DUMFRIES AND GALLOWAY
INTEGRATION JOINT BOARD

HEALTH AND SOCIAL CARE
WIGTOWNSHIRE LOCALITY REPORT

DUMFRIES AND GALLOWAY
Health and Social Care

October 2019

Contents

This report has been produced by:

Wigtownshire Locality Team and the
Strategic Planning, Commissioning and Performance Team,
Dumfries and Galloway Health and Social Care Partnership

October 2019

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Foreword

This is the sixth performance report for Wigtownshire which continues to demonstrate our progress on delivering on the 'We Will' commitments outlined in the Wigtownshire 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:

- designing sustainable, safe and effective health and social care that meets the specific needs of the people of Wigtownshire through the Transforming Wigtownshire Programme
- using technology to support people and communities to live healthy and independent lives
- projects which contribute to improving health and wellbeing and reducing health inequalities
- working with the Carer's Centre to support Carer's
- housing with care and support to maintain the health and wellbeing of vulnerable people in Wigtownshire
- supporting GP colleagues on implementing specific areas of the new GMS contract

There continues to be significant challenges across the partnership in particular around recruitment and retention of staff across all sectors, 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 Wigtownshire.

Stephanie Mottram
Acting Locality Manager - Wigtownshire
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 Wigtownshire 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.

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

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

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

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

Health and social care services contribute to reducing health inequalities

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

People using health and social care services are safe from harm

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

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

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

2. Outcome 2

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

2.1 How we support this in our locality

In the future, people's 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 work towards this outcome through:

- Community Link
- mPower
- Community Health Synchronisation (CoH-Sync) project
- health and wellbeing projects
- community flow
- housing with care and support

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:

6 Develop the way we work with people and in particular to support people to plan their own care to maintain their health and retain as much personal responsibility and control as possible. This includes supporting people to build and retain their confidence and skills.

7 Work with all partners to understand local current and future housing needs so that we can develop a full range of suitable housing options.

8 Develop our use of assistive technology and other aids and adaptations to support people to be as independent as possible.

9 Ensure that any operational service improvement or development is outcome focussed (Outcome 3: operational delivery, Dumfries and Galloway partnership improvement action plan).

10 We will continue to explore ways of ensuring that our care at home and care home provision meets local demand.

11 We will continue to explore and implement approaches to move towards more sustainable primary care services, such as the training of advanced nurse practitioners to support GPs. However it is accepted that this alone will not solve the problem, more will be required.

12 Work together to create "dementia friendly communities."

Evaluation shows three out of four people **(75%)** attending said their confidence had increased and nine out of ten people **(90%)** said their mobility had improved.

2.2.1. Community link

Since August 2018 the Community Link Team has been providing community based services for people with long term medical conditions such as arthritis and stroke across Wigtownshire. Partners such as Psychology, Support in Mind, Alzheimer's Scotland and emergency services provide input at these sessions.

Although this service is predominantly accessed by people over the age of 65 (65%) there is a growing number of people under 65 (35%).

Sessions will continue to be provided in both Newton Stewart and Stranraer with plans to deliver outreach sessions for people living in more remote communities.

2.2.2 mPower

mPower aims to empower people to take control of their long term conditions at home by using technology, while simultaneously freeing up the time of GPs and other healthcare professionals. Work is ongoing to increase and improve the use of technology to support people and communities to live healthy and independent lives.

Some examples of this include:

- Introducing Home and Mobile Health Monitoring (HMHM) through the use of Florence, a text messaging service that enables people to receive, record and share relevant information about their health and wellbeing. For example, receiving medication reminders or submitting blood pressure readings.
- Community navigators providing information, discussing health and wellbeing plans and completing anticipatory care plans with people. The navigators have connected with 137 people with many having completed personal outcome plans
- Supporting the implementation and increased use of NHS Attend Anywhere, a safe and secure digital space through which people can attend video consultations with health and social care professionals. This can reduce the need for people to travel.
- Increasing the use of technology with health and social care teams such as community pharmacy.
- Introducing people to the My Diabetes, My Way app system, an interactive website provided by NHS Scotland that supports people with diabetes, their family and friends

2.2.3 CoH-Sync

The EU funded Interreg VA Community Health Synchronisation (CoH-Sync) project is a health and wellbeing programme that is now being delivered in Nithsdale and Wigtownshire. It aims to promote healthier lifestyles and focuses on the risk factors associated with long term conditions.

