DUMFRIES AND GALLOWAY
INTEGRATION JOINT BOARD

HEALTH AND SOCIAL CARE ANNUAL PERFORMANCE REPORT

2016/17

Contents

Foreword

The Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) required Health Boards and Local Authorities to delegate the planning and delivery of certain adult health and social care services to integration authorities. On 1st April 2016 responsibility for the planning and delivery of health and adult social care services transferred to the Dumfries and Galloway Integration Joint Board (IJB). This document is the first annual report of the IJB reporting on the performance of the Dumfries and Galloway Health and Social Care Partnership (D&GHSCP) for those services delegated. It has been developed in line with the Public Bodies (Joint Working) (Scotland) Act 2014 and related guidance.

Through 2015/16, IJB developed its own strategic plan, the 'Integration Joint Board Health and Social Care Strategic Plan, 2016-2019'. This plan identifies the main challenges facing health and social care in the region and the priority areas for action. Planning health and social care in an integrated way, has given us an unprecedented opportunity to work innovatively with people to find new ways of delivering health and social care and support that are much more centred around the needs of individual, their families and Carers.

This first annual performance report of the IJB measures progress of against a range of indicators to enable people to see where progress has been made against the nine national health and wellbeing outcomes (please see page 6). Importantly, the indicators are qualitative as well as quantitative in nature to help us better understand people's experience of care.

From day one, we have recognised that the people of Dumfries & Galloway are our greatest asset and that it is only by working together that we will be able to overcome the challenges that we face to achieve the continued delivery of the highest quality care to people. I am delighted that we are able to provide so many examples of effective working together in this report. I am also pleased with the progress we are making to support the many Carers in the region. Their contribution to the delivery of care is recognised and greatly valued. Effectively supporting Carers will remain a priority area of focus going forward.

Whilst there is much to be proud of in this first annual report we acknowledge that there is still a great deal to be done. We continue to face ever more difficult financial and demographic challenges as we strive to make every aspect of care and support person-centred and as positive an experience of care as it can possibly be for every person and their families and Carers. I am confident that if we continue going forward together to meet these and overcome these challenges, we will achieve this.

Penny Halliday
Chair of Dumfries and Galloway Integration Joint Board (IJB)
July 2017

Introduction

The **Public Bodies (Joint Working) (Scotland) Act 2014 (the Act)** 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 Council and NHS to this new body.

Dumfries and Galloway Integration Joint Board developed a three-year strategic plan for health and social care (Strategic Plan 2016-19). This plan for the Dumfries and Galloway Health and Social Care Partnership (DGHSCP) was developed by consulting with, and listening to, people who use services, their families, Carers, members of the public, people who work in the statutory health and social care organisations and third and independent sector partner organisations. It sets out the case for change, priority areas of focus, challenges and opportunities and commitments over the next three years. The Strategic Plan 2016-19 can be accessed on the **DG Change website**.

The Strategic Plan 2016-19 states that the Integration Joint Board will make sure that integrated health and social care budgets are used effectively and efficiently to achieve quality and consistency and to bring about a shift in the balance of care from institutional to community based care (institutional based care is defined by the Scottish Government Information Services Division as “hospital based care and all accommodation based social care”).

Across Scotland, health and social care partnerships are responsible for delivering a range of nationally agreed outcomes. To do this will require the strengthening of the role of people who use services, their families and Carers, building the resilience of communities and being innovative about how care and support is delivered.

Over time, the progress against the Strategic Plan 2016-19 will be monitored and evaluated and this will be reported as ‘performance’ to the IJB. To ensure that performance is open and accountable, section 42 of the 2014 Act obliges partnerships to publish an annual performance report setting out an assessment of performance with regard to the planning and carrying out of the integration functions for which they are responsible.

This first annual performance report of the Dumfries & Galloway Integration Joint Board considers the progress of the DGHSCP against nine national health and wellbeing outcomes and the commitments within the Strategic Plan 2016-19 (sections 1 to 9). Section 10 of this report considers the financial performance of the partnership. An update of progress within each of the four localities is available in Section 11. The remaining sections report the results of any inspections in 2016/17, any Significant Decisions made by the IJB (i.e. decisions that lie outwith the context of their strategic plan) and any review of the Strategic Plan. (Appendix 1 includes a summary of the 23 National Core Indicators for Integration.)

Throughout this report, figures are reported for the financial year 2016/17 where available; earlier time periods have been used where this is the most current information available.

The Nine National Health and Wellbeing Outcomes

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

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

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

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

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

Health and social care services contribute to reducing health inequalities

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

People using health and social care services are safe from harm

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

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

The nine national health and wellbeing outcomes set the direction of travel for service delivery in the Health and Social Care Partnership and are the benchmark against which progress is measured.

1. Outcome 1

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

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

There is a wide range of initiatives across the Partnership intended to help people to improve their own health and wellbeing. These initiatives aim to bring a more holistic approach to improving wellbeing that supports people to improve many aspects of their lifestyles to build their level of personal resilience.

Our commitments:

- We will support more people to be able to manage their own conditions, and their health and wellbeing generally
- We will support people to lead healthier lives
- We will develop, as part of a Scottish Government initiative, online access to information and tools to give people the power to take responsibility for their own care

Year One Key Achievements:

- restructuring of health and wellbeing teams
- embedding 'Good Conversations' across the Partnership
- continuing development of social prescribing initiatives

Challenges:

- supporting as many people as possible to look after their own health and wellbeing so that the health of the population is improved
- embedding self management approaches into mainstream practice
- communicating with people to raise awareness of the range of community support that is available

1.1 Health and Wellbeing Teams

Each locality has a health and wellbeing team that works with individuals and communities, building on the capability of the individual or group to develop resilience and encourage change when appropriate. These teams have recently been restructured to make better use of locality resources.

Some examples of support delivered by health and wellbeing teams include courses on 'Mindfulness', 'Living Life To The Full' and the 'Steps' mental health initiative. These approaches help to reduce people's feelings of anxiety, stress and low mood, thereby improving and maintaining mental wellbeing. The courses are also open to Carers and health and social care staff, including partners in the third and independent sectors.

The health and wellbeing teams also support volunteers to run their own community initiatives and collaborate with partners to develop innovative programmes that encourage and support people to look after themselves better.

A partnership between health and wellbeing teams, Police Scotland and local driving instructors in Dumfries & Galloway has launched the 'Safer Wheels Mature Drivers Scheme'. This scheme offers people over the age of 65 a private driving lesson with a local instructor. The instructor provides the person with advice and information to help improve their confidence to support them to keep driving for longer and to stay safe on the roads. Initiatives such as this can also help to reduce social isolation.

1.2 Good Conversations

People providing health and social care are undertaking 'Good Conversations' training. 'Good Conversations' promotes a culture where the person being supported is actively encouraged to be in control and take responsibility for their own health. This training focuses on building the confidence of health and social care professionals to hold conversations that are focused on achieving outcomes.

95% of adults surveyed reported that they are able to look after their health well (Scotland 94%)

Health & Social Care Experience Survey (2015/16)

The Health and Social Care Experience Survey (2016) showed that a high proportion of the general public felt they were able to look after their own health.

1.3 Social Prescribing

A good example of changing the way people think about how to improve their health and wellbeing is called social prescribing. Social prescribing can be an alternative to, or an addition to, traditional medical solutions. People are supported by GPs and others to identify personal outcomes and are signposted to local resources that may be helpful.

Healthy Connections is an initiative based on a social prescribing model. It provides lifestyle clinics, often in GP practice settings, on a one-to-one or a group basis and works closely with a range of third and independent providers. Healthy Connections also supports people to identify their own personal outcomes. Onward referrals are routinely made from Healthy Connections to the Carers Centre, Financial Inclusion Team, Visibility Scotland and Capability Scotland.

In Wigtownshire, health and social care staff are working together to support people with complex health conditions to reduce their dependence on emergency department attendances at the Galloway Community Hospital

Community Respiratory Early Warning System (CREWS) is a telehealth tool being piloted in Annandale & Eskdale. CREWS supports people with chronic lung disease to manage their own condition, enabling them to live at home as independently as possible.

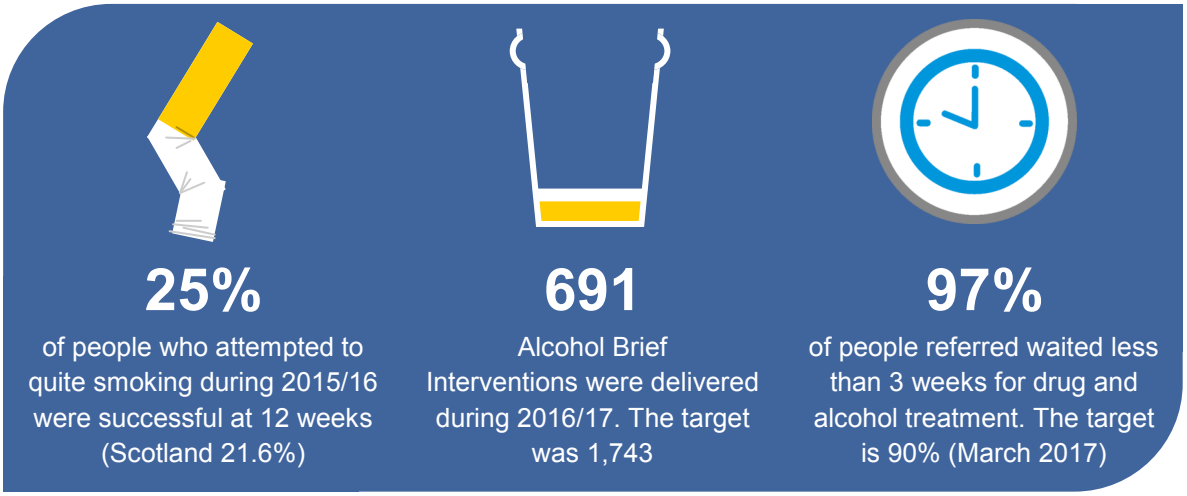
Work in localities has focussed on exploring with local communities ways of developing initiatives or using assets differently to meet identified needs. For instance, examples from Annandale & Eskdale included the Powfoot Lunch Club, a 'Men's Shed', Tea & Tennis and a 'Knit & Natter' group in an Annan Care Home. Other activities include First Aid training and 'Let's Motivate', a physical activity project.

Feedback from people using these services indicates that this type of low level support can make a huge difference to people's lives by reducing loneliness and connecting people back into their community.

Mental health practitioners are working with GP practices to help people with distress or moderate psychological difficulties to access a wide variety of mental health-enhancing activities and third sector resources. There are two pilot projects in Dumfries & Galloway working across several GP practices. These pilot projects enable people with more complex mental health needs to be seen earlier and more easily by specialist services.

Cree Valley Community Council has funded a new initiative called 'Login & Connect'. People can bring their own electronic devices and get support and advice on how to use them and how to stay safe.

There are a number of initiatives that specifically target behaviours that impact on health and wellbeing. Below are some performance indicators that illustrate how the Partnership supports people to improve behaviours relating to smoking, alcohol and drug use.



NHS Dumfries & Galloway (2017)

The initiatives for smoking cessation and drugs and alcohol waiting times have successfully met the targets set for the latest reported time period.

It has been challenging to deliver enough alcohol brief interventions (ABIs) in the last year. There has been agreement that people working in smoking cessation and criminal justice will also support the delivery of ABIs. The recording issues in hospital emergency departments, which were a barrier to recording ABIs properly, are being addressed.

1.4 Falls Prevention

Physical exercise that encourages strength and balance can have a very positive impact on preventing falls.

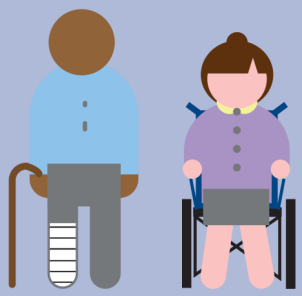
'Let's Motivate' is an innovative project led by Dumfries & Galloway Council's Leisure and Sport Service in partnership with NHS Dumfries & Galloway. This unique project aims to embed opportunities for physical activity in a sustainable way within care homes and community settings including day centres. Training sessions are provided to people working with older adults so that they can introduce safe and inclusive physical activity for the people they support.

In Wigtownshire, Tai Chi is offered in GP practice and day centre settings in Stranraer. Gentle exercise to music ('Dancercise') is offered to people with limited mobility at the Newton Stewart Activity Resource Centre to help support the prevention of falls.

During 2016/17, the number of falls for every 1,000 people aged 65 years or older was

15

(Scotland: 21)



ISD Scotland (2017) (provisional)

"Dancercise has helped on all levels, my mobility has improved and I have made new friends. As well as the exercise, we have a laugh & coffee afterwards. It gives me a purpose to get up and get moving. I really look forward to the class."

Wigtownshire, 2017

"What impressed me most was the way in which the [podiatry] assessment was translated into wearing a pair of orthoses [shoe splints] in 24 hours. Fast track private treatment could not have been any better or efficient. Many thanks for such wonderful service."

NHS Dumfries and Galloway Podiatry Department Survey 2016

2. Outcome 2

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

In the future, people's care needs will be increasingly met in the home and in the community, so the way that services are planned and delivered needs to reflect this shift.

There are a number of ways that the Partnership is working towards enabling people to live as independently as possible in a homely setting. During the financial year 2016/17, work concentrated largely on five main areas of development: integrated models of care and support, developing and strengthening communities, volunteering, care at home and care homes and housing. (Technology enabled care is discussed under Outcome 9.)

Year One Key Achievements:

- developing the 'One Team' approach where partners work together collaboratively to support people in their communities
- implementing the Scottish Living Wage across the Care at Home and Care Home sectors to improve recruitment and retention in these services
- building on the existing strengths and assets of people and their communities to improve resilience

Challenges:

- challenging the cultural barriers that prevent the delivery of effective person-centred care
- shifting care and support from institutional to community based settings
- shifting the approach from managing crises to preventative and early intervention support

2.1 Integrated Models of Care and Support

Our commitments:

- We will adopt re-ablement as both a first approach and as an ongoing model of care and support
- We will work to identify people who have an increased risk of reaching crisis and take early steps to avoid this
- We will deliver healthcare in community settings as the norm and only deliver it within the district general hospital when clinically necessary

A re-ablement approach means supporting people to achieve their best possible level of independence. The multi-professional Short Term Assessment Re-ablement Service (STARS) works with people at home to improve daily living activities and renew self confidence. STARS also supports people to get home from hospital and back to daily living sooner, reduce dependency on care and support and help prevent further admissions to hospital.

