DUMFRIES AND GALLOWAY
INTEGRATION JOINT BOARD

HEALTH AND SOCIAL CARE

ANNANDALE AND ESKDALE LOCALITY REPORT

DUMFRIES AND GALLOWAY
Health and Social Care

April 2020

DRAFT 1.0

Contents

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Foreword

Following the establishment of the Integrated Joint Board for Health and Social Care in 2016, people and organisations across Annandale and Eskdale have worked together to share the job of making our communities the best place to live active, safe and healthy lives by promoting independence, choice and control. I am pleased to present this report which sets out the progress made during 2019 in promoting the health and wellbeing of people across Annandale and Eskdale.

As you will read, during 2019 we made significant progress in a number of areas in transforming how we support local people and meeting the commitments set out in our locality plan. At the same time, we are mindful that further progress needs to be made to ensure that people are supported by the right person, in the right place, at the right time every time.

In this report we have set out the progress and challenges we faced in 2019 in delivering 4 of the 9 National Health and Wellbeing Outcomes, namely:

- **Outcome 1** – People are able to look after and improve their own health and wellbeing and live in good health for longer
- **Outcome 4** – Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
- **Outcome 7** – People using health and social care services are safe from harm
- **Outcome 9** – Resources are used effectively and efficiently in the provision of health and social care services

We can be rightly proud of the many examples from across Annandale and Eskdale of creative and effective ways that staff and volunteers have worked together in 2019 to sustain and transform health and social care. However, we know that in 2019 too many people were delayed from being discharged from hospital. We need to provide a greater range of housing with care and support for older people and people with learning disabilities and we need to do more to provide a rapid, community based response to help prevent or delay the need for admission into hospital. Similarly, we made progress in 2019 towards sustaining and transforming primary care services. However, we are aware that we need to do more in engaging local communities in the process of changing how we deliver services and support people to maintain and improve their quality of life.

Building on the strong platform of integrated and person centred working in Annandale and Eskdale, I am confident that we are well placed to make further progress in 2020 in supporting people to live long, healthy and fulfilling lives in their own homes and communities.

Gary Sheehan
Locality Manager - Annandale and Eskdale
April 2020

Introduction

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

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

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

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

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

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

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

Dumfries and Galloway Scheme of Integration
http://www.dg-change.org.uk/wp-content/uploads/2015/07/Dumfries-and-Galloway-Integration-Scheme.pdf (last access 30 January 2019)

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

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

The symbols we use

i) How we are addressing this outcome in our locality

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

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

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

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

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

ii) How we are getting on

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

1. People are able to look after and improve their own health and wellbeing and live in good health for longer
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
3. People who use health and social care services have positive experiences of those services, and have their dignity respected
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
5. Health and social care services contribute to reducing health inequalities
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
7. People using health and social care services are safe from harm
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
9. 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.

1. Outcome 1

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

1.1 How we support this in our locality

Making the most of and maintaining health and wellbeing is better than treating illness. The aim is to promote good health and prevent ill health or, where health and social care needs are identified, to make sure there are appropriate levels of planning and support to maximise health and wellbeing.

Across the locality we actively encourage early intervention as a way of reducing the likelihood of people reaching crisis or needing to be admitted to hospital. Increasing the use of pharmacy, GP practices and other support services can have very positive impact on outcomes for people and help avoid pressure in the wider health and social care system.

We encourage our workforce to think about every contact or conversation with people as being an opportunity to support people to manage their own health and wellbeing. This includes helping people to recognise the support they already have through their friends, family and communities.

In our locality we work towards this aim by:

- Community Link
- Health promotion initiatives
- Frailty Collaborative and Anticipatory Care Planning
- One Team and Multi Disciplinary Team approaches
- New technology
- Mental Health support

1.2 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:

1. We will have different conversations with people about their health and care needs to support them to take personal responsibility for their own health and wellbeing
2. We will support people to plan ahead and to consider their options and wishes at an early stage through the expansion of forward looking care plans.
3. We will develop and support our workforce to develop a more holistic and integrated approach to promote health and wellbeing through the development of Integrated team at a local community level.
4. We will identify and maximise the use of individual and community assets to support personal health and wellbeing.
5. We will review the current use of new technology to promote greater independence and safety and develop plans for a more effective use of such technology.
6. We will provide accessible information for people to help them access the range of support that is available.

1.2.1 Community Link

We are continuing to build on the Community Link service to ensure people are supported, encouraged to engage and make positive changes to their lives. This service will be expanded in April 2020. Community Link Workers (CLWs) will become an integral part of the new contract for GP practices. The Community Link Service works with the most vulnerable in the community supporting people to engage with mainstream services. Referrals to the service come from practitioners across the sectors and through all of our GP practices. It takes a person centred, asset based approach working with people, to strengthen their resilience and improve their health and wellbeing. In a 6 month period the service currently receives approximately 180 referrals. People are supported with issues such as housing, finance and benefits, mental wellbeing and confidence.

> " I don't know how I would have got through the time I was having without the Community Link Worker, I can't thank them enough for helping me tackle all the stuff I needed to sort out… which was mostly my own head."
>
> Community Link Client

1.2.2 Frailty Collaborative and Anticipatory Care Planning

Annandale and Eskdale is now part of the Scottish Frailty Collaborative. The focus of the collaborative is to identify people with frailty and try to intervene early by having conversations with people to ensure they are able to live and keep well for longer. The other key focus is increasing the number of people who have an Anticipatory Care Plan (ACP) in place. This ensures that their wishes and options are recorded on their Key Information Summary (KIS), which is held by GPs and shared with people like the ambulance service and the emergency department. The conversations involved in completing this plan enables and empowers people to take a 'can do' attitude and encourages self care and behaviour changes that help improve health and wellbeing and quality of life. In Annandale and Eskdale we try to encourage this as early as possible and the CLWs and community nurses take a very proactive approach supporting people to forward plan and have conversations much earlier about issues such as Power Of Attorney (POA).

1.2.3 One Team and Multi Disciplinary Team approaches

We are continuing to build on the Multi Disciplinary Team (MDT) approach so that we can ensure people are supported by the right person at the right time every time and that every potential solution is explored so that people get their best outcome possible. There are also very early developments around the future vision of Home Teams. These teams will work much closer to communities and will focus on flow, preventing admission to hospital and supporting people to remain in a homely setting.

