Appendix 1

Transforming Wigtownshire Report
May 2019 to May 2020

I am honoured to present the Transforming Wigtownshire Programme 2019 – 2020 report to the Health and Social Care Operational Group.

It is not new information that Health and Social Care is unable to maintain the current level of service provision and while pressures are felt across the region and the nation, because of the rural location and an ageing population and workforce, pressures in Wigtownshire are felt more acutely in regard to recruitment, finances, infrastructure, increasing demand, health inequalities and deprivation, all of which contribute to health and wellbeing outcomes.

The Transforming Wigtownshire Programme set out a different approach in its aim to develop new models of sustainable, safe and effective health and social care services to meet the needs of the local community. The approach we undertook was “co-production”, essentially working in partnership with local communities and stakeholders to co-produce the review and redesign of health and social care services in Wigtownshire, including the Galloway Community Hospital (GCH).

We had a timeframe of two years to complete the programme and the first year was spent planning and engaging with communities and stakeholders to establish a mutual understanding of the current situation and what people envisioned for the future of Wigtownshire by asking *“What Matters to You?”* Feedback from this engagement provided evidence for the implementation team to build on the good work already happening and also to design and develop new models of health and social care. It is important to highlight that the programme board and the implementation group were made up of both professionals and members of the public.

This way of working, whilst scary, was one of the most positive outcomes as evidenced by the programme evaluation. The transparency that the co-productive approach offered coupled with the ability to have frank conversations around the delivery challenges we faced together, created trust and helped to reduce the anxiety that change most often brings. The relationship building between the partner providers, members of the community and elected members was apparent. Working in a truly co-productive way is extremely challenging and the approach takes time, bravery and considerable energy. We didn’t get it right every time, but as a lifetime resident of Wigtownshire I believe we were able to achieve what we set out to do.

With the onset of the COVID-19 pandemic in March 2020, the work of the programme came to a halt with strict social distancing rules and the deployment of workforce teams to support critical response. Several of the new models of health and care we had been developing and testing were catapulted forward to continue to provide services and business continuity. NHS Near Me was available for many professional providers, including GP’s, to connect remotely with service users. Microsoft Teams was rapidly introduced to professionals across all sectors to connect and meet remotely. The Health and Wellbeing Team were already developing digital solutions and continued to adapt and provide support. The development of housing care and support at the Garrick site in Stranraer, the creation of community digital

hubs and ambulatory care and bed use service redesign within Galloway Community Hospital have been delayed but will resume when appropriate.

I believe that the scope of the Transforming Wigtownshire Programme including what we learned from the communities and our partner providers, reinforces to me that we were on the right track and the learning from the programme will go a long way in influencing the future delivery of health and care across the region.

I felt privileged to take on the role of Programme Board Chair and would like to take this opportunity to convey my sincere appreciation to the Transforming Wigtownshire Programme Board professionals and members of the community for their expertise and guidance and for being a critical friend to the operational groups. The experience for me has been most rewarding. The support we had from the meetings held all over Wigtownshire was very encouraging. This gave us the confidence to progress with this report which we hope will ensure sustainable services into the future.

John Ross
Chair of the Transforming Wigtownshire Programme Board

July 2020

Appendix 1

Transforming Wigtownshire Workstreams

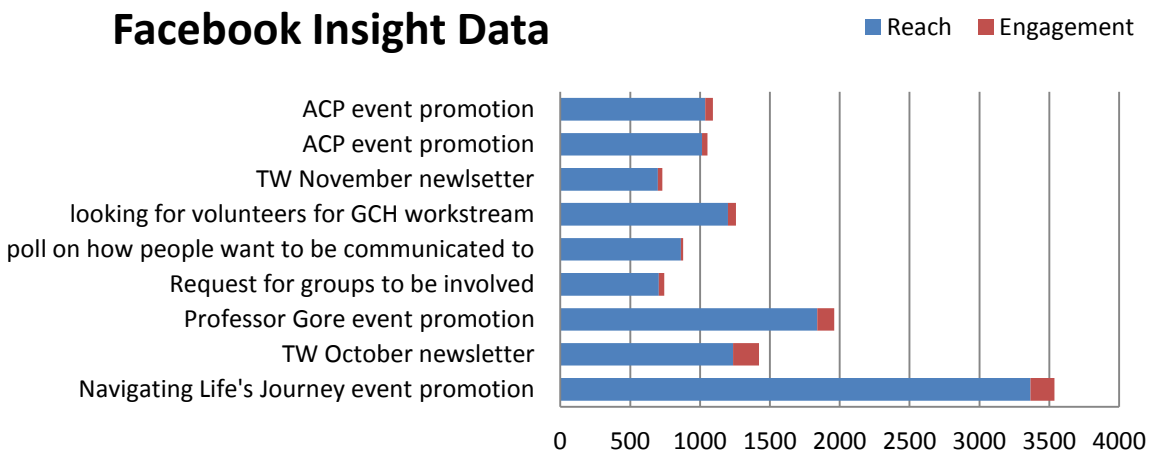
Following extensive community and staff engagement in 2018/19 the following key areas were identified for the programme. Six workstreams were established to progress this work.

