DUMFRIES AND GALLOWAY
INTEGRATION JOINT BOARD

PERFORMANCE MANAGEMENT

AREA COMMITTEE REPORT

DUMFRIES AND GALLOWAY
Health and Social Care

Annandale & Eskdale

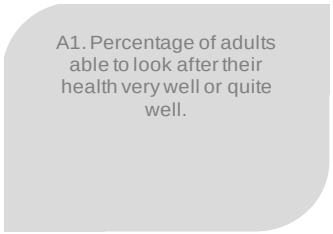
April 2017 - December 2017

Contents

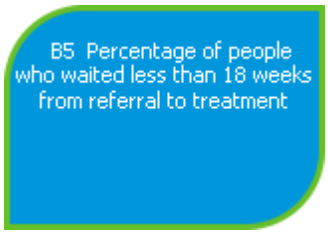
Document Features

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

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



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



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

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

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

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

National Outcomes

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

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

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

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

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

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

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

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

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

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

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

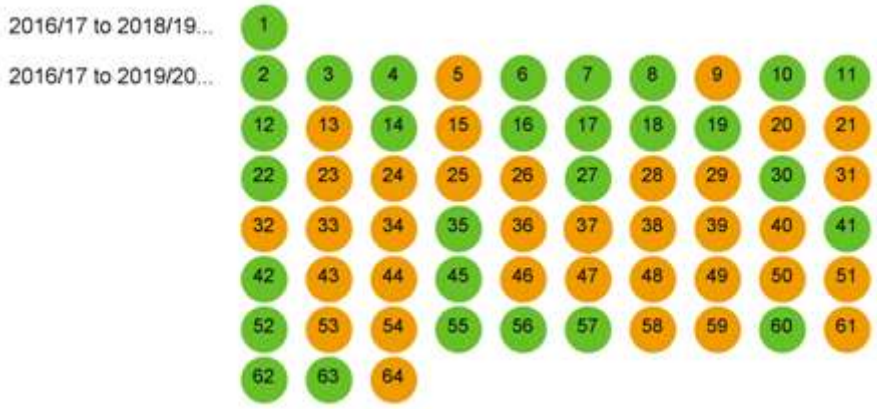
Dumfries & Galloway Priority Areas

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

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

Locality Plan "We Will" Commitments

Red/Amber/Green status of each "We Will" commitment in the Annandale & Eskdale Locality Plan



During a period of rising demand and finite resources, co-production is the key to developing new models of care and support to enable people across Annandale and Eskdale to live active, safe and healthy lives. Co-production is the process of active dialogue and engagement between people who use services and those who provide them. It is about combining our mutual strengths and capacity so that we can work with one another on an equal basis to achieve positive change.

Although there is still lots more to be done, we have continued to make good progress in delivering upon the commitments set out in the 3 year Health and Social Care Locality Plan for Annandale and Eskdale. This has been achieved by working with a range of partners through a process of co-production. For example, we have strengthened our links with housing partners and have been at the forefront of developing new models of housing with care, for people with particular needs across the Locality. Although still at the planning stage, we are building the foundations to develop new Extra Care housing and Supported Living projects across the Locality. These will enable older and younger adults to live as independently as possible within their own homes. Over the next 2 years, we plan to turn our housing aspirations into a reality and extend greater choice, independence and control for local people.

In Moffat, Esk Valley and Annan we have invested time and resources in engaging local people, staff and agencies from all sectors of our community. We have developed ideas about how to transform existing services and how to develop new models of care and support. In Moffat and Beattock, we have launched a public engagement process to explore options for developing a more sustainable primary care service, new models of intermediate care and new models of extra care housing. In Esk Valley, we will continue to explore suitable sites to help develop a new Extra Care and Intermediate Care Service. Whilst in Annan, we are well advanced with plans to develop a new supported living service for younger people with complex needs and developing a new Health and Well Being Centre adjacent to Annan hospital. We have upgraded facilities and support at Lochmaben hospital and have recruited a dedicated team of staff to support the rehabilitation of people within the hospital.

The Moffat High Street GP Practice has been sustained through the Health Board taking on responsibility through the '2c' contract arrangement. This has required some alteration to surgery schedules and the employment of salaried doctors. One salaried GP has been recruited and in December 2017, the recruitment process for 2 more salaried GPs started. The service has been maintained with minimal disruption to people using the service. There are opportunities to look at how skill mix could change, to further improve service stability and sustainability.

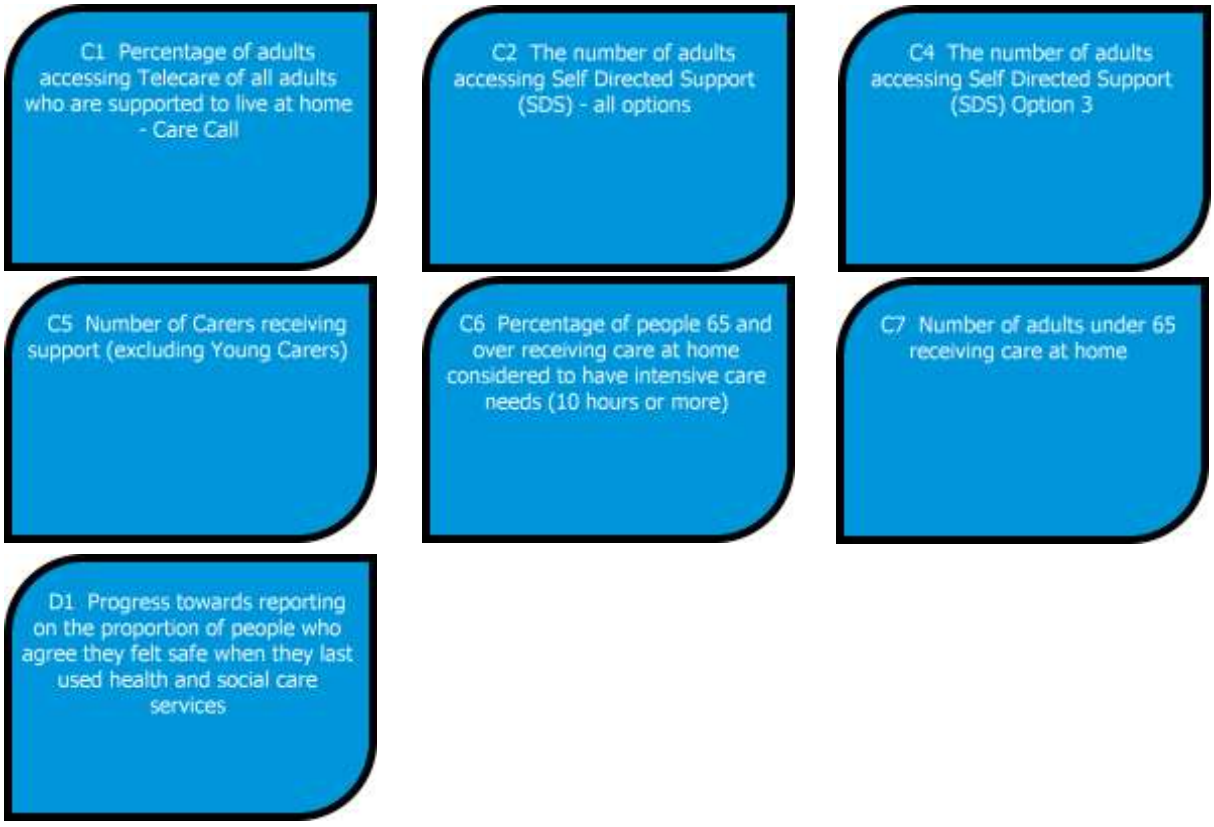
As well as developing new homes and fit for purpose health and social care premises, we have continued to make good progress in developing a one team approach. This person centred approach supports people to look after and improve their own health through Good Conversations. Through the continuing roll out of Forward Looking Planning, we are supporting more people to plan ahead. Our Community Link programme is now embedded within the Locality and helps people to maximise the support that is already available within their local communities. We have effective adult safeguarding processes in place and it is pleasing to note that there has been a significant improvement in our response rates to referrers within 5 days from 49% in April 2017 to 87% in December 2017. Within our 4 community hospitals, we have introduced a new “Excellence in Care” quality assurance system. The rollout of a complexity toolkit will enable us to target nursing support more effectively for people using services in the community. It is especially pleasing to note that the senior charge nurse for our community nursing service, Hazel Hamilton, has just been made a recipient of the Queen’s Nurse Award.

