DUMFRIES AND GALLOWAY NHS BOARD

PUBLIC MEETING

A meeting of the Dumfries and Galloway NHS Board will be held at 10am on Monday 4th February 2019 in the Conference Room, Crichton Hall, Bankend Road, Dumfries.

AGENDA

Time	No	Agenda Item	Who	Attached / Verbal
10.00am	247	Apologies	L Geddes	Verbal
10.00am	248	Declarations of Interest	N Morris	Verbal
10.05am	249	Previous Minutes	N Morris	Attached
10.10am	250	Matters Arising and Review of Actions List	N Morris	Attached
QUALITY & SAFETY ASSURANCE				
10.15am	251	Patient Services Feedback Report	E Docherty	Attached
10.25am	252	Healthcare Associated Infection Report	E Docherty	Attached
10.35am	253	Spiritual Care, Volunteering and Patient Services Team Report	E Docherty	Attached
10.45am	254	Improving Safety, Reducing Harm Report	E Docherty	Attached
PERFORMANCE ASSURANCE				
10.55am	255	'At a Glance' – Summary operational performance report.	J White	Attached
11.05am	256	Review of Integration Joint Board Performance Framework	J White	Attached
11.15am	257	Dumfries and Galloway Integration Joint Board Strategic Plan for Health and Social Care 2018 - 2021	J White	Attached
11.25am	258	Dumfries and Galloway Integration Joint Board 2018/19 Quarter 2 and Ministerial Strategic Group performance update	J White	Attached
11.35am	259	Ministerial Strategic Group Improvement Objectives Draft Proposal for 2019/20	J White	Attached
11.45am	260	Scottish Graduate Medical School Update	K Donaldson	Attached

Time	No	Agenda Item	Who	Attached / Verbal
FINANCE & INFRASTRUCTURE				
11.55am	261	Financial Performance Update	K Lewis	Attached
PUBLIC HEALTH & STRATEGIC PLANNING				
12.05pm	262	Regional Delivery Plan	J Ace	Verbal
12.15pm	263	Potential Development of a "Maggie's" Centre in Dumfries	J Ace	Verbal
12.25pm	264	Update on National Public Health Reform	M McCoy	Verbal
GOVERNANCE				
12.35pm	265	Board Briefing	J Ace	Attached
12.40pm	266	FOI Annual Report	L Geddes	Attached
12.45pm	267	NHS Board Dates 2019/20	L Geddes	Attached
12.55pm	268	Committee Minutes • Staff Governance Committee– 24 September 2018 • Audit & Risk Committee – 17 September 2018 • Person Centred Health & Care Committee – 20 August 2018 • Person Centred Health & Care Committee – 22 October 2018 • Healthcare Governance Committee Minutes – 12 November 2018 • Area Clinical Forum Committee Minutes – 28 November 2018		Attached
ANY OTHER COMPETENT BUSINESS				
DATE AND TIME OF NEXT MEETING				
1.00pm		• 8th April 2019 @ 10am – 1pm. The venue for the meeting will be confirmed prior to the meeting.		

Agenda Item 249

DUMFRIES AND GALLOWAY NHS BOARD

NHS Board Meeting

Minutes of the NHS Board Meeting held on 3rd December 2018 at 10am – 12.30pm in the Conference Room, Crichton Hall, Bankend Road, Dumfries, DG1 4TG.

Minute Nos: 230-246

Present

Mrs P Halliday (PH)	-	Interim Chair
Mr J Ace (JA)	-	Chief Executive
Mrs K Lewis (KL)	-	Director of Finance
Ms M McCoy (MMc)	-	Interim Director of Public Health
Mr E Docherty (ED)	-	Nurse Director
Dr K Donaldson (KD)	-	Medical Director
Mr A Ferguson (AF)	-	Non Executive Member
Mrs G Cardozo (GC)	-	Non Executive Member
Mr S Hare (SH)	-	Non Executive Member
Mr N Morris (NM)	-	Non Executive Member
Dr L Douglas (LD)	-	Non Executive Member
Ms L Bryce (LB)	-	Non Executive Member
Ms M Gunn (MG)	-	Non Executive Member

In Attendance

Dr R Thomas (RT)	-	Consultant Haematologist
Mrs J White (JW)	-	Chief Officer
Mrs V Freeman (VF)	-	Head of Strategic Planning and Commissioning
Mrs L Geddes (LG)	-	Corporate Business Manager
Mrs L McKie (LM)	-	Executive Assistant (Minute Secretary)

Apologies

Ms C Sharp (CS)	-	Workforce Director
Mrs L Carr (LC)	-	Non Executive Member

PH thanked Board Members for attending the NHS Board Meeting, welcoming Dr Ranjit Thomas to the meeting, who was attending as Deputy Chair of Area Clinical Forum in place of Lorna Carr. It was noted that this was the last full board meeting of 2018 and members were asked to take time to reflect at the end of the meeting on the changes over the last year.

230. Apologies for Absence

Apologies as noted above.

231. Declarations of Interest

PH asked members if they had any declarations of interest in relation to the items listed on the agenda for this meeting.

It was noted that no declarations of interest were put forward.

232. Minutes of meeting held on 1st October 2018

The minute of the previous meeting on 1st October 2018 were approved as an accurate record of discussions, subject to the following amendments, LM was asked to make the necessary amendments and recirculate to Board Members:

Action: LM

Item 212 – Patient Experience Report*:*

NM enquired to whether there was detailed analysis within the report to identify the rise in complaints in July and August and to whether the perceived car parking issue at DGRI had added to the level of recent complaints.

should read:

NM enquired to whether previous discussions regarding the patient feedback report had given assurance, indicating that high numbers of 'concerns' raised over the December to April period had been due to car parking issues. The classification of types of concerns however seemed to indicate that this had not been the case.

***Item 219 - Dumfries* & Galloway British Sign Language Plan**

NHS Board Members were advised that the first draft of the British Sign Language plan was developed following an initial focus group consultation event on 8th May 2018 with local British Sign Language users, Dumfries and Galloway partners, Visibility Scotland and British Sign Language translators. Two further consultation events were held in Stranraer and Dumfries during September 2018.

should read:

NHS Board Members were advised that the first draft of the British Sign Language plan was developed following an initial focus group consultation event on 8th May 2018 with local British Sign Language users, Dumfries and Galloway partners, Visibility Scotland and British Sign Language translators. A further consultation event was held in Dumfries in September 2018, however, a delay has been noted to the consultation event planned for Stranraer.

Item 220 - Financial Performance Update Report

NM asked what the future plan is that may help the current capacity issues and what CRES impact assessment work is being undertaken on clinical services. GS advised that Transformational Change Managers and Workstreams are now in place and discussions are ongoing to understand and work through ideas to ensure more sustainable models are put in place going forward.

JW gave assurance that impact assessments had been presented to the Integration Joint Board (IJB), with discussion concluding with JA agreeing that the NHS Board as the accountable body for NHS financial outturn and clinical quality also needs to receive impact assessment reports regarding CRES schemes. GS agreed to bring a further update to the NHS December board.

should read:

NM asked what the future plan is that may help the current capacity issues and what CRES impact assessment work is being undertaken on clinical services. GS advised that Transformational Change Managers and Workstreams are now in place and discussions are ongoing to understand and work through ideas to ensure more sustainable models are put in place going forward.

JW gave assurance that impact assessments had been presented to the Integration Joint Board (IJB). JA agreeing that the NHS Board, as the accountable body, for NHS financial outturn and clinical quality also needs to receive impact assessment reports regarding CRES schemes. GS agreed to bring a further update to a future NHS board meeting.

233. Matters Arising and Review of Actions List

PH presented the Actions List, taking members through the updates that had been received, noting that all actions listed were progressing as expected.

ED noted an update on Item 215 - Patient Safety and Improvement Annual Report 2017-2018, advising that following the discussion on pressure ulcers and the implementation of revised processes, there has not been statistically significant improvement seen within the current data. This has been raised with Healthcare Improvement Scotland (HIS) for review. The next update to NHS Board will include benchmarking data for pressure Ulcers and will be brought back to the February 2019 meeting.

Action: ED

LB enquired to whether there was an update available on Item 38 – Urological Cancer Update. JA advised that the delay in bringing a paper back to NHS Board around this was due to delays in progress to agree joint pathway arrangements, noting that once agreement was confirmed a formal paper would be presented at Healthcare Governance Committee and NHS Board.

ED noted an update on Item 132 and Item 111, noting that verbal updates had been given at the last NHS Board meeting in response to the questions raised. LM was asked to note both actions as being closed.

Action: LM

LD enquired to the number of actions still outstanding on the Action List, with PH agreeing that NHS Board Members required clarity and assurance that actions were being closed off.

NM highlighted that he felt that outstanding actions should be reported back to Board within 3 months. MG noted that she would prefer a time/date added to close of all actions rather than an update paper coming back to Board every 3 months.

LB agreed with MG and asked that an agenda matrix be added to the end of the Actions List for future board updates.

Discussion continued on NHS Board Members thoughts and it was agreed that LG would include an agenda matrix within the actions list for the February 2019 Board Meeting.

Action: LG

GC enquired to the reason why there was only a verbal update on “Maggies Centre” instead of a formal report. JA advised that following discussions with PH, it was agreed to postpone bringing a formal paper to Board until after the new Chair is in post.

NHS Board Members noted the Actions List.

234. Patient Experience Report

ED presented the Patient Experience Report, which provided an update on the Board’s complaints performance for September and October 2018 including key feedback themes.

NHS Board Members were directed to the key items within the report, noting the new format of the report, which was reviewed at Healthcare Governance Committee in August 2018 and further discussed at a recent meeting of the Complaints Assurance Group.

NHS Members were made aware of the new Patient Experience Group, which met for the first time in October 2018 and is currently working on testing a new approach for improving learning from significant complaints.

It was noted that Patient Services were working closely with Directorates to ensure that all teams are supported with training, templates, guidance and advice as required in relation to the handling and investigation of complaints.

NHS Board Members commented that the report did not give members adequate assurances around pace of improvement of performance and processes.

NM stated that he felt since May 2018 NHS Board Members there had been no changes to the assurance levels members had been able to take from the complaints performance. NM stressed that he recognised the ongoing work of the Associate Director of Allied Health Professionals and her team, but that the reports do not present adequate evidence of any learning, or of benchmarking data to give assurance to NHS Board Members that complaints are being managed to deliver improvements in care.

JA noted that although there were capacity issues to resolve within the Acute & Diagnostics Team there is significant progress being made by the Executive Team on reviewing processes, however, he would be happy to address any individuals concerns for further assurance on learning from complaints.

LD highlighted that although she was keen to support the teams in their work given their capacity issues, the level of assurance gave significant concerns, noting the need to gain an understanding on how as a Board we prioritise the backlog of complaints is required.

LB highlighted that she felt Board Members were losing sight of the key aims of the report and although it covered complaints, it also looked at areas of improvement within patient experiences and compliments received. LB emphasized that the report was intended to give assurance on quality of care and patient experience.

GC highlighted that the numbers within the report mean little in isolation, acknowledging the fact that as a Board we must learn when we get things wrong. JA advised that the Board needed to achieve a balance between strategic and operational concerns, with a need to maintain focus on a more rounded view of safety and quality.

RT highlighted Table 2.1 within the report advising NHS Board Members that as a Board compliments do not seem to be regularly collected, therefore, was unsure why it would be noted in the report.

NM highlighted that there was a need to evidence what is going wrong with the complaints process, noting that the current report offers no information on key areas of improvement or to whether there is any learning arising from these complaints.

ED confirmed that he would work with the team to address all of the points raised at the meeting, ensuring that a revised report is brought back to the February 2019 NHS Board Meeting,

Action: ED

JW highlighted that discussions were underway with General Managers to address concerns with performance levels in relation to complaints, noting that there is potential investment within the Acute & Diagnostics Directorate to recruit a clinical lead within the Patient Safety and Experience Team to co-ordinate and support the investigation process and lead on the co-ordination of improvement work.

PH noted that although Members were happy to note the Report, it was highlighted that the report offered limited assurance in relation to the Board's performance around complaints management.

235. Healthcare Associated Infection Report

ED presented the Healthcare Associated Infection Report, noting the Board's position with regard to the Staphylococcus Aureus Bacteraemia (SAB) and Clostridium Difficile Infection (C Diff).

NHS Board Members were advised that there had been an increase in the SAB figures over the last two months, however, when the quarterly rolling average is used there has been a reduction over the previous twelve months.

It was noted that there has been a significant increase in cases of CDiff infections. Additional measures were introduced between June and August 2018, the impact of which is starting to be seen.

NHS Board Members were made aware that an inspection was carried out at Galloway Community Hospital on 22nd November 2018, the verbal feedback from which was excellent and praised the staff for the improvements that had been made. No requirements for improvement were put forward and the formal report is due to be issued in January 2019.

In relation to compliance with national HAI screening programmes, ED advised that figures are both in excess of the national rate.

LD enquired to whether the Board was doing enough to lower infection rates within Maternity Services. ED noted the issue of small number variation and explained work underway in the directorate.

In relation to the Hand Hygiene data, ED advised that teams are continuing to encourage all staff on good hand hygiene procedures, with a recruitment drive in place for additional domestic staff over the Winter period.

NHS Board Members noted:

- The update paper.
- The increase in Staphylococcus aureus bacteraemia and the actions taken.
- The actions to address HAI Clostridium DIfficile Infection.

236. Performance Report

JW presented the Performance Report, asking NHS Board Members to note and discuss the NHS Board 'At a Glance' Report for September 2018.

NHS Board Members were advised that the information within the report is generated from local information systems. The figures are an early indication of activity and may not exactly match the National Official Statistics publications which are issued later in the year.

JW noted the performance data within Appendix 1, highlighting that Cancer performance data remains above target with an increase in in-patient Treatment Time Guarantee (TTG) breaches; however plans are in place to bring the position back under control.

NHS Board Members were informed of the addition of a General Surgeon within Colorectal Surgery who would invrease surgical capacity in that pathway.

Looking at cancer rates, JW made NHS Board Members aware of changes to the radiology guidelines for MRI scans, which impact on the length of patient pathways.

JA highlighted that the Board has a Qlikview dashboard that NHS Board Members may find useful to access, it was noted that a workshop was being arranged to give members a demonstration of this dashboard and following discussions would now incorporate training on how to use the system.

Action: LG

NM expressed his concern in capacity issues and what is being done to resolve the workforce issues.

LB enquired to where NHS Board members get their assurances on the sustainability of the workforce if they are not a member of the Staff Governance Committee, noting that there should be additional information made available rather than a brief update on committees at the end of the NHS Board agenda.

PH agreed that each committee chair should give an update at Board on progress to date.

JW enquired on NHS Board Members thoughts on proposals for future papers and to whether NHS Board Members were content to receive a one page summary along with a verbal update.

LD advised that she felt as Audit and Risk Chair it would be beneficially to receive any significant updates in writing, with NM highlighting that with the use of dashboards this would be an ideal opportunity to address all outstanding issues.

JW advised that she would be content to add paragraphs to the covering paper which would include up to date information and would highlight any significant deviations in performance statistics.

Action: JW

NHS Board members noted the report.

237. Integration Joint Board Annual Report

JW gave an update on the Integration Joint Board meeting on 5th October 2018 held in Annan, noting that the key focus points from the meeting were the Integration Joint Board Membership, which had seen the reappointment of PH, GC, LD and LB for a further term.

NHS Board Members were made aware that the Integration Joint Board had approved the Strategic Plan for Adults.

It was noted that the Integration Joint Board approved the Winter Plan for 2018/19 and noted the significant amount of joint working currently ongoing across the Partnership in preparation for the Winter period.

JW highlighted that the Performance Management Locality Reports for Area Committee had been approved. The reports identify the activity taken forward for Year One of the Primary Care Transformation Programme in support of delivery of the 2018 GMS Contract.

VF advised that there was a need to develop a long term plan to address challenges to aid the shift of care, highlighting that there was to be a planned workshop for NHS Board Members in early 2019 to aid discussion, which will form a sharper vision of care in the future.

NHS Board Members noted the report.

238. Financial Performance Update Report

KL presented the Financial Performance Report, asking NHS Board Members to note the position for the period as at end of October 2018, noting that an additional non-recurring saving of £3.5m has still to be identified to bridge the in-year gap.

NHS Board Members were made aware that although Medical Locum costs were still high within the Acute & Diagnostics directorate, the current position was improving due to confirmation that the directorate will manage pressures to contain this cost, improving the position by £500k from the Quarter One estimate.

It was noted that there was an increase in prescribing growth and price increases, as well as a fall in the level of discounts received on Primary Care prescribing.

NM mentioned that he had spoken with KL this morning in relation to identifying CRES savings for 2019, noting the current challenges to deliver services in 2018 and the need to gain a sense of the proposed model moving forward.

LD asked for clarity around when the new Director of Pharmacy would be taking up post and if budgets were in place. KD advised that the post would commence in January 2019 and that a meeting was planned to confirm budgets this week.

NHS Board Members were highlighted to the pressures on Acute Services with JW noting the percentage of spend to both Acute and Community Services.

NHS Board Members noted:

- The updated financial position at the end of October 2018, month 7.
- The ongoing level of financial risk in the position.
- The break-even position following the Mid-year review.
- The assumption that funding will be released in-year from the contingency
- The current underlying recurring savings gap
- The position in relation to the IJB delegated budgets reports

239. Capital Update

KL presented the Capital Update report, asking NHS Board Members to approve the amendment to the Capital Plan to reflect the additional £450k secured for the Galloway Community Hospital (GCH) CT Scanner.

PH enquired to the reasons behind investing in the mobile unit within the GHC. JA advised that although there was only an average of 1,200 scans per year it was felt that it was critical for effective stroke pathway treatment for patients in the West of the Region.

PH enquired to whether this would free up space in the east of the region with patients travelling to the west for treatment. JA advised that referral protocols were being reviewed but that patient choice was a key limiting factor.

Action: JA

KL will provide a more detailed report on the future capital programme at future Board meetings as part of the capital plan development.

JW highlighted the communication campaign around the OCT Machine in the GCH to enhance the Ophthalmology service. PH highlighted that patients need to be informed of the difference the equipment will bring to the area.

AF enquired to the processes behind the equipment lease disposals. KL advised that the Access Management Strategy received regular updates from the Strategic Capital Programme Board on relevant issues with any decision making coming back to the NHS Board, which is in line with the Standing Financial Instruction.

NHS Board Members approved the amendment to the Capital Plan to reflect the additional £450k secured for the GCH CT Scanner.

240. Regional Delivery Plan

JA gave NHS Board Members a verbal update on activities and discussions in relation to the Regional Delivery Plan.

NM enquired to the status of the Regional Delivery Plan, JA advised that this required some further work at regional and national level before being brought forward for formal consideration.

NHS Board Members noted the verbal update.

241. Potential Development of a Maggies Centre in Dumfries

JA gave NHS Board Members a verbal update on the potential development of a Maggies Centre in Dumfries.

NHS Board Members were advised that although there was a paper which addresses previous committee discussions, agreement has been made with that due to the scale of the decision the Board should wait until the appointment of the new Chair for the Health Board is in place.

NHS Board Members noted the verbal update.

242. Brexit

JA gave NHS Board Members a verbal update on the implications for business continuity in the event of an exit from the European Union without transition arrangements.

NHS Board Members were made aware of the National Resilience Partnership Group, which is chaired by Gavin Stevenson, D&G Council Chief Executive and the includes members of the Scottish Resilience Partnership sub-group, in which, JA is the Health Board Representative.

JA advised NHS Board Members that Scottish Government have encouraged NHS Boards to support EU27 staff.

NHS Board Members were advised that there were significant concerns over supply chains for medicines and more general supplies in the event of EU exit without a deal. The scale of potential disruption could affect most aspects of health and care provision as well as having an impact on wider society. At the moment, we are being asked to plan on the basis of disruption to usual supplies from the continent lasting up to 12 weeks.

NHS Board Members were highlighted to the possibility of the end of reciprocal health care arrangements, it is possible that UK citizens, resident in continental Europe, will require to access treatment in the UK. This impact has not been quantified in detail but may bring localised pressures to healthcare systems.

AF enquired to whether those individuals living abroad have been notified of possible changes to their health care. JA advised that guidance wwas being made available nationally but that precise arrangements are not yet clear..

LB enquired to whether there had been discussions with front line staff on plans for an exit from the European Union without transition arrangements. JA advised that no communication had been shared with staff and would not considered until into 2019, once the likelihood of various options became clearer.

NHS Board Members noted the verbal update.

RT and ED left the meeting

243. Board Briefing

PH presented the Board Briefing paper to NHS Board Members, which raises awareness of events and achievements that have occurred within the Board over the past 2 months.

PH noted that Michelle Currie was presented with the CAMHS award for her work to improve access, extending thanks to Michelle and her team for the work undertaken.

JA wished Donald Miller, Project Manager well in his retirement.

NHS Board Members noted the report.

244. Committee Minutes

PH introduced the minutes from various Board Committees to NHS Board members asking the Lead Director and Committee Chair to highlight any key points for noting.

- Staff Goverance Committee – 23rd July 2018
  LB presented the minute from the Staff Governance Committee meeting on 23rd July 2018, which received an update report on the Working Well Campaign.

  NHS Board Members noted the minute.

- Performance Committee – 9th July 2018
  LD presented the minute from the Performance Committee meeting on 9th July 2018, which received an updated on progress of Self Management and the Transformational Change Programme.

  NHS Board Members noted the minute.

- Performance Committee – 3rd September 2018
  LD presented the minute from the Performance Committee meeting on 3rd September 2018, which received an updated report from the Integration Joint Board on performance for 2017-18 Quarter 4

  NHS Board Members noted the minute.

245. Any Other Competent Business.

PH highlighted that it was a good idea to look at recording future NHS Board meetings, with a view to making the audio recording available on the internet. A recording of the February 2019 meeting would be made as a test.

PH thanked JA, JW, KD and Phil Jones for their attendance at the Health and Sport Committee on 30th October 2018.

246. Date of Next Meeting

The next meeting of the NHS Board will be held on 4th February 2019 at 10am – 1pm in the Conference Room, Crichton Hall.

Agenda Item 250

Actions List from NHS Board – Public Meeting

Date of Meeting	Agenda Item	Action	Responsible Manager	Current Status	Anticipated End Date	Date Completed
05/06/2017	38.	**Urological Cancer Update** VF advised Members that to address recruitment challenges locally, work is being progressed with NHS Ayrshire and Arran to establish joint working arrangements for on-call and shared clinics in Stranraer. A further update on progress will be brought back to the August 2017 NHS Board meeting.	Vicky Freeman	Information is still being gathered to allow a paper to be prepared. It has been agreed to push this paper back to the Board meeting for review in early 2019.		
07/08/2017	58.	**Tobacco Control Action Plan** PH further noted the reduction of GP referrals being made to smoking services, noting that this was a national problem as Information Services Division data was also showing a 5% reduction in smoking cessation specialist services. PH requested data evidence of GP referrals be including within the next update to be brought back to NHS Board.	Ken Donaldson	An update on this item will be brought back to NHS Board in early 2019, to include the data evidence of GP referrals.		

Date of Meeting	Agenda Item	Action	Responsible Manager	Current Status	Anticipated End Date	Date Completed
04/12/2017	96.	**Lochside and Lincluden Oral Health Action Plan Update and Lochside Dental Clinic Withdrawal Update** PH further enquired to whether the communities of Lochside and Lincluden had participated in appraisals. VW advised that appraisals had been carried out at the start of the process and although the data confirmed that only 43% of patients resided in the Lochside and Lincluden areas, data was not available to break down any further. VW agreed to address data issues and feedback to Board Members at a later date.	Valerie White	A review of the data issues is being undertaken and an update will be provided to NHS Board when available.		
04/12/2017	96.	**Lochside and Lincluden Oral Health Action Plan Update and Lochside Dental Clinic Withdrawal Update** NHS Board Members were highlighted to the discussion at the last Health and Social Care Management Team meeting, where Alistair Kelly noted his concerns at the lack of administrative provision for Podiatry Services. KL advised that there would be a further review of services to aid administration support and agreed to update Board Members accordingly.	Katy Lewis	An update on this item will be provided to NHS Board members, when available.		

Date of Meeting	Agenda Item	Action	Responsible Manager	Current Status	Anticipated End Date	Date Completed
05/02/2018	111.	**Improving Safety, Reducing Harm Report** PH enquired to how the Board's performance in this area compared with other NHS Scotland Boards, highlighting the recent news article on defibrillation figures which showed that there were more females dying of cardiac arrest and whether there was anything that the Board could do to raise awareness. KD noted that he was not aware of any national campaign for females and ED agreed to speak to the national team and share the information once received with Board Members.	Eddie Docherty	A verbal update had been given at the October NHS Board meeting in response to the questions raised.	07/01/2019	07/01/2019
09/04/2018	130.	**Patient Experience Report** PNJ enquired to whether future reports may be amended to improve the clarity of data as PNJ felt that the feedback charts within the report did not highlight sufficiently the key information for Board members. ED agreed to review the report and amend the format for future submissions.	Eddie Docherty	All future reports are being amended to incorporate this action and will be evident from the August 2018 NHS Board onwards.	06/08/2018	06/08/2018

Date of Meeting	Agenda Item	Action	Responsible Manager	Current Status	Anticipated End Date	Date Completed
09/04/2018	132.	**Improving Safety, Reducing Harm Report** AF noted his interest in how many individuals were involved in the number of falls without harm. ED advised that the Board do investigate the number of individuals involved and agreed to share the information with Board Members.	Eddie Docherty	A verbal update had been given at the October NHS Board meeting in response to the questions raised.	07/01/2019	07/01/2019
09/04/2018	133.	**Safeguarding Volunteers** GS enquired to whether Non Executive Board Members could be Mentors for the Volunteers. ED agreed to take the suggestion forward.	Eddie Docherty	Discussions on this item are being taken through Person Centred Health and Care Committee.	03/12/2018	03/12/2018
09/04/2018	141.	**Supporting an Increase in Physical Activity** GS enquired as to the link between social prescribing, physical activity options and mental health with physical activity. RS advised that he would source and circulate information to Board Members.	Richard Smith	Information will be circulated to NHS Board Members when available.	27/04/2018	27/04/2018

Date of Meeting	Agenda Item	Action	Responsible Manager	Current Status	Anticipated End Date	Date Completed
04/06/2018	158.	**Spiritual Care and Volunteering Report** NHS Board Members were directed to the unannounced HEI Inspection from 29th – 31st May 2018, at DGRI, with ED noting that the Inspection had followed a new format that covered all aspects of environmental standards from leadership in the prevention and control of infection through to traditional cleanliness standards. ED continued to note that the draft report would be received by email on 11th July 2018, with the final report published on 8th August 2018. It was agreed that a copy of the report would be shared with Board Members when available.	Eddie Docherty	A copy of the report was shared with NHS Board Members.	01/10/2018	01/10/2018
04/06/2018	160.	**Improving Safety, Reducing Harm Report – Mental Health Directorate** GC enquired to the level of community engagement to aid further improvement in the outcomes and statement of approach, ED agreed that he would investigate the level of community engagement and share the information with Board Members when available.	Eddie Docherty	Information on this item is still being gathered and will be shared with NHS Board Members when available.		

Date of Meeting	Agenda Item	Action	Responsible Manager	Current Status	Anticipated End Date	Date Completed
06/08/2018	187.	**Risk Management Annual Report** PH asked whether there was a mechanism in place to address the monitoring and shared learning from Leadership Walkrounds. ED advised that each Directorate produces an 'Improving Quality Reducing Harm' paper, which is presented to Healthcare Governance Committee on an annual cycle. PH advised that she thought sharing the paper with NHS Board Members would be beneficially.	Eddie Docherty	Each of the Directorate reports are being brought to NHS Board under the Improving Quality Reducing Harm item.	01/10/2018	01/10/2018
06/08/2018	198.	**Scotland's New Public Health Priorities** AF asked for further clarity around why the Public Health Committee was disbanded, querying if it could be revived. JA advised that the Public Health Committee was disbanded due to the workload of Non Executive Board Members whom at the time were unable to commit to more than one day a week. NHS Board Members agreed to look at options outwith the meeting and bring a proposal back to the December 2018 NHS Board meeting.	Jeff Ace / Laura Geddes	Laura Geddes to have discussions around committee structures will be held with the new Chair of the Health Board and Chief Executive before bringing an update back to NHS Board.	30/04/2019	

Date of Meeting	Agenda Item	Action	Responsible Manager	Current Status	Anticipated End Date	Date Completed
06/08/2018	198.	**Scotland's New Public Health Priorities** GC mentioned that it is important to ensure that Impact Assessments are undertaken on strategic policies, plans and service developments and are accessible to a variety of groups including ethnic and religious groups. AC gave assurance that all information would be accessible to all groups and agreed to share further information with GC.	Andrew Carnon	Relevant information will be shared with Grace Cardozo when available in relation to the Impact Assessments. Work has progressed in terms of working with Senior Teams to deliver Inequalities and Impact Assessment Workshops (H&SC Senior Management Team plus committed dates for Community Health and Social Care Directorate Management Team Women's and Children's Management Team). Impact Assessment Training is currently being developed (by Public Health and the Workforce Directorate) for the wider organisation with a view to a 2 hour training session and Bite-size training being available from April 2019. A Communication Plan to promote the training will be launched when the training becomes available.	July 2019 April 2019 and then ongoing	

Date of Meeting	Agenda Item	Action	Responsible Manager	Current Status	Anticipated End Date	Date Completed
				As part of the Inequalities and Impact Assessment Workshops reference is made to the H&SCP Health Inequalities Performance Measure. Detailed guidance on this indicator is currently being prepared and will be shared senior managers and appropriate Committees.	March 2019	
01/10/2018	215.	**Patient Safety and Improvement Annual Report 2017-2018** PH enquired to whether there was any improvement on pressure ulcers now that there was a Tissue Viability Nurse in post. ED advised that the Nurse had just come into post, but agreed to share a further update next Board Meeting.	E Docherty	Update paper planned for March HCGC and then April Board.		
01/10/2018	216.	**Performance Report** PH commented that there was a need to help support staff and patients noting the possible opportunity to address through the aid of a workshop for NHS Board Members. PH agreed to pick up a discussion on this with LG.	P Halliday	Clarification on the workshop topic and details to be covered has still to be gleaned from Penny Halliday before the workshop can be arranged. Details for the workshop will be emailed out to all Board Members for information once arrangements have been progressed.	28/02/2019	

Date of Meeting	Agenda Item	Action	Responsible Manager	Current Status	Anticipated End Date	Date Completed
01/10/2018	219.	**Dumfries & Galloway British Sign Language Plan** PH commented that she was aware that there were difficulties with various partners and raised concerns that many individuals were not being heard, therefore as leaders of the Plan the NHS Board have a priority to make sure the Plan is person-centred and co-produced. CS agreed to pick up a further discussion with PH on engagement out with the NHS Board Meeting.	C Sharp	Discussions on this item will be held between Caroline Sharp and Penny Halliday outwith the meeting. No further actions at this time for the NHS Board.	01/10/2018	01/10/2018
01/10/2018	220.	**Financial Performance Update Report** NM asked what the future plan is that may help the current capacity issues and what CRES impact assessment work is being undertaken on clinical services. GS advised that Transformational Change Managers and Workstreams are now in place and discussions are ongoing to understand and work through ideas to ensure more sustainable models are put in place going forward.	G Stewart	An update on this item will be brought back to the February 2019 NHS Board meeting.		

Date of Meeting	Agenda Item	Action	Responsible Manager	Current Status	Anticipated End Date	Date Completed
		JW gave assurance that impact assessments had been presented to the Integration Joint Board (IJB), with discussion concluding with JA agreeing that the NHS Board as the accountable body for NHS financial outturn and clinical quality also needs to receive impact assessment reports regarding CRES schemes. GS agreed to bring a further update to the NHS February board.				
01/10/2018	223.	**Inequalities & Health Inequalities Report** PH commented that although it was an excellent idea to have an Inequalities Steering Group, she felt unsure to the purpose of the group, and further enquiring to where the group would report to and how often so as to gain a level of governance structure. AC confirmed that the terms of reference for the steering group are still being finalised, agreeing to share them with Board Members once they are complete for reference.	A Carnon	The terms of reference will be circulated to NHS Board members for information when available. Terms of reference are currently in the latter stages of development and discussions are taking place with senior managers in respect of agreeing the content and staff representation on the Group.	March 2019	
01/10/2018	228.	**Any Other Competent Business**. NHS Board Members were content with this proposal and asked for formal notification to be passed through to the	L Geddes	An email was issued to Alison Warrick to confirm the decision around substitute voting	01/10/2018	01/10/2018

Date of Meeting	Agenda Item	Action	Responsible Manager	Current Status	Anticipated End Date	Date Completed
		Integration Joint Board.		members for the IJB.		
03/12/18	230.	**Minutes of meeting held on 1st October 2018** The minute of the previous meeting on 1st October 2018 were approved as an accurate record of discussions, subject to the following amendments, LM was asked to make the necessary amendments and recirculate to Board Members:	L Mckie	Minutes updated and will be circulated with approved December Board minutes once approved by Chair and CE.		
03/12/19	233.	**Matters Arising and Review of Actions List** ED noted an update on Item 215 - Patient Safety and Improvement Annual Report 2017-2018, advising that following the discussion on pressure ulcers and the implementation of revised processes, there has not been statistically significant improvement seen within the current data. As Chair of the Acute Care Delivery Portfolio Group within Health Improvement Scotland ED noted we are within normal variation within the funnel chart. This information will be taken as part of the paper going to March HCGC and then April Board.	E Docherty	Information will be taken as part of the paper going to March HCGC and then April Board.		

Date of Meeting	Agenda Item	Action	Responsible Manager	Current Status	Anticipated End Date	Date Completed
03/12/19	233.	**Matters Arising and Review of Actions List** ED noted an update on Item 132 and Item 111, noting that verbal updates had been given at the last NHS Board meeting in response to the questions raised. LM was asked to note both actions as being closed.	L McKie	Action List updated	07/01/2019	07/01/2019
03/12/19	233.	**Matters Arising and Review of Actions List** Discussion continued on NHS Board Members thoughts and it was agreed that LG would include an agenda matrix within the actions list for the February 2019 Board Meeting.	L Geddes			
03/12/19	234.	**Patient Experience Report** ED confirmed that he would work with the team to address all of the points raised at the meeting, ensuring that a revised report is brought back to the February 2019 NHS Board Meeting,	E Dochety	Revised report - February Board.		Feb 2019

Date of Meeting	Agenda Item	Action	Responsible Manager	Current Status	Anticipated End Date	Date Completed
03/1219	236.	**Performance Report** JA highlighted that the Board has a Qlikview dashboard that NHS Board Members may find useful to access, it was noted that a workshop was being arranged to give members a demonstration of this dashboard and following discussions would now incorporate training on how to use the system.	L Geddes			
03/12/19	236.	**Performance Report** JW advised that she would be content to add paragraphs to the covering paper which would include up to date information and would highlight any significant deviations in performance statistics.	L Geddes			
03/12/19	239.	**Capital Update** PH enquired to whether this would free up space in the east of the region with patients travelling to the west for treatment. JA advised that referral protocols were being reviewed but that patient choice was a key limiting factor.	J Ace	Referral guidelines to be reviewed on successful operation of new scanner.	March 2019	

Agenda Item 251

DUMFRIES and GALLOWAY NHS BOARD

4th February 2019

Patient Services Feedback Report

Author:
Joan Pollard
Associate Director of Allied Health Professions

Sponsoring Director:
Eddie Docherty
Executive Director for Nursing, Midwifery and Allied Health Professions

Date: 9th January 2019

RECOMMENDATION

The Board is asked **to discuss and note** the following point:

- the NHS Board's complaints performance for November and December 2018, including key feedback themes and details of the resulting learning and improvements.

CONTEXT

Strategy / Policy:

This paper provides information in support of the implementation of the Healthcare Quality Strategy (2010), and Patients Rights (Scotland) Act (2012). The Board is required to adhere to the Patients Rights (Scotland) Act (2012) with regard to seeking and responding to patient / family feedback.

Organisational Context / Why is this paper important / Key messages:

Patient feedback can provide an indication of the experience of care provided by the Board to patients and their carers. Used alongside other performance information it can help identify areas where the Board is performing well or where there is a need to improve. It also assists the Board in delivering our CORE values and remaining person centred.

Key messages:

- The Board continues to face challenges in meeting compliance with complaint timescales as set by the Scottish Public Services Ombudsman (SPSO).
- Patient Services are continuing to work with responsible Managers and Feedback Coordinators to address compliance issues.
- Actions to address areas of under capacity within feedback and complaints handling are underway
- Dialogue has been initiated with Scottish Public Services Ombudsman to explore what improvement support they may be able to offer.

GLOSSARY OF TERMS	
DGRI	Dumfries and Galloway Royal Infirmary
SPSO	Scottish Public Services Ombudsman
NHS D&G	NHS Dumfries & Galloway
CHP	Complaints Handling Procedure
Complaint	NHS Dumfries and Galloway's definition of a complaint is: *'An expression of dissatisfaction by one or more members of the public about the organisation's action or lack of action, or about the standard of service provided by or on behalf of the organisation.'*
Comment	Comments, feedback or observations which reflect how someone felt about the service.
Concern	Concerns are matters where people require reassurance, further information or explanation to resolve a matter of concern. These fall short of a complaint as the person is not expressing significant dissatisfaction, but wishes to be more fully informed.
A&D	Acute and Diagnostics
CH&SC	Community Health and Social Care
MH	Mental Health
W,C&SH	Women, Children's and Sexual Health
S1/Stage One	Stage One complaint. This is the 'early resolution' stage of the complaints procedure where complaints are required to be responded to within 5 working days.
S2/ Stage Two	Stage Two complaint. This is the 'investigation' stage of the complaints procedure where complaints are required to be responded to within 20 working days. Complaints can go 'direct' to Stage Two of the procedure or can be 'escalated' to that stage following a Stage One response.

MONITORING FORM

Policy / Strategy	Healthcare Quality Strategy Person Centred Health and Care Collaborative
Staffing Implications	Ensuring staff learn from patient feedback in relation to issues raised.
Financial Implications	Not required
Consultation / Consideration	Not required
Risk Assessment	Actions from feedback followed through and reported to General Managers and Nurse Managers who have a responsibility to take account of any associated risk.
Risk Appetite	Low [ ] Medium [X] High [ ] It is considered that the risk appetite for this paper is medium in the context of Reputational where the Board has an expressed risk appetite of medium.
Sustainability	Not required
Compliance with Corporate Objectives	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
Local Outcome Improvement Plan (LOIP)	Outcome 2, 3, 6, 7 and 8
Best Value	Vision and Leadership Effective Partnerships Governance and Accountability Performance Management
Impact Assessment The failure to deliver adequate patient feedback functions could result in reputational damage and a failure to understand which services might be struggling to meet patient need. Not undertaken as learning from patient feedback applies to all users	

1. Introduction

This report outlines the patient feedback activity for NHS Dumfries and Galloway (NHS D&G) and performance against compliance targets for the period November and December 2018, set against an annualised pattern of feedback information. The report includes details of planned improvement actions.

2. Patient Feedback

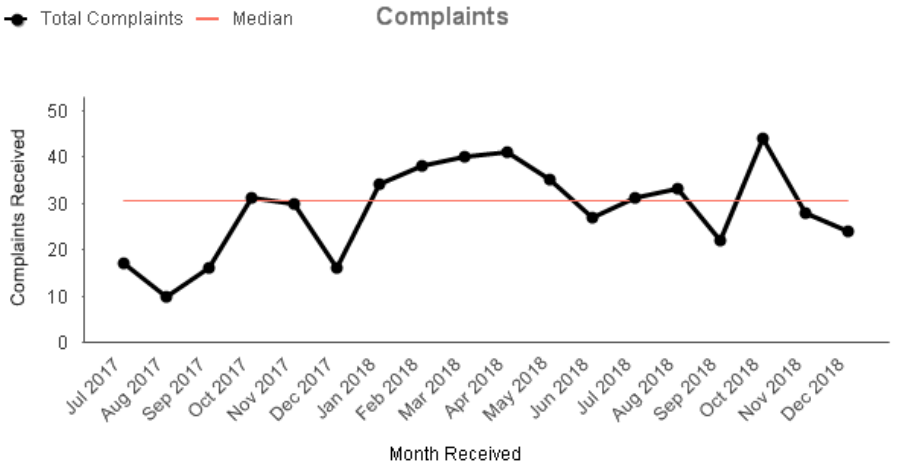
This following section provides a commentary and summary statistics on new patient feedback received throughout NHS Dumfries and Galloway for the period September and October 2018.

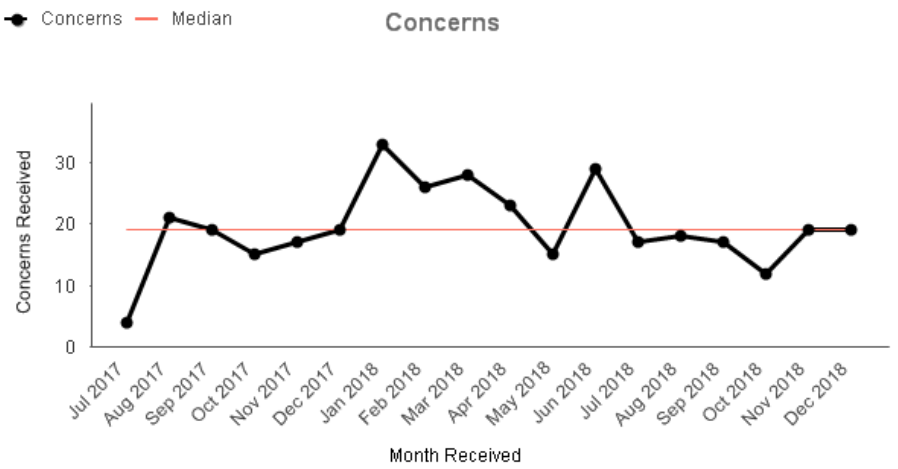
2.1 Feedback Received

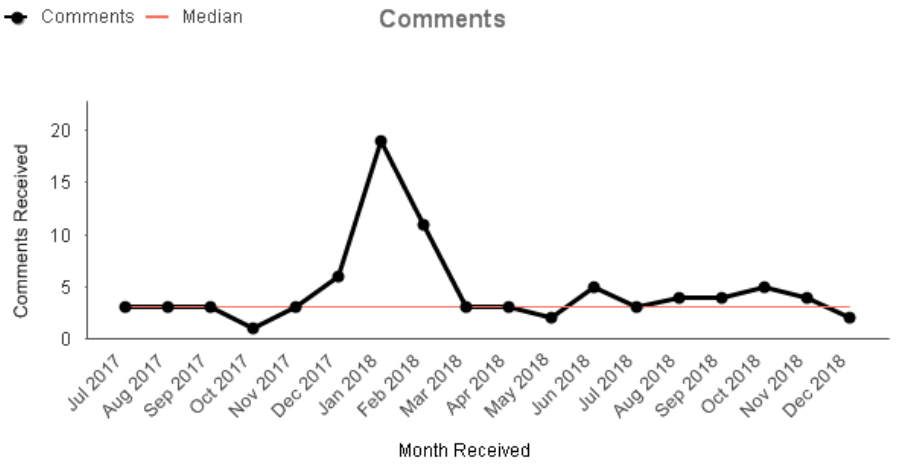
The Board recorded 69 pieces of feedback in November 2018 and 55 in December 2018.

Feedback Received	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Total
No. Complaints	34	38	40	41	35	27	31	33	22	44	28	24	**397**
No. Comments	19	11	3	3	2	5	3	4	4	5	4	2	**65**
No. Compliments	14	12	18	20	13	6	10	19	9	15	18	10	**164**
No. Concerns	33	26	28	23	15	29	17	18	17	12	19	19	**256**
Total	**100**	**87**	**89**	**87**	**65**	**67**	**61**	**74**	**52**	**76**	**69**	**55**	**882**

Feedback by month received







2.2 Care Opinion

Care Opinion is an online approach, which enables the public to provide and view feedback on experience of our services. When a story is added to Care Opinion the relevant staff are alerted so that they can view the feedback and respond as required. The majority of the feedback the Board receives through Care Opinion is positive. Where a story is critical the author is invited and encouraged to make direct contact in order that we can provide further advice and support to resolve any issues which are raised.

NHS Dumfries and Galloway received six Care Opinion stories during the reporting period. At the time of writing, those six stories had been viewed 306 times. Care Opinion are currently developing an online reporting mechanism to provide a more detailed account of stories, including themes.

All NHS D&G stories are available to view at www.careopinion.org.uk.

2.3 Compliments

During the period, Patient Services recorded 28 formal 'compliments' in addition to those received by local teams.

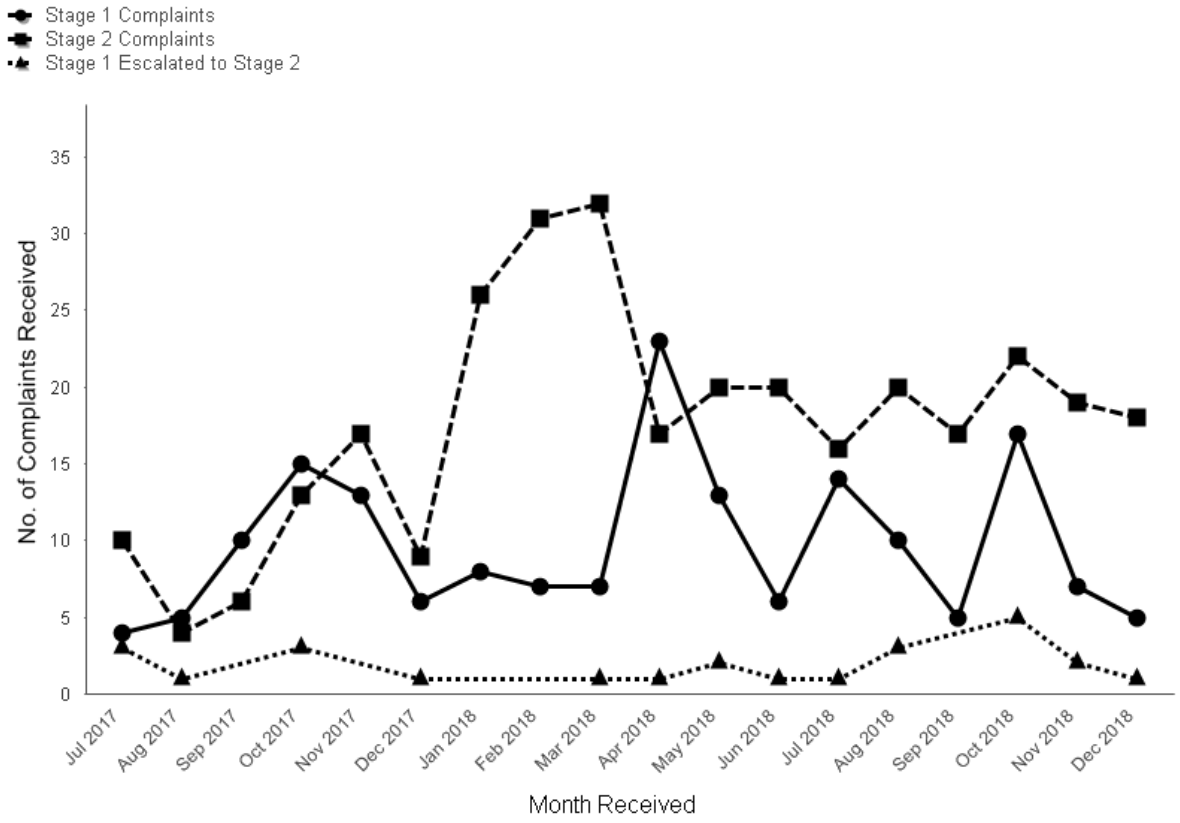
Compliments received by Patient Services are shared with the relevant teams to ensure they are aware of the feedback.

2.4 Complaints

Of the 124 pieces of feedback received, 52 were complaints.

Feedback Received	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Total
No. Stage One	8	7	7	23	13	6	14	10	5	17	7	5	**122**
No. Escalated to Stage Two	0	0	1	1	2	1	1	3	0	5	2	1	**17**
No. Stage Two Direct	26	31	32	17	20	20	16	20	17	22	19	18	**258**
Total	**34**	**38**	**40**	**41**	**35**	**27**	**31**	**33**	**22**	**44**	**28**	**24**	**397**

Complaints by complaint stage by month received



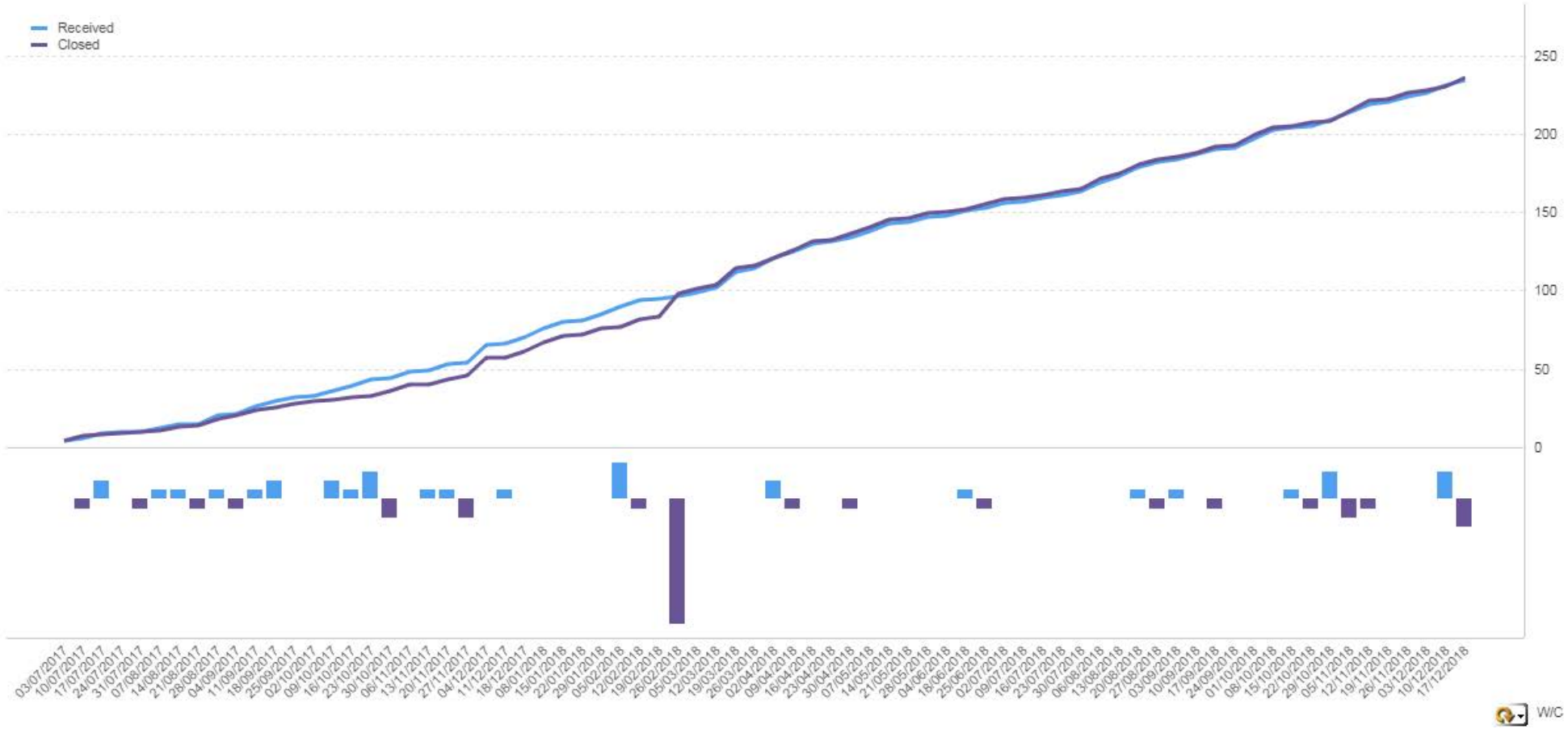
The complaints received related to the following areas:

Service Area	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Total
Acute & Diagnostics	17	25	24	29	15	17	27	15	14	32	18	18	**251**
CH&SC	5	2	1	2	6	2	1	2	4	1	0	3	**29**
Prison	5	0	10	2	3	0	0	2	0	1	3	1	**27**
Women's and Children	2	6	4	2	3	5	1	7	1	7	3	1	**42**
Corporate	2	4	0	2	0	1	1	4	1	0	1	1	**17**
Mental Health	2	1	1	2	8	2	1	3	1	3	3	0	**27**
Operational Services	1	0	0	2	0	0	0	0	1	0	0	0	**4**
Total	**34**	**38**	**40**	**41**	**35**	**27**	**31**	**33**	**22**	**44**	**28**	**24**	**397**

NB: Figures include complaints escalated from Stage 1 to Stage 2

The graphs associated with the above are included in Appendix 1.

Number of new complaints versus complaints closed 01/07/2017 – 31/12/2018



Source: Qlikview 09/01/2019
This is provisional data for information only as extract system is being developed.

Themes of Feedback

The complaints received related to the following subjects. Feedback often contains more than one issue and therefore one complaint may be listed against numerous themes. There are also occasions the information is not recorded within Datix, which is why the number of themes listed is less than the number of complaints received over the period. Patient Services are planning a session with Feedback Coordinators to focus on Datix and the importance of record quality. This session will be held early in 2019.

Themes	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Total
Clinical Treatment	34	26	25	23	16	23	10	32	9	17	8	0	223
Staff Communication (Oral)	6	3	12	9	8	3	1	6	0	9	1	0	58
Staff Attitude and Behaviour	2	3	3	2	8	5	3	5	5	4	4	1	45
Waiting Time for Date for Appointment	3	2	3	5	3	2	9	2	4	2	2	2	39
Other	2	5	6	2	2	2	4	3	2	3	5	11	47
Staff Communication (Written)	0	2	3	0	5	2	0	3	0	2	1	0	18
Personal Records	0	0	0	1	0	0	2	2	1	2	0	0	8
Waiting Time for Date of Admission / Attendance	0	0	2	0	0	2	0	1	0	2	2	0	9
Staff Competence	0	1	0	0	0	2	0	1	0	3	0	0	7
Premises	2	0	0	3	0	0	1	0	1	0	0	0	7
Waiting Time for Test Results	0	0	0	2	0	0	1	0	0	1	1	0	5
Delay in Outpatient and Other Clinics	0	1	1	0	0	0	0	1	0	1	0	0	4
Transport	0	1	0	0	1	0	0	0	1	1	0	0	4
Aids / Appliances / Equipment	0	0	0	1	0	0	0	0	0	2	0	0	3
Policy and Commercial Decisions of the Board	1	1	0	0	0	1	0	0	0	0	0	0	3
Cleanliness	0	0	0	0	0	0	0	1	0	0	0	0	1
Delay in Admission / Transfer / Discharge	0	2	0	0	0	0	0	0	0	0	0	0	2
Total	**50**	**47**	**55**	**48**	**43**	**42**	**31**	**57**	**23**	**49**	**24**	**14**	**483**

*Policy and Commercial decisions of the Board commonly relates to decisions around exceptional referrals or non provision of treatment modalities e.g. alternative therapies etc
* Other relates to complaints where there is no defined code within the Datix system.

A national short life working group is currently reviewing and updating theme codes to ensure a consistent approach across Boards. Once agreed at national level, the necessary technical changes will be undertaken to ensure the new codes can be implemented locally. The anticipated timescale for implementing the changes locally is 1 April 2019.

Independent Contractors

Local GPs, Dentists, Opticians and Pharmacists provide the Board with monthly performance information relating to the number of complaints they have received. This arrangement is voluntary as there is currently no obligation for independent contractors to provide us with this information.

	Nov-18			Dec-18		
Service	Number of responses	Number of complaints	% of all complaints	Number of responses	Number of complaints	% of all complaints
GPs *(n:31)*	25	5	56	14	5	100
Pharmacy* *(n:34)*	6	4	44	2	0	0
Dental *(n:33)*	16	0	0	9	0	0
Opticians* *(n:21)*	13	0	0	9	0	0
Totals:	**60**	**9**		**34**	**5**	

NB - data for Pharmacy and Opticians is currently incomplete as the majority of these services report quarterly and the deadline for reporting is beyond submission dates for this paper.

As part of the new Complaints Handling Procedure introduced from 1 April 2017, all NHS Boards in Scotland are required to report their complaints performance against a suite of new indicators determined by the Scottish Public Services Ombudsman (SPSO). Those indicators can be summarised as follows:

Indicator	Description
Indicator One: Learning from complaints	A statement outlining changes or improvements to services or procedures as a result of consideration of complaints including matters arising under the duty of candour.
Indicator Two: Complaint process experience	A statement to report the person making the complaint's experience in relation to the complaints service provided.
Indicator Three: Staff awareness and training	A statement to report on levels of staff awareness and training.
Indicator Four: The total number of complaints received	Details of the number of complaints received per episode of care and recorded against a consistent benchmark such as the number of staff employed.
Indicator Five: Complaints closed at each stage	Details of the number of complaints responded to at each stage of the Complaints Handling Procedure.
Indicator Six: Complaints upheld, partially upheld and not upheld	Details of the number of complaints that had each of the above listed outcomes.
Indicator Seven: Average response times	Details of the average time in working days to close complaints at each stage of the Complaints Handling Procedure.
Indicator Eight: Complaints closed in full within the timescales	Details of how many complaints were responses to within the timescales required of the Complaints Handling Procedure.
Indicator Nine: Number of cases where an extension was authorised	Details of how many complaints required an extension to the standard timescales.

Further details of the indicators can be found in appendix six of NHS Dumfries and Galloway's Complaints Handling Procedure.

Indicator 1 - Learning from complaints

'A statement outlining changes or improvements to services or procedures as a result of consideration of complaints including matters arising under the Duty of Candour.'

Process Improvements

- A three year licence for NVIVO has now been purchased. Once fully implemented, this software will assist in the qualitative analysis of complaints received.
- A Patient Experience Group (PEG) with senior representation from across the directorates has been established and has had its first two meetings. The multi-disciplinary group considered a number of on-going complex complaints (anonymised) and agreed a planned way forward for each. As that work progresses, a learning summary will be prepared for those cases with a draft presented to the PEG group for input. It may not be possible to present the full learning summaries in formal papers, as given the complexities of the cases the patients may be identifiable. General learning will however be shared through this report as appropriate.
- Patient Services have been testing an approach to capturing learning within the Women, Children's and Sexual Health and Acute and Diagnostics Directorates. This approach involves preparing a Learning Summary for those complaints that are complex or where significant learning has been identified. Whilst some Learning Summaries have been prepared during the initial testing, there is work required to improve the quality of those summaries and the consistency of approach. There is also work required to ensure that the Learning Summaries are being prepared and agreed by those involved with the related service (rather than Feedback Coordinators for example). There has been some positive feedback from the on the Learning Summaries submitted to their offices in relation to individual complaints. Patient Services will continue to work with Directorates to build on this work and to refine our approach.

Directorate Learning

Acute and Diagnostics:

- As a result of a complaint to the SPSO about a patient's experience with the care and treatment received from Haematology, the service developed a new pericardiocentesis pathway with all patients being sent to the Golden Jubilee National Hospital for this procedure. The SPSO's Decision Letter in relation to this complaint can be accessed here - https://www.spso.org.uk/decision-reports/2018/november/decision-report-201704104-201704104.
- A family complained to the SPSO about the care and treatment received by their loved one which included concerns about fluid balance charts not being completed appropriately. The service has now introduced a new fluid balance chart with training provided to staff by a Specialist Nurse. A fluid balance guidance chart is now also included in every patient's notes. The SPSO's Decision Letter in relation to this complaint can be accessed here -

https://www.spso.org.uk/decision-reports/2018/december/decision-report-201800972-201800972

- The service identified that patient flow in the Combined Assessment Unit (CAU) was sub-optimal. Following discussions with appropriate staff and a visit to another Board's CAU unit, a number of improvements were implemented, with further improvements planned. Further details of this work are included in the 'Learning Summary' in Appendix 2.

As a result of learning from feedback in the current period

- A patient will share her story at the Senior Nurses Acute Group
- As a result of feedback Customer Service training for Patient Access and Patient Focussed Booking is being explored.
- The team is exploring the use of the Healthcare complaints Analysis Tool (HCAT) for coding, triaging and categorising feedback. This will contribute to the impact of NVIVO when it is installed.
- Improved processes are being introduced for ongoing feedback following action plan development

Indicator 2 - Complaints Process Experience
'A statement to report the person making the complaint's experience in relation to the complaints service provided.'

Complainants are invited to share their experience of the complaints process when they receive their response letters. Complainants can answer via Survey Monkey or via hard copy questionnaire. They are asked 16 questions about their experience with the complaints process. These questions are based on guidance from the SPSO and are consistent with the questions asked by other Boards. NHS Dumfries and Galloway have been promoting the questionnaires since February 2018. A low return rate for a survey of this kind is to be expected and so a more detailed report will be provided in the annual report for 2018/19.

To ensure learning from these surveys, Patient Services will share the responses with the relevant services and work with them to address and key areas requiring improvement.

Indicator 3 - Staff Awareness and Training
'A statement to report on levels of staff awareness and training.'

Patient Services regularly run two training courses; Complaints Handling and Investigation Skills. These courses have been running since 2017 and attendance to date is shown below:

Complaints Handling Training

Acute and Diagnostics	17
CHSC	61
Mental Health	3
Independent Contractors	41
Women, Children's and Sexual Health	19
Other	2
Total No. Attendees	**143**

Investigation Skills Training

Acute and Diagnostics	8
CHSC	47
Mental Health	5
Independent Contractors	34
Women, Children's and Sexual Health	15
Other	2
Total No. Attendees	**111**

In addition to the above, tailored feedback training has also been delivered directly to a number of teams including:

- Specialist Drug and Alcohol Service
- Midpark Staff
- Speech and Language Therapy

Feedback training has also been delivered to three cohorts of the ASPIRE to Lead course.

Patient Services are currently working on the 2019 training calendar, which will be circulated to staff in January 2019. Training has also been booked in for a number of individual teams in 2019.

Definitions:
Stage One – complaints closed at Stage One Frontline Resolution;
Stage Two (direct) – complaints that by-passed Stage One and went directly to Stage Two Investigation (e.g. complex complaints);
Escalated Stage Two – complaints which were dealt with at Stage One and were subsequently escalated to Stage Two investigation (e.g. because the complainant remained dissatisfied)

Indicator 4 Total number of complaints received
'Details of the number of complaints received per episode of care and recorded against a consistent benchmark such as the number of staff employed.'

Indicator 4 - The rate of complaints received per.....		
Description	**Nov 2018**	**Dec 2018**
Per 1000 population	0.02	0.02

** It is not possible to provide the rate of complaints in relation to patient episode as not all episodes are captured in an electronically searchable manner. Rate per population has therefore been selected as a proxy measure. Work is ongoing to explore the potential to measure against staff employed.*

A short life working group consisting of representatives from NHS complaints teams, the Scottish Government and the SPSO, are currently updating the statutory Key Performance Indicators to ensure clear and consistent guidance is available to Boards. From this work, it has been agreed that the above indicator will be amended going forward to simply detail the number of complaints received. This change will take place in local reports from 1 April 2019.

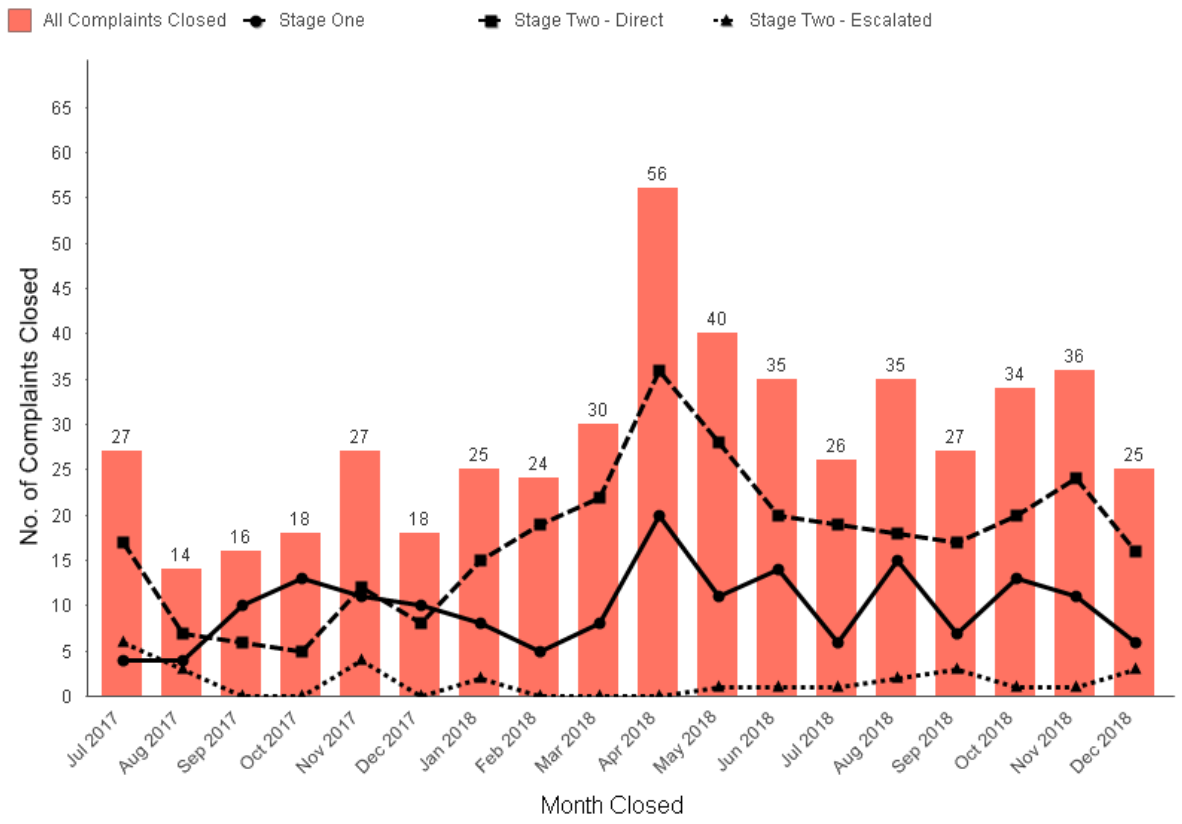
All information from this point forwards relates to Complaints which have been completed i.e. have received a response.

Indicator Five: Complaints closed at each stage

"Details of the number of complaints responded to at each stage of the Complaints Handling Procedure."

Complaint Type	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Total
Stage One	8	5	8	20	11	14	6	15	7	13	11	6	**124**
Stage Two - Escalated	2	0	0	0	1	1	1	2	3	1	1	3	**15**
Stage Two - Direct	15	19	22	36	28	20	19	18	17	20	24	16	**254**
Total Complaints Closed	**25**	**24**	**30**	**56**	**40**	**35**	**26**	**35**	**27**	**34**	**36**	**25**	**393**

Complaints by stage by month complaint closed



Indicator Six: Complaints upheld, partially upheld and not upheld

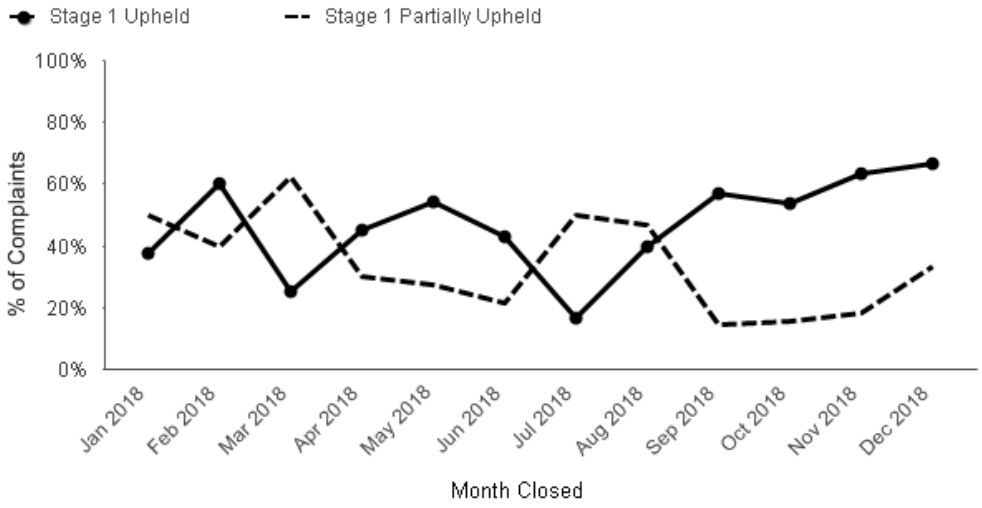
'Details of the number of complaints that had each of the above listed outcomes.'