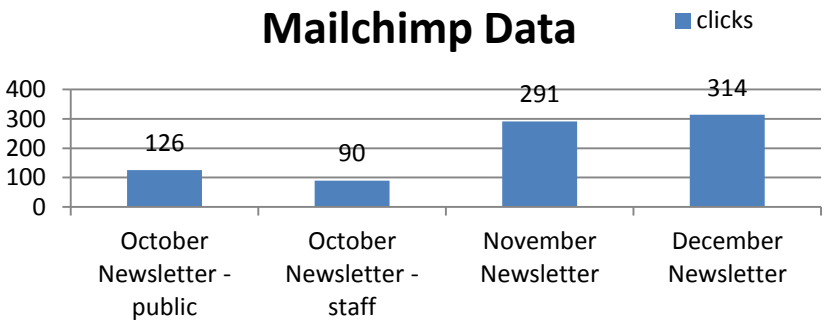
1. Communication and Education
2. Health and Wellbeing
3. South Machars Community Digital Hub
4. Making the Most Of Galloway Community Hospital Campus
5. Housing Care and Support
6. Women and Children's Family Centre

Communication and Education Workstream

The main aim of this workstream was to transform the way we communicate with, provide information to, and receive information from communities, staff and partners.

A number of different communication mediums such as the Wigtownshire Health and Wellbeing Facebook page (with over 2000 followers), newsletters, local newspapers, Survey Monkey and MailChimp were used for feedback, to provide updates on the programme, advertise events and to share people's stories.





Communication methods and content were tested with primary and secondary school pupils as well as young and older adults. Feedback from this exercise included not using jargon, acronyms and that information should be provided visually and in an easy read format. A member of the community joined the workstream which was extremely valuable.

Community Health and Wellbeing Information Hubs

Community health and wellbeing information hubs have been established in five community council areas; Isle of Whithorn, Whithorn, Kirkcolm, Kirkcowan and Drummore following feedback from community engagement sessions. These five areas have identified a building to host a local hub and local people, who will be referred to as Community Partners, to support. A training plan has been created for Community Partners. The hubs will provide an access point for local information in the form of a booklet (co-produced with partners and local communities) to support health and wellbeing.

Due to COVID-19 restrictions the following actions are currently on hold:

- Attendance by the project manager and chair of the programme board to other community council's to consider the request to host an information hub in their village;
- Training for Community Partners in the five established hub areas;
- Funding proposal to NHS D&G Endowment for 5000 information booklets.

In the interim the digital version of the booklet has been uploaded to the NHS Inform Services Directory https://www.nhsinform.scot/scotlands-service-directory .

Next Steps

In light of COVID-19 we may need to revise the distribution methods for the paper version of the information booklets and training plans for the Community Partners.
Communication and engagement will continue to be a key focus for the locality building on what is already in existence such as the: -

- Wigtownshire Health and Wellbeing Facebook page and
- Wigtownshire Health and Wellbeing Partnership, which has been in existence for a number of years. The Programme Board recognises the partnership as a potential vehicle to support future community and public engagement.

Community Education Events

Navigating Life's Journey

In July 2019, the Transforming Wigtownshire Programme Team helped to organise the 'Navigating Life's Journey' event at the Ryan Centre in Stranraer. The event was attended by 61 people from across the locality and was supported by D&G Health and Social Care staff as well as Third and Independent sector partners.

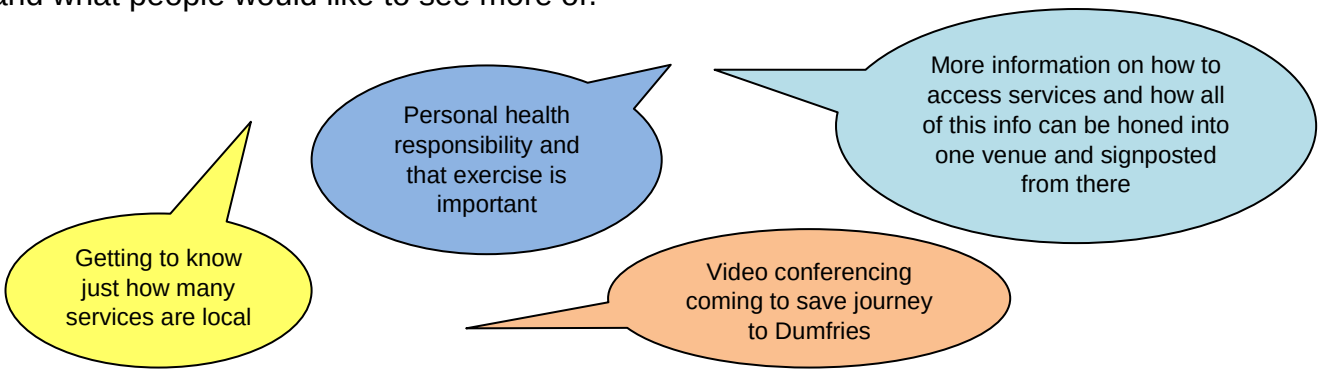
The aims of the event were to:

- engage people of Wigtownshire in conversations about health and wellbeing and ask "what matters to you and why"?
- provide information to help increase knowledge of what health and wellbeing support

is available to the Wigtownshire community.

- inform the Wigtownshire community about the Transforming Wigtownshire Programme and how we can work together to support our communities to be the best place to live active, safe and healthy lives by promoting independence, choice and control.

