DUMFRIES AND GALLOWAY
INTEGRATION JOINT BOARD

PERFORMANCE MANAGEMENT

AREA COMMITTEE REPORT

DUMFRIES AND GALLOWAY
Health and Social Care

Stewartry

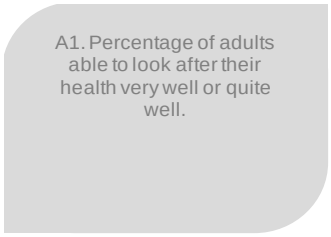
January 2018 – June 2018

Contents

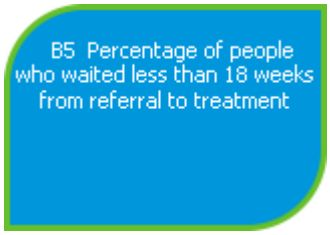
Document Features

In this area committee report ‘RAG status’ (Red, Amber, Green) is used in two ways: firstly to gauge progress in delivering the series of commitments made in the locality plans, and secondly to indicate whether performance indicators are being successfully attained. See descriptions below.

Grey – Work to implement the commitment is not yet due to start.
Green – Progress in implementing the commitment is on or ahead of schedule or the work has been completed.
Amber – Early warning that progress in implementing the commitment is slightly behind schedule.
Red – Progress in implementing the commitment is significantly behind schedule or work has not started when it was due to start.



At the start of each section of performance indicators there is an overview page summarising the section’s content. This is done using ‘leaves’.
If the leaf is **grey** then that indicator/measurement has not been included in this edition of the report. If the leaf is **coloured in** then that indicator/measurement is included in this edition.



The border of the leaf will be coloured according to the following:
Black – It is not possible to determine whether the indicator suggests success or lack thereof in attaining the desired outcomes. This may be due to insufficient data and not having a trend over time, or the interpretation of the information is not straightforward.
Green – The indicator or measurement suggests that we are being successful in attaining our outcomes.
Amber – Early warning that the indicator or measure suggests that we may not be successful in attaining our outcomes.
Red – The indicator or measure suggests that we have/will not attain our outcomes.

This section indicates which of the 9 National Health and Wellbeing Outcomes the measurement/indicator supports.

This section indicates which of the 10 Areas of Priority for Dumfries and Galloway as described in the Strategic Plan the measurement/indicator supports.

Indicators with a “C” code are the Local Authority Publically Accountable Measures for adult social work services.
Indicators with a “D” code are locally agreed measures.

National Outcomes

The Scottish Government has set out nine national health and wellbeing outcomes for people. These outcomes are central to the strategic plan and the locality plans in Dumfries and Galloway. They are the long term objectives the Integration Joint Board are striving to achieve.

The progress Dumfries and Galloway is making towards achieving the national outcomes is measured in different ways: quantitative, qualitative, and process measures. Each measure may relate to more than one outcome but it is unlikely that any one measure will indicate progress to all outcomes at the same time. In this report, each measure is mapped to one or more of the national outcomes. Combined these measures provide an overall assessment of Dumfries and Galloway's progress towards these outcomes.

1. People are able to look after and improve their own health and wellbeing and live in good health for longer

2. People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community

3. People who use health and social care services have positive experiences of those services, and have their dignity respected

4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services

5. Health and social care services contribute to reducing health inequalities

6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing

7. People who use health and social care services are safe from harm

8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide

9. Resources are used effectively and efficiently in the provision of health and social care services

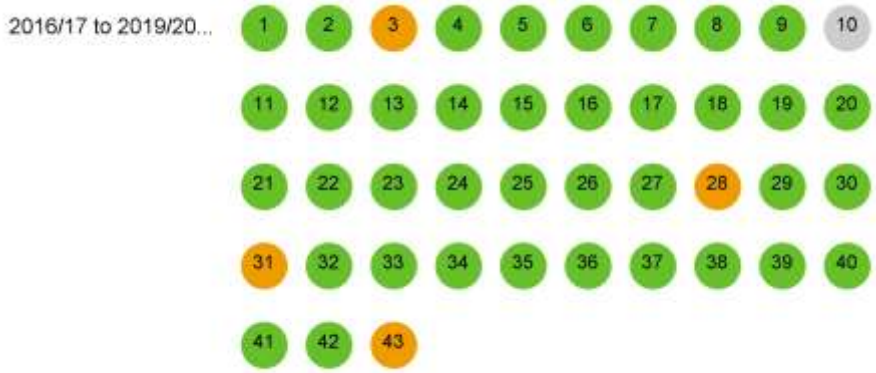
Dumfries and Galloway Priority Areas

To deliver the nine national health and wellbeing outcomes, the Strategic Plan identified ten priority areas of focus. Each measure in this report is also mapped to one or more of these ten priority areas.

1. Enabling people to have more choice and control
2. Supporting Carers
3. Developing and strengthening communities
4. Making the most of wellbeing
5. Maintaining safe, high quality care and protecting vulnerable adults
6. Shifting the focus from institutional care to home and community based care
7. Integrated ways of working
8. Reducing health inequalities
9. Working efficiently and effectively
10. Making the best use of technology

Locality Plan "We Will" Commitments

Red/Amber/Green status of each "We Will" commitment in the Stewartry Locality Plan



Stewartry locality has started to move forward 42 out of the 43 'We Will' commitments identified in the Stewartry Locality Plan 2016-2019.

The areas of work identified below and highlighted within this report show the progress we are making towards delivery of the 9 National Outcomes.

There are still some significant challenges we need to overcome to enable us to achieve our delivery goals, such as Information Technology (IT) infrastructure, recruitment to specialist posts and the sustainability of core services across the partnership, for example cottage hospitals, physiotherapy, nursing and social care provision in a rural area.

Across Stewartry we are continuing to develop new and sustainable models of care.

In early 2018, a consultation and engagement group was formed to oversee the communication process. The group has been working with the Scottish Health Council to ensure a robust public participation process is adhered to. The group has carried out a stakeholder mapping exercise and produced a briefing paper for health and social care senior management team on the intended process. Next steps will include a public engagement process where the Partnership will have good, honest conversations with staff, public and other stakeholders around current challenges of sustaining services.

Our Healthy Connections programme has received 68 new referrals; between 7 and 10 per month from January to June 2018. These referrals continue to be received mainly from health and social care professionals and now from the Dumfries and Galloway Carer's Centre. Between January 2018 and June 2018 there were 78 planned appointments with 57 attendances (73%). From these 12 (21%) did not engage, with ill health being one of the key factors.

A trainee Advanced Nurse Practitioner (ANP) is now in their second year of training at Castle Douglas Hospital. The Locality is looking at how ANPs could be used to support unscheduled care and the new General Medical Services (GMS) contract.

There is currently no standardised monitoring and evaluation framework across the region to support locality teams who deliver low level one to one health and wellbeing interventions across a range of issues. A minimum data set and core outcome indicators were developed and piloted with Stewartry Health and Wellbeing Team between January and April 2018. Full implementation across the region will commence in September 2018.

Food Train Friends has 44 people registered for the service with another 6 waiting to be assessed (as of the end of March 2018). 54 referrals have been received by the service, 34 of these coming directly from health and social care professionals. There are 31 volunteers

signed up and fully trained to deliver the befriending services which include telephone befriending, one to one matches, group activities and outings. The training the volunteers complete includes in house befriending workshop, dementia training, manual handling, first aid, Midas training, how to use a defibrillator and macular degeneration.

