DUMFRIES AND GALLOWAY
INTEGRATION JOINT BOARD

PERFORMANCE MANAGEMENT

AREA COMMITTEE REPORT

DUMFRIES AND GALLOWAY
Health and Social Care

Wigtownshire

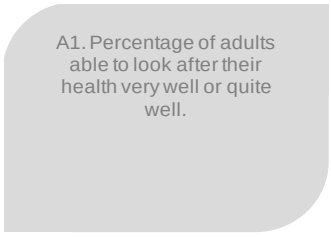
October 2016 - March 2017

Contents

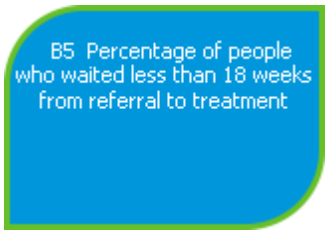
Document Features

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.

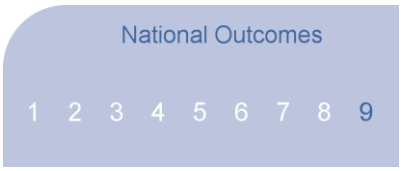
Grey – Work to implement the commitment is not yet due to start.
Green – Progress in implementing the commitment is on or ahead of schedule or the work has been completed.
Amber – Early warning that progress in implementing the commitment is slightly behind schedule.
Red – Progress in implementing the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

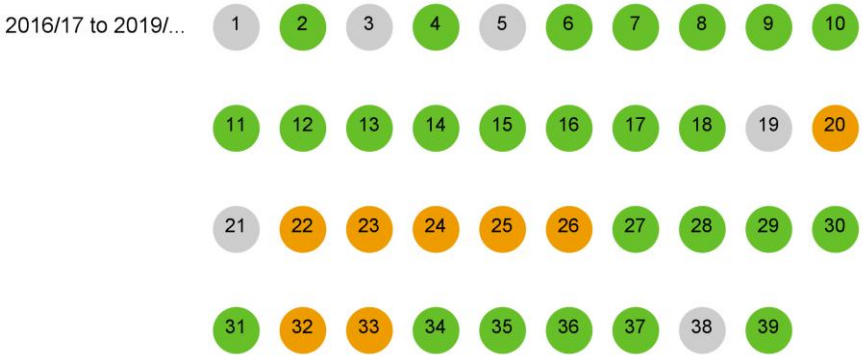
Dumfries & Galloway Priority Areas

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



The ambition is to make Wigtownshire's communities the best places to live active, safe and healthy lives by promoting independence, choice and control. To achieve this requires health and social care professionals, third sector, independent providers and communities across Wigtownshire to work in partnership to create models of care that are pioneering, courageous and innovative. Conversations have started with the public to discuss the challenges Wigtownshire faces to deliver sustainable services.

NHS Dumfries & Galloway have been successful in attracting two four year EU INTERREG (European Regional Development Funded) projects. Wigtownshire has been chosen as the deployment site for both projects: mPower and Community Health Sync (CoH-Sync). Both projects will support the locality in achieving its vision.

Health and Wellbeing

The Health and Wellbeing Team has been engaging with local communities to explore how they can further develop both individual and commuity reslience. Identifying community assets and using proactive approaches has led to a range of activities being co-created and delivered across Wigtownshire including Tai Chi, Dancercise and IT training to provide people with opportunities to improve their health and wellbeing.

NHS Education for Scotland (NES) have provided funding for one year to the Psychology Service for Older Adults to increase the identification of mental health difficulties in older people coupled with increased access to psychological intervention, particularly for those who may be experiencing loneliness and/or social isolation.

Loneliness has been identified as having a significant impact on physical and mental wellbeing in the elderly and has been found to have an impact on health care costs within this population. A recent report published by NHS Highland suggested that an elderly person experiencing loneliness can cost the health service around £12,000 over a five year period based, in part, on Emergency Department (ED) and GP surgery presentations. Mental health difficulties such as depression are under-reported in the older adult population and symptoms are often misinterpreted as normal parts of the ageing process.

The Psychology department, in partnership with health and wellbeing teams, have proposed a pathway to support early identification and intervention for people age over 65 experiencing mental health difficulties, loneliness and social isolation. A pilot of this new pathway is running for a 9 month period (April 2017 to January 2018) followed by evaluation and regional roll out. The pathway will focus on streamlining existing services within psychology and public health in order to ensure sustainability, following completion of the

pilot phase. Wigtownshire has been chosen as the locality to test this pilot. Work has included a launch of the 'beating the lows' public awareness campaign across the locality.

Mental Health services to Older Adults-Wigtownshire are also piloting a two year project to enhance mental health services in primary care settings. Two additional full time community mental health posts have been recruited for this work. The pilot will run in the Waverly Medical Practice and will offer individuals with mental health distress a wide range of accessible mental health expertise and interventions in this primary care setting.

The CoH-Sync initiative aims to synchronise the efforts of the community, voluntary and statutory sectors, using an asset-based community development approach. It is intended that there will be a positive impact on the health and wellbeing of individuals and communities, empowering and supporting them to manage their own health needs. People will be assisted to improve their health behaviours through personal health and wellbeing plans, supported by qualified staff and volunteers based and managed within the Third Sector and supported through health and social care locality teams and public health.

The project aims to:

- assist people to improve their lives by enabling them to find ways to sustainably imrpove their health and wellbeing within a supportive community development framework.
- empower and support people to manage their own health needs through the use of locally available interventions which focus on improving health literacy, prevention of and early intervention of long term illhealth and the main risk factors. This will in turn, help to stem the flow of people who develop long term conditions and thereby reducing the burden of chronic disease.
- reduce the barriers between the statutory and community sectors by creating locally based health and wellbeing 'community hubs' that will focus on synchronising the efforts of local projects, organisations and opportunities.
- explore and utilise novel approaches to health behaviour change especially for deprived populations, thereby reducing health inequalities.

Technology Enabled Care

The success of Milburn Court (*a pop up home from home, with the aim to promote awareness to community service users how their home can be adapted to support independent living for people with dementia, sensory impairment, and the elderly)* provided the locality with the foundation to further develop the use of Technology Enabled Care to support people to stay independently at home for longer.

The mPower project aims to improve the health and wellbeing of people living in the region by implementing 'community navigators', utilising eHealth interventions to support health and care service delivery. The project is aimed towards people agedover 65 (and their Carers) who are either current high users of health and social care services or who are identified as having a significant level of risk with regard to their wellbeing.

This project will involve partners from Ireland (two partners), Northern Ireland (two partners) and NHS Boards in the west of Scotland (Ayrshire & Arran, Western Isles and Dumfries & Galloway).

