DUMFRIES AND GALLOWAY
INTEGRATION JOINT BOARD

HEALTH AND SOCIAL CARE
STEWARTRY LOCALITY REPORT

DUMFRIES AND GALLOWAY
Health and Social Care

April 2020

DRAFT 1.0

Contents

This report has been produced by:

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

March 2020

For more information visit www.dghscp.co.uk

Foreword

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

This report will focus on 4 of the 9 National Health and Wellbeing Outcomes and the associated commitments. These are Outcome 1, Outcome 4, Outcome 7 and Outcome 9.

Our focus for the reporting period has been on:

- Implementation of mental health pathway in GP surgeries
- Adult support and protection
- Delayed discharges
- Care Home staff training
- Virtual clinics within GP premises

In particular, our cottage hospitals received bronze awards in relation to Care Assurance audits and our social work colleagues have been identified as having "excellent practice" in relation to Adult Support and Protection.

There continues to be significant challenges across the partnership including recruitment and retention of staff across all sectors, timely discharge of people, securing care and support packages and the difficult financial climate.

Despite these challenges staff teams and partners continue to provide the best care and support as well as identifying new ways of working to meet the outcomes of people in Stewartry.

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

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

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

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

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

ii) How we are getting on

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

In our locality we work towards this aim by:

- delivery of Let's Prevent programme
- delivery of Scottish Mental Health First Aid training
- Healthy Connections programme
- Macmillan Move More programme
- Social Isolation Partnership
- Multi agency support planning

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 further expand the Community Link approach to support people to become involved in their communities, work with individuals and our partners to provide relevant information that will allow people to make the best use of local assets to meet their health and well-being needs.
2. We will work with staff and partners to explore different approaches to early intervention and ensure staff have the necessary skills and knowledge to adopt these approaches.
3. We will support people to identify potential future health and care needs, and to plan ahead at an earlier stage, where appropriate.
4. We will explore transport initiatives which will allow people to have easy access to support, activities and services in their local community.

1.2.1 Let's Prevent programme

Let's Prevent is a person centred support programme for people identified by their GP practice as having pre diabetes, or those at risk who may want help to make lifestyle changes. The programme consists of two 3 hour sessions where information about pre-diabetes and type 2 diabetes, diet and physical activity is provided. People taking part are encouraged and supported to set personal goals regarding lifestyle changes which could reduce the risks of developing type 2 diabetes. From July to December 2019, 8 people attended the programme. Some people's Carers also attended.

1.2.2 Scottish Mental Health First Aid Training

Scottish Mental Health First Aid (SMHFA) is an accredited training course which offers general information about mental health problems. The main aim of the course is to help remove stigma and fear and give confidence to participants in approaching a person in distress.

In 2019, 2 SMHFA courses were delivered. One was for all community members and the other was a closed session for Stewartry Rugby Football Club. A total of 20 people attended the training and initial feedback was that SMHFA was a very helpful and comprehensive course which increased people's confidence around the subject of mental health.

A member of the health and wellbeing team is trained to deliver the accredited course and the offer of this free training has been made to communities and community groups across the locality.

1.2.4 Healthy Connections

The Healthy Connections team, which consists of two Community Link Workers, works with people to identify what is important to them and supports them to achieve personal outcomes. The Community Link Workers deliver one to one therapeutic interventions based on person centred conversations, signposting and support. This approach helps people build confidence and motivation, enabling them to access relevant activities, groups, organisations to improve their health and wellbeing.

Between May 2019 and January 2020, Healthy Connections received 158 referrals from GP practices, other health and social care professionals, partners in the third sector and self referrals.

What people tell us: Sally's story

Due to existing medical conditions Sally (not her real name) has been regularly in and out of hospital. She can spend long periods of time in hospital and has become demotivated and isolated as a result of this.

Sally was initially seen by a Community Link Worker (CLW) in the GP practice, however due to health conditions the appointments were changed to her home. The service was partially explained to her and she said after the first meeting it was so much better than expected. She felt instantly at ease and could not praise the CLW or the service enough.

At the time of her most recent hospital admission, the CLW and Sally had met 5 times. They had discussed what matters to her and what she would like to achieve. When admitted to hospital most recently, Sally said that the work she had been doing with the CLW had given her the push and increased her motivation to get out of hospital. Previously they relied on medical professionals to get them better and decide when she would be discharged. This time, Sally felt empowered and able to take responsibility for her own health and believes that this reduced her hospital admission by days.

Before meeting with the CLW, Sally said she had lots of ups and downs but now the ups are much more regular that the downs.

1.2.3 MacMillian Move More

The Move More project supports people living with cancer, their Carers, family members and friends. The project supports people to become more active and help manage the consequences of treatment such as fatigue, depression and heart damage through gentle physical activity. In partnership with MacMillan Cancer Support, we have developed a range of free classes for people affected by cancer. From walking and gardening groups to circuits and gentle movement sessions there is something for everyone. More information can be accessed at www.nhsdg.scot.nhs.uk/Dumfries/MoveMore

1.2.4 The Stewartry Social Isolation Partnership

The Stewartry Social Isolation Partnership (SSIP) has representation from the public and third sector and is coordinated by the Stewartry Health and Wellbeing Team. The purpose is to share learning and promote measures (identified through community engagement in 2018) which can improve social inclusion.

