DUMFRIES AND GALLOWAY
INTEGRATION JOINT BOARD

HEALTH AND SOCIAL CARE
WIGTOWNSHIRE LOCALITY REPORT

DUMFRIES AND GALLOWAY
Health and Social Care

May 2019

Contents

This report has been produced by:

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

April 2019

For more information visit www.dghscp.co.uk or contact

June Watters, Locality Manager junewatters@nhs.net

Lynda McKie, Project Manager lynda.mckie1@nhs.net

Foreword

At a time of rising demand for services, growing public expectations and increasing financial restrictions it was recognised that we needed to approach these challenges differently. The Transforming Wigtownshire Programme was launched to review and redesign safe, sustainable services in a co-production way with the people of Wigtownshire and their partners.

The aims of Transforming Wigtownshire are:

- work in partnership with the local community and stakeholders to co-produce the review and design of health and social care in Wigtownshire, including Galloway Community Hospital
- work with communities to enable them to make Wigtownshire a healthier place to live now and in the future
- develop a model of sustainable, safe and effective health and social care that meets the needs of the local community

This report highlights the many different improvement projects that are happening across health and social care in that support the Transforming Wigtownshire Programme. This includes 2 projects, mPower and CoH-Sync, that are funded by the European Union INTERREG VA Programme and managed by the Special EU Programmes Body.

Projects also include the development of the Community Link Unit at Newton Stewart Hospital, piloting the mental health liaison service within GP practices and the ongoing work of Building Healthy Communities. The Wigtownshire Pharmacy Team and GP practices have actively promoted the Scottish pharmacy initiative Pharmacy First which aims to increase the service provision by community pharmacies, enabling access to treatments previously only available from GP practices, such as antibiotics for urinary tract infections.

Through these projects and the Transforming Wigtownshire Programme we are working to ensure that people are able to make the most of their health and wellbeing and live as independently as possible.

June Watters
Locality Manager - Wigtownshire
April 2019

Introduction

This is the first locality report for Wigtownshire.

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

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

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

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

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

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

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

Dumfries and Galloway Scheme of Integration
http://www.dg-change.org.uk/wp-content/uploads/2015/07/Dumfries-and-Galloway-Integration-Scheme.pdf (last access 30 January 2019)

Strategic Plan 2016- 2019
www.dg-change.org.uk/our-vision-and-plan/ (last accessed 19 May 2017)

The symbols we use

i) How we are addressing this outcome in our locality

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

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

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

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

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

ii) How we are getting on

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

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.

In our locality we work towards this aim through:

- the mPower project
- the Community Health Sync (CoH-Sync) project
- the Community Link Unit (CLU) at Newton Stewart Hospital
- Building Healthy Communities (BHC) projects

1.2 How we are addressing this outcome in our locality

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

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

Joint working and initiatives to support people to live as independently as possible at home and to support people who wish to improve either their physical or mental health or wellbeing have included:

Two projects, mPower and CoH-Sync, are funded by the European Union INTERREG VA Programme and managed by the Special EU Programmes Body. These projects are driving the transformation of health and social care provision across Wigtownshire.

1.2.1 mPower

mPower aims to empower people to take control of their long term conditions at home by using technology, while simultaneously freeing up GPs and other healthcare professionals so that they can treat more people.

The project focuses on people aged 65 and older with one or more long term condition and access services on a frequent basis. mPower aims to introduce self management to this cohort through:

- person centred and outcome focussed wellbeing plans that incorporate national anticipatory care plans (ACPs)
- introducing new digital ways of managing long term conditions
- maintaining or improving health and wellbeing through increasing the use of digital solutions and maximising social prescribing opportunities.

mPower has supported the digital health and social care strategy by working with and supporting clinical teams in Wigtownshire who are introducing digital solutions into their practice. The Wigtownshire mPower team have worked closely with 7 partners from cross border locations in Ireland and the west of Scotland to share learning and develop services which, in turn, provide an evidence base for future development.

In 2018 the service supported 109 beneficiaries and delivered 242 digital interventions. Examples of the digital support people can access include:

Florence – a Home and Mobile Health Monitoring (HMHM) system through which people can send and receive text messages such as medication reminders or for submitting blood pressure readings.

NHS Attend Anywhere – a safe and secure digital space through which people can attend video consultations with health and social care professionals. This reduces the need for people to travel.

My Diabetes, My Way – an interactive website provided by NHS Scotland that supports people with diabetes, their families and friends.

1.2.2 Community Health Synchronisation (CoH-Sync)

Early recognition and prevention of long term conditions reduces the number of GP visits people make and hospital admissions. The cross border collaborative, CoH-Sync, came to Wigtownshire in August 2018. The programme aims to promote healthier lifestyles and focuses on the risk factors associated with long term conditions. This includes physical activity, nutrition, smoking cessation, alcohol misuse and mental health resilience. People living in targeted geographical areas have been supported to manage their own health need through access to local initiatives.

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

The project will run until December 2021 and aims to deliver 1,248 health and wellbeing plans to people across Wigtownshire. This amounts to approximately 5% of the population age 18 years or older. CoH-Sync also aims to build links with organisations and groups in the third sector to continue the implementation of the project beyond December 2021. Helping to create positive relationships within the local community and supporting the creation of a network of referral pathways is key to the success of the project.

1.2.3 Community Link Unit (CLU) at Newton Stewart Hospital

Over the last three years the needs of people, referral processes and the types of rehabilitation support, care and treatment available have changed. It is essential that the service provided through Newton Stewart Hospital adapts and evolves to meet these changing needs. We have looked at what the real need is in Wigtownshire and compared this to other areas in Scotland and researched national and international guidelines. For example, information from the Census of 2011 highlighted that 54% of adults aged 34 to 74 years old in Wigtownshire are living with one or more long term conditions. These have been the key drivers for the establishment of the Newton Stewart Community Link Unit (CLU).

The CLU aims to:

- enable people to self manage their long term conditions and prevent crises
- improve people's knowledge of and access to services
- empower people through reablement,
- help people to develop their own support networks,
- educe social exclusion and isolation
- enable people to live as independently as possible at home or in a homely setting

The CLU has worked with teams from across the health and social work partnership, including third and independent sector organisations to develop a service framework. In addition, the service has helped to reduce pressure on GP practices and hospital services though improved collaborative working and increasing efficiency.