The objectives of the project are to:

- Increase the numbers of older people living independently in the community, who are empowered to look after and improve their health and wellbeing.
- Establish high level, cross-sectoral collaboration across Ireland, Northern Ireland and Scotland to support greater mobility and reach of health and care professionals and services.
- Increase adoption of eHealth interventions and an improved understanding of the role these can play in supporting sustainable service delivery.

- Enhance engagement of people and communities with the development of new models of health and care services.

General Practice

General Practice continues to face challenges across Scotland. These are magnified across Wigtownshire due to the rurality of the area. Increased workload, increased risk to staff and premises, recruitment and retention are all factors in the challenge to deliver sustainable local General Practitioner (GP) services. General Practice requires a team approach relying on clinical and non-clinical staff including medicine, nursing, healthcare assistance and practice management. The local approach (which is mirrored across Scotland) is to extend this core practice-based team to include additional professionals. Initially this will be pharmacy and mental health professionals and advanced nurse practitioners. This is expected to free up GPs to enable them to focus on more complex care and provide more clinical leadership. The locality is developing an extended core practice-based team in Stranraer due to the continued challenge of recruiting GPs.

Prescribing

Prescribing medication is the most common patient level action that the NHS undertakes. In line with national trends, prescribing costs continue to rise across the locality. In an attempt to support and enhance access to primary care services, the Scottish Government plan to invest £16.2m over three years, to recruit up to 140 whole time equivalent additional pharmacists with advanced clinical skills training across Scotland. They will work directly with GP practices to support the care of people with long term conditions. Because these people with long term conditions will be seen by a suitably qualified medical professional, there will be increased GP time available to spend with other people. By year 3, all of these pharmacists should be independent prescribers with advanced clinical skills. Wigtownshire have appointed two part-time pharmacists who are working with GP practices across the locality including GP services in Stranraer across all sectors of healthcare. Medication is prescribed to treat existing conditions and prevent ill health. It is the second highest area of spending in the NHS after staffing costs.

Locally a new approach has been taken to “grow our own” professional workforce which is enabling the development of a robust workforce for the future.

The Prescribing team are working with GPs to review the way in which medication is prescribed across Wigtownshire. The focus for the localtiy has been to work in partnership with GPs and the residents of Wigtownshire to consider how we can:

- prescribe non-branded medicines where available
- review repeat prescriptions to ensure the patients who require on-going repeat prescriptions are taking the medication as prescribed
- reduce waste

These are a few examples of how we are tackling the increase in spend on drugs.

Palliative Care

Dumfries & Galloway Health and Social Care Partnership and Marie Curie are working together to look at the provision of 24 hour palliative care. This is includes ‘hands on’ care, emotional support and practical information for terminally ill people and their families as delivered through the Galloway Community and Newton Stewart Hospitals, by GP surgeries, in care homes and in people’s own homes.

Residents across Wigtownshire were asked to share their experience of palliative and end of life care to help shape future service delivery. The report will be considered by the Health and Social Care Partnership to develop improvements to future care and support for local residents.

Out of Hours

Urgent care medical cover is provided when GP Practices are closed - 6pm to 8am Monday to Friday and at all times at weekends and on Public Holidays. During this time, NHS24 (telephone contact via '111') provides the initial contact and if any face to face urgent care need is identified, the local NHS Dumfries & Galloway Out of Hours Service (OOHs) will provide this support. The OOHs service is appointment based and does not operate a 'walk-in' service. Access to suitable premises and staffing resources are key factors in this arrangement.

Across Scotland it is a significant challenge to secure appropriate GP cover for the OOHs. This issue is of particular concern in rural Dumfries & Galloway.

The Scottish Government have invested £400,000 in Wigtownshire to establish and test a Nursing Out of Hours service across Wigtownshire over a two year period which includes the employment of two Advanced Nurse Practioners who will be based in Wigtownshire.

Community Flow

The establishment of a 'community flow' meeting has transformed the way in which care is provided in the Newton Stewart area. Prior to health and social care integration, health and Social Work professionals met seperately to manage the care of people who use services. In September 2016 a community flow meeting with a preventative focus was established plus bi-weekly multi-disciplinary discharge huddle in Newton Stewart Community Hospital. The community flow meeting has all professional groups in attendance: community nursing, adult Social Work team, NHS and Social Work occupational health teams, health and wellbeing team, physiotherapy and Rehab Day Unit staff.

Outcomes:

- Timely intervention reducing waiting times from an average of 6 to 12 weeks to 8 working days from referral to first contact.
- Care cost saving – Approximately £4,950 saved in care packages through more appropriate triaging and assessment while increasing independence through service user engagement in rehabilitative approaches (Sept 2016-Feb 2017).
- Improved communication and role understanding.
- Less meeting time (from 5 hours to 2) thus increased contact time with people.
- Improved local relations enabling future integrated care developments.

A community flow meeting will be established in the Stranraer area from Autumn 2017. The community flow meeting in Stranraer will be run by community health and social care professionals, as well as health professionals from the Galloway Community Hosptial.

Communication

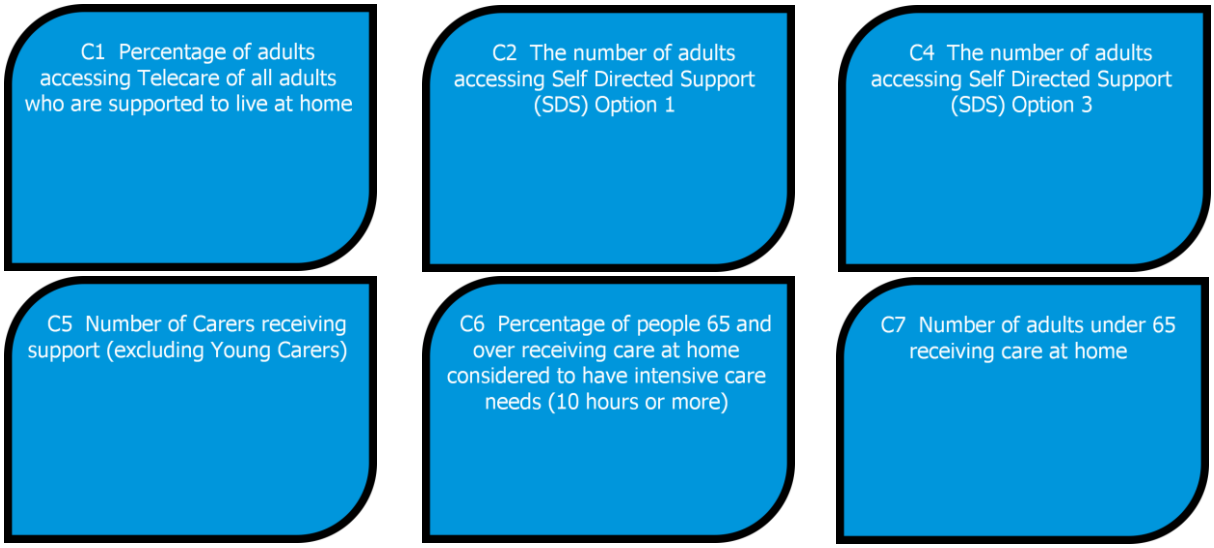
Communicating and engaging with the population of Wigtownshire, as well as community health and social care staff continues to be a focus for the locality. The Health and Social Care Locality Manager meets quarterly with local elected members to discuss the progress of delivery against the Locality Plan, an update on the redesign of new contemporary models of care and challenges in delivering sustainable services.

