Local Delivery Plan 2015-16

Foreword from NHS Dumfries & Galloway Chief Executive, Jeff Ace

This is NHS Dumfries & Galloway's tenth Local Delivery Plan (LDP), developed in line with Scottish Government Health Directorates (SGHD) guidance of 19 and 23 December 2014, and early feedback from Scottish Government leads during March 2015.

The LDP is the delivery contract between SGHD and Dumfries & Galloway NHS Board. The 2015/16 LDP is reflective of the Government's national ambitions articulated in the 2020 Vision for Health & Social Care in Scotland (May 2013), with a focus on 6 Strategic Priority areas. It also provides details of on-going HEAT Targets and Standards (now titled LDP Standards), is underpinned by an associated Financial Plan, the Everyone Matters: 2020 Vision Workforce Vision Implementation Plan, and the local NHS contributions to Community Planning Partnerships in accordance with the Agreement on Joint Working on Community Planning and Resourcing.

On 1 April 2015 responsibility for adult health and social care services transfers formally to the new Health & Social Care Partnership within Dumfries and Galloway which will be responsible for a number of service areas, and, accordingly, for delivery of a number of the Standards and Priorities outlined in this Local Delivery Plan. During 2015/16, the partnership will develop a Joint Strategic Commissioning Plan (JSCP) setting out how it will achieve the 9 national health and well-being outcomes and the suite of 18 core indicators being developed to measure progress towards these. LDPs and JSCPs need to be mutually supportive, and steps will be taken locally to ensure that there is coherence and congruence between this LDP and the emerging JSCP during 2015/16.

Delivery of our LDP is also supported by a range of local service strategies and improvement plans, designed to ensure that we not only achieve the LDP Strategic Priorities and Standards, but also continue to deliver high quality, safe and effective care to the people of Dumfries & Galloway in line with the Government's 2020 Vision for Health and Social Care in Scotland

Risks and Issues

In developing this LDP, we have identified a number of risks and issues to delivery and summarise these below.

Financial issues

There are a number of risks within the financial plan:-

- Continued delivery of a breakeven position beyond 2015/16
- Uncertainty about financial allocations beyond 2015/16
- Delivery of 3% CRES, current gap £1.1m , with reliance of £1.3m non recurring savings, giving a recurring gap of £2.4m and high risk profile of existing plans
- Management of on-going cost pressures most notably medical locum costs which are requiring £4.8m non recurring support for 2015/16
- Ongoing medical recruitment challenges not just in the Acute Sector but increasing pressures in General Practice
- Planning for the financial implications of the new hospital including transitional costs
- Increased volume and costs pressures in primary and secondary care prescribing costs
- A number of non recurring sources have been used to deliver the financial position for 2015/16 outlined above

Targets and standards

Given the financial and service pressures across the system, there will be significant challenges to deliver all of the required targets in 2015/16. At the timeout the Board heard the detail of work in progress to try to address the service issues for unscheduled care. There are also a series of cost pressures related to delivering elective targets, most particularly workforce costs. Risks are captured within the LDP standards section of the LDP.

Delayed discharges: the plan requires a major reduction in the current level of delayed discharges, including consistent delivery of the national targets to enable the acute sector to achieve the bed reductions included in the savings plan and improve unscheduled care.

Service change proposals: the plan includes a number of service change proposals which need to be delivered during 2015/16 to achieve in year balance and also proposals to be delivered from the start of 2016/17 to ensure that recurring balance is restored. If any of these changes are not able to be delivered then balance in 2015/16 is at risk and the financial challenge of 2016/17 increases.

While presenting this LDP as a statement of our aims and ambitions in relation to the Strategic Priorities and Standards, we are being prudent in highlighting areas where progress may be hampered by factors that are unknown at time of writing.

Local Delivery Plan 2015-16

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Triple Aim		**Quality of Care Health of the Population Value and Sustainability**					
Quality Ambitions		**Person Centred**	**Safe**	**Effective**			
Six Priority Areas for Improvement		**Person Centred Care**	**Safe Care**	**Primary Care**	**Integration**	**Antenatal and Early Years**	**Health Inequalities and Prevention**
Documents to support delivery of the Priority Areas							
1	Joint Health and Wellbeing Unit Action Plan 2011 http://www.nhsdg.scot.nhs.uk/files/JHWU_Action_Plan.pdf	✔		✔	✔	✔	✔
2	Single Outcome Agreement 2013-16 http://www.dumgal.gov.uk/CHttpHandler.ashx?id=216&p=0	✔			✔	✔	✔
3	NHS D&G Winter Plan 2014-15 http://www.nhsdg.scot.nhs.uk/About_Us/Publications/Files/Winter_Plan_2014-15.pdf	✔	✔		✔		
4	Health Improvement - Sexual Health and Wellbeing Strategy for Dumfries and Galloway 2011-2015 http://www.dghealthandwellbeing.co.uk/index.aspx?articleid=11481	✔			✔	✔	✔
5	Building Healthy Communities - Strategy and Action Plan 2008-2013 http://www.dumgal.gov.uk/CHttpHandler.ashx?id=3605&p=0	✔			✔	✔	✔
6	Integration of Adult Health and Social Care in Scotland - D&G Strategic Partnership submission http://www.dumgal.gov.uk/communityplanning/CHttpHandler.ashx?id=10857&p=0	✔		✔	✔	✔	✔
7	Putting You First Programme 2010-2015 http://www.nhsdg.scot.nhs.uk/Departments_and_Services/Putting_You_First/Putting_You_First_Home	✔		✔	✔		✔
8	Alcohol and Drugs Partnership Delivery Plan 2012-2015 http://www.nhsdg.scot.nhs.uk/files/Delivery_Plan_2012-15.pdf	✔	✔		✔		✔

‘At a Glance’ Map of Key Local Plans (2/2)

Triple Aim		**Quality of Care Health of the Population Value and Sustainability**						
Quality Ambitions		**Person Centred**	**Safe**	**Effective**				
Six Priority Areas for Improvement		**Person Centred Care**	**Safe Care**	**Primary Care**	**Integration**	**Antenatal and Early Years**	**Health Inequalities and Prevention**
Documents to support delivery of the Priority Areas								
9	Dumfries & Galloway Health Board Prescribing Support Team Website http://www.dgprescribingmatters.co.uk/index.asp	✔	✔		✔		
10	DG Health and Wellbeing Adults and Older People Action Plan Refresh 2013-2015 http://www.dumgal.gov.uk/dghw/CHttpHandler.ashx?id=13457&p=0	✔			✔		
11	NHS Dumfries & Galloway Workforce Plan 2013-2017 http://www.nhsdg.scot.nhs.uk/About_Us/Publications/Files/Workforce_Plan_2013_-_17.pdf	✔	✔		✔		
12	Dumfries & Galloway Joint Carers Strategy http://www.nhsdg.scot.nhs.uk/Resources/Carers/Documents/Carers_Strategy_2012_to_2017_FINAL_VS.pdf	✔			✔		
13	Dumfries & Galloway Joint Strategic Plan For Older People 2012-2022 http://www.puttingyoufirst.org.uk/documents/Joint_Strategic_Plan.pdf From 23rd March 2015 this will appear at: http://www.nhsdg.scot.nhs.uk/Departments_and_Services/Putting_You_First/Putting_You_First_Home	✔	✔		✔		✔
14	Draft Dumfries & Galloway Local Housing Strategy 2011-2016 http://www.dumgal.gov.uk/CHttpHandler.ashx?id=6689&p=0	✔	✔		✔		✔
15	Dumfries & Galloway Children’s Services Plan *Going to Committee on 26 March for final approval and will then be posted on the Council website*	✔			✔	✔	

Section One:

Improvement Priorities

1. Health Inequalities and Prevention

Action to address health improvement and reduce health inequalities is led by DG Health and Wellbeing, a joint unit between the NHS and Council, which was established in June 2011. (DG Health and Wellbeing is part of Public Health in NHS D&G).

Given the complex nature of improving the health and wellbeing of the whole population and reducing health inequalities, much of the work of DG Health and Wellbeing is progressed in partnership, taking a life course approach (addressing health issues at key stages of life and revisiting them at appropriate transition points over the life course).

A jointly agreed action plan, which identified a large number of actions, often interlinked, has been agreed across the partners and is expected to be sustained with a long term commitment. However, refinement of the agreed action plan has been undertaken to ensure appropriate focus in the future. The life stage approach means that health issues are addressed at key stages of life and revisited at appropriate transition points over the life course.

The strategic direction is aligned to a number of national and local policy drivers including; Getting it Right for Every Child, Single Outcome Agreement 2013 -16, Health and Social Care Integration. The work of DG Health and Wellbeing is also aligned to a number of local strategies and action plans for example physical activity, sexual health and locality health improvement plans.

The vision is for:

- Children and young people enter adulthood with optimum levels of health and wellbeing
- All adults and older people living and working in Dumfries and Galloway will have the opportunity to achieve optimum levels of health and wellbeing

The high level outcomes identified to support progress towards the vision are:

1. Children enter primary school with optimum levels of health and wellbeing
2. Children enter secondary school with optimum levels of health and wellbeing
3. Young people enter adulthood with optimum levels of health and wellbeing
4. Adults and older people experience good mental and physical health and wellbeing
5. High levels of social capital, safety and security are experienced by all through community capacity building
6. People in work experience optimal health and wellbeing and the impact of financial hardship is mitigated

Building resilience in individuals, families and across communities is recognised as being effective in improving health and wellbeing outcomes. A life stage approach is taken to improving outcomes across the life course. This recognises that the opportunities to improve outcomes are different, depending on the life stage; early years, adolescents, adults and older people.

The actions identified have been set based on; national priorities, local need and the evidence base.

They fall into four key areas: strengthening local communities, including schools, improving mental health and wellbeing; increasing physical activity and addressing food and health; increasing partnership working to address health inequalities. Programmes of work are a mix of topic based activity (based on national and local need and evidence of impact on long term health outcomes) and holistic approaches to increase individual and community resilience to improve health and reduce health inequalities.

Approach

Programmes of work will continue to take an assets based approach which ensures local engagement and participation on an individual, family and community level. The aim is to work with individuals and communities to meet need, promoting equity and sustainability.

DG Health and Wellbeing aims to encourage and enable people to take control of their lives by continuously putting the person at the centre of everything we do. This is consistent with the person centred approach at the centre of both the NHS Quality Framework and the report of the Christie Commission on the future of Public Services delivery.

