DUMFRIES AND GALLOWAY
INTEGRATION JOINT BOARD

HEALTH AND SOCIAL CARE
NITHSDALE LOCALITY REPORT

DUMFRIES AND GALLOWAY
Health and Social Care

October 2019

Contents

Foreword

Welcome to the latest report from Nithsdale locality covering the period January – June 2019. This has been a busy time for teams across the locality as they strive to enhance the care and support they provide to Nithsdale residents. At the same time, dealing with competing demands and managing locally the challenges faced nationally around recruitment and availability of care at home services. We are working to embed solutions across the locality to support people and to help address these challenges.

Supporting people through a safe discharge from hospital and preventing unnecessary delays in discharge from hospital remains a priority across the locality. In early 2019, we reviewed our locality flow meetings and in February 2019 embedded this within our Single Point of Contact (SPoC). This involved representation from the wider Nithsdale in Partnership (NiP) services, cottage hospitals, and flow coordinators (Attend Anywhere was set up to facilitate virtual attendance). Flow is now an integral part of the daily SPoC huddle and indeed SPoC itself.

We have been able to combine resource from our transitional care team with our healthcare support worker resource, pulling together to support patients home from hospital. And indeed to support them when home, reducing delayed discharges across the locality and freeing up cottage hospital beds to promote flow. Currently, with the combined resource we are supporting 34 people in their homes which equates to 231 hours of care this week. Mainly, the team are providing care at home to people as they await long term care.

At the time of writing there are 15 Nithsdale residents across the region considered to be experiencing a delayed discharge:

- Awaiting Guardianship = 01
- Awaiting Care at Home = 11
- Awaiting Housing = 01
- Ongoing Assessment = 02

It is important not to forget that prevention and early intervention work are crucial in supporting people to improve their health and wellbeing and to remain as independent as they can for as long as possible. Throughout this report we give examples of the ongoing valuable work undertaken by the Health and Wellbeing and Community Development teams, jointly with colleagues in the 3rd sector to support better preventative outcomes and to help reduce health inequalities. Further information in Outcome 6 gives examples of the work being undertaken to support unpaid carers. Outcome 5 gives a flavour of the work with community and vulnerable groups to support improved health and wellbeing.

Finally, this report gives an opportunity for me to express my appreciation and thanks to the staff across the locality for their hard work and dedication and for their commitment to transforming how we provide our services as we work together to address the challenges across health and social care.

Alison Solley
Locality Manager - Nithsdale
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." These reports are published through the year on the Partnership's website (here).

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

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

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 Nithsdale 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: A1

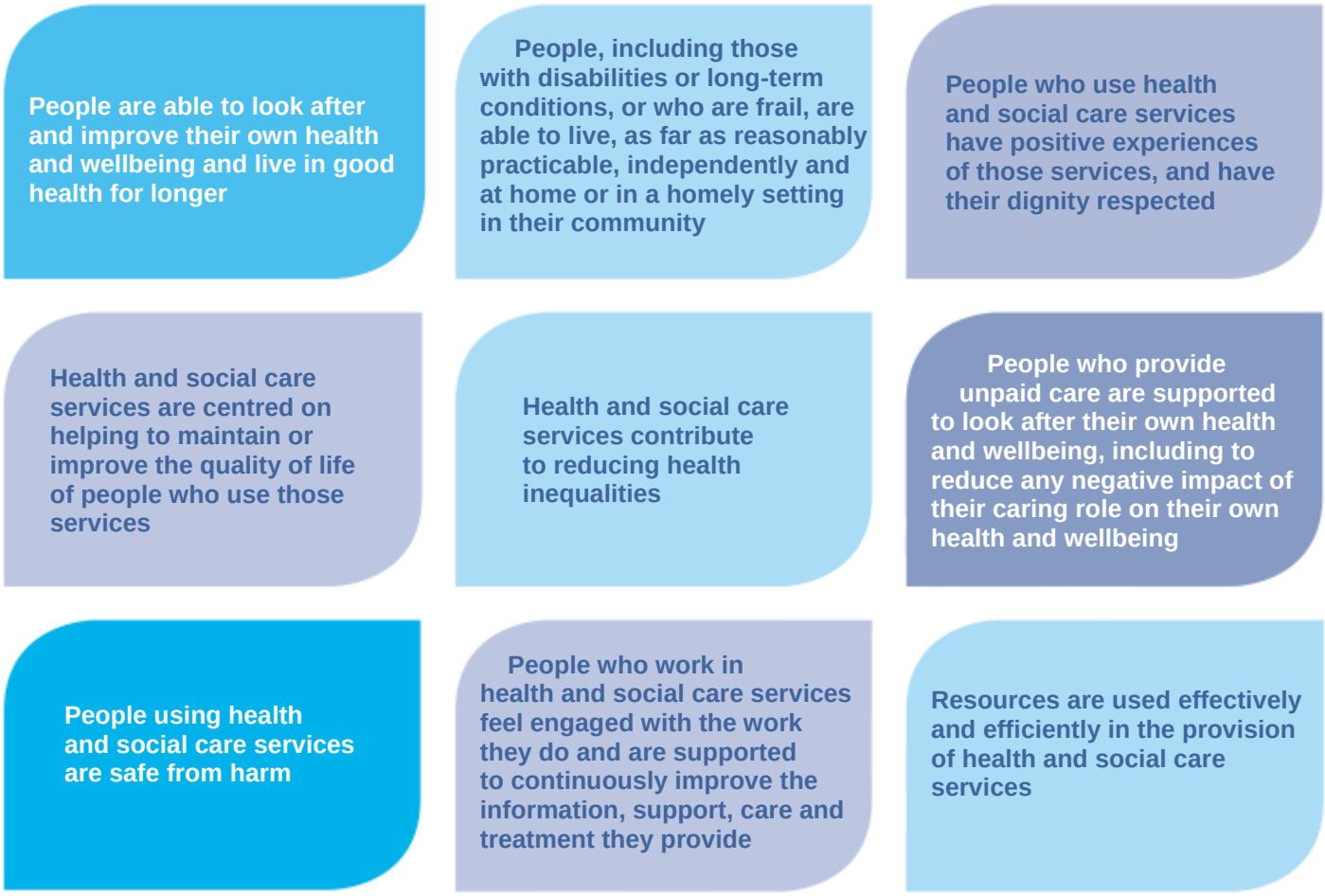
The first circle shows the indicator number. Information about why and how each indicator is measured can be found in the Performance Handbook, which is available on the Dumfries and Galloway Health and Social Care Partnership website (www.dghscp.co.uk/performance-and-data/our-performance/). Where there 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.