1.2.4 Building Healthy Communities (BHC) projects

Move More

Dumfries and Galloway Council and Building Health Communities (BHC) work in partnership to support the delivery of the Macmillan Cancer Support Move More programme. The programme has set up a number of different groups including:

- Move More gentle movements project group
- Move More gym circuit project group
- Move More walking group

These groups are facilitated by BHC volunteers who have received training from Macmillan Cancer Support. The programme is now in its third year and groups are well established in Stranraer and Lochans. It has been encouraging to hear from the sports and leisure trainers who facilitate the Move More gym circuit group, that older participants attending weekly have vastly increased their level of fitness

"It's keeping us physically healthy, but also it's a social group and it takes you away from the day today stress we experience"

Arts Group

The arts group, facilitated by 3 BHC volunteers, continues to meet at the Coronation Day Centre in Stranraer. The group is intergenerational and has become self sustained. It has been encouraging to have received referrals from Wigtownshire Adult Social Services department. The programme is open to all in the community and sessions are now well established and self sustained across four groups in Stranraer and Lochans.

Tai Chi for Health programme

"Blood sugar level has come down and blood pressure down from 200/100 to acceptable level"

The Tai Chi for Health programme provides both practical and theoretical knowledge to enable people to develop healthier lifestyles as well as providing volunteering opportunities, raising confidence and self esteem of those participating. The sessions are delivered by 6 qualified BHC volunteer facilitators and 2 BHC volunteers who have been developing their skills over the last 15 months. Due to the high demand, a ten week introduction programme has been developed for 2019, allowing people time to develop skills and confidence before joining one of the established groups. Also a fifth group is due to start in New Luce in March 2019.

"It has helped my diabetes and I have new friends and a place to go"

Home Buddies initiative

"Gives me energy and makes me sleep well at night"

The BHC team has worked in partnership with Wigtownshire Stuff, Coronation Day Centre and the Galloway Action Team to develop a pilot intergenerational programme called Home Buddies. This uses a community collaborative approach to develop skills and social engagement with young people with educational needs and disabilities and the elderly in the community. The project will launch in May 2019. Wigtownshire Stuff, Stranraer College and the Coronation Day Centre have all provided facilities from which the initiative will run. The college is providing accreditation opportunities and assessment via ASSDAN.

1.2.5 Stranraer Armed Forces and Veterans Breakfast Club

"Thank you for supporting my dad attending the breakfast club, he as getting so lonely and isolated, it has given him a new lease in life, we have seen such a change in him."

An armed forces and veteran breakfast club has been established in Stranraer and now has more than 25 members. The club supports both young and older service personnel with the ages of those attending ranging from 25 to 90 years old. The club's main aim is to combat isolation and loneliness in a social setting where individuals with similar career and soldier understanding can offer support, guidance and direction if needed. The club provides a social setting where former service men have an open door to chat and gain support and guidance here in our community of Wigtownshire.

"If it was not for the Breakfast club, I don't know where I would be. They have supported me putting a roof over my head and the comradeship and support has really helped us."

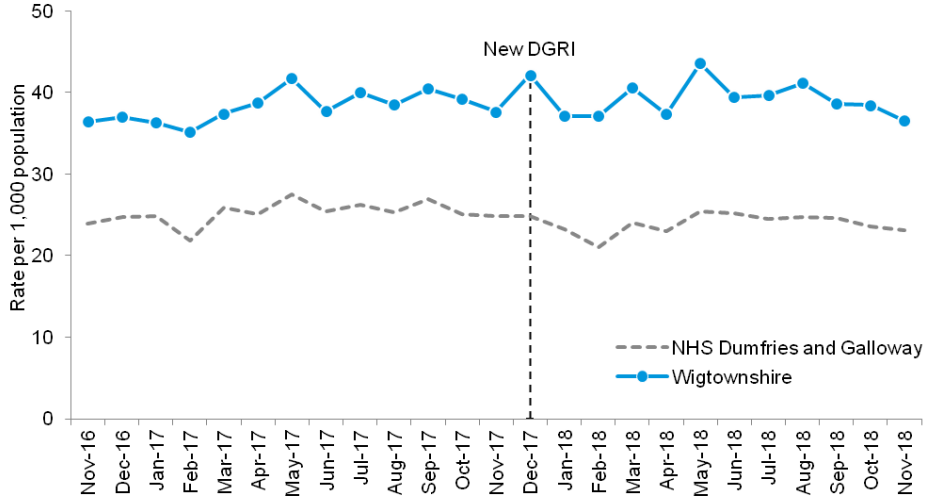
Since its development the club has helped soldiers sleeping rough to access permanent accommodation and supported the families of former soldiers with their caring role. The group are registered on the Nation Armed Forces Breakfast club network and promote their activities through social media.

1.3 How we are getting on

An important measure of how well people are able to manage their health and wellbeing in the community setting is how often their healthcare occurs as an emergency. There will always be the need for urgent and emergency care, but where possible the aim is to support people in the community and prevent crisis events.