Within this performance report, there are lots of good examples of the progress we have made in enabling people to live active, safe and healthy lives. Over the next 6 months, we plan to make further progress in using new technology to support staff and people in our local communities. We also respond positively to the opportunities presented by the new GP contract to transform primary care.

Gary Sheehan
Annandale and Eskdale Locality Manager

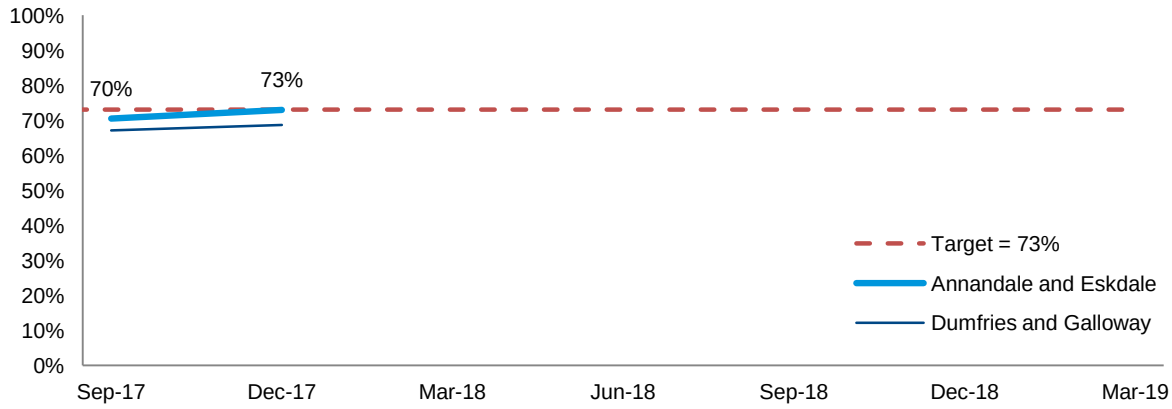
Performance Indicator Overview

Clinical and Care Governance



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

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



Key Points

The percentage of adults supported to live at home who are accessing telecare in Annandale and Eskdale was 73% in December 2017. Annandale and Eskdale's performance is higher than for Dumfries and Galloway, where 68.6% of adults supported to live at home are accessing telecare.

The Wider Context

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

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

Improvement Actions

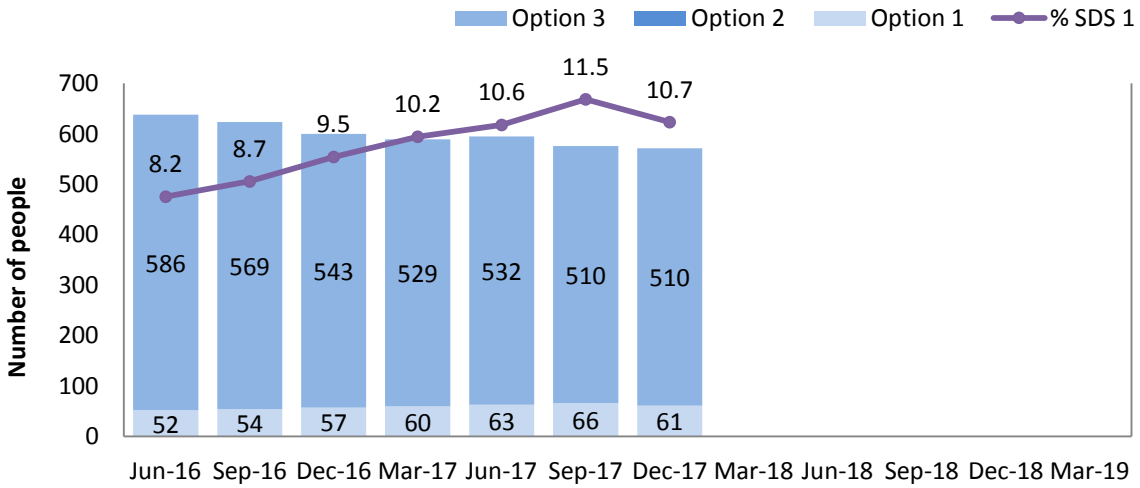
A Locality-wide event was held in April 2017 with staff from all sectors to raise awareness of assistive technology and to encourage more referrals to the telecare service. Staff work with family and friends to identify local responders and, where appropriate, commission a provider response service.

The increased number of Telecare Assessor Installers has enabled increased levels of promotion and awareness of the service to people who would find it helpful. This includes expanding the range of Care Call 'add-on' functions that people might find helpful. Adult Social Work has produced a template which is used as a checklist to ensure Telecare is considered in all social work assessments. Access to Care Call has improved through simplifying the application process. This can be done with a telephone call to the Contact Centre leading to a direct referral to the installers.

In Moffat a website offering information on Services and Clinics available in the High Street Surgery as well as links to NHS Inform and Patient access websites is being developed for launch in January 2018. www.moffatdoctors.co.uk/

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

The number of adults accessing Self Directed Support (SDS) – All Options; Annandale & Eskdale



Key Points

This is a Data Only indicator.
The number of adults from Annandale & Eskdale receiving care at home through Self Directed Support (SDS) Option 1 was 61 people in December 2017. This number has remained stable since December 2016 when there were 57 people from Annandale & Eskdale receiving care at home through SDS Option 1.

The Wider Context

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

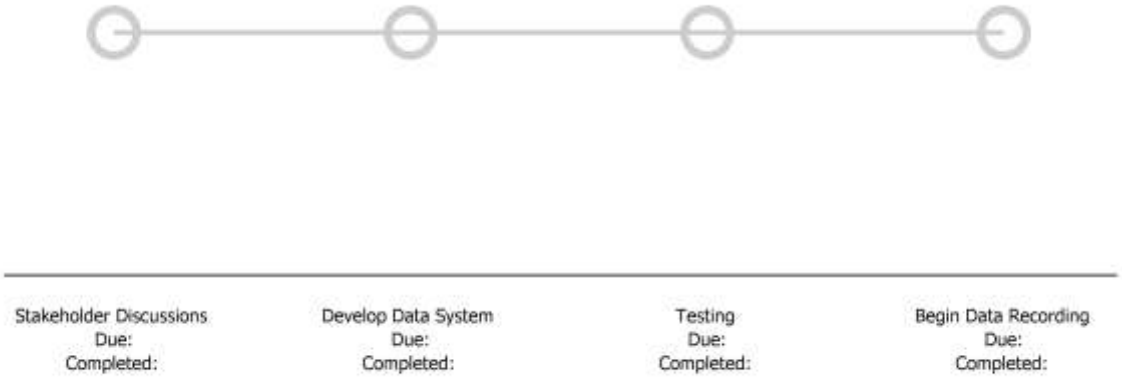
Improvement Actions

Adult Social Services have successfully recruited 2 full-time Reviewing Officers. They support people to access the correct level of care and ensure resources are being used effectively.
Good Conversations training supports staff to use a personal outcomes approach, and to identify the values and beliefs of people they are working with. 'Deep listening' skills are learned to discover what is important to people. This fits well with the Social Care (Self Directed Support) (Scotland) Act 2013, putting people in control of designing and delivering their care and support. Through supported self-assessment, people can develop a personal plan with clear outcomes. The roll out of the Good Conversations training has been comprehensive. It has been undertaken by every member of frontline Social Work staff across the Locality. It is now being delivered to Care Home and Health Improvement staff across the Locality. A local Mental Health worker who undertook Good Conversations training and who is hoping to go on to become a trainer said:

"It is very person centred and empowers the person, reminding them of the skills, strengths and qualities they have in themselves that they have perhaps lost due to ill health."

