DUMFRIES AND GALLOWAY
INTEGRATION JOINT BOARD

PERFORMANCE MANAGEMENT

AREA COMMITTEE REPORT

DUMFRIES AND GALLOWAY
Health and Social Care

Wigtownshire

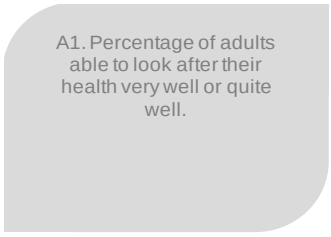
April 2017 - December 2017

Contents

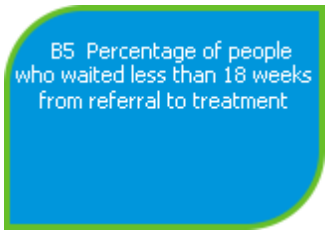
Document Features

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 Wigtownshire Locality Plan

We are experiencing many exciting changes within health and social care across Wigtownshire. Change does not always mean improvement, however; if we don't change, we cannot improve.

To achieve successful outcomes in health and wellbeing takes more than just 'doing to' and 'doing for' people. More and more evidence shows that 'doing with' people is more successful for a variety of reasons; increased self-resilience, self-respect and self-worth being some of those reasons.

We are all in this together, and we must continue to work with each other to make Wigtownshire's communities the best places to live active, safe and healthy lives by promoting independence, choice and control.

What constitutes wellbeing or 'being well' may be different to everyone, but being well is the responsibility of the individual in partnership with the care professionals. That is why Wigtownshire Health and Social Care is undertaking a model of Co-Production, the planning of which is underway.

Co-Production is the combining of mutual strengths and capacities so that people can work with one another on an equal basis to make positive change. In our case Co-Production means...

"delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. When activities are co-produced in this way, both services and neighbourhoods become far more effective agents of change". http://www.coproductionscotland.org.uk/about/what-is-co-production/

Co-production does not, however, take away difficult and complex decisions on how safe, effective, efficient, person centred services are delivered. The Wigtownshire Locality Plan sets out how the integration (joining together) of health and social care will be taken forward. http://www.dg-change.org.uk/strategic plan

General Practice Sustainability

The extreme challenges in recruiting GPs is felt across Scotland and especially in rural areas such as Wigtownshire. The Scottish Government Programme with the University of Dundee aims to have 30 trainee GPs in Dumfries and Galloway by September 2019. While this may ease some of the current difficulties we continue to look to the future and how we will provide care to the people of Wigtownshire. The new GP contract published in January 2018 proposes a refocusing of the GP role as an "expert medical generalist". The aim is to

enable GPs to do the job they train to do, as experts in holistic, person-centred care, allowing them to see people who have complex medical needs. In 2017 we have introduced a practice-based pharmacist at Waverley Medical Centre and a community mental health professional in Lochinch and Lochree practices.

Lochinch Practice is managed by NHS Dumfries and Galloway. The Locality Project Management Team has been working closely with the practice to design new ways of providing care. The aim is to provide the most appropriate care, by the most appropriate health and social care professional. While we design and implement new ways to provide care it remains a top priority to continue to explore innovative ways to recruit GPs to Wigtownshire. The redesign of GP services directly impacts on the way in which the population of Wigtownshire will access services and therefore requires us all to think differently on how we use our services and recognise the support other professions are able to provide, including community pharmacists.

Community Nursing and Out of Hours Services

Wigtownshire has two hubs of community nurses, 1 based in Stranraer covering the entire Rhins area and 1 based in Newton Stewart, covering the entire Machars area. At the end of 2017 the Newton Stewart base provided community nursing cover between the hours of 8:00am and 6:00pm. The Stranraer base provided cover between 8:00am and 8:00pm. There is an on call service until 11:30pm, but this is not available every night of the week. There are 6 nights cover in Stranraer area and an average of 4 nights in Newton Stewart area due to available staffing levels. Plans are in place to further extend cover across the whole of Wigtownshire. The community nursing staff includes registered nurses and healthcare support workers. There are 2 senior charge nurses and 3 charge nurses. A senior charge nurses also has responsibility for Newton Stewart Hospital.

There are currently 2 Advanced Nurse Practitioners (ANPs) in training to provide Out Of Hours (OOH) service in Wigtownshire, who will qualify in June 2018. OOH doctor cover remains variable and the Rhins community nursing team has helped out by covering overnight at least twice a month from April to December when no doctor has been available to go out from the Galloway Community Hospital. A pilot of 24/7 community nursing cover is being planned for January 2018 to test alternative approaches to support people at home. We will evaluate the programme and measure the impact this could have on daytime services, the availability of resources to provide this cover and how cost effective it will be. As always, the overall aim is to provide safe, effective and efficient person centred care.