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

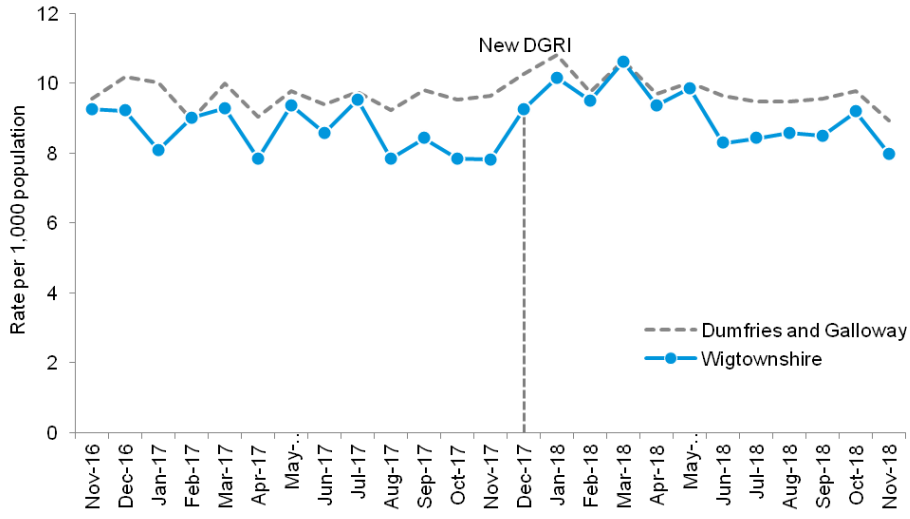
Residents of Wigtownshire locality,
Rate of Emergency Department attendances per 1,000 population



Source: NSS Discovery, from National A&E Datamart

D23

Residents of Wigtownshire locality,
Rate of emergency hospital admissions per 1,000 population



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

D24

Spotlight on
Transforming Wigtownshire

There are many pressures facing health and social care services including:

Recruitment - we are currently unable to recruit to many vacancies and our working age population is getting older.

Funding - there is no new money in system. Across Dumfries and Galloway, health and social care needed to make savings of £15.8m during 2018/19.

Infrastructure - many of our buildings are old and not designed to deliver modern health and social care services.

Increasing demand - there are more people living with long term conditions for longer who require care and support.

We recognise that we needed to approach these challenges differently. The Transforming Wigtownshire Programme was launched to review and redesign safe, sustainable services in a co-production way with the people of Wigtownshire and their partners.

The aims of Transforming Wigtownshire are:

- work in partnership with the local community and stakeholders to co-produce the review and design of health and social care in Wigtownshire, including Galloway Community Hospital
- work with communities to enable them to make Wigtownshire a healthier place to live now and in the future
- develop a model of sustainable, safe and effective health and social care that meets the needs of the local community

The approach we are using for the programme is co-production. Co-production is...

"when people with different interests come together to create change as a group."

In this case, the community will work together with health and social care professionals and service providers to transform health and social care within Wigtownshire.

It is extremely important that we work together with people who use services, Carers, staff, volunteers, service providers and other stakeholders. The forthcoming events will identify the first areas to be reviewed. Short Life Working Groups will be set up and be supported by an Expert Group. These groups will work together to develop a sustainable model of health and social care.

Since 27 June 2018 the Independent Chair and Project Manager have attended Community Council meeting across Wigtownshire. Response at meetings has been positive, there seems to be an understanding that services are under pressure and that we cannot continue to deliver services in the same way. However there is also an awareness that difficult decisions will have to be taken as the programme progresses.

The team has met with the local MP, MSPs, elected members and local influencers to gain support and understanding. Staff meetings have taken place to explain the aims of the project and to engage staff in the process.

Teams from across health and social care attended both Stranraer and Wigtown shows. Attendees were asked to tell us 'What Matters To You?' and were asked to choose from 8 categories the 3 most important to them. Across both shows the 3 things that mattered most were:

- Mental Wellbeing
- Physical Wellbeing and
- Health and Social Care Communication and Education

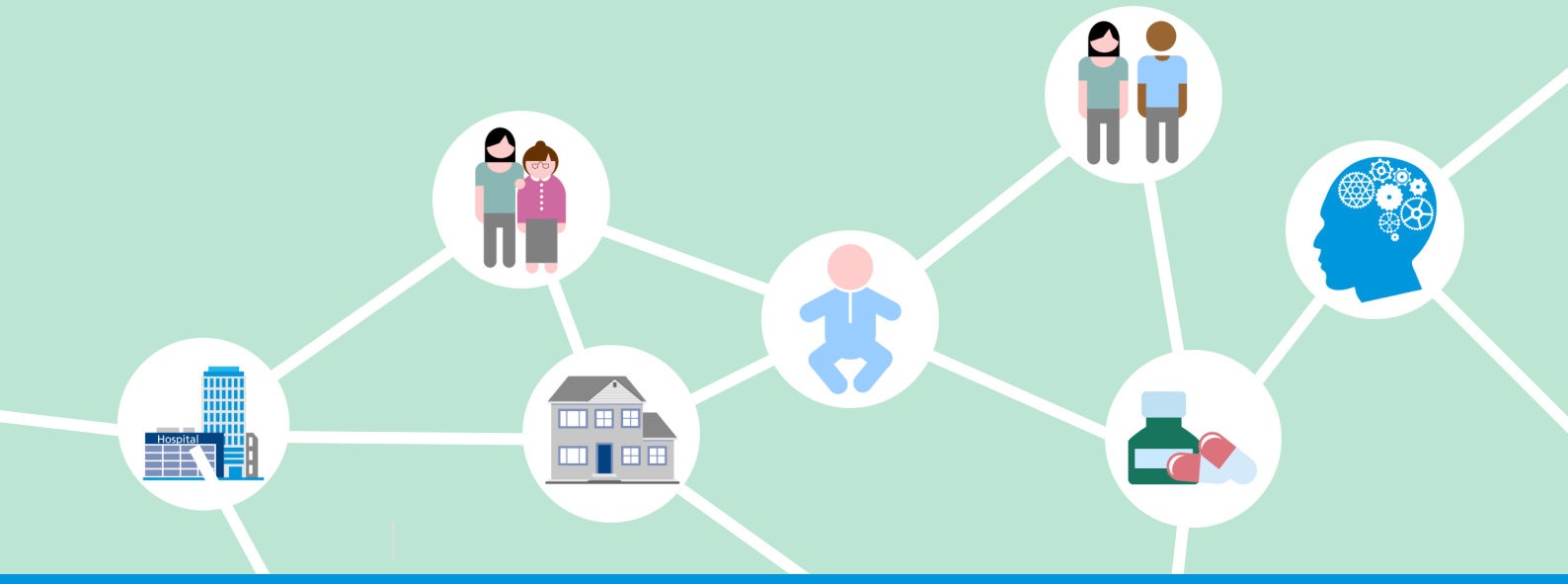
Other events include:

Third Sector Event - our third sector partners invited their members to attend a meeting where we presented information about the Transforming Wigtownshire programme. The aim was to try to encourage third sector involvement in the programme.