A specialist psychology therapist and an assistant psychologist have been in post since February 2017. They are working with 2 GP practices (in Dalbeattie and Annan). From May 2017 to May 2018, 82 people were referred to the service (24 from Dalbeattie). Of these, 24 people were redirected to other services such as the Community Mental Health Team (CMHT), to self-help support, to adult mental health psychology, or to support provided through the community and third sectors. Feedback from people using the service highlighted that the 'service was very helpful and understanding of their needs'; 'very relaxed so I was able to say as little or as much as I wanted'; 'very helpful to have someone in my local surgery with the experience to understand my problems'.

The mental health liaison service has been operational since May 2017, working from 2 GP practices, the Castle Douglas Medical Group and the Solway Medical Group. A community mental health nurse and a support worker run clinics from GP practices to provide low level mental health support to people who have been referred. This enables quicker access to support, with the aim of helping more people before they reach crisis point and enabling them to manage their own mental health and wellbeing. From April 2017 to May 2018, the service received a total of 392 referrals, with 341 first assessments being completed. Feedback from people using the service: 'I didn't know what to expect but found it helped to prevent things from getting worse'; being able to speak to someone quickly, when I was feeling low and stressed'.

In early 2018, a Dementia Champions group was brought together to enable local Dementia Champions to share their knowledge and experience in their area of work around dementia and take forward improvements in the Locality. There is representation on this group from nursing, allied health professionals, care homes, social work and mental health. Current priorities for the group for 2018/19 include:

- Promoting Dementia Awareness training and supporting all staff working in Stewartry health and social care to complete a basic level awareness course
- Promoting the use of This is Me passport
- Educating staff and public around the effects of anyone living with or caring for someone with dementia.

The social worker working within Craignair Health Centre has received 32 referrals as part of the social work in primary care pilot. Interim feedback from other professionals at Craignair and people who have been in receipt of the service indicates that there has been a marked improvement in access to services and support and has helped foster closer working relationships between social work and the practice.

In order to move forward with Technology Enabled Care (TEC) we will be undertaking a test here in the Stewartry in partnership with Just Checking. There are a small number of adults with a learning disability who have sleepover or waking overnight support. With the permission of these people and their families or guardians, we will test using a remote monitoring system called Just Checking for overnight monitoring. The Just Checking system is linked remotely to a polar wrist band, worn by the person receiving support. The aim of the test is to demonstrate which people require support overnight and will also identify those people who may benefit more from a service such as a responder. This will promote people's independence and ensure that resources are being used efficiently.

Funding for a 12 month improvement advisor post has been approved by the health and social care senior management team commencing at the end of June 2018 to drive forward anticipatory care planning across Dumfries and Galloway.

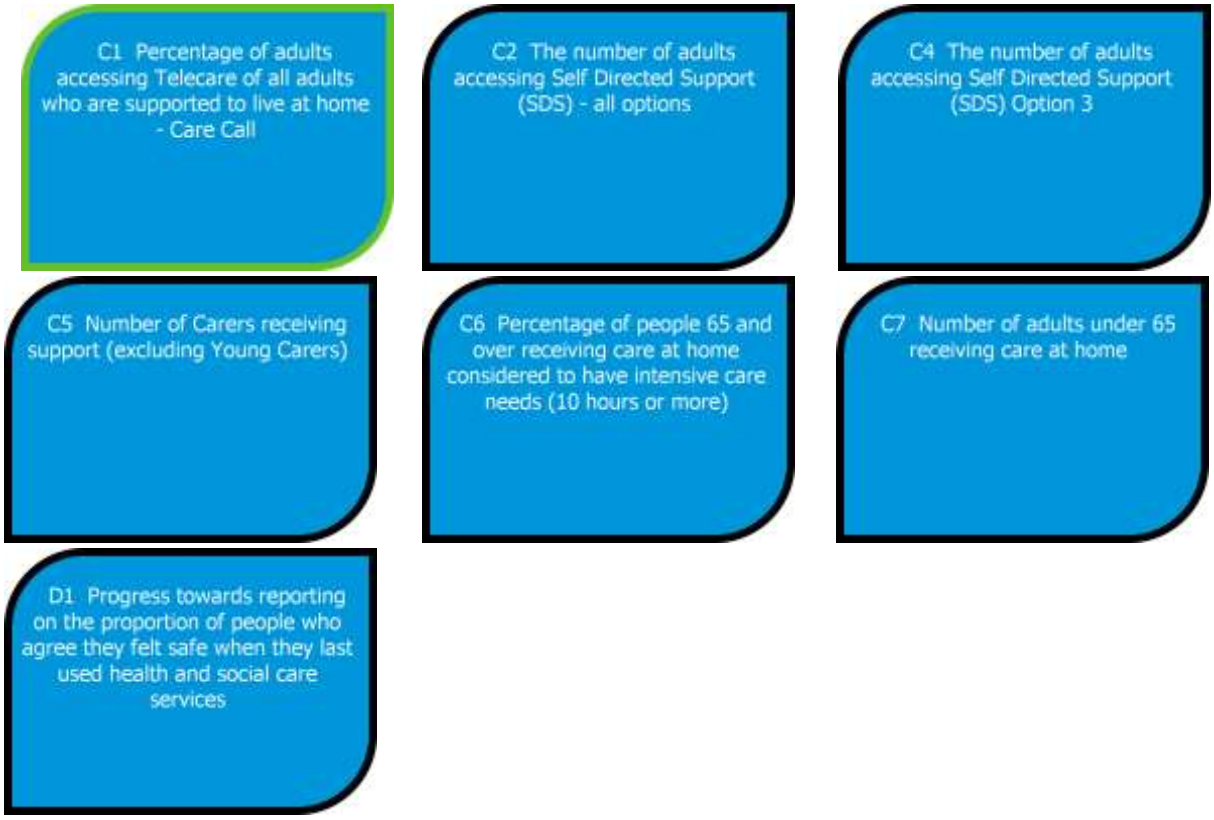
The focus over the coming 6 to 12 months is:

- Implement engagement and consultation programme for inpatient and community services
- Workforce planning and development
- Dementia
- Carers' health and wellbeing
- Evaluate and monitor pilot or test projects using assistive technology, such as for sleepovers
- Develop a respite action plan
- Develop an action plan based on recommendations from the recent day services report
- Develop priority actions based on the national and local consultation on social isolation and loneliness
- Implementation of the General Medical Services (GMS) Contract.

