DUMFRIES AND GALLOWAY INTEGRATION JOINT BOARD

# HEALTH AND SOCIAL CARE
## LOCALITY PLAN

WORKING TOGETHER FOR THE FUTURE OF HEALTH AND SOCIAL CARE

DUMFRIES AND GALLOWAY
**Health and Social Care**

## Wigtownshire 2016 – 2019

# Contents



**If you would like some help understanding this or need it in another format or language please contact 030 33 33 3000**

# Foreword

People from health, social care and community services have worked together to produce this Wigtownshire locality plan. This plan is for all of us in Wigtownshire and has been developed within the context of the Dumfries and Galloway Health and Social Care Strategic Plan. The Strategic Plan and all the supporting documents, including locality plans, have been informed by national and local policies and guidance, legislation, external inspections such as the joint inspection of older adults (early 2016) and builds on learning from programmes such as 'Putting You First.' Appendix 2 of the strategic plan includes details and links to some of these. It can be viewed at (www.dg-change.org.uk/strategic-plan).

This is a time of change and challenge. We want to make sure that the health and social care services we arrange and pay for are safe and effective. At the same time, as a community, we must all support significant change and our plan reflects the actions we will take to make this a reality. Central to this is the need to shift activity and resources into the community. We will build on, and strengthen, what already exists and is provided by NHS, social services and third and independent sectors. These sectors will formally be working in partnership from the 1st April 2016 under the Dumfries and Galloway Integration Authority. With the increasing demand on services, resources and budgets comes the need to reshape the way we support people in our community. This will allow people to look after themselves, safe in the knowledge that health and social care services are there when needed. In short, we need to do things differently. Developing this integrated care partnership and producing this final plan together in that partnership, along with the strategic plan is aimed to help deliver this vision. You are a central part of this plan.

This plan involves health, social work and third and independent sector services. This includes our hospitals, GPs, community nurses, occupational therapists, physiotherapists, podiatrists, speech therapists, social workers, housing officers, care homes, care providers and unpaid Carers, voluntary and charitable organisations. We believe that we can work with you to better organise care and support. With improved and increased communication and networking across the region, we aim to support you closer to home. Technology will be important in delivering this model of care.

This locality plan sets out our direction for the next three years. A supporting Wigtownshire health and social care integration delivery plan will set out more specifically what we plan to do and how. This will continue to develop over time in a dynamic manner. This is a journey to which I am committed and together we will work to make sure we effectively involve everyone with an interest to make sure that the needs of our population are at the heart of this process. My overall aim, as Interim Locality Manager is to make a difference to you as an individual, so you can live a healthy and well life in Wigtownshire. I am certain the permanent incoming Locality Manager, June Watters, will have the same aim.

**Mhairi Hastings**
Interim Locality Manager

# 1 Introduction

## 1.1 What is this Locality Plan?

This locality plan is about how health and social care integration will be taken forward in Wigtownshire as part of the new Dumfries and Galloway Integration Authority. It sets out specific locality data identifying what is working well, as well as some of the key challenges which need to be addressed. It is an appendix to the Dumfries and Galloway Health and Social Care Strategic Plan. For more information about health and social care integration see the strategic plan (**www.dg-change.org.uk/strategic-plan**).

The plan is about health and social care services and support. It is also about how people and communities can be supported to help and support themselves.

This is the first plan of its kind and sets out in broad terms how we will all work together using an asset based approach for the best possible outcomes for everyone living in the locality. An asset based approach starts with getting to know the strengths of individuals, groups and communities and building upon these. Importantly, much of the plan is based on what people who live in the locality and those currently involved in delivering health and social care in the locality have said about how things could be better and what would make a difference. There was a wide consultation on a draft version during the period of October to December 2015. This locality plan is supported by a Wigtownshire health and social care integration delivery plan that will be an evolving, developing document, setting out the activities, projects and work to be undertaken over the next three years to meet the required outcomes for people living in the locality.

## 1.2 Who is this Locality Plan for?

This plan is for everyone who lives or works in Wigtownshire with a focus on adults. It is for those who currently use health and social care services, for example, people who need day to day help with personal care or who need more regular support to manage a long term condition and also those who may need to do so in the future. It is also for people who are well and wish to maintain or improve their current level of independence, health and well-being.

## 1.3 What is included in this Plan?

All adult social care, adult primary and community health care services, most acute hospital services and some elements of housing are included within the new Dumfries and Galloway Integration Authority. Services relating to children are currently not included.

## 1.4 Where does this Plan fit into the wider picture?

This plan is one of four locality plans for Dumfries and Galloway and forms an annex to the overarching strategic plan for the region www.dg-change.org.uk/strategic-plan There are also a number of other important national and local strategies which have informed this plan, for example, "The keys to life – Improving Quality of Life for People with Learning Disabilities 2013" and the "Dumfries and Galloway Joint Strategic Plan for Older People 2012 – 2022". A more comprehensive list of these important strategies can be found in Appendix 2 of the strategic plan. (**www.dg-change.org.uk/strategic-plan).**

The strategic plan, this plan and the Wigtownshire health and social care integration delivery plan will be further informed by the findings of the joint inspection of adult services. At the time of writing this inspection is being carried out by the Care Inspectorate and Health Improvement Scotland across Dumfries and Galloway. The findings of the inspection will be developed into a Dumfries and Galloway partnership improvement plan and these improvements will be incorporated into the Wigtownshire locality development plan. Actions required following the pre inspection are already reflected within the Wigtownshire commitments (section 5) of this plan.

### 1.5 What are we hoping to achieve?

There are nine national health and well-being outcomes agreed by Scottish Government that our locality will need to deliver against. A summary of the outcomes is set out here. Section 5 of this plan outlines the key issues for these locally and our commitments against each outcome.

**People are able to look after and improve their own health and well-being and live in good health for longer**

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

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

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

**Health and social care services contribute to reducing health inequalities**

**People who provide unpaid care are supported to look after their own health and well-being, including to reduce any negative impact of their caring role on their own health and well-being**

**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**

**People using health and social care services are safe from harm**

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

This plan is shaped around the vision for Dumfries and Galloway as set out in the Dumfries and Galloway integration scheme - "A Dumfries and Galloway - where we share the job of making our communities the best place to live active, safe and healthy lives by promoting independence, choice and control".

For people in our locality this means:

- offering a better experience for people, families and their Carers who currently receive services and support and making these more effective and efficient
- shifting choice and responsibility from services to individuals in terms of their physical and mental health and well-being
- making sure that people, their families and Carers are at the centre of the decision-making process: offering as much choice and control as possible about the services and support they receive
- making sure that the most vulnerable members of our communities are supported to live as independently as possible within their own homes or within a homely setting
- supporting people to make positive lifestyle changes
- finding new solutions through working together in partnership

### 1.6 What are our main challenges?

Many of the challenges we face in Wigtownshire are the same as those identified in the Dumfries and Galloway Strategic Plan which have been set out as:

- health inequalities leading to poorer outcomes for people's health and well-being
- an increasing number of people with multiple long-term conditions, including dementia, who need higher levels of support so they can live independently and at home or in a homely setting in the community
- lack of appropriate housing to meet expected need and demand in areas where people want to live, creating unsustainable and imbalanced communities
- an increasing number of Carers needing greater levels of support to reduce the negative effect their caring role may have on their own health and well-being
- maintaining high-quality, safe care and protecting vulnerable adults in the face of increasing need and fewer resources
- sustaining existing community based services, including GPs, out-of-hours and care-at-home services
- a reducing working age population resulting in fewer people to care for an increasing number of older people
- national challenges in relation to recruiting health and social care staff
- current and expected rise in hospital admissions and delayed discharges resulting in increased pressures across all health and social-care services

These challenges are also similar to those being faced nationally. However because of local factors such as our rural geography and demographics (the profile of people living in the local area) some of these challenges are more acute in our locality. Consequently, the priority areas and how we plan to meet these challenges may be different in Wigtownshire compared to elsewhere.

While the rural nature of Dumfries and Galloway brings some advantages and benefits, it can also increase each of the main challenges. Problems such as physical and social isolation, transport difficulties, recruiting and keeping staff all need to be considered.

As well as the challenges already outlined we have identified the following challenges for Wigtownshire:

- access to support and services
- integrated working and co-ordination of care and support
- current and expected capacity within local care homes and care at home services

At this time we have ongoing waiting lists for care homes and for care at home provision. An increasing number of people from Wigtownshire are now in hospitals where their discharge is delayed. We currently have vacancies in important posts such as GPs and are having difficulty in attracting people to posts where direct contact with the public is the main focus i.e. in social work, health and care. These challenges reflect the regional and national picture but are currently felt more strongly in Wigtownshire than in other areas.

# 2 About the locality

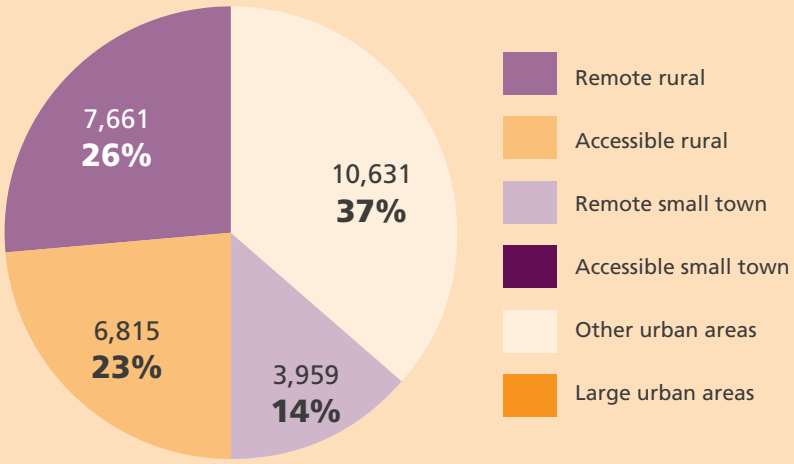
## 2.1 Geography

Wigtownshire is the furthest west of the four localities in Dumfries and Galloway. It has a population of 28,775. This locality accounts for 19% of the Dumfries and Galloway population.

