

DUMFRIES AND GALLOWAY NHS BOARD



**Agenda and notice for meeting on Monday 11 May 2009
at 1.30pm**

VENUE: Queens Hotel, Lockerbie.

**John Burns
Chief Executive**

AGENDA

1 Apologies for absence

2 Declarations of Interest

This item gives members the opportunity to declare an interest in any of the items appearing on today's agenda.

3 Minute of the Meeting held on 6 April 2009

The Board is asked to approve the Minute of the meeting held on 6 April 2009.

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4 Matters Arising

5 Patient Safety

The patient safety programme continues to spread through NHS Dumfries and Galloway and this paper provides the regular progress report.

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6 Patient Experience: Reporting Period – March 2009

This paper reports information gathered from the NHS Dumfries and Galloway electronic feedback system, through enquires and complaints.

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7 Infection Prevention and Control Update

This report provides an update on infection prevention and control across NHS Dumfries and Galloway.

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Reports from Committee Chairs

*Scrutiny Committee – Mr Keggans
Healthcare Governance Committee – Mrs Brash*

ITEMS OF STRATEGY

9 Clinical Services Strategy

verbal update

10 Endowment Fund Investment Strategy

The Endowment Fund paper presented to the April Board advised that the Scrutiny Committee in April would review the Endowment Fund Investment Strategy. This review has concluded and two recommendations are presented for approval.

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ITEMS OF PERFORMANCE / DELIVERY

11 Financial Performance

This paper presents to Board the financial performance to 31 March 2009.

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12 Waiting Time and Activity Report

This report summarises activity and waiting times performance as at 31 March 2009 and compares activity levels with the same period in the previous year.

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13 Review of HEAT Targets 2008 / 2009

to follow

14 NHS Dumfries and Galloway Workforce Plan 2009 / 10

This paper notes the approvals from the Staff Governance Committee to the NHS Dumfries and Galloway Workforce Headlines and the Chief Executive's endorsement of the workforce predictions subject to financial plan approvals.

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ITEMS FOR DECISION / DISCUSSION

15 Single Outcome Agreement

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16 Equality and Diversity – Delivering a Fairer Future

This paper provides contextual highlights for the Equality and Diversity horizon, a reminder of the key NHS Dumfries and Galloway Equality and Diversity activities and headlines for progressing this agenda.

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17 Board Briefing

This paper provides Members with a briefing on a range of health and partnership related issues.

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18 Any Other Competent Business

Members should notify the Board Administrator of any items of business not on the agenda that they wish to raise prior to the commencement of Board Business at 1.30 pm.

19 Date of Next Meeting

The next meeting of the NHS Board is Monday 1 June, 2009.

ITEMS FOR NOTING

20 Note of the Board Workshop held on 6 April 2009

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21 Minute of the Community Planning Joint Board held on 12 March 2009

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DUMFRIES AND GALLOWAY NHS BOARD

Minute of the meeting of Dumfries and Galloway NHS Board held on 6 April 2009.



Minute Nos: 1 - 29

Present

Mr M Keggans	Chairman
Mr J Burns	Chief Executive
Mr J Ace	Director of Health Services
Mrs H Borland	Nurse Director
Mrs H Brash	Non Executive Member
Dr A Cameron	Medical Director
Mr A Campbell	Non Executive Member
Dr D Cox	Director of Public Health
Mr E Hunter	Non Executive Member
Mr I Hyslop	Non Executive Member
Mr A Johnston	Non Executive Member
Mr D Lockhart	Employee Director
Mr C Marriott	Director of Finance
Dr R Park	Non Executive Member
Ms C Sharp	Director of HR and Workforce Strategy
Mr K Warford	Vice Chairman

Apologies

Mrs H Dykes	Non Executive Member
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Attending

Mr J Callaghan	Chair – AHP Advisory Committee
Dr A Eccleston	Consultant Paediatrician
Mr J Glover	Head of Communications
Mrs M Mack	Head Occupational Therapist (Item 22)
Mr A McCullough	Medical Director – Acute Services
Mrs J Milligan	General Manager – Child Health Services (Item 22)
Mrs B Thorpe	Head of Midwifery Services
Mrs J Wilson	Board Administrator

Chairman's Opening Remarks

The Chairman welcomed everyone to the April meeting of the Board and commended the workshop held during the morning. The press release from the Scottish Government regarding the appointment of the Independent Scrutiny Panel was noted and welcomed. The Chairmen's regular meeting with the Cabinet Secretary on Monday 30 March evolved to a summit on healthcare acquired infection involving Chairs, Chief Executive, Nurse Directors and Medical Directors.

1 Apologies

Apologies as noted above.

2 Declarations of Interest

No declarations of interest were advised.

3 Minute of the Meeting held on 2 March 2009

The minute of the meeting held on 2 March 2009 was approved as an accurate record.

4 Minute of the Meeting held on 16 March 2009

The minute of the meeting held on 16 March 2009 was approved as an accurate record.

5 Matters Arising

There were no matters arising.

6 Patient Safety

The Nurse Director presented this regular report and highlighted the work being done through the patient safety walkrounds. Since March 2007 eighty wards and clinical areas have been visited and staff in all wards and community hospitals have now participated in at least one walkround. Three hundred and ninety-two actions were agreed and of these, two hundred and thirty-five have been completed and sixty-five categorised as closed. Of the remaining ninety-two actions, twenty-two are ongoing and a further seventy are being updated. The five most frequently recurring themes were staffing, transfer of care, equipment, environment and systems of care. The focus has changed from the environment to systems and clinical areas and there has been a definite shift in attitude. The Board Management Group is currently revising the work programme for the walkrounds and is keen for these to become leadership walkrounds that are themed to maximise them. A small team of frontline staff represented NHS Dumfries and Galloway at the International Forum on Quality and Safety in Healthcare with two poster presentations and one oral presentation on the multi-disciplinary approach to medicine reconciliation. Work continues on developing a local faculty to ensure the sustainability of the

patient safety programme.

Mr Warford sought clarity on the faculty concept and what benefit it would bring.

The Nurse Director advised that a significant number of staff had been involved in patient safety from the start and were now involved in spreading the work across the region. Maternity services, mental health and primary care are interested in that work. The faculty would support maximising that expertise and marry into the clinical improvement work to build up a knowledge base that brings all this together.

Mrs Brash enquired if the walkround programme included the laboratories and this was confirmed.

The Board

- noted progress.

7 Patient Experience: Reporting Period January – February 2009

The Nurse Director presented the regular report. In the two months being reported the patient services team handled eighty-two enquiries, thirty-two of which were complaints. The remainder were enquiries and the team are working to resolve concerns, requests etc to support swifter resolution. The run chart shows the recentralisation of the way complaints are responded to. There have been significant improvements in February but there is still a lot of work to do. Volunteers have now been recruited and have completed induction. This initiative will provide real time patient feedback and will report in two / three months' time. There are no complaints with the Procurator Fiscal and there are three complaints with the Ombudsman.

The Board

- noted the report.

8 Infection Prevention and Control Update

The Nurse Director presented this paper. Members were advised that this will now be a monthly report to provide real time information and that future reports will be themed and may focus on a particular area. From an infection surveillance perspective there had been a significant period of time without any staphylococcus bacteraemia with only four in the previous two months and five months with none at all. It is six days from the last MRSA and eleven days from the last MSSA and working with the teams to understand. The Clostridium Difficile HEAT target is 40% reduction and performance against these trajectories will be given in future updates. Hand hygiene will meet national targets and the audit assessed the proportion of visitors using alcohol gel on entering wards at 80%. NHS Dumfries and Galloway has one of the highest completion rates for cleanliness champions and a conference was held at the end of March to celebrate some of their successes.

Dr Park enquired if MRSA infections were in clusters. The Nurse Director

advised that these have happened where patients are in a critical care situation and that can sometimes cause that to happen. There will be further detail in the next report.

The Medical Director commented that it was not cross infection between patients. Evidence suggests that when patients get infection there are often patient reasons, for example immuno-suppression or multiple medications. There is nothing to suggest environmental causes as these have not occurred in the same ward at the same time. There is a trend of more cases in winter as there are more sick people with multiple conditions in hospital.

The Chief Executive reminded Board Members of the Inspectorate coming into place. The post of chief inspector is being advertised and there will be both announced and unannounced visits looking at the wider environmental issues. There are over six hundred cleanliness champions in Dumfries and Galloway and at the recent event the enthusiasm and interest amongst these champions was very encouraging.

The Board

- noted the update.

9 Reports from Committee Chairs

Healthcare Governance Committee

Mrs Brash reported on the Healthcare Governance Committee meeting held on 25 March. The theme of the meeting was infection control and as well as the usual standing items the Committee received the infection control surveillance update report, the hand hygiene compliance update report, education and cleanliness champions, the infection control workplan for the past year and the draft plan for 2009 / 10 and a report on progress against the Scottish Government HAI action plan. Internal reports received were the health records management code of practice and an update on clinical recording, the final draft of the unacceptable actions policy, the Quality Improvement Framework and the corporate risk register risk review. An update on the Forensic Services West of Scotland Clinical Governance Group was also received and reports for noting were the NHS QiS operational protocol and the minutes of the Quality Improvement Working Group and the Infection Control Committee.

Scrutiny Committee

Mr Keggans reported on the Scrutiny Committee meeting held on 24 March and advised Members that the three main issues discussed were on today's agenda. The Committee received a presentation from the endowment fund advisers which resulted in a refreshed strategy coming to Board. The other two substantive items were the five year financial plan and the ten year capital plan, again both of which are on the agenda today.

Audit Committee

Mr Hunter reported on the Audit Committee meeting held on 27 March. The

Committee received two Audit Scotland reports and the key messages report was highlighted to Members. Committee also received a report from Internal Audit, their 2009/10 workplan and an update on the fraud risk register. Fraud and counter fraud will have a higher profile in the Scottish Government and the changes to accounting standards are part of that. The internal interim management report from KPMG for year ending March 2009 was also received with some helpful recommendations.

The Chief Executive advised Members that Audit Scotland Reports are taken to the Board Management Group and a director is identified to take leadership in terms of actions which will then be reported to the appropriate committee.

Staff Governance Committee

Mr Campbell reported on the staff Governance Committee held during the morning. The meeting covered a wide agenda including the workforce response to 'Better Health, Better Care'. A detailed paper on the results of the staff survey was received as was an action plan put in place to meet shortfalls in HR.net. An accident reduction strategy was received with particular focus on violence and aggression. The Committee welcomed Caroline Fee who was able to give a valuable insight to the national agenda.

The Board

- noted the verbal reports.

10 Clinical Services Strategy

The Chief Executive presented this item and advised Members that since the meeting on 16 March he had been working with colleagues in the Scottish Government to take forward the independent scrutiny of services. The Cabinet Secretary released a press statement on Friday intimating the names of the panel members; the panel will be chaired by Professor Frank Clark, currently Convenor of the Care Commission, and the other two panel members are Professor Gordon Peterkin and Professor Jane Farmer. It is intended that the work will start this month and it is expected that the review will be complete in six weeks with the team producing a report for the Cabinet Secretary. In addition, the Scottish Health Council has been asked to assess the Board's pre consultation proposals and how the Board has taken account of local stakeholders. The Scottish Health Council has been asked to do this work as they have been involved and are well placed to take a view. The terms of reference have not yet been finalised but colleagues at the Scottish Government Health Directorate are working to finalise these with the Panel Chair. It is anticipated that the terms of reference will look at the safety and sustainability of services, the model base used taking account of a patient centred approach, best practice and the viability of the options proposed. The independent scrutiny is being done in advance of consultation and is a very positive approach prior to the consultation on the options for services in the future.

In terms of the next steps, colleagues continue with the work on the outline business case for Dumfries and Galloway Royal Infirmary. A discussion on the

consultation will be necessary following receipt of the report of the Independent Scrutiny Panel.

Mr Warford commented on the interest generated in the community and enquired if the Board would work to sustain interest in the interim. The Chief Executive confirmed that he would wish to discuss this with the Chair of the Panel in terms of what would be acceptable to ensure the Board was not seen to be either influencing or seeking to influence the work of the Independent Scrutiny Panel.

The Board

- noted the verbal update.

11 Endowment Strategy 2009 / 10

The Director of Finance presented the endowment proposals for 2009/10, the key message throughout being that expenditure is set below the level of income. Looking at the investment return, this has been consistent with the dip in the market. The Board's investment advisers have proposed a review of the strategy going forward and they have been invited to the next Scrutiny Committee. The investment strategy needs to be geared up to take advantage of any recovery in the market.

The Board

- approved the proposed budget for 2009 / 10; and
- noted the investment adviser's comments as presented to the Scrutiny Committee on 24 March.

12 Financial Performance: Eleven Months to 28 February 2009

The Director of Finance presented this item and advised that the Board was on target in terms of delivering the year end out-turn of a £4½ million carry forward. The Board is also well on track in terms of delivery of the efficiency target and colleagues continue to monitor against that. A key focus is to ensure that reserves built up are spent at year end.

The Board

- noted the financial performance to 28 February 2009.

13 Financial Plan

The Director of Finance presented the five year financial plan and advised Members that there was a requirement to produce this plan on an annual basis. There was a focus on the five year revenue plan and the ten year capital plan to ensure the two plans dovetailed. It is essential to deliver efficiencies as there is a five year timeframe to take £1m per annum to ensure monies are available to support the clinical strategy which must be affordable. Appendix 4 shows that the level of growth is not going to be sustained and further financial efficiencies may be required. Appendix 3 shows the resources available. The Board has done well to maintain that position and by 2013/14 there will be sufficient

recurrent financial reserve to fund the clinical services strategy. There are key areas of pressure moving forward and local, regional and national pressures are being taken into account. The plan will be updated on an annual basis. While there are a number of challenges, Appendix 5 demonstrates the number of developments built in. The Director of Finance advised that there are going to be challenges moving forward and a robust approach is needed, focusing on the totality of what the Board has to spend and not just new money.

Mr Johnston highlighted concerns regarding the number of unknowns, for example Agenda for Change reviews, and sought reassurance that the Board has information systems in place that support monitoring and review in time to make adjustments and not just catch up on CRES (cash releasing efficiency savings) challenges.

The Director of Finance advised Board that an Efficiency Group has been agreed with the Scrutiny Committee, that it was essential not to start double or triple counting and that responsibility sits with himself and the Finance Team. An efficiency programme has been built up for 2009/10 which will be taken back to the Scrutiny Committee. By the end of December there will be a CRES plan for 2010/11 and managers across the organisation need to take responsibility in terms of the level of savings. The Board needs to look at some of the bigger issues where we can get the benefit from non recurring investment and how we can learn from other boards and the national work that is going on. The Board is well positioned, is in recurring financial balance and is sighted on and preparing for the clinical services strategy.

The Board

- approved the five year financial plan for 2009 / 10 to 2013 / 2014.

14 2008 / 09 Capital Plan Update and Draft Ten Year Capital Plan

The Director of Finance presented this item and advised Members that a review of the ten year capital plan had been carried out to assess the affordability of the clinical strategy and other future schemes against the expected sources of funding. At the moment the amount of funding built into the clinical strategy is at a high level and within the confines of the information there is a best estimate of what capital costs will look like. The Director of Finance also advised Members that a Capital Investment Group (CIG) will be established to oversee the delivery of the capital plan and the annual achievement of the capital resource limit. The CIG will provide regular reports on progress to the Scrutiny Committee. The continued investment in IM&T and the mental health development were highlighted as commitments made and schemes progressing.

The Director of Health Services reminded Members of a previous presentation to Board and the life cost of projects; addressing design issues may have higher capital costs but produce many times the savings.

Mr Warford commented that in terms of the clinical strategy the Board will require resources from the Scottish Government. The Director of Finance advised Members that there were discussions at various levels with the Scottish

Government and that they were keen to see the outline business case going forward to their Capital Investment Group

The Board noted

- progress against the 2008 / 09 allocation;
- the anticipated receipts due over the next ten years;
- the commitments already made;
- the impact of the clinical services strategy;
- the associated revenue consequences of approving capital schemes; and
- approval to formalisation of Capital Investment Group.

15 Waiting Time and Activity Report

The Director of Health Services presented this report, concentrating on waiting times and covering the period to the end of February showing progress against the twelve week target. Draft March figures are available and are currently being checked with twelve weeks on in patient, out patient and all diagnostics other than ultrasound. It appears that the Board has hit all the main waiting time targets for the year. The cancer target for quarter three showed an unusually poor performance and draft figures for quarter four show a far superior performance which is very close to the national target, sitting around 94%. A huge amount of work has been undertaken around the pathways and quarter three looks to be out of line.

Accident and Emergency (A&E) did not quite hit 98% in January and February and March looks to be similar. The unscheduled care meetings have been reconvened to explore the reasons why the A&E pathway hasn't been as reliable as last year. The acute services have been extremely busy with normal activity elsewhere.

The Board

- noted the report.

16 Local Delivery Plan

The Director of Health Services presented this paper and advised Members that the Local Delivery Plan (LDP) had been accepted by the Scottish Government. The Clostridium Difficile target was subject to a late change and the trajectory has been recalibrated. The draft LDP has been presented to Scrutiny Committee where the more at risk trajectories were identified. Most of the health improvement targets and some of the efficiency targets will be particularly challenging. In terms of treatment quality the LDP is going to be more challenging but the baseline positions are broadly good and will be monitored closely at the Scrutiny Committee.

Mrs Brash commented on the target to reduce the suicide rate by 20% and noted this was not addressed in the narrative. The Director of Health Services advised that this used to be a straight target on suicide rates and the trajectory was used to reflect the rate. It was felt nationally that this was an unrealistic

trajectory and therefore the trajectory has been changed to train 50% of front line staff and the Board is already achieving the levels.

Mrs Brash also highlighted the 8% reduction in the smoking population and asked what the original size of the smoking population was. With regard to H8 Mrs Brash asked if there was an agreed number for cardiovascular checks.

The Director of Health Services advised that the smoking target equates to approximately seven hundred smokers. The baseline performance is about five hundred and work is underway to address this. The health inequalities target is a new target and will require further dialogue with the Scottish Government to flesh out the exact target. The Director of Public Health advised that in terms of the cardiovascular checks the figure was two hundred.

The Director of Health Services advised that there had been a quite dramatic improvement in some of the HEAT targets, for example day case rates and changes in the new to return ratio which has financial implications and financial savings when delivered. Each target is to be explored to see where savings can be generated to take out of the budget.

Dr Park highlighted A8, 48 hour access for advance booking with a trajectory of 80%. The Director of Health Services advised that the two GP targets are new and a survey is due to be undertaken.

Mr Johnston highlighted H3, the child healthy weight intervention programme. The narrative on risk notes the different approaches across the four localities. The success of the Stewartry model had been discussed previously with the possibility of rolling out a one-to-one approach and that the risk was slightly reduced.

The Director of Health Services noted the work being taken forward by the Public Health Directorate in trying to provide a unified response to this target which would put the Board in a much better place going forward, involving a number of interventions. The Director of Public Health advised that Health Scotland have not been in a position to provide Boards with guidance on how to deliver this target which is going to be challenging.

The Medical Director highlighted the reduction in the use of antidepressants which is more challenging than it appears on paper. It is suggested that the current economic position will result in more prescribing but the Board is recommending not using antidepressants in stressful situations caused by life circumstances.

The Board

- agreed to formally adopt the Local Delivery Plan for 2009 / 10.

17 Review of Health Service's Performance in Winter 2008 / 09

The Director of Health Services presented this item which starts the process of informing next year's winter plan. In the last few months A&E has experienced difficulty in achieving the four hour target and can identify some of the reasons

with their activity. There was a significant surge in activity in January but this was not reflected in December or February. Emergency admissions were quite exceptional over the winter and January was the busiest month ever. Occupancy figures don't reflect the position; the surge of activity is when staff are trying to admit and discharge patients. The system coped as it maintained a relatively low average length of stay. As the business increases discharge of patients tends to worsen. In January staff managed to keep the length of stay relatively low and that supported the system. Less important, but very useful, was the day case rates being significantly higher than a year ago. The biggest single factor is the pre-assessment unit and this is keeping elective patients out of hospital beds and streaming through the day case unit. In terms of beds, Dumfries and Galloway Royal Infirmary ran this winter five beds lower due to shower upgrades and other works. Sickness absence rates were also lower this winter. Through the winter the service has managed to step under last year's position which gave extra staff, making a huge difference in wards and clinical environments. Next steps are to marry this data with much more qualitative data and with financial data. There has been a very good performance this winter with staff consistently managing high levels of activity.

Mrs Brash noted the average length of stay was down in December, January and February and asked that the Board thank staff for the way they have coped over a sustained busy period.

Dr Park enquired if the winter activity was mirrored in other Health Boards across Scotland and noted that the perception in the community is that it was no different from the last three years. The Director of Health Services advised that the West of Scotland was put on notice because of pressures but it is very difficult to see a pattern when you look at who is being admitted. The age profile is approximately the same, respiratory figures look about the same and it was colder than last winter but it is hard to see a pattern as to why things got so busy relatively quickly and stayed busy for longer than normal.

The Chief Executive commented that the Board needed to understand the information and use this as part of the planning for next year with a report going to the Scrutiny Committee setting out the impact of the investment in an acute physician, capacity managers etc. The Chief Executive asked that referrals and admissions be reviewed in terms of appropriateness. A&E activity was higher than previously and the level of transmission to admission was also greater than seen previously. For this to inform next winter a deeper understanding is required and a more in depth review should be undertaken to determine what actions can be taken to ensure that winter is managed in a more planned and understood way.

Mr Hyslop enquired if any information was specific to actions for the Council; for example if there are respiratory problems is it due to older people being unable to heat their homes.

The Chairman asked that staff be formally thanked for their contribution to winter performance.

The Board

- noted the preliminary review of the performance of acute health services in NHS Dumfries and Galloway through winter 2008 / 09.

18 NHS Dumfries and Galloway Workforce Submissions 2009 / 10

The Director of HR and Workforce Strategy presented this item which picks up on some of the themes seen in a number of papers today. The workforce submissions require three pieces of key information. The first of those is the workforce narrative that sits around the LDP; that has already been submitted and picks up a range of issues. Following on from that, and recognising the HEAT targets in the LDP do not cover the whole range and complexity of services delivered, the Board is required to submit a workforce headlines document and a set of workforce projections by 30 April. The information already available gives a great deal of useful and valuable information on the long term future of the workforce. In terms of headline information, there are a number of significant issues that connect into finance papers and also into the medical workforce paper later on the agenda. Picking out the headlines, there will be issues within the medical workforce, a range of issues around the clinical strategy, shifting the balance of care, LDP issues, developing more multi-disciplinary teams, new roles across the organisation, opportunities of generic workers and positive career paths. Finally, there is a continual challenge in having an IT enabled workforce to use e-health and on-line training. A full workforce plan is being developed and will develop over the coming months. In the meantime, the Board has the timetable being worked through in order to complete this piece of work.

The Employee Director expressed concern at the skill mix situation and enquired why the focus was on nurses and Allied Health Professions (AHPs). The Director of HR and Workforce Strategy advised that at this stage it had been decided to focus on the skill mix of nursing, midwifery and AHPs as this constitutes over half the workforce and was therefore a very positive place to start, also recognising national opportunities. Where opportunities for skill mix are identified in other areas they will also be worked through.

The Director of Public Health noted that the public health workforce was missing and the Director of HR and Workforce Strategy advised that she would ensure this was picked up.

Mr Hunter commented on the difficulty in recruiting to some posts and enquired if there was any plan to make Dumfries and Galloway a more attractive place to live and work. The Director of HR and Workforce Strategy acknowledged that the ability to recruit and retain staff is a very substantial one that needs to be dealt with at an organisational level and with our partners. There have been some initial conversations with the Council and a little more focused work in terms of how joint opportunities can be built on is required.

The Chief Executive advised Members that there are one or two areas which are more challenging than others but that some positive work has already been done building up the recruitment packages and linking into wider Dumfries and Galloway information.

The Board

- agreed the proposed local process for providing the Scottish Government with the 2009 / 10 workforce submissions.

19 Community Health Partnership in Dumfries and Galloway – Proposed Interim Changes to the Scheme of Establishment

The Director of Health Services presented this item and advised that the existing Local Health Partnership (LHP) arrangements were based on four LHPs with four managers but that currently there are only two managers. That does not fit with the Scheme of Establishment and therefore a temporary change to the Scheme of Establishment was being requested to recognise the current management structures. This supports a compliant CHP (Community Health Partnership) Committee with an amendment to LHP managers and changed membership for the year.

The Nurse Director noted that the proposed revised clinical membership did not include any nursing representation. The Chief Executive confirmed that under the guidance there was one seat for nursing and this was an omission.

Mr Campbell enquired if this would still allow links with the Council. The Chief Executive advised that there would continue to be links with the Council and that this amendment was not to dilute the arrangements but strengthen them.

Mr Warford sought clarification between the different roles of the CHP and the Community Health and Social Care Partnership Board (CHSCP). The Chief Executive advised that the CHSCP is about policy resourcing and prioritisation at a strategic level and it is that strategic link between the Council and the Board that is essential to taking forward the community care agenda. The CHP is much more tactical in looking at primary and community care, looking at the work of the LHPs and the work being developed there, ensuring the direction remains appropriate and taking forward improvements in terms of the clinical services strategy and the day to day services. The link is one that needs to develop as the CHP could be an important vehicle for taking forward some of the delivery aspects of the CHSCP. The CHP may be a vehicle in terms of its remit where some of that could be translated into the service.

The Employee Director enquired if there was a staff side representative on the CHP originally. The Director of Health Services advised that what was set out in the paper was a membership compliant with the Statutory Instrument. There are key people not in this who need to be round the table and this paper is the minimum to satisfy statutory requirements.

The Board

- approved the temporary changes to the Community Health Partnership Scheme of Establishment.

20 Patient Focus, Public Involvement Assessment Process

The Nurse Director presented this paper and reminded Members that the Board

is required to meet six key Patient Focus Public Involvement (PFPI) actions. There are ten actions in the table in total. These actions are in addition to the exercise that has already been completed and covers the final quarter to the end of March 2009. The complete self assessment will be presented to Board in June. There is a raft of evidence sitting behind this paper which is not attached but is available.

The Board

- agreed the final quarterly submission of 2008 / 09 to the Scottish Health Council.

21 Medical Workforce Issues

The Chairman introduced this item and commended the very detailed and lengthy workshop held during the morning.

The Medical Director presented this paper which followed on from the workshop where the Board discussed the background and context of the medical workforce. Paragraph 9 onwards is the recommendation for the employment of extra doctors for NHS Dumfries and Galloway and these were highlighted in order of priority.

Paediatrics - there is a shortage of middle grade staff throughout the country and there is a need for active recruitment. The recommendation is to have five specialty doctors in addition to a middle grade trainee.

Accident and Emergency (A&E)– there are two consultants and an associate specialist. There are eight training doctors who rotate every four or six months. Permanent staff in A&E would improve safety and the recommendation is to employ GP trained doctors. This works well elsewhere and provides medical staff with a wide breadth of experience. This may also afford opportunities to review the out-of-hours position.

Obstetrics – there are no issues with junior or consultant staff but a shortage of middle grade staff. To ensure working time compliance two additional doctors are required.

Medicine – the current rota is working time compliant but a more senior level is required to lead at night. Additional doctors are required which would also give more capacity in clinics.

General Surgery – an additional staff member in Urology, contributing to general surgery, would ensure compliance with the EWTD (European Working Time Directive) and support the ability to meet all waiting time targets.

Orthopaedics – no change to the numbers proposed but recruit two specialty doctors.

There was no change recommended in psychiatry or anaesthetics.

The proposals require approval before the recruitment process can begin and

this is a significant investment.

The Chief Executive commented that it was important for the Board to look forward to August in terms of the EWTD and MMC (Modernising Medical Careers) and where that has had an impact on a number of Boards in Scotland. The Medical Director has looked at what is required to maintain the standards of service offered in Dumfries and Galloway. This provides an opportunity to sustain the medical workforce but also creates opportunities to address further improvements in out patients and other services that will have added benefits other than addressing the EWTD requirements and rota compliance.

The Finance Director advised members that this had been built into the financial plan and that what was presented was affordable.

Mr Warford asked what benefit patients would get beyond compliance with the EWTD. The Medical Director advised that in many ways this is a first step to a change in the medical workforce. The proposal delivers on the EWTD and takes a step from doctors in training to trained doctors. There will be increased capacity in terms of additional clinical activity and patients will see a more senior and experienced doctor. There is the benefit of a doctor working no more than forty-eight hours. A significant benefit for patients will be having a high level of expertise immediately available in the hospital at night.

Mr Hunter commented on the intense competition for these doctors in the UK and asked what confidence was that the Board would be able to recruit. The Medical Director confirmed that there were varying degrees of confidence, for example surgery should not be a problem but there was a national shortage of paediatricians.

Mrs Brash supported the proposals and suggested gathering intelligence from those employed in Dumfries and Galloway as to what attracted them here. Mrs Brash also suggested that information should be fed to the medical schools in terms of where there are shortages as potentially there are a lot of young doctors not going to find jobs.

Mr Campbell expressed surprise at the position, recognising the high standard of delivery of care in the health service locally and enquired if these posts would be permanent full time positions. The Medical Director confirmed that the posts would be advertised as permanent, full time positions but noted that part time would be considered to make the posts as attractive as possible.

The Board

- agreed the proposals.

22 National Delivery Plan for Children and Young People's Specialist Services in Scotland

The Director of Public Health introduced this report which covered the requirement of the Delivery Plan, the implications for children's health services in Dumfries and Galloway and outlined the allocation of £32 million committed in £2m, £10m and £20 m steps by the Scottish Government over the next three

years.

Mrs Milligan presented the report, recognising that this level of new investment offers an opportunity to address specialist paediatric services nationally and is unlikely again in the near future. There is increasing concern about the variability of very specialist services and variability of access to specialist services, remote and rural issues and some logical and rational approaches to the very specialist services provided in Edinburgh, Glasgow, Aberdeen and Dundee.

Against the allocation, NHS Dumfries and Galloway will have to demonstrate measurable outcomes and if successful in our bids will be asked to report on a six monthly basis, what are the benefits to patients, sustainability and also evidence that the money is used to best effect. Dr Eccleston commented that this allocation presents an opportunity to change how services are delivered across Scotland. Mrs Mack highlighted the difficulty in recruiting highly specialist AHP and nursing staff locally and suggested this provided an opportunity to extend the knowledge base of existing staff which would motivate staff to say. Mrs Milligan commented on the ability to demonstrate the benefit of the child protection sessions and noted that it is much easier to recruit to permanent posts. The Director of Public Health advised that the money was available to develop a tertiary level of expertise in child protection locally and would allow doctors to have a clinical attachment in Glasgow.

The Chief Executive advised Members that this was complex and it is essential to prove that these monies are delivering outcome and benefit. The Board must consider whether they would want this money to be allocated to the team on a recurring basis. The Director of Public Health strongly supported regarding this money as recurring and the Chief Executive reminded Members that this has not been budgeted in the financial plan.

The Director of Finance advised Board that they needed to be aware that there are a number of pots of money that are one, two and three year funding and exit strategies should be considered. There is a risk in that if the funding doesn't become recurring further efficiencies will be required to fund the gap.

The Chief Executive advised that much of the investment is adding to existing posts and that can be done non recurrently without a great deal of risk. BMG has already approved £60k for two years for CAMHS to help primary healthcare workers. If this £63k came in it would be in addition and there could be an exit strategy. If given the opportunity, CAMHS is an area where investment would be supported. The Chief Executive suggested supporting the £63k to CAMHS and the four consultant paediatrician sessions, everything else should be considered as non recurring. This still puts a significant non recurring risk in the plan.

The Board

- noted the delivery plan; and
- agreed to treat Delivery Plan funding allocated to Dumfries and Galloway for CAMHS as recurring.

23 Energy Reduction and Carbon Management

The Director of Health Services presented this item. The Local Delivery Plan (LDP) target is a mixture of energy utilisation and CO2 reduction and will become a CO2 reduction target. This paper sets out the position. The biomass boiler installed last financial year puts the Board in a very good position for CO2 reduction. The biomass boiler has had a small number of teething problems but is now up and running and supplying half the site. This paper noted that to achieve the target going forward the challenge will be an increase in electricity usage. There are schemes to mitigate this but on the current trajectory the Board will require to become an electricity producer. This needs to be explored with partners in terms of viability.

Mr Warford enquired what the impact would be of installing another biomass boiler and commented that the concept of the Board going into energy generation was not something he could support.

The Director of Health Services advised that the biomass boiler meets all the Board's steam generation at the current time. As the footprint of Dumfries and Galloway Royal Infirmary expands the Board may get to a maximum but the push on energy efficiency will assist. The Board's energy use is going to increase taking into consideration the CT scanner, MRI scanner etc.

Mr Hunter suggested that other Boards must be facing the same problem. The Director of Health Services advised that the LDP target is to be low carbon and to operate that way at the moment would require the Board to get into generation.

The Medical Director noted that the IT Department recognised an issue on equipment being left on overnight. 'My Watchman' has been purchased and will turn off all PCs at 8 pm with a payback period of four months. There are currently 168 servers using only 2% of the capacity and by re-wiring it will be possible to reduce the number by approximately 60. This will save electricity and air conditioning, looks to produce savings of approximately £200k and is being progressed.

Mr Warford commented on the large number of very good projects and recommended supporting and encouraging these. The Director of Health Services highlighted the Dental Centre as a prime example of efficiencies.

The Board

- approved a continuous energy awareness campaign in partnership with Dumfries and Galloway Council; and
- agreed that the Director of Health Services and the Director of Finance take the other schemes to the Capital Investment Group.
-

24 Board Briefing

The Chief Executive presented this item highlighting Exercise Quintana Roo and acknowledging the contribution of all partners from across Dumfries and

Galloway on the day.

The Board

- noted the briefing.

25 Any Other Competent Business

There were no other items of business.

26 Date of Next Meeting

The next meeting of the NHS Board will be held on Monday 11 May 2009 in Lockerbie.

27 Minute of Area Clinical Forum held on 21 January 2009

The Board

- noted the minute of the Area Clinical Forum held on 21 January 2009.