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 care needs will be increasingly met in the home and in the community, so the way that services are planned and delivered needs to reflect this shift.

In our locality, examples of how we are working towards this outcome are as follows:

- Rapid Response Team
- Advanced Nursing Practice Service relating to Rapid Response Team
- Community Rehabilitation and Wellbeing Team

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:

5	Make efficient use of our staff resources and services by improving communications and coordination.
6	Work with all partners to create opportunities for people living with dementia to remain active, involved in their existing interests and living in their preferred community where possible.
7	Work with partners to consider housing and support options to reflect the needs of Nithsdale locality.
8	Creatively look at developing different approaches to how we use care-homes, care at home and other resources.
9	Ensure access to self directed support and person centred approaches by utilising the appropriate resources and skills of the partnership.
10	Enable people including those with disabilities, long term conditions or who are frail to access information and support when they need it.

2.2.1 Rapid Response Team

Rapid Response are a highly skilled multi disciplinary team which supports individuals, families and Carers at point of crisis, support safe and timely discharge and prevent hospital admission. The team assess the individual holistically, planning and providing support and where necessary putting in transitional care.

The Rapid Response team most commonly treats people who have:

- Fallen (we are involved in pilot work with the Scottish Ambulance Service (SAS) and continue to work closely with them)
- urinary tract infections (UTIs)
- chest infections
- respiratory conditions (from 29 July 2019 Rapid Response will have an integral role in the new Integrated Respiratory Pathway (IRP) supporting people to remain safely at home)

2.2.2 Advanced Nursing Practice

Discussions have been underway, looking at Advanced Nursing Practice (ANP) work in the Nithsdale in Partnership Rapid Response Team with particular focus on

- Older People's Team, Frailty Team, Discharge Team and Front Door Services (Occupational Therapy, Physiotherapy and Frailty Specialist Nurse)
- supporting development of processes identifying older people who are frail and have been referred to NiP
- assessing these people using ANP skills and knowledge, the Frailty Tool (Rockwood) and Geriatric Comprehensive Assessment

An ANP trainee started with the rapid response team on the 1 July 2019. Further progress will be reported in future reports.

2.2.3 Community Rehabilitation and Wellbeing Team

A range of activities are undertaken which support this outcome including

Seated Exercise Group

The 6 week sessions were attended by 8 people on average, on a weekly basis. Although this did fulfil a need, these people have not been able to continue low level exercise as the group disbanded.

Swimming Exercise Session

Following discussion with Dumfries and Galloway Council this will be relocated to DGOne commencing 1 August 2019. 20 people hope to attend on a weekly basis. Carers will also be attending to give support and for their own health benefits. This session is supported by rehab staff and it is hoped that this will be multi-disciplinary support in future.

STEPS course

STEPS is a course which encourages you to take a fresh look at your life. It helps you to:

- understand why you think the way you do about yourself and your situation
- see what you are capable of achieving
- gives you the tools to make changes for the better

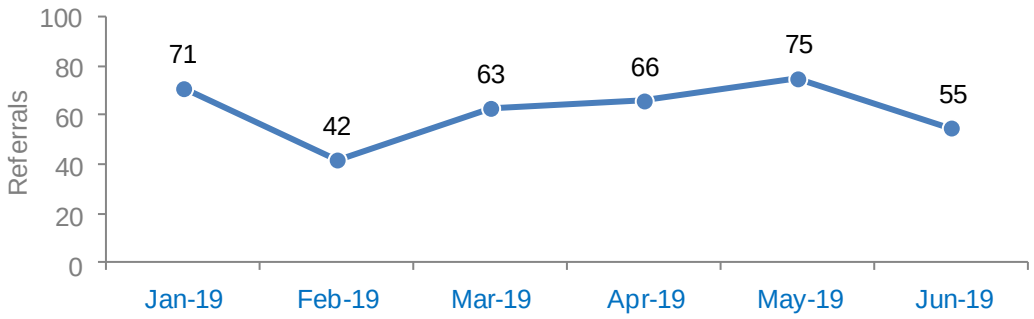
We have run 2 STEPS Courses over the past year which will conclude in August. Attendees have found that it has improved their management of long term conditions by boosting motivation, self esteem and confidence.