1.2.4 New Technology

We are actively seeking new ways of embedding the use of technology within mainstream services and practice. The use of Attend Anywhere (a secure video consultation application) is being promoted across all teams. We are also working to promote this approach with the public and people we work with. As part of the new housing developments in Station Yard in Annan we are ensuring that technology will be used to ensure greater independence and safety for future residents.

1.2.5 Mental Health support

Our mental health approach in Annandale and Eskdale is in line with National Institute for Clinical Excellence (NICE) guidelines.

We have recently secured funding to train 12 STEPS facilitators across the locality. STEPS facilitators will support people experiencing low confidence and low self esteem. STEPS is a globally recognised and fully accredited course. The training will take place in February 2020 and programmes will be available soon afterwards.

The Community Mental Health Team (CMHT) is working on a parity of esteem project alongside the Royal College of Nursing (RCN) and primary care. This project is focused on improving the physical health of people with severe mental health issues who are often have an increased risk of developing long term conditions and dying younger. The project aims to ensure equality between physical health and mental health needs and to ensure people can access services and be supported to overcome barriers and stigma that often prevent them doing so.

1.2.6 Health Promotion

Across Annandale and Eskdale there are projects supporting people to make positive health behaviour changes and to improve their health and wellbeing. Here are some examples:

- **Lets Prevent** is a new programme that aims reverse the rise in and prevalence of type 2 diabetes. Making changes to your lifestyle can reverse the onset of type 2 diabetes. We now have 3 trained Let's Prevent facilitators with the Health Improvement Team and Leisure and Sport Team who deliver programmes across the locality. People identified with an increased risk of developing diabetes through a blood test are referred into the programme by GP practices. We are working closely with GP practices and the diabetes service to try and ensure people who may not initially engage with the Lets Prevent programme are supported to do so.
- **ShElf the Sugar** initiative aims to reduce the sugar consumption in young people though working with young people, their parents and Carers and school staff. There have been long term rises in child obesity, type 2 diabetes and dental decay in young people. During a pilot at 3 primary schools in Annandale and Eskdale people taking part demonstrated up to 64% reduction in consumption of sugar. ShElf the Sugar are continuing to work with with primary schools to explore how this initiative can be rolled out to other schools.
- **Child Healthy Weight** services have been available through the Health Improvement Team for a few years now but the number of families accessing the services has been low. We recognise that we need to change what we are doing. We have started scoping and engagement work to try and establish what is working well and what needs to be improved or strengthened to ensure the services and pathways are meeting the needs of families and young people. This is region wide and links are being made with Early Years providers and women and children's services to look at the whole system approach.

> "Information presented really well and I can't believe the kids are trying and eating different foods… thank you for all your support…"
>
> Parent

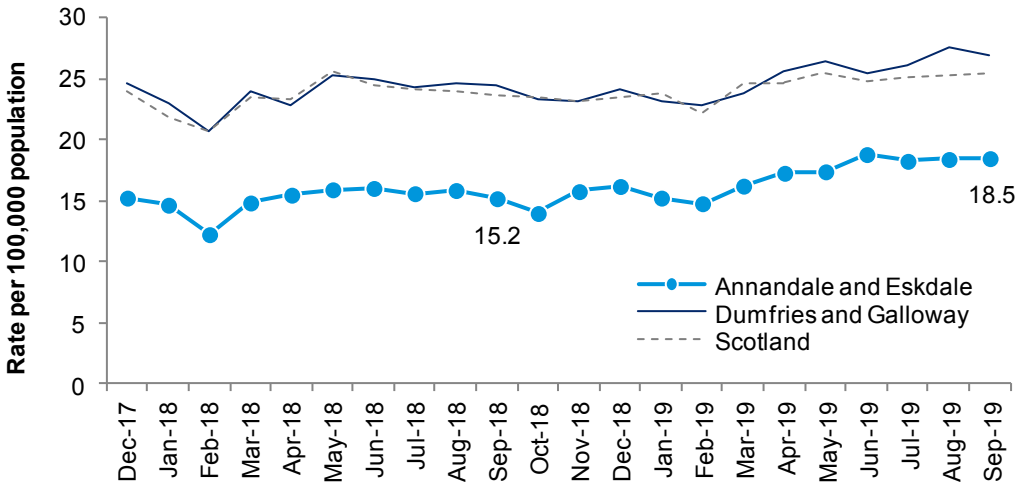
- **Move More** provides physical activity and social opportunities for people affected by cancer and long term health conditions. It offers free and low cost classes that are delivered by trained instructors in villages across Annandale and Eskdale. The new programme aims to reach and encourage people who may be experiencing health inequalities to take part.
- **Lets Cook** provides opportunities for people to learn basic skills and to feel more confident in the kitchen and in budgeting and planning meals and snacks. The programme is about reaching and supporting some of the most vulnerable in our communities who may be experiencing inequalities and need support to make healthier choices or changes to improve their health outcomes. Over 60 people have been supported through group sessions.
- **Positive Steps** is a group for people living with Parkinson's disease. At least 12 people attend the group on a regular basis. People tell us that it helps to keep them mobile and allows them to share experiences with others in the same position.

1.3 How we are getting on

An important measure of how well people are able to manage their health and wellbeing in the community setting is how often their healthcare occurs as an emergency. There will always be the need for urgent and emergency care, but where possible the aim is to support people in the community and prevent crisis events. In Annandale and Eskdale over the last year, the number of people attending an emergency department (anywhere in Scotland) high risen modestly and people having an emergency admission to hospital have been relatively stable and lower than Dumfries and Galloway.

It should be noted that many residents of Annandale and Eskdale access hospital services in Carlisle; English activity is **not** included in these figures.

