DUMFRIES AND GALLOWAY NHS BOARD

PUBLIC MEETING

A meeting of the Dumfries and Galloway NHS Board will be held at 1pm on Monday 4th June 2018 in the Conference Room, Crichton Hall, Bankend Road, Dumfries.

AGENDA

Time	No	Agenda Item	Who	Attached / Verbal
1.00pm	153	Apologies	L Geddes	Verbal
1.00pm	154	Declarations of Interest	P Jones	Verbal
1.05pm	155	Previous Minutes	P Jones	Attached
1.10pm	156	Matters Arising and Review of Actions List	P Jones	Attached
QUALITY & SAFETY ASSURANCE				
1.15pm	157	Patient Experience Report	E Docherty	Attached
1.30pm	158	Spiritual Care and Volunteering Report	E Docherty	Attached
1.45pm	159	Healthcare Associated Infection Report	E Docherty	Attached
2.00pm	160	Improving Safety, Reducing Harm Report – Mental Health Directorate	E Docherty	Attached
PERFORMANCE ASSURANCE				
2.15pm	161	Quarter 3 Performance and At a Glance Report	J White	Attached
2.25pm	162	Integration Joint Board Update	J White	Verbal
2.30pm	163	Dumfries and Galloway Integration Joint Board – Health and Social Care Strategic Plan	J White	Attached
FINANCE & INFRASTRUCTURE				
2.40pm	164	Financial Performance and Capital Update – 12 months to 31st March 2018.	K Lewis	Attached
2.55pm	165	Financial Performance Update 2018/19 - Position to Month 1 as at 30th April 2018	K Lewis	Attached

Time	No	Agenda Item	Who	Attached / Verbal
PUBLIC HEALTH & STRATEGIC PLANNING				
3.10pm	166	Regional Delivery Plan	J Ace	Verbal
3.15pm	167	Considerations for the Board in relation to the Potential Development of a "Maggie's" Centre in Dumfries	J Ace	Attached
3.25pm	168	Population Health and Wellbeing Interventions: Cost Effectiveness and Contribution to Sustainability of NHS Services	A Carnon	Attached
GOVERNANCE				
3.35pm	169	Register of Members' Interest	L Geddes	Attached
3.45pm	170	Integration Joint Board Membership and Substitutes	P Jones / L Geddes	Attached
3.50pm	171	Board Briefing	J Ace	Attached
3.55pm	172	Committee Minutes • Person Centred Health & Care Committee Minutes – 26 February 2018. • Person Centred Health & Care Committee Minutes – 21 August 2018	P Jones	Attached
ANY OTHER BUSINESS				
4.00pm	173			
DATE AND TIME OF NEXT MEETING				
	174	• 6th August 2018 @ 10am – 1pm in the Conference Room, Crichton Hall, Bankend Road, Dumfries		

Agenda Item 155

DUMFRIES AND GALLOWAY NHS BOARD

NHS Board Meeting

Minutes of the NHS Board Meeting held on 9th April 2018 at 10am – 1pm in the Conference Room, Crichton Hall, Bankend Road, Dumfries, DG1 4TG.

Minute Nos: 126-146

Present

Mr P N Jones (PNJ)	-	Chairman
Dr L Douglas (LD)	-	Non Executive Member
Mrs L Carr (LC)	-	Non Executive Member
Mr S Hare (SH)	-	Non Executive Member
Mr A Ferguson (AF)	-	Non Executive Member
Ms G Stanyard (GS)	-	Non Executive Member
Mr E Docherty (ED)	-	Nurse Director
Mrs K Lewis (KL)	-	Director of Finance

In Attendance

Mrs J White (JW)	-	Chief Officer
Ms C Sharp (CS)	-	Workforce Director
Dr A Carnon (AC)	-	Consultant In Public Health Medicine
Mr R Smith (RS)	-	Health Improvement Officer
Mrs L Geddes (LG)	-	Corporate Business Manager
Mrs L McKie (LM)	-	Executive Assistant (Minute Secretary)

Apologies

Mrs P Halliday (PH)	-	Vice Chair
Mrs G Cardozo (GC)	-	Non Executive Member
Ms L Bryce (LB)	-	Non Executive Member
Mr J Ace (JA)	-	Chief Executive
Dr K Donaldson (KD)	-	Medical Director
Ms M McCoy (MMc)	-	Interim Director of Public Health

PNJ welcomed Board Members and members of the public to the NHS Board Meeting, noting that it was GS's last NHS Board meeting prior to the end of her 4 years as a Non Executive Board Member. PNJ thanked GS for all her contributions and hard work over the last 4 years of service and wished her well for the future.

126. Apologies for Absence

Apologies as noted above.

127. Declarations of Interest

The Chairman 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.

128. Minutes of meeting held on 2nd February 2018

The minute of the previous meeting on 2nd February 2018 were approved as an accurate record of discussions, with no amendments.

129. Matters Arising and Review of Actions List

PNJ presented the Actions List to members, noting that all actions listed were progressing well, noting the progress of the following items:

- Early Years Collaborative Progress Report
- Financial Performance Update
- Patient Experience Report and the support of young volunteers

PNJ enquired with LD if she had received an update from ED on the Patient Experience Annual Report. LD advised that she had received a full update on the Patient Experience Report. ED confirmed that this action was complete and asked for it to be noted as closed on the actions list.

Action: LMcK

NHS Board Members noted the Actions List.

130. Patient Experience Report

ED presented the Patient Experience Report, asking NHS Board Members to note the Board's performance around complaints, in particular the implementation of the Healthcare Quality Strategy (2010), and Patients Rights (Scotland) Act (2012).

It was noted that progress continues within the establishment of Volunteering and the refresh of Spiritual Care support across the region, which, along with the commencement of the current recruitment process in January 2018 and the two information sessions has resulted in the recruitment of 20 new volunteers.

It was highlighted that NHS Dumfries and Galloway received 22 formal compliments for this period.

NHS Board Members noted the reduction in patient complaints in January and February. It was emphasised that this was due to the improvement in internal processes within the Acute Services Administrative Support, with additional continued support from the Deputy Nurse Director.

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.

Action: ED

AF enquired as to the complaint figures escalated from Stage 1 to Stage 2 for January 2018 and to the foot fall of patients. ED advised that under the current regulations the Board are required to follow a suite of new indicators determined by the Scottish Public Services Ombudsman (SPSO).

LD enquired to the management of complex complaints and to what was being done to address the current challenges. ED advised that with the additional administrative support now in place, complaints would be reviewed more efficiently.

LD enquired as to what was being done to improve the Family Health Services Contractors performance figures in relation to complaints. ED advised that work was ongoing to engage with Dental and General Practitioner (GP) practices.

LD questioned the provision of New Testament Bibles for every patient room and ward socialisation areas within the new hospital and whether the books could be provided within the Sanctuary rather than in patient rooms. ED advised that the provision of single new testaments within rooms and social areas were a late development and agreed to discuss Board Members' thoughts with members of Person Centred Health and Care Committee.

Action: ED

JW advised that she would ensure New Testaments would be available within the Sanctuary, along with books from a number of other religions.

Action: JW

GS asked whether as a board we are confident that we are capturing the improvements to services or procedures as a result of consideration of complaints including matters arising under the duty of candour. ED advised that there had been a considerable amount of work across the organisation to ensure staff and managers understand the act and when it should be invoked. Regulated professionals should already be aware and working to the principles of this new piece of legislation around Duty of Candour.

NHS Board Members:

- Noted the report which provided an update on the activities of the Patient Services team.

- Noted the Board's complaints performance for January and February 2018 including key feedback themes and details of the resulting learning and improvements.

- Noted the update on Spiritual Care and Volunteering.

131. Healthcare Associated Infection Report

ED presented the Healthcare Associated Infection Report, asking NHS Board Members to note the report, in particular the Board's position with regard to the Staphylococcus Aureus Bacteraemia (SAB) and the Clostridium Difficile Infection (CDI) Healthcare Associated Infection Local Delivery Plan targets.

NHS Board Members were advised that there were 2 cases of SAB in January and 2 in February 2018, the target however has been exceeded overall as there has been 31 cases and our local target was 26.

ED advised NHS Board Members that cases of Clostridium Difficile (CDI) had seen a rise which is not unexpected given the high rate of hospital admission and circulating respiratory infections, which has exacerbated chronic chest conditions necessitating in antibiotic prescriptions.

ED made Board Members aware that there had been 115 cases of E. coli Bacteraemia to date this reporting year, highlighting that Primary Care were continuing to monitor E. coli bacteraemia (ECB).

PNJ enquired to whether the rise in figures was due to the move to the new hospital. ED advised that there was no evidence of cross contamination.

JW mentioned that the Post Project Evaluation paper on the transfer to the new Dumfries and Galloway Royal Infirmary would come to NHS Board for review and approval for submission to Scottish Government's committees in December 2018.

AC made NHS Board Members aware that the uptake of the Flu vaccination programme for staff had been well received, noting that this may have been due in part to the introduction of the reinstated individual appointments for staff.

CS highlighted that the Occupational Health Team had explored a slightly different approach for targeting staff by using the iMatter data for sending out letters.

PNJ enquired as to whether services were settling down within the new hospital. JW advised that there were still challenges which were being addressed through the Medical Staff Committee.

NHS Board Members were made aware of the additional car parking which was now available for patients and families, which should alleviate some of the parking issues.

NHS Board Members noted the update.

132. Improving Safety, Reducing Harm Report

ED presented the Acute Adult Patient Safety Programme report, asking NHS Board Members to note the new template, which sets out the Improving Safety Reducing Harm themes into one paper.

NHS Board Members were highlighted to the completed risk assessment process for the management and protection of patient safety, whereby Management had identified 3 key risks.

ED made NHS Board Members aware of the high volume of adverse events reported by the Mental Health Directorate, noting the management of Self Harm and Suicide.

GS enquired whether there were therapy pathways for females suffering from behavioural disorders. ED advised that he would investigate and share the information with Board Members.

Action: ED

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.

Action: ED

NHS Board Members noted the update.

133. Safeguarding Volunteers

ED presented the Safeguarding Volunteers paper, asking NHS Board Members to note the report which provides an update on supporting and safeguarding young volunteers and identifies any areas for development. The report also explores current links established with local Third Sector agencies in relation to single room environment in the new hospital.

GS enquired to whether Non Executive Board Members could be Mentors for the Volunteers. ED agreed to take the suggestion forward.

Action: ED

NHS Board Members noted the update.

134. Performance Report

JW presented the At a Glance Performance Report, asking NHS Board Members to note the update for the period January to March 2018, highlighting the challenges being faced in relation to Waiting Times and Treatment Time Guarantees and advising that the full Performance Report would be presented to the Integration Joint Board's Performance and Finance Committee on 19th April 2018.

NHS Board Members were made aware of the continued challenges with Medical Recruitment, noting the ongoing plans and substantial investment, to address the issues.

NHS Board Members were advised that Cancer Waiting Times were still experiencing challenges due to recruitment issues, although staff have been working hard to alleviate the pressures, with the assistance of Scottish Government to look at the whole system and address processes.

JW made NHS Board Members aware of the improvement to Delayed Discharges due to weekly assessments and continued discussions with Multi Agency Groups to look at patient flows across the Board.

NHS Board Members were made aware that the Day of Care Survey had been undertaken in Cottage Hospitals, which had seen improvements, although challenges had continued over the winter period.

NHS Board Members noted the report.

135. Integration Joint Board Update

JW gave an update on the Integration Joint Board, highlighting the activity and any key points of interest since the last NHS Board meeting.

NHS Board Members were made aware that the Integration Joint Board last met on 5th April 2018 at the Corner House Hotel in Annan. It was noted that a number of items were discussed at the meeting, including the Carers (Scotland) Act 2016 and the Carers Eligibility Framework, which were approved by the Integration Joint Board.

At the meeting the Integration Joint Board also received a paper on the Budget Setting 2018/19 Financial Plan, which set out the Financial Plan of the Integration Joint Board for 2018/19 and which provided an update on the savings plans to work towards a balanced position at year end.

JW gave NHS Board Members an update on the Scottish Living Wage (SLW) Implications for Delegated Adults, in which the Scottish Government policy sets out that all Health and Social Care Partnerships ensure payment of the Scottish Living Wage (SLW) to all adult social care workers.

NHS Board Members were highlighted to the Strategic Plan discussions, whereby the Public Bodies (Joint Working) (Scotland) Act 2014 requires all Integration Authorities to review their Strategic Plans at least once in every relevant period, with JW noting that the Integration Joint Board had agreed to retain the current Strategic Plan, making some minor amendments.

NHS Board Members were highlighted to the first meeting of the Primary Care Transformation Programme Board on 2nd May 2018. The main aim of the Programme Board is to ensure the development of a sustainable model for Primary Care Services and optimising the skills of our workforce.

AF raised a question around the number of members required on the Integration Joint Board for both the Local Authority and Health Board, as the number of Elective Members for the Local Authority has reduced to 43. JW advised that both Local Authority and the NHS Board had the right to suggest a change in membership if they wished; however, they were both content to retain the 5 places each on the Board.

NHS Board Members noted the verbal update.

136. Capital Plan 2018/19 to 20122/23

KL presented the Capital Plan, asking NHS Board Members to approve the draft Capital Plan for 2018/19 to 2022/23.

It was noted that the Board has a requirement to submit an Operational Plan, which includes both the Capital and Financial Plans, to Scottish Government. The final draft of the Operational Plan was issued to Scottish Government at the end of March 2018, confirming that an approved plan will be submitted following formal approval at the NHS Board meeting on 9th April 2018.

NHS Board Members were made aware that the paper provides information on the capital element of the Financial Plan and comprises of known Board commitments, such as the Mountainhall Project and the Board's rolling replacement and development programme supported by formula allocation.

NHS Board Members were highlighted to the number of risks within the 5 year plan, in particular the pressures on the Capital Budget.

KL highlighted that there had been an omission on the board agenda for today and that the Capital and Infrastructure Update paper would be circulated to Board Members, with a full discussion on Capital performance at the next Performance Committee meeting in May 2018.

Action: KL

PNJ asked for assurance on the funding for backlog maintenance work which does not qualify as capital and may require a capital to revenue virement. KL advised that this would be managed as in previous years.

The NHS Board Members approved the Capital Plan for 2018/19 to 2022/23.

137. Financial Plan 2018/19 to 2020/23

KL presented the Financial Plan asking NHS Board Members to approve the current phasing of banked funding of £7m to be drawn down in full for 2018/19.

NHS Board Members were made aware of the General Medical Council contract and local Primary Care Transformation Programme, with KL noting that this had been delegated to the Integration Joint Board to support the implementation of the contract changes.

KL highlighted the expected additional consequences to support the increased pay award costs following discussions in England.

NHS Board Members were highlighted to the financial risks identified within the current position including the risk of further GP resignations, pressures in GP prescribing and non-recurring savings identified to balance the position.

KL advised NHS Board Members that LG would circulate a copy of the latest version of the draft West of Scotland (WoS) Regional Plan for review.

Action: LG

AF enquired to the service developments relating to the new 'Freestyle libre' and whether this would be readily available for patients. KL confirmed that the Board Management Team had re-considered as part of the financial planning process for 2018/19 and the Board have now approved funding of Freestyle Libre for patients that meet the clinical criteria.

LD enquired to the Medical Locums costs delegated to the Integration Joint Board and to whether there was a relatively clear plan on recruitment retention. KL advised that she had already asked finance colleagues to collate a report on Medical Locum costs and would bring this back to Performance Committee.

LD enquired as to the Acute Services Redevelopment Project, in particular the emerging staffing issues in the new DGRI and whether these were being reviewed by the Acute Team.

KL advised that she was preparing a business case focusing on the current assumptions to address staffing issues on mainstream wards.

GS enquired as to who has ownership of the Primary Care Improvement Plan. JW advised that it was the responsibility of the Integration Joint Board.

NHS Board Members:

- Approved the final budget for NHS Dumfries and Galloway for 2018/19 noting the current level of unidentified savings at £6.2m from an overall savings target of £17.346m.

- Approved the allocation of £10.197m for the Social Care Fund to the Integration Joint Board as directed by Scottish Government.

- Approved that the Primary Care Transformation fund, (once the values are confirmed by Scottish Government), should be delegated to the Integration Joint Board to support the delivery of the General Medical Council contract and local Primary Care Transformation Programme.

- Approved the current phasing of banked funding of £7m to be drawn down in full for 2018/19.

- Approved the delegation of budgets to the Integration Joint Board as set out in paragraph 47 of the paper.

138. Financial Performance Update

KL presented the Financial Performance Update, highlighting that the report reflects the 2017/18 position as at the end of February 2018, noting the reported overspend position of £228k, which is in line with the improved forecast of break-even by the end of the year.

NHS Board Members were highlighted to the recent NHS Tayside situation and the use of charitable assets, in particular the retrospective application of NHS Endowment Funds. KL advised NHS Board Members that all funds allocated, since the 2013 guidance was issued, have been awarded and used appropriately in compliance with the charitable legislation.

AF highlighted that he was unsure of the processes around the 2013 guidance. AF agreed to meet with JW and KL to gain a better understanding.

Action: JW/KL

PNJ highlighted NHS Board Members to the recent letter received from Paul Gray, Chief Executive of NHS Scotland, on the use of Endowment Funds within Boards, asking for all Board's to give assurances on the way Endowment Funds have been used, by 30th April 2018.

NHS Board Members:

- Noted the financial position to month 11.

- Noted the improved overall position towards achieving a break-even position.

- Noted the ongoing financial risks and challenges identified in the underlying financial position.

- Noted the current financial position for the services delegated to the Integration Joint Board.

- Noted the updated position on Efficiency Savings for 2017/18 and the recurring gap moving into 2018/19.

- Noted the ongoing pressure and growth of External Service Level Agreements (SLAs) with both Scottish and English Providers.

139. Procurement Strategy

KL presented the Procurement Strategy paper asking NHS Board Members to approve the Procurement Strategy and note the national work on the NHS Scotland Procurement Transformation Programme.

NHS Board Members were advised that the draft Procurement Strategy would be presented to the Performance Committee on 14th May 2018 to reflect a clear and concise approach to NHS Dumfries & Galloway's procurement activities outlining what will be done, how and when it will be achieved over the period April 2018 to March 2020.

LD noted the incorrect date within paragraph 3 on page 4 of the Procurement Strategy, which read November 2017 – March 2020 and should read April 2018 – March 2021.

GS raised a question around Information Technology fraud and whether as a Board we are adhering to best practice. KL assured NHS Board Members that all Information Technology Teams were fully trained in fraud processes.

NHS Board Members:

- Approved the Procurement Strategy
- Noted the national work on the NHS Scotland Procurement Transformation Programme.

140. Operational Annual Plan

KL presented the paper asking NHS Board Members to approve the NHS Dumfries and Galloway Annual Operational Plan for 2018/19, highlighting that this replaces the Local Delivery Plan.

NHS Board Members approved the NHS Dumfries and Galloway Annual Operational Plan for 2018/19.

141. Supporting an Increase in Physical Activity

AC asked Richard Smith (RS), Health Improvement Officer to present the paper on Supporting an Increase in levels of Physical Activity across the population of Dumfries and Galloway, asking Board Members to note the health, wellbeing and economic benefits of population level approaches to increasing levels of physical activity.

NHS Board Members were made aware that Dumfries and Galloway has the joint lowest proportion of adults in Scotland meeting physical activity guidelines. By comparison, only 22% of school pupils achieve 60 minutes of health enhancing physical activity every day.

RS advised that Dumfries and Galloway were working with Edinburgh and Glasgow universities to gain an understanding of the reach and current impact of projects across Dumfries and Galloway.

GS enquired as to the link between social prescribing and physical activity options and mental health with physical activity. RS advised that he would source and circulate information to Board Members.

Action: RS

AF enquired as to the delegate list for the Health & Social Care Integration and Physical Activity group, noting that he was under the impression that the group had been disbanded. It was advised that the Physical Activity Group event was a standalone event and was only intended to be held once. The Public Health Committee was an NHS Board sub-committee, which was disbanded in 2016, with all papers that would have come to that committee to come to the public NHS Board meetings instead.

AF noted that he thought that the group had been a joint committee therefore any decision should have been made with Local Authority colleagues present. It was noted that the Public Health Committee was a NHS Board committee and not an Integration Joint Board committee. AF agreed to discuss with PNJ and LG.

Action: LG

NHS Board Members:

- Noted the health, wellbeing and economic benefits of population level approaches to increasing levels of physical activity.

- Noted the effectiveness of current physical activity programmes delivered in partnership across Dumfries and Galloway at both regional and locality levels.

- Noted the systematic process and partnership approach to developing recommendations to increase population levels of physical activity in Dumfries and Galloway.

- Noted the development of a joint NHS Dumfries and Galloway and Dumfries and Galloway Council implementation plan for physical activity with performance to be reported into Community Planning governance structures.

- Noted that the implementation plan will fall under the umbrella of relevant NHS and Council policies / strategies including the Dumfries and Galloway Active – A Sport and Physical Activity Strategy (2018-2021).

- Supported the Dumfries and Galloway Physical Activity Alliance, chaired by the Interim Director of Public Health, to oversee delivery of the implementation plan.

- Supported the recommendation that NHS Dumfries and Galloway will be responsible for leading on the implementation of key actions to increase population physical activity levels via services within our scope of responsibility.

142. Board Briefing

PNJ 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.

NHS Board Members noted the report.

143. Board Agenda Matrix

LG presented the Board Agenda Matrix asking NHS Board Members highlighting the complete matrix for 2017/18, which gave an overview of the information that had been presented to the NHS Board meetings in year. The paper also gave a draft agenda matrix for 2018/19, which highlighted planned topics that are due to come to NHS Board between April 2018 – March 2019.

NHS Board Members:

- Reviewed and noted the 2017/18 Board Agenda Matrix as a complete record of items taken to NHS Dumfries and Galloway Board Meetings in year.

- Approved the 2018/19 Board Agenda Matrix as a plan of activity coming to NHS Dumfries and Galloway Board meetings between April 2018 – March 2019.

144. Committee Minutes

PNJ 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:

- Audit and Risk Committee – 18th December 2017
  PNJ presented the minute from the Audit and Risk Committee meeting on 18th December 2017, noting that an update was received on the processes for the Internal Audit Plan.

  NHS Board Members noted the minute.

- Performance Committee – 6 November 2017
  PNJ presented the minute from the Performance Committee meeting on 6 November 2017, highlighting that members were given an update on the Financial Strategy.

  NHS Board Members noted the minute.

- Performance Committee – 29th January 2018
  PNJ presented the minute from the Performance Committee meeting on 29th January 2018, noting that an update was received on the draft Financial Plan for 2018/19 to 2020/21.

  NHS Board Members noted the minute.

- Person Centred Health Committee – 18th December 2017
  PNJ presented the minute from the Performance Committee meeting on 18th December 2017, noting that an update was received on the volunteering programme.

  NHS Board Members noted the minute.

- Staff Governance Committee – 22nd January 2018
  GS presented the minute from the Staff Governance Committee meeting on 22nd January 2018, which received a presentation from Kelvin Frew, Queens Nurse demonstrating his journey to becoming a Queens Nurse.

NHS Board Members noted the minute.

145. Any Other Competent Business.

There was no other competent business noted.

146. Date of Next Meeting

The next meeting of the NHS Board will be held on 4th June 2018 at 10am – 1pm in the Conference Room, Crichton Hall, Bankend Road, Dumfries, DG1 4TG.

Agenda Item 156

Actions List from NHS Board – Public Meeting

Date of Meeting	Agenda Item	Action	Responsible Manager	Current Status	Date Completed
05/12/2016	125.	**Early Years Collaborative Progress Report** A Non-Executive Board Member highlighted that this initiative will have an impact on several of the equality characteristics and asked if the enough work was being undertaken around attachment and implementation locally. The Nurse Director confirmed that a national event has been hosted and the Early Years Collaborative is seen as a significant platform to promote this piece of work. The Nurse Director confirmed that he would bring further information in relation to equalities back to Board within the next progress report.	Eddie Docherty	An update on this item was given at the last NHS Board Meeting. Further updates will be brought back to NHS Board as and when available.	09/04/2018
05/06/2017	30.	**Improving Safety Reducing Harm in Primary Care Report** GC asked for further information to be made available on performance indicators for the Children's Service Plan. JW advised Members there work was ongoing nationally on indicators, but advised Members that a workshop on both Children and Young Adult Mental Health would be arranged to discuss local priorities.	Alice Wilson	An update on this item was given at the last NHS Board Meeting. Further updates will be brought back to NHS Board as and when available.	09/04/2018

Date of Meeting	Agenda Item	Action	Responsible Manager	Current Status	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 Autumn 2018 Board meeting for review.	
07/08/2017	49.	**Patient Safety Annual Report** LD asked for an update on expected results following the recent case review on the increase of stillbirths both locally and nationally. ED advised that he was currently in discussion with the Head of Midwifery and would provide an update back to LD when the information has been analysed.	Eddie Docherty	An update on this item was provided to LD at the February 2018 Board Meeting. No further action at this time.	05/02/2018
07/08/2017	49.	**Patient Safety Annual Report** AF queried where the organisation records the statistics for adult and children protection outcomes and whether they could be added within the annual report. ED advised that currently the statistics were flagged to Healthcare Governance Committee on a regular basis and that all nurses were sighted on pathways, noting that a matrix could be added to future annual reports.	Eddie Docherty	An update on this item was provided at the February 2018 Board Meeting. No further action at this time.	05/02/2018

Date of Meeting	Agenda Item	Action	Responsible Manager	Current Status	Date Completed
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 Autumn 2018, to include the data evidence of GP referrals.	
04/12/2017	86.	**Patient Experience Report** GC enquired to whether the Board were aware of the different type of support young volunteers required, whether risk assessments had been completed and what links had been established with local agencies around the single room environment within the new hospital. ED advised that all volunteer activities had been risk assessed, although was unsure of what links had been established and agreed to share this information once received with Board Members.	Eddie Docherty	Volunteer link information has been forwarded to NHS Board members when available.	09/04/2018

Date of Meeting	Agenda Item	Action	Responsible Manager	Current Status	Date Completed
04/12/2017	92.	**Financial Performance Update** It was noted that there was concern on the scale of the financial gap for 2018/19, with a £10m recurring deficit in additional uplifts, with zero percentages forecasted for 2018/19. KL agreed to send budget information to PNJ for information.	Katy Lewis	Budget information has been forwarded to PNJ for information.	09/04/2018
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.	

Date of Meeting	Agenda Item	Action	Responsible Manager	Current Status	Date Completed
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.	
05/02/2018	109.	**Patient Experience Report** JA highlighted that he thought December's complaint figures would have shown a surge, since this was not the case it would be interesting to know whether this was due to the volume of volunteers and the Patient Experience Team being visible over the migration period. The findings will be captured in the full report later in the year. ED suggested that he would contact Joan Pollard to gain a broader understanding from Volunteers and agreed to share this information once received with Board Members	Eddie Docherty	An update on this item as included in the Patient Experience Report that was taken through the April 2018 NHS Board	09/04/2018

Date of Meeting	Agenda Item	Action	Responsible Manager	Current Status	Date Completed
05/02/2018	109.	**Patient Experience Report** LD enquired to whether there was an opportunity to thank all staff and volunteers for the work they have done. PH noted that this had also been discussed at Performance Committee on 29th January 2018. CS continued to highlight that it was important to remember the community and universal effort across a host of agencies over the migration period and agreed to look at possible arrangements while mindful of the whole system level.	Caroline Sharp	An update on this item has been provided to NHS Board members.	09/04/2018
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	An update on this item will be provided to NHS Board members, when available.	

Date of Meeting	Agenda Item	Action	Responsible Manager	Current Status	Date Completed
09/04/2018	129.	**Matters Arising and Review of Actions List** PNJ enquired with LD if she had received an update from ED on the Patient Experience Annual Report. LD advised that she had received a full update on the Patient Experience Report. ED confirmed that this action was complete and asked for it to be noted as closed on the actions list.	Linda McKie	Item 109 from the February 2018 Board meeting has been closed off on the actions list.	09/04/2018
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.	
09/04/2018	130.	**Patient Experience Report** LD questioned the provision of New Testament Bibles for every patient room and ward socialisation areas within the new hospital and whether the books could be provided within the Sanctuary rather than in patient rooms. ED advised that the provision of single new testaments within rooms and social areas was a late development and agreed to discuss Board Members' thoughts with members of Person Centred Health and Care Committee.	Eddie Docherty	A discussion on this item will be taken to the next Person Centred Health and Care Committee to agree to provide the bibles within the Sanctuary only.	04/06/2018

Date of Meeting	Agenda Item	Action	Responsible Manager	Current Status	Date Completed
09/04/2018	130.	**Patient Experience Report** JW advised that she would ensure New Testaments would be available within the Sanctuary, along with books from a number of other religions.	Julie White	Confirmation has been received that New Testament Bibles are available in the Sanctuary.	09/04/2018
09/04/2018	132.	**Improving Safety, Reducing Harm Report** GS enquired whether there were therapy pathways for females suffering from behavioural disorders. ED advised that he would investigate and share the information with Board Members.	Eddie Docherty	An update on this item was given to Gill Stanyard outwith the NHS Board meeting.	04/06/2018
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	An update on this item will be shared with Board Members on receipt of the most up to date figures.	
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	A discussion on this item was being taken through Person Centred Health and Care Committee and will be reported back to NHS Board Members.	

Date of Meeting	Agenda Item	Action	Responsible Manager	Current Status	Date Completed
09/04/2018	136.	**Capital Plan 2018/19 to 20122/23** KL highlighted that there had been an omission on the board agenda for today and that the Capital and Infrastructure Update paper would be circulated to Board Members, with a full discussion on Capital performance at the next Performance Committee meeting in May 2018.	Katy Lewis	A copy of the Capital Paper was circulated to NHS Board Members as the May 2018 Performance Committee meeting was cancelled due to the National Board Members event.	10/05/2018
09/04/2018	137.	**Financial Plan 2018/19 to 2020/23** KL advised NHS Board Members that LG would circulate a copy of the latest version of the draft West of Scotland (WoS) Regional Plan for review.	Laura Geddes	A copy of the latest Regional Plan was circulated to NHS Board Members following the Board Meeting.	09/04/2018
09/04/2018	138.	**Financial Performance Update** AF highlighted that he was unsure of the processes around the 2013 guidance. AF agreed to meet with JW and KL to gain a better understanding.	Katy Lewis/Julie White	A meeting is being arranged to provide the clarity in relation to this item. No further action to be taken through NHS Board.	09/04/2018
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.	

Date of Meeting	Agenda Item	Action	Responsible Manager	Current Status	Date Completed
09/04/2018	141.	**Supporting an Increase in Physical Activity** AF noted that he thought that the group had been a joint committee therefore any decision should have been made with Local Authority colleagues present. It was noted that the Public Health Committee was a NHS Board committee and not an Integration Joint Board committee. AF agreed to discuss with PNJ and LG.	Laura Geddes	A meeting is being arranged to provide the clarity in relation to this item. No further action to be taken through NHS Board.	09/04/2018

Agenda Item 157

DUMFRIES and GALLOWAY NHS BOARD

4th June 2018

INVOLVING PEOPLE IMPROVING QUALITY

Patient Experience Report

Author:
Emma Murphy
Patient Feedback Manager

Joan Pollard
Associate Director of Allied Health Professions

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

Date: 15th May 2018

RECOMMENDATION

The NHS Board is asked to :

- consider this report which provides an update on the activities of the Patient Services team in relation to Feedback and Complaints.

- note the Board's complaints performance for March and April 2018 including key feedback themes and details of the resulting learning and improvements.

CONTEXT

Strategy / Policy:
This paper demonstrates 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 provides key information about the areas where the Board is performing well and those where there is need for improvement. It also assists the Board in delivering our CORE values and remaining person centred.

Key messages:

- The Board continues to face challenges around compliance with complaint timescales.
- Patient Services are continuing to work with Responsible Managers and Feedback Co-ordinators to address compliance issues.

GLOSSARY OF TERMS

NHS D&G	-	National Health Service Dumfries and Galloway
DGRI	-	Dumfries and Galloway Royal Infirmary
GCH	-	Galloway Community Hospital
CHP	-	Complaints Handling Procedure
SPSO	-	Scottish Public Services Ombudsman
ISD	-	Information Services Division

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)	Outcomes 2, 3, 6, 7 and 8
Best Value	Commitment and leadership Accountability Responsiveness and consultation Joint Working
Impact Assessment Not undertaken as learning from patient feedback applies to all users	

1. Introduction

This report outlines the key activities in relation to Patient Feedback and Complaints for the period March and April 2018 and details planned improvement actions and recent achievements.

2. Patient Feedback

This following section provides a commentary and summary statistics on patient feedback throughout NHS Dumfries and Galloway for the period March and April 2018.

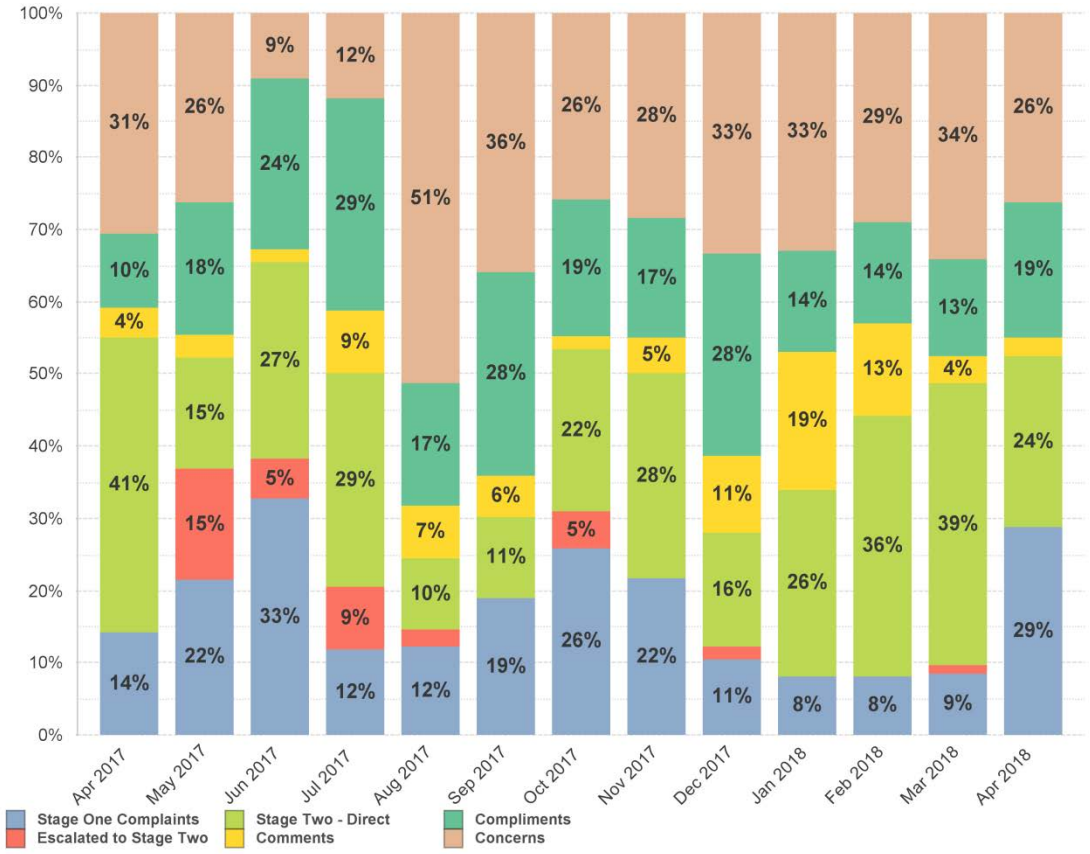
2.1 Feedback Received

Patient Services recorded 82 pieces of feedback in March and 80 in April 2018. Of the feedback recorded 40 in March 2018 and 42 in April 2018 were complaints. This is a slight increase in the monthly average of 33 complaints per month for 2016/17.

	March 2018		April 2018	
Feedback Type	**Number**	**%**	**Number**	**%**
Stage One Complaints	7	9%	23	29%
Escalated to Stage Two	1	1%	0	0%
Stage Two Complaints - Direct	32	39%	19	24%
Comments	3	4%	2	3%
Compliments	11	13%	15	19%
Concerns	28	34%	21	26%
Totals:	**82**		**80**	

Source: Qlikview – 03/05/18

Feedback by first received date (month/year) and feedback type



2.2 Care Opinion

Care Opinion is an online approach, actively supported by the Scottish Government, which enables the public to provide and view feedback on the services they have received. NHS Dumfries and Galloway received twelve Care Opinion stories during the period, ten of which were positive. Where a story is not positive we encourage the author to make contact with Patient Services in order that we provide further advice and support to resolve issues raised.

2.3 Compliments

During this period, and in addition to compliments received by local teams and Care Opinion, NHS Dumfries and Galloway received 18 formal 'compliments'. This positive feedback was largely around the caring and professional attitude of staff and the excellent care and treatment received. We also recorded two comments.

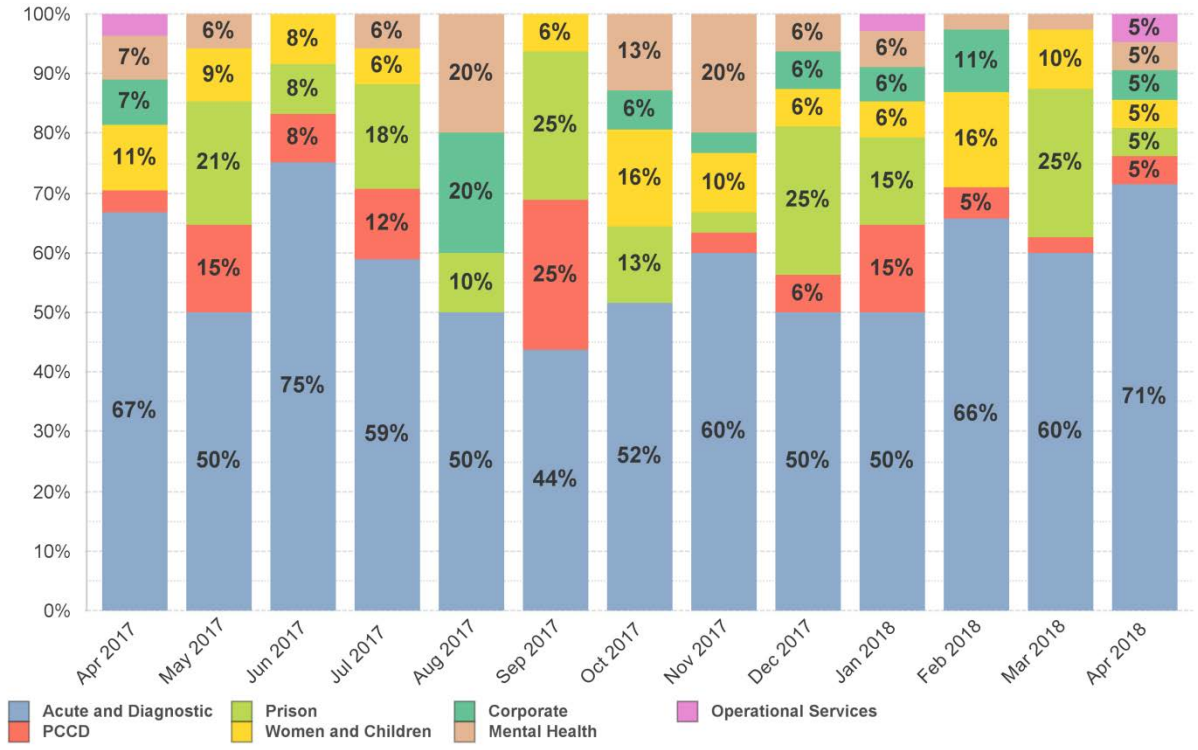
2.4 Complaints

The complaints received related to the following areas:

	March 2018		April 2018	
Service	**Number**	**%**	**Number**	**%**
Acute and Diagnostic	24	60%	30	71%
PCCD	1	3%	2	5%
Prison	10	25%	2	5%
Women and Children	4	10%	2	5%
Corporate	0	0%	2	5%
Mental Health	1	3%	2	5%
Operational Services	0	0%	2	5%
Totals:	**40**		**42**	

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

Complaints by first received date (month and year) and service



Under the Regulations of the Complaints Handling Procedure, Family Health Services Contractors are obligated to provide us with regular performance figures in relation to complaints. Below are the performance submissions for this period.

	Mar 18			Apr 18		
Service	**Number of respondents**	**Number of complaints**	**% of all complaints**	**Number of respondents**	**Number of complaints**	**% of all complaints**
GPs *(n:31)*	21	1	8%	26	6	86%
Pharmacy* *(n:34)*	28	10	83%	5	0	0%
Dental *(n:33)*	14	1	8%	14	1	14%
Opticians* *(n:21)*	2	0	0%	2	0	0%
Totals:	**65**	**12**		**47**	**7**	

* *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

As part of this indicator, the Board are required to record how many resolution meetings took place with complainants. These meetings may take place during the complaints process or following the provision of the complaints response. Three resolution meetings took place over the reporting period. Patient Services recognise it would be useful to capture more information about these resolution meetings and are working with relevant colleagues to explore the most effective way to capture this.

The Board recording of learning from feedback requires further development. The Patient Services and Patient Safety teams are preparing to embark upon a joint project to improve how the Board records, investigates, reports, responds to and manages complaints and adverse events in order to maximise opportunities for learning.

The Board is currently working towards the purchase of qualitative software to further assist in the analysis of complaints and feedback information.

Indicator 2 - Complaints Process Experience

As per the previous paper, complainants are now being invited to share their experience of the complaints process. Two responses have been received to date. An update on results will be provided in the next paper.

Indicator 3 - Staff Awareness and Training

Staff continue to be provided with opportunities to attend training and awareness raising sessions on feedback and complaints. These have been well received to date and there continues to be demand for further sessions.

An initial awareness raising session on local advocacy services is provisionally scheduled for June 2018 in Dumfries and if successful further sessions will be delivered across the region later in the year.

The remaining performance indicators focus on the quantitative data associated with our complaints handling and are reported as follows.

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	**Mar 2018**	**Apr 2018**
Per 1000 population	0.2	0.2

** 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.*

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

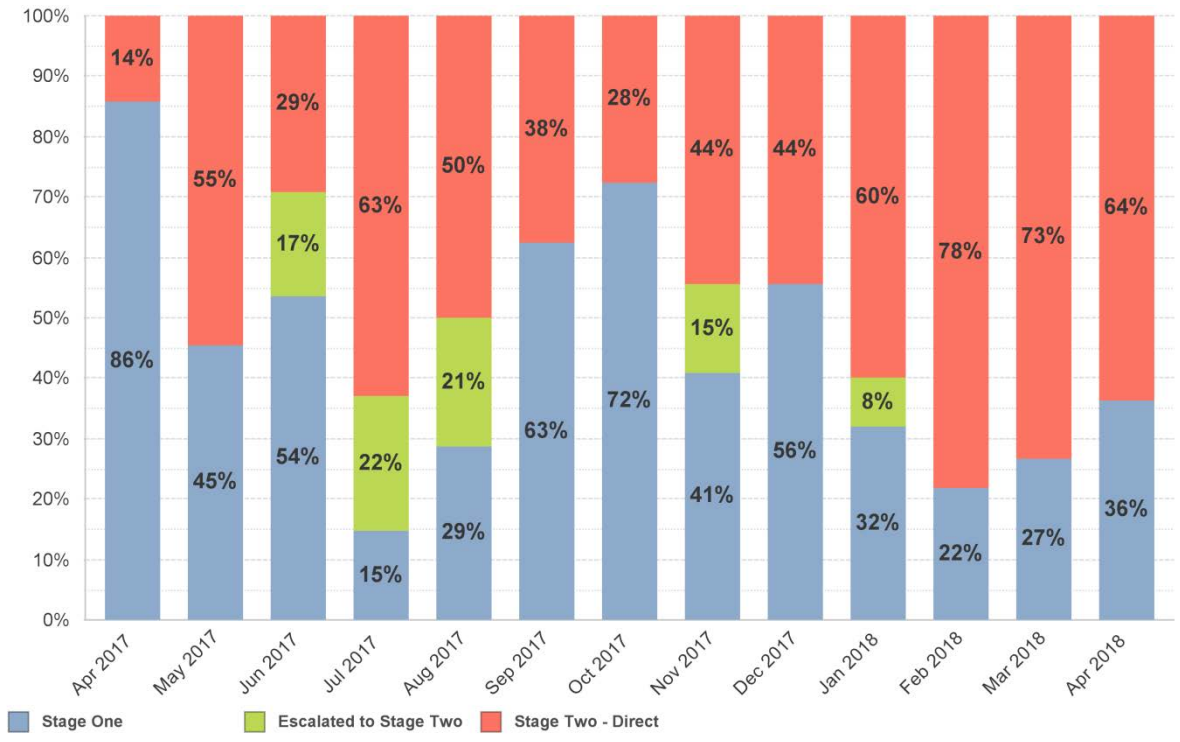
Indicator Five: Complaints closed at each stage

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

Indicator 5 - Complaints closed *(responded to)* at Stage One and Stage Two as a percentage of all complaints closed *(responded to)*.		
Description	**March 2018**	**April 2018**
Number of complaints closed at Stage One as % of all complaints closed	27% (8 of 30)	36% (20 of 55)
Number of complaints closed after Escalation to Stage Two as % of all complaints closed	0% (0 of 30)	0% (0 of 55)
Number of complaints closed at Stage Two as % of all complaints closed	73% (22 of 30)	64% (35 of 55)
NB: The escalated complaints referred to above were also responded at Stage One.		