C5 Carers receiving support (excluding Young Carers)

Number of Carers receiving support (excluding Young Carers); Annandale & Eskdale



Key Points

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

The Wider Context

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

Dumfries and Galloway Carers Centre (DGCC) remains the lead service in respect of Carers in Annandale and Eskdale.

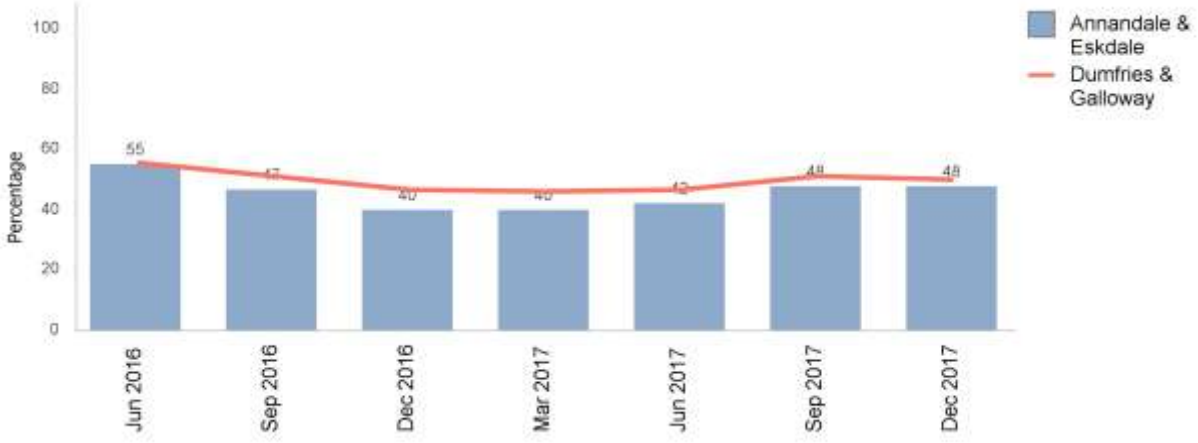
Improvement Actions

Partners from across health and social care services, including social work, community link and community nursing staff, routinely refer people to DGCC. They encourage the Carer to have an Adult Carers Support Plan (ACSP) in place and to carry a Carers Emergency Card (CEC) with them which identifies them as a Carer in the event something should happen to them. Social services can be the responder on the CEC when people have no suitable family or friend who can fill this role.

A multi-disciplinary partnership approach is being used to ensure Carers are identified and supported. This is aimed at ensuring the Carer's health and wellbeing is not adversely affected by their Caring role. We ensure Carers are specifically asked to be involved and included in the local engagement activities including completing questionnaires and participating in drop-in sessions, in relation to potential changes to services locally (particularly the Moffat and Annan Clinic projects). Carers, through DGCC, are represented at the GP learning sessions, ensuring the issues that affect them are kept on the agenda.

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

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



Key Points

This is a Data Only indicator.

The percentage of people aged over 65 receiving care at home through Self Direct Support (SDS) Option 3 who have intensive care needs (10 hours or more) from Annandale and Eskdale was 48% in December 2017.

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

The Wider Context

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

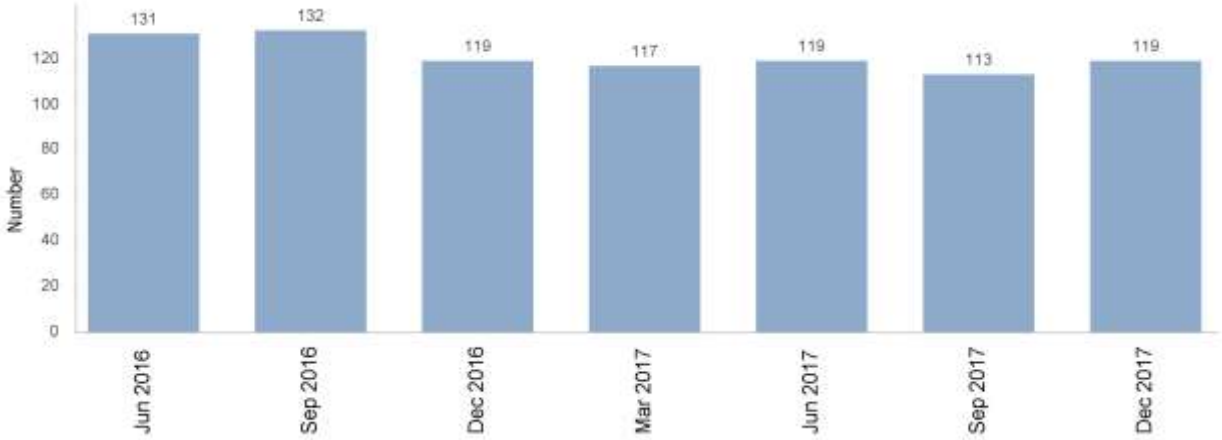
The new SDS models of care offer more person-centred solutions and offer more alternative and efficient solutions.

Improvement Actions

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

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

Number of adults under 65 receiving care at home; Annandale & Eskdale



Key Points

This is a Data Only indicator.

The number of adults from Annandale and Eskdale aged under 65 years receiving personal care at home through Self Directed Support (SDS) Option 3 was 119 in December 2017.

The number of people receiving personal care at home via Option 3 has fallen in Annandale and Eskdale by 10% since September 2016.

The Wider Context

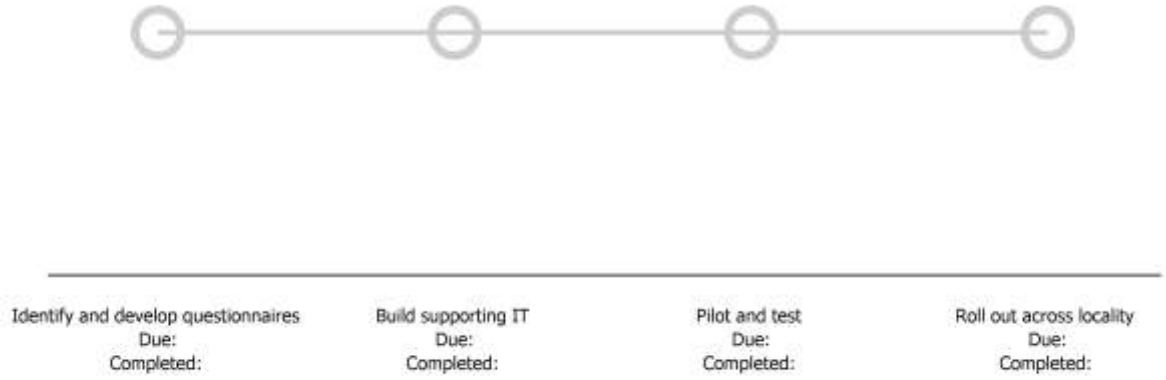
SDS Option 3 is where Social Work Services organise and purchase and manage care for people. For people under the age of 65 and depending upon individual financial assessments, care at home may be charged for. There are multiple factors that can influence the number of people under 65 receiving personal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

Improvement Actions

There is a commitment to supporting self management and the use of individual and community assets. The Annandale and Eskdale locality team continues to encourage and support people aged under 65 to move to SDS Options 1 and 2 (once available) through which they can take more control of their care and employ their own personal assistants or purchase directly from a specialist provider of care.

D1 Feeling safe when using health and social care services

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



Key Points

This indicator has not yet been developed.

