DUMFRIES AND GALLOWAY
INTEGRATION JOINT BOARD

# HEALTH AND SOCIAL CARE

## ANNANDALE AND ESKDALE LOCALITY REPORT

DUMFRIES AND GALLOWAY
Health and Social Care

**April 2019**

# Contents




This report has been produced by:

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

April 2019



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# Foreword

I am pleased to present the fifth performance report from Annandale and Eskdale which sets out the progress we have made in integrating health and social care across the locality to support our communities to be the best place to live active, safe and healthy lives by promoting independence, choice and control.

There is a lot going on in Annandale and Eskdale, lots of challenges and lots of great ideas and new initiatives. Within this report we have focused in particular on how staff and volunteers from all parts of the health and social care partnership have worked together as one team with local people, their families and Carers to help deliver 4 of the 9 national health and wellbeing outcomes.

We are committed to working **with** rather than **for** people. Over the last 12 months we have increasingly focused on the need to promote Good Conversations to help people look after themselves (Outcome 1), helping people maintain or improve their quality of life (Outcome 4), helping keep people safe from harm (Outcome7) and helping ensure that we use our resources effectively (Outcome 9).

New challenges require new ways of thinking and new ways to best meet the changing health and social care needs of people across Annandale and Eskdale. Last winter, freezing snow presented a major challenge in protecting the most vulnerable members of our community. However through local communities pulling together as one team, talking to each other and creatively using our shared community assets, together we were able to protect vulnerable people from harm and help people maintain their quality of life.

In this report, you will read about many other positive examples of how good conversations can lead to positive changes. At the same time, I am aware that there is more to be done to help transform our primary care services, reduce delays in discharging patients from hospitals, help deliver a consistent approach to how we develop our learning disability services, utilise new technology more effectively and develop a better understanding of the benefits of Realistic Medicine with local people. We also know that recruiting staff in health and social care continues to be a challenge, particularly in the more rural areas, and over the next 12 months we will continue to work with local providers to both support our existing staff and help attract and recruit new staff to meet the needs of local people.

We have achieved a lot and through good conversations with all members of the Annandale and Eskdale community, I am confident that collectively we can develop new solutions to new challenges to enable local people to live active, safe and health lives.

**Gary Sheehan**
**Locality Manager - Annandale and Eskdale**
**April 2019**

# Introduction

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

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

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

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

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

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

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

Strategic Plan 2018- 2021
http://dghscp.co.uk/wp-content/uploads/2018/12/Strategic-Plan-2018-2021.pdf (last accessed 25 February 2019)

Annandale and Eskdale Locality Plan 2016-2019
http://dghscp.co.uk/wp-conthttp://dghscp.co.uk/wp-content/uploads/2018/12/Annandale-and-Eskdale-Locality-Plan.pdf (last accessed 25 February 2019)

Dumfries and Galloway Scheme of Integration
http://dghscp.co.uk/wp-content/uploads/2018/12/Integration-Scheme.pdf (last accessed 25 February 2019)

# The symbols we use

### i) How we are addressing this outcome in our locality

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

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

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

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

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

### ii) How we are getting on

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


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

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

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

# The 9 National Health and Wellbeing Outcomes

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

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 9 national health and wellbeing outcomes set the direction of travel for services in the health and social care partnership and are the benchmark against which progress is measured. The Scottish Government has not numbered these outcomes to reflect that they are all equally important. However, locally we have added numbers solely for the purpose of tracking progress through our performance framework.

# 1. Outcome 1

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

### 1.1 How we support this in our locality

Making the most of and maintaining health and wellbeing is better than treating illness. The aim is to promote good health and prevent ill health or, where health and social care needs are identified, to make sure there are appropriate levels of planning and support to maximise health and wellbeing. There are a number of ways we support this outcome in Annandale and Eskdale.

#### Different Conversations

We are supporting our workforce, across the sectors, to have different and consistent conversations. Examples of this include the roll out of Good Conversations training and the one to one health and wellbeing behaviour change training. Good Conversations are a way of encouraging and supporting people to take control and responsibility and to openly discuss their options and wishes at all stages of their lives. A recent celebration event focused on ensuring staff felt confident and supported in having these conversations with people. Particularly those nearing the end of life so that wishes are known and recorded.

#### Community Link

We are continuing to build on the Community Link Programme and ensuring people are supported and encouraged to engage and make positive changes. The link worker service works with the most vulnerable in the community often supporting people to engage with mainstream services. Referrals to the service come from practitioners across the sectors and through all of our general practices. The service is available to all practitioners working across the disciplines and sectors, taking a person centred, asset based approach working with people to strengthen their resilience and ability to achieve and improve their health and wellbeing through identifying personal outcomes.

#### Forward Planning and Anticipatory Care Plans (ACPs)

We are continuing to encourage people to forward plan and have conversations much earlier so that their wishes are known to those who are supporting and caring for them. We are increasing the number of people who have Forward Looking Plans and Anticipatory Care Plans (ACPs) across the locality.

#### One Team Approach and Multi Disciplinary Teams (MDT)

We continue to build on the Multi Disciplinary Team (MDT) model to ensure people are supported by the right person at the right time. Emerging from the One Team model we have developed a specific interest group looking at mental health support and pathways of care and support.

#### Capacity building

We are developing skills in others through capacity building and on a one to one basis addressing the population issue of overweight, obesity and the prevalence of Type 2 Diabetes across different age ranges.

### Asset based Approaches

People's own assets are utilised through having Good Conversations. We encourage our workforce to think about every contact or conversation with a person as an opportunity to identify and maximise people's assets to support their own health and wellbeing. The setting of personal goals and aspirations allow us to support people to help themselves whilst building confidence and skills. An example is the Personal Outcome Plans used within the community link service and also the Outcome Star in social services.

### Partnership Working and Community Development

We are working in partnership across communities to identify and maximise assets and assist people and groups to develop services, activities and initiatives that provide support for local people. This provides opportunities for people in similar situations to engage and connect with each other. Examples include the setting up of Men's Sheds, a new parents group, arts and crafts groups and day opportunities programmes.

### Information

A local Activity Guide is produced regularly through the Safe and Healthy Action Partnership (SHAP) that has information about the wide range of support, activities and opportunities across Annandale and Eskdale.