28 Update on the Older People's Consultative Group

The Board

- noted the update on the Older People's Consultative Group.

29 Minutes of the Older People's Consultative Group held on 1 October 2008, 3 December 2008 and 27 January 2009

The Board

- noted the minutes of the Older People's Consultative Group held on 1 October 2008, 3 December 2008 and 27 January 2009.

DUMFRIES AND GALLOWAY NHS BOARD

11 May 2009

PATIENT SAFETY



Author

Maureen Stevenson

Sponsoring Director

Hazel Borland, Nurse Director

Date: 29 April 2009

RECOMMENDATION

The Board is asked to note progress with the patient safety programme.

SUMMARY

The patient safety programme continues to spread through NHS Dumfries and Galloway as the Scottish Patient Safety Programme progresses.

The improvement work throughout the acute hospital and more recently Community Hospitals will drive towards achievement of the over arching goals of the Patient Safety Programme in addition to those specific to the individual work streams:

- To reduce mortality by 15%
- To reduce adverse events by 30%
- To reduce hospital acquired infection by 50%

Work towards attaining these targets commenced in February 2007 with Safer Patient Initiative 2 (SPI 2) and continues in DGRI with the Scottish Patient Safety Programme. The local Community Hospital programme which commenced in November 2008 builds on this work.

Progress Report

Monthly data and a narrative report submitted to the Scottish Patient Safety Programme is used by IHI to assess the progress of the patient safety programme. Central to progression through the change programme is a focus on sustained reliability and spread to all relevant clinical areas. Spread of the programme within DGRI has been ongoing for some time now and as previously reported formal spread to Community Hospitals has also commenced. All clinical areas within DGRI are now working on more than one element of the change package. Elements of the programme have started spreading informally to Community Nursing (SBAR), Mental Health (considering medicine management and communication tools) and Primary Care (medicine management), building will and enthusiasm for quality improvement.

This informal spread has occurred as clinical teams within DGRI and Community Hospitals share their success and start to look at all elements of a patient journey through the health care service.

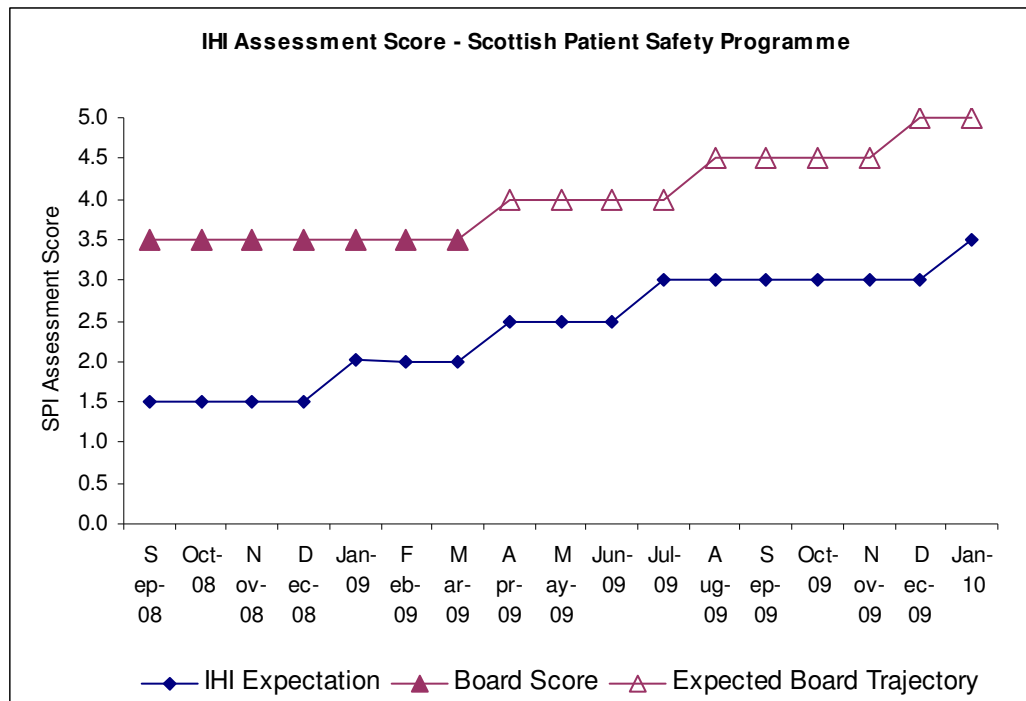
Summary of Spread

	<i>% of clinical areas in DGRI spread to</i>	<i>Other services/specialties beyond pilot area where you're starting to put into practice the Model for Improvement methodology</i>
Critical Care		
Ventilator bundle	100%	No spread beyond ICU
Central Line bundle	100%	Implemented in all areas where central lines inserted
Multidisciplinary rounds	100%	Implemented in ICU
Daily Goal sheets	100%	Implemented in ICU
General Ward		
Safety huddles	100%	All Ward / Clinical areas throughout DGRI testing or implementing a daily safety briefing
SBAR	85%	Being used routinely throughout DGRI for communications including nursing handover, medical handover, inter-ward transfer, referral, intra-hospital transfer, inter-hospital transfer, critical situations.
EWS/outreach team	100%	Early warning score existed pre-collaborative, development work in all general wards by MEWS Facilitator. Paediatric EWS developed and implemented in A&E and Ward 15
Leadership		
Walkrounds	100%	Alteration to process being agreed by Board Management Group
Medicines Management		
Reconciliation (all points)	60%	Continuing to spread through medical wards with focus on start of process at Medical Admission Unit. Testing in Surgical wards. Small scale tests undertaken in A&E at clerk-in of surgical emergency admissions. Continuing test of patient completed record in Out Patient Department.
Anticoagulation management	100%	Guidelines for thromboprophylaxis prescribing circulated by Patient Safety Alert Anticoagulant Therapy Group. Need to audit compliance and work with frontline staff to identify tests of change to implement process.
Peri-operative Management		
Safety briefings	100%	All theatres testing adaptation of WHO Surgical Pause
DVT prophylaxis	50%	Implemented Ward 16, Ward 6
Beta blocker use	75%	Implemented Ward 16 Testing Ward 3, Ward 6
SSI bundle	75%	Implemented Ward 16 Testing Ward 6, 3
SBAR	65%	Implemented Ward 4, Ward 6 and Ward 16 for handover. Preparing to test in Out Patient Department.
Infection control		
Hand hygiene	100%	Bundle implemented in all wards, Cancer Services, Theatre Reception Recovery, Day Surgery Unit. Testing in Theatres and preparing to test in Out Patient Department.

Within DGRI progress to spread all relevant elements of the change package to all appropriate clinical areas are well underway. Tools to measure the improvements being made are being used to demonstrate improvement and sustainability of process improvements.

Trajectory

NHS Dumfries & Galloway have agreed a trajectory in relation to the spread of the programme components within DGRI which will see all elements of the change package in place in all relevant clinical areas by end of 2009.



Our work on the Safer Patient Initiative has put DGRI ahead of the SPSP schedule and as such we aim to achieve a score of 5.0 one year ahead of the IHI timeline. This will require spread of all relevant elements of the change package to all appropriate clinical areas within the acute hospital with no backward slippage of outcome measures for a minimum of three months. As the summary table above demonstrates we are well on plan to achieve spread throughout the hospital within this timescale however ensuring that the tempo and pace of improvement is continued will be critical. The Patient Safety Delivery Group will play a key role in monitoring progress on a monthly basis and identifying areas where the tempo is slipping and assessing progress in improving outcome measures.

Further elements to be added to the change programme are currently being discussed by Scottish Patient Safety Alliance and Delivery Group, including pressure sores, paediatrics and cardiac care. It may be necessary to revise the trajectory as more information on these new areas becomes available.

Local trajectories for Community Hospitals are currently being developed to sustain the improvement journey beyond the end of the formal programme of learning sessions.

Sustainability

Ensuring continuing focus on safety and quality improvement resulting from frontline staff involvement in the patient safety programme is a key challenge for the future. If the improvements made are to be sustained and the use of the improvement methodology to become 'the way we work' a formal plan for supporting and mentoring staff as they work through improvement projects is necessary. Alongside the development of a Patient Safety Faculty the Delivery Group has examined options for delivering training with opportunities for shared learning throughout DGRI. These options will be considered by the Board Management Group before this work is progressed, however the need to undertake work in DGRI with wards who have not been involved in either SPI 2 or SPSP learning sessions has been identified as a priority for development.

Consideration of how we build knowledge of patient safety, the tools for driving change and improvement links with other organisational priorities is essential in developing a mechanism for sustainability that balances the need for training, shared learning and safe staffing of clinical areas. This will have the added benefit of ensuring patient safety permeates all that we do and is not seen as a stand alone project or programme.

Safer Patients Network

As an SPI 2 site the Health Foundation has invited NHS Dumfries and Galloway to submit an application to join the Safer Patient Network. Through a focus on research and development and developing capability to change the vision for the network is to:

- Develop a self-sustaining member-driven learning Community that seeks to continually improve and sustain and spread excellent results;
- Enable the further development of skills and knowledge to ensure reliable delivery of care;
- Seek additional ways in which SPI organisations can catalyse safety improvements across their respective national systems.

Learning about the challenges to improvement work, building capability, harnessing innovation will be key outcomes of this next phase of the Safer Patient Initiative.

Conclusions and Recommendations

The Board are asked to note the progress of the work we are doing in NHS Dumfries & Galloway and continue to provide support and encouragement to front line teams delivering a challenging agenda.

MONITORING FORM

Policy/Strategy Implications	<i>Delivering SGHD SPSP</i>
Staffing Implications	<i>Encouraging staff across NHS Dumfries and Galloway to take forward learning from patient safety activities.</i>
Financial Implications	<i>None</i>
Consultation	<i>No consultation</i>
Consultation with Professional Committees	<i>Patient safety discussed at Area Clinical Forum</i>
Risk Assessment	<i>Patient safety and risk management connected activities.</i>
Best Value	<i>Commitment and leadership Sound governance at strategic and operational level Contribution to sustainable development</i>
Compliance with Corporate Objectives	<i>Corporate Objective 2</i>
Impact Assessment	<i>No Equality Impact Assessment required.</i>

DUMFRIES and GALLOWAY NHS BOARD

11 May 2009

**Patient Experience
Reporting Period – March 2009****Author:**
Carol Reece, Patient Services Manager**Sponsoring Director:**
Hazel Borland, Nurse Director**Date:** 29 April 2009**RECOMMENDATION**

The Board is asked to consider the Patient Experience report for March 2009.

SUMMARY

Patient Services are pleased to lay before the Board an evolving monthly report based on the summation of Patient Experience information.

As a result of disappointing statistics, particularly over the period October 2008 to January 2009, the Patient Services Manager undertook a review of process, carrying out small tests of change in a number of areas with a view to improving not only target response times but also the handling, investigation and response reports.

With a cautionary note, it has been encouraging to see the target acknowledgement times at a steady 100% since January 2009 and the 20 working day response times continuing to make steady upward progress.

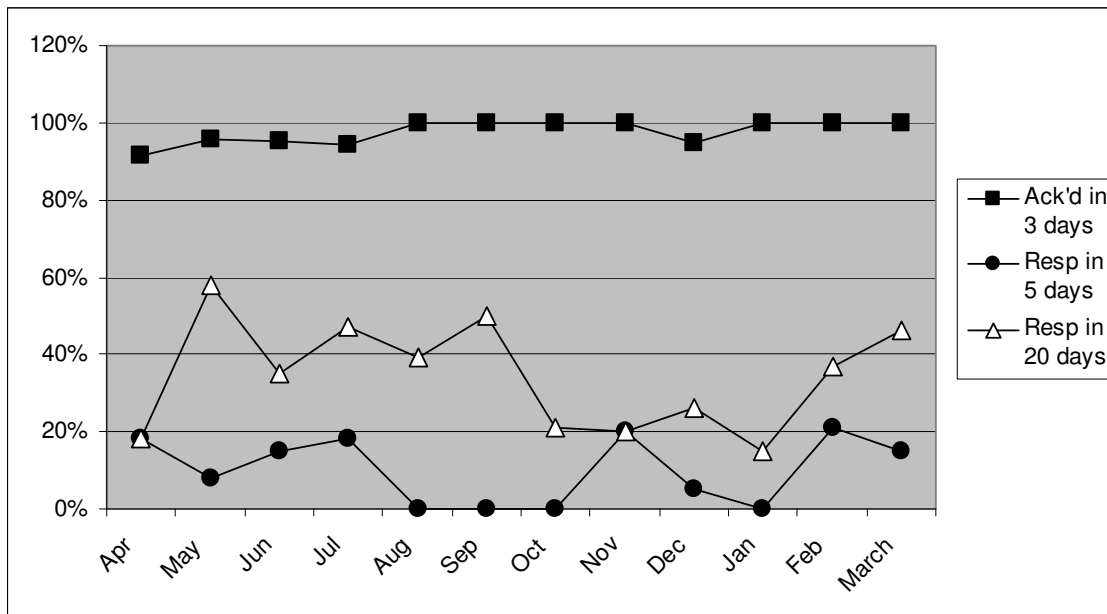
A number of lessons have been drawn from the small tests of change to date. It has proved helpful to confirm understanding of the complaint with some of the complainants before finally responding; it has been found beneficial to speak to the complainant, either in person or by telephone, to establish that the understanding of the complaint is shared and to discuss options for taking all or part of the complaint forward. This has been particularly helpful when trying to address any emotional and experiential issues raised; the letter writer cannot always anticipate how a recipient will experience their letter but the care over language used is very important; the value of face to face meetings with complainants.

Lessons continue to be drawn as work on evaluating the process continues which will inform the review of future policy and procedure in the management of feedback, including complaints.

INTRODUCTION

In this reporting period the Patient Services Team have received 22 lines of enquiry of which 13 were complaints. We have also received 5 letters of appreciation regarding staff and services; 2 in respect of Kirkcudbright Hospital; 2 for A & E at Dumfries and Galloway Royal Infirmary and 1 in respect of Nursing care on Ward 16.

Compliance with National Timescales



In this reporting period of the 13 complaints, 15% (2) were responded to within 5 working days, 46% (6) were responded to within 20 working days, 4 are waiting to be signed and 1 has been returned for further investigation.

The issues highlighted in the overarching themes of communication, information, attitude/behaviour and treatment, once investigated and analysed hinge on public expectation, the use of clear and understandable language, and the provision of clear and up to date information. For example, one complainant did not appear to be aware of the self referral option to therapy services and had out of date waiting time information about the service. Had this information been available it is unlikely the complaint would have been made. Patient Experience Reports to General/Nurse Managers and Heads of Department have been improved with the introduction of the DATIX system and each closed complaint now includes recommendations for action where appropriate. Options for further refinement of the system are currently being discussed.

BETTER TOGETHER: PATIENT EXPERIENCE PROJECT

The Patient Experience Volunteering Project was launched during the first week of April 2009 following local induction and training. Five volunteers currently support the project, which is being piloted on wards 7, 9, 16 and 18 for three months. The project aim is to help NHS Dumfries and Galloway provide a healthcare environment

in which patients experience caring, kindness and respect and so do their families and the hospital staff. Feedback after each visit is provided by the volunteer to the nurse in charge of the ward. Reports from the pilot will be received by Quality Improvement Working Group. The first Patient Experience volunteer network meeting is scheduled for the end of April when feedback and experience will be collated.

BETTER TOGETHER: INPATIENT SURVEY PILOT

The better together programme has developed an in-patient survey on behalf of NHS Scotland, which will collect detailed data about patient's experience of admission, ward and the environment, treatment and care by staff, discharge, prescribing as well as their overall feelings about their stay.

Before the survey is rolled out nationally the questionnaire and guidance documents will be piloted to ensure the survey is fit for purpose and can be conducted consistently across NHS Boards. Out Board area has been working with the Health Analytical Services Division in the Scottish Government with a view to piloting the survey in NHS Dumfries and Galloway. Three other NHS Boards have also agreed to pilot the survey, Ayrshire and Arran, Fife and Greater Glasgow and Clyde.

Over the next few months, Better Together and the NHS National Procurement will be working with Boards' Patient Experience and Procurement leads to support us in the procurement of a quantitative survey field work contractor in advance of the in-patient survey, which is scheduled to be sent out to patients during the autumn of 2009.

REPORTS TO THE PROCURATOR FISCAL

We are not currently in communication with the Procurator Fiscal on any complaints.

PUBLIC SERVICE OMBUDSMAN

We are currently in correspondence with the Ombudsman on 3 complaints, one of which the Ombudsman has decided not to investigate, but has made recommendations to the Board, which have been actioned.

MONITORING FORM

Policy / Strategy Implications	<i>Complaints Policy.</i>
Staffing Implications	<i>Ensuring staff learn from complaints in relation to issues raised.</i>
Financial Implications	<i>None</i>
Consultation	<i>None</i>
Consultation with Professional Committees	<i>None</i>
Risk Assessment	<i>Actions from complaints followed through and reported to General Managers and Clinical Nurse Managers who have a responsibility to take account of any associated risk.</i>
Best Value	<i>Commitment and leadership Accountability Responsiveness and consultation</i>
Compliance with Corporate Objectives	<i>To promote and embed continuous improvement by connecting a range of quality and safety activities to deliver the highest quality of service across NHS Dumfries and Galloway</i>
Impact Assessment	<i>Not undertaken as applies to all users.</i>

DUMFRIES and GALLOWAY NHS BOARD

11 May 2009

Prevention and Control of Infection Update



Author:

Sam Whiting, Infection Control Manager

Sponsoring Director:

Hazel Borland, Nurse Director

Date: 16 April 2009

RECOMMENDATION

The Board is asked to note this report which provides an update on infection prevention and control across NHS Dumfries and Galloway.

SUMMARY

This paper is a routine monthly update on specific aspects of Infection Control. The Scottish Government Health Directorate requires all NHS Boards to receive bi-monthly infection control updates from January 2009. The first such update was provided for Board in November 2008.

The Scottish Government requires all NHS Boards to receive a bi-monthly infection control update on the following areas which are all addressed in this paper:-

- Infection surveillance
- Hand hygiene by hospital (including visitors)
- Education
- Outbreaks
- Cleaning
- Risks and incidents

The Scottish Government Health Directorate has also issued an action plan for NHS Boards to implement relating to Healthcare Associated Infection (HAI). Each Board is required to provide the Cabinet Secretary for Health and Wellbeing with a monthly progress report on the implementation of the actions.

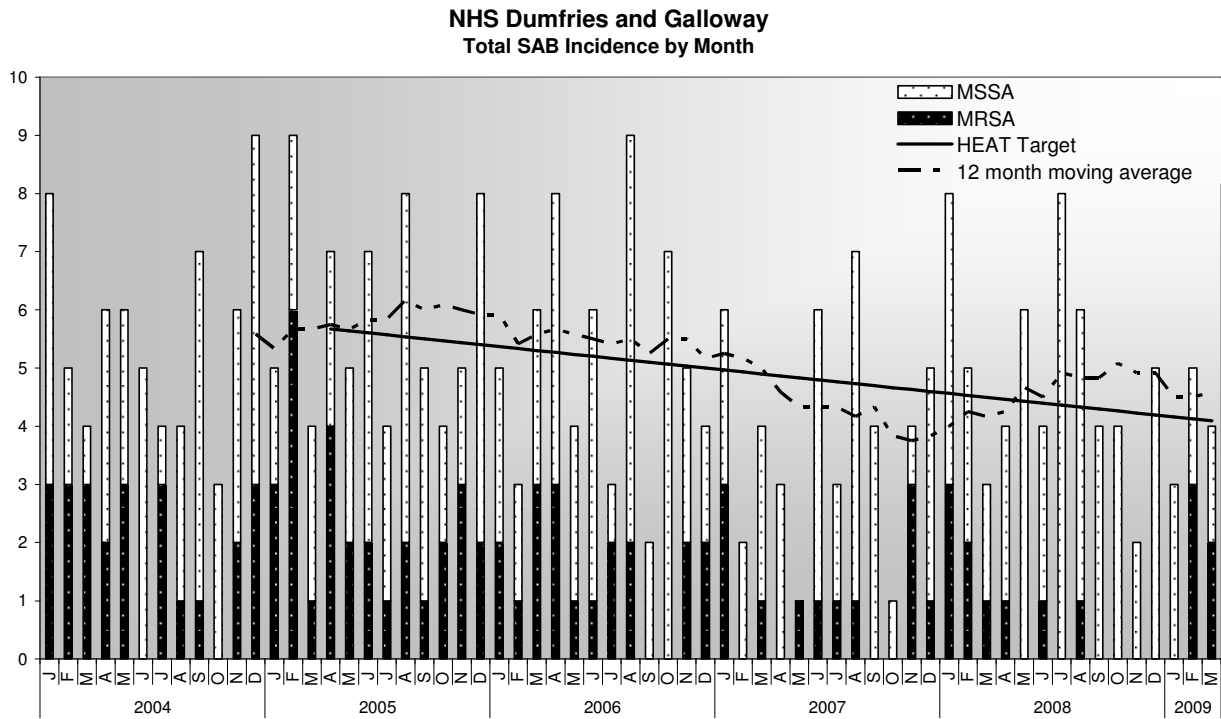
Through the proactive approach taken by NHS Dumfries and Galloway on key infection control issues including mandatory training, antimicrobial prescribing, cleaning and hand hygiene, NHS Dumfries and Galloway has been able to confirm implementation of 21 of the 24 actions (Appendix A). Work is ongoing to implement the remaining three actions. One action is for all staff to have an HAI objective in their personal development plan and this remains a challenge although a work plan and trajectory for achieving the related HEAT target has been established.

Infection Surveillance

In NHS Dumfries and Galloway, infection control surveillance includes close monitoring of *Clostridium difficile* infection (CDI) and *Staphylococcus aureus* bacteraemia (SAB).

As at the date of this report, 29 days have elapsed since the last Meticillin Resistant *Staphylococcus aureus* (MRSA) bacteraemia and 13 days have elapsed since the last Meticillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemia in Dumfries and Galloway.

NHS Dumfries and Galloway has a Health improvement, Efficiency, Access and Treatment (HEAT) target of a 30% reduction in SAB bacteraemia by 2010. Ongoing work to reduce cases is required to ensure that this target is met. The graph below shows the monthly SAB incidence against the HEAT target trajectory.



In March 2009, there was one SAB recorded in Galloway Community Hospital with the remaining within Dumfries and Galloway Royal Infirmary.

In April 2009, Health Protection Scotland published the latest quarterly report on SAB rates for Scotland (for full report visit www.hps.scot.nhs.co.uk). For the quarter October 2008 to December 2008, The SAB rate for Scotland was 0.411 per 1000 Acute Occupied Bed Days (AOBDs). During the same period the rate in Dumfries and Galloway was 0.348 SAB per 1000 AOBDs.

Ongoing initiatives to reduce SAB cases includes:-

- Through the Patient Safety Programme, a care bundle for the use of peripheral intravenous cannula is currently being tested in a number of clinical areas within Dumfries and Galloway Royal Infirmary (DGRI).
- MRSA screening increased from February 2009.
- Ongoing compliance with risk assessed MRSA screening together with an Integrated Care Pathway (ICP) to improve the management and care of MRSA positive patients is helping to reduce the risk of colonisation leading to infection of self and colonisation of others.
- All SAB cases are fully investigated using a standardised tool. Until recently, this was done by the Infection Control Team but is now being completed by the clinical teams caring for the patient.
- Infection surveillance data is fed back to clinical managers.

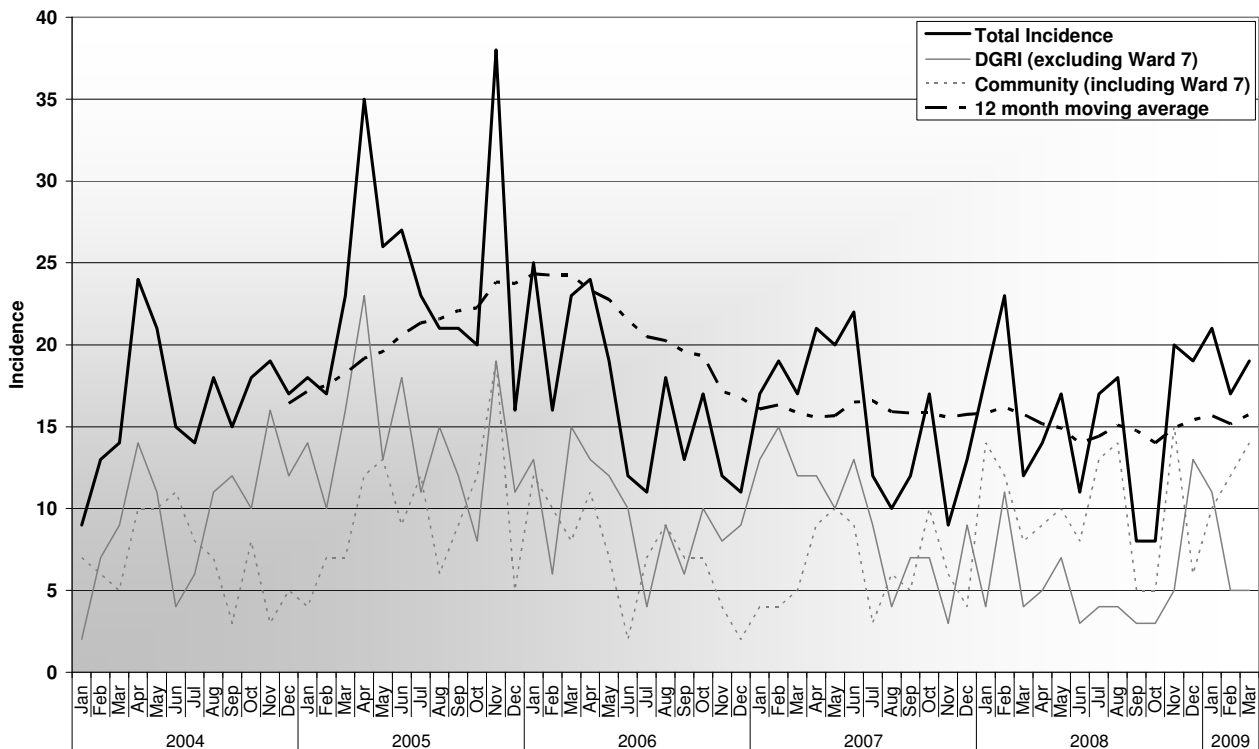
Clostridium difficile Infection (CDI)

The graph below shows the total monthly incidence of *Clostridium difficile* infection (CDI) from January 2006 to March 2009 across NHS Dumfries and Galloway.

The data in all the graphs below have duplicates removed (as per HPS data definitions). If a case is diagnosed twice within a 28 day period, the second toxin positive test is considered a duplicate.

NHS Dumfries and Galloway Total Clostridium difficile Incidence

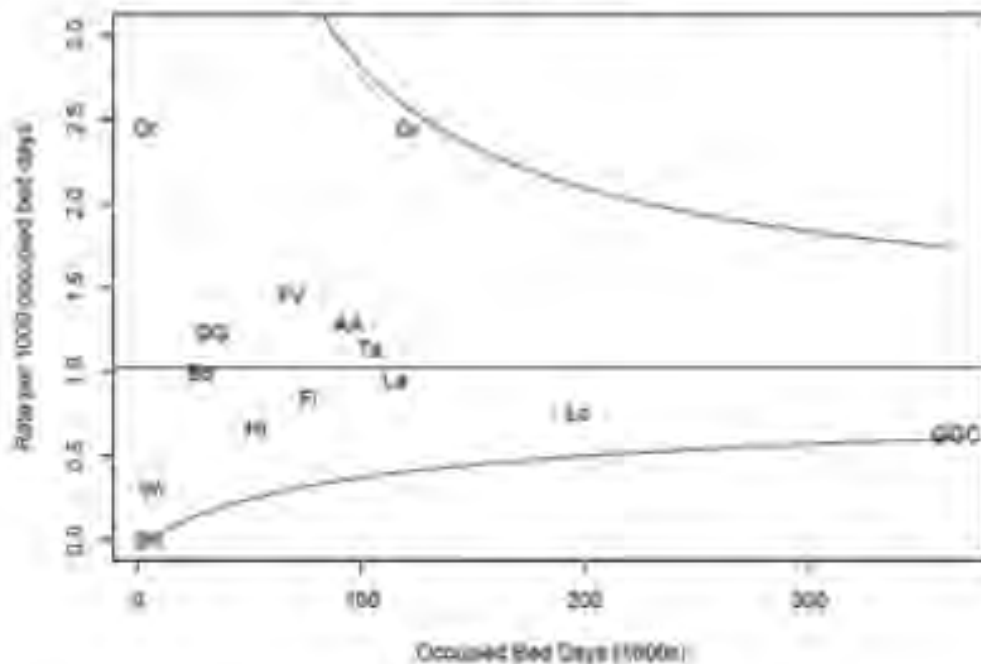
January 2004 - February 2009



In April 2009, Health Protection Scotland (HPS) published the latest quarterly report on CDI rates for Scotland (for full report visit www.hps.scot.nhs.co.uk). For the quarter October 2008 to December 2008, The CDI rate for Scotland was 1.02 cases per 1000 Total Occupied Bed Days (OCBDs). During the same period the rate in Dumfries and Galloway was 1.23 CDI cases per 1000 OCBDs.

The graph below shows a funnel plot of rates of CDI for all NHS Boards in Scotland against total occupied bed days (x1000) for the period October 2008 to December 2008. Concave lines represent 95% confidence limits and the horizontal line the mean rate of CDI. Dumfries and Galloway is represented by "DG".

Clostridium Difficile rates by Scottish NHS Board

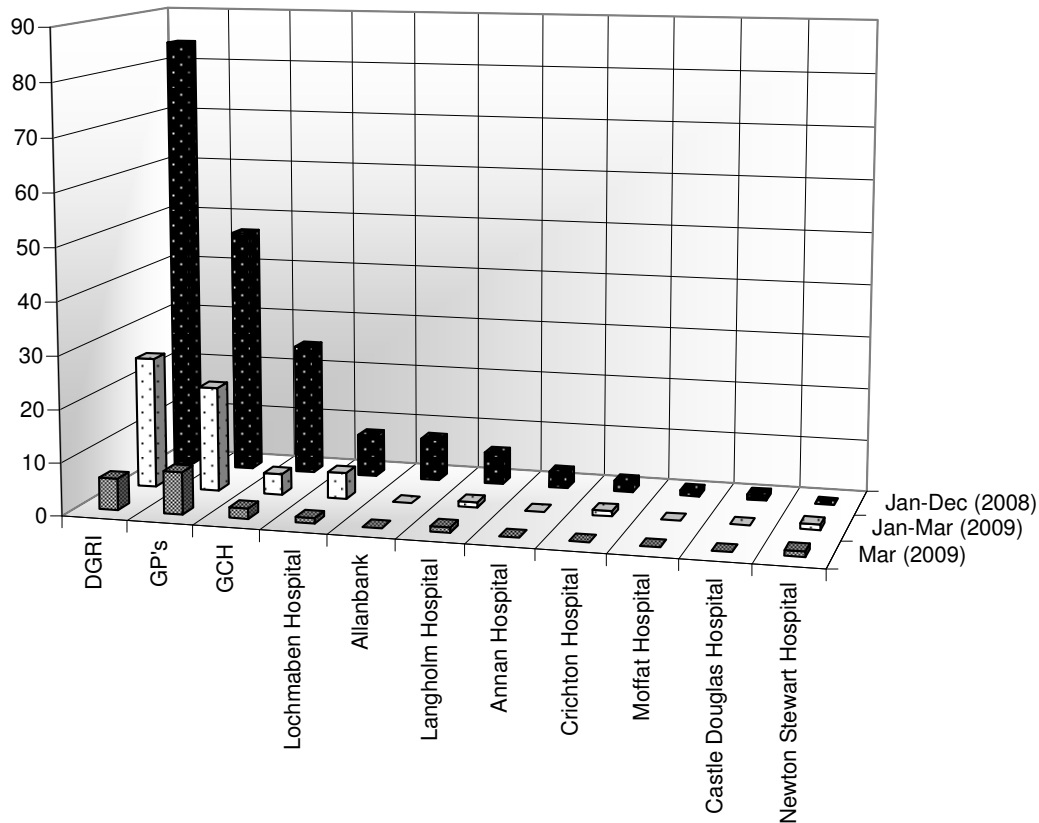


The Scottish Government Health Directorate (SGHD) has set a HEAT target of a 40% reduction in CDI rates. Performance against trajectory calculations will be included in future Board updates.

The following graph shows the incidence of CDI by location for the last month, quarter and year.