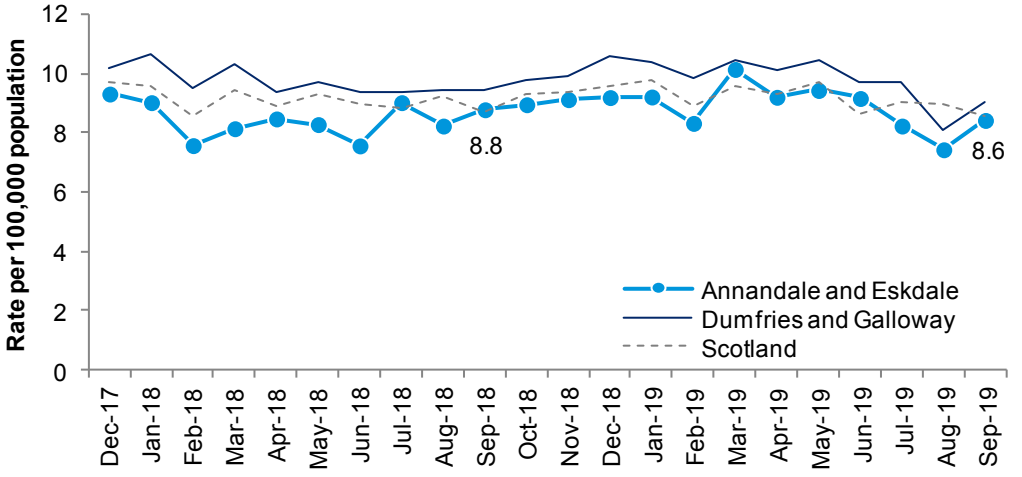
Rate of emergency department attendance per 1,000 population, Annandale and Eskdale



Source: NSS Discovery, from National A&E Datamart

D23

Rate of emergency admissions to hospital per 1,000 population, Annandale and Eskdale



Source: NSS Discovery, GP Cluster Activity, from Scottish Morbidity Records (SMR01)

D24

4. Outcome 4

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

4.1 How we support this in our locality

The way that we work with people, designing and delivering their care and support, fundamentally focuses on maintaining quality of life.

In our locality, we work towards this by

- Good Conversations
- Self Directed Support
- Locality Provider Forum
- Care Assurance
- Timely discharge from hospital

4.2 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:

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

19 We will make sure appropriate information is available for people to access the support they need to maintain or improve their quality of life.

20 We will build in a regular review process to make sure people who use our services are getting the support they need to live a good quality of life.

21 We will review and develop and use outcome star approaches across Annandale and Eskdale.

22 We will conduct a day of care audit within our cottage hospital to help shape their future development.

23 We will review and develop the use of the IORN (indicator of relative need) assessment tool across Annandale and Eskdale to help identify the different and changing needs of people and inform the development of how we support them.

4.2.1 Good Conversations

Through our commitment to a person centred approach, all our health and social care staff work in partnership with people to identify their outcomes. This involves the use of Good Conversations, which all of our front line staff have undertaken training in. This approach assists in exploring what people can do for themselves, what community and family supports are available and what level of support and care is needed thereafter to meet their outcomes and improve their quality of life. Having good conversations helps to encourage and support people to take control and responsibility and to openly discuss their options and wishes at all stages of life.

4.2.2 Self Directed Support (SDS)

Self Directed Support Option 1 is where people choose to take control of purchasing their own care and support. However, people's ability to choose is often limited by the availability of care providers and personal assistants in our locality. Work is being undertaken to develop a new framework for the delivery of care at home across Dumfries and Galloway. The Locality Manager and Locality Social Work Manager for Annandale and Eskdale are fully involved in this process. Ensuring all practitioners are aware of the opportunities with SDS is important so that conversations with people can take place early. This enables people, their families and Carers to begin to think about and plan their options sooner. The social work team recently did a session for CLWs to raise awareness of Self Directed Support. More of this 'sharing of learning' is planned.

4.2.3 Locality Provider Forum

We continue to meet with our care providers on a regular basis to explore the opportunities and challenges we face. Work is taking place to reduce support workers' travel times by better coordinating how care providers deliver support and care in Annandale and Eskdale.

There have been particular difficulties in sourcing care at home support in the more rural areas of Annandale and Eskdale. During 2019, we carried out an extensive review of the challenges to sourcing care at home. An agreement has been reached to expand the Partnership's in house Care and Support Service (CASS). An additional 12.5 whole time equivalent staff will support upper Annandale and the Langholm and Canonbie areas where there has been significant recruitment challenges.

4.2.4 Care Assurance

As a locality we are committed to provide safe, high quality and effective care within our 4 Cottage Hospitals. We measure the quality of care that is being delivered in our hospital through our Care Assurance process. Our approach is about continuous improvement support for staff, identifying areas of good practice and recognising areas of practice that may not meet the agreed standards.

There are three levels of Care Assurance :

- **Level 1** is carried out by the senior charge nurse and charge nurse twice a week with a registered nurse or health care support worker.
- **Level 2** is carried out by the nurse manager once a month with a registered nurse or health care support worker.
- **Level 3** is carried out by various health professionals from across all localities. Level 3 reviews the quality of care being provided based on the national standards.

The scoring matrix for level 3 Care Assurance has four levels. In order to achieve these, the percentage shown must be achieved in each of the nine standards.

Bronze - each standard at least 75% compliance

Silver - each standard at least 85% compliance

Gold - each standard at least 95% compliance

Exemplary - 3 consecutive gold assessments in succession

All of our cottage hospitals have completed Level 3 Care Assurance with the following results.

Annan Hospital	Lochmaben Hospital	Moffat Hospital	Thomas Hope Hospital
Gold	Silver	Bronze	Silver

We will continue to strive and to maintain and build on these levels of Care Assurance by continually monitoring our cottage hospitals.

4.2.5 Timely Discharge from hospital

Every month an assessment called a Day of Care Survey is done across all hospitals in Dumfries and Galloway including Dumfries and Galloway Royal Infirmary (DGRI) and the 4 cottage hospitals in Annandale and Eskdale. This assessment uses a set of criteria to determine if people are being cared for and supported in the most appropriate setting. We know that delays in discharging people can undermine the rehabilitation process and frustrate people who want to return home.

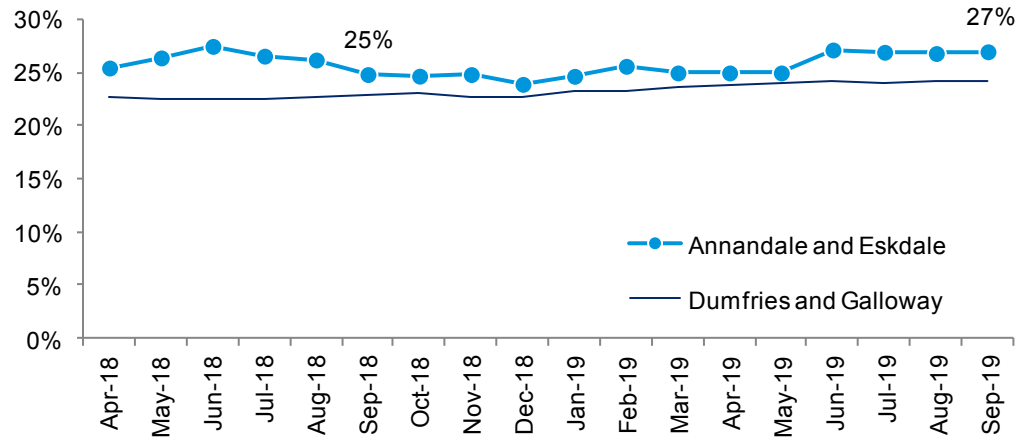
During 2019, the Day of Care Surveys in our 4 cottage hospitals consistently showed that up to 50% of people at any one time could have been supported in a more appropriate setting. The surveys also showed that people were waiting longer in hospital to be discharged. In response to such delays, we have invested more resources in care at home services, we will be reviewing capacity in our care home sector and will be developing new models of care and support, such as Extra Care, Intermediate care and Home Teams.