Trained facilitators work with people over the age of 16 to manage their own health and wellbeing and signpost them to community support and other organisations across health and social care.

Since October 2018, **422 health and wellbeing plans** were developed with people who live and work in Wigtownshire. An ambitious target has been set for the next six months with 624 plans to be completed by the end of December 2019

What People Tell Us: CoH-Sync

"I would highly recommend the CoH-Sync team to friends and family as it is such a great service....it will allow me hopefully in time to let go a little grief from my mother's death and this will make a difference to my home life, me personally, and my work. The support of the facilitator "has made me feel better within myself and I am gradually getting better due to attending grief counselling. Due to researching and making myself and my family balanced and nutritious meals we as a family have more energy".

2.2.4 Health and wellbeing projects

Health, wellbeing and community development projects are developed with people, communities and partners to improve the health and wellbeing of people living and working in Wigtownshire.

Examples of current work include:

- Login and Connect - this group meets weekly in Newton Stewart to support and increase IT skills for older people
- Healthy Connections Programme - supports people who suffer from low mood or anxiety and the resulting support with self management prevents deterioration and reliance on medical interventions
- Community development volunteers support the delivery of Tai Chi in Stranraer, New Luce and Lochans

What People Tell Us: Jessie's Tai Chi Story

After a visit from a community navigator and completing an Anticipatory Care Plan which focuses on self management, setting goals and keeping well, Jessie wanted to attend Tai Chi classes to increase exercise in a gentle way improving her mobility and balance.

"I love it, Tai Chi is exercise that is easily achievable even for a lady of 80! It made me feel good about myself again. The group was very friendly and made me feel welcome and I met some lovely new people. Tai Chi is definitely something I want to continue and it has certainly helped my health and the way I feel about myself in a positive way. I just hope more people can benefit from services like mPower."

- Jessie has given consent for us to use her name.

2.2.5 Community flow

There are Community Flow Teams in both Stranraer and Newton Stewart which are led by Social Work senior managers. By working closely with our colleagues from across the partnership we are able to plan a balanced approach to care, support and adaptations based on need.

Where we have challenges with the availability of care at home support, this is addressed through our providers meeting as well as regular communication to ensure that capacity is maximised.

2.2.6 Housing with care and support

There are many challenges in providing housing with care and support to maintain the health and wellbeing of vulnerable people in Wigtownshire. These challenges are linked to the rural nature of our locality, increased demand due to our ageing population and the need to provide fit for purpose, affordable and supported housing provision for our most vulnerable people.

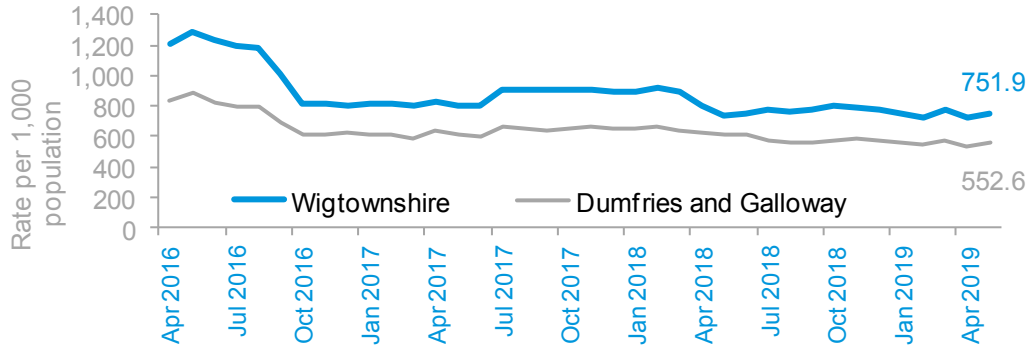
Loreburn Housing is currently building bungalows and flats which will be designed to accommodate the needs of people with dementia, intellectual disabilities or physical needs on the old Garrick Hospital site. The work is expected to be completed by late spring 2020.