97% (30 people) who completed the event evaluation stated that the aims of the event were achieved.
Additional information was collected about what was most valuable, the top things learned, and what people would like to see more of.



The information collated from the event helped to further shape the programmes of work as well as other wider work out with the direct scope of the Transforming Wigtownshire programme. These include areas such as child bereavement support, anticipatory care planning and improved access to other health care professionals for example Pharmacy or Community Link instead of a GP. Provider participants told us it was useful for networking and a better understanding of services and roles.

Enabling People to Live Better for Longer (Healthy Ageing and LifeCurve)

In October 2019, mPower hosted a learning event in Wigtownshire on healthy ageing and the LifeCurve. The event was delivered by Professor Peter Gore and his team. Professor Gore (Professor of Practice in Ageing and Vitality, Newcastle University Institute for Ageing) is at the forefront of developing approaches to healthy ageing and provides educational sessions to Health and Social Care practitioners.

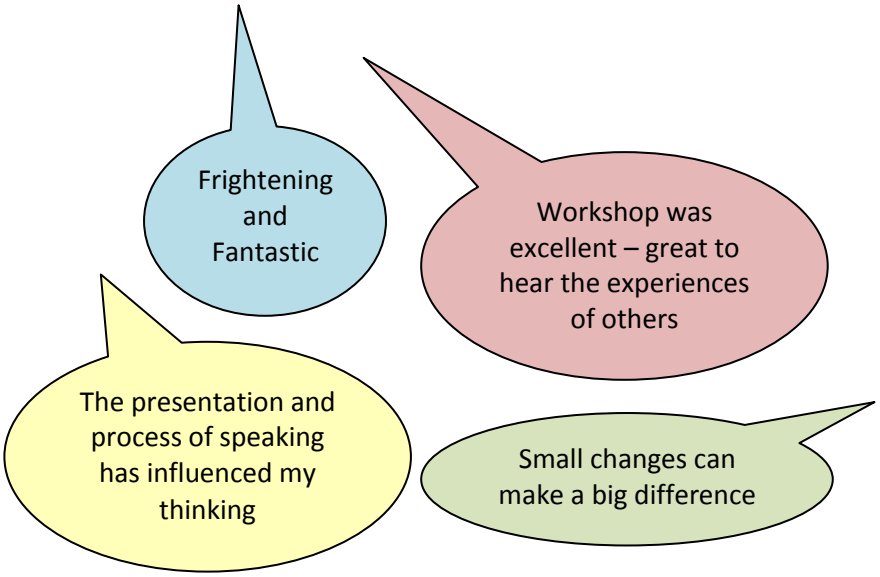
The aim of the event was to challenge traditional thinking and to provide Health and Social Care Practitioners with the evidence based scientific research that supports a new approach to delivering Health and Social Care services.

The event provided an opportunity to showcase some of the digital equipment and community activities that are able to support the healthy ageing approach.

The event was attended by 176 people from a wide range of health and social care services and 112 evaluation forms were completed.
Some of the comments from the event are highlighted below: -

Appendix 1

Excellent	45	46%
very good	40	40%
good	11	11%
fair	3	3%
poor	0	0%



Planning Life's Journey

In January 2020 a follow up event took place in response to the July 2019 feedback and a local community action group. The 'Planning Life's Journey' event focussed on Anticipatory Care Plans (ACP) and Power of Attorney (POA) and asked 'whose role is it anyway'? The event was attended by 64 people and more than half (55%) were members of the public.

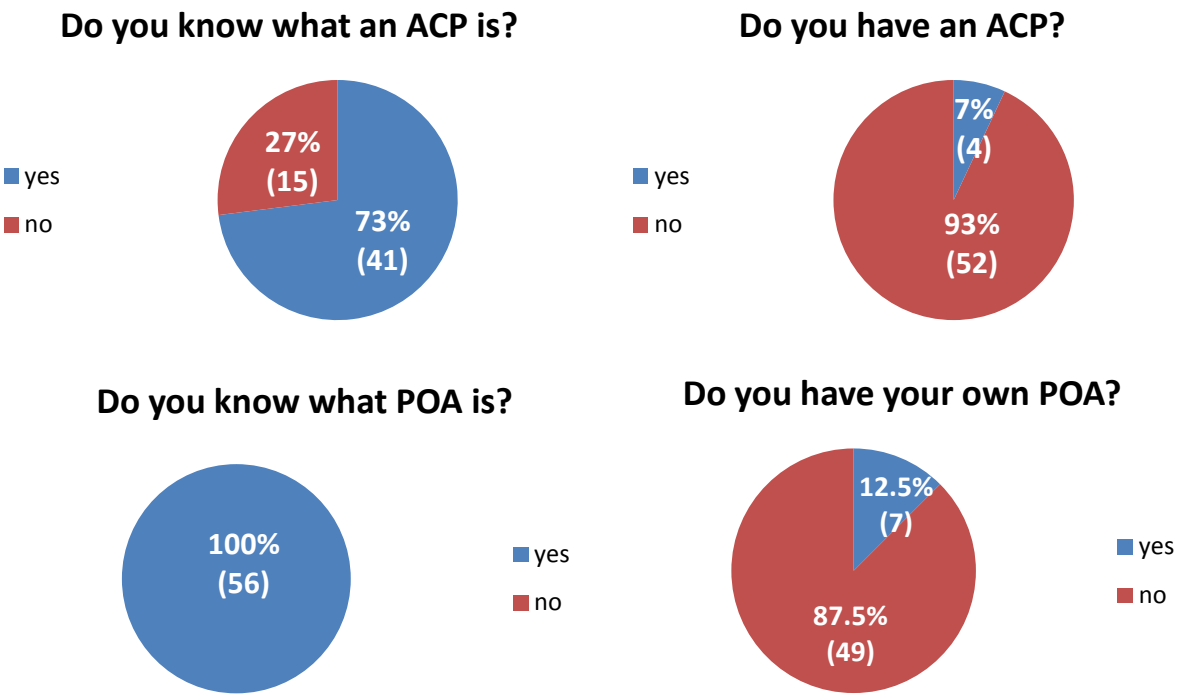
The main aim of the event was to stimulate people's thinking about the importance of having conversations with family, loved ones and friends about what matters to them in relation to their future health and social care wishes and how this information can be recorded on an Anticipatory Care Plan. Health and Social Care professionals presented information using a variety of mediums such as pictures, slides and videos. Permission from local people enabled real lived experiences to be shared with the audience.