NHS Dumfries and Galloway

Total Clostridium difficile Incidence by Location (Last Month, Last Quarter, Last Year)



Antimicrobial Stewardship

In addition to general infection control improvements such as hand hygiene, antimicrobial stewardship is essential to drive down CDI rates. The Antimicrobial Management Team (AMT) is leading a programme of work to improve antimicrobial stewardship and has already implemented a range of actions together with the Infection Control Team:

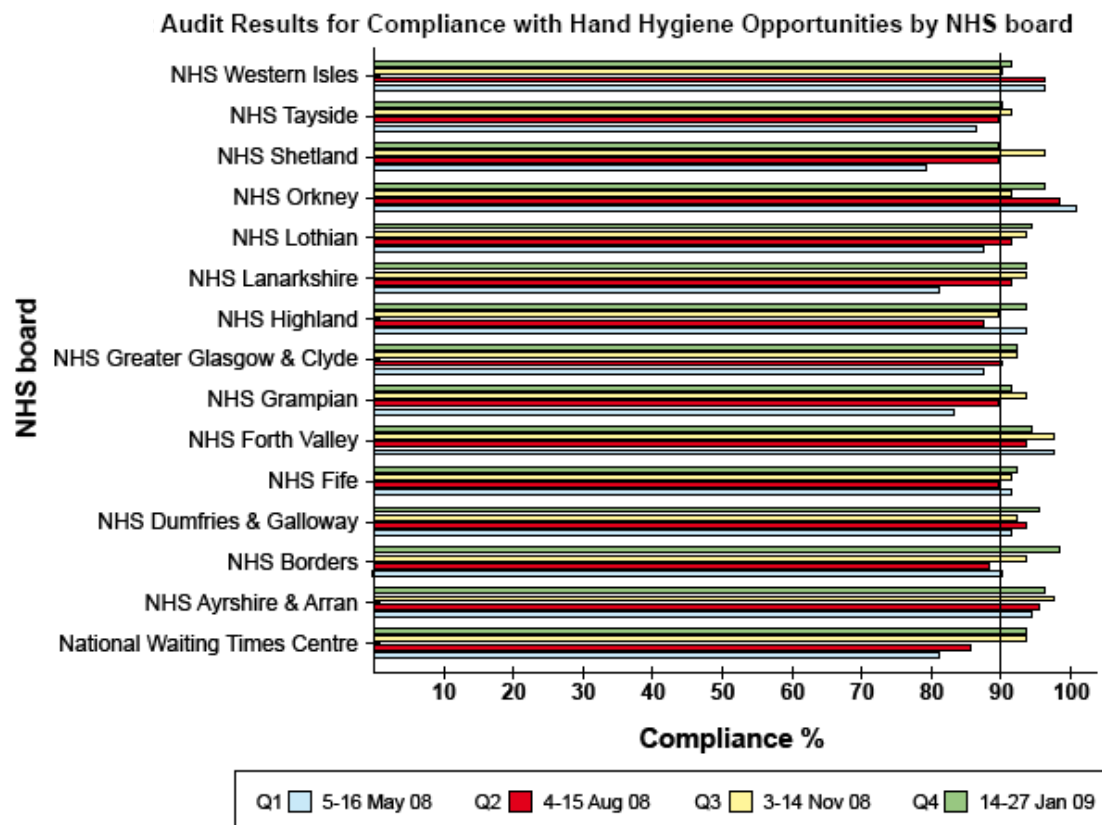
- Implementation of a CDI focussed acute antimicrobial formulary
- GP formulary reviewed and updated
- The Microbiology laboratory has stopped reporting cephalosporin sensitivity
- Antimicrobial restricted list developed and in use.
- Antimicrobial Formulary compliance audits are conducted weekly
- Feedback and education to prescribing doctors
- A letter has been sent from the Medical Directors to all GPs regarding antimicrobial prescribing
- Completed IV to oral switch policy
- Completed paediatric antimicrobial policy
- CDI Integrated Care Pathway (ICP) developed and in use.
- Emergency CDI outbreak formulary developed.

- Implemented Integrated Care Pathway for CDI positive patients
- All CDI cases are fully investigated using a standardised tool. Until recently, this was done by the Infection Control Team but is now being completed by the clinical teams caring for the patient.

Hand Hygiene

Staff hand hygiene compliance is monitored through daily audits as part of the Patient Safety Programme. In addition, bi-monthly hand hygiene audits are conducted in each NHS Board as part of the national hand hygiene campaign.

In March 2009, HPS published the latest Hand Hygiene compliance report for NHS Scotland. The results are summarised in the graph below.



(The vertical line represents the at least 90 % compliance target set by the Cabinet Secretary for Health and Wellbeing in November 2007)

In the national audits in January, the average Scottish hand hygiene compliance rate was 93% with NHS Dumfries and Galloway achieving 95%.

The table below shows the results of a recent audit of hand hygiene compliance in community hospitals.

Hospital	Hand hygiene compliance
Annan Hospital	100%
Castle Douglas Hospital	95%
Kirkcudbright Hospital	95%
Thomas Hope Hospital	95%
Lochmaben Hospital	100%
Moffat Hospital	100%
Newton Stewart Hospital	100%
Thornhill Hospital	95%

An audit of visitor hand hygiene compliance was conducted in April 2009 in Dumfries and Galloway Royal Infirmary. This audit assessed the proportion of visitors that used the alcohol gel on entering a ward and identified that 82% of visitors did use the alcohol gel.

Education

Staff across NHS Dumfries and Galloway are supported to complete the Cleanliness Champions Programme developed by NHS Education Scotland (NES). As at the date of this report there are 643 completed Cleanliness Champions and 484 in training in Dumfries and Galloway. There are also a further 31 members of staff working through a NES Decontamination Programme.

NHS Dumfries and Galloway continues to develop the mandatory training programme and has taken forward on-line training for infection control. All new employees joining the organisation receive mandatory training including infection control prior to starting in the workplace.

On 26th March 2009 there was a Cleanliness Champions conference in Dumfries. 90 Cleanliness Champions attended from across Dumfries and Galloway and were updated on infection control topics as well as given practical tips on changing practice and behaviour.

Outbreaks

There have been no outbreaks since the last Board update paper.

Cleaning

Recent cleaning results by locality are listed below. These are aggregated cleaning audit scores for the period January 2009 to March 2009 based on compliance with the national cleaning specification.

Area	Cleaning audit Scores January - March
Stewartry Locality	98.6%
Annandale and Eskdale Locality	98.4%
Wigtownshire Locality	98.2%
Dumfries and Galloway Royal Infirmary	95.8%
Nithsdale Locality	96.7%

Incidents and Risk

In March, the Infection Control Team were notified of 7 incidents of which 3 related to staff being exposed to a risk of infection through sharps injuries. The remaining 4 incidents did not result in any patients getting an infection.

The Corporate Risk Register for NHS Dumfries and Galloway incorporates the risk of HAI. The Infection Control Team also holds a risk register which considers operational risks and works with clinical teams to reduce those risks. This is kept in constant review.

Appendix A

HAI ACTION PLAN

All Boards will empower their Charge Nurses to deliver against their responsibilities
Status: Complete

Implement the recommendations in the Senior Charge Nurse Review
Completion Date: December 2010 Status: Green

HAI SCRIBE (Healthcare Associated Infection System for Controlling Risk in the Built Environment) sections 3 &4 to be applied to all existing buildings to ensure fabric of healthcare facilities maintained to minimise risk of infection
Status: Complete

Planned preventative maintenance programmes reflect requirements of prevention and control of infection
Status: Complete

NHS Boards to have 'zero tolerance' to non-compliance with hand hygiene
Status: Complete

NHS Boards to report hand hygiene compliance (staff and visitors) and facilities on a hospital basis to 2 monthly Board meetings
Status: Complete

NHS Boards to ensure HAI budget requirements are reflected in capital, maintenance and operational programmes
Status: Complete

NHS Boards to have identified budget for urgent repairs and replacement equipment available to Charge Nurses
Status: Complete

All patients to receive information on HAI
Status: Complete

All information is available in a variety of formats that facilitates public understanding

Status: Complete

Scottish Patient Safety Programme (HAI elements) are integrated with HAI agenda at NHS Board level

Status: Complete

Progress on implementation of Scottish Patient Safety Programme (HAI elements) to be included in HAI reports to 2 monthly Board

Status: Complete

NHS Board's infection control policies include primary and community care

Status: Complete

Structure and resources to provide effective infection control service across NHS Board area (hospital and community) assessed and agreed by NHS Boards, including:

- Human resources
- Equipment
- Budget

Status: Complete

NHS Boards policy/guidance on completing death certificates reviewed to include documenting death associated with HAI

Status: Complete

NHS Boards local surveillance to include setting of control limits and trajectories for reduction of rates / incidence of HAI

Status: Complete

NHS Boards Risk Register details HAI risks

Status: Complete

HAI incidents and issues recorded on NHS Boards Risk Register reporting systems and reported to 2 monthly Board meetings

Status: Complete

NHS Boards to self assess current compliance with QIS HAI Standards (March 2008)

Status: Complete

All healthcare workers receive appropriate level of HAI education and training in line with position, including antimicrobial prescribing and resistance

Completion Date: April 2009

Status: Green

Infection Control staff undertake appropriate level of education and training

Status: Complete

Cleaning matrix and schedule including discipline responsible for cleaning is available in all healthcare settings

Status: Complete

All staff to have HAI objective in annual professional development plans

Completion Date: April 2009

Status: Amber

MONITORING FORM

Policy / Strategy Implications	<i>HEAT targets</i>
Staffing Implications	<i>Not required</i>
Financial Implications	<i>Not required</i>
Consultation	<i>Not required</i>
Consultation with Professional Committees	<i>Not required</i>
Risk Assessment	<i>Addressed through Corporate and Infection Control Team risk register</i>
Best Value	<i>Best Value Public Involvement Partnership working</i>
Compliance with Corporate Objectives	<i>2,3,7</i>
Impact Assessment	
<i>General update paper – not applicable</i>	

DUMFRIES and GALLOWAY NHS BOARD

11 May 2009

Endowment Fund Investment Strategy



Author:

Jim Steen, Head of Financial Services

Sponsoring Director:

Craig Marriott, Director of Finance

Date: 30 April 2009

<p>RECOMMENDATION</p> <p>The Board members, as Trustees of the Fund, are asked to approve the changes to the Fund's investment strategy as endorsed by the Scrutiny Committee on 28 April 2009.</p>
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<p>SUMMARY</p> <p>The Endowment Fund paper presented to the April Board advised that the Scrutiny Committee in April would review the Endowment Fund Investment Strategy. This review has concluded and two recommendations are presented for approval.</p>
--

Background

The Endowment Strategy over the last few years has been to carry a large cash deposit, currently c. £3.8 million, which until the economic downturn was earning interest at a rate in excess of the shares portfolio's dividend return. The advice from our investment advisors is that the key future risk to our investment portfolio is from inflation due to the impact of quantitative easing.

Two recommendations are therefore submitted for approval to mitigate this risk.

1. Portfolio Investment

Following our investment adviser's presentation to the Scrutiny Committee in March he prepared the proposal attached as Appendix 1.

<p>Recommendation 1 – when the one-month term expires on 14 May, £1 million is transferred to our investment adviser to invest as outlined in their proposal</p>

2. Cash Investment

Currently our cash investment is delivering a poor rate of return (0.75%). From a review of competitor products the Clydesdale Bank which has this month announced a Charity Term Deposit Fund for deposits between £25,000 and £5 million. Interest rates are on a sliding scale up to 2.35% for 12-month deposits. As the Endowment Fund is a registered Charity (no. SC001116) we could take advantage of this account.

Under the bank's lending policy these funds would be available to support local businesses.

By initially setting up tranches at 3 month redemption intervals, then re-investing each for 12 months, after 9 months all our deposits would be obtaining the maximum interest rate. Additionally, if the Fund required large sums for investment in a particular project, funds would become available on a quarterly basis.

Recommendation 2 – when the one-month term expires on 14 May, transfer a balance of c. £2.4 million to the bank's Charity Term Deposit Fund to be invested in 4 tranches of £600,000 at 3-month redemption intervals

MONITORING FORM

Policy / Strategy Implications	<i>This proposal affects the Endowment Fund only</i>
Staffing Implications	<i>None</i>
Financial Implications	<i>None for the Board but potentially increased returns for the Endowment Fund within its terms of reference</i>
Consultation	<i>Investment managers / bankers</i>
Consultation with Professional Committees	<i>Scrutiny Committee</i>
Risk Assessment	<i>N/A</i>
Best Value	<i>N/A</i>
Compliance with Corporate Objectives	<i>N/A</i>
Impact Assessment	<i>N/A</i>

Dumfries & Galloway Health Board - Endowment Fund
Proposal to Invest Further Funds Presently held in Cash Reserve - March 2009

Background

This matter was loosely discussed at the Scrutiny Committee today and the detailed proposal for consideration is as follows:

At present the Endowment Fund is invested in the following proportions:

			Yield
Cash	55%	£3.15m	Below 1%
Index-Linked Gilts	7.5%	£0.43m	2.2%+ inflation
Other Fixed Interest Investments	9.5%	£0.47m	2.4%*
Equities	29.5%	£1.7m	4.5%

* Gross redemption yield (i.e. taking into account repayment at £100) when the fixed interest investment redeems

Recommendation

Over the last two years the cash reserve maintained outwith the Speirs & Jeffrey discretionary portfolio has significantly cushioned the overall value of the fund. In general, fixed interest investments now look quite fully valued. Equities have fallen from summer 2007 levels by c. 40%.

The investment background is difficult to assess at present. Strenuous and unprecedented efforts are being made to reflate Western economies by (a) slashing interest rates and (b) engaging in quantitative easing (i.e. printing money). The overwhelming likelihood is that this will lead to significant inflation in due course. The view taken is that a combination of index-linked gilts and equities is the best way to be positioned in such circumstances and this is therefore the direction we should be moving in now. It is proposed therefore that the proportions in the categories shown above should change over the next twelve months to reflect this expectation.

Reducing the cash balance by £1m now would facilitate a significant move in the appropriate direction which would be in our view both prudent and pragmatic in current circumstances. This would reduce the cash proportion by 17.5% (from 55% to 37.5% of the total) - still over a third and permit equities to rise to c. 45% plus some increase in the proportion invested in index-linked gilts to over 10%.

We would be looking at index-linked gilt investments redeeming in 2016 and 2020 i.e. giving sufficient time for inflation to emerge. These investments would not necessarily need to be maintained until redemption, but could be if appropriate.

The additional monies going into equity investments would be used to reinforce exposure to selections within the top 150 UK companies and also collective funds investing both in the UK and overseas. A useful by-product of such a strategy would be to improve the overall level of income. Whilst this is not a target in itself, we believe investments in companies like BP yielding 7%, etc are likely to perform relatively well over the next three years.



DUMFRIES AND GALLOWAY NHS BOARD

11 May 2009

Financial Performance: 12 Months to 31 March 2009



Author
Katy Lewis, Deputy Director of Finance

Sponsoring Director
Craig Marriott, Director of Finance

Date 4 May 2009

RECOMMENDATION

The Board is asked to note the financial performance to 31st March 2009.

SUMMARY

The Board is reporting that in 2008/09 it will carry forward £4.5 million of accumulated funding into future years in line with the Local Delivery Plan agreed at the start of the financial year. These figures are still subject to external audit and contain estimates of the costs of potential liabilities which may require adjustment. The revenue resource limit for 2008/09 is still subject to agreement with the Scottish Government.

Income

1. There have been a number of minor changes to income estimates since the April Board report, the overall total income for the year is £295.6 million. Appendix 1 details the movements.

Financial Performance

2. Appendix 2 is a summary of the Board's overall financial performance for the year to 31st March 2009. We spent £291.1 million of the £295.6 million funding available to us, leaving £4.5 million to carry forward into 2008/09 (subject to Scottish Government approval).
3. Within the three large acute directorates – medicine, surgery and anaesthetics – the medical and nursing pay, equipment and surgical stores overspends were worse than forecast increasing the year end overspend by £408k to £1.641 million (£1.233 million as per April Board). Whilst some of the increase can be attributed to revision of estimates for the cost of enhancements and overtime for nursing staff which were provided for (£110k), the increased cost of locum staffing for medical cover and other medical staffing pressures contributes to the overall overspend (£168k). The final month also saw additional purchases of equipment to the value of £84k.

4. Waiting times budgets, which were previously forecast to underspend by £315k, by the final year end position expenditure were marginally overspent by £6k. Refer to waiting times and activity paper for more detail.
5. Although the high cost drugs reserve for GP prescribing overspent by £315k (based on January prescribing figures) overall prescribing budgets underspent by £198k. LHP budgets overspent by £165k. However, this was an improvement of £16k on April Board forecast position.
6. Operational services overspend is £443k greater than forecast at March Board which is a significant shift in month. Expenditure on central maintenance increased by £53k this month and minor capital expenditure, as a result of transferring expenditure from capital to revenue, exceeded previous forecasts by £161k. Catering expenditure has increased by £70k following the appointment to a number of staff vacancies, not previously taken into account in forecasts. Despite rebasing energy budgets during the year, an overspend of £46k has arisen in the final month in this area.
7. The nursing directorate is now showing an overspend position at the year end, a £108k movement in the position from the April Board forecast. This comprises a £15k movement in the costs of the Joint Equipment Store, late working time directive costs for the regional nurse bank staff (not recharged out to departments) and Marie Curie Nursing costs exceeding budget by £15k.
8. Although still underspent, the Directorate of Public Health year end forecast moved by £119k in the final month. This reflects a combination of changes in estimates and reduction in income assumptions across Health Improvement and Strategic planning.

2008-09 Capital Plan Update

9. Total allocations received from SGHD to the end of March 2009 are £10.9m as anticipated, an allocation is expected to reduce this overall funding to match expenditure and bank the funding for future years.
10. Full year expenditure for 2008-09 schemes was as forecast with an outturn of £8.015m. This was effectively managed by accelerating equipment expenditure to offset a number of estate scheme underspends. Appendix 4 sets out the expenditure for the 2008-09 financial year against budget.
11. On this basis, the in-year carry forward anticipated to be £2.8m brings the total carry forward for future years to £12.5m. This carry forward will be used to support the 10 year capital plan previously shared with the Board.

Risks

12. Certain liabilities, particularly those surrounding Agenda for Change/Prescribing, are still estimates and may yet be subject to adjustments if new information comes to light before the balance sheet date.

13. The final income position is still being reconciled with the SGHD.

2009/10 Financial Plan

14. The financial plan for 2009/10 was approved by the Board at its April meeting and has been signed off by the Scottish Government.
15. The plan is contingent upon delivery of £3.3 million recurring cash releasing efficiency savings. An Efficiency Group has been constituted to support the delivery of these efficiencies, with regular reports being submitted to the Board within the monthly financial update.
16. Included within the plan is a recurring sum of £1.5 million to cover existing cost pressures and for prioritised developments for 2009/10. Discussions have been taking place to identify how this resource will be committed for the year.
17. Further updates on delivery against the plan will be brought to the Board in future month reports, along with regular reports to the Scrutiny Committee.

Policy/Strategy Implications	N/A
Staffing Implications	N/A
Financial Implications	Part of the financial planning and reporting cycle
Consultation	N/A
Consultation with Professional Committees	N/A
Risk Assessment	Part of paper.
Best Value	This paper contributes to Best Value goals of sound governance, accountability, performance scrutiny and sound use of resources.
Compliance with Corporate Objectives	Underpins achievement of many corporate objectives.
IMPACT ASSESSMENT	
N/A	

NHS DUMFRIES AND GALLOWAY REVENUE RESOURCE ANALYSIS AS AT 31st MARCH 2009		
		£000s
Projected revenue resource limit per April board paper (including cfwd.)		295,343
<u>New or increased allocations</u>		
Additional Training in Midwifery - One year Guarantee funding		27
NSD Positron Emission Tomography increase		(12)
AHP support & dev scheme year 2 outputs		2
Open University Pre-Reg Nursing Education Programme		9
Enhanced services - Extended hours & Nursing provision		176
Primary Medical Services Allocations increase		39
<u>Revisions to anticipated allocations</u>		
GDS Plus - Independent Dental Holdings reduction		(57)
Top sliced Orphan Drugs		(32)
Gender Based Violence Action Plan		(10)
<u>Increase in Other Income</u>		
Service agreement and other income		(186)
Service/project income matched by increased expenditure		32
Non Cash Ltd- other pharmacy adjustments		243
Total resources (including cfwd funds)		<u>295,574</u>
Total in year resources (excluding cfwd funds)		<u>288,567</u>
Appx2		

NHS DUMFRIES AND GALLOWAY 12 MONTHS ENDED 31st MARCH 2009					
	Actual Year to Date £000	Plan Year to Date £000	Variance Year to Date £000	Plan as at April Board £000	Forecast £000
Revenue Resource Limit for Year	261,962	261,962	0	261,067	261,962
Deduct previous years carry forward				(7,007)	(7,007)
Other NHS Scotland	5,618	5,676	(58)	5,678	5,618
Anticipated Allocations			0	753	0
FHS Non-discretionary allocation	14,352	13,968	384	14,109	14,352
Other NHS not Scotland	1,001	1,001	0	1,026	1,001
Other	12,641	12,695	(54)	12,710	12,641
Total Resources	295,574	295,302	272	288,336	288,567
Expenditure					
Clinical Services	144,845	143,661	(1,184)	142,851	144,845
LHP	53,424	53,260	(165)	53,401	53,424
Clinical Support Services	44,436	43,939	(496)	43,382	44,436
Admin. & Non Clinical Support Services	16,728	16,797	69	14,752	16,728
Externals	22,500	22,365	(135)	22,437	22,500
Reserves & Unreleased Budgets		1,606	1,606	4,846	0
Depreciation & Capital charges	9,140	9,174	34	9,174	9,140
Total Expenditure	291,073	290,802	(271)	290,843	291,073
Underspend/(Overspend) for Year	4,501	4,500		(2,507)	(2,506)
Funding carried forward from previous years				7,007	7,007
Uncommitted funds as at reporting date				4,500	4,501

NHS DUMFRIES AND GALLOWAY												
EXPENDITURE ANALYSIS												
12 MONTHS ENDED 31st MARCH 2009												
Annual Pay Budget £000	Annual Supplies Budget £000		Pays			Supplies			Total			Cum Var %
			Expend £000	Budget £000	Variance £000	Expend £000	Budget £000	Variance £000	Expend £000	Budget £000	Variance £000	
		Clinical Services										
13,791	4,351	Medicine	14,136	13,791	(345)	4,733	4,351	(382)	18,868	18,142	(727)	-4.1%
13,415	3,516	Surgery	13,682	13,415	(268)	3,749	3,516	(233)	17,431	16,930	(501)	-3.1%
7,905	1,497	Anaesthetics	8,048	7,905	(143)	1,768	1,497	(271)	9,816	9,403	(413)	-4.6%
1,887	1,261	Waiting Times	1,887	1,887	(0)	1,266	1,261	(6)	3,153	3,148	(6)	-0.2%
2,018	1,875	Cancer Services	2,006	2,018	12	1,997	1,875	(122)	4,004	3,893	(111)	-2.8%
8,134	755	Womens Services	8,148	8,134	(13)	794	755	(39)	8,941	8,889	(52)	-1.6%
6,011	533	Child Health	5,971	6,011	40	539	533	(6)	6,511	6,544	34	0.3%
5,241	2,266	Laboratory Medicine	5,189	5,241	52	2,367	2,266	(102)	7,556	7,507	(49)	-0.7%
2,574	647	Radiology	2,605	2,574	(31)	606	647	40	3,212	3,221	9	0.3%
18,022	2,029	Mental Health & Learning Disability	17,580	18,022	442	2,035	2,029	(6)	19,614	20,050	436	2.2%
325	40,929	Primary Care	373	325	(48)	40,806	40,929	123	41,179	41,255	75	0.2%
877	329	Dental	837	877	40	201	329	128	1,038	1,206	169	14.0%
3,192	280	GP Out of Hours	3,244	3,192	(52)	276	280	4	3,521	3,473	(48)	-1.4%
83,392	60,269		83,706	83,392	(314)	61,139	60,269	(870)	144,845	143,661	(1,184)	-0.9%
		LHCC										
6,272	7,486	Annandale & Eskdale	6,312	6,272	(39)	7,582	7,486	(96)	13,894	13,759	(135)	-1.0%
4,761	10,664	Nithsdale	4,700	4,761	61	10,735	10,664	(71)	15,435	15,425	(10)	-0.1%
3,896	4,946	Stewartry	3,763	3,896	133	5,115	4,946	(169)	8,878	8,842	(36)	-0.4%
7,779	7,455	Wigtownshire	7,665	7,779	114	7,553	7,455	(98)	15,218	15,234	16	0.1%
22,709	30,551		22,439	22,709	270	30,985	30,551	(434)	53,424	53,260	(165)	-0.3%
		Clinical Support Services										
3,788	664	Paramedical Services	3,577	3,788	211	671	664	(6)	4,247	4,452	205	4.6%
572	96	Family Planning & Sexual Health	488	572	84	163	96	(67)	651	667	16	2.4%
373	49	Managed Clinical Networks	347	373	26	76	49	(26)	423	422	(1)	-0.1%
1,497	8,276	Resource Transfer	1,376	1,497	121	8,312	8,276	(37)	9,689	9,773	84	0.9%
1,317	1,042	Pharmaceutical and Other Services	1,316	1,317	1	1,048	1,042	(6)	2,365	2,359	(5)	-0.2%
1,222	140	Medical Director	1,165	1,222	57	145	140	(5)	1,310	1,362	52	3.8%
1,994	662	Director of Nursing and Quality	2,022	1,994	(27)	696	662	(33)	2,717	2,657	(61)	-2.3%
8,319	13,928	Operational Services	8,206	8,319	114	14,828	13,928	(900)	23,034	22,247	(787)	-3.5%
19,083	24,856		18,498	19,083	585	25,938	24,856	(1,081)	44,436	43,939	(496)	-1.1%
		Administration & Non Clinical Support Services										
6,620	4,812	Executive Directorates	6,442	6,620	178	5,093	4,812	(282)	11,535	11,431	(104)	-0.9%
3,811	1,554	Director of Public Health	3,618	3,811	194	1,575	1,554	(21)	5,193	5,366	172	3.2%
10,431	6,366		10,059	10,431	372	6,669	6,366	(303)	16,728	16,797	69	0.4%
		Healthcare Providers outwith D&G Region										
0	22,365	Externals	0	0	0	22,500	22,365	(135)	22,500	22,365	(135)	-0.6%
135,615	144,407		134,702	135,615	913	147,231	144,407	(2,824)	281,933	280,022	(1,911)	-0.7%

** Forecast overspend after setting off earmarked reserves approved by the Board

	Approved Budget	Out turn	Variance
2008-09 CAPITAL EXPENDITURE STATEMENT	£000s	£000s	£000s
I.M. & T			
IM&T balance of approved Capital Budget	189	212	(23)
Clustering Considerations	61	61	0
Replacement Telephone System-Annan	0	0	0
Late Costs - 07/08 IM&T Projects	0	0	0
	250	273	(23)
Equipment			
Replacement Medical Equipment - Recurring	950	1,183	(233)
Replacement Medical Equipment - A&E Trolleys	108	108	0
Replacement Medical Equipment - Haematology	0	0	0
Replacement Medical Equipment - Analyser	165	138	27
Rolling Programme - General Equipment	80	109	(29)
Rolling Programme - Catering Equipment	73	73	0
Rolling Programme - X-ray Equipment	284	260	24
Angiography Equipment	588	607	(20)
CSSD Steriliser	45	45	0
CT Scanner	523	526	(3)
Ophthalmic Equipment	89	79	10
Susceptibility testing equipment	29	29	0
Late Costs - 07/08 Equipment Projects	0	0	0
	2,933	3,157	(224)
Estate			
Acute Mental Health Development	100	0	100
Family Planning & Sexual Health	400	348	52
DGRI A&E Refurbishment	110	0	110
DGRI Biomass Boiler	110	110	0
DGRI CT Scanner Rm	144	130	14
DGRI Dental Centre - Clinical Skills Room	120	103	17
DGRI Education Centre	516	496	20
DGRI MRI Scanner & Electrical Substation	803	857	(54)
DGRI Outpatients Department Entrance	60	61	(1)
DGRI Pre-Admission, Assessment and Admissions	64	65	(1)
DGRI Residences - valves	39	39	0
DGRI Theatre Upgrade - Ventilation	255	288	(33)
DGRI Traffic Management & Car Parking	350	349	1
DGRI X-Ray Refurbishment	355	359	(4)
DGRI/GCH Ophthalmology Redesign	135	135	0
Gatehouse Primary Care Centre	226	225	1
GCH - Helipad	42	54	(12)
Greencroft & Hospital Extension	604	601	3
Kelloholm PCC: Provisional	32	32	0
Lochfield Road GP Development	70	96	(26)
Nithbank Purchase of SAS Site	187	187	0
Late costs - 07/08 Estates Projects	20	45	(25)
	4,742	4,580	162
Additional schemes to be identified	90	0	90
Loss on Disposal	0	5	(5)
TOTAL PROJECTS APPROVED	8,015	8,015	0

DUMFRIES and GALLOWAY NHS BOARD

11 May 2009

WAITING TIME AND ACTIVITY REPORT



Author:

Jennifer Watt, Divisional Finance Manager

Sponsoring Director:

Jeff Ace, Director of Health Services

Date: 1 May 2009

RECOMMENDATION

The Board is asked to note the content of this report.

SUMMARY

This report summarises activity and waiting times performance relate to NHS Dumfries and Galloway residents as at 31st March 2009. It also compares activity levels with the same period in the previous year.

1. BACKGROUND

NHS Dumfries and Galloway have agreed local access targets with the Scottish Government's Performance Directorate.

Inpatients, Day Cases	12 weeks from GP referral to a first outpatient appointment from 31 st March 2009
Outpatients	12 weeks from GP referral to a first outpatient appointment from 31 st March 2009
8 Key Diagnostic tests	no patient to wait longer than 4 weeks for one of the tests from 31 st March 2009

(The National access targets for the same time frame are 15, 15 and 6 weeks respectively.)

It should be noted that as from 1st April 2009 the National access targets are that no patient will wait longer than 12 weeks from referral to first outpatient appointment from 31st March 2010. No patient will also wait longer than 12

weeks from being placed on the waiting list to admission for inpatient or day case treatment from 31st March 2010.

In addition to these the following targets remain in place:-

Ophthalmology	18 weeks from referral to procedure for cataracts
Cardiology	total target of 16 weeks for new angina patients (including tertiary treatment)
A&E	98% within 4 hours

2. ACTIVITY

The activity schedule (Appendix 1) gives an indication of the activity throughout NHS Dumfries and Galloway for the period to 31st March 2009. The 3% rise in emergency activity is the largest in recent years but not exceptional if compared with long term trends. It is encouraging to note the scale of switch from inpatient to day case elective surgery in the year that has resulted largely from investment in enhanced pre-operative assessment.

3. CURRENT WAITING TIMES

Position as at end February 2009

Appendix 2 shows the end of March waiting times position using the 'new ways' methodology. There were no breaches of the 12 week target in either outpatients or inpatients and day cases.

Return outpatients

The table below highlights the ongoing capacity issues regarding return outpatients within various specialties

Specialty	Number >8 weeks optimum date (23.4.09)	Number >8 weeks optimum date (23/3/09)	Action
Endocrinology	179	231	Specialist Nurse clinics being arranged
General Medicine	50	56	
Ophthalmology	366	325	Review of clinic profiles
Orthodontics	282	272	Continuation of review of treatment waiting list
	877	892	

Diagnostics

There are 3 breaches of diagnostic scopes as at 31st March 09 (2 over 4 weeks and 1 over 6 weeks.) There were also 5 diagnostic ultrasound breaches of the 6 week target.

HEAT targets

Appendix 3 shows the current position against HEAT targets in inpatients/day cases, out patients and diagnostics. The graphs reflect the outstanding achievement in inpatients and day cases to have no one waiting over 12 weeks as at 31st March 2009. The very small number of breaches within diagnostics, although disappointing, reflects the efforts of the specific department to maintain challenging waiting times.

Accident and Emergency Waiting Time

Performance against the 4 hour A&E target remained at 97% in March. This reflected continuing difficulties in managing Flow 3 and 4 patients (medical and surgical / orthopaedic patients respectively). Performance from mid April has returned to 98% and above.

4. CONCLUSION

Performance against this year's very challenging access targets is satisfactory and puts the Board in an excellent position to move to an 18 week whole pathway target by 2011.

Performance is particularly impressive when put in context of a substantial rise in non-elective flows that has created consistent workload pressures on staff.