### Mental Health

The Locality uses a stepped model approach in line with NICE guidelines to provide the right support at the right time. Where more complex or severe mental health problems are identified, we ensure people have access to appropriate specialist mental health services. The Locality will continue to deliver self management models through therapeutic engagement, education, social prescribing, psychosocial interventions and working closely with families and Carers.

## 1.2 How we are addressing this outcome in our locality

Our We Will commitments which support this outcome and their current Red, Amber, Green (RAG) status:

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

"I was on a real downward spiral in terms of my health and didn't think I could get back to feeling ok again, but having someone listen to me and help me make small steps has really made a difference.."

(Community Link client)

### 1.2.1 Community Link Programme

The Community Link Programme is identifying some of our most vulnerable who have may have fallen through the safety net of mainstream services including mental health services, or who do not meet the criteria for social services. It also works with people with very chaotic lives or complex needs who have disengaged or who refuse with engage with mainstream services. A very high number of the people we work with are vulnerable and experience inequalities. Many are supported with issues such as housing, finance and benefits, mental wellbeing and confidence. People who have disengaged are often supported to access mainstream services.

"We feel supported and listened to. We can now look forward to having a better quality of life. I (husband) feel I've now got support in my caring role and I'm managing to get to take some breaks and getting some sleep. We have reduced visits to our GP and are managing much better"

(Community Link clients)

### 1.2.2 Development of Community Support

**New Horizons Drop In** - Working in partnership with Alzheimer Scotland and Parkinson's UK we have an established drop in service on a monthly basis for people with long term progressive neurological conditions. This supports and increases self care options for people by highlighting services which can assist.

Our **Let's Cook** and **Healthy Weight Programmes** target vulnerable people, parents and parents to be. They deliver cooking skills, meal planning and budgeting sessions. Evaluations show improved skills, knowledge and confidence in the people who take part as well as positive changes to behaviours and choices.

We are actively working with partners and the community to identify needs and increase facilities and choice through the Safe and Healthy Action Partnership (SHAP) and are involved in supporting the development of these. One example of this is where a GP highlighted that there appeared to be no support for new parents in Annan. We worked together with the GP, new parents and others to develop a group which is now very well attended. We have had feedback from people taking part that they feel less isolated. One person reported having no need for antidepressants anymore. The group is now being supported to become self sufficient.

### 1.2.3 Partnership working

Close working with Home Energy Scotland ensures we are supporting vulnerable and low income individuals to ensure their homes are insulated, warm and efficient.

### 1.2.4 Workforce Development

A group of workers from across the sectors recently went through the accredited Best Practice in Dementia Care course which was developed by Stirling University. Participants included workers from social work services, Crossroads and health services.

Three Care Providers from Annandale and Eskdale have undertaken Mainstreaming Good Conversations training, which promotes learning on Asset Based Outcome Focused (ABOF) conversations with people in receipt of services. This programme is also designed to use same methodology in achieving ABOF conversations with staff and teams to support and promote reliable and committed workforce. Further cohorts are being planned during 2019.

### 1.2.5 Addressing Inequalities in Health

The Community Mental Health Team (CMHT) are currently working on a Parity of Esteem project alongside the Royal College of Nursing (RCN) and primary care. This is a project to improve the physical health and physical health screening of people with severe mental health issues who are often at risk of earlier mortality and morbidity. The focus of the work is to ensure equality between physical and mental health needs and to ensure people can access services and be supported to overcome barriers and stigma that often prevent them from doing so.

### 1.2.6 Forward Looking Planning

Forward Looking Planning helps to support very vulnerable people who are at risk of admission to hospital or of crisis and supports them forward plan and to consider Power of Attorney

### 1.2.7 Transforming Primary Care

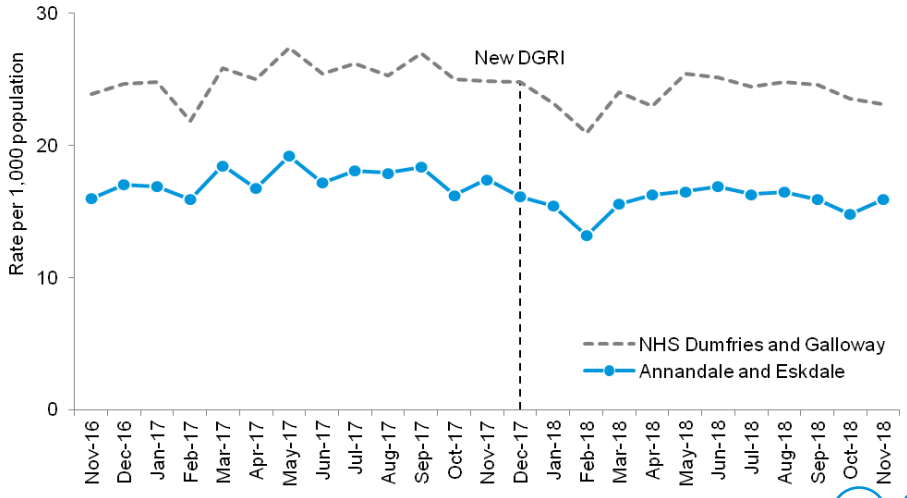
The new GP contract is moving towards a new model of primary care where we support people to take responsibility for managing their own health and wellbeing. It is also about ensuring that people get to see the most appropriate person within their practice. We are at the beginning of this development as it will take place in stages over 3 to 4 years but we already have Advanced Nurse Practitioners (ANPs), pharmacists and mental health nurses working in general practices. Across the locality we are taking a One Team approach to ensure people have information about these changes.

### 1.3 How we are getting on

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

There are two things to note. Many residents of Annandale and Eskdale access hospital services in Carlisle; English activity is NOT included in these figures. Also, the new DGRI has a Combined Assessment Unit (CAU), which means that people arriving at the front door are managed along different care pathways to previously.