There were a number of new initiatives involving STARS during 2016/17:

- Re-ablement awareness training has been developed for providers of care and support. STARS have also worked in partnership with Dumfries & Galloway College to deliver an accredited qualification in re-ablement. This course is helping to embed re-ablement principles into learning and development for staff employed by care providers and also in other learning environments (e.g. 1st year nursing, college learners and S5/6 high school students).
- Allied Health Professionals (AHPs) collaborate within the Emergency Department, the Acute Medicine Unit and involve STARS where appropriate. This helps to avoid unnecessary admission to hospital, enable a home assessment to be undertaken and return people safely home supported by re-ablement.
- STARS now routinely collaborates with discharge managers and flow co-ordinators in hospital to use re-ablement as a primary approach in supporting people to be discharged in a timely manner. This has been implemented within Dumfries and Galloway Royal Infirmary (DGRI) as well as Thornhill, Kirkcudbright and Castle Douglas cottage hospitals. These combined efforts are contributing to fewer people being delayed in hospital.
- There is an assessment tool to help identify people's personal outcomes called IoRN2 (Indicator of Relative Need). IoRN2 was developed specifically for integrated community teams across re-ablement services, intermediate care and housing. STARS is leading on the national test with NHS National Service Scotland to embed this tool into routine practice, which will help to evidence how effectively people's outcomes from re-ablement are met.

The 'Just Checking' re-ablement insight tool is a web-based assessment tool that support professionals in completing objective, evidence-based re-ablement assessments. Social Work, Telecare and STARS now use this tool.

Another new model of care and support being developed across Dumfries & Galloway is the 'One Team' approach. 'One Teams' bring together multi-disciplinary health and social care staff to work collaboratively with partner organisations to better co-ordinate people's care and support, reduce duplication of effort and improve outcomes for people.

An example of this approach is the shared mapping of cottage hospital pathways to identify areas of duplication, test new ways of working and assess training needs that was undertaken in the Stewartry.

The early positive outcomes from the One Team approach include:

- more opportunities for learning that support a new shared workplace culture
- better identification of Carers through the shared One Team discussions reported by Annandale & Eskdale
- more timely and seamless discharge processes resulting in people getting home from hospital with fewer delays, through the introduction of Flow Co-ordinators

86% of adults surveyed agreed that they are supported to live as independently as possible (Scotland 84%)

Health & Social Care Experience Survey (2015/16)

2.2 Developing and Strengthening Communities

Our commitments:

- We will work with people to identify and make best use of assets to build community strength and resilience
- We will actively promote, develop and support volunteering opportunities
- We will strengthen public involvement at all levels of planning health and social care and support

The new integrated models being developed will support people to build on their personal strengths and the strengths in their communities. This is called an 'assets-based' approach. This way of working encourages partnerships to listen to what people say matters to them. It also means involving people in decision-making, so that they can help shape and influence what care and support looks like in the future.

Here are a few examples of community partnerships in action:

- Two communities in Stewartry, Auchencairn and New Galloway, are building health and wellbeing into their existing emergency and resilience plans. These plans centre on the use of local assets and now include activities such as 'Living Well' screenings, early intervention occupational therapy clinics, larger building developments and asset transfer schemes.

Time-banking is a community initiative that supports people with everyday tasks. Time bank members report feeling less isolated and more involved in their communities giving them a real sense of purpose.

- In Nithsdale the success of the Men's Shed project, a project for men of all ages to increase social contact, reduce isolation and improve mental wellbeing, has led to the development of a Men's Shed network. Two Men's Sheds are already up and running in Nithsdale, and another two are planned, including one specifically for men to attend with their Carers.
- In Annandale & Eskdale a wide range of dementia initiatives and training is supporting the development of 'Dementia Friendly Communities'.
- The Day Opportunity Fund supports a range of community groups and activities helping to reduce isolation and promote independence (e.g. Allanton Community Garden, Summerhill Lunch Club).

Auchencairn is part of the national pilot of the Place Standard tool. This tool can be used to evaluate the quality of a place, help to identify priorities and strengths and enable resources to be targeted to where they are needed most.

2.3 Volunteers

The value of volunteers to communities is well documented, as are the benefits of volunteering to the individual. There is evidence that volunteering can improve wellbeing, increase confidence and strengthen someone's links with their community.

In the last year, NHS Dumfries & Galloway has been looking at a range of new volunteer opportunities, refreshed induction training and has agreed to test a different way of working. A feasibility study into the volunteer model for the new district general hospital has been completed.

Food Train has been commissioned to deliver a project across Stewartry befriending vulnerable older people.

The Volunteering Steering Group is revisiting the Volunteering Policy and Strategy and undertaking the self assessment element of renewing the Investing in Volunteering award, demonstrating good quality of practice in managing volunteers.

Volunteers in Stranraer lead a Tai Chi programme providing them with opportunities to develop their practical and facilitation skills.

2.4 Care at Home and Care Homes

Supporting people to live at home or in a homely setting through care at home (personal care provided by a paid carer in someone's own home) and care homes is critically important to the delivery of health and social care.

Our commitments:

- We will work with providers to support them to pay the national living wage
- We will identify with partners and people who use services, models of care at home and care home provision that deliver improved outcomes for people

The challenge is to make sure that appropriate levels of care and support are available to meet an increasing level of need in the context of limited public finances and available workforce. To achieve this, a programme of work involving all partners has been set up to review both care at home and care homes across Dumfries & Galloway.

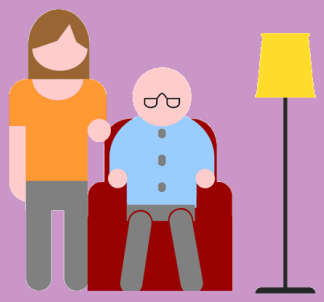
Despite the financial challenges, the Partnership successfully implemented payment of the Scottish Living Wage across the care at home sector for adults and older people in Dumfries & Galloway in 2016. This has directly improved the terms and conditions for approximately 1,800 care workers. This exceeded the Partnership's commitment to implementing the National Living Wage.

Pay levels for care staff in care homes for older people was maintained at The Scottish Living Wage through continued sign up to the terms of the National Care Home Contract for Older People by all providers in Dumfries & Galloway.

The process for engaging and involving care providers in Annandale & Eskdale has been streamlined by the introduction of an Independent Providers Forum. This has been set up in partnership with Scottish Care.

65%

of all adults with long-term care needs receive support at home (Scotland: 62%)



Scottish Government (2016)

2.5 Housing

Appropriate housing is critical to the success and continued sustainability of health and social care and support.

Our commitments:

- We will combine the information from the **Housing Need and Demand Assessment (HNDA)** with the **Strategic Needs Assessment (SNA)** to help us with planning
- We will develop housing related services and new affordable housing that is designed to reduce both unplanned admissions to hospital and the number of people unnecessarily delayed in hospital

A Housing and Health Needs Assessment was commissioned and commenced in 2016/17. The aim of this assessment is to bring together current knowledge to identify key priorities and actions required to ensure living conditions and housing support people's health and wellbeing. This work will inform ongoing developments in supported accommodation.

Access to appropriate housing for the most vulnerable people is a key priority for the Partnership. A multi-agency approach supports the goal of having modern and affordable 'life time' homes. These homes optimise the use of equipment and adaptations based on people's changing needs. This supports people to stay in their own home or in a homely environment for as long as possible.

Case Study:

Making the Move from Care Home to Supported Accommodation

In partnership with residents, families, housing, social work and social care, a registered care home with shared facilities and living environment supporting people with complex health and social care needs for 30 years, was de-commissioned in September 2016.

As people's needs changed, it was recognised that a more modern and adaptive property could better promote the independence of the people living there. This move from a care home model of care to a one of supported living means that people are now tenants in their own home. This model enables the delivery of more personalised support, giving people greater control over their own lives.

A recent evaluation (Jan/Feb 2017) carried out with Welfare Guardians (family members), support staff and Social Work, demonstrated that people were supported to move safely, successfully and smoothly and families were supported to manage any anxieties. After the move the overall reaction by family and staff was a positive one. One family member stated: "*It is exactly what is needed. I can't think of anything that could be better.*" A staff member told us "*It has been positive in every way".*

(School Close Development, Kirkcudbright).

A Strategic Housing Development Forum meets as a multi agency partnership to identify housing needs and priorities across the area.

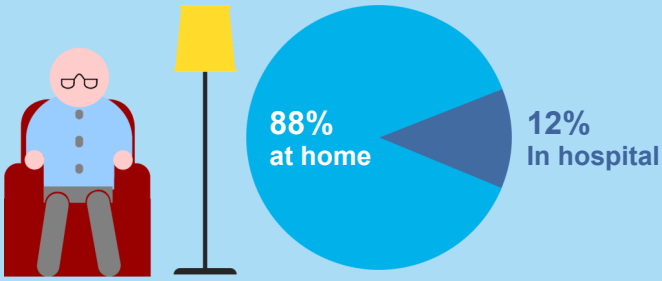
The Partnership is piloting a trial housing lead officer role to facilitate stronger cohesive working in housing development. This role brings together best practice, innovation and structured project planning to ensure that opportunities for new housing developments realise their full potential.

Loreburn Housing Association, local businesses and health and social care partners opened a 'Pop Up House' in Stranraer to showcase telecare equipment and other equipment and adaptations available to support people living with dementia, sensory impairment and frailty. People were able to see how these enablers can support independent living, investigate the equipment costs and where to purchase them.

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

88%

of their time at home or in a homely setting. (Scotland: 88%)



ISD Scotland (2016/17) (provisional)

3. Outcome 3

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

There is a range of ways that people are able to give feedback about their experiences of health and social care. Feedback may come in the form of comments, responses to surveys, consultations and complaints.

The Partnership uses this feedback to continually improve services and help those providing health and social care to understand and respect the views of the people they support.

A critical part of ensuring services are person-centred and respecting people's dignity is planning a person's health and social care with the person, their family and Carers, identifying 'what matters to them'.

Our commitments:

- We will use feedback from people to develop new approaches to delivering outcomes
- We will work to overcome barriers to people involved in their own care
- We will make sure that people have access to independent advocacy if they want or need help to express their views and preferences
- We will make sure that effective and sustainable models of care are tested and implemented prior to transition from the current DGRI to the new district general

Year One Key Achievements:

- there is now a combined feedback website for health and social care called Care Opinion
- members of the public can 'sign up' for alerts about participation and engagement opportunities
- increased dementia awareness training for people providing health and social care

Challenges:

- ensuring that learning from health and social care complaints, comments and other feedback lead to quality improvement
- ensuring that changing models of health and social care delivery are person-centred
- ensuring everyone who would benefit from an anticipatory care plan has one

3.1 Understanding People's Experience

The national Patient Opinion website that enables people to send comments to those providing healthcare has been expanded to include social care and is now known as **Care Opinion**. People can make comments on all aspects of health and social care and help those planning and delivering services to understand their views.

"Our [mother], who is undergoing chemotherapy, recently took ill when visiting and was seen within four hours, despite not being registered at the practice. Fantastic accessibility and a genuine willingness to put people first."

Annandale & Eskdale 2016

"I am [age removed] years old, and have worked all over the world. This is the best GP surgery we have ever had. They and DGRI, Dumfries, have saved my life at least twice."

Stewartry 2016

A Participation and Engagement Network (PEN) has recently formed to provide opportunities for people in Dumfries & Galloway to have their say in the development, design and delivery of services. The PEN enables members of the public to 'sign up' for alerts about local consultation and engagement activities.

85%

of adults surveyed rate the care or support they receive as 'excellent' or 'good' (Scotland 81%)

Health & Social Care Experience Survey (2015/16)

91%

of adults surveyed reported having a positive experience of care provided by their GP practice (Scotland 87%)

Health & Social Care Experience Survey (2015/16)

In addition to Care Opinion, working with computer programming students from the University of Glasgow, an 'app' has been developed that will enable the Health and Social Care Partnership to ask people about aspects of their experience. Questions might include:

- was the communication good?
- did services seem well coordinated?
- was the information they needed easy to find?
- overall, how satisfied were they?

The app will be piloted over the coming months to make sure people find it easy to use.

3.2 Complaints

The Scottish Public Services Ombudsman recently published a new complaints handling procedure for both Social Work Services and the NHS, bringing these different procedures in line with each other. Implementing these procedures from 1 April 2017 will help provide an improved experience for people making complaints and ensure an increased focus on the lessons that can be learned.

New software to help NHS and Social Care managers understand the patterns in complaints and comments has been tested locally and shows promising early results. This software will be used in the new complaints system

A scoping exercise in Stewartry has led to an action plan for delivering day care services. Three key themes were identified: respite issues, post-diagnostic support for people with dementia and the effective use of resources.

3.3 Raising Awareness of Dementia

In order to ensure that the people providing health and social care continue to develop their understanding and awareness of the people they support, ongoing training is a core commitment of the Partnership.

'Dumfries and Galloway Dementia Friendly Communities' is an initiative that started in March 2015 involving people with dementia, Carers, NHS Dumfries & Galloway, Dumfries & Galloway Council, and Alzheimer's Scotland. Work in the initiative is supporting, empowering and involving people affected by dementia so that, regardless of where they live, they feel valued, understood and part of a supportive community.

Dementia Champions are committed to supporting people living with dementia, their families and Carers through promoting an enabling approach. The Short Term Assessment Re-ablement Service (STARS) has embedded Level1 and Level 2 dementia training for all re-ablement staff. This is also embedded in training for all care and support staff within the Care and Support Service (CASS), the Dumfries and Galloway Council in-house care at home service.

- The Dementia Awareness Fayre was held in May 2016 starting a week of events, run by Alzheimer Scotland, promoting dementia awareness
- Alzheimer Scotland has been delivering dementia friendly training to a wide range of health and social care staff
- The Dementia Newsletter is widely circulated four times a year containing information about local services

All levels of healthcare staff are progressing through the Interventions for Dementia, Education, Assessment and Support (IDEAS) team training. This is in line with the local policy and strategy for meeting the National Dementia Strategy and 'Promoting Excellence' Framework. This training helps to support staff to manage behaviours that are challenging. For people with dementia this will lead to improved support and reduced dependency on anti psychotic drugs.

3.4 Anticipatory Care Planning

People are becoming more aware of the importance of taking an approach to planning that anticipates future needs. This enables earlier, lower level interventions to be implemented to help avoid a person, a family or a Carer reaching a point of crisis. This is anticipatory care planning. Anticipatory care planning also enables people to express and record their wishes with regard to care and support, making these known to those providing services when needed.

82%

of adults surveyed agreed that they had a say in how their help, care or support was provided (Scotland 79%)

Health & Social Care Experience Survey (2015/16)

An important part of anticipatory care planning is for the process to be person-centred, respecting people's dignity and understanding what matters to them. It is therefore important to ensure that planning a person's health and social care and support is a shared activity between the health and care professional and the person, and where appropriate, their families and Carers.

In Annandale & Eskdale anticipatory care plans are known as Forward Looking Care Plans. These plans stay with the individual. Feedback from people with a plan in place has been very positive and people say they feel listened to, better able to manage their health conditions and have peace of mind.

Dumfries & Galloway Partnership has one of the highest proportions of people with an electronic Key Information Summary (eKIS) in Scotland. The eKIS is a collection of information that GP practices can, with people's consent, share with other services such as out of hours services and ambulance crews.

Social work staff have recently attended training where they were mobilised and hoisted using different apparatus. This enabled staff to experience firsthand what it is like for a person on the receiving end of care.

3.5 Advocacy

In the last year, over 600 people in Dumfries & Galloway were supported by independent advocacy. Independent advocacy helps people have a stronger voice and to have as much control as possible over their own lives. The advocacy provided included support to people with a mental health disorder as defined by the 'Mental Health and Care Treatment Act' 2003 and other vulnerable people. A review of independent advocacy for the area is currently being undertaken to provide an up to date Independent Advocacy Plan for Dumfries & Galloway.