Wigtownshire covers an area of over 1,700 square kilometres, which includes Scotland's most southerly point, Mull of Galloway, the low lying fertile peninsulas of the Rhins and the Machars, and the rugged uplands of the Galloway Forest Park. It also includes Merrick (843metres), the highest hill in the South of Scotland.

More than half of the population live in the market towns of Stranraer (population of 10,600) and Newton Stewart (4,100). 40% of the residents of Wigtownshire live in communities defined as remote by the Scottish Government.

### Number of people in Wigtownshire by urban rural classification




Source: Scottish Urban Rural Classification 2013-14: National Records Scotland Small Area Popluation Estimates 2012

| Scottish Government 6 fold urban rural classification | |
|---|---|
| **1 Large urban areas** | Settlements of 125,000 or more people. |
| **2 Other urban areas** | Settlements of 10,000 to 124,999 people. |
| **3 Accessibles mall towns** | Settlements of 3,000 to 9,999 people and within 30 minutes drive of a settlement of 10,000 or more. |
| **4 Remote small towns** | Settlements of 3,000 to 9,999 people and with a drive time of over 30 minutes to a settlement of 10,000 or more. |
| **5 Accessible rural** | Areas with a population of less than 3,000 people, and within a 30 minute drive time of a settlement of 10,000 or more. |
| **6 Remote rural** | Areas with a population of less than 3,000 people, and with a drive time of over 30 minutes to a settlement of 10,000 or more. |

Population sizes for the main settlements (to the nearest 100) based on the 2011 Census are shown in table 1 below.

**Table 1: Population size for main settlements in Wigtownshire**

| Settlement (500+ people) | Population size |
|---|---|
| Stranraer | 10,600 |
| Newton Stewart | 4,100 |
| Wigtown | 900 |
| Whithorn | 800 |
| Creetown | 700 |
| Glenluce | 600 |
| Port William | 500 |
| Portpatrick | 500 |

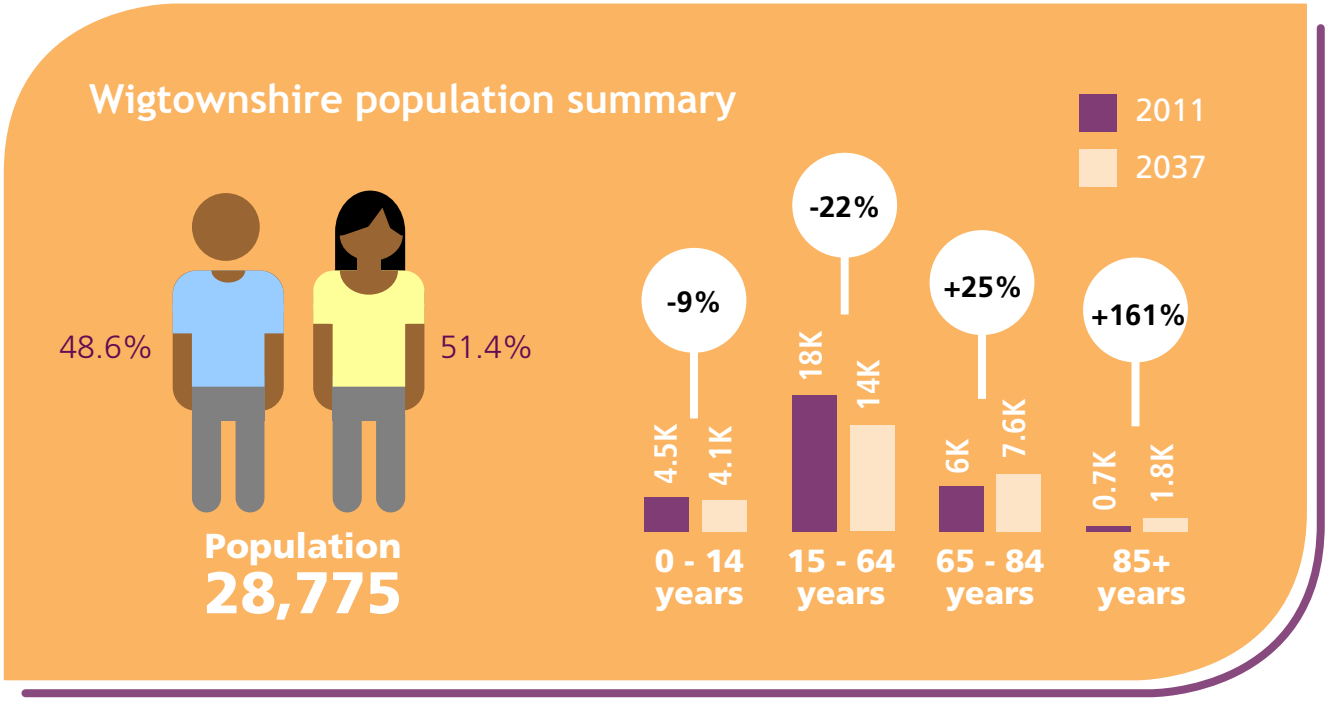
### 2.2 Population and demographic changes

Compared to Scotland as a whole, Dumfries and Galloway has an older population. The average age across the region is 43.6 years, compared to 40.3 years nationally. In Wigtownshire the average age is higher at 44.1 years.

Dumfries & Galloway has the highest proportion of men of pensionable age (22% are aged 65 or over) and the third highest proportion of women (31.7% are aged 60 and over) of any council area in Scotland.

Looking forward on a locality basis is difficult as different localities have different factors affecting population growth, such as birth rates and the number of people moving into and out of the locality.

The graphic below shows an estimate of the expected population change for Wigtownshire by 2037 based on the expected percentage change for Dumfries and Galloway.




Sources: National Records Scotland and Census 2011

# A snapshot of the population in Wigtownshire

At the time of the 2011 Census there were

28,775 people living in Wigtownshire

5,480 (19.0%) aged 65-79

1,640 (5.7%) aged 80+

970 (11%) of Carers providing 50 or more hours of care a week

230 (0.8%) from black and ethnic minority groups including gypsy travellers

1,020 (5%) working age people unemployed

1,162 (5%) had never worked and were long term unemployed

4,500 (16%) were income deprived

1 in 4 households with no car or van

290 births and 390 deaths in the year

In 2013/14 there were

Just less than 80 older people from Wigtownshire admitted to a care home

1,209 (4.1%) reporting themselves as having a long term mental health condition

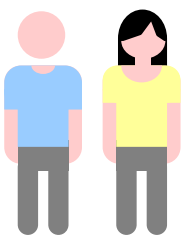
261 people from Wigtownshire admitted to a cottage hospital

2,717 Wigtownshire residents admitted as emergencies to acute care (DGRI & GCH)

448 people receiving a care at home service and of these, 178 were receiving at least 10 hours of care a week

337 (3%) of households do not have central heating

171 adult support and protection referrals



### 2.3 Health inequalities

Health inequalities are the differences in health between people or groups due to a wide range of factors that may be social, geographical, biological or other factors such as discrimination. These differences have a huge impact on people's ability to live long and healthy lives. Generally the people who are worst off experience poorer health and shorter lives. For example, poor education, as well as personal experience and confidence, can prevent people from contacting and finding their way around health and social care services. Living in rural areas and having poor access to public transport can affect a person's ability to access services. Poor housing can directly affect people's health. Poor diet, lack of exercise, smoking and not being able to take part in the local community are often due to having a low income, being unemployed and people's wider circumstances, such as having caring responsibilities.

The Scottish Index of Multiple Deprivation (SIMD) is a geographical measure of deprivation and considers several different factors including income, employment, crime levels, education, health, housing and access to services.

Reducing health inequalities is the responsibility of all partners and involves action on the broader social issues that can affect a person's health including: education, housing, isolation, employment and income. These wider inequalities have a direct impact on and in many cases create health inequalities. An understanding of the impact of these wider determinants of health is vital in preventing such inequalities increasing.

Health inequalities must be considered in the planning stages of service and programme development. The most disadvantaged individuals and communities are least likely to engage with services. This can lead to those with more advantages using services more effectively, leading to increasing health inequality. Transport and access to services can also have a huge impact. It is therefore important that services are designed and delivered in a way that focuses on easy access to services, targeting high risk individuals and groups.

As well as specifically focusing on health and social care for adults, programmes of work will need to be delivered to improve the health and well-being of children and young people to make sure they grow into healthy adults and reduce the risk of ill health in later life.

#### Equality and diversity

Equality and diversity will be central to the work of health and social care integration in Wigtownshire. The public sector equality duty sets out an obligation for the partners to ensure they give due regard to the need to:

- eliminate discrimination, harassment, victimisation and any other conduct prohibited under the Equality Act 2010
- advance equality of opportunity between persons who share a protected characteristic by removing or minimising disadvantage, meeting the needs of particular groups that are different from the needs of others and encouraging participation in public life
- foster good relationships between persons who share a protected characteristic and those who do not

The protected characteristics are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race and ethnicity, religion and belief, sex/gender and sexual orientation.

### 2.4 Asset-based approach

Taking an asset-based approach ensures that we are thinking about people, communities, buildings, equipment and land as the total asset that we have available to us to deliver excellent health and social care as well as support.

People are our most valuable resource in the delivery of health and social care. Families, friends and neighbours play an essential role supporting people socially, emotionally and with practical help. There are significant numbers of dedicated volunteers supporting people in their own homes and local communities through a wide variety of local clubs, community groups and services. For those in need of more formal interventions we have committed staff working in the NHS, council, housing, care at home services and care homes providing important health and social care services.

"Community assets" refer to the resources available to the community. This can include groups and social opportunities as well as physical resources.

Physical resources such as buildings, land and equipment can be used to improve the quality of community life for people. Buildings can include community centres and village halls. A summary of the main physical assets in Wigtownshire is given in Table 2 below.

Like other remote areas of Scotland (such as the Highlands and Islands), some specialist health services will need to be accessed in Glasgow, Edinburgh or other centres of excellence. Therefore, ensuring that the people of Wigtownshire access and receive the highest quality and standards of care available. Availability of transportation in the locality is essential to ensuring that these services are accessible.

**Physical assets in Wigtownshire as at August 2015.**

The table below identifies some of the physical assets in Wigtownshire, however it is important to remember that we will be working in partnership with voluntary and independent services and agencies which will give greater access to physical assets.