SSIP Priorities for 2019 to 2020 are:

- **Working with communities to develop opportunities for informal volunteering** – The partnership has engaged with communities who have developed a culture of informal 'helping out' one another. Planning is at an early stage to work with groups to showcase and share good practice across the locality.
- **Challenging stigma** – Workplace workshops where people with lived experience discuss what can help them to feel included has taken place throughout 2019. Next steps for 2020 is to use the learning from the workshops to promote more formalised training which is delivered by community based partners such as DG Voice.
- **Community Access Surveys** - These involve working with people with lived experience to identify small and larger scale changes which could improve access and inclusion in communities. Work is ongoing with communities who have previously participated to put learning into action. One of these areas is to develop a user friendly community access survey template which can be used by local communities and groups.

1.2.5 Multi agency support planning

Social Work teams work jointly with multi agency professionals to support vulnerable people living in our local community. An example of this type of support includes developing a multi agency adult support and protection plan, to help people address and manage some of the key areas of vulnerability in their lives. This is done in conjunction with housing, Community Mental Health Team (CMHT) and a local care agency.

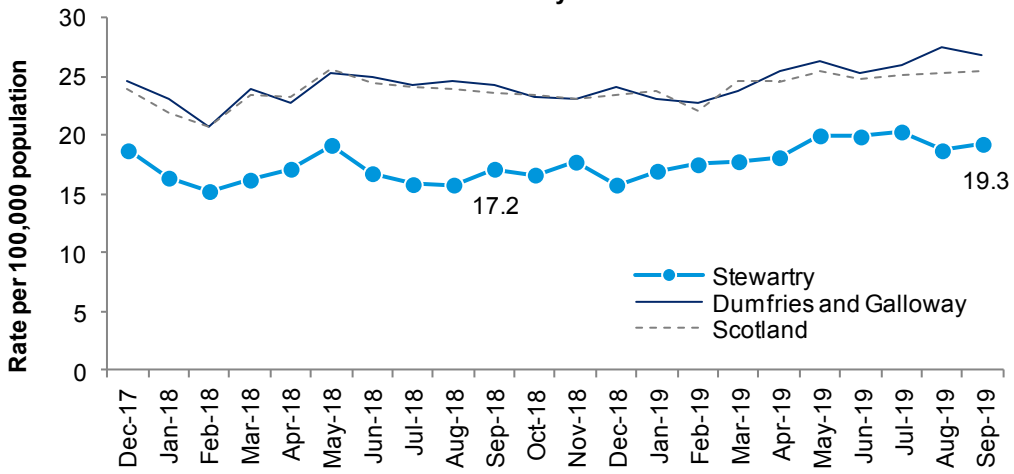
The multi agency adult support and protection plan is reviewed regularly to ensure that the agreed actions are being addressed. This type of approach is truly person centred and provides vulnerable people with a joined up, robust plan of support to help them look after and improve their own health and wellbeing.

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 Stewartry over the last year, the number of people attending an emergency department (anywhere in Scotland) has risen. The rate of attendances is typically lower than for Dumfries and Galloway, which reflects the distance to an emergency centre.

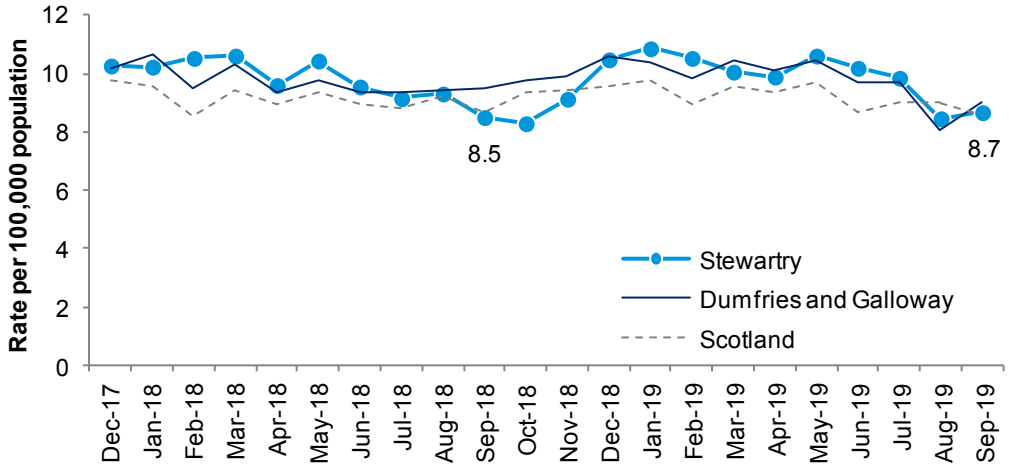
Rate of emergency department attendance per 1,000 population, Stewartry



Source: NSS Discovery, from National A&E Datamart

D23

Rate of emergency admissions to hospital per 1,000 population, Stewartry



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, a good example of this is:

- Community Link mental health pathway
- Dementia Champions
- Self Directed Support and Anticipatory Care Plans
- Delayed discharge

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:

17 We will promote the value and embed self-directed support and person-centred care, as it relates to individual outcomes.

