DUMFRIES AND GALLOWAY
INTEGRATION JOINT BOARD

PERFORMANCE MANAGEMENT

AREA COMMITTEE REPORT

DUMFRIES AND GALLOWAY
Health and Social Care

Nithsdale

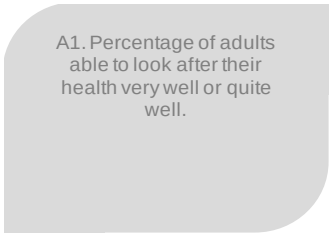
April 2017 - December 2017

Contents

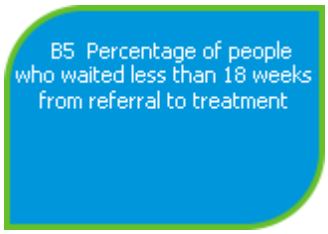
Document Features

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

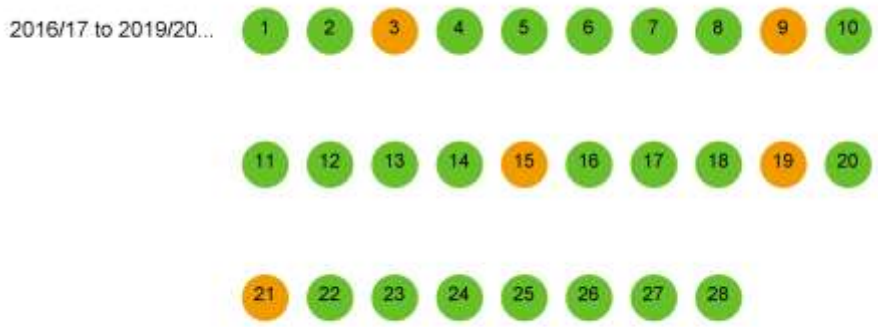
Dumfries & Galloway Priority Areas

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 Nithsdale Locality Plan



Work continues across the Locality to deliver on the commitments within the Locality plan which align with the 9 national outcomes and Integration Joint Board's Strategic Plan.

The content of this report demonstrates our success to date in achieving the delivery of our commitments, working in partnership with the people who use our services, stakeholders, the third and independent sectors.

We continue to develop a One Team approach in Nithsdale to improve the delivery of care and support across the Locality. This ambitious, innovative and transformational approach will be implemented and embedded systematically in Nithsdale during the duration of this Locality plan.

A fundamental approach of the One Team is:

- supporting people in their own home,
- avoiding unnecessary admission and readmission to hospital and
- intervening at the earliest opportunity to prevent escalation and deterioration.

Preventing these negative outcomes for people has an impact across the whole health and social care system. This part of our approach is delivering gains now, through the recently established Rapid Response Team. Our approach is underpinned by a longer term strategy of prevention and wellbeing.

Through a focus on the commitments in the Locality Plan, progress has been made in a number of the areas which are central to the delivery of the One Team approach in Nithsdale. We recognise the importance of working with local care home and care at home providers, the third sector and supporting unpaid Carers.

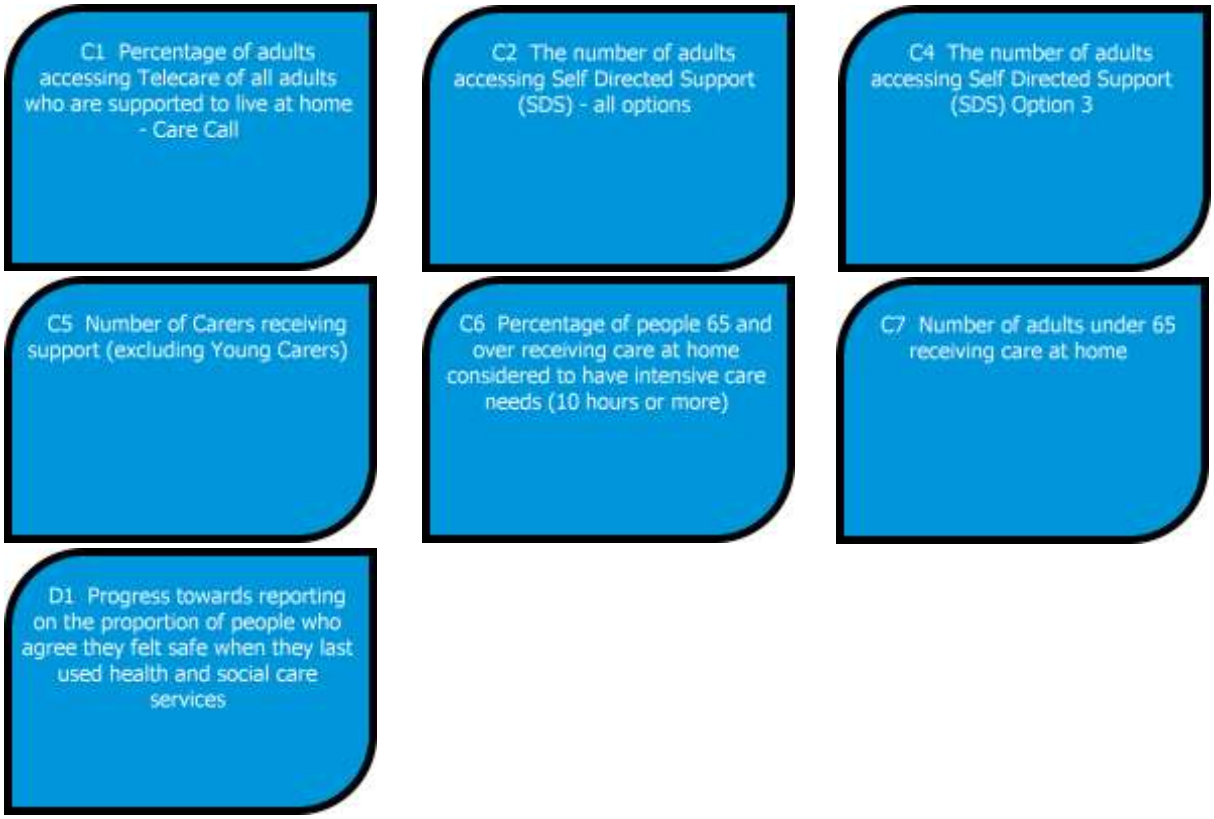
In line with national trends, recruitment to General Practice (GP) posts poses an increasing challenge across the Locality and we continue to support GP colleagues in addressing these issues. For example, our pharmacy team is working directly with practices to optimise people's medication.