**Table 2 – Main physical assets in Wigtownshire**

| Category | Resource | Number |
|---|---|---|
| Health | GP practices/surgeries inc. branch surgeries | 13 |
| | Community pharmacies | 7 |
| | Opticians | 5 |
| | Dental surgeries | 7 |
| | Cottage hospitals | 1 |
| | Community hospitals | 1 |
| | NHS EMI intermediate care facility * | 1 |

| Category | Resource | Number |
|---|---|---|
| Social care/ housing | Care homes (older adults) | 5 |
| | Day centre | 2 |
| | Sheltered housing | 138 |
| | Very sheltered housing/extra care housing | 24 |
| | Supported accommodation - for people under 65 years with a physical disability, learning disability, or mental health problem | 44 |
| Community | Activity and resource centres | 2 |
| | Community centres and halls | 17 |
| | Leisure facility | 2 |
| | Library | 5 |

* Currently under review

### 2.5 Summary of key information and data

The following section highlights some of the main challenges facing the locality now and in the future. Some of this information is taken from the strategic needs assessment for Dumfries and Galloway however, much of it is specific to Wigtownshire.

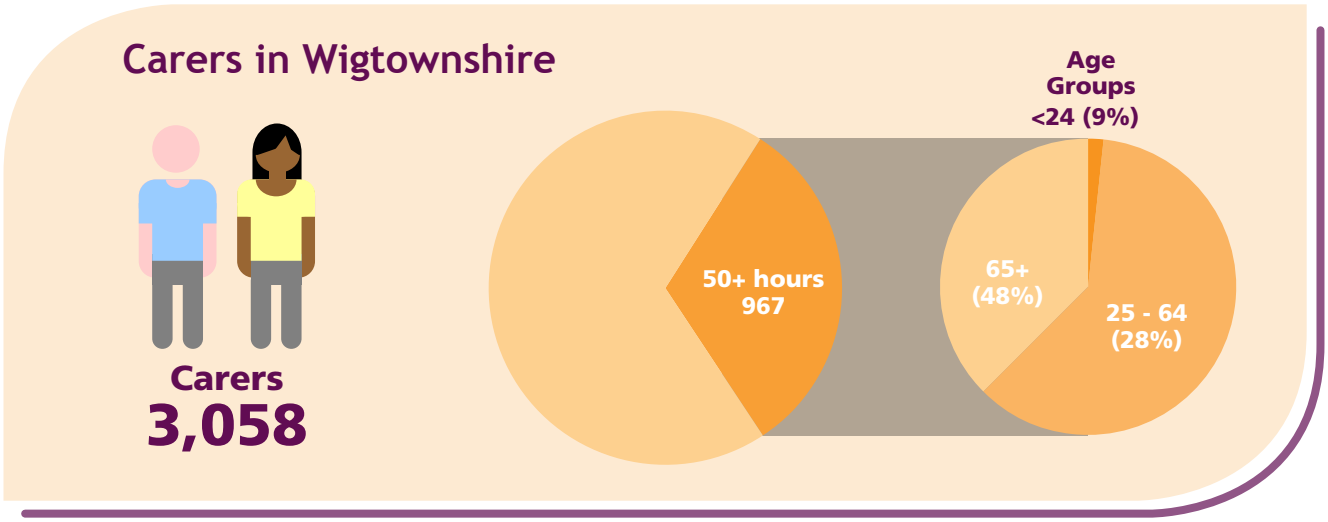
**Wigtownshire local area profile**

#### 2.5.1 Carers

A Carer is someone who, without payment, provides help and support to a partner, child, relative, friend or neighbour, who could not otherwise manage without their help. This could be due to age, long term condition, physical or mental illness, addiction or disability. They may be of any age.

The results of the Census 2011 show that almost 15,000 people in Dumfries and Galloway provide unpaid care with a large percentage providing care for over 50 hours per week.

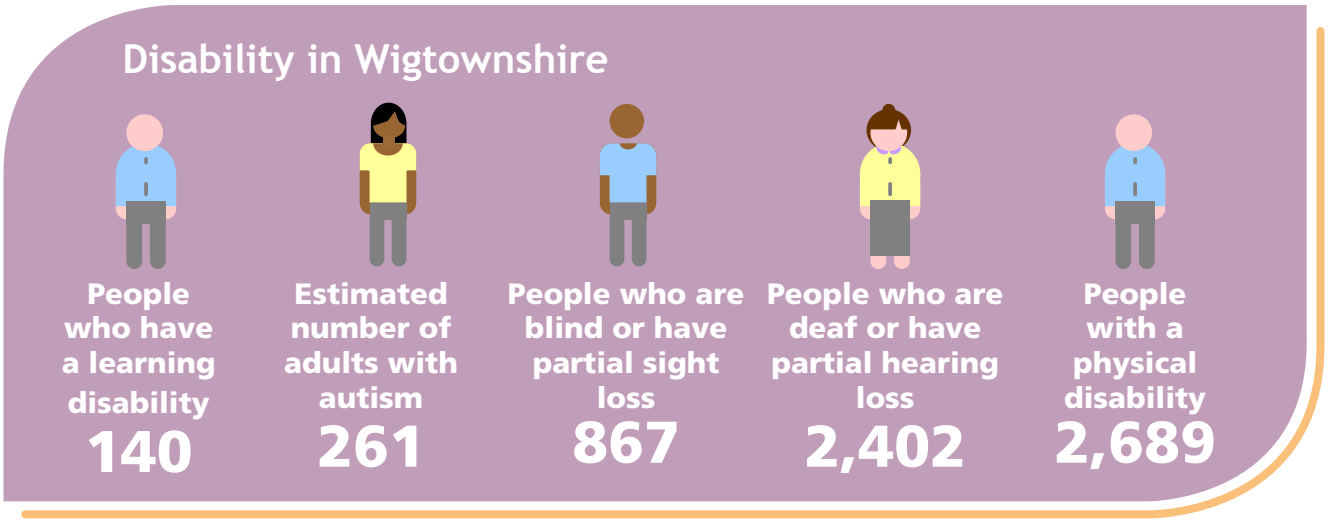
The graphic below provides information on Carers in Wigtownshire.




Source: Census 2011

### 2.5.2 Sensory impairment, physical and learning disabilities and autistic spectrum disorders

The graphic below shows the number of people in Wigtownshire at the time of the Census in 2011 with different disabilities:




Source: Census 2011 and National Autistic Society

People with learning disabilities are a vulnerable group who require the right support and services. The strategic outcomes for people living with a learning disability are the same as those identified through the nine national health and well-being outcomes. Work is also required as described in Section 2.3 of this plan in relation to health inequalities, ensuring that all people are protected and that independence is improved and promoted. The four main outcomes identified for people living with a learning disability, identified in the 'keys to life strategy' are:

- healthy life
- choice and control
- independence
- active citizenship

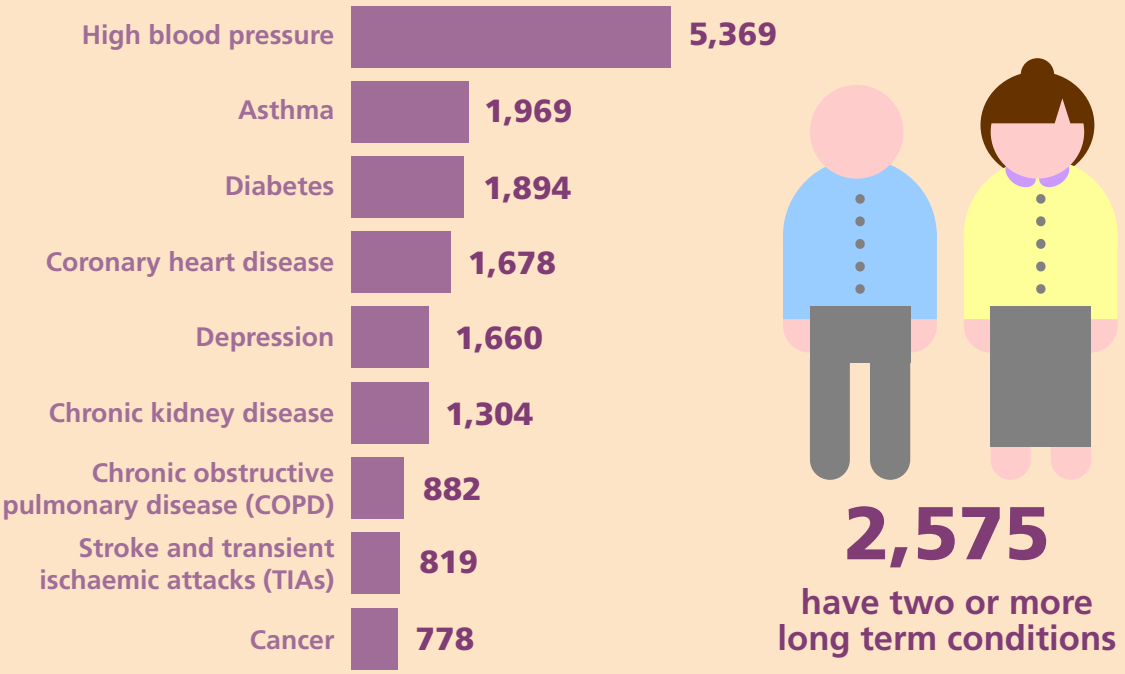
Partnership working has already begun to support people in the locality living with sensory impairment, physical and learning disabilities and autistic spectrum disorders. A suite of services including respite, housing support and short breaks are already provided by organisations such as Key Community Supports, Turning Point Scotland, Leonard Cheshire Disability and Richmond Fellowship Scotland. Building on the partnership working with existing and new organisations who can offer this support is critical to meet individual needs as well as the national health and well-being outcomes.

### 2.5.3 Long term and multiple long-term conditions

As the population ages, the number of people with long term conditions and more than one long term condition will also increase. This has significant implications for health and social care services.

The following graph sets out the number of people living with the most common long term conditions in Wigtownshire. It also shows the number of people living with more than one condition. There are many less frequent conditions that are not listed here but do however require significant health and social care resources.