The launch of a Wigtownshire facebook page has provided an opportunity for the locality to further engage with the community on events and issues. The locality manager meets regularly with health and social care staff and has run staff awareness sessions to update staff on health and social care integration.

June Watters
Wigtownshire Locality Manager

Performance Indicator Overview

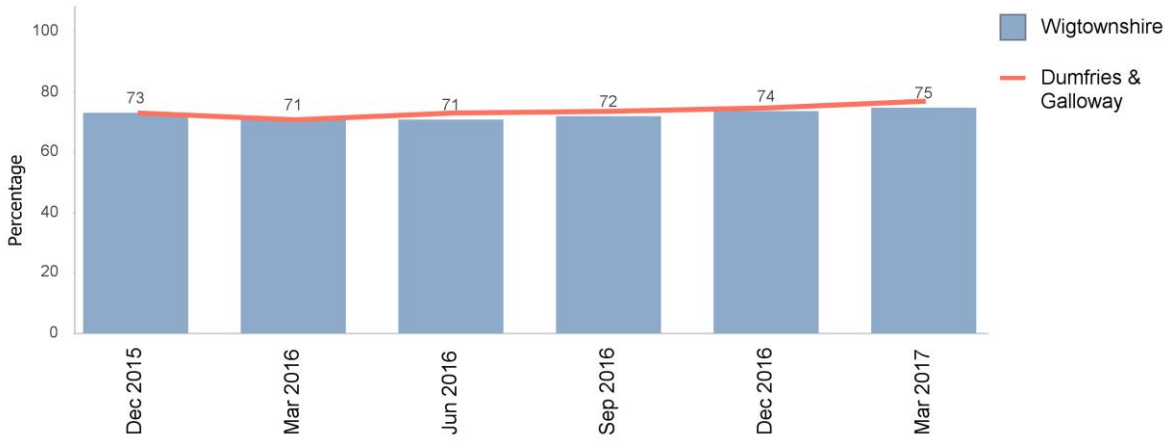
Clinical and Care Governance



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; Wigtownshire



Key Points

The percentage of adults supported to live at home who are accessing telecare in Wigtownshire was 75% in March 2017 and has remained stable since October 2015. Wigtownshire performance is similar to that of Dumfries & Galloway (77.1%).

The Wider Context

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.

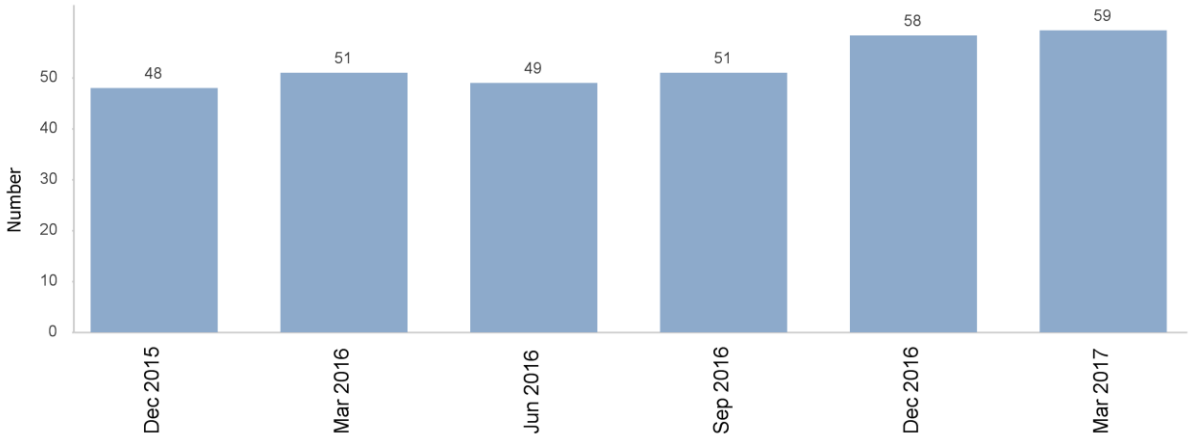
Currently, this measure relates to Care Call, however TEC includes a wide range of other services (e.g. 'Just checking' – 24 hour sensors and 'Attend Anywhere' – video GP consultation) that are not captured by this measure. Also there is 'lead-in' time to the introduction of any telecare, enabling discussions 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

Adult Social Work has produced a template which is used as a checklist to ensure Telecare is considered in all Social Work assessments. Access to Care Call has improved through simplifying the application process. This can be done with a telephone call to the Contact Centre leading to a direct referral to the installers.

C2 Number of adults receiving care at home via SDS Option 1

The number of adults accessing Self Directed Support (SDS) Option 1; 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 59 people in March 2017.

This number has risen since March 2016 when there were 51 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. The gradual increase in the number of people choosing this option across the region is in line with more people becoming confident enough to take control of managing of their choice of care and support.