How we are getting on: Healthy Connections in GP Practice

Referrals into the Rapid Response service during the period April – June 2019 are as follows:

- 187 referrals received and accepted = on average 62 per month
- 54 were supported hospital discharge (9 Cottage Hospitals, 45 DGRI)
- 86% of the 187 referred remained out of hospital 4 weeks following discharge from Rapid Response
- 7 referrals from mid and upper Nithsdale (geographical criteria broadened April 2019)
- 49 public referrals

Rapid Response Referrals



Source: Rapid Response Team

"The service was absolutely brilliant; you couldn't improve on it."

"They worked well together, and gave me plenty of time."

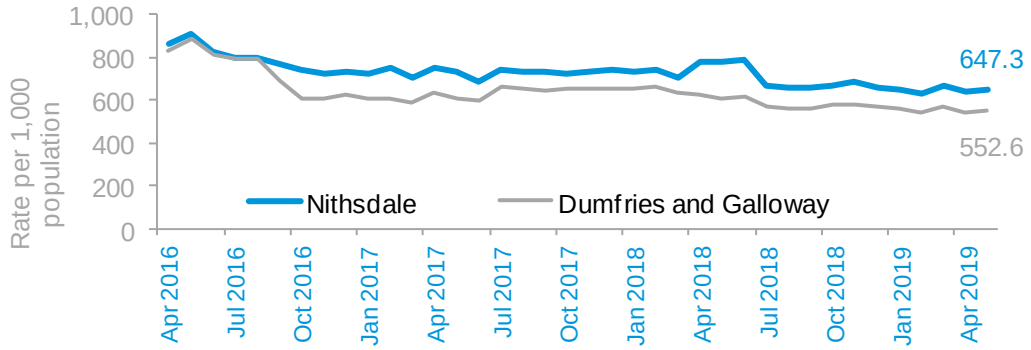
"I was amazed [by the service] and so grateful. I didn't know that it existed. We're so lucky in this area."

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; Nithsdale



C8

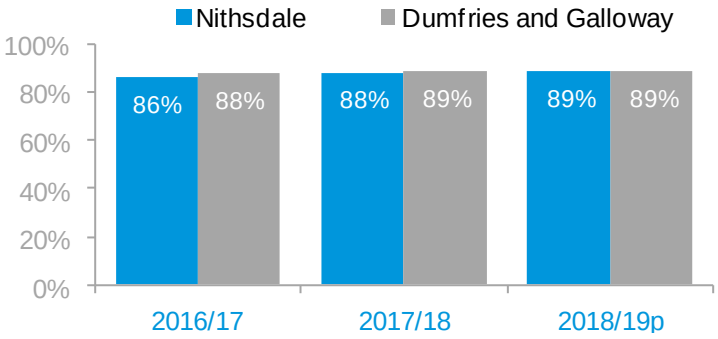
Source: Dumfries and Galloway Council

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

89%

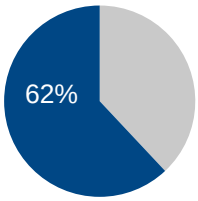
of their time at home or in a homely setting.

A15 E5



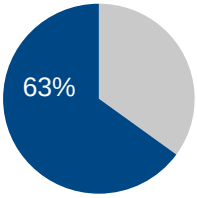
Source: ISD Scotland (p - provisional result)

Dumfries and Galloway 2018



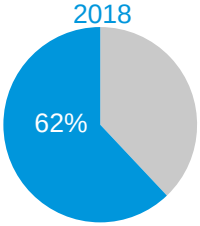
62% of adults with long term care needs receive care at home.

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.

In our locality examples of how we are working towards this outcome are as follows

- Nithsdale Single Point of Contact (SPoC)
- development of a centre for the examination of victims of rape and sexual assault out with police custody

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:

11 Develop the role of the community flow coordinator to deliver a positive home from hospital experience for people living in Nithsdale

12 Support staff to increase and/or acquire the necessary skills, knowledge and experience to adopt a person centre approach to the planning and delivery of care and support

3.2.1 Nithsdale Single Point of Contact (SPoC)

Nithsdale Single Point of Contact (SPoC) launched in October 2018. The aim is to streamline non-emergency Health and Social Care referrals for anyone living in Nithsdale who is aged 16+, initially for DG1/DG2 postcode district. In April 2019 we then slowly widened this to include DG3/DG4 postcode district. People can refer themselves directly to SPoC. Services are working closely together in order to ensure the right person is being seen, by the right service, at the right time thereby reducing duplication.

3.2.2 Forensic Health Service for people who have experienced rape, sexual assault

The Scottish Government vision is for consistent, person centred, trauma informed healthcare and forensic medical services. And access to recovery for anyone who has experienced rape or sexual assault in Scotland; adults, young people and children.

The service will provide forensic examinations for adults and young people (trauma informed person centred care), whilst meeting all the evidence guidelines to satisfy the needs of Police Scotland and the Procurator Fiscal. In the meantime, children will continue to use the forensic service at Wishaw General Hospital, until a West of Scotland paediatric model is developed.

