DUMFRIES AND GALLOWAY
INTEGRATION JOINT BOARD

PERFORMANCE MANAGEMENT

AREA COMMITTEE REPORT

DUMFRIES AND GALLOWAY
Health and Social Care

Wigtownshire

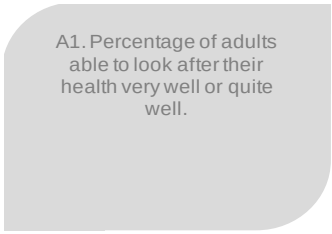
January 2018 - June 2018

Contents

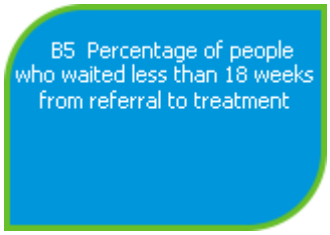
Document Features

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.

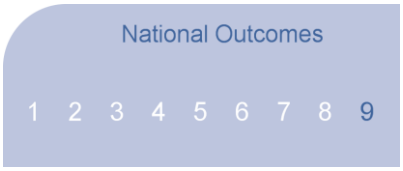
Grey – Work to implement the commitment is not yet due to start.
Green – Progress in implementing the commitment is on or ahead of schedule or the work has been completed.
Amber – Early warning that progress in implementing the commitment is slightly behind schedule.
Red – Progress in implementing the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

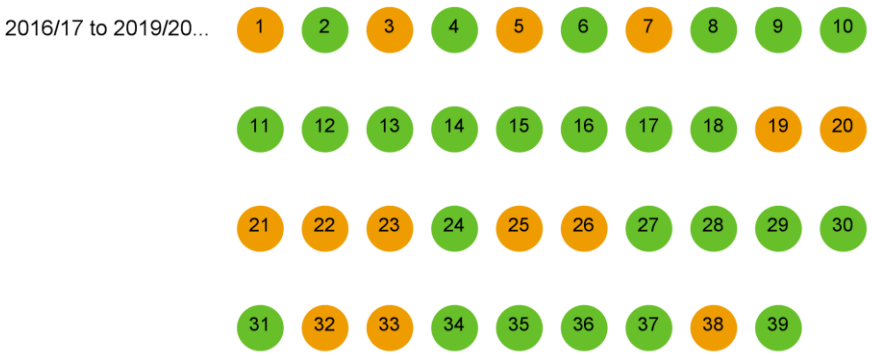
Dumfries and Galloway Priority Areas

To deliver the 9 national health and wellbeing outcomes, the Strategic Plan identified 10 priority areas of focus. Each measure in this report is also mapped to one or more of these 10 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



Wigtownshire is an area of outstanding natural beauty and has always attracted a high level of retirees, and more recently the number of tourists is starting to increase.

In contrast Wigtownshire has the highest level of health inequalities in Dumfries and Galloway. This is due to a variety of reasons, such as high unemployment, the low wage economy and many of the contracts available are zero hours. To help support this, and also help us to develop the health and social care workforce, we are recruiting younger health and wellbeing staff to work specifically with young people. These staff will be given a wide range of training and will target our most vulnerable young people in the community. They will look at key life style issues of smoking, alcohol use, mental health, physical activity and nutrition. The outcome of this work is prevention. If we work to understand the issues earlier on it is possible to stop people needing care and support later on.

Housing and lack of appropriate housing for both young and old continues to be a challenge. This has been more evident during recent recruitment campaigns to bring GPs and medical staff to Wigtownshire. Professionals often struggle to find modern attractive homes. Excellent examples are starting to emerge, such as the Loreburn Development at the Garrick site. However, moving forward we require a more developed community planning approach to the development of the infrastructure in Wigtownshire.

The Wigtownshire Health and Wellbeing Team continues to work with a variety of partners across all communities in Wigtownshire and we are increasing our understanding of what can be done to keep people well in their own homes for longer. We have many assets in our communities and the aim of our work is to continue to support people and communities to build resilience and develop less reliance on statutory care and support services.

There are many pressures currently facing health and social care service delivery across Wigtownshire, including:

- Recruitment - We continue to have great difficulty in recruiting to vacancies due in part to an ageing working population and our remote and rural location.
- Funding – There is no new money coming into the system and Dumfries and Galloway Health and Social Care needs to make savings of approximately £17m this financial year.
- Infrastructure - Some buildings are no longer fit for providing modern care and support, including Newton Stewart Hospital.
- Issues such as deprivation affect people's health and wellbeing.
- Increasing demand on current services due in part to an ageing population with multiple medical issues.

The aims of the Transforming Wigtownshire programme are to develop a model of sustainable, safe and effective health and social care that meets the needs of the local community. Working in partnership with the local community and stakeholders we will co-produce the review and design of health and social care in Wigtownshire, including the Galloway Community Hospital. Co-production is when people with different interests come together to create change as a group. In this case, the community will work together with health and social care professionals and service providers to transform health and social care within Wigtownshire. An independent chair and project manager have been appointed to take the programme forward. Initial work will be undertaken looking at 3 specific areas which are:

- care of elderly people
- maternity services
- urgent and emergency care.

A steering group has been established and a programme board will be in place by the end of October 2018. Short life working groups will be established to look at each area of work. These will be supported by expert advisors who will provide experience and knowledge from across all aspects of health and social care both locally, regionally and nationally.

The Wigtownshire Heath and Social Care Team have been developing alternative ways to keep people well and living well in their own community. We now have a range of national policies which support the need to look at alternatives to the traditional medical services, such as Realistic Medicine.

Over the past year we have had good numbers of staff attending Good Conversations Training and Health Behaviour Change Training. Healthy Connections, mPower, CoH Sync, Community Link Unit and Building Communities are working across Wigtownshire and are further developing this person centred approach.

Individuals are being given the opportunity to complete an Anticipatory Care Plan, and often this has been the only chance to have discussions about how people want to be treated. This plan covers important aspects as hospital admissions and even planning their funeral.

A test of change has been developed in partnership with local GPs and The Department of Work and Pensions (DWP). There is now the opportunity for GPs to refer people who have long standing employment issues, due to poor health. GPs acknowledged that often they did not have an understanding on how best to support people. There is a variety of evidence to support that working or volunteering can be good for peoples' health. People are now referred to a member staff from DWP who is based in the Waverley Medical Centre. This is a supportive environment and a variety of options are available. Often the staff member can act as an advocate within workplaces and support people back into the workplace. If this is not an option then volunteering can be considered and links made to the local community.

The Wigtownshire Health and Social Care Team continue to build on the success of social media, promoting where to get help through local pharmacies at the weekend. Recently the mPower project has been working with pharmacy teams and people to better understand how we can safely administer medicines in people's homes using Tele Care equipment such as medicine reminders.

The speed at which change occurs has increased tremendously in the last several decades. A lot of this created by technology. There is an ever-increasing need to do things faster and more efficiently and a need to accomplish things with less of the traditional resources.

General Practice Sustainability

GP recruitment will continue to be challenging across our region. This is mainly due to GPs retiring, others approaching retirement within a few years and in part due to the difficulties recruiting to our region. As of June 2018, there are GP vacancies in 4 out of the 6 practices

in the Rhins (including Glenluce) and vacancies in all 3 of the Machars practices. We expect a Scottish Government programme with the University of Dundee will produce 30 trainee GPs in Dumfries and Galloway by September 2019. While this may ease the burden in the future, it does not address our current pressures.

A recent additional pressure, due to a GP illness, led us to very quickly implement a business continuity plan. While the pressures on the remaining GP meant there was only one GP in the practice most days and increased use of the regular locum, the changes we made to the appointments system and other processes sustained the services.

The general public were instrumental in helping achieve this by seeing other clinical providers, for example the Advanced Nurse Practitioner (ANP), the practice nurse and community pharmacy services. This allowed those people with urgent needs to see the GP. We thank the general public for their patience and understanding. The situation did show us what we can achieve with the support of other clinicians and the public. This was essentially a precursor to the "new normal" as we begin to implement the new GMS contract outlined in the previous report. More information will be forthcoming around the expansion of a practice-based pharmacy team and community mental health professionals based at the Waverley Medical Centre.