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; Wigtownshire

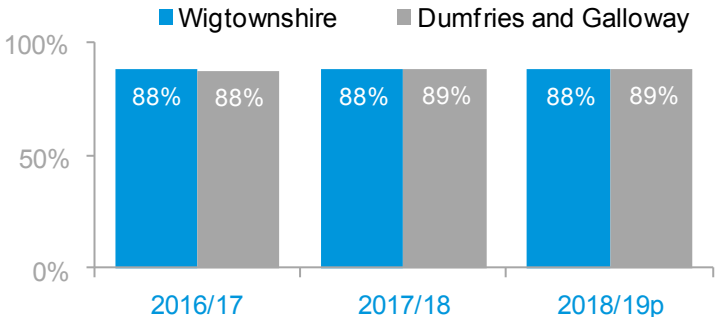


C8 Source: Dumfries and Galloway Council

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

88%

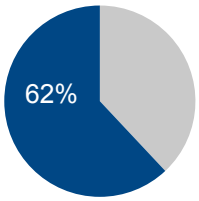
of their time at home or in a homely setting.



A15 E5

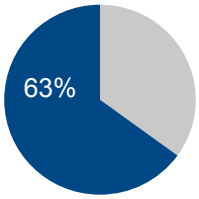
Source: ISD Scotland (p - provisional result)

Dumfries and Galloway 2018



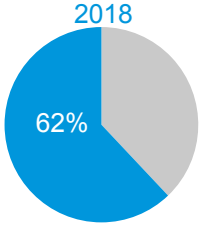
62% of adults with long term care needs receive care at home.

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:

- participatory appraisal
- Transforming Wigtownshire Programme
- iMatter
- social media
- Care Assurance

3.2 How we are addressing this outcome in our locality

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

13 Develop and implement approaches to seek feedback from people who use services with a view to better understanding what is working well and what is not working well. Learn from feedback about service and use this to continually improve services.

3.2.1 Participatory appraisal

The Wigtownshire health and wellbeing team members are trained in participatory appraisal. This is an inclusive approach to gather information from people and communities to help develop and improve future work.

The team provide the opportunity and encourage people who have been involved with their services to share their experiences in the form of a case study which can be shared with others.

3.2.2 Transforming Wigtownshire programme

The Transforming Wigtownshire Programme has been launched to review and redesign safe, sustainable services in a co-productive way with the people of Wigtownshire and partners.

A communication and engagement strategy has been developed which aims to ensure that staff and the public are equipped with the correct information and are reassured by the changes that are taking place as the programme progresses.

A set of guiding principles lie at the very heart of this strategy, including openness, transparency, issues and challenges, key milestones, and feedback on all engagement activities.

Feedback is taken at every opportunity and the team are continually exploring innovative ways to reach people.

3.2.3 Social media

The Wigtownshire Health and Social Care Facebook page continues to play a big part in communication and engagement with our population. This is constantly updated by people from the Health and Wellbeing Team, hospital, social work and the independent sector.

A recent post about recruitment and several other good news stories attracted over 10 thousand views. A testimonial video has been created of a woman who benefited from the Florence text messaging system.

Ten beneficiaries have given interviews to an independent researcher from the University of Highland and Islands (UHI) on their experience with the mPower team and the education and support that has been provided.

3.2.4 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 Dumfries and Galloway Royal Infirmary, Galloway Community Hospital and at all of our cottage hospitals.