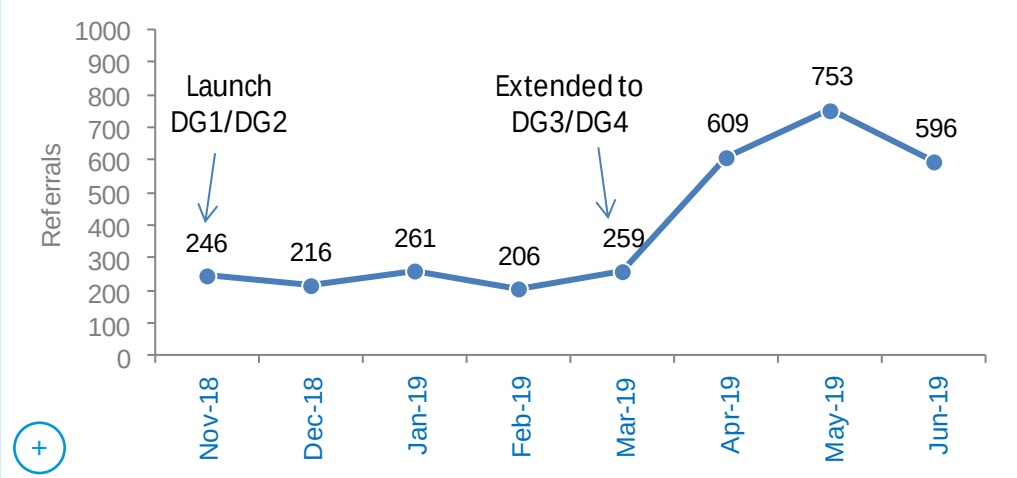
NHS Dumfries and Galloway have a established a multi agency Forensic Suite within NHS estates, moving this service from the Police Estate in June 19. A true multi agency approach was required in establishing the centre outwith the police estate and involved Rape Crisis, Police Scotland, NHS Sexual Health Services and locality staff working together.

We are enhancing local person centred recovery pathways, enabling survivors to choose, at their own their pace, how to easily access both health and psychological support locally. This includes access to immediate clinical needs and aftercare, and supporting survivors to access specialist provision for one off advice and information, or support over time.

How we are getting on: Single Point of Contact (SPoC)

The first point of contact is via the Council Access Team contact centre. Clearly single service referrals are sent straight to the service, otherwise referrals are triaged by a team encompassing health, social work, third and independent sectors.

The graph below shows the increasing number of referrals received in SPoC since November 2018:



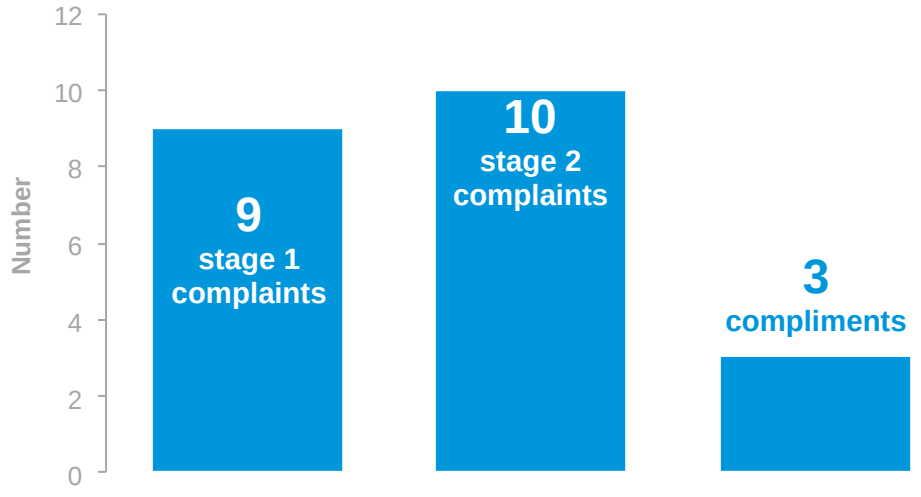
> ""It's better for the person as it means their needs are met quickly, and without them having to move round a variety of services. And it's better for our services too, as it cuts out duplication, and perhaps someone being referred to a service which isn't quite right for their requirements." (GP)

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, Nithsdale locality team received...



D2

Sources: Dumfries and Galloway Council, NHS Dumfries and Galloway

GP Out of Hours (OOH) and the Bladder and Bowel Health Services are 2 of the 8 region wide services hosted in Nithsdale which received feedback in this time period.

All complaints and concerns or enquiries have been responded to and closed. Around one third of complaints were not upheld and another third only partially upheld. Learning has been taken by individual services.

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.

In our locality, there are a number of good examples of how we are addressing health inequalities through the locality Community Development and Healthy Connections teams. These examples involve close working with 3rd sector organisations and include:

Community Development Team:

- A range of activities to support tackling Food Poverty in Upper Nithsdale

Healthy Connections Team:

- Hen's Shed
- Supporting Job Centre Plus
- Men's Shed Thursday Club
- Partnership working with ILS (Independent Living Support)

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:

14 Work towards reducing the health inequalities experienced by particular people, groups and communities.

5.2.1 Community development approach to tackling food poverty in Upper Nithsdale

Food poverty and food availability have been a long term issue in Upper Nithsdale and we have always tried to support healthy eating and budgeting through groups and activities including schools. Over the past few years with food poverty becoming more of a national issue there has been increased focus on meeting the needs of local people and organisations in Upper Nithsdale.