We look forward to working closely with partners to continue our journey in delivering on the commitments made in the Nithsdale Locality plan by March 2019.

Alison Solley
Locality Manager

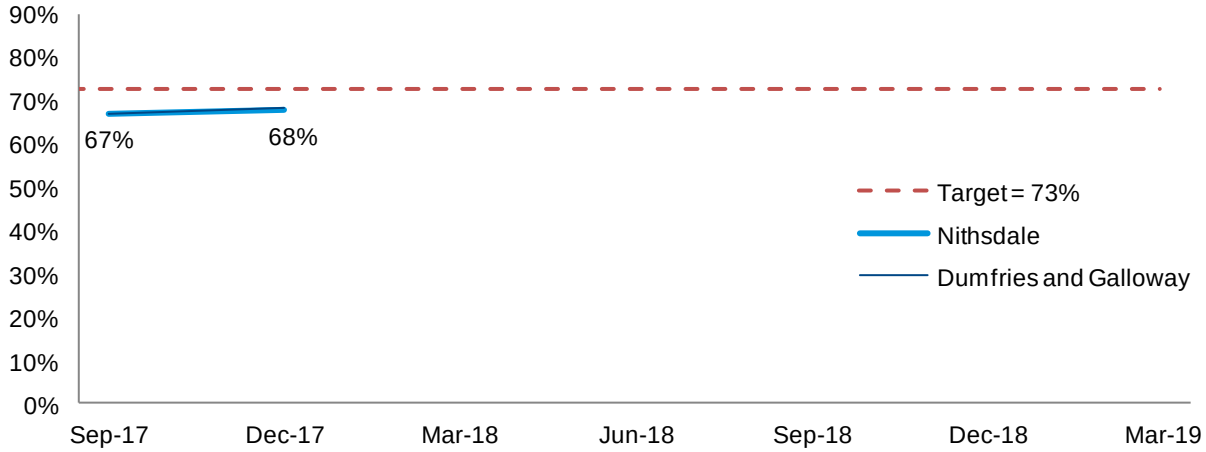
Performance Indicator Overview

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; Nithsdale



Key Points

The percentage of adults supported to live at home who are accessing telecare in Nithsdale was 68% in December 2017. Nithsdale performance is very similar to that of Dumfries and Galloway where 68.6% of adults supported to live at home were 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.

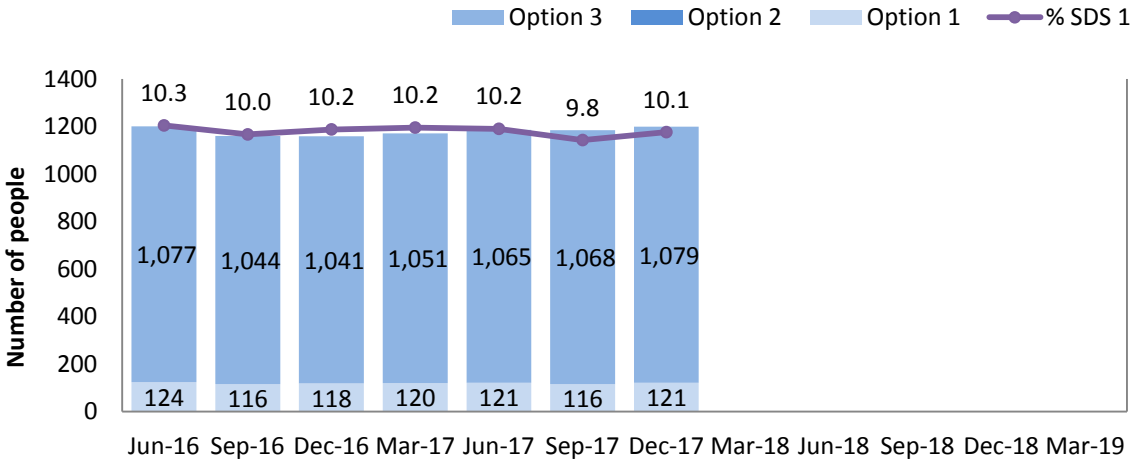
Improvement Actions

As part of a Scotland wide initiative to reduce hospital admissions caused by falls by 50%, we are trailing a pilot in DG1 and DG2 post codes areas. This pilot is in partnership with the Scottish Ambulance Service (SAS) and Nithsdale in Partnership (NiP). When ambulance crews respond to a call where someone has fallen at home and make an assessment that the person is able to remain at home safely, the crew will contact the Care Call 24 x 7 contact centre to request a visit by the NiP team. NiP carries out a multi disciplinary assessment at home. It is anticipated that this will result in a reduction in hospital admissions from falls, and most importantly allow people to stay safely at home. In addition, SAS crews are training to act as telecare assessors to give people quicker access to telecare in the right circumstances.

The pilot started in September 2017 has improved access to appropriate services in the community. Between September 2017 and December 2017, the NiP assessment at home team assessed 12 people in their homes following a fall. They were able to provide equipment and therapy inputs which resulted in the people being able to stay at home. These numbers were in line with the national expectations for the Scottish Ambulance Service reduction in falls.

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; Nithsdale



Key Points

This is a Data Only indicator.
The number of adults from Nithsdale receiving care at home through Self Directed Support (SDS) Option 1 was 121 people in December 2017. This number has remained stable since May 2016.

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

In Nithsdale, we have continued to raise awareness of SDS both within our teams and with people who use our services. Our next steps include:

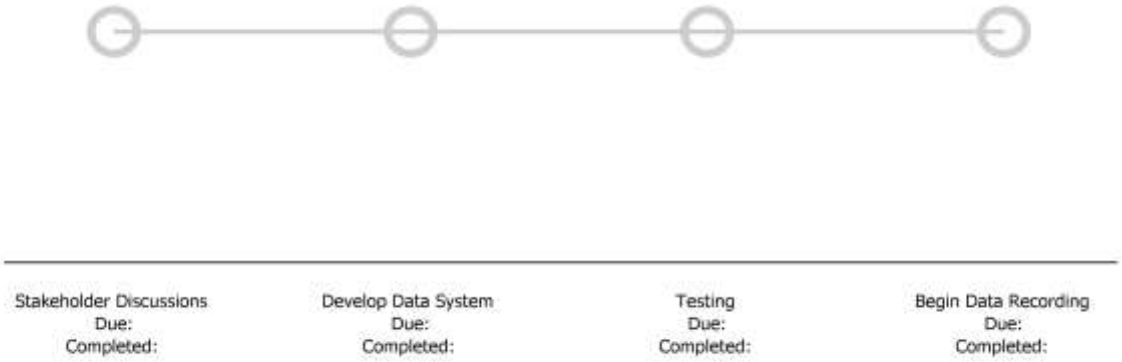
- Exploring how we support people to access assistive technology through SDS.
- Completing the pilot for the use of SDS Option 2 within Nithsdale and assessing the feedback from the pilot.
- Exploring how to improve the coordination and communication between people, their family and Carers, and the health and social care professionals involved.

