DUMFRIES AND GALLOWAY
INTEGRATION JOINT BOARD

PERFORMANCE MANAGEMENT

AREA COMMITTEE REPORT

Stewartry

April 2017 - December 2017

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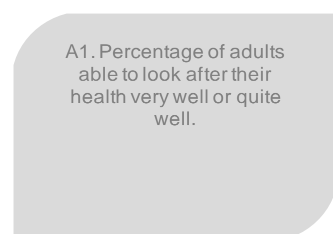
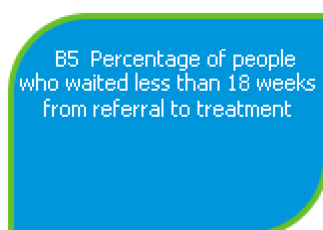
Document Features

In this area committee report 'RAG status' (Red, Amber, Green) is used in two ways: firstly to gauge progress in delivering the series of commitments made in the locality plans, and secondly to indicate whether performance indicators are being successfully attained. See descriptions below.

Grey – Work to implement the commitment is not yet due to start.
Green – Progress in implementing the commitment is on or ahead of schedule or the work has been completed.
Amber – Early warning that progress in implementing the commitment is slightly behind schedule.
Red – Progress in implementing the commitment is significantly behind schedule or work has not started when it was due to start.



At the start of each section of performance indicators there is an overview page summarising the section's content. This is done using 'leaves'.
If the leaf is **grey** then that indicator/measurement has not been included in this edition of the report. If the leaf is **coloured in** then that indicator/measurement is included in this edition.



The border of the leaf will be coloured according to the following:
Black – It is not possible to determine whether the indicator suggests success or lack thereof in attaining the desired outcomes. This may be due to insufficient data and not having a trend over time, or the interpretation of the information is not straightforward.
Green – The indicator or measurement suggests that we are being successful in attaining our outcomes.
Amber – Early warning that the indicator or measure suggests that we may not be successful in attaining our outcomes.
Red – The indicator or measure suggests that we have/will not attain our outcomes.

This section indicates which of the 9 National Health and Wellbeing Outcomes the measurement/indicator supports.

This section indicates which of the 10 Areas of Priority for Dumfries & Galloway as described in the Strategic Plan the measurement/indicator supports.

Indicators with a "C" code are the Local Authority Publically Accountable Measures for adult social work services.
Indicators with a "D" code are locally agreed measures.

National Outcomes

The Scottish Government has set out nine national health and wellbeing outcomes for people. These outcomes are central to the strategic plan and the locality plans in Dumfries & Galloway. They are the long term objectives the Integration Joint Board are striving to achieve.

The progress Dumfries & Galloway is making towards achieving the national outcomes is measured in different ways: quantitative, qualitative, and process measures. Each measure may relate to more than one outcome but it is unlikely that any one measure will indicate progress to all outcomes at the same time. In this report, each measure is mapped to one or more of the national outcomes. Combined these measures provide an overall assessment of Dumfries & Galloway's progress towards these outcomes.

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

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

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

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

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

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

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

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

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

Dumfries & Galloway Priority Areas

To deliver the nine national health and wellbeing outcomes, the Strategic Plan identified ten priority areas of focus. Each measure in this report is also mapped to one or more of these ten priority areas.

1. Enabling people to have more choice and control
2. Supporting Carers
3. Developing and strengthening communities
4. Making the most of wellbeing
5. Maintaining safe, high quality care and protecting vulnerable adults
6. Shifting the focus from institutional care to home and community based care
7. Integrated ways of working
8. Reducing health inequalities
9. Working efficiently and effectively
10. Making the best use of technology.

Locality Plan “We Will” Commitments

Red/Amber/Green status of each “We Will” commitment in the Stewartry Locality Plan

In the second year of integration, Stewartry locality has started to move forward 32 out of the 43 ‘We Will’ commitments identified in the Stewartry Locality Plan 2016-2019.

The areas of work identified below and highlighted within this report show the progress we are making towards delivery of the 9 National Outcomes.

There are still some significant challenges we need to overcome to enable us to achieve our delivery goals such as Information Technology (IT) infrastructure, recruitment to specialist posts and the sustainability of social care provision in a rural area.

Across Stewartry we are continuing to develop new and sustainable models of care:

- In 2017, a considerable amount of work scoping and gathering information took place. This will enable the Locality to explore different models of care for both in-patient services and community teams, with an aim to sustaining services. An Integrated Pathways work stream was established with representation from GPs, nursing, workforce, finance, health intelligence and locality management to work up a high level vision for what our services could look like in the future. As part of this planning, the Locality team is now at the stage of considering how to best engage and consult with staff and public. This will help shape care and support services so that they are sustainable, and support people to live as independently as possible at home or in a homely setting in their community for longer.

- Scottish Care is working closely with their partners at a locality, regional and national level to help maintain the sustainability of care providers. This work will help to ensure services remain available for the local population as well as providing a choice for local residents.

- A trainee Advanced Nurse Practitioner (ANP) was employed in October 2017 for 23 months based at Castle Douglas hospital. The trainee will be supported and mentored by a specialty doctor who will provide medical cover to Castle Douglas hospital. This is with a view to employing ANPs in our cottage hospitals in the future to support sustainable medical provision.

- A specialist psychology therapist and an assistant psychologist have been in post since February 2017. They are working with 2 GP practices (in Dalbeattie and Annan). From March 2017 to September 2017, 44 people were referred to the service. Of these, 19 people were discharged after appropriate intervention. Some people were re-directed to the Community Mental Health Team (CMHT), to self-help support, to Adult Mental Health psychology, or to support provided through the community and third sectors. Feedback from people using the service highlighted that the service had met their needs, people had got what they wanted from the service, people were satisfied with the quality of

service, people were satisfied with the number of sessions, and people felt that the psychologists knew how to help them.

- The Mental Health Liaison service has been operational since May 2017, working from 2 GP Practices, the Castle Douglas Medical Group and the Solway Medical Group. A community mental health nurse and a support worker run clinics from GP practices to provide low level mental health support to people who have been referred. This enables quicker access to support, with the aim of helping more people before they reach crisis point and enabling them to manage their own mental health and wellbeing. From May 2017 to December 2017, the service received a total of 260 referrals, with 218 first assessments being completed. The outputs for people referred have included: requests for advice, signposting, desired outcomes achieved, referrals to another service and discharge from service. The impact this service is having is illustrated by the feedback people have given:

  "The quick response from enquiring about the service until I was seen and then the convenience of follow up sessions"

  "The service is vital and I'm very appreciative to have been able to use it in my time of need"

- A regional health and wellbeing model is being developed to support the delivery of safe and effective practice and enable teams to make decisions about the support they offer based on robust evidence. Currently there are variations in services provided by health and wellbeing teams at a locality level, dependent on population need, identified priorities and available resources. The model should support locality health and wellbeing teams and specific support services, such as Smoking Cessation, to provide safe and effective services.