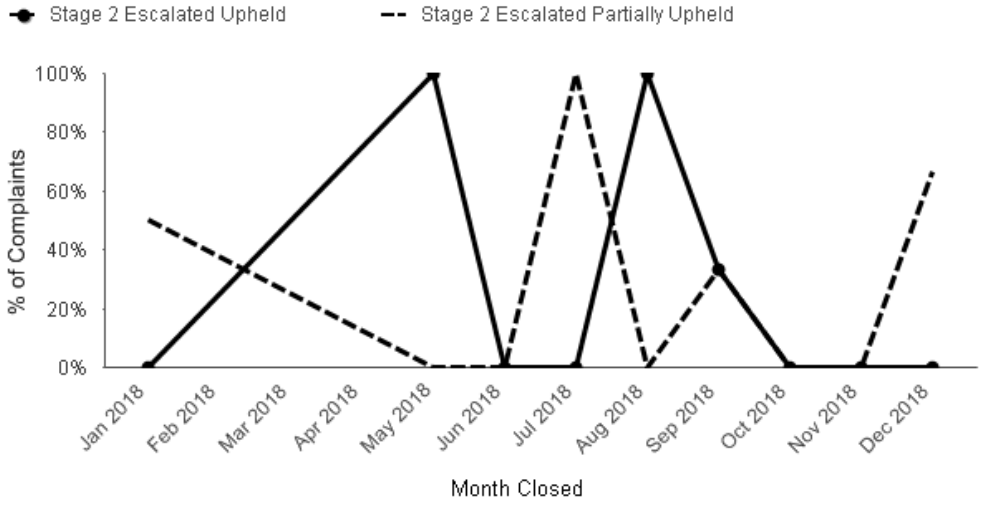
Complaint Type		Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Total
Stage 1	Upheld	3	3	2	9	6	6	1	6	4	7	7	4	58
	Partially Upheld	4	2	5	6	3	3	3	7	1	2	2	2	40
	Not Upheld	1	0	1	5	2	4	2	2	2	3	2	0	24
	Other Outcome	0	0	0	0	0	1	0	0	0	1	0	0	2
	Total Closed	8	5	8	20	11	14	6	15	7	13	11	6	124
Stage 2 Direct	Upheld	0	1	6	6	5	1	3	6	2	6	2	1	39
	Partially Upheld	8	10	9	13	15	9	10	5	7	8	16	7	117
	Not Upheld	7	6	6	13	8	9	5	5	8	6	4	5	82
	Other Outcome	0	2	1	4	0	1	1	2	0	0	2	3	16
	Total Closed	15	19	22	36	28	20	19	18	17	20	24	16	254
Stage 2 Escalated	Upheld	0	0	0	0	1	0	0	2	1	0	0	0	4
	Partially Upheld	1	0	0	0	0	0	1	0	1	0	0	2	5
	Not Upheld	1	0	0	0	0	1	0	0	1	1	1	0	5
	Other Outcome	0	0	0	0	0	0	0	0	0	0	0	1	1
	Total Closed	2	0	0	0	1	1	1	2	3	1	1	3	15

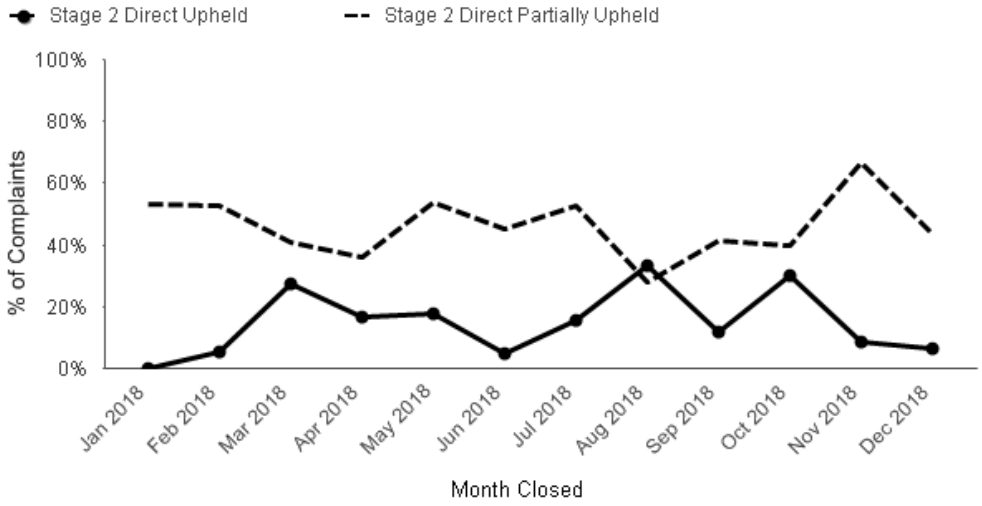
Complaint Type		Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Total
Stage 1	Upheld	37.5%	60.0%	25.0%	45.0%	54.5%	42.9%	16.7%	40.0%	57.1%	53.8%	63.6%	66.7%	46.8%
	Partially Upheld	50.0%	40.0%	62.5%	30.0%	27.3%	21.4%	50.0%	46.7%	14.3%	15.4%	18.2%	33.3%	32.3%
	Not Upheld	12.5%	0.0%	12.5%	25.0%	18.2%	28.6%	33.3%	13.3%	28.6%	23.1%	18.2%	0.0%	19.4%
	Other Outcome	0.0%	0.0%	0.0%	0.0%	0.0%	7.1%	0.0%	0.0%	0.0%	7.7%	0.0%	0.0%	1.6%
	Total Closed	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Stage 2 Direct	Upheld	0.0%	5.3%	27.3%	16.7%	17.9%	5.0%	15.8%	33.3%	11.8%	30.0%	8.3%	6.3%	15.4%
	Partially Upheld	53.3%	52.6%	40.9%	36.1%	53.6%	45.0%	52.6%	27.8%	41.2%	40.0%	66.7%	43.8%	46.1%
	Not Upheld	46.7%	31.6%	27.3%	36.1%	28.6%	45.0%	26.3%	27.8%	47.1%	30.0%	16.7%	31.3%	32.3%
	Other Outcome	0.0%	10.5%	4.5%	11.1%	0.0%	5.0%	5.3%	11.1%	0.0%	0.0%	8.3%	18.8%	6.3%
	Total Closed	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Stage 2 Escalated	Upheld	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	100.0%	33.3%	0.0%	0.0%	0.0%	26.7%
	Partially Upheld	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	33.3%	0.0%	0.0%	66.7%	33.3%
	Not Upheld	50.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	33.3%	100.0%	100.0%	0.0%	33.3%
	Other Outcome	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	33.3%	6.7%
	Total Closed	100.0%	0.0%	0.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

'Other' includes matters where consent has not been received; the complaint has been withdrawn or is resolved. It can also include complaints where an outcome has not been recorded at the time of reporting.

Outcome of all complaints Upheld or Partially Upheld by month complaint closed







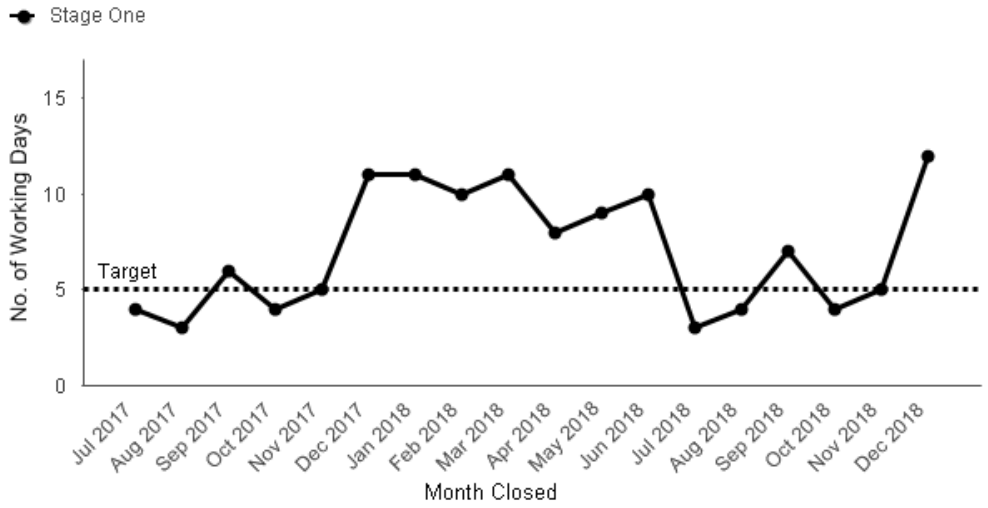
Indicator Seven: Average response times

'Details of the average time in working days to close complaints at each stage of the Complaints Handling Procedure.'

MonthYear	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Avg.
Stage One (5 Working Days)	11	10	11	8	9	10	3	4	7	4	5	12	**8**
Stage Two (20 Working Days)	31	24	28	31	38	40	24	30	25	44	30	41	**32**
Stage Two Escalation (20 Working Days)	27	0	0	0	12	10	13	73	52	5	3	20	**31**
All Complaints	**24**	**21**	**24**	**23**	**29**	**27**	**19**	**22**	**23**	**28**	**22**	**32**	**24**

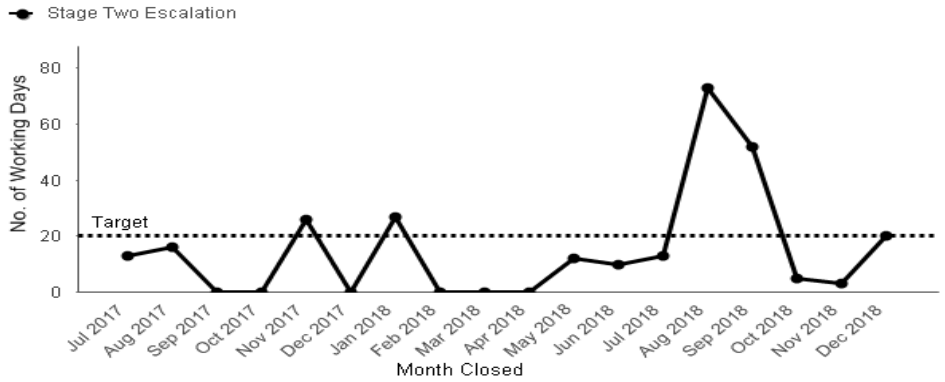
Average time for complaint to be closed

Stage 1 Complaints

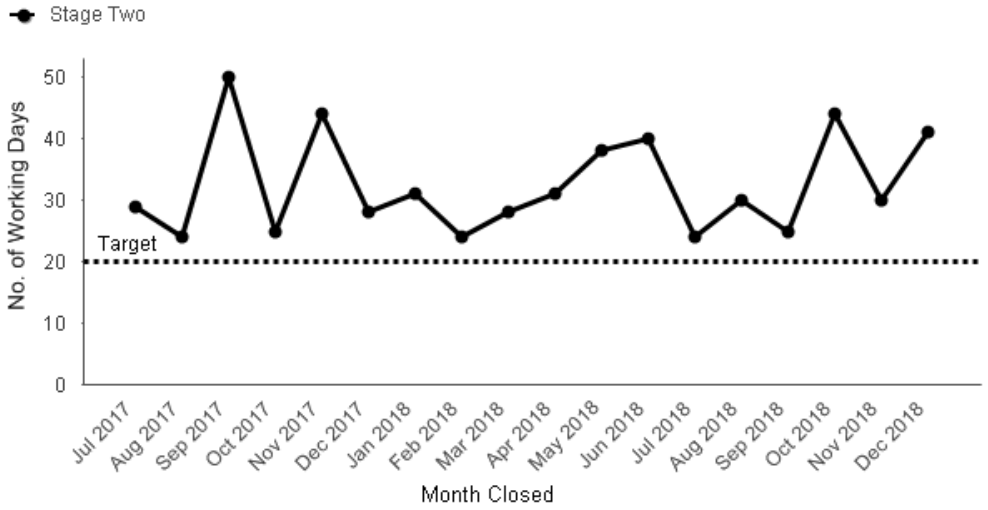


One of the Stage One complaints responded to in December took 50 working days. A meeting needed to take place before the response could be issued and the complainant agreed the extended timescale. The complainant was satisfied with the response and did not progress to the next stage of the procedure.

Escalated to Stage 2



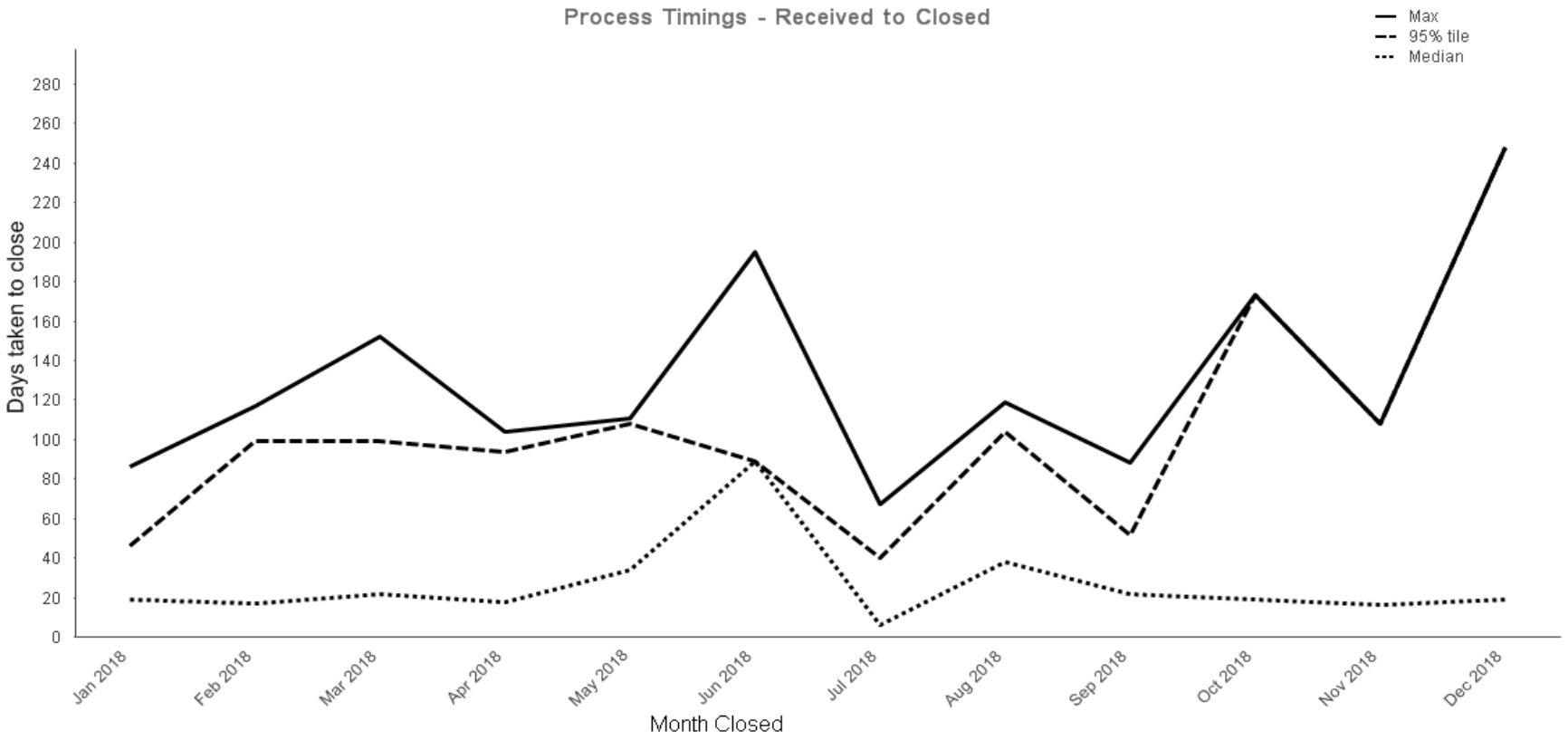
Direct to Stage 2



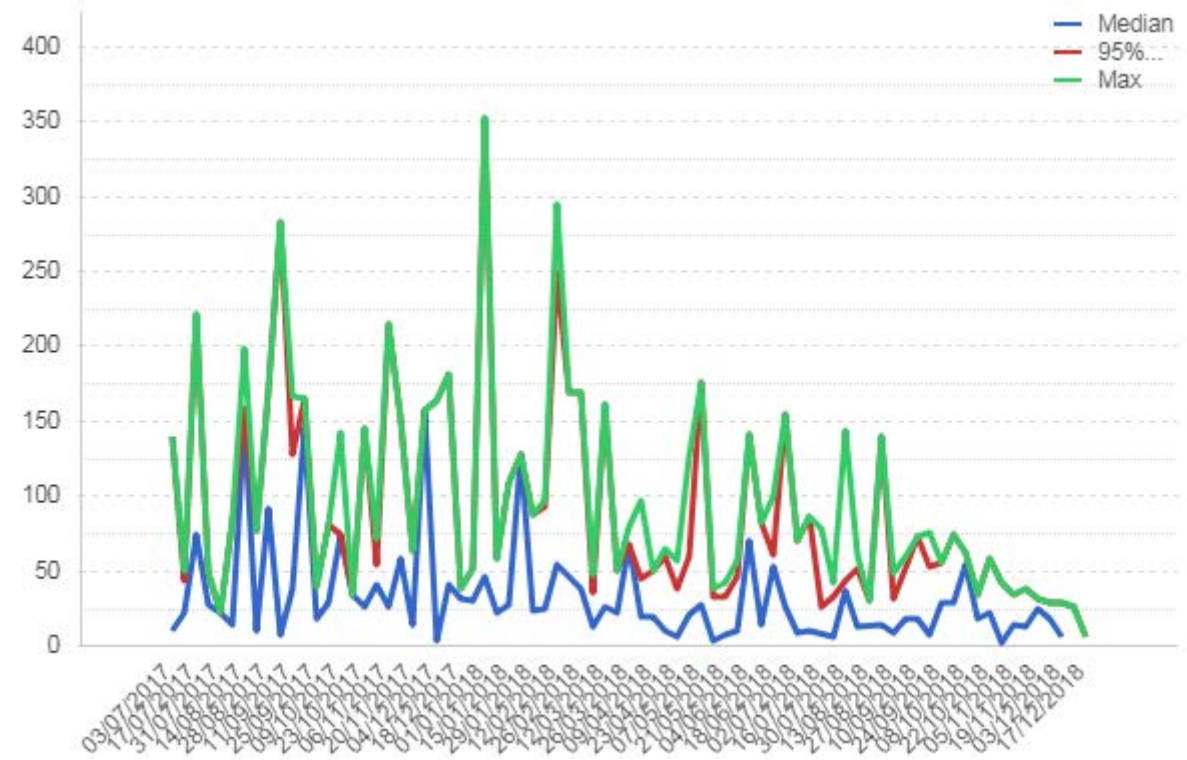
In recognition of current under capacity within Acute and Diagnostics the following improvement actions are underway:

- The specialist nurses are providing support around areas of clinical concern in order to support the ability to meet response timescales
- A clinical lead post for the Patient Safety and Experience Team has been approved and there are plans to combine the teams within Acute and Diagnostics and Women, Children and Sexual Health Directorates.

Time for Complaint to be closed

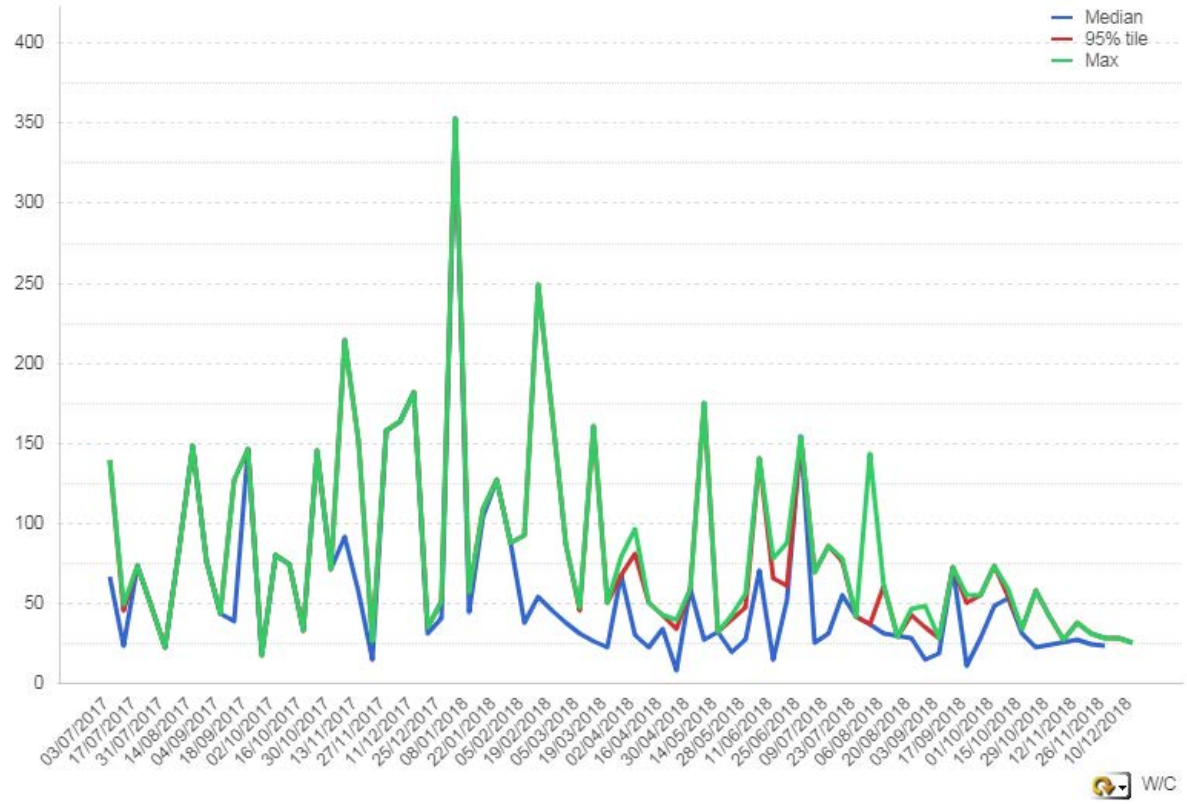


Stage 1 received to closed – 01/07/2017 – 30/12/2018



Source: Qlikview 10/01/2019 This is provisional data for information only as extract system is being developed.

Stage 2 (all) received to closed – 01/07/2017 – 30/12/2018



Source: Qlikview 10/01/2019 This is provisional data for information only as extract system is being developed.

Whilst compliance with the targets is still challenging these charts indicate a direction of improvement.

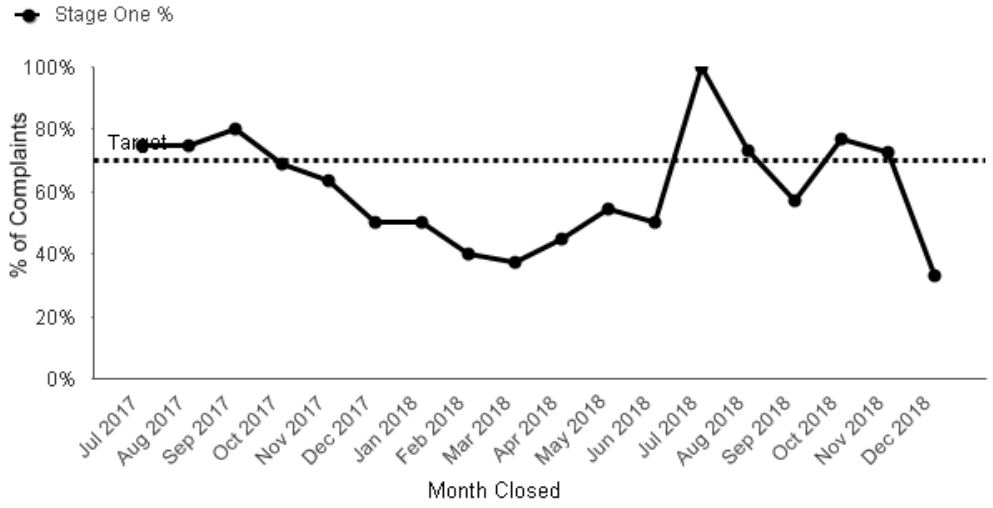
Indicator Eight: Complaints closed in full within the timescales

'Details of how many complaints were responses to within the timescales required of the Complaints Handling Procedure.'

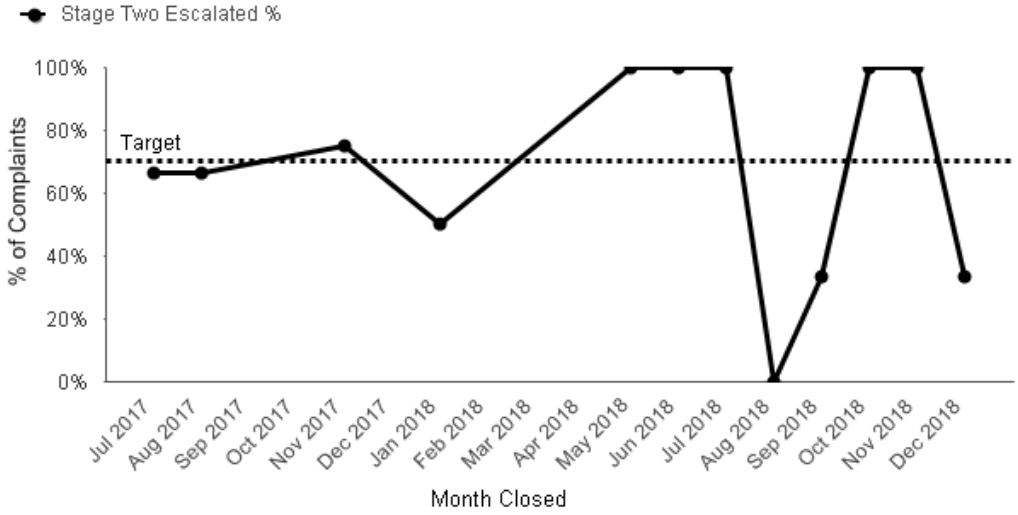
Complaint Type	Closed Within	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Stage 1	5 Working Days	4	2	3	9	6	7	6	11	4	10	8	2
	Total Closed	**8**	**5**	**8**	**20**	**11**	**14**	**6**	**15**	**7**	**13**	**11**	**6**
Complaint Type	Closed Within	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Stage 2 Direct	20 Working Days	6	13	11	19	7	11	10	8	10	8	14	9
	Total Closed	**15**	**19**	**22**	**36**	**28**	**20**	**19**	**18**	**17**	**20**	**24**	**16**
Stage 2 Escalated	20 Working Days	1	0	0	0	1	1	1	0	1	1	1	1
	Total Closed	**2**	**0**	**0**	**0**	**1**	**1**	**1**	**2**	**3**	**1**	**1**	**3**
Complaint Type	Closed Within	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Stage 1	5 Working Days	50.0%	40.0%	37.5%	45.0%	54.5%	50.0%	100.0%	73.3%	57.1%	76.9%	72.7%	33.3%
	Total Closed	**8**	**5**	**8**	**20**	**11**	**14**	**6**	**15**	**7**	**13**	**11**	**6**
Complaint Type	Closed Within	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Stage 2 Direct	20 Working Days	40.0%	68.4%	50.0%	52.8%	25.0%	55.0%	52.6%	44.4%	58.8%	40.0%	58.3%	56.3%
	Total Closed	**15**	**19**	**22**	**36**	**28**	**20**	**19**	**18**	**17**	**20**	**24**	**16**
Stage 2 Escalated	20 Working Days	50.0%	0	0	0	100.0%	100.0%	100.0%	0.0%	33.3%	100.0%	100.0%	33.3%
	Total Closed	**2**	**0**	**0**	**0**	**1**	**1**	**1**	**2**	**3**	**1**	**1**	**3**

Complaints closed in Set Timescale by month closed against a target of 70%

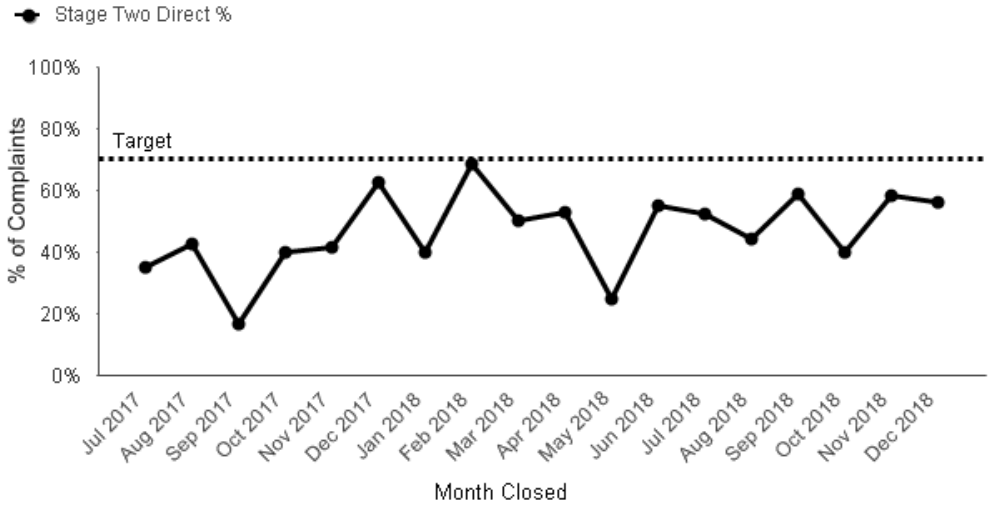
Stage 1 Complaints closed in 5 days



Escalated to Stage 2 closed in 20 days



Stage 2 Direct closed in 20 days



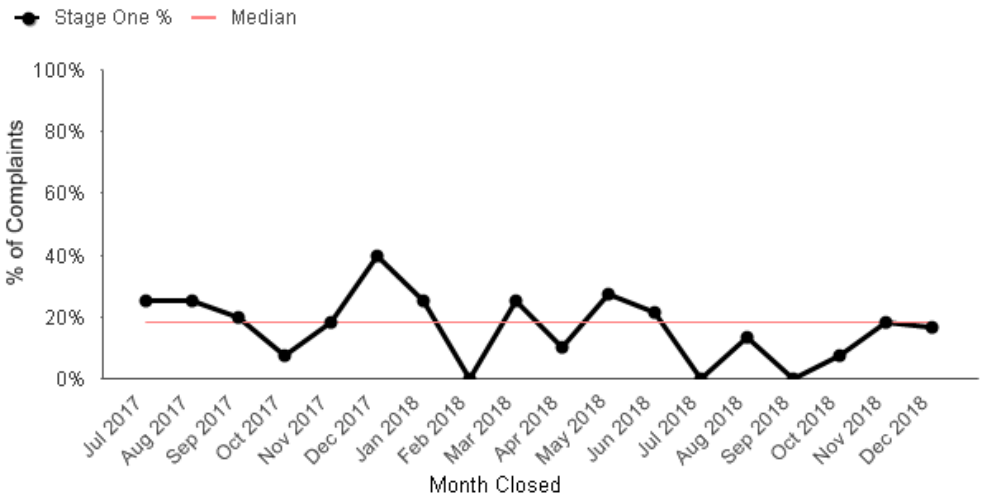
Indicator Nine: Number of cases where an extension was authorised

'Details of how many complaints required an extension to the standard timescales.'

Complaint Type	Extend.	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Stage 1 (5 Working Days)	No. Extend.	2	0	2	2	3	3	0	2	0	1	2	1
	% Extend.	25.0%	0.0%	25.0%	10.0%	27.3%	21.4%	0.0%	13.3%	0.0%	7.7%	18.2%	16.7%
	Total Closed	**8**	**5**	**8**	**20**	**11**	**14**	**6**	**15**	**7**	**13**	**11**	**6**
Stage 2 Direct (20 Working Days)	No. Extend.	7	5	6	14	17	8	8	6	6	8	10	6
	% Extend.	46.7%	26.3%	27.3%	38.9%	60.7%	40.0%	42.1%	33.3%	35.3%	40.0%	41.7%	37.5%
	Total Closed	**15**	**19**	**22**	**36**	**28**	**20**	**19**	**18**	**17**	**20**	**24**	**16**
Stage 2 Escalated (20 Working Days)	No. Extend.	1	0	0	0	0	1	1	1	1	1	0	2
	% Extend.	50.0%	0	0	0	0.0%	100.0%	100.0%	50.0%	33.3%	100.0%	0.0%	66.7%
	Total Closed	**2**	**0**	**0**	**0**	**1**	**1**	**1**	**2**	**3**	**1**	**1**	**3**

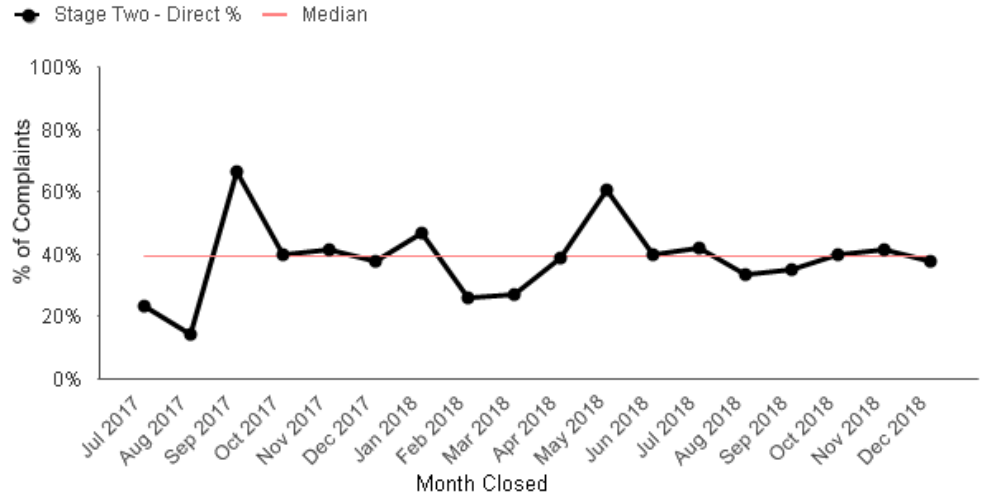
Complaints closed where extension to set timescale authorised by month closed

Stage 1 Complaints with authorised extension



Escalated to Stage 2 Complaints with authorised extension

Stage 2 Direct Complaints with authorised extension



2.5 Scottish Public Services Ombudsman Complaints

Individuals who are dissatisfied with NHS D&G's complaint handling or response can refer their complaint for further investigation to the SPSO. At the time of producing this report, there were 15 live complaints with the SPSO for their consideration. Their status was recorded as follows:

Case Status	A&D	CH&SC	MH	WC&SH	Other
File Requested *The SPSO have received a new complaint and have requested our complaints file and the associated medical records*					
Under Investigation/File Sent *The SPSO are considering the complaint and files sent*	8	1	1		
Further Information Requested *The SPSO have requested additional information*					
Decision Letter Received – Recommendations Made *The SPSO have issued their decision and made recommendations to the Board*	5				
Decision Letter Received – No Recommendations Made *The SPSO have issued their decision and have not made any recommendations to the Board*					
Action Plan Sent *We have responded to the Decision Letter providing evidence of those recommendations already undertaken and an action plan for those outstanding. At this stage we are awaiting the SPSO's approval of what was provided.*					
Report Laid Before Parliament *The SPSO have decided to lay a report before Parliament.*					

Further information on SPSO decision letters and investigations can be found on their website - https://www.spso.org.uk/our-findings. Patient Services can assist if there are any difficulties accessing reports.

2.6 Compliance

Compliance with complaints timescales continues to be below target and to fluctuate. There are a number of reasons for this including the complexity of issues and capacity challenges.

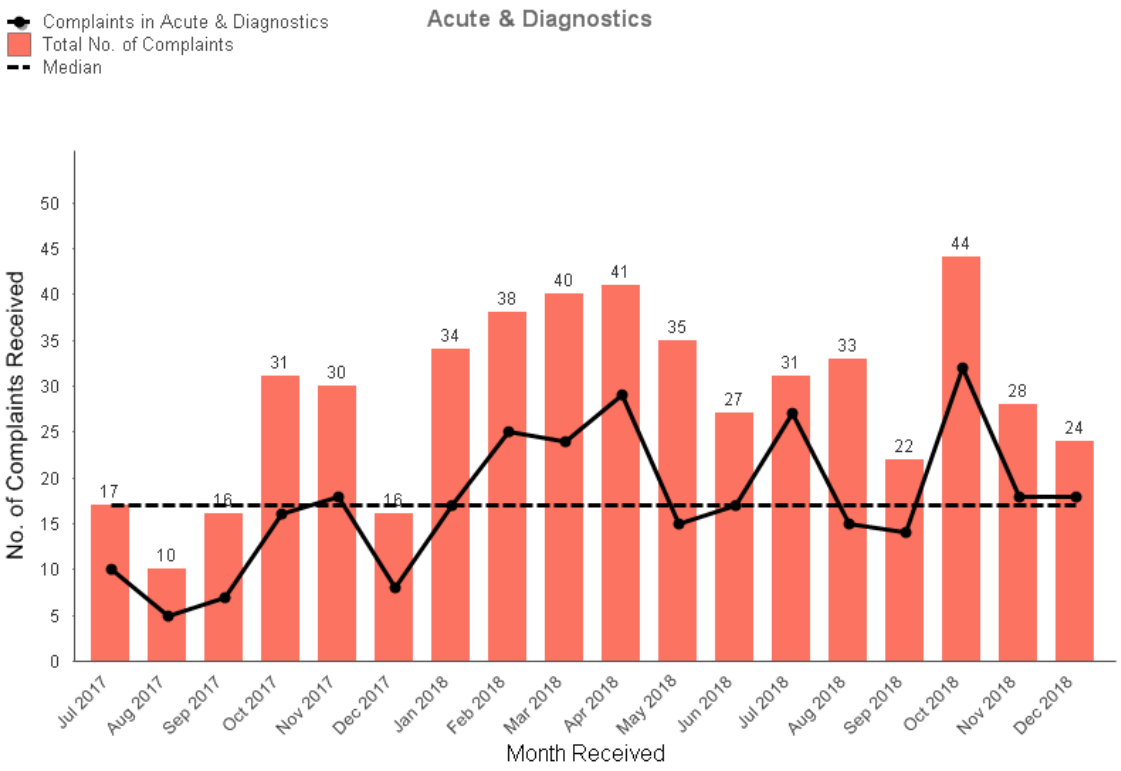
As previously reported, the short life Complaints Assurance Group recently discussed complaints processes and performance. As a result of those discussions, the group tasked directorates with self assessing their complaints handling against the SPSO's Complaints Improvement Framework. Patient Services also completed the framework from a corporate perspective. The findings from these assessments are due to be fed back to the next Complaints Assurance Group (date to be confirmed). This exercise will aid directorates to identify areas of strength in relation to complaints handling and any areas of potential improvement. Patient Services will provide support and assistance to directorates to help prioritise and progress the resulting actions. In addition NHS D&G has approached SPSO to seek their advice and guidance into improving our complaints processes and performance with an initial meeting to explore this further currently in the process of being scheduled.

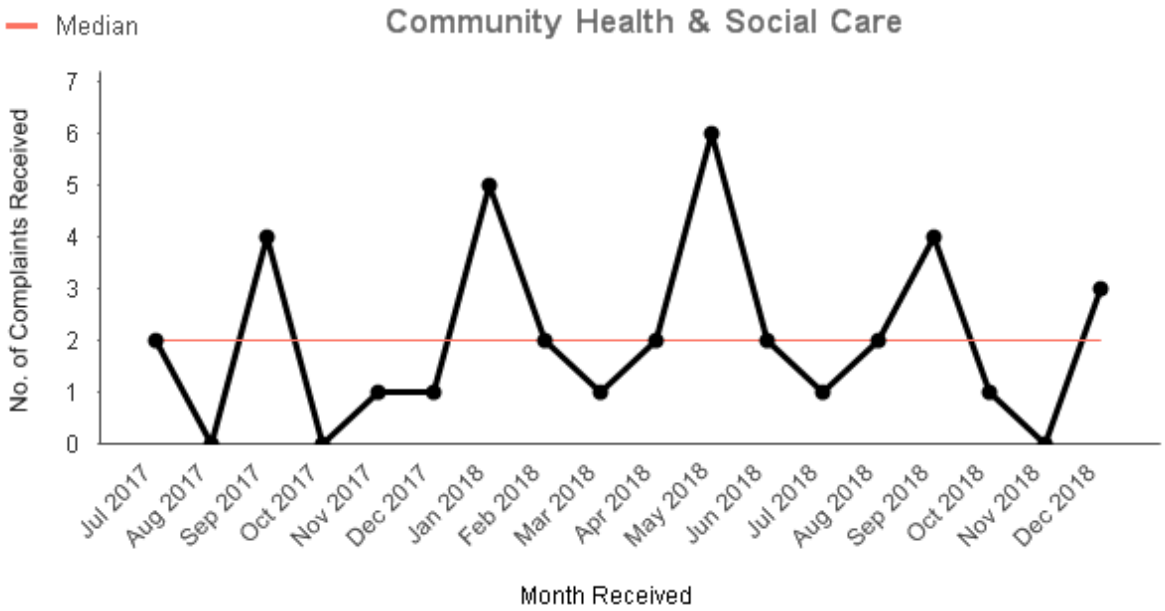
3. Conclusion

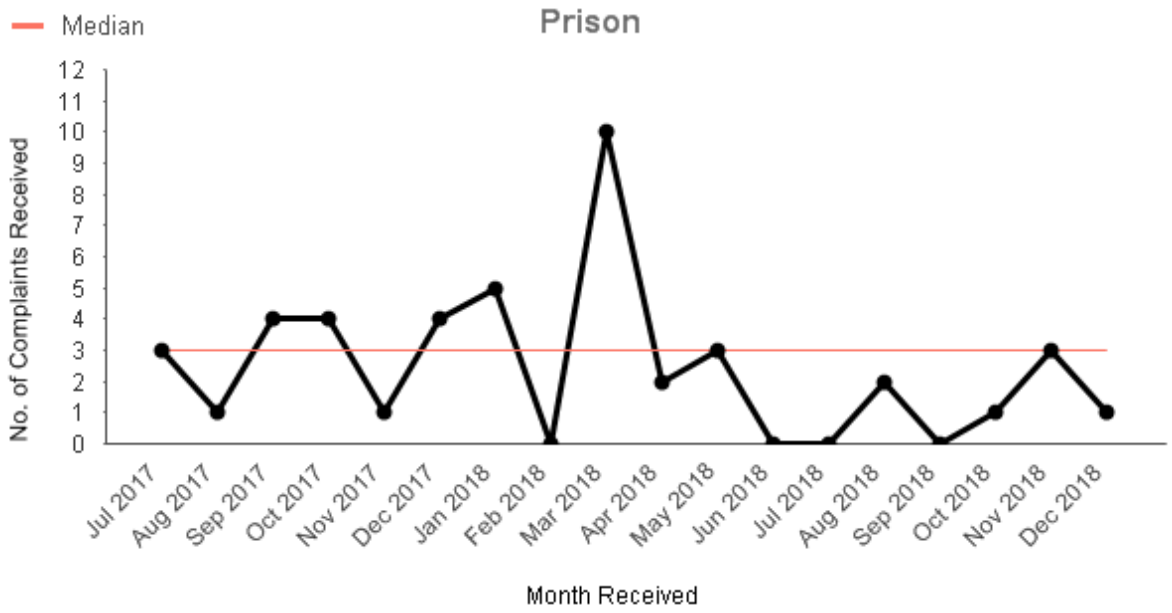
Compliance with response timescales continues to present a challenge. The Directorates and Patient Services are working closely together to ensure the teams are supported with training, templates, guidance and advice as required.

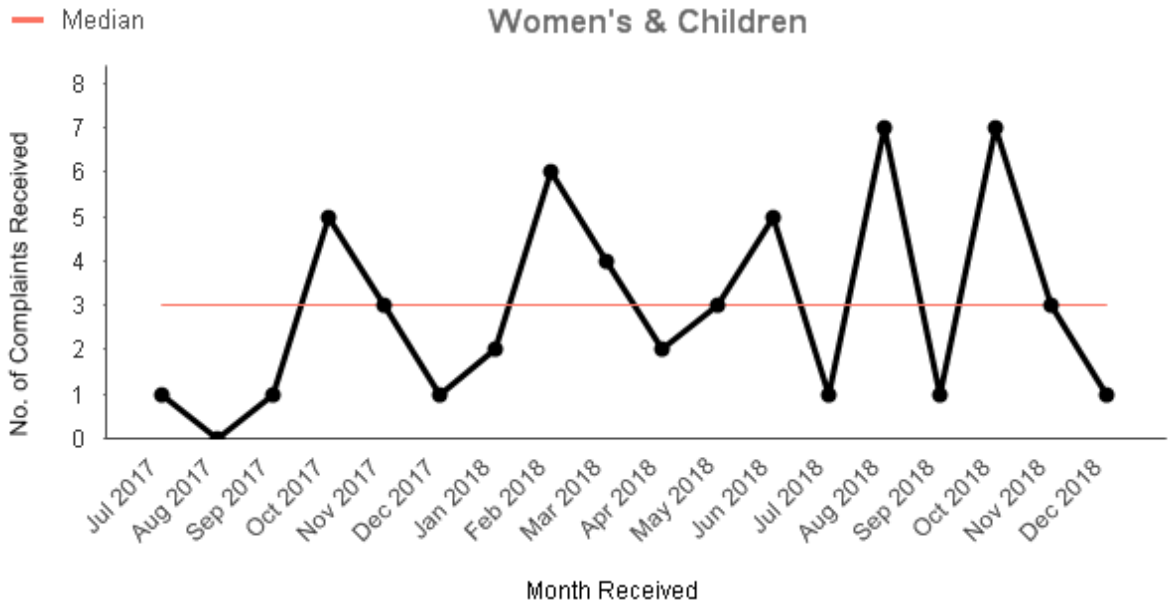
Appendix 1

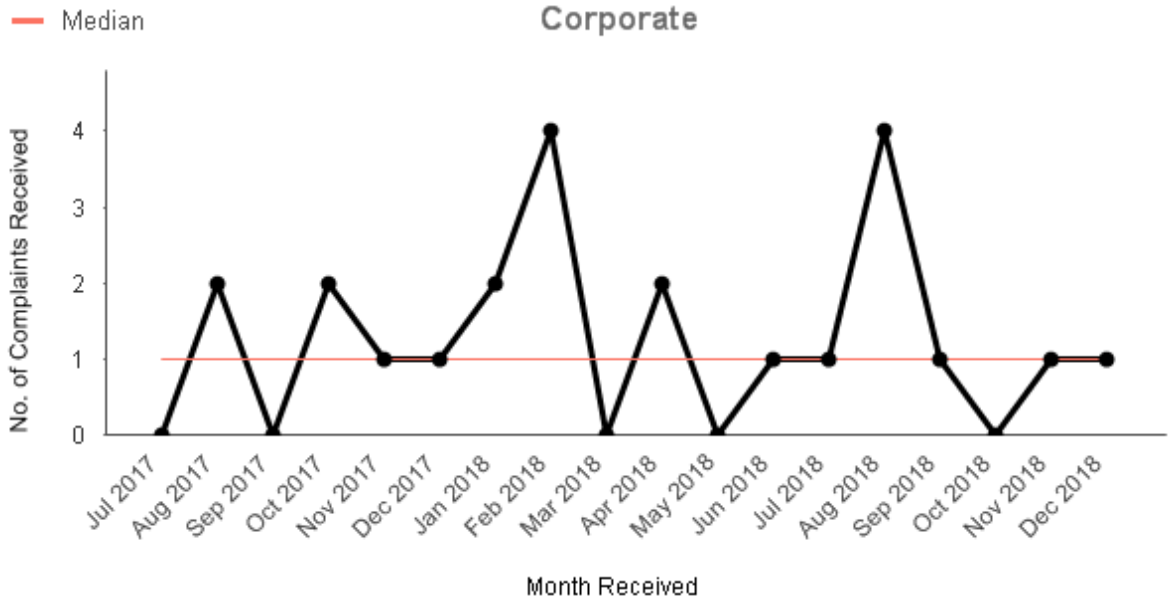
Complaints by first received date and service

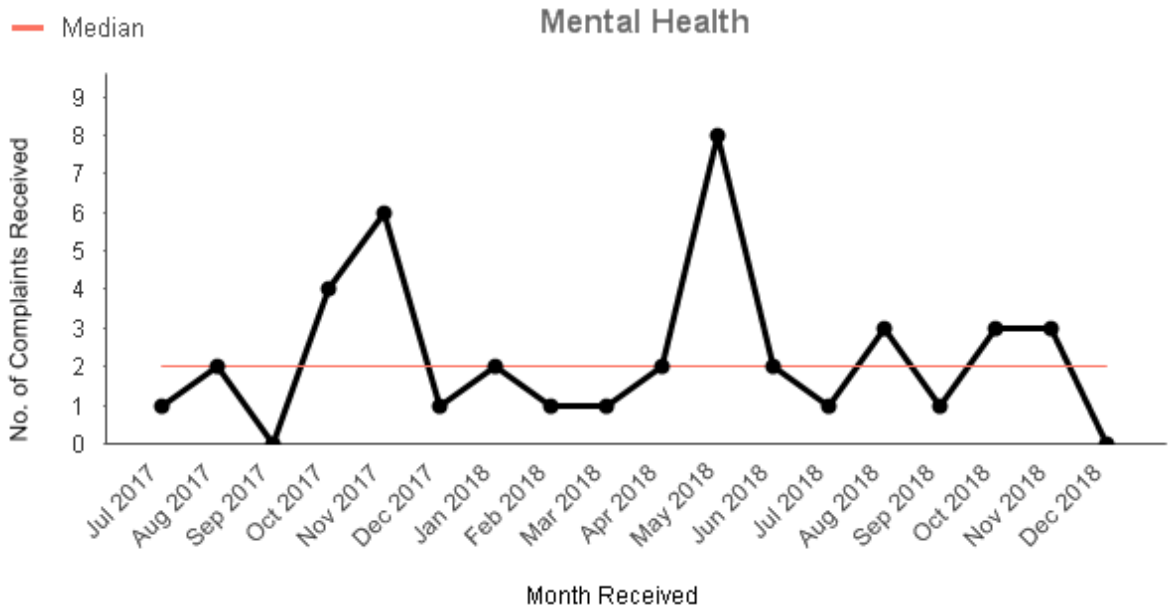


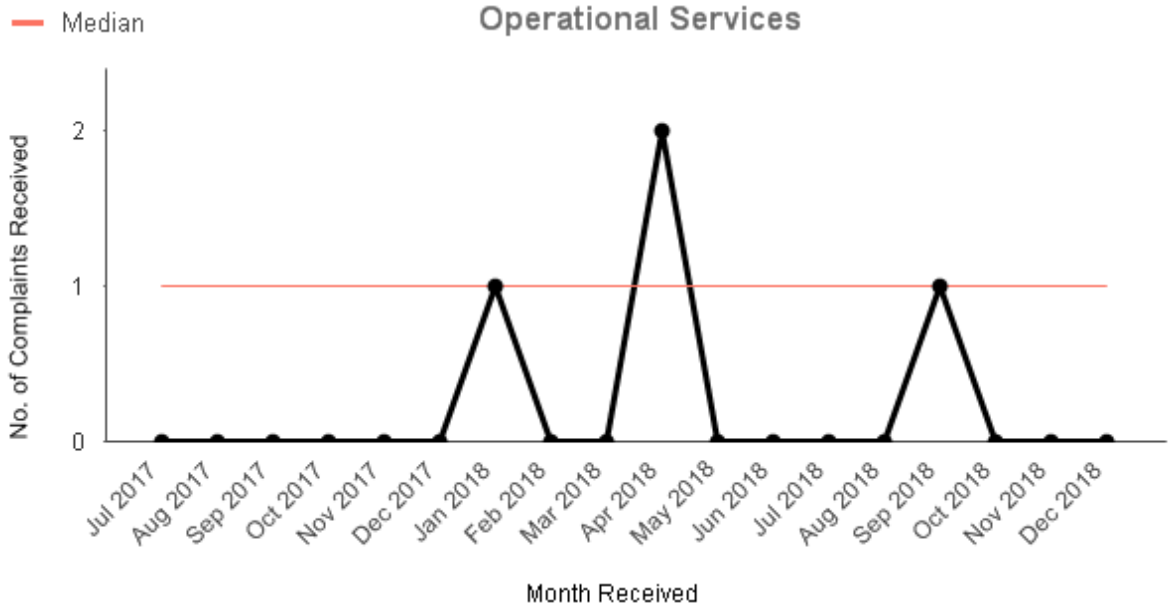



Median
Prison
No. of Complaints Received
0
1
2
3
4
5
6
7
8
9
10
11
12
Jul 2017
Aug 2017
Sep 2017
Oct 2017
Nov 2017
Dec 2017
Jan 2018
Feb 2018
Mar 2018
Apr 2018
May 2018
Jun 2018
Jul 2018
Aug 2018
Sep 2018
Oct 2018
Nov 2018
Dec 2018
Month Received


Median
Women's & Children
No. of Complaints Received
0
1
2
3
4
5
6
7
8
Jul 2017
Aug 2017
Sep 2017
Oct 2017
Nov 2017
Dec 2017
Jan 2018
Feb 2018
Mar 2018
Apr 2018
May 2018
Jun 2018
Jul 2018
Aug 2018
Sep 2018
Oct 2018
Nov 2018
Dec 2018
Month Received


Median
Corporate
No. of Complaints Received
0
1
2
3
4
Jul 2017
Aug 2017
Sep 2017
Oct 2017
Nov 2017
Dec 2017
Jan 2018
Feb 2018
Mar 2018
Apr 2018
May 2018
Jun 2018
Jul 2018
Aug 2018
Sep 2018
Oct 2018
Nov 2018
Dec 2018
Month Received


Median
Mental Health
No. of Complaints Received
0
1
2
3
4
5
6
7
8
9
Jul 2017
Aug 2017
Sep 2017
Oct 2017
Nov 2017
Dec 2017
Jan 2018
Feb 2018
Mar 2018
Apr 2018
May 2018
Jun 2018
Jul 2018
Aug 2018
Sep 2018
Oct 2018
Nov 2018
Dec 2018
Month Received


Median
Operational Services
No. of Complaints Received
0
1
2
Jul 2017
Aug 2017
Sep 2017
Oct 2017
Nov 2017
Dec 2017
Jan 2018
Feb 2018
Mar 2018
Apr 2018
May 2018
Jun 2018
Jul 2018
Aug 2018
Sep 2018
Oct 2018
Nov 2018
Dec 2018
Month Received

Appendix 2 – Acute and Diagnostics

Directorate: Acute & Diagnostics

Key Complaint Issues: Clinical Treatment

If other, please specify:

Datix Reference:

What happened?

Since opening the Combined Assessment Unit (CAU) in December of 2017, it was evident through patient complaints, exit blocking from the Emergency Department (ED) and an over filled waiting area in CAU, that patient flow was sub optimal.

Discussions with the surgeons at the surgical meeting identified the requirement to have a dedicated area to cohort the surgical patients in CAU. This was straight forward to implement the changes after discussions with the SCN in CAU, the lead surgeon for SAU and the CSM.

Nursing staff and the CSM visited another CAU at Ayr Hospital to gain knowledge and information sharing. This took planning and working with High Wood Health to make the environmental changes to adapt the Capacity Manager's office into test of change NTA area.

What went well?

A dedicated Surgical Assessment Area defined in Pod A of CAU, allocating 8 surgical assessment spaces. This provided us to cohort surgical patients.

Nurse triage area (NTA)

Communications between ED and CAU coordinators improving

What, if anything, could we improve?

Future plans to exchange hospital beds in CAU to patient trolleys

Place CAU on a local 4 hour target

Aim to improve discharges directly from CAU back to usual place of residence/care home – current performance is 41%.

What have we learnt?

Understanding of each other's department in ECC (ED & CAU).

Close working relationships with SAS & GPs required promoting patient flow.

Patient information prior to attending CAU would inform patients what to expect when attending for assessment.

What actions are planned or have been taken?

1. Improve communication and co-ordinated working practices between ED and CAU
2. Dedicated surgical assessment area identified
3. Improved communications with Scottish Ambulance Service (SAS)
4. Nurse Led Triage Area (NTA) identified
5. Patient information literature in progress
6. Close working and improved communications with Support Services supporting patient flow

Agenda Item 252

DUMFRIES and GALLOWAY NHS BOARD

4th February 2019

Involving People, Improving Quality
Healthcare Associated Infection Report

Author:
Elaine Ross
Infection Control Manager

Sponsoring Director
Eddie Docherty
Executive Director Nursing Midwifery & Allied Health Professionals

Date 11th January 2019

RECOMMENDATION
The Board is asked **to approve** this update paper.

The Board is asked **to discuss and note** the following points:

- The position of NHS Dumfries and Galloway in relation to HAI targets and other Scottish Boards.

CONTEXT

Strategy / Policy
This paper demonstrates implementation of the national HAI Taskforce at NHS Board level. This HAI harm reduction activity supports implementation of the Healthcare Quality Strategy.

Organisational Context / Why is this paper important?
The Scottish Healthcare Associated Infection (HAI) standards are requirements expected to be met by NHS Boards and subject to inspection by the Healthcare Environment Inspectorate. This includes scrutiny not only of performance against local delivery plan targets and key performance indicators but systems and processes in place to escalate concerns and address poor performance at ward level.

Key messages:

- In November there were no cases of SAB. This is the first occasion this has occurred since November 2012.

- Hydrogen peroxide vapour has been utilised to provide an enhanced level of disinfection and assurance as a measure to reduce C.diff transmission. Over 300 rooms have been decontaminated using this method in DGRI.

- Galloway Community Hospital received an unannounced HAI visit from the Healthcare Environment Inspectorate 21&22 November. The report will be published 13 February.

GLOSSARY OF TERMS

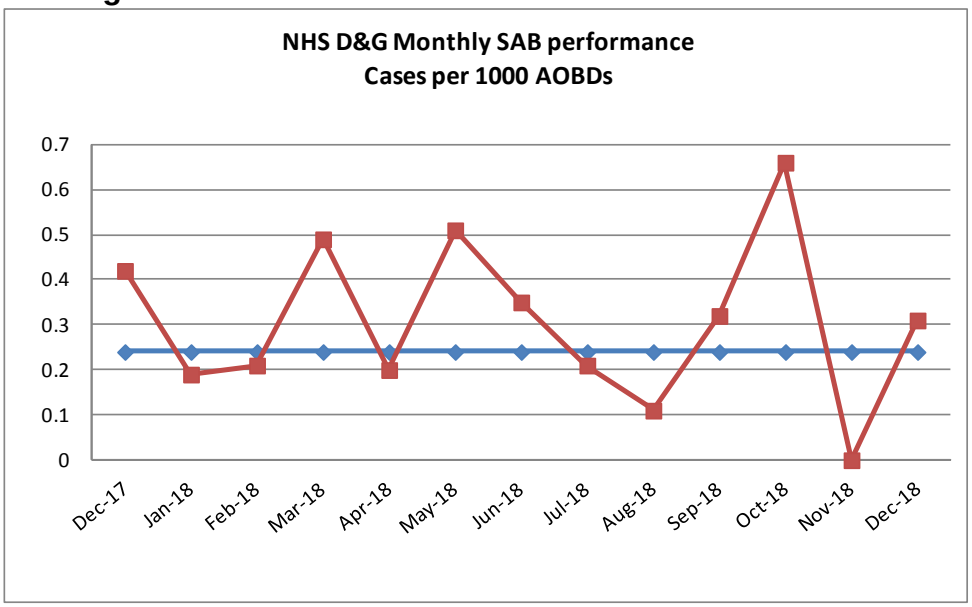
Carbapenemase Producing Enterobacteriaceae (CPE)
Central Vascular Cannula (CVC)
Clostridium difficile Infection (CDI)
Community Associated Infection (CAI)
E.coli Bacteraemia (ECB)
Healthcare Associated Infection (HCAI)
Healthcare Environment Inspectorate (HEI)
Health Protection Scotland (HPS)
Health Protection Team (HPT)
Infection Prevention and Control Team (IPCT)
Intravenous Drug Users (IVDU)
Local Delivery Plan (LDP)
Peripheral Vascular Cannula (PVC)
Peripheral Inserted Central Catheter (PICC)
Staphylococcus aureus bacteraemia (SAB)
Surgical Site Infection (SSI)

MONITORING FORM

Policy / Strategy	*Healthcare Quality Strategy: reduction of har. Achievement of HAI LDP targets*
Staffing Implications	*Nil*
Financial Implications	*Nil*
Consultation / Consideration	*Update paper only*
Risk Assessment	*Addressed through corporate risk register*
Risk Appetite	Low [X] Medium [ ] High [ ] This paper gives an update on the progress in relation to infection control within the Board, which is directly related to Patient Safety, therefore, a low risk appetite has been noted above.
Sustainability	*Fewer infections will reduce bed occupancy and use of resources*
Compliance with Corporate Objectives	*7.* To meet and where possible, exceed goals and targets set by the Scottish Government Health Directorate for NHS Scotland, whilst delivering the measurable targets in the Single Outcome Agreement.
Local Outcome Improvement Plan (LOIP)	*Outcome 6. People are safe and feel safe*
Best Value	Performance Management • *sound governance at a strategic and operational level*
Impact Assessment *Not applicable - Update paper only*	

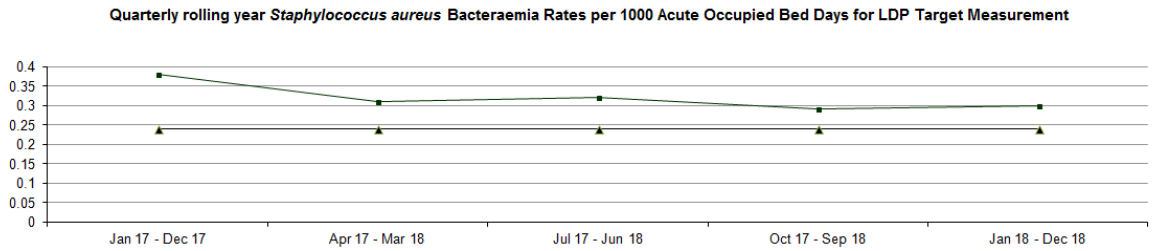
1. Staphylococcus aureus bacteraemia (SAB)

Figure 1 - Local data



In November there were no cases of SAB. This is the first occasion this has occurred since November 2012.

Figure 2- Local data



	Jan 17 - Dec 17	Apr 17 - Mar 18	Jul 17 - Jun 18	Oct 17 - Sep 18	Jan 18 - Dec 18
Actual Performance	0.38	0.31	0.32	0.29	0.30
Target	0.24	0.24	0.24	0.24	0.24

Whilst we remain above the local LDP target the national reporting, figure 3, shows NHS Dumfries & Galloway performing well when measured against other Scottish health boards for HAI SAB.

Figure 3-National data

Funnel plot of SAB incidence rates (per 100,000 TOBD) in healthcare associated infection cases for all NHS Boards in Scotland in Q3 2018. (HPS 2019)

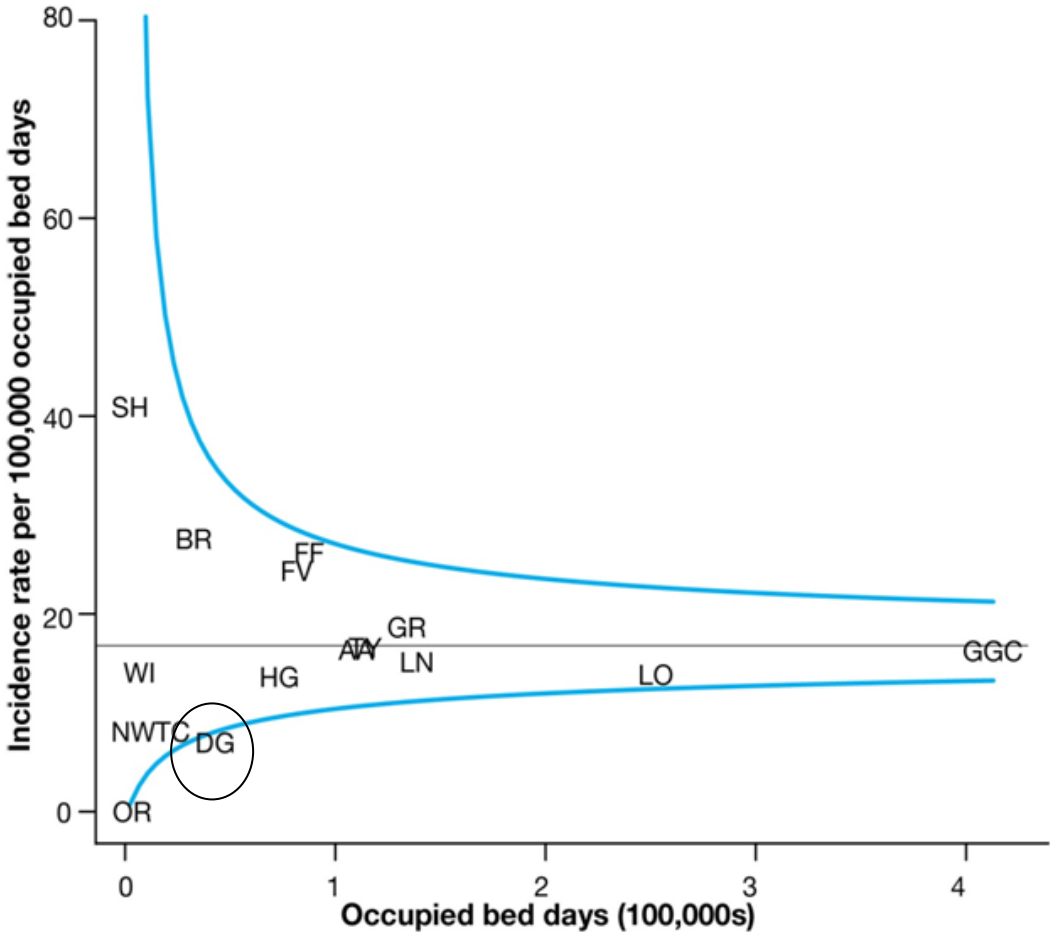
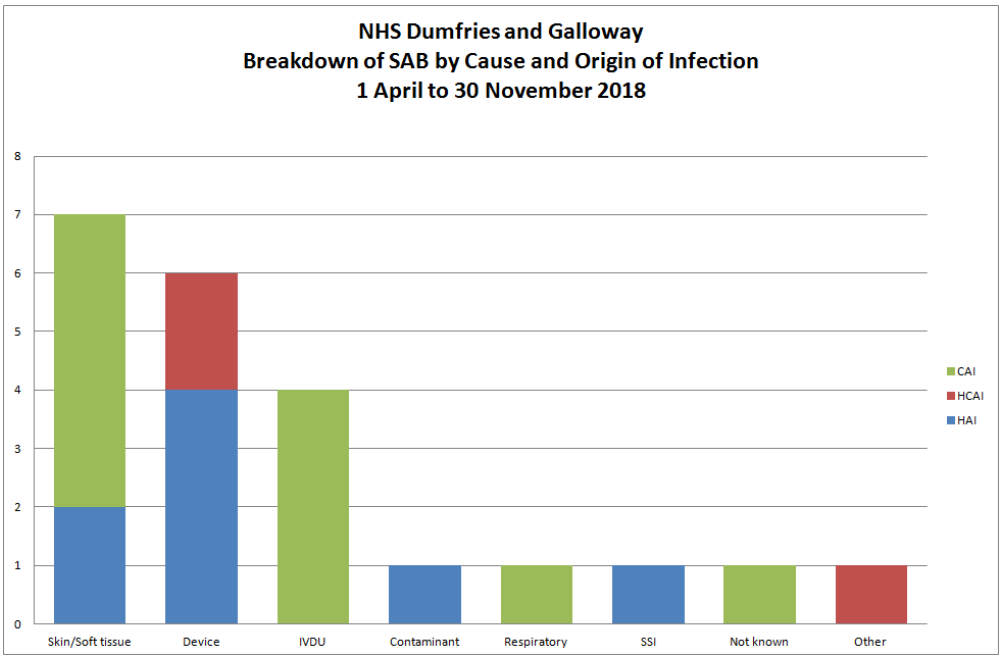


Figure 4



1. Clostridium difficile

As the Board are aware, the IPCT have been treating HAI CDI very seriously in 2018. Considerable efforts have been made to understand the reason for this increase and the variation in the data having previously reached our lowest rates since surveillance commenced.

Whilst these results do not cause concern nationally, there is a local desire to reduce rates and meet the LDP target of 0.32 cases per 1000 total occupied bed days as illustrated below.

Figure 5- Local data

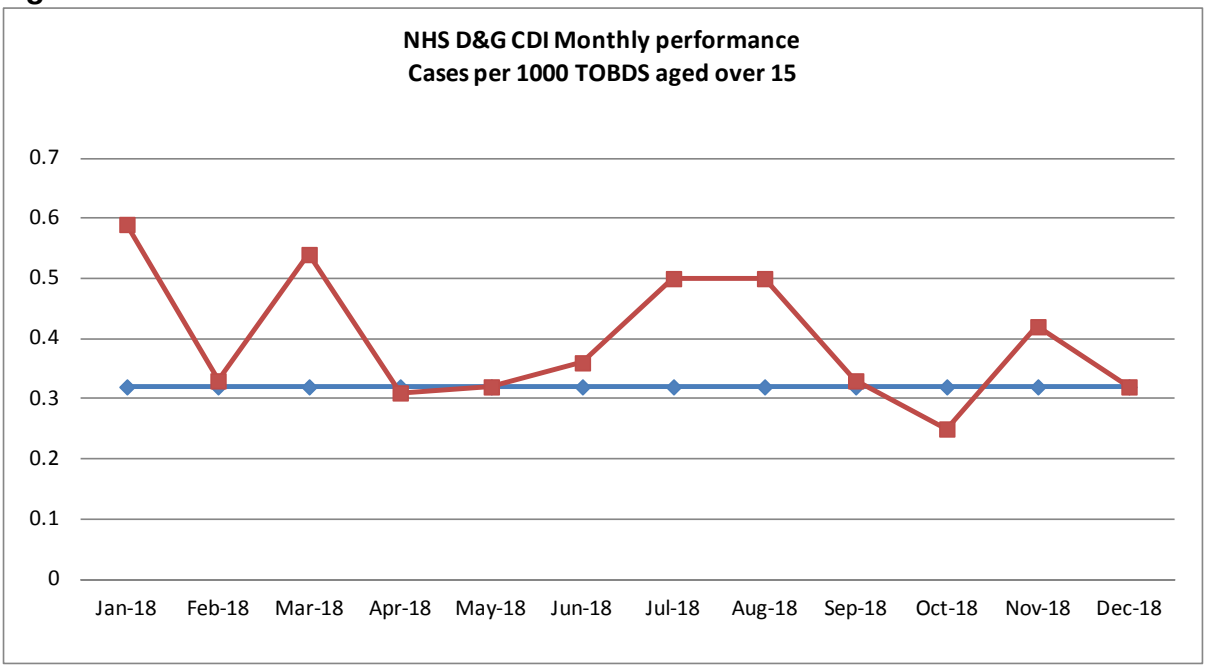
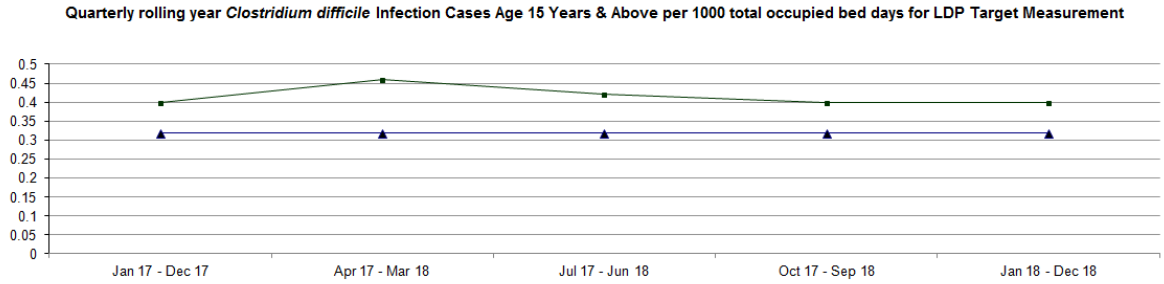


Figure 6- Local data



	Jan 17 - Dec 17	Apr 17 - Mar 18	Jul 17 - Jun 18	Oct 17 - Sep 18	Jan 18 - Dec 18
Actual Performance	0.40	0.46	0.42	0.40	0.40
Target	0.32	0.32	0.32	0.32	0.32

The quartely rolling average shows a reduction in overall CDI.