## Long term conditions in Wigtownshire




Source: Information Services Division Scotland: Quality and Outcomes Framework 2013/14 and SPARRA

This data has been taken from the Scottish Patients at Risk of Readmission and Admission (SPARRA) register. It is designed to help health care professionals to prioritise patients with complex care needs who are likely to benefit most from health care aimed at predicting a patient's risk of being admitted to hospital as an emergency in a particular year. The number of adults in Wigtownshire with multiple long term conditions registered on SPARRA in 2015 was 2,575. This represents 10.5% of all adult patients registered with a GP practice. Of these, 867 are aged 75 or over.

As well as the statutory services offering treatment and support to people with long term conditions there are also a number of small third and independent organisations in Wigtownshire that already support self management and health. We will in the future be looking to foster stronger links and partnership working with groups such as the hard of hearing group, the pain association and the shawl group.

**Diabetes**

The high incidence of diabetes in our local population is worrying due to the significant impact that the condition can have on the health and well-being of people. This locality plan provides an opportunity to focus on planning a more effective and sustainable diabetes service for the future. A range of approaches from early detection to equipping individuals to self manage their condition effectively, requires significant attention in the planning of our integrated services. Collaboration within the partnership will be essential to acknowledge the future impact of incidence rates and the work that is required to be undertaken to reduce the risk of complications associated with a diagnosis of diabetes.

The vision for the integration of health and social care in Dumfries and Galloway, along with the nine national health and well-being outcomes will help to focus the work required to support people living with this long term condition. This will require consideration of, for example, dietetic support, physical disability, the requirement for housing adaptation psychological support health psychology and physiological support. There is also the need to reduce the incidence of diabetes in the longer term.

### Mental health & well-being

Mental health combines both mental well-being (the combination of feeling good in terms of emotions, life satisfaction and functioning effectively such as self-acceptance, positive relationships, purpose in life and autonomy) and mental illness (diagnosed conditions such as depression, anxiety (sometimes referred to as common mental health problems) as well as schizophrenia and bipolar disorder (sometimes referred to as severe mental illness). Mental disorder is defined as people with diagnosed mental illness, a learning disability or a personality disorder.

Mental well-being is a fundamental component that is important to good health and quality of life. Achieving good mental health and well-being is vital for helping everyone to reach their potential and to lead happy and fulfilled lives. A wide range of determinants affect our emotional health, from our personal relationships and activities to the environment and circumstances within which we live. A lack of mental well-being can underpin many physical diseases, unhealthy lifestyles and social inequalities in health including a reduced life expectancy.

Research and evidence suggests that early intervention approaches can have a positive impact on mental health and well-being. This includes the potential to alleviate the impact of mental disorder and poor well-being, reduce health and social inequalities and help achieve a balance of mental health and physical health.

### Specialist NHS mental health, learning disability, substance misuse and psychology services

This is a secondary specialist service provided by NHS Dumfries and Galloway mental health service directorate that provides assessment and ongoing specialist care for individuals with severe and persistent mental health disorders, including dementia. It comprises of professionals from a range of disciplines who work in partnership with individuals and their carers, statutory, third and independent sectors to deliver comprehensive services to address individual needs.

The service is largely community based and is provided either in an individual's home or in a homely setting. The service provides a range of expertise, including diagnosis, a range of specialist assessments, interventions and support to individuals that promotes independence and encourages individuals to live well with dementia at home, or in a homely setting, for as long as possible.

Where admission for acute mental health assessment and treatment is identified, this is provided at Midpark Hospital, an 85 bedded inpatient mental health unit in Dumfries, with an aim to return individuals back to their community as quickly as possible.


Source: NHS Dumfries and Galloway 2013/14

**Dementia**

The graphic below shows estimates for the number of people with dementia for Dumfries and Galloway as a whole over the next 20 years.


Sources: EuroCoDe 2012

In Wigtownshire the number of people with a confirmed diagnosis of dementia as at 1 January 2014 was 306. However, Europe wide estimates suggest that the overall number living with dementia in the locality is likely to be double this figure.

In 2014, the number of referrals for support after a diagnosis of dementia in Wigtownshire was 56.

Partnership working between statutory services, third and independent sector organisations is key to ensuring good dementia services in the future. In terms of assets available to the people of Wigtownshire, it is notable that Alzheimer Scotland has a dementia resource centre in Stranraer which operates an outreach service across Wigtownshire. This includes providing information for early stage and onset support. In addition, there is currently day care provision in both Stranraer & Newton Stewart, weekend day care in Stranraer, home support, Carer support, and a series of self-help recreational groups designed to promote people living well at home or in a homely setting with dementia.

### 2.5.4 Housing

In Wigtownshire, as throughout Dumfries & Galloway, there is a lack of housing. The majority of people in the area are either homeowners or tenants of private landlords. The locality has a common housing register (CHR), called 'homes 4D&G' in operation. The CHR is a single computer based waiting list which the four major registered social landlords (RSLs) in the region use to register applicants for housing. This system allows the allocation of houses based on a points system.

The following graphic shows the predicted rise in the number of older people living alone:


Source: Census 2011 and National Records Scotland

This increase in older people living alone is important to acknowledge as they will affect how we develop services to help people become more independent and support people living at home, in accordance with the nine national health and well-being outcomes. Developing appropriate housing and care options will be an important consideration in planning for the future. We will need to build upon existing services such as the Care & Repair service, operated by Loreburn Housing Association on behalf of Dumfries and Galloway Council. Adaptations to socially rented housing, to aid independent living, are the responsibility of the landlord following a referral from an occupational therapist. Funding is made available from the Scottish Government annually to each RSL for adaptations.

Fuel poverty is particularly significant in Dumfries and Galloway with much higher rates compared with Scotland as a whole. Fuel poverty is where a household has to spend more than 10% of its income on household fuel (heat, light and power). Throughout Wigtownshire fuel poverty is a major challenge in many areas of the locality 40% or more of households are in fuel poverty.

### 2.5.5 Transport

Wigtownshire has many small communities, making transportation and links throughout the rural areas very important. Without adequate transportation people can experience social isolation and may find it difficult to access services. In the locality only Stranraer has a railway station, which provides direct links to Ayr, Kilmarnock and Glasgow. Bus services provide links between villages but access to a car is important, particularly for people living away from larger settlements. Access to

affordable transportation is essential in Wigtownshire to enable people to utilise services and maximise employment opportunities. Transport can also help to make the best use of available social housing in the locality. The costs associated with transport can also contribute to poverty levels.

### 2.5.6 People delayed in hospital

This is sometimes referred to as 'delayed discharges'. It is when a patient in hospital is clinically ready to leave hospital to go to a more appropriate care setting, or home but is prevented from doing so for a number of reasons. Reducing delays as far as possible is important because when older people are in hospital for a long time, it can affect their independence and reduce their long-term ability to care for themselves.

There are three main reasons for the increase in the number of people who have experience having delayed stays in hospital. These are:

**Social care reasons** - largely due to the lack of available care-at-home and care home capacity and support to allow the patient to return to their own home or a homely setting.

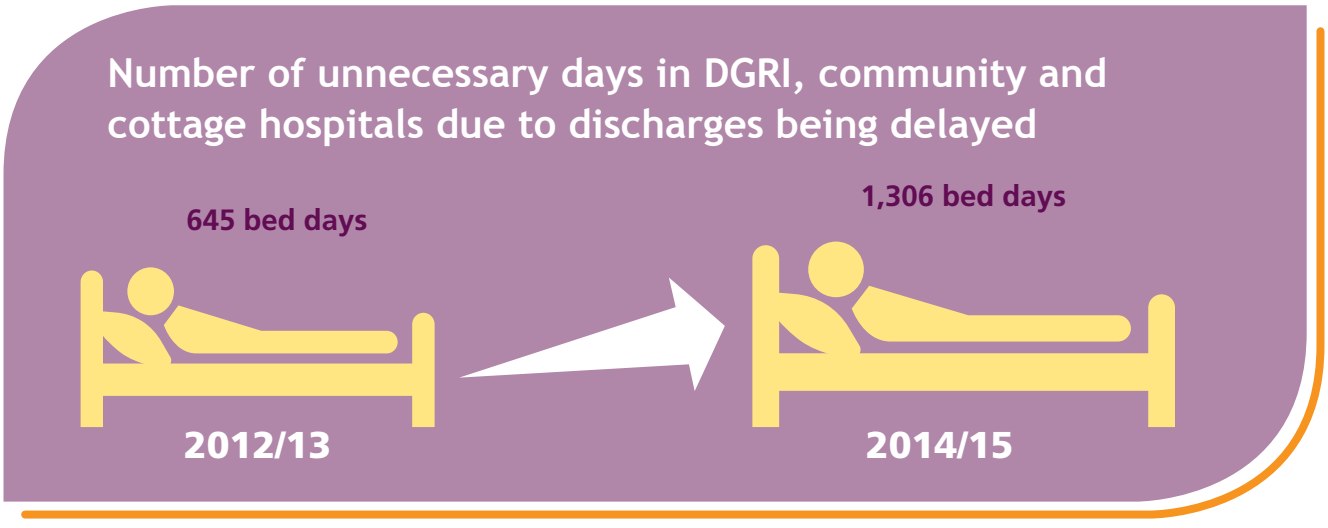
**Health care reasons** - due to the inability to discharge or transfer people to another inpatient facility when necessary and appropriate, either in a different locality or their own locality due to lack of capacity (for example, from DGRI to a cottage hospital).

**Patient related reasons** - mainly due to people not having a power of attorney in place and as such a legal guardian needs to be appointed. Obtaining a guardianship order is a legal process that can take a significant period of time to arrange. There is anecdotal evidence locally suggesting that people are being delayed in hospital for up to nine months while this is arranged.

The national outcomes help focus our attention on solutions which will assist here, such as:

- working in partnership with the third and independent sectors to commission services locally and increase capacity in care at home and care home provision
- ensuring that people in the locality are able to easily access information on how a pre arranged power of attorney document will assist them to remain more in control when or if the need arises

The graphic below shows the increase in the number of bed days (available beds per day) lost to people being delayed in hospital between 2011/12 and 2014/15.




Source: NHS Dumfries and Galloway

### 2.5.7 Prescribing in primary care

Prescribing medication is the most common patient level action that the NHS undertakes 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.

