Agenda Item 47

Local Delivery Plan 2016/17

Foreword from NHS Dumfries & Galloway Chief Executive, Jeff Ace

This is NHS Dumfries & Galloway's eleventh Local Delivery Plan (LDP), developed in line with the Scottish Government Health Directorate (SGHD) guidance of 13th January and 18th February 2016.

The LDP is the delivery contract between SGHD and NHS Dumfries & Galloway. The 2016/17 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 9 Strategic Improvement Priority areas. It also provides details of on-going LDP Standards; it is underpinned by an associated Financial Plan and the local NHS contributions to Community Planning Partnerships in accordance with the Agreement on Joint Working on Community Planning and Resourcing.

On 1st April 2016 responsibility for planning and delivery of health and adult social care services transferred formally to the new Integrated Joint Board partnership within Dumfries and Galloway. The NHS Board has delegated to the IJB delivery of a number of the Standards and Priorities outlined in this LDP but will retain ultimate accountability for performance. During 2016/17, the partnership will develop implementation plans for the 4 local delivery plans, which will set out how they will achieve the 9 national health and well-being outcomes, utilising the core suite of 23 indicators alongside a range of local and national performance indicators. This LDP will be used in conjunction with measures and indicators produced by the Integrated Joint Board to ensure that services within Dumfries and Galloway are delivered efficiently and to a high quality.

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.

The Board and IJB utilise risk management processes to ensure the greatest likelihood of success in delivering LDP trajectories. 2016/17 brings a substantial increase in financial risk to the Board due to our requirement to deliver around 5% (c £13M) of cash releasing efficiency savings to bridge the gap between funding growth and anticipated costs of service delivery. This savings target exceeds any previously delivered by NHS Dumfries & Galloway and, at time of writing, is substantially greater than the sum of efficiency savings identified. The Board will continue to make every effort to achieve its LDP standards and targets within this challenging financial context.

Risks and Issues

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

Targets and Standards

Given the financial and service pressures across the system, it will be a will be a significant challenges to deliver all of the required targets in 2016/17. 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 2016/17 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 2016/17 is at risk and the financial challenge 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

Contents

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 on behalf of the Directorate of Public Health.

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 (a joint unit between the NHS and Council) is progressed in partnership, taking a life course approach.

In progressing this work, the challenges faced are many and complex, requiring action across the NHS, social care system and in partnership with communities and society at large. In the last year the Directorate of Public Health, which takes a strategic lead role in improving population health and reducing health inequalities has revised its draft Strategic Framework to support focused activity across partners so that individual and community resilience for health and wellbeing is increased. The following priorities have been identified:

- Strengthening community resilience
- Strengthening individual resilience
- Improving mental health and wellbeing
- Improving physical activity
- Promoting food and health
- Creating environments supportive of health and wellbeing

To support this work, Public Health have developed an Outcome Focussed Framework which identifies the actions being taken forward by DG Health and Wellbeing in partnership with key stakeholders. This framework identifies the long, medium and short term outcomes for this programme of work, and sets them against actions and performance indicators to provide a clear outline of the work being delivered.

In addition, Public Health has led on the development of a Health Inequalities Action Framework. This is aimed at supporting all those involved in developing policies, guidelines, interventions, programmes and services by providing information and tools necessary to addressing inequalities. Its main aims are:

- To establish a shared understanding across partners of the causes of health inequalities with reference to the wider inequalities within society
- To support organisations and partnerships in identifying and agreeing the actions they can take to contribute reducing inequalities
- To support the shift to prevention and early intervention rather than dealing with problems in health and social care after they have arisen
- To ensure that policies tackle social, economic and environmental inequalities
- To support action to prioritise disadvantaged groups and areas of deprivation
- To provide tools to ensure that those planning, designing and implementing policies and interventions identify the impact of their work on inequalities (and

related health inequalities) and are able take action to eliminate these

The NHS is also working with the Council to support the implementation of their Anti-Poverty Strategy. This is being incorporated into the development of the Council's Local Outcome Improvement Plan, and action will be supported through the joint work of DG Health and Wellbeing.

The Alcohol and Drug Partnership's involvement in prevention work includes funding part of Police Scotland's Dumfries and Galloway Division's Substance Misuse coordinator who provides input to local prevention work. This includes numerous educational inputs with schools, festival harm reduction initiatives, drink and drug awareness campaigns and New Psychoactive Substance awareness sessions for staff across a variety of sectors.

Funding is also being provided to pilot peer naloxone training in two pharmacies in Dumfries and Gretna, to raise overdose awareness with clients accessing injecting equipment provision services and provide them with naloxone.

Alcohol Brief Interventions (ABIs) continue to be delivered within hospitals, community settings and GP practices, albeit data collection can be sporadic. ABIs are not yet embedded in all settings and with current Board financial pressures future targets may be at risk.

Some prevention initiatives will not be funded this year including taxi stewards, Alcohol Awareness Week and some Risky Behaviour work.

During the next year a strategic action plan will be developed for the organisation to support action to reduce health inequalities across all functions and services of the NHS in Dumfries and Galloway. This is being supported by the NHS Board. This will link to Board procurement and employment policies.

This work is aligned to a number of national and local policy drivers, including the recently published National Review of Public Health.

Actions to reduce health inequalities also link closely with work on the Health Promoting Health Service (HPHS). Building on current HPHS actions, a number of areas have been identified as areas for development in 2016/17. These include:

- Engagement with Managed Clinical Networks to embed HPHS within core practice
- Development of physical health assessments within mental health settings
- Development of a staff health and wellbeing action plan
- Development of a local behaviour change policy setting out how NHS Dumfries and Galloway will support behaviour change in clinical settings.

To progress the NHS corporate responsibility to address health inequalities, the plan over the next year is to agree actions to take forward implementation of the Strategic Framework for population health and wellbeing and reducing health inequalities. This will be progressed throughout the NHS Board, Integrated Joint Board and Community Planning Partnership.

NHS Dumfries and Galloway has a strong Community Development Programme which is fundamental to our work in progressing community resilience. This programme is led by Public Health on behalf of the organisation and plans for the next financial year are to ensure that this programme supports the local action plans for building community resilience as part of health and social care integration.

Supporting resilience and positive health behaviours across all life stages is a priority activity. Health and wellbeing priorities are: increasing physical activity levels, addressing food, health and overweight in the population and improving mental health and wellbeing. This work focuses on improving individual resilience, which in turn impacts on community resilience.

In supporting activity to build individual resilience, plans are underway to take the learning from the local Keep Well Programme and Child Healthy Weight to develop service provision which is tailored to meet the needs of individuals and uses the evidence based approach of health coaching. Finalising these plans will be possible once the financial settlement from the Scottish Government for Health and Wellbeing is received along with the Outcome Focused Framework.
It is expected that the priority areas identified for action across Dumfries and Galloway will be in line with the national priorities.

Priorities for the population health and wellbeing programme led by Public Health are reported on a bi-monthly basis to the Public Health Committee that includes membership representation from the local authority. Actions are also identified in the local SOA (Local Outcome Improvement Plan Outcomes from April 2016) and progress reported to the Community and Customer Services Committee in the Council. Future governance arrangements will be reviewed in the next year in line with emerging structures for HSCI, Community Planning and NHS Board responsibilities.

2. Antenatal and Early Years

Key work continues to be taken forward following the Children's Services Inspection in 2014/15 with the focus being on Keeping Children Safe, Getting it Right for Every Child, Corporate Parenting and Early Years.

The Children's Services Executive Group (CSEG) is responsible for setting the strategic direction of change, monitoring progress and overseeing all programmes of work. All strategic groups report to the Children's Services Executive Group with regard to performance and improvement.

The current multi-agency Children's Services Plan is an improvement plan based on the recommendations of the Joint Inspection of Children's Services in 2014. The Early Years element of the plan is delivered through the Early Years Strategic Group.
The main focus has been on the pre-birth to three years population and three main themes:

- Vulnerability – implementation of vulnerability pathway
- Parenting – provision of equitable wrap around support to vulnerable families
- Communication needs of the child – in response to 27-30 month health visitor review

There are three improvement teams linked to the themes above and each team is using the Early Years Improvement Methodology to shape changes and monitor data. Local data is reviewed as it pertains to the stretch aims of the Early Years Collaborative.

Activity has included:

- Strategic Needs Assessment of pre-birth to three populations
- Developing improvement expertise across years agencies
- Implementation of vulnerable pathway
- Agreeing and implementing core parenting interventions
- Development of family Information Service
- Investment in the development of family centres in five localities
- Roll out of incredible years parenting groups
- Promotion of positive mental health and the prevention of long term mental health difficulties
- Focus on health promoting positive lifestyle behaviour with regard to obesity
- Targeted and universal approaches to tackling children's oral health
- Implementation of new Health Visiting Pathway

A workshop in December 2015 was facilitated by the Improvement Manager for the Development and Assurance Team and the new Chair of the Early Years Group with the focus remaining on recommendations from the Care Inspectorate, CPC Improvement plan and Early Years Collaborative stretch aims. The workshop has facilitated an emphasis on the need to focus on the most vulnerable children in order to prioritise improving outcomes for that identified group.

Agreed Priority Actions for 2016/17 are:

- Family and Parenting Support for the most Vulnerable Families
- Focus on children on the Child Protection Register under one year old

The agreed priority actions by the Early Years Group has resulted in an emphasis on the need to specifically focus on intensive parenting support to unborn babies and children under one year of age who's names are on the Dumfries and Galloway Child Protection Register.

Refreshed Health Visiting Pathway

Capacity across the workforce will be reviewed on an on-going basis and the following actions are being progressed:

Implementation of the Refreshed Universal Health Visiting Pathway: Pre Birth to Pre School is underway. Delivery of The Universal Health Visiting Pathway in Scotland (2015) has begun for women in the antenatal period whose babies will be born in spring 2016.

The Board will meet its named person duties under the Children & Young People (Scotland) Act 2014. In doing so, only staff employed in the role of the Health Visitor registered with the Nursing and Midwifery Council will be the Named Person for pre-

school children. A dedicated generic email address for each Health Visitor has been implemented to ensure clear and effective communication routes are available.
In line with the implementation of the new pathway and the requirements of the Board to meet its named person duties under the Children & Young People (Scotland) Act 2014, the baseline whole time equivalent number (WTE) of Health Visitors has grown, from 33.9 WTE in March 2014 to 37.24 in February 2016. At 1st April 2016 there is 0.8 WTE health visiting vacancy. We are continuing to support the role of health visiting through the health visiting training programme and currently have two students who are expected to complete this programme in September 2016.

Workforce planning has been undertaken with the existing workforce and, with a view to expected changes in the workforce from planned retirements, recruitment is underway to a further four student placements to commence the health visiting programme in September 2016.

Workforce planning will be ongoing to ensure that the Board will continue to meet its duties with regard to both the implementation of the Refreshed Pathway and under the named person duties under the 2014 Act. However, the total allocation of additional funding from Scottish Government to grow the workforce to 44.41wte is not due to be reached until August 2018. Therefore, the Board can only be confident of its current position. The future number of health visitors is reliant on the continued additional support and funding from Scottish Government.

Health Visitors are being supported to deliver the new Universal Pathway and their named person duties through training and development. Plans are in place for all Health Visitors to have completed the NHS Education for Scotland master classes by May 2016.

The established multi-agency Children's Services Learning and Development Group has developed the Dumfries & Galloway Children's Services Learning and Development Core Competency Framework. One of the aims of the framework is to provide a tool which helps practitioners self-evaluate and identify the continuing professional development their training requires to undertake the Named Person and Lead Professional roles. A calendar of multi-agency training delivered locally is available for information.

Continuing professional development is also delivered to all Health Visitors via single agency Development Days held quarterly within the Board. Plans are in place for all Health Visitors to receive an update from Speech & Language staff at the Development Day in June 2016.

Work is underway to ensure that the Board will meet its child's plan duties under the 2014 Act:

- All Health Visitors have attended Child's Plan training
- Child's Plan training is available to all staff via the multi-agency training and development calendar
- The Child's Plan content is as specified by Scottish Government
- There is assurance that Health Visitors are instigating Child's Plans and Child's Plan meetings

- Other disciplines of staff are involved in multi-agency Child's Plan meetings
- Other disciplines of staff are acting as Lead Professional, although the numbers are currently very small
- Audit of Child's Plans instigated by Health Visitors for quantity and quality assurance is underway
- Audit of numbers of Child's Plans that Health Visitors are involved with partner agencies is underway

Work is ongoing both within the Board to raise awareness of the 2014 Act duties among all staff via:

- Regular Children's Services Executive Group (CSEG) briefings to all staff
- An established Getting It Right For Every Child (GIRFEC) Champions group with representation from all services within the Women, Children & Sexual Health Directorate, including a lead Pediatrician. The remit of the group includes communication to staff
- The GIRFEC Implementation Officer available to all staff for information, updates, and to raise issues via an issues log
- GIRFEC page on the staff intranet with information and links direct to the 2014 Act via legislation.gov.uk page
- GIRFEC page also links to the Local Authority web page with further information relating to GIRFEC and the multi-agency Learning & Development calendar

Partnership working in relation to Getting It Right For Every Child group is well established in Dumfries & Galloway. There is Board representation on the GIRFEC Leadership and Implementation Groups working with partners from Education, Police and Local Authority working together to implement the Children and Young People (Scotland) Act 2014 Revised Draft Statutory Guidance for Parts 4, 5 and 18 (Section 96) (2015). These groups report directly to the Children's Services Executive Group.