"I have worked in many areas of the country and am very impressed with the service offered by D&G Advocacy; supportive and understanding, provided an excellent service".

Dumfries & Galloway Advocacy feedback. 2016/17

People using the independent advocacy service are complimentary about the support they receive to access services across the Partnership, in particular the help given around the court process for guardianships.

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."

The **Social Care (Self-directed Support) (Scotland) Act 2013** puts people in control of the design and delivery of their care and support. Through supported self-assessment the person can develop a personal plan with clear outcomes. Personal planning includes identifying the resources available from the person and their family and community networks as well as any need for input from health, social work or other agencies to support the achievement of the identified outcomes. More information about Self-directed Support can be found on this website: **www.selfdirectedsupportscotland.org.uk/**

Our commitments:

- We will enable people, especially vulnerable adults and those important to them, to decide their own personal outcomes
- We will change the focus of contracting from specifying levels of input activity to delivering health and wellbeing outcomes for people
- We will provide opportunities and support for people to develop and review their own forward looking care and support plans
- We will develop an online learning tool that enables staff across the Partnership to have a better understanding of self directed support and embed it in practice
- We will measure performance against good practice from elsewhere and encourage and support new ideas locally

All purchased care and support in Dumfries & Galloway is arranged via Self-directed Support (SDS). Where purchased care and support are required, there are different options for people to choose from. The Partnership aims to help people to move towards SDS options that give them increased control over their care and support. The different options support varying levels of control for the person.

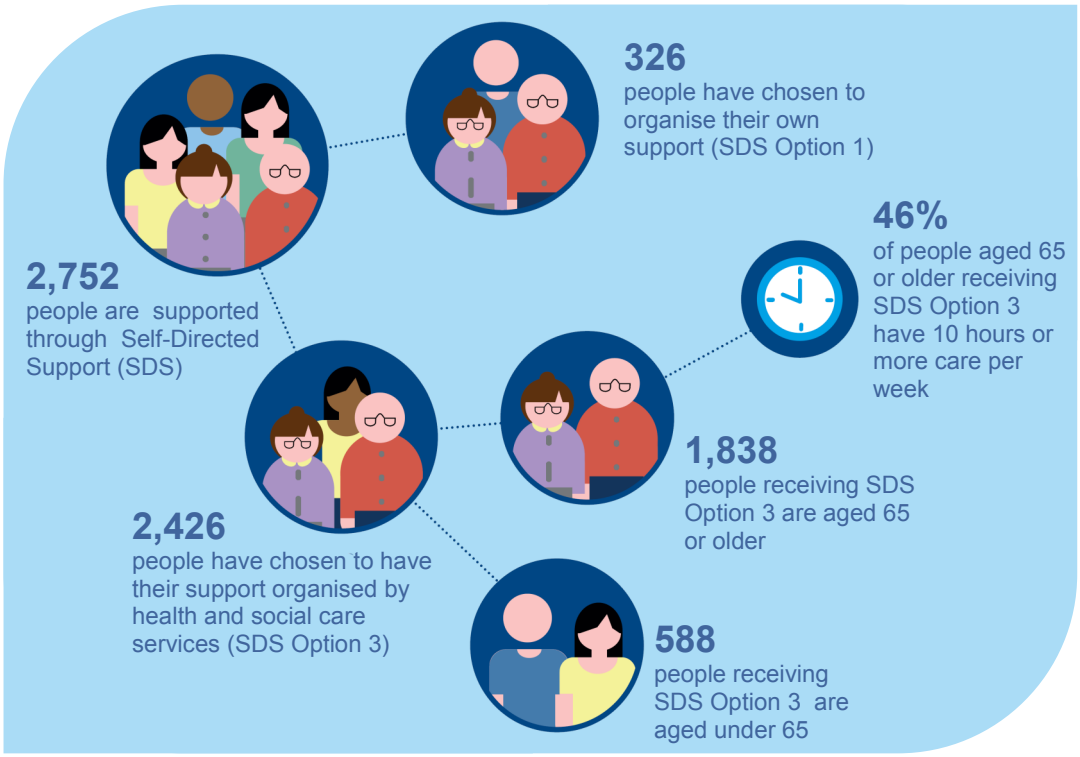
- SDS Option 1 is where people take ownership and control of purchasing their own care and support
- SDS Option 2 is where people choose the organisation they want to be supported by and the local authority transfers funds to that organisation who then arrange care and support to meet their agreed needs and outcomes
- SDS Option 3 is where social work services organise and purchase care and support for people
- SDS Option 4 is a mix of any of the above

82%

of adults supported at home agree that their health and social care services seemed well co-ordinated (Scotland 75%)

Health & Social Care Experience Survey (2015/16)

This graphic illustrates the number of people accessing social care and support through different SDS options and shows which options are currently being followed (snapshot at 31st March 2017).



Dumfries & Galloway Council (31 March 2017)

Implementing SDS legislation promotes choice, control, dignity and respect for people accessing social work support and care. In some areas, there is a lack of available personal assistants and work is ongoing to support the development of these roles.

Year One Key Achievements:

- staff in the health and social care sectors have been up-skilled via a new training package to help people understand the Self-directed Support Options. This will help staff to better support people to make the choices that are right for them
- an online learning tool is in the final stages of testing. There are plans to roll this out during 2017
- development of SDS Champions within social work services to support the ongoing cultural change for staff in promoting choice and control
- a personal outcomes approach is being embedded across the Partnership, based on the 'Good Conversations' personalised approach in social work and realistic medicine (see Outcome 9)
- more people are having choice and control over their own care which is shown by the steady increase in the number of people choosing SDS Option 1

Challenges:

- establishing SDS Option 2 across Dumfries & Galloway
- the implementation of the personal outcomes approach across the whole system
- the continued change in culture to shift choice and control in favour of the people accessing care and support

4.1 Outcome Focussed Commissioning

To support people, especially vulnerable adults and those important to them, to take part in deciding their own personal outcomes, an outcome focused tool has been developed. This tool guides those providing and using care through the process of defining personal outcomes and then through a review process to assess how far these outcomes have been achieved.

87%

of adults surveyed agreed that their services and support had an impact on improving or maintaining their quality of life (Scotland: 79%)

Health & Social Care Experience Survey (2015/16)

The Partnership continues to work towards a personal outcomes based commissioning approach, with a shift from block purchasing (for groups of people) to spot purchasing (for individuals). The shift to outcomes focus will be further supported by the implementation of SDS Option 2.

People delivering care are learning from **'Eileen's Story'**: a DVD created with the help of a person who is supported by care services, illustrating how a different approach, that focussed on outcomes, has enabled her to make significant improvements in her health and wellbeing.

4.2 Changing the Balance of SDS Options

To help people move towards greater choice and control of their own care and support, a better understanding of the options available to people is being embedded across the Partnership. People who provide health and social care have been given training and support to help them have informed discussions with people accessing care and support.

Work is underway to introduce SDS Option 2. Workshops with care providers across the area have guided the development of Dumfries & Galloway's approach. Innovative approaches to delivering Option 2 have been co-produced with two providers in Nithsdale. As in the rest of Scotland, it has taken some time to establish how Option 2 will work within Dumfries & Galloway. However, the work over the past year, including the development of a service specification and practice guidance for staff, has set strong foundations for implementation in 2017.

'Pets As Therapy' volunteers visit local care homes and the Activity Resource Centre in Newton Stewart. This initiative enhances people's quality of life by providing companionship to help tackle loneliness and provides animal assisted interventions as part of a holistic approach to treatment.

4.3 Improving the Physical Health of People with Mental Health Needs

To improve the quality of life for people with mental health needs, mental health practitioners support individuals to access a range of other health services. For instance, support for physical health changes that may result from eating disorders, or potential side effects of medications. People with a learning disability are supported to access health services, including reasonable adjustments made to services to facilitate access or provide more appropriate support to meet individual's needs.

A two year pilot project that promotes physical health monitoring for individuals who have a range of enduring mental health diagnose was designed and began in late spring 2017 in two localities in Dumfries & Galloway.

All people admitted to mental health services receive a physical health check within 24 hours of admission and have a physical health action plan to support recovery.

To promote healthier food options, a new community run café has been set up at Midpark Acute Mental Health Hospital. The co-location of occupational therapy and dietetics services at Midpark Hospital also promotes healthy lifestyle choices. Partnerships with local sports groups such as the Greystone Foundation help to promote physical health through the delivery of the ‘Exercise to Happiness’ agenda.

5. Outcome 5

"Health and social care services contribute to reducing health inequalities."

Health inequalities occur as a result of wider inequalities experienced by people in their daily lives. These inequalities can arise from the circumstances in which people live and the opportunities available to them. Reducing health inequalities involves action on the broader social issues that can affect a person's health and wellbeing, including education, housing, loneliness and isolation, employment, income and poverty. People from minority communities or with protected characteristics (e.g. religion or belief, race or disability) are known to be more likely to experience health inequalities.

The Strategic Plan highlights that inequalities must be considered in the planning stages of services and programmes to make the most of their potential for contributing to reducing inequalities.

Our commitments:

- We will develop a health inequalities action framework aimed at reducing health inequalities
- We will share learning about health and care inequalities, including their causes and consequences, and use this information to drive change
- We will reduce, as far as possible, the effect of social and economic inequalities on access to health and social care

Year One Key Achievements:

- The development of an Inequalities Action Framework and Toolkit
- the endorsement of the Inequalities Action Framework by key management teams across Dumfries & Galloway
- delivering multiple initiatives across Dumfries & Galloway aimed at reducing inequalities (such as cancer screening, smoking cessation and suicide prevention work)

Challenges:

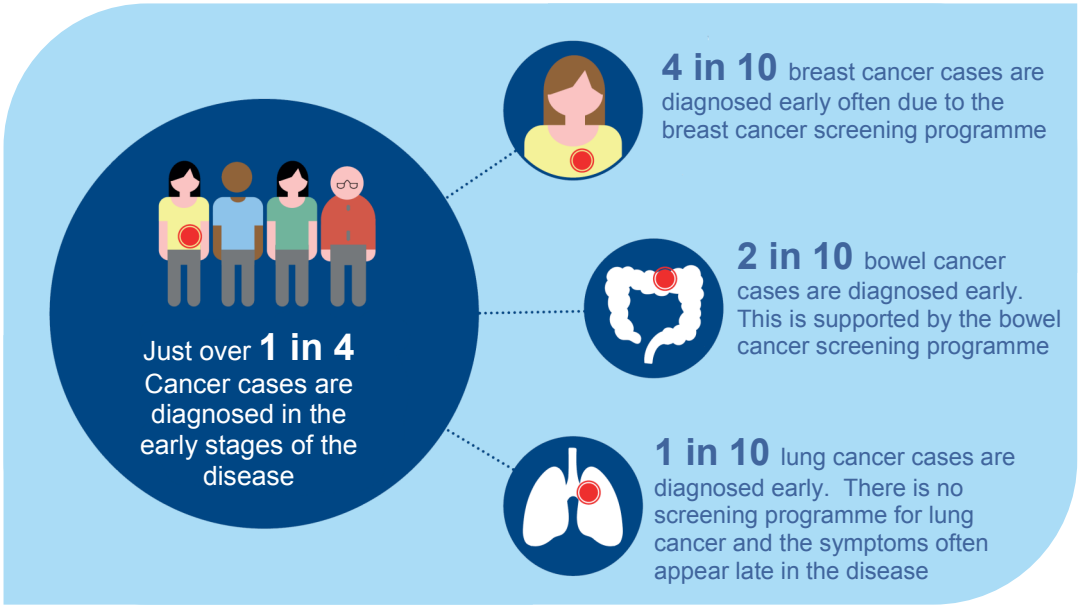
- embedding the use of the Inequalities Action Framework across the Partnership
- agreeing ways to collect data and measure the impact of changes to health and social care services on health inequalities
- improving how services support people to prevent, undo or mitigate against the causes of inequality

5.1 Inequalities Action Framework

Public Health has led on the development of the Inequalities Action Framework and Toolkit which has been endorsed by the NHS Board Management Team, Community Planning Executive Group and Health and Social Care Management Team. This framework supports the development of policies, programmes and services by providing information and tools to help address inequalities, including health inequalities.

Reducing inequalities is a core priority for the Health and Social Care Partnership. Inequalities training workshops are planned for 2017 to ensure a consistent understanding of inequalities and how to use the Inequalities Action Framework.

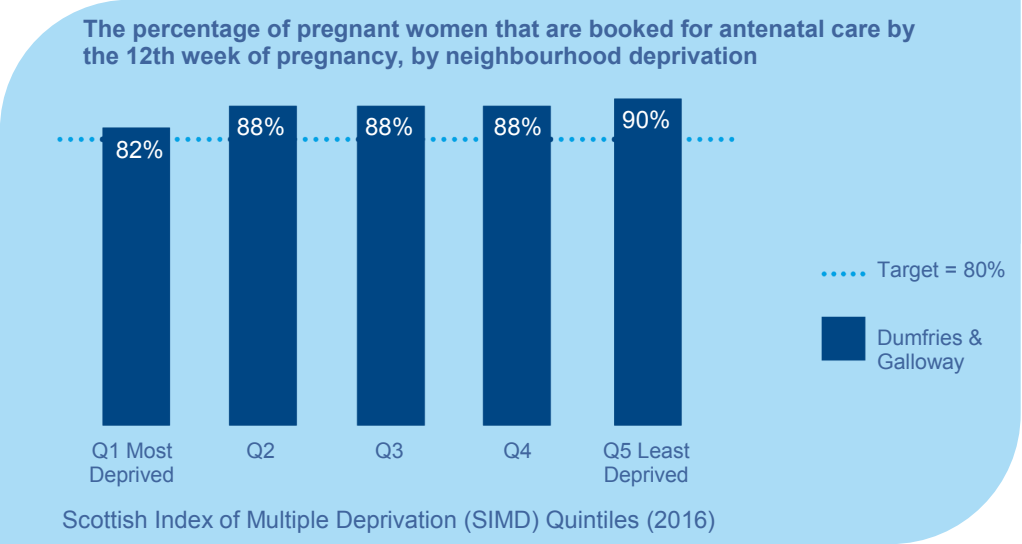
5.2 Early Intervention



ISD Scotland (2016). The Scotland target is for 1 in 3 cancer cases to be diagnosed early.

One way that inequalities can be seen to translate into health inequalities is in the likelihood of developing cancer because some of the risk factors, such as smoking, are more common in less affluent communities. The Partnership aims to reduce these inequalities by funding prevention and early intervention initiatives such as smoking cessation services and screening services to detect cancer as early as possible.

Supporting women early with antenatal (pregnancy) care is also important. There is evidence that the women at highest risk of poor pregnancy outcomes are those less likely to access antenatal care early. In 2015/16, Dumfries & Galloway performed well against the target to ensure that women from all communities are equally likely to be seen within 12 weeks of becoming pregnant.



