DUMFRIES AND GALLOWAY
INTEGRATION JOINT BOARD

HEALTH AND SOCIAL CARE

ANNANDALE AND ESKDALE LOCALITY REPORT

DUMFRIES AND GALLOWAY
Health and Social Care

October 2019

Contents

This report has been produced by:

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October 2019

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Foreword

Annandale and Eskdale is a great place to live and work. We can be rightly proud of how local communities, agencies and individuals work together to support the health and wellbeing of local people.

However just as financial, technological and demographic changes are having a profound impact on how services are delivered in other parts of our lives, it is evident that similar changes are required in how we deliver health and social care. For example, as more and more people use Skype to keep in touch with friends and relatives, new technology can also provide opportunities for people and their clinicians to communicate with each other. Using the Attend Anywhere technology can reduce time spent travelling. The pace of change will continue to increase and presents both challenges and opportunities for us to support people across Annandale and Eskdale to lead healthy and fulfilling lives.

This report sets out the progress and challenges we have faced over the last 12 months in delivering 5 of the 9 National Health and Wellbeing Outcomes. As part of our commitment to support people to live as independently as possible in a homely setting (Outcome 2), we have made good progress in developing new housing with care services. However, we have found it increasingly difficult to source care at home services, particularly in the more rural areas. This has led to significant delays in discharging some people from hospital and in the timely provision of support which helps prevent admission into hospital.

We are continuing to engage in good conversations with local people to help maximise access to natural forms of community support. Work has begun to review our current framework agreement with local providers to help improve the availability of care at home services across all parts of Annandale and Eskdale

Within this report, you will read more about the experience of people who use health and social care services (Outcome 3), the progress we have made in reducing health inequalities (Outcome 5), the support we provide for unpaid Carers (Outcome 6) and how we engage our workforce in all sectors to help continually improve the information, support, care and treatment they provide. Whilst we have made good progress in some areas, we know that demand is increasing, waiting times are growing, our workforce is ageing, and some of our buildings and services are not fit for purpose.

Over the next 12 months we will have to increase the pace of change. Engaging with our wider workforce, both paid and unpaid, continuing to roll out good and open conversations within all parts of our community and a more creative use of new technology will be key to us developing and delivering a programme of sustainability and modernisation. We live in challenging times but by working together, new and creative ways of delivering excellent health and social care can and will be developed moving forward.

For as the renowned anthropologist, Margaret Mead, once said “Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has”.

Gary Sheehan
Locality Manager - Annandale and Eskdale
October 2019

Introduction

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

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

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

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

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

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

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

Dumfries and Galloway Scheme of Integration
http://www.dg-change.org.uk/wp-content/uploads/2015/07/Dumfries-and-Galloway-Integration-Scheme.pdf (last access 30 January 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 symbols we use

i) How we are addressing this outcome in our locality

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

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

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

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

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

ii) How we are getting on

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

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

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

- We are meeting or exceeding the target or number we compare against
- We are within 3% of meeting the target or number we compare against
- We are more than 3% away from meeting the target or number we compare against
- Statistical tests 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 services in the health and social care partnership and are the benchmark against which progress is measured. The Scottish Government has not numbered these outcomes to reflect that they are all equally important. However, locally we have added numbers solely for the purpose of tracking progress through our performance framework.

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.

2.1 How we support this in our locality

In the future, people's health and social care needs will increasingly be met in their home and in the community. The way that services are planned, delivered and coproduced reflects this shift. We will be working collaboratively with local people and agencies from all parts of the health and social care sector and beyond. We are committed to ensuring that people are supported by the right person, at the right time and in the right place.

2.1.1 Housing with care and support

In our locality we are working towards this outcome by working across the Health and Social Care Partnership (HSCP) and with registered social landlords to explore new housing with care initiatives. Through the Handyvan and Care and Repair services, we also facilitate minor and major adaptations to people's homes. These aim to enable people to remain as independent as possible in their own community.

2.1.2 Day support

We have continued to explore new opportunities to enhance the delivery of low levels of care within our day centres. This follows on from the review of day care services being undertaken with our colleagues in the Strategic Planning and Commissioning Team. This initiative has allowed some service users to continue using the services of Langholm Day Centre, keeping people active within their community and decreasing the likelihood of social isolation.

2.1.3 Safe and Healthy Action Partnership (SHAP)

Working closely with Moffat Town Hall Development Trust we are trying to support the further development and sustainability of the Monday and Friday Clubs which they have developed. These clubs provide a hot meal, stimulation and company for older people and for people living with dementia in the community.

The Friday Club is open to all and is primarily focused on people who are isolated through living in a remote location or lack of transport. The club caters for 60 people each week.

The Monday club evolved from the Friday Club in 2018, when it became apparent that some members with physical or mental disabilities needed more personal care.

2.1.4 New technology

We encourage people, where appropriate, who are assessed by our front line social work staff to consider using Technology Enabled Care. We recognise that this can bring challenges at times, but with the right support it is proving to be very positive with many people and their families who are finding it very reassuring. We are also working with local care homes and GPs to roll out Attend Anywhere technology. This enables people to communicate with their clinicians through a video link.

2.1.5 Care Providers Forum in Annandale and Eskdale

The Care Providers Forum is very active. This is facilitated by our locality social work manager, who is also part of the Care at Home work stream of the Healthy Ageing Programme Board and advocates strongly on behalf of our community.

However, we continue to face significant challenges in the delivery of care at home in Annandale and Eskdale, particularly in the more remote parts of the area. It is anticipated this will be addressed, in part, by the new service framework when it is delivered later in 2020. Our partners in the care at home sector continue to attempt to recruit on an ongoing basis though recruitment remains problematic for some.