4.3 How we are getting on

The proportion of people in Annandale and Eskdale receiving support through Self Directed Support Options 1 or 2, which have the largest levels of personal responsibility has remained stable for the past two years. Whilst we support people to have the confidence to choose Options 1 and 2 for themselves, many people continue to prefer to choose Option 3.

Around one in four people aged under 65 have chosen these Options, whilst for people aged 65 or older, it is around one person in 16. In September 2019 there were 44 people aged under 65 receiving care through SDS and 35 people aged 65 or older.

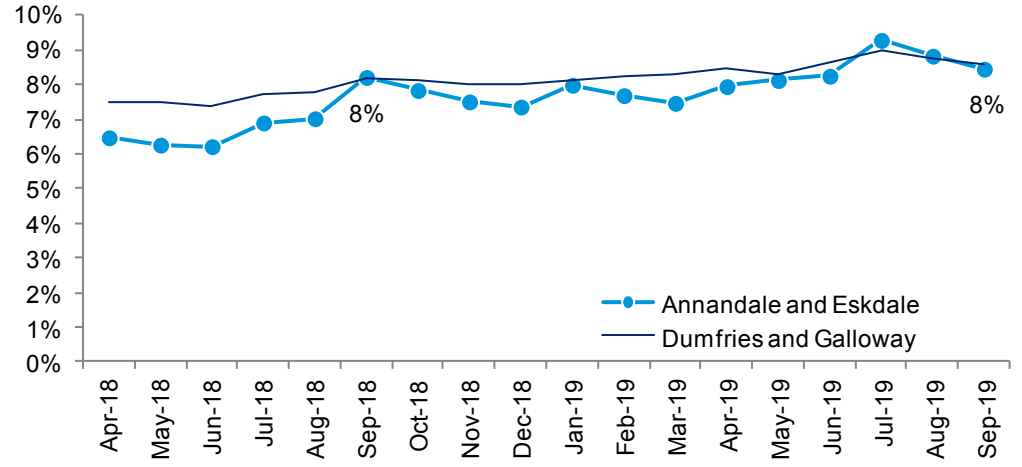
Percentage of people under 65 years with SDS accessing options 1 and 2; Annandale and Eskdale



Source: Dumfries and Galloway Council, local figures

C10

Percentage of people 65 and over with SDS accessing options 1 and 2; Annandale and Eskdale



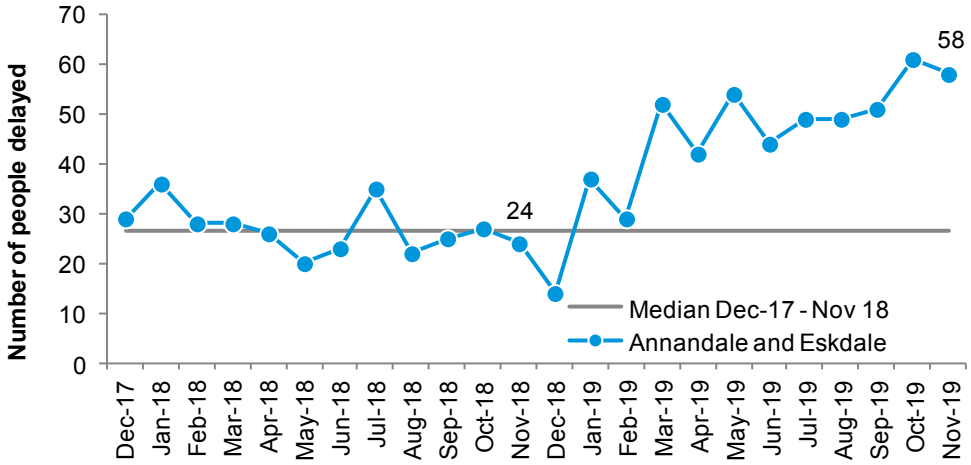
Source: Dumfries and Galloway Council, local figures

C11

One measure of the successful coordination of people's journey of care, is the amount of time spent in hospital settings when people were ready to be discharged to a less acute setting or into the community. When people are not in the most appropriate place for their care we refer to this as a delayed discharge.

In Annandale and Eskdale, over the last year the number of people experiencing a delayed discharge (in acute, community or cottage hospital setting) has risen. Reasons for this include recruitment challenges across both health and social care sectors and complex legal arrangements including guardianship. A dedicated flow coordinator works with the multidisciplinary team to enable smooth transitions from one setting to another.

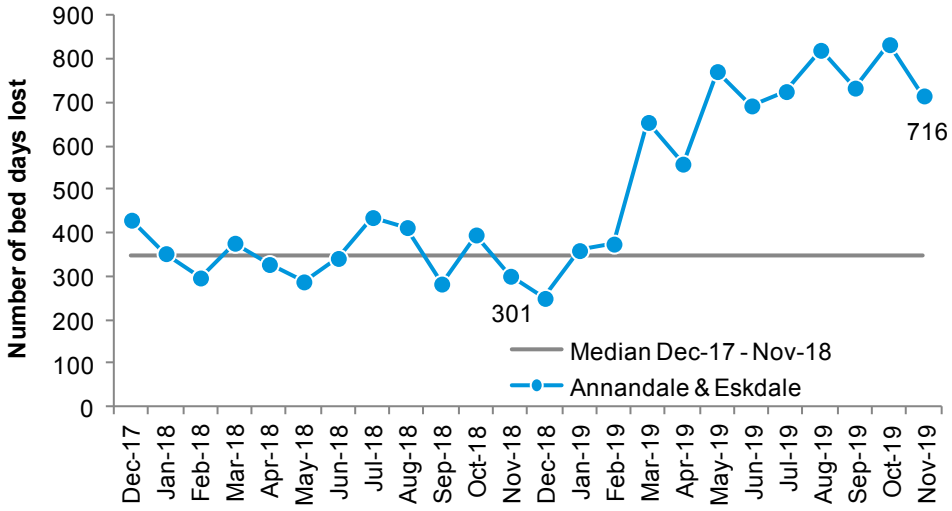
Number of people experiencing a delayed discharge at the end of each month; Annandale and Eskdale locality residents



Source: NHS Dumfries and Galloway, local figures

D25

Number of bed days lost to delayed discharge each month; Annandale and Eskdale locality residents



Source: NHS Dumfries and Galloway, local figures

D26

7. Outcome 7

People using health and social care services are safe from harm

7.1 How we support this in our locality

Making sure people are safe from harm is about maintaining safe, high quality care and protecting vulnerable people. In some instances activities focus on protecting people already identified as vulnerable. Other activities are focussed on improving the safety of services, aiming to reduce the risk of harm to all people.

