DUMFRIES AND GALLOWAY INTEGRATION JOINT BOARD

HEALTH AND SOCIAL CARE
LOCALITY PLAN

WORKING TOGETHER FOR THE FUTURE OF HEALTH AND SOCIAL CARE

DUMFRIES AND GALLOWAY
Health and Social Care

Annandale and Eskdale 2016 – 2019

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Foreword

Annandale and Eskdale is a great place to live and work and we want to make it even better by supporting people to live active, safe and healthy lives. We will do this by promoting greater personal independence, choice and control. It is good news that people are living longer and healthier lives. However, if we are to continue to make further improvements in Annandale and Eskdale, including the need to reduce health inequalities, at a time when the number of older people is rising and the number of younger, working-age people is reducing, we have to change how we help people to lead healthy and fulfilling lives. We need to develop new models of working which support people from our diverse communities to take control of their own health and well-being and move away from the more traditional way of fixing people's problems. We need to take advantage of the skills, resources and ideas that already exist in local people, communities, staff and volunteers working in the third, independent, health and social care sectors to help produce services which tackle the needs and aspirations of people in Annandale and Eskdale. In short, we want to work in partnership with local people and communities to develop person-centred support which delivers positive outcomes, healthier lives and stronger communities.

Integrating health and social care gives us an opportunity to be creative, innovative and radical in developing new ways to support people to tackle the needs and priorities which are set out in this locality plan. We have drawn up this plan after listening to what local people and organisations think are the main achievements and challenges in Annandale and Eskdale. It sets out the actions we plan to take to deliver further improvements. This plan has been built up with local people and is a key part of the wider Dumfries and Galloway Health and social care strategic plan.

I would like to thank the third sector and the independent sector for their support in helping to develop and shape this plan. Above all I would like to thank the people of Annandale and Eskdale for their ideas and suggestions about what we need to do together to support people to live active, safe and healthy lives. The commitments, set out in section 6, over the next 3 years are challenging and can only be achieved by us all working together to harness the assets we have in our local communities. With all our partners in local communities, we are developing detailed and dynamic delivery plans setting out how we will meet our commitments. It won't be easy and there are bound to be a few bumps and changes along the way. However, by working together and by continuously listening to and checking in with each other, I am confident that together we can develop new ways to continue to make Annandale and Eskdale a healthy, strong and fulfilling place to live.

Gary Sheehan, Locality Manager
Annandale and Eskdale

1 Introduction

1.1 What is this locality plan?

This plan is about how we will be integrating health and social care in Annandale and Eskdale as part of a new Dumfries and Galloway Integration Authority. It forms part of our wider strategic plan across Dumfries and Galloway for the integration of health and social care. Our locality plan sets out specific information, where this is available, and identifies what is working well but also some of the main challenges which we need to tackle. Importantly, much of the plan is based on what people who live in the area and those currently involved in delivering health and social care in the area have said about how things could be better and what would make a difference.

The plan is not just about health and social care services and support – it is also about how people and communities can be supported to help and support themselves too.

This is the first integrated health and social care locality plan for Annandale and Eskdale and sets out the need to develop new and more creative ways of working with people in their local communities to help deliver the best-possible outcomes for everyone living in Annandale and Eskdale. The 3 year commitments we have set out in section 6 will be delivered through a detailed implementation plan drawn up with all our key partners, particularly colleagues from the third and independent sectors. An executive summary of the locality plan is available in part 2 of the wider strategic plan for Dumfries and Galloway.

1.2 Who is this plan for?

This plan is for everyone who lives or works in Annandale and Eskdale, with a focus on adults. It is for those who currently use health and social care services, for example, people who need day-to-day help with personal care or who need more regular support to manage a long-term condition and also those who may need to do so in the future. It is also for people who are well and want to maintain or improve their current level of health and well-being.

1.3 What is included in this plan?

All adult social care, adult primary and community health care services, most acute hospital services and some elements of housing are all included within the new Dumfries and Galloway integration authority. Services relating to children are currently not included.

1.4 Where does this plan fit into the wider picture?

This plan is one of four locality plans for Dumfries and Galloway and forms an annex to the strategic plan for the region. There are also a number of other important national and local strategies which have helped us develop this plan, for example, The keys to life – improving quality of life for people with learning disabilities 2013 and the Dumfries and Galloway joint strategic plan for older people 2012 – 2022. A more comprehensive list of these can be found in **Appendix 2** of the strategic plan.

The plan has also been informed by the joint inspection of adult services across Dumfries and Galloway carried out by the care inspectorate and health improvement scotland in early 2016.

1.5 What are we hoping to achieve?

This plan is shaped around the vision for Dumfries and Galloway as set out in the Dumfries and Galloway integration scheme - "Dumfries and Galloway - where we share the job of making our communities the best place to live active, safe and healthy lives by promoting independence, choice and control."

This means for people in our community:

- offering a better experience for people, families and their Carers who currently receive services and support and making these more effective and efficient
- enabling people to take personal responsibility for their heath and well being
- making sure that people, their families and Carers are at the centre of the decision-making process and offering as much choice and control as possible about the support they receive
- making sure that the most vulnerable members of our communities are supported to live as independently as possible within their own homes or within a homely setting
- supporting people to make positive lifestyle changes
- finding new solutions and ways of working with local people and local communities to improve individual health and well being

We are committed to reducing health inequalities for our diverse communities across Annandale and Eskdale and recognise that there are a range of factors that contribute to such inequalities. Reducing health inequalities is the responsibility of all partners and involves action on the broader social issues that can affect a person's health including: education, housing, isolation, employment and income. These wider inequalities have a direct impact on, and in many cases create health inequalities. We will consider health inequalities when planning and developing services ensuring they are accessible and flexible to all.

1.6 National health and well-being outcomes

The Scottish Government has set out the following nine national health and well-being outcomes to be achieved through the integration of adult health and social care.

People are able to look after and improve their own health and well-being and live in good health for longer

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

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

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

Health and social care services contribute to reducing health inequalities

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 well-being

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

People using health and social care services are safe from harm

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

1.7 Main challenges

The main challenges in Annandale and Eskdale broadly reflect those for the whole region as set out in the Dumfries and Galloway strategic plan.

- health inequalities leading to poorer outcomes for people's health and well-being
- an increasing number of people with multiple long-term conditions, including dementia, who need higher levels of support so they can live independently and at home or in a homely setting in the community
- lack of appropriate housing to meet expected need and demand in areas where people want to live, creating unsustainable and imbalanced communities
- an increasing number of Carers needing greater levels of support to reduce the negative effect their caring role may have on their own health and well-being
- maintaining high-quality, safe care and protecting vulnerable adults in the face of increasing need and fewer resources

- sustaining existing community-based services, including GPs, out-of-hours and care-at-home services
- a reducing working-age population resulting in fewer people to care for an increasing number of older people
- national challenges in relation to recruiting health and social care staff
- current and expected rise in hospital admissions and delayed discharges resulting in increased pressures across all health and social care services

The rural nature of Dumfries and Galloway brings some advantages and benefits, it can also increase each of the main challenges set out above. Problems such as physical and social isolation, transport difficulties, and the provision of a rapid response service all need to be considered. An additional local challenge is addressing the cross border issues which results in some people being required to access acute and primary care services in Cumbria.

1.8 Main areas of focus

The following 10 areas of focus reflect the same areas of focus as in the Dumfries and Galloway Partnership strategic plan with a summary of what each of these relate to in practice.

D&G strategic plan - area of focus	
Helping people to have more choice and control	• People who meet the criteria for care and support through social work will be offered a range of options for how this care and support is arranged including being able to receive a direct payment, or having their care and support managed by a care provider through self-directed support. • People with long-term conditions are supported to be active partners in their own care, making decisions jointly with health and social care staff and managing their own health on a day-to-day basis. • Arranging and paying for services will be based on delivering the right outcomes for people and encouraging organisations to work together in a more joined-up way.
Supporting Carers	• Carers are supported to have a life outside of their caring role, living fulfilled lives as individuals with their own interests and aspirations.
Developing and strengthening communities	• Involving local people in decision-making. • Making sure there is a good range of low-level community and social supports in communities and working with people to identify what really matters to them and what would make a difference. • Supporting communities to provide local support.

D&G strategic plan - area of focus	
Making the most of well-being	• Making the most of health and well-being and encouraging people to take responsibility for their own health at as early an age as possible. • Working to prevent ill health or further deterioration of health. • Discussing future care and support needs with people as soon as possible and developing a plan which is individual and owned by the person.
Maintaining safe, high quality care and protecting vulnerable adults	• All adults have the right to live free from physical, sexual, psychological, emotional and financial abuse or neglect. • Improving the safety of care of people at all points of delivering care.
Shifting the focus from institutional care to home and community-based services	• Involving people who use services, their Carers and families in designing new models of care which better meet their needs. • Providing care in or as close to a person's home as possible wherever it is safe to do so, and only admitting someone to an acute hospital bed when their condition means this is the only option. • Working with housing providers to develop new and innovative housing options for people.
Integrated ways of working	• Having the right people with the right skills in the right place at the right time. • Making the best use of all our people from across all four sectors – the NHS, council, third and independent sectors recognising that a multi-agency approach can bring better outcomes for people. • Respecting the different 'cultures' which exist and different professional boundaries. • Having staff teams all working to a shared vision of where we need to get to. • Building on existing skills that people have and recognising that new skills will be needed as well. • Making time for staff to build relationships with colleagues in other areas of work and understand each other's roles and responsibilities.