Scottish Women's Institute (SWI) Event - the SWI arranged an event for us where over 80 members attended. The opportunity was taken to raise awareness of Transforming Wigtownshire, but also of other work being carried out such as mPower, CoH Sync, the Community Link Unit and pharmacy work.

Public Events in Wigtown and Stranraer - we held two public meetings in October 2018. Both were well attended. We provided information about Transforming Wigtownshire and had discussion groups around about the 3 key issues raised through previous public events.

A steering group has been established and meets on a monthly basis, reviewing actions to date ensuring progress against plan. A Scottish Health Council representative is a member of the steering group to support our co-production approach and how we ensure people from Wigtownshire are involved. A programme board meets every 2 months and acts as a critical friend.



4. Outcome 4

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

4.1 How we support this in our locality

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

In our locality, good examples of this are:

- Care at home
- Working with Scottish Care
- Primary care mental health service

4.2 How we are addressing this outcome in our locality

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

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

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

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

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

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

4.2.1 Care at home

There is a challenge for those living within remote parts of the region regarding the access of providers to deliver their personal care. Within larger towns, this is less of an issue. Health and social care should be deliverable and consistent regardless of a person's postcode.

This has been a challenge we have tried to address by introducing regular meetings with all the local providers in order to maximise the capacity we have for social care. This has seen, for the first time, providers coming face to face with their competitors, to work together to take a more holistic, person centred approach to the delivery of care, whilst maximising social care capacity at the same time

In recent months, we have also seen an increase in the use of Personal Assistants (PAs) to deliver personal care, particularly in the more remote parts of Wigtownshire. Recognising the benefit that this service offers in terms of choice and control, the Transforming Wigtownshire programme have been looking at how we might widen the role of Personal Assistant to the wider community.

4.2.2 Working with Scottish Care

Scottish Care is a representative body for independent social care services in Scotland. They represent independent and third sector organisations of all different sizes. Scottish Care work closely with their National Head Office to ensure all our health and social care providers are kept up to date with latest information regarding recruitment, training, registration and all regulatory information and opportunities. This also allows issues to be shared when the Scottish Care National team are working with the regulatory partners.

Scottish Care are active participants of the Dumfries and Galloway operational workforce subgroup, ensuring that the independent sector workforce in represented during all regional planning.

A pilot of the new Anticipatory Care Plan (ACP) has been undertaken with a number of care at home and care home providers. Formal feedback on the outcomes and learning from this is awaited. Scottish Care will support a roll out of ACPs to care providers. The vision for Dumfries and Galloway is that by June 2020 95% of residents in a care home will have an ACP summary shared with their GP.

The Scottish Care Team has been liaising with the health and social care partnership to discuss technology advancement and use locally. A member of the health and social care team attended a regional meeting with care providers in December 2018. Further workshops are planned to ensure providers are fully aware of what is on offer throughout Dumfries and Galloway.

Work is underway to offer care providers NHS e-mail addresses to facilitate the secure sending and receiving of information electronically across the Health and Social Care Partnership, work on this commenced in December 2018.

NHS Attend Anywhere, the online GP waiting room and appointment video conferencing platform, has been shared with providers. Wigtownshire care homes have been heavily involved and held up as champions for Attend Anywhere.

Two providers from Wigtownshire have undertaken Mainstreaming Good Conversations training, which promotes learning on asset based outcome focussed conversations with people. Conversational strategies have been used to enable people to examine how they are currently coping and how improving their outcomes might look and feel. This programme is also designed to use the same methodology in achieving asset based outcomes focussed conversations with staff and teams to support and promote reliable and committed workforce. Further training is being planned for 2019.

4.2.3 Primary Care Mental Health Liaison Service

In February 2016 Scottish Government Health Secretary announced the need to increase the role that other health professionals play in delivering primary care, making it much more of a team approach. The funding encouraged GPs to take a multi disciplinary approach to care within the community. GPs, together with the health and social care partnership, have identified the need for mental health professionals to work more closely within practices providing assessment and appropriately signposting people to community services.

Lochinch and Lochree practices have tested a primary mental health liaison services in line with guidelines in the new GP contract. People from these two practices can be directed to the community psychiatric nurse for a short term intervention of up to eight weeks. This has enabled people with low level mental health issues such as mild to moderate depression and anxiety to be seen quickly in the practice rather than wait longer for an outpatient appointment. A community psychiatric nurse is based in Waverley Medical Centre. The funding for the current pilot is in place until May 2019.

This test of change has been successful. Feedback has been very positive with mental health becoming less of a taboo for people. The project has also created efficiencies by enabling medical reception staff to triage people directly to the mental health liaison service without the need to see the GP first. Additional funding is being requested from the Scottish Government Transforming Primary Care fund.

"I didn't know what to expect but found it helped to prevent things from getting worse."

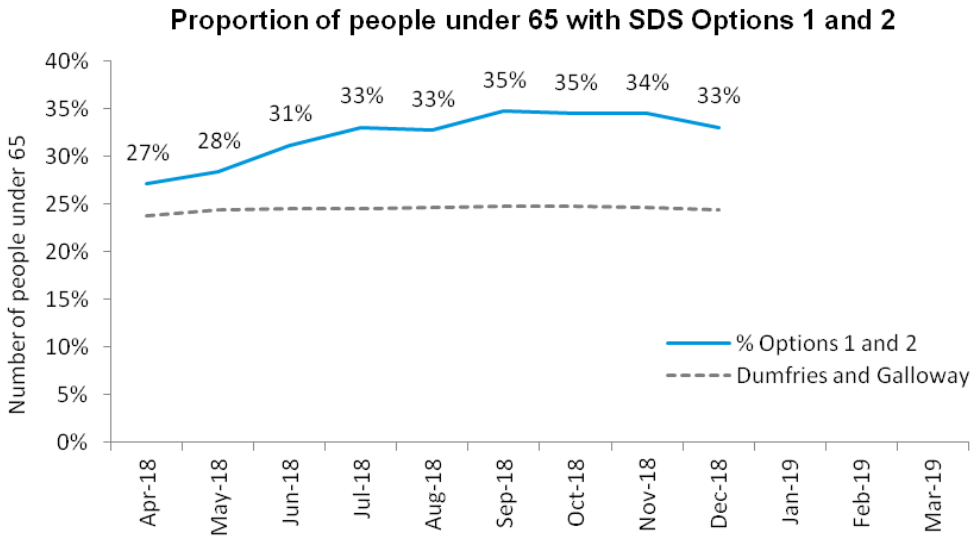
"Got signposted to the right support for carers."

