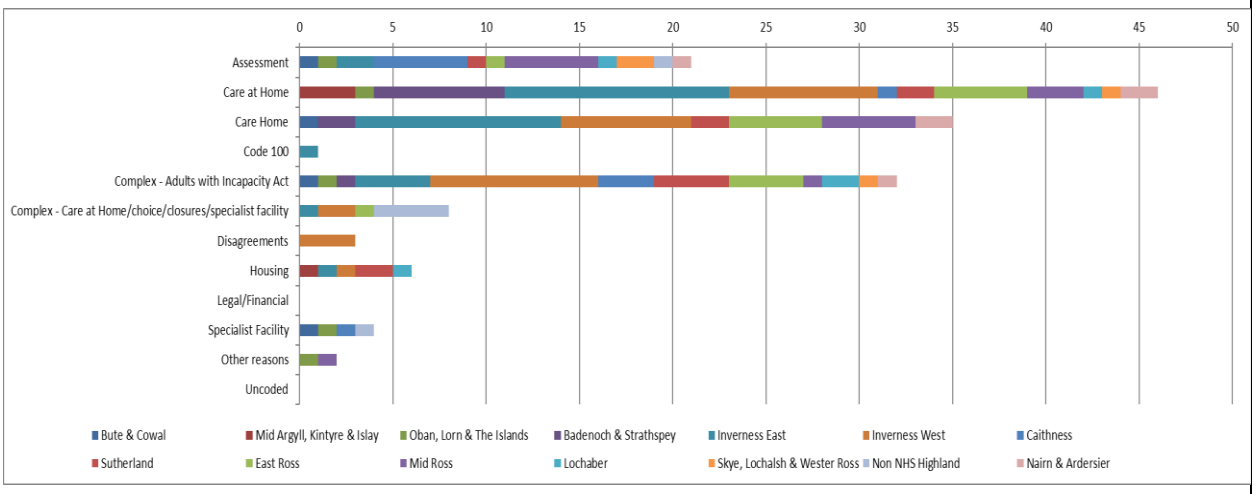
The hospital runs at capacity 100% of the time.

Wait period for a Community Hospital Place (systems pressure report 21/11/2022)



While the hospital is running at 100% capacity the above graph demonstrates the efficiencies within the Nairn hospital system that allow for short waiting periods for transfers. We have a daily system in place which brings oversight to people in hospital, and pull them through to either the hospital or out to the community where appropriate. We currently use an EDD for patients however meetings are arranged to discuss embedding PDD within the district.

Delayed Discharges by District (systems pressure report 21/11/2022)



A system is in place to review our DDs on an ongoing basis. Pressures exist with the long wait for guardianship processes and many areas utilising any care home beds that become available. The above table highlights the 4 main areas of delay pressure which are care home, care at home, AWI and assessment by social work.

DATA ANALYSIS – DQ Errors by Category and Hospital Location (September 2022)
Nairn is among the teams who that ensure appropriate DD codes are utilised, thus reducing errors in reporting and data collection.

Unmet Need Hours by Locality (systems pressure report 21/11/2022)

Despite the withdrawal of Providers from Nairn described further below in this report, Nairn has managed to maintain a level of control of the unmet need and plans are in place to improve the unmet need, and allow for contingencies should further providers reduce or withdraw their services.

Patient Feedback
We have many examples of patient feedback the most recent example is detailed below.

"For NHS purposes my full name is xxxx and my CHI number is xxxx. As you can see it has been a challenging year for me medically this year with a herniated disc, suspected MS, mental health challenges, diagnosis of Neurological Lyme and IV treatment.

As we draw to year end all the tests for MS are negative the diagnosis for Lyme's was confirmed and my IV treatment has now finished. During the whole of this time, I have received outstanding service from the NHS, particularly Nairn Healthcare and the various GPs I have seen, Raigmore and the AEC team and consultants plus the OPAC team and finally the District Nurses at Nairn who were great undertaking my daily IV transfusions. Finally, the receptionists at the GP practice and indeed xxxx at MIU".

Opportunities and Developments

Again opportunity to raise what you are currently developing and the good work that is ongoing on within the districts improving C@H discharge to assess etc clinical bridge..

Recognising the financial constraints what can you do differently or let go?

Clinical Bridge
The Clinical Bridge which is being piloted in Nairn is a software package aimed at supporting integrated teams to better manage their "at risk" patients. There have been connectivity issues and we are hopeful these can be fully resolved. This will allow us to move forward to develop our "virtual ward" accessible by the teams allowing easy access to information for at risk patients. The system works through Bridge interfaces/viewing screens which include patient details, ACP in place, AWI/Guardianship and all team actions/outstanding actions. These interfaces are situated in the GP Duty Room, ward, integrated team office and the physiotherapy gym where AHPs have their daily huddle.

Currently within this "virtual ward" we have included patients who are inpatients at Nairn but are not DDs, patients who are recently discharged from hospital as well as patients who are on end of life care, or who have Just in Case medications in their home. The plan is to develop this further in liaison with the general practice and the integrated team to include other vulnerable patients. The Bridge allows each team to add in their actions to allow the other teams to identify what is in place and what is outstanding. Maximising the potential is dependent on improving the Bridge connectivity, as well as our ability to staff vacant HSCC posts who will be responsible for inputting information.

Care at Home Redesign

Independent Sector provision of Care at Home has been challenging for several years. New providers came into the area in 2020 however unfortunately, over the last two year we have seen the withdrawal of three providers. Recruitment and retention are cited as the reason for withdrawal. We have one new provider to the area who came in 2021, and we have also as a result of rural location being developing our in house service.