2.16 Supporting people living with Parkinson's Disease

Through the SHAP we are also working with local people and Parkinson's UK to develop sustainable support and activities for people living with Parkinson's. An exercise and mobility class has been tested and the evaluation has shown that people greatly benefitted. The group are currently working together so that it becomes self sufficient and sustainable in the longer term.

How we are getting on: Parkinson's Exercise Group

The Parkinson's Exercise Group received a small Grant from SHAP and Parkinson's UK to initially get started. There are around 12 people regularly attending, including some Carers/friends, who all say they are benefiting both physically and mentally and enjoying the chance to keep mobile, socialise and share experiences with others.

Comments from people taking part in the Parkinson's Exercise Group included:

"I feel my balance is improving"

"A real sense of community; a chance to catch up with refreshments afterwards. Exercises are geared to help different aspects of difficulty e.g. balance, concentration, relaxation and body strength"

"Enjoyed classes and I am more aware of balance and posture and my walking has improved."

2.2 How we are addressing this outcome in our locality

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

7 We will work in partnership with local communities to develop new sustainable, flexible and integrated models of community based day, residential, supported living and other specialist services to meet the needs of local people.

8 We will work in partnership with care providers to develop sustainable care at home and care home services which strive to optimise people's independence and quality of life.

9 We actively support people with chronic conditions in the community to help reduce the need for people to be admitted to hospital.

10 We will work in partnership to develop 'dementia friendly' communities across Annandale and Eskdale.

11 We will establish a locality housing group with housing providers and other partners to develop new models of housing and support to meet the needs of people across Annandale and Eskdale.

12 We will promote care and repair grant opportunities to enable people to remain living within their own homes for as long as possible.

2.3 How we are getting on

2.3.1 Developing supported housing - Moffat and Langholm

Subject to final planning permission, we are progressing plans with Loreburn Housing to develop 2 new Extra Care Housing schemes for older and younger people in Moffat and Langholm. These schemes will see the delivery of 20 units on each site with a central hub where care can be delivered and social activities take place. Our Housing Project Management Team have a Design Sub Group and our front line staff and care providers have been fully involved in the design of the properties in Moffat and Langholm. These will be fully accessible and designed to Housing our Ageing Population Panel for Innovation (HAPPI) standards. The bungalows in Moffat are also Passiv Haus designed.

In terms of our housing development programme there has been ongoing community engagement in the towns of Moffat and Langholm. There has been some very positive feedback from some members of both communities who have expressed an interest in being considered for housing with care. However, there have been concerns raised by others in the community who are unsure about possible adverse impacts it may have on our already stretched GP practices in particular. It is understandable that some members of the community have raised their concerns and we will continue to work with the local community and GPs to ensure that we continue to transform primary care to meet the changing needs of our local people.

2.3.2 Developing supported housing - Annan

We have established a housing project management team within our locality with representatives from social work, technology enabled care team, welfare benefits team, IDEAS team, nursing, occupational therapy, finance, commissioning, Care Inspectorate and Loreburn Housing.

In partnership with Loreburn Housing, we have commissioned the development of a block of 9 flats in Station Yard in Annan for people with a learning disability**.** This development is currently on site and due to be handed over in June 2020. This new development will provide long term housing and support and increase the number of beds available for short breaks for people with learning disabilities, their family and Carers. This will enable people with learning disabilities to remain living in Annan rather than having to move elsewhere for specialist supported accommodation. Some of the flats will be bespoke designs and the scheme itself will be located close to key local transport services in the heart of Annan.

What people tell us: Developing supported housing

"We are very pleased to be working alongside the Health and Social Care Partnership to deliver specialist housing in the region. There is strong evidence that housing with support and care is under developed and we are keen to work with partners to meet that need and create homes which meet the aspirations of tenants and their families. The Annan development is a great example of this joint working."

Lorraine Usher, CEO of Loreburn Housing

"It has been a privilege to have been part of this project from concept to fruition. Historically some adults with complex needs may have had to move way to find suitable accommodation. However this project supports individuals to remain connected to their family, friends and community."

Allison Breen, Social Work

2.3.3 Day services

As well as reviewing the funding arrangements for the 4 day centres for older people across the locality, we are aware of the need to support other day services being provided (mainly through volunteers) by Moffat Town Hall Development Trust where there is a real challenge in terms of sourcing recurring funding. These types of community led initiatives are crucial to people living in our communities and our Health and Wellbeing Team is working with them to help find ways to support them to become sustainable.

2.3.4 Integrating health and social care

As we integrate our services further across the Health and Social Care Partnership, opportunities have arisen to improve communication, and subsequently outcomes for people in our community. Our senior district charge nurse is now part of the management team within Social Work which makes decisions on the outcomes and needs of individuals. This has resulted in enhanced joint working between social workers, community nurses and care providers resulting in better outcomes for some people and avoided the need for hospitalisation in some cases. Keeping people out of hospital and encouraging them to be active is also a vital aspect of prevention and self management.

2.3.5 Frailty collaborative

With the support of Health Education Scotland (HES), we are developing a frailty collaborative project with local GPs to identify people at risk of frailty. The collaborative is seeking to develop new ways of supporting these people to help prevent the need for hospital admission or re-admission. A multi disciplinary project team has been established to deliver this project. Our team of occupational therapists are in the project team to help ensure people have the right equipment, aids and adaptations to allow them to remain in their own homes for as long as possible and prevent the need for hospital admission or requiring a residential care home.