"I liked that I was given a lot of time and patience to adjust to the sessions which really helped me."

4.3 How we are getting on

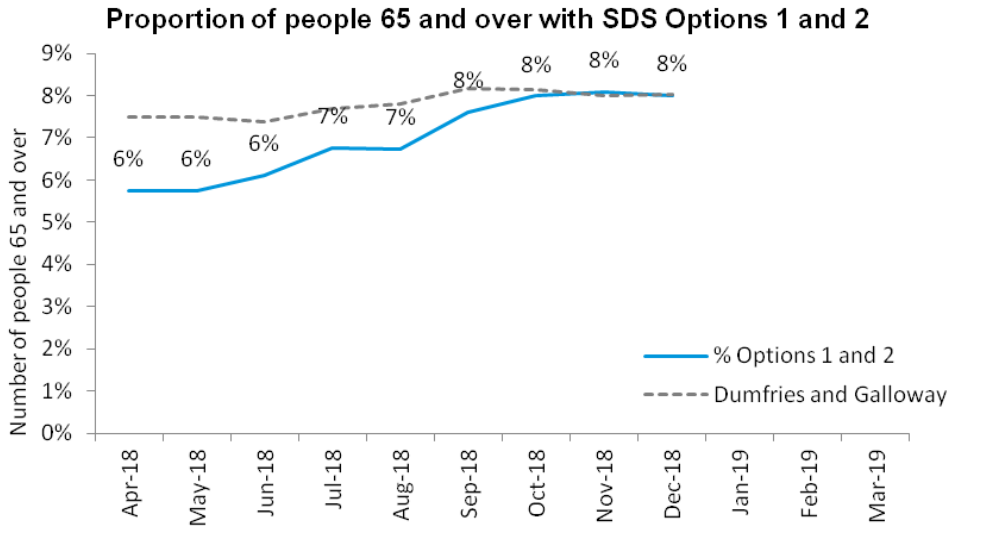
The proportion of people in Wigtownshire receiving support through Self Directed Support Options 1 or 2, which have the largest levels of personal responsibility has been gradually increasing for the past year. Whilst we support people to have the confidence to choose Options 1 and 2 for themselves, many people continue to prefer to choose Option 3.

Around one in three people aged under 65 have chosen these Options, whilst for people aged 65 or older, it is around one person in twenty. In December 2018 there were 157 people aged under 65 receiving care through SDS and 486 people aged 65 or older. It is not clear why the proportion of people electing for Options 1 and 2 might be higher in Wigtownshire compared to Dumfries and Galloway.



