2020 Local Delivery Plan

Section One:
Improvement & Co-production Plan 2014-15

Contents

1. Introduction from Jeff Ace, Chief Executive

The Local Delivery Plan (LDP) is the 'delivery contract' between Scottish Government and the Board, providing assurance and underpinning our Annual Review. The LDP focuses on the priorities for the NHS in Scotland and supports delivery of the Scottish Government's national performance framework, the Health and Social care outcomes that are being developed in partnership, and the 2020 vision for high quality and sustainable health and social care.

The LDP has to support the Board to embed the performance gains that have been delivered over the last five years. It also has to support us to achieve the transformational change required to deliver NHS Scotland's ambition to be world leader in quality care and its 2020 Vision described through the Route Map.

This year's LDP has evolved from previous years, shifting away from an emphasis on achievement of HEAT targets and standards into a more strategic document and taking on more of a narrative style. The aim is to outline a broad range of plans, closely linked to the 2020 Route Map for Health and Social Care and to do so it has required contributions from across a range of directorates and areas of responsibility throughout the board, co-ordinated into a coherent plan.

The new LDP has 4 elements which are underpinned by finance and workforce planning:

- Improvement & Co-production Plan
- Strategic Assessment of Primary Care
- NHS Board Contribution to Community Planning Partnership Plan
- HEAT risk management plans and delivery trajectories

This final version of the LDP takes into account and acts on generic and specific feedback from Scottish Government executive leads following the submission of our draft LDP in mid-February 2014.

2. Valuing the Workforce and treating people well by delivering 'Everyone Matters'

NHS Dumfries and Galloway will continue to build on its effective and valued partnership working with staff and staff side organisations during 2014/15 to plan and deliver change and improvements in respect of the 5 priorities for action detailed within the 2020 workforce vision.

This planning will be led by the Area Partnership forum, in accordance with the staff governance monitoring framework, and will be fully integrated into the existing planning, delivery and review programme set within the Board, and overseen by the Staff Governance Committee in line with staff governance standards. We believe that each will support and enhance the effectiveness of the other to embed cultures, practices and behaviours which will improve staff experience and in so doing, maximise the use of staff resources available and enhance the experience of users of our services, and partners working with us to deliver more integrated and sustainable services in the future.

Preparatory work has already commenced to engage staff and partners to develop understanding and embed the NHSScotland core values as early priorities. Information relating to the core values has been cascaded throughout the organisation and in addition, a number of targeted developmental events have been undertaken which will impact on this. These include;

- Values based practice learning events, particularly focused on clinical teams, including medical staff

- An APF / ACF joint partnership conference was held in October 2013 which focused on learning from the Francis report to support the design of a localised 'values statement' for the Board and the local workforce

- Engagement sessions for staff with the Chief Executive have been planned for February – March 2014 across the region, which will communicate and debate the outcomes of the 2013 national staff survey, to outcomes of which will inform the 2014-16 Staff Governance / 2020 vision action plan. This plan will be developed and submitted to SGHD by 9 May 2014 in accordance with the timetable set out in CEL 26 (2013)

- Incorporation of staff experience into the role and remit of the Person Centred Health and Care Committee, which is a sub- committee of the Board

- Planning commenced with the national programme team for the roll out of iMatter (staff experience framework) across NHS D&G over the next 24 months. We participated as a pilot site during the staff experience national programme design phase 1, however we are keen to develop a comprehensive plan for the roll out, so that we can fully realise the benefits we believe this new approach will deliver for staff and for the organisation over the next 3 - 5 years.

We believe this early work has created a solid foundation from which to build our action plan and deliver improvements, in accordance with the priorities for action set out in the 2020 Workforce Vision, during 2014 – 15.

3. Delivering Safe Care at all times

NHS Dumfries and Galloway is part of the Scottish Patient Safety Programme and also part of the trial of the Patient Safety Indicator. We have recently agreed and new, more structured approach to support the 9 point of care priorities in acute services.

Our Acute Adult Safety programme is led by our Head of Clinical Governance and a Clinical lead who is an Associate Medical Director of Acute Care. The Executive Sponsor is the Nurse Director. The programme reports as follows:

- Monthly ward scorecards
- Quarterly Report to Hospital Management Board
- 2 X year report to Healthcare Governance Committee
- 2 X year report to Board

We are looking to enhance these reporting arrangements this year to include the following:

- Weekly ward scorecard review with Improvement Advisor/Project Officer
- Weekly huddle in clinical area with SCN and team testing
- Monthly walk rounds by Clinical Lead & Nurse Manager to review Safety Essentials
- Monthly review of progress with Programme Manager and work stream leads
- Monthly report to Hospital Management Board
- Quarterly report to Management Team or Quality and Patient Safety Leadership Group
- 2 X year report to HCGC
- 2 X year report to Board

Safety Essentials

We are currently reviewing and verifying data on levels of reliability with a view to stepping down monthly audit to quarterly with verification from the Infection Control Team, Senior Charge Nurses and Nurse Managers. The Safety Essentials cover the following areas:

- Hand Hygiene
- Leadership Walk Rounds
- Surgical Pause & Brief
- General Ward Safety Brief
- ICU Daily Goals
- VAP
- MEWS
- CVC Insertion
- CVC Maintenance
- PVC Bundle

Point of Care Priorities

Supporting these work streams will be the focus of the Safety and Improvement Teams agenda. A clinical lead, day to day lead and Improvement Advisor will be assigned to each team and supported by a project officer. The Point of Care priorities will cover:

- Deteriorating Patients
- Sepsis
- VTE
- Heart Failure
- SSI
- CAUTI
- Falls
- Pressure Ulcers
- Safer Use of Medicines –Medicines Reconciliation

Outside of the Secondary Care environment we have plans to extend the patient safety work into the following areas:

- Mental Health: Communication at transition; Medicines management; Risk assessment & safety planning; Restraint, seclusion and emergency sedation; leadership and culture
- Primary Care: Culture; Global Trigger Tool; High Risk Medicines; Communication; Result Handling
- Maternity & Children's Quality Improvement Collaborative: Maternity Services; Paediatrics; Neonatal;

4. Person Centred Care That Learns from Feedback

The emphasis on change in relation to person-centred care that learns from feedback has been within acute services as this is where the majority of the organisation's complaints and patient dissatisfaction arises. This is not surprising due to the volume of patients going through the main hospital coupled with the complexity of care.

There are a number of ways in which improvement is being undertaken. This includes:

- Rolling out the use of Patient Opinion across the organisation
- Continually reviewing the complaints procedures to develop a more streamlined process
- Using patient stories to inform staff and also the governance process
- Developing closer working with other statutory agencies and the third and independent sectors to improve public engagement
- Developing an easily recognised heading for person centred learning under 'dgLearn'

More specifically, weekly triage meetings have been introduced at which the patient services staff, general manager, senior nurse and associate medical directors discuss adverse incidents that have arisen in the previous week as well as any complaints that have been received.

This allows for a more responsive approach that is aimed at resolving any issue as quickly and effectively as possible. Actions from these meetings can include contacting individual patients or families to ascertain the preferred method of dealing with their complaint or concern – telephone call, meeting, letter etc.; identifying any patterns of poor performance that could provide learning for more than one area of the hospital or picking out those complaints which are complex and will require more detailed exploration thus allowing any investigation to be started more quickly.

A Patient Experience and Learning Group (PELG) has been established. This meets monthly and is the group that identifies and agrees what learning needs to be implemented based on the knowledge gained from the patient experience process. Learning is undertaken in a range of ways, including:

- Weekly Blog (dghealth)
- Newsletters
- Twitter links
- Emails
- HIPPO (NHS D&G Intranet)
- Patient Experience Events
- Departmental/professional training that has a focus on patient stories

The plan is for all of the above to be incorporated into what will be known as ‘dgLearn’ which will be an overarching title for any learning and development work that has a direct link to improving the patient experience. This will facilitate a more robust approach to helping staff be Person Centred in everything they do.

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

The committee works proactively to anticipate or act on person centred health and care governance issues. This includes ensuring that causal links are made and that opportunities for organisational learning are recognised, shared and used to direct improvement activities.

As such, the Person Centred Health and Care Committee will commission actions and receive information, updates, and reports from the sources outlined below:

Care environment observations	Older People In Acute Hospitals work
Patient Experience Indicators	Learning from Feedback, Comments, Concerns and Complaints
Staff Experience Indicators	Volunteering and Patient Focus and Public Involvement
Leading Better Care	Any actions arising from the Francis report specific to this area
Spiritual Care	Integrated Health and Social Care

5. Hospitals Working With GPs, Community Teams, SAS and NHS24 to Transform Care

NHS Dumfries and Galloway and our partner organisations recognise the importance of providing a whole system approach to the delivery of safe, sustainable, and high quality unscheduled care for our local population. A Local Unscheduled Care Action Plan (LUCAP) has been produced which details both the actions required to deliver upon the Scottish Government 4 hour emergency care waiting times guarantee and also the changing model of care required for our new District General Hospital.

The plan therefore addresses necessary improvements across the five key themes: Flow and the Acute Hospital; Promoting Senior Decision Making; Ensuring Safe Effective and Safe Care at the Hospital Front Door; Making the Community the Right Place and Developing the Primary Care Response. Our LUCAP plan links very closely with our Reshaping Care for Older People agenda thus ensuring that delivery of high quality unscheduled care is supported by the whole system rather than within the acute hospital alone.

Delivery of the LUCAP is overseen by the Unscheduled Care Steering Group chaired by the Chief Operating Officer and including representation from Hospital and Community Services, Out of Hours, Social Work Services, Scottish Ambulance Service and the joint Strategic Planning and Commissioning Team.

Examples of key achievements in 2013 /14 include:

- Performance against the 4 hour emergency care waiting times guarantee for NHS Dumfries and Galloway has improved with year to date performance of 95%. This is compared to 93.9% for 2012/13.

Flow and the acute hospital

- The opening of a new Surgical Assessment Unit improving the journey for surgical emergency presentations and providing more rapid access to the specialist team.

- Delivery of initial steps towards 7 day working with access to AHPs, transport and social work services and care services during key weekends in the winter period.

- Recruitment of additional capacity management resource to increase focus upon flow within each of the surgical and medical streams.

- The introduction of whole hospital bed management huddles

Promoting Senior Decision Making

- Recruitment of additional middle grade doctors for the emergency department and two additional Acute Physicians for the Acute Medicine Unit enabling earlier assessment, care planning and decision making in these key department.

Ensuring Safe Effective and Safe Care at the Hospital Front Door

- Increased nurse resource during peak periods within the emergency department to ensure timely access to triage

Making the Community the Right Place

- Review of the GP contract for Cottage Hospitals enabling patients to be transferred to these hospitals, and therefore care nearer home, earlier in their admission.

- All people currently resident within a care home are expected to have anticipatory care plans in place. These care plans are reviewed by the patient's GP and are shared with the Out of Hours service.

- As part of our Reshaping Care for Older people agenda we have developed a collocated multiagency team in Dumfries which includes District Nursing, AHPs, Short Term Assessment and Rehabilitation Service, Social Work Services and a Third Sector partner – Royal Voluntary Services who act as a single point of contact and advocate for the wider Third Sector agencies. This new team are adopting the Personalisation Agenda approach within Social Work Services and work with individuals around how they may best manage their own care and anticipatory care/ prevention using access to a wider range of services providing co-ordinated responses wherever necessary.

- The development of a non- transferred falls pathway in partnership with SAS, the Council, GPs, AHPs and the Fire Service which utilises the Council's call centre as a single point of contact for SAS. Information is transferred to the person's GP and appropriate medical assessment is undertaken. The person is also asked for permission for information to be shared with the Fire Service who subsequently attend and undertake a full Fire Safety inspection of the individual's home providing advice and equipment as required.

Developing the Primary Care Response

- 15% of patients with a SPARRA score of between 40 – 60% will undergo a poly-pharmacy review and will have an anticipatory care plan shared via e-KIS by March 14.

- The introduction of psychology resources to support teams within the acute wards to manage people with long term conditions and support for the Emergency Department and their partners - GPs; OOHs and SAS - to develop the skills to manage our frequent attendees more appropriately.

Improving Performance

Despite our recent improvement against the 4 hour emergency care waiting times guarantee delivery remains challenging and therefore further work will be required. The Unscheduled Care Steering Group is committed to identifying and supporting

further action to deliver the 98% target. The Galloway Community Hospital consistently performs well against the 4 hour target with year to date performance sitting at 97.4%. For Dumfries and Galloway Royal Infirmary we are working on the following:

Continued improvement in patient flow

- Daily rounds in all specialties
- Introduction of electronic whiteboards and focus upon Estimated Date of Discharge and morning discharges
- Improved engagement with Cottage hospitals in whole system bed huddle to ensure flow throughout the whole bed base.
- Use of technology for whole system bed base view

Scoping the benefit of seven day working

- A small multiagency working group has been established to look at developing a whole system approach to 7 day working. A test of 7 day working is currently in progress within DGRI for the month of March which will inform the model for the future. Increased resources for this pilot are targeted to the weekend, are focussed around discharge and include AHPs, Medical middle grade staff, Social Work Services and Scottish Ambulance Services.