The Board is changing and developing information systems and protocols to facilitate 2014 Act duties including:

- Information sharing ePortal within the Board. A pilot of this, undertaken by Health Visitors is underway
- All Health Visitors have moved to using ePens and eCasenote
- Transition Pathway Named Midwife to Named Person (Health Visitor) - Handover Guidance has been developed and implemented from March 2016
- Letter to GP's to inform of the Named Person (Health Visitor) details has been developed and implemented from March 2016
- Transition Pathway Named Person (Health Visitor) to Named Person (Education) was implemented in 2015. Work is underway in 2016/17 with partners in Education to develop this further
- Transition Pathway Named Person (HV) to Named Person (HV) when child moves are within Scotland is under review
- Transition Pathway Named Person (HV) to Health Visitor when child moves outside of Scotland is under review
- Multi-agency Named Person Service Information Leaflet has been developed by the GIRFEC Implementation Group and is distributed by Health Visitors at Primary Birth Visits

- Existing multi-agency Information Sharing Practitioner Guidance will be reviewed by the GIRFEC Implementation Group in line with the final revised statutory guidance from Scottish Government
- Creation of any new Information Sharing eProtocols in support required as a result of the requirements
- Development of a multi-agency Single Point of Contact for Police and other well-being concerns is underway

NHS Dumfries & Galloway is also one of two early adopter sites in Scotland testing a revised model of School Nursing. This includes a national review of the role of the School Nurse and associated team, universal pathway, and all current and future education and career pathways. This work is being led by The School Nursing Steering Group, a sub group of the Children, Young People and Family Nursing Advisory Group. Testing of the revised model began on 1 November 2015 for a period of one year.

NHS Dumfries & Galloway also has representation on the group leading on the review of the Community Children's Nursing Service. This work is also being led by the Children, Young People and Family Nursing Advisory Group.

3. Safe Care

Safe Care

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

- Mental Health
- Primary Care; including a new pilot in General Dental Practice
- 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 2016/17 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. During 2016/17 we will increase our emphasis on cross system working to ensure that safety and the experience of care is improved across the patients' journey.

Progress has been made across each of the programmes during 2015/16:

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.

Our HSMR (Hospital Standardised Mortality Ratio) for Dumfries & Galloway Royal Infirmary has reduced by 16.8% (based on July – Sept 15 data) with the Harm Indicator identifying that in excess of 99% of patients are discharged from DGRI free from harm as measured by SPSI3.

To achieve this during 2015/16 we focused initially on the 9 Point of Care Priorities plus one local priority (clinical handover). This was reprioritised in year in recognition of local capacity issues to focus on:

- Deteriorating Patients, including Sepsis
- Pressure Ulcers
- Venous Thromboembolism
- Catheter Associated Urinary Tract Infection (CAUTI)
- Falls with Harm
- Safer Medicines
- Clinical Handover

With the exception of Clinical Handover these will remain our priorities for 2016/17. We will in addition scope how the improvements we are making within acute care might be tested within community settings e.g. pressure ulcer prevention, CAUTI prevention and

falls prevention. The work will initially involve one locality within the region.

SPSP Primary Care

Year 2 of our local Primary Care PSP commenced in September 2014 with 32 out of 34 practices participating in the Local Enhanced Service for Medicines Reconciliation.

Of the 70% of practices who submitted their data, all demonstrated improvement in practice processes with 70-80% of patients receiving all elements of the Medicines Reconciliation Bundle.

The new Local Enhanced Service for High Risk Medications commenced in January 2016. The focus is on high risk prescribing, specifically patients who are over 65 who receive the 'triple whammy' medication combination, and other combinations including Non Steroidal Anti Inflammatory Drugs (NSAIDS). 27 practices have signed up to participate.

Local learning events continue to be run to support practices.

SPSP MCQIC

The aim for all strands of this programme is to reduce avoidable harm by 30% by March 2016 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. Progress has been made in formalising measurement systems and in developing improvement capability particularly within the Maternity stream that have benefitted from funding for a Maternity Champion. This will continue to be a focus for 2016/17.

The Patient Safety & Improvement Team are working with the Women and Children's Directorate to explore priorities for 2016/17 and how these might be supported. It is currently unclear whether the MCQIC programme will continue beyond March 2016, locally we will continue with priorities from 2015/16.

Maternity have made significant progress in reducing the incidence of stillbirth and post partum haemorrhage (PPH). Work has been carried out to improve the guidance provided surrounding PPH, educating women of the dangers and the steps to take. The introduction of safety briefings, monitoring of CO levels and MEWS has reduced our incidences of PPH and stillbirth. Greater attendance at our Multiagency Clinics for vulnerable women is also a positive step towards the overall reduction of stillbirths and PPH.

The Neonatal team have demonstrated a good level of compliance with PVC Management and the Gentamicin Bundle and have been working to improve person centred care.

Our Paediatric team continues to focus on Paediatric Early Warning System and have supported testing of the National system, improving communication through Safety Briefs, medicines reconciliation and person centred care.

4. Person-Centred

Our partnership within Dumfries and Galloway is committed to delivering person centred care to everybody within our communities. In relation to older people standards and Health and Social Care Integration (HSCI) the board has been focusing on ensuring person centeredness is at the heart of our day to day business.

One of the ways in which NHS D&G will fulfill its responsibilities is by contributing to the implementation of the Integration Joint Board (IJB) Participation and Engagement Strategy. The Strategy will engage people in our communities in a number of different ways and routes, providing a range of opportunities to express views and opinions on health and social care. In line with the NHS D&G adoption of the National Standards of Community Engagement, the IJB Strategy also promotes the Standards. This includes the 'Feedback' Standard which sets out how we will give feedback to respondents and the improvements made as a result of their contribution.

One of the engagement routes to be used by NHS D&G, the IJB, the Council and other partners is the Dumfries and Galloway Public Involvement Panel (PIP). This is a network of people and organisations from across the region who have expressed an interest in participating in engagement activity about their public services. The PIP has a Steering Group that will coordinate planned engagement activity across all the partners, provide peer support for professionals and discuss feedback to improve the quality of engagement activity. NHS D&G will be represented on the Steering Group and has agreed to act as the coordinator for the PIP membership and also editor of the regular newsletter. NHS D&G therefore has a clear plan about how it interacts with local communities and communities of interest to ensure they have a strong voice within Dumfries and Galloway.

Supporting the 5 'must do with me' principles of care within Dumfries and Galloway is one that the partnership is committed to. Incorporating this into our patient records, documentation and mindset is currently being taken forward within all areas of the partnership. There are some inconsistencies in different areas and the partnership is currently reviewing the current records and processes that support this to ensure continuity and application is equal across the region. The inclusion of a specific section of the patient record asking 'what matters to you?' will assist to ensure that people are engaged on a personal level and will give them the opportunity and ability to shape and influence what their individual, social, psychological, physiological and physical needs are. This addition will aide the meeting of an individuals personal goal in improving or maintaining their health and wellbeing. Training in this area has been commenced and is an on-going area of interest within teams to embed it and ensure the person is at the centre of their care. Part of the training for staff is around ensuring the planning element of person centred care is fully explored with the individual. It is key that the plan is not recorded as a series of lists and we will work with our teams to ensure the care plan agreed will meet the individuals outcomes agreed by them and practitioners.

We are proposing and undergoing testing with a variety of ways to support our ageing population, it is highlighted that visiting people can be difficult especially due to our rural geography. It is recognised that understanding the needs of people with dementia is a crucial role in their rehabilitation process. A significant part of that role is retaining consistency with surroundings and people when they are out of their own environment. Linking with 'John's Campaign' we are working in improving the flexibility in visiting

times and duration. We are importantly working on our conversations with relatives and inviting them to inform us of how they wish to be involved in their relatives care and making that as convenient and easy as possible.

Patient stories and feedback is the methodology we use to continually improve our services and environment. This is done with the aim of ensuring a positive, high quality experience for staff and patients. We are expanding the use of patient stories and utilising information and experiences provided through methods such as emotional touch pads to help inform our work going forward. This work and information has and is already helping with our design of services for the new hospital.

A successful pilot was run that involved the presence of a Physiotherapist and Occupational Therapist being present at the Emergency Department (ED) and our Medical Admissions Unit (MAU). Acknowledging the successes of this model, the posts have been made permanent and will continue to develop in ensuring that individuals where possible will not have to be admitted to hospital and thus reducing their length of stay away from their own environment.

We are currently working towards the inclusion of all of our AHP services booking processes to be part of Patient Focused Booking (PFB). We are currently working where appropriate, to have booking of clinics through PFB to ensure equity of access and timeous appointment booking for out-patient appointments. Whilst booking, we are following guidance around providing, where possible, individuals with appointments that are both reasonable and convenient. Improvement work within the AHP services have resulted in MSK (Musculoskeletal) services being the only board in Scotland adhering to the four week timescale of providing referral to first contact. Referral pathways have been improved to ensure the individual is seen by the right person at the right time. This work will continue into 2016/17 to further streamline the routes of referral to the most appropriate whilst acknowledging that patient safety and experience must not be compromised. Naturally this process will reach a saturation point and any further streamlining may be detrimental to the individuals journey and the individual themselves, we are aware that this is a risk that must be acknowledged and monitored.

MSK services are working with NHS24 in triaging as many Musculoskeletal queries as possible, the helpline launched by NHS24 has aided the referral process and will, as knowledge of the service within our communities improves, reduce the number of visits to GPs and more importantly inappropriate referrals, overall resulting in a more person-centred approach and better overall journey. Further to this podiatry services are working to introduce a self-referral pathway during 2016/17 which will negate the need for a GP referral.

Further to last year's development and trial of a greatly streamlined and responsive complaints process within the Acute and Diagnostic Services and Women's and Childrens Service, adoption within health services in the community has taken place. It is hoped that complaints in any form are dealt with quicker, ensuring that contact is made with the complainant within three days. This facilitates a relationship centred approach to resolving the complaint at the earliest opportunity. Initial indications are good and work continues to ensure that cases with a greater deal of complexity are dealt with, within an acceptable and reasonable timescale that is both thorough and person centred. The Integration Joint Board will, during 2016/17, be discussing the procedural steps involved and the roles and responsibilities for an Integrated Complaints Management Framework.

5. Primary Care

This section of the LDP is set out in the recommended way and provides a general overview of Primary Care within Dumfries and Galloway. It details the developments for the four sub-contractor groups, and the Out of Hours Services, the details of which will be under the 4 headings of:

1. Leadership & Workforce
2. Planning and Interfaces
3. Technology and Data
4. Contracts and Resources

It is important however to describe the context within Dumfries and Galloway: We provide services to a population of approximately 148,000, dispersed widely throughout an extensive area, with only three settlements having a population of over 10,000 people.

We are in the process of a major hospital replacement, with the new Dumfries & Galloway Royal Infirmary due to be handed over in the autumn of next year. The new hospital will have slightly fewer beds than at present, and so, appreciating the increasing number of older (and isolated) people in our area, we have to change the ability of services in communities to provide health and social care to keep people out of hospital where possible, and to enable them to return home as soon as possible to an appropriately supported environment. This requirement, and the pressures on primary care, has led us to set up a multi-disciplinary Clinical Services Change Programme which will ensure that service change is progressed before the new hospital is opened.

The Integration Joint Board formally undertook its role at the start of April, and it is seen to be unique in that a decision has been made to include all of acute services along with primary care and mental health. We believe that this will ensure the maintenance of good links between primary and secondary care, and it will be the setting for debate between acute and primary care regarding use of our resources – we believe firmly that we need to accelerate the transfer of resources to primary and social care in order to protect the current functioning of our acute services.

Like all areas, the sustainability of many of our services is challenged by recruitment issues, especially, but not exclusively, in General Medical Practice. We have 34 practices, and surveying them regularly regarding staffing issues, reveals that 4 practices are at high risk of being unable to continue in their present form, and several others are under increased pressure as a result of longer-term vacancies. We have also had multiple vacancies in our GP training programme, and expect this to be a continuing problem in the medium term.

The impact of failure to recruit GPs may be felt beyond practices, as we have 8 cottage hospitals that are provided with medical input by GPs, and have the GP input to the Prison Service within HMP Dumfries. It is likely that GP input to 2 of the cottage hospitals, and the Prison Service will not continue under the current arrangements. Although currently stable, we would, if unable to secure GP, look to provide cover from consultants in Care of the Elderly, though recognise the considerable difficulties in

recruiting Care of the Elderly Consultants. To complement our medical input, considerations are being made to the training and utilisation of Advanced Nurse Practitioners (ANPs). Fortunately however, we seem to be able to maintain the GP Out of Hours service using a mix of local GPs, salaried doctors, locums, ANPs, and occasionally with support from extended scope community paramedics from the Scottish Ambulance Service – in that respect we are pre-empting the suggestions set out in Sir Lewis Ritchie's review suggesting a greater breadth of professional input to our Out of Hours (OOH) services.