About two thirds of all prescribing costs in Dumfries and Galloway are associated with primary care (GP practices). Approximately 75% of prescriptions issued in primary care are repeat prescriptions which patients take regularly. Repeat prescriptions account for about 80% of primary care prescribing costs.

The healthcare team strive to prescribe high quality, safe, effective and cost-effective treatment where it is indicated, to improve the health of the population. They use national and local guidelines to help them do this.

In Wigtownshire, our prescribing support team work with and support GP practices to review prescribing on an ongoing basis. They do this to check that prescribing is in line with current best practice, but also to ensure that they are making best use of the money spent on medicines locally. Together the team support people in the locality to make informed decisions about their medication. This is important as a significant amount of money is wasted every year by people not taking their medication correctly.

Looking at the costs of prescribing across the locality, one way we can analyse change is by looking at the cost per patient. That means counting anyone who has received one or more prescriptions in the period being considered. This is set out in the graphic below:


Source: PRISMS

Prescribing non-branded medicines where available, reviewing repeat prescriptions and reducing waste are a few examples of how we are tackling the increase in spend on drugs.

## 2.6 Where are we now?

### What is working well?

In Wigtownshire we live in a beautiful part of the world: that goes without saying. We have an active voluntary sector taking forward leisure and community opportunities. We have a long tradition of joint working including working together to find local solutions to local challenges. The NHS Dumfries and Galloway and Dumfries and Galloway Council have developed good working relationships with partner agencies in the third and independent sectors. We have good resources, assets and teams delivering quality services across all sectors. Our staff are committed and go the extra mile, and we consistently support more people in their own homes than elsewhere in the region.

Locally we are open to new approaches, pilots and trying new things. We have good experience of communities developing support and networks working together to strengthen the community. Wigtownshire health and wellbeing partnership was set up locally and membership of this partnership continues to grow. We have a variety of effective third sector organisations working both regionally and within individual communities, to develop and improve people's well-being. We have a large number of Carers providing a substantial amount of care and have active Carer support groups such as those developed through the 'Dumfries and Galloway Carer's centre'. We have disability rights groups, service user advocacy and support groups and networks in mental health services and learning disability services, for example 'DG Voice' and 'Enable services'.

In developing our response to the challenges of joining together health and social care services, we will continue to build on what works well within our local area. The following 'spotlights' describe some of the successful initiatives which we may want to build on.

**Community Resilience: VOICE volunteer training**

Local organisations worked in partnership to plan and deliver a comprehensive training package to support existing volunteers and recruit additional volunteers. 99 volunteers accessed training of which 69 were new volunteers. These volunteers included older people, people with disabilities, young people and people from minority groups. Volunteers trained increased their confidence, skills and knowledge to enable them to start or continue volunteering in activities such as sports coaching. New groups have been set up and are being run by volunteers who have attended the training.

**Supporting Carers - Wigtownshire Carers service**

The prince's royal trust project in Wigtownshire offers Carers a wide and varied calendar of events as well as practical, emotional support and information, relevant to their caring role. In a 3 month period in 2015 there were a total of 31 groups held in Wigtownshire and 156 Carers attended these meetings. The Wigtownshire Carers support worker also saw 50 Carers on an individual basis for support and advice. The service also provides one to one support and groups for young Carers. Carer support activities include organised trips, access to training and the chance to meet up on a regular basis.

**Promoting & maintaining independence: mature drivers**

The mature driver scheme was run in west Wigtownshire and aimed to give people over the age of 70 the guidance and support they need to keep driving safely for longer. The scheme consisted of a driver evaluation with a local driving instructor, further refresher lessons if required and an information session. Having a driving evaluation with a professional early enough can allow for faults to be corrected and driving ability raised to a safer and more satisfactory standard. The scheme had an excellent uptake and the feedback from participants was extremely positive with many feeling that it would help them stay independent for longer.

**Preparing for emergencies - community resilience teams**

Volunteer community resilience teams have been set up to support. communities to become more resilient and better prepared for emergency situations such as severe flooding, snow and power outages. 29 teams have been established so far. Volunteers help to check on vulnerable people, provide hot food to those in need and relay key information to the council and emergency services to help ensure an effective response where required. Funding has been secured for many teams to purchase equipment such as shovels, sand bags and generators. Four resilience "young teams" have been established in Whithorn, Port William, Garlieston and Wigtown.

**Building on multidisciplinary and person-centred care planning**

In health and social care we have been working in an integrated manner for a number of years. For example, when a person is in hospital, input to the persons care plan is sought from everyone involved in the person's care. This includes hospital, volunteers, neighbours and friends (where appropriate), social workers, community nurses, short term augmented reablement team, general practitioners, mental health services, agencies and groups (i.e. Coronation and Riverside Day Centre) and most importantly the person and their family. It is this type of partnership working which health and social care integration should build on, not just when a person is in hospital but at every point of a person's care.

**Social prescribing (known locally as healthy connections Wigtownshire)**

A formal process for primary care services to refer patients with social, emotional or practical needs to a variety of local non-clinical services, which are often provided by the third and independent sectors. Social prescribing supports people to access an increased range of practical services, encourages and supports self-care, supports more appropriate use of GP time and reduces frequent practice attendance. The benefits for patients include, allowing time to be heard, improved health and well-being, improved self-esteem and confidence, health and lifestyle change and increased specialised local knowledge.

## Mr and Mrs C's story

**Central heating system – Housing support**

Mr and Mrs C are both in their 90s and have lived in their detached, pre-fabricated bungalow for the past 30 years having chosen the property as their retirement home. The bungalow was heated by a back boiler and coal fire. In June 2015, their chimney sweep was carrying out a routine clean of the chimney when he noticed that the back boiler was leaking. He condemned the boiler and, having concerns for his clients' welfare with no heating and limited hot water, contacted the care & repair manager for Dumfries & Galloway.

He then referred the case to the community liaison officer of home energy Scotland (HES), to carry out a visit and assess if HES could provide any assistance. The visit was carried out promptly and the office determined the couple required urgent assistance and should be treated as an occupational therapy (OT) referral as opposed to waiting for the new tranche of HES funding to be released in September.

The formal OT referral was received by care & repair in July. In discussion with the couple, it was agreed that the coal fire needed to be removed and an electric heating system installed to replace it. The works were instructed to a local firm in September and completed in October, just 4 months after the chimney sweep's initial visit.

Both Mr and Mrs C are delighted with their new electric heating system and are finding it much easier and cleaner to use than their former coal fire. The works were completed within 1 day and the installer visited again a few days later to ensure all was working correctly.

Thanks to promotional partnership work through the hub – your community action centre's winter warmth for older people project, the chimney sweep was aware of care & repair and was able to make the referral. Had this not been done, Mr and Mrs C may have waited some time before any assistance was forthcoming. As it was, this case demonstrates exemplar inter-agency working with involvement and coordination from the chimney sweep, home energy Scotland, the occupational therapy service, care & repair and the local contractor.

# 3. People and finances

### 3.1 Who makes up the locality management team?

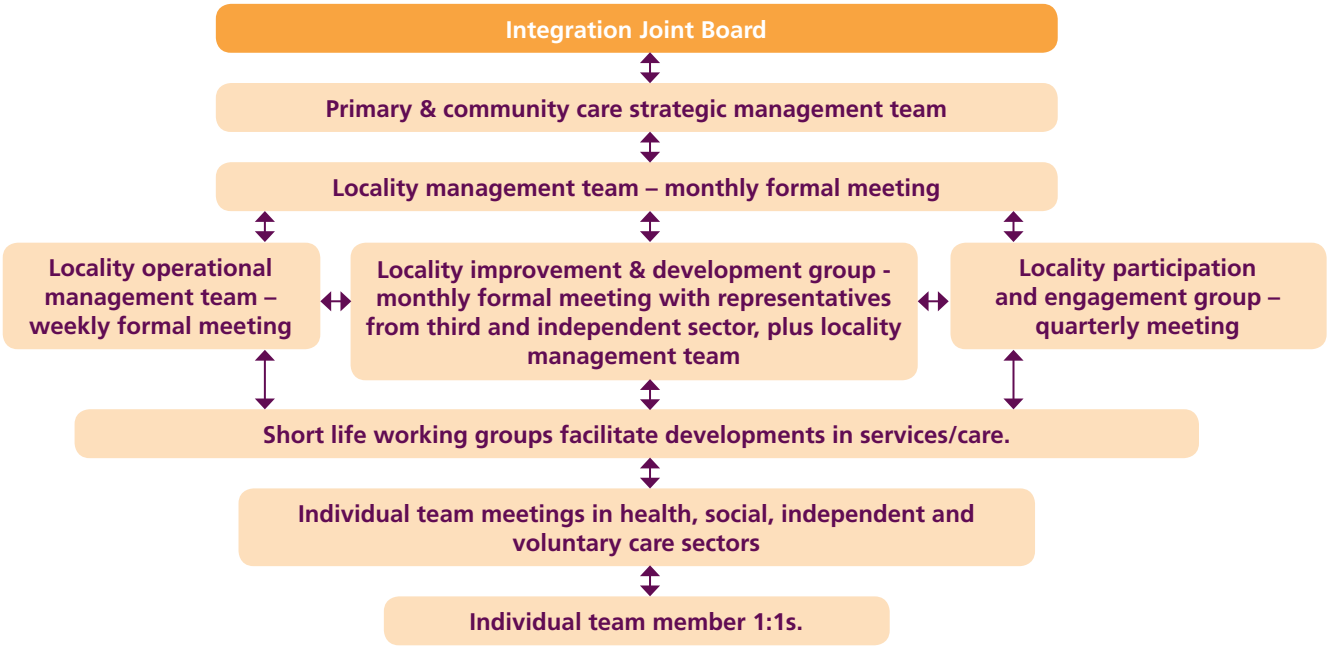
The Wigtownshire locality management team is made up of the locality manager, GP clinical lead, social work manager, nurse manager, public health practitioner, divisional finance manager, workforce business and organisational development partners, commissioning representative, regional service representatives (i.e. mental health, learning disabilities, allied health professionals) and heads of local services.

A wide range of staff and volunteers work across Wigtownshire in the NHS, council, independent and third sectors. They will all be involved through formal links in the services with the locality management team

It is essential that not only staff are involved but also that people living in the locality have their say about how the locality is meeting the needs of individuals. To that end the graphic below sets out the current reporting line of how communications will flow up and down from the Integration Joint Board, through the strategic management team, through the Wigtownshire locality teams to each individual living or working in the locality. This structure is also being developed in the other three localities.