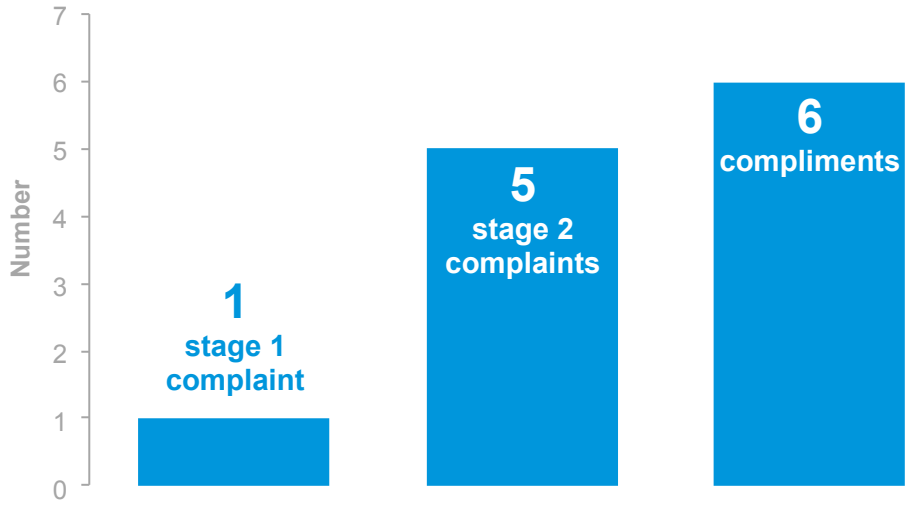
Care Assurance feedback reports are reviewed, investigations carried out when determined necessary based on indication of potential or actual harm and performance improvement actions plans are created and followed up to prevent similar issues occurring. Each experience provides a learning opportunity.

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, Wigtownshire 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, a good example of this is

- community pharmacy
- health and wellbeing
- social work

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:

19 Through the provision of appropriate information, support people to take more control of their own health and well-being.

20 Begin to set out priorities around addressing health inequalities and seek opportunities to work with other partners across sectors.

21 Begin to address key factors affecting health inequalities, such as employment, education and housing.

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

5.2.1 Community pharmacy

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

The pharmacy team are developing the skills of local people through student pharmacy technician training in primary care. This enables employment of staff with no previous pharmacy experience to be offered training and development leading to a formal qualification.

5.2.2 Health and Wellbeing team

The health and wellbeing team are involved in a number of projects and initiatives which contribute to reducing health inequalities such as:

- The mPower project which is focused on supporting people 65 and over who have one or more long term medical conditions. The project supports people and communities through community navigators as one way of improving their health and wellbeing. Attendance at health and social care team partnership meetings such as care providers to raise awareness of the project and the services available for people they work with.
- The community development team are trained in participatory appraisal. This approach can be used to work with communities to understand need. They have been involved in engaging with communities about the Transforming Wigtownshire programme, screening services and the health and wellbeing service review.

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.

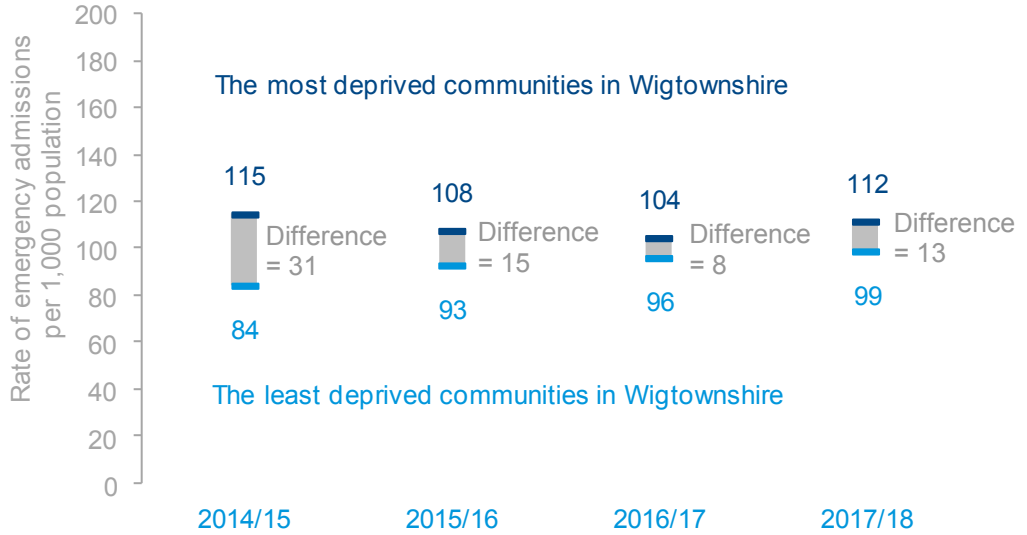
The only measure of relative deprivation that is available for the whole population of Dumfries and Galloway is the Scottish Index of Multiple Deprivation (SIMD). This is a tool used by Scottish Government to identify deprived communities across Scotland. It considers 7 different aspects of deprivation: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



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 through:

- joint working with Carer's Centre
- respite opportunities
- Carer's meetings
- Carer's week 2019

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:

23 Identify current and potential Carers as early as possible.

24 Listen to the views of Carers and take appropriate action in response.

25 Ensure all Carers are informed of their right to an adult Carer support plan (previously known as Carer assessment), so that the needs of the Carer are addressed in their own right.