Implementation of Choice Guidance

- The Dumfries and Galloway Partnership is currently in the process of agreeing the model of adoption of the new Choice Guidance and supporting processes and training.
- The issue of delayed discharge has begun to cause pressure in the system. The Unscheduled care steering group is demonstrating keen interest and leadership with the issue being discussed in detail at their regular meetings.

We also plan to undertake demand and capacity analysis to inform workforce planning and explore the findings of current scoping around the model of Acute Care in the Home for Dumfries and Galloway.

6. Preparing for Integrated Health and Social Care

We are jointly creating our integration model from the service user's point of view so have to date concentrated on building up the service model at a locality level. We have a working agreement that wholly integrated health and adult social care services will be provided in each of our four natural localities.

Current work centres on the resources available in each locality and the management and professional leadership models that will provide greatest effectiveness.

In health we have developed an innovative whole systems map of resource use in each locality (attached at Appendix A) which we will use to inform both resource allocation and to underpin analysis of the impact of joint redesign initiatives such as the Dumfries Hub, a collocation of social work and NHS community staff that became operational in mid 2013.

We are intending to set up at least one (and ideally all four) of these fully integrated locality structures in 2014/15. The established Health and Social Care Partnership Board can act as the Committee designated by the two Public Bodies to oversee overall performance and to ensure that the objectives of integration are delivered.

The integrated localities themselves contain an element of Acute Services through the Galloway Community Hospital in Stranraer. We also intend to report the performance of the remainder of Acute Services through to the H&SCPB in order to provide members with a complete assessment of health and adult social care across the region.

The ultimate superstructure of governance will be put in place once we have established the four localities as effective joint bodies. Our current working assumption is that this will be a Body Corporate type mechanism but we have set up workshops for the H&SCPB members (first on February 14) to inform the final decision.

The reality is that the effective establishment of the integrated locality teams will be far more important to the success of integration in D&G than the nature of the top governance vehicle. This is why we are attempting to build up an integrated model rather than start our planning at the point furthest from the community and the service user.

We have begun work on communications strategies for public and staff to highlight the coming changes and will launch these early in 2014.

All work to date has been conducted with good engagement from staff side colleagues who sit as full members of our Integration Project Group. We believe that we can achieve integrated working without whole scale transfers of staff between bodies, which will avoid a lot of lengthy debate about HR type complexities and, again, allows us to focus more on the practical benefits of integration at a community level.

7. Learning Disabilities

Addressing health and social care inequalities for people with learning disabilities is recognised as a key agenda in Dumfries and Galloway and one which is underpinned by a robust partnership approach. Following the launch of the Keys to Life the key themes and recommendations from the report have been formally considered by the NHS Management Team, Social Work Services Senior Management Team and at our Community Health and Social Care Partnership Board/Shadow Health and Social Care Partnership Board.

Active reporting on progress on the Keys to Life is now required through the Partnership Board. Developing our local priorities and action planning under the Keys to Life is in at an early stage but a partnership approach is being taken across health and social work services with people with learning disabilities, carers, providers and other partner agencies. Identifying our local population of people with learning disabilities will be an important element of our work going forward.

Current focus in response to the Keys to Life is on mapping our current position, setting out where we are in relation to each of the 52 recommendations and identifying our local priorities. We have an active self-advocacy network through which groups of people with learning disabilities have participated in facilitated discussions on The Keys to Life and their identified priorities will continue to inform the local agenda.

The current approach builds on previous work locally that has seen the engagement and involvement of with people with learning disabilities result in significant improvements in the way we support people with learning disabilities using health services.

Improvements include the development of Health Passports and a Learning Disabilities Champions programme for staff within the NHS. A commissioned, “Review of People with Learning Disabilities Experience of using NHS Services in D&G” reported in 2013 and in response to this tests of change are currently being developed within the DGRI.

Under the health inequalities programme Dumfries and Galloway NHS are actively engaged in a national initiative around education for professionals within learning disability services. A local learning disabilities parenting programme initiative supported by Health Inequalities Funding is currently underway with a view to further addressing inequalities through an education programme pitched at parents.

Going forward, the local lead for this work will be Derek Cox, Director of Public Health. We will work with ScotPHN to make available a database complete with CHI numbers. We will also commit to work with the ScotPHN / SLDO to develop a plan to measure an aspect of health/health care and to develop health/healthcare improvement plan(s) for this population.

8. Delivering on Early Years

Dumfries and Galloway is committed to the Early Years Collaborative. The Nurse Director is the Executive Lead for the collaborative on behalf of the partners. A collaborative delivery structure has been established, with a Leadership Group Chaired by the Executive Lead, and sub groups for each of the workstreams, Chaired by the workstream leads.

The NHS Board Patient Safety and Improvement Manager oversees the collaborative as Programme Manager and an improvement support post has been appointed for the collaborative.

Workstream Leads are as follows:

- Workstream 1: Head of Midwifery
- Workstream 2: Nurse Manager Child Health
- Workstream 3: Integrated Children's Services Manager.

We have actively involved the local third sector in all our work and some have been leading tests of change. We consider this to crucial to success and will continue to work alongside them.

Two local learning events have been held to bring together staff who have been at the national learning events and staff who have not, with a third event planned. The national Early Years Collaborative team has supported us with these events and more will be planned as the collaborative progresses. The NHS and Council Chief Executives have carried out leadership walk rounds and our next step is to plan a schedule of these for senior leaders across the partner agencies.

We have established a baseline dataset which is about to be presented to Chief Officers and the CPP so that a regular reporting schedule can be agreed based on this data through the coming year.

9. Stroke Care

During 2013 69.4% of patients admitted with acute stroke by NHS Dumfries & Galloway received the key elements of the stroke care bundle which includes access to a Stroke unit, CT head scan, Swallow screen test and Aspirin. The Stroke service in NHS Dumfries & Galloway delivers an acute service across two sites at Dumfries and Galloway Royal Infirmary and Galloway Community Hospital in Stranraer. This has enabled the delivery of stroke thrombolysis region wide as well as the provision of acute stroke unit care to all of our local population.

The stroke MCN recognises that though early admission to a stroke unit underpins excellent care this is only guaranteed if all the other standards are met. Thus combining the standards together in a single 'bundle' is a simple tool for providing easy and clear confirmation that optimum care is being provided.

The Stroke MCN also self monitor's stroke service performance to each individual patient through a process called 'exception reporting'. Through this process we are able to identify why a standard was not met for an individual and whether this was avoidable or medically appropriate.

By mapping patients' pathways in this way it is possible to identify sources of delay or other issues and then design solutions to overcome these. An example of this was altering out-patient clinic times to permit confirmatory CT angiography to be added as part of a patient's initial assessment if carotid ultrasound suggested severe carotid artery narrowing.

A key remaining challenge is the consistent timely application of the standard bundle out with normal working hours when the service is provided by the duty on call medical team.

In order to continuously improve the delivery of stroke services across Dumfries & Galloway the Stroke MCN works closely with colleagues in the ambulance service, the Emergency Department, X-ray, the Medical Admission Unit and vascular surgery to provide an optimum service.

We will continue using exception reporting to provide detailed analysis of issues as they arise and to help design solutions within resource and geographical constraints. These reports will continue to be provided to the Stroke MCN Management team and relevant senior managers on a monthly basis.

In order to improve the effective delivery of the stroke care bundle, we have identified and set out our improvement aims and the priority actions to achieve these. Please refer to the detailed table in Appendix B

The Stroke MCN has access to the Scottish stroke care audit (SSCA) and self monitor's performance of the stroke service across NHS D&G through the process of exception reporting which is an agreed methodology across Scotland. The exception reporting includes all the elements of the stroke bundle. This process allows us to identify why a standard was not met for an individual and whether this was avoidable or medically appropriate.

The reports provide detailed analysis of issues as they arise and help the stroke MCN to design solutions within the resources and geographical constraints. The report is shared with the stroke management team and relevant senior managers on a monthly basis. Data is displayed on the Quality improvement boards in both stroke integrated units.

Annual review meetings are undertaken by the Lead Quality Improvement officer for stroke and SSCA clinical coordinator as part of the Scottish Government Performance Management Team. Feedback is given with detailed actions to be taken forward. This year there are plans to also undertake case note ascertainment.

10. Chronic Pain Management

NHS Dumfries and Galloway set up a Chronic Pain Improvement Group (CPIG) in April 2012, with multidisciplinary membership from primary and secondary care, plus the Pain Association and the national clinical lead (Steve Gilbert). Our short-term funding bid was approved in July 2012, which has supported improvement work overseen by a steering group and manage through 5 sub-groups covering: -

- Staff Education and Training
- Public/Patient Information/ Self -management
- Primary Care Pathways
- Secondary Care Pathways
- Medication Management

To date we have had limited involvement of patients, although we have undertaken surveys of people with chronic pain through Pain Association attendees and community pharmacies ('bag-shot'). We have set up a Patient Focus Group meeting in Feb 2014 including those people who have expressed an interest from above surveys - and welcome the input they will provide.

Primary Care and supported self-management

Our improvement group includes two GPs, community pharmacy and community physiotherapy. All have been actively engaged in promoting self management and we have arranged for primary care staff to be able to electronically refer patients to the Pain Association as early as possible (see below). Dr Purdie and Dr Bell contributed to the national Pain Pathways meeting in recognition of the focus on primary care within NHS Dumfries & Galloway.

The local CPIG Steering Group is now focusing on the implementation of SIGN Guideline 136. Members have already been engaged with various aspects, including prescribing guidelines. This will be supported by work already underway such as - training of community pharmacists and physiotherapists in CBT principles, implementation of StarT Back triage, completed roll out of IT system upgrade in order to allow the NHS 24 MSK service to go live in the near future.

Collaboration with third sector

NHS D&G has a service agreement with Pain Association Scotland for the provision of monthly group meetings in Dumfries and Stranraer, plus three intensive pain management courses per year. As mentioned above we have arranged electronic referrals from NHS clinicians to the Pain Association, and look forward to national implementation of direct SCI Gateway referral system. All GPs and community physiotherapists have been issued with agreed guidelines for referral which can happen in parallel to referral to secondary care where appropriate.

Secondary Care

NHS D&G has two consultant anaesthetists (0.8 wte) providing chronic pain services, one being the clinical lead. The ESP (extended scope practitioner) back pain physiotherapist works closely with other chronic pain colleagues.

Recent success has been in the recruitment of a clinical psychologist with a 2 sessional commitment to chronic pain, who is keen to help us redesign our service in the coming months, including sustainable approaches to delivering multidisciplinary pain management programmes.

We are linking with Children's commissioning to address the needs of children and young people with chronic pain.

Improvement Offer

NHS D&G has benefited greatly from the support provided through the national chronic pain improvement funding, plus the input of the HIS team including the national clinical lead and facilitators.

There has been learning through the sharing of good practice via the WebEx sessions, and we welcome continuation of these. The Board Planning and Commissioning Manager will also be taking on the role of Chair of the national steering group from April 2014.

A team from NHS D&G will attend the HIS event in March when the output of the recent data collection will be shared. This information, especially the views of patients, will allow us to develop our service in line with the feedback.

Monitoring

In terms of aims and objectives, those included in the 2012 CPIG funding bid still stand - as below:

*The overarching **aim** is to develop a person-centred effective and sustainable care pathway for chronic pain, based on the Scottish Chronic Pain Service Model, in order to improve the lives and reduce the suffering of adults with chronic pain in Dumfries and Galloway. This will be supported by the following key **objectives**:*

- *Develop and implement chronic pain management pathways within primary care, that are effective and efficient*
- *Provide a multi-disciplinary approach to chronic pain services within secondary care*
- *Enable people with chronic pain to self-manage their condition as much as possible, through person-centred information, resources, education and continued partnership working with the Pain Association Scotland.*

Delivery of these will be supported by the following key actions over the next 6-9 months, which also comply with SIGN Guideline 136:

- Using clinical psychology input, develop and test options for delivering sustainable multidisciplinary pain management programme.

- Through a pharmacy project, improve appropriate use of analgesics and reduce polypharmacy for patients by review of primary care prescribing and education of GPs, community pharmacists and patients.

- Through further training and support to local physiotherapy service, ensure forthcoming launch of NHS 24 MSK service in D&G enhances chronic pain pathway.

- Arrange education for all clinicians in chronic pain, including SIGN 136, through evening sessions and chronic pain symposium.

- Link with Children's Services to agree improvement work for chronic pain.

11. Delivering for Patients with Multi-Morbidity

Our approach to delivering for patients with multi-morbidity can be summarised through a number of key activities detailed below.

Anticipatory Care Planning

This is being taken forward in Primary Care as part of the GP contract with an initial focus on persons in care homes/ nursing homes, and those with a high SPARRA score. This is improving the quality of decision making at the time of admission, particularly when the patient requires urgent assessment out of hours.