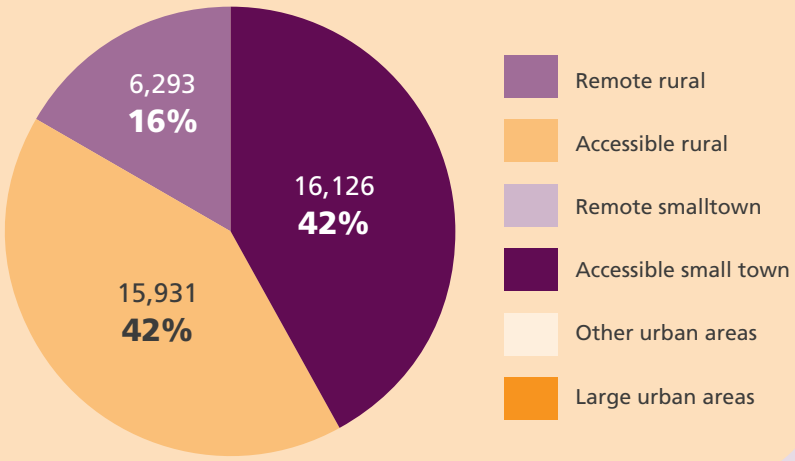
D&G strategic plan - area of focus	
Reducing health inequalities	• Designing health and social care services in a way that allows those most in need easy access. • Providing services proportionately and in a co-ordinated way according to people's identified needs. • Partners working together to deal with broader inequalities in society.
Working efficiently and effectively	• Thinking in new ways about how to do things differently. • Following evidence and guidance on both the clinical effectiveness and cost-effectiveness of existing and new technologies which are likely to have a positive effect. • Considering options involving investing and also withdrawing investment – where do we need to invest and what can we stop doing? • Tackling variation – both in terms of practice and cost. • Making best use of all the physical assets (buildings and land) in our communities.
Make the best use of technology	• Where appropriate, providing support for people with common multiple illnesses and chronic conditions through home monitoring and managing them by phone (Telehealthcare). • Sharing appropriate real-time information between care providers. • Shared Forward-Looking Care plans for people classed as 'at risk'. • Encouraging a higher take-up of the broad range of telecare equipment.

2 About the Locality

2.1 Geography

Dumfries and Galloway is one of the most rural areas of Scotland, where issues such as transport, access to services and rural deprivation can have a marked effect. Dumfries and Galloway has the third highest proportion (22%) of the population living in remote rural locations, behind Argyll and Bute and the Highlands. Annandale and Eskdale is one of four localities for health and social care integration in Dumfries and Galloway and makes up about one quarter of the total area of the region.

Number of people in Annandale and Eskdale by urban/rural Classification



Source: Scottish Urban Rural Classification 2013-14: National Records Scotland Small Area Popluation Estimates 2012

Scottish Government 6 fold urban rural classification	
1 Large urbanareas	Settlements of 125,000 or more people.
2 Other urban areas	Settlements of 10,000 to 124,999 people.
3 Accessible small towns	Settlements of 3,000 to 9,999 people and within 30 minutes drive of a settlement of 10,000 or more.
4 Remote small towns	Settlements of 3,000 to 9,999 people and with a drive time of over 30 minutes to a settlement of 10,000 or more.
5 Accessible rural	Areas with a population of less than 3,000 people, and within a 30 minute drive time of a settlement of 10,000 or more.
6 Remote rural	Areas with a population of less than 3,000 people, and with a drive time of over 30 minutes to a settlement of 10,000 or more.

Table 1: Population size for main settlements in Annandale and Eskdale

Settlement (500+ people)	Population size
Annan	9,000
Eaglesfield	700
Eastriggs	1,900
Ecclefechan	800
Gretna	3,100
Langholm	2,200
Lochmaben	1,900
Lockerbie	4,300
Moffat	2,600
Total	26,500

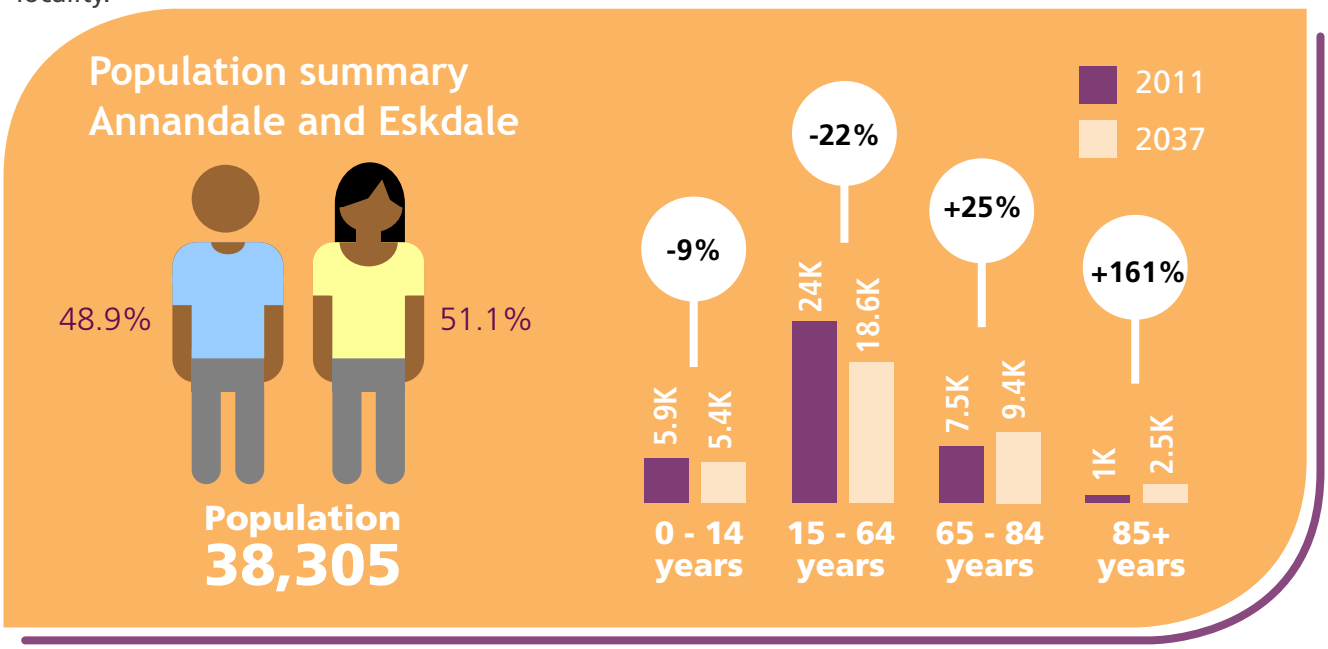
2.2 The population

The current population of Dumfries and Galloway is already substantially different from the overall profile of the Scottish population, with a larger percentage of older people and a markedly smaller percentage of young people. Dumfries and Galloway has the highest percentage of men of pensionable age (22% aged 65 or over) and the third highest percentage of women aged 60 and over (31.7%) of all councils in Scotland. This means that demand on health and social care and support is already higher than average and has a considerable effect on how current services are being delivered.

38,305 people live in Annandale and Eskdale out of a total population for the region of around 150,270 people (population estimates for small areas 2013 (2011 datazones).

Looking forward on an locality basis is difficult as different localities have different factors affecting population growth, such as birth rates and the number of people moving into and out of the locality.

The graphic below shows an estimate based on the expected percentage change for the locality.



Sources: National Records Scotland and Census 2011

A snapshot of the population in Annandale and Eskdale

At the time of the 2011 Census there were

168 (15%) of Carers providing 50 or more hours of care a week reported as having bad or very bad health

374 people from black and ethnic-minority groups

1,021 (4%) working-age people unemployed

890 (3%) had never worked or were long-term unemployed

3,331 households (1 in 5 households) with no car or van

385 people over the age of 65 living alone lived in a 'remote rural' area

3,786 people who classed themselves as Carers and of these, 1,100 were providing 50 or more hours of care a week

51% of those aged 16 - 34 have no or few qualifications

In 2013/14 there were

1,262 people reporting themselves as having a long-term mental health condition (3.3% of the population)

473 people admitted to a cottage hospital from Annandale and Eskdale

3,272 emergency admissions to Dumfries and Galloway royal infirmary from Annandale and Eskdale residents

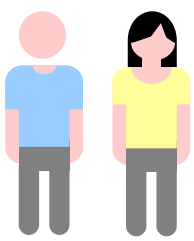
501 people receiving a care-at-home service and of these, 210 receive at least 10 hours of care per week

Just under 120 older people from Annadale and Eskdale were admitted to a care home

158 adult support and protection referrals

304 (2%) of households do not have central heating

153 new referrals to social work in January 2016



2.3 Asset-based approach

In Annandale and Eskdale we are committed to taking a comprehensive assets based approach in developing support for local people and communities. Taking an asset-based approach ensures that we are planning to tap into all the available assets that rest within people, communities, buildings, equipment, money and land that we have available to us to deliver excellent health and social care.

People are our most valuable resource in the delivery of health and social care. Families, friends and neighbours play an essential role supporting people socially, emotionally and with practical help. We have significant numbers of dedicated volunteers supporting people in their own homes and local communities through a wide variety of local clubs, community groups and services. For those in need of more formal intervention we have committed staff working in the NHS, council, housing, care at home services and care homes providing important health and social care services.

Buildings, land, equipment and vehicles

While people are our most valuable resource, it is important that we make the best use of all the buildings, land, equipment and vehicles (physical assets) in communities across Annandale and Eskdale. We should consider how these might be better used to improve quality of community life and deliver better outcomes for people

A summary of some of the key physical assets in the area is given in table 2 below.

Table 2: Main physical assets in Annandale and Eskdale as at January 2016

Category	Physical asset	Total number	Location (where in only limited locations)
Health	GP Surgeries	10	
	Community pharmacies Dispensing surgeries	9 2	
	Opticians	4	Lockerbie (2), Annan (2)
	Dental surgeries	8	
	Cottage hospitals (Total bed numbers)	4 (56)	Langholm, Moffat, Lochmaben, Annan
	Psychiatric hospitals	0	
	General hospitals	0	

Category	Physical asset	Total number	Location (where in only limited locations)
Housing	Care homes – older people (Residential bed numbers) (Elderly mentally ill (EMI) bed numbers) Care homes – LD* and MH*	8 (249) (29) 1	Ecclefechan Lockerbie
	Commissioned Supported accommodation – under 65 PD*, LD and MH	17 places	
	Sheltered housing (developments) (Total number of flats) Number with communal lounge	13 (200) 3	Annan, Moffat and Langholm
	Extra care / very sheltered housing	0	
Community	Activity and resource centres (LD)	1	Annan
	Community centres / village halls	38	
	Day centres (not in community centre / village hall)	0	
	Leisure facilities	4	
	Libraries	5	

*EMI refers to more specialist residential care homes for older people

*LD = Learning Disability *MH = Mental Health *PD = Physical Disability

While the regional general hospital is in Dumfries, many living in the east of the area use the Cumberland Infirmary rather than Dumfries and Galloway Royal Infirmary, due to better transport links and less distance to travel. Many specialist health services need to be accessed out with the locality.

2.4 Summary of identified and projected levels of need in Annandale and Eskdale

An assessment of levels of need across the whole region was undertaken as part of the work to develop a strategic plan.

The following section provides information on identified levels of need in some areas of care and support in Annandale and Eskdale.

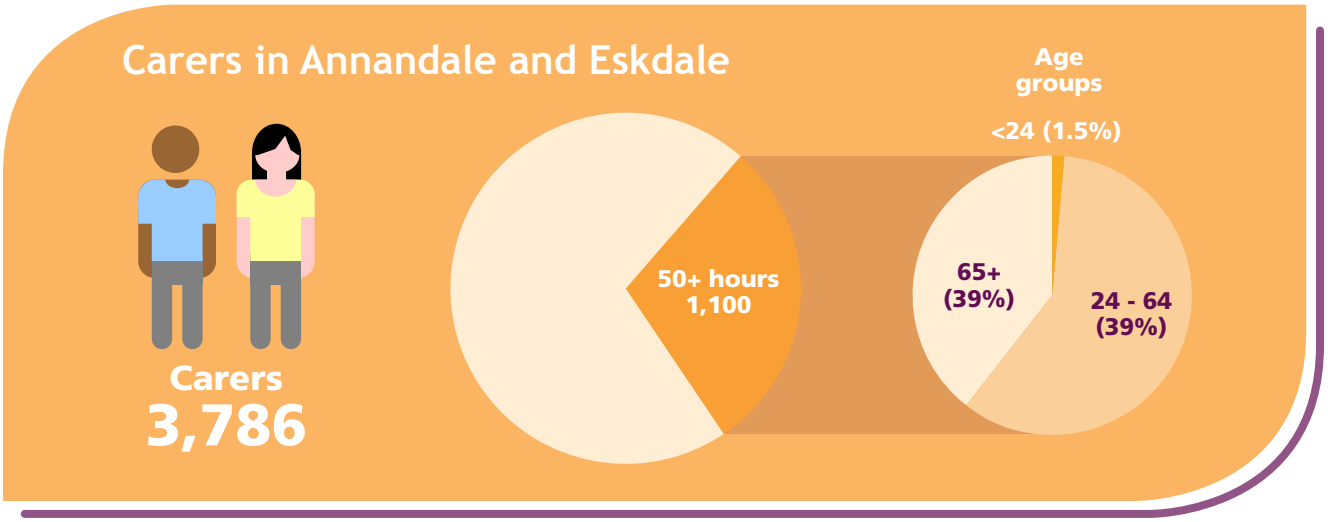
Carers

A Carer is someone of any age who provides unpaid support to a member of their family or a friend who is affected by long-term illness, disability, age or addiction.

Source: Census 2011

The results of the Census 2011 show that almost 15,000 people in Dumfries and Galloway provide unpaid care with a large percentage providing care for over 50 hours per week.

The graphic below provides information on Carers in Annandale & Eskdale.



Source: Census 2011

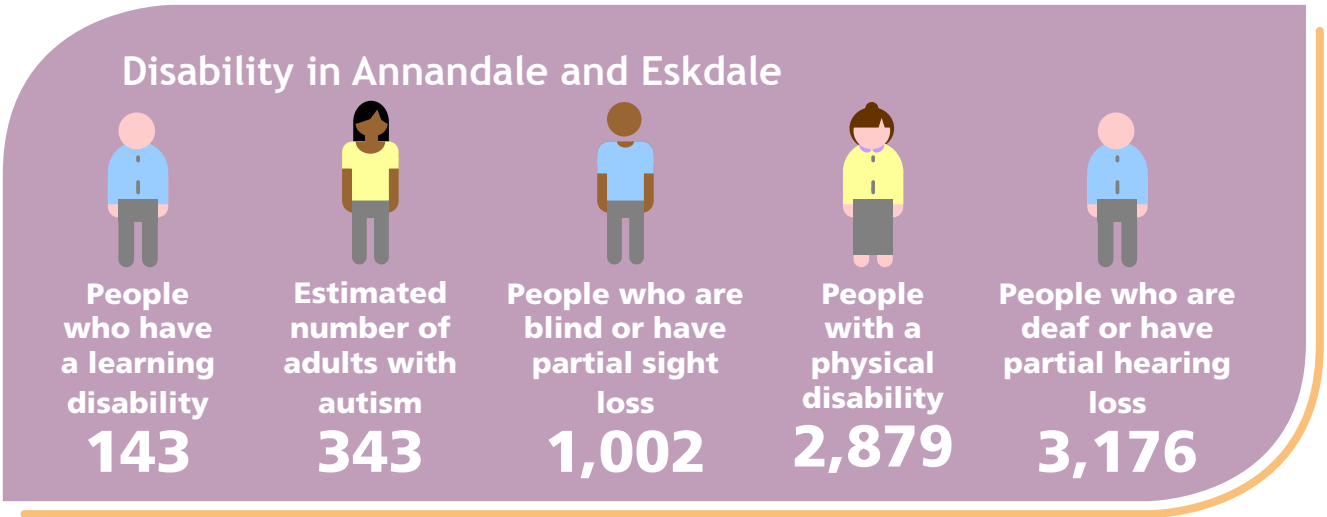
Drugs and alcohol

Across Dumfries and Galloway region wide the prevalence rate for adults who suffer from problem drug use (1.4%) represents an estimated 330 people aged 16-64 years in Annandale & Eskdale.

41% of adults drink more than recommended weekly limits. This is equivalent to 13,200 adults across the locality. However, "above recommended limits" includes a wide range of behaviours from those that ought to just cut down a bit, binge drinkers and people with severe alcohol problems.

Sensory impairment, physical and learning disabilities and autistic spectrum disorders

The graphic below shows the number of people in Annandale and Eskdale at the time of the Census in 2011 with different disabilities:

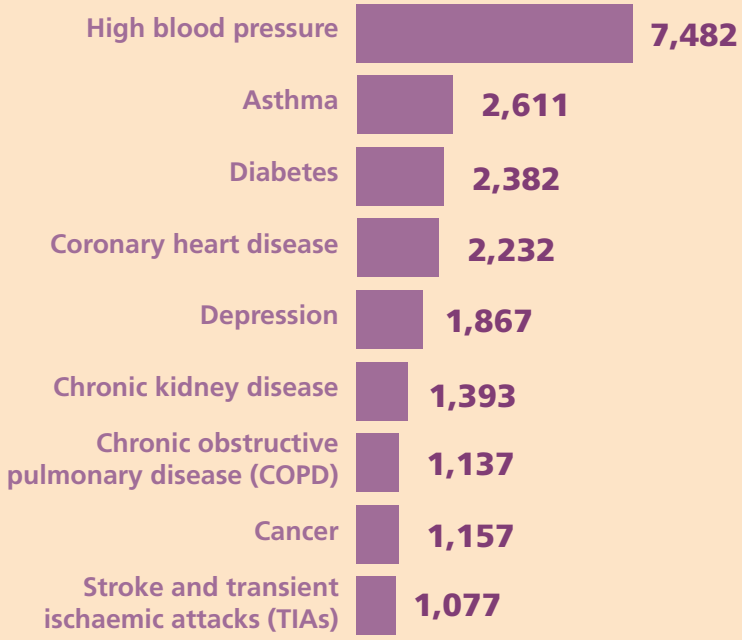


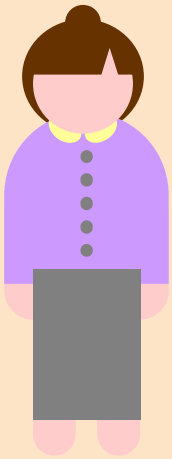
Source: Census 2011 and National Autistic Society

Long-term conditions

With the number of people in the older age groups increasing each year, the number of people with long-term conditions and more than one condition will also increase. This has significant implications for health and social care services.

Long term conditions in Annandale and Eskdale





3,099

have two or more long term conditions

Source: Information Services Division Scotland: Quality and Outcomes Framework 2013/14 and SPARRA

Scottish patients at risk of readmission and admission (SPARRA)

The SPARRA register is designed to help health and social care professionals identify people with complex care needs and who are at risk of being admitted to hospital as an emergency in a particular year.

The number of adults in Annandale and Eskdale with multiple long-term conditions registered on SPARRA in 2015 is 3,099. This represents 9% of all adult patients registered with a GP practice. Of these, 1,575 are aged 75 or over.

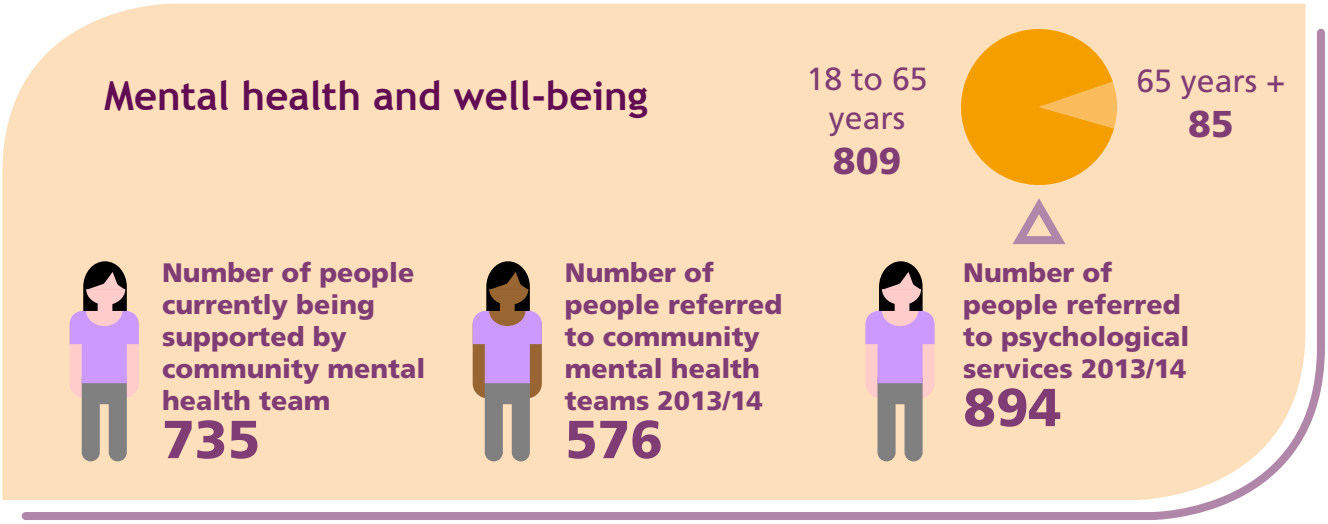
(The 'at risk' population in Annandale and Eskdale is likely to be an underestimate as hospital admissions to the Cumberland Infirmary have not been included).

Mental health

Common mental health problems include diagnosed conditions such as depression and anxiety.

A severe mental illness would include a diagnosis of schizophrenia and bipolar disorder.

The graphic below provides information on the number of people supported by the mental health team in Annandale and Eskdale:

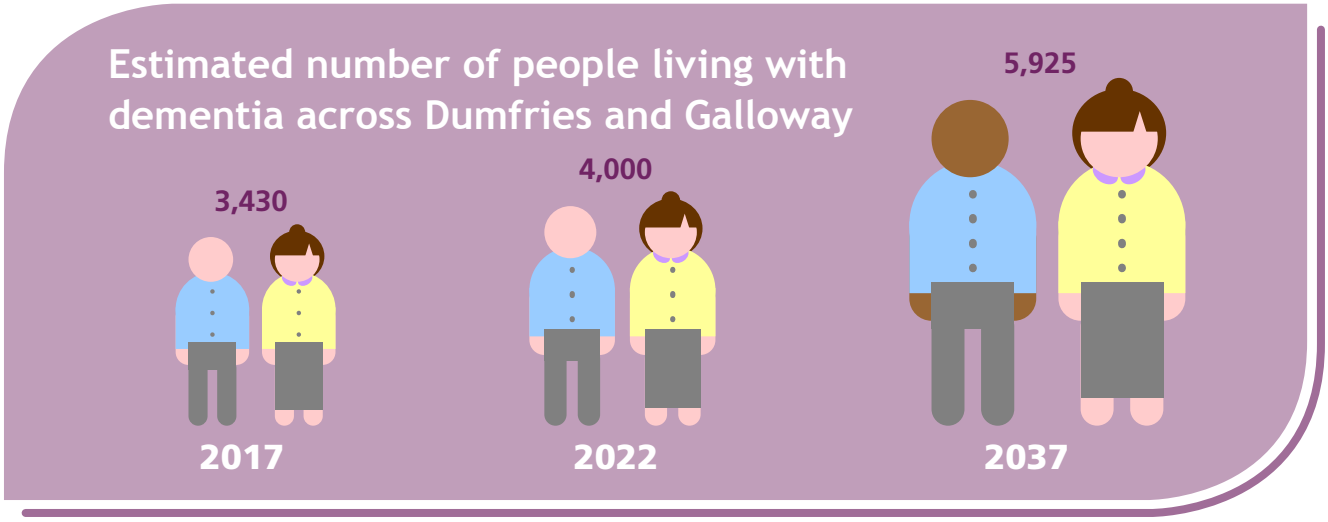


Source: NHS Dumfries and Galloway 2013/14

Dementia

Dementia is the term used to describe a variety of conditions that result in the gradual loss of a person's mental functions. Symptoms can range from some memory loss and confusion to complete dependence on others for all aspects of personal care. Dementia is a condition strongly associated with age so, as the number of older people rises in the population, so too will the number with dementia.

The graphic below shows estimates for the number of people with dementia for Dumfries and Galloway as a whole over the next 20 years:



Sources: EuroCoDe 2012

In Annandale and Eskdale the number of people with a confirmed diagnosis of dementia as at 1 January 2014 was 359. However, the Europe-wide estimates show that the overall number with dementia in the area would be double this figure.

In 2014, the number of referrals for support after a diagnosis of dementia in Annandale and Eskdale was 77.

Health inequalities, deprivation and poverty

Health inequalities are the differences in health people experience depending on the circumstances in which they live and the opportunities they have for achieving health and social well-being.

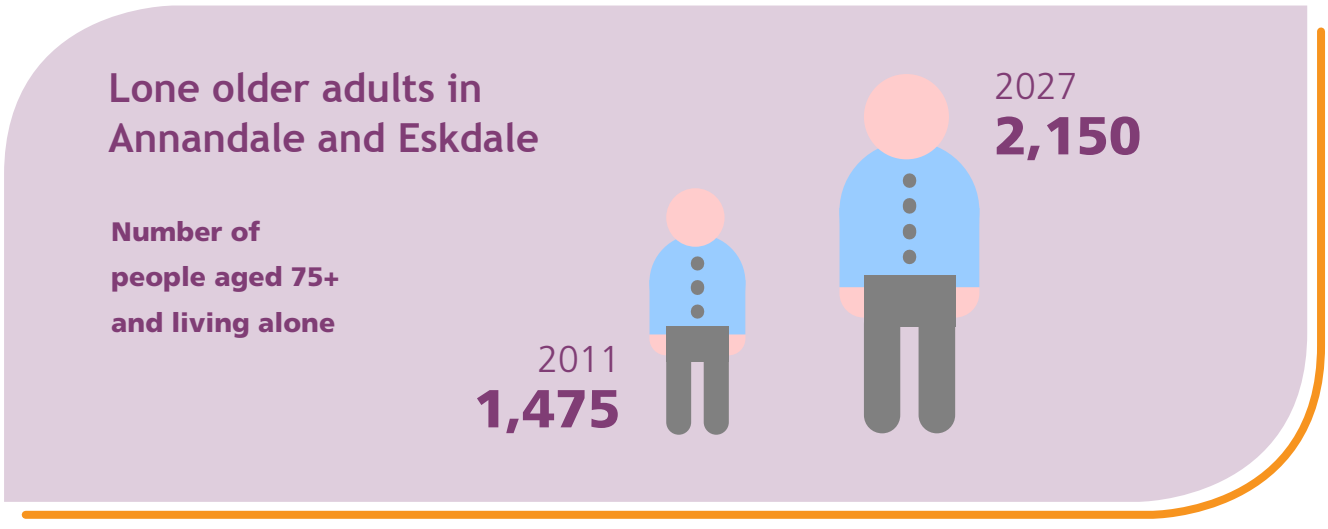
The Scottish Index of Multiple Deprivation (SIMD) is a geographic measure of deprivation and considers several different factors including income, employment, crime levels, education, health, housing and access to services.

While there are parts of Annandale and Eskdale with relatively high levels of deprivation, analysis shows that in Dumfries and Galloway the majority of our most deprived people do not live within the areas classed as most deprived using the SIMD. This is particularly the case for older people.

Fuel poverty is particularly significant in Dumfries and Galloway with much higher rates compared with Scotland as a whole. Fuel poverty is where a household has to spend more than 10% of its income on household fuel.

Housing

The following graphic shows the expected rise in the number of older people living alone:



Source: Census 2011 and National Records Scotland 2013/14

These changes are important in how we develop services to help people become more independent and support people living at home. Developing appropriate housing and care options will be a particularly important consideration in planning for the future.

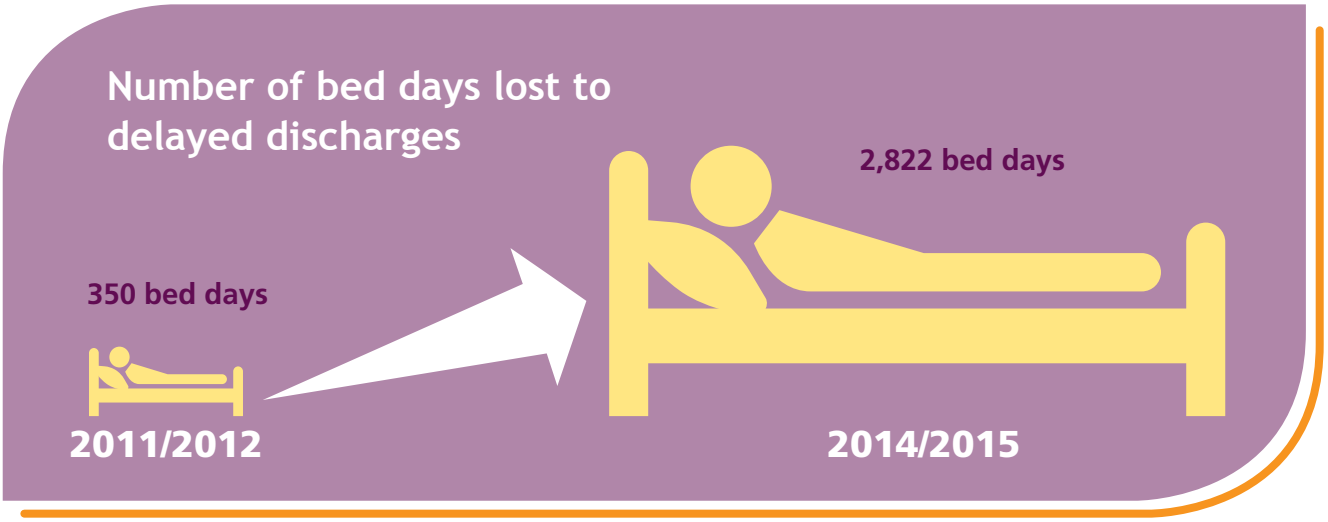
People who are unnecessarily delayed in hospital

A delayed discharge is a term used to describe an instance where someone in hospital is clinically ready to leave but is unable to do so. This can occur for a number of reasons such as:

- an inability to identify available care at home support to enable the person to return to their own home
- an inability to discharge someone from an acute hospital in to a bed in a more appropriate facility (for example, a cottage hospital)
- someone waiting for a placement in a preferred care home
- waiting for adaptations or alterations to be made within their own home

Reducing the number of unnecessary delayed discharges as far as possible is important because when people are in hospital for a long time, it can affect their independence potentially reducing their longer term ability to care for themselves and have other overall negative impacts on a person's health and well-being. It is also a waste of much needed resource.

The graphic below shows the increase in the number of bed days lost to delayed discharges between 2011 /12 and 2014/15 in the cottage hospitals in Annandale and Eskdale.



Source: NHS Dumfries and Galloway

Prescribing in primary care

In addition to GP practices, primary care covers dental practices, community pharmacies and high street optometrists.

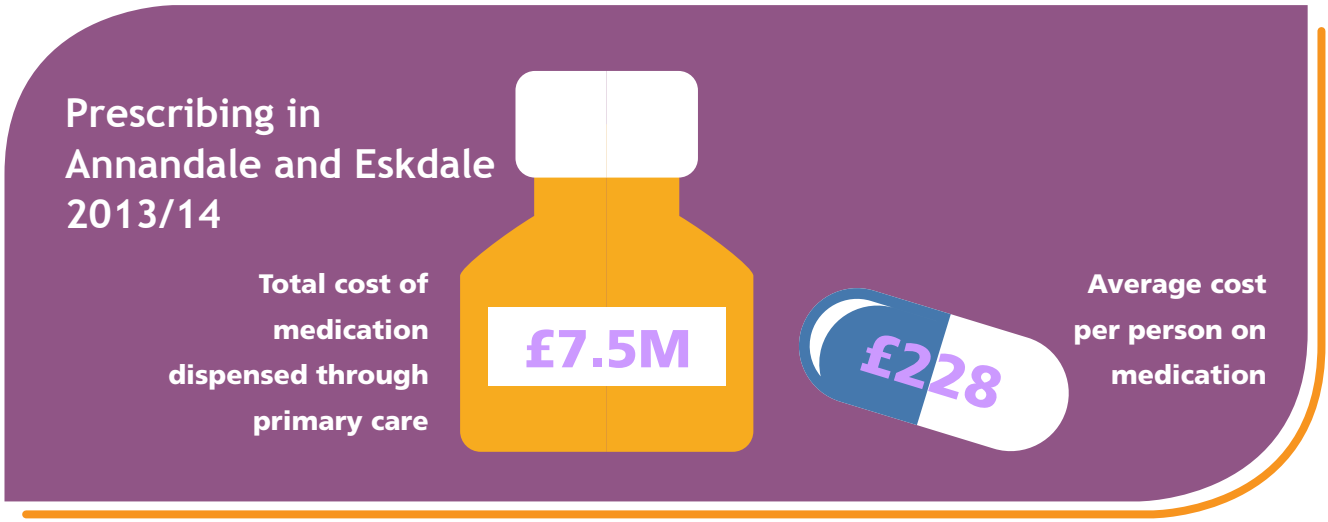
Prescribing is the most common action the NHS undertakes for people across all sectors of health care – primary, hospital, public and community. It is the second highest area of spending in the NHS, after staffing costs.

About two-thirds of all prescribing costs in Dumfries and Galloway are associated with primary care. It is important that we continue to work with and support GPs to analyse and review prescribing in line with best practice. This includes supporting people in our communities to make informed decisions about their medication.

The overall cost and volume of prescribing has continued to increase. Moving forward we plan to increase public awareness, explore how we can improve prescribing processes and expand the range of non medical support so we can meet the needs of local people.

Through our community link workers, for example, we are supporting people to reconnect with their local communities and reduce social isolation for people who traditionally may have sought medical solutions for their problems. We also want to make sure that prescriptions, particularly repeat prescriptions are managed effectively by the public to help avoid unnecessary costs and inappropriate storage of medication.

Looking at the costs of prescribing across the locality, one way we can see patterns is by looking at the cost per person on medication. That means counting anyone who has received one or more prescriptions in the period being considered. This is set out in the graphic below:



Source: PRISMS

3. People and finances

3.1 Who makes up the locality management team?

Managers and staff from both Health and Social Care have joined together as one integrated locality team across Annandale and Eskdale. The team is made up of the locality manager, clinical lead, social work manager, nurse manager, public health practitioner, allied health professionals and heads of service and is supported by a divisional finance manager, commissioning officer and workforce adviser. The locality management team works closely with the third sector and independent sector and has regular meetings with the Third Sector, Dumfries and Galloway and Scottish Care to help develop a more holistic approach in shaping and delivering the commitments set out in this locality plan.

A wide range of staff and volunteers work across Annandale and Eskdale in the NHS, council, independent and third sectors. The main staff groups working within the area include GPs, nursing staff, social work staff, allied health professionals, mental health teams, community pharmacists, dentists, opticians, residential and home care workers. To support our plans to develop a more effective and integrated health and social care workforce, we will be working with colleagues in the independent and third sectors to help develop more integrated working within the locality and support each other in recruiting, developing and retaining a person centred workforce.