**Residents of Annandale and Eskdale locality,**
**Rate of Emergency Department attendances per 1,000 population**




Source: NSS Discovery, from National A&E Datamart

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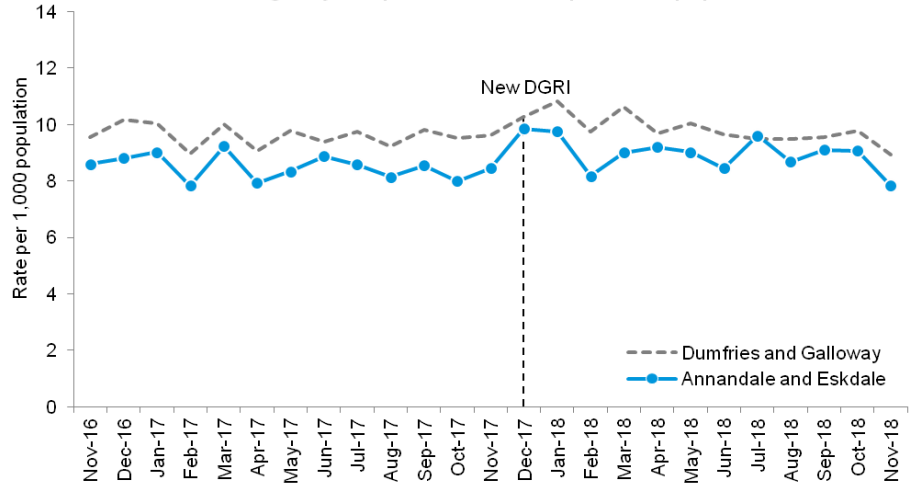
**Residents of Annandale and Eskdale locality,**
**Rate of emergency hospital admissions per 1,000 population**




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

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# 4. Outcome 4

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

### 4.1 How we support this in our locality

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

**Community Hospitals** - as a locality we are committed to provide safe, high quality and effective care. Quality care is not an accident. It is about a conscious objective to make things better for the people in our care. Measuring the quality of care being delivered can be a complex process. The programme used in NHS Dumfries and Galloway is called Care Assurance.

Care Assurance aims to ensure regularity in the delivery of high quality care. It identifies areas of good practice and recognises areas of practice that may not meet the locally agreed standards. The programme supports staff to continuously improve using the knowledge gained from the Care Assurance reports.

NHS Dumfries and Galloway have three levels of Care Assurance to enable the assurance of care delivered to people:

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

All Care Assurance levels are discussed with the people we are caring for and it is not simply the nurses opinion. This enables the capture of the person centred care which assures us that people are at the centre of the care delivery.

**Daily Dynamic Discharge** - There are many things which have the potential to cause delay and unnecessarily prolong a person's stay in hospital. Some of these factors can be categorised as external however, there are also internal causes of non clinical delay and these equally add to a poor experience for people. Evidence from the Day of Care Audits carried out across the 4 community hospitals in Annandale and Eskdale indicates that at any one time, between 30% and 50% of people in a hospital bed no longer require acute care but their transfer to another area for continuing care, or discharge to General Practitioner has been delayed.

Balancing the day's clinical and care delivery needs, with the suitable completion of tasks required ensuring timely discharge is an ever present challenge for ward teams. Staff constantly cope with doing what's best to support the movement of people and making the best use of the available resources. By adopting the Daily Dynamic Discharge it enables us to identify as a multi disciplinary team the potential issues that may arise and prevent people returning home or to a homely setting.

**Community Nursing** - The number of people requiring to be nursed and cared for at home, with multiple and complex needs has gradually risen. The skills and knowledge of our Community Adult General Nurses (CAGN) are crucial to deliver safe, effective and person centred care. Effective use of this important service is therefore essential.

At present the CAGN service is currently under review. The main aim of this is to develop, agree and drive forward the implementation of a refocused role for community nursing in NHS Scotland and NHS Dumfries and Galloway in line with the Chief Nursing Officer paper 'Transforming Roles'. There has been development of national guidance clarifying the role and the unique contribution of the CAGN service and the associated assessment tools. This is required to enable the service to meet the future health needs of the people in Annandale and Eskdale.

CAGNs, social services staff and the Community Link Service work closely as part of the integrated locality team to identify people who may need some extra support to improve their circumstances and quality of life. They also work together to actively encourage people to have much earlier conversations and forward plan in relation to wishes and options around their future health and social care.

### 4.2 How we are addressing this outcome in our locality

Our We Will commitments which support this outcome and their current Red, Amber, Green (RAG) status:

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

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

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

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

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

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

#### 4.2.1 Care Assurance

Currently 3 of our 4 cottage hospitals have completed Level 3 Care Assurance with 2 of our cottage hospitals achieving bronze status. One hospital is awaiting results from Level 3 and the other hospital is presently undergoing Level 3 at the moment. We will continue to strive to maintain and build on the bronze level of Care Assurance.

### 4.2.2 Daily Dynamic Discharge

Daily Dynamic Discharge is now active within all our cottage hospitals to support with discharge planning. We continue to work hand in hand with our acute colleagues and our multi disciplinary team to enable and assist in a seamless person centred discharge for our people.

### 4.2.3 Community Nursing Review

We continue to make progress in developing our community nursing service through our review group which meets quarterly, supported by 4 agreed subgroups focusing on:

- Governance and Supervision
- Data
- Education and Development
- IT

This will enable us to ensure a more effective and consistent delivery of the service within the community of Annandale and Eskdale.

By the implementing the Quality Tool associated with the Workload, Workforce Planning Tool we will be able to measure the quality of care we deliver in the community setting. This data will enable us to celebrate the areas of practice we do well and recognise areas of practice that we may need to develop further.

## How we are getting on: Community Nursing

We constantly gather feedback from patients on what works well and what could be improved with our services. For example the following feedback has been provided on our community nursing service:

What worked well?

"Very kind, patient and considerate. The nurses were very knowledgeable and good at their job. Very efficient. Every one of the nurses is a gem. I could not say one is better than the next. They are brilliant and very friendly and make you feel at ease when they come through the door. Good work girls"

What could be improved?

"Having the same nurses come to visit us. We get to know them very well, not different one every visit. Both my parents cannot think that there is anything you can improve. Obviously it is difficult for you if you don't have the time to sit and talk but when you don't have the staff they understand this"

### 4.2.4 Forward Looking Care

We continually strive to increase the number of people who have a Forward Care Plan in place and work closely with our primary care teams, mental health teams and others to ensure Good Conversations are taking place across the locality and people are taking responsibility to forward plan and ensure their wishes are known.

### 4.2.5 Information

A local Activity Guide is produced regularly through the Safe and Healthy Action Partnership (SHAP) that has information about the wide range of support, activities and opportunities across Annandale and Eskdale. This is used by all staff to ensure people have information about what is available in terms of living a good quality of life. Similarly a short life working group is currently in the process of developing an information leaflet with regards to the service our community nursing service provides. It is hoped that this will provide the people with an informative description of the service and what will be provide within the community setting.

