DUMFRIES AND GALLOWAY
INTEGRATION JOINT BOARD

HEALTH AND SOCIAL CARE ANNUAL PERFORMANCE REPORT

DUMFRIES AND GALLOWAY
Health and Social Care

2018/19

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Foreword

Dumfries and Galloway Health and Social Care Partnership (the Partnership) brings together a wide range of people who share the vision of 'supporting our communities to be the best place to live active, safe and healthy lives by promoting independence, choice and control'.

As the new Chair of the Integration Joint Board (IJB), I am pleased to present the third Annual Performance Report for Dumfries and Galloway, completing the first period of relevance of our Strategic Plan. This report enables us all to reflect on the work of the previous year, celebrate the significant progress made, identify what remains areas of challenge for us and consider how we can best work towards fulfilling the ambitions and priorities outlined in our Strategic Plan.

Following a report from Audit Scotland, the IJB undertook to assess how well Dumfries and Galloway were doing in regards to the integration of health and social care (see page 15). Whilst there are some areas of integration that require further work, overall, our Partnership is doing well with some good examples of exemplary practice.

Despite the challenges of recruiting new staff, financial constraints and increasing demand, we managed to deliver a balanced budget in 2018/19 and remain committed to working together as a partnership to meet the challenges we face.

Improving waiting times for people accessing health and care services, and reducing the number of people who are delayed in hospital when their needs could be better met elsewhere, will improve people's overall experience of treatment and care. This is why they will remain key areas of focus for us.

People are being supported by the Partnership to gain confidence and independence and have greater control over their own care through choosing Self Directed Support Option 1.

There is good progress towards transforming primary care services to make them sustainable for the future.

Throughout this report, there are good examples of innovative practice and people telling us their experiences of health and social care. It is only by understanding people's experience of care and support and what matters to them, that we will be able co-create and develop new models of care that will continue to deliver high quality care and support for people in Dumfries and Galloway.

There is much to be proud of in this report and much for us still to do. The IJB recognise the need to provide courageous, innovative and compassionate leadership to successfully take health and social care forward into the future providing people with the best experience of treatment and support possible.

Andy Ferguson
Chair of Dumfries and Galloway Integration Joint Board (IJB)
July 2019

Introduction

This is the third annual performance report of the Dumfries and Galloway Integration Joint Board (IJB) and completes the first 3 year period of relevance of the Strategic Plan.

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 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.

As required by the Act all integration authorities must have a strategic plan. The IJB reviewed the Strategic Plan for Dumfries and Galloway in 2017/18 and decided to retain the current plan, extending the relevant period to April 2021. This plan for the Dumfries and Galloway Health and Social Care Partnership (the Partnership) was developed by consulting with, and listening to, people who use services, their families, Carers, members of the public, people who work in health and social care and third and independent sector partner organisations. It set out the case for change, priority areas of focus, challenges and opportunities and commitments. The Strategic Plan can be accessed on the Partnership's website, www.dghscp.co.uk.

Across Scotland, health and social care partnerships are responsible for delivering a range of nationally agreed outcomes. To ensure that performance is open and accountable, section 42 of the Act obliges partnerships to publish an annual performance report setting out an assessment of performance with regard to the planning and carrying out of the integration functions for which they are responsible.

In this report, we discuss the progress of the Partnership against the 9 national health and wellbeing outcomes and the commitments contained within the Strategic Plan (sections 1 to 9). Section 10 of this report considers the financial performance of the Partnership. The remaining sections report the results of any inspections in 2018/19, any significant decisions made by the IJB and any review of the Strategic Plan. During 2018/19 the IJB agreed changes to the performance framework to ensure that the framework continues to reflect our outcomes and commitments. (Appendix 1 includes a summary of the 23 National Core Indicators for Integration.)

Public Bodies (Joint Working) (Scotland) Act 2014
www.legislation.gov.uk/asp/2014/9/contents/enacted (last access 8 May 2019)

Strategic Plan 2018- 2021
dghscp.co.uk/wp-content/uploads/2018/12/Strategic-Plan-2018-2021.pdf (last accessed 20 June 2019)

Dumfries and Galloway Health and Social Care Performance Reports
www.dghscp.co.uk/performance-and-data/our-performance (last accessed 8 May 2019)

The 4 localities in Dumfries and Galloway defined in the Health and Social Care Partnership follow traditional boundaries of Annandale and Eskdale, Nithsdale, Stewartry and Wigtownshire. This report includes sections looking at what is happening in each locality and good examples of locality initiatives are included throughout the report.

In accordance with the Scheme of Integration, localities report every 6 months to their Local Authority Area Committee in relation to the delivery of their Locality Plan. In addition interim reports are produced for the IJB to discuss ongoing progress. These reports are published through the year on the Partnership's website (here).

How we are getting on: The symbols we use

Next to each infographic in this report there are 2 circles, like this: A1

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 DG Change website (www.dg-change.org.uk/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 suggest the number has increased over time
- Statistical tests suggest there is no change over time
- Statistical tests suggest 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 delivering services in the Health and Social Care Partnership and are the benchmark against which progress is measured.

1. Outcome 1

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

Early intervention and prevention are key to enabling people to maintain good health and wellbeing and in supporting people to manage existing long term conditions.

There is a wide range of initiatives across the Partnership intended to help people improve their own health and wellbeing. These initiatives aim to bring a holistic approach to improving wellbeing, supporting people to improve many aspects of their lifestyles and building their level of personal resilience.

Our commitments:

- We will support more people to be able to manage their own conditions, and their health and wellbeing generally
- We will support people to lead healthier lives
- We will develop, as part of a Scottish Government initiative, online access to information and tools to give people the power to take responsibility for their own care

Key Messages

- The social prescribing approach to health and wellbeing has been embraced across Dumfries and Galloway.
- The CoH-Sync project is now being delivered in Nithsdale and Wigtownshire.
- Teams across Dumfries and Galloway are supporting communities to make them the best place to live active, safe and healthy lives.

1.1 Supporting people in their communities

1.1.1 Social prescribing

Social prescribing is an approach that aims to enable people to improve their wellbeing. This may be achieved by linking people to various activities and organisations in their community. These activities can be either on an individual or a group basis. This approach can include financial advice, social support and physical activities. Social prescribing is focused on those in most need as a result of loneliness, isolation, stress or living with a long term condition.

Social prescribing supports people to access third sector organisations and opportunities they may not have previously known about. For example, in Nithsdale, the Healthy Connections team have introduced people to over 90 different third sector organisations.

Mr G lives with cerebral palsy and relies on a wheelchair to get around. Mr G felt that social opportunities were limited. However, since his contact with Healthy Connections he has started volunteering 2 days a week at The Usual Place and his confidence and self esteem have greatly increased.

A regional strategic framework has been developed to provide an overview for social prescribing. This framework sets out common standards for delivering this service across Dumfries and Galloway. Social prescribing is delivered through Healthy Connections and Community Link Teams. Following successful testing, a core data set for public health practitioners will be rolled out during 2019/20. This will help us to understand how social prescribing is supporting people's health and wellbeing.

Good practice and innovation: Stewartry Rugby Club

Stewartry Health and Wellbeing Team are working with 12 members of their local rugby club to trial a sports training app. The app records aspects of wellbeing including levels of tiredness, mood, muscle fatigue and sleep patterns. The team coach is using this information to inform the training programme and reduce potentially negative issues.

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.

1.1.2 Community Health Synchronisation (CoH-Sync) project

Early recognition and prevention of long term conditions reduces the number of GP visits people make and hospital admissions. This cross border programme, involving the Republic of Ireland, Northern Ireland and Dumfries and Galloway, started in August 2018. It aims to promote healthier lifestyles and focuses on the risk factors associated with long term conditions. This includes physical activity, nutrition, smoking, alcohol misuse and mental health resilience. The project is being delivered in Nithsdale and Wigtownshire. People are supported, in a person centred way, to develop health and wellbeing plans.

In 2018, **645 health and wellbeing plans** were developed with people who live and work in Dumfries and Galloway

CoH-Sync is funded by the European Union INTERREG VA Programme and managed by the Special EU Programmes Body. The project will run until December 2021 and aims to deliver 2,500 health and wellbeing plans to people across Dumfries and Galloway. This amounts to approximately 3% of the population age 18 years or older.

1.1.3 Supporting expectant mums

Maternity Notes is a new IT system that enables expectant mums to access, in real time, their maternity records using their smartphone, tablet or home computer. Expectant mums can also use the system to create birth plans, access information and provide feedback to maternity services. All information is held securely and cannot be accessed without appropriate login details (similar to internet banking). Since its launch, 90% of expectant mums from Dumfries and Galloway have used this system.

1.1.4 Falls prevention

Falls and falls related injuries are a common and serious problem for older people. It is estimated that 30% of people aged 65 and over and 50% of people over 80 fall at least once a year. Falls can cause distress, pain, injury, loss of confidence, loss of independence or loss of life.

During 2018/19 we have been working:

- to improve access across Dumfries and Galloway to physical activity classes that promote strength and balance
- with the Scottish Ambulance Service to prevent unnecessary visits to the emergency department following a fall by creating links with local multidisciplinary teams
- with Loreburn Housing at Giffhorn House to test using Advanced Risk Modelling for Early Detection (ARMED) which uses wearable technology to predict when someone is at risk of falling. 34 people have used this technology during 2018/19. In the 6 months before people started using ARMED there were 8 falls. Since people have started using ARMED there have been no falls. (We are exploring how this technology could be used with other vulnerable people such as those with learning disabilities.)

How we are getting on: Falls

There has been no real change for Dumfries and Galloway since 2018/19 when the rate was 19.

Hospital admission for falls per 1,000 population aged 65 and over in Dumfries and Galloway in 2018/19

17 (p)

A16

Source: ISD Scotland (2019)
(p) provisional result

Good practice and innovation: Pain Association Scotland App

The Partnership has supported the Pain Association Scotland to work in collaboration with computing science students from the University of Glasgow to produce a new mobile app. This app has been designed to help people manage chronic pain by:

- using a daily tracker to identify pain triggers and monitor mood
- providing daily reminders and alerts for exercise and medication
- providing easy access to the association's self management videos
- noting discussion points for people's next outpatient appointment
- providing details of the nearest association group

The app has been specifically developed with people who have chronic pain to design features that are most important to them.

1.1.5 Alcohol and Drug Partnership

The Alcohol and Drug Partnership (ADP) works with third sector organisations and the NHS Specialist Drug and Alcohol Service to provide a range of prevention, support and recovery services for people with alcohol and drug problems. They also work with organisations providing support for people affected by the alcohol and drug use of others.

Reducing drug deaths is a key priority for the ADP. The number of drug deaths across Dumfries and Galloway has risen from 17 in 2017 to 22 in 2018. During 2018/19 over 90% of people who accessed treatment and support for drug and alcohol problems waited less than 3 weeks for their treatment to start. The ADP has worked with people at risk of overdose and their families to improve their awareness and to distribute Naloxone kits. Naloxone kits are a safety precaution and contain emergency medication to be used when someone experiences an opioid overdose.

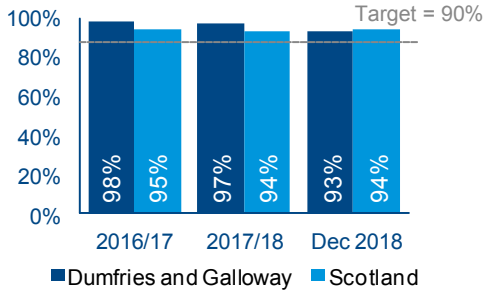
The ADP supports teams to use the Alcohol Brief Intervention (ABI) framework when they discuss alcohol consumption with people. However capturing the number of ABIs delivered each year continues to be challenging.

As a safety precaution, between April and December 2018, **233 Naloxone kits** were distributed.

This is more than for the same period in 2017 when 160 kits were distributed.

How we are getting on: Alcohol and Drug Partnership

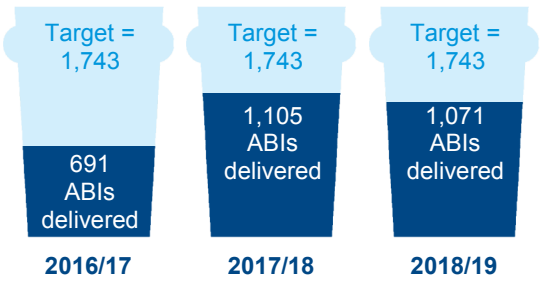
At the end of December 2018, **93%** of people waited no longer than 3 weeks from when a referral is received to when they receive appropriate drug or alcohol treatment that supports their recovery.



Dumfries and Galloway's performance has declined slightly over the last 3 years however, it is still above the national target of 90%.

B14 Source: ISD Scotland

1,071 Alcohol Brief Interventions (ABIs) were reported across Dumfries and Galloway in 2018/19. This was 61% of the annual target of 1,743.



There were 34 fewer ABIs reported across Dumfries and Galloway in 2018/19 compared to the year before. New reporting processes should make the data more complete in the future.

B15 Source: Alcohol and Drug Partnership, Dumfries and Galloway

1.2 Supporting communities

A key priority for the Partnership is to support communities to help themselves to improve their health and wellbeing. Teams across Dumfries and Galloway are working with different communities in different ways to support them to make their community the best place to live active, safe and healthy lives.

- In Annandale and Eskdale, a local activity guide is produced regularly through the Safe and Healthy Action Partnership (SHAP). This guide has information about the wide range of support, activities and opportunities available across the locality.
- In Nithsdale, teams are in the early stages of planning to ask people from North West Dumfries about producing a community development plan. This is an exciting opportunity to work together to support the community to identify ways they can improve health and wellbeing.
- In response to community engagement activity, a number of organisations, including Stewartry Locality Team, is working with a number of organisations to form a Social Isolation Partnership. Members include Dumfries and Galloway Council, Visibility Scotland, Better Lives Partnership, Castle Douglas IT Centre, Third Sector Dumfries and Galloway and Galloway Glens Landscape Partnership. The group is working to raise awareness of the causes of, and ways to reduce, social isolation.
- In Wigtownshire, teams are working in partnership to deliver the Macmillan Cancer Support Move More Programme. Volunteers have been trained to deliver this physical activity programme. A number of groups have been established across the locality and they have been very popular. Consequently work is underway to set up more opportunities for people to take part in 2019.

"It's keeping us physically healthy, but also it's a social group and it takes you away from the day to day stress we experience "

Good practice and innovation: Stranraer Armed Forces and Veterans Breakfast Club

An armed forces and veterans breakfast club has been established in Stranraer and now has more than 25 members. The club supports service personnel ranging in age from 25 to 90 years old. Its aim is to combat isolation and loneliness in a social setting. The club provides a place where former service personnel have an open door to chat, gain guidance, and support each other.

Since its development, the club has helped soldiers sleeping rough to access permanent accommodation and supported the families of former soldiers with their caring role. The group are registered on the National Armed Forces Breakfast Club Network and promote their activities through social media.

"Thank you for supporting my dad attending the Breakfast Club. He was getting so lonely and isolated. It has given him a new lease in life. We have seen such a change in him."

"If it was not for the Breakfast Club, I don't know where I would be. They have supported me putting a roof over my head and the comradeship and support has really helped us."

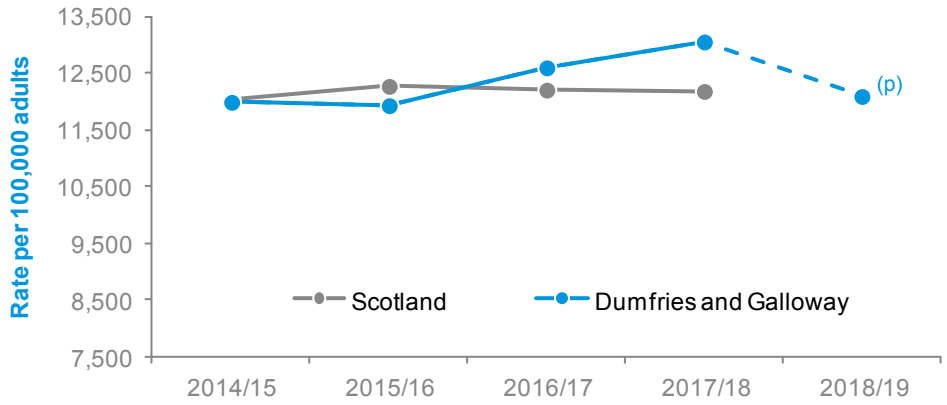
How we are getting on: Emergency Admissions

An important measure of how well people are able to manage their health and wellbeing in the community is how often their health care 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.

Provisional figures for 2018/19 show that for every 100,000 adults in Dumfries and Galloway there were 12,103 emergency admissions amounting to 127,272 bed days.

A12 A13

Rate of Emergency Admissions amongst adults



Source: ISD Scotland (p) = provisional result

Spotlight on
Integration Joint Board (IJB)

In November 2018, Audit Scotland published the report Health and Social Care Integration: Update on Progress. This highlighted the welcome improvements Integration Authorities have delivered. It also acknowledged the extremely challenging environment partnerships are operating within and the significant barriers that must be overcome to speed up change.

In February 2019, the Ministerial Strategic Group for Health and Community Care (MSG) issued a response to the Audit Scotland report. The MSG recognised the good practice developing both in terms of how IJBs are operating, and in how services are being planned and delivered to provide better outcomes.

Integration Authorities were asked to reflect on how integration was being established across 22 proposals. A self assessment exercise was undertaken to discuss current performance against the areas of practice, the evidence and potential improvement actions for the future. Proposed improvement actions have been set out against each proposal.

The overall assessment, showing the number of proposals scored as Not Yet Established, Partly Established, Established or Exemplary is shown below.

Aspect of Integration	Not Yet Established	Partly Established	Established	Exemplary
Collaborative leadership and building relationships	0	1	2	0
Integrated finances and financial planning	0	1	4	1
Effective strategic planning for improvement	0	0	2	1
Governance and accountability arrangements	0	2	3	0
Ability and willingness to share information	0	0	1	1
Meaningful and sustained engagement	0	3	0	0
All Features	**0**	**7**	**12**	**3**

Particular areas the IJB plans to work on include:

- clarifying the governance arrangements of the IJB
- developing relationships with the third and independent sectors
- reviewing the role of the Strategic Planning Group
- developing and enhancing communication and engagement skills across the Partnership

Audit Scotland; Health and Social Care Integration: Update on Progress
www.audit-scotland.gov.uk/uploads/docs/report/2018/nr_181115_health_socialcare_update.pdf

Ministerial Strategic Group; Review of Progress with Integration of Health and Social Care
www.gov.scot/publications/ministerial-strategic-group-health-community-care-review-progress-integration-health-social-care-final-report/

A programme of transformation in primary care

A transformation is currently underway within primary care in Dumfries and Galloway as a result of a new national contract for GPs.

Paramedics, pharmacists and mental health professionals are among the first to take on new responsibilities. This is part of a 3 year programme to implement the General Medical Services contract developed by the Scottish Government and the British Medical Association and agreed in January 2018. The contract moves responsibilities for delivering services such as blood tests, repeat prescriptions and dealing with minor ailments to Dumfries and Galloway Health and Social Care Partnership.

Here are some of the ways primary care services are being transformed:

- Clinical pharmacists already had a more developed role within GP practices. This is now being further developed as they meet people and provide expert consultation on medication.
- Paramedics are starting to play a key role in providing home visits. A 6 month trial supporting some GP practices is currently underway in Wigtownshire.
- Following a successful pilot, mental health professionals are now set to become a regular feature in GP practices. They will deliver support, early help and intervention. This includes Children and Adolescent Mental Health Services (CAMHS).
- The role of Advanced Nurse Practitioners (ANPs) is being developed to support the sustainability of primary care services.