The Wider Context

All people have the right to live free from physical, sexual, psychological or emotional, financial or material neglect, discriminatory harm or abuse. The Strategic Plan recognises this as a key priority. Over the reporting period, Multi Agency Safeguarding Hub (MASH) feedback to referrers within 5 days has increased from 49% in April 2017 to 87% in December 2017, which is a marked improvement.

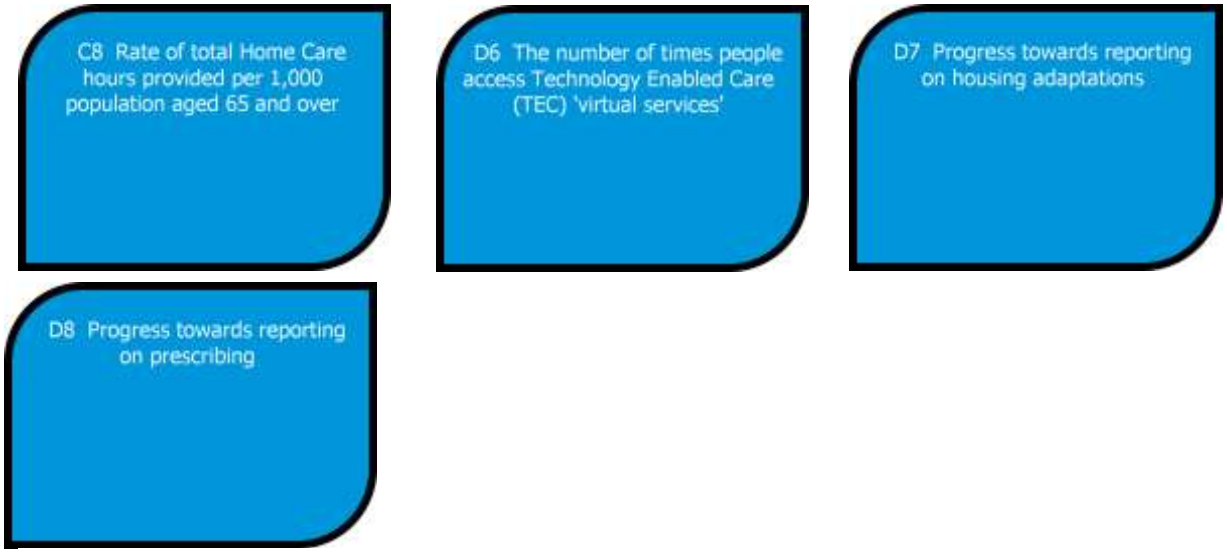
Improvement Actions

Some recent improvement actions include:

- MASH reducing the response times for feedback provided to people who refer. The MASH also has enhanced engagement with the Locality team.
- Social work staff are being supported to gain Scottish Vocational Qualification (SVQ) 4 in social care
- Improved engagement between the Multi-Disciplinary Team (MDT) and Daily Discharge (DDD) meetings
- Safeguarding processes are in place and regularly monitored.

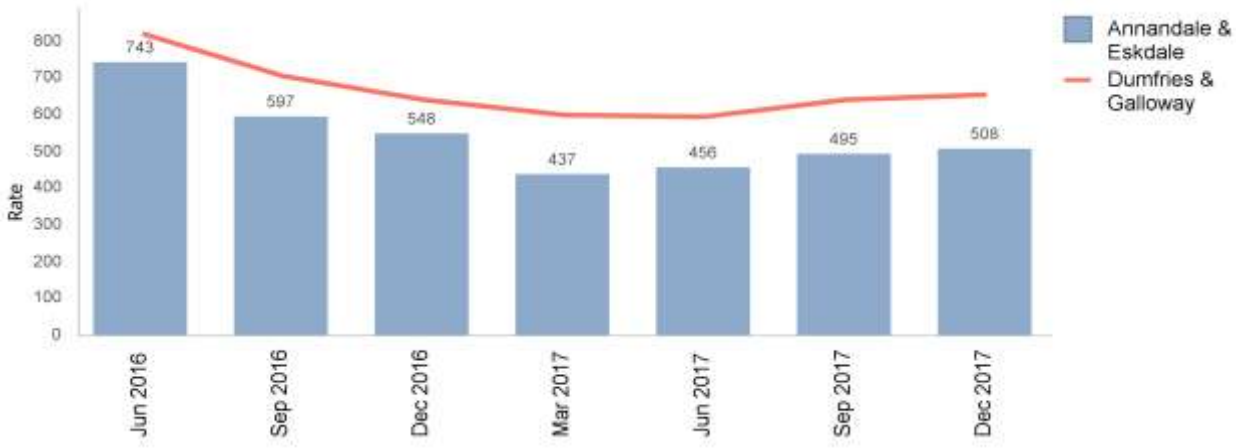
Performance Indicator Overview

Finance and Resources



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

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



Key Points

This is a Data Only indicator.

In December 2017 the rate of homecare provision in Annandale and Eskdale was 508 hours per 1,000 population aged 65 and over.

The rate for Annandale and Eskdale is lower than the rate observed across Dumfries and Galloway (655 hours per 1,000 population aged 65 and over).

The Wider Context

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

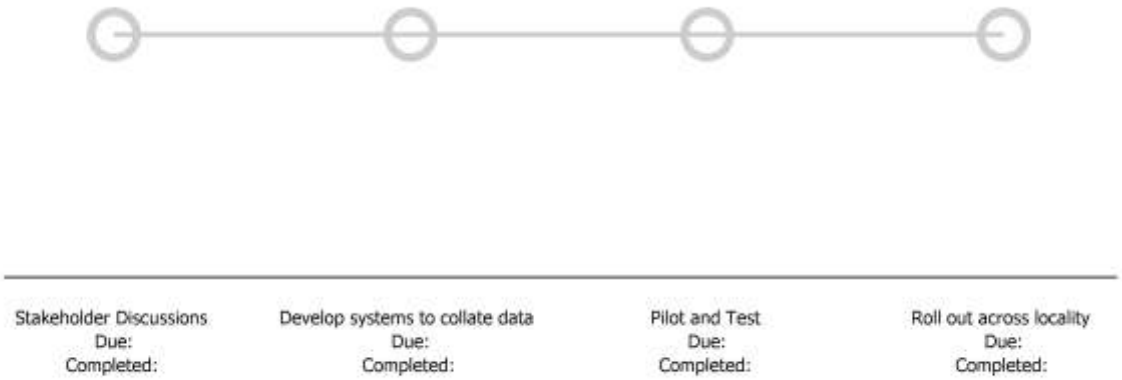
Improvement Actions

There are challenges in accessing care at home provision in the more rural areas of Annandale and Eskdale. The District Nursing Team in Annandale and Eskdale has been supporting the Short Term Assessment Reablement Service (STARS), who were at capacity, by picking up some short term home care packages.

This historic indicator needs to be reviewed.

D6 Technology Enabled Care (TEC) - Virtual Services

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



Key Points

This indicator has not yet been developed.