MONITORING FORM

Policy / Strategy Implications	<i>Waiting Times</i>
Staffing Implications	<i>Additional internal capacity may impact on workload/staffing levels</i>
Financial Implications	<i>Discussed with Director of Finance and Director of Health Services</i>
Consultation	<i>As above</i>
Consultation with Professional Committees	<i>N/A</i>
Risk Assessment	<i>N/A</i>
Best Value	<i>Complies with principles of Best Value</i>
Compliance with Corporate Objectives	<i>Corporate Objective 7</i>
Impact Assessment	<i>Not required</i>

NHS Dumfries and Galloway

Comparison of Activity
April to March 2007/08 and 2008/09

		April 2007 to March 2008	April 2008 to March 2009	% Variance
Elective	(Acute, Maternity and Geriatric)			
	Inpatients	7,791	7,536	-3.3%
	Day Cases	15,735	16,748	6.4%
	Day Patients (Haemodialysis)	8,596	8,664	0.8%
	New Out patients	31,743	34,499	8.7%
	Return Outpatients	75,614	79,923	5.7%
Emergency	(Acute, Maternity and Geriatric)			
	Inpatients	18,457	19,024	3.1%
	A&E	49,277	49,328	0.1%
Births		1,467	1,417	-3.4%
Community Hospitals				
	Occupied bed days	42,983	43,468	1.1%
Mental Health	(General & Psychogeriatric - CRH)			
	Inpatients	560	534	-4.6%
	Occupied bed days	25,830	22,908	-11.3%
Labs		2,344,296	2,512,860	7.2%
Radiology (GP referral based activity)		15,809	15,492	-2.0%

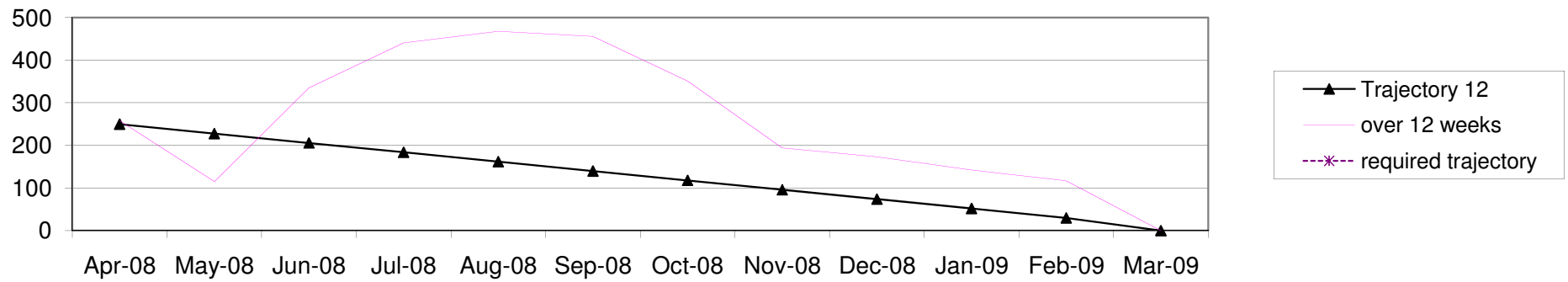
Waiting Times as at 31st March 2009

Inpatients and Day Cases Total					
	between 0 and 6 weeks	between 6 and 12 weeks	between 12 and 15 weeks	over 15 weeks	Total
ALL	1718	569	0	0	2287
Percentage of total waiting made up of	75%	25%	0%	0%	
Cardiology	35	7	0	0	42
Community Dental	31	23	0	0	54
ENT	106	48	0	0	154
Gastroenterology	30	3	0	0	33
General Medicine	23	4	0	0	27
General Surgery	479	129	0	0	608
Gynaecology	107	22	0	0	129
Medical Paediatrics	2	0	0	0	2
Neurology	10	0	0	0	10
Ophthalmology	285	39	0	0	324
Oral Surgery	158	135	0	0	293
Pain Relief	12	6	0	0	18
Palliative Medicine	1	0	0	0	1
Rehabilitation Medicine	1	1	0	0	2
Trauma & Orthopaedics	303	146	0	0	449
Urology	135	6	0	0	141
	1718	569	0	0	2287

Outpatients					
	between 0 and 6 weeks	between 6 and 12 weeks	between 12 and 15 weeks	over 15 weeks	Total
ALL	3612	895	0	0	4507
Percentage of total waiting made up of	80.1%	19.9%	0.0%	0.00%	
Anaesthetics(Pain)	45	8	0	0	53
Cardiology	178	78	0	0	256
Clinical Oncology	13	1	0	0	14
Dermatology	168	6	0	0	174
Endocrinology & Diabetes	117	38	0	0	155
ENT	284	52	0	0	336
Gastro enterology	109	28	0	0	137
General Medicine	138	19	0	0	157
General Surgery	498	66	0	0	564
Geriatric Medicine	28	1	0	0	29
Gynaecology	328	85	0	0	413
Haematology	7	0	0	0	7
Medical Paediatrics	94	18	0	0	112
Nephrology	6	1	0	0	7
Neurology	98	72	0	0	170
Ophthalmology	403	117	0	0	520
Oral Surgery	176	35	0	0	211
Orthodontics	97	25	0	0	122
Palliative Medicine	1	2	0	0	3
Rehabilitation	12	2	0	0	14
Rheumatology	79	30	0	0	109
Trauma & Orthopaedics	592	192	0	0	784
Urology	141	19	0	0	160
	3612	895	0	0	4507

Diagnostics					
	between 0 and 4 weeks	between 4 and 6 weeks	between 6 and 9 weeks	over 9 weeks	Total
Upper Endoscopy	158	1	1	0	160
Lower Endoscopy	16	0	0	0	16
Colonoscopy	80	1	0	0	81
Cystoscopy	70	0	0	0	70
CT Scans	119	0	0	0	119
MRI	121	0	0	0	121
Ultrasound	321	73	5	0	399
Barium Studies	4	0	0	0	4
	889	75	6	0	970
Percentage of total waiting	92%	8%	1%	0%	

New Outpatients over 12 weeks



DUMFRIES AND GALLOWAY NHS BOARD

11 May 2009

**NHSD&G Workforce Plan 2009/10****Author:** Tracy Davidson**Sponsoring Director:**

Caroline Sharp, Director of HR and Workforce Strategy

Date: 30 April 2009**RECOMMENDATION**

The NHS Board is asked to note the approvals from the Staff Governance Committee to the NHSD&G Workforce Headlines and the Chief Executive's endorsement of the workforce predictions subject to financial plan approvals.

SUMMARY

NHS Dumfries and Galloway was expected to submit the following key pieces of workforce data to Scottish Government in 2009/10;

1. Local Delivery Plan (LDP) workforce narrative
2. Workforce Headlines submission by 30th April 2009 (Appendix 1)
3. 2009 Workforce Projections by 30th April 2009 (Appendix 2)

1. LOCAL DELIVERY PLAN (LDP)

The LDP continues to require a risk assessment of the workforce implications of each of the HEAT targets and contextual information on how these risks are being managed. LDP guidance suggests that the workforce narrative "should include an assessment of staff availability to deliver the target, the need for any training and development to ensure staff have the competency levels required, and consideration of affordability cross referenced to the Financial Plan".

This year's LDP has been submitted in draft to the Scottish Government, and is taken to committee via the Director of Health Services for approvals.

2. WORKFORCE PLAN

The Scottish Government recognise that HEAT targets and LDPs do not represent the complete range of NHS Board services which rely on the right workforce mix for successful delivery and, therefore, although not required to be submitted to the

SGHD, Boards are required to continue to publish their full workforce plans by April 2009 at a local level. In the past, NHS D&G have published full workforce plans each year, however it was agreed that as we are in the process of developing our workforce plans for new clinical service models, that our efforts this year are concentrated on highlighting the big workforce challenges we face which we can capture through the Workforce Headlines document described below. In addition, workforce planning is currently being undertaken in specific staff groups outwith those affected by the clinical strategy for example in Integrated Children's Services and as part of the Mental Health Service Development Project.

3. WORKFORCE HEADLINES

The Scottish Government have indicated that this year they wish to be informed of the key workforce issues emerging from the wider workforce planning activity underway within Boards, and as a result Boards are asked to submit a general workforce summary together with the April 2009 projections, which should cover at least the following headlines:

- Information on significant changes in skill mix and the plans to take this forward;
- Existing and planned new service areas with particular workforce pressures and possible solutions; and
- Other significant workforce issues that the Scottish Government should be aware of that may require a national focus.

The production of the Workforce Headlines for NHSD&G was discussed within the Workforce Steering Group, and it was agreed that professional heads would take responsibility for completing this for their areas

It was also agreed that for this year because of the focus on workforce planning for the clinical strategy, the Workforce Headlines would constitute our Board Workforce Plan and would be supplemented for local use by a set of workforce statistics, ethnic monitoring report and the sign off of the 08/09 Workforce Action Plan.

The NHSD&G Workforce Headlines document is attached at Appendix 1.

4. WORKFORCE PROJECTIONS

The Scottish Government have indicated their intention to align workforce projections with the production of the LDP, and consequently ISD published baseline workforce data early this year (December rather than late January) to facilitate this. It was however agreed not to pursue this objective in 09/10 but to maintain this as future objective.

The purpose of undertaking the projections work is to enable the Scottish Government to make decisions about training numbers for controlled staff groups, and there is an expectation that Boards will submit robust numbers that have been tested for *affordability, availability and adaptability*. Projections are a mandatory requirement and the deadline for submission to the Scottish Government is **30 April 2009**.

Medical projections up to three years will be captured as part of the projections template this year, however beyond this timeframe will be picked up through the new medical workforce framework which will have a later submission date closer to the autumn of 2009. To date this framework is still in draft form having being piloted across a number of specialties in January 2009.

The timetable for developing workforce projections this year, and the leads responsible for developing workforce forecasts are as follows;

Date	Action
22 December 08	ISD Populated templates issued to projection leads
22 Dec – 28 Feb 09	Projection Leads/Finance to develop 1 st draft projections Workforce Headlines to Leads
28 Feb – 31 Mar 09	First draft projections/Headlines to Exec Dirs for review
31 Mar – 6 Apr 09	Exec Dir Feedback to Finance for adjustments to be made
6 Apr – 17 Apr 09	Finance/Projection Leads - final adjustments to projections
20 Apr 09	Final Projections to CEO for sign off and to Staff Governance Committee for remote approval by 24 th Apr 09
30 Apr 09	Submit projections to Scottish Government

Staff Group	Projections Lead
Medical/Dental	Angus Cameron
Nursing & Midwifery ❖ Children ❖ Mental Health ❖ Learning Disability ❖ Maternity	Hazel Borland leading and in conjunction with Jennifer Milligan Iain Boddy Heather Collington Brenda Thorpe
AHPs	Hazel Dykes
Clinical Psychology & Counselling	Ian Hancock
Pharmacy	Michael Pratt
Admin, Support Services	David Bryson
Healthcare Science	Sam Whiting

5. Next Steps

The context within which we plan our workforce is changing; there are potential changes in the local labour market because of the current economic crisis; the development of new service delivery models locally will mean new ways of working and new opportunities for our workforce; plus our financial allocations will impact on the way we use our workforce to ensure maximum efficiency.

Our 2010 Workforce Plan should reflect this and continue to be developed by ensuring an integrated approach of workforce, service and financial involvement in all service planning activity.

MONITORING FORM

Policy/Strategy Implications	Workforce Strategy Development in general and possibility of impact upon some HRWFS policies in the future although not clear at the moment
Staffing Implications	Future staffing projections are included in the plan, however future data validation is required before the staffing figures can be safely ratified. The continuing development of SWISS and HR.net will assist in this process.
Financial Implications	Any workforce planning activity must meet the three A's test as highlighted in HDL 52 (2005) ' <i>Affordability, Availability & Adaptability</i> '
Consultation	The Workforce Plan has been agreed and approved by NHSD&G Staff Governance Committee as per HDL (2005) 52.
Consultation with Professional Committees	Not applicable to this paper
Risk Assessment	Not applicable to this paper
Best Value	
Compliance with Corporate Objectives	Corporate Objectives 2, 3
IMPACT ASSESSMENT	

Appendix 1



NHS Dumfries and Galloway

Workforce Plan 2009

Section 1: Workforce Headlines

Can you explain the principles behind the development of your workforce projections?

- 1-3 year projections are aligned to the NHS Board financial plan to ensure affordability. Where growth is expected in the longer term there is reference made to relevant policy drivers.
- Projections take into consideration the delivery of new clinical services strategy that will involve more effective use of community nursing teams and community hospitals (Shifting the balance from acute to community).
- Awareness of numbers of staff due to retire in next 5-10 years.
- Awareness of the need to invest in a higher level of practice for nurses e.g. Advanced Nurse Practitioners within Hospital at Night.
- Awareness of demand management and recruitment implications.
- Service redesign outwith the clinical services strategy e.g. Maternity Services Review.

What process did you go through to approve these?

- An integrated approach is taken to develop workforce projections involving service, finance and workforce colleagues.
- Draft workforce projections will be presented to NHS Board Directors, NHS Dumfries and Galloway Workforce Steering Group, Area Partnership Forum, Staff Governance Committee.
- Sign Off by Chief Executive then to NHS Board for final approval.

What are the key workforce issues for each of the following occupational groups facing your Board which might be of interest at Regional and/or National level?

All occupational groups within NHSD&G are currently part of a clinical services strategy review and the potential options for future service delivery are being developed with workforce plans to support them.

Medical and Dental

There are multiple pressures facing NHS D&G medical workforce in the short term, and longer term including a small number of long standing consultant vacancies which we will continue our efforts to fill this year e.g. Care of the Elderly, Orthodontics and Pathology.

The need to develop middle grade rotas that are compliant with the European Working Time Directive has led to significant re-examination of the medical staffing model of many departments. Plans are in place to achieve full compliance by August 2009, and this will be achieved by the recruitment of speciality doctors, and by a joint paediatric/obstetric on call rota at the junior level. A number of speciality doctor posts have recently been approved by the NHS Board in order to ensure WTD compliance and to plan forward for the future pressures around availability of doctors.

In the longer term, workforce planning will need to focus around the impact of the expected reduction in the number of doctors in training and developing robust workforce plans that will support an expected 40% reduction whilst balancing the expected demand in activity created by for example the 18 week RTT and the increased throughput in Dumfries & Galloway Royal Infirmary as a result of our clinical strategy.

It should be highlighted that the situation in relation to transfer of funds from NES to Boards following disestablishment of posts has not been confirmed, and we feel that the development of concrete understanding of how the funds will transfer would be of great assistance to all boards as they develop their plans for a redesigned workforce across all specialities.

Recruitment of dentists remains challenging, however the opening of the new Dumfries Dental Centre

and dental training centre should support long term workforce stability.

Nursing and Midwifery

Workforce planning activity for this staff group is focussed around developing robust workforce plans to support the delivery of the clinical services strategy.

Specifically there are ongoing challenges of recruitment and retention, particularly for specialist groups e.g. Public Health Nurses.

Accurate assessments of Workload/Workforce requirements to underpin workforce planning need reliable and refined tools.

Workforce planning activity needs to balance a need for increased capacity to meet demographic trends with a restricted financial envelope. Implementation of "Releasing Time to Care" will assist this work.

In neonatal nursing there are difficulties in recruiting to Advanced Neonatal Nurse Practitioner posts, and it is now no longer recommended to employ midwives in neonatal units.

Healthcare Science

Difficulty in filling Biomedical Sciences vacancies, coupled with a significant number of likely retirements in the next few years

Significant problems in audiology will be further exacerbated by the introduction of the audiology RTT from 2011. There are local issues around AfC Bands and a shortage of Audiologists locally and nationally. Workforce planning in this area has been undertaken, and Assistant Practitioner training commence in autumn of this year.

Cardiology RTT is impacting upon Cardiac Clinical Physiology, and activity data demonstrates need for one additional Band 7 Technician. Temporary funding has prevented recruitment and locum cover is being provided. A further bid will be made through prioritisation process over next few months.

Allied Health Professionals

Workforce planning activity is focused around the needs of the clinical services strategy and its impact on the AHP workforce.

In general, workforce planning for this staff group needs to support Shifting the Balance of Care but within the constraints of a rural area where travel and access to services are the challenge.

Other staff groups

Ancillary

There are a number of areas impacting upon this staff group presently which will require the workforce to develop quite significantly. Electronic technology could support workforce change in particularly medical records e.g. electronic patient record, and work is underway in this area to redesign the service.

The impact of single room provision for the proposed redevelopment of Dumfries and Galloway Royal Infirmary is not known at present, however this is being addressed as part of the clinical strategy workforce planning activity.

There is a need to understand the impact on domestic services of HAI developments on training requirements and cleaning frequencies as well as a need to clarify responsibilities within the wider

healthcare team.

Pharmacy

Substantial long term difficulties exist in pharmacist recruitment throughout the grade range, although this is a national problem, the rurality of Dumfries and Galloway, and the relatively small staffing emphasises this problem in this area.

Recent recruitment of pharmacy technicians is proving difficult and inhibiting service development.

Do you anticipate a significant change in skill/grade mix? If so where/ who/ what?

Medical and Dental

Medical workforce planning is being undertaken with the anticipation that any new consultant posts will be on the basis of a 9:1 DCC/SPA contract, with only change to that arrangement in consideration of specific tasks that the Board requires. In the longer term it is recognised that there may be a fall in the number of junior doctors at FY1 and FY2 level, and therefore our workforce plans will take consideration of the need to develop non-medical staff to replace doctors – for example the development of more Advanced Nurse Practitioners to help with the Hospital at Night Team.

It is expected that there will be a bulge in CCT holders over the next few years, and we plan to take advantage of this by offering speciality doctor posts which would be of sufficient seniority and interest to attract new CCT holders.

It is recognised that many of the doctors who complete their GP vocational training are not going directly into partnership, and we are exploring ways in which this workforce could be harnessed in providing some work in general practice, but also providing some service delivery (and developing extra skills/knowledge).

Nursing & Midwifery

Workforce planning is currently underway to identify the role developments required to meet the needs of patients, individuals and communities, and the NHSD&G Clinical Services Strategy will inform this.

Plans are in place to increase the current complement of Advanced Nurse Practitioners within

- Accident & Emergency
- Medical Assessment Unit
- Hospital @ Night
- Outreach provision: Detection & Response to the Deteriorating Patient

It is expected that wherever possible a 60:40 ratio will be maintained.

At this time it is anticipated that progress will be made within development of Band 4 in line with the national work in this area, and already Maternity Care Assistants have been introduced.

Work is currently underway within the development of generic workers – Health, Social Care, AHPs – Band 3. This group of staff will work to detailed care plans following assessment of need by the appropriate professional.

A local review commensurate with the national census has been undertaken recently within Public Health Nursing. Plans are now being formulated re additional specialist training and implementation of skill mix. A similar review will be undertaken within District Nursing in the autumn

Health Science

Work is underway nationally to review career structures for healthcare science staff. Given the current recruitment challenge D&G are already developing a Band 4 position within microbiology linked to additional training and development.

AHP

Work is currently underway to identify role development requirements in various areas. It is expected that the development of the Assistant Practitioner grade could have a positive impact on recruitment, and training is now complete for two Radiography Assistant Practitioners.

Alongside this will be alongside this will be role development for Band 7 to Band 8a for some professions e.g. Specialist Physio and OT in Stroke Care, Specialist MSK Physiotherapist.

In Radiography training is now underway for Advanced Practitioner Radiographers in Image Reporting and in mammography.

Which areas of the service do you anticipate will give you the most significant workforce challenges?

Medical and Dental

Consultant vacancies described earlier i.e. Care of the Elderly, Orthodontics, Pathology. EWTD requirement to develop compliant middle grade rotas.

NHSD&G continues to carry a small number of dental vacancies which we expect to recruit to later this year. Overall, we are pleased that the percentage of the adult population registered with an NHS Dentist has increased from 40% to around 57%.

Nursing & Midwifery

Particular areas are within Public Health, Critical Care, Renal Services, Advanced Practice due to lead in training time.

Health Science

Labs – Biomedical Scientists

AHP

Most AHP areas are affected by the rurality of the area and its distance from Central Belt. There are difficulties recruiting to Band 6 and above, however the most significant issue is around the temporary funding of many posts. This approach to service resourcing results in the long run in cost inefficiencies as expensive locum staff have often to be used to maintain service continuity.

What are your recruitment hotspots?

Medical & Dental

In general, NHSD&G struggles to attract medical students, however this also applies to the recruitment and retention of permanent medical staff. There are a number of outstanding vacancies described above. NHSD&G have undertaken to examine how it markets this area, linking in with the Local Authority in an effort to attract medical staff and their families to the region.

Nursing & Midwifery

Public Health Nurses.

Advanced Nurse Practitioners - as previously stated there is a need for us to develop these roles from within our existing workforce however is a limit to the number of nurses who have the desire and capability to progress their practice in this way.

Specialist Areas – there is an outreach service provision for renal and chemotherapy services in an area which is 150 miles from the DGH which presents particular challenges for supervision, management and maintenance of skills.

Recruitment and succession planning to Senior Charge Nurse posts is difficult but it is hoped that Leading Better Care will help to promote this role.

AHP

As described above there are challenges recruiting to some senior AHP posts particularly in more rural areas e.g. Wigtownshire, when coupled with temporary funding, this creates hotspots. In Radiography NHSD&G are experiencing difficulty in recruiting Sonographers.

What other workforce challenges are facing you at present?

- Impact of EWTD on medical staffing from August 2009
- Impact of MMC – decreasing numbers of doctors in training
- Loss of FTSTA posts in Aug 2009
- New Speciality Doctor Contract
- Agenda For Change reviews are ongoing therefore actual workforce configuration will not be known until these have been completed
- Reconfiguration of workforce in some areas to meet HEAT targets
- Competition with other local agencies e.g. Local Authority within a decreasing working age population.
- Financial investment required to “grow our own”
- Overcoming professional preciousness and actively promoting the blurring of boundaries to provide a flexible workforce
- Robust evaluation of impact/outcome of resource allocation/service delivery
- Part time staff present operational challenges in maintaining rotas in some areas.
- Temporary funding means inability to recruit and use of locums in short term
- Ineffective service development planning within clinical teams leading to crisis management rather than planned change based on best value and patient centred care.

Are there any other workforce headlines which you feel the SGHD should be aware of?

NHS D&G is progressing the development of a Band 3 Generic Worker role which will deliver personal, social and enablement/rehabilitation care. Given our geographic spread and pockets of isolation/remoteness this will enable us:

- to reduce duplication
- to minimise the number of individual services attending an individual's home
- to provide a more intense level of prescribed care
- to ensure individuals achieve their optimum level of independence as soon as possible
- to prevent unnecessary admission to hospital and to facilitate the earliest possible discharge from hospital

Section 2: Workforce Profile

The data in this section is based on published ISD data taken at 30 September 2008. NHS Dumfries & Galloway employs over 4,000 people across the region. ISD data reflects Agenda for Change staff categories and medical/dental career grades.

1. NHS Dumfries & Galloway Workforce summary by staff group

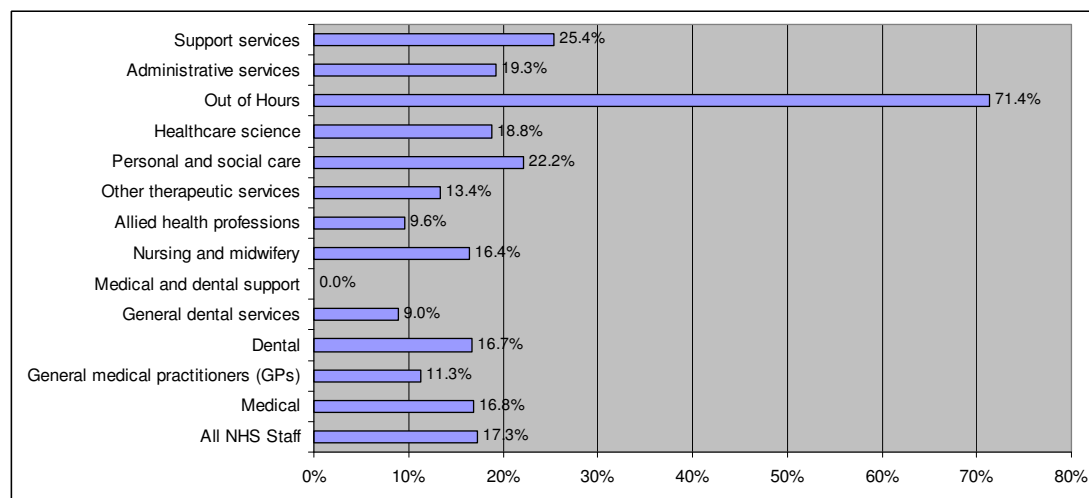
Data as at 30 September 2008	Headcount	WTE
Medical (Hospital, community and public health services)	291	240.25
General medical practitioners (GPs)	159	Not available
Dental (Hospital, community and public health services)	18	15.81
General dental services	67	Not available
Medical and dental support	39	32.96
Nursing and midwifery	2198	1766.83
Allied health professions	302	236.36
Other therapeutic services	112	85.64
Personal and social care	9	8.40
Healthcare science	117	102.85
Out Of Hours	21	12.73
Administrative services	799	641.54
Support services	578	406.50
Total Workforce	4710	3549.89

Source:

Scottish Workforce Information Standard System (SWISS)

WTE = Whole Time Equivalent

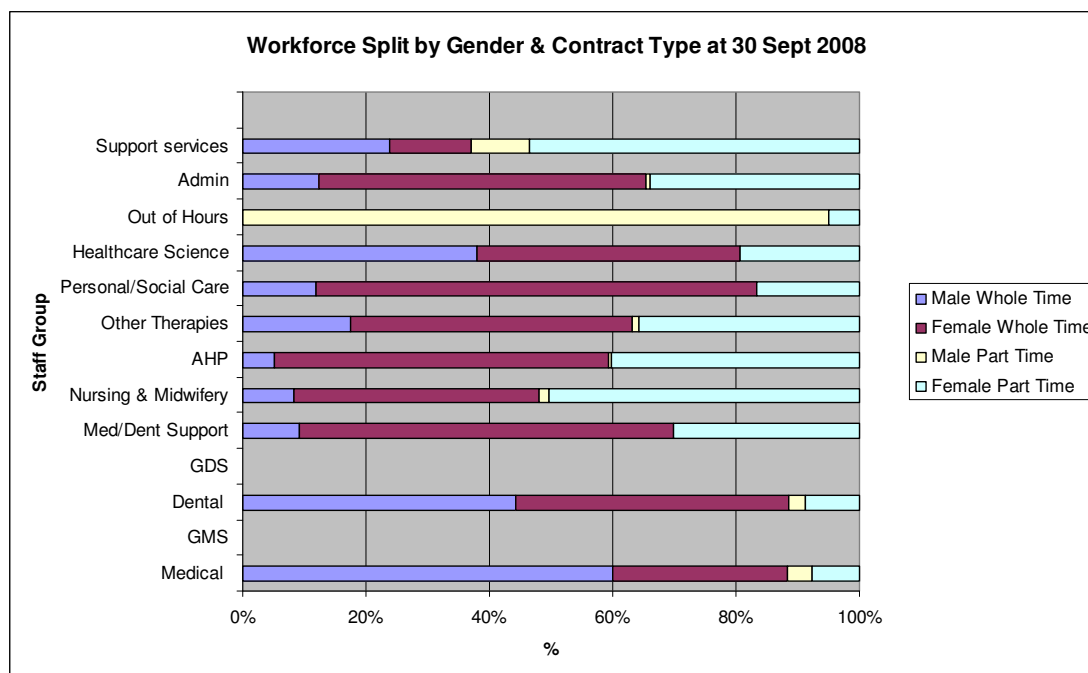
2. Proportion of NHS D&G Staff by Staff Group Aged 55 & Over at 30 September 2008 (Headcount)



Source: ISD Overall Staff in Post Summary

Employees aged 55 or over, who will be contemplating their retirement plans in the near future, account for just over 821 people in NHS Dumfries & Galloway. It is also important to remember that many NHS jobs have a physical element that may become less attractive to older employees, who may wish to change the type of work they take on.

3. NHS Dumfries & Galloway Workforce by Gender & Contract Type



The workforce in NHS Dumfries & Galloway is over 80% female, with the majority of staff groups being more than half female employees. The exceptions are hospital doctors, GPs and dentists who are more than 60% male. This follows a similar pattern to the Scottish NHS workforce.

While female employees outnumber male employees 5:1, the majority of women working in the NHS work on a part time basis.

4. NHS Dumfries & Galloway Vacancies as at 30 September 2008 (WTE) compared with vacancies at 30 September 2007

Consultant Vacancies	2008	2007
Establishment	114.6	104.2
Staff in Post	107.7	92.6
Posts under review		
Total Vacancies	6.9	11.6
Posts vacant over 6 months	1.5	9
Total Vacancy Rate %	6.0%	11.10%
Over 6 months Vacancy Rate	1.3%	8.60%
Nursing & Midwifery Vacancies	2008	2007
Establishment	1,804.0	1,806.40

Staff in Post	1,776.8	1,770.40
Posts under Review	1.0	2
Total Vacancies	36.1	34
Posts Vacant less than 3 months	27.5	26.4
Posts Vacant more than 3 months	6.0	7.6
Total Vacancy Rate %	2.0%	1.90%
Over 6 months Vacancy Rate	0.3%	0.40%

AHP Vacancies	2008	2007
Establishment	248.3	244.5
Staff in Post	236.4	239
Posts under Review		1.7
Total Vacancies	12.0	3.8
Posts Vacant less than 3 months	7.1	3.8
Posts Vacant more than 3 months	4.9	-
Total Vacancy Rate %	4.8%	1.60%
Over 6 months Vacancy Rate	2.0%	0.00%

There has been a clear rise in the number of AHP vacancies which are in the following AHP groups; Physiotherapy, Occupational Therapy, Podiatry and Speech and Language Therapy.

5. NHS D&G Turnover 1st October 2007 to 30 September 2008

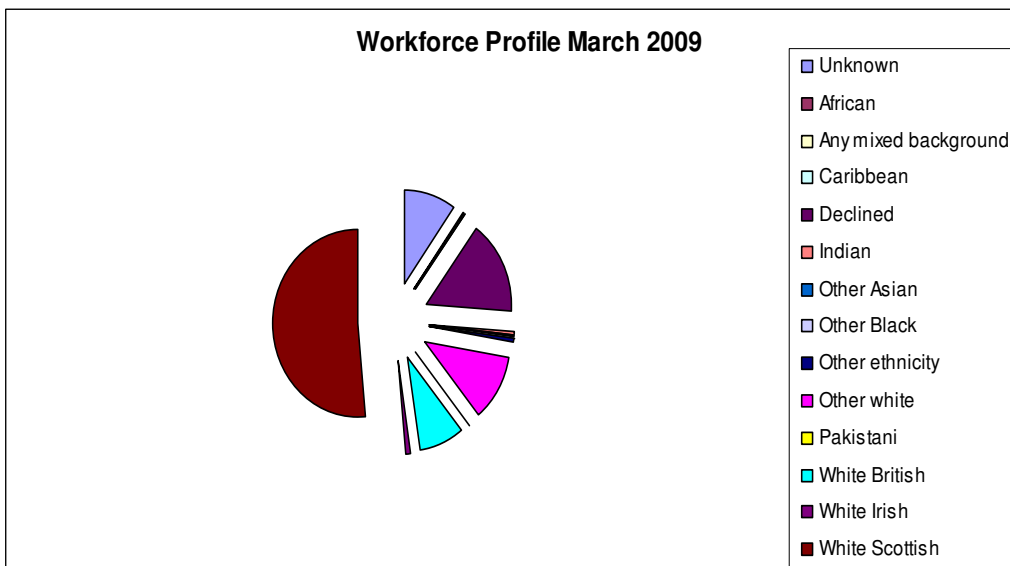
Staff Group	Staff in post		Leavers	Turnover
	01-Oct 07	30-Sep 08		
All	4192	4186	405	7.0%
Administrative Services	765	781	110	9.5%
Allied Health Profession	306	302	37	8.1%
Out of Hours	25	21	4	11.3%
Health Science Services	108	114	13	7.9%
Medical and Dental	10	9	1	6.9%
Medical and Dental Support	37	40	2	3.5%
Nursing/Midwifery	2,213	2,202	170	5.1%
Other Therapeutic Service	103	111	11	6.9%
Personal and Social Care	9	8	1	7.7%
Senior Management	24	19	6	17.9%
Support Services	592	579	85	9.6%

'Turnover' is defined as the number of 'leavers' divided by the average number of staff in post in the year concerned. The denominator is calculated as: (staff post at yr(n) + staff in post at yr(n+1))/2. The overall turnover rate has reduced from 9.8% in 2006/07 to 7.0% in 2007/08. A number of workforce areas have reduced turnover e.g. Admin & Clerical reduced from 15.8% to 9.5% and Health Sciences reduced from 13.3% to 7.9%. Otherwise any increases in turnover are within very small staff groups e.g. senior management.

