DUMFRIES AND GALLOWAY
INTEGRATION JOINT BOARD

HEALTH AND SOCIAL CARE
WIGTOWNSHIRE LOCALITY REPORT

DUMFRIES AND GALLOWAY
Health and Social Care

April 2020

DRAFT 1.0

Contents

This report has been produced by:

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Strategic Planning, Commissioning and Performance Team,
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Foreword

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

This report will focus on 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:

- completing health and wellbeing plans
- pharmacy hubs
- education and information (The Life Curve)
- planning for introducing new technology into care homes
- Adult Support and Protection audits
- delayed discharges

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

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

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

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

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

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

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

ii) How we are getting on

Next to each infographic in this report there are 2 circles, like this: A1

The first circle shows the indicator number. Information about why and how each indicator is measured can be found in the Performance Handbook, which is available on the Dumfries and Galloway Health and Social Care Partnership website (www.dghscp.co.uk/performance-and-data/our-performance/). Where there is a + instead of a number, the figures are not standard indicators, but additional information thought to be helpful.

The second circle shows red, amber or green colour (RAG status) and an arrow to indicate the direction the numbers are going in. We have used these definitions to set the colour and arrows:

- We are meeting or exceeding the target or number we compare against
- We are within 3% of meeting the target or number we compare against
- We are more than 3% away from meeting the target or number we compare against
- Statistical tests suggest the number has increased over time
- Statistical tests suggest there is no change over time
- Statistical tests suggest the number has decreased over time

The 9 National Health and Wellbeing Outcomes

The Scottish Government has set out 9 national health and wellbeing outcomes for people.

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 Wigtownshire we are working towards this outcome through:

- mPower Programme
- Community Health Synchronisation (CoH-Sync) project
- Community Health and Wellbeing Information Hubs
- Machars Cancer Drop In
- Whithorn African Drumming and Rhythm Circles

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. Develop information and make this information accessible to people and relevant to their own circumstances so that they can take responsibility for, and be in-control of, their own health and wellbeing.
2. Actively develop alternatives to traditional services to support people to maintain their health and well-being – both physical health and mental wellbeing.
3. Support people to develop their knowledge and skills to lead healthier lifestyles and be more in control of their own health and wellbeing.
4. Continue to deliver and build on existing initiatives that promote health and wellbeing such as let's cook, walking groups, living life to the full and mindfulness.
5. Ensure that person centred planning, record keeping and risk assessments are developed in partnership (outcomes 1 : performance management 2, person centred planning 5, record keeping, D&G partnership improvement action plan).

1.2.1 mPower Programme

An interim evaluation of the mPower programme has been carried out by researchers from the University of Highlands and Islands. The key findings from the interim evaluation show:

- 8% of people living in Wigtownshire aged 65 and over have been reached by the mPower project
- 122 people have completed health and wellbeing plans leading to the completion of an anticipatory care plan
- People have increased their confidence and sense of wellbeing

One person taking part in mPower told the researcher:

> "And the way I see it is…part of the problem is confidence… ken I think … I really do believe I feel better with the exercise. And you are not on your own, you see, if you are lonely… so whether that…maybe changed a wee bit of my brain, I don't know"
>
> Wigtownshire resident

1.2.2 Community Health Synchronisation (CoH-Sync) project

The CoH-Sync project encourages people to self manage their own health and wellbeing through the use of signposting to local groups and clubs, apps, websites, advice and information which can support positive health behaviour change. Face to face contact is provided at a convenient time and place for people. Improvement is measured through a person centred health and wellbeing plan.

In 2019, 384 people engaged with the project with 346 completing health and wellbeing plans.

What people tell us: a CoH-Sync story

"I signed up to the CoH-Sync project because I wanted to change my eating habits and improve my physical and mental health. I am a single parent to three young children and suffer from anxiety and feel isolated as a result. I could not manage to eat one meal a day, instead snacking on unhealthy options throughout the day. I would drive to my local shop and rarely left the house to engage with anyone in the community"

"CoH-Sync helped give me goals to improve my lifestyle. I was provided with nutrition advice and a food diary helping me eat at regular times throughout the day. I started off walking and counting my daily steps using a app on my mobile phone recommended by my health and wellbeing facilitator, starting with a small goal of 2,000 steps a day, and daily aiming to achieve more until I was able to reach a daily goal of 7,000 steps. My health and wellbeing facilitator also encouraged me to attend a local Tai Chi class with a friend, which helped ease my anxiety and meet new people and make new friends"

"CoH-Sync has allowed me to take control of my eating habits and increasing my exercise has given me more energy, which has had a positive impact on my relationship with my children. I feel more confident being around new people and have new friends who support me. I feel healthier and happier thanks to the support of CoH-Sync"

1.2.3 Community Health and Wellbeing Information Hubs

Discussions with local people through the Transforming Wigtownshire programme identified communication and education as one of the key areas of focus. In particular, people wanted to find out which local services might support their health and wellbeing. A booklet of these services has been developed and will be available from local hubs in communities. At these hubs people will also be able to get information on local groups and activities.