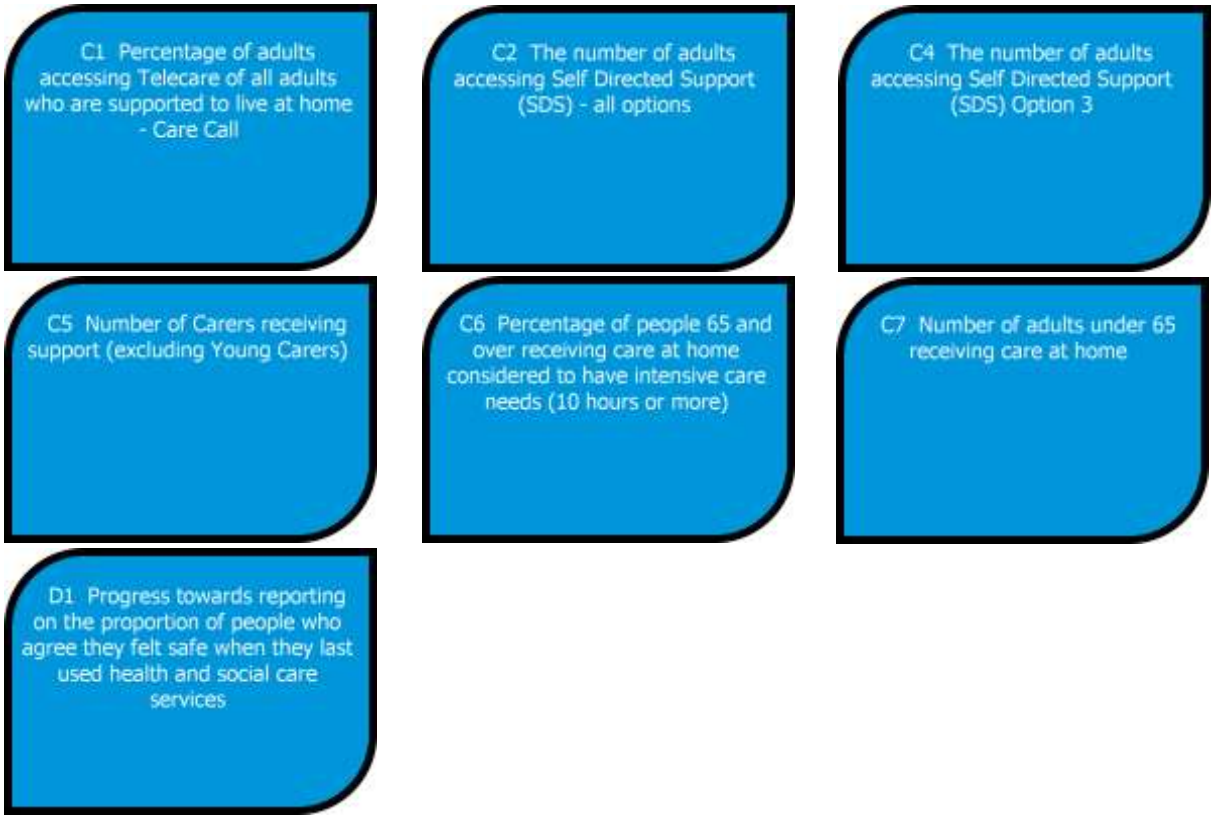
Health and Wellbeing

West Wigtownshire, with a population of approximately 18,000, was chosen as one of the 4 areas to be part of the Building Healthy Communities project in Dumfries and Galloway. We have been recognised as an area experiencing some of highest levels of health inequalities and deprivation across Dumfries and Galloway. Young, single parents, the unemployed, those living in more rurally isolated areas and an increasingly higher proportion of elderly are among those fitting this classification. Wigtownshire's remoteness from some services, job prospects and sparseness of the population means that higher costs are incurred in the delivery of local services which includes health and social care. The West Wigtownshire Area Partnership brings together statutory, private and third sector organisations with local people to identify and tackle community health issues. This may involve the development and delivery of relevant activities. Volunteers play a huge and valuable part in all aspects of the programme and are listened to, supported and trained in order to bring out the best in the individual volunteer themselves which in turn benefits their respective communities.

June Watters
Wigtownshire Locality Manager

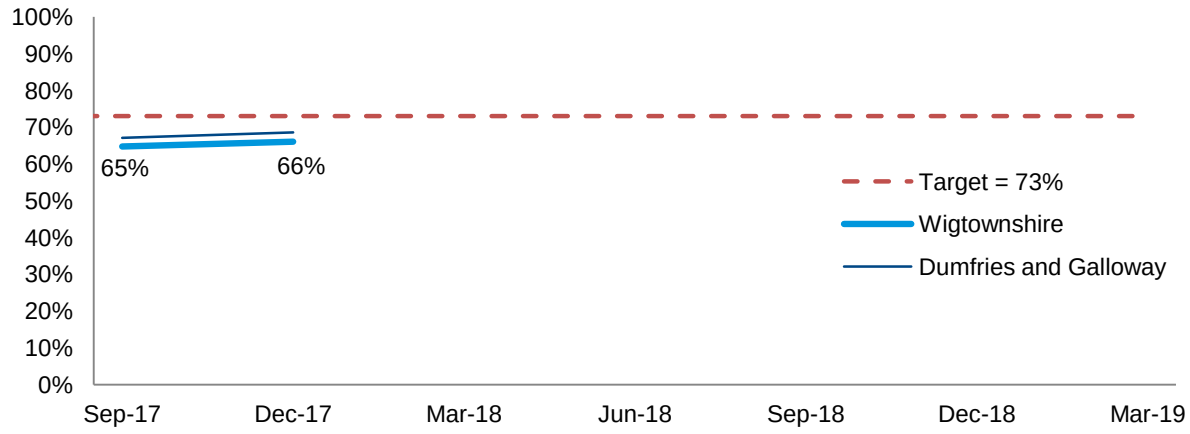
Performance Indicator Overview

Clinical and Care Governance



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; Wigtownshire



Key Points

The percentage of adults supported to live at home who are accessing telecare in Wigtownshire was 66% in December 2017 and has reduced since June 2016. Wigtownshire performance is similar to that of Dumfries and Galloway (68.6%).

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.

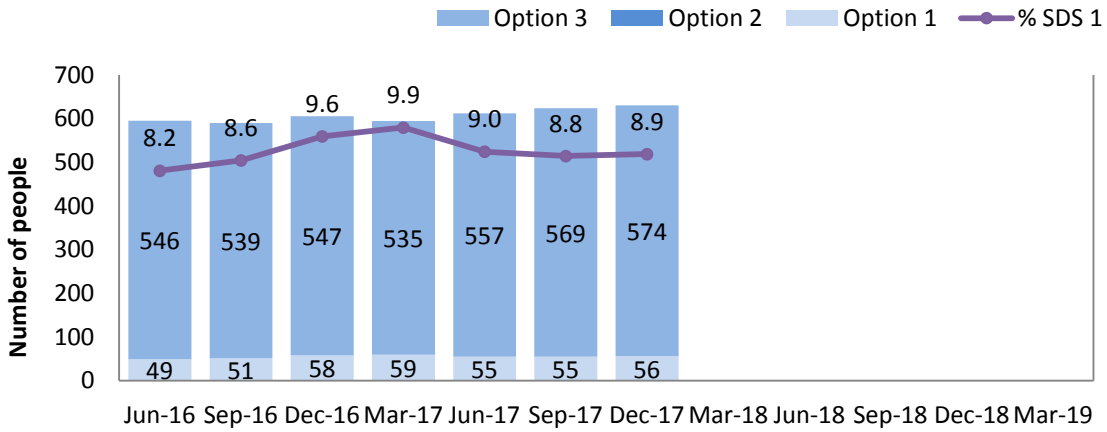
Improvement Actions

The Newton Stewart Community Flow Meeting is held weekly and is attended by professionals from across health and social care. A Telecare specialist now attends the flow meeting. This has enabled early discussions on whether TEC will assist people to maintain their independence in their own home.

For example, installing Care Call and other associated safety mechanisms can provide many benefits to people and their families. Telecare also has a profound impact on preventing loneliness for those individuals who live in the more rural and isolated areas of Wigtownshire. Loneliness can impact on people's quality of life, with serious implications for physical and mental health.

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; Wigtownshire



Key Points

This is a Data Only indicator.

The number of adults from Wigtownshire receiving care at home through Self Directed Support (SDS) Option 1 was 56 people in December 2017. This number has risen since June 2016 when there were 49 people from Wigtownshire receiving care at home 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

The Stranraer Community Flow Team meeting was established in early November 2017. The Newton Stewart Flow Meeting was established in 2012 and has proved to be incredibly successful. The Stranraer team was designed to replicate the structure of the Newton Stewart meeting because of the good outcomes demonstrated. It is attended by a wide range of health and social care professionals which will be joined by a community mental health professional in 2018. Feedback from staff taking part in the flow meeting includes:

> "I am learning so much at the Flow Meeting and I have a better understanding and appreciation of what other professionals do and how we can work together to provide appropriate services for people."

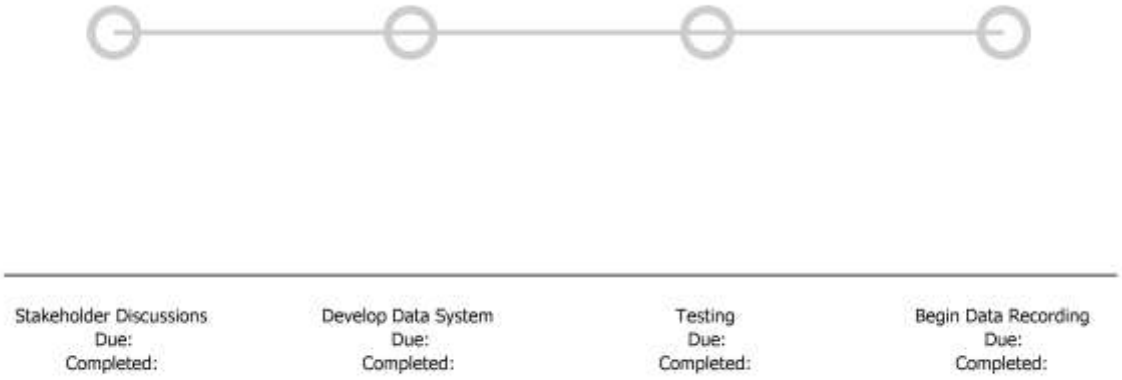
> "The open forum generates good discussions on how to solve problems."