Section 3: Ethnic Monitoring

1. NHS D&G Workforce by Ethnicity

Ethnic Group	No.	%
Unknown	491	9.82%
African	5	0.10%
Any mixed background	8	0.16%
Caribbean	2	0.04%
Declined	805	16.10%
Indian	29	0.58%
Other Asian	6	0.12%
Other Black	1	0.02%
Other ethnicity	21	0.42%
Other white	584	11.68%
Pakistani	6	0.12%
White British	428	8.56%
White Irish	46	0.92%
White Scottish	2567	51.35%



2. Non Medical Recruits by Ethnicity

Total Jobs Advertised in 2008	568
Total no of applicants	5146
Total no. shortlisted	379
Total no. appointments	625

NB. Shortlisted numbers incomplete due to internal processes failure. Therefore the % in 'Appointed table' are skewed

Ethnic Group	no. of applicants	% of total applicants
White Scottish	3775	73.36%
Other White British	708	13.76%
White Irish	71	1.38%
Other White	171	3.32%
Indian	110	2.14%
Pakistani	16	0.31%
Bangla-deshi	5	0.10%
Other South Asian	39	0.76%
Chinese	6	0.12%
Caribbean	0	0.00%
African	22	0.43%
Black Scot or Other Black	2	0.04%
Any Mixed Back ground	15	0.29%
Other Ethnic Group	12	0.23%
Not Answered	194	3.77%

Ethnic Group	no. Shortlisted	% of total no. shortlisted	% of respective ethnic group applications
White Scottish	274	72.30%	7.26%
Other White British	61	16.09%	8.62%
White Irish	4	1.06%	5.63%
Other White	11	2.90%	6.43%
Indian	6	1.58%	5.45%
Pakistani	3	0.79%	18.75%
Bangla-deshi	0	0.00%	0.00%
Other South Asian	2	0.53%	5.13%
Chinese	0	0.00%	0.00%
Caribbean	0	0.00%	0.00%
African	2	0.53%	9.09%
Black Scot or Other Black	0	0.00%	0.00%
Any Mixed Back ground	1	0.26%	6.67%
Other Ethnic Group	1	0.26%	8.33%
Not Answered	14	3.69%	7.22%

Ethnic Group	No. appointed	% of no. appointed	% of respective ethnic group applications	% of respective ethnic group shortlisted
White Scottish	195	31.20%	5.17%	71.17%
Other White British	55	8.80%	7.77%	90.16%
White Irish	2	0.32%	2.82%	50.00%
Other White	8	1.28%	4.68%	72.73%
Indian	3	0.48%	2.73%	50.00%
Pakistani	0	0.00%	0.00%	0.00%
Bangla-deshi	0	0.00%	0.00%	0.00%
Other South Asian	1	0.16%	2.56%	50.00%
Chinese	0	0.00%	0.00%	0.00%
Caribbean	0	0.00%	0.00%	0.00%
African	0	0.00%	0.00%	0.00%
Black Scot or Other Black	0	0.00%	0.00%	0.00%
Any Mixed Back ground	2	0.32%	13.33%	200.00%
Other Ethnic Group	0	0.00%	0.00%	0.00%
Not Answered	359	57.44%	185.05%	2564.29%

Source: HR.net and Marje

3. Non Medical Recruits by Ethnicity

Total Jobs Advertised in 2008	53
Total no of applicants	102
Total no. shortlisted	45
Total no. appointments	25

Ethnic Group	no. of applicants	% of total applicants
White Scottish	6	5.88%
Other White British	5	4.90%
White Irish	0	0.00%
Other White	3	2.94%
Indian	6	5.88%
Pakistani	3	2.94%
Bangla-deshi	0	0.00%
Other South Asian	1	0.98%
Chinese	0	0.00%
Caribbean	1	0.98%
African	6	5.88%
Black Scot or Other Black	1	0.98%
Any Mixed Back ground	0	0.00%
Other Ethnic Group	5	4.90%
Not Answered	63	61.76%

Ethnic Group	no. Shortlisted	% of total no. shortlisted	% of respective ethnic group applications
White Scottish	4	8.89%	66.67%
Other White British	3	6.67%	60.00%
White Irish	0	0.00%	0.00%
Other White	1	2.22%	33.33%
Indian	0	0.00%	0.00%
Pakistani	0	0.00%	0.00%
Bangla-deshi	0	0.00%	0.00%
Other South Asian	0	0.00%	0.00%
Chinese	0	0.00%	0.00%
Caribbean	1	2.22%	0.00%
African	1	2.22%	16.67%
Black Scot or Other Black	0	0.00%	0.00%
Any Mixed Back ground	1	2.22%	0.00%
Other Ethnic Group	1	2.22%	20.00%
Not Answered	33	73.33%	52.38%

Ethnic Group	No. appointed	% of no. appointed	% of respective ethnic group applications	% of respective ethnic group shortlisted
White Scottish	3	12.00%	50.00%	75.00%
Other White British	1	4.00%	20.00%	33.33%
White Irish	0	0.00%	0.00%	0.00%
Other White	1	4.00%	33.33%	100.00%
Indian	0	0.00%	0.00%	0.00%
Pakistani	0	0.00%	0.00%	0.00%
Bangla-deshi	0	0.00%	0.00%	0.00%
Other South Asian	0	0.00%	0.00%	0.00%
Chinese	0	0.00%	0.00%	0.00%
Caribbean	1	4.00%	0.00%	0.00%
African	1	4.00%	16.67%	100.00%
Black Scot or Other Black	0	0.00%	0.00%	0.00%
Any Mixed Back ground	0	0.00%	0.00%	0.00%
Other Ethnic Group	0	0.00%	0.00%	0.00%
Not Answered	18	72.00%	28.57%	54.55%

Source: Medical Recruitment Spreadsheet held in HR Dept

4. Training attended Jan 08 to Dec 08 by Ethnicity

	Non-mandatory training courses attended Jan - Dec 2008	
Ethnic Group	No.	% terms
White Scottish	478	57.94%
White British	58	7.03%
White Irish	11	1.33%
Other White	85	10.30%
Indian	5	0.61%
African	2	0.24%
Any Mixed background	3	0.36%
Declined	122	14.79%
No ethnicity recorded	56	6.79%
Other Ethnic Group	5	0.61%
TOTALS	825	100.00%

Source: HR.net

5. Grievances by Ethnicity April 08 – March 09

	Submitted a grievance	Formal Resolution	Informal Resolution
Ethnic Group			
White Scottish	15	9	6
Other White British	1		1
White Irish			
Other White			
Indian	1	1	0
Pakistani			
Bangladeshi			
Other South Asian			
Chinese			
Carribbean			
African			
Black Scot or other			
Any Mixed background	1	1	
Declined to comment	1		1
TOTALS	19	11	8

Source: Internal HR Records

6. Disciplinary Cases by Ethnicity April 08 – March 09

Ethnic Group	Subject to disciplinary
White Scottish	15
Other White British	3
White Irish	
Other White	
Indian	

Pakistani	
Bangla Deshi	
Other South Asian	
Chinese	
Caribbean	
African	
Black Scot or other	
Any Mixed background	
Declined	
TOTAL	18

Source: Internal HR Records

7. Turnover by Ethnicity Jan 08 – Dec 08

Ethnic Group	Staff turnover Jan - Dec 2008	% terms
Unknown	114	14.90%
African	3	0.39%
Any mixed background	3	0.39%
Caribbean	1	0.13%
Chinese	1	0.13%
Declined	109	14.25%
Indian	23	3.01%
Other Asian	3	0.39%
Other Black	0	0.00%
Other ethnic background	4	0.52%
Other white	49	6.41%
Pakistani	3	0.39%
White British	69	9.02%
White Irish	11	1.44%
White Scottish	372	48.63%
Total	765	100.00%

Source: HR.net

Section 4: Workforce Projections - Summary

NHSScotland Workforce Summary

NHS Dumfries & Galloway

[See Advice for Completion](#)[ATC post descriptors](#)

	Year ending 30th September					
	ISD Baseline Data	Year 1	Year 2	Year 3	Year 5	Year 10
	2008	2009	2010	2011	2013	2018
	WTE Staff in Post (at 30th Sept)	WTE Expected	WTE Expected	WTE Expected	WTE Expected	WTE Expected
HCHS medical and dental staff^{1,2}	163.6	200.4	204.4	211.4	-	-
HCHS medical staff²	149.8	149.1	153.1	160.1	-	-
Consultant ³	108.7	106.1	107.1	109.1	-	-
Staff and associate specialist grades	26.3	42.7	45.7	50.7	-	-
Other trained grades	14.8	0.3	0.3	0.3	-	-
HCHS dental staff²	13.8	18.3	18.3	18.3	-	-
Consultant ³	1.0	3.5	3.5	3.5	-	-
Staff and associate specialist grades	1.0	2.0	2.0	2.0	-	-
Other trained grades	11.8	12.8	12.8	12.8	-	-
Medical and dental support	33.0	33.0	33.0	33.0	-	-
Nursing and midwifery staff⁴	1,766.8	1,790.2	1,810.9	1,810.9	1,810.9	-
Adult	1,205.7	1,205.7	1,205.7	1,205.7	1,205.7	-
Children	50.4	62.2	62.2	62.2	62.2	-
Mental health	293.0	308.9	329.6	329.6	329.6	-
Learning disabilities	96.6	96.6	96.6	96.6	96.6	-
Maternity	116.8	116.8	116.8	116.8	116.8	-
Not assimilated	4.3	-	-	-	-	-
Allied health professions⁴	236.4	239.5	238.4	238.4	-	-
Arts therapy (art/music/drama)	-	-	-	-	-	-
Dietetics	13.1	13.6	13.1	13.1	-	-
Occupational therapy	55.2	55.3	55.2	55.2	-	-
Orthoptics	4.0	4.0	4.0	4.0	-	-
Orthotics	-	-	-	-	-	-
Physiotherapy	67.3	67.8	67.3	67.3	-	-
Podiatry	28.7	28.7	28.7	28.7	-	-
Prosthetics	-	-	-	-	-	-
Radiography	35.6	37.6	37.6	37.6	-	-
Speech and language therapy	30.5	30.5	30.5	30.5	-	-
Multi skilled ⁵	2.0	2.0	2.0	2.0	-	-
Not assimilated	-	-	-	-	-	-
Other therapeutic staff⁴	85.6	76.1	73.1	69.5	-	-
Clinical psychology and counselling ⁶	44.4	35.9	32.9	29.3	-	-
Genetic counselling	-	-	-	-	-	-
Optometry	-	-	-	-	-	-
Pharmacy	39.2	39.2	39.2	39.2	-	-
Play specialists (nursery nurses)	1.0	1.0	1.0	1.0	-	-
Not assimilated	1.0	-	-	-	-	-
Personal and social care	8.4	-	-	-	-	-
Healthcare science staff	102.8	106.5	106.5	106.5	-	-
Biomedical sciences	58.5	60.5	60.5	60.5	-	-
Clinical sciences	25.8	28.5	28.5	28.5	-	-
Clinical physiology	6.9	6.9	6.9	6.9	-	-
Clinical technology	9.6	9.6	9.6	9.6	-	-
Other healthcare science staff	1.0	1.0	1.0	1.0	-	-
Not assimilated	1.0	-	-	-	-	-
Emergency services	12.7	12.7	12.7	12.7	-	-
Administrative services	641.5	641.5	641.5	641.5	-	-

Section 5: Review of 08/09 Action Plan

2008/09 WORKFORCE ACTION PLAN					
Responsible Lead	Work Area	2008 Workforce Plan Objective	Outcome Expected	Progress Update	Status
Medical Director	Medical	Continue to plan medical staffing to ensure appropriate levels of service are maintained in relation to; <ul style="list-style-type: none"> • Medical staffing at Galloway Community Hospital (GCH) • Ensuring all junior and middle grade rotas are compliant with EWTD • Reviewing implications of new SAS contract • Cover for junior/middle grade staff 	Establishing sustainable medical manpower in GCH: Maintaining all essential medical rotas in DGRI	Plans in place to achieve full EWTD compliance by Aug 2009. A number of Specialty Doc posts have been approved to address workforce challenges.	Ongoing during 09/10
		Be responsive to the implications MMC following the Tooke report	Adapting to opportunities and threats presented by MMC, SAS contract & EWTD	Efforts continue to develop sustainable medical workforce by looking at medical and non medical roles linked into D&G clinical services strategy as well as national drivers.	Ongoing during 09/10
Associate Nurse Director	Nursing	Foster multidisciplinary/multi-agency working and explore the development of an integrated ongoing recruitment pathway, progressing through a competency based framework for the delivery of basic care by development and implementation of Pilot Scheme during 2007 linking to STARS and Combined Services.	Access to larger, flexible workforce	The 3rd tranche of training will commence in September. Evaluation in progress.	Ongoing 2009-2012
		Undertake a comprehensive assessment of future training needs within Long Term Conditions Strategy and Community Nursing	Anticipated future gaps will be bridged	Future training needs will be comprehensively analysed following confirmation of the agreed model for NHS D &G Clinical Strategy.	Ongoing during 09/10
		Develop and implement a robust, centrally co-ordinate work experience programme. To promote within schools by June 2007	Promotion of NHS as career choice	A programme consisting of a "Flavour of Health" has been developed. This is promoted to schools within our open sessions at all secondary schools every 2 years.	Complete
		Appropriate measurement of workload volume and timing to be introduced to link directly with nursing outcome indicators	Efficient and effective use of resources and improved quality care	National Workforce Planning tools have been incorporated and a 3rd run of the tools has recently been completed. The outcome from implementation of the tools will be linked to sickness/absence rates, bank utilisation and the implementation of Key Quality Indicators (Leading Better Care).	Complete however this will be ongoing work.

Responsible Lead	Work Area	2008 Workforce Plan Objective	Outcome Expected	Progress Update	Status
Acute Services General Manager	Unscheduled & Planned Care	In 2008/9 appoint replacement consultant posts in: Cardiology; Orthodontics	Successful appointments	Orthodontic post still to be filled	Ongoing during 09/10
		Take forward service redesign with the National Collaborative Programmes as per agreed workplan as appropriate, in respect of : Unscheduled Care & Planned Care; Diagnostics; Eyecare Redesign & Cataract Delivery; National Theatres; Orthopaedic Services review; Demand/capacity review	Service redesign to meet national and LDP targets	Ongoing objective being taken forward locally	Ongoing during 09/10
		Review of out-patient clinics undertaken at peripheral locations (Refer Re-design & Demand/Capacity Review)	Service redesign to meet national and LDP targets	Ongoing objective part of Clinical Strategy.	Ongoing during 09/10
		Examine working in different ways (e.g. orthopaedic consultants seeing more new outpatients, whilst their elective/fracture review patients are seen by "extended role" nursing/ AHP/other staff). (Refer Re-design & Demand/Capacity Review)	Service redesign to meet national and LDP targets	Ongoing objective	Ongoing during 09/10
		Through Job Plan Review, Objective Setting & Appraisal, ensure productivity improvement measures are in place to (a) reduce staff absence (b) increase consultant productivity	Achievement of relevant LDP targets	Ongoing objective	Ongoing during 09/10
Labs General Manager	Labs	Explore the possibility of future staff providing a 24/7 service on a contracted basis that complies with the EWTD and prepare Business Case for CMT by March 2008	Stabilise and secure the ongoing provision of a 24/7 lab service	On-hold whilst national working group reviews laboratory on-call arrangements	Ongoing during 09/10
		Review Stranraer staffing to ensure that an adequate service is sustainable	Improved lab service for better patient care. More stable and sustainable service	24/7 service now implemented with recurring funding in place	Complete
		Explore the potential for extended roles for MLAs through training and development	Recognise recruitment difficulties in qualified staff. More cost effective way of working	MLAs now undertaking more duties. Newly developed Band 4 also roles being advertised	Complete
		Ensure that the labs training status is maintained and try to attract students to the lab by building strong relationships with Robert Gordon University	Maintain flow of junior staff for future succession planning	Labs are supporting training and development of junior staff to become qualified.	Complete
Gen Mgr Child Health	Children & Young People	Develop GPs with a Special Interest in paediatrics within Stewartry LHP	Stewartry development of a paediatric "Gold Standard" for Primary Care	No funding at LHP level for this to progress	Stopped

Responsible Lead	Work Area	2008 Workforce Plan Objective	Outcome Expected	Progress Update	Status
		Develop business case and costings to ensure that a 24-hour EWTD paediatric medical workforce with the right levels of skills workforce is available and sustainable into the next five years to meet current and future service needs	Compliance with EUWT directive Sustainable workforce model	Medical Director taking forward plans to address	Ongoing during 09/10
		Provide an acute health service for Children and Young People in the right setting for their individual needs within an integrated Outpatient/Ambulatory/Day Care/Inpatient Unit.	Estate work complete by summer 2008	Capital spend approved in April 2009. Will be progressed during 09/10	Ongoing during 09/10
General Manager for Cancer and Palliative Care Services	Cancer Services	Continue to move away from traditional 'roles' and towards generic clinical staff who undertake those clinical tasks for which they have undergone recognised training and are deemed competent. Continue to work closely with Cancer Networks and academic institutes to plan how this can be achieved	Provision of sustainable services in line with 'Delivering Health'	This year, the D&G oncology nursing team were awarded a 'Highly Commended 2008' award at the Pfizer <i>Excellence in Oncology Awards</i> . An 'Education Champion' in palliative care has now been identified for NHS Dumfries and Galloway	Completed but ongoing work
		Continue to link with cancer networks re workforce required over network and options re deployment of staff.	Service improvement will be delivered	SCAN Surgical Gynae-oncology service review and non-surgical oncology review continuing.	Ongoing during 09/10
		Implement the Regional (South East Scotland) IT Strategy through SCAN E-Health Group by end 2007 Anticipated between 2-5 yrs to implement GCS in all site specific groups. Anticipated 2 yrs to fully introduce CEPAS	Provision of IT systems that are compatible across Board boundaries. Paperless systems of recording	Due to commence implementation of the SCAN .Net electronic system into breast services June 09 (Following on from the GCS system)	June 2009
		Consider regional appointments at Consultant level in the field of palliative care - discussions are currently underway	Providing 24 hour access to specialist palliative care advice is progressed within SCAN palliative care group	No regional appointments made to date though this may be considered as part of the SCAN Surgical Gynae-oncology service review	On hold
		Secure appropriate approvals and funding to recruit sufficient clinical staff to undertake extended roles to provide sustainable chemo service across D&G	Sustainable chemo service		Complete
Lead AHP	AHPs	Continue throughout 2008 to develop rotational posts for Physiotherapy and Occupational Therapy services.	Flexible workforce. Enhanced ability to recruit to posts. Development of more attractive junior posts.	Progressing as vacancies arise and services changes are required.	Ongoing during 09/10
		Identify enhanced roles for specialist practitioners/consultant AHPs as required to address MMC and modernisation agenda through National Leadership Programme.	Development of very highly skilled AHP staff to undertake work currently carried out by medical consultants	Slow progress. Requires changes within speciality teams. Orthopaedics Specialist Physiotherapy post being considered.	Ongoing during 09/10

Responsible Lead	Work Area	2008 Workforce Plan Objective	Outcome Expected	Progress Update	Status
		Continue D&G 3-year pilot commenced in Oct 2006 to support Practice Education Facilitator to carry out work related to student placements, staff supervision, CPD and post-graduate training. Links with HEIs strengthened.	Improved recruitment and retention. Joint working initiated. Links to regional and national AHP pre/post registration education through NES.	Now substantive post.	Complete
		Develop links with National Programme to develop Assistant Practitioner posts for AHPs	More flexible workforce with appropriate staff in place to carry out assessment and treatment as required.	HNC courses now in place for OT, Radiography, SLT and Physiotherapy.	Complete
Maternity Services Mgr	Maternity Services	Identify future midwife training numbers required to deliver a sustainable midwifery service over the next 5 years	Requirements for future midwifery services considered through business case process	Work recommenced, led by Senior Midwifery Manager. National training numbers of midwives for Scotland agreed with Chief Nursing Officer (i.e. reduction).	Expected completion date for work December 2009. Delivery plan will then be put in place
LHP General Mgrs	Primary Care	Implement Delivering for Health/Shifting the Balance of Care within the national collaborative initiatives by working with Acute Services staff to transfer appropriate services to a primary care e.g. Pre-op Assessments and follow up visits.	Opportunities through redesign are explored	Pre op assess ongoing in GCH	Ongoing during 09/10
		Maximise opportunities from the new Community Pharmacy Contract and Supplementary Prescribing e.g. Shared Care Substance Abuse.	New services being provided by community pharmacists and all opportunities are explored	Work currently underway as part of Strategic Service reviews to identify actions to optimise opportunities for further developments in primary care, specifically in general practice and community pharmacy.	Ongoing during 09/10
		Further develop plans to review role and remit of District Nursing teams with general practices during 2007	To ensure the skills of DN teams are fully utilised	Awaiting Community Nursing review but skill mix being reviewed as part of D&G Clinical Services Strategy Review	Ongoing during 09/10
Workforce Development Mgr		Improve the quality of workforce data throughout service areas and within General Practice through development of SWISS and local manpower reporting by Workforce Manager	Workforce planning can be undertaken with robust and accurate data in a more rapid and responsive manner	Work underway to improve links between local and national workforce databases being led by WF Dev Mgr	Ongoing – HR.net Project ends Apr 2010
Head of HR	Diversity	Increase awareness of needs and benefits of “diversity aware workforce” across all staff groups	100% staff attend diversity awareness training by March 2009	As at end march 2009 72% of workforce had attended the course	End date has been changed to July 2009

DUMFRIES and GALLOWAY NHS BOARD

11 May 2009

Single Outcome Agreement**Author:****Sponsoring Director:**

Dr Derek Cox, Director of Public Health

Date: 5 May 2009**RECOMMENDATION**

The Board is asked to agree the Dumfries and Galloway Single Outcome Agreement.

SUMMARY

The detail within the Community Plan and the Single Outcome Agreement (SOA) is the result of an extensive two phase consultation programme with partners and communities. The SOA for Dumfries and Galloway

- outlines how partners developed the Community Plan and the SOA;
- details the performance framework, including the links between the national outcomes and the local outcomes, and performance reporting;
- outlines the governance and accountability arrangements;
- sets out the background information about the area as the evidence for the objectives and indicators; and
- sets out the indicators that will be used to measure achievement and the targets set.

MONITORING FORM

Policy / Strategy Implications	<i>Please describe any implications this paper has for Board / other strategies or policies.</i>
Staffing Implications	<i>Please describe any implications this has for staffing (eg additional resources, saving on staff time and whether or not HR / APF have been involved.</i>
Financial Implications	<i>Please indicate here if the paper has any financial implications. These must have been discussed with the Finance Director.</i>
Consultation	<i>With partners and with communities</i>
Consultation with Professional Committees	<i>Indicate here if the Board's Professional Advisory Committees have been consulted or engaged in this work.</i>
Risk Assessment	<i>Indicate here if a risk assessment has been carried out or is planned.</i>
Best Value	Securing best value Commitment and leadership Sound governance at a strategic and operational level Sound management of resources Contribution to sustainable development Equal opportunities arrangements Joint working
Compliance with Corporate Objectives	<i>1,2,5,6,7</i>
Impact Assessment	

Dumfries and Galloway



TOGETHER IS BETTER
Dumfries and Galloway Single Outcome Agreement
for 2009-2011



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1. Introduction

This Single Outcome Agreement (SOA) for Dumfries and Galloway:

- outlines how partners developed the Community Plan and the SOA;
- details the performance framework, including the links between the national outcomes and the local outcomes, and performance reporting;
- outlines the governance and accountability arrangements;
- sets out the background information about the area as the evidence for our objectives and indicators; and
- sets out the indicators we will use to measure achievement and the targets we have set.

2. Developing the Community Plan and SOA

The detail within the Community Plan and the SOA is the result of an extensive two phase consultation programme with partners and communities.

The first phase was during October 2008 - December 2008 and started with a Challenge Day for members of the Community Planning Joint Board (CPJB) and the Joint Management Team (JMT). The CPJB comprises the Council's five political group leaders and the Chief Executive; Chairman and Chief Executive of NHS Dumfries & Galloway; Chair of the Regional Transport Partnership; Regional Director Scottish Enterprise; third sector representatives; private sector representatives; and the Chief Constable. The JMT comprises the senior managers of the Council, NHS D&G, Scottish Enterprise, D&G Constabulary and D&G Fire and Rescue Service and representatives from the third sector.

In addition national guidance and a small number of local strategic documents were used as the basis on which to build the Community Plan and the SOA. These include:

- D&G Community Plan 2004-09
- D&G Council Corporate Plan 2007-11
- D&G SOA 2008-09
- D&G Compact 'A Partnership Agreement between Voluntary, Community and Public Sector Bodies in Dumfries and Galloway'

The consultation programme followed the National Standards for Community Engagement and used a number of different methods of engagement including online surveys, customer service surveys and facilitated discussions and a number of written submissions were also received. All Elected Members of the Council have had a range of opportunities to contribute throughout the programme.

A draft Community Plan and draft SOA were published prior to Christmas 2008 and the second phase of the consultation comprised workshops and online consultation and an Elected Member Consultation Session/formal Council response in January/February 2009.

The results of this consultation process were used to draft the new Community Plan, the strategic document that provides the vision, principles and prioritised objectives for the region. The second phase also looked at performance information within the SOA.

The development of the Community Plan was overseen by an inter-agency Working Group and for the SOA, four senior managers from three different partners. The final content of the documents is based on the proposals arising from the consultation process assessed against the national guidance, advice from the Improvement Service and Scottish Government, and the availability of data and research.

The Community Plan was subject to an impact assessment screening in March and it had a high positive impact in relation to social, health, equalities and environment.. They (i.e. CP & SOA) will be reviewed and updated annually to take account of changing circumstances.

3. Performance Framework

3.1 Dumfries and Galloway Community Plan

The Dumfries and Galloway Community Plan sets out the vision, principles, Local Outcomes and objectives that say what we want to achieve for the region. The SOA details the specific areas we are measuring so we can monitor progress and the targets we have set so we will know when we have achieved them.

The Community Plan has as its vision:

‘working together to create an ambitious, prosperous and confident Dumfries and Galloway, where people achieve their full potential’

The Community Plan has as its underpinning principles:

*Best Value
Engagement
Diversity
Sustainability
Working together*

A summary of the five outcomes that we want to achieve for everyone in our region are outlined below along with the 19 Objectives and 36 Indicators that will demonstrate progress

Table 1

Dumfries and Galloway Local Outcomes, Objectives and Indicators

<p>1. An innovative and prosperous economy</p> <p>1.1 Improving employment and business opportunities - gap between the Dumfries & Galloway Gross Value Added and the Scottish average - number of business start ups</p> <p>1.2 Improving physical and technical infrastructure - condition of strategic roads</p> <p>1.3 Increasing the provision of affordable housing - availability of affordable housing</p> <p>1.4 Maximising household income - amount of unclaimed benefits accessed</p> <p>1.5 Making the most of the cultural and natural heritage - value of the tourism product across the region - economic impact of four priority festivals and events</p>
<p>2. Healthy and happy lives</p> <p>2.1 Achieving good mental wellbeing - the mean score of Dumfries and Galloway wellbeing scale</p> <p>2.2 Caring for vulnerable people - the proportion of people needing care or support who are able to sustain an independent quality of life as part of the community- - number of Looked After Children per 1000 of population compared to comparator authorities - percentage of clients (drug users) offered an appointment within 2 weeks of referral.</p> <p>2.3 Accessing quality health and care services - delayed discharge per 1000 population admitted to hospital</p> <p>2.4 Reducing health inequalities - healthy life expectancy at birth in the most deprived areas</p> <p>2.5 Leading healthier lifestyles - the rate of increase in the proportion of children with their Body Mass Index outwith a healthy range by 2018 - fruit and vegetable consumption - attendance at pools/leisure facilities - sickness absence rates across public sector employees</p>
<p>3. Where people feel safe and respected in the community</p> <p>3.1 Improving community safety - three year average volume and rate of crime per 10,000 population - percentage of survey respondents stating they feel safe or fairly safe going out after dark - number of domestic abuse incidents per 100,000 of population - number of people killed or injured in road traffic collisions, criminal violence, misuse of fires</p>

<p>3.2 Supporting communities</p> <ul style="list-style-type: none"> - <i>percentage of residents stating they are satisfied with their neighbourhood</i> - <i>number of third sector organisations formally signed up to the Dumfries and Galloway Compact</i>
<p>4. being better equipped for a changing world and having improved life chances</p>
<p>4.1 Improving school achievement</p> <ul style="list-style-type: none"> - <i>relative cumulative attainment in National Qualifications by all pupils in publicly funded schools and for vulnerable groups</i> - <i>range of wider achievement recorded for pupils aged 3-18</i> <p>4.2 Improving participation and access to learning</p> <ul style="list-style-type: none"> - <i>enrolment and attendance at nursery preschool</i> - <i>attendance and inclusion for all young people including vulnerable groups</i> - <i>lifelong learning opportunities for adults</i> <p>4.3 Targeting skills training for employment</p> <ul style="list-style-type: none"> - <i>offers of appropriate training or education for young people, made well in advance of their school leaving date</i> <p>4.4 Encouraging responsible citizenship</p> <ul style="list-style-type: none"> - <i>number of opportunities for wider service among young people and adults in communities</i> - <i>opportunities for community capacity building</i>
<p>5. An environment that is protected and enhanced</p>
<p>5.1 Reducing the region's carbon footprint</p> <ul style="list-style-type: none"> - <i>use of public transport</i> - <i>megawatts of renewable energy capacity consented</i> <p>5.2 Maintaining Biodiversity</p> <ul style="list-style-type: none"> - <i>the proportion of protected nature sites in favourable condition</i> <p>5.3 Managing our waste</p> <ul style="list-style-type: none"> - <i>tonnage of biodegradable municipal waste land-filled</i> - <i>tonnage of municipal waste recycled and composted</i>

It is important to highlight that the SOA performance framework is supported by a number of Plans and Strategies with further performance indicators and targets. Only when all taken together can the Community Plan vision and objectives be achieved.

3.2 Links to the national performance framework and other strategies

The Local Outcomes to deliver the Community Plan follow the Scottish Government strategic objectives of wealthier and fairer, healthier, safer, smarter and greener. The five Local Outcomes contribute to the 15 National Outcomes as outlined in Table 2. It is important to recognise the inter-dependence of the Local Outcomes and that each contributes to more than one National Outcome and national strategy.

In addition the SOA incorporates local delivery of the Government Economic Strategy, the Early Years Framework, Equally Well, Achieving Our Potential, Community Care Framework and Fairer Scotland Fund. It is also consistent with Scotland's Transport Future white paper.

Table 2

Dumfries and Galloway Local Outcomes	National Outcomes														
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1. An innovative and prosperous economy															
2. Healthy and happy lives															
3. Feeling safe and respected within the community															
4. Being better equipped for a changing world and having improved life chances															
5. An environment that is protected and enhanced															

National outcomes:

1. We live in a Scotland that is the most attractive place for doing business in Europe.
2. We realise our full economic potential with more and better employment opportunities for our people.
3. We are better educated, more skilled and more successful, renowned for our research and innovation.
4. Our young people are successful learners, confident individuals, effective contributors and responsible citizens.
5. Our children have the best start in life and are ready to succeed.
6. We live longer, healthier lives.
7. We have tackled the significant inequalities in Scottish society.
8. We have improved the life chances for children, young people and families at risk.
9. We live our lives safe from crime, disorder and danger.
10. We live in well-designed, sustainable places where we are able to access the amenities and services we need.
11. We have strong, resilient and supportive communities where people take responsibility for their own actions and how they affect others.
12. We value and enjoy our built and natural environment and protect it and enhance it for future generations.
13. We take pride in a strong, fair and inclusive national identity.
14. We reduce the local and global environmental impact of our consumption and production.
15. Our public services are high quality, continually improving, efficient and responsive to local people's needs.

3.3 Performance recording arrangements

It is recognised that there is an ongoing need to improve performance information and in particular consolidating trend and baseline information and identifying new strategic indicators and/or new recording mechanisms.

The partners are looking to implement a shared approach to performance management and they have agreed to use the computer based Covalent system as the preferred tool for this.

3.4 Performance reporting

On a partnership basis:

- Quarterly progress reports on the overall SOA will be assessed by the CPJB.
- A publication called 'Broadcast' is delivered to every household in Dumfries and Galloway twice a year. The autumn edition is used to tell local people about progress in achieving performance targets.
- A Community Planning report is published in June each year about how partners are working together and operational performance and participation.
- The performance reports on the SOA as required by Scottish Government will be submitted on time as and when required.
- Progress of projects and services are reported to the CPJB on an ongoing basis.
- Local media, email newsletters and the recently updated website www.dgcommunity.net are employed to ensure information is available to public and all partners.

On an individual basis:

Partners will report progress on the delivery of their contribution to the SOA through their own performance and reporting arrangements.

4. Governance, accountability and funding

Dumfries and Galloway community planning partners evidence openness, inclusiveness and accountability through the formal decision making processes.

Oversight of the SOA is the responsibility of the CPJB with the JMT undertaking a problem solving role in relation to any progress not on schedule.

In accordance with the national Guidance, Dumfries and Galloway community planning partners have agreed to deliver on the overall set of commitments. Individual partner agencies will ensure that they are able to deliver on the SOA by having the agreed outcomes and indicators reflected in their respective strategic plans and service planning.

Community planning partners collectively through the Leadership Working Group and individually will be reviewing decision-making procedures, governance and monitoring arrangements to ensure their structures and arrangements support the delivery of the Community Plan and SOA.

Dumfries and Galloway acknowledges the new relationship with Scottish Government being fostered through the Concordat and SOA process that is built on partnership and mutual respect. Along with this new relationship there is a reduction in ring fencing of local government expenditure and reporting mechanisms. This gives the local authority greater flexibility but also more responsibility. The local authority as part of this agreement has again frozen the Council Tax level for 2009/10 and remains the lowest Council Tax on mainland Scotland.

It is recognised that delivery of the SOA and Concordat is inevitably contingent on adequate funding and all local partners commit to working constructively with the Scottish Government to secure that. A Resourcing Protocol is to be developed to ensure that all partners are directing their financial resources to achieve the overall Community Plan and SOA.

5. Area Profile

The Area Profile of Dumfries and Galloway gives an overview of our region and demonstrates why the particular Local Outcomes and Objectives have emerged through the consultation process.

5.1 Background

Size and location

Dumfries and Galloway is the third largest region in Scotland. It covers 2,380 square miles and has an estimated population of 148,030.

We are at the crossroads of the UK with our neighbours being Scotland, north of England and Northern Ireland. The Loch Ryan ports in the west and Gretna in the east are therefore key gateways of national and international significance.

Rurality

Dumfries and Galloway is characterised by small settlements spread across a large area. The region has around 60 people per square mile compared with the Scottish average of 168. Over a quarter of our population live more than 30minutes drive from a large town.

People live mainly in small communities of 4,000 or less or in the countryside. The biggest town is Dumfries with an estimated population of 37,110, followed by Stranraer with 10,600 and Annan with 8,240.

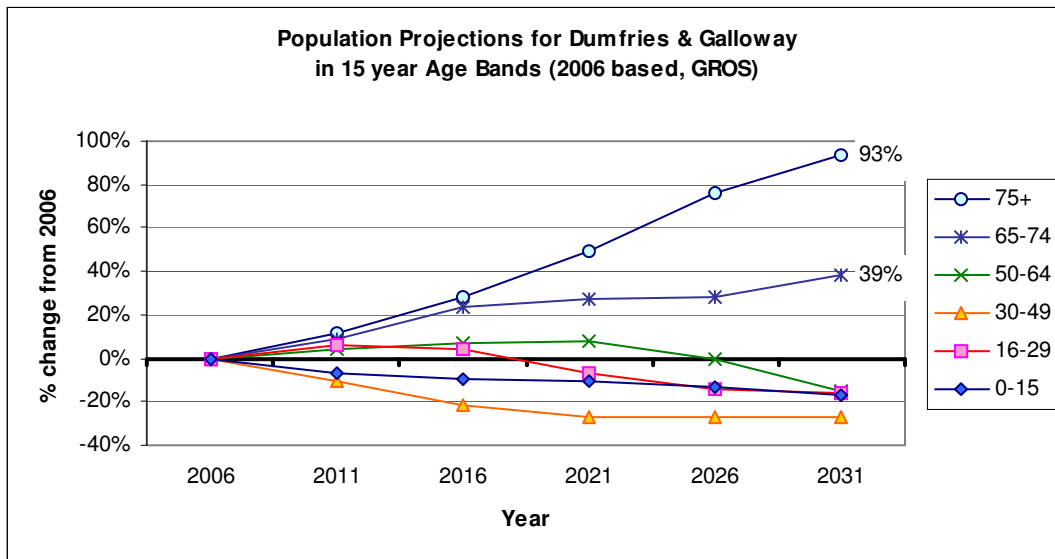
40% of schools have fewer than 50 pupils with six of our secondaries having fewer than 500 pupils.

Demographics

The population figure has remained steady, but the demographics are changing quite rapidly and present a challenge for the region in the years ahead. We have a declining birth rate and an average age of 41.8 compared to the Scottish average of 38.3. School rolls are expected to decrease by 17% over the next ten years, well above the anticipated national average of 9.7%.

Dumfries and Galloway's population of pensioners is 24.2% compared with the Scottish average of 16.4% and only 17.4% of the population are aged under 16. Projections to 2024 indicate a 14% reduction of 30-64 age group and 51% will be over 65.

Table 3



Our Diverse Region

The 2001 census showed the size of the non-white minority ethnic population in Dumfries and Galloway to be 960 or 0.65% and in 1991 was 528 – 0.36%. So although the numbers are small there is an ongoing increase.

The area has a 0.7% ethnic minority population which is significantly lower than the Scottish average (2.0%)

97.55 % of population are white Scottish, or other white British and the total white population is 99.35%.

Since the last census in 2001 the size of the minority population has dramatically increased mainly through Polish and other A8 country migrants. The figure has peaked at 4000 migrant workers in 2008 and is now declining although still significant. Research has taken place commissioned by Scottish Enterprise into the skills and needs of this community. Research took place in 2005 on determining the minority ethnic health needs.

