DUMFRIES AND GALLOWAY
INTEGRATION JOINT BOARD

HEALTH AND SOCIAL CARE
STEWARTRY LOCALITY REPORT

DUMFRIES AND GALLOWAY
Health and Social Care

October 2019

Contents

Foreword

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

This report will focus on 5 of the 9 National Health and Wellbeing Outcomes and the associated commitments. These are Outcome 2, Outcome 3, Outcome 5, Outcome 6 and Outcome 8.

Our focus for the reporting period has been on:

- health and social care staff and care providers working collaboratively to improve patient flow across the health and social care system
- implementing phase one of an innovative technology project which has the potential to transform how we deliver overnight support
- exploring new ways of working to support unscheduled and urgent care in the care home setting
- maximising the potential impact our dementia champions can have in supporting people living with, or caring for, those with dementia
- developing a proposal with colleagues in DGRI to improve people's experiences of death, dying, loss and care
- projects which contribute to reducing health inequalities
- a scoping exercise to identify current and future short break needs
- joint working with Dumfries and Galloway's employability and skills team to provide work experience for young people

There continues to be significant challenges across the partnership in particular recruitment and retention of staff across all sectors, timely discharge of people, securing care and support packages and the difficult financial climate. Despite these challenges, staff teams and partners continue to provide the best care and support as well as identifying new ways of working to meet the outcomes of people in Stewartry.

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

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

Amber - Early warning that progress in implementing the commitment is 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

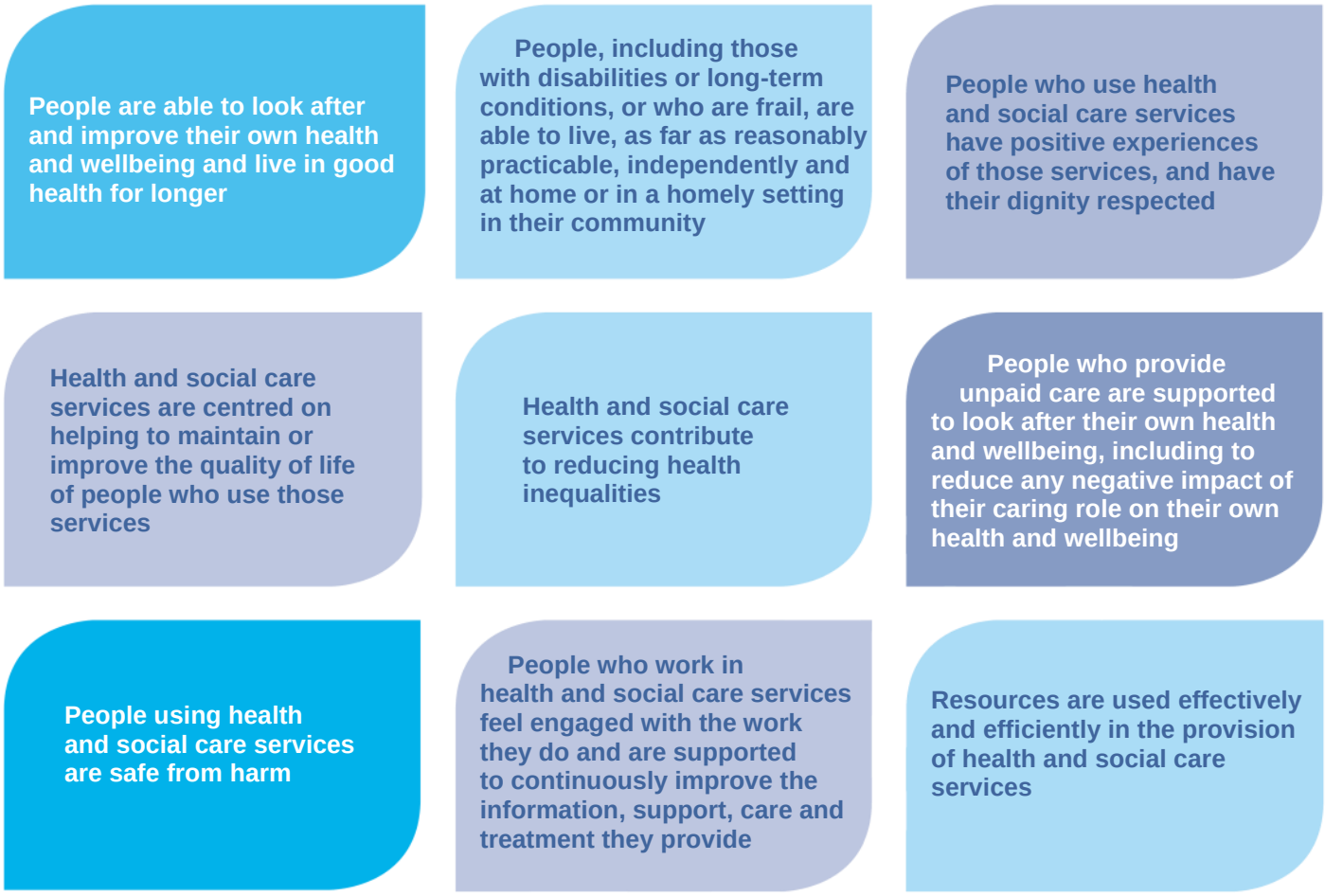
Statistical tests suggest the number has increased over time