2.3.6 Day of Care audit

Some people will always require higher levels of care and ultimately hospital admission or residential care. However our Day of Care audits consistently shows that less than 50% of the people supported in our cottage hospitals are still benefitting from being there. As well as improving access to care at home and reablement services in the community, we are progressing proposals to develop new intermediate care services across Annandale and Eskdale.

2.3.7 Care homes

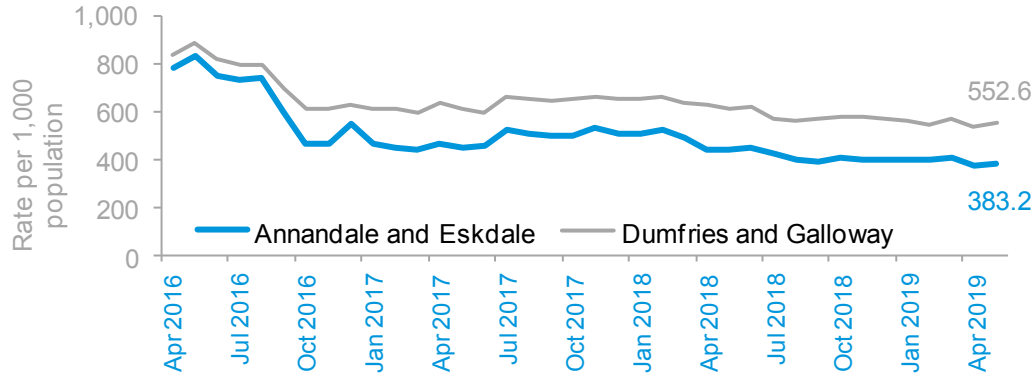
Over the past 12 months we have continued to work with Scottish Care and our local residential care homes to enable them to provide sustainable, high quality care and support. The roll out Anticipatory Care Plans (ACPs) in all homes has continued. We have also developed a Service Improvement Team which included partners from the Care Inspectorate, nursing, locality management, social work and commissioning teams. This team is helping deliver improved performance and Care Inspectorate gradings for a local care home. Moving forward, we plan to build on this approach to help support ongoing improvements across all care homes in the locality.

2.3 How we are getting on

Care and support at home 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. Across Dumfries and Galloway, approximately 20% of care and support is delivered by the Partnership's Care and Support Service (CASS).

People supported at home

The rate of care at home hours provided for people aged 65 and over; Annandale and Eskdale

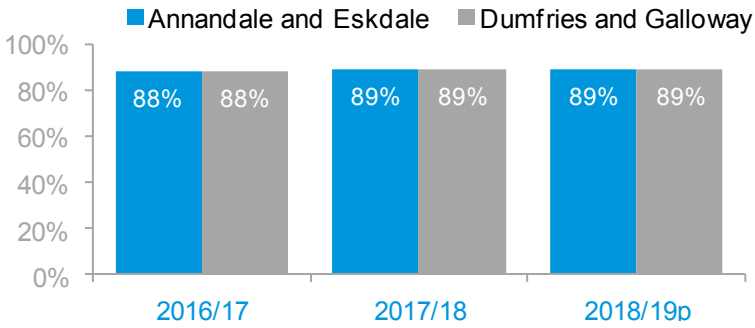


C8 Source: Dumfries and Galloway Council

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

89%

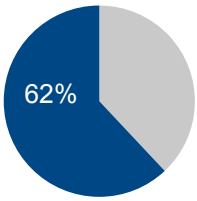
of their time at home or in a homely setting.



A15 E5

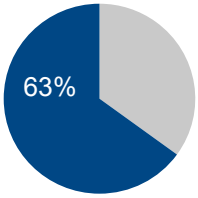
Source: ISD Scotland (p - provisional result)

Dumfries and Galloway 2018



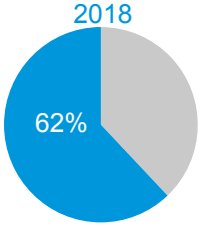
62% of adults with long term care needs receive care at home.

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

3. Outcome 3

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

3.1 How we support this in our locality

There are a range of ways people are able to give feedback about their experience of health and social care. Feedback may come in the form of comments, responses to surveys, consultations and complaints. Our locality uses this feedback to continually improve services and help those providing health and social care understand and respect the views of the people they support.

We aim to provide the highest quality services possible to people in our communities through the delivery of safe, effective and person centred care. Whenever the care we provide can be improved, we must listen and act.

3.1.1 Complaints

Our complaints procedure reflects our commitment to welcoming all forms of feedback, including complaints. It reflects our commitment to using this feedback to improve our services, to address complaints in a person centred way and to respect the rights of everyone involved. As well as addressing concerns at an early stage, we strive to investigate and respond to complaints in a timely fashion and share the learning both to help improve service delivery and also the experiences of people using our services.

3.1.2 Care Assurance

As a locality we are committed to provide safe, high quality and effective care. We continually strive to make things better for the people in our care. Measuring the quality of care being delivered is a complex process. By using our Care Assurance programme within our cottage hospitals, and soon to be implemented within our community and adult general nursing service, this enables us to obtain feedback from the people using our service. It also supports staff to continuously improve using the feedback and knowledge from the Care Assurance reports.