Source – Qlikview – 03/05/18

Complaints Closed, based on closed date



Indicator Six: Complaints upheld, partially upheld and not upheld
"Details of the number of complaints that had each of the above listed outcomes."

Indicator 6 - The number of complaints upheld/ partially upheld/ not upheld at each stage as a percentage of complaints closed *(responded to)* in full at each stage.		
Upheld		
Description	**March 2018**	**April 2018**
Number of complaints upheld at Stage One as % of all complaints closed at Stage One	25% (2 of 8)	45% (9 of 20)
Number Escalated to Stage Two complaints upheld at Stage Two as % of escalated complaints closed at Stage Two	- (0 of 0)	- (0 of 0)
Number complaints upheld at Stage Two as % of complaints closed at Stage Two	27% (6 of 22)	17% (6 of 35)

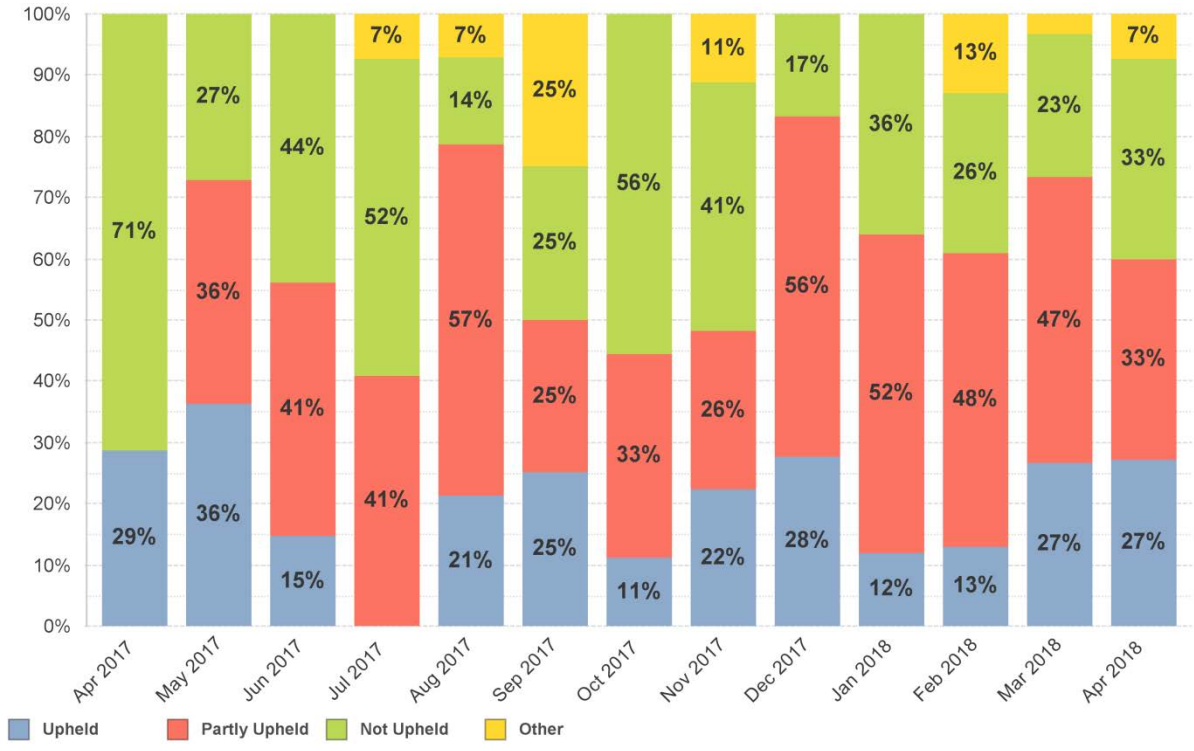
Partially Upheld		
Description	**March 2018**	**April 2018**
Number of complaints partially upheld at Stage One as % of all complaints closed at Stage One	63% (5 of 8)	30% (6 of 20)
Number Escalated to Stage Two complaints partially upheld at Stage Two as % of escalated complaints closed at Stage Two	- (0 of 0)	- (0 of 0)
Number complaints partially upheld at Stage Two as % of complaints closed at Stage Two	41% (9 of 22)	34% (12 of 35)

Not Upheld		
Description	**March 2018**	**April 2018**
Number of complaints not upheld at Stage One as % of all complaints closed at Stage One	13% (1 of 8)	25% (5 of 20)
Number Escalated to Stage Two complaints not upheld at Stage Two as % of escalated complaints closed at Stage Two	- (0 of 0)	- (0 of 0)
Number complaints not upheld at Stage Two as % of complaints closed at Stage Two	27% (6 of 22)	37% (13 of 35)

Other		
Description	**March 2018**	**April 2018**
Number of Stage 1 complaints where “other” outcome recorded as % of all complaints closed at Stage One	0% (0 of 8)	0% (0 of 20)
Number of complaints Escalated to Stage 2 where “other” outcome recorded as % of complaints closed at Stage Two	- (0 of 0)	- (0 of 0)
Number of Complaints direct to Stage 2 where “other” outcome recorded as % of complaints closed at Stage Two	5% (1 of 22)	11% (4 of 35)
NB: ‘Other’ includes matters where consent has not been received; the complaint has been withdrawn or is resolved. It can also include complaints that have progressed down another route part way through the process (e.g. to a legal claim) or where an outcome has not been recorded at the time of reporting.		

Patient Services conduct regular quality monitoring to ensure that complaint outcomes are appropriate.

Outcome of All Complaints Closed, based on closed date

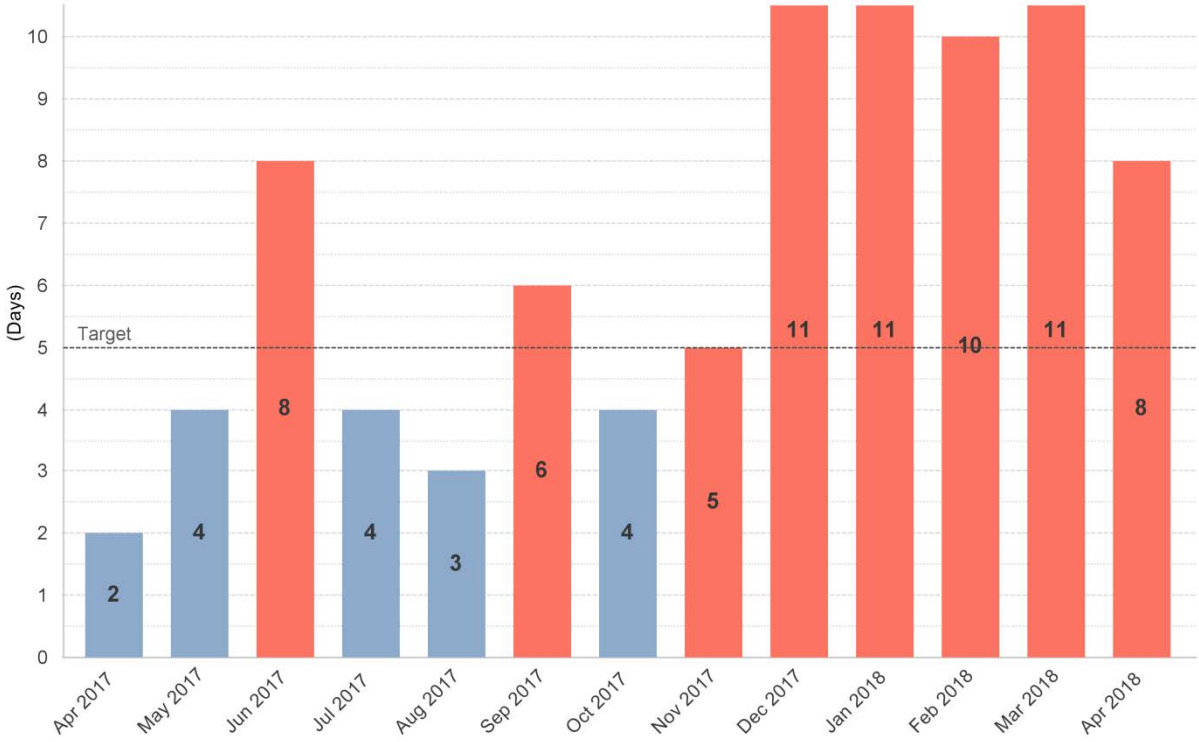


Indicator Seven: Average response times

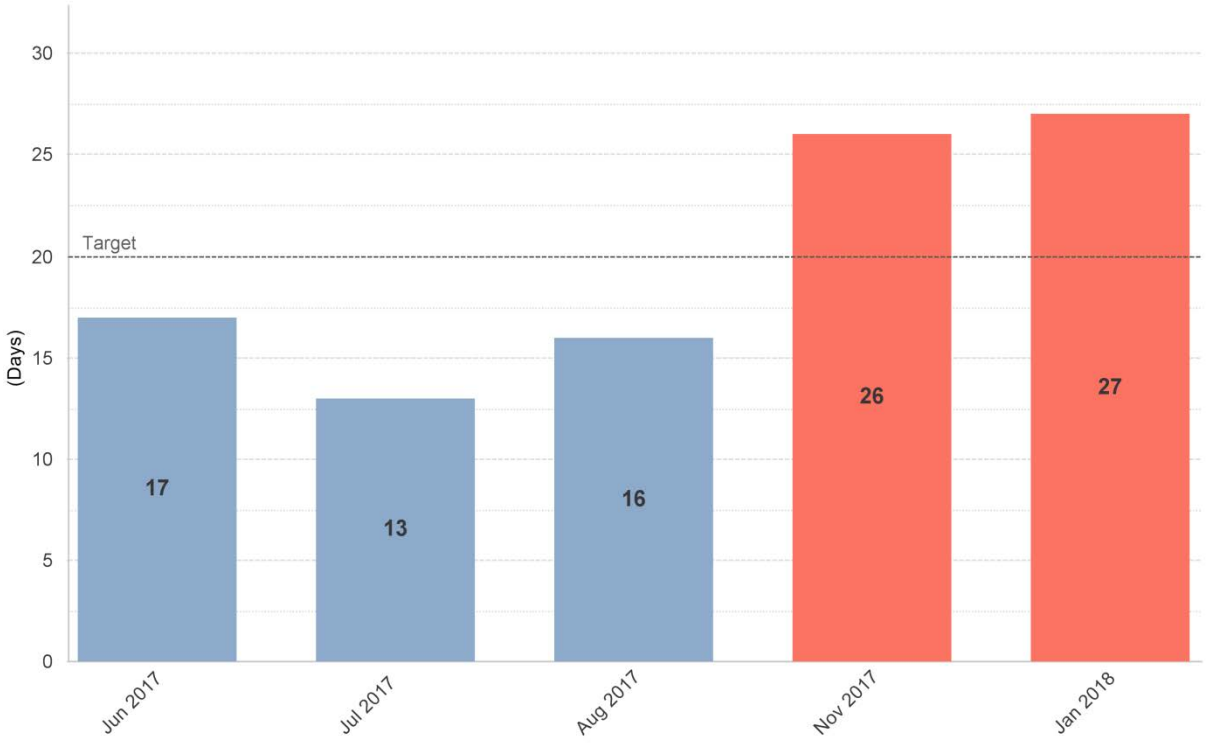
"Details of the average time in working days to close complaints at each stage of the Complaints Handling Procedure."

Indicator 7 - The average time in working days for a full response to complaints at each stage			
Description	**March 2018**	**April 2018**	**Target**
Average time in working days to respond to complaints at Stage One	11	8	**5**
Average time in working days to respond to complaints after Escalated to Stage Two	0	0	**20**
Average time in working days to respond to complaints at Stage Two	28	29	**20**

Stage One – Average Time for Complaint to be Closed, based on closed date

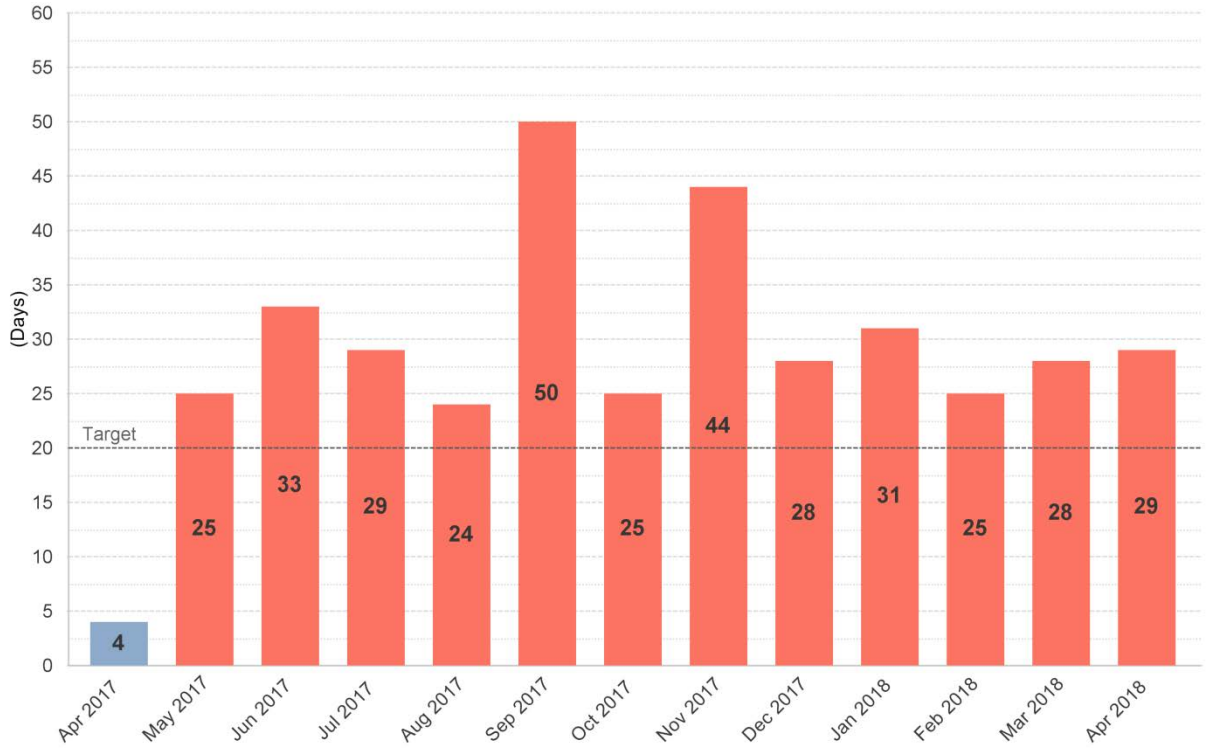


Stage Two Escalated – Average Time for Complaint to be closed, based on closed date

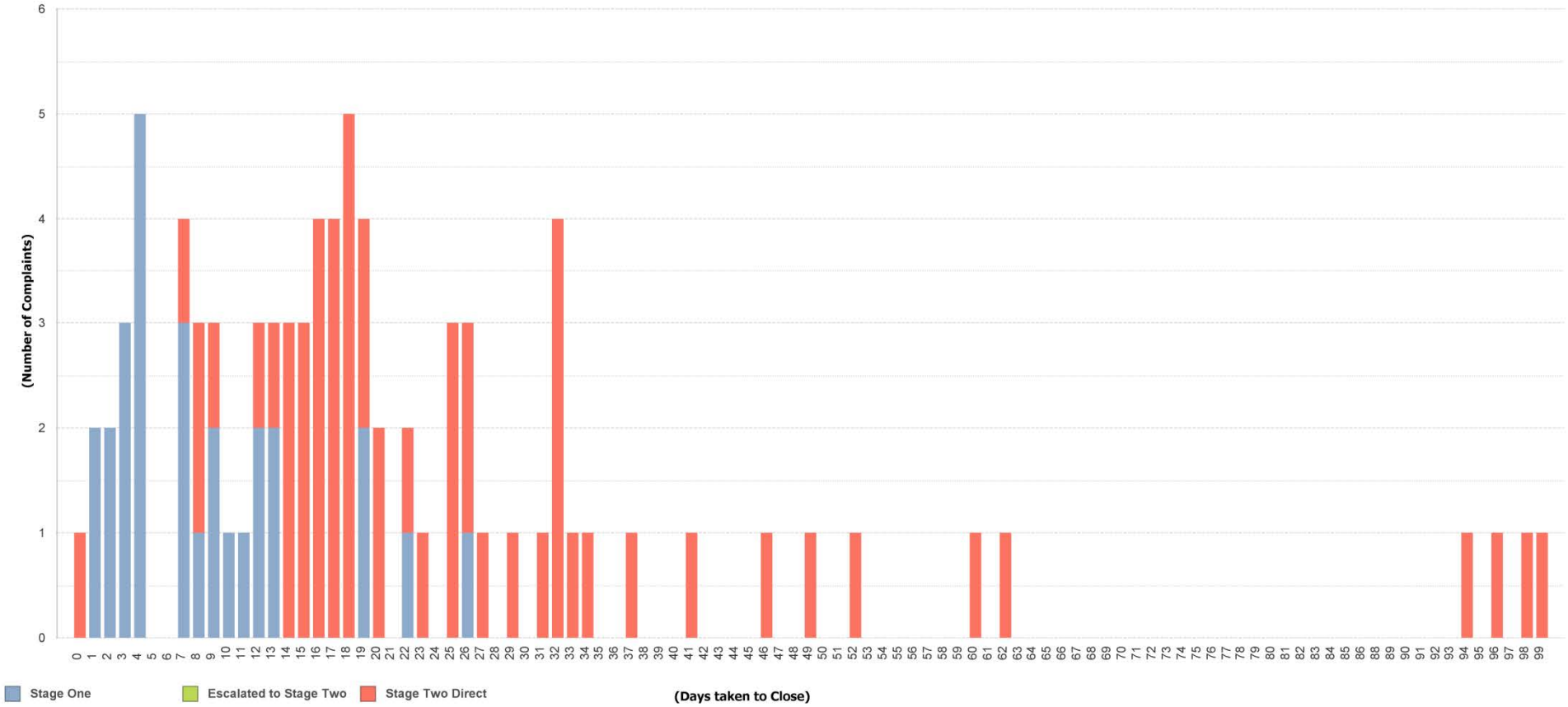


NB – Some months there are no Stage Two Escalated complaints.

Stage Two Direct – Average Time for Complaint to be closed, based on closed date



Distribution of time for Complaint to be closed



The Complaints Handling Procedure states that: Stage One complaints should be responded to within 5 working days and Stage Two complaints within 20 working days. The procedure does make provision for extensions to be requested in exceptional circumstances. Indicator 9 details the number of cases where such an extension was authorised.

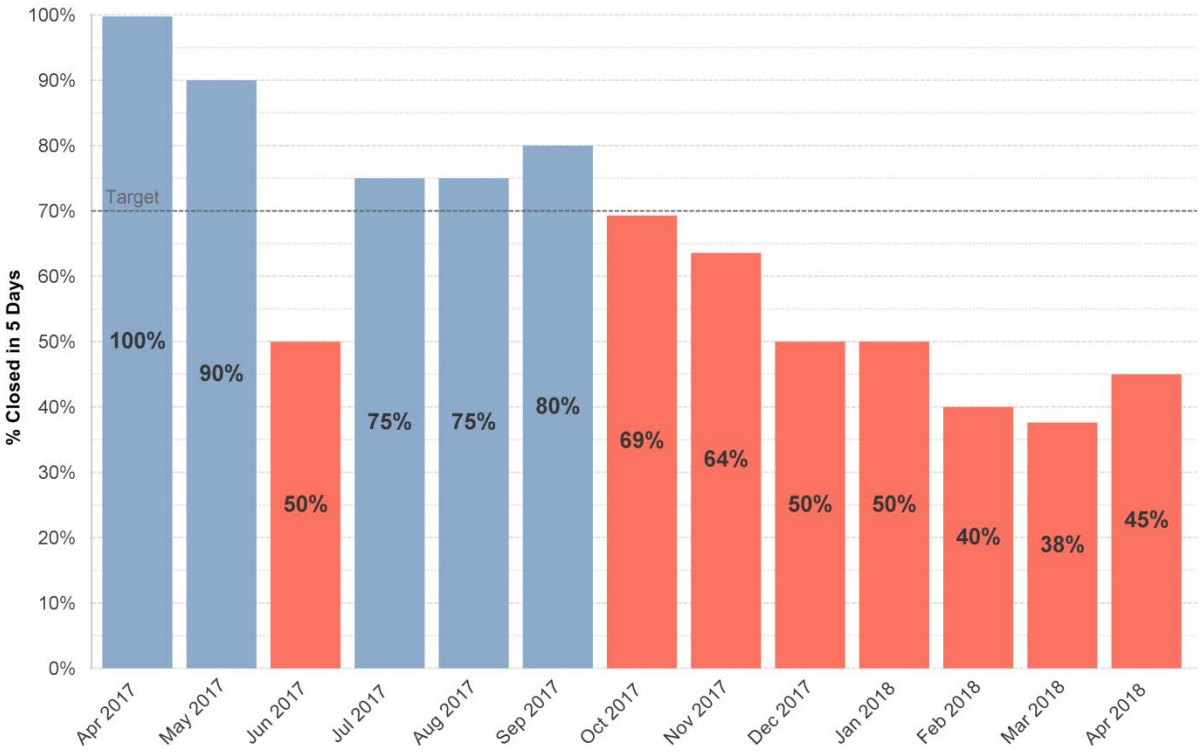
Indicator Eight: Complaints closed in full within the timescales

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

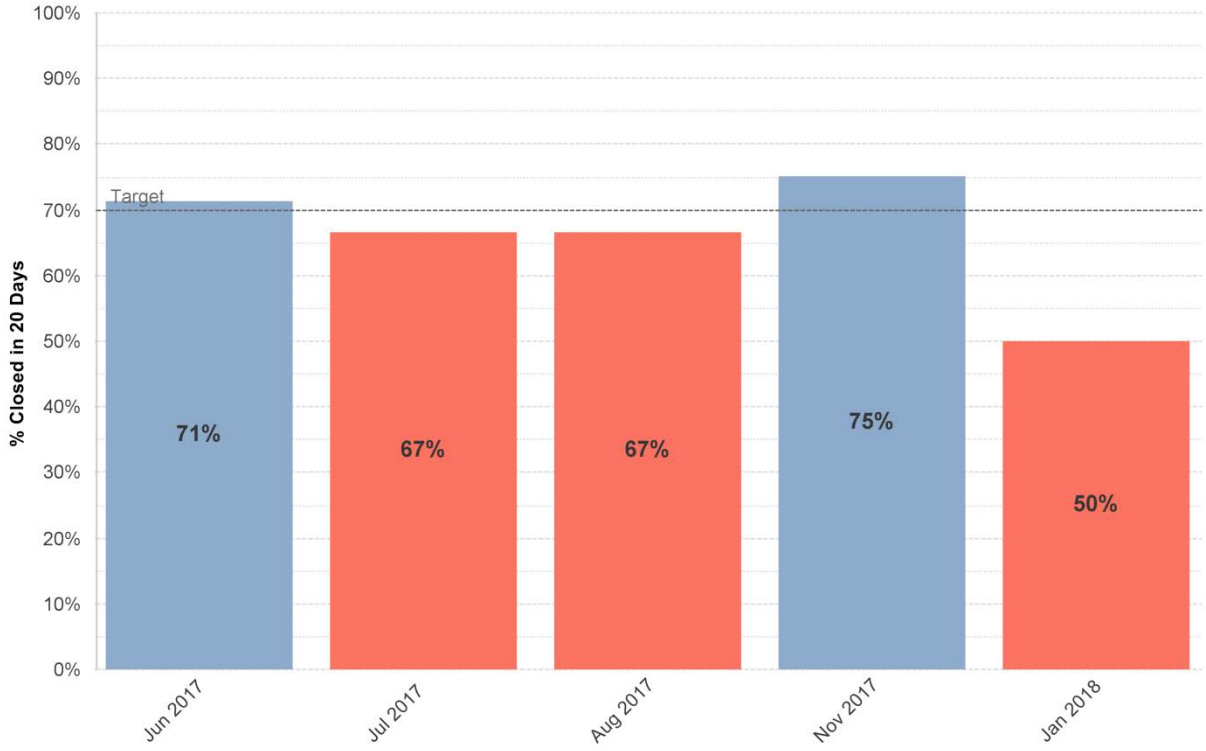
Indicator 8 - The number and percentage of complaints at each stage which were closed *(responded to)* in full within the set timescales of 5 and 20 working days			
Description	**March 2018**	**April 2018**	**Target**
Number complaints closed at Stage One within 5 working days as % of Stage One complaints	38% (3 of 8)	45% (9 of 20)	**70%**
Number complaints Escalated to Stage Two closed within 20 working days as % of escalated Stage Two complaints	- (0 of 0)	- (0 of 0)	**70%**
Number complaints closed at Stage Two within 20 working days as % of Stage Two complaints	50% (11 of 22)	54% (19 of 35)	**70%**

Compliance with complaints timescales continues to be below target and continues to fluctuate. There are a number of reasons for this including the complexity of issues and capacity challenges. Patient Services are working closely Directorates to further review and improve processes with a view to improving performance.

Stage One - Complaints Closed in Set Timescale, based on closed date

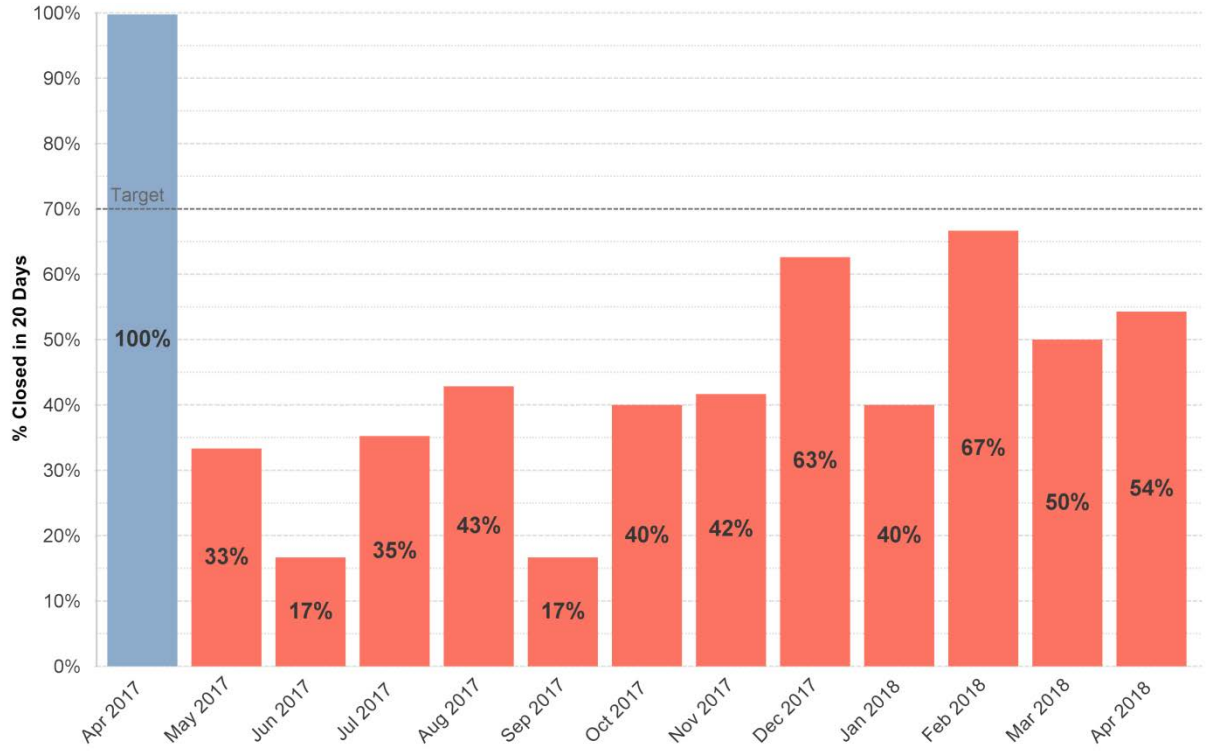


Escalated to Stage Two - Complaints Closed in Set Timescale, based on closed date



NB – Some months there are no Stage Two Escalated complaints.

Stage Two Direct - Complaints Closed in Set Timescale, based on closed date



Indicator Nine: Number of cases where an extension was authorised
"Details of how many complaints required an extension to the standard timescales."

Indicator 9 - The number and percentage of complaints at each stage where an extension to the 5 or 20 working day timeline has been authorised.		
Description	**March 2018**	**April 2018**
% of complaints at Stage One where extension was authorised	25% (2 of 8)	10% (2 of 20)
% of Escalated to Stage Two complaints where extension was authorised	- (0 of 0)	- (0 of 0)
% of complaints at Stage Two where extension was authorised	27% (6 of 22)	37% (13 of 35)

2.4 Scottish Public Services Ombudsman Complaints

Individuals who are dissatisfied with NHS Dumfries and Galloway's complaint handling or response can refer their complaint for further investigation to the Scottish Public Services Ombudsman (SPSO).

There are currently 25 complaints with the SPSO for their consideration. Five files have been requested and are being prepared for submission to the SPSO. Fifteen complaints are currently under investigation and await the Ombudsman's decision on these complaints.

The SPSO have issued decision letters regarding five complaints and the recommendations are currently being actioned. Two action plans have already been sent to the Ombudsman and once complete the remaining action plans will be sent to the Ombudsman for their consideration.

3. Conclusion

Compliance with response timescales continues to present a challenge. Patient Services are working closely with services to ensure they are supported with training, templates, guidance and advice as required.

Agenda Item 158

DUMFRIES and GALLOWAY NHS BOARD

4th June 2018

INVOLVING PEOPLE IMPROVING QUALITY

Spiritual Care and Volunteering

Author:
Joan Pollard
Associate Director of Allied Health Professions

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

Date: 18th May 2018

RECOMMENDATION

The Board is asked to:

- note the progress within Spiritual Care and Volunteering
- note the activities of the Patient Services Team

CONTEXT

Strategy / Policy:

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

- 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
- Supports delivery of HDL (2002) 76

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

NHS Dumfries and Galloway Volunteering Programme continues to recruit, train and create new volunteering roles and develop/support the existing volunteers through peer mentoring sessions.

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]

[1] Spiritual Care in NHS National Services Scotland, NHS National Services 2006

A Spiritual Care Service is required to follow principles as outlined in HDL (2002) 76[2]

In delivering their services Boards are required to appoint a spiritual care lead, provide access to accommodation, information accessories and facilities for worship of relevant faith communities

Key Messages:

- Progress continues within the establishment of Volunteering and the refresh of Spiritual Care support across the region.

GLOSSARY OF TERMS

NHS D&G	-	National Health Service Dumfries and Galloway
DGRI	-	Dumfries and Galloway Royal Infirmary
CCL	-	Community Chaplaincy Listening

[2] http://www.sehd.scot.nhs.uk/mels/hdl2002_76.pdf

MONITORING FORM

Policy / Strategy	• Healthcare Quality Strategy (2010), • Scottish Government Commitment : A Nation with Ambition • 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 • Supports delivery of HDL (2002) 76
Staffing Implications	*Nil*
Financial Implications	*Nil*
Consultation / Consideration	*N/A*
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	**Demonstrate a contribution to sustainable development by actively considering the social, economic and environmental impact.*
Compliance with Corporate Objectives	*Corporate objectives 1, 3, 4, 6*
Local Outcome Improvement Plan (LOIP)	*Outcome 1* *Outcome 2* *Outcome 6* *Outcome 8*
Best Value	*Vision and leadership* *Equality*
Impact Assessment **Please confirm that an Equality Impact Assessment (EQIA) has been carried out and that an electronic copy of the completed EQIA has been forwarded to the NHS D&G Equality Lead for publication on the NHS D&G website in accordance with equality legislation.*	

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, Patient Information, and the Participation and Engagement Network. This report outlines the key activities over the period March and April 2018, details planned improvement actions and recent achievements.

2. Spiritual Care

2.1 Sanctuary within DGRI

As part of the funded art-project, staff attended workshops, led by world renowned sculptor Jim Buchanan, to create 'hand held objects' depicting journeys for the sanctuary.

Privacy within the sanctuary has been achieved and a new sign has been hung across the corridor outside of the sanctuary.

2.2 Bereavement Support

Work is ongoing towards a Palliative End of Life and Bereavement draft strategy. Plans are progressing for a bereavement workshop to take place in the autumn of 2018.

2.3 Staff Support

Referrals continue to increase at a manageable level for staff and teams. Team support is frequently requested in the event of the death of a colleague in service.

Information about support for staff is available within the newly designed Spiritual Care Team Homepages section in Beacon.

2.4 Spiritual Care Volunteering

The two spiritual care volunteers who were introduced to the Senior Nursing Acute Group in February are proving beneficial to patients and their loved ones in Dumfries & Galloway Royal Infirmary (DGRI). They are available are required for patients and respond to requests for assistance from nursing and medical staff. Sadly one of the existing volunteers has had to leave and on behalf of the Board wish to extend her our thanks for offering her time, skills and support to assist our patients with meeting their spiritual care needs. Her input will be greatly missed.

Recruitment for further new Spiritual Care volunteers is on going with another newly trained volunteer joining the team. The Spiritual Care Lead has met with a couple of other people interested in the spiritual care volunteer role with other interested people requesting information.

2.5 Patient Listening Service

The Patient Listening Service is a short term intervention currently offered at Craignair Health Centre, Dalbeattie and Gillbrae Health Centre, Dumfries by two trained volunteer listeners. It is part of the national NHS Education for Scotland (Community Chaplaincy Listening (CCL) programme. The three newest spiritual care volunteers joined the Spiritual Care Lead on a recent CCL training day in Perth, they will undergo the four day training this summer, hosted by NHS Lanarkshire and trained by national CCL trainers.

3. Volunteering

3.1 Volunteers' Week 2018

Volunteers' Week is the national celebration of volunteering from 1-7June. It is a great opportunity to recognise volunteers and celebrate the difference volunteering is making in NHS D&G. This year the tagline is 'Volunteering for All' which gives an opportunity to promote volunteering throughout the region by highlighting that volunteering is for everyone.

A planning group of NHS D&G volunteers has been formed and are raising the profile of volunteering in Wigtownshire on Friday 1 June and in the Main Atrium of DGRI from 1 – 7 June. An information stand will be set up in both locations giving volunteers the chance to meet people, share their stories and encourage potential new volunteers to find out more.

The Volunteers are also hosting a Quiz Night to celebrate their achievements and learning throughout the year.

The Volunteer Co-ordinator has nominated the new hospital volunteers to the Third Sector Dumfries & Galloway, VOSCARS Awards under the category of Health, Wellbeing & Sport.

3.2 Training

To develop the skills and confidence of volunteers' four new training courses were introduced and delivered over the last 5 weeks. This resulted in 154 training hours given by NHS volunteers via these eighty training places occupied. The courses were:

- **Wheelchair Assistance:** Forty four Welcome Guides participated in Moving & Handling training so that additional support could be provided to visitors and patients in need of wheelchair assistance in the DGRI. This has now commenced in DGRI.

- **Sensory Awareness Training:** Visibility Dumfries & Galloway's See Hear Team delivered a workshop in Lockerbie to raise awareness of the needs of those with sight and hearing loss. This was highlighted as potential training for all volunteers in this Board with four NHS volunteers and staff attending with other agencies. From the observations and learning of the group the See

Hear Team are currently developing this workshop so that it can be delivered to all NHS volunteers in Dumfries & Galloway.

- **Fire Safety:** This 30 minute awareness raising course complemented the initial training given to all volunteers at the Induction Tours of the new hospital. The additional training highlighted the fire warning system, emergency lighting, common causes of fire and the emergency and evacuation procedures.

- **Dealing with Conflict:** This training was facilitated by two NHS staff to give volunteers:
  - A basic awareness of managing conflict in their volunteering role
  - An understanding of how to manage challenging behaviour by identifying the causes of conflict and recognise warning signs
  - A greater knowledge of how to use a positive approach to manage conflict

3.3 Investing in Volunteers Award (IiV):

The Development Plan and supporting evidence for (IiV) will be submitted to Volunteer Scotland in July 2018. In August/September Volunteer Scotland Assessors will carry out a variety of interviews with randomly chosen volunteers, Board members, Volunteer Steering Group members and NHS staff working with or supporting volunteers. This will include Senior Charge Nurses and/or Volunteer Champions in Wards. The Quality Assurance Panel will meet in October 2018 to consider the application for Investing in Volunteers Award.

The Investing in Volunteers Standard comprises **nine indicators** which NHS Dumfries & Galloway will be measured by, these are designed to cover all the aspects of volunteer management and include:

- **Indicator 1:** There is an expressed commitment to the involvement of volunteers, and recognition throughout the organisation that volunteering is a two-way process which benefits volunteers and the organisation.
- **Indicator 2:** The organisation commits appropriate resources to working with all volunteers, such as money, management, staff time and materials.
- **Indicator 3:** The organisation is open to involving volunteers who reflect the diversity of the local community and actively seeks to do this in accordance with its stated aims.
- **Indicator 4:** The organisation develops appropriate roles for volunteers in line with its aims and objectives, which are of value to the volunteers.
- **Indicator 5:** The organisation is committed to ensuring that, as far as possible, volunteers are protected from physical, financial and emotional harm arising from volunteering.
- **Indicator 6:** The organisation is committed to using fair, efficient and consistent recruitment procedures for all potential volunteers.
- **Indicator 7:** Clear procedures are put into action for introducing new volunteers to their role, the organisation, its work, policies, practices and relevant personnel.

- **Indicator 8:** The organisation takes account of the varying support and supervision needs of volunteers.
- **Indicator 9:** The whole organisation is aware of the need to give volunteers recognition.

4. Participation and Engagement Network

Participation and Engagement Network leaflets will be sent out to local groups in May 2018 alongside promotion on our social media sites and staff Core Briefing, with a view to generating additional members for the network.

Further information on the Participation and Engagement Network can be found on the DG Change website at www.dg-change.org.uk/participation-engagement-network.

5. Patient and Carer Information

Patient Services are supporting the Equality Lead to ensure that we are compliant with the British Sign Language (Scotland) Act 2015 and the requirement to have a local action plan in place by October 2018.

DUMFRIES and GALLOWAY NHS BOARD

Agenda Item 159

4th June 2018

Involving People, Improving Quality

Healthcare Associated Infection Report

Author:
Elaine Ross
Infection Control Manager

Sponsoring Director
Eddie Docherty
Nursing Midwifery & Allied Heath Professional Executive Director

Date: 25th May 2018

RECOMMENDATION

The Board is asked to receive this Healthcare Associated Infection report and note in particular the position of NHS Dumfries and Galloway with regard to the SAB and C Diff HAI Local Delivery Plan targets.

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?
This report meets the Scottish Government requirements for reporting of key Healthcare Associated Infection (HAI) data, including performance against HAI Delivery Plan targets for *Staphylococcus aureus* bacteraemia (SAB) and *Clostridium difficile* infection (CDI). It is prepared using the national standardised template and is placed on the NHS Dumfries & Galloway public web site following endorsement by the NHS board.

Key messages:

- The two Healthcare Associated Infection LDP targets were not met for the year ended March 31 2018.
- Whilst the *Staphylococcus aureus* bacteraemia (SAB) LDP target was missed we are one of the boards with the lowest rate of healthcare associated SAB
- We are one of the health boards with higher rates of *Clostridium difficile* infection (CDI) though we remain within the acceptable parameters and not an outlier.
- There are two incidents with potential for healthcare infection and one outbreak reported in this paper.

- *E. Coli* Bacteraemia (ECB) is not yet a target but reporting is mandatory and is forming a baseline against which a target will be set. Again we are one of the boards with the lowest rate of healthcare associated ECB.
- At the time of writing the Scottish Government Health and Social Care Department has not yet confirmed their expectations of health boards in terms of infection prevention targets or delivery.
- In Dumfries and Galloway we will continue to work towards achieving best in class in the existing LDP targets and ECB.
- Within our target areas the number of HAI is very low. Achieving further reductions will be challenging but we continue to strive for zero preventable infections.
- The area for focus now needs to be the community and will require different strategies, interventions and an engaged population.

GLOSSARY OF TERMS

CVC	-	Central Vascular Cannula
CDI	-	*Clostridium difficile* Infection
CAI	-	Community Associated Infection
ECB	-	*E.coli* Bacteraemia
HAI	-	Healthcare Associated Infection
HIIAT	-	Healthcare Infection Incident Assessment Template
HPS	-	Health Protection Scotland
HPT	-	Health Protection Team
IMT	-	Incident Management Team
IPCT	-	Infection Prevention and Control Team
IVDU	-	Intravenous Drug Users
LDP	-	Local Delivery Plan
PVC	-	Peripheral Vascular Cannula
PICC	-	Peripheral Inserted Central Catheter
RSV	-	Respiratory Syncytial Virus
SAB	-	*Staphylococcus aureus* bacteraemia
SSI	-	Surgical Site Infection

MONITORING FORM

Policy / Strategy Implications	Healthcare Quality Strategy: reduction of harm Achievement of HAI LDP targets
Staffing Implications	Not applicable
Financial Implications	Not applicable
Consultation / Consideration	Not applicable
Risk Assessment	Addressed through the corporate risk register
Risk Appetite	Low [✓] 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
Best Value	Governance and Accountability • sound governance at a strategic and operational level
Impact Assessment Not required. Update paper only	

NHS Dumfries and Galloway
Healthcare Associated Infection Reporting Template (HAIRT)

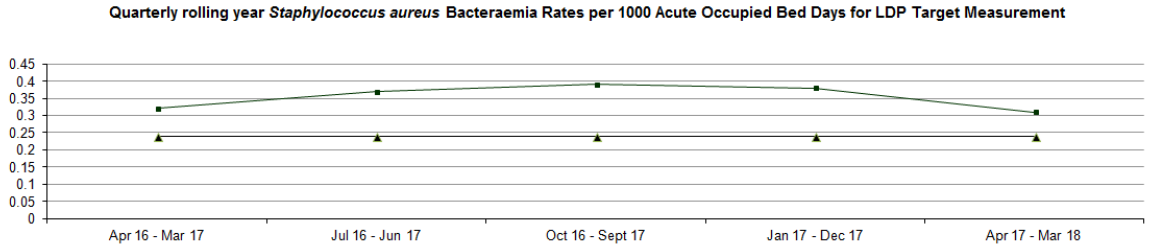
Section 1– Board Wide Issues

This section of the HAIRT covers Board wide infection prevention and control activity and actions. For reports on individual hospitals, please refer to the 'Healthcare Associated Infection Report Cards' in Section 2.
A report card summarising Board wide statistics can be found at the end of section 1

- The two Healthcare Associated Infection LDP targets were not met for the year ended March 31 2018.
- Whilst the *Staphylococcus aureus* bacteraemia (SAB) LDP target was missed we are one of the boards with the lowest rate of healthcare associated SAB
- We are one of the health boards with higher rates of *Clostridium difficile* infection (CDI) though we remain within the acceptable parameters and not an outlier.
- There are two incidents with potential for healthcare infection and one outbreak reported in this paper.
- *E. Coli* Bacteraemia (ECB) is not yet a target but reporting is mandatory and is forming a baseline against which a target will be set. Again we are one of the boards with the lowest rate of healthcare associated ECB.
- At the time of writing the Scottish Government Health and Social Care Department has not yet confirmed their expectations of health boards in terms of infection prevention targets or delivery.
- In Dumfries and Galloway we will continue to work towards achieving best in class in the existing LDP targets and ECB.
- Within our target areas the number of HAI is very low. Achieving further reductions will be challenging but we continue to strive for zero preventable infections.
- The area for focus now needs to be the community and will require different strategies, interventions and an engaged population.