- The Food Train Friends Befriending Project has engaged with 42 people locally and has trained 31 volunteer befrienders. Some of the volunteers befriend more than 1 person. Each supported person is seen for approximately 1 hour a week, depending on their need. There are before and after measurements (after 6 months) recorded for each person befriended to identify personal outcomes being supported through befriending. Exit interviews are also carried out to support learning and development of the service. Food Train has recently been awarded Quality in Befriending Accreditation by the Befriending Network.

- A Social Work and primary care pilot has been introduced to establish whether having a social worker present at Craignair Health Centre once a week would make a difference to outcomes for people, their family members or Carers, GPs and other health and social work professionals. The pilot is considering the following areas:

  -Increasing early intervention and prevention work
  -Working better together and improving working relationships
  -Reducing inappropriate referrals to social work services

The focus for Stewartry locality over the coming 6 to 12 months is:

- Develop a robust communication and engagement strategy to support the new models of care consultation and engagement programme
- Workforce Planning development
- Delivering dementia focused activities
- Carer's Health and Wellbeing
- Evaluating and monitoring pilot/test projects such as using assistive technology for sleepovers
- Develop a respite action plan

Stephanie Mottram
Stewartry Locality Manager

Performance Indicator Overview

Clinical and Care Governance

C1 Percentage of adults accessing Telecare of all adults who are supported to live at home - Care Call

C2 The number of adults accessing Self Directed Support (SDS) - all options

C4 The number of adults accessing Self Directed Support (SDS) Option 3

C5 Number of Carers receiving support (excluding Young Carers)

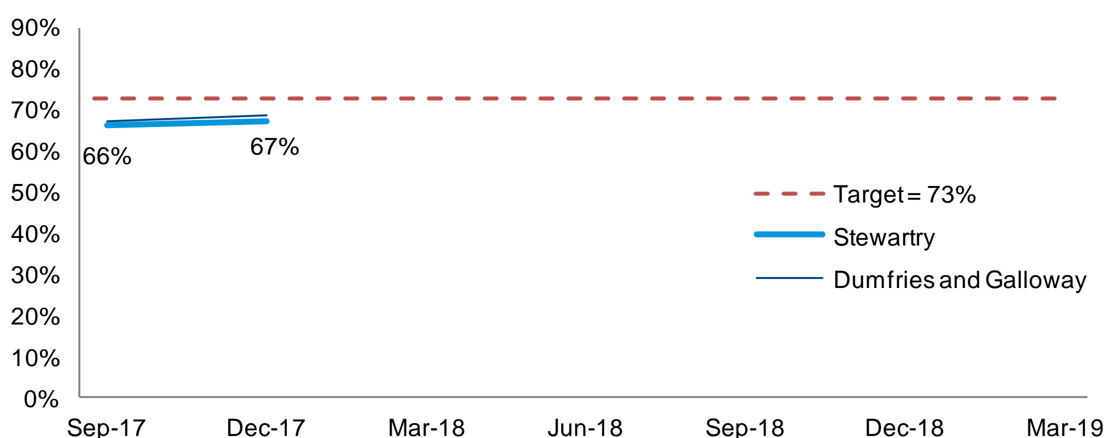
C6 Percentage of people 65 and over receiving care at home considered to have intensive care needs (10 hours or more)

C7 Number of adults under 65 receiving care at home

D1 Progress towards reporting on the proportion of people who agree they felt safe when they last used health and social care services

C1 Adults accessing Telecare as a percentage of the total number of adults supported to live at home

Percentage of adults accessing Telecare of all adults who are supported to live at home - Care Call; Stewartry



Key Points

The percentage of adults supported to live at home who were accessing telecare in Stewartry was 67% in December 2017. Stewartry performance is very similar to that of Dumfries and Galloway where 69% of adults supported to live at home were accessing telecare.

The Wider Context

In July 2017, the move from Framework-i to the Mosaic computer system gave the opportunity to review the definitions of how this indicator was calculated and to tidy old records. Therefore the current values for this indicator are not comparable with previous figures. Only telecare provided to users of the social work service are included in this definition. The previous target of 73% has not been changed.

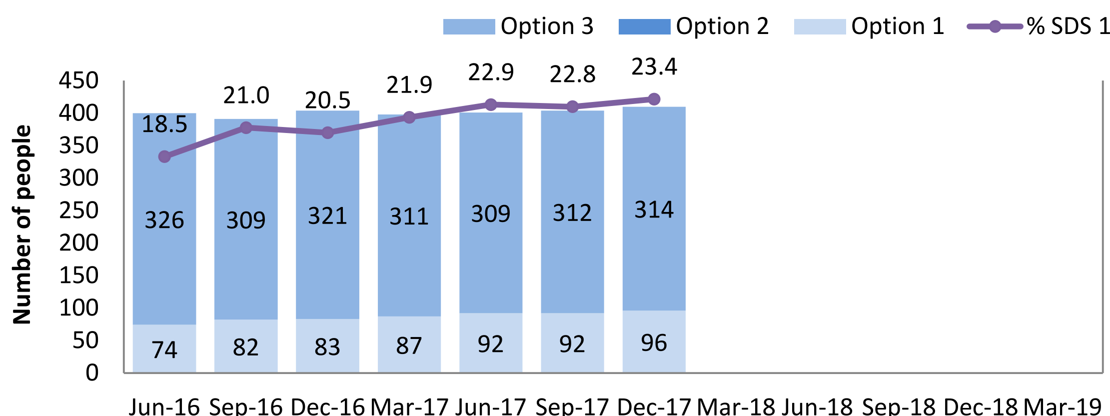
Technology Enabled Care (TEC) is core to the strategy of enabling people to stay at home. All Social Work assessments prioritise telecare as a key option within the assessment. There is ‘lead-in’ time to the introduction of any telecare, enabling discussions with the person regarding their choice of TEC, being assured that they fully understand and have made an informed choice and learning to confidently use the equipment.

Improvement Actions

Scottish Care and social work colleagues have co-produced improved versions of initial assessment tools. These are currently being installed on the social work computer system. These tools will help ensure that an outcomes focussed, asset based approach is consistently implemented across different sectors. The aim is to ensure that all partners will be able to use the same paperwork to meet the needs of local people and their relevant regulatory bodies.