ISD Scotland (2015/16)

5.3 Community Link Programme

In Annandale & Eskdale the Community Link Programme engages with people who often don't feel able to engage with health and social care services. The support from a Community Link Worker can help people to:

- raise their level of confidence
- reconnect with their local community and
- take back control of their lives

This programme also enables people to access a wide range of services including housing, transport and finance. This in turn, supports people to take the first steps towards improving their own health and wellbeing. Most of the people referred to a Community Link Worker are experiencing inequalities. The Community Link Workers are working with the One Teams and Safe and Healthy Action Partnership (SHAP) to ensure those in greatest need are able to access health and social care services.

5.4 Inequality and Mental Health

People experiencing health inequalities can be at higher risk of poor mental health (and vice versa). There are a number of projects underway to help address this aspect of health inequalities.

- Last year 350 people attended training programmes that provide suicide intervention skills to frontline staff and community members. The aim is to improve people's understanding of suicidal behaviours and improve access to help and support.
- A multi-agency suicide review process is being developed to better understand the factors that influence suicides amongst people from Dumfries & Galloway. Data collection processes and information pathways have been refined. Work is ongoing to establish information sharing agreements between partner agencies. The learning from this review should help identify additional information on factors that influence mental health inequalities.

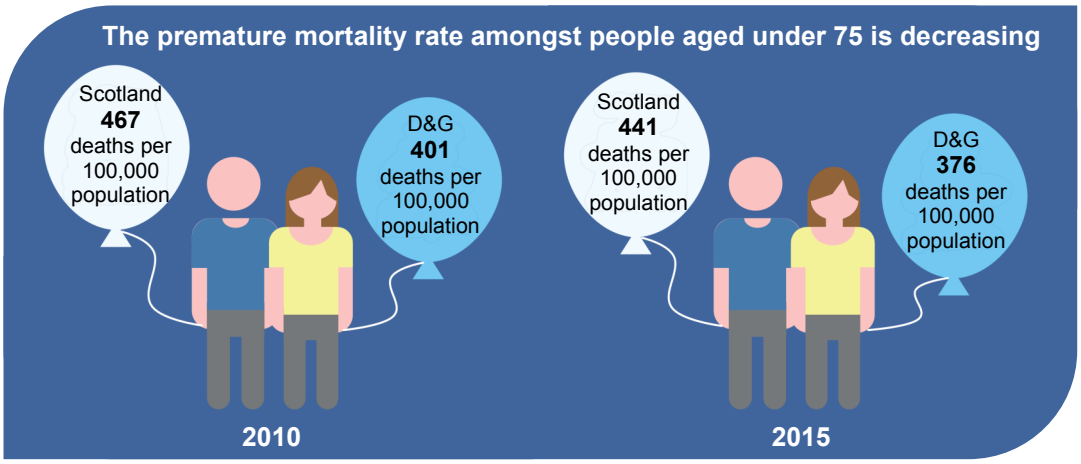
- Wider partnership work aims to ensure that transition periods for young people with a history of mental health issues are well supported as they move from Child and Adolescent Mental Health Services (CAMHS) to adult services.

5.5 Reducing Inequalities

Health and social care services can help to reduce inequalities by supporting Dumfries & Galloway Council's Anti-Poverty Strategy. For instance, 'drop in' clinics for benefits and welfare advice at Dumfries & Galloway Royal Infirmary, Craignair Clinic (Dalbeattie) and the GP practice in Kelloholm are helping people to maximise access to benefits.

A training package, with supporting guidance, aimed at GPs is helping to ensure a better understanding of welfare reform changes. This raises awareness of local services which provide support for those at risk of, or experiencing, poverty.

NHS Dumfries & Galloway and Dumfries & Galloway Council have been raising awareness of gender inequality across the local population. They have hosted three events aiming to provide opportunities to explore gender inequality and identify actions to challenge this.



ISD Scotland (2016)

The premature mortality rate monitors the number of people who die early, defined as people under the age of 75. This rate is affected by a large number of factors many of which are linked to inequalities. In recent years, across both Dumfries and Galloway and Scotland, this rate has fallen. Research has shown that some of this decrease can be attributed to fewer people smoking, detecting cancer early and falling levels of violent crime which tends to disproportionately affect younger people.

6. Outcome 6

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

Unpaid Carers are the largest group of care providers in Scotland, providing more care than the NHS and Councils combined. Providing support to Carers is an increasing local and national priority.

A Carer is generally defined as a person of any age who provides unpaid help and support to someone who cannot manage to live independently without the Carer's help due to frailty, illness, disability or addiction. The term 'Adult Carer' refers to anyone over the age of 16, but within this group those aged 16 - 24 are identified as 'Young Adult Carers'.

Our commitments:

- We will provide support to Carers (including the provision of short breaks) so that they can continue to care, if they so wish, in better health and have a life alongside caring
- We will develop a consistent approach across the workforce to make sure that the needs of the Carer are identified and that Carers are supported in their own right
- We will work towards developing "Carer Positive" as an approach across the Partnership; identifying staff that are Carers and supporting them in their own personal caring roles

Year One Key Achievements:

- consultation with Carers about what matters to them to inform the development of the new Carers Strategy
- development of a new Carers Strategy for Dumfries & Galloway
- both NHS Dumfries & Galloway and Dumfries & Galloway Council achieved the 'Engaged' status for the Carer Positive Award (please see below)

Challenges:

To implement the Carers (Scotland) Act 2016 including:

- developing local eligibility criteria
- preparing and publishing a short breaks services statement. This document will describe the short break services available in Scotland for Carers and cared-for people
- continuing to develop and promote Adult Carer Support Plans and Young Carer Statements

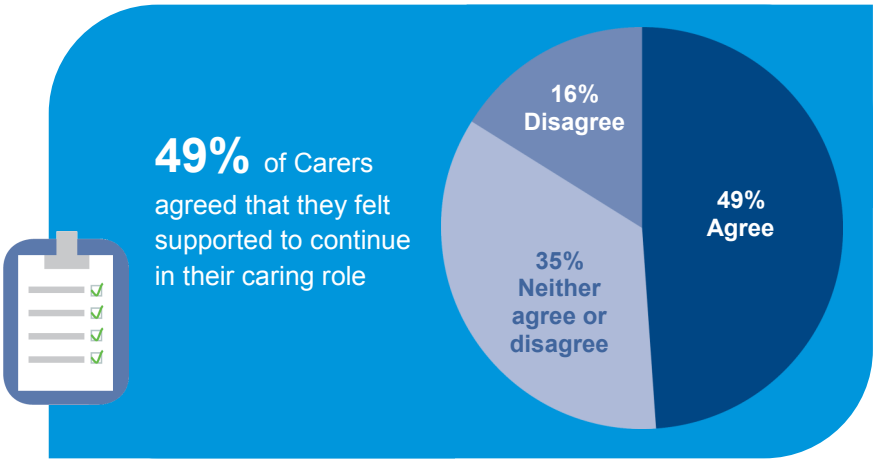
6.1 Carer Positive

Carer Positive is a Scottish Government funded initiative to recognise those employers who offer the best support to Carers, enabling them the flexibility they often need to provide care. NHS Dumfries & Galloway and Dumfries & Galloway Council have been recognised for the support they provide for Carers in the workforce. In achieving Carer Positive status both organisations have demonstrated a genuine commitment to supporting staff who balance work with a caring role in a culture where they feel valued.

6.2 Supporting Carers

A range of support is available to Carers in Dumfries & Galloway. This includes practical support (for example transport or equipment), counselling or emotional support, training and learning, advocacy services, short breaks, health and wellbeing opportunities and help to access financial support. This support is provided by the statutory partners and/or organisations in the third sector.

Short breaks grants have been offered to Carers. These grants have created opportunities for innovative short breaks such as relaxation therapies or a bicycle, as well as the more traditional overnight break. There are a number of services providing short breaks for Carers of adults with disabilities region-wide however, it is recognised that access to residential respite for older adults is limited at present. Considering how this might be addressed is an area of Carer support that is being prioritised in 2017.



Health & Social Care Experience Survey (2015/16)

Every two years, a sample of the Dumfries & Galloway population is surveyed about their experience of health and social care services. Around one in eight people that respond identify themselves as a Carer. The results published in May 2016 showed that 49% of Carers in Dumfries & Galloway felt supported to continue in their caring role. This compares to 41% for Scotland.

Carers may be receiving support from a range of available services and organisations across Dumfries & Galloway. At this time, it is not possible to identify when Carers receive support from more than one organisation.

A key challenge for Carers is maintaining good mental health. The 'Mindfulness-Based Stress Reduction' course is offered annually to Carers through the Carers Centre and is facilitated by accredited practitioners.

Dumfries & Galloway's only regional specific Carer support service is the Dumfries & Galloway Carers Centre. During 2016/17 the Carers Centre provided support to 1,042 adult Carers. The number of new adult Carers referred to the Carers Centre increased by 53% from the previous year to 654. Referrals from Social Work have more than doubled (to 128) as a direct result of closer working with the Council's Contact Centre and referrals from STARS has also risen substantially (to 73) after training and awareness raising with their staff teams.

6.3 Adult Carer Support Plans

Adult Carers Support Plans (ACSP) were introduced in April 2016. These plans help Carers to identify support in their own right that may help them to continue in good health in their caring role. Many Carers may not need services, but an ACSP may form part of a Carer's support. Only a small percentage of ACSPs require services provided by social work. Many of the support needs highlighted in ACSPs to date are provided through the Partnership or third sector organisations.

"Advice is the best thing available to Carers – somewhere that finance, physical, mental wellbeing and services can be accessed under one umbrella"

Carer's feedback 2016/17

Results from a personal outcomes tool used as part of the ACSP process indicate that 78% of Carers score 'low' when answering questions about how they feel. However, 30% of Carers score 'low' when answering questions about how well they are managing at home. More outcomes and actions have been recorded in outcome plans to enable Carers to cope with these emotional impacts, than have been recorded for practical aspects like managing at home and finances.

"For me the ACSP was given at a time when I was going through significant changes in my life and had some very important decisions to make (that were not easy). The plan supported me through this and allowed me to look at various areas of my life and how one was impacting on the other. The outcomes let me focus specifically on what was important to me and I acted on them fairly quickly."

Carer's feedback 2016/17

6.4 Carer Aware

'Carer Aware' is training designed to help staff understand who Carers are, what they do and the support available for Carers. Nearly 600 sessions of Carer Aware training were delivered in 2016/17 to staff across the Health and Social Care Partnership, both online and face to face. This training has helped staff to identify Carers and be generally better informed about Carers and the issues impacting on their lives. In Wigtownshire, volunteers are being supported to become Carer Awareness Champions to encourage more people to sign up for this training.

7. Outcome 7

"People who use health and social care services are safe from harm."

All people have the right to live free from physical, sexual, psychological or emotional, financial or material neglect, discriminatory harm or abuse. The Strategic Plan recognises this as a key priority. There are a number of programmes aiming to reduce the risk of harm to people.

Under the Adult Support and Protection (Scotland) Act 2007, public sector staff have a duty to report concerns relating to 'adults at risk' and the Council must take action to find out about and, where necessary, intervene to make sure vulnerable adults are protected.

Making sure people are safe from harm is also about ensuring that health and social care services are of a high quality and continuously looking to make improvements.

Our commitments:

- We will support the provision of a Multi-Agency Safeguarding Hub to ensure a joined up approach in terms of identifying, sharing information about and responding to adults at risk of harm
- We will make sure that all staff can identify, understand, assess and respond to adults at risk
- We will make care as safe as possible and identify opportunities to reduce harm

Year One Key Achievements:

- Multi-Agency Safeguarding Hub (MASH) established to improve inter-agency communication and coordination
- development of knowledge across the Partnership of adult support and protection
- Quality Improvement Hub established to empower those providing support to improve the quality and safety of services

Challenges:

- ensuring a consistent approach in protecting adults at risk of harm
- maintaining high quality services in the context of limited public finances and available workforce
- maintaining high quality services in the context of substantial change to the way services are delivered

7.1 Multi-Agency Safeguarding Hub (MASH)

The MASH is a new and unique service where practitioners from health and social care and the police share a workplace and information regarding the protection of adults in the community. This model now operates across all four localities and is embedding a consistent approach to adult support and protection referrals.

At the end of March 2017, 45% of people who referred cases to the MASH received feedback within 5 days. The definition of what constitutes 'feedback' needs to be further refined in order to accurately reflect the activity of the MASH.

A significant amount of multi-agency training has been undertaken to raise staff knowledge and understanding of adults at risk of harm and the role of the adult support and protection team.

Development of a competency framework, that will support the delivery of adult support and protection training, has started. This will help to identify both the training needs of specific practitioner groups and any knowledge gaps.

44%

of people who referred cases to Adult Support & Protection received feedback within 5 days

Dumfries & Galloway Council (March 2017)

'Message in a Bottle' is a partnership project with Stewartry Council of Voluntary Services to support emergency services to quickly assess and treat vulnerable individuals.

7.2 Scottish Patient Safety Programme

In Dumfries & Galloway the Partnership takes part in the Scottish Patient Safety Programme (SPSP). This focuses on reducing harm in adult hospital services, maternity and children's care, mental health care and primary care.

As a result of the SPSP, hospital mortality across Scotland has reduced by 8.6% in the two and half years up to September 2016. In DGRI, the reduction has been more than 10%.

Historically, infections in hospital were problematic however, the development of a positive infection control culture means that Dumfries & Galloway and Scotland have achieved some of the lowest infection rates for Clostridium Difficile and Staphylococcus Aureas on record.

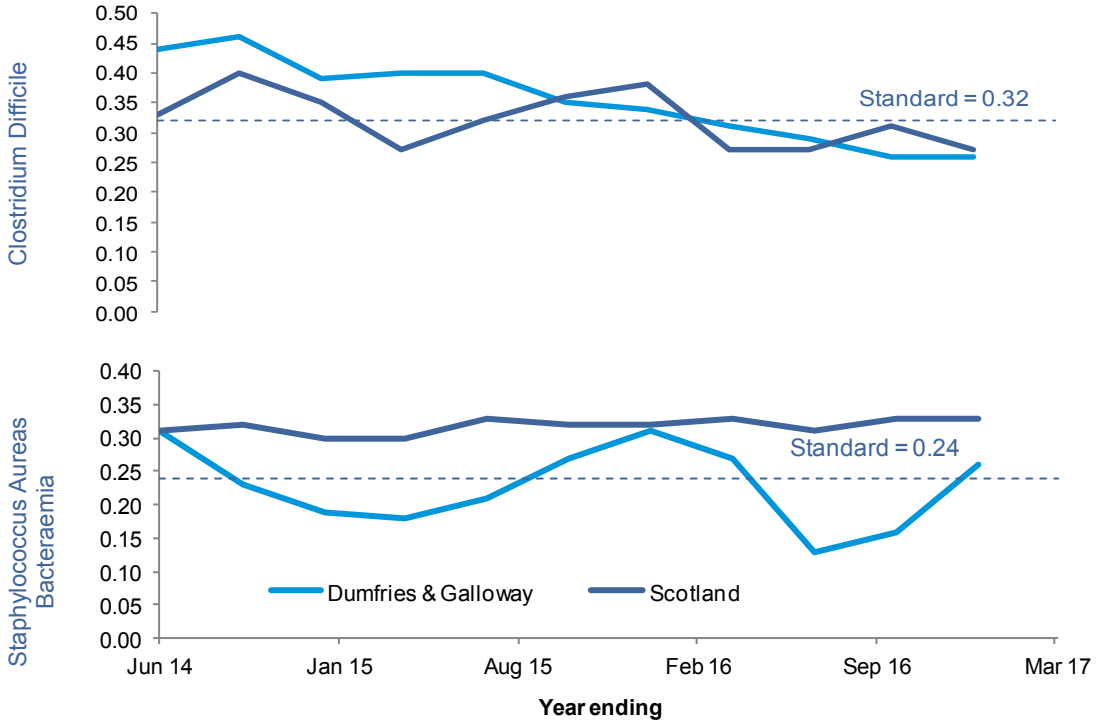
The Scottish Patient Safety Programme has been extended to care homes in Dumfries & Galloway where work is underway to reduce the incidence of pressure ulcers.