1. Staphylococcus aureus (including MRSA)

Figure 1- Local data



	Apr 16 - Mar 17	Jul 16 - Jun 17	Oct 16 - Sept 17	Jan 17 - Dec 17	Apr 17 - Mar 18
Actual Performance	0.32	0.37	0.39	0.38	0.31
Target	0.24	0.24	0.24	0.24	0.24

Figure 2- Local data

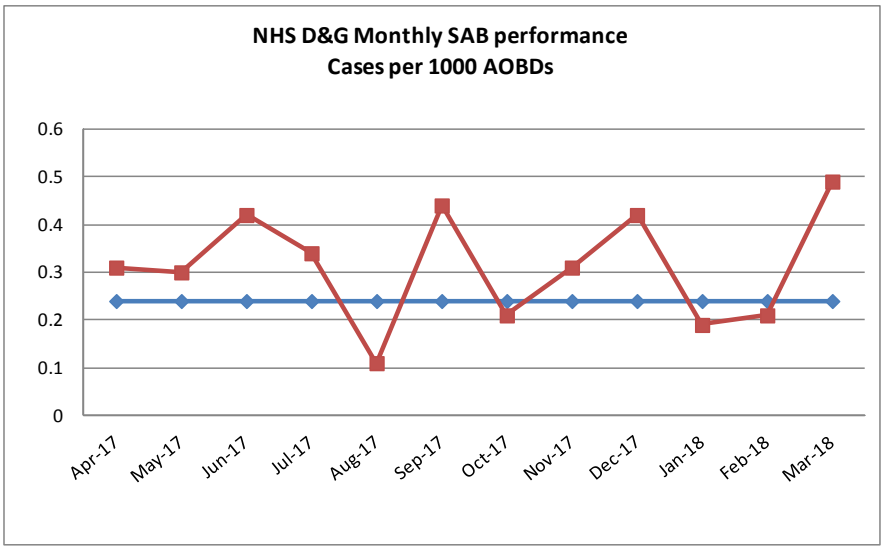
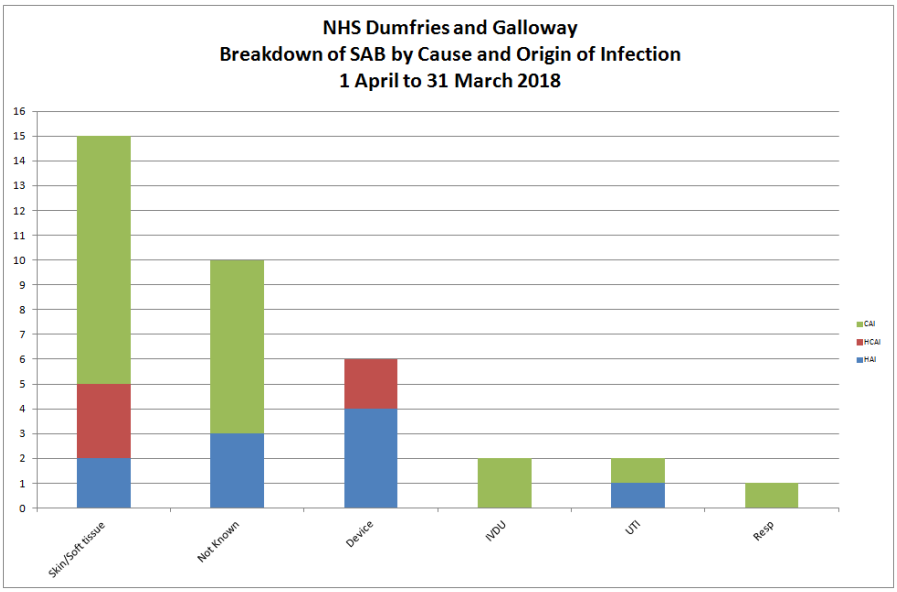


Figure 3



Of the device associated SAB 2 were Peripheral Inserted Central Catheter (PICC) lines, 1 was a fistula 2 were Peripheral vascular Cannula (PVC) and 1 a Central Vascular Catheter (CVC) line.

A Vascular access network is in place. This has reported variance in practice and knowledge levels across acute areas and a protocol for management of lines has been developed and will be implemented across the board.

2. *Clostridium difficile*

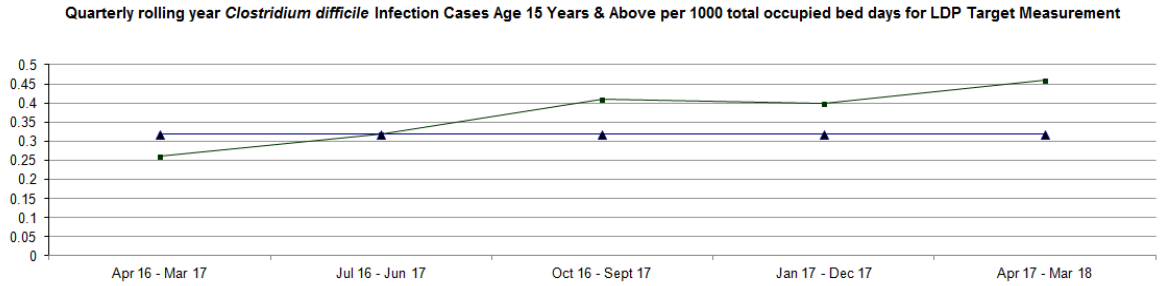
There were 8 cases of CDI in January, 4 cases in February and 7 in March.

There were 70 reported cases of CDI, 10 of these cases are recurrence of infection.

The increase in the early part of the year we believe resulted from prescribing for respiratory infections, in the mid to later part of the year this was ascribed to a shortage of Tazocin internationally and NHS Dumfries and Galloway, being high users of this antibiotic previously, noted a greater difference when alternatives had to be used.

In the final quarter respiratory infections and prescriptions to treat these had part to play as did a number of patients who developed a recurrent C. Diff infection whilst in hospital.

Figure 4- Local data



	Apr 16 - Mar 17	Jul 16 - Jun 17	Oct 16 - Sept 17	Jan 17 - Dec 17	Apr 17 - Mar 18
Actual Performance	0.26	0.32	0.41	0.40	0.46
Target	0.32	0.32	0.32	0.32	0.32

Figure 5- Local data

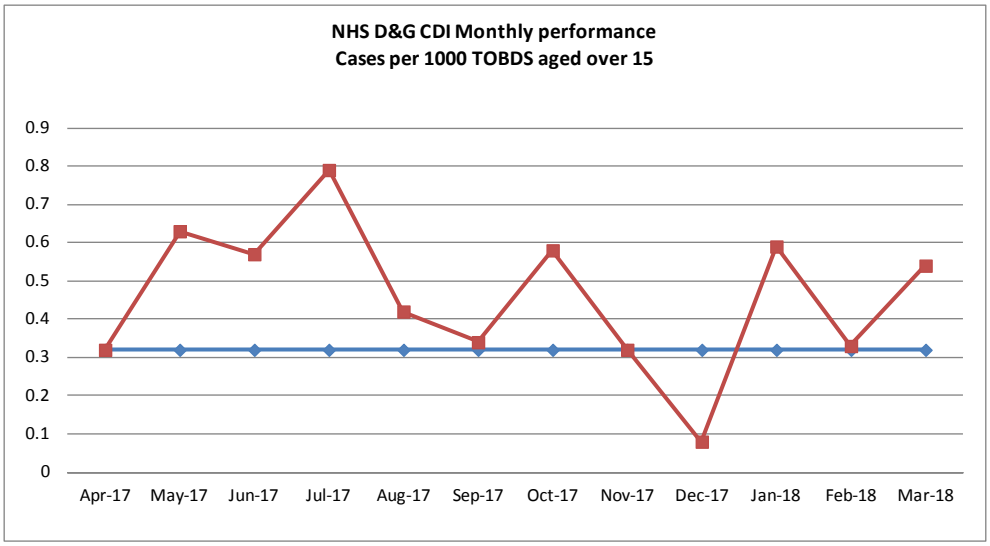
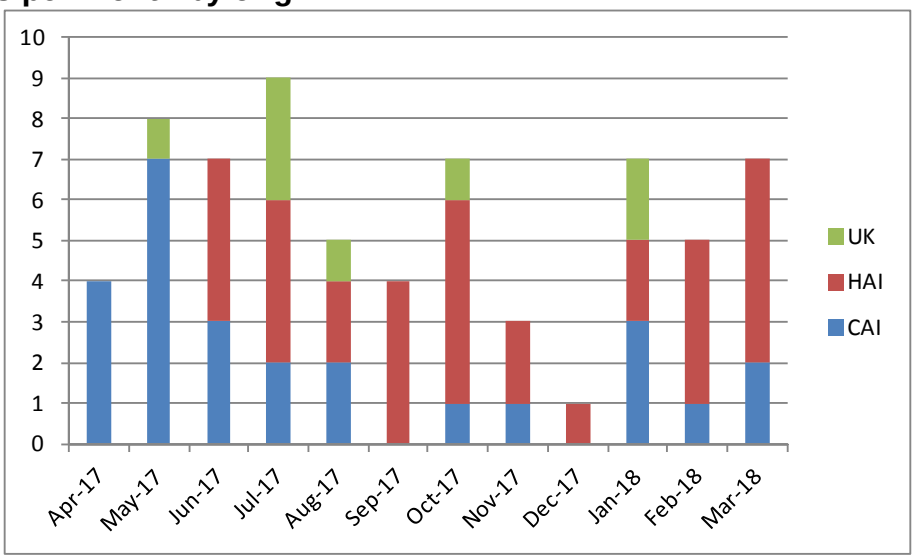


Figure 6
CDI Cases per month by origin



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

3. E. coli bacteraemia (ECB)

Whilst *E. coli* bacteraemia is not currently an LDP or national target as yet, monitoring of *E. coli* bloodstream infections is mandatory**.** A national imporvement target is anticipated at the time of writing. This is likely to be focused on healthcare associated ECB. This will be a significant challenge as improvements have already been made so the obvious actions have been taken and gains have been made. Clarity on the criteria for 'Heathcare associated' has been requested.

There have been 124 cases of *E. coli* Bacteraemia to date this reporting year.

78 = Community Acquired Infection
19 = Healthcare Associated Infection
27 = Hospital Acquired Infection

Figure 7

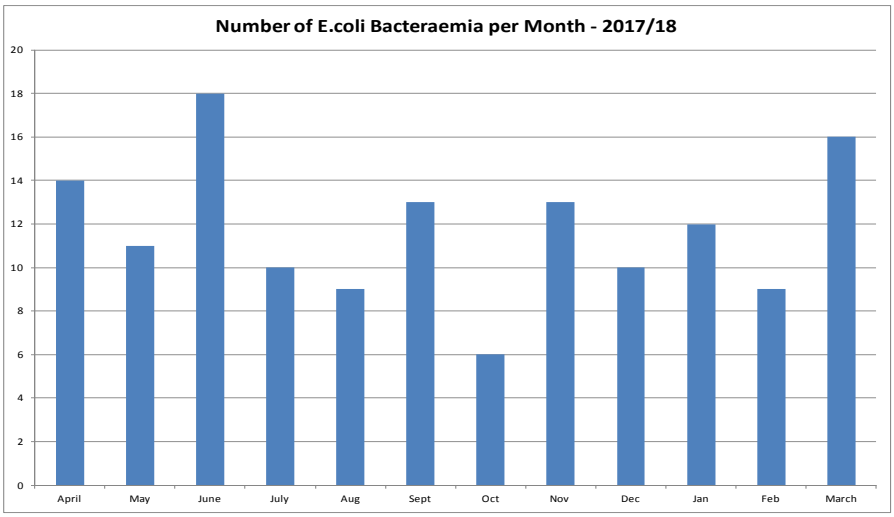
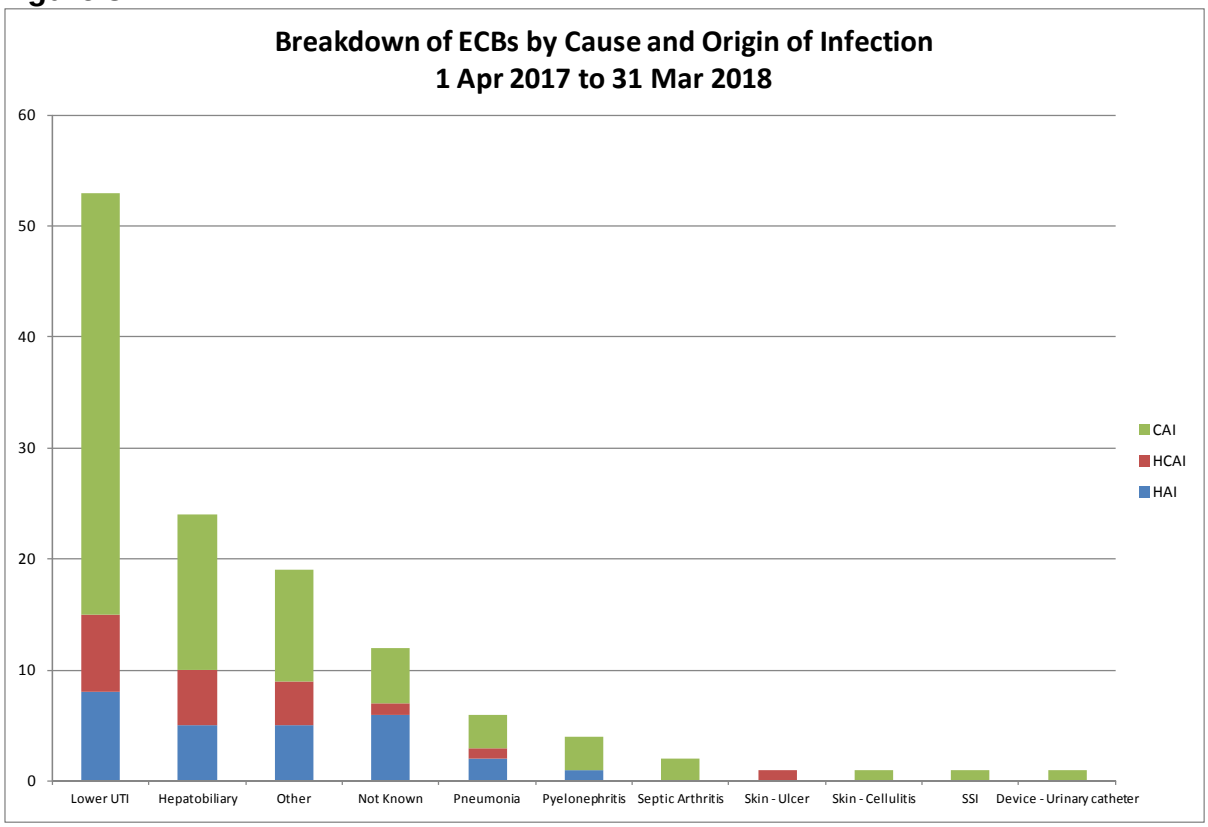


Figure 8



4. Incidents and Outbreaks

4.1 Pseudomonas identified in water samples in Maternity and Neonatal unit.

During commissioning sampling of the new water supply, outlets in neonatal and maternity were found to have levels of pseudomonas bacteria. No clinical infections have resulted from this.

Repeat samples also identified the presence of pseudomonas bacteria.

Pseudomonas is a common environmental organism found in many water supplies. There have been 5 outbreaks of pseudomonas in neonatal units across the country over the last 5 years.

A total of 3 incident management team meetings have been held and number of actions taken to address possible causes of persistent pseudomonas in the water outlets. These have included disinfection of the taps, checking of the engineering works and increased flushing of the outlets.

Due to the media interest in Glasgow's Queen Elizabeth hospital our findings have been shared with Health Protection Scotland who are satisfied that our response has been correct and proportionate.

4.2 Bacillus Sp.

4 Bacillus Sp. isolated within 2 weeks from metal work and bone removed in orthopaedic procedures in theatre and grown in enrichment culture. There have been no wound infections and no patients giving clinical cause for concern.
The presence of bacillus is often related to environmental issues and dust. This is of concern as deep joint infections may take some months to become evident.

A full examination of all processes was undertaken by the IPCT and laboratory staff. Two Incident Management Meetings have been held to date and Health Protection Scotland was informed using the Healthcare Infection Incident Assessment Template (HIIAT) reporting process. This is classed as a HIIAT GREEN.

A number of actions were identified and have been taken. The situation remains under review.

4.3 Norovirus- Thomas Hope Hospital, Langholm

Thomas Hope hospital was closed for 8 days. 8 patients and 10 members of staff reported symptoms consistent with Norovirus.

The staff were very alert to the possibility of an outbreak and contacted the IPCT promptly allowing the hospital to be closed as precautionary measure on Friday 31st March and control measure to be implemented. The virus was subsequently confirmed by PCR over the weekend. As a consequence of the design of the hospital the attack rate was high but the IPCT were confident all control measures were being used well by staff.

NHS Dumfries and Galloway Board report card

Staphylococcus aureus bacteraemia monthly case numbers

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
MRSA	0	0	0	0	0	0	0	0	1	0	0	0
MSSA	3	4	3	1	4	2	3	4	1	2	5	2
Total SABS	3	4	3	1	4	2	3	4	2	2	5	2

Clostridium difficile infection monthly case numbers

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
Ages 15-64	5	2	3	2	1	1	0	0	1	1	1	0
Ages 65 plus	3	6	6	4	3	6	4	1	7	3	6	4
Ages 15 plus	8	8	9	6	4	7	4	1	8	4	7	4

Cleaning Compliance (%)

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
Board Total	96.3	96.9	96.5	96.9	96.7	97.0	96.3	-	96.4	96.9	97.7	97.0

Estates Monitoring Compliance (%)

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
Board Total	99.7	99.7	99.7	99.7	99.8	99.6	99.7	-	99.0	99.2	99.4	99.0

NHS HOSPITAL REPORT CARD - DGRI

Staphylococcus aureus bacteraemia monthly case numbers

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
MRSA	0	0	0	0	0	0	0	0	1	0	0	0
MSSA	3	4	3	1	4	2	2	4	1	2	5	1
Total SABS	3	4	3	1	4	2	2	4	2	2	5	1

Clostridium difficile infection monthly case numbers

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
Ages 15-64	2	1	1	0	1	0	0	0	0	1	0	0
Ages 65 plus	2	2	1	1	3	5	3	1	4	2	4	0
Ages 15 plus	4	3	2	1	4	5	3	1	4	3	4	0

Cleaning Compliance (%)

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
Board Total	95.8	95.9	95.2	95.5	95.3	94.1	95.8	-	92.2	92.2	94.2	95.3

Estates Monitoring Compliance (%)

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
Board Total	99.2	98.9	98.2	98.6	98.9	97.8	98.9	-	99.2	99.2	98.4	99.7

NHS HOSPITAL REPORT CARD – Galloway Community Hospital

Staphylococcus aureus bacteraemia monthly case numbers

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
MRSA	0	0	0	0	0	0	0	0	0	0	0	0
MSSA	0	0	0	0	0	0	1	0	0	0	0	1
Total SABS	0	0	0	0	0	0	1	0	0	0	0	1

Clostridium difficile infection monthly case numbers

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
Ages 15-64	0	0	0	1	0	0	0	0	0	0	0	0
Ages 65 plus	0	1	0	0	0	0	0	0	0	0	0	0
Ages 15 plus	0	1	0	1	0	0	0	0	0	0	0	0

Cleaning Compliance (%)

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
Board Total	95.5	96.6	95.1	96.9	97.2	98.1	97.2	-	95.7	96.6	95.9	95.4

Estates Monitoring Compliance (%)

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
Board Total	98.9	98.8	99.4	98.9	99.2	98.8	98.6	-	97.5	98.0	99.3	99.0

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**

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 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**

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
Ages 15-64	0	0	0	0	0	0	0	0	0	0	0	0
Ages 65 plus	0	1	2	0	0	0	0	0	0	0	0	0
Ages 15 plus	0	1	2	0	0	0	0	0	0	0	0	0

NHS OUT OF HOSPITAL REPORT CARD

***Staphylococcus aureus* bacteraemia monthly case numbers**

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 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**

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
Ages 15-64	3	1	2	1	0	1	0	0	1	0	1	0
Ages 65 plus	1	2	3	3	0	1	1	0	3	1	2	4
Ages 15 plus	4	3	5	4	0	2	1	0	4	1	3	4

Agenda Item 160

DUMFRIES and GALLOWAY NHS BOARD

4th June 2018

Improving Safety, Reducing Harm: Mental Health Directorate

Author:
Denise Moffat
General Manager for Mental Health Directorate

Lynda Forrest
Performance Manager and AHP Lead for Mental Health Directorate

Maureen Stevenson
Patient Safety and Improvement Manager

Sponsoring Director:
Eddie Docherty
Executive Nurse Director

Date: 18th May 2018

RECOMMENDATION

The Board is asked to:

- Seek assurance from this Improving Safety, Reducing Harm Mental Health Directorate update.

CONTEXT

Strategy / Policy:

This paper sets out the Improving Safety Reducing Harm themes into one paper.

This fits with the National Quality Strategy and the 20:20 Workforce Vision and locally with the ambition to connect quality and safety within operational Directorates. The three ambitions articulated within our National Quality Strategy: Safe, Effective, Person Centred Care are integral to our local arrangements to integrate and connect all the components of quality and safety, which together support teams and services to continuously improve the quality, the safety, the effectiveness and the personalisation of care.

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

We are bringing together safety, improvement and risk into one report for a Directorate.

Appended to this front cover is the Mental Health Improving Safety Reducing Harm paper.

GLOSSARY OF TERMS

NHS - National Health Service
AHP - Allied Health Professional

MONITORING FORM

Policy / Strategy	Healthcare Quality Strategy
Staffing Implications	No staffing implications were identified when drafting this paper.
Financial Implications	No financial implications were identified when drafting this paper.
Consultation / Consideration	Mental Health Directorate
Risk Assessment	Not applicable
Risk Appetite	Low [✓] Medium [ ] High [ ] This paper demonstrates the activity within the Mental Health Directorate to improve the service, while maintaining safe clinical practices; therefore, a low risk tolerance has been noted against this paper.
Sustainability	Within current resources
Compliance with Corporate Objectives	2
Local Outcome Improvement Plan (LOIP)	Outcome 1, 2, 3 and 6
Best Value	• Vision and leadership • Governance & Accountability
Impact Assessment Not required	

News in Brief

Priority Areas

In 2016/17, we have focused on 3 key priority areas that aim to improve the experience and outcomes of people who use mental health services. These are;

- Increasing access to services
- Reducing harm
- Working in partnership with patients and carers

IDEAS Team Annual Report 2016/2017

The IDEAS Team (Intervention for Dementia Education Assessment Support) provides specialist support to people working and caring for individuals who have dementia and associated behaviours contributing to stress and distress.

Support includes:

- Specialist advice
- Training and education
- Specialist assessment and consultation

The multi-disciplinary team is based within the Mental Health Directorate, and consists of Nursing, Occupational Therapy, Psychology, Speech and Language Therapy and Social Work staff. The IDEAS Team formed in January 2016 and became operational on 7th March 2016. The annual report is embedded at the bottom of this document.

Walkrounds

4 walkrounds have taken place between 31st January and 1st February 2018 however one was cancelled. Themes from the walkrounds include mobile phone issues within locality, issues with sharing of information between partners, GP crisis and the collaborative working with GP Practices. It was agreed that Tricia would speak to Nigel Gammage in IM&T regarding the mobile phones; all issues with mobile phones will be pulled together on a bigger scale and added to DATIX. Tricia will raise the mobile phones issue at the next Management Team Meeting, and mobile phones issue is to be included on the risk assessment.

Managing Risk and Protecting Patient Safety

Proactive Risk Management
The Directorate have identified the top 3 risks:

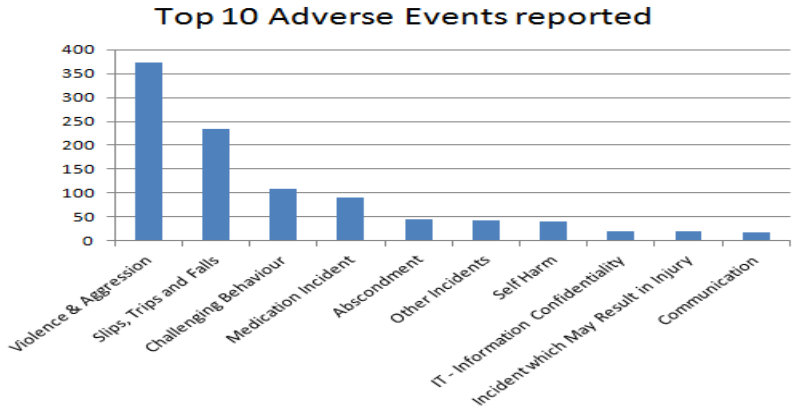
- Management of falls without harm
- Management of self harm and suicide
- Management of stress and distress

Adverse Events

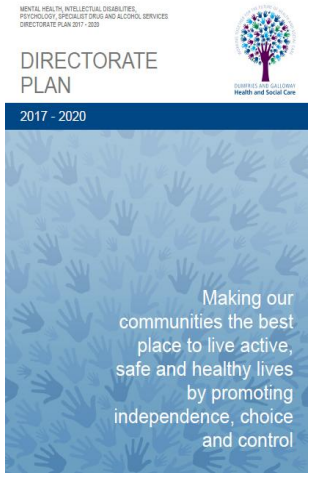
From the period 1st November 2016 to 31st October 2017 a total of 1130 adverse events were reported.

- 723 Category A-D
- 327 Category E-F
- 22 Category G-I

The graph below identifies the top 10 adverse events reported by the Mental Health Directorate.



Mental Health 3 Year Delivery Plan



The directorate has developed a 3 year plan that sets the direction for the Mental Health, Intellectual Disabilities, Psychology and Drug and Alcohol Services. It will be used by managers and staff to guide or vision and goals, underpinned by the values required to deliver high quality care and support. The plan supports our aim for people to receive the right help at the right time, in a recovery focused, person centred and rights based way, free from discrimination, stigma and harm.

The plan uses the 6 dimensions of healthcare quality and identifies 12 key outcomes to provide focus for operational delivery and performance.

A performance management framework is being developed to monitor and evaluate progress towards delivering quality outcomes. This will be supported through strengthening leadership, aligning policy, processes and resources, developing effective partnerships, and promoting learning and innovation at every level.

Our over-arching priority for 2018 is to continue to improve patient experience and outcomes, enabling shared decision-making and working in partnership in line with the integration agenda. Key actions to support that aim include delivering our eHealth project, undertaking SPSP climate tools to help us better understand patient experience, and developing an improvement project to reduce the number of violence and aggression incidents.

eHealth Project

During 2017, electronic data recording systems have been developed to include risk assessment documentation, forms for patient contacts, collation and evaluation of data from the new primary care liaison service, and post diagnostic support checklists and support plans.

In 2018, the eHealth project has 4 main themes;

- Facilitate health and social care integration through digital information sharing and communications; (Formstream, Cortix, RMS and TOPAS)
- Support efficient work of health and social care professionals by providing digital tools for information gathering, processing, analysis and use; (MORSE, Caseload and Workload Reports)
- Support the people to digitally manage their own health and wellbeing and live longer, healthier lives at home or in a community setting; (LYNC, NHS Access Anywhere)
- Enable Scotland to be a long term leader in digitally enabled care by supporting innovation through partnership. (ICHOM, CHAD)

SPSP

The SPSP climate tool will be carried out within all wards in Midpark, with both patients and staff. The information from this evaluation will be used to inform how we:

- Support services and systems to understand high impact opportunities for improvement
- Design processes, care models and systems which will improve outcomes
- Provide practical support to enable staff to implement changes that will lead to improvement

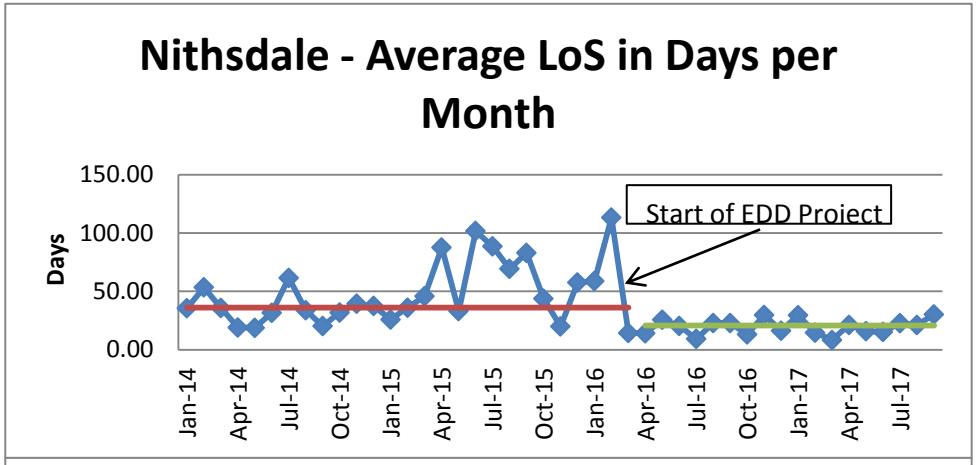
Reducing Harm

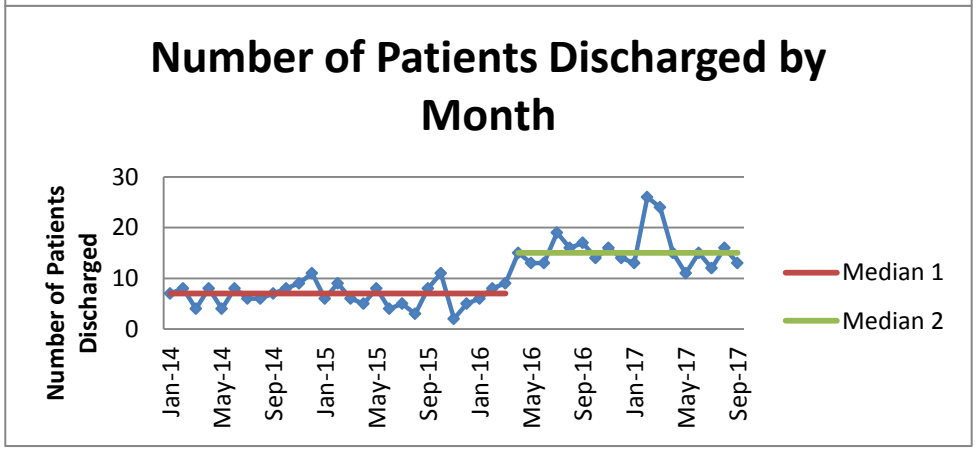
Our risk monitoring processes indicate that more work is required to reduce incidents of violence and aggression, which is the top most recorded adverse event in mental health. A focused project is planned for 2018 that aims to reduce the number of incidents, with no associated increase in the number of people on observation.

Updates

Increasing Access to Services

In January 2016, work in Midpark hospital to improve patient flow was commenced. On Nithsdale ward, Estimated Dates of Discharge (EDD) were introduced for people at the first Multi-Disciplinary Team (MDT) meeting following their initial 72 hour assessment period. This required a whole system approach involving input from health and social care and partners, and patients and carers. There has been a sustained shift in the reduction of average length of stay, from 37 to 20 bed days per month (diagram 1), and the number of people being discharged per month has increased from an average of 7, to 15 (diagram 2). The data indicates that more people are returning to a homely setting sooner, which increases the availability of beds for those people who require hospital admission.

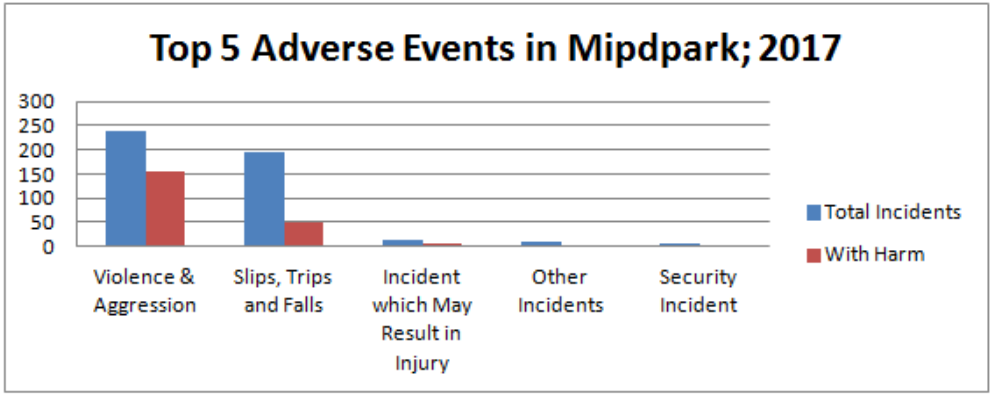




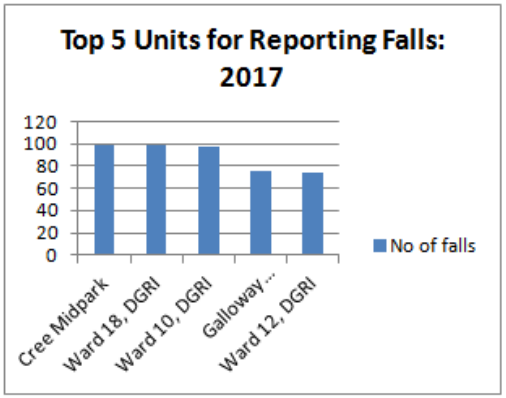
Bed occupancy rates have remained stable, and there has been no increase in readmission rates.

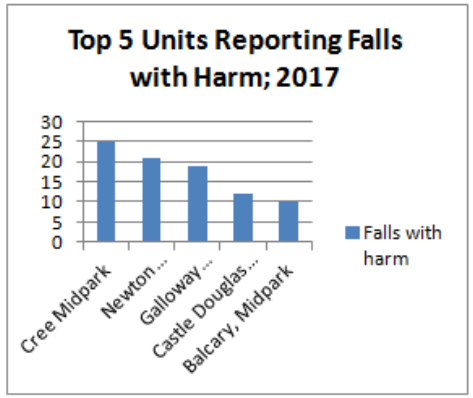
Reducing Harm

Through monthly risk monitoring procedures, the Mental Health Directorate have identified 2 high level risk areas that cause harm to patients; Violence and Aggression, and Slips, Trips and Falls. Of the 240 V&A incidents, 154 resulted in harm to a patient. 49 of the 196 reported slips, trips and falls resulted in harm.



Looking across the board for reporting on slips, trips and falls, Cree Ward in Midpark report the highest incidence both for total number of falls, and number of falls with harm. Cree is an acute admission ward for people with organic conditions, including dementia. People with dementia are 2-3 times more likely to fall, and 8 times more likely to experience an injury as a result of a fall.

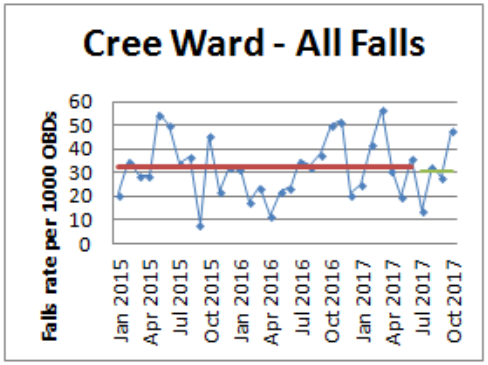


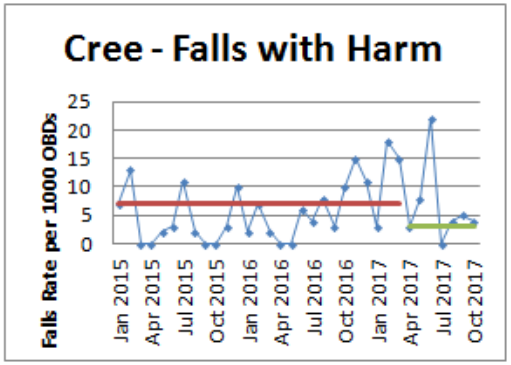


In April this year, an improvement project was developed to support a proactive approach to identifying individuals at risk of falling. A key aim was to develop person-centred care planning to help reduce the number of falls, and the associated risk of subsequent harm.

Our overall approach was to incorporate good dementia care and falls prevention methodology, with supported person-centred assessment and interventions.

Early data collection shows a slight reduction in the number of falls from the baseline of 33, to 31. The number of falls with harm has reduced by 57%, from a baseline of 7 per month, to 3.



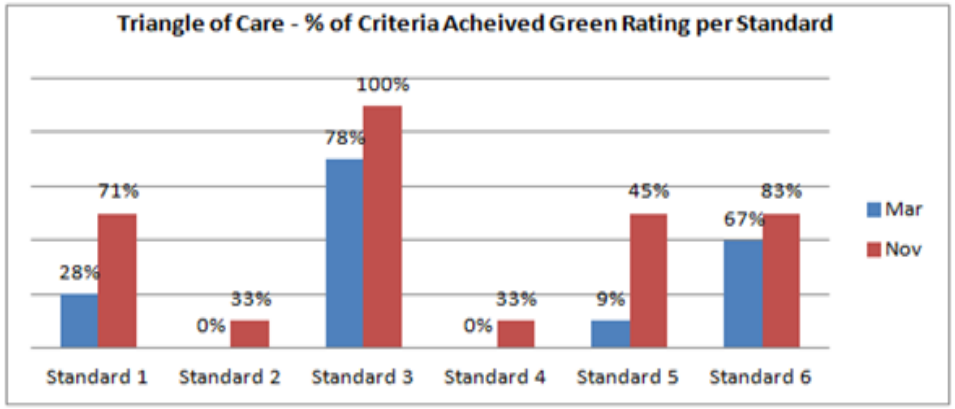


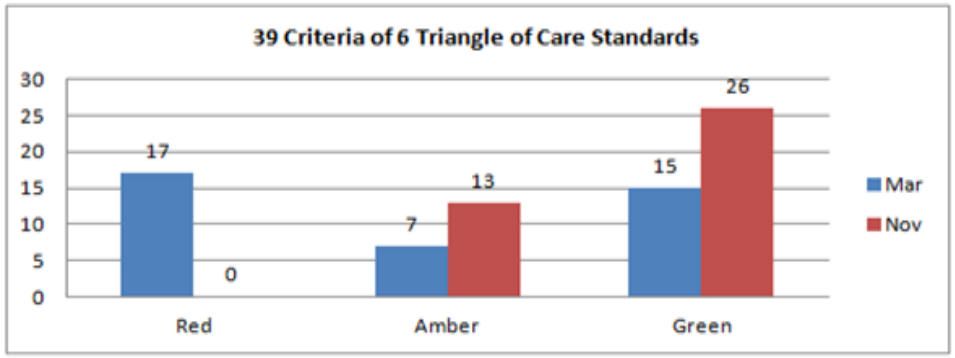
Working in Partnership with Patients and Carers

The Triangle of Care (TOC) is a working collaboration between the person using the service, their carer, and the professional. It promotes safety, sustains well-being and promotes recovery through recognising patients and carers as partners in care. The best practice guide identifies 6 standards that are required for better collaboration and partnership. Improvement work to develop a carer pathway at Midpark was undertaken, using these 6 principles.

TOC Leads were identified to carry out a self-assessment tool to establish a baseline measure. The audit showed that while ward staff were engaging with carers, there was no consistency, with lack of documentation to demonstrate any input from carers in patient care. A traffic light system showed that none of the 6 standards were fully implemented, and of the 39 criteria within the standards, only 15 were green, 7 amber, and 17 red.

A working group was formed with a range of partners to analyse gaps and issues in the processes, and to develop a plan for improvement. Improvement actions included guidance for staff on how to use the tool, and carers checklists and information sheets. Following improvements at 6 months, 26 criteria were at green on the traffic light system, 13 in amber, and none in red. All six standards were fully or partially met. On-going improvements include roll out to other wards, community hospitals, and community teams.





Carers Comments

Reduced my anxieties

Felt listened to and valued

Able to participate in (the patients) care whilst in hospital

Staff Comments

Useful in breaking down barriers with carers, offering reassurance and alleviating anxieties.

Enhanced positive relationships between staff and carers

Having time to spend with carer/family was very beneficial

SPSP Dashboard

Scottish Patient Safety Programme – Mental Health

The aim of the SPSP for mental health is *People are and feel safe, Staff are and feel safe,* with an initial focus on adult in-patient services. There are focused improvement activities taking place on all wards in Midpark, spanning all 5 workstreams:

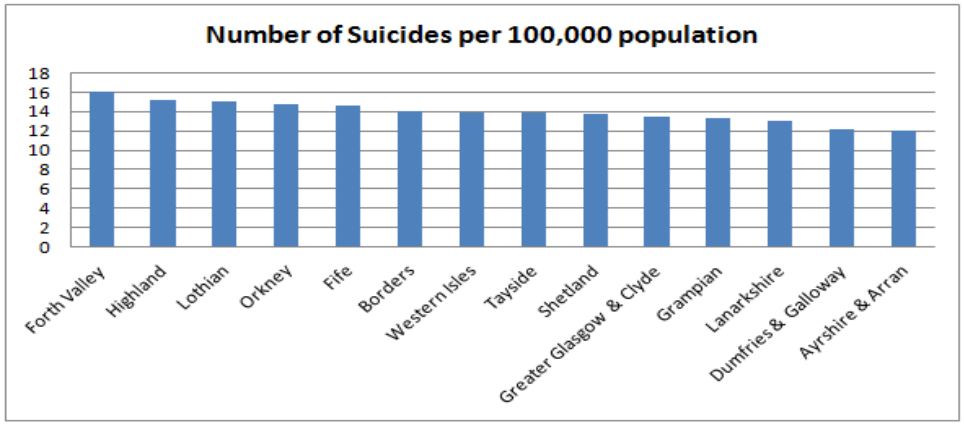
- Risk assessment and safety planning (eg, daily safety huddles and safety briefs implemented in all wards)
- Communications at transitions (eg, more effective and efficient handovers using SBARs and CORTIX systems)
- Safer medicines management (eg, improved compliance with prescribing standards for 'as required' medication)
- Restraint and seclusion (eg, weekly risk triage meetings has increased understanding of attitudes to restraint and better management)
- Leadership and culture (eg, implementation of the Nominated Hospital Lead Role)

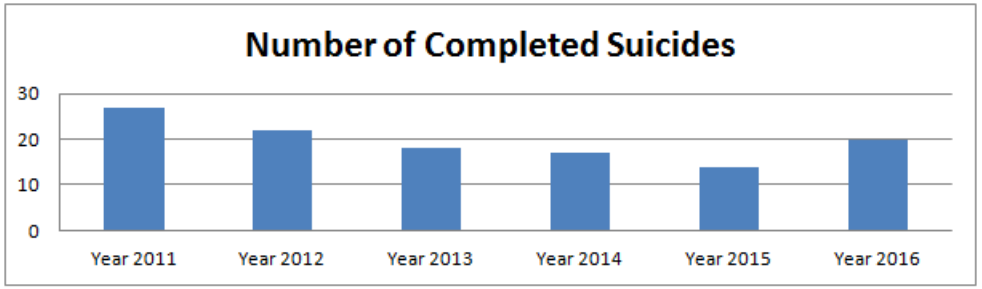
Engaging service users, carers, families and staff is integral and essential to achieving the aim of the SPSP programme, and cultivating learning among those delivering and in receipt of care, and using that knowledge to improve safety are core values. To help support success, the SPSP climate tool will be carried out again with staff and patients on all wards in Midpark in January 2018. The climate tool is designed to enquire about environmental, relational, medical and personal safety. The learning from the survey will be used to identify, prioritise and inform the next phase of improvements for the hospital.

Significant Adverse Event Reviews

In mental health, arguably the most significant adverse review is a completed suicide. When viewed in comparison with other Scottish boards, the data indicates that Dumfries and Galloway have the second lowest rate of suicide per 100,000 population.

Local monitoring processes in the MH directorate identified an increase in the number of suicides this past year.