1. General Medical Practice:

    i) Leadership and Workforce

There have been significant changes as a result of the impending integration in that we have returned to a locality structure, with 4 localities (which are coterminous with social work locality teams) across Dumfries & Galloway. Meetings have taken place in all localities to ensure that GPs are able to influence locality plans, as well as seeking their support in implementing newer ways of working.

Each locality will continue to have a GP clinical lead, who will work alongside a locality team including a nurse manager and social work manager, as well as the locality manager. In addition to that locality structure, practices in Wigtownshire have shared the employment of a half time representative who will seek to elicit views from all practices, and ensure that they are fed back firmly to the locality and regional strategic planning processes.

We have appointed a half-time Deputy Medical Director for Primary Care who will, as part of their remit lead the implementation of the new GMS contract and contribution to the Clinical Services Change Programme. They will also be the GP representative on the Integration Joint Board, as well as helping, with the Medical Director, enhance recruitment to this area, and seek to arrange support for practices that are challenged by recruitment difficulties.

Our approach to the workforce problems in primary care is to start by enhancing recruitment. We have developed a recruitment website - www.dumfriesmedicalrecruitment.co.uk – and have assisted practices in recruitment drives in Holland and Southern Ireland. We continue to work to make our training scheme as attractive as possible: as a new initiative, we have forged links with the Falkland Islands, and will be arranging for GP registrars to prepare for work in remote and rural settings by having a placement in the Falklands as an option. We have also funded two rural fellow posts, which may also exercise the option to work in the Falklands – again attempting to appeal to doctors who wish to become remote and rural GPs – hopefully staying in Dumfries & Galloway after their year as a rural fellow.

We recognise however that we will be unlikely to attract enough GPs to the area as a result of the national reduction in doctors entering GP training: We seek to build alternative capacity in primary care and will fund the training each year of at least 4 nurses to become Advanced Nurse Practitioners in General Practice. In addition it is hoped that we will be able to fund minor illness training for practice nurses who will then be able to extend their role, and take some pressure off of doctors.

We have considered the development of clusters of practices, but as yet we have not, in this rural setting, been convinced of any service delivery benefits, though there seem to be benefits in the sharing of some tasks such as ANP training.

Our experience tells us that small rural practices are becoming less attractive for new GPs – they are not attracted by the potential professional and social isolation. Some practical difficulties arise in small practices (Several of which have remote branch surgeries) such as difficulties in taking any annual leave due to the excessive challenges in recruiting locums. It is highly likely that there will be a significant reduction in the number of small rural practices, with larger practices more able to recruit and build a wider range of services.

The Primary Care department has discussed the issue of Golden Hello inducement payments for first practice GPs, and we have maintained this across our region.

We have a well developed prescribing support team which is able to support practices in cost-effective prescribing. They have been developing their roles in line with PfE and are now prescribers, and take on considerable work in polypharmacy reviews in order to ensure that the benefit/harm ratio is positive for all items prescribed.

We recognise the experience of areas that have used Link Workers to help direct patients to community groups and patient groups that may support patients in increased self-management of their illnesses: We have invested in such staff; this role has been working well within two areas of our region and is looking at being extended to support the services within the localities to be joined up and more informed to make the right referral where appropriate.

We note an invitation from CNO to become a trial area in relation to the Buurtzorg arrangements for district nursing (which was developed in the Netherlands). We hope to trial this working, which is framed around small autonomous teams reliant on professionalism to maintain standards and deliver high quality care: We feel that this will provide more prompt re-ablement, will enhance recruitment, and should increase the overall capacity in primary care – though not directly in General Practice, we anticipate benefits.

ii) Planning and Interfaces:

Like all areas, we have spent a considerable amount of time and effort in drafting an Integration Strategic Plan, which has then been widely consulted on across our region. The strategic plan was developed on the basis of a strategic needs assessment of the 4 localities, and informed by public engagement which helped define what developments the communities wished for.

The development of the Strategic Plan has also been assisted by increased understanding of the Integrated Resource Framework, which shows where resources have been used, and highlights where change might bring about better results for less resource usage.

The regional Strategic Plan is supported by 4 locality plans which provide more detail about how the principles will be delivered on the ground. The aims of all of the plans are to develop alternatives to admission where possible by identifying those at most

risk and ensuring that they have appropriate current support, as well as developing plans to escalate care as required in the event of a deterioration or exacerbation of their long-term conditions or other problems. We also plan a major emphasis on supporting early discharge from hospital, recognising that a large number of beds are occupied by patients who are clinically ready to return home. We recognise that for too many older persons we default to a medical solution to primarily social problems by admitting patients to hospital, whereas a proportion of admissions can be avoided by having in place, services that are flexible enough to provide rapid escalation of supportive social care – which may also include short-term admission to a care home (as has been successfully trialed in Dumfries & Galloway).

The transfer of our NRAC share of the £250 million Government Funds has allowed us to support social services to provide a living wage to care staff from October, and we anticipate that there will be additionality in terms of greater access to care packages to allow early discharge.

We have had a daily "huddle" within our hospital to update on bed occupancy, and to review discharge plans for the day. We have now set up a similar "huddle" in social and primary care services that communicates with the acute services huddle, and plans to draw patients out of the hospital and back to their homes with appropriate support. This will ensure that health and social services are working effectively at the interface between primary and secondary care.

We have received notification of the Primary Care Transition Fund, and the Primary Care funding for Mental Health Services. A small group has been set up across the region consisting of GP leads and managers to determine how we will deploy these resources. The plans for the transition fund will focus primarily on building capacity in primary care – mainly by investing in ANP training. With the Mental Health Funding we plan to set up to relieve – with third sector organisations – the social isolation and loneliness that often leads to depression, and is often a consequence of long-term conditions forcing patients to withdraw from a participative role in communities. We believe that this pro-active approach will improve the experience patients have of long term conditions, as well as recognising that psycho-social support reduces progression as well as exacerbations.

iii) Technology and Data:

We have a number of plans - which follow on from last years work – to increase the use of technology in primary care. We have noted that the process of anticoagulant monitoring is a high risk area, and have arranged for a number of practices to trial point of care testing for INR monitoring, believing that this will improve safety and reduce workload.

We have been conducting research on low cost telemonitoring for COPD (Chronic Obstructive Pulmonary Disease), with success that appears to be extremely cost-effective overall: The monitoring is based on patient reported self-assessment using a simple pulse oximeter and thermometer and is demonstrating good results for a total investment of £30 per patient.

A small number of practices have started improving patient access to services by using electronic ordering of prescriptions, and we plan to encourage this across a wider range of practices, along with a trial of appointment scheduling.

Data will be needed to ensure that we have a focus on continuous improvement. The Strategic Plan has developed integration performance standards which are designed to reflect patient outcomes rather than activity: the challenge in GP data is to develop measures of outcomes that are not bio-medical (as in QoF) but are validated measures of consequences for patients of treatment. We strongly believe that this requires national development.

Working with the local social services, the Board has funded invites to all persons aged 75 and over to have an assessment of telecare needs in their home. This has been a direct response to the relative low levels of provision of telecare in the region.

All GP practices in the region have participated in an extensive study of the validity of urine HPV (Human Papilloma Virus) testing as an alternative to smear testing. We have a vast amount of data that shows that a negative HPV test excludes the possibility of cervical cancer or pre-cancer, and this non-intrusive testing could form the basis of a completely redesigned screening service that could reduce inconvenience and discomfort for patients, save money, and probably increase participation rates so a greater number of patients take part in the testing. Again, we feel that this requires urgent national support – and decisions are required to be made in the future as historic HPV immunisation becomes more prevalent.

iv) Contracts and resources:

Within General Practice, the main changes relate to the abolition of QoF, and the advent of the new GMS contract.

We are gearing up capacity – as described above – to implement the new contract, recognising that the last change to the GMS contract in 2004 required a considerable amount of effort and discussion to implement. This will be achieved by increased staffing within our Primary Care Development Department, and an Deputy Medical Director for Primary Care.

We have decided to maintain our list of Enhanced Services for the time being.

As described we have set up a region-wide group of managers and GPs to develop proposals for the Primary Care Transition funds, recognising that the imperative is to improve capacity within Primary Care.

However much of our management of contracts will relate to the pressures being felt within practices to provide services: Several practices are considering dropping additional services, which, if not provided by practices will have to be delivered direct by Health Board services – which is likely to be more costly. Our aim therefore is to support practices to provide services as much as possible.

In 2014 we negotiated a new contract for the provision of medical input to Cottage Hospitals which based payment on a mixture of patient payments along with an adjustment for occupancy and turnover, which was designed to reward efforts to allow

early, supported, planned discharge of patients. This contract has become less rewarding for GPs, especially as the complexity of patients has increased and the time spent in the hospitals by GPs has increased. This will be reviewed in the next few months, aiming to increase the attractiveness of the work, and possibly drawing other practices in to the work. It is likely that this will cost a significant resource – possibly £50 – £100,000 to maintain this level of input – a level of investment which may mean that alternative staffing by acute hospital staff becomes more cost-effective.

We have a contract for the medical input to the prison in Dumfries. Currently this is held by a practice that is facing two resignations, and is unlikely to be able to recruit alternative doctors. The cost of re-letting the contract is likely to involve a significant increase in costs that will not be found within the envelope of costs that was transferred along with the responsibility for the provision of prison health services.

2. Dental Services:

i) Leadership and Workforce.

We have developed a strong combined arrangement for the management and clinical leadership of primary care dental services. The management resources include a Director of Primary Care Dentistry (a dentist), our Public Health Consultant in Dentistry, the manager of the Primary Care Development department, and the manager of the salaried services.

With input from the Dental Reference Service, we have an oversight group that sets clinical standards, and investigates and provides support when any quality issues become apparent, through a formal system designed to detect weaknesses before they become problems. This group has been able to provide assurance that dental standards are being maintained throughout Dumfries & Galloway, as well as overseeing the Dental Practice Inspection process and the listing of new dentists. The dental management group works well with the Dental Advisory Committee, which meets on a two monthly basis.

We have had a thorough review of our salaried dental services, which, after a long period of consultation with staff and patients, made recommendations to the board in October 2014. Many of the changes have now been progressed, but we have chosen to slow the closure of salaried services in two locations as a result of patient concerns, drawing up plans to meet their objections. It seems as if the review of salaried dental services has been an exemplar in terms of staff and patient engagement with the process throughout.

ii) Planning and Interfaces:

The main planning has been in relation to the reduction of salaried services now that we have adequate provision of NHS General Dental services across Dumfries & Galloway – as described above.

We have also been carefully monitoring our progress in relation to fluoride varnish applications, and to nursery tooth brushing initiatives. These programmes are now both on track, and we have been pleased to see a steady improvement in the percentage of children without tooth decay through the NDIP (National Dental Inspection Programme) monitoring process.

We continue to provide training in conjunction with the University of the Highlands, producing qualified dental therapists from our specially developed Dumfries Dental Centre. This building continues to provide training for dental students, dental nurses, GDP (General Dental Practitioners) trainees and dental therapists, as well as providing services for patients.

The Emergency Dental Service is working satisfactorily operating chiefly from the Dumfries Dental Centre and Stranraer.

We have had an orthodontic network across Primary and Secondary care that had worked well and allowed specialist treatment planning, with some treatment being carried out in primary care. This has not been working satisfactorily recently, and an external review of Orthodontics has just been completed with a view to re-plan the clinical pathways and thresholds for secondary care referral. This is likely to be material in meeting treatment time targets by streaming demand to the most appropriate service provider.

Our local OMFS consultant has moved to another area, and we are unable to recruit a replacement. We are arranging a visiting service for specialist services from Glasgow, supported by an oral surgeon working in secondary care. This has introduced a degree of complexity regarding referral pathways, and these will be developed, tested and communicated to primary care dentists to ensure appropriate referrals

iii) Technology and Data:

We continue to measure the effectiveness of our oral health programme, including the fluoride varnish application initiative, by the routine collection of data through the national NDIP process, with analysis of the gap between the most and least affluent schools to guide service focus.

We will continue practice inspections to ensure that standards are being met. While we have a number of practices using local decontamination processes (which are inspected) we continue to provide CSSD services for salaried dental services, and for some contractors who work with Integrated Dental Holdings: This ensures compliance with the highest standards of decontamination.

Particular attention has been paid recently to the IRMER (Ionising Radiation (Medical Exposure) Regulations) regulations relating to radiology, and we continue to check that dentists have appropriate levels of equipment, and that they are compliant with standard operating processes.

The Dental Support and Patient Safety Group uses data from a wide range of sources to assure quality of care – including DRS reports, complaints, significant incidents, and prescribing data.

iv) Contracts and Resources.

We have plans to review the resource use that is used to meet targets now that the bundled approach for funding is in place.

We do not have any contracts in place other than the national terms and conditions for General Dental Practitioners.