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.



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 we are working towards this outcome by

- improving patient flow
- redesigning overnight support
- supporting urgent care

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 We will support the development of a range of community based day services to meet local need.

6 We will work with staff and partners to explore different approaches to early intervention and ensure staff have the necessary skills and knowledge to adopt these approaches.

7 We will encourage people to use self management techniques and build people's confidence and skills around this.

8 We will development approaches which will support early discharge from hospital and prevent hospital admission (e.g. rapid response service/managing conditions in a day case setting.)

9 We will continue to work towards providing or sourcing appropriate support that enables people to remain in their local communities (e.g. Dementia Friendly communities, Befriending or shopping services.)

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

11 We will take account of housing needs and work with individual and partners to consider housing and support options that will enable independent living.

2.2.1 Improving patient flow

In the last 3 months there has been an increase in people delayed in hospital due to lack of resource to support them to return home. There has been a 65% increase in the number of people delayed waiting on a care package from 2017/18 to 2018/19. People experiencing a longer length of stay in hospital are at an increased risk of developing a hospital acquired infection and a reduction in independence.

To improve patient flow there are a number of areas of activity such as

- weekly community flow meetings looking at current resources within health and social care to meet demand
- monthly meetings with care agencies, social work and health to look at current challenges and solutions to increase workforce in the community
- regional flow discharge workshops bringing together health, social care and third sector to gain a better understanding of roles, responsibilities and challenges
- improved working arrangements and solutions to support people to live in their community

2.2.1.1 Guardianship

There are times when people are admitted to hospital, and due to changes in their ability, they lack the capacity to make some or all decisions for themselves. If there is no attorney with suitable welfare powers, it may be necessary to apply to the court for a guardianship order, which can take about 12 weeks. These people are unable to be discharged from hospital until there are appropriate legal powers in place.

To reduce the number of people being delayed due to guardianship we now have earlier conversations with families and Carers about guardianship processes. We work with the legal teams and mental health services, supporting people to ensure timely interventions.

2.2.2 Redesigning overnight support

The Just Checking project uses a range of sensors, permanently installed around a property to send live alerts to a mobile phone app. When alerts are raised, the app shows who is responding, where they are and when a call is resolved. Alerts are based on the risks to each person's safety, as well as their expected activity using a green, amber and red system. The project is now in phase 2, the collection of data, data analysis and linking people to the Healthy Connections programme.

2.2.3 Urgent care

Stewartry GP Cluster has been exploring new ways of working to support Unscheduled and Urgent Care. One area of focus is Vital Signs training for Care Home staff. The training will enable staff to understand common reasons for deterioration in vital signs, recognise when deteriorating vital signs require medical intervention and take appropriate action. Enabling these discussions between staff in Care Homes and healthcare staff could potentially reduce GP callouts as well as hospital admissions.

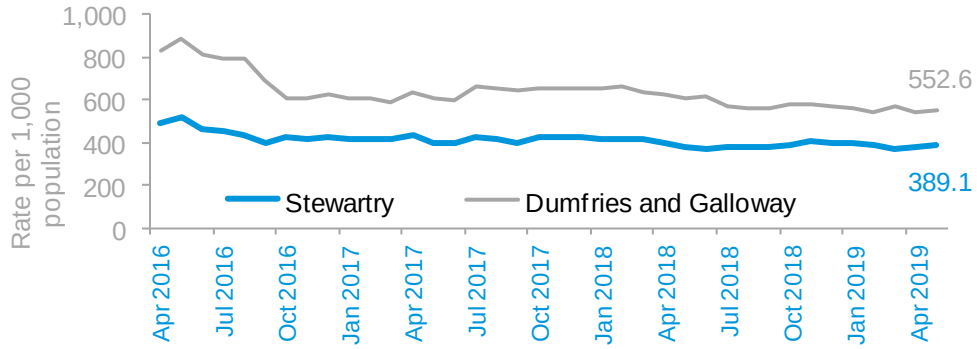
Training will be delivered to 60 members of Care Home staff in October and November 2019 by a local training provider.