Kirkcowan and Whithorn Community Councils have already identified community hub locations and community members who will act as champions and work with health and social care professionals. Future meetings with Kirkcolm and Portpatrick Community Councils are scheduled for early 2020.

1.2.5 The Machars Cancer Drop In

The Machars Cancer Drop In was launched at Newton Stewart Health Centre in November 2019 and is run on a weekly basis by trained NHS volunteers. The aim is to provide a supportive listening ear to people including people with cancer, their families, friends and Carers, who often feel vulnerable, isolated and in need of some extra emotional support.

1.2.6 Whithorn African Drumming and Rhythm Circles

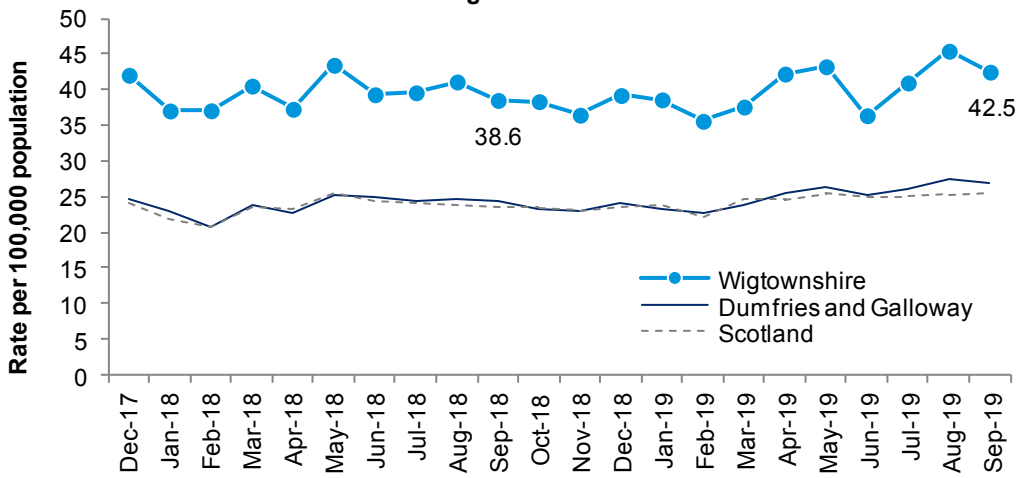
Following taster sessions held in September 2019 the Whithorn African Drumming and Rhythm Circles Group has been established. This group is led by volunteers with funding and donations for equipment secured from Wigtown Community Shop, Wigtownshire Health and Wellbeing Partnership, Machars Partnership and the Stranraer Drum4Fun Group.

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 Wigtownshire over the last year, the number of people attending an emergency department (anywhere in Scotland) has been variable. The rate of Emergency Department attendances is typically higher than for Dumfries and Galloway, which reflects the close proximity of a sizable population to an emergency centre.

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



Source: NSS Discovery, from National A&E Datamart

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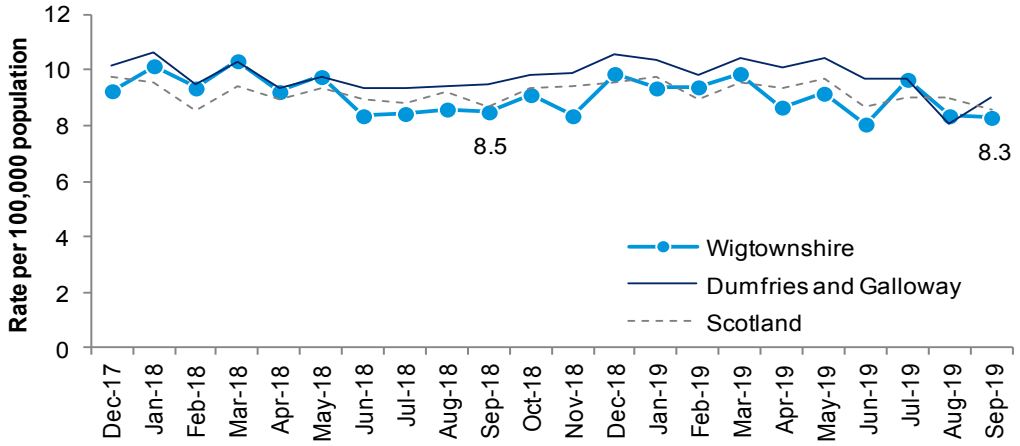
Rate of emergency admissions to hospital per 1,000 population, Wigtownshire



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. We are working towards this outcome through:

- Self Directed Support and Anticipatory Care Plans
- Delayed discharge
- mPower Programme

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:

14 Improve how we monitor evaluate and manage performance across the whole partnership (Outcome 1: performance management, D&G partnership improvement action plan).