Figure 7- National data

Funnel plot of CDI incidence rates (per 100,000 TOBD) in healthcare associated infection cases for all NHS Boards in Scotland in Q3 2018. (HPS 2019)

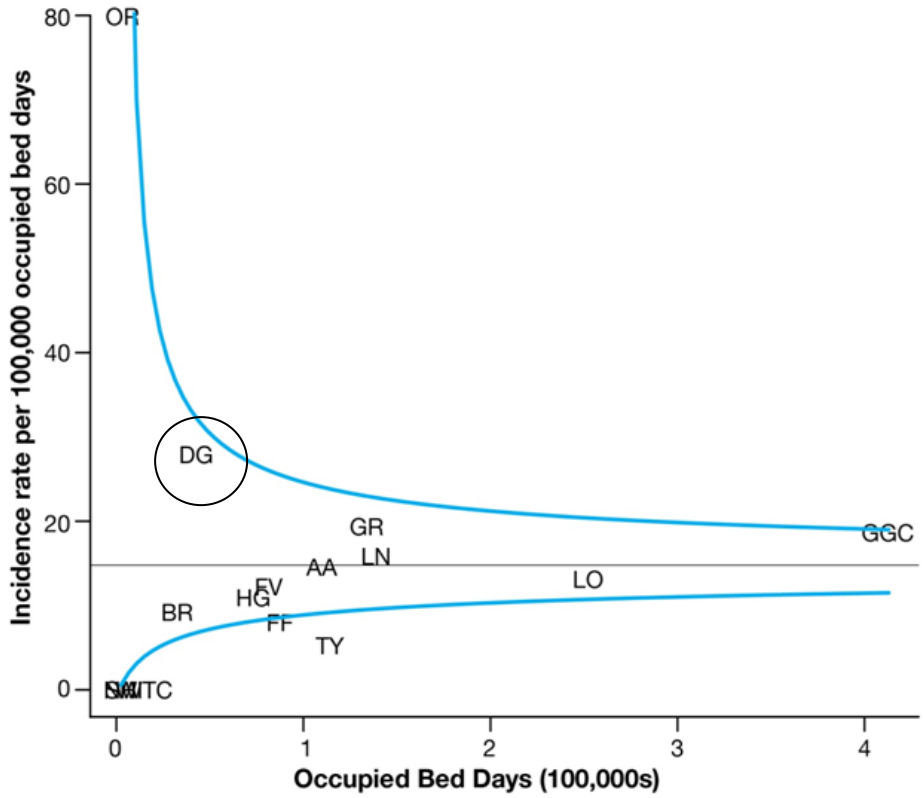


Figure 7 show NHS D&G as the Board who Quarter 3 experienced the highest rate of HAI CDI however this is well within the control limits.

CDI Cases per month by origin

HAI- cases occurring after 48 hours or within 4 weeks of hospital admission
CAI - cases occurring within 48 hours of hospital admission or more than 12 weeks post hospital admission
Unknown – between 4 &12 weeks since hospital admission

	HAI	CAI	Unknown
August 2018	5	1	0
September 2018	3	1	0
October 2018	2	1	0
November 2018	5	0	0
December 2018	3	0	1

Actions taken to address CDI

In addition to the actions already reported to the Board there has been a concerted campaign to eradicate any potential environmental source within DGRI.
Chlorine releasing agents have been in use since June and are effective against C. diff spores. However, this is a manual process dependant on the method of application and the contact time achieved.

Hydrogen peroxide vapour (HPV) has been established as a highly effective method of environmental decontamination. It eradicates microorganisms by direct contact but has no residual effect. The method we have chosen is applied using a spray gun which delivers HPV that is electro statically charged. This reduces the time taken as the charge encourages the gas to attach to surfaces rather than simply circulate and settle.

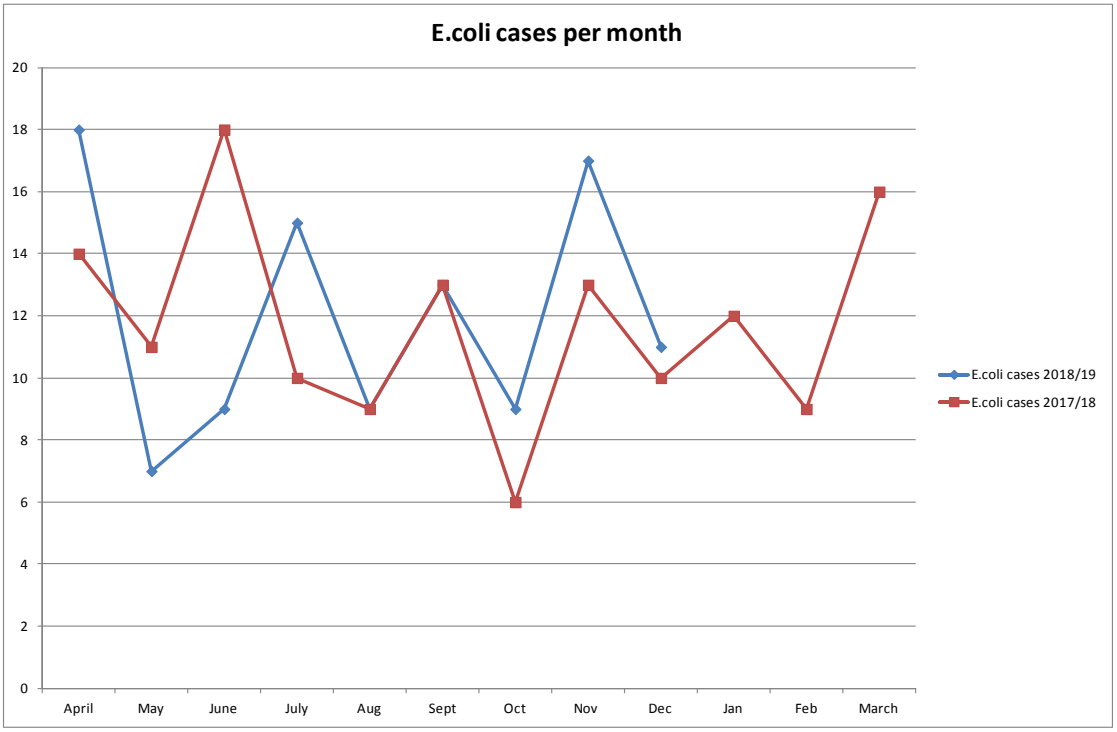
In the 6 weeks prior to Christmas it has been possible to decontaminate over 300 bedrooms, bathrooms, core toilets and support rooms using hydrogen peroxide vapour. This is a magnificent achievement in a working hospital. It has been a logistical challenge and one which has been well supported by support services, nursing management and coordinated by an IPCN.

Due to bed pressures and staffing challenges it was not possible to complete the entire programme before Christmas and there is one ward remaining with around 20 rooms still to decontaminate. This will be completed in the New Year.

2. E. coli bacteraemia (ECB)

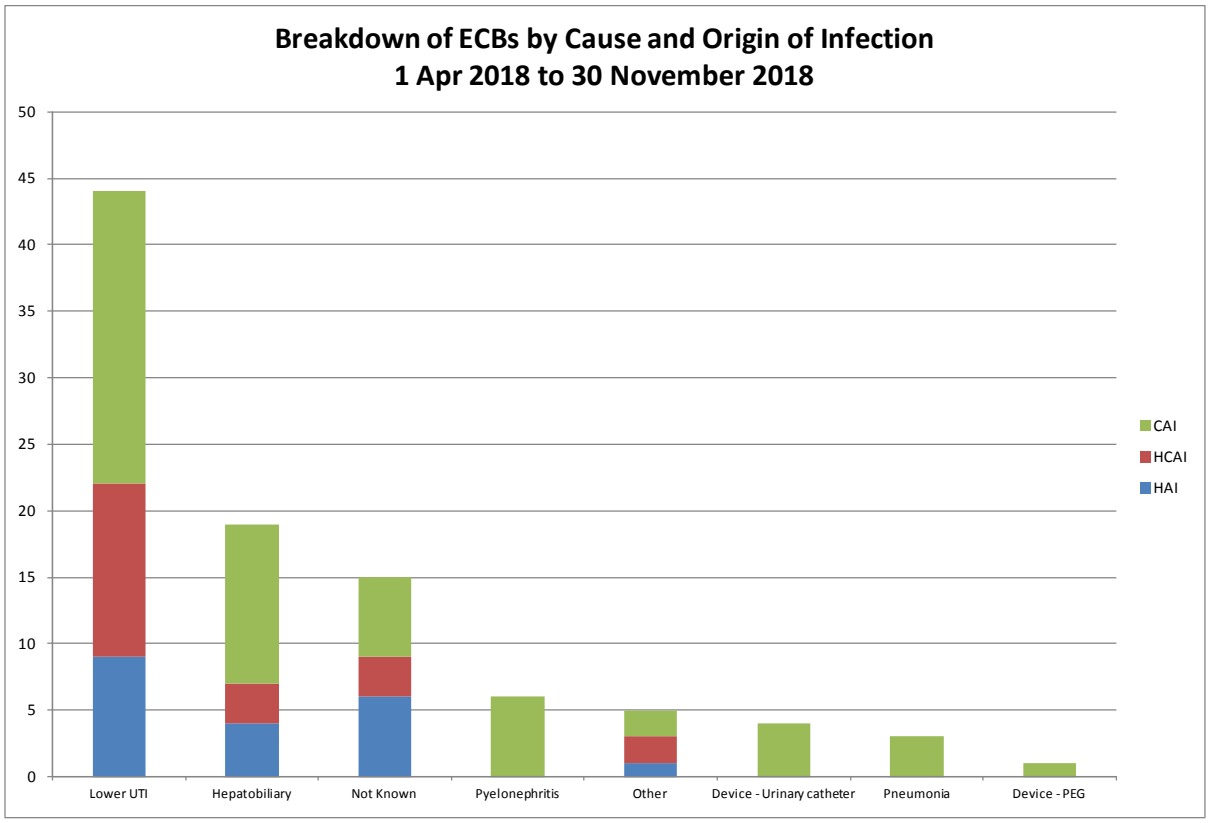
There has been no significant change since the last report to board.
The majority of infections continue to be community in origin.

Figure 8- Local data



Urinary tract infections continue to feature as the most common cause. There have been 4 community acquired infections attributed to urinary catheters and there may be scope for improvement in this area going forwards.

Figure 9- Local data



3. Surgical site infection (SSI)

Figure 10 - Funnel plot of caesarean section SSI incidence (per 100 procedures) in inpatients and PDS to day 10 for all NHS Boards in Scotland in Q3 2018. (HPS 2019)

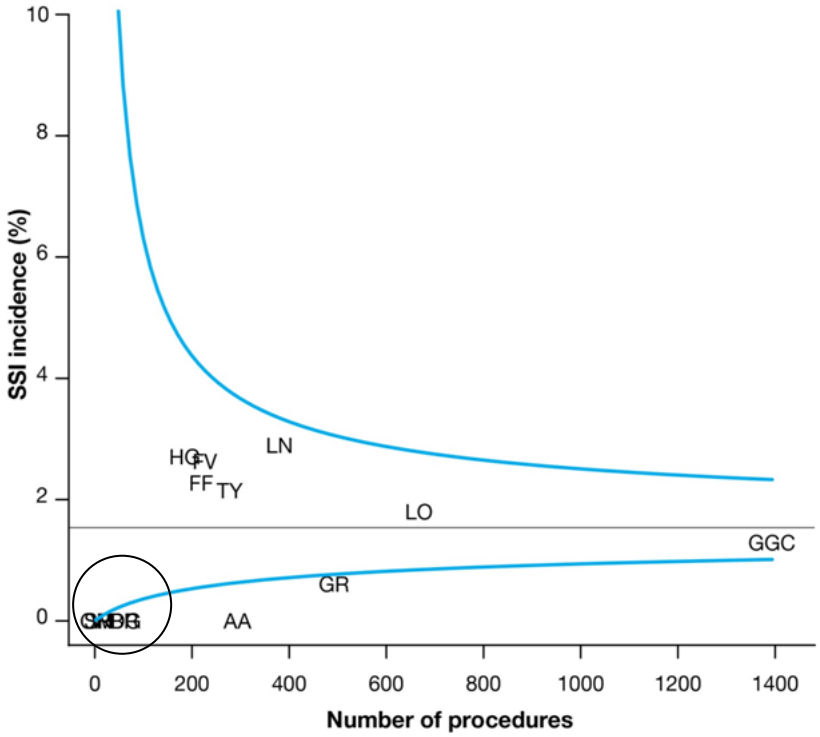
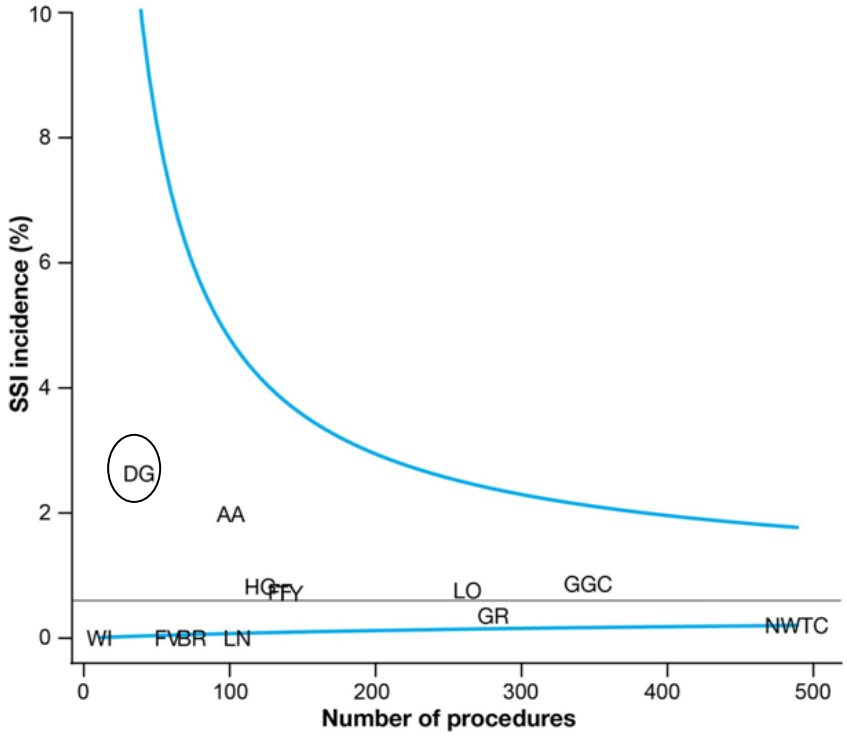


Figure 11 - Funnel plot of hip arthroplasty SSI incidence (per 100 procedures) in inpatients and on readmission to day 30 for all NHS Boards in Scotland in Q3 2018.



It should be noted that whilst this incidence looks higher than other Boards the information is based on 4 infections in a quarter.

4. HEI inspection- Galloway Community Hospital

A two day unannounced inspection of Galloway Community Hospital was undertaken by the Healthcare Environment Inspectorate 21& 22 November.
Inspectors commented positively on the welcome they received and were impressed by the range of service provided at the hospital.

The standards inspected against were

- Standard 1: Leadership
- Standard 2: Education
- Standard 6: Policies and procedures
- Standard 8: Decontamination

The report will be published 13th February.

NHS Dumfries and Galloway Board report card

Staphylococcus aureus bacteraemia monthly case numbers

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
MRSA	1	0	0	0	1	0	0	0	0	0	0	0
MSSA	1	2	5	2	4	3	2	1	3	6	0	3
Total SABS	2	2	5	2	5	3	2	1	3	6	0	3

Clostridium difficile infection monthly case numbers

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Ages 15-64	1	1	1	0	1	2	0	1	0	1	1	2
Ages 65 plus	7	3	6	4	3	2	6	5	4	2	4	2
Ages 15 plus	8	4	7	4	4	4	6	6	4	3	5	4

Cleaning Compliance (%)

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Board Total	96.4	96.9	97.7	97.0	96.9	95.6	97.8	96.9	97.6	96.9	97.5	96.5

Estates Monitoring Compliance (%)

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Board Total	99.0	99.2	99.4	99.0	99.4	99.6	99.5	99.3	99.5	99.4	99.2	99.4

NHS HOSPITAL REPORT CARD - DGRI

Staphylococcus aureus bacteraemia monthly case numbers

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
MRSA	1	0	0	0	1	0	0	0	0	0	0	0
MSSA	1	2	5	1	4	3	2	1	2	5	0	3
Total SABS	2	2	5	1	5	3	2	1	2	5	0	3

Clostridium difficile infection monthly case numbers

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Ages 15-64	0	1	0	0	0	0	0	1	0	1	0	2
Ages 65 plus	4	2	4	0	1	0	2	2	2	1	3	0
Ages 15 plus	4	3	4	0	1	0	2	3	2	2	3	2

Cleaning Compliance (%)

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Board Total	92.2	92.2	94.2	95.3	95.5	95.9	96.0	96.9	96.6	96.0	95.7	96.6

Estates Monitoring Compliance (%)

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Board Total	99.2	99.2	98.4	99.7	99.0	99.4	99.6	98.9	99.5	99.0	99.4	99.2

NHS HOSPITAL REPORT CARD – Galloway Community Hospital

Staphylococcus aureus bacteraemia monthly case numbers

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
MRSA	0	0	0	0	0	0	0	0	0	0	0	0
MSSA	0	0	0	1	0	0	0	0	1	1	0	0
Total SABS	0	0	0	1	0	0	0	0	1	1	0	0

Clostridium difficile infection monthly case numbers

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Ages 15-64	0	0	0	0	1	0	0	0	0	0	0	0
Ages 65 plus	0	0	0	0	1	0	0	0	0	0	1	2
Ages 15 plus	0	0	0	0	2	0	0	0	0	0	1	2

Cleaning Compliance (%)

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Board Total	95.7	96.6	95.9	95.4	94.9	95.2	95.2	96.6	97.1	97.2	97.6	95.9

Estates Monitoring Compliance (%)

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Board Total	97.5	98.0	99.3	99.0	99.8	98.9	99.4	99.1	99.0	99.3	98.9	98.5

NHS COMMUNITY HOSPITALS REPORT CARD

The community hospitals covered in this report card include:

- **Annan Hospital**
- **Castle Douglas**
- **Kirkcudbright**
- **Lochmaben**
- **Moffat**
- **Newton Stewart**
- **Thomas Hope**
- **Thornhill**

Staphylococcus aureus bacteraemia monthly case numbers

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
MRSA	0	0	0	0	0	0	0	0	0	0	0	0
MSSA	0	0	0	0	0	0	0	0	0	0	0	0
Total SABS	0	0	0	0	0	0	0	0	0	0	0	0

Clostridium difficile infection monthly case numbers

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Ages 15-64	0	0	0	0	0	0	0	0	0	0	0	0
Ages 65 plus	0	0	0	0	1	1	0	1	1	1	0	0
Ages 15 plus	0	0	0	0	1	1	0	1	1	1	0	0

NHS OUT OF HOSPITAL REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
MRSA	0	0	0	0	0	0	0	0	0	0	0	0
MSSA	0	0	0	0	0	0	0	0	0	0	0	0
Total SABS	0	0	0	0	0	0	0	0	0	0	0	0

Clostridium difficile infection monthly case numbers

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Ages 15-64	1	0	1	0	0	2	0	0	0	0	1	0
Ages 65 plus	3	1	2	4	0	1	4	2	1	0	0	0
Ages 15 plus	4	1	3	4	0	3	4	2	1	0	1	0

Agenda Item 253

DUMFRIES and GALLOWAY NHS BOARD

4th February 2019

Spiritual Care, Volunteering and Patient Services Team

Author:
Joan Pollard
Associate Director of Allied Health Professions

Sponsoring Director:
Eddie Docherty
Executive Director for Nursing, Midwifery and Allied Health Professions

Date: 14 January 2019

RECOMMENDATION

The Board is asked to **discuss and note** the following points:

- the progress within Spiritual Care
- the progress within Volunteering
- developments within Patient and Carer Information

CONTEXT

Strategy / Policy:

This paper demonstrates implementation of the Healthcare Quality Strategy (2010), and supports the delivery of :

- The draft National Delivery Plan (NDP) for Health and Social Care Chaplaincy and Spiritual Care in Scotland will supersede the previous CEL (2008) 49 (Scottish Government 2009b). Since the publication of the previous guidance on Spiritual Care a profound shift in the approach to health and social care in Scotland has taken place.
- the Scottish Government Commitment: A Nation with Ambition
- the Refreshed Strategy for Volunteering in the NHS in Scotland and the supporting Volunteering in NHS Scotland A Handbook for Volunteering (2014)
- the Dumfries and Galloway Health and Social Care Strategic Plan 2016-19

Organisational Context / Why is this paper important:

Under the integration agenda there is a requirement for spiritual care to be provided also in social care settings. It is recognised that Integrated Joint Boards and Health Boards are trying to embrace integration with finite resources. A Spiritual Care Service is guided by the NDP's five overarching outcomes and key deliverables.

NHS Scotland defines Spiritual Care as *"care that is usually given in a one-to-one relationship and is completely person-centred and makes no assumptions about the personal conviction or life orientation"*[1]

NHS Dumfries and Galloway Volunteering Programme provides recruitment, training and development for all volunteers throughout the region.

Key messages:

- During Interfaith week a successful event was held in the Santuary.
- Child Bereavement UK Scotland (CBUK) will run an educational conference at Easterbrook Hall on 14th March
- There has been an increase in Staff Support delivered during this period
- The Volunteering Programme is now expanding to rural communities

GLOSSARY OF TERMS

NHS D&G	-	NHS Dumfries & Galloway
DGRI	-	Dumfries & Galloway Royal Infirmary
BFPS	-	Breastfeeding Peer Support
CAU	-	Combined Assessment Unit
PAT	-	Pets as Therapy
IDEAS	-	Interventions in Dementia: Education, Assessment and Support
NDP	-	National Delivery Plan
CEL	-	Chairman's Executive Letter
MiP	-	MacMillan Cancer Pathways Public Involvement

MONITORING FORM

Policy / Strategy	• The draft CEL (2013) National Delivery Plan (NDP) for Health and Social Care Chaplaincy and Spiritual Care supersedes the previous CEL (2008) 49 (Scottish Government 2009b). • Healthcare Quality Strategy (2010) • Scottish Government Commitment: A Nation with Ambition (2017) • Refreshed Strategy for Volunteering in the NHS in Scotland and the supporting Volunteering in NHS Scotland A Handbook for Volunteering (2014) • Dumfries and Galloway Health and Social Care Strategic Plan 2016-19
Staffing Implications	*Nil*
Financial Implications	*Nil*
Consultation / Consideration	*Not applicable*
Risk Assessment	*Not Planned*
Risk Appetite	Low [ ] Medium [X] High [ ] *This is in the context of reputational where the Board has a risk appetite of Medium*
Sustainability	*Not applicable*
Compliance with Corporate Objectives	*Corporate Objectives 1,3,4 and 6*
Local Outcome Improvement Plan (LOIP)	***Spiritual Care:*** *Outcomes 1, 2, 6 and 8* ***Volunteering:*** *Outcomes 3 and 8*
Best Value	Vision and Leadership • *commitment and leadership* • *responsiveness and consultation* • *sound governance at a strategic and operational level* Equality • *Equal Opportunities arrangements* Sustainability *a contribution to sustainable development*
Impact Assessment *Volunteering Policy 25th May 17*	

1. Introduction

The NHS Dumfries and Galloway (NHS D&G) Patient Services team are responsible for a number of areas of work including Spiritual Care, Volunteering and Patient Information. This report outlines the key activities relating to those areas over the period November and December 2018.

2. Spiritual Care

NHS Scotland defines; **Religious care** is given in the context of the shared religious beliefs, values, liturgies and lifestyles of a faith community.

Spiritual Care can be given in one to one or group relationships, is person-centred and makes no assumptions about personal conviction or life orientation.

Spiritual care is not necessarily religious, but religious care should *always* be spiritual.

A Spiritual Care Service is guided by the National Delivery Plan's five overarching outcomes and key deliverables as outlined in the CEL (2013).

Arising out of HDL (2002) 76 and CEL (2008) 49, together with the increasing integration and development of Spiritual Care there are 13 core requirements for the delivery of spiritual care services across inpatient and primary care as well as integrated care settings. The basic requirements of NHS Dumfries & Galloway are:

- employ a Spiritual Care Lead based on their qualifications, experience, pastoral/relational abilities and capacity to demonstrate a mature, reflexive, spiritual world view;
- provide levels of staffing commensurate with the delivery of a high quality, integrated, proactive, responsive, spiritual care service;
- provide appropriate accommodation, information accessories, practical resources, a dedicated sanctuary and quiet room in inpatient settings;

2.1 InterFaith Week in DGRI

The outcome of the local InterFaith Group event on the evening of Wednesday 14th November, during InterFaith Week, in the DGRI sanctuary was very positive. A spiritual care volunteer welcomed everyone and showed them around DGRI in small groups with refreshments provided in the DGRI cafe afterwards.

- Approximately 30 people representing the following faiths attended including: Christian's from Church of Scotland, Episcopalian, Methodist, Bethany (Independent Christian), Mormon's - Church of Jesus Christ of Latter Day Saints, World Peace Prayer Society, Baha'i, Jewish, Quaker and one or two with no affiliation.
- Aspects of inter-generational relationships like skill-sharing, respect and ways of encouraging contact and co-operation between generations were discussed. There was a particular emphasis on celebrating and building on the contribution which their members make to local neighbourhoods and to

the wider community in Dumfries and Galloway. Respect featured prominently in the comments as being essential for harmonious relationships.

- Practical ways to encourage the generations to mix included, sharing food, giving time to listen well and communicate meaningfully, to share in making music and ideas to introduce young people into residential care homes to benefit lonely older people and encourage generations to mix more naturally.
- Discussion thoughts and comments were displayed on cardboard leaves for all to see at the close of the evening. Several guests left their contact details, InterFaith Dumfries hope that this may herald the beginning of a renewed interest in InterFaith work locally. Photographs were taken of everyone who attended and of the thoughts and comments on the cardboard leaves which were included with a report and submitted to be published in the InterFaith Scotland newsletter.

2.2 Bereavement Support

There is ongoing work in ad hoc provision of advice, information and support from the Spiritual Care Lead for NHS acute, community and locality teams and GP practice staff teams. Some staff affected are still off work and others have recently returned to work after bereavement time off.

The Working Well Group is aware of an idea raised by bereaved staff for the need to have a staff bereavement group available to access within DGRI. This would provide mutual peer support to enable staff to cope better on their return to work after bereavement leave.

A CFL - 'Conversation for Life' workshop was facilitated with a Health and Wellbeing Team in November to help raise awareness about why having a conversation about their wishes with loved ones would benefit everyone in a family at the end of life. The workshop was well received and the team realised they had a lot to talk about something often avoided to enhance their conversations with people in the community.

Child Bereavement UK Scotland (CBUK) will run an educational conference at Easterbrook Hall on 14th March to help raise awareness about the value of training staff to know how to appropriately support children, young people and parents who have been bereaved. The information about the conference will be widely disseminated among all IJB staff via NHS D&G Communications on social media

2.3 Staff Care and Support

The breakdown of staff support referrals Oct - Dec 2018:

Referrals	**October**	**November**	**December**
New	3	1	5
Ongoing	5	4	7
Total	**8**	**5**	**12**
	Appointments		
Reason for support	**October**	**November**	**December**
Bereavement/Loss	5	2	8
Family/Personal	2	2	4 *
Health/Physical/Mental			
Work Concerns	1 *	1 *	
Total	**8**	**5**	**12**

*Appointments included supporting teams

2.4 Spiritual Care Volunteering

The spiritual care volunteer team will increase to a total of seven people in January 2019. The seventh member of the team will be trained in January and will also shadow more experienced volunteers. Shadowing different experienced volunteers after training provides new volunteers with confidence before they visit patients and visitors on their own. Patient ward visits are being recorded more easily via the colour-coded spiritual care stickers which will enable more accurate annual figures.

2.5 Values Based Reflective Practice

The NHS D&G Values Based Reflective Practice (VBRP) cohort is due to meet early in 2019. VBRP headquarters at NHS Education for Scotland (NES) have requested a list of all staff that participate and/or lead VBRP sessions in all NHS Scotland health boards to maintain an accurate register of practitioners at varying levels.

2.6 Arts Committee

The Spiritual Care Lead remains involved in the Arts Committee group which meets to discuss artwork and installations in all NHS D&G buildings. These include the development of quiet rooms, sanctuaries and gardens among other areas used by patients, staff and public. As plans progress in Mountainhall a similar approach to art within the new DGRI is being undertaken. The committee agreed that guidelines would need to be written up to refer staff to for future reference when approaching any future art purchases and/or projects.

3. Volunteering

3.1 Recruitment Events in Rural Communities

The scoping exercise carried out by the Volunteer Co-ordinator with staff in rural communities identified similar volunteering needs and roles in each of the Community Hospitals and in the Galloway Community Hospital. This indicated that there is a need for approximately 90 volunteers; with 70 Monday – Sunday in all rural areas and an additional 20 required for Breast Feeding Peer Support and Mid Park volunteering.

Eight recruitment events took place during November from Langholm to Stranraer. A further event will be hosted in Wigtown early in the New Year to encourage additional support in Newton Stewart and Stranraer Community Hospitals. Although numbers were low in most individual areas the cumulative total for these events have brought 32 new enquires for volunteering with 69% coming from rural areas.

Castle Douglas/Kirkcudbright	**10**	**Annan**	**6**
Newton Stewart	**3**	**Langholm**	**0**
Stranraer	**2**	**Moffat/Lochmaben**	**1**
Crichton Hall Dumfries	**10**	**Thornhill**	**0**
c/f **Wigtown January 2019**			

Two Syrian Refugees who have recently resettled in Dumfries & Galloway attended the Crichton Hall Recruitment Event. Both potential volunteers are highly qualified in their own fields of pharmacy assistant and anaesthetist assistant. NHS D&G are working with Dumfries & Galloway Council's Resettlement Worker to explore potential work experience.

3.2 Collaborate Survey

During week commencing 14th – 18th January 19 volunteers, mainly Welcome Guides, will be assisting Clinical Efficiency Manager-Realistic Medicine with the Collaborate Survey in DGRI which will cover out-patient bays 1, 2 and 3 along with Rheumatology and Orthopaedics. The purpose of the survey will be to take a snap-shot of patient experience during this five day period.

3.3 Electronic Sign in for Volunteers

Over the last number of months we have been working with ICT team and the General Manager of ICT to install an electronic sign-in via BEACON for all volunteers. This will be piloted during January 2019 with volunteer Welcome Guides. Once fully operational this will assist with volunteering statistics which will give number of volunteering sessions/hours provided each month.

3.4 Clear Pathways - Third Sector

Clear Pathways Guidance for NHS Boards was adopted at the November 2018 Health Care Governance meeting. This gives guidance to NHS Boards who have Third Sector organisations providing a service for the NHS on NHS premises. During

recent visits with Third Sector organisations it is apparent that we need to have a consistency of approach across the region with these groups. A meeting took place with Third Sector Dumfries and Galloway (TSD&G) in December to work in partnership with TSD&G to implement the Clear Pathways Guidance. This partnership approach will ensure a Terms of Reference is in place for all Third Sector Groups on NHS premises thus safeguarding patients and users of NHS D&G.

3.5 Statistics & Training

Recruitment and training continues to be ongoing, with 32 new volunteers taking part in the recent Corporate Induction training on 29th November, 2018. In addition to this a further 12 new volunteers will take part in the next induction training scheduled for 24th January 2019.

The statistics and training table below indicates an increase in volunteering with 28 volunteers regularly committing to dual roles and/or multiple sessions covering 61 volunteering opportunities on a weekly basis.

Statistics and Training		
Current Volunteer Roles	**31st Dec 2018**	**Proposed 2019**
BFPS (6) / Maternity Link (4)	**10**	30
Cancer Information & Support	**11**	12
Combined Assessment Unit (CAU)	**5**	7
Falls Prevention	**2**	7
Food Satisfaction	**5**	7
IDEAS Team	**3**	4
Infection Control	**10**	9
MiP MacMillan Cancer Pathways Public Involvement	**11**	11
Pets as Therapy	**1**	5
Specialist Outpatient Rheumatology	**3**	5
Specialist Outpatient Cancer Neck & Head	1	1
Spiritual Care - DGRI	**5**	10
Spiritual Care - Patient Listening	**2**	34
Ward Children Family Entertainer	**1**	1
Ward Paediatrics	**2**	3
Ward Volunteer	**64**	126
Ward Volunteer Care of Older People	**8**	18
Ward Volunteers - Hand and Arm Massage	**2**	2
Welcome Desk (MHTC)	**17**	20
Welcome Guides	**55**	55
Welcome Guides - Critical Care Unit	**6**	10
Total Volunteering Opportunities **	**224**	377
Less: Dual Roles/Multiple Sessions (61)	**28**	
Total Number of Current Volunteers	**196**	
Applications in Progress or Training (239)	**43**	

Moving & Handling Training: Due to the high volume of new staff requiring moving and handling training the November wheelchair assistance training for ward volunteers was postponed. This is now taking place January, February & March 2019 providing ten training places each month giving and additional 30 training places for wheelchair assistance for volunteers.

3.6 New Roles

Patient Experience Volunteers: Two new roles to encourage feedback and help develop services are being explored. Conversations with Lead Nurse/Deputy General Manager, Acute and Diagnostics Directorate and Patient Feedback Manager are taking place regarding a new volunteer role for Patient Experience. At present good practice from other NHS Boards is being gathered and a suitable role descriptor is being designed for the pilot programme. This role will assist in capturing the patient experience and measure the impact of patients, visitors and staff.

MacMillan Cancer Pathways (MiP): Following on from the conversations that took place with MacMillan Cancer Pathways volunteering project 11 new volunteers were recently recruited and took part in NHS Corporate Induction Training which was tailored to suit the needs of this group. The purpose of the MiP is to ensure that the expertise of service users is provided to the MiP and to approve the funding allocations from the Small Grant Fund. This group will be supported by Strategic Planning and Commissioning Manager Dumfries and Galloway Health and Social Care.

MiP Volunteers and Patient Experience Volunteers will enable the voice of patients, families and users of NHS D&G to be heard using methods that will be meaningful and appropriate to those taking part.

3.7 Good News Story

A volunteer good news story to share:

A recent good news story to share from a volunteer who has MS and who has been a wheelchair user for the last four years:

> *"Last year I came across an advert on Facebook for volunteers at the new hospital. I thought it was something that I would be able to do even with my limited mobility, so I registered an interest. It was the right thing for me to do because, the people that I have met through taking up this role has only made my life better. From visitors to the hospital through to fellow volunteers and staff, it has only enhanced my life. The appreciation of what we do from everyone that we come across allows me to feel good that I can help people rather than sitting at home. That in turn has given me a lot of satisfaction and I have also met some interesting people along the way. I volunteer three sessions per week, Wednesday and Friday as Welcome Guide and one additional session to support outpatients at the Rheumatology clinic."*
>
> *I B – Volunteer*

4. Patient and Carer Information

4.1 Information for Cancer and Palliative Care Patients

Patient Services have worked closely with Macmillan Cancer Information & Support Centre and the Specialist Palliative Care Team to review South East Scotland Cancer Network (SCAN) website. SCAN aims to improve cancer care in the South East of Scotland by facilitating communication and partnership working. Their website includes a wealth of information for anyone affected by cancer and includes details of local cancer services. The information relating to Dumfries and Galloway was reviewed and has now been updated on the SCAN website.

Patient Services and the Palliative Care team have also been working together to develop bedside information folders for the Palliative Unit (B1). These folders have now been introduced to the Unit and include leaflets that both patients and relatives/carers will find useful.

4.2 Information for Carers

Patient Services are working with Strategic Planning and Commissioning and the IT Department to develop a new Carers page on Beacon. The page is designed to help staff access relevant Carer's information more easily, whether for themselves or patients/families they are supporting. The page is almost complete and is due to go live by the end of January 2019.

4.3 Surgery School

Patient Services are working with colleagues in Anaesthetics to develop a patient information package to support the patient journey pre and post surgery. This work will ensure that patients are provided with the right information, at the right time to support their surgery preparation and recovery.

Agenda Item 254

DUMFRIES and GALLOWAY NHS BOARD

4th February 2019

Improving Safety Reducing Harm:
Acute and Diagnostics Directorate

Author:
Maureen Stevenson
Patient Safety & Improvement Manager

Sponsoring Director:
Eddie Docherty
Executive Nurse Director

Date: 10th January 2019

RECOMMENDATION

The Board is asked **to discuss and note** the following points:

- The Improving Safety Reducing Harm report from the Acute Directorate

CONTEXT

Strategy / Policy:

- Healthcare Quality Strategy
- Delivering the Scottish Patient Safety Programme from Scottish Government Health Department

Improving Safety and Reducing Harm remains a strategic priority for NHS Dumfries and Galloway. The Improving Safety Reducing Harm report updates previously separate themes into one paper and fits with the Healthcare Quality Strategy whilst delivering the work associated with the Scottish Patient Safety Programme. The report gives a flavour of the progress in year with highlights from each of the programmes of work and the infrastructure required to continually improve the quality and safety of health and care in Dumfries and Galloway.

Organisational Context / Why is this paper important / Key messages:
The Improving Safety and Reducing Harm report was noted at the Healthcare Governance Committee on the 19th November 2018. The Healthcare Quality Strategy and Scottish Patient Safety Programme are integral to our local arrangements to integrate and connect all components of quality and safety, which together support teams and services to continuously improve the quality, safety, effectiveness and personalisation of care.

The report outlines the progress in the Acute Directorate with highlights from each of the programmes of work and the infrastructure required to continually improve the quality and safety of health and care in Dumfries and Galloway.

GLOSSARY OF TERMS

ACP	-	Anticipatory Care Plan
CAUTI	-	Catheter associated Urinary Tract Infection
DGRI	-	Dumfries and Galloway Royal Infirmary
HCSW	-	Healthcare Support Worker
NEWS	-	National Early warning Score
SAE	-	Significant Adverse Events
SCLIP	-	Scottish Coaching and Leading for Improvement
SIS	-	Scottish Improvement Skills
SPSP	-	Scottish Patient Safety Programme

MONITORING FORM

Policy / Strategy	Links to Healthcare Quality Strategy and work of the Scottish Patient Safety Programme.
Staffing Implications	Encouraging staff across NHS Dumfries and Galloway to take forward learning from patient safety activities.
Financial Implications	Nil
Consultation / Consideration	Patient safety and risk management are connected activities. Improving patient safety reduces the risk to patients, staff and the organisation.
Risk Assessment	Within current resources
Risk Appetite	Low [x] Medium [ ] High [ ] This paper demonstrates the activity within the Acute and Diagnostic Directorate to improve the service, while maintaining safe clinical practices; therefore, a low risk tolerance has been noted against this paper.
Sustainability	Embedding continuous improvement enables us to ensure sustainability and reliability of processes and outcomes for patients
Compliance with Corporate Objectives	Supports corporate objectives around continuous improvement, efficient service and motivated workforce.
Local Outcome Improvement Plan (LOIP)	Supports the Local Outcome Improvement Plans Outcomes 3 and 6
Best Value	Supports Vision and Leadership: ▪ Commitment and leadership ▪ Sound governance at strategic and operational level ▪ Sustainability
Impact Assessment Not required.	

Improving Safety Reducing Harm
In Acute and Diagnostics Directorate
September 2017 to August 2018

News in Brief

Managing Risk and Protecting Patient Safety

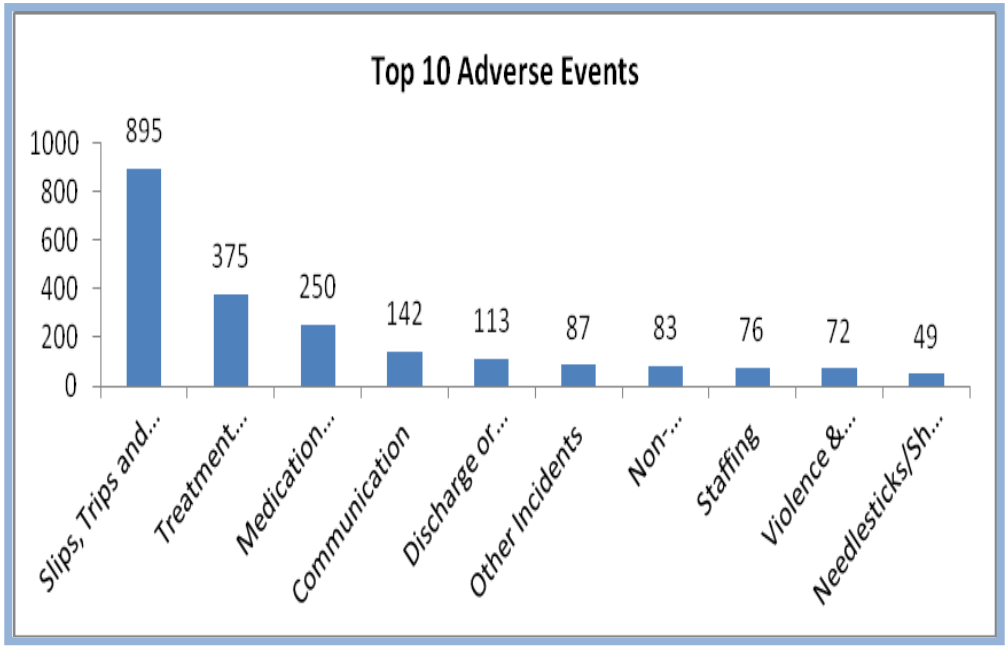
Proactive Risk Management
The Acute and Diagnostic Directorate have identified 2 very high risks which impact on their ability to deliver safe, effective, person centred, timely and efficient care:

- Staffing
- Audibility of Emergency Call Buzzers

These risks have been escalated and a coordinated corporate response has been agreed. Operational and tactical measures have been deployed to reduce immediate risk.

Adverse Events

There were 26840 adverse events reported from 1 Sept 2017 to 31st Aug 2018, of these 2031 resulted in no harm, 648 resulted in harm with 28 resulting in significant harm or death. Slips, trips and falls remained the highest reported adverse event.



Scottish Patient Safety Programme – Adult Acute

The national Scottish Patient Safety Programme (SPSP) Acute Adult Programme now forms part of an overarching Acute Care Portfolio.

The portfolio contains the SPSP Adult Acute Programme, SPSP Healthcare Associated infections and the Improving Older People's Acute Care Programme (OPAC).

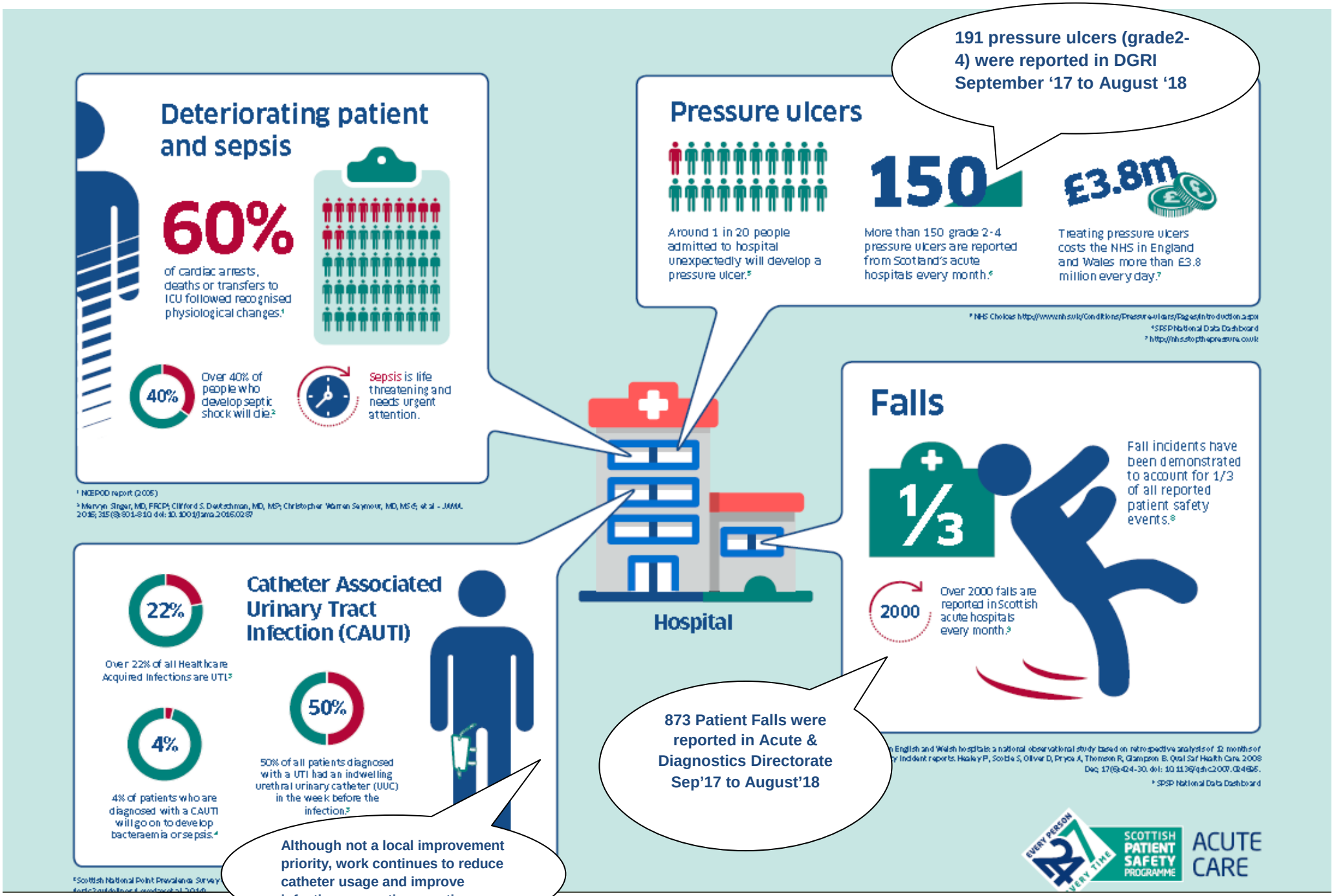
Local Priorities	Outcomes
Deteriorating Patient including Sepsis and Cardiac Arrest	➢ To reduce Hospital Standardised Mortality Ratio (HSMR) by 10% by December 2018 ➢ To reduce mortality from Sepsis
Pressure Ulcers	➢ To reduce hospital acquired pressure ulcers by 50% by September 2019
Falls and Falls with Harm Frailty at the Front Door	➢ To reduce harm from falls by 20% by March 2019
Unscheduled Care Improvement Programme	➢ Safe, person centre care delivered to every person without unnecessary wait, delays or duplication.
Realistic Medicine	➢ To reduce variation in clinical practice. Reduce overtreatment and promote a culture of shared decision making.

Walkrounds

There have been 21 walkrounds within the acute and diagnostics directorate from 1st September 2017 to 31st August 2018. 3 were cancelled during the migration. Issues discussed included the implementation of new care processes, capacity, audibility of call buzzers staffing ratios, recruitment and snagging issues within the new build.

Princess Royal opens new state of the art DGRI on 15 July 2018. DGRI has been designed to improve the safety, the effectiveness and experience of care.

New models and pathways of care have been introduced to improve quality.


191 pressure ulcers (grade2-4) were reported in DGRI September '17 to August '18
Deteriorating patient and sepsis
60%
of cardiac arrests, deaths or transfers to ICU followed recognised physiological changes.[1]
40%
Over 40% of people who develop septic shock will die.[2]
Sepsis is life threatening and needs urgent attention.
[1] NCEPOD report (2005)
[2] Mervyn Singer, MD, FRCP; Clifford S. Deutschman, MD, MS; Christopher Warren Seymour, MD, MSc; et al - JAMA. 2016; 315(8):801-810 doi: 10.1001/jama.2016.0287
Pressure ulcers
Around 1 in 20 people admitted to hospital unexpectedly will develop a pressure ulcer.[5]
150
More than 150 grade 2-4 pressure ulcers are reported from Scotland's acute hospitals every month.[6]
£3.8m
Treating pressure ulcers costs the NHS in England and Wales more than £3.8 million every day.[7]
[5] NHS Choices http://www.nhs.uk/Conditions/Pressure-ulcers/Pages/Introduction.aspx
[6] SPSP National Data Dashboard
[7] http://nhs.stopthepressure.co.uk
Hospital
Falls
1/3
Fall incidents have been demonstrated to account for 1/3 of all reported patient safety events.[8]
2000
Over 2000 falls are reported in Scottish acute hospitals every month.[9]
873 Patient Falls were reported in Acute & Diagnostics Directorate Sep'17 to August'18
[8] English and Welsh hospitals: a national observational study based on retrospective analysis of 12 months of ... incident reports. Healey F, Scobie S, Oliver D, Pryce A, Thomson R, Glampson B. Qual Saf Health Care. 2008 Dec; 17(6):424-30. doi: 10.1136/qshc.2007.024695.
[9] SPSP National Data Dashboard
Catheter Associated Urinary Tract Infection (CAUTI)
22%
Over 22% of all Healthcare Acquired Infections are UTI.[3]
4%
4% of patients who are diagnosed with a CAUTI will go on to develop bacteraemia or sepsis.[4]
50%
50% of all patients diagnosed with a UTI had an indwelling urethral urinary catheter (UUC) in the week before the infection.[3]
Although not a local improvement priority, work continues to reduce catheter usage and improve infection prevention practice
[3] Scottish National Point Prevalence Survey
EVERY PERSON EVERY TIME
SCOTTISH PATIENT SAFETY PROGRAMME
ACUTE CARE

Acute Improvement Updates

Unscheduled Care Improvement Programme

The Acute team are participating in a number of national initiatives to improve flow variability in unscheduled care:

- Twice daily Hospital Huddle
- Standard operating procedures for patient flow and escalation
- Predictive demand management
- Daily Dynamic Discharge
- Bed remodelling to reflect demand
- Locality & DGRI Flow meetings to avoid discharge delays.

Care Assurance

As part of the national Excellence in Care programme, a local Care Assurance process has been piloted with 3 acute wards within DGRI. The local Care Assurance process is designed to provide evidence on the quality of safe, effective and person centred care being provided, for people who use the services within NHS Dumfries & Galloway and is now being rolled out to all wards within DGRI.

Frailty at the Front Door

There is compelling evidence to support the benefits of early and effective comprehensive geriatric assessment, re-ablement and intermediate care for people living with frailty. Optimal outcomes are achieved when community health and social care services and hospital systems are fully aligned, well-coordinated, and attuned to the specific needs of people living with frailty. Dumfries & Galloway are one of 5 sites taking part in an 18 month collaborative, which commenced December 2017, working with HIS to improve the processes for identifying frailty and coordinating care to deliver better care and outcomes for people living with frailty. The current focus is at the front door of acute care, but we recognise that we need to look at flow across the whole system and link with work around Anticipatory Care Planning and Paliative Care.

SPSP Dashboard

Hospital Standardised Mortality Ratio (HSMR)

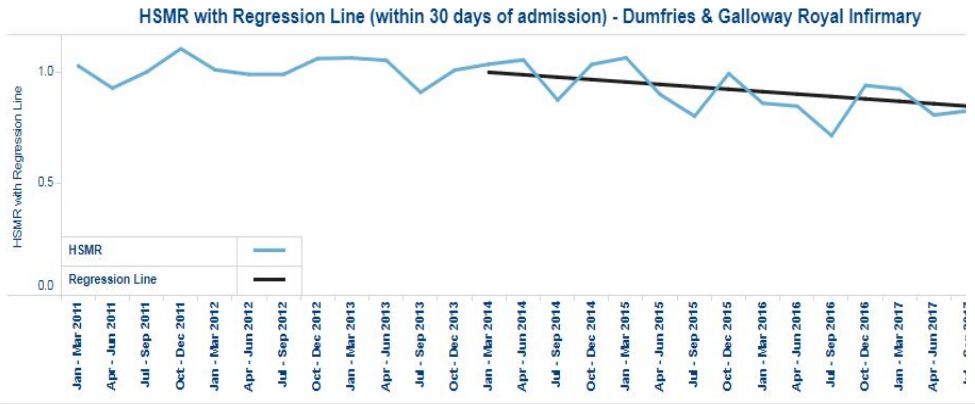
HSMR continues to be used as an indicator of the Acute Adult Safety Programme.

The HSMR is based on all acute inpatient and day case patients admitted to all specialties in hospital. The calculation takes account of patients who died within 30 days from admission, and includes deaths that occurred in the community as well as those occurring in-hospital.

HSMR = Observed Deaths / Predicted Deaths.

ISD has produced quarterly HSMR for all Scottish hospitals participating in the Scottish Patient Safety Programme since December 2009; the programme aim is to reduce hospital mortality by 10% by the end of December 2018. The data below indicates the HSMR for Dumfries & Galloway Royal Infirmary (DGRI), has reduced by 17.3% from our baseline in 2014.

	Crude Rate (%)	HSMR	Change in HSMR (%)
Jan - Mar 2018p	4.0	0.96	-17.3



SPSP Progress Update

Deteriorating Patient, Cardiac Arrests and Sepsis

Recognition and response to deterioration continues to be a key focus. Improvement teams for deteriorating patients and sepsis are working together to improve timely interventions that will contribute to reducing HSMR, reducing mortality from Sepsis by 30% and sustaining our reduction in Cardiac Arrests in hospital.

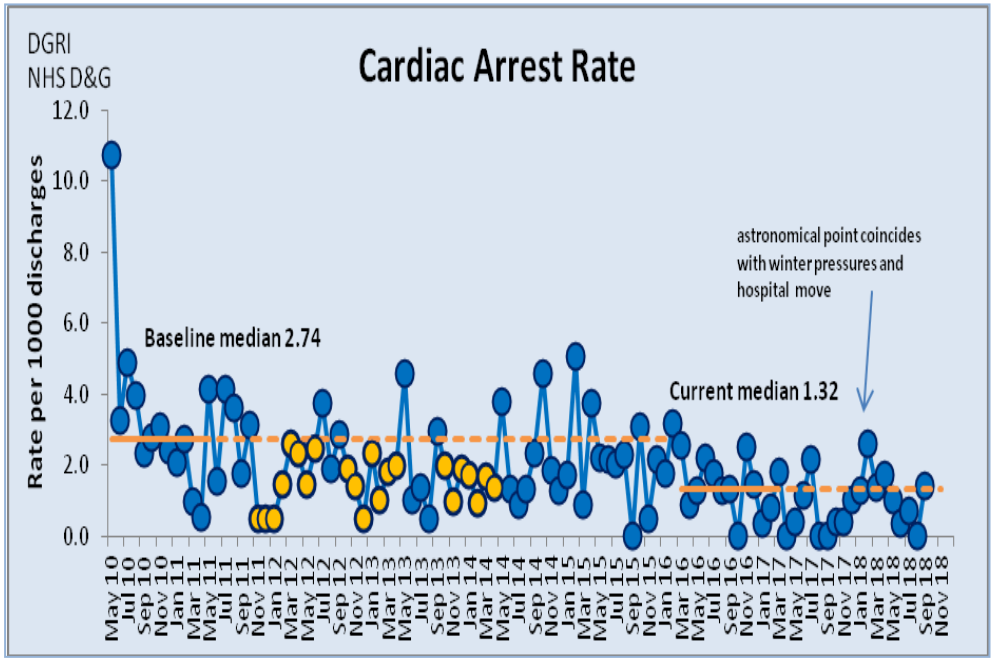
NHS Dumfries & Galloway have adopted National Early Warning Score (NEWS) In line with recommendations from Health Improvement Scotland and are currently exploring a move to an electronic NEWS system.

Some other support measures introduced are outlined below:

- Cardiac arrest 2222 calls are reported and reviewed as adverse events
- Treatment escalation plans have been tested and implemented in two wards with scale up and spread planning underway
- review of sepsis management is underway in the emergency department who are testing an adapted sepsis screening tool
- Acute leads are working jointly with teams from across health and social care partnerships to implement Anticipatory Care Planning (ACP) within Dumfries & Galloway. ACP will enable clinical teams to understand patient's choices regarding care and treatment in the event of a flare up or deterioration in their condition.

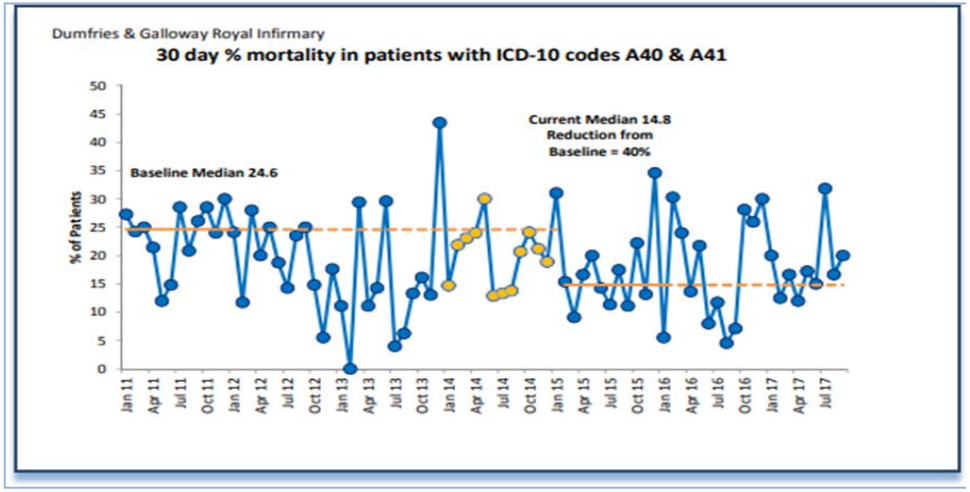
Measuring Impact - Outcomes

Cardiac Arrest data shows a sustained improvement, on target with a 52% reduction in Cardiac arrests within DGRI.



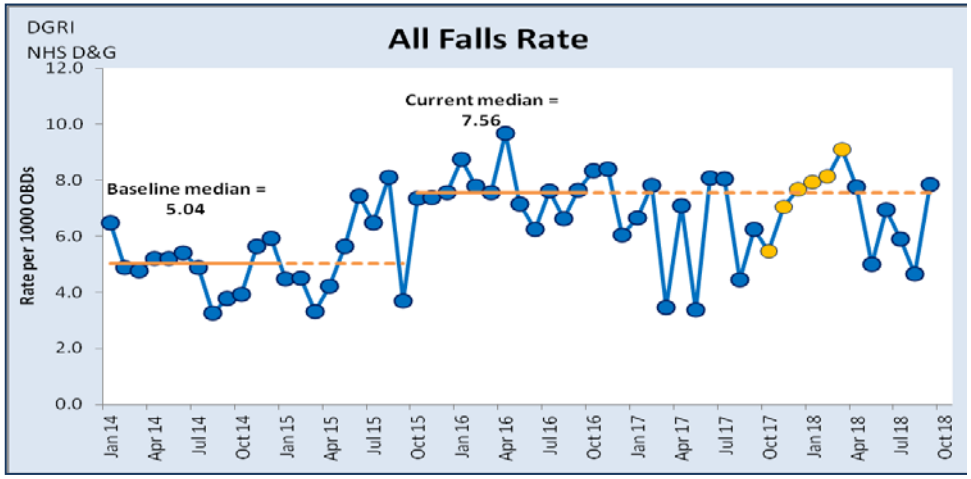
Sepsis

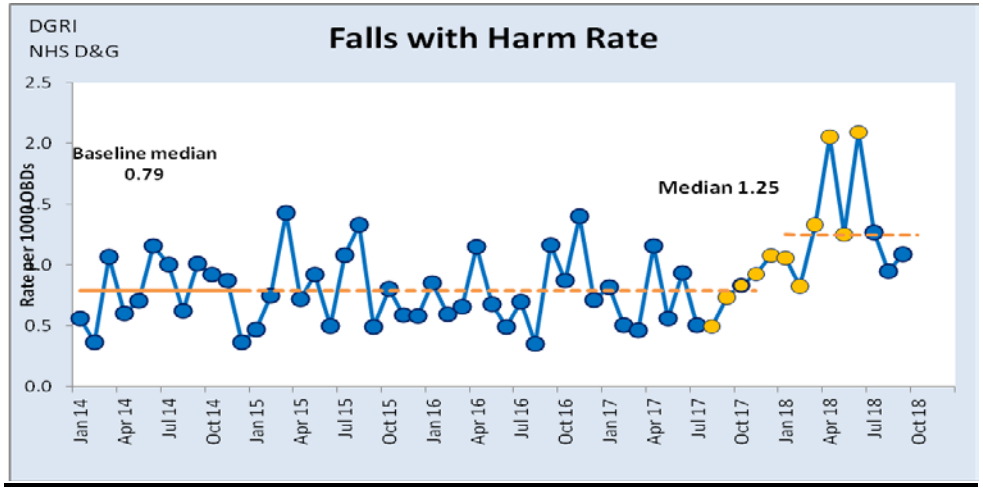
Sepsis; 30 day % mortality for patients demonstrates a sustained improvement in survival rates with a 40% reduction from a baseline median of 24.6 to 14.8 due in part to earlier recognition and application of Sepsis 6.



Falls

Falls continue to be the most frequently reported adverse event in Acute Care: 378 people suffered harm as a result of a fall in the last year. Data below indicates that our falls rate is increasing both for the total number of falls and falls with harm. We believe this increase in reported falls is due to improved reporting and an increase in the frailty of the patient group.





The falls bundle; is now a core component of assessment documentation on admission for all inpatients in DGRI and cottage hospitals.

Reducing falls is complex and works hand in hand with other work around hydration, early mobilisation and Frailty.

The Acute Nursing Quality & Safety Group have prioritised falls reduction and are working collectively to share and explore detailed data and improvement ideas.

Volunteers with additional training are supporting falls prevention activity and we are testing a range of technology and education options.

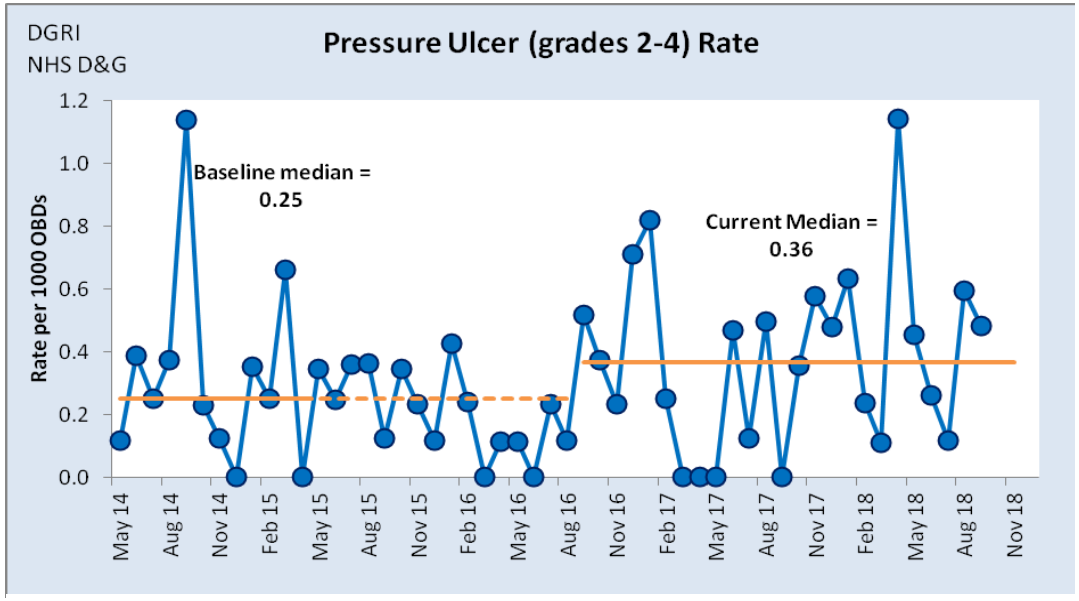
Pressure Ulcers

We have seen a 44% increase in our pressure ulcer rate for grades 2-4 within DGRI, from our baseline median of 0.25 per 1000 occupied bed days (OBD) to 0.36. This we believe is a more accurate reflection of actual pressure ulcer numbers.

Assessment and prevention of pressure ulcers is a core risk assessment and is completed on admission for all patients. A grading system supports accurate identification and recording of all pressure ulcers. Outcome data is gathered from self reporting on Datix.

An improvement collaborative has commenced which brings together staff from acute and community to test interventions to reduce incidence and severity of pressure ulcers across the patients journey.

A Tissue Viability Nurse Specialist has recently been appointed to support this work.



Realistic Medicine

Realistic Medicine promotes the practice of shared decision making. It is designed to reduce harm to patients from unwarranted variation in practice, overtreatment and efficient utilisation of resources. A number of local projects are supported which include:

- **Clinical Lab Optimisation** Group reviews variation in requests for lab tests and works with clinicians to reduce inappropriate testing
- **Shared Decision Making** – supporting clinical teams to develop and use decision aid tools.
- **It's Good to Ask** campaign to support patients to ask 'choosing wisely' questions during consultations to ensure they make informed choices around care and treatment
- **Education & Training:**
- Good Consultation Videos
- Take the Pledge Campaign
- CPD sessions for ANP's

Preventing Healthcare Associated Infection

We have been taking a different approach to hand hygiene auditing due to the difficulty of observing in single rooms and are asking patients for their opinion. We have asked them on a scale of 1-10 how confident they are that different staff groups clean their hands. Responses have been positive so far and it appears to be raising awareness of hand hygiene, notices have been placed on the back of bedroom doors asking 'have you cleaned your hands' as a prompt for staff.

Learning from Significant Adverse Events around SABs has prompted us to test an invasive lines bundle to reduce the recording burden on staff.

Electronic audit tools are being tested that enable real time data review at ward level.

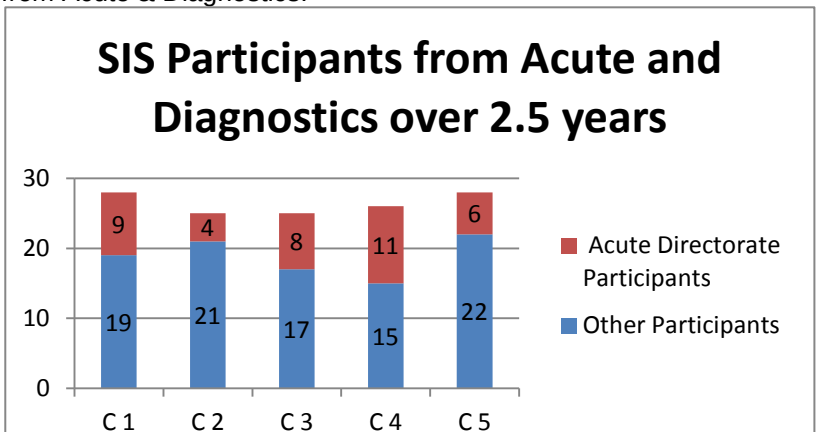
System Enablers

System Enablers are the infrastructure that supports the delivery of safe, high quality healthcare and are woven throughout our safety and improvement work. They include:

- Developing and utilising QI capacity and capability
- Designing and using effective measurement systems
- Programme Management
- Leadership attuned to improving quality and safety of care
- Effective Communication
- Managing Transitions of Care

Building Improvement Capability

To date 38 people have completed the Scottish Improvement Skills (SIS) programme from Acute & Diagnostics.



Scottish Coaching and Leading for Improvement Programme

Qi Hub
Connect Inspire Improve

The Scottish Coaching and Leading for Improvement Programme (SCLIP)

Are you a leader and need to support individuals and teams to achieve Improvement Strategies ?

SCLIP is designed to develop Leaders and Leadership teams across Health and Social Care who will coach and facilitate teams to deliver improvement and support achievement of improvement strategies within the organisation. **The first cohort of SCLIP, developed by NES will be delivered in Dumfries & Galloway from January 2019.**

By the end of the programme participants will be able to confidently apply their skills across:

Quality Improvement

- Understand approaches and apply tools and techniques to accomplish improvement interventions
- Use data for improvement, including how to use run charts
- Describe concepts of implementation
- Explain the key concepts of the science of improvement spread, and scale-up and have ability to apply appropriately in a working situation

Coaching

- Explain the similarities and differences between coaching for individuals and teams
- Apply coaching skills to support teams to develop, test, and implement change
- Use coaching approaches to achieve deeper conversations that facilitate team work
- Apply participatory decision-making tools to facilitate team decision making

Leadership

- Use Strengths Deployment Inventory to demonstrate self-awareness and work effectively with difference
- Explain the characteristics of high performing teams and team leaders
- Apply theories to effectively lead teams through change
- Use project management tools to lead delivery of improvement interventions
- Participants are expected to apply the principles of coaching and leadership to support a team or teams to apply improvement methodology and share their experiences with other programme participants

Programme Outline

Go To 1 Welcome	First Workshop (2 days)	Go To 2 Coaching	Go To 3 Leadership	Second Workshop (2days)	Go To 4 Quality Improvement	Third Workshop (2 days)	Go To 5 3 Month Evaluation	Go To 6 6 Month Evaluation	Celebration event
Jan	5&6th Feb			13th & 14th March		30th April 1st May			

Closing Date Friday 30th November 2018 no later than 5PM

For more information and a copy of the application form, call the Patient Safety and Improvement Team on 01387 244154 or email dumf-uhb.patientsafety@nhs.net

NHS Dumfries & Galloway

Plan for the year ahead

- We recognise the significant challenges in taking forward improvement during 2017 with a 6 month pause on improvement activity due to the complexities and resources required for the safe transition to a new hospital.
- As services are settling into their new teams and environments they are starting to find some space to think, plan and drive improvement forward. Senior management teams are committed to support local priorities and to develop the capacity and capability of their staff.
- The nursing quality and safety group is an excellent opportunity for managers and teams to come together and use data to identify themes and develop plans to drive improvement.
- We recognise the need to find this space for wider multidisciplinary teams and are exploring opportunities to achieve this.
- Testing a process that offers reflective & reflexive learning for junior doctors in relation to near misses and opportunities to engage in improvement, has been valued and benefits recognised, resulted in this being factored into the timetable for our new junior doctors over the coming year.
- In recognising the change in complexity and flow of patients alongside workforce pressures, retaining a focus on key priorities will be key to achieving our agreed outcomes.
- We need to ensure we are working across systems with colleagues in health and social care to effectively utilise resources throughout transitions of care and maximise the quality and experience for those who use and deliver our services.