Working in partnership is a key premise of DG Health and Wellbeing and team members work with local staff and partner agencies to ensure the best possible use of all local resources. Therefore, the DG Health and Wellbeing Action Plan does not stand in isolation and should be viewed in association with local health partnership action plans and the action plans of partner agencies. Priority areas such as smoking, drugs and alcohol are progressed through partner planning.

The Action Plan for Health and Wellbeing improvement is agreed with NHS and Local Authority with 6-monthly reporting to the NHS Public Health Committee (which includes Council) and the Customer and Community Services Committee in the Council.

To progress the NHS corporate responsibility to address health inequalities, the plan over the next year is to agree a health inequalities strategy for Dumfries and Galloway which draws together all the actions being taken forward by partners.

Tobacco related health inequalities

Our approach will focus in two main areas which will be:-

1. Improving and increasing our smoking cessation delivery

and

2. Creating an updated local Tobacco Control Action Plan that encompasses all existing work and develops new ways of working to tackle specifically tobacco and inequalities

1.Stop Smoking Services- Improvement plan in relation to meeting the standard (successfully quit at 12 weeks) and addressing key challenges will include the following:-

- We will work to increase numbers of smokers using specialist services. This means we need to maintain the referral numbers where referral pathways are working well and encouraging greater ownership of the target across the NHS and work with GP practices where we need to encourage more referrals

- For smokers who refer themselves to stop smoking services we will provide instant access to stop smoking support through a telephone/face to face quit programme.

- We will work more with employers and business in the region to offer on site quit smoking programmes targeting key geographic areas initially and working alongside other health professionals.

- We will provide dedicated staff time in specialist services to do more work on Lost to follow up and we will in conjunction with this, include in our first time appointments a relapse prevention discussion. This work will be prioritised in deprived communities and more rural and isolated communities.

- We will increase our client contact throughout their quit attempt to try and address Lost to follow up and we will do this with more texting and phone interventions along with the conventional face to face appointments.

- We will do more proactive work to promote stop smoking services in key geographic areas, for example door to door promotion in small communities.

- We will provide each pharmacy with the offer of on site training for their pharmacy and in conjunction with this we will also offer training sessions on prescribing and using the PCR system across the region.

- We will work with our Pharmacy colleagues to integrate specialist and community pharmacies services to establish a D&G standard.

- We will ask more clients for their story to try and use more real life client situations to encourage greater engagement of clients in different communities.

- We will review our clinic delivery times and locations, and there will be an increased focus on locations and times in deprived areas along with isolated communities

- We will continue to take a partnership approach to promote to work with specific groups i.e. mental health services, maternity services and multi agency clinics, Addiction services.

- We will work more closely with Smoking cessation services in our prison to address to ensure service improvements are universal in the community hospital and within prison services.

- We will review prescribing protocols in light of changes in relation to E.cigarette use and Cut down to quit programmes

2.Broader Tobacco Control

We will develop and agree a Dumfries & Galloway Tobacco Action Plan and this plan will include current work in Smoking Prevention and Control as well as increasing our efforts in the following areas :-

- Early Years Collaborative work – which will include training with all Health Visitors in REFRESH and implementing a similar referral model as with maternity services. This will also include taking forward a Second Hand Smoke campaign message through nursery education (subject to discussion and agreement with childrens services) and we would want to extend this work to have more family based intervention work on Second Hand Smoke. We will also deliver SHS training to NHS staff and community partnerships.

- ASSIST programme, we will be trialling the ASSIST programme in D&G taking a partnership approach to this work with NHS Ayrshire & Arran. Schools and geographic areas will be prioritised in the delivery of this programme.

- Education - A series of educational programmes of work with young people are delivered through Primary, Secondary and Further education (this includes classroom & assembly programmes, young people events and through youth settings). This work is delivered in all schools across the region and a greater intensity of work is prioritised in key geographic areas in the region.

- Education and smoke free grounds, we will work with education to support a fully implemented Smoke free grounds policy for all secondary education.

- We will increase our communication and marketing with a much greater use of social media and marketing specifically with young people.

2. Antenatal and Early Years

A Children's Services Inspection in 2014-2015 enabled Dumfries and Galloway to refocus and prioritise on vulnerability. Key work has been taken forward under themes of Keeping Children Safe; Getting It Right For Every Child; Corporate Parenting (including Looked After Children); Early Years.

A multi-agency Children's Services Executive Group (CSEG) has been established with strategic groups for each of the four themes above reporting into this with regard to activity, aims and improvements.

A specific work stream to review and improve our multi-agency Pre-birth Pathway has been established in 2014-15 and this work will come to fruition in 2015-16. Improvements will be demonstrated with regard to risk assessment processes, completion timescales and support offered to women and families. This work also links closely to MCQIC goals.

The Early Years Collaborative is being implemented locally, with the Executive Nurse Director as the local multi-agency Lead. Workstream Leads are identified across agencies. Measurements to demonstrate reducing still birth rates, improving 27-30 month milestones are submitted nationally and published quarterly once validated by ISD. A key priority for Early Years work during 2015-16 is to review and develop a new multi-agency Parenting Strategy.

A multi-agency Children's Services Plan for 2015-16 has been developed with specific sections on each of the four themes highlighted above. The Early Years element of this plan is being delivered through the Early Years Group, reporting into and being monitored by the Children's Services Executive Group.

Actions to ensure that that the relevant parts of the workforce will have the capacity, training and relevant protocols to carry out duties under the Act by 1 August 2016 include:

- Distribution of the CYP Act - Consultation on draft Statutory Guidance and Orders - Engaging Children, Young People and Families will be undertaken to raise public awareness.

- Workforce succession planning and recruitment to vacant posts within Health Visiting. The Board has traditionally faced challenges with regard to recruitment. In response, a 'grow your own' approach is being taken, recruiting to Staff Nurses posts with progression through the Health Visitor training programme.

- A mulit-agency Children's Services Learning and Development Group has been established, which is a sub-group of the strategic Getting It Right For Every Child Group (GIRFEC). The role and remit of this group is the development of a Learning and Development Strategy for Dumfries and Galloway and the development and implementation of a Children's Services Training Calendar. Training is underway specific to Information Sharing and Child's Plan, prioritising staff who will undertake the roles of Named Person and Lead Professional and available to all staff.

- Work is also underway to develop a local training programme specific to staff who will undertake the roles of Named Person and Lead Professional.

- The strategic GIRFEC has also overseen the development of Dumfries and Galloway Practice Guidance and Information Sharing Guidance which is available to all staff in both hard copy and electronically.

- A Health Getting It Right For Every Child Group Champions Group has been developed with representation from all services within the Women, Children's and Sexual Health Directorate. Awareness rising with NHS staff of the Act is underway via this group.

- A multi-agency information sharing Portal is being developed lead by the Board's Head of IM&T.

- The Board has representation on the Children, Young People and Families Nursing Advisory Group.

With regard to Getting It Right For Every Child (GIRFEC) implementation we are undertaking the following:

- Public Awareness: awareness raising as to the effects, timings and benefits of the new provisions and duties in readiness for commencement on 1 August 2016 by using the nationally developed (when available) and locally adapted information leaflets.

- Health Visiting: capacity and capability workforce development planning to deliver the Named Person service from 1 August 2016 by using the national workload / case load tool to review and ensure appropriate skill mix for children and family needs. During 2015-16 we are working with partners in NES with regard to our viability for future implementation of Family Nurse Partnership and its principles of practice.

- Awareness raising with all NHS staff of their responsibilities under the Act and the relevant local policies, processes and procedures to support them - particularly around the sharing of information in relation to wellbeing concerns - and how these relate to current responsibilities for child protection.

- Child's Plans: an improvement workstream has already been under way during 2014-15 in reposnse to our local Children's Services Inspection. This work is continuing through 2015-16 with the roll out of multi agency training and case file audit to montiro implementation and quality assure the plans.

3. Person Centred Care

NHS Dumfries and Galloway continues to be committed to delivering person centred care, including delivery of the Person Centred Health and Care Collaborative. During 2015-16 this will build on and work towards sustainability in, previously initiated work including:

- Rolling out the use of Patient Opinion across the organisation, learning from tests in pilot areas. This will focus on timely responses devolved to as near-point of care as possible. In particular SCNs are testing responding to their own ward postings. The Nurse Director now also has the ability to respond to postings directly. The number and type of postings will continue to be reported to Board and Healthcare Governance Committee.

- A focussed review of our local complaints process to develop a more streamlined and responsive approach which is more person centred form staff and patient/family perspective. During 2015-16 key elements of this will be taken forward by joint funding with UWS of a PhD student looking at Restorative Practice in Complaints Practice. This will include establishment of a stakeholder reference group with a remit to make specific suggestions for tests of change which will be measured using improvement methodology and reported to the Person Centred Health and Care Committee. Another element of this work will be to review the information available (including content, medium, opportunities) to patients, families and carers that advises how to provide feedback.

- Using patient stories at governance committees to ground meetings in the patient experience, and at staff learning events to enable improvements to be identified, tested and reported. Developing closer working with other statutory agencies and the third and independent sectors to improve public engagement

- Developing an easily recognised heading for person centred learning under 'dgLearn'

- Weekly triage meetings within Acute & Diagnostics Directorate continue; at which Patient Services staff, general manager, senior nurses and associate medical directors discuss adverse incidents that have arisen in the previous week as well as any complaints and other elements of patient experience feedback that have been received. This will enable timely feedback and/or responses to those who have provided the feedback. A number of people who have feedback in this way have already been involved in our local Enhanced Patient Experience Days – where teams of staff interact with patients and families who have experienced our services.
- Development of a Public Involvement Panel to replace the PPF. This work is being undertaken with guidance and support from the Scottish Health Council and will support integration of health and socal care, both at IJB and locality level. Further detail with regard to this wil be developed and tested during 2015-16.

In addition during 2014-15 the following work has been developed and begun which is also supporting delivery of this agenda:

Leadership:

A locally developed and delivered Aspire to Lead Programme for aspiring Band 6 and Band 7 nurses. This is underpinned by caring conversations methodology and the impact on transforming culture on wards and units.

Staff Engagement

We are building capacity by training a local team of facilitators to grow and embed VBRP within health and social care, and third sector to aid reflection on practice and deepen self-awareness in practice - influencing attitudes and behaviours, building team relationships and enhancing staff fulfilment at work.