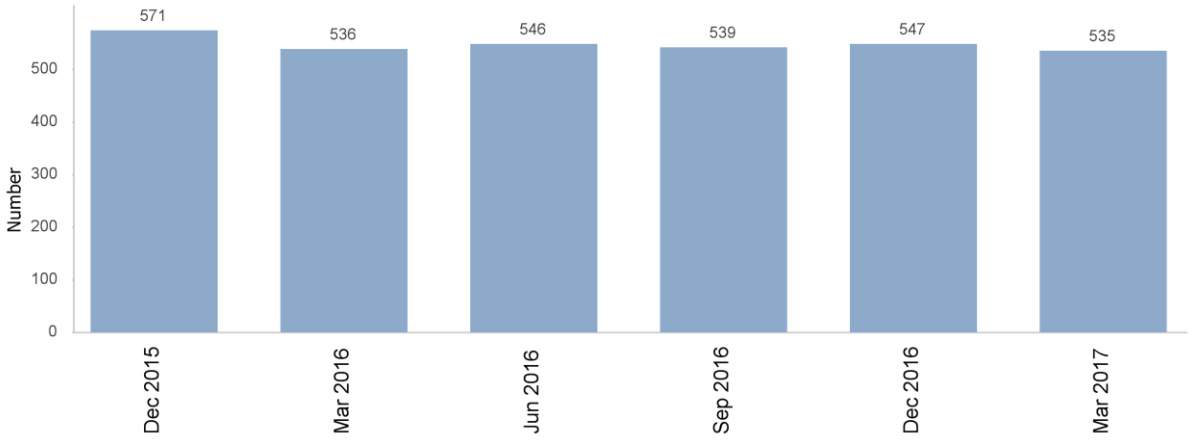
Improvement Actions

There are qualitative examples of the success which SDS Option 1 is providing people in Dumfries & Galloway, on two separate YouTube films:
Firstly, Eileen’s story, https://www.youtube.com/watch?v=Sz0OSZ7TFWY and secondly Chris’s story (which is a collaboration with Social work, Carers centre and key community supports) https://vimeo.com/enterprisescreen/review/106401503/9473ed7794SDS .

SDS Option 2 is when a person chooses the organisation they want to be supported by and the local authority transfers funds to that organisation who then arrange care to meet the person’s agreed outcomes. It is anticipated that as Option 2 is introduced, the proportion of people taking up Option 3 will reduce and Option 1 may also reduce, as Option 2 becomes the more favoured approach as it allows people to be in control without the added responsibility of being an employer.

C4 Number of adults receiving care at home via SDS Option 3

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



Key Points

This is “Data only” indicator.

In March 2017 there were 535 adults from Wigtownshire receiving care at home through Self Directed Support (SDS) Option 3, which is approximately 90% of all SDS Options. This is higher than the Dumfries & Galloway value of 88%.

The Wider Context

SDS Option 3 is where Social Work services organise, purchase and manage care for people.

Improvement Actions

To increase the choices available to people in receipt of care and support, work is underway to introduce SDS Option 2 for early 2017. It is anticipated that as Option 2 is introduced, the proportion of people taking up Option 3 will reduce.

C5 Carers receiving support (excluding Young Carers)

Feedback from Carers with Adult Carer Support Plans (ACSP)

"For me the ACSP was given at a time when I was going through significant changes in my life and had some very important decisions to make (that were not easy).
The plan supported me through this and allowed me to look at various areas of my life and how one was impacting on the other.
The outcomes let me focus specifically on what was important to me and I acted on them fairly quickly."

"This has made a big difference to me. I was coping but was starting to slip due to the increasing demand of my caring role for two people. This really started to bother me and affect me.
My own budget has meant that I now have space to do things for me and I can't tell you how much peace of mind this gives me and I feel I have a little more control over my life."

Source: Dumfries & Galloway Carers Centre.

Key Points

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

The Wider Context

There are a number of organisations across Dumfries & Galloway who provide support to Carers. A new Carers Strategy was available for public consultation between April and June 2017.

Identifying Carers is a key priority and a requirement of the Carers (Scotland) Act 2016, which will be implemented on 1st April 2018.

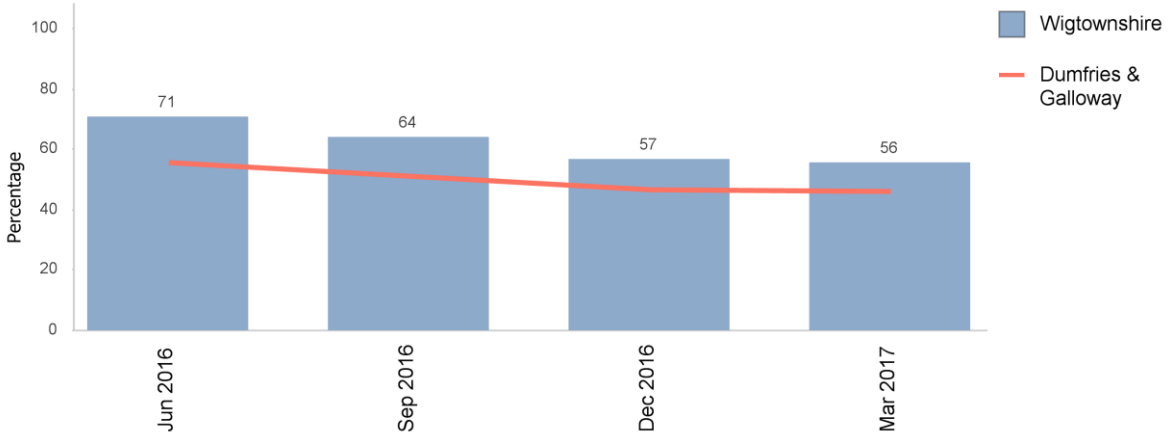
The Carers Centre currently undertakes completion of Adult Carer Support Plan Assessments (ACSP).

Improvement Actions

From Wigtownshire there were 24 Adult Care Support Plans completed between February 2016 to March 2017 by the Carers Centre.

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 56% in March 2017.

This rate is higher than that seen across Dumfries & Galloway at 46.2%.

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.

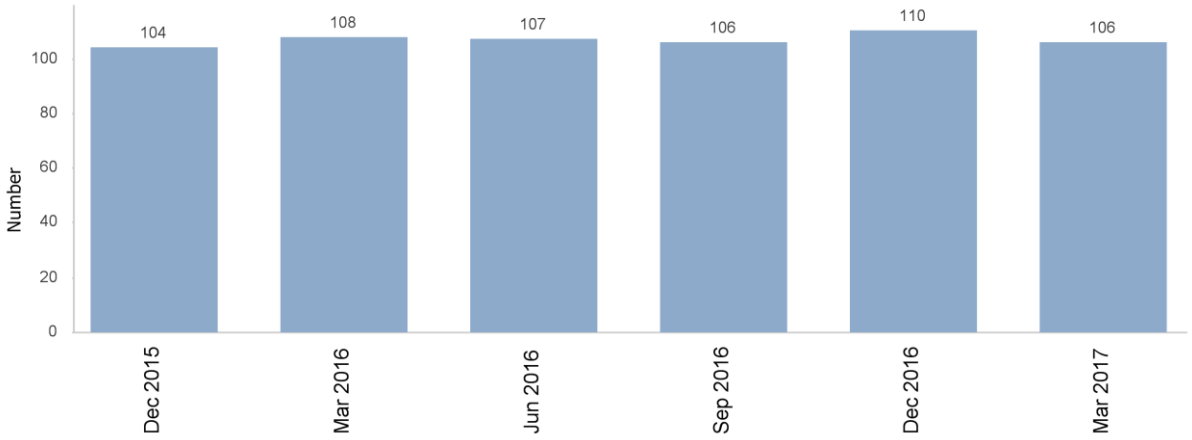
The new SDS models of care offer more person centred solutions and offer more alternative and efficient solutions.