3. Pharmacy:

i) Leadership and Workforce:

Leadership is provided by our Chief Pharmacist, working with our local Area Drug and Therapeutics Committee to establish local protocols on prescribing and dispensing, with some input from the Primary Care Development Department that oversees all payment to contractors.

This is augmented by our team of prescribing advisors, who we have recently increased. As well as providing assistance to GPs to improve cost-effectiveness and safety, they produce a widely read prescribing newssheet every month – "Nostrum" which provides advice to all clinicians including pharmacists.

Local pharmacists are being invited to attend locality meetings of the integrated structure, and we hope that this will lead to steadily improving relationships.

We are not aware of significant workforce challenges in pharmacy across Dumfries & Galloway: There has been a slow uptake of independent prescribing amongst pharmacists, and the uptake of Chronic Medication Services has been slow, but we hope that a more integrated structure in each locality will encourage greater participation in more direct patient care.

ii) Planning and Interfaces:

As with all Boards, the steady rise in primary care prescribing costs remains a challenge to our ability to provide a full range of services. As a result we held a recent "Prescribing Summit" attended by pharmacists and GPs, as well as the prescribing support team, and our prescribing analyst. This has identified potential for increased cost effectiveness by reducing waste, by switching some medications and by increasing further generic prescribing. The most significant impact will, we believe, come from agreeing an area wide cessation of the pharmacy run 'Managed Repeat Prescription Services'. This may cause some concern amongst patients in that they may feel inconvenienced, but we have identified considerable anecdotal evidence of excessive ordering. We are also aware of significant reductions in volume of prescriptions that occurred elsewhere following a ban on 'Managed Repeat Systems'. We feel that the weaknesses in systems have led to some tensions in the interface between GPs and pharmacies, which we wish to improve.

We have considerable pressure in general practices in relation to workload, with the result that polypharmacy reviews are not carried out in sufficient quantities to support patient safety or cost-effective prescribing. We have managed to provide pharmacy support to several practices to help with this task, with a focus particularly on care and nursing home patients. We follow the advice given in the polypharmacy review published last year by Scottish Government.

We note the inherent conflict of interests in dispensing practices, and although our dispensing practices show a range of prescribing costs, we would like to see national work on an alternative contract for dispensing practices that isolates the cost of medications from the practice remuneration.

iii) Technology and Data.

We have the ability to access a great deal of prescribing data from the national PRISMS (Prescribing and Medicines) data: In order to make the best use of this data we have appointed an analyst who prepares reports on the data, along with recommendations on where to target efforts to improve the cost effectiveness of our prescribing. This informs, for example, targeted visits by the medical director or the locality clinical leads along with the chief pharmacist in order to reduce variation in prescribing. Prescribing savings have saved us annual sums of around £2 million, the main contributor to CRES savings across the Board, though this is becoming increasingly difficult to maintain.

Dumfries & Galloway were the first Board to completely review and replace domiciliary oxygen supplies, tightening oxygen provision protocols, and transferring patients who required long-term oxygen to oxygen concentrators provided and maintained by Dolby: This use of improved technology has improved the service for patients, and has allowed considerable savings to be made.

iv) Contracts and Resources.

Our interactions with pharmacies are governed by the national contracts, and the resources used are governed by activity.

We recognise the added value that can be provided to practices by the employment of pharmacists to work on all prescribing issues within practices, and have funded the part-time employment of pharmacists working in practices, using the resources supplied by Scottish Government.

4. Optometry:

We have probably not made as effective use as possible of high street optometrists in the provision of eye care to the population.

We have agreed protocols on the referral of patients with cataracts – referred electronically to SCI gateway – to reduce the number of patients who are assessed in our hospital out-patient clinics and then decide not to proceed with cataract extraction. The guidance has also reduced the number of cataracts that are operated on, which has been an appropriate change as D&G was a significant outlier nationally in the age adjusted rate of cataract extraction.

We have an ophthalmology department that is under considerable pressure, and so have arranged an external review to advise on ways in which we may become more efficient, and also more patient centred. The review has proposed a move to greater use of high street optometrists in the management of chronic glaucoma, and we will plan to develop a glaucoma service that follows the lead set by Grampian in engaging optometrists in the follow-up of chronic stable glaucoma.

5. Out of Hours Service:

Despite the pressures on GP recruitment, we have managed to maintain staffing of the Out of Hours service, making good use of general practitioner input, doctors who have recently retired from practice, salaried doctors, GP trainees and more recently Advanced Nurse Practitioners. Although not used on a regular basis, we have also utilised community paramedics in the west of the region at times of particular pressure.

We have improved the relationship between ED (Emergency Department) and out of hours so that both services will assist the other in dealing with surges of demand, and referring patients round if it seems more appropriate. This has been facilitated by having our two main Primary Care Emergency Centres co-located with the ED departments. This model will be replicated in our new hospital, with sharing of some common facilities such as reception staff.

Access to KIS and ePCS has been helpful, and has increased, and allows doctors to overcome the communication challenges that would otherwise occur.

The GP clinical lead has an organised programme of teaching, and ensures that a proportion of records are reviewed in order to assure quality standards are maintained.

We are changing the process of discharge letters from the hospital so that staff from the OOHs service get feedback in relation to the patients they have admitted – an important issue in on-going development of the service.

Summary:

Dumfries & Galloway, a large rural area, relies on high quality provision of GP services to maintain an effective and cost-effective health system. We recognise however that the system is extremely challenged by the changing demographics, workforce pressures and financial constraints. We will work hard in the next year to improve recruitment, although recognise that in the current market it will not be possible to fill all vacant posts, and so will seek to urgently build capacity by the training of Advanced Nurse Practitioners, as well as employing pharmacists within practices to improve prescribing and take some workload from GPs. We recognise that integration and increased resources in social care will, if properly managed, allow us to prevent some admissions, and reduce discharge delay – a pre-requisite to more selectively investing in primary and community care.

This will be delivered by the locality structures working with the acute led Clinical Services Change Programme, supported by data from, amongst other sources, the Integrated Resource Framework, and our own Needs Assessment.

6. Integration

Integrating health and social care for all adults in Dumfries and Galloway continues to progress. Delivering the nine national health and wellbeing outcomes remains our focus for integration and ensuring our partnership delivers the best for individuals in Dumfries and Galloway. Dumfries and Galloway is in a unique position due to the amount of resource being delegated to the Integration Joint Board. It is expected that this delegation will allow the opportunity to appraise services in a way which gains best possible quality and efficiency for the people of Dumfries and Galloway.

Engaging a wide range of people and communities has been critical to the integration agenda. For this, our aims have been to:

- Provide people with as much opportunity as possible to help shape the future of health and social care;
- Ensure people remain well informed and are aware regarding ongoing planning and development in the region.

A full statement of consultation laying out all of the detail on this engagement activity will be published at the same time as our strategic plan on 1st April 2016.

Whilst this engagement will remain an essential element of an iterative process of strategic commissioning, our engagement work to date has culminated in what is now, the first integrated strategic plan for health and social care in the region and a locality plan for each of the four localities.

To support these documents going forward, our strategic framework contains other core strategic documents. These are the strategic needs assessment, finance plan, market facilitation plan and performance management framework.

In addition, an Integration Joint Board Participation, Engagement strategy and Integrated Equalities Outcomes Framework document have also been developed.

The main areas of focus contained within the strategic plan are:

- Enabling people to have more choice and control
- Supporting carers
- Developing and strengthening communities
- Making the most of wellbeing
- Maintaining safe, high-quality care and protecting vulnerable adults
- Shifting the focus from institutional care to home and community based services
- Integrated ways of working
- Reducing health inequalities
- Working efficiently and effectively
- Making the best use of technology

The Integration Joint Board has made a number of commitments against each of these key areas of focus. Progress towards achieving each of these commitments will form part of the performance management of the strategic plan.

As part of Health and Social Care Integration a 'cultural diagnostic survey' has been undertaken to help us develop a much greater understanding of the different cultures that currently exist across the partnership organisations; public sector, third sector and independent sector; and what we need to do to move towards our ideal culture. The data from the surveys is currently being collated and converted into reports which will be available in late May. These reports will be made available and used to develop delivery action plans based on the outcomes. All partner organisations have staff accredited to interpret the reports and provide support in planning for the ideal culture.

Work is ongoing to ensure that clear governance arrangements for the new Integration Joint Board are in place and effectively communicated. In addition to the strategic bodies in the integrated structure, four new locality groups have been identified to take forward operational and developmental priorities at a tactical and operational level. Public and community engagement and involvement is central to our localities and the Participation & Engagement Group will ensure that the voice and ideas of our communities are captured and used to develop services. Steering groups have been established to take forward identified integration priorities at a tactical and operational level.

Through the life of this local delivery plan, we will develop a clear process for 'review and revision' of our strategic plans against the national health and well-being outcomes, core suite of indicators and delivery principles. This process will reflect the requirement to undergo this process at least 3 yearly.

Through our Performance Management Workstream further work in 2016/17 will be undertaken to identify and align the measurement of both the strategic and local plans to the national outcomes and core suite of indicators alongside other national and local standards/targets that we currently collect. There is an acknowledgement that there will be areas where-by we do not currently collect measures and indicators that effectively monitor areas we wish. In response to this we will need to work with our teams to identify further robust indicators and measures as part of our performance management framework, to ensure we are delivering services effectively to individuals. It is envisaged that these will be used at both an operational level within the management groups to inform performance of each locality and at an aggregate level for the Integration Joint Board.

7. Scheduled Care

Dumfries and Galloway is working towards opening our new District General Hospital in December 2017. The Clinical and Service Change Programme has been established to support the development and implementation of new models of care and ways of working for our new hospital and our community services.

This programme will support the process of transition of services and staff, ensuring that they are fully prepared for the move to the new hospital in December 2017. This is also intended to be a pro-active approach to altering our current ways of working due to the increased demand on our health and social care system. The increase in demands placed upon our system is as a result of changing demographics (in particular the rise in the over 75 and over 85 population) and changes in the pattern of clinical need in Dumfries and Galloway. This, coupled with a reduction in the working age population (which will potentially impact on availability of workforce), means that we must develop

new ways of working for the future. Colleagues across the health and social care sector are involved in the delivery and development of services. The work undertaken will be aligned with the National Scheduled Care Programme (sustainability) to ensure a focused and strategic approach is taken.

To ensure the transformation change occurs, the change programme is supporting the development and implementation of new models of care and new ways of working for our new hospital and links with our colleagues within community and social work services. The programme will ensure that a joined up approach is taken between the new hospital project and Health and Social Care Integration to ensure delivery of the necessary changes across the system.

The Change Programme is now underway and involves clinical and non-clinical workgroups taking forward, for example the development and implementation of new models of care in the Combined Critical Care Unit and the Emergency Care Centre (i.e. Combined Assessment Unit, Emergency Department, Out of Hours). Also being taken forward are the introduction of new ward profiles; improved patient pathways; introduction of integrated teams; changes in communication and links with our cottage hospitals. Work is ongoing in developing a programme for the implementation of the tests of change which will require to be carried out, particularly given the new models of care/profiles planned for these areas. This will be produced by June 2016, and will include a timeframe which is important, given that these tests of change will need to be completed and embedded well in advance of migration to the new hospital.

Understanding our flow into and out of our hospital and wider community is an area that will be continually reviewed. Identifying the difference between the actual flow of individuals against our proposed flow will be assessed to ensure that we are predicting the movement efficiently. This work is part of the National Flow Variability workstream, previously ScotPFA from QuEST. Through analysis of data and agreement with the wider acute team, NHS Dumfries & Galloway are taking forward the programme of work around the medical in-patient flow analysis. The team will focus on Dynamic Discharge including; ward huddles; checklists; and Estimated Date of Discharge (EDD) for all patients.

Room Scheduling is a key process within our scheduled care pathway. We are piloting an electronic system which identifies utilisation across the clinic setting. The pilot currently running is anticipated to be implemented across further areas to ensure that work timetabling within clinics is as efficient as possible. This is aligned to the scheduled rotas to increase utilisation of timetables and the process of scheduled care. Early indications are that this process has identified more effective and efficient working patterns. Ultimately the expected outcome will be to reduce unnecessary out of core hour clinics within the areas this is being piloted. Further to this we are scoping an electronic booking system which will link clinic booking processes with waiting time lists, in a bid to improve our waiting list management.

Further collaboration with national colleagues is being undertaken within NHS Dumfries and Galloway through the national Developing Out-patient Integration Together (DOIT) Programme. Through the programme there is a focus on areas including:

- Technology and workforce enabled models
- Integrated working and whole system pathways
- Improving the quality and use of data nationally and locally
- Implementing what we know works

Through the programme there is a national focus around Dermatology and Gastroenterology, with the ability for local Boards to include further specialties in the programme. As a team it was decided that Neurology and Ophthalmology would also be included in the programme.

Within our theatres there has been a review of all theatre efficiency programs to re-align current workloads. During 2016/17 we are undertaking scoping work around specialty utilisation and repatriation of external cases within our scheduled elective activity. There is work going forward in identifying and defining cost implications and potential cost savings with repatriation of certain cases.