Self-management co-production:

Community Chaplaincy Listening: Building capacity to promote supported self-management in community contexts and the normalisation of feelings associated with transition and loss through recruitment, training and supervision of local community assets (experienced able listeners)

The NHS Dumfries and Galloway Person Centred Health and Care Committee provides assurance to the Board on the implementation of the national Person Centred Health and Care Programme. The role involves putting in place assurance mechanisms aimed at developing and enhancing a culture in which health and care services are consistently person centred.

4. Safe Care

NHS Dumfries & Galloway continues to be an active participant in all of the Scottish Patient Safety Programmes:

- Mental Health
- Primary Care
- Acute Adult
- Maternity & Children's Quality Improvement Collaborative (Maternity, Neonates & Paediatrics)

Executive Sponsor for the Safety Programmes is the Executive Nurse Director with programme support delivered by the Patient Safety & Improvement Team. Directorate Management Teams are responsible for delivery with Clinical Leads in place to provide on the ground leadership and direction.

Our goals for 2015/16 include developing improvement capacity and capability across our programmes, to support local ownership of improvement goals and to share learning across each of our programmes.

Progress has been made across each of the programmes during 2014/15:

Acute Adult

The overall aim of the Acute Adult Programme is to reduce avoidable mortality by 20 % and harm as identified by the Patient Safety Indicator.
To achieve this we are focusing on 10 Point of Care Priorities (9 national and one local).

Our HSMR for Dumfries & Galloway Royal Infirmary has reduced by 15.8% (based on July – Sept 14 data)

The Patient Safety & Improvement Team completed a validation of the 10 Safety Essentials in DGRI whereby all clinical areas were visited and compliance with the 10 Patient Safety Essentials was assessed through a review of self reported measures, discussion with staff, observation of practice and ward based audits. Eight out of the ten essentials were verified as being in universal practice. Work is ongoing with the Acute Management Team to address areas which require further focus.

Priorities for Improvement for 2014 – 2016 are the following Point of Care Priorities:

- Deteriorating Patients
- Sepsis
- Heart Failure
- Pressure Ulcers
- Surgical Site Infection
- Venous Thromboembolism
- Catheter Associated Urinary Tract Infection (CAUTI)
- Falls with Harm
- Safer Medicines
- Clinical Handover

Clinical Leads have now been appointed for each of the care priorities and teams established to support testing and implementation within a pilot unit. Each of the teams is at different stages of maturity with some only recently formed.

SPSP Primary Care

Year one of the Primary Care Safety Programme came to an end in August 2014. It focused on Warfarin Management. 32 out of 34 practices participated. Improvement was demonstrated by every practice although few have yet achieved the 95% goal for the Warfarin Bundle.

85% of practices completed the Safety Climate Survey and 82% of practices conducted Trigger Tool Case Note Reviews.

The new Local Enhanced Service for Medicine Reconciliation commenced in September with 32 out of 34 practices signing up to participate.

Four Local Learning events have taken place over the last 12 months to support practices with this work.

SPSP Mental Health

The aim of the MH Safety programme is to systematically reduce harm experienced by people using MH services. The programme moved out of its pilot stage in April 2014 with the local programme expanding to take in all 6 wards at Midpark Hospital. Several successful initiatives were developed during the pilot phase In Balcary Ward these included:

- Risk Assessment and management plans
- Improved practice in relation to observation levels
- Improved clinical handovers
- Introducing Safety Briefs to improve communication

The expansion into the new areas will not concentrate solely on spreading changes and successes from the pilot sites but will also encourage new tests of change and innovations to encourage engagement and ownership and to reflect the differing needs of each client group.

SPSP MCQIC

The aim for all strands of this programme is to reduce avoidable harm by 30% by December 2015 and to improve satisfaction with the care experience.

Each of the three areas is at a different stage of maturity with Neonates being the most recent addition in May 2014. Significant progress has been made in formalising measurement systems and in developing improvement capacity and capability. This will continue to be a focus for 2015.

Maternity have made significant progress in reducing the incidence of still birth and post partum haemorrhage through the introduction of safety briefs, CO monitoring and MEWs.

The Neonatal team have demonstrated good compliance with PVC Management and the Gentamicin Bundle and are currently reviewing priorities for 2015. Our Paediatric team continue to focus on Paediatric Early Warning System, improving communication through Safety Briefs and person centred care.

Vale of Leven Enquiry

During 2015-16 a piece of work will be established to test how to ensure appropriate quality and patient safety learning from all external scrutiny reports, such as Vale of Leven Inquiry Report, Morecambe Bay Inquiry Report. This will start with development of a recommendations and action log which will include identification of named leads and timescales for action.

In the context of this, during 2015-16 we will work with the Vale of Leven Inquiry associated Implementation Group and Reference Group, Scottish Government and our colleagues in Special Boards to take forward recommendations.

5. Primary Care

Primary care is considered to be the bedrock of NHS care provision, offering people comprehensive first-point-of-access advice, diagnosis and treatment, together with ongoing care coordination and support. It has a strong role in preventative health through screening and vaccination programmes, as well as a well-established secondary prevention role via the Qualities & Outcome Framework (QoF). Most practices also provide input to care and nursing homes, or cottage hospitals. Practices also have a strong role in the palliative care of patients dying at home or in the community.

The Scottish Government's 20:20 vision for healthcare in Scotland proposes that we will move to the provision of more and more care in people's homes or their communities, and hospital care will only be delivered when clinical need drives admission, and even then, the default position will be that hospital care will be delivered as day case treatment. The implication of this vision is that primary and community care services will be called upon to provide more services.

Scottish Government has indicated that it wishes to work in a collaborative manner with GP negotiators to develop a Scottish GMS contract. To aid this, the Government have signalled that there will be a period of minimal change in the GP contract until 2017, by when it is hoped that a new contract will have been agreed. The signs are that the new contract will aim to reduce the bureaucracy that is associated with aspects of the current contract, will support the preservation of General Practice in rural areas, and will make General Practice more attractive to new graduates. (Currently it is estimated that General Practice requires to recruit around 50% of new graduates, whereas the actual percentage is now just below 40%, and 10% of training places for general practice are unfilled)

The quality of the professionals in General Practice is a key factor in its ability to provide an effective service. There is considerable evidence (as in Accident and Emergency units) that a senior clinician seeing patients at presentation leads to more effective and efficient care. There is therefore a need to ensure that we have well trained and skilled doctors recruited to General Practice, although there is an equal need for the GPs to work as part of a small team, using other professionals to deliver care as appropriate.

They are many complex issues that are creating pressure in General Practice, threatening its sustainability: However there is almost no evidence to suggest that there are problems with the care that it delivers at present: Overall, patient satisfaction with GP services in Dumfries & Galloway – as assessed by a national patient survey last year – remains high, and although there is evidence that the level of satisfaction is decreasing slightly, the results show higher scores in Dumfries & Galloway than in other parts of Scotland.

There is however variation in practice ratings across the region. Partial evidence of clinical effectiveness is provided by the annual Quality and Outcomes Framework scores showing that most practices are scoring highly against the clinical domain criteria, which judge the adequacy of care across the main chronic disease standards.

Assessments of General Practice referrals and admissions by secondary care specialists suggests that local General Practitioners access secondary care services appropriately. However the current General Practice arrangements may not be sustainable due to a considerable number of pressures:

Recruitment

There is a national shortage of qualified GPs, which is becoming more and more of an issue in Dumfries & Galloway, where there have been 135 GPs working in practices. A survey in summer 2014 showed that over 25% of all GPs in Dumfries & Galloway were over the age of 55. In the face of decreasing income, increased workload, lowered job satisfaction, criticism by the media and changes in pension arrangements, many of these GPs will leave the practices they are in in the next few years.

Already the loss of a number of doctors through retirement has led to long term vacancies in practices in the area. While at least 12 vacancies are known, the results of a survey of practices taken in January 2015 is not yet available, and may show higher figures. The vacancies may be compounded by sickness and/or maternity leave, leaving some practices vulnerable to either having to withdraw services, or to failure, requiring the NHS Board to make arrangements to provide services directly. It is considered that the Board would have great difficulty in running a practice, particularly in the current recruitment market. For all practices, the current recruitment challenges have resulted in extreme difficulties in accessing locums – which are becoming more and more expensive.

Young entrants to General Practice have developed changed views of General Practice compared to their immediate predecessors – many view with concern the prospects of taking on a partnership role, and wish to avoid the management and employer responsibilities that come with this role. In addition, in some cases new partners are expected to buy from a retiring partner a share in any equity in the business. Whilst this is less common these days, a significant number of practices still have GP owned premises, creating a disincentive to recruitment.

Integration

The Board is preparing for the integration of health and adult social care, with the shadow Integrated Joint Board starting in April 2015, and followed one year later by a fully operational Joint Board. The thinking behind integration is that joint delivery of health and social care by one organisation will be more efficient, reduce duplication, and provide seamless joined up care to the population. This, it is argued, will produce services that are more economical in an age of continuing austerity, and will allow the resources provided to provide adequate services to the increasing number of older patients.

Within Dumfries & Galloway it has decided that there will be a return to a locality based structure with the previous 4 localities re-established, and controlling health and adult social services. The development of locality services provides an opportunity to engage practices in local issues, but given the workload and recruitment pressures on general practice at present, it will require resource to free up GPs to contribute to the design and implementation of improved services. With the return of locality

management here are greater possibilities for federations of practices working co-operatively across a locality.

Clinical Services Change Programme

The Board has almost reached financial close on the construction of a replacement District General Hospital: This £200million investment will provide a state of the art hospital that will have approximately the same number of beds as currently – a challenging decision that will mean that we will have to use the bed base extremely effectively if we are able to cope with the increasing number of older persons in the population.

The challenges are being addressed by a Clinical Services Change Programme which has both primary and secondary care sub-groups. There is an absolute need to succeed in this change programme if the hospital is not to be overwhelmed by pressure on beds: Whilst there is a reserve capacity of 14 beds built into the design of the hospital – which can be opened at short notice – the Board will face significant costs in staffing these extra beds, and will have no future expansion potential in bed numbers.

It is essential that any plan for General Practice is completely consistent with the Clinical Service Change Programme – and essential that the Board plans to ensure the sustainability of General Practice services throughout the area. The pressure on one practice faced with 2 vacancies has already led to the practice being forced to give notice of withdrawal of services from Castle Douglas hospital: If alternative arrangements are not found to maintain the hospital, the acute services will require a minimum of a further 14 beds (based on 100% occupancy): This calculation emphasises the absolutely crucial need to ensure a sustainable General Practice in Dumfries & Galloway.