### 4.2.6 Good Conversations

All of our front line social work staff, including care co-ordinators and social workers, have completed Good Conversations training. This allows them to focus specifically on what is important to people, what their natural assets are in terms of family, community and third sector organisations that could offer them support.

### 4.2.7 Self Directed Support Information

Part of any good conversation with people involves the sharing of information that is valuable to them in terms of meeting their needs and delivering the outcomes people wish to achieve. We inform people of the different options available to them under Self Directed Support (SDS) as well as provide relevant written information using leaflets and directing people to relevant websites such as the Care Inspectorate.

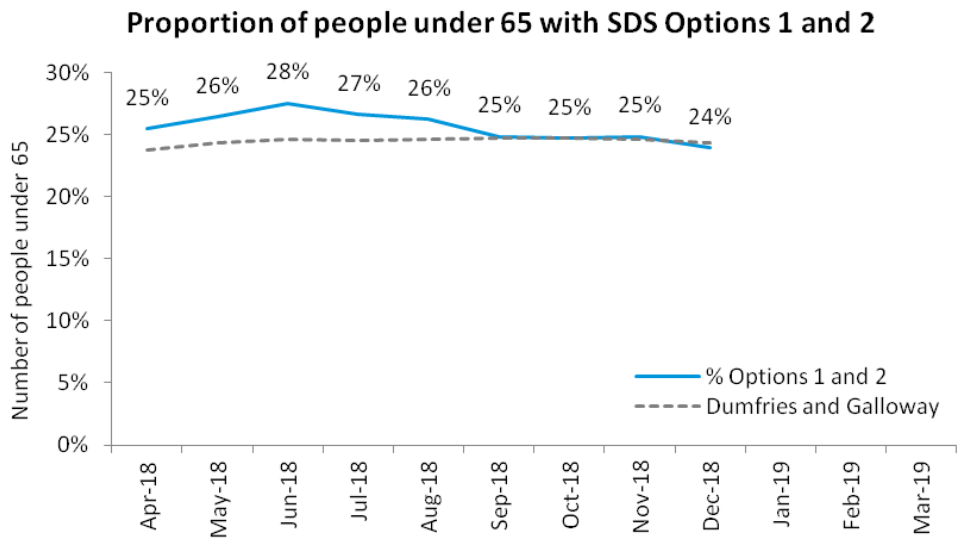
### 4.2.8 Reviewing

We now have a full time care co-ordinator within our social work team and a temporary social worker who are employed specifically to review care plans. This has resulted in a significant improvement in the number of reviews of care packages as well as ensuring that all people discharged from hospital have their care package reviewed within 6 weeks of hospital discharge.

### 4.3 How we are getting on

The proportion of people in Annandale and Eskdale receiving support through Self Directed Support Options 1 or 2, which have the largest levels of personal responsibility has reduced amongst younger adults since the previous year and increased a small amount for older adults. Whilst we support people to have the confidence to choose Options 1 and 2 for themselves, many people continue to prefer to choose Option 3.

Around one in four people aged under 65 have chosen these Options, whilst for people aged 65 or older, it is around one person in every 12. In December 2018 there were 163 people aged under 65 receiving care through SDS and 421 people aged 65 or older. The number of people with SDS Options 1 and 2 has been stable, it appears the proportion has lowered because more people have started on SDS and chosen a preference for Option 3.




Source: Dumfries and Galloway Council, local figures

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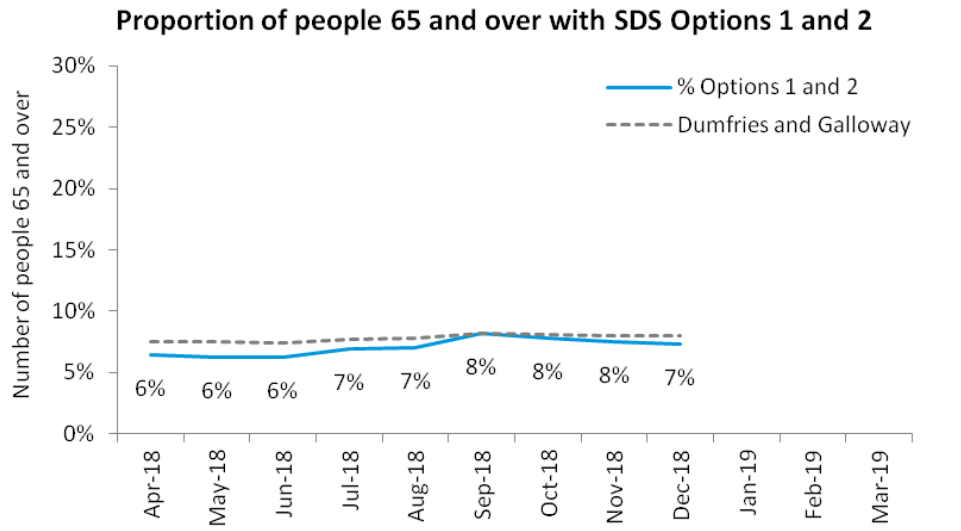


Source: Dumfries and Galloway Council, local figures

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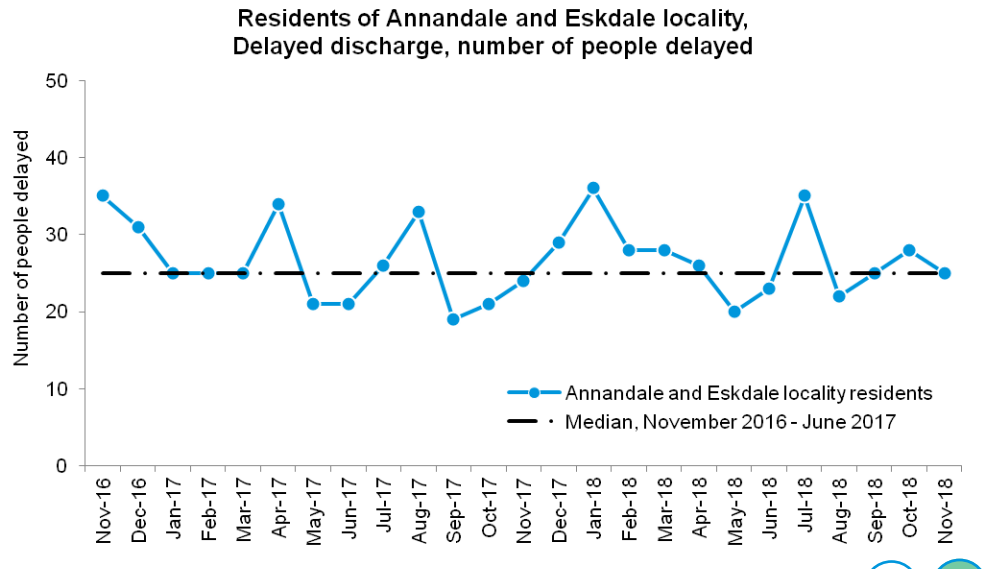
### 4.3 How we are getting on, continued