In our locality we work towards this aim by:

- Improving communication and joint working
- Housing with Care and Support
- Infection Control
- Managing risk and maintaining business continuity

7.2 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:

35 We will help people recognise and report abuse and harm at the earliest stage possible.

36 We will develop the skills and knowledge of staff and managers to protect people from harm.

37 We will record and share information in a joined up professional and confidential manner.

38 We will make sure that all incidents of abuse and harm are investigated and dealt with in a timely way.

39 We will identify the main risk areas and trends and develop local strategies to reduce harm.

40 We will identify key risks for people and develop risk management plans in a consistent, holistic and person centred manner.

7.2.1 Improving communication and joint working

New developments and activities in our locality have resulted in improved communications between our social work and NHS colleagues. Social work staff now have access to an NHS information portal. Also our social work and Community Mental Health Nursing Team (CMHT) are piloting a collaborative approach to supporting people with Emotionally Unstable Personality Disorder.

By working more effectively as a team and sharing knowledge, skills and information we have seen an increase in the number of people who have an Adult Support and Protection Plan in place. A core group of professionals, including social work, CLW and district nurses, work with people with an Adult Support and Protection Plan to reduce harm.

7.2.2 Housing with Care and Support

A new housing with care development in Annan for people with a learning disability is taking shape and nearing completion. This development will be handed over in summer 2020 and plans are in place for people to move into this with the appropriate support. This will include digitally enabled telecare. Also, in this development we will see the delivery of short breaks for this group and their families. This will be an enhanced level of support from what was previously available when this service was based at Long Meadow Avenue.

Agreement has been reached to develop Extra Care housing in Moffat and Langholm. This will see the building of 22 bungalows on each site where 24 hour care will be available with support from our district nursing service. This will allow vulnerable older people to remain living in their own homes and communities longer, as well as provide an alternative for the first time to residential care. All the properties we are involved in developing have been co-designed between our front line operational staff, the design team at Loreburn Housing Association and their architects. This has included our front line care at home staff, occupational therapists, dementia nurses, social workers, specialists in benefit entitlement and our telecare team. The properties have also been designed, where possible, in line with the Council's policy on lowering carbon emissions. This has resulted in some homes being designed to a Passivhaus Standard including using solar panels and air source heat pumps as an alternative to gas central heating systems. The Extra Care housing will support more than 40 people and are planned to open in late 2021.

7.2.3 Infection Control

Ensuring high quality and a safe delivery of care within our 4 cottage hospitals is paramount. In May 2019, 3 of our cottage hospitals received an announced Safe and Cleanliness Inspection from Health Improvement Scotland (HIS). This was the first inspection of these hospitals against the HIS Healthcare Associated Infection (HAI) Standards (February 2015). The standards focused on this inspection were:

Standard 2 – Education to support the prevention and control of infection

Standard 6 – Infection prevention and control policies, procedures and guidance

Standard 8 – Decontamination

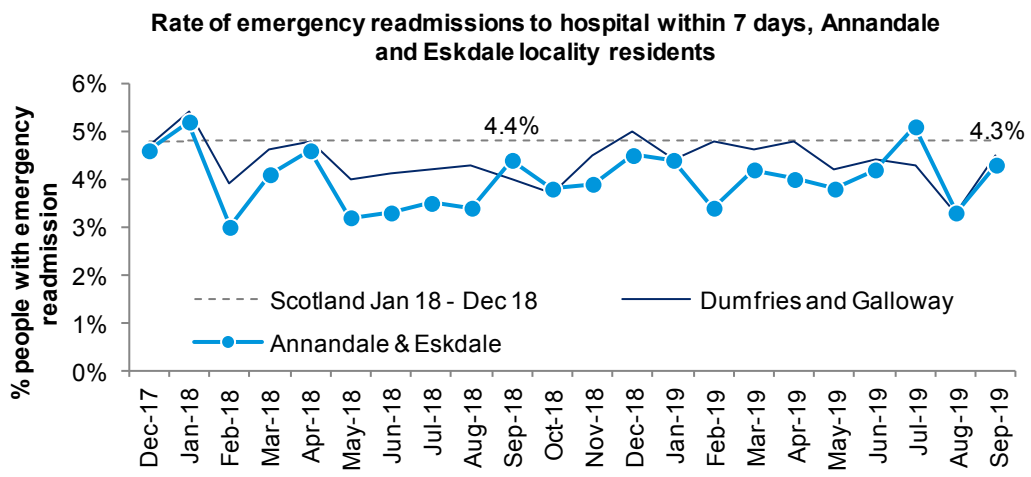
Following the inspection it was shown that there was excellent compliance with mandatory infection control education and good staff compliance with standard infection control precautions. It was noted however that the fabric of our buildings must be maintained to enable effective cleaning.

7.2.4 Managing risk and maintaining business continuity

To keep people safe from harm, it is imperative that key risks are identified and that we maintain services through emergencies, including adverse weather. As and where appropriate, health and social care staff develop risk management plans which identify key risks for people and actions for minimising such risks. All services are also responsible for developing business continuity plans which set out how the most vulnerable members of our community will be supported during an emergency. Across the locality we have established business continuity plans to enable us to respond effectively in an emergency to support the most vulnerable members of our community. We have also developed and updated a register of key service risks.