C2-C4 Number of adults receiving care at home via SDS Option 1, 2 and 3

The number of adults accessing Self Directed Support (SDS) – All Options; Stewartry



Key Points

This is a Data Only indicator.
The number of adults from Stewartry receiving care at home through Self Directed Support (SDS) Option 1 was 96 people in December 2017.
This number has increased by 41% since Jun 2016 when there were 74 people from Stewartry receiving care at home through SDS Option 1. As of December 2017, approximately 23% of adults receiving care at home did so through SDS Option 1.

The Wider Context

SDS Option 1 enables people to take ownership and control of arranging and managing their own care. SDS Option 2 enables people to choose their provider of care and Social Work services organise, purchase and manage care for people. SDS Option 3 is where Social Work services organise, purchase and manage care for people.

Improvement Actions

A social work and primary care pilot has been introduced to establish whether having a social worker present at Craignair Health Centre once a week would make a difference to outcomes for people, their family members or Carers, GPs and other health and social work professionals. The pilot is considering the following areas:

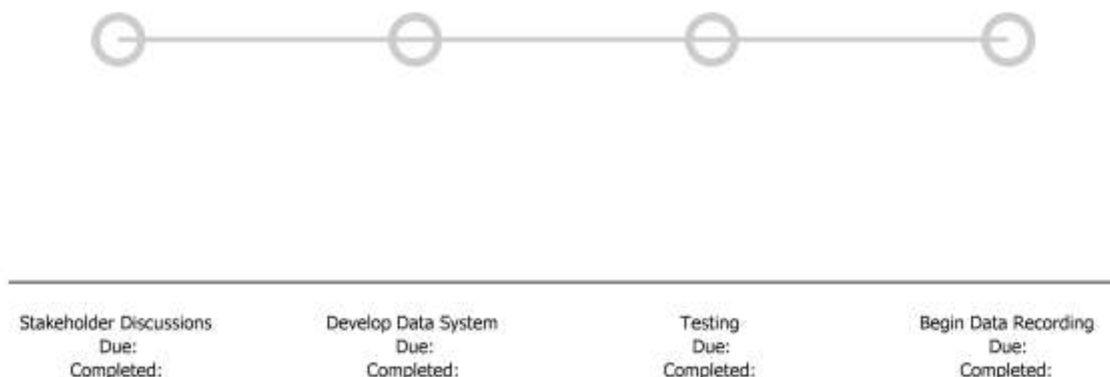
- Increasing early intervention and prevention work
- Working better together and improving working relationships
- Reducing inappropriate referrals to social work services

24 people have been referred to the pilot since it started (as of January 2017). Some of the outputs for the people referred include signposting, supporting people to attend appointments with other agencies, and referrals to social work for support such as Self Directed Support (SDS) assessments. Also, some referrals have led to people having an early review of their existing care and support and changes being made in a timely manner so as to avoid a crisis.

Scottish Care represents a group of independent sector health and social care providers across Scotland. They have developed a bespoke training programme, Mainstreaming Good Conversations. This gives care providers tools and techniques to help embed an outcomes focussed, asset-based approach to their care and support services. The training helps managers, supervisors and front line workers to improve their day to day support for people. This training is in line with the new health and social care standards and helps to embed a human rights approach to the design, delivery and evaluation of care and support.

C5 Carers receiving support (excluding Young Carers)

Number of Carers receiving support (excluding Young Carers); Stewartry



Key Points

Development of this indicator is under discussion by the Dumfries and Galloway Carers Strategy Group.

The Wider Context

Unpaid Carers are the largest group of care providers in Scotland. The Carers (Scotland) Act 2016 which comes into force on 1st April 2018 will ensure that identifying and providing support to Carers remains a local and national priority.

Dumfries and Galloway Carers Centre (DGCC) remain the lead service in respect of Carers in Stewartry.

Improvement Actions

In November 2017 a review of the information leaflets for people using our services at Stewartry cottage hospitals was undertaken. As a result there will be a revised section to describe the discharge planning process and inform people and Carers how they can be involved.

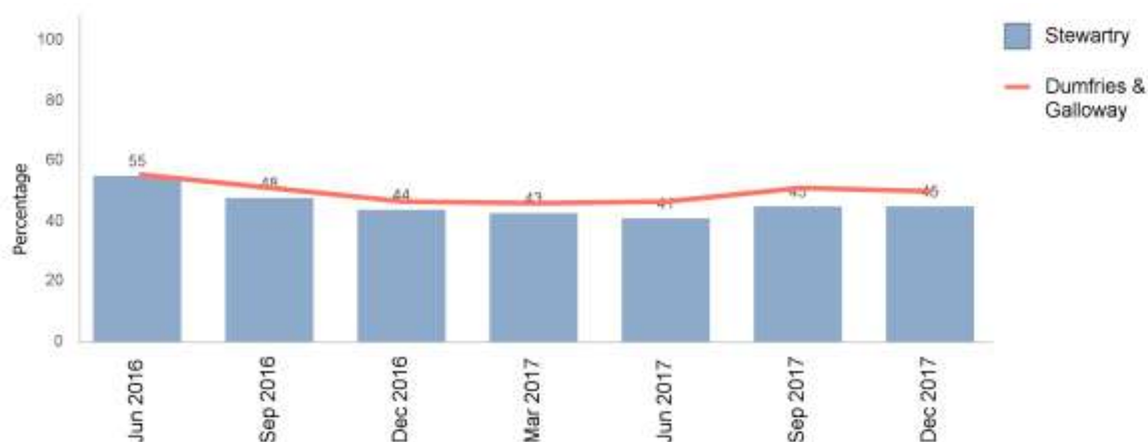
To help support Carers' health and wellbeing it has been agreed that DGCC would link directly with Healthy Connections social prescribing initiative. Referrals will start in January 2018.

A respite scoping exercise for the Locality started in June 2017. This exercise aims to understand the current respite provision and to identify gaps. The first stage involved a consultation with Carers using a questionnaire to gain their views on what respite means to them. 21 Carers participated in the questionnaire. Information gathered through the questionnaires and a Carers focus group will be shared with all the local Care at Home providers to highlight these findings.

The next step for early 2018 will be to bring together local providers to discuss how the Health and Social Care partnership can work together to meet some of the gaps and address opportunities.

C6 Proportion of people 65 and over receiving care at home (via Option 3) with intensive care needs

Percentage of people 65 and over receiving care at home considered to have intensive care needs (10 hours or more); Stewartry



Key Points

This is a Data Only indicator.

The percentage of people aged 65 and over receiving care at home through Self Direct Support (SDS) Option 3 who have intensive care needs (10 hours or more) from Stewartry was 45% in December 2017.