87%

of adults supported at home reported that they felt safe (Scotland: 84%)

Health & Social Care Experience Survey (2015/16)

The infection rate for Clostridium Difficile (D. Diff) and Staphylococcus Aureas Bacteraemia (SAB), per 1,000 occupied bed days



NHS Dumfries & Galloway (March 2017)

7.3 Quality Improvement Hub

The Quality Improvement Hub has been established to bring together teams from across health and social care to identify and deliver improvements. The Scottish Improvement Skills programme teaches the skills required to apply a scientific approach to improving the quality and safety of services.

In the past year there was a range of quality improvement projects undertaken across

Dumfries & Galloway including:

- supporting hospital discharges in cottage hospitals
- developing an 'Invasive Line Passport' to improve the management of invasive lines
- reducing pressure ulcers in care home settings
- making colonoscopy information packs easier to understand and reducing the number of appointments people need to complete a colonoscopy
- improving treatment planning for dental patients with high risk medical histories
- streamlining children's referral triage to allied health professional (AHP) services
- improving the communication and self management of a particular high risk medication combination
- improving communication at times of transition when a young person requires specialised mental health in-patient provision
- supporting people with specific vulnerabilities within specialist drug and alcohol services

8. Outcome 8

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

It is important to acknowledge that different workplace cultures exist across the Partnership. Acknowledging the diversity of these different cultures will lead to understanding and respecting each other's values and beliefs and bring new and different opportunities. However, diversity also brings challenges that can act as barriers to integrated ways of working.

Our commitments:

- We will support staff to be informed, involved and motivated to achieve national and local outcomes
- We will develop a plan that describes and shapes our future workforce across all sectors
- We will provide opportunities for staff, volunteers, Carers and people who use services to learn together
- We will aim to be the best place to work in Scotland

Year One Key Achievements:

- delivery of cultural diagnostic assessment has enabled teams to share an understanding of work place culture
- development of a workforce plan for the Partnership has identified needs across multiple sectors and settings
- Expanded the shared learning opportunities across the health and social care Partnership

Challenges:

- supporting staff as integrated models of care are introduced across the Partnership
- nurturing and embedding a shared culture for the Partnership

Formal cultural diagnostic tools have been used to assess the current cultures and determine the ideal culture the Partnership would like to achieve. Actions have been identified that could enable the Partnership to move towards its ideal culture.

8.1 Life Style Inventory

To promote strong leadership, a tool called the Life Style Inventory (LSI) has been adopted and shared with IJB members, senior management team, locality managers and representatives from the third and independent sector. The LSI is a '360 degree' feedback tool that helps leaders to reflect on their personal effectiveness in their current role.

'Mindfulness' sessions are offered on an ongoing basis for staff. This can help promote their physical and mental wellbeing.

8.2 Workforce Plan

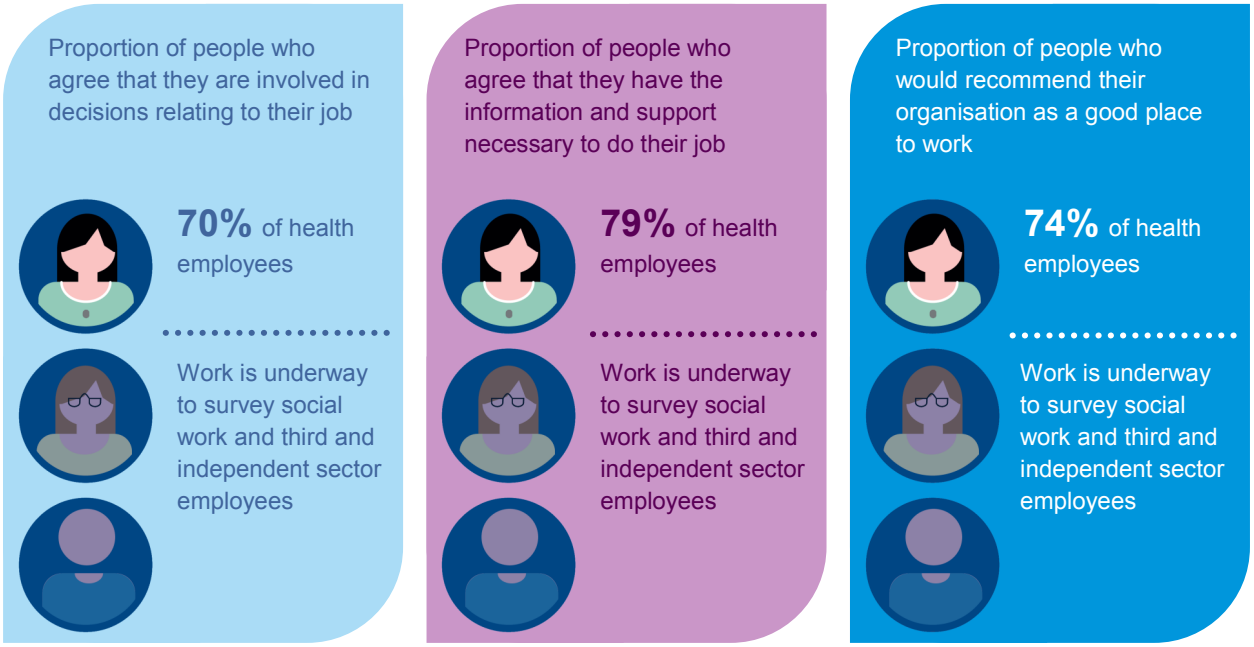
The IJB has developed a workforce plan for the period 2016-2019 to determine the workforce needed to address the future strategic, financial and service planning requirements. Information about the current workforce has been reviewed to consider:

- the current and future skills required
- the number of people and the roles required to deliver health and social care
- promoting effectiveness and efficiency through integrated models of care

The Workforce Plan also outlines five ambitions including promoting health and social care as a career of choice and nurturing a healthy, sustainable, capable and motivated workforce.

8.3 iMatter

To support people in the workplace a new staff survey approach, iMatter, has been introduced. This includes reflective learning and the development of action plans within teams to build a positive workplace culture. The iMatter tool is a national programme that started in the NHS and the aim locally is to extend its use across the Partnership.



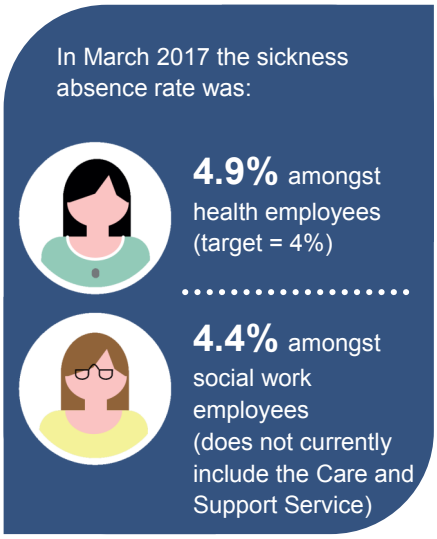
NHS Dumfries & Galloway (iMatter) (2016)
Provisional figures, at the time of writing, the iMatter tool had only been rolled out to 70% of NHS Dumfries & Galloway departments (64% response rate)

8.4 Sickness Absence

Sickness absence in the workforce can result in reduced efficiency, through cancelled appointments, increased pressure on remaining staff and increased costs of employing temporary staff. The target set for the NHS in Scotland is 4% of the total hours people could have worked.

A three year NHS strategic change programme has been developed that aims to promote an engaged and motivated workforce who recognise and value both physical and mental health and wellbeing as a key workforce asset.

In Adult Social Work there is a dedicated HR Maximising Attendance Team which actively monitors monthly absence, deliver Maximising Attendance training and support managers to appropriately apply policy and procedures. The service has taken a pro-active approach to the monitoring of absence management, including scrutinising persistent behaviour and engaging Health and Social Care Locality managers to enable them to support the required monitoring and follow up with social work managers.



NHS Dumfries & Galloway
Dumfries & Galloway Council
(April 2017)

8.5 Employability

Vocational rehabilitation aims to support individuals experiencing mental ill health to remain in or return to work, or to identify new employment opportunities. Mental health occupational therapists provide assessment, advice, treatment and partnership building to support individuals.

8.6 Developing Roles

There are challenges in attracting people with the right skills to work in rural communities. This affects the whole Partnership. There are a range of roles that are being developed to work across traditional boundaries to improve people's experience of health and social care.

One area the Partnership is focussing on is how GP practices are supported:

- Advanced Nurse Practitioners (ANPs) have higher levels of training and greater responsibilities that help increase capacity in GP practice
- A number of pharmacists are currently undertaking advanced clinical training and developing their roles to support GP practices
- specialist nurses for older people will co-ordinate between community and hospital care with a focus on preventing unnecessary admissions and smoother discharges from hospital

The Wigtownshire locality is testing the use of Advanced Nurse Practitioners to support delivering the out-of-hours service.

8.7 Shared Learning Opportunities

Fostering a new culture across the Partnership is supported by shared learning opportunities. Recent examples include:

- the expansion of dementia awareness training across health and local authority settings, third sector and private care homes
- the principles of re-ablement are being embedded across partners through training
- working with care homes to improve infection control
- in Wigtownshire, staff are supported to attend Consultation Institute Training to develop a standard approach to engagement
- making better use of social media

These changes are seeking to communicate the vision and principles for health and social care integration more widely across the Partnership.

The Open University (OU) Open Learn module about Self Directed Support offers 50 hours of material, developed in Dumfries & Galloway using local examples, available for all staff. Small groups of staff are supported by an OU tutor over 3 sessions to maximise the use of the material.

In Stewartry the Adult Support & Protection Social Workers Group now meets every six weeks to support one another and improve practice.

9. Outcome 9

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

There are various ways that the Partnership is seeking to ensure that resources are used effectively and efficiently. These include identifying and reducing unnecessary variation, implementing quality improvement programmes and making the best use of technology. The Partnership is also maximising the efficient use of the considerable resource in buildings and equipment used to deliver health and social care.

Our commitments:

- We will reduce variation in practice, outcomes and costs which cannot be justified
- We will involve staff to develop a new culture that promotes different ways of working for the future
- We will support staff and partners to develop new and better ways to provide health and social care, to reduce duplication and increase efficiency
- We will ensure that there is good linkage between work relating to the new hospital project and community based health and social care

9.1 Reducing Unnecessary Variation

Variation is the term used to describe the differences in practice, outcome or costs that cannot be explained on the basis of need, evidence or preference. The aim is to strike a balance between reducing unnecessary variation whilst protecting personal choice to ensure that care is person-centred, efficient, safe and of high quality. Reducing variation is a key element of **'Realistic Medicine'**, outlined in the first Annual Report of Scotland's Chief Medical Officer.

Year One Key Achievements:

- Reduction in the burden and harm that people experience from over-investigation and over-treatment, such as reducing unnecessary medical tests
- Reduction in unnecessary variation in clinical practice to achieve the best outcomes for people (some examples below)
- introduction of measures to ensure value for money and reduction of waste, such as stopping medications people no longer need

Challenges:

- changing the culture for both the people who use services and the people who provide services to embrace the principles of Realistic Medicine and shared decision making
- changing attitudes and perceptions of risk
- achieving the pace of change required

A Clinical Efficiency Group has been set up to evaluate and compare local activity with national benchmarking data. Causes of variation are being investigated, and working with directorates, GP practices and clinical teams, ideas are being developed to reduce unwarranted variation and waste. This work should help reduce the burden and harm that people can experience from over-investigation and over-treatment.

To make sure that the right people are being offered the right level of intervention, here are some examples that have been investigated and developed:

- the number of pace maker insertions (cardiology team)
- the number of cataract operations performed in D&G in comparison with the national average (ophthalmology team)
- variation in GPs requesting of pelvic ultrasound scans (radiology group)
- understanding the appropriateness of laboratory testing and minimum re-testing intervals performed in GP practice and hospital settings (laboratories group)
- introducing a scoring matrix to help GPs assess the best course of action for managing varicose veins (vascular team)
- development of revised instructions for when it is appropriate to send people for echocardiograms (heart tests) (clinical physiology team)

9.2 Social Work Reviews and Service Redesign

In social work and social care, a review team has been working with service users, Carers and care providers to review individual packages of care and support to ensure they are efficient, effective and are delivering good outcomes. This has resulted in significant changes in service delivery.

The delivery of overnight care and support has also been subject to review and work is underway with service users, Carers and providers to redesign overnight support around assistive technology.

The Partnership supports providers of care and support services to improve standards through regular contract monitoring. Commissioning officers share areas for improvement, common themes across providers and good practice. For example, sharing improvement standards for the management of medication.

In Stewartry the Social Work team is now assessing new referrals with the Eligibility Screening Tool, via a telephone call, to identify and signpost those who may not be appropriate for social work intervention at an earlier stage. Those people receive a letter with signposting information.

ISD Scotland (2015/16) (provisional)

9.3 Hospital Pathways

Another way in which the Partnership looks at how efficiently health and social care services work, is by developing a detailed understanding of people's journey through the hospital, from booking appointments to having treatment and going home again. The ideal journey would have short waiting times to be seen and people going home after an admission just as soon as they are ready.