As part of the enhancement of our service the focus is on our unmet need and to reactive patient flow. This will significantly expand our in house care at home service, and further recruitment is currently in hand. Our aim is to enhance both in house enablement and care at home services. The enablement part of the service will also be expanded to ensure that service users potential for independence is fully maximised, and this will be a supportive branch of the overall team. We foresee a key link being supporting patient discharges home from hospital for assessment, with appropriate ongoing rehabilitation from the wider team.

FIT Homes

Nairn is set to benefit from a new generation of advanced assisted living homes. We expect that the FIT homes will meet the needs of people at all stages of life including those with health conditions that affect their mobility and who may need care and support at home. The FIT homes are being built on land just north of the Hermitage, St Olaf Manor, Cawdor Road to provide accommodation for tenants with various medical needs that allows them to be supported while maintaining their independence. There are 6 x 1 bedroom and 4 x 2 bedroom flats with completion due in September 2023.

We expect priority will be given to individuals:

- who are likely to benefit from the key FIT Home features (additional space, fully accessible, easily adaptable, digital support opportunities, cluster setting)
- whose existing home no longer meets their needs
- who currently receive care and support services at home, or are likely to in the near future, including those who may be considering residential care or who cannot return home from hospital
- whose physical mobility is reduced as the result of a long-term health condition or ageing
- who already live in Nairn

The NHS, Highland Council and the Albyn Housing Society are the 3 partners who will be involved in considering allocations of the Homes. Meetings are ongoing on these considerations and it is likely there will be agreement to maintain a balance of needs within the FIT Homes cluster to keep a self- supporting environment alongside care and support provision.

Community Engagement

How are you linking into the CPP and the Community Councils also generally members of the public and our partners including third sector – the meetings that you have with the independent sector etc

Community Planning Partnership (CPP)
The Nairn CPP is a strong active group which is chaired by our police colleagues which meets on a quarterly basis. Sub groups are in place who meet on a more regular basis and are responsible for taking forward actions.

We had undertaken community engagement sessions in May 2019 in Nairn and Arderseir supported by the community engagement officers which were allocated to the Community Planning Partnership related to NHS performance in Nairn. Feedback received related to the GP practice, transport, discharges from Raigmore and schools. Any issues were passed on to the appropriate department/organsation and a response fed back to the Community Planning Partnership.

Independent Sector
The General Practice has routine meetings with the Independent Care Home managers to which the District and Social Work Manager are invited. Whilst these meetings stopped as a result of the pandemic, they have now been restarted. This provides a platform to discuss any issues and concerns and is welcomed. The Social Work team have developed strong links with the providers, which has proved beneficial.

Regular meetings take place with our Care at Home Independent Sector providers. Four weekly review meetings are in place which includes Contracts, along with weekly allocation meetings with our local team. We have strong links with our providers, and whilst there has been delay in some pick up of packages with one particular provider, we anticipate some improvement.

Highland Council
Monthly locality meetings take place to which a local Councillor is invited and attends along with representatives from children's services. The Ward Manager sits on the local Care for People Group.

Community Councils
The 7 Community Councils that exist in Nairn are invited to and frequently attend and engage at the Nairn Community Planning Partnership. A meeting is arranged with the Council Ward Manager as to how we can further engage with the community councils to look at community resilience. To date it has been challenging to bring these groups together, or to bring them in to both the Care for People group, and the previous Adult Plan Sub Group.

The Adult Plan had completed all the actions allocated with the direction from NCPP to focus on the Community Led Support (CLS) HUB.

CLS
The first community 'Here for Nairn' pop up hub took place on the morning of Thursday 30 June 2022 in the Library in Nairn, and these have taken place monthly until November. The 'Here for Nairn' is a series of community pop-up hubs which highlight all the ways in which the community can help its population. Colleagues from NHS Highland, other organisations and 3rd Sector representatives attend to help the local

community in Nairn understand what community led support is available to them from the various community groups that exist locally.

We aim to enable people to explore the wide range of options and services available to them in their community. These are drop-in events which will allow people to come along at a time and chat to those in attendance. This allows us to highlight all the different ranges of support available, not only from organisations such as the NHS or Council, but also voluntary groups who can also provide support and advice.

The events have been advertised via NHS Highland social media accounts, the general practice and by the local community groups and organisations involved. The community pop up hubs are part of the Community Led Support project, which was part of a Scottish Government initiative for which Nairn has been designated as a pilot site.

The agencies/groups who have expressed their interest in attending includes:

Highland Third Sector Interface	Move On Project	CAB
Home Start	High Life Highland	Housing
Mikey's Line	Sense in Mind	Listen Well Scotland
Highland Senior Citizens Network	Alzheimers Scotland	Connecting Carers
Welfare Team	Home Energy Scotland	SFRS
Wellbeing Project 23:3 Project	KOMP (tech enabled care)	Health Walks in Nairn
Social Security Scotland		

The footfall to the HUB has been disappointing and we have only supported 16 people to date with no footfall at all on 2 occasions. We currently have free use of an area in the High Life Highland library in the High Street which limits the number of organisations we can invite on each HUB session. The format will be reviewed and we are trying to source funding from the Council Discretionary Fund in liaison with the Ward Manager, to allow us to resource using a larger venue and arrange a large event which may bring greater success.

Completed by: Date: