DUMFRIES AND GALLOWAY
INTEGRATION JOINT BOARD

HEALTH AND SOCIAL CARE
STEWARTRY LOCALITY REPORT

DUMFRIES AND GALLOWAY
Health and Social Care

April 2019

DRAFT 1.0

Contents

Foreword

This is the fifth performance report from Stewartry which continues to demonstrate our progress on delivering on the 'We Will' commitments outlined in the Stewartry Locality Plan.

From the 43 commitments, 42 of these have progressed.

This report will focus on 4 of the 9 National Health and Wellbeing Outcomes and the associated commitments. These are Outcome 1, Outcome 4, Outcome 7 and Outcome 9.

Our focus for the reporting period has been on:

- working with local communities and communities of interest to improve outcomes for people living in Stewartry
- supporting GP colleagues on implementing specific areas of the new GMS contract
- development of technology to improve communication and efficient patient care and support
- promotion of self directed support options enabling service users to have informed choice and take more control of their support
- care assurance audits which have resulted in awards for our Stewartry hospitals
- staff involvement in the development of risk assessment tools to protect our most vulnerable adults
- supporting timely discharge and securing care packages to enable effective flow of people across the health and social care system and
- development of an innovative technology project which has the potential to transform how we deliver over night support

This work has been delivered against the backdrop of significant challenges across the partnership in particular recruitment and retention of staff across all sectors, continued growth and demand and the difficult financial climate.

Acknowledgment must be made to the dedication of our staff teams and partners who ensure we continue to provide the best care and support to meet the outcomes of people in Stewartry.

Stephanie Mottram
Locality Manager - Stewartry
April 2019

Introduction

The Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) (here) set a legal framework for integrating (combining) health and social care in Scotland. This legislation says that each health board and council must delegate (transfer) some of its functions to new integration authorities. By doing this, a single system for planning and delivering health and social care services is created locally.

The integration authority in this area came into existence in the form of Dumfries and Galloway Integration Joint Board (IJB) on 1 April 2016. The responsibility for the planning and delivery of the majority of adult health and social care services are delegated from the Local Authority and NHS to this new body.

The Scottish Government has set out 9 National Health and Wellbeing Outcomes. These outcomes set the direction for health and social care partnerships and their localities, and are the benchmark against which progress is measured. These outcomes have been adopted by the IJB in its Strategic Plan (here).

The Act requires each integration authority to establish localities. The 4 localities in Dumfries and Galloway follow the traditional boundaries of Annandale and Eskdale, Nithsdale, Stewartry and Wigtownshire. Each locality has developed its own Locality Plan (here).

In Dumfries and Galloway the Local Authority and NHS have agreed, through their Scheme of Integration, that "Health and social care services in each locality will be accountable to their local community through Area Committees and to the IJB". It was also agreed that "Area Committees will scrutinise the delivery of Locality Plans against the planned outcomes established within the Strategic Plan." (here)

In November 2018 the IJB agreed the revised performance framework for the Partnership. This framework requires each locality to report to their respective Area Committee every 6 months. Each locality report focuses on either 4 or 5 of the 9 National Health and Wellbeing Outcomes so that, over the course of a year, progress towards each outcome is reported once to Area Committees.

Public Bodies (Joint Working) (Scotland) Act 2014
www.legislation.gov.uk/asp/2014/9/contents/enacted (last access 23 May 2017)

Strategic Plan 2018- 2021
http://dghscp.co.uk/wp-content/uploads/2018/12/Strategic-Plan-2018-2021.pdf (last accessed 25 February 2019)

Stewartry Locality Plan 2016-2019
http://dghscp.co.uk/wp-content/uploads/2018/12/Stewartry-Locality-Plan.pdf (last accessed 25 February 2019)

Dumfries and Galloway Scheme of Integration
http://dghscp.co.uk/wp-content/uploads/2018/12/Integration-Scheme.pdf (last accessed 25 February 2019)

The symbols we use

i) How we are addressing this outcome in our locality

The Locality Plan for Stewartry details our commitments that support the National Health and Wellbeing Outcomes and Dumfries and Galloway's Strategic Plan. These are repeated here, under their respective outcome, together with a Red, Amber, Green (RAG) Status that indicates our assessment of progress.

Red - Progress in implementing the commitment is significantly behind schedule or work has not started when it was due to start.

Amber - Early warning that progress in implementing the commitment is behind schedule.

Green - Progress in implementing the commitment is on or ahead of schedule or the work has been completed.

Grey - Work to implement the commitment is not yet due to start.

ii) How we are getting on

Next to each infographic in this report there are 2 circles, like this: 

The first circle shows the indicator number. Information about why and how each indicator is measured can be found in the Performance Handbook, which is available on the Dumfries and Galloway Health and Social Care Partnership website (www.dghscp.co.uk/performance-and-data/our-performance/). Where there is a (+) instead of a number, the figures are not standard indicators, but additional information thought to be helpful.

The second circle shows red, amber or green colour (RAG status) and an arrow to indicate the direction the numbers are going in. We have used these definitions to set the colour and arrows:

- We are meeting or exceeding the target or number we compare against
- We are within 3% of meeting the target or number we compare against
- We are more than 3% away from meeting the target or number we compare against
- Statistical tests confirm the number has increased over time
- Statistical tests suggest there is no change over time
- Statistical tests confirm the number has decreased over time

The 9 National Health and Wellbeing Outcomes

The Scottish Government has set out 9 national health and wellbeing outcomes for people.

People are able to look after and improve their own health and wellbeing 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 wellbeing

People using health and social care services are safe from harm

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

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

The 9 national health and wellbeing outcomes set the direction of travel for services in the health and social care partnership and are the benchmark against which progress is measured. The Scottish Government has not numbered these outcomes to reflect that they are all equally important. However, locally we have added numbers solely for the purpose of tracking progress through our performance framework.

1. Outcome 1

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

1.1 How we support this in our locality

Making the most of and maintaining health and wellbeing is better than treating illness. The aim is to promote good health and prevent ill health or, where health and social care needs are identified, to make sure there are appropriate levels of planning and support to maximise health and wellbeing.

In our locality we work towards this aim through the following:

- Community Link and Social Prescribing
- Health and wellbeing in the farming community
- Community development
- Anticipatory care planning

1.2 How we are addressing this outcome in our locality

Our We Will commitments which support this outcome and their current Red, Amber, Green (RAG) status:

1. We will further expand the Community Link approach to support people to become involved in their communities, 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 well-being needs.
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.

1.2.1 Community Link and Social Prescribing

There is an average of 8 referrals every 4 weeks to the Healthy Connections team with a maximum reached in July 2018 of 16 referrals. GP and adult social care referrals account for approximately two thirds of referrals with the remainder coming from a range of sources including community organisations, Dumfries and Galloway Royal Infirmary (DGRI) consultants and Allied Health Professionals (AHPs). All GP practices within the locality refer into the programme and approximately 40% of referrals are managed by working with other practitioners and professionals.

Outcomes for people referred to Healthy Connections include:

- increasing social contact after getting focused input from a specialist service (referred into by Healthy Connections);
- increasing the amount of time spent focusing on themselves (rather than others, as many people have multiple unpaid Caring roles);
- unpaid Carers of those referred are offered input, if appropriate, and in one case this led to the feedback that the service had helped both to 'turn a corner in their life'.

In addition to face to face referrals, practitioners from a range of disciplines access the team's knowledge of local resources to pass onto people they are working with.

1.2.2 Health and Wellbeing in the Farming Community

The Health and Wellbeing Team are working with Stewartry Rugby Football Club who is trialling a sports training app which can also give an indication of potentially negative changes in wellbeing. 12 participants are using the app to record aspects of wellbeing including levels of tiredness, mood, muscle fatigue and sleep patterns. The coach is using this information to inform the training programme and adjustments have been made to reduce potentially negative issues.

In addition, all participants have used the UCLA loneliness and self efficacy tools which in one instance has led to the coach being given a 'heads up' that the person was feeling significantly isolated. The coach has the option of speaking with the community health development worker or a local social worker (also the child protection officer for the club) regarding any concerns. Conversations are ongoing regarding whether any further input is advised for people or the team as a whole.

The project was developed following a number of incidents which highlighted mental health concerns amongst some rugby players. As rugby is a popular game within the farming community, connections were also made to the mental wellbeing of younger members of the farming community.

In April 2018 funding was secure via Life Changes Trust to develop provision for older members of the farming community, in particular those affected by dementia, along with their unpaid Carers.

The initial focus was work with a small group of retired members of the farming community who met informally to establish a sustainable social group. The Retired Farming Social Group is now established and whilst they are maintaining links with the National Farmers Union for Scotland (NFUS) and the Royal Scottish Agricultural Benevolent Institution (RSABI), they are operating independently.

The focus of the project has now moved to developing individual and community based farming memory resources. The capacity of the Dementia Champions is currently being explored in terms of identifying, engaging and doing structured work with members of the farming community affected by dementia. As part of the programme there will be guidance regarding taking people affected by dementia out to places where they can experience farming sights sounds and smell as well as bringing reminiscence material to them.

A scoping exercise is underway to identify existing sources of farming memorabilia. The next stage will be to establish how to increase access to these resources and to decide whether there is the need for a physical resource in the Stewartry.

1.2.3 Community Development

Community Access Surveys

Community Access Surveys were completed in New Galloway in 2017 and Crossmichael in 2018. Support has been ongoing in these communities with changes including the purchase of a disabled parking space in New Galloway and the commissioning of an options study to investigate wheelchair access for Crossmichael Church.

In February 2019, a similar survey will be done in Castle Douglas. People with personal experience will provide their insight to identify examples of good practice and both small and longer term changes which could improve access in the town.

As a development from previous surveys, more challenges are being considered including supporting people with autism and parents with children in buggies. The survey will run over several days and a questionnaire will be made available online to gain wider insight into access. There will also be some semi structured interviews with people who may have access challenges. Practitioners and third sector organisations who have front line experience will also be involved.

A series of planning, recording and reporting templates are also being trialled with a view that in the future, a toolkit will be available to communities to conduct their own surveys independently.

Inclusive Playpark

Stewartry Health and Social Care are supporting Castle Douglas Development Forum to design and develop an Accessible Playpark along with Changing Places facilities, following the allocation of £125 000 by Dumfries and Galloway Council. The role of health and social care will be to support with project coordination, identifying and securing additional funding and undertaking the community engagement.

Cooking in the Community

A successful pilot workshop was held in December 2018, with the TLC Café, Station House Cookery School and Café and Castle Douglas IT Centre. Following this, a series of workshops are planned for 2019 through which participants will learn about economic, nutritious, accessible and transferable cooking techniques. This links to wider initiatives around anti poverty, obesity and promoting independence.

Workshops will include how to reduce food costs by smart shopping and skills such as the use of seasoning along with a practical session. Each workshop will be filmed, to enable the sharing of learning more widely. Workshops will be designed around the participants, and some will be targeted at specific groups such as young people in first tenancies and unpaid Carers. People taking part will be supported to share their learning within their communities. Follow up engagement at 2 and 12 weeks will be used both to inform any further support needed for this and to track behaviour change.

Stewartry Social Isolation Partnership

A community engagement exercise was done in 2018, as part of the Scottish Government consultation on isolation and loneliness. Following this, a number of partners have joined Stewartry Health and Social Care to form the Stewartry Social Isolation Partnership. These include Dumfries and Galloway Council, Visibility Scotland, Better Lives Partnership, Castle Douglas IT Centre and Third Sector Dumfries and Galloway and Galloway Glens Landscape Partnership.

The purpose of the partnership is to promote awareness of the causes of social isolation, as identified by the local community, along with ways in which it can be tackled. Pieces of work by both staff and students, are increasing learning about social isolation in the areas of young people, learning disability, dementia and how animals can help to facilitate connection. Members of the partnership act to share and cascade learning, as well as to support projects which have been informed by their work.

1.2.4 Anticipatory Care Planning (ACP)

NHS Dumfries and Galloway local delivery plan 2017/18 has a stated aim to progressively roll out Anticipatory Care Plans (ACPs). Starting with people in care homes, those receiving care at home or who have complex, palliative or end of life needs. We are working towards ensuring everyone has the opportunity to have an ACP that is effectively shared across health and social care services.

Since June 2018, the project has gained momentum and is making progress to have the ACPs shared, however with the complexity of the project, more time is required to fully roll out the use of ACPs across Dumfries & Galloway.

1.2.5 Podiatry

Podiatry continues to deliver personal foot care sessions for health and local authority services on request. The fundamental aim of this initially is to promote and suggest ways in which people can continue self care for as long as possible to preserve independence. This is the first stage of the Active and Independent Living Programme (AILP) life curve.

Podiatry has its first Dementia Champion, who is supporting all staff to undertake learning to recognise and support people who have dementia in our workplace.

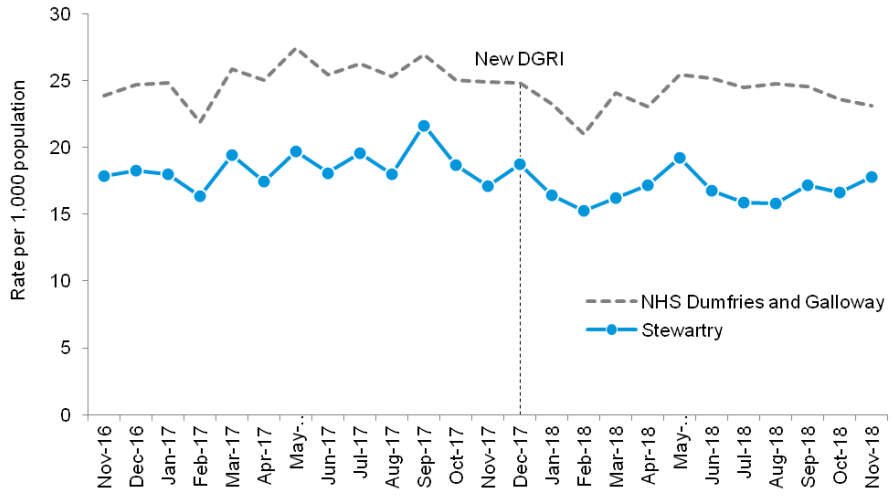
We are looking at further ways to support people around their ongoing care, including wound care. We are also involved in falls education sessions and education sessions for newly diagnosed diabetics.

1.3 How we are getting on

An important measure of how well people are able to manage their health and wellbeing in the community setting is how often their healthcare occurs as an emergency. There will always be the need for urgent and emergency care, but where possible the aim is to support people in the community and prevent crisis events.

In Stewartry over the last year, the number of people attending an emergency department (anywhere in Scotland) has been relatively stable. The rate of attendances is typically lower than for Dumfries and Galloway, which reflects the distance to an emergency centre. Historically, the rate of emergency admissions for Stewartry residents has closely matched the Dumfries and Galloway rate, however, recent levels of admissions have been lower. Note that the new DGRI has a Combined Assessment Unit (CAU), which means that people arriving at the front door are managed along different care pathways to previously.

Residents of Stewartry locality,
Rate of Emergency Department attendances per 1,000 population



Source: NSS Discovery, from National A&E Datamart

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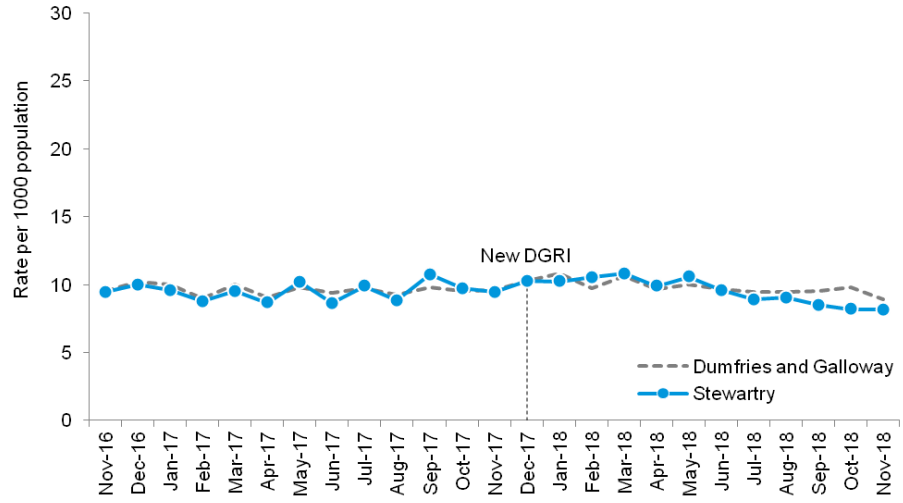
Residents of Stewartry locality,
Rate of emergency hospital admissions per 1,000 population



Source: NSS Discovery, GP Cluster Activity, from Scottish Morbidity Records (SMR01)

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4. Outcome 4

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

4.1 How we support this in our locality

The way that we work with people, designing and delivering their care and support, fundamentally focuses on maintaining quality of life.

In our locality, good examples of this are:

- Allied Health Professional (AHP) programme
- Primary Mental Health Liaison Programme
- Pharmacotherapy in GP surgeries, Social Work and Craignair Practice
- Roll out of MORSE IT System
- Self Directed Support (SDS)

4.2 How we are addressing this outcome in our locality

Our We Will commitments which support this outcome and their current Red, Amber, Green (RAG) status:

17 We will promote the value and embed self-directed support and person-centred care, as it relates to individual outcomes.

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 the skills mix.

20 We will explore different models of care for our 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.

4.2.1 Allied Health Professional (AHP) programme

This improvement programme will focus on the redesign of allied health professional functions in Dumfries and Galloway Health and Social Care including AHPs in hospitals and in the community. The programme is seeking to maximise the contribution that AHPs make to the people's care and support. Extensive scoping and development of 4 framework models took place from March 2018 and November 2018. There was also extensive staff engagement throughout November 2018 to inform the models for the options appraisal.

The non financial benefits appraisal took place in December 2018 and identified the preferred pathway model. Costings will need to be included before it is possible to arrive at the final preferred model, which will be undertaken in early 2019.

Following this, a business case needs to be presented to Health and Social Care Senior Management Team who will take the decision as to whether the proposal can be supported.

Staff feedback included:

- more patient centred
- see the right person at the right time
- promotes integration and team working
- lack of professional voice
- rehab and re-ablement too big a group and needs to be split, unsure how this would work in practice
- everyone is involved and part of it, STARS (Short Term Assessment Re-ablement Service) and all AHPs

All staff feedback and frequently asked questions have been collated and are being used to inform the next stage of the process.

4.2.2 Primary Mental Health Liaison Programme

The pilot project which was delivered in 4 general practices; 2 in Stewartry and 2 in Wigtownshire will now be rolled out across Dumfries and Galloway through the Transforming Primary Care Programme. Stewartry has successfully recruited 2 Primary Mental Health Nurses to cover the 5 general practices.

A pilot project between the Health and Wellbeing Team and Primary Care Mental Health Service will see a Community Link worker aligned to the Primary Care Mental Health Service early next year.

4.2.3 Pharmacotherapy in GP Surgeries

As part of the proposed General Medical Service (GMS) contract, a new pharmacotherapy service will be introduced across all general practices in Scotland. Pharmacists and pharmacy technicians will be required to take on key roles and responsibilities in order to allow GPs to focus on their role as expert medical generalists. It is thought that multi disciplinary team working will improve clinical outcomes, appropriately distribute workload, address GP practice sustainability and support prescribing improvement work.

By April 2021, every practice should benefit from the pharmacotherapy service delivering specified core elements. Additional elements may also be available dependent on the workforce availability.

Within Stewartry there is an ongoing programme of recruitment. One student pharmacy technician will work within both community and prescribing support teams further strengthening the links in primary care. This is a relatively new development within the region where we are ‘growing our own’ staff.

Additional GP clinical pharmacist hours will provide Stewartry with two full time pharmacists who will be based within general practices throughout the locality. In addition, we have a new joint post where a full time foundation clinical pharmacist spends 6 months of the year within our team in primary care and the other 6 months in the acute hospital setting.

The pharmacy team continue to provide input to the two community hospitals helping facilitate discharges and working with people and staff regarding all aspects of medication.

4.2.4 Social Work and Craignair Practice

The pilot between social work services and Craignair Practice has been in place since November 2017. The pilot demonstrated the successful outcomes of having a social worker directly on site at the practice. A social worker is now working in the practice one day every two weeks and discussions are underway to roll this provision out to other general practices across Stewartry.

4.2.5 Roll out of MORSE IT System

MORSE is a paperless system enabling clinicians to securely access all relevant, up to date clinical information using an iPad when in unfamiliar clinics or whilst doing home visits.

Electronic notes are more legible and using a template structure gives consistency to how the information is recorded. Carrying out audits will be made easier because of the way the assessment forms are compiled.

As MORSE can operate as an off line system, having no wifi or a poor wifi signal does not stop clinicians from being able to complete accurate records.

Having the additional ability to upload photographs, such as in monitoring the progress of wound care, is proving very beneficial for clinical and medical staff as a useful aid to show people, Carers or relatives improvement or deterioration.

MORSE will be rolled out during 2019 using a staged approach.

4.2.6 Self Directed Support (SDS)

There is now a robust screening process for all people being referred to adult social care 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.

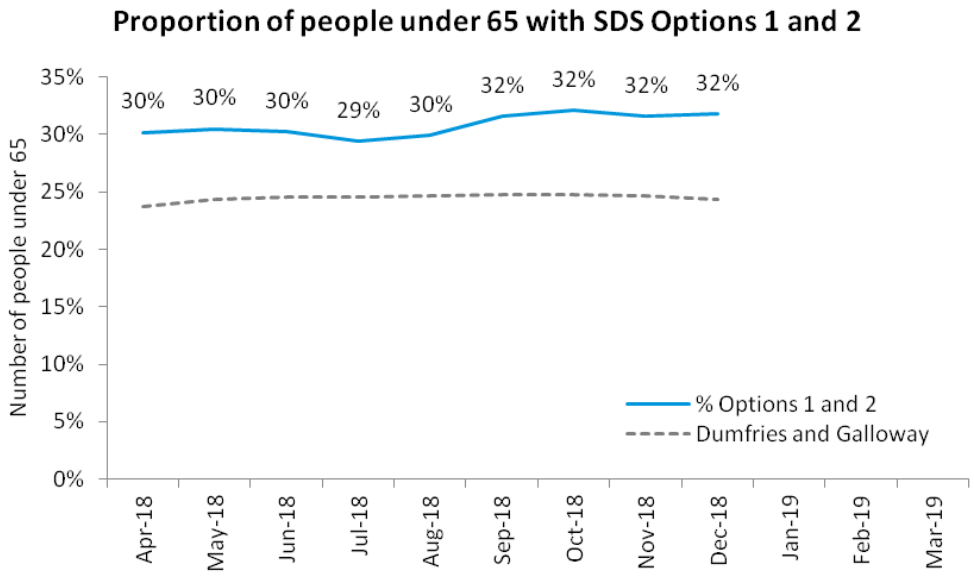
Social work staff promote a personalised approach to social care by providing information about all of the 4 SDS Options. This enables people to make informed choices and take control on how their support will be managed. Training needs with the roll out of the various Options has been met by the self directed support coordinator. This person has offered pop in sessions to adult services Stewartry staff as well as offer joint visits and reviews for people receiving social work support.

There are 2 video clips showing success stories from Stewartry social work team. One is about a young gentleman that accessed SDS Option 1 as part of his transition from children's to adult services and the second a lady who was supported via SDS Option 2. These were shared with elected members in 2018. The videos are available at this link: **https://youtu.be/Hk0cUJlcZUk**

4.3 How we are getting on

The proportion of people in the Stewartry receiving support through Self Directed Support Options 1 or 2, which have the largest levels of personal responsibility, is consistently higher than the regional average. Whilst we support people to have the confidence to choose Options 1 and 2 for themselves, many people continue to prefer to choose Option 3.

Around one third of people aged under 65 have chosen this Option, whilst for people aged 65 or older, it is around a quarter. In December 2018 there were 129 people aged under 65 receiving care through SDS and 272 people aged 65 or older. It is not clear why a higher proportion of people electing for Options 1 and 2 might be higher in the Stewartry.



Source: Dumfries and Galloway Council, local figures

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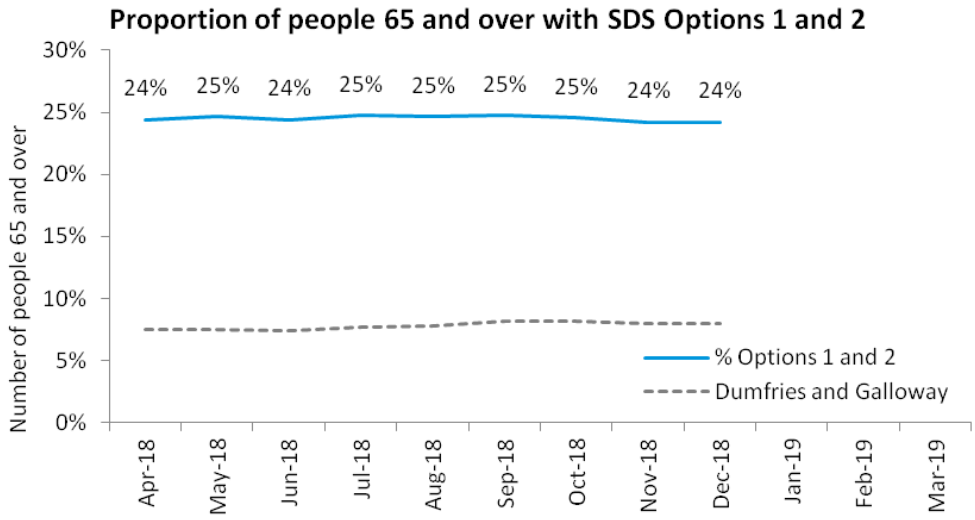

Source: Dumfries and Galloway Council, local figures

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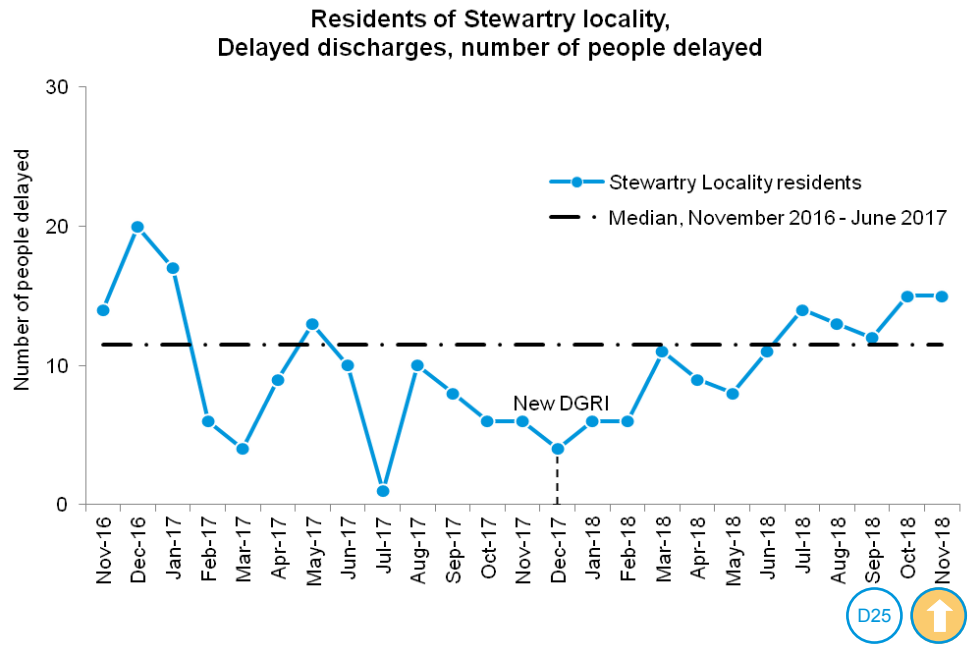
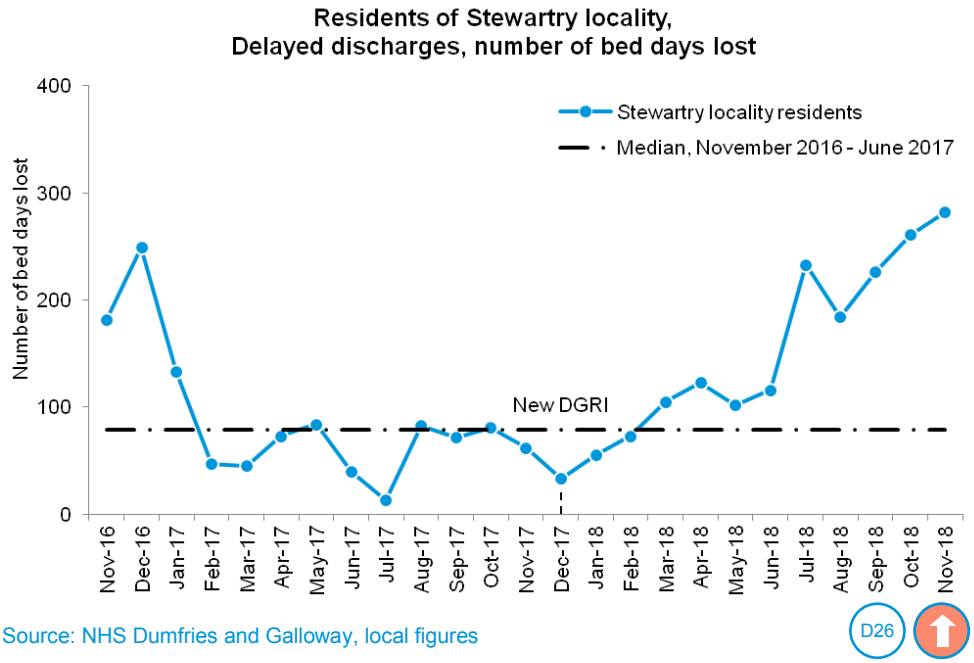
4.3 How we are getting on, continued

One measure of the successful coordination of people's journey of care, is the amount of time spent in hospital settings when people were ready to be discharged to a less acute setting or into the community. When people are not in the most appropriate place for their care we refer to this as a delayed discharge.

In Stewartry, and across Dumfries and Galloway over the last year, the number of people experiencing a delayed discharge (in acute, community or cottage hospital setting) has risen. Reasons for this include recruitment challenges across both health and social care sectors and complex legal arrangements including guardianship. A dedicated flow coordinator works with the multidisciplinary team to enable smooth transitions from one setting to another.





Source: NHS Dumfries and Galloway, local figures

7. Outcome 7

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

7.1 How we support this in our locality

Making sure people are safe from harm is about maintaining safe, high quality care and protecting vulnerable people. In some instances activities focus on protecting people already identified as vulnerable. Other activities are focused on improving the safety of services, aiming to reduce the risk of harm to all people. Examples of this in Stewartry are:

- Care Assurance Audits
- Health and Wellbeing Model
- Adult Support and Protection

7.2 How we are addressing this outcome in our locality

Our We Will commitments which support this outcome and their current Red, Amber, Green (RAG) status:

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. Safe Patient/ Adverse incidents) to reduce unnecessary harm to people.

7.2.1 Care Assurance Audits

Care Assurance audit is a nursing peer review process that also enables people staying in hospital the opportunity to feedback to us their experience of care and suggest potential improvements.

Castle Douglas hospital has been awarded bronze level 3 Care Assurance and Kirkcudbright hospital are working towards bronze level 3. Level 1 audits are completed weekly by a senior charge nurse or a charge nurse. Level 2 Care Assurance is completed monthly by the nurse manager.

So far the care assurance audits have highlighted that patient assessments are always reviewed in good time, feedback given to staff is taken onboard and there is a good standard of documentation.

7.2.2 Health and Wellbeing Model

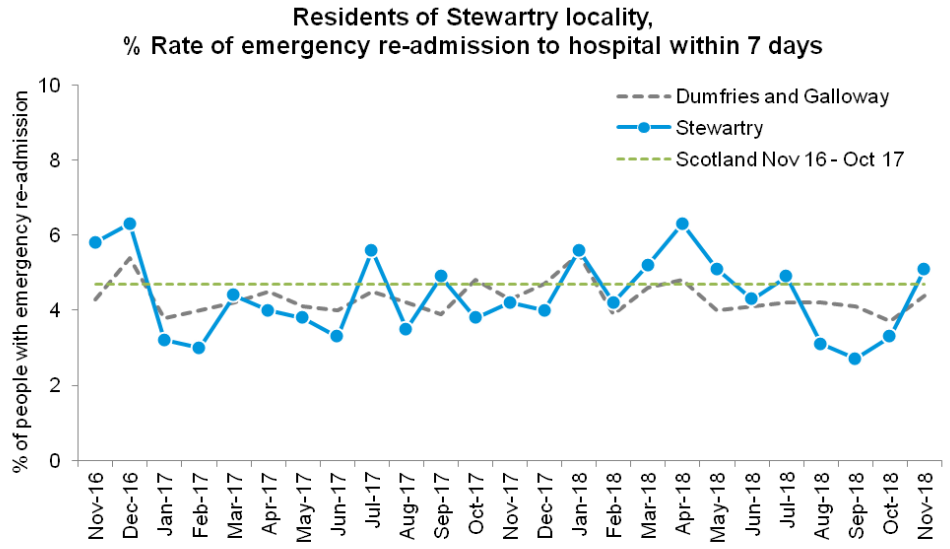
Following the development of the health and wellbeing framework and guidance document to provide consistency to one to one support and group work a training package has been developed. All relevant staff completed the training in 2018. The next stage is the development of a similar framework and structure for community development for health and wellbeing.

7.2.3 Adult Support and Protection (ASP)

An Adult Support and Protection (ASP) plan linked to key partnership services has been developed by the locality social work team. To ensure we continue to develop and improve practice that supports people who are vulnerable and at risk, senior social workers are working closely with regionally trained colleagues. Representatives sit on short life working groups involved in developing a robust ASP risk assessment tool to use when working with people who are at risk.

7.3 How we are getting on

One aspect of keeping people safe is monitoring re-admissions to hospital. Whilst a discharge quickly followed by an emergency admission may be entirely appropriate in many cases, it could mean in some cases that people were discharged before they were ready. Readmission rates are typically below the Scottish rate of 4.7% for both Stewartry and Dumfries and Galloway. The figures for Stewartry residents are more variable, which reflects the smaller number of people involved.



Source: NSS Discovery, GP Cluster Activity, from Scottish Morbidity Records (SMR01)

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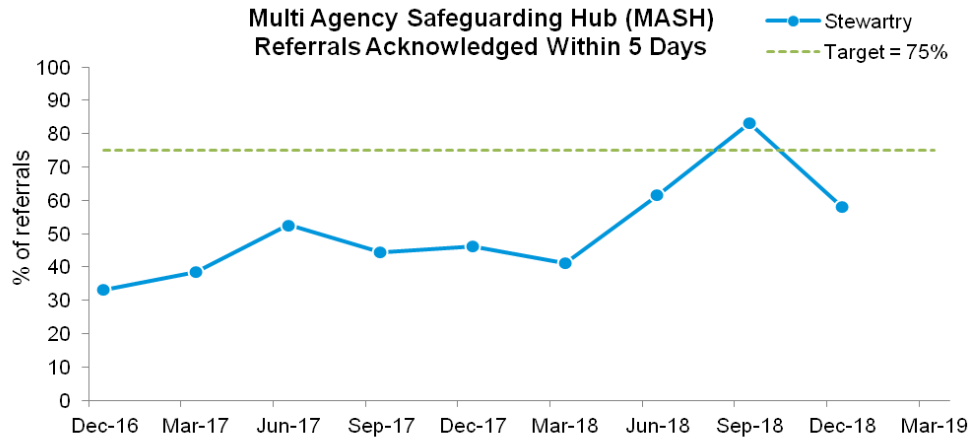
Adult Support and Protection activity is scrutinised through the Public Protection Committee (PPC). The PCC Performance and Quality subcommittee is currently redesigning the analysis and reporting of performance figures for Adult Support and Protection. It is expected that when performance reporting has been agreed, an appropriate locality level measure will be reported here. In the interim, the previous indicator showing the percentage of people making referrals who receive feedback within 5 days of receipt of their referral, was 58.1% in December 2018.



Source: Dumfries and Galloway Council, local figures

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9. Outcome 9

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

9.1 How we support this in our locality

There are various ways that the Partnership is seeking to ensure that resources are used effectively and efficiently. We are improving quality and efficiency by making the best use of technology and trying new ways of working to improve consistency and remove duplication. The Partnership is committed to using its buildings and land in the most efficient and effective way. Examples of this in our locality include:

- Social Work and Care providers working together
- NHS Attend Anywhere
- Just Checking Project
- Prescribing

9.2 How we are addressing this outcome in our locality

Our We Will commitments which support this outcome and their current Red, Amber, Green (RAG) status:

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 wellbeing.

43 We will maximise the use of technology to reduce waste and duplication in the system.

9.2.1 Social Work and Care Providers working together

Local care at home providers and Adult Services Stewartry meet monthly to discuss how they can support one another in collectively addressing unmet care and support need. These meetings are successfully supporting changes to the allocation of social work care packages. This helps address timely reviews for those who need a reduction in their care package and, as a result, this has allowed resources to be reallocated to those who have unmet needs.

A senior social worker has explored different ways resources can be shared, to address the challenges of providing care and support to those in rural areas and for people who have complex needs. They also look at how they can maximise their own resource through sharing training and development opportunities and examples of good practice.

The CM2000 real time monitoring system enables providers to access and offer to pick up support packages in a systematic way. It is intended that this system be extended to providers of services for people aged under 65 in 2019.

9.2.2 Technology/Attend Anywhere

NHS Attend Anywhere is a video conferencing system being introduced across the health and social care partnership. Funding has recently been awarded by the national Technology Enabled Care Programme to support the scale up of NHS Attend Anywhere across Dumfries and Galloway.

This will focus on supporting outpatient appointments and enabling all care homes across the region to be able to access NHS Attend Anywhere. Support to care homes will be offered in the form of equipment, contribution towards connectivity within the home and training for staff to be confident and competent using the NHS Attend Anywhere system.

9.2.3 Just Checking Project

The Keys to Life Strategy highlights that many adults with learning disabilities have limited access to day time activities which can lead to them becoming socially isolated and disconnected from the communities they live in. It is also recognised that adults with learning disabilities have greater health inequalities than the general population.

Historically, services and professionals have been risk averse in the provision of care and support for adults with learning disabilities resulting in a significant number of people accessing overnight support.

In order to improve health and social care outcomes for adults with learning disabilities a pilot project is testing the use of Just Checking's Roaming Night prototype and CM2000 Advanced Risk Modelling for Early Detection (ARMED).

The planning and development phase of the project is complete and implementation of the pilot project will commence in early 2019. The first phase of the test will involve ten service users and three providers (The Richmond Fellowship, Turning Point Scotland and Dunmuir Park).

During the first month of the test we will collect data on sleep patterns and day and night activities while referring the participants to the Stewartry Locality Healthy Connections and social prescribing services for a personal assessment. Data captured during months two and three will inform the redesigning of night support for implementation from month four.

Here is a link to a short film about Just roaming

https://vimeo.com/246992572

Password: roamingnight

9.2.4 Prescribing

Community prescribing plays a large role in the overall expenditure of the Health and Social Care Partnership. Upwards of £32 million is spent each year in Dumfries and Galloway on medication prescribed through GP practices.

The Prescribing Support Team have increased the number of home visit medication reviews that they undertake. Social work has been able to utilise the skills of the pharmacy team by referring people who are struggling with their medicines. Reviews have allowed medication regimes to be simplified, helping people to manage their own medication for longer and level C (Carer's administering medications) has been arranged where other options have been exhausted.

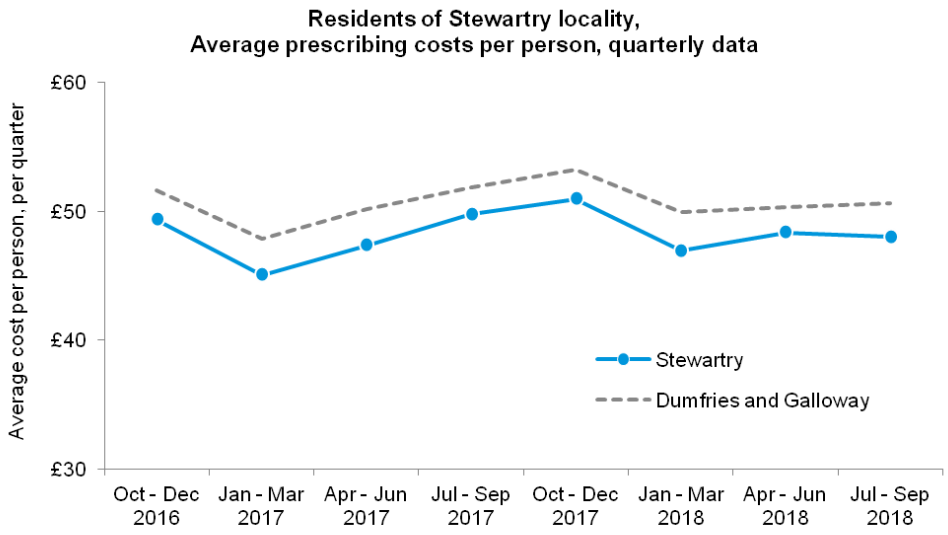
Where persons receiving care have appropriate independence, providers will work with the social work team and pharmacist to highlight opportunities to move from level C medication support to level B.

9.2.5 Podiatry

Podiatry have introduced a telephone self referral process, which has already significantly reduced referrals from GPs. This has reduced the need for input from GPs and reduced unnecessary practice visits for people to access the podiatry service.

9.3 How we are getting on

The Strategic Plan Adults Needs Assessment indicates that over 75% of the population receives a prescription at least once per year. In 2016/17 the annual cost per person ranged from £137 - £277 across the GP practices. This is partly because of the different mix of people they support. Stewartry has a lower cost per person compared to Dumfries and Galloway. The figure for Jul-Sep 2018 is lower than the same period in the previous year.

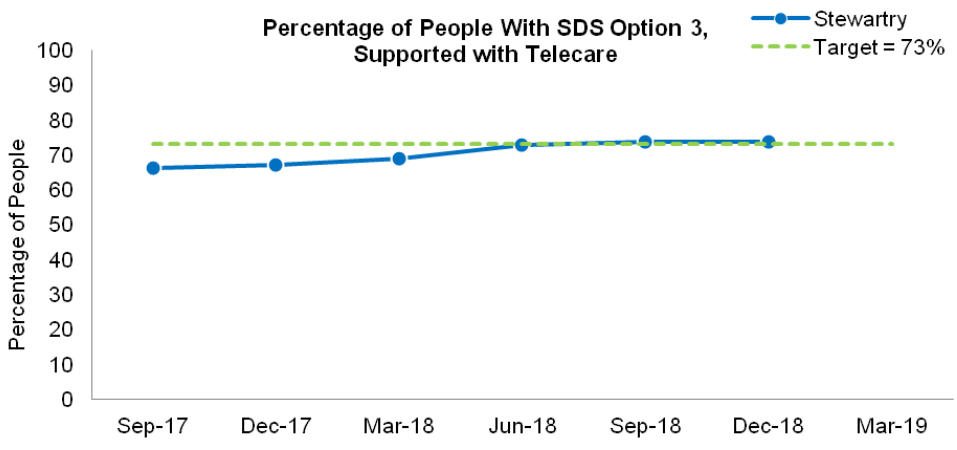


Source: PRISM, LHP Average Prescribing Costs Per 1000 People

D28

Note that these figures are not adjusted for age profile. Also, the cost of medications is strongly influenced by market forces, not just the volume of medication dispensed.

Another measure of efficiency is how effectively the Partnership uses technology to support people, both to live independently and to access services equitably. An indicator is under development to demonstrate how Technology Enabled Care is being rolled out. This will include both the well established Telecare support, and also Home Health Care Monitoring and Virtual Appointments. In the interim, the previous indicator showing the percentage of people with SDS Option 3 supported with Telecare, was 73.6% in December 2018.



Source: Dumfries and Galloway Council, local figures

C1

Appendix 1: Summary of Locality Indicators

Locality Indicator			Previous Value			Current Value		
			Time Period	Dumfries and Galloway	Stewartry	Time Period	Dumfries and Galloway	Stewartry
Outcome 1	D23	Rate of Emergency Department attendance by locality of residence per 1,000 population	Nov 17	24.88	17.08	Nov 18	23.13	17.75
	D24	Rate of emergency admission by locality of residence per 1,000 population	Nov 17	9.63	9.43	Nov 18	8.93	8.16
Outcome 2		Indicator to be reported in next cycle						
Outcome 3		Indicator to be reported in next cycle						

Source: ISD Scotland, HACE Dashboard

We are meeting or exceeding the target or number we compare against

We are within 3% of meeting the target or number we compare against

We are more than 3% away from meeting the target or number we compare against

		Locality Indicator	Previous Value			Current Value		
			Time Period	Dumfries and Galloway	Stewartry	Time Period	Dumfries and Galloway	Stewartry
Outcome 4	C10	Percentage of people supported by SDS Option 1 or Option 2, under 65 years of age	Dec 17	23%	NA	Dec 18	24%	32%
	C11	Percentage of people supported by SDS Option 1 or Option 2, 65 years and older	Dec 17	8%	NA	Dec 18	8%	24%
	D25	Number of people with delayed discharge in all hospitals (Dumfries and Galloway Royal Infirmary, Galloway Community Hospital and Cottage Hospitals) by locality of residence	Nov 17-Oct 17	541	84	Nov 17-Oct 18	652	69
	D26	Number of bed days lost to delayed discharge by locality of residence	Nov 16-Oct 17	12,565	1,102	Nov 17-Oct 18	14,337	1,573
Outcome 5		Indicator to be reported in next cycle						
Outcome 6		Indicator to be reported in next cycle						

Source: ISD Scotland, HACE Dashboard

We are meeting or exceeding the target or number we compare against

We are within 3% of meeting the target or number we compare against

We are more than 3% away from meeting the target or number we compare against

Locality Indicator			Previous Value			Current Value		
			Time Period	Dumfries and Galloway	Stewartry	Time Period	Dumfries and Galloway	Stewartry
Outcome 7	D27	Percentage rate of emergency re-admission to hospital within seven days	Nov 16-Oct 17	4.3%	4.3%	Nov 17-Oct 18	4.3%	4.5%
	C9	Percentage rate of referrals to the Multi Agency Safeguarding Hub (MASH) acknowledged within 5 days	Oct 17 - Dec 17	66.5%	46.2%	Oct 18 - Dec 18	69.0%	58.1%
Outcome 8		Indicator to be reported in next cycle						
Outcome 9	D28	Average prescribing costs per person	Oct 16-Sep 17	£202	£192	Oct 17-Sep 18	£204	£194
	C1	Percentage of People With SDS Option 3,Supported with Telecare	Dec 17	68.6%	67.1%	Dec 18	72.8%	73.6%

Source: ISD Scotland, HACE Dashboard

We are meeting or exceeding the target or number we compare against

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Appendix 2: Glossary of Terms

Allied health professionals (AHPs)
Professionals related to healthcare distinct from nursing and medicine. Examples include podiatrists, physiotherapists, occupational therapists and speech and language therapists.

Anticipatory care / Forward looking care planning
A term used to describe an approach where the actual or potential care and support needs of someone are predicted. By doing this, steps can be taken much earlier to minimise or avoid altogether the impacts of these.

Carer
Someone who provides unpaid care and support to a family member, neighbour or friend.

Combined Assessment Unit (CAU)
A hospital department next to the Emergency Department where people have access to early assessment and diagnostic tests, early senior clinical decision-making and treatment by the multidisciplinary team, before either being admitted to hospital or discharged home.

Community Link Workers
Based in General Practice, Community Link Workers help people to find groups/services to meet their needs and interests, including money and benefit advice, debt management and budgeting, self-help and support activities, Carer support, social and volunteering activities

Locality
The term outlined in the Public Bodies (Joint Working) (Scotland) Act 2014 to identify local areas. Every local authority must define at least 2 localities within its boundaries for the purpose of Locality planning. In Dumfries and Galloway there are 4 localities - Annandale and Eskdale, Nithsdale, Stewartry and Wigtownshire.

Partnership
Health and Social care under the Integrated Joint Authority, encompassing NHS Dumfries and Galloway and Adult Social Care.

Re-ablement
A hands-off approach to care and support that helps people learn or re-learn the skills needed for daily living. A focus on regaining physical ability and re-assessment is central to this way of working.

Social prescribing
Supporting people's health and wellbeing, including their mental health, through non-medical sources of support or resources within their community. Social prescribing is an approach used to support self-management.

Technology enabled care (TEC)
A Scottish Government programme to enable a major roll out of telehealth and telecare in Scotland. Technology Enabled Care (TEC) is the utilisation of a range of digital and mobile technologies to provide health and social care support at a distance.

Telecare
Telecare is the term for offering remote care of elderly and physically less able people, providing the care and reassurance needed to allow them to remain living in their own homes, for example, personal alarms or sensors.

If you would like some help understanding this or need it in another format or language please contact dg.ijbenquiries@nhs.net or telephone 01387 241346