Membership terms of reference, agendas and minutes of all meetings will be available to anyone who wants to see them and can be viewed at www.dg-change.org.uk.

**The Wigtownshire locality communication and reporting lines**




### 3.2 How is the money spent?

The budget in 2015/2016 for the Dumfries and Galloway partnership is £296.1 million. You can find more details of the overall finance plan in Annexe 3 of the strategic plan for Dumfries and Galloway. A total of £109.8 million of resources has been set aside for the four localities of Annandale and Eskdale, Wigtownshire, Stewartry and Nithsdale. The current budget of £24.84 million for Wigtownshire is summarised in table 3.

**Table 3: Dumfries and Galloway health and social care Wigtownshire yearly budget**

| Area | Pay (wages) £000 | Non pay £000 | Income £000 | Total £000 |
|---|---|---|---|---|
| **Council services** | | | | |
| Assessment & fieldwork | 709 | 26 | (46) | 689 |
| Day care | 0 | 224 | 0 | 224 |
| Domiciliary care | 0 | 5,913 | (345) | 5,568 |
| Meals on wheels | 0 | 6 | (5) | 1 |
| Nursing care | 0 | 722 | (261) | 461 |
| Occupational therapy | 180 | 114 | 0 | 294 |
| Residential care | 0 | 4,195 | (1,503) | 2,692 |
| | **889** | **11,200** | **(2,160)** | **9,929** |
| **NHS services** | | | | |
| Community hospitals | 6,458 | 703 | (66) | 7,095 |
| Community nursing | 1,208 | 150 | (19) | 1,339 |
| Health centres & clinics | 76 | 52 | (162) | (34) |
| Management & admin | 207 | 31 | 0 | 238 |
| Prescribing support | 66 | 6,114 | 0 | 6,180 |
| Public health | 85 | 10 | 0 | 95 |
| | **8,100** | **7,060** | **(247)** | **14,913** |
| **Total** | **8,989** | **18,260** | **(2,407)** | **24,842** |

The chief officer and chief finance officer of the Integration Joint Board will review the budget for Wigtownshire each year to make sure that the overall finance plan is able to deal with:

- changes in what we do
- increases in costs
- efficiency savings
- performance against outcomes
- legal and government requirements

In light of the twin pressures of rising demand and restricted resources, a major challenge is to improve our understanding of how resources are used in the locality to meet changing needs and priorities. At the same time, we will need to take account of the following important challenges and risks.

- As an integrated partnership we will need to contain costs within existing resources and continue to make efficiency savings year on year. For NHS services this is likely to continue to be around 5% each year for the foreseeable future, with different (although similar) expectations from council budgets.
- The main risks highlighted in the NHS budgets include the costs of keeping up medical staffing levels (both in acute hospital and primary care), GP prescribing, making savings, increased activity through the acute system and maintaining access and other performance targets.

- The main risks for social-work budgets include the effect of new legislation, including that related to self-directed support and the related expectations of people, pressures increasing the number of people needing care, (particularly older people but also people with learning disabilities and physical disabilities), also growing pressures on price levels charged by care providers and the effect of capacity issues, particularly in rural parts of the region.

As well as the locality budgets, a further budget of £52.1 million for strategic primary care service is currently held at a regional level for the following services.

### Dumfries and Galloway health and social care regional yearly budget

The locality management team in Wigtownshire will work with local staff, organisations and people to review how the current range of services are delivered and paid for in the locality meet the needs of local people. The team will identify how we can best use local and region wide health, social care and local community resources to promote the health and well-being of the people of Wigtownshire.

| Area | Pay (Wages) £000 | Non-pay £000 | Income £000 | Total £000 |
|---|---|---|---|---|
| **Council services** | | | | |
| Assessment and fieldwork | 310 | 142 | (36) | 416 |
| Care call | 0 | 40 | 0 | 40 |
| Community support | 882 | 17 | 0 | 899 |
| Day care | 0 | 169 | (45) | 124 |
| Day care - ARC | 2,114 | 408 | (27) | 2,495 |
| In-house supported accommodation | 624 | 101 | 0 | 725 |
| Occupational therapy | 96 | 34 | 0 | 130 |
| Ordinary residence L.D. | 0 | 0 | 0 | 0 |
| Resettlement | 0 | 5,850 | (6,245) | (395) |
| Resource transfer | 0 | 0 | (3,584) | (3,584) |
| Sensory impairment | 339 | 45 | (16) | 368 |
| Short break | 45 | 10 | 0 | 55 |
| Women's and children's directorate | 0 | 2,169 | (61) | 2,108 |
| Non social work services | | 8,500 | | 8,500 |
| | **4,410** | **17,485** | **(10,014)** | **11,881** |
| **NHS services** | | | | |
| Management and admin | 545 | 9 | (6) | 548 |
| Marie Curie nursing | 0 | 140 | 0 | 140 |
| Regional prescribing | 0 | 56 | 0 | 56 |
| Stars | 683 | 82 | (10) | 755 |
| Primary medical services | 385 | 40,261 | (1,885) | 38,761 |
| | **1,613** | **40,548** | **(1,901)** | **40,260** |
| **Total** | **6,023** | **58,033** | **(11,915)** | **52,141** |

# 4. What are people in the locality telling us?

## 4.1 Consultations and surveys

### Key messages from local consultations

A number of key consultation exercises have been carried out in Wigtownshire in recent years.

These have included surveys under the "Putting You First" programme, community learning and development surveys, building healthy communities consultations, a community nursing survey, Carer consultation linked to the Carers strategy, staff surveys and the mental health day services consultation. The most recent consultation was the consultation on the draft version of this locality plan (October – December 2015). Due to the significance of this piece of work in forming this version of the locality plan, the findings of this consultation are reported in further detail below. Local views expressed across all these consultations suggest that people in Wigtownshire very much value and want better access to local services and want access to traditional services. For example people tell us they want better access to services , to GPs, emergency departments, podiatry, social care, residential care and to respite care for Carers. There is also clear recognition of the importance of local communities, individuals and groups in supporting health and well-being. Some of the key messages and findings are outlined here:

### Community Consultation

A community consultation exercise in relation to health and social care services was carried out in 2014. The results indicate that people want easier access to out of hours services, better knowledge of who to contact, greater access to GPs, awareness of available equipment and better access to transport. The survey found that many people in the locality still have a preference for traditional services such as face to face contact with a GP rather than options such as e-mail, live chat or video calls.

This survey asked about the types of service people felt would help them stay at home for longer. The top five responses were podiatry, physiotherapy, transport, help with food shopping/delivery and personal care. A key theme of the consultation was the importance of keeping people moving and able to keep up with day to day tasks. Another was the need for more information of who to contact when in need, especially when it is out of hours.

### Mental health and well-being

A 2014 consultation on ways of improving people's mental health and well-being found that only 20% were about changes to services and 60% were about developing confidence and self-esteem through better support and understanding. Amongst the responses were important key messages about awareness and acceptance by others.

> 'the development of integration needed to go hand in hand with the development of the locality in general. That the health and well-being of the residents of Wigtownshire was directly linked to the health and well-being of the place itself, in terms of opportunities and a sense of community'
>
> Wigtownshire health and well-being partnership, 2014

### Accident and emergency services survey

In 2014 a small survey of people attending the emergency department at Galloway Community Hospital found that over two thirds attended without exploring any other service. Half of those who had not tried another service went directly to the emergency department because they thought it would be quicker or because they knew it would be open. The survey results show that education is still needed around the role and purpose of emergency departments and that people require more information about out of hours and alternative services.

### Summary of key challenges and themes from all consultations

Key challenges and common themes have emerged from the consultations to date including the consultation of the draft health and social care locality plan. These include the following (not listed in any order of priority or importance):

- improving access to easy read information about services and supports
- improving communication, working and information sharing between services and sectors
- enhancing availability of care at home support
- supporting people in the locality to have more responsibility, choice and control of their own health and well-being
- improving support for Carers, including better provision for short breaks
- enhancing access to health services, such as GPs and consultant appointments
- recognising the importance of activity and social contact to prevent isolation: Supporting day care facilities
- enhancing education, training and employment opportunities for young people
- addressing problems in accessing transport to improve health and well-being (social transport and transport for health)
- accepting that the increased rurality of Wigtownshire, in comparison to the other localities leads to an enhanced challenge to support and develop all of the above

### Wigtownshire health and social care integration draft locality plan consultation

Consultation on the draft locality plan was undertaken between October and December 2015.

The two questions asked throughout the consultation were:

1. Do you think we have missed anything in the plan that you feel is important? If yes, what is missing?
2. How do you think we can all work together better to make sure people receive the support they need to manage their personal health and well-being?

Over 400 individual comments were returned to the locality team either directly at one of the public or group events or directly fed back via the website. These comments have now all been analysed and have informed the development of both this final version of the locality plan as well as the Wigtownshire health and social care integration delivery plan.

Suggestions were mainly related to there being no mention of specific services and the impact that these services have on the individual's health and well-being, services such as day care centres and specific voluntary organisations. Furthermore, there was concern that the plan does not set out in enough detail what we are going to do.

That the many comments received reiterated the key challenges set out by the locality management team in Wigtownshire (as listed below) was reassuring. Ensuring that the challenges set out are supported by the people of Wigtownshire gives us confidence in taking forward the actions required to begin to address them.