Through the monitoring and review procedures, it was identified that of the 20 deaths coded as suicide, the minority of those people had been in direct contact with mental health services. Further, it was identified that the more recent suicides were completed by people who misuse substances, or, have a personality disorder. It was also identified that risk assessment and management practice was an area that required improvement, and that significant work is needed to identify any opportunities where intervention may have prevented deaths for those people who had completed suicide, and had not been referred to mental health services. This may help inform actions that will improve access to services for those in greatest and/or immediate need.

In January 2018, the Directorate will undertake a staff climate tool to help understand perceptions of the 3 clinical areas identified in the most recent significant events; suicide, personality disorder, and drug and alcohol misuse.

As a direct result of the monitoring of significant adverse events, the clinical risk policy for the directorate has undergone a full review. Significant investment has been made in revising, updating and improving the clinical risk assessment processes and associated documentation.

A bespoke training package has been delivered to 95% of all registered staff, and it is expected that the team approach that underpins the new policy will support more robust clinical risk assessment and management. The processes and procedures will be subject to on-going review to monitor effectiveness and identify areas for further improvement.

Glossary

IDEAS – Intervention of Dementia Education, Awareness and Support
EDD – Estimated Date of Discharge
MDT – Multi-Disciplinary Team
ICHOM – International Consortium of Health Outcome Measures
CMHNT – Community Mental Health Nursing Team
RMS – Referral Management System
CHAD – Community Health Activity Data
TOC – Triangle of Care
SPSP - Scottish Patient Safety Programme

Building Improvement Capability

Programme	Name	Project
Scottish Improvement Skills – Cohort 1	Martin Stewart (Team Lead – CAMHS)	To improve communication at times of transition when a young person requires specialised mental health in-patient provision.
	Jennifer Halliday (Clinical Lead – CAMHS)	To understand the young person's needs in a timely manner so that significant mental illness is picked up and acted upon quickly.
	Dionne McLachlan (Staff Nurse Cree Ward)	To review falls policy and look at what measures are in place to help manage these risks.
Scottish Improvement Skills – Cohort 2	Michelle Currie (Mental Health Worker	Improve access by providing an early intervention clinic within one GP Practice
Scottish Improvement Skills – Cohort 3	Gillian Coupland (Dementia Improvement Lead/ Post Diagnostic Support Lead)	To implement and evaluate the testing of the delivery of dementia post diagnostic support
	Fiona Findlay (Autism Nurse)	To be defined
	Itziar Goiriena (Mental Health Worker)	To measure the benefit and effectiveness of the urgent outpatient clinic recently introduced by CAMHS

Supporting Documents

IDEAS Annual Report
April 2016 - March 20

Diary of QI Hub Events

Event	Flyer
Scottish Improvement Skills Cohorts 4 and 5 – Now Recruiting!	SIS Flyer.pdf; SIS Application Form.doc
QI Book Club for SIS Course Members	Book club poster.pdf
Scottish Improvement Foundation Skills	SIFS Flyer.pdf

Agenda Item 161

DUMFRIES and GALLOWAY NHS BOARD

4th June 2018

Quarter 3 Performance & At A Glance Report

Author:
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Performance and Intelligence Manager

Sponsoring Director:
Vicky Freeman
Head of Strategic Planning

Date: 4th June 2018

RECOMMENDATION

The Board is asked to note and discuss the Dumfries and Galloway Health and Social Care Partnership Quarterly Performance Report 1 October 2017 to 31 December 2017 and 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 the third quarterly report of 2017/18 and follows on from work previously undertaken to develop the performance management arrangements for the Dumfries and Galloway Health and Social Care Partnership

GLOSSARY OF TERMS

CAMHS	-	Child and Adolescent Mental Health Services
IJB	-	Integration Joint Board
LDP	-	Local Delivery Plan
RAG	-	Red, Amber, Green status
SAB	-	Staphylococcus aureus bacteraemias
SDS	-	Self Directed Support

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 Health and Social Care Partnership.

2 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. In February 2018 the IJB agreed at the Performance and Finance Committee in February 2018 that these 6 indicators would be incorporated into the quarterly performance reports and reported every three months.

3 The IJB requested that performance trajectories be included within the quarterly performance reporting. Trajectories have been developed in accordance with historic activity, national priorities and managerial professional opinion. Discussions with operational managers regarding performance trajectories are ongoing.

3.1 The Scottish Government has requested that each Health Board submit an Annual Operational Plan for 2018-19. This plan replaces the Local Delivery Plan.

3.2 The guidance for the Annual Operational Plan states that the minimum aim for waiting times measures is to return to/at least maintain the waiting times at 31st March 2017 levels. Trajectories have been set on this basis for the following indicators:

- B6 12 weeks first outpatient appointment
- B19 Emergency department waiting times

3.3 The MSG indicator trajectories were calculated using the methodology set out in “Measuring Performance Under Integration” (March 2017). These highlight the predicted activity as well as a desired trajectory. Trajectories have been set on this basis for the following indicators:

- A19 Number of days people aged 75 or older spent in hospital when ready for discharge
- B4 Treatment time guarantee (TTG)
- B11 Psychological therapies waiting times
- E1 Emergency admissions per month
- E2 Unscheduled hospital bed days for acute specialities
- E3 Emergency Department monthly attendances
- E4 Bed days occupied by all people experiencing a delay in their discharge from hospital

3.4 For indicators E5 “Percentage of last 6 months of life by setting” and E6 “Balance of care: person years in community or institutional settings”, the aim is to match or exceed the best performance in the last 3 years.

3.5 In those areas of performance where Dumfries and Galloway activity currently meets or exceeds the target, the target has been set as the trajectory. This is relevant to 6 indicators.

3.6 No trajectories are currently set for 'Data Only' indicators.

Key points from Quarterly Report (Appendix 1)

4 **A19 Number of days people aged 75 or older spent in hospital when ready for discharge (p.9)** and **E4 Bed days occupied by all people experiencing a delay in their discharge from hospital (p.40)** – The number and rate of delayed discharges is lower than expected for both people aged 75 and older and for all ages. If this performance is sustained for a full year, trajectories will be recalculated.

5 **B4 Treatment time guarantee (TTG) (p.12)** – The December 2017 figure of 88.3% is higher than both the predicted position for Dumfries and Galloway and the national rate for Scotland. The figure is higher than at March 2017, (the aim set by Scottish Government - please see background), therefore an improvement trajectory has been set at 90%.

6 **B6 Percentage of patients waiting less than 12 weeks for a new appointment (not included)** – This indicator is not included in this quarterly report due to a technical issue in the way these figures are calculated being identified. This is currently being addressed and national figures will reflect the true values in the next quarterly publication.

7 **B10 Child and Adolescent Mental Health Services (CAMHS) waiting times (p. 15)** – In October 2017, unusual circumstances caused an unexpected mismatch between capacity and demand. This meant that the appointments available were unable to fully meet the demand for CAMHS treatment, and fewer people were treated within 18 weeks. There is evidence of recovery since then.

8 **B11 Psychological therapies waiting times (p. 16)** – The figures published for September 2017 have been amended. In the 3 months ending December 2017, 73.1% of people were seen within 18 weeks. This is below the target of 90% but slightly above the desired trajectory value of 72.5%.

9 **B19 Emergency department waiting times (p. 18)** – The proportion of people attending the emergency departments in Dumfries and Galloway seen within 4 hours was 90.9% in the 3 months ending December 2017. The target is 95%. Unprecedented winter pressures affected emergency departments throughout the UK during this period.

10 **C1 Adults assessing Telecare as a percentage of the total number of adults supported to live at home (p.19)** – The figures for September 2017 and December 2017 represent the improved definition used in the new computer system, Mosaic.

11 **B12 Rate of Clostridium Difficile infections (p. 30)** – The rate of C Difficile infections has increased to 0.42 cases per 1,000 occupied bed days against a target of 0.32. The rate for Scotland was 0.28 cases per 1,000 occupied bed days.

12 **B13 Rate of Staphylococcus Aureus (SAB) (MRSA/MSSA) bacteraemias (p. 31)** – The rate of MRSA/MSSA infections has increased to 0.39 cases per 1,000 occupied bed days against a target of 0.24. The rate for Scotland was 0.33 cases per 1,000 occupied bed days.

13 **B18 Sickness Absence Rate (p.35)** – NHS sickness absence was 4.9% in the 3 months ending December 2017 against a target of 4%. Sickness absence amongst Adult Social Care staff was 6.0% in the same time period. This figure for Adult Social Care staff represents a reduction of 25% on the levels of sickness absence seen in March 2017.

14 There are further performance indicators in development, against which progress can be reported.

14.1 Work has started in conjunction with the Integrated Organisational Development Steering Group (which includes representatives from the Local Authority, Health Board and Third and Independent sectors) to develop workforce performance indicators. It is intended that the focus of these indicators will be the workplace culture and how it is changing. These indicators will build on the cultural diagnostic survey that the health and social care partnership recently undertook.

14.2 Undertaking work to tackle and reduce health inequalities is a key priority for the Health and Social Care Partnership. In order to take forward the development of performance indicators for health inequalities (within the jurisdiction of the Health and Social Care Partnership) a Short-Life Working Group has been established. This Group is tasked with scoping and developing the proposed health inequalities indicator for the Health and Social Care Partnership, including undertaking an options appraisal of indicators, producing a work programme to support implementation of the indicator, overseeing the governance pathway for agreeing the indicator and supporting the monitoring and future performance reporting of the preferred indicator. The Group has undertaken an option appraisal and is in the process of identifying a suitable indicator.

14.3 A Short-Life Working Group has been established to develop a suitable performance indicator for prescribing. Different measures of prescribing performance are still under discussion.

Key points from 'At A Glance' (Appendix 2)

15 **Treatment Time Guarantees** – These continue to be very challenging. In addition to ongoing staffing pressures, winter pressures led to higher levels of cancelled operations which had a negative impact on TTG waiting times.

16 **Dr led new outpatients 12 weeks** - A technical problem in the way these figures are calculated was discovered, which made our performance appear worse than actual. A repair has been made.

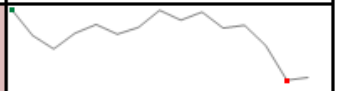
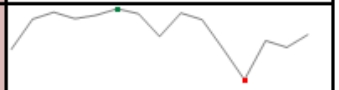
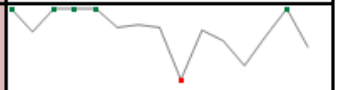
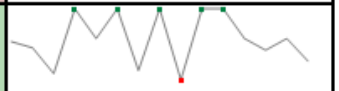
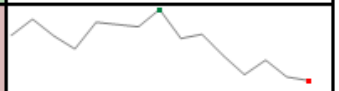
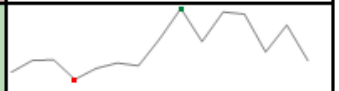
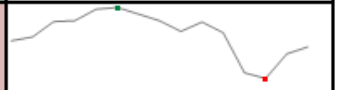
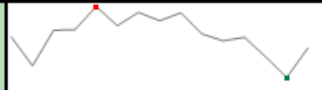
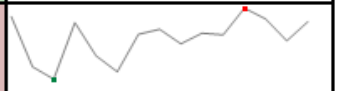
17 **Emergency Department Waiting Times** – The proportion of people seen within 4 hours is starting to recover.

Recommendations

18 NHS Board is asked to note and discuss the Dumfries and Galloway Health and Social Care Partnership Quarterly Performance Report 1 October 2017 to 31 December 2017 and the NHS Board 'At A Glance' Report.

At a Glance Performance Indicators: March 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	February 2018	March 2018	Last 3 Months (Jan 18 - Mar 18)	Last 3 Months Last Year (Jan 17 - Mar 17)	Direction	15 Month Trend
TTG (% waited under 12 weeks for Treatment)	100%	72.8%	73.5%	75.8%	85.4%	▽	
Dr Led New Outpatients (% waiting under 12 weeks at end of month)	95%	84.9%	90.8%	85.7%	90.6%	▽	
Diagnostics (% waiting under 6 weeks at end of month)	100%	97.2%	98%	97.6%	98.4%	▽	
AHP MSK (% waiting under 4 weeks at end of month)	90%	79.5%	75.5%	76.5%	85.4%	▽	
Cancer (Within 31 day target)	95%	100.0% (January 2018)	95.7% (February 2018)	97.5% Average (Dec 17 - Feb 18)	99.1% Average (Dec 16 - Feb 17)	▽	
Cancer (Within 62 day target)	95%	96.2% (January 2018)	93.3% (February 2018)	94.7% Average (Dec 17 - Feb 18)	94.2% Average (Dec 16 - Feb 17)	△	
18 Weeks Performance	90%	86.2%	85.9%	86.5% Average	89.8% Average	▽	
18 Weeks Linkage	90%	97.6%	96.9%	97.2% Average	96.8% Average	△	
Emergency Department (% Within 4 Hour)	98%	89.1%	90.1%	88.3%	92.1%	▽	
Emergency Department (Absolute Attendances)	▽	3,307	3,802	10,762	11,591	▽	
Delayed Discharges (Bed Days Lost)	▽	1,023	1,169	3,382	2,762	△	
Dr Led Return Tickets (Beyond Latest Date at end of month)	▽	3,812	3,569	11,267	15,402	▽	

At a Glance Performance Indicators: March 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.	Winter pressures led to higher levels of cancelled operations which has a negative impact on TTG waiting times
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.	A technical problem in the way these figures are calculated was discovered, which made our performance appear worse than actual. A repair has been made.
Diagnostics 6 weeks	This aspect of the 18 week waiting times journey would be reported as B7 in the quarterly performance reporting, but has not been reported due to it having been removed from the Local Delivery Plan. An aspirational local target is set at 4 weeks.	Local figures are consistently above 95% for 6 weeks and above 85% for 4 weeks
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.	In the past year, figures have been between 60-80% against a 90% target
Cancer 31 day	This indicator is one of two 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.	Target was met in Jan 2018 and Feb 2018
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.	Target was met in Jan 2018 and was not met in Feb 2018, but was within 3% of target
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.	The last time 18 weeks figures were above 90% was August 2017
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. 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%.	Ensuring efficient flow through the emergency department has been strongly impacted by winter pressures

Indicator	Background	Points to note
Emergency department attendances	While it appears that emergency department (ED) attendances are falling, this is affected by the new ways of working with the combined assessment unit (CAU). Part of the traffic that would have been seen in ED now goes directly to CAU.	Falling numbers of people attending ED are not thought to represent fewer people accessing the acute hospitals
Delayed discharges bed days	This indicator is a measure of the numbers of bed days 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 E4.	Regular Day of Care audits indicate that there are different causes of people being delayed in the acute and cottage hospitals
Dr led return tickets	This measure is about the efficient use of outpatient appointments.	There is a long term downward trend.

DUMFRIES AND GALLOWAY
INTEGRATION JOINT BOARD

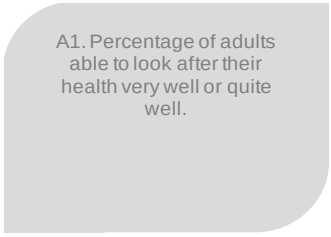
PERFORMANCE MANAGEMENT
QUARTERLY REPORT

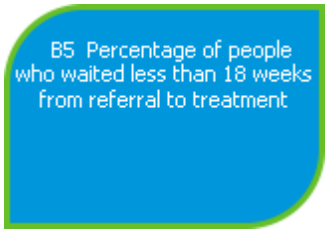
DUMFRIES AND GALLOWAY
Health and Social Care

Q3 October - December 2017

Contents

Document Features





At the start of each section there is an overview page summarising the sections content. This is done using 'leaves'.

If the leaf is **grey** then that indicator/measurement has not been included in this edition of the quarterly report. If the leaf is **coloured in** then that indicator/measurement is included in this edition.

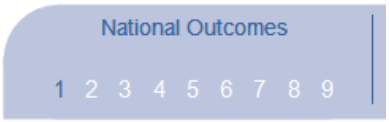
The border of the leaf will be coloured according to the following:

Grey – there is insufficient data available at this time to determine whether or not we are being successful in attaining our outcomes.

Green – the indicator or measurement suggests that we are being successful in attaining our outcomes.

Amber – early warning that the indicator or measure suggests that we may not be successful in attaining our outcomes.

Red – the indicator or measure suggests that we have/will not attain our outcomes.



This section indicates which of the 9 National Outcomes for Integration the measurement/indicator supports.

This section indicates which of the 10 Areas of Priority for Dumfries & Galloway as described in the Strategic Plan the measurement/indicator supports.

Basic 'meta-data' indicating the measurement/indicator was last published; how frequently it is published; and who publishes it.

Each indicator in this report is prefixed with an "A", "B", "C" or "D" code. This refers to origin of the indicator:

Indicators with an "A" code are from the "Core Suite of Integration Indicators" defined by the Scottish Government.
Indicators with a "B" code are the NHS Publically Accountable Measures.
Indicators with a "C" code are the Local Authority Publically Accountable Measures for adult social work services.
Indicators with a "D" code are locally agreed measures.

National Outcomes

The Scottish Government has set out 9 national health and wellbeing outcomes for people. These outcomes are central to the strategic plan and the locality plans in Dumfries & Galloway. They are the long term objectives the Integration Joint Board are striving to achieve.

The progress Dumfries & Galloway is making towards achieving the national outcomes is measured in different ways: quantitative, qualitative, and process measures. Each measure may relate to more than one outcome but it is unlikely that any one measure will indicate progress to all outcomes at the same time. In this report, each measure is mapped to one or more of the national outcomes. Combined these measures provide an overall assessment of Dumfries & Galloway's progress towards these outcomes.

1. People are able to look after and improve their own health and wellbeing and live in good health for longer

2. 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

3. People who use health and social care services have positive experiences of those services, and have their dignity respected

4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services

5. Health and social care services contribute to reducing health inequalities

6. 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

7. People who use health and social care services are safe from harm

8. 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

9. Resources are used effectively and efficiently in the provision of health and social care services

Dumfries & Galloway Priority Areas

To deliver the 9 national health and wellbeing outcomes, the Strategic Plan identified 10 priority areas of focus. Each measure in this report is also mapped to one or more of these ten priority areas.

1. Enabling people to have more choice and control
2. Supporting carers
3. Developing and strengthening communities
4. Making the most of wellbeing
5. Maintaining safe, high quality care and protecting vulnerable adults
6. Shifting the focus from institutional care to home and community based care
7. Integrated ways of working
8. Reducing health inequalities
9. Working efficiently and effectively
10. Making the best use of technology.

Clinical and Care Governance

Overview

A1 The percentage of adults able to look after their health very well or quite well

A9 The percentage of adults supported at home who agree they felt safe

A11 European age-standardised mortality rate per 100,000 for people aged under 75

A12 The rate of acute emergency admissions per 100,000 adult population

A13 The rate of acute emergency admission bed days per 100,000 adult population

A15 Proportion of the last 6 months of life spent at home or in a community setting

A18 Percentage of adults (18+) with "intensive" social care needs who receive care at home

A19 Number of days people aged 75 or older spent in hospital when they are ready to be discharged, per 1,000 population

A21 Percentage of people admitted to hospital from home during the year, who are discharged to a care home

A22 Percentage of people who are discharged from hospital within 72 hours of being ready

B1 Percentage of cancer patients diagnosed at stage 1 for breast, colorectal and lung cancers combined

B2(1) Percentage of newly diagnosed cancer patients whose treatment started within 31 days of the decision to treat

B2(2) Percentage of people referred urgently with a suspicion of cancer that begin treatment within 62 days of receipt of the referral

B4 Percentage of people who have agreed to inpatient or day case treatment who have waited less than 12 weeks

B5 Percentage of people who waited less than 18 weeks from referral to treatment starting

B6 Percentage of patients waiting less than 12 weeks for a new outpatient appointment

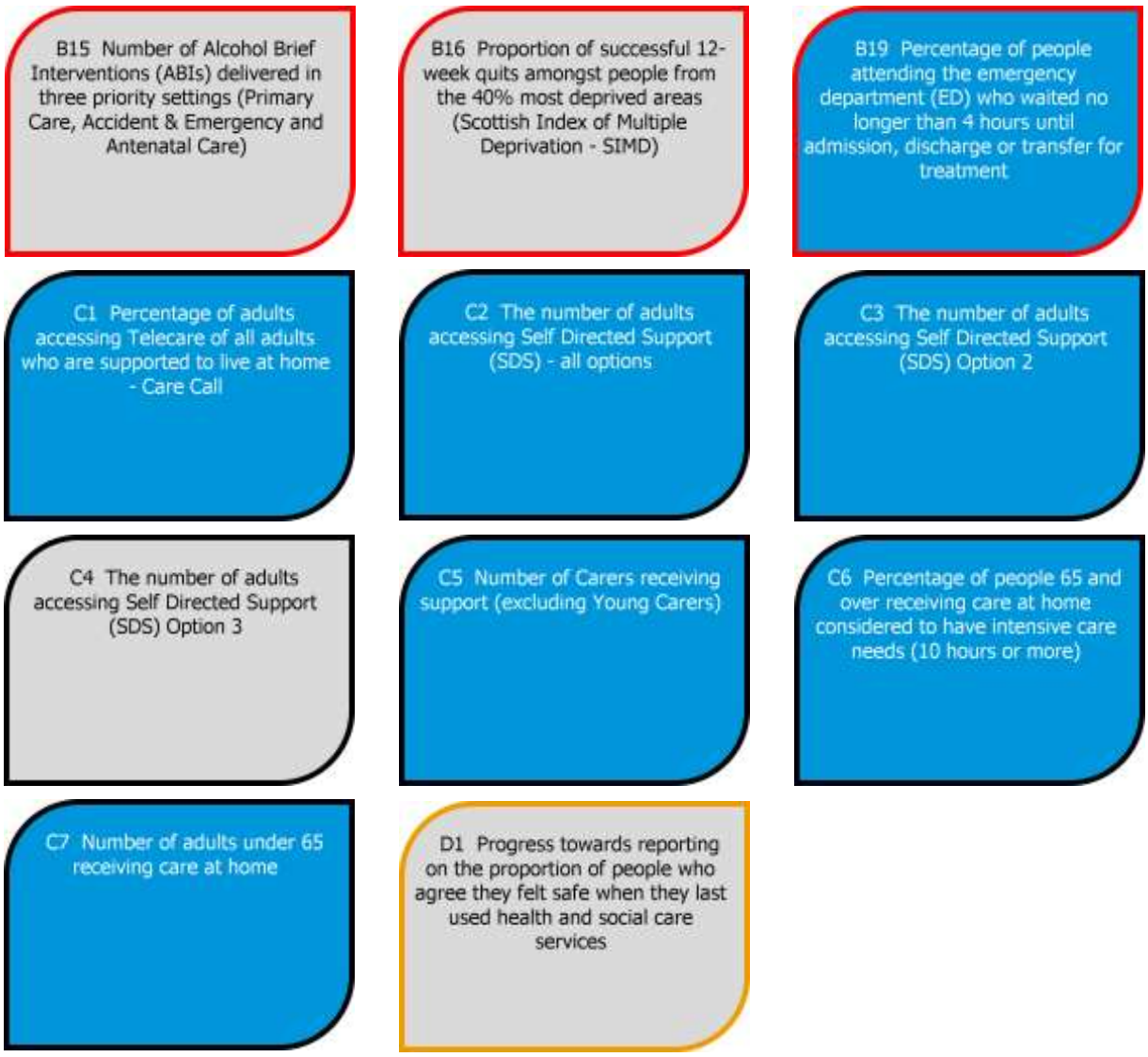
B8 Early access (booking by 12 weeks) to antenatal service in the worst performing SIMD (Health Board) quintile

B9 Percentage of eligible people who begin IVF treatment within 12 months

B10 Percentage of those who commence treatment for specialist Child and Adolescent Mental Health Services (CAMHS) within 18 weeks of referral

B11 Percentage of eligible patients who commence psychological therapies within 18 weeks of being referred

B14 Percentage of people who wait no longer than 3 weeks from when a referral is received to when they receive appropriate drug and alcohol treament that supports their recovery


B15 Number of Alcohol Brief Interventions (ABIs) delivered in three priority settings (Primary Care, Accident & Emergency and Antenatal Care)
B16 Proportion of successful 12-week quits amongst people from the 40% most deprived areas (Scottish Index of Multiple Deprivation - SIMD)
B19 Percentage of people attending the emergency department (ED) who waited no longer than 4 hours until admission, discharge or transfer for treatment
C1 Percentage of adults accessing Telecare of all adults who are supported to live at home - Care Call
C2 The number of adults accessing Self Directed Support (SDS) - all options
C3 The number of adults accessing Self Directed Support (SDS) Option 2
C4 The number of adults accessing Self Directed Support (SDS) Option 3
C5 Number of Carers receiving support (excluding Young Carers)
C6 Percentage of people 65 and over receiving care at home considered to have intensive care needs (10 hours or more)
C7 Number of adults under 65 receiving care at home
D1 Progress towards reporting on the proportion of people who agree they felt safe when they last used health and social care services

A19 Number of days people aged 75 or older spent in hospital when ready for discharge

National Outcomes: 1 2 3 4 5 6 7 8 9 | Dumfries & Galloway Priority Area: 1 2 3 4 5 6 7 8 9 10

Reported: 01/12/2017
Frequency: Quarterly
Source: Local

Number of days people aged 75 or older spent in hospital when they are ready to be discharged, per 1,000 population

Date	Actual	Desired trajectory	Predicted	Dumfries & Galloway 12 month average	Scotland 12 month average
Jan-Mar 17	457.8	661	671	593	842
Apr-Jun 17	508.1	680	700	569	813
Jul-Sep 17	632.7	699	729	594	797

Key Points

Based on historic data, the rate of delayed discharges for people aged 75 or older was predicted to nearly double by March 2019. A desired trajectory was calculated to show 10% improvement, in line with the focus of the national Health and Social Care Delivery Plan (published December 2016).
Since December 2016, the 12 month average number of days people aged 75 or older were delayed prior to discharge from hospital has remained just below 600 days per 1,000 people.
The rate of delayed discharges has remained lower than Scotland and also lower than either the prediction or the desired trajectory, which suggests that the performance is better than had been expected.

The Wider Context

The delayed discharge rate is an indicator of how timely people flow through the health and social care system. Reducing delayed discharges is part of the national focus to reduce unscheduled bed-days in hospital care by up to 10 per cent.

Improvement Actions

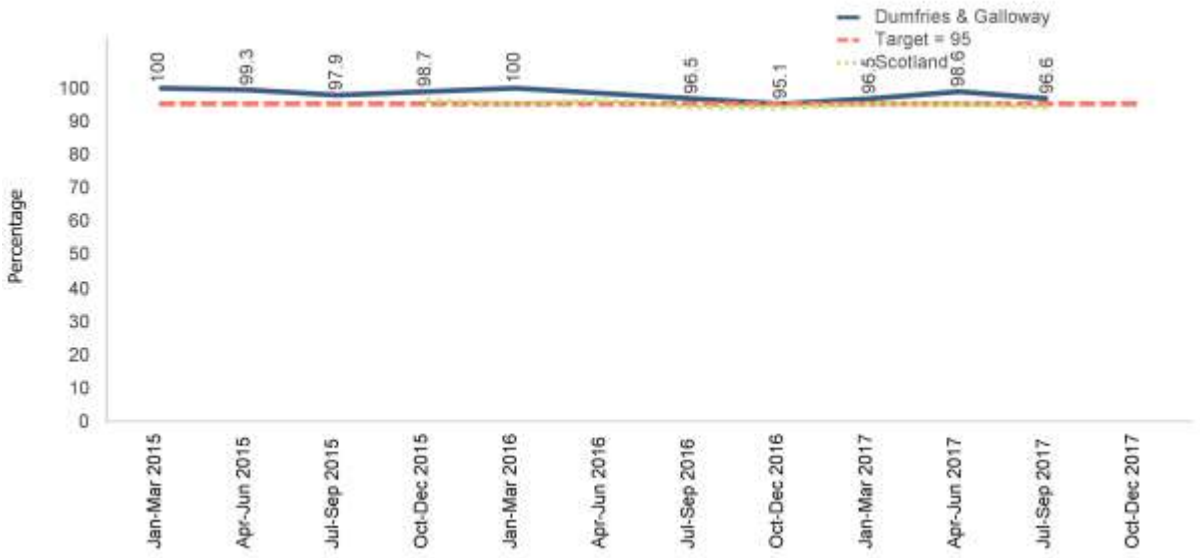
In the October 2017 Community Day of Care survey, the most frequent reason for delayed discharge was Home Care support availability/funding.
The “Step Down” model is being used in the Lochmaben hospital, where appropriately skilled teams support people to return to their homes and the hospital environment is being made more suitable for this work.
Flow coordinators are active in each locality, working with the Dumfries and Galloway Royal Infirmary to help coordinate people returning home or to a more suitable setting.
A project to publicise Power Of Attorney (POA) is being run across the area. POA helps family and Carers make appropriate decisions in a timely way when people come into hospital.
A local programme is currently exploring ways to develop Anticipatory Care Plans (ACP), in line with national work. There is also ongoing work on electronic key information summaries (eKIS). These documents clarify people’s personal situations and medical preferences.

B2(1) Cancer waiting times (part 1)

National Outcomes: 1 2 3 4 5 6 7 8 9 | Dumfries & Galloway Priority Area: 1 2 3 4 5 6 7 8 9 10

Reported: 01/12/2017
Frequency: Quarterly
Source: ISD Scotland

Percentage of newly diagnosed cancer patients whose treatment started within 31 days of the decision to treat



Key Points

In Dumfries and Galloway the percentage of people who had started treatment within 31 days of the decision to treat was 96.6% in September 2017. This is above the Scottish national rate of 94.5% and the national target of 95%.

The Wider Context

Per month, approximately 50 people in Dumfries and Galloway are newly diagnosed with a reportable cancer that goes on to be treated. This small number of people means that marked fluctuations in performance can be caused by just one or two diagnoses. Cancer pathways for people living in this area often involve onward referral to other health boards for further investigation or treatment depending on the tumour site. Our performance can therefore be directly impacted by capacity and service challenges in other health board areas. We are involved in ongoing discussions with the Scottish Government and regional cancer networks to address issues relating to cancer waiting times.

Improvement Actions

The acute services operational team hold weekly meetings to assess performance against waiting times, identify any instances where particular cases need to be prioritised and agree actions to reduce delays. The cancer tracking team are able to raise issues as they arise and, on a daily basis if required, before they impact on services. A programme of work is underway to deliver recommendations on the diagnosis and treatment pathways to tertiary centres (typically Edinburgh and Glasgow) on a tumour by tumour basis.

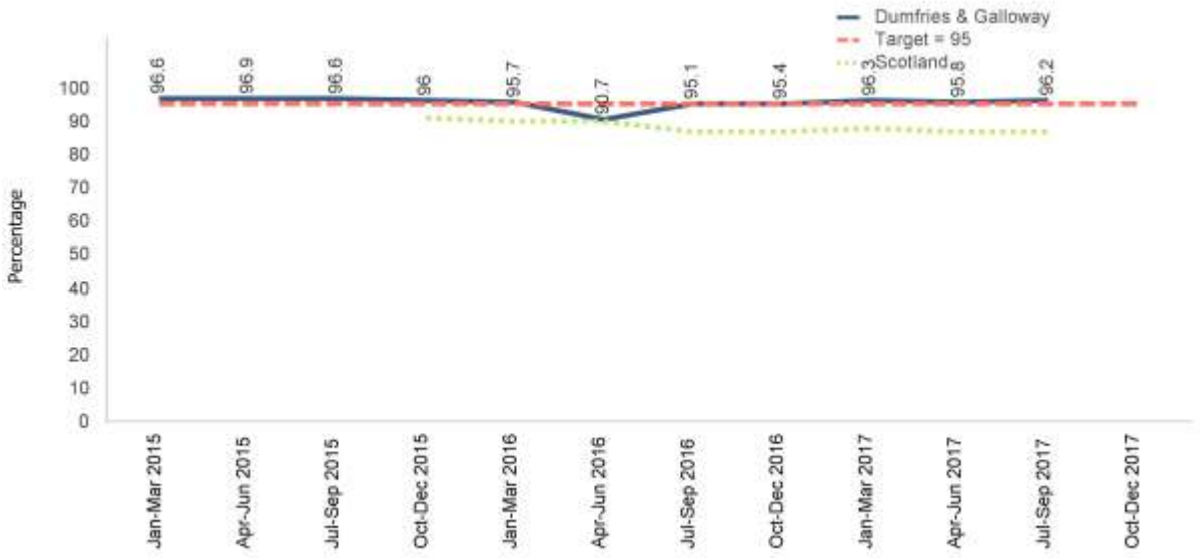
Cancer services in Dumfries and Galloway will continue to work to deliver care, support and treatment that is compassionate and person centred to those affected by a cancer diagnosis. We will work closely with both South East Scotland Cancer Network (SCAN) and the West of Scotland Cancer Network (WoSCAN) to ensure ongoing quality and safety during changes in care pathways for those accessing cancer services.

B2(2) Cancer waiting times (part 2)

National Outcomes: 1 2 3 4 5 6 7 8 9 | Dumfries & Galloway Priority Area: 1 2 3 4 5 6 7 8 9 10

Reported: 01/12/2017
Frequency: Quarterly
Source: ISD Scotland

Percentage of people referred urgently with a suspicion of cancer that begin treatment within 62 days of receipt of the referral



Key Points

Dumfries and Galloway's performance remains consistently high and was 96.2% in September 2017. This is above the national target of 95% for this indicator and above the rate for Scotland of 87.2%.

The Wider Context

Per month, across Dumfries and Galloway, there are approximately 30 people (aged 16+) diagnosed with cancer who are eligible for this target. This small number means that marked fluctuations in performance can occur by just one or two more or less people being referred for treatment.

Improvement Actions

Performance against the 62 day target is also influenced by onward referrals to other Health Boards. The close communication between the local team and tertiary centres enable this target to be met.

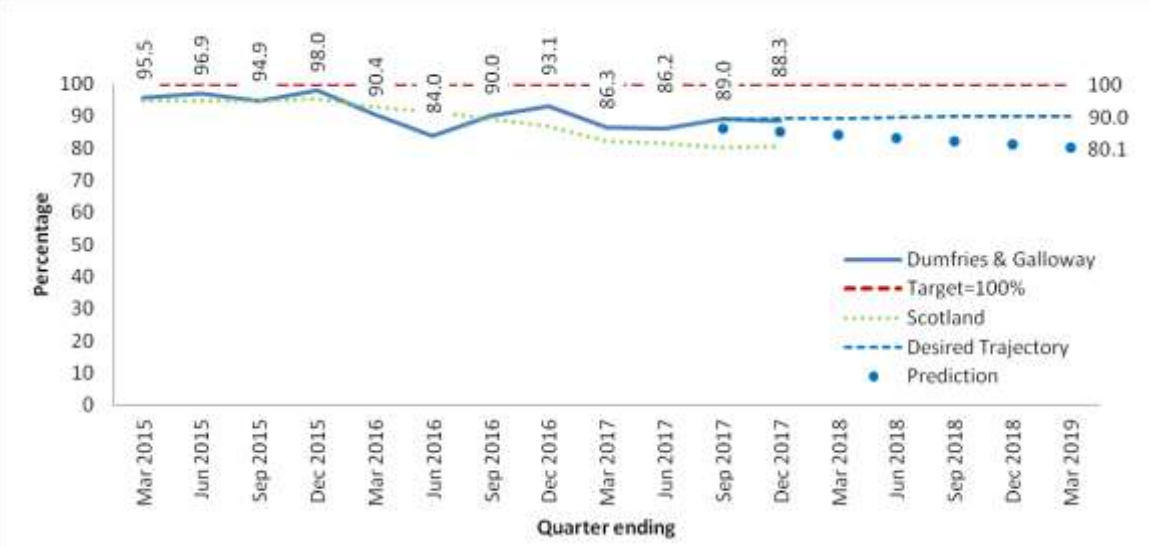
Dumfries and Galloway is part of the South East Scotland Cancer Network (SCAN), which also includes NHS Lothian, NHS Fife, and NHS Borders and as such continually works with regional colleagues to address capacity challenges.

We will continue to work closely with both South East Scotland Cancer Network (SCAN) and the West of Scotland Cancer Network (WoSCAN) to ensure ongoing quality and safety during changes in care pathways for those accessing cancer services.

B4 Treatment time guarantee (TTG)

National Outcomes	Dumfries & Galloway Priority Area		
1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9 10	Reported:	01/12/2017
		Frequency:	Quarterly
		Source:	ISD Scotland

Percentage of people who have agreed to inpatient or day case treatment who have waited less than 12 weeks



Key Points

Dumfries and Galloway's performance was 88.3% in the quarter ending December 2017. The longer term trend for this indicator is downward. Dumfries and Galloway's performance is currently below the national target of 100%.

Improvement work around waiting times will focus on actions aiming to return the system to greater stability, with the ambition to achieve above 90% of people treated within 12 weeks consistently by March 2019.

The Wider Context

The Scottish rate in the quarter ending December 2017 was 80.4%.

In Dumfries and Galloway 260 people who were treated in December 2017 had waited more than 12 weeks, which is fewer than in the previous quarter.

Figures for the December quarter do not reflect normal activity, due to the particular efforts of the clinical teams to manage activity in such a way as to enable the smooth transition into the new Dumfries and Galloway Royal Infirmary.

Improvement Actions

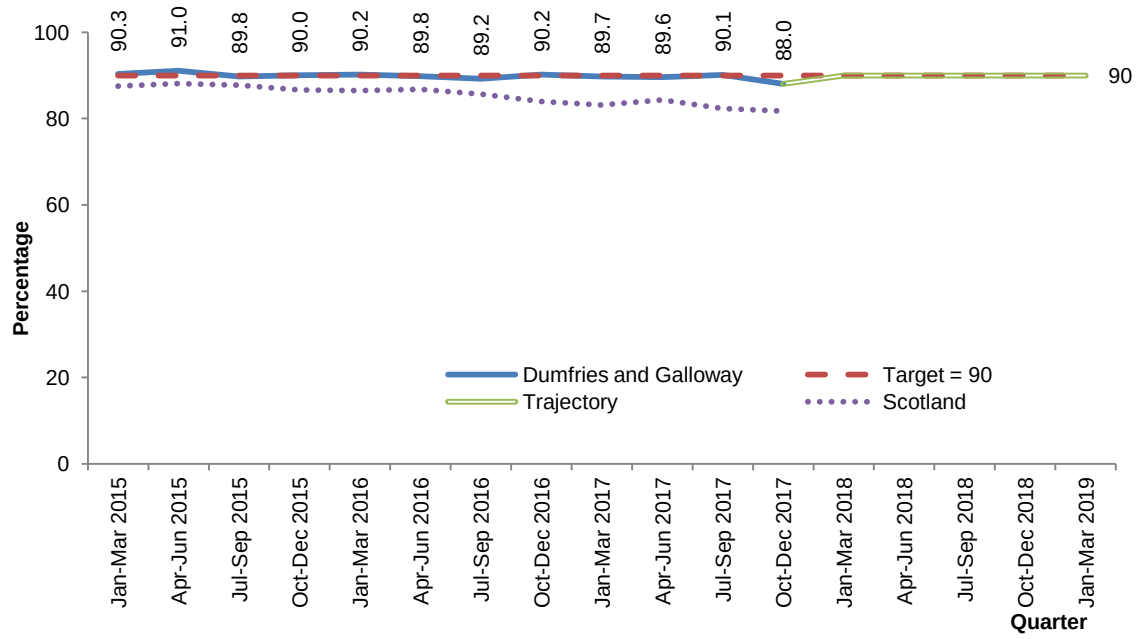
The level of medical vacancies, which currently sits at 20%, continues to impact on this indicator. Our recruitment strategy is being re-energised through the use of a private recruitment agent to help fill long term vacancies and to source applicants. Efforts are continuing to find appropriately skilled locums but these can be challenging to get hold of. This has an adverse impact on capacity and the ability to develop sustainable improvements.

There is current work on operating theatre efficiencies and list sizes, particularly around aligning ophthalmology activity. In orthopaedics there is improvement work ongoing as part of cash releasing efficiency savings (CRES) reviews. There are further discussions about how boards work together at a regional level and with the Golden Jubilee hospital.

B5 18 weeks referral to treatment

National Outcomes	Dumfries & Galloway Priority Area		
1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9 10	Reported:	01/12/2017
		Frequency:	Quarterly
		Source:	ISD Scotland

Percentage of people who waited less than 18 weeks from referral to treatment starting



Key Points

The percentage of people treated within 18 weeks of referral was 88.0% between October and December 2017, against a target of 90%. The Scottish rate for the same period was 81.7%.

The rate for Dumfries and Galloway has remained relatively stable over time.

The trajectory for this indicator is to aim to continue to deliver the 90% target.

The Wider Context

Indicator B5 differs from indicator B4 (treatment time guarantee) and indicator B6 (12 weeks to first outpatient appointment) in that it considers the whole pathway of care from referral to the point a person receives treatment as opposed to just one part of this pathway. Improvements in performance against indicators B4 and B6 will positively impact on indicator B5.

Figures for the December quarter will not reflect normal activity, due to the particular efforts of the clinical teams to manage activity in such a way as to enable the smooth transition into the new Dumfries and Galloway Royal Infirmary.

Improvement Actions

Stabilising the previous indicator, B4 - 12 week Treatment Time Guarantee, is a priority for the acute and diagnostic management team. This will have a positive knock on effect on this 18 week indicator.

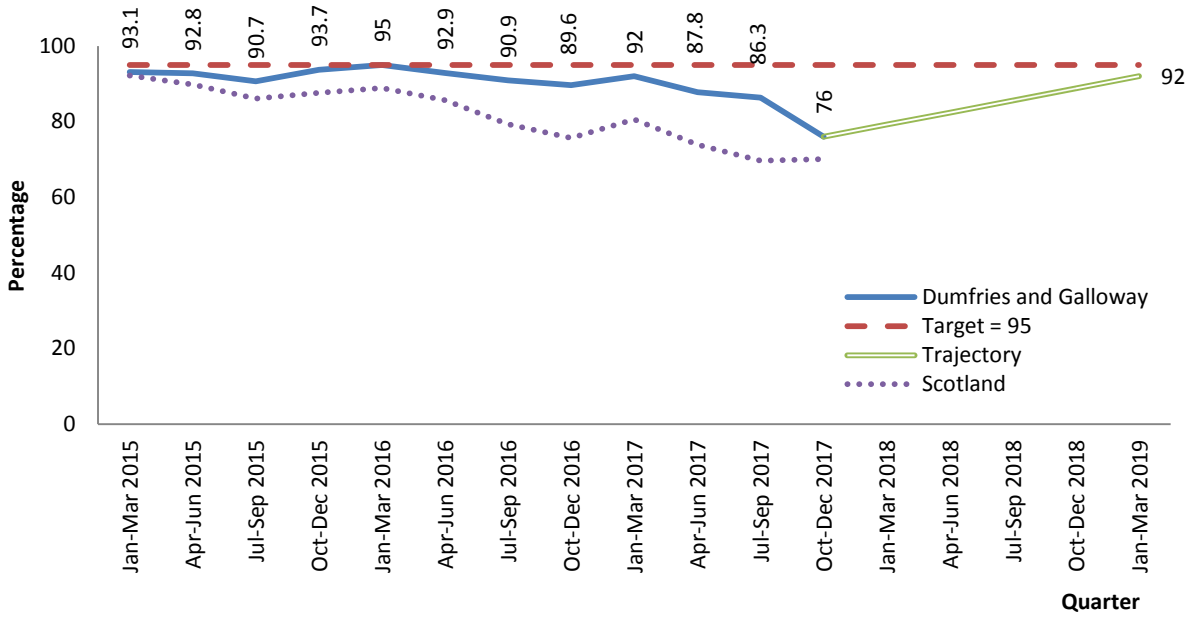
The management team is undertaking demand, capacity, activity and queuing (DCAQ) modelling to better identify and make best use of available capacity.

Clinicians and staff are benefiting from the Clinical Portal, which provides linked electronic patient information. The 60 millionth piece of paper was scanned in January 2018. The Clinical Portal aims to provide access to the right information in the right place at the right time.