Stephanie Mottram
Stewartry Locality Manager

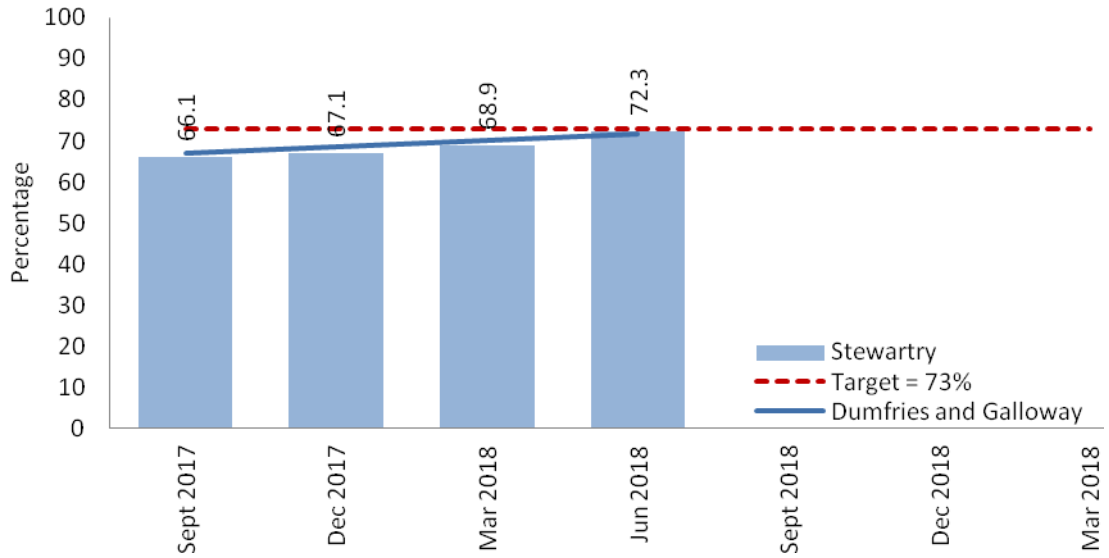
Performance Indicator Overview

Clinical and Care Governance



C1 Adults accessing Telecare as a percentage of the total number of adults supported to live at home

Percentage of adults accessing Telecare of all adults who are supported to live at home - Care Call; Stewartry



Key Points

The percentage of adults supported to live at home who were accessing Telecare in Stewartry was 72.3% in June 2018. Stewartry performance is very similar to that of Dumfries and Galloway where 71.6% of adults supported to live at home were accessing Telecare.

In June 2018, there were 481 people using Care Call technology across the Locality, which is an 8% increase on the end of the previous quarter.

The Wider Context

This measure only relates to Care Call, which is a 24 hour monitoring service, based on an emergency button linked through to a call responder. Despite the recalculation of this measure following the move to the Mosaic IT system, the target of 73% has not been changed.

There is lead in time to the introduction of any Telecare, enabling discussions with the person regarding their choices and learning to confidently use the equipment. A new Digital Health and Care Strategy 2017-22 for Scotland was published in April 2018. This will integrate the Technology Enabled Care (TEC) programme and e-health strategy for Scotland.

Improvement Actions

From April 2018, social work have been piloting a new approach to screening new referrals to ensure that the services of Telecare and occupational therapy are explored as a first option for anyone being referred to social work. As part of this test of change, all social work allocations are screened and cases are discussed initially with occupational therapy. People are also selected if it is felt that they would benefit from a Telecare assessment. The aim of the test is to promote early intervention and prevention as a means of enabling people to remain living at home as independently as possible, for as long as possible.

C2 Number of adults receiving care at home via SDS Option 1, 2 and 3

The number of adults accessing Self Directed Support (SDS) - all options; Stewartry

Key Points

This is a Data Only indicator.
A snapshot in June 2018 showed the number of adults receiving care at home through Self Directed Support (SDS) was 82 people through Option 1, less than 5 people through Option 2 and 294 people through Option 3.
The total number of people being support by SDS is now the lowest since September 2016, when it was 391. In June 2018, this was 381 people.

The Wider Context

The Partnership aims to help people and support them to make the most appropriate choice of option under the Self Directed Support legislation. SDS Option 1 is where people choose to take control of purchasing and managing their own care and support. Option 2 is where people choose the organisation they want to be supported by and the Partnership transfers funds to that organisation, for care and support to be arranged in line with the personal plan. SDS Option 3 is where people choose for social work services to arrange and purchase their care and support.

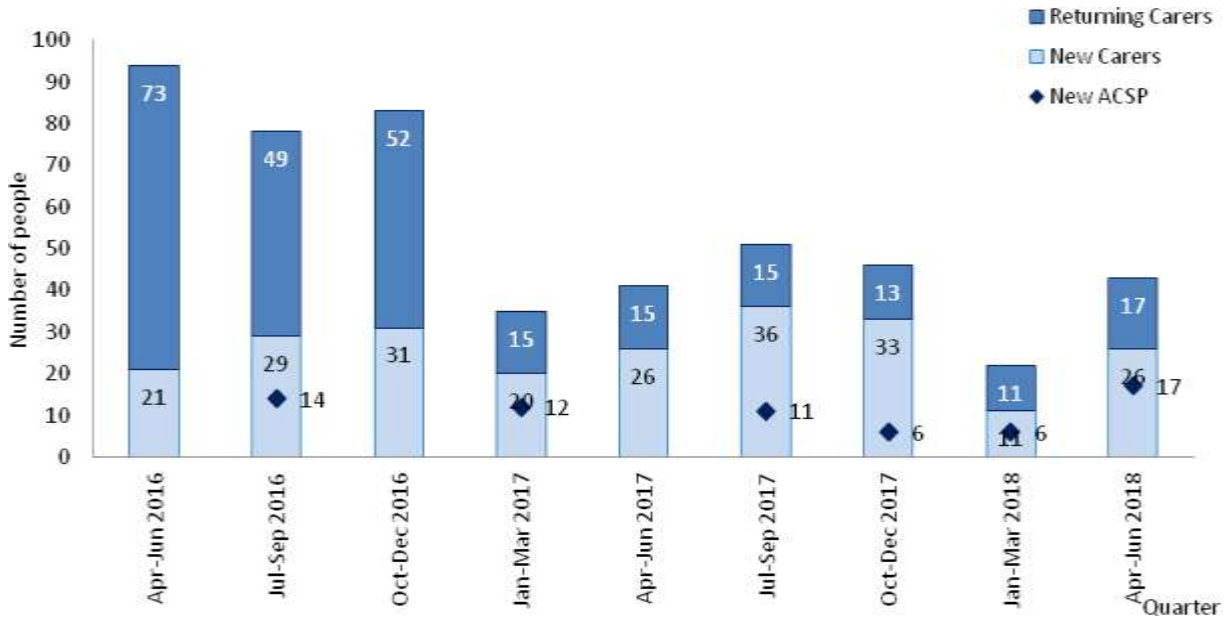
Improvement Actions

A multi disciplinary approach to screening people referred for care packages at the resource allocation process and is supporting people to self manage more and determine the most appropriate and tailored level of care, enhancing person centred care.
A new role introduced to the locality pharmacy team is the addition of an Optimise Pharmacist. Based 1 day a week within Stewartry this person attends the multidisciplinary meetings with social work. They work closely with people taking medications, Carers, colleagues and wider members of the team to review people's medications taking account of national guidelines such as polypharmacy and Realistic Medicine.

There is now a robust screening process for all people being referred to adult services. An eligibility screening assessment is undertaken to establish if people have eligible needs and require a service from social work. This will have assisted in ensuring that we are providing services to people who require them and to those who have critical need. Through signposting to family, friends, community and other professional agencies this has reduced the need for social work intervention, which, in this case, SDS care at home.

C5 Carers receiving support (excluding Young Carers)

Number of Carers receiving support (excluding Young Carers); Stewartry



Key Points

There were 23 new Adult Carer Support Plans (ACSP) completed for Carers from Stewartry in the period January to June 2018 by the Dumfries and Galloway Carers' Centre (DGCC). From Stewartry, the DGCC saw 37 new adult Carers between January 2018 to June 2018 and 28 returning Carers used their services. Alzheimer Scotland had 241 existing and existing Carers whilst Support in Mind had 15 existing and new Carers between January 2018 to June 2018 (there may be overlap between these 3 organisations).