15 Fully implement the principles, values and practice of self-directed support. We will focus on keeping the person at the centre and in control as far as possible of their own of care and support. For example, develop approaches to planning for the future with forward looking care plans and supported self-assessment and care and support plans.

16 Continue to develop staff across the organisation to support people to be in control and to focus on outcomes for people.

17 We will build on training and other outcomes focussed training initiatives already underway.

18 Develop approaches that will evaluate and record outcomes achieved in practice.

4.2.1 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.

Anticipatory Care Plans help to support people to plan their future care and support and to make them known to services. This may include arranging a Power of Attorney. The link between Self Directed Support and Anticipatory Care Planning (ACP) should be seamless. Both encourage people to make positive, proactive choices for themselves.

Guardianship still remains as one of the top reasons for people being delayed in hospital. An Anticipatory Care Plan event was held in Stranraer in January 2020.

4.2.2 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, the surveys have shown that an average of 40% of people in Newton Stewart Hospital did not meet the criteria and could have been 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 the delays were:

- Awaiting care at home
- Choice guidance
- Guardianship

4.2.3 mPower programme

The mPower programme aims to empower people to take control of their long term conditions by using technology, while simultaneously freeing up the time of GPs and other health and social care professionals. This is achieved through access to digital interventions such as:

My Diabetes My Way – Southern Machars and Lochinch Practice have increased the number of people making use of this system to help manage their diabetes.

Remote Blood Pressure Monitoring – Southern Machars practice has introduced the Florence system to support people to monitor their own blood pressure for accurate diagnosis of hypertension

Remote Clinic Appointments – work is underway to trial the use of Attend Anywhere from a number of community settings. (Attend Anywhere is a secure video consultation application.)

4.2.3 Community Health and Synchronisation (CoH-Sync) Programme

Health and wellbeing programmes have been developed in the heart of the community at the Coronation Day Centre in Stranraer and the Riverside Day Centre in Newton Stewart.

These programmes range from 6 to 8 weeks and provide interactive information on specific health and wellbeing topics. They are delivered jointly by health and social care staff as required.

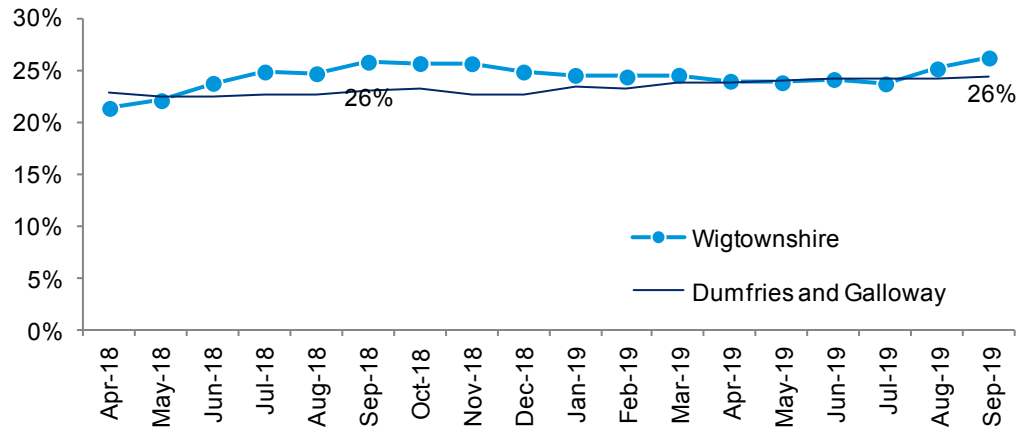
Personal appraisal sessions are being undertaken in Stranraer Academy and Douglas Ewart High School with a view to delivering health and wellbeing programmes to S5 and S6 pupils early in 2020.

4.3 How we are getting on

The proportion of people in Wigtownshire receiving support through Self Directed Support Options 1 or 2, which have the largest levels of personal responsibility has been gradually increasing for the past year. 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 Options 1 and 2, whilst for people aged 65 or older, it is around one person in twenty. In September 2019 there were 44 people aged under 65 receiving care through SDS and 37 people aged 65 or older.