The Community Health Development Practitioner, Dumfries and Galloway Council staff and other locally based organisations realised that food parcels and soup kitchens were not dealing with the causes and long term eradication of food poverty. We agreed to spend time

looking at the bigger picture and engaging local people and organisations in the discussions as part of a collaborative approach.

- Developments with the day centre in Kirkconnel have led to wider discussions on support to lunch groups and food provision models. The wider community and partners need to make the best possible use of opportunities and reduce the potential stigma associated with some anti poverty activity.
- An open event in Kirkconnel in January 2019 led to a steering group being formed to help advance community led solutions to increasing availability and access to fresh food and community based food sharing activities. As Fareshare is a volunteer led model, we will be supporting a variety of volunteer roles and identified training and development needs therefore building capacity, resilience and social capital.
- Building Healthy Communities and Kirkconnel and Kelloholm Development Trust have been successful in securing £15,000 from Dumfries and Galloway Council's Participatory Budgeting funding. This will support Fareshare to operate in Upper Nithsdale, delivered by local volunteers and supported by community development workers.
- The Community Foodsharing Group will also support and contribute to developing Volunteers for the Allotment Project (Food Growing Initiative), presenting opportunities for communities to become involved in growing their own food.
- The Community Action through Participation and Engagement Network (C.A.P.E) has undertaken community engagement work to support refreshing the Kirkconnel and Kelloholm Community Action Plan (2014 -2019).

Evidence shows that being outside and involved with gardening and being outdoors can be therapeutic to all.

Healthy Homes was an event held in Kirkconnel in February, in partnership with Home Energy Scotland. People got help and learned about cost free energy efficiency measures, reducing damp and mould, fuel poverty and fire safety.

Learning from **Fairshare** delivery models in Glasgow and Dumfries, Spokes are being identified for the potential Hub in Upper Nithsdale. A'the Airts in Sanquhar and The Cabin in Kirkconnel are early Spokes and other local organisations are being encouraged to take part in the Fareshare scheme.

The 'Rhubarb Experience' was an intergenerational skill share, making cordial, jam and pastry from scratch. The public tasting session, recipe swap and reminiscence of childhood stories associated with rhubarb were widely enjoyed.

The Cabin Committee in Kirkconnel responded to the need for a Lunch Club to fill any gaps following the closure of the Day Centre and have employed a cook and recruited volunteers to deliver a weekly lunch club.

The Social Team arranged activities that address 'holiday hunger' for families facing food poverty issues during school holidays.

5.2.2 Hen's Shed

The Hen's Shed was developed after a need for a new approach was identified for women with a mild or undiagnosed learning disability. These women lacked confidence and self esteem to access mainstream activities or groups, with the potential for risk taking and potential exposure to abuse.

The group was shaped using a community-development approach and collaboration with other services has been in place from the outset. A gradual build up through consultation with initial members allowed the women's needs and wishes to guide the direction of the group. A diverse mix of people has grown slowly and resulted in a supportive group with friendships building. Coffee, chat and craft activities help build confidence, self esteem with the chance to learn new skills in a safe, relaxing atmosphere.

"You can just be yourself"

"There are no expectations put on you"

"Can we not have the group on every day?"

Collaboration with other services such as Women's Aid, Learning Together and Sexual Health and supportive conversations with Healthy Connections, has prompted women to access a range of services they had not previously engaged with. Two recent members, who were finding themselves socially isolated are now attending the group on a regular basis. One is building new Arts and Crafts skills and has felt confident enough to explore other craft groups in the town.

5.2.3 Supporting Job Centre Plus

Networking with Job Centre Plus identified that many people supported by work coaches are facing health inequalities, which subsequently impacts on their health and wellbeing. Factors such as reduced access to income, employment and good quality housing have a significant impact on their resilience to overcome challenges they may face, both physically and mentally.

Since April 2019, the Health and Wellbeing Team now offer a clinic in The Job Centre twice monthly to those who would like additional support and advice regarding their health and wellbeing. To date, this has been well attended with an average of 4 out of the 6 appointment slots booked each session. Mental health, in particular anxiety, is a common concern throughout most of the referrals received.

Many individuals are reluctant to attend GP appointments, access services or to ask for the appropriate help. The Health and Wellbeing Team have supported people to attend GP appointments to review medication, to access community groups to reduce social isolation and helped to enable individuals to make informed choices based on guided conversations.

"feel listened to"

"I was given time to reflect on what was important to me"

"supported to make positive change"

5.2.3 Men's Shed Thursday Club

This weekly social group in Dumfries is for men who have mild or undiagnosed learning disabilities or autism. The project is for men who cannot access specialist services because they do not meet the criteria, as their symptoms are not severe enough. It was developed due to a lack of social opportunities or support for these men, leading to loneliness, isolation and poor health. It differs from other Men's Shed groups in that the sessions are staffed. Twelve men now attend regularly.

The Club started in September 2018, and is run in partnership by:

- Healthy Connections Service NHS [lead partner]
- Intellectual Disabilities Service NHS
- Men's Shed Dumfries SCIO

Outcomes so far have included:

Increased confidence due to having a social circle outside their immediate families

Improved mental health from being supported to attend Kaleidoscope mental health social group

Reduced loneliness and isolation leading to improved mental wellbeing

Better physical health from being supported to arrange and attend medical appointments

Life skills – volunteers are helping the men to improve their cooking, computer, literacy and numeracy

What people tell us: Mike's story

Mike is aged 30 and has a diagnosis of autism spectrum disorder. He lives on his own, and is very isolated.