B6 12 weeks first outpatient appointment

National Outcomes 1 2 3 4 5 6 7 8 9 | Dumfries & Galloway Priority Area 1 2 3 4 5 6 7 8 9 10 | Reported: 01/12/2017 | Frequency: Quarterly | Source: ISD Scotland

Percentage of patients waiting less than 12 weeks for a new outpatient appointment



Key Points

Across Dumfries and Galloway, the percentage of people waiting less than 12 weeks for a first outpatient appointment was 76.0% in the month of December 2017.

Dumfries and Galloway's performance is currently below the national target of 95% and has declined since March 2017 when the percentage was 92.0%.

The Scottish rate was 70.1% in the month of December 2017.

The Wider Context

NHS Dumfries and Galloway's first Annual Operational Plan (AOP) replaces the Local Delivery Plan. The AOP has been produced in line with guidance received from the Scottish Government's NHS Scotland Director of Performance and Delivery on 9th February 2018. The guidance sets out a minimum aim to return to/at least maintain waiting times at the level they were on 31st March 2017.

This sets an improvement trajectory to return to 92.0% by March 2019. In addition to this, the aim is reduce the number of people waiting over 26 weeks by 50%.

Improvement Actions

An improvement programme is underway to ensure that the access policy is applied consistently. This should enable people waiting for treatment to be managed in the most appropriate way, offering people choice and the most suitable appointments. This person centred approach is expected to reduce the number of people who do not attend their appointments.

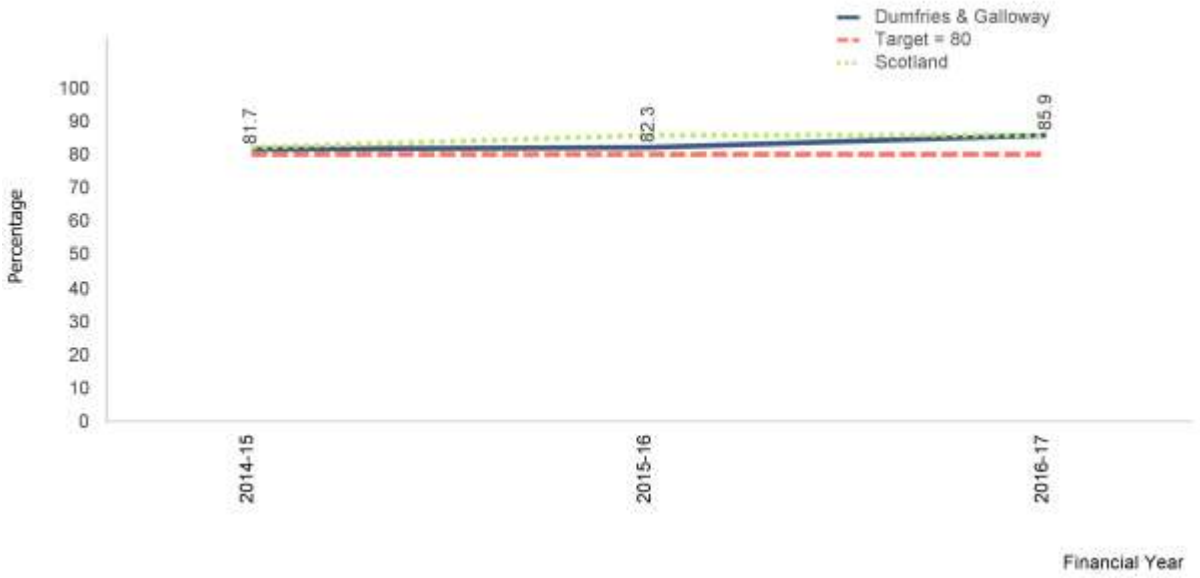
In Urology there is a good example of regional collaborative working. Visiting support has been offered by Ayrshire and Arran to address staff vacancy in Dumfries and Galloway. This has reduced waiting times for appointments and subsequent return appointment bookings have been timelier.

B8 Antenatal access

National Outcomes: 1 2 3 4 5 6 7 8 9 | Dumfries & Galloway Priority Area: 1 2 3 4 5 6 7 8 9 10

Reported: 01/12/2017
Frequency: 1 Year
Source: ISD Scotland

Early access (booking by 12 weeks) to antenatal service in the worst performing SIMD (Health Board) quintile



Key Points

For the financial year 2016/17, across Dumfries and Galloway 85.9% of pregnant women were booked by the 12th week of gestation. The corresponding rate for Scotland was 86.0%.

Dumfries and Galloway's performance is above the national target of 80%.

The Wider Context

Deprivation and performance amongst the most deprived communities is a key focus for this indicator with the Scottish Government stipulating that the target of 80% should be achieved across all quintiles of the Scottish Index of Multiple Deprivation (SIMD).

It is anticipated that Dumfries and Galloway will continue to achieve the target of 80% and that the current risk of failing to achieve this standard is minimal.

Improvement Actions

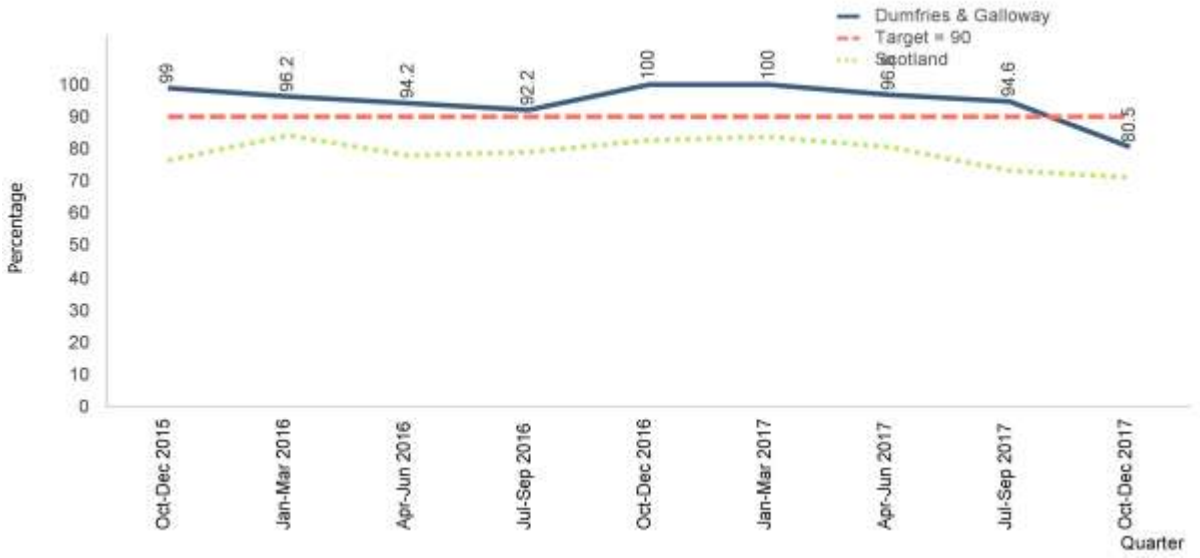
Implementation of the BadgerNet maternity information system in October 2016 has helped to streamline the referral process with direct electronic referral to midwives rather than clerical teams. Previous pregnancy records are now accessed through context launch from BadgerNet to Clinical Portal enabling instant access to past clinical information that is required for the booking process. A pregnancy indicator is also visible within Clinical Portal which highlights to non maternity staff that the woman is pregnant.

Through multi agency working and appropriate information sharing, there is easier access to comprehensive up to date information. Vulnerable pregnant women are being identified earlier and are being advised and encouraged to access early antenatal care directly from the community midwifery teams. This supports quality driven care and improved patient outcomes.

B10 Child and Adolescent Mental Health Services (CAMHS) waiting times

National Outcomes	Dumfries & Galloway Priority Area		
1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9 10	Reported:	01/12/2017
		Frequency:	Quarterly
		Source:	ISD Scotland

Percentage of those who commence treatment for specialist Child and Adolescent Mental Health Services (CAMHS) within 18 weeks of referral



Key Points

In the quarter ending December 2017, across Dumfries and Galloway, 80.5% of people referred to CAMHS commenced treatment within 18 weeks of referral, which is below the national target of 90%. Dumfries and Galloway remains above the overall rate for Scotland, 71.1%.

The Wider Context

CAHMS waiting times delivery has historically been above the 90% target. However, in the October to December 2017 period, unusual circumstances caused an unexpected mismatch between capacity and demand. This meant that the appointments available were unable to fully meet the demand for CAMHS treatment, and fewer people were treated within 18 weeks (73.5% in October 2017). In November and December 2017 the percentage of people treated within 18 weeks had increased to 80% and 88% respectively, and we expect the January to March 2018 quarter to continue to improve.

Improvement Actions

All referrals are screened 3 times a week. Urgent referrals are prioritised and assessed that day or the next. Clinicians are reviewing all urgent referrals and ward based assessments to improve processes within the service and the experience of young people.

A primary Mental Health Worker based in a GP practice in Dumfries is booking young people directly into appointments for assessment and treatment, enabling a timely and appropriate level of brief intervention to be offered, without unnecessary waiting time to CAMHS.

A school referral model is currently being used in 2 schools in Dumfries. The model of consultation as a first step is agreed with education staff as the most appropriate way to decide if a CAMHS assessment should be further considered.

An improvement project for young people with Autism Spectrum Disorder and Mental Health difficulties is being undertaken. Families who would meet this criteria are identified from screening enabling direct and timely contact to be made with them.

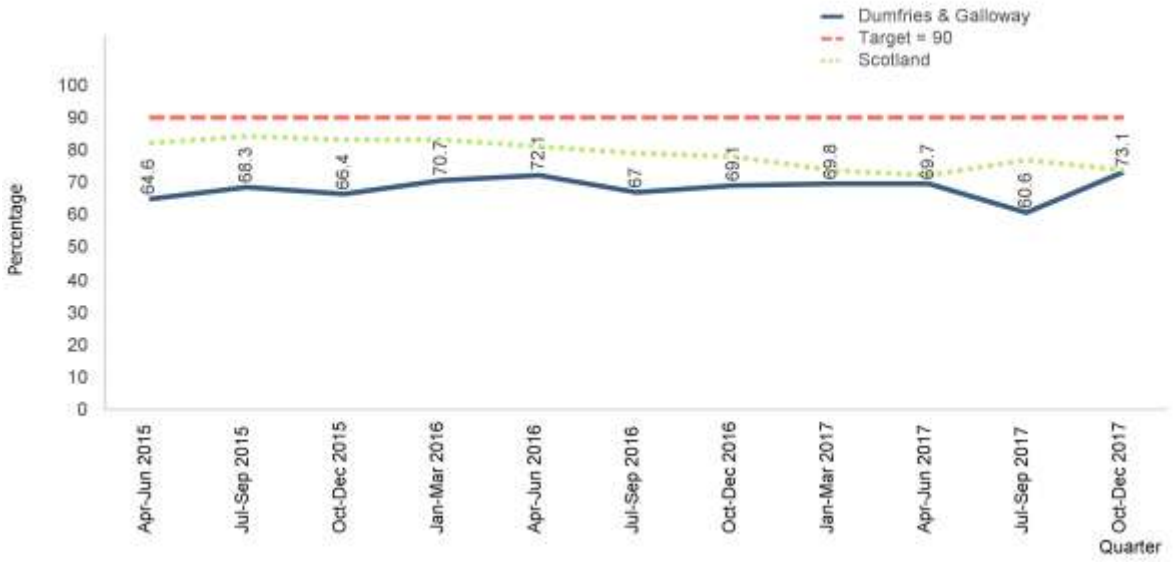
To reduce the number of people who do not attend their appointments, we send out text reminders. A more time efficient IT reminder solution called “Netcall” remains a long term consideration.

B11 Psychological therapies waiting times

National Outcomes: 1 2 3 4 5 6 7 8 9 | Dumfries & Galloway Priority Area: 1 2 3 4 5 6 7 8 9 10

Reported: 01/12/2017
Frequency: Quarterly
Source: ISD Scotland

Percentage of eligible patients who commence psychological therapies within 18 weeks of being referred



Key Points

Between October and December 2017, the percentage of eligible new people across Dumfries and Galloway who commenced psychological therapies within 18 weeks of being referred was 73.1% (against a national target of 90%). The figure for Scotland was 73.7%.

The Wider Context

Approximately 340 new people, including around 40 people for computerised Cognitive Behavioural Therapy (cCBT) and approximately 1,000 return appointments are seen every month for psychological therapies across Dumfries and Galloway. Since July 2016, reductions to the hours worked by staff have resulted in the equivalent of the loss of 1 full time clinical person. This has reduced overall capacity in the psychological therapies teams. Additionally there are continuing challenges of planned long term absences.

The referral rate of 6.1 per 1,000 population for Dumfries and Galloway is generally amongst the highest in Scotland, with 951 referrals. Approximately 254 people have been referred for cCBT in the 9 months from April 2017, when this service was introduced.

Improvement Actions

Demand, capacity, activity and queue (DCAQ) analysis is ongoing to better understand and manage the imbalance between referrals and first appointments. The team are keen to ensure that increased efficiency does not impact on the quality of the clinical care.

Alternative avenues to care for clients who are less able to commit to intensive courses of psychological therapy have been developed. Low intensity interventions include computerised cognitive behavioural therapy (cCBT) and seeing the Primary Care Liaison. How people progress from these programmes into secondary care is being analysed to explore the effectiveness of these services.

A permanent psychology role has been successfully recruited, starting in April 2018. When the new staff member joins, this post will have been vacant for 1 year, which has impacted on waiting times. A locum has been recruited to work on waiting lists until the new permanent staff member joins.

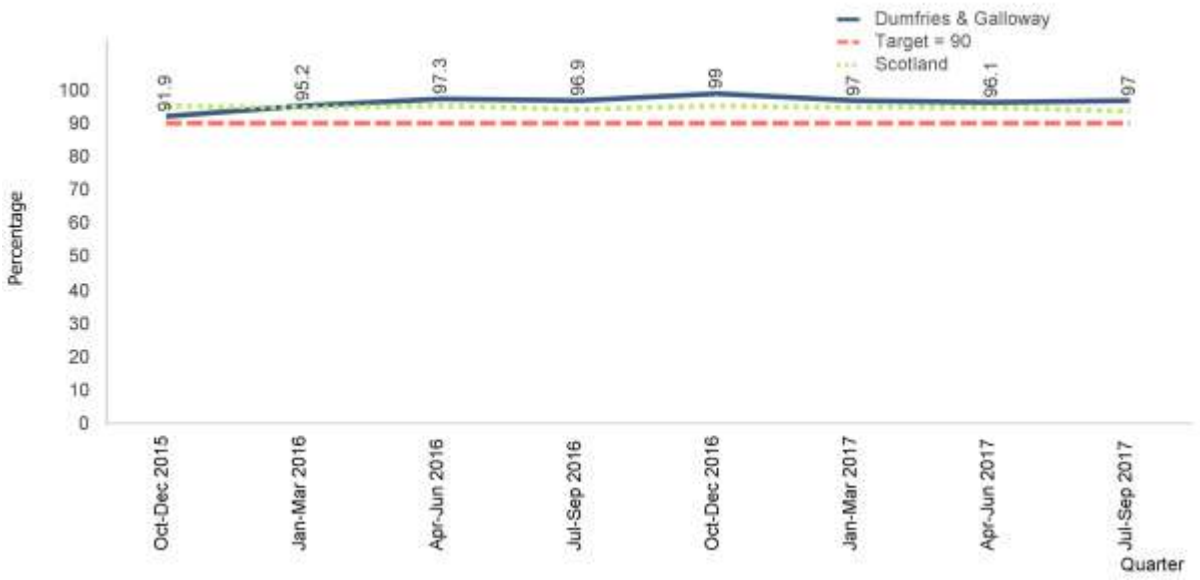
In Dumfries, a service for people who have frequent attendances at GP practice is anticipated to start in the next financial year.

B14 Drug and alcohol treatment waiting times

National Outcomes: 1 2 3 4 5 6 7 8 9 | Dumfries & Galloway Priority Area: 1 2 3 4 5 6 7 8 9 10

Reported: 01/12/2017
Frequency: Quarterly
Source: ISD Scotland

Percentage of people who wait no longer than 3 weeks from when a referral is received to when they receive appropriate drug and alcohol treament that supports their recovery



Key Points

Across Dumfries and Galloway during the 3 months ending September 2017, 97.0% of people referred for drug and alcohol treatment started treatment within 3 weeks.

The rate for Dumfries and Galloway is above the national target of 90% and above the Scotland rate of 93.8%.

The Wider Context

This indicator is based on episodes of care. An episode of care is the time between a person's initial referral for alcohol or drug treatment and the end of treatment. People are counted in this indicator when their episode of care is concluded. Between July to September 2017 there were 498 people referred (313 for alcohol and 185 for drugs), and 202 complete episodes of care (planned discharges only) across Dumfries and Galloway.

Improvement Actions

Referrals have increased 11% in the period July to September 2017 when compared to the previous quarter (when 449 people were referred). Monitoring of these will continue during 2017/18. In addition to medical input from the NHS, Alcohol and Drugs Partnership (ADP) commissions 3rd sector organisation to provide a range of recovery interventions. ADP is directly funded by Scottish government.

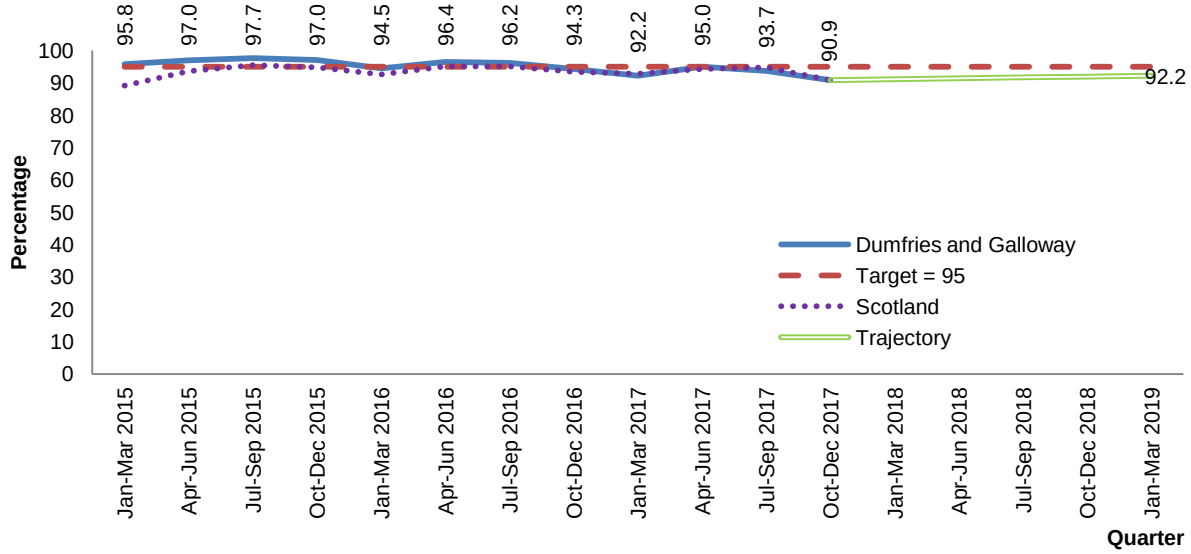
It is anticipated that the waiting times target will continue to be achieved through 2017/18.

The national Drug and Alcohol Information System (DAISy) is due to go live in April 2018. All ADP partnership services will be participating with this system. Work is ongoing to ensure a smooth transition from the existing SDMD database to the new DAISy system.

B19 Emergency department waiting times

National Outcomes 1 2 3 4 5 6 7 8 9 | Dumfries & Galloway Priority Area 1 2 3 4 5 6 7 8 9 10 | Reported: 01/12/2017 | Frequency: Quarterly | Source: ISD Scotland

Percentage of people attending the emergency department (ED) who waited no longer than 4 hours until admission, discharge or transfer for treatment



Key Points

The percentage of people attending an emergency department (ED) who were seen within 4 hours was 90.9% between October and December 2017. Dumfries and Galloway's performance against this indicator has reduced this quarter and is below the national target of 95%. For Scotland, the rate was 90.8%.

The Wider Context

December 2017 was a particularly difficult month for the ED, with unprecedented levels of winter illness such as flu, seen in Dumfries and Galloway and across the UK.

NHS Dumfries and Galloway's first Annual Operational Plan (AOP) replaces the Local Delivery Plan. The AOP has been produced in line with guidance received from the Scottish Government's NHS Scotland Director of Performance and Delivery on 9th February 2018. The guidance sets out a minimum aim to return to/at least maintain waiting times at the level they were on 31st March 2017. This sets an improvement trajectory to return to 92.2% by March 2019.

Improvement Actions

There have been some operational challenges with new ways of working in the new hospital, new clinical pathways and the impact one of the busiest winters. Despite these challenges Dumfries and Galloway performed no worse than Scotland as a whole.

In addition to the traditional publicity campaign "Meet ED", social media has been used effectively to advise people how to get appropriate medical advice, when to use the ED and to warn when the hospital has been particularly busy. Despite the flu, diarrhoea and vomiting bugs, the new Dumfries and Galloway Royal Infirmary (DGRI) has not closed any wards.

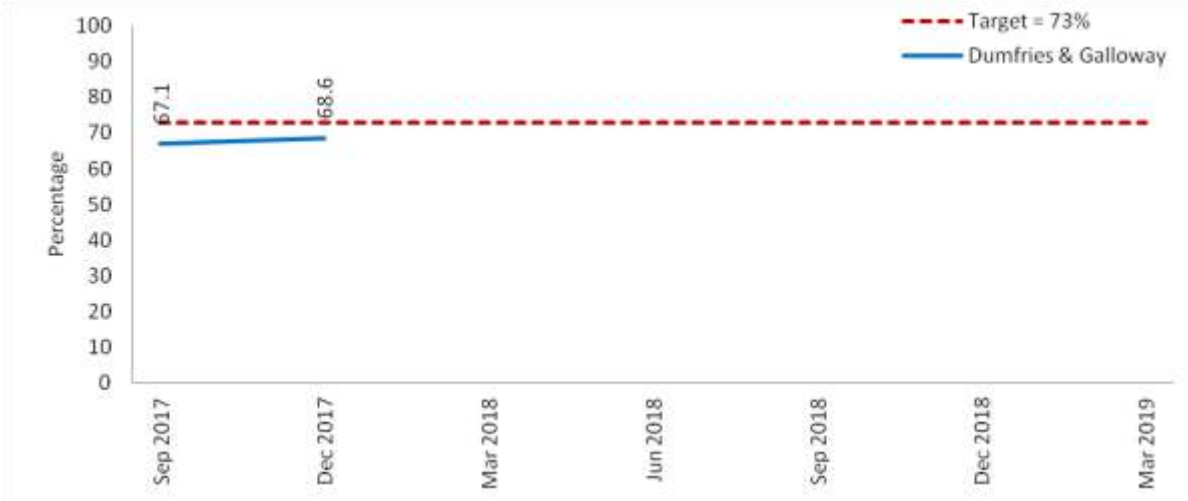
We are working with Scottish Government quality improvement team to improve flow through the hospital and there is a dedicated team in place for this. People can be referred to the new Combined Assessment Unit (CAU) from a number of sources, so at particular times of day the CAU can become busy. The CAU in the new hospital has treated 1,703 people since opening in December, which is an average of 243 people per week.

The previous hospital could only provide critical care beds for 4-5 people. The new DGRI has accommodated up to 7 people with severe respiratory problems at once this winter. In the past the additional people would have had to be transferred to other facilities, which is a positive outcome for these people.

C1 Adults accessing Telecare as a percentage of the total number of adults supported to live at home

National Outcomes	Dumfries & Galloway Priority Area		
1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9 10	Reported:	01/12/2017
		Frequency:	Quarterly
		Source:	Dumgal Council

Percentage of adults accessing Telecare of all adults who are supported to live at home - Care Call



Key Points

The percentage of adults supported to live at home who are accessing telecare was 67.4% in December 2017.

In December 2017, there were 2,891 people using Care Call technology across the region, which is a 4% increase on the previous quarter. This amounts to around 10,000 calls per month, of which less than 10% required a physical response.

The Wider Context

In July 2017, the move from Framework-i to the Mosaic computer system gave the opportunity to review the definitions of how this indicator was calculated and to tidy old records. Therefore the current values for this indicator are not comparable with previous figures. Only telecare provided to users of the social work service are included in this definition. The previous target of 73% has not been changed.

This measure only relates to Care Call, which is a 24 hour monitoring service, based on an emergency button which links through to a call responder.

There is 'lead-in' time to the introduction of any telecare, enabling discussions with the person regarding their choices and learning to confidently use the equipment. There is a new national Digital Health and Social Care Strategy 2017-22, due very soon, which will integrate the Technology Enabled Care (TEC) programme and e-health strategy for Scotland.

Improvement Actions

The telehealthcare team (based within DG Council customer services) consists of 4 technician assessors and 3 Carecall officers. Social workers continue to carry out assessments where people have more complex needs.

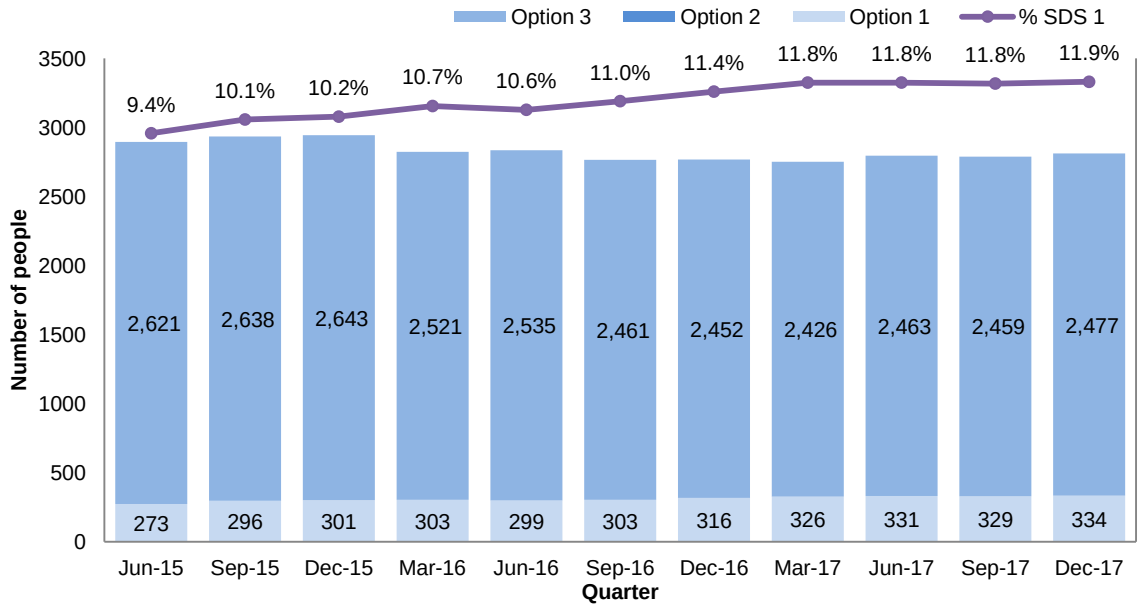
During Digital Health and Social care week in November 2017, a video was launched entitled "Live independently with telecare" and a demonstration flat at JM Barrie house in Dumfries showcased telecare, sensory support, Occupational Therapy and dementia friendly equipment.

Telecare training was provided by the Telecare Services Association to staff from the Short Term Assessment & Reablement Service (STARS), Occupational Therapy and Sensory Support. Further training has taken place in March for staff across the partnership.

C2-C4 Number of adults receiving care at home via SDS Option 1, 2 and 3

National Outcomes	Dumfries & Galloway Priority Area		
1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9 10	Reported:	01/12/2017
		Frequency:	Quarterly
		Source:	Dumgal Council

The number of adults accessing Self Directed Support (SDS) - all options



Key Points

These are Data Only indicators, which do not have targets or benchmarking associated with them. Increasing the proportion of people accessing SDS through Option 1 is seen as positive.

At the end of the quarter, a snapshot in December 2017 showed the number of adults receiving care at home through Self Directed Support (SDS) were 334 people through Option 1, 0 people through Option 2 and 2,477 people through Option 3.

The total number of people being support by SDS has remained stable since June 2016. In the December 2017, this was 2,811 people.

The Wider Context

SDS Option 1 enables people to take ownership and control of arranging and managing their own care. SDS Option 2 enables people to choose their provider of care and Social Work services organise, purchase and manage care for people. SDS Option 3 is where Social Work services organise, purchase and manage care for people.

Improvement Actions

There is a gradual increase in the number of people choosing Option 1, as more people become confident to take control of managing their own care and support.

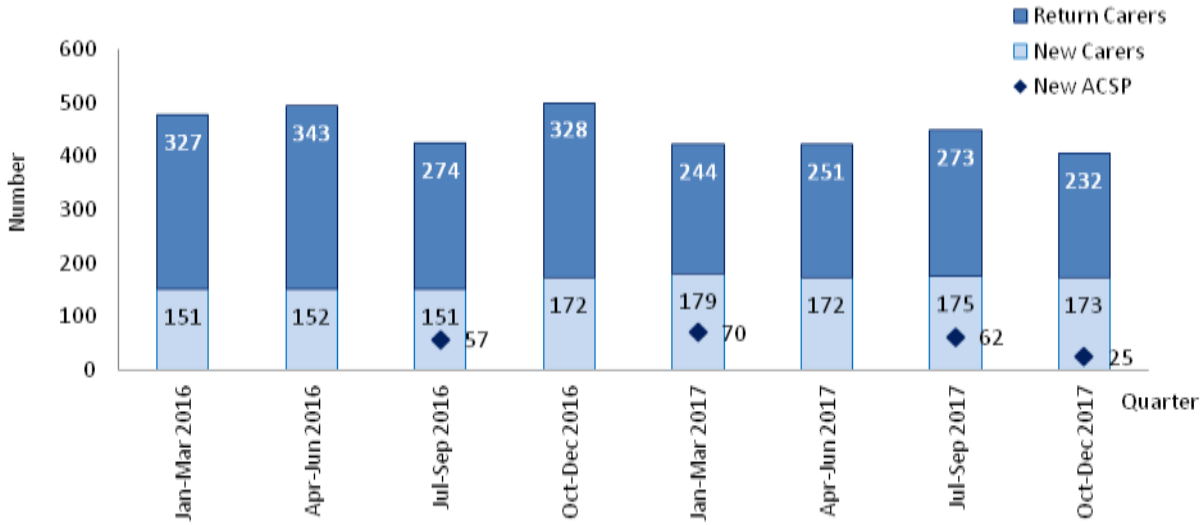
Officers are working with several organisations to support them to develop SDS Option 2. The arrangements required to deliver SDS Option 2 effectively are complex and discussions with providers are ongoing. Winter pressures have made rolling out Option 2 more challenging.

Option 3 remains a popular choice for many older people, who may chose not to manage their own care.

C5 Carers receiving support (excluding Young Carers)

National Outcomes	Dumfries & Galloway Priority Area		
1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9 10	Reported:	01/12/2017
		Frequency:	Quarterly
		Source:	Dumgal Council

Number of Carers receiving support (excluding Young Carers)



Key Points

There were 25 new Adult Carer Support Plans (ACSP) completed in the quarter October to December 2017 by the Carers' Centre.

The Dumfries and Galloway Carers' Centre saw 173 new adult Carers between October and December 2017 and 232 returning Carers used their services. The Carers' Centre also conducted 435 One-to-Ones with Carers. Alzheimer Scotland had 1,006 existing Carers whilst Support in Mind had 138 existing Carers and 6 new Carers between October and December 2017 (there may be overlap between these 3 organisations).

The Wider Context

There are a number of organisations across Dumfries and Galloway who provide support to Carers. The Carers' Centre is commissioned to deliver Adult Carer Support Plan assessments. Only a small proportion of Carers will require an ACSP and fewer still will require social care resources.

Identifying Carers is a key priority and a requirement of the Carers (Scotland) Act 2016, due to commence on 1st April 2018. It is anticipated that the Scottish Government will publish draft guidelines to support the implementation of the Carers (Scotland) Act 2016 prior to this date.

Improvement Actions

The Carers Strategy was approved by the IJB on the 29th November 2017. Work to implement this strategy is being developed. There was a consultation between October and December 2017 on the eligibility criteria for Carers' support. The results of this consultation will be taken to a future IJB committee.

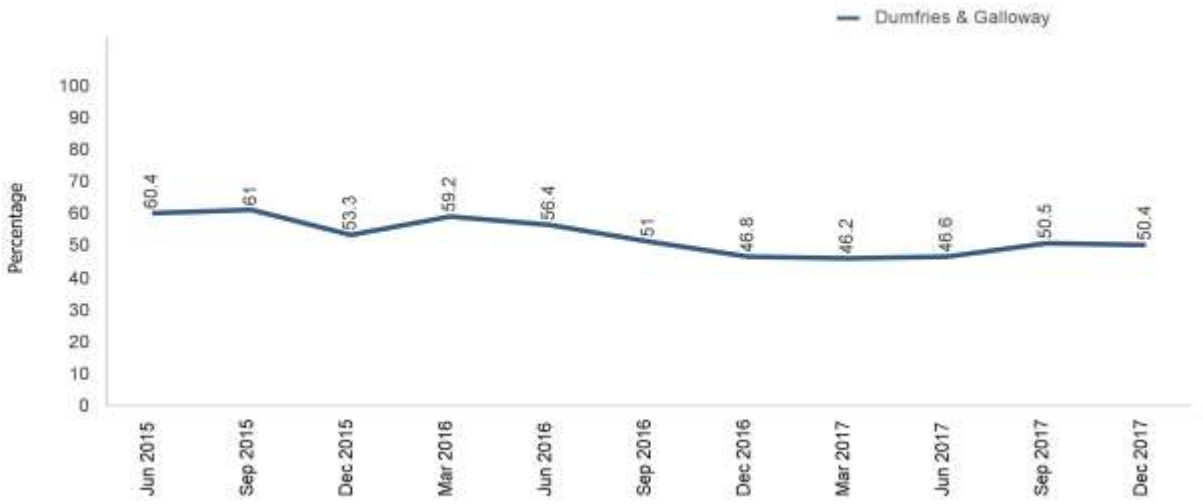
A National Carers dataset has been launched, and a scoping exercise is planned to assess the existing data and IT infrastructure in readiness to implement the Carers' census.

In addition to ACSPs, it is anticipated that other support will be provided to Carers through third and independent sector providers.

C6 Proportion of people 65 and over receiving care at home (via Option 3) with intensive care needs

National Outcomes	Dumfries & Galloway Priority Area		
1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9 10	Reported:	01/12/2017
		Frequency:	Quarterly
		Source:	Dumgal Council

Percentage of people 65 and over receiving care at home considered to have intensive care needs (10 hours or more)



	2011-12	2012-13	2013-14	2014-15	2015-16
Dumfries & Galloway	51.1	47.6	40.0	51.4	41.1
Scotland	33.0	34.1	34.3	35.3	34.8

Key Points

This is a Data Only indicator, which does not have a target associated with it.

In December there were 916 people being supported with 10 hours or more of care at home provision. This was 50.4% of all people aged 65 and over receiving care at home through Self Directed Support (SDS) Option 3.

Published results show that Dumfries and Galloway historically has had a greater proportion of people with more intensive care needs than Scotland.

The Wider Context

This is an historical indicator, which predates the introduction of Self Directed Support and whose relevance has changed since the introduction of SDS. In this indicator, Intensive Care Needs is defined as a person needing 10 or more hours of care per week. This is an historic threshold of care and therefore less relevant in the context of the changing policy position in respect of Self Directed Support.

The calculation for this indicator is based on those people who have chosen SDS Option 3. The new SDS models of care offer more person centred solutions and more alternative flexible and efficient solutions.

Improvement Actions

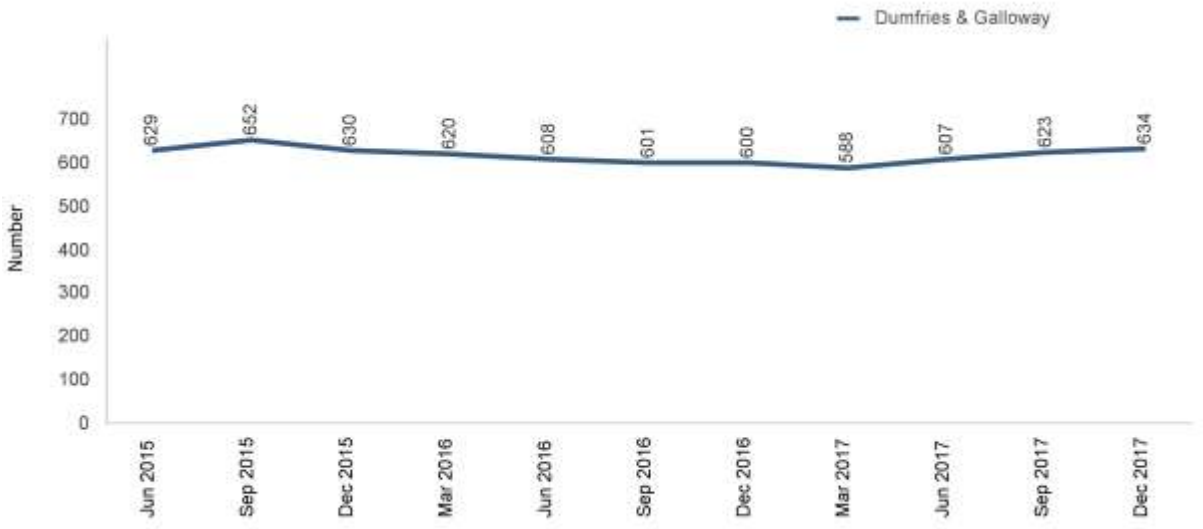
No improvement actions required at this time.

C7 Number of adults under 65 receiving care at home (via SDS Option 3)

National Outcomes: 1 2 3 4 5 6 7 8 9 | Dumfries & Galloway Priority Area: 1 2 3 4 5 6 7 8 9 10

Reported: 01/12/2017
Frequency: Quarterly
Source: Dumgal Council

Number of adults under 65 receiving care at home



Key Points

This is a Data Only indicator, which does not have a target or benchmarking associated with it.

The number of adults aged under 65 years receiving personal care at home through Self Directed Support (SDS) Option 3 was 634 in December 2017.

Despite an increase in the last two quarters, there has been a decline since a peak of 652 people in September 2015. Since September 2015, there has been a 3% decrease in the number of adults under 65 receiving care through SDS Option 3 which will be reflected in part by the small increase in the number of people who have chosen Option 1.

The Wider Context

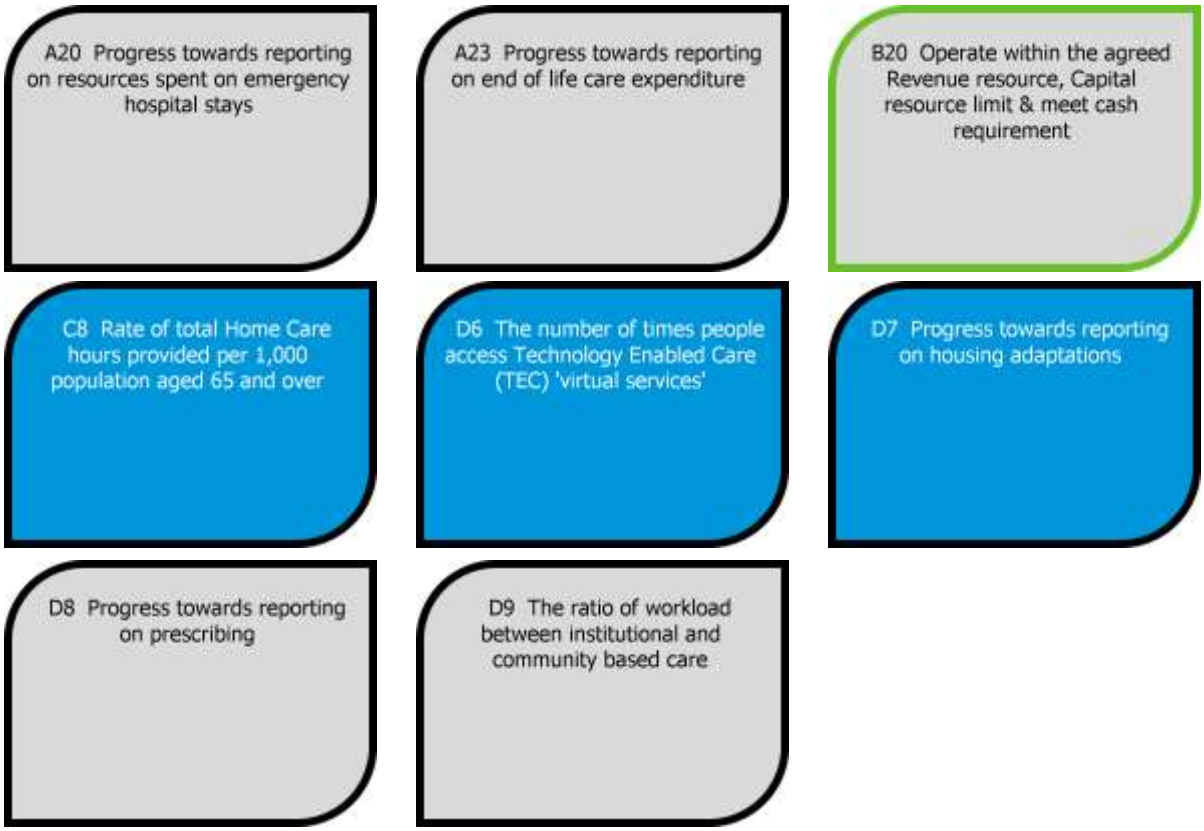
SDS Option 3 is where Social Work Services organise, purchase and manage care for people. For people under the age of 65 and depending upon individual financial assessments, care at home may be charged for. There are multiple factors that can influence the number of people under 65 receiving personal care at home: they may be accessing other services such as day care or optimising the use of their own assets to meet their personal outcomes. Another influencing factor may be challenges regarding the supply of care in local areas.

Improvement Actions

Locality teams continue to encourage people who have capacity aged under 65, to move to SDS Options 1 or 2 which would enable them to take more control of their own care. Over time, this will impact on the results demonstrated by this indicator.

Finance and Resources

Overview

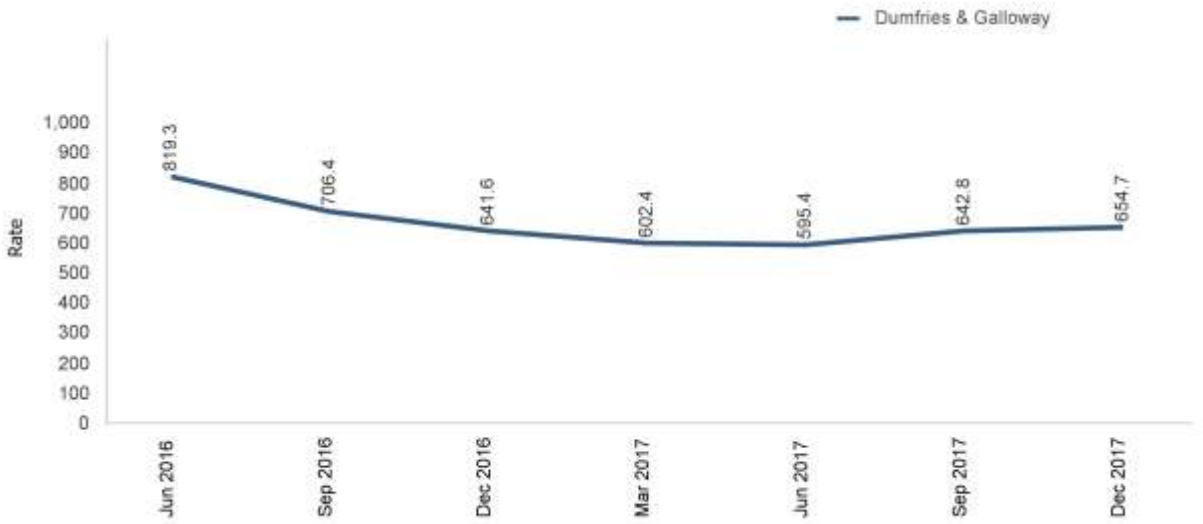


C8 Total number of Home Care hours provided as a rate per 1,000 population aged 65 and over

National Outcomes: 1 2 3 4 5 6 7 8 9 | Dumfries & Galloway Priority Area: 1 2 3 4 5 6 7 8 9 10

Reported: 01/12/2017
Frequency: Quarterly
Source: Dumgal Council

Rate of total Home Care hours provided per 1,000 population aged 65 and over



Key Points

This is a Data Only indicator, which does not have a target or benchmarking associated with it.