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

In Annandale and Eskdale, over the last year the number of people experiencing a delayed discharge (in acute, community or cottage hospital setting) has been stable. This is in contrast to a rise observed across Dumfries and Galloway. A dedicated flow coordinator works with the multidisciplinary team to enable smooth transitions from one setting to another.




Source: NHS Dumfries and Galloway, local figures

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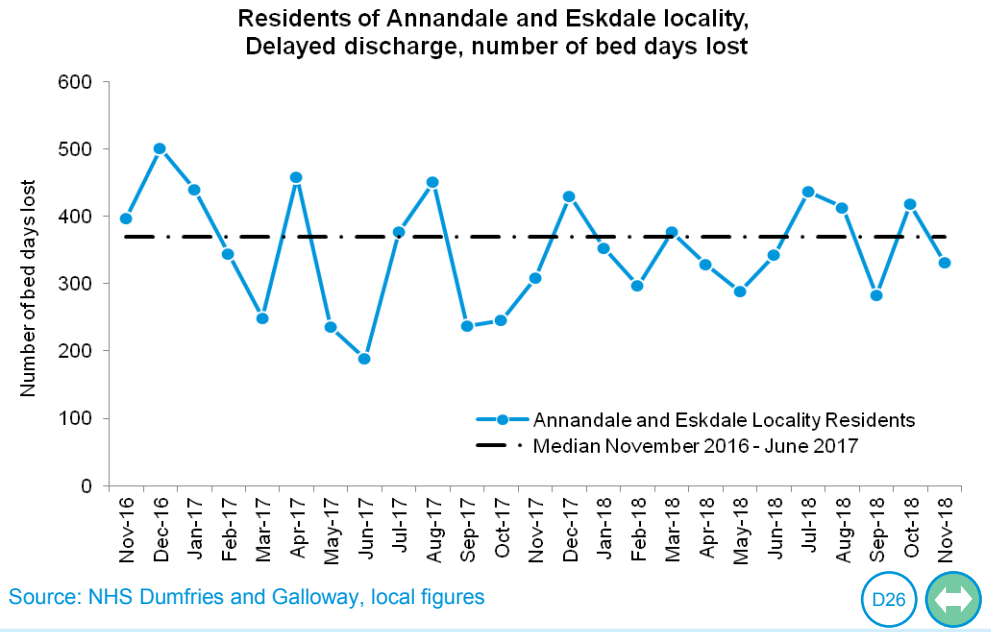


Source: NHS Dumfries and Galloway, local figures

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# 7. Outcome 7

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

### 7.1 How we support this in our locality

Making sure people are safe from harm is about maintaining safe, high quality care and protecting vulnerable people. In some instances activities focus on protecting people already identified as vulnerable. Other activities are focussed on improving the safety of services, aiming to reduce the risk of harm to all people. We also, as a locality team, try to work together to ensure we are able to identify people who may be at risk of becoming vulnerable or have the potential to be at risk of harm and try to intervene earlier through our Community Link Service. Many of the people referred to the Link Service have disengaged with mainstream services or do not fit the criteria for a referral to others. We feel this work is allowing us to work together to intervene and offer support at an earlier stage.

**Developing our workforce** - Over the past year we have seen significant positive developments within our social work team based in Annan town hall. This has included our locality social work manager chairing and facilitating all Adult Support and Protection (ASP) case conferences. In addition, we have successfully built on our expertise in that 3 additional social workers have completed their Council Officer Training which allows them to carry out and complete ASP inquiries and investigations as required. This has resulted in all qualified social workers in the team now being fully trained council officers and impacted positively on the availability of staff to complete inquiries and investigations.

**Supporting people with dementia** - We have worked in partnership with our colleagues across the council and the health and social care partnership to increase knowledge and understanding of dementia. One of our senior social workers and dementia champion has just completed delivering the University of Stirling's Awareness Raising in Dementia course to 6 staff in various front office and public facing receptions such as GP practice and town hall receptions. This has also been delivered to staff within care homes, care at home services and to health care support workers in cottage hospitals .

**One Team Approach** - Our staff attend regular multi disciplinary team meetings in GP practices and all cottage hospitals which allows us to share appropriate information with our colleagues across the health sector and includes GP's, physiotherapists, occupational therapists, nurses, mental health teams and community link workers. These meetings allow for better planning with people requiring care and support on discharge from hospital. This planning includes finding ways to prevent crises and hospital admissions.

One of our senior social workers is completing a post graduate course of study in personality disorder. We are involved in developing a more collaborative approach along with our partners in the mental health directorate and the police to work with people impacted upon by this condition.

**Sharing Information** - Annandale and Eskdale has been chosen to test a new shared information portal for the health and social care partnership. This portal will give our front line social work team access to a basic set of health information for people in need of support and protection. This will speed up the sharing of information and allow for improved outcomes for people, by removing the delay built into inquiries and investigations as a result having to wait to receive information.

### 7.2 How we are addressing this outcome in our locality

Our We Will commitments which support this outcome and their current Red, Amber, Green (RAG) status:

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

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

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

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

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

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

#### 7.2.1 One Team Approach

To help people recognise and report abuse and harm we will continue to participate in all multi disciplinary team meetings in our GP practices and cottage hospitals where conversations take place about vulnerable patients. We will also continue to reach out to our partners across the health and social care partnership, the police and the service delivery arm of our care at home and residential home services and assist where possible to address concerns relating to abuse and harm.

#### 7.2.2 Developing our staff

All our staff have up to date personal development plans that help them to continue to grow and learn as front line practitioners. These plans identify key learning objectives for staff and increase their skills and knowledge in this area.