A full staffing review is being undertaken with the review of staff roles and responsibilities. In light of the move to the new hospital, roles and responsibilities may change within certain areas. This Change Programme will also include additional staff training and education to undertake these new roles. The training programmes provided will ensure our staff have the right skills, in the right place and at the right time. The increasing financial challenges will make ongoing delivery of targets more difficult given the level of non recurring financial support the Board has previously invested in delivery of targets.

Pre-assessment processes are being reviewed and additional protocols developed to reduce the individuals' journey. A more streamlined patient pathway will ensure that the individual is being treated where appropriate, at the earliest possible time. Work is being undertaken to ensure individuals wherever possible, are not brought into hospital before they are required, this will provide both increased capacity and decreased patient length of stay. This is particularly important in ensuring individuals are within their own environment for as long as possible, decreasing the possibility of extended or unnecessary periods of stay.

8. Unscheduled Care

Following the release of the 6 Essential Actions to Improving Unscheduled Care, NHS Dumfries and Galloway are supporting the continuation of sharing best practice and engaging all partners; both locally and nationally. Further to the 6 Essential Actions, work is ongoing to align the work plan around the allocation noted within the letter received on the 4th of May 2016.

Clinically focused and empowered management:

Within our Acute Services we have clear site management which includes a tripartite arrangement between General Management, Medical Management and Nurse Management at both senior and specialty levels.

We currently have capacity management in place across 24 hours per day and seven days per week. Dumfries and Galloway Royal Infirmary (DGRI) and the Galloway Community Hospital (GCH) have established whole hospital huddles, chaired by a member of the senior leadership team or senior nurse. These huddles provide an up to date situation within the hospital (utilising predictions for admissions for both elective and emergency admissions in DGRI) and allows any developing or imminent concerns to be addressed. At the end of the morning huddle there is a debrief session where any potential issues regarding flow or safety from the previous day are identified and, where

necessary, action plans developed to resolve and manage issues. Both debriefs are noted and widely distributed.
We are currently working with community colleagues around replication of a similar process across the cottage hospital bed base and the potential for a link around whole system bed capacity. This began testing in January 2016 and we are currently undertaking PDSA cycles to ensure both the community huddle and the whole system flow discussion add maximal impact.

A Capacity Management Escalation Policy has been developed and agreed across Acute, Community, Scottish Ambulance and Social Work Services. This has been tested and refined upon several occasions and will continually be utilised and updated where required throughout 2016/17.

In the light of newly published guidance around escalation plan and triggers for the Emergency Department (ED) and the Acute Medicine Unit (AMU) we are reviewing our guidance to incorporate and utilise this new evidence.

Capacity and Patient Flow

Effective patient flow within Acute Services is dependent upon effective flow throughout the health care system and ensuring adequate capacity, efficient processes and robust transfer and discharge agreements. We are currently revising the Dumfries and Galloway Partnership 'Admission, Transfer and Effective Discharge of Patients' policy.

During the coming year we plan on exploring mechanisms to ensure that wherever possible we are able to capture capacity within the partnership as a whole. Bed capacity within the NHS system is made visible by a three times daily email distributed widely across management and clinical communities within our acute and community services; this includes commissioning, Scottish Ambulance Services and STARS.

DGRI has committed to working with the Whole System Flow Programme and the Scottish Patient Flow Analysis to explore our patient flow with the intention to identify a potential improvement programme to reduce artificial variation and improve flow and overall patient experience. Working with QuEST (Quality and Efficiency Support Team) and IHI (Institute for Healthcare Improvement) we are currently planning an improvement programme for 2016/17 within the medical flow of patients.

Managing the patient journey rather than bed management

Electronic capture of progress within the patient journey is now embedded in the wards via whiteboards and cortex allowing the ability to identify, at a glance, individuals who are nearing discharge readiness. The nurse management team will work with the ward teams over the next few months to refine the 'ward huddle' script with a focus on ensuring that the patient's journey is progressing and that plans for discharge are being put in place in a timely manner. Further to this work, the criteria surrounding such Admission, Discharge, Transfer (ADT) will be reviewed to ensure the patients journey is safe and efficient during there stay and beyond. This work as part of the Unscheduled Care, is also being aligned to the ScotPFA project being utilised.

Following a successful test of change, Patient Flow Coordinators have now been made permanent. The role of the Patient Flow Coordinator, within DGRI, is to manage the flow of complex individuals through their journey, ensuring that each individual is on the correct pathway. A test of a similar model commenced in January 2016 within Nithsdale and Annandale and Eskdale, with early indications that this is being successful in identifying potential care package opportunities and thus supporting individuals to return to the community smoothly. Further to this, flow co-coordinators across the Wigtownshire and Stewartry are being explored to link the whole region and will provide additional support in ensuring that where appropriate, an individual is returned home, or to a homely setting as quickly as possible.

Medical and Surgical Processes Arranged to Improve Patient Flow through the Unscheduled Care Pathway

Medical and surgical processes designed to pull patients from the ED

Within the AMU we are currently testing models of ambulatory care where patients, otherwise destined for admission, are being supported by the Consultant and Advanced Nurse Practitioner to receive diagnostic testing, advice and possible discharge from a chair based model utilising a greater outpatient led approach. Early indications are that this has been successful in providing alternatives to admission.

Also currently being tested, and proving highly successful, is a model of frailty assessment involving Occupational Therapy and Physiotherapy within the AMU and ED. The AHPs are assessing and providing early access to rehabilitation within the AMU and the ED, providing the potential for outreach therapy to support early discharge or admission avoidance.

Multidisciplinary processes supporting discharges are currently in place across the hospital. Tests of change are being undertaken to embed criteria led discharge within certain specialties. It is anticipated that the criteria, where appropriate, will be adapted and utilised within other specialties to enable efficient and early supported discharge. Although not currently embedded across the 7 day period, sustainable models are being explored to ensure that these processes are utilised across the week. The work and models discussed will support the drive around increasing the number of discharges before noon.

Seven Day Services

Agreement has been reached to support seven day discharge by increasing the multidisciplinary team presence within DGRI at the weekend. We are currently working with teams to provide this support; Social Work Services and Pharmacy have adjusted their working practices and are now available at the weekend until 1630 and 1700 respectively.

Occupational Therapy and Physiotherapy have interim solutions in place to provide additional presence at the weekend with anticipation that a permanent model will be in place from April 2016.

Ensuring patients are cared for in their own homes

Partnerships within Dumfries and Galloway fully support and actively encourage caring for individuals where appropriate within their own environment. Action to deliver this requires current models to be altered and reviewed. It is our aim that through 2016/17 we will scope and improve areas to ensure that this is possible and accomplished within our current constraints. Links to the delivery plans around the Locality plans is crucial and will support this long term focus.

Part of the plan through 2016/17 is to ensure that individuals are educated around the range of urgent services available and how and when these can be accessed. NHS Dumfries and Galloway have developed the 'Meet ED' campaign to support this education. This high impact change also incorporates any work around delayed discharges where we have recently introduced a regular senior operational level discussion around potential alternative solutions. In addition, during 2016/17 discussions will extend to include those patients with a longer length of stay within Acute Services. Further to this a delayed discharge partnership will be set-up to ensure every service within the partnership is sighted and working with each other to ensure individuals return home as quickly as possible.

9. Mental Health

Recent appointments within Psychological Services have aided the reduction in long waiting times. Previous workforce vacancies and leave within Psychological Services has had a negative effect on waiting times. Moving forward, recent appointments to posts will enable a more robust workforce to cover upcoming leave without detrimental effect to waiting times within Dumfries and Galloway.

The achievement within our CAMHS team against the access target of 95% is one that the team takes great pride in. It is acknowledged that referral rates are rising and as such, the ability to continue this is increasingly challenging, compounded with changes within staffing and periods of vacancies. The team are working to support the volume of referrals they are receiving through regular review of demand and capacity to ensure that not only is their service working to the best of its ability, but also that the person is at the centre of receiving the correct engagement at the right time and by the right person with the appropriate skills. The Choice & Partnership Approach (CAPA) is the approach adopted by the service to support this.

Utilisation of the Mental Health fund to improve access to both CAHMS and Psychological Therapies will be addressed within 2016/17. The funding provided will be utilised in a number of ways including reviewing referral rates into the services at current time. We acknowledge that referral rates are high and as such, would aim to review the both the referrals and the adjoining pathways.

The work of the IDEAS Team (Intervention for Dementia, Education, Assessment & Support) in raising awareness and providing education and training in care homes across our region, has been successful and nationally recognised as such. This work is now extended and as part of a significant mental health clinical change programme which also includes enhancing CATS, home based memory rehabilitation availability and services to carers of those with dementia.

We continue to examine data on a locality and GP practice level and have initiated discussions with GPs in the area to further examine ways in which diagnosis rates and dementia register figures may be increased. We recognise that raising awareness of the value of a diagnosis is necessary so that the person with dementia and their family/carers can be well supported with PDS.

A process mapping exercise in relation to our PDS pathway is underway, which will help to identify any gaps and inconsistencies in the PDS process; this will contribute to developing a clearer, consistent and efficient pathway for those diagnosed with dementia. Within this pathway, we plan to include access from other services, which should positively impact on diagnosis rates and dementia register figures. This integrated approach to working will ensure that the individual receives the best and most appropriate care. As such, the partnership working with MHAIST, will be welcomed to further explore the PDS process amongst other areas within Mental Health.

Perinatal Mental Health Care

Developments in Perinatal mental health to deliver appropriate and timely specialist Perinatal mental health care have been recognised both locally and nationally. Connections have been made with the West of Scotland Perinatal Network and Leverndale Mother and Baby Unit to look at how other Boards in Scotland provide services in this area of care, and what would be appropriate in D&G considering the low prevalence and limited staff resource.

Staff have been identified from within community mental health nursing, Midpark in-patient services, psychology, specialist drug and alcohol services, AHPs, learning disabilities and CATS team who had a keen interest in this area of care.

These enthusiasts were brought together for a workshop to raise awareness about Perinatal mental health issues, to gather views and ideas regarding how best to develop the service and create appropriate systems which would meet the needs of local service users in line with national standards and guidelines.

Training was provided to these mental health link workers via specialists from Leverndale Mother and Baby Unit including the national Perinatal lead, which will be cascaded to the wider mental health teams.

The model of care was agreed and links were established with colleagues from Midwifery and Health Visitors to ensure a joined up approach. This new model of care provides a sustainable solution to an identified need.

Home Based Memory Rehabilitation (HBMR)

Home Based Memory Rehabilitation (HBMR) aims to teach people with mild cognitive impairment to access the benefits of early interventions. HBMR provides strategies to compensate for everyday memory difficulties in order to preserve independence and to reduce caregiver burden. Additional HBMR resources have enhanced capacity to meet on-going, increasing demand for HBMR across the area. Additional self-help materials based on HBMR strategies are being produced, to widen the opportunity for people with mild cognitive impairment to access the benefits of earlier intervention. The programme has attracted significant national interest.

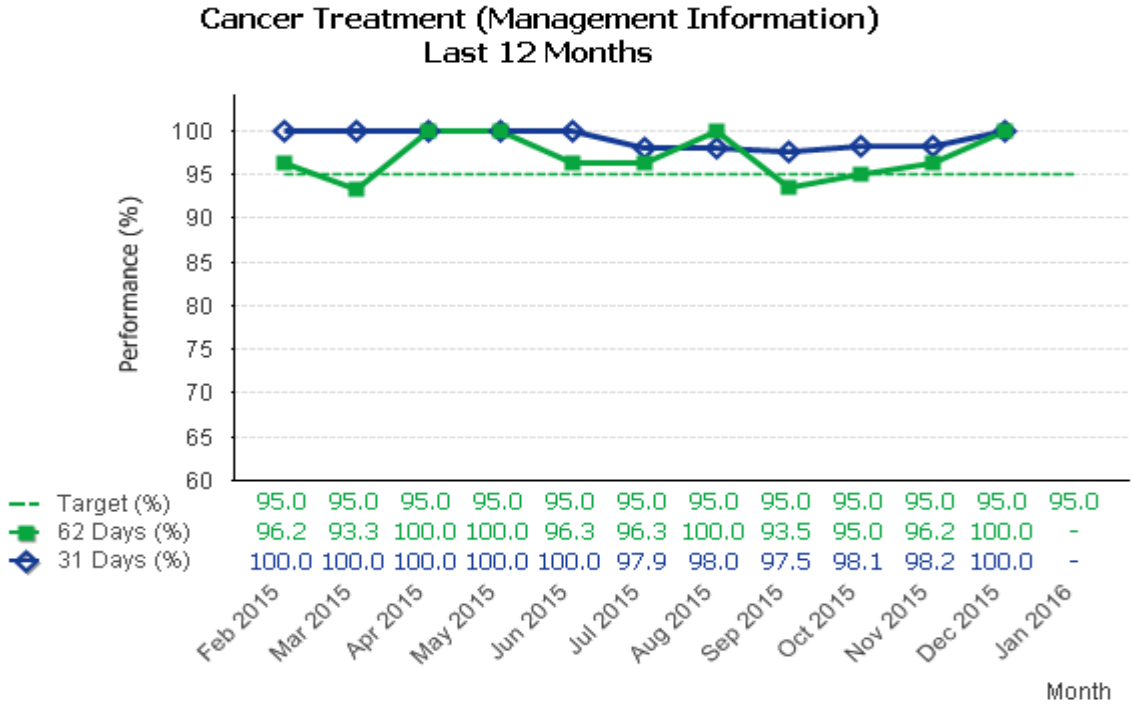
Section Two:
LDP Standards

1. Detect Cancer Early

Board Lead: Nicole Hamlet – General Manager – Acute & Diagnostics

Current Performance:

Most recent period of measurement	Waiting Time Standard	Target	Actual
December 2015 (Management Information)	31 days from decision to treat to first cancer treatment	95%	100.0%
	62 days from urgent referral with a suspicion of cancer to first cancer treatment	95%	100.0%



Analysis

Performance for the 31 and 62 day targets returned to 100% for the month of December.