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



Source: Dumfries and Galloway Council, local figures

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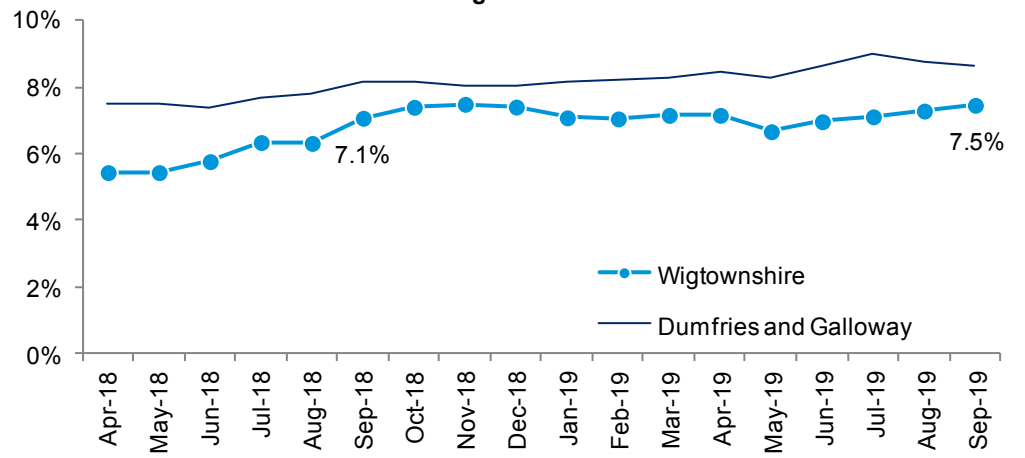
Percentage of people 65 and over with SDS accessing options 1 and 2; Wigtownshire

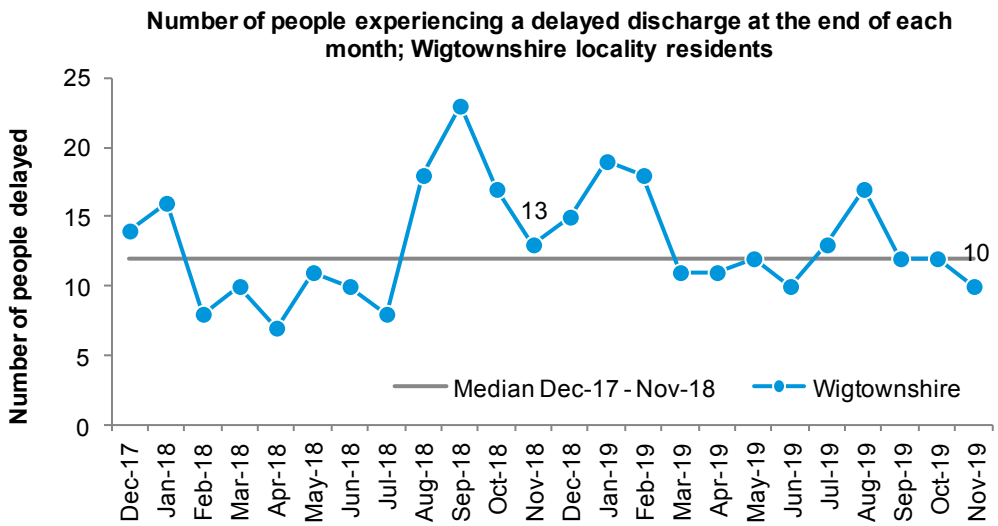


Source: Dumfries and Galloway Council, local figures

C11

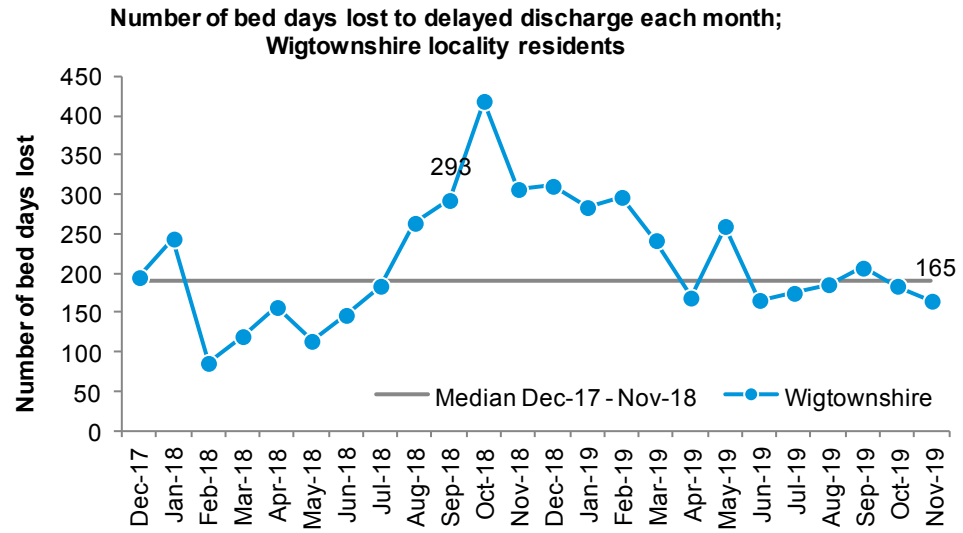
One measure of the successful coordination of people's journey of care, is the amount of time spent in hospital settings when people were ready to be discharged to a less acute setting or into the community. When people are not in the most appropriate place for their care we refer to this as a delayed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