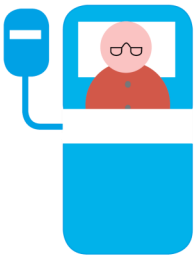
94.7% of people were seen within 4 hours during 2016/17 (target: 95%)

People attended **40,000** new doctor led outpatient appointments during 2016/17

There were **48,300** visits to the emergency department at DGRI or Galloway Community Hospital during 2016/17

33% of people who attended the emergency department during 2016/17 were admitted for longer term care

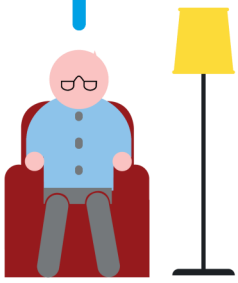
A snapshot taken at the end of March 2017 showed that **92%** of people waited less than 12 weeks for their first outpatient appointment (target: 95%)



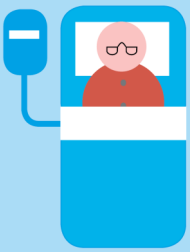
During 2016/17, there were **18,500** planned inpatient and daycase visits to hospital

The snapshot taken at the end of March 2017 showed that **86%** of people waited less than 12 weeks for their treatment (target: 100%)

During 2016/17, for every 1,000 people aged 75 or older, **591** days were spent in hospital when people were ready to be discharged
(Scotland: 842)



Journeys in and out of hospital can be complex, with many different stages. Delays in one part can have knock on effects right through the system. The Partnership has not always met the waiting times standards in the last year, and many strands of work are ongoing to address this:



Figures for 2015/16 show that for every 100,000 adults in Dumfries & Galloway, there were **11,400** emergency admissions amounting to **128,200** bed days

ISD Scotland (2016) (provisional)

- weekend lists are being run in some areas of care to try and accommodate people where possible
- in ophthalmology, nurses have been trained to undertake eye injection clinics to improve the current waiting times for people with macular degeneration
- a pilot involving Allied Health Professional (AHP) triaging has been introduced in orthopaedics to ensure that people are directed to the most appropriate service in the first instance
- an occupational therapist has been trained to undertake steroid injections for hand conditions, which will improve efficiency and reduce the waiting times of both orthopaedic and rheumatology clinics
- each hospital speciality is undertaking activity modelling and developing improvement plans in anticipation of the move to the new hospital
- the Golden Jubilee Hospital has agreed to provide prioritised access to Dumfries & Galloway to increase capacity, particularly for the period of transition to the new hospital

24%
of health and social care resource is spent on hospital stays where the person is admitted as an emergency

ISD Scotland (2016) (provisional)

The day of care audit is a one day snapshot of everyone who is in hospital and a review of the appropriateness of their current setting. It is being used to inform and improve services and discharge from acute, community and cottage hospitals.

9.4 Prescribing Source:

The Partnership has a strong focus on how medications are managed. In 2015/16 Dumfries & Galloway spent nearly £37 million on medicine. Prescribing costs continue to rise. Ineffective and inefficient prescribing can be both unsafe (e.g. when people are given medicines that don't work well together) and wasteful (e.g. when people are given or request medicines that they don't need.)

The Prescribing Support Team explores variation in prescribing patterns between GPs, practice clusters, similar Health Boards and Scotland to identify examples of best practice and areas where variation could be reduced.

Nithsdale have adopted the 'Optimise' project where pharmacists with enhanced roles work with GP practices to undertake medications reviews with people.

These reviews have resulted in some people needing fewer medications and other people having simplified routines to make it easier to take medications the right way.

Pharmacists are working closely with social work to review the medications of people with care packages. This will improve the co-ordination and timing of medicines with home visits by providers of care. These reviews have led to stopping medication that is not required, reducing doses and reducing side effects.

A Scottish Government initiative began in 2016/17 where pharmacists with enhanced clinical skills are employed as part of integrated general practice teams. This initiative aims to increase capacity and provide easier access to primary care services.

A Dumfries & Galloway strategy for polypharmacy (where people are taking multiple medicines) is currently in development that includes GP practice and hospital medication. There is a particular focus on how medicines are managed in care homes using the **'National 7 Steps'** program which gives a structured approach to making decisions about which medications people are prescribed.

In Nithsdale, initial planning discussions have taken place to support pharmacists and the health and wellbeing team to organise pharmacist-run 'No-Drugs Clinics', focusing on areas of greatest need.

9.5 Making the Best Use of Technology

Developing and delivering information and communication technologies (ICT) and a programme of 'Technology Enabled Care' (TEC) is critical to achieving seamless and sustainable care and support across the entire health and social care system.

The purpose of developing ICT is to enable greater access to real time, relevant information for making decisions and to improve communication between people delivering health and social care.

In Dumfries & Galloway this focuses on:

- enabling the sharing of care and support plans appropriately
- helping to embed anticipatory care across Dumfries & Galloway
- providing easier access to clinical and social care information
- supporting people to manage their own care online

Our commitments:

- We will deliver a single system that enables public sector staff to access or update relevant information electronically
- We will introduce and embed a programme of technology enabled care that supports the development of new models of care and new ways of working

The main achievement in the first year is the creation and deployment of the new Health & Social Care Portal. This ICT solution has been designed to bring together health and social care information to support joint working. So far, twelve NHS ICT systems have been built into the Portal and over 1,400 staff have been trained and are now using the solution. The Portal has been designed to link to the social care Framework-i information system to enable data to be shared across the Partnership, once appropriate consent has been agreed.

Information sharing protocols have been signed in principle, and now the detailed governance on how data will be shared, stored and protected is being developed.

Another achievement is the rollout of the 'Order Comms System' which enables laboratory test results to be accessed more quickly and easily, enabling front line staff to make decisions sooner. This is now being implemented in GP practices. The test results will be posted within the Portal described above, as part of the electronic case record.

Waiting times for psychological therapies, an area where standards have not been met, have been reduced by introducing computerised Cognitive Behavioural Therapy (cCBT) for people with mild to moderate psychological difficulties who may find it helpful.

All acute hospital medical records have now been fully scanned and the paper records destroyed. Over the last year this work has been completed and all records are presented in the new Portal. Records in cottage hospitals will be scanned over the coming year. This development has been a major step in helping to improve record keeping and to become more effective and efficient as a system of care and support.

70%

of people referred to psychological therapies began treatment within 18 weeks of referral (March 2017) (Target: 90%)

ISD Scotland (2017)

The Portal continues to be developed and there has been good progress towards joining up networks and record numbering systems in the last year. The next task is to further develop these systems to enable staff from any sector to access the right information at the right time from any location where care is delivered. This will support joint planning and improve service delivery.

Challenges:

- obtaining linked numbers between health and social care systems to enable the Portal to deliver a truly integrated information system
- moving the existing ICT systems and networks from DGRI into the new hospital
- developing a single ICT working environment for both health and social care teams along with shared data collection solutions for use in the community setting where most care is delivered

In the past year over 180 Dumfries & Galloway Local Authority, NHS and pharmacy, eye care and dental properties have been connected via SWAN (Scottish Wide Area Network), a series of dedicated cables which will enable easy information sharing no matter which building on the network people are working from.

9.6 Technology Enabled Care

A sub group of the eHealth Board has now been established for Technology Enabled Care (TEC) with representation from across the Partnership. The TEC sub group has developed a Programme of TEC for Dumfries & Galloway going forward.

Technology should be utilised in every instance where it could provide support to a person where this is their choice. This programme is largely based on the Scottish Government TEC Action Plan, learning from previous 'tests of change' and from what is happening elsewhere in Scotland and the world.

"We particularly feel much better for having Care Call installed, which we find a valuable support for peace".

Carer's consultation 2016

An objective of the programme is to embed familiar technology across services. This includes using an individual's smart phone, tablet or other device. The programme aims to offer a range of technological solutions including video consultation, home and mobile health monitoring, telecare and digital services.

Examples of technology being trialled in Nithsdale locality: Advanced Risk Model for Early Detection (ARMED) assisted technology (in a sheltered housing setting) with Loreburn Housing supported through Napier University, CM2000 care management system and the eFraility tool for the early detection of deteriorating older adults.

9.7 Making Effective Use of Buildings, Land, Equipment and Vehicles

Dumfries & Galloway Council and NHS Dumfries & Galloway have substantial physical assets in buildings, land, equipment and vehicles. It is important to make the most effective use of these assets and other community resources such as optician's premises, care homes, sheltered housing and pharmacies.

Our commitments:

- We will develop a plan to make sure we use physical assets, such as buildings and land, more efficiently and effectively
- We will make sure that physical assets utilised by the Integration Joint Board are safe, secure and high quality and, where appropriate promote health and wellbeing

Year One Key Achievements:

- development of the new district general hospital
- sharing agreement between the NHS and Council to get the best use out of buildings and other assets, e.g. office space, pool cars
- surplus assets marketed to recover resource that can be directed back into service delivery

Challenges:

- maintaining safe services during transition into the new general hospital and into the refurbished Cresswell building
- delivering of appropriate Partnership wide physical infrastructure in a time of limited capital resource
- • disposing of inefficient properties

In Annandale & Eskdale, the locality team is developing the use of community assets. There has been a review of all services in Moffat and a business case has been developed for services provided in Esk Valley.

Careful decisions are being made about where to invest and where to reduce or withdraw investment to best support the delivery of care closer to home. These decisions are being considered in the context of the best use of space, environmental sustainability, reducing the Partnership's carbon footprint and improving the experience of people who use services.

Both NHS and Council Asset Management Strategies focus on disinvesting from old and inefficient buildings and, where funding permits, replacing them with new or refurbished buildings that are fit for purpose. A joint refurbishment project is currently underway which will host health services within a Council facility with the principle aim of delivering health promotion.

The grounds of the new DGRI are being landscaped to ensure the outside spaces contribute to the health and wellbeing of patients and staff.

To improve the efficiency of how equipment is managed, Radio Frequency Identification (RFID) tags have been rolled out across the health service.

10. Financial Performance and Best Value

For 2016/17 the Integration Joint Board delivered a break even financial position with an agreed carry-forward of £4.3m resulting from the balance of the Social Care and Integrated Care Funds. This included the delivery of savings in the year of £11.7m (£7m recurrently).

The net amount in total of delegated resource to the IJB for 2016/17 was £281m, with £219m of NHS delegated resources and £62m of Council Services delegated resources.

The total resource by service was as follows:

IJB Service	Annual Budget £000s
Council Services	
Children & Families	107
Adult Services	14,474
Older People	22,316
People with Learning Disability	16,763
People with Physical Disability	5,772
People with Mental Health Need	2,145
Adults with Addiction/Substance Misuse	263
Sub-total Council Services	**61,840**
NHS Services	
Primary Care and Community Services	60,359
Mental Health	21,150
Women & Children	20,873
Acute & Diagnostics	96,768
Facilities & Clinical Support	20,097
Sub-total NHS Services	**219,247**
Total Delegated Services	**281,087**

The IJB also has a duty under the Local Government Act 2003 to make arrangements to secure 'Best Value', through continuous improvement in the way in which its functions are exercised. Best Value includes aspects with regard to economy, efficiency, effectiveness, the need to meet the equal opportunity requirements, and contributing to the achievement of sustainable development.

In discharging this overall responsibility, the IJB is responsible for putting in place proper arrangements for the governance of its affairs and facilitating the effective exercise of its functions, which includes arrangements for the management of risk. During 2016/17 these arrangements have been progressed through the establishment of committees, development and implementation of performance arrangements, a risk management strategy was approved and an internal audit of the governance arrangements is in progress.

In 2016, the Council tendered for all Care at Home and Support services for adults and older people. A primary driver for this was to support the implementation of the Scottish Living Wage for care staff. All providers operating locally in 2016 made an explicit commitment to pay the living wage of £8.25 from the 1st October 2016.

There is evidence from providers that the improved pay rates impacted on recruitment and retention of support staff. Maintaining an effective and skilled workforce, in the context of increasing numbers of older people and people with complex health and social care needs, a reducing working age population and within available finance remains an ongoing fundamental challenge.

Locally there are a number of factors which impact on the provision of social care, including rurality which leads to increased travel times. There is an open dialogue with providers and the Partnership has undertaken benchmarking in rates.

In order to achieve Best Value the IJB has effective arrangements for scrutinising performance, monitoring progress towards their strategic objectives as set out in the Strategic and Locality Plans.

11. Inspection of Services

The Partnership is required to report details of any inspections carried out relating to the functions delegated to the Partnership. During 2016/17 there were two inspections:

12.1 Services for Older People in Dumfries and Galloway – October 2016

From January to March 2016, the Care Inspectorate and Healthcare Improvement Scotland carried out a joint inspection of health and social work services for older people in Dumfries and Galloway. This report was published on the Care Inspectorate website on the 18th October 2016.

This report can be accessed by following this link to the **Care Inspectorate website**

This evaluation reported that services were all either “Good” or “Adequate”. There were a number of recommendations made and action plans have been developed from this inspection, which are available from NHS Dumfries & Galloway Health Board on request.

12.2 Dumfries & Galloway Royal Infirmary - Care of Older People in Acute Hospitals Inspection Report: 24-26 January 2017

The inspection was conducted on the 24th to 26th January 2017. The report was published in April 2017 and can be accessed by following this link to the **Healthcare Improvement Scotland website**

This inspection resulted in six areas of good practice and twelve areas for improvement. An action plan has been developed in response to this inspection, which is available from Healthcare Improvement Scotland on request.

12. Significant Decisions

'Significant decisions' is a legal term defined within section 36 of the Public Bodies Joint Working (Scotland) Act 2014. It relates to making a decision that would have a significant effect on the provision of a service outwith the context of the Strategic Plan. In considering these types of decisions the Integration Joint Board must involve and consult its' Strategic Planning Group and people who use, or may use the service in question.

No decisions defined as 'significant decisions' under this definition were taken by the IJB in 2016/17.

13. Review of the Strategic Plan

Legislation requires that the Partnership must review the effectiveness of its' strategic plan at least once every three years. This may result in the preparation of a replacement strategic plan. The review must be carried out with the involvement of the Strategic Planning Group.

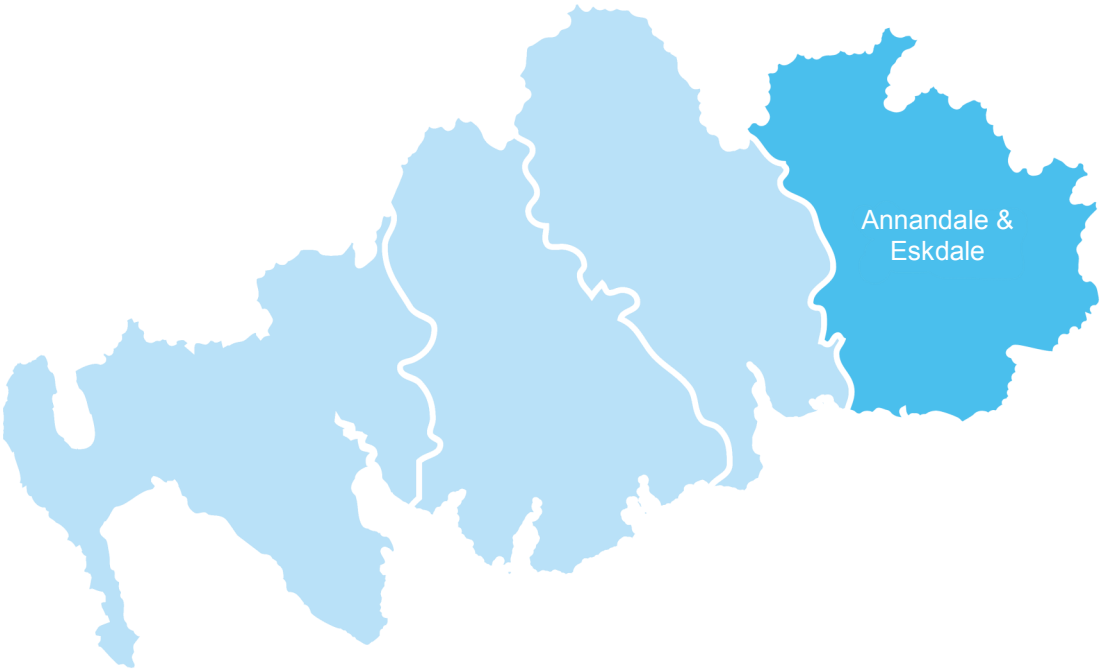
The financial year 2016/17 is the first year of the current Strategic Plan therefore no review took place.