3.1.3 Good Conversations

Open and effective communication with the people using our service, including their families and Carers, should begin at the start of their care and continue throughout all the care they receive. Being open and honest when things go wrong is paramount in the relationship between the people using services and the people who care for them. Acknowledging and explaining when things go wrong is paramount. Good communication is key to ensure the people accessing services get the support they need, particularly as many of them are vulnerable. To this end all of our link workers, care co-ordinators and social workers are trained in Good Conversations. This includes effective listening to what the person has to say and allows them to work in partnership with people to identify how their outcomes can be best met.

3.2 How we are addressing this outcome in our locality

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

13 We will listen to what people think of our services and let them know what improvement actions we have taken.

14 We will develop of locality participation and engagement group.

15 We will provide a range of accessible ways for people to communicate their views and wishes.

16 We will develop end of life care in line with the needs and wishes of people and their families.

17 We will develop clusters of integrated care communities across Annandale and Eskdale to promote more integrated ways of working and more effective points of access to support.

3.2.1 Care Assurance

We continue to implement the Care Assurance programme throughout our cottage hospitals across Annandale and Eskdale. Within our locality

- 3 of our 4 hospitals have already achieved Silver status following Level 3 Care Assurance
- the fourth hospital is currently undergoing Level 3, currently on Bronze status

We will continue to strive, maintain and build on the current levels within our hospitals. The introduction of the Care Assurance Programme is currently under development for the community adult general nursing teams.

3.2.2 Working together to improve services

We are demonstrating how we are learning from experiences and striving to improve. For example, following a recent Care Inspectorate report we pulled together a Service Improvement Team with partners from across the HSCP and third sector, to support a service and assist them with developing an improvement plan. This has been positive, resulting in an improved service which is delivering improved outcomes to vulnerable people. The process also strengthened our partnership and there was significant learning for us in how we can work effectively together with our care providers.

3.2.3 Using learning summaries

We believe the best way to reduce harm is to adopt unequivocally a culture of learning. Within our locality, learning from adverse events is an essential part of our approach to managing risk. Using learning summaries we will continue to be open and honest about what has happened and will discuss adverse events promptly, fully and compassionately with all concerned. Learning is shared, ensuring it is a core element for informing future planning and development.

3.2.4 Community engagement

We have listened to people using services who have told us how their outcomes can be best met. This has included listening to people with a learning disability and to older people about how the right type of housing and care can be integrated and delivered. (See Outcome 2 in relation to Annan, Moffat and Langholm). These discussions will also inform the wider discussions now required with our communities in respect of point 16 of our We Wills relating to end of life care as well as point 17 in developing clusters of integrated care communities.

As part of the review of health and wellbeing teams across Dumfries and Galloway the local team have been engaging with local people and stakeholders to get their views, ideas and suggestions as to what is currently working well and what may need strengthening or improving. As part of the review of health and wellbeing services we engaged with 150 people.

What people tell us: Health and Wellbeing Team and Community Link

"When we started getting help, it helped improve our circumstances and gave us some much needed peace of mind. If it was not for getting help me and my partner would still be in really bad positions in life and wouldn't know what to do."

- Community Link client

"I think Community Link is excellent but clearly not enough. The way the team pulls together is very helpful; liaison with practices makes communication work well and action planning easier.

The wider range of activities is great although with reducing resources this will be hard to sustain."

- local GP

"The team responds flexibly and positively to our requests for help and we feel comfortable referring clients into their support systems.

The team have built a positive reputation for effective intervention and we have been delighted to work with them in the past."

- local person working in a community initiative

"The Community Link Worker understood my son and his challenges and also saw his potential. She made him feel secure and he trusted her. The link worker set up for him to volunteer at the Day Centre. His self confidence blossomed and he now has such a huge sense of self worth and I've noticed how much more confident he is when talking to people. I know to many people the input from the link worker may seem small but she made all the difference to my son and to his future I can't thank her enough!"

- Person whose son used Community Link Service

"Thank you for all of the support that you gave me while I was struggling up there. Without you giving me help and a kick up the ****, I don't think I would even be alive. It was a very unpleasant period and you helped me to get through it"

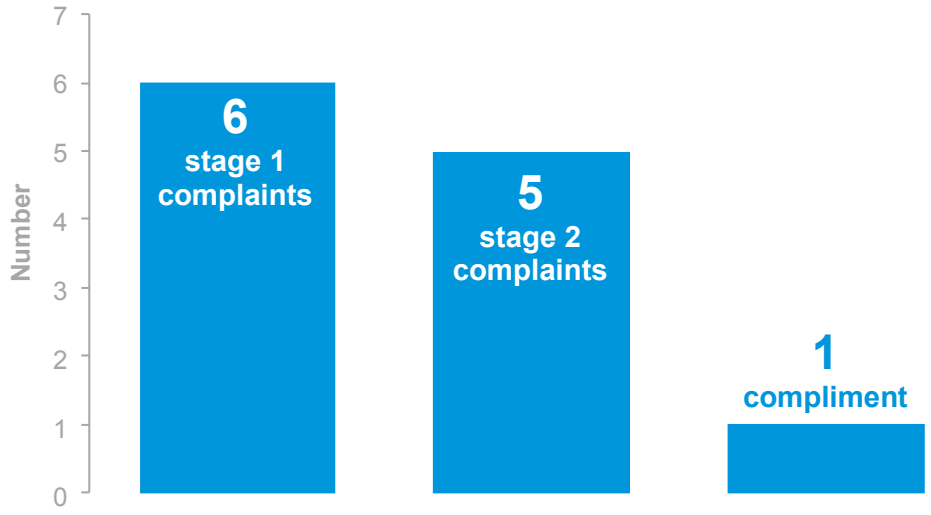
- Community Link client

3.3 How we are getting on

The Scottish Public Services Ombudsman's Model Complaints Handling Procedure was introduced from 1 April 2017, This procedure is for all public services 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.