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 106 in March 2017.

Performance against this indicator in Wigtownshire has been relatively stable since December 2015.

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 challenges regarding the supply of care in local areas.

Improvement Actions

No improvement actions required at this time.

Performance Indicator Overview

Finance and Resources

C8 Rate of total Home Care hours provided per 1,000 population aged 65 and over

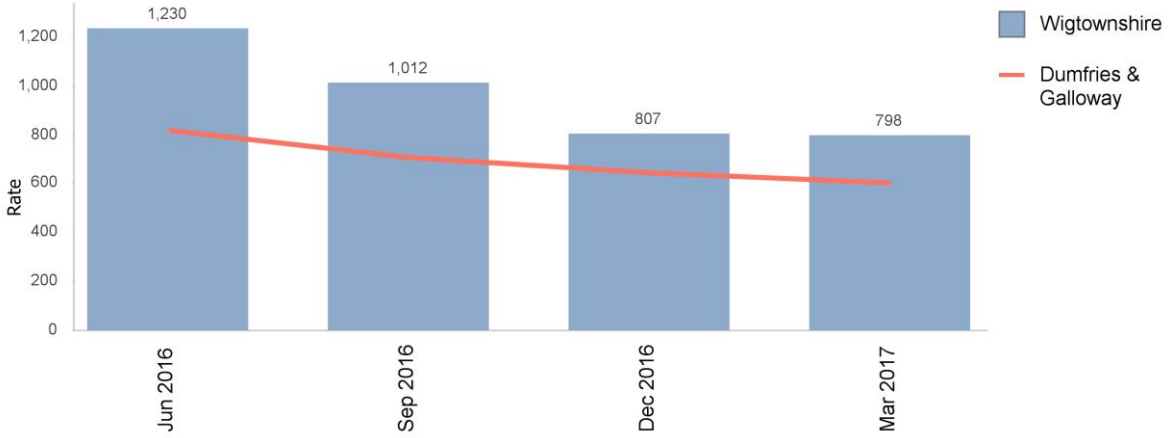
D6 The number of times people access 'virtual services'

D7 Progress towards reporting on housing adaptations

D8 Progress towards reporting on prescribing

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 March 2017 the rate of Home Care provision in Wigtownshire was 798 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 & Galloway (602 hours per 1,000 population aged 65 or older).

The Wider Context

Across Dumfries & 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.

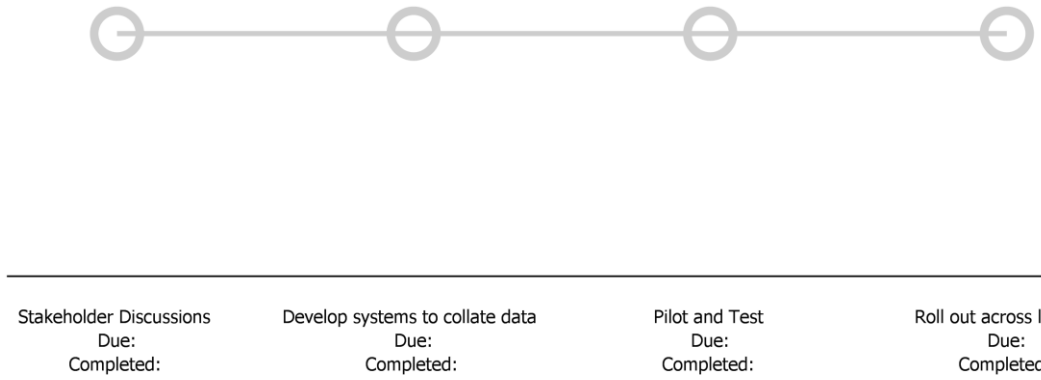
Improvement Actions

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

D6 Technology Enabled Care (TEC) - Virtual Services

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

The number of times people access 'virtual services'; Wigtownshire



Key Points

This indicator has not yet been developed.

The Wider Context

Dumfries & 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.

An Assistive Technology Care strategy for Dumfries & Galloway is being prepared. This document will include a plan for the development of all types of technology from traditional adaptations, such as grab rails to high tech equipment.

Improvement Actions

Cree Valley Community Council has funded a new initiative called ‘Login & Connect’. People can bring their own electronic devices and get support and advice on how to use them and how to stay safe.

Loreburn Housing Association, local businesses and health and social care partners opened a ‘Pop Up House’ (Milburn Court) in Stranraer to showcase telecare equipment and other equipment and adaptations available to support people living with dementia, sensory impairment and frailty. People were able to see how these enablers can support independent living, investigate the equipment costs and where to purchase them.

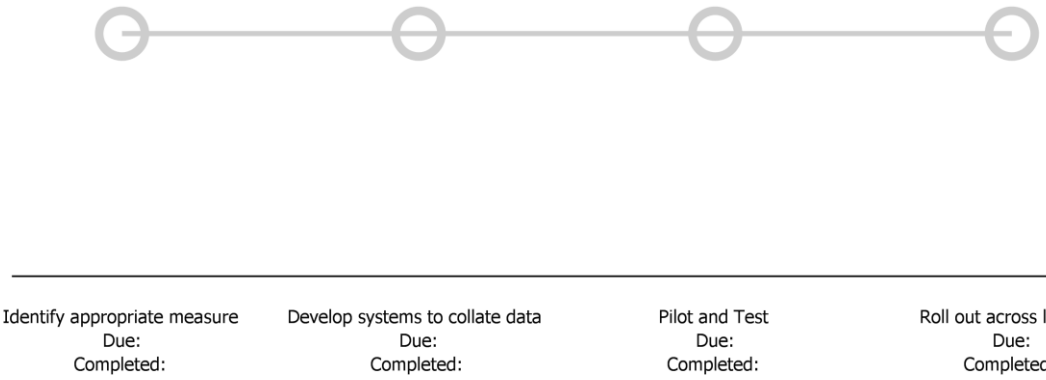
The mPower project aims to improve the health and well-being of people living in the region by implementing ‘community navigators’, utilising eHealth interventions to support health and care service delivery. The project will target people over 65 (and their Carers) who are either current high users of health and social care services or who are identified as having a significant level of risk with regard to their wellbeing.

Wigtownshire secured two Just Checking systems which provide evidence of individual support going to the right person at the right time, allowing the person to remain as independent as possible. It supports decision making for residential care and the review of current care and new care package requests.

D7 Housing adaptations

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	7

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

An Assistive Technology Care strategy for Dumfries & Galloway is being prepared. This document will include a plan for the development of all types of technology from traditional adaptations, such as grab rails to high tech equipment.