This rate is lower than that across Dumfries and Galloway at 50%.

The Wider Context

This is an historical indicator, which predates the introduction of Self Directed Support, whose relevance has changed since the introduction of SDS. In this indicator “intensive care needs” is defined as a person needing 10 or more hours of care per week. This is an historic threshold of care and therefore less relevant in the context of the changing policy position in respect of self-directed support. The calculation for this indicator is based on those people who have chosen Option 3.

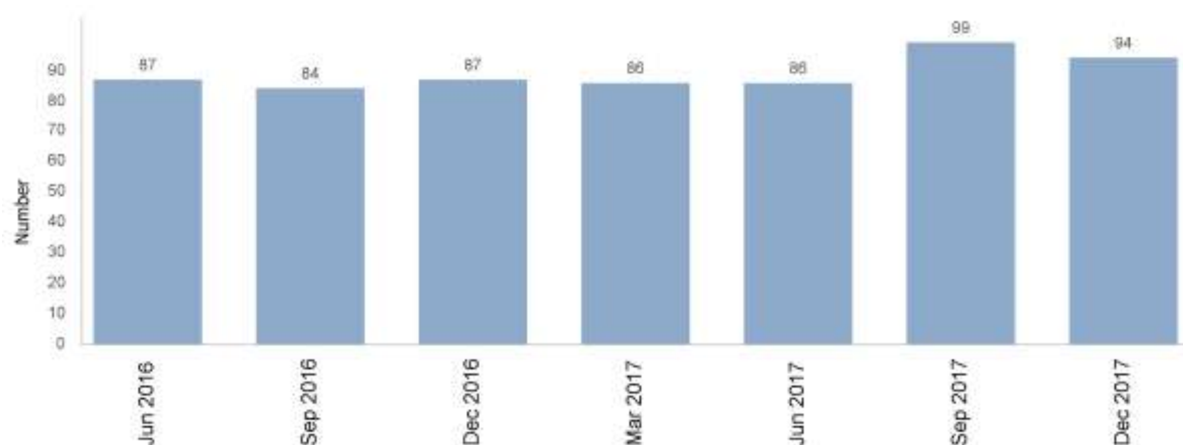
The new SDS models of care offer more person-centred solutions and offer more alternative and efficient solutions.

Improvement Actions

No improvement actions required at this time. This historic indicator needs to be reviewed.

C7 Number of adults under 65 receiving care at home (via SDS Option 3)

Number of adults under 65 receiving care at home; Stewartry



Key Points

This is a Data Only indicator.

The number of adults from Stewartry aged under 65 years receiving care at home through Self Directed Support (SDS) Option 3 was 94 in December 2017.

Performance against this indicator in Stewartry has been relatively stable since April 2016.

The Wider Context

SDS Option 3 is where Social Work Services organise and purchase and manage care for people. For people under the age of 65 and depending upon individual financial assessments, care at home may be charged for. There are multiple factors that can influence the number of people under 65 receiving personal care at home: they may be accessing other services such as day care or optimising the use of their own assets to meet their personal outcomes. Another influencing factor may be issues with the supply of care in local areas.

Improvement Actions

The Food Train Friends Befriending Project has engaged with 42 people locally and has trained 31 volunteer befrienders (as of January 2018). Some of the volunteers befriend more than 1 person. Each supported person is seen for approximately 1 hour a week, depending on their need. There are before and after measurements (after 6 months) recorded for each person befriended to identify personal outcomes being supported through befriending. Exit interviews are also carried out to support learning and development of the service. Food Train has recently been awarded Quality in Befriending Accreditation by the Befriending Network.

D1 Feeling safe when using health and social care services

Progress towards reporting on the proportion of people who agree they felt safe when they last used health and social care services; Stewartry

Stakeholder Discussions Due: Completed:	Develop Data System Due: Completed:	Testing Due: Completed:	Begin Data Recording Due: Completed:

Key Points

This indicator has not yet been developed.

The Wider Context

All people have the right to live free from physical, sexual, psychological or emotional, financial or material neglect, discriminatory harm or abuse. The Strategic Plan recognises this as a key priority.

Improvement Actions

The Locality Social Work team have developed an Adult Support and Protection (ASP) plan. This will link key services already in place to protect vulnerable adults. Staff will be supported and will have opportunities for development. A working group will be established to be responsible for auditing ASP referrals and ensuring lessons and experiences are shared across the Locality and used to inform improvements. The ASP unit is developing a framework for auditing investigations and this will be completed in 2018.

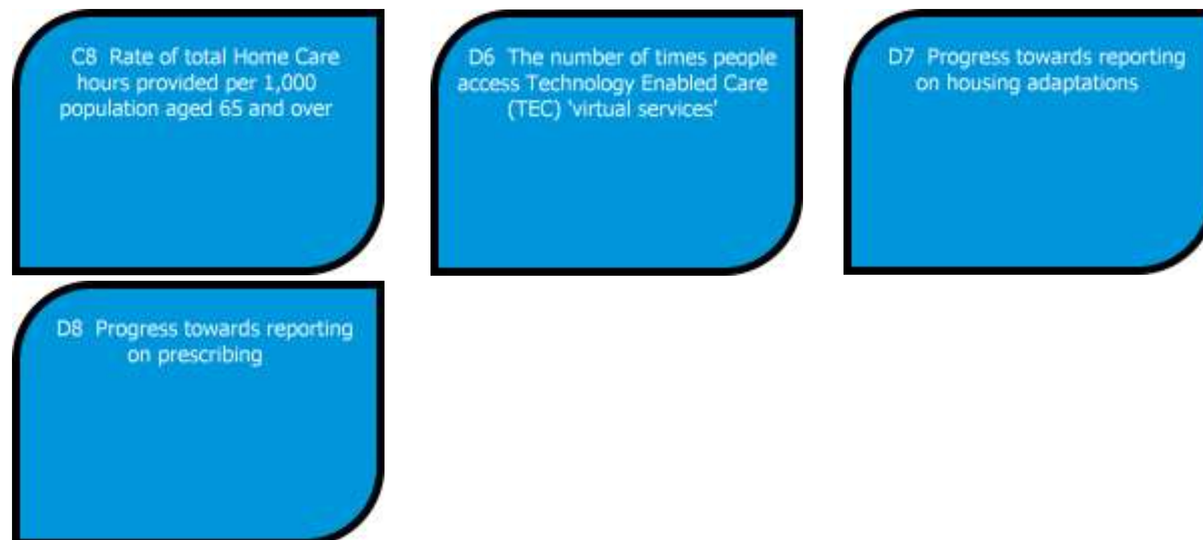
Scottish Care has been sharing information and has established a good relationship with the health protection team in Stewartry. This is improving outcomes for people by ensuring staff are better informed through the sharing of relevant local information. For example, health and social care providers were recently updated about the implementation of the National Catheter Passport.