In Wigtownshire, the number of people experiencing a delayed discharge (in acute, community or cottage hospital setting) has remained steady during 2019. This is in contrast to Dumfries and Galloway as a whole where the number of people delayed has risen during the same time period.



Source: NHS Dumfries and Galloway, local figures

D25



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 to reduce the risk of harm to all people. In our locality we work towards this aim by:

- Keeping people safe in hospital
- mPower programme – ARMED project
- Auditing Adult Protection

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 Promote approaches that help people to be more knowledgeable and aware of their own personal safety and that of others.

29 Ensure that all staff are trained appropriate to their role in assessing a person's capability and assessing and managing risks to the person.

30 Ensure that all partners are trained in and consistently work to agreed multi-agency adult support and protection procedures.

31 Ensure that we learn from adverse incidents of all kinds across services.

7.2.1 Keeping people safe in hospital

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

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

During a recent Care Assurance audit, Newton Stewart Hospital achieved the silver award. Areas highlighted for continued improvement included:

- cognition
- food, fluid and nutrition
- documentation

The hospital team have since reviewed their practice and redesigned services to ensure that all people are now assessed on admission using the 4AT score which provides early indication of delirium. They are also liaising with GP practices to ensure documentation is completed accurately.

7.2.2 mPower programme – ARMED project

The mPower programme has secured funding to test the use of ARMED technology to reduce the risk of adverse incidents such as falls for people living in care homes and residential care accommodation. The ARMED system uses polar loop technology to monitor:

- Heart rate
- Hydration levels
- Grip strength
- Muscle mass
- Sleep patterns and levels of activity

The test will start in early 2020 and will include development of health and wellbeing plans for those taking part to monitor confidence to live independently, manage long term conditions and overall sense of wellbeing.

7.2.3 Auditing Adult Protection

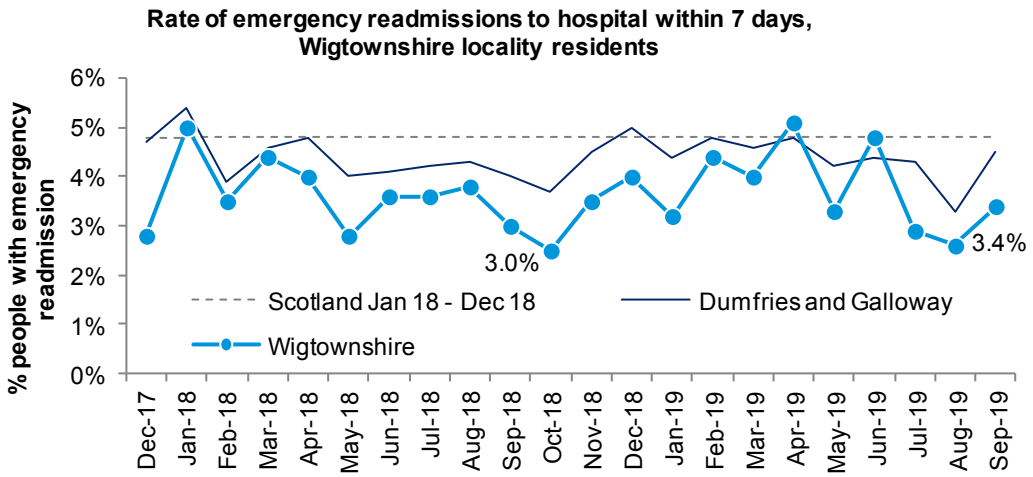
In February 2019 a joint audit with the Care Inspectorate of 24 Adult Support and Protection cases was completed. Detailed examination of all aspects of people's records were scrutinised by partners from across the Public Protection Partnership including police, health and social work.

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 in which 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.

7.3 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 for Wigtownshire are typically below the Scottish rate of 4.7% average and the Dumfries and Galloway rate. The figures for Wigtownshire residents are more variable, which reflects the smaller number of people involved.