Loreburn Housing Association, local businesses and health and social care partners opened a ‘Pop Up House’ in Stranraer to showcase telecare equipment and other equipment and adaptations available to support people living with dementia, sensory impairment and frailty. People were able to see how these enablers can support independent living, investigate the equipment costs and where to purchase them.

D8 Prescribing

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	39

Progress towards reporting on prescribing; Wigtownshire

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

Key Points

Development of this indicator is on schedule.

The Wider Context

Choosing the most suitable and cost effective medicine is important to provide the best care for people consistently across the Partnership. Ineffective and inefficient prescribing can be both unsafe (e.g. when people are given medicines that don't work well together) and wasteful (e.g. when people are given or request medicines that they don't need.)

Development of an appropriate indicator is underway.

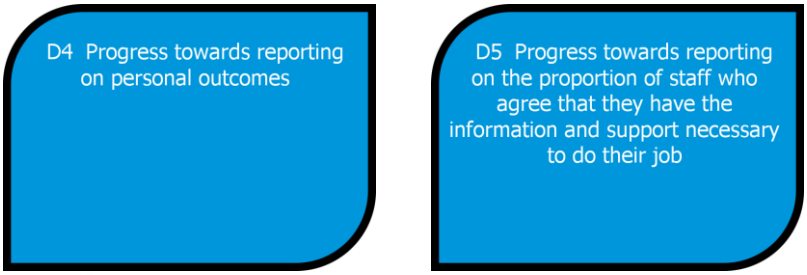
Improvement Actions

Wigtownshire has appointed two part-time pharmacists, who with advances clinical skills training, are working with GP practices across the locality.
The prescribing team are working with GPs to review the way in which medication is prescribed across Wigtownshire. Some examples of how spending of drugs is being tackled are:

- prescribe non-branded medicines where available
- reviewing repeat prescriptions to ensure people who require on-going repeat prescriptions, and those that are receiving them, are taking the medication as prescribed
- reduce waste.

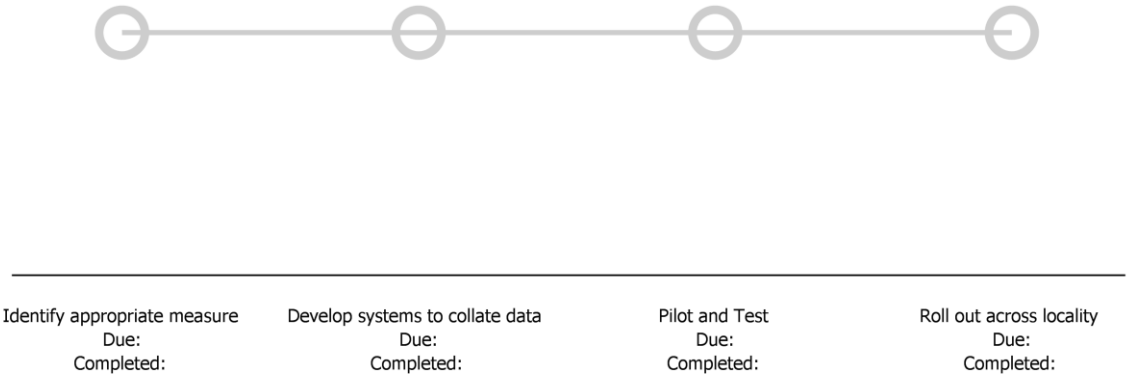
Performance Indicator Overview

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 & Galloway Health and Social Care Partnership is supporting people to achieve them.

Improvement Actions

Gentle exercise to music ('Dancercise') is offered to people with limited mobility at the Newton Stewart Activity Resource Centre to help support the prevention of falls.

‘Pets As Therapy’ volunteers visit local care homes and the Activity Resource Centre in Newton Stewart. This initiative enhances people’s quality of life by providing companionship to help tackle loneliness and provides animal assisted interventions as part of a holistic approach to treatment.

D5 Staff have the information and support to do their job

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	32

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

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

Key Points

Development of this indicator 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.This indicator may include using iMatter to survey the responses of staff and this would need to be rolled out across the NHS and adult Social Work teams.

Improvement Actions

In Wigtownshire, staff are supported to attend Consultation Institute Training to develop a standard approach to engagement.

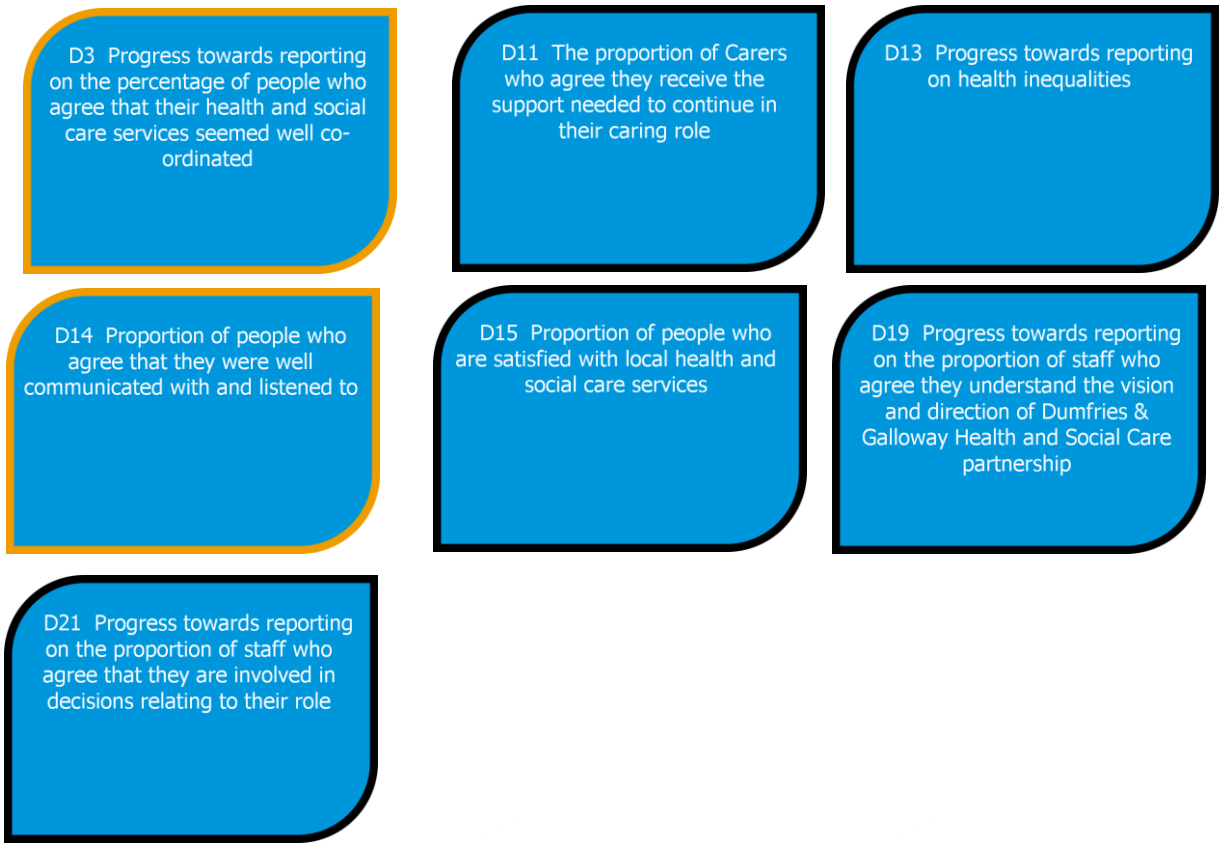
Staff have an annual review and appraisal system in place supported by a personal developement plan, enabling staff to voice any concerns about support, training or other matters relating to their role. These are supplemented by monthly one-to-one/ informal meetings and team meetings. We have run a team development session to support the integration of the Buiding Health Communities and Health Improvement Teams.