7.3 How we are getting on

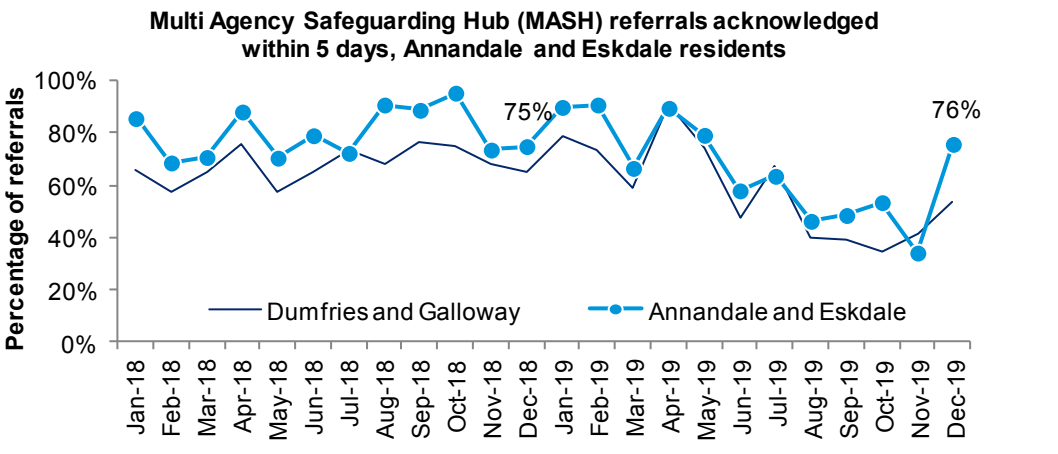
One aspect of keeping people safe is monitoring readmissions to hospital. Whilst a discharge quickly followed by an emergency admission may be entirely appropriate in many cases, it could mean in some cases that people were possibly discharged before they were ready. Readmission rates are typically below the Scottish rate of 4.7% for both Annandale and Eskdale and Dumfries and Galloway. Note: many residents of Annandale and Eskdale access hospital services in Carlisle; English activity is NOT included in these figures.



Source: NSS Discovery, GP Cluster Activity, from Scottish Morbidity Records (SMR01)

D27

Adult Support and Protection activity is scrutinised through the Public Protection Committee (PPC). The PCC Performance and Quality subcommittee is currently redesigning the analysis and reporting of performance figures for Adult Support and Protection. It is expected that when performance reporting has been agreed, an appropriate locality level measure will be reported here. In the interim, the previous indicator showing the percentage of people making referrals who receive feedback within 5 days of receipt of their referral, was 76% in December 2019.

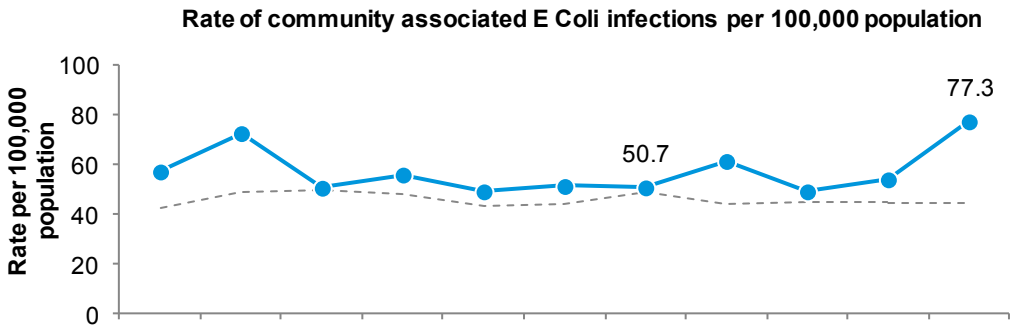


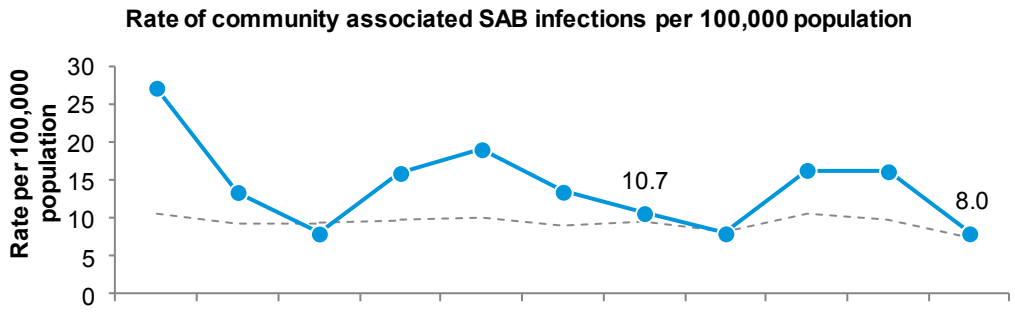
Source: Dumfries and Galloway Council, local figures

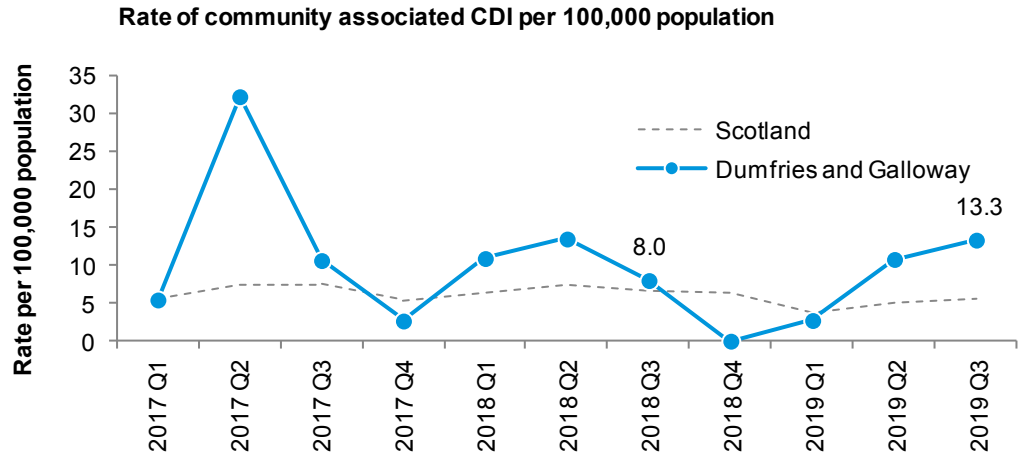
C9

Infections can be acquired in different environments: hospital, other health care settings, and in the community such as people's own home and care homes. The charts below show rates of infection associated with community settings for Dumfries and Galloway (locality rates not available) compared to Scotland for infections monitored by Health Protection Scotland.