It is important to note that this covers non-cancer disease, as well as social and mental health issues. The data is uploaded onto the GP OOHs service information system, and to eKIS.

Further work is required at present to ensure that ACPs are available to ambulance staff called to patients: We have received feedback from the Scottish Ambulance Service that they should have this facility available within the ambulances within the next 2 months.

We have also attended meetings of care home managers to discuss the process of ACPs and to ensure that they are done with knowledge and support of care home managers, who are then confident of dealing with a patient who has elected not to be admitted to hospital, particularly when the patient is dying.

Polypharmacy Reviews

We consider this to be an extremely important issue both from a patient safety and cost effectiveness aspect. GPs have been funded to carry out polypharmacy reviews on all patients on more than 10 prescription items prior to the national changes to the GMS contract which now requires them to do this. Initial feedback over the last 3 years is that there are a number of patients who are clearly much better after stopping medications, and GPs and Practice Nurses are gaining confidence in addressing the issues.

A prescribing support team of 6 pharmacists provides support to the 34 practices for both polypharmacy reviews and prescribing switches etc. Polypharmacy review is part of the falls pathway, and aims to help reduce the risk of future falls. We have circulated to all GPs and practice nurses a copy of the excellent advice from Dr Martin Wilson, consultant from Inverness on numbers needed to treat in the elderly.

We have funded a very well attended half day practice release session on polypharmacy, and got Dr Martin Wilson down to speak that day. Within hospital we have now changed the prescribing chart so that there is a bold line after 6 items: Anyone writing below that line (i.e. adding a 7th Drug) is required to carry out (and document) a polypharmacy review.

Expanding use of Cottage Hospitals

The Medical Director has negotiated a new contract for the provision of medical input to Cottage Hospitals which specifies exactly the service required and the standards to which that service will be required.

The new contract moves to a single GP taking responsibility for the vast bulk of the input, along with attending regular review meetings with the locality manager and the lead nurse to ensure that standards are maintained: It is anticipated that even before integration we will have senior social workers attending these meetings.

GPs providing services to the Cottage Hospitals are being funded to undertake the Diploma in Geriatric Medicine (or in some cases, MRCP). Nurse training has ensured that nurses are taking on a number of new skills, including phlebotomy, IV line insertion and maintenance, IV antibiotic administration, and reliable recognition and escalation of the deteriorating patients.

We have confirmed that there is adequate AHP input to all of the hospitals, and have enhanced transport arrangements to take patients from acute care to the Cottage Hospitals. We have also arranged improved IT in the hospitals and the provision of feedback to consultants where a patient has been transferred from secondary care.

Some of the Cottage Hospitals have been developed as suitable for more specialist care in some clinical areas – for example stroke rehabilitation, and more general rehab. The impact of these changes appears to have become evident already with average occupancy rising from approximately 60% to around 80+% at the current time.

Integrated Multi-Disciplinary Community Teams

Developing Community Based, Integrated Hubs

Gillbrae Hub

The co-location of a Social Work OT assistant within the GP practice at Gillbrae facilitates a collaborative and joined up approach towards the provision of seamless care for an individual. This approach places the person and their Carers at the centre of planning care that seeks to meet the individual's personal outcomes.

Other advantages of co-locating agencies in this way include:

- Supporting the development of effective working relationships that inspire mutual confidence and trust

- Addressing, through the care management approach, joined up care and support for those with multiple long term conditions and frailties

- Reducing referral times from one health and care professional to another from an average of 8 days to a maximum of 2 days with many referrals immediate as team members discuss them directly with one another.

The Gillbrae test of change has enabled enhanced working relationships with the Third Sector to develop and improved the practice's overall approach to providing support to the care and welfare of Carers and was nominated for the 'Caring About Carers Award' in 2013 by patients. The Gillbrae Hub was successfully awarded both the Scottish and the UK awards.

Dumfries Health and Social Care Hub

Putting You First, Dumfries and Galloway Change Programme is testing a community hub bringing together staff within Dumfries and Galloway Council, NHS Dumfries and Galloway and the Third Sector. It is testing new ways of providing early intervention and intermediate care for the over 65 population of two GP practices. The Hub has had some successes in enabling people, including those with multiple morbidities to stay in their own homes with STARS (Short Term Augmented Response Service), social work, third sector and health all working together to provide person centred, joined up care and support.

Annan Remote Monitoring

The Annan Supported Remote Monitoring (ARM) test has the potential to transform the way people living with COPD manage their condition on a daily basis which in turn improves their quality of life and reduces the need for unplanned hospital admissions.

People taking part in the test are provided with electronic monitoring devices which relay blood oxygen levels, temperature readings and other key information to a non clinical response centre managed by Dumfries and Galloway Council, where staff can check for any early signs of deterioration in their condition against parameters

set by the individuals own GP. If a there is any indication that someone would benefit from a clinical intervention, response centre staff alert the appropriate health service to enable them to take action quickly.

Addressing Stress and Distress

People living with dementia and suffering from associated stress and distress now have a dedicated team working to improve their quality of life and reduce the amount of anti-psychotic drugs used in their treatment.

Putting You First is supporting the Interventions for Dementia: Education, Assessment and Support (IDEAS) team launched in January 2013. The IDEAS team includes staff from nursing, occupational therapy and clinical psychology. Independent care home staff have worked closely with the IDEAS team to develop this approach to supporting people with dementia, their Carers and staff.

As well as delivering training from foundation to advanced levels, the IDEAS team has offered support and guidance to residents, their families and the staff who support them; including extensive mapping of dementia care with feedback to relatives. They have also helped staff to devise support plans, identify possible triggers of stress and distress and support people when they are suffering from stress and distress.

Intermediate Care – Step Up/Step Down

This initiative is testing the direct GP admission of older people, usually with multiple morbidities, to a care home bed for a maximum period of three days. To date there is evidence that this test of change has reduced the number of admissions to acute services and delivered services centred on the person, their family and Carers.

Forward Looking Care

GPs, District Nurses and Social Work staff are working together to assist older people and those with a long term condition by offering extended appointments to discuss their actual and potential care needs in the future and complete forward looking care plans.

Part of this process means they offer the individual and/or their Carer an appointment with a Community Link Worker who will work with individuals and Carers to ensure they have access to appropriate opportunities, low level support and services in the community that will help them maintain a good quality of life.

Support for individuals with long term conditions

Across the region, a variety of low level support groups have been established with people who have long term, chronic conditions. These are sometimes condition specific, but others cater for a range of long term conditions and focus on activities open to all such as Tai Chi, Reminiscence, Craft groups (Knit and Natter) and social groups.

12. Secondary Care Demand and Capacity

NHS Dumfries and Galloway recognise that the use of the independent sector should only be used to support short-term capacity issues within the service. Unfortunately over recent months, due to unforeseen circumstances the independent sector has been used to create additional capacity in order to meet waiting times guarantees.

It is a clear objective to cease the use of the independent sector at the earliest opportunity and a review of demand and capacity will be undertaken to sustain this. However, given the number of single handed sub-speciality areas the use of the private sector will continue to be a last option when we are faced with unplanned capacity challenges.

NHS Dumfries and Galloway have additional NHS capacity at Golden Jubilee National Hospital for Orthopaedics. We have an excellent arrangement with GJNH and have successfully piloted the 'See and Treat' model fully utilising available capacity.

13. Approach to Innovation

Background and work to date

NHS Dumfries and Galloway is a small health board but has a track record of 'punching above its weight' when it comes to innovation. Examples of Innovation are apparent in many areas, examples being:

- Information Technology
    - Electronic Medical Records
    - Digital Dictation
    - Clinical Portals
    - Electronic Ward Based management systems (Cortix)
    - Real time reporting and analysis (Qlikview)

- Patient Safety and Quality Improvement Work
    - Safety Essentials
    - Point of Care Priorities

- The work streams that underpin our Unscheduled Care Action Plan
    - Psychologist input into A&E department to build skills of the A&E team to managed complex attendances differently which we are not aware of happening anywhere else.
    - Dumfries Hub approach where we have brought together health, local authority and third sector into a co-located base
    - Working with local fire service on our falls programme which again, we are not aware of happening anywhere else
    - CREWS (Community Respiratory Early Warning system) - a research programme led by our specialist respiratory nurse.

- The work streams that underpin our Putting You First Programme
    - Communication Logs in patients homes – a multi-agency common communication tool
    - One Team approach in Langholm – joining together hospital, district nursing services, and the local authority Care and Support Services (CASS)
    - Low Level Support in Annan (supporting resilience) which has been picked up by the Joint Improvement Team as an innovative development.

- The work streams that underpin our Clinical Change Programme in preparation for the move to a new acute hospital in 2018.

- The 'What If' Innovation Fund – a seed fund in order to facilitate projects to improve and innovate around services. Since its inception in 2011-12, we have invested or have plans to invest approximately £2m in non-recurring funding in a number of schemes which members of staff have brought forward for consideration. Examples include:
    - A pilot and further roll out of eRostering
    - A pilot to examine the merits of Band 3 Health Care Support Workers
    - Re-design of the Gynaecology Outpatient Service

- Contribution to the Scottish Collaborative Innovation Partnership Process (SCIPP): One of our Senior Strategic Planning Managers is a member of this group.

We have held a number of Efficiency and Productivity Workshops in the last 12 months where we have brought in experts from universities and think tanks in order to introduce our senior staff to the three horizons concept and how we can try to completely re-imagine delivery of health services in the future.

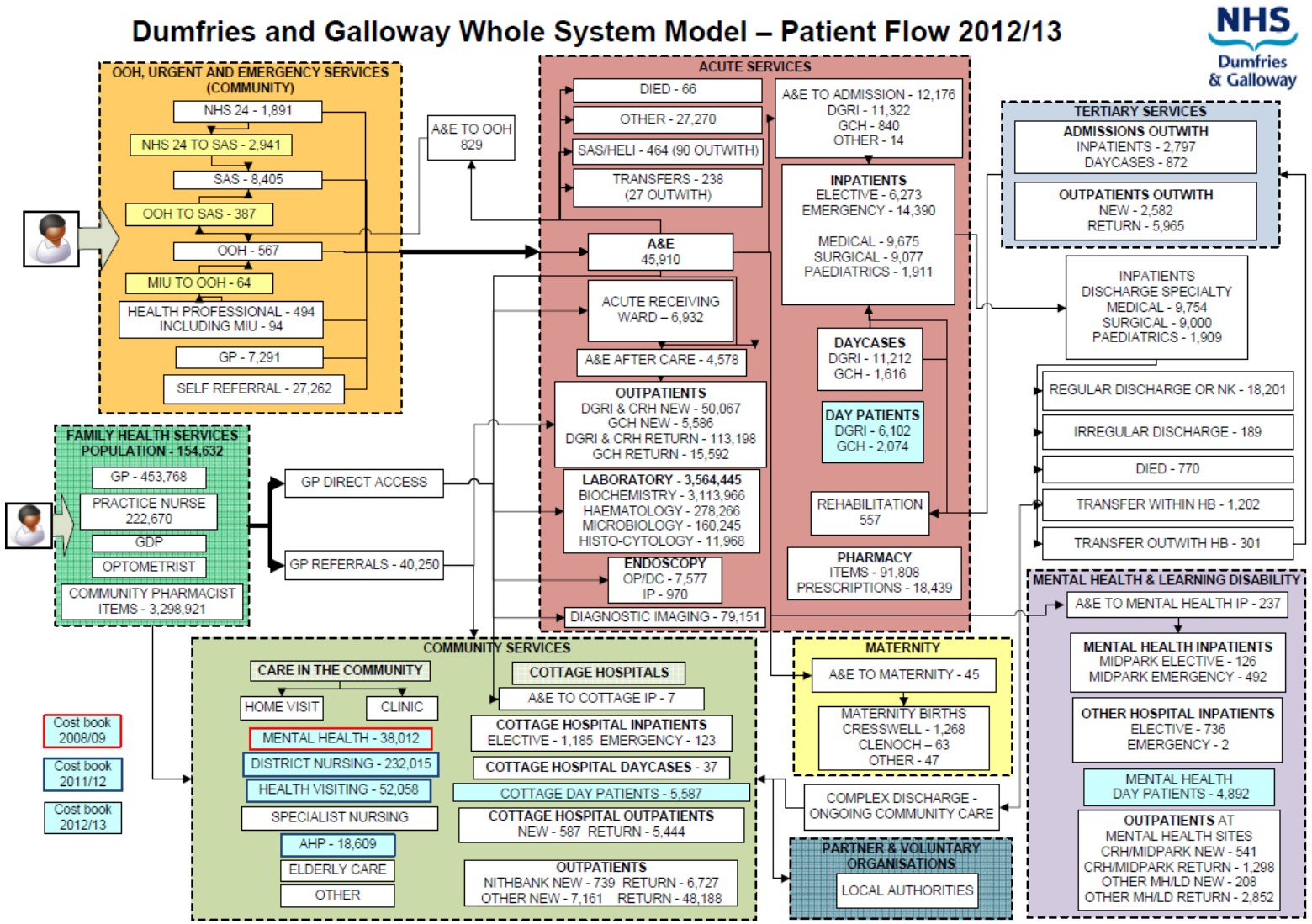
We have picked up a growing desire from some staff to completely re-think the way in which we work, for example, questioning the need for inpatient stays for diagnostic tests and the rationale behind out-patient appointments.