The use of the Short Term Managed Services (STMS) has enabled social work to respond to priority care needs and the provision of new care packages, which in turn allows a quicker discharge from hospital. We are also continually reviewing long standing care packages to ensure people are receiving the most benefit from the care being provided. Social work also performs audits for unspent direct payments in order to redirect funds equitably to those in greatest need.

We have been assessing and will continue to perform rigorous evaluations to identify the needs of people affected by changes in the provision of respite and day care services in Stranraer. The Care Providers are working in partnership with Health and Social Care to identify the most appropriate alternative care settings to meet the needs of these people.

C5 Carers receiving support (excluding Young Carers)

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



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 Wigtownshire.

Improvement Actions

The Carers Centre has seen 94 new adult Carers between April 2017 and December 2017 with 150 returning Carers from the Locality using their services.

From April 2017 to December 2017, there were 17 Adult Carers Support Plans completed with individual Carers with support from the Dumfries and Galloway Carers Centre (DGCC).

The Carers' Strategy was approved by the IJB on the 29th November 2017. Work to implement this strategy is being developed, which will influence how Carers in Wigtownshire are supported.

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); Wigtownshire

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 or more hours) was 58% in December 2017.

This rate is higher than that seen 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.

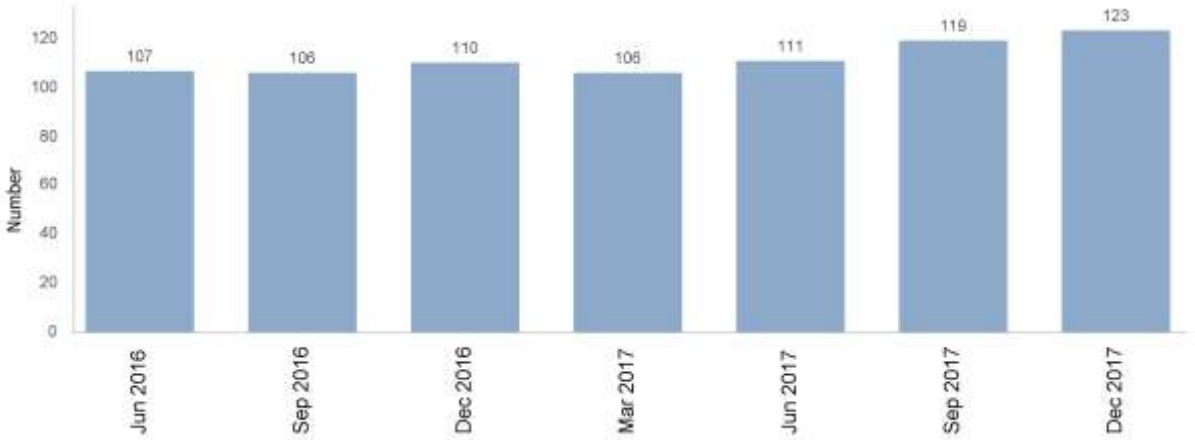
The new SDS models of care offer more person-centred solutions and offer more alternative and efficient solutions.

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; Wigtownshire



Key Points

This is a Data Only indicator.

The number of adults from Wigtownshire aged under 65 years receiving personal care at home through Self Directed Support (SDS) Option 3 was 123 in December 2017.

Performance against this indicator in Wigtownshire has been gradually increasing since February 2016.

The Wider Context

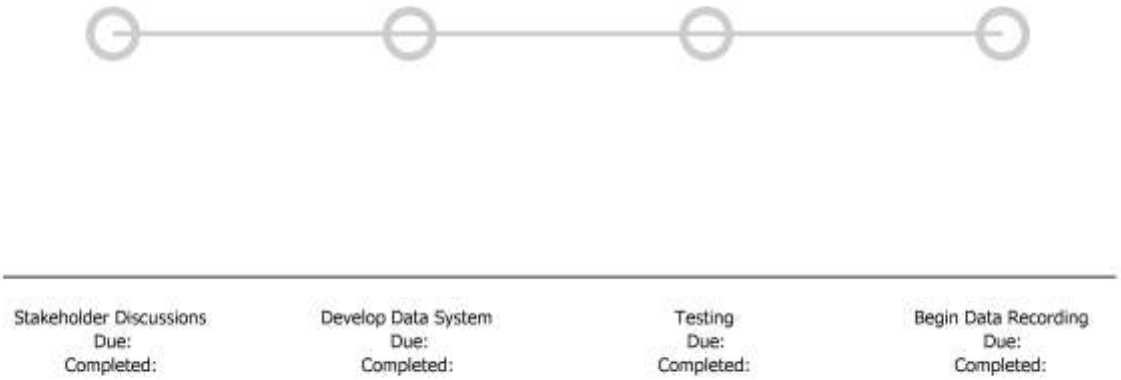
SDS Option 3 is where Social Work Services organise and purchase and manage care for people. For people under the age of 65 and depending upon individual financial assessments, care at home may be charged for. There are multiple factors that can influence the number of people under 65 receiving personal 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

No improvement actions required at this time.

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; Wigtownshire



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.

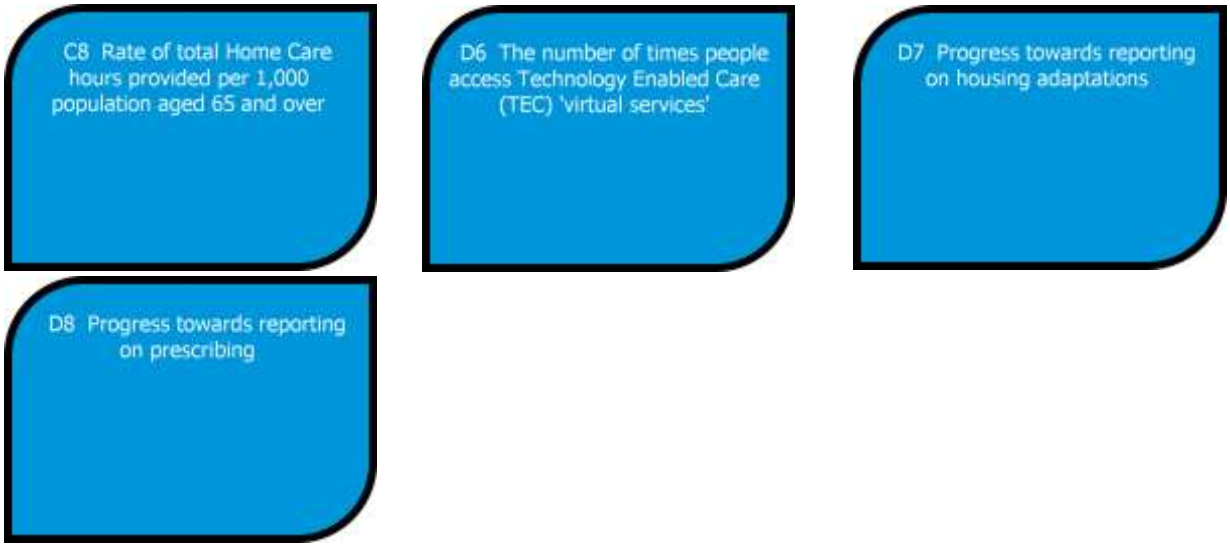
Improvement Actions

There are a number of programmes aiming to reduce the risk of harm to people. The locality activity includes both protection of the vulnerable and programmes to reduce risk of harm in the way that services are delivered. These include:

- Review and assessment of Adult Support and Protection cases to ensure a consistent approach.
- The Wigtownshire Health and Wellbeing Partnership is a collaboration between social work, trading standards, police, health services and others to work together to raise awareness and promote the financial harm toolkit.
- The health and social care teams record all adverse events in Datix. The Datix system helps us manage near misses and adverse events, from how the incident is documented to the way in which the incident is investigated and the analysis of the causes. The system greatly improves the reporting, tracking, ownership and management of safety issues. We promote a learning culture in the locality to enable everyone to learn from all events and implement the necessary improvements to prevent the reoccurrence of similar issues.
- Building Healthy Communities (BHC) carry out a risk assessment for all BHC activities. These are reviewed and adapted every 6 months or sooner if needed. New volunteers attend an induction where all BHC policies, health & safety and personal safety are discussed.

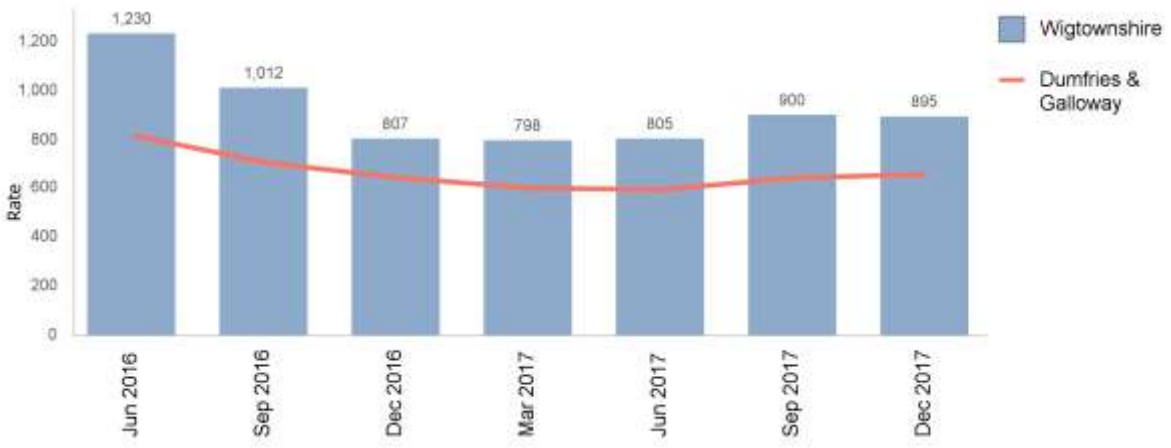
Performance Indicator Overview

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; Wigtownshire



Key Points

This is a Data Only indicator.

In December 2017 the rate of Home Care provision in Wigtownshire was 895 hours per 1,000 population aged 65 or older. There has been a decrease since June 2016.

The rate for Wigtownshire is higher 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.

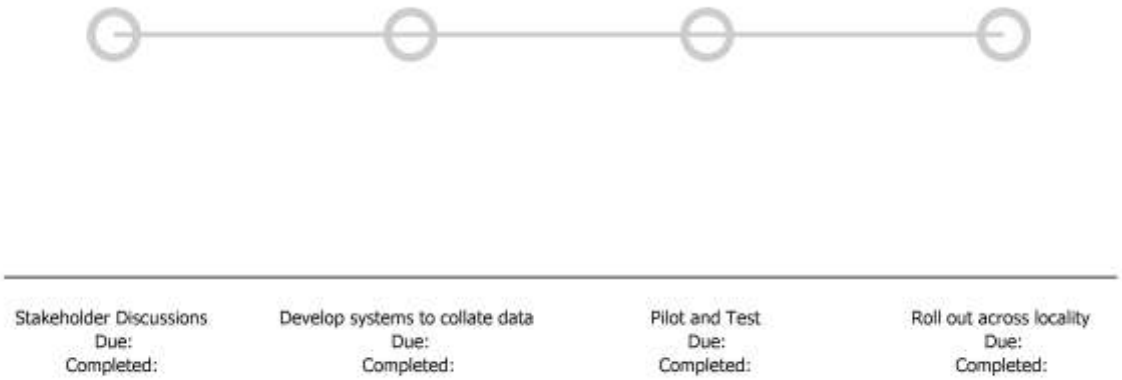
It is anticipated that there will be a further decrease as more people opt for Self Directed Support (SDS) Options 1 and 2. However, there will be a need to understand how many people are in receipt of care and support through all the options and not just home care hours. Records on the Framework-i information 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'; Wigtownshire



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 Locality recognises and embraces the advances in technology which have the potential to improve communications, cost effectiveness and the quality of care provided in the home.

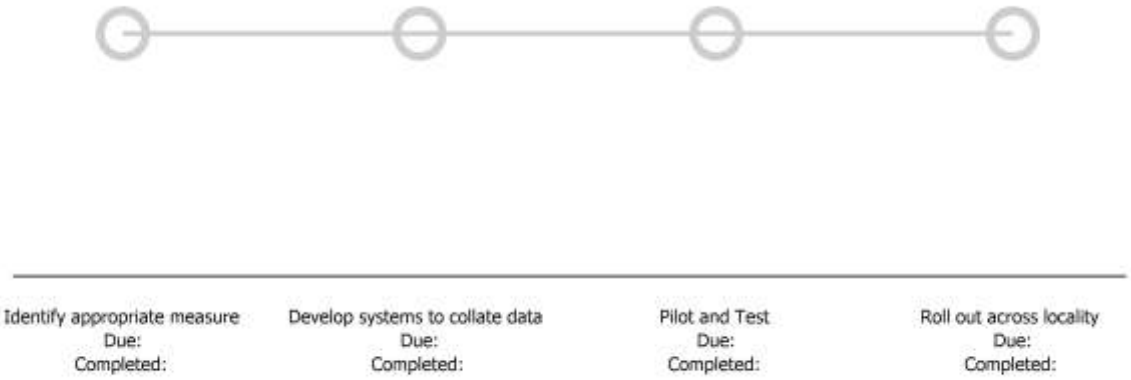
Wigtownshire Locality is participating in a project called mPower. The primary focus of mPower is prevention. The objective is to help people 65 years and older to take the steps needed to live well, safely, and independently in their own home through self-management of their own health and care needs in the community.

The mPower project is a 5-year, €8.7 million, EU-funded project operating in the border areas of the Republic of Ireland, Northern Ireland and Scotland (NHS Dumfries and Galloway, NHS Ayrshire and Arran and NHS Western Isles). The project will implement a 'community navigator' model and eHealth digital interventions to support the provisions of health and care services.