Locality teams may receive complaints through both Dumfries and Galloway Council or NHS Dumfries and Galloway.

In total, during 2018/19, Annandale and Eskdale locality team received...



D2

Sources: Dumfries and Galloway Council, NHS Dumfries and Galloway

The complaint handling process we follow enables us to streamline the complaint and ensure an early local resolution within an acceptable timeframe. Complaints give us valuable information and a first hand account of the experiences of the people we are caring for. This allows us to identify and improve our services and ensure the problem does not happen again.

5. Outcome 5

Health and social care services contribute to reducing health inequalities.

5.1 How we support this in our locality

Health inequalities occur as a result of wider inequalities 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 health inequalities involves action on the broader social issues than can affect a person's health and wellbeing, including education, housing, loneliness and isolation, employment, income and poverty. People from minority communities or with protected characteristics (such as religion or belief, race or disability) are known to be more likely to experience health inequalities.

5.2 How we are addressing this outcome in our locality

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

24 We will work together to implement and deliver support that addresses and tackles health inequalities.

25 We will work together to identify people in greatest need and those who may have very specific needs.

26 We will target support for specific groups and communities with identified health inequalities.

27 We will support people to reconnect with their communities and help them to make informed choices.

28 We will work towards reducing health inequalities experienced by particular people, groups and communities.

5.2.1 Health improvement

In our locality, a good example of this is the Health and Wellbeing Model which is the agreed model for Dumfries and Galloway. It focuses on supporting people and communities to utilise their own assets to build and strengthen resilience, enabling them to take an active role in maintaining or improving their health and well-being and to reduce health inequalities.

The Health Improvement Team is based in Annan but work across the locality. Their key role is to reduce health inequality and support people to achieve better health outcomes. This involves working with

- teams and staff across the Health and Social Care Partnership to influence and encourage health and wellbeing approaches and support prevention and early intervention
- community groups and organisations, in particular those who work with those experiencing inequalities

- people, providing one to one support through Community Link, Let's Cook or Healthy Weight programmes.

The health improvement function within the locality is currently under review but the focus will remain on reducing health inequalities.

There is a need to be able to offer confidence building courses as this has been identified as a gap. We are currently looking to source funding to develop a local team of STEPS facilitators.

We carry out an Equality Impact Assessment in relation to any service change or development to ensure health inequalities are not being increased.

5.2.2 Community Link

Our Community Link programme continues to evolve as we build on the well established model which was co-produced with our partners and communities over 7 years ago. The service is working with some of our most vulnerable people, who have may have fallen through the safety net of mainstream services, including mental health services, or who do not meet the criteria for social services.

Many who access the service are leading very chaotic lives or have complex needs and have disengaged with mainstream services. Having different conversations, where people are supported to identify solutions and make small step changes, is improving outcomes for people. It is also making more effective use of time and resources as part of a One Team approach in the locality.

Many people are supported with issues such as housing, finance and benefits, mental wellbeing and confidence and very often, supporting people to get the help they need from re-engaging with mainstream services.

The Community Link workers received almost 400 referrals in the last year. Of these 180 were from postcode district DG12. Within the locality this postcode has the greatest deprivation according to the data available.

What people tell us: Joan's story

Joan approached her GP, feeling bereft after losing her husband and at sea because her late husband had dealt with all their financial affairs. She was newly diagnosed with Parkinson's, had no family living locally and was feeling very socially isolated. The GP referred Joan to the Community Link service.

Following some support from a community link worker Joan has greatly improved her life. She feels she is coping with her grief, she feels listened to, confident in contacting people and managing her finances. Joan is pro-actively managing her health conditions and is now attending an exercise group for people with Parkinson's. She has been supported to access Attendance Allowance. This has enabled her to pay someone to maintain her garden, which was of great importance to her, as she was unfit to do so. Joan has also accessed the Winter Fuel payment which gives her financial confidence in keeping her home warm.

5.2.3 Health Weight

Our Let's Cook and Healthy Weight programmes target vulnerable people, parents and parents to be. They deliver cooking skills, meal planning and budgeting sessions. Evaluations show improved skills, knowledge and confidence in people who take part as well as positive changes to behaviours and choices.

5.2.4 Safe and Healthy Action Partnership (SHAP)

We continue to work with partners across the sectors and with communities to identify and maximise assets and assist people and groups to develop services, activities and initiatives which strengthen community support for local people. The Safe and Healthy Action Partnership (SHAP) is managed and administered by the Health Improvement Team. We have a community health development worker who drives forward plans and supports the development of initiatives, opportunities and ideas. The SHAP currently has over 115 members and has an inequality focus.

Example 1:

A GP highlighted that there was little support for new parents in Annan. We worked together with the GP, new parents and others to develop a group which is now very well attended. We have had feedback from people taking part that they feel less isolated. One person reported having no need for antidepressants anymore. The group is now being supported to become self sufficient.

Example 2:

The New Horizons Drop In is another example where we worked in partnership with Alzheimer Scotland, Parkinson's UK and the local community to establish a drop in service on a monthly basis for people with long term progressive neurological conditions. This supports and increases self care options for people by highlighting services which can assist.

5.2.5 Good Conversations

Building capacity of the workforce across the sectors also can help to ensure people's own assets are utilised. We encourage our workforce to think about every contact or conversation with a person as an opportunity to identify and maximise people's assets to support their own health and wellbeing. Good Conversations training is key to this and we have teams across the locality trained to work in this way and we will continue to roll this out. The setting of personal goals and aspirations allow us to support people to help themselves whilst building confidence and skills.