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

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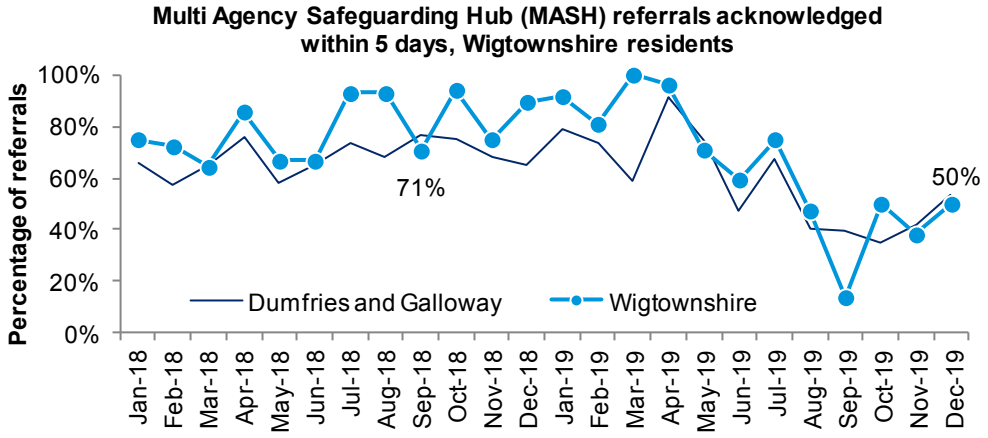
Adult Support and Protection activity is scrutinised through the Public Protection Committee (PPC). The PPC Performance and Quality subcommittee is currently redesigning the analysis and reporting of performance figures for Adult Support and Protection. It is expected that when performance reporting 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 50% in December 2019.