The number of people from Dumfries and Galloway contracting these infections is small. Typically in the community across the region, during a 3 month period, fewer than 30 people are diagnosed with an Escheriachia coli (E Coli) infection, fewer than 5 people are diagnosed with a Staphylococcus aureus Bacteraemia (SAB) infection, and fewer than 5 people are diagnosed with a Clostridium Difficile (C Diff) infection. These small numbers mean that changes in infection rates over time can appear variable and erratic. However, these changes represent month to month differences of just 1 or 2 people. The small numbers also mean that it is not possible to report rates at a locality level.







Source: ISD Scotland (Discovery)

9. Outcome 9

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

9.1 How we support this in our locality

There are various ways that the Partnership is seeking to ensure that resources are used effectively and efficiently. We are improving quality and efficiency by making the best use of technology and trying new ways of working to improve consistency and remove duplication. The Partnership is committed to using its buildings and land in the most efficient and effective way.

In our Locality we work towards this aim by:

- Making best use of our buildings
- Maximising Income Opportunities
- Prescribing
- Technology
- Sustainable Primary Care
- Day Centre Review

9.2 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:

52 We will develop a range of new initiatives, including public awareness, to enable us to meet the rising challenges of prescribing and managing medication which meets individual needs in a safe, therapeutic and cost effective way.

53 We will support people to get home from hospital earlier by identifying and strengthening our local community assets and support services.

54 We will regularly review all health and social care packages to make sure that they are promoting individual well being, independence and are delivering positive outcomes.

55 We will regularly review the cost and quality of our services and benchmark them in accordance with best practice.

56 We will develop new integrated working models with local partners to support the future development and sustainability of general practice across Annandale and Eskdale.

57 We will develop a more robust district nursing service, with closer links to the wider multi-disciplinary team, with the capacity to keep more people in their own home in Annandale and Eskdale.

58 We will review and develop the role of our social workers through the development of more integrated ways of working with the wider multi-disciplinary team.

59 We will develop new models of community support with local partners for the future development of our allied health professional services to increase our capacity to keep more people in their own home and which promote their independence, safety and quality of life in Annandale and Eskdale.

60 We will review the role of our 4 cottage hospitals across Annandale and Eskdale to ensure that they continue to meet the changing need of local people.

61 We will develop alternatives to hospital care including the development of new step up and step down services.

62 We will develop and establish local clustered care communities to identify and develop proposals for providing more integrate and accessible health and social care support at a local level which are delivered and available at the right time.

63 We will promote the development of self directed support across the locality.

64 We will review and develop proposals for the more effective use of office accommodation and support services to help more integrated and cost effective working.

9.2.1 Making best use of our buildings

We have carried out a review of the accommodation at Charles Street clinic in Annan with people who use services and staff. The review concluded that this accommodation is no longer fit for purpose. Proposals have been approved to relocate the service to more appropriate accommodation in Annan in a building that is not currently being used. Subject to final approval of the capital investment group, it is anticipated that the Charles Street Clinic in Annan will relocate to the Treastaigh building in Annan in the summer of 2020.

9.2.2 Maximising Income Opportunities

We continue to work with partners, particularly through the Safe and Healthy Action Partnership (SHAP) to make the best use of opportunities for attracting and securing funding into the locality to improve services, support and outcomes for people. The STEPS facilitators mentioned in Outcome 1 are an example of this. We also support different organisations and groups attract funding and to take forward community initiatives or activities. This includes the Moffat Town Hall Redevelopment Trust who required funding to continue the provision of Day Services.

9.2.3 Prescribing

During 2019, we expanded the size of our prescribing support team in Annandale and Eskdale to provide dedicated support to all local GP practices and to strengthen our capacity to manage prescribing in a cost effective and clinically beneficial way.

Whilst the average prescribing cost per person in Annandale and Eskdale is less than the average for Scotland, we know that there continue to be variations in the cost per person across our different GP practices. There will be a renewed focus on the promotion of prescribing according to the formulary to reduce variation and costs, where there is no clinical benefit to prescribing medicines not in the formulary. We will also be working closely with colleagues at DGRI to manage the prescribing which is initiated through outpatient clinics or after a hospital stay.

9.2.4 Technology

Following a review of the working practices of our community nursing team, we identified the need to improve technological support for staff to enable them to work in a more cost effective and clinically efficient way. Following this review, we have developed plans to roll out a new IT system called MORSE. This system runs on tablet computers enabling community nursing staff to create electronic medical records in real time rather than using pen and paper and typing it up at a later time. We plan to roll out MORSE during 2020.

9.2.5 Sustainable Primary Care

Through the primary care transformation programme, we are developing ways to support GP practices and deliver more sustainable primary care services. During 2019, we recruited a new team of mental health workers and an expanded prescribing team to provide dedicated support. We have also finalised plans to expand the Community Link Service across Annandale and Eskdale in 2020 to also support GP practices. As well as transforming our primary care workforce, we also identified the need to improve some of our accommodation for GP practices, particularly in Moffat, and work will progress to address this need in 2020.

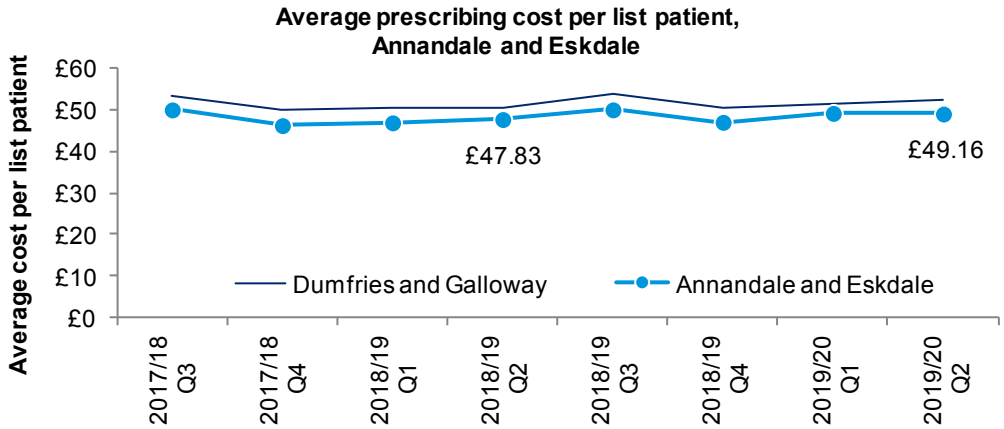
9.2.6 Day Centre Review

Our 4 day centres for older people across Annandale and Eskdale were reviewed in 2019 as part of a wider programme to review all day centres across Dumfries and Galloway. The day centre review focused on ensuring that all day centres were outcome focussed and that funding for day centres was allocated in a transparent and cost effective way. The review concluded that all 4 day centres played a positive role in supporting older people across the locality and they were all committed to delivering positive outcomes in support of the health and wellbeing of older people. Funding levels for all 4 day centres for older people across Annandale and Eskdale will be increased from April 2020.