The transformation in primary care will give GPs more time to focus on working with people in their expert role whilst keeping oversight of people's clinical care. People will benefit from this new way of working by seeing the most appropriate professional in a timely manner.

Social work services have been working with Craignair GP practice in Dalbeattie. Following a successful pilot in November 2017, a social worker is now working in the practice one day every 2 weeks. Discussions are underway to roll this provision out to other general practices across Stewartry.

During the pilot, children and young people who were seen by the CAMHS mental health worker at their GP practice, on average, waited 3 weeks (target: 18 weeks)

The Nithsdale Healthy Connections team offer Healthy Weight sessions at 6 GP practices. These sessions focus on achieving and maintaining a healthy weight to help prevent type 2 diabetes, heart disease and depression.

Videos exploring the transformations in primary care can be found at this YouTube channel: www.youtube.com/user/DGNHS

What people tell us:

Clinical Pharmacy

Hannah Brawley is a Clinical Pharmacist working across 3 GP practices. Here is what Hannah told us about her work:

"Pharmacists coming into GP practices is a relatively new thing. Looking forward to the new GP contract we'll see more and more pharmacists being linked to general practice, as well as working in the community. It allows people to speak to somebody more specialised in a certain area. If it's more of a medication query, it allows us to do more in depth reviews with people. So it does really help with general prescribing and safety around prescribing as well. As people see pharmacists in the surgery more, we're really hoping that people can see the benefits of the range of services that pharmacists can offer in GP practices.

It's been a really positive experience so far and I feel I've been really welcomed by all members of staff in the surgeries and all the patients."

Mental Health

Justina Ritchie is Service Manager for Community Mental Health Nursing. Here is what she said about mental health professionals working with GP practices:

"The pilot has been really successful. We have had really good outcomes for people and good feedback from GPs. The pilot has been shown to save GP time and people are now being seen quicker by a mental health professional based within the practice. The plan is now to roll this model out across the region.

This approach is freeing up GP time. People are being seen quickly. Short term interventions have been put in place to enable them to self manage, and the outcomes for them have been really positive."

Paramedic Home Visits

Dr Charlie Dunnett is a GP at Galloway Hills Medical Group and Kenny McFadzean is Head of Ambulance Services for Dumfries and Galloway:

Charlie

"This is a 6 month pilot project where we are using the skills that paramedics have to help the practice with home visits. The premise is to determine whether or not it's a good model of care, making use of paramedics' skills in assessing people in their own home. Paramedics will be working alongside, and under the supervision, of the general practitioners. When the house call request comes in, the GP will decide if that's an appropriate house call for the paramedic.

Kenny

"This is a great opportunity for paramedics to expand their skill base and work closely with general practitioners and use the skills that they already have to deliver with urgent and emergency patients in their home to the benefit of local practices."

2. Outcome 2

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

In the future, people's care needs will be increasingly met in the home or in a homely setting in the community. Therefore the way that care and support services are planned and delivered needs to reflect this shift.

There are a number of ways that the Partnership is working towards enabling people to live as independently as possible in a homely setting. During the financial year 2018/19, work concentrated largely on 5 main areas of development: co-production, using technology at home, volunteering, care at home and care homes, and housing. We recognise that maintaining good outcomes also requires an increased focus on maximising opportunities for people to live active, safe and healthy lives. (See Outcome 7 for Telecare and Outcome 9 for Technology Enabled Care).

Key Messages

- The Partnership is developing its use of co-production to design care and support with people.
- We are starting to use technology, such as Home and Mobile Health Monitoring, to support people to live at home as independently as possible.
- Recruitment and retention of care and support staff is both a local and national challenge due to competing job opportunities and fewer working age people.

2.1 Involving people

Our commitments:

- We will actively promote, develop and support volunteering opportunities
- We will strengthen public involvement at all levels of planning health and social care and support

During 2018/19, the Partnership has focused on developing an approach to involve people in designing services called co-production. Co-production is...

> "when people with different interests come together to create change as a group."

It is extremely important that we work together with people who use services, Carers, staff, volunteers, service providers and other stakeholders. Communities from across Dumfries and Galloway have been working together with health and social care professionals and service providers to transform health and social care. A local example of co-production that is well established is the Transforming Wigtownshire Programme. During 2018, the IJB established several co-production workshops. These workshops aimed to support staff across the Partnership to understand co-production as an approach and to identify opportunities to co-design, co-create, co-deliver and co-assess care and support.

Good practice and innovation: Transforming Wigtownshire

The Transforming Wigtownshire Programme has been established to review and redesign safe, sustainable services in a co-productive way.

The aims of Transforming Wigtownshire are to:

- work in partnership with the local community and stakeholders to co-produce the review and design of health and social care in Wigtownshire, including Galloway Community Hospital
- work with communities to enable them to make Wigtownshire a healthier place to live now and in the future
- develop a model of sustainable, safe and effective health and social care that meets the needs of the local community

Since June 2018 the Independent Chair and Project Manager have attended Community Council meetings across Wigtownshire. Engagement with the local community has included attending the Stranraer and Wigtownshire agricultural shows, attending the Scottish Women's Institute (SWI) and holding 2 public meetings. Staff meetings have taken place to explain the aims of the project and to engage staff in the process. The team has also met with third sector partners, the local MP, MSPs, elected members and local influencers. The response has been positive. A greater understanding is developing that services are under increasing pressure and that we cannot continue to deliver care and support in the same way. There is also an increased awareness that difficult decisions will have to be taken as the programme progresses.

Transforming Wigtownshire asked people 'What Matters To You?'

The 3 things that mattered most were

- mental wellbeing
- physical wellbeing
- communication and education relating to health and social care.

2.2 Supporting people to stay at home

Our commitments:

- We will work to identify people who have an increased risk of reaching crisis and take early steps to avoid this
- We will work with people to identify and make best use of assets to build community strength and resilience

Supporting people to be independent involves a wide range of activities and services. Many of these are provided by third sector organisations. By identifying third sector led opportunities for early intervention, people can be supported before more intensive care at home is are needed. Many third sector organisations depend on the support of volunteers to support people at home. Volunteering makes the best use of people's interests and skills to support our communities and sustaining the health and wellbeing of the volunteer.

DRAFT

Food Train is a third sector organisation that supports people through services including grocery delivery, home support, meal share and befriending. This helps people to live independently in their own homes and in their own communities. During 2018/19 Food Train made over 14,000 shopping deliveries, carried out over 700 small support tasks and spent over 6,500 hours supporting people through their befriending service. Half of people who use this service are aged 85 or older and the majority are living on their own.

"I would be totally lost without the help of Food Train, I feel very lucky to have this support"

2.3 Home and Mobile Health Monitoring (HMHM)

HMHM is the use of mobile technology to enable people to receive, record and share relevant information about their health and wellbeing. It is used by people and professionals to:

- inform or guide self management
- support treatment
- support decision-making

'Florence' text messaging service and 'My Diabetes My Way' are examples of HMHM being used locally.

What people tell us: Daphne's story

Daphne has lived in Newton Stewart for 51 years. After a relative raised some concerns about her memory, Daphne started to use 'Florence' for medication reminders:

"I don't know who suggested this, how it came about, but it may have been the doctor, I'm not sure, but I was very happy with it. I think I had missed it, missed taking medication. Florence is a voice on the phone, no not a voice, it's just text. And it's always very, it's just like a friend really: 'Hello this is Florence, hope you're having a nice day. Please remember to take your medication'. The phone rings and I pick it up and the message that usually comes through is displayed as text, just a few lines, a sentence or so. Yes it's definitely helped me, it's just a phone call, it's just to remind you."

2.4 Housing

Our commitments:

- We will combine the information from the Housing Need and Demand Assessment (HNDA) with the Strategic Needs Assessment (SNA) to help us with planning **(Completed)**
- We will develop housing related services and new affordable housing that is designed to reduce both unplanned admissions to hospital and the number of people unnecessarily delayed in hospital

DRAFT

Good quality housing is fundamental for a person's health and wellbeing. The Partnership is working closely with colleagues in the housing sector to develop supportive models of housing. Under the Healthy Ageing Programme Board, the Particular Needs Housing Strategy Group is working to:

- create and develop a Care and Support Needs Housing Strategy by July 2019
- provide a platform for strategic discussion and decision making
- make recommendations on proposed and prioritised new housing with care and support projects
- work with the localities to identify and develop proposals for housing with care or support needs across the region

In Annan, a new supported housing project is currently being developed for people with learning disabilities.

2.5 Re-ablement

Our commitments:

- We will adopt re-ablement as both a first approach and as an ongoing model of care and support
- We will deliver healthcare in community settings as the norm and only deliver it within the district general hospital when clinically necessary

Re-ablement means supporting people to adapt to their disability or long term condition, including frailty, to achieve their best possible level of independence. The multi professional Short Term Assessment Re-ablement Service (STARS) works with people to identify what matters to them and the goals they want to achieve to experience independence.

Community adult general nursing and cottage hospital staff have been provided with re-ablement training in order to shift the focus of support from care to reablement and where practicable, enabling people to live as independently as possible.

1,274 people were referred to STARS for support in 2018/19. This is an **increase of 24%** since 2017/18 when 1,028 people were referred.

63% of people who completed the STARS intervention achieved **complete independence at home** during 2018/19.

What people tell us: A Care Opinion story about STARS

"Provided with assistance visits morning and evening. This service is second to none - exceptional. The keynote is unobtrusive support provided with patience and kindness to enable independent living. Gentle encouragement to do what one can do for one's self helps to make progress towards recovery.

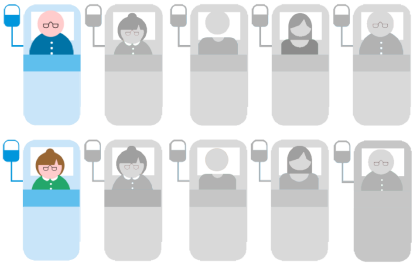
Practitioners are scrupulous in ensuring dignity is maintained while providing support.

No praise is high enough for the exceptional people who provide this service - I am truly grateful."

Day of Care Survey

Every month an assessment called a Day of Care Survey is done across our hospitals. This assessment uses a set of criteria to determine if people are being cared for and supported in the most appropriate setting. The criteria are different for acute and cottage hospitals. Here is what the assessment told us in March 2019:

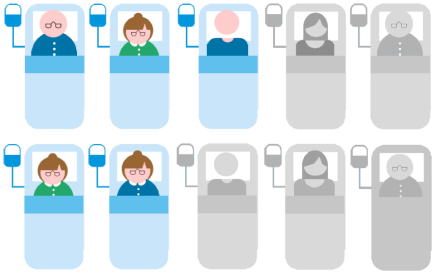
Dumfries and Galloway Royal Infirmary



2 in 10 people in an acute hospital could have been supported in a more appropriate setting.

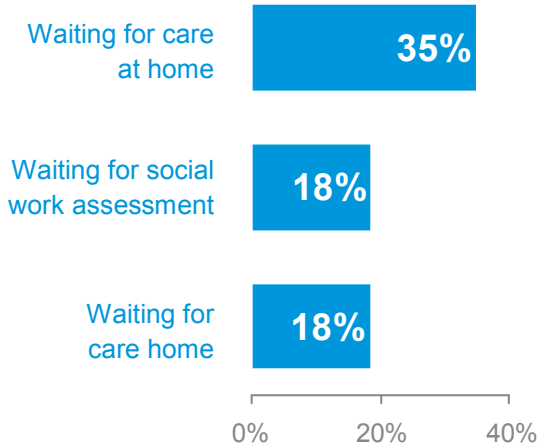
Top 3 reasons for not meeting the acute hospital criteria:

8 Cottage Hospitals*



5 in 10 people in a cottage hospital could have been supported in a more appropriate setting.

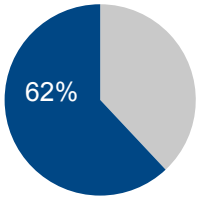
Top 3 reasons for not meeting the cottage hospital criteria:



Source: Dumfries and Galloway Health and Social Care Partnership
*Includes Annan Hospital, Castle Douglas Hospital, Kirkcudbright Hospital, Lochmaben Hospital, Moffat Hospital, Netwon Stewart Hospital, Thomas Hope Hospital and Thornhill Hospital.

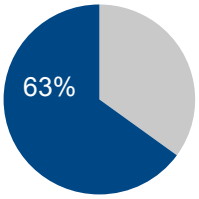
People supported at home

Dumfries and Galloway 2018



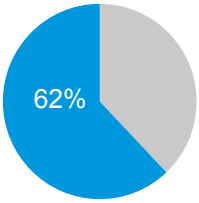
62% of adults with long term care needs receive care at home.

Dumfries and Galloway 2017



This proportion has not changed across Dumfries and Galloway since 2016.

Scotland 2018



Dumfries and Galloway supports the same proportion of people with long term care needs at home compared to Scotland overall.

A18 Source: ISD Scotland, Social Care Statistics

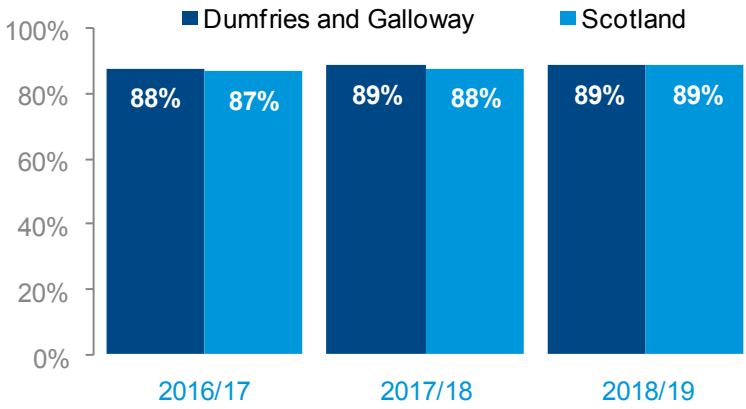
On average, during the last six months of life, people spend

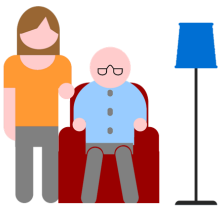
89%

of their time at home or in a homely setting.

A15 E5

Source: ISD Scotland





568

The number of homecare hours provided per 1,000 people aged 65 or older in March 2019 (compared to 635 in March 2018).

C8 Source: Dumfries and Galloway Council (March 2018)

The Scottish Government are currently looking at ways for Integration Authorities to monitor how many people are discharged from a hospital directly to a care home (Indicator A21).

2.6 Care and support at home

Our commitments:

- We will work with providers to support them to pay the national living wage
- We will identify with partners and people who use services, models of care at home and care home provision that deliver improved outcomes for people

Delivering care and support at home or in a homely setting is critically important to help people achieve their best possible outcomes and ensure that care continues to be delivered in the right place at the right time. This support is provided through a contract framework agreement for the delivery of care and support at home and is mainly provided by third and independent sector organisations. Approximately 20% of care and support is delivered by the Partnership's Care and Support Services (CASS).

We work with care and support at home providers to ensure that pay rates are maintained at the Scottish Living Wage (SLW) for people aged 25 and over. However, as the SLW has increased, providers are experiencing higher overall running costs. Whilst third sector providers have managed to pay the SLW to front line staff, some have not been able to provide similar increases to other members of staff. This has impacted upon their ability to recruit and retain staff.

Recruitment and retention of care and support staff is a national challenge. However, there are additional challenges for those living within remote parts of the region in accessing care and support at home. These include increased financial costs of delivering support, and a smaller staffing resource available in rural areas. This can have an effect on how quickly people who are ready to be discharged from hospital are able to return to a homely setting.

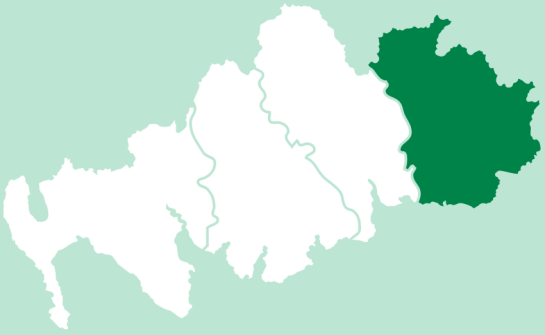
A multi stakeholder Care at Home subgroup has been set up to consider the challenges and opportunities in the delivery of care and support at home in future. This group will report to the Healthy Ageing Programme Board who, in turn, will shape the strategic direction of travel.

Localities have introduced regular meetings with providers operating in their areas to consider how social care capacity can be maximised. This has seen providers working together in a more collaborative way, coordinating existing care packages, and creating opportunities to support people newly requiring assistance at home.

The Partnership recognises the variation in the rates paid to providers across Scotland. The new contract framework will be developed co-productively with providers.

Spotlight on

Annandale and Eskdale



There is a lot going on in Annandale and Eskdale, lots of challenges and lots of great ideas and new initiatives. Staff and volunteers from all parts of the Health and Social Care Partnership are working together as one team with local people, their families and Carers to help deliver the 9 national health and wellbeing outcomes.

Last winter, freezing snow presented a major challenge in protecting the most vulnerable members of the community. However, local people pulled together as one team, talked to each other and creatively used shared community resources. Together we were able to protect vulnerable people from harm and help people maintain their quality of life.

Good Conversations are a way of encouraging and supporting people to take control and responsibility and to openly discuss their options and wishes at all stages of their lives. Annandale and Eskdale is supporting the workforce, across the sectors, to have different and consistent conversations with people who use services. Teams have also undertaken one to one health and wellbeing behaviour change training. A recent celebration event focused on ensuring staff felt confident and supported in having these conversations with people, particularly those nearing the end of life so that their wishes are known, recorded and acted upon.

Recruiting staff in health and social care continues to be a challenge, particularly in the more rural areas. Annandale and Eskdale continue to work with local providers to support existing staff and help attract and recruit new staff to meet the needs of local people.

The locality team is aware that there is more to be done including:

- transforming primary care services
- reducing delays in discharging people from hospital
- developing learning disability services
- using new technology more effectively

3. Outcome 3

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

There is a range of ways that people are able to give feedback about their experiences of health and social care. Feedback may come in the form of comments, public engagement, consultations and complaints.

The Partnership uses this feedback to continually improve services and help those providing health and social care to understand and respect the views of the people they support.

A critical part of ensuring that services are person centred and respect dignity is planning a person's health and social care to identify what matters to them, their family and Carers.

Our commitments:

- We will use feedback from people to develop new approaches to delivering outcomes
- We will work to overcome barriers to people being involved in their own care
- We will make sure that people have access to independent advocacy if they want or need help to express their views and preferences
- We will make sure that effective and sustainable models of care are tested and implemented prior to transition from the current DGRI to the new district general hospital **(Completed)**

Key messages

- The IJB approved a new Independent Advocacy Plan in November 2018.
- More people are sharing their experiences with us and we are improving how we share the learning from these stories.
- We are improving how we work with the communities we serve through better use of public engagement.

3.1 Advocacy

Independent Advocacy supports people to have their voices heard and their rights and interests protected. Within health and social care this means ensuring that people have a strong voice and as much control over their own health and wellbeing as possible.

A new Independent Advocacy Plan for 2018 - 2021 was approved by the IJB in November 2018. This is a requirement by the Mental Welfare Commission to support the discharge of the Mental Health Care and Treatment (Scotland) Act 2003 (updated in 2015). Hospital staff have had information and awareness sessions about the importance of Independent Advocacy for people.

18 out of 19 people (95%) asked between April and September 2018, felt having an advocate helped put their views across to others in the lead up to any decisions being made.

3.2 Understanding people's experience

The Partnership is committed to delivering safe, effective and person centred care. The use of feedback is central to ensuring delivery of these aims and we offer a variety of approaches which enable people to choose a feedback mechanism that best suits their needs.