The Wider Context

There are a number of organisations across Dumfries and Galloway who provide support to Carers. The DGCC is commissioned to deliver Adult Carer Support Plan Assessments. Only a small proportion of Carers will require an ACSP and of these, fewer still require social care resources. Identifying Carers is a key priority of the Carers (Scotland) Act 2016.

Improvement Actions

All people seen through Healthy Connections are asked if they are or have an unpaid Carer. Between January 2018 and June 2018 there have been 9 unpaid Carers, 13 people who have unpaid Carers and 5 dual roles (have a Carer and are a Carer) referred to the Stewartry branch of the DGCC.

A Carer's resources pack has been developed in partnership with Carers locally. There have been 175 packs distributed to GP practices, libraries and cottage hospitals. 123 packs have been taken with 3 venues requesting more. Early feedback indicates the resource is very useful but contains a lot of information. A new cover sheet is being devised to support people to access relevant information quickly.

Staff at Castle Douglas Hospital and Kirkcudbright Hospital are working closely with the patient information co-ordinator to streamline information available to people using services and their families across all hospitals in Dumfries and Galloway. This will include information on discharging people home from cottage hospital, and advice for people and their Carers on how to be involved in the discharge planning process.

The DGCC is represented on the local dementia project group and contributed to the recent social isolation consultation.

C6 Proportion of people 65 and over receiving care at home (via Option 3) with intensive care needs

Percentage of people 65 and over receiving care at home considered to have intensive care needs (10 hours or more); Stewartry

Key Points

This is a Data Only indicator.

The percentage of people aged 65 and over receiving care at home through Self Direct Support (SDS) Option 3 who have intensive care needs (10 hours or more) from Stewartry was 41.5% in June 2018.

This rate is lower than that across Dumfries and Galloway at 48.3%.

The Wider Context

This is an historical indicator, which predates the introduction of Self Directed Support, whose relevance has changed since the introduction of SDS. In this indicator “intensive care needs” is defined as a person needing 10 or more hours of care per week. This is an historic threshold of care and therefore less relevant in the context of the changing policy position in respect of self-directed support. The calculation for this indicator is based on those people who have chosen Option 3.

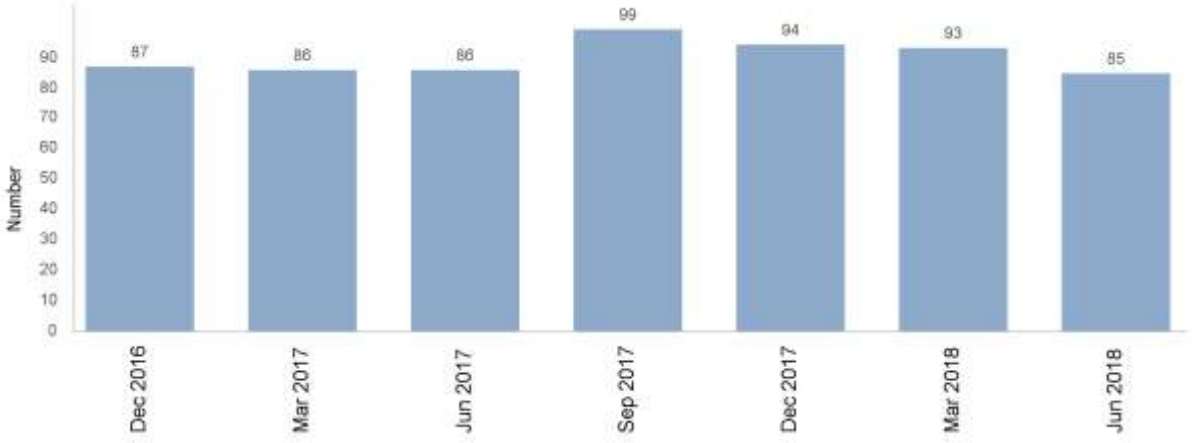
The new SDS models of care offer more person-centred solutions and offer more alternative and efficient solutions.

Improvement Actions

No improvement actions required at this time. This historic indicator needs to be reviewed.

C7 Number of adults under 65 receiving care at home (via SDS Option 3)

Number of adults under 65 receiving care at home; Stewartry



Key Points

This is a Data Only indicator.

The number of adults from Stewartry aged under 65 years receiving care at home through Self Directed Support (SDS) Option 3 was 85 in June 2018.

Performance against this indicator in Stewartry reduced since July 2017, however it has been stable since April 2018.

The Wider Context

SDS Option 3 is where people choose for social work services to arrange and purchase their care and support. For people under the age of 65 and depending upon individual financial assessments, care at home may be charged for.

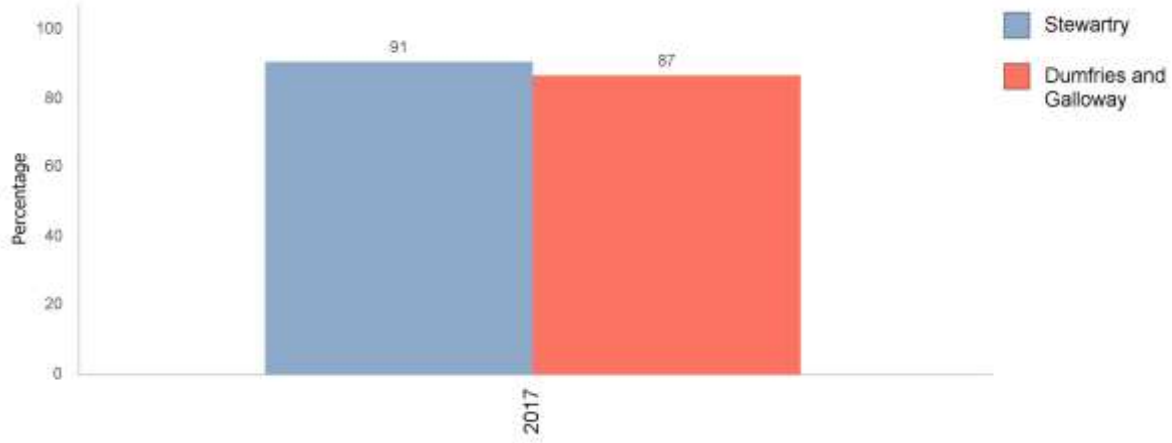
There are multiple factors that can influence the number of people under 65 receiving personal care at home: they may be accessing other services such as day care or optimising the use of their own assets to meet their personal outcomes. Another influencing factor may be challenges regarding the supply of care in local areas.

Improvement Actions

No improvement actions required at this time.

D1 Feeling safe when using health and social care services

The proportion of people who agree they felt safe when they last used health and social care services; Stewartry



Key Points

91% of people who responded said they felt safe when asked about using the care, support and help with everyday living in the Health and Care Experience Survey (HACE). A further 8% answered 'neither agree nor disagree' and 3% responded that they did not feel safe when asked about using the care, support and help with everyday living.

The percentage who agreed is 4% higher than Dumfries and Galloway (87%) and Scotland (83%).

The number of responses to this question was 37 people from Stewartry.

The Wider Context

Of the 721 people who answered the HACE survey in Stewartry, only a maximum of 6.0% (43 people) had direct experience of social care, which is a higher proportion than for Dumfries and Galloway (5.7%) for Scotland (5.7%).

The overall response rate to the survey for Stewartry was 35% (721 people), which is 4% higher than for Dumfries and Galloway (31%) and 13% higher than Scotland (22%).