26 Identify and promote local services and resources to help improve the quality of life of Carers.

27 Continue to raise "Carer awareness" across our workforce following the equal partners in care core principles.

6.2.1 Joint working with Carer's Centre

Social Care is working closely with the Carers Centre in our locality to support our Carers and recognises the importance of this role by ensuring that when assessments are completed for the cared for person, that consideration is also given to those providing the care through developing an Adults Carer Support Plan, including the provision of respite.

Unpaid Carers are provided with relevant advice and support about support groups in their area and signposted to guidance and training that may assist in their caring role.

6.2.2 Respite opportunities

The day care service run by Skillstation is now providing respite opportunities for Carers in Stranraer.

6.2.3 Carer's meetings

mPower has been attending Machars Carers meetings to try to increase the use of digital technology services, for example Florence medication reminders.

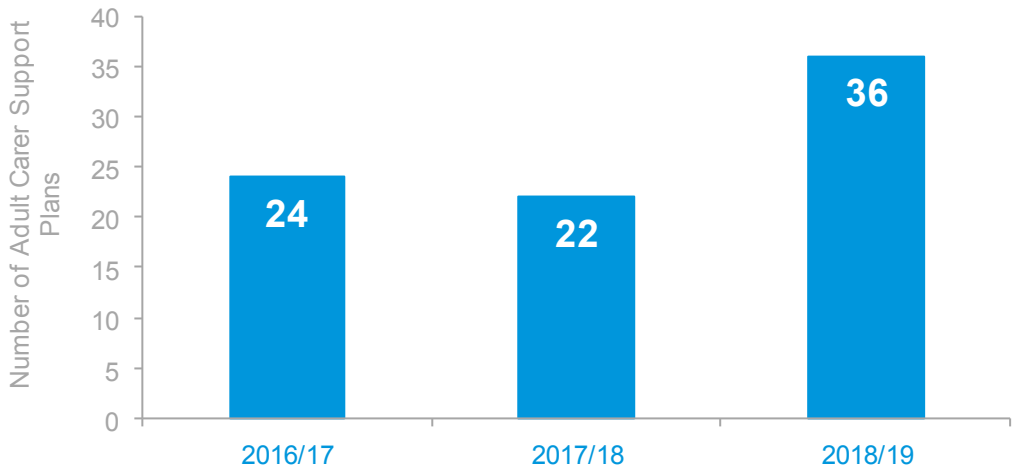
6.2.4 Carer's week 2019

In May 2019 information, support and advice was provided for Carers across different parts of Wigtownshire by the locality health and social care team. Communications included posters and a Getting Carers Connected document that contained contacts for multiple sources of support available for Carers, the person they care for and their family.

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; Wigtownshire



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.

- implementation of the new GP contract
- pharmacy
- mPower and social work joint post
- iMatter

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:

32 Improve communications within and between services and develop working arrangements within multidisciplinary team so that staff across services feel valued and engaged in practice decisions and service developments.

33 Acknowledge the pressures on staff providing support and care. Develop and implement approaches to seek feedback from staff with a view to better understand what is working well and what is not working well.

34 Explore opportunities to address issues about recruitment and retention including how to make care more attractive as a career choice for local people.

8.2.1 Implementation of the new GP contract

A primary mental health worker has been based in the Waverley Medical Centre for nearly 2 years, initially to support Lochinch and more recently Loch Ree practice. This service provides access for patients with low level mental health issues with a 6 to 8 week intervention. The intention is to roll out this approach across Wigtownshire by 2021. There are some challenges to overcome, in particular in relation to recruitment of sufficient staff, administrative technicalities and embedding a previously secondary care role within primary care.