Next Steps

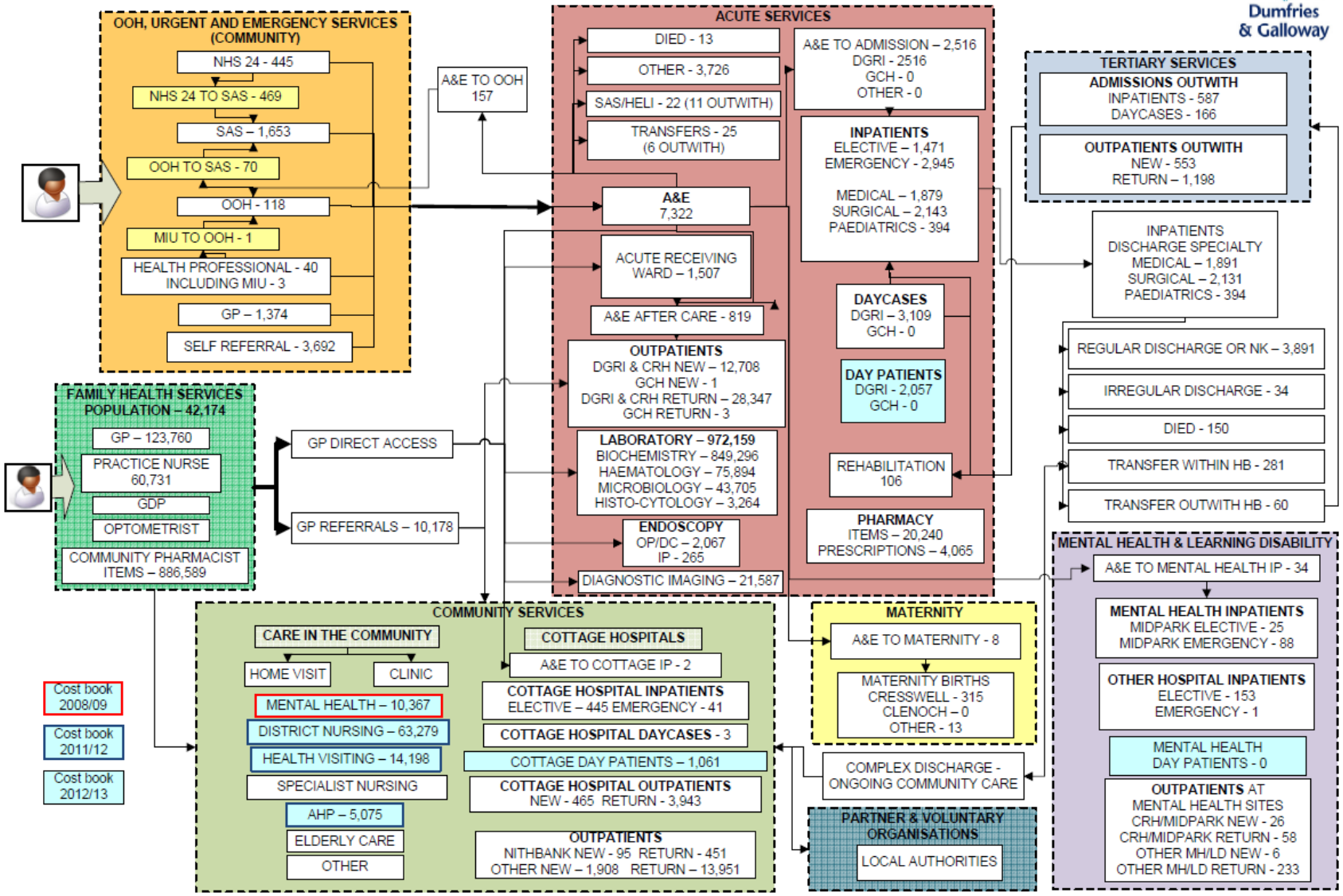
We are aware that while there are many initiatives happening throughout the board, there is a distinction to be drawn between innovation and continuous improvement. This is a distinction which is not universally understood at present; however our plan is to form an innovation network comprising of key members of staff who are involved in many of the approaches outlined above, with the initial intention of using the network to ensure that there is a mutual understanding of each other's areas of work, before moving on to potential areas of collaboration.

In due course, the network will be able to agree an innovation framework comprising of the core areas where the health board is investing resource in innovation and how the network can help to nurture and promote these areas. This will be the priority for 2014-15.

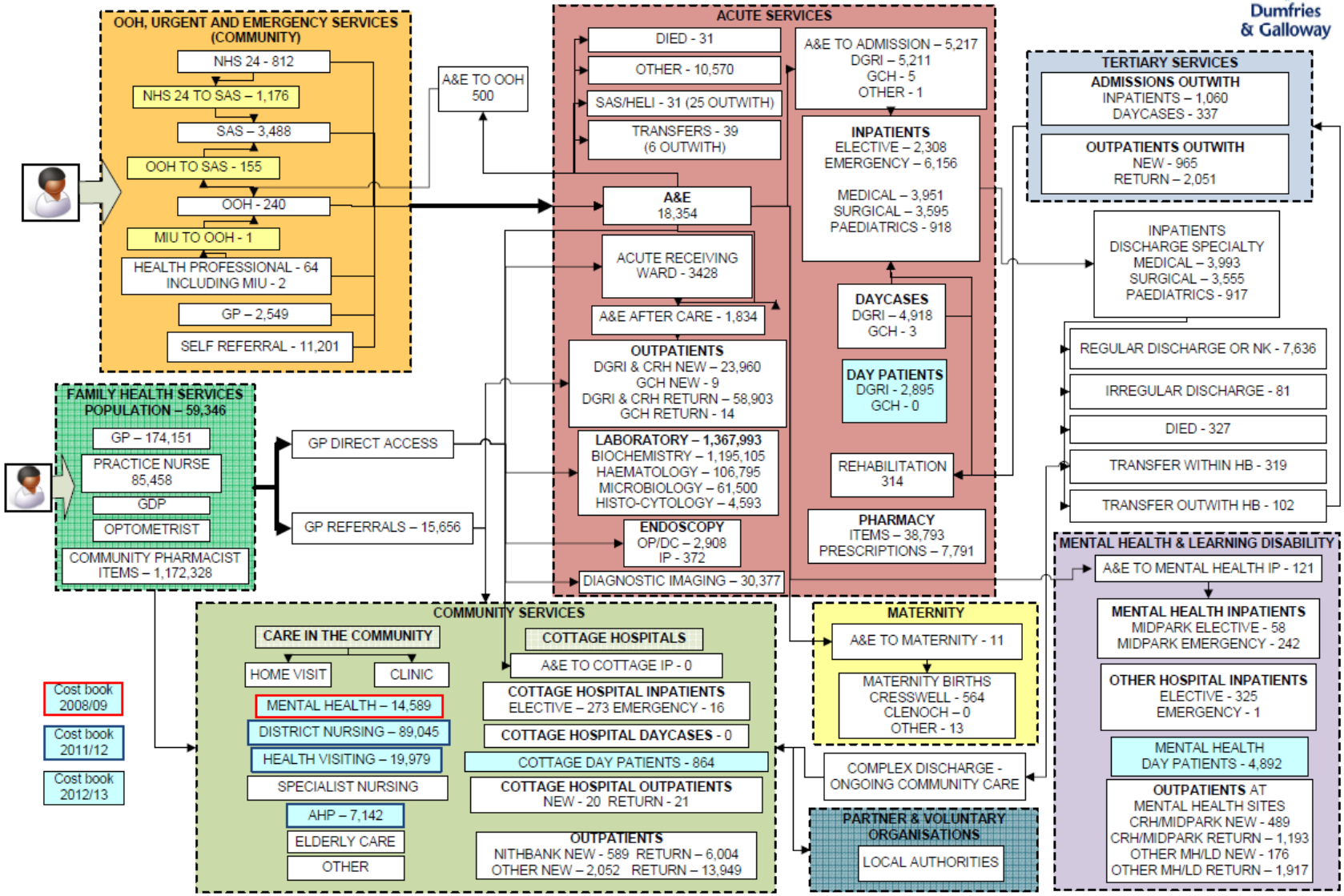
Appendix A


Dumfries and Galloway Whole System Model – Patient Flow 2012/13
NHS Dumfries & Galloway
OOH, URGENT AND EMERGENCY SERVICES (COMMUNITY)
NHS 24 - 1,891
NHS 24 TO SAS - 2,941
SAS - 8,405
OOH TO SAS - 387
OOH - 567
MIU TO OOH - 64
HEALTH PROFESSIONAL - 494 INCLUDING MIU - 94
GP - 7,291
SELF REFERRAL - 27,262
A&E TO OOH 829
ACUTE SERVICES
DIED - 66
OTHER - 27,270
SAS/HELI - 464 (90 OUTWITH)
TRANSFERS - 238 (27 OUTWITH)
A&E TO ADMISSION - 12,176
DGRI - 11,322
GCH - 840
OTHER - 14
INPATIENTS
ELECTIVE - 6,273
EMERGENCY - 14,390
MEDICAL - 9,675
SURGICAL - 9,077
PAEDIATRICS - 1,911
A&E 45,910
ACUTE RECEIVING WARD – 6,932
A&E AFTER CARE - 4,578
DAYCASES
DGRI - 11,212
GCH - 1,616
DAY PATIENTS
DGRI - 6,102
GCH - 2,074
OUTPATIENTS
DGRI & CRH NEW - 50,067
GCH NEW - 5,586
DGRI & CRH RETURN - 113,198
GCH RETURN - 15,592
LABORATORY - 3,564,445
BIOCHEMISTRY - 3,113,966
HAEMATOLOGY - 278,266
MICROBIOLOGY - 160,245
HISTO-CYTOLOGY - 11,968
REHABILITATION 557
PHARMACY
ITEMS - 91,808
PRESCRIPTIONS - 18,439
ENDOSCOPY
OP/DC - 7,577
IP - 970
DIAGNOSTIC IMAGING - 79,151
TERTIARY SERVICES
ADMISSIONS OUTWITH
INPATIENTS - 2,797
DAYCASES - 872
OUTPATIENTS OUTWITH
NEW - 2,582
RETURN - 5,965
INPATIENTS DISCHARGE SPECIALTY
MEDICAL - 9,754
SURGICAL - 9,000
PAEDIATRICS - 1,909
REGULAR DISCHARGE OR NK - 18,201
IRREGULAR DISCHARGE - 189
DIED - 770
TRANSFER WITHIN HB - 1,202
TRANSFER OUTWITH HB - 301
FAMILY HEALTH SERVICES POPULATION - 154,632
GP - 453,768
PRACTICE NURSE 222,670
GDP
OPTOMETRIST
COMMUNITY PHARMACIST ITEMS - 3,298,921
GP DIRECT ACCESS
GP REFERRALS - 40,250
MENTAL HEALTH & LEARNING DISABILITY
A&E TO MENTAL HEALTH IP - 237
MENTAL HEALTH INPATIENTS
MIDPARK ELECTIVE - 126
MIDPARK EMERGENCY - 492
OTHER HOSPITAL INPATIENTS
ELECTIVE - 736
EMERGENCY - 2
MENTAL HEALTH DAY PATIENTS - 4,892
OUTPATIENTS AT MENTAL HEALTH SITES
CRH/MIDPARK NEW - 541
CRH/MIDPARK RETURN - 1,298
OTHER MH/LD NEW - 208
OTHER MH/LD RETURN - 2,852
COMMUNITY SERVICES
CARE IN THE COMMUNITY
HOME VISIT
CLINIC
MENTAL HEALTH - 38,012
DISTRICT NURSING - 232,015
HEALTH VISITING - 52,058
SPECIALIST NURSING
AHP - 18,609
ELDERLY CARE
OTHER
COTTAGE HOSPITALS
A&E TO COTTAGE IP - 7
COTTAGE HOSPITAL INPATIENTS
ELECTIVE - 1,185 EMERGENCY - 123
COTTAGE HOSPITAL DAYCASES - 37
COTTAGE DAY PATIENTS - 5,587
COTTAGE HOSPITAL OUTPATIENTS
NEW - 587 RETURN - 5,444
OUTPATIENTS
NITHBANK NEW - 739 RETURN - 6,727
OTHER NEW - 7,161 RETURN - 48,188
MATERNITY
A&E TO MATERNITY - 45
MATERNITY BIRTHS
CRESSWELL - 1,268
CLENOCH – 63
OTHER - 47
COMPLEX DISCHARGE - ONGOING COMMUNITY CARE
PARTNER & VOLUNTARY ORGANISATIONS
LOCAL AUTHORITIES
Cost book 2008/09
Cost book 2011/12
Cost book 2012/13