In December 2017 the rate of care at home provided through Self Directed Support (SDS) Option 3 was 654.7 hours per 1,000 population aged 65 and over.

The Wider Context

It is reported that across Dumfries and Galloway approximately 1 million hours of homecare are provided each year. It is anticipated that this indicator will decrease as more people opt for SDS Options 1 and 2. There will be a need to understand how many people are in receipt of care and support through all of the SDS options (see indicators C2 – C4).

Improvement Actions

No improvement actions required at this time. This historic indicator needs to be reviewed.

D6 Technology Enabled Care (TEC) - Virtual Services

National Outcomes	Dumfries & Galloway Priority Area		
1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9 10	Reported:	01/12/2017
		Frequency:	Quarterly
		Source:	Local

The number of times people access Technology Enabled Care (TEC) 'virtual services'

Stakeholder Discussions	Develop systems to collate data	Pilot and Test	Roll out across region
Due:	Due:	Due:	Due:
Completed:	Completed:	Completed:	Completed:

Key Points

The specifics of this indicator have not yet been developed.

The Wider Context

Dumfries and Galloway have made a commitment in the Strategic Plan to develop a Technology Enabled Care (TEC) programme that will explore the use of virtual services, such as text messaging, apps and video conferencing within health and social care settings.

An Assistive Technology Care strategy for Dumfries and Galloway was approved at the November 2017 Health and Social Care Senior Management Team meeting and work began in February 2018 on an engagement plan and an action plan to take this forward.

Improvement Actions

The NHS Attend Anywhere video consultation system virtually replicates a physical waiting area and enables people to participate in a video consultation from anywhere where they can access the internet. 14 waiting areas have been created across a variety of services and Health and Social Care Partners for testing. Cairnsmore Medical Practice in Newton Stewart is using the system with 2 local Care Homes. Annan North GP practice, the Primary Care Out of Hours (OOH) Service, Mental Health and the Carers' Centre are all due to go live in February 2018.

The Florence Home and Mobile Health Monitoring (HMHM) system has been purchased by the Partnership. A training day in Wigtownshire during November 2017 was attended by 8 different services. Protocols are currently in development to support people registered on the Beating the Blues computerised Cognitive Behavioural Therapy program and for medication reminders.

The TEC Sub Group has approved the purchase of 50 licences for the Jointly app, to be distributed through Care Support agencies. Jointly improves communication and coordination between those who share the care of people.

Moffat High Street Surgery website has been redeveloped to promote options for self care and enable people to better understand the support available to them through their community services. It can be accessed at http://www.moffatdoctors.co.uk

In Nithsdale, the DGRI Flow team, Locality Flow Coordinator and Nithsdale in Partnership teams have all been enabled for Lync video call system, to improve communication.

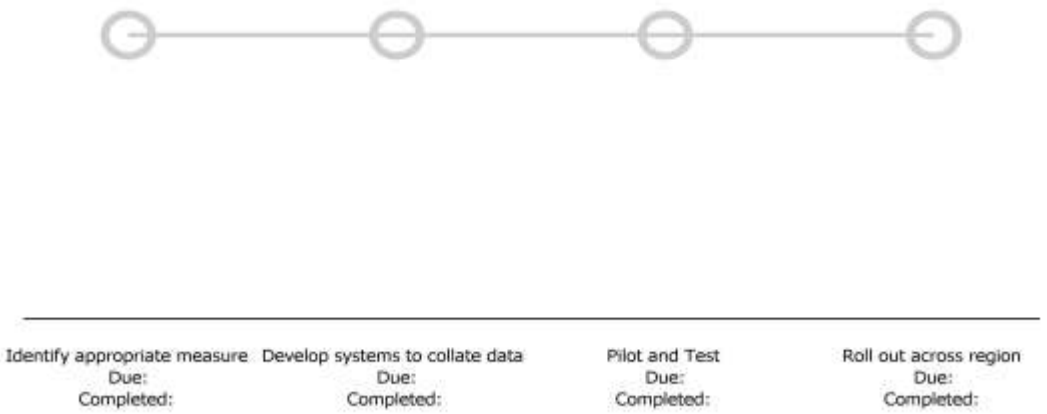
In Stewartry, Castle Douglas and Kirkcudbright Hospitals will soon be able to access out of hours GP support from Dumfries and Galloway Royal Infirmary through video call on tablets.

In Wigtownshire, the mPower project aims to improve the health and wellbeing of people by utilising eHealth interventions to support health and care service delivery. A short life working group has been established to enable the development of a supporting IT system.

D7 Housing adaptations

National Outcomes	Dumfries & Galloway Priority Area		
1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9 10	Reported:	01/12/2017
		Frequency:	Quarterly
		Source:	Local

Progress towards reporting on housing adaptations



Key Points

The specifics of this indicator have not yet been developed.

The Wider Context

People have expressed their wish to remain at home or in a homely setting for as long as possible. The Health and Social Care Partnership is focused on supporting people to enable them to remain at home as long as possible.

Improvement Actions

An Assistive Technology Care strategy for Dumfries and Galloway was approved at the November 2017 Health and Social Care Senior Management Team meeting. An action plan to take forward the aims and outcomes of the strategy will be developed to include all types of technology from traditional adaptations, such as grab rails, to high tech equipment.

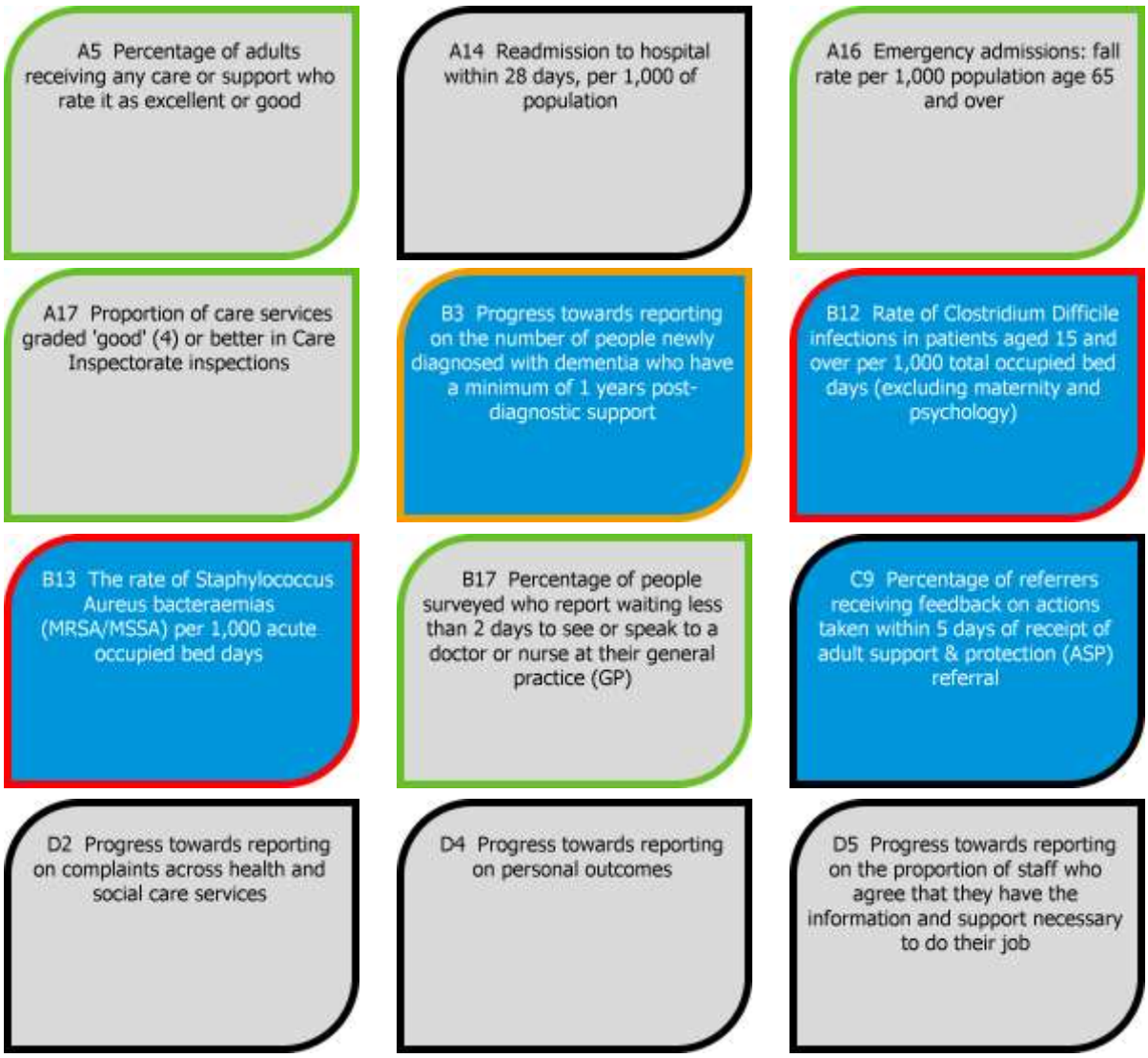
An event showcasing Technology Enabled Care (TEC) is in development which will be a collaboration between Community Health and Social Care, Social Work Services, the Telecare Service and private organisations which provide TEC and Smart devices. This event will be targeted at both staff and people who might benefit from this equipment. The event will showcase the support available through the Health and Social Care partnership for people to remain at home longer, alongside the TEC and smart technology that is available for individuals to purchase themselves locally. The event is expected to take place later in summer 2018.

People will get hands-on experience with Telecare and other equipment at Dumfries and Galloway Royal Infirmary (DGRI) in the Activities of Daily Living (ADL) suite. In the ADL suite Telecare, Smart devices and other assistive and inclusive technologies are installed, so people can learn more about the options available to support people to remain in their own homes. It is an aim to duplicate this process in the cottage hospitals.

In Stewartry, a 2 month test of change is due to start in February 2018 trialling SentriKey, a smart keysafe system that removes the need for code management and can enable access to a property in case of emergency. This trial is being run in partnership with the Stewartry Responder Service provided by Stewartry Care.

Quality

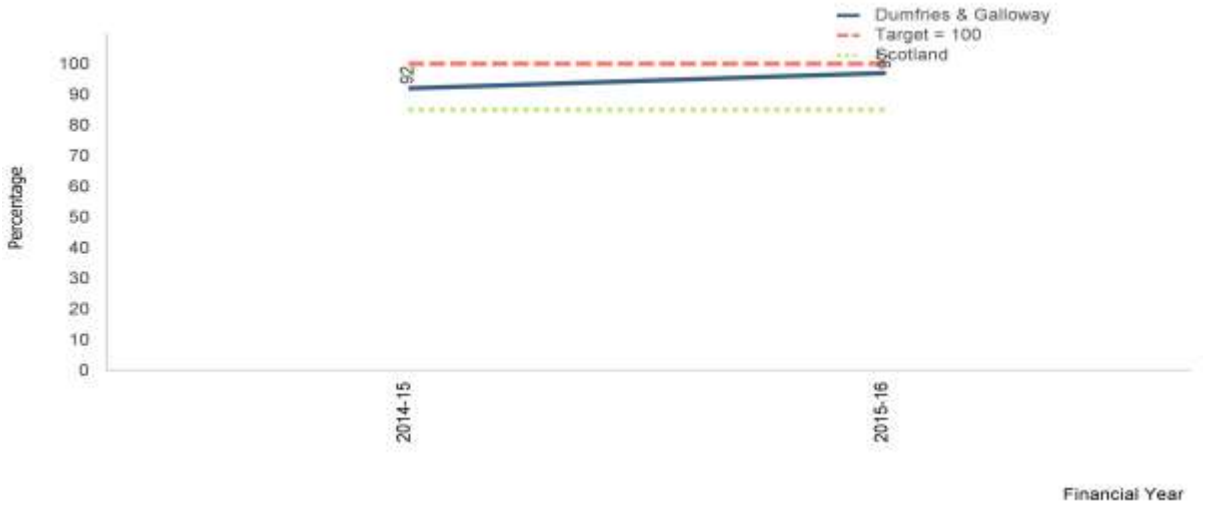
Overview



B3 Dementia post diagnostic support

National Outcomes	Dumfries & Galloway Priority Area		
1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9 10	Reported:	01/12/2017
		Frequency:	1 Year
		Source:	ISD Scotland

Progress towards reporting on the number of people newly diagnosed with dementia who have a minimum of 1 years post-diagnostic support



Key Points

Information Services Division (ISD) Scotland has published provisional statistics which show an estimated 631 people were expected to be diagnosed with Dementia in 2015/16 in Dumfries and Galloway. Of this estimated number of people, 292 (46%) were referred for post-diagnostic support (PDS). Of those referred to post-diagnostic services within Dumfries and Galloway, 97% of individuals received 12 months of support.

This is 12% higher than the overall Scottish performance where 85% of individuals received 12 months of support.

The Wider Context

The Local Delivery Plan standard is to deliver expected rates of dementia diagnosis and that all people newly diagnosed with dementia receive a minimum of 1 year of post-diagnostic support and have a person-centred plan in place at the end of that support period.

Local data shows there were 292 people newly diagnosed with Dementia in 2015/16, giving a 100% referral rate for PDS. Some people drop out of support programme before 12 months is complete.

Improvement Actions

There is a local Dementia Champion Programme, running since 2007, through collaboration between NHS, Alzheimer Scotland, and User and Carer Involvement (UCI). To date, there are around 145 dementia champions across the region in a diverse range of clinical areas and departments, with a further 23 on the current local programme.

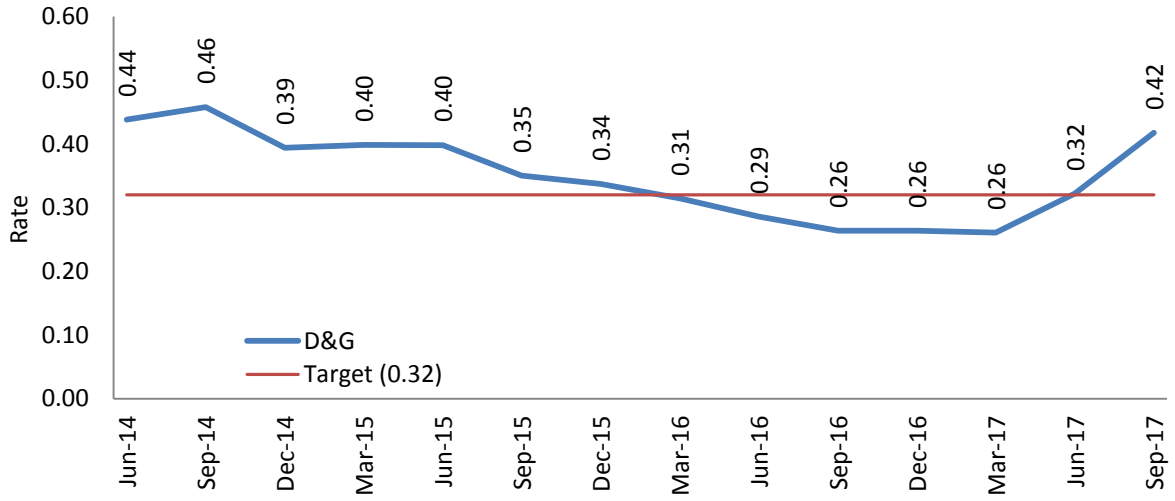
There is a 2 year project in Nithsdale for post diagnostic support looking at outcome measures where PDS is delivered in primary care, rather than the traditional model of care. We're looking to support GPs making non-complex dementia diagnoses, in prescribing cognitive enhancing medication and managing this, and to increase numbers of those diagnosed.

Dumfries and Galloway is the first health board in Scotland to work with ICHOM (International Consortium of Healthcare Outcome Measures) to use a suite of outcome measures. These will enable us to evaluate how people experience their dementia, including accessing their care and support via secondary services, compared to primary care.

B12 Rate of Clostridium Difficile infections

National Outcomes: 1 2 3 4 5 6 7 8 9 | Dumfries & Galloway Priority Area: 1 2 3 4 5 6 7 8 9 10 | Reported: 01/12/2017 | Frequency: Quarterly | Source: Local

Rate of Clostridium Difficile infections in patients aged 15 and over per 1,000 total occupied bed days (excluding maternity and psychology)



Key Points

The published infection rate for Clostridium difficile (C. difficile) for the 12 months ending 30th September 2017 was 0.42 cases per 1,000 occupied bed days. This is above the rate for Scotland of 0.28 cases per 1,000 occupied bed days.

The Wider Context

Following a year when Dumfries and Galloway achieved some of the lowest figures since mandatory surveillance began, the number of C. difficile infections has increased. National reporting now defines infections as either community associated or healthcare associated and reports these rates separately. Community associated infections are where the person has had no contact with a hospital in the previous 12 weeks. The control of community acquired infections is challenging as it relies on the general public being aware of both good hand hygiene and good home hygiene.

Improvement Actions

Local records show there have been 51 cases from April to December 2017. Of the 51 cases 23 were in the Dumfries and Galloway Royal Infirmary (DGRI), 2 in the Galloway Community Hospital and 3 in the cottage hospitals. Approximately half of the infections associated were associated with the community and half associated with healthcare settings.

The Health Protection Team (HPT) works to ensure appropriate infection prevention and control precautions are in place for any active cases identified as living in an enclosed care community. The HPT proactively provide up to date guidance, education and resources to all local care and care at home services. Recent training has included antibiotic stewardship to encourage appropriate in-house prescribing, which will tackle the emerging threat of antibiotic resistant pathogens in care home settings in addition to C.difficile.

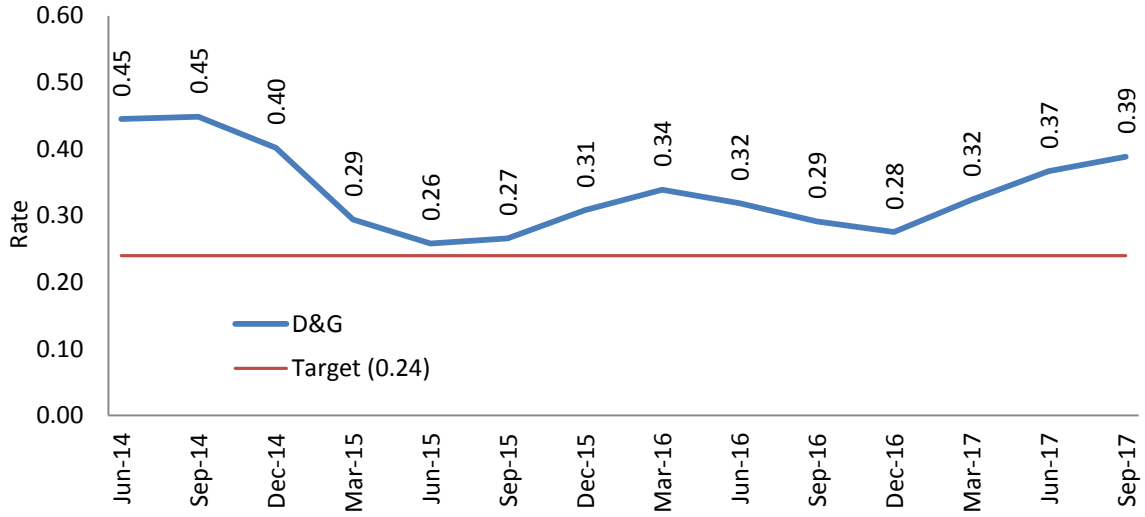
From 20 October 2017, all cleaning taking place in the DGRI has been undertaken using Actichlor Plus 1,000ppm, a powerful disinfecting agent. From 10 January 2018, the HPT recommended that care homes use bleach based cleaning agents for all routine cleaning, which will reduce the risk of C. difficile acquisition.

The Healthcare Environment Inspectorate published a report in May 2017 on the Galloway Community Hospital following an unannounced Hospital Acquired Infection inspection. The report showed good adherence to standard infection control precautions and the report included positive comments from patients regarding environmental cleanliness.

B13 Rate of Staphylococcus Aureus (SAB) (MRSA/MSSA) bacteraemias

National Outcomes 1 2 3 4 5 6 7 8 9 | Dumfries & Galloway Priority Area 1 2 3 4 5 6 7 8 9 10 | Reported: 01/12/2017 | Frequency: Quarterly | Source: Local

The rate of Staphylococcus Aureus bacteraemias (MRSA/MSSA) per 1,000 acute occupied bed days



Key Points

The infection rate for Staphylococcus aureus bacteraemia (SAB) in the 12 months ending 30th September 2017 was 0.39 cases per 1,000 acute occupied bed days. This is the 3rd quarterly increase since December 2016 when the rate was 0.28 cases per 1,000 occupied bed days. Local data shows during the quarter ending September 2017 there were 8 cases of SAB.
The infection rate for SAB in Dumfries and Galloway (DG) is above the target rate of 0.24 cases per 1,000 occupied bed days. The rate for Scotland was 0.33 cases per 1,000 occupied bed days.

The Wider Context

Across Scotland, invasive medical devices continue to be a leading cause of SAB, together with skin and soft tissue infections and intravenous drug use.
Infections are defined as either community associated or healthcare associated. Community associated infections are where the person has had no contact with a hospital in the previous 12 weeks. Healthcare associated infections have remained relatively stable, whereas there has been more variability over the last year in community associated infections.

Improvement Actions

Local records show there have been 27 cases from April to December 2017 split almost equally between healthcare associated and community associated infection. Data on ICNet allows people, who need special infection control, to be flagged (on Cortex) so wards can manage new admissions appropriately. This reduces exposure for both staff and people using services. Screening for MRSA in Dumfries and Galloway is one of the highest in Scotland, at 97% in the quarter ending December 2017.
Invasive devices will be a focus for improvement work in 2018.
Prompt recognition of a SAB infection secondary to intravenous drug use (IVDU) will prompt notification to the Health Protection Team (HPT) who can support or provide the person a harm reduction brief intervention in a bid to reduce reoccurrence. Alerts are also made to partners in the wider drug and alcohol services when a local increase in IVDU related SAB occurs. This alert is used to encourage potential new cases to seek timely medical help and assists the HPT to identify emerging patterns of disease and investigate common source contamination / infection.

C9 Feedback received by referrers on actions taken within 5 days of receipt of adult protection referral

National Outcomes	Dumfries & Galloway Priority Area		
1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9 10	Reported:	01/12/2017
		Frequency:	Quarterly
		Source:	Dumgal Council

Percentage of referrers receiving feedback on actions taken within 5 days of receipt of adult support & protection (ASP) referral

Key Points

Across Dumfries and Galloway in the quarter ending December 2017 66.5% of people referring a Duty to Inquire case to Adult Support and Protection (ASP) received feedback within 5 days of receipt of referral. There has been a steady improvement in the figures.

The Wider Context

Across Dumfries and Galloway there are typically 80 to 100 ASP Duty to Inquire referrals per month. All relevant adult referrals are assessed to determine if they meet the requirements that would classify the referral as a Duty to Inquire. This indicator, introduced in January 2016, should be considered to be in a testing phase. Discussions are underway in relation to reporting timescales and determining what should count as feedback to ensure the data is as complete as possible.

The type of feedback differs depending on the source of the referral. Where a professional has referred, it can be noted that the adult is being progressed under Duty to Inquire, with a consideration as to the need to take to Investigation. If a family member makes a referral, it is likely they will be involved in the progression of the referral so they will receive more detailed feedback. If a member of the public makes a referral they will be told that we have received the referral and are giving consideration as to how to take this forward.

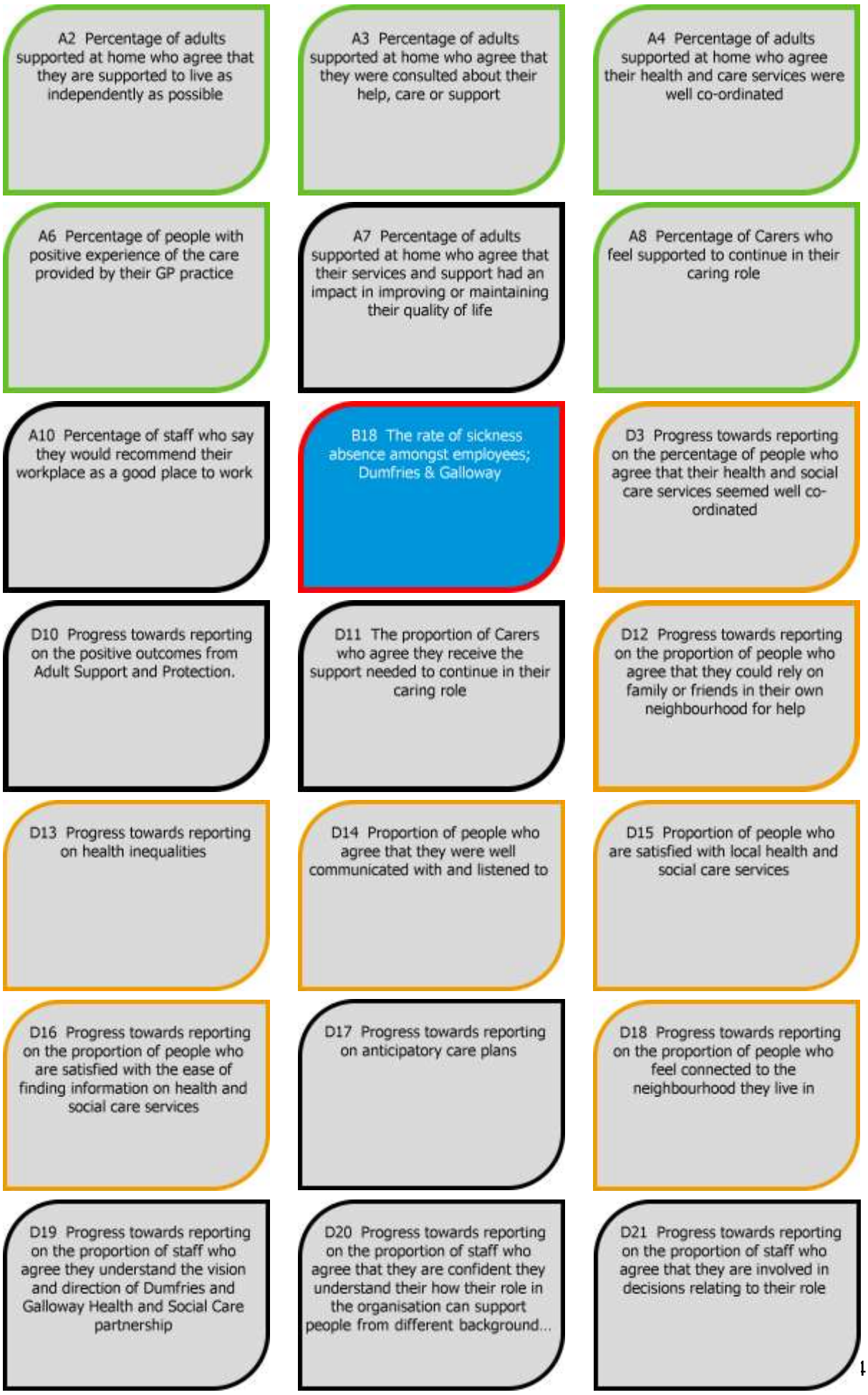
Improvement Actions

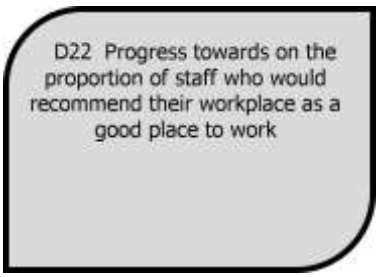
Improving communication between ASP and referrers was identified as a priority by the Adult Support and Protection Executive Group (ASPEG) and the Adult Support and Protection Committee (APC). An annual review was commissioned by ASPEG into Adult Multi-Agency Safeguarding Hub (MASH) processes. Considerations on the findings of this review have been identified with a report on revised MASH arrangements presented to APC in March 2018. Performance continues to be monitored and regular reports shared with senior manager and frontline practitioners to improve information sharing and speedier decision making.

The MASH holds primary responsibility for providing feedback. This will become a core function in MASH to continue to support consistent practice and joint information sharing at an earlier stage.

Stakeholder Experience

Overview

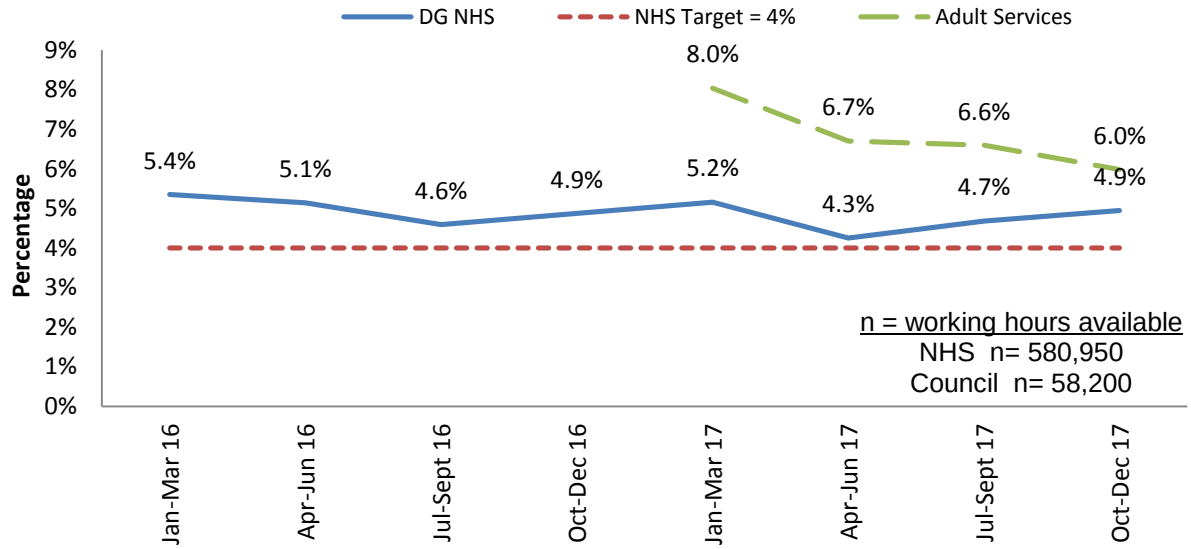



D22 Progress towards on the proportion of staff who would recommend their workplace as a good place to work

B18 Sickness absence rate

National Outcomes: 1 2 3 4 5 6 7 8 9 | Dumfries & Galloway Priority Area: 1 2 3 4 5 6 7 8 9 10 | Reported: 01/12/2017 | Frequency: Quarterly | Source: ISD Scotland

The rate of sickness absence amongst employees; Dumfries & Galloway



Key Points

The rate of sickness absence amongst NHS employees from October to December 2017 was 4.9% and for Adult Social Services in the council it was 6.0%. The sickness absence rate for adult social services has fallen for the last 3 quarters.

These rates remain higher than the national target of 4% (NHS Staff).

The Wider Context

Across Dumfries and Galloway there are approximately 3,540 whole time equivalent (wte) NHS employees and 427 wte Adult Social Services employees. The smaller number of Adult Social Services employees means that there is likely to be greater variation in the sickness absence rate compared to the rate for NHS employees.

Improvement Actions

The Working Well review undertaken on behalf of the NHS Staff Governance Committee has led to the establishment of a range of priorities for supporting staff health and wellbeing in 2018. The first priority has been the establishment of a Working Well Partnership Group to lead this work on behalf of the Staff Governance Committee. The membership of this group has been agreed. Further priorities include the development of data analysis and reporting of sickness absence and management, specifically focused on awareness raising and engagement on wellbeing and exploring ways of supporting mental health and team resilience.

In Adult Social Services, there continues to be focus on attendance at work, which is a priority for the council. This is managed proactively through line manager intervention, support from HR case officers and also continued support from the 'Maximising Attendance Team'. Corporate training is available on a monthly basis which is in addition to on line training which can be accessed at any point. Monthly reports are provided to managers to highlight absence rates within teams and to allow focused intervention.

Sickness absence remains a standing agenda item for the Integration Partnership Forum.

Ministerial Strategic Group [Not Official Statistics: for management purposes only]

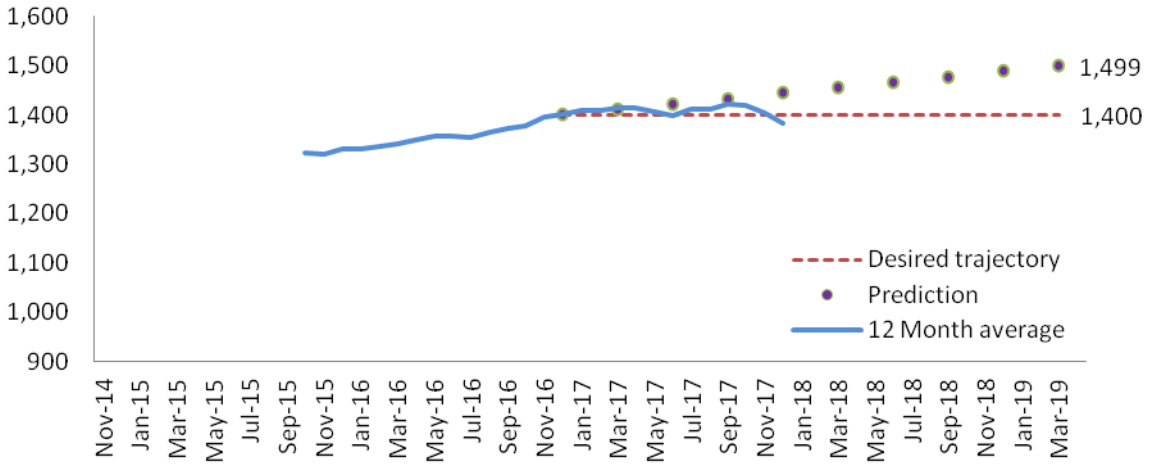
Overview

E1 Emergency admissions per month

National Outcomes: 1 2 3 4 5 6 7 8 9 | Dumfries & Galloway Priority Area: 1 2 3 4 5 6 7 8 9 10

Reported: 01/12/2017
Frequency: Quarterly
Source: ISD Scotland

The number of emergency admissions per month for people of all ages



Date	Actual	Desired	Predicted	12 month average	Data Completeness
Oct 17	1,350	1,400	1,437	1,419	96%
Nov 17	1,256	1,400	1,441	1,404	90%
Dec 17	1,293	1,400	1,444	1,383	85%

Key Points

The number of people of all ages, admitted as urgent or an emergency, to all hospital locations in Scotland, for residents of Dumfries and Galloway was 1,383 in December 2017. If the number of emergency admissions could be maintained at or below an average of 1,400 per month, this would equate to a drop of 7% compared to the likely result had no changes been made. This is shown on the chart as the 'prediction'. The prediction was based on the previous 2 years' figures (recalculated in December 2017).
The rolling 12 month average is increasing and in line with the prediction.

The Wider Context

These figures are reported from the Scottish Morbidity Recording 01(SMR01) dataset and there is currently a backlog causing data completeness issues. These figures include people admitted through the emergency department and also admissions direct to a ward arranged by a GP.
Research shows that approximately 40-50% of the rise in emergency admissions in the last 15 years can be attributed to demographic changes. It is believed that the growth in emergency admissions could, in part, be reduced by redesigning services to meet the needs of those people whose admission to hospital may have been avoidable in the community.

Improvement Actions

Nithsdale in Partnership (NIP) is a community based team dedicated to supporting people living in the DG1/DG2 postcode areas. Since its launch in August 2017, up to the end of December 2017 NIP has provided support to 206 people.
Stronger relationships between health and social care professionals and a wider network of partners, including local police, is helping to address some of the social challenges which previously could have resulted in admission to hospital.

A bid has been submitted to the Scottish Government to fund a community respiratory nurse to support people with Chronic Obstructive Pulmonary Disease to remain in their own home environment.

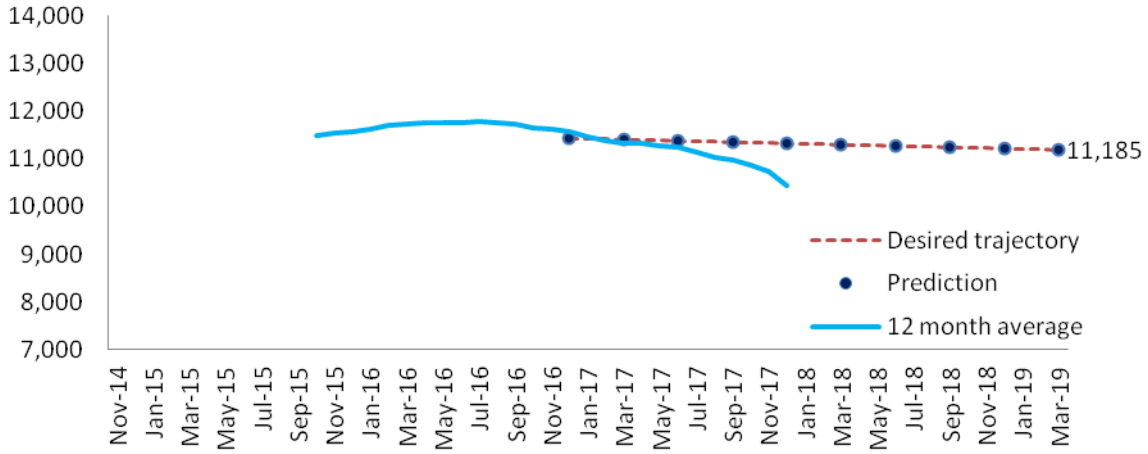
An important contribution to managing people's care in the most appropriate way is good anticipatory care planning. Work to scale up and embed anticipatory care planning within Dumfries and Galloway Health and Social Care Partnership has recently commenced.

E2 Unscheduled hospital bed days for acute specialties

National Outcomes: 1 2 3 4 5 6 7 8 9 | Dumfries & Galloway Priority Area: 1 2 3 4 5 6 7 8 9 10

Reported: 01/12/2017
Frequency: Quarterly
Source: ISD Scotland

The number of unscheduled hospital bed days for acute specialties per month



Date	Actual	Desired	Predicted	12 month average	Data Completeness
Oct 17	9,849	11,338	11,338	10,871	96%
Nov 17	9,565	11,329	11,329	10,723	90%
Dec 17	8,150	11,320	11,320	10,447	85%

Key Points

The number of bed days for people of all ages, admitted as urgent or an emergency, to all hospital locations in Scotland, for residents of Dumfries and Galloway was 8,150 in December 2017.

The rolling 12 month average is a little lower than the prediction, which was based on the previous 2 years' figures (recalculated in December 2017). As the prediction is heading in a desirable direction, this has also been taken as the desired trajectory. If the number of emergency bed days continues to follow this trajectory, it would equate to a drop of 3.8% compared to the 12 month average reference point in November 2016.

Recent actions/changes in this area of care appear to have made an impact on this indicator. If this direction continues for a full year, a new desired trajectory will be calculated.

The Wider Context

These figures are reported from the Scottish Morbidity Recording 01(SMR01) dataset and there is currently a backlog causing completeness issues.
How long a person stays in hospital will be strongly related to the complexity of any procedure carried out as well the underlying health condition of the person. People admitted as emergencies generally stay longer than planned hospital admissions. In Scotland, in 2016/17, the average length of stay for a planned admission was 3.7 days. For an emergency admission, the average length of stay was 6.9 days.

Improvement Actions

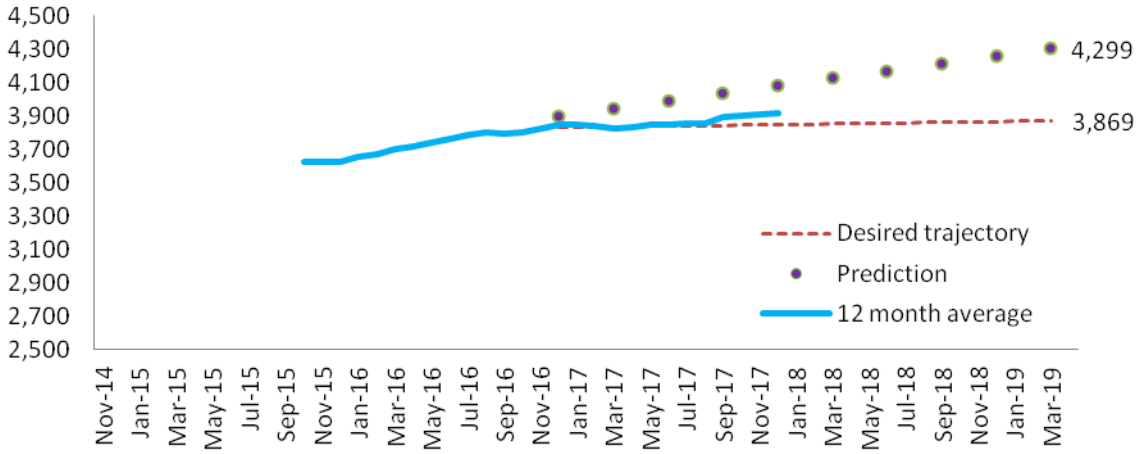
Daily Dynamic Discharge (DDD) is being rolled out across all hospital settings to improve the flow of people's journey through hospital. The Short Term Assessment Re-ablement Service (STARS) has started working with the discharge manager, patient flow coordinators and the senior social worker at Dumfries and Galloway Royal Infirmary. They hold a daily flow meeting to identify people suitable for re-ablement and/or home assessment. STARS have also started to link with locality teams to replicate this approach.
There are four new flow co-ordinator posts, one for each Locality, who support the discharge process from cottage hospitals to a homely setting.

E3 Emergency department monthly attendances

National Outcomes: 1 2 3 4 5 6 7 8 9 | Dumfries & Galloway Priority Area: 1 2 3 4 5 6 7 8 9 10

Reported: 01/12/2017
Frequency: Quarterly
Source: ISD Scotland

The number of people attending emergency department per month



Date	Actual	Desired	Predicted	12 month average
Oct 17	3,876	3,843	4,047	3,900
Nov 17	3,837	3,845	4,062	3,910
Dec 17	3,853	3,846	4,076	3,912

Key Points

The number of people attending any emergency department location in Dumfries and Galloway was 3,853 in December 2017.

If the number of people attending emergency departments follows the desired trajectory, this would equate to a drop of 10% compared to the likely result had no changes been made. This is shown on the chart as the 'prediction'. The prediction was based on the previous 2 years' figures (recalculated in December 2017).

The rolling 12 month average is increasing and is a little higher than the desired trajectory but below the number of attendances predicted.

The Wider Context

These figures are reported from the A&E datamart and do not include planned returns. There are no completion issues with this dataset.
In Scotland 25% of ED attendances in 2016/17 resulted in an admission to the same hospital. 30% of ED attendances in Dumfries and Galloway were admitted in 2016/17.
For emergency department waiting times, see indicator B19.

Improvement Actions

The Meet ED public awareness campaign has started to direct people to the most appropriate setting, which may not be the ED, through the busy winter months. We are using social media to communicate with the public when the department is particularly busy.

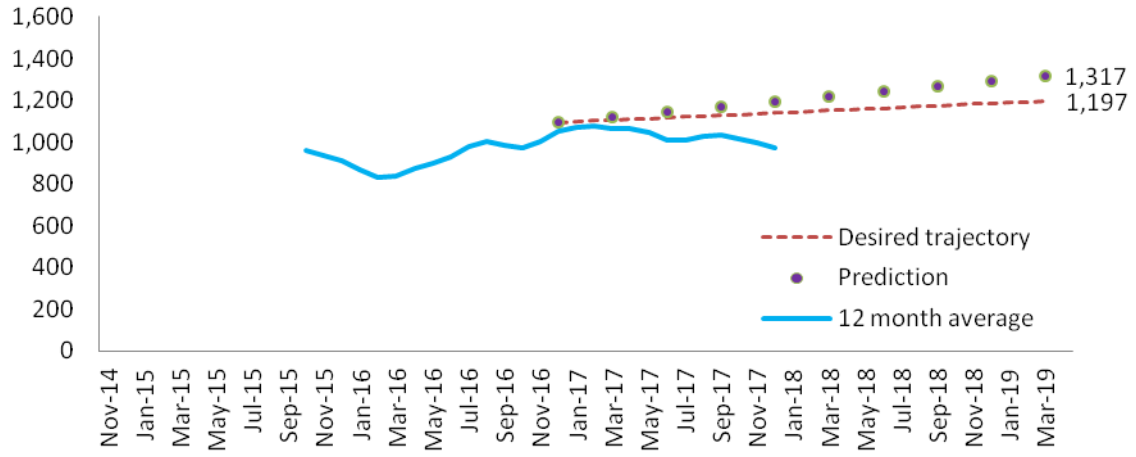
A case note review will be undertaken in the next quarter to assess the clinical appropriateness of medical admissions from the ED. This review will inform professionals where people might have been more appropriately treated or supported.