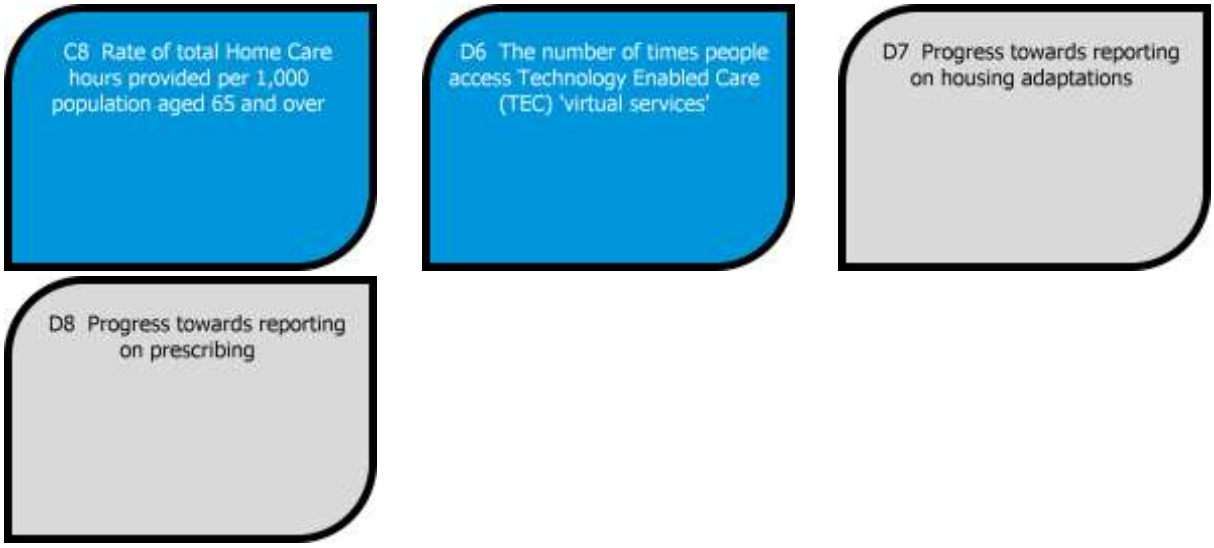
The HACE Survey captures people's feelings about the care they experience, at the time the survey is taken. Local figures should be compared to the experiences of other people across Scotland in the same time period. Results were not available at locality level in previous surveys and therefore no comparisons can be made with earlier surveys.

Improvement Actions

There is a plan in place for Adult Support Plans (ASP), which has been developed by the social work team. Key services across the Partnership are linked into the plan. Senior social workers meet regularly with our 4 qualified council officers to ensure that we are developing and improving our learning and practice around supporting people who are vulnerable and at risk. We have representatives that sit on short life working groups that are involved in developing a robust adult support and protection risk assessment tool to use when working with people who are at risk and in developing an adult support and protection tool.

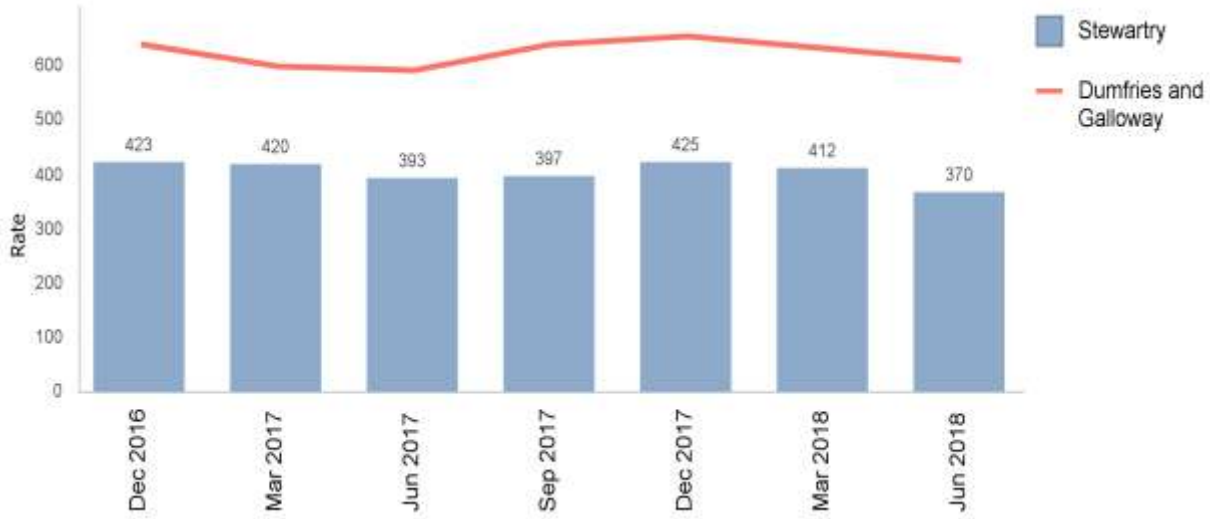
Performance Indicator Overview

Finance and Resources



C8 Total number of Home Care hours provided as a rate per 1,000 population aged 65 and over

Rate of total Home Care hours provided per 1,000 population aged 65 and over; Stewartry



Key Points

This is a Data Only indicator.

In June 2018 the rate of Home Care provision in Stewartry was 370 hours per 1,000 population aged 65 or older.

The rate for Stewartry is consistently lower than the rate observed across Dumfries and Galloway (614 hours per 1,000 population aged 65 or older).

The Wider Context

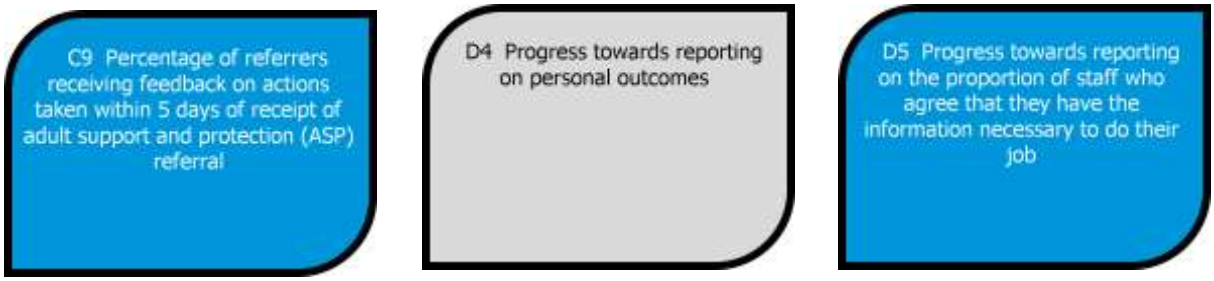
It is reported that across Dumfries and Galloway approximately 1 million hours of homecare are provided each year. It is anticipated that this indicator will decrease as more people opt for SDS Options 1 and 2. There will be a need to understand how many people are in receipt of care and support through all of the SDS options (see indicators C2 – C4).

Improvement Actions

No improvement actions required at this time. This historic indicator needs to be reviewed.