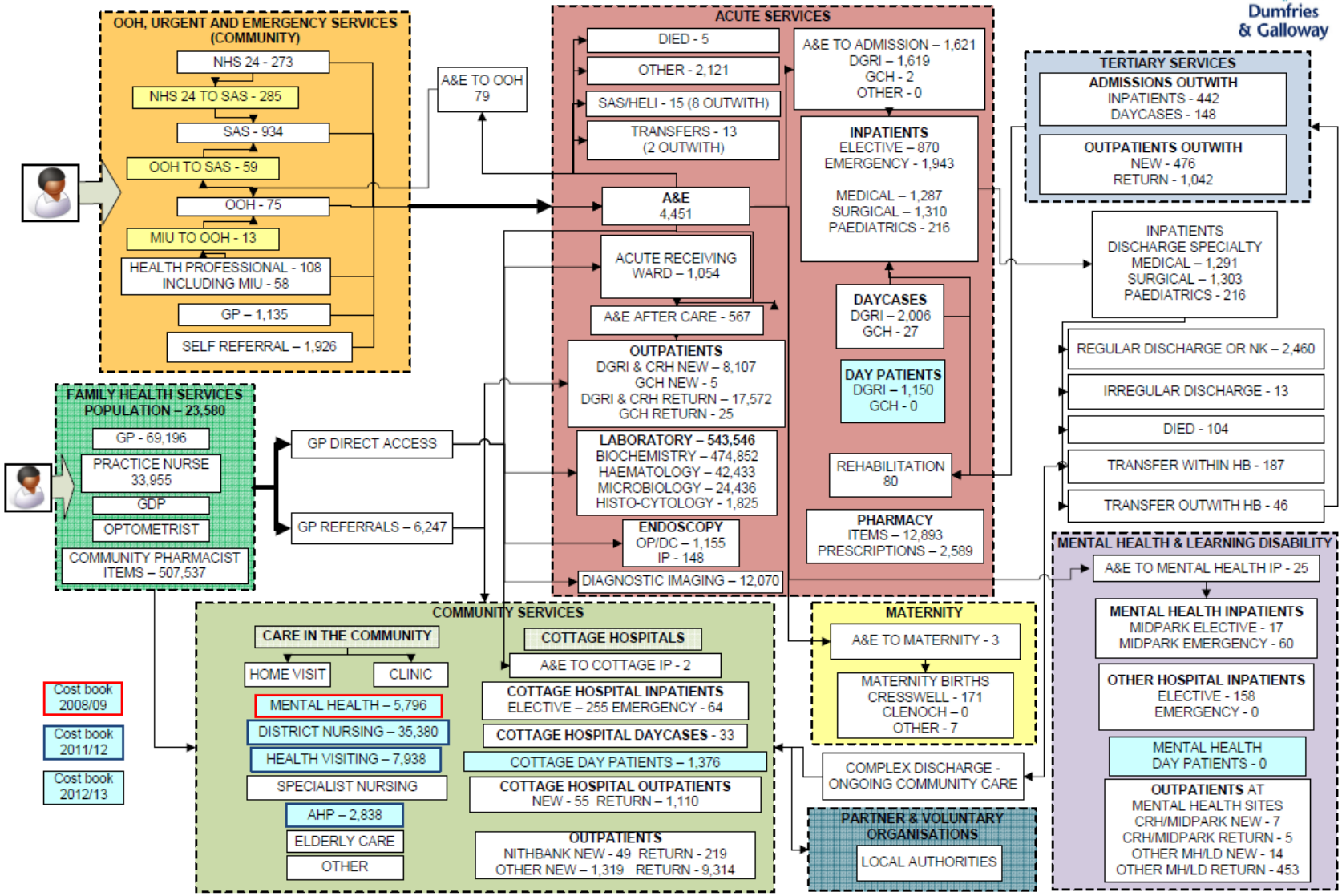
Annandale & Eskdale Whole System Model – Patient Flow 2012/13



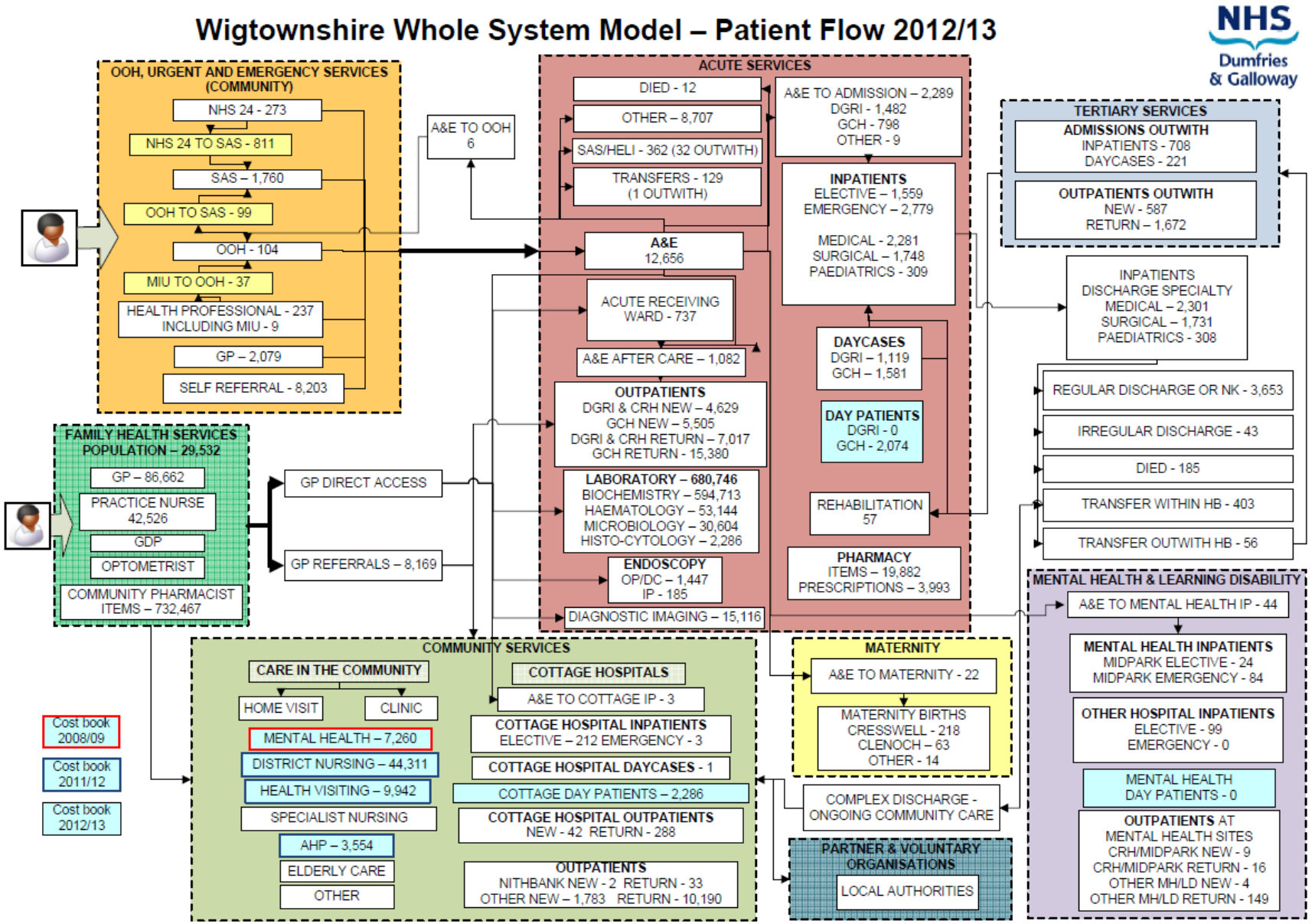
Dumfries & Upper Nithsdale Whole System Model – Patient Flow 2012/13



Stewartry Whole System Model – Patient Flow 2012/13



Wigtownshire Whole System Model – Patient Flow 2012/13



Appendix B

LDP ACTION PLAN 2014/15	SCOTTISH STROKE CARE STANDARD	TARGET	2013	2014/15	ACTION
Stroke Care Bundle	By March 2015, an increased number of patients admitted to hospital with a diagnosis of stroke must receive all the key elements of the stroke care bundle.	75%	69.4%	75%	During 2013 69.4% of patients admitted with acute stroke by NHS Dumfries & Galloway received the key elements of the stroke care bundle which includes access to a Stroke unit, CT head scan, Swallow screen test and Aspirin. The Stroke service in NHS Dumfries & Galloway delivers an acute service across two sites at Dumfries and Galloway Royal Infirmary and Galloway Community Hospital in Stranraer. This has enabled the delivery of stroke thrombolysis region wide as well as the provision of acute stroke unit care to all of our local population. The stroke MCN recognises that though early admission to a stroke unit underpins excellent care this is only guaranteed if all the other standards are met. Thus combining the standards together in a single 'bundle' is a simple tool for providing easy and clear confirmation that optimum care is being provided. The Stroke MCN also self monitor's stroke service performance to each individual patient through a process called 'exception reporting'. Through this process we are able to identify why a standard was not met for an individual and whether this was avoidable or medically appropriate. By mapping patients' pathways in this way it is possible to identify sources of delay or other issues and then design solutions to overcome these. An example of this was altering out-patient clinic times to permit confirmatory CT angiography to be added as part of a patient's initial assessment if carotid ultrasound suggested severe carotid artery narrowing. A key remaining challenge is the consistent timely application of the standard bundle out with normal working hours when the service is provided by the duty on call medical team. In order to continuously improve the delivery of stroke services across Dumfries & Galloway the Stroke MCN works closely with colleagues in the ambulance service, the Emergency Department, X-ray, the Medical Admission Unit and vascular surgery to provide an optimum service. We will continue using exception reporting to provide detailed analysis of issues as they arise and to help design solutions within resource and geographical constraints. These reports will continue to be provided to the Stroke MCN Management team and relevant senior managers on a monthly basis.
Access to a stroke care unit	90% of all patients admitted to hospital with a diagnosis of stroke must be admitted to a stroke unit on the day of admission, or the day following presentation at hospital.	90%	89%	90%	
CT scan	90% of stroke patients will have a CT scan within 24 hours of admission.	90%	88%	90%	
Swallow screen test	90% of stroke patients will have a swallow screen on the day of admission.	90%	88%	90%	
Aspirin	100% of ischaemic stroke patients will have aspirin by the day following admission.	100%	88%	100%	

Appendix C: Strategic Fit with 2020 Priorities

2020 Priority	Map to Local Delivery Plan
Person Centred Care	Use of Patient Opinion; Use of Patient Stories; Improving engagement through closer links with statutory agencies, third and independent sectors; Patient Experience and Learning Group (PELG); DGLearn Programme, Chronic Pain Improvement Group
Safe Care	Acute Adult Safety Programme; Safety Essentials Programme, Point of Care Priorities; Stroke MCN
Primary Care	Change fund being used to trial a range of initiatives in shifting the balance of care; Dumfries hub co-location of services; Anticipatory Care Plans initially focusing on Care Homes/Nursing Homes; Polypharmacy Reviews; Increased use of telemedicine/telecare
Unscheduled Emergency Care	New Surgical Assessment Unit opened December 2013; Plans to test seven day working; Investment in additional middle grade doctors, nurses at peak times and bed capacity management resource; Multi-agency team in Dumfries (Dumfries Hub); Development of non-transferred falls pathway with the Scottish Ambulance Service
Integrated Care	Joint creation of integration model from service user perspective; Development of Whole Systems Map; One to Four Integrated Locality structures to be in place during 2014-15
Care for Multiple and Chronic Illnesses	Anticipatory Care Plans initially focusing on Care Homes/Nursing Homes; Polypharmacy Reviews; Expanding the use of Cottage Hospitals; Integrated multi-disciplinary community teams
Early Years	Pregnant Women Screened for Alcohol Abuse; Maternity & Children Quality Improvement Collaborative; Early Intervention Family Support Project; GIRFEC Plan in place
Health Inequalities	Keys to Life implementation; Plans to mitigate against impact of welfare reform; Social prescribing project; Capacity Building project; DG Commonwealth Legacy Plan
Prevention	Providing Opportunities for young people (Modern Apprentices, Work Experience, Work Placements); Developing Social Capital; Working Closely with Criminal Justice Social Work tom improve the health of community managed offenders
Workforce	Partnership Working; Staff Governance Monitoring Framework; Plans to embed the NHSScotland Core Values; Values-based practice learning events; Staff engagement sessions with CEO; Staff experience embedded into Person Centred Health and Care Committee, iMatter staff experience framework
Innovation	Innovative areas of work include IT innovations, Patient Safety and Quality Improvements, Putting You First Programme, Unscheduled Care Action Plan and establishment of a local Innovation Fund; Establishment of an Innovation Network to prioritise innovation work.
Efficiency and Productivity	Efficiency and Productivity Workshops; Continued delivery of Cash Releasing Savings Programme to deliver financial balance

Appendix D

2020 Priorities: Board Leads

2020 Priority	Board Lead
Person Centred Care	Hazel Borland, Nursing, Midwifery and AHPs Director
Safe Care	Hazel Borland, Nursing, Midwifery and AHPs Director
Primary Care	Angus Cameron, Medical Director
Unscheduled Emergency Care	Julie White, Chief Operating Officer
Integrated Care	Jeff Ace, Chief Executive
Care for Multiple and Chronic Illnesses	Angus Cameron, Medical Director
Early Years	Hazel Borland, Nursing, Midwifery and AHPs Director
Health Inequalities	Derek Cox, Director of Public Health
Prevention	Derek Cox, Director of Public Health
Workforce	Caroline Sharp, Workforce Director
Innovation	Chris Sanderson, Efficiency & Productivity Manager
Efficiency and Productivity	Katy Lewis, Director of Finance

2020 Local Delivery Plan

Section Two:
Community Planning Partnership Statement 2014-15

Contents

1. Introduction

Dumfries and Galloway Strategic Partnership

NHS Dumfries and Galloway both leads and participates in a wide range of partnership activity linked to the region's Community Planning Board – the Strategic Partnership and in terms of the wider Board ambitions in delivering priorities under the Single Outcome Agreement.