Three Mindfulness Courses have been run for health and social care staff across Wigtownshire. Two members of staff are now qualified Mindfulness teachers.

Staff drop-in sessions have been delivered by the locality manager.

Performance Indicator Overview

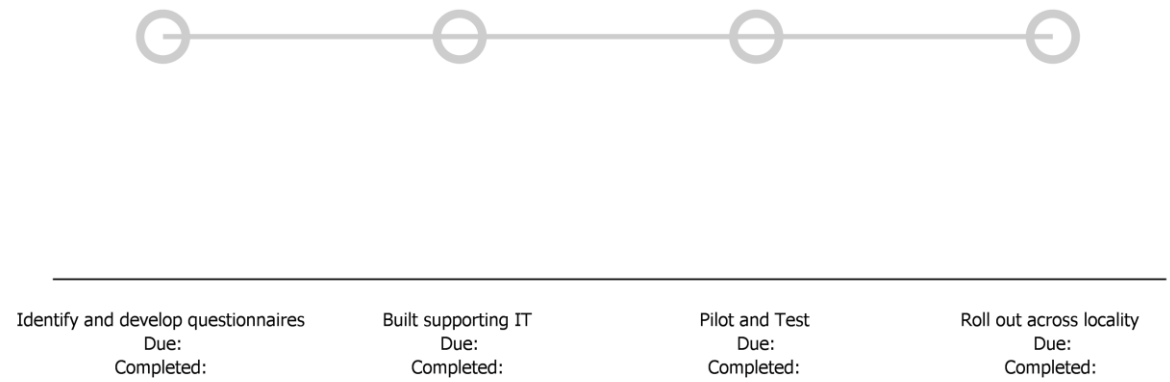
Stakeholder Experience



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

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



Key Points

The local survey tool is complete, however there has been some delay on piloting the tool; therefore this indicator has been set a 'RAG' status of amber. Some actions to begin this pilot are currently being identified.

The Wider Context

This indicator is one of the new measures being developed locally in Dumfries & Galloway to support performance monitoring of health and social care integration. This indicator has been adapted from the Health and Social Care Experience Survey, a national survey carried out every 2 years. It is intended that locally, this question will be asked more frequently and of more people, to better monitor how changes in the way services are delivered impact on people.

Dumfries & Galloway have collaborated with computing science students from the University of Glasgow to develop a survey tool to capture people's responses to the survey questions.

Improvement Actions

TA weekly community flow team meeting brings staff from health and social services together to discuss peoples discharge and care plans. There is a bi-weekly multi-disciplinary discharge huddle in the Newton Stewart Community Hospital. This is currently being evaluated.

In Wigtownshire, health and social care staff are working together to support people with complex health conditions to reduce their dependence on emergency department attendances at the Galloway Community Hospital.

The Scottish Government have invested £400,000 in Wigtownshire to establish and test a Nursing Out of Hours service across Wigtownshire over a two year period which includes the employment of two Advanced Nurse Practioners based in Wigtownshire.

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

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	6 23 24 25

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

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

Key Points

Development of this indicator is 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.

D13 Health inequalities

Progress towards reporting on health inequalities: Wigtownshire

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

Key Points

Development of this indicator has not begun.

The Wider Context

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

Improvement Actions

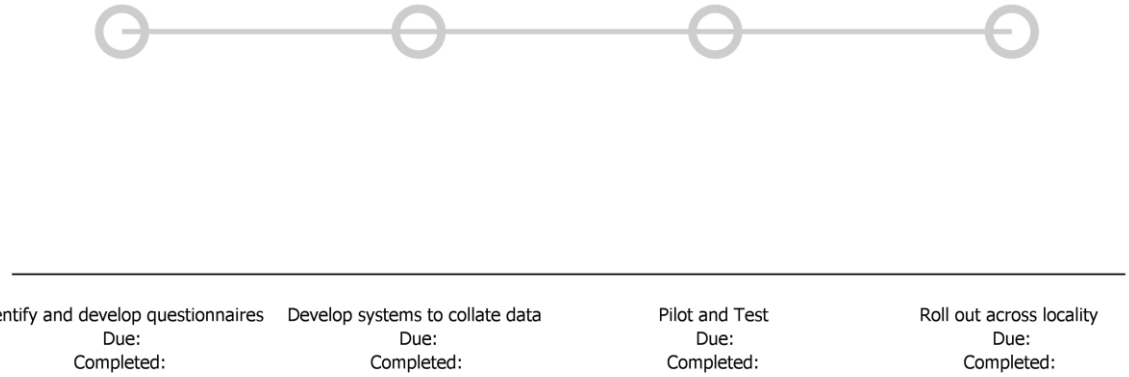
An Inequalities Action Framework and toolkit has been developed and is endorsed and supported by the Health and Social Care Senior Management Team, the NHS Board Management Team and the Community Planning Executive Group. Work is underway to ensure that implementation of the framework is embedded across all partners.