Every effort is being made to attract GPs to Wigtownshire. The GP recruitment weekend event in April 2018 held at the Creebridge Hotel in Newton Stewart and in Portpatrick the following day, generated a great deal of interest. 7 visiting GPs were offered tours of all the local GP practices and met most of our local GPs, with the merits of living and working in the area highlighted. 2 GPs are due to start working in the Locality in the autumn and discussions are still ongoing with others.

Community Nursing and Out of Hours services

Wigtownshire has 3 Community Adult General Nursing Teams. The teams are made up of Health Care Support Workers (HCSWs) and registered nurses. There is one team based in Stranraer at the Waverley Medical Centre which provides cover to the Rhins area during the hours of 8:00am and 8:00pm. This team aims to provide evening service cover until 11:30pm, however due to recruitment issues an average of 6 evenings a week are being covered.

Teams are also based and deployed from Newton Stewart Health Centre and Whithorn. The Machars teams are working to extend their hours of cover from 8:00am to 6:00pm to 8:00am to 8:00pm. Similar to the Rhins team, the Machars teams aim to support an on call service until 11:30pm however again, with recruitment and retention challenges, an average of 4 nights per week are currently covered. Plans are in place to further extend cover across the whole of Wigtownshire in line with the Transforming Nursing Roles Agenda for Scotland (District Nursing).

There are currently 2 ANPs in training from Wigtownshire within the Out of Hours service (OOH). The aim is to begin to embed Advanced Practice into OOH service by the year 2020. Out Of Hours doctor cover remains variable and the Rhins Community Adult General Nursing team continues to support the OOH service wherever possible. A pilot of 24/7 community nursing deployment was tested in January 2018; however this did not meet the needs of the people of Wigtownshire effectively and efficiently. Using available learning from other areas of Scotland, in line with the OOH Review, a further service evaluation is in progress to consider the future skill mix necessary within the OOH Service to best meet the needs of the people of Wigtownshire.

Social work services

One of the key challenges faced by the Health and Social Care Team is the changes to day services in Stranraer. As a health and social care team, we have been working in partnership with Community Integrated Care (CIC) to ensure that day services continue in the future. We are acutely aware of the benefits that day care services bring to people and their families and are committed to seeing this service continuing in the future. CIC have

extended their commitment to day care services until December 2018, to give the Partnership more time to secure a suitable alternative.

Another key challenge is the availability of home care provision for those living within the community. In order to ensure that we are able to offer as much cover as possible, particularly in relation to our hard to reach, more rural areas of the Locality, we have now established a rural Providers Meeting. Social work services meet with all care providers to discuss the demand within the area in order to reduce waiting times on care packages and delayed discharges. It was good to see excellent representation from a number of providers at our first meeting in June 2018.

We continue to promote choice and control to people who use services through the use of Self Directed Support (SDS).

We are working in partnership with 2 European projects, mPower and CoH-sync to offer greater choice and control to service users.

Prescribing

In January 2018 the General Medical Services (GMS) Contract was approved by Scotland's GPs. In line with this and our commitment to integrated working, we continue to redesign and develop the Wigtownshire pharmacy team to achieve what is set out in the contract relating to pharmacotherapy services.

We are working with GPs and practice managers to develop new ways of providing support to release GPs from medication management reviews. This will allow them more time to fulfil their role as an expert medical generalist and to care for the ever growing elderly population who have complex medical needs. To do this we are growing our own workforce and up skilling the current team to take on extended roles. This includes our pharmacy technicians assessing people ability to manage their medicines and training all our pharmacists to become independent prescribers. In the near future we will be recruiting additional pharmacy team members to further this work but, like all processes, it will take time in order to test and implement successfully.

A key aspect to the work plan is to roll out the national Serial Prescription service whereby people can get their repeat prescriptions via the pharmacy rather than ordering at the GP practice every month. We continue to work on cost effective prescribing initiatives delivered across all our GP practices to help manage and monitor prescribing budgets. We have successfully implemented a care at home pharmacy service with referrals being received from social work, GP practices, community pharmacies and community nursing. The up skilling of technical staff allows them to take on some of this work to help maximise people's independence at home which, in turn, helps to release funds which would have gone to care packages.

We are helping people to maintain their independence and help build their resilience by promoting self management. The Sunday pharmacy opening pilot has been extended until October 2018 so we can assess the impact of summer holiday time and the launch of other new services which can be offered via community pharmacies. Pharmacy First has become embedded in the GP practice where staff encourage people to visit their pharmacy first. Through local media campaigns we are encouraging people to buy their own over the counter medicines and minimise medicines waste.

Technology Enabled Care (TEC)

TEC and how it can help us all is at the forefront of our work. We are proud to say we were the first team in Dumfries and Galloway to arrange a person's medication reminders using a system called FLORENCE. We work closely with our mPower colleagues to develop referral pathways with community pharmacies and GP practices to embed TEC in routine practice. The previous Area Committee Report outlined how Wigtownshire Locality is participating in a project called mPower. 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.

Challenges do exist around infrastructure especially in the Southern Machars and Rhins areas and the local communities show high reservations about digital interventions. The systems being introduced will operate on a low band width and mobile connectivity is set to improve.

Local primary care teams are enthusiastic and motivated to adopt new models of care but taking time to develop protocols and systems and to learn the new systems presents challenges for implementation. Support from IT has been secured and this will increase capacity for mPower to support teams to work through new processes.

Some examples are:

- Cairnsmore Medical Practice in Newton Stewart have been making use of the NHS Attend Anywhere service which enables people to access GP appointments by video from their own home using their own device. The GPs are using the system to provide support to residents from Cumloden Manor and the first consultations took place in March 2018. While the system has had limited use, it has proven successful in reducing the need for a GP to attend in person.
- Other teams and services that support care homes including Dietetics, Community Mental Health and Speech and Language are also working to develop services that can be provided by video.
- 3 of the 5 Care Homes in the Locality have had a device setup and support provided to staff that will enable them to use Attend Anywhere.
- Daily Dynamic Discharge meetings at Newton Stewart Hospital are using Lync which allows colleagues to attend by video if they are unable to be there in person.

Work is ongoing to develop Home and Mobile Health Monitoring (HMHM) using the FLORENCE text messaging system with services across the region. The system has been introduced for medication reminders through the Community Pharmacy service in Wigtownshire. A number of interventions are being trialled and monitored:

- A generic protocol is being managed by mPower
- Case by case support is being managed by Community Pharmacy
- Level C medication management trial – an intervention aimed at people who leave hospital on a Level C care package and who may after a period of time be able to be responsible for taking their own medication. (Level C people are older people who have been assessed by a multidisciplinary team as being unable to manage their medicines on their own. These people have a care package that includes care at home workers being responsible for ensuring that the person receives the correct medicine, in the correct way and at the correct time).
- People accessing services at Lochinch Practice who have been newly diagnosed with a long term condition will be offered the FLORENCE service. It is anticipated that podiatry, Beating the Blues and Smoking Cessation services will launch services in Autumn 2018 to support people to self manage and encourage adherence to the advice they are being given.

<u>Telecare</u>

A care pathway to mPower has been agreed for over 65s from Wigtownshire who call the Contact Centre for Social Services. All people calling who meet the criteria will be offered a referral to mPower. The care pathway will be introduced in the autumn. People calling who agree to a referral will be offered an outcome focussed intervention through a one to one meeting with the community navigator who uses a self management approach to goal setting and action planning.

The basic Telecare package of Care Call will be promoted and the community navigator has been trained as an assessor who can arrange installation.

Video conferencing (VC)
Outpatient clinics which provide VC appointments linking to consultants in Dumfries provides the opportunity for care closer to home, particularly for our ageing population and where there are transportation challenges. This also successfully reduces the carbon footprint. VC appointments have been implemented successfully by several services, including Respiratory, Diabetes, Neurology and Biochemistry. We anticipate that more will follow.

Services are being approached to create a pathway to mPower for those who attend the VC clinics. They will be contacted and offered an eHealth questionnaire that explores the experience of the intervention. They will also be given the opportunity to have a one to one meeting with the mPower community navigator.