The following links are two of the resources provided to the attendees at the event

https://ihub.scot/project-toolkits/anticipatory-care-planning-toolkit/anticipatory-care-planning-toolkit/
https://www.publicguardian-scotland.gov.uk/

A pre-event questionnaire, completed by 56 participants, captured information on people's knowledge and understanding of ACP and POA.

Appendix 1



A three month post event questionnaire was planned to measure any shift in understanding of ACP and POA and also to establish if participants had completed an ACP themselves or with a loved one or someone they know. Due to COVID-19 and the shift in resources and focus to critical response this has not been achieved.

In the near future the questionnaire will be repeated with participants. Other localities were interested in holding their own ACP and POA event which may require the use of technology and a 'virtual world café' approach to move this work forward.

Next Steps

Learning from the events needs to be considered in relation to the development of Home Teams and in particular the early adopter sites.

The following areas should be an early focus: -

- LifeCurve as an approved app for health and social care professionals;
- Continued focus and awareness raising of ACP and POA;
- Post-event questionnaire to be administered to measure any shift in understanding of ACP and POA as well as establish if there is an increase in completion of ACP's;
- Share learning and opportunities from the events with other localities.

Health and Wellbeing Workstream

mPower Project

The mPower project is a five year project supported by the European Union's INTERREG VA Programme managed by the Special EU Programmes Body (SEUPB), to stimulate transformation in older people's services in Ireland, Northern Ireland and Scotland (Dumfries and Galloway, Ayrshire and Arran and Western Isles Health Boards).

Appendix 1

Wigtownshire was chosen as the initial focus of the project from its beginning in 2018 and will run through to the end of 2021.

The project focuses on people aged 65 and older with one or more long term condition who access services on a frequent basis. One of the aims of the project is to empower people to take control of their long term conditions at home by using technology, while simultaneously freeing up GP's and other health and social care professionals.

mPower also aims to introduce self management to this cohort through:

- person centred and outcome focussed wellbeing plans that incorporate national anticipatory care plans (ACPs) of which 193 have been delivered by mPower Community Navigators since 2018;
- introducing new digital ways of managing long term conditions;
- maintaining or improving health and wellbeing through increasing the use of digital solutions and maximising social prescribing opportunities.

mPower has supported the digital health and social care strategy by working with and supporting clinical teams in Wigtownshire who are introducing eHealth solutions into their practice.

Since 2018, the project has delivered 587 eHealth interventions. Examples of eHealth interventions available to support health and social care practice include: -

Florence – a Home and Mobile Health Monitoring (HMHM) system through which people can send and receive text messages such as medication reminders or for submitting blood pressure readings.
Southern Machars practice has introduced the Florence system to support people to monitor their own blood pressure for accurate diagnosis of hypertension.

NHS Attend Anywhere – a safe and secure digital space through which people can attend video consultations with health and social care professionals. This reduces the need for people to travel.
Work is underway to trial (see South Machars Digital Hub section) the use of Attend Anywhere in a community setting. This is now referred to as NHS Near Me and the mPower team will continue to link with the regional team.

My Diabetes, My Way – an interactive website provided by NHS Scotland that supports people with diabetes, their families and friends.
Southern Machars and Lochinch practices have increased the number of people making use of this system to help manage their diabetes.

Case study

***Referra*l**
A 70 year old lady was referred to the service to discuss a referral to Tele-care.

Appendix 1

Background
She lives alone with great support from her family however they don't live local. Has chronic obstructive pulmonary disease and requires long term oxygen therapy to help with her breathing. She also has arthritis which can make getting around a bit more challenging. A home visit was arranged to discuss the process of developing a wellbeing and anticipatory care plan (ACP).

Outcome
A referral to Tele-care was agreed. Following the conversations that the ACP facilitated she made contact with her family to discuss something very important to her.
She planned for the future and made her wishes known and by introducing the ACP to her family she felt it also made this discussion easier to have.
Along with support from her family this wish was made formal and allowed her to feel in control. The ACP did effectively 'what it says on the tin'.

mPower Advanced Risk Modelling for Early Detection Trial

The use of digital technology to support people to remain healthy and independent in their own homes is one of the ways that services are transforming to help them meet the increase in demand. There is a lot to be learned about what kind of technology can be used in what way to provide the best outcomes.