The many ways people can get in touch with Dumfries and Galloway Health and Social Care Partnership

See inside cover for contact details

3.2.1 Information for people

We know that people having access to the right information, at the right time and in the right way is an important part of having a positive experience. There are lots of good examples of how we are developing information for people accessing services.

With the move to the new hospital, bed side folders were introduced. These contain useful information for people staying in hospital. Following feedback from people, during 2018/19 the content of these folders was reviewed and changes were made to increase the accessibility of the information.

We have worked with people with learning disabilities to develop easy read information leaflets. Topics include outpatient appointments, sexual health, having your blood pressure taken, and ophthalmology. These are to be made available on our public websites.

Anaesthetists and specialist nurses have been working with patient services to develop a Surgery School for people preparing to have a colorectal operation. This includes information sessions and practical support on health and wellbeing. Initial feedback from people has been very positive.

3.2.2 Public engagement

Over the past year the Partnership has been developing its communication and engagement with people. A new Partnership website was launched in November 2018 (www.dghscp.co.uk) and we have continued to develop our presence on social media.

Teams from across the Health and Social Care Partnership have been engaging with and involving the public during 2018/19. Some of the larger scale examples of this include Transforming Wigtownshire (see page 19), the Moffat general practice developments, and in collaboration with Macmillan Cancer Support, the review of cancer care and support and creating a new palliative care strategy for Dumfries and Galloway.

Posts on the Partnership's Facebook page regularly attract between **6,000 and 7,000** hits.

Over 150 people from Moffat took part in a survey about health and social care services

We continue to strive to improve working with people and communities. One of the ways that we do this is by listening to the feedback that people give us. For example, recently people told us, they felt that they had not been given enough time and information to engage with us properly around changes that were happening in their community. We have heard this and we are now ensuring that people feel they have sufficient and appropriate time and information to contribute meaningfully to the process. Following our work with the Consultation Institute, the IJB approved a new consultation framework in January 2019.

All IJB board meetings are held in public and rotate around the region. Dumfries and Galloway Health and Social Care Partnership was the first Integration Authority to hold an annual review in public. Building on the success of these events, this Annual Performance Report will form the basis of the next review in public.

Good practice and innovation: Social accounting

Independent sector organisations use social accounting and evaluation tools to understand the experience of people that use their services. An example of this is Stewartry Care. Here is what people said in their annual survey done in January 2019:

95% of people felt Stewartry Care has a positive impact on their quality of life

100% of people who work for Stewartry Care are proud to do so

100% of people would recommend Stewartry Care to others as a care provider.

3.2.3 Care Opinion

Care Opinion is a national website which enables people to provide feedback and get personal responses about the health and care services they have received. The majority of the feedback received through Care Opinion is positive. Further information on Care Opinion, including details of our stories, can be found at www.careopinion.org.uk .

There were 51 stories shared through Care Opinion in 2018/19, which were read over 6,500

times. Most stories receive a response within 48 hours and all of our stories have received a reply. Where stories have been critical, we offer an opportunity for people to discuss their concerns with us directly and in a number of cases, this offer has been accepted. This has helped to ensure that advice and support can be provided to resolve any issues. Stories are shared with the relevant teams and where possible, we identify learning from the feedback we receive.

3.2.4 Concerns and complaints

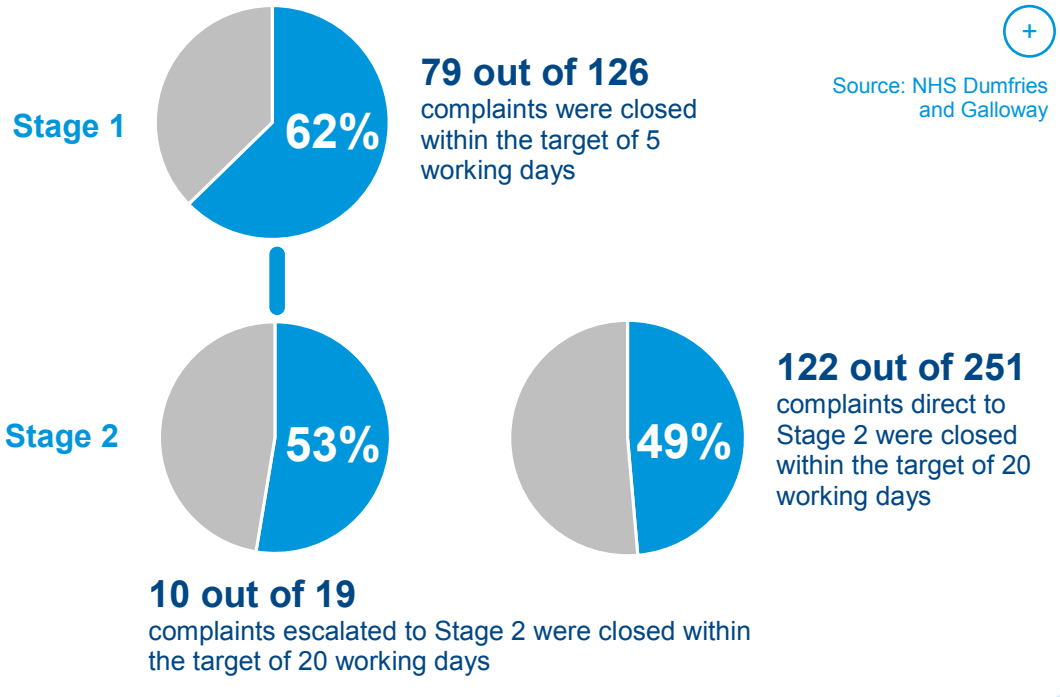
Where people feed back when something has gone wrong, these are managed through the complaints process a nationally agreed procedure.

The Health and Social Care Partnership received 418 complaints (398 through NHS Dumfries and Galloway and 20 through Dumfries and Galloway Council Adult Social Work Services) and 200 concerns in 2018/19, against a backdrop of over 300,000 outpatient appointments, 36,000 admissions, 46,600 visits to the emergency departments and 2 million hours of home care. This is slightly more complaints than in 2017/18 when 348 complaints were received by health and social care combined.

As well as the many thank you cards and messages that teams receive directly, there were 228 instances where people also contacted the NHS feedback team to share their compliments.

How we are getting on: Complaints closed within timescales

The Scottish Public Services Ombudsman's Model Complaints Handling Procedure was introduced from 1 April 2017. This procedure sets statutory timescales for all public services to respond to complaints, and has 2 stages. Stage 1 focuses on the early resolution of complaints and Stage 2 provides an opportunity for detailed investigation of the issues raised.



Good practice and innovation: Learning from complaints

Feedback provides a valuable opportunity for us to learn from people's experiences. A 'Learning Summary' template has been introduced to capture learning from complaints. This has been seen by the Ombudsman and Scottish Government, and has been identified as good practice. Here is an example:

What happened?

The Combined Assessment Unit (CAU) opened in December of 2017. It became evident through complaints, and an over filled waiting area, that people's experience at the CAU could be improved.

Discussions with the surgeons identified the need to have a dedicated area in the CAU for people requiring surgery. Clinical staff visited a CAU elsewhere in Scotland to try to get a better understanding of how this unit works.

What went well?

- A dedicated surgical assessment area was created as part of the CAU
- Communication between the emergency department and the CAU improved

What, if anything, could we improve?

- Develop a local target to monitor people's flow through the CAU
- Review how people can be discharged from the CAU back to their own home

What have we learnt?

We have developed a shared understanding of the different roles and responsibilities between the emergency department and the CAU.

We have created closer working relationships with the Scottish Ambulance Service (SAS) and GP practices that help people flow more smoothly in to and out of the CAU.

Providing people with information about what to expect at the CAU before their visit is important.

What actions are planned or have been taken?

- communication and coordination between the emergency department and the CAU has been improved
- a dedicated surgical assessment area has been created
- communication with the Scottish Ambulance Service has been improved
- a CAU information leaflet is being developed
- a nurse led triage area has been created
- closer working and improved communication is helping people to move into and out of the CAU more easily.

We now need to apply these learning summaries consistently and develop ways to share the learning more widely. There is an increased focus on learning and improvement within the complaints training and supporting materials.

It is important that all people who use our services are able to provide feedback. Information on how people can raise concerns and make complaints can be found on our websites (www.dghscp.co.uk, www.nhsdg.scot.nhs.uk or www.dumgal.gov.uk). Information leaflets are available on wards, in waiting areas and on notice boards. People can provide feedback in different ways, by e-mail, letter, telephone or in person. The Patient Advice and Support Service (PASS) work independently to support people who want to provide feedback. ContactScotland supports people who use British Sign Language (BSL) to provide feedback.

We recognise that there is further scope to improve how people can provide feedback. Guidance is being developed for teams to support people who need translation and interpretation services to provide feedback.

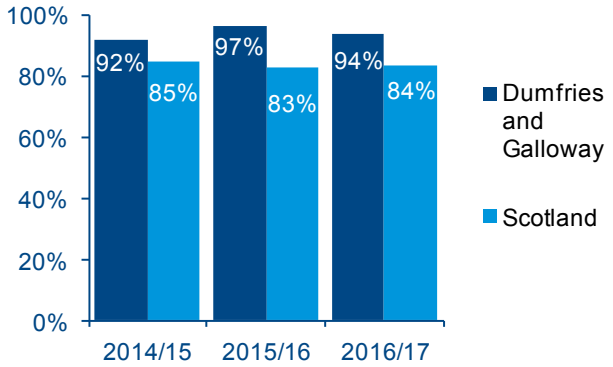
Regular training and awareness raising sessions are held with teams across the Partnership. These sessions help teams to build and maintain positive working relationships and learning from feedback and were highlighted as good practice in a report from the Scottish Government reviewing how feedback is used across NHS Boards.

How we are getting on: Dementia support

One area where supporting people to have the most positive experience of health and social care is very important, is with people, families and Carers who are affected by dementia.

94%

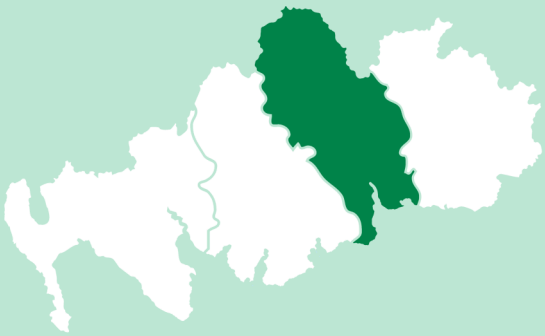
of people newly diagnosed with dementia in Dumfries and Galloway received support after they were diagnosed (target: 100%)



B3

Source: ISD Scotland

Spotlight on Nithsdale



Recent developments across Nithsdale locality include:

- The development of a single point of contact to ensure an efficient and collaborative approach to those presenting with the most complex needs.
- The role out of CoH-Sync and health and wellbeing plans. These plans help people to set goals, build motivation and encourage positive lifestyle changes.
- During 2018/19, 312 health and wellbeing plans were facilitated by Nithsdale Health and Wellbeing team.
- The multi disciplinary Rapid Response service started in Autumn 2017. The service supports people living in DG1 and DG2 areas to stay at home and prevent admissions to hospital.
- Healthy Connections supports people to engage with their communities and third sector organisations to reduce the impact of isolation and loneliness. Healthy Connections has been expanded to GP practices in Mid and Upper Nithsdale.

The Nithsdale locality team are supporting staff in many different ways. The Healthy Working Lives programme focuses on staff health and wellbeing. They are also investing in enhanced training and development for staff. This includes supporting staff to better understand each other's roles and responsibilities and to work together as a team. To shape the way they support people, they are seeking the views of staff from across the Health and Social Care Partnership.

Over the coming year, the Nithsdale team will be focussing on developing supported and enhanced housing models and working with partners to find ways of addressing inequalities.

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.

The way that we work with people from Dumfries and Galloway, designing and delivering their care and support, fundamentally focuses on maintaining independence and quality of life. Often people can be supported by signposting to local groups and third and independent sector services in their community without needing formal support from adult social work services. For people who need support from adult social work services we apply a personalised approach (Self Directed Support) in all cases.

In addition and to contribute to how we plan social care, the Partnership is delivering anticipatory care plans to ensure that what is important to people is at the core of their care.

Our commitments:

- We will enable people, especially vulnerable adults and those important to them, to decide their own personal outcomes
- We will change the focus of contracting from specifying levels of input activity to delivering health and wellbeing outcomes for people
- We will provide opportunities and support for people to develop and review their own forward looking care and support plans
- We will develop an online learning tool that enables staff across the Partnership to have a better understanding of Self Directed Support and embed it in practice **(Completed)**
- We will measure performance against good practice from elsewhere and encourage and support new ideas locally

Key Messages

- All people who need support from social work services are support through Self Directed Support (SDS).
- There are support options available through SDS Option 2, which nationally has been the most challenging option to implement.
- The mPower project is supporting people to manage their own long term conditions.

4.1 Self Directed Support (SDS)

The Social Care (Self Directed Support) (Scotland) Act 2013 puts people in control of designing and managing their care. Through supported self assessment, people develop personal plans. These plans build on people's existing supports and can be implemmented through community and health and social care resources. More information on Self Directed Support can be found at www.selfdirectedsupportscotland.org.uk. All purchased care and support in Dumfries and Galloway is arranged through Self Directed Support.

The Partnership aims to help people and support them to make the most appropriate choice of option under the Self Directed Support legislation. The different options support varying levels of control for the person:

- SDS Option 1 – people choose to take control of purchasing and managing their own care and support
- SDS Option 2 – people choose an approved organisation they want to be supported by and the Partnership transfers funds to that organisation, for care and support to be arranged in line with the personal plan
- SDS Option 3 – people choose for social work services to arrange and purchase their care and support from approved third and independent sector providers or from the Partnership's Care and Support Service (CASS)
- SDS Option 4 – people choose more than one of the above options

Social work staff promote a personalised approach to social care by providing information about all 4 SDS Options. In addition to full and open conversations, we provide written information using leaflets and direct people to websites such as the Care Inspectorate. This includes exploring the use of technology and enables people to make informed choices and take control of how their support will be managed. We have continued to use Good Conversations training across the Partnership to promote outcome focused conversations with people.

SDS Option 1 offers the greatest flexibility but with this comes a high level of personal responsibility. In order to increase people's choices we have worked with a range of partners, including local brokerage services providing independent support to assist people to become an employer. Through this local support, individuals have become more able and confident in the use of personal budgets and the management of their own care and support.

In Wigtownshire staff from 2 independent providers attended Good Conversations training during 2018/19.

SDS Option 2 increases the choice and control available to people who need support without requiring them to make arrangements themselves or employ the staff to support them. We have developed a specific contract and specification which has been available from September 2017. This enables people and the organisations providing support, to work together, to achieve the outcomes agreed in the personal plans thereby increasing people's ability to use resources in a more flexible way.

Across Dumfries and Galloway the majority of people supported through SDS continue to be supported through Option 3. Although less well used, SDS Option 4 provides maximum flexibility in achieving personal outcomes.

To help people continue to achieve their best possible personal outcomes, how people are supported is reviewed regularly. For people who have required care following a stay in hospital, this is reviewed within 6 weeks of leaving hospital, supporting them to be as independent as possible.

How we are getting on: Self Directed Support

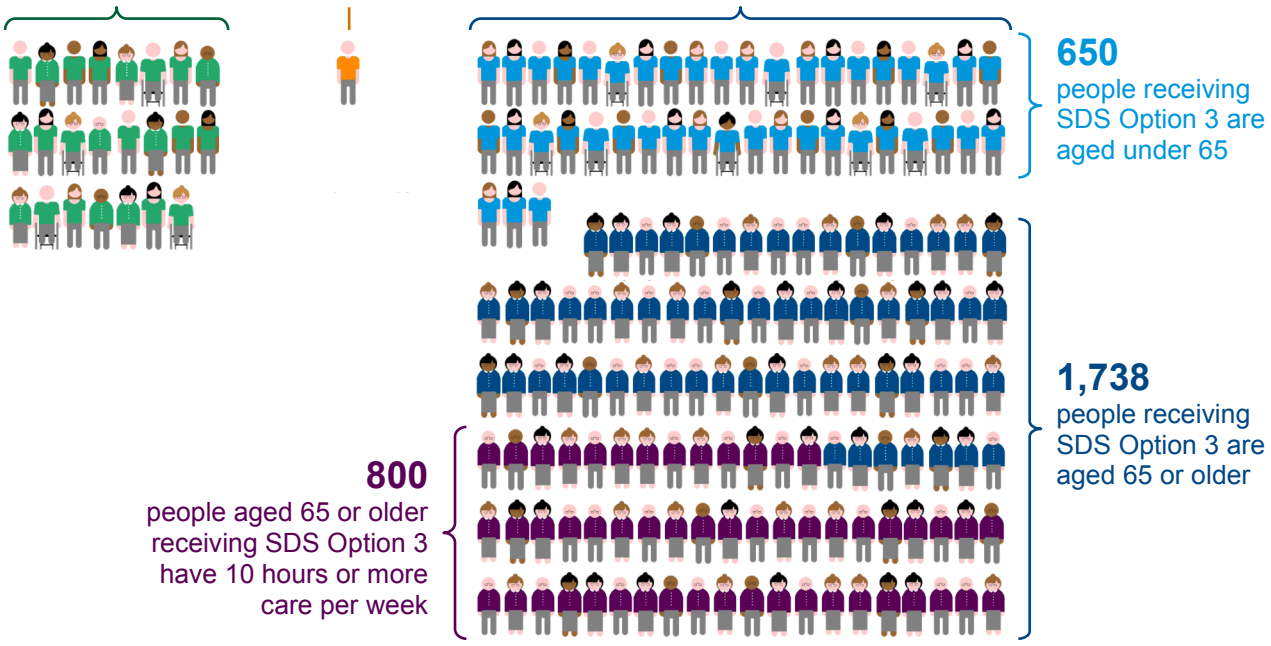
A snapshot taken at the end of March 2019 showed that...

In total, **2,745 people** are supported through Self Directed Support (SDS)

345 (12%)
people have chosen to organise their own support (SDS Option 1)

12 (1%)
people have chosen an organisation to arrange their support (SDS Option 2)

2,388 (87%)
people have chosen to have their support organised by health and social care services (SDS Option 3)



650
people receiving SDS Option 3 are aged under 65

1,738
people receiving SDS Option 3 are aged 65 or older

800
people aged 65 or older receiving SDS Option 3 have 10 hours or more care per week

C2 C3 C4 C6 C7 Source: Dumfries and Galloway Council (31 March 2019)

= approximately 15 people

4.2 Anticipatory Care Plans

The links between Self Directed Support (SDS) and Anticipatory Care Planning (ACP) are, and should be, seamless. Both encourage people to make positive proactive choices for themselves. Both are guided by shared principles that include person centred care, dignity, choice and control.

Anticipatory Care Plans help to support people to plan their future health and social care and support and to make them known to services. This may include considering arranging a Power of Attorney.

Locality teams have been working with care home and care at home providers to support the roll out of Anticipatory Care Plans. The vision for Dumfries and Galloway is that by June 2020 95% of residents in a care home will have an Anticipatory Care Plan summary shared with their GP.

What people tell us: Dennis' story

"When I first saw the Anticipatory Care Plan, to be honest with you, I thought 'oh, not another...' It seems to be, rather too often, that you're faced with these things. They're a bit daunting in some respects because they touch on subjects that you're not really very comfortable talking about. You perhaps don't even want to think about. But after a while, I looked at it again and I came to the conclusion that it's actually a very positive document."

"Overall, I think the document is a very positive one. I think the greatest thing about it is that you are actually in control and you can make decisions about your future. You may be able to make decisions that you couldn't at a later stage because you might not be well enough to really make those decisions."