Partners from across health and social care have worked together to develop new protocols for supporting people who have had a fall. Scottish Care has organised demonstrations of Raizer equipment. This equipment is now available across Dumfries and Galloway in community hospitals to support people who have fallen to the floor and need assistance to get up. Staff training has been organised so that care providers can access and use this equipment.

The Let's Motivate programme aims to encourage physical movement and gentle exercise amongst care home residents which in turn, can help to prevent falls. The specialist trainer encourages care staff to learn more about the benefits of physical exercise for older people and how to design appropriate and tailored activities for their residents.

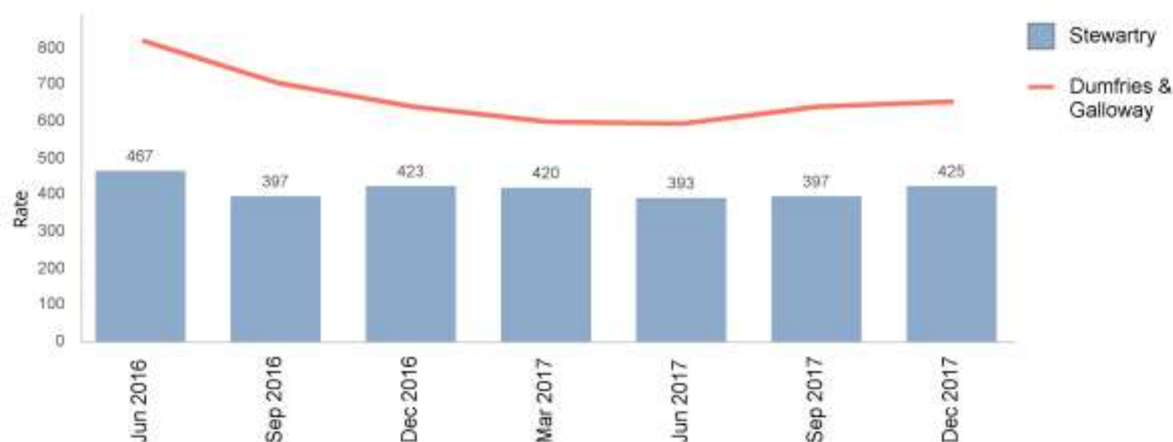
Performance Indicator Overview

Finance and Resources



C8 Total number of Home Care hours provided as a rate per 1,000 population aged 65 and over

Rate of total Home Care hours provided per 1,000 population aged 65 and over; Stewartry



Key Points

This is a Data Only indicator.

In December 2017 the rate of Home Care provision in Stewartry was 425 hours per 1,000 population aged 65 or older.

The rate for Stewartry is persistently lower than the rate observed across Dumfries and Galloway (655 hours per 1,000 population aged 65 or older).

The Wider Context

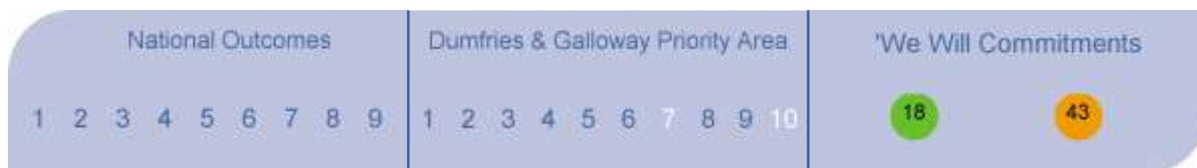
Across Dumfries and Galloway approximately 1 million hours of care at home are provided each year.

It is anticipated that there will be a further decrease as more people opt for Self Directed Support (SDS) Options 1 and 2. However, there will be a need to understand how many people are in receipt of care and support through all the options and not just home care hours. Records on the Framework-i information system have been reviewed and rationalised in preparation for migration to the new Mosaic information system. This will be monitored.

Improvement Actions

No improvement actions required at this time. This historic indicator needs to be reviewed.

D6 Technology Enabled Care (TEC) - Virtual Services



The number of times people access Technology Enabled Care (TEC) 'virtual services'; Stewartry

Stakeholder Discussions Due: Completed:	Develop systems to collate data Due: Completed:	Pilot and Test Due: Completed:	Roll out across locality Due: Completed:

Key Points

This indicator has not yet been developed.

The Wider Context

Dumfries and Galloway have made a commitment in the Strategic Plan to develop a Technology Enabled Care (TEC) programme that will explore the use of virtual services, such as text messaging, apps and video conferencing, and their use within health and social care settings.

Improvement Actions

The Message in a Bottle initiative has been updated using Quick Response (QR) codes, which are a type of square shaped bar code that can be shared online. Stewartry Community Voluntary Service (SCVS) has been encouraging people who suffer from medical conditions to fill out a form listing their medication which is then transferred onto a QR code and made into a key ring, fridge magnet and card the size of a business card. These enable emergency services to obtain important medical information in an emergency by scanning the code. This helps improve the person centred care people receive in a medical emergency. The launch of this project was delayed whilst a robust data protection policy and practice were put in place. This has now happened and the project launched in November 2017.

With support from Scottish Care, the NHS local care homes have been encouraged to install special computer software to enable secure face to face meetings and consultations online. This will not only save time and costs but will enable different health and social care services to connect and communicate more effectively. It will also provide individual residents with a choice of either a face to face or a virtual consultation with their GP or other health and social care professional.

Scottish Care has been working with the lead diabetic nurse and care providers to provide an enhanced blood glucose monitoring service for residents in nursing home using new monitoring equipment.

D7 Housing adaptations

Progress towards reporting on housing adaptations; Stewartry

Identify appropriate measure Due: Completed:	Develop systems to collate data Due: Completed:	Pilot and Test Due: Completed:	Roll out across locality Due: Completed:

Key Points

This indicator has not yet been developed.

The Wider Context

People have expressed their wish to remain at home or in a homely setting for as long as possible. The Health and Social Care Partnership is focused on supporting people to enable them to remain at home as long as possible.

Improvement Actions

In spring 2017, residents with learning disabilities and staff members affected by the move from shared supported living accommodation at Mansefield House to single tenant flats at School Close, Kirkcudbright were contacted to give their thoughts on the process.

8 residents and family members, 9 staff members and 5 social work staff participated in the evaluation. Whilst the majority of the feedback about the new accommodation and overall impact was promising, points were made which could inform similar initiatives in the future.