This trial provides the opportunity to use predictive technology to encourage 70 people to take control of their own health and wellbeing, helping them to understand their own health and earlier recognition of deteriorating health. The technology used to support the trial is the Advanced Risk Modelling for Early Detection (ARMED) system that has been developed by HAS Technology.

The cohort for the trial is people who have been identified as having an elevated risk of falls.

Next steps
The trial will: -

- Commence in July 2020 for a 12 month period; original date was April 2020 but due to a number of challenges in relation to procurement, COVID-19 and the need to alter the approach due to continued restrictions, the start date has been delayed;
- Be delivered in three localities (Wigtownshire, Stewartry and Annandale and Eskdale);
- Recruit people from four different areas i.e. sheltered accommodation (Wigtownshire), residential care home (Wigtownshire), care at home package (Stewartry) and GP practices (Annandale and Eskdale);
- Provide progress reports and outcomes to Community Health and Social Care Management Team and the Sustainability and Modernisation Programme. Timeframe for reporting has still to be agreed.

Appendix 1

Health and Wellbeing Services in Hospital and on Discharge from Hospital

Prior to COVID-19 early discussions with Galloway Community Hospital Management team indicated a willingness to work with mPower, the wider Health and Wellbeing Team and other partners to introduce pathways to prevention, self-management and enablement services.

The deployment of a Community Navigator to the Galloway Hospital to assist patient flow, as a response to COVID-19, has provided a greater understanding of the opportunities where the mPower project and the wider health and wellbeing team could be used to enhance a patients discharge from hospital back into a community setting e.g. eHealth interventions, health and wellbeing plans and ACP.

Discussions are now continuing, in light of recovery planning for health and social care and hospital services, to identify the health and wellbeing interventions that could be implemented either in hospital or at home soon after discharge. At this time, engagement will be through the use of digital and technological solutions in order to adhere with physical distancing.

Community Health Synchronisation

Community Health Synchronisation (CoH-Sync) is supported by the European Union's INTERREG VA Programme managed by the Special EU Programmes Body (SEUPB). The project commenced in September 2018 and will finish December 2021.

CoH-Sync health and wellbeing facilitators have been trained locally to provide a person centred approach to supporting healthier lifestyle choices. The service offers a community based, free and confidential personal health and wellbeing plan aimed at creating a positive impact on the health and wellbeing of people and communities. Community health facilitators are developing their knowledge and resources to be able to provide advice and signpost people to the appropriate support networks.

The project aims to deliver 1,248 health and wellbeing plans to people across Wigtownshire. This amounts to approximately 5% of the population age 18 years or older. CoH-Sync also aims to build links with organisations and groups in the third and community sector to continue implementation of the project beyond December 2021.

Health & Wellbeing Plans Status	2019	Overall
Completed plans	346	507
Open Plans	38	84

Case Study

Referral

A 42 year old female self-referred to CoH Sync for support to improve overall health and wellbeing in particular her mental wellbeing.

Appendix 1

Intervention
CoH Sync facilitator suggested applying for a social welfare fund and speaking to Apex about their 'moving in package' and food parcels as well as a meeting with the local community reuse shop. A referral was also made to local addiction services.

Feedback
The lady said she was in a better place and the support from the facilitator helped her sort out her life. She helped me untangle the knots and make my future path clearer. I will be forever grateful for her help to support me to untangle my worries.

Next Steps:
There is a need to: -

- Maximise the opportunity offered through the two European funded projects (mPower and CoHSync) over the next eighteen months;
- Continue to work towards the targets and outcomes set by the funders;
- Embed health and wellbeing approaches, as well as early interventions, into new models of health and social care e.g. Home Teams and wider SAM developments.

Community Based Health and Wellbeing Support Training

This training course has been developed for staff delivering community-based health and wellbeing support and is based on the most up to date evidence for health and wellbeing (Health and Wellbeing Guidance, 2019). The course aims to support staff to develop new skills or enhance existing ones in order to provide safe and effective health and wellbeing support for people.

In February 2020, the first two day training was provided by Public Health Practitioners to 8 individuals from across the partnership these included staff from Wigtownshire Health and Wellbeing Team, Skills Station, Short Term Assessment Reablement Service (STARS), Community Mental Health and Support in Mind. Follow up training and evaluation was planned for March 2020. Due to COVID-19 and deployment of staff to provide critical response only 2 participants have been involved in a follow up session. Future follow up sessions will be through telephone or digital platforms such as MS Teams.

The main points from the training were the benefit of knowing who and what is available across services and the wider community to support people to remain well and live as independently as possible.
The importance of working in a person centred way and the need to build reflection into everyday practice.

COVID-19 response and recovery dictates that there will be no face to face courses for the foreseeable. There are plans to adapt the 2-day course to online delivery.

Appendix 1

Next steps

There will be a need to: -

- Arrange a follow up session with the initial cohort of participants using digital platforms or telephone;
- Use feedback from the initial cohort to support future face to face delivery of the training and development of the online course.