"It was relatively easy to complete, simply because there were all the guidance notes and it asks specific things that I could simply give quick answers to but, at the same time; they had significant implications for how I planned for the future."

"I'm about to go into hospital. I'm going in for some surgery and as a result of doing the document, I'm now aware of the need to actually take the document with me in my pre-assessment appointment and when I have the surgery. The same goes really for the GP, because keeping the GP up to date with where I'm at, means they can actually respond to the here and now of my needs. So I'm already using it practically."

4.3 Day care and day services

Day Care and Day Centres provide a range of activities that help reduce loneliness and social isolation whilst also improving wellbeing. They also support people to live at home for longer. Day Care includes personal care and there are services across Dumfries and Galloway for adults and people living with dementia. Day Centres are community led organisations.

A review of Day Services (Day Care and Day Centres) was undertaken and a report was presented to the IJB with a series of recommendations. This report highlights the important role that these services play in supporting people in their own communities to maintain their health and wellbeing.

There are 1,118 people who are members of day centres. The 9 day centres provide over 65,000 meals per year and are open for meals, activities and socialisation for over 10,250 hours a year.

Work is underway to redesign day services to be more outcome focussed and to implement the recommendations of the Day Services Review. A new day care service has opened in Dumfries in the Mountainhall Treatment Centre and, following a tendering exercise, a new Stranraer day care service opened in May 2019.

4.4 mPower project

mPower aims to empower people to take control of their long term conditions at home by using technology, while simultaneously freeing up the time of GPs and other healthcare professionals.

The project focuses on people aged 65 and older with one or more long term condition and access services on a frequent basis. mPower aims to introduce self management to this group through:

- person centred and outcome focussed wellbeing plans that incorporate national Anticipatory Care Plans (ACPs)
- introducing new digital ways of managing long term conditions
- maintaining or improving health and wellbeing through increasing the use of digital solutions and maximising social prescribing opportunities.

mPower has supported the digital health and social care strategy by working with and supporting clinical teams in Wigtownshire who are introducing digital solutions into their practice. The Wigtownshire mPower team have worked closely with 7 partners from cross border locations in Ireland and the west of Scotland to share learning and develop services which, in turn, provide an evidence base for future development.

In 2018 the service supported 109 people and delivered 242 digital interventions. Examples of the digital support people can access include:

- Florence – a Home and Mobile Health Monitoring (HMHM) system through which people can send and receive text messages such as medication reminders or for submitting blood pressure readings.
- NHS Attend Anywhere – a safe and secure digital space through which people can attend video consultations with health and social care professionals. This reduces the need for people to travel.
- My Diabetes, My Way – an interactive website provided by NHS Scotland that supports people with diabetes, their families and friends.

5. Outcome 5

Health and social care services contribute to reducing health inequalities.

Health inequalities are the result of wider inequalities which are experienced by people in their daily lives. These inequalities can arise from the circumstances in which people live and the opportunities available to them. Reducing inequalities requires action on the broader social issues that can affect a person's health and wellbeing including; education, employment status, income and poverty, housing and loneliness and isolation. People from minority communities or with protected characteristics (religion or belief, race, disability, sex, gender reassignment, sexual orientation, marriage and civil partnership, age and pregnancy and maternity) are known to be more likely to experience health inequalities.

The Strategic Plan highlights that inequalities must be considered in the planning stages of services and programmes to make the most of the potential for contributing to reducing inequalities.

Our commitments:

- We will develop a health inequalities action framework aimed at reducing health inequalities **(Completed)**
- We will share learning about health and care inequalities, including their causes and consequences, and use this information to drive change
- We will reduce, as far as possible, the effect of social and economic inequalities on access to health and social care

Key Messages

- The Partnership has adopted an Impact Assessment tool that ensures that inequalities are considered when decisions are taken.
- There is evidence that the inequality gap for people visiting hospital in an emergency has widened in Dumfries and Galloway.
- There are many ways that services are improving how they support people to prevent, undo or lessen the effects of inequality.

5.1 Mainstreaming equality

The Fairer Scotland Duty came into force in April 2018. This supports the Equality Act (2010). The duty places a legal responsibility on particular public bodies in Scotland to actively consider how they can reduce socioeconomic inequalities when making strategic decisions. Public bodies are required to publish a written assessment showing how they have done this.

Impact Assessment is a process designed to ensure that decisions and changes to services do not discriminate against people likely to experience health inequalities. A review in 2017/18 highlighted that 1 in 20 reports presented to the IJB were associated with an Impact Assessment. To improve this further, the IJB has agreed that all reports presented to them that propose changes to services will now require evidence of a completed Impact

Assessment.

A shared tool for Impact Assessments has been developed by Dumfries and Galloway Council and NHS Dumfries and Galloway. This tool has been endorsed by the Community Planning Partnership and adopted by Dumfries and Galloway Health and Social Care Partnership. To raise awareness of this tool, a series of workshops started in 2018. As part of these workshops, senior managers and team leaders have been supported to complete an effective Impact Assessment. Further workshops are scheduled for 2019/20.

An Inequalities Working Group will be established in 2019/20. This group will be responsible for monitoring the number of and quality of Impact Assessments associated with reports submitted to the IJB.

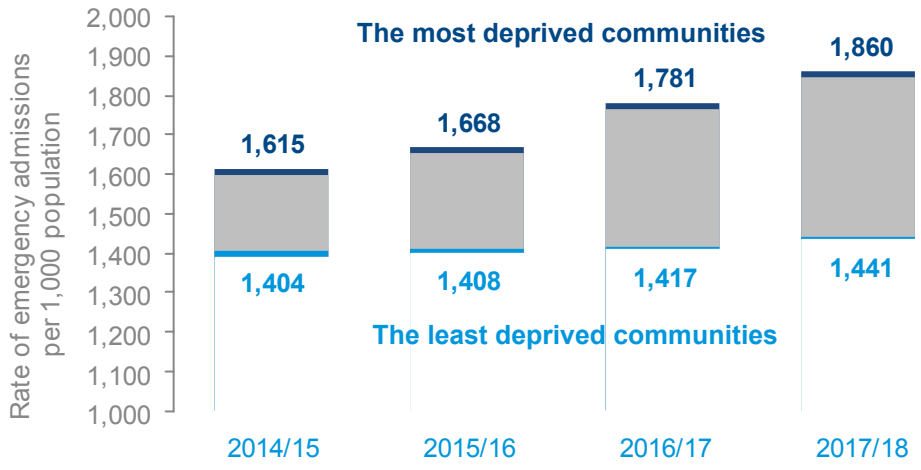
In April 2018, the Partnership worked with Engender (a national feminist organisation) to hold 2 events with local women from Dumfries and Galloway. These events focussed on women's rights and women's equality.

How we are getting on: Emergency admissions by deprivation

The Scottish Index of Multiple Deprivation (SIMD) is a tool used by the Scottish Government to identify deprived communities across Scotland. SIMD considers 7 different aspects of deprivation: income, employment, housing, education, crime, health and access to services. SIMD can be used to look at the impact of inequalities by comparing communities considered to be the most deprived to those considered to be the least deprived.

There are many different factors that influence how often people need to go to hospital in an emergency. These can include the type of work people do, housing conditions and how well people are able to manage their own long term conditions. The chart below shows that there is an inequalities gap between the most deprived and the least deprived communities in Dumfries and Galloway and how often they go to hospital in an emergency. The chart also shows that this gap is getting wider.

The rate at which people attend a hospital in an emergency comparing the most deprived and the least deprived communities in Dumfries and Galloway



Source: ISD Scotland

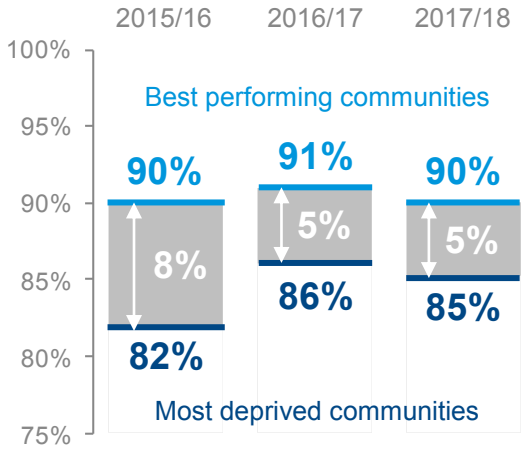
How we are getting on: Health inequalities

Measuring how inequalities impact on people's health and wellbeing is complex. Current work that attempts to address the impact of inequalities includes looking at the different outcomes for antenatal booking, smoking cessation and premature mortality.

Early booking of antenatal care

There is evidence that the women at risk of poor pregnancy outcomes are those less likely to access antenatal care early. Vulnerable pregnant women are being identified earlier and are being advised and encouraged to access early antenatal care directly from the community midwifery teams. In Dumfries and Galloway in the most deprived communities, 85% of pregnant women were booked by the 12th week of gestation. In the best performing communities this was 90%. This range is narrower than in 2015/16 and continues to be better than the national target of 80%.

Proportion of pregnant women booked by the 12 week of gestation

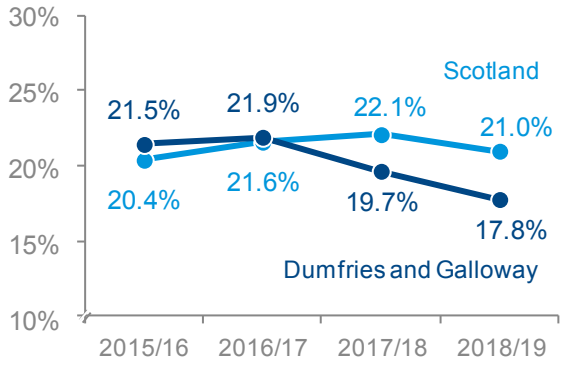


Source: ISD Scotland B8

Smoking cessation

Supporting people from deprived communities to stop smoking is a priority for smoking cessation services in Dumfries and Galloway. In 2018/19, there were 326 people from deprived communities who attempted to stop smoking. Of these, 58 people succeeded in stopping smoking for at least 12 weeks. This gives a quit rate of 17.8%. This is lower than the Scotland rate (21.0%) and lower than the rate achieved in previous years (the rate for Dumfries and Galloway in 2016/17 was 21.9%)

12 week quit rate for smoking in deprived communities

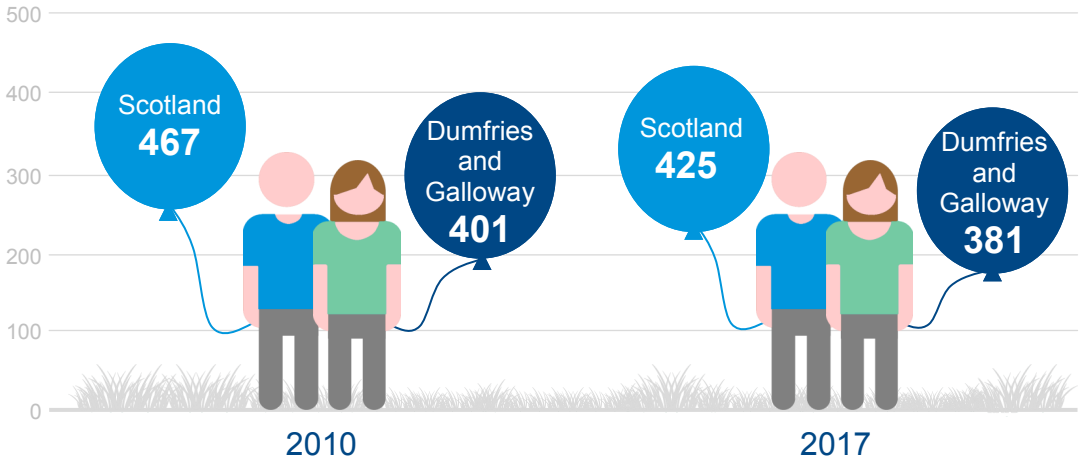


Source: ISD Scotland B16

Premature mortality

The premature mortality rate looks at the number of people who die early, defined as people under the age of 75. This rate is affected by a large number of factors many of which are linked to inequalities. Premature mortality is lower in Dumfries and Galloway than in Scotland as a whole however, in recent years this rate has fallen across the country.

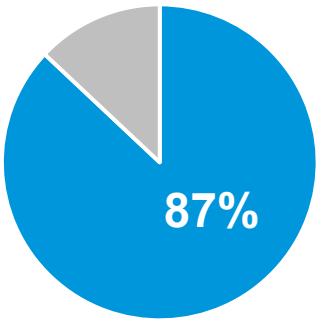
The premature mortality rates amongst people aged under 75
(deaths per 100,000 population)



A11 Source: ISD Scotland

Looked After Children health assessments

The Looked After Children (LAC) Health and Wellbeing Team are responsible for overseeing all of the health assessments for LAC children and young people in Dumfries and Galloway. The team carries out all new health assessments for children and young people in foster and residential care. Delivering health assessments supports the team's aim of improving the mental health of children and young people who have experienced trauma and neglect.



During 2018/19, 87% of LAC Health and Wellbeing Team assessments were completed within 4 weeks (target 90%)

Source: NHS Dumfries and Galloway

5.2 Challenging inequalities

Teams across the Partnership are working with different groups of people to help reduce health inequalities and their impact. Some examples of the work include:

- People with learnng disabilities have some of the poorest health in Scotland. Health Facilitators promote the use of health passports and help people to access and understand services. Easy read guides are used to help people better understand complex information. This enables them to know what to expect before attending their appointments or procedures. As a result people are able to express their own needs and wants and be more involved in their own care.

- People with severe mental health conditions have an increased risk of premature mortality and an increased risk of developing a physical long term condition. Through the Screening Inequality Engagement Programme, the Community Mental Health Teams are working with the Directorate of Public Health to develop ways to support people with mental health issues to attend screening services. This includes screening for bowel, breast and cervical cancer.

- Health Equity Audit (HEA) is used to assess how fairly services and resources are accessed by their local community. A HEA of NHS Dumfries and Galloway's Sexual Health Service was conducted to find out if they are reaching people who may be most in need of their support. The HEA provided an opportunity to understand more about the people who use the service and identify groups of people who experience poorer access. The Sexual Health Service is now considering what actions to take to make access fairer.

- Dumfries and Galloway Council's Financial Inclusion and Welfare Support Team and Dumfries and Galloway Citizens Advice Service run welfare advice clinics at DGRI and Midpark Hospital. In total, during 2018/19 there were 412 referrals to these clinics and the total additional annual income gained by people was £547,113.

On average, the total annual additional income gained by someone referred to a welfare clinic is **£1,327**

- Alcohol and Drugs Support South West Scotland has seen referrals to its specialist housing support service increase by 34% during 2018/19 compared to the year before. People are referred by the Dumfries and Galloway Council's housing and homeless teams. Most people referred are vulnerable as a result of substance misuse and are experiencing chaotic personal circumstances.

6. Outcome 6

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

Unpaid Carers are the largest group of care providers in Scotland, providing more care than health and social care services combined. Providing support to Carers is an increasing local and national priority.

A Carer is generally defined as a person of any age who provides unpaid help and support to someone who cannot manage to live independently without the Carer's help due to frailty, illness, disability or addiction. The term Adult Carer refers to anyone over the age of 16, but within this group those aged 16-24 are identified as Young Adult Carers.

Our commitments:

- We will provide support to Carers (including the provision of short breaks) so that they can continue to care, if they so wish, in better health and have a life alongside caring
- We will develop a consistent approach across the workforce to make sure that the needs of the Carer are identified and that Carers are supported in their own right
- We will work towards developing Carer Positive as an approach across the Partnership; identifying staff that are Carers and supporting them in their own personal caring roles

Key Messages

- The Carers (Scotland) Act 2016 came into effect on 1 April 2018
- A Short Breaks Service Statement was produced
- Carers have told us what feeling supported means to them
- We could still improve how we identify Carers and help them to access the wide range of support available to them

Supporting Carers to maintain their caring role is widely acknowledged as vital to the long term sustainability of health and social care services. The development of new legislation, national and local strategies, outcomes for Carers and performance measures are all contributing to a new agenda for Carers.

The Carers (Scotland) Act 2016, which took effect on 1 April 2018, is a key piece of legislation to "promote, defend and extend the rights" of Adult and Young Carers across Scotland. It brings a renewed focus to the role of unpaid Carers and challenges statutory, independent and third sector services to provide greater levels of support to help Carers maintain their health and wellbeing.

6.1 Asking Carers what feeling supported means

The Health and Care Experience Survey 2017/18 highlighted that 1 in 5 Carers surveyed from Dumfries and Galloway did not feel supported in their caring role. To help understand what feeling supported means, a local Carers' survey took place in September 2018. A summary of the findings are included on the next page.

What people tell us: What feeling supported means to me...

367 Carers responded to the survey. It was clear that the concept of feeling supported in a caring role meant different things to different Carers. What constitutes support includes help with the day to day activity of caring, awareness in local communities, financial support and services, and help with mental health and wellbeing. Four themes emerged from the responses:

- Sharing the caring responsibility
- Flexibility and understanding
- Accessibility
- Promoting good mental health and wellbeing

Carers told us:

"Support to me means someone else other than myself helping in a physical way."

"Someone else sharing the load, appreciating what I do and offering a listening ear, providing regular breaks for me where she is still cared for appropriately."

"Help and advice available when you need it."

"Knowing that if I require time off work to take my parent to appointments that I will not be penalised."

"I find it emotionally difficult being a Carer, watching the person who was fit and healthy descend both physically and mentally."

"People realising what it is like to care for someone who needs care everyday of their life."

"That my contribution is recognised, valued and validated by the statutory agencies who have responsibility for the care and support for those who need it."

An action plan has been developed and work is underway to improve these issues.

A survey by the Coalition of Carers for Scotland showed that 65% of Carers in Dumfries and Galloway who responded to the survey had a greater awareness of the Carers (Scotland) Act 2016 than the Scottish Average of 51%. Across Scotland, 61% of Carers who answered didn't know they could have an Adult Carers Support Plan and we were 46%.

6.2 Raising awareness of the Carers (Scotland) Act 2016

A media campaign was undertaken locally to inform Carers about their new rights following the implementation of the Carers (Scotland) Act 2016. This included a short animated video, information sessions, social media and information leaflets.

6.3 Short break service statement

A short break is any form of support that enables Carers to have time away from their caring routine or responsibilities. There are many different types of short break. They support Carers' health and wellbeing so they feel able to continue in their caring role.

The Carers (Scotland) Act 2016 required a document to be produced which lists short breaks available in Scotland to Carers who live or care in Dumfries and Galloway. This document was co-produced with Carers and Carers organisations.

141 Carers have successfully accessed short breaks from the Time to Live fund. This fund has supported Carers to have alternative short breaks such as gym membership to allow shorter, more frequent breaks alongside the more traditional holiday style breaks.

Good practice and innovation: Parent Inclusion Network

A Dad, separated from his partner, used the short break Family Days to be able to do something which he knows his son enjoys. The Dad was lacking in confidence to try mainstream activities because he had concerns about managing his child's behaviour and dealing with reactions from the general public. Since meeting other dads in similar situations at Family Days, this family has accessed more activities within the community. This has given the dad more confidence in supporting his child, peer support as a Carer and has enabled his child to build friendships.

6.4 Adult Carer Support Plans

From 1 April 2018 the Carers (Scotland) Act 2016 gives rights to Carers to have a support plan that addresses their needs. Anyone can start to develop an Adult Carers Support Plan (ACSP). The Dumfries and Galloway Carers Centre provide support to help people through this process. Many Carers find that the information, advice and support they receive from Carers organisations meets their needs. Only a small proportion of Carers will go on to develop an ACSP and of these, fewer still will require additional resources to meet their needs.