In Nithsdale we are exploring the links between SDS and Anticipatory Care Planning (ACP). Both encourage people to make positive choices about what they should do for themselves, from whom they should seek support, and to think ahead to future needs. They are dynamic records that develop over time, guided by shared principles of person centred care, dignity, choice and control. The techniques developed though the Good Conversations training will help support both SDS and ACP.

In December 2017 we introduced a small transitional team, who are hosted in our Care and Support Service service. This has enabled us to provide short term care for people while they are waiting for a long term care package. This has helped enable people to be discharged from hospital earlier. We have also used this team when a person has been ill at home and will recover to full capacity. The recent flu epidemic is a great example. We were able to provide short term care, and then withdraw when the person regained their health, thus avoiding an unnecessary admission to hospital. In the 3 weeks that the team were operational in December 2017, they provided approximately 80 hours of care.

C5 Carers receiving support (excluding Young Carers)

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



Key Points

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

The Wider Context

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

Dumfries and Galloway Carers Centre (DGCC) remain the lead service in respect of Carers in Nithsdale.

Improvement Actions

We are working in partnership with the DGCC to improve the health and wellbeing of unpaid Carers. We have a member of staff dedicated to linking with DGCC. Examples of this work include:

- Offering health and wellbeing appointments in a variety of settings including at a location in North West Dumfries, one of the most deprived communities in Nithsdale.
- Running Mindfulness-Based Stress Reduction (MBSR) courses specifically for Carers. These courses aim to improve the mental wellbeing of those taking part.

65 Carers from Nithsdale have been referred to DGCC since March 2017. Of these, 50 Carers are receiving ongoing support due to complex health and wellbeing needs, especially around low mood, anxiety and isolation. Following a referral to DGCC, Carers may be offered support from other health and social care professionals, such as a pharmacist to support optimising medicines or financial advice from the Financial Inclusion and Assessment Team. Further person centred support is available on a time limited basis through Healthy Connections. Carers who have attended MBSR have said:

> "I'm a lot less stressed and a nurse at my practice could see a big difference in me. She said I was more happy looking and relaxed."

> "I have been sleeping better. More positive, looking at my surroundings. Realising my situation is not all negative."

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); Nithsdale

Key Points

This is a Data Only indicator.

The percentage of people aged 65 and over receiving care at home through Self Directed Support (SDS) Option 3 who have intensive care needs (10 hours or more) from Nithsdale was 49% in December 2017.

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

The Wider Context

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

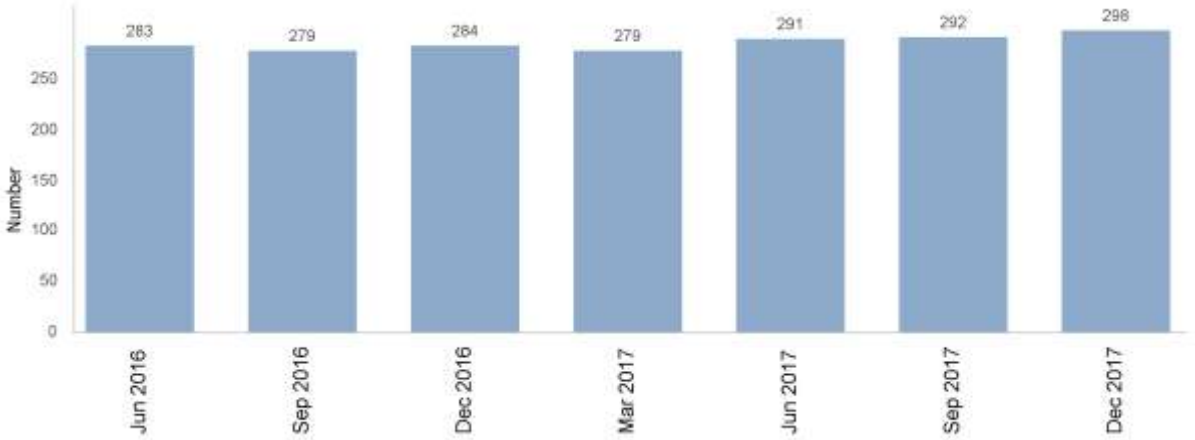
The new SDS models of care offer more person-centred solutions and offer more alternative and efficient solutions.

Improvement Actions

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

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

Number of adults under 65 receiving care at home; Nithsdale



Key Points

This is a Data Only indicator.

The number of adults from Nithsdale aged under 65 years receiving personal care at home through Self Directed Support (SDS) Option 3 was 298 in December 2017.

Performance against this indicator in Nithsdale has been stable since April 2017.

The Wider Context

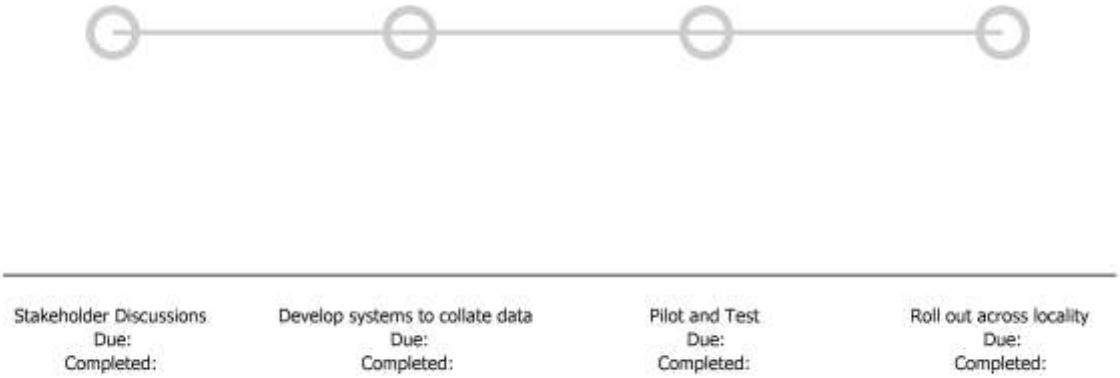
SDS Option 3 is where Social Work Services organise and purchase and manage care for people. For people under the age of 65 and depending upon individual financial assessments, care at home may be charged for. There are multiple factors that can influence the number of people under 65 receiving personal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

Improvement Actions

Nithsdale Health and Wellbeing Partnership (NHWP) are funded by Nithsdale Locality to develop day opportunities in partnership with third sector agencies and community groups. This includes the Friendship and Lunch Club at the Oasis Centre. This club is a weekly lunch and activity club for young adults who have additional support needs, so that they can meet new people, learn new skills and feel less isolated. Activities include craft work, games and exercise sessions.