Forecast 2016/17:

NHS D&G will continue to monitor the performance throughout 2016/17 however, there are ongoing pressures within specific pathways and diagnostic test which may affect performance during the beginning of 2016.

2. Dementia Post Diagnostic Support

Board Lead: Linda Mckechnie – Community Mental Health Nurse Manager

Current Performance: The LDP Standard has 2 elements:

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 January 2016 and show a variance across the 4 localities:

Locality	Performance
Annandale and Eskdale	46%
Dumfries and Nithsdale	54%
Stewartry	46%
Wigtownshire	50%
Regional	**47.3%**

Number of People diagnosed with Dementia who have had at least 12 months of Post Diagnostic Support (PDS)

The table below shows the latest figures from ISD management report – these figures can be taken as an approximation of LDP Standard achievement.

Dumfries and Galloway (figures provided as a percentage)

Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15
88.0	70.0	65.4	56.5	39.1	33.3	20.0	0.0	0.0	0.0

Scotland (figures provided as a percentage)

Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15
71.7	68.4	67.6	63.1	60.9	61.6	44.6	22.5	6.7	3.3

2016/17 Forecast:

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

- Staff resources – the Dumfries and Nithsdale team has been carrying a vacancy for some months for a staff-grade psychiatrist which will have reduced the numbers of people being diagnosed within the memory clinic, and as a result, the numbers being added to the primary care dementia registers has reduced. This post is advertised and has attracted some interest, and once filled we should see an increase in the dementia register figures in this area.
- The accuracy of prevalence and incidence rates may be questionable and are currently being studied nationally – report is due early 2016.
- Variable care home population in each GP catchment area.

In terms of the PDS element of the target, the accuracy of data collected is currently questionable as the data collection system is not sophisticated enough to highlight individual variance, for example, some people will not receive 12 months PDS due to a variety of reasons such as choice, capacity issues etc. The 5 pillars model of PDS is not fully appropriate for people who are diagnosed in the later stages of the illness, however, the 8 pillar model is currently being piloted in 5 areas of Scotland and it is thought likely that this will be rolled out nationally.

There is wide variability in the quality of completion of the data collection spreadsheet – ISD are working on a new data collection spreadsheet which aims to reduce the length of time required to complete, the number of validation issues, such as duplication and missing records, and the size and complexity of the document. We are currently working with ISD and the Scottish Government on this, contributing to discussions and decisions regarding the way forward with improving data quality for the data set.

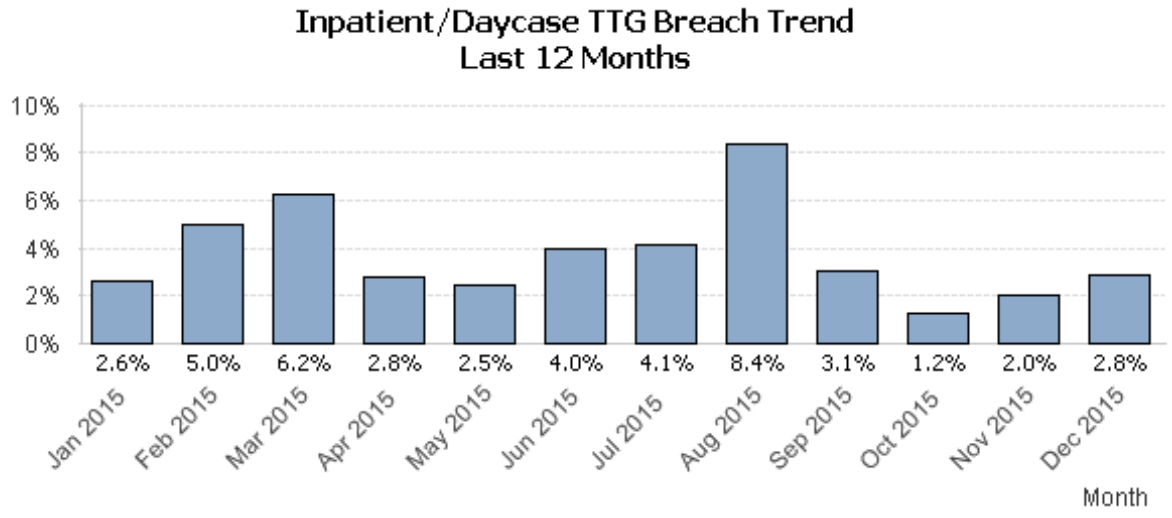
3. Access Standards

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

In-patients / Day-cases

Throughout 2015 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.

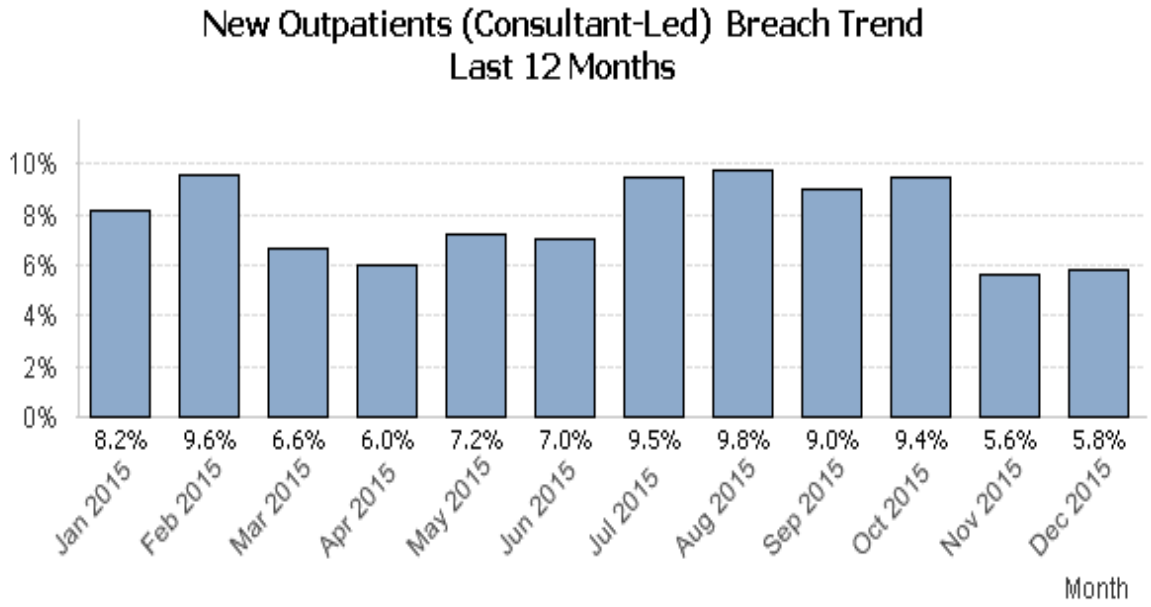


	Jan 2015 - Dec 2015
In-patient/Day-cases Treated Out-with Guarantee Date	406
In-patient/Day-cases Treated Within Guarantee Date	10,325
TTG Breach (%)	3.8%

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 specialties which will also improve our TTG performance.

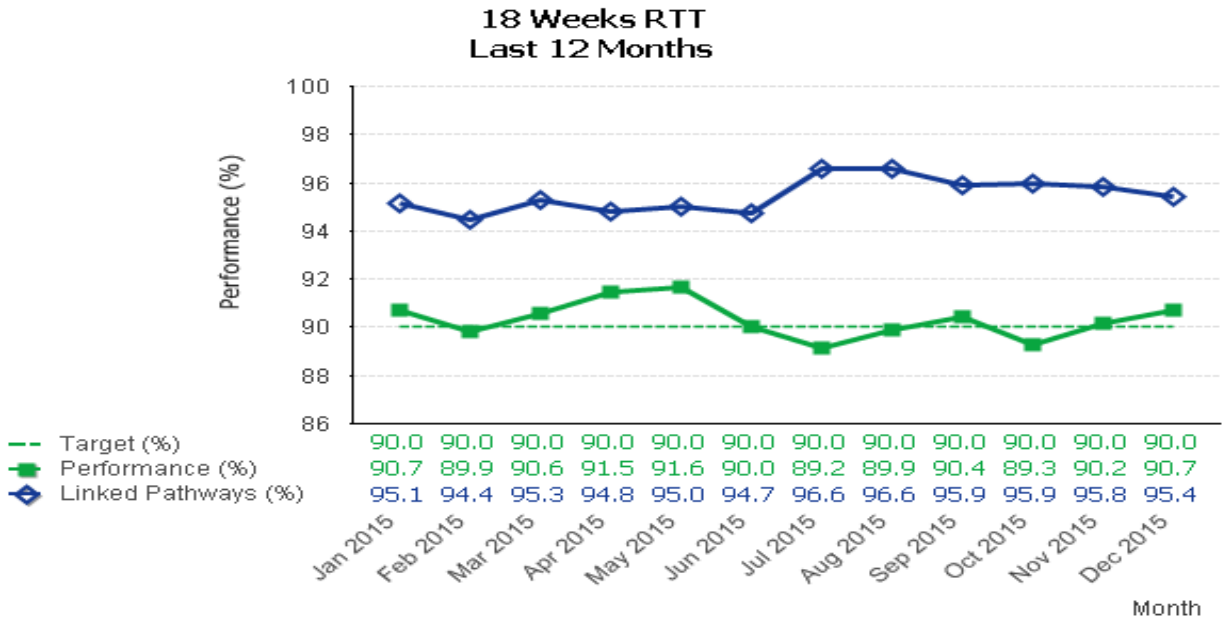
Out-patients

Out-patient performance challenges have been similar to those seen for in-patients throughout 2015. The main reason for patients not meeting their 12 week out-patient 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.



18 Week Referral to Treatment Standard

Measure	Period	Target	Actual
Linked Pathways	December 2015	90%	95.4%
Performance	December 2015	90%	90.7%



Analysis

The linked pathways have been consistently above the 90% target for the last 12 months. An action plan was developed and has seen success to maximise 18 week compliance which includes a rolling programme of training for medical secretaries and the patient access team.

The training, aimed at improving the use of the “Unique Care Pathway Number” to support the ability to measure ‘linked pathways’ and there was also priority given to areas which will deliver the biggest improvement in performance. The year 2015 has seen a sustained improvement in the ability to link pathways at around 95-96% (in excess of the 90% target). This has now been achieved for the last six consecutive months.

4. Early Access to Antenatal Care

Board Lead: Joyce Reekie – Head of Midwifery

Current performance:

Data to the period ending 31st March 2015 indicated performance of 86.4% against the trajectory target of 83.5%. Local management information indicates that for the first 3 quarters of 2015/16 the performance in each SIMD is above 80% and the average across the five SIMD quintile is ~88.2%.

Forecast 2016/17:

It is not anticipated that there will be any risk to ongoing achievement of the LDP standard. Implementation of the Badger Maternity Information system is ongoing and this will help to streamline the referral process further with direct electronic referral to midwives rather than clerical teams. Access to previous pregnancy records is now via eCasenote which means that there is instant access to the past clinical information that is required for the booking process.

5. IVF Treatment Times

Board Lead: Angus Cameron – Medical Director

Current Performance:

All identified individuals are referred to tertiary centres within recommended guidelines. To date, there have been no individuals referred who have been deemed unsuitable for treatment.

2016/17 Forecast:

Individuals from Dumfries and Galloway are referred when the national access criteria has been met along with national guidelines. Ongoing dialogue is taking place with tertiary centres to improve performance where possible. Dumfries and Galloway will 'continually' work to ensure that referrals are processed to tertiary centres as timely as possible.

6. Faster Access to Mental Health Services – CAMHS

Board Lead: Elaine Wylie – CAMHS Nurse Manager

Current Performance:

CAMHS are achieving the 18 week referral to treatment target of 95%.

The last quarter of 2015 is due for publication March 1st 2016.

D&G performance, 'under 18 weeks experienced waiting times from referral to treatment'.

2015		% Under 18 Weeks	
		D&G	Scotland
Quarter 1	Jan - March	100%	78.9%
Quarter 2	April - June	97%	76.6%
Quarter 3	July - September	95.9%	73%

NHS Dumfries & Galloway median waiting times for referral to treatment are 7-8 weeks over this period. Scotland average is 9 weeks.