He first attended Men's Shed Thursday Club in November 2018. Mike was clearly extremely nervous and did not engage in the group activities nor the conversation and banter.

Over the last 8 months, Mike has very gradually started to engage in both the activities and the banter of the group. His body language has changed markedly, and he now seems to be much more relaxed and confident

5.2.4 Partnership working with Independent Living Support (ILS)

ILS is a small local charity with bases in Dumfries and Stranraer. They offer practical, social and emotional support to people from all backgrounds, and currently deliver Housing Support on behalf of Dumfries and Galloway Council and Youth Services in partnership with key funders.

The Locality team has been working with ILS around several strands of work

- support to reinstate the Homelessness and Risk Management Group, development of an action plan and administrative support for the group
- consultation on how to develop support through the Hen's Shed for women with mild intellectual disabilities and mental health needs who are vulnerable and at risk
- development of a pathway into health and wellbeing services for people who aren't engaging with statutory services or who feel overwhelmed or unable to access support through their GP. The aim is to provide a gateway into more formal support and build confidence and abilities to manage appointments with professionals.

How we are getting on: Healthy Connections

The Healthy Connections Team supports individuals to make behaviour changes around mental wellbeing, physical activity, weight, food choices, alcohol and smoking. They also support individuals to access many Third Sector opportunities and statutory services. The figures below show that a larger proportion of referrals are for people living in neighbourhoods with higher levels of deprivation.

Number of Referrals per month January – June 2019		Number of referrals per SIMD area*				
		1	2	3	4	5
January	39	1	12	19	6	1
February	31	5	8	9	5	4
March	49	8	13	13	10	4
April	39	7	8	11	8	5
May	60	15	12	18	9	5
June	43	11	12	11	7	5
Total	260	47	65	81	45	24
Distribution of referrals	100%	18%	25%	31%	17%	9%
All Nithsdale Population	100%	14%	18%	28%	25%	14%

*Highest area of deprivation = SIMD 1
Lowest area of deprivation = SIMD 5

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.

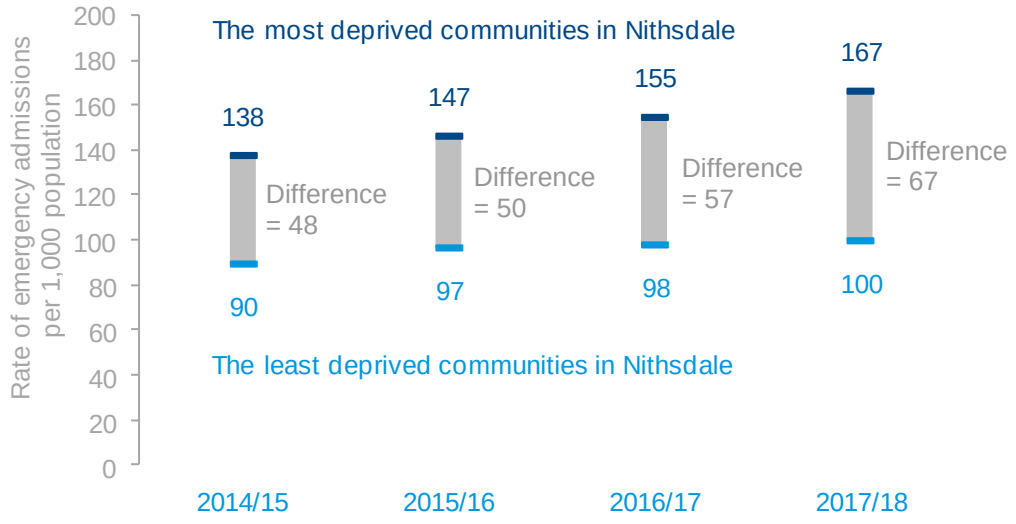
The only measure of relative deprivation that is available for the whole population of Dumfries and Galloway is the Scottish Index of Multiple Deprivation (SIMD). This is a tool used by Scottish Government to identify deprived communities across Scotland. It considers 7 different aspects of deprivation: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



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 to 24 are identified as Young Adult Carers.

A priority within the locality is Supporting unpaid Carers. Examples include work with:

- Supporting Dumfries and Galloway Carers Centre
- Mindfulness for Carers
- Thornhill Hospital – Engaging with Carers

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:

15 Listen to and involve Carers in discussions with the person they care for.

16 Improve support for Carers by promoting local services and resources.

17 Implement and support Carer Awareness across our workforce; this will help identify carers.

18 Support Carers to identify ways in which they can be supported to enhance their quality of life.

6.2.1 Supporting Dumfries and Galloway Carers Centre

The Nithsdale Health and Wellbeing Team continues to support those who look after others in an unpaid Carer's role. Our aim is to promote opportunities to improve self care in order to prevent deterioration in unpaid Carer's health and wellbeing. This includes

- using guided conversations to enable future planning while considering the caring role
- developing confidence and motivation to engage in support
- exploring appropriate resources and services

The Locality Team work in partnership with both statutory service and third sector organisations to support and enable those in a caring role. Having strong links with the Dumfries and Galloway Carers Centre allows us to work with individuals already identified as fulfilling a caring role. Attending multidisciplinary team meetings such as Single Point of Contact increases our opportunities to identify those in a hidden or unrecognised caring role.