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; Nithsdale



Key Points

This indicator has not yet been developed.

The Wider Context

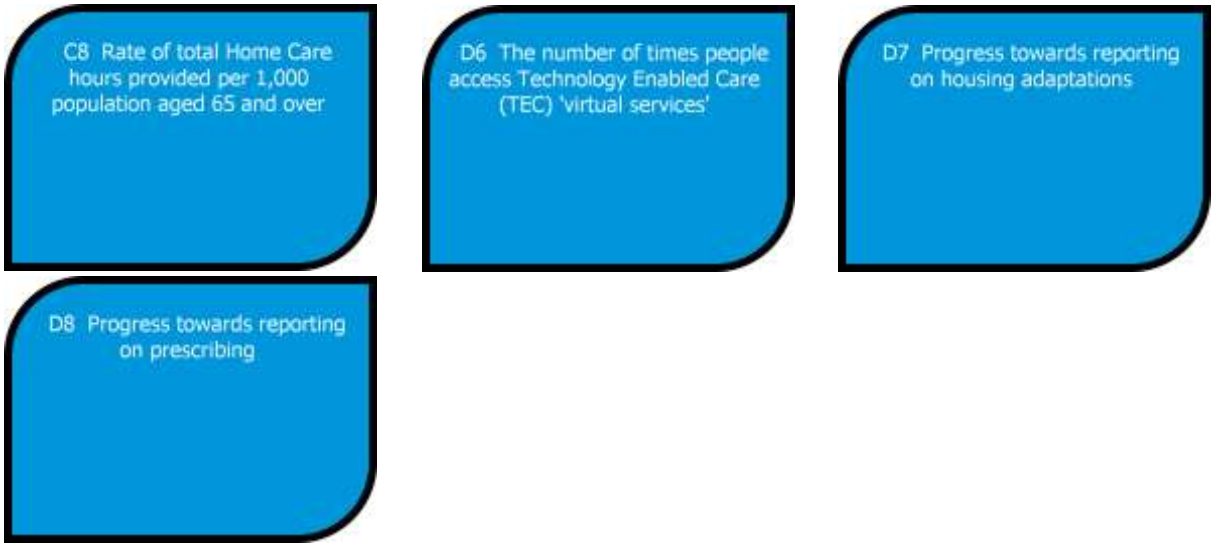
All people have the right to live free from physical, sexual, psychological or emotional, financial or material neglect, discriminatory harm or abuse. The Strategic Plan recognises this as a key priority.

Improvement Actions

A Multi Agency Screening Hub (MASH) has been successfully implemented for Dumfries and Galloway. The MASH screen and respond to referrals where there is a concern that an adult may be at risk of harm. Within this service social services, police and health services are based together to share information and make informed decisions about the protection of adults in our community. Nithsdale Locality has supported the MASH development and continues to oversee the social work input.

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; Nithsdale

Key Points

This is a Data Only indicator.

In December 2017 the rate of Home Care provision in Nithsdale was 744 hours per 1,000 population aged 65 and over. This has increased since March 2017, when the rate as 683 hours.

The rate for Nithsdale is higher 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 care at home are provided each year. It is anticipated that there will be a further decrease as more people opt for Self Directed Support (SDS) Options 1 and 2. However, there will be a need to understand how many people are in receipt of care and support through all the options and not just care at home hours.

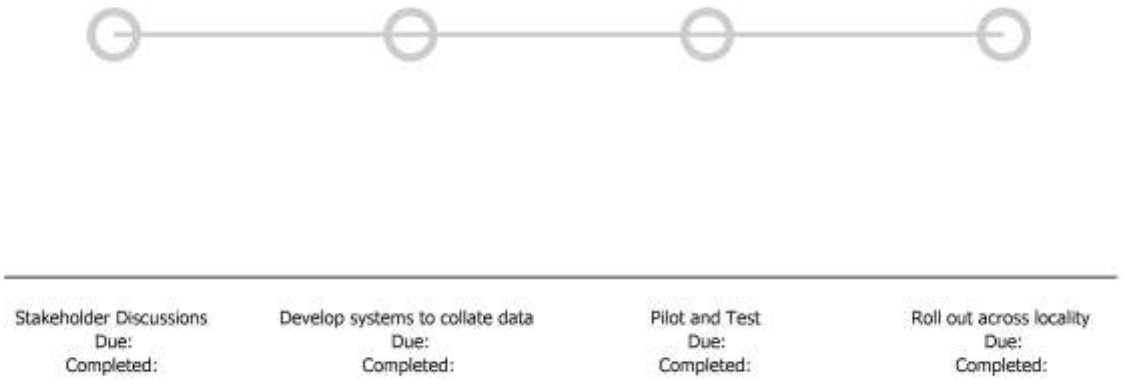
Records on the Framework-i information system have been reviewed and rationalised in preparation for migration to the new Mosaic information system. This will be monitored.

Improvement Actions

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

D6 Technology Enabled Care (TEC) - Virtual Services

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



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

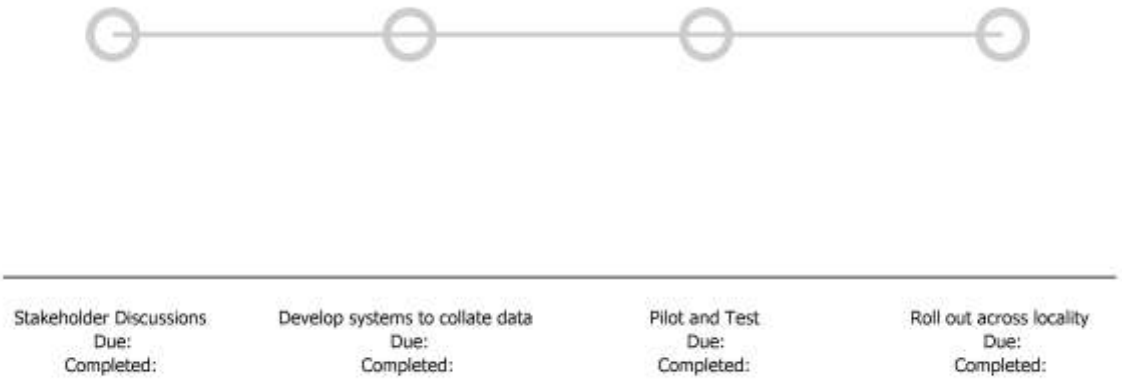
Recognising the need to develop systems that support Self Directed Support (SDS) within an integrated environment, we are developing a new Outcome Focussed Tool. This development is funded by the Nithsdale Locality.

