APPENDIX

Scrutiny of DG Health and Wellbeing (DGHW, formerly the Joint Health and Wellbeing Unit)
Summary of evidence session Thursday 16 May 2013

Member question (MQ) 1 : We understand that DGHW is at the forefront of innovative work in health and wellbeing. What is it that makes your approach so innovative compared to others working in this field? What is the current thinking and were other areas taking this forward?

NHS Dumfries and Galloway (DC): The approach being taken in our region is consistent with the s drive by the Chief Medical Officer, and is an assets based approach – this means we look at the positive assets we have across Dumfries and Galloway rather than focussing on the deficits within a particular area or community. Dumfries and Galloway has a long track record in this work, particularly around health improvement, and as we have been doing this for a number of years it's really a case of other areas are really catching up with us. The Joint Unit between the Council and NHS is however innovative and is a step change which goes beyond normal partnership working and is reducing duplication.

MQ 2 : How did you identify the local needs to be addressed? Are you confident that the priorities you are progressing will meet these evidenced needs? At paragraph 2.3 on page 16 you say that there are emerging priorities - why are these only coming to the fore now? Why were priorities set but funding not identified?

DC: we are not starting with a blank sheet of paper – we had a sound knowledge base of the health inequalities and needs of communities based on regular assessment . These local needs were looked at, guided by national strategy to identify what the Unit should be tackling. E.g. he Equally Well document was a good guide to taking this forward – veterans were identified as having significant needs which had not been previously identified. The Action Plan was deliberately aspirational and is designed to allow new and emerging areas to develop.. Development work is ongoing to identify available funding streams for projects and unmet need.

MQ 3: Is there ownership and buy-in from all partners for the ambitions of DGHW and ensuring that the outcomes in the Action Plan are successfully achieved? How well has the team merged? Expand on how the partnership approach was better.

DC: Time has been spent consulting and developing relationships with partners to take the Unit forward and there are shared ambitions and outcomes. The recent development in England has seen public health transferred to local government so there is recognition that the issues are shared between the two organisations. However the English model, has encountered difficulties due to NHS transferring insufficient resource and so lessons cannot be drawn at this stage about how successful that approach has been.

MQ 4: Given that DGHW is at the cutting edge of the health and wellbeing agenda and in an enviable position to attract national interest, what actions are you taking to ensure that all available funding opportunities (local and national) are explored and exhausted? For example from the Change Fund or Putting You First.

DC: Some success has been achieved in attracting funding, but it is acknowledged that more could be done to attract external/national funding/support in kind.

MQ 5: Do you have the optimum staff complement to deliver your Action Plan?

DC: Staffing levels are just about right – we have avoided areas of duplication between the two organisations and make the most efficient use of staff.

MQ 6: In terms of challenging financial and staffing resources, is DGHW able to prioritise and expand its current work programme as it had intended? How will you address the situation? Does the Council get involved everywhere we can and is the Unit involved at the right time to get the best outcome?

DC: The Unit's ambition is to sustain current work and expand into other areas, for example on the psychology of parenting. To do this we will work with the relevant bodies e.g for the parenting work we are working with GIRFEC to agree our activity and the transfer of resources that are needed. Generally, yes, the Unit is involved at the right stage We have identified that greater engagement in relation to the health and wellbeing of the DGC Workforce would be beneficial.

MQ 7: What obstacles do you face in successfully delivering your Action Plan? How do you intend to overcome major difficulties?

DC: Traditional medical professionals do not seem to have a high regard for the health and wellbeing agenda so the barriers were attitudinal as well as financial. There is significant dialogue at local level, including with the Chief Medical Officer, and increasingly the preventative/health improvement agenda is recognised as effective. However, while the preventative agenda spend has improved, more resources are needed to ensure services are expanded.

MQ 8: How sustainable is DGHW?

DC: The Unit must demonstrate its value and that it makes a difference. There is confidence that funding will continue from the Health Board and the Council which will sustain the Unit.