Table 4

People with a disability		
Scotland		830,000
D&G		37,500
Key types of disability	Learning difficulties	Wheelchair users
Scotland	120,000	96,000
D&G	900	2880

Baseline information for the populations representing the different diversity strands is being addressed in Dumfries and Galloway through commissioning of research and data gathering by the different diversity groups. This work although important is slow and difficult due to lack of sizable populations. Joint working with all statutory partners' capacity building in the communities is therefore the focus. Anecdotal evidence and links with representative groups has ensured that equalities issues are taken into account in the development and prioritisation of public sector services.

Local Outcome 1 - An innovative and prosperous rural economy

Background

The key drivers for the economy are firstly that it is distinctly rural and secondly that it needs to be sustainable. The current international and national economic situation clearly has an impact on our position and an Economic Action Plan with £500k funding will be in place by the end of April 2009. The action plan looks at four distinct areas-

- Councils Capital Programme
- Financial advice and support to families and individuals
- Employment
- Business advice and support

The region has a precedent for such work in the Foot and Mouth Economic Recovery Plan which successfully levered in significant support from national agencies.

The public sector in D&G is the main employer and provides the backbone to our local economy. The current ration of private to public sector employment is 60:40 (with Council and NHS comprising about 33%). Much lower than it has been historically- in 1999 the ratio was 70:30.

Gross Value Added (GVA) has grown by an average 1.9% a year (1999/2006 – Scotland 2%). In 2006 GVA per head was £12,335 (Scotland £16,370). GVA in the region is expected to grow at a slower rate than the national average over the period to 2010.

Table 5

GVA (D&G compared with Scottish average)					
	2002	2003	2004	2005	2006
D&G	75	74	74	72	72
Scottish average	94	94	95	96	96

The two gateways of Loch Ryan and Gretna, the two main towns of Dumfries and Stranraer, and a series of small towns with distinct themes and features across the region provide the network for development.

Employment and business opportunities

Research shows a distinctive rural economy with high economic activity rates, and high business start up rates. Significant acceleration of the business start up rate is an outcome in the Regional Economic Strategy – the current base is around 300 each year.

The employment rate is 82% (Scotland 75.7%). However these statistics can mask high levels of self employment, part-time and seasonal employment in lower wage jobs. In Dumfries and Galloway, the latest figures show that 71,000 people are economically active. Of this number, nearly 21,900 work in public administration, education and health, which is 31.2%. The Local Social Economy is worth c£15M.

Unemployment levels in the region are low and trail the Scottish average by only 0.1%, although there are still pockets of high unemployment in some areas.

The table below shows the trend in business start ups over the past years. Business start up rates are traditionally very high here and can be artificially high following redundancies of skilled workers when people often go self-employed. It is the sustainability of these businesses that will make the difference.

Table 6

Business Gateway assisted business start ups (Scottish Enterprise)			
2005/06	2006/07	2007/08	2008/09
333	328	360	348

The traditional sectors of agriculture, forestry, fishing, tourism, food and drink continue to be particularly important. Only 4% of businesses employ more than 250 people. At the other end of the scale 87% employ fewer than 9 people. Dumfries and Galloway's working age population represents 58.4% of the overall population compared to 62.6% in Scotland. Dumfries and Galloway has also

attracted significant numbers of migrant workers. By early 2007 the estimate was that there were between 2,000 and 2,500 overseas migrant workers in the region.

Physical and technical infrastructure

The physical infrastructure in the two main towns of Dumfries and Stranraer is key to the success of the region. The Dumfries Town Centre Strategy developer partner has had to withdraw its support in light of the international economic situation. However other elements of the strategy are being progressed including the Vennel refurbishment giving a focal point to the townscape. The Stranraer Waterfront project has secured funding of £3.85M and comprises 27 projects – the Marina was completed in summer 2008.

The South of Scotland Broadband Pathfinder project brought investment of £27M into the region from the Scottish Government to provide high speed access by the public sector. A new data centre at the Crichton has better connected Council services and investment by the NHS now means it has 92 buildings with hi speed and secure network. The knowledge economy approach underpins the Regional Economic Strategy and within the public sector, data and information sharing is a particular strength.

In terms of general water and utilities infrastructure, these companies continue to be lobbied by the Council to improve investment in the region.

The transport infrastructure sees £2.224M capital and £600k revenue available to the new SWestrans Regional Transport Partnership, an additional £3M for public bus services and £20M has been allocated for a Strategic Roads Fund. There are 2,900 miles of road.

Table 7

% of the strategic road network that should be considered for maintenance				
2003/04	2004/05	2005/06	2006/07	2007/08
44.9% (Audited SPI)	42.5% (Audited SPI)	43.1% (Audited SPI)	47.7% (Audited SPI)	46.5% (Road Condition Indicator)

There have been significant improvements in disabled access at Lockerbie, the key station on the main West Coast Main Line and discussions are ongoing about the service to be available which could have a significant impact on our economy. The Southern Dumfries Access Strategy is a key issue for the future as the addition of the College on the Crichton site leads to traffic congestion. Lobbying continues for improvements to the TransEuropean routes A75 and A77.

Housing

House prices have increased by 130% since 1998. 30% of all properties for sale are purchased by external buyers moving into the region.

The Strategic Housing Investment Plan for the region which is produced in consultation with Registered Social Landlords (RSLs) plans for 1,284 affordable homes over the coming five year period.

Homelessness rates continue to be about 2.3% of all households, slightly below the national average of 2.5%. This means that actual cases of homelessness are about 1600 a year. Wider housing demand through RSLs waiting lists is about 5,500. 82% of all clients of homeless households in priority need secure permanent accommodation (5th highest in Scotland).

Household income

This is about both benefits maximisation but also addressing the low wage economy of the region so that people have greater income overall.

The average gross weekly pay is currently £480 per week, which is only 95% of the Scottish average.

Research shows a low take up of benefits in Dumfries and Galloway. Several agencies are working to address this and collectively in 2006-07 secured an additional £12.3m for local residents. There are three distinct activities addressing accessing benefits these are B – Max (Benefits Maximisation Team), FSF (Fairer Scotland Fund) and Dumfries and Galloway Citizens Advice Service (DAGCAS). This objective of maximising household income is not just about benefits maximisation but ensuring that households have an economic income and new business start-ups will assist in increasing employment. RSLs are also undertaking a number of initiatives in relation to benefit awareness and general benefit advice is a key aim of housing support being delivered across the region by a number of agencies.

Cultural and natural heritage

The region has a wealth of cultural and natural resources and the development of a Cultural Strategy will provide a strong framework so we can optimise the benefits of this both for local people and tourism. The contribution of cultural activities to all aspects of life and all the Local Outcomes is recognised but there is a particular contribution to the local economy.

Table 8

Tourism Spend in Dumfries and Galloway			
	UK resident spend in D&G	Overseas tourism spend in D&G	Total spend in D&G
2005	£200M	£26M	£226M
2006	£147M	£20M	£167M
2007	£102M	£16.5M	£118.5M

The Events Strategy focuses on a small number of 'beacon events' throughout the year, maximising the region's unique heritage and links.

The Arts and Craft Trade Development Project employed 408 people in 2005 and this has grown to 540 in 2007 and the 'Spring Fling' (visiting artists in their studios) event had 25,000 visitors. In 2008 Spring Fling saw 24% economic growth.

The Seven Stanes Bike Trail, the Red Kite Trail and the Wildlife Wetlands Trust centre at Caerlaverock are three resources that have a national profile and there are a further group of natural heritage related facilities run by national agencies including National Trust for Scotland, Royal Society for the Protection of Birds and the Forestry Commission for Scotland.

Local Outcome 2 - Healthy and Happy lives

Mental wellbeing

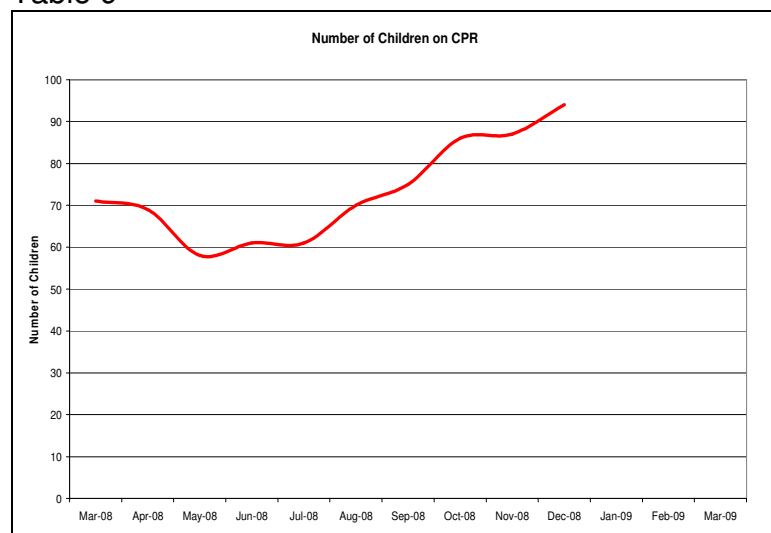
The Dumfries and Galloway Wellbeing survey launched in July 2007 showed local people with higher than average levels of mild or moderate depression - 16% against the 9.7% UK average. Recent research has also proven the direct link between good mental wellbeing, confidence, active lifestyle and prevention of illness later in life e.g. arthritis, heart conditions and strokes.

Caring for vulnerable people

Particularly because of the ageing population in our region referred to earlier, the increase in people with dementia is expected to grow by 40% in the next 20 years and by 150% by 2050. We are above the national average for lone pensioner households. Because of the rural nature of our region, the focus is on supporting people to remain in their own home and local community. So our Short Term Augmented Response Service (STARS) support almost 400 people each year either in their own home or with discharge from hospital.

Our HMIE Child Protection Inspection Report was generally positive (10 'adequate' and seven 'good' ratings) and the progress in the Council's Improvement Programme for Social Work Services has been deemed acceptable by the Social Work Inspection Agency. The number of children on the Child Protection Register is 94 as at December 2008 and is steadily rising. A publicity campaign and interagency staff training programme may be contributing to the rise in this figure. We are currently on a par with the national average.

Table 9



We are above the national average for Looked After Children, 13.5 per 1000 population compared to the Scottish average 12.6 and comparator authorities 10.4. While local demographics suggest an aging population, the numbers of children with additional support needs, in need of protection and/or requiring being looked after are increasing. Our Local Demonstration Site in Lower Annandale has adopted the "Getting it Right for Every Child" approach. We are focussing on how we deliver services to vulnerable children, trying to demonstrate that by working together more

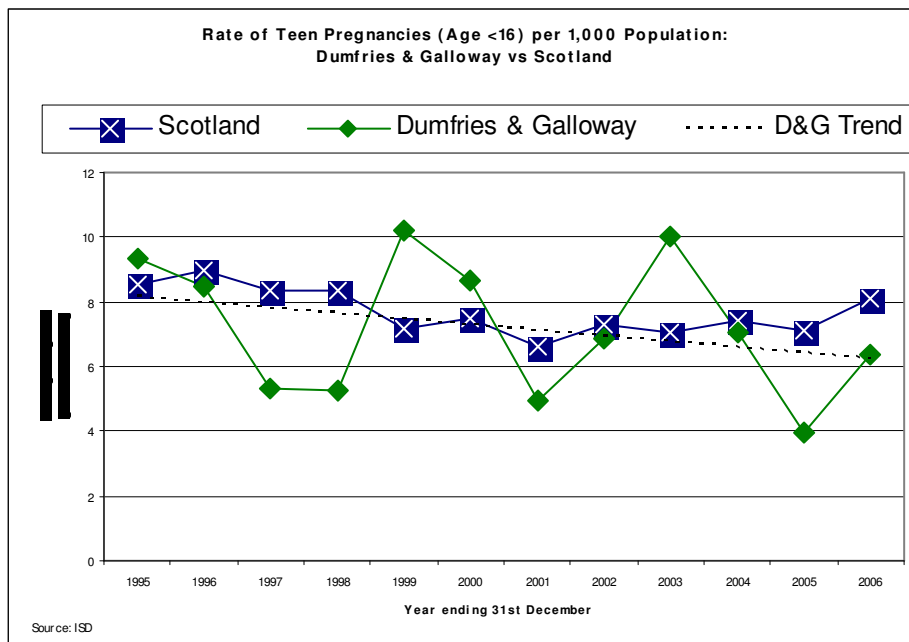
effectively and making changes to practice, systems and processes where required, we can deliver better outcomes for children, young people and families.

One of the key priorities of the ICS Plan is early intervention, both in the life of the child and in the identification of the problem. The Early Years Planning and Delivery Group is taking the lead on the implementation of the Early Years Framework, in line with local need, and in the context of Equally Well and Achieving Our Potential. Our current priorities include actioning the parenting strategy and developing consistent and equitable access to good quality services.

Our Corporate Parent responsibilities for Looked After Children have been given a high priority, with Chief Executives of the Council and the Health Board acting as local champions. For the last four years our local action plan has focussed on improving educational outcomes. Recent developments include a partnership with Dumfries and Galloway College and a commitment from elected Members to develop work experience/employment opportunities for Looked After Children in the Council and its partner agencies.

Teenage pregnancies, because their numbers are small, tend to fluctuate considerably from year to year, but the general trend is downward, at least in part attributable to the work on this topic included in the health promoting schools project, which involves every school in the region.

Table 10



The Strategic Housing Investment Plan allows for the provision of 109 homes for special needs/elderly accommodation over the coming five years. There is a significant number of innovative health and homelessness projects and also training for vulnerable children in food preparation, nutrition and sexual health.

The focus is on Individuals in need receiving timely, sensitive and appropriate support. This is based on evidence that key to achieving recovery is ensuring that

services are available to people at the point at which they are most motivated, and therefore these need to be easily accessible, and with minimal waiting.

In the past three years there was a package of funding from the government which carried with it a key requirement to increase numbers accessing drug treatment services in Nithsdale, and linked to this a waiting time target of two weeks was largely met. In further developing the two week target, we aim to maintain equitable access to services for all across the region.

Access to quality health services

The NHS Clinical Governance Strategy is being updated and is looking at key issues facing the region- the upgrading of the region's main hospital; palliative care; stroke services; and older people's services. Work is also ongoing about the balance of care into communities as this is a key issue for the people of our region.

98% of presentations to Accident and Emergency are treated and discharged or admitted to a hospital ward within the national four hour target (we have over 45,000 presentations) and we achieved a number of national access targets ahead of schedule, including access to a GP or appropriate clinician within 48 hours.

Significant improvement to NHS dentistry has been experienced with proactive recruitment resulting in 34,000 new patients and there now being 56% people registered. Our P1 child dental health is above the national average.

We are below the national average for early deaths from heart disease, cancer and stroke.

Health inequalities

Dumfries and Galloway has 16 'data zones' in the 20% of the most deprived areas in Scotland. However 80% of income deprived and 82% of employment deprived people in our region live outwith these data zones. That means we have very small pockets of deprivation across the region. Support therefore needs to be targeted at individuals and specific families, not only at geographic communities, to be most effective. The 'key worker' model being adopted for the Fairer Scotland Fund is based on this approach and the Building Healthy Communities work also recognises this pattern in its work.

Work to support specific communities does take place alongside this e.g. 556 of the new homes to be build in the Housing programme relate to the regeneration of North West Dumfries and South Central Stranraer.

Healthy lifestyles

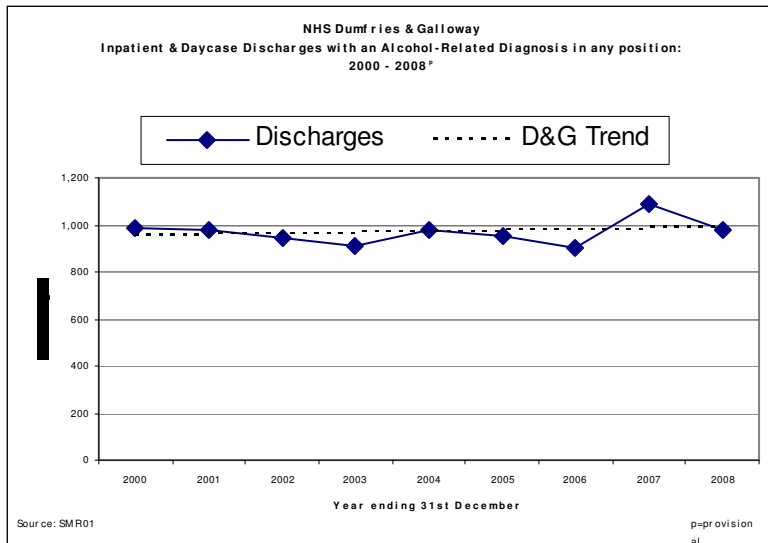
Prevention and intervention are key issues –for example from the Wellbeing Survey sample we know that 44% of people are not eating the recommended five portions of fruit and vegetables a day and 57% of people are obese or overweight with a clear upward trend reflecting the national position

However a new Regional Leisure Complex opened in September 2008 and has already exceeded anticipated customer numbers.

24 businesses have achieved the Healthy Working Lives Award and all schools are Health Promoting Schools.

120 people a year are estimated to reduce their drinking following a brief intervention by their GP. Alcohol related deaths are well below the national average as are the numbers of alcohol related hospital admissions. These are showing a largely steady trend, in comparison to the steeply rising trend in Scotland as a whole.

Table 11



The estimated number of smokers (25.6%, Atlas of Tobacco Smoking in Scotland, 2007) is below the Scottish average (27.2%). The estimated annual uptake of smoking cessation services in the region is 4.6% in comparison to the average in Scotland of 3.9% (Data from ISD figures 2007). The target in smoking cessation requires supporting 8% of their population of smokers to successfully quit at one-month post quit (using smoking cessation services) over the period 2008/09-2010/11. Based on previous experience this target is well within D&G NHS capability to deliver.

Local Outcome 3 - feeling safe and respected within the community

Community safety

Dumfries and Galloway remains a safe place to live. Overall recorded crime (Groups 1-5) was the 8th lowest among the local authorities in mainland Scotland in 2007-8 (Source Scottish Govt Statistical Bulletin 2007-8). Levels of violent and sexual crime remain in real and relative terms amongst the lowest in Scotland.

In 2008, the first Community Safety Strategic Assessment for Dumfries and Galloway was compiled and listed seven priority areas. These were Domestic Abuse, Substance Misuse, Road Safety, Antisocial behaviour, Sexual Offences, Violence and Vulnerable Young People. The priority areas are identified in light of a combination of analyses surrounding factors such as the most recent performance trends against national averages increased reporting and public concern voiced through systematic consultation.

In each of these seven priority areas, while enforcement of legislation and the pursuit of prosecution remains one of the core functions of the safety agenda, programmes and procedures that support prevention and early intervention will gain a greater prominence in forthcoming Community Safety activities.

A particular issue for a rural area is the need to create the environment where victims of domestic abuse feel confident to report the crime.

Although actual numbers of road deaths saw a slight decrease in the last year, the overall picture in Dumfries and Galloway is that the region suffers above average rates of serious injury and deaths on our roads, when set against standard formula applied to all regions of Scotland. This, added to the high level of public concern, keeps the issue of road safety high on the list of priorities. Young drivers schemes are in place as well as traditional enforcement. 37 out of 106 planned 20mph zones around Primary Schools and Safer Routes to Schools have commenced.

Last year there was one Dispersal Order and 21 Anti Social Behaviour Orders issued with the focus being on noise, vandalism, minor fire raising and alcohol misuse among a small group of persistent young offenders. There is a focus on prevention e.g. Midnight Football Scheme which has had over 11,000 attendances and won a national Excellence award. The reporting of instances of Domestic Abuse continues to rise in Dumfries and Galloway, from 803 incidents per 100,000 population in 2005/6 to the latest recorded level of 854 incidents per 100,000 people in 2008/9. This is as a result of better reporting and response policies since 2005 and further time is required to allow this figure to settle at its true level. The issue remains a priority as domestic abuse incidents are at a higher level than the Scottish average.

It is recognised that design can make a significant contribution to crime prevention and secure by design accreditation is promoted across all partners.

Supporting communities

A Compact has been developed and agreed - this is a Partnership Agreement between Voluntary, Community and Public Sector bodies and the implementation of this agreement is ongoing including identifying and training Champions across all sectors and recording and addressing breaches of the Compact principles. The

Compact should see a significant improvement in the relationship between these bodies in the seven areas of: partnership working, consultation, equal opportunities, recognition, representation, resources, and joint undertakings.

People in Dumfries and Galloway people have a clear sense of community and civic pride. There are, for example, 92 active Community Councils out of a possible 107 and there is strong support for traditional local events and festivals. Local Civic Pride groups and the People's Project in Dumfries work towards supporting communities and enhancing citizenship.

In terms of communities of interest, there are now representative groupings for each of the strands of diversity – age, disability, gender, race, religion and sexuality – good links have been established across and between the strands and promotion of events and information that celebrates diversity.

Local Outcome 4 - being better equipped for a changing world and having improved life chances

Improving school achievement

Investment in the region's 14 secondary, 103 primary, two all through and two special school buildings will provide a positive learning environment for our 21,000 pupils. A £108M Public Private Partnership to build nine new schools and one refurbishment and extension is due to be completed in 2011/12

S4 levels of attainment had been rising from 2005-7 but declined in 2008 to a position that remains just above the national average values. S5/6 levels of attainment had been declining in the period 2005-7 but have risen in 2008 to position above the national average values and in line with comparator authorities.

Table 12

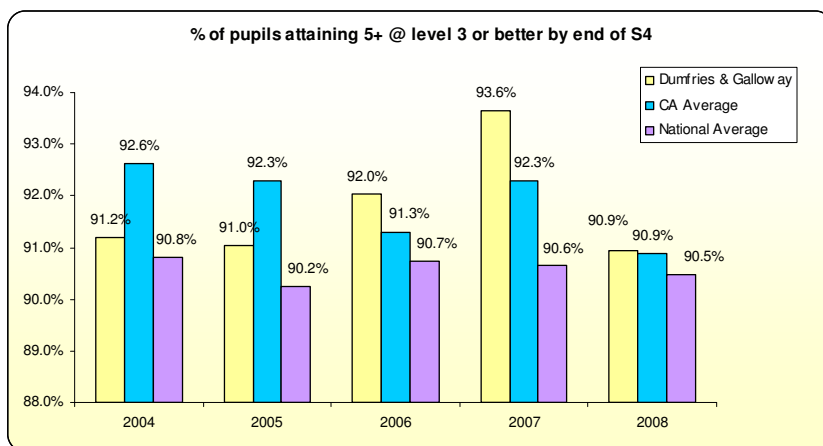


Table 13

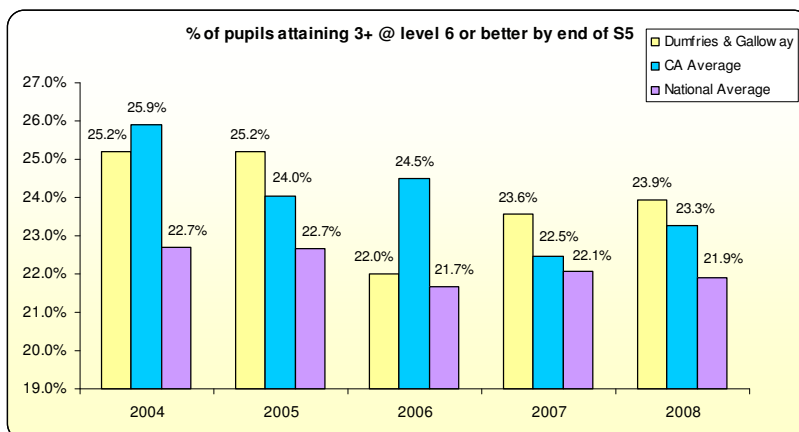


Table 14

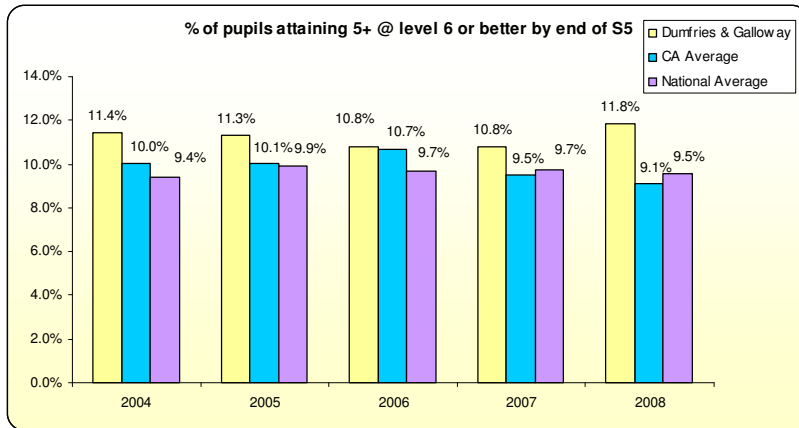
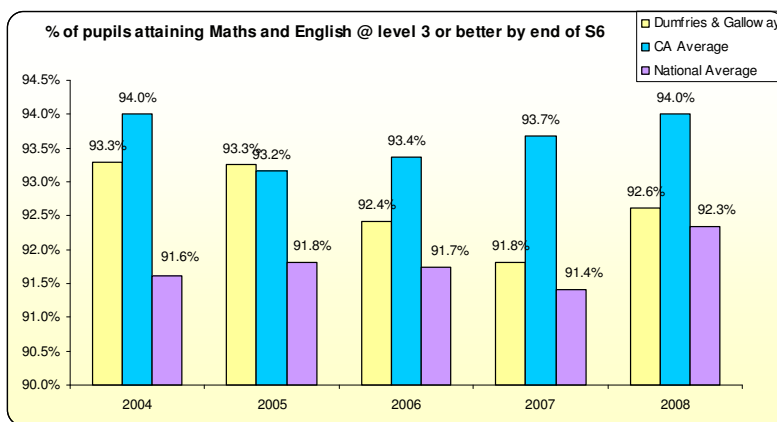


Table 15



In the wider sense of achievement, pupils in secondary and primary schools are engaged in a range of initiatives through e.g. Active Schools and various cultural and creative projects.

Improving participation and access to learning

ICS Planning has taken on responsibility for strategic planning and local delivery of the Early Years Framework including performance and financial management (Sure Start funding continues to be ring fenced locally). Multi agency and partnership working are central to our approach. To date our focus has been on improving access to universal services, providing targeted support to very young children and families in vulnerable circumstances and building community capacity, reflecting the Getting it Right for Every Child principles of having the right help available at the right time in the right way.

Pupils in our schools have higher levels of attendance and lower levels of exclusion that the national average.

Table 16

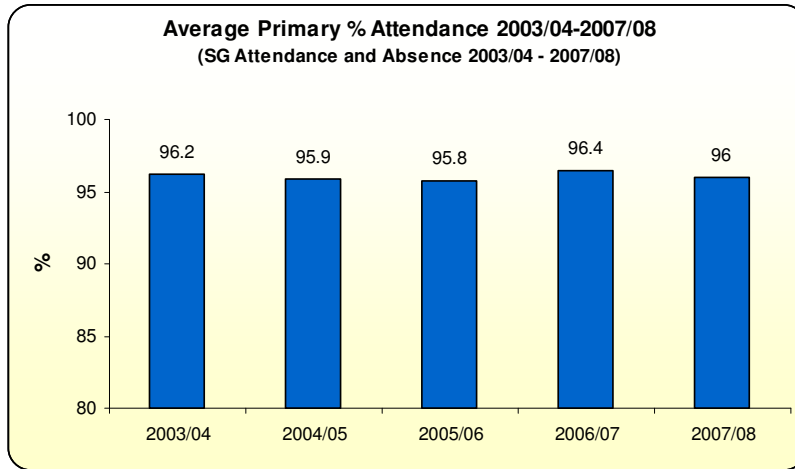
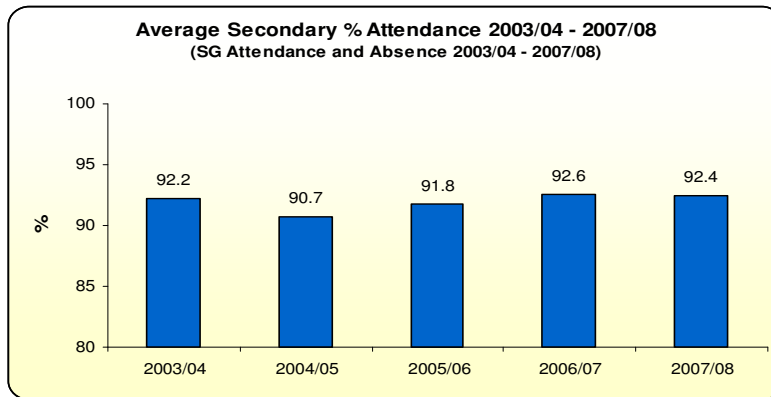


Table 17



Enrolment and attendance at pre-school nursery is well above the national average and continues to rise. However, more targeted measures are required to improve the evidence of impact of early years services offered to children and families. These are currently in development and will enhance our locality profiling to inform the future decisions about service delivery and funding priorities.

Table 18

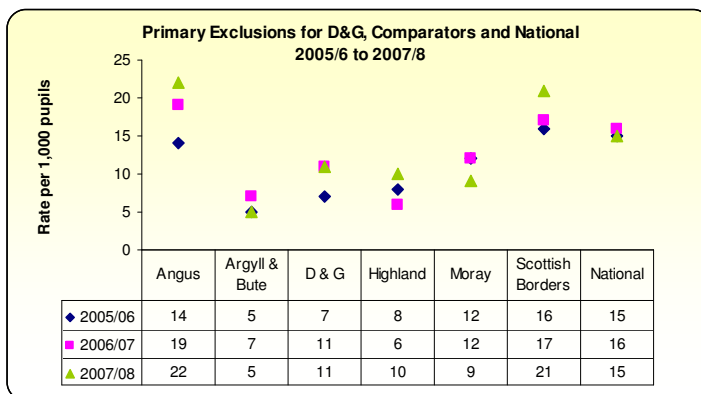
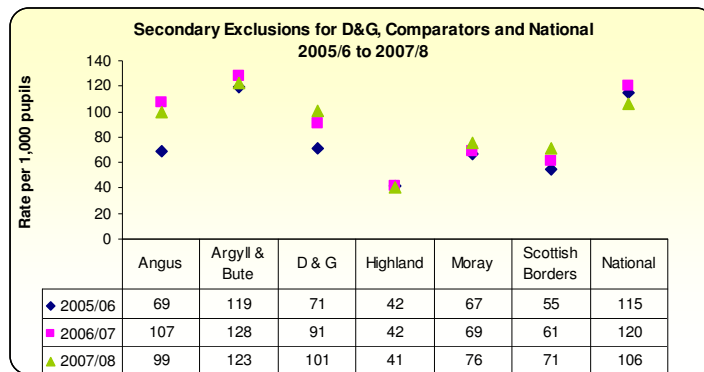


Table 19



Partners across the sectors continue to work with adults who require literacy, numeracy and ESOL (English for Speakers of Other Languages). There has been an increase of 12% in numbers involved in adult literacy and numeracy. Our childcare and early years provision has grown very rapidly in recent years and there is a complex network of providers and establishments. Our Lifelong Learning Partnership is being refreshed to give a stronger focus on community learning development. We are currently undertaking an employability mapping exercise the results of which will help inform future developments.

Since 2001 participation levels in literacy and numeracy provision have increased from 301 in 2001 to 1665 in 2006-07. Anecdotal evidence suggests that there are 'hidden' needs in this area due to young people traditionally leaving school as early as possible to go and work in the family business. Also, being a rural area, there is the potential for social stigma because learners are visible and known within the community. We therefore still want to see the numbers continue to increase.

In FE and HE national policy is directing provision away from part-time flexible learning to more full time places for students. While this increase in provision is welcome we want to continue to offer a range of provision for all learners.

Targeting skills training

The opening of a new £37M College on the Crichton site in September 2008 offers further education a positive boost along with ongoing investment in the site. We have 86% of school leavers who go into employment, education or training - but there is still a significant number (560) of 16-19 year olds who are not.

Specific areas of training identified within the Regional Economic Strategy (Theme 4 developing a competitive workforce) are science, technology, environment, food, socio-cultural-heritage, rural entrepreneurship and land based industries.

Encouraging responsible citizenship

There are core principles embedded in the Curriculum for Excellence and we have an active Youth Issues Unit that works with the Scottish Youth Parliament and other democratic initiatives to encourage responsible citizenship. The Compact and Community Council activity also contribute to this agenda and we are updating our Volunteering Strategies to further enhance this area. Community Service is supported and schools are also a focus - for example 100% of schools are involved in the eco-schools initiative and some are also working towards Fairtrade status.

Local Outcome 5 - an environment that is protected and enhanced

Background

Dumfries and Galloway is a beautiful place and its diverse landscape is a major asset. Branded 'the natural place' for the last decade, this is an area with a strong sense of place and a commitment to its preservation. The role of public sector bodies is crucial but recognition that individual behaviour and sharing responsibility has a major role to play is also welcome. There are many opportunities for volunteering in the environment sector. We have the best eco-schools record in Scotland.

Carbon footprint

Public sector bodies are the initial focus of this work and have initiatives in place to reduce their energy consumption in buildings. The refuse collection fleet was renewed with special engines to reduce fuel consumption. And the ENER-G company at the new Eco-Deco plant is cutting carbon emissions by 20,000 tonnes from the old landfill arrangement.

The region is well placed to maximise onshore wind technology as a result of its geography and topology. There are already wind farms in three sites with planning applications in process for another two.

Table 20

Megawatts renewable energy capacity consented		
Date	Installed	Consented
March 2008	Nil	520MW
March 2009	295 MW	566MW

In terms of buses and trains, Dumfries and Galloway usage is well below the national average: for buses: frequent users are 12% (24% national average) and never use 72% (56% national average). And for trains: once or more a week 1% (6% national average) and never use 91% (81% national average).

The statistic is slightly better for getting the bus to school 28% (national average 23%) but walking to school is 42% compared to the national average of 52%.

However the rural nature of the region means that private car use is essential. Video conferencing and car sharing are therefore also important strands of our work in this area.