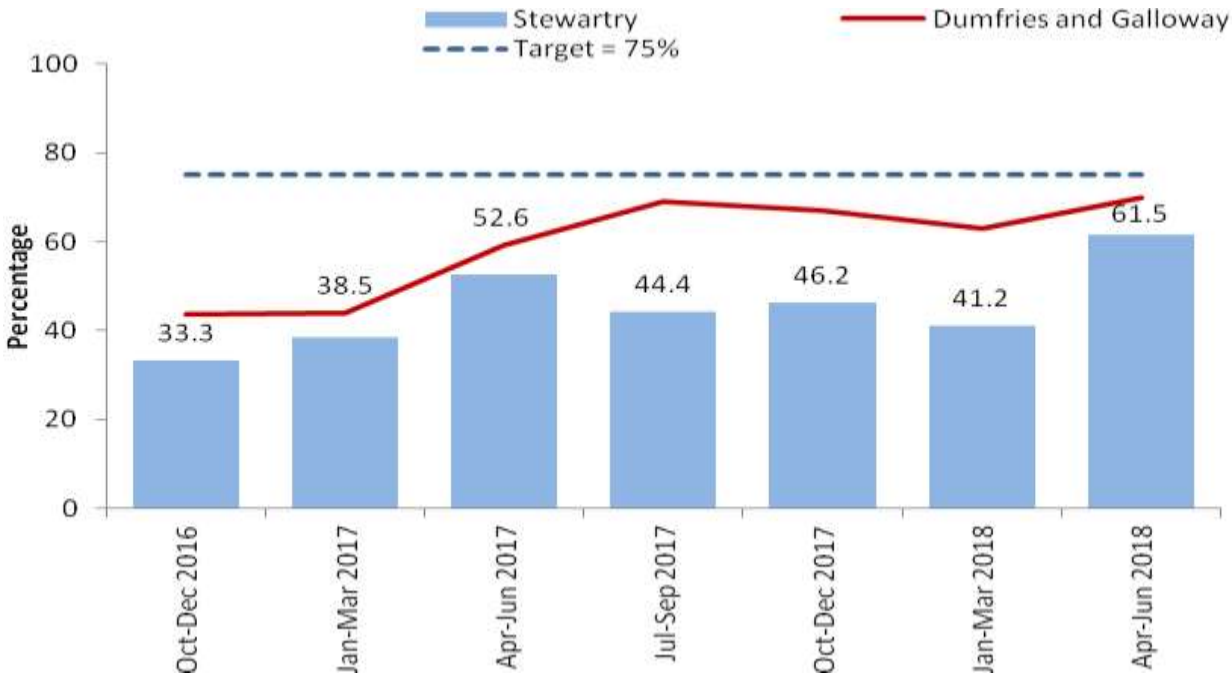
Performance Indicator Overview

Quality



C9 Feedback received by referrers on actions taken within 5 days of receipt of adult protection referral

Percentage of referrers receiving feedback on actions taken within 5 days of receipt of adult support and protection (ASP) referral; Stewartry



Key Points

In the quarter ending June 2018, across Stewartry 61.5% of referrers to Adult Support Protection (ASP) received feedback within 5 days of receipt of referral. This is lower than the rate observed across Dumfries and Galloway for the quarter ending June 2018 of 70.3%.

The Wider Context

Across Stewartry there are typically between 6 and 10 ASP Duty to Inquire referrals per month. However, small numbers such as these can lead to marked variation from month to month. All relevant adult referrals are assessed to determine if they meet the requirements that would classify the referral as a Duty to Inquire. Discussions are underway in relation to reporting timescales and determining what should count as feedback to ensure the data is as complete as possible.

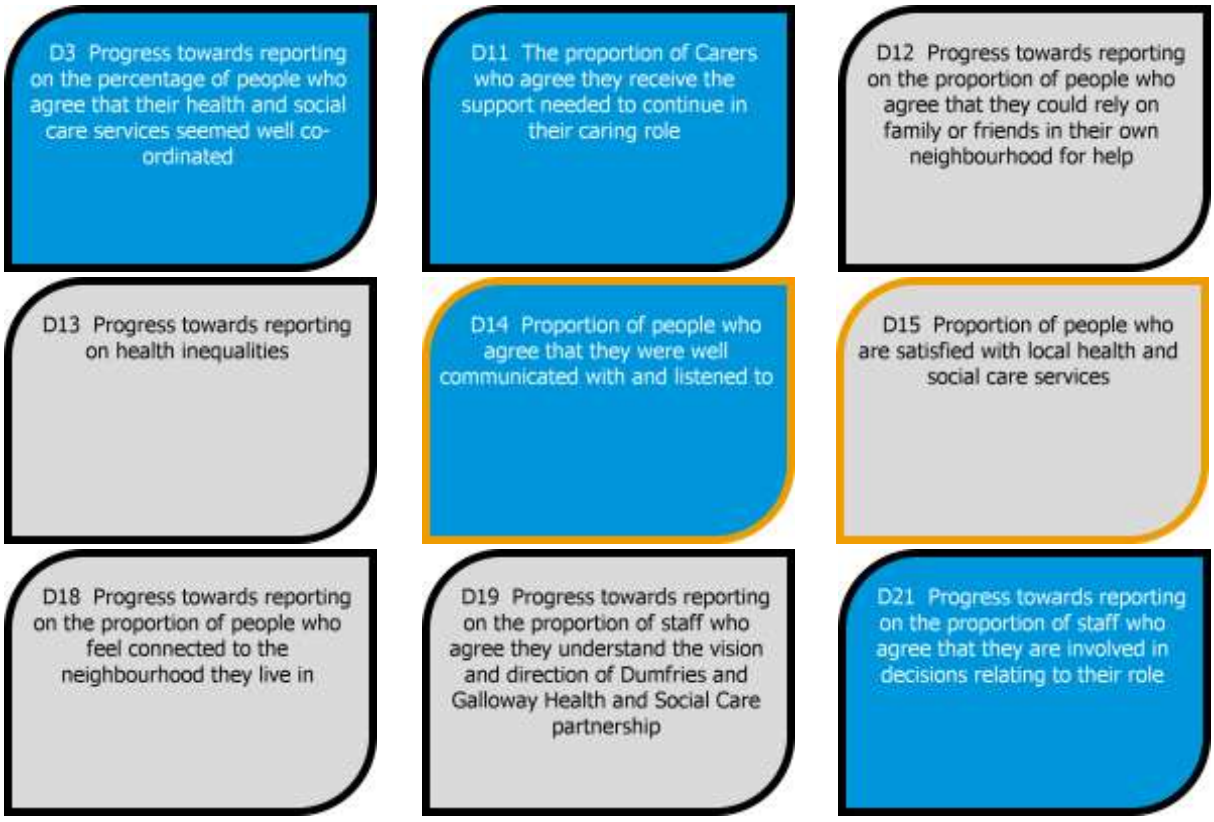
The type of feedback is different depending on the source of the referral. Where a professional has made the referral it can be noted that the adult is being progressed under Duty to Inquire. If a family member makes a referral, it is likely they will be involved in the progression of the referral so they will receive more detailed feedback. If a member of the public makes a referral they will be told that we have received the referral and are giving consideration as to how to take this forward.

Improvement Actions

The Multi Agency Safeguarding Hub (MASH) is operational across the whole region and qualitative evidence is being collected to demonstrate how this has improved the working practices for staff and the outcomes for people using services. We will share this once this information is available.