2. Improving Partnerships

Dumfries and Galloway Strategic Partnership*

(Indicates where an NHS representative is the Chair or Vice Chair)*

Dumfries and Galloway Strategic Partnership is a partnership of agencies and organisations from the public, private, voluntary and community sectors that have an interest in Dumfries and Galloway. It is an unincorporated body. The aim of the Strategic Partnership is to work together 'to create an ambitious, prosperous and confident Dumfries and Galloway where people achieve their potential'.

Remit

- Set out a joint vision and high level outcomes for Dumfries and Galloway in the form of a Single Outcome Agreement
- Set out the contribution expected from partners towards delivering these outcomes
- Monitor and evaluate progress on agreed outcomes, and receive regular reports on these. Identify and agree corrective action where appropriate
- Identify and secure the resources necessary to achieve the agreed outcomes
- Influence the national agenda to secure the best outcomes for Dumfries and Galloway
- Co-ordinate joint Dumfries and Galloway responses on issues
- Adopt a way of working together which properly reflects and enhances the governance arrangements of the partners
- Through the Executive Group, receive reports on significant issues facing thematic and strategic partnerships and forums, for example changes in policy direction and budget challenges

Criteria for Membership

- Appointed/Elected Members and/or most senior officials of organisations named as having a duty of Community Planning in legislation
- Representatives of Third Sector and private sector
- The organisations represented must have a strategic role in setting the agenda for the region
- The representatives must be able to commit funding and/or other resources to Community Planning
- Members may nominate a substitute

Chair/Vice Chair

- The Partnership will be chaired by the Leader of Dumfries and Galloway Council, and the Vice Chair is the Chair of NHS Dumfries and Galloway

Meetings

- The Strategic Partnership will meet six times per year with the venue rotating between the membership organisations
- Decisions taken by the Strategic Partnership must be followed through by reports being submitted to the relevant partner agencies' decision making system, e.g. for the Council, the relevant Council Committee

Key issues dealt with over 2013/14 include: scrutiny of the six SOA 2012-15 Priorities; welfare reform; the Director of Public Health's Report 'From Cradle to Grave Sustainably'; Health and Social care integration; Police and Fire and Rescue Reform; development of the Crichton Institute and Observatory; and development of the updated SOA for 2013-16.

Thematic Partnerships

- Community Health and Social Care Partnership Board (CHSCPB)*
- Alcohol and Drug Partnership (ADP)*
- *Putting You First* Programme Board*
- SWESTRANS*
- Domestic Abuse and Violence Against Women Partnership*
- D&G Wellbeing*
- GIRFEC
- Adult Protection Committee*
- Child Protection Committee*
- Crichton Institute Partnership and Observatory Technical Group
- Strategic Co-ordinating Group

Community Planning Working Groups

- Armed Forces Community Covenant
- Communications
- Compact
- Demographic *
- Efficiency*
- Executive
- Diversity
- Performance Management
- Poverty, Deprivation and Inequalities
- Public Involvement *(currently under development as part of the new arrangements for the Public Partnership Forum)*
- Training

3. Economic Recovery and Growth

NHS Board Contribution

The Alcohol and Drugs Partnership contributes resources to the Dumfries and Galloway Recovery College which allows people in recovery from alcohol or drug misuse to access college based learning to enhance their skills and knowledge base and thus increase their future employment prospects. Resources are also allocated to a number of region-wide gardening and other agricultural projects, which both help regenerate run down areas of land and increase service user skills and employability.

We will support the development of volunteering across the region and will develop an understanding of Dumfries and Galloway's Social Capital. This is a key action highlighted in the Single Outcome Agreement for Dumfries and Galloway 2013 - 2016.

Whilst resources allow NHS Dumfries and Galloway will continue to implement the Healthy Working Lives Programme, which aims to help employers create a safer, healthier and more motivated workforce, this in turn will lead to greater efficiency and increased productivity, while at the same time reducing inequalities.

There will be a increased focus on supporting SME's and targeted work aimed at lower paid workers and employees who have a caring role. We will continue to build upon our existing partnerships to promote and deliver the Healthy Working Lives agenda.

In relation to welfare reform the Board will work with National and local partners to deliver actions which mitigate the impact of welfare reform on health and NHS services and support the achievement of outcomes highlighted in the Scottish Government Welfare Reform Outcome Focussed Plan (2013). Such actions will include:

- Supporting a multi-agency approach to ensuring all front-line staff have a key understanding of welfare reform changes and how these may impact on patients and the wider community
- Working closely with CPP's to ensure that consistent messages are communicated to the public in relation to welfare reform
- Working with Citizens Advice Service and local GP's to extend the provision of welfare advice in General Practice settings
- Working with Citizens Advice Service to provide welfare reform updates and learning opportunities to GP Practice staff
- Recognising and supporting NHS employees who may be impacted by welfare reform changes

The Board will, where possible, seek to utilise local contractors in the development and build of the new Dumfries and Galloway Royal Infirmary. In addition, the Board, where possible within national procurement requirements, will seek to procure supplies and services from local businesses. We will, in partnership with our CPP's,

work with the Food for Life initiative to develop a sustainable approach to food supplies and purchasing.

The Board will continue to contribute to the development of the D&G Financial Inclusion Strategy and Action Plan.

Current and Planned Performance Levels

[no data]

4. Employment

The Alcohol and Drugs Partnership Assists service users to manage their alcohol or drug misuse to improve their chances of finding employment or remaining employed. Resources are allocated to Third Sector partners to provide volunteering, work preparation or work experience opportunities to prepare and enable service users to gain experiences which prepare them for employment. The Board will continue to take an active role in the work of the local Employability Partnership. This will include promoting the links between good work and health.

The Board will continue to support the local Employability Pipeline in the following ways:

- Developing and building upon existing programmes of work that will facilitate the return to work/and remaining in work for individuals facing health barriers e.g. the Working Health Services Fit for Work Service provides support for employees from SME's who have no access to OH&S provision. This provision includes access to physiotherapy and CBT interventions. The key focus is on early intervention.

- The Board provides Occupational Health and Safety services to a number of local organisations, promoting health and safety and good workplace mental health and wellbeing.
- The Board will continue to promote the characteristics of good work through procurement requirements within supply chains. For example, ensuring contractors adhere to equality guidance and legislation.
- The Board will continue to provide a volunteering programme and work experience opportunities to enable individuals to gain experience and prepare for employment, this could be through programmes such as Building Healthy Communities or direct work experience within the NHS.

- The Board will continue to strive towards being an 'exemplar employer' through providing good job and work opportunities. This will take into consideration the needs of individuals with complex employment needs.

- The Board will continue to develop its work in relation to the needs of carers. This includes supporting workplaces to understand the needs of carers and develop policies which recognise and support the needs of carers. This action is

included within the Single Outcome Agreement for Dumfries and Galloway 2013 - 2016.

- The Board will support Carers Scotland and the Scottish Government to develop and implement the Employers Carers Kitemark.

- Employees who have a carer's role will also be supported to improve their resilience and mental health and wellbeing through being offered Keep Well Health checks and support. This action is included within the Single Outcome Agreement for Dumfries and Galloway 2013 - 2016.

- The Board continues to work to provide opportunities for younger people (16-24). We consider wider opportunities which we can offer younger people including Modern Apprenticeships, Work Experience and Work Placements. We are also working closely with our Local Authority colleagues to consider additional opportunities and have a jointly funded post to assist with Work Placements. Work will continue to explore further opportunities over the coming months.

The Board will recognise and continue to support the equality and diversity agenda through its employability actions.

Current and Planned Performance Levels

[no data]

5. Early Years and Early Intervention

Maternity services contribute to the H4 HEAT Standard by ensuring that every pregnant women is given a screening for their alcohol use (and thereafter an Alcohol Brief Intervention if necessary), at first booking appointment. All pregnant women are offered CO monitoring at booking appointment and all women who smoke are referred to Smoking Cessation services (this is an opt out service). There is a national tailored package of care being introduced for women who continue to smoke during pregnancy (this work is part of the Maternity and ChIldren Quality improvement Collaborative). Working with partners in social work, a special clinic is held weekly for those prospective parents identified as having an alcohol or drug-related problem and coordinated service inputs agreed and delivered pre-birth as necessary.

Alcohol and Drug Partnership resources are invested in an early intervention Family Support Project covering two thirds of Dumfries and Galloway, with plans to develop regionwide in 2014-15. This service works with children who have a drug or alcohol misusing parent and focuses on parenting skills; healthy diet; school attendance and the development of socialisation and social skills.

The Alcohol and Drug Partnership also invests in the regionwide CAMHS service which offers services to children and young people who are affected either by their own alcohol or drug misuse or that of others, normally their parents. Both of the above services operate an open access model and potential service users are

subject to monitoring of waiting times as under the A11 HEAT Target and will access services as guaranteed by this target.

The GIRFEC Plan is in place with six priorities: Keeping children safe; Early intervention; Early years; Transition; health; Managing risk and responding to crisis. The GIRFEC Plan is where the vision for integrated working is put into practice. It contains actions that belong to all partner agencies involved and can only be carried out through joint working.

The GIRFEC Strategy Group is in the progress of updating the action plan and this will involve the views of recipients of services as well as that of providers In addition to the actions noted in the priority areas for the plan, work is underway across the partnership to embed practice and systems for the national programme for Getting it Right for Every Child which ensures that the health and wellbeing needs of all children, young and their families are being met. To achieve this, systems across all services are being reviewed alongside a programme of capacity building for staff working with families. The actions in the GIRFEC Plan will ensure that the most vulnerable children in the region have a good start in life and are prepared for adulthood

Since the national Early Years Collaborative was established, a programme of work has progressed locally which is supported by a leadership group. Through the application of improvement methodology, staff across agencies are working together to implement 'tests of change' aimed at improving outcomes for all children in the early years. The nationally set stretched aims are therefore being progressed locally and colleagues from D&G have attended all of the national events.

Current and Planned Performance Levels

- H3 HEAT Target – Health Weight of Children
- H11 HEAT Target – Early Access to Antenatal Services
- % of mothers recorded at booking as screened for alcohol use in the last three months
- % of mothers identified at booking as drinking 1 or more units of alcohol a week in the last three months
- Number of alcohol brief interventions carried out in maternity setting

6. Safer and Stronger Communities and Offending

The Board is working closely with Criminal Justice Social Work to look at improving the health and well being of community managed offenders. Research indicates that good mental well being has associations with reduced criminal behaviour and risk taking behaviour. A one year pilot project has been implemented where community managed offenders are offered a Keep Well Health Check and subsequent Health Coaching working with those individuals with a community payback order to improve mental health and wellbeing, resilience and coping skills and to support access to other health related interventions.

Work is being progressed to consider and develop a local response to the Suicide Prevention Strategy 2013-16 recently released by the Scottish Government, However, work continues with a range of partners and agencies on the suicide prevention agenda to improve the safety of vulnerable adults. This includes the provision of suicide prevention training, awareness raising and developing interventions for those classified in high risk groups.

NHS Dumfries and Galloway leads a multi-agency Alcohol Licensing Information Group that developed evidence- based advice and guidance for the Local Authority Licensing Boards' policy development, with particular reference to over-provision. This included health, police and service-based information at intermediate data zone level. This led to the Licensing Boards being provided with detailed information to help inform their licensing decisions.

Counselling services are being delivered to alcohol or drug users regionwide, including in HMP Dumfries as part of the reducing reoffending initiative. NHS Dumfries and Galloway now has management and delivery responsibilities for health services in HMP Dumfries and in Police custody suites and thus the opportunity to deliver Alcohol Brief Interventions is greatly enhanced.