The tool focuses on the person's wellbeing, the resources and assets at their disposal and the resources offered by services. It provides a common outcomes-focused framework that enables people, their family and Carers, health and social care professionals and providers to work better together. The tool will eventually take over from the current SDS planning tool in the Mosaic computer system.

A short life working group was established to design, test and implement the tool and to ensure it is useful for all sectors. The tool has been created and is currently out for consultation across practitioner groups. All of the feedback will be collated and relevant changes made to the tool before it goes live. Nithsdale Locality will support with the training and implementation of this tool for all localities.

D7 Housing adaptations

Progress towards reporting on housing adaptations; Nithsdale



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

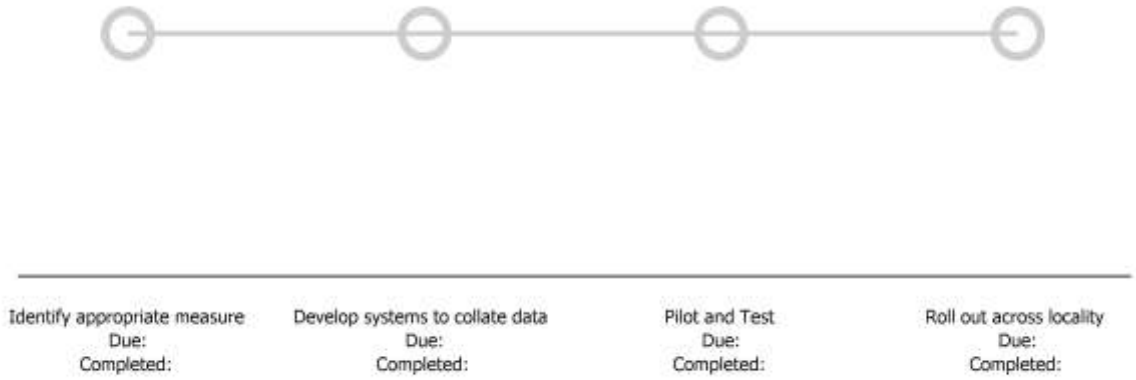
Nithsdale in Partnership (NiP) - Assessment at Home:

The aim of this team is to reduce unnecessary admissions to hospital, by supporting GPs, and improving the flow of people discharged from Dumfries and Galloway Royal Infirmary (DGRI) to return to their home. The team is working in collaboration with colleagues at the Short Term Assessment Reablement Service (STARS), Social Work Services, Care and Support Service (CASS) and other health and social care partners.

People who live in DG1 or DG2 can be referred to NiP by their GP, hospital, or any other health and social care partner. NiP assesses people in their own homes. They provide support and expertise in the initial period of re-adjustment back to their home setting after a hospital stay, or help keep people at home. This can range from a single visit to multiple visits over a period of time. The team provide a range of interventions including Occupational Therapy (OT), social work, pharmacy, community nursing, physiotherapy and health and wellbeing support. The rapid response team work closely with colleagues and can identify people at an earlier point in their journey for housing and equipment adaptations liaising with colleagues and the equipment bank to ensure this support in put in place to assist people to live safely and as independently as possible at home.

D8 Prescribing

Progress towards reporting on prescribing; Nithsdale



Key Points

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

The Wider Context

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

Improvement Actions

The Optimise initiative is being led by the prescribing support team in Nithsdale Locality. This initiative aims to identify and prioritise groups of people where detailed medication reviews in a homely setting may be of benefit. Pharmacists can receive referrals from across the health and social care partnership. Optimise has received referrals from a variety of sources including Short Term Assessment Reablement Service (STARS), Social Work, speech and language therapy and the Nithsdale in Partnership Assessment at Home team. Examples of changes made following medication reviews include:

- Changing to the most appropriate combinations of medication
- Stopping unnecessary medication
- Reducing the number of times a day people need to take medication

In addition, the prescribing support pharmacists have been working closely with the secondary care outreach pharmacists, who follow up people discharged from Dumfries and Galloway Royal Infirmary (DGRI) with medication issues. For example, some people's medication doses need to be adjusted.

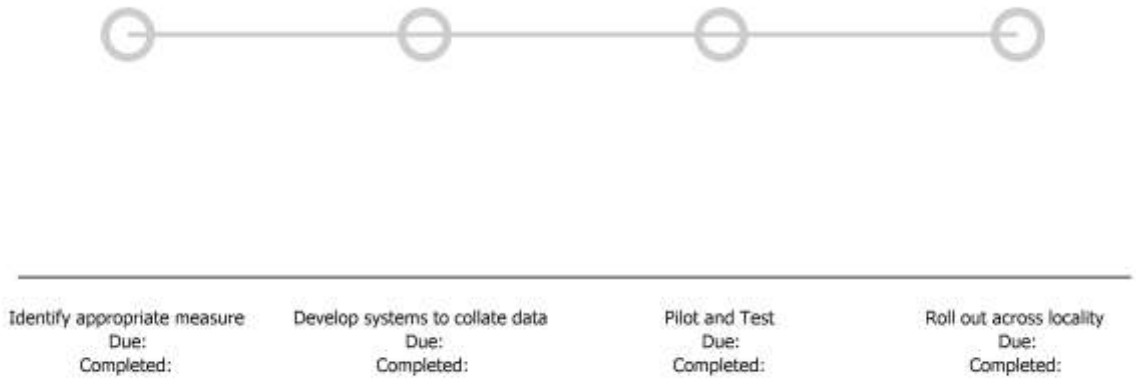
The team also continues to work closely with GP practices supporting safe and effective prescribing. The roll out of new GP contract in April 2018 will provide new opportunities for pharmacists to support the pharmacotherapy service as detailed in the GP contract.

Performance Indicator Overview

Quality

D4 People's progress towards achieving personal outcomes

Progress towards reporting on personal outcomes; Nithsdale



Key Points

Development of this indicator has not begun.

The Wider Context

A key aim of health and social care integration is to make care more person centred. This indicator is a measurement focusing on peoples own goals and how Dumfries and Galloway Health and Social Care Partnership is supporting people to achieve them.