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; Stewartry

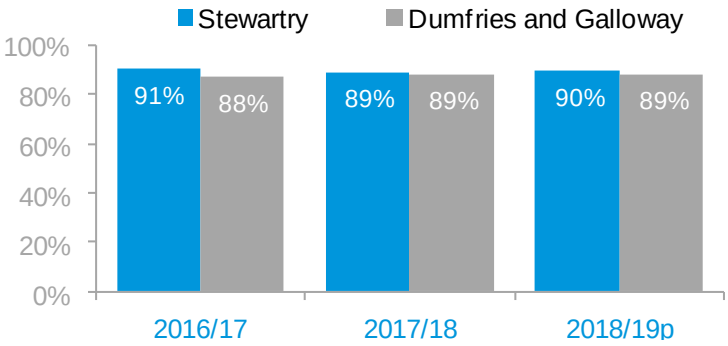


C8 Source: Dumfries and Galloway Council

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

90%

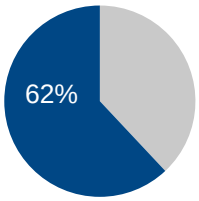
of their time at home or in a homely setting.



A15 E5

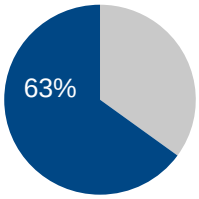
Source: ISD Scotland (p - provisional result)

Dumfries and Galloway 2018



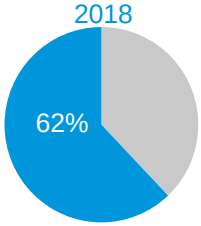
62% of adults with long term care needs receive care at home.

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 we are working towards this outcome by:

- developing support for people with palliative care needs through the Truacanta Project
- Anticipatory Care Planning (ACP)
- supporting people with learning disabilities

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:

12 We will through our communication and engagement framework, provide a listening platform for people to communicate their views and needs share learning across the partnership and raise awareness of issues that will influence the design of services.

13 We will ensure that person centred approaches and a focus on personal outcomes are central to health and social care work paying attention to protected characteristics and any specific needs thereof.

14 We will hold conversations with people to identify what really matters to them and help them develop a plan that will enable them to maintain or improve their quality of life and independence.

15 We will promote living well and end of life care in our communities, respecting the needs and wishes of individuals and their families.

16 We will develop a culture where people using our services can expect a high level of customer services.

3.2.1 Truacanta project

The Truacanta Project is a new initiative being run by the Scottish Partnership for Palliative Care, and funded by Macmillan Cancer Support. The project will support local communities across Scotland who is interested in taking community action to improve people's experiences of death, dying, loss and care.

The Stewartry Health and Wellbeing Team are working with local colleagues in Palliative Care and the Truacanta team to develop a proposal to be considered for this programme. If successful we will receive additional community development support from the Truacanta team.

Areas currently being developed are:

- developing compassionate communities - joint working with communities focusing on encouraging and supporting people to have good conversations about death and dying and to forward plan
- supporting our workforce – discuss 'You Behind the Uniform' training and Healthy Working Lives

3.2.2 Anticipatory care planning (ACP)

Work has been ongoing over the past year to embed the national Anticipatory Care Plan (ACP) across the Health and Social Care Partnership and to raise awareness with the public. Over 300 members of staff across the partnership have accessed ACP training from December 2018 to August 2019 to enable staff to support people to have an ACP. Work has been ongoing with Care Homes to increase the number of residents that have an ACP.

Working in collaboration with the ACP project lead Scottish Care has been using a variety of mechanisms to promote the use of ACPs such as through training and newsletter updates.

To date 43% of Care Homes and 61% of Care at Home services have attended the ACP education and training. In June 2019 50% of individuals living in a Care Home have an ACP which was the Project's identified target.

The ability to share ACPs with relevant Health and Social Care Professionals (including Out of Hours and Scottish Ambulance Service) is being progressed to help with decisions such as clinical treatment and admission to hospital.