The Wider Context

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

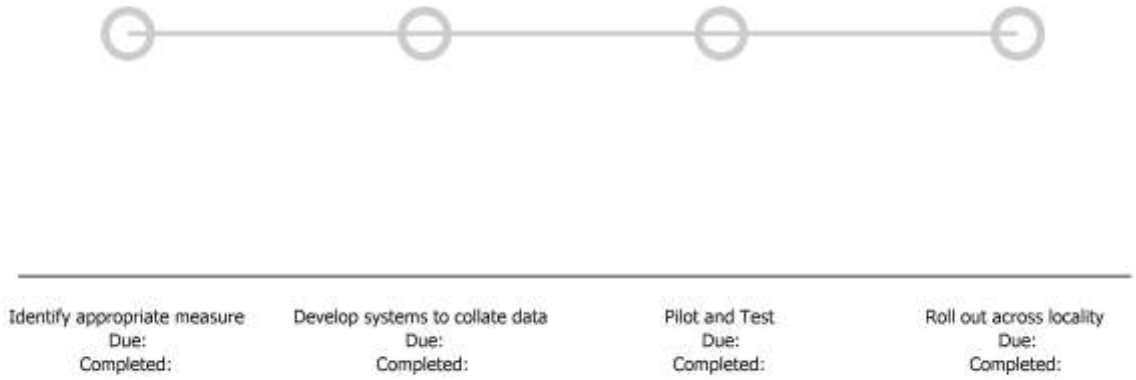
Improvement Actions

Some recent examples of the wider technology being used to support health and social care include:

- All diabetic people are now encouraged to make use of My Diabetes My Way. This is a resource of personalised information about how to manage their condition. Anecdotal evidence points towards a gradual increase in the number of active users.
- An electronic laboratory ordering system has been introduced in Annan. An initial evaluation of this shows a 20% reduction in test ordering in the first month of its installation.
- GP practice teams are supporting the sharing of important information within the health and social care partnership by using Forward Looking Plans (FLPs) to complete the electronic Key Information Summary (eKIS) for vulnerable people.
- The number of eKIS completed across the Locality has increased by around 14% from 1,492 in April 2017 to 1,701 in December 2017 which is indicative of a similar increase in FLPs.

D7 Housing adaptations

Progress towards reporting on housing adaptations; Annandale & Eskdale



Key Points

This indicator has not yet been developed.

The Wider Context

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

Improvement Actions

There is a need to work co-productively with local communities, housing and care providers to develop new models of community based care and supported living. New particular needs housing developments could revolutionise opportunities for the provision of residential, supported living and specialist services to meet the needs of local people.

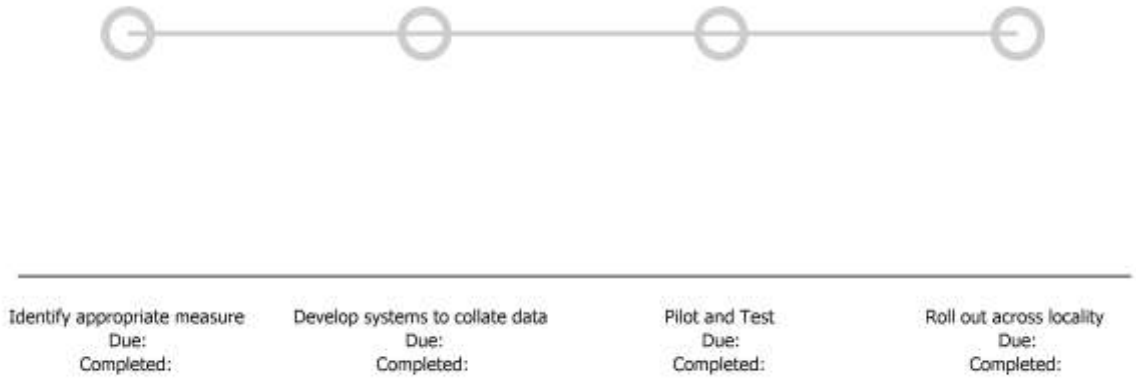
Community opinion and ideas are being taken into account in the planning process via the Esk Valley Report and the Transforming Health and Social Care survey in Moffat and Beattock which started in October 2017. Local reference groups made up of local elected and community representatives have been active throughout the planning process. Stakeholder groups are being established to support the development of services going forward.

The establishment of the integrated post of Housing Lead Officer (HLO) has supported the ongoing plans to develop supported living in Station Yard, Annan and developing Extra Care Housing in the Esk Valley and Moffat. A member of the Integrated Health and Social Care team in Annandale and Eskdale reported that:

> "Having an HLO who can attend a meeting in Langholm and put a potential development there into a regional context and describing the issues and benefits of similar developments elsewhere has been very useful, avoiding duplication and aiding communication."

D8 Prescribing

Progress towards reporting on prescribing; Annandale & Eskdale



Key Points

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

The Wider Context

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

Improvement Actions

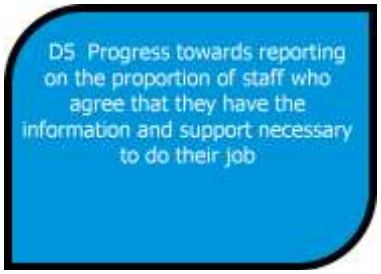
Systems are in place through Prescribing Support to protect people who manage their own medication that may be at risk due to failing eyesight, dexterity or cognitive function. Care providers are now referring to Prescribing Support when they have concerns about people's safety regarding medication.

The Prescribing Support pharmacists deliver a service called Optimise, where they review people's medication and simplify where possible. This ensures that people receive the most appropriate prescribing, and supports them to achieve their personal outcomes. There is limited staff resource for Optimise and longer term funding is required to enable the continuation of the project.

A team of 0.8 Whole Time Equivalent (WTE) pharmacy technicians and 1 WTE pharmacists has been established to support improvements in relation to cost effective prescribing using a number of tools across Annandale and Eskdale. GP practices have participated in the Primary Care Digital Services program which is aimed at improving the efficiency of practices. Recent data indicates that the cost per patient has fallen below the regional and national averages. April-November 2017 data from ISD show Annandale and Eskdale's average monthly cost per patient is £16.06 compared to £18.83 across Dumfries and Galloway and £17.58 across Scotland. This positive outcome is despite the increasing pressures on the budget of new drugs and increasing cost of existing drugs. Prescribing support continues to prioritise cost effectiveness, while engaging with people around the need for change.

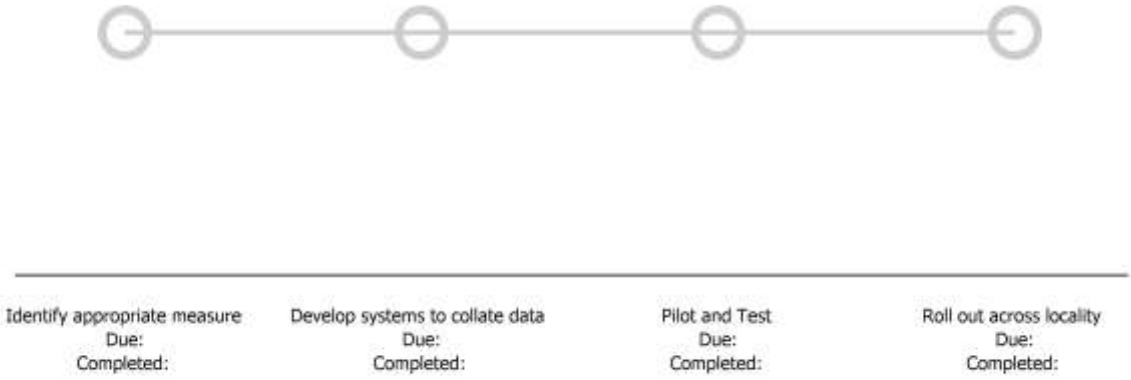
Performance Indicator Overview

Quality



D5 Staff have the information and support to do their job

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



Key Points

Development of this indicator has not begun.

The Wider Context

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

Improvement Actions

Locality celebration events are being held twice a year, providing opportunities for people to learn about and feel engaged with the different services, cultures and sectors across the Partnership. These events which involve people from all sectors and all levels lead to new and different opportunities to improve the support, care and treatment delivered through better communication and knowledge. Feedback from the celebration events has been fairly positive. People reported that they had a better knowledge of what their colleagues in other disciplines did and made new connections.