An example is the Personal Outcome Plan used within the Community Link service. We also now offer and deliver Let's Prevent programme to people who are identified as being at risk of type 2 diabetes.

5.1.5 Information about local activities

A local Activity Guide is produced and updated regularly through the Safe and Healthy Action Partnership (SHAP) which contains information about the wide range of support, activities and opportunities across Annandale and Eskdale. This supports communities and other services and partners to make the best use of limited resources, target those who need support and who are experiencing health inequality.

5.3 How we are getting on

Identifying appropriate local indicators to monitor health inequalities is challenging. It requires both a measure of relative deprivation, and a measurable output that is predominantly within the remit of the health and social care partnership.

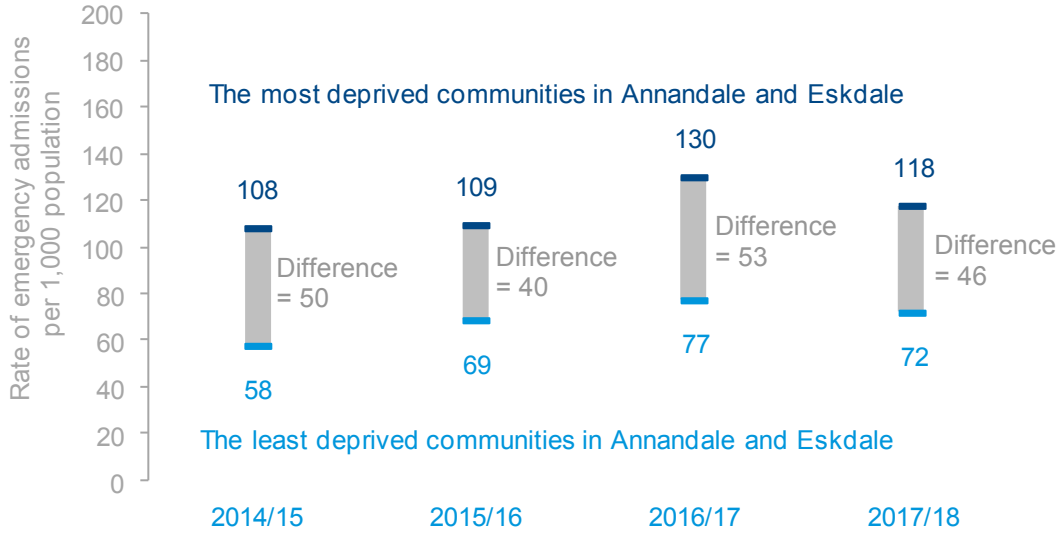
The only measure of relative deprivation that is available for the whole population of Dumfries and Galloway is the Scottish Index of Multiple Deprivation (SIMD). This is a tool used by Scottish Government to identify deprived communities across Scotland. It considers 7 different aspects of deprivation: income, employment, housing, education, crime, health and access to services.

SIMD is calculated using geographical areas called datazones. There are 6,976 datazones across Scotland. These are ranked in order from 1, the most deprived datazone, to 6,976, the least deprived datazone. We have used this ranking to identify the most deprived and the least deprived communities within each locality, even if they are not nationally recognised as deprived.

There are limitations to using SIMD in rural areas like Dumfries and Galloway. Indicators using SIMD should be considered as indirect measures of health inequalities as some people living in deprived circumstances will be living in communities not considered deprived. When making planning decisions, SIMD should be considered alongside other measures of deprivation and local intelligence.

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 least deprived communities and how often they go to hospital in an emergency.

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



D27 Source: ISD Scotland (ACaDMe)

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.

6.1 How we support this in our locality

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.

6.1.1 Dumfries and Galloway Carers Centre (DGCC)

We work very closely with the Dumfries and Galloway Carers Centre (DGCC) whose Annandale and Eskdale worker is co-located with the Health Improvement Team. Together with the Community Link workers in particular, they identify and support Carers across the locality. We work to ensure Carers receive appropriate support to access services and activities that help them to look after their own health and wellbeing.

It must be noted however that not all Carers see themselves as Carers and may not want an Adult Carer Support Plan (ACSP). Many are looking for some assistance to navigate their way through the system, some emotional support, and information about what is available in terms of activities and groups or links to others in similar situations. We are reviewing Adult Carer Support Plans (ACSP) to ensure they reflect best practice.

Within the data available Annandale and Eskdale has a relatively low uptake from Carers for an Adult Carer support Plan (ACSP) but has a high number of Adult Carers identified and supported. Over the last 12 months, we have identified and referred 128 new adult Carers, 10 Young adult Carers and 25 young Carers for support from the Carers Centre.

6.1.2 Community Link

The Community Link service provides support to Carers who may not otherwise have been identified. Often when a Community lLink worker visits a person who has been referred to the service there is a Carer in the home who may also require some support (we estimate this to be about 60% of cases).

> "The feedback I have received from people I have referred to the Community link service has been really positive, the support people have received is first class and workers knowledge base is immense. The team are really good at supporting people to improve their situations, particularly housing, which has been life changing for people."
>
> - Worker from Dumfries and Galloway Carers Centre

We also work closely with Alzheimer's Scotland, who has a Carers Group. This group aims to ensure the health and wellbeing needs of Carers are heard within the appropriate forum and that people are given the opportunity to highlight issues and to get actively involved in local developments through the local Dementia Forum.