The Wigtownshire Locality has had the good fortune to appoint both an mPower Programme Implementation Lead and a Community Navigator by the end of 2017. This has allowed us to participate in early collaboration and high level planning, helping to design and create what the overall programme will look like.

D7 Housing adaptations

Progress towards reporting on housing adaptations; Wigtownshire



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.

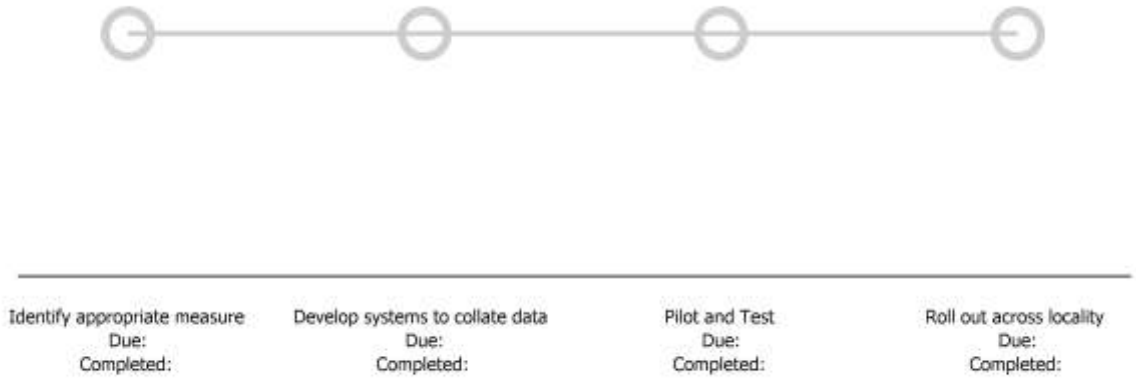
Improvement Actions

The Garrick site is agreed in the Strategic Housing Investment Plan (SHIP) and is being developed by Loreburn Housing Association with planning pending approval in early 2018.

The site will be built to meet a wider range of needs from the outset, offering accommodation for people who have increased vulnerability. The site is proposed to offer accommodation for different tenant groups including older people, those with dementia, learning disabilities, physical disabilities and a proposed foyer with accommodation for young people who are committed to developing employability skills.

D8 Prescribing

Progress towards reporting on prescribing; Wigtownshire



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

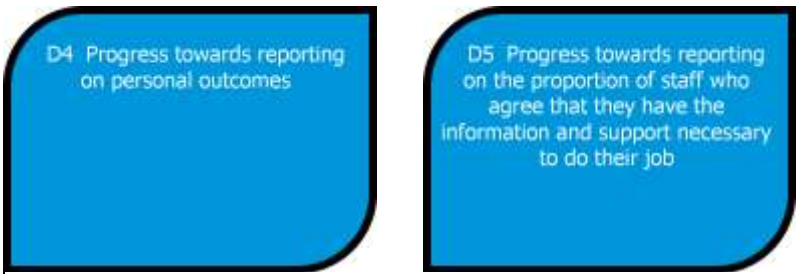
Health and social care integration has enabled the Wigtownshire Locality Pharmacy Team to undergo radical transformation in the past two years. The team is being developed in line with the new General Medical Services contract published in January 2018. The Pharmacists offer a cost-efficient savings programme to GP practices within the Locality. Pharmacists have long been the mainstay of the Locality Pharmacy Team, however we recognised the great work and potential role development of our Pharmacy Technicians to take on patient-facing roles which free up the Pharmacist's time for more complex work.

Within the Locality we are trying to embed the idea of community resilience within the population. An integral part of this is to encourage people to take responsibility for their current and future health. We are working closely with our community pharmacy colleagues, Wigtownshire Health and Wellbeing Team and GP practices to help increase awareness of Pharmacy First. This initiative encourages people to purchase over-the-counter medications.

In addition we are looking to develop our community pharmacists to become independent prescribers. Our care at home programme is taking off. Through referrals from GPs, Social Work, community nursing, or the community hospitals, a pharmacist can review peoples' medications with them in their own home. This helps to ensure the person and their family understand and can manage their medicines safely and appropriately. We will continue to develop this work by using innovative technology, such as electronic medication reminders, texts and phone 'apps'.

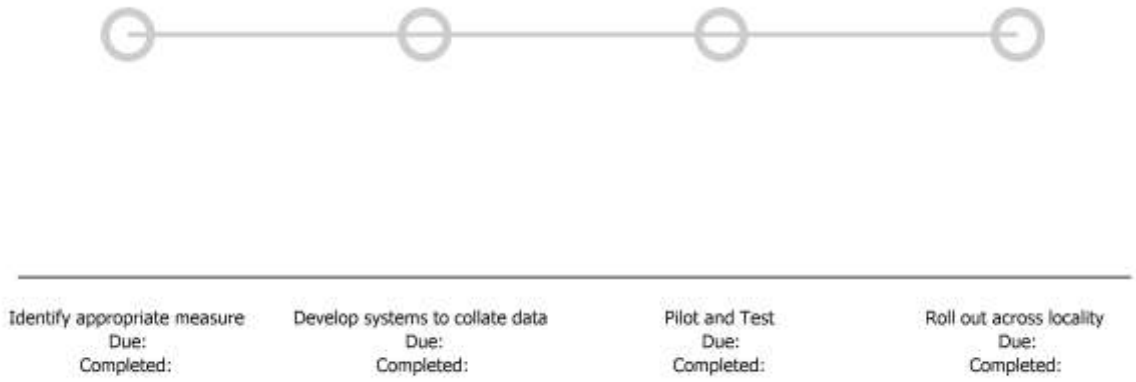
Performance Indicator Overview

Quality



D4 People's progress towards achieving personal outcomes

Progress towards reporting on personal outcomes; Wigtownshire



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.

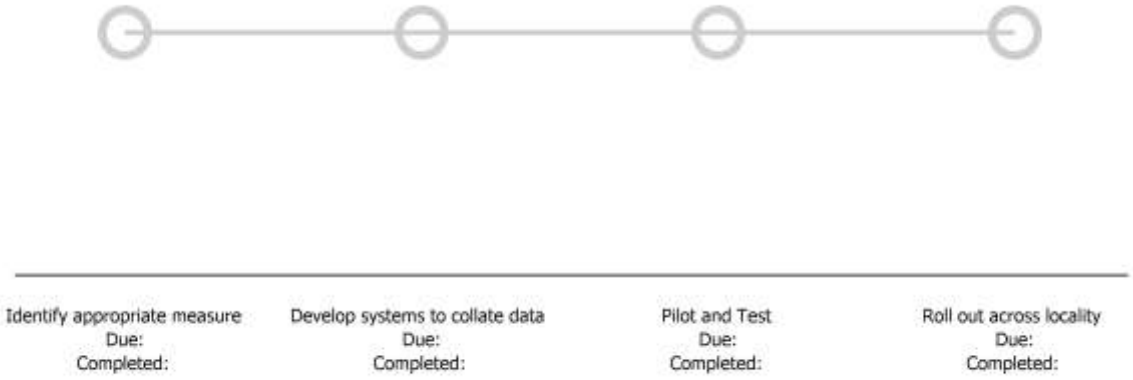
Improvement Actions

The Wigtownshire Locality Team is working with the Short Term Assessment Reablement Service (STARS) to support people to achieve their personal outcomes. STARS provide rehabilitation services for people following an illness or diagnosis of a long term condition, or physical impairment. People can be referred by their GP, community nursing and any other health professional or through their social worker. The rehabilitation team consists of nurses, physiotherapists and occupational therapists who deliver treatments, therapies and support both within the unit and in the community depending on people's needs.