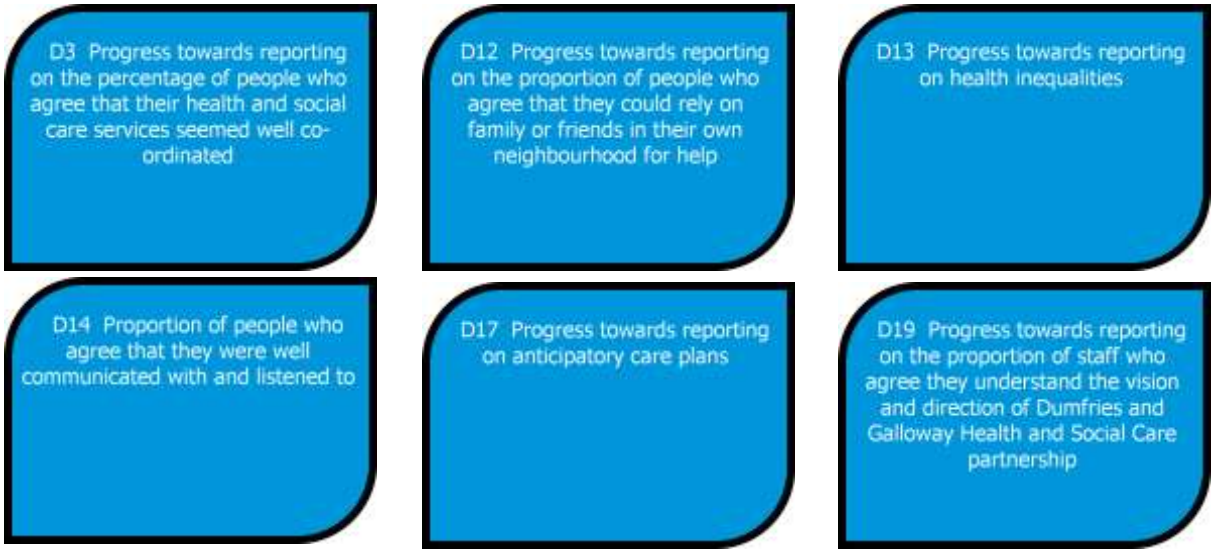
Dementia Awareness training is being rolled out for public facing staff across all sectors. Staff who have undertaken this training have said that they feel more confident and competent in relation to supporting someone with dementia.

Training and induction programmes have been developed through a partnership approach at Lochmaben hospital. This is as part of the redesign of services delivered at the hospital. The co-production between multi-disciplinary staff, contractors, the voluntary sector and the community has enabled a relatively smooth transition from 14 community hospital beds to 7 community beds and 7 rehabilitation beds.

3rd year nursing students supported the development of skills and knowledge in care homes in relation to healthy skin care.

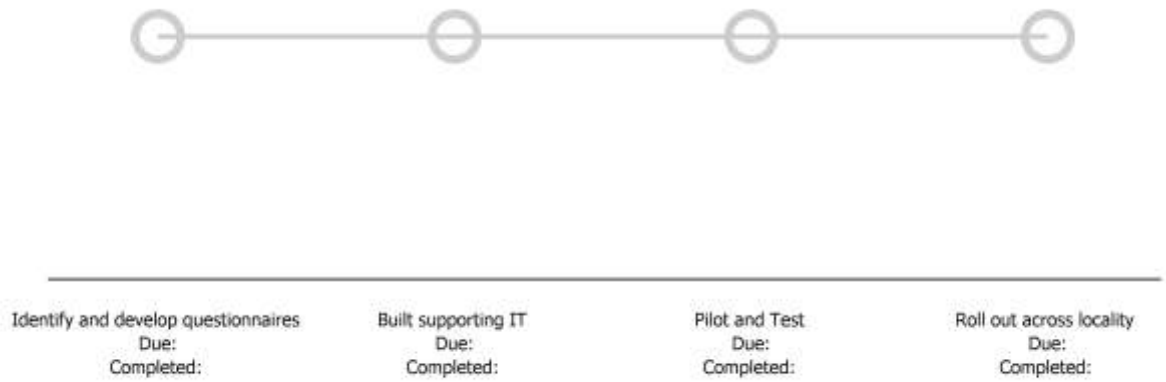
Performance Indicator Overview

Stakeholder Experience



D3 Well co-ordinated health and social care services

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



Key Points

Development of this indicator has not begun.

The Wider Context

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

Improvement Actions

The Community Link Worker (CLW) Programme is a Locality wide initiative using a co-productive approach to offer support and information to people. This helps people identify 'what matters to them' and to take control and exercise personal choice about how to look after and improve their health and wellbeing.

The CLW Programme is embedded in the service provision within the Locality. Although the majority (48%) of referrals come from GPs, referrals are also now coming from a range of partners from across health and social care, including the third and independent sectors. The number of referrals has increased by 5%, from 188 in April 2017 to 198 at the end of December 2017.

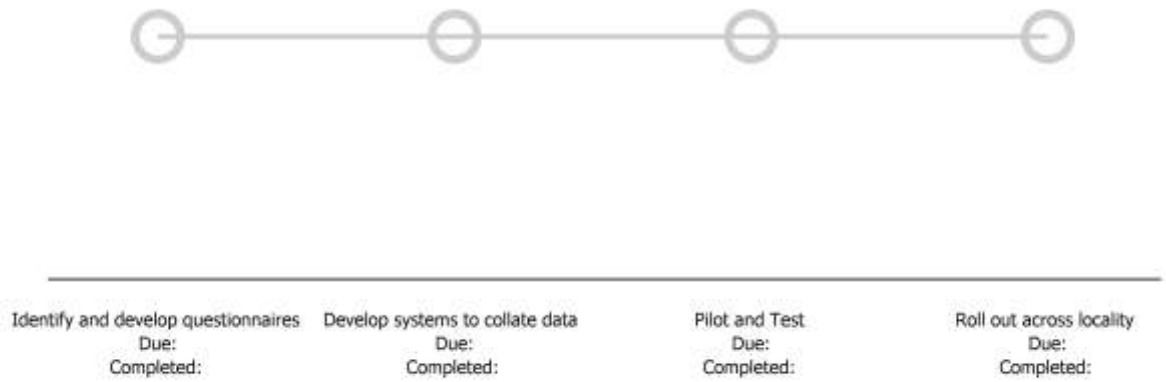
The success of the CLW programme has brought pressures. With more referrals coming through and the number of people with more complex needs becoming more frequent, it has been necessary to implement a triage system for referrals to identify those who are in most urgent need of support.

People using our services have been vocal in their praise of the CLW programme. A family, who were referred by a GP due to concerns about mental health and an associated risk of losing their home in Oct 2017, said they

"Would have had no hope without the support from CLW and the other services they referred us to."

D12 Community strength: community support

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



Key Points

Development of this indicator has not begun.

The Wider Context

There is clear evidence in the research literature of a proportional relationship between how many people feel they can rely on friends and family in their community, and community strength. The responses to this indicator provide an indirect measure for community strength.

Improvement Actions

A quarterly Activity Booklet, which helps to identify and maximise the use of individual and community assets, has been developed. This supports people to improve their health and wellbeing by raising awareness of opportunities to get active and participate in their community.

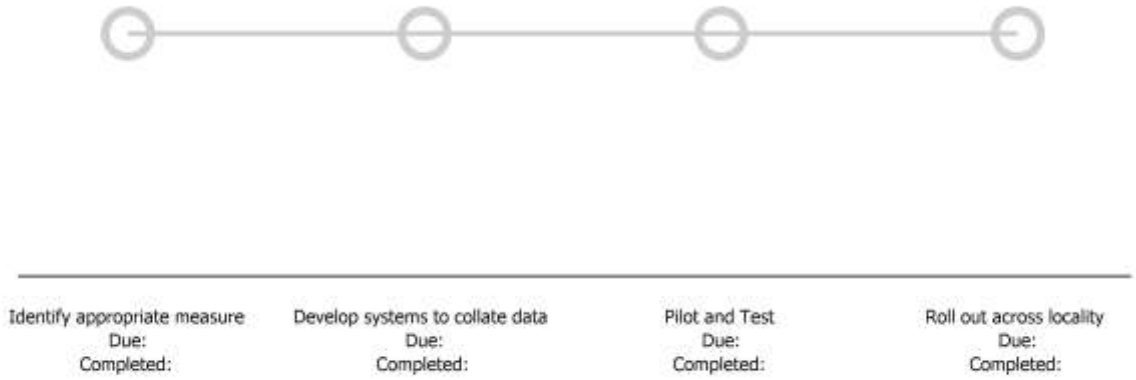
The booklet also acts as a reference guide or directory for service providers to help direct people. The booklet is distributed throughout the Locality through the Safe and Health Action Partnership (SHAP) and electronically to 92 members.