What People Tell Us: Healthy Connections in GP Practice

Diane attended a 1 to 1 Healthy Connections appointment at her local medical practice. She had been experiencing low mood and had felt anxious for some time. It was identified through conversation that Diane was an unpaid Carer for her husband that she was struggling to cope in this role.

Diane was supported to discuss her feelings of low mood and anxiety further with her GP. She has now been prescribed antidepressants. Diane was also referred to the Dumfries and Galloway Carers Centre for support in her caring role. She now has an allocated Carer Support Worker and has accessed massage therapy to enhance self care and aid stress reduction.

6.2.2 MBSR Mindfulness for Carers Course

The Mindfulness Based Stress Reduction (MBSR) programme is an eight-week evidence-based program that offers secular, intensive mindfulness training to assist people with stress, anxiety, depression and pain. This 8 session course continues to run in partnership with the Carers Centre, however the person's caring role is not part of the programme discussions.

Those in a care giving role often experience significantly poorer mental and physical health than the general population. A recent independent evaluation of this work concluded that the course improves self care by reducing anxiety levels for the Carer and improved relationships between the Carer and the cared for have been noted.

What People Tell Us: Mindfulness Based Stress Reduction

"I understand it's ok to want me time"

"I'm sleeping better and realising my situation isn't all negative"

"I don't stress eat anymore, I breathe instead. I have cut down on my smoking and have lost weight"

"Splendid, beneficial and enjoyable ...a lifelong tool"

"I'm calmer and not so self critical"

"Mindfulness...taught me how to value myself, as a Carer that's not always easy, even though other people may value you, caring can leave you with low self esteem"

6.2.3 Thornhill Hospital: Engaging with Carers

The Triangle of Care approach is a Scottish Government initiative launched in 2015. This successful initiative was implemented in Thornhill cottage hospital to improve Carer engagement

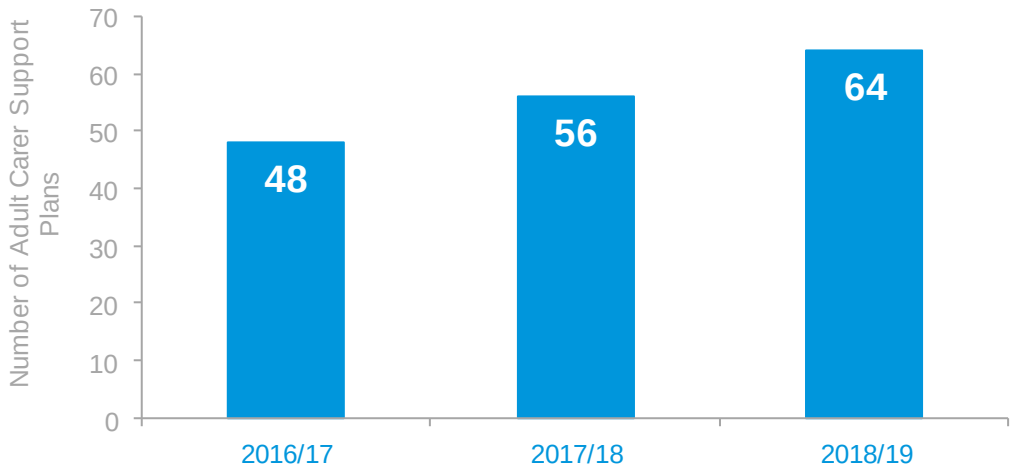
The Triangle of Care approach involves Carers in the care and treatment of the person they care for. All Carers of in-patients completed a self assessment on their involvement in their relative's care. Staff meantime implemented a Carers checklist to ensure compliance. From March 2018 to September 2018, Thornhill Hospital had 100% compliance with this initiative.

Discussions are now underway to invite representatives of the Dumfries and Galloway Carers Centre to attend the weekly Multi Disciplinary Meeting.

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; Nithsdale



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.

In our locality examples of how we are working towards this outcome are as follows:

- Transforming Nursing Roles Initiative (Community Adult General Nursing)
- Workforce and Workload Planning
- Electronic Record Keeping Solutions for Community Nursing Staff
- Test of change regarding Health Care Support Worker staff
- Enhancing integrated working via Nithsdale Single Point of Contact (SPoC)

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:

20 Identify where integrated approaches can support and develop the existing workforce using a variety of resources, reducing duplication and promoting the sharing of skills and training.

21 Identify where integrated approaches can support and develop the existing workforce using a variety of resources, reducing duplication and promoting the sharing of skills and training.

43 Explore opportunities to use technology to support the workforce.

44 Engage with and listen to the views of staff.

8.2.1 Transforming Nursing Roles Initiative (Community Adult General Nursing)

A programme is underway to develop our community staff to enable them to meet the challenges of the National Transforming Nursing Roles programme. Locally this is being facilitated by the lead nurse with each nurse manager taking forward one of four work streams, topics are

- Governance and Supervision
- Education and Development
- Improvement and Data
- e-Health and Information and Communication Technology (ICT).

All grades of staff in our teams are fully represented on each group, with the main steering group meeting four times per year, considering issues such as Job Descriptions, Person Specifications and Competency Frameworks.