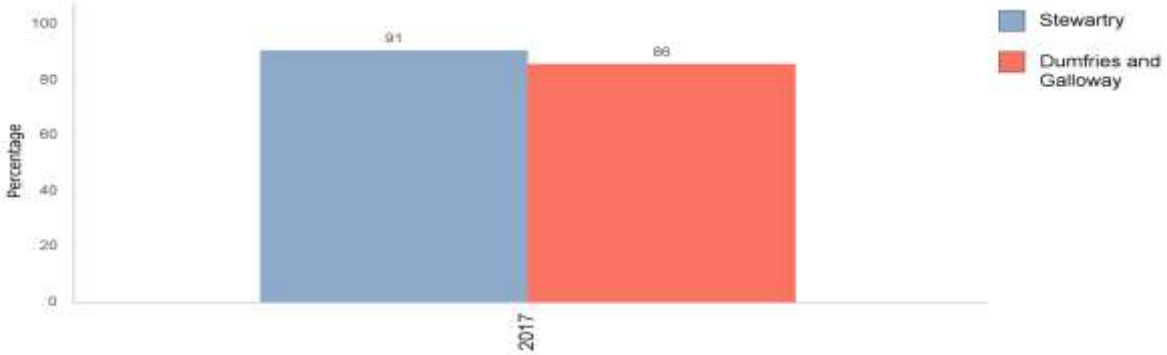
Performance Indicator Overview

Stakeholder Experience



D3 Well co-ordinated health and social care services

The percentage of people who agree that their health and social care services seemed well co-ordinated; Stewartry



Key Points

91% of adults in Stewartry supported at home who responded to the Health and Care Experience (HACE) survey agreed that their health care services seemed to be well co-ordinated. A further 6% answered 'neither agree nor disagree' and 3% responded that they did not agree that their health care services seem to be well co-ordinated. This is higher than the result for Dumfries and Galloway (83%) and Scotland (74%).
The number of responses to this question was 38 people from Stewartry.

The Wider Context

Of the 721 people who answered the HACE survey in Stewartry, only a maximum of 6.0% (43 people) had direct experience of social care, which is a higher proportion to that for Dumfries and Galloway (5.7%) for Scotland (5.7%).
The HACE Survey captures people's feelings about the care they experience, at the time the survey is taken. Local figures should be compared to the experiences of other people across Dumfries and Galloway and Scotland in the same time period. Results were not available at locality level in previous surveys and therefore no comparisons can be made with earlier surveys.

Improvement Actions

All occupational therapy (OT) staff, who are based in or work into Stewartry Locality, have met for several workshops in 2017/18 to explore the possibility of an One Team approach. This greater alignment of community OT in Stewartry is to support the delivery of a seamless service, aiming to achieve better outcomes for people and their Carers. Key areas of work in development are workforce planning and development, single point of contact, shared assessment and Information Technology (IT). Next steps include:

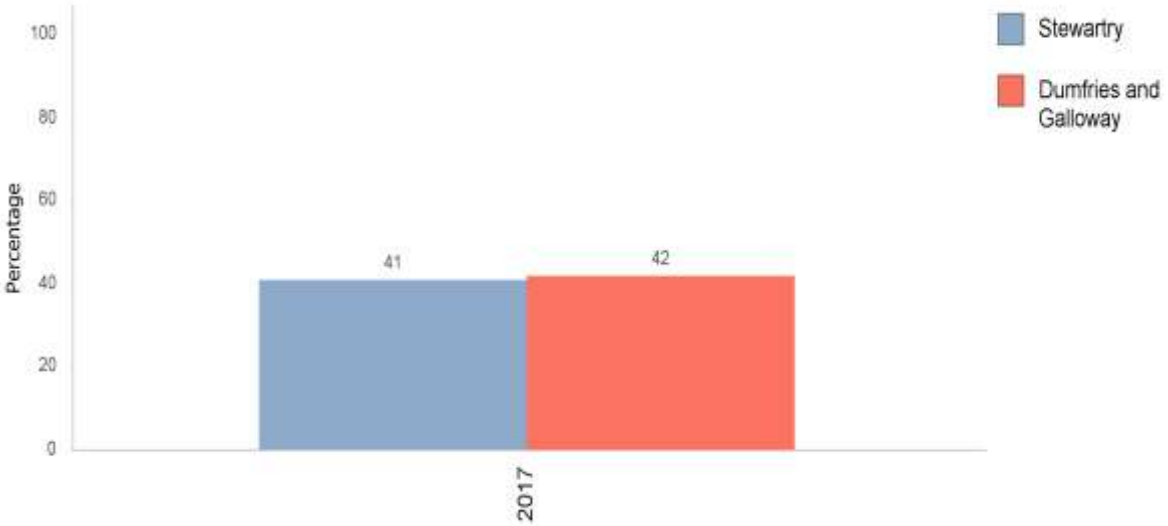
- evaluate the joint OT post
- identify training and development needs to enable every occupational therapist in Stewartry (and beyond at a later date) to deliver core interventions across all teams
- share learning across localities and allied health professional teams.

The national Day of Care survey was most recently conducted on 26 April 2018. This highlighted that 16% of people at Castle Douglas Hospital and 36% of people at Kirkcudbright Hospital did not need to be in a hospital setting. The top 2 reasons identified were legal or financial (ongoing guardianship process) and home care support availability.

As of August 2018, there will be a new system that will allow social work case management staff to upload information around new care packages directly to the portal which is accessed on a daily basis by local care providers. This will allow all providers to have a real time overview of care required and can work together with others to resource this appropriately and as efficiently as possible.

D11 Carers who agree they receive the support needed to continue in their caring role

The proportion of Carers who agree they receive the support needed to continue in their caring role; Stewartry



Key Points

Of the 92 Carers from Stewartry who responded to this question in the Health and Care Experience Survey (HACE), 41% responded that they agreed they felt supported to continue in their caring role. A further 41% answered 'neither agree nor disagree' and 18% responded that they did not agree they felt supported to continue in their caring role.

The percentage of Carers who agreed in Stewartry is higher than for Dumfries and Galloway (40%) and Scotland (37%).

The Wider Context

Of the 721 people who answered the HACE survey in Stewartry, 14.3% (103 people) identified as Carers. This is similar to the proportion who answered for Dumfries and Galloway (15.1%) and Scotland (15.0%).

The HACE Survey captures people's feelings about the care they experience, at the time the survey is taken. Local figures should be compared to the experiences of other people across Dumfries and Galloway and Scotland in the same time period. Results were not available at locality level in previous surveys and therefore no comparisons can be made with earlier surveys.