One family member commented:

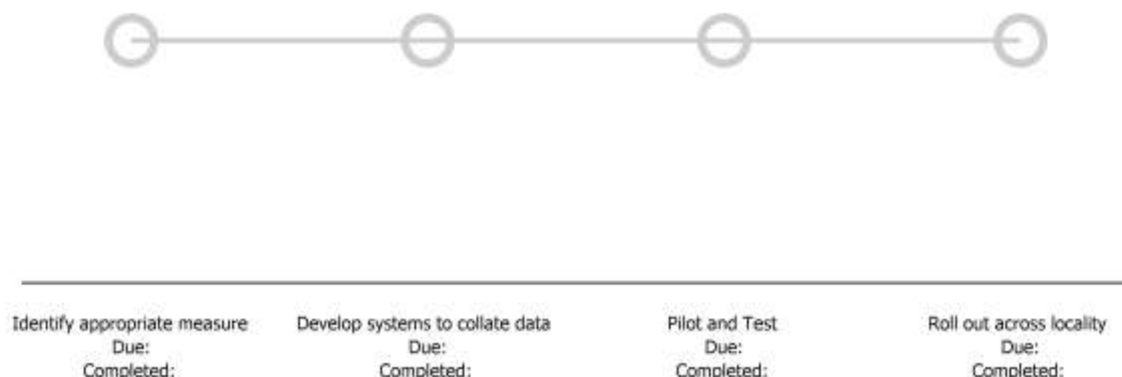
> “It has surprised me how well they [the residents] have adapted.”

Feedback from staff highlighted that residents were beginning to take ownership of their new homes by offering to make cups of tea for visitors and purchasing personal décor for their flats. These feedback conversations took place within 6 months of the move.

A further review is planned for spring 2018 to assess the longer term impacts of the move and a changing resident group.

D8 Prescribing

Progress towards reporting on prescribing; Stewartry



Identify appropriate measure	Develop systems to collate data	Pilot and Test	Roll out across locality
Due:	Due:	Due:	Due:
Completed:	Completed:	Completed:	Completed:

Key Points

This indicator is being developed by a short life working group.

The Wider Context

Choosing the most suitable and cost effective medicine is important in providing the best care for people consistently across the Partnership. Ineffective and inefficient prescribing can be both unsafe (for example, when people are given medicines that don't work well together) and wasteful (for example, when people are given or request medicines that they don't need). Development of an appropriate indicator is underway.

Improvement Actions

A pilot project between the Glenkens GP practice and the community shop will be implemented in early 2018 encouraging people to buy over the counter medication from the shop. The aim of the project is to reduce prescribing levels for affordable self-help medications and supporting access to such medicines locally.

Performance Indicator Overview

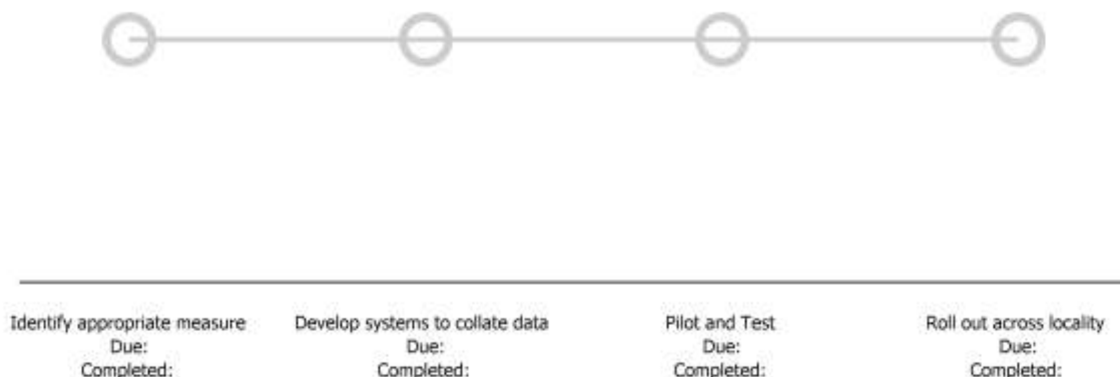
Quality

D4 Progress towards reporting on personal outcomes

D5 Progress towards reporting on the proportion of staff who agree that they have the information and support necessary to do their job

D4 People's progress towards achieving personal outcomes

Progress towards reporting on personal outcomes; Stewartry



Identify appropriate measure
Due:
Completed:

Develop systems to collate data
Due:
Completed:

Pilot and Test
Due:
Completed:

Roll out across locality
Due:
Completed:

Key Points

Development of this indicator has not begun.

The Wider Context

A key aim of health and social care integration is to make care more person centred. This indicator is a measurement focusing on peoples own goals and how Dumfries and Galloway Health and Social Care Partnership is supporting people to achieve them.

Improvement Actions

As part of the Patient Safety and Improvement Programme locally, social prescribing referral routes, triage systems and associated risk assessments are being reviewed and developed. This work started in November 2017 with the introduction of new referral routes and process mapping and development sessions. Work will continue in the first part of 2018.

Between April 2017 and December 2017, there were 55 people referred to Healthy Connections social prescribing initiative. This has resulted in 55 face to face contacts. Between April 2017 and September 2017, due to staffing capacity, referrals were only accepted from GPs. However, since September 2017, a support worker has joined the health and wellbeing team and new referral routes have been developed. Referrals are now being received from adult social care, Community Mental Health Teams, community nursing and occupational therapy. There has been an increase in coordinated working with the psychology liaison pilot and other health professionals. People who have used this service have reported positive outcomes including identifying and participating in new interests and learning and volunteering opportunities, successfully engaging with an employability service, and developing strategies to relax and reduce anxiety.

During 2017 a minimum dataset has been designed for social prescribing. The dataset includes demographics, protected characteristics, referral details, support and engagement details and outcomes for people. From January2018 to April 2018, there will be pilot with the Stewartry Healthy Connections programme to test the use of the dataset. This will consider the practicalities of data collection, data quality and the potential usefulness of collecting this data on a long term basis. This pilot will be evaluated in April 2018.

D5 Staff have the information and support to do their job

Progress towards reporting on the proportion of staff who agree that they have the information and support necessary to do their job; Stewartry

Identify appropriate measure Due: Completed:	Develop systems to collate data Due: Completed:	Pilot and Test Due: Completed:	Roll out across locality Due: Completed:

Key Points

Development of this indicator has not begun.

The Wider Context

The sharing of appropriate information between teams across health and social care is important for the safe and effective delivery of services. Appropriate information sharing can improve the co-ordination of services and lead to improved outcomes for people. The Locality plan includes commitments regarding effective information sharing.