3.2.3 Learning disabilities project

The Stewartry Health and Wellbeing Team identified a trend in people with mild to moderate learning disabilities being referred to Healthy Connections with issues of social isolation. A project was undertaken late in 2018 by a student studying with Glasgow University. The project detailed activities and facilities which are used well and those that could be used better.

Three tests of change were recommended:

- community based education provided through Better Lives Partnership and Visibility Scotland
- a proposed change to the timetable and scheduling at the Castle Douglas Activity and Resource Centre (CD ARC) to enable greater community participation
- training and activity changes at Dunmuir Park

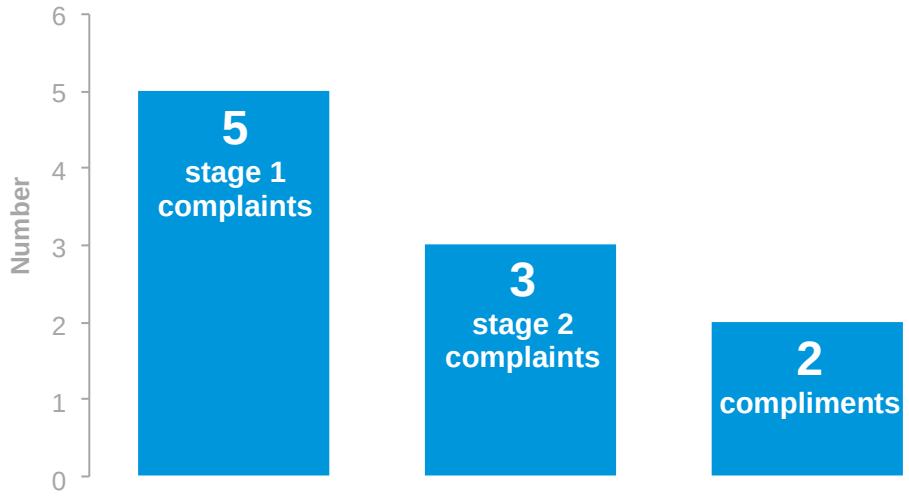
These recommendations will be considered by the Stewartry Social Isolation Partnership in 2019/20.

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, Stewartry locality team received...



D2

Sources: Dumfries and Galloway Council, NHS Dumfries and Galloway

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 some good examples of this are:

- supporting the bid for an inclusive play park
- Kirkcudbright cooking project
- Castle Douglas Access survey
- mental health first aid training
- joint working in Occupational Therapy (OT)

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:

22 We will work with appropriate partners to address some of the logistical challenges presented to some individuals which prevent universal access to services (e.g. transport links, wheelchair access).

23 We will further develop links with housing and other specialist service providers to foster approaches which where possible, present problems from arising (e.g. earlier access to aids and adaptations).

24 We will identify and work directly with groups and communities with specific health and social challenges.

5.2.1 Inclusive play park

Stewartry health and wellbeing team are supporting Castle Douglas Development forum with community engagement, project coordination, and additional funding applications for the play park. The design specification has been agreed and will go to tender through Dumfries and Galloway Council. The focus is now on generating matched funding applications.

The project links to wider work around social isolation (environments where people will naturally interact) and access for all.

5.2.2 Kirkcudbright cooking project

Four Cooking on a Budget workshops have been delivered between December 2018 and July 2019. Fifty people have benefitted from these workshops, with the majority of recruitment from Alcohol and Drug Support TLC Cafes and Castle Douglas IT Centre. The workshops have been funded through the Kirkcudbright Common Good fund and Stewartry Health and Social Care and supported by Castle Douglas IT Centre, Tesco and the Co-op. An evaluation report for Year 1 will be available in September 2019.

Funding has been secured for 2019/20 by Alcohol and Drug Support South West Scotland through Dumfries and Galloway Council Anti Poverty programme to support project coordination and delivery.

5.2.3 Access survey in Castle Douglas

Community access surveys have been conducted in New Galloway (2017) and Crossmichael (2018) and a similar event was held in Castle Douglas (March 2019). The Castle Douglas access survey included an online survey as well as field visits with greater liaison with private businesses (20 contributed). A summary of the findings has been produced which has contributed to the Inclusive Play-park development. Work is planned for 2019-20 to put the learning into action, in Castle Douglas and more widely. Conversations are in their early stages with the community of Dalry around an access survey.