9.3 How we are getting on

The Strategic Plan Adults Needs Assessment indicates that over 75% of the population receives a prescription at least once per year. In 2016/17 the annual cost per person ranged from £137 - £277 across the GP practices. This is partly because of the different mix of people they support. Annandale and Eskdale has a very similar cost per person to Dumfries and Galloway. The figure for Jul-Sep 2019 is higher than the same period in the previous year. Note that these figures are not adjusted for age profile. Also, the cost of medications is strongly influenced by market forces, not just the volume of medication dispensed.

Another measure of efficiency is how effectively the Partnership uses technology to support people, both to live independently and to access services equitably. An indicator is under development to demonstrate how Technology Enabled Care is being rolled out. This will include both the well established telecare support, and also Home and Mobile Health Monitoring (such as text message medication reminders) and video consultations. The current indicator shows the percentage of people with SDS Option 3 supported with telecare, was 77% in December 2019.



Source: PRISM, LHP Average Prescribing Costs Per 1,000 People

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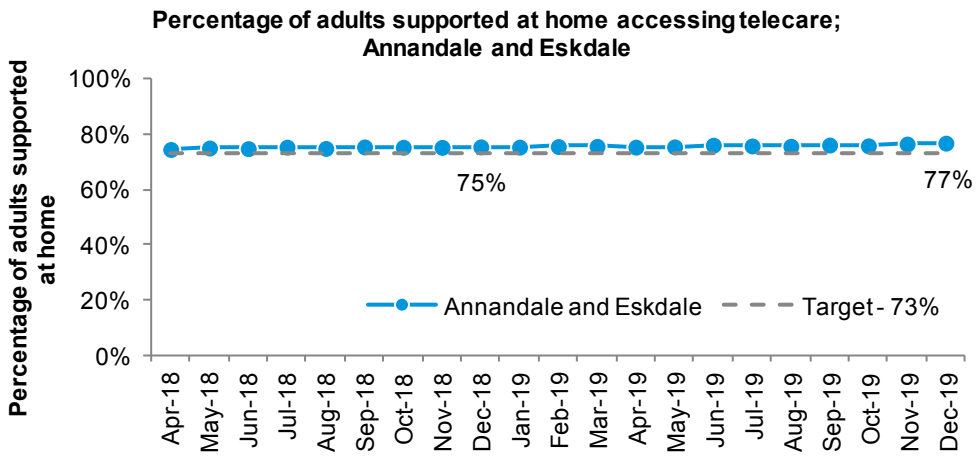

Source: Dumfries and Galloway Council, local data

C1

Appendix 1: Summary of Locality Indicators

Locality Indicator			Previous Value			Current Value		
			Time Period	Dumfries and Galloway	Annandale and Eskdale	Time Period	Dumfries and Galloway	Annandale and Eskdale
Outcome 1	D23	Rate of emergency department attendances by locality of residence per 1,000 population	Sep 2018	24.4	15.2	Sep 2019	26.8	18.5
	D24	Rate of emergency admission by locality of residence per 1,000 population	Sep 2018	9.5	8.8	Sep 2019	9.0	8.6
Outcome 2	C8	Total number of care at home hours provided as a rate per 1,000 population aged 65 and over	Dec 2018	566.2	508.4	Dec 2019	548.5	382.6
	A15 / E5	Proportion of last 6 months of life spent at home or in a community setting	2017/18	89%	88%	2018/19	89%	89%
Outcome 3	D2	Number of complaints received by the locality team (all stages)	-	-	-	2018/19	-	11

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

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

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

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

Locality Indicator			Previous Value			Current Value		
			Time Period	Dumfries and Galloway	Annandale and Eskdale	Time Period	Dumfries and Galloway	Annandale and Eskdale
Outcome 4	C10	Percentage of people supported by SDS Option 1 or Option 2, under 65 years of age	Sep 2018	25%	25%	Sep 2019	24%	27%
	C11	Percentage of people supported by SDS Option 1 or Option 2, 65 years and older	Sep 2018	8%	8%	Sep 2019	9%	8%
	D25	Number of people delayed in all hospitals (Dumfries and Galloway Infirmary, Galloway Community Hospital and Cottage Hospitals) by locality of residence	Dec 2017 - Nov 2018	628	203	Dec 2018 - Nov 2019	968	305
	D26	Number of bed days lost to delayed discharge by locality of residence	Dec 2017 - Nov 2018	14,622	4,244	Dec 2018 - Nov 2019	22,527	7,495
Outcome 5	D13	Difference in the rate at which people attend hospital in an emergency between the most deprived and least deprived communities in the locality (per 1,000 population)	2016/17	38	53	2017/18	41	46
Outcome 6	C5	Number of Adult Carer Support Plans developed within the locality	2017/18	-	11	2018/19	-	27

Source: ISD Scotland, HACE Dashboard

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

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

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

Locality Indicator			Previous Value			Current Value		
			Time Period	Dumfries and Galloway	Annandale and Eskdale	Time Period	Dumfries and Galloway	Annandale and Eskdale
Outcome 7	D27	Percentage rate of emergency re-admission to hospital within 7 days	Sep 2018	4.0%	4.4%	Sep 2019	4.5%	4.3%
	C9	Percentage rate of referrals to the Multi Agency Safeguarding Hub (MASH) acknowledged within 5 days	Oct - Dec 2018	69%	82%	Oct - Dec 2019	44%	53%
Outcome 8	D5	Proportion of people who agree that they have the information necessary to do their job	2017	80%	n/a	2019	79%	82%
	D21	Proportion of people who agree that they are involved in decisions relating to their job	2017	70%	n/a	2019	69%	72%
	D22	Proportion of people who would recommend their organisation as a good place to work	2017	74%	n/a	2019	74%	78%
Outcome 9	D28	Average prescribing costs per person for 3 months	Jul - Sep 2018	£50.60	£47.83	Jul - Sep 2019	£52.41	£49.16
	C1	Percentage of People With SDS Option 3,Supported with Telecare	Dec 2018	73%	75%	Dec 2019	73%	77%

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