How we are getting on: Adult Carer Support Plans

Around 1 Carer in 10 accessing the wide range of support from the Carers Centre goes on to develop an Adult Carer Support Plan (ASCP).

173 Carers from Dumfries and Galloway created an Adult Carer Support Plan during 2018/19. This is higher than in 2017/18 when 112 plans were created.

C5

Source: Dumfries and Galloway Carers Centre

6.5 Carer involvement

The triangle of care approach in acute mental health services has led to Carers being involved in the care and treatment of the person they care for. This was tested in 2 wards and from April 2018 this has been rolled out across Midpark Hospital. Staff have been trained in Carer Awareness and a new protocol has been implemented to ensure that Carers are offered opportunities to be involved. This approach was also tested in Thornhill Hospital, Newton Stewart Hospital and with the Stewartry Community Mental Health Team. Here is what Carers who have been involved in the triangle of care told us:

Of the **214** recorded opportunities to implement the triangle of care protocol, **52% were completed fully**

"Felt listened to and valued"

"Contributed to care of patient"

"Established positive relationship with staff"

6.6 Carer Positive

Carer Positive is a national award with 3 levels, recognising employers who offer best support to employees who may have a caring role. Both NHS Dumfries and Galloway and Dumfries and Galloway Council have achieved the "Engaged" status (level 1) and the Council has achieved the "Exemplary" status (level 3).
The NHS has a group working towards applying for Established Status (level 2) during 2019/20.

"I receive support from my family and from the Carers Centre. My employers are also very understanding and are currently working with me to facilitate my return to work on reduced hours."

7. Outcome 7

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

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 such as Adult Support and Protection. Other activities are focussed on improving the safety of services, aiming to reduce the risk of harm to all people such as the Care Assurance programme.

Under the Adult Support and Protection (Scotland) Act 2007, public sector staff have a duty to report concerns relating to adults at risk. The local authority must take action to find out about and, where necessary, intervene to make sure vulnerable adults are protected.

The Scottish Patient Safety Programme (SPSP) is a national initiative aiming to improve the safety and reliability of healthcare and reduce avoidable harm whenever care is delivered. SPSP supports the Scottish Government's 2020 Vision to provide safe high quality care whatever the setting.

Our commitments:

- We will support the provision of a Multi-Agency Safeguarding Hub to ensure a joined up approach in terms of identifying, sharing information about and responding to adults at risk of harm **(Completed)**
- We will make sure that all staff can identify, understand, assess and respond to adults at risk
- We will make care as safe as possible and identify opportunities to reduce harm

Key messages

- Telecare helps keep people safe in their homes and now we are exploring how telecare can be used to keep people in hospital.
- The Public Protection Committee has been established.
- Infection rates for Clostridium Difficile and Escherichia Coli are higher in Dumfries and Galloway compared to Scotland.

7.1 Adult Support and Protection

7.1.1 Streamlining public protection processes

The three former committees dealing with Public Protection (Adults, Children's and Violence Against Women and Girls) have come together as one Public Protection Committee. This will enable learning, skills and resources to be shared across the partnership to maintain a unified focus on public safety.

The new public protection website is available to the public here:

www.dgppp.org.uk

It includes how to keep safe and how to contact us if you have a concern about a vulnerable person, 24 hours a day.

7.1.2 Auditing adult protection

In February 2019 a joint audit was undertaken with the Care Inspectorate of 24 adult support and protection cases. Detailed

examination involving all aspects of people's records were scrutinised by partners from across the public protection partnership, including police, health and social work.

The findings showed examples of excellent practice in relation to engaging with complex cases, involving personal, legal and environmental aspects. One case flagged as excellent highlighted timely intervention to prevent financial harm. These are being used as examples of best practice that can be shared for training purposes.

Learning was identified from the audit to improve ways regarding how risk is addressed to provide the most effective support, in the most person centred and least restrictive way. The potential to use advocacy more widely was also identified.

7.1.3 Adult Support and Protection National Improvement Plan

The national plan aims to standardise adult support and protection processes across Scotland. Dumfries and Galloway are using this as the template for improving services to keep people safe. An inspection against this framework will take place in 2019/20.

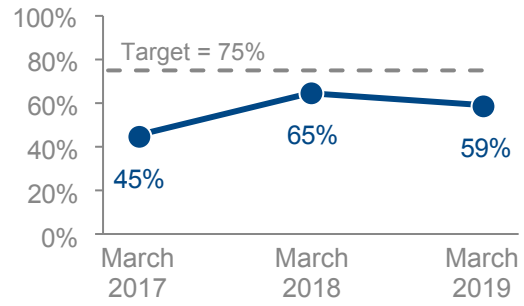
How we are getting on: Adult Support and Protection

During 2018/19 the Multi Agency Support Hub (MASH) screened 4,497 referral that raised concerns about a persons safety. 1,076 were identified as meeting the Duty to Inquire criteria. Of these, 103 went to a full investigation.

To monitor how efficient the Adult Support and Protection process is, we look at how soon people who have been referred someone to the MASH receive feedback on what has happened to that person.

Between March 2018 and March 2019 the proportion of people receiving feedback within 5 days has decreased from 65% to 59%. This is below the target we have set ourselves of 75%.

Proportion of people who receive feedback within 5 days



Source: Dumfries and Galloway Council C9

7.2 Keeping people safe in their communities

7.2.1 Technology

The Partnership aims to support people to be safe through the use of technology. People, their family and Carers are supported to identify risks to their wellbeing in their local environment. Potential solutions are discussed and advice and information is provided.

Telecare uses a range of emergency alerts to provide support and assistance that enables people to continue to live independently. These alerts are monitored 24 hours a day, 365 days a year by a team in Dumfries and Galloway. This team will coordinate an appropriate local response to an alert.

In September 2018 a second week of Telecare Awareness Training was provided bringing the number of people trained to deliver a basic assessment to 105. Participants included the Scottish Ambulance Service, occupational therapists, pharmacists, social work, care coordinators, the Care and Support Service (CASS) as well as colleagues from the third sector and the independent sector.

The Activities of Daily Living Suite at DGRI now has telecare and sensory support equipment available in it to enable people to find out more about how this equipment can support them as they return home.

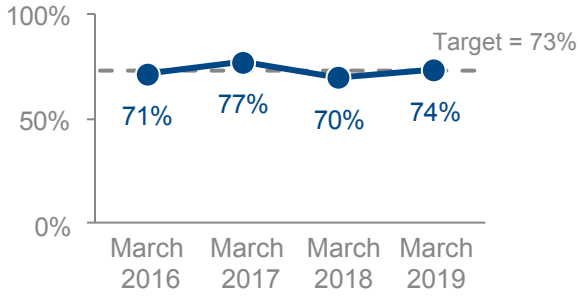
Telecare equipment has been introduced at Thomas Hope Hospital in Langholm to support safety. Sensors have been linked to beds and chairs to alert staff through a pager system when someone may be in difficulty. Telecare equipment has also been made available for people to try out before they return home from hospital.

How we are getting on: Telecare

Telecare is one of the first options considered to help people live as independently as possible. We monitor the proportion of people supported at home who have Telecare as part of their care and support.

Snapshots taken at the end of March each year show that the proportion of people supported by Telecare has stayed fairly steady. In March 2019, 74% of people supported at home had Telecare. This is above the target we have set ourselves of 73%.

Proportion of people supported at home who have Telecare



Source: Dumfries and Galloway Council C1

7.3 Keeping people safe in hospital

Care Assurance audit is a nursing peer review process that enables people staying in hospital to tell us about their experience and suggest potential improvements. The Care Assurance process aims to reflect national and local priorities but also to:

- ensure consistency in the delivery of high quality standards of care
- to identify and celebrate good practice and promote sharing good practice
- to identify and provide support for areas of practice which need to be improved

Care Assurance is carried out at DGRI, Galloway Community Hospital and at all of our cottage hospitals.

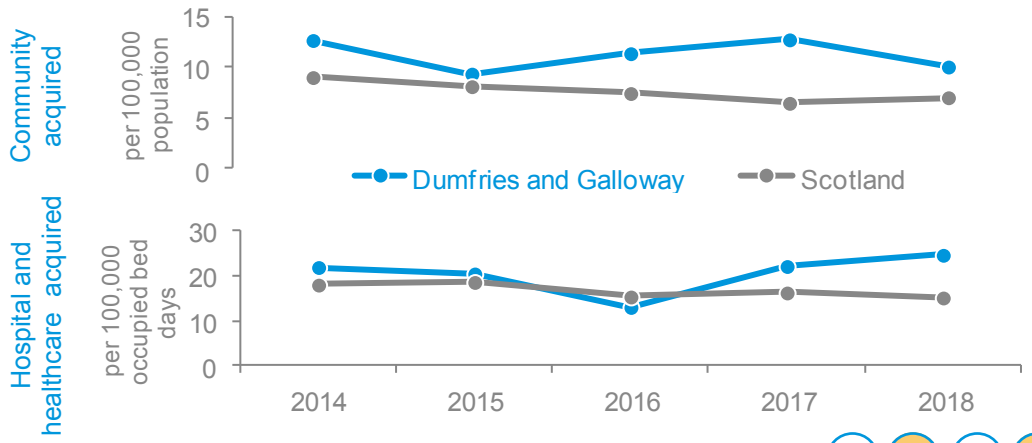
During its recent care assurance audit, Newton Stewart Hospital has achieved the silver award. Areas highlighted for continued improvement included cognition, food, fluid and nutrition and documentation. The hospital team have since reviewed their practice and redesigned services to ensure that all people are now assessed on admission using the 4AT score which provides an early indication of delirium. They are also liaising with GP practices to ensure documentation is completed accurately.

How we are getting on: Infections

Infections can be acquired in different environments: hospital, other health care settings, and in community settings such as people's own home and care homes.

Rates of Clostridium Difficile (C.Diff) infection acquired in the community have decreased in the last year. In 2018 there were 10.1 cases per 100,000 population across Dumfries and Galloway. However, for health care acquired and health care associated C.Diff infections, there was an increase to 24.7 cases per 100,000 population (up from 22.2 cases per 100,000 population in 2017). An important way that the risk of infection is managed is through preventing the misuse of antibiotic medication.

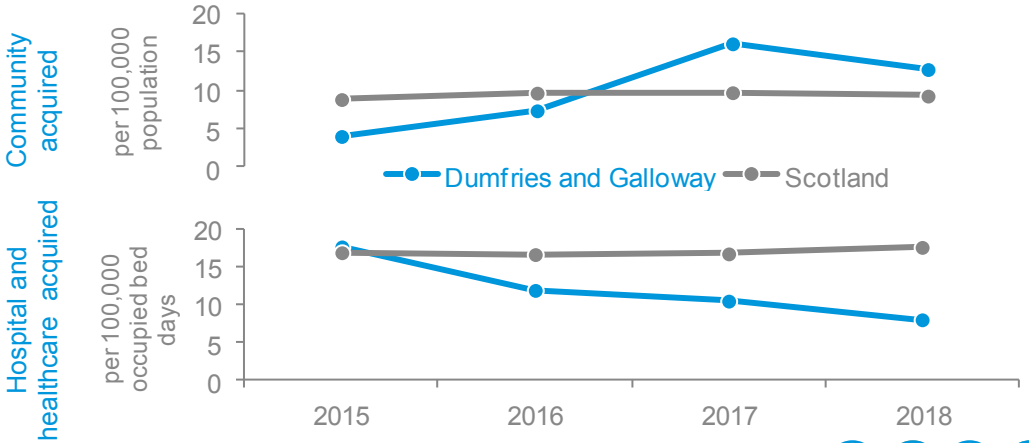
Infection rates for Clostridium Difficile (C.Diff) by setting



Source: ISD Scotland (Discovery) B13 2 B13 1

Staphylococcus Aureus Bacteraemias (SAB) is associated with wounds and using needles and catheters. Across Dumfries and Galloway the rate of SAB infection has recently decreased. During 2018 the there were 12.7 cases per 100,000 total occupied bed days of SAB acquired in the community, down from 16.1 cases per 100,000 occupied bed days. For healthcare acquired and healthcare associated SAB infections there were 8.1 cases per 100,000 per occupied bed days in 2018, down from 10.5 cases per 100,000 occupied bed days in 2017.

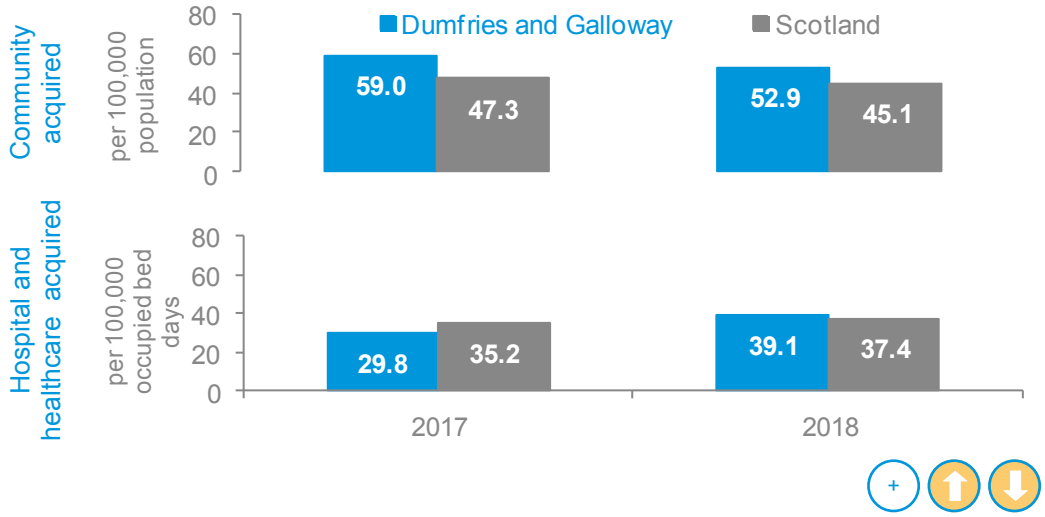
Infection rates for Staphylococcus Aureas Bacteraemia (SAB) by setting



Source: ISD Scotland (Discovery) B13 1 B13 2

Escherichia Coli (E.Coli) is a bug that lives naturally in people's bodies. It is frequently associated with Urinary Tract Infections (UTIs), abscesses and liver and gall bladder problems. In severe cases, this infection can lead to sepsis. Keeping well hydrated can help to prevent and support the recovery from these infections. Although there has been no national standard set in Scotland, E.Coli infection rates are closely monitored to support preventative work. In 2018, for community acquired infections across Dumfries and Galloway there were 52.9 cases per 100,000 population, down from 59 cases per 100,000 population in 2017. For healthcare acquired and healthcare associated E.Coli infections there were 39.1 cases per 100,000 population in 2018, up from 29.8 cases per 100,000 population in 2017.

Infection rates for E.Coli by setting



Across the Partnership we are using the materials developed by the Scottish Urinary Tract Infection Network to promote good hydration. This is important in supporting people to prevent infections including both SAB and E.Coli and has included visiting community groups such as women's groups and retirement groups. There is an active infection control public involvement group that are supporting this work. This work is increasingly important as we have recently started to see an increase in antibiotic resistant UTIs.

Viral infections, such as Influenza (flu) and Norovirus, are closely monitored in our hospitals. Following outbreaks in cottage hospitals over winter, a review is being carried out by the Infection Control Committee looking at the spaces between hospital beds to see if there are changes that can be reasonably made to prevent the spread of infection. Since the introduction of single rooms at Dumfries and Galloway Royal Infirmary there has been no transmission between people in the acute hospital of flu or norovirus.

7.4 Keeping children safe from a health perspective

Under the existing scheme of integration, children's health care is delegated to the IJB, whereas children's social care is retained by the Local Authority. There are robust systems in place to safeguard vulnerable children in Dumfries and Galloway, but these are not discussed in detail here as they are not wholly the responsibility of the Dumfries and Galloway Health and Social Care Partnership. Here are some of the ways that services delegated to the IJB contribute to keeping children safe.

7.4.1 Children and Adolescent Mental Health Services (CAMHS)

CAMHS plays an important role in keeping children safe. During 2018/19 CAMHS tested redesigning their service to simplify how children and young people access it. The aim is to reduce the time people wait by using early interventions. Two primary mental health workers, on a part time basis, are working in schools, GP practices and other community settings. Recruiting qualified staff continues to be a challenge for the CAMHS team. In March 2019 90.1% of children and young people referred started treatment with CAMHS within the 18 week national standard. The rate for Scotland in the same period was 73.6%.

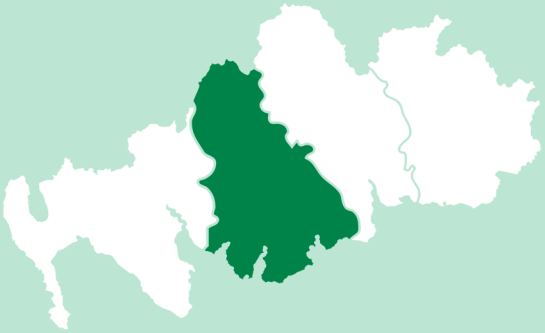
7.4.2 Best Start

Best Start is a national improvement programme focusing on maternity and neonatal services. One of its key aims is to support normal safe birth processes and avoid unnecessary interventions such as caesarean sections. Across Dumfries and Galloway during March 2019 the percentage of pregnant women who gave birth through caesarean section was 17%. The annual rate for Scotland in 2018/19 was 32%. Dumfries and Galloway has been consistently below the Scottish average for the past 24 months.

7.4.3 Safety of children admitted to hospital

The Paediatric Early Warning Score (PEWS) chart was introduced last year. This aims to assess and record vital signs and escalate problems in a safe, effective and integrated manner. During 2018/19 monthly audit samples showed that 95% of children identified as at risk had appropriate interventions and were managed effectively using the PEWS chart.

Spotlight on Stewartry



In Stewartry we have been focussing 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 contract
- developing technology to improve communication and efficient care and support
- promoting Self Directed Support (SDS) options enabling people to make informed choices and take more control of their support
- Care Assurance audits which have resulted in awards for our Stewartry hospitals
- developing risk assessment tools with our staff, 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
- developing an innovative technology project which has the potential to transform how we deliver over night support

This work has been delivered against a backdrop of significant challenges, including recruitment and retention of staff across all sectors, continued growth and demand and a challenging 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.

8. Outcome 8

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

It is important to acknowledge that different workplace cultures exist across the Partnership. Acknowledging the diversity of these different cultures will lead to understanding and respecting each other's values and beliefs and bring new and different opportunities. However, diversity also brings challenges that can act as barriers to integrated ways of working. The Partnership is supporting staff to learn together and develop leadership skills to enables us to move towards a shared positive culture.

Our commitments:

- We will support staff to be informed, involved and motivated to achieve national and local outcomes
- We will develop a plan that describes and shapes our future workforce across all sectors **(Completed)**
- We will provide opportunities for staff, volunteers, Carers and people who use services to learn together
- We will aim to be the best place to work in Scotland

Key messages

- Recruitment to jobs in health and social care remains a significant challenge across health, social work, third and independent sectors.
- There are many ways that organisations across the Partnership are using to support and keep staff.
- There has been further progress in developing a positive workplace culture across the Partnership however, more work is required to develop compassionate leadership.

8.1 The recruitment challenge

Attracting people to work in health and social care and keeping them, remains a considerable challenge across the Partnership for both the statutory, third and independent sectors.

Within health, the sustainability for a wide range of professions, including doctors, nurses and Allied Health Professionals (AHPs), has been reported as a high risk for the health board. Cost associated with employing temporary essential staff remains very high. Working with temporary staff requires enhanced levels of management and scrutiny to maintain high quality services where people have a positive experience of care and support.