During 2018/19, following the Crossmichael survey, work has commenced with Crossmichael Church to explore options for improving access. This included commissioning an architect to design wheelchair access in sympathy with the historic building and surrounding church grounds. Designs are currently with the Church Committee along with suggestions (from discussions with them) about smaller changes which could have an impact. Working in partnership with Dumfries and Galloway Council around access from the public roads is a key concern.

Good Practice and Innovation: Minor Ailment Remedies

A pilot project to have budget brand minor ailment remedies available in a local shop was undertaken between December 2018 and March 2019 in New Galloway.

The pilot was able to conclude increased access but insufficient data was available to demonstrate impact on prescribing. A larger scale project is planned late 2019/20 with the inclusion of the whole of the Glenkens and other rural areas such as the Colvend coast

5.2.4 Mental health first aid training

A member of Stewartry health and wellbeing team is qualified to deliver 2 day Scottish Mental Health First Aid training.

The training will be offered to local communities and community groups. Shorter mental health awareness sessions are being discussed as these may be more accessible.

5.2.5 Occupational therapy (OT)

A joint post between Social Work OT and Health OT was tested over the summer period in 2018. This post provided benefits such as

- sharing of skills and understanding of processes to enable seamless care and support
- consistency of the person's journey rather than multiple referrals
- reduction in waiting times and multiple assessments for more effective use of time

There are some challenges which need to be overcome prior to full implementation of a One Team approach for Occupational Therapy. These include:

- complex social work systems require additional training and development
- prioritising between hospital and community caseload when reliant on one member of staff with access to both teams

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.

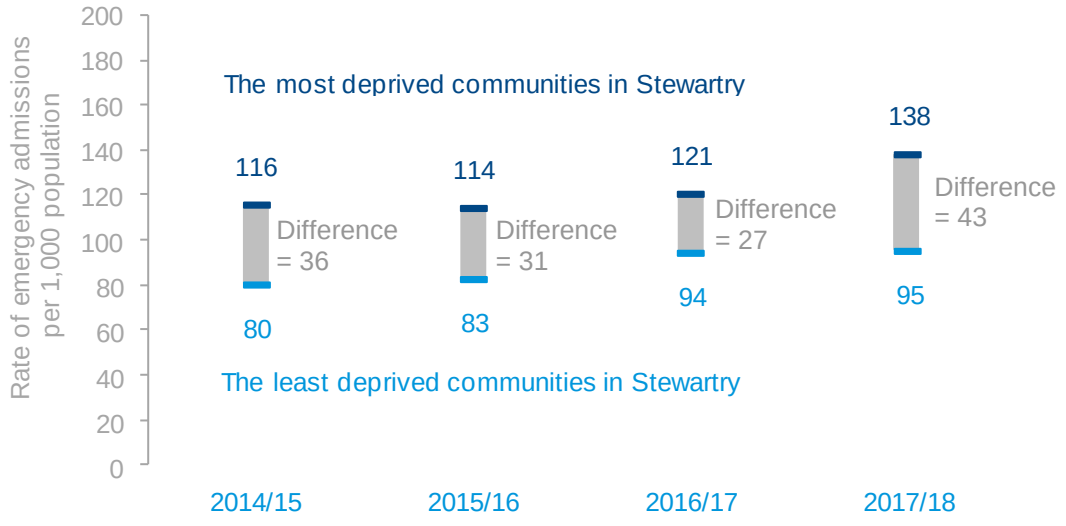
The only measure of relative deprivation that is available for the whole population of Dumfries and Galloway is the Scottish Index of Multiple Deprivation (SIMD). This is a tool used by Scottish Government to identify deprived communities across Scotland. It considers 7 different aspects of deprivation: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



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.

In our locality we are working towards this outcome by:

- Carer's Adult Support Plans
- Healthy Connections referrals
- Carer's short breaks
- Carer's week

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:

25 We will actively identify unpaid Carers in our community and within our workforce and signpost them to the most appropriate support.

26 We will promote the value of the Carer's strategy and work with partners and Carers to develop solutions to support the health and well-being of unpaid Carers and identify alternative support options.

27 We will explore respite options for Carers and identify timely support options that will reduce the need for crisis management.

6.2.1 Adult Carer's Support Plans (ACSP)

Unpaid Carers continue to be identified and signposted to the Carers centre to enable them to develop an Adult Carers Support Plan if they require one. Plans that require additional support from social work are discussed with Carers to identify what support would best meet their needs and the needs of the cared for person. There are a variety of options currently available including care support hours at home or respite for Carers. Fewer than 10% of people who are supported by the Carer's Centre choose to develop a formal ACSP.