14. Reporting on Localities

The four localities in Dumfries & Galloway defined in the Health and Social Care Partnership follow the traditional boundaries of Annandale & Eskdale, Nithsdale, Stewartry and Wigtownshire.

The localities were central to the development of and consultation on the Partnership's Strategic Plan. They are also represented on the Dumfries and Galloway Strategic Planning Group which had a key role in shaping and influencing the development of the plan.

Each locality developed its own Locality Plan as part of the suite of documents that came together to form the overall Strategic Plan for Dumfries and Galloway Health and Social Care Partnership. Each Locality Plan contains a set of commitments against identified priorities. Progress against these commitments is reported to the IJB and Area Committees every six months.



14.1 Spotlight on Annandale & Eskdale

During the first year of the Plan, strong progress has been made in delivering the ambitious commitments set out in the Locality Plan for Annandale & Eskdale. In the context of rising demand, limited supply of skilled workers and finite resources, work has begun on engaging with local people and communities to support them to develop new ways of enabling them to live active, safe and healthy lives.

Year One Key Achievements:

- development of a 'One Team' approach across the locality
- strengthened community engagement and participation in developing new ways of addressing health and social care needs
- agreement to develop a new rehabilitation service at Lochmaben Hospital

Challenges:

- sustainability of general practice
- capacity of home care provider market
- prescribing costs

Building on the strong local partnerships already in place, good progress has been made in developing integrated care communities though the 'One Team' approach. The change in the way people work has improved communication, improved relationships between services and has made identifying people at risk of crisis more effective.

Annandale & Eskdale has identified and signposted an increasing number of Carers to Carer support organisations. Working together to support Carers ensures they receive the support they need much earlier.

A focus on early intervention and prevention is supported through the Community Link service and the roll out of Forward Looking Care Plans. These are plans where actual or potential care and support needs of someone are predicted. The work in GP practices to address improved self management, as well as the closer links with the third sector through time-banking and other community initiatives, support people to look after themselves better.

A partnership with local housing providers has been forged to help develop a broader range of supported housing options.

Despite the progress made and the development of a new 'Framework Agreement for Support at Home Providers', it is recognised that improvements are still required

to enable people to be discharged from hospital in a timely manner. Alternatives to hospital care need to be developed through the provision of 'step up' and 'step down' services at a locality level.

A 'Day of Care' survey has been carried out at each of the 4 cottage hospitals in the locality to help inform how people can be supported to return home or to a homely setting.

In response to growing evidence about the risks of polypharmacy (people taking multiple medications) and prescribing costs continuing to rise, work is underway to

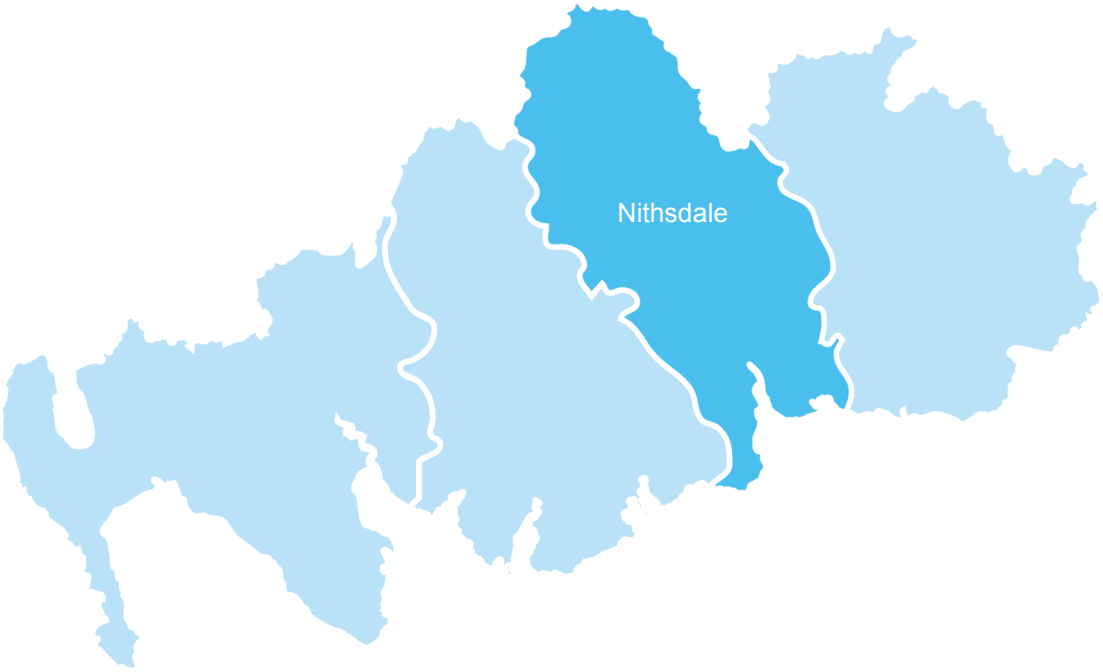
- review the use of repeat prescriptions
- review people on a large number of medications
- raise public awareness of these pressures
- have a greater focus on social prescribing

There continues to be significant challenges in recruitment and work is underway in general practice to develop new models of working which can ease identified gaps in the current workforce arrangements. There are significant challenges ahead. The team continues to strengthen the participation and engagement of local people and communities in identifying, reshaping and utilising community assets across Annandale & Eskdale.

'Vital Signs' training has been introduced in residential care homes to help staff communicate important information with doctors over the phone.

Helping people to plan their future needs, avoid crisis and express their future wishes through Forward Looking Care Plans

"All for One and One for all" Improving the way those who provide care work together to support people through the 'One Team' approach



14.2 Spotlight on Nithsdale

The Nithsdale Locality Management Team, working closely with partners, continues to progress towards delivery of the commitments made in the Nithsdale Locality Plan.

Year One Key Achievements:

- the Optimise initiative – providing detailed medication reviews to people in their own home
- Healthy Connections – a versatile health and wellbeing initiative providing one-to-one and group lifestyle clinics at a number of GP practices
- the 'One Team' development ('Nithsdale in Partnership') - a fundamental change to the way people work together to support people in the community

Challenges:

- GP recruitment and retention
- lack of community resources to support people living at home in the community
- delivering a single IT system for community health and social care provision

Substantial progress has been made in the first year of the plan to embed integrated ways of working and look at new and creative approaches to supporting people. The delivery of commitments within the Nithsdale Locality Plan is interlinked with the development of the Nithsdale Change Programme. This ambitious programme has great potential to sustainably improve health and social care outcomes for people, supporting them to lead healthy and fulfilling lives.

'Nithsdale in Partnership' bringing together multi-disciplinary health and social team teams to work collaboratively and better coordinate peoples' care and support.

The Nithsdale Change Programme will develop an innovative and transformational 'One Team' approach to the delivery of support across the locality. The programme will be implemented and embedded in Nithsdale during the lifetime of this locality plan.

Through a focus on the commitments in the Locality Plan, progress has been made in a number of the areas which are central to the delivery of the One Team approach in Nithsdale. The locality plan identified a number of explicit commitments and recognised the importance of working with care home and care at home providers, the third sector and supporting Carers.

Examples of the work undertaken include:

- supporting care homes: five of the nine care homes in Nithsdale are participating in a new initiative called the Pressure Ulcer Collaborative. Through the Scottish Patient Safety Programme (SPSP) this improvement work with the support of Scottish Care and the Care Inspectorate aims to reduce pressure ulcers in care homes and will continue until December 2017.
- working closely with the Carers Centre to develop support options available to Carers across the locality and raising awareness of Carers through face-to-face and on-line training for staff.
- developing initiatives with partners in the third sector to promote day opportunities (e.g. Crichton Garden Project, 'Men's Sheds' and working with partners in organisations such as Food Train to support a befriending service locally).
- working in partnership with communities to develop low level support options to reduce isolation and loneliness.

The Nithsdale Locality team look forward to working closely with partners to continue our journey in delivering on the commitments made in the Nithsdale locality plan by 2019.

Reducing the incidence of pressure ulcers in residential care settings through the Scottish Patient Safety Programme (SPSP)

Testing Technology Enabled Care (TEC) in sheltered housing setting

14.3 Spotlight on Stewartry

In the first year of integration, Stewartry locality has started to move forward 30 of the 43 'we will' commitments identified in the Stewartry Locality Plan.

Year One Key Achievements:

- improved 'flow' of people across the Health and Social Care System
- introduction of a befriending project and working in partnership with two communities to identify their health and wellbeing priorities and community led solutions
- broadening the range of roles within general practice

Challenges:

- Information Technology (IT) infrastructure
- recruitment to specialist posts
- sustainability of social care provision in rural areas

The Locality Planning and Development Group is an integrated partnership with overarching responsibility for the change programme, ensuring the delivery of its work streams and governance arrangements are being adhered to. Five work streams have been established within the locality:

1) Integrated Pathways Work Stream

This brings together the 'One Team' approach and cottage hospital activity to develop a sustainable model of clinical care. A 'Flow Team' has been established to review delayed hospital discharges and other delays in the health and social care system. Options around a new model of care are currently being developed.

Working with two local communities (New Galloway and Auchencairn) to develop community-led health, wellbeing and resilience plans.

2) Health and Wellbeing Work Stream

This work stream has concentrated on developing a range of initiatives related to improving health and wellbeing. These have included the introduction of a befriending service and working with day centres to look at a joint approach to future service development. It is also working with two communities (Auchencairn and New Galloway) to develop asset-based project plans. The Galloway Gateway project is being developed in partnership with Loreburn Housing Association.

Reducing social isolation for people aged over 65 through befriending service run by The Food Train

3) Housing Work Stream

Stewartry locality has been involved in the Dumfries & Galloway Health and Housing Needs Assessment and is working with the Regional Housing Partnership to identify potential housing development opportunities. The work stream, alongside partners, has established clearer and prompter communication channels for housing equipment & adaptations. The work stream has also focussed on developing Technology Enabled Care (TEC) solutions.

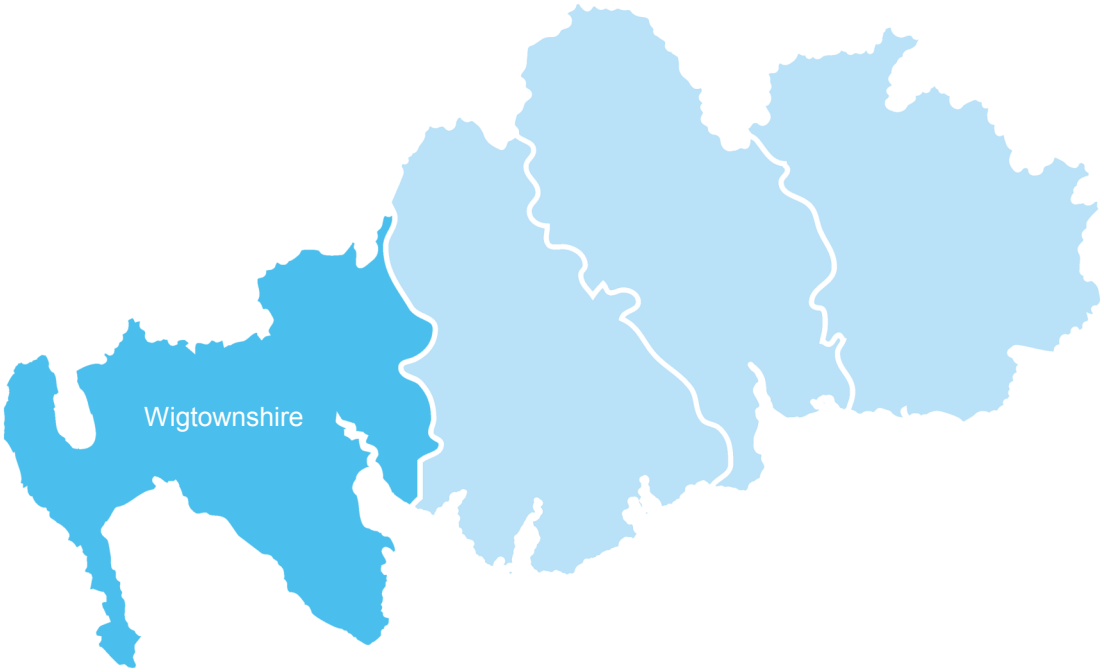
4) Workforce and Organisational Development Work Stream

This group supports sustainability of the workforce through the 'Healthy Working Lives' Gold Award. Customer service standards are being produced. A health and wellbeing plan to support people providing health and social care and support will also be developed.

5) General Practice Work Stream

Five GP practices are now working as one 'cluster' (as defined in the new GP contract). Additional pharmacy support has been introduced to all GP practices to improve health outcomes and reduce prescribing costs. There are a number of innovative posts being recruited to support the work in general practice including advanced nurse practitioners, mental health primary care nurses and psychology liaison professionals. The first year of the plan has resulted in the locality developing detailed information that will help shape future services to meet the needs of the local population and improve outcomes for people in an effective and efficient manner.

"Multi-disciplinary 'flow' team meetings are improving how people move between acute (DGRI), cottage hospitals and the community



14.4 Spotlight on Wigtownshire

The ambition is to make Wigtownshire's communities the best places to live active, safe and healthy lives by promoting independence, choice and control.

To achieve this requires the people providing health and social care in the statutory, third and independent sectors and the communities across Wigtownshire to work in partnership to create models of care that are pioneering, courageous and innovative.

Year One Key Achievements:

- formation of effective cluster group in the locality
- GP practices working in partnership with pharmacy to improve people's care
- Millburn Court 'Pop Up' House showcasing the range of telehealth aids, adaptations and other equipment available to support people

Challenges:

- difficulties recruiting GPs
- maintaining the level of skilled staff
- the sustainability of care home and care at home services

Social work leading the redesign of how people are supported by integrated health and social care services

The areas of focus for the period 2016/17 have been:

- engaging with people across Wigtownshire through Wigtownshire Health & Wellbeing Team to reduce loneliness and isolation and improve individual health and wellbeing
- engaging with people who use health and social care services through several workshops to focus on the development of a locality action plan to implement:
  - Carers' strategy
  - transport options
  - communications and engagement planning
- collaborating with independent providers to develop innovative solutions to deliver sustainable services
- developing the local workforce to "grow our own" to overcome the challenges of attracting health and social care applicants from outside the area
- Wigtown and Merrick GP practices have merged to form the new Galloway Hills Practice
- the development of the Health and Social Care Locality Leadership Team to support the delivery of both the Dumfries & Galloway Strategic Plan and Locality Plan

Extending GP practice teams to include advanced nurse practitioners and pharmacists

Across Scotland, general practice is facing increased challenges. Increased workload, increased risk to staff and premises, recruitment and retention are all factors in the challenge to deliver sustainable GP services. These are magnified across Wigtownshire due to the rurality of the area.