It is likely that a strong General Practice foundation in Dumfries & Galloway will help the survival of the Out of Hours Service, both by reducing the workload left over to the Out of Hours period, but also by increasing the pool of potential GPs who could contribute to the service. It is unlikely that the new hospital bed numbers will be adequate to cope with admissions if an adequate Out of Hours Service is not provided.

The relationship between General Practice ability and hospital pressure is demonstrated by consideration of the following statistics. General Practice deals with approximately 95% of all new presentations of undifferentiated problems presented, with only 5% of patients being referred for hospital services. If the percentage of patients dealt with fully by their GP reduces to 92.5%, this – viewed from General Practice – feels like a modest change in activity, but would of course be enough to double the number of patients referred to secondary care services. It is essential therefore for the survival of acute services, that a strong and effective General Practice is maintained in Dumfries & Galloway.

Areas for Action

- **Recruitment -** There are a wide variety of actions in place and the Board is considering further areas which would assist

- **Development of other Primary Care Professionals –** Development of nurse practitioners in General Practice, local training programmes for practice nurses, enhanced community pharmacy service and enhanced training of staff in care homes and nursing homes

- **Plurality of Local Contracts with General Practice –** looking at the potential for a mixed model of nGMS, MPIG and section 17c contracts

- **Collaborative Working/Federations –** looking at the structure of General Practice so as to enable primary care to take on a greater range of services

Conclusions

Effective general practice services are shown to be effective in delivering personalised high quality care that is cost effective. Sustaining General practice, especially in the rural areas of the Board is essential both for the Board to deliver good primary healthcare, but also to prevent the new hospital from being overwhelmed, and to be well placed to allow a shift of care from secondary to primary care.

General Practice provides the majority of primary care, and yet currently feels isolated from decision making, and struggles to find the time, in the face of an increasing workload, to contribute to planning decisions that may significantly affect general practice.

General Practice in Dumfries & Galloway is severely threatened by a growing recruitment crisis. Failure to make general practice more attractive in Dumfries & Galloway is likely to result in a decrease in service delivery by practices (such as cottage hospital input), and result in very significant costs for the Board to replace equivalent services locally. Experience in other Board areas has shown that where a Board has to take on the running of a practice which has failed due to failure of recruitment, costs are extremely high, care is generally provided by expensive and short term locums, and referrals to secondary care increase.

The Board is considering a series of possible actions and it will be important to discuss (and add to) these proposals before drawing up a prioritised and costed list of actions to be taken forward. Any proposals should be led by either the Primary Care Development Department (such as regional actions) or by the emerging locality management structures. It will be necessary to ensure that there is sufficient management support to deliver this work.

An understanding of the pressures facing general practice must be had by the team leading the Clinical Services Change Programme, and there must be good co-ordination of work between the various groups.

6. Integration

As Health and Social Care Integration progresses, within NHS Dumfries and Galloway and the wider region, a significant amount of engagement with communities, service users, carers and the third & independent sector has been undertaken over the last two years.

Engagement events have been promoted through local newspapers and radio. Community Engagement Events were subsequently held in local venues including the super markets, health centres, town halls, libraries, post offices, community hospitals and community centres to engage with and capture the views of the local community regarding health and social care services and developing a much greater understanding of what matters to them.

Questionnaires were made available online and posted directly to service users, Carers and communities of interest. Questionnaires were also sent to GP practices with a request that people registered with the practices complete and return them. Engagement work has also been undertaken by door knocking.

Whilst undertaking this work, people received information and /or were referred or signposted to local services and sources of support. These included services such as the Handy Van, Social Care Services, Alzheimer Scotland, Food Train, Befriending, Carers Trust and New Horizons. People were also invited to an Asset Mapping Workshop.

Community development approaches and targeting work towards disadvantaged communities, such as Building Healthy Communities, Self-management Programme. Keep Well and Living Life to the Full is a programme of work which also focuses on tackling inequalities and needs to be supported, particularly around the work with carers in the short term.

These approaches have proved effective and we will continue to use them to maximise the contribution of stakeholders across all sectors. We are also linking into the local Clinical Change Programme that the process is seamless between hospital and community. We are also developing a website that covers the new hospital, clinical change programme and Health and Social Care Integration.

Clinical and Care Professionals have been an integral and continues element of strategic planning over the last four year change programme ‘Putting You First’ (PYF). This wide range of professional involvement has been a feature at every level of the programme from the Programme Board, through the key work stream groups and locality steering groups.

Building on our learning from this work, we have identified our priority areas of focus going forward as

- Developing Communities/Building Community Resilience
- Optimising Technology as an Enabler
- Integrated Ways of Working
- Preventative/Anticipatory Approaches

We are currently in the process of transitioning from PYF to integration and establishing a Dumfries and Galloway Joint Strategic Planning Group as part of this process.

As with our previous strategy, engagement and involvement of health and care professionals in this group will be a significant and valued element of it. Additionally we would seek to identify as broad a range of multi-professionals as possible throughout the whole of the planning structure and at every stage of development of our Joint Strategic Plan

Section Two:
LDP Standards

1. Detect Cancer Early

Board Lead: Alex Little

Current Performance: The statistics show that there has been a 10% increase in cancer referrals over the last 12 months – this compares to a 1.4% general increase in non-cancer referrals. There was a significant change in referral patterns for lung cancer and a noticeable change for other cancers. This is most likely to be as a result of the Awareness Sessions and Awareness Raising Road Shows. In addition there has been an increase in uptake of bowel cancer screening (now over 70%).

2015-16 Forecast: In terms of sustainability post the end of the programme: biggest pressures are on colorectal work & cancer trackers to ensure timescales are met. Work is ongoing to develop a standardised clinical pathway for colorectal cancer & appointment of 9th General Surgeon has been made. A colorectal "hub" has been set up in which 2 surgeons on a monthly basis review repeat colonoscopies – aim to reduce number of repeat colonoscopies undertaken. For breast cancer follow up (post 5 years) GPs will be undertaking follow up reviews & this will lead to increased capacity in the Breast Team.

2. Dementia Post Diagnostic Support

Board Lead: Linda Mckechnie

Current Performance: The HEAT target has 2 elements:

a) Number of people on the primary care registers.

We continue to sit slightly below the 50% overall target for diagnosis rates (latest figures are from Nov 2014) and show a variance across the 4 localities)

Annandale and Eskdale	44%
Dumfries and Nithsdale	55%
Stewartry	46%
Wigtownshire	51%
Regional	**47.3%**

b) The Number of People who are Diagnosed with Dementia and have had at least 12 months of Post Diagnostic Support

Table below shows latest figures from ISD management report. These figures can be taken as an approximation of HEAT target achievement.

Dumfries and Galloway
Figures provided as a percentage

Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14
90.9	80.0	73.1	41.9	53.3	46.7	12.0	2.8	0.0	4.3

Scotland
Figures provide as a percentage

Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14
58.5	62.4	55.2	53.6	52.3	41.8	23.5	6.3	2.7	1.9

2015-16 Forecast: The locality variance in the number of people with a diagnosis of dementia who are placed on the primary care dementia registers may be explained by a number of factors including:

- Staff resources within secondary care teams have been reduced in Stewartry and Annandale teams over the past year
- The accuracy of prevalence and incidence rates may be questionable and are currently being studied nationally
- The number of people on dementia registers may be strongly influenced by the care home population in each GP catchment area

We continue to examine data on a locality and GP practice level on a regular basis and aim to have ongoing discussions with individual GP practices where necessary to further examine ways in which diagnosis rates might increase if the rates are deemed to be significantly low in specific practices.

We are currently developing a pilot project to assess whether there is scope to streamline the diagnosis process without necessarily attending memory clinics and delivering full secondary care assessments.

Regarding the PDS elements of the target, as stated in the ISD management report:
These figures count people who have started PDS and have completed a minimum 12 months.

The accuracy of the data is currently questionable as the data collection system is not sophisticated enough to highlight individual variance for example, iIt should be acknowledged that some people will not receive 12 months PDS due to various reasons such as choice, capacity issues, moving into a care home The 5 pillars model of PDS may not be appropriate for people who are diagnosed in the later stages of the illness.

Also, there is wide variability in the quality of completion of the data collection spreadsheet and this is an area we are currently examining with a view to providing further support to link workers regarding data management.

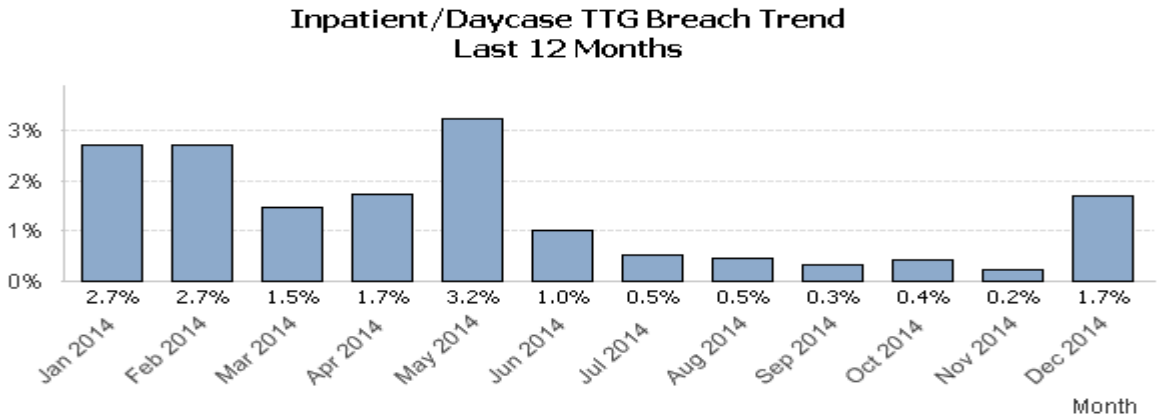
3. Access Standards

Board Lead: Nicole Hamlet, General Manager Acute & Diagnostic Services

Inpatients / Day Cases

Throughout 2014 we have faced some challenges common throughout many of the specialities when delivering on TTG. Unexpected medical staff absence throughout the year, retirement of consultants, use of locum staff and in some specialties being unable to secure high quality locum cover contributed to issues we faced ensuring all patients met the 12 week TTG target.

The 12 month rolling trend is shown in the table below.