South Machars Digital Hub Workstream

In May 2019, TWP was approached by two communities in South Machars to discuss health and wellbeing support for local people. Initial discussions focused on remote blood pressure checks i.e. using digital/technological solutions to reduce travel for short appointments.

The mPower team explored with key stakeholders the feasibility of a Community Digital Hub. In February 2020, a six month trial was agreed with the Southern Machars Community Centre Management Group and planning for the implementation of the digital hub is underway. Initially the digital hub will provide a platform for people in the Southern Machars to access selected NHS services from a community based facility.

The trial will provide a roadmap for future community based digital hubs across Dumfries and Galloway and the learning will be shared with our local Sustainability and Modernisation programme in particular the Home Team programme and the National mPower programme.

Making the Most of Galloway Community Hospital

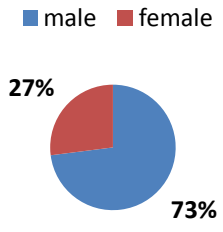
In October 2017, an initial report was presented to Health and Social Care Senior Management Team (HSCSMT). At that time, data showed there was capacity to increase the provision of both in-patient and out-patient services at the Galloway Community Hospital (GCH).

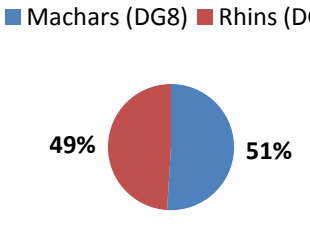
The key areas of focus were: -

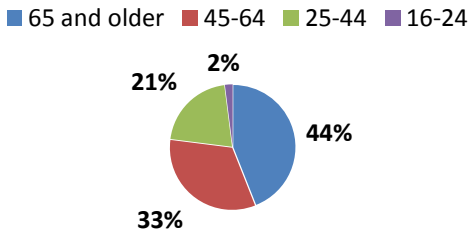
- Inpatient/Unscheduled Care and
- Elective/Scheduled Care

Prior to April 2019, the Wigtownshire Health and Wellbeing Team (WHWBT) engaged with communities around their understanding of local urgent and emergency care services.

The team consulted with 140 people from the Wigtownshire area. Demographic breakdown is highlighted below: -







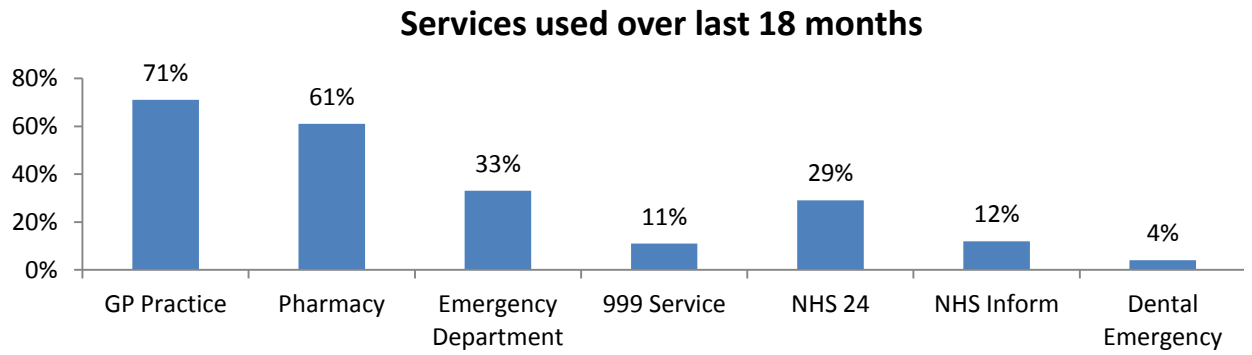
Appendix 1

The initial part of the engagement was to find out people's understanding of 'urgent' and 'emergency' care based on the following definitions: 'requiring of urgent medical attention but is not life threatening' and 'requiring emergency medical attention that is life-threatening'.

Out of 421 comments for urgent care 12% were correct; 47% were describing emergencies and 37% were deemed as not urgent.

Out of 325 comments for emergency care 70% were correct; 9% deemed urgent; 7% as non-urgent and 11% described emergency the same as urgent.

People were asked what services they had used over the previous 18 months and why they chose that service.



The majority of people had never heard of NHS Inform. 16 people had been redirected by their GP to a 999 service, Emergency department, Pharmacy or NHS Inform.

The GP practice is first choice for people looking for medical assistance and information. The main reasons given were: knowing their GP and confident the GP understands their condition. Pharmacists were seen as very helpful with treatment, support and advice for medical conditions and emergency department was seen as a natural 'first choice' to attend especially during out of hours.

At the end of the engagement people were given a leaflet providing information on urgent and emergency care services available in Wigtownshire.

The decision to refocus the workstream to Inpatient/Unscheduled Care and Elective/Scheduled Care and the follow up engagement was not completed. The information collected from this initial engagement provides us with baseline data to use in phase 2 of transforming health and social care services.

In-patient/Unscheduled Care and Elective/Scheduled Care

2016/17 data revealed that Garrick ward which has 20 staffed beds had an average occupancy of 78% (an average of 4 beds not being used).

A plan was produced to support the development of a four bedded area in Garrick ward to expand out-patient and ambulatory care services as well as improve in-patient unscheduled care.