General practice requires a team approach relying on clinical and non-clinical staff. The local approach (which is mirrored across Scotland) is to extend this core practice-based team to include additional professionals; initially this will be pharmacy, mental health professionals and advanced nurse practitioners. This is expected to release GPs' time to enable them to focus on more complex care and provide more clinical leadership. This extended core practice-based team is being developed in Stranraer due to the continued challenge of recruiting GPs.

In line with national trends, prescribing costs continue to rise in Wigtownshire. To enhance access to primary care services, the Scottish Government is investing across Scotland in additional pharmacists with advanced clinical skills and the ability to prescribe medication. They will work directly with GP practices to support the care of people with long term conditions. Two of these pharmacists have been appointed to work part-time with GP practices across Wigtownshire.

Showcasing telehealth equipment and other adaptations in a 'Pop-Up House' to help people think creatively about independent living

There is an ongoing strategy of engaging with the public to help people change the way they use GP services, including the use of community pharmacy, reviewing medications and considering alternative social prescribing such as walking groups.

Appendix 1 National Core Indicators: At a Glance Summary

Health and Social Care Integration - Core Suite of Integration Indicators - Annual Performance (March 2017)

	Indicator	Title	Latest Time Period	Dumfries & Galloway	Scotland
Outcome Indicators	A1	Percentage of adults able to look after their health very well or quite well	2015/16	95%	94%
	A2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	2015/16	86%	84%
	A3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	2015/16	82%	79%
	A4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	2015/16	82%*	75%
	A5	Total % of adults receiving any care or support who rated it as excellent or good	2015/16	85%	81%
	A6	Percentage of people with positive experience of the care provided by their GP practice	2015/16	91%*	87%
	A7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	2015/16	87%	84%
	A8	Total combined % carers who feel supported to continue in their caring role	2015/16	49%*	41%
	A9	Percentage of adults supported at home who agreed they felt safe	2015/16	87%	84%
	A10	Percentage of staff who say they would recommend their workplace as a good place to work	Under development		

* Statistically significantly better than Scotland (in other words, statistics show this is not a chance finding)

	Indicator	Title	Latest Time Period	Dumfries & Galloway	Scotland
Data Indicators	A11	Premature mortality rate per 100,000 persons	2015	376	441
	A12	Emergency admission rate (per 100,000 population) – Adults	2015/16	11,400 (p)	12,500
	A13	Emergency bed day rate (per 100,000 population) – Adults	2015/16	128,200 (p)	124,500
	A14	Readmission to hospital within 28 days (per 1,000 admissions)	2015/16	83 (p)	‡
	A15	Proportion of last 6 months of life spent at home or in a community setting	2016/17	88% (p)	88%
	A16	Falls rate per 1,000 population aged 65+	2016/17	17 (p)	21
	A17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	2015/16	79% (p)	‡
	A18	Percentage of adults with intensive care needs receiving care at home	2016	65%	62%
	A19	Number of days people aged 75 or older spend in hospital when they are ready to be discharged (per 1,000 population)	2016/17	591	842
	A20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	2015/16	24%	‡
	A21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home	Under development		
	A22	Percentage of people who are discharged from hospital within 72 hours of being ready	Under development		
	A23	Expenditure on end of life care, cost in last 6 months per death	Under development		

p = provisional figures
‡ - figures not published
Quarterly performance reports highlighting the improvement actions being taken by the Partnership against each performance indicator are available at the web page: www.dg-change.org.uk/our-performance/

The same or better than Scotland
Marginally worse than Scotland
Worse than Scotland

Appendix 2 Locally Agreed Integration Indicators: At a Glance Summary

Health and Social Care Integration - Locally Agreed Integration Indicators - Annual Performance (March 2017)

	Indicator	Title	Latest Time Period	Dumfries & Galloway	Target
Local Delivery Plan	B1	Detect cancer early	2014 - 2015	26.1%	33.3%
	B2(1)	Cancer waiting time (part 1): The percentage of all patients diagnosed with cancer who begin treatment within 31 days of the decision to treat	Jan - Mar 2017	96.5%	95%
	B2(2)	Cancer waiting time (part 2): The percentage of patients diagnosed with cancer who were referred urgently with a suspicion of cancer who began treatment within 62 days of receipt of referral	Jan - Mar 2017	96.3%	95%
	B3	The number of people newly diagnosed with dementia who have a minimum of 1 years post-diagnostic support	2014/15	82%	100%
	B4	Treatment Time Guarantee: People wait no longer than 12 weeks from agreeing treatment with the hospital to receiving treatment as an inpatient or day case.	Jan - Mar 2017	85.5%	100%
	B5	18 weeks referral to treatment: The percentage of planned/elective patients that commence treatment within 18 weeks or referral	Jan - Mar 2017	89.7%	90%
	B6	12 weeks first outpatient appointment: Percentage of people who wait no longer than 12 weeks from referral to first outpatient appointment.	Jan - Mar 2017	92.2%	95%
	B8	Early access to antenatal service: The percentage of pregnant women in each Scottish Index of Multiple Deprivation (SIMD) quintile that are booked for antenatal care by the 12th week of gestation.	Jan - Mar 2017	83.7%	80%
	B9	IVF waiting times: Percentage of eligible people who commence IVF treatment within 12 months of referral.	Jan - Mar 2017	100%	100%
	B10	CAMHS Waiting Times: Percentage of young people who commence treatment for specialist Child and Adolescent Mental Health Services within 18 weeks of referral	Jan - Mar 2017	100%	90%
	B11	Psychological therapies waiting times: Percentage of people who commence Psychological Therapy based treatment within 18 weeks of referral.	Jan - Mar 2017	69.8%	90%
	B12	Rate of Clostridium Difficile infections in patients aged 15 and over per 1,000 total occupied bed days.	2016/17	0.26	0.32
	B13	The rate of Staphylococcus Aureus Bacteraemias (MRSA/MSSA) per 1,000 occupied bed days	2016/17	0.32	0.24
	B14	Drug and alcohol treatment waiting times: Percentage of people who wait no longer than 3 weeks from when a referral is received to when they receive approporiate drug or alcohol treatment that supports their recovery.	Oct - Dec 2016	99%	90%
	B15	Alcohol Brief Interventions: Number of interventions delivered in three priority settings (primary care, Accident & Emergency and antenatal care)	2016/17	691	1,746
	B16	Smoking cessation: To sustain and embed successful smoking quits at 12 weeks post quit, in the 40 per cent most deprived SIMD (Scottish Index of Multiple Deprivation) areas.	2015/16	25%	Scotland 21.6%
	B17	GPs provide 48 hour access or advance booking to an appropriate member of the GP team for at least 90 per cent of patients	2015/16	89%	Scotland 84%
	B18	Sickness Absence Rate (%)	March 2017	4.9% NHS 4.4% Social work (not CASS)	4%
	B19	Accident and Emergency waiting times: Percentage of people who wait no longer than 4 hours from arriving in Accident and Emergency to admission, discharge or transfer for treatment.	2016/17	94.7%	95%
	B20	The NHS Board operates within their Revenue Resource Limit (RRL), their Capital Resource Limit (CRL) and meet their Cash Requirement	2016/17	100%	

Social Work	C1	Adults accessing telecare as a percentage of the total number adults supported to live at home	March 2017	77.1%	73%
	C2	The number of adults accessing self directed support Option 1 (see glossary)	March 2017	326	318
	C3	The number of adults accessing self directed support Option 2 (see glossary)		n/a	n/a
	C4	The number of adults accessing self directed support Option 3 (see glossary)	March 2017	2,426	2,387
	C5	Carers: The number of adult Carers being supported		Under development	
	C6	Proportion of people 65 and over receiving care at home (via Option 3) with intensive needs (plus 10 hours)	March 2017		65%
	C7	The number of adults under 65 receiving personal care at home (via SDS Option 3)	March 2017		660
	C8	Total number of homecare hours provided as a rate per 1,000 population aged 65 and over	March 2017	602.4	n/a
	C9	Percentage of referrers receiving feedback on actions within 5 days of receipt of referral	Jan - Mar 2017	44%	75%
Locally Developed Indicators	D1	Proportion of people who agree they felt safe when they last used health & social care services		Under development	
	D2	The number of complaints received by health & social care services		Under development	
	D3	The percentage of adults who agree their health and social care support seemed well co-ordinated		Under development	
	D4	Of those who have had their personal outcomes assessed, the proportion who have made progress towards achieving them		Under development	
	D5	The proportion of staff who agree that they get the information they need to do their job well [provisional findings from iMatter, still in rollout phase, currently NHS only]	2016	79% (p)	n/a
	D6	Technology Enabled Healthcare - The number of times people access "virtual services"		Under development	
	D7	Housing Indicator		Under development	
	D8	Prescribing Indicator		Under development	
	D9	The ratio of workload between institutional and community based care		Under development	
	D10	Adult Support & Protection: Percentage of people referred to ASP who agree that have had a positive outcome		Under development	
	D11	The proportion of Carers who agree they receive the support needed to continue in their caring role		Under development	
	D12	Proportion of people who agree that they could rely on family or friends in their own neighbourhood for help		Under development	
	D13	Health Inequalities Indicator		Under development	
	D14	Proportion of people who agree that they were communicated with well and listened to		Under development	
	D15	Proportion of people who are satisfied with local health and social care services		Under development	
	D16	Proportion of people who agree they are satisfied with the ease of finding information on health & social care services		Under development	
	D17	In a community setting (including care homes), the number of new anticipatory care plans		Under development	
	D18	The proportion of people who feel connected to the neighbourhood they live		Under development	
	D19	The proportion of staff who agree that they understand the vision and direction of Dumfries and Galloway Health and Social Care		Under development	
	D20	The proportion of staff who agree that they are confident they understand how their role in the organisation can support people from different backgrounds and with different needs		Under development	
	D21	The proportion of staff who agree that they are involved in decisions relating to their job [provisional findings from iMatter, still in rollout phase, currently NHS only]	2016	70% (p)	n/a
	D22	Percentage of staff who say they would recommend their organisation as a good place to work [provisional findings from iMatter, still in rollout phase, currently NHS only]	2016	73% (p)	n/a

p = provisional figures

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Worse than Scotland

Glossary of Terms

360 degree feedback
A personal development tool where people receive confidential, anonymous feedback from the people who work around them. This typically includes the employee's manager, peers, and direct reports.

Allied health professionals (AHPs)
Professionals related to healthcare distinct from nursing and medicine. Examples include podiatrists, physiotherapists, occupational therapists and speech and language therapists.

Anticipatory care
A term used to describe an approach whereby the actual or potential care and support needs of someone are predicted. By doing this, steps can be taken much earlier to minimise or avoid altogether the impacts of these. (See also forward- looking care).

Asset-based approach
Identifying and making best use of all the resources that exist at both an individual and community level.

Care and support plan
An agreed document, developed and maintained by the person and their health and/or social care professional, that identifies and records discussion with regard to personal aims and outcomes, needs, risk and any required action. It can be electronically stored or written on paper and accessible to the person.

Carer
Someone who provides unpaid care and support to a family member, neighbour or friend.

Delayed discharge
A term used to describe an incident whereby someone clinically ready for discharge cannot leave hospital because the care, support or accommodation they require is not available.

Dementia
A term used to describe a group of symptoms that occur when brain cells stop working properly, which can affect thinking, memory and communication skills.

Forward-looking care
A term used to describe an approach whereby the actual or potential care and support needs of someone are predicted. By doing this, steps can be taken much earlier to minimise or avoid altogether the impacts of these. (See also anticipatory care).

Health inequalities
A term that refers to the gap between the health of different population groups, such as the wealthy compared to poorer communities or people with different ethnic backgrounds.

Independent sector
A general term for non-statutory bodies including private enterprise, voluntary, charitable or not-for-profit organisations.

Integration authority
An integration joint board or lead agency, responsible for services delegated to it by the NHS and council.

Integration Joint Board (IJB)
A body established where a health board and local authority agree to put in place a 'Body Corporate' model. The integration joint board is responsible for the planning of integrated arrangements and onward service delivery.

Locality
The term outlined in the Public Bodies (Joint Working) (Scotland) Act 2014 to identify local areas. Every local authority must define at least two localities within its boundaries for the purpose of locality planning. In Dumfries & Galloway there are four localities - Annandale & Eskdale, Nithsdale, Stewartry and Wigtownshire.

Long term conditions
These are health conditions that last a year or longer, impact on a person's life and may require ongoing care and support. These are also known as chronic conditions.

Mobile technologies
Technology that is portable, including mobile phones, tablet devices and laptops.

Personalised
Tailoring health and/or social care and support specifically to an individual.

Person-centred
Focuses care and support on the needs of a person and is a way of thinking and doing things that sees the people using health and social care as equal partners in planning, developing and monitoring care to make sure it meets their needs.

Personal outcomes
The end result or impact of activity on a person. A personal outcomes approach identifies what matters to people through good conversations during care and support planning.

Polypharmacy
When a person is taking multiple medications (typically four or more). Polypharmacy is considered important to monitor as there can be unforeseen interactions between medications.

Primary care
Health care provided in the community. For example services provided by GP practices, dental practices, community pharmacies and high street opticians, as well as community nurses and allied health professionals.

Protected characteristics
As it is recognised that people may face discrimination due to these characteristics the Equality Act 2010 describes age, disability, sex, race, religion or belief, pregnancy and maternity, marriage and civil partnership, sexual orientation and gender reassignment as protected characteristics.

Re-ablement
A 'hands-off' approach to care and support that helps people learn or re- learn the skills necessary for daily living. A focus on regaining physical ability and re-assessment is central to this way of working.

Self-directed support (SDS)
A term that describes a direct payment support service that gives people more choice and control over the support they use to meet their social care needs, including personal budgets.

> **SDS Option 1:** This is where people take ownership and control of purchasing their own care and support
>
> **SDS Option 2:** This is where people choose the organisation they want to be supported by and the local authority transfers funds to that organisation who then arrange care and support to meet their agreed needs and outcomes
>
> **SDS Option 3:** This is where social work services organise and purchase care and support for people
>
> **SDS Option 4:** This is a mix of any of the above SDS Options 1, 2 and 3

Self-management
People making decisions about, and managing their own health and wellbeing.

Strategic needs assessment (SNA)
An analysis of the health and social care and support needs of a population that helps to inform health and social care planning.

Strategic plan
A high level plan that sets the future direction of travel for health and social care by identifying key challenges and priority areas of focus and aligning resources to activity.

Technology enabled care
A Scottish Government programme to enable a major roll out of 'telehealth' and 'telecare' in Scotland.

Tests of change
A method for improvement that involves multiple cycles of trying out small scale changes. making adjustments and testing again.

Third sector
A vast range of organisations which have a social purpose and are not-for-profit, such as voluntary organisations, charities, or social enterprises. The types of services and the opportunities they provide include health and social care and support, information, advocacy and volunteering.

Volunteering
Any activity that involves spending time, unpaid, doing something that aims to benefit the environment or someone (individuals or groups) other than, or in addition to, close relatives.

Vulnerable adult
A person over the age of 18 at risk of being harmed by reason of disability, age or illness.

Wellbeing
Wellbeing is a complex combination of a person's physical, mental, emotional and social health. Wellbeing is strongly linked to happiness and satisfaction in life.

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