18 We will develop joint systems and processes (including I.T. systems) across the partnership to improve communication, reduce duplication, promote continuity of care and maximise individual outcomes.

19 We will explore, in partnership with our GP practices, options in relation to the skills mix.

20 We will explore different models of care for our cottage hospitals.

21 We will make sure staff across all sectors are skilled and have the most up-to-date knowledge and information to provide continuously improving support, care and treatment for individuals.

4.2.1 Community Link Mental Health Pathway

In May 2019 a pilot project between the Health and Wellbeing Team and the Primary Care Mental Health Service started. A Community Link mental health pathway was developed and is currently being tested.

Between May 2019 and December 2019, 158 referrals were received. Of these, 61 people (41%) were supported through the new mental health pathway. An interim report is in the process of being produced and this will make recommendations on the next steps.

4.2.2 Dementia Champions

The local podiatry team have celebrated the work of their first dementia champion who has been involved in local, national and profession specific dementia working groups.

Having someone in this role promotes a better understanding of how to recognise the condition and support people with dementia and their Carers to continue to live independently and self manage their feet.

Podiatry staff have contributed to the 'Let's talk about Dementia' blogs, which are sent out by email weekly, to update and inform the public and other health and social care professionals. Podiatry have also produced a short video www.youtube.com/watch?v=HRV6LGlRouY

4.2.3 Self Directed Support and Anticipatory Care Plans

Social work staff promote a personalised approach to social care by providing information about all 4 Self Directed Support (SDS) options. This includes exploring the use of technology. This approach enables people to make informed choices and take control of how their support will be managed.

The link between Self Directed Support and Anticipatory Care Planning (ACP) should be seamless. Both encourage people to make positive, proactive choices for themselves.

Anticipatory Care Plans help to support people to plan their future health, social care and support and to make their wishes known to services. This may include arranging a Power of Attorney. Guardianship still remains one of the top reasons for people being delayed in hospital. An Anticipatory Care Plan and Power of Attorney event will be held in Stewartry in 2020.

4.2.4 Delayed discharge

When people are admitted to hospital, planning for their return home starts as soon as possible. The daily dynamic discharge process ensures that people, their families, Carers and professionals involved in their care contribute to this planning. When people stay too long in hospital and are receiving care in the wrong setting this is known as a delayed discharge.

We monitor how many people experience a delayed discharge and also regularly audit, through the Day of Care Survey, whether people are in the right setting for the care they need. Over the past year, surveys have shown that, on average, 40% of people in Castle Douglas Hospital and 50% of people in Kirkcudbright Hospital could have been better supported in a more appropriate setting.

Weekly flow meetings bring together a range of health and social care professionals to review the care of people currently in hospital. The flow meeting seeks to ensure that people are supported to move between acute hospitals, cottage hospitals and home or a homely setting in a timely way. This is not always possible, resulting in people being delayed.

The top three reasons for a delay were:

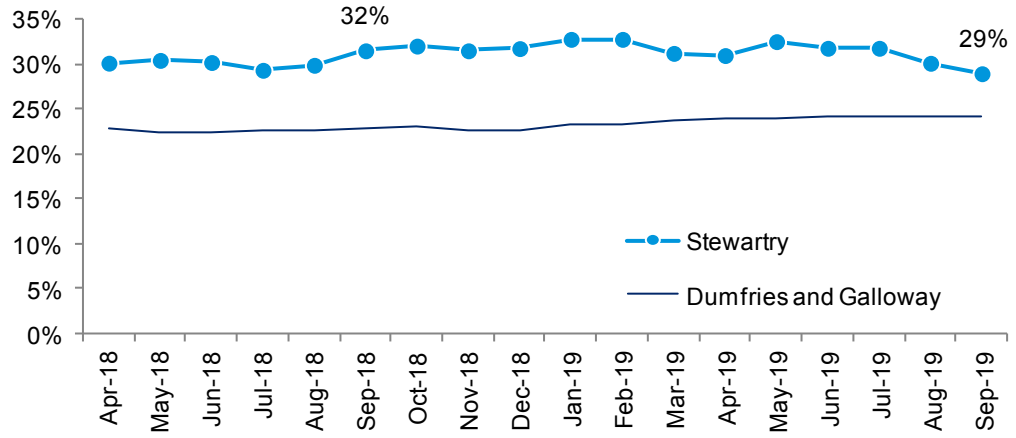
- awaiting care at home
- choice guidance
- guardianship

4.3 How we are getting on

The proportion of people in the Stewartry receiving support through Self Directed Support Options 1 or 2, which have the largest levels of personal responsibility, is consistently higher than the regional average. 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 third of people aged under 65 have chosen this Option, whilst for people aged 65 or older, it is around a quarter. In September 2019 there were 40 people aged under 65 receiving care through SDS and 62 people aged 65 or older. It is not clear why a higher proportion of people electing for Options 1 and 2 might be higher in the Stewartry.