Appendix 1

It was proposed to reassign two of the beds within Garrick ward to allow an extension of the opening hours of Ambulatory Care from Monday to Friday 08.00 to 15.00 to Monday to Friday 08.00 to 20.00. This would provide people with more flexibility to schedule care and treatment around their needs, for example, around their own or their Carers work day.
Pre Covid-19, the medical equipment to begin this was in place and staffing rotas and appointment lists were in progress.

Work is underway to determine how the other two beds can be used to accommodate people who present at the Emergency Department (ED) and do not require an inpatient admission or transfer.
One of the proposals being considered was to provide assessment under a short stay or observation status if assessment and treatment could not be carried out within the 4-hour timeframe.
Criteria, pathways, staff engagement and education were being developed just as COVID-19 arrived and changed the way care and treatment was delivered in ED, inpatient and out-patient care settings.

While some progress was initially halted with the onset of COVID-19 restrictions, the plans to upscale and deliver technological solutions within the GCH outpatient department continued. Development of the NHS Near Me remote technology platform has been rapidly rolled out to give access to providers from across health and social care.
As services start to 'switch back on' the use of NHS Near Me or other technological/digital solutions should continue to be part of the new way of delivering quality health and social care services.

The four bedded area in Garrick requires further development in relation to the definition and categorisation of patient type. Data collation to inform decision making around demand optimisation and effective bed configuration is crucial. Rapid review of historic data relating to demand on the in-patient ward and the ambulatory care is required to understand true requirement for bed numbers. The ED observation beds also require some further review to ensure robust processes are in place and adequate medical support is available for these patients.

The use of technology in the outpatient setting in GCH has reduced travel for both patients and staff and has supported the need for physical distancing adherence now and in the future. It is anticipated that the use of NHS Near Me and telephone consultations will continue to increase and that a reduction in return appointments will be more aligned to Patient Initiated Returns (PIR) than automatically bringing patients back. Increased clinics within GCH using technology will be supported and expanded to optimise the space available.

The increased use of Day Surgery for minor operations and endoscopy services will again support the wider partnership. There is capacity within the existing nursing team at GCH to support greater throughput within Day Surgery. With the provision of 24/7 anaesthetic availability on-site there is the ability to provide Day Surgery work within the theatre.

There is an on-going review into the support required to manage both the elective and unscheduled workload within anaesthetics and this will look to support the ongoing model of providing elective care within GCH.

It should be noted that in phase 1 the opportunities were not maximised in relation to Primary, Secondary and Community Care and this will be a key focus for phase 2.

Next Steps
In phase 2 we need to: -

- Maximise the opportunities in relation to Primary, Secondary and Community Care, in particular the provision of community beds out with an NHS inpatient setting;
- Continue the journey towards integrated care by reviewing the concept of the Galloway Community Campus in line with the development of Home Teams;
- Provide in and out reach from the Home Teams to Galloway Community Hospital ensuring streamlined processes are in place to provide efficient and effective service provision.

Housing Care and Support Workstream

This workstream had several sub-workstreams; housing re-provision; leaving care and extra care housing.

Housing Re-provision for Physical and Learning Disabilities in Stranraer

In partnership with Loreburn housing three service users with a learning disability and one with a physical disability will soon be moving to a purpose built facility at the former Garrick Hospital site in Stranraer. The move was due to happen in July 2020 but due to COVID-19 building work ceased and a final completion date is, at present, unknown. Plans continue to be developed in partnership with guardians, care providers, parents and additional support personnel.

Leaving Care

Initial data obtained in 2019 appeared to show evidence that in Wigtownshire there are a higher percentage (27.75%) of young people leaving care than the rest of Dumfries and Galloway i.e. 400 care leavers in Dumfries and Galloway, 111 of those were from Wigtownshire.

Analysis of the data across a longer time frame (April 2014 to January 2020) showed on average 3 young people a month (range of 0 to 8) were leaving care in Wigtownshire.

A recent meeting between D&G Care Leaver group and TWP team revealed a regional stakeholder group has been tasked to produce a Care Leavers protocol and develop new models for the future. At this point, the needs of young care leavers are being met in Wigtownshire and are kept under continual review. The TWP team will continue to link with the D&G Care Leavers group.

Extra Care Housing

Work is ongoing to scope out the detailed requirements for extra care housing in the Wigtownshire area as part of delivering on the Dumfries and Galloway Health and Social Care Housing with Care and Support Strategy (2020 – 2023).

Appendix 1

Newton Stewart Initiative

In November 2019, an initial meeting was held with various stakeholders across the partnership who had recently intimated the need to look at future models of care and service provision as a partnership model within the Newton Stewart area.

The following areas have initially been identified as in scope:

- Provision of inpatient and community beds
- Extra care housing
- Community Services – development of Neighbourhood Teams
- Social Work (Adult Services) – accommodation requirements
- Newton Stewart Health Centre / GMS contract – accommodation requirements
- CIC (Community Integrated Care) – Care Home service re-provision
- Loreburn Housing – housing developments
- Newton Stewart Community Initiative – Sports and business facilities
- Digital and Technology Solutions

At this juncture it is not yet known the full extent of potential development opportunities.

Next Steps

- Continue to scope housing with care and support opportunities in particular extra care housing;
- Develop a detailed plan of the partnership model in Newton Stewart;
- Link to Home Team developments.