There are a range of activities underway in Wigtownshire working towards improving health and wellbeing and the reduction of inequalities. These include:

- The Wigtownshire Health and Wellbeing Team have supported the Rhins Mens Shed to become established. A small grant was provided through working in partnership with the Wigtownshire Health and Wellbeing Partnership which enabled the group to make Stoneykirk wind and watertight.
- Tai Chi is offered in GP practices and also in day centre settings in Stranraer
- NHS Education for Scotland (NES) have provided funding for one year to the Psychology Service for Older Adults to increase identification of mental health issues coupled with increased access to psychological intervention for older people who may be experiencing loneliness and/or social isolation.
- Community art groups are supported by the Wigtownshire Health and Welbeing Team in Stranraer,Wigtown and Whithorn.
- ‘Jills of all trades’ support volunteers to become skilled in a number of DIY areas. This enhances confidence, self esteem and resilence, which in turn enables people to tackle jobs in their own homes.
- A ‘Login and Connect’ group runs weekly in Newton Stewart to support older people to become more confident using IT and helping connect with family through social media.
- The Monday Club meets every week in Newton Stewart to provide a social group and offers speakers and some gentle exercise.
- A range of other actvities such as Boccia and New Age Curling are on offer across Wigtowshire.

D14 Well communicated with and listened to

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



Key Points

The local survey tool is complete, however there has been some delay on piloting the tool; therefore this indicator has been set a 'RAG' status of amber. Some actions to begin this pilot are currently being identified.

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. Dumfries and Galloway Health and Social Care is collaborating with computing science students from the University of Glasgow to develop a database and tools to capture people's responses to different "customer satisfaction" style questions such as this indicator. The students are developing web-apps, mobile apps and considering scanning technologies to capture data submitted on paper forms. Suitable settings for testing these new technologies are being identified.

Improvement Actions

A Wigtownshire Facebook page has been launched, providing an opportunity for the locality to further engage with the community on events and issues.

Residents across Wigtownshire have been asked to share their experience of palliative and end of life care to help shape future service delivery and support for local people.

In Wigtownshire, staff are supported to attend Consultation Institute Training to develop a standard approach to engagement.

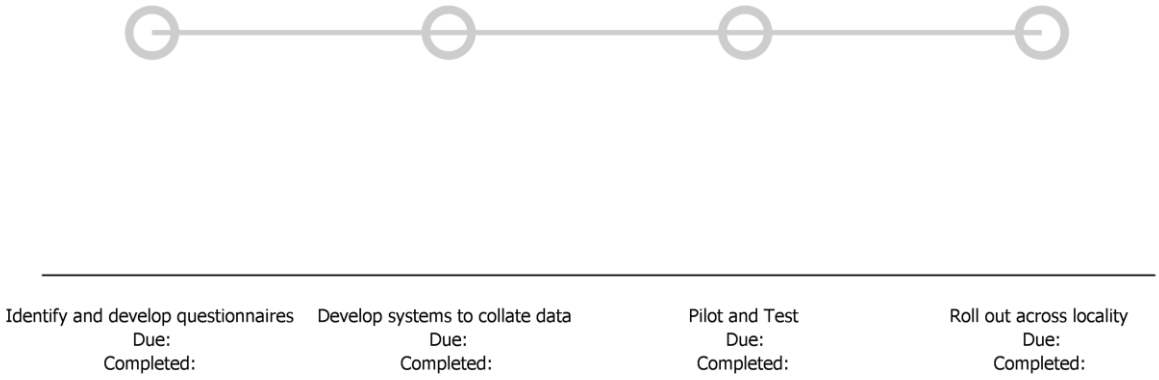
Staff have an annual review and appraisal system in place supported by a personal developement plan, enabling staff to voice any concerns about support, training or other matters relating to their role. These are supplemented by monthly one-to-one informal meetings and team meetings. We have run a team development session to support the integration of the Buiding Health Communities and Health Improvement Teams.

Three Mindfulness Courses have been run for Health and Social Care staff across Wigtownshire, as well as, two members of staff are now qualified Mindfulness Teachers.

Staff drop-in sessions have been delivered by the locality manager.

D15 Satisfaction with local health and social care services

Proportion of people who are satisfied with local health and social care services; Wigtownshire



Key Points

Development of this indicator is on schedule

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.

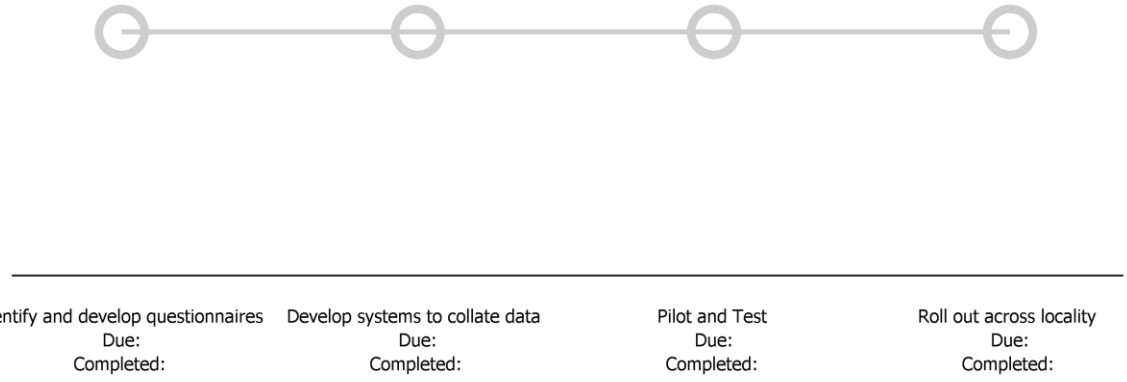
Dumfries and Galloway Health and Social Care is collaborating with computing science students from the University of Glasgow to develop a database and tools to capture people's responses to different "customer satisfaction" style questions such as this indicator. The students are developing web-apps, mobile apps and considering scanning technologies to capture data submitted on paper forms. Suitable settings for testing these new technologies are being identified.

Improvement Actions

Engagement with people across Wigtownshire is providing a greater understanding of their views and experiences of health and social care services. Wigtownshire locality will test capturing people's responses to "customer satisfaction" style questions and the technology being developed by the students at the University of Glasgow during 2017.

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

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



Key Points

This indicator has not yet been developed.

The Wider Context

As health and social care services work more closely together it is important that there is a collective understanding of the vision and direction of the partnership underpinned by strong leadership. This shared understanding can positively impact on how different teams communicate with each other and communicate with people who use services. This can positively impact on the outcomes for people.

Improvement Actions

The locality manager meets regularly with health and social care staff and has run staff awareness sessions to update staff on health and social care integration.

D21 Staff involved in decisions

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	32

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

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

Key Points

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

The design, development and implementation of the flow meeting ('One Team' approach) has brought together staff to across the different professions across the locality who have engaged and developed new ways of working together.

There are regular monthly and quarterly meetings where senior staff can discuss practical operational issues and share staff feedback to ensure decisions are reviewed and amended where necessary following staff input.

Appendix 1: Table of "We Wills"

Ref	Description	RAG Status
1	Develop information and make this information accessible to people and relevant to their own circumstances so that they can take responsibility for and be in control of their own 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)	