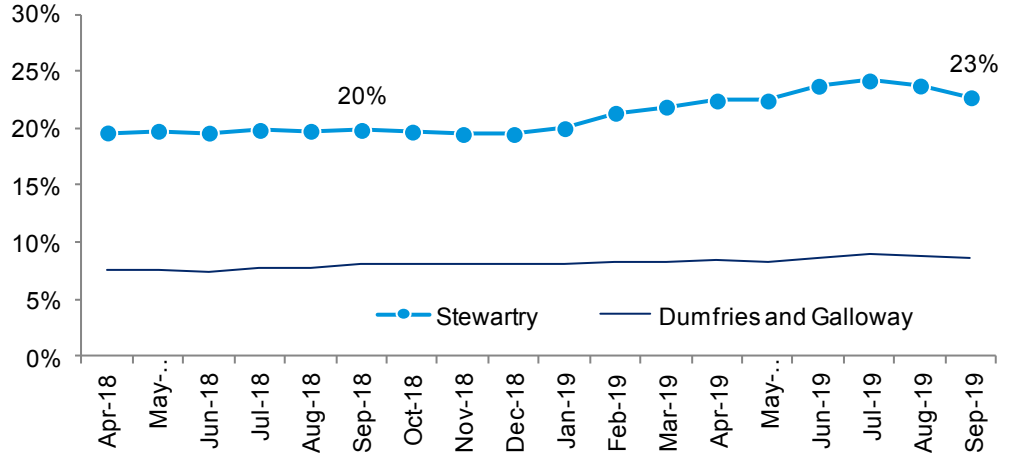
Percentage of people under 65 years with SDS accessing options 1 and 2; Stewartry



Source: Dumfries and Galloway Council, local figures

C10

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



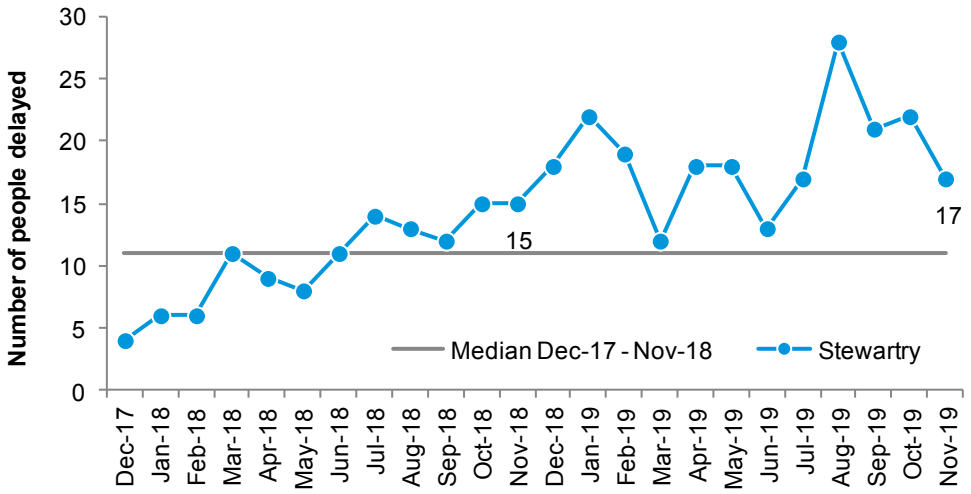
Source: Dumfries and Galloway Council, local figures

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 Stewartry, and across Dumfries and Galloway 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.

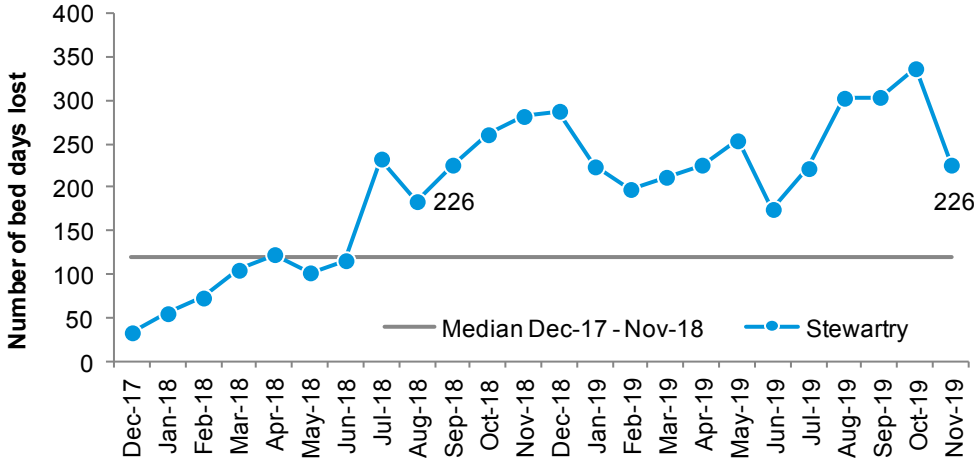
Number of people experiencing a delayed discharge at the end of each month; Stewartry locality residents



Source: NHS Dumfries and Galloway, local figures

D25

Number of bed days lost to delayed discharge each month; Stewartry 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 Stewartry we are working towards this aim by:

- Adult Support and Protection Quality Assurance
- Auditing Adult Protection
- Care Assurance in Cottage Hospitals

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:

28 We will ensure that all staff are trained appropriate to their role in assessing a person's capacity and assessing and managing risks to the person.