### 7.2.3 Timely Responses

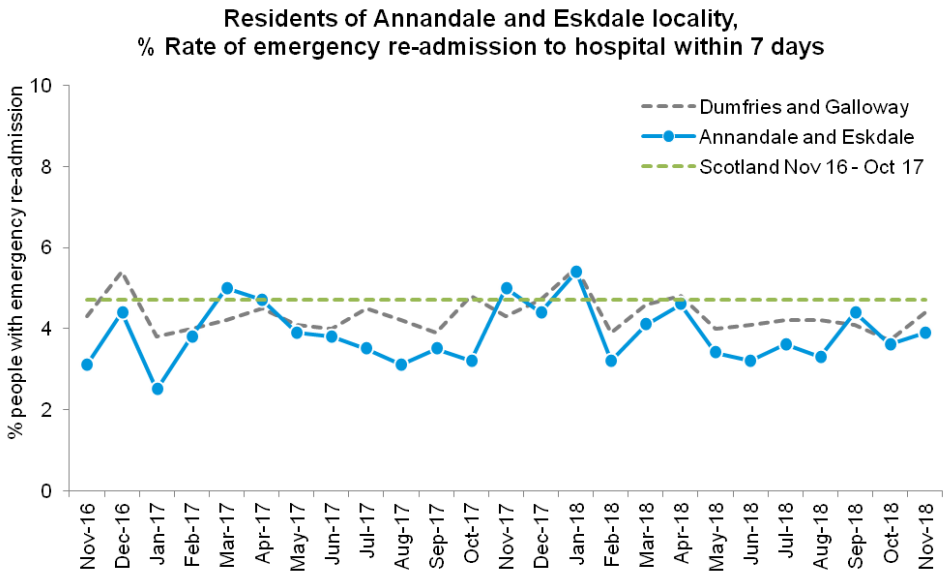
With the delivery and programme of change within our Multi Agency Screening Hub (MASH) and the introduction of a second senior social worker in this team we expect significant improvement in the timescales for the completion of Adult Support and Protection (ASP) inquiries. This will also allow for a greater understanding of the main risk areas and developing trends in the area and the subsequent development of any strategies required to address these.

### 7.2.4 Person Centred approach

All adults will have an Adult Support and Protection Plan as required following the conclusion of an investigation. We will develop this protection plan in partnership with them or their guardian and other key partners involved in the adult protection case conference. This will ensure we have dealt with the holistic needs of the individual in a person centred way.

### 7.3 How we are getting on

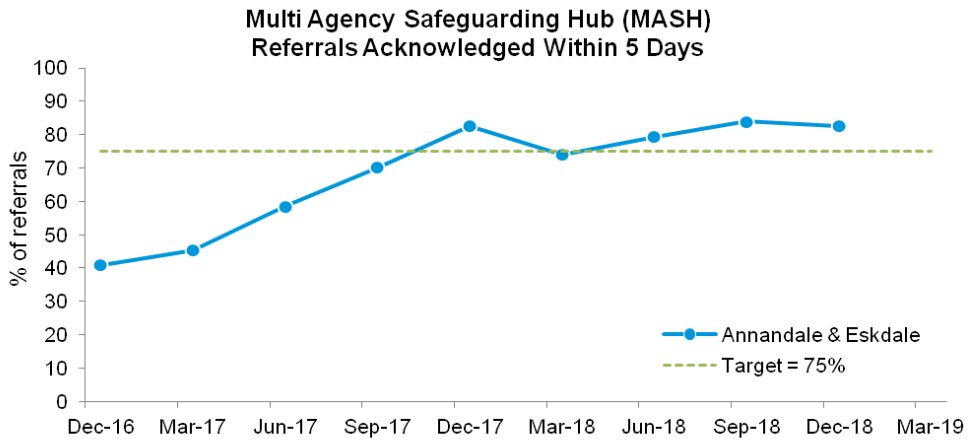
One aspect of keeping people safe is monitoring re-admissions to hospital. Whilst a discharge quickly followed by an emergency admission may be entirely appropriate in many cases, it could mean in some cases that people were possibly discharged before they were ready. Readmission rates are typically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




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

D27

Adult Support and Protection activity is scrutinised through the Public Protection Committee (PPC). The PCC Performance and Quality subcommittee is currently redesigning the analysis and reporting of performance figures for Adult Support and Protection. It is expected that when performance reporting has been agreed, an appropriate locality level measure will be reported here. In the interim, the previous indicator showing the percentage of people making referrals who receive feedback on actions within 5 days of receipt of their referral, was 82.5% in December 2018.




Source: Dumfries and Galloway Council, local figures

C9

# 9. Outcome 9

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

### 9.1 How we support this in our locality

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

**Medication** - We spend over £7.4 million on prescribing medication across Annandale and Eskdale which represents about 50% of our community health budget. Although our average cost per patient is below the average for Scotland, we are aware that up to 20% of prescribed medication is never used. There are considerable differences in the average cost per patient across practices and that for some people we need to develop alternative ways of meeting their needs. Areas of work that contribute to reducing prescribing costs include promoting healthier lifestyles, implementing Realistic Medicine, regular pharmacy reviews, and switching from branded to generic medication where clinically appropriate. Annandale and Eskdale has a well established prescribing group of local GPs and pharmacists who work together to review how best to deliver a cost effective and clinically appropriate prescribing programme.

**Reviewing care packages and patient flow** – the needs of all people are assessed and reviewed through a one team, multi disciplinary approach on a daily, weekly and annual basis to make sure that we provide care and support in accordance with each person's needs and which make use of all available community assets . All 4 of our cottage hospitals convene daily dynamic discharge meetings to promote patient flow. Weekly multi disciplinary meetings and locality flow meetings are held to review new and existing cases and we aim to review all care packages on at least an annual basis. All staff are expected to use Good Conversations with people to focus on a joint responsibility for maximising personal independence and making best use of all available community assets.

**Day Of Care** – We hold regular Day Of Care audits in all 4 of our cottage hospitals to help us monitor patient flow and help us plan for meeting the changing needs of local people. Audit reports are discussed and monitored by the locality management team and Locality patient flow group to help us minimise delayed discharges and help put in place an appropriate, person centred package of care.

**Reducing office and administration costs** – We have an ongoing programme of reducing our office and administration costs. In both health and social care, staff are becoming increasingly self reliant through developing their IT skills and this has led to a reduction in administration costs. Following consultation with people and staff, we have also developed a business case to relocate Annan Clinic to the Treastaigh building in Annan. As well as delivering cost efficiencies, the Treastaigh project will also deliver a better working environment and experience for people.