6.2.2 Healthy connections referrals

A two way referral system has been developed with the Carer's Centre and Healthy Connections in Stewartry. If an unpaid Carer has been referred to the Healthy Connections programme they will be offered a home visit if required. This enables us to ensure Carers in touch with services are identified and offered support.

6.2.3 Carer's short breaks

A scoping exercise is underway into the current and future need for buildings based short breaks with a focus initially on the Rowans. The locality team are in the process of developing understanding of the people we have identified. Some are younger people (14+) and approaching transition stage.

A short breaks panel has been developed in Nithsdale for Atkinson Road, and this approach will also be used for the Rowans. The aim is to move towards a point where we are clear about current and future need for respite at the Rowans, to increase capacity with an appropriate staffing model in place and to develop the service to ensure that people experience a short break which meets their identified outcomes. We will also use the information identified through the scoping exercise to look at future supported tenancy requirements and potential housing developments.

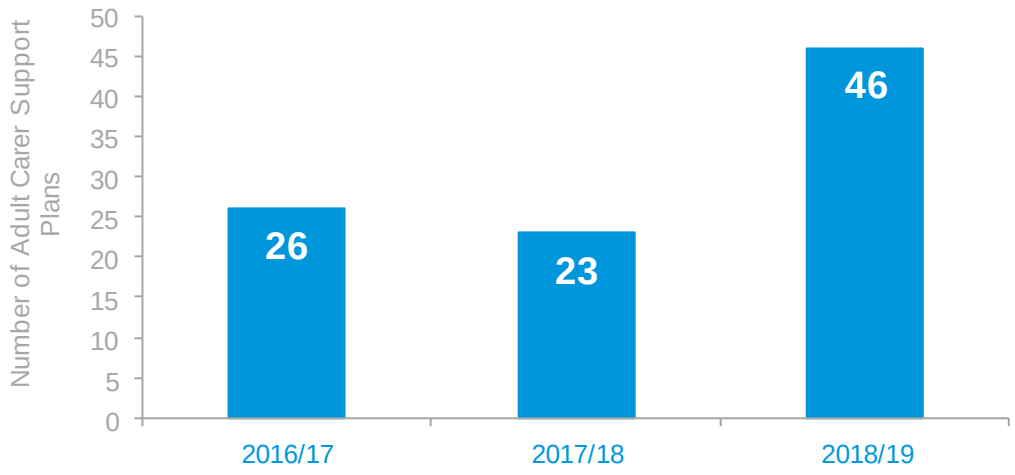
6.2.4 Carer's week

During Carer's week and for the following months, enhanced information was made available to Carers. Stewartry team promoted the Partnership's wider communication strategy. Leaflet stands were placed in each GP practice in Stewartry in June and July along with a display in the foyer of Gardenhill. Stewartry Health and Social Care also supported the information stand in Dumfries and Galloway Royal Infirmary (DGRI) during Carers Week.

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; Stewartry



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.

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.

- Care Assurance
- Quality Assurance
- young people's programme
- communication and engagement
- staff health and wellbeing
- recruitment, retention and volunteering

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:

34 We will actively list to the views and ideas of staff from across the partnership and keep them updated on the actions we have taken to respond.

35 We will provide regular information for staff to keep them up to date and abreast of developments in the locality.

36 We will provide a variety of support mechanisms for staff to access to help them manage the programme of change which is required across the health and social care setting.

37 We will explore new ways and opportunities to recruit, retain and increase the skills within our existing workforce to meet future need (e.g. new career pathways.)

38 We will identify ways for staff to access the most appropriate information at the most information at the most appropriate time to support optimum care giving.