29 We will ensure that all partners are trained in a consistent manner in relation to adult support and protection to enable prompt identification of individuals at risk.

30 We will work with our wider partners (e.g. Police Scotland and Fire and Rescue) to address issues related to community safety for the most vulnerable members of our communities.

31 We will explore ways of safely managing the sharing of information across the locality partnership.

32 We will develop a programme of audits across the partnership which will allow us to regularly monitor and review our performance in the locality.

33 We will use the learning and build upon existing initiatives (e.g. Safe Patient/ Adverse incidents) to reduce unnecessary harm to people.

7.1.1 Adult Support and Protection Quality Assurance

Adult Support and Protection (ASP) routinely seek feedback from adults who have been subject to ASP processes.

Following an initial case conference, the adult or their advocate is asked for their consent to contact them for a discussion on the ASP process. If they agree, they are contacted by out of hours social work service staff and asked to comment, on how the process was for them and did they feel it was person centred. The feedback is used to identify ways of making the process easier.

Feedback is currently being analysed and an improvement plan will be produced.

7.1.2 Auditing Adult Protection

In February 2019, a joint audit with the Care Inspectorate of 24 adult support and protection cases was completed. Detailed examination of all aspects of people's records were scrutinised by partners from across the Public Protection Partnership including police, health and social work.

The findings showed examples of excellent practice in relation to engaging with complex cases, involving personal, legal and environmental aspects. One case flagged as excellent highlighted timely intervention to prevent financial harm. These are being used as examples of best practice that can be shared for training purposes.

Learning was identified from the audit to improve ways regarding how risk is addressed, to provide the most effective support, in the most person centred and least restrictive way. The potential to use advocacy more widely was also identified.

7.1.2 Care Assurance in Cottage Hospitals

Care Assurance audit is a nursing peer review process that also enables people staying in hospital the opportunity to feedback to us their experience of care and suggest potential improvements to ensure safe clinical practice across various standards.

The Care Assurance process aims to reflect national and local priorities but also to:

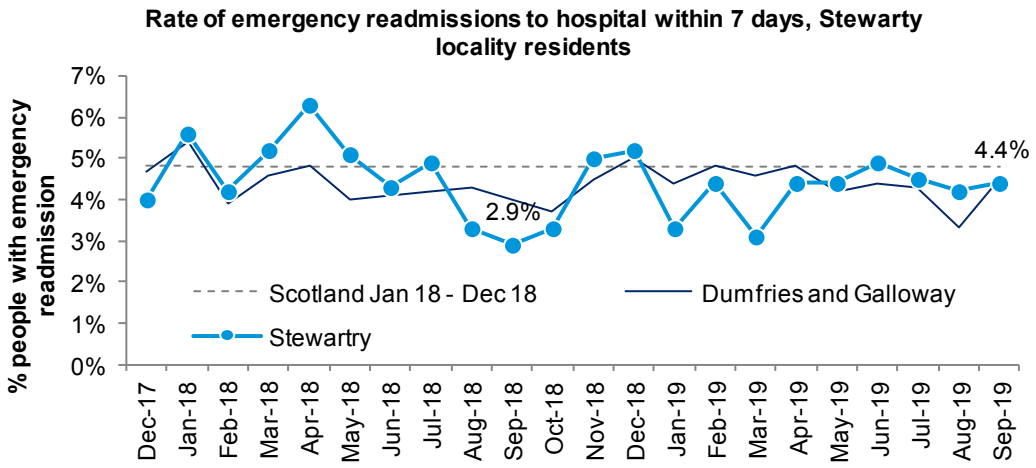
- ensure consistency in the delivery of high quality standards of care
- to identify and celebrate good practice and promote sharing good practice
- to identify and provide support for areas of practice which need to be improved

During a recent Care Assurance audit both Castle Douglas Hospital and Kirkcudbright Hospital achieved the bronze award.

In the most recent report in September 2019, Castle Douglas Hospital scored over 90% compliance across all criteria related to falls, pressure area care, medication, infection control, safe discharge and transfer and staff development.