Technology Enabled Care (TEC) programme is working towards a VC system similar to the NHSNearMe model, developed by NHS Highland, and will include a pathway to mPower in the protocols that are developed.

Clinical expertise is essential to introducing effective interventions and this resource is being pursued at the programme management level.

Newton Stewart Hospital

Newton Stewart Hospital has been functioning since the 1940s. It has served many functions for the community over the years and currently provides adult inpatient care, rehabilitation, and palliative care services. It traditionally has a 22 bed capacity and is accessed by local GPs and consultants from Dumfries and Galloway Royal Infirmary (DGRI) and Galloway Community Hospital. Bed occupancy averaged 73% between March 2017 and February 2018. Of the 22 beds, an average of 16 were occupied. In May 2018, the decision to limit capacity to 14 beds was made because of registered nurse vacancies and long term sickness absence and, more importantly, in order to maintain safety for people and staff. Efforts are on-going to recruit staff nurses to vacant positions.

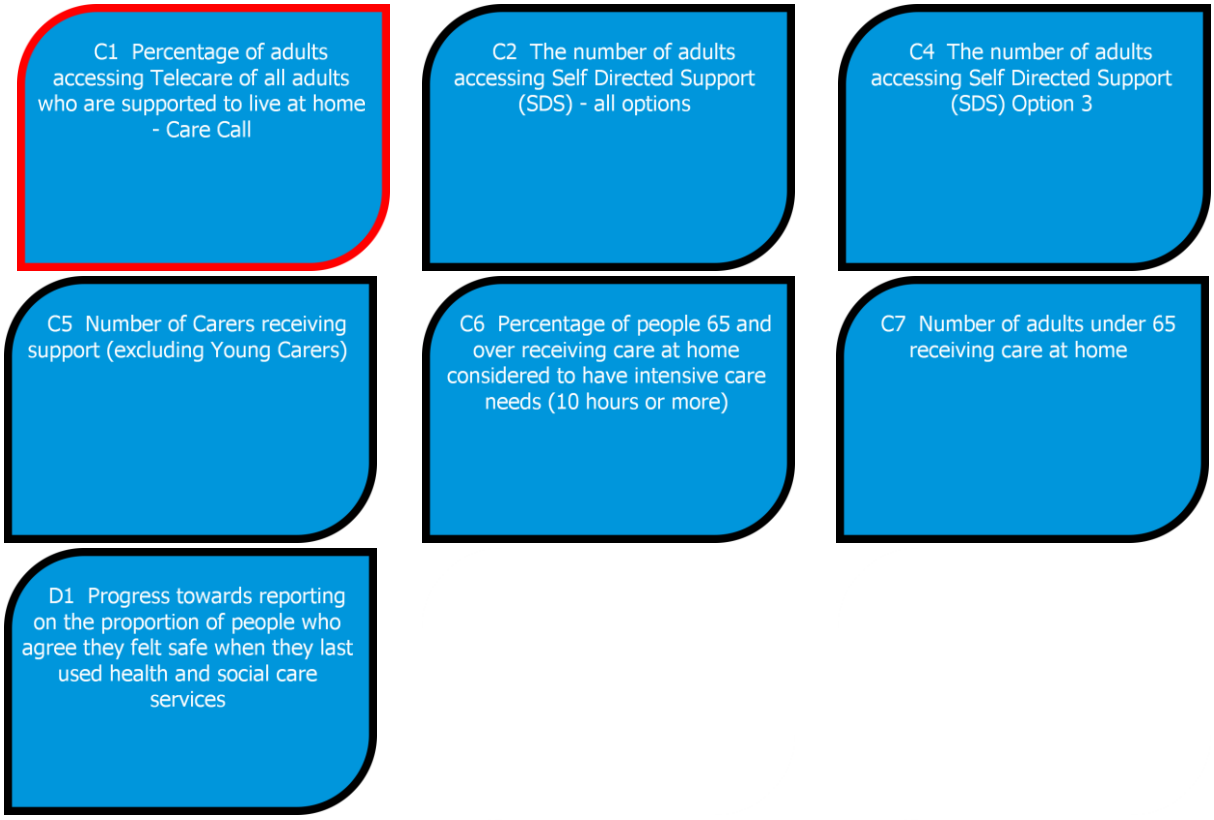
The hospital also provides outpatient services. A Community Link unit has been established at Newton Stewart Hospital, the focus of which is to provide holistic, person-centred support of people who have a chronic, long term condition and is aimed at helping to maintain or even improve their health. On offer is a 12-week course, which takes a head-to-toe approach, looking at everything from psychology to podiatry services which can help to reduce the impact of a chronic condition such as stroke, chronic respiratory disease, Parkinson's disease, fibromyalgia, and other long term illnesses on physical and mental health, as well as social health and wellbeing.

Referrals to the service can come from any health, social care and third sector team. People can also self refer. It is open to all adults in the region. We acknowledge that there are limited services of this kind within the area, however, the unit's work will help empower and enable people to live independently at home, and also re-able others to do so. The course can also help prevent hospital admissions and help achieve earlier discharge from hospital and it is also being seen to help prevent social isolation. The team's success was recognised nationally in Edinburgh recently when they delivered a presentation on their innovative approach.

June Watters
Wigtownshire Locality Manager.

Performance Indicator Overview

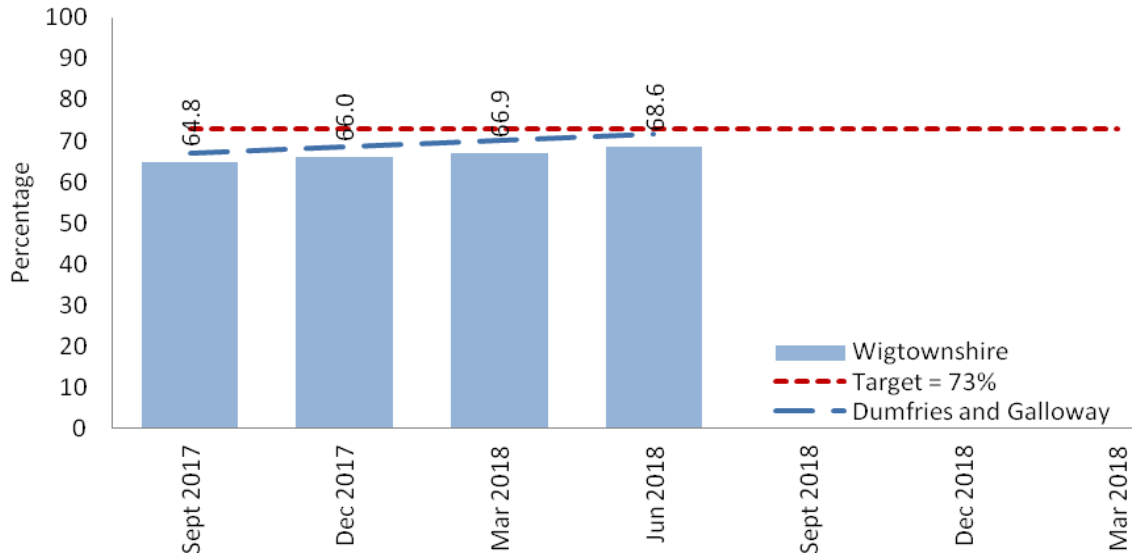
Clinical and Care Governance



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

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	8

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 68.6% in June 2018. Wigtownshire performance is lower than that of Dumfries and Galloway (71.6%).

In June 2018, there were 650 people using Care Call technology across the Locality, which is a 1% increase on the end of the previous quarter.

The Wider Context

This measure only relates to Care Call, which is a 24 hour monitoring service, based on an emergency button linked through to a call responder. Although we have recalculated this measure following the move to the Mosaic IT system, the target of 73% has not been changed.

There is lead in time to the introduction of any Telecare, enabling discussions with the person regarding their choices and learning to confidently use the equipment. A new Digital Health and Care Strategy 2017-22 for Scotland was published in April 2018. This will integrate the Technology Enabled Care (TEC) programme and e-health strategy for Scotland.