8.2.1 Care Assurance

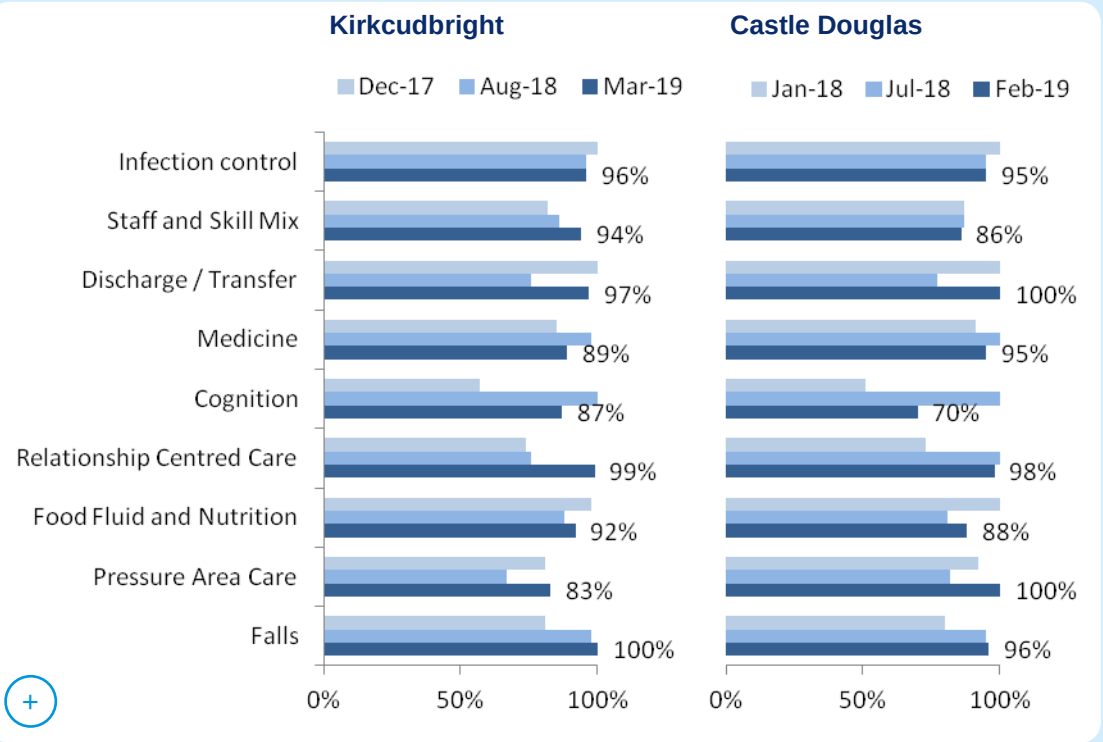
Care Assurance audit is a nursing peer review process that enables people staying in hospital to tell us about their experience and suggest potential improvements. The Care Assurance process aims to reflect national and local priorities but also to:

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

Care Assurance is carried out at DGRI, Galloway Community Hospital and at all of our cottage hospitals. The current Care Assurance achievements for Kirkcudbright and Castle Douglas Cottage Hospitals are provided below.

How we are getting on: Care Assurance

Kirkcudbright Cottage Hospital and Castle Cottage Hospital both have the bronze award in Care Assurance.



8.2.2 Quality Assurance

In 2019, the community adult general nursing teams began completing the quality tool as part of workforce and workload planning. The quality tool is designed to highlight issues that affect staffing and workload and indicate problems in systems and the environment that may inadvertently impact on the standard of care. There are 3 sections in the questionnaire; management, care delivery and safe and effective care.

How we are getting on: Quality Assurance

The overall scores for each area meet the requirement of 70%. Improvements have been made since March 2019.

Quality Indicator	Castle Douglas and New Galloway	Dalbeattie	Kirkcudbright and Gatehouse
Management	93%	81%	77%
Care Delivery	100%	85%	100%
Safe and Effective Care	97%	96%	100%
Overall Score	94%	87%	94%

8.2.3 Young people's programme

Stewartry Health and Wellbeing Team have joined up with Dumfries and Galloway Council Employability and Skills team and NHS Dumfries and Galloway Organisational Development and Learning Team to provide innovative opportunities. Young people from a diverse range of backgrounds are being given opportunities within the workplace to participate and engage in a work experience programme.

From June to August 2019, two young men have participated in an 8 week programme which has involved many activities and pieces of work including

- visits to local Care Homes
- organising and adding to an ever-expanding community resources library
- planning and hosting an event for staff

The staff event was a Lawn Bowling taster session which helped develop skills in planning, coaching, communication, coordination and confidence. Nine members of Health and Social Care staff attended the session and this will also contribute to Stewartry's Healthy Working Lives Programme for which we currently hold a Gold Award.

8.2.4 Staff health and wellbeing

The Stewartry Management Team which has representation from all teams delivering health and social care services across the locality have agreed a Health and Wellbeing Plan for staff for 2019/20. The plan was developed using feedback and ideas from staff. Some of the activities include:

- free taster session for lawn bowling, led by two work experience placement students
- promoting a healthy eating/living environment within the workplace, for example encouraging staff to take breaks away from their desks, easy access to water
- supporting staff with stress and anxiety
- supporting staff with muscular skeletal problems and prevention

8.2.5 Communication and engagement

Between June and July 2019 staff completed an iMatter questionnaire which covered four key areas

- staff governance standards
- experience as an individual
- my team and my direct line manager
- my organisation

Individual teams and the wider directorate are in the process of developing action plans based on the RAG scoring system used across these areas.