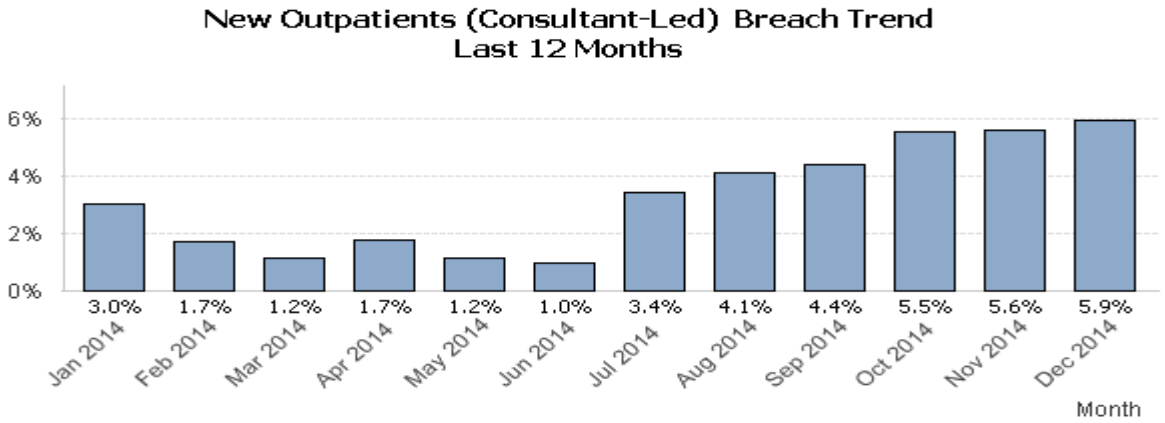


	Financial Year To Date 31/12/2014
Inpatient/Daycases Treated Outwith Guarantee Date	91
Inpatient/Daycases Treated Within Guarantee Date	8250
TTG Breach (%)	1.1%

Unplanned absence is in itself variable in occurrence but these challenges can be overcome through better planning and capacity awareness at the beginning of the year. There has been a lot of work to date and further work is being completed on streamlining the theatre efficiency and utilisation also. We have live action plans for a number of specialities which will also improve our TTG performance.

Outpatients

Out-patient performance challenges have been similar to those seen for inpatients throughout 2014. The main reason for patients not meeting their 12 week outpatient standard was due to difficulties in finding cover for consultants due to unanticipated leave in a number of specialties. We have a working group set up who are analysing the demand and capacity factors across each speciality. Through this work there have been a number of improvement steps and efficiencies that could be implemented. Through the TOPS working group we are in the process of initiating meetings with each specialty team to go discuss these.

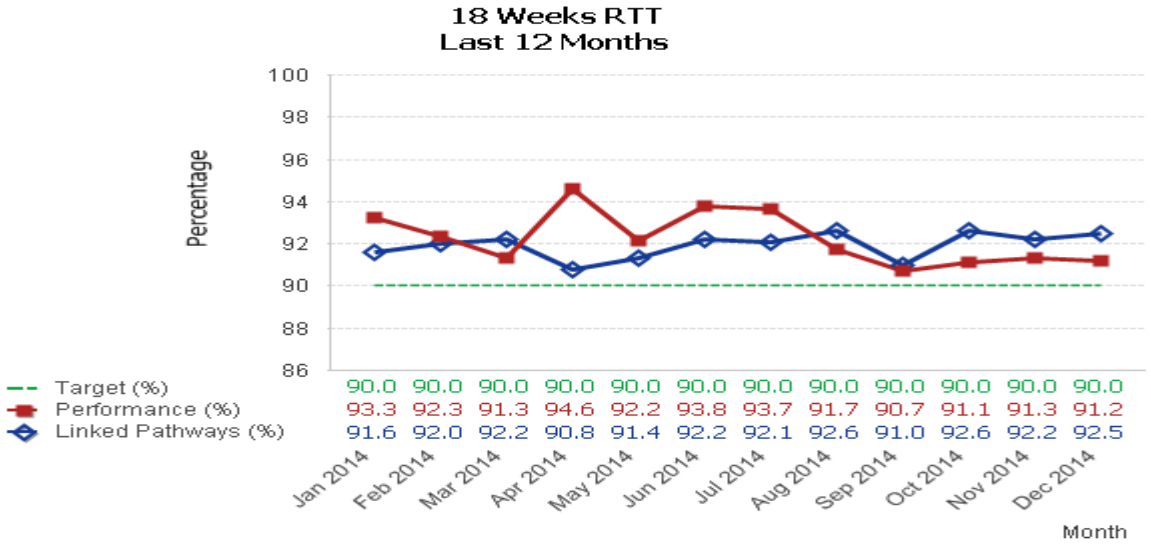


Note: July 2014 is the first month in which measurement of out-patient waiting times has changed to mirror that of in-patient waiting times, i.e., following the calculation rules described within the TTG regulations.

18 Week Referral to Treatment Standard

Performance at December 2014 was above target and as the chart below shows, it has been above target for the 12 month period prior.

Measure	Period	Target	Actual
Linked Pathways	December 2014	90%	92.5%
Performance	December 2014	90%	91.2%



Both linked pathways and performance have been consistently above the 90% target for the last 12 months. An action plan has been developed to maximise 18 week compliance which includes a rolling programme of training for medical secretaries and the Patient Access Team.

The training is initially aimed at improving the use of the “Unique Care Pathway Number” which support our ability to measure the ‘linked pathways’ and prioritising areas which will deliver the biggest improvement in performance.

4. Early Access to Antenatal Care

Board Lead: Joyce Reekie

Current Performance: Data to the period ending 30th June 2013 indicated performance of 85.1% against a trajectory target of 83.5%. Local Management information for the first 3 quarters of 2014-15 shows that performance averaged at 83.4%, above the new standard of 80%. Performance in each SIMD quintile was above 80%

2015-16 Forecast: The only risk to ongoing achievement of the standard will be around sickness absence. In terms of systems and process, a new electronic system due to be implemented later this year should make the process more robust, therefore the forecast for 2015-16 is that we will continue to meet the new LDP standard.

5. IVF Treatment Times

Board Lead: Angus Cameron

Current Performance: Data to the quarter ending September 2014 showed that for Dumfries & Galloway patients referred to the tertiary centre 71.5% had received treatment within 12 months against a trajectory target of 76.8%.

2015-16 Forecast: Patients from Dumfries and Galloway are referred when indicated by national guidelines and when couples fulfil national access criteria into a service delivered by a tertiary board, so there is little that can be done locally to influence performance. Ongoing dialogue is taking place with the tertiary centre to improve performance.

6. Faster Access to Mental Health Services – CAMHS

Board Lead: Elaine Wylie

Current Performance: Achieving 2015-16 Forecast The standard has been 26wks referral to treatment up until Dec 2014 when it changed to 18weeks.

ISD have collected and demonstrated data for 18 wks RTT, alongside 26 wks, since 2013. 100% of children and young people in Dumfries & Galloway have waited less than 26 wks since the target commenced. Since Oct 2013 when 18 weeks was recorded alongside 26wks, 100% of children and young people have waited less than 18wks.

CAMHS have experienced high number of vacancies in the service and high referral rates and there has been a cumulative effect on lengths of waits. Oct-Dec 2014 will be published on February 23rd.

There is a risk in that quarter's report that although performance may demonstrate 26 weeks RTT, given the pressures in the service especially in those months, it is very

unlikely that we will see the same high performance in respect of % of young people starting treatment within 18weeks.

CAMHS have already reported this position to the mental health division of S.Govt during their Autumn Implementation visit last year and to the General Manager for Women & Children's Services.

Future performance for 2015/16: New staff are now in place, and are or will soon be, fully operational in their posts. The quarter of Jan-March 2015 will still capture the period of time where the team has been 'catching up' and when new staff have still been relatively new.

There is a remaining risk in that period of reporting that the new 18 week standard will not have been achieved to 100%. There is no further anticipated risk for the remainder if the year.

7. Faster Access to Mental Health Services – Psychological Therapies

Board Lead: Frances Groves

Current Performance: About 75% of people seen within 18 weeks. The figure has fallen due to maternity and sick leave together with a long term vacancy in LD Services, which has just been filled. A reconfiguration of services has created an extra clinical psychology post which was filled in November 2014 and is starting to impact on the longest waits.

2015-16 Forecast: It is anticipated that the compliance rate of 90% could be achieved within 2015-2016 once the large number of maternity leave staff return to post and all posts remain filled.

Two posts are now filled which are focussed on targeting the historic queue to reduce the longest waiting times. This should start to be reflected in the percentage compliance early in 2015.

Any short term monies that become available will be used to temporarily create posts to achieve the standard.

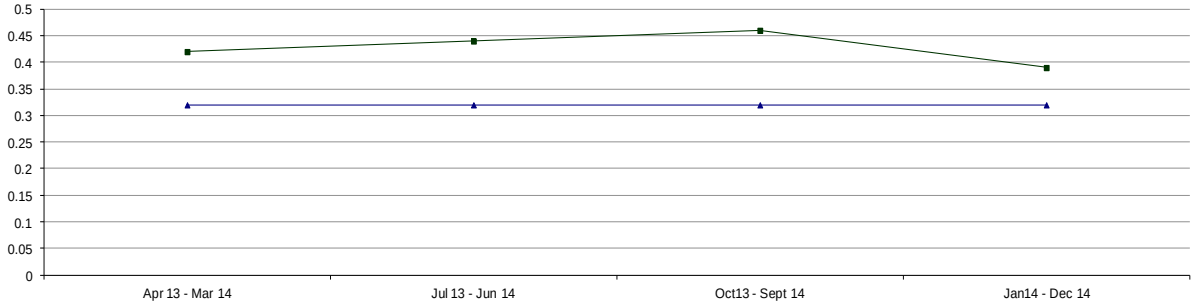
The risk to achievement will be that of further long term leave which cannot be covered due to lack of locum cover and funding.