The consultation provides evidence that the people of Wigtownshire feel that the following aspects are important to support the health and well-being of the locality:

- further education opportunities
- sport and music opportunities
- jobs
- rural community transport
- development of the tourism industry
- better housing
- better access to information and support, and finally
- better partnership working of the teams who provide care and support

**Key issues and suggestions for change**

An overarching comment of significant importance, received during our consultation was that: 'The partnership must accept the increased rurality of Wigtownshire, in comparison to the other localities, as this increases the challenges faced'. Building upon that principle, the following are a flavour of the comments and ideas we have had from people through our consultation. They are presented here to demonstrate what people are concerned about and the ideas about how things are being taken into account in the ongoing development of the Wigtownshire health and social care integration delivery plan.

| Challenge | Comments and suggestions received from the public during the consultation on the draft Wigtownshire locality plan |
|---|---|
| Improving access to easy read information about services and supports | 'The need to make everyone aware of what is going on. Too many people do not know.'<br><br>'Use language we all understand.'<br><br>'Information sharing is key, it empowers people.'<br><br>'Unless you engage at the right level, you will not get the people/communities to take part.'<br><br>'Needs more discussions with the public.'<br><br>'A booklet to let everyone know what's out there.'<br><br>'As far as the public is concerned, it may mean pulling the plug on services with a low attendance (4 or 5 people) in order to use the money/resources for services with more patients/people - this will upset quite a lot of people as they won't know or understand the reasons why.'<br><br>'It would help if there was one telephone number to give information when help is needed suddenly. I found it difficult to find out how to obtain assistance when I was caring for my husband especially as his mobility decreased.' |
| Improving communication, working and information sharing between services and sectors | 'Communication between agencies and service users.'<br><br>'Sharing Information and supporting ideas. Good communication with different parts of multi disciplinary team.'<br><br>'Better links with the police.'<br><br>'Involve all partners fire/police - remove duplication.'<br><br>'Proper integration of the 3rd and voluntary sector and proper funding of that process.' |
| Enhancing availability of care at home support | 'Not enough carers.'<br><br>'Within the independent/voluntary sector, who is responsible to ensure staff have received the immunisation they need to carry out their role (for example a carer)?'<br><br>'Telehealth to support independent living.'<br><br>'Home Carers: Provide a suitable rota which would allow more caring time and less travelling - home carers are complaining to their clients about the amount of travelling they have to do between clients, especially in rural areas as they are given clients who are nowhere near each other and they spend the majority of their times in their car rather than with the clients. The person making up the rota seem geographically unaware of the rural area. Home Carers also feel they are under pressure, time wise, to do as many clients as possible in a very short time - this obviously has a big effect on the quality service the clients are receiving. Example of one 93 year old lady who is receiving daily home care. When a care plan was set up, she was assured the home carers would be regular ones. This has not been the case and it is proving very distressing as she feels vulnerable and uncomfortable to be showered by someone unfamiliar everyday.' |

| Challenge | Comments and suggestions received from the public during the consultation on the draft Wigtownshire locality plan |
|---|---|
| Supporting people in the locality to have more responsibility, choice and control of their own health and well-being | 'I think people need to be encouraged to do more for themselves if fit and able.'<br><br>'People could do more for themselves if they are able to do so rather than relying on staff and doctors.'<br><br>'Needs serious conversations.'<br><br>'What is missing? More focus on prevention and reducing people coming into the system.'<br><br>'Educate young people to be less dependent.' |
| Improving support for carers, including better provision for short breaks | "…It helps to gets you out and meet people, a chance to share experiences, to know you are not alone."<br><br>"Provides a good chance to speak with a member of staff and find out what support is available."<br><br>"The groups reduce stress and lift your spirits".<br><br>"Better planned programme of respite for carers, care and medical treatment closer to home." |
| Enhancing access to health services, such as GPs and Consultant appointments | "Elimination of needless trips to DGRI from rural areas"<br><br>"We require closer links to Ayrshire and Glasgow for health care - especially for treatment and surgery for the DG9 area. The travelling to Edinburgh is ridiculous when there are shorter options especially when you are ill and in severe pain. NHS Scotland requires to look at boundaries and understand real patient needs and care in future and forget postcodes".<br><br>"I complained … about the 8.5 hours taken to attend a ten minute interview in DGRI. I feel that I should write to let you know that last week my wife and I had a very different experience ….with an interview with Dumfries Doctor. I accompanied my wife to the local hospital where she had a Tele medicine interview, using a TV camera and screen. This took place over a few minutes – an enormous improvement over my previous experience."<br><br>"Being remote and rural makes access to health/ social provision very difficult, young chronic sick – very limited."<br><br>"Feel that we get left out in this area for health and advice." |

| Challenge | Comments and suggestions received from the public during the consultation on the draft Wigtownshire locality plan |
|---|---|
| Recognising the importance of activity and social contact to prevent isolation. Supporting day care facilities | 'Inclusion of leisure and sport representatives who can offer opportunities to be physically active which can prevent or minimise effects of some conditions.'<br><br>'Never heard anything about day centre mentioned.'<br><br>'If it wasn't for the day centre that I attend my health would deteriorate and I would not feel very happy.'<br><br>'The day centres have not been considered in the plan. The centre do good work, they should be supported.'<br><br>'There is no mention of the Newton Stewart and Stranraer Day centres - these keep people active mentally and physically and also keep an eye on the health or determination of regular attendees. Possibly saving the NHS money in the long run.'<br><br>'You have missed the day centre, provides hearty food to help elderly people get well. Being together makes you feel better. The day centre gives you that togetherness and cheerfulness.'<br><br>"….visit day centre 3 times a week, would never get out otherwise". |
| Enhancing education, training and employment opportunities for young people | 'Can't recruit professionals to come and work in our areas, especially the young ones.'<br><br>'Modern Apprenticeships - Could there be more Modern Apprenticeships available, for example in Health Care?'<br><br>'Children/young people - We should aspire for our children to have more opportunities. More work should be done in schools, especially school leavers, taking responsibility for their own health.' |
| Addressing problems in accessing transport to improve health and well-being (social transport and transport for health). | 'Transport is a big issue.'<br><br>'We need to work more closely with the Job centres/job clubs to ensure that what is being asked of the unemployed people does not have an effect on their health and well being - for example being asked to travel to Stranraer twice a week at present and pay for their transport out of the benefit they receive. People have been going to their GPs and asking for a letter to support their case.'<br><br>'Example of one patient who lives 3 miles away from Stranraer and uses public transport to come into town. One of the buses with the busiest occupancy, being around 2pm, has been stopped since they have moved onto 'the winter time Timetables.'<br><br>'Buses are not linked to travel to Dumfries Hospital.'<br><br>'Trains - the one which students used to travel to college is no longer available - better train services required.'<br><br>'Community Transport: Possibly Crowd Funded? It would help enable those who live in remote rural areas across more of the community services.' |

# 5. What do we need to do?

As outlined in this plan the Scottish Government has set out clear expectations about what changes it wants to achieve under health and social care integration and in particular what difference this will make to people's lives. In this section we set out key challenges and our way forward under each of the nine national health and well-being outcomes. We address each outcome in turn, inform of what the Dumfries and Galloway priority areas of focus are for the region, identify the key issues around this for Wigtownshire, outline our commitment to take this forward and offer some examples of work already underway or being planned. The commitments and activities outlined in each section about what we intend to do are pitched at a high level in this document. The Wigtownshire health and social care integration delivery plan which supports the locality plan will set out in more detail what we intend to do and how. It will highlight and provide further detailed information regarding the projects and actions required to address the challenges and ensure that the commitments are fulfilled.

| National Outcome | Dumfries & Galloway priority areas of focus | Wigtownshire locality challenges | Our commitments In Wigtownshire | Work already underway or planned |
|---|---|---|---|---|
| People are able to look after and improve their own health and well-being and live in good health for longer | Enabling people to have more choice and control<br><br>Making the most of well-being | We know from local information and feedback from staff and people living in our locality that many people of all ages in our towns and rural communities feel isolated and alone.<br><br>We have a high incidence of unemployment, a lack of housing and varying levels of deprivation.<br><br>We know we have challenges locally around supporting people to develop and maintain healthy lifestyles to stop the rising trends in obesity and related illnesses.<br><br>We have supportive communities with community clubs, groups and local resources to help people to look after their own health and well-being.<br><br>We have formal initiatives and screening programmes aimed at preventing ill health.<br><br>There is not enough information available about what people can do for themselves or what they could do to support their own health and well-being.<br><br>People often depend on services more than they need to.<br><br>People's expectations of what services can provide and the demand on local services is more than we can provide locally.<br><br>We need to develop and use alternative ways to improve our health and well-being. | **We will:**<br>Develop information and make this information accessible to people and relevant to their own circumstances so that they can take responsibility for, and be in control of, their own health and well-being.<br><br>Actively develop alternatives to traditional services to support people to maintain their health and well-being - both physical health and mental well-being.<br><br>Support people to develop their knowledge and skills to lead healthier lifestyles and be more in control of their own health and well-being.<br><br>Continue to deliver and build on existing initiatives that promote health and well-being such as let's cook, walking groups, living life to the full and mindfulness.<br><br>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). | Galloway strollers<br><br>Healthy connections<br><br>Person centred care planning<br><br>Building health communities<br><br>Grounds for better health<br><br>Smoking matters<br><br>CPR for feet<br><br>Mindfulness training<br><br>Recovery cafe |

| National Outcome | Dumfries & Galloway priority areas of focus | Wigtownshire locality challenges | Our commitments In Wigtownshire | Work already underway or planned |
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| People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as resonable practicable, independently and at home or in a homely setting in their community. | Developing and strengthening communities<br><br>Making the most of well-being<br><br>Shifting the focus from institutional care to home and community based services | In Wigtownshire we know we have significant numbers of people with chronic health conditions including chronic and enduring mental illness.<br><br>We have people with learning disabilities and autistic spectrum disorders many of whom have complex health and social care needs.<br><br>We know that people are living longer with chronic illness and long term conditions and with this increasing dependence on services.<br><br>We have an aging population and the number of people with dementia is continuously rising.<br><br>Within our services and in our communities we have a culture of doing things for people instead of supporting people to do things for themselves.<br><br>We have increasing demand on local services and a reducing capacity to meet demand. Our care at home services are struggling to meet local needs and our local care homes have limited vacancies. We do not have enough suitable housing options to meet people's needs.<br><br>We have increasing challenges with provision of GP services, including several vacancies in local GP practices.<br><br>We will need to look at how primary care is provided locally - it may not be possible to sustain some of our most isolated health centres with the worsening GP recruitment crisis. | **We will:**<br>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.<br><br>Work with all partners to understand local current and future housing needs so that we can develop a full range of suitable housing options.<br><br>Develop our use of assistive technology and other aids and adaptations to support people to be as independent as possible.<br><br>Ensure that any operational service improvement or development is outcome focussed (Outcome 3: operational delivery, Dumfries and Galloway partnership improvement action plan).<br><br>We will continue to explore ways of ensuring that our care at home and care home provision meets local demand.<br><br>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 GPs. However it is accepted that this alone will not solve the problem, more will be required.<br><br>Work together to create "dementia friendly communities". | Handy van service<br><br>Care and repair service<br><br>Food train<br><br>Befriending<br><br>Community learning & development training.<br><br>Community respiratory early warning score<br><br>GP practice television<br><br>Stranraer reablement project<br><br>Chair based exercise<br><br>Tai-chi<br><br>Advanced nurse practitioner modelling<br><br>Housing needs assessment |