3.2 How is the money spent?

The budget in 2015/2016 for the Dumfries and Galloway Partnership is £296.1 million. You can find more details of the overall finance plan in Annex 3 of the strategic plan for Dumfries and Galloway. A total of £109.8 million of resources has been set aside for the four localities of Annandale and Eskdale, Wigtownshire, Stewartry and Nithsdale. The current budget of £26.14 million for Annandale and Eskdale is summarised in table 3.

Table 3: Dumfries and Galloway health and social care Annandale and Eskdale yearly budget

Area	Pay (wages) £000	Non-pay £000	Income £000	Total £000
Council services				
Assessment and fieldwork	756	15	(11)	760
Day care	0	326	0	326
Domiciliary care	0	5,162	(304)	4,858
Meals on wheels	0	35	(17)	18
Nursing care	0	397	(70)	327
Occupational therapy	137	119	0	256
Residential care	0	6,896	(2,863)	4,033
	893	**12,950**	**(3,265)**	**10,578**
NHS services				
Community hospitals	3,411	315	(12)	3,714
Community nursing	1,055	122	(14)	1,163
Health centres and clinics	68	159	(49)	178
Management and admin	210	33	0	243
Prescribing support	52	7,552	0	7,604
Public health	156	21	(2)	175
Regional occupational therapy	975	73	(3)	1,045
Regional podiatry	1,326	124	(4)	1,446
	7,253	**8,399**	**(84)**	**15,568**
Total	**8,146**	**21,349**	**(3,349)**	**26,146**

The Chief Officer and Chief Finance Officer of the IJB will review the budget for Annandale and Eskdale each year to make sure that the overall finance plan is able to deal with:

- changes in what we do
- increases in costs
- efficiency savings
- performance against outcomes
- legal and government requirements

In light of the twin pressures of rising demand and restricted resources, a major challenge is to improve our understanding of how resources are used in the locality to meet changing needs and priorities. At the same time, we will need to take account of the following important challenges and risks.

- As an integrated system we will need to contain costs within existing resources and continue to make efficiency savings year on year. For NHS services this is likely to continue to be around 5% each year for the foreseeable future, with different (although similar) expectations from council budgets
- The main risks highlighted in the NHS budgets include the costs of keeping up medical staffing levels (both in acute hospital and primary care), GP prescribing, making savings, increased activity through the acute system and maintaining access and other performance targets
- The main risks for social work budgets include the effect of new legislation, including that related to self-directed support and the related expectations of people, pressures increasing the number of people needing care, (particularly older people but also people with learning disabilities and physical disabilities), and also growing pressures on price levels charged by care providers and the effect of capacity issues, particularly in rural parts of the region

As well as the locality budgets, a further budget of £52.1 million for strategic primary care service is currently held at a regional level for the following services.

Dumfries and Galloway health and social care regional yearly budget

Area	Pay (Wages) £000	Non-pay £000	Income £000	Total £000
Council services				
Assessment and fieldwork	310	142	(36)	416
Care call	0	40	0	40
Community support	882	17	0	899
Day care	0	169	(45)	124
Day care - ARC	2,114	408	(27)	2,495
In-house supported accommodation	624	101	0	725
Occupational therapy	96	34	0	130
Ordinary residence L.D.	0	0	0	0
Resettlement	0	5,850	(6,245)	(395)
Resource transfer	0	0	(3,584)	(3,584)
Sensory impairment	339	45	(16)	368
Short break	45	10	0	55
Women's and Children's Directorate	0	2,169	(61)	2,108
Non-social-work services		8,500		8,500
	4,410	**17,485**	**(10,014)**	**11,881**
NHS services				
Management and admin	545	9	(6)	548
Marie Curie nursing	0	140	0	140
Regional prescribing	0	56	0	56
Stars (Reablement service)	683	82	(10)	755
Primary medical services	385	40,261	(1,885)	38,761
	1,613	**40,548**	**(1,901)**	**40,260**
Total	**6,023**	**58,033**	**(11,915)**	**52,141**

The locality senior management team in Annandale and Eskdale will work with local staff, organisations and people to review how the current range of services delivered and paid for in the locality meets the needs of local people and will identify how we can best use local and region-wide health, social care and local community resources to promote the health and well-being of the people of Annandale and Eskdale.

4 What are people in the locality telling us?

4.1 The main messages from local engagement and consultation

We have carried out engagement and consultation across the locality in a variety of ways including going out into communities and villages and knocking on doors. Working with our partners in the third and independent sectors to access people who use services and attend groups and activities in the community and also through organising public meetings.

"Having a visiting scheme for people living alone to check they are OK would be good".

This section highlights some of the main messages emerging from our discussions. It also includes the views of people who work to provide health and social care across the sectors in Annandale and Eskdale.

Some of the key themes from the comments and views of people in our communities:

- we need to make best use of the resources available to us
- we need to address loneliness and isolation
- we need to support people to take responsibility for their own health so that they can take better care of themselves, particularly in managing their health conditions

"I would like to see a walk-in place where access to information for health and social care could be accessed".

- we must work together to build and strengthen our communities so that people can live independently at home for longer
- we must work together to support people who live with dementia
- we need to work with Carers to ensure they feel informed, involved and supported
- we need to address transport issues as these have a huge impact on isolation and ability to access services and supportive activities
- we need to work together to ensure there are appropriate respite opportunities

"I want to be more physically active but not sure where to start… it would be good to have more groups, to be able to learn new things and to have exercises to help with my arthritis".

- we need to be clear about the cross border issues i.e. Dumfries/Carlisle hospitals
- we need to continue to support personal resilience and independence through initiatives like forward looking care and community link workers
- we must address our high prescribing costs
- we need to look at availability and provision of care at home and residential care in the area

"I would like listening and supportive health professionals who recognise the importance of supporting me so that I can continue to support my daughter who has a mental illness and her children".

- we need to think about younger people and the move from children's services to adult services
- peoples journeys through services and hospital are smooth

"Provision of respite is absolutely vital".

Examples of comments from people in communities:

"we need to continue to focus on identifying people who are Carers and make sure they are getting the support they need such as being able to take a break, someone to talk to in a similar position and even some training"

"we need less duplication to avoid having to provide the same information to lots of different people"

"easier access to GP appointments would be good"

"it would have been good to have a chance to meet others in the same situation….I now realise I had a lack of knowledge on things such as mood change, irritability etc. which are precursors of dementia".

"we need increased support within our communities – services, activities and involvement and expand the role of the community link worker"

"there should be more support for younger people with long-term conditions"

"we need to make sure people can leave hospital as soon as they are ready and improve arrangements to make sure people do not end up back in hospital"

"We need less duplication of paperwork and more joined-up thinking".

"We want to work with one named person and not a multitude of people"

What those who provide health and social care services are telling us:

- we need to change public expectations in terms of what people can expect from public services in the future
- we need to move from 'providing' services to working 'with people', encouraging and supporting them to look after their own health and well-being. This includes drawing on support from families, friends and communities
- we need to focus on tackling loneliness and isolation and identify people who need support much earlier. we need to be better at identifying people at risk of 'crisis'
- we need to extend opportunities for everyone to have a forward looking care plan if they wish
- there needs to be better co-ordination and flow between different services and a named person for a single point of contact
- we need to put self-directed support into practice
- we need to work with the whole person

"Training to help care home and care at home staff take basic measurements and identify signs of deterioration in health has really helped to reduce the pressures on health services and avoided potential crises. Care staff have increased their skills and confidence and all partners have worked well together to ensure safety and quality remain at the forefront – we are optimising the use of all our joint assets" (local care provider) to be able to learn new things and to have exercises to help with my arthritis".

and not just focus on illness or health particular conditions

- we need to tackle the lack of care at home
- we need better links between primary care and acute services

"As a professional working in the social work sector, I would like to see better pay and working conditions and fairer funding for providers of care services" (Social Worker)

- we need the third sector to be equal partners and get involved at as early a stage as possible
- we need to improve the level of support for people with long term conditions
- we need to consider the difference in the level of support available between those aged under 65 and those aged over 65

"It has been beneficial to introduce Forward Looking Care Plans. It has really helped with knowing what people would like to happen when they are no longer able to cope on their own" (Practice Nurse)

5. Where are we now?

5.1 What is working well?

This section sets out what is already working well in Annandale and Eskdale. The 'spotlight' boxes highlight some examples of good practice.

Spotlight on community link workers

Funding from the change fund supported the development of the community link worker role. Link workers support people identify what really matters to them and work with them to find solutions. This work has not only supported many people live better lives in their own homes but also has helped identify gaps in local services. The workers have also helped local communities to develop the kinds of support that people have said would make a real difference to their health, wellbeing and quality of life. They have also been able to tell people about opportunities they would otherwise not have been aware of.

People tell us this has made a real difference to their lives and meant they feel more in control of their own health and well-being.