6.2 How we are addressing this outcome in our locality

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

29 We will listen to the views of Carers and will identify the action we will take to support them.

30 We will identify current and potential Carers as early as possible.

31 We will make sure all Carers are told about their right to an adult care support plan (previously known as Carers assessment) so that the needs of Carers are dealt with in their own right.

32 We will identify, develop and promote local services to help improve the quality of life of Carers.

33 We will continue to raise Care awareness across our workforce following the equal partners in care core principles.

34 We will identify and support the particular needs of Young Carers.

6.2.1 Short Breaks

In response to feedback from Carers, we have developed and progressed plans for a new and larger short breaks service in Annan for adults with a learning disability. Building work has started on the new service which will open in June 2020.

6.2.2 Carer Awareness

We have continued to raise Carer Awareness across our wider workforce. A wide range of individuals and agencies identify Carers and, where appropriate, refer them onto the DGCC for additional support and information.

6.2.3 Carers' Programme Board

The Carers Programme Board has recently established a subgroup to review our current commissioning arrangements and priorities for supporting carers and will develop proposals for consideration by the Programme Board.

We are committed to the safe sharing of information within multi disciplinary team meetings with Carer organisations to support Carers and are developing an information sharing protocol.

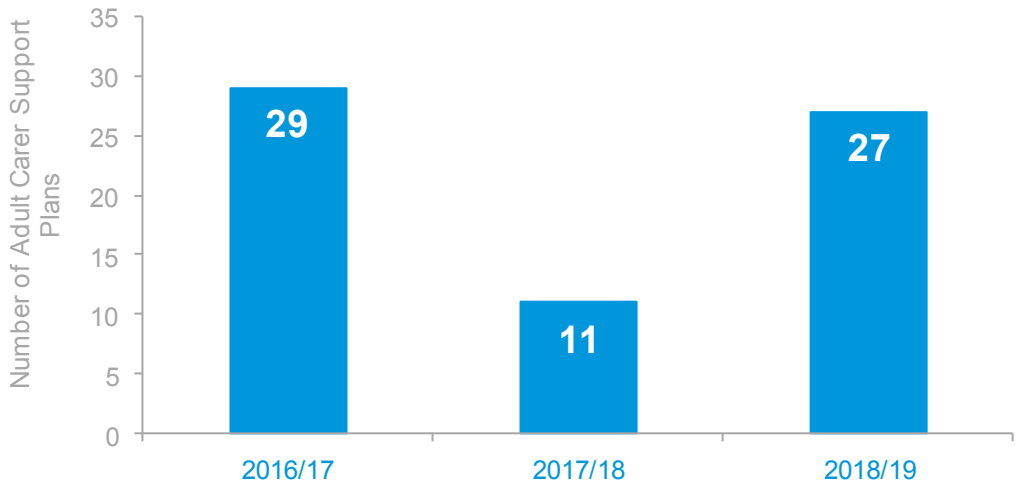
6.2.4 Carers within the Partnership

We recognise that many paid staff are also unpaid Carers providing support and care to members of their own family and we strive to provide support and flexible working to enable them to fulfil both sets of commitments. We have secured Carer Positive established status (level 2) as an employer and are developing plans to achieve outstanding level 3 status.

6.3 How we are getting on

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 services to meet their needs.

The number of Adult Carer Support Plans (ACSPs) completed by financial year; Annandale and Eskdale



C5 Source: Dumfries and Galloway Carers Centre

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.

8.1 How we support this in our locality

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. Our locality is supporting staff to learn together and develop leadership skills to enable us to move towards a shared positive culture.

Across Annandale and Eskdale we strive to ensure teams are engaged, involved and listened to with regard to planning and delivery of services. We do this in a number of ways including organising an annual locality celebration event whereby staff from all disciplines and agencies celebrate our successes, identify gaps, share learning and develop ideas for improving service delivery.

8.1.1 Supporting and developing locality teams

Our Locality Management Team is drawn from staff from all sectors and disciplines and meets monthly to monitor and promote integrated ways of working. Through regular 1 to 1 meetings, team meetings and annual performance reviews, we provide staff with an opportunity to feel engaged with the work they do and an opportunity to contribute to continuous improvements both individually and part of a wider team

It is important that the workforce across all sectors feel involved and we use the Safe and Healthy Action Partnership to ensure communication, engagement and involvement of the Third and Independent sector at all times. An example of this is the Health and Wellbeing Review whereby the SHAP were actively involved in all of the engagement sessions. We also hold regular meetings with staff from the third and independent sector to identify common challenges and develop shared plans to address such needs.

The Health and Social Care Locality Plan for Annandale and Eskdale was drawn up and reviewed with staff across all sectors and is monitored on a monthly basis by the multi agency local management team.

Learning opportunities have also been significant within our Social Work team this year and this has resulted in 4 of our Care Co-ordinators completing SVQ Level 4 in Health and Social Care as well as 1 of our Senior Social workers completing post graduate studies in emotionally unstable personality disorder (EUPD).

8.2 How we are addressing this outcome in our locality

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

41 We will involve staff from all sectors in developing, delivering and reviewing this plan.

42 We will make sure that local voluntary and community groups are able to shape and continue to play a central role in delivering integrated health and social care support.

43 We will support health and social care staff to develop their skills and knowledge to enable them to develop their role, reduce duplication and work to optimum level.

44 We will consult with and listen to the views of staff and keep them updated on the improvement actions we plan to take to develop more integrated ways of working.

45 We will develop a culture where respectful challenge is encouraged, underpinned by openness, transparency and mutual respect.