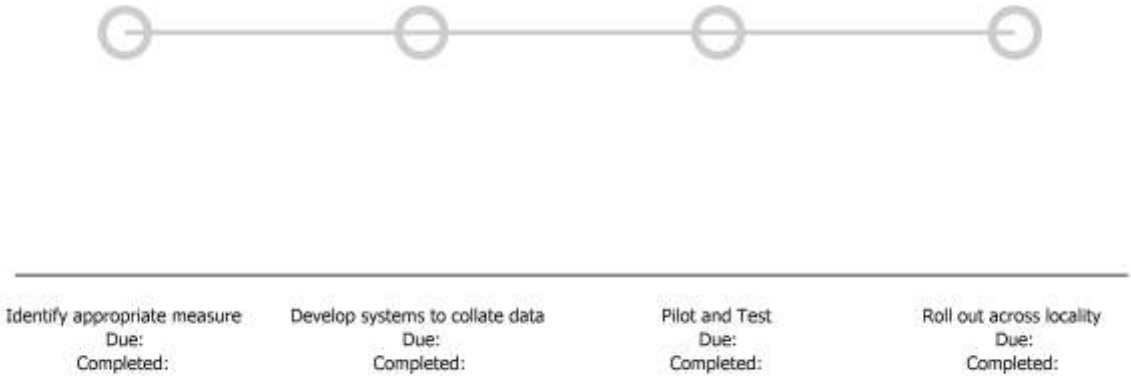
Improvement Actions

The Nithsdale Health and Wellbeing Team use Healthy Connections as an approach to enable people to improve their health and wellbeing. This is done by linking people to different activities and organisations in the community or, through lifestyle coaching, either on an individual or a group basis. This service focuses on those in most need as a result of loneliness, isolation, stress or living with a long term condition. People can access Healthy Connections either through a referral from a range of health and social care partners or through a self referral.
Some of the initiatives supported by Healthy Connections include:

- Increasing people's engagement with their local community by signposting to relevant day opportunities such as the Friendship Group or the Community Garden. People can be accompanied to these groups initially by a member of staff to support them if they are too anxious to attend groups for the first time on their own. Often they are usually fine after the first session.
- Men's Sheds attract a broad range of men from professional backgrounds through to those who are vulnerable. They are self sustaining, with participants supporting each other. Between 40 and 50 people use Men's Sheds in Dumfries each week.
- The Mature Drivers scheme for those over 60 years old aims to keep people mobile, reduce isolation and increase both confidence and driving ability. This scheme is provided in conjunction with Police Scotland and local driving instructors. During 2017 34 people took up this offer of support, 28 from Dumfries town and 6 from more rural areas of Nithsdale.
- Living Life to the Full courses are run with the aim of helping people to improving their mental wellbeing by looking at ways to better cope with life's stresses. 26 people completed this course in 2017.

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; Nithsdale



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

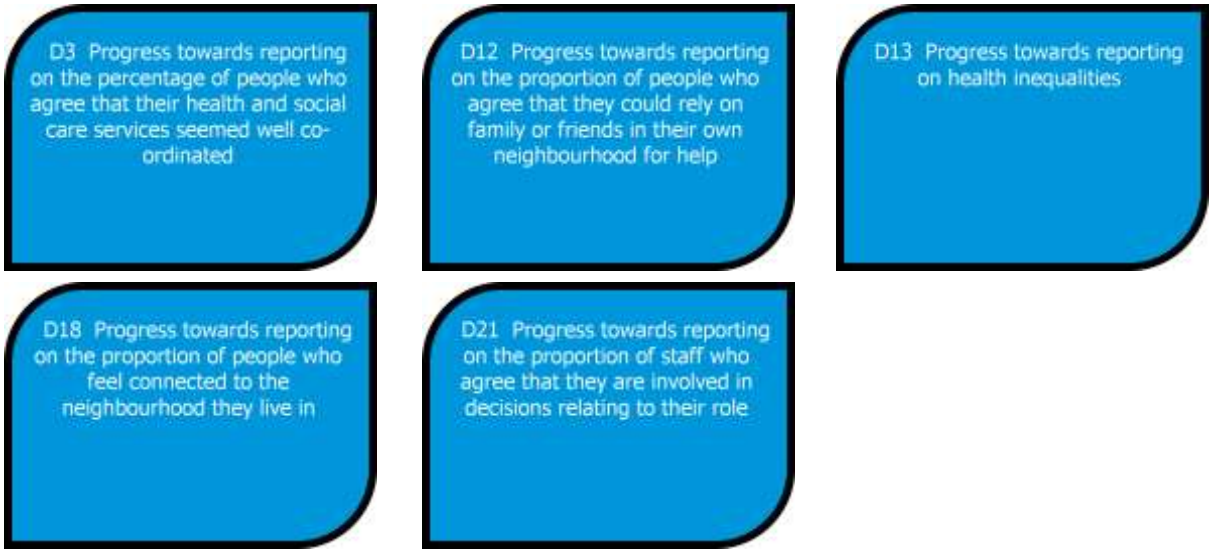
We have recently introduced a work force forum for people who do not hold a supervisor or team leader position. We have representatives from all areas in Nithsdale including people and areas that are hosted outwith Nithsdale Locality but within Dumfries and Galloway, like Care and Support Service (CASS) and Short Term Assessment Reablement Service (STARS).

The purpose of the group is to facilitate a sense of 'we are all in this together' and to understand what is really happening on the ground. The group has identified good practice in our communication and also gaps in some areas where there is room for improvement. The group have all agreed to write a short piece describing 'what is my job' and 'my typical day' to share and circulate in the Locality. After the first session in November 2017, one of our district nurses said:

'Already I'm getting a better sense of what others are doing and I've leant lots this morning in an hour, a good use of my time.'