Health and well-being

- community link workers are supporting people to take better care of themselves and live more active healthy lives
- the local health improvement team are supporting groups and communities to develop new opportunities and activities where there are gaps
- keep well health checks for Carers
- increasing access to be more physically active e.g. tea & tennis, beat the street, tai chi training, let's motivate training for care home staff
- extensive joint working through the safe and healthy action partnership (shap) e.g. activities addressing risk taking behaviours, increasing opportunities to be more physically active, healthy weight initiatives and supporting transition
- testing home-based technologies – this has worked well and there are now opportunities to expand this e.g. monitoring some long-term conditions using technology from a person's own home

"it is great having a wider variety of clinical skills in different areas"

"The improved flexibility of staff makes a big difference"

District nursing and community hospitals

- changing the district nursing service, from seven teams to two teams, has led to a more effective and efficient nursing service across Annandale and Eskdale. Nursing staff have responded positively to the changes
- the introduction of new e-pen technology and documents across the nursing service has also led to a more person-centred approach and improved communication and sharing of information

"Having one base is good"

- the ongoing development of cottage hospital nursing staff skills has helped with transferring patients from acute care at an earlier stage. For example cannulation training at Annan Hospital allows patients to receive intravenous antibiotic therapy as an outpatient or as an inpatient. Similarly the blood transfusion service at Moffat Hospital allows patients to be treated closer to home

"The care is excellent. When you say you're going to come you do turn up. I think all the nurses are professional – what does that mean? It means I can trust you!" District nurse patient

Mr S's story

Mr S, aged 59, who has many health problems and is confined to a wheelchair, felt very isolated and wanted to get out of the house more. A community link worker discussed a number of activity groups which were running locally. Mr S now goes to the local day centre where he is enjoying the company, activities and lunch which the day centre provides. He has also been supported to apply for a taxi card so that he can hire a wheelchair-friendly taxi to take him to other local activities.

End-of-life care

- forward looking care planning enabling peoples wishes to be known to health & social care services
- district nurses taking a much more person-centred approach with palliative care patients
- having the resources of a Macmillan Nurse who can provide a quick response

"I feel valued and respected as an equal partner in my care."

"Through this discussion, my family are now aware of what I do and don't want to happen to me."

Spotlight on "One Team"

The "One Team" is an approach which was piloted in Langholm. It involved care at home staff, health care support workers from the cottage hospital and district nurses working in a more joined up way to reduce duplication of visits wherever possible. Staff explored commonalities in existing skills and knowledge of team members and planned training/upskilling as appropriate where gaps were identified. This resulted in:

- a shared understanding of clinical competencies
- care at home staff trained to deliver minor interventions
- a reduction in community nurse travel
- a reduction in out of hours call outs
- More efficient use of district nurse and care at home staff time

Supporting Carers

- Carer aware training being delivered across all sectors
- Carers' assessments are offered by social work
- two Carer support workers based in Dumfries and Galloway Royal Infirmary
- wide range of information available
- comprehensive programme of free short course training for Carers
- emergency cards for Carers are now widely available

Mrs C's story

Mrs C had been caring for her husband, who has dementia, on her own for many years as she saw this as her responsibility. However, she was reaching breaking point and her own health was beginning to be badly affected. A community link worker who was calling on people in the village where Mrs C lived recognised the situation and was able to tell Mrs C about the D&G Carers Centre and help her with a referral to the local social-work office. Mrs C is now meeting others in a similar situation and is also able to have a little time to herself, so a crisis was avoided.

Social work services

- supporting a large number of people to stay living in their own home for as long as possible
- the personalised approach to care – having a 'good conversation' with people and putting people at the centre of their own care
- positive approaches to supporting vulnerable adults
- care co-ordinators linked to cottage hospitals to support discharge planning

Mr J's story

Mr J was admitted to a local cottage hospital after falling. He had not been eating properly or looking after himself. His mobility was poor and his heating had stopped working. He had mental-health problems and had been refusing help from both his family and social work for years. With close working between the staff in the cottage hospital and social work, Mr J eventually agreed to receive some support. He also agreed to have some support from his family. His house was tidied and anything he could trip over was dealt with. His heating was fixed and he agreed to receive some home care. The care agency helped by using a flexible, gentle approach. He now receives care every day. A charity helped Mr J get a new boiler, reducing his heating costs and he is now warm and feeding himself better, improving his general health.

Mrs L's story

Mrs L, an 85-year-old woman was befriended by someone she had previously only known by sight many years ago. Social work was aware of previous difficulties relating to Mrs L being financially abused through mail scams and she was understood to be vulnerable as a result of long-standing mental-health issues. The 'friend' in question persuaded Mrs L to give her a house key. Mrs L's neighbours reported to social work that the 'friend' was often at the house with a male companion.

Shortly after Mrs L returned home after a hospital stay, social work were told that Mrs L had built up large personal debts despite having an adequate income. Social work carried out enquiries into these allegations under the Adult Support and Protection (Scotland Act) 2007. Mrs L gave permission for them to share relevant information with the police, health services and her care agency to make sure that she was safe and her care needs were dealt with. In keeping with Mrs L's wishes, social work advised and supported her in getting a financial power of attorney. A solicitor now acts in her best interests as her power of attorney and this, together with an effective package of care at home, is protecting her from any further abuse or harm.

Dementia

- a consistent approach to training across all sectors through the 'Best Practice in Dementia Care' training and the Community Dementia Partners Programmes
- an active dementia forum which helps to co-ordinate activities
- development of Annan as a 'dementia-friendly community'
- providing a range of peer support groups

SPOTLIGHT on community dementia partners

People living with Dementia are often supported by a number of people including families, friends and staff from all sectors. It is important that both family carers and paid staff are well informed and supported to do their work well. It is also important that we listen to one another and value the roles that everyone has.

Community dementia partners is an education programme, led by Scottish care aimed at all those who support people living with dementia in our communities. This includes family carers, workers in care at home services, care homes, NHS and council staff.

It is a blended learning approach encouraging everyone to come together to talk, learn and share experiences.

The two day programme gives people the opportunity to think about how a person with dementia may feel about their lived experience and how they can improve the support they provide.

Health inequalities, poverty and deprivation

- support to help people make the most of their income (through region wide services)
- collaboration between partners is positive and on the increase
- there is continued effort to focus on 'the person' rather than 'the illness'

Hospital discharge planning

- current programme of work looking at patients in the admissions ward of the hospital and arranging discharge if a person is found to be admitted when they shouldn't have been
- short-term 'step-up' provision in the community if a person does not need to be admitted to hospital but some short-term care is needed on a 24-hour basis
- arrangements with local pharmacies to provide medication when people leave hospital to avoid delays
- social work has, this year, developed a small hospital discharge team with funding from the integrated care fund

Spotlight on step up care

A number of beds in both residential care homes in Annan and Annan Hospital were identified as "step-up beds" for a period of time to test whether these could provide a flexible option and alternative to an acute hospital admission where it was appropriate to do so.

A total of 21 people were admitted to these community beds as an alternative to DGRI. Peoples' stories highlighted that those using the service and their families as well as staff taking part found the experience to be extremely positive as were the overall outcomes.

Delivery of care was safe and co-ordinated and effective team work enabled peoples' journeys to be much more person-centred and appropriate.

Housing

- there is joint working between social work and local housing associations (RSLs) to identify unmet need for specialist housing and identify appropriate sites for future developments

Primary care including GP practices

- according to engagement with local people and through surveys, people say they are generally very happy with the services they receive in Annandale and Eskdale and local GP practices score well in the national patient satisfaction survey

- to address issues around recruitment of GPs in this region we are supporting our 10 GP surgeries to help develop a plan which helps integrate health and social care so that practices can develop patient-centred care processes, get involved with the local community link worker team and develop more care plans aimed at preventing illness. A series of workshops have already started with local GPs, practice staff and other professionals at a community level to help develop a 'one-team' approach

Spotlight on forward looking care (FLC)

GP practices in Annan have introduced forward looking care planning which has a real focus on supporting people to identify their wishes for future care and meet their personal outcomes.

Taking a preventative approach enabled people to identify and plan for their current and future needs, enabling them to keep well and reach their full potential. People reported feeling more in control of their health and better able to manage their condition and medication. People also felt listened to and happy that their wishes were known should their health deteriorate.

Practitioners in health and social care also felt positively about the approach in the fact that peoples' wishes and preferences were known in advance, ensuring the appropriate information, support or care could be provided by the right service at the right time.

6. What do we need to do?

6.1 Our commitments

In accordance with the nine national health and well-being outcomes set by the Scottish Government, our key areas of focus, our strategic plan, the needs and challenges identified and set out earlier in this locality plan for Annandale and Eskdale and our joint inspection self assessment position statement, we have identified the following key commitments that will be delivered from 2016 to 2019.

The commitments set out what we plan to do and we will develop more detailed plans to set out how we will meet these commitments. We will monitor and map progress against each of our commitments in accordance with our performance management and governance frameworks and will ensure that we provide opportunities for the people of Annandale and Eskdale to be fully engaged in the delivery, review and reshaping of our commitments.