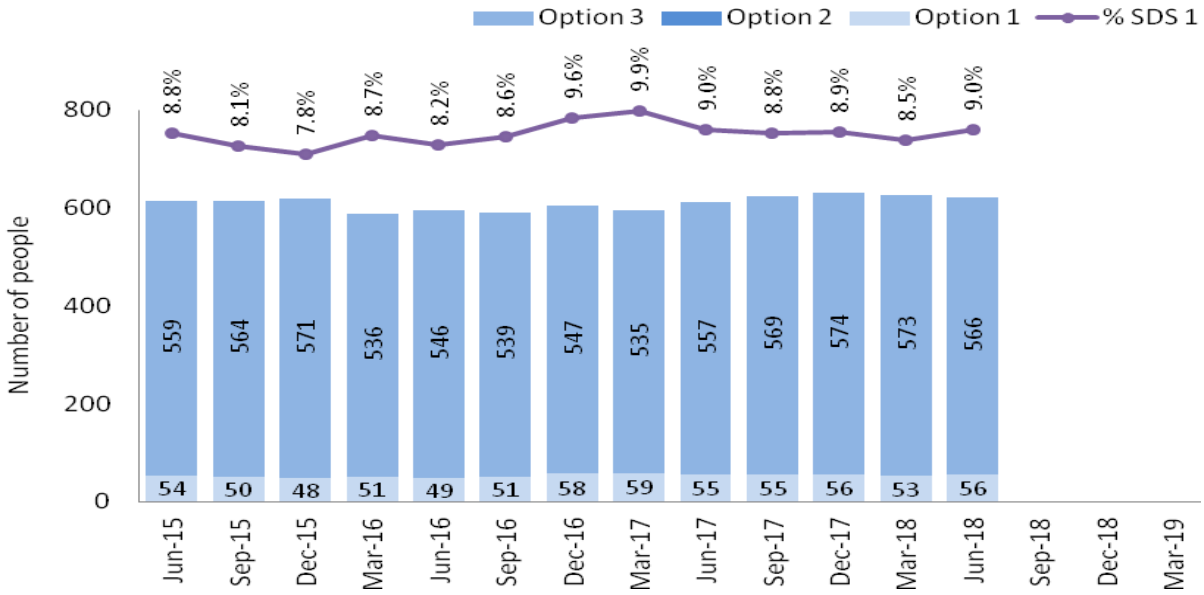
Improvement Actions

A Care Call representative attends both the Newton Stewart and Stranraer community flow team meetings where discussions are held around needs and challenges. An issue raised in these meetings is some elderly people see using this technology as taking away their independence instead of assisting them to maintain their independence in their own home. By having these discussions around specific cases and challenges, the team can help strategise and formulate the best way to engage the people using services, their family, Carers and other providers in making the most of Telecare support.

It is evidenced that Telecare has a profound impact on preventing loneliness for those people 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 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. A snapshot in June 2018 showed the number of adults receiving care at home through Self Directed Support (SDS) was 56 people through Option 1, no people through Option 2 and 566 people through Option 3.
The total number of people being support by SDS has remained stable since September 2017. In June 2018, this was 622 people.

The Wider Context

The Partnership aims to help people and support them to make the most appropriate choice of option under the Self Directed Support legislation. SDS Option 1 is where people choose to take control of purchasing and managing their own care and support. Option 2 is where people choose the organisation they want to be supported by and the Partnership transfers funds to that organisation, for care and support to be arranged in line with the personal plan. SDS Option 3 is where people choose for social work services to arrange and purchase their care and support.

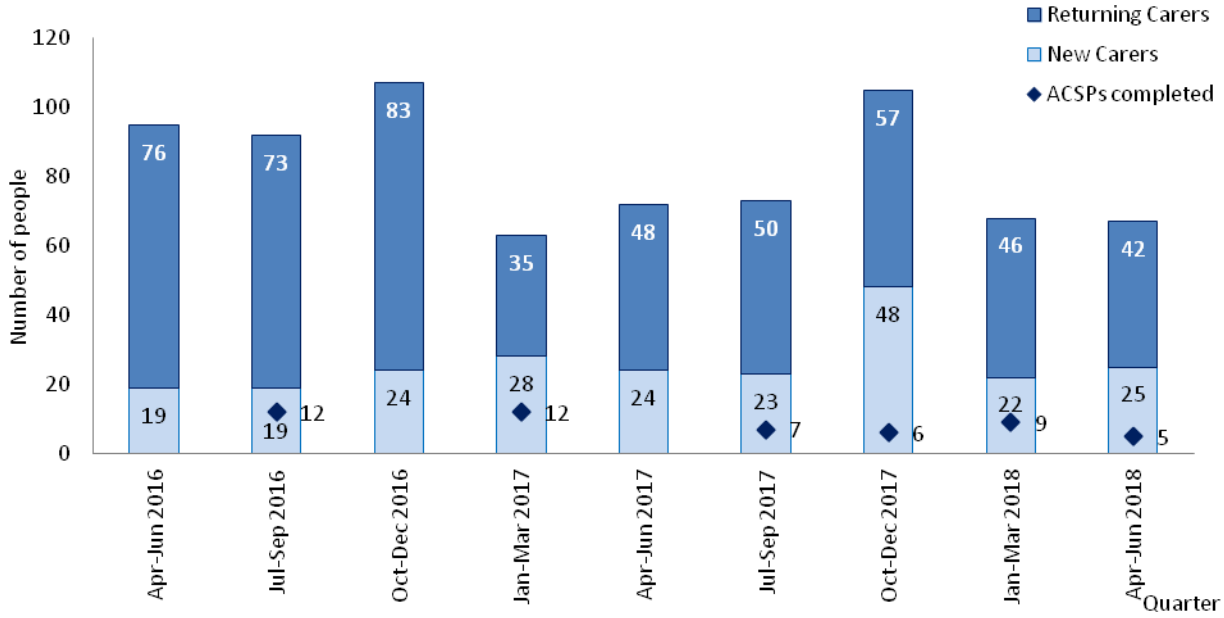
Improvement Actions

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 need of these people.

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.

C5 Carers receiving support (excluding Young Carers)

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



Key Points

There were 14 new Adult Carer Support Plans (ACSP) completed for Carers from Wigtownshire in the period January to June 2018 by the Dumfries and Galloway Carers' Centre (DGCC).

From Wigtownshire, the DGCC saw 47 new adult Carers between January 2018 to June 2018 and 88 returning Carers used their services. Alzheimer Scotland had 370 existing Carers whilst Support in Mind had 27 existing and new Carers between January 2018 to June 2018 (there may be overlap between these 3 organisations).

The Wider Context

There are a number of organisations across Dumfries and Galloway who provide support to Carers. The DGCC is commissioned to deliver Adult Carer Support Plan Assessments. Only a small proportion of Carers will require an ACSP and of these, fewer still require social care resources. Identifying Carers is a key priority of the Carers (Scotland) Act 2016.

Improvement Actions

The Carers' Strategy which was approved by the Integration Joint Board in November 2017 continues to be a priority focus in the region and locally.