46 We will involve employees in developing and promoting a Health Working Lives programme across Annandale and Eskdale.

47 We will review and develop our supervision and appraisal processes to ensure that we support and develop staff in an appropriate and consistent manner.

48 We will explore the opportunities to use new technology to support our workforce.

49 We will identify and promote career pathways which allow local workers to develop to meet future gaps in the workforce.

50 We will promote more cross sector training opportunities to help support the development of integrated ways of working.

51 We will work with all sectors to improve staff recruitment and retention.

Following feedback from staff, we have improved Wi-Fi access for staff and plan to roll out MORSE technology to enable more effective mobile working.

8.3 How we are getting on

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 2018/19, more people in the Partnership participated in iMatter.

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.

Staff survey results are very stable at an organisation level, but can be variable year to year for small teams due to small numbers.

The Locality team is currently developing this year's action plan towards building a positive work culture. Please note these results include region wide services hosted in Nithsdale as well as core locality services.

	iMatter Responses	Dumfries and Galloway 2017	Dumfries and Galloway 2019	Annandale and Eskdale Locality 2019
D5	4 out of 5 people agree that they have the information necessary to do their job.	80%	79%	82%
D21	7 out of 10 people agree that they are involved in decisions relating to their job.	70%	69%	72%
D22	3 out 4 people would recommend their organisation as a good place to work	74%	74%	78%

Source: NHS Dumfries and Galloway (iMatter Board Report) (2019)

Through iMatter, all teams are expected to identify 3 key actions to help improve staff engagement processes.

Over 60% of staff across Annandale and Eskdale took part in the annual iMatter staff survey and confirmed that staff satisfaction rates are relatively high. However the survey also confirmed that staff wanted more visible senior management and more opportunities to share their ideas on how to improve service delivery. All teams are developing 3 key actions to support the findings of the staff survey and the new Sustainability and Modernisation Programme (SAM) will provide an opportunity for staff at all levels to share their service improvement ideas with Senior Managers.

Appendix 1: Summary of Locality Indicators

Locality Indicator			Previous Value			Current Value		
			Time Period	Dumfries and Galloway	Annandale and Eskdale	Time Period	Dumfries and Galloway	Annandale and Eskdale
Outcome 1	D23	Rate of emergency department attendances by locality of residence per 1,000 population	May 2018	25.2	15.7	May 2019	26.2	17.2
	D24	Rate of emergency admission by locality of residence per 1,000 population	May 2018	9.73	8.31	May 2019	6.81	6.07
Outcome 2	C8	Total number of care at home hours provided as a rate per 1,000 population aged 65 and over	May 2018	609.6	442.6	May 2019	552.6	383.2
	A15 / E5	Proportion of last 6 months of life spent at home or in a community setting	2017/18	89%	89%	2018/19(p)	89%	89%
Outcome 3	D2	Number of complaints received by the locality team (all stages)	-	-	-	2018/19	-	11

Source: ISD Scotland, HACE Dashboard, Dumfries and Galloway Council (p) - Provisional result

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

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

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

Locality Indicator			Previous Value			Current Value		
			Time Period	Dumfries and Galloway	Annandale and Eskdale	Time Period	Dumfries and Galloway	Annandale and Eskdale
Outcome 4	C10	Percentage of people supported by SDS Option 1 or Option 2, under 65 years of age	June 2018	25%	28%	June 2019	24%	27%
	C11	Percentage of people supported by SDS Option 1 or Option 2, 65 years and older	June 2018	7%	6%	June 2019	9%	8%
	D25	Number of people delayed in all hospitals (Dumfries and Galloway Infirmary, Galloway Community Hospital and Cottage Hospitals) by locality of residence	Jul 17 - Jun 18	604	201	Jul 18 - Jun 19	807	244
	D26	Number of bed days lost to delayed discharge by locality of residence	Jul 17 - Jun 18	12,890	4,033	Jul 18 - Jun 19	19,526	5,493
Outcome 5	D27	Difference in the rate at which people attend hospital in an emergency between the most deprived and least deprived communities in the locality (per 1,000 population)	2016/17	38	53	2017/18	41	46
Outcome 6	C5	Number of Adult Carer Support Plans developed within the locality	2017/18	-	11	2018/19	-	27

Source: ISD Scotland, HACE Dashboard

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

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

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

Locality Indicator			Previous Value			Current Value		
			Time Period	Dumfries and Galloway	Annandale and Eskdale	Time Period	Dumfries and Galloway	Annandale and Eskdale
Outcome 7	D27	Percentage rate of emergency re-admission to hospital within 7 days	Jun 17 - May 18	4.4%	3.9%	Jun 18 - May 19	4.3%	3.9%
	C9	Percentage rate of referrals to the Multi Agency Safeguarding Hub (MASH) acknowledged within 5 days	Apr - Jun 18	67%	79%	Apr - Jun 19	47%	58%
Outcome 8	D5	Proportion of people who agree that they have the information necessary to do their job	2017	80%	n/a	2019	79%	82%
	D21	Proportion of people who agree that they are involved in decisions relating to their job	2017	70%	n/a	2019	69%	72%
	D22	Proportion of people who would recommend their organisation as a good place to work	2017	74%	n/a	2019	74%	78%
Outcome 9	D28	Average prescribing costs per person for 3 months	Jan - Mar 2018	£49.92	£46.36	Jan - Mar 2019	£50.68	£47.15
	C1	Percentage of People With SDS Option 3,Supported with Telecare	June 2018	72%	75%	June 2019	74%	76%

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

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