Within the hospital setting the number of consultant vacancies has been as high as 20 during 2018/19. There are also significant challenges recruiting to AHP roles such as physiotherapists. This is impacting on how quickly people are able to be seen in the community for musculoskeletal problems. Within the community, GP vacancies are also a

challenge and a recent sustainability survey indicated that just over half of GP practices across Dumfries and Galloway had concerns for their future sustainability.

8.2 Supporting and keeping our staff

8.2.1 iMatter

iMatter is an annual staff survey tool that includes the development of team action plans to build a positive workplace culture. At present, iMatter has been rolled out across health teams including some staff employed by the local authority who work within fully integrated teams. Building on the learning from 2017/18, more people participated in iMatter and more teams developed action plans during 2018/19. The percentage of actions plans developed rose from 12% in 2017 to 46% in 2018 bringing us in line with the national average.

The Scottish Government has identified iMatter as the key tool for measuring and promoting a positive workplace culture. There are ongoing challenges to using iMatter as a staff survey tool across the Partnership. Dumfries and Galloway participation was marginally below the level required to generate organisation wide statistics. This impacts on indicators D5, D21 and D22.

Good practice and innovation: Nithsdale Locality Team

88% of people in the Nithsdale Locality Team completed the iMatter tool. From the results 3 areas of focus were identified:

- supporting staff to do their job well
- giving staff time and resources to support their learning
- improving the visibility of senior managers responsible for the wider organisation

These areas of focus were included in a locality action plan. Other aspects incorporated into the plan included Healthy Working Lives, staff focus groups, Clinical Leadership in Practice (CLiP) and What Matters to Me.

To explore how best to support staff to do their job well, the team are carrying out a Strengths Opportunities Aspirations and Results (SOAR) analysis. This will be completed during 2019.

As part of increasing the visibility of senior managers, the general manager for the Community Health and Social Care Directorate and the Director of Finance have both attended Nithsdale locality team meetings. The Chief Officer has also visited offices at Lahraig.

iMatter provided a ‘sense check’ that encouraged the team to think differently. The locality team consider themselves to be at the beginning of their staff support journey. They are planning to enhance how iMatter is used when the next survey comes out.

8.2.2 Information sharing

Across Dumfries and Galloway, health and care professionals have access to a range of information and communication technology (ICT) systems to support them to carry out their work. It is estimated that there are well over 100 systems involved in the delivery of care and support in Dumfries and Galloway. However, many of these systems work in isolation which means it is difficult to share information between services, organisations and health and care professionals.

Good practice and innovation: MORSE

In a rural area like Dumfries and Galloway, internet connectivity can be challenging. MORSE is an IT system for health professionals working in the community that enables them to download up to date information about the people that they are working with. Once the information is securely downloaded, no wifi signal is required. This means that staff can work offline and make changes or complete paperwork while they are with the person. When staff return to a secure internet connection, they are then able to upload their saved work.

The application reduces the amount of time that professionals spend completing paperwork, enabling them to spend more time with people. MORSE is currently being developed for teams across NHS Dumfries and Galloway.

Health visitors and school nurses have been involved in the early testing of a this new IT system. Here is what some of them told us about the new system:

"Staff can see the whole history of the child and we can type straight into clinical notes. We can see and have rapid access to information. Sharing of information is quick and timely. Whilst I was doing a visit, the parents were able to be involved and see what was discussed. They were very happy with this."

"Previously we had a laborious system involving printing forms. Now we can download them onto the MORSE system to demonstrate to people. The potential of this is fab. Work life is so much easier. Love it, love it. Love it."

8.2.3 Young person employability plan

The Partnership supports the Scottish Government programme to develop the young workforce and promote employment opportunities in health and social care. In Stewartry, a project has been developed to support staff and young people to address barriers to employment. The Partnership has been working collaboratively to establish ways of engaging with young people and create opportunities to stay in Dumfries and Galloway. The first group of young people will start this programme in June 2019.

In 2018 a careers event was held at DGRI for school age children to come along and find out more about careers in health and social care. **118 school aged young people** from the region attended this event.

8.2.4 Workforce plan

The Integrated Workforce Plan was first developed in 2016. It is reviewed and updated every year by the Organisational Development IJB Steering Group. This group has representatives from the health board, local authority, third sector, independent sector and staff side representatives.

8.2.5 Working Well

NHS and Local Authority use standard absence management processes routinely. However sickness absence levels have continued to be a challenge within both organisations.

Both organisations have health and wellbeing programmes in place to support staff to be well and at work. The aim is to improve physical and mental health and wellbeing across our integrated workforce for those at work and for those who are absent. One example is our participation in a pilot facilitated by the West of Scotland learning network for newly qualified social workers to ensure the appropriate level of support is offered at this early stage of someone's career. In 2019/20 the Partnership will build and bring together the programmes already established and continue to focus together on building a workforce which is well and at work.

8.2 Learning together

8.2.1 Good conversations

Good Conversations is a programme that supports staff to have more meaningful conversations with each other and with people who use services. This means people are more likely to achieve their personal outcomes. Over 300 people who work for health and social care services, including third and independent sector organisations, have now completed the training. Also, a small number of staff are being supported by the course providers to design and deliver Good Conversations in a way that works for Dumfries and Galloway. This is a positive, long term investment in our staff however, there are ongoing challenges to releasing and backfilling staff. This is compounded by the limited number of available trainers and the large geographical area, raising the cost of providing training. Good Conversations supports the development of a positive workplace culture. The impact of this training will take time to build and develop.

8.2.2 Leadership 3

Leadership 3 is a cross region programme developed in collaboration with NHS Ayrshire and Arran, NHS Greater Glasgow and Clyde, Golden Jubilee Hospital and NHS Dumfries and Galloway. The programme provides people with key leadership skills and was initially available to NHS Staff. This year, Dumfries and Galloway supported 3 staff from the local authority to take advantage of this programme and develop projects that impacted across the Partnership.

8.3 A positive workplace culture

8.3.1 IJB OD steering group

The IJB Organisational Development (OD) Steering Group was established to oversee activities resulting from the IJB workplace culture project. The group has created an asset list of all training activities provided across the Partnership and is now working with short life working groups to provide learning opportunities that cross traditional organisational

boundaries. The OD steering group has completed the actions within its first plan and is now reviewing how best to ensure this area of work continues.

8.3.2 Michael West event and compassionate leadership

The Health and Social Care Management Team invited Professor Michael West to share the substantial evidence and practice he has gathered in relation to compassionate leadership and its positive impact on people. Compassionate leadership is an approach to support good relationships and a positive culture in the workplace. The management team have agreed to use this model of leadership to identify priorities for the next financial year.

8.3.3 Care and support providers

Providing specialist care and support at home or in a homely setting to people living with a learning disability or mental health condition is critically important to the delivery of health and social care. This type of care and support is delivered mainly by the third and independent sector.

In February 2019 over 900 staff relocated to Mountain Hall Treatment Centre from Crichton Hall. This involved substantial changes to the Mountain Hall building, changing it from hospital wards to office accommodation. Staff worked together to make this move seamlessly and minimise disruption to services.

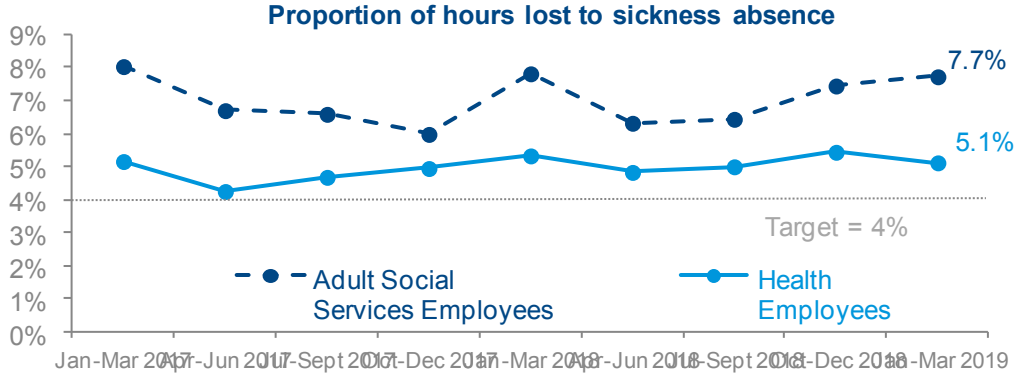
Through contract monitoring and regular provider forums, examples of good practice are supported and shared. This helps to achieve good workforce regulatory practice, ongoing workforce development and supports recruitment and selection standards such as those set by the Scottish Social Service Council.

How we are getting on: Sickness absence

In March 2019 the sickness absence rate was:

5.1% amongst health employees (target = 4%)

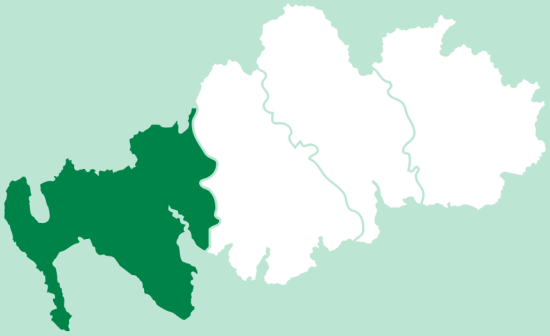
7.7% amongst adult social services employees



The sickness absence rate amongst adult social services employees has increased during 2018/19. Amongst health employees the sickness absence rate for 2017/18 has stayed above the 4% national target.

B18 Source: NHS Dumfries and Galloway, Dumfries and Galloway Council (April 2019)

Spotlight on Wigtownshire



At a time of rising demand for services, growing public expectations and increasing financial restrictions it was recognised that we needed to approach these challenges differently. The Transforming Wigtownshire Programme was launched to review and redesign safe, sustainable services in a co-productive way with the people of Wigtownshire and their partners.

The aims of Transforming Wigtownshire are to:

- work in partnership with the local community and stakeholders to co-produce the review and design of health and social care in Wigtownshire, including Galloway Community Hospital
- work with communities to enable them to make Wigtownshire a healthier place to live now and in the future
- develop a model of sustainable, safe and effective health and social care and support that meets the needs of the local community

This report highlights the many different improvement projects that are happening across health and social care that support the Transforming Wigtownshire Programme. This includes 2 projects, mPower and CoH-Sync, that are funded by the European Union INTERREG VA Programme and managed by the Special EU Programmes Body.

Projects also include the development of the Community Link Unit at Newton Stewart Hospital and piloting the mental health liaison service within GP practices.

The Wigtownshire Pharmacy Team and GP practices have actively promoted the Scottish pharmacy initiative, Pharmacy First. This initiative aims to increase service provision by community pharmacies, enabling access to treatments previously only available from GP practices, such as antibiotics for urinary tract infections.

9. Outcome 9

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

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 also committed to using its buildings and land in the most efficient and effective way.

Our commitments:

- We will reduce variation in practice, outcomes and costs which cannot be justified
- We will involve staff to develop a new culture that promotes different ways of working for the future
- We will support staff and partners to develop new and better ways to provide health and social care, to reduce duplication and increase efficiency
- We will ensure that there is good linkage between work relating to the new hospital project and community based health and social care **(Completed)**

Key Messages

- Technology such as NHS Attend Anywhere is helping to make services more easily accessible and reduce travel times.
- The number of days people spent in hospital after they were deemed ready to be discharged has increased.
- The target of 95% of people to be discharged from the Emergency Department within 4 hours was not met in 2018/19.
- Medication reviews are helping people to manage their medicines and their long term conditions.

9.1 Using technology

Our commitments:

- We will deliver a single system that enables public sector staff to access or update relevant information electronically
- We will introduce and embed a programme of technology enabled care that supports the development of new models of care and new ways of working

The Partnership has a Technology Enabled Care (TEC) programme supported by the Scottish Government. There are 4 key areas to this programme:

- video consultations
- home and mobile health monitoring (see Outcome 2)
- providing responder services (see Outcome 7)
- apps and national online services (see Outcome 1)

The Dumfries and Galloway Digital Health and Care Strategy has been developed during 2018/19. This has been prepared in line with the national strategy and describes how digital health and care will be delivered locally.

NHS Attend Anywhere is a secure platform for people using their own devices, to have video consultations with health and social care professionals.

What people tell us: Kim's story

Kim was diagnosed with cancer. She found that using NHS Attend Anywhere to keep in touch with her oncologist helped to reduce the stress of travelling for appointments:

"I first came to hear about Attend Anywhere when I went to Dumfries for an appointment to see my oncologist. She had problems in the morning so she was unable to travel from Edinburgh to Dumfries. So when I arrived they asked if I would be ok to do the video conferencing with my oncologist. I was taken into a room along with my husband and there was also one of the nurses in the room along side us. She was there just in case there was anything was required, if bloods were required, or a weight or height measurement but also to help if something technical went wrong. We discussed everything that we would have discussed at the appointment anyway, which was only going to be a 5 to 10 minute appointment. Because that worked so well, they actually scheduled, there and then, the appointments that I was supposed to have, 3 months later in Edinburgh, to do exactly the same thing."

"Doing video link absolutely makes so much sense. Once you've been diagnosed with cancer you've got scans, you've got x-rays you've got appointments. Within a week you can maybe have 5 different appointments in 5 different places. I know myself that I did. I come from a small village just outside Newton Stewart. It's probably another 15-20mins from Newton Stewart so travelling is big thing for myself. Going to Edinburgh to meet up with an oncologist to say this is what we're going to do at your next visit, a 5 minute appointment, for a 7 hour round trip for myself."

9.2 Pathways of care and support

The health and social care system can be complex with people receiving care and support from different teams so that they get the right care at the right time. Co-ordinating how people make their way through the health and social care system is challenging. (Please note, supporting good health in order to prevent hospital admissions is discussed in Outcome 1.)

Health and Social Care Partnerships across Scotland face challenges with caring for people in the right settings. The Scottish Government has introduced 2 improvement programmes looking at what happens when people go to hospital (6 Essential Actions to Improve Unscheduled Care and Waiting Times Improvement Plan).

How we are getting on:

Hospital Pathways

Outpatients

A snapshot taken at the end of March 2019 showed that **96%** of people waited less than 12 weeks for their first outpatient appointment. (target: 95%)

Dumfries and Galloway's performance is **better than Scotland**. The Scottish rate was 75% in March 2019. B6

People attended just over **300,000** outpatient appointments during 2018/19

More Waiting Times

During January, February and March 2019...

93% of people diagnosed with cancer from Dumfries and Galloway began treatment within 62 days of their referral (target: 95%) (Scotland: 80%) B2.2

96% of people diagnosed with cancer from Dumfries and Galloway began treatment within 31 days of the decision to treat (target: 95%) (Scotland: 94%) B2.1

74% of people from Dumfries and Galloway started psychological therapy treatment within 18 weeks of their referral (target: 90%) (Scotland: 77%) B11

90% of young people from Dumfries and Galloway started treatment for specialist Child and Adolescent Mental Health Services (CAMHS) within 18 weeks of their referral (target: 90%) (Scotland: 74%) B10

100% of people from Dumfries and Galloway started IVF treatment within 12 months of their referral (target: 100%) (Scotland: 100%) B9

95% of people from Dumfries and Galloway waited less than 6 weeks for diagnostic tests and investigations (target: 100%) (Scotland: 84%) B7

A snapshot taken at the end of March 2019 showed that **88%** of people were treated within 18 weeks of their referral. (target: 90%)

Dumfries and Galloway's performance is **higher than the Scottish rate** which was 77% in March 2019. B5

There were **46,600** visits to the emergency departments at Dumfries and Galloway Royal Infirmary (DGRI) and Galloway Community Hospital during 2018/19

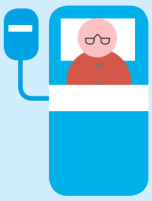
Emergency and Unscheduled Care

In March 2019 there were **3,681** visits to the emergency departments at DGRI and Galloway Community Hospital. E3

In March 2019, **93%** of people were treated within 4 hours (target: 95%)

Dumfries and Galloway's performance is **higher than Scotland**. The Scottish rate is 91%. B19

Inpatients and Day Cases



During 2018/19, there were **14,500** planned inpatient and day case visits to hospital that took place in Dumfries and Galloway

A snapshot taken at the end of March 2019 showed that **81%** of people waited less than 12 weeks for their treatment. (target: 100%)

Dumfries and Galloway's performance is **higher than the Scottish rate** which was 68% in March 2019.

B4

Returning to Hospital

Provisional figures indicate that during 2018/19, for every 1,000 people who were admitted to hospital, **86 people** returned to hospital within 28 days of going home.

A14

During the year ending March 2019, for every 1,000 people aged 75 or older, **618 days** per year were spent in hospital when people were ready to be discharged.

Dumfries and Galloway's performance is **better than Scotland**. The Scottish rate was 805 days per year.

A19

In the month March 2019, the number of bed days occupied by adults experiencing a delay in their discharge from hospital was 1,648 across Dumfries and Galloway.

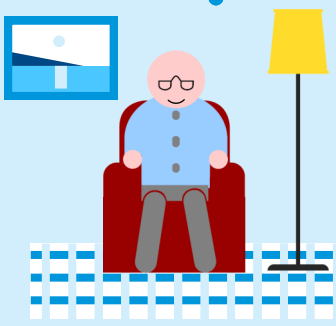
E4

The number of people admitted to hospital in an emergency during March 2019 was **916**. This amounted to **5,453** bed days.

E1 E2

Provisional figures indicate that **24%** of health and social care resource was spent on hospital stays where the person is admitted as an emergency during 2018/19.

A20



Homely Setting

Note: The Scottish Government are currently developing an indicator to reflect the proportion of people discharged within 72 hours of being ready to go home (Indicator A22).

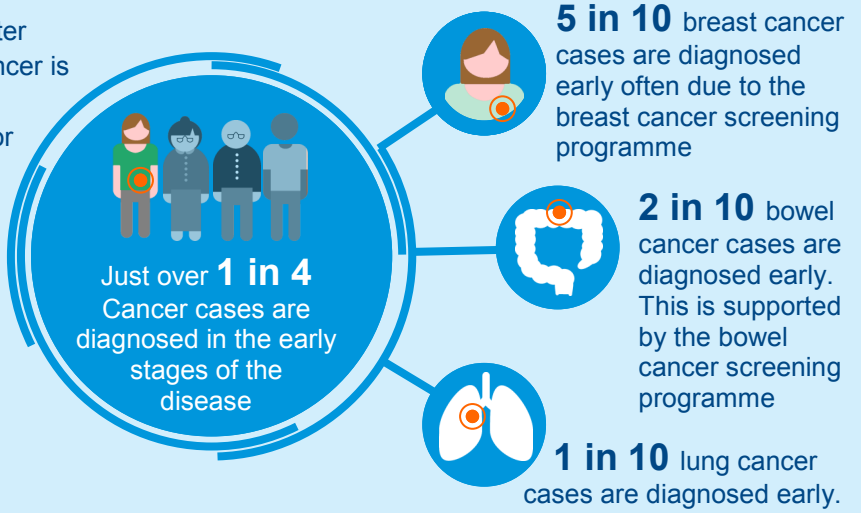
When people are admitted to hospital, planning for their return home starts as soon as possible. The Daily Dynamic Discharge (DDD) process ensures that people, their family and Carers, and professionals involved in their care contribute to this planning. When people stay too long in hospital and are receiving care in the wrong setting this is known as a delayed discharge. We monitor how many people experience a delayed discharge and also regularly audit, through the Day of Care Survey, whether people are in the right setting for the care they need.