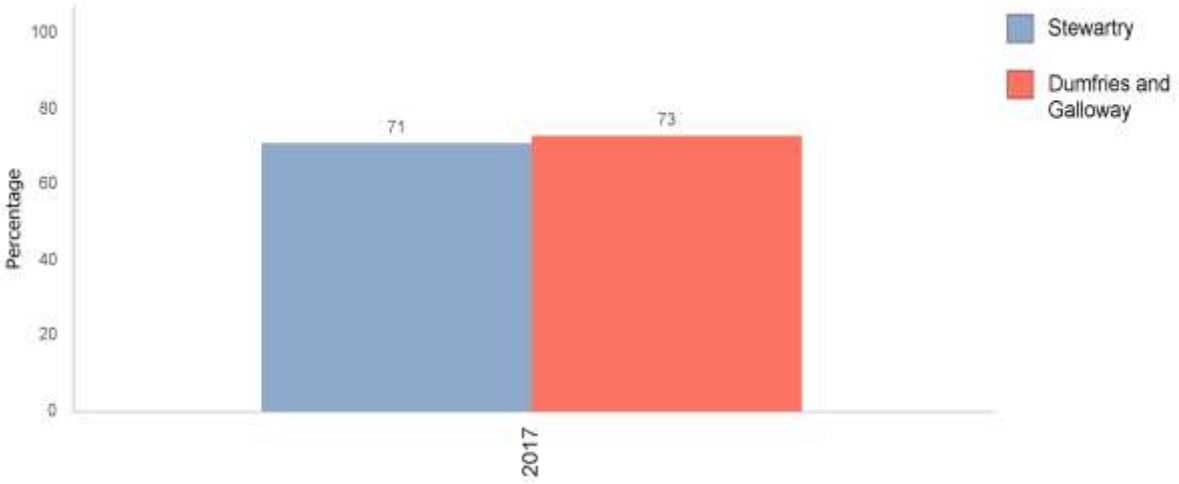
Improvement Actions

Work is ongoing to develop and tailor our eligibility screening tool and our resource allocation tool to meet the needs of people who have a caring role and are referred for assessment. There is work underway across the region to help us understand what is available in terms of short breaks here in the Stewartry and across the whole region.

We are beginning the process of reviewing our residential short breaks services to establish if those people who are currently accessing a building based short break could benefit from an alternative form of short break. This may promote people's independence and meet their outcomes more positively.

D14 Well communicated with and listened to

Proportion of people who agree that they were well communicated with and listened to; Stewartry



Key Points

71% of adults in Stewartry who are supported to live at home who responded to the Health and Care Experience Survey (HACE) agreed that they were aware of the help, care and support options available to them. A further 22% answered 'neither agree nor disagree' and 7% responded that they did not agree they were aware of the help, care and support options available to them.

The percentage of those who agreed is lower than the result for Dumfries and Galloway (73%) and Scotland (73%).

The number of responses to this question was 39 people from Stewartry.

The Wider Context

Of the 721 people who answered the HACE survey in Stewartry, only a maximum of 6.0% (43 people) had direct experience of social care, which is a higher than the proportion for Dumfries and Galloway (5.7%) for Scotland (5.7%).

The HACE Survey captures people's feelings about the care they experience, at the time the survey is taken. Local figures should be compared to the experiences of other people across Dumfries and Galloway and Scotland in the same time period. Results were not available at locality level in previous surveys and therefore no comparisons can be made with earlier surveys.

Improvement Actions

In February, an Ask the Experts event was run in Crossmichael village. People with lived experiences of physical disability and sensory loss were made guests of the village and gave their insight into short, medium and longer term changes which could improve access.
As a result of this, the church committee are being supported to investigate how to get wheelchair access to the church.

Appendix 1: Table of “We Wills”

Ref & RAG Status	Description
1	We will further expand the community link approach to support people to become involved in their communities; and work with individuals and our partners to provide relevant information that will allow people to make the best use of local assets to meet their health and wellbeing need.
2	We will work with staff and partners to explore different approaches to early intervention and ensure staff have the necessary skills and knowledge to adopt these approaches.
3	We will support people to identify potential future health and care needs, and to plan ahead at an earlier stage, where appropriate.
4	We will explore transport initiatives which will allow people to have easy access to support, activities and services in their local community.
5	We will support the development of a range of community based day services to meet with local need.
6	We will work with staff and partners to explore different approaches to early intervention and ensure staff have the necessary skills and knowledge to adopt these approaches.
7	We will encourage people to use self management techniques and build people’s confidence and skills around this.
8	We will develop approaches which will support early discharge from hospital and prevent hospital admission (e.g. rapid response service / managing conditions in a day case setting).
9	We will continue to work towards providing or sourcing appropriate support that enables people to remain in their local communities (e.g. Dementia Friendly communities, Befriending or shopping services).
10	We will work in partnership with care providers to develop sustainable care at home services which strive to optimise people’s independence and quality of life.
11	We will take account of housing needs and work with individual and partners to consider housing and support options that will enable independent living.
12	We will, through our communication and engagement framework, provide a listening platform for people to communicate their views and needs; share learning across the partnership and raise awareness of issues that will influence the design of services.
13	We will ensure that person centred approaches and a focus on personal outcomes are central to health and social care work; paying attention to protected characteristics and any specific needs thereof.
14	We will hold conversations with people to identify what really matters to them and help them develop a plan that will enable them to maintain or improve their quality of life and independence.

15	We will promote living well and end of life care in our communities, respecting the needs and wishes of individuals and their families.
16	We will develop a culture where people using our services can expect a high level of customer service.
17	We will promote the value of self directed support and person centred care, as it relates to individual outcomes and ensure this is embedded in our practice.
18	We will develop joint systems and processes (including I.T. systems) across the partnership to improve communication, reduce duplication, promote continuity of care and maximise individual outcomes.
19	We will explore, in partnership with our GP practices, options in relation to skill mix.
20	We will explore different models of care for out cottage hospitals.
21	We will make sure staff across all sectors are skilled and have the most up-to-date knowledge and information to provide continuously improving support, care and treatment for individuals.
22	We will work with appropriate partners to address some of the logistical challenges presented to some individuals which prevent universal access to services (e.g. transport links, wheelchair access).
23	We will further develop links with housing and other specialist service providers to foster approaches which, where possible, present problems from arising (e.g. earlier access to aids and adaptations).
24	We will identify and work directly with groups and communities identified with specific health challenges.
25	We will actively identify unpaid carers in our community and within our workforce and signpost them to the most appropriate support.
26	We will promote the value of the carer's strategy and work with partners and carers to develop solutions to support the health and, wellbeing of unpaid carers and identify alternative support options.
27	We will explore respite options for carers and identify timely support options that will reduce the need for crisis management.
28	We will ensure that all staff are trained appropriate to their role in assessing a person's capacity and assessing and managing risks to the person.
29	We will ensure that all partners are trained in a consistent manner in relation to Adult Support and Protection to enable prompt identification of individuals at risk.
30	We will work with our wider partners (e.g. Police Scotland and Fire and Rescue) to address issues related to community safety for the most vulnerable members of our communities.
31	We will explore ways of safely managing the sharing of information across the locality partnership.
32	We will develop a programme of audits across the partnership which will allow us to regularly monitor and review our performance in the locality.
33	We will use the learning and build upon existing initiatives (e.g. Safer Patient / Adverse incidents) to reduce un-necessary harm to people.

34	We will actively listen to the views and ideas of staff from across the Partnership and keep them updated on the actions we have taken to respond.
35	We will provide regular information for staff to keep them up to date and abreast of developments in the Locality.
36	We will provide a variety of support mechanisms for staff to access to help them manage the programme of change which is required across the health and social care setting.
37	We will explore new ways and opportunities to recruit, retain and increase the skills within our existing workforce to meet future need (e.g. new career pathways).
38	We will identify ways for staff to access the most appropriate information at the most appropriate time to support optimum care giving.
39	We will work in partnership to develop alternative, sustainable models of care which maximise the use of existing resources.
40	We will support our workforce in gaining an understanding of the value of working in partnership within an integrated system, and how collective resources can be employed to deliver services; ultimately reducing duplication.
41	We will continue to introduce and promote prescribing initiatives to ensure safe, appropriate, effective prescribing.
42	We will regularly review health and social care packages as multi-disciplinary teams to make sure that they are right for the individual, achieve agreed outcomes and promote well-being.
43	We will maximise the use of technology to reduce waste and duplication in the system.