A test of change in the Combined Assessment Unit has introduced a rapid assessment by a senior clinician (Advanced Nurse Practitioner), reviewing test results and making a general assessment to provide a rapid decision about admission to hospital. The waiting environment has been changed to enable people to remain in their own clothes, supporting the expectation to return home rather than be admitted, where appropriate.

E4 Bed days occupied by all people experiencing a delay in their discharge from hospital

National Outcomes: 1 2 3 4 5 6 7 8 9 | Dumfries & Galloway Priority Area: 1 2 3 4 5 6 7 8 9 10 | Reported: 01/12/2017 | Frequency: Quarterly | Source: ISD Scotland

The number of bed days occupied by all people experiencing a delay in their discharge from hospital, per month, people aged 18 and older



Date	Actual	Desired	Predicted	12 month average
Oct 17	1,040	1,132	1,177	1,013
Nov 17	1,018	1,136	1,185	998
Dec 17	1,143	1,140	1,193	975

Key Points

The number of bed days occupied by all people experiencing a delay in their discharge from any hospital was 1,143 for adult residents of Dumfries and Galloway in December 2017
The rolling 12 month average is lower than the desired trajectory suggesting that the performance is better than had been expected.
If the number of delayed bed days follows the desired trajectory line, this would equate to a real term drop of 10% compared to the likely result had no changes been made. This is shown on the chart as the prediction. The prediction was based on the previous 2 years' figures (recalculated in December 2017).

Recent improvement actions appear to have made an impact on this indicator. If this direction continues for a full year, a new desired trajectory will be calculated.

The Wider Context

These figures are reported as part of a monthly national delayed discharge audit. There are no completion issues with this dataset. Note that this is different to National Integration indicator A19, which reports delayed discharge bed days for people aged 75 or older.

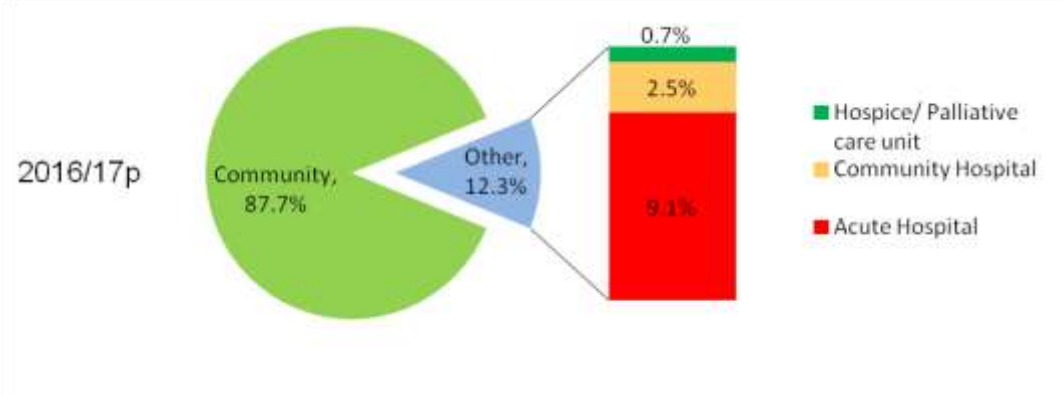
Improvement Actions

Dynamic Daily Discharge (DDD) planning by multi disciplinary teams enables the team to prioritise the actions required to ensure that people remain on track with their treatment plan in anticipation of a timely planned discharge. This approach is beneficial for both acute and cottage hospital settings. Kirkcudbright, Castle Douglas, Newton Stewart, Thornhill and Lochmaben cottage hospitals have introduced DDD or weekly dynamic discharge to improve the timeliness of people's discharges.
The number of people whose discharge was delayed from Dumfries and Galloway Royal Infirmary (DGRI) has reduced in the last 6 months from 195 to 85, in June 17. Discharging people before noon is challenging. Most people are discharged in the afternoon. This is being reviewed and improvement actions identified.
The Day of Care Survey now takes place on a monthly basis in the DGRI. The latest survey showed an improvement in the number of people who could have been discharged earlier, from 30.5% in September 2016 to 19.0% in January 2018.

E5 Percentage of last 6 months of life by setting

National Outcomes 1 2 3 4 5 6 7 8 9 | Dumfries & Galloway Priority Area 1 2 3 4 5 6 7 8 9 10 | Reported: 01/12/2017 | Frequency: Quarterly | Source: ISD Scotland

Where people who died spent their last 6 months of life, by setting - MSG



Date	Community	Hospice/ Palliative care unit	Community Hospital	Acute Hospital
2014/15	88.9%	0.8%	1.9%	8.4%
2015/16	87.9%	0.7%	2.1%	9.3%
2016/17p	88.7%	0.7%	2.5%	9.1%

Key Points

In Dumfries and Galloway the proportion of time that people who died, spent in a community setting in the last 6 months of their life, has risen from 87.9% in 2015/16 to 87.7% in 2016/17 (figures still provisional).

Across health and social care partnerships for 2016/17, this percentage ranged from 84.9% to 93.8%, with the Scotland average being 87.3%. The overall trend for Scotland is a slowly increasing proportion of the last 6 months of life spent in a community setting (85.3% in 2010/11 has risen to 87.3% in 2016/17.)

People appear to have spent less time in their last 6 months of life in an acute hospital setting in Dumfries and Galloway, from 9.3% in 2015/16 to 9.1% in 2016/17.

The Wider Context

This measure is the same as National Integration indicator A15, which compares the proportion of time spent in the community, but does not detail the other locations. The desired aim is to match or be lower than the 2014/15 figure of 8.4%, for proportion of time spent in a large hospital setting.

In 2016/17 there were 1,771 deaths recorded by the National Records for Scotland for residents of Dumfries and Galloway, excluding external causes of death (for example unintentional injuries). This measure is calculated by determining the proportion of time people spent in hospital, and subtracting this from the total time in 6 months. Activity in the Alex. Unit is recorded under hospice/palliative care unit.

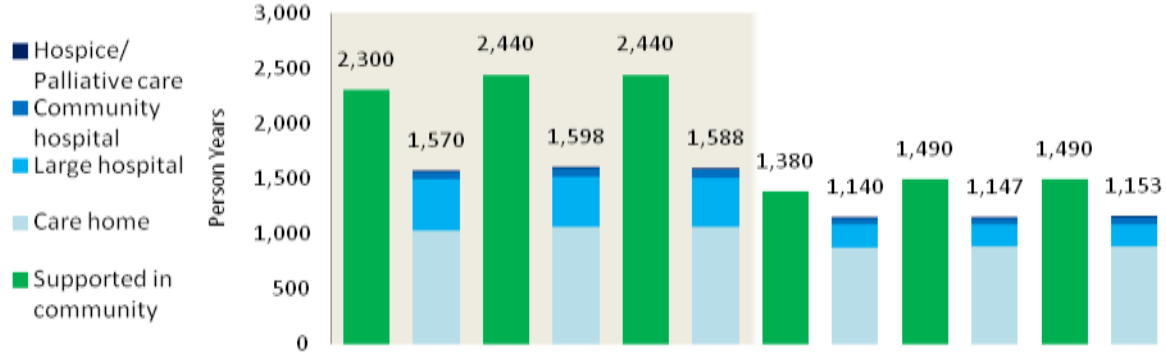
Improvement Actions

The health board actively monitors the hospital standardised mortality ratio (hSMR) which is an indicator of deaths in hospital. The Scottish patient safety programme (SPSP) has a range of service improvements to reduce issues such as catheter associated urinary tract infection (CAUTI), pressure ulcers and venous thrombo-embolism (VTE). It has been calculated that as a result of the SPSP, hospital mortality across Scotland has reduced by 8.6% in the two and half years up to September 2016. In this time, in the Dumfries and Galloway Royal Infirmary the reduction in mortality has been more than 10%.
Good anticipatory care planning will impact on where people spend their last six months of life. We are currently developing a new palliative care strategy for Dumfries and Galloway. Part of this process will include a scoping of palliative and end of life care options in Dumfries and Galloway.

E6 Balance of Care: Person years in community or institutional settings

National Outcomes: 1 2 3 4 5 6 7 8 9 | Dumfries & Galloway Priority Area: 1 2 3 4 5 6 7 8 9 10 | Reported: 01/12/2017 | Frequency: Quarterly | Source: ISD Scotland

The number of person-years spent in community or institutional settings



Setting	All ages 2014/15	All ages 2015/16	All ages 2016/17p	Aged 75+ 2014/15	Aged 75+ 2015/16	Aged 75+ 2016/17p
Hospice/Palliative care	8	7	7	3	2	4
Community hospital	64	72	75	53	58	62
Large hospital	474	461	447	209	206	207
Care home	1,024	1,058	1,058	874	881	881
Total institutional	**1,570**	**1,598**	**1,588**	**1,140**	**1,147**	**1,153**
Supported in community	2,300	2,440	2,440	1,380	1,490	1,490

Key Points

The total amount of time that people are supported in the community is rising for people of all ages, including people aged 75 years and older. For people aged 75 years and older in 2014/15 the number of person years spent in the community was 1,380. This had risen to 1,490 person years in 2016/17, an increase of 8%.

The total amount of time that people are cared for in institutional settings is broadly remaining the same for all ages, and increasing a small amount for people aged 75 years and older. For people aged 75 years and older in 2014/15 the number of person years spent in all institutional settings was 1,140. This had risen to 1,153 person years in 2016/17, an increase of 1%.

The Wider Context

A person year is the total amount of time one person has in one year. If someone has a home care support package all year round, this would equal one full person year of being supported in the community. If a person has a hospital admission for one month, this would equal one twelfth of a person year spent in an institutional setting. The activity of all Dumfries and Galloway residents is added together to give the person year total for the whole region. These figures do not include the activity of people who fund their own care and support, people who are supported solely by unpaid Carers and/or the voluntary sector or any outpatient or community health activity such as STARS, community nursing and mental health.

Improvement Actions

The majority of the population experience very little institutional care or home support in the community in any given year. The amount of person years spent by the entire region in the community unsupported is equal to the total population's person years (approximately 149,000) minus the above figures.

The proportion of time spent in the community unsupported ranged from 96.9% to 98.5% across all of the health and social care partnerships in 2016/17. The proportion for Dumfries and Galloway was 97.31%. The remaining 2.69% of time accounts for all hospital and social care activity in the region paid for by the statutory sector.

This measure lacks the sensitivity required to be able to demonstrate shifts in the balance of care. The issue has been raised with a visiting representative of the Ministerial Strategic Group.

Agenda Item 163

DUMFRIES and GALLOWAY NHS BOARD

4th June 2018

Dumfries and Galloway Integration Joint Board – Health and Social Care Strategic Plan

Author: Vicky Freeman
Head of Strategic Planning

Sponsoring Director: Julie White
Chief Operating Officer

Date: 13th April 2018

RECOMMENDATION

The NHS Board is asked to note

- The decision of the Integration Joint Board (IJB) on 5th April 2018, to retain their current Strategic Plan

- That as a result of this decision, the new 'period of relevance' for the Integration Joint Board is 05/04/2018 to 04/04/2021

CONTEXT

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 current relevant period is 2016-19).

The legislation outlines two options for integration authorities:

- Retain the current strategic plan, restarting the relevant period at the date of this decision (new period of relevance April 2018-21) or
- Replace the strategic plan at the end of the current relevant period (new period of relevance April 2019-22)

The integration authority, when considering whether or not to retain or replace their strategic plan, must:

- Seek and have regard to the views of its Strategic Planning Group (SPG) on the effectiveness of the arrangements for carrying out the integration functions and whether the integration authority should prepare a replacement strategic plan.
- Have regard to the integration principles and national health and wellbeing outcomes.

The IJB, having undertaken formal processes in regard to both the above through 2017/18, made the decision at their meeting on the 5th April 2018 to retain their current Strategic Plan.

The new 'period of relevance' commences from the date of this decision.

GLOSSARY
Period of relevance
"relevant period", in relation to an integration authority, means—

(a) the period of 3 years beginning with the integration start day as defined in the Public Bodies (Scotland) Act 2014; and
(b) each subsequent period of 3 years beginning with—

Public Bodies (Joint Working) (Scotland) Act 2014 (asp 9) 21
Part 1—Functions of local authorities and Health Boards
(i) where a replacement strategic plan is prepared following a review under subsection (1), the day specified under subsection (9),
(ii) where no replacement strategic plan is prepared following such a review, the day on which the integration authority decides not to prepare a replacement strategic plan.

MONITORING FORM

Policy / Strategy	*Public Bodies (Scotland)Act 2014*
Staffing Implications	No staffing implications were identified
Financial Implications	No financial implications were identified.
Consultation / Consideration	*Integration Joint Board*
Risk Assessment	*Not applicable*
Risk Appetite	Low ☐ Medium ☐ High ☑ The delivery of the Health and Social Care Strategic Plan relates to service redesign while maintaining patient safety and financial sustainability, therefore, a high risk appetite has been noted.
Sustainability	Not applicable
Compliance with Corporate Objectives	*To deliver the Strategic Plan would mean compliance with all Corporate Objectives for the Board.*
Local Outcome Improvement Plan (LOIP)	Outcomes 1, 2, 3 and 6
Best Value	• Vision and Leadership • Effective Partnerships • Governance and Accountability • Performance Management
Impact Assessment None	

Agenda Item 164

DUMFRIES and GALLOWAY NHS BOARD

4th June 2018

Financial Performance and Capital Update – 12 months to 31st March 2018

Author:
Graham Stewart
Deputy Director of Finance

Sponsoring Director:
Katy Lewis
Director of Finance

Date: 20th April 2018

RECOMMENDATION

The NHS Board is asked to:

- Discuss and consider this paper and note the draft financial position presented for month 12 of the 2017/18 financial year. This is subject to final review by external audit.
- Note the capital expenditure for the year to 31 March 2018.

CONTEXT

Strategy/Policy:

The Board has a statutory financial target to deliver a break-even position against its Revenue Resource Limit (RRL) and Capital Resource Limit (CRL).

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

Financial Performance

This report provides the proposed final summary position for the year as at March 2018 which confirms a surplus of **£61k**, achieving a break-even position for 2017/18 as planned.

Cash Releasing Efficiency Savings (CRES) have been identified in full in-year through the release and identification of non-recurring solutions and corporate non-recurrent support, however, there remains a **£9.63m** recurring gap on efficiency plans that now forms part of the efficiency gap for 2018/19.

This report also highlights separately the financial performance of the NHS services delegated to the Integrated Joint Board (IJB).

Capital

Allocations of £40.6m were received from the Scottish Government Health and Social Care Directorate (SGHSCD) for the year ended 31 March 2018.

Expenditure of £40.012m was incurred for the year ended 31 March 2018 which includes the final NPD asset addition.

GLOSSARY OF TERMS

AME	-	Annually Managed Expenditure
ASRP	-	Acute Services Redevelopment Project
CNORIS	-	Clinical Negligence and Other Risks Scheme
CRES	-	Cash Releasing Efficiency Savings
CRL	-	Capital Resource Limit
FHS	-	Family Health Services
IJB	-	Integrated Joint Board
IM&T	-	Information Management & Technology
LDP	-	Local Delivery Plan
NPD	-	Not for Profit Distribution
RRL	-	Revenue Resource Limit
RTA	-	Road Traffic Accidents
SGHSCD	-	Scottish Government Health and Social Care Directorate
SLA	-	Service Level Agreements
TEC	-	Technology Enabled Care
UNPACS	-	Unplanned Activities
WTE	-	Whole Time Equivalent
YTD	-	Year To Date

MONITORING FORM

Policy/Strategy	Supports agreed financial strategy in Local Delivery Plan.
Staffing Implications	Additional WTE analysis provided in the paper.
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 [ ] <u>Financial Performance</u> The scale of the challenge moving into the new financial year regarding the recurring gap on CRES is rated as a high risk against the statutory requirement to breakeven year on year.
Sustainability	Financial Plan supports the sustainability agenda through the delivery of efficient solutions to the delivery of CRES.
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)	• Outcome 3: Health and wellbeing inequalities are reduced • Outcome 6: People are safe and feel safe • Outcome 8: Individuals and communities are empowered
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.	

Summary Update 2017/18: Final Proposed Year End Position

1. NHS Dumfries and Galloway reports a break-even position for 2017/18, showing a surplus of **£61k** for the year.

2. The Revenue Resource Limit (RRL) and Capital Resource Limit (CRL) have been agreed and notified to us by the Scottish Government, with allocations of **£370.582m** and **£40.6m** respectively. **Appendix 1** provides a summary of the confirmed 2017/18 RRL allocations.

3. A detailed schedule is provided at **Appendix 2** which shows the final budget under/overspends position by Directorate. It also reflects the split of budgets and services which are delegated to the IJB.

Overall Financial Position

4. The main variances as at the year end, behind the break-even position are as follows:

    - Pays **£259k** underspent, reflecting the level of vacancies and additional costs of Medical Locum costs.
    - Offset by an overspend on Non-pays of **£23k,** mainly within Primary Care Prescribing and unachieved Directorate CRES plans, offset with non-recurrent Board funding.
    - An under recovery on income of **£175k,** reflecting a reduction on Road Traffic Act (RTA) income and other income reductions.

5. **Appendix 2** provides further details on the individual Directorate positions year end outturn.

Efficiency Savings

6. The Board's Financial Plan identifies the requirement to deliver recurring cash efficiencies of **£22.6m**. Recurring schemes to the value of **£6.1m** have been indentified, implemented and achieved.

7. Additional non-recurrent schemes have also been identified of **£16.5m**, reducing the in-year gap to nil. Within this non-recurring amount, **£5.2m** of non-recurrent support has been identified in the Financial Plan, in order to enable Directorates time to identify recurring schemes this financial year.

8. The scale of the recurrent gap on CRES of **£9.63m** has been included within the overall target for 2018/19. This is being taken forward as part of the overall workstream into identifying the 2018/19 efficiency requirement.

9. **Appendix 3** provides a high level summary of the annual CRES target and achievement to date by Directorate, identifying the Year to Date (YTD) plan against YTD achievement and the expected achievement by the year end, split between recurring and non-recurring schemes.

Key Actions and Recommendations

10. Planning assumptions for 2018/19 and beyond have built the current scale of the recurrent gap into the overall level of efficiencies required to break-even next year, reported as **£17.3m** in the Board's submission to the Scottish Government.

Financial Risks

11. The Financial Plan for 2018/19 reflects known financial risks and these will continue to be monitored and reviewed through the financial reporting cycle. These have not changed from previous Finance reports and include the following:

    - Recurrent gap on Efficiency Plans – **£9.63m.**
    - Primary Care Prescribing – recurrent overspend of **£1.9m**.
    - Medical Locum Funding – **£4.8m** non-recurring reserve in addition to the **£850k** recurring reserve.
    - Increasing pressures on external Service Level Agreements (SLAs) with other Scottish Boards – **£1m**.

Key Actions and Recommendations

12. The Realistic Medicine Project Team now has a Project Manager in place and are working through the initial areas identified by Finance and Health Intelligence. This group will be supported by Health Intelligence and Finance Teams to identify potential areas of opportunity to reduce clinical variation, where appropriate and necessary.

13. A Board workshop was held in March 2018, where schemes agreed to be taken forward by this group include the following:

    - Prescribing workstreams, including bio-similars, polypharmacy and variation in Primary Care Prescribing by GP cluster groupings.
    - Variation and Waste – National benchmarking, procedures of limited value and reduction on Pathology demand/requests.
    - Lab Demand Optimisation – currently led by a Sub-Group of the Project Group.

DIRECTORATES' OVERVIEW POSITIONS

Delegated Budgets to IJB

14. The final year end position for the delegated budgets to the IJB reports a break-even position, with some additional non-recurring funding identified to off-set the under achievement on Prescribing CRES schemes. The following table provides a high level summary by Directorate:

Table 1

IJB DELEGATED SERVICES	Pays Variance £000s	Non-pays variance £000s	Drugs Variance £000s	Income Variance £000s	Total variance £000s
Acute & Diagnostics	155	(1,375)	185	76	(960)
Facilities & Clinical Support	215	(451)	0	1	(234)
Mental Health Directorate	(32)	200	(107)	2	62
Primary & Community Care	115	77	(1,498)	35	(1,270)
Women's & Children's Directorate	187	14	(43)	0	158
E-Health	246	(420)	0	(113)	(288)
Strategic IJB Services	112	(40)	0	1	72
Property CRES	0	(436)	0	0	(436)
IJB Unidentified CRES	0	2,895	0	0	2,895
IJB SERVICES TOTAL	**998**	**464**	**(1,463)**	**2**	**0**

15. Key Variances within the IJB:

- As reported throughout the year, the final position reflects the known pressures across the IJB services, which include:
    - Medical Locum expenditure - **£12.6m** as at end March 2018, funded non-recurrently in-year (an increase over 2016/17 levels of **£1m**, or 9%).
    - Primary Care Prescribing - **£1.9m**, reflecting the level of unidentified CRES in the position (**£1.3m**) and the increased costs of short-supply drugs (**£800k**), off-set by non-recurrent drug reserve funding (**£400k**).
    - General activity levels in the Acute Hospital, as demonstrated by the recent pressures over the past few months, reflect the position on Non-pays across Labs (Radiology and Bio-chemistry activity) and Audiology, off-set to a degree by underspends across Pays and Drugs.
    - Continued pressures within Facilities and Clinical Support relating to heat, light and power as well as ongoing Laundry pressures and refuse waste costs are the key variances in the final position.
    - E-Health increased expenditure across service contracts and increasing telephone costs account for the increased cost pressure reported.

- General unidentified/unachieved Directorate CRES targets, funded non-recurrently by the Board in-year, to allow time for Business Transformation Plans to be implemented (**£1,074k**).

16. As part of the review of the expenditure within the Integrated Care Fund, the remaining balance of **£1.062m** has been carried forward again this year as part of the IJB reserve position from the health side, increasing the overall IJB reserves to £3.289m cumulatively.

17. Whilst the final position of the IJB presents a break-even position as forecast, the non-recurring support released by the Health Board has been utilised to ensure a break-even position.

18. This reflects the requirement contained within the Integration Scheme, where any overspend must be funded in proportion to the budgets delegated from the partner organisations.

19. Further detail on the year to date position by directorate is included in **Appendix 2.**

20. An additional appendix on the key areas of Pays variances is included within **Appendix 4**, highlighting the key variances by staff group by Directorate.

NHS Board Resources (not delegated to IJB)

21. Overall, the functions not delegated to the IJB and retained by the Health Board are reporting a final year position of **£61k** underspend. These includes all of the corporate budgets managed directly by the NHS Directors and External Contracts with other Health Boards and external companies.

22. The main variances relating to Health Board corporate services are as follows:

- Pays are **£738k** overspent, reflecting the level of funding issued to Directorates for off-setting medical locum costs. Otherwise, the Corporate Directorate Pay variance is **£107k** underspent at year end.
- Whilst Non-pays are **£977k** underspent, there is an underlying pressure across External SLAs of **£2m**, showing the level of growth in activity being sent outwith the Board. Specifically, activity at both Newcastle and Carlisle has increased, with ongoing increases being seen across high cost excluded drugs and Unplanned Activities (UNPACS) recharges from NHS Greater Glasgow and Clyde and NHS Lothian overall.
- Income is **£177k** below plan, mainly related to the reduction in income from Road Traffic Accidents (RTAs) and national training monies.

23. Revised SLAs will be negotiated with the major Health Boards and NHS Trusts to ensure the position moving into 2018/19 is clearly understood around the overall level of activity being commissioned outwith the Region.

Efficiency Savings

24. The final summary position on the achievement of CRES targets is highlighted in the table below:

Table 2

	Total 2017/18 Target £000	Total 2017/18 Schemes £000	In Year 2017/18 CRES Gap £000	2017/18 Recurring CRES Gap £000
IJB Delegated services	15,214	14,140	(1,074)	(8,008)
NHS Board services	7,421	8,495	1,074	(1,623)
TOTAL	**22,635**	**23,192**	**0**	**(9,631)**

25. As identified above, there is currently a significant level of unidentified recurring CRES outstanding at the year end of (**£9.6m**).

26. The overall Prescribing gap in-year is **£1.38m**, resulting in a recurring gap on CRES of £2.1m for the year.

27. A breakdown of CRES by Directorate is provided in **Appendix 3.** Whilst the Board has identified the in-year CRES target in full, this includes overall non-recurring corporate support of **£11.2m**, leaving a recurring gap overall of **£9.6m**.

Key Actions and Recommendations

28. The Directorates are now focussed on identifying their business transformation plans and agreeing timeframes for when recurring savings will be implemented as we move into the new financial year.

29. The IJB continues to pursue further opportunities to identify CRES in full and is working closely with the Finance team to identify and agree transformational schemes to identify recurring plans for efficiency moving forwards. Managers are actively reviewing all other means of identifying further recurring and non-recurring initiatives.

30. Whilst plans continue to be developed across all services, there remains a significant level of work to be undertaken to close the **£9.6m** recurring gap which will be reported to Scottish Government. This gap on savings plans forms part of the updated Financial Plan being developed by the Director of Finance.

31. Further work is required across all corporate areas to fully develop the principals of shared services and regional working to ensure the maximum level of service efficiency and effectiveness is delivered in the coming months.

32. The Clinical Efficiency Group (Realistic Medicine) continues to be supported by Health Intelligence and Finance Teams to identify potential areas of opportunity to reduce clinical variation, where appropriate and necessary. Workstreams continue to challenge areas of significant clinical variation in order to identify further efficiencies to be made.

Financial Risks

33. The Financial Plan for 2018/19 reflects all known financial risks and these have been highlighted as part of the LDP process and include the following:

- Deliverability of CRES – both from a recurrent and non-recurrent position.
- Assessment of the increasing requirement and impact of medical temporary staffing across all sites and services.
- Double running of the New Hospital and Mountain Hall.
- Review of Primary Care Prescribing practices and growth.
- Review of Secondary Care Prescribing Services.
- Growth on activity sent out of area to other providers.

34. Work is ongoing to progress the Financial Plan and to look to identify savings schemes to develop a balanced Financial Plan for 2018/19. Schemes identified to date include the following:

- Medical Locum, Nurse Agency and Bank spend (2 strands, reducing both demand and reducing cost).
- Further challenge back to General Managers and Budget Holders to identify further savings.
- Assessing the opportunity for further non-recurring savings.
- Property Strategy and infrastructure work.
- All funding and allocations expected to be received in 2018/19 (including Integrated Care Fund).
- Further development of Corporate savings.
- Review of external contracts to identify savings, opportunities and assess risks.
- Review of balance sheet and other options for non-recurring flexibility.
- Assessment of further Procurement opportunities.
- Review of any other potential savings opportunities.

Capital Position Update

35. Table 3 below shows the final allocations received from SGHSCD for capital.

Table 3

ANTICIPATED ALLOCATIONS	Allocation Received to 31/03/18 £000
Formula Allocation	3,475
NPD - Asset Addition	26,428
NPD - Enabling Funding	27,101
Capital to Revenue	(7,000)
Return of 2016/17 virement	1,566
Virement 2017/18	(11,000)
Ophthalmology Equipment	30
	40,600

Capital Budget and Expenditure Update

36. For the year ended 31 March 2018, expenditure of £40.012m was incurred on the capital programme including the NPD Addition, leaving an underspend of £588k. Table 4 below shows the expenditure against previously approved budgets.

Table 4

CAPITAL EXPENDITURE PLAN	Approved Budget Feb 2018 £000	2017/18 Capital Expenditure
ASRP – Equipment	11,063	11,065
ASRP – Cresswell	1,349	947
ASRP – Asset	26,428	26,428
Replacement, Contingency, Development	1,760	1,572
Total	**40,600**	**40,012**
	Variance	*588*

Appendices

37. This report includes the following appendices:

i. **Appendix 1** provides details of all revenue allocations received during the year. It also highlights anticipated allocations and the Board's expected final RRL.

ii. **Appendix 2** provides a detailed analysis of the budgeted and actual financial position by Operating Directorate for period to 31st March 2018. It identifies variances against budget and also highlights where CRES targets have not been allocated to operating budgets.

iii. **Appendix 3** summarises the CRES plan for 2017/18.

iv. **Appendix 4** provides a high level analysis of the key areas of Pays variances.

Recommendations

38. The Board is asked to:

- Discuss and consider this paper and note the draft financial position presented for month 12 of the 2017/18 financial year. This is subject to final review by external audit.
- Note the capital expenditure for the year to 31 March 2018.

NHS DUMFRIES AND GALLOWAY
REVENUE RESOURCE ANALYSIS
At 31st March 2018

	Baseline Recurring £000s	Earmarked Recurring £000s	Non Recurring £000s	Non Core £000s	Total £000s
Revenue Allocation as at 28th February 2018	284,983	10,643	30,287	26,926	352,839
Other					
Cancer Strategy			81		81
TEC Funding			0		0
Golden Jubliee Top Slice			(32)		(32)
qFIT Programme			102		102
DGRI Depreciation			1,493		1,493
Non Core					
Non Core Depreciation				(414)	
AME Impairments				(400)	
AME Provisions				(76)	
CNORIS Provision				972	
Total Allocations	0	0	1,645	82	1,645
Revenue Allocation as at 31st March 2018	**284,983**	**10,643**	**31,932**	**27,008**	**354,565**
Anticipated Allocations					0
Total Revenue Allocation (excl FHS)	**284,983**	**10,643**	**31,932**	**27,008**	**354,565**
Family Health Services Non Discretionary Allocation					16,017
Total Revenue Allocation (incl FHS)					**370,582**

NHS DUMFRIES AND GALLOWAY
EXPENDITURE ANALYSIS - 12 MONTHS TO 31st March 2018

AREA	Annual Budget				Pays Ytd			Non Pay Ytd			Income Ytd			Total Ytd			
	Pay £000	Non Pay £000	Income £000	Total £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Variance %
IJB DELEGATED SERVICES																	
Acute & Diagnostics	80,979	25,291	(1,775)	104,496	80,979	80,824	155	25,291	26,482	(1,190)	(1,775)	(1,851)	76	104,496	105,455	(960)	-1%
Acute Services Redesign	629	1,181	(23)	1,787	629	630	(0)	1,181	1,181	(0)	(23)	(23)	(0)	1,787	1,787	(0)	0%
Facilities & Clinical Support	3,490	12,260	(1,121)	14,629	3,490	3,275	215	12,260	12,710	(451)	(1,121)	(1,122)	1	14,629	14,864	(234)	-2%
Mental Health Directorate	19,032	2,695	(633)	21,094	19,032	19,064	(32)	2,695	2,603	93	(633)	(635)	2	21,094	21,032	62	0%
Primary & Community Care	28,318	75,719	(4,576)	99,461	28,318	28,203	115	75,719	77,140	(1,421)	(4,576)	(4,611)	35	99,461	100,732	(1,270)	-1%
Womens & Childrens Directorate	19,213	2,189	(825)	20,577	19,213	19,026	187	2,189	2,218	(29)	(825)	(825)	(0)	20,577	20,419	158	1%
E Health	2,764	3,590	(302)	6,051	2,764	2,518	246	3,590	4,010	(420)	(302)	(189)	(113)	6,051	6,339	(288)	-5%
Strategic IJB Services	751	20,223	(40)	20,934	751	639	112	20,223	20,263	(40)	(40)	(41)	1	20,934	20,861	72	0%
Property CRES	0	(436)	0	(436)	0	0	0	(436)	0	(436)	0	0	0	(436)	0	(436)	100%
IJB Unidentified CRES	0	2,895	0	2,895	0	0	0	2,895	0	2,895	0	0	0	2,895	0	2,895	100%
IJB SERVICES TOTAL	**155,177**	**145,607**	**(9,295)**	**291,488**	**155,177**	**154,180**	**997**	**145,607**	**146,606**	**(999)**	**(9,295)**	**(9,297)**	**2**	**291,488**	**291,489**	**(0)**	**0%**
BOARD SERVICES																	
Chief Executive	984	2,134	(21)	3,096	984	962	22	2,134	2,207	(73)	(21)	(31)	10	3,096	3,137	(41)	-1%
Public Health	2,082	490	(460)	2,112	2,082	2,125	(43)	490	387	103	(460)	(399)	(60)	2,112	2,113	(0)	0%
Medical Director	5,148	2,579	(985)	6,743	5,148	4,772	377	2,579	2,554	25	(985)	(849)	(136)	6,743	6,478	265	4%
Nursing Directorate	2,247	153	(230)	2,170	2,247	2,200	46	153	138	15	(230)	(225)	(5)	2,170	2,113	57	3%
Workforce Directorate	1,995	245	(315)	1,925	1,995	1,845	150	245	338	(94)	(315)	(350)	36	1,925	1,833	92	5%
Finance Directorate	2,983	(887)	(938)	1,159	2,983	3,372	(389)	(887)	(1,183)	296	(938)	(1,062)	124	1,159	1,128	31	15%
Non Recurring Projects	91	617	(42)	666	91	146	(55)	617	573	44	(42)	(48)	6	666	671	(5)	-1%
Strategic Capital	932	16,180	(653)	16,460	932	932	0	16,180	16,164	16	(653)	(661)	8	16,460	16,435	24	0%
Central Income	0	0	(4,986)	(4,986)	0	0	0	0	0	0	(4,986)	(4,824)	(162)	(4,986)	(4,824)	(162)	3%
Externals	0	26,317	(3,010)	23,307	0	0	0	26,317	28,276	(1,959)	(3,010)	(3,013)	3	23,307	25,263	(1,956)	-9%
Board Unidentified CRES	0	1,507	0	1,507	0	0	0	1,507	0	1,507	0	0	0	1,507	0	1,507	100%
BOARD SERVICES TOTAL	**16,461**	**49,336**	**(11,639)**	**54,158**	**16,461**	**16,354**	**107**	**49,336**	**49,455**	**(120)**	**(11,639)**	**(11,462)**	**(177)**	**54,158**	**54,347**	**(189)**	**0%**
Non Core	0	24,678	0	24,678	0	0	0	24,678	24,685	(7)	0	0	0	24,678	24,685	(7)	0%
Reserves	(846)	1,104	0	258	(846)	0	(846)	1,104	0	1,104	0	0	0	258	0	258	100%
NON CORE & RESERVES TOTAL	**(846)**	**25,782**	**0**	**24,936**	**(846)**	**0**	**(846)**	**25,782**	**24,685**	**1,097**	**0**	**0**	**0**	**24,936**	**24,685**	**251**	**1%**
GRAND TOTAL	**170,792**	**220,725**	**(20,935)**	**370,582**	**170,792**	**170,533**	**259**	**220,725**	**220,747**	**(23)**	**(20,935)**	**(20,759)**	**(175)**	**370,582**	**370,521**	**61**	**0%**

NHS DUMFRIES AND GALLOWAY
SUMMARY CRES PLAN 2017/18

	Recurring 2017/18 Target £000	Non recurring 2017/18 Target £000	Total 2017/18 Target £000	YTD Planned Savings £000	YTD Actual Savings £000	Scheme Variance YTD £000	2017/18 Recurring Schemes £000	Non Recurring 2017/18 Schemes £000	Total 2017/18 Schemes £000	In Year 2017/18 CRES Gap £000	2017/18 Recurring CRES Gap £000
Delegated Services - IJB											
Acute and Diagnostics	1,489	1,650	3,139	3,139	2,548	(591)	441	2,107	2,548	(591)	(1,048)
Facilities and Clinical Support	779		779	779	545	(234)	288	257	545	(234)	(491)
Mental Health	1,228		1,228	1,228	1,228	0	891	337	1,228	0	(337)
Primary and Community Care	1,637		1,637	1,637	1,637	0	599	1,038	1,637	0	(1,038)
Women and Children	1,102		1,102	1,102	1,052	(50)	352	700	1,052	(50)	(750)
E-Health	329		329	329	122	(207)	122	0	122	(207)	(207)
IJB Strategic Services	0		0	0	57	57	0	57	57	57	0
Prescribing	4,500		4,500	4,500	3,116	(1,384)	2,405	711	3,116	(1,384)	(2,095)
Property CRES	1,000		1,000	1,000	564	(436)	458	106	564	(436)	(542)
IJB Unidentified CRES	1,500		1,500	1,500	3,271	1,771	0	3,271	3,271	1,771	(1,500)
Delegated Services - IJB Total	**13,564**	**1,650**	**15,214**	**15,214**	**14,140**	**(1,074)**	**5,556**	**8,583**	**14,140**	**(1,074)**	**(8,008)**
Board Services											
External SLAs	1,000		1,000	1,000	0	(1,000)	0	0	0	(1,000)	(1,000)
Corporate CRES	1,000		1,000	1,000	3,074	2,074	377	2,697	3,074	2,074	(623)
Procurment	200		200	200	200	0	200	0	200	0	0
Board Services Total	**2,200**	**0**	**2,200**	**2,200**	**3,274**	**1,074**	**577**	**2,697**	**3,274**	**1,074**	**(1,623)**
Non-Recurring Central Support	0	5,221	5,221	0	5,221	0	0	5,221	5,221	0	0
Grand Total	**15,764**	**6,871**	**22,635**	**17,414**	**22,635**	**(0)**	**6,133**	**16,501**	**22,635**	**(0)**	**(9,631)**

Risk Profile of Identified Schemes	
High	33.80%
Medium	4.12%
Low	62.08%

NHS DUMFRIES AND GALLOWAY
Pay Variance Report

Directorate	Staff Group	Annual Budget £	Actuals £	Variance £	WTE Budget	WTE Actual	WTE Variance	Key Variances Explained
Acute Directorate	Admin & Clerical	5,089,711	4,822,438	267,273	175.48	169.50	5.98	General Vacancies throughout the year across the Administration services/departments
	Allied Health Professionals	2,359,187	2,690,808	-331,621	50.24	56.42	-6.18	Requirement of agency staff within Audiology (£77k) and Radiology (£373k) due to vacancies, difficulties recruiting staff and increased activity.
	Healthcare Sciences	4,174,467	3,860,028	314,439	93.65	88.48	5.17	A number of vacancies across all labs disciplines, the most notable being the Blood Sciences Lab Manager.
	Medical Dental Support	234,660	193,983	40,677	5.97	5.37	0.60	
	Medical & Dental	29,614,215	29,576,250	37,965	220.23	217.85	2.38	WTE variance amended to reflect level of cover throughout the year.
	Nursing & Midwifery	33,247,981	33,450,916	-202,934	881.24	886.08	-4.84	Small 0.60% variance to £33m budget - agency requirement (£256k) the majority of which utilised in Critical Care (£202k) due to vacancies.
	Other Therapeutic	85,543	85,543	0	0.00	0.00	0.00	
	Support Services	6,173,099	6,144,304	28,795	247.27	247.50	-0.23	
Acute Directorate Total		**80,978,864**	**80,824,271**	**154,593**	**1,674**	**1,671**	**2.87**	
Facilities & Clinical Support	Admin & Clerical	709,910	686,726	23,184	22.39	20.48	1.91	
	Healthcare Sciences	380,808	386,355	-5,547	5.00	9.17	-4.17	
	Support Services	2,399,515	2,202,152	197,363	72.65	68.53	4.12	Estates vacancies across Support Services throughout the year (being reviewed as part of restructure).
Facilities & Clinical Support Total		**3,490,233**	**3,275,234**	**214,999**	**100.04**	**98.19**	**1.86**	
Mental Health Directorate	Admin & Clerical	1,032,506	919,138	113,368	39.01	37.54	1.47	Band 3 vacancy & Band 5 reduction in hours
	Allied Health Professionals	864,234	803,049	61,185	21.12	17.66	3.46	Includes Band 6 vacancy & Band 7 secondment not backfilled
	Medical Dental Support	6,317	6,240	77	0.24	0.42	-0.18	
	Medical & Dental	2,753,213	2,799,224	-46,011	27.46	24.02	3.44	Vacancies covered by locums and Consultants working additional hours
	Nursing & Midwifery	11,716,310	11,883,326	-167,016	293.30	302.65	-9.35	Social Care funding stopped - 3 members of staff still to be redeployed
	Other Therapeutic	2,465,229	2,408,383	56,846	43.56	43.09	0.47	Psychology vacancies throughout the year
	Personal Social Care	37,211	104,126	-66,915	1.00	2.42	-1.42	Increases relate to changes in the GP Contract for providing cover to the prison
	Support Services	156,952	140,659	16,293	5.23	5.94	-0.71	
Mental Health Directorate Total		**19,031,972**	**19,064,145**	**-32,173**	**430.92**	**433.73**	**-2.81**	
Primary & Community Care	Admin & Clerical	2,581,620	2,475,291	106,329	81.51	77.27	4.24	
	Allied Health Professionals	6,683,368	6,678,203	5,165	172.12	171.79	0.33	Vacancies covered by Agency and Agency Wtes are estimated
	Medical & Dental	2,777,042	2,828,428	-51,386	16.96	18.14	-1.18	
	Nursing & Midwifery	12,810,577	12,807,093	3,484	342.36	334.90	7.46	SCN working accross hospitals, STARS vacancies
	Other Therapeutic	790,607	752,326	38,281	17.20	14.26	2.94	
	Personal Social Care	928,646	913,473	15,173	29.98	26.53	3.46	Public Health vacancies and staff reducing hours
	Support Services	1,746,562	1,748,292	-1,729	68.15	66.51	1.64	
Primary & Community Care Total		**28,318,422**	**28,203,105**	**115,317**	**728.28**	**709.40**	**18.88**	
Womens & Childrens Directorate	Admin & Clerical	1,187,074	1,187,084	-10	42.05	41.07	0.98	Gaps between staff leaving and new starts. 1 psst still vacant.
	Allied Health Professionals	1,480,162	1,460,494	19,668	35.73	33.92	1.81	Internal promotions created gaps lower down scale. Recruitment difficulties in SLT.
	Healthcare Sciences	33,418	34,459	-1,041	0.75	0.83	-0.08	Additional hours worked in Fertility Clinic
	Medical & Dental	5,445,554	5,461,841	-16,287	49.82	46.07	3.75	Gaps in Obs/Gynae Middle Grade filled by Locums. Paed Cons & Spec Dr vacancy
	Nursing & Midwifery	10,925,544	10,746,348	179,196	276.75	252.67	24.08	Recruitment difficulties in Health Visiting and Midwifery. Neonatal staff rostered on in line with activity in Unit.
	Other Therapeutic	63,883	63,037	846	2.12	2.11	0.01	
	Personal Social Care	53,206	53,276	-70	1.00	1.00	0.00	
	Support Services	23,874	19,038	4,836	0.95	0.80	0.15	Includes Agency - figure should be 0.8wte
Womens & Childrens Directorate Total		**19,212,715**	**19,025,578**	**187,137**	**409.17**	**378.47**	**30.70**	
Ehealth	Admin & Clerical	2,751,217	2,495,804	255,413	79.21	74.01	5.20	
	Medical & Dental	12,922	18,526	-5,604	0.00	0.00	0.00	
	Nursing & Midwifery	0	3,901	-3,901	0.00	0.04	-0.04	
Ehealth Total		**2,764,139**	**2,518,231**	**245,908**	**79.21**	**74.05**	**5.16**	
Strategic IJB Services	Admin & Clerical	751,164	639,419	111,745	12.46	12.47	-0.01	
Strategic IJB Services Total		**751,164**	**639,419**	**111,745**	**12.46**	**12.47**	**-0.01**	
IJB Delegated Services Sub Total		**154,547,509**	**153,549,982**	**997,526**	**3,434**	**3,378**	**57**	
Corporate Services	Admin & Clerical	6,102,195	6,744,913	-642,718	169.70	152.66	17.04	Increase in the central provision for costs associated with Enhancements During Leave included in Corporate area
	Allied Health Professionals	213,301	214,151	-850	3.85	3.91	-0.06	
	Healthcare Sciences	42,790	42,864	-74	1.00	1.00	-0.00	
	Medical Dental Support	700,062	673,416	26,646	19.60	19.44	0.16	
	Medical & Dental	1,956,863	1,209,951	746,912	21.79	19.60	2.19	Central Corporate Reserve for funding of Medical Locum costs
	Nursing & Midwifery	2,325,924	2,325,433	491	46.78	46.67	0.11	
	Other Therapeutic	1,976,259	1,930,951	45,308	48.43	48.19	0.25	
	Personal Social Care	367,398	442,077	-74,679	6.00	6.79	-0.79	
	Senior Managers	689,608	684,725	4,883	15.00	14.08	0.92	
	Support Services	526,607	528,066	-1,459	18.04	18.78	-0.74	
Corporate Services Total		**14,901,007**	**14,796,546**	**104,461**	**350.19**	**331.13**	**19.06**	
Strategic	Admin & Clerical	637,720	658,252	-20,532	9.36	13.95	-4.59	
	Nursing & Midwifery	153,389	155,860	-2,471	4.49	2.99	1.50	
	Support Services	141,064	118,061	23,003	5.61	1.97	3.64	
Strategic Total		**932,173**	**932,172**	**1**	**19.46**	**18.91**	**0.55**	
Board Services Sub Total		**15,833,180**	**15,728,719**	**104,461**	**369.65**	**350.04**	**20**	
Grand Total		**170,380,689**	**169,278,701**	**1,101,988**	**3,803.81**	**3,727.55**	**76**	

Agenda Item 165

DUMFRIES and GALLOWAY NHS BOARD

4th June 2018

Financial Performance Update 2018/19 - Position to Month 1 as at 30th April 2018

Author:
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Deputy Director of Finance

Sponsoring Director:
Katy Lewis
Director of Finance

Date: 18th May 2018

RECOMMENDATION

The NHS Board is asked to note the revenue financial position to month 1.