Innovations Supporting Recruitment & Retention of staff

We recognise that insufficient staffing is a very high risk and have a range of short and longer term solutions to address this whist working across the Partnership to design and deliver new models of care. These include:

- Management Team support in recruiting digital media and marketing specialists
- Band 6 Development Posts
- Band 3 Development Roles
- Teambuilding and Resilience training and support
- Recruiting HCSW to boost staffing in key areas
- Nursing Foundation Programme to 'grow our own'.

Qi Hub
Connect Inspire Improve

What's on?

OCTOBER

Mon 22	Special Edition Newsletter : Celebration Event
Wed 31	Zen Sessions in the Qi Hub (12pm-2pm)
Wed 31	Qi CONNECT: Fiona Godlee screening in the Qi Hub (4pm-5pm)

NOVEMBER

Thurs 01	Qi workshop - 'How to write a successful abstract' in the Qi Hub (10am-12pm)
Mon 05	Qi workshop - 'How to make a good poster' in the Qi hub (1pm-4.30pm)
Mon 26	Qi clinic - 'Supporting your improvers to get the best possible Qi project outcomes' in the Qi hub (2.30pm-4.30pm)
Tues 27	Zen sessions in the Qi hub (9am-12pm)
Wed 29	Qi CONNECT: ePatient Dave in the Qi hub (4pm-5pm)

DECEMBER

Mon 10	Qi clinic - 'Scale up & spread' in the Qi hub (10am-12pm)
Thurs 13	Zen Sessions in the Qi Hub (9am-12pm)

For further information or to book a space, please email:
dumf-uhb.patientsafety@nhs.net

Glossary

ACP	Anticipatory Care Plan
CAUTI	Catheter associated Urinary Tract Infection
DGRI	Dumfries and Galloway Royal Infirmary
HCSW	Healthcare Support Worker
NEWS	National Early warning Score
SAE	Significant Adverse Events
SCLIP	Scottish Coaching and Leading for Improvement
SIS	Scottish Improvement Skills

Agenda Item 255

DUMFRIES and GALLOWAY NHS BOARD

4th February 2019

NHS Board Performance At a Glance Report

Author:
Ananda Allan
Performance and Intelligence Manager

Sponsoring Director:
Julie White
Chief Operating Officer

Date: 04 February 2019

RECOMMENDATION

The Board is asked **to discuss and note** the following points:

- the NHS Board 'At a Glance' Report.

CONTEXT

Strategy / Policy:
Dumfries and Galloway Integration Joint Board Strategic Plan

Section 42 of the 2014 Public Bodies (Joint Working) (Scotland) Act requires that Performance Reports be prepared by the Health and Social Care Partnership.

Organisational Context / Why is this paper important / Key messages:

This performance report is an overview of operational performance using local management information.

GLOSSARY OF TERMS

AHP	-	Allied Health Professional
CAU	-	Combined Assessment Unit
ED	-	Emergency Department
MSK	-	Musculoskeletal
TTG	-	Treatment Time Guarantee

MONITORING FORM

Policy / Strategy	Dumfries and Galloway Integration Joint Board Strategic Plan
Staffing Implications	None
Financial Implications	None
Consultation / Consideration	Integration Joint Board Performance Committee
Risk Assessment	Risks will be considered by the NHS Board
Risk Appetite	Low [x] Medium [ ] High [ ] Performance includes many aspects of clinical care, which the NHS Board has designated a low appetite for risk
Sustainability	Individual measures can be an indicator of ongoing sustainability
Compliance with Corporate Objectives	To promote and embed continuous quality improvement To maximise the benefit of the financial allocation by delivering clinically and cost effective services efficiently To meet and where possible, exceed goals and targets set by the Scottish Government Health Directorate for NHSScotland, whilst delivering the measurable targets in the Single Outcome Agreement
Local Outcome Improvement Plan (LOIP)	Outcome 6: People are safe and feel safe
Best Value	Performance Management
Impact Assessment *Not applicable*	

Background

1 The At a Glance report is management information automatically generated from local information systems. These figures are an early indication of activity and may not exactly match the National Official Statistics publications which are issued later in time.

Key points from At a Glance (Appendix 1)

2 **Treatment Time Guarantees** – The figure for December 2018 was 88.4%. Scottish Government has issued Health Boards with interim targets for the treatment time guarantee:

- 75% by October 2019
- 85% by October 2020
- 100% by March 2021

3 **AHP MSK 4 weeks** – The figure for December 2018 was 29.9%. Waiting times for the musculoskeletal service continue to grow.

4 **Cancer** – technical problems mean this figures are currently unavailable through the automated ‘At a Glance’ report.

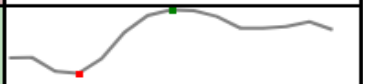
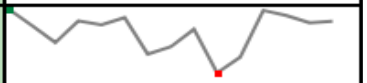
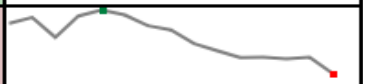
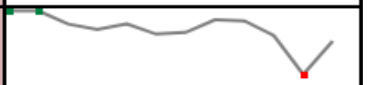
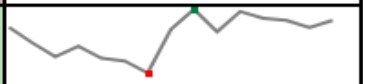
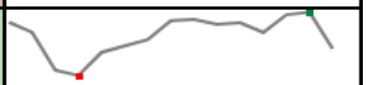
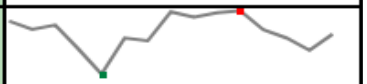
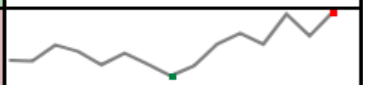
5 **Delayed discharges** – The number of delayed bed days has steadily risen and was 1,686 in December 2018.

Recommendations

6 NHS Board is asked to note and discuss the NHS Board ‘At a Glance’ report.

At a Glance Performance Indicators: December 2018

Note: The directional arrow is comparing *performance in the last three months v the same three months, in the previous year* *[Local figures; NOT OFFICIAL STATISTICS]*

Indicator	Target	November 2018	December 2018	Last 3 Months (Oct 18 - Dec 18)	Last 3 Months Last Year (Oct 17 - Dec 17)	Direction	15 Month Trend
TTG (% waited under 12 weeks for Treatment)	100%	82.8%	88.4%	83.5%	87.9%	▽	
Dr Led New Outpatients (% waiting under 12 weeks at end of month)	95%	93.1%	91.3%	92.1%	84.1%	△	
Diagnostics (% waiting under 6 weeks at end of month)	100%	97.4%	97.6%	97.8%	96.9%	△	
AHP MSK (% waiting under 4 weeks at end of month)	90%	42.6%	29.9%	37.8%	67.3%	▽	
Cancer (Within 31 day target)	95%	% (October 2018)	% (November 2018)	% Average (Sep 18 - Nov 18)	95.9% Average (Sep 17 - Nov 17)	▽	
Cancer (Within 62 day target)	95%	% (October 2018)	% (November 2018)	% Average (Sep 18 - Nov 18)	98.7% Average (Sep 17 - Nov 17)	▽	
18 Weeks Performance	90%	89.4%	90.1%	89.9% Average	87.9% Average	△	
18 Weeks Linkage	90%	96.7%	97.4%	97.2% Average	97.7% Average	▽	
Emergency Department (% Within 4 Hour)	98%	95.0%	89.7%	93.1%	90.7%	△	
Emergency Department (Absolute Attendances)	▽	3,634	3,857	11,295	11,939	▽	
Delayed Discharges (Bed Days Lost)	▽	1,387	1,686	4,735	3,421	△	
Dr Led Return Tickets (Beyond Latest Date at end of month)	▽	5,033	5,307	15,503	12,309	△	

[See note overleaf]

At a Glance Performance Indicators: December 2018 [Notes]

Indicator	Background	Points to note
TTG 12 weeks	The Treatment Time Guarantee (TTG) is set out in 'The Patient Right's (Scotland) Act 2011' which places a legal requirement on health boards. Once planned inpatient or day case treatment has been agreed, the person must receive that treatment within 12 weeks. This is reported quarterly as indicator B4. Boards have been asked to commit to bring performance back to the level at March 2017, which was a target of 86.3%. The general manager has agreed a goal to reach 90% by March 2019.	This indicator exceeded the target of 86.3% in December 18 and has moved closer towards the goal of 90%. 3 month period is 4.4% lower than same time last year.
Dr led new outpatients 12 weeks	Not all outpatient clinics are led by doctors. This figure only includes doctor led clinics. This aspect of the 18 week waiting times journey is reported as B6 in the quarterly performance reporting.	Waiting times were below the 95% target. The 3 month period is 8% above the result for the same time last year.
Diagnostics 6 weeks	This aspect of the 18 week waiting times journey is reported as B7 in the quarterly performance reporting. An aspirational local target is set at 4 weeks.	Waiting times were below the target of 100%. The 3 month period was 0.9% higher than same time last year.
AHP MSK 4 weeks	Allied Health Professional Musculoskeletal services - This aspect of the 18 week waiting times journey is not reported in the quarterly performance reporting.	Compliance fell 12.7% between November and December and was at 29.9%. There are known issue around staffing levels and where current staff are deployed.
Cancer 31 day	This indicator is 1 of 2 Local Delivery Plan (LDP) Standards, chosen by the Scottish Government, that focus on the efficient delivery of support and treatment when a suspicion of cancer is raised. It is reported quarterly as indicator B2(1). The figures shown here are for a single month and can be based on small numbers of individuals and therefore fluctuate substantially from one month to the next.	Note: an information linkage problem has occurred, which hampers automated reporting of the cancer figures. Work is underway to correct this.
Cancer 62 day	This indicator is the second of two Local Delivery Plan (LDP) Standards, reported quarterly as indicator B2(2). The figures shown here are for a single month and can be based on small numbers of individuals and therefore fluctuate substantially from one month to the next.	As above. Local performance for 62 days was 90.9% in December 18 (93.6% for Q4). 31 days data for Dec 18 not yet available.
18 weeks performance	The complete 18 week waiting times journey from referral to treatment is reported as B8 in the quarterly performance reporting, This indicator is impacted by all the above partial segments of the 18 week pathways.	December figure has met the national target, (90.1%).
18 weeks linkage	This indicator demonstrates how well record keeping in maintained.	Figures remain consistently above 95%.
Emergency department 4 hours	This measure indicates the length of time people experience between arrival and discharge from the emergency department (ED). This indicator is reported as B19 in the quarterly performance reporting. Boards have been asked to commit to bring performance back to the level at March 2017, which was a target of 92.2%.	ED waits were longer during December 2018. Performance is currently 89.7%, which is below the March 2017 locally agreed interim target.
Emergency department attendances	The new ways of working with the combined assessment unit (CAU) affects how activity seen in the ED is managed. This area is the focus of large scale redesign work supported by Scottish Government. This aspect of activity is reported as indicator E3 in the quarterly performance reports.	The number of people has increased between November and December. Not clear if 2017 figures are comparable due to new CAU model.
Delayed discharges bed days	This indicator is a measure of the number of bed days that are occupied by people who have been assessed as appropriate to be discharged to another setting. It includes all hospital settings, acute, community, cottage and mental health. These figures are for all ages, figures for people aged 18 or over is reported quarterly as indicator E4.	The number of delayed discharge bed days rose in December 2018.
Dr led return tickets	This measure is about the efficient use of outpatient appointments.	This figure has risen since previous month and is 20.6% higher than this time the previous year.

Agenda Item 256

DUMFRIES and GALLOWAY NHS BOARD

4th February 2019

Review of Integration Joint Board - Performance Framework

Author:
Ananda Allan
Performance and Intelligence Manager

Sponsoring Director:
Vicky Freeman
Head of Strategic Planning

Date: 4th February 2019

RECOMMENDATION

The Board is asked **to discuss and note** the following points:

- The Review of the Integration Joint Board Performance Framework.
- The Annual and Mid Year Reports providing strategic level performance. information ,replacing the existing quarterly reports.
- The content and timing of 'At A Glance' performance information contained within 'At A Glance' operational report.
- The continued quarterly reporting of the Ministerial Strategic Group for Health and Community Care (MSG) to March 2020.
- The planned expansion of information contained within 'At A Glance' operational performance management reports.

CONTEXT

Strategy / Policy:

Dumfries and Galloway Integration Joint Board Strategic Plan

Section 42 of the 2014 Public Bodies (Joint Working) (Scotland) Act requires that Performance Reports be prepared by the Health and Social Care Partnership.

Organisational Context / Why is this paper important / Key messages:

This report make recommendations to change the performance management arrangements for the Dumfries and Galloway Health and Social Care Partnership

GLOSSARY OF TERMS

DGHSCP	-Dumfries and Galloway Health and Social Care Partnership
IJB	- Integration Joint Board
MSG	- Ministerial Strategic Group

MONITORING FORM

Policy / Strategy	Dumfries and Galloway Integration Joint Board Strategic Plan
Staffing Implications	None
Financial Implications	None
Consultation / Consideration	Integration Joint Board Performance Committee
Risk Assessment	Risks will be considered by the NHS Board
Risk Appetite	Low [x] Medium [ ] High [ ] Performance includes many aspects of clinical care, which the NHS Board has designated a low appetite for risk
Sustainability	Individual measures can be an indicator of ongoing sustainability
Compliance with Corporate Objectives	To promote and embed continuous quality improvement To maximise the benefit of the financial allocation by delivering clinically and cost effective services efficiently To meet and where possible, exceed goals and targets set by the Scottish Government Health Directorate for NHSScotland, whilst delivering the measurable targets in the Single Outcome Agreement
Local Outcome Improvement Plan (LOIP)	Outcome 6: People are safe and feel safe
Best Value	Performance Management
Impact Assessment *Not applicable*	

Background

1 On 6th April 2018, the IJB agreed to retain their Strategic Plan, introducing a new period of relevance, from 5th April 2018 to 4th April 2021.

2 Section 42 of the 2014 Public Bodies (Joint Working) (Scotland) Act requires that Performance Reports be prepared by the Health and Social Care Partnership.

3 The framework and flow of reporting were previously agreed by Dumfries and Galloway Integration Joint Board.

4 Since the inception of the current performance framework, it has been necessary to make some amendments to take into account changes in relation to performance at government and local levels.

5 In light of both the above and the IJB decision to retain its strategic plan, this paper proposes further changes to the performance framework to ensure continued effectiveness and efficiency of the reporting pathways.

6 The performance management framework, published to support the Strategic Plan 2016 – 2019, was developed in 2015 whilst new governance structures within the partnership were still emerging. Since that time,

- New performance indicators have been introduced by the Ministerial Strategic Group (MSG). These are currently included in quarterly performance reports as 'E' indicators
- New local trajectories have been agreed for a range of indicators
- The governance arrangements and organisational roles within the Health and Social Care Partnership are clearer/better understood
- Following an elected members IJB workshop, locality reports have been redesigned to clarify their function in relation to providing information regarding the progress towards the delivery of the Locality Plans: *"2.3.8 Health and social care services in each locality will be accountable to their local community through the Area Committees and to the IJB"* (Dumfries and Galloway Integration Scheme)

7 This paper follows on from work previously undertaken to develop the performance management arrangements for the Dumfries and Galloway Health and Social Care Partnership (HSCP).

Main Body of the Report

8 The performance framework sets out both a schedule of reporting and a suite of performance indicators. The latest information about performance processes and indicators is available in the Performance Handbook.

9 The Handbook is updated as required, with the most current version always available on the DG-change website: http://www.dg-change.org.uk/our-performance/

10 The performance information presented to the IJB, a strategic commissioning body, is appropriately at a strategic level, reflecting progress against the 9 national outcomes, thereby enabling this body to make strategic level decisions.

11 Strategic performance information is based on the same day to day information used for operational performance management but has particular characteristics.

12 Strategic information:

- Is the most accurate, final, 'clean' information, preferably produced by a recognised professional body with a remit for official statistics (like National Statistics Scotland)
- Is benchmarked against other systems and agreed standards, including targets and trajectories
- Reflects long term trends and high level system outcomes, which means that the information is historic (at least 3 months past) and general

13 Strategic performance information changes very little in a three month period. Therefore it is proposed to report strategic performance information to the IJB twice per year.

- The IJB Annual Performance Report is a statutory requirement and must be published by the end of July every year. This report is intended for the public and reflects progress against the 9 national outcomes. The annual performance report includes all indicators in the performance framework.
- A Mid Year Performance Report would include as many indicators from the performance framework as possible (some are only reported once per year), benchmarking, trends and improvement actions.

It is proposed these two reports replace the current quarterly reports.

14 Performance information about the delivery of the 9 national outcomes in communities by means of the locality plans is reported through the Local Authority's Area Committees.

- Locality reports will be produced twice a year for the relevant Area Committees. It is anticipated that this will be in November/December and May/June each year.
- The locality reports will be structured around the 9 national outcomes with all outcomes addressed within an Area Committee Report over the course of the full year.

15 In early 2017, the Ministerial Strategic Group for Health and Community Care (MSG) agreed six main indicators to be used as a high level assessment of the progress of Health and Social Care Integration. The MSG requires partnerships to report on these indicators quarterly.

- The MSG indicators will continue to be reported quarterly to the MSG, using the reporting template set by them.

- The same indicators will be reported as indicators E1 – E6 in the mid year and annual performance report.

16 An example calendar of IJB performance reporting in a twelve month period is shown below, (please note, exact timings are subject to when various meetings occur).

Month	**Report**	**Proposed Reporting**	**Then**
November	IJB Mid Year Performance	All information available up to the end of September	To next NHS Board/ NHS Performance Committee **for noting**
March	IJB Locality Performance 1	Locality reporting against first half of 9 national outcomes x 4	Area Committees in May
July	IJB Annual Performance Report	Full financial year across all 9 national outcomes, including all agreed indicators	NHS Board and Full Council **for noting,** Basis of the annual public review
September	IJB Locality Performance 2	Locality reporting against second half of 9 national outcomes x 4	Area Committee in November

17 Robust and appropriate reporting arrangements for the delivery arms of the Integration Board, i.e. the NHS and Council, are also currently being reviewed and revised.

18 The NHS Board currently receives a summary of acute operational activity, known as the ‘At a Glance’ report. The information contained within the ‘At Glance’ Report is currently reviewed at NHS directorate management teams before being submitted to NHS Board. The purpose of the ‘At a Glance’ Report is to support operational level performance management and has particular characteristics.

19 Operational performance information:

- Is provisional management information, with only cursory ‘cleaning’. Data/information may be incomplete and subject to change over time

- Is not analysed or benchmarked to the same level as official statistics

- Can be volatile from one period to the next and subject to seasonal variation, 'jumps' due to small numbers and other influences that get accounted for when producing the cleaned, aggregated national statistics

- Is the most timely information available

20 The information provided for operational performance management will be broadened to reflect activity across all of the Health and Social Care Partnership including acute, mental health, women and children's, community and corporate functions.

- Summary operational information will be produced in the fourth week of each month for the preceding month.

- This information will be approved for circulation by the NHS Chief Executive and/or the Chief Operating Officer.

- Thereafter, the information will be circulated to NHS Management Team, and NHS Board/NHS Performance committee **for any appropriate action**. The information will also be circulated to Health and Social Care Senior Management Team and IJB/Performance and Finance Committee **for discussion and noting.**

- **The information will be circulated to all relevant parties in the same timeframe.**

21 Additional performance reporting in relation to other aspects of NHS or Local Authority operational performance may be produced outwith the proposed calendar of reporting. This could include progress of specific improvement projects, public surveys and actions plans. Circulation of these additional reports to the IJB will be at the discretion of the NHS Board/Local Authority.

Conclusions

23 It is important that we keep the performance framework a living document that is frequently reviewed and revised to ensure its continued fitness for purpose.

24 Whilst all reported performance information is public, it is important to note that the performance information needs of the various Boards/Committees is not the same, as their respective functions (i.e. strategic commissioning body, operational delivery arm) are not the same.

25 Improving the efficiency of performance reporting will release much needed capacity within the performance team thereby helping to ensure that they are able to provide better support for performance management arrangements across all of the Partnership.

Recommendations

26 NHS Board is asked to note and discuss the following points:

- The Annual and Mid Year Reports providing strategic level performance information, replacing the existing quarterly reports

- The content and timing of ‘At A Glance’ performance information contained within ‘At A Glance’ operational report

- The continued quarterly reporting of the Ministerial Strategic Group for Health and Community Care (MSG) to March 2020

- The planned expansion of information contained within ‘At A Glance’ operational performance management reports

Agenda Item 257

DUMFRIES and GALLOWAY NHS BOARD

4th February 2019

Dumfries and Galloway Integration Joint Board Strategic Plan for Health and Social Care 2018 - 2021

Author:
Vicky Freeman
Head of Strategic Planning

Sponsoring Director: Julie White, Chief Operating Officer

Date: 11th January 2019

RECOMMENDATION

The Board is asked **to discuss and note** the following points:

- The Dumfries and Galloway Integration Joint Board Strategic Plan for Health and Social Care 2018 – 2021
- The new relevant period is from 5 April 2018 to 4 April 2021

CONTEXT

Strategy / Policy:

The Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) requires that each integration authority has a strategic plan and that these are subject to a formal review every three years.

Organisational Context / Why is this paper important / Key messages:

All adult primary care, community and Dumfries and Galloway level acute health care services have been delegated to the Integration Joint Board (IJB). The IJB is responsible for the planning and delivery of these services.

At their meeting on 5 April 2018 the IJB decided to retain the current strategic plan therefore the new 'relevant period' is from 5 April 2018 to 4 April 2021.

The IJB agreed to recommendations from the Strategic Planning Group to refresh some of the data and information within the Strategic Plan.

The Strategic Plan has been refreshed and subsequently approved by the IJB at their meeting in November 2018.

GLOSSARY OF TERMS

IJB – Integration Joint Board
SPG – Strategic Planning Group

MONITORING FORM

Policy / Strategy	Public Bodies (Joint Working) (Scotland) Act 2014 Relevant documents and strategies are included within appendix 2 of the Strategic Plan
Staffing Implications	Staffing implications are laid out in detail in a separate integration workforce plan.
Financial Implications	The Strategic Plan includes details of the budget for health and social care in Dumfries and Galloway.
Consultation / Consideration	The Strategic Plan was subject to wide consultation and engagement when it was being developed. The formal review of the Strategic Plan was led by the Strategic Planning Group which has 40 members, with representation from a wide range of partners and stakeholders.
Risk Assessment	The Strategic Plan has been subject to a formal review within the three year relevant period, therefore meeting the legal requirements of the Public Bodies (Joint Working) (Scotland) Act 2014.
Risk Appetite	Low [ ] Medium [ ] High [X] The Strategic Plan sets out the vision for health and social care in Dumfries and Galloway. The business risk category carries a high risk appetite to explore the opportunity for service redesign.
Sustainability	Not applicable
Compliance with Corporate Objectives	The Strategic Plan considers each of the corporate objectives within it.
Local Outcome Improvement Plan (LOIP)	Outcome 3 – Health and wellbeing inequalities are reduced
Best Value	The Strategic Plan addresses vision and leadership; effective partnerships; performance management
Impact Assessment The strategic plan was impact assessed on **8 October 2015**. The summary report is available on the Dumfries and Galloway Council website and can be access by following this link Strategic Plan Impact Assessment. The Dumfries and Galloway Equality Lead advised that this impact assessment remains relevant and does not need to be updated.	

1. Introduction

1.1 After a formal review, as required by The Public Bodies (Joint Working) (Scotland) Act 2014, at its meeting on 5 April 2018, the Integration Joint Board (IJB) decided to retain the current Dumfries and Galloway Integration Joint Board Strategic Plan for Health and Social Care. The IJB also agreed to refresh some of the data and information contained within the plan following the formal review with the Strategic Planning Group (SPG).

1.2 The Strategic Plan has been refreshed and subsequently approved by the IJB at their meeting in November 2018. The refreshed Dumfries and Galloway Integration Joint Board Strategic Plan for Health and Social Care 2018 – 2021 is attached at appendix 1.

2. Background

2.1 The Dumfries and Galloway Integration Joint Board Strategic Plan 2016 – 2019 was developed in consultation with, and listening to, people who use services, their families, Carers, members of the public, people who work in health and social care and the third and independent partner organisations. It sets out the vision of the IJB, the case for change, how we plan to achieve the vision, priority areas of focus and commitments.

2.2 The Public Bodies (Joint Working) (Scotland) Act 2014 places a legislative requirement on integration authorities to review their strategic plans at least once every relevant period. There are two options available to the integration authority:

- Retain the current strategic plan, restarting the relevant period at the date of this decision or
- Replace the strategic plan at the end of the relevant period

2.3 The review must seek and have regard to the views of the integration authority's Strategic Planning Group and have regard to the integration principles and national health and wellbeing outcomes.

3. Main Body of the Report

3.1 At their meeting on 5 April 2018 the IJB decided to retain the current strategic plan therefore the new 'relevant period' is from 5 April 2018 to 4 April 2021.

3.2 The IJB also agreed to recommendations from the Strategic Planning Group to refresh some of the data and information within the Strategic Plan.

3.3 The Strategic Plan has been refreshed and subsequently approved by the IJB at their meeting in November 2018.

4. Conclusions

4.1 The Dumfries and Galloway Integration Joint Board Strategic Plan for Health and Social Care 2018 – 2021 was approved by the IJB at their meeting on 29 November 2018.

4.2 The current relevant period is from 5 April 2018 to 4 April 2021.

DUMFRIES AND GALLOWAY
Integration Joint Board

HEALTH AND SOCIAL CARE
STRATEGIC PLAN
Part 1

DUMFRIES AND GALLOWAY
Health and Social Care

2018 – 2021

Contents

Part 2

The annexes to the strategic plan are provided in part 2, which is a separate document.

www.dg-change.org.uk/Strategic-Plan

If you would like some help understanding this or need it in another format or language please contact 030 33 33 3000

Foreword

The Public Bodies (Joint Working) (Scotland) Act 2014 requires us to join together health and adult social care in Dumfries and Galloway. This creates a single, responsive and flexible health and social care system for the region that delivers better outcomes for those people who need care and support, their families and communities. It also offers us an unprecedented opportunity to work innovatively with the people of Dumfries and Galloway, who are our greatest asset. Together we are working towards our vision:

"Supporting our communities to be the best place to live active, safe and healthy lives by promoting independence, choice and control."

The Public Bodies (Scotland) Act 2014 places a legislative requirement on integration authorities to review their strategic plans at least once in every relevant period (the original relevant period was 2016 - 2019). During 2017/18 a formal review of the strategic plan was undertaken in accordance with the requirements of the Act. On 5 April 2018 the Integration Joint Board made the decision to retain the current strategic plan with minor changes to update some of the supporting information. This includes taking account of new legislation and guidance relating to health and social care. The strategic plan is now relevant until March 2021.

This strategic plan was developed by consulting with, and listening to, people who use services, their families, Carers, members of the public, people who work in health and social care, and third and independent sector partner organisations. It sets out the case for change, priority areas of focus, challenges and opportunities, and our commitments over the next three years.

Taking a people centred approach, with a community focus, that empowers people and provides greater resilience, choice and control, is essential to achieving our vision. This plan provides a framework for people to develop new relationships, new partnerships and new cultures. This in turn will create opportunities for different conversations that lead to innovative solutions that address key challenges such as reducing health inequalities.

I am delighted to be chairing the Integration Joint Board for the region and am looking forward to working with staff, partners, people who use services and the general public to make sure we deliver our shared ambitions.

Penny Halliday

Chair of Dumfries and Galloway Integration Joint Board (IJB)

September 2018

1. Introduction

1.1 What is the integration of health and social care?

The Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) sets a legal framework for integrating (combining) health and social care in Scotland. This legislation says that each health board and council must delegate (transfer) some of its functions to new integration authorities. By doing this, a single system for planning and delivering health and social care services is created locally.

The main purpose of integrating health and social care is to improve the wellbeing of people who use those services, particularly those whose needs are complex and require support from health and social care at the same time.

For people to have the best possible experience and outcomes, care and support needs to be:

- personalised - designed and developed with the person, their family and their Carers (as appropriate)
- regularly reviewed and reshaped to meet the changing needs of a person
- focused on a person's wellbeing
- forward looking – avoiding a crisis management approach
- well coordinated between different sectors and services

"I am at my wits end, struggling to get the support I need and deserve. It was quite difficult to find out where and who to go to. Everything that was needed was in all different departments. Support should be [accessible] in one place instead of going from pillar to post."

The integration authority in this region came into existence in the form of Dumfries and Galloway Integration Joint Board on 1 April 2016. The responsibility for the planning and delivery of the majority of adult health and social care services are delegated from the council and NHS to this new body. (For a detailed list of delegated services, see **Appendix 3**.)

Across Scotland, integration authorities are responsible for delivering a range of nationally agreed outcomes (as set out in section 2.2 of this document). To do this, Integration Joint Boards, along with council and NHS, must strengthen the role of staff, localities, communities, and third and independent sectors.

Integration Joint Boards will make sure that integrated health and social care budgets are used effectively and efficiently to achieve quality and consistency, and to bring about a shift in the balance of care from institutional to community based care. (Institutional based care is defined by the Scottish Government Information Services Division as "hospital based care and all accommodation based social care".)

1.2 Local principles of integration

Local principles of integration for Dumfries and Galloway were agreed some time ago. (Dumfries and Galloway Integration Scheme – see link in **Appendix 2**.)

These include:

- integration must focus on improved health and wellbeing outcomes for local people: quality of care and the needs of the individual are central to how we plan and provide services
- self determination and a commitment to a person centred approach to care are central in our considerations and decisions
- all adult health and social care services, including acute services, will be included from the outset – opportunities to extend integration across other services will be actively explored
- services will be provided at community or locality level wherever possible and we will avoid unnecessary hospital admissions and duplication of professional input
- local GPs must be at the heart of our community and locality services
- clear and robust decision making structures will fully reflect the unique and different roles of the NHS and the local authority, retaining the respective accountability for resources, outcomes and performance and quality of services through a continuing commissioning approach
- the Integration Joint Board will have oversight of the delivery of all commissioned services
- health and social care services in each locality will be accountable to their local communities through the area committees and to the Integration Joint Board
- clear and robust structures will provide for full delegation and empowered decision making
- professional leadership and oversight and practice development should remain with senior professional officers in each organisation

Integrated ways of working are much more than simply joining public sector health and social care staff and services together. Whilst the council and the NHS locally have a long and successful history of working together with partners, we need to be much more proactive in involving people who use services, their Carers and families, and communities, in planning and delivering care and support. The third and independent sectors, and other key providers such as the Scottish Ambulance Service and NHS 24, are also central to providing and maintaining effective care and support.

"Social care ....needs to be chased up then you have to go through whole story again regarding mum's care to different people."

The independent sector is the largest social services employer in Scotland and in Dumfries and Galloway. It has a major role in providing care with most social care services delivered by them. Scottish Care is the umbrella organisation in Scotland that represents the largest group of health and social care sector independent providers.

The third sector in Dumfries and Galloway is made up of a wide range of organisations, some of which are run as social enterprises. The range of services and the opportunities they provide include health, social care and support, information, advocacy and volunteering. Third Sector Dumfries and Galloway is the organisation that acts as the local link for this sector, supporting them to make a lasting contribution to the wellbeing of the people and communities of Dumfries and Galloway.

1.3 What is this strategic plan?

It is an exciting and opportune time in Dumfries and Galloway to plan new ways of working. As well as the integration of health and social care services, we will have a new acute district general hospital by the end of 2017.

This plan sets out the 9 national health and wellbeing outcomes for people that we are seeking to achieve, key challenges for the region, the priority areas of focus for health and social care and our commitments within each of these areas of focus.

In developing the strategic plan and establishing a process for regular review, the Integration Joint Board is supported by a strategic planning group (see **Appendix 1**). This group includes representation from a wide range of people as required by legislation.

This strategic plan is supported by the following documents which are included in part 2 of the plan (**www.dg-change.org.uk/Strategic-Plan**).

Annex 1 - A short summary of the strategic needs assessment	A summary of evidence that sets out the background for integration, with links to the executive summary and the full strategic needs assessment.
Annex 2 - Executive summary of the locality plans for Annandale and Eskdale, Nithsdale, Stewartry and Wigtownshire	A summary of the content of the locality plans with links to the full plan for each locality, setting out how health and social care integration will be taken forward.
Annex 3 - Finance plan	A summary of the overall resources relating to integration, covering the financial years 2015/2016 to 2018/2019.
Annex 4 - Market facilitation plan key messages	A short plan which aims to influence and shape the range of non statutory organisations supporting people and to make sure that there is a wide range of care and support available to achieve the right outcomes for people.
Annex 5 - Performance management framework	A document which describes how we will monitor progress on integration and the achievement of the commitments within the strategic plan.
Annex 6 - Dumfries and Galloway integration scheme	Overview of the local arrangements for integration with a link to the full document.

The planning and policy landscape is complicated. Therefore it is critical that planning and delivery are strongly connected to achieve improved outcomes for local people. This strategic plan aims to build on the learning from previous years and existing good practice.

We have developed the plan using:

- national and local policies and guidance
- learning from a wide range of programmes such as Putting You First
- legislation such as the Self directed Support (Scotland) Act 2013
- external inspections such as the Joint Adult Services Inspection
- the Dumfries and Galloway Single Outcome Agreement (SOA) 2013 – 2016

We have included details and links to some of these in **Appendix 2**

1.4 Who is this plan for?

All adult social care, adult primary care, community and acute health care services, as well as some elements of housing, have been delegated to the Integration Joint Board. A full list of services included in the Integration Joint Board is in **Appendix 3**.

The plan covers adults:

- with long term conditions or disabilities
- who have unpaid caring responsibilities
- who have a degree of vulnerability or are in need of protection
- who need an intensive or acute level of service
- who are experiencing health or social care inequalities (see section 5.8 for more information)

The strategic plan is also for people who are well and want to maintain or improve their current level of health and wellbeing.

In Dumfries and Galloway there is also a Children's Services Plan (see the link in **Appendix 2**).

2. Vision and purpose

2.1 What is our vision and purpose?

This plan is shaped around our vision:

"Supporting our communities to be the best place to live active, safe and healthy lives by promoting independence, choice and control."

2.2 What are we trying to achieve?

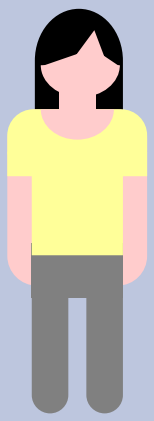
The Scottish Government has set out 9 national health and wellbeing outcomes for people.

- People are able to look after and improve their own health and wellbeing and live in good health for longer
- People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
- People who use health and social care services have positive experiences of those services, and have their dignity respected
- Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
- Health and social care services contribute to reducing health inequalities
- People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing
- People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide
- People using health and social care services are safe from harm
- Resources are used effectively and efficiently in the provision of health and social care services

2.3 Mrs Galloway – before and after integration

Mrs Galloway is a woman who lives in Dumfries and Galloway. She is 48 years old and requires care and support as a result of a range of long term health and social care problems. She has been diagnosed with severe anxiety and depression, high blood pressure, and recently had high blood sugar levels indicating that she may also have type 2 diabetes. Mrs Galloway has a low paid job working at the local supermarket and is a Carer for her profoundly disabled son who also receives support and care from the local authority.

Before integration

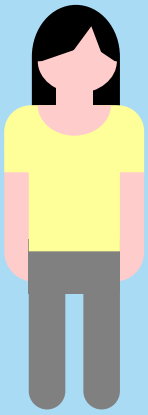


- Uncoordinated care and support
- Very little involvement in decision making
- Lots of travelling to appointments
- Caring role not recognised
- Having to repeat information
- Small social support network
- Falling into crisis

Leading to

- Confusing messages
- Increased anxiety
- Reduced confidence
- Poorer health and wellbeing
- Not feeling listened to
- Feeling overburdened by caring role
- Feeling lonely

After integration



- Coordinated care and support
- Telling the story only once
- Connected to a support network
- Equal partner in decision making
- Care closer to home
- Role as a Carer recognised and supported
- Planning before things become a problem

Leading to

- Improved health and wellbeing
- Reassured that plans are in place
- Increased confidence and self worth
- Feeling involved in care and support
- Feeling involved in the community
- Feeling valued as a Carer

3. The case for change

At a time of rising demand for services, growing public expectations and increasing financial restrictions, it is essential to make sure that community and hospital services work well together. If this does not happen, gaps or weaknesses in one part of the system will have a negative effect elsewhere. For example, where there is an inability to provide an adequate level of care and support at home for someone who needs it, this can result in an unnecessary admission to hospital. Similarly, over reliance on hospital or residential care focuses resources on these areas and away from community services.

The Scottish Government consultation exercise on integration (Integration of Adult Health and Social Care in Scotland: Consultation on Proposals May 2012) highlighted:

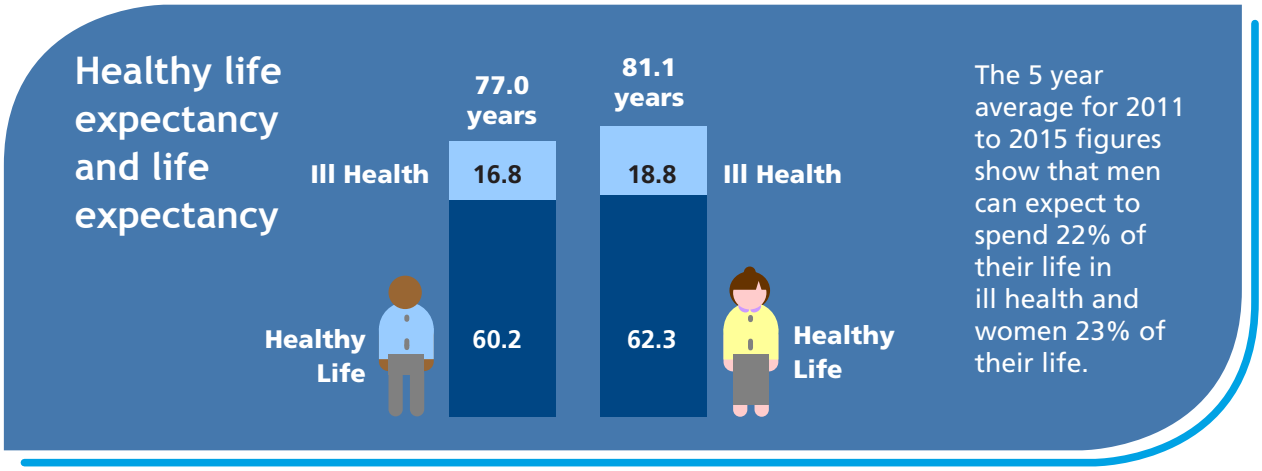
- **inconsistency in the quality of care for people and the support provided to Carers across Scotland, particularly in terms of older people's services**
- **that people are too often unnecessarily delayed in hospital when they are clinically ready to leave**
- **that the services needed to enable people to stay safely at home or in a homely setting are not always available quickly enough, which can lead to unnecessary admissions to hospital**
- **that there is little association between the amount spent on health and social care services and the outcomes achieved**
- **evidence of disjointed care**

There is recognition and acceptance that the existing models for providing care and support are no longer a realistic option. This is based on the evidence from the Scottish Government (see above), the specific local key challenges we have identified in this plan (section 4) and the collection of evidence set out in the strategic needs assessment (**Annex 1**). To address these challenges whilst ensuring that we continue to meet the increasing health and social care needs of our population, we must deliver change now and at a scale and pace that we have never achieved before.

3.1 Demographic change

Demographic (the study of populations) trends in Dumfries and Galloway show that in future, on average, people will be living much longer. This is good news but critically, despite this increase in overall life years, the number of years that people live in good health has not increased.

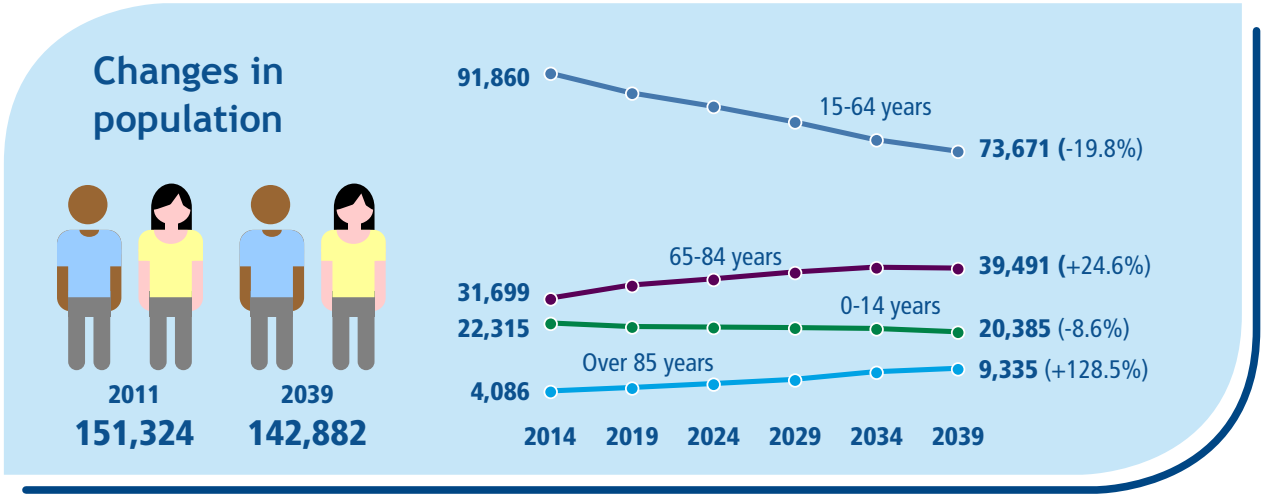
There are approximately 12,500 people in Dumfries and Galloway who are living with 2 or more chronic illnesses, with this increasing by about 300 people every year.



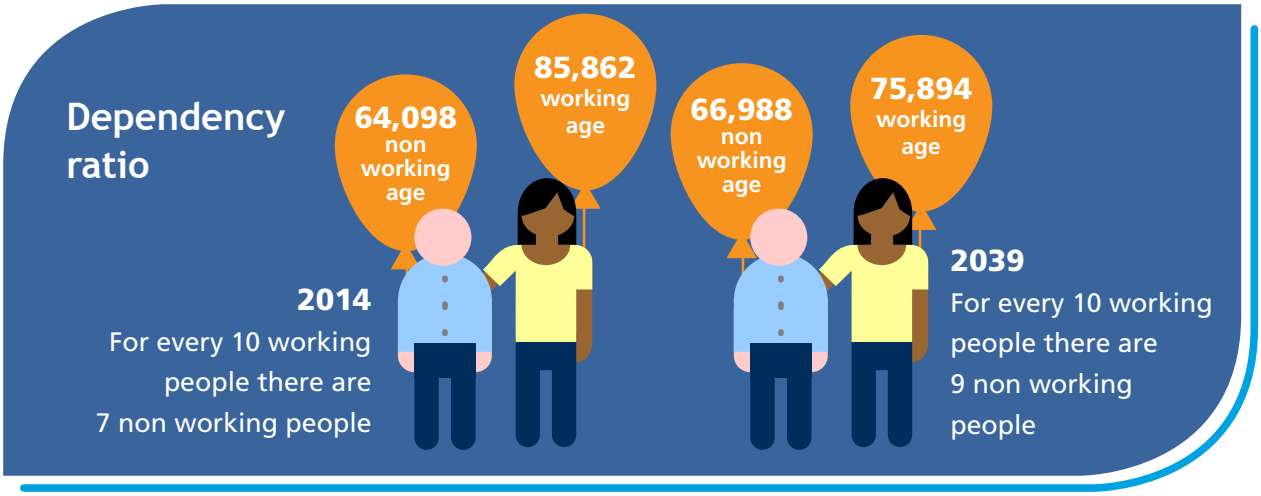
Source: ScotPHO 2011-2015 (Five year average)

Our demographic trends also show that:

- there is estimated to be a reduction in the number of working age people, from 85,900 in 2014 to 75,900 in 2039, resulting in fewer people to work in the health and care sectors
- there will be an increase in the number of people living with two or more long term conditions. This is estimated to be 300 more people per year
- the number of older people (aged 75 and over) living alone is likely to increase dramatically by 2039, from 6,900 in 2014 to 11,300 in 2039
- the number of children aged 0 – 14 years is expected to decrease by 1,900 (8.6%) by 2039. This will have a significant impact on the future workforce.



Source: National Records of Scotland 2014 and Census 2011



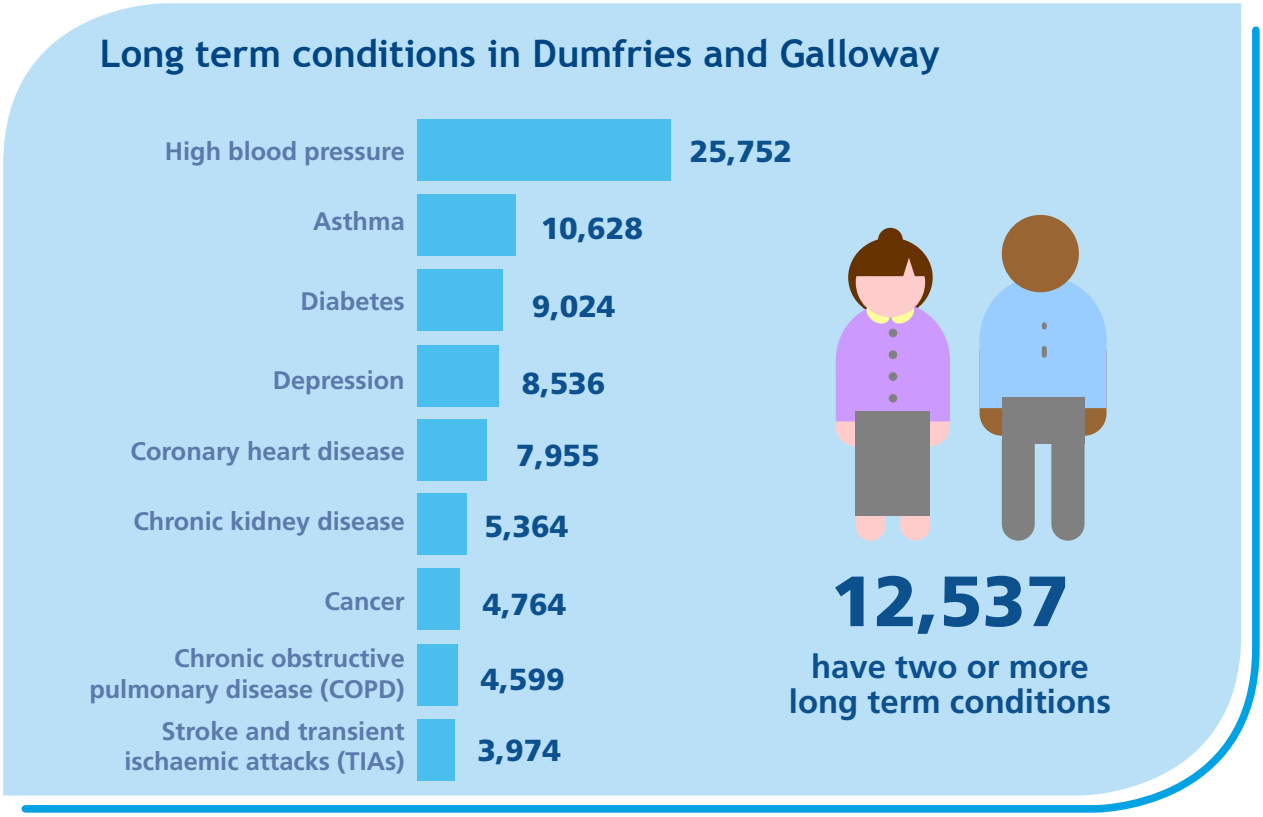
Source: National Records of Scotland 2014 and Census 2011

As a result of this demographic profile, those providing care and support are challenged with balancing increasing levels of need with available capacity.

3.2 Multiple long term conditions

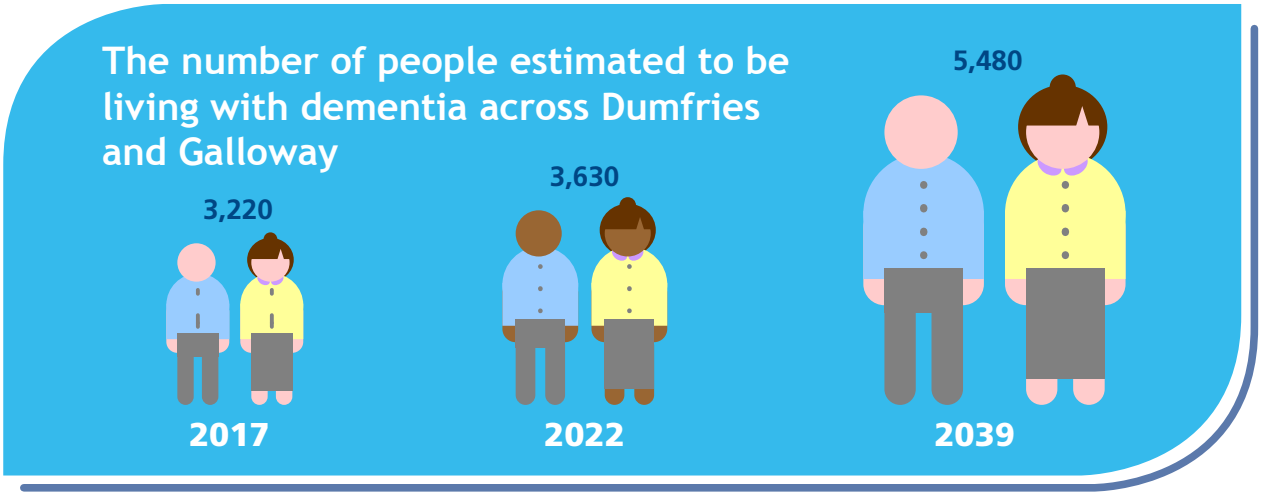
There are growing numbers of people of all ages with long term (sometimes called chronic) conditions such as heart disease, anxiety disorders, lung disease and diabetes. Increasingly, people have more than one long term condition and this can lead to complex and, at times, disjointed care.

Someone who suffers from multiple long term conditions is more likely to be affected by health inequalities than someone who does not. This is made worse if one of the long term conditions is a mental health condition. (Multi morbidity Advice Note 2014 – see link in **Appendix 2.**)



Source: Information Services Division Scotland: Quality and Outcomes Framework 2015/16 and SPARRA

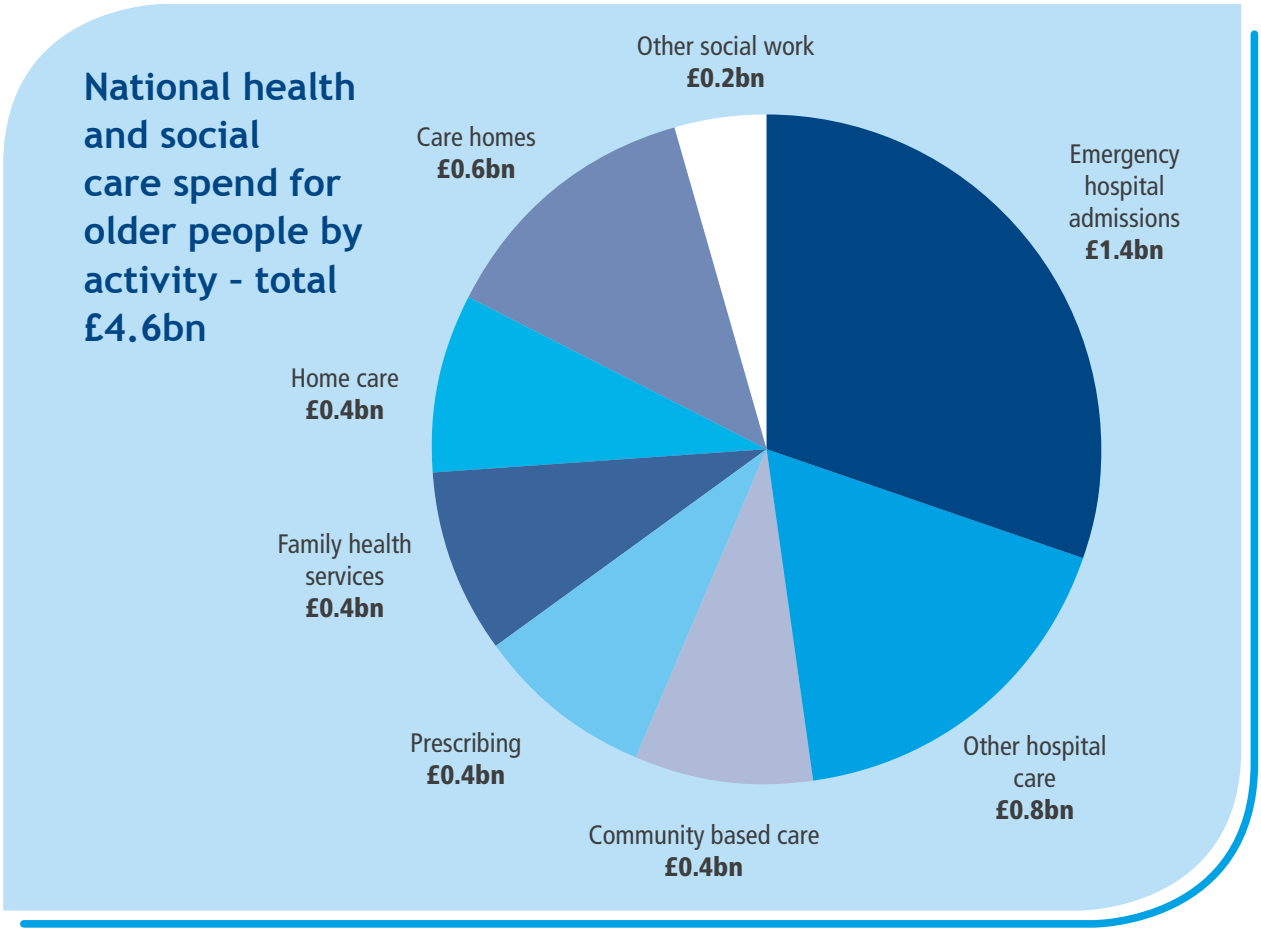
Dementia is a condition strongly associated with age therefore, as the number of older people rises in the population, so too will the number living with dementia.



Sources: EuroCoDe and National Records of Scotland 2014

3.3 Financial background

In Scotland, approximately one third of the budget for health and social care for older people is spent on unplanned emergency activity in acute hospital care. This includes emergency admissions to hospital and unnecessary days spent in hospital due to discharges being delayed.



Sources: Scottish Government

This strategic plan and its associated programmes will have to be delivered within the existing resources available to all partner organisations.

Given the recent announcements made in the draft budget for 2018/19 onwards, the unprecedented scale of the economic challenge facing public services as a whole, as we move toward an integrated health and social care budget, will require a higher level of savings that have previously been delivered in recent times. The expectation is that savings of at least 5% are anticipated for the 2018/19 financial year for Dumfries and Galloway. This is around £15million across the system.

The draft integrated budget for the Dumfries and Galloway Partnership is summarised below.

Combined integrated draft finance plan – 2018 - 2021				
	2017/18 £million	**2018/19 £million**	**2019/20 £million**	**2020/21 £million**
Council services	67.1	71.1	73.8	75.3
NHS services	291.5	273.7	278.0	282.0
Total integrated finance plan	358.6	344.8	351.8	357.3

General Practice prescribing accounts for approximately £30million worth of medicines each year in Dumfries and Galloway

4. Key challenges

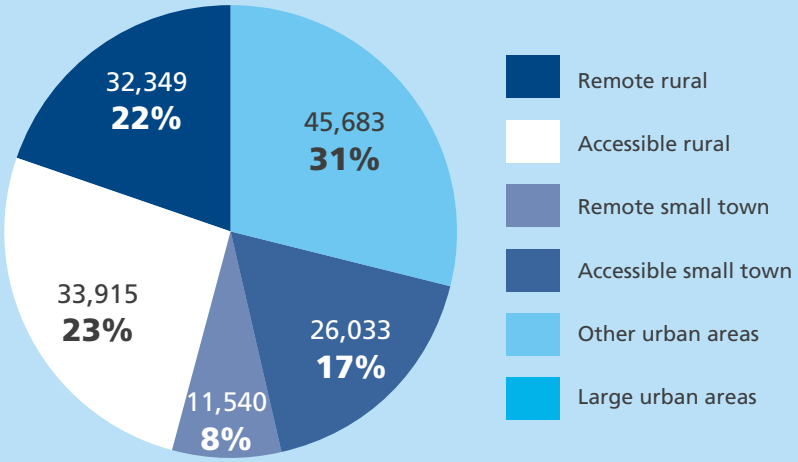
In consultation with all stakeholders, and reflecting the main messages from the strategic needs assessment, we have identified the following key challenges for Dumfries and Galloway in health and social care:

- **health inequalities leading to poorer outcomes for people's health and wellbeing**
- **increasing number of people with multiple long term conditions, including dementia, requiring higher levels of support to enable them to live independently and at home or in a homely setting in the community**
- **projected housing need and demand in areas where people wish to live, creating unsustainable and imbalanced communities**
- **increasing number of Carers requiring greater levels of support to reduce any negative impact of their caring role on their own health and wellbeing**
- **maintaining high quality, safe care and protecting vulnerable adults in the face of increasing need and reducing resources**
- **future sustainability of community based services (including GP, out of hours and care at home services)**
- **fewer people to provide care and support to an increasing number of older people, including in relation to paid and unpaid Carers**
- **national challenges in relation to the recruitment of health and social care staff**
- **present and anticipated rise in hospital admissions and delayed discharges resulting in increased pressures across all of health and social care**

While the rural nature of Dumfries and Galloway brings some advantages and benefits, we recognise that it can also further complicate each of the key challenges noted above. Additionally, rurality can impact on how we provide care and support to a dispersed population efficiently and effectively. Other negative impacts of rurality may include physical and social isolation, loneliness and limited access to suitable transport.

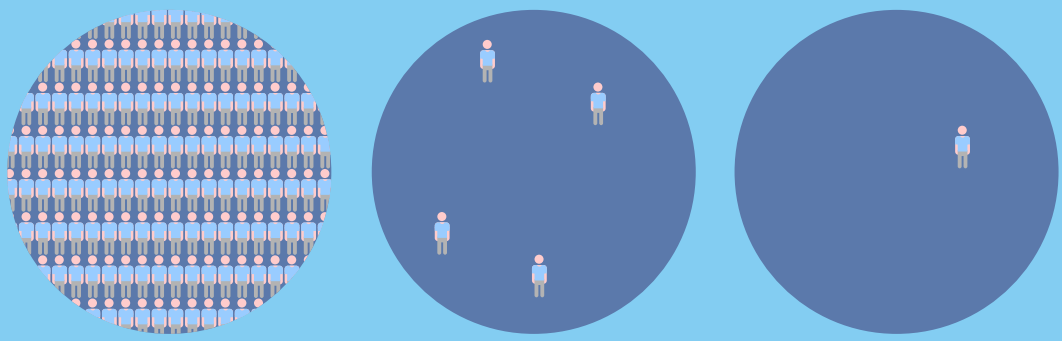
Scottish Government 6 fold urban rural classification	
1 Large urban areas	Settlements of 125,000 or more people.
2 Other urban areas	Settlements of 10,000 to 124,999 people.
3 Accessible small towns	Settlements of 3,000 to 9,999 people and within 30 minutes drive of a settlement of 10,000 or more.
4 Remote small towns	Settlements of 3,000 to 9,999 people and with a drive time of over 30 minutes to a settlement of 10,000 or more.
5 Accessible rural	Areas with a population of less than 3,000 people, and within a 30 minute drive time of a settlement of 10,000 or more.
6 Remote rural	Areas with a population of less than 3,000 people, and with a drive time of over 30 minutes to a settlement of 10,000 or more.

Number of people in Dumfries and Galloway by urban rural classification



Source: Scottish Urban Rural Classification 2016: National Records Scotland Small Area Popluation Estimates 2016

Population density - number of people per hectare (10,000m²)



Source: Census 2011

5. How we plan to achieve our vision

To deliver our vision and the 9 national health and wellbeing outcomes, we need to effectively tackle the key challenges. To do this, we have identified 10 priority areas of focus:

- enabling people to have more choice and control
- supporting Carers
- developing and strengthening communities
- making the most of wellbeing
- maintaining safe, high quality care and protecting vulnerable adults
- shifting the focus from institutional care to home and community based care
- integrated ways of working
- reducing health inequalities
- working efficiently and effectively
- making the best use of technology

In the following section, under each of these areas of focus are a number of commitments (**we will** statements). These commitments will be the basis for measuring how we put this plan into practice, so that we achieve our vision and the 9 national health and wellbeing outcomes.

The commitments are summarised in 5.11, set against the 9 national health and wellbeing outcomes and the 10 local priority areas of focus.

5.1 Enabling people to have more choice and control

We need to enable people to have more choice and control of their lives, drawing on support from their families, friends and communities to make the most of their potential and abilities. New approaches must be much more person centred, with the person being in control of their own care and support and being an equal partner in making decisions about their care.

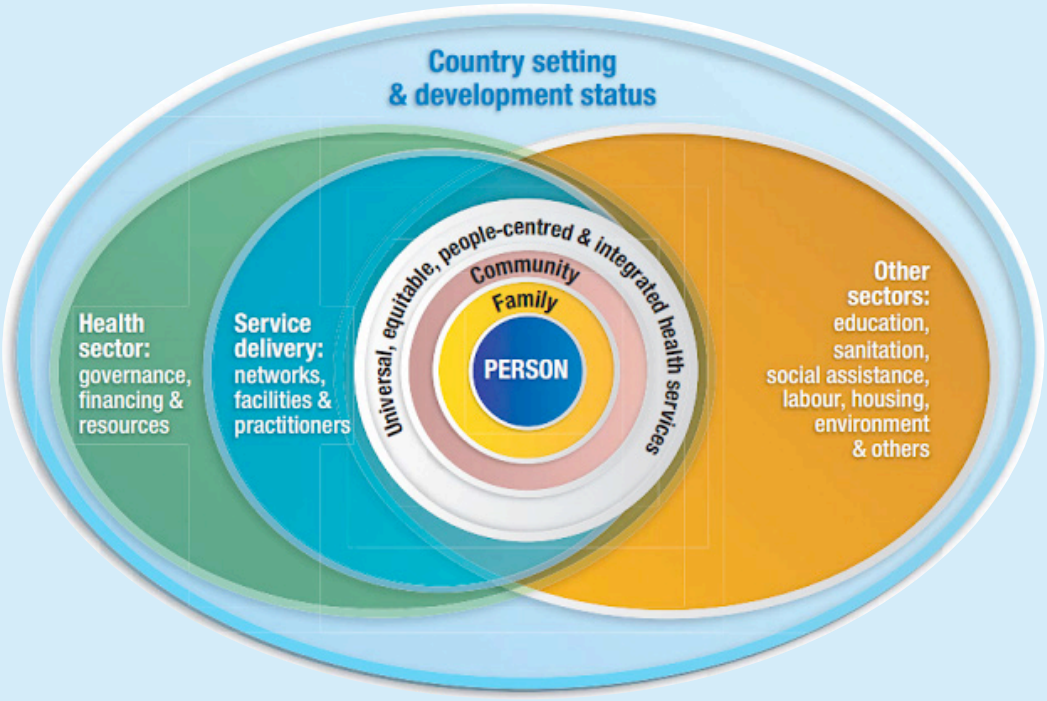
We will enable people, especially vulnerable adults and those important to them, to decide their own personal outcomes.

We will work to overcome barriers to people being involved in their own care.

We will use feedback from people to develop new approaches to delivering outcomes.

This approach of putting the person at the centre is supported internationally as shown in the World Health Organisation diagram below.

Conceptual framework for people centred and integrated health services



World Health Organisation (2015)

Self directed support

The local authority has a duty to offer a choice of 4 options to enable people to decide how their care and support should be delivered.

Option 1 - the person chooses to arrange their support through a direct payment.

Option 2 - the person chooses their support to be managed by someone else.

Option 3 - the person chooses their support to be managed by the local authority.

Option 4 - a mixture of the first three options.

The Social Care (Self directed Support) (Scotland) Act 2013 (see link in **Appendix 2**) puts people in control of the process of asking for care and support through a supported self assessment. This can include professional input to help develop a personal plan with clear outcomes. The plan includes identifying the resources available from the person and their family and community networks, as well as any need for input from health, social work or other agencies to support the achievement of the identified outcomes.

We will develop an online learning tool that enables staff across the Partnership to have a better understanding of self directed support and embed it in practice. (Completed)

Commissioning for outcomes

The Scottish Government defines the strategic commissioning process as analysing, planning, implementing and reviewing what we do. Categorising people into groups such as older people, people with mental health problems, people with physical and sensory impairments or Carers, forms the basis for traditional approaches to commissioning.

We have also generally contracted and monitored services based on levels of activity or inputs. Commissioning for outcomes is central to delivering self directed support as it is based on the benefits a person can get from the appropriate level of good, joined up care and support rather than from the service itself. The approach:

- recognises people have increasing multiple long term conditions and the associated complexity and connections of a range of factors that need to come together to deliver the right outcomes for people
- gives sectors and organisations an incentive to work in an integrated way

We will change the focus of contracting from specifying levels of input activity to delivering health and wellbeing outcomes for people.

"I felt so enabled and empowered by the anaesthetist I saw for my chronic pain that I feel that I can now effectively self manage my own condition."

Self management

Self management is the term used when people make decisions about, and manage, their own health and wellbeing. It means people moving away, or being helped to move away, from passively receiving care to taking a leading and more proactive role. It can apply to people who are healthy and well, those managing their own long term conditions or those who are acutely ill.

To do this, people need to develop their knowledge, skills and confidence to make informed decisions. There are various training programmes that support both people and providers of health and care support. We need to make far better use of the self management models that exist and identify and develop these further.

We will support more people to be able to manage their own conditions, and their health and wellbeing generally.

We will develop, as part of a Scottish Government initiative, online access to information and tools that give people the power to take responsibility for their own care.

Independent advocacy

We are committed to ensuring that there is support available to safeguard people who are:

- at risk
- in situations where they may be vulnerable
- unable to speak up for themselves
- in need of help to express their views and make their own decisions and contributions

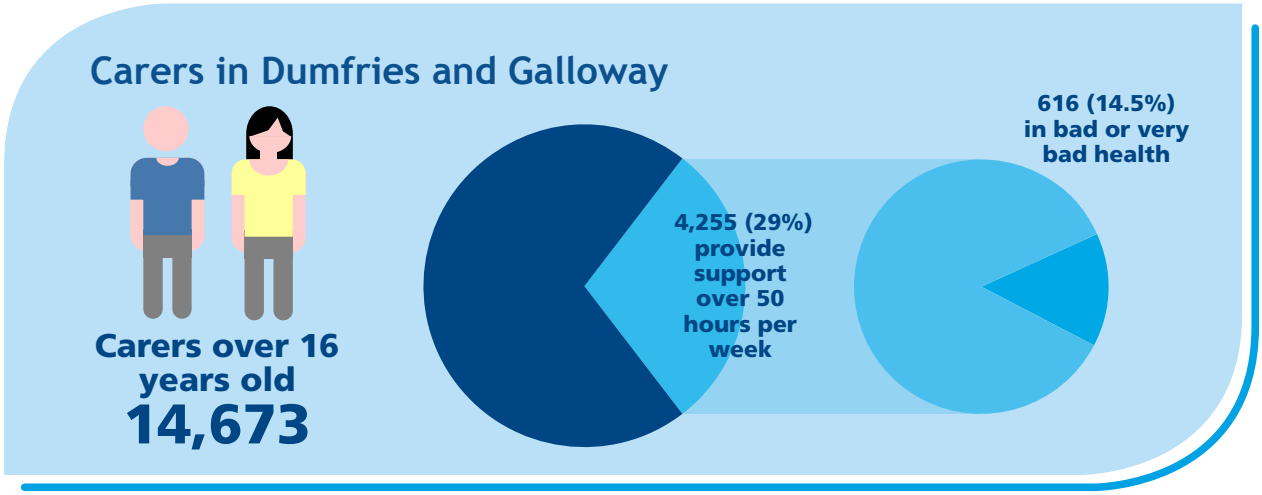
We will make sure that people have access to independent advocacy if they want or need help to express their views and preferences.

5.2 Supporting Carers

As the responsibility for delivering care falls ever more on unpaid Carers (i.e. families, friends, partner or significant other and neighbours), providing support to Carers becomes an increasing local and national priority. They are the largest group of care providers in Scotland, providing more care than the NHS and council combined.

A Carer is generally defined as a person of any age who provides unpaid help and support to someone who cannot manage to live independently without the Carer's help due to frailty, illness, disability or addiction. The term Adult Carer refers to anyone over the age of 16, but within this group those aged 16 – 24 are identified as Young Adult Carers.

At the 2011 census, 10% of the population of Dumfries and Galloway identified themselves as Carers (14,995 – this includes children who are Carers).



Source: Census 2011

The current Dumfries and Galloway Carers Strategy (see link in **Appendix 2**) was developed in consultation with local Carers. It outlines the overarching themes and priorities for Carers and sets out a local plan for action.

Equal Partners in Care (EPiC – see link in **Appendix 2**) provides training resources for staff on involving Carers in the planning and decision making processes for the person they care for.

The Carers (Scotland) Act 2016 (see link in **Appendix 2**) states that Carers should be better supported on a consistent basis so they can continue to care (if this is what they want) in good health and wellbeing, and have a life alongside of caring. How we achieve this is detailed within the Dumfries and Galloway Carers Strategy 2017 - 2021.

The provision of short breaks is one way in which Carers can be supported in their caring role. Short breaks are breaks from routine and can be time spent apart or together with extra support. Respite is the positive outcome of the short break and should benefit both the person being cared for and their Carer, supporting their relationship and offering opportunities and experiences.

"It's good to know that there are people looking out for you and your health as people like myself are sometimes too busy looking after everyone else and tend to forget about ourselves."

Short breaks are usually arranged on a planned basis but can also be a means of providing immediate support in a crisis situation. However, a preventative, forward looking plan to avoid crisis situations should be the approach used.

We are committed to creating a supportive working environment for Carers within the Dumfries and Galloway Partnership. Carer Positive is an award for employers in Scotland who achieve this.

We will provide support to Carers (including the provision of short breaks) so that they can continue to care, if they so wish, in better health and have a life alongside caring.

We will develop a consistent approach across the workforce to make sure that the needs of the Carer are identified and that Carers are supported in their own right.

We will work towards developing Carer Positive as an approach across the Partnership, identifying staff who are Carers and supporting them in their own personal caring roles.

5.3 Developing and strengthening communities

The physical, mental and social wellbeing of the local population is greatly influenced by issues such as deprivation, employment, education, housing and the environment. There is evidence that using low level community and social supports can greatly increase a person's potential to better manage their health, live well in their homes and communities for longer, and reduce loneliness.