8.2.2 National Workforce, Workload Planning Tool

This tool is being run three times per year. The main objective of this is to support plans to introduce safe staffing levels. We gather data to help inform how our teams could be configured for the future, taking account of the caseload numbers, the dependency of patients, complexity of care needs and skill mix of the staff required to deliver the care.

8.2.3 Electronic Record Keeping Solutions for Community Nursing Staff

As part of the work of the Improvement and Data subgroup, a paper is being prepared to propose an electronic solution for our district nursing teams which would support record keeping, caseload management and staff deployment across all four localities.

8.2.4 Test of change regarding Health Care Support Worker staff

We are considering a test of change where some of our Health Care Support Worker (HCSW) resource could be deployed by our Rapid Response or Single Point of Contact teams. People would support the Partnership's Care and Support Services (CASS) transition team which supports keeping people at home longer and bringing people home from hospital.

This would then have the advantage of defining roles and responsibilities and would allow the remaining HCSW staff to focus on Health Care.

8.2.5 Enhancing integrated working via Nithsdale Single Point of Contact (SPoC)

SPoC provides a central hub where referrals are robustly triaged and transitioned to appropriate service(s). A range of disciplines are represented at the SPoC, working together across traditional professional boundaries. The benefits of integrated working

- a wealth of knowledge and experience is brought to the daily huddle from all services
- multidisciplinary triage and huddles have meant there is less duplication. People are usually already known to some services and this way the discussions are more joined up, so people are supported by the right services at the right time
- improved communication and team working

- person centred approach
- development and growth of daily huddle includes nearly all Nithsdale in Partnership partner services. Attendance can be in person, via PowWow or Attend Anywhere
- GPs and the Scottish Ambulance Service have been given a direct line to Single Point of Contact (SPoC) allowing quick and direct contact when making a referral
- joint working has significantly improved relations between services, further embedding the One Team approach and ethos

A huddle feedback questionnaire has been sent to all departments to find out what works well, what would work better, what makes people attend or not, and how can we encourage participation. Feedback will be available for the next report.

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	Nithsdale Locality 2019
D5	4 out of 5 people agree that they have the information necessary to do their job.	80%	79%	78%
D21	7 out of 10 people agree that they are involved in decisions relating to their job.	70%	69%	68%
D22	3 out 4 people would recommend their organisation as a good place to work	74%	74%	74%

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

Appendix 1: Summary of Locality Indicators

Locality Indicator			Previous Value			Current Value		
			Time Period	Dumfries and Galloway	Nithsdale	Time Period	Dumfries and Galloway	Nithsdale
Outcome 1	D23	Rate of Emergency Department attendances by locality of residence per 1,000 population	May 2018	25.2	25.4	May 2019	26.2	26.8
	D24	Rate of emergency admission by locality of residence per 1,000 population	May 2018	9.73	10.47	May 2019	6.81	7.94
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	777.1	May 2019	552.6	647.3
	A15 / E5	Proportion of last 6 months of life spent at home or in a community setting	2017/18	89%	88%	2018/19(p)	89%	89%
Outcome 3	D2	Number of complaints received by the locality team (all stages)	-	-	-	2018/19	-	19

Source: ISD Scotland, HACE Dashboard, Dumfries and Galloway Council, iMatter

(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	Nithsdale	Time Period	Dumfries and Galloway	Nithsdale
Outcome 4	C10	Percentage of people supported by SDS Option 1 or Option 2, under 65 years of age	June 2018	25%	22%	June 2019	24%	20%
	C11	Percentage of people supported by SDS Option 1 or Option 2, 65 years and older	June 2018	7%	5%	June 2019	9%	5%
	D25	Number of people with delayed discharge in all hospitals (Dumfries and Galloway Royal Infirmary, Galloway Community Hospital and Cottage Hospitals) by locality of residence	Jul 17 - Jun 18	604	254	Jul 18 - Jun 19	807	377
	D26	Number of bed days lost to delayed discharge by locality of residence	Jul 17 - Jun 18	12,890	4,979	Jul 18 - Jun 19	19,526	8,069
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	57	2018/19	41	67
Outcome 6	C5	Number of Adult Carer Support Plans developed within the locality	2017/18	-	56	2018/19	-	64

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	Nithsdale	Time Period	Dumfries and Galloway	Nithsdale
Outcome 7	D27	Percentage rate of emergency re-admission to hospital within 7	Jun 17 - May 18	4.4%	5.0%	Jun 18 - May 19	4.3%	5.0%
	C9	Percentage rate of referrals to the Multi Agency Safeguarding Hub (MASH) acknowledged within 5 days	Apr - Jun 18	67%	57%	Apr - Jun 19	47%	38.5%
Outcome 8	D5	Proportion of people who agree that they have the information necessary to do their job	2017	80%	n/a	2019	79%	78%
	D21	Proportion of people who agree that they are involved in decisions relating to their job	2017	70%	n/a	2019	69%	68%
	D22	Proportion of people who would recommend their organisation as a good place to work	2017	74%	n/a	2019	74%	74%
Outcome 9	D28	Average prescribing costs per person for 3 months	Jan - Mar 2018	£49.92	£49.49	Jan - Mar 2019	£50.62	£49.90
	C1	Percentage of People With SDS Option 3,supported with Telecare	June 2018	72%	71%	June 2019	74%	73%

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