A community link unit has been developed at Newton Stewart Community Hospital. This has replaced the traditional day service model. The staff working from the unit continue to work in partnership with people with long term conditions who use this service to think about "what can I do for myself?" rather than "what can the service do for me?" The initial pilot has been very successful with people who use the service expressing how helpful the unit has been in reabling them both physically and mentally. An evaluation highlighted that people who use the service saw a 25% improvement in their Tinetti Balance and Gait outcome measure and an improvement in their FES1 Activity of daily living and falls confidence score.

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; Wigtownshire



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.

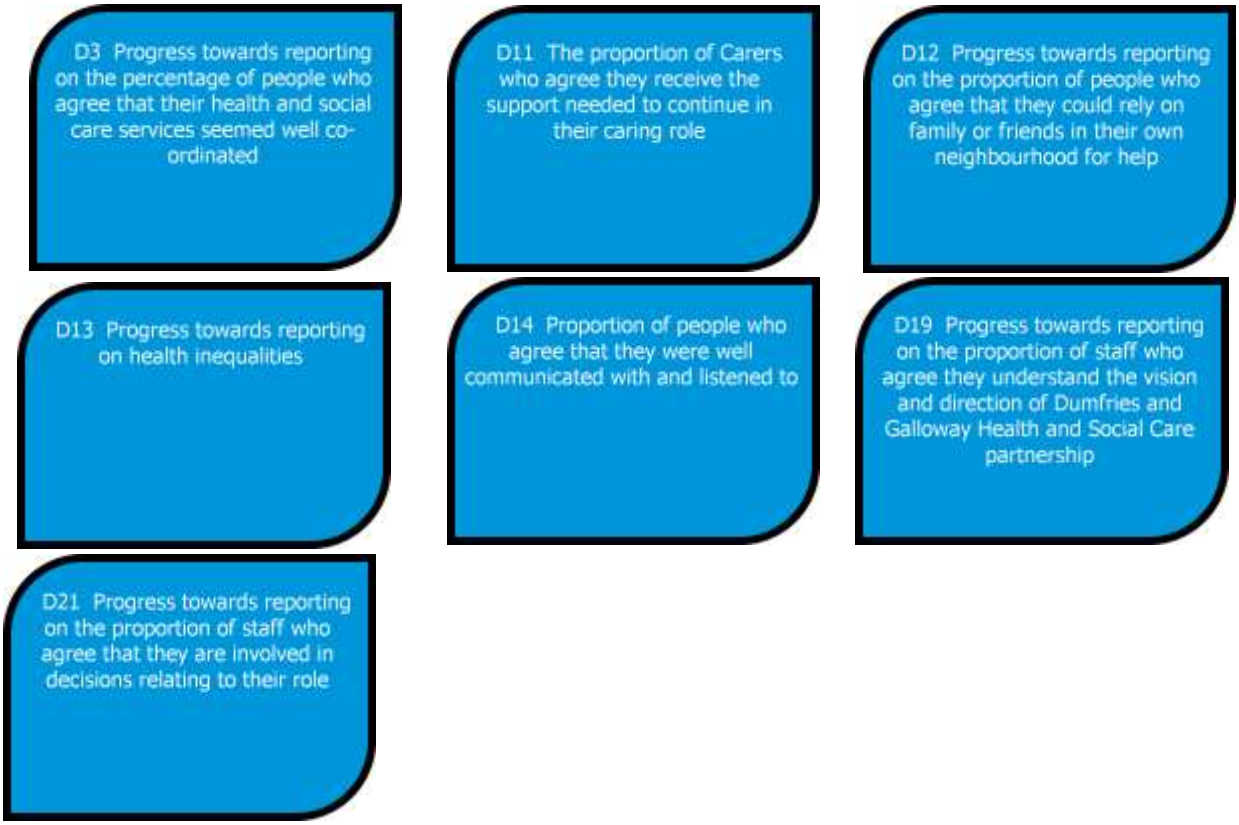
Improvement Actions

The evolution and success of the Newton Stewart Community Flow Meeting from 2012 to 2017 has actively transformed the way in which care is provided in the Machars. A Stranraer Community Flow Meeting was established in early November 2017 in order to emulate the success of the Newton Stewart team. It is attended by social work team members, community nursing, Allied Health Professionals (AHPs), flow coordinator and nursing from Galloway Community Hospital (GCH), the locality health and wellbeing team, Short Term Assessment Reablement Service (STARS), telecare team and soon we will have representation from the Community Mental Health Team (CMHT).

The STAIR and MAY funds support local staff to further develop their skills and expertise which in turns supports the delivery of local services.

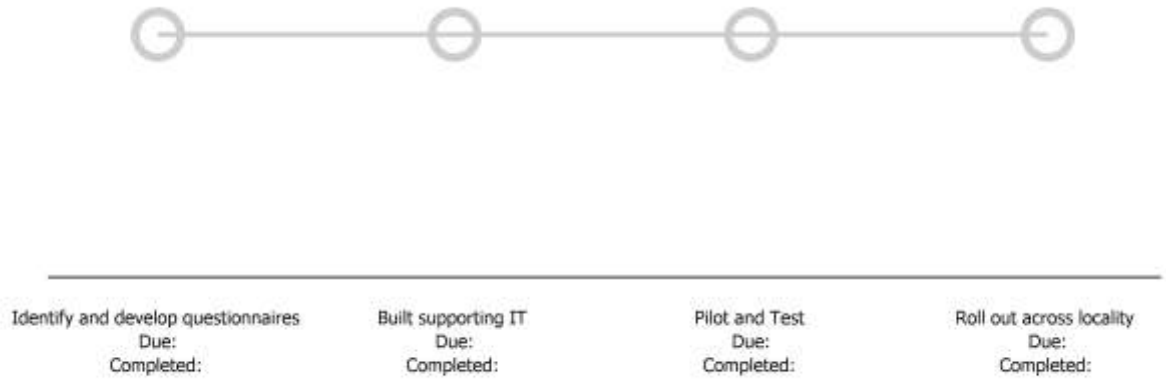
Performance Indicator Overview

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; Wigtownshire



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 community flow meetings (Newton Stewart and Stranraer) are a key aspect in ensuring that health and social care services are coordinated appropriately.

Another initiative that supports better coordinated care is the pilot underway at Waverly Medical Practice that aims to provide support for people with mental health needs at the earliest opportunity. Referrals to the mental health practitioner are made by GPs (with people's consent). The pilot was started in April 2017. By August 2017, 72 people had been seen. Only 4 people have not shown for their pre-arranged appointment. There is also a support worker who provides community support in the form of re-socialisation, education and introductions to support groups.

People are seen more quickly and therefore are getting back to work sooner. There is preliminary evidence to suggest that the pilot is having an impact on the way mental health is being treated through a more appropriate use of medications and therapy to treat anxiety and depression. People who have been supported by this pilot have said:

> "I'm a lot less depressed and I feel more outgoing. I have not had to go to doctor in last 4 months and I have lots of new friends and interests."