**Transforming primary care** – Following the resignation of independent GP contractors, we took the decision to take over and merge the 2 GP practices in Moffat and take over the direct management of the Lockerbie GP practice. As well as sustaining access to primary care services for people at all 3 practices, we have also embarked on a wider, transformation programme of supporting all GP practices across Annandale and Eskdale to support the future development and sustainability of primary care across the locality.

**Transforming our workforce** – In response to the changing needs of local people, challenges in recruiting staff across all professions and opportunities presented by new technology, we have started a review of our workforce in a number of areas. Through the Transforming Primary Care Programme we are developing proposals to support GPs to become expert general medical practitioners who will be supported by a multi disciplinary team of health and social care professionals. To help improve public health, we have commissioned a review of our health and well being teams to ensure that we are best placed to help prevent ill health. We are also reviewing the management arrangements for our Allied Health Professionals (AHPs) to help improve the pathways of care. Through the community nursing review we are committed to seeking further improvements in the provision of nursing support in the community.

### 9.2 How we are addressing this outcome in our locality

Our We Will commitments which support this outcome and their current Red, Amber, Green (RAG) status:

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

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

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

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

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

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

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

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

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

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

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

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

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

### 9.2.1 Medication

Across Annandale and Eskdale we continue to spend less per patient than the Scottish average. We have been proactive in raising public awareness of avoiding waste and through our community link service have supported patients to access mainstream community services to help improve their health. We have increased the size of our prescribing team to provide additional support to GPs and their patients in reviewing their medication needs. We have also appointed 3 additional Community Mental Health Workers to provide dedicated support across all our practices.

### 9.2.2 Transforming Primary Care

In addition to increasing the size of our prescribing team to provide additional support to GPs, we have also appointed 3 additional community mental health workers to provide dedicated support across all our practices. We completed the merger of the 2 GP Practices in Moffat, have recruited 2 new Advanced Nurse Practitioners (ANPs) and continue to develop plans to support the sustainability of primary care services across Annandale and Eskdale.

### 9.2.3 Supporting People to get home from hospital

There have been several significant developments within our locality that support people to get home from hospital. These include the continued development of our Care Providers Forum which is now focusing more on our assets and how we use them. We identify which care agencies are in the same towns and villages at the same time and where appropriate facilitate the swopping of care packages to help deliver a more effective care at home service. We still face significant challenges in some very rural areas in sourcing a care provider and with Scottish Care and other partners we continue to support care providers in their recruitment of staff. For example, we participated in a job fair held in Annan in 2018.

### 9.2.4 Review care packages and patient flow

Supported by new staff in the social work team, we continue to make further progress in reviewing care packages to support patient flow. A senior charge nurse from our District Nursing Team is part of the social work screening process which approves new care packages as well reviewing existing packages which may need to be enhanced or reduced because of a change in need. This new approach has been particularly useful in the community and has helped prevent hospital admissions and has resulted in a more integrated approach to delivering services.

### 9.2.5 Developing role of social workers

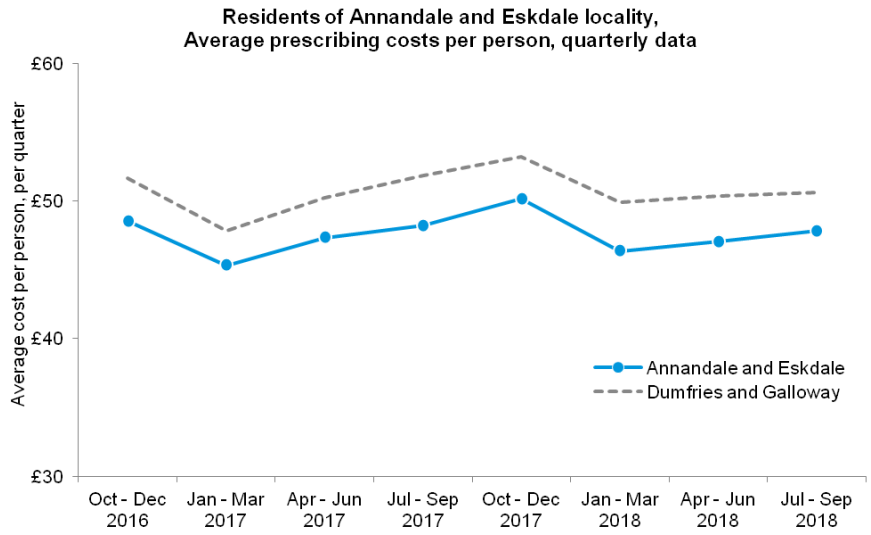
Our social workers and care co-ordinators attend all community hospital multi disciplinary team meetings where planning takes place for all patients being discharged from hospital. In addition, our locality social work manager or senior social work manager attend a weekly patient flow meeting to consider all people in our cottage hospitals alongside our locality patient flow co-ordinator, senior charge nurses and the health and social care locality manager. A further development this year has seen one of our senior social workers commence post graduate studies in personality disorder. We have continued to build our partnership with the Community Mental Health Team (CMHT) and we are in the process of developing a collaborative model of supporting people with complex needs in the locality.

### 9.2.6 Housing

Annandale and Eskdale continues to lead in working with our colleagues in strategic housing and registered social landlords in Dumfries and Galloway. We have established a Housing Project Management Team which is currently working on the delivery of potential new extra care housing developments in our area as well as a new housing with care development for people with a learning disability.

### 9.3 How we are getting on

The Adults Needs Assessment that supports the Strategic Plan indicates that over 75% of the population receives a prescription at least once per year. In 2016/17 the annual cost per person ranged from £137 - £277 across the GP practices. This is partly because of the different mix of people they support. Annandale and Eskdale has a lower cost per person compared to Dumfries and Galloway. The figure for Jul-Sep 2018 is lower than the same period in the previous year.