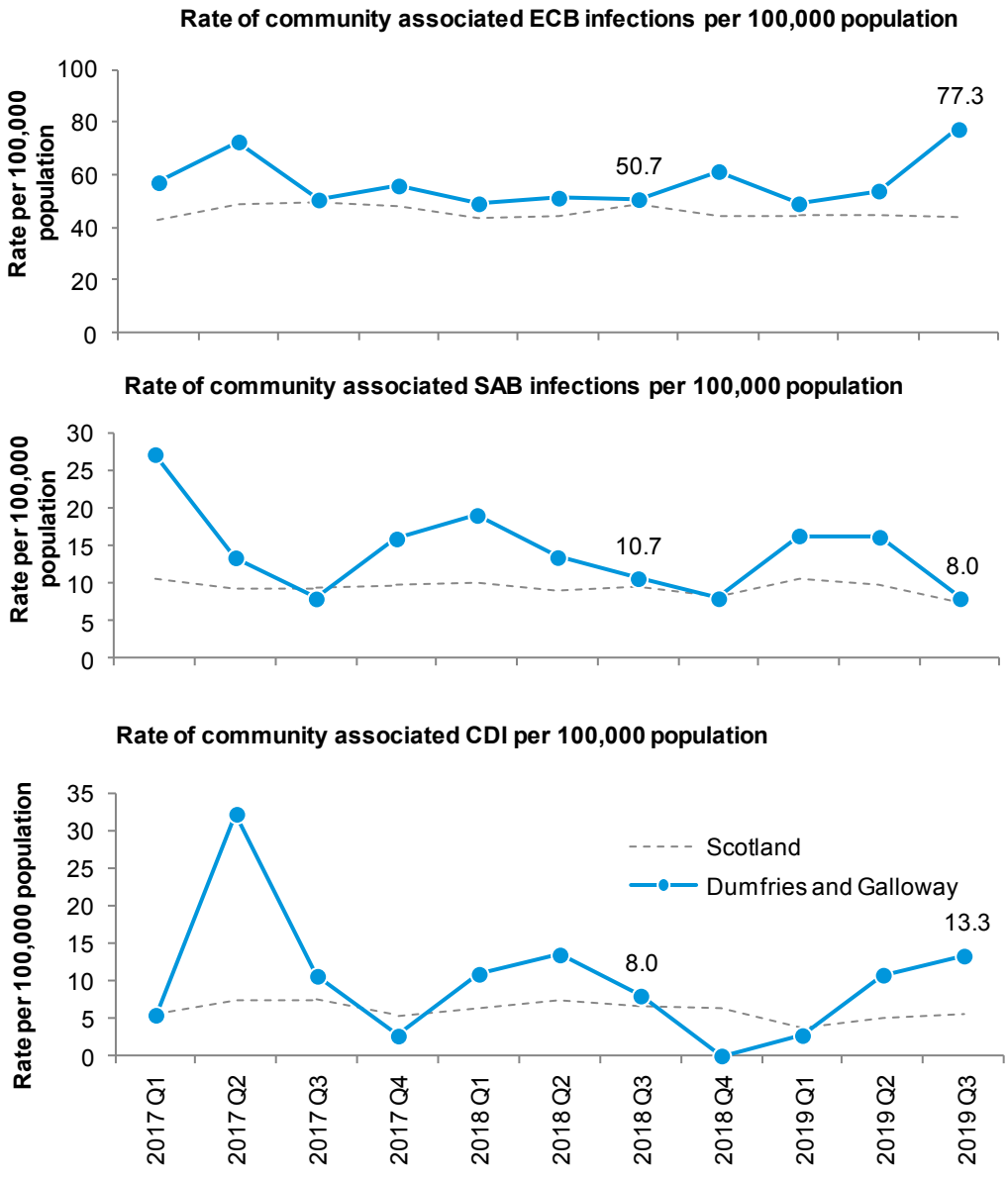


Source: Dumfries and Galloway Council, local figures

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. In our locality we are working towards this aim by:

- mPower programme
- Transforming roles in nursing
- Pharmacy hubs

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:

36 Work in partnership across sectors and with local communities to develop alternative models of care and support.

37 Develop a shared understanding of each other's roles and responsibilities across the different sectors including the voluntary sector and community groups and how resources, people and finance are currently used.

38 Actively seek to reduce duplication in health and social care provision and explore options as to how we could redesign and develop systems and services to become more efficient and effective.

39 Actively support people to make the best choices to use services and products, supplied by the partnership, effectively and efficiently.

40 Develop processes to help us to assess and utilise our efficiency and effectiveness, making change where it is required. (Outcome 4: whole system, D&G partnership improvement action plan).

9.2.1 mPower programme

Special EU Programme Boards (SEUPB) funding has been made available to mPower to develop relationships, share learning and promote efficiency across services.

Examples of activities undertaken include:

- Professor Peter Gore of Newcastle University delivered a learning event on healthy ageing and the Life Curve to 167 people who work in health and social care
- A care coordinator in the Adult Social Work team provides an expert understanding of how health and wellbeing services can be utilised to support the work of the social work team

- A community navigator will be available weekly in Galloway Community Hospital and Newton Stewart Hospital to engage with people before they leave hospital
- Anticipatory Care Plans are being used as a tool to initiate conversations with people to support decision making around their future health and social care needs
- Links have been developed with the telecare team to offer a wellbeing plan to those people who have telecare installed
- Working with Southern Machars Community Centre Management Group to coproduce a digital hub that will allow Attend Anywhere clinics to be accessed in the community centre
- Working closely with pharmacy team to increase the uptake of the text messaging medication reminder service

9.2.2 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. The programme supports national policy in favour of community based services, reducing inequalities and supporting people to improve and manage their own health and wellbeing. This will allow people with more complex conditions to be nursed in the community rather than in hospital.

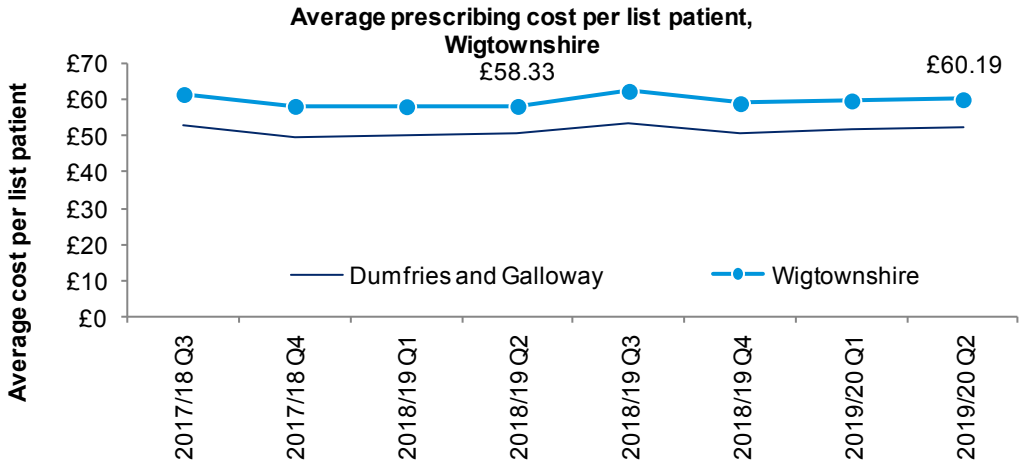
9.2.3 Pharmacy Hubs

Two pharmacy hubs in Stranraer and Newton Stewart opened in 2019 providing a 5 day service to the GP practices. These hubs have pharmacists, pharmacy technicians and pharmacy support workers. Also, local community pharmacies are much more involved in helping people take their medicines effectively, appropriately and safely. The value of this way of working means that the pharmacy team are located together, right in the middle of the GP practice team, so they can work more closely with the doctors and nurses.