| National Outcome | Dumfries & Galloway priority areas of focus | Wigtownshire locality challenges | Our commitments In Wigtownshire | Work already underway or planned |
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| People who use health and social care services have positive experiences of those services, and have their dignity respected. | Enabling people to have more choice and control<br><br>Maintaining safe, high quality care and protecting vulnerable adults<br><br>Working effectively and efficiently | We have committed staff working in services across the locality who often go the extra mile to ensure people have very positive experiences of service.<br><br>However we do not currently have a consistent approach to evaluating services to see what works well for people and what could be better. | **We will:**<br>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. | Locality participation and engagement group<br><br>Public involvement panel (PIP) |
| Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services | Enabling people to have more choice and control<br><br>Making the most of well-being<br><br>Working effectively and efficiently | Ensuring services are person-centred, supporting choice and the person being in control is now expected of staff working in health and social care services.<br><br>However there is still a local challenge to ensure these approaches are consistently reflected in practice across our services.<br><br>There is an ongoing challenge around taking forward a consistent approach to personalised approach to health and social care within all sectors. | **We will:**<br>Improve how we monitor, evaluate and manage performance across the whole partnership. (Outcome 1: performance management: D&G partnership improvement action plan)<br><br>Fully implement the principles, values and practice of self-directed support. We will focus on keeping the person at the centre and in control as far as possible of their own of care and support. For example, develop approaches to planning for the future with forward looking care plans and supported self-assessment and care and support plans.<br><br>Continue to develop staff across the organisation to support people to be in control and to focus on outcomes for people.<br><br>We will build on training and other outcomes focussed training initiatives already underway.<br><br>Develop approaches that will evaluate and record outcomes achieved in practice. | Development of performance dashboard<br><br>Roll out of outcome star<br><br>Good conversations training<br><br>Richter training<br><br>Reablement training<br><br>Cultural diagnostic study<br><br>Development of governance arrangements |

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| Health and social care services contribute to reducing health inequalities | Reducing health inequalities | In Wigtownshire we have a significant number of people living in some of the most deprived areas of the country.<br><br>We have significant issues with low levels of education attainment, high levels of unemployment and low levels of income.<br><br>The welfare reform is beginning to have an impact on local people and we have local challenges around smoking, diets, drugs and alcohol.<br><br>Locally we have to begin to address the key factors that affect health inequalities – education, training, employment, incomes and housing.<br><br>We need to ensure our resources are focussed on those who need it the most. | **We will:**<br><br>Through the provision of appropriate information, support people to take more control of their own health and well-being.<br><br>Begin to set out priorities around addressing health inequalities and seek opportunities to work with other partners across sectors.<br><br>Begin to address key factors affecting health inequalities, such as employment, education and housing.<br><br>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. | Recruitment<br><br>Workforce development<br><br>Modern apprenticeships<br><br>Work placements<br><br>Volunteer drivers<br><br>Pharmacy technician training<br><br>Care at home review<br><br>Care home review |
| People who provide unpaid care are supported to look after their own health and well-being, including to reduce any negative impact of their caring role on their own health and well-being | Supporting Carers | We have a large number of people who identify themselves as carers yet we have contact with only a small percentage of these.<br><br>We are not yet consistently identifying carers who may be in need of advice or assistance to support them in their caring role.<br><br>Carers do not have enough access to information and advice. There are particular challenges around local access to short breaks. | **We will:**<br><br>Identify current and potential Carers as early as possible.<br><br>Listen to the views of Carers and take appropriate action in response.<br><br>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.<br><br>Identify and promote local services and resources to help improve the quality of life of Carers.<br><br>Continue to raise "Carer awareness" across our workforce following the equal partners in care core principles. | Carers strategy<br><br>Carer assessments<br><br>Link worker scoping<br><br>Learning needs analysis of Carers |

| National Outcome | Dumfries & Galloway priority areas of focus | Wigtownshire locality challenges | Our commitments In Wigtownshire | Work already underway or planned |
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| People using health and social care services are safe from harm. | Maintaining safe, high-quality care and protect vulnerable adults<br><br>Working effectively and efficiently | Keeping adults safe is everyone's business. For organisations delivering health and social care it is essential that we continue to improve the safety of the services we deliver. The patient safety programme in health services and multi-agency adult support and protection procedures are some of the measures in place to keep people who use services safe. There is an ongoing challenge across services about ensuring consistency in practice in implementing these and other safety approaches. There is a need to ensure families, neighbours and communities are involved in supporting people to be safe in their own homes and communities. | **We will:**<br><br>Promote approaches that help people to be more knowledgeable and aware of their own personal safety and that of others.<br><br>Ensure that all staff are trained appropriate to their role in assessing a person's capacity and assessing and managing risks to the person.<br><br>Ensure that all partners are trained in and consistently work to agreed multi-agency adult support and protection procedures.<br><br>Ensure that we learn from adverse incidents of all kinds across services. | Emergency planning and resiliency<br><br>Cold calling awareness<br><br>Adult support and protection training & awareness raising<br><br>Mature driver scheme<br><br>Medication reconciliation<br><br>Falls projects<br><br>Out of hours review<br><br>Fire home safety checks |
| 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 | Integrating ways of working<br><br>Making the best use of technology | In Wigtownshire we have increasing demands on all of our services. Staff across services are having to do more work with fewer resources. There are issues about pay and conditions that impact particularly on staff working with care providers. We have significant problems locally recruiting staff to practitioner and managerial jobs across the sectors. We are at critical levels of staffing in key positions such as in GP practices, social work and social care provider services. We are losing our young people from the local community with many leaving for further education or employment. There is evidence from staff surveys and from staff turnover that staff do not feel supported and valued in the work that they do. | **We will:**<br><br>Whilst working towards implementation and improvement on all outcomes of the Dumfries and Galloway partnership improvement action plan, specifically we will:<br><br>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.<br><br>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.<br><br>Explore opportunities to address issues about recruitment and retention including how to make care more attractive as a career choice for local people. | GP support workers<br><br>Health and wellbeing partnership<br><br>Improvement and development group<br><br>Formalised governance arrangements<br><br>Individual staff meetings |

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| Resources are used effectively and efficiently in the provision of health and social care services | Integrated ways of working<br><br>Working effectively and efficiently<br><br>Shifting the focus from institutional care to home and community-based services<br><br>Making the best use of technology | The current financial climate means that resources in Wigtownshire are stretched and we have to meet increasing health and social care demand with reducing resources. We know that in Wigtownshire there is an ever increasing demand on formal health and social care services across NHS, social work services and care providers. Many of our resources are stretched to breaking point and this is evidenced in delayed discharges from hospitals, delays in the provision of care and support in people's own homes and a lack of capacity in local care homes.<br><br>This is further evidenced in the cost and volume of medications prescribed. We have a current shortage of GPs and care staff and we have difficulty recruiting staff to a range of key posts. We need to make better use of the resources that we have locally.<br><br>We need to ensure that the services we provide are targeted at those who need them most and find new and creative ways of meeting needs in health and social care. There are local challenges around current expectations of services. No single agency can address the problems it is experiencing in isolation from other services and from local communities. | **We will:**<br><br>Work in partnership across sectors and with local communities to develop alternative models of care and support.<br><br>Develop a shared understanding of each other's roles and responsibilities across the different sectors including the voluntary sector and community groups and how resources, people and finance are currently used.<br><br>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.<br><br>Actively support people to make the best choices to use services and products, supplied by the partnership, effectively and efficiently.<br><br>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). | Workforce review<br><br>Locality baseline review<br><br>Community nursing review<br><br>Electronic records/ e-pen usage<br><br>Link worker review<br><br>Video conferencing<br><br>TEC hub |

# 6 How will we know we are getting there?

### 6.1 Measuring performance

To help us monitor progress of this plan, we will develop a performance framework to make sure we are taking a consistent approach to measuring performance across the whole partnership. We will develop a series of joint measures alongside activity and financial information and these will apply across the partnership, including the third and independent sectors.

The nine national health and well-being outcomes set out on page 5 along with the 'we will' statements in both the strategic plan and this locality plan, will form the basis for accountability. The framework will make sure there are clear links between the nine outcomes, the Dumfries and Galloway single outcome agreement, the strategic plan, this locality plan as well as service delivery plans such as The Wigtownshire Health and social care integration delivery plan.

Measures will also include targets which either the NHS or the council currently report against relating to services under the Integration Joint Board.

Not all of the information is currently available at a locality level, but we will address this as we move forward.

The Dumfries and Galloway Integration Joint Board will be responsible for checking this performance information. It has also been agreed that, in each area, an area committee will check on the delivery of the locality plans. Over time, this information will allow the Integration Joint Board to see what effect the approach to integrating services is having, particularly for those who use services and support. They will also put together a performance report each year as required by law.

Best evidence will be used to make sure we measure the things that matter to those using services and Carers, as well as front-line staff. We will use information on quality as well as quantity and include feedback from those using services, service audits and support and care record systems. We will not simply use this information to monitor how we are keeping to targets but to also improve services.

It will be important that all staff members understand their own responsibility for making sure high quality information is available for reporting on performance, and how this is relevant to the quality of care and support they provide.

Being clear around progress and achievement should be something everyone can be aware of. Teams should have the information they need to know how they are doing, when to ask for help and when to share good practice and successful approaches. Developing strong relationships and team working based on a shared vision and shared values will support this. This is what this Locality Plan is all about.

You can find more detailed information on the performance management framework at **www.dg-change.org.uk/Strategic-Plan** in annex 5 of the strategic plan.

**If you would like some help understanding this or need it in another format or language please contact 030 33 33 3000**