NHS Dumfries and Galloway has a strong representation on the Alcohol and Drugs Partnership, which is chaired by the Director of Public Health. This enables a strong health focus on alcohol and drug issues in the region.

Current and Planned Performance Levels

[no data]

7. Health Inequalities and Physical Activity

We will continue to work with partners to ensure delivery of the indicators in our Physical activity index tool (PHIT). This is an index of key actions required to help realise our ambitions of increasing the number of people (adults and children) achieving the minimum recommended levels of physical activity, and provide a self assessment measure of the work going on to progress these actions. The tool was developed by a multi-agency strategic group set up through the community planning process to oversee implementation of Dumfries and Galloway's Physical Activity Strategy, and it is this tool which now represents physical activity progress in our SOA.

The PHIT rescoring will be completed in February/March 2013 regionally and through locality groups. As the indicator is due to end in March 2014, it is envisaged that the Physical Activity Alliance will take forward a refreshed action.

A 'test of change' social prescribing project between two GP Practices and local community resources to tackle health inequalities and improve health and well being outcomes has been developed with a range of partners and is now in early stages of implementation. This includes access to a variety of opportunities and activities

including art, physical activity and volunteering and advice and support on employment and financial issues.

The Health Board is undertaking a capacity building project which aims to increase:

- Physical activity levels of vulnerable adults and older people by building capacity of staff.
- Let's Motivate staff training developed and delivered. (Let's Motivate roll out across Localities ongoing).
- A women and girls physical activity project in one of our most deprived areas. The project has been completed with a final evaluation received.
- A mental health and physical activity inclusivity project which aims to reduce barriers to physical activity for people with mental health issues In agreement with partners,
- Mental Health Inclusivity programmes will now commence in mid to late 2014.

A key programme of work this year will be to increase through roll out of training, the capacity of staff in acute and secondary care settings to give brief advice on physical activity to those patients not meeting current guidelines. A total of 193 staff have attended Raising the Issue of Physical Activity Training including over 100 Allied Health Professionals. Training has also included staff at Mid Park hospital with future sessions to be delivered with Maternity Services and other staff groups.

We will continue to work with our key partners to deliver the aspirations of the DG Commonwealth Legacy plan.

In terms of reducing health inequalities within the prison and police custody environment we will:

- Aim to empower and inspire prisoners to make positive informed choices that can improve their lives, good health is a part of that lifestyle choice
- Work with Scottish Prison Service and 3rd sector agencies to formulate and implement a Health Promotion Framework that addresses the 11 key elements set out in *Better health, better live for prisoners*. The aim of this framework is to achieve a better and healthier life for prisoners, their families and communities
- Work in partnership with Prison Health Staff to provide a person centred, holistic Keep Well service.

Current and Planned Performance Levels

15% increase in overall PHIT score by 31 March 2014

- % change at March 2012 = 13.8%
- % change at March 2013 = 6.8%
- Cumulative % change at March 2013 = 21.5%

8. Older People

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

The programme 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.

In support of our ambitions under both this change programme and our ambitions toward Adult Health and Social Care Integration, work has been undertaken on the Integrated Resource Framework and through our Joint Efficiencies work to have deeper understanding of how the whole resource across health and social care can be maximised in support of our change plans.

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.

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. An eighteen month pilot project is being implemented where carers (aged 16 plus) are offered a Keep Well Health Check and Health Coaching. Enabling carers to be supported and recognised as key partners in service delivery and supporting carers to continue in their caring role through maintaining their health, wellbeing and contribution to their communities is critical.

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

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

Current and Planned Performance Levels

[no data]

2020 Local Delivery Plan

Section Three:
Strategic Assessment of Primary Care 2014-15

Contents

1. Introduction

Dumfries and Galloway has a population of just over 150,000 spread over a large rural area with only two towns with a population above 10,000. The area is served by 34 practices of varying size, with one single handed practice, and a number of other small practices in the rural areas. There are 15 dispensing practices and a network of pharmacists that provide adequate dispensing services. Expansion of General dental services in the area has led to the development of a service with good capacity, and there is no difficulty in accessing a dental practice (Consequently we are reviewing and downsizing our salaried dental service). While there has been some Board contact with local optometrists this has been limited and optometrists in D&G do not carry out extended roles – though this is being reviewed with an aim to support secondary care and reduce travel.

The region has 8 community hospitals run by GPs: A new contract has been negotiated to ensure high standards of care, and a single doctor responsibility for each hospital. Strategically we recognise the need to enhance the provision of treatment within Community Hospitals to reduce reliance on secondary care services.

Secondary care is provided from the Royal Infirmary in Dumfries and the Galloway Community Hospital in Stranraer. Staffing of the Galloway Hospital is by GP trained doctors, with input from some local GPs for the A&E and ward services.

The Out of Hours service is delivered from beside the A&E departments in Dumfries and Stranraer, and there is good collaboration between A&E and OOHs.

The Board has taken over the Prison Health Service and has introduced a number of improvements. Recently the Board has also begun to provide healthcare and FME services to the police for persons in custody.

The Management Structure within D&G consists of the Executive Management Team, with Hospital, Primary Care and Mental Health Management Teams chaired by our Chief Operating Officer, and reporting to the Management Team. The Primary & Community Care Management Team has responsibility for developing Primary Care. The presence of two executive directors at both primary care and secondary care management teams means better connection across the interface.

NHS Dumfries & Galloway is coterminous with the local authority and has good working relationships with the Social Work Department, and the Education Department. While the over-arching structures of integration between health and social work are still being developed, there is universal enthusiasm for the return to a 4 locality model with local management and accountability for all primary care and social work services, as well as a responsibility for health improvement activity.

We have experimented with the co-location of district nursing, social work community AHP services and third sector providers in the Dumfries “Hub” and recognise the advantages, but need to consider how this may closer connect with general practice to ensure good communication.

There are Community Mental Health Teams for older mental health, adult mental health, and for Learning Difficulty. They have close connections with General Practice and act as a liaison service between primary and secondary care.

We have managed clinical networks in Cardiology, Diabetes, Respiratory Medicine and Palliative Care: They have helped standardise standards of care, and to shift the balance of care to the community.

The Area Drug and Therapeutics Committee provides strong leadership to primary care via a network of prescribing support pharmacists, and with GPs has managed a very significant improvement in effective and cost-effective prescribing over the last 5 years.

2. Service Planning

Strengths

- Effective primary & Community Care Management Team – with 2 executive directors, managers, planners GPs, nurses, social workers and public health practitioners
- Financial stability having achieved CRES targets over last 4 years
- Co-terminus with social work department
- We have developed a Clinical Services Change Strategy to support the new hospital and reduce admissions, and have allied this work to the Change programme developed from the Change Fund resource.

Barriers to Future Vision

- GPs less engaged since loss of locality management structure – so reverting to 4 locality management structure, with integration of social work teams
- GP recruitment an issue – for practices & OOHs service: Enhanced retention of new GPVTS graduates in local area with multiple hospital/practice posts developed.
- Challenges of resource shifting due to financial pressures and development of new DGH
- Challenge of recruitment difficulties to care worker posts

Local Interventions:

Increased Mental Health Crisis& Assessment Team availability – now 24/7 area wide	£140,000
Enhanced Community Rehab Team, Annandale & Eskdale	£160,000
Referrals Management Advisor covering Referrals & Admissions	£20,000
Anticipatory Care Planning Investment	£175,000
Falls Prevention Programme	£73,000

Resource Shift Identified

See appendix A

3. Interfaces and Integration

Current Strengths

We have good relationships between social work and primary care with some co-location in practices and in the Dumfries hub. Recognising current pressures within Social Work the Board has transferred an extra £1,819,000 to support Social Work services to support early discharge and maintaining patients at home.

The interface between primary and secondary care will be improved by the Clinical Services Change Strategy and issues reduced by the development of improved IT connections as we develop an electronic case note system within secondary care. Practices work collaboratively and the Practice Manager monthly meeting ensures joint working and raises standards. There are some examples of practices sharing premises, and some practices share practice managers. The interface between social work and primary care works well at an operational level, with some co-location: we believe that this will be further improved by the locality structure for health and social care.

We have excellent support from a number of voluntary agencies – eg Hale & Hearty Cardiac Rehab, Breathe Easy, Pain Association Scotland, Attack Arthritis etc – all of whom provide on-going support in self-management

Current Barriers

- Recruitment of care workers, GPs, OOHs doctors and Health Visitors particularly.
- Lack of locality structure (planned for as part of integration process

Proposed Interventions

- Joint health and social work management in localities
- Development of devolved shared budgets to localities, with greater involvement in management of practice teams, local community services, Social Work teams and the Third sector.

Resource Shift Identified

See appendix A

4. Infrastructure

Current Service strengths

We have almost completed a programme over several years of improving primary care premises, with only 4 practice facilities outstanding for development. (2 underway at present) We have aided the development of dental practices, with improved compliance against disabled access and infection control standards. Community services premises require further development, but improvements have been made with some co-location with social work and practices.

We have strengths in IT infrastructure, with all but one practice using EMIS web (allowing Board wide audit and data collection), and a number of initiatives in district nursing, including the use of ePens. N3 connectivity with dentists, optometrists and pharmacists has been achieved, and there are connections to the prison and the police custody suite. Good information sharing protocols have been developed between health and social care

Current Barriers

There is a need to further develop 2 general practices (plans in development), and a need to improve community and social work services co-location with practice teams. All bar one of our community hospitals require substantial redevelopment and backlog maintenance. There is also a need to draw engagement from general practices in local design of services, which we believe will occur with the re-development of a locality structure and devolved shared budgets.

Proposed local interventions

In terms of management structure, the main driver for change will be the Clinical Services Change Strategy, further understanding of the Integrated Resource Framework, local devolution of joint budgets and local accountability. Plans are progressing for redevelopment of premises where required, with the exception of community hospitals where no capital resource has been identified.

Necessary resource shift identified

Currently the resources required for delivery of integrated services across Health and Social Work are not clear. There is a view that Adult Social Work is currently under-resourced and the total size of combined budgets is not clear. It is also not clear to what degree joint working will result in overall efficiencies – if indeed any given the increasing older age group in our local population.

Planned investment shown in Appendix A

5. Workforce

Current Service Strengths

- NHS D&G has traditionally had a stable workforce with low turnover
- The standard of General Practice is particularly high – especially in the rural areas
- Excellent working relationships with Social Workers
- Shortage of dentists now solved.

Current Barriers

- Looming recruitment challenges in General Practice, Health Visiting, Care workers

- GP OOHs service particularly challenged to recruit & fill shifts
- Recruitment to Health Visitor posts has been extremely difficult, so we are arranging a programme of local training to ensure that we can supply staff to this essential and high priority workforce.

Proposed local interventions

Improve productivity – e.g. Following the Productive Community Nurse programme, use of ePens, geographical area working, scrutinise need for reviews, increased use of tele-monitoring

Necessary Resource Shift

See appendix A

6. General Practice

Recruitment to Health Visitor posts has been extremely difficult, so we are arranging a programme of local training to ensure that we can supply staff to this essential and high priority workforce. Dental recruitment, and dental nurse recruitment does not seem to be a problem anymore, although there have been occasional concerns regarding the clinical skills/behaviours of some of the dentists.

Proposed local interventions

We plan to change formal practice visits so that they move away from sometimes narrow conversations about contract monitoring to understand broader staffing issues, and to help understand what extra resource would be needed to make a step change in service provision for each practice. Within community teams, nurse managers are reviewing the possibilities of changed skill mix and geographic area working, along with issues like ePens and clinical recording changes.

Necessary Resource Shift:

At present this is not clear: It is increasingly difficult in a constrained financial envelop, and in a world of increasing demands from politicians and the public for more and faster acute services, to identify recurrent resources to transfer from secondary to primary & community care, including social work. We are hopeful that integration will allow some efficiencies to be delivered on in communities, and that changes to the national GMS contract will also help allow extra capacity there.

7. Leadership

Current Service Strengths

- Within each of the 4 localities we have GP clinical leads who have been in post for some time.
- Moving to support this by move to locality structure, so triad of manager, lead GP and nurse manager in each locality
- We have a Dental Practice Advisor in post, who works closely with the Clinical Director of Primary Care Dentistry and a consultant in Dental Public Health. These three individuals have set up an effective process to ensure standards of dentistry throughout the region.
- Within the nursing structures in community hospitals, the advent of "Releasing Time to Care" allows senior staff to have a more effective leadership role.

Current Barriers:

- Lack of locality structure reduces visibility of leaders/managers

Proposed local interventions

- The development of locality structures will enhance clinical leadership – the new structures will give clinical leaders greater focus on a smaller area, a greater visibility to local clinicians and will prompt reviews of objectives in line with local priorities.

8. Data and Improvement

Current Strengths

The in-house Health Intelligence department produces high quality data and analysis across Health, and will soon join with social work to give more complete data across all of primary and community care. Practices are well used to comparative data (with regards to prescribing, referrals, admissions, lab investigations etc) and understand, following the Primary Care Patient Safety Roll-out, the principles of Improvement work.