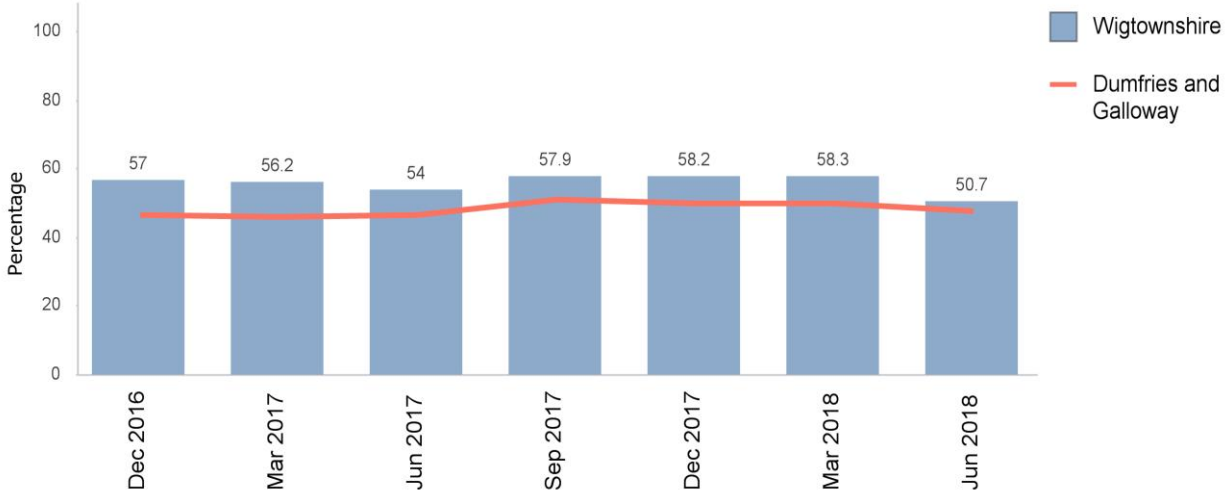
A test of change to implement the triangle of care approach to supporting Carers is underway in Newton Stewart Hospital. The triangle of care is an approach that has worked well in mental health and is being tested in 2 cottage hospitals in Dumfries and Galloway. The test aims to meet the requirement of the Carers (Scotland) Act 2016, regarding Carer involvement in hospital discharge. A report on Newton Stewart Hospital and Thornhill Hospital will be available by the end of 2018.

The Carers (Scotland) Act 2016 requires that a Short Break Services Statement is published by 31 December 2018. This is a document that provides information and advice to Carers to access short breaks. This is currently out for comment with Carers and Carers organisations. A Dumfries and Galloway Carers Survey 2018 will be coming out in August, the purpose of which is to gain a greater understanding of what feeling supported means for Carers.

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

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	3 10 15

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 50.7% in June 2018.

This rate is higher than that across Dumfries and Galloway at 48.3%.

The Wider Context

This is an historical indicator, which predates the introduction of Self Directed Support and 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 a historic threshold of care and therefore less relevant in the context of the changing policy position in respect of Self Directed Support.

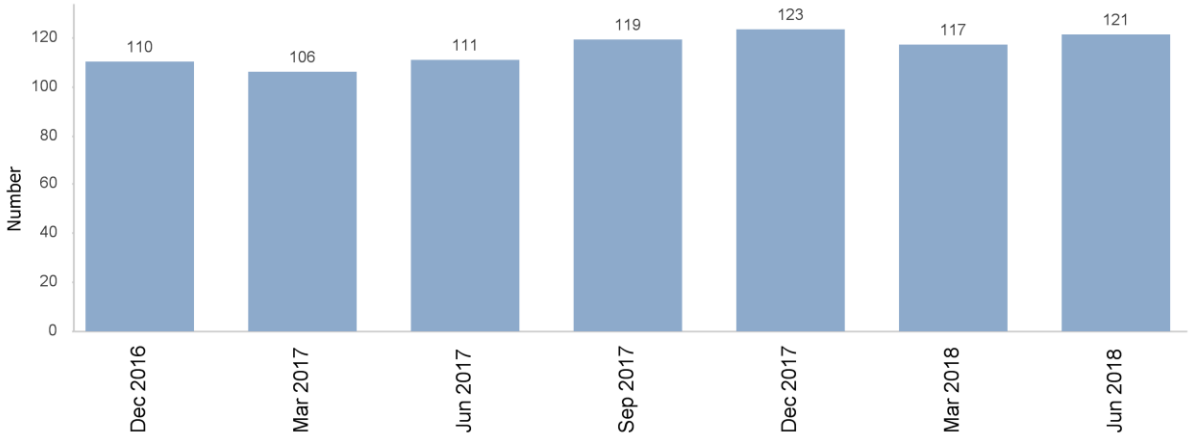
The calculation for this indicator is based on those people who have chosen SDS Option 3. The new SDS models of care offer more person centred solutions and more alternative flexible and efficient solutions.

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 121 in June 2018.

The number of people under 65 receiving personal care at home via Option 3 has increased in Wigtownshire by 3% since December 2016.

The Wider Context

SDS Option 3 is where people choose for social work services to arrange and purchase their care and support. 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 challenges regarding the supply of care in local areas.

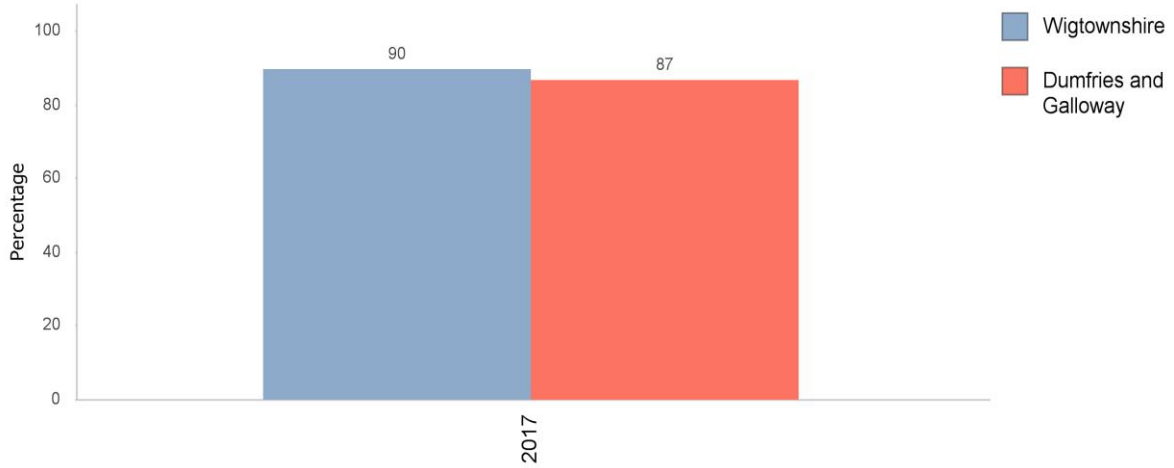
Improvement Actions

No improvement actions required at this time.

D1 Feeling safe when using health and social care services

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	28

The proportion of people who agree they felt safe when they last used health and social care services: Wigtownshire



Key Points

90% of people who responded said they felt safe when asked about using the care, support and help with everyday living in the Health and Care Experience Survey (HACE). This is 7% higher than Dumfries and Galloway (83%) and Scotland (83%). A further 8% answered 'neither agree nor disagree' and 3% responded that they did not feel safe when asked about using the care, support and help with everyday living. The number of responses to this question was 63 people from Wigtownshire.

The Wider Context

Of the 1,282 people who answered the HACE survey in Wigtownshire, only a maximum of 5.6% (73 people) had direct experience of social care.

The overall response rate to the survey for Wigtownshire was 29% (1,282 people), which is 2% lower than for Dumfries and Galloway (31%) and 7% higher than Scotland (22%).

The HACE Survey captures people's feelings about the care they experience, at the time the survey is taken. Local figures should be compared to the experiences of other people across Scotland in the same time period. Results were not available at Locality level in previous surveys and therefore no comparisons can be made with earlier surveys.