Identifying and making best use of the assets and resources that exist at both an individual and community level is therefore a valuable starting point to do this. Assets can be individuals, families, communities, knowledge, skills, buildings, groups or money. There is a real willingness and enthusiasm within communities, community planning partners and the third and independent sectors to support this asset based approach.

The value of volunteers to communities is well documented, as are the benefits of volunteering to the individual. There is evidence that volunteering can improve wellbeing, increase confidence and strengthen someone's links with their community.

This way of working encourages real partnerships which mean listening to what people say they need and what would make a difference. It also means involving people in decision making, so that they can be in control rather than passively receiving services.

We know that to work effectively with communities:

- requires a significant investment of time and resources
- needs to be maintained over the longer term
- requires a specific set of skills

We will work with people to identify and make best use of assets to build community strength and resilience.

We will actively promote, develop and support volunteering opportunities.

We will strengthen public involvement at all levels of planning health and social care and support.

5.4 Making the most of wellbeing

Making the most of and maintaining health and wellbeing is always better than treating illness. Where possible the aim is to prevent ill health or, where health or social care needs are identified, to make sure there are appropriate levels of planning and support to prevent further deterioration.

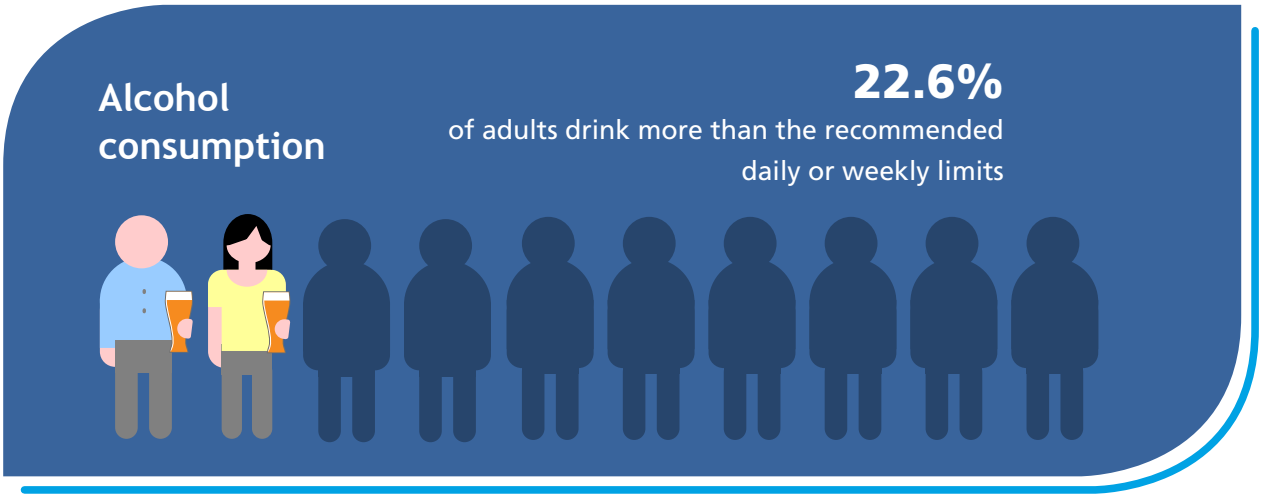
A proactive approach is required to achieve this aim, including:

- action from an early age and across the whole of a person's life
- an awareness of the potential impacts of physical, spiritual, psychological and social influences on a person's wellbeing
- identification of issues that can impact negatively on a person's overall wellbeing such as loneliness, isolation, financial poverty

We will support people to lead healthier lives.

We will provide opportunities and support for people to develop and review their own forward looking care and support plans.

We will work to identify people who have an increased risk of reaching crisis and take early steps to avoid this.



Source: ScotPho 2015 - Dumfries and Galloway Health Board Alcohol Profile

5.5 Maintaining safe, high quality care and protecting vulnerable adults

Adult support and protection

All adults have the right to live free from physical, sexual, psychological or emotional, financial or material neglect and failure to act, discriminatory harm or abuse. This is a key priority for the Integration Joint Board.

National policy to protect people has moved forwards significantly over the last 10 to 20 years with new laws for adults with incapacity, mental health care and treatment and, most recently, adult support and protection (see link in **Appendix 2**).

"We in D and G need a safe place to take our [partners with dementia] when things become frantic, especially in the evenings."

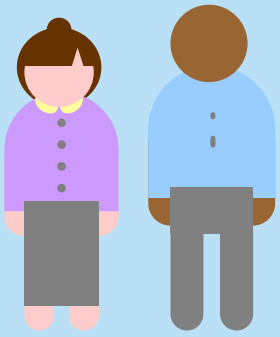
Under the Adult Support and Protection (Scotland) Act 2007, public sectors have a duty to report concerns relating to adults at risk and the council must take action to find out about and, where necessary, intervene to make sure vulnerable adults are protected.

The necessary procedures and frameworks to deliver this are in place. However, these need further development and are being reviewed and monitored through the Adult Protection Committee. Key partners are fully aware of their shared responsibility in the protection of vulnerable adults.

We will make sure that all staff can identify, understand, assess and respond to adults at risk.

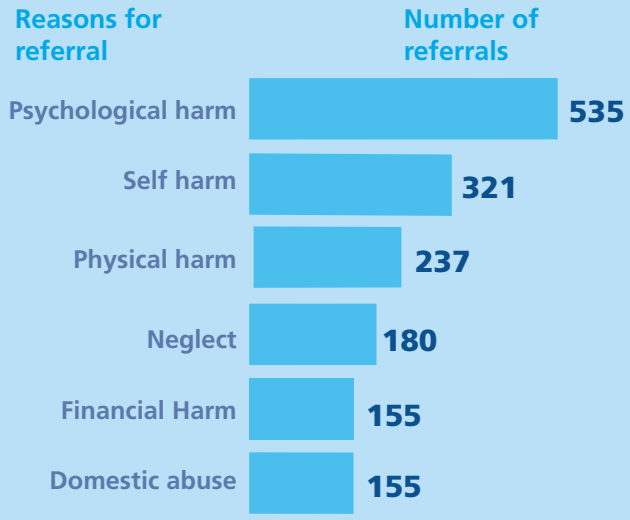
We will support the provision of a Multi Agency Safeguarding Hub to ensure a joined up approach in terms of identifying, sharing information about and responding to adults at risk of harm. (Completed)

Adult support and protection



2,211

adults were referred to the adult support and protection team in 2016/17



Other types of harm recorded include: institutional, discriminatory, human rights, sexual.

People may have been referred for more than one type of harm.

Source: Dumfries and Galloway Council

Patient safety programme

There are a number of programmes aiming to reduce the risk of harm to people. The Scottish Patient Safety Programme (SPSP), launched in 2008, is one of these. While at first this programme was focused on acute (hospital based) care, it now includes:

- acute adult care
- maternity and children's care
- mental health care
- primary care

We will make care as safe as possible and identify opportunities to reduce harm.

5.6 Shifting the focus from institutional care to home and community based care

Developing new models of care and support

New models of care and support should reflect and promote the shift towards greater choice and control for people and make a positive difference to their outcomes. As a result, it is crucial that people who use services, and their Carers and families, are involved in designing them.

To achieve positive differences we need to develop clinical and care pathways that:

- shift the point where care is delivered from institutions to home and community based settings
- shift responsibility for managing and delivering care towards people and their communities
- shift care and support from managing crises to preventing them in the first place and taking action early

The Scottish Government recognises health and social care partnerships as the main way through which these shifts will happen.

In Dumfries and Galloway, emergency admissions to hospital for people aged 85+ have gone up 22% over the last seven years (1,600 in 2009/10 to 1,950 in 2015/16)

Options for tackling this include developing new models of delivering care such as:

- consultants supporting community based, multi disciplinary teams
- developing advanced practitioner roles for nurses and allied health professionals
- identifying more appropriate pathways of care for people who do not require an acute level of care but are not quite fit enough to return home
- adopting reablement approaches, this means supporting people to achieve their best possible level of independence

We will adopt reablement as both a first approach and as an ongoing model of care and support.

We will deliver healthcare within community settings as the norm and only deliver it within the district general hospital when clinically necessary.

Source: NHS Dumfries and Galloway

Care at home and care homes

Care at home (personal care provided by a paid carer in someone's own home) and care homes (residential care homes and/or nursing homes) are critically important resources within the current delivery of health and social care.

In Dumfries and Galloway, around 900 people aged over 65 receive 10 or more hours of care at home per week.

The challenge is to make sure that appropriate levels of care and support are available and sustainable to meet increasing needs within existing resources. To achieve this, a programme of work involving all 4 sectors has been set up to review both care at home and care homes across the region.

In moving forward it is essential that:

- care providers are supported to be innovative, to collaboratively develop new models of care and to work in new ways with partners
- workforce recruitment and retention challenges are addressed

"Care homes and older people's services are often not even aware of the existence of LGBT older adults, far less their needs."

We will work with providers to support them to pay the national living wage.

We will identify with partners and people who use services, models of care at home and care home provision that deliver improved outcomes for people.

Housing

Housing is critical to the success and continued sustainability of health and social care and support.

Certain limited aspects relating to housing are within the scope of health and social care integration, for example Care and Repair. However, the broader aspects of the housing sector also provide a significant contribution to the national outcomes for health and wellbeing, including helping people to stay in their own homes. These include:

- information and advice on housing options
- low level preventative services
- housing support based on an individual assessment of need
- physical adaptations to properties
- investment in new affordable homes
- involving tenants in a range of community based activities
- services to homeless people

A new housing need and demand assessment will feed directly into a future update of the strategic needs assessment (see Annex 1) and will be the evidence base for the new local housing strategy. It is likely this work will result in opportunities to redesign sheltered and very sheltered housing and develop a range of intermediate care options.

The council has recently established a new lifetime homes fund from council tax second homes income. This will provide additional funding to housing associations in the region to build a percentage of all new housing to an enhanced specification with a more flexible design to support people with particular needs. This will avoid the need for retro fit solutions after the homes have been let.

We will combine the information from the housing need and demand assessment with the strategic needs assessment to help us with planning.

We will develop housing related services and new affordable housing that is designed to reduce both unplanned admissions to hospital and the number of people unnecessarily delayed in hospital.

A housing contribution statement has been developed (see link in **Appendix 2**).

5.7 Integrated ways of working

A skilled and motivated workforce across health and social care is critical to delivering national and local outcomes. Our aim is that integrated ways of working will value and recognise the contribution of all staff, provide opportunities for developing careers and roles, and support people in developing creative solutions.

We will achieve new, effective integrated models of care by supporting and helping our collective workforce, and their representatives, to develop and work together in integrated ways. This will be supported further by improving social enterprise, volunteering and commissioning based on outcomes.

It is important that we acknowledge and accept that different cultures exist within each sector (council, NHS, third and independent sectors) and that there are minicultures within each of the cultures. It helps us to develop our understanding and to respect each other's values and beliefs. The diversity of these cultures brings opportunities offering new and different viewpoints and a more multi dimensional view of what we are trying to achieve. However, diversity also brings challenges that can act as barriers to integrated ways of working.

By challenging these barriers we will work towards achieving:

- a healthy organisational culture
- a sustainable workforce
- a capable and empowered workforce
- an integrated workforce
- effective leadership with a focus on:
  - cross sector working
  - using approaches that are driven by values
  - honest dialogue
  - strengthening management
  - leading teams and involving people

We will support staff to be informed, involved and motivated to achieve national and local outcomes.

We will involve staff to develop a new culture that promotes different ways of working for the future.

We will provide opportunities for staff, volunteers, Carers and people who use services to learn together.

Integrated workforce plan

An integrated workforce plan for the integrated services across all sectors will help to make sure that we have the right people with the right skills in the right place at the right time. A successfully integrated workforce will need leaders locally to commit to a shared ambition, shared goals and who support staff to work across role, geographical or organisational boundaries.

New roles will emerge as service models change, and this will mean building on existing skills and developing new ones for our current workforce and new staff.

To develop this, we will need a combination of:

- workforce information – a challenge is collecting and sharing information across all sectors
- workforce planning – we need to take account of current and future demand, local demographics, the local and national job market and available budget
- workforce development activities – we need to explore how to do things differently and give staff adequate and appropriate skills to deliver new models of care and support

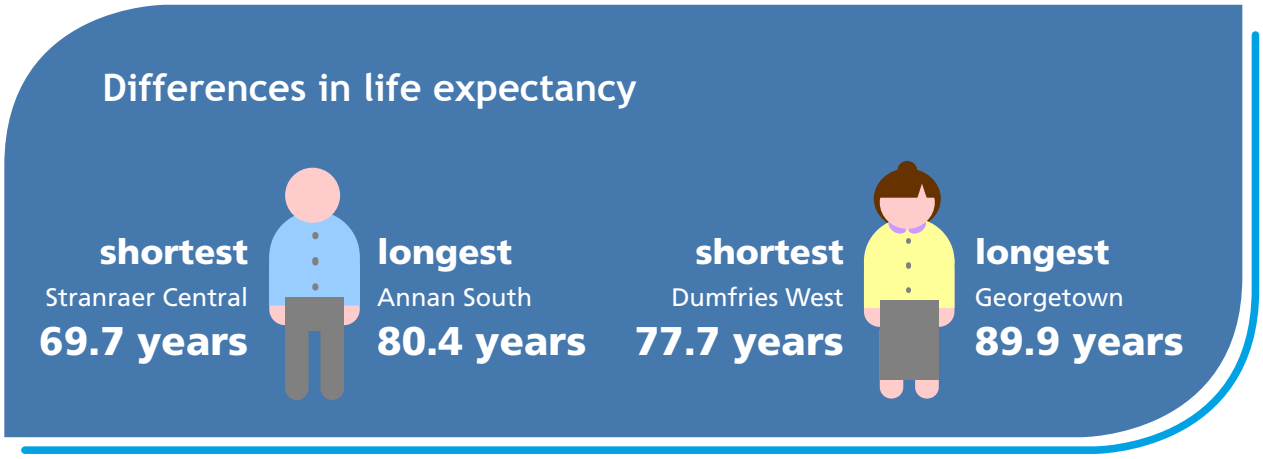
We will develop a plan that describes and shapes our future workforce across all sectors. (Completed)

We will aim to be the best place to work in Scotland.

5.8 Reducing health inequalities

Health inequalities are unjust differences in health outcomes experienced by people. These can arise from the circumstances in which people live, the long term conditions that they have (see section 3.2) and the opportunities they have for health and social wellbeing. People from minority communities or with protected characteristics (including religion or belief, race or disability) especially may experience health inequalities, for example in accessing care and support.

There is a range of factors that contribute to health inequalities including poverty. Reducing health inequalities involves action on the broader social issues that can affect a person's health, including education, housing, loneliness and isolation, employment and income. Wellbeing will not be achieved by focusing only on improving the health of individuals.



Source: ScotPHO Profiles 2015. Gretna and Canonbie are excluded due to errors in collecting cross border data.

Health and social inequalities must be considered in the planning stages of services and programmes to make the most of their potential for contributing to reducing inequalities. There is already effective partnership working to tackle inequalities through specific action contained in the Single Outcome Agreement and Dumfries and Galloway Anti Poverty Strategy (see link in **Appendix 2**).

It is important that services are designed and delivered in a way that enables those most in need to have easy access. It is this approach, at both a strategic and locality level, which will lead to healthier adults, able to live fulfilling and independent lives.

As well as focusing specifically on health and social care for adults, programmes of work will need to be delivered to improve the health and wellbeing of children and young people to make sure they grow into healthy adults - see link to Dumfries and Galloway Children's Services Plan in **Appendix 2**.

"Although outcomes are generally improving for most people in Scotland they are not improving fast enough for the poorest and most disadvantaged sections of our society, nor for those who face barriers because of their race, gender, age, disability, sexual orientation or religion or belief."

We will reduce, as far as possible, the effect of social and economic inequalities on access to health and social care.

We will share learning about health and social care inequalities, including their causes and consequences, and use this information to drive change.

We will develop a health inequalities action framework aimed at reducing health inequalities. (Completed)

5.9 Working efficiently and effectively

Innovation

Innovation is one of the 12 priority areas of action in A Route Map to the 2020 Vision (see link in **Appendix 2**) for achieving high quality long term health and social care.

The Institute for Research and Innovation in Social Services (IRISS) develops and promotes the use of tools and techniques to help strengthen evidence and innovation in social services (see link in **Appendix 2**).

The Scottish Health Technologies Group (SHTG) provides advice on the evidence about the clinical and cost effectiveness of existing and new technologies likely to have significant implications for care and support in Scotland (see link in **Appendix 2**).

The above will support us to deliver innovative practice, (that contributes to the development of a body of evidence), support research and use new and creative ideas, products and models of care.

We will measure performance against good practice from elsewhere, and encourage and support new ideas locally.

We will support staff and partners to develop new and better ways to provide health and social care, to reduce duplication and increase efficiency.

Clinical and service change programme

This programme will manage and put into practice the changes needed to deliver the benefits from the move to a new district general hospital in Dumfries and Galloway in December 2017. This work will contribute to the achievement of good health and social care outcomes for people.

As we move towards fuller integration, we will face difficult decisions about agreeing how services will function in the future. We will need to invest more in some areas and less in others to deliver the most effective and efficient services which match the themes and priorities in this plan. This should take account of the new approaches discussed in section 5.6.

We will make sure that effective and sustainable models of care are tested and implemented prior to transition from the current DGRI to the new district general hospital. (Completed)

We will ensure that there is good linkage between work relating to the new hospital project and community based health and social care. (Completed)

Tackling variation

Variation is the term used to describe the differences in practice, outcome or costs that cannot be explained on the basis of need, evidence or preference. Organisations use this to be more efficient and effective as part of redesigning and improving services. The main aim is to reduce bad variation while protecting the good variation that makes care person centred, safe and high quality.

We will reduce variation in practice, outcomes and costs which cannot be justified.

During 2016/17 the average cost of prescribing for each person who received at least one prescription that year ranged across GP practices from £137 to £277.

Buildings, land, equipment and vehicles

"Pharmacies are a wonderful local resource: They need to be promoted more."

The council and the NHS have significant physical assets in buildings, land, equipment and vehicles.

We need to make more effective use of these and existing wider community assets such as opticians, care homes, sheltered housing and pharmacies. This will support the focus of delivering care closer to home by making careful decisions about where to invest and where to reduce or withdraw investment. These decisions will need to consider the use of space, environmental sustainability, reducing our carbon footprint and improving the experience of people who use services (see link in **Appendix 2**).

We will develop a plan to make sure we use physical assets such as buildings and land more efficiently and effectively. (Completed)

We will make sure that physical assets used by the Integration Joint Board are safe, secure and high quality and, where appropriate promote health and wellbeing.

5.10 Making the best use of technology

"Sometimes I need to see the GP but can't get an appointment they say I should phone at 8am, but I need someone to help me phone, and my support workers are not here at that time in the morning."

Using technology to help achieve our aims is a basic building block to delivering the 20:20 vision for Scotland (see link in **Appendix 2**). In the future, the vast majority of care and support will be provided in community settings. Developing and delivering information and communication technologies and a programme of Technology Enabled Care (TEC) is critical to achieving seamless and sustainable care and support across the entire health and social care spectrum.

Information and communication technology (ICT)

Enabling greater access to real time, relevant information and improving communication between partners is the purpose of developing information and communication technologies. In Dumfries and Galloway this will focus on:

- helping embed forward looking care across the region
- enabling the sharing of care and support plans appropriately
- providing easier access to clinical and social care information
- supporting people to manage their own care online

We will deliver a single system that enables public sector staff to access or update relevant information electronically.

Technology enabled care

Technology enabled care is the use of a range of digital and mobile technologies to deliver health and social care and support at a distance. This can include:

- gathering and sending a person's physiological measurements from their home for clinical review and early action. This is known as home remote health monitoring
- the use of digital technologies to enable supported self management
- teleconsultations where technology such as email, phone, video conferencing, digital imaging, websites and digital television are used to support consultations between someone and their health or social care professional
- personal alarms, devices and sensors in the home including monitors for daily activity patterns such as safer walking in the community for people with mental or physical conditions, detecting falls and/or epilepsy seizures and medication reminders

"Patients in this area have to travel 120 miles round trip to Dumfries for maybe a five minute interview with a doctor."

We will introduce and embed a programme of technology enabled care that supports the development of new models of care and support and new ways of working.

5.11 Summary table

This summary sets out:

- the 9 national health and wellbeing outcomes
- the priority areas of focus as they relate to one or more national health and wellbeing outcomes
- our commitments – the we will statements – as they relate to the 10 priority areas of focus and the 9 national health and wellbeing outcomes

The commitments are the basis of measuring how we are putting this plan into action and therefore the progress towards achieving our vision and the 9 national health and wellbeing outcomes. The measures, where available, against each of the commitments are shown in the performance management framework in **Annex 5**. **www.dg-change.org.uk/Strategic-Plan**

We have to deliver the strategic plan, and its associated programmes, including the commitments, within the resources we have available.

Summary table

National outcome	Priority areas of focus	Our commitments
People are able to look after and improve their own health and wellbeing and live in good health for longer.	Enabling people to have more choice and control Making the most of wellbeing	• We will support more people to be able to manage their own conditions, and their health and wellbeing generally. • We will develop, as part of a Scottish Government initiative, online access to information and tools to give people the power to take responsibility for their own care. • We will support people to lead healthier lives.
People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.	Developing and strengthening communities Making the most of wellbeing Shifting the focus from institutional care to home and community based services	• We will work with people to identify and make best use of assets to build community strength and resilience. • We will work to identify people who have an increased risk of reaching crisis and take early steps to avoid this. • We will deliver healthcare within community settings as the norm and only deliver it within the district general hospital when clinically necessary. • We will adopt reablement as both a first approach and as an ongoing model of care and support. • We will combine the information from the housing need and demand assessment with the strategic needs assessment to help us with planning. • We will develop housing related services and new affordable housing that is designed to reduce both unplanned admissions to hospital and the number of people unnecessarily delayed in hospital. • We will actively promote, develop and support volunteering opportunities. • We will strengthen public involvement at all levels of planning health and social care and support. • We will work with providers to support them to pay the national living wage.

Summary table

National outcome	Priority areas of focus	Our commitments
People who use health and social care services have positive experiences of those services, and have their dignity respected.	Enabling people to have more choice and control Maintaining safe, high quality care and protecting vulnerable adults Working effectively and efficiently	• We will use feedback from people to develop new approaches to delivering outcomes. • We will work to overcome barriers to people being involved in their own care. • We will make sure that people have access to independent advocacy if they want or need help to express their views and preferences. • We will make sure that effective and sustainable models of care are tested and implemented prior to transition from the current DGRI to the new district general hospital. • We will make sure that physical assets used by the Integration Joint Board are safe, secure and high quality and, where appropriate, promote health and wellbeing. • We will support the provision of a Multi Agency Safeguarding Hub to ensure a joined up approach in terms of identifying, sharing information about and responding to adults at risk of harm.
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	Enabling people to have more choice and control Making the most of wellbeing Working effectively and efficiently	• We will enable people, especially vulnerable adults and those important to them, to decide their own personal outcomes. • We will change the focus of contracting from specifying levels of input activity to delivering health and wellbeing outcomes for people. • We will provide opportunities and support for people to develop and review their own forward looking care and support plans. • We will measure performance against good practice from elsewhere and encourage and support new ideas locally. • We will develop an online learning tool that enables staff across the Partnership to have a better understanding of self directed support and embed it in practice.

Summary table

National outcome	Priority areas of focus	Our commitments
Health and social care services contribute to reducing health inequalities.	Reducing health inequalities	• We will reduce, as far as possible, the effect of social and economic inequalities on access to health and social care. • We will share learning about health and social care inequalities, including their causes and consequences, and use this information to drive change. • We will develop a health inequalities action framework aimed at reducing health inequalities.
People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.	Supporting Carers	• We will develop a consistent approach across the workforce to make sure that the needs of the Carer are identified and that Carers are supported in their own right. • We will work towards developing Carer Positive as an approach across the Partnership, identifying staff who are Carers and supporting them in their own personal caring roles. • We will provide support to Carers (including the provision of short breaks) so that they can continue to care, if they so wish, in better health and have a life alongside caring.
People using health and social care services are safe from harm.	Maintaining safe, high quality care and protect vulnerable adults Working effectively and efficiently	• We will make care as safe as possible and identify opportunities to reduce harm. • We will make sure that all staff can identify, understand, assess and respond to adults at risk.

Summary table

National outcome	Priority areas of focus	Our commitments
People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	Integrated ways of working Making the best use of technology	• We will support staff to be informed, involved and motivated to achieve national and local outcomes. • We will develop a plan that describes and shapes our future workforce across all sectors. • We will provide opportunities for staff, volunteers, Carers and people who use services to learn together. • We will aim to be the best place to work in Scotland. • We will deliver a single system that enables public sector staff to access or update relevant information electronically.
Resources are used effectively and efficiently in the provision of health and social care services.	Integrated ways of working Working effectively and efficiently Shifting the focus from institutional care to home and community based services Making the best use of technology	• We will involve staff to develop a new culture that promotes different ways of working for the future. • We will reduce variation in practice, outcomes and costs which cannot be justified. • We will develop a plan to make sure we use physical assets, such as buildings and land, more efficiently and effectively. • We will identify with partners and people who use services, models of care at home and care home provision that deliver improved outcomes for people. • We will introduce and embed a programme of technology enabled care that supports the development of new models of care and new ways of working. • We will support staff and partners to develop new and better ways to provide health and social care, to reduce duplication and increase efficiency. • We will ensure that there is good linkage between work relating to the new hospital project and community based health and social care.

6. Good governance and evaluating the strategic plan

Dumfries and Galloway Integration Joint Board, are an organisation which must answer to the public for our actions. We will continue to involve all our stakeholders and partners to put the changes described within this plan into practice and it will make information on our progress available to the public.

The governance arrangements for the Integration Joint Board are described in the Dumfries and Galloway Integration Scheme (see link in **Appendix 2**).

The 9 national health and wellbeing outcomes will form the basis of how we are measured for the new Partnership. The Integration Joint Board will be responsible for delivering the outcomes.

We will support the outcomes using certain measures to assess our progress, alongside a wide range of pre existing performance measures. These measures will form part of our yearly reporting on our performance, required by the act, along with other information.

For details of performance measures and outcome measures, see the performance management framework in part 2 **Annex 5**.

Glossary of terms

Allied health professional (AHP)

Professionals related to healthcare distinct from nursing, medicine and pharmacy. Examples include podiatrists, physiotherapists, occupational therapists and speech and language therapists.

Anticipatory care

A term used to describe an approach whereby actual or potential care and support needs of someone are predicted. By doing this, steps can be taken much earlier to minimise or avoid altogether the impacts of these. (See also forward looking care).

Asset based approach

Identifying and making best use of all the resources that exist at both an individual and community level.

Care and support plan

An agreed document between the person and their health and/or social care professional that identifies and records discussion with regard to personal aims and outcomes, needs, risk and any required action. It can be electronically stored or written on paper and accessible to the person.

Carer

Someone who provides unpaid care and support to a family member, neighbour or a friend.

Chief Officer

The lead manager of the Integration Joint Board with responsibility for the delivery of services within allocated resources.

Delayed discharges

A term used to describe an incidence whereby someone clinically ready for discharge cannot leave hospital because care, support or accommodation they require is not available.

Dementia

An umbrella term used to describe symptoms affecting the brain. These can include memory loss, problem solving or more general difficulties with thinking.

Demographic

Demography is the science of human populations – their size, how they are made up and distribution – and the process through which populations change.

Digital technologies

Electronic tools, systems and devices including social media, applications, systems that work together and mobile devices.

Forward looking care

A term used to describe an approach whereby actual or potential care and support needs of someone are predicted. By doing this, steps can be taken much earlier to minimise or avoid altogether the impacts of these. (See also anticipatory care).

Health and social care integration

Bringing together adult health and social care in the public sector into one statutory body.

Health inequalities

A term that refers to the gap between the health of different population groups such as the wealthy compared to poorer communities or people with different ethnic backgrounds.

Home or remote health monitoring

The use of technology to monitor someone's health outside of traditional clinical settings. For example someone's health can be monitored in their own home enabling real time clinical review and early action.

Housing need and demand assessment (HNDA)

A document that provides fact and figures on housing need and demand

Impact assessment (see also protected characteristics)

A process to assess the impact of applying a proposed new or revised plan, policy, function or service.

Independent sector

A general term for non statutory bodies including private enterprise, voluntary, charitable or not for profit organisations and Independent Advocacy.

Integration authority

An Integration Joint Board or lead agency responsible for services delegated to it by the NHS and council.

Integration Joint Board

A body established where a health board and local authority agree to put in place a Body Corporate model. The Integration Joint Board is responsible for the planning of integrated arrangements and onward service delivery.

Integration scheme

A document setting out the key integration arrangements for an integration authority.

Institutional care

Hospital based care and all accommodation based social care.

Locality

The term outlined in the Public Bodies (Joint Working) (Scotland) Act 2014 to identify local areas. Every local authority must define at least two localities within its boundaries for the purpose of locality planning. In Dumfries and Galloway there are 4 localities - Annandale and Eskdale, Nithsdale, Stewartry and Wigtownshire.

Long term conditions

These are health conditions that last a year or longer, impact on a person's life, and may require ongoing care and support. These are also known as chronic conditions.

Market facilitation

The part of the strategic commissioning cycle which seeks to influence and shape markets to ensure that there is a diverse range of affordable and sustainable health and social care and support provision to deliver good outcomes for people and meet the needs of the population, both now and in the future.

Mobile technologies

Technology that is portable including mobile phones, tablet devices and laptops.

Organisational culture

The way in which members of an organisation relate to each other, their work and the outside world.

Personalised

Tailoring health and/or social care and support specifically to an individual.

Person centred

Focuses care and support on the needs of a person and is a way of thinking and doing things that sees the people using health and social care as equal partners in planning, developing and monitoring care to make sure it meets their needs.

Personal outcomes

The end result or impact of activity on a person. A personal outcomes approach identifies what matters to people through good conversations during care and support planning.

Preventative

Promoting and maintaining good health and wellbeing as a primary approach, anticipating and identifying potential, future health and/or social care needs and implementing a range of actions to avoid these.

Primary care

Health care provided in the community. For example services provided by GP practices, dental practices, community pharmacies and high street opticians, as well as community nurses and allied health professionals.

Protected characteristics

As it is recoginsed that people may face discrimination due to these characteristics the Equality Act 2010 describes age, disability, sex, race, religion or belief, pregnancy and maternity, marriage and civil partnership, sexual orientation and gender reassignment as protected characteristics.

Public Health

Promoting and protecting health and wellbeing and preventing ill health.

Reablement

A hands off approach to care and support that helps people learn or relearn the skills necessary for daily living. A focus on regaining physical ability and reassessment is central to this way of working.

Self directed support

A term that describes a direct payment support service that gives people more choice and control over the support they use to meet their social care needs, including personal budgets.

Self management

People making decisions about, and managing their own health and wellbeing.

Stakeholder

Anybody who can effect or is effected by an organisation, strategy or project. They include people who use services, their Carers, other organisations and the general public.

Strategic needs assessment (SNA)

An analysis of the health and social care and support needs of a population that helps to inform health and social care planning.

Strategic plan

A high level plan that sets the future direction of travel for health and social care by identifying key challenges and priority areas of focus and aligning resources to activity.

Technology enabled care

A Scottish Government programme to enable a major roll out of telehealth and telecare in Scotland.

Third sector

A vast range of organisations that have a social purpose and are not for profit, such as voluntary organisations, charities, or social enterprises. The types of services and the opportunities they provide include health and social care and support, information, advocacy and volunteering.

Volunteering

Any activity that involves spending time, unpaid, doing something that aims to benefit the environment or someone (individuals or groups) other than, or in addition to close relatives.

Vulnerable adult

A person over the age of 18 at risk of being harmed by reason of disability, age or illness.

Wellbeing

Wellbeing is a complex combination of a person's physical, mental, emotional and social health. Wellbeing is strongly linked to happiness and satisfaction in life.

Appendix 1: Membership of the strategic planning group

Representing users of healthcare services

Jeff Holt – Scottish Health Council

Carolyn Little – User and Carer Involvement (UCI) - Users and Carers Group (also representing users of social care services)

Vanessa Martin

Stella McPherson

Representing Carers of people who use health and social care services

Claudine Brindle – Dumfries and Galloway Carers Centre

Jim McColm

Martin Rogan

Alex Russell

Representing health professions

Moira Cossar – Area clinical forum

Ken Donaldson – Medicine

Charles Dunnett – General Practice

Graham Gault – NHS general management group

Joan Pollard – Allied health professions

Alice Wilson – Nursing

Representing independent sector

Jim Gatherum – Care home provider

Sue Newberry – Scottish Care

Representing social care professions

Graham Abrines – Social work

Kate Macleod – Care and facilities

Fiona Wright – Occupational therapy

Representing users of social care services

Louise Boustead – Enable learning disability service user (supported by Jack Collett)

Representing housing (non commercial providers and local authority strategic housing)

Jamie Carruthers – Scottish land and estates

David McMillan – Community council

Jim O'Neill – Council strategic housing

Representing third sector

David Coulter – Third Sector Dumfries and Galloway

Tony Freeman – Care Training Consortium

Martyn Robert Hawthorn – Royal British Legion

Martin Holmes – Community Integrated Care

Richy Lewis – Key Community Supports

Gerry McCoy – Alzheimer Scotland

Jane Middleton – Care Training Consortium

Hugh Robertson – Addaction

Alex Thorburn – Dumfries and Galloway Disability Access Panel

Representing diversity groups

Joseph Kidd-Bentley, LGBT Plus

Frank Smith, DG Voice

Representing staff

Jimmy Beattie – Unison

Ann Farrell – Unite

Ewan Kelly – NHS Dumfries and Galloway Spiritual Lead

Brian Morton – Royal College of Nursing

Representing localities

Gary Sheehan – Locality Manager, Annandale and Eskdale

Mhairi Hastings – Interim Locality Manager, Wigtownshire

Alison Solley – Locality Manager, Nithsdale

Stephanie Mottram – Locality Manager, Stewartry

Commercial providers of healthcare services

(included in independent sector Representatives)

Non commercial providers of healthcare services

(included in third sector representatives)

Appendix 2: Links to useful documents

National sources

A National Telehealth and Telecare Delivery Plan for Scotland to 2015

A Route Map to the 2020 Vision for Health and Social Care

Adult Support and Protection (Scotland) Act 2007

Age Home and Community: A Strategy for Housing for Older People 2012 - 2022

Carers (Scotland) Act 2016

Caring together – The Carers' Strategy for Scotland 2010 – 2015

Community Empowerment (Scotland) Act 2015

Equal Partners in Care

Equality Act - 2010

Health and Social Care Delivery Plan 2016

Health and Social Care Standards: My support, my life 2017

Healthcare Quality Strategy for NHS Scotland 2010

Scottish Commission for Human Rights Act 2006

Institute for Research and Innovation in Social Services (IRISS)

Keys to Life: Improving quality of life for people with Learning Disabilities 2013

Living and Dying Well: A national action plan for palliative care and end of life care in Scotland 2008

Mental Health (Scotland) Act 2015

Mental Health Strategy 2017 - 2027

Multi Morbidity Action Note 2014

National Clinical Strategy 2016

National Health and Social Care Workforce Plan 2017

Public Health (Scotland) Act 2008

Promoting Excellence: A framework for all health and social services staff working with people with dementia, their families and carers 2011

Public Bodies (Joint Working) (Scotland) Act 2014

Reshaping Care for Older People – A Programme for Change 2011 - 2021

Scotland's Digital Health and Social Care Strategy 2018

Scotland eHealth Strategy 2011 – 2017

Scotland's Equal Opportunities Committee Report – Age and Social Isolation

Scotland's National Dementia Strategy 2013 - 2016

Scottish Health Technologies Group

Scottish Patient Safety Programme 2008

Social Care (Self directed Support) (Scotland) Act 2013

Standards of Care for Dementia in Scotland

Scotland's National Dementia Strategy 2013 - 2016

The National Delivery Plan for the Allied Health Professions in Scotland 2012 - 2015

The Scottish Strategy for Autism 2011

Welfare Reform Act 2012

Local sources

Dumfries and Galloway Anti Poverty Strategy 2015 – 2020

Dumfries and Galloway Carers' Strategy 2017 - 2021

Dumfries and Galloway Common Housing Register

Dumfries and Galloway Dementia Standards Assurance Framework 2015 – 2018 (to be published April 2016)

Dumfries and Galloway Children's Services Plan March 2015 – September 2016

Dumfries and Galloway Council Equalities Outcomes report

Dumfries and Galloway Data Dictionary

Dumfries and Galloway Housing Strategy 2011 - 2016

Dumfries and Galloway Housing Contribution Statement

Dumfries and Galloway Integration Scheme

Dumfries and Galloway Joint Strategic Plan for Older People 2012 - 2022

Dumfries and Galloway Physical Assets Management Strategy 2015

Dumfries and Galloway Single Outcome Agreement 2013 - 2016

Dumfries and Galloway Spiritual Care Policy

Dumfries and Galloway Young Carers' Strategy

NHS Dumfries and Galloway Equalities Outcomes Report

Putting You First end of programme evaluation report

Appendix 3: Services included within the Integration Joint Board in Dumfries and Galloway (in alphabetical order)

Adult placement services

Adult protection and domestic abuse services

All district general hospital inpatient (scheduled and unscheduled) and outpatient services

Aspects of housing support, including aids and adaptions

Care home services

Carers support services

Community care assessment teams

Community children's NHS services - child and adolescent mental health service, primary mental health workers, public health nursing, health visiting, school nursing, learning disability nursing, speech and language therapy, occupational therapy, physiotherapy and audiology, and community paediatricians

Community hospital services

Community nursing, allied health professionals specialist end of life care, older adult, reablement, learning disability specialist, community midwifery, speech and language therapy, physiotherapy, audiology

Day services

Diagnostic services

Drug and alcohol services

General and community dental services

GP prescribing

GP services

Health improvement services

Hotel services and facilities management

Local area coordination

Mental health services

Occupational therapy services

Paediatrics

Public health practitioner services

Reablement services, equipment and telecare

Respite provision

Services and support for adults with physical disabilities and learning disabilities

Social work services for adults and older people

Support services

Please note social work children's services and health services delivered outside of Dumfries and Galloway are NOT delegated to the Integration Joint Board.

Appendix 4: Impact assessment summary

SUMMARY SHEET

SUMMARY OF IMPACT ASSESSMENT (IA)

Policy	Draft Health and Social Care Strategic Plan for Dumfries and Galloway	Date of process	8 October 2015
Lead service	Strategic Planning, NHS Dumfries and Galloway	Contact person for process	Liz Manson 01387 260074

Names of those involved in process

Dumfires and Galloway Council – Rebecca Aldrige, Liz Manson and Sheila Davies

NHS Dumfries and Galloway – Vicky Freeman, Viv Gration, Chris Sanderson and Catherine Withington

Dumfries and Galloway LGBT Plus – Grace Cardozo

Summary of IA

The Council is required to publish the findings and results of all IAs conducted. The publication should include a summary of the following:

Research and data (section 3)	A wide range of stakeholders from across public, third and independent sectors have been engaged in a variety of ways - see the Consultation Statement attached to the Strategic Plan for details Scottish Parliament legislation Scottish Government Guidance benchmarking with other areas Strategic Needs Assessment 2014 incorporating the Community Survey 2011 Expert officers have been involved in developing the Plan for their particular professional area along with practitioners and service users The region's agreed Equalities Monitoring Form has been used throughout the first round of consultation to ensure that we have an accurate picture of our respondents. Phase two of the consultation programme will ensure that any under representedunder represented groups are engaged in different ways to ensure that the final Plan reflects our population.
Impact Assessment (section 4)	Positive Impacts – 12 4 high - human rights health and wellbeing and health inequalities economic and social sustainability environmental sustainability, climate change and energy management 2 medium - age, disability 6 low - sex gender reassignment and transgender race pregnancy and maternity religion or belief sexual orientation 1 no Impact - marriage and civil partnership Negative Impacts – 4 4 low - age disability gender reassignment and transgender sexual orientation

Monitoring and review (section 5)	The updating of the Strategy will be overseen by the Integration Joint Board

Summary of actions arising from the Impact Assessment

Actions	Responsibility	Timescale
Change for vulnerable groups: (particularly older and disabled people, sex, sexual orientation and gender reassignment and transgender and those with intersectional identities) • The change to the health and social care arrangements will be carefully planned and the transition managed. • The Workforce Development Plan will be in place the information and data sharing protocol is in place under the Scottish Accord on the Sharing of Personal Information (SASPI) (10) (which is compliant with the non disclosure section of the Gender Recognition Act in relation to gender reassignment). • Consideration could be given to some dedicated resource to support any particular vulnerable people or groups including those with intersectional identities during the change.	Chief Officer Health and Social Care Integration	April 2016
Information management and data sharing: • The integration of services and joint working across professionals will bring more staff and volunteers into contact with people whose personal data is particularly sensitive and changing - particularly gender reassignment and transgender. While the actual number of people involved is likely to be small, the potential impact on them is very significant and therefore the information and data sharing protocol in place under SASPI (Scottish accord for sharing personal information) must ensure that forms and records reflect more than a binary definition of gender identity.	Chief Officer Health and Social Care Integration	April 2016
Identification of need of Protected Characteristics: • The Community Survey undertaken in 2014 and personal testimony information is available and should be incorporated into the Strategic Needs Assessment that informs the Strategy. Links to additional local material - e.g. Equality Outcomes of key partners and the associated Action Plans the NHS Dumfries and Galloway Spiritual Care Policy and Delivery Plan the Young Carers Strategy should be referenced in Appendix 2 to provide more in depth local information.	Chief Officer Health and Social Care Integration	February 2016

Appendix 5 – Statement of consultation

1 Introduction

The Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) section 33 sets particular requirements for the preparation of a strategic plan for health and social care integration. It states that integration authorities must:

1. Prepare proposals for what the strategic plan should contain and seek the views of The Strategic Planning Group (SPG)
2. Take account of the views of the SPG and prepare a first draft of a strategic plan for further consultation
3. Prepare a second draft of the strategic plan taking account of views expressed and further consult with persons it considers appropriate
4. When finalising the plan, take account of any views expressed during consultation

This document provides information on the involvement, communication and engagement activities undertaken as part of the development of the Dumfries and Galloway Health and Social Care Strategic Plan. This meets the requirement set out in section 35 (2) of the Act that "at the same time as publishing a strategic plan, an integration authority must also publish a statement of the action which took place in pursuance of section 33" (preparation of a strategic plan).

This is a summary of the statement of consultation, the full document and appendices can be viewed at **http://www.dg-change.org.uk/strategic-plan**.

2 National standards for community engagement

In undertaking the consultation on the strategic plan for Dumfries and Galloway, the 10 National Standards for Community Engagement (2005) (**National Standards for Community Engagement**) were applied. A supplementary advice note to the national standards relating specifically to remote rural practice (**Remote Rural Advice Note**) provided further guidance.

Visioning Outcomes in Community Engagement (**VOiCE**), a 4 step, (analyse, plan, do, review), online planning and evaluation tool designed to assist the design and delivery of effective community engagement was also used.

A self assessment scorecard which provides evidence of work to meet the 10 national standards and the remote rural advice note is attached as Appendix 1 of the full statement of consultation which can be viewed at **www.dg-change.org.uk/strategic-plan**.

3 Strategic planning group (SPG)

The SPG was established in February 2015. It has a wide representation from across a range of stakeholders with 43 members in total; a copy of the membership is attached at Appendix 1 of the strategic plan (page 41). The ongoing role of this group is to shape, influence and review the strategic plan.

4 Aims of the strategic plan consultation

The aims of consultation on the strategic plan were to:

- Involve people in shaping the future of health and social care
- Develop a better understanding of what matters to people
- Inform people about the drivers for change and seek their views on what they thought were/should be priority areas of focus
- Give as many people as possible, across the region, the opportunity to engage with the consultation on the strategic plan

5 Stakeholder Groups included within the consultation

- Communities
- People who use services
- Carers
- Provider organisations (including provider and non provider third sector, independent sector and public sector health and social care organisations)
- Staff groups across health and social care
- Housing
- Diversity groups
- Staff side representatives
- Locality representatives
- Boards and committees
- General Practitioners

6 Development of the strategic plan (February 2015 – March 2016)

Phase One – Engagement on the consultation document – February 2015 to August 2015	
February – August 2015	Completion of the strategic needs assessment
3 February 2015	Engagement with strategic planning group
March – June 2015	Development of the consultation document including plain English and easy read versions
14 May 2015	Engagement with strategic planning group
22 June – 28 August 2015	First period of consultation undertaken (for methods of communication and engagement activities please see Appendix 3 of the full document **www.dg-change.org/strategic-plan**).

Phase Two – August 2015 to December 2015	
August 2015	Engagement with key stakeholders to identify the we will commitments for each of the 10 priority areas of focus
1 – 29 September 2015	Review of all comments received during the consultation process to inform the development of a draft strategic plan
September 2015	Identifying communities or groups of people that did not comment/engage to inform the planning of future consultation events
September/October 2015	Consultation planning group (CPG) established with representation from key stakeholders and networks to plan and coordinate the second period of community engagement. Members of the CPG include representation from building healthy communities, public health, health improvement teams, community learning, third and independent sectors, localities, strategic planning and integration programme team
September/October 2015	Develop a draft strategic plan (including plain English and easy read versions)
14 and 15 September 2015	Further engagement with strategic planning group to share comments received during the first period of consultation and to seek their views on the draft we will commitments
6 October 2015	Strategic plan workshop with the Integration Joint Board
8 October 2015	Impact assessment of draft strategic plan
19 October – 11 December 2015	Second period of community engagement (alongside consultation of locality plans and other supporting documents contained within the strategic framework) (for methods of communication and engagement activities please see Appendix 3 of the full document **www.dg-change.org/strategic-plan**)

Phase three – December 2015 to March 2016	
14 December 2015 – 26 January 2016	Review of all comments received during the second period of consultation to inform the redrafting of the strategic plan into a final draft document
15 and 18 January 2016	Engagement with strategic planning group to share comments received during the second period of consultation and provide a final opportunity, at this stage, for shaping and influencing this document
16 February 2016	Strategic plan workshop with the Integration Joint Board
7 – 24 March 2016	Share the final draft strategic plan with management groups, NHS board, council, partners
17 March 2016	Seek agreement of the final draft plan at the Integration Joint Board

7 Level of consultation and comments received

Over the course of the two periods of engagement there were 260 opportunities to discuss the strategic plan and associated documents such as conferences, team meetings, focus groups and consultation events. A full list of the engagement activities is available at Appendix 4 of the main full statement of consultation at **www.dg-change.org/strategic-plan**.

It is believed that there was engagement with over 4,410 people throughout both periods of engagement. This number is an estimation based on information from:

- Online questionnaire returns (171)
- Equality monitoring forms (332)
- The number of people recorded at engagement events

Comments

Engagement activity resulted in 4,589 comments.

All comments received were:

- recorded into a single comments document and scrutinised to capture/identify any emerging themes and
- forwarded to relevant lead officers and teams for their consideration in the revision of documents

1,286 of the 4,589 comments related directly to the strategic plan and annexes.

The remainder related to the locality plans (3303):

- 216 comments related to the Annandale and Eskdale plan
- 747 comments related to the Nithsdale plan
- 1801 comments related to the Stewartry plan
- 495 comments related to the Wigtownshire plan
- 73 comments related to all plans

The numbers of comments received as noted above, reflect that:

- each of the 4 locality teams has taken different approaches in how they have engaged with their communities i.e. these numbers reflect the levels of engagement during the consultation period only whereas, some localities have been engaging with their communities over a much longer period and
- variation in recording the number of comments received

8 Next Steps

Build on the learning from the consultation on the strategic plan to inform the development of the participation and engagement strategy to improve future consultations

Identify key learning from VOiCE to also improve future consultations

Develop a consultation and engagement template to ensure more consistent recording of consultation and engagement across the region

If you would like some help understanding this or need it in another format or language please contact 030 33 33 3000

Agenda Item 259

DUMFRIES and GALLOWAY NHS BOARD

4th February 2019

Ministerial Strategic Group Improvement Objectives Draft Proposal for 2019/20

Author:
Ananda Allan
Performance and Intelligence Manager

Sponsoring Director:
Vicky Freeman
Head of Strategic Planning

Date: 4th February 2019

RECOMMENDATION

The Board is asked **to discuss and note** the following points:

- the Dumfries and Galloway Health and Social Care Partnership Ministerial Strategic Group Improvement Objectives Draft Proposal for 2019/20.

CONTEXT

Strategy / Policy:
Dumfries and Galloway Integration Joint Board Strategic Plan

Section 42 of the 2014 Public Bodies (Joint Working) (Scotland) Act requires that Performance Reports be prepared by the Health and Social Care Partnership.

Organisational Context / Why is this paper important / Key messages:

This report sets out improvement objectives required to be reported by the Dumfries and Galloway Health and Social Care Partnership to the Ministerial Strategic Group. The delivery of these improvement objectives are the responsibility of the NHS Board.

GLOSSARY OF TERMS

A&E	- Accident and Emergency
CAU	- Combined Assessment Unit
COSLA	- Convention of Scottish Local Authorities
DGHSCP	- Dumfries and Galloway Health and Social Care Partnership
ED	- Emergency Department
IJB	- Integration Joint Board
ISD	- Information and Statistics Division
MSG	- Ministerial Strategic Group
NHS	- National Health Service
NSS	- National Services Scotland
SMR01	- Scottish Morbidity Recording Scheme 01

MONITORING FORM

Policy / Strategy	Dumfries and Galloway Integration Joint Board Strategic Plan
Staffing Implications	None
Financial Implications	None
Consultation / Consideration	Integration Joint Board Performance Committee
Risk Assessment	Risks will be considered by the NHS Board
Risk Appetite	Low [x] Medium [ ] High [ ] Performance includes many aspects of clinical care, which the NHS Board has designated a low appetite for risk
Sustainability	Individual measures can be an indicator of ongoing sustainability
Compliance with Corporate Objectives	To promote and embed continuous quality improvement To maximise the benefit of the financial allocation by delivering clinically and cost effective services efficiently To meet and where possible, exceed goals and targets set by the Scottish Government Health Directorate for NHSScotland, whilst delivering the measurable targets in the Single Outcome Agreement
Local Outcome Improvement Plan (LOIP)	Outcome 6: People are safe and feel safe
Best Value	Performance Management
Impact Assessment Not applicable	

Background

1 Section 42 of the 2014 Public Bodies (Joint Working) (Scotland) Act requires that Performance Reports be prepared by the Partnership.

2 The Ministerial Strategic Group for Health and Community Care (MSG) has overall responsibility for policy matters that cross the local government / NHS Scotland interface and is a key forum for taking forward COSLA and the Scottish Government's joint political leadership of health and social care integration.

3 Integration Authorities have been asked to set trajectories against a suite of integration indictors and report regular (quarterly) progress to the MSG.

4 In February 2017 the Ministerial Strategic Group (MSG) asked Integration Authorities to set trajectories for progress against 6 key areas of health and social care. The 6 key areas are:

- Number of emergency admissions into acute specialties (all ages)
- Number of unscheduled hospital bed days, in acute specialities (all ages)
- Number of A&E attendances and the percentage of patients seen within 4 hours
- Number of delayed discharge bed days (ages 18 and over)
- Percentage of last 6 months of life spent in the community and other settings
- Percentage of population residing in non-hospital setting for all adults and people aged 75 and over.

5 Trajectories against the 6 key areas were agreed by the IJB in March 2017. These trajectories took into account past performance, National Delivery Plan targets and knowledge of local performance in the target areas.

6 The MSG has an established a small working group that considers how Integration Authorities can best provide regular progress updates. The working group has developed a reporting template for providing new trajectories for 2019/20 to the MSG.

7 These MSG performance objectives are based on integration performance indicators version 1.12, released by ISD in December 2018 containing SMR01 data up to June 2018.

Main Body of the Report

8 Partnerships have been requested to set their improvement objectives for 2019/20. Please see Appendix One.

9 Progress against the existing 2018/19 improvement objectives are as follows, based on data released November 2018:

Unplanned admissions	12 month rolling average 1,486 (May 18) is higher than both prediction and desired trajectory.
Unplanned bed days - Acute	12 month rolling average 11,385 (May 18) is following target objective.
Unplanned bed days - Geriatric Long Stay	Not currently reported
Unplanned bed days - Mental Health	Not currently reported
A&E attendances	12 month rolling average 3,779 (Aug 18) is lower than the desired objective.
Delayed discharge bed days	12 month rolling average 1,047 (Aug 18) is higher than the new desired objective.
Last 6 months of life	8.2% spent in acute hospital setting (17/18p) is lower than the target of 8.4%
Balance of Care	Large hospital activity has increased from 446 to 450 (2017/18p). Community hospital activity has decreased from 75 to 69 (2017/18p). Palliative care unit activity has remained the same at 7 (2017/18p).

10 The MSG has asked that Partnerships now agree trajectories for 2019/20.

11 The MSG request that people aged under 18 and 18 and over are reported separately, to enable the overall picture for Scotland to be collated more easily.

12 Details for each indicator is as follows (see Appendix One):

- **1. Unscheduled admissions; (continuous inpatient stays) (p.1)** – The previous objective was a zero percent increase in unscheduled admissions from December 2016. This objective was not met and the current trajectory is rising. The new proposed objective is a zero percent increase in unscheduled admissions from March 2018, for both adults and children.

- **2a. Unscheduled bed days; acute specialties (continuous inpatient stays) (p.2)** – The current objective for adults is on track, while fro people aged under 18 has risen modestly. The proposed objective for adults is to extend the previously agreed reduction of 2% per year. For children the proposal is to maintain or improve unscheduled bed days observed in 2017/18.

- **2b. Unscheduled bed days; geriatric long stay** – Dumfries and Galloway has a very small number of geriatric long stay unscheduled bed days; less than 100 in the past two years. Therefore, this aspect is not reported.

- **2c. Unscheduled bed days; mental health specialties (p.3)** – A new objective for unscheduled mental health bed days is proposed for both children and adults; to maintain or improve unscheduled bed days observed in 2017/18.

- **3. Emergency Department Attendances (p.4)** – Due to the challenges of predicting ED attendances from the new model at DGRI, the proposal is maintain or reduce the observed level of attendances in 2017/18 for both adults and children.

- **4. Delayed discharge bed days (Aged 18+ only) (p.5)** – The stretch reduction aim was not met as at August 2018. There are known issues in the community setting that are anticipated to have a knock-on effect on timely discharge from hospital. Therefore the proposed objective for 2019/20 is to maintain or improve the number of bed days observed in 2017/18.

- **5. Percentage of last six months of life by setting (all ages) (p.6)** – The Partnerships are asked to propose a trajectory for greater time spent in a community setting. We also propose that **less** time should be spent in the acute hospital setting.

- **6. Balance of care: Percentage of population in community or institutional settings (Aged 65+) (p.7)** – Previous figures were reported for all ages and people aged 75 or older. The MSG now asks for this to be reported for people aged 65 or older. The Partnerships have been asked to propose a trajectory for greater time spent in a community setting. We also propose that less time should be spent in the acute hospital setting.

Recommendations

13 NHS Board is asked to note and discuss the Dumfries and Galloway Health and Social Care Partnership Ministerial Strategic Group Improvement Objectives Draft Proposal for 2019/20.

Agenda Item 260

DUMFRIES and GALLOWAY NHS BOARD

4th February 2019

Scottish Graduate Entry Medical School Update

Author:
Dr Fiona Graham
Director of Medical Education

Sponsoring Director:
Dr Ken Donaldson
Medical Director

Date: 24th January 2018

RECOMMENDATION

The Board is asked **to discuss and note** the following points:

- this development, which has considerable potential to support recruitment and retention of GPs – though the full impact will not be felt for several years.
- Dumfries & Galloway is a founding partner in the development of a Scottish Graduate Entry Medical School.

CONTEXT

Strategy / Policy:
This paper supports a number of local and national policies and strategies to enhance the sustainability of medical staffing.

Organisational Context / Why is this paper important / Key messages:
NHS Dumfries & Galloway has been working with St Andrews University, Dundee University, NHS Fife and NHS Highland to deliver the Scottish Government's vision to develop a Graduate Entry Medical School for Scotland

Delivery of this project should increase recruitment both in the short and longer term

The Medical School is being structured to educate rural generalists, that is GPs and general physicians/surgeons etc

GLOSSARY OF TERMS
Scottish Graduate Entry Medical School (ScotGEM)
Case Based Learning (CBL)
Full Time Equivalent (FTE)
Generalist Clinical Mentors (GCMs)
Longitudinal Integrated Clerkship (LIC)
Clinical Interactions Course (CLIC)
Agents of Change (AoC)

MONITORING FORM

Policy / Strategy	Supports sustainability of medical staffing
Staffing Implications	See paper
Financial Implications	No
Consultation / Consideration	Regular collaboration with all stakeholders, especially St Andrews and Dundee University Awareness raising only
Risk Assessment	There remains a risk that we do not have enough capacity in general practice secondary care to sustain teaching.
Sustainability	Not applicable
Compliance with Corporate Objectives	Complies with Objective No 3, 4, 6 and 7.
Single Outcome Agreement (SOA)	Not applicable
Best Value	If enhances recruitment it will be of enormous value.
Impact Assessment The Universities have policies on supporting students with characteristics protected under discrimination law: we will follow these to ensure that our portion of the training does not present barriers to any potential students.	

SCOTTISH GRADUATE ENTRY MEDICINE (ScotGEM)

An update for NHS Dumfries and Galloway - January 2019

This paper should be read in the context of 'ScotGEM update January 2018

Background

'ScotGEM is designed to develop doctors interested in a career as a generalist practitioner within NHS Scotland, with a focus on rural medicine and healthcare improvement. It offers a unique and innovative 4-year graduate entry medical programme tailored to meet the contemporary and future needs of the NHS in Scotland'[1]

Prior to advent of the ScotGEM programme, any Scottish based graduate who wished to study medicine had to begin again with an undergraduate course or move elsewhere. The Scottish Government prioritised the development of a graduate entry medicine course and asked the Scottish medical schools to tender for this. A collaboration between the University of Dundee, University of St Andrews, University of the Highlands and Islands (UHI) and NHS Scotland (specifically NHS Fife, Tayside, Highland and Dumfries and Galloway) was the successful bid. The partnership approach, innovative curriculum and aim to support teaching, training and recruitment to rural areas in Scotland all contributed to the bid's success.

55 students were recruited and began training in August 2018 at the University of St Andrews. Scottish/EU student's fees are met and a bursary of £4000/year is available. If the bursary is accepted the student must undertake to work for a year in NHS Scotland for each year of the bursary.

Staffing

The ScotGEM Programme Director is Prof Jon Dowell, Professor of General Practice, University of Dundee. Key to the delivery of the programme is the Generalist Clinical Mentors (GCMs). These are GPs who will coordinate and deliver teaching and training across all years. Dr Robert Scully was appointed Lead GCM in November 2017 and he has been overseeing the appointment of the other GCMs required. 8 GCMs were appointed in Fife for first year (2018/19)

Three GCMs will be needed in Dumfries and Galloway (D&G) to begin in April 2019. These are 0.4 full time equivalent (FTE) ScotGEM posts that will be linked to clinical sessions at a GP base (minimum 0.2). Ideally these will be 'new blood' appointments that will bring GPs with an interest in education into the area but may also be suitable for local practitioners looking at career development. A national advert with NHS Fife was posted in December 2018, with a closing date for applications of 17th January and interviews to be held at DGRI on 31st January. There has been interest expressed in these posts from both local and more distant applicants.

For the 3rd year, a further GCM will be needed to oversee the Longitudinal Integrated Clerkship (LIC - see below) students and up to 15 Practice Based Tutors, also GPs. These posts are already included in the ScotGEM financial plan but there will be scope for identification of specific staffing needs in NHS D&G (e.g. Clinical Teaching Fellows within secondary care) where bids can be developed for ScotGEM funding.

Curriculum/Timetable

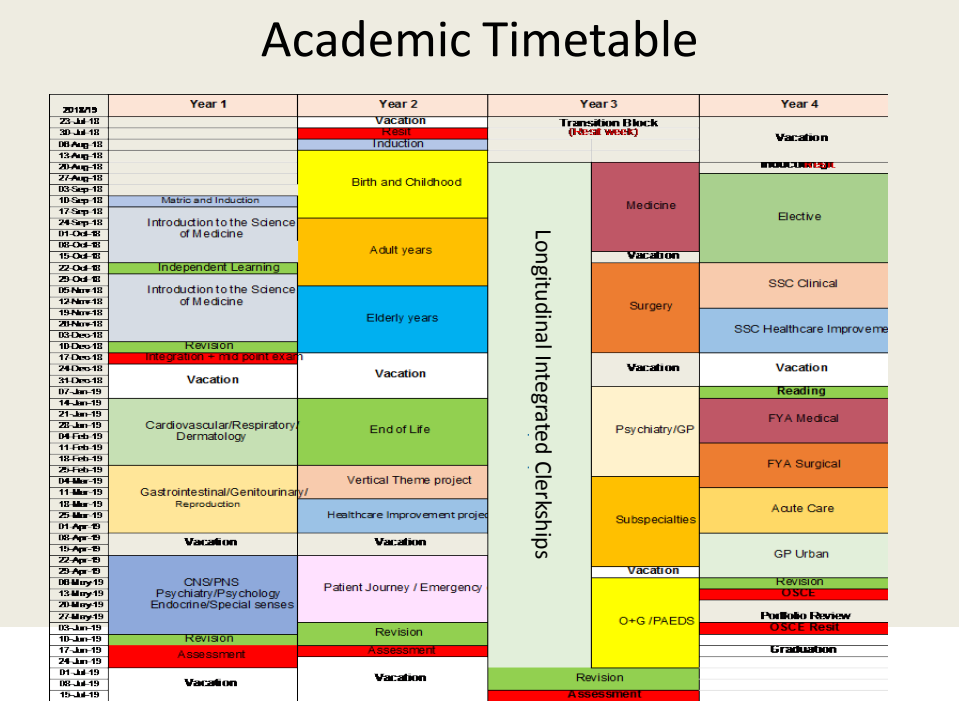


Figure 1 ScotGEM 4 Year timetable

ScotGEM will use a Case Based Learning (CBL) approach with students in the first and second year, relating all their learning, including the basic sciences, to patients. From the beginning of their first year, when they are based at St Andrews University/NHS Fife, they will meet on a weekly basis with their GCM to consider a case and set learning objectives for that week. There will also be 'Vertical Themes'[2] which will run throughout the course that are aimed at making ScotGEM graduates 'Agents of Change'(AoC), future leaders in Scottish healthcare.

In the 2nd year the students will follow 6 week 'Lifecycle' blocks and will be dispersed across the partner health boards. Between 10-15 students will be based in Dumfries and Galloway from August 2019. The three Dumfries and Galloway GCMs will each have responsibility for 5 students and will meet with them weekly, at their GP practice base, to discuss the previous week's cases and introduce a new one. There will also be centrally organised teaching (by the universities) and a session a week gaining secondary care experience

The 3rd year will follow a Longitudinal Clerkship (LIC) approach where students will be based in a general practice, with a practice based tutor (GP) for the year. LICs have been used across the world in the training of doctors (Australia, Canada, USA and South Africa) and have been shown to increase patient centeredness and the return to rural areas to work when qualified. Again 10-15 students will spend this year in Dumfries and Galloway with the first cohort starting in 2020. In D&G we are in our third year of a pilot project where two 4th year students, from the existing 5 year MBCHB course at the University of Dundee, are undertaking a LIC for 40 weeks. This year we have six students based in the region in Annan (2), Lochmaben, Dalbeattie, Castle Douglas and Newton Stewart. This experience is helping us identify any challenges of the LIC approach that we can overcome before we welcome a bigger group of students through ScotGEM. Prof Maggie Bartlett leads on the LIC approach at the University of Dundee – she reports that she has experienced a great deal of interest in this pilot project at the international meetings she is attending. She is about to publish an academic paper about the evaluation of the pilot

All ScotGEM students will be based in Dundee for the 4th year.

Challenges for NHS D&G

Staffing – medical manpower will be essential to the success of ScotGEM both in primary and secondary care. We have has sufficient expressions of interest from suitable practices in hosting the new GCMs. For LIC students we plan to group them in the 4 localities, with 3-4 based in each. Work is well underway with developing the secondary care experiences needed for the second year students. Dr Cara Hammond, Clinical Development Fellow (ST5 COTE) is meeting with colleagues to timetable outpatient, ward rounds, clerking and MDT experiences within the Lifecycle blocks. Extra resources will be needed to support Lifecycle block Clinical Leads and bids will be developed to submit to the ScotGEM Regional ACT group for funding. We are working with Dr Mike Quigley, Simulation lead and ED consultant on the timetable for the ED/patient journey block and to plan the CLIC course delivery.

Accommodation – The first students will arrive in Dumfries and Galloway in the summer of 2019 and will need to be accommodated. In summer 2020 the 15 LIC students will need accommodated around the region. We feel quality accommodation is essential to welcome the students to our region. David Bryson, General Manager Facilities and Clinical Support Services, has been helping us consider options. It is likely that the 2nd Year students will be accommodated together in Dumfries in newly refurbished flats.

In the 2nd year, DGRI will be the base for the CLIC course, plenaries and centrally organised teaching (fulfilling the role St Andrews University will take in Fife) As such, there will need to be some development of facilities, equipment and staff. We have identified an area within the Education Centre that we plan to develop as a Student Hub. Here students will be able to meet to discuss their AoC projects, network and study. Library facilities are in the process of being developed to meet the needs of all of our students and we are awaiting details from the CLIC lead in St Andrews about simulation equipment that we will need to purchase.

Opportunities for NHS D&G

- Staffing – ScotGEM offers the opportunity to recruit new medical staff to the area and career development for those already here.

- Training the next generation of doctors who are more likely to return to the region after qualifying.

- Multidisciplinary teaching and learning – there will be opportunities for other staff groups e.g. pharmacists in the Prescribing and Therapeutics vertical theme and nursing staff in simulation.

- Partnership with universities and health boards across Scotland.

- Learning about new ways of teaching, training and evaluation.

- Developing/strengthening links with other local education providers e.g. UWS and Glasgow University input on Vertical themes, Dumfries and Galloway College collaboration on supporting students from the region to apply for ScotGEM.

- Being an integral part of an exciting flagship national programme.

The Next Steps

- GCM interviews DGRI 31st January 2018.

- GCMs start April/May 2019 – training will include communication skills, simulation skills, QI methodology.

- CLIC course coordinator/Year 2 lead/Lead GCM visit to Dumfries and Galloway February 2019 to assess facilities, equipment, timetables for secondary care experiences, structure of Patient Journey/Emergency Care block and to discuss the structure and development of 2nd year cases.

- Finalise 2nd Year timetable/block leads and submit funding bids February/March 2019.

- Finalise arrangements for accommodation February/March 2019.

- First students arrive 12th August 2019 Birth and Childhood block.

Further details or clarification on any aspect of ScotGEM are available from:

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Agenda Item 261

DUMFRIES and GALLOWAY NHS BOARD

4th February 2019

Financial Performance Update 2018/19
Position to Month 9 as at 31st December 2018

Author:
Graham Stewart
Deputy Director of Finance

Sponsoring Director:
Katy Lewis
Director of Finance

Date: 14th January 2019

RECOMMENDATION

The Board is asked to **discuss and note** the following points:

- The updated financial position at the end of December 2018, month 9.
- The current underlying recurring savings gap (recurring deficit) of £12.6m before the reassessment of the Financial Plan position for 2019/20 onwards.
- The assessment of a break-even position by the year end is still forecast.
- The ongoing level of financial risk in the position relating to Prescribing and Medical Locums.

CONTEXT

Strategy/Policy:

The Board has a statutory financial target to deliver a break-even position against its Revenue Resource Limit (RRL).

Organisational Context/Why is this paper important/Key messages:

This report provides the position as at end 31st December 2018, month 9. The NHS Board is reporting an overspend position of £146k, consistent with achievement of a break-even position by the year end.

The key issues driving the Year to Date (YTD) overspend are:

- The level of unidentified/unachieved Cash Releasing Efficiency Savings (CRES) devolved to services as well as held centrally.
- Activity and growth pressures in maintaining waiting times.
- Prescribing growth and price increases, and slippage on savings schemes.

Workstreams identified to date around delivering efficiencies include:

- Directorates will be reviewing the YTD position as at month 9 to update their forecast outturn positions as part of the Quarter Three Review meetings.
- Recruitment to medical and nursing vacancies remain a key priority in not only sustaining the clinical services but also in minimising the expenditure on agency replacement.
- Following a workshop session with the General Managers in early January 2019, an updated three year Financial Plan is being developed to reflect the level of challenge faced by the Board and IJB following the release of the draft Scottish Budget on 12th December 2018.
- All ongoing financial risks will also be re-assessed as part of the sustainability of the financial recovery of the organisation.

GLOSSARY OF TERMS

AHP	-	Allied Health Professional
CRES	-	Cash Releasing Efficiency Savings
FHS	-	Family Health Services
GP	-	General Practice
IJB	-	Integration Joint Board
LDP	-	Local Delivery Plan
MYR	-	Mid-year Review
RRL	-	Revenue Resource Limit
SLA	-	Service Level Agreement
YTD	-	Year to Date

MONITORING FORM

Policy / Strategy	Supports agreed financial strategy in the Annual Operational Plan.
Staffing Implications	Not required.
Financial Implications	Financial reporting paper presented by Director of Finance as part of the financial planning and reporting cycle.
Consultation / Consideration	Board Management Team.
Risk Assessment	Financial Risks included in paper.
Risk Appetite	Low [X] Medium [ ] High [ ] The opening Financial Plan submitted to the Scottish Government reported the £6.2m unidentified savings. This paper updates this position, following the MYRs to an improved position with savings in place to deliver a break-even position for 2018/19 on a non recurring basis, noting the ongoing level of financial risk identified in the main body of the report.
Sustainability	The Financial Plan supports the sustainability agenda through the delivery of efficient solutions to the delivery of CRES. The Board is forecasting a break-even position based on the assessment of the financial position. The YTD position reflects the agreed release of flexibilities as part of the MYR.
Compliance with Corporate Objectives	To maximise the benefit of the financial allocation by delivering efficient services, to ensure that we sustain and improve services and support the future model of services. To meet and, where possible, exceed Scottish Government goals and targets for NHS Scotland.
Local Outcome Improvement Plan (LOIP)	Not required.
Best Value	This paper contributes to Best Value goals of sound governance, accountability, performance scrutiny and sound use of resources.
Impact Assessment A detailed impact assessment of individual efficiency schemes will be undertaken through this process as individual schemes are developed.	