7.3 How we are getting on

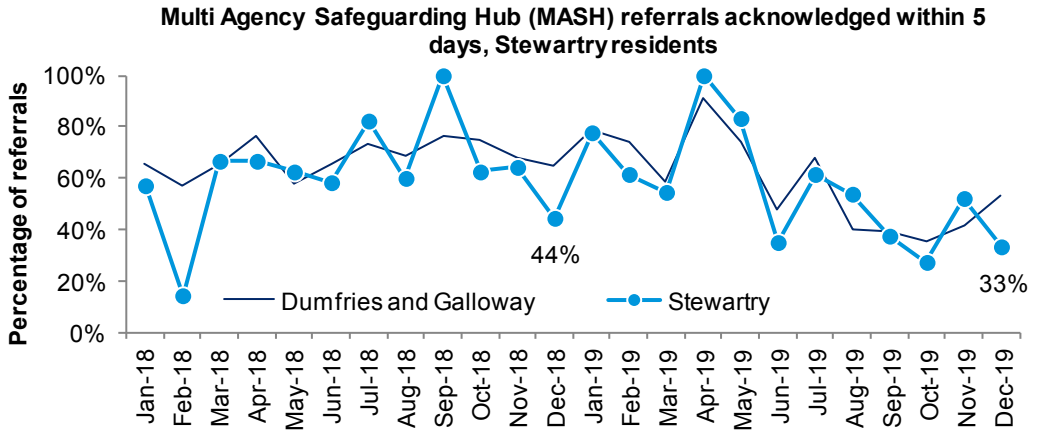
One aspect of keeping people safe is monitoring readmissions to hospital. Whilst a discharge quickly followed by an emergency admission may be entirely appropriate in many cases, it could mean in some cases that people were possibly discharged before they were ready. Readmission rates are typically below the Scottish rate of 4.7% for both Stewartry and Dumfries and Galloway. The figures for Stewartry residents are more variable, which reflects the smaller number of people involved.



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 PPC 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 33% in December 2019.

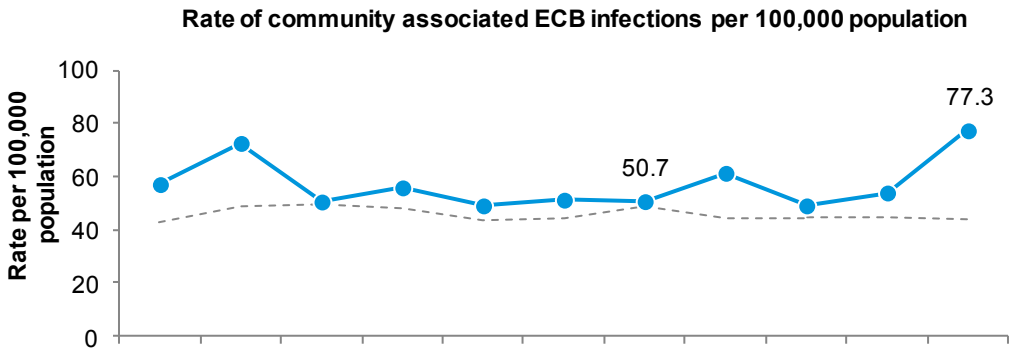


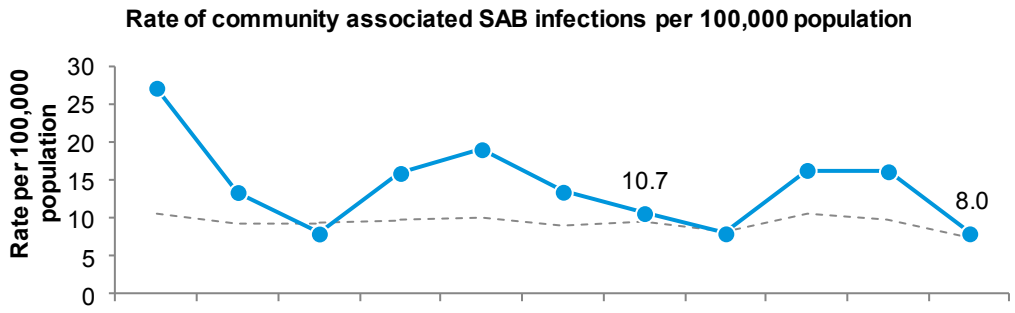
Source: Dumfries and Galloway Council, local figures

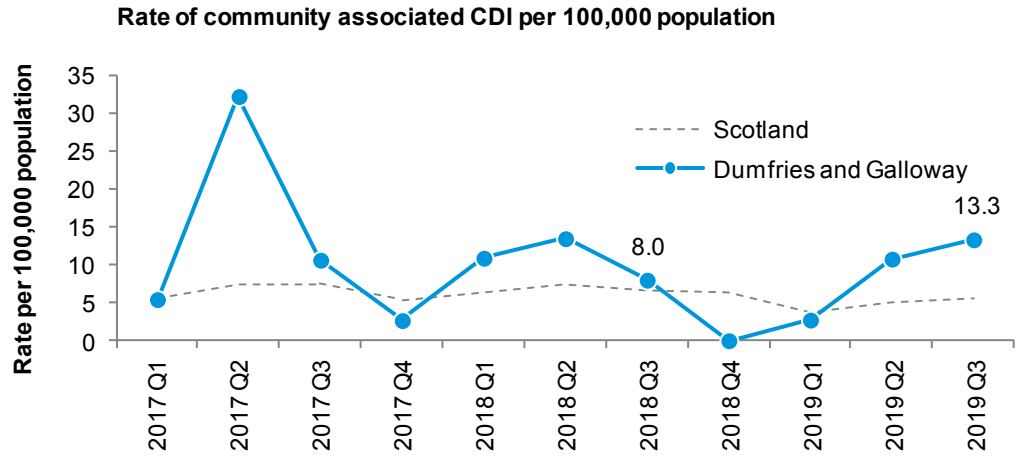
C9

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 community settings for Dumfries and Galloway compared to Scotland for infections regularly 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. Good examples of this in Stewartry are:

- Redesign of overnight support
- Care home staff training
- Transforming roles in nursing
- Attend Anywhere

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:

39 We will work in partnership to develop alternative, sustainable models of care which maximise the use of existing resources.