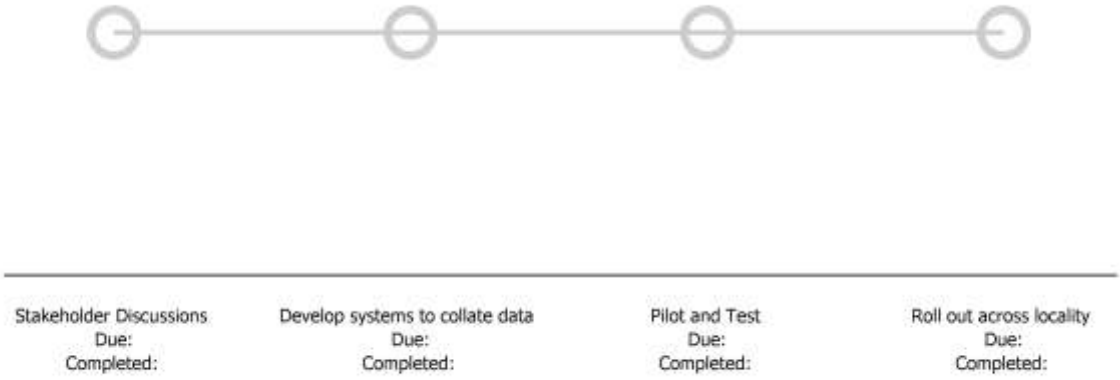
> "I have not visited the doctor in the last 9 months. I have benefited greatly from the group."

People who have a diagnosis of severe and enduring mental illness and are on the GP register who require annual physical review (as per Scottish Government guidelines) are supported to attend their yearly appointments.

In addition, people may be referred on to other support agencies such as Support in Mind, Ad Action, Men's Shed, Community Mental Health Team (eating disorder & dementia) and Psychology.

D11 Carers who agree they receive the support needed to continue in their caring role

The proportion of Carers who agree they receive the support needed to continue in their caring role; Wigtownshire



Key Points

Development of this indicator is under discussion within the Carers Strategy Group.

The Wider Context

This indicator has been adapted from a question in the two-yearly Health and Social Care Experience Survey carried out by the Scottish Government. Carers are an important partner in delivering health and social care. It has been agreed that this question should be asked of more Carers, more regularly than currently, to provide better local knowledge of the challenges faced by Carers.

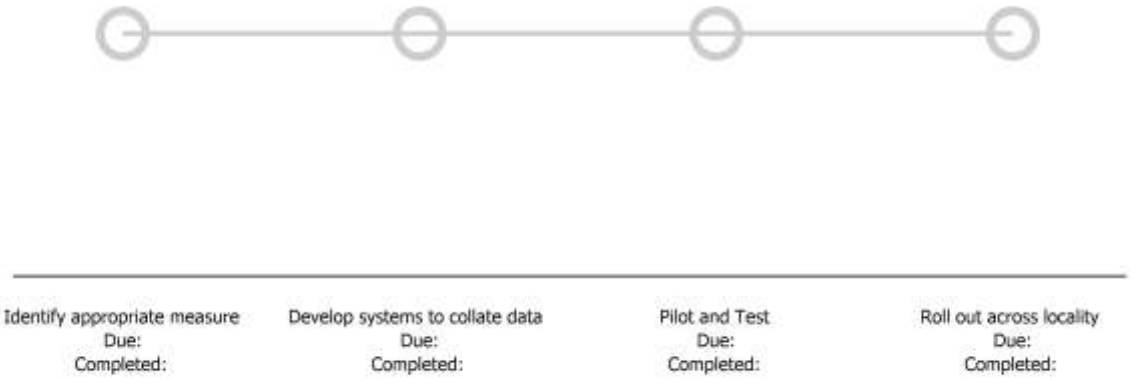
Improvement Actions

'Carer Aware' is training designed to help staff understand who Carers are, what they do and the support available for Carers. This training has helped staff to identify Carers and be generally better informed about Carers and the issues impacting on their lives.

In Wigtownshire, volunteers are being supported to become Carer Awareness Champions to encourage more people to sign up for this training. Carer training awareness was carried out during February 2017. A Carers' engagement session was held in November 2016 followed by further engagement events held in supermarkets in Stranraer and Newton Stewart.

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; Wigtownshire



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.

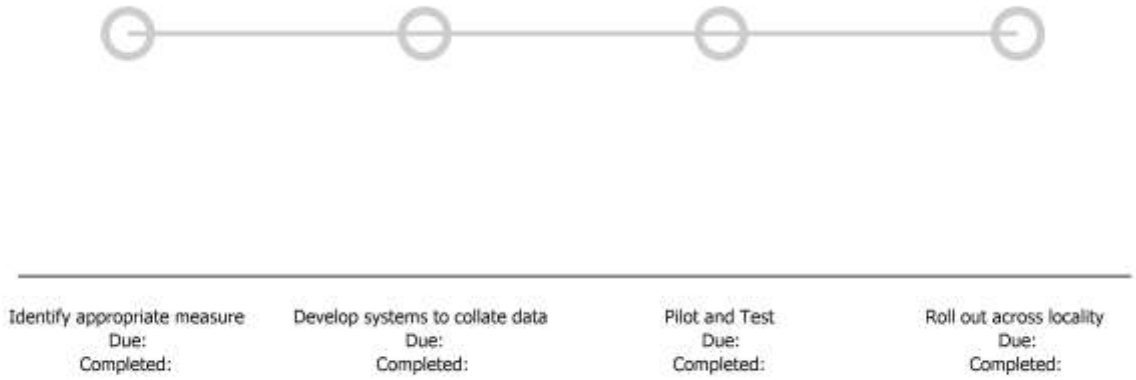
Improvement Actions

Exercise improves the health and wellbeing of all. Move More is a programme supported by McMillan Cancer Support in partnership with Stranraer cancer drop in centre in the Galloway Community Hospital. All people affected by cancer, including family and friends can participate in “Free Walks”. This event is led and supported by a member of the Locality staff and is held weekly. Move More has also introduced gardening projects at Potters Field in Stair Park.

Login and Connect is a weekly event held at Newton Stewart health centre and is aimed to help those who have an electronic device, mobile phone, tablet or laptop and want to learn more about how to make the most of the technology. More information can be obtained on the Wigtownshire Health and Social Care team web-site or by contacting Building Healthy Communities directly on 01988 501111.

D13 Health inequalities

Progress towards reporting on health inequalities; Wigtownshire



Key Points

Development of this indicator is underway.

The Wider Context

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

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.