Executive Summary

1. The Board is reporting an adverse variance position as at month 9 of £146k (£105k month 8). This is in line with the trajectory of a break-even position as advised after the MYRs. This is being reviewed in line with the Quarter Three Review.

2. The Board has received confirmation of the 2018/19 allocation letter from Scottish Government. **Appendix 1** provides a summary of the allocations confirmed to date of £352.4m as at the end of December 2018, with only (£0.12m) of anticipated allocations yet to be confirmed.

3. The table below provides a high level summary of the income and expenditure position for the services delegated to the IJB and the NHS Board services, showing the variance against plan for the first 9 months of the financial year:

Table 1

Service	YTD Budget £000s	YTD Actuals £000s	YTD Variance £000s	YTD Variance %
IJB Delegated Services	222,045	223,707	(1,662)	(0.75%)
NHS Board Services	46,762	45,246	1,516	3.24%
Total NHS Board	**268,807**	**268,953**	**(146)**	**(0.05%)**

Month 9 Financial Position - Delegated Services to IJB

4. Table 2 below summarises the current year to date position by main expenditure category for services delegated to the IJB:

Table 2

Expenditure Type	Annual Budget £000s	YTD Budget £000s	YTD Actuals £000s	YTD Variance £000s	YTD Variance %
Pays	163,077	120,664	119,497	1,167	0.97%
Non-pays	95,581	70,584	71,485	(900)	(1.28%)
Drugs	51,151	39,248	41,598	(2,350)	(5.99%)
Income	(10,336)	(8,450)	(8,871)	421	(4.98%)
Total	**299,473**	**222,046**	**223,708**	**(1,662)**	**(0.75%)**

5. The key risks across the Directorates are as follows:

- Acute and Diagnostics Directorate main overspends relate to the continued, increased growth of activity pressures whilst working to improve waiting time targets, combined with pressures across Pays of £449k, relating to the level of nursing vacancies and associated agency expenditure to maintain staffing levels. The Directorate has now spent £7.9m on medical locum staff YTD (£7.5m same period 2017/18).

Nurse agency costs are £701k YTD (£278k total in 2017/18), reflecting the pressures across unscheduled care and emergency care services. The YTD variance on CRES is £563k, reflecting the £750k still outstanding.

- Primary and Community Care Directorate position is reporting a £1,642k YTD overspend, £1,854k of which relates to the Primary Care Prescribing position. Whilst the Directorate CRES target of £700k has been achieved in-year, there remains a recurring gap of £482k. The key variances within the directorate are as follows;

    - Pays £240k underspent across nursing - £189k, AHPs - £109k, Ancillary - £99k and Health Sciences - £73k. This is off-setting the overspends within medical pays of £233k. The continued pressure on filling GP vacancies across the 2c practices is the main reason for the overspend within Primary Medical Services of £99k.
    - Non-pays (excluding Prescribing) is £374k overspent. The key pressures continue to be related to the consumables for insulin pumps within community nursing of £195k. General overspends across surgical particularly within Annan and Eskdale account for a further £110k pressure.
    - Primary Care Prescribing is £1.85m overspent due to the combination of unidentified CRES YTD (£181k), slippage on identified schemes YTD (£706k), general increases in volume and price of drugs prescribed (£603k), and reduced levels of discounts (£308k).

- The services delegated to the IJB have identified savings in-year of £2,630k against the 2% operational target of £3,380k (excluding prescribing); much of these savings are non-recurring (£1.96m, leaving a recurring gap of £2.7m) and there has been slippage on assumed recurring savings delivery from the opening Financial Plan. The detailed directorate positions are reflected in **Appendix 3**.

6. As identified above, nurse agency costs are an increasing pressure this financial year. The overall board cost last year was £278k whereas cost to date this year is currently sitting at £701k. The unscheduled and emergency care services continue to be the main users of agency with pressures also being seen in the high demand Medical and Care of the Elderly wards. The use of agency staff dipped in the past two months but has risen again due to the increased capacity required to deal with winter pressures and subsequent surge beds. The difficulty has been recruitment of registered nurses so agency has been required to fill the gaps to ensure patient safety. This is further influenced with the ongoing high levels of absence, which put continued pressure on the system and the resilience of staff.

7. The winter planning for surge areas is in place but despite all efforts, the availability of trained nurses is limited which impacts on the ability to radically reduce dependency on agency to fill essential gaps whilst ensuring safe patient care. The additional staffing will be funded from winter funding but may still be partly filled by agency.

8. The table below provides a high level summary of the IJB year to date position by Directorate.

Table 3

IJB DELEGATED SERVICES	Pays Variance £000s	Non-pays variance £000s	Drugs Variance £000s	Income Variance £000s	Total variance £000s
Acute & Diagnostics	(449)	(1,173)	(288)	92	(1,819)
Facilities & Clinical Support	57	(76)	0	(25)	(45)
Mental Health Directorate	341	94	(155)	3	284
Primary & Community Care	240	(374)	(1,854)	347	(1,642)
Women's & Children's	819	(51)	(53)	0	715
E Health	105	(20)		(7)	78
Strategic IJB Services	55	(15)		11	52
IJB Unidentified CRES	0	(1,161)		0	(1,161)
IJB Reserves	0	1,875		0	1,875
IJB SERVICES TOTAL	**1,167**	**(900)**	**(2,350)**	**421**	**(1,662)**

9. Key variances within the delegated budget are included in **Appendix 2 and 3** of this report.

Services Retained by the Health Board

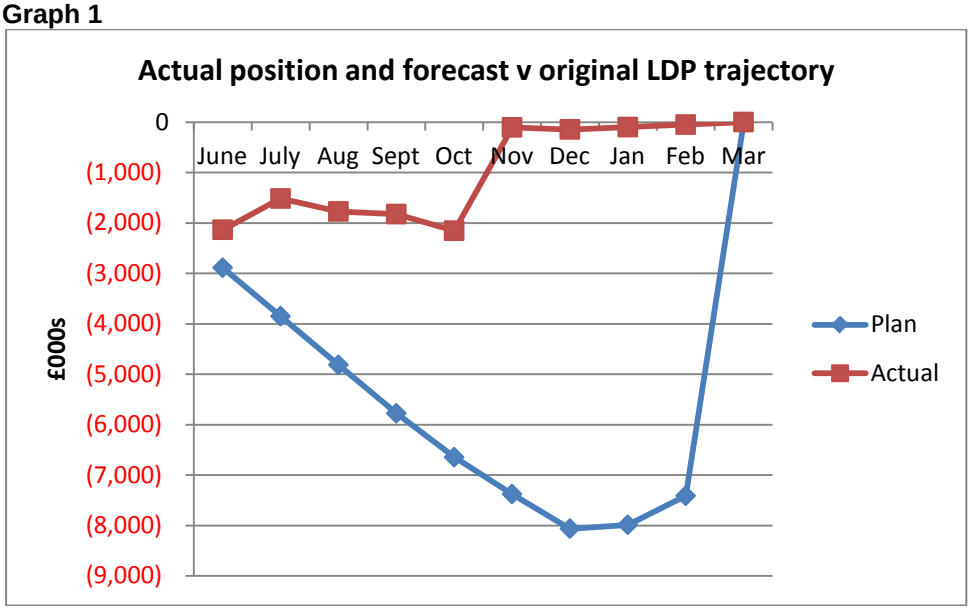
10. Overall, the functions not delegated to the IJB and retained by the Health Board are reporting a year to date underspend of £1.5m. There are a range of pressures against the External Service Level Agreement (SLA) areas with increased levels of activity from other providers, especially relating to high cost drugs and exclusions from the main SLAs which continue to be volatile month on month. The most recent invoices for high cost exclusions have seen an increase of £258k for November and December, against an expected cost of £113k based upon recent trends. This has shifted the Externals position to £96k overspent YTD.

11. We have also recently received the final confirmation of the increase to both the NHS Lothian and Greater Glasgow and Clyde SLAs which both show significant increases in unit costs across specialties where our activity has remained stable. The increase (excluding agreed inflation) for the Lothian SLA is £338k and NHS GG&C is £250k. We are currently challenging the reasons behind such large cost amendments to the underlying cost base where the underlying activity is either reducing or fairly stable for NHS Dumfries and Galloway.

Trajectory against Plan

12. The graph below demonstrates the improvement in the trajectory of the financial position against the original Local Delivery Plan (LDP) trajectory. The main improvements follow the decisions made around non-recurrent flexibilities following each of the quarterly reviews:

Graph 1



Following the Quarter One Review in July, the financial gap was reduced to £6.2m and then following the Quarter Two review a break-even position was confirmed. This explains the key changes in the differences to the trajectory as submitted as part of the LDP.

Efficiency Savings and Strategy

13. An update on efficiency savings delivery has been provided in **Appendix 4.** This indicates a projected savings delivery of £14.6m in-year as compared to the target of £17.3m.

14. Whilst this is a positive position (reflecting the efforts of the services in identifying savings in a period of significant organisational change) the level of non-recurring savings has increased by £2.9m as compared to the original target, with £5.6m slippage on recurring savings. The recurring gap (underlying recurring deficit) is £12.6m. This will be reflected in the development of the Financial Plan for 2019/20.

Quarter Three Review

15. Following on from the MYR meetings with the Director of Finance and Chief Operating Officer, a similar process will be undertaken over late January/ early February. Each directorate will update their YTD position as well as their revised forecast for the year-end.

16. Following this, the Director of Finance will able to update on the forecast position for 2018/19 and start the development of savings plans for 2019/20.

17. There remains a significant level of financial risk in the system as identified in the main body of this report and the challenge remains for Directorates to continue to identify savings schemes and reduce areas of overspend in order to ensure a break-even position can be delivered for 2018/19.

18. A workshop undertaken at the start of January and jointly chaired by the Director of Finance and Chief Operating Officer, focussed on compiling a long list of potential savings opportunities, whilst at the same time reviewing the potential impact on services. This formed part of a workstream that culminated in the IJB workshop on the Financial Plan in mid-January.

19. As part of the update to the Financial Plan and following the Quarter Three budget scrutiny meetings, a more robust impact assessment process will be undertaken when advising of the potential CRES schemes for 2019/20 and beyond. This will be included as part of the financial performance report to the March Performance Committee.

Key Actions and Outstanding Issues

20. There are a number of areas/actions which are being progressed:

- Review of Pharmacy budgets, pending appointment of new Director and devolution of Acute Pharmacy budgets to Acute Directorate.
- Review of the impact of the Community Pharmacy Contract, GP prescribing and discounts.
- Update on Financial Plan for presentation to NHS Board workshop session on 4th February 2019. Review of any further non-recurring savings opportunities in-year and overall management of the year end position.
- We continue to challenge the increased SLA proposals provided by both NHS Lothian and NHS Greater Glasgow and Clyde on the basis of the significant level of increase on their cost base with minimal change to underlying activity overall.

21. Appendices to this paper are noted below:

- **Appendix 1** – Revenue Resource Analysis
- **Appendix 2** – Key Variances within Directorates
- **Appendix 3** - Overall position by Directorate
- **Appendix 4** - Summary CRES Plan

Appendix 1

NHS DUMFRIES AND GALLOWAY
REVENUE RESOURCE ANALYSIS
At 31st December 2018

	Baseline Recurring £000s	Earmarked Recurring £000s	Non Recurring £000s	Non Core £000s	Total £000s
Revenue Allocation as at 30th November 2018	292,320	16,583	32,240	9,035	350,177
Other					
Capital to Revenue Transfer			2,000		2,000
Primary Care Fund GP Subcommittees for GP contract		15			15
Primary Care Fund Dispensing Practices per GP contract			71		71
TEC Programme funding to support scale up			108		108
Total Allocations	0	15	2,179	0	2,194
Revenue Allocation as at 31st December 2018	**292,320**	**16,598**	**34,419**	**9,035**	**352,371**
Anticipated Allocations		(184)	(528)	592	(120)
Total Revenue Allocation (excl FHS)	**292,320**	**16,414**	**33,891**	**9,627**	**352,251**
Family Health Services Non Discretionary Allocation					16,728
Total Revenue Allocation (incl FHS)					**368,979**

Key Variances within the delegated budget

Appendix 2

Directorate	Month 9 Position	Risks/Issues/Challenges and Opportunities
Acute and Diagnostics (including Acute prescribing)	(£1.819m) overspend	• CRES £704k unachieved YTD (£563k directorate and £141k prescribing). • Pays £449k overspent – On nursing (£611k) due to difficulty in recruiting registered nurses and the cost of agency. The in month spend on agency increased compared to the previous two months due to the increased capacity required to deal with winter pressures and surge beds. • Non-pays £610k overspent – pressures on travel and patient transport, activity pressures in labs and theatres. • Drugs - £288k over due to unachieved CRES YTD and increased costs related to activity growth across gastroenterology. Pharmacy are meeting with the clinicians to review the changes in prescribing practice. • Income - £83k overachievement due to catering income which is offset with anoverspend in cost of provisions.
Facilities and Clinical Support	(£45k) overspend	• Vacancies in Pays results in an YTD underspend of £57k, the directorate is currently carrying a small number of vacancies particularly within support services. • Non-pays overspend of £76k - The VAT refund received last month has now been moved to CRES as a non-recurring scheme for 2018-19. Health, Light and Power are now £57k underspent YTD. Waste is still continuing to overspend (£46k) mainly due to non-clinical waste. An estimated amount of £30k in expenditure has been transferred in month to the Mountainhall project as a result of clearing out Crichton Hall
Mental Health Directorate	£284k underspend	• Pays underspent by £341k – across Community Services, Medical Staffing, Psychology, OT and Substance Misuse. • Non-pays overspent by (£60k) – mainly related to drug pressures (overspend £155k) offset by underspends in travel and general services.
Women's and Children's	£715k underspend	• Pays £819k underspent related to public health nursing (£380k), midwifery (£299k), Ward 15 (£110k), Learning Disability (£133k), AHPs (£59k), Neonatal (£64k) offset with overspends in Management and Governance (£285k). The overspend in Management and Governance reflects the level of CRES (£209k) moved to Nursing Pays, reflecting the overall level of underspends YTD which are off-setting the underachievement on CRES non-recurrently. • Non-pays are (£104k) overspent relating to drugs (£53k of which £35k is unachieved Drug CRES YTD) and a variety of overspends across equipment and service contracts and clinical supplies.

Appendix 2

Key Variances within the delegated budget

Directorate	Month 9 Position	Risks/Issues/Challenges and Opportunities
Primary and Community Care – NHS	(£1.642m) overspend	• Primary Care Prescribing is £1.85m overspent related to the combination of unachieved CRES (£181k), slippage on identified schemes (£706k) general increases in volume and price of drugs prescribed (£603k) and discounts not received (£308k). The increasing overspend reflects the number of previously identified CRES schemes that are not delivering as expected. This is being reviewed as part of the Q3 Review. • The Pays position is £240k under-spent across the Directorate. £189k relates to Nursing budgets. AHP £109k under, Health Sciences £73k under, Admin budgets are £5k over, Miscellaneous £7k under. Medical budgets are over spent by £233k. Ancillary are under spent by £99k. • Non-pays (excluding Prescribing) is £374k overspent. The key pressures continue to be related to the consumables for insulin pumps within community nursing of £195k. • Income £347k over achieved relating to Primary Medical services with 2 practices that have become 2c and require budgets to be set.
E health	£78k underspend	• Pays underspent by £105k, mainly due to vacancies in Clinical Prep, Scanning team, Referrals team and Support team. • Non-pays are overspent by £20k due to overspend within telephones because of a move to national contract and GMS (General Medical Services) because of the new GP contracts which are offset by underspends within new service contracts.
Strategic IJB services (strategic planning etc)	£52k underspend	• Pays underspent due to a change in work patterns within strategic planning.
IJB Non-recurring CRES	(£1.161m) overspend	• Balance of remaining IJB CRES to be devolved and identified.
IJB Reserve	£1.875m underspend	• Reserve balance release to ensure year-end balance position.
Corporate Services (Health Board)	£1.516m underspend	• Pays underspend of £65k is mainly due to vacancies within the corporate areas, mainly within the Medical Director and Nursing Directorate. • Non-pays £1,217k underspent with a release of reserves of £1.1m and related underspends within the new DGRI unitary charge (£115k), public Health BBV and Screening (£105k), Nursing Directorate (£80k) which is offset by overspend in medical directorate (£45k) Externals SLA and Drugs (£178k) and unidentified CRES (£25k). • There is an overachievement in income of £135k which relates to, Road Traffic Act higher than budgeted, Medical in Training (£59k) and externals non-contract activity (£82k). • Reserve balance reflects the release required to ensure year-end balanced position overall.

NHS DUMFRIES AND GALLOWAY
EXPENDITURE ANALYSIS - 9 MONTHS TO 31st DECEMBER 2018

AREA	Annual Budget				Pays Ytd			Non Pay Ytd			Income Ytd			Total Ytd			
	Pay	Non Pay	Income	Total	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	%
IJB DELEGATED SERVICES																	
Acute & Diagnostics	86,298	25,933	(3,133)	109,099	63,537	63,986	(449)	20,366	21,828	(1,462)	(2,813)	(2,905)	92	81,090	82,908	(1,819)	-2%
Facilities & Clinical Support	3,334	14,123	(744)	16,712	2,332	2,276	57	10,044	10,120	(76)	(569)	(543)	(25)	11,807	11,852	(45)	0%
Mental Health Directorate	19,597	2,802	(575)	21,823	14,665	14,324	341	1,798	1,858	(60)	(473)	(476)	3	15,990	15,706	284	2%
Primary & Community Care	30,079	77,148	(4,637)	102,589	22,434	22,194	240	57,714	59,942	(2,228)	(3,593)	(3,940)	347	76,555	78,197	(1,642)	-2%
Womens & Childrens Directorate	19,866	2,109	(728)	21,247	14,790	13,971	819	1,528	1,632	(104)	(597)	(597)	0	15,721	15,006	715	5%
E Health	2,549	2,921	(329)	5,141	1,898	1,793	105	2,237	2,257	(20)	(255)	(248)	(7)	3,880	3,802	78	2%
IJB Strategic Services	1,355	20,945	(190)	22,110	1,008	952	55	15,632	15,646	(15)	(150)	(162)	11	16,489	16,437	52	0%
IJB Unidentified CRES	0	(1,748)	0	(1,748)	0	0	0	(1,361)	(200)	(1,161)	0	0	0	(1,361)	(200)	(1,161)	85%
IJB Reserves	0	2,500	0	2,500	0	0	0	1,875	0	1,875	0	0	0	1,875	0	1,875	100%
IJB SERVICES TOTAL	**163,076**	**146,732**	**(10,336)**	**299,472**	**120,663**	**119,496**	**1,167**	**109,832**	**113,082**	**(3,250)**	**(8,450)**	**(8,871)**	**421**	**222,045**	**223,707**	**(1,662)**	**-1%**
BOARD SERVICES																	
Chief Executive	1,069	1,385	(31)	2,422	780	745	35	703	676	27	(24)	(23)	(0)	1,460	1,398	62	4%
Public Health	2,152	569	(496)	2,226	1,626	1,613	13	239	134	105	(278)	(233)	(45)	1,587	1,515	72	5%
Medical Director	4,993	2,436	(963)	6,466	3,743	3,679	64	1,853	1,898	(45)	(698)	(706)	8	4,898	4,871	26	1%
Nursing Directorate	2,356	253	(303)	2,307	1,733	1,698	35	176	96	80	(227)	(227)	(0)	1,682	1,567	115	7%
Workforce Directorate	2,436	270	(286)	2,420	1,761	1,764	(3)	203	211	(8)	(225)	(253)	28	1,738	1,722	17	1%
Finance Directorate	2,927	1,425	(405)	3,948	2,188	2,231	(43)	506	524	(18)	(372)	(358)	(14)	2,322	2,397	(75)	-3%
Non Rec Projects	134	494	(31)	597	50	80	(30)	232	201	31	(16)	(32)	16	266	249	17	6%
Strategic Capital	307	18,699	(16)	18,991	236	241	(6)	12,498	12,375	124	(16)	(40)	25	12,719	12,576	142	1%
Central Income	0	0	(4,986)	(4,986)	0	0	0	0	0	0	(3,740)	(3,875)	135	(3,740)	(3,875)	135	-4%
Externals	0	25,642	(3,042)	22,600	0	0	0	18,655	18,832	(178)	(2,282)	(2,364)	82	16,373	16,469	(96)	-1%
Board Unidentified CRES	0	(23)	0	(23)	0	0	0	(25)	0	(25)	0	0	0	(25)	0	(25)	100%
Board Reserves	1,411	1,502	0	2,913	0	0	0	1,125	0	1,125	0	0	0	1,125	0	1,125	100%
BOARD SERVICES TOTAL	**17,785**	**52,654**	**(10,559)**	**59,880**	**12,116**	**12,050**	**65**	**36,165**	**34,948**	**1,217**	**(7,877)**	**(8,111)**	**233**	**40,404**	**38,888**	**1,516**	**4%**
NON CORE TOTAL	**0**	**9,627**	**0**	**9,627**	**0**	**0**	**0**	**6,358**	**6,358**	**0**	**0**	**0**	**0**	**6,358**	**6,358**	**0**	**0%**
GRAND TOTAL	**180,862**	**209,013**	**(20,896)**	**368,979**	**132,779**	**131,546**	**1,232**	**152,356**	**154,389**	**(2,033)**	**(16,327)**	**(16,982)**	**655**	**268,807**	**268,953**	**(146)**	**0%**

NHS DUMFRIES AND GALLOWAY

SUMMARY CRES PLAN 2018-19

	Recurring Target £000	Non recurring Target £000	Total Target £000	Recurring Schemes Identified £000	Non Recurring Schemes identified £000	Total Identified Schemes £000	Recurring Diff to Target £000	Non Recurring Diff to Target £000	In Year Gap £000	Recurring Gap £000
IJB Savings										
Reduction in use of medical locums	1,000		1,000	0	600	600	(1,000)	600	(400)	(1,000)
Effective prescribing (Secondary Care)	1,250		1,250	841	216	1,057	(409)	216	(193)	(409)
Effective prescribing (Primary Care)	1,750		1,750	1,258	250	1,508	(492)	250	(242)	(492)
Service efficiency (2%) - NHS	3,380		3,380	674	1,956	2,630	(2,706)	1,956	(750)	(2,706)
Realistic Medicine	500		500	0	0	0	(500)	0	(500)	(500)
Business Transformation Programme	500		500	0	0	0	(500)	0	(500)	(500)
Property and Asset Management Strategy	500		500	500	0	500	0	0	0	0
Non recurring savings/ flexibility		4,800	4,800	500	4,152	4,652	500	(648)	(148)	(4,300)
Sub-total IJB	**8,880**	**4,800**	**13,680**	**3,773**	**7,174**	**10,947**	**(5,107)**	**2,374**	**(2,733)**	**(9,907)**
Procurement	300		300	300	0	300	0	0	0	0
Corporate savings	700		700	168	631	799	(532)	631	99	(532)
Non recurring savings/ flexibility		2,666	2,666	0	2,544	2,544	0	(122)	(122)	(2,177)
Sub-total NHS Board	**1,000**	**2,666**	**3,666**	**468**	**3,175**	**3,643**	**(532)**	**509**	**(23)**	**(2,709)**
Total NHS Savings	**9,880**	**7,466**	**17,346**	**4,241**	**10,349**	**14,590**	**(5,639)**	**2,883**	**(2,756)**	**(12,616)**

Agenda Item 265

DUMFRIES and GALLOWAY NHS BOARD

4th February 2019

BOARD BRIEFING

Author:
Rachel Hinchliffe
Communications Assistant

Sponsoring Director:
Jeff Ace
Chief Executive

Date: 21st January 2019

RECOMMENDATION

The Board is asked to discuss and note the Board Briefing.

CONTEXT

Strategy / Policy:

This paper supports the Board's Communication Strategy and gives recognition to key events within the Board.

Organisational Context / Why is this paper important / Key messages:

The purpose of this paper is to raise awareness of the events and achievements that have been acknowledged within the Board over the past 2 months, as well as giving an indication of the consultations that are currently underway and the commitments for both the Chief Executive and Chairman going forward.

GLOSSARY OF TERMS

NHS - National Health Service

MONITORING FORM

Policy / Strategy	NHS Dumfries and Galloway Communication Strategy
Staffing Implications	Not applicable
Financial Implications	Not applicable
Consultation / Consideration	The information within this briefing is populated with items of interest provided by any member of staff.
Risk Assessment	Not applicable.
Risk Appetite	Low [ ] Medium [✓] High [ ] This paper aims to demonstrate the activities that have been undertaken between the NHS Board Meetings, which promotes a positive reputation for the Board, therefore, a medium risk appetite level has been noted above.
Sustainability	Not applicable.
Compliance with Corporate Objectives	This paper encompasses all 7 Corporate Objectives.
Local Outcome Improvement Plan (LOIP)	Outcome 6
Best Value	• Vision and Leadership • Effective Partnerships • Use of Resources • Performance Management • Equality
Impact Assessment Not applicable.	

SECTION 1 – EVENTS

NHS Scotland Event 2019: 30 – 31 May 2019
This year's Event is being held on 30 and 31 May 2019 at the Scottish Event Campus (SEC), Glasgow. The title of the Event is 'Working Together, Improving Outcomes'.

The NHSScotland Event is the leading health event in Scotland. In its 13th year, the Event continues to be the 'premier meeting place' for those committed to providing sustainable high-quality health and social care services for the people of Scotland. It provides the opportunity for those working in and with the NHS in Scotland to come together to consider the challenges, to share best practice and the most innovative approaches to delivering the highest quality of care, and to take away tools and techniques that will support them in their various roles.

Child Bereavement Conference
Child Bereavement UK Scotland is holding a conference in Dumfries at Easterbrook Hall on 14 March 2019 for education, health and social care, acute and primary care staff.

Dawn Allan, Spiritual Care Lead and Bereavement Co-ordinator for NHS Dumfries and Galloway is chairing the conference and will be a day of talks and workshops providing information, tools and advice to support children and young people who face bereavement.

Full details about the conference programme, cost and booking can be found at the following link:

Useful links:
- The event webpage link is: https://childbereavementuk.org/for-professionals/our-courses/supporting-sudden-and-traumatic-bereavement/
- The event online booking link is: https://www.eventbrite.co.uk/e/education-conference-supporting-sudden-and-traumatic-bereavement-tickets-52522785064
- The facebook event (you can share this if you are on facebook): https://www.facebook.com/events/1412156672249850/

Head Injury Information Day
A Head Injury Information Day is being held on 27 March 2019 at the Easterbrook Hall in Dumfries. This is a free information event for professionals, public, family and carers affected by all types of acquired brain and head injury. For further information contact Kirsten Smith (kirsten.smith@digbybrown.co.uk or phone 0141 566 9569) or David Sawden (david@cbisl.org or 01387 261 166) or visit the website www.hiid.org.uk

SECTION 2 – STAFFING CHANGES, INCLUDING NEW STARTS, RETIREMENTS

New Appointments

HMP Dumfries Health Team
Laura Dunlop has joined the administration team based at HMP Dumfries.

Mental Health and Intellectual Disability OT
Emma Ward has been appointed to Band 6 post within the Mental Health and Intellectual Disability Occupational Therapy Service. Emma's new post will be based at both Midpark Hospital and Gardenhill Primary Care Centre.

Nurse Consultant, Clinical Risk
Kelvin Frew, team leader in the CATS Team, has been appointed to the post of Nurse Consultant, Clinical Risk. This is a 23 month post and Kelvin will work across the Health and Social Care Partnership, providing expertise and advice in relation to clinical risk assessment and management of individuals who present with high risks and complex mental health presentations. Kelvin will also act as the key contact and mental health link with MASH.

Kelvin brings a wealth of experience, knowledge and expertise to this key post and we wish him well in this challenging and exciting role over the next 2 years.

Retirement

Pamela McQuaker left the NHS in December 2018 after completed 40 years service. During that time she has held a range of nursing roles in services including, Adult Nursing, Midwifery, Paediatrics, Health Visiting (including Health Visitor for Gypsy and Travelling Families and Lochside Family Centre). Among her achievements Pamela led the development and management of the Parents as First Teachers programme in Dumfries and Galloway, which has been running since July 2011. Pamela also held the post of Nurse Manager within Child and Public Health Nursing.

Gail Coupland has been a key member of the Sonas Team over 12 years and worked across Annandale and Eskdale and Dumfries and Galloway for nearly 43 years before retiring from the NHS.

Promotions

Fiona Paton has been promoted to the post of Clinical Manager, Child and Public Health Nurse. Fiona was previously employed in the role of Senior Health Visitor.

Lynn Cuddihy has been promoted to the post of Clinical Manager, CAMHS, Looked After Children and Acorn House. Lynn was previously employed in the role of Primary Mental Health Lead within Children and Adolescent Mental Health Service (CAMHS).

Fiona and Lynn took up their new roles on 1 December 2018, and are based at The Willows.

SECTION 3 - CURRENT CONSULTATIONS

From	Topic	Response due by
Scottish Government	Changes proposed by The NHS Superannuation and Pension Schemes (Miscellaneous Amendments) (Scotland) Regulations 2019	11/01/2019
Scottish Government	Draft Nation Action Plan for Neurological Conditions 2019-2024	08/02/2019

SECTION 4 – CHIEF EXECUTIVE AND CHAIRMAN COMMITMENTS

Chief Executive's Diary **Key Events**		**Vice Chairman's Diary** **Key Events**
February		**February**
4th - NHS Board Meeting 5th - NHS Chief Executives Meetings 6th - NHS Chief Executives Meetings 15th - WoS Health and Social Care Delivery Plan Programme Board 19th - Board Management Team 25th - Joint Chairs and Chief Executives meeting 26th - Scottish Access Collaborative - Programme Board Meeting 27th - Strategic Capital Programme Board		4th - NHS Board Meeting 15th - WoS Regional Chairs Group Meeting 25th - Joint Chairs and Chief Executives meeting
March		**March**
4th - Performance Committee 5th - Once for Scotland' PDG Engagement Event 8th - West Region Laboratory Medicine Delivery Board meeting 12th - NHS Chief Executives Meetings 13th - NHS Chief Executives Meetings 15th - Community Planning Partnership Board 18th - Healthcare Governance Committee 18th - Endowment Trustees Committee 20th - Strategic Capital Programme Board 26th - Board Management Team		4th - Performance Committee 18th - Endowment Trustees Committee 25th - NHS Chairs Meeting

Chief Executive Appointments to Regional and National Groups

Chair of NHS Board Chief Executives
Chair of Transforming Care after Cancer Treatment Programme Board
Chair of Radiology Transformation Board
Co-Chair of Sustainability and Value Board
Chair of the National Planning Forum
Chair of Diagnostic Steering Group
Member of Children and Young People's Cancer MSN

Chairman Appointments to Regional and National Groups

Member of Fit for Work Scotland - Programme Board
Member of Quality of Care Design Panel and Strategic Group Meeting
Member of West of Scotland Regional Chairs
Member of Guiding Coalition - Integration Workstream

Agenda Item 266

DUMFRIES and GALLOWAY NHS BOARD

4th February 2019

Freedom of Information (Scotland) Act 2002 – Year end Report

Author:
Laura Geddes
Corporate Business Manager

Sponsoring Director:
Jeff Ace
Chief Executive

Date: 21st January 2019

RECOMMENDATION

The Board is asked **to discuss and note** the following points:

- the performance of, and compliance with, the Freedom of Information (Scotland) Act 2002 for the period 1st January – 31st December 2018.

CONTEXT

Strategy / Policy:

This paper supports national legislation through implementation of the Freedom of Information (Scotland) Act 2002 and the local Freedom of Information Policy.

Organisational Context / Why is this paper important / Key messages:

Performance in the handling of Freedom of Information Requests has seen a further reduction in responding to the requests within the 20 working days timeline. 2017 saw 82% of all responses issued on time, where 2018 has highlighted only 68% of requests responded to within the timeline.

A full review of the processes is being undertaken within February – March 2019 and areas of improvement will be reported back to NHS Board as part of the 6 monthly review report, which will be taken to the August 2019 meeting.

GLOSSARY OF TERMS

Act	-	Freedom of Information (Scotland) Act 2002
Commissioner	-	Scottish Information Commissioner
FOI	-	Freedom of Information
FOISA	-	Freedom of Information (Scotland) Act 2002
OSIC	-	Office of the Scottish Information Commissioner

MONITORING FORM

Policy / Strategy	• Freedom of Information (Scotland) Act 2002 • Freedom of Information Policy • Guide to information available through the Model Publication Scheme
Staffing Implications	There are no staffing implications related to this paper.
Financial Implications	There are no financial implications related to this paper.
Consultation / Consideration	This paper has been reviewed by the Chief Executive prior to being presented at NHS Board for noting.
Risk Assessment	No risk assessment was required as part of the preparation of this paper.
Risk Appetite	Low [✓] Medium [ ] High [ ] If the information released into the public domain through Freedom of Information requests is mismanaged, it could result in the identification of patient information or other commercially sensitive information, therefore, breaching the legislation and our information governance protocols. With this in mind, a low risk appetite has been noted.
Sustainability	Not applicable.
Compliance with Corporate Objectives	This paper supports all of the Board's Corporate Objectives.
Local Outcome Improvement Plan (LOIP)	Outcome 6
Best Value	• Vision and Leadership • Governance and Accountability • Use of Resources • Performance Management
Impact Assessment An impact assessment has been undertaken in regard to the Freedom of Information Policy and has been published on the external website, no further impact assessment was required as part of the paper.	

Introduction

1. The Freedom of Information (Scotland) Act 2002 (the Act) came into force on 1st January 2005. The Act provides a statutory right of access to information held by Scottish public bodies including NHS Boards.

2. Information is available through links within the Board's "Guide to information available through the Model Publication Scheme" and our external website, which can be found at www.nhsdg.scot.org.uk

3. Where information is not available through these sources an applicant can, under the Act, make a request for information. The request must be in a permanently recorded form, for example a letter or an e-mail and can be made by anyone, whether resident in the UK or not, for information held prior to and after the enactment of the Act.

4. While most information requested can be released, some information is exempt under the Act. The right of access to information is subject to a number of exemptions within the Act and may also require public interest or harm test to be applied.

Freedom of Information Request

5. The Act requires that requests for information are acknowledged and responded to within twenty working days. As mentioned above there will be occasions where the issue of the information may not be appropriate, as it could identify a patient, which would breach the confidentiality section of the Act and also the Data Protection principles. The Act details a number of exemptions that the Public Body should consider when being asked for information and if the decision is made by the Freedom of Information Officer or Freedom of Information Lead to withhold specific information then the response must clearly state the exemption being applied and the justification for the application of the exemption.

Request for Review

6. Following a request for information, an applicant has a right to ask for a review of the Board's handling of a request to be undertaken, if they are dissatisfied with the response received. An applicant has up to forty working days following receipt of a response in which to submit their request for a review. The Board must acknowledge receipt of the request for review and provide a full response within twenty working days.

7. During 2018, 26 requests for a review of the initial response issued by NHS Dumfries and Galloway were received.

Scottish Information Commissioner

8. The Scottish Information Commissioner is an independent body, who has been given designated authority by Scottish Government to administer this piece of legislation and to hold Scottish public authorities to account through the implementation of the criteria within the Act.

9. Following receipt of the response to a review request from the Board, if the applicant remains dissatisfied, they have a further right of appeal to the Scottish Information Commissioner. An applicant has up to six months following the outcome of the review from the Public Body, in which, to apply to the Commissioner.

10. The Commissioner will investigate the application and will make a decision on evidence provided as to whether compliance with the Act can be demonstrated. Once a decision has been made a formal decision notice will be issued that confirms the outcome of the review and sets out any steps the authority should take, for example by giving all or part of the information requested. If the Board fails to take these steps, the Commissioner can inform the Court of Session that the authority has not done so, who will then undertake their own investigate and may find the Board in contempt of court, which could result in an unlimited fine.

11. Following a decision by the Commissioner an applicant who remains dissatisfied has a further right of review to the Court of Session, but on a point of law only.

Application

12. Since the Act came into force on 1 January 2005 NHS Dumfries and Galloway has sought to ensure that robust arrangements for managing requests for information are in place. These arrangements have been adapted where necessary to respond to the increasing number of requests in an appropriate and timely manner and to ensure the Board complies with legislation.

13. Requests are managed through the Chief Executive's Office who gather the information from various teams and departments throughout the service to compile the appropriate response to the requester.

14. Freedom of Information requests are in the main received electronically via dg.feedback@nhs.net with a small number of requests received in writing.

Number of Requests Received

15. 661 requests for information were received in 2018, which demonstrates a 9.5% increase on 2017, where 598 requests were received. Of the 661 requests received 14 requests were handled as Environmental Information Requests and the remaining 647 requests were dealt with through the Freedom of Information (Scotland) Act 2002.

16. Within 2018, the Board responded to 68% of the information requests within the 20 working days response period stated within the legislation, which is a reduced position compared to 2017 where 82% of responses were issued within the same time period. A breakdown of the breaches to the time period are noted below:

Month response due in 2018	**Period breached beyond 20 days timeline**			
	1-5 days	*6-10 days*	*11-20 days*	*21+ days*
January	0	0	2	0
February	4	4	3	5
March	4	1	3	4
April	0	8	2	3
May	7	4	3	10
June	7	5	2	7
July	4	0	2	8
August	4	4	7	5
September	7	8	7	7
October	7	4	3	9
November	6	7	5	5
December	7	3	2	3
TOTAL	**57**	**48**	**41**	**66**

17. A significant decrease in performance against the response times noted within the legislation has been highlighted above. No specific reasons around this reduction in performance could be identified other than a continuous increase to staff workload. A full review of the current process is being undertaken in February – March 2019 to identify any areas of improvement that can be made to the processes to try to improve the performance. Further updates on any revisions to the processes will be highlighted in the 6 monthly report to NHS Board in August 2019.

18. Attached at **Appendix 1** is a summary of all the requests received between 1st January 2018 – 31st December 2018, highlighting where the breaches have occurred, the information requests where a review has been requested and also if any Scottish Information Commissioner requests have been received in year.

Scottish Information Commissioner Applications

19. A review of the Freedom of Information requests has confirmed that to date 5 applications have been made to the Scottish Information Commissioner in relation to requests received in 2018.

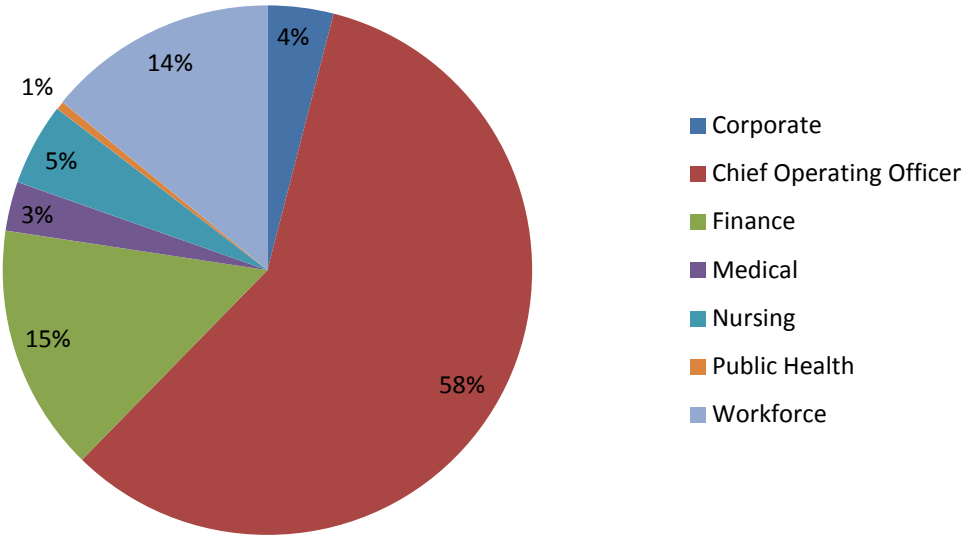
20. Details of the notices received are listed below, along with a link to the Scottish Information Commissioners website, where more detailed information can be viewed on the full decision report.

SIC Reference	Decision Date	Outcome and link to SIC website	Action Required
160-2018	12th October 2018	NHS Dumfries and Galloway had failed to respond to the request in accordance with Part 1 of FOISA, but did not require it to take any action as a new response and apology had already been issued to the requester. https://www.itspublicknowledge.info/uploadedFiles/Decision160-2018.pdf	No action required by NHS Dumfries and Galloway
161-2018	12th October 2018	NHS Dumfries and Galloway had failed to respond to the request in accordance with Part 1 of FOISA, but he did not require it to take any action because it had already issued a new response with an apology. https://www.itspublicknowledge.info/uploadedFiles/Decision161-2018.pdf	No action was required by NHS Dumfries and Galloway

21. Decision notices for the two remaining applications that are being reviewed by the Scottish Information Commissioner have not yet been issued. Any decision notices can be viewed by through the commissioners website at www.itspublicknowledge.info

Directorate Providing Information for Responses

22. The diagram below details the volume of requests that have been handled through each of the Board's directorates.



Type of Information Requested

23. A wide range of information has been requested from NHS Dumfries and Galloway, which often contain a significant number of separate elements and varying degree of complexity. Similar themes have been identified for the requests, which include:-

- Acute Services
- Assaults on Staff
- Slips, trips and falls
- Delayed Discharges
- Finance
- Workforce
- Maternity
- Pharmacy / Prescribing

Publication Scheme

24. As part of the implementation of the Act, the Scottish Information Commissioner requires all Scottish public authorities to be proactive in regard to information requests and publish a "Guide to Information available through the publication Scheme", which is based on the Commissioners Model Publication Scheme template. A copy of the Board's Guide is available on the Board's internal and external websites for reference.

25. The key benefits that can be seen through proactive publication are to:-
- demonstrate accountability and transparency to build reputation;
- engage and communicate to build relationships; and
- increase efficiency by reducing the impact of request handling.

26. The reputational benefits are derived from being open about who we are, what we do and how we do it, which leads to actual and perceived accountability and transparency demonstrating that the organisation has nothing to hide.

27. Communication is an iterative process between those giving a message and those receiving it. Proactive publication is about initiating a conversation and then being prepared to listen. The Board achieves a reputation of being an organisation that listens.

28. NHS Dumfries and Galloway are looking at options around the publication of the information and is working with the Information Assurance Committee to agree the most effective approach to ensure openness and transparency of the information held.

'Popularity' of FOISA

29. The figures below demonstrate the increased 'popularity' of Freedom of Information and Environmental Information requests since its introduction in 2005.

Year	*No of Requests*	*% change from previous year*	*% increase from 2006*
2018	661	+11%	568%
2017	598	+2%	504%
2016	584	+16%	490%
2015	505	+3%	410%
2014	492	+13%	397%
2013	434	+5%	338%
2012	413	+22%	317%
2011	339	-7%	242%
2010	364	+48%	268%
2009	246	+37%	148%
2008	180	+84%	82%
2007	98	-1%	1%
2006	99	N/A	N/A

Conclusion

30. The Freedom of Information (Scotland) Act 2002 generates an increasing number of requests for information and we will continue to strive to improve performance and compliance rates whilst acknowledging the number of requests received and the challenge this presents to teams and departments.

31. A full review of the process for handling Freedom of Information requests is being undertaken in February – March 2019, with any revisions to the process being reported to Board within the next 6 monthly update paper.

File Number	EIR/FOI	Date Received	Due date	Date Closed / withdrawn	Breach 20 days	Breach 1-5 days	Breach 6-10 days
18-001	FOI	03/01/18	31/01/18	19/02/18	YES		
18-002	FOI	03/01/18	31/01/18	12/02/18	YES		
18-003	FOI	03/01/18	31/01/18	19/01/18	NO		
18-004	FOI	03/01/18	31/01/18	22/01/18	NO		
18-005	FOI	04/01/18	01/02/18	02/02/18	YES	YES	
18-006	FOI	04/01/18	01/02/18	19/01/18	NO		
18-007	FOI	05/01/18	02/02/18	12/02/18	YES		YES
18-008	FOI	08/01/18	05/02/18	22/01/18	NO		
18-009	FOI	08/01/18	05/02/18	01/02/18	NO		
18-010	FOI	08/01/18	05/02/18	31/01/18	NO		
18-011	FOI	09/01/18	06/02/18	31/01/18	NO		
18-012	FOI	10/01/18	07/02/18	02/05/18	YES		
18-013	FOI	05/01/18	02/02/18	15/03/18	YES		
18-014	FOI	10/01/18	07/02/18	10/04/18	YES		
18-015	EIR	10/01/18	07/02/18	01/02/18	NO		
18-016	FOI	11/01/18	08/02/18	26/01/18	NO		
18-017	FOI	12/01/18	09/02/18	02/02/18	NO		
18-018	FOI	12/01/18	09/02/18	01/03/18	YES		
18-019	FOI	12/01/18	09/02/18	26/01/18	NO		
18-020	FOI	15/01/18	12/02/18	02/02/18	NO		
18-021	FOI	15/01/18	12/02/18	21/02/18	YES		YES
18-022	EIR	15/01/18	12/02/18	17/01/18	NO		
18-023	FOI	17/01/18	14/02/18	21/02/18	YES		YES
18-024	FOI	17/01/18	14/02/18	29/01/18	NO		
18-025	FOI	19/01/18	16/02/18	13/02/18	NO		
18-026	FOI	18/01/18	15/02/18	02/02/18	NO		
18-027	FOI	18/01/18	15/02/18	13/02/18	NO		
18-028	FOI	19/01/18	16/02/18	14/02/18	NO		
18-029	FOI	19/01/18	16/02/18	05/03/18	YES		
18-030	FOI	19/01/18	16/02/18	16/02/18	NO		
18-031	FOI	19/01/18	16/02/18	13/02/18	NO		
18-032	FOI	22/01/18	19/02/18	21/02/18	YES	YES	
18-033	FOI	22/01/18	19/02/18	13/02/18	NO		
18-034	FOI	22/01/18	19/02/18	19/02/18	NO		
18-035	FOI	22/01/18	19/02/18	14/02/18	NO		
18-036	FOI	23/01/18	20/02/18	13/02/18	NO		
18-037	FOI	23/01/18	20/02/18	13/02/18	NO		
18-038	FOI	23/01/18	20/02/18	23/01/18	NO		
18-039	FOI	23/01/18	20/02/18	19/02/18	NO		
18-040	FOI	24/01/18	21/02/18	06/03/18	YES		
18-041	FOI	24/01/18	21/02/18	13/02/18	NO		
18-042	FOI	25/01/18	22/02/18	21/02/18	NO		
18-043	FOI	25/01/18	22/02/18	21/02/18	NO		
18-044	FOI	26/01/18	23/02/18	13/02/18	NO		
18-045	FOI	26/01/18	23/02/18	26/01/18	NO		
18-046	FOI	26/01/18	23/02/18	26/03/18	YES		
18-047	FOI	29/01/18	26/02/18	23/02/18	NO		
18-048	FOI	29/01/18	26/02/18	20/02/18	NO		
18-049	FOI	29/01/18	26/02/18	01/03/18	YES	YES	

18-050	FOI	29/01/18	26/02/18	01/03/18	YES	YES	
18-051	FOI	31/01/18	28/02/18	06/03/18	YES		YES
18-052	FOI	30/01/18	27/02/18	16/03/18	YES		
18-053	FOI	01/02/18	01/03/18	21/02/18	NO		
18-054	EIR	01/02/18	01/03/18	20/02/18	NO		
18-055	FOI	01/02/18	01/03/18	20/02/18	NO		
18-056	FOI	02/02/18	02/03/18	22/03/18	YES		
18-057	FOI	06/02/18	06/03/18	19/02/18	NO		
18-058	FOI	06/02/18	06/03/18	20/02/18	NO		
18-059	FOI	06/02/18	06/03/18	05/03/18	NO		
18-060	FOI	07/02/18	07/03/18	01/03/18	NO		
18-061	FOI	08/02/18	08/03/18	20/02/18	NO		
18-062	FOI	08/02/18	08/03/18	12/03/18	YES	YES	
18-063	FOI	09/02/18	09/03/18	16/04/18	YES		
18-064	FOI	09/02/18	09/03/18	26/03/18	YES		
18-065	FOI	07/02/18	07/03/18	20/02/18	NO		
18-066	FOI	07/02/18	07/03/18	21/02/18	NO		
18-067	FOI	12/02/18	12/03/18	12/03/18	NO		
18-068	FOI	12/02/18	12/03/18	15/03/18	YES	YES	
18-069	FOI	13/02/18	13/03/18	21/02/18	NO		
18-070	FOI	13/02/18	13/03/18	01/03/18	NO		
18-071	FOI	13/02/18	13/03/18	12/03/18	NO		
18-072	FOI	14/02/18	14/03/18	21/02/18	NO		
18-073	FOI	14/02/18	14/03/18	12/03/18	NO		
18-074	FOI	14/02/18	14/03/18	12/03/18	NO		
18-075	FOI	15/02/18	15/03/18	15/03/18	NO		
18-076	EIR	15/02/18	15/03/18	19/02/18	NO		
18-077	FOI	15/02/18	15/03/18	12/03/18	NO		
18-078	FOI	16/02/18	16/03/18	12/03/18	NO		
18-079	FOI	16/02/18	16/03/18	12/03/18	NO		
18-080	FOI	16/02/18	16/03/18	12/03/18	NO		
18-081	FOI	19/02/18	19/03/18	10/04/18	YES		
18-082	FOI	20/02/18	20/03/18	12/03/18	NO		
18-083	FOI	19/02/18	19/03/18	22/03/18	YES	YES	
18-084	FOI	19/02/18	19/03/18	12/03/18	NO		
18-085	FOI	19/02/18	19/03/18	26/04/18	YES		
18-086	FOI	21/02/18	21/03/18	28/03/18	YES		YES
18-087	FOI	21/02/18	21/03/18	16/05/18	YES		
18-088	FOI	22/02/18	22/03/18	12/03/18	NO		
18-089	FOI	22/02/18	22/03/18	12/03/18	NO		
18-090	FOI	22/02/18	22/03/18	12/03/18	NO		

18-091	FOI	26/02/18	26/03/18	26/02/18	NO		
18-092	FOI	23/02/18	23/03/18	28/03/18	YES	YES	
18-093	FOI	23/02/18	23/03/18	22/03/18	NO		
18-094	FOI	23/02/18	23/03/18	01/03/18	NO		
18-095	FOI	23/02/18	23/03/18	12/03/18	NO		
18-096	FOI	27/02/18	27/03/18	27/03/18	NO		
18-097	FOI	27/02/18	27/03/18	22/03/18	NO		
18-098	FOI	28/02/18	28/03/18	27/03/18	NO		
18-099	FOI	28/02/18	28/03/18	28/03/18	NO		
18-100	FOI	28/02/18	28/03/18	16/03/18	NO		
18-101	FOI	28/02/18	28/03/18	28/03/18	NO		
18-102	FOI	28/02/18	28/03/18	12/03/18	NO		
18-103	FOI	02/03/18	30/03/18	10/04/18	YES		
18-104	FOI	02/03/18	30/03/18	12/03/18	NO		
18-105	FOI	05/03/18	02/04/18	09/04/18	YES		YES
18-106	FOI	05/03/18	02/04/18	23/03/18	NO		
18-107	FOI	05/03/18	02/04/18	09/04/18	YES		YES
18-108	FOI	06/03/18	03/04/18	30/03/18	NO		
18-109	FOI	08/03/18	05/04/18	15/03/18	NO		
18-110	FOI	08/03/18	05/04/18	15/03/18	NO		
18-111	FOI	08/03/18	05/04/18	12/04/18	YES		YES
18-112	FOI	08/03/18	05/04/18	05/04/18	NO		
18-113	FOI	09/03/18	06/04/18	17/04/18	YES		
18-114	FOI	09/03/18	06/04/18	16/03/18	NO		
18-115	FOI	12/03/18	09/04/18	04/04/18	NO		
18-116	FOI	12/03/18	09/04/18	28/03/18	NO		
18-117	FOI	13/03/18	10/04/18	05/04/18	NO		
18-118	FOI	13/03/18	10/04/18	23/03/18	NO		
18-119	FOI	13/03/18	10/04/18	16/04/18	YES		YES
18-120	FOI	14/03/18	11/04/18	28/03/18	NO		
18-121	FOI	14/03/18	11/04/18	26/04/18	YES		
18-122	FOI	14/03/18	11/04/18	09/04/18	NO		
18-123	FOI	12/03/18	09/04/18	29/03/18	NO		
18-124	FOI	12/03/18	09/04/18	28/03/18	NO		
18-125	FOI	16/03/18	13/04/18	11/04/18	NO		
18-126	FOI	12/03/18	09/04/18	04/04/18	NO		
18-127	FOI	19/03/18	16/04/18	23/03/18	NO		
18-128	FOI	20/03/18	17/04/18	09/04/18	NO		
18-129	FOI	20/03/18	17/04/18	29/03/18	NO		
18-130	FOI	20/03/18	17/04/18	09/04/18	NO		
18-131	FOI	20/03/18	17/04/18	25/04/18	YES		YES
18-132	FOI	21/03/18	18/04/18	17/04/18	NO		
18-133	FOI	21/03/18	18/04/18	16/04/18	NO		

18-134	FOI	21/03/18	18/04/18	17/04/18	NO		
18-135	FOI	22/03/18	19/04/18	04/04/18	NO		
18-136	FOI	22/03/18	19/04/18	12/09/18	YES		YES
18-137	FOI	22/03/18	19/04/18	20/04/18	YES		YES
18-138	FOI	22/03/18	19/04/18	17/04/18	NO		
18-139	FOI	23/03/18	20/04/18	17/04/18	NO		
18-140	FOI	23/03/18	20/04/18	27/04/18	YES		YES
18-141	FOI	23/03/18	20/04/18	17/04/18	NO		
18-142	FOI	23/03/18	20/04/18	17/04/18	NO		
18-143	FOI	26/03/18	23/04/18	17/04/18	NO		
18-144	FOI	26/03/18	23/04/18	28/03/18	NO		
18-145	FOI	26/03/18	23/04/18	17/04/18	NO		
18-146	FOI	28/03/18	25/04/18	20/04/18	NO		
18-147	FOI	28/03/18	25/04/18	17/05/18	YES		
18-148	FOI	29/03/18	26/04/18	17/05/18	YES		
18-149	FOI	03/04/18	01/05/18	17/05/18	YES		
18-150	FOI	03/04/18	01/05/18	20/04/18	NO		
18-151	FOI	04/04/18	02/05/18	26/04/18	NO		
18-152	FOI	04/04/18	02/05/18	02/05/18	NO		
18-153	FOI	04/04/18	02/05/18	25/04/18	NO		
18-154	FOI	04/04/18	02/05/18	02/05/18	NO		
18-155	FOI	04/04/18	02/05/18	09/07/18	YES		
18-156	FOI	05/04/18	03/05/18	10/05/18	YES		YES
18-157	FOI	28/03/18	25/04/18	22/05/18	YES		
18-158	FOI	28/03/18	26/04/18	26/04/18	NO		
18-159	FOI	10/05/18	07/06/18	17/05/18	NO		
18-160	FOI	05/04/18	03/05/18	20/04/18	NO		
18-161	FOI	06/04/18	04/05/18	10/05/18	YES		YES
18-162	FOI	06/04/18	04/05/18	20/04/18	NO		
18-163	FOI	06/04/18	04/05/18	11/06/18	YES		YES
18-164	FOI	09/04/18	07/05/18	26/04/18	NO		
18-165	FOI	09/04/18	07/05/18	10/05/18	YES	YES	
18-166	FOI	09/04/18	07/05/18	26/04/18	NO		
18-167	FOI	09/04/18	07/05/18	11/05/18	YES	YES	
18-168	FOI	10/04/18	08/05/18	18/06/18	YES		
18-169	FOI	10/04/18	08/05/18	10/05/18	YES	YES	
18-170	FOI	10/04/18	08/05/18	06/06/18	YES		
18-171	FOI	11/04/18	09/05/18	29/05/18	YES		

18-172	FOI	11/04/18	09/05/18	10/05/18	YES	YES	
18-173	FOI	11/04/18	09/05/18	23/05/18	YES		
18-174	FOI	12/04/18	10/05/18	10/05/18	NO		
18-175	FOI	12/04/18	10/05/18	10/05/18	NO		
18-176	FOI	12/04/18	10/05/18	10/05/18	NO		
18-177	FOI	12/04/18	10/05/18	10/05/18	NO		
18-178	FOI	12/04/18	10/05/18	10/05/18	NO		
18-179	FOI	16/04/18	14/05/18	10/05/18	NO		
18-180	FOI	16/04/18	14/05/18	10/05/18	NO		
18-181	FOI	16/04/18	14/05/18	26/04/18	NO		
18-182	FOI	16/04/18	14/05/18	11/05/18	NO		
18-183	FOI	18/04/18	16/05/18	10/05/18	NO		
18-184	FOI	18/04/18	16/05/18	10/05/18	NO		
18-185	FOI	18/04/18	16/05/18	10/05/18	NO		
18-186	FOI	18/04/18	16/05/18	10/05/18	NO		
18-187	FOI	18/04/18	16/05/18	15/05/18	NO		
18-188	FOI	18/04/18	16/05/18	18/06/18	YES		
18-189	FOI	18/04/18	16/05/18	26/06/18	YES		
18-190	FOI	18/04/18	16/05/18	11/05/18	NO		
18-191	FOI	19/04/18	17/05/18	25/05/18	YES		YES
18-192	FOI	19/04/18	17/05/18	30/08/18	YES		
18-193	FOI	19/04/18	17/05/18	22/08/18	YES		
18-194	FOI	19/04/18	17/05/18	11/05/18	NO		
18-195	FOI	19/04/18	17/05/18	11/05/18	NO		
18-196	FOI	20/04/18	18/05/18	13/06/18	YES		
18-197	FOI	23/04/18	21/05/18	22/05/18	YES	YES	
18-198	FOI	23/04/18	21/05/18	22/05/18	YES	YES	
18-199	FOI	24/04/18	22/05/18	11/05/18	NO		
18-200	FOI	24/04/18	22/05/18	11/05/18	NO		
18-201	FOI	24/04/18	22/05/18	11/05/18	NO		
18-202	FOI	26/04/18	24/05/18	11/05/18	NO		
18-203	FOI	26/04/18	24/05/18	17/05/18	NO		
18-204	FOI	26/04/18	24/05/18	11/05/18	NO		
18-205	FOI	26/04/18	24/05/18	22/05/18	NO		
18-206	FOI	25/04/18	23/05/18	11/05/18	NO		
18-207	FOI	26/04/18	24/05/18	25/05/18	YES	YES	
18-208	FOI	27/04/18	25/05/18	14/05/18	NO		
18-209	FOI	27/04/18	25/05/18	16/07/18	YES		
18-210	FOI	27/04/18	25/05/18	17/05/18	NO		
18-211	FOI	30/04/18	28/05/18	02/05/18	NO		
18-212	EIR	30/04/18	28/05/18	22/05/18	NO		
18-213	FOI	01/05/18	29/05/18	29/05/18	NO		
18-214	FOI	01/05/18	29/05/18	23/05/18	NO		
18-215	FOI	01/05/18	29/05/18	29/05/18	NO		
18-216	FOI	02/05/18	30/05/18	17/05/18	NO		
18-217	FOI	02/05/18	30/05/18	11/05/18	NO		
18-218	FOI	02/05/18	30/05/18	25/05/18	NO		
18-219	FOI	03/05/18	31/05/18	11/05/18	NO		
18-220	FOI	03/05/18	31/05/18	27/06/18	YES		
18-221	FOI	03/05/18	31/05/18	24/05/18	NO		
18-222	FOI	03/05/18	31/05/18	24/05/18	NO		

18-223	FOI	03/05/18	31/05/18	25/05/18	NO		
18-224	FOI	08/05/18	05/06/18	22/05/18	NO		
18-225	FOI	08/05/18	05/06/18	13/06/18	YES		YES
18-226	EIR	08/05/18	05/06/18	01/06/18	NO		
18-227	FOI	08/05/18	05/06/18	17/05/18	NO		
18-228	FOI	08/05/18	05/06/18	25/05/18	NO		
18-229	FOI	08/05/18	05/06/18	12/06/18	YES		YES
18-230	FOI	04/05/18	01/06/18	27/07/18	YES		
18-231	FOI	07/05/18	04/06/18	14/05/18	NO		
18-232	FOI	09/05/18	06/06/18	25/05/18	NO		
18-233	FOI	09/05/18	06/06/18	13/06/18	YES		YES
18-234	FOI	09/05/18	06/06/18	13/06/18	YES		YES
18-235	FOI	10/05/18	07/06/18	16/07/18	YES		
18-236	EIR	10/05/18	07/06/18	25/05/18	NO		
18-237	FOI	10/05/18	07/06/18	12/06/18	YES	YES	
18-238	FOI	10/05/18	07/06/18	10/05/18	NO		
18-239	FOI	14/05/18	11/06/18	05/06/18	NO		
18-240	EIR	14/05/18	11/06/18	13/06/18	YES	YES	
18-241	FOI	15/05/18	12/06/18	13/06/18	YES	YES	
18-242	FOI	15/05/18	12/06/18	14/06/18	YES	YES	
18-243	FOI	15/05/18	12/06/18	25/05/18	NO		
18-244	FOI	16/05/18	13/06/18	14/06/18	YES	YES	
18-245	FOI	16/05/18	13/06/18	31/05/18	NO		
18-246	FOI	16/05/18	13/06/18	13/06/18	NO		
18-247	FOI	16/05/18	13/06/18	25/05/18	NO		
18-248	FOI	16/05/18	13/06/18	18/06/18	YES	YES	
18-249	FOI	16/05/18	13/06/18	16/07/18	YES		
18-250	FOI	16/05/18	13/06/18	26/06/18	YES		
18-251	FOI	16/05/18	13/06/18	14/06/18	YES	YES	
18-252	FOI	17/05/18	14/06/18	12/09/18	YES		
18-253	FOI	17/05/18	14/06/18	08/06/18	NO		
18-254	FOI	18/05/18	15/06/18	15/06/18	NO		
18-255	FOI	18/05/18	15/06/18	02/05/18	NO		
18-256	FOI	18/05/18	15/06/18	25/05/18	NO		
18-257	FOI	23/05/18	20/06/18	13/06/18	NO		
18-258	FOI	21/05/18	18/06/18	01/06/18	NO		
18-259	FOI	23/05/18	20/06/18	14/06/18	NO		
18-260	FOI	23/05/18	20/06/18	14/06/18	NO		
18-261	FOI	24/05/18	21/06/18	25/05/18	NO		
18-262	FOI	25/05/18	22/06/18	07/08/18	YES		
18-263	FOI	28/05/18	25/06/18	20/06/18	NO		
18-264	FOI	28/05/18	25/06/18	14/06/18	NO		
18-265	FOI	29/05/18	26/06/18	24/08/18	YES		
18-266	FOI	28/05/18	25/06/18	20/06/18	NO		
18-267	FOI	29/05/18	26/06/18	05/06/18	NO		
18-268	FOI	29/05/18	26/06/18	18/06/18	NO		
18-269	FOI	29/05/18	26/06/18	09/07/18	YES		
18-270	FOI	31/05/18	28/06/18	15/06/18	NO		
18-271	FOI	01/06/18	29/06/18	09/07/18	YES		YES
18-272	FOI	04/06/18	02/07/18	19/06/18	NO		
18-273	FOI	05/06/18	03/07/18	10/08/18	YES		
18-274	FOI	06/06/18	04/07/18	26/07/18	YES		

18-275	FOI	06/06/18	04/07/18	19/06/18	NO		
18-276	FOI	07/06/18	05/07/18	10/07/18	YES	YES	
18-277	FOI	08/06/18	06/07/18	07/08/18	YES		
18-278	FOI	11/06/18	09/07/18	27/06/18	NO		
18-279	FOI	11/06/18	09/07/18	08/07/18	NO		
18-280	FOI	11/06/18	09/07/18	09/07/18	NO		
18-281	FOI	07/06/18	05/07/18	09/07/18	YES	YES	
18-282	FOI	07/06/18	05/07/18	27/06/18	NO		
18-283	FOI	12/06/18	10/07/18	10/07/18	NO		
18-284	FOI	12/06/18	10/07/18	27/06/18	NO		
18-285	FOI	13/06/18	11/07/18	30/08/18	YES		
18-286	FOI	14/06/18	12/07/18	21/06/18	NO		
18-287	FOI	14/06/18	12/07/18	25/07/18	YES		
18-288	FOI	15/06/18	13/07/18	26/06/18	NO		
18-289	FOI	15/06/18	13/07/18	27/06/18	NO		
18-290	FOI	18/06/18	16/07/18	19/06/18	NO		
18-291	FOI	18/06/18	16/07/18	16/07/18	NO		
18-292	FOI	21/05/18	18/06/18	02/10/18	YES		
18-293	FOI	19/06/18	17/07/18	18/07/18	YES	YES	
18-294	FOI	19/06/18	17/07/18	16/08/18	YES		
18-295	FOI	20/06/18	18/07/18	23/07/18	YES	YES	
18-296	FOI	20/06/18	18/07/18	09/07/18	NO		
18-297	FOI	20/06/18	18/07/18	26/06/18	NO		
18-298	FOI	21/06/18	19/07/18	09/07/18	NO		
18-299	FOI	21/06/18	19/07/18	16/08/18	YES		
18-300	FOI	21/06/18	19/07/18	09/07/18	NO		
18-301	FOI	21/06/18	19/07/18	21/11/18	YES		
18-302	FOI	22/06/18	20/07/18	17/08/18	YES		
18-303	FOI	22/06/18	20/07/18	09/07/18	NO		
18-304	FOI	25/06/18	23/07/18	09/07/18	NO		
18-305	FOI	25/06/18	23/07/18	09/07/18	NO		
18-306	FOI	27/06/18	25/07/18	23/07/18	NO		
18-307	FOI	27/06/18	25/07/18	16/07/18	NO		
18-308	FOI	28/06/18	26/07/18	20/07/18	NO		
18-309	FOI	28/06/18	26/07/18	23/07/18	NO		
18-310	EIR	26/06/18	24/07/18	23/07/18	NO		
18-311	FOI	29/06/18	27/07/18	17/08/18	YES		
18-312	FOI	29/06/18	27/07/18	23/07/18	NO		
18-313	FOI	02/07/18	30/07/18	23/07/18	NO		
18-314	FOI	02/07/18	30/07/18	16/07/18	NO		
18-315	FOI	04/07/18	01/08/18	16/07/18	NO		
18-316	FOI	04/07/18	01/08/18	08/08/18	YES		YES
18-317	FOI	04/07/18	01/08/18	31/07/18	NO		
18-318	FOI	10/07/18	07/08/18	26/07/18	NO		
18-319	FOI	11/07/18	08/08/18	16/07/18	NO		
18-320	FOI	11/07/18	08/08/18	23/07/18	NO		
18-321	FOI	11/07/18	08/08/18	26/09/18	YES		
18-322	FOI	11/07/18	08/08/18	14/08/18	YES		YES
18-323	FOI	11/07/18	08/08/18	17/07/18	NO		
18-324	FOI	11/07/18	08/08/18	07/08/18	NO		
18-325	FOI	12/07/18	09/08/18	26/07/18	NO		
18-326	FOI	12/07/18	09/08/18	07/08/18	NO		
18-327	FOI	12/07/18	09/08/18	26/07/18	NO		
18-328	FOI	13/07/18	10/08/18	26/07/18	NO		

18-329	FOI	12/07/18	09/08/18	07/08/18	NO		
18-330	FOI	13/07/18	10/08/18	16/07/18	NO		
18-331	FOI	16/07/18	13/08/18	10/08/18	NO		
18-332	FOI	16/07/18	13/08/18	10/08/18	NO		
18-333	FOI	16/07/18	13/08/18	08/08/18	NO		
18-334	FOI	16/07/18	13/08/18	26/07/18	NO		
18-335	FOI	17/07/18	14/08/18	20/07/18	NO		
18-336	FOI	17/07/18	14/08/18	09/08/18	NO		
18-337	FOI	17/07/18	14/08/18	23/08/18	YES		YES
18-338	FOI	17/07/18	14/08/18	08/08/18	NO		
18-339	FOI	18/07/18	15/08/18	26/07/18	NO		
18-340	FOI	18/07/18	15/08/18	26/11/18	YES		
18-341	FOI	18/07/18	15/08/18	28/08/18	YES		
18-342	FOI	18/07/18	15/08/18	08/08/18	NO		
18-343	FOI	19/07/18	16/08/18	08/08/18	NO		
18-344	FOI	19/07/18	16/08/18	26/07/18	NO		
18-345	FOI	19/07/18	16/08/18	26/07/18	NO		
18-346	FOI	19/07/18	16/08/18	14/08/18	NO		
18-347	FOI	19/07/18	16/08/18	08/08/18	NO		
18-348	FOI	19/07/18	16/08/18	08/08/18	NO		
18-349	FOI	19/07/18	16/08/18	25/07/18	NO		
18-350	FOI	19/07/18	16/08/18	30/08/18	YES		
18-351	FOI	11/07/18	08/08/18	08/08/18	NO		
18-352	FOI	20/07/18	17/08/18	08/08/18	NO		
18-353	FOI	20/07/18	17/08/18	13/08/18	NO		
18-354	FOI	20/07/18	17/08/18	10/08/18	NO		
18-355	FOI	23/07/18	20/08/18	14/08/18	NO		
18-356	FOI	23/07/18	20/08/18	08/08/18	NO		
18-357	FOI	23/07/18	20/08/18	09/09/18	YES		
18-358	FOI	23/07/18	20/08/18	10/08/18	NO		
18-359	FOI	20/07/18	17/08/18	10/08/18	NO		
18-360	FOI	23/07/18	20/08/18	30/08/18	YES		YES
18-361	FOI	23/07/18	20/08/18	09/08/18	NO		
18-362	FOI	25/07/18	22/08/18	24/08/18	YES	YES	
18-363	FOI	25/07/18	22/08/18	10/08/18	NO		
18-364	FOI	25/07/18	22/08/18	10/08/18	NO		
18-365	FOI	26/07/18	23/08/18	21/09/18	YES		
18-366	FOI	26/07/18	23/08/18	13/08/18	NO		
18-367	FOI	26/07/18	23/08/18	28/08/18	YES	YES	
18-368	FOI	27/07/18	24/08/18	13/08/18	NO		
18-369	FOI	27/07/18	24/08/18	28/08/18	YES	YES	
18-370	FOI	30/07/18	27/08/18	13/08/18	NO		
18-371	FOI	30/07/18	27/08/18	14/08/18	NO		
18-372	FOI	30/07/18	27/08/18	14/09/18	YES		
18-373	FOI	31/07/18	28/08/18	14/08/18	NO		
18-374	FOI	31/07/18	28/08/18	24/08/18	NO		
18-375	FOI	31/07/18	28/08/18	31/08/18	YES	YES	
18-376	EIR	01/08/18	29/08/18	13/08/18	NO		
18-377	FOI	01/08/18	29/08/18	12/12/18	YES		
18-378	FOI	01/08/18	29/08/18	24/09/18	YES		
18-379	FOI	02/08/18	30/08/18	24/08/18	NO		
18-380	FOI	02/08/18	30/08/18	10/09/18	YES		
18-381	FOI	02/08/18	30/08/18	24/08/18	NO		
18-382	FOI	02/08/18	30/08/18	14/09/18	YES		