40 We will support our workforce in gaining an understanding of the value of working in partnership within an integrated system, and how collective resources can be employed to deliver services ultimately reducing duplication.

41 We will continue to introduce and promote prescribing initiatives to ensure safe, appropriate, effective prescribing.

42 We will regularly review health and social care packages as multi-disciplinary teams to make sure that they are right for the individual, achieve agreed outcomes and promote wellbeing.

43 We will maximise the use of technology to reduce waste and duplication in the system.

9.1.1 Redesign of overnight support

It is recognised that many adults with learning disabilities have:

- limited access to daytime activities, which can lead to social isolation and disconnection from the communities they live in
- have greater health inequalities than the general population

Historically, services and professionals have been risk averse in the provision of support for adults with learning disabilities. This has resulted in high numbers of people accessing overnight support which can be inappropriate for the person receiving the support as well as being high cost to health and social care providers.

It is important that the redesign of overnight support promotes independence as well as enabling people to feel safe and supported in their homes at night.

We are testing technology, in the form of polar wrist bands, to collect data on people's sleep patterns, day and night activity levels and key indicators of general health. We want to ensure that people feel comfortable and confident about the use of technology as a means of support.

Remote monitoring would enable sleepover support to change to waking overnight support and allow the member of staff to respond to other properties within the area if required. This approach to overnight support could provide a technological solution for people to stay in their own homes safely overnight.

A report will be available early 2020 with recommendations for next steps.

9.1.2 Care home staff training

In partnership with Scottish Care and local care homes, a number of approaches are being tested to help reduce GP practice workload, create a new skill mix within the independent sector and ensure people are receiving the right support at the right time.

- An Advanced Nurse Practitioner (ANP) has been working with 2 care homes in Stewartry to support unscheduled home visit requests to GP Practices.
- 60 care home staff in Stewartry have been trained to take a person's vital signs such as temperature, blood pressure and oxygen levels. This gives staff the opportunity to consolidate their learning, gain exposure to and experience of people with acute and chronic illness and injury, develop closer relationships with primary care colleagues and offer a sustainable service.

Over the next 6 months our focus will be on data collection and evaluation of the impact on unscheduled visit requests made to GP practices and implementation of the vital signs practice within a care home setting.

9.1.3 Transforming Roles in Nursing

NHS Education for Scotland (NES) is commissioning the design and delivery of an education programme to prepare nurses to work flexibly in roles within the adult integrated community nursing team. This team includes district nursing, general practice nursing and care home nursing roles.

This new education programme will ensure consistency of provision and qualifications for community nursing across Scotland and supports national policy in favour of community based services, reducing inequalities and supporting people to improve and manage their own health and wellbeing.

Within Stewartry community nursing, there are two charge nurses who are currently undergoing post graduate education to enable them to transition to the specialist practitioner district nurse role. This new role develops and enhances the district nurse role within the community teams which enables them to provide new and innovative ways of delivering care within the community setting. This will allow people with more complex conditions to be nursed in the community rather than in hospital.

9.1.4 Attend Anywhere

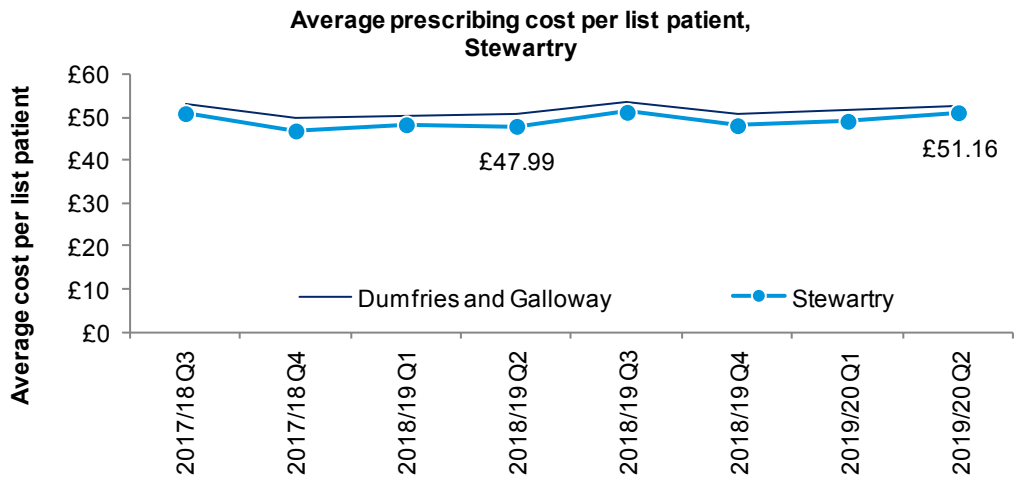
Attend Anywhere is secure video consultation software. Virtual waiting rooms are setup to replicate a real waiting room, supporting people to attend clinics remotely, as well as enabling staff meetings to take place virtually across the region.