Improvement Actions

Since October 2017, review work with the Occupational Therapy (OT) teams in Stewartry (OT teams from health, Social Work and Short Term Assessment Reablement Service) has been exploring ways to integrate work and to streamline services.

A mapping exercise has been completed, which identified input at each stage of a person's journey from their own home and community, into Dumfries and Galloway Royal Infirmary (DGRI), to cottage hospitals, and returning to their surrounding community networks (GP, family, Carers and so on). This has been well received by staff, who are keen to improve the way people are supported. Social work and health OT services are now being managed together to enable better integration and co-ordination. A current challenge is joining up the IT systems to be able to share relevant information. The community teams are currently working very closely with the NHS Dumfries and Galloway IT team to try to find ways of sharing access to systems and case notes.

Commissioners and Scottish Care hold a quarterly seminar specifically for care providers, designed to share good practice and address contractual issues. These events have proven an effective method for ensuring that care providers are actively involved in health and social care integration and kept informed of new initiatives, changes to contracts or regulations. These seminars also support providers to share good practice, for example, the implementation of the Carers Act from April 2018.

Performance Indicator Overview

Stakeholder Experience

D3 Well co-ordinated health and social care services

Progress towards reporting on the percentage of people who agree that their health and social care services seemed well co-ordinated; Stewartry

Identify and develop questionnaires Due: Completed:	Built supporting IT Due: Completed:	Pilot and Test Due: Completed:	Roll out across locality Due: Completed:

Key Points

Development of this indicator has not begun.

The Wider Context

In order to prevent ill health or, where health or social care needs are identified, to make sure there are appropriate levels of planning and support to maximise health and wellbeing.

Improvement Actions

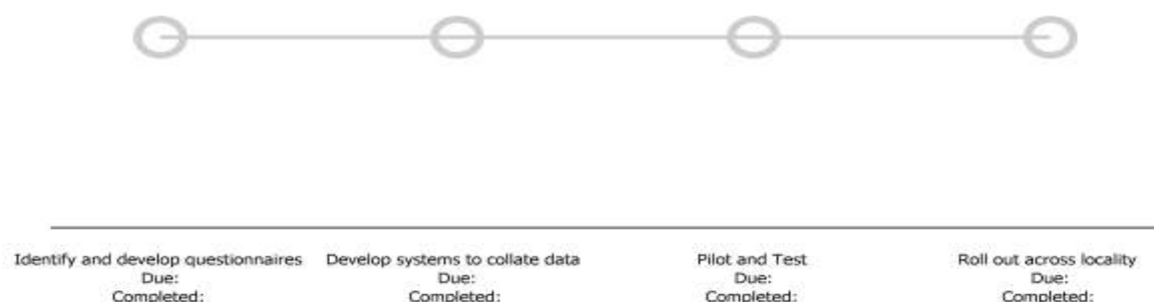
The Daily Dynamic Discharge (DDD) approach has now been implemented in all cottage hospitals across Stewartry. The DDD approach focuses on the management of the person's journey from care provided in hospital through to being discharged in a safe and timely way. Planning starts when a person is first admitted to hospital to ensure that when the person is discharged this can happen without delay.

The multi-agency team, working with people receiving care in Castle Douglas and Kirkcudbright hospitals, meet 3 times a week to discuss and agree key actions needed for discharge. Potential benefits of this consistent open communication will be the reduction in the amount of time people need to spend in hospital, the reduction in delays, and improved flow of people to community based care and support. The DDD meetings are focussed around each person, ensuring their needs and outcomes are being met appropriately, ensuring their involvement in decisions and the person's decisions are made known to the team.

Work is ongoing with both Castle Douglas and Dalbeattie day centres to identify further opportunities to work together and optimise the use of resources. The 2 day centres are sharing facilities: Castle Douglas day centre has taken their members to Dalbeattie day centre to visit on days when Castle Douglas day centre is not open. This has increased availability and access for the day centre members. Day centre managers have attended Social Work meetings at Garden Hill Primary Care Centre to raise awareness and promote the work of day centres.

D12 Community strength: community support

Progress towards reporting on the proportion of people who agree that they could rely on family or friends in their own neighbourhood for help; Stewartry



Key Points

Development of this indicator has not begun.

The Wider Context

There is clear evidence in the research literature of a proportional relationship between how many people feel they can rely on friends and family in their community, and community strength. The responses to this indicator provide an indirect measure for community strength.
The Scottish Government has published its third National Dementia Strategy for 2017-2020.

Improvement Actions

Work is progressing well in New Galloway with developing a Community Wellbeing plan. This plan links the town hall community shop and community council. The weekly town hall lunch group has been identified as being helpful to reduce the effects of isolation. 60 people have so far benefited from this lunch group with at least 12 people attending weekly. The sustainability of the group is being explored with support from our community health and wellbeing development worker.

In August 2017 an Ask the Experts event in New Galloway was organised where a group of physically disabled people were invited to the community to visit various public places. Feedback was offered covering the positive aspects of access and suggestions made for short and longer term changes. Direct outcomes from this include: improvement of the disabled parking signage, the community shop is recognising feedback during planned renovations and funds are being sourced to improve disabled access to the Town Hall. The report has been given to the community and is being used to both inform and evidence funding applications.

Crossmichael Community Council has health and wellbeing as a regular agenda item at its council meetings. In 2017, it was agreed the group would focus on 4 key areas around health and wellbeing. These are

- an ‘Ask the Experts’ event looking at disabled access
- longer term first aid training
- the development of a local heritage project.

The ‘Ask the Expert’ event will take place in Crossmichael on 27th February 2018. First aid training will be explored further from April 2018.

We will be working with 3 new communities early in 2018: Borgue, Kirkgunzeon and Dalry, and Colvend.

D13 Health inequalities

National Outcomes	Dumfries & Galloway Priority Area	'We Will Commitments
1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9 10	22

Progress towards reporting on health inequalities; Stewartry

Identify appropriate measure	Develop systems to collate data	Pilot and Test	Roll out across locality
Due:	Due:	Due:	Due:
Completed:	Completed:	Completed:	Completed:

Key Points

Development of this indicator is underway.

The Wider Context

There is currently no national agreed indicator to measure reductions in health inequalities. Health inequalities are understood to be a major contributor to reducing positive health outcomes. Reducing inequalities is a priority area of focus for the Integration Joint Board. The Public Health department and the Performance and Intelligence team are leading discussions to identify an appropriate performance indicator.

Improvement Actions

The Health and Wellbeing in the Farming Community project is a joint approach between the National Farmers Union (NFU) Scotland, Dumfries and Galloway Health and Social Care and DG Health and Wellbeing.