Since December 2018, 2 separate pilots have been running where paramedics have been doing home visits under the supervision of the GPs for the 3 Waverley Medical Centre GP practices, Galloway Hills and Southern Machars practices. They have also occasionally seen patients for unscheduled appointments within the GP surgeries.

Staff and patient feedback has been extremely positive, with paramedics able to spend more time than GPs on each visit and more time to arrange hospital admissions.

Preliminary analysis has shown that paramedics have saved each GP practice a considerable number of hours per week of GP time and a significant proportion of this has been travel time.

8.2.2 Pharmacy

Pharmacy Hubs have been developed at Waverley Medical Centre and Newton Stewart Health Centre. It is an innovative approach where a prescribing pharmacist leads a team to provide 5 day support in GP practices to provide medication management and appropriate medication use with patients. More GP time is released to provide clinical care. There are many benefits to the patient such as safety.

8.2.3 mPower and Social Work joint post

A proposal has been made for mPower to fund social worker hours to embed some of the mPower project into the Social Work review process. This will increase the number of people receiving the support of mPower programmes and sustainable change towards self management.

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.

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 and my organisation.

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	Wigtownshire Locality 2019
D5	4 out of 5 people agree that they have the information necessary to do their job.	80%	79%	79%
D21	3 out of 4 people agree that they are involved in decisions relating to their job.	70%	69%	76%
D22	4 out 5 people would recommend their organisation as a good place to work	74%	74%	80%

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	Wigtownshire	Time Period	Dumfries and Galloway	Wigtownshire
Outcome 1	D23	Rate of Emergency Department attendances by locality of residence per 1,000 population	May 2018	25.2	43.5	May 2019	26.2	43.2
	D24	Rate of emergency admission by locality of residence per 1,000 population	May 2018	9.73	9.67	May 2019	6.81	6.36
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	757.9	May 2019	552.6	751.9
	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%	88%
Outcome 3	D2	Number of complaints received by the locality team (all stages)	-	-	-	2018/19	-	6

Source: ISD Scotland, HACE Dashboard

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

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

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

Locality Indicator			Previous Value			Current Value		
			Time Period	Dumfries and Galloway	Wigtownshire	Time Period	Dumfries and Galloway	Wigtownshire
Outcome 4	C10	Percentage of people supported by SDS Option 1 or Option 2, under 65 years of age	June 2018	25%	31%	June 2019	24%	24%
	C11	Percentage of people supported by SDS Option 1 or Option 2, 65 years and older	June 2018	7%	6%	June 2019	9%	7%
	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	87	Jul 18 - Jun 19	807	76
	D26	Number of bed days lost to delayed discharge by locality of residence	Jul 17 - Jun 18	12,890	2,960	Jul 18 - Jun 19	19,526	3,201
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	8	2017/18	41	13
Outcome 6	C5	Number of Adult Carer Support Plans developed within the locality	2017/18	-	22	2018/19	-	36

Source: ISD Scotland, HACE Dashboard

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

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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	Wigtownshire	Time Period	Dumfries and Galloway	Wigtownshire
Outcome 7	D27	Percentage rate of emergency re-admission to hospital within 7	Jun 17 - May 18	4.4%	3.7%	Jun 18 - May 19	4.3%	3.6%
	C9	Percentage rate of referrals to the Multi Agency Safeguarding Hub (MASH) acknowledged within 5 days	Apr - Jun 2018	67%	77%	Apr - Jun 2019	47%	59%
Outcome 8	D5	Proportion of people who agree that they have the information necessary to do their job	2017	80%	n/a	2019	79%	79%
	D21	Proportion of people who agree that they are involved in decisions relating to their job	2017	70%	n/a	2019	69%	76%
	D22	Proportion of people who would recommend their organisation as a good place to work	2017	74%	n/a	2019	74%	80%
Outcome 9	D28	Average prescribing costs per person for 3 months	Jan - Mar 2018	£49.92	£58.34	Jan - Mar 2019	£50.62	£59.09
	C1	Percentage of People With SDS Option 3,Supported with Telecare	June 2018	72%	69%	June 2019	74%	72%

Source: ISD Scotland, HACE Dashboard

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

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