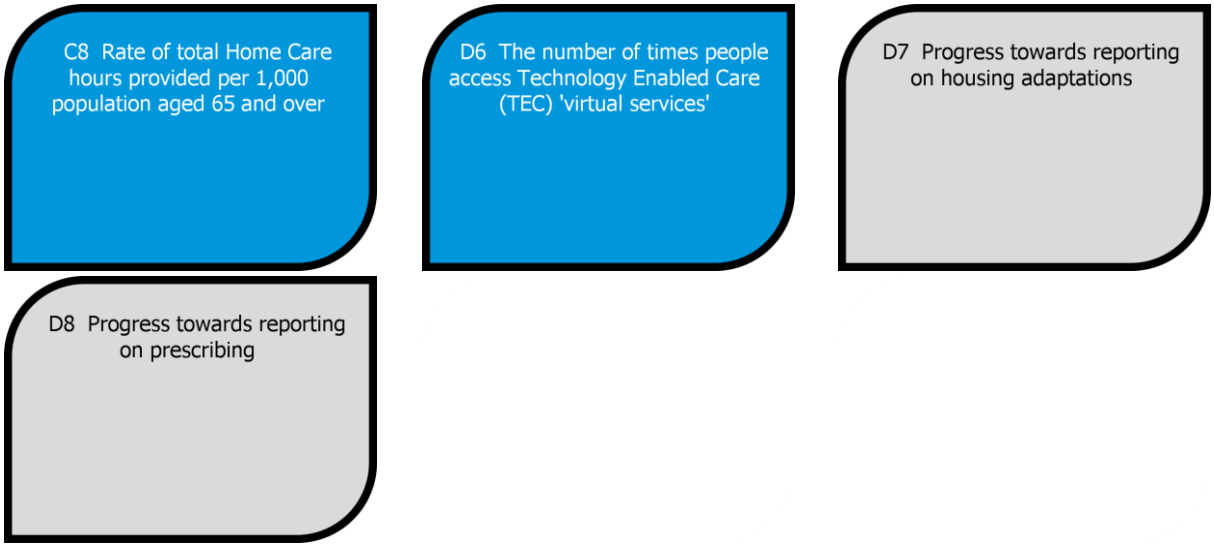
Improvement Actions

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

- Adult support and protection. The Multi-Agency Safeguarding Hub (MASH) has been fully operational since March 2017 consisting of health, social work and police teams, co-located at Cornwall Mount in Dumfries. A review of progress has been carried out and a number of improvements were identified to build on the strong start. An adult support and protection executive group (ASPEG) briefing session was held in the Waverley Medical Centre on May 1, 2018 and was attended by several members of each locality team.
- The health and social care teams record all adverse events in the Datix IT system which helps manage near misses and adverse events. We can review the event from how the incident is documented to the way in which the incident is investigated and analyse 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. For more information see http://www.scottishpatientsafetyprogramme.scot.nhs.uk/

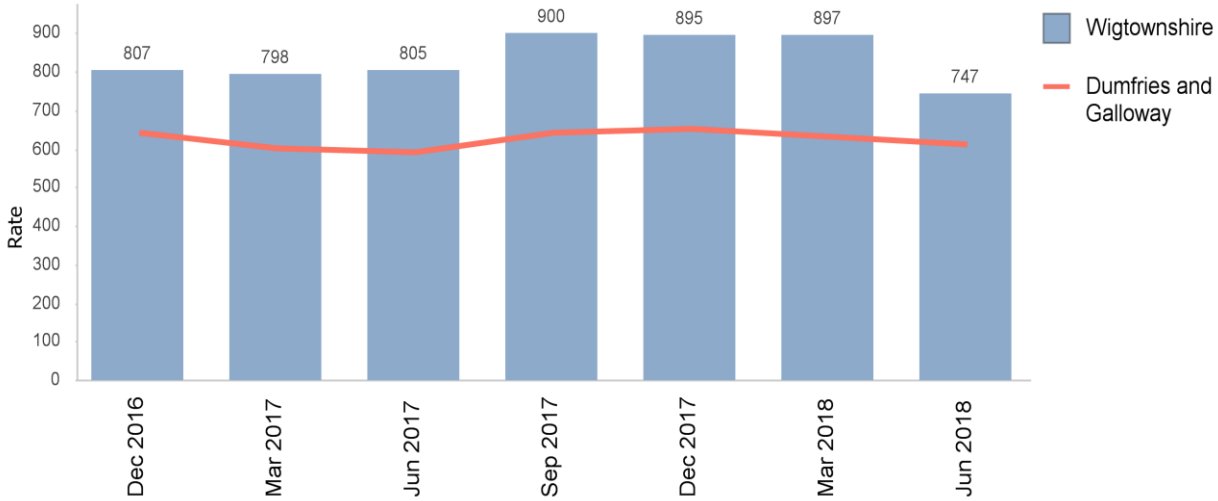
Performance Indicator Overview

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 June 2018 the rate of homecare provision in Wigtownshire was 747.3 hours per 1,000 population aged 65 or older. There has been a decrease in the quarter ending at June 2018 of 6%.

The rate for Wigtownshire is consistently higher than the rate observed across Dumfries and Galloway (614 hours per 1,000 population aged 65 or older).

The Wider Context

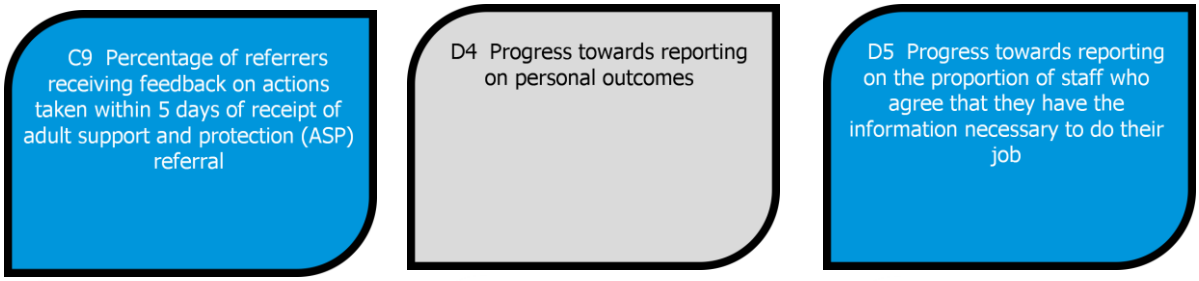
It is reported that across Dumfries and Galloway approximately 1 million hours of homecare are provided each year. It is anticipated that this indicator will decrease as more people opt for SDS Options 1 and 2. There will be a need to understand how many people are in receipt of care and support through all of the SDS options (see indicators C2 – C4).

Improvement Actions

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

Performance Indicator Overview

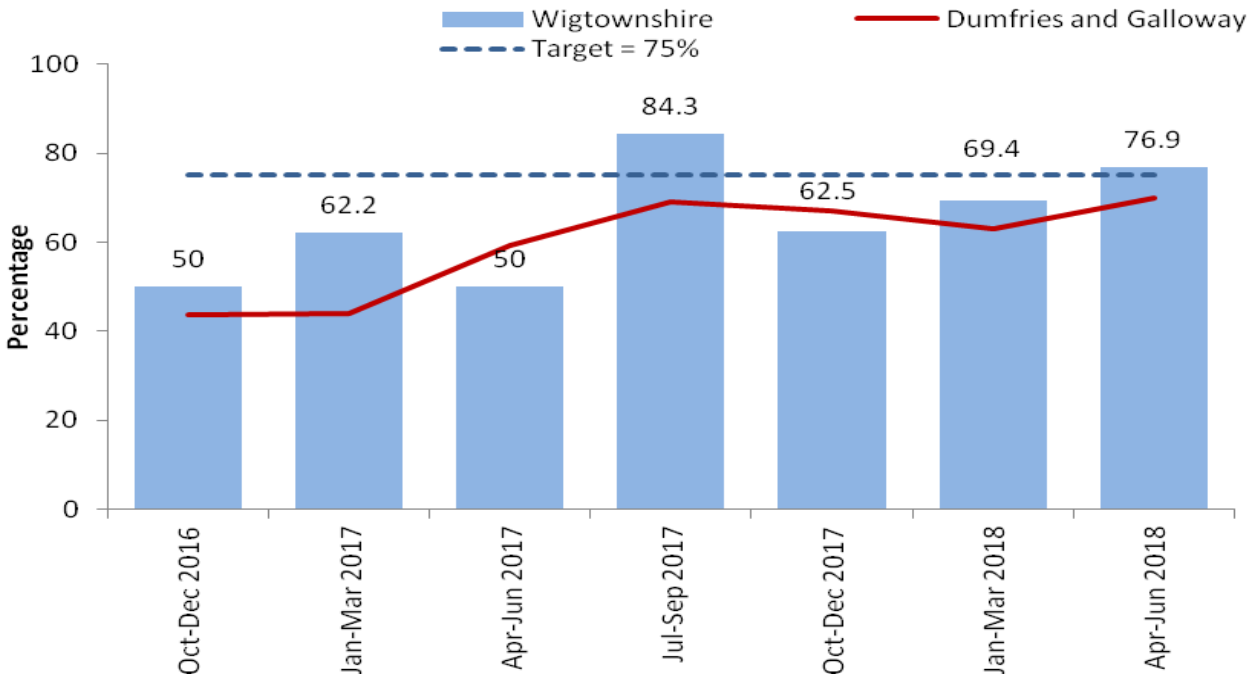
Quality



C9 Feedback received by referrers on actions taken within 5 days of receipt of adult protection referral

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	30

Percentage of referrers receiving feedback on actions taken within 5 days of receipt of adult support and protection (ASP) referral; Wigtownshire



Key Points

At June 2018 across Wigtownshire 76.9% of referrers to Adult Support Protection (ASP) received feedback within 5 days of receipt of referral. This is above the rate observed across Dumfries and Galloway (70.3%) during the same period.