The table below shows the referral rates over a 3 year period:

Year	Referral Numbers
2013	1004
2014	1027
2015	1081

Forecast 2016/17:

Locally CAMHS will aim to continue to achieve the target, compliance has been 100% since introduction of RTT.
However the margins for this are becoming closer and rising referral rates are relevant in predicting performance.
Currently the management of new referrals is informed by Choice & Partnership Approach (CAPA) which is used by many CAMHS teams in the UK.

7. Faster Access to Mental Health Services – Psychological Therapies

Board Lead: Dr Louise Cumbley, Director of Psychology.

Current Performance:

Currently 78% of people are being seen within 18 weeks however this fell to 60% due to a number of leaves and long term sickness. It is expected that this will continue to improve over the coming months.

Further leave will take place over the next 12 months but a new post has been created, following redesign, to offer cover during such vacancies. The new member of staff took up post in April 2016 and they are already working to offer services to practices that will be affected by current and upcoming extended periods of leave over 2016/17. Other leaves are expected to end by the 2nd and 3rd quarter of this financial year, although two others will be starting in this same period.

Forecast 2016/17:

The very long waits have been reduced due to the new posts filled in November 2014. Further leave should not have the impact previously experienced due to the new post to be filled in April 2016.
It is anticipated that the compliance of 90% should be achieved by December 2016.

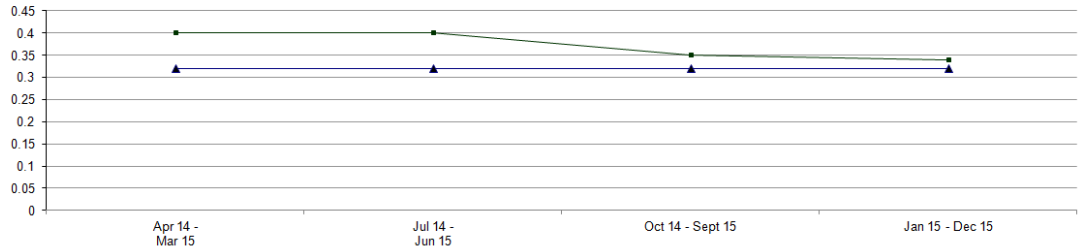
8. SAB and C.Diff

Board Lead: Elaine Ross – Infection Control Manager

Current Performance:

Clostridium Difficile Infections

Quarterly rolling year average Clostridium difficile infections ages 15 & above per 1000 total occupied bed days (April 2014-Dec 2015)



	Apr 14 - Mar 15	Jul 14 - Jun 15	Oct 14 - Sept 15	Jan 15 - Dec 15
Actual Performance	0.40	0.40	0.35	0.34
Target	0.32	0.32	0.32	0.32

2016/17 Forecast:

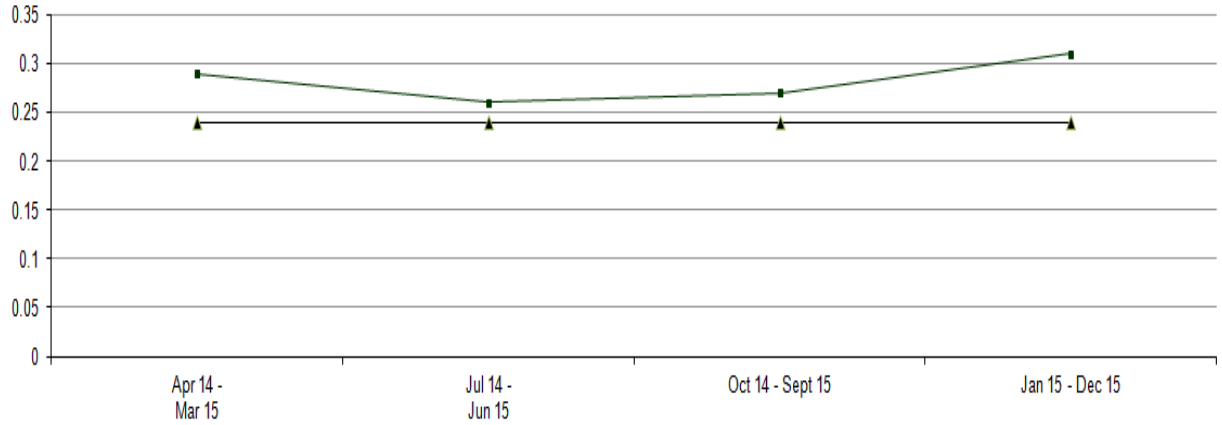
If improvements are sustained then it is possible for NHS Dumfries & Galloway to meet the 2017 target.

The following measures are in place;

- Root cause analysis of every patient who has a positive Clostridium difficile infection (CDI) either in the hospital or in the community
- Patients identified as having had CDI are issued with a plastic card to carry and present to prescribers for one year following diagnosis
- 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
- 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

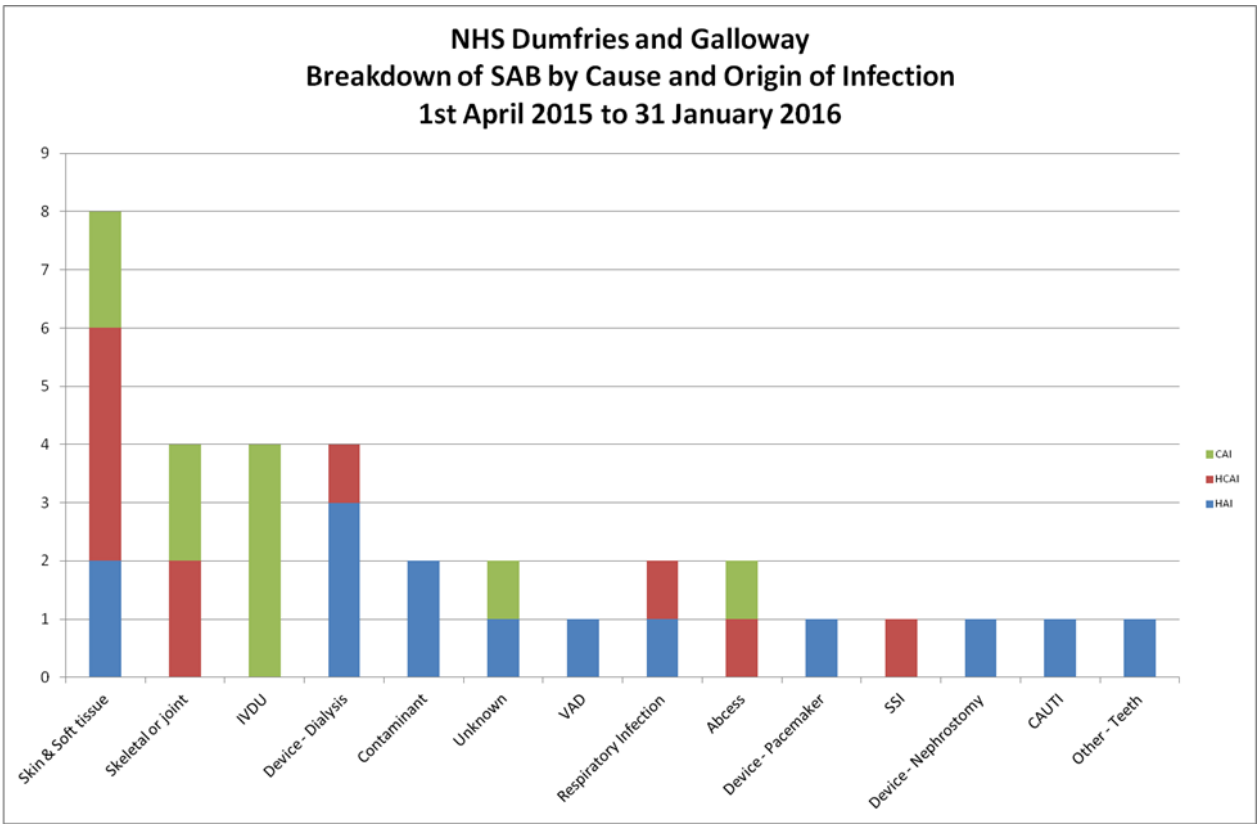
Quarterly rolling Staphylococcus Aureus Bacteraemia Rates per 1000 Acute Occupied Bed Days April 2014 - December 2015.



	Apr 14 - Mar 15	Jul 14 - Jun 15	Oct 14 - Sept 15	Jan 15 - Dec 15
Actual Performance	0.29	0.26	0.27	0.31
Target	0.24	0.24	0.24	0.24

2016/17 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 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
- An increase in SAB seen in renal lines was investigated and all practices confirmed to be in line with best practice. The number of patients on dialysis increased during 2015
- We continue to liaise with the Drug and Alcohol services over each SAB in any intravenous drug user
- A patient safety CAUTI improvement group is in place
- The findings of any SAB connected to an invasive device are discussed at the invasive device network so any lessons learned can be shared and acted upon.
- An improvement plan to reduce the number of contaminated samples has been tested in A&E has been successful. It is hoped to spread this to other areas
- An outpatient antibiotic team is in place to support delivery of antibiotic treatment as per the SAPG guideline
- MRSA screening compliance is audited by the IPCT as per the national protocol and any results below 95% compliance are escalated to Hospital Management Board.

9. Drug and Alcohol Referral to Treatment Standard

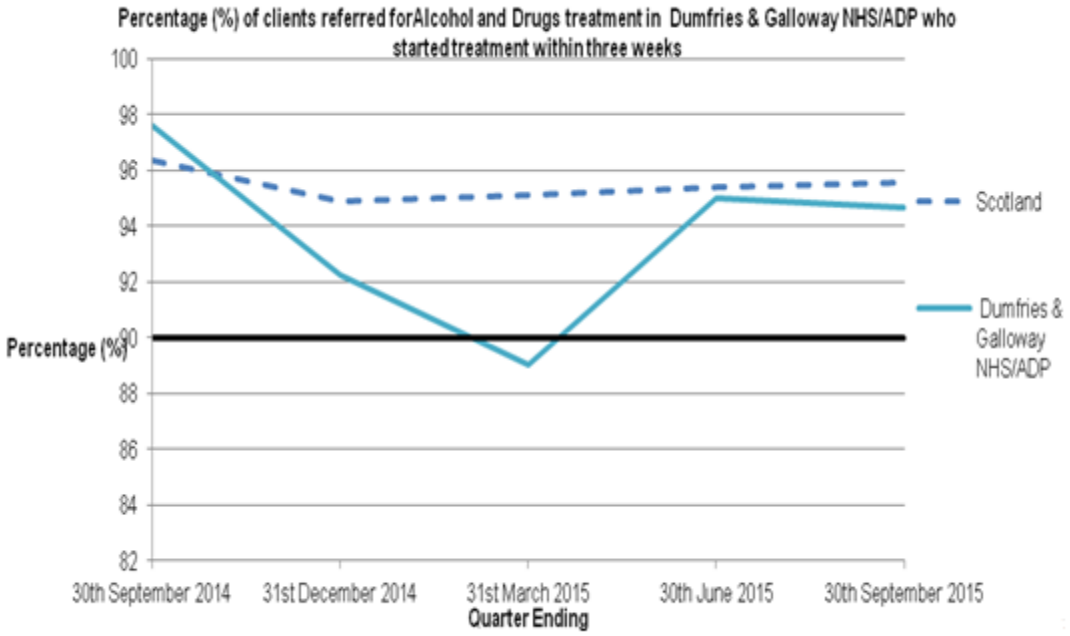
Board Lead: Jackie Davies – ADP Coordinator

Current Performance:

Latest published figures (July – Sept 15) show that 94.6% of alcohol and drug clients waited no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery.

Forecast 2016/17:

Work will continue during 2016/17 to ensure that waiting times are maintained in light of potential changes to the way in which services are funded and resourced.



10. Alcohol Brief Interventions

Board Lead: Jackie Davies – ADP Coordinator

Current Performance:

Annual target of 1743.

Between April 2015 and March 2016, a total of 1750 ABIs were delivered, achieving the annual target.

2015/16 (ABIs)	Primary Care	A&E	Antenatal	Wider settings	Health Board Total
ABIs delivered between 01 April 2015 - 30th June 2015 (Q1)	**348**	**5**	**1**	**0**	**354**
ABIs delivered between 01 July 2015 - 30th September 2015 (Q2)	**388**	**0**	**0**	**181**	**569**
ABIs delivered between 01 October 2015 - 31st December 2015 (Q3)	**239**	**3**	**0**	**3**	**245**
ABIs delivered between 01 January 2016 - 31st March 2016 (Q4)	**576**	**6**	**0**	**0**	**582**

Forecast 2016/17:

ABIs do not appear to be embedded in all settings and there are particular issues within the Accident and Emergency department and Ante-natal settings (though Ante-natal records a large number of screenings). ADP funding has ceased for the community Public Health Improvement teams which will also impact on the numbers recorded next year. The Wickerman festival will not take place in 2016, which will also impact on the numbers of ABIs delivered.