Biodiversity

The quality of the landscape has been recognised in the designation of three National Scenic Areas (NSA). Add to that: 10 Regional Scenic Areas, 7 Special Protection Areas, 17 Special Areas of Conservation, 5 Wetlands of International Importance and 97 Sites of Special Scientific Interest.

These are living, working landscapes and management strategies have been prepared with local communities to ensure they continue to justify their recognition as nationally important landscapes.

The Dumfries and Galloway Local Biodiversity Action Plan 1999 (LBAP) was one of the first LBAPs in Scotland. It identified 22 habitats and 123 species as local priorities and more than 700 actions to conserve and enhance local priority habitats and species.

Since then, more than 80 organisations have become involved in the Dumfries and Galloway Biodiversity Partnership - statutory agencies, voluntary groups, land managers and communities. More than 630 actions are complete or in progress. We have 22,000 records of features of archaeological or historical interest.

Managing waste

The establishment of an eco deco plant is part of a waste management and recycling PFI contract over 25 years at a total cost of £115M. The statutory performance indicators for waste management show an improvement in the region – one example is that the recycling/composting rate has gone up from 5% to 32% since signing the contract and we reduced the percentage of household waste going to landfill from 89.6% in 2005/06 to 76.8% in 06/07.

Table 21

Tonnage of biodegradable municipal waste landfilled		
2006/07	2007/08	2008/09
45,479T (44.5%)	37,021T (36.9%)	27,256T (27.5%)

Table 22

Tonnage of municipal waste recycled and composted		
2006/07	2007/08	2008/09
23,665T (23.0%)	31,245T (31.0%)	33,444T (34.0%)
Actual figure	Actual figure	

6. Performance indicators and targets

6.1 An innovative and prosperous rural economy

National Outcomes

1. We live in a Scotland that is the most attractive place for doing business in Europe
2. We realise our full economic potential with more and better employment opportunities for our people
7. We have tackled the significant inequalities in Scottish society
12. We value and enjoy our built and natural environment and protect it and enhance it for future generations
15. Our public services are high quality, continually improving, efficient and responsive to local people's needs

Local context –relevant extracts from the Area Profile

1.1 Improving employment and business opportunities - Our Gross Value Added has grown by an average of 1.9% in 1999-2006, less than the Scottish average of 2% and is expected to grow at a slower rate over the period to 2010. The Competitiveness Strategy is working to address this.

1.2 Improving the physical and technical infrastructure- to support business, employment and personal opportunities in a large rural area we need excellent connectivity in road networks.

1.3 Increase the provision of affordable housing- house prices have increased by 130% over the past ten years and 30% are bought by people moving into the region. This may mean that local people find it more difficult to buy locally. We need to provide affordable housing to enable people to stay and work in the region as well as supporting vulnerable people in our society. There is a specific focus on the delivery of affordable housing in all tenures. This outcome will be achieved through implementation of the strategic targets set out in the Local housing Strategy, Local Development Plan and Strategic Housing Investment Plan.

1.4 Maximising household income- local research shows that benefits that local people are entitled to are not being claimed and so that money is missing from our economy. FSF Employability and Financial Inclusion activities contribute to this objective.

1.5 Making the most of the cultural and natural heritage - D&G has a wealth of cultural and natural heritage opportunities. We need to optimise the benefits for visitors and residents and promote further the local Events Strategy one event of which, The Tour of Britain, already contributes over £250k to our economy.

6.1 An innovative and prosperous rural economy

Local Outcome	Objective	Indicator	Baseline	Progress target/s to 2010-11	'End' target/s & timescale/s
1. An innovative and prosperous rural economy	1.1 improving employment and business opportunities	The gap between the D&G Gross Value Added and the Scottish average	D&G GVA – 72 Scottish average -96	Maintain at 72 against a downward trend since 1993	Achieve the Scottish average
		Number of business start ups (Business Gateway)	300	320 in 2009-10	330 in 2010-11
	1.2 improving physical and technical infrastructure	Condition of strategic roads	2006-07 33.6% of the road network that should be considered for maintenance	£20m Strategic Roads Fund established	2019-20 2.6% improvement in condition (i.e. Road Condition Indicator of 31%)
	1.3 Increasing affordable housing	Availability of affordable housing	252 in 2004/06	906 completion or in progress 2010	a) LHS 2004/09 – 300 additional units by 2009. b) SHIP 2009/14 - 1,284 additional units by 2014.
	1.4 maximising household income	Amount of unclaimed benefits accessed	2009-07 £12,331,354 (B-Max, FSF & DAGCAS)	£32.2m	Increase
	1.5 making the most of the cultural and natural heritage	Value of the tourism product across the region	Spend of £118.5M	Target for 2011 Spend of £143.9M	Target for 2015 Spend of £169.3M
		Economic impact of four priority festivals and events	2007/08 four events created economic impact of £2.699m	2009-10 Target £2.7m	2010-11 Target is £2.85m

Relevant plans or other commitments of the local partners to support delivery of the outcome

- A Joint Academic Strategy for the Crichton Campus 2008-13
- D & G Carers Strategy
- D&G Area Tourism Partnership Plan - Strategy for Growth 2007-09
- D&G Council Local Housing Strategy 2004-09
- D&G Cultural Strategy (in development)
- D&G Fairer Scotland Fund Action Plans 2008-11

- D&G Poverty, Inequality and Deprivation Working Group Work Plan 2008-09
- D&G Regional Economic Strategy 2008-13
- D & G Young Carers Strategy
- D&G Young People's Vision and Youth Strategy Action Plan 2006-11
- Partnership in Practice Agreement
- South West of Scotland Transport Partnership's Regional Transport Strategy 2008-23
- The Crichton Strategic Development Framework 2004
- The South of Scotland Competitiveness Strategy 2007-13

6.2 Healthy and happy lives

National Outcomes

- 5. Our children have the best start in life and are ready to succeed
- 6. We live longer, healthier lives
- 8. We have improved the life chances for children, young people and families at risk
- 10. We live in well-designed, sustainable places where we are able to access the amenities and services we need
- 15. Our public services are high quality, continually improving, efficient and responsive to local people's needs

Local context –relevant extracts from the Area Profile

2.1 Achieving good mental wellbeing- local research shows that people in D&G have higher than average levels of mild depression, 16%, which is above the UK average of 9.7%. We clearly need to tackle this to ensure that people can achieve good health and participate fully in life. FSF Health & Wellbeing and Building Social Capital activities contribute to this objective.

2.2 Caring for vulnerable people- we want to assist people with care needs who want to remain at home and this requirement is expected to increase due to our ageing population. Our Looked After Children level is higher than both the Scottish average and our comparator authorities.

2.3 Access to quality health and care services- we need to ensure that residents have access to appropriate health and care services in terms of locality and speed. Discharge from hospital is a key issue for our region.

2.4 Reducing health inequalities- there are 16 data zones in the 20% most deprived areas in Scotland. FSF Health and Wellbeing and Employability activities contribute to this objective.

2.5 Leading healthier lifestyles- local research shows that 44% of people do not eat the recommended 5 portions of fruit per day and that 57% are obese or overweight. Work is ongoing in terms of food and diet and physical activity to address this in schools, workplaces and homes. FSF Health and Wellbeing activities contribute to this objective. Problem drinking, although an important health and social concern, remains below the national average.

		Attendance at pools/indoor leisure facilities	1,088,961 (2006/7) 1,073,988 (2007/8)	Maintain	Maintain
		Sickness absence rates across public sector employee	NHSD&G 5.14% D&GC 5.8%	5% reduction	

Relevant plans or other commitments of the local partners to support delivery of the outcome

- A Food and Health Strategy and Action Plan for D&G 2007-10
- Breastfeeding Strategy and Action Plan for D&G 2008-13
- Building Healthy Communities in D&G - Strategy and Action Plan 2008-13
- D&G Alcohol and Drug Action Team Strategy 2006-9
- D & G Carers Strategy
- D&G Cultural Strategy (in development)
- D&G Fairer Scotland Fund Action Plans 2008-11
- D&G Health and Community Care Plan 2008-09
- D&G Mental Health and Wellbeing Strategy (in development)
- D & G Young Carers Strategy
- D&G Young People's Vision and Youth Strategy Action Plan 2006-11
- D&G Leisure and Sports Facilities and Sports Pitch Strategy
- Leisure and Sport Strategy for Dumfries and Galloway 2006-10
- NHS D&G Clinical Services Strategy
- Partnership in Practice Agreement
- Physical Activity Strategy for D&G 2008-11
- Sexual Health and Wellbeing Action Plan for D&G 2007-10
- The Model of Service – Mental Health
- Tobacco Control Strategy for D&G 2005
- Whit fettle? D&G Wellbeing and Lifestyle Survey 2007
- Working together for children, young people and families - Integrated Children and Young People's Services Planning 2008-10

6.3 Feeling safe and respected within the community

National Outcomes

- 6. We live longer, healthier lives
- 8. We have improved the life chances for children, young people and families at risk
- 9. We live our lives safe from crime, disorder and danger
- 10. We live in well-designed, sustainable places where we are able to access the amenities and services we need
- 11. We have strong, resilient and supportive communities where people take responsibility for their own actions and how they affect others

Local context – relevant extract from Area Profile

3.1 Improving Community Safety – the crime rate in Dumfries and Galloway remains low and indeed has dropped in comparison to the rest of Scotland (currently 8th lowest). The issue is about people feeling safe in their communities. Domestic Abuse, Anti-Social Behaviour, and Road Safety are all in the top seven priorities in the Community Safety Strategic Assessment undertaken in 2008.

3.2 Supporting Communities – the overall high quality of life for the people of the region is often referred to and satisfaction with their neighbourhood is seen as a key determinant of that. In addition, by working and communicating with communities in Dumfries and Galloway more extensively, through processes developed through the Compact Agreement, partner agencies can help to enhance the sense of community in the region's population. FSF Building Social Capital and Inclusion for Children and Families contribute to this objective.

Local Outcome	Objective	Indicator	Baseline	Progress target/s to 2010-11	'End' target/s & timescale/s
3. Feeling safe and respected within the community	3.1 improving community safety	The three year average volume and rate of crime (of violence, indecency, dishonesty, vandalism—groups 1-4) per 10,000 population	Total 623 crimes per 10,000 Violence – 11 Indecency – 9 Dishonesty – 234 Vandalism – 219	overall percentage reduction Increase to 65% To be determined following review of D&G Protocol	Year on year reduction against three year average Increase to 70% by 2012 To be determined following review of D&G Protocol in
		Percentage of survey respondents stating they feel safe or fairly safe going out after dark	60.7%		
		Number of domestic abuse incidents per 10,000 of population	82		

		Number of people killed or injured in road traffic collisions, criminal violence, substance misuse or fires.	Road deaths – 15 Road serious injury – 131 Murder – 1 Substance misuse deaths – 8 (all figures three year average 2006-09) Home fire deaths – 2 (average 2003-7)	in 2010 Overall reduction (road deaths and serious injury targets set nationally)	2010 Overall reduction (road deaths and serious injury targets set nationally)
	3.2 supporting communities	Percentage of residents stating they are satisfied with their neighbourhood Number of organisations formally signed up to the Dumfries and Galloway Compact Agreement.	80% 40 in November 2008	88% 100	90% by 2012 New qualitative indicator in development

Feeling safe and respected within the community

Relevant plans or other commitments of the local partners to support delivery of the outcome

- Community Promise 2008-09, D&G Constabulary (reviewed annually)
- Disability, Gender and Race Equality Schemes
- D&G Alcohol and Drug Action Team Strategy 2006-09
- D&G Antisocial Behaviour Strategy 2008-11
- D&G Child Protection Annual Report and Business Plan 2008-09
- D&G Community Safety Partnership Strategic Assessment 2008-09 (reviewed annually)
- D&G Community Learning and Development Strategy
- D&G Diversity Working Group Work Plan 2007-10
- D&G Domestic Abuse and Violence Against Women Partnership Strategy and Action Framework 2009-12
- D&G Fire and Rescue Authority's Service Improvement Plan 2009-10 (reviewed annually)
- D&G Road Safety Plan 2009-12
- D&G Compact Agreement
- D&G Leisure and Sport Strategy 2006-2010
- D&G Public Involvement Strategy
- D&G Resilience Plan
- D&G Youth Justice Strategy 2009-12
- Social Work Policy and Procedures – Adult Support and Protection Procedures, October 2008
- DGC & NHS Volunteering Strategies (to be developed/updated)
- Registered Social Landlord Plans
- South West Scotland Community Justice Authority Area Plan 2008-11

6.4 Being better equipped for a changing world and having improved life chances

National Outcomes

- 3. We are better educated, more skilled and more successful, renowned for our research and innovation
- 4. Our young people are successful learners, confident individuals, effective contributors and responsible citizens.
- 5. Our children have the best start in life and are ready to succeed
- 8. We have improved the life chances for children, young people and families at risk
- 10. We live in well-designed, sustainable places where we are able to access the amenities and services we need
- 11. We have strong, resilient and supportive communities where people take responsibility for their own actions and how they affect others
- 13. We take pride in a strong, fair and inclusive national identity
- 15. Our public services are high quality, continually improving, efficient and responsive to local people's needs

Local context –relevant extract from Area Profile

4.1 Improving school achievement- S4 levels of attainment had been rising from 2005-2007 but declined in 2008 to a position that remains just above national average values. S5/6 levels of attainment had been declining in the period 2005-2007 but have risen in 2008 to position above national average values and in line with Comparator Authorities. Achievement is seen in a wider context through Active Schools and a range of creative projects. Within the context of continuous improvement these indicators can be used to evidence our continued commitment to narrowing the gap between Looked After Children and their peers in terms of achievement, attendance and exclusion. FSF More Choices More Chances and Inclusion for Children, Young People activities contribute to this objective.

4.2 Improving participation and access to learning-

Enrolment and attendance at pre-school nursery is well above the national average and continues to rise. However, more targeted measures are required to improve the evidence of impact of early years services offered to children and families. These are currently in development and will enhance our locality profiling to inform the future decisions about service delivery and funding priorities.

On average pupils in D&G schools have higher than average attendance rates and the avoidance of exclusions, particularly for looked after children is important. Adult education, formal and informal is available in a variety of different formats and locations. FSF More Choices More Chances, Inclusion for Children, Young People and Employability activities contribute to this objective.

4.3 Targeting skills training- to ensure that local people have the right skills to meet job opportunities we need to target training provision. This was identified in the Regional Economic Strategy and we recognise it also links in to the wider health and well being agenda. FSF More Choices More Chances and Employability activities contribute to this objective.

4.4 Encouraging responsible citizenship- We support community projects and also voluntary contributions by all our residents and especially by encouraging young people. The core principles highlighted in Curriculum for Excellence are therefore

particularly welcome. FSF More Choices More Chances activities contribute to this objective.

6.4 Being better equipped for a changing world and having improved life chances

Local Outcome	Objective	Indicator	Baseline	'Progress' target/s to 2010-11	'End' target/s & timescale/s
4. Being better equipped for a changing world and having improved life chances	4.1 Improving school achievement	Relative cumulative attainment in National Qualifications by all pupils in publicly funded schools and for vulnerable groups	Average Authority Ranking against 32 Authorities 1+,3+,5+ at Level 6 13 th out of 32 5+ at Level 3 Eng/Maths 17 th out of 32 5+ at level 3 Secondary All Pupils 92.7% LAC Pupils 21%	Improve average rankings by 1 or more	Improve average rankings by 2 or more
		Range of wider achievement recorded for pupils aged 3-18	n/a (new indicator) – being established through new SEEMIS system	Continue to improve and narrow the gap between all pupils and LAC Increase recorded uptake in creative & sporting activities by 5%	Continue to improve and narrow the gap between all pupils and LAC Increase recorded uptake in creative and sporting activities by 10%
	4.2 Improving participation and access to learning	Enrolment and attendance at nursery pre-school	83% enrolment 94% attendance	Maintain our position in top three of our comparative authorities	New qualitative indicator in development for 2010-11
		Attendance and inclusion figures for all young people including vulnerable groups	Average Authority ranking out of 32 Authorities: Attendance: Primary - 7 th Secondary- 8 th Exclusions (per 1000 pupils): Primary – 14 th Secondary 17 th Average attendance	Improve figure and average rankings by 1 or more Continue to improve and	Improve figure and average rankings by 2 or more Continue to improve and

			<p>Primary All 96% LAC 93.8% Secondary All 92.4% LAC 80.5%</p> <p>Exclusions per 1,000 pupils Primary All pupils 11 LAC 39</p> <p>Secondary All 101 LAC 300 (2007-08)</p> <p>FE- 1025 enrolments HE – 259 enrolments</p> <p>Adult Literacy and Numeracy- 1665</p>	<p>narrow the gap between all children & LAC</p> <p>Continue to improve and to narrow the gap between all children and LAC</p> <p>FE – 1300 HE - 350</p> <p>Increase in new ALN learners</p>	<p>narrow the gap between all children & LAC</p> <p>maintain at 2010 level</p> <p>Increase in new ALN learners</p>
	4.3 Targeting skills training	Offer of appropriate training or education place for young people to be made well in advance of their school leaving date(in line with guidance set out in 16+ learning choices)	Number of offers made in Christmas leavers 2008 16+ pilot Wallace Hall Academy & Douglas Ewart High School	Year on year targets to be agreed and notified Pilot for summer leavers 2008. 5 schools one in each area plus one in Dumfries Burgh All leavers associated with pilot schools being made offer	All the region's school leavers being made formal learning offers in line with 16+ Learning Choices December 2009
	4.4 Encouraging responsible citizenship	Number of opportunities for wider service among young people and adults in communities	n/a – new indicator being established through new Wider Achievement PIs gathered through new SEEMIS Information system	Increase recorded involvement in service category by 5%	Increase recorded involvement in service category by 10%

		Opportunities for community capacity building	n/a (new indicator - baseline to be established Performance Information and Evaluation System (PIES))	Year on year increase (to be negotiated with delivery partners)	Year on year increase (to be negotiated with delivery partners)
<p>Relevant plans or other commitments of the local partners to support delivery of the outcome</p> <ul style="list-style-type: none"> • A Joint Academic Strategy for the Crichton Campus 2008-13 • D & G Carers Strategy • D&G Council Education Improvement Plan 2008-11 • D&G Community Learning and Development Strategy • D&G Council Smarter Schools - Final Business Plan 2008 • D&G Cultural Strategy (in development) • D&G Fairer Scotland Fund Action Plans 2008-11 • D & G Young Carers Strategy • D&G Young People's Vision and Youth Strategy Action Plan 2006-11 • Integrated Children's Services Plan (ICSP) • Partnership in Practice Agreement • Regional Economic Strategy 					

6.5 An environment that is protected and enhanced

National Outcomes

12 We value and enjoy our built and natural environment and protect it and enhance it for future generations

14. We reduce the local and global environmental impact of our consumption and production

15. Our public services are high quality, continually improving, efficient and responsive to local people's needs

Local context – relevant extract from Area Profile

5.1 Reducing the region's carbon footprint - Greener travel is a key strand of work as in terms of public transport usage Dumfries and Galloway is below the national average; 72% never use public transport compared to a national average of 56%. The rural nature of the region means that targets have to be realistic here but individual behaviours also have a contribution to make.

Dumfries and Galloway also sees itself making a significant contribution to renewable energy.

5.2 Maintaining biodiversity - the Dumfries and Galloway Local Biodiversity Action Plan identifies local priorities to protect and enhance local biodiversity which will also contribute to wider environmental, social and economic targets.

5.3 Managing our waste - the focus here is on prevention and recovery. The establishment of the Eco-Deco plant has already achieved a reduction in landfill from 89.6% in 2005-06 to 76.8% in 2006-07. The commitment of residents to reduce, re-use and recycle is a key requirement for success here.

6.5 An environment that is protected and enhanced

Local Outcome	Objective	Indicator	Baseline	'Progress' target/s to 2010-11	'End' target/s & timescale/s
5. An environment that is protected and enhanced	5.1 reducing the region's carbon footprint	Use of public transport Megawatts renewable energy capacity consented	4.13M public transport journeys per year 520mw (to March 2008)	Initial increase of +1% (40,000 passenger journeys) Target will be developed by 2010 as part of the Council's future Local Development Plan	Proposed initial end target of 5M passenger journeys Target will be developed by 2010 as part of the Council's future Local Development Plan
	5.2 maintaining biodiversity	Proportion of protected nature sites in favourable condition	At 31 March 2005 75%	Increase	Target for 2012 is 95%
	5.3 manage our waste	Tonnage of biodegradable municipal waste land filled	45, 479T (44.5%)	35,741 by 2009 - 2010 (36%) 31770 (31%) by 2010-11	50% by 2013 35% by 2020 (% of 1995 arisings)
		Tonnage of municipal waste recycled and composted	23, 665T (23.1%)	2009-10 35, 032T (35%)	Maintain at 35%
<p>Relevant plans or other commitments of the local partners to support delivery of these outcome</p> <ul style="list-style-type: none"> • D&G Climate Change Strategy (in development) • D&G Council Corporate Waste Strategy (in development) • D&G Local Biodiversity Action Plan • D&G Structure Plan and 4 Adopted Local Plans for Annandale & Eskdale, Nithsdale, Stewartry and Wigtown • D&G Young People's Vision and Youth Strategy Action Plan 2006-11 • South West of Scotland Transport Partnership's Regional Transport Strategy 2008-23 					

DUMFRIES and GALLOWAY NHS BOARD

11 May 2009

Equality and Diversity – Delivering a fairer future.



Author:
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Sponsoring Director:
Caroline Sharp, Director of HR and
Workforce Strategy

Date: 30 April 2009

RECOMMENDATION

The Board is asked to note current progress and endorse the direction of travel which will be required to achieve an embedded Equality and Diversity culture across NHS Dumfries and Galloway.

SUMMARY

The paper provides; contextual highlights for the Equality and Diversity horizon; a reminder of the key NHS Dumfries and Galloway Equality and Diversity activities; and headlines for progressing this agenda further.

1.0 Introduction

Our society is becoming more complex and diverse; overall population is growing, we are more ethnically diverse, and we are getting older. New patterns of migration have affected previously homogenous communities.

Equality legislation has helped challenge much discrimination and prejudice, but there are still big equality gaps. Public Sector agencies have a real opportunity to challenge those inequalities, to ensure that everyone has an equal chance in life and to respond to the diverse needs of the communities they serve.¹ This is our corporate, legal, moral, ethical and fundamental responsibility.

In addition to being our shared responsibility, Equality and Diversity is integral to the realisation of our corporate vision:

Our Purpose	To deliver excellent care that is safe, effective, efficient and reliable.
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To reduce health inequalities across Dumfries and Galloway

¹ Improvement and Development Agency <http://www.idea.gov.uk/idk/core/page.do?pageId=5145172>

Achieved by	Creating a momentum for improvement by engaging enthusiasm of staff to achieve excellence.
Our outcomes	Improved outcomes for patients Improved working environment for staff leading to improved job satisfaction Efficiencies to support continuous quality improvement and sustainability

2.0 Context for Equality and Diversity direction

2.1 Single Equality Bill

The following paragraphs summarise some of the provisions of the new Single Equality Bill (due for publication in April 2009).

A new Equality Duty on the public sector, will bring together the three existing duties (race, disability and gender) and extend to incorporate gender reassignment, age, sexual orientation and religion or belief. It will also cover the legal requirements on equal pay. Public bodies will be required to tackle discrimination and promote equality on all the key diversity strands.

Age discrimination, will become unlawful in service delivery as well as employment. The Bill will outlaw unjustifiable age discrimination by organisations providing goods, facilities and services, and those carrying out public services.

Operational transparency will be maintained by requiring public bodies to comply with the Equality Duty and report on areas such as gender pay, ethnic minority employment and disability employment. Public bodies will also need to promote equality through their purchasing function. Linked to this, the Bill aims to improve transparency in the private sector, in particular through the introduction of a new 'kite-mark' that recognises those employers who are transparent about reporting their progress on equality

The scope of positive action will be extended, requiring employers to take into account the under-representation of disadvantaged groups when selecting between two equally qualified candidates e.g. women and people from ethnic minority communities

Enforcement will be strengthened, by allowing tribunals to make wider recommendations in discrimination cases, going beyond the individual involved. The Government is also exploring how cases can be brought on combined multiple grounds (e.g. age and gender), as well as allowing representative actions (e.g. trade unions making cases on behalf of groups of people). Furthermore, the Government intends to ensure support for trade union equality representatives

It should be stressed that this is a Bill, it is not yet legislation. It is possible that its terms will be amended over the next 1-2 years and there is no certainty that these proposals will actually become law. However, if the Bill does become law, the likely timescale is 2011, or 2010 at the earliest.

2.2 Human Rights

The Human Rights Act protects the right to enjoy the freedoms outlined under the Act, without discrimination on any ground such as sex, race, colour, language, religion and political or other opinion. It covers both employment and service delivery. The Government's Equality Bill introduced a new single Commission for Equality and Human Rights (CEHR) in October 2007 and this organisation is now responsible for promoting equality throughout society and, for the first time, provides institutional support for human rights.

Respect for the human rights of an individual or group is fundamental to ensuring their quality of life. The economic, social and cultural rights, including the rights to fair employment conditions and health care without discrimination, are relevant to the NHS as both an employer and service provider.

With this in mind NHSD&G should be considering how to incorporate and embed this overarching strand of equality and diversity. NHSD&G should consider whether a principle of dignity and respect for all individuals with respect to their individuality is a more positive approach to both service and employment provision than categorising someone according to their race, gender, sexuality, religion or belief, disability or age. This philosophy will be debated in our Diversity Working Groups and formal recommendations will be put to the Staff Governance Committee for strategic endorsement.

3.0 Current Framework for delivering the Equality and Diversity vision in NHS Dumfries and Galloway

3.1 Diversity Training

Currently the organisation has two tiers of diversity training. There is a half day 'face-to-face' session which was made mandatory for all staff in Spring 2007; there is also an on-line refresher training course which is in the final stages of implementation at the date of this paper. The refresher should be taken every 2 years and can be done at any desk top computer with a web connection.

Half-day Training

The half-day diversity awareness-raising session was re-designed in late 2008 to make it more interactive, lively and thought-provoking. It is now delivered by in-house staff members.

In late 2008 the organisation anticipated that the 100% attendance target by March 2009 was not going to be achieved, and whilst all new starts are covered through the comprehensive corporate induction programme, there remained a significant proportion (30% approximately) of existing staff who still needed to attend. The situation was flagged through the Board

Management Group in early 2009 and a number of remedial actions were put in place. The situation is currently being monitored and the target date of 100% compliance has been put back to the end of July 2009.

On-line Training

Recognising the operational challenges of attending mandatory training the decision was taken to allow staff members to update their mandatory diversity training from a desk top computer, at a time and date to suit them (facilitated classroom sessions will be made available for individuals who don't have access to a computer and/or need support with using a computer).

3.2 Equality Impact Assessment Training

The organisation has recently provided 2x1 day training courses in Equality Impact Assessment with a view to achieving a 'critical mass' who are competent in carrying out impact assessments. We now have in the region of 70 people who have been trained in impact assessment and the next stage in the process is to design and deliver a rolling programme of impact assessment training.

The Board should not underestimate the importance of equipping the organisation with a robust impact assessment resource. Recent guidance from the Equality and Human Rights Commission (EHRC) has highlighted the fundamental need for ensuring that effective impact assessment provisions exist within organisations. See attached document – Appendix 1.

Partnership Conference

A clear example of NHS D&G's commitment to Impact Assessment was the recent Partnership Conference (1st April 2009) where the entire day was dedicated to impact assessing the 3 Clinical Services Strategy options. The information captured at this event will make a significant contribution to the overall impact assessment of the Clinical Services Strategy, and can be used to illustrate a best practice model in the development of other key organisational strategies.

3.3 Diversity Structure

In June 2007 the Board launched it's Diversity Structure, which comprised of 6 working groups and an overarching steering group. In June 2008 the structure was reviewed and refined to 3 working groups and the steering group was removed. Later this year we will be striving to amalgamate our existing equality schemes into a Single Equality Scheme; perhaps consideration should now be given to consolidating our diversity structure further into a single Equality Working Group. This too will be discussed amongst the working groups with a view to making formal recommendations to the Staff Governance Committee.

4.0 Mainstreaming

Mainstreaming equality is generally defined as "the incorporation of Equal Opportunities issues into all actions, programmes and policies from the

outset.”² However, there are a number of barriers that the organisation still needs overcome to achieve this. Some of the major obstacles are as follows:

4.1 Barriers

Awareness & Understanding

Whilst we have made progress to ensuring a level of equality and diversity awareness and understanding across the organisation, through the introduction of the mandatory half day training session, we need to use this as a building block for further development. A half-day session will raise awareness but will not heavily impact on culture and processes. Individuals not only need to acknowledge that they have a role to play in the elimination and/or prevention of discrimination; they need to understand how they can fulfil that role on a day to day basis in everything they do.

Ownership

There is often a tendency to assume that anything related to Equality and Diversity should be channelled to the organisation's Equality Lead. This instinctive reaction, whilst understandable, must change if we are to achieve a culture and practice of mainstreamed equality and diversity. Each and every member of staff should endeavour to understand what their contribution to Equality and Diversity is and/or can be.

4.2 Enablers

We have a number of enabling tools available to us, some of which are already well established. These are as follows:

KSF & Training Department

One of the 'core dimensions' (elementary competencies) in the Knowledge and Skills Framework (KSF)³ is the Equality and Diversity dimension. As we embed the relatively new performance review tool, we should start to truly appreciate what it can do for Equality and Diversity. It is through the implementation of KSF that the organisation can develop robust structures of assessing and feeding back, through the Training Needs Analysis, what our Organisational Development needs are in this field of work.

Equality Impact Assessment (EQIA)

The organisation is currently going through the process of instilling a culture and practice of Equality and Diversity. In pursuit of that goal we should be using the principles of EQIA at every opportunity, even when it is not a strict legal requirement, to be identifying any potential negative impact. EQIA principles could be included as a standing item on all team, department, functional, project meeting agendas. It could be as simple as "Are there likely

² Rees, T. (1998) *Equality in the European Union: Education, Training and Labour Market Policies* London: Routledge

³ The KSF has been developed through a partnership approach between management and staff side and is essentially a development tool that will also contribute to decisions about pay progression. It is made up of thirty dimensions.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009176

to be any potential equality and diversity impacts based on what has been discussed today?" All members of the organisation, including Board members, have a responsibility in this area and can therefore support this cultural shift through constructive questioning.

Leadership

For an organisation to acknowledge, support and truly believe in a shared responsibility, 'buy-in' needs to be evident at all levels.

The network of DDI (Delivering Dynamic Improvement) Change Agents presents an opportunity for the organisation to demonstrate a positive commitment to Equality and Diversity. The practicalities and possibilities of this, as a route to cultural infusion, should be discussed and agreed by the DDI sponsors i.e. the Board Management Group

Furthermore, the organisation should feel confident that Equality and Diversity is not simply a mandatory training requirement for staff but that it is also a fundamental element of the Board members' ongoing development programme. An organisation which promotes rights and equality should practise what it preaches.

5.0 Summary

Assuring equality and embracing diversity is key to:

- an organisation's reputation - a good reputation attracts talent from all communities, helping to meet service delivery needs
- staff recruitment and retention - valuing diversity enables employers to recruit and retain the best people for the job
- productivity - staff perform better in organisations that value diversity and are committed to employees' well being
- mitigating organisational risks - effective diversity management limits the risk of legal challenges and costly awards⁴

⁴ The business case for diversity NHS Employers website www.nhsemployers.org

Appendix 1.

Equality and
Human Rights
Commission

equalityhumanrights.com

The Public Sector Equality Duties and Financial Decisions

An Advice Note for Public Authorities⁵

The recent downturn in the economic climate is likely to have a significant impact on public authorities. Financial constraints have already resulted in many authorities making important decisions about their operation and the services they provide. These decisions include efficiency drives; budget cuts; reorganisations and relocations; redundancies⁶; and service reductions.

The Equality and Human Rights Commission is concerned that some decisions may have a disproportionate effect on different groups of people, and may be contrary to the statutory equality obligations to which public authorities are subject.

Recent press reports substantiate these concerns, by suggesting, for example, that women are more likely to be affected by redundancies than men, as companies revise their maternity and flexible working policies in an attempt to save money.⁷

While acknowledging the difficult economic environment in which public authorities are now operating, the Commission is emphasising the mandatory nature of the equality duties, and the importance of public authorities meeting their duties when making significant decisions.

The equality duties

A positive duty on public bodies to promote race equality was introduced in 2001⁸. A duty to promote equality for disabled people came into effect in December 2006⁹, and this was followed by a duty to promote gender equality which came into effect in April 2007¹⁰.

⁵ This document is not a definitive statement of the law. Authorities should consult with the relevant Acts, Regulations and statutory Codes of Practice.

⁶ The Commission has recently published guidance on redundancies and equality issues, *A short guide to managing the downturn and preparing for recovery*. See <http://www.here4business.net/a-guide-to-redundancy/>

⁷ See <http://www.timesonline.co.uk/tol/news/politics/article5581549.ece>

⁸ Race Relations (Amendment) Act 2000

⁹ Disability Discrimination Act 2005

¹⁰ Equality Act 2006

While each duty places distinct legal obligations on public authorities, collectively the duties have the common aim of ensuring that the public authorities work to eliminate discrimination and promote equality in their activities.

This means that when developing proposals and making policy decisions, including those about finance and service provision, public authorities must comply with their statutory equality duties. Public authorities must ensure that decisions are made in such a way as to minimise unfairness, and do not have a disproportionately negative effect on people from different ethnic groups; disabled people; and men and women.

Case study: Harrow¹¹ - the importance of taking public sector equality duties into account

To make savings in light of budget deficits, the London Borough of Harrow proposed to restrict the provision of adult care services to people with critical needs only.

A consultation and an equality impact assessment were carried out regarding the proposed change. During this process, concerns were identified that the proposed decision would have a differential impact on particular groups of disabled people.

A report on the issues, including analyses of the results of the consultation process and the equality impact assessment, was then considered at a Cabinet meeting, where the Council decided to effect the proposed change. However, the Disability Equality Duty, and the specific obligations it places on the Council, was not explicitly brought to the Councillors' attention when they made the decision.