Data on resource usage across localities is now available allowing us to benchmark and understand differences – an essential pre-requisite to efficiency and effectiveness improvement.

The use of data to drive change and improvement is also well known to our community hospitals and nursing teams where the patient safety programme has led to an understanding of data for improvement – not just in safety, but in many other aspects of improving services.

Current Barriers

We are concerned that the data collection and performance management systems in social services may be a lot weaker than within health and this may lead to challenges in understanding what resources are used where and to what benefit.

Proposed Local Interventions

We are planning the integration of social work and health information analysts to ensure that we have enough information to understand how we can reduce duplication, improve services and deliver in an equitable manner.
Resource Shift: We do not feel that this will require significant extra resource – more collaborative working to achieve a better understanding of total resources used.

9. What support is required at a national level?

We believe that the re-negotiation of the GMS contract has been a helpful first step in this respect, and we look forward to further output from the national Primary Care Strategy Group. Ultimately however Boards face considerable pressure as a result of a performance management system that is heavily geared towards secondary care service targets – if this changes to a greater emphasis on primary care performance management, then it will be easier for Boards to shift resource in terms of money and time & effort to primary care. The performance management arrangements for integrated organisations will require to be thought through carefully.

Appendix A

Investment in Primary and Community Care: NHS Dumfries & Galloway - 2013/14 and 2014/15		
Capital Investments:	**Investment**	**Notes**
Dunscore Health Centre New Build:	£1,400,000	Complete 2014
Dalbeattie Health Centre New Build:	£1,800,000	Complete 2014
Kirkcudbright Health Centred (planned)	£1,900,000	Via community group/big lottery funding
Moffat Health Centre	TBC	Proposals being w orked up
Sub Total	**£5,100,000**	
Revenue Investments:		
General Practice:		
New Community Hospital Medical Contract	£50,000	
Transforming Care after (Cancer) Treatment	£25,000	
Patient Safety in Primary Care	£140,000	
Prescribing LES to support effective GP presecribing	£180,000	
Prescribing Support Team Pharamcists expansion	£80,000	
Sub Total	**£475,000**	
Mental Health including Dementia/EMI		
Redeployment of Annan Hospital team to Enhanced Community Rehab Team	TBC	
Extension of community Crisis and Assessment Mental Health Team to 24/7 working	TBC	
Others:		
Telehealthcare in Primary and Community Care	£543,000	(Covers remote monitoring pilots, teleclinics, tele-rehab etc)
New Enhanced Falls Programme	£78,000	
Partnership Appraoch to basic foot care	£90,000	
New Physio & OT service delivery project	£105,000	
Developing Dumfries Health & Social Care co-location hub	£646,000	
Anticipatory Care Planning	£175,000	
Social Work Review Team	£300,000	
Social Work integration with Short Team Augmented Response Team	£285,000	
Enhanced sensory community care for advanced dementia	£35,000	
Community OT investment	£50,000	
Training support for home care workers/care assistants	£106,000	
Third Sector Single Point of Contact	£57,000	
Third Sector Posts	£120,000	
Support Services for Hard of Hearing	£86,000	
Specilaised tyraining & support for care of dementia	£240,000	
Acute Care in the Home Project	£500,000	
ePens. EMIS web and other It developments	£100,000	
Increased Resource Treansfer to Council to support Care Packages	£1,819,000	
Sub Total	**£5,335,000**	
Grand Total	**£10,910,000**	

2020 Local Delivery Plan

Section Four:
HEAT Target Trajectories 2014-15

Contents

1. Introduction

Last year's Local Delivery Plans included HEAT Risk Management Plans providing contextual information on key risks to the delivery of each existing HEAT target and how these risks are being managed. The Board will continue to manage these risks and have on-going dialogue with the Scottish Government as appropriate.

The Board also set out planned performance against each existing HEAT target allowing both internal and external reporting and tracking of actual operational performance against our plans. The delivery trajectories therefore provide an objective, factual basis to allow a dialogue between the Board and Scottish Government regarding any operational performance issues that may arise during the plan period and to discuss any support required to achieve improvement as required.

The Scottish Government Directorate for Health Workforce & Performance will continue to support Boards in benchmarking their performance, and will work on spreading good practice associated with improving performance.

NHS Boards are required to re-submit only the delivery trajectories for existing HEAT targets which have proposed changes from last year. NHS Boards are not required to submit Risk Management Plans, but should continue to maintain these locally and continue the dialogue with Scottish Government target leads.

The Scottish Government will continue to monitor the HEAT standards, NHS Boards are not required to provide delivery trajectories and risk narratives. Performance against HEAT standards is reported through the Scotland Performs website. For 2014/15 there are no changes to the HEAT standards.

2. HEAT Trajectories 2014-15 – No proposed changes

Detect Cancer Early

Proportion of Colorectal, Lung and Breast Cancer Patients Diagnosed at First Stage of Disease	**Dumfries & Galloway**
2010/2011	**19.1%**
2013/2014	24.0%
2014/2015	29.0%
Notes:	
1. Data based on sets of 2 calendar years.	
2. Performance in 2014/2015 should be at least 29%	

Early Access to Antenatal Services

Percentage of Pregnant Women Booked for Antenatal Care by 12th Week of Gestation in the worst performing quintile	Dumfries & Galloway
2010/11	**83.8%**
2011/12	**81.5%**
Apr-Jun 14	83.5%
Jul-Sep 14	83.5%
Oct-Dec 14	83.5%
Jan-Mar 15	83.5%

Notes:
1. Boards submitted 3-year trajectories for number of interventions in the 2012/13 LDPs. These are provided in the table above (along with any amendments since then).
2. Performance in Jan-Mar 2015 should be at least 80%

Reduce Carbon Emissions

Year	Dumfries & Galloway
2009/10	**5,875**
2012/13	**4,600**
2013/14	5,201
2014/15	5,044

Notes:
1. Values are in tonnes of CO2
2. Information for 2009/10 (baseline) and published data for 2012/13 is included in table
3. For future years, the baseline amounts may be revised to account for site closures/openings or weather correction. Trajectories have been based on the current baseline amounts. Actual targets may vary.

Reduce Energy Consumption

Year	Dumfries & Galloway
2009/10	**183,151**
2012/13	**160,142**
2013/14	162,144
2014/15	157,272

Notes:
1. Values are in GJ.
2. Information for 2009/10 (baseline) and published data for 2012/13 is included in table
3. For future years, the baseline amounts may be revised to account for site closures/openings or weather correction. Trajectories have been based on the current baseline amounts. Actual targets may vary.

Faster Access to CAMHS

Patients who started treatment within 18 weeks of referral: Quarter of Treatment	Dumfries & Galloway
Jul-Sep 13	**97.6%**
Apr-Jun 14	100.0%
Jul-Sep 14	100.0%
Oct-Dec 14	100.0%
Jan-Mar 15	90.0%
1. Percentage of patients who started treatment within 18 weeks of referral	
2. Based on Patients seen during each quarter (Adjusted)	

Faster Access to Psychological Therapies

Patients who started treatment within 18 weeks of referral: Quarter of Treatment	Dumfries & Galloway
Jul-Sep 13	**84.0%**
Apr-Jun 14	86.7%
Jul-Sep 14	87.9%
Oct-Dec 14	89.1%
Jan-Mar 15	90.0%
Notes:	
1. Percentage of patients who started treatment within 18 weeks of referral	
2. Based on Patients seen during each quarter (Adjusted)	

3. HEAT Trajectories 2014-15 - Proposed changes

Smoking Cessation

No current trajectory was shown in the file sent out by Scottish Government, therefore a trajectory to achieve the 2014-15 level of target quits has been proposed below:

Smoking Cessation (SIMD)

Cumulative total	Dumfries & Galloway
Apr 14 - Jun 14	88
Apr 14 - Sep 14	88
Apr 14 - Dec 14	89
Apr 14 - Mar 15	**353**

Notes:
1. Number of successful quits at 12 weeks post quit in the 40% most deprived within-board SIMD areas i.e the bottom two local SIMD quintilesover the 1 year ending March 2015.

14 Days Delayed Discharge

A revised trajectory has been proposed taking into account the baseline position at October 2013 and where we are required to get to by April 2015

Census Night	Dumfries & Galloway
Oct-13	**10**
Apr-14	10
Jul-14	8
Oct-14	6
Jan-15	4
Apr-15	0

Notes:

1. Number of NHS Delayed Discharges above 14 Days (2 Weeks)
2. Census night in October 2013 is included in the table

Reduction in Emergency Bed Days for patients aged 75+

The Board agreed an original trajectory with Scottish Government modelled on a 0.56% incremental decrease in rate from Apr 2012 (20% by Mar 2015). Performance in 2012-13, out-stripped the original trajectory and we were asked to consider a more challenging trajectory beyond the standard 20% trajectory for 2013-14. A revised trajectory was agreed in January 2013, modelled on 0.3% incremental decrease in rate from Sep-2012 (24% by Mar 2015).

However, in 2013-14, the reduction in emergency bed days rate has not fallen in line with this revised trajectory and we now propose another revision calculated in January 2014 and modelled on a 0.4% incremental decrease in rate from July 2013, (a return to the original 20% by March 2015). It is felt that this is a more realistic target in terms of current performance but also recognising a number of planned initiatives in between now and March 2015 which should positively impact on our over 75 emergency bed day rate.

The proposed trajectory is shown below:

Year Ending	Dumfries & Galloway
Mar-10	**5,314**
Mar-11	**5,254**
Mar-12	**4,637**
Mar-13	**4,458**
Apr-14	4,479
May-14	4,460
Jun-14	4,441
Jul-14	4,423
Aug-14	4,404
Sep-14	4,386
Oct-14	4,367
Nov-14	4,348
Dec-14	4,330
Jan-15	4,311
Feb-15	4,293
Mar-15	4,274

Notes:

1. Boards submitted 3-year trajectories for emergency bed days in the 2012/13 LDPs. These are provided in the table above (along with any amendments since then).
2. The data are the number of emergency bed days in a year per 1,000 population
3. Boards have access to more recent performance management information

MRSA/MSSA Bacterium

A revised trajectory has been proposed taking into account the baseline position at June 2013 and where we are required to get to by March 2015

Year Ending	Dumfries & Galloway
Jun-13	**0.29**
Jun-14	0.28
Sep-14	0.27
Dec-14	0.25
Mar-15	0.24

Notes:

1. Boards are expected to achieve a rate of 0.24 cases per 1,000 acute occupied bed days or lower by year ending March 2015. Boards currently with a rate of less than 0.24 are expected to at least maintain this, as reflected in their trajectories.
2. Boards will be held to account against the 0.24 rate.
3. Information for year ending June 2013 is included in the table

Clostridium Difficile Infections

Again, a revised trajectory has been proposed taking into account the baseline position at June 2013 and where we are required to get to by March 2015

Year Ending	Dumfries & Galloway
Jun-13	**0.45**
Jun-14	0.41
Sep-14	0.38
Dec-14	0.34
Mar-15	0.32

Notes:

1. Boards are expected to achieve a rate of 0.32 cases per 1,000 occupied bed days by year ending March 2015. This relates to people aged 15 and over. Boards currently with a rate of less than 0.32 are expected to at least maintain this, as reflected in their trajectories.
2. Boards will be held to account against the 0.32 rate.
3. Information for year ending June 2013 is included in the table
4. Based on C Difficile Infection (CDI) data from Health Protection Scotland

2020 Local Delivery Plan

Section Five:
Workforce Plan 2014-15

Contents

1. Introduction

As outlined in section 1 of our Improvement and Co-Production Plan, NHS Dumfries & Galloway continue to develop plans to deliver change and improvements in respect of the 5 priorities for action within the 2020 Vision.

Integral to that will be continued use of the Nursing & Midwifery Workload tools to support robust decision workforce planning.

2. Use of Workload Tools

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

2.1 Adult Inpatient & Professional Judgement Tool

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

The findings from the most recent application (November 2013) are being compared to past applications, triangulated and reviewed against increase in activity/occupancy levels. This work will have been completed by March 2014 and will inform changes to our current staffing level and workforce projections for 2014/15. This detailed process will then be utilised to inform the necessary staffing levels for our new Models of Care and our New Hospital during 2014/15.

2.2 Small Wards

The small wards tool has been utilised within our palliative care facility and is currently being piloted in one of our Cottage Hospitals. It is anticipated that this will be rolled out to all our Cottage Hospitals and will inform future safe staffing levels for our Models of Care to shift the balance of care within 2014/15.

2.3 Emergency Department

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

2.4 Clinical Nurse Specialist (CNS)

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

2.5 Community Nursing Benchmarking Tool

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

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

2.6 Women & Children's

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

2.7 Mental Health

A substantial amount of workforce planning was undertaken to support the development of a recently opened inpatient facility in Dumfries. The workload tool for mental health will be refreshed again in 2014.

3. Workforce Projections

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