Each locality has flow meetings which brings together a range of health and social care professionals to review the care of people currently in hospital. The flow meeting seeks to ensure that people are supported to move between acute hospitals, cottage hospitals and home or a homely setting in a timely way. Supporting people through re-ablement and self management remains a priority to enable people to achieve their best possible level of independence. The group agrees the collective resources needed to address this. We recognise the challenge of ensuring that the independent sector is involved where necessary in the flow meetings.

Discharging people earlier in the day enables beds to be prepared for mid afternoon which is usually the busiest time of the day for people being admitted to hospital. A discharge lounge at DGRI opened in November 2018. The initial indications are that the introduction of this facility has increased the number of people leaving hospital before 2pm.

How we are getting on: Detecting Cancer Early

People achieve better outcomes when cancer is detected early. The Scotland target is for 1 in 3 cancer cases to be diagnosed early.



B1 ISD Scotland (2018).

9.3 Prescribing

Supporting people to be confident with medicines has a number of benefits. It keeps people safe and increases efficiency as people only use the medicines they need when they need them.

The Prescribing Support Team have increased the number of home visit medication reviews that they do. Social work has been able to use the skills of the pharmacy team by referring

people who are struggling with their medicines. Medication reviews have enabled medication routines to be simplified, helping people to manage their own medication for longer. The team has also worked closely with local care homes and third sector agencies, such as the Mental Health Association and Turning Point, to do regular medication reviews.

Pharmacists provide specialist clinics at some GP practices for common clinical conditions, pain, respiratory and hypertension. Over £30 million is spent each year in Dumfries and Galloway on medication prescribed through GP practices. Areas of work that help to keep prescribing costs sustainable include promoting healthier lifestyles, regular medication reviews, and switching from branded to generic medication where clinically appropriate. In this way, GPs and pharmacists work together to respond to changes and fluctuations in pharmaceutical supplies.

9.4 Optimising our use of buildings and other assets

Our commitments:

- We will develop a plan to make sure we use physical assets, such as buildings and land, more efficiently and effectively **(Completed)**
- We will make sure that physical assets utilised by the Integration Joint Board are safe, secure and high quality and, where appropriate, promote health and wellbeing

9.4.1 Reducing office and administration costs

We have an ongoing programme of reducing office and administration costs. In both health and social care, staff are becoming increasingly self reliant through developing their IT skills and this has led to a reduction in administration costs. Following consultation with people and staff, we have also developed a business case to relocate Annan Clinic to the Treastaigh building in Annan. As well as delivering cost efficiencies, the Treastaigh project will also deliver a better working environment and experience of care for people.

9.4.2 Transforming primary care

Following the resignation of independent GP contractors, we took the decision to administer and merge the 2 GP practices in Moffat and to take over the direct management of the Lockerbie GP practice. We are also responsible for the direct management of a GP practice in Wigtownshire. As well as sustaining access to primary care services for people at all 4 practices, we have also embarked on a wider, transformation programme of supporting all GP practices across Dumfries and Galloway to support the future development and sustainability of primary care.

10. Financial Performance and Best Value

10.1 End of year financial position

The Integration Joint Board delivered a financial break even position for 2018/19, building upon the success of balanced positions in 2016/17 and 2017/18. The ring fenced reserves carry forward of £8.4m (million) relates to the balance of social care and integrated care funds from 2018/19 balances as well as the additional balances from primary care transformation, mental health action 15 and Alcohol, Drugs and Prevention (ADP) monies. These reserves are already committed to the delivery of future care and support in ongoing programmes of work.

2018/19 was another challenging year, with the Partnership having to operate within significant budget constraints and increased expectations on savings delivery. The Partnership delivered in excess of £13.1m savings throughout the year against a target of £15.8m. A significant proportion of the savings were non recurrent leaving a £10.5m recurring gap as we move into 2019/20.

Some of the ongoing challenges facing the Partnership include:

- Increasing workforce challenges across the partnership with vacancies in key clinical roles across acute and primary care services, with the associated costs of locum cover. In addition providers are finding it increasingly more difficult to recruit to care at home vacancies.
- The growth in primary care prescribing and increase in new drug therapies coming to market.
- Sustainability of the social care market due to financial and workforce pressures.
- Delivering on national waiting time targets within the resource and capacity available.
- Demographics and increased levels of care dependency will always put pressure on existing financial resources. This is proving to be a considerable cost pressure within younger adults' services.

The net amount of total delegated resource to the IJB for 2018/19 was £377m, with £306m of NHS delegated resources and £72m of council services delegated resources.

The final position for 2018/19 is shown in the table opposite, as well as the total resources delegated over the current 3 year time period that the IJB has been operational. Overspend is indicated by numbers in brackets.

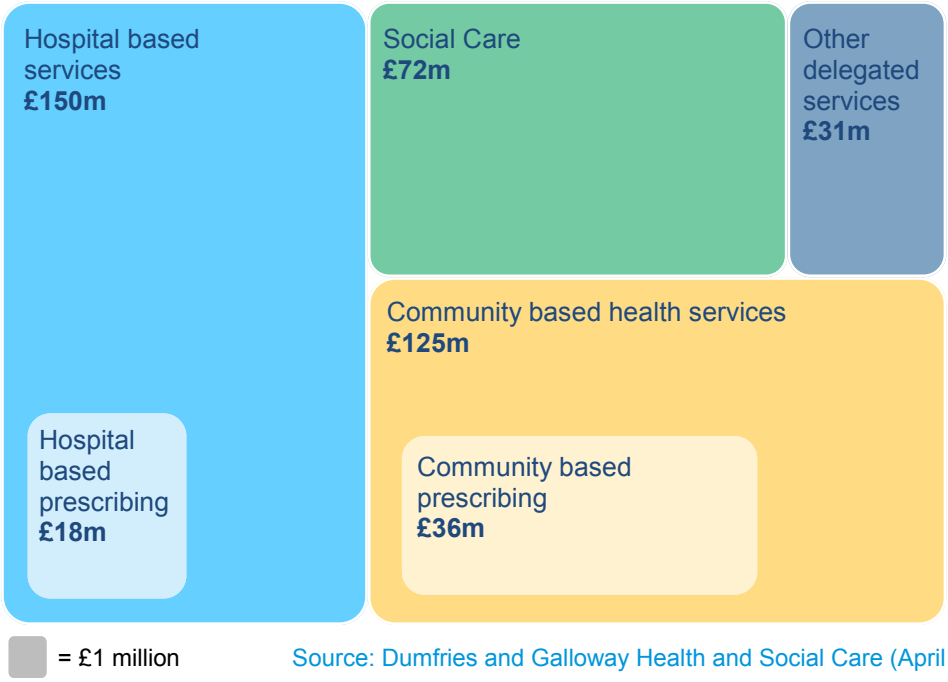
The increasing resource delegated to the IJB in 2017/18 and continued in 2018/19, reflects new services which have been delegated into the IJB, including eHealth and strategic planning and commissioning and resource transfer. In addition, non recurring funding was released into the position in year, including items such as funding towards medical locum

IJB Service	2016/17 Budget £000s	2017/18 Budget £000s	Budget £000s	2018/19 Actual £000s	Variance £000s
Council Services					
Children and Families	107	107	107	101	6
Adult Services	14,474	13,632	14,392	13,972	420
Older People	22,316	27,480	27,522	27,052	470
People with Learning Disability	16,763	18,632	20,635	21,990	(1,355)
People with Physical Disability	5,772	5,529	5,283	5,543	260
People with Mental Health Need	2,145	2,117	1,692	1,367	325
Adults with Addiction/ or Substance Misuse	263	263	263	224	39
Strategic commissioning			2,512	2,157	355
Sub-total Council Services	**61,840**	**67,760**	**72,406**	**72,406**	**0**
NHS Services					
Primary Care and Community Services	60,359	99,461	103,262	105,562	(2,300)
Mental Health	21,150	21,094	21,697	21,546	150
Women and Children	20,873	20,577	21,260	20,318	942
Acute and Diagnostics	96,768	106,283	112,435	114,242	(1,807)
Facilities and Clinical Support	20,097	14,629	16,366	16,507	(141)
E-Health		6,051	5,162	4,956	206
IJB Strategic Services		23,393	22,813	22,630	183
IJB Reserves/Savings			2,566	(200)	2,766
Sub-total NHS Services	**219,247**	**291,488**	**305,562**	**305,562**	**0**
Total Delegated Services	**281,087**	**359,248**	**377,967**	**377,967**	**0**

Locality	Annual Budget (£000s)		
	2016/17	2017/18	2018/19
Annandale and Eskdale	28,093	28,618	26,977
Nithsdale	43,191	44,446	46,541
Stewartry	21,500	22,024	25,873
Wigtownshire	20,482	21,328	22,040
Regional Services	167,820	242,833	256,536
Total Delegated Services	**281,087**	**359,248**	**377,967**

costs and one off costs, such as those associated with the opening of the new hospital in 2017/18 and increased funding for primary care transformation and ADP in 2018/19.

Dumfries and Galloway Health and Social Care Partnership spending 2018/19



Source: Dumfries and Galloway Health and Social Care (April 2019)

10.3 Transforming Services

The IJB is responsible for putting in place proper arrangements for the governance of its affairs and facilitating the effective exercise of its functions, including arrangements for managing risk and ensuring decision making is accountable, transparent and carried out with integrity.

A formal governance structure has been established, which incorporates the IJB, Health and Social Care Senior Management Team and the IJB committees for performance and finance, audit and risk, and clinical and care governance. The focus of these arrangements is to ensure performance is monitored and objectives within the Strategic Plan delivered, so as to ensure performance arrangements and risk management are in place.

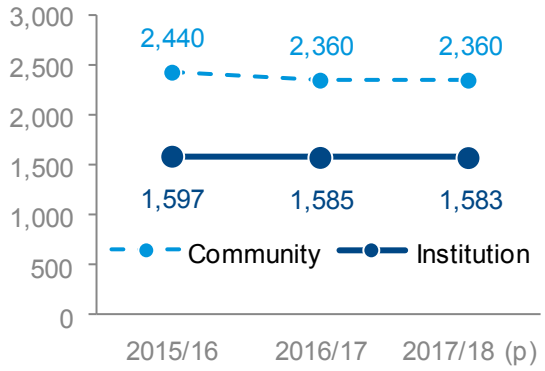
The programme of transformational redesign which commenced before the IJB was formally set up, most significantly demonstrated by the creation of a state of the art hospital in Dumfries, continues to review and transform services across the entire IJB portfolio of services. Models of care being developed will continue to enhance local community services and operate within the level of resource available to the IJB.

The increased financial challenges experienced across the entire region will require transformational redesign to be at the heart of providing solutions to improve efficiency of

How we are getting on: Balance of Care

One of the priority areas of focus identified in the Strategic Plan is shifting the focus from institutional care to home and community based care. Institutional care includes hospitals, care homes and hospices. To monitor whether we are achieving this objective, we look at the total amount of time people from Dumfries and Galloway Health and Social Care Partnership (DGHSCP) collectively spend either in an institutional setting or supported in communities.

Number of person-years spent in community or institutional settings



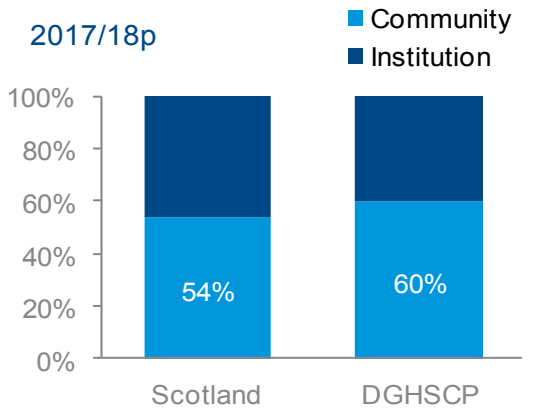
Source: ISD Scotland E6

The amount of time people are receiving care and support in the community is stable, as is the amount of time people spend in institutional settings.

The figures left reflect the model of care and support in Dumfries and Galloway.

We have a higher proportion of people supported in the community than in institutional settings, in comparison with Scotland.

Proportion of person-years spent in community or institutional settings



Source: ISD Scotland +

The Scottish Government are currently developing an indicator to reflect the expenditure on end of life care in the last 6 months of life (Indicator A23).

services for the residents of Dumfries and Galloway. We will require further significant redesign of local services in 2019/20 and beyond.

The key challenge moving forwards across the Partnership is to ensure the right person is treated at the right time and in the right place enabling the provision of care and support to transform to meet the needs of the population of Dumfries and Galloway.

In the longer term this reflects the will of the Partnership to deliver as much care and support as close to the home as possible and enable independent and free living for the people of the region.

10.4 Financial Outlook 2019/20

The level of financial restraint operating across IJB areas of responsibility will continue to present significant challenges across delegated budgets to live within their means.

As highlighted previously, service reform and redesign is key to ensuring the IJB can continue to provide services within the resources delegated by the NHS Board and the Local Authority.

The IJB has strengthened the overall governance supporting the transformational agenda with programme boards in place to develop the key strategic priorities for the services provided across Dumfries and Galloway.

Key areas of risk that have been identified in the operational success of these reforms are as follows:

- recruitment to key clinical staff, with particular emphasis on nursing and medical staff vacancies
- effective control of prescribing growth
- provision of sustainable services to maintain key national waiting time expectations
- continual demographic growth on services where care dependency increases year after year

The programme reflects the integration of services between health and social care, reviewing the way services are arranged and improving the way they are delivered so they better meet the needs of the population of Dumfries and Galloway.

2019/20 will once again prove to be a very challenging financial climate across the Partnership, with the total savings requirement amounting to £19.5m. To date, £12.7m of savings have been identified of the total required, leaving a remaining gap of £6.85m.

A financial improvement programme governed by the Sustainability and Modernisation (SAM) programme board will provide rigorous support and challenge to the transformation of IJB services over the coming months and years.

To date £12.7m of savings have been identified from a total requirement of £19.5m, leaving a remaining challenge to find of £6.85m.

SAM will review the progress of the financial improvement programme delivery and act as a point of escalation to ensure any bottlenecks/ or barriers can be quickly remedied across the Partnership. Clear leadership throughout the organisation will be provided to the programme and also to ensure effective communication strategy is in place.

11. Inspection of Services

Health and Social Care services delivered by statutory and non statutory providers in Dumfries and Galloway are regularly monitored and inspected in a range of ways to give assurance about the quality of people's care. The Partnership is required to report details of any inspections carried out relating to the functions delegated to the Partnership.

- The Care Inspectorate is a scrutiny body which looks at the quality of care in Scotland to ensure it meets high standards. Their vision is that everyone experiences safe, high quality care that meets their needs, rights and choices.
- Healthcare Improvement Scotland (HIS) provides public assurance about the quality and safety of healthcare through the scrutiny of NHS hospitals and services.
- In addition to inspections, the Partnership's commissioning officers also apply contract monitoring processes to services commissioned to deliver health and social care on behalf of the Partnership.

Since last year's performance report there were 6 inspections relating to adult services undertaken by the Care Inspectorate. The aim is to have all regulated services graded at good or above (scores 4, 5 or 6). However, 2 services, Dunmuir Park Respite Unit (The Rowans) and Dunmuir Park were graded at 3 and below during this period. Progress on the action plans against the requirements and recommendations for these services continue to be implemented and monitored until a future inspection improves the grading.

How we are getting on: Inspections

81% of care services in Dumfries and Galloway were graded Good (4) or better in Care Inspectorate inspections during 2018/19.

This is similar to the rate across Scotland which is **82%.**

This was lower than in 2017/18 when the figure was 87%.

Source: ISD Scotland A17

Please note that for sections 11.1 to 11.6 "n/a" means not assessed during the inspection.

11.1 Castle Douglas Community Support Service (January 2018)

Recommendations related to:

- providing regular supervisions to support staff to develop and improve through reflective practice

Quality Indicator	Nov 2016	Jan 2018
Quality of Care and Support	Very Good	Good
Quality of Staffing	n/a	n/a
Quality of Environment	n/a	Good
Quality of Management and Leadership	Good	n/a

- ensuring there are good quality assurance systems and processes in place reviewing and auditing all aspects of the service delivery
- developing a Continuous Improvement Plan which reflects the findings of quality assurance processes and the involvement of stakeholders

Since the inspection, improvement actions have been put in place to address all of the recommendations.

11.2 Newton Stewart Community Support Service (March 2018)

There were no recommendations and no requirements for this service.

Quality Indicator	Jan 2017	Mar 2018
Quality of Care and Support	Very Good	Very Good
Quality of Staffing	n/a	n/a
Quality of Environment	n/a	Very Good
Quality of Management and Leadership	Good	n/a

The Inspection Report noted an experienced and skilled staff team who worked very well together and provided support. The staff demonstrated a very good awareness of peoples likes, dislikes and daily routines. Very good practice where staff treated people with respect was observed.

11.3 Care and Support Service (CASS) (May 2018)

As care is delivered in people's own property, this service is never inspected on Quality of Environment.

Quality Indicator	May 2017	May 2018
Quality of Care and Support	Very Good	Very Good
Quality of Staffing	n/a	Very Good
Quality of Environment	n/a	n/a
Quality of Management and Leadership	Very Good	n/a

Recommendations related to:

- developing the personal plans of care ensuring that interventions detailed are specific in nature
- where developments in staff practice are required, objectives set are specific, can be measured, and are linked to the grading system
- encouraging a culture of continuous reflection amongst the staff group

Since the inspection, improvement actions have been put in place to address all of the recommendations.

11.4 Dunmuir Park Respite Unit (The Rowans) (July 2018)

Requirement:

- The service provider must ensure staff who require to be registered with SSSC do this within timescales set and monitor this effectively

Quality Indicator	Oct 2017	July 2018
Quality of Care and Support	Good	Good
Quality of Staffing	n/a	n/a
Quality of Environment	n/a	Adequate
Quality of Management and Leadership	Good	n/a

A process to manage and monitor registration applications was implemented immediately following this inspection, with registrations now audited on a fortnightly basis.

Recommendation related to:

- making sure staff are supported through regular supervision to identify areas of support and improve practice

New supervision guidance has been introduced together with a recording template which reflects the new Health and Social Care Standards. The Care Inspector visited on 26/03/19 and confirmed that the service is compliant, and no further action is required.

11.5 Castle Douglas Community Support Service (October 2018)

Recommendation related to:

- ensuring that risk assessments are in place to meet the needs of people supported
- ensuring good quality assurance systems and processes in place, reviewing and auditing all aspects of service delivery

Since the inspection, improvement actions have been put in place to address these recommendations.

Quality Indicator	Jan 2018	Oct 2018
Quality of Care and Support	Good	Good
Quality of Staffing	n/a	n/a
Quality of Environment	Good	Good
Quality of Management and Leadership	n/a	n/a

11.6 Dunmuir Park (December 2018)

Two requirements were identified from the inspection:

- The service provider must have adequate staff numbers in place at all times to meet peoples contracted support hours by 22 February 2019

  Since December 2018 the service has recruited 5 fulltime equivalent staff which has addressed the shortfall in staffing levels.

Quality Indicator	Nov 2017	Dec 2018
Quality of Care and Support	Good	Adequate
Quality of Staffing	n/a	n/a
Quality of Environment	Good	Adequate
Quality of Management and Leadership	Good	Weak

- The service provider must ensure that the Care Inspectorate is notified of all significant events as per Care Inspectorate Notification Guidance immediately from the date of inspection

New notification processes, guidelines and audit trails have been introduced to address this requirement.

Recommendations related to:

- reviewing people's support at least once in every 6 months
- ensuring that staff and managers follow the correct procedure when a medication error has occurred
- reviewing people's rota of support and developing these with people supported and their representative
- providing effective, regular supervision to staff to support them in their role

- evaluating how the current management structure supports the needs of people supported and the staff team
- ensuring that responsive action is taken to ensure people being supported are protected and kept safe
- reviewing the purpose of audits currently in place and completing quality assurance procedures for all essential audits

Action plans have been developed in line with the Care Inspection recommendations and services continue to be monitored until a future inspection improves the grading.