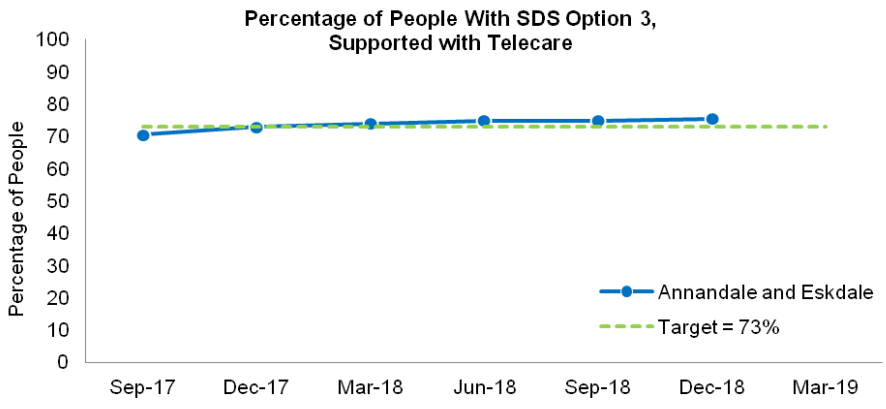



Source: PRISM, LHP Average Prescribing Costs Per 1000 People

D28

Note that these figures are not adjusted for age profile. Also, the cost of prescribing medications is strongly influenced by market forces, not just the volume of medication dispensed.

Another measure of efficiency is how effectively the Partnership uses technology to support people, both to live independently and to access services equitably. An indicator is under development to demonstrate how Technology Enabled Care is being rolled out. This will include both the well established Telecare support, and also Home Health Care Monitoring and Virtual Appointments. In the interim, the previous indicator showed that 75.5% of adult supported to live at home are accessing Telecare. Across Dumfries and Galloway the rate was 75.5%.




Source: Dumfries and Galloway Council, local figures

C1

# Appendix 1: Summary of Locality Indicators

| Locality Indicator | | | Previous Value | | | Current Value | | |
|---|---|---|---|---|---|---|---|---|
| | | | Time Period | Dumfries and Galloway | Annandale and Eskdale | Time Period | Dumfries and Galloway | Annandale and Eskdale |
| Outcome 1 | D23 | Rate of emergency department attendances by locality of residence per 1,000 population | Nov 17 | 24.88 | 17.43 | Nov 18 | 23.13 | 15.9 |
| Outcome 1 | D24 | Rate of emergency admission by locality of residence per 1,000 population | Nov 17 | 9.63 | 8.45 | Nov 18 | 8.93 | 7.83 |
| Outcome 2 | | Indicator to be reported in next cycle | | | | | | |
| Outcome 3 | | Indicator to be reported in next cycle | | | | | | |

Source: ISD Scotland, HACE Dashboard

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

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

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

| Locality Indicator | | | Previous Value | | | Current Value | | |
|---|---|---|---|---|---|---|---|---|
| | | | Time Period | Dumfries and Galloway | Annandale and Eskdale | Time Period | Dumfries and Galloway | Annandale and Eskdale |
| Outcome 4 | C10 | Percentage of people supported by SDS Option 1 or Option 2, under 65 years of age | Dec 17 | 23% | n/a | Dec 18 | 24% | 24% |
| | C11 | Percentage of people supported by SDS Option 1 or Option 2, 65 years and older | Dec 17 | 8% | n/a | Dec 18 | 8% | 7% |
| | D25 | Number of people delayed in all hospitals (Dumfries and Galloway Infirmary, Galloway Community Hospital and Cottage Hospitals) by locality of residence | Nov 16-Oct17 | 541 | 181 | Nov 17-Oct 18 | 652 | 207 |
| | D26 | Number of bed days lost to delayed discharge by locality of residence | Nov 16-Oct17 | 12,565 | 4,121 | Nov 17-Oct 18 | 14,337 | 4.273 |
| Outcome 5 | | Indicator to be reported in next cycle | | | | | | |
| Outcome 6 | | Indicator to be reported in next cycle | | | | | | |

Source: ISD Scotland, HACE Dashboard

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

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

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

| | Locality Indicator | | Previous Value | | | Current Value | | |
|---|---|---|---|---|---|---|---|---|
| | | | Time Period | Dumfries and Galloway | Annandale and Eskdale | Time Period | Dumfries and Galloway | Annandale and Eskdale |
| Outcome 7 | D27 | Percentage rate of emergency re-admission to hospital within seven days | Nov16-Oct 17 | 4.3% | 3.7% | Nov 17-Oct 18 | 4.3% | 4.0% |
| | C9 | Percentage rate of referrals to the Multi Agency Safeguarding Hub (MASH) acknowledged within 5 days | Oct 17-Dec 17 | 66.5% | 82.5% | Oct 18 - Dec 18 | 69.0% | 82.5% |
| Outcome 8 | | Indicator to be reported in next cycle | | | | | | |
| Outcome 9 | D28 | Average prescribing costs per person | Dec 17 | £202 | £189 | Dec 18 | £204 | £191 |
| | C1 | Percentage of People With SDS Option 3,Supported with Telecare | Dec 17 | 68.6% | 72.9% | Dec 18 | 72.8% | 75.5% |

Source: ISD Scotland, HACE Dashboard

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

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

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

# **Appendix 2:** Glossary of Terms

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

**Combined Assessment Unit (CAU)**
A hospital department next to the Emergency Department where people have access to early assessment and diagnostic tests, early senior clinical decision-making and treatment by the multidisciplinary team, before either being admitted to hospital or discharged home.

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

**Locality**
The term outlined in the Public Bodies (Joint Working) (Scotland) Act 2014 to identify local areas. Every local authority must define at least 2 localities within its boundaries for the purpose of Locality planning. In Dumfries and Galloway there are 4 localities - Annandale and Eskdale, Nithsdale, Stewartry and Wigtownshire.

**One Team Approach**
A multi disciplinary way of working which includes professionals from different areas, who work together to improve care and outcomes for people.

**Partnership**
Health and Social care under the Integrated Joint Authority, encompassing NHS Dumfries and Galloway and Adult Social Care.

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

**Social prescribing**
Supporting people's health and wellbeing, including their mental health, through non-medical sources of support or resources within their community. Social prescribing is an approach used to support self-management.

**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.

**Technology enabled care (TEC)**
A Scottish Government programme to enable a major roll out of telehealth and telecare in Scotland. Technology Enabled Care (TEC) is the utilisation of a range of digital and mobile technologies to provide health and social care support at a distance.

**Telecare**
Telecare is the term for offering remote care of elderly and physically less able people, providing the care and reassurance needed to allow them to remain living in their own homes, for example, personal alarms or sensors.

**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**