It can also be found online at:
https://www.aandeshap.co.uk/events-and-training/activity-guide-annandale-and-eskdale

Dementia Friends training has been taking place across the Locality with 35 sessions delivered to 25 different groups from small businesses and community groups, to schools and large companies, like Tesco, which in all created 444 Dementia Friends.

D13 Health inequalities

Progress towards reporting on health inequalities; Annandale & Eskdale



Key Points

Development of this indicator is underway.

The Wider Context

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

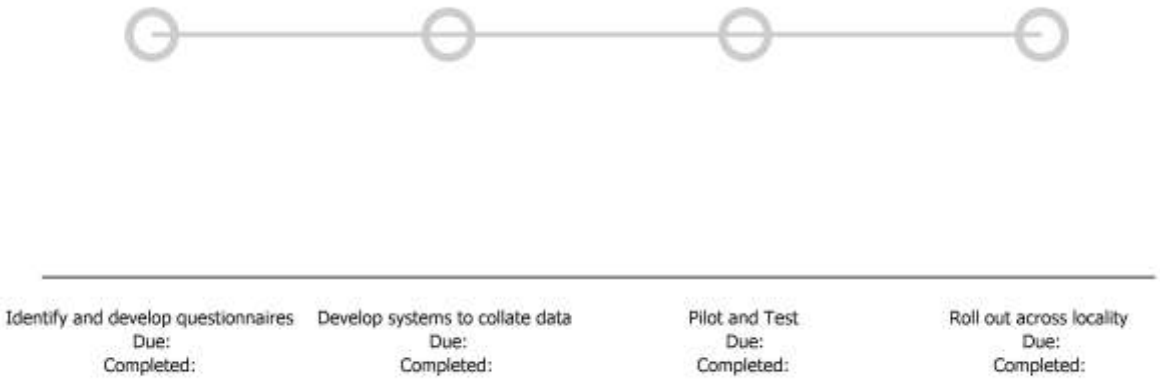
Improvement Actions

Annandale and Eskdale was selected, based on the Scottish Index of Multiple Deprivation (SIMD) data, to be the location for 1 of 2 pilots for a Home Energy Scotland (HES) project. The project provides free impartial advice and support to access subsidised insulation, draught-proofing and in some circumstances, a new heating system. Referrals to the project now come from a range of multi-disciplinary organisations including health and social care partners. Of the 21 homes which have qualified so far for insulation or heating, 1 has been completed and 19 are in progress (1 person declined the offer).

Impact Assessment and Equality questionnaires are a required part of the project planning process to ensure that we are mindful of protected characteristics. Impact Assessments have been carried out for the community engagement activities in Moffat, Esk Valley and also in regards to the proposed moving of Annan Clinic to Treastaigh. Consultation has been carried out to ensure any potential impact of these projects in respect of protected characteristics is carefully considered. The knowledge and understanding of the issues faced by people with protected characteristics, means the groups or services that represent them are best placed to comment. However, feedback to support the Impact Assessments has been difficult to get at times.

D14 Well communicated with and listened to

Proportion of people who agree that they were well communicated with and listened to; Annandale & Eskdale



Key Points

Development of this indicator has not begun.

The Wider Context

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

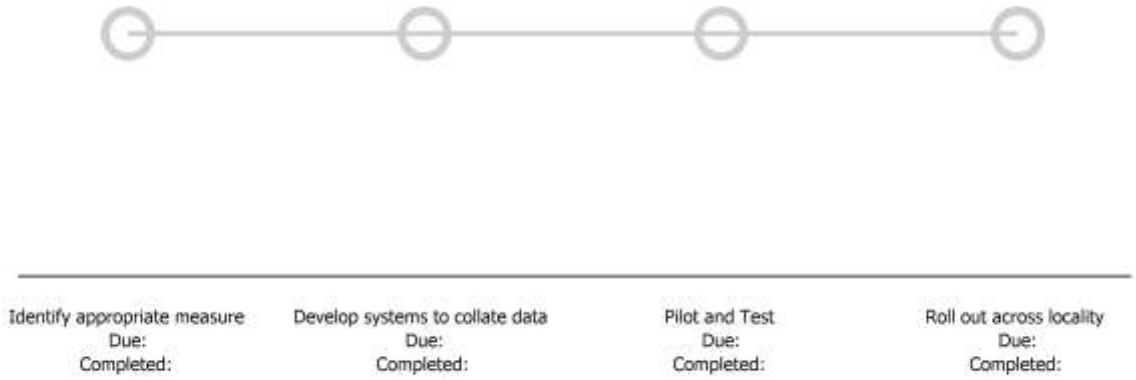
Improvement Actions

Multi Disciplinary Team (MDT) meetings are happening across Annandale and Eskdale. One Teams have been established in Langholm, Moffat, and Annan. Although each is unique, the format and membership of the groups have shared guiding principles. The MDT process for hospitals is currently under review to ensure that people who use services, or their advocate, are present at meetings where practicable. This ensures that people using services contribute to all decisions being made regarding their future care arrangements, and follows the principle of “nothing about me without me”.

End of life care and intermediate care are the primary concerns for many people. The feedback from community members and staff from the Esk Valley and Moffat engagement work consistently mentions that provision of these services locally is the most important factor in relation to health and social care. The development of end of life care in line with the needs and wishes of people and their families is being taken into account in the design of intermediate and Extra Care facilities across Annandale and Eskdale.

D17 Anticipatory care plans

Progress towards reporting on anticipatory care plans; Annandale & Eskdale



Key Points

This indicator has not yet been developed.

The Wider Context

Forward Looking Plans enable conversations to take place that ensure people are engaged in the provision of their own care at an early stage. These conversations enable the timely implementation of low level interventions.

Improvement Actions

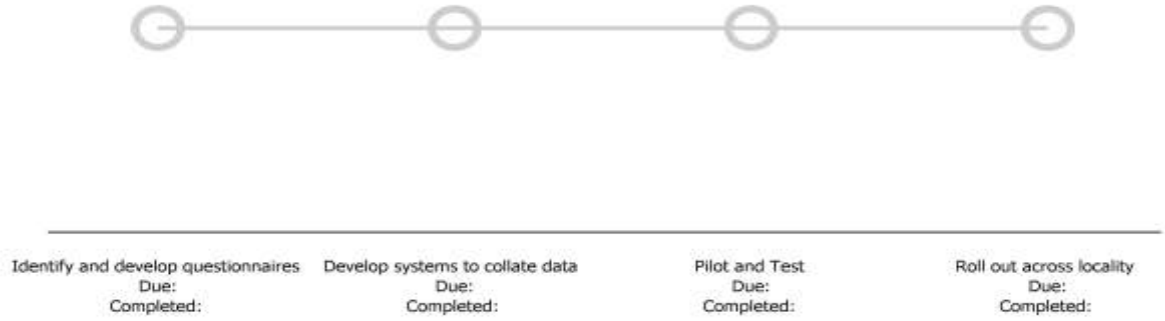
Forward Looking Planning is a Locality wide programme which supports people to think about and to plan for their future care while they are able to do so. This empowers people and Carers to record their wishes. This also serves to start conversations between people and their care providers about various topics including Power of Attorney, Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) and guardianship. If a Forward Looking Plan (FLP) is in place, this can have a significant positive impact on a person's future care, by supporting how people flow through the hospital and the smoother progression from hospital to home or residential care settings.