The Wider Context

Across Wigtownshire there are typically between 5 and 10 ASP Duty to Inquire referrals per month. All relevant adult referrals are assessed to determine if they meet the requirements that would classify the referral as a Duty to Inquire. Discussions are underway in relation to reporting timescales and determining what should count as feedback to ensure the data is as complete as possible.

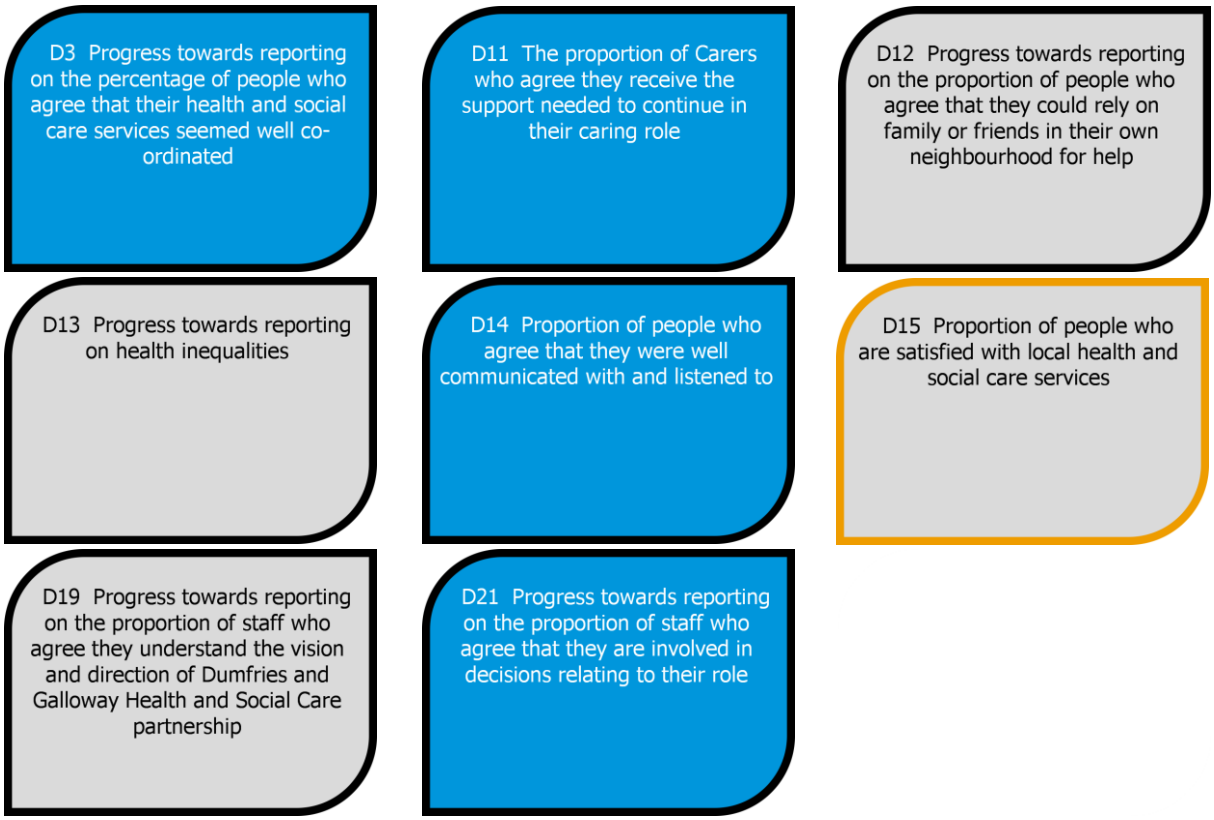
The type of feedback is different depending on the source of the referral. Where a professional has made the referral it can be noted that the adult is being progressed under Duty to Inquire. If a family member makes a referral, it is likely they will be involved in the progression of the referral so they will receive more detailed feedback. If a member of the public makes a referral they will be told that we have received the referral and are giving consideration as to how to take this forward.

Improvement Actions

Improving the communication between adult support and protection and referrers was identified as a priority through the work of the adult services executive group and the adult support and protection committee.

Performance Indicator Overview

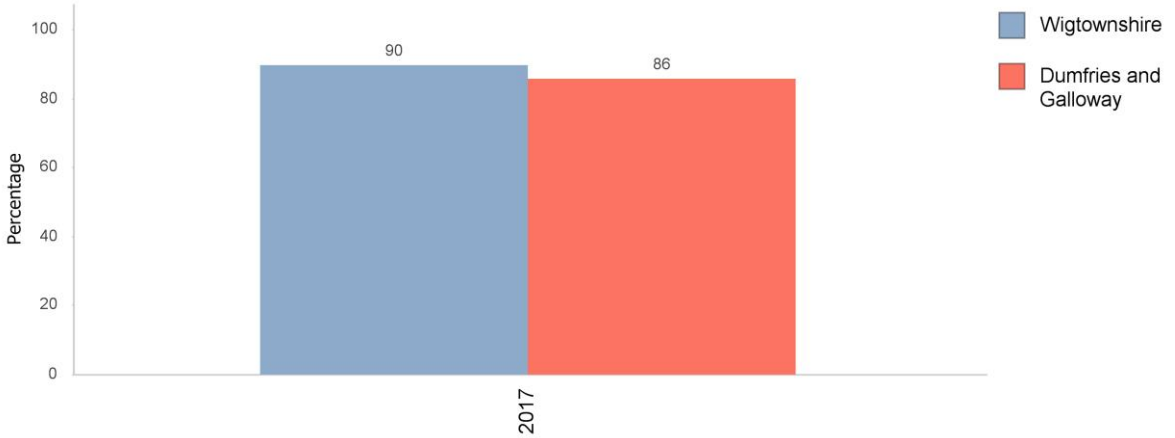
Stakeholder Experience



D3 Well co-ordinated health and social care services

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	15

The percentage of people who agree that their health and social care services seemed well co-ordinated; Wigtownshire



Key Points

90% of adults in Wigtownshire supported at home who responded to the Health and Care Experience (HACE) survey, agreed that their health care services seemed well co-ordinated. A further 6% answered 'neither agree nor disagree' and 4% responded that they did not agree that their health care services seem to be well co-ordinated.

The percent of people who agreed is higher than the result for Dumfries and Galloway (83%) and Scotland (74%).

The number of responses to this question was 66 people from Wigtownshire.

The Wider Context

Of the 1,282 people who answered the HACE survey in Wigtownshire, only a maximum of 5.6% (73 people) had direct experience of social care.

The HACE Survey captures people's feelings about the care they experience, at the time the survey is taken. Local figures should be compared to the experiences of other people across Dumfries and Galloway and Scotland in the same time period. Results were not available at locality level in previous surveys and therefore no comparisons can be made with earlier surveys.

Improvement Actions

The Stranraer and Newton Stewart community flow teams meet weekly. These multispecialty provider teams have representatives from adult social work, community and acute care occupational therapy, acute care flow co-ordination, acute care and community nursing, STARS Rehabilitation, mPower community navigator, CoH-Sync (health and wellbeing team), community pharmacist, community mental health and Telecare. Peoples' cases stay on the agenda until a safe and satisfactory outcome is achieved. Standing agenda items are placement waiting list update, delayed discharges and care home vacancies. The investment of time and resources to this collaboration is strengthening the role of community providers, stimulating and reducing people's need to access acute medical care in line with the Transforming Wigtownshire programme.