The first phase of the project, the Big Conversation, took place from August 2017 to November 2017. This involved over 100 conversations with groups and individuals from the farming community to identify the priority concerns around health and wellbeing.

Social isolation and loneliness, mental wellbeing, health and safety and access to services were all identified priorities. We are now looking at how we can work in partnership with the community to design and deliver effective projects and initiatives that work to improve outcomes for people under these identified priority areas.

A pilot ran in October 2017 to look at how to make information about community resources more widely available. Resource packs were developed and given to 5 communities within Stewartry and 3 groups of health professionals to test. Feedback will be collated in early 2018. The pilot was developed following a comment from a health professional that it would be beneficial to be able to provide support on issues which become apparent during home visits, such as poor heating.

D19 Staff understanding of vision and direction of the health and social care partnership

Progress towards reporting on the proportion of staff who agree they understand the vision and direction of Dumfries and Galloway Health and Social Care partnership; Stewartry

Identify and develop questionnaires	Develop systems to collate data	Pilot and Test	Roll out across locality
Due:	Due:	Due:	Due:
Completed:	Completed:	Completed:	Completed:

Key Points

Development of this indicator is being progressed by the Integrated Organisational Development Group.

The Wider Context

The input from staff can help shape the future direction of services to improve the support and care people receive. In turn, this can improve outcomes for people.

Improvement Actions

As part of the work we are doing to explore potential new models of care within the Locality, a staff and public engagement programme will start in spring 2018. This engagement programme will support both the general public and staff from across the health and social care partnership to help shape how our services will look in the future. A consultation and engagement group has been formed to take this work forward.

We have been looking at ways to strengthen the representation from non-statutory care providers. This is being achieved through local volunteer representatives, who join our branch chairs, and core team members who attend partnership meetings and undertake work with partners through short life working groups. This latest group of volunteer representatives includes managers from both for profit and not for profit organisations.

Appendix 1: Table of “We Wills”

Ref & RAG Status	Description
1	We will further expand the community link approach to support people to become involved in their communities; and work with individuals and our partners to provide relevant information that will allow people to make the best use of local assets to meet their health and wellbeing need.
2	We will work with staff and partners to explore different approaches to early intervention and ensure staff have the necessary skills and knowledge to adopt these approaches
3	We will support people to identify potential future health and care needs, and to plan ahead at an earlier stage, where appropriate
4	We will explore transport initiatives which will allow people to have easy access to support, activities and services in their local community.
5	We will support the development of a range of community based day services to meet with local need.
6	We will work with staff and partners to explore different approaches to early intervention and ensure staff have the necessary skills and knowledge to adopt these approaches.
7	We will encourage people to use self management techniques and build people’s confidence and skills around this.
8	We will develop approaches which will support early discharge from hospital and prevent hospital admission (e.g. rapid response service / managing conditions in a day case setting.)
9	We will continue to work towards providing or sourcing appropriate support that enables people to remain in their local communities (e.g. Dementia Friendly communities, Befriending or shopping services).
10	We will work in partnership with care providers to develop sustainable care at home services which strive to optimise people’s independence and quality of life.
11	We will take account of housing needs and work with individual and partners to consider housing and support options that will enable independent living.
12	We will, through our communication and engagement framework, provide a listening platform for people to communicate their views and needs; share learning across the partnership and raise awareness of issues that will influence the design of services.
13	We will ensure that person centred approaches and a focus on personal outcomes are central to health and social care work; paying attention to protected characteristics and any specific needs thereof.
14	We will hold conversations with people to identify what really matters to them and help them develop a plan that will enable them to maintain or improve their quality of life and independence
15	We will promote living well and end of life care in our communities, respecting the needs and wishes of individuals and their families.

16	We will develop a culture where people using our services can expect a high level of customer service.
17	We will promote the value of self directed support and person centred care, as it relates to individual outcomes and ensure this is embedded in our practice.
18	We will develop joint systems and processes (including I.T. systems) across the partnership to improve communication, reduce duplication, promote continuity of care and maximise individual outcomes.
19	We will explore, in partnership with our GP practices, options in relation to skill mix
20	We will explore different models of care for out cottage hospitals
21	We will make sure staff across all sectors are skilled and have the most up-to-date knowledge and information to provide continuously improving support, care and treatment for individuals.
22	We will work with appropriate partners to address some of the logistical challenges presented to some individuals which prevent universal access to services (e.g. transport links, wheelchair access)
23	We will further develop links with housing and other specialist service providers to foster approaches which, where possible, present problems from arising (e.g. earlier access to aids and adaptations)
24	We will identify and work directly with groups and communities identified with specific health challenges.
25	We will actively identify unpaid carers in our community and within our workforce and signpost them to the most appropriate support.
26	We will promote the value of the carer's strategy and work with partners and carers to develop solutions to support the health and, wellbeing of unpaid carers and identify alternative support options.
27	We will explore respite options for carers and identify timely support options that will reduce the need for crisis management.
28	We will ensure that all staff are trained appropriate to their role in assessing a person's capacity and assessing and managing risks to the person.
29	We will ensure that all partners are trained in a consistent manner in relation to Adult Support and Protection to enable prompt identification of individuals at risk.
30	We will work with our wider partners (e.g. Police Scotland and Fire and Rescue) to address issues related to community safety for the most vulnerable members of our communities.
31	We will explore ways of safely managing the sharing of information across the locality partnership.
32	We will develop a programme of audits across the partnership which will allow us to regularly monitor and review our performance in the locality
33	We will use the learning and build upon existing initiatives (e.g. Safer Patient / Adverse incidents) to reduce un-necessary harm to people.

34	We will actively listen to the views and ideas of staff from across the partnership and keep them updated on the actions we have taken to respond.
35	We will provide regular information for staff to keep them up to date and abreast of developments in the locality.
36	We will provide a variety of support mechanisms for staff to access to help them manage the programme of change which is required across the health and social care setting.
37	We will explore new ways and opportunities to recruit, retain and increase the skills within our existing workforce to meet future need (e.g. new career pathways)
38	We will identify ways for staff to access the most appropriate information at the most appropriate time to support optimum care giving.
39	We will work in partnership to develop alternative, sustainable models of care which maximise the use of existing resources.
40	We will support our workforce in gaining an understanding of the value of working in partnership within an integrated system, and how collective resources can be employed to deliver services; ultimately reducing duplication.
41	We will continue to introduce and promote prescribing initiatives to ensure safe, appropriate, effective prescribing.
42	We will regularly review health and social care packages as multi-disciplinary teams to make sure that they are right for the individual, achieve agreed outcomes and promote well-being.
43	We will maximise the use of technology to reduce waste and duplication in the system.