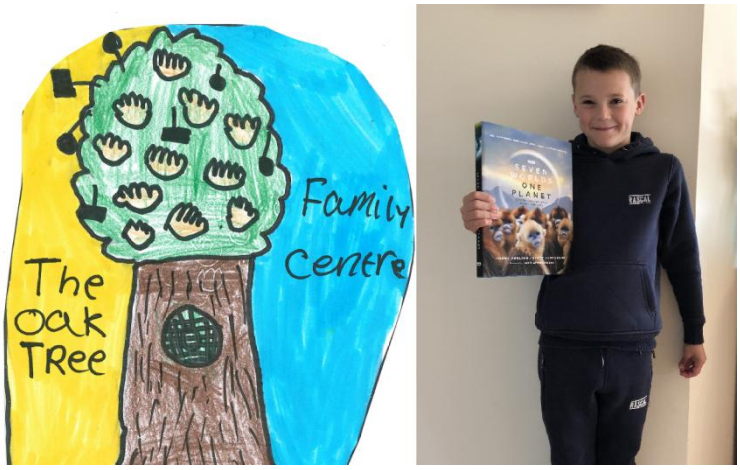
Women, Children and Family Services Workstream

The Transforming Wigtownshire Team was asked to support the operational group overseeing the development of the co-location of Women, Children and Family services in Stranraer. In particular, they wanted to incorporate the learning from the engagement and co-production approaches used in the Transforming Wigtownshire Programme.

The naming of the new facility has been co-produced with children who live in Wigtownshire. All local primary schools were invited by letter and an advertisement in the local newspaper to take part in the naming competition.

In early 2020, the top four facility names were chosen by the TWIG and a final decision was endorsed by the TWPB. The 'Oak Tree Family Centre' was expected to open in April 2020, with the winner invited to take part in the opening ceremony. Due to COVID-19 there has been a delay for the move. July 2020 is the new expected timeframe.

Appendix 1



Owen McCalmont, aged 10, from Belmont Primary School, Stranraer receiving his prize and his winning entry

The co-engagement, transparency and co-production evidenced within the development and implementation phase of this change was critical to achieving a successful outcome. It is essential to provide clear and concise information to communities and opportunities for discussion and involvement so that there is an understanding of the reasons for and benefits of the change.

Programme Evaluation

The plan to have a facilitated workshop by Health Improvement Scotland Community Engagement team (formerly Scottish Health Council) with members of the TWIG and TWPB was planned but due to Covid-19 restrictions was unable to be held.

A broad community survey was agreed by the Programme Executive Group, Programme Board Chair and a member of the Health Improvement Scotland Community Engagement team as a valid alternative to the facilitated workshop.

A summary of the survey results can be found below along with some comments captured through the free text boxes.

- 32 people responded to the survey with 37% being a member of the Transforming Wigtownshire Board; 25% member of the Transforming Wigtownshire Implementation Group; 21% Health and Social Care provider; 17% Partner provider.

- The majority (84.38%) of people agreed the programme aims and what it hoped to achieve were clear.

- In the main (68.75%) participants found it easy to find progress updates and other information on the programme.

- The majority (62.5%) of participants agreed they were actively involved in planning how local communities could be involved in the programme.

- The majority (87.5%) of participants agreed local communities could help design or influence the programme plans.

Appendix 1

Comments from free text boxes

- As with all areas, there are pockets within the Local community that are more engaging and resilient than others - but all were given the opportunity to get involved in areas that were relevant or applicable to their own needs.
- The local community is VITAL as it helps identify local issues, local assets and resources and ensure the local communities are involved in the development of new services. They have the voice of the local people.
- Community resilience is strong in this rural area. This is something that has to be revisited once we are through the current pandemic situation as to how sustainable conversations and resources can be allocated to shape the design of future service delivery.
- The programme brought multi-professionals together as well as the public and other stakeholders. We gained knowledge in each other's roles and began to develop new ways of working through integration and co-production.
- The aims were clear but the context of how was not as clear as the co-productive approach was a new concept for me. Everything became clearer as we moved through the process. Meeting days and times were flexible.
- The group was dealing with current issues but was also starting to think and plan as a group - bigger issues/longer term solutions.
- These were available prior to all Implementation Group meetings and helped me keep track.
- This became simpler as time went on. I felt that initially I became mired in long discussions without fully understanding where we heading.
- Communication was regular and detailed - Minutes, agendas, work plans and action trackers were all received timely by email.
- As a public voice I felt very much included and valued.
- In the early stages/first year I was heavily involved, again this changed and my involvement became reduced as I was no longer asked to participate in the way I had been.
- I found it immensely interesting and loved being involved. I appreciated that the professional members listened to what we had to say with great patience.

Conclusion

The ethos and principles of co-production have been at the core of the Transforming Wigtownshire Programme. The first year focused on building the foundations for developing and implementing a programme of work which was true to the co-production approach. This required time, energy and a change in mindset for equal relationships to be built that recognised the combined assets people brought to the process.

The programme has grown organically over the past two years building on the feedback from community and stakeholder engagement sessions and events. Although the programme came to a sudden halt with the COVID-19 pandemic in March 2020 several areas of work were implemented quicker to support the response i.e. technology solutions such as NHS Near Me.

This paper reports on phase one of the journey with the road being paved for phase two of developing and delivering new models of care and support in Wigtownshire.