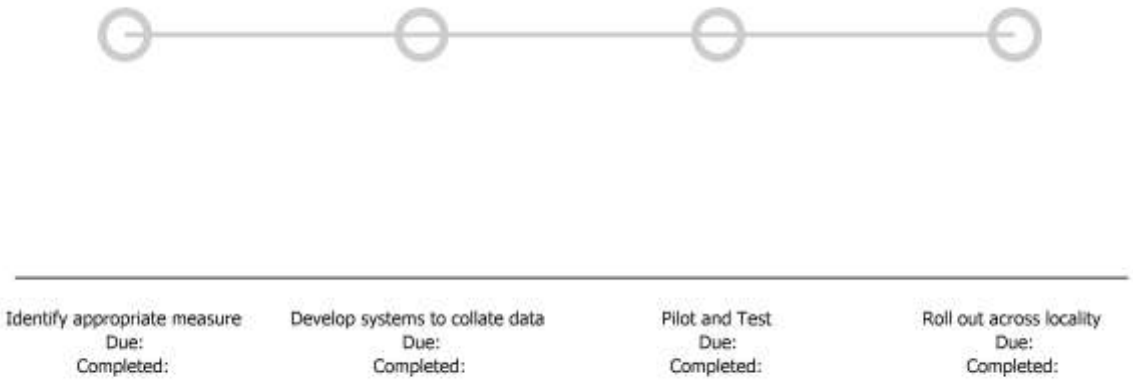
Performance Indicator Overview

Stakeholder Experience



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; Nithsdale



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.

The Scottish Government has published its third National Dementia Strategy for 2017-2020.

Improvement Actions

Focus on Dementia are testing the value of delivering post-diagnostic support from primary care settings which is Commitment 2 in the third National Dementia Strategy. Nithsdale Locality has been successful in bidding for 2 year funding to build post diagnosis support pathways in primary care. The aims of this programme include:

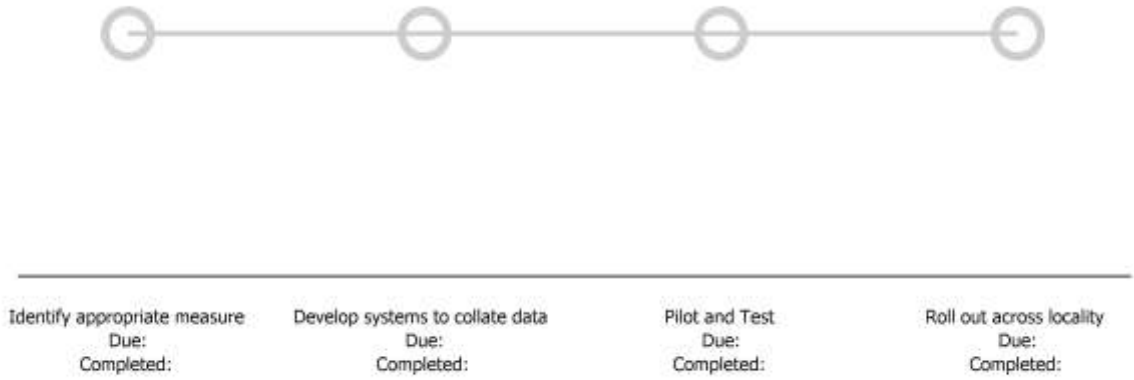
- GPs and staff in primary care will have an improved knowledge of dementia care management and available support services and networks
- GPs and staff in primary care will have improved and established links with specialist service and third sector organisations involved in providing support to people with dementia, their families and Carers. This will improve and create effective joint working to meet people and Carer's needs.
- GPs and staff in primary care will be able to offer people with dementia and their families and Carers a significantly improved service. This includes coordinated, holistic and timely care and treatment. Consideration is given to both physical and mental health, with easier access to services, care and treatment, and therefore reducing health inequalities.

Community Development staff, through the Building Healthy Communities (BHC) programme continues to support volunteers to deliver Tai Chi across the Locality. Approximately 140 people benefitted from this activity during 2017. Feedback from people has highlighted how important the social aspect of this activity is:

"I feel the benefit of Tai Chi classes – I'm more relaxed and really enjoy the social aspect too"

D13 Health inequalities

Progress towards reporting on health inequalities; Nithsdale



Key Points

Development of this indicator is underway.

The Wider Context

Development and implementation of a locally agreed indicator is currently under discussion by a short life working group. The group is tasked with scoping and developing the proposed health inequalities indicator and producing a work programme to support implementation of the indicator. This work will include linking with the Equality Implementation Group, overseeing the governance pathway for agreeing the indicator and supporting the monitoring and future performance reporting of the preferred indicator.

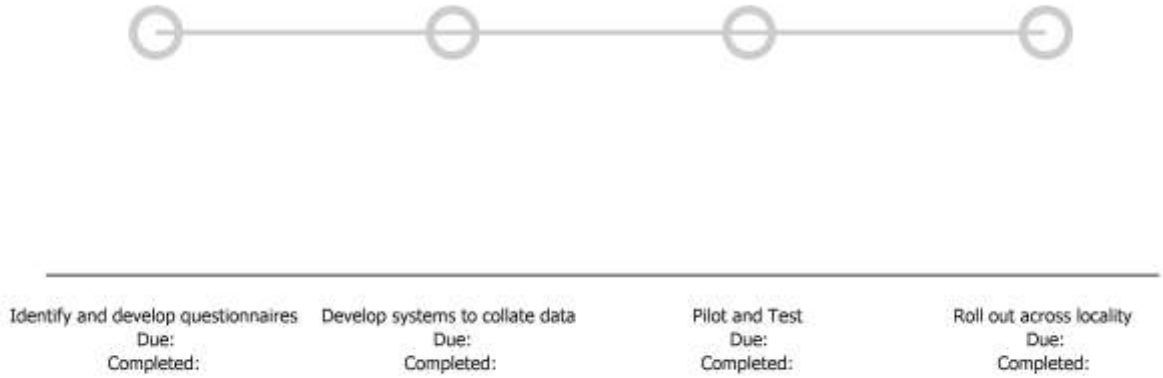
Improvement Actions

Nithsdale Locality funds the Nithsdale Health and Wellbeing Partnership (NHWP) to develop day opportunities in partnership with third sector agencies and community groups. NHWP has partners from health and social care, including representatives from the third sector and representatives from the public. Projects funded between April 2017 and December 2017 include:

- Replacement of the heating boiler at Locharbriggs Village Hall, so that the hall can continue to be used by many different user groups
- Women's Social Group at Dumfries Get Together - A ladies group which aims to build confidence and combat social isolation by offering a range of activities such as coffee afternoons, walking groups, theatre trips and day trips. There are currently 95 members aged 35-81 years.
- Freedom Cafe at D&G LGBT Plus - A safe, private, LGBT affirming space, where LGBT Plus adults can meet, without fear of discrimination or victimisation, every month. This provides an opportunity for peer to peer support.
- Veterans Breakfast Club by The First Base Agency - An opportunity for veterans of all ages to meet up to enjoy comradeship. Attended by an average of 25 veterans each month, the club offers them a space for informal peer support, so that people feel less isolated and lonely (especially in their experiences of combat and returning to civilian life).