Due to the rural nature of the region using this type of technology will support us to significantly reduce travel time and costs for people and staff as well as lowering our carbon emissions and maximising our existing resources.

9.3 How we are getting on

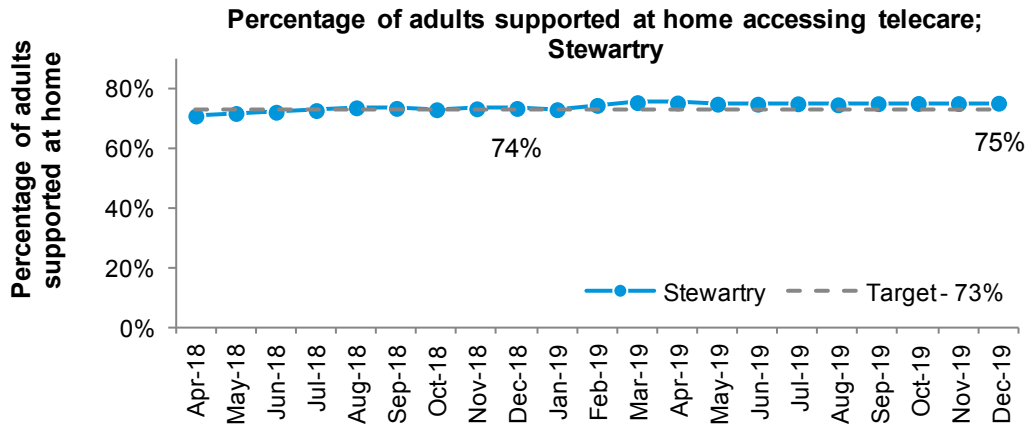
The Strategic Plan Adults Needs Assessment indicates that over 75% of the population receives a prescription at least once per year. In 2016/17 the annual cost per person ranged from £137 - £277 across the GP practices. This is partly because of the different mix of people they support. Stewartry has a very similar cost per person to Dumfries and Galloway. The figure for July to September 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 75% in December 2019.



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

D28



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	Stewartry	Time Period	Dumfries and Galloway	Stewartry
Outcome 1	D23	Rate of Emergency Department attendance by locality of residence per 1,000 population	Sep 2018	24.4	17.2	Sep 2019	26.8	19.3
	D24	Rate of emergency admission by locality of residence per 1,000 population	Sep 2018	9.5	8.5	Sep 2019	9.0	8.7
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	397.4	Dec 2019	548.5	378.7
	A15 / E5	Proportion of last 6 months of life spent at home or in a community setting	2017/18	89%	89%	2018/19	89%	89%
Outcome 3	D2	Number of complaints received by the locality team (all stages)	-	-	-	2018/19	-	8

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

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

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

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

Locality Indicator			Previous Value			Current Value		
			Time Period	Dumfries and Galloway	Stewartry	Time Period	Dumfries and Galloway	Stewartry
Outcome 4	C10	Percentage of people supported by SDS Option 1 or Option 2, under 65 years of age	Sep 2018	25%	32%	Sep 2019	24%	29%
	C11	Percentage of people supported by SDS Option 1 or Option 2, 65 years and older	Sep 2018	8%	20%	Sep 2019	9%	23%
	D25	Number of people with delayed discharge in all hospitals (Dumfries and Galloway Royal Infirmary, Galloway Community Hospital and Cottage Hospitals) by locality of residence	Dec 2017 - Nov 2018	628	71	Dec 2018 - Nov 2019	968	143
	D26	Number of bed days lost to delayed discharge by locality of residence	Dec 2017 - Nov 2018	14,622	1,793	Dec 2018 - Nov 2019	22,527	2,969
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	27	2017/18	41	43
Outcome 6	C5	Number of Adult Carer Support Plans developed within the locality	2017/18	-	23	2018/19	-	46

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

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

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

Locality Indicator			Previous Value			Current Value		
			Time Period	Dumfries and Galloway	Stewartry	Time Period	Dumfries and Galloway	Stewartry
Outcome 7	D27	Percentage rate of emergency re-admission to hospital within seven days	Sep 2018	4.0%	2.9%	Sep 2019	4.5%	4.4%
	C9	Percentage rate of referrals to the Multi Agency Safeguarding Hub (MASH) acknowledged within 5 days	Oct - Dec 2018	69%	58%	Oct - Dec 2019	44%	38%
Outcome 8	D5	Proportion of people who agree that they have the information necessary to do their job	2017	80%	n/a	2019	79%	81%
	D21	Proportion of people who agree that they are involved in decisions relating to their job	2017	70%	n/a	2019	69%	74%
	D22	Proportion of people who would recommend their organisation as a good place to work	2017	74%	n/a	2019	74%	75%
Outcome 9	D28	Average prescribing costs per person for 3 months	Jul - Sep 2018	£50.60	£47.99	Jul - Sep 2019	£52.41	£51.16
	C1	Percentage of People With SDS Option 3,Supported with Telecare	Dec 2018	73%	74%	Dec 2019	73%	75%

Source: ISD Scotland, HACE Dashboard

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

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

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

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