National Outcome	What the Scottish Government says people can expect	Our commitments in Annandale and Eskdale
People are able to look after and improve their own health and wellbeing and live in good health for longer	I am supported to look after my own health and well being I am able to live a healthy life for as long as possible I am able to access information	We will have different conversations with people about their health and care needs to support them to take personal responsibility for their own health and well being. We will support people to plan ahead and to consider their options and wishes at an early stage through the expansion of forward looking care plans. We will develop and support our workforce to develop a more holistic and integrated approach to promote health and well being through the development of Integrated teams at a local community level. We will identify and maximise the use of individual and community assets to support personal heath and well being. We will review the current use of new technology to promote greater independence and safety and develop plans for a more effective use of such technology. We will provide accessible information for people to help them access the range of support that is available.
People, including those with disabilities or long term conditions, or who are frail, are able to live independently and at home or in a homely setting in their community	I am able to live as independently as possible for as long as I want Community based services are available to me I can get involved in my community	We will work in partnership with local communities to develop new sustainable, flexible and integrated models of community based day, residential , supported living and other specialist services to meet the needs of local people. We will work in partnership with care providers to develop sustainable care at home and care home services which strive to optimise people's independence and quality of life. We will actively support people with chronic conditions in the community to help reduce the need for people to be admitted into hospital. We will work in partnership to develop 'dementia friendly' communities across Annandale and Eskdale. We will establish a locality housing group with housing providers and other partners to develop new models of housing and support to meet the needs of people across Annandale and Eskdale. We will promote care and repair grant opportunities to enable people to remain living within their own homes for as long as possible.

National Outcome	What the Scottish Government says people can expect	Our commitments in Annandale and Eskdale
People who use health and social care services have positive experiences of those services, and have their dignity respected	I have my privacy respected I have positive experiences of services I feel that my views are listened to I feel that I am treated as a person by the people doing the work - we develop a relationship that helps us work together Services and support are reliable and respond to what I say	We will listen to what people think of our services and let them know what improvement actions we plan to take. We will develop a locality participation and engagement group. We will provide a range of accessible ways for people to communicate their views and wishes. We will develop end of life care in line with the needs and wishes of people and their families. We will develop clusters of integrated care communities across Annandale and Eskdale to promote more integrated ways of working and more effective points of access to support.
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services	I'm supported to do the things that matter to me Services and support help me reduce the symptoms that I am concerned about I feel that the services I am using are continuously improving The services I use improve my quality of life	We will hold conversations with people to identify what really matters to them and help them develop a plan that will maintain or improve their quality of life. We will make sure appropriate information is available for people to access the support they need to maintain or improve their quality of life. We will build in a regular review process to make sure people who use our services are getting the support they need to live a good quality of life. We will review and develop the use of outcome star approaches across Annandale and Eskdale. We will conduct a day of care audit within our cottage hospital to help shape their future development. We will review and develop the use of the IORN (indicator of relative need) assessment tool across Annandale and Eskdale to help identify the different and changing needs of people and inform the development of how we support them.

National Outcome	What the Scottish Government says people can expect	Our commitments in Annandale and Eskdale
Health and social care services contribute to reducing health inequalities	My local community gets the support and information it needs to be a safe and healthy place to be Support and services are available to me My individual circumstances are taken into account	We will work together to implement and deliver support that addresses and tackles health inequalities. We will work together to identify people in greatest need and those who may have very specific needs. We will target support for specific groups and communities with identified health inequalities. We will support people to reconnect with their communities and help them to make informed choices. We will work towards reducing the health inequalities experienced by particular people, groups and communities.
People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing	I feel I get the support I need to keep on with my caring role for as long as I want to do that I am happy with the quality of my life and the life of the person I care for I can look after my own heath and well being	We will listen to the views of Carers and will identify the action we will take to support them. We will identify current and potential Carers as early as possible. We will make sure all Carers are told about their right to an adult care support plan (previously known as Carers assessment) so that the needs of Carers are dealt with in their own right. We will identify, develop and promote local services to help improve the quality of life of Carers. We will continue to raise Carers awareness across our workforce following the equal partners in care core principles. We will identify and support the particular needs of young Carers.

National Outcome	What the Scottish Government says people can expect	Our commitments in Annandale and Eskdale
People using health and social care services are safe from harm.	I feel safe and am protected from abuse and harm Support and services I use protect me from harm My choices are respected in making decisions about keeping me safe from harm	We will help people recognise and report abuse and harm at the earliest stage possible. We will develop the skills and knowledge of staff and managers to protect people from harm. We will record and share information in a joined up professional and confidential manner. We will make sure that all incidents of abuse and harm are investigated and dealt with in a timely way. We will identify the main risk areas and trends and develop local strategies to reduce harm. We will identify key risks for people and develop risk management plans in a consistent, holistic and person centred manner.
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	I feel that the outcomes that matter to me are taken account of in my work I feel that I get the support and resources I need to do my job well I feel that my views are taken into account in decisions	We will involve staff from all sectors in developing, delivering and reviewing this plan. We will make sure that local voluntary and community groups are able to shape and continue to play a central role in delivering integrated health and social care support. We will support health and social care staff to develop their skills and knowledge to enable them to develop their role, reduce duplication and work to their optimum level. We will consult with and listen to the views of staff and keep them updated on the improvement actions we plan to take to develop more integrated ways of working. We will develop a culture where respectful challenge is encouraged, underpinned by openness, transparency and mutual respect. We will involve employees in developing and promoting a Healthy Working Lives programme across Annandale and Eskdale. We will review and develop our supervision and appraisal processes to ensure that we support and develop staff in an appropriate and consistent manner. We will explore the opportunities to use new technology to support our workforce. We will identify and promote career pathways which allow local workers to develop to meet future gaps in the workforce. We will promote more cross sector training opportunities to help support the development of integrated ways of working. We will work with all sectors to improve staff recruitment and retention.

National Outcome	What the Scottish Government says people can expect	Our commitments in Annandale and Eskdale
Resources are used effectively and efficiently in the provision of health and social care services	I feel resources are used appropriately Services and support are available to me when I need them The right care for me is delivered at the right time	We will develop a range of new initiatives, including public awareness, to enable us to meet the rising challenges of prescribing and managing medication which meets individual needs in a safe, therapeutic and cost effective way. We will support people to get home from hospital earlier by identifying and strengthening our local community assets and support services . We will regularly review all health and social care packages to make sure that they are promoting individual well being, independence and are delivering positive outcomes. We will regularly review the cost and quality of our services and benchmark them in accordance with best practice. We will develop new integrated working models with local partners to support the future development and sustainability of general practice across Annandale and Eskdale. We will develop a more robust district nursing service, with closer links to the wider multi-disciplinary team, with the capacity to keep more people in their own home in Annandale and Eskdale. We will review and develop the role of our social workers through the development of more integrated ways of working with the wider multi-disciplinary team. We will develop new models of community support with local partners for the future development of our allied health professional services to increase our capacity to keep more people in their own home and which promote their independence, safety and quality of life in Annandale and Eskdale. We will review the role of our 4 cottage hospitals across Annandale and Eskdale to ensure that they continue to meet the changing needs of local people. We will develop alternatives to hospital care including the development of new step up and step down services. We will develop and establish local clustered care communities to identify and develop proposals for providing more integrated and accessible health and social care support at a local level which are delivered and available at the right time. We will promote the development of self directed support across the locality. We will review and develop proposals for the more effective use of office accommodation and support services to help more integrated and cost effective working.

7. How will we know we are getting there?

7.1 Measuring performance

To help us monitor progress of this plan, we will develop a performance framework to make sure we are taking a consistent approach to measuring performance across the whole partnership. We will develop a series of joint measures alongside activity and financial information and these will apply across the partnership, including the third and independent sectors.

The nine national health and well-being outcomes set out on page 6, along with the 'we will' statements in both the strategic plan and this plan will form the basis for accountability. The framework will make sure there are clear links between the nine outcomes, the Dumfries and Galloway single outcome agreement, the strategic plan, this locality plan as well as service delivery plans.

Measures will also include targets which either the NHS or the council currently report against relating to services under the Integration Joint Board.

Not all of the information is currently available at an area level but we will deal with this going forward.

The Dumfries and Galloway Integration Joint Board will be responsible for checking this performance information. It has also been agreed that, in each locality, an area committee will check on the delivery of the locality plans. Over time, this information will allow the Integration Joint Board to see what effect the approach to integrating services is having, particularly for those who use services and support. They will also put together a performance report each year as required by law.

Best evidence will be used to make sure we measure the things that matter to those using services and Carers, as well as front-line staff. We will use information on quality as well as quantity and include feedback from those using services, service audits and support and care record systems. We will not simply use this information to monitor how we are keeping to targets but to also improve services.

It will be important that all staff members understand their own responsibility for making sure high quality information is available for reporting on performance, and how this is relevant to the quality of care and support they provide.

Being clear around progress and achievement should be something everyone can be aware of. Teams should have the information they need to know how they are doing, when to ask for help and when to share good practice and successful approaches. Developing strong relationships and team-working based on a shared vision and shared values will support this. This is what this plan is all about.

You can find more detailed information on the performance management framework at www.dg-change.org.uk/Strategic-Plan

If you would like some help understanding this or need it in another format or language please contact 030 33 33 3000