8. SAB and C.Diff

Board Lead: Elaine Ross

Clostridium difficile infections

Current Performance: Quarterly rolling year average Clostridium difficile infections ages 15 & above per 1000 total occupied bed days (April 2013-Dec 2014)



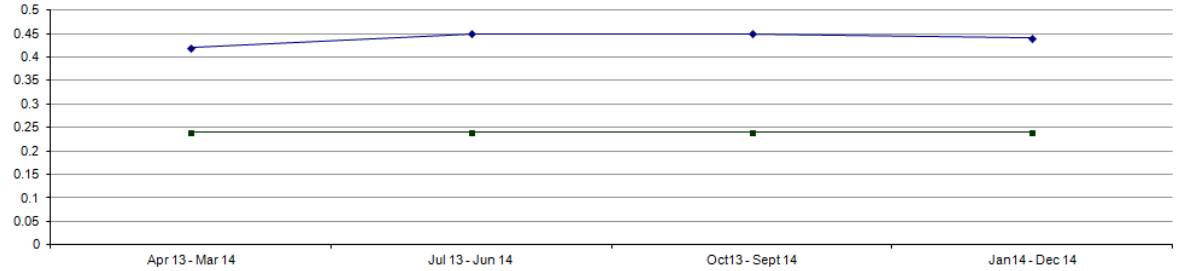
	Apr 13 - Mar 14	Jul 13 - Jun 14	Oct13 - Sept 14	Jan14 - Dec 14
Actual Performance	0.42	0.44	0.46	0.39
Target	0.32	0.32	0.32	0.32

2015-16 Forecast: We are aware that NHS Dumfries & Galloway is not currently on target however the following measures are in place to address the root cause of infection:

- Root cause analysis of every patient who has a positive Clostridium difficile infection (CDI) either in the hospital or in the community. Where a sample has been collected in the community enhanced surveillance will be undertaken by the Health Protection Nurse who will telephone the GP practice
- A joint weekly review of cases is held by the Infection Control Team and Health Protection Nurse
- Patients identified as having had CDI are issued with a plastic card to carry and present to prescribers for one year following diagnosis.
- Where there are lessons learned these are fed back to clinicians
- An Integrated Care Pathway (ICP) is in place for all patients with symptoms of diarrhoea. This includes instruction on isolation and cleaning using a chlorine releasing agent
- Compliance with antibiotic prescribing policy is subject to targeted auditing in primary care by prescribing advisers and through the use of the root cause analysis process in secondary care. Audits of compliance with empirical prescribing policy are also undertaken routinely as per the Scottish Antimicrobial Prescribing Group (SAPG) requirements. The Antimicrobial Management Team (AMT) also receive information regarding patients with CDI and findings of root cause analysis
- Audits of bedpan and commode cleanliness are undertaken
- All sanitary areas and toileting aids are routinely cleaned using ‘Actichlor plus’
- At times of increased incidence it has been possible to switch to ‘Actichlor plus’ for all routine cleaning of the environment and patient equipment.

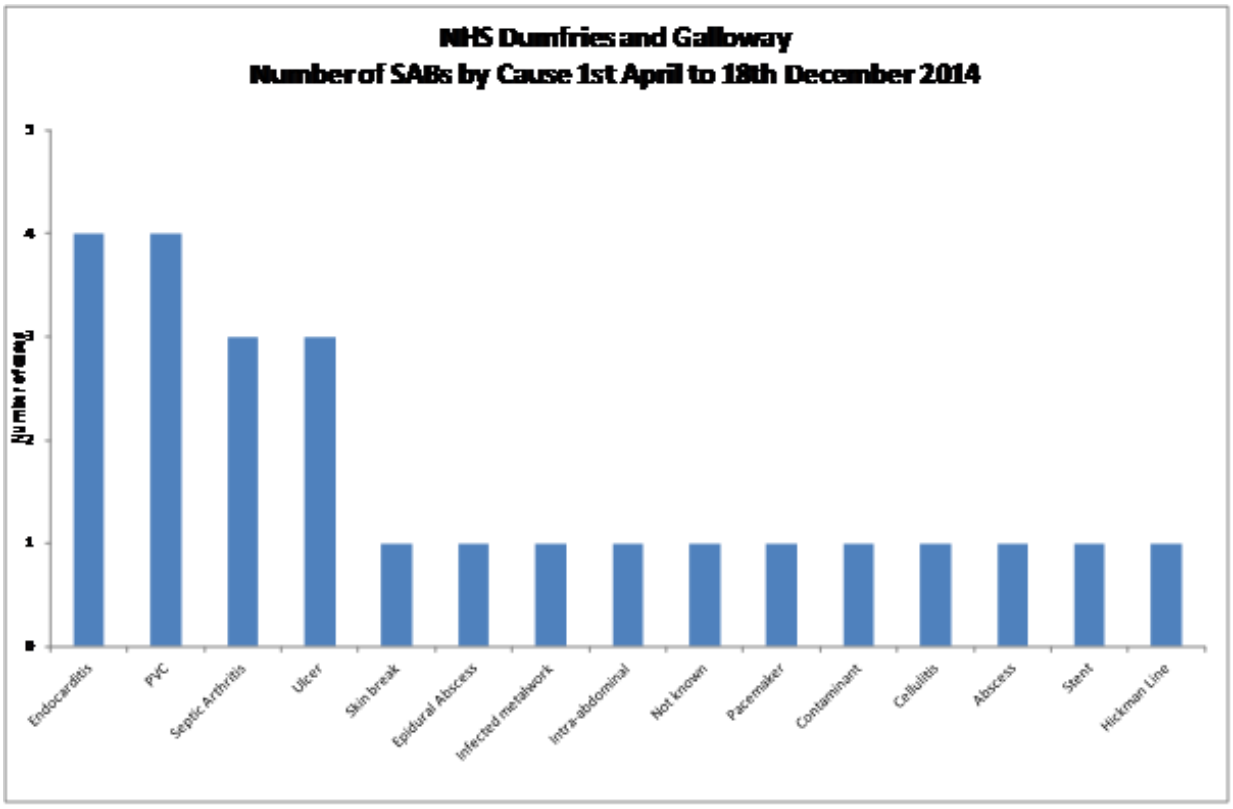
Staphylococcus aureus Bacteraemia

Current Performance: Quarterly rolling *Staphylococcus aureus* Bacteraemia Rates per 1000 Acute Occupied Bed Days April 2013- December 2014



	Apr 13 - Mar 14	Jul 13 - Jun 14	Oct13 - Sept 14	Jan14 - Dec 14
Actual Performance	0.42	0.45	0.45	0.44
Target	0.24	0.24	0.24	0.24

2015-16 Forecast: NHS Dumfries & Galloway is not achieving the standard to date but have conducted Root Cause Analysis on each case of SAB, results of which are below. Our aim remains that no patient shall suffer a preventable SAB.



A review of all SAB is undertaken on a monthly basis by the Infection Control Doctor (ICD) and the Audit and Surveillance Officer. Preventable HAI SABs are logged on the incident management system DATIX. Results of reviews are fed back to the Clinical team by the ICD.

Endocarditis

- 3 of the 4 cases of endocarditis occurred in patients who were active injecting drug users.
- Liaison with Drug and Alcohol services has supported improved injection site surveillance and follow up of patients admitted to hospital with SAB.

Invasive devices

- A local invasive device network has been established to support and spread best practice. This will include assessment of the right line for the patient which may reduce the number of Peripheral vascular cannulas (PVCs).
- There is ongoing education covering the use of lines and appropriate care and maintenance which is delivered by the clinical skills team.
- A vascular access study day is planned in June 2015
- PVCs continue to be a focus for the patient safety and infection control teams.
- Documentation of PVC insertion and maintenance is to be performed by utilising CORTEX. This will allow compliance to be audited electronically and includes a prompt for device removal.

Contaminated samples

An improvement plan is in place to reduce the number of contaminated samples. This is being tested in A&E and if successful will be spread to other areas.

Ulcers

Referral pathways have been reviewed and antibiotic management of patients with chronic wounds is a subject for discussion by the Antimicrobial Management Team which includes GPs.

OPAT

An outpatient antibiotic team is in place to support delivery of antibiotic treatment as per the SAPG guideline.

MRSA screening

Compliance with MRSA screening is conducted as per national requirements and has been consistently in excess of 95%. Auditing will continue.

9. Drug and Alcohol Referral to Treatment Standard

Board Lead: Jackie Davies

Current Performance: Jul - Sept 14 : 97.8% of clients started treatment within 3 weeks

2015-16 Forecast: Drug and alcohol services will continue to meet the standard on a quarterly basis. Risks to not achieving the target could be if we had high levels of staff sickness and staff leaving their employment. To date this has not been an issue.

10. Alcohol Brief Interventions

Board Lead: Jim Parker, Lead Officer

Current Performance: Board and its Partners are currently exceeding targets by a significant number.

2015-16 Forecast: Targets being met and significantly exceeded. Financial package in place to resource ongoing work led by community-based public health teams region wide. This includes ongoing staff training and ABI delivery. In the process of embedding delivery into core business and ongoing financial resourcing required for at least next year.

11. Smoking Cessation

Board Lead: Trish Grierson

Current Performance: Our current performance against this target is that we are under-performing (ISD data quarterly HEAT reporting) by 50%. Our total figure to achieve 2014/15 3 month HEAT target should be 383 successful quitters. On current performance projection of meeting this target would be 191 successful quit attempts at 3 month follow up.

2015-16 Forecast: This target is being significantly compromised owing to a number of factors such as:-

- A series of national issues with regard to the national Patient Recording System (PCR) for Community Pharmacies – which has resulted in number of Community ot all CP record currently being on the national smoking creation database
- A drop in number of referrals from GP practices and other referral sources
- An increase in the number of opt-out referrals
- An increase in the availability and use of the Electronic cigarette as a compromise to smoking cessation

Actions needed to resolve

- Increase the number of referrals to specialist services from GP practices and the wider NHS community
- Nationally ISD is working though a high volume of Pharmacy records, there is a plan in place between Health Boards and ISD to resolve these issues
- Provide more information to smokers about E.cigarettes and seek changes to protocols as more information becomes available
- Increase successful partnership working projects such as the Stopathons in specific geographic areas
- Provide workplaces in the region with a range of engagement options from Stopping Smoking interventions to Tobacco Policy Development
- Implement all national and local improvements to stop smoking services

12. GP 48hr Access / Advance Booking Standard

Board Lead: Linda Bunney

Current Performance: The results of the 2013/14 Scottish Health and Care Experience Survey published via the Scotland Performs website indicate that 95.4% of those surveyed were able to see or speak to a doctor or nurse within 2 working days. 84.2% of patients surveyed were able to book a doctor's appointment 3 or more working days in advance; two of the Board's 34 practices have open access. Of those unable to see or speak within 2 working days 49% of these were unable due to wanting to see a preferred person or the times being offered not being convenient.

2015-16 Forecast: Practices participating in QS002(S) of the 2014/15 QOF are undertaking a review of access using the tool agreed between Scottish Government and Scottish General Practices Committee and will provide a practice action report of the findings to the NHS Board. The Board has supported 3 GP practices to undertake the data collection module of 'Doctors First' which is a model of triage by GP to improve access. Once completed, the practices will consider the results of the work before identifying any potential improvements to their systems. It is anticipated that we can maintain or better our current level of performance.