Source: Dumfries and Galloway Council, local figures

C10

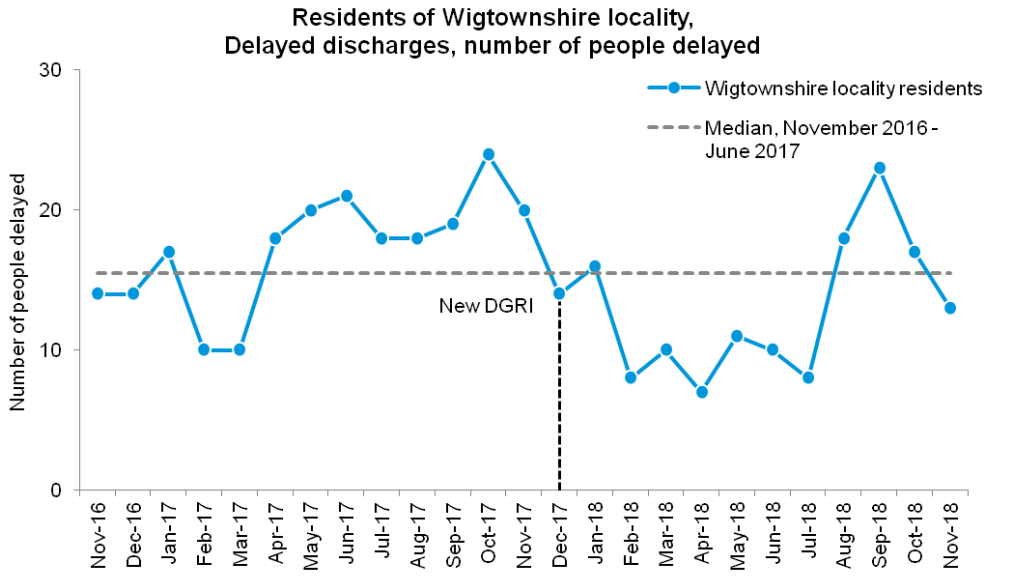


Source: Dumfries and Galloway Council, local figures

C11

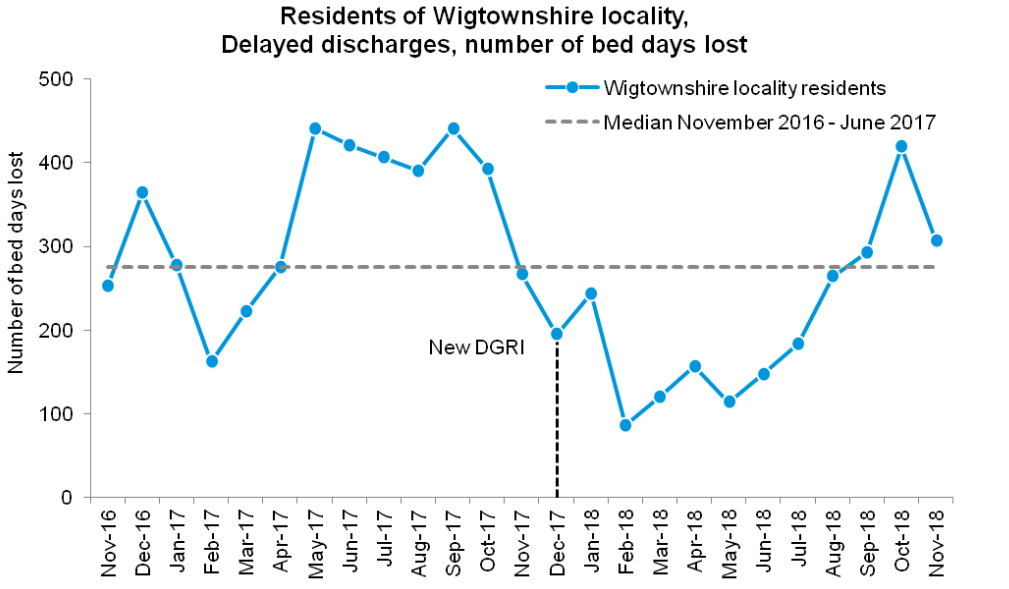
One measure of the successful coordination of people's journey of care, is the amount of time spent in hospital settings when people were ready to be discharged to a less acute setting or into the community. When people are not in the most appropriate place for their care we refer to this as a delayed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

In Wigtownshire, and across Dumfries and Galloway over the last year, the number of people experiencing a delayed discharge (in acute, community or cottage hospital setting) has risen on average. Reasons for this include recruitment challenges across both health and social care sectors and complex legal arrangements including guardianship. A dedicated flow coordinator works with the multidisciplinary team to enable smooth transitions from one setting to another.



Source: NHS Dumfries and Galloway, local figures

D25



Source: NHS Dumfries and Galloway, local figures

D26

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. Examples of this in Wigtownshire are:

- the multi disciplinary adult support and protection audit tool and review of practice
- supporting staff working in adult support and protection
- Care Assurance

7.2 How we are addressing this outcome in our locality

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

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

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

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

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

7.2.1 Multi disciplinary adult support and protection tool and review of practice

In 2018, an adult support and protection audit tool was created across the disciplines of health, police and social work to review practice. There is a wider audit currently taking place regarding adult support and protection work across the region.

In Wigtownshire we have strengthened the model around our adult support and protection work through the establishment of core group meetings between initial case conferences and the review conference to ensure a more streamlined approach to assessment and risk management. This regular core group meeting has allowed progress to be monitored and reviewed and assessments updated over the course of the adult support and protection period.

7.2.2 Supporting staff working in adult support and protection

Adult support and protection work can be complex and challenging for workers. A short life working group has been established to look at ways of supporting practitioners. Currently we are exploring evidence based assessment tools that can be used for assessment and care planning as well as refining roles, responsibilities and expectation within practice. We are also looking to improve our timescales around the completion of adult support and protection work. This work will contribute towards people using health and social care services being and feeling safe from harm.

7.2.3 Care Assurance

Within NHS Dumfries and Galloway a local Care Assurance process has been developed, which asks people who use services about their experience of care and provides clinical supervision to registered nurses and health care support workers.

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

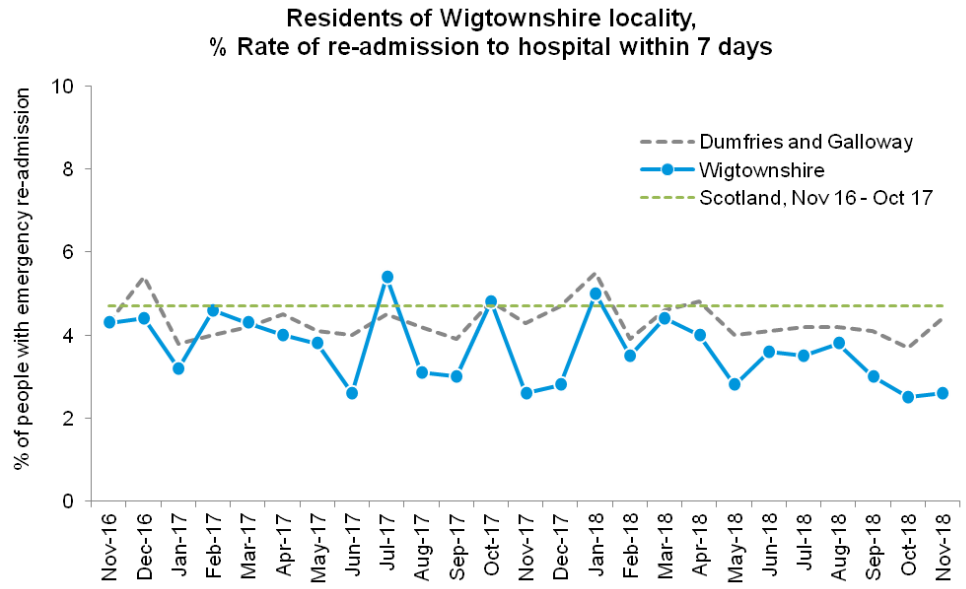
- ensure consistency in the delivery of high quality standards of care, initially within inpatient settings
- to identify and celebrate good practice and promote sharing good practice throughout the organisation
- to identify and provide support for areas of practice which need to be improved

Newton Stewart Hospital has achieved the silver award. A recent audit highlighted areas for continued improvement including cognition, food fluid and nutrition and documentation. The hospital team have since reviewed their practice and redesigned services to ensure that all people are now assessed on admission using the 4AT score which provides an early indication of delirium. They are also liaising with GP practices to ensure documentation is completed accurately.

To ensure standards are maintained, care assurance audits are carried out by a senior charge nurse twice a week and by a nurse manager every month.