The Council's decision was challenged by service users. The Court held that elected members could not come to a balanced conclusion without being aware of what its responsibilities were under the Disability Equality Duty. As a result, the decision to restrict adult care services was held to be unlawful.

The equality duties are legal obligations which should remain a priority, even in times of economic difficulty. The duties are an invaluable tool to help ensure that decisions do not create or perpetuate inequality.

To ensure that they have complied with the equality duties, and to ensure that any decision made do not unfairly discriminate, public authorities should carry out robust equality impact assessments, and consult and involve relevant stakeholders, as part of the decision-making process.

Equality Impact Assessment

A key requirement of the public sector duties is for public authorities to carry out equality impact assessment for all relevant policies and decisions.

When public authorities are making financial decisions, it is vital that such decisions are equality impact assessed; the impact assessment being carried out when policy is initiated, as a central part of the policy development process.

As well as being a legal obligation under the public sector duties, equality impact assessment is an invaluable tool to assist authorities in ensuring that the interests of all groups are properly taken into account when difficult choices about resources are required.

Case study: Southall Black Sisters¹² - the need to impact assess decisions

¹¹ R (Chavda and others) v London Borough of Harrow [2007] EWHC 3064 (Admin)

¹² R (Kaur) v London Borough of Ealing [2008] EWHC 2062 (Admin)

Southall Black Sisters (SBS) provides specialist services to Asian and Afro-Caribbean women, particularly in relation to domestic violence issues.

In June 2007, Ealing Council announced proposals to move away from funding particular organisations (such as SBS), towards commissioning services (including domestic violence services) following a competitive bidding exercise.

Despite concerns raised during consultation that plans had not been equality impact assessed, and that commissioning could disadvantage grassroots community initiatives, Ealing decided to press ahead with its proposals.

During discussions about criteria for commissioning domestic violence services, SBS had highlighted the adverse impact the criteria could have on pre-existing domestic violence services provided to women from ethnic minority communities, and so an equality impact assessment should be carried out.

Ealing carried out belated impact assessments on proposals before deciding to proceed with the existing domestic violence services commissioning criteria, resulting in two SBS service users launching a judicial review of the decision.

Ultimately, Ealing conceded these submissions and withdrew from the case. However, in an oral judgement, Lord Justice Moses reiterated the importance of undertaking an equality impact assessment, and also the importance of carrying out an impact assessment before policy formulation.

Impact assessment requires public authorities to consider all relevant, available information in order to anticipate any likely negative impact on people from different racial groups; on disabled people; or on men and women; and seek to avoid that negative impact by taking alternative courses of action wherever possible.

For example, the equality duties require public authorities to consider the potential impact of redundancies or reductions in service on race relations. If ethnic minority staff are disproportionately affected by a 'last in first out' redundancy policy, could this lead to tensions or a sense of grievance in the community, as well as potentially being indirectly discriminatory?

Similarly, under the Disability Equality Duty, public authorities are required to promote disabled people's participation in public life. 'Public life' is defined very broadly in the statutory Codes of Practice¹³ and can include participation in tenants' associations, school councils, or in public appointments. Decisions which restrict disabled people's ability to participate in such forums, for example by restricting access to community transport, may hamper an authority's ability to meet its statutory obligations. Such decisions may also inhibit the organisation's ability to promote positive images of disabled people.

So in making a decision regarding funding or service provision, public authorities must assess the potential impact of that decision, both positive and negative, as regards race, disability and gender. Where further action is required, public authorities must take this into account. Should a public authority be unable to avoid any potential negative impact which arises as a result of the decision, this must be a key consideration of future action, such as considering the effect of the decision when the financial situation has improved.

¹³ For both the England and Wales, and Scotland, Codes of Practice, see <http://www.equalityhumanrights.com/en/forbusinessesandorganisation/publicauthorities/disabilityequality/Pages/Codesofpractice1.aspx>

The reality is that, in times of financial constraint, public authorities will have to make difficult and often unpopular decisions regarding funding and service provision. The public sector equality duties do not prevent authorities making these decisions, provided that decisions are taken in accordance with the duties.

The importance of consultation and involvement

Under Gender Equality Duty, public authorities must consult staff, service users and other relevant bodies. Under the Disability Equality Duty, authorities must promote disabled people's participation and involve disabled people. Involvement requires much more active engagement of disabled stakeholders than consultation.

Public authorities should consult and involve relevant stakeholders before making important decisions. By effectively consulting and involving stakeholders, as an integral part of their decision-making processes, public authorities will be able to make better decisions by getting a clearer picture of the main equality issues in their work; gathering evidence to use in carrying out impact assessments; and increasing transparency and openness in decision-making.

Conclusion

Considering the economic climate public authorities are facing it is more important than ever that authorities meet their statutory equality duties when making decisions, particularly those regarding finance or service provision.

All such decisions should be subject to robust impact assessment, which should entail a sound consideration of relevant data to identify if the decision may have a negative impact on particular groups, and seek to avoid this. The decision-making process also requires effective consultation and involvement with stakeholders to identify and address relevant issues. When decisions are made, decision makers must have the relevant data, including the results of equality impact assessment, and of consultation and involvement, before them to ensure they reach an informed decision.

Not only are public authorities under a legal obligation to meet the duties, but the duties also constitute a tool for better decision-making, ensuring that decisions are taken in an accountable manner and do not adversely affect different ethnic groups; disabled people; or men and women.

MONITORING FORM

Policy / Strategy Implications	<i>Equality and diversity supports achievement of the Boards aim to reduce inequalities, and is also a legislative requirement in respect of equality duties</i>
Staffing Implications	<i>None</i>
Financial Implications	<i>None</i>
Consultation	<i>Not relevant</i>
Consultation with Professional Committees	<i>APF and staff Governance Committee support and promote equality and diversity across NHS D&G</i>
Risk Assessment	<i>Not relevant</i>
Best Value	<i>Yes, E&D work features within best value requirements for sound governance</i>
Compliance with Corporate Objectives	<i>1, 2, 3</i>
Impact Assessment	<i>Not required</i>

DUMFRIES AND GALLOWAY NHS BOARD

May 2009

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REGULAR FEATURES

Delivering for Health Update
 New from the Scottish Executive including HDLs
 Current Consultations
 Chief Executive's Diary
 Chairman's Diary

Delivering for Health Update**Service Improvement Planning and Prioritisation Events**

The Board has been working with ATOS Consulting to identify potential improvements to patient pathways that can be delivered using lean techniques. Following a successful workshop on 22 April, a final event to prioritise improvement pathways will be held on 25 May. This event has been delayed from 5 May to take account of workload pressures caused by pandemic 'flu planning.

Hospital Caterers Association

John Brown, Area Catering Manager, has been awarded the 'Outstanding Service Award' at the recent HCA Awards Ceremony on 23 April. This award is in recognition of John's many years of commitment to excellence in healthcare catering and is a fabulous achievement.

Young Carers Strategy

Dumfries and Galloway have developed, in partnership, a Young Carers Strategy. This strategy recognises that young carers comprise a group of young people who

have specific support needs. It is acknowledged that young carers provide a substantial amount of care on a regular basis and the provision of such care is having a major impact on their lives. Young people should not be expected to carry the same care responsibilities as an adult. They should have the same life opportunities as other young people and they require additional support to achieve this.

The overall purpose of the strategy is to act as a practical tool to improve the support for young carers throughout Dumfries and Galloway. It does this by:

- providing a framework to enable better interagency working within current statutory guidance;
- setting out to identify key local issues for young carers support in Dumfries and Galloway;
- raising public and professional awareness of who young carers are and the important and demanding work that they do;
- enabling a life balance for young carers between their complex role as carers for siblings, grandparents, aunt, uncle and / or parents and growing up as a child or young person; and
- ensuring their right to a young carers assessment to assess and support their needs

This strategy sets out to achieve the creation of a medium to long term sustainable process that will enable all young carers to have the same life chances as other young people and support their continued development into adult life.

Monitoring Arrangements

An Action Plan has been developed with key outcomes and targets to be attained in accordance with a timeline from March 2009 until April 2011. The Young Carers Project, in partnership with statutory agencies, will meet on a quarterly basis to ensure the actions identified in the strategy are being delivered and that there is evidence of improved outcomes for young carers.

A group of young carers will meet regularly to consider the impact of the strategy on their day to day caring responsibilities and the quality of their lives.

The strategy actions will be overseen by a multi agency reference group who will meet annually to review the progress on actions and outcomes as defined in the strategy and to review and evaluate the impact of the strategy on the lives of young carers and their families.

Retirements

Nancy Gibson retired at end of March after forty-four years with NHS, our longest serving employee. In this year of "Homecoming" it is ironic that Nancy has never been away from this area all of her life. Some would say her retirement marks the end of an "era". Rabbie Burns would have called her a colourful character. Nancy ended her career in High West, Crichton Hall in Management Accounts only a few

corridors away from where she began in 1965 straight from school joining Patient Funds in Logan East. In 1967 patient funds moved to Campbell House and Nancy moved with them. Sometime between 1967 and 1970, Management Accounts was formed and Nancy joined the team as a trainee accountant. In 1970 Management Accounts moved to Nithbank and again Nancy moved with the team. For the next twenty-one years Nancy worked for the Board until it split in 1991 when she moved with the Mental Health Team back to Crichton Hall. From 1991 to her retirement in 2009 Nancy worked as a Management Accountant Assistant. Nancy was a keen tennis and badminton player and for many years was Treasurer of the Crichton Clubs. In 1995 Nancy received her 30 years service award and also represented the staff at the Queen's Garden Party in Holyrood Palace. Turning back the clock to the glory days of "Wreck Hall Parties", Nancy's fancy dress themed retirement do was "School's Out" at the Cairndale Hotel.

Jennifer Milligan, Child Health Commissioner and General Manager for Child Health Services retires on 11 May after nearly twenty-five years service to NHS Dumfries and Galloway.

Both colleagues have the very best wishes of all their friends and colleagues for a long and happy retirement.

West of Scotland Regional Planning Group

The West of Scotland Regional Planning Group met on 13 March and the items discussed included

- Specialist Oncology ~Services: Review of Implementation of FRMC Recommendations;
- Implications for the Symptomatic Service of the Scottish Breast Screening Programme Policy Extension to Include Two View Screening at All Rounds;
- Clinical Governance: Cancer Chemotherapy Services;
- Specialist Services Workstream;
- Proposed New Workstream – Efficiency and Productivity; and
- Glasgow New Children's Hospital – Update on Progress.

New from Scottish Executive Health Department

PCS (DD) 2009/1 Amendment to the Terms and Conditions of Service for Hospital Medical, Dental and Public Health Medicine Consultants Employed under the 2004 Consultant Contract: Change to Code of Conduct for Private Practice: Recommended Standards of Practice for NHS Consultants (Appendix 8 of the Contract)

Removes the principle that a patient cannot be both a private and an NHS patient for the treatment of one condition during a single visit to an NHS organisation.

PCS (AFC) 2009/3 Pay Award 2009-10: Payment on Account to Staff not yet Assimilated to Agenda for Change

This circular confirms that staff who remain on Whitley pay scales should receive a pay increase of 2.4% with effect from 1 April 2009

CMO (2009) 3 Arrangements for NHS Patients Receiving Healthcare Services through Private Healthcare Arrangements

The guidance provides a framework to support local decisions concerning the possible combination of elements of NHS and private care for individual patients. The principles contained in the guidance apply to all aspects of care – i.e. it is not restricted to access to medicines.

CEL 10 (2009) NHS Health Boards and Special Health Boards Remuneration Increase 2008-09: for Chairs and Non-Executive Members

This letter announces a 2% remuneration increase for NHS Board Chairs and Non-executive members in 2008-09.

CCD2/2009 Revised Guidance on Charging for Residential Accommodation

Two sets of regulations made under the National Assistance Act 1948 come into force on 6 April 2009. This circular provides information on the content of the regulations

PCA (D) (2009) 2 General Dental Services: Changes to the Continuing Care and Capitation Period

This letter advises NHS Boards and Practitioner Services of an agreement reached with the dental professions' representative body to extend the duration of a continuing care and capitation arrangement with effect from 1 April 2009

PCA (P)6(M)3(2009) Prescription Stationery Version 5

Prescription Stationery Version 5

Advises NHS Boards of a revision to NHS Circular PCA(P)6(M)3(2009) concerning the ordering of version 5 prescription stationery.

PCS (AFC) 2009/5 Recruitment and Retention Premia for Staff in Medium Secure Units

The Annex to this circular sets out what has been agreed and replaces any previous arrangements for Medium Secure Units.

PCS (AFC)2009/4 New Statutory Leave Entitlement

Under the Working Time Regulations, the statutory entitlement to paid annual leave

increases from 24 to 28 days.

PCA(D)(2009)3 Results of GDP Practice Premises 2009 Re-evaluation Exercise

This letter advises NHS Boards and General Dental Practitioners (GDPs) of the completion of the re-evaluation exercise of GDP practice premises undertaken by GVA Grimley on behalf of the Scottish Government.

PCA(P)(2009)8 Additional Pharmaceutical Services: Public Health Service

This circular informs NHS Boards and community pharmacy contractors of the Public Health Service (PHS) poster campaign programme for 2009-10 agreed with Community Pharmacy Scotland.

CEL 13 (2009) Hospital Eye Services: 1. Increase in Optical Voucher Values from 1 April 2009; 2. Increase in NHS Domiciliary Visiting Fees for Optometrists and Ophthalmic Medical Practitioners from 1 April 2008

CEL 11 (2009) A Revised Framework for National Surveillance of Healthcare Associated Infection and the Introduction of a New Health Efficiency and Access to Treatment (HEAT) Target for Clostridium Difficile Associated Disease (CDAD) for NHS Scotland

The purpose of this letter is to confirm the terms of the HEAT target for Clostridium difficile Associated Disease (CDAD); the terms of the extension of mandatory surveillance of Clostridium difficile Associated Disease (CDAD); and the changes to surveillance of Caesarean sections.

PCA(P)(2009)7 Community Pharmacy Remuneration 2009-10: Provisional Arrangements from 1 April 2009

This circular sets out provisional arrangements to apply for remunerating and reimbursing community pharmacy contractors for the period commencing 1 April 2009 pending the outcome of the Global Sum 2009-10 negotiations

CEL 15 2009 Sustainable Development Strategy for NHSScotland

Sustainable Development Strategy for NHSScotland which has been prepared by Health Facilities Scotland in consultation with relevant Scottish Government stakeholders. The Strategy takes all the key legislative and policy requirements impacting on NHSScotland and creates a framework within which NHS Boards can prioritise, develop and manage their actions and performance in accordance with the Scottish Government's requirements for sustainable development.

PCS (SDIA)2009/1 Scottish Distant Islands Allowance

This circular notifies the service of increases to Scottish Distant Islands Allowance rates, effective from 1 April 2008 and 1 April 2009.

CEL 14 (2009) Working Time Regulation Compliance Guidance

Guidance to Scottish Health Boards on how to comply with Working Time Regulations for trainee doctors

Freedom of Information Requests

During requests were made under the Freedom of Information Act and all responses due by the time of printing met the twenty working day requirement.

Date Received	Name and Contact Details	Nature of Request	Reply Sent
02/03/09	Andrew Picken	Outstanding fees for operations performed on non EU patients.	23/03/09
02/03/09	Nicola Beckford	<p>1. How much revenue have hospitals managed by the board made from bedside entertainment suites (ie telephones, TV and radio systems paid for by patients) in financial year 2007-2008? Please provide a sum total for all the hospitals managed by the Board.</p> <p>2. How much have hospitals managed by the board made in telephone revenue sharing (ie where the trust has received a proportion of the cost of the call) from 0844, 0845 or other higher than local rate telephone numbers in financial year 2007-2008?</p>	03/03/09
04/03/09	Radostina A. Petrova Research and Analysis Manager The National Health Intelligence Service	Names of specialist nurses/directors etc.	25/03/09
04/03/09	Katherine Andrew 43 Old Queen St London SW1H 9JA	<p>To outline my query as clearly as possible, I am requesting details on the hospitals use of:</p> <ul style="list-style-type: none"> a. LINAC (linear accelerator) b. PET (Positive Emission tomography) 	19/03/2009

		<p>c. CT (Computerised tomography) d. MRI (Magnetic Resonance Imaging) e. Lithotripters</p> <p>How many (if any) of these devices (listed above) were found on site, in all hospitals controlled by the Trust, in 2008? Please specify which particular devices are found on the Trust's sites, and state clearly how many of each device there is (for example, 1 MRI scanner; 3 Lithotripters).</p> <p>How many times was each of these devices (listed above) used in 2008? Please state clearly how many times each individual device was used (for example, LINAC – 3000 separate uses; Lithotripters – 5000 separate uses).</p> <p>Please note if any of these devices were bought, replaced or disposed of during 2008, and state when that took place.</p>	
05/03/09	Employment for Childcare Vouchers	Info regarding Childcare Voucher Scheme	23/03/09
05/03/09	Royal College of Nursing	Amount spent on consultancy services and project works undertaken by consultancy companies	23/03/2009
05/03/09 – 02/04/09	Mark Harrison	Members interest	27/03/2009
09/03/09 – 06/03/09	Unison Health Care	Staff Suspensions	02/04/2009
09/03/09	Graeme Littlejohn Press Officer Scottish Liberal Democrats	NHS Dumfries and Galloway plan to meet the European Working Time Directive regulations, specifically for junior doctors.	31/03/2009

10/03/09	Danielle Revers Parliamentary Assistant for Jeremy Purvis MSP Tweeddale, Ettrick and Lauderdale	Whether any data disks, flash drives, memory sticks, or other electronic media has been lost since 28 November 2007 and if so, what information/data was included on the lost media.	23/03/2009
10/03/09 – 07/03/09	Kirsteen Paterson Deputy News Editor Metro Scotland	How many babies have been born to mothers taking prescribed methadone within the NHS board area during 2003-2008? Please break this figure down by year. Please also break this down by hospital. What percentage of total births does this group make up? Of the babies born to mothers taking prescribed methadone, how many suffered Neonatal Abstinence Syndrome? How many of these children were premature? How many cot days in neonatal units were used to care for this group?	01/04/2009
13/03/09	Patricia Kane Mail on Sunday	Pest Control information and Taxi Fares to transfer consultants between hospitals.	25/03/2009
17/03/09 – 15/04/09	Ian Harrison	Spend on hospitals re catering	10/04/2009
13/03/09 – 10/04/09	Yukari Imai Policy and Campaigns Muscular Dystrophy Campaign 61 Southwark street London SE1 0HL	Equipment for adults with neuromuscular conditions	27/04/2009

12/03/09	John Paul Breslin Deputy Chief Reporter The Sunday Post, 10 Annandale Street, Edinburgh EH7 4AN	Clinical Psychology	30/03/2009
19 March 09 – 16/04/09	Lend Lease Project Ltd 16 Forth Street Edinburgh	Info regarding professional services	02/04/2009
25/03/09	University of Glasgow	Info re Mental Health Services Info recd needs to be sorted – discuss with Iain Boddy on Tuesday 7 April.	14/04/2009
27/03/09 – 24/04/09	The Scottish Parliament Dr Richard Simpson MSP Mid Scotland & Fife	Bacterial contamination on water dispensers	23/04/2009
27/03/09	Giuseppe De Santis 11 Bishops Way London - E2 9HB	How much this NHS spent in interpreters and translation in 2008?	31/03/2009
30/03/09	Mark Aitken Political Editor Sunday Mail	Police Post or Mini Station	30/03/2009
30/03/09	Mark Aitken Political Editor Sunday Mail	What operations or procedures are refused or not offered to patients who smoke?	31/03/2009

25/03/09 – 20/04/09	Jodie Harrison	Lost or stolen data	20/04/2009
26/03/09	Graham Grant Daily Mail	<p>a) Please tell me how many women involved in same-sex relationships have undergone IVF treatment paid for by your NHS board in each of the past five years?</p> <p>b) How many single women have undergone IVF treatment paid for by your NHS board in each of the past five years?</p> <p>c) How many single gay women have undergone IVF treatment paid for by your NHS board in each of the past five years?</p> <p>d) How much has been spent on IVF treatments for all of the categories outlined above.</p> <p>b)</p>	03/04/2009
26/03/09	Joe Dorfman Director Video3 Technologies Ltd	<p>For the period April 2007 – March 2008</p> <p>No of staff employed</p> <p>Full time</p> <p>Part time</p> <p>Amount of business miles travelled attending meetings, conferences and clients.</p> <p>The actual cost of Business Miles reimbursements</p> <p>The cost for overnight accommodation and subsistence.</p>	03/04/2009

Current Consultations

From	Topic	Response due by
NMC	Review of Guidance for Students and Personal and Professional Conduct <i>No response sent</i>	20 April 2009
Health Facilities Scotland	Resilience Planning for the Healthcare Estate <i>Response sent 27/04/2009</i>	24 April 2009
Health Professions Council	Guidance on Health and Character and Guidance on Conduct and Ethics for Students <i>Response sent 11/2/09</i>	30 April 2009
Scottish Government	Draft Quality Standards In Paediatric Audiology	20 April 2009
Scottish Government	Tobacco and Primary Medical Services (Scotland) Bill <i>Response sent 1/04/2009</i>	8 April 2009
BMA Scotland	Key issues in general practice in Scotland	22/05/2009
NHS 24	Equality and Diversity	22/05/2009
Food Standards Agency	Launches Consultation on Strategy for 2010 2015	30/05/2009
Home Office	Reducing the vulnerability of crowded places to terrorist attack	10/07/2009

DUMFRIES AND GALLOWAY NHS BOARD

Note of the Medical Workforce Workshop held on 6 April 2009.



Present

Mr M Keggans	Chairman
Mr J Burns	Chief Executive
Mr J Ace	Director of Health Services
Mrs H Borland	Nurse Director
Mrs H Brash	Non Executive Member
Dr A Cameron	Medical Director
Mr A Campbell	Non Executive Member
Dr D Cox	Director of Public Health
Mr E Hunter	Non Executive Member
Mr I Hyslop	Non Executive Member
Mr A Johnston	Non Executive Member
Mr D Lockhart	Employee Director
Mr C Marriott	Director of Finance
Dr R Park	Non Executive Member
Ms C Sharp	Director of HR and Workforce Strategy
Mr K Warford	Vice Chairman

Apologies

Mrs H Dykes	Non Executive Member
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Attending

Dr A Eccleston	Consultant Paediatrician
Mr A McCullough	Medical Director – Acute Services
Mr S Whitelaw	Consultant Surgeon
Mrs J Wilson	Board Administrator

The Medical Director delivered the workshop on medical workforce and described the challenges in meeting the European Working Time Directive and the additional posts required to support that and sustain services.

COMMUNITY PLANNING JOINT BOARD

Meeting of Thursday 12 March 2009

Fire and Rescue Service Headquarters, Dumfries

Present

Chair: Ivor Hyslop - Leader
Dumfries and Galloway Council

Vice Chair: Mike Keggans - Chairman
NHS Dumfries and Galloway

John Burns - Chief Executive
NHS Dumfries and Galloway

Brian Collins - Chairman
Swestrans

David Gass - Regional Director South
Scottish Enterprise

Mike Gilboy - Local Economic Forum

George Graham - Deputy Chief Constable
Dumfries and Galloway Constabulary (to Item 9)

Joyce Harkness - Executive Officer
Dumfries and Galloway Federation of Councils
of Voluntary Services

Philip N Jones - Chief Executive
Dumfries and Galloway Council

Jane Maitland - Councillor (Independent Group Leader)

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Sandra McDowall - Councillor (Lib Dem Group Leader)

Irene Mungall - Chief Executive
Dumfries and Galloway Citizens Advice Service

Ronnie Nicholson - Councillor (Labour Group Leader)

Patrick Shearer - Chief Constable
Dumfries and Galloway Constabulary
(Items 10 and 11)

Alastair Witts - Councillor (SNP Group Deputy Leader)

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Rob Davidson - Councillor (SNP Group Leader)

Gordon Mann - Local Economic Forum

In attendance

Liz Manson - Corporate and Community Planning Manager

Hew Smith - Development Officer (Looked After Children) (Item 10)

Tony Jakimciw - Lifelong Learning Partnership – Chair (Item 10)

Donna Mounce - Policy Officer (Items 3 and 4)

Peter Ross - Voluntary sector (Item 10)

Agnes Henderson - Voluntary sector (Item 10)

Colin Grant - Director Schools Services (Item 10)

Ann Stephenson - Chair Nith Local Rural Partnership (Item 6)

Robert Thom - Area Manager Nithsdale (Item 6)

0.1 NOTED concerns that a number of meetings were taking place at the same date and time and that every effort was made to avoid this, including scheduling Board meetings more than a year in advance.

1. MINUTE OF MEETING OF COMMUNITY PLANNING JOINT BOARD OF 22 JANUARY 2009

1.1 **AGREED** as a correct record.

2. MATTERS ARISING

NOTED

2.1 updates on: the satisfactory position of community planning in the Best Value and Community Planning Audit of Dumfries and Galloway Council; progress in the new arrangements for Third Sector Interface; implementation of the Compact; development of the regional and local Third Sector Forums; arrangements for the involvement of stakeholders during the recruitment process for the new Chief Executive of Dumfries and Galloway Council; and the positive reception by the Council's Corporate Policy Committee of the proposed Development Day and Local Action Plan for Equally Well.

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2.2 **AGREED** to receive an update on the Task Force on Voluntary Sector Funding at the next meeting.

ACTION: OPERATIONS MANAGER COMMUNITY LEARNING AND DEVELOPMENT

3. PROGRESS REPORT ON SINGLE OUTCOME AGREEMENT 2008/09

3.1 **APPROVED** the Dumfries and Galloway mid-term SOA progress report for submission to Scottish Government;

3.2 **NOTED** the draft full term progress report will be submitted for consideration at the July meeting.

ACTION: CORPORATE AND COMMUNITY PLANNING MANAGER

3.3 Arising from the discussion about hate crime, **HIGHLIGHTED** the need for partners to support local diversity groups to achieve an inclusive society for all our residents and visitors. The proposed submission of a LEADER+ application was **WELCOMED** as a constructive way forward for this region.

ACTION: DIVERSITY WORKING GROUP

4. THE NEW DUMFRIES AND GALLOWAY COMMUNITY PLAN AND SINGLE OUTCOME AGREEMENT FOR 2009-11

4.1 **APPROVED** the new Community Plan for 2009-12, **NOTING** that all statutory partners (Council, NHS, Regional Transport Partnership, Scottish Enterprise and the Chief Constable) had unanimously agreed the Plan and it had been endorsed by the other bodies represented on the Board, the Third Sector Forum and members of the Local Economic Forum. **NOTED** that Councillor Nicholson recorded his dissent to the decision;

4.2 **APPROVED** the SOA 2009-11 including the final adjustments to the detailed performance information as tabled and agreement about measuring school exclusion and attendance by local numbers as well as comparison with other areas;

4.3 **AGREED** that every effort be made to have the Scottish Government response to the draft by mid April so that the formal approval of the final SOA could be considered at scheduled meetings of the Council and NHS in early May and the final endorsement at the Board meeting on 14 May 2009;

4.4 **NOTED** that a formal review of the consultation programme will be undertaken and the results reported to a future meeting;

4.5 **COMMENDED** the Policy Team and the Outcome Leads for the Community Plan and the draft SOA, **NOTING** that both documents had been very well received and their clarity and prioritisation generally welcomed;

4.6 **AGREED** that the Community Plan and the SOA be launched at a Conference event in June 2009, combined with the Voluntary Sector Conference that was a commitment in the Compact.

ACTION: CORPORATE AND COMMUNITY PLANNING MANAGER

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5. ECONOMIC POSITION IN DUMFRIES AND GALLOWAY

- 5.1 **NOTED** the presentation by David Gass Regional Director South, Scottish Enterprise about the messages coming from a recent survey of companies and that the current economic recession had implications for all community planning partners through regeneration projects, benefits and business advice and services to support people with mental health problems.
- 5.2 While the industry structure and public sector programme of investment meant that the position in Dumfries and Galloway was less critical than other parts of the UK, the impact on a wide range of businesses including local solicitors and home improvement firms was **NOTED**.
- 5.3 As in the Economic Recovery Plan following the Foot and Mouth crisis, tourism was seen to be key in sustaining the local economy with particular issues being the quality of the tourism product and marketing. The Year of Homecoming and new types of industry at the Crichton Campus were seen as opportunities.
- 5.4 It was **AGREED** that these issues be included in the themed discussion on 'Wealthier and Fairer' discussion at the next Board meeting.

ACTION: CORPORATE AND COMMUNITY PLANNING MANAGER

Ivor Hyslop left the meeting and Mike Keggans Vice Chairman took over as chair for the rest of the meeting

6. REPORT ON COMMUNITY PLANNING AT LOCAL LEVEL – NITHSDALE

- 6.1 **NOTED** the Community Planning Co-ordinator post has been vacant in Nithsdale for a year but the revised post of Partnership Support Officer commenced on 15 January 2009 and so there would be increased activity:
- 6.2 The role of the Joint Officers Group, the work carried out to sustain and support the Local Rural Partnership and the lessons learned about how best to structure and allocate aspects of the workplan;
- 6.3 That a review of Nith Local Rural Partnership is being launched and local priorities will be identified at the Visioning Day on 24 March 2009 as part of the process of producing the Nith Action Plan:
- 6.4 The examples of good community planning partnership initiatives right across the Nithsdale area and the involvement of all public sector partners working with individuals and organisations to achieve the workplan. The example of themed roadshows in a number of small communities was commended; .
- 6.5 In addition to the 61 members of the LRP, engagement with the wider community regularly took place and that they had wider networks and contacts. Of particular note was the involvement of Community Councils; and

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6.6 The work of the Area Committee was focussed on Council issues because the size of the Nithsdale area meant there was a significant volume of business for decision;

ACTION: AREA MANAGER NITHSDALE

6.7 The Chairman **THANKED** the Nith LRP Chair for her work over the last year in particular during the officer vacancy.

6.8 **HIGHLIGHTED** the value of joint working across the four areas to ensure consistency where appropriate and to share best practice and ideas.

ACTION: CORPORATE AND COMMUNITY PLANNING MANAGER

7. COMMUNITY PLANNING BUDGET MONITORING REPORT AND DRAFT 2009-10 BUDGET

7.1 **NOTED** the community planning monitoring report to February 2009 and the forecast satisfactory outturn position at the end of the financial year;

7.2 **AGREED** the outline community planning budget for 2009-10 including an allocation of £2,500 for activity related to LRP and Third Sector Forum activity; and

7.3 **NOTED** the work plans and budget which supported local community planning activity in 2008-09 and that payments for Local Licensing Forum and a small grants scheme had been included in this definition by area management. .

ACTION: CORPORATE AND COMMUNITY PLANNING MANAGER

8. MINUTES

NOTED the draft Joint Management Team of 13 February 2009 and in relation to Item 3.3 of this minute, **NOTED** that all the public sector organisations represented on the JMT had each agreed to provide professional officer support and in kind support for events for one of the local diversity groups.

9. MAY AGENDA

AGREED the draft agenda for the meeting 14 May 2009 with Wealthier and Fairer to be the Themed Discussion topic, and Annandale and Eskdale to be the local area considered.

ACTION: CORPORATE AND COMMUNITY PLANNING MANAGER

10. THEMED DISCUSSION – SMARTER

The Local Outcome Lead for Smarter, Colin Grant Director of School Services Dumfries and Galloway Council, gave a presentation on key issues, and discussion took place about the current position and future development of issues. **Appendix 1** details the issues raised during the debate.

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11. FUTURE ARRANGEMENTS FOR ALCOHOL AND DRUG ACTION TEAM/PARTNERSHIP

- 11.1 **ENDORSED** the establishment of a Dumfries and Galloway Alcohol and Drugs Partnership to replace the Dumfries and Galloway Alcohol and Drug Action Team
- 11.2 **NOTED** the first meeting of the ADP will take place in June 2009 and the proposed Operating Arrangements
- 11.3 **AGREED** that the ADP will be recognised as one of the thematic groupings contributing to the Community Plan and Single Outcome Agreement; and
- 11.4 **NOTED** that the ADAT Support Team will change its designation to ADP support team, and begin to operate to national guidelines realigning the work of current ADAT groups to the delivery of national priorities.

ACTION LEAD OFFICER SUBSTANCE MISUSE

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Appendix 1



NOTE AS AT 12 MARCH 2009

THEMED DISCUSSION ON 'SMARTER' - BEING BETTER EQUIPPED FOR A CHANGING WORLD AND HAVING IMPROVED LIFE CHANCES

Key themes/issues

- School attainment – educational qualifications
- School achievement – wider opportunities for sport and cultural activities
- Inclusion and attendance rates – particularly for Looked After Children but also for other hard to reach groups of children like those living in poverty
- Lifelong learning opportunities for adults – with the local FE sector able to determine its own priorities for courses
- Targeting skills training – important to recognise that it's the needs of local employers that drive the training needs – link to the Regional Economic Strategy. This aspect is about job opportunities not individual aspirations
- Responsible citizenship – links in to volunteering and community projects

Main challenges

- Performance data – new performance systems are being put in place but much of the data is still in early stages so there's no baseline information. Also sometimes comparisons are not always possible because different areas measure things differently. 'Softer' measures are becoming increasingly popular.
- Linking performance frameworks – e.g HMIE Inspections with the SOA progress reports so there is no duplication and inconsistencies.
- Ownership and engagement – good work has been done with Headteachers and there's good understanding of how the 'golden thread' works from the Community Plan and SOA through to individual schools and pupils; other bodies who have contributed to the development of the Community Plan and SOA need to have a fuller understanding of the detail and implications.

Current performance

Current performance is satisfactory:

- The current SOA has 16 targets in the Smarter section with two not on target (number of young people on pre get ready for work project in D&G; and the number of adults successfully completing classes targeted at improving Literacy and Numeracy) and 14 on target or in progress
- The new SOA has only four objectives so it is a meaningful set of information

Partnerships and groupings

There is an existing network of partnership grouping that is able to take forward this agenda, including:

- Lifelong Learning Partnership – refocusing and refreshing membership
- The Crichton Foundation and other bodies associated with the Campus
- Integrated Children's Services
- Local Economic Forum