MQ 9: A proactive approach to DGHW's wide-ranging activities is essential. Can you give us an example of how you address any less well-performing areas in your Action Plan?

DC: One area identified and being developed is health and wellbeing within the criminal justice system . We have given detailed consideration to the issues and staff resources and are confident that we have a programme that will make best use of the resources available and take this area forward.

MQ 10: Would you agree that the profile of DGHW needs to be enhanced – the asset based approach is not in the public's consciousness - what are your proposals

for this and how do you think the Council and community planning partners could help?

DC: More could be done to promote the work of the Unit and a Communications Strategy is in development. A website has been created and the Unit are looking to improve social networking. We have also made a recent presentation to the Council's Corporate Management Team.

MQ 11: At paragraph 2.3 on page16 you say that you there has been a planned under-commitment of resources. Can you give a brief resume of this?

DC: We always knew that the projects and initiatives we were looking at were beyond the funding that we had but I was keen that we were aspirational about what we wanted to do, rather than constrained by the budget we knew we had. We have ongoing discussions for transferring/maintaining resources for existing projects such as maternity/health visiting and the Keep Well Initiative at local and national level. We recognise that evidence is needed to persuade funders to support projects and initiatives.

MQ 12: Can more use be made of school nurses? How do you ensure there's no duplication of service?

DC: School nurse numbers are already short of four full-time nurses to support child health needs; the service is already stretched/pressurised and under-funded, so regrettably there is no possibility of using school nurses more than presently.

MQ 13: At 2.3.2 you give the example of the community health development worker in the Stewartry - what's happening in the rest of the region? Is this a disproportionate resource being focussed in the Stewartry?

DC: Historically community development workers existed in the former Wigtownshire and Nithsdale areas. Latterly this service has been expanded into Annandale and Eskdale, and so to ensure the whole region is covered our proposal is to support a worker in the Stewartry.

MQ 14.: Can you explain how the governance arrangements through the Public Health Governance Committee will work?

DC: The Unit reports regularly on a range of individual issues e.g.health protection, monitoring services, data analysis and health improvement all report to the NHS Public Health Governance Committee and then to the Health Board. It is recognised that a stronger reporting line into the Council would be beneficial.

MQ 15: You highlight the theory of Aaron Antonovsky on page 19 - his theory also considers the 'meaningfulness' of life. To what extent have you adapted this theory to support the approach the Unit is using?

DC: The assets based approach and the language of wellbeing that we use draws on Antonovsky and also other international sources e.g Max von Neef a Chilean Economist.

MQ 16: Can you explain the progress chart on page 20: there's been no progress on four indicators - why is that? Are 56 indicators the right number? It seems quite a lot for the team? You've also stated that a refinement in the work being progressed has taken place. Why is this and what has been the result?

DC: This has already been covered in previous responses. A range of indicators were put forward in the Action Plan, some of which were work in progress or a longer term nature with various organisations and departments so that is why there is ongoing refinement.

MQ 17: Are there specific areas we need to address as a matter of urgency?

DC: Two areas which I suggest should be our focus are (1) the psychology of parenting, as I believe this requires a more widespread and cohesive parental approach and (2) workplace wellbeing, which requires improvements in management style and organisational justice.

MQ 18: Can you explain why the UK was placed in the bottom third across five of the six dimensions analysed? What can we do to improve our region's position in this regard?

DC: The health record of Dumfries and Galloway is seen to fit most closely with northern England (being marginally worse than the east of Scotland, but better than the west Scotland). There is no single reason for poor health levels and social factors contribute.

MQ 19: "Priorities for the future fall into two key categories; sustainability and 'wicked' health issues." This paints quite a Doomsday scenario; can you explain the anticipated timescale for the impact of these actions to be measurable?

DC: Environmental issues play a major role here and so the timescale is generational. My recent Annual Report highlights the need to address the impacts of global warming (rising sea levels, population migration, and oil production) and I personally advocate the production of a Peak Oil Plan as I believe this is a significant issue for the future.