7.3 How we are getting on

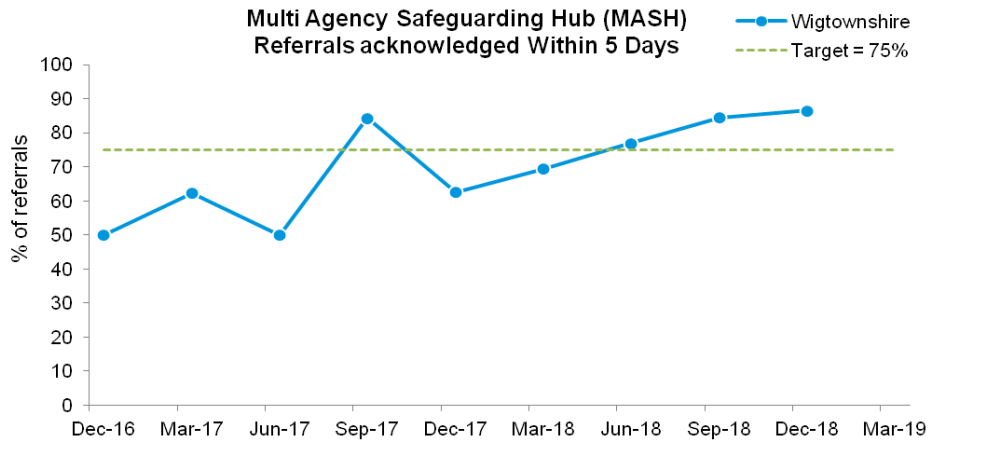
One aspect of keeping people safe is monitoring re-admissions to hospital. Whilst a discharge quickly followed by an emergency admission may be entirely appropriate in many cases, it could mean in some cases that people were possibly discharged before they were ready. Readmission rates for Wigtownshire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



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

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 within 5 days of receipt of their referral, was 86.5% 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.

In our locality, good examples of this are:

- Pharmacy
- Community flow
- Paramedic home visits

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:

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

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

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

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

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

9.2.1 Pharmacy

The pharmacy workforce plan puts maintaining people's ability to manage their own medicines as a key objective. Enabling people to be confident with medicines has a number of benefits. It keeps people safe and increases efficiency as people only use the medicines they need when they need them.

Wigtownshire Pharmacy Team and GP practices have actively promoted the Scottish pharmacy initiative Pharmacy First which aims to increase the service provision by community pharmacies, enabling access to treatments previously only available from general practice, such as antibiotics for urinary tract infections

The Minor Ailments Service advice has been made available seven days per week in the locality demonstrating the commitment to improving peoples access to services to improve their own health and wellbeing. This has enabled access to necessary treatments, sometimes free of charge, for all for common ailments.

Through their work with GP practices and community pharmacists, the Wigtownshire Pharmacy Team regularly communicates with Carers. Medication can cause a large burden of stress for Carers. The team provides advice on medication and managing medicines. Issues which we routinely help with:

- synchronising medicines so they only have to be ordered once a month,
- raising awareness of community pharmacy services
- providing education on what medicines are

The team has attended an Alzheimer Scotland Carers group, which is specially designed to support Carers, for a two hour session where Carers could ask us whatever they wanted to know about medicines. This was very positively received. We are currently investigating the possibility of a holding a regular session like this through day care services.

Referrals for medication management and assessment are received by the pharmacy team from social work, third sector agencies, private care companies, GP practices and directly from concerned family members and Carers. The team visits people in their own home and assesses how they manage their medicines. People may be supported by using Florence, a Home and Mobile Health Monitoring platform that provides text message reminders, or by using compliance devices.

The team has worked closely with local care homes and third sector agencies such as the Mental Health Association and Turning Point to do regular medication reviews. There has been close working with mPower and CoH-Sync to ensure joint working across the locality in relation to people with long term conditions. By linking in with community pharmacy and GP practices we were the first locality in Dumfries and Galloway to have people use the Florence text messaging reminder service. Technology has been a key feature of our service delivery model and we are planning to use Attend Anywhere software in our Pharmacy Hubs to enable us to do medication reviews and education sessions remotely. This will help to address difficulties experienced seeing people in GP practices where there is often insufficient clinic room space.

The importance of keeping staff local is well recognised. People growing up and living in the area are familiar with the complex needs of the locality population and retention of staff should be higher. As a result our first “grow your own” pharmacy technician in primary care training model has been developed. We are currently in the process of “growing” three pharmacy technicians, all from the local area, and the model is now being replicated across Scotland.

9.2.2 Community Flow

Our weekly multi-agency FLOW meetings both in Newton Stewart and Stranraer continue to prove successful in assessing referrals received and deciding who is best to respond to the referral. The overarching aim of the meeting has been to...

“Identify and deliver service that is equitable, timely, safe and appropriate to optimize independence and which is of the most benefit to service users.”

These meetings are well attended by a multi disciplinary group of professionals from across health and social care including community nursing, acute care nursing, health and wellbeing team, community mental health, acute care flow coordination, allied health professionals from health and social care, pharmacy, STARS and Telecare. Reablement and self management remains our priority therefore any support provision identified will examine how the person could be helped to fulfil this task themselves.

9.2.3 Paramedic home visits

In December 2018 paramedics started a six month pilot to visit people at home visits instead of GPs. This pilot was based in the Galloway Hills and Southern Machars practices. Three paramedics have been covering appropriate home visits on a rota basis, with one paramedic being on duty per week. The paramedics have also occasionally seen people for unscheduled appointments within the GP practice. The paramedics are under the supervision of the GPs and are only undertaking visits considered to be appropriate by the GP. Feedback from people visited at home by a paramedic has been extremely positive. Paramedics have been able to spend more time with people than GPs on each visit, and have more time to arrange hospital admissions. The Waverley Medical Centre also started a similar pilot since December, with two specialist paramedics taking working on a six week rota. Feedback has also been very good for this pilot.

This idea of using paramedics for GP home visits is in line with the new GP contract where more of a multi disciplinary team approach is stipulated for primary care. Preliminary analysis has shown that the paramedics have been saving each GP practice at least 4 hours per week of GP time, and a significant proportion of this has been travel time.