Another initiative that supports better coordinated care is the pilot at Waverly Medical Practice that aims to provide support for people with mental health needs at the earliest opportunity. The pilot was started in April 2017 with the Lochinch practice and has expanded to cover Lochree practice. By August 2018, 434 people had been referred, 264 people had been assessed, 45 people did not attend their pre-arranged assessment appointment and

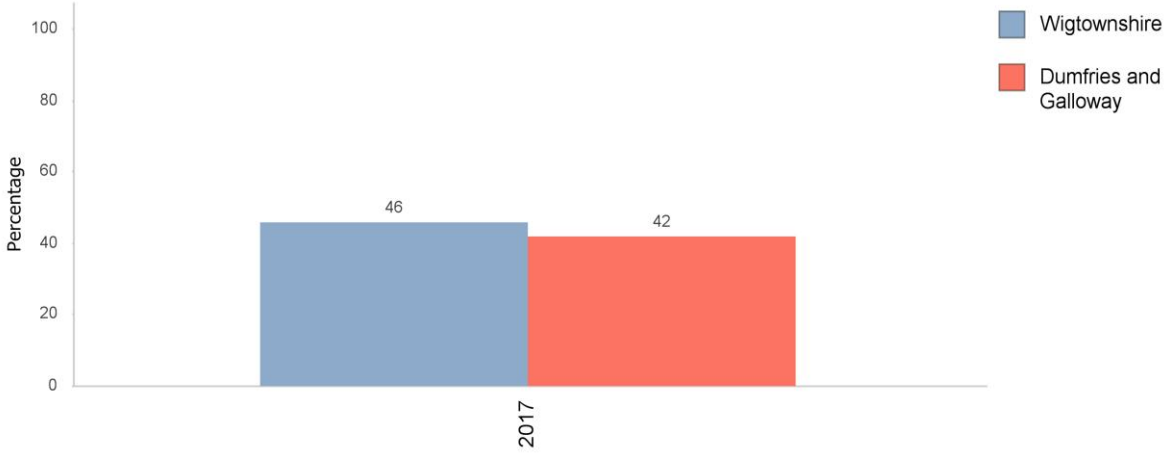
105 people were signposted to other services. There is a support worker who provides community support in the form of re-socialisation, promoting return to work, providing education and introductions to support groups.

Plans to further expand community mental health services within Wigtownshire are in the early stages and will go through bidding and approval processes at the Scottish government level. 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 and 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

Of the 169 Carers from Wigtownshire who responded to this question in the Health and Care Experience Survey (HACE), 46% responded that they agreed they felt supported to continue in their caring role. A further 40% answered 'neither agree nor disagree' and 14% responded that they did not agree they felt supported to continue in their caring role.

The rate for Wigtownshire was higher than Dumfries and Galloway (40%) and Scotland (37%).

The Wider Context

Of the 1,282 people who answered the HACE survey in Wigtownshire 14.8% (191 people) identified as Carers. This is lower than the proportion who answered for Dumfries and Galloway (15.1%) and Scotland (15.0%).

The HACE Survey captures people's feelings about the care they experience, at the time the survey is taken. Local figures should be compared to the experiences of other people across Dumfries and Galloway and Scotland in the same time period. Results were not available at locality level in previous surveys and therefore no comparisons can be made with earlier surveys.

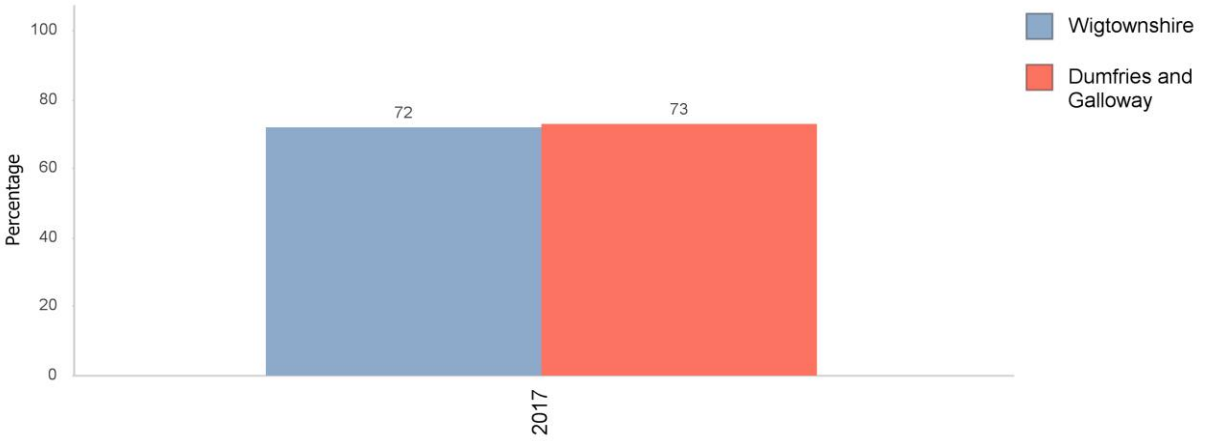
Improvement Actions

Supporting Carers is also central to what to what we do. Identifying Carers can be challenging. We are finding success with the use of social media. Wigtownshire health and social care team have developed a page that can share local information on a range of support that is available. We are able to record activity and shares, we do however acknowledge that social media is not accessing our most hard to reach and continue to work with the Dumfries and Galloway Carers Centre to understand how we communicate and support Carers.

Developing and supporting volunteering across Wigtownshire continues to be a key focus for the Wigtownshire health and social care team. In support of 2018 volunteer week, 2 workshops were organised, one in Stranraer and one in Newton Stewart. These were well attended by staff and communities. We are now conducting an engagement exercise with staff from Galloway Community Hospital to understand what volunteering opportunities are available.

D14 Well communicated with and listened to

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



Key Points

Across Wigtownshire, the percentage of adults who agreed in the Health and Care Experience Survey (HACE), they were aware of the help, care and support options available to them was 72%. A further 15% answered 'neither agree nor disagree' and 13% responded that they were not aware of the help, care and support options. This is lower than the result for Dumfries and Galloway (73%) and Scotland (74%).

The number of responses to this question was 72 people from Wigtownshire.

The Wider Context

Of the 1,282 people who answered the HACE survey in Wigtownshire, only a maximum of 5.6% (73 people) had direct experience of social care.

The HACE Survey captures people's feelings about the care they experience, at the time the survey is taken. Local figures should be compared to the experiences of other people across Dumfries and Galloway and Scotland in the same time period. Results were not available at locality level in previous surveys and therefore no comparisons can be made with earlier surveys.

Improvement Actions

Throughout the transforming Wigtownshire programme co-production is used to develop future plans. There have been a number of events with community councils, where the current pressures on services and the aims of programme have been explained. Feedback received from communities highlight the issues important to them. Meetings have also taken place with the local MP, MSPs, elected members and local influencers. Again, the pressures facing health and social care in Wigtownshire and the aims of the project were explained. Positive feedback was received. The team attended the Stranraer and Wigtown agricultural shows. Here people attending were asked 'What's important to you?' in regard to care and support. Feedback again was positive and a number of people expressed interest in being involved in future work. There are 3 future events being planned. 1 in Wigtown/Newton Stewart, 1 in Stranraer and the Wigtownshire W.I. have already organised an event in early October.

Meetings have also been set up to discuss the programme with staff across Wigtownshire. To be successful it is important that people are involved throughout the programme and that their views are heard.

The Wigtownshire health and social care Facebook page has 1,208 likes. It is regularly updated by staff from social work, NHS communication team, health and wellbeing team and Galloway Community Hospital who ensures there is a good range of information available. The feedback often given is people don't know what is happening locally so this page enables the sharing of local groups and activities. Information on what is happening in health and social care is also provided. People can, and have, contacted us directly to discuss issues that they may have in the community, for example pharmacy opening times. This forum is really useful to promote Wigtownshire and recruitment as we have followers from across the world.

Appendix 1: Table of "We Wills"

Ref & 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).