The roll out of FLPs has been taking place for some time and is beginning to be embedded in practice across the Locality. GP practice teams are supporting the sharing of important information within the health and social care partnership by using FLPs and completing an electronic Key Information Summary (eKIS) for vulnerable people. The number of eKIS across the Locality has increased by around 14% from 1,492 in April 2017 to 1,701 in December 2017 which is similar to the level of increase in FLPs.

GP practices have been encouraged to use the person centred House of Care model in managing long term conditions. The ending of the Quality and Outcomes Framework (QOF) has allowed GPs to take a more person centred approach, focussed on the issues that are important to the person. This approach provides people with information about their condition, which helps them understand what they need to do to care for themselves better.

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

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



Key Points

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

The Wider Context

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

Improvement Actions

People working in health and social care services have been involved in consultation and design of services across the Locality through staff meetings and surveys. Improvement meetings have been taking place since September 2017. These meetings provide an opportunity for staff to reflect, to celebrate what is working well, and to work through issues as a group. The quarterly improvement meetings for community nursing has enabled people to feedback the issues that they have encountered and use the opportunity to highlight good practice as well as risks. The sessions are solution focussed, and staff have highlighted “good team working”, “need for better communication” in some areas, “good skills mix”, a need to “focus on complexity” and “good communication”.

So far 3 people from this Locality have completed the Scottish Improvement Skills (SIS) training through the Improvement Hub in Dumfries. People from various cross sector disciplines across the region came together to develop individual improvement projects. Those who completed the SIS course felt that they learnt valuable skills in relation to improving the information, support, care and treatment they provide. They also felt they made new connections and networking links from working with partners from different disciplines.

In Annan there have been 5 separate meetings in relation to the relocation of Annan Clinic to Treastaigh. Also there have been 2 surveys that included people who use services, Carers and staff, and a drop in session for people potentially affected by the proposed changes. Further meetings are planned for early 2018. Draft plans have been drawn up for the development of a Health and Wellbeing Centre on the Treastaigh site in partnership with estates and service leads. Feedback from people working in the buildings affected and people who access services there, has been taken into account during the planning stage. Although there have been delays due to capacity, changes of staffing and commitment to the new build, planning for improved multi-disciplinary service provision for Annan is progressing.

Appendix 1: Table of “We Wills”

Ref & RAG Status	Description
1	We will have different conversations with people about their health and care needs to support them to take personal responsibility for their own health and well being
2	We will support people to plan ahead and to consider their options and wishes at an early stage through the expansion of Forward Looking Care plans
3	We will develop and support our workforce to develop a more holistic and integrated approach to promote health and well being through the development of Integrated teams at a local community level
4	We will identify and maximise the use of individual and community assets to support personal heath and well being
5	We will review the current use of new technology to promote greater independence and safety and develop plans for a more effective use of such technology
6	We will provide accessible information for people to help them access the range of support that is available
7	We will work in partnership with local communities to develop new sustainable, flexible and integrated models of community based day, residential , supported living and other specialist services to meet the needs of local people
8	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
9	We will actively support people with chronic conditions in the community to help reduce the need for people to be admitted into hospital
10	We will work in partnership to develop ‘Dementia Friendly’ communities across Annandale and Eskdale
11	We will establish a Locality Housing Group with Housing Providers and other partners to develop new models of housing and support to meet the needs of people across Annandale and Eskdale
12	We will promote Care and Repair grant opportunities to enable people to remain living within their own homes for as long as possible
13	We will listen to what people think of our services and let them know what improvement actions we plan to take
14	We will develop a Locality Participation and Engagement Group
15	We will provide a range of accessible ways for people to communicate their views and wishes
16	We will develop end of life care in line with the needs and wishes of people and their families
17	We will develop clusters of Integrated Care Communities across Annandale and Eskdale to promote more integrated ways of working and more effective points of access to support

18	We will hold conversations with people to identify what really matters to them and help them develop a plan that will maintain or improve their quality of life
19	We will make sure appropriate information is available for people to access the support they need to maintain or improve their quality of life
20	We will build in a regular review process to make sure people who use our services are getting the support they need to live a good quality of life
21	We will review and develop the use of Outcome Star approaches across Annandale and Eskdale
22	We will conduct a Day of care Audit within our community hospital to help shape their future development.
23	We will review and develop the use of the IORN (Indicator of Relative Need) assessment tool across Annandale and Eskdale to help identify the different and changing needs of the people and inform the development of how we support them
24	We will work together to implement and deliver support that address and tackle health inequalities
25	We will work together to identify people in greatest need and those who may have very specific needs
26	We will target support for specific groups and communities with identified health inequalities
27	We will support people to reconnect with their communities and help them to make informed choices
28	We will work towards reducing the health inequalities experienced by particular people, groups and communities.
29	We will listen to the views of Carers and will identify the action we will take to support them
30	We will identify current and potential Carers as early as possible
31	We will make sure all Carers are told about their right to an adult care Support plan (previously known as Carers assessment) so that the needs of Carers are dealt with in their own right
32	We will identify, develop and promote local services to help improve the quality of life of Carers
33	We will continue to raise Carers awareness across our workforce following the equal partners in care core principles
34	We will identify and support the particular needs of young Carers
35	We will help people recognise and report abuse and harm at the earliest stage possible
36	We will develop the skills and knowledge of staff and managers to protect people from harm
37	We will record and share information in a joined up professional and confidential manner

38	We will make sure that all incidents of abuse and harm are investigated and dealt with in a timely way
39	We will identify the main risk areas and trends and develop local strategies to reduce harm
40	We will identify key risks for people and develop risk management plans in a consistent, holistic and person centred manner
41	We will involve staff from all sectors in developing, delivering and reviewing this plan
42	We will make sure that local voluntary and community groups are able to shape and continue to play a central role in delivering integrated health and social care support
43	We will support health and social care staff to develop their skills and knowledge to enable them to develop their role, reduce duplication and work to their optimum level
44	We will consult with and listen to the views of staff and keep them updated on the improvement actions we plan to take to develop more integrated ways of working
45	We will develop a culture where respectful challenge is encouraged, underpinned by openness, transparency and mutual respect
46	We will involve employees in developing and promoting a Healthy Working lives Programme across Annandale and Eskdale
47	We will review and develop our supervision and appraisal processes to ensure that we support and develop staff in an appropriate and consistent manner
48	We will explore the opportunities to use new technology to support our workforce
49	We will identify and promote career pathways which allow local workers to develop to meet future gaps in the workforce.
50	We will promote more cross sector training opportunities to help support the development of integrated ways of working
51	We will work with all sectors to improve staff recruitment and retention
52	We will develop a range of new initiatives, including public awareness, to enable us to meet the rising challenging of prescribing and managing medication which meets individual needs in a safe, therapeutic and cost effective way
53	We will support people to get home from hospital earlier by identifying and strengthening our local community assets and support services
54	We will regularly review all health and social care packages to make sure that they are promoting individual well being, independence and are delivering positive outcomes
55	We will regularly review the cost and quality of our services and benchmark them in accordance with best practice
56	We will develop new integrated working models with local partners to support the future development and sustainability of General Practice across Annandale and Eskdale
57	We will develop a more robust District Nursing Service, with closer links to the wider Multi-disciplinary Team, with the capacity to keep more people in their own home in Annandale and Eskdale

58	We will review and develop the role of our social workers through the development of more integrated ways of working with the wider multi-disciplinary team
59	We will develop new models of community support with local partners for the future development of our Allied Health Professional services to increase our capacity to keep more people in their own home and which promote their independence, safety and quality of life in Annandale and Eskdale
60	We will review the role of our 4 Cottage Hospitals across Annandale and Eskdale to ensure that they continue to meet the changing needs of local people
61	We will develop alternatives to hospital care including the development of new step up and step down services
62	We will develop and establish local clustered care communities to identify and develop proposals for providing more integrated and accessible health and social care support at a local level which are delivered and available at the right time
63	We will promote the development of self directed support across the Locality
64	We will review and develop proposals for the more effective use of office accommodation and support services to help more integrated and cost effective working