11.7 Dumfries and Galloway Royal Infirmary (May 2018)

Dumfries and Galloway Royal Infirmary had a safety and cleanliness unannounced inspection by HIS in May 2018. Due to concerns about the levels of dust in the outer areas of the theatre departments, such as corridors and storage areas, a further unannounced inspection was undertaken.

During this second inspection, it was found that the issues with the dust in these areas remained unresolved. NHS Dumfries and Galloway was asked to submit an action plan detailing how the NHS board would respond to these concerns. A subsequent inspection found that sufficient remedial actions had been taken and there were no further issues with the levels of dust in these areas.

What the hospital did well

- The infection prevention and control team's new annual HAI inspection audit and live action plan.
- Staff knowledge on aseptic technique when inserting invasive devices.

What the hospital could do better

- Management of dust in theatre corridor and storage areas.
- Staff compliance with standard infection control precautions.
- Completion of invasive devices documentation.

"We inspected a variety of patient equipment across all wards and departments. The majority of equipment was clean and well maintained.

"However, to improve care, NHS Dumfries and Galloway should ensure all infection control policies are reviewed regularly and that there is continued monitoring of the theatre environment and storage areas to ensure they remain dust free."

Head of Quality of Care, Healthcare Improvement Scotland

11.8 Galloway Community Hospital (November 2018)

Galloway Community Hospital had a safety and cleanliness unannounced inspection by HIS in November 2018.

What the hospital did well:

- A good standard of environmental cleaning in all areas inspected.
- Good staff compliance with mandatory infection prevention and control training.

What the hospital could do better:

- NHS Dumfries and Galloway must ensure that patient equipment is clean and well maintained.
- NHS Dumfries and Galloway must follow infection prevention and control advice relating to bladeless fans.

"Inspectors found a good standard of cleaning in the ward areas inspected and staff demonstrated good compliance with infection prevention and control training. However, to improve care NHS Dumfries & Galloway must ensure that patient equipment is clean and well maintained."

Head of Quality of Care, Healthcare Improvement Scotland

12. Significant Decisions and Directions

12.1 Significant decisions

Significant Decisions is a legal term defined within section 36 of the Public Bodies Joint Working (Scotland) Act 2014. It relates to making a decision that would have a significant effect on a service outwith the context of the Strategic Plan. A process for making significant decisions is in place and includes consulting the IJB Strategic Planning Group and people who use, or may use the service.

No Significant Decisions were made by the IJB in 2018/19.

12.2 Directions

Integration Authorities require a mechanism to action their Strategic Plan and this is laid out in sections 26 to 28 of the Act. This mechanism takes the form of binding directions from the Integration Authority to the Health Board or Local Authority or both.

Directions may name the Health Board or Local Authority or both to implement a direction.

The following Directions were issued by the IJB in 2018/19:

Reference Number	Direction title	Date Issued, superseded	To Whom	Web link
IJBD1801	Development of a Strategic Advocacy Plan for Adults	31/05/2018	NHS Dumfries and Galloway Dumfries and Galloway Council	Here
IJBD1802	Digital Strategy and Delivery Plan	26/07/2018	NHS Dumfries and Galloway Dumfries and Galloway Council	Here
IJBD1803	Development of a Dumfries and Galloway Learning Disability Strategy	29/11/2018	NHS Dumfries and Galloway Dumfries and Galloway Council	Here
IJBD1804	Day Services Review	29/11/2018	NHS Dumfries and Galloway Dumfries and Galloway Council	Here
IJBD1901	Provision of GP Services in Moffat	30/01/2019	NHS Dumfries and Galloway	Here

13. Review of the Strategic Plan

The Dumfries and Galloway Integration Joint Board (IJB) Strategic Plan 2016-19 was agreed in April 2016. This plan was developed by consulting with, and listening to, people who use services, their families, Carers, members of the public, people who work in health and social care, and third and independent sector partner organisations. It sets out the vision of the IJB, the case for change, how we plan to achieve the vision, priority areas of focus and our commitments against each of these.

The Public Bodies (Scotland) Act 2014 places a legislative requirement on integration authorities to review their strategic plans at least once in every relevant period.

The legislation outlines two options for integration authorities:

- Retain the current strategic plan, restarting the relevant period at the date of this decision (New Period of Relevance April 2018-21) or
- Replace the strategic plan at the end of the current relevant period (New Period of Relevance April 2019-22)

The Integration Authority, when considering whether or not to retain or replace their strategic plan, must:

- Seek and have regard to the views of its Strategic Planning Group (SPG) on the effectiveness of the arrangements for carrying out the Integration functions and whether the Integration Authority should prepare a replacement strategic plan
- Have regard to the Integration principles and national health and wellbeing outcomes.

The IJB, at its meeting in May 2017, agreed the process for reviewing the strategic plan. This process involved extensive discussions with the Strategic Planning Group

The Dumfries and Galloway SPG consists of 40 members, with representation from a wide range of partners and stakeholders. This includes people representing staff in the statutory and non-statutory sectors, people who have experienced or are experiencing health and social care support and Carers.

The role of the SPG is to shape and influence the strategic plan and continuing to review progress measured against the 9 National Outcomes.

Members of the SPG were asked to review each section of the strategic plan and provide comments and an overall view on whether to retain or replace the document for the next relevant period.

The view from the feedback that we received from members of the Strategic Planning Group was strongly that the existing strategic plan should be retained.

The IJB agreed on 5 April 2018 that the Strategic Plan should be retained, restarting the relevant period from the date of this decision. Therefore, the new period of relevance for the Dumfries and Galloway Health and Social Care Partnership Strategic Plan is April 2018-March 2021.

Appendix 1: National Core Indicators

Indicator		2015/16		2017/18		2019/20	
		Scotland	Dumfries and Galloway	Scotland	Dumfries and Galloway	Scotland	Dumfries and Galloway
A1	Percentage of adults able to look after their health very well or quite well	95%	95%	93%	93%		
A2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	83%	85%	81%	85%		
A3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	79%	83%	76%	80%		
A4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	75%	82%	74%	83%		
A5	Total % of adults receiving any care or support who rated it as excellent or good	81%	86%	80%	85%		
A6	Percentage of people with positive experience of the care provided by their GP practice	85%	90%	83%	86%		
A7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	83%	85%	80%	86%		
A8	Total combined % carers who feel supported to continue in their caring role	40%	48%	37%	40%		
A9	Percentage of adults supported at home who agreed they felt safe	83%	85%	83%	87%		

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

Indicator		Year 1			Year 2			Year 3		
		Time Period	Scotland	Dumfries and Galloway	Time Period	Scotland	Dumfries and Galloway	Time Period	Scotland	Dumfries and Galloway
A10	Percentage of staff who say they would recommend their workplace as a good place to	Under Development			Under Development			Under Development		
A11	Premature mortality rate per 100,000 persons	2015	441	376	2016	440	388	2017	425	381
A12	Emergency admission rate (per 100,000 population) – Adults	2016/17	12,215	12,609	2017/18	12,192	13,066	2018/19		12,103 (p)
A13	Emergency bed day rate (per 100,000 population) – Adults	2016/17	126,945	132,361	2017/18	123,160	134,001	2018/19		127,272 (p)
A14	Readmission to hospital within 28 days (per 1,000 admissions)	2016/17	101	87	2017/18	103	95	2018/19		86 (p)
A15 / E5	Proportion of last 6 months of life spent at home or in a community setting	2016/17	87%	88%	2017/18	88%	89%	2018/19	89%	89%
A16	Falls rate per 1,000 population aged 65+	2016/17	21.8	16.6	2017/18	22.7	18.7	2018/19		17.0 (p)
A17	Proportion of care services graded good (4) or better in Care Inspectorate inspections	2016/17	84%	84%	2017/18	85%	87%	2018/19	82%	81%
A18	Percentage of adults with intensive care needs receiving care at home	2016	62%	65%	2017	61%	63%	2018	62%	62%
A19	Number of days people aged 75 or older spend in hospital when they are ready to be	2016/17	841	591	2017/18	762	554	2018/19	805	618
A20	Percentage of health and care resource spent on hospital stays where the patient was	2016/17	24%	23%	2017/18	25%	25%	2018/19		24% (p)
A21	Percentage of people admitted to hospital from home during the year, who are discharged to a	Under development			Under development			Under development		
A22	Percentage of people who are discharged from hospital within 72 hours of being ready	Under development			Under development			Under development		
A23	Expenditure on end of life care, cost in last 6 months per death	Under development			Under development			Under development		

(p) = provisional result

Appendix 2: Indicators regularly monitored by the Partnership

Indicator		Target	Year 1			Year 2			Year 3		
			Time Period	Scotland	Dumfries and Galloway	Time Period	Scotland	Dumfries and Galloway	Time Period	Scotland	Dumfries and Galloway
B1	Detect cancer early	33.3%	2014 - 2015	25.3%	26.1%	2015 - 2016	25.4%	22.4%	2016 - 2017	25.3%	22.6%
B2 (1)	The percentage of all people diagnosed with cancer who begin treatment within 31 days of the decision to treat	95%	Jan - Mar 2017	95%	97%	Jan - Mar 2018	94%	97%	Jan - Mar 2019	94%	96%
B2 (2)	The percentage of people diagnosed with cancer who were referred urgently with a suspicion of cancer who began treatment within 62 days of receipt of referral	95%	Jan - Mar 2017	88%	96%	Jan - Mar 2018	85%	95%	Jan - Mar 2019	80%	93%
B3	The number of people newly diagnosed with dementia who have a minimum of 1 years post diagnostic support	100%	2014/15	85%	92%	2015/16	83%	97%	2016/17	84%	94%
B4	People wait no longer than 12 weeks from agreeing treatment with the hospital to receiving treatment as an inpatient or day case (Treatment Time Guarantee (TTG))	100%	Jan - Mar 2017	82%	86%	Jan - Mar 2018	76%	78%	Jan - Mar 2019	68%	81%
B5	The percentage of planned/elective patients that start treatment within 18 weeks of referral	90%	March 2017	83%	90%	March 2018	81%	84%	March 2019	77%	88%
B6	The percentage of people who wait no longer than 12 weeks from referral to first outpatient appointment	95%	March 2017	81%	92%	March 2018	75%	90%	March 2019	75%	96%

Source: ISD Scotland

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

Indicator		Target	Year 1			Year 2			Year 3		
			Time Period	Scotland	Dumfries and Galloway	Time Period	Scotland	Dumfries and Galloway	Time Period	Scotland	Dumfries and Galloway
B7	The percentage of people who waited no longer than 6 weeks for diagnostic tests and investigations	100%				Jan - Mar 2018	81%	98%	Jan - Mar 2019	84%	95%
B8	The percentage of pregnant women in each Scottish Index of Multiple (SIMD) quintile that are booked for antenatal care by the 12th week of gestation	80%	2015/16	86%	82%	2016/17		86%	2017/18	84%	85%
B9	The percentage of eligible people who commence IVF treatment within 12 months of referral	100%	Jan - Mar 2017	100%	100%	Jan - Mar 2018	100%	100%	Jan - Mar 2019	100%	100%
B10	The percentage of young people who start treatment for specialist Child and Adolescent Mental Health Services (CAMHS) within 18 weeks of referral	90%	Jan - Mar 2017	84%	100%	Jan - Mar 2018	71%	90%	Jan - Mar 2019	74%	90%
B11	The percentage of people who start psychological therapy based treatment within 18 weeks of referral	90%	Jan - Mar 2017	74%	70%	Jan - Mar 2018	78%	78%	Jan - Mar 2019	77%	74%
B12	The rate of Clostridium Difficile infections in people aged 15 and over per, 1,000 total occupied bed days	0.32	December 2016	0.28	0.28	December 2017	0.28	0.39	No longer reported in this format		
B13	The rate of Staphylococcus Aureus Bacteraemias (MRSA/MSSA) per, 1,000 total occupied bed days	0.24	December 2016	0.32	0.21	December 2017	0.33	0.28	No longer reported in this format		
B14	The percentage of people who wait no longer than 3 weeks from when a referral is received to when they receive appropriate drug or alcohol treatment that supports their recovery	90%	Oct - Dec 2016	95%	99%	Oct - Dec 2017	94%	98%	Oct - Dec 2018	94%	93%
B15	Number of alcohol brief interventions delivered in three priority settings (primary care, accident and emergency and antenatal care)	(Target)	2016/17	86,560 (61,081)	691 (1,743)	2017/18	61,081 (81,177)	1,105 (1,743)	2018/19		1,071 (1,743)

Indicator		Target	Year 1			Year 2			Year 3		
			Time Period	Scotland	Dumfries and Galloway	Time Period	Scotland	Dumfries and Galloway	Time Period	Scotland	Dumfries and Galloway
B17	GP practices provide 48 hour access or advance booking to an appropriate member of the GP team for at least 90 per cent of people	90%	2015/16	84%	89%	2017/18	93%	96%	Results expected 2019/20		
B18	Sickness absence rate for NHS employees	4%	2016/17	5.2%	5.1%	2017/18	5.4%	4.9%	2018/19	5.4%	5.2%
B18 (Suppl)	Sickness absence rate for adult social work employees		Jan - Mar 2017		8.0%	Jan - Mar 2018		7.8%	Jan - Mar 2019		7.7%
B19	The percentage of people who wait no longer than 4 hours from arriving in accident and emergency to admission, discharge or transfer for treatment	95%	March 2017	94%	94%	March 2018	88%	90%	March 2019	91%	93%
B20	The NHS Board operates within their Revenue Resource Limit (RRL), their Capital Resource Limit (CRL) and meet their Cash Requirement	100%	2016/17		100%	2017/18		100%	2018/19		100%
C1	Adults accessing telecare as a percentage of the total number of adults supported to live at home	73%	March 2017		77%	March 2018		70%	March 2019		74%
C2	The number of adults accessing Self Directed Support (SDS) Option 1		March 2017		326	March 2018		325	March 2019		345
C3	The number of adults accessing Self Directed Support (SDS) Option 2								March 2019		12
C4	The number of adults accessing Self Directed Support (SDS) Option 3		March 2017		2,426	March 2018		2,434	March 2019		2,388
C5	The number of Carers being supported					2017/18		112	2018/19		173

Indicator		Target	Year 1			Year 2			Year 3		
			Time Period	Scotland	Dumfries and Galloway	Time Period	Scotland	Dumfries and Galloway	Time Period	Scotland	Dumfries and Galloway
C6	Proportion of people aged 65 and over receiving care at home (via Option 3) with intensive needs (10 hours or more)		March 2017		46%	March 2018		50%	March 2019		46%
C7	The number of adults under 65 receiving personal care at home (via Option 3)		March 2017		588	March 2018		616	March 2019		650
C8	Total number of care at home hours provided as a rate per 1,000 population aged 65 and over		March 2017		602	March 2018		635	March 2019		568
C9	Percentage of referrers receiving feedback on actions within 5 days of receipt of referral		Jan - Mar 2017		44%	Jan - Mar 2018		65%	Jan - Mar 2019		59%
E1	The number of emergency admissions per month for people of all ages	(Target)	December 2016		1,549	December 2017		1,549 (1,400)	December 2018		1,576 (1,400)
E2	The number of unscheduled hospital bed days for acute specialities per month	(Target)	December 2016		11,521	December 2017		11,977 (11,320)	December 2018		11,500 (11,212)
E3	The number of people attending the emergency department per month	(Target)	March 2017		3,981 (3,832)	March 2018		3,731 (3,851)	March 2019		3,681 (3,869)
E4	The number of bed days occupied by all people experiencing a delay in their discharge from hospital, per month, people aged 18 and older	(Target)	March 2017		702	March 2018		1,176 (998)	March 2019		1,648 (1,116)
E6	The number of person-years spent in institutional settings	1,570	2015/16		1,597	2016/17		1,585	2017/18		1,583

Source: ISD Scotland

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

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
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. (See also Forward looking care).

Asset-based approach
Identifying and making best use of all the resources at an individual and community level.

Care and support plan
An agreed document, developed and maintained by the person and their health and/or social care professional, that identifies and records discussion with regard to personal aims and outcomes, needs, risk and any required action. It can be electronically stored or written on paper and accessible to the person.

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

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

Co-produce / Co-production
A way of working where people and professionals share power to plan and deliver support together.

COSLA
The Convention of Scottish Local Authorities. COSLA is the voice of Local Government in Scotland, providing political leadership on national issues and working with councils to improve local services and strengthen local democracy.

Culture
The way in which members of an organisation relate to each other, their work and the outside world.

Dementia
A term used to describe a group of symptoms that occur when brain cells stop working properly, which can affect thinking, memory and communication skills.

GP
General Practitioner, sometimes referred to as a family doctor.

Health and social care integration
Bringing together adult health and social care in the public sector into one statutory body, for example an Integration Authority.

Health inequalities
A term that refers to the gap between the health of different population groups, such as wealthier compared to poorer communities or people with different ethnic backgrounds.

Impact assessment (see also protected characteristics)
A process to assess the impact of applying a proposed new or revised plan, policy, function or service.

Independent sector
A general term for non-statutory bodies including private enterprise, voluntary, charitable or not-for-profit organisations.

Integration Authority
An integration joint board or lead agency, responsible for services delegated to it by the NHS and local authority.

Integration Joint Board (IJB)
A body established where a health board and local authority agree to put in place a Body Corporate model. The integration joint board is responsible for planning integrated arrangements and onward service delivery.

IT Systems
Information technology systems, which can include specialist systems within a hospital environment to aid the delivery of care and also systems to record patient information.

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.

Long term conditions
These are health conditions that last a year or longer, impact on a person's life and might require ongoing care and support. These are also known as chronic conditions.

Ministerial Strategic Group (MSG)
The MSG is a forum for leaders from health and social care to provide direction and support, for taking forward COSLA and the Scottish Government's joint political leadership of health and social care integration. It is chaired by the Cabinet Secretary for Health and Sport and includes representation across multiple sectors with an interest in how health and social care are delivered.

Mobile technologies
Technology that is portable, including mobile phones, tablet devices and laptops.

One Team Approach
A multi disciplinary way of working which includes professionals from different areas, who work together to improve care and outcomes for people.

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

Personalised
Tailoring health and/or social care and support specifically to an individual.

Person-centred
Focuses care and support on the needs of a person and is a way of thinking and doing things that sees the people using health and social care as equal partners in planning, developing and monitoring care to make sure it meets their needs.

Personal outcomes
The end result or impact of activity on a person. A personal outcomes approach identifies what matters to people through good conversations during care and support planning.

Protected characteristics
It is recognised that people may face discrimination due to these characteristics. The Equality Act 2010 describes age, disability, sex, race, religion or belief, pregnancy and maternity, marriage and civil partnership, sexual orientation and gender reassignment as protected characteristics.

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.

Self-management
People making decisions about and managing their own health and wellbeing.

Strategic needs assessment (SNA)
An analysis of the health and social care and support needs of a population that helps to inform health and social care planning.

Strategic plan
A high level plan that sets the future direction of travel for health and social care by identifying key challenges and priority areas of focus and aligning resources to activity.

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.

Telehealth
The provision of healthcare remotely by means of telecommunications technology.

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.

Third sector
An extensive range of organisations that have a social purpose and are not-for-profit, such as voluntary organisations, charities, or social enterprises. The types of services and the opportunities they provide include health and social care and support, information, advocacy and volunteering.

Vulnerable adult
A person over the age of 18 at risk of being harmed by reason of disability, age or illness.

Wellbeing
Wellbeing is a complex combination of a person's physical, mental, emotional and social health. Wellbeing is strongly linked to happiness and satisfaction in life.

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