11. Smoking Cessation

Board Lead: Trish Grierson – Tobacco Control Service Manager

Current Performance:

Owing to a re-calculation of the smoking cessation LDP Standard (15/16) for all Health boards in Scotland, as a board and on data provided by ISD (October 2015) we were marginally missing our target in the 1st quarter by 1% (target is total 207 quits over one year).

Forecast 2016/17:

Subject to the new LDP standard for our board being the same or similar to the above figure (207) this would be achieved by working on a number of actions in smoking cessation. These actions form part of a wider approach we are taking to tackle tobacco and inequalities (Dumfries & Galloway Tobacco Control Action Plan 2015-19).
Our intention is to address this target from a geographic perspective along with a specific population based approach, for example we will target our services in key geographic areas and with important groups of smokers:-

1. Our Staff - we will deliver different promotional activities and use the opportunity of integration as a way of piloting a small joined up project to encourage more staff to consider stopping smoking.

2. Smokers who live in key geographic areas – our intention is to increase referral numbers in specific geographic areas by delivering targeted promotional and educational activities working with Community Pharmacies, GP practices, Educational services and businesses.

3. Women who smoke in pregnancy – we will work alongside maternity services and other service providers to review our current plans and put in place improvements.

4. Smokers who have mental health difficulties – we will work to sustain our activities in this area by reviewing care pathways, deliver more promotional activities with patients and staff, and revisit previous work in this area.

5. Smokers in Secondary care – our aim in the acute setting is to continue to deliver training on the integrated Care Pathway and raise the profile of this work with medical staff.

6. Smokers who have one or more Long-term conditions – we will work with GP practices and specialist areas to increase referrals.

7. Smokers who are in prison – we will work with prison services to fully implement the recommendations of the national review of prison services in Scotland.

8. Service improvements – we will continue to work with Community pharmacy colleagues to ensure areas of inconsistency are addressed to improve standards of service delivery across the region.

12. GP 48hr Access / Advance Booking Standard

Board Lead: Linda Bunney – Head of Primary Care Development

Current Performance:

NHS Dumfries & Galloway has 34 GP practices, 33 with a standard GMS contract and 1 with a Section 17c contract. Two of the practices operate an open access system of appointments and all 34 provide extended hours via enhanced services arrangements.

The results of the 2013/14 Scottish Health and Care Experience Survey published in May 2014 indicate that 90% of those surveyed were able to see or speak to a doctor or nurse within 2 working days. 84% 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 the 10% 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.

Forecast 2016/17:

The 2015/16 Scottish Health and Care Experience Survey was completed in January 2016 and is anticipated to report in the Summer of 2016.

Practices participating in QS002(S) of the 2014/15 QOF undertook a review of access using the tool agreed between Scottish Government and Scottish General Practices Committee and provided a practice action report of the findings to the NHS Board. Participation in 2015/16 is underway with practices either undertaking a further review or seeking to implement change using improvement methodology. Reports from the 2015/16 work will be submitted late March 2016 for review by the Board with subsequent sharing of learning across practices.

Following support by the Board one practice has implemented the 'Doctors First' model which introduces initial triage by GP to improve access.

13. Sickness Absence Standard

Board Lead: Caroline Sharp – Workforce Director.

Current Performance:

D&G overall sickness absence rate for December 2015 was 5.50% which is in line with the NHS Scotland average of 5.48%. The overall 2015 absence rate for D&G was 4.95% set against a national average of 5.12%

Forecast 2016/17:

Our strategy agreed with our staff governance committee continues to be 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 2016/17 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)
- Standing Operating Procedure and Managers Guidance has been developed and will be implemented during 2016/17 These procedures relate to staff who receive a fit note to return to the workplace but to a role other than their substantive post as supported by Occupational Health. This facilitates a return to work sooner where this is deemed appropriate
- 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.

Within the Directorate areas, further examples of work under development to support attendance at work include:

- Ongoing 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 continues within the Mental Health Directorate. However during 2016/17, this provision will also be delivered across other Directorate area
- Monthly performance conversations continue to take place between service leaders and workforce business partners occurring regularly where attendance management is scrutinised incorporating information on most regular absentees,

themes, management of those individuals. The focus for this work is currently on repeated short term absence

- New HR Audit of management of the return to work interviews, focusing on the quality of these conversations rather than only on the fact they have occurred

Within Acute & Diagnostic Directorate, following on from sessions which were set up during 2015/16 with staff, workforce business partners and trade unions to discuss absence and what else could be considered to tackle the issue of absence, some suggestions are being further considered with a view to further discussions and roll out during 2016/17. These include:

- Further work on how information is recorded and monitored on an individual's absence and ensure consistency of approach
- Acknowledgment of perfect attendance – staff had suggested that they receive a certificate if they achieved 6 months attendance. Further consideration and discussion will take place on this area
- Following on from a pilot within one Ward area, debrief huddles are to be rolled out to each ward level within DGRI. Outcomes from the pilot indicated that a debrief huddle at the end of each shift would allow people to 'off load' about how the shift had went for them. The feeling was that it allowed staff to say if they had had a bad shift and discuss this with colleagues prior to going home. This approach allowed staff to go home without worrying, feeling down about something that had happened on shift
- Quarterly meetings will be arranged with the Workforce Team and Trade Unions with staff following on from the initial meetings during 2016/17
- An Action Plan is being is being produced to state how the above actions will be achieved during 2016/17.

In addition, within Acute & Diagnostics Directorate, an exercise has been undertaken to identify the staff with the highest number of episodes of absence within a 12 month period. This has focused on the top 20 individuals and an Workforce Business Partner meeting with the Line Manager to review all absence paperwork to ensure that the manager is following the policy correctly. Meetings are thereafter held with the individual member of staff to highlight their absence record and to make them aware that their absence is being monitored.

Every week the Workforce Team for Acute & Diagnostics, Facilities and Corporate services meeting will have an absence huddle. Members of this group include HR Support Officer and Workforce Business Partners.

This meeting allows the team to discuss:

- Difficult cases to ensure consistency of management
- Agree if further specific action needs to be taken
- For all parties to have knowledge across the teams of absence
- To review all LTS
- Highlight any areas with high short term sickness, agreeing what actions need to be taken to identify the reasons for the high absence levels

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 2016/17 to end of January 2016 is 96.9%, a minor improvement on year 2015/16.

Forecast 2016/17:

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 to have good partnership representation and is committed to identifying and supporting further action to deliver the 4 hour target and has a continued focus upon the 6 Essential Actions Programme for Unscheduled Care launched in 2015/16.

Section Three

Community Planning Partnerships

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 coordination
- 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.

The local Alcohol and Drug Partnership (ADP) is Chaired by the Interim Director of Public Health 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 practice 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 behavior. To inform our understanding of activity amongst children, we have begun collection of annual surveys of all school children in Dumfries & Galloway.

Older People

The Board continues to work in partnership with the Council, Third and Independent Sectors to develop and test innovative approaches to supporting older people. A wide-ranging Joint Strategic Needs Assessment has been developed which has been the basis for our first Joint Strategic Plan. This plan is 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.

The effectiveness of partnership working in Dumfries & Galloway has been externally assessed this year by the HIS / Care Inspectorate in their Joint Inspection for Services for Older People. We will build their recommendations into an implementation plan within each of our four localities.

Section Four

Workforce Plan

Use of Workload Tools

NHS Dumfries and Galloway continue to utilise the wide range of Workforce Planning Tools annually i.e.

- Adult Inpatient and Professional Judgment Tool
- Small Wards Tool
- Emergency Department Tool
- Clinical Nurse Specialist Tool
- Community Nursing Tool
- Women and Children Tool
- Mental Health Tool

General

NHS Dumfries and Galloway is currently building a new acute hospital with 100% single rooms (Autumn 2017). Workforce planning is currently intense and detailed across all of the wards and departments within the existing hospital to model the current workforce against the required workforce. It is acknowledged that readying our staff for the transition to the new hospital as early as possible will result in the best outcome for both staff and patients. Since the ward profiles for the new hospital have been finalised, colleagues have been working within the confines of the new hospital to begin, as far as possible, implementing these within the existing fabrication. This will allow staff to be trained, supported and developed appropriately prior to transition.

To aide our working practice and to reduce variation across the hospital, detailed work is ongoing in all wards within Dumfries and Galloway Royal Infirmary. The purpose of which is to review current establishments, shift patterns and trends within acuity and dependency.

The aim is to:

- Establish a standardised approach to shift patterns
- Facilitate the sustainment of safe staffing levels across the twenty four hour period
- Simulate the anticipated variances between the current bed profiles and ward layout and those within the new hospital

To support and facilitate this effective model of sustained quality a Quality Rostering Policy has been embedded. Staff now roster electronically which will help the realisation of the aims above. All managers have a clear responsibility to analyse the data produced by the system thereby applying a proactive approach to changes in staffing levels/skill mix.

Our workforce within the hospital environment could not function without the work of our Community hospitals; during 2016/17 staff will undergo the detailed support work to ensure that the aims above are also met within our community. The supporting function of eRostering will be key to this and will coincide this piece of work.

A seamless transition between any of our services is essential, none more so than between the acute setting and our community, whether that be a downstream bed or to their home/homely setting. With the aid of integrated working across the partnership, additional training is being given to staff to facilitate a seamless and timely flow ensuring that the person is at the centre of their journey. The work of the integrated teams is essential in ensuring that the flow both in and out of our hospitals as well as in the community is vital and our strong working partnerships will continue to grow and foster.

A Combined Assessment Unit (CAU) is planned within the new hospital. The CAU is a key component within the new Emergency Centre (CAU, Emergency Department and Out of Hours). This work will be completed with the aid of Sir Lewis Ritchie's report surrounding Out of Hours and Urgent Care. The partnership acknowledges the report and its effect on patient care and staff supervision. To coincide this, there is a review of the Emergency Department attendances, with the aim of modeling the future staffing models required within the large new Emergency Centre.

NHS Dumfries and Galloway has embedded the Everyone Matters actions plan within our Staff Governance Action Plan and annual self assessment process since its launch, and will continue with this approach for 2016/17. This integrated approach between Everyone Matters and the Staff Governance standards ensures that all aspects of the planning, recruitment, development and experience of staff across our workforce are undertaken in partnership, and comply with the statutory requirements of the staff governance standards set out for the NHS Workforce across Scotland. Our 2016/17 SAAT and Everyone Matters plan is currently under development, in accordance with the timescales set out separately by the SG Workforce Directorate.

As indicated above, in the second half of 2015 the IJB undertook a very significant piece of cultural diagnostic work across all staff groups and partner organisations, to inform the development of the IJB OD plan for 2016–21. The initial findings from this diagnostic exercise will be reported to the IJB in late April, and subsequently will be cascaded to all partner organisations, including the NHS, for action planning and development in the first half of the financial year. This work will drive the transformation of our organisational culture in support of the needs of the IJB to deliver the outcomes set out in the strategic plan, and will have an impact on our leadership and management development across the partnership, including all NHS staff. The roll out of 'Imatter' across NHS D&G through 2016/17 will align with this work, as part of the strategic change programme we are developing.

In addition to this, NHS D&G continue to undertake a wide range of leadership and management development across the service, including our bespoke programmes; ASPIRE to lead and leadership 3. We are investing in the development of qualified coaches to support the leaders across our partnership to expand our coaching capacity and capability during 2016/17, and they will be assisted in this work thorough access to MBTI, Insights and LSI type profiles and accredited capability.

Demographics

Dumfries and Galloway has a higher than average proportion of older people. Initial plans have been developed to explore the potential of deploying Mental Health trained staff and Adult Nurses within the Elderly Medicine Ward.

A number of nursing and midwifery staff will reach retirement age over the next few years. There is a concern that the change to a new hospital and the changes within the NMC's approach to revalidation may precipitate retirement earlier than expected. Work is ongoing to identify the risks and work with the local teams to support them.

Recruitment

Recruiting to senior posts within nursing, in particular, has become more challenging. In response to this, development programmes and Aspire to Lead programmes have been developed and delivered locally. Response to, and outcomes from this have been positive. A Skills Passport for all registered nurses has been developed and training to support this initiative is work in progress.

Set within our hospital at night team and emergency centre are our Advanced Nurse Practitioners, further recruitment and training to these posts will continue. Recruitment to these posts is also underway within our GP practices.

Workforce Projections

The Board is currently developing 2016/17 workforce projections based on the aforementioned detailed work. The workforce will change due to factors previously mentioned, alongside the integration of health and social care, natural turnover and the ongoing requirement to make CRES savings year on year.

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.

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 was established under the joint leadership of the NHS Workforce Director and the Council Head of HR and OD, which will remain active during 2016/17. Membership includes third and independent sector, and staff side representatives. The remit of the group in 2016/17 is to oversee the implementation of the IJB integration OD plan which will be developed from the Cultural Diagnostic work undertaken during H2 2015/16 and additional joint HR and OD resources have been appointed to support this. The Partnership has written its first Integrated Workforce Plan which was approved by the Integration Joint Board in March 2016. This plan covers NHS, Local Authority, 3rd and Independent Sector staff.