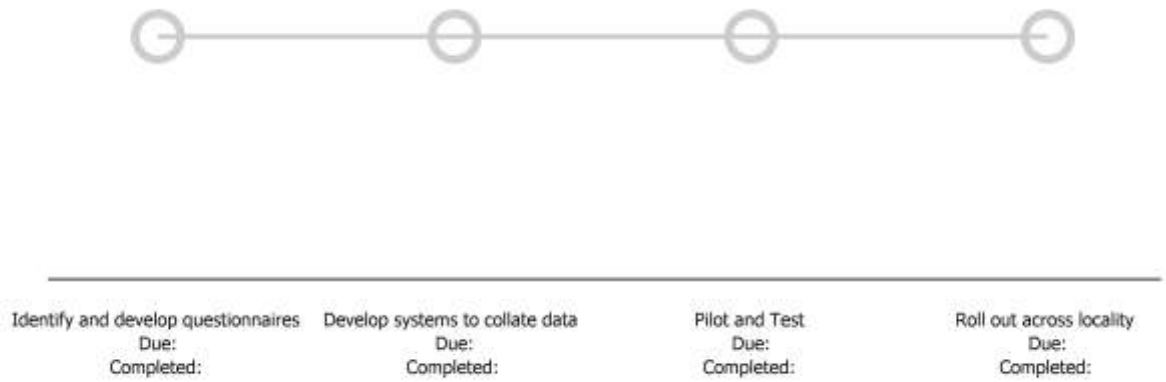
Improvement Actions

Building Healthy Communities (BHC) activities are provided based on assessed needs and are being delivered in the heart of the community to ensure ease of access to everyone. Some activities are also being delivered to people belonging to partner organisations whose circumstances stop them from attending the regular BHC groups. Recent BHC activities include:

- Heartstart is a community led CPR (cardio-pulmonary resuscitation) course which has been delivered to Police Youth Volunteers, the Order of St. John, Glen of Luce Compass, Stranraer Academy senior pupils and members of the public.
- 'Pets As Therapy' visits take place at Cumloden Manor and the Adult Resource Centre in Newton Stewart on a monthly basis. There are plans to train a therapy dog for Stranraer ARC.
- Gentle exercise was delivered at the Newton Stewart Adult Resource Centre in August and September 2017 (closed during the winter months).

D14 Well communicated with and listened to

Proportion of people who agree that they were well communicated with and listened to; Wigtownshire



Key Points

Development of this indicator has not begun.

The Wider Context

This indicator is being developed as part of the new suite of locally agreed indicators for health and social care integration that focus on outcomes for people and their experience of services.

Improvement Actions

There are many changes and developments occurring in Wigtownshire in relation to health and social care. We have a new communications manager who brings a wealth of experience to that role. Our aim is to provide information regularly and quickly in a variety of ways.

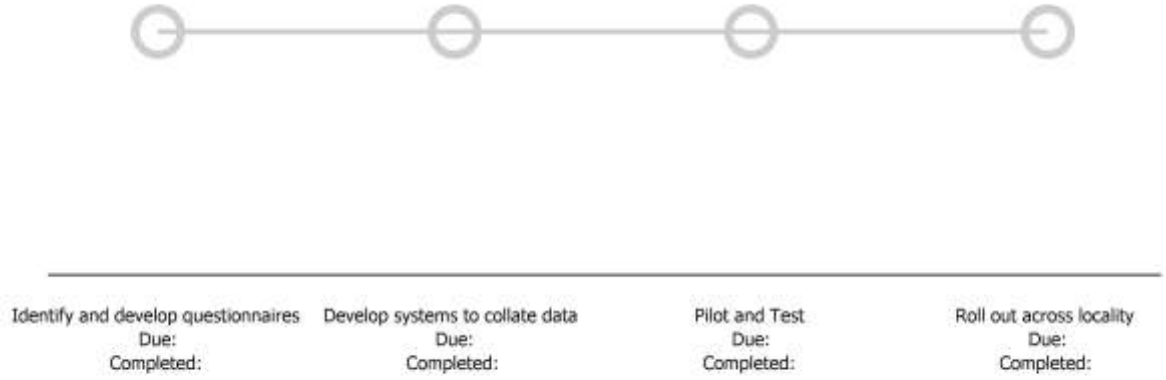
There are a range of ways that people are able to get information and to give feedback about their experiences of health and social care. Feedback may come in the form of comments, responses to surveys, consultations or complaints. The locality team actively engage with the community through Facebook.

Wigtownshire Health and Social Care Team have a Facebook page (https://www.facebook.com/wigtownshireHSCT/). It was developed May 5th 2017.

Between May 5th and 31st December the page had a total of 777 followers and 758 'likes'. This allows members of the public to give feedback about their experiences of health and social care from the comfort of their own home. They are able to message privately or leave comments on posts. Facebook allows professionals and members of the community to have conversations without having to meet face to face.

D21 Staff involved in decisions

Progress towards reporting on the proportion of staff who agree that they are involved in decisions relating to their role; Wigtownshire



Key Points

This indicator has not yet been developed.

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

It is important to acknowledge that different workplace cultures exist across the Partnership. Acknowledging the diversity of these different cultures will lead to understanding and respecting each other's values and beliefs and bring new and different opportunities.

The Locality Leadership Team, which has representatives from across the health and social care partnership, meets on a monthly basis. They are supported by an external organisational development consultant commissioned through the NHS Scotland Quality Improvement Hub. The monthly workshops, led by Helen Ross Associates, focus on the development of courageous leaders who can influence change, place confidence in a shared vision and enable their staff, colleagues across the partnership and the population across Wigtownshire to transform health and social care.

Heads of service continue to have regular team meetings with their staff to consider how they can further develop and transform their service.

Appendix 1: Table of “We Wills”

Ref and RAG Status	Description
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 their own health and wellbeing.
2	Actively develop alternatives to traditional services to support people to maintain their health and wellbeing -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).
6	Develop the way we work with people and in particular to support people to plan their own care to maintain their health and retain as much personal responsibility and control as possible. This includes supporting people to build and retain their confidence and skills.
7	Work across all the partners to understand local current and future housing needs so that we can develop a full range of suitable housing options.
8	Develop our use of assistive technology and other aids and adaptations to support people to be as independent as possible.
9	Ensure that any Operational Service improvement or development is outcome focussed (Outcome 3: Operational Delivery, D&G Partnership Improvement Action Plan).
10	We will continue to explore ways of ensuring that our care at home and care home provision meets local demand.
11	We will continue to explore and implement approaches to move towards more sustainable Primary Care services, such as the training of Advanced Nurse Practitioners to support GP’s. However it is accepted that this alone will not solve the problem, more will be required.
12	Work together to create “dementia-friendly communities”.
13	Develop and implement approaches to seek feedback from people who use services with a view to better understanding what is working well and what is not working well. Learn from feedback about service and use this to continually improve services.
14	Improve how we monitor, evaluate and manage performance across the whole system. (Outcome 1: Performance Management: D&G Partnership Improvement Action Plan)
15	Fully implement the principles, values and practice of self-directed support. We will focus on keeping the person at the centre and in control as far as possible of their own of care and support. For example, we will 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.

19	Through the provision of appropriate information we will support people to take more control of their own health and wellbeing.
20	We will begin to set out priorities around addressing health inequalities and seek opportunities to work with other partners across sectors.
21	We will to begin to address key factors affecting health inequalities, such as employment, education and housing.
22	We will work in partnership with care providers to develop sustainable care at home and care home services which strive to optimise people's independence and quality of life.
23	Identify current and potential Carers as early as possible.
24	Listen to the views of Carers and take appropriate action in response.
25	Ensure all Carers are informed of their right to an Adult Carer Support Plan (previously known as Carer Assessment), so that the needs of the Carer are addressed in their own right.
26	Identify and promote local services and resources to help improve the quality of life of Carers.
27	Continue to raise "Carer awareness" across our workforce following the Equal Partners in Care core principles.
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 capacity 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.
32	Improve communication within and between services and develop working arrangements within multidisciplinary team so that staff across services feel valued and engaged in practice decisions and service developments.
33	Acknowledge the pressures on staff providing support and care. Develop and implement approaches to seek feedback from staff with a view to better understanding what is working well and what is not working well.
34	Explore opportunities to address issues about recruitment and retention including how to make care more attractive as a career choice for local people.
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 is 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)