18-383	FOI	02/08/18	30/08/18	10/09/18	YES		
18-384	FOI	03/08/18	31/08/18	20/08/18	NO		
18-385	FOI	03/08/18	31/08/18	13/08/18	NO		
18-386	FOI	15/08/18	12/09/18	17/09/18	YES	YES	
18-387	FOI	06/08/18	03/09/18	14/08/18	NO		
18-388	FOI	06/08/18	03/09/18	14/08/18	NO		
18-389	FOI	06/08/18	03/09/18	14/08/18	NO		
18-390	FOI	09/08/18	06/09/18	03/09/18	NO		
18-391	FOI	07/08/18	04/09/18	03/09/18	NO		
18-392	FOI	07/08/18	04/09/18	14/09/18	YES		YES
18-393	FOI	07/08/18	04/09/18	10/09/18	YES		YES
18-394	FOI	08/08/18	05/09/18	20/08/18	NO		
18-395	FOI	09/08/18	06/09/18	14/08/18	NO		
18-396	FOI	08/08/18	05/09/18	14/09/18	YES		YES
18-397	FOI	08/08/18	05/09/18	20/08/18	NO		
18-398	FOI	09/08/18	06/09/18	03/09/18	NO		
18-399	FOI	13/08/18	10/09/18	14/08/18	NO		
18-400	FOI	13/08/18	10/09/18	14/08/18	NO		
18-401	FOI	11/08/18	08/09/18	04/10/18	YES		
18-402	FOI	11/08/18	08/09/18	17/09/18	YES		YES
18-403	FOI	14/08/18	11/09/18	14/09/18	YES	YES	
18-404	FOI	14/08/18	11/09/18	17/10/18	YES		
18-405	FOI	14/08/18	11/09/18	14/09/18	YES	YES	
18-406	FOI	15/08/18	12/09/18	20/09/18	YES		YES
18-407	FOI	15/08/18	12/09/18	20/09/18	YES		YES
18-408	FOI	15/08/18	12/09/18	03/09/18	NO		
18-409	FOI	16/08/18	13/09/18	03/09/18	NO		
18-410	FOI	16/08/18	13/09/18	13/09/18	NO		
18-411	FOI	16/08/18	13/09/18	18/10/18	YES		
18-412	FOI	16/08/18	13/09/18	02/10/18	YES		
18-413	FOI	17/08/18	14/09/18	10/09/18	NO		
18-414	FOI	17/08/18	14/09/18	17/08/18	NO		
18-415	FOI	17/08/18	14/09/18	24/08/18	NO		
18-416	FOI	20/08/18	17/09/18	03/10/18	YES		
18-417	FOI	17/08/18	14/09/18	09/10/18	YES		
18-418	FOI	17/08/18	14/09/18	02/10/18	YES		
18-419	FOI	20/08/18	17/09/18	14/09/18	NO		
18-420	FOI	20/08/18	17/09/18	04/10/18	YES		
18-421	FOI	20/08/18	17/09/18	09/10/18	YES		
18-422	FOI	20/08/18	17/09/18	01/10/18	YES		
18-423	FOI	20/08/18	17/09/18	14/09/18	NO		
18-424	FOI	21/08/18	18/09/18	14/09/18	NO		
18-425	FOI	23/08/18	20/09/18	14/09/18	NO		
18-426	FOI	23/08/18	20/09/18	13/09/18	NO		
18-427	FOI	24/08/18	21/09/18	23/10/18	YES		
18-428	FOI	22/08/18	19/09/18	20/09/18	YES	YES	
18-429	FOI	24/08/18	21/09/18	28/08/18	NO		
18-430	EIR	24/08/18	21/09/18	13/09/18	NO		
18-431	FOI	29/08/18	26/09/18	29/08/18	NO		
18-432	FOI	28/08/18	25/09/18	20/09/18	NO		
18-433	FOI	28/08/18	25/09/18	15/11/18	YES		

18-434	FOI	28/08/18	25/09/18	08/10/18	YES		
18-435	FOI	28/08/18	25/09/18	21/09/18	NO		
18-436	FOI	29/08/18	26/09/18	11/10/18	YES		
18-437	FOI	30/08/18	27/09/18	05/10/18	YES		YES
18-438	FOI	30/08/18	27/09/18	28/09/18	YES	YES	
18-439	FOI	30/08/18	27/09/18	31/08/18	NO		
18-440	FOI	31/08/18	28/09/18	02/10/18	YES	YES	
18-441	FOI	31/08/18	28/09/18	05/10/18	YES		YES
18-442	FOI	31/08/18	28/09/18	01/10/18	YES	YES	
18-443	FOI	31/08/18	28/09/18	21/09/18	NO		
18-444	FOI	03/09/18	01/10/18	21/09/18	NO		
18-445	FOI	03/09/18	01/10/18	11/10/18	YES		YES
18-446	FOI	03/09/18	01/10/18	24/09/18	NO		
18-447	FOI	03/09/18	01/10/18	10/09/18	NO		
18-448	FOI	03/09/18	01/10/18	10/09/18	NO		
18-449	FOI	03/09/18	01/10/18	05/10/18	YES	YES	
18-450	FOI	03/09/18	01/10/18	08/11/18	YES		
18-451	FOI	03/09/18	01/10/18	07/09/18	NO		
18-452	FOI	04/09/18	02/10/18	02/10/18	NO		
18-453	FOI	04/09/18	02/10/18	23/10/18	YES		
18-454	FOI	04/09/18	02/10/18	24/09/18	NO		
18-455	FOI	04/09/18	02/10/18	26/09/18	NO		
18-456	FOI	04/09/18	02/10/18	24/09/18	NO		
18-457	FOI	05/09/18	03/10/18	05/10/18	YES	YES	
18-458	FOI	06/09/18	04/10/18	23/10/18	YES		
18-459	FOI	06/09/18	04/10/18	26/11/18	YES		
18-460	FOI	07/09/18	05/10/18	24/09/18	NO		
18-461	FOI	07/09/18	05/10/18	02/10/18	NO		
18-462	FOI	07/09/18	05/10/18	05/10/18	NO		
18-463	FOI	10/09/18	08/10/18	16/10/18	YES		YES
18-464	FOI	10/09/18	08/10/18	02/10/18	NO		
18-465	FOI	07/09/18	05/10/18	13/09/18	NO		
18-466	FOI	07/09/18	05/10/18	15/11/18	YES		
18-467	FOI	10/09/18	08/10/18	05/10/18	NO		
18-468	FOI	10/09/18	08/10/18	14/09/18	NO		
18-469	FOI	11/09/18	09/10/18	26/09/18	NO		
18-470	FOI	11/09/18	09/10/18	14/09/18	NO		
18-471	FOI	11/09/18	09/10/18	11/10/18	YES	YES	
18-472	FOI	11/09/18	09/10/18	11/10/18	YES	YES	
18-473	FOI	11/09/18	09/10/18	14/09/18	NO		
18-474	FOI	12/09/18	10/10/18	14/09/18	NO		
18-475	FOI	12/09/18	10/10/18	05/10/18	NO		
18-476	FOI	12/09/18	10/10/18	18/10/18	YES		YES
18-477	FOI	14/09/18	12/10/18	08/10/18	NO		
18-478	FOI	14/09/18	12/10/18	31/10/18	YES		
18-479	FOI	12/09/18	10/10/18	02/10/18	NO		
18-480	FOI	14/09/18	12/10/18	23/10/18	YES		
18-481	FOI	17/09/18	15/10/18	02/10/18	NO		
18-482	FOI	17/09/18	15/10/18	13/11/18	YES		
18-483	FOI	17/09/18	15/10/18	11/10/18	NO		
18-484	FOI	17/09/18	15/10/18	11/10/18	NO		
18-485	FOI	18/09/18	16/10/18	15/11/18	YES		
18-486	FOI	20/09/18	18/10/18	11/10/18	NO		
18-487	FOI	21/09/18	19/10/18	24/09/18	NO		
18-488	FOI	21/09/18	19/10/18	11/10/18	NO		

18-489	FOI	21/09/18	19/10/18	23/10/18	YES	YES	
18-490	FOI	20/09/18	18/10/18	01/10/18	NO		
18-491	FOI	24/09/18	22/10/18	08/10/18	NO		
18-492	FOI	24/09/18	22/10/18	16/11/18	YES		
18-493	FOI	24/09/18	22/10/18	24/10/18	YES	YES	
18-494	FOI	25/09/18	23/10/18	08/10/18	NO		
18-495	FOI	26/09/18	24/10/18	01/11/18	YES		YES
18-496	FOI	27/09/18	25/10/18	23/10/18	NO		
18-497	FOI	28/09/18	26/10/18	29/09/18	NO		
18-498	FOI	29/09/18	27/10/18	04/12/18	YES		
18-499	FOI	28/09/18	26/10/18	23/10/18	NO		
18-500	FOI	01/10/18	29/10/18	08/10/18	NO		
18-501	FOI	01/10/18	29/10/18	01/11/18	YES	YES	
18-502	FOI	01/10/18	29/10/18	23/10/18	NO		
18-503	FOI	01/10/18	29/10/18	23/10/18	NO		
18-504	FOI	02/10/18	30/10/18	26/11/18	YES		
18-505	FOI	03/10/18	31/10/18	23/10/18	NO		
18-506	FOI	03/10/18	31/10/18	17/10/18	NO		
18-507	FOI	03/10/18	31/10/18	11/10/18	NO		
18-508	FOI	03/10/18	31/10/18	18/10/18	NO		
18-509	EIR	04/10/18	01/11/18	11/10/18	NO		
18-510	FOI	08/10/18	05/11/18	08/11/18	YES	YES	
18-511	FOI	08/10/18	05/11/18	23/10/18	NO		
18-512	FOI	08/10/18	05/11/18	14/01/19	YES		
18-513	FOI	09/10/18	06/11/18	30/10/18	NO		
18-514	FOI	09/10/18	06/11/18	10/12/18	YES		
18-515	FOI	09/10/18	06/11/18	23/10/18	NO		
18-516	FOI	10/10/18	07/11/18	15/01/19	YES		
18-517	FOI	11/10/18	08/11/18	08/11/18	NO		
18-518	FOI	12/10/18	09/11/18	23/10/18	NO		
18-519	FOI	10/10/18	07/11/18	26/11/18	YES		
18-520	FOI	12/10/18	09/11/18	21/12/18	YES		
18-521	FOI	16/10/18	13/11/18	12/11/18	NO		
18-522	FOI	16/10/18	13/11/18	14/11/18	YES	YES	
18-523	FOI	16/10/18	13/11/18	01/11/18	NO		
18-524	FOI	16/10/18	13/11/18	08/11/18	NO		
18-525	FOI	16/10/18	13/11/18	23/10/18	NO		
18-526	FOI	16/10/18	13/11/18	23/10/18	NO		
18-527	FOI	16/10/18	13/11/18	23/10/18	NO		
18-528	FOI	16/10/18	13/11/18	15/11/18	YES	YES	
18-529	FOI	16/10/18	13/11/18	06/11/18	NO		
18-530	FOI	16/10/18	13/11/18	04/12/18	YES		
18-531	FOI	16/10/18	13/11/18	19/10/18	NO		
18-532	FOI	17/10/18	14/11/18	26/11/18	YES		
18-533	FOI	17/10/18	14/11/18	29/10/18	NO		
18-534	EIR	17/10/18	14/11/18	23/10/18	NO		
18-535	FOI	17/10/18	14/11/18	09/11/18	NO		
18-536	FOI	18/10/18	15/11/18	26/11/18	YES		YES
18-537	FOI	18/10/18	15/11/18	09/11/18	NO		
18-538	FOI	18/10/18	15/11/18	09/11/18	NO		
18-539	FOI	18/10/18	15/11/18	09/11/18	NO		
18-540	FOI	19/10/18	16/11/18	20/11/18	YES	YES	
18-541	FOI	19/10/18	16/11/18	09/11/18	NO		
18-542	FOI	19/10/18	16/11/18	12/11/18	NO		
18-543	FOI	19/10/18	16/11/18	26/11/18	YES		YES
18-544	FOI	22/10/18	19/11/18	12/11/18	NO		

18-545	FOI	22/10/18	19/11/18	12/11/18	NO		
18-546	FOI	23/10/18	20/11/18	26/11/18	YES		YES
18-547	FOI	23/10/18	20/11/18	19/12/18	YES		
18-548	FOI	23/10/18	20/11/18	26/11/18	YES		YES
18-549	FOI	24/10/18	21/11/18	12/11/18	NO		
18-550	FOI	24/10/18	21/11/18	24/10/18	NO		
18-551	FOI	25/10/18	22/11/18	12/11/18	NO		
18-552	FOI	25/10/18	22/11/18	12/11/18	NO		
18-553	FOI	26/10/18	23/11/18	26/11/18	YES	YES	
18-554	FOI	26/10/18	23/11/18	14/11/18	NO		
18-555	FOI	29/10/18	26/11/18	05/12/18	YES		YES
18-556	FOI	29/10/18	26/11/18	04/12/18	YES		YES
18-557	FOI	29/10/18	26/11/18	26/11/18	NO		
18-558	FOI	29/10/18	26/11/18	14/11/18	NO		
18-559	FOI	29/10/18	26/11/18	16/11/18	NO		
18-560	FOI	29/10/18	26/11/18	03/12/18	YES		YES
18-561	FOI	30/10/18	27/11/18	14/11/18	NO		
18-562	FOI	31/10/18	28/11/18	26/11/18	NO		
18-563	FOI	31/10/18	28/11/18	10/12/18	YES		
18-564	FOI	31/10/18	28/11/18	14/12/18	YES		
18-565	FOI	01/11/18	29/11/18	08/11/18	NO		
18-566	FOI	01/11/18	29/11/18	04/12/18	YES	YES	
18-567	FOI	01/11/18	29/11/18	27/11/18	NO		
18-568	FOI	01/11/18	29/11/18	14/11/18	NO		
18-569	FOI	01/11/18	29/11/18	26/11/18	NO		
18-570	FOI	02/11/18	30/11/18	26/11/18	NO		
18-571	FOI	06/11/18	04/12/18	04/12/18	NO		
18-572	FOI	05/11/18	03/12/18	03/12/18	NO		
18-573	FOI	05/11/18	03/12/18	15/11/18	NO		
18-574	FOI	06/11/18	04/12/18	26/11/18	NO		
18-575	FOI	06/11/18	04/12/18	03/12/18	NO		
18-576	FOI	06/11/18	04/12/18	03/12/18	NO		
18-577	FOI	07/11/18	05/12/18	07/11/18	NO		
18-578	FOI	07/11/18	05/12/18	26/11/18	NO		
18-579	FOI	07/11/18	05/12/18	15/11/18	NO		
18-580	FOI	08/11/18	06/12/18	07/12/18	YES	YES	
18-581	FOI	08/11/18	06/12/18	26/11/18	NO		
18-582	FOI	09/11/18	07/12/18	26/11/18	NO		
18-583	FOI	12/11/18	10/12/18	04/12/18	NO		
18-584	FOI	12/11/18	10/12/18	13/11/18	NO		
18-585	FOI	12/11/18	10/12/18	12/12/18	YES	YES	
18-586	FOI	13/11/18	11/12/18	04/12/18	NO		
18-587	FOI	13/11/18	11/12/18	07/01/19	YES		
18-588	FOI	14/11/18	12/12/18	05/12/18	NO		
18-589	FOI	15/11/18	13/12/18	26/11/18	NO		
18-590	FOI	15/11/18	13/12/18	10/12/18	NO		
18-591	FOI	16/11/18	14/12/18	18/12/18	YES	YES	
18-592	FOI	16/11/18	14/12/18	05/12/18	NO		
18-593	EIR	19/11/18	17/12/18	26/11/18	NO		
18-594	FOI	20/11/18	18/12/18	18/12/18	NO		
18-595	FOI	20/11/18	18/12/18	07/12/18	NO		
18-596	FOI	20/11/18	18/12/18	12/12/18	NO		
18-597	FOI	20/11/18	18/12/18	10/12/18	NO		
18-598	FOI	20/11/18	18/12/18	12/12/18	NO		
18-599	FOI	21/11/18	19/12/18	12/12/18	NO		
18-600	FOI	21/11/18	19/12/18	31/12/18	YES		
18-601	FOI	21/11/18	19/12/18	12/12/18	NO		

18-602	FOI	21/11/18	19/12/18	10/12/18	NO			
18-603	FOI	21/11/18	19/12/18	04/12/18	NO			
18-604	FOI	21/11/18	19/12/18	11/12/18	NO			
18-605	FOI	21/11/18	19/12/18	10/12/18	NO			
18-606	FOI	19/10/18	16/11/18	11/12/18	NO			
18-607	FOI	22/11/18	20/12/18	18/12/18	NO			
18-608	FOI	23/11/18	21/12/18	21/12/18	NO			
18-609	FOI	23/11/18	21/12/18	19/12/18	NO			
18-610	FOI	23/11/18	21/12/18	12/12/18	NO			
18-611	FOI	23/11/18	21/12/18	07/12/18	NO			
18-612	FOI	23/11/18	21/12/18	12/12/18	NO			
18-613	FOI	26/11/18	24/12/18	15/01/19	YES			
18-614	FOI	26/11/18	24/12/18	15/01/19	YES			
18-615	FOI	26/11/18	24/12/18	12/12/18	NO			
18-616	FOI	26/11/18	24/12/18	31/12/18	YES			YES
18-617	FOI	27/11/18	27/12/18	20/12/18	NO			
18-618	FOI	27/11/18	27/12/18	21/12/18	NO			
18-619	FOI	27/11/18	27/12/18	12/12/18	NO			
18-620	FOI	27/11/18	27/12/18	21/12/18	NO			
18-621	FOI	28/11/18	28/12/18	12/12/18	NO			
18-622	FOI	28/11/18	28/12/18	21/12/18	NO			
18-623	FOI	30/11/18	30/12/18	12/12/18	NO			
18-624	FOI	30/11/18	28/12/18	12/12/18	NO			
18-625	FOI	29/11/18	27/12/18	07/01/19	YES			
18-626	FOI	03/12/18	31/12/18	03/01/18	YES		YES	
18-627	FOI	03/12/18	31/12/18	21/12/18	NO			
18-628	FOI	05/12/18	02/01/19	12/12/18	NO			
18-629	FOI	05/12/18	02/01/19	03/01/19	YES		YES	
18-630	FOI	05/12/18	02/01/19	03/01/19	YES		YES	
18-631	FOI	05/12/18	02/01/19	07/12/18	NO			
18-632	FOI	06/12/18	03/01/19	21/12/18	NO			
18-633	FOI	07/12/18	04/01/19	10/01/19	YES			YES
18-634	FOI	07/12/18	04/01/19	18/12/18	NO			
18-635	FOI	06/12/18	03/01/19	21/12/18	NO			
18-636	FOI	07/12/18	04/01/19	31/12/18	NO			
18-637	FOI	10/12/18	11/01/19	17/01/19	YES			YES
18-638	FOI	11/12/18	08/01/19	31/12/18	NO			
18-639	FOI	11/12/18	08/01/19	31/12/18	NO			
18-640	FOI	07/12/18	04/01/19	31/12/18	NO			
18-641	FOI	11/12/18	08/01/19	18/12/18	NO			
18-642	FOI	12/12/18	13/01/19		Not Known			
18-643	FOI	12/12/18	09/01/19	14/01/19	YES		YES	
18-644	FOI	14/12/18	15/01/19	15/01/19	NO			
18-645	FOI	14/12/18	15/01/19	31/12/18	NO			
18-646	FOI	17/12/18	18/01/19	20/12/18	NO			
18-647	FOI	17/12/18	18/01/19	20/12/18	NO			
18-648	FOI	18/12/18	19/01/19	17/01/19	NO			
18-649	FOI	18/12/18	19/01/19	21/12/18	NO			
18-650	FOI	19/12/18	20/01/19	21/12/18	NO			
18-651	FOI	19/12/18	20/01/19	17/01/19	NO			
18-652	FOI	20/12/18	21/01/19	31/12/18	NO			
18-653	FOI	20/12/18	21/01/19	08/01/19	NO			
18-654	FOI	20/12/18	21/01/19		Not Known			
18-655	FOI	20/12/18	21/01/19		Not Known			
18-656	FOI	21/12/18	22/01/19	07/01/19	NO			
18-657	FOI	21/12/18	22/01/19		Not Known			

18-658	FOI	21/12/18	22/01/19		Not Known
18-659	FOI	22/12/18	23/01/19		Not Known
18-660	FOI	27/12/18	28/01/19		Not Known
18-661	FOI	28/12/18	29/01/19	14/01/19	NO

Breach 11-20 days	Breach 21+ days	Summary of Request	Review Request Received	SIC Application Received
YES		Caesarian requests		
YES		Lynch syndrome testing		
		Private cataract operations		
		Baby box SIMD		
		Agency nurse spent		
		Locum Consultant and nurse spend		
		A&E Waits		
		Information of Attention Deficit Hyperactivity Disorder (ADHD)		
		GP Vacancies		
		Information on pay scales across the protected characteristics	YES	
		Dental treatment for children		
	YES	Research and funding		
	YES	Contract agency spend		
	YES	Network provision		
		Full list of subcontractors/suppliers for DGRI		
		Milk Allergies		
		Overseas visits regarding recruitment		
	YES	Implants used for wet AMD		
		Diagnosed eye conditions		
		Consultant vacancies		
		Equipment for bariatric patients		
		Parking permits for staff		
		Locum and agency staffing		
		Pastoral care provision		
		CSSD Software management		
		Consultant overtime payments		
		Unfilled out of hours GP shifts		
		Acorn House reconfiguration finance meetings		
YES		MS patient drug treatments		
		CAMHS Waits		
		A&E admissions for children due to self harm		
		International Recruitment		
		Staff sickness - flu		
		Breast screening systems	YES	
		Hospital Food		
		MRI Scanners Operating		
		Board gender equality		
		Management roles		
		Accidents in the home		
YES		Digital dictation/speech recognition software		
		Mental Health in A&E/OOH		
		Social Media		
		Missing medical equipment		
		GP Restricted Lists		
		Board portal / software supplier for paperless board meetings		
	YES	Top ten consultants		
		Settlement agreements that contain gagging clauses		
		U16 prescribed contraception		
		EU Cross-Border Healthcare Directive		

		Iloprost 0.5mg/0.5ml Ampoules Melatonin 1mg/ml oral solution, Melatonin 2mg Capsules, Melatonin 3mg Capsules, Melatonin 5mg Capsules, Melatonin 3mg Tablets Mexiletine 200mg capsules Diazoxide 50mg/ml oral suspension dispensed per quarter	
		Staff messaging Apps	
YES		Private ambulance usage	
		Private ambulance costs for The Red Cross	
		Contracts with building companies	
		Staff Parking	
YES		Counselling	
		Correspondence with malicious, offensive or insulting language	
		Hospital TV	
		Hip Replacements	
		Type 2 Diabetes in Children under 18 years of age	
		Ovarian cancer patient and treatments	
		Treatment for Asthma patients	
	YES	Medical Staff numbers on duty over a specific period at 12noon	
YES		Medical Staff numbers on duty over a specific period at 12.01am	
		Weather A&E presentations	
		Paternity Leave	
		Alzhiemer/Dementia/Parkinsons/Lung Cancer/Pancreatic Cancer cases for the last 10 years	
		Overtime payments	
		Consultants offered posts but refused UK visa	
		Incontinence service for women following birth	
		Inspection reports for disabled toilet in Bay 1	YES
		OPD DGRI	
		Headcount paramedic	
		Recruitment advertising	
		Consultant posts	
		Cost of agency midwives	
		Road Inspection	
		Clinical Waste Bag Seals	
		boys born with hypospadias, women prescribed Letrozole, babies born with a birth defect to mothers who had been prescribed Letrozole	
		EU Trained medical staff	
		Acid attacks	
	YES	Printing services	
		CAMHS cases due to use of cannabinoids	
		SUIs resulting in death for U18s	
		Suicides in U18 as a result of cannabinoids	
	YES	Locum doctor/nurse spend	
		Sepsis cases	
	YES	Money owed by other UK NHS	
		Accidental radiation	
		Cost of meals	
		Installed bases	

	Number of FOIs broken down by source		
	Prostate biopsies		
	Cost per patient/per meal		
	Complaints re special diet requests		
	Knee arthroscopies and knee replacements		
	Waiting time initiative consultant pay		
	Equality and Diversity training and LGBT complaints		
	Correspondence with Synaptik		
	Chronic pain patients referred		
	buprenorphine transdermal patches		
	Admissions to GCH A&E and waits		
	CT Scanners and angiography		
YES	Numbers and cost of ANP, Doctors, theatre nurses, midwives, emergency nurse practitioners		
	Dentist reimbursements		
	ASD assessments 2017		
	Rota for surgical trainees		
	Spend on agency doctors/consultants		
	Minutes for the Acorn House Reconfiguration Meetings		
	Health Board Elections since 2012		
	Confidentiality clauses		
	grievances raised by staff members against management		
	Gardening leave		
YES	Biomarker testing		
	Holter Monitors		
	Request for own correspondence deemed malicious, threatening and aggressive	YES	YES
	contact details of the Manager of your Pathology Department.		
	Unplanned ward closures		
	patients who are prescribed Quinine from Sanquhar and Kelloholm clinics for the relief of muscle cramp.		
	Medical letters		
	Unclaimed bodies		
YES	Taxi Spend		
	Procurement Report 2017-18		
	MRI procedures for HMP		
	Cost and length of time of MRI in Glasgow		
	Look After Children health assessments		
	Request for own correspondence with threatening language.	YES	YES
	Self-refer process for young people with eating disorders		
	C-Sections carried out for non-medical reasons		
	Medical treatment for Prisoners relating to Spice or other NPS		
	Information relating to SAERs		
	Public relations, media and press officer costs for the Board		
	FOI request, review and complaints received over the last 3 years		
	Headcount and trade union contributions		

		Bank Nurse and Bank Doctor spend and audit	
		Register of Competing Interests for all employees	
		Spend, use and brand of Sodium Hyaluronate eye drops	
		Donations above £2k given to NHS Dumfries and Galloway	YES
		Past and current contracts with Medinet	
		Treatment for Metastic hepatocellular carcinoma, metastatic renal cell carcinoma and metastatic melanoma with specific drugs	
		Patients treated for Colorectal Cancer	
		Antenatal education	
		Cervical Screening awareness	
		Flexible working	
		NVAF Treatment	
		Chestfeeding documentation	
		ECG Equipment	
	YES	Supervision fees to chemists	
	YES	patients treated with Apixaban/Dabigatran/Edoxaban/Rivaroxaban/ Warfarin/Heparin.	
YES		Waiting times for mental health and Xray services	
		Nursing bullying and harassment	
		Violence and agression against staff on NHS premises	
		Child weight programmes	
		Health improvement initiative	
		Obesity programmes for pregnant women	
	YES	National Fraud Initiative (NFI)	
		Donations	
	YES	Daily rate for Locum GP	
		Human hair wigs	
		Risk Assessments of Dental Practice in Castle Douglas	
		FTE Chemo Nurses	
		Purchase cards for Executive staff	
		CAMHS Waits	
		Delayed discharges	
		Homonal therapy for gender reassignement for under 18s	
		Violence and agression against staff on NHS premises	
		aparoscopic procedures requiring morcellation	
		Spend on prescription paracetamol in the most recent financial year	
	YES	Expenditure in relation to NRS Infrastructure, Career Researcher Fellowship Funding and Biorepository	
		Psychology waits	
	YES	research into Non-Small Cell Lung Cancer (NSCLC).	
YES		clinical protocol(s) for therapeutic venesection	

		Trainee Clinical Psychologists on the 'Clinical Psychology Programme' commencing (i) 2016, (ii) 2017, (iii) 2018	
YES		Mesh tapes	
		Surgical procedures refused due to obesity/smoking	
		Big babies	
		DVT Risk assessments	
		paediatric neuropsychologists wte	
		Urothelial cancer patients	
		HR data and costs	
		Endowment spend	
		Executive salaries	
		Spend on paracetamol prescriptions	
		Surgical errors	
		Pay for suspended staff	
		Delayed discharges	
		Director/Manager IT	
		Cleaning records for Bay 1 OPD	
	YES	Third Party Data Sharing	YES
	YES	Use of Health Apps	
		Self harm u11	
		Recording of notes	YES
	YES	Prefilled syringes	
	YES	clinical pathways or standard operating procedures (SOPs) for the use of MabThera	
		Taxi freephones	
		Date of closure for GP clinics	
	YES	Orthotics	
		Psychosis diagnosis and sectioning	
		Contract information on operating tables	
		Sexual assaults allegations by patients in hospital	
		Radiography vacancies	
		AC absences	
		Non disclosure agreements	
		Equality and Diversity training	
		Data Protection training	
		Use of drugs	
		Communication software	
		Medication for HMP Dumfries prisoners	
		Outsourced teleradiology	
	YES	Brain injuries specialists	
		Health and Wellbeing event for breast cancer patients	
		Outsourced endoscopy	
		Environmental diagnosis	
		Biomedical scientists shifts	
		Sex change drugs for u18s	
		Alcohol gel consumption	
		STIs in U16s	
		Charity monies expenditure and SG correspondence	
		Taxi fares	YES
		Insourced/Outsourced Ophthalmology Services	
	YES	Third party financial review services	
		Misdiagnoses	
		Negligence compensation (Cancer)	

		Public dental service		
		Internal Audits		
		Thyroid Surgery		
		Energy Supply		
		Absence management systems		
		CMHT Workforce		
		Communication Workforce		
	YES	Referrals to vascular/gen surgery		
		Diversified workforce		
		Bereavement support for family of drug/Alcohol deaths		
		Metastatic Squamous Cell Non-small cell lung cancer (NSCLC)		
		Damaged patient equipment		
	YES	Unidentified bodies		
		Hospital asbestos exposures		
		HAI respiratory		
		Endowment spend		
		STI and terminations		
		Energy Management		
		MS disease modifying drugs		
		Agency spend		
		Mental Health Spend		
		Locum doctor/nurse spend		
		Taxi firms and spend		
		Hospital equipment for patients at home		
		OOH Mental Health		
		Maternity Unit closures		
	YES	Delayed operations		
YES		Private operations		
		Hours lost		
	YES	drugs for either Rheumatology, Dermatology or Gastroenterology		
		Palate function in babies		
		Volume of intra-vitreal vials / implants used for specific drugs in the last 4 months.		
		Patient TV		
		Portuguese nationals		
		Correspondence to Agencies and employment businesses from KL and GS		
		Sexual Health Committee Minutes		
		Cannulation Policies		
		Overseas radiology recruitment		
		Client Occupational Health records		
	YES	Hourly rates internal bank		
		GDPR in relation to GiRFEC, SHANARRI, wellbeing, and all other processing of data at non-child protection level	YES	
		Data Protection training	YES	YES
	YES	Mental health drugs		
		Pay arrears		
		Psychology notes guidelines		
		CAMHS Waits		
YES		IT systems		
		Psychiatric beds		
		ecasenotes	YES	
		Contact details for senior staff		
	YES	Vasectomy procedures	YES	
YES		HMRC Penalties		

		Protected characteristics	
		Contract register	
	YES	Self funded drug treatment	
		Settlement agreements	
		Dr Cameron absences	YES
		Disability equipment for children	
		Access to sexual health services by residents from Northern Ireland	
		Current Asset Register data	
		Injuries sustained in MH facilities	
		Operational Pressures Escalation Levels	
	YES	Biologic medicines	
		Mental Health Complaints	
YES		Inpatient mental health beds	
		Lack of beds in maternity	
		Institute for Healthcare Improvement payments	
		Domestic Violence policy	
		Physical restraints	YES
	YES	Direct Engagement Scheme	
		Agency nurses spend	
	YES	GP OOH	
		Adverse events in neurosurgery	
		Surgeons in neurosurgery	
		Expectant mothers turned away from maternity unit due to capacity	
		Data sharing legal framework	
	YES	Psoriasis biologics	
		Pacemakers	
	YES	Referrals to the GJH	
	YES	Cocaine on prescription	
		Directive compliance	
		Data back up failures	
		Memory Services	
		Cost of equipment for obese patients exceptional funding	
		Suicides at Midpark	YES
		Facebook Advertising	
		Energy suppliers	
	YES	Contracted out radiology	
		Neonatal abstinence	
		Locum doctor/nurse suppliers	
		Xanax deaths	
		EPR software	
		Lucentis injections	
		Sterile Services activity	
		ICO correspondence audit	
		Bonuses paid to senior managers and consultants	
		Drug use in children	
	YES	Outside Health Board spend	
		Staff shortages	
		Staff Stress	
		Patient Entertainment Systems	
		Carbon Monoxide Poisoning	
		Ketone Meters	
		Rehabilitation, Thormbolysis Pathways and Stroke statistics	
		Equipment more than 10 years old	

		Wages query	
		Request for decease person's medical records	YES
		Joint complaints procedure	
		Spend on methadone	
		Breaching waiting times	
		Mortuary Fridges	
		Organisation chart	
		Nurse vacancies, agency costs	
		Telephone system maintenance	
		Births	
		Overnight discharges	
	YES	LAN Networks	
YES		Unreturned mobility equipment	
		Out of area inpatients	
		Learning disability inpatients	
		GP Practice closures	
		Overnight discharges	
		Boarding admissions	
		Cost of private treatment/commissioned procedures/efficiency savings/agency nurse hours/Childhood obesity funding	
		Early retirement/EU citizens	
		GP practice closures/GP early retirement/HB run GP practices	
YES		Waits/post diagnosis support	
		Staff working in Balcary Ward	
		PrEP medication waits	
		Radiology Service Provision	
		Meals for parents of sick children/infants	
		Maternity Training Questionnaire	YES
		Details of pharmacy dept	
YES		UK Paediatric Allergy Services Survey	
		GP Registrations	
		Staffing	
		FASD Policies	
		Assaults on workforce	
		Locum agency spend	
		Mental Health nurse agency spend	
		Stress leave days	
	YES	Mental Health and CAMHS Organisational Charts	
		PAS Systems	
		Radiology spend and recruitment	
		Eye condition treatments	
		Safeguarding	
		Lyme Disease diagnosis	
		Restraint by age/gender/ethnicity	
YES		Unreported PACS	YES
		Cath Lab Nurse staffing	
		Paediatric inpatient	
		Impact of Brexit preparations	
		BEMs/BMS	
	YES	ICT Expenditure	
	YES	Appointments by provider	
		Suicides at Midpark	YES
YES		Dentistry Organisational Chart	
		Naxalone Kits	
YES		Post natal depression	

YES		Junior Doctor schedules	
		Communications received from Scottish Government in relation to GIRFEC, Children's Wellbeing, SHANARRI and Named Person.	
		Cardiace MRI Scans performed	
		Pre-examination protocol for patient in Learning Disability	YES
		Myocardial perfusion scans	
		stress perfusion Cardiac MRI scans	
		Stress echocardiograms	
		WTE Nurse Vacancies	
		Down syndrome babies	YES
		Asthma patients and treatments	
		Employment statistics	
		CAMHS users by condition/ethnicity	
		Telephone system maintenance	
		Endometriosis	
		CAMHS referrals by age	
		Adult mental health referrals	
		CT Angiography scans	
		Treadmill ECG tests	
	YES	Myofacial trigger point injections for Chronic Pain	
		ECT	
		DG2 dental registrations	
	YES	Viscosupplementation injections / Bone Stimulators	
		Self harm u17	
		Breast cancer treatments	
		OOH service and handling and cost	
		Missed appointments	
		Private weight management	
		Radiotherapy staff and spend	
	YES	Facial nerve palsy	
YES		Stress related absences	
		Maternity staffing	
		Cost of treatment and injections at Midpark	
		Audit trails	
YES		Disease diagnostic tests	
	YES	Agency spend	
YES		Cancer patient referrals to mental health	
		Home births and transfers	
YES		lost patient records	
	YES	Vending machine income	
YES		Plaque psoriasis treatment	
		T2 Diabetes under 25s	
		Acromegaly treatments	
		CAMHS Provision	
		Year long stay patients	
	YES	Stroke prevention awareness	
		Mental health outside Scotland	
		Overseas screening results	
		Maintenance assessments at DGRI	
		SAS responses to calls	
		Paediatricians in NHS Dumfries and Galloway, waiting times and CAMHS	
	YES	Epilepsy diagnosis and A&E admissions	

YES		Orthopaedic surgeons and procedures and protocols		
		Community Mental Health Teams		
YES		Forearm fractures in adults and children		
		Visa and vacancies		
		Claims		
		FOIs and refusals		
		Staff turnover		
		Art purchases for DGRI		
		Art at Mountainhall/CRH		
		Cancelled operations		
		Physical restraints		
		Locum psychiatry staff		
		Physical restraints		
		Grievances - Dom Serv Managers		
		Grievances - Dom Serv Staff		
		SAERs reported to the PF		
	YES	System Spend		
		Board members remuneration		
		List of all suppliers in 2017-19		
	YES	Agency and bank spend		
		research into Non-Small Cell Lung Cancer (NSCLC).		
		Bullying and harrassment cases		
		Hepatitis C data		
		3rd Party providers		
YES		Pulmonary rehab		
	YES	Diagnostic tests and Biomarkers		
		Urothelial cancer patients		
		Referrals to CAMHS		
		Brexit		
		Phlebotomy Services		
		patients with Multiple Sclerosis have been treated with MS disease modifying drugs in the past 6 months		
		Remuneration of Board 2017-18		
	YES	Treatment of private patients and cost		
		Medicine waste		
		Disclosure Checks		
		prescribed pregablin		
		Bone grafts		
		Zero hour contracts		
		Spend on security		
		IT outage		
		Fax machines		
		Staff payments		
		Staff payments	YES	YES
		Wet AMD		
YES		IT Spend		
		Misoprostol terminations		
YES		neutral vend contract - agency doctors		
		Baby blood tests		
	YES	International Recruitment		
		sexual assaults mental health		
		Vending machine profit		
	YES	Hearing test waits		
		Cataract surgery		
		Systems use		
		Autism Spectrum procedures		

		Breastfeeding clinics
		Number of Sepsis Deaths
		Brexit Assessments
	YES	Procedures and Treatment carried out abroad
		Pulmonary Rehabilitation programmes provided by the NHS
		Eating disorders detained in hospital
		Stolen property in the new hospital
		Headache clinics
		Ambulance Call outs for the drug "spice"
	YES	Paediatric staffing and locum / agency spend
		Prescribing for T3 (Liothyronine)
		Dietary requirements
		Breast reconstruction
		Medical Consultants WTE
		Number of mental health patients
	YES	MND Service Provision
		Restraints
		A&E attendances by postcode
		DNA CAMHS + Psych services
		Employment reviews
		CCTV Contracts
		Mental Health restraints adverse incidents
		Urothelial patients
	YES	Septic arthritis surveys paeds and adults
		Medical locum supply
	YES	Transvaginal Mesh
		Use of bromide
	YES	Overall Spend
		Details of confract - Pharmacy Robotics
		Peer Approved Clinical Systems
YES		IT Contracts
YES		Sanitary products
		Staff Salary Schemes
		Detained eating disorder patients
		Drug related deaths
		Staff and agency spend
		Treatments by drug
		Social media disciplinary
		Occupational Health appointments and waits
		Bullying and harrassment cases
		Social media disciplinary
	YES	Locum agency spend AHP
		Sexual offences staff
YES		Homeless deaths
		CAMHS referrals by age
		Pest control incidents
		Abusive correspondence
		Information Asset Register
		Patient Rights
		Amputations
		Operating/endoscopy/CSSD locations
		Payments by results
		MS Neurology patients
		On call rotas
		CAMHS Waits
		Sex of unborn babies

		Hand hygiene breaches by staff	
		Agency locums/staff over Xmas	
	YES	Boarding admissions and cost	
		PDA numbers	
		P-card purchases	
		Dental Practices	
		Dupuytrens disease	
		Gifts and hospitality	
		Community Hospitals	
		NSCLC patients	
		12 WTTG	
		Ecasenotes	YES
		Labs student staffing	
		Medical staff absences due to stress	
		Cerebral palsy instances	
		Chemical fires	
		Spiked drugs	
		Epilepsy specialists	
YES		AHP/HSS Spend	
YES		Dermatitis treatments	
		Unsocial hour payments	YES
		Psychiatric inpatient and use of restraints 2016	
		Podiatry waits	
		Date rape drug procedure	
		Sexual assaults in mental health inpatient wards	
		Telephone system Contracts	
		Stats relating to Sepsis	
		Vitamin B12 deficiency	
		ADTC	
		FGM	
		B12 guidelines	
		Suspended staff	
		Subject Access Request for births	
		Nurse suicides	
		Brexit Committees	
		B12 Blood samples	
		treatments for metatastic colorectal cancer	
		Non disclosure agreements	
		Foundation Doctors not completing training	
		Request for copies of references	
		Christmas rotas for doctors	
		Challenging Behaviour Practice	
	YES	Clinical psychologists in prison	
		Discharges between 10pm and 8am	
		Endoscopy software	
		Named Person Costs	
		Delayed discharges	
		Winter planning beds	
		Noise on wards	
		Delayed discharges	
		Myeloma and haematology services	YES
		Alcohol dependency pregnancies	
		Waste medicines	
		Stolen items	
		Equipment recycling	
YES		Chronic pain staff	
		Chronic pain services	

		third party endoscopy service
		Rheumatoid arthritis
		LES Scheme
		Zoledronic Acid
		Fax machines and transfering records
		Bariatric procedures
		Missed surgery appointments
		Spend on AHP agency locums
		Mixed sex wards
		Reference checking
		Gifts and hospitality
	YES	Security cameras
	YES	Security cameras
		Meat products
		Rostering software
		Knife admissions
		Unentitled NHS Treatment patients
		Medicinal canabis
		Higland Cow injuries
		Nursing home costs and placements
		Antidepressants prescribed to under 16s
		SAERs last 3 years
		Falls in hospital
YES		Whistleblowing guidance
		Assaults on workforce
		Free prescriptions
		Local Enhanced Services Diabetes
		cancer treatments
		Structural renovation
		Theatres
		Staff payments
		Finance of the pfi of new DGRI
		Autism waiting times
		Locum GPs and expenditure
		Cervical Screening
		Stammering service for 3-18 year olds
		Out of hours shortages
		Out of hours adverse incidents
		adult psychiatric provision
		Closed lists GPs
		Misdiagnoses
		Vegetative state
		Private Sector Healthcare spend
		Cancer patients referred to Edinbrugh including costs
		Cystic Fibrosis stats
		HEPMA System details
		Cardiology role descriptions
		Scottish minimum wage
		SG Brokerage
		Substance dependency refused treatment
		Call charges
		Sustainability concerns at GP Practices
		Best Start Grant Pregnancy and Baby Payment to new mothers
		Referrals to other hospitals
		Modern Apprentices
		Overtime and backpay

Trust policies on charging overseas visitors for NHS Services and Information specific to maternity services
Exemptions from charging for overseas visitors and NHS debsts for charges for overseas visitors
Legal advice
Updated list of consultants by location

Agenda Item 267

DUMFRIES and GALLOWAY NHS BOARD

4th February 2019

Schedule of Board Meeting Dates - April 2019 to March 2020

Author:
Laura Geddes
Corporate Business Manager

Sponsoring Director:
Jeff Ace
Chief Executive

Date: 21st January 2019

RECOMMENDATION

The Board is asked **to approve** the following points:

- the proposed schedule of NHS Board meeting dates for the period April 2019 to March 2020.

Strategy / Policy:

This paper supports the governance arrangements laid out within the Board's Standing Orders.

Organisational Context / Why is this paper important / Key messages:

Noted below is the proposed schedule of meeting dates for the April 2019 to March 2020.

It is proposed to continue with the programme of a public meetings every second month with a governance committee on alternative months.

If Board agrees the schedule of meeting dates set out in this paper it will allow arrangements to be finalised for all committee meetings throughout that period and allow the public meeting dates to be posted on the Board's external websites and the internal Corporate Diary.

GLOSSARY OF TERMS

NHS - National Health Service

MONITORING FORM

Policy / Strategy	Complies with Board's Standing Orders.
Staffing Implications	No staffing implications were noted within this paper.
Financial Implications	No financial implications were noted within this paper.
Consultation / Consideration	Consultation on this matter has been held with individual Directors and at Board Management Team.
Risk Assessment	No risk assessment was undertaken as part of this paper.
Risk Appetite	Low ☐ Medium ☐ High ☑ This paper relates to the meetings of the NHS Board, where decisions around service redesign or improvements to the way the business operates, which the Board places high importance on, therefore, a high risk appetite has been noted.
Sustainability	Supports the Board to carry out its statutory obligations in terms of governance etc.
Compliance with Corporate Objectives	Supports the Board to fulfil its obligations in terms of all corporate objectives.
Local Outcome Improvement Plan (LOIP)	Outcome 6
Best Value	Sound Governance. Accountability.
Impact Assessment No impact assessment has been undertaken whilst developing this paper.	

Introduction

1. The meeting dates proposed follow the agreed pattern of meeting dates. Board Members are asked to approve the pattern of dates from April 2019 – March 2020.

Proposed Meeting Dates

April 2019 to March 2020

8th April 2019	Board Meeting and Workshop
3rd June 2019	Board Meeting and Workshop
17th June 2019	Special Board meeting for the Annual Accounts
5th August 2019	Board Meeting and Workshop
7th October 2019	Board Meeting and Workshop
2nd December 2019	Board Meeting and Workshop
3rd February 2020	Board Meeting and Workshop

Governance

2. If Board approves the schedule of dates proposed above, the public meeting dates will be posted on the Board's external website.

3. This will also facilitate management of the corporate diary with all statutory governance and other Board committee dates being finalised.

4. A paper will be brought back to the February 2020 NHS Public Board meeting with proposed meeting dates for the 2020/21 financial year.

Agenda Item 268

DUMFRIES AND GALLOWAY NHS BOARD

Area Clinical Forum

Minutes of the Area Clinical Forum meeting held on Wednesday 28th November 2018 at 6.15 pm in Seminar Room 2, Education Centre, DGRI.

Present

Ranjit Thomas (Chair)	RT	
Adele Foster	AF	
Kim Heathcote	KH	
Ruth Millican	RM	
Carolina Mroczkowski	CM	
John Higgon	JH	(attending on behalf of Ross Warrick)
Lynn Kean	LK	(attending on behalf of Gordon Loughran)

Apologies

Lorna Carr	LC
Fraser Gibb	FG
Bill Irving	BI
Gordon Loughran	GL
Graham Pender	GP
Ross Warwick	RW

In Attendance

Jeff Ace	JA	Chief Executive (Item 7 only) by VC
Katy Lewis	KL	Director of Finance
Maureen Stevenson	MS	Patient Safety and Improvement Manager (Item 1-3 only)
Lesley Bass	LBa	Executive Assistant to Director of Finance (Minute Secretary)

Welcome and Introductions

RT welcomed members to the meeting and introductions were made.

1. Apologies for Absence

Apologies as noted above. RT has met GP and he has agreed to attend the next meeting in January to represent dentists as they have continually been missing this meeting.

2. Note of meeting held on 24th October 2018

It was noted that the previous meeting was not quorate, therefore a note of the meeting only was taken. One amendment was noted as detailed below:

- Page 3, 2nd paragraph – This should read CM gave an update on District Nursing Healthcare Support Workers highlighting that following communication from the CNO, all HCSW have returned to district nursing teams giving them more professional supervision.

With this amendment, the notes were confirmed as accurate.

3. Matters Arising and Review of Actions List

RT took members through the matters arising from previous meeting. The following updates were provided:

- Maggies Proposal – KL confirmed that the proposal had previously been discussed at NHS Board and the Integration Joint Board (IJB) in October. A consultation process is in place via various NHS forums and we are continuing to work with Maggies to consider an alternative model. JA will provide a verbal update at NHS Board on 3 December 2018.
- Restructuring of AHP Services – RM provided an update. Four options are being considered and a staff engagement exercise is currently being undertaken.
- District Nursing Healthcare Support Workers – CM provided further clarification on this and an amendment to the note of the meeting was made (as per Item 2 above).
- Pharmacy representation – It was noted that Susan Roberts (previously Chief Pharmacist) has left the organisation. A discussion took place around pharmacy representation on the Committee going forward. LK agreed to discuss this further with GL. RT felt that a Director of the division might not be the best representative at an advisory committee.
  Action: LK

- ACF representation and GPs - There was discussion around GP representation on the ACF with RT highlighting that as the AMC has not been meeting, there is no GP representation at this meeting. He did not therefore feel he was representing GPs, but only hospital doctors. He felt that it was essential, regardless of other pathways being constructed to improve primary-secondary care interactions, that there was a route for GP advise to reach the Board and vice versa. KL understood that the ACF should have GP representation as part of the ACF role to review business of the Area Professional Committees, and to support a co-ordinated approach on clinical matters across all NHS areas. KL will take this to other executive directors and let the Committee know the outcome of discussions.

  Action: KL

4. Duty of Candour

MS presented the item advising that the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 received Royal Assent on 1 April 2016 and introduced a new organisational duty of candour on health, care and social work services. All health and social care providers were required to comply with the act from 1 April 2018. The overall purpose of the new duty is to ensure that organisations are open, honest and supportive when there is an unexpected or unintended incident resulting in death or harm, as defined in the Act. This duty requires organisations to follow a duty of candour procedure which includes:

- Notifying the person affected
- Providing a written apology (within 5 working days)
- Offering a meeting to give an account of what happened

MS provided further explanation re the procedures and systems we have put in place to support this. An implementation plan has been developed and is being taken forward by the Patient Safety and Improvement team. MS explained the role of the team and the Patient Safety Group in reviewing adverse events and complaints. The purpose of the briefing today was for ACF to note the formal process now in place and to offer support to professional staff if required. MS circulated a briefing paper (this will be circulated electronically after the meeting) and a Duty of Candour booklet. Committee noted the report with some brief comments made as noted below:

- RT noted that guidance on Duty of Candour is also provided via professional bodies.
- CM felt that her staff would benefit from some support and training, highlighting the importance of closure for both patients and staff.
- KH asked for clarity on the type of support offered. MS advised that support could be provided on how to report incidents. The Duty of Candour support was specifically relating to the broader impact eg. difficult conversations, findings and follow through.
- MS referred to the Duty of Candour training module (link in briefing circulated) and advised that this is useful to undertake with others to encourage discussion (approx 40 mins duration). JH queried if this was mandatory training. MS advised not at the current time, noting that there is regulated training via professional bodies. There was a brief discussion re revalidation.

Committee noted the report.

MS left at this point in the meeting.

5. Standing Items

a. Chairs Report

RT advised that LC had prepared a Chairs briefing which had been circulated to Committee with the agenda.

In term of Realistic Medicine, RT advised the Ewan Bell has been invited to attend the January ACF meeting.

b. Integrated Joint Board

KL provided further information on a number of areas including the Workforce Plan, Moffat GP practices (and Lockerbie), and the Particular Needs Housing Strategy. KL explained the workforce challenges in relation to GP practices, noting that these are independent businesses. If a practice can no longer sustain the service, the Board has a responsibility to take over the management of the practice.

RT noted a recent talk by Derek Cox relating to councils investing in befriending services and queried if this could be considered by the IJB. KL advised that we currently have a range of befriending services across the region and provided examples of these eg. food train. RT queried how we strengthen the message that these are value for money. KL advised of the current investment via public health services, adding that Locality Managers are also based throughout the region to help develop services. KL agreed to feedback to Julie White/Public Health on this.

Action: KL

RT advised that Andrew Carnon (Public Health) would be invited to the next ACF.

c. Feedback from Committees

Area Medical Committee/ Medical Staff Committee (AMC /MSC)

AMC has not met and is currently not functional (see section 3 in minutes. There was nothing particularly noteworthy from MSC for this committee. It was noted that the directors regularly attend MSC and are aware of any issue raised.

Health Care Science Advisory Committee (HCSAC)

KH advised that the Committee has not met for some time. KH provided an update on the current structure (around 7 representatives) and the challenges around seeking a new chair. KH and AF provided background information on the work of the previous Health Care Science lead, noting that this role is no longer in place.

Allied Health Professions Advisory Committee (AHPAC)

RM provided an update on recruitment challenges within Physio. There are currently 14 vacancies; some posts have been advertised a number of times, some covered by locums, some maternity leave. RM spoke of number of areas being looked at to support recruitment eg. career/recruitment events, 'grow your own', social media.

LK confirmed similar issues in pharmacy and targeted recruitment drives in areas such as Carlisle and Belfast. KL confirmed that there are significant challenges in terms of recruitment across all services in NHS Dumfries and Galloway. KL advised of a number of recent initiatives to support this going forward eg. major recruitment campaigns, carers event. KL added that workforce challenges remain one of the critical areas of focus for the Board.

Committee noted that this was both a local and national issue. Committee discussed some of the possible reasons for the challenges eg. retirals, encouraging school leavers to stay, people more willing to travel to other areas, attracting people to the area.

Area Nursing and Midwifery Committee (ANMAC)

CM echoed issues around vacancies, similar to RM above.

Area Psychology Advisory Committee

JH provided an update on the number of psychology professionals within the service. No committee meetings have taken place recently, however, there are regular meetings of services. RT indicated that there are good reasons why the advisory committee system is separate from the line management system, but if the staff feels it works, there probably is little need to change this, but the committee would values the attendance of psychologists.

5. Joint Session

a. <u>Mountainhall (MT) Update</u>

KL advised that the move to MT is being undertaking in three phases: 1. Crichton Hall staff, 2. Nithbank, 3. Long term future. KL is the lead director for the programme. There is a very quick timescale for moving staff to Mountainhall. The primary purpose of the move is due to the sale of Crichton Hall (still to be finalised) and we need to vacate 500+ staff and services from the building by end of Feb 2019. The MT Project Team is currently working on a migration plan and departments have now been advised where they will be moving to. This is significant undertaking for all involved.

KL provided updates on a number of areas including building/refit work, flexible working, sharing offices, orientation sessions and decluttering of Crichton Hall. KL concluded by advising that the Project Team has been meeting with services on a regular basis and staff engagement sessions will be taking place on 29 and 30 Nov (both at MT and Crichton Hall). All staff are encouraged to attend.

RT highlighted concerns from the Ophthalmology theatre who are currently based on the 3rd floor and have concerns relating to moving their equipment to their new location. KL confirmed that Nicole Hamlet and the Acute team have been tasked with addressing this via the Acute Management team. RT asked that the Theatre Users Group also be kept informed of progress around this. KL advised that Nicole will provide feedback on this.

RT queried the progress in relation to the Cresswell Building and PFI (Private Finance Initiative) issue. KL provided a brief update. There have been concerned raised by some staff, it was noted that JA will be meeting them to discuss.

RT advised of concerns raised in relation to hot food access at MT, noting the dietary requirement and restrictions on patient requiring dialysis. KL provided background information to this and work that is ongoing with Alison Solley and the Acute Management Team to consider options. KL advised there will be an enhanced catering provision at MT. KL added that the kitchen will be relocated more centrally, noting that a significant refurb would be required if it remained at its current location; it was also felt that the kitchen should be more centrally located. The lower ground floor of the old hospital will be closed to no clinical staff and a proportion of the old dining room will be taken up by cardiac rehab,

In terms of further future moves, RT highlighted that the Renal team have expressed a preference to remain in MT (rather than move to the Cresswell building in the future). KL advised that there will be a continual review of the location of all services but could not see any reason to change is the clinical staff felt that this was appropriate. KL added that it is hoped MT will become a more active and integrated facility, and that staff will see a positive change.

In terms of the antiques in Crichton Hall, KL confirmed that a paper is being presented to the Endowments Committee in December which outlines potential options for these.

KL left at this point in the meeting.

JA joined the meeting by VC.

b. Regionalisation

JA provided an update on the West of Scotland Regional Delivery Plan, advising that some positive progress has been made in a number of areas including the Capital Plan; Service side (some progress around individual activities eg. ophthalmology and the Golden Jubilee business case for expansion) and Trauma Centres.

c. Brexit

JA advised of his role as NHS Board representative on a multi-agency Brexit group and ongoing planning to support this. JA advised of a number of significant implications should a 'no-deal' Brexit be reached. JA spoke about the potential impact including supply chain challenges (medicines, radioactive materials), stock piling issues (noting that we are being asked to plan for minimum of 12 weeks), fresh food supplies (staff and patients). JA spoke of major multi-agency plans that are being put in place to deal with the possible knock on effects. JA advised that there are serious concerns around supply chains; these are being escalated to the highest level. In terms of major incident planning, Boards have plans in place for 4-5 days; should these extend to 12 weeks, this could have a major impact on NHS Dumfries and Galloway and other Boards.

There was a brief discussion around the implications of no-deal in terms of regulations, qualifications and nurses outwith the EU.

d. Recruitment

Committee noted the recruitment update from KL earlier in the agenda. JA added that we have successfully recruited 2 new radiologists (and hopefully to a 3rd post shortly). JA spoke positively of the recent Careers Event at DGRI, which had been very well attended and organised. JA recognised that recruitment is a major challenge for the NHS at the current time and that we need to consider both short term and long term solutions to support our workforce going forward.

6. AOCB

No items noted.

7. Date and Time of Next Meeting

The next meeting of the Area Clinical Forum will be held on Wednesday 23rd January 2019.

Agenda Item 268

DUMFRIES AND GALLOWAY NHS BOARD

Audit and Risk Committee

Minutes of the Audit and Risk Committee meeting held on Monday 17th September 2018 at 10.00 am to 1.00 pm in the New Boardroom, Crichton Hall, Bankend Road, Dumfries, DG1 4TG.

Present

Dr L Douglas	LD	Non-Executive Board Member (Chair)
Ms M Gunn	MG	Non-Executive Board Member
Mr S Hare	SH	Non-Executive Board Member
Mr N Morris	NM	Non-Executive Board Member

In Attendance

Mr J Ace	JA	Chief Executive
Ms S Thompson	ST	Deputy Director of Finance
Ms L Bass	LBa	Executive Assistant to Director of Finance (Minute Secretary)
Mr E Docherty	ED	Nurse Director (Item 12 only)
Mrs L Geddes	LG	Corporate Business Manager (Items 12 and 14 only)
Mrs S Thompson	SaTh	Internal Auditor (Item 8 and 9 only)

Apologies

Ms J Brown	JBr	External Auditor – Grant Thornton UK LLP
Ms L Carr	LC	Non-Executive Board Member
Mrs G Cardozo	GC	Non-Executive Board Member
Mrs K Lewis	KL	Director of Finance
Ms J Watters	JW	Chief Internal Auditor

1. Apologies for Absence

Apologies as noted above.

2. Declarations of Interest

The Committee Chair asked members if they had any declarations of interest in relation to the items listed on the agenda for this meeting. It was noted that no declarations of interest were put forward at this time.

3. Minutes of meeting held on 18th June 2018

NM referred to the first paragraph on page 3 and suggested the following amendment:

*"GG **re**assured the Committee that the core IT security was in place for the organisation" ('assured' changed to 'reassured').*

Committee agreed this amendment and approved the minutes dated 18th June 2018.

4. Matters Arising and Review of Actions List

LD took members through the actions from the previous meeting and the following was noted:

- It was noted that some actions had been marked as closed, however, it was felt that the overall action was still outstanding. The process for closing off actions was briefly discussed. It was agreed that the following should remain open.
    - Page 4 – Information Assurance Update
    - Page 7 – Annual Compliance with SFIs Report (not all items completed)
    - Page 8 – Annual Gifts and Hospitality Update

Action: LB (Dec 2018)

- There was a general discussion around how we present the actions list and whether this could be re-ordered into themes and also if a column should be added to include timescales for completion set by the Committee. This will be explored further.

Action: LB (Dec 2018)

- IJB and Internal Audit function – LD provided an update from a recent IJB meeting where it was noted that JW has been confirmed as lead auditor for the IJB. LD noted that the IJB risk register is still to be developed to allow the Internal Auditor to produce an audit plan for the IJB. Committee was clear that funding for this should come from the IJB.

- Risk Management Assurance Update: Key Highlights – LD noted that the key highlights had not been included in the paper presented this month; this will be flagged to ED and will remain on the actions list (noted as an action under Item 12 of these minutes).

- Audit Scotland Reports Update (update of wording) – LD queried how this had been updated. ST explained that 'due course' had been removed from the sentence in the main report; relevant reporting dates will be included in the appendix to the report.

- Counter Fraud Champion – LD confirmed that this was still outstanding; LD will discuss with the Non-Executives.

Action: LD (Dec 2018)

Audit and Risk Committee noted the Actions List.

5. 2018/19 Audit and Risk Committee Agenda Setting Matrix

ST provided a verbal update to Committee advising that work has commenced on the development of the matrix for 2018/19.

ST advised of discussions that have taken place around the Board annual accounts workshop, with a view to making this a formal Audit and Risk Committee meeting in June to review the governance assurance statements. This would also provide an opportunity for the routine quarterly business to be carried out in the meeting usually focused on the delivery of the annual report and accounts.

ST explained some of the challenges around timings for gathering the appropriate assurances for the annual report and accounts. ST also advised of some work that has been done to review dates with the possibility of moving some meetings forward to support more appropriate reporting periods. LD felt that moving the Audit and Risk Committee meeting forward a month could work for Committee members also.

ST queried the current format of the annual reports provided and sought the Committee's views on the type of assurances they are looking for on an annual basis. LD will discuss this with members of the Audit and Risk Committee and report back to ST.

Action: LD (Nov 2018)

Following discussion, it was agreed that ST should continue to develop the matrix, with a view to holding an extra Audit and Risk Committee meeting in June to approve the annual accounts. The matrix will run from June 2019 to March 2020 and a paper bought back to the December 2018 Audit and Risk Committee meeting with a revised proposal.

Action: ST (Dec 2018)

Audit and Risk Committee noted the report.

6. External Audit Quarterly Progress Update

ST provided a verbal update from the External Auditors:

- NHS Overview report is due out mid-November 2018. Main themes will include financial sustainability, leadership (including capacity and capability), workforce planning and new models of care.
- The Audit Scotland planning guidance is out mid-October 2018. Grant Thornton will start the planning process shortly after that, with a view to bringing a plan to the December Audit and Risk Committee.

- The Integration of Health and Social Care report will be published in November 2018.
- Fees for 2018/19 will be made available by Audit Scotland early December 2018.

Audit and Risk Committee noted the verbal update.

7. Audit Scotland Reports Update

ST presented the Audit Scotland Reports Update report to Committee:

- Since the previous meeting of Audit and Risk Committee, one report has been issued (The National Fraud Initiative in Scotland); this was attached as an appendix.
- It was noted that the update for the 'Principles for a digital future' report is still outstanding; an update will be provided at the December Audit and Risk Committee meeting.
- As mentioned previously, two reports are due to be published in October/November 2018 ('NHS in Scotland 2018' and 'Health and Social Integration – update on progress'). These will be presented to Audit and Risk Committee in December 2018. JA commented that it may be useful to review these alongside each other.

NM asked for clarity on the process for including reports on the register within the report. ST confirmed that only reports with open actions are included. Following discussion, it was agreed, for completeness, to add the 'Principles for a digital future' back into the register.

Action: ST (Dec 2018)

Audit and Risk Committee noted the report.

SaTh arrived at this point in the meeting.

8. Internal Audit Activity Quarterly Progress Report

JW prepared a paper for Committee which provided an update on the progress against the 2018/19 Audit Plan. Key points from the report included:

- An appendix demonstrating progress against this year's audits.
- Further to a successful internal appointment, there is currently a vacancy in the audit team. Recruitment options are currently being reviewed. JA confirmed that we are looking to backfill this post on a permanent basis.
- An update was provided on the outstanding audit actions exercise. It was noted that the position has improved significantly following a process of review by the Chief Executive, Director of Finance and Chief Internal Auditor together with a focussed group of owners of overdue actions, which commenced in July 2018. Audit has consequently received supporting evidence to enable close off of a number of these actions and has revised the target date of a further number where the review team recognised and agreed additional action is still required.

Audit and Risk Committee wished to formally thank Kelly Armstrong, Internal Auditor, for her commitment to the Internal Audit team over the past few years, as she takes up her new role.

Audit and Risk Committee acknowledged the positive work that has been undertaken on the outstanding actions and were keen that the momentum to close off actions is maintained.

LD noted that one of the common themes identified during the exercise was a requirement for risk management training for senior managers. LD queried how this would be taken forward. JA confirmed that he will progress this.

Action: JA (Dec 2018)

Given the reduced internal audit capacity moving forward, LD noted that Internal Audit are currently reviewing all the audits within the audit plan and are looking to consult with managers on the assurances provided across all the proposed audit areas to allow the audit plan to be prioritised within current and future staffing restraints. SaTh provided further information on this, advising that a self assessment is being issued to collate this data and this will be fully reviewed to revise the in-year plan.

Audit and Risk Committee noted the report.

9. Limited Assurance Audit Update

JW prepared a paper which provided:

- An update on the two previous Limited Assurance audits that have one action remaining each (Risk Management and Waste Management).
- An update on the two new Limited Assurance audits - Information Governance & Security Improvement Measures - DL17(2015) and Health and Safety Policy and Procedures (copies of the reports were included as appendices).
- An update on the Out of Hours Moderate Assurance audit. This was requested at the previous meeting because it was close to Limited. A copy of the audit was attached as an appendix.

LD asked for an update on the Risk Management and Waste Management outstanding actions (one remaining action each). LD noted that the Risk Management action had also been discussed at an IJB meeting recently. JA confirmed that he would look into this further and would contact Audit and Risk Committee with an update on both.

Action: JA (Dec 2018)

NM referred to the requirements of DL (2015) 17 as outlined at 6.1 of the Information Governance and Security Improvement Measures audit. NM queried the process for recording and following up Scottish Government recommendations.

SaTh and JA explained the process for logging circulars and reporting actions/updates via Management Team. It was noted that further improvements have been made over the past few months to support the process; JA and SaTh confirmed that they were satisfied with the progress made on this. JA commented that the circulars log had, in the past, been submitted to Audit and Risk Committee for information; JA will look at submitting an up to date log for the December Audit and Risk Committee meeting.

Action: JA (Dec 2018)

NM referred to point 6.1.1 (Senior Information Risk Owner (SIRO)) of the report and concerns highlighted around capacity and training in relation to the SIRO role. NM queried why this hadn't been recorded as a recommendation. This will be fedback to JW to respond.

Action: JW (Dec 2018)

LD noted that there have been no previous audits in relation to DL (2015) 17, however, there are 24 outstanding recommendations remaining from a number of other applicable previous audits (Information Governance, Records Management, Data Protection and Caldicott Guardian Principles, Medical Records and Patient Administration Systems). LD queried the progress on these. SaTh noted some of these may have been addressed (given the timing of the report – May 2018) but a number could be outstanding.

NM referred to the 2nd paragraph under the Scheme of Delegation section under page 6 of the Health and Safety Policy and Procedures audit, and asked for further explanation around this. SaTh provided clarity on this.

LD noted that the Out of Hours audit had been bought back to Audit and Risk Committee as this was almost a Limited Assurance audit and recalled that this had also been discussed recently at NHS Board. JA advised that this issue was predominately around staffing and noted the fragility of the service at the current time. JA highlighted developments to support recruitment going forward. Audit and Risk Committee agreed that an Out of Hours overview report should be submitted to Performance Committee.

Action: JA (Jan 2019)

SaTh left at this point in the meeting

LD referred to JW's recommendation that relevant managers are requested to provide a written update on improvements at the Audit and Risk Committee meeting in December 2018. Audit and Risk Committee agreed to this recommendation. Leads will be contacted and asked to submit an update report and to attend the meeting to answer any queries. LD also highlighted that the Committee expects timely progress to be made over the next 3 months. This relates to the following audits:

- Information Governance & Security Improvement Measures. This report should also specifically include an update on the 24 remaining outstanding actions from previous audits (as discussed above ie: Information Governance, Records Management, Data Protection and Caldicott Guardian Principles, Medical Records and Patient Administration Systems).
- Health and Safety Policy and Procedures
- Out of Hours

Action: Limited Assurance Audit Owners (Dec 2018)

10. Outstanding Audit Actions Management Update

JA provided a verbal update on progress that has been made since the last meeting. JA advised that the Chief Executive, Director of Finance and Chief Internal Auditor held meetings with all key leads of overdue actions to discuss progress and reasons for delay. This resulted in a considerable reduction of outstanding actions. JA provided feedback on some of the key themes and outcomes from these meetings. It was noted that the risk management training would support the process going forward. JA anticipated that numbers would be reduced further over the coming months (hopefully to single figures) and that an update would be provided at the next Audit and Risk Committee meeting.

Action: JA (Dec 2018)

Audit and Risk Committee noted the report.

11. Property Transactions Monitoring 2017/18

JW provided a paper which asked Committee Members to note the Annual Property Transactions return which will be issued to the Scottish Government Health and Social Care Directorates (SGHSCD) by the 30th October 2018 deadline. It was noted that there were no transactions concluded during the 2017/18 financial year and this will be reported as such to the SGHSCD. A copy of the nil return was included as an appendix.

Audit and Risk Committee noted the report.

12. Risk Management Assurance Update

ED presented the paper which provided an update on the following key areas:

- Corporate Risk Register – At the Audit and Risk Committee in June 2018, a request was put forward to include an update on where on the risk rating scale each corporate risk sat; this was included in the paper.
- Risk Assurance Framework – A copy was provided as an appendix.
- Operational Risk Management - A change has been made to the quarterly paper to include key performance indicators to demonstrate any areas of challenge, as well as any areas where improved positions can be seen around risks at an operational level.

- Risk Appetite - A full review of the Risk Appetite Statement was due to be brought to Audit and Risk Committee, however, following discussions at the NHS Board meeting on 6th August 2018, members asked for a Board Workshop to be held to review the statement; this has been scheduled for 5th November 2018,
- Risk Executive Group - A copy of the minutes from the March and June 2018 meetings were attached as appendices.
- ED provided an update on corporate risks in relation to information security and the complexities in relation to GDPR.