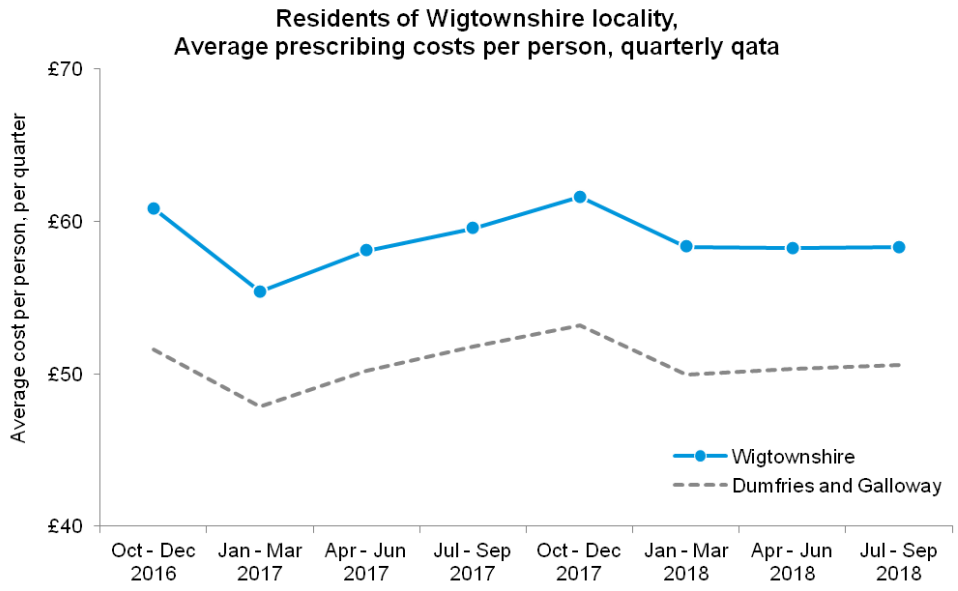
“The importance of local knowledge. Our paramedics know most of the people in the same way we do. This is crucial.”

“On a busy day like yesterday with 4 house calls in the morning that came in dribs and drabs having [the paramedic] was a real game changer. Without him there would have been several hours wait for the visit and a real pressure on my day.”

“Not seeing any bounce back of house calls the next day which would indicate patients are happy with things and outcomes are correct.”

9.3 How we are getting on

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

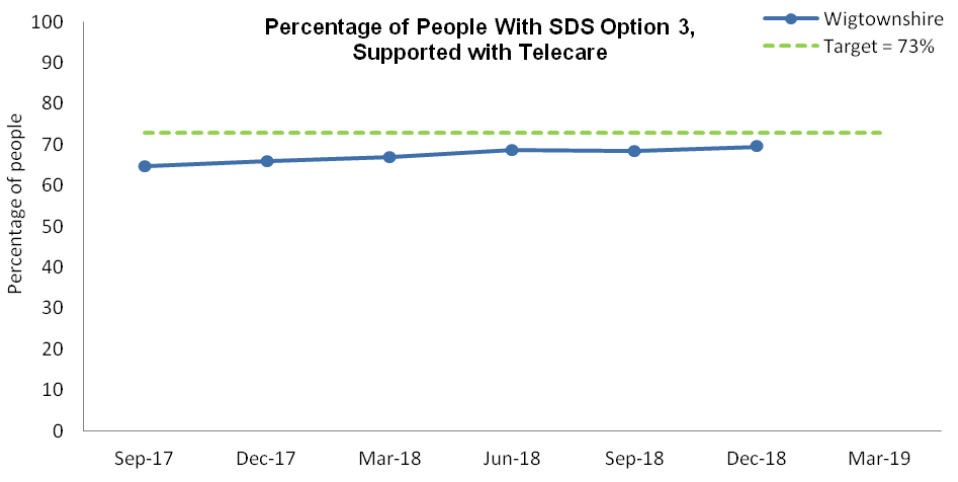


Source: PRISM, LHP Average Prescribing Costs Per 1,000 People

D28

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

Another measure of efficiency is how effectively the Partnership uses technology to support people, both to live independently and to access services equitably. An indicator is under development to demonstrate how Technology Enabled Care is being rolled out. This will include both the well established Telecare support, and also Home Health Care Monitoring and Virtual Appointments. In the interim, the previous indicator showing the percentage of people with SDS Option 3 supported with Telecare, was 72.8% in December 2018.



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	Wigtownshire	Time Period	Dumfries and Galloway	Wigtownshire
Outcome 1	D23	Rate of Emergency Department attendances by locality of residence per 1,000 population	Nov 17	24.88	37.62	Nov-18	23.13	36.52
	D24	Rate of emergency admission by locality of residence per 1,000 population	Nov 18	9.63	7.81	Nov 18	8.93	7.98
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	Wigtownshire	Time Period	Dumfries and Galloway	Wigtownshire
Outcome 4	C10	Percentage of people supported by SDS Option 1 or Option 2, under 65 years of age	Dec 17	23%	n/a	Dec 18	24%	33%
	C11	Percentage of people supported by SDS Option 1 or Option 2, 65 years and older	Dec 17	8%	n/a	Dec 18	8%	8%
	D25	Number of people with delayed discharge in all hospitals (Dumfries and Galloway Royal Infirmary, Galloway Community Hospital and Cottage Hospitals) by locality of residence	Nov 16-Oct 17	541	80	Nov 17-Oct 18	652	91
	D26	Number of bed days lost to delayed discharge by locality of residence	Nov 16-Oct 17	12,565	4.045	Nov 17-Oct 18	14,337	2,490
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	Wigtownshire	Time Period	Dumfries and Galloway	Wigtownshire
Outcome 7	D27	Percentage rate of emergency re-admission to hospital within seven	Nov 16-Oct17	4.3%	4.0%	Nov 17-Oct 18	4.3%	3.5%
	C9	Percentage rate of referrals to the Multi Agency Safeguarding Hub (MASH) acknowledged within 5 days	Oct 17 - Dec 17	66.5%		Oct 18 - Dec 18	69.0%	86.5%
Outcome 8		Indicator to be reported in next cycle						
Outcome 9	D28	Average prescribing costs per person	Oct 16-Sep 17	£202	£234	Oct 17-Sep 18	£204	£237
	C1	Percentage of People With SDS Option 3,Supported with Telecare	Dec 17	68.6%	73.7%	Dec 18	72.8%	66.0%

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