Engagement with communities and staff are integral to service improvement and project development. There is currently a review of the health and wellbeing function within localities which has included engagement with a range of staff and communities.

Social media, in particular Facebook, is being used as a mechanism to cascade information about the locality and a way to encourage feedback from staff as well as the wider public. Scottish Care is also using Facebook for additional engagement and interaction with providers and staff. Following feedback from providers, they produce a weekly newsletter to reduce the amount of emails.

8.2.6 Recruitment, retention and volunteering

Challenges continue to exist across the health and social care partnership to recruitment and retention. In response to current issues around recruitment, retention and financial issues in the Care sector 16 Routes for Resolution has been developed. Eight of these are being considered within the Care at Home sector.

Scottish Care has shared, on behalf of the Care Inspectorate, their Guidance Document: Volunteers in Care Homes, which is relevant across all Care Services. Support for providers is also on offer by our team and two Care Providers have been supported to establish policies and procedures to facilitate the safe use of volunteers in their services.

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.

	iMatter Responses	Dumfries and Galloway 2017	Dumfries and Galloway 2019	Stewartry Locality 2019
D5	4 out of 5 people agree that they have the information necessary to do their job.	80%	79%	81%
D21	3 out of 4 people agree that they are involved in decisions relating to their job.	70%	69%	74%
D22	3 out 4 people would recommend their organisation as a good place to work	74%	74%	75%

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	Stewartry	Time Period	Dumfries and Galloway	Stewartry
Outcome 1	D23	Rate of Emergency Department attendance by locality of residence per 1,000 population	May 2019	25.2	19.2	May 2019	26.2	19.9
	D24	Rate of emergency admission by locality of residence per 1,000 population	May 2018	9.73	10.44	May 2019	6.81	5.83
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	381.7	May 2019	552.6	389.1
	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%	90%
Outcome 3	D2	Number of complaints received by the locality team (all stages)	-	-	-	2018/19	-	8

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	Stewartry	Time Period	Dumfries and Galloway	Stewartry
Outcome 4	C10	Percentage of people supported by SDS Option 1 or Option 2, under 65 years of age	June 2018	25%	30%	June 2019	24%	32%
	C11	Percentage of people supported by SDS Option 1 or Option 2, 65 years and older	June 2018	7%	24%	June 2019	9%	24%
	D25	Number of people with delayed discharge in all hospitals (Dumfries and Galloway Royal Infirmary, Galloway Community Hospital and Cottage Hospitals) by locality of residence	Jul 17 - Jun 18	604	62	Jul 18 - Jun 19	807	110
	D26	Number of bed days lost to delayed discharge by locality of residence	Jul 17 - Jun 18	12,890	918	Jul 18 - Jun 19	19,526	2,763
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	27	2017/18	41	43
Outcome 6	C5	Number of Adult Carer Support Plans developed within the locality	2017/18	-	23	2018/19	-	46

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

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

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

Locality Indicator			Previous Value			Current Value		
			Time Period	Dumfries and Galloway	Stewartry	Time Period	Dumfries and Galloway	Stewartry
Outcome 7	D27	Percentage rate of emergency re-admission to hospital within seven days	Jun 17 - May 18	4.4%	4.7%	Jun 18 - May 19	4.3%	4.0%
	C9	Percentage rate of referrals to the Multi Agency Safeguarding Hub (MASH) acknowledged within 5 days	Apr - Jun 2018	67%	62%	Apr - Jun 19	47%	35%
Outcome 8	D5	Proportion of people who agree that they have the information necessary to do their job	2017	80%	n/a	2019	79%	81%
	D21	Proportion of people who agree that they are involved in decisions relating to their job	2017	70%	n/a	2019	69%	74%
	D22	Proportion of people who would recommend their organisation as a good place to work	2017	74%	n/a	2019	74%	75%
Outcome 9	D28	Average prescribing costs per person for 3 months	Jan - Mar 2018	£49.92	£46.92	Jan - Mar 2019	£50.62	£48.14
	C1	Percentage of People With SDS Option 3,Supported with Telecare	June 2018	72%	73%	June 2019	74%	75%

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

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