NM noted that a full review of the Acute and Diagnostic risk was undertaken in August 2018, which has seen a reduction in the number of risks from 132 to 14. NM queried some of the lessons learned from this exercise. ED highlighted that there was a better understanding of risk across the directorate and also a focus on data cleansing and profiling. This led to a general discussion around risk management, quality improvement, training and embedding risk appetite into the organisation.

LD commented that it would have been useful for an update on how the risk appetite is embedding in the organisation to have been included in this month's report, however, noted that a workshop would be taking place in November 2018 to support this.

LD referred to her previous request for an executive summary to be included in future risk reports. It was also noted that the background information included in each report could now be removed. ED agreed to review the report content with a view to improving future reporting.

Action: ED (Dec 2018)

Audit and Risk Committee noted the report.

13. Acute Services Redevelopment Project – Risk Register Close Out

ST presented the paper which advised that the Strategic Capital Programme Board (SCPB) have approved the following for the Acute Services Redevelopment Project (ASRP) risk register:

- The closure of a number of risks now that the project has moved into the operational phase.
- The transfer of risks to be managed though alternative risk arrangements.
- The remaining 4 risks (as outlined in the paper) will continue to be held by SCPB.

ST provided further background information on this. A copy of the risk register was attached as an appendix.

NM noted that the ASRP risk register was last presented to Programme Board in October 2017 and circulated to risk owners in March 2018 for review. NM queried the process for review between October 2017 and March 2018.

ST and JA confirmed that risk management would have been undertaken on a day to day basis during the transition/move period.

Audit and Risk Committee noted the report.

It was agreed to move onto Item 15 at this point in the meeting.

15. Compliance with Standing Financial Instructions (SFIs) Update

ST presented the paper which provided updates on the following areas:

- Progress on SFIs since previously reported.
- Update on previous queries raised by Audit and Risk Committee.
- Ongoing work to improve reporting of compliance - Confirmation has been requested from Directors and General Managers that they are content that controls are in place within their area of responsibility to ensure that the SFIs are being followed. The outcome of this is currently being collated for presentation to Management Team for follow up.
- SFI waivers approved to date – These have reduced, following the opening of the new hospital. The waiver form has been refreshed to align with the approved SFIs. A copy was attached as an appendix.
- SFI breaches – A summary of breaches was included as an appendix. Significant work is continuing in relation to the full implementation of No Purchase Order No Pay. From 1 April to 31 August 2018, less than 10% (367) of non-catalogue orders raised have been identified as not following the process set out within the SFIs. NM queried if there were any patterns identified in relation to the 367 orders; ST advised that this is still to be analysed in detail.

Audit and Risk Committee noted the report.

14. Information Assurance Quarterly Update

LG presented the paper on behalf of KD. The paper provided an update on the review of the Information Assurance Committee remit and core objectives, to enable them to provide the appropriate levels of assurance going forward. LG highlighted the key points from the paper:

- Update on the Short Life Working Group and their assessments.
- Terms of Reference – This has been updated to take account of 5 key themes. A draft copy was included as an appendix. The final version of this document will be taken to the Information Assurance Committee in November 2018 and included within the quarterly update to Audit and Risk Committee in December 2018.
- Update on the agenda setting matrix process.
- Committee support – Management of the Committee will now be led by the Medical Director/Senior Information Risk Owner (SIRO).

- Information Assurance Committee membership – Numbers have been reduced to 7 core members, including the chair. It is proposed that at least 1 Non-Executive Board Member be nominated as a member and also sit as the Chair of the committee.

LD confirmed that NM had agreed to be the Non-Executive Board Member and Chair of the Information Assurance Committee. NM had a number of thoughts on this role and the Terms of Reference. NM felt that the Non-Executive Board Member involvement (and their role as Chair) should be time limited (eg. 1 year) to support the redevelopment of the Information Assurance Committee at initial stages. NM felt that Board should be sighted of this change in role for the Non-Executive Board Member for this period of time, whilst the SIRO role is being developed. NM suggested that the SIRO should then act as the Chair and should directly report to the Audit and Risk Committee on the work of the Information Assurance Committee. NM spoke of a number of other proposed amendments in relation to reporting arrangements and performance measures.

ST agreed that it should be clear that the Non-Executive role was an interim arrangement. ST queried whether the Information Assurance Committee was a formal Sub-Committee of the Audit and Risk Committee/Board, noting the role of other committees that do not formally report via the Board structure (eg. Health and Safety Committee). This led to a brief discussion on the need to ensure clear lines of corporate and operational reporting, and ensuring that we do not set a precedent moving forward. It was agreed that this was not a Sub-Committee and that this was a specific time limited appointment to get the required assurances worked through.

Action: LD to raise the proposed Non-Executive involvement with the Chair and Vice-Chair of the Board (Dec 2018)

Audit and Risk Committee noted the report

16. Fraud Policy Review

A paper was provided which advised that the Fraud Policy has had minor amendments made to key contact details within the Board (a copy was attached as an appendix). NHS Counter Fraud Services have advised that a "once for Scotland" approach is being looked at for Fraud policies and associated guidance therefore minimal changes have been made to this policy.

NM queried if it was appropriate for the Internal Auditor to also be the policy lead for fraud. JA confirmed he was comfortable with this as a pragmatic approach for a small NHS Board.

Audit and Risk Committee noted the report.

17. Fraud Quarterly Report

JW provided a paper which included five Intelligence Alerts received from Counter Fraud Services (CFS). A CFS Flash report was also included which provided a snapshot summary of CFS work during 2017/18.

LD noted that the alerts are posted on the internal Fraud Intranet page and queried how many people accesses this. JA agreed to look into this and report back.

Action: JA (Dec 2018)

NM queried the process for closing off actions relating to the intelligence alerts and if we are aware of any that are still relevant/open. Committee discussed this briefly and agreed that the table at Appendix 1 in the report and supporting processes needed to be considered further in relation to this. ST agreed to pick this up with JW.

Action: ST/JW (March 2018)

Audit and Risk Committee noted the report.

18. Financial Reporting Quarterly Update

ST presented the paper which provided an update on the following areas:

- Banking Arrangements
- Procurement of Supplies and Services
- Accounting Policies
- Losses and Special Payments
- Technical Bulletin summary
- Review of significant fraud event – Dundee City Council

ST explained Appendix 1 to the report which summarised the reporting and approval requirements for Audit and Risk Committee, as outlined in the SFIs and SOD. These have been given a Red, Amber Green (RAG) status to allow Committee to see what assurances they are receiving on a quarterly basis. ST proposed that this be included in each quarterly report.

ST referred to the technical bulletins attached to the report, noting that these were now slightly out of date due to the reporting periods. Committee agreed that these should be emailed to Audit and Risk Committee members on receipt to support timely review.

Action: ST (on receipt of bulletin)

ST advised that Audit and Risk Committee were asked to approve the addition of one signatory and removal of one signatory for the Endowment fund accounts. LD queried whether this should be approved by the Endowments Committee. ST advised that the SFIs apply to endowments and that bank account additions are approved by the Audit and Risk Committee.

LD acknowledged this and suggested it would be helpful for the Endowments Committee to have oversight of the banking arrangements for endowment also; Committee agreed. ST agreed to include in the next Endowment finance update.

Action: ST (Dec 2018)

LD referred to the Losses and Special Payments appendix and asked JA his view on the clinical negligence claims. JA confirmed that he was content with the robust processes that are in place around this and the CNORIS (Clinical Negligence and Other Risks Indemnity) scheme we have in place.

LD referred to the review of the significant fraud event in relation to Dundee City Council, noting that the Financial Controller had reviewed the findings and highlighted the key points. LD asked if an update could be provided to Audit and Risk Committee.

Action: ST (March 2019)

Audit and Risk Committee:

- Noted the report.
- Approved the addition to the authorised signatories for bank accounts.

19. Scottish Government Audit and Assurance Committee Handbook – March 2018

ST advised the Scottish Government Audit and Assurance Committee Handbook had been updated in March 2018; this was being circulated to Committee members for information.

LD highlighted a number of areas to Committee members:

- Chapter 3 Skills – LD encouraged Committee members to feedback any thoughts on any areas for development.
- Assurance Map – LD recalled that work had commenced on this last year and felt that this needed revisited to look at how we can further develop this.
- Annex F: Prompt questions – LD noted that these were useful for all members to consider.
- Self assessment – LD recalled that the Audit and Risk Committee undertake this on an annual basis; a session will be arranged over the coming months for this.

20. Date and Time of Next Meeting

The next meeting of the Audit and Risk Committee will be held on 28TH January 2018 at 1.30 pm to 4.30 pm in the New Boardroom, Crichton Hall, Dumfries.

Agenda Item 268

DUMFRIES AND GALLOWAY NHS BOARD

HEALTHCARE GOVERNANCE COMMITTEE

12 November 2018
10 a.m., New Board Room, Crichton Hall

Present:	Mrs. Penny Halliday	Non Executive Member (Chair)
	Ms. Lesley Bryce	Non Executive Member
	Dr. Martin Connor	Infection Control Doctor
	Ms. Grace Cordozo	Non Executive Member
	Mr. Eddie Docherty	Nurse Director
	Dr. Ken Donaldson	Medical Director
	Mr. Nick Morris	Non Executive Member
	Mr. Bill Rogerson	Lay Member
	Mrs. Elaine Ross	Infection Control Manager
	Mrs. Julie White	Chief Operating Officer
Apologies:	Mr. Jeff Ace	Chief Executive
	Dr. Grecy Bell	Associate Medical Director, Primary Care
	Ms. Lorna Carr	Chair – Area Clinical Forum
	Ms. Laura Douglas	Non Executive Member
	Ms. Michele McCoy	Interim Director of Public Health
	Mrs. Joan Pollard	Associate Director of AHPs
	Ms. Christiane Shrimpton	Associate Medical Director, Acute
	Mrs. Alice Wilson	Deputy Nurse Director
In Attendance:	Ms. Margaret Johnstone	E.A. to Nurse Director
	Louise	Patient Story
	Ms. Emma Murphy	Patient Feedback Manager
	Ms. Margaret McGroggan	Volunteer Co-Ordinator
	Ms. Gail Meier	Lead Nurse/Deputy General Manager
	Dr. Nigel Calvert	Consultant in Public Health Medicine
	Ms. Lorraine Haining	IDEAS Team Manager
	Ms. Jilly Poulson	IDEAS Team
	Ms. Maureen Stevenson	Patient Safety and Improvement Manager
	Ms. Emma McGaughie	Observer
	Ms. Alexandra Little	Strategic Planning Manager/Commissioner for Cancer, Palliative Care & Children's Services

Patient Story

Louise, accompanied by Lorraine Haining, attended to share her Uncle Jimmy's patient experience explaining that she had previously worked with support agencies in Dumfries. Her uncle who lived in Edinburgh had moved to Dumfries and Galloway to be nearer his family, his health deteriorated and he was admitted to DGRI, then moved to a community hospital for rehabilitation and the outcome was that he was unable to live alone, even with a care package, and he was admitted to a care home.

Louise commented that there was no communication between the community hospital and the care home with no pain management programme being implemented resulting in poor care for her uncle. Louise explained that due to her care background she knew who to contact via the GP but as the process is really slow she initiated a meeting with the appropriate people and arranged for her uncle to be admitted to Midpark Hospital where the staff saved his life and her family's sanity, the staff kept the family up-to-date and pain management was under control. Louise, and her family, through other avenues found another care home and although her uncle was reluctant after his previous experience he has now settled in, is really happy, although not physically fit and the family are delighted to have their uncle back.

PH asked why MPH had made such a difference and Louise responded that the staff had respect for the patient, had knowledge and their communication was amazing. PH asked if this communication was with her uncle as well as the family and Louise replied that there were advocates involved at MPH, acknowledging that it was a massive responsibility for her family to take the decision that her uncle should be admitted but the family knew the advocates were listening and felt they had made the right decision.

GC asked if things may have been more challenging for her if Louise had not had the background knowledge and what would have helped her at this time. Louise replied that it was about finding the right support networks and getting a Social Worker who would help you and take you through things, saying that it would be hard if you do not know how the system works, usually first call would be to GP and often they are not available or on leave and this is very stressful to families.

NM asked if her uncle had moved from Edinburgh to the care home and Louise responded that no, he had moved to a retirement flat but his health had deteriorated and he needed more support and wanted to move nearer to where he had lived in his early life. Louise and her family had researched and visited four or five care homes and opted for the care home as it appeared to be good and she knew some of the people who worked there but things did not turn out well. NM commented that he was interested that she had spoken with a Social Worker and others before her uncle went to MPH and asked if this was about her concerns and Louise replied that they had asked questions at the care home and the staff had said it was her uncle's behaviour but someone else at the meeting said it was physical more than behaviour.

BR asked if her uncle had a health passport and Louise responded that this is a lengthy document for care givers to go through but this was in place at the care home and redone at MPH where it was adhered to.

JW highlighted the positive outcome from MPH and highlighted the community hospital link with the first care home asking about no communication, what had happened there and what we could do differently to improve outcomes. Louise responded that there was no pain relief in the community hospital and that physiotherapy was promised but did not happen. She commented that they did not push mobility in the community hospital and when her uncle left there was no pain relief plan in place, he went from being on a high dose to nothing at all. At the care home, as her uncle was not physically fit they used hoists, there was no transition, cannot walk so get the hoist and her uncle was terrified by the hoist.

JW asked Louise if she felt this was due to lack of communication between hospital and care home and an action plan for pain relief not being completed. Louise responded yes saying that there was not much communication between the GPs which had to be changed as well.

PH asked if Louise had thought about making a complaint and she replied yes but family did not want to as all the care homes seem to be linked and they did not want to be blackballed. PH asked if she felt her uncle was at risk and she replied yes, he was stressed and had bitten through his bottom lip and had marks on his body from the hoist. NM asked if there was any evidence he was abused and Louise replied no but people should not be treated like this, this was a negative experience for her uncle. ED commented that this is a big concern and he understood how Louise felt, and said that we can help her to complain and we can link in with these groups. If people are potentially at risk in any area we can have conversations with the Care Inspectorate and get advocacy and support to do this. Louise said she would speak to her uncle about this.

GC highlighted the care home uncle is in now is very different to the first one, commenting on the differences in culture from one place to another and Louise replied that it comes down to training, people's personal experience and how other people treat people.

PH highlighted that carers across Scotland do not feel valued, saying to Louise that what she had described is a loving family for her uncle, and sometimes carers do not feel valued by services if they do not feel listened to and Louise responded that it's not just being listened to but having the action taken to deal with things, as soon as we got to MPH communication was constant and excellent. PH commented that it is important that carers and families speak up.

NM asked Louise, as she had presented her story at this Committee, would she mind if we made use of this across the organisation to allow us to develop this story as he thought this would be really beneficial in the future. LH explained that Louise had made us a short film of her experience in MPH which helps with the triangle of care. PH commented to KD that this fits in with what he is doing around patient experience with different staff groups.

PH thanked Louise for coming along to tell her story. Louise and LH left the meeting.

PH requested a conversation with JW outside the meeting as this is an IJB matter.

1. **Apologies for Absence**
   Apologies as noted above.

2. **Declarations of Interest**
   Nil.

3. **Notes of meeting held on 10 September 2018**
   Accepted with minor changes.

   NM left the meeting after Item 9.

Under AOCB add to PH bullet points, are we offering quality of care in line with the Marie Curie Report.

4. **Matters Arising**

Better Blood Transfusion

KD noted the Blood Transfusion Team had been active at the Realistic Medicine Conference last year around reducing the amount of blood transfusions we do. This resulted in a Planned Blood Management work plan around good practice being implemented with a person centred approach to these guidelines and reports will be via the Hospital Blood Transfusion Committee.

Child Protection

ED highlighted the Child Protection discussion around Health Visiting saying that he would not support some of the comments made and that the individual was not aware this was a national process, suggesting this may be a relationship issue and will keep a close eye on this. He noted that an extensive internal audit review of Child Protection resulted in two recommendations, one of which was to update the Terms of Reference of the Health Child Protection Committee and this has been addressed, along with the role and function of Child Protection as it stands now, and saying that positive feedback was received following the last external review.

NM highlighted changes to the core plan and ED noted that the Universal Pathway has a significant series of milestones and what has been agreed is that not all need to be implemented, we are prioritising what we need first and by 2019/2020 it will be fully implemented. There is lots of evidence based work around the Family Nurse Partnership (FNP) which we are testing in Dumfries and Galloway. We do not meet the recommendations for FNP due to our under 19 years and under 24 years presentations but given this is the national way forward we have agreed to test. ED noted that from a health visitor numbers point of view we are in a stable position and considerably better than bigger Health Boards. Work by the team has resulted in appropriate numbers and trainees will be trained by mid 2019. Health Visitors are also included in work around transforming roles and although other Boards are removing School Nurses we are retaining them.

JW highlighted the comment around the inability to deal with Child Protection cases saying that the Health Visitor has responsibility around prioritisation and escalation, we had agreed to pathway for families but now know that this takes away from Child Protection, saying the Health Visitor Teams are no doubt under pressure and busy but this comment gives cause for alarm. GC highlighted the difference between the individual's perception and the numbers, saying that when spending time with families it may be that child protection issues go unnoticed, but this is only one caseload and what about everyone else?

ED highlighted the use of workforce tools which look at complexity along with balance of activity and the current workforce projections are one or two short for completion of the pathway. We have a retention challenge within health visiting and are meeting this by increasing numbers, growing our own and ensuring supervision is in place for child protection.

ED noted that previously he had said he was worried about health visiting but is much more worried about recruitment in other areas. NM asked about assurance around these pressures and GC noted this will come up under the Children's Services Plan to assure that our children and families are becoming safer because of the work we are doing. PH noted that ED has given this assurance this morning on the quality of service we deliver, saying that ED has looked into this matter and the workload described by the individual and this is not the case. NM asked if, in terms of assurance to the Board, something could come back to the Committee around outcomes of the review of health visiting. ED noted that child protection at risk comes to the Health Child Protection Committee via external review and internal audit and we work on this consistently as we did not have any assurance around child protection but now have positive feedback on developments. PH highlighted that an internal audit of child protection had taken place this year looking at a variety of issues, suggesting that the next HCPC update should include this.

GC requested a conversation with ED outside the meeting.

5. **Action List and Draft Agenda**

NM highlighted deferred papers in the action list and PH agreed that papers should come to the Committee on the agreed date.

ED highlighted his deferred Looked After Children (LAC) verbal update saying that the planned meeting with the Care Inspectorate had been cancelled due to family bereavement. PH highlighted the concerns around notifications of Looked After Children.

STANDING ITEMS

6. **Patient Services Feedback Report**

PH highlighted the Scottish Public Services Ombudsman (SPSO) complaints asking if we are learning from the complaints process and saying that we will always have complaints that go to the SPSO, highlighting one complaint laid before the Scottish Parliament. EM explained that learning in relation to complaints is a challenge and although there is lots of work going on we cannot say we are learning, maybe on individual complaints but not more widely. EM highlighted a piece of work with the Acute Directorate and the Women, Children's and Sexual Health Services around testing an approach to capturing learning and a short term solution to sharing learning. She noted that more complaints are going to the SPSO who come back with recommendations and we provide evidence in an action plan that we have implemented these robustly. SPSO have developed a self assessment tool to assist Boards which includes learning and we will be doing a lot of work around this to try and improve. In addition, JP is pulling together a Patient Experience Group, similar to the Patient Safety Group, to focus on complaints and outstanding issues. PH noted the Committee is aware we are not learning and have procedures in place to try and address this, asking EM how far on the road do you think we are? EM responded that we are in a similar position to other Boards using the model complaints procedure as a consistent approach and it makes sense to have a consistent approach to learning.

PH noted the key thing is that learning is on the list, there's something positive in trying to bring balance to complaints and still learning where to capture it all, suggesting that if we are replying positively to patients we ask if we can share this.

EM noted compliments received are shared with teams to ensure staff are aware of feedback, these are gathered via social media and are comments from people saying they have had a good experience.

NM commented that we are still not maximising the presentation of this information to the Committee, highlighting learning, the number of cases to the SPSO and the number resolved internally, asking how can we not capture this information across the organisation, there must be something staff have been told to do differently or is it a lack of ability to capture this in reports. He highlighted the number of complaints in the Women, Children's and Sexual Health Directorate (WCSHD) asking if any benchmarking had been done. NM highlighted the difference in numbers of complaints saying that we would expect Acute to receive more than WCSH but it looks like there have been consistent delays over the last few months. PH commented that this should be picked up operationally and NM asked by whom, there's nothing to say this has been picked up on. EM explained that she is still working with the Team to get the format of this report right and is looking at this and how we can better share this. NM commented that without benchmarking the information in the report is not much use and requested this by the next meeting or reasons why this cannot be included. ED commented that complaints and adverse events are looked at by quality groups to obtain trends and issues, for example, the Cardiac Arrest spike via the Patient Safety Group, and there's no reason why we cannot benchmark for this area, JP was having conversations around the last points we discussed. JW commented that what was being asked for is not just about the numbers of complaints, it's about what we benchmark against, the spike in August was in relation to "XYZ" and there is no reason we cannot get this and we can work with the directorates around what kind of information they are inputting to this report. PH noted that benchmarking should be included in the next report along with some information from each directorate on trends in complaints.

LB highlighted the difficulties in people making a complaint or raising a concern asking if we are doing enough to make people feel that they can do this. EM responded that we ask people to give feedback rather than just complain, outlining a number of various avenues for feedback. She noted that she had more work to do building relationships with local community groups which will continue to be helpful. EM explained Margaret McGroggan, Volunteer Co-Ordinator, is looking at Patient Experience Volunteers in other Boards and scoping out best practice with a view to volunteers linking with patients and it may be possible to take this forward.

GC highlighted Care Opinion and inviting feedback saying that there is nothing for us to say that we have done something about it and asked how we could simplify this. ED responded that we capture the care assurance conversation staff are having with patients on admission, we know the wards are doing this and we could add a feedback request.

He suggested that we ask each directorate what they are doing with their learning, particularly around complex complaints. PH commented that learning is about patient experience and we need to plan mechanisms for people to use.

The Committee:

- Discussed and noted the report

7. **Spiritual Care, Volunteer, Patient and Carer Information Report**

Spiritual Care
PH highlighted the Patient Listening Service (formerly Community Chaplaincy Listening) which had been raised at Person Centred Health and Care Committee, saying "well done" and asking MMcG to pass this on to Dawn and her Team.

Investing in Volunteers
MMcG confirmed that NHS Dumfries and Galloway had been successful in obtaining the Investing in Volunteers Award. She outlined the process, which had included BR, of interviews with 26 volunteers and 11 members of staff. PH offered congratulations to MMcG and asked her to pass these on to her Team.

Volunteering
MMcG noted a scoping exercise to identify volunteering needs in community hospitals, Galloway Community Hospital (GCH) and Midpark Hospital (MH) has been completed and recruitment starts this week until 28 November throughout the region. She explained that each community hospital requires 7 volunteers and GCH requires 10 volunteers with further volunteers required for MH and Breast Feeding Peer Support.

GC highlighted the Focus Group on Developing the Young Work Force suggesting that it would be good to involve MMcG in this Group, MMcG agreed and GC will contact her. MMcG noted that at a recent peer support meeting progression routes had been discussed and six young people are now studying nursing, pharmacy and medicine and two have joined volunteering in DGRI.

GC highlighted ensuring volunteers are supported and safe within the region asking how adequately we are able to provide ongoing support and supervision. MMcG responded that the Peer Support Group, which includes Welcome Guides and Ward Volunteers, meets to talk about what is working, what is not and capture all the good things. She highlighted the Third Sector User Group Meeting to capture feedback from different groups, for example, Blood Bikes and Building Healthy Communities, who support their own volunteers, highlighting the Clear Pathway Guidance. GC asked if our volunteers are able to report, if they are given a main contact and "go to" person and MMcG responded that the Volunteer Induction Training covers this.

The Committee:

- Discussed and noted the report

8. **Spiritual Care, Volunteer, Patient and Carer Information Clear Pathway Guidance**

PH highlighted the recommendation to adopt the Clear Pathway Guidance to ensure safe, effective and person centred volunteering where we are working with Third Sector organisations to deliver volunteering on our behalf and to create a formal agreement in relation to this.

NM highlighted the DL(2017)07 and the Lampard Review asking where do we sit in our compliance of this, suggesting a six monthly report to the Committee to provide assurance we are compliant and what we still need to do around the core actions from adoption of this report.

The Committee:

- Approved the adoption of the Clear Pathway Guidance
- Requested a report to May 2019 meeting around the points raised

9. **H.A.I. Report**

ER presented the usual report noting that we are making inroads in HAI C.Diff with a rolling programme of deep cleaning with Hydrogen Peroxide Vapour (HPV) in place. She highlighted good teamwork among the staff with 100 rooms being cleaned so far and is confident that the hospital will see a difference. ER highlighted device related SABs which had led to education around this, particularly for phlebotomists. ER highlighted SSI saying that as previously reported verbally we have not seen an increase in infections. ER highlighted the previously discussed risks around hand hygiene which have now been addressed.

NM highlighted the duty of candour and patients being alerted because of this.

The Committee:

- Discussed and noted the report

INTERNAL REPORTS

10. **Improving Safety, Reducing Harm : Acute and Diagnostics Directorate**

GM presented the paper highlighting two high level risks around staffing and the audibility of emergency call buzzers.

Staffing

GM noted that a range of initiatives are in place in relation to the recruitment of medical staff, nursing staff and allied health professionals. Lots of advertising is going on with staff attending recruitment fairs and we have engaged with a team from NHS Borders to look into a joint international recruitment initiative. GM noted that internally we have created Band 6 Development Posts and Band 3 Development Roles to support our staff. We have a new doctor in Galloway Community Hospital and are looking at medical models going forward.

Audibility of Emergency Call Buzzers

GM noted that contingencies are in place and Mediplan are rolling out a programme to address the issue.

Patient Safety
GM noted:

- an increase in falls/falls with harm and confirmed that this was not due to single rooms but probably due to better reporting and an increase in the number of frail patients we are looking after
- good input from volunteers who sit with people and keep them company
- Pressure Ulcer Collaborative has commenced in three wards in DGRI, two Teams in Galloway Community Hospital and Podiatry in Acute.
- Realistic Medicine – now linking in with this programme and involving people in discussions around treatment, including people with palliative care needs and anticipatory care planning.
- HAI, recent inspection and working with Elaine Ross and her team to keep things moving forward.
- Improvement Programme now running with staff participating. Band 6 Development Programme participants take on projects around improvement. We had a six month pause in improvement due to the move to the new hospital, things were still happening but time was an issue.
- Care Assurance, positive work which involves the whole team. Number of SCN retirals coming up and we are training staff coming through to ensure we are giving them the right skills and knowledge to take up these posts.

PH noted the increase in falls and asked what getting better at reporting means, if single rooms have an effect and if having volunteers in the rooms reduced the number of falls. ED responded that a step change in DATIX reporting had shown falls to be slightly higher and pressure ulcers are on the same step change. PH requested that the Committee receive evidence regarding the increase in falls and any link between single rooms and falls. JW responded that she would not be able to get this information for the next meeting but would bring a paper to the March meeting. She said her understanding is that we are not seeing significant increases in falls with harm, same areas in old and new hospital, may be patient mix rather than environment having an impact.

MS noted the increase was across the board and we are seeing that people can make an impact in a short period of time noting that the frailty work can make some progress and have an impact on falls. MS explained that the idea of volunteers in the single rooms was tested in Ireland for a long time, we have planned this and are now testing in DGRI, noting that people are in hospital for a shorter time and more people are coming through. PH commented that we need to be clear around the points Maureen has outlined and if there is any link with single rooms, what is happening nationally and locally, is it the same patient group as in the old hospital, we need to see the whole picture. JW responded that if we do think single rooms are having an impact putting volunteers in rooms is about thinking these people may fall, asking what else can we do, using volunteers is recognising that we have an issue. NM asked if there was a formal approach around single rooms and JW suggested that there may be the potential to link with the Ulcer Collaborative and do something around single rooms, including privacy and dignity.

NM highlighted a potential research approach with ED responding that from our own process the person centred approach should be the right way forward because we should not see a difference. LB highlighted the 18 month frailty collaborative asking what impact this has had, if we are going to continue with it and NM asked how are we measuring to see if we are making a difference. GM responded that there is no question that the frailty collaborative will be carried on, work is in process and we are starting to see the impact with lots of things going on and to build on this will be meeting with colleagues in primary care to move forward. KD highlighted how do we measure this, saying that the collaborative tool has a question for patients after out-patient clinics around how well they were involved in their appointment, testing commenced in OPD in December and will move on to teams. GC highlighted how we evidence the hospital has been providing safe and effective care one year on.

The Committee:

- Requested an update around the increase in falls and any link between single rooms and falls for the March meeting

11. **Dumfries and Galloway Cervical Cancer Screening Programme 2017 – 2020**

NC presented the report noting that the service is performing well with an uptake rate of almost 80%. We continue to review uptake around health inequalities. He noted that it is planned to change the actual test by asking women to test themselves in the future. Currently tests are processed at Monklands Hospital.

NC commented that they are looking for a public representative for the programme steering group and ED advised him to contact Joan Pollard about the Public Panel.

NM highlighted the new approach to the screening process asking if this may miss some people and NC responded that numbers are small with no specific way to pick this up. NM highlighted disadvantaged groups and NC responded that there are quality audits around this which is part of the inclusion work that is going on to reduce barriers. He highlighted the process in Scandinavia saying that Dr. Gwen Baxter had carried out a piece of research on this a few years ago although he pointed out that there is no visual examination included.

The Committee:

- Discussed and noted the report

12. **Dumfries and Galloway Bowel Cancer Screening Programme 2017 – 2020**

NC presented the report noting that the service is performing well with an uptake rate of 60%, the Scottish average being 55.6%. He noted that a new screening test was introduced in November 2017 (with a one off sample request) and uptake has increased as has the demand for colonoscopy. PH asked how much this has increased by and NC replied by 5%. JW confirmed that locally there was a spike in relation to colonoscopy and screening levels had increased by 65% but this was for the next stage rather than the number of people and she would be keeping an eye on this.

- Discussed and noted the report

13. **IDEAS Team Annual Report**

ED introduced LH and JP from our award winning IDEAS Team. LH presented the paper highlighting the ongoing education and training programme which is delivered across the region and has been attended by a variety of staff groups across health, social work and the third sector. Training sessions are followed by focussed workshops. 2,500 people have attended the training and we have developed good relationships across the region, we now have a waiting list for places. LH commented that we have made an impact via social media which is a good way to implement training and communicate. She noted that survey results show that following the training staff have increased knowledge, a better understanding of the needs of people with dementia and resulted in changes to staff's approach and communication. JP highlighted community project work with the local prison to promote gardening, in exchange for the use of the five acre garden and prison staff input the IDEAS Team will provide training for prison staff about dementia.

PH offered congratulations to LH and her Team on their very successful wide-spread creative and innovative initiative, saying their encouragement and positive interactions has transformed services. JW thanked LH for the report saying it is a great reflection of the work underway, highlighting that the care homes are not waiting until they reach crisis point before contact. She asked about capacity, as the IDEAS Team is small, and how we can roll this out and how can we make it sustainable. LH responded that the challenge is about resources. She noted there are projects in Dumfries and Annandale and Eskdale and we are trying to bring other people in Wigtownshire and looking at how we can do things differently as staff who have been on the training can put things in place within their services with a bit of support. GC asked about engagement with primary care such as dentists and GPs. LH responded that the GPs are a challenge although the Practice Nurses are coming around. JP highlighted contact with GPs around patients in care homes but this does not happen very often. LH noted that anyone can contact the IDEAS Team for advice. NM highlighted JW point about the care homes making contact early saying the opportunity to change the culture in care homes is good.

The Committee:

- Discussed and approved the report

14. **Health Adult Support and Protection Update (HASP)**

ED presented the update which outlines progress based on the agreed work plan. He noted our biggest challenges arose when the Public Protection Nurse Consultant left, however, her replacement starts this week. ED noted the key point in the paper is the significant increase in vulnerable adult referrals saying that we now have ASP input from health to the Public Protection Committee, and the sub-groups, and conversations are now taking place which were not before.

PH highlighted attendance at the Health Child Protection Committee saying that she had raised this at a previous Committee meeting and looking at the minutes from the meetings she had serious concerns at the number of apologies. ED noted that the frequency of the meetings has been changed and attendance appears to have improved but he is happy to put this message out to the groups.

PH asked for assurance in relation to training for adult protection asking if our staff were able to support vulnerable adults and ED responded that this is part of mandatory training. GC highlighted the action plan saying that this is all upstream, although understands why the document is at Committee rather than just one little bit. ED responded that adult protection should just mirror child protection and GC is right, it is not there and we need clear thresholds and he will flag up the need to do this. NM asked if we have numbers of staff who need to be aware of this and what percentage of staff require training. PH requested assurance that everyone is trained appropriately in ASP, asking JW if a patient is discharged from hospital, how do we know that our systems are robust. She highlighted this morning's patient story, saying the patient was vulnerable and there is something we need to look at around training particularly for adult support as lots of assumptions are made around families. PH asked if we could look at doing some sort of "toe in the water" stuff around are staff dealing with this and are they using their training the way they should. JW asked PH if we are measuring impact, saying that ASP has been about Child Protection, locally have tried to increase focus on this, all staff do the mandatory training although other members of teams require enhanced training. We do not know what we are measuring but could ask through Public Protection Leads to see if they have anything. PH responded that she thought this should come back to the Committee.

The Committee:

- Discussed and noted the report

15. **Patient Safety Group – Significant Adverse Events**

MS presented the paper highlighting the increased number of adverse events being reported. She explained that, from 1 April 2018, the Duty of Candour Legislation for Scotland came into effect and a paper went to the Performance Committee around implementation of the plan which was accepted. This paper showed an overall increase in number of reported incidents and significant adverse events across the board. MS highlighted the focus on investigations in the Patient Safety Group around two pressure ulcers, emphasising that previously they would not have been there, along with Cardiac Arrests, HAI, SAE, which are part of the increase in adverse events. Viewing this positively and working with staff to make sure they feel comfortable reporting an AE, as they may feel under pressure to do this, takes a long time. We are robustly investigating and sharing this learning throughout organisation. MS noted a number of issues around systems of care, not just about 1-1 care to stop this happening, but about the big things that go on, saying that the Patient Safety Group has been much more active in the last year or so. MS noted that Emma McGauchie will include learning summaries in the future SAE reports.

GC commented that the Committee have been talking about the way we share learning about complaints and this is a good piece of work, about how learning is being discussed and learning from and sharing across organisation. ED noted the launch of the Patient Experience Group using the same process with Emma McGauchie driving this work forward. PH commented on the shared learning saying that she would like to know how you did this and requested a paper to the Committee showing this information.

The Committee

- Requested a shared learning paper

16. **Dumfries and Galloway Children's Services Plan 2017 – 2020**
AL presented the Children's Services Plan reporting on progress since submission to the Scottish Government in July of this year. She highlighted the work being taken forward by multi-agencies for children and young people, the population being less than 25,000 under the age of 25, with 400 Looked after Children and 200 on the Risk Register, along with those with complex needs and mental disabilities.

The Committee:

- Discussed and not the report
- Agreed draft plan for next year should come to May 2019 meeting

ITEMS FOR NOTING

17. **Healthcare Governance Committee Dates for 2019**
The HCGC dates for 2019 were noted.

18. **Circulars and Safety Action Notices Update - 2018/19**
The Circulars and Safety Action Notices Update was noted.

NM commented that the paper does not give assurance that the circulars are being actioned and circulated appropriately. ED will feed back to Laura Geddes/Jeff Ace.

19. **Board Donation Notes – 8 February 2018**
The notes of the Board Donation Committee held on 8 February 2018 were noted.

20. **Infection Control Committee Notes – 3 July 2018**
The notes of the Infection Control Committee held on 3 July 2018 were noted.

Any Other Competent Business

Date of Next Meeting
Monday 21 January 2019, 10 am, New Board Room, Crichton Hall.

Agenda Item 268

DUMFRIES AND GALLOWAY NHS BOARD

PERSON CENTRED HEALTH AND CARE COMMITTEE

20 August 2018

1.30pm , New Board Room, Crichton Hall

Present:	Ms. Lesley Bryce	Non Executive Member (Chair)
	Ms. Dawn Allan	Spiritual Care Lead
	Mr. Stephen Hare	Chair of Area Partnership Forum
	Ms. Phyllis Wright	Council/Social Work Representative
	Mrs. Joan Pollard	Associate Director of Allied Health Professionals
	Ms. Caroline Sharp	Workforce Director
	Mrs. Margaret McGroggan	Volunteer Co – Ordinator
	Ms. Mandy Spence	Midwifery Representative
	Ms. Vicky Freeman	Head of Strategic Planning
In Attendance:	Ms. Nicola Ross	PA, Associate Director of AHPs
	Ms. Claire Thirlwall	Health & Wellbeing Specialist
	Ms. Rachel Byers	Alzheimer Scotland
	Ms. Jill Rennie	Alzheimer Scotland
Apologies:	Ms. Penny Halliday	Non Executive Member
	Ms. Lynsey Fitzpatrick	Equality and Diversity Lead
	Mrs. Nicole Hamlet	General Manager, Acute Services
	Ms. Michele McCoy	Interim Director of Public Health
	MS. Claire Brown	Operation's Manager, Third Sector Dumfries & Galloway
	Mr Eddie Docherty	Nursing, Midwifery and AHP Director
	Mrs. Lorraine Haining	Partnership Lead/Specialist Nurse Practitioner
	Mrs. Lorna Carr	Chair of Area Clinical Forum
	Dr. Ken Donaldson	Medical Director

1. **Dementia Friendly Communities Report**

Rachel Byers and Jill Rennie from Alzheimer Scotland attended to highlight the key messages in the report. Both Rachel and Jill were part of the project, although in different localities.

The key messages from the report were:

- 76 people living with dementia and 70 carers consulted.
- 3000 Dementia Friends across the region
- 285 Dementia Friends sessions

- 80 business, organisations, shops and schools supported to become

dementia friendly organisations

- 8 businesses adapted their premises in response to an environmental audit.
- 262 Community Activities were delivered across the region
- 780 people living with dementia, 300 of which live in care homes participated in community activities
- 410 carers attended community activities.
- 20 community activity groups running across the region
- 60 volunteers support the community activities
- 20 community awareness raising activities
- 2 relaxed lanes in Tesco supermarkets
- All D&G Boots chemists dementia friendly

Both Rachel and Jill commented that partnership working was key to the success of the project. Building relationships and engaging with the community helped the project grow and develop as well as the receipt of financial contributions and fundraising support.

The community activity workers are still in post and employed by Alzheimer Scotland to continue working with people who have already engaged.

LB commented that the project was hugely successful and that a lot of this was down to the partnership working. Rachel and Jill agreed and Jill felt that because each of the link workers were from their locality, this really helped as they had a good working knowledge of the area which allowed them to meet people face to face. Also, by ensuring they had the right people in their groups helped, as they needed people who could influence a wider group of people.

PW asked they were able to target many people who are diagnosed with dementia between the aged from 40 – 55 years old. Rachel and Jill answered by saying no, this was still a hard to reach group and was challenging.

There was a Retired Farmer Group which has been established through this project. This group is out for consultation just now and it is hoped that this will be supported through the partnership to continue. It is currently out for consultation.

DA asked if people who are living in isolation are being supported/encourage to attend these activities. Jill has been in touch with people who are reluctant to try the groups and has found that through visiting them at home and building a relationship, some of them attend and find them enjoyable.

JP asked if throughout the work with local businesses, employers were given information about how to support people with earlier diagnoses of dementia to remain at work. All local businesses were given an information pack which had a variety of information in it which included information for employees but wondered if large organisations were using these such as NHS and Council. CS advised that we have comprehensive Occupational Health team in each of these services who may be able to make the specific requirements rather than general awareness tools.

PW suggested that this may be able to be added to front page of intranet. CS is happy to share the packs with the Council and with Working Well Strategy Group to see how this can be promoted via internal sites.

MS asked if the carers had noticed a difference in how employers reacted if time was required to support a person with Dementia. Rachel said that they had learned a lot through the training and hearing people's stories that made them reflect on different situations and consider alternative options for the future.

2. **Apologies for Absence**
Noted and recorded as above. Due to the number of apologies, the committee was not quorate and LB, as chair, sought approval from the committee to go ahead with the meeting. Everyone was in agreement as there were no items for approval – they were all for noting.

3. **Declarations of Interest**
Nil to note.

4. **Minutes of meeting – 11 June 2018**
LB checked the minutes for accuracy with the committee. Those in attendance agreed and did not raise any comments and as chair LB was happy to agree as accurate. PH had not made any further comments to NR prior to the meeting.

5. **Matters Arising**
There were no new matters arising that weren't already covered in the action tracker.

6. **Action List**
Social Prescribing
CT attended the meeting to give an overview of the key findings of a report on perceptions and experiences on social prescribing. A fourth year student completed this research as part of their honour year studies and the key messages taken from their findings include:

- The term social prescribing can be confusing to the community however, participants were positive about the concept and willing to consider this in conjunction with other resources to improve health and wellbeing.

- Potential benefits mentioned by participants included feeling connected and feeling a part of their community. This complements the notion that having involvement in your community can increase social capital, where the benefits from participation include social relationships

- Participants identified that the key reason that they would attend their GP's was for physical ailments. Most participants indicated reluctance to consult their GP regarding mental health issues.

- Alternatives to medication to be explored where possible by their GP was recommended by participants

- Participants understanding of self-management included knowing about how to look after and understand what their minds and bodies needed.

- It was felt by participants that self-management is something that was taught to them by a health care professional or a group they had been referred to by their GP.

PW commented that it is interesting to hear that we are still facing the same barriers with people with mental health illnesses. There has been a range of work around encouraging people to go to the GP early but this research proves that this is still a challenge.

Consideration will be given to the findings as part of the development of the regional social prescribing framework.

Co-Production
VF provided an update on the Co-Production workshops. There is a challenge in keeping the numbers of people attending the workshops to be consistent. The people who are attending seem really committed and determined to do something around co-production and have learned a lot more about the concept. The work will be ongoing for some time as it requires a change in culture and mindset.

Following the fourth workshop, VF is hoping that 100 day working labs will be set up to allow people who have pieces of work to co-produce to do this with support.

VF would hope to be able to feedback to a committee in the future and give examples of work that is ongoing through the working labs. Staff and managers are supportive of this work.

Carer Positive/Carer Strategy
CS provided an update following the last committee. CS has been working on scoping the work that is going on around Carer Positive and considering what direction this will move in the future and how it will feed into the Carer Strategy.

CS has arranged a meeting with key individuals; the members of the previous carer positive working group, a member of the strategic planning team and also from public health. This meeting is taking place next week. The purpose of the meeting is to seek clarity of the work and the governance that will sit around this and support it to move forward.

LB is really keen that this starts to move forward as it has been dormant for a couple of years. CS will provide a further update at the October meeting.

7. **Patient Experience**
This agenda item has been deferred to the next committee.

8. **Spiritual Care and Bereavement Support**

DA presented the report and update on Spiritual Care and Bereavement Support. *The front page of DA's paper should have read 'note' instead of approve.*

The key messages from the paper were:

- Referral template
- Spiritual Care Volunteering

DA is trialling a new referral template to capture how many staff are being referred and the reasons for their referrals. Between June and July 2018, there has been an increase in the number of referrals which have been received.

CS reflected on the staff referrals and supported the idea of reporting these figures as it is useful to see any trends. CS also felt it would be beneficial to share these figures, once further data have been collected, with the Staff Governance Committee paper around staff and wellbeing.

CS also suggested that it may be helpful to see the spread of the referrals and how many of these are coming from DGRI and how many are from other areas. DA will record whether the referral is from DGRI or another source initially to track the spread.
DA needs to be able to sustain her role and there is a need to monitor the referrals to ensure that she has the appropriate capacity.

PW asked about the referrals to Bereavement Support and wondered why the route had changed from CRUSE. DA advised that Relationship Scotland do the Bereavement Support as well as relationship advice and also offer late night appointments up until 9pm which suits people who work during the day. People who have been have had positive experiences.

PW also asked for clarity around the Bereavement Working Group. JP advised that this is now sitting with the Palliative and End of Life Care Strategy and the work will move forward together.

9. **Volunteering Update**

MMcG presented the report and update on Volunteering.

The key points from the paper were:

- Investing in Volunteers
- VOICES training
- Progression Routes

MMcG updated that the Investing in Volunteers (IiV) assessor had been down and carried out 35 informal interviews with a mix of staff and volunteers. The initial feedback was positive however, the report will go to the IiV panel early October with us being notified of the outcome the following week.

JP advised that if there are areas for development identified, then we will continue to complete this work to ensure that we can gain the award at a later date.

MMcG advised that seven volunteers have taken part in the VOICES Scotland training which was facilitated by the Scottish Health Council. The feedback from the volunteers was that this was really valuable.

The training was free and the same group will come together 3 months post training to regroup. This was a pilot but the hope is that this will roll out to other volunteers. The workshops were very interactive and the volunteers engaged well with the support.

A number of our recruited volunteers have now progressed on with a couple of the young people being interviewed for volunteering roles with Paediatrics to provide them with the experience they require for university/college. Joanne To, who has previously spoken at PCHCC has secured a placement in the Pharmacy team.

MMcG has volunteers who are supporting the Falls Prevention work and also some others that are trialling volunteering in CAU to see if there is a role for them there. Work is continually ongoing with teams to increase the number of volunteering opportunities that the Board can offer.

10. **Values Based Reflective Practice (VBRP)**
DA facilitated the session a VBRP session with the use of Envision cards. This allowed the committee to reflect on the meeting.

11. **Any other Competent Business**
Nil

Date of Next Meeting
Monday 22 October 2018, at 1.30 pm – 3.30 pm, in the New Board Room, Crichton Hall.

Agenda Item 268

DUMFRIES AND GALLOWAY NHS BOARD

PERSON CENTRED HEALTH AND CARE COMMITTEE

22 October 2018

1.30pm , New Board Room, Crichton Hall

Present:	Ms. Penny Halliday	Non Executive Member (chair)
	Ms. Lesley Bryce	Non Executive Member
	Ms. Vicky Freeman	Head of Strategic Planning
	Mrs. Lorna Carr	Chair of Area Clinical Forum
	Ms. Mandy Spence	Midwifery Representative
	Mrs. Nicole Hamlet	General Manager, Acute Services
	Ms. Phyllis Wright	Council/Social Work Representative
	Ms. Dawn Allan	Spiritual Care Lead
	Mr. Eddie Docherty	Nursing, Midwifery and AHP Director
	Ms. Caroline Sharp	Workforce Director
In Attendance:	Mrs. Nicola McDill	PA, Associate Director of AHPs
	Ms. Sally Pattinson	Shadowing - Spiritual Care Lead
	Ms. Kim Britton	Anticipatory Care Planning Project Officer
	Mrs. Sheila Webster	Welcome Guide – Volunteer
	Ms. Alex Little	Strategic Planning Manager/Commissioner for Cancer, Palliative Care
	Ms. Liz Forsyth	
Apologies:	Mrs. Joan Pollard	Associate Director of AHPs
	Mrs. Lorraine Haining	Partnership Lead/Specialist Nurse Practitioner
	Dr. Ken Donaldson	Medical Director
	Ms. Michele McCoy	Interim Director of Public Health

1. **Volunteer Story – Welcome Guide**

Sheila Webster attended the committee to share her experience as a Welcome Guide. Sheila has volunteered with the NHS for almost eleven years following her retirement at the post office. Sheila initially volunteered in Mountainhall when it was the old hospital before moving to the new hospital when it opened in December 2017.

Sheila attended the Queen Elizabeth Hospital Good Practice visit prior to the hospital opening along with MMcG and a few others to see how volunteers supported staff in other Boards and felt that it was a really valuable experience.

Sheila advised that there are sixty regular Welcome Guides at present who volunteer from Monday – Friday and many of them have become friends. Sheila said that her slot is a Monday afternoon and some of them meet for lunch before their shift begins. If more than four welcome guides are on at any one time, they also provide cover for the Women and Children's wing.

The purpose of a Welcome Guide is to meet and greet people who are coming into the hospital and to assist where possible. Initially, when the hospital opened, there were some issues with patients coming into the main hospital for Orthopaedic Outpatient appointments and they had to be re-directed back round to the Accident and Emergency Department. The volunteers shared this with the acute senior management team and directions have now been added to the letters which are sent to the patients. This has been really useful.

Sheila advised that forty-six Welcome Guides have now undertaken wheelchair assistance training and are now able to support patients/carers/visitors within the hospital setting. Although they have recently raised that there is a shortage of wheelchairs. NH responded to advise that a further 20 wheelchairs have now been ordered based on the feedback from the volunteers. Sheila also raised at the Queen Margaret visit, porters did a sweep of the hospital and brought the wheelchairs back to the main entrance. NH advised that they were going to introduce this to DGRI too but would be dependent on porter's capacity.

MS asked if there would be wheelchairs available in the Women and Children's Wing as they always used to have two at the main entrance of the old Cresswell. NH will speak to Linda Williamson, General Manager for Women & Children's regarding this and feedback.

The Welcome Guides undertake regular training. New volunteers complete full induction training prior to starting with all volunteers who have been volunteering for two years or more undertaking refresher training.

A number of the volunteers have now taken on additional volunteering roles in other areas such as Combined Assessment Unit (CAU) and the Critical Care Unit (CCU).

To celebrate Volunteer Week, the volunteers arranged a Quiz Night at the Easterbrook Hall which was very well attended with over 50 volunteers.

To celebrate 70 years of the NHS, the Volunteers hosted two afternoon teas, one at Hetland Hall Hotel and the other at Lochside House Hotel.

Sheila highlighted that the volunteers have received a number of compliments for the extra support they provide people with which is very heart warming to hear.

Finally, Sheila shared a lovely poem regarding volunteering with the committee. ED thanked Sheila for this poem and asked if it would be possible to share with the Executive Team and Non-Executive's of the Board as well as the communication team. MMcG will forward this poem on.

ED asked Sheila how the volunteers felt when they were managing complaints or people who were anxious. Sheila advised that the majority of the concerns raised were around car parking or the use of the e-kiosks. Nothing has been too challenging so far and they are aware that they can give people the 'We welcome you feedback' forms to complete if they would like to make a formal complaint.

CS reflected from the comments raised by Sheila around the wheelchairs and orthopaedic outpatient letters that volunteers are making a difference to the service we provide by raising these issues.

LB thanked Sheila for attending and asked if she felt that the purple polo-shirts were making a difference. Sheila felt that they were as it easy for people to pick these out. The volunteers will also be getting hello my name is badges to wear too which will be helpful. ED approved this.

PH thanked Sheila for coming to the meeting, not only on behalf of the Person Centred Health and Care Committee but also on behalf of the NHS Board. She noted that the value that volunteers are adding to Patient Experience has been significant.

PH asked us to consider if this is the there may be any spare wheelchairs at alternative venues that may be able to be used. NH will pick this up with David Bryson, General Manager for Operations.

2. **Apologies for Absence**
Noted as above.

3. **Declarations of Interest**
Nil to note.

4. **Minutes of meeting – 11 June 2018**
Agreed as accurate.

5. **Matters Arising**
Nil to note.

6. **Volunteering Strategic Planning Group**
PH updated that this group met for the first time a couple of weeks ago and one of the key points from the discussion was that they are hoping to appoint a Volunteer Manager/Fundraiser who would be able to support MMcG with volunteering across the region. The aspiration is that this post would be funded partly by Endowments but they cannot be expected to fund fully so there needs to be an element of fundraising as part of the role.

The next stage is for a small group to meet and agree the job description and PH will update at the next meeting.

PW highlighted that Social Work are moving away from the model of four visits per day and are looking at different approaches so people can be supported in ways that will benefit them eg. if a person has an interest in a particular hobby, it's looking at ways that may be possible for the individual to receive support to achieve this.

Anticipatory Care Planning

Kim Britton, Anticipatory Care Planning Improvement Advisor attended the committee to provide a verbal update. KB came into post in June 2018 and the post was initially for 12 months however, following a recent discussion at H&SCSMT there is a chance that this post may be extended.

The national ACP has been adopted in Dumfries and Galloway to be in line with the rest of Scotland. The national team have recently developed a mobile app which will allow people to update their ACP easily and email it to the GP once completed.

KB highlighted that the biggest challenge is sharing the information between primary and secondary care via eKIS and Clinical Portal. A section has recently been developed onto Clinical Portal to allow this to happen although testing is undergoing before being rolled out. Work is also ongoing on TOPAS to add an alert for staff if an ACP has been completed. Current testing on the indicator section on the summary pages is undergoing in care homes initially.

KB highlighted that awareness and education is going to be one of her main focuses over the next few months across the region. KB is attending some flu clinics over the next few weeks to speak to members of the public to raise awareness of the ACPs and answer any questions people may have around them.

KB advised that there is a day centre in Newton Stewart which is holding an 8 week block session to raise awareness to the public of services available in the Wigtownshire area and this will include ACPs and Power of Attorney. PH suggested these types of events should be highlighted via social media.

CS was challenged in an IJB setting to complete an ACP on a personal level which was very difficult and thought-provoking and how this may change over the months/year as your circumstances change.

VF noted that the concept of ACP was introduced 6 years ago in Annandale and Eskdale and was called Forward Looking Care Planning. This piece of work is challenging and we need to really try to address ACP and make it work for the individual and their families. We need to address as early intervention as it's easier to deal with issues at this stage and not when the individual or their family are in crisis.

ACPs apply to everyone as no one has any idea what the future holds for them so it is important to have their wishes documented. PW said ACP and Power of Attorney's sit hand in hand and she will liaise with KB around how they can promote this.

KB advised that an ACP newsletter has been developed and will be published on a quarterly basis.

VF would like to see us develop outcome measures for ACP but this piece of work would need to be agreed via the Integrated Joint Board.

DA would like to bring the 'Conversations for Life' cards to a future committee meeting for everyone to participate in and experience an 'easy' way to start to think and talk about what's important to them if they became seriously ill and needed others to know their wishes. The Conversation for Life cards help people to take what can often be a difficult first step towards a conversation with loved ones.

The Committee:

- Requested a further update in April 2019.

Mindfulness

Jo Kopela submitted an SBAR to the committee and asked for them to discuss and note the creation of a mindfulness strategic framework for NHS Dumfries & Galloway.

CS highlighted that Mindfulness is a great tool which can be used with both staff and service users however; there is a limited resource across the region to deliver this.

ED suggested that we test what a spread of the training would look like with the current resource and see what the difference would be. PH highlighted that there is a member of staff who is trained in Wigtownshire but is not being utilised to deliver the training and there is a need to identify the reasons why are and also if there are any other trainers in the same position.

PH noted that if this was successful then there would be a need for some budget to be invested in this to allow further training to be implemented.

CS is keen to see how much input Jo is getting through our Occupational Health Department as Mindfulness is not only an 8 week course, it can be one or two sessions. CS will discuss this with Jo. PW highlighted that it may be useful for staff/service users to be able to attend virtually rather than in person.

PW noted that the Council have identified Mental Health and Wellbeing Champions to look out for colleagues and keep people save at work.

The Committee:

- Sought further information regarding the SBAR prior to making a decision
- CS will discuss further with Jo Kopela and Ros Kelly and provide an update
  at the December Committee

Carer Positive/Carer Strategy

CS provided a verbal update following the working groups meeting in October. The group re-visited the action plan that was created over two years ago and identified that a lot of the work hadn't progressed over this time.

The action plan has now been updated to reflect what stage the organisation is at just now.

CS noted that the group had had a stand at the recent Celebration Event and had this gave staff an opportunity to engage with members of our workforce and seek their thoughts on what the carer positive framework should include. The group were really keen to hear from people who had previous had or are currently caring for people whilst remaining at work.

CS will also speak to other directors in other health boards across Scotland to see what they are doing. CS has spoken to NHS Lothian and they advised to start from what the staff feel they need and build it from there. CS advised that the date for the next working group meeting is still to be agreed.

PH is pleased to hear that this is moving forward and thanked CS and LB for taking thing forward without any additional capacity.

The Committee:

- Requested an update paper for the December meeting.

Co-Production

VF provided a verbal update on the Co-Production work that has been ongoing throughout this year. This has been a challenging journey to keep people engaged in the work as it requires a huge commitment and there has been a lot of learning. It has been agreed that if the work doesn't meet the co-delivery element then it cannot be considered as co-production. The work is much more limited than what we thought at the beginning and cannot be done quickly. It requires a change in culture and the way people work. For those who are still engaged in this work, there are they are about to commence the 100 day labs.

PH is part of a 'mentoring women for cancer' group and this will take place in the West of the region. There will be women who have been affected by cancer as part of the group. The main reason for this group is because people are looking for people to talk to both on diagnosis, during treatment and after their treatment has finished.

VF will feedback to the committee after the 100 day labs in the Spring and will ask the committee to review the feedback following this.

The committee:

- Requested an update in April 2019

7. **Patient Experience**

PH would like to have a Patient Experience campaign across the whole region next year. VF asked if we should re-consider the title of the campaign as it will be broader that just the patients, it will include family members, carers and other service users/providers across health and social care. The committee agreed that this would now be called 'People's Experience of Healthcare'.

PH had met with Ken Donaldson (KD) and Joan Pollard (JP) prior to the committee and would like volunteers to join a working group to run this campaign in 2019. PH highlighted that there may also be some Patient Experience volunteers who could take part.

The nominations for the working group are PW, LC, PH, KD and JP. ED advised that there will be a new Associate Nurse Director in post and this person could join the group. LC and PW will also invite along two service users from Mental and Physical Health and PW will ask for representation from the criminal justice service.

PH would like to arrange this meeting for December 2018.

8. **Palliative Care and End of Life Care Strategy**

Alex Little (AL) and Liz Forsyth (LF) attended the meeting to provide a verbal update. The strategy is currently in draft but has been agreed by HSCSMT. LF is new to the team and is undertaking induction but the team have put some time aside this week to complete the pre consultation work for both cancer and palliative care.

AL advised that throughout November there will be consultation training for the team, communication to service users/providers etc regarding the consultation and also the consultation plan will also be submitted to HSCSMT.

The consultation will run for a 12 week period and will conclude at the end of January on the strategy. This will be followed by an evaluation of responses/editing and consultation report will be undertaken throughout February with a final version being submitted to governance groups in March/April 2019 for sign off.

From April 2019 onwards, the team will work with colleagues and partners, including further consultation to develop action plans that will drive the strategy.

AL noted that there are going to be challenges faced within this as some of the conversations will be very emotional for people. AL stated that the team hope to meet with people on a 1:1 basis or in small groups to ensure it is manageable and people receive the correct support.

PH acknowledged that it may be difficult for some members of the community to talk about death and dying, depending on their circumstances. PH asked if AL will be linking with DA to provide this support to people who may benefit. AL responded that they will work together to provide additional support for anyone who may need it.

AL has put in sufficient supervision for staff at a local level as it will be challenging for them too. They will also meet groups in two or three to support each other.

9. **Spiritual Care and Bereavement Support**

DA presented the report on Spiritual Care and Bereavement Support. DA highlighted the National Delivery Plan and advised that this strategic plan that is still in draft. The Practice Lead Group have been working on this NDP over the last few years and as a Board, this is what we have been working towards however we are still awaiting final sign off from the Scottish Government.

Volunteers in DGRI

DA has designed a label with the Senior Nursing Acute Group (SNAG) to be inserted in to the patient's notes in DGRI when a volunteer has seen an individual because they are unable to document this in the nursing notes. This is being trialled until the end of 2018 and will help to audit the number of visits the volunteers are doing.

CCL

DA is working with a GP practice in Castle Douglas and has a volunteer who is willing to carry out CCL between Dalbeattie and Castle Douglas on alternative weeks. DA has had a discussion with the GP in Castle Douglas and is awaiting a decision.

PH asked how many CCL volunteers we have. DA advised that we only have two at present. Two others have just completed the training but she is unsure if both of these will start.

The committee:

- Discussed and noted the report

10 **Volunteering**

MMcG presented the Volunteering report. MMcG highlighted from the report that the Ward Volunteers are now providing support to the IDEAS team when they are carrying out Dementia Awareness training which is not only allowing the staff to deliver more training but they are gaining additional training themselves on dealing with people with dementia. Eight of these volunteers are going to support the next IDEAS team Activity Fayre and be involved in the planning of it along with staff.

Recruitment

MMcG noted that a number of young people have left their volunteering roles due to moving onto university/college or just simply the role wasn't for them. MMcG has been carrying out interviews for more young people with a further 12 being interviewed this week. They will commence their training at the end of November if suitable.

MMcG is looking to recruit 66 volunteers for community hospitals and the recruitment days for this will commence in the middle on November. MMcG has worked on the role descriptors with the Senior Charge Nurse for each hospital Each Community Hospital is seeking one volunteer per day with the exception of the Galloway Community Hospital and they are looking for two which is one for each ward.

MMcG noted that she is working along with Natalie Adams, Nurse Manager at

Stranraer as they are looking to introduce Tai-Chi for staff. MMcG is working through the process with her to ensure that they follow the correct protocol and have terms of reference in place.

The committee:

- Discussed and noted the report

11. **AOCB**

PH had recently conversation with Gail Meier (GM) about how staff are feeling following a very busy summer. Following a recent social event for a staff member's retirement, this really boosted staff morale as it was an opportunity for everyone to come together. PH would like the committee to focus on ways that we can support staff morale and consider if an annual event should be held next year to bring staff together.

GM is looking at ideas to support things for the Acute team and is considering a 'chill out' room for staff to go and have a break – not a staff room but a quiet space.

Date of Next Meeting

Monday 17 December 2018, at 1.30 pm – 3.30 pm, in the New Board Room, Crichton Hall.

Agenda Item 268

Staff Governance Committee
New Board Room, Crichton Hall
Minutes of the Meeting held on 24 September 2018 at 10am

Present

Lesley Bryce	Non Executive Board Member (Chair)
Sandra Milne	Staff Side Representative
Melissa Gunn	Non Executive Board Member
Stephen Hare	Staff Side Representative

In Attendance

Jeff Ace	Chief Executive
Lynsey Fitzpatrick	Equality & Diversity Lead (for Item 11)
Lorraine Haining	Partnership Lead/Specialist Nurse Practitioner IDEAS Team (for Item 8)
Pamela Jamieson	Head of Service - HR Manager
Ros Kelly	Head of Service – Occupational Health Manager
Arlene Melbourne	Executive Assistant to Workforce Director
Natalie Morel	Head of Service – OD&L Manager
Caroline Sharp	Workforce Director
Alice Wilson	Deputy Nurse Director

		ACTION
1	**Welcome, Introduction and Apologies** Apologies were received from Val Douglas, Andy Ferguson and Philip Jones.	
2	**Draft Minutes of the Previous Meeting held on 23 July 2018** Melissa Gunn asked for more clarification on item 6, 2nd bullet. Caroline Sharp would get an alternative form of wording for the minute. <u>Action List</u> *Carer Positive* – the action group have met and had a good discussion and they are having stand at the Celebrating Event at Easterbrook. Caroline Sharp had spoken to the Lead in NHS Lothian as they have	**CJS**

	exemplar status and they have sent through materials they have used as they have a similar approach to ourselves. *Non Executive Induction Sessions* – Caroline Sharp had organised 2 sessions and no-one had attended the 2nd session so this was disbanded. Caroline and Lesley would pick this up. *EEI Letter* – this will be picked up under Item 13 on the agenda.	**CJS/LB**
3	**Matters Arising** *BREXIT* - Jeff Ace reported that it was on the Corporate Risk Register but difficult to describe as a risk. Chief Executive's have a 2 hour session on it in October with Scottish Government. He stated that there were 2 risks, a long term one which was around challenges to recruitment, technical issues, economic impact to funding the public sector etc and short term risk around what happens if there is no deal by 30 March as this would be a huge business continuity risk. Jeff would take a paper to Board in December for clarity. *SAAT* - Caroline Sharp stated that Staff Governance Committee had approved the Self Assessment Monitoring Report for 2017/18 for submission to Scottish Government in May. The report has now been analysed by Scottish Government and a letter has been received from them giving feedback. Caroline has circulated the letter to her team to prepare the further information which is to be submitted and Arlene would circulate a copy of the letter to Staff Governance Committee members. Caroline would prepare a response to the feedback letter and get it approved by Lesley Bryce & Stephen Hare and will then submit it to Scottish Government by 31 October. The response would also be circulated to Staff Governance members for information	**AFM** **CJS/LB/SH** **AFM**
4	**Corporate Risk Register** Caroline Sharp reported that this was the routine paper with the 3 corporate risks continuing to be reviewed: • Sustainable workforce • Health and wellbeing • Organisational culture and development	

	Lesley Bryce asked if further development work was happening with partners in joint integrated services. Caroline responded that significant dialogue had taken place and a Draft MOU had been developed for all to sign up to but the Council did not support the disciplinary issues and Julie White would take this forward. The Draft MOU had therefore not been taken forward through Board and Council partnership structures yet. Staff Governance Committee discussed and noted the Staff Governance Corporate Risks and were assured that appropriate and effective processes are in place to manage the risk register.	
5	**Terms of Reference - Remuneration Sub Committee** Staff Governance Committee approved the revised Terms of Reference for Remuneration Sub Committee.	
6	**Meeting Dates in 2019** The meeting dates were approved.	
7	**Working Well Update** Caroline Sharp had circulated the minutes of the latest Working Well Steering Group, the Communications Action Plan which is being worked on and an SBAR describing the approach that George Noakes and Laura Durling were doing around the next level of data analysis. A draft report was expected in January and this would come to Staff Governance Committee and will inform the programme for 2019/20. The latest video was shown which was Louise Cumbley, Director of Psychology giving details of the survey being sent out around mental health issues. There was discussion around the membership of the Working Well Steering Group and Caroline confirmed that staff side representatives were on the group but not a member of every staff group and she outlined how various staff groups have their voices heard in different structures within the organisation. *Lorraine Haining entered the meeting*	
8	**Nursing Older People Award** Lorraine Haining had brought along her award to show the Committee. She explained that her team had put her	

	forward for the award and had completed the application form. She had to go to London to do a presentation and had based it on the Wizard of Oz film. Lorraine circulated paper copies of her presentation to the Committee. Lesley Bryce congratulated Lorraine on her award and thanked her for attending to talk about it. *Lorraine Haining left the meeting* The Committee agreed that they would like to continue to have staff members attend to share their celebration stories and Caroline would work with colleagues to plan attendance at meetings. Alice Wilson highlighted that she could offer further papers sharing innovative developments that are being undertaken within the organisation. Caroline agreed to liaise with Alice to identify how best to incorporate these into future agendas and Lesley asked to be involved in that meeting.	**CJS** **CJS/AW/LB**
9	**Medical Workforce** Pamela Jamieson circulated a paper which had gone to Management Team the previous week. She reported that we were currently sitting with 23 Consultant and 7 Speciality Doctor vacancies. She reported the following: • We had taken part in the national/international Radiology campaign and made 4 offers of appointment • The Head Medical campaign saw us make 5 offers of appointment • A paper had been put together on recruitment across the Board and had been agreed by Management Team • A full tendering process was being done for both medical and nursing posts • Additional resources were to go in around: - How we market ourselves as a Board - Dedicated workforce support Jeff suggested having a workshop for Non Executives for them to be sighted on what is being done. *Lynsey Fitzpatrick entered the meeting*	**CJS/JAA**

10	**Staff Health, Safety and Wellbeing Report including Sickness Absence Update** Ros Kelly presented the routine report and highlighted the following areas: • *Staff seasonal flu campaign* • *Staff accident & incident update* <u>Attendance Management</u> This was the routine paper reporting on sickness absence statistics and Ros discussed the absence figures. The Staff Governance Committee noted the latest Staff Health, Safety and Wellbeing Report and assessed our continuing progress against Staff Governance Standard E – "Provided with an Improved and Safe Working Environment".	
11	**Staff Networks** Lynsey Fitzpatrick explained that by having staff networks it will help us meet some of our duties under the Equality Act and foster good relations. Lynsey highlighted the following from the paper: • Benefits to the organisation of having different staff networks and it will help to build understanding some of the issues • Would it be worthwhile for staff to have networks? • Promoting an organisation that values equality and diversity Next steps are to get Staff Governance support and then find staff who would be interested in coming together and she will keep Staff Governance Committee up to date. *Ken Donaldson entered the meeting* The paper was supported by Staff Governance Committee *Lynsey Fitzpatrick left the meeting*	
12	**Workforce Report** Pamela stated that this was the routine report and highlighted the following:	

	• The largest increase in staffing was in nursing & midwifery • Reduction in medical numbers • Work being done around fixed term contracts to get 'other' recorded and 'end dates' recorded Lesley asked for clearer correlation of risks and narrative in the Workforce Report and Pamela responded that she was going to review the Workforce Report and develop further alignment of narrative with the risk register paper routinely presented. Caroline Sharp flagged the last section on Employee Relations and reported that one whistleblowing case had been raised. The case had been raised and closed and Lesley as the Non Executive Whistleblowing Champion, was fully involved as per the process that had been agreed following the learning from the first case. Jeff Ace was also involved as he was the recipient of the views issued in the case. Lesley and Caroline have had discussions since around appropriate openness around these cases to ensure that staff see and feel that it is ok to raise an issue and that it will be listened to and dealt with in a welcoming way. It was agreed that Lesley, Caroline and Stephen would have more of a conversation around this and take it forward. Caroline also asked that Alice Wilson and Graham Stewart, as the Confidential Contacts, had the opportunity to feed in. The paper was noted.	**PJ** **CJS/LB/SH/AW/GS**
13	**Update on National Staff Survey/iMatter and Dignity at Work Report – Outcomes and Action Plan** Natalie Morel reported that the paper was a follow up from the report in March. She highlighted the following: • 59.4% response rate to the survey • Need to look at blue behaviours to encourage staff • TURAS appraisal • Visibility of senior management • Running seminars on action planning • Engagement with teams who did not make the 60% response rate was taking place • Dignity at Work analysis looking at focus group models The paper was noted.	

14	**Remuneration Sub Committee Update** Caroline Sharp reported that the paper demonstrates the flow of work which is done by the Remuneration Sub Committee and for Staff Governance Committee to note the items which were discussed and approved.	
	Items to Note	
15	APF Minutes – June 2018 – Noted	
16	Medical Education Committee Minutes – Noted	
17	Advice to NHS Scotland on TU Facility Time – Stephen Hare stated that this had came out from SWAG Secretariat and has been passed back by the Trade Unions. The Item was Noted	
18	Once for Scotland Workforce Policies –Noted Arlene had circulated a communication from Mhairi Hastings prior to the meeting – this was also noted.	
19	**Any Other Business** There was no other business.	
20	**Date of Next Meeting** The next meeting will be held at 10am on Monday 26 November 2018 in the New Board Room, Crichton Hall.	