9.3 How we are getting on

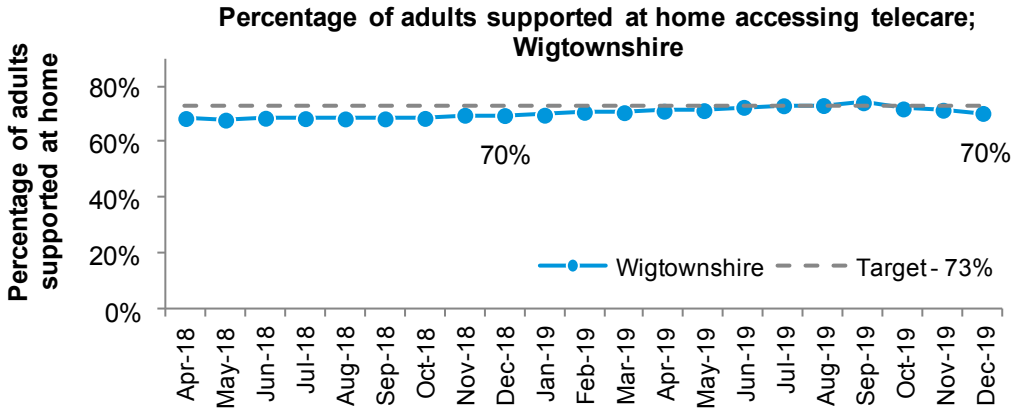
The Strategic Plan Adults Needs Assessment indicates that over 75% of the population receives a prescription at least once per year. In 2016/17 the annual cost per person ranged from £137 - £277 across the GP practices. This is partly because of the different mix of people they support. Wigtownshire costs per person are higher than 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 70% 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	Wigtownshire	Time Period	Dumfries and Galloway	Wigtownshire
Outcome 1	D23	Rate of Emergency Department attendances by locality of residence per 1,000 population	Sep 2018	24.4	38.6	Sep 2019	26.8	42.5
	D24	Rate of emergency admission by locality of residence per 1,000 population	Sep 2018	9.5	8.5	Sep 2019	9.0	8.3
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	774.6	Dec 2019	548.5	762.3
	A15 / E5	Proportion of last 6 months of life spent at home or in a community setting	2017/18	89%	88%	2018/19	89%	88%
Outcome 3	D2	Number of complaints received by the locality team (all stages)	-	-	-	2018/19	-	6

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	Wigtownshire	Time Period	Dumfries and Galloway	Wigtownshire
Outcome 4	C10	Percentage of people supported by SDS Option 1 or Option 2, under 65 years of age	Sep 2018	25%	26%	Sep 2019	24%	26%
	C11	Percentage of people supported by SDS Option 1 or Option 2, 65 years and older	Sep 2018	8%	7%	Sep 2019	9%	7%
	D25	Number of people with delayed discharge in all hospitals (Dumfries and Galloway Royal Infirmary, Galloway Community Hospital and Cottage Hospitals) by locality of residence	Dec 2017 - Nov 2018	628	79	Dec 2018 - Nov 2019	968	83
	D26	Number of bed days lost to delayed discharge by locality of residence	Dec 2017 - Nov 2018	14,622	2,530	Dec 2018 - Nov 2019	22,527	2,646
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	8	2017/18	41	13
Outcome 6	C5	Number of Adult Carer Support Plans developed within the locality	2017/18	-	22	2018/19	-	36

Source: ISD Scotland, HACE Dashboard

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

Locality Indicator			Previous Value			Current Value		
			Time Period	Dumfries and Galloway	Wigtownshire	Time Period	Dumfries and Galloway	Wigtownshire
Outcome 7	D27	Percentage rate of emergency re-admission to hospital within 7	Sep 2018	4.0%	3.0%	Sep 2019	4.5%	3.4%
	C9	Percentage rate of referrals to the Multi Agency Safeguarding Hub (MASH) acknowledged within 5 days	Oct - Dec 2018	69%	87%	Oct - Dec 2019	44%	46%
Outcome 8	D5	Proportion of people who agree that they have the information necessary to do their job	2017	80%	n/a	2019	79%	79%
	D21	Proportion of people who agree that they are involved in decisions relating to their job	2017	70%	n/a	2019	69%	76%
	D22	Proportion of people who would recommend their organisation as a good place to work	2017	74%	n/a	2019	74%	80%
Outcome 9	D28	Average prescribing costs per person for 3 months	Jul - Sep 2018	£50.60	£58.33	Jul - Sep 2019	£52.41	£60.19
	C1	Percentage of People With SDS Option 3,Supported with Telecare	Dec 2018	73%	70%	Dec 2019	73%	70%

Source: ISD Scotland, HACE Dashboard

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

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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