D18 Community strength: connectedness

Progress towards reporting on the proportion of people who feel connected to the neighbourhood they live in; Nithsdale



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 are connected to their community, and community strength. The responses to this indicator provide an indirect measure for community strength.

Improvement Actions

Healthy Connections is an approach that aims to enable people to improve their wellbeing. A key aspect of Healthy Connections is tackling social isolation. The latest Health Scotland publication (*see below) on social isolation identified that there is no 'typical profile' for someone at risk of social isolation or loneliness. However people with socio-economic disadvantage, poor physical or mental health or who may be living alone can be at an increased risk of loneliness.

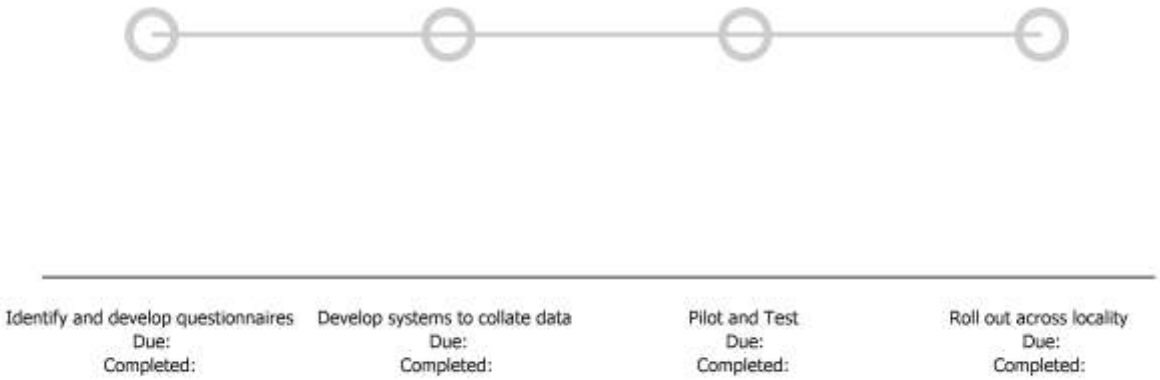
Between April 2017 and December 2017 healthy connections received 331 referrals. 70% of referrals are for those living in deprived circumstances. Referrals have come from a wide variety of partners including General Practice, Social Work, Dumfries and Galloway Carers Centre (DGCC), self-referrals and Short Term Assessment Reablement Service (STARS).

People who have engaged with Healthy Connections have been introduced to over 90 different third sector organisations, including DGCC, Financial Inclusion and Assessment Team (FIAT) advice, Cuppa Club and Men's Shed.

*Teuton, J (2018) Social Isolation and Loneliness in Scotland, available from: http://www.healthscotland.scot/media/1712/social-isolation-and-loneliness-in-scotland-a-review-of-prevalence-and-trends.pdf

D21 Staff involved in decisions

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



Key Points

This indicator has not yet been developed.

The Wider Context

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

Improvement Actions

The implementation of Nithsdale in Partnership (NiP) and the One Team concept has already had an impact and our teams are working better together. We are achieving this through joint process mapping, communication and engagement sessions and the staff forum. Staff are undertaking Collaborative Leadership in Practice through NHS Education for Scotland (NES) and the Scottish Social Services Council (SSSC). In addition we are working closely with the Care and Support Service transitional support team.

Nithsdale Locality continues to support staff from across the health and social care partnership. This support includes:

- Healthy Working Lives is a standing item on management team agenda with reaccreditation of the gold award achieved in October 2017
- Meetings are held every 2 months with Nithsdale GP practices to explore issues faced by general practice and how they may be supported
- Following the iMatter survey in undertaken by NHS employees in 2017, an action plan has been developed
- A staff mindfulness course is run annually
- The Nithsdale integration newsletter is produced monthly. This has a focus on the different roles involved in the health and social care partnership and their contribution to integration

Appendix 1: Table of “We Wills”

Ref & RAG Status	Description
1	We will develop community link approaches within Nithsdale locality which enable people to have the information, motivation and opportunity to live a healthy life for as long as possible
2	We will support people to participate and engage in their communities as they choose; to access day opportunities and activities which they feel are important to them, to stay as independent as possible, happy, safe and well
3	We will work with staff groups within health and social care, enabling them to motivate, educate and support people to improve their health and wellbeing
4	We will roll out programmes such as Mindfulness, Living Life To The Full and Ten Keys To Happier Living. .
5	We will make efficient use of our staff resources and services by improving communication and co-ordination.
6	We will work with all partners to create opportunities for people living with dementia to remain active, and involved in their existing interests and chosen communities where possible.
7	We will work with partners to consider housing and support options to reflect the needs of Nithsdale locality
8	We will creatively look at developing different approaches to how we use care-home, care at home and other resources
9	We will ensure access to self-directed support and person-centred approaches by utilising the appropriate resources and skills of the partnership.
10	We will enable people including those with disabilities, long term conditions or who are frail to access information and support when they need it.
11	We will develop the role of the community flow coordinator to deliver a positive home from hospital experience for people living in Nithsdale
12	We will support staff to increase and/or acquire the necessary skills, knowledge and experience to adopt a person centred approach to the planning and delivery of care and support.
13	We will work in partnership to promote consistency of practice and person centred approaches
14	We will work towards reducing the health inequalities experienced by particular people, groups and communities.
15	We will listen to and involve Carers in discussions with the person they care for regarding their caring role
16	We will improve support for Carers by promoting local services and resources

17	We will implement and support ‘carer awareness’ across our workforce which will help identify carers
18	We will support Carers to identify ways in which they can be supported to enhance their quality of life
19	We will keep people at the centre of what we do, working with all partners to improve the way we identify, support and protect adults who are vulnerable to physical, psychological or financial harm
20	We will identify where integrated approaches can support and develop the existing workforce using a variety of resources, reducing duplication and promoting the sharing of skills and training.
21	We will identify and promote career pathways which enable local workers to develop their knowledge and skills to meet future gaps in the workforce.
22	We will explore the opportunities to use technology to support the workforce
23	We will engage with them, listening to the views of staff
24	We will through effective use of resources, including those of the individual, support the redesign of integrated services
25	We will develop and promote a culture amongst staff and the people who use services that will support and engage with the redesign of services. These services will be sustainable, promote independence, support an ethos of reablement and deliver person centred outcomes.
26	We will encourage and support recruitment in to the care sector
27	We will work with all partners to look at how we can make the best use of assets and resources
28	We will build on the existing initiatives in Nithsdale to ensure safe, appropriate, effective prescribing