13. Sickness Absence Standard

Board Lead: Caroline Sharp, Workforce Director.

Current Performance: D&G overall sickness absence rate for Dec 14 was 5.16% compared to a NHS Scotland average of 5.41%. The overall 2014 absence rate for D&G was 5.09% set against a national average of 4.97%

Since national monitoring has been undertaken D&G has tended to sit within mid range compared to the other Boards although this year we have moved to the higher end of the range. We have undertaken a detailed review of our absence profile for 14/15 in conjunction with our public health directorate in order to inform our improvement strategy for 15 / 16, under direction from our staff governance committee.

2015-16 Forecast: Our strategy agreed with our staff governance committee remains that NHS D&G are committed to work to the 4% target with a view to a stretch target of 3.5% for high performing teams.

A number of initiatives have commenced to achieve this as follows:

- HR operations (with support from OH) are leading the focus on the reduction of incidences of short term absences, working with local Managers to ensure that the Attendance Management Policy and associated procedures are implemented consistently and robustly across all parts of the organisation. Under the direction of the APF, the current policy will be reviewed during 15/16 to ensure is ongoing effectiveness, and compliance with the revised PIN once released.

- OH services (with support from HR) are leading the focus on reducing the length of long terms absences to manage timely and safe return to work and to support the overall improvement of workforce resilience and wellbeing (including preventative measures).

  This includes the development of a protocol and operational guide to manage instances relating to any staff member who receives a fit note to return to the work place but not within their own area, due to short terms restrictions.

  This will encourage and support staff safely back to the workplace earlier, which will enhance their rehabilitation whist they develop their fitness to return to their substantive duties. This protocol will extend beyond the arrangements already in place for staff to return on a phased return, and will enable the organisation to utilise staff members' skills in a flexible way across the organisation.

Further examples of work under development to support attendance at work include:

- Development of a managerial supervision policy within Women & Children's Directorate

- Provision of training "bite size" sessions on the practical application of policies relevant to promoting attendance within Mental Health

- General Manager led case management reviews with Line Managers within the Acute Services Directorate. This involves discussions with line managers of staff who have the highest level of short term absence, identifying how the line manager is dealing with these and whether the member of staff and / or the line manager is receiving all the support they require to manage the individuals absence and return to work.

14. Emergency Department 4hr Access Standard

Board Lead: Julie White, Chief Operating Officer.

Current Performance: The Board is consistently delivering against the 95% standard and is working towards achieving the 98% stretch target. Performance for the year 14/15 to end of January 15 is 96.8%

2015-16 Forecast: Despite our recent performance against the 4 hour emergency care waiting time standard delivery of the stretch target to 98% remains challenging.
Our Unscheduled Care Steering group continues have good partnership representation and is committed to identifying and supporting further action to deliver the 4 hour target.

Improvements planned for 2015/16 include:

Continued improvement in patient flow:

- Refresh of Hospital Safety Huddles
- Continued focus on morning discharges
- Partnership working to maximise available transport solutions to support discharge.
- A focus upon turnover within the cottage hospitals to ensure patient flow maintained.

Delayed discharges

- Partnership working with Council and independent sector to reduce delays.

15. Financial Performance (E5)

Board Lead: Katy Lewis, Director of Finance

2015-16 Forecast: This target relates to financial performance and is reported on a monthly basis to the NHS Board. The current status is that the board is predicting it will break even in 2015-16, however there are a number of risks within the financial plan:-

- Continued delivery of a breakeven position beyond 2015/16
- Uncertainty about financial allocations beyond 2015/16
- Delivery of 3% CRES, current gap £1.1m , with reliance of £1.3m non recurring savings, giving a recurring gap of £2.4m and high risk profile of existing plans
- Management of on-going cost pressures most notably medical locum costs which are requiring £4.8m non recurring support for 2015/16
- Ongoing medical recruitment challenges not just in the Acute Sector but increasing pressures in General Practice
- Planning for the financial implications of the new hospital including transitional costs
- Increased volume and costs pressures in primary and secondary care prescribing costs
- A number of non recurring sources have been used to deliver the financial position for 2015/16 outlined above

Section Three:
Workforce Plan

NHS Dumfries & Galloway have integrated their Staff Governance Action Plan with the Everyone Matters 2015/16 Plan as per 2014/15. This ensures that all areas are covered and we focus resources towards the main priorities of both.

The 5 priorities are: Healthy Organisational Culture, Sustainable Workforce, Capable Workforce, Integrated Workforce and Effective Leadership and Management.

1. Healthy Organisational Culture

CORE values were developed and agreed in partnership with the Area Partnership Forum and Area Clinical Forum during 2013/14. These were subsequently approved by NHS Dumfries & Galloway Board in May 2014. A sub-group was established to identify what actions will support the organisation's shift from concept to reality, and to embed the CORE values at a behavioural and cultural level within our organisation.

Our CORE values are;

- Compassion
- Openness
- Respect
- Excellence

Taking the first steps

The group have identified two key actions that would comprise the first steps on the journey to fully embed the CORE values. These steps support the themes of 'branding' and 'leadership'.

Branding

At present, the Values do not have a visible 'look and feel' through which they can be promoted visibly on letter heads, posters and other promotional materials. During 15/16 we plan to commission a design / creative agency under the direction of the Head of Communications to create a 'brand' for our CORE values, from which all subsequent communications and awareness raising can be developed.

Leadership

It is recommended that the Board launch a 'Big Conversation' in order to demonstrate its commitment to, and leadership around the CORE values.

This would comprise of a cascade discussion throughout the organisation, sponsored by the Employee Director / Chair of APF and the Chair of the Area Clinical Forum around the following 3 questions;

1. What matters to me in my role in this organisation and citizen of D&G?
2. What will be different when the CORE values are embedded across the organisation? (Impact)
3. What will I do differently from today in my role to lead and demonstrate behaviours consistent with the CORE values? (Willingness to change)

The Board have committed to commence this dialogue at their first Board Development and Challenge day in 2015.

The other activities set out in the action plan will flow forward from this launch, ensuring relevance, and congruence with the CORE values awareness raising campaign and demonstration of leadership commitment by the Board.

iMatter

NHS Dumfries & Galloway have plans in place to implement iMatter during 15/16, 16/17 and beyond. As from the 19 Jan we have gone live with the programme, working with three teams in the organisation, including the senior leadership team. Briefing sessions have commenced, in line with the national programme requirements. The i Matter questionnaire is now being completed by staff in the first cohort. It is anticipated that progress will continue to be monitored in accordance with our agreed implementation programme, and that a full evaluation of the process will be undertaken on completion of cohort 1, to ensure that subsequent roll out across operational directorates reflects lessons learned, and ensures maximum benefit and impact of the tool across the organisation in future years.

2. Sustainable / Capable / Integrated Workforce

NHS Dumfries and Galloway has piloted and/or implemented a range of the Workforce Planning Tools

2.1 Adult Inpatient & Professional Judgement Tool

The Adult Inpatient Tool has been utilised on four separate occasions within Dumfries & Galloway Regional Infirmary. This has been triangulated with the Professional Judgement Tool incorporating a review of sickness absence and utilisation of bank staff.

The findings from the most recent run are being compared to past applications, triangulated and reviewed against increase in activity/occupancy levels. This work will have been completed by March 2015and will inform changes to our current staffing level and workforce projections for 2015/16. This detailed process will then be utilised to inform the necessary staffing levels for our new Models of Care and our New Hospital during 2015/16.

2.2 Small Wards

The small wards tool has been utilised within our palliative care facility and is currently being piloted in one of our Cottage Hospitals. It is anticipated that this will be rolled out to all our Cottage Hospitals and will inform future safe staffing levels for our Models of Care to shift the balance of care within 2015/16.

2.3 Emergency Department

NHS Dumfries and Galloway was a pilot site for the Emergency Department Tool. Whilst initially medical staff were reluctant to participate, the Tool is now being applied with support from all disciplines.

2.4 Clinical Nurse Specialist (CNS)

NHS Dumfries and Galloway was a pilot site for this tool which is now available on the SSTS Platform. Further discussions are taking place to plan how we begin to roll this out on an ongoing basis.

2.5 Community Nursing Benchmarking Tool

NHS Dumfries and Galloway was a pilot site for the Community Nursing Tool and work is underway to plan how best to roll this out locally to get maximum benefit from the tool.

"Releasing Time To Care" is supportive of the Community workload tool particularly the definitions for Direct/ Indirect facing time. RTC will advocate that the tool can be used to facilitate RTC data collection.

2.6 Women & Children's

Both the Maternity and Neonatal tools have been used regularly to assess workload demand.

2.7 Mental Health

A substantial amount of workforce planning was undertaken to support the development of a recently opened inpatient facility in Dumfries. The workload tool for mental health will be refreshed again in 2015.

3. General

Detailed work has been undertaken within all wards within Dumfries & Galloway Royal Infirmary. The purpose of which has been to review current establishments, shift patterns and trends within acuity and dependency. This work is currently ongoing. The aim of this work is to:

- Establish a standardised approach to shift patterns
- Facilitate the sustainment of safe staffing levels across the twenty four hour spectrum

A Quality Rostering Policy has been agreed and implemented. E-rostering has been piloted and is currently being implemented throughout the hospital. This will support the realisation of the above aims. The Lead Nurses have a clear responsibility to analyse the data produced by the system thereby applying a proactive approach to changes in staffing levels.

The next step is to implement, later this year a system to measure acuity and dependence in real time. This work will be carried out later within the Cottage Hospitals. A significant amount of additional funding has been agreed by the Board to support the outcome of this work in preparation for the move to a single room facility for all wards in the new hospital.

In addition a Relief Pool has been implemented in addition to the Nurse Bank. This means that additional Nurses/HCSWs will be on shift throughout the day and early evening to respond to hot beds of activity/unexpected rise in sickness/absence.

A review of the Emergency Department (ED) has been undertaken with support from an experienced ED Consultant from elsewhere. Daily reporting on activity is in place.

Recruitment and training of Advanced Nurse Practitioners continues annually.

All Lead Nurses are directly accountable to the Nurse Director for Workforce Planning in their respective areas.

4. Staffing Concerns

As a result of an increasing number of Consultant vacancies, a Project Manager has been put in place to specifically focus on medical recruitment requirements, processes and activity, social media approaches and collaborative working with Scottish Government relating to medical recruitment issues. This role has had a positive impact across the medical workforce with several vacancies being filled and there is going to be a focus over the next 12 months to further review processes and procedures to ensure that NHS Dumfries & Galloway are an employer of choice for medical professionals. On the back of this success, we are looking to expand this work to include other medical professions such at GP's and also Senior Nursing/ AHP staff, where we have also had some challenges in recruiting, including Stranraer (Galloway Community Hospital) and the west of the region.

5. Workforce Projections

The Board is currently developing 2015/16 workforce projections. The process is underpinned by the planning for the new build DGRI due to be operational in 2018. Between now and then, the workforce will change due to a number of factors linked to the planning for the new build, integration of health and social care, the future of the Change Fund programme, natural turnover and the ongoing requirement to make CRES savings year on year.

On 25 February 2015 the Board is running a significant workforce planning event for all key staff involved in the new build and associated clinical change programme in conjunction with the HR and OD team from Greater Glasgow and Clyde. This is a key opportunity for the whole team to learn from the teams' experience of planning for the mobilisation of the new Southern General, and will shape the direction and focus of the workforce planning agenda for the Board for the next 3 – 5 years.

6. Integrated Workforce

Work is ongoing to ensure linkages are made between the Clinical Services Strategy, Health & Social Care Integration and the Acute Services New Build. There is a fundamental requirement to work more closely to understand interaction between primary and community care especially if different ways of working and learning implications (see 5 above)

As part of the Board's planning towards an IJB to deliver integrated Health and Social Care services across our region, an OD work stream has been established under the joint leadership of the NHS Workforce Director and the Council Head of HR and OD. Membership includes third and independent sector, and staff side representatives. The remit of the group is to oversee the implementation of the transitional integration OD plan and associated funds agreed with Scottish Government in April 2014. Additional joint HR and OD resources have been appointed to support teams at locality level with this. The work stream group are in the process of commissioning a cultural diagnostic review across Council, NHS, third, and independent sectors (including GP's). This will commence during the first quarter of 2015. The results of this review will inform the future OD interventions and approaches required to support the IJB to set and embed a vision, purpose and values for the future integrated system as part of its strategic work plan in the 2015/16 shadow year.

7. Effective Leadership and Management

Through feedback and performance assessment we have recognised the challenges that newly appointed and promoted managers face as they develop their people management skills in new leadership roles. To support our managers development, management induction/performance folders are being developed for all new managers which will be used to monitor progress of managers in their first year – setting out goals to reach around the LDP, specifying and supporting attendance at identified bite size sessions, development of additional learn pro modules purely for managers influenced by the Boards and Directorates objectives.

Work has already commenced in 2014/15 on a re-examination of recruitment processes to build in much more competency and evidence based recruitment. This review includes;

- application form and recruitment process
- induction/performance for managers
- leadership development timeline
- All underpinned by clear organisational goals

This work will continue during 2015/16.

During 2014/15 we commenced our second cohort of our joint clinical leadership programme Leadership 3 – in conjunction with Ayrshire and Arran and GJNH. This second cohort will complete in late February 2015, and current indicators are that this second programme will evaluate as positively as the first, run the year before. We are planning a third cohort with partners, to commence later in 2015. Locally we have seen a positive ROI from those who attended cohort 1, including successful promotions to more senior leadership roles, and positive role modelling of the attitudes and behaviours promulgated by the programme within clinical leadership settings and interactions.

Section Four:
Community Planning Partnership Contribution

Our contribution to Community Planning focuses on 3 main areas:

- Safer and Stronger Communities and Offending
- Health Inequalities and Physical Activity
- Older People

Safer and Stronger Communities and Offending

Suicide Prevention is a top national priority. A local action plan has been developed in full consultation with key stakeholders including senior NHS staff from Public Health and Mental Health Services, in response to the national Suicide Prevention Action Plan 2013-16. This sets out future actions that consider both the priority areas of the new national strategy and the refreshed objectives from 2010, whilst considering the foundation of work developed previously under Choose Life Dumfries and Galloway and other relevant work streams.

The overarching outcome for the action plan is to reduce the incidence of suicide and self-harm. Seven core objectives with corresponding actions have been identified to take forward:

- Leadership and co-ordination
- A shared understanding of local suicides
- Responding to distress
- Identify and intervene to reduce suicidal behaviour in high risk groups
- Improving service response
- Improved knowledge on suicidal behaviour and awareness of the help available
- Early Intervention and improving resilience

A new multi-agency working group was established in 2014 and continues to provide strategic direction and oversee actions that contribute to suicide prevention in Dumfries & Galloway. This provides an opportunity for stronger partnership working and co-ordination. Action will be taken forward that will continue to gain a better understanding of the incidence locally, focus on how services respond, developing interventions that will reduce the incidence of suicide ideation, training in suicide intervention skills and raising awareness.

NHS Dumfries and Galloway continues to work with colleagues in Licensing (Dumfries and Galloway Council) and Police Scotland on a range of issues concerned with the sale and availability of alcohol. An evidence based report on overprovision has been considered by two of the local Licensing Boards from areas where overprovision was

identified; a collaborative intervention into street drinking in the largest town in the area is targeting both individuals and the drinking cohort as a whole and we are involved in an innovative project which will target off-licenses and seek their voluntary cooperation to remove high-strength beers and ciders from sale.

The local Alcohol and Drug Partnership (ADP) is Chaired by the Chief Executive of Dumfries and Galloway. This ensures a strong health focus on alcohol and drug issues across the region and affords a shorter access route to Chief Officers (Council and Police Scotland), when joined-up collaborative actions are necessary. For example, NHS Dumfries and Galloway is consistently meeting and exceeding national targets in respect of delivery of Alcohol Brief Interventions and Waiting Times for access to treatment for drug and alcohol related problems. This is in part due to the mature joint working arrangements with a range of partners which is both supported and encouraged by the most senior officials in the region.

Health Inequalities and Physical Activity

The Dumfries and Galloway Physical Activity Alliance was established in late 2014. It is a cross-sector group of strategic partners responsible for creating the policy and the environments to increase physical activity and lead on local delivery of the delivery themes for the National Physical Activity Implementation Plan, A More Active Scotland - Building a Legacy from the Commonwealth Games which was published by Scottish Government in 2014.

The Alliance has drafted a number of local outcomes and agreed six principles which should underpin policy and practise locally and are listed below:

1. A life course approach to physical activity
2. Collaborative working across sectors
3. Tackling health inequalities
4. Changing the behaviour of individuals
5. Building the capacity of individuals and the physical activity workforce
6. Supporting people to be physically literate

A range of interventions to increase physical activity levels will continue across the region. These include action to build capacity in staff groupings to address the role of physical activity to health and wellbeing, including work with the University of the West of Scotland student nurses to feel confident and empowered to raise the issue of physical activity with patients in their future healthcare careers.

Specific projects will target increasing levels of physical activity via Maternity Services and also working with Macmillan Scotland to support people affected by cancer to be more physically active.

A short term priority for the Alliance will be to progress a relevant framework of indicators to measure how local policy and practice are contributing to increasing levels of physical activity while combating inactivity and sedentary behaviour.

Currently, there is no local or National annual measurement of physical activity in Dumfries and Galloway across any population group.

Agreement has recently been obtained from Education Services to conduct an annual primary and secondary schools physical activity survey. Developing an annual measure for adults (19-64 years) and older adults (65+) is providing more problematic. The Scottish Health Survey for example provides board level analysis every four years. Previously, the Physical Activity Index Tool (PHIT) was developed to provide an annual measure of all physical activity across the life course in Dumfries and Galloway.

PHIT was an index of key actions required to help realise our ambitions of increasing the number of people (adults and children) achieving the minimum recommended levels of physical activity, and provide a self-assessment measure of the work going on to progress these actions. Partners agreed that the PHIT was useful and consistent tool in capturing the major contributing factors to physical activity although the scoring process was viewed as highly subjective and a laborious process resulting in ongoing engagement becoming an increasing challenge.

The target was for the PHIT indicators were for a 15% increase (5% annual) over three year from the 2011 baseline figure. The actual reported cumulative increase equalled 28.6% with the 5% annual target also achieved (13.8%, 6.8% and 5.8%).

Current and Planned Performance Levels:

- Adult/older adult annual indicator to be prioritised for development by the Physical Activity Alliance

- Number of children and young people of school age achieving recommended levels of physical activity

Within the Public Health department, the focus of the work is to address all of the above and the establishment of the joint Health and Wellbeing Unit (NHS and Council resourced) is a key part of this. This also includes Building Healthy Communities, our community development project. An example of where NHS Dumfries and Galloway have shifted resource this year to address inequalities and prevention is the allocation of recurring funding to develop the Looked After Children and Young People's Health Service. Public Health continues to work with a range of partners (including the wider NHS) to both indentify and shift resource to address inequalities and prevention.

Older People

The Board continues to work in partnership with the Council, Third and Independent Sectors through its Putting You First programme to develop and test innovative approaches to supporting older people. Although funding for Putting You First finishes

at the end of March 2015, learning will inform decisions to be made to support our ambitions toward Adult Health and Social Care Integration.

A wide-ranging Joint Strategic Needs Assessment is being developed currently, and this work will be an iterative on process that will inform the Joint Strategic Plan. It is anticipated that the plan will take learning form the Putting You First programme, which was based on ambitions to support people to live independently in their communities for as long as possible and is predicated on ambitions to support this through the use of technology, partnership working, personalised and person centred approaches and through developing anticipatory care, integrated and seamless approaches across all services.

Aligned to this the Board, with its Community Planning partners has supported the ongoing development of its joint Short Term Augmented Response Service (STARS) which supports older people through prevention of emergency admission to acute care and early supported discharge for those admitted, which will continue in the coming year.

Carers needs are being identified and action taken under the Joint Carers' strategy – making clear the Board's ongoing commitment to support this significant group of people, many of whom are themselves older, or provide care for older people. Funding is being sought to continue a project where carers (aged 16 plus) are offered a Keep Well Health Check and Health Coaching. This has enabled carers to be supported and recognised as key partners in service delivery and supporting carers to continue in their caring role through maintaining their health, wellbeing and contribution to their communities is critical.

We are currently preparing papers on Alcohol Related Brain Damage (ARBD) for NHS and Social Work Managers to consider, before agreeing on services to be developed. Although not necessarily restricted to older people, this condition will have an age-gradient relationship.

A local area forum have developed local responses to assessed need, including the development of alcohol information leaflets for older people; the provision of measured-glasses for alcohol consumption and support for parents and carers of drug and/or alcohol users where indicated.