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 30th April 2018, month 1.

The NHS Board is reporting an overspend position of £711k.

The key issues resulting in this level of overspend are as follows;

- Delivery of Operation Savings Plans - £861k
- Delivery of Corporate Wide savings plans - £306k
- These are offset through underspends across Pays of £235k.

The Board has yet to have a balanced Financial Plan for 2018/19, with a current forecast deficit position of £6m.

Significant workstreams identified to date around delivering efficiencies include;

- Reviewing the use of medical locum expenditure and recruitment to remaining vacancies.
- Driving Transformational Plans forwards in as timely timeframe as possible as well as indentifying further plans in 2019/20 and beyond.

- Ongoing re-assessment of all financial risks on the sustainability of the financial recovery of the organisation, as we identify the risk of achieving financial breakeven position.

  Any member of the Board wishing additional information on the detail of this paper should contact the Director of Finance for additional information.

GLOSSARY OF TERMS

CRES	-	Cash Releasing Efficiency Savings
GMS	-	General Medical Services
GP	-	General Practice
IJB	-	Integrated Joint Board
PPRS	-	Pharmaceutical Price Regulation Scheme
RRL	-	Revenue Resource Limit
SLA	-	Service Level Agreement
YTD	-	Year to Date

MONITORING FORM

Policy / Strategy	Supports agreed financial strategy in 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 [ ] To-date the Financial Plan submitted to the Scottish Government reports a £6m deficit and not a breakeven position. With no agreed additional savings in place to-date, the risk of achieving breakeven remains low.
Sustainability	The Financial Plan supports the sustainability agenda through the delivery of efficient solutions to the delivery of CRES. The Board is forecasting a £6m deficit currently with further additional work to be undertaken to identify plans to reduce this gap.
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 reports an adverse variance position as at month 1 of £711k.

2. The Board has yet to receive its first allocation letter from Scottish Government, but this is expected by the end of May and is expected to confirm the baseline allocation of £291.5m and other uplifts agreed in the Scottish Budget in December 2017. The baseline uplift has been confirmed however allocations for Primary Care, Mental Health and Transformation have not been notified to the Board at the time of writing this paper. There has been an indication that Access funding will be allocated from the transformation fund to Boards at a level of £25m for the first six months of 2018/19 (circa £750k for Dumfries and Galloway). On the assumption this funding will be received waiting times activity has continued to be progressed during April and May.

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 month of the financial year:

Table 1

Service	YTD Budget £000s	YTD Actual £000s	YTD Variance £000s	YTD Variance %
IJB Delegated Services	21,541	22,037	(495)	(2.3%)
NHS Board Services	5,507	5,722	(215)	(3.9%)
Total NHS Board	**27,048**	**27,759**	**(711)**	**(2.6%)**

Month 1 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	152,506	13,071	12,748	323	2.5%
Non-pays	80,855	5,027	5,683	(656)	(13.1%)
Drugs	47,273	3,989	4,191	(202)	(5.1%)
Income	(6,976)	(545)	(585)	40	7.3%
Total	**273,658**	**21,541**	**22,037**	**(495)**	**(2.3%)**

5. The main issue resulting in the current adverse position relates to the level of unidentified and unachieved CRES savings as at the end of April 2018. Plans continue to be formulated and identified and the overall delivery on CRES will improve in the coming weeks as plans are actioned and budgets re-aligned to reflect the savings identified.

6. The current underspends across non-pays offsets the overall overspend due to CRES non-delivery by £205k across the IJB delegated budgets.

7. 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	(69)	(93)	(91)	33	(220)
Facilities & Clinical Support	16	(39)	0	3	(20)
Mental Health Directorate	61	(2)	(1)	(2)	56
Primary & Community Care	156	(85)	(114)	13	(30)
Women's & Children's Directorate	114	(34)	4	2	86
E Health	37	(26)	0	(16)	(4)
Strategic IJB Services	8	(2)	0	5	12
IJB Unidentified CRES	0	(375)	0	0	(375)
IJB SERVICES TOTAL	**323**	**(656)**	**(202)**	**40**	**(495)**

8. Key Variances within the IJB are included within **Appendix 1** of this report and the overall position by Directorate is provided in **Appendix 2**.

Services Retained by the Health Board

9. Overall the functions not delegated to the IJB and retained by the Health Board are reporting a year to date overspend of £215k. The main reason for this variance is once again the current delivery against CRES as at the end of April.

Efficiency Savings

10. The current summary position on the achievement of CRES targets is highlighted in the table below:

Table 4

	Total 2018/19 Target £000s	YTD 2018/19 CRES Gap £000s	2018/19 Recurring CRES Gap (at Month 1) £000s	Total Identified Savings in plan £000s	Recurring Gap as per plan £000s
IJB Delegated services	13,680	(861)	(13,369)	8,300	(5,300)
NHS Board services	3,666	(306)	(3,177)	2,800	(900)
TOTAL	**17,346**	**(1,166)**	**(16,546)**	**11,100**	**(6,200)**

11. The position above reflects a prudent view of the current level of savings identified to-date, with workplans still being updated for month 2 reporting. Table 6 below shows the planned level of savings identified by the directorates

to date, not all of which have been actioned within the month 1 position, until further work is undertaken to remove from the appropriate areas.

Key Actions and Recommendations

12. The Directorates are now focussed on identifying their transformative plans and agreeing timeframes for when recurring savings will be implemented and month 2 will provide a further update on these.

13. Whilst plans continue to be developed across all services, there remains a significant level of work to be undertaken to close the £6m gap in the financial plan.

14. Further work is required across all corporate areas to fully embrace the principals of shared services and regional working to ensure the maximum level of service efficiency and effectiveness is delivered in the coming months.

2018/19 CRES Update

16. NHS Dumfries & Galloway has identified a CRES requirement of £17.346m in 2018/19 in its opening financial plan. The initial draft savings target was increased (by £200k) after a review of cost pressures and developments was undertaken by the Board Management Team. The savings target is summarised below:

Table 5

Summary CRES	**£000s**
Recurring balance b/f	9,631
Medical Locums	5,300
Recurring 2018/19 CRES	4,722
Non-recurring 2018/19 CRES	489
Reserve Review/Cost Pressure Review	(2,796)
TOTAL	**17,346**

17. This represents a 5.95% target when compared to the Boards recurring baseline allocation and 4.78% when compared to total spend.

18. The savings have been allocated to the IJB as per the table below:

Table 6

	2018/19 Target	2018/19 Identified to date	Unidentified Savings
	£m	£m	£m
NHS Board savings			
IJB savings requirement	8.8	5.5	3.3
Procurement	0.3	0.3	0.0
Corporate savings	0.7	0.5	0.2
TOTAL RECURRING	**9.8**	**6.3**	**3.5**
Non-recurring savings/flexibility - IJB	4.8	2.8	2.0
Non-recurring savings/flexibility - NHS	2.7	2.0	0.7
TOTAL NON-RECURRING	**7.5**	**4.8**	**2.7**
TOTAL NHS Board Requirement	**17.3**	**11.1**	**6.2**
IJB	**13.6**	**8.3**	**5.3**
NHS BOARD	**3.7**	**2.8**	**0.9**
OVERALL BOARD POSITION	**17.3**	**11.1**	**6.2**

19. This financial plan acknowledges the likely higher level of non-recurring savings in 2018/19 given the time required to develop and progress the more complex service redesign linked with the transformation programme. The overall plan would be to reduce the level of non-recurring savings requirement over the three years over the plan to 2020/21 to bring the Board back into recurring financial balance. The plan as currently assessed has an unidentified savings challenge remaining of £6.2m, for which further savings plans and options require to be developed.

Efficiency Plans Development 2018/19

20. Progress has already been made towards identifying savings against the 2018/19 target. The progress to date against the targeted areas are set out below. Monitoring of the detailed schemes will be undertaken through the Finance Team and will be presented and discussed through Performance Committee and regular updates will be presented through this update paper in future months.

21. Medical Locum costs is an area we are targeting for savings through a combination of increasing the level of directly engaged doctors with the Board as well as adhering to the rate card cap agreed by the West of Scotland Steering Group, which will deliver a significant reduction in current costs.

22. During 2017/18, savings of £1.8m have been delivered through savings in Primary Care Prescribing. This is planned to continue into 2018/19 through a variety of initiatives which have been set up and agreed with the Pharmacy Support Team to specifically look at areas of expenditure and volume changes across each practice. This links directly with work undertaken by the Realistic Medicine Project in better understanding clinical variation in prescribing.

23. Secondary Care Prescribing is an area we are continuing to target for savings, with a number of initiatives focussed on switching to more effective biological treatments and reviewing alternative formulary choices to further reduce costs in 2018/19.

24. All NHS directorates have been provided with a 2% efficiency target challenge where plans already have been identified around workforce redesign, including skill-mix reviews and administrative reviews, lean principles, catering reviews, co-location of services and review of technology.

25. Corporate services across the NHS Board have been set a higher target to deliver savings of £0.7m for 2018/19 and are similarly expected to undertake service reviews and drive forward savings across all areas of business.

26. It was agreed that the IJB would progress the work on the Business Transformation Programme and these would be presented for scrutiny and review through the Performance and Finance meetings of the IJB. Details of the proposals were presented at the April 2018 meeting, with updates and progress on all schemes to date. This remains one of the key strands of the IJB's sustainability and efficiency work and whilst details of any specific savings have not been developed at this early stage, the plan would be for a three year financial framework to be developed.

27. The facilities management and property costs are part of the delegated budget and, as such, are subject to an efficiency target. This has been one of the targeted areas of the savings plans to release savings from vacant buildings, consider property disposals and reconfigure services to use our accommodation more efficiently. Various property disposals are expected to occur during 2018/19 and there is a level of certainty about deliverability of the savings targets which have been set for this area.

Financial Risks

15. The Financial Plan risks for 2018/19 are well known and many continue from prior years, reflecting the overall level of risk associated with CRES delivery.

16. All known financial risks have been highlighted as part of the Financial Plan process and are highlighted in the table below:

Table 6

Key Assumptions / Risks	Risk rating	Impact
Delivery of CRES	High	Failure of Statutory Requirement to Breakeven
Medical Locum Expenditure	High	Increasing level of expenditure requires additional funding which adds to overall CRES requirement and impact on ability to deliver Breakeven
GP & Acute Prescribing	Medium	A sustained level of ongoing growth and price increases have been included in the financial plan, however there is the potential for increases to be greater than projected.
Pharmaceutical Price Regulation Scheme (PPRS)	Low	The Pharmaceutical Price Regulation Scheme has provided a source of funding in previous year to offset the cost of approved IPTRs and New Medicines. At present the risk of not receiving any ongoing funding is low as no benefit has been assumed for future years.

Key Assumptions / Risks	Risk rating	Impact
Delayed Discharge	High	Need to manage the volume of delayed discharges and the cost of new initiatives that will be required to deliver the required reductions.
External SLA Growth	High	Ongoing increases in activity undertaken in Scottish Board outwith NHS D&G as well as growth in English SLAs (Cumbria & Newcastle)
New Hospital/Mountain Hall Treatment Centre Double Running	High	Continuation of double running of costs associated with opening of new hospital and services maintained within Mountain Hall Treatment Centre
Winter Costs	High	The risk remains whether sufficient additional resources are available to meet the pressures from anticipated winter demand
New GP Contract	Medium	No additional costs of the new GP contract ie immunisation, GMS premises have been included in the financial outlook
Waiting Times	High	There requires to be continued management of the financial exposure on elective capacity pressures. The risk is that the current investment plans to deliver capacity will not deliver the required volume and meet the National Strategy.

Appendix 1

Directorate	M1 Position	Risks/Issues/Challenges and Opportunities
Acute and Diagnostics (including acute prescribing)	(£222k) o/s	• CRES £83k unachieved YTD • Pays £70k overspent – Mainly on nursing due to difficulty in recruiting registered nurses and the increased cost of agency • Non-pays £11k overspent – pressures on travel and patient transport and activity in labs. • Drugs - £91k due to unachieved CRES YTD.
Facilities and Clinical Support	(£20k) o/s	• Main variance relates to unachieved CRES YTD of £15k • Vacancies in Pays results in a YTD underspend of £26k • Non-pays overspend of £23k relates to Heat, Light and power
Mental Health Directorate	£56k u/s	• Pays underspent by £61k – across Community services, medical staffing and psychology. • NPays overspent by £4k – mainly related to CRES unachievement.
Primary and Community Care – NHS	(£30k) o/s	• PCare Prescribing is £114k overspent related to unachieved CRES • Pays is £156k underspent - £68k across Nursing (vacancies), £47k across Medical Staffing and £24k within Admin areas. • Npays are £85k overspent due to unachieved CRES YTD
Women's and Children's	£86k u/s	• Pays £114k underspent related to Medical Staffing (£13k), Ward 15 nursing (£13k), public health nursing (£38k) and midwifery (£34k). • NPays - £30k overspent – due to unachieved CRES YTD
E health	(£4k) o/s	• Pays underspent by £37k, mainly due to vacancies in clinical prep. • Npays is overspent by £26k mainly due to unachieved CRES • Income is underachieved by £15k due to ongoing negotiations around the clinical portal with the Council.
Strategic IJB services (strategic planning etc)	£12k u/s	• Pays is £8k underspent due to vacancies and Npays is £2k overspent due to unachieved CRES YTD. • This is offset with increased income in month 1 relating to MPower
IJB Unidentified CRES	(£375k) o/s	• Balance of remaining IJB CRES to be devolved and identified.
Corporate Services (Health Board)	(£215k) o/s	• Overspend mainly related to the unachieved Corporate CRES of £279k, off-set with underspends within Npays

AREA	Annual Budget				Pays Ytd			Non Pay Ytd			Income Ytd			Total Ytd			
	Pay £000	Non Pay £000	Income £000	Total £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Variance %
OPERATING DIRECTORATES																	
Acute & Diagnostics	77,401	22,535	(940)	98,996	6,866	6,936	(70)	1,903	2,088	(185)	(75)	(108)	33	8,694	8,915	(222)	-3%
Acute Services Redesign	0	40	0	40	0	(1)	1	40	39	1	0	0	0	40	38	2	5%
Facilities & Clinical Support	3,528	12,483	(730)	15,281	269	253	16	947	986	(39)	(54)	(58)	3	1,161	1,181	(20)	-2%
Mental Health Directorate	19,143	2,298	(401)	21,040	1,606	1,545	61	129	133	(4)	(37)	(35)	(2)	1,698	1,642	56	3%
Primary & Community Care	29,632	73,179	(4,099)	98,712	2,427	2,270	156	6,125	6,324	(199)	(349)	(362)	13	8,202	8,232	(30)	0%
Womens & Childrens Directorate	19,562	1,281	(590)	20,253	1,625	1,511	114	123	153	(30)	(12)	(15)	2	1,735	1,649	86	5%
E Health	2,508	3,558	(197)	5,869	209	172	37	116	142	(26)	(16)	(1)	(16)	309	313	(4)	-1%
IJB Strategic Services	733	20,053	(19)	20,767	71	63	8	7	9	(2)	(2)	(7)	5	76	65	12	15%
IJB Unidentified CRES	0	(7,300)	0	(7,300)	0	0	0	(375)	0	(375)	0	0	0	(375)	0	(375)	100%
OPERATING DIRECTORATES TOTAL	**152,506**	**128,128**	**(6,976)**	**273,658**	**13,071**	**12,748**	**323**	**9,015**	**9,874**	**(859)**	**(545)**	**(585)**	**40**	**21,541**	**22,037**	**(495)**	**-2%**
BOARD SERVICES																	
Chief Executive	1,054	1,113	(11)	2,156	88	86	2	80	76	5	(1)	(1)	(0)	167	160	7	4%
Public Health	2,221	667	(459)	2,428	185	175	10	28	12	16	(28)	(23)	(5)	186	165	21	11%
Medical Director	5,032	2,305	(746)	6,591	414	410	4	190	117	73	(62)	(23)	(39)	541	503	38	7%
Nursing Directorate	2,025	242	(106)	2,161	169	176	(7)	20	11	9	(9)	(13)	4	180	174	6	4%
Workforce Directorate	1,982	270	(185)	2,066	151	160	(8)	23	16	7	(15)	(6)	(9)	158	169	(11)	-7%
Finance Directorate	2,838	1,279	(61)	4,055	184	241	(57)	112	13	99	(5)	(2)	(3)	291	253	38	13%
Non Rec Projects	17	299	0	316	3	8	(5)	25	0	25	0	0	0	28	8	20	72%
Strategic Capital	165	15,687	0	15,852	11	37	(27)	2,043	2,046	(3)	0	0	0	2,054	2,083	(29)	-1%
Central Income	0	0	(4,986)	(4,986)	0	0	0	0	0	0	(416)	(404)	(11)	(416)	(404)	(11)	3%
Externals	0	26,129	(3,030)	23,098	0	0	0	2,169	2,170	(1)	(253)	(239)	(13)	1,917	1,931	(14)	-1%
Board Unidentified CRES	0	(3,353)	0	(3,353)	0	0	0	(279)	0	(279)	0	0	0	(279)	0	(279)	100%
BOARD SERVICES TOTAL	**15,335**	**44,637**	**(9,587)**	**50,385**	**1,204**	**1,293**	**(89)**	**4,411**	**4,461**	**(50)**	**(788)**	**(712)**	**(77)**	**4,827**	**5,042**	**(215)**	**-4%**
Non Core	0	9,535	0	9,535	0	0	0	680	680	0	0	0	0	680	680	0	0%
Reserves	3,715	23,600	0	27,315	(0)	0	(0)	0	0	0	0	0	0	(0)	0	(0)	100%
NON CORE & RESERVES TOTAL	**3,715**	**33,135**	**0**	**36,850**	**(0)**	**0**	**(0)**	**680**	**680**	**0**	**0**	**0**	**0**	**680**	**680**	**(0)**	**0%**
GRAND TOTAL	**171,556**	**205,900**	**(16,563)**	**360,893**	**14,275**	**14,041**	**235**	**14,107**	**15,015**	**(909)**	**(1,334)**	**(1,297)**	**(37)**	**27,048**	**27,759**	**(711)**	**-3%**

Agenda Item 167

DUMFRIES and GALLOWAY NHS BOARD

4th June 2018

Considerations for the Board in relation to the Potential Development of a "Maggie's" Centre in Dumfries

Authors:
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Sponsoring Director:
Jeff Ace
Chief Executive

Date: 20th May 2018

RECOMMENDATION

The Board is asked to consider the proposal to develop a Maggie's Centre in Dumfries. In particular, it is asked to agree;

- The IJB role in the governance of decision making.
- Financial contribution.
- Land availability
- Utilisation of Area Clinical Forum to provide formal guidance to Board and IJB.

CONTEXT

Strategy / Policy: This paper can be considered in the context of the National Cancer Plan and the IJB's Strategic Planning framework.

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

The paper highlights potential to facilitate delivery of a major new facility in Dumfries which would provide third sector led support to patients, families and carers experiencing cancer. Such facilities have previously only been available at tertiary treatment centres in Glasgow and Edinburgh.

GLOSSARY OF TERMS

NHS - National Health Service

MONITORING FORM

Policy / Strategy	Health and Social Care Strategic Plan. National Cancer Strategy
Staffing Implications	None for NHS D&G
Financial Implications	Up to £250,000 capital with a recurring revenue commitment of £80,000.
Consultation / Consideration	Consultation with Board Management Team
Risk Assessment	Strategic discussion paper hence no formal risk assessment carried out.
Risk Appetite	Low [✓] Medium [ ] High [ ] This paper relates to a service change, as well as a financial risk and clinical impact, therefore, a low risk appetite has been noted for this paper.
Sustainability	Not applicable
Compliance with Corporate Objectives	1. To reduce health inequalities across NHS Dumfries and Galloway. 5. To maximise the benefit of the financial allocation by delivering clinically and cost effective services efficiently. 6. Continue to support and develop partnership working to improve outcomes for the people of Dumfries and Galloway.
Local Outcome Improvement Plan (LOIP)	Outcomes 3 and 6
Best Value	• Use of resources • Equality • Sustainability
Impact Assessment Impact assessment has not been carried out as this is a general strategic discussion paper. Any definitive proposals that may arise from the paper will have impact assessment carried out as part of their planning.	

EXECUTIVE SUMMARY

This report was commissioned by the Chief Executive of NHS Dumfries and Galloway to support consideration of the proposal to develop a “Maggie’s” Centre in Dumfries.

Section 1 of this report begins with the necessity for change in how services are provided in Dumfries and Galloway. It links to relevant National and local policies.

Section 2 of the report briefly presents the context for population health in Dumfries and Galloway in terms of demographics and the particular impact of cancer on the population.

Section 3 of the report sets out the“Maggie’s” proposal for the development of a local Centre and the key decisions for Board consideration.

The report concludes with a recommendation as to the appropriate way forward for the Board.

1. Strategic Context

The economic crisis that began in 2008-09 has led to increased pressures on health and social care funding. Simultaneously the rising costs of health care, the development of new medicines and technologies, the impact of ageing populations, social isolation, reduced social care services and high patient expectations have increased demand and added to financial pressure on health services. From all of these factors, the one certainty is that health and social care face considerable and ongoing resource challenges.

The current pattern of health and social care services is widely recognised as unsustainable. The key drivers for change can be summarised as:

- The need to respond to changing conditions in Dumfries and Galloway’s population
- Unsustainable current and predicted future costs of ill-health
- Long term health and social care service challenges including the staffing of services
- The need to continue to improve, or at least to maintain, the quality of health and social care services.

1.1 Strategy and Policy

Within Dumfries and Galloway, the Health and Social Care Strategic Plan aims to bring about radical service change: http://www.dg-change.org.uk/strategic-plan/

This is an exciting and opportune time in Dumfries and Galloway to plan new ways of working. Our new acute district general hospital successfully opened at the end of 2017 and the integration of health and social care is on the way to changing the way that health and care services are planned and delivered.

"Beating Cancer: Ambition and Action (March 2016), www.gov.scot/Resource/0049/00496709.pdf seeks to improve the outcomes and experiences of people affected by cancer across Scotland by improving service delivery and reducing health inequalities. A significant challenge in achieving these ambitions is for health, social care and third sector services to develop sustainable and innovative approaches to cancer care.

The strategy acknowledges Scotland's changing demographic profile; i.e. by 2039 the number of people aged over 65 years is expected to rise by 53% to 1.5 million. This will have an inevitable impact on the demand for health and social care services, including cancer services as increases in the incidence of cancer are partly due to the ageing population.

The NHS Dumfries and Galloway Lead Cancer Team are responsible for delivering the recommendations within the National Cancer Strategy, and are currently refreshing the Dumfries and Galloway Action Plan.

In 2015, the Scottish Government stated its vision for palliative and end of life care:

"By 2021 everyone who needs palliative, end of life care and bereavement support will have appropriate access, regardless of age, gender, diagnosis, social group or location"

"We aim to provide a "good death" for all, one which emphasises respect and dignity, underpinned by patient and carer preferences and choices and the provision of genuinely person centred care".

A Dumfries and Galloway strategic outline for co-production is currently in draft and progressing through NHS governance groups, prior to broad consultation and co-production; and articulates the vision and aspirations for Dumfries and Galloway in this area.

This strategic co-production approach will set priorities and seek to enable best value in terms of outcomes, experiences and use of resources and also reduce the risk of inadvertently creating inequity of access or provision.

Scottish Government has set out nine national health and wellbeing outcomes (Scottish Government, 2015). Two of the outcomes are particularly relevant to this report:

- Outcome 4: Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
- Outcome 9: Resources are used effectively and efficiently in the provision of health and social care services.

2. CONTEXT

2.1 Population Profile

Dumfries and Galloway is one of the most rural areas of Scotland, where issues such as transport, access to services and rural deprivation can have a marked impact. The region covers 6,426 square kilometres with a population of approximately 150,270 people.

Almost half of the population (46%) live in areas classified as rural, which is defined as living in settlements with fewer than 3,000 people and many (22%) live in remote rural locations.

The only urban areas are the towns of Dumfries and Stranraer, though neither of these is classified as a large urban area.

In terms of accessibility; just over a quarter (27%) of the population live in areas classified as remote (remote rural or remote small towns), which are defined as further than 30 minutes' drive away from a large town.

The latest population projections from the National Records of Scotland indicate that over the next 25 years younger people will make up a smaller proportion of our population than is currently the case.

2.2 Cancer in Scotland

It is estimated that more than 2 in 5 people in Scotland will develop some form of cancer, with increased risk over the age of 65. Data trends predict that there will be over 168,000 cases of cancer diagnosed in adults in Scotland during 2016 – 2020 around 33,000 cases p.a.

*(*Cancer in Scotland: Sustaining Change Cancer Incidence Projections for Scotland (2001 – 202) Scottish Executive 2004).

2.3 Local Cancer Incidence

Overall, 2.9% of men and 3.7% of women in Scotland are living with cancer (2,882 men and 3,699 women per 100,000) this equates to almost 4,500 men and over 5,500 women in Dumfries and Galloway.

The following table represents the number of actual incidents of cancer by locality in Dumfries and Galloway during 2012-2014:

source ACaDMe

Year	Annandale & Eskdale	Nithsdale	Stewartry	Wigtownshire	Total
2012	253	354	178	216	1001
2013	235	373	164	187	959
2014	311	401	226	229	1167

Future estimated incidences of cancer by locality are demonstrated below; however it is worth noting that the actual incidences of cancer were slightly less than those estimated for 2012-2014 (93 less in 2012, 148 less in 2013 and 44 less in 2014):

Year	Annandale & Eskdale	Nithsdale	Stewartry	Wigtownshire	Total
2015	295	415	203	225	1137
2016	300	420	205	227	1152
2017	305	427	207	230	1169
2018	310	434	209	232	1184
2019	314	440	211	234	1199
2020	319	445	212	236	1213
2021	323	451	214	239	1227
2022	328	457	216	241	1242
2023	332	463	217	242	1255
2024	336	469	219	244	1268
2025	340	474	220	246	1280
2026	344	479	222	247	1292

Estimated numbers based on 2012-based locality population projections, National Records of Scotland (NRS) applied to all cancer (excluding non-melanoma skin cancer) incident rates, at 5 year age groups, for Scotland 2008-2012 (rates taken from ISD Cancer Incidence projections 2012-2037, http://www.isdscotland.org/Health-Topics/Cancer/Cancer-Statistics/Incidence-Projections/)

Each year around 1,900 people die in Dumfries and Galloway. On average approximately 28% of deaths are attributed to cancer.

Cause of Death	Average %
Cancer	28%
Ischaemic Heart Disease	14%
Respiratory Disease	13%
Stroke	8%
Dementia	7%
External Causes	4%
Other Diseases (combined)	26%

Source: NRS

3. THE MAGGIE'S CENTRE PROPOSAL

3.1 An opportunity has arisen to work with "Maggie's" to build a Centre in the grounds of DGRI to support people affected by cancer, their family and carers.

Appendix 1 is a paper produced by Sarah Beard of Maggie's that sets out the organisation's perspective on the development and provides clarity on the key requirements for NHS Dumfries and Galloway, namely;

1. Land at a peppercorn rent at the new D&G Royal Infirmary
2. Confirmation of a financial contribution (the revenue contribution is particularly important)
3. Formal Support from the Health Board Execs and senior clinicians for a Maggie's Centre at Dumfries

4. Confirmation of numbers of new cancers diagnosed per annum

Taking each of these in turn;

3.2 Land Availability

Appendix 1 highlights the potential site for a Dumfries 'Maggie's Centre' at the new DGRI. This is currently a landscaped area adjacent to the main entrance and patient car park and has not been earmarked for alternative use. It would be possible within the framework of NHS Scotland's Property Transactions Manual to make this site available to 'Maggie's' at a notional rent. The site could be made easily accessible though we would need to undertake traffic assessments to determine requirement for additional car parking provision. We would also need to mitigate any impact on current patient access and parking during construction.

Whilst there is obviously an opportunity cost associated with land use, the overall risk to the Board in utilising this space for a 'Maggie's Centre' appears low and manageable. We would, of course, be subject to the usual planning processes managed by Dumfries and Galloway Council.

3.3 Financial Contribution

Early discussions on the quantum of financial support required by the Board have led to an in-principle commitment of capital support of £250,000 and a recurring revenue contribution of £80,000. These are significant sums in the context of the Board's overall financial position and its requirement for significant cash releasing savings. If the Board formally commits to this sum, additional savings from either clinical or other services will be required in order to achieve our statutory duty of break even.

3.4 Board and Clinical Support

Since the creation of the Integrated Joint Board (IJB), the issue of decision making on major projects has become somewhat more complex. The NHS Board holds all assets and is responsible for capital infrastructure decisions. However, the IJB has primacy in the strategic planning and commissioning of services and therefore has a legitimate interest in service developments of this scale together with their associated costs. It may therefore be appropriate for both bodies to consider the proposal and align their views on best way forward.

There has been considerable clinical discussion around the proposal and its fit both with existing cancer advice services and with our wider approach to chronic conditions management. The Area Clinical Forum is best placed to offer definitive guidance to the Board and, if agreed, a formal request for advice can be submitted following this discussion.

3.5 Confirmation of Cancer Diagnoses

This data is provided in the report.

4. CONCLUSIONS

The paper at Appendix 1 provides a succinct evaluation of the potential advantages to the population of Dumfries & Galloway from the development of a ‘Maggie’s Centre’ in Dumfries. These centres have proved enormously popular with patients across the UK and have a proven track record of support to families at a particularly stressful time.

Board considerations of this proposal should include its affordability in the current financial environment and the governance of the decision making to ensure alignment of all key stakeholders.

References

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Report prepared by: Sarah Beard, Business Development Director, Maggie's

Report Sponsored by: Jeff Ace, CEO Dumfries and Galloway Health Board

Potential Maggie's Centre Development at Dumfries and Galloway Health Board
April 2018

1.0 Purpose and Introduction:

The purpose of this paper is to provide information to D&G Health Board regarding the potential development of a Maggie's Centre at the newly built Dumfries and Galloway Royal Infirmary.

2.0 Background:

Over the last three years there has been growing interest from groups and individuals from within and outside the Healthcare community for the development for a Maggie's Centre at Dumfries. An Interest group, chaired by Prof David Clark has been established to support the proposed development.

In 2015/16 D&G Health Board generously pledged £250k towards a Maggie's Centre capital development and an £80k per annum revenue commitment. A Maggie's development could not be taken forward if this commitment (particularly the revenue funds) is not formally confirmed. D&G Health Board are planning to ratify this commitment at Performance Committee in May 2018.

2.1 Dumfries and Galloway – Geographic challenges

It well known and accepted that Dumfries and Galloway is a challenging region for the delivery of equitably accessed health care services. D&G is a rural area with a dispersed population of just over 150,000. The main town and centre of population is Dumfries (pop 31,000). The region stretches over 100 miles from Stranraer in the west to Langholm in the east. It has an ageing population and the proportion of those people age 65 and over will make up 27% of those living in the region by 2020. The over 75s will grow by 77% from less than 15,000 in 2010 to 26,000 in 2035.

2.2 Cancer diagnosis and treatment

Across Dumfries and Galloway there are people with a variety of health and social problems of a kind that can be ameliorated by person-centered care organised through services where the main goals are to reduce the burden of illness, improve quality of life and promote resilience. These goals assume particular salience in the face of life-threatening and progressive disease, and are especially relevant in the context of cancer care. Each year there is c.1,400 new cases of cancer in the region, including skin cancers. These figures could rise in line with national forecasts by 28% over the next 20 years. In the years 2005-10 malignant neoplasms accounted for 3124 deaths in Dumfries and Galloway.

2.3 Strategic Fit for Maggie's

Maggie's now operates at all major cancer centres in Scotland. Furthermore, we have successfully established Maggie's Centres at three Cancer Units; Lanarkshire, Fife and Forth Valley. Establishing a Maggie's Centre at Dumfries would enable Maggie's to meet the cancer support needs of those living in the Borders of Scotland, and would make a significant impact in our organisational coverage across Scotland.

Dumfries, Maggie Keswick Jencks' home town, also has significance in our organisation's history.

2.4 Strategic Fit for Dumfries and Galloway

Over the last few years D&G Health Board have been driving to improve the quality, delivery and experience of cancer services. Local cancer strategies have been aimed at two key goals: improving overall cancer detection and survival rates; and enabling positive experiences of care and improved quality in service delivery.

Key ambitions within the strategies include: optimising individual choice and decision making as well as partnership working across NHS Dumfries & Galloway, Dumfries & Galloway Council and the Third Sector to maximise the benefits to those with cancer and their carers; developing services that deliver improvements in quality of life, increasing self-reliance and resilience; improved access to services, and better long term outcomes for people diagnosed with cancer.

These goals and ambitions are clearly relevant to the development of a Maggie's Centre in Dumfries and Galloway and provide a strong supporting framework for such a proposal. At the moment people with cancer in Dumfries and Galloway can only access Maggie's services by visiting Centres in Edinburgh and Glasgow – at least two hours away by car.

2.4.1 Existing support services

There are cancer information centres in both Dumfries and Galloway Royal Infirmary (Dumfries) and the Galloway Community Hospital (Stranraer) with a part time centre based in Newton Stewart, all are supported by Macmillan. These centres offer information on treatment and support, Cognitive Behavioural Therapy and psychological support input and benefits advice as well as facilitating support groups and running classes for people who have completed treatment. They are managed by salaried staff and supported by volunteers.

3.0 Current position:

Maggie's are keen to work with D&G Health Board to create a Centre that will be sustainable over the long term and will be regarded as a valuable community asset.

Maggie's requires the following commitment from D&G Health Board:

5. Land at a peppercorn rent at the new D&G Royal Infirmary
6. Confirmation of a financial contribution (the revenue contribution is particularly important)
7. Formal Support from the Health Board Execs and senior clinicians for a Maggie's Centre at Dumfries
8. Confirmation of numbers of new cancer diagnosed per annum (1,400 p/a)

In return, Maggie's pledges to provide:

9. A high quality cancer support facility that is free of charge to all that wish to use it
10. Centre of significant architectural merit
11. A commitment to consider evolving the availability and accessibility of our support service to groups and individuals beyond those with a cancer diagnosis – once the centre is fully operational (3-5 years)

As soon as this project is formalised by D&G Health Board (Maggie's Board have already approved the project in principle, subject to confirmation of financial support from D&G Health Board) the project can begin. It's likely to take 4 years for Maggie's to complete the project and open the Centre, albeit, our timescales are fundraising dependent.

3.1 Projected activity with Maggie's Dumfries

It's acknowledged that the population of Dumfries and Galloway is small and dispersed and the number of new cancer diagnosed each year is smaller (at 1,400 p/a) than any of the other cancer units Maggie's currently supports. However, based on our Programme Framework and informed by the activity levels of Maggie's Centres located at Cancer Units we would expect to see 4,000-7,000 visits per annum in years 1-3 of operation. We would expect this figure to rise to 7,000–9,000 visits per annum in subsequent years.

The Centre team would be made up of a Centre Head (usually an oncology nurse by background), a Clinical psychologist and Benefits and Welfare Advisor. This team would also be supported by paid sessional staff who would deliver specific programme elements such as nutritional workshops, yoga, Tai Chi, relaxation and art therapy (for Kids days) See Appendix A for an example timetable.

3.2 Potential future developments

Maggie's would be committed to ensuring a Centre at Dumfries is successful. Our focus across Scotland is to ensure that our Centres support at least 40% of the new cancer population. We are committed to ensuring activity levels at each of our Centres continues to grow – which is currently being achieved in the majority of centres (see appendix B).

Maggie's would be committed to establishing a high quality cancer information and support service at Dumfries and Maggie's would work collaboratively with D&G Health Board to improve access to support services and improved patient experience across the region.

A Maggie's Centre usually takes 3 years to become fully utilised and embedded within the local community; at which point Maggie's would formally review the Centres' effectiveness and identify opportunities for further grow and development. Maggie's would be open to other 'group's using the Centre as a venue for wellbeing activities and would potentially considering widening the population the Centre supports.

4.0 Fundraising and Financial Sustainability

Maggie's has commissioned an external fundraising feasibility and competitor analysis to confirm that a Maggie's Centre in Dumfries is financially viable.

The exercise is not yet complete but early indications suggest that Maggie's Dumfries is a viable project and will be sustainable over the long term. We are also confident that a Centre in Dumfries will also contribute positively to our reach, access and organisational awareness across Scotland.

Maggie's in-house prospect research and major giving team have also begun to identify a number of potential major donors, Trusts and Individuals capable of multi-million pound donations. Following the formal outcome of the fundraising feasibility, a robust and comprehensive campaign plan will be created to support the successful delivery of the campaign.

D & G Health Board have generously pledged £250k towards the capital development and an £80k per annum revenue commitment. A Maggie's development will not be taken forward if this commitment (particularly the revenue funds) is not formally confirmed. D&G Health Board are planning to ratify this commitment at the May 2018 Performance Committee.

It's likely that Maggie's would establish a £3-4m fundraising campaign to support the development of Maggie's in Dumfries.

4.0 Consideration of Site Options

D&G Health Board have allocated a potential site for Maggie's at the new Royal Infirmary Hospital (see appendix C) Formal confirmation that this site is still available for Maggie's is required.

Once this project has been formally approved by D&G Health Board, Maggie's will look to appoint an architect to delivery the scheme.

5.0 Conclusion:

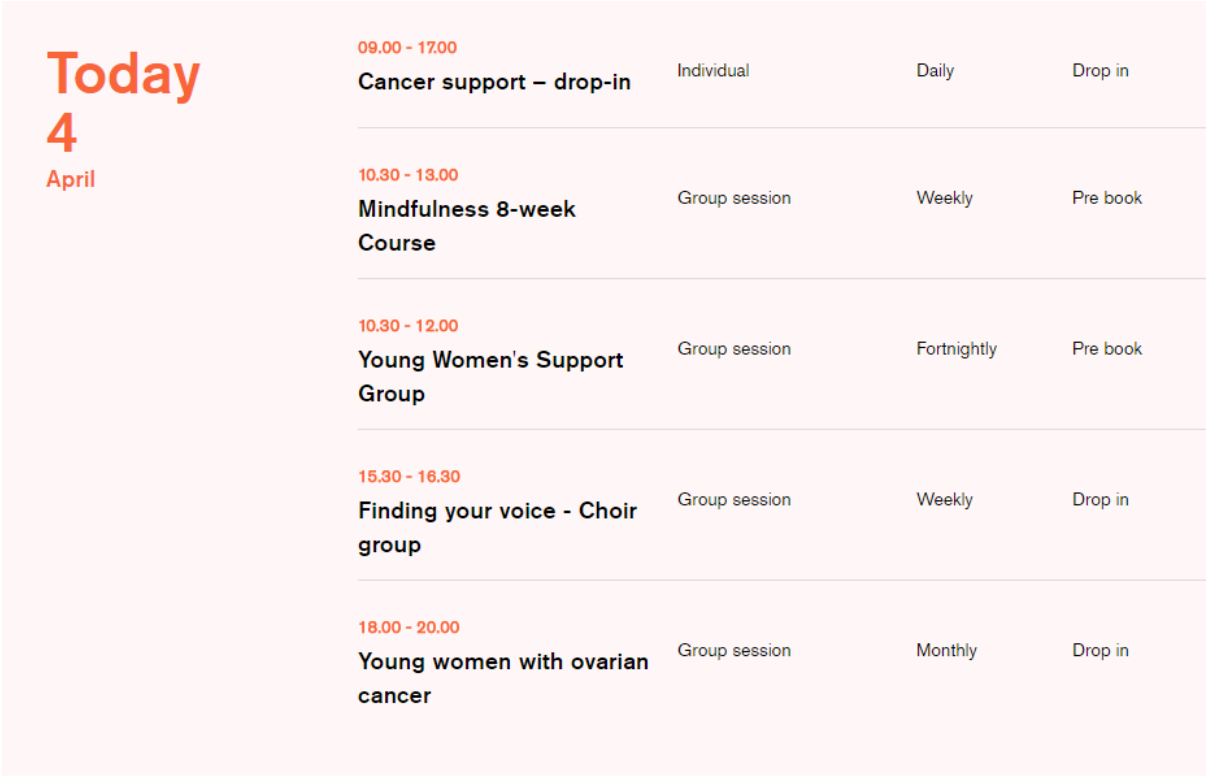
Maggie's is keen to work with D&G Health Board to establish a Maggie's Centre in the grounds of the new Royal Infirmary. As soon as D&G Health Board are able to formalise their commitment to the project, through the allocation of land and financial resources the project will begin.

Maggie's is ambitious to make a positive contribution to the quality of care and experience of those affected by cancer in Dumfries and Galloway.

Appendix A

Example Timetables

09.00 – 17.00:	**Cancer support drop-in**
10.00 – 11.00:	Yoga (drop in)
11.15 – 12.30:	Support Group for people with secondary cancer
13.00 – 15.00:	Brain tumour support group (monthly)
13.00 – 15.00:	Look Good Feel Better
14 00 – 15.00:	Drop in Relaxation group
13.15 – 16.15:	Managing Sleep Difficulties
14.00 – 15.30:	Bereavement Group



Today
4
April

09.00 - 17.00	Cancer support – drop-in	Individual	Daily	Drop in
10.30 - 13.00	Mindfulness 8-week Course	Group session	Weekly	Pre book
10.30 - 12.00	Young Women's Support Group	Group session	Fortnightly	Pre book
15.30 - 16.30	Finding your voice - Choir group	Group session	Weekly	Drop in
18.00 - 20.00	Young women with ovarian cancer	Group session	Monthly	Drop in

Appendix B

Activity throughout all Maggie's Centres in Scotland

Maggie's (No. of cancer diagnosis p/a)		**2015**	**2016**	**2017**
Aberdeen (2,700)	All visits	**9,332**	**10,253**	**9,958**
	PWC	4,696	5,400	4,983
	Carers	3,172	3,749	3,880
Dundee (2,100)	All visits	**10,762**	**12,067**	**13,535**
	PWC	6,088	6,839	7,523
	Carers	3,973	4,401	4,721
Edinburgh (4,400)	All visits	**20,152**	**20,792**	**20,130**
	PWC	12,469	12,976	12,323
	Carers	7,091	7,169	7,186
Fife (1,700)	All visits	**7,755**	**6,984**	**6,978**
	PWC	4,368	4,410	3,692
	Carers	2,634	2,175	2,666
Forth Valley (1,600)	All visits			**5,619**
	PWC			2,796
	Carers			1,524
Glasgow (8,000)	All visits	**20,218**	**17,699**	**16,336**
	PWC	11,819	10,856	9,588
	Carers	6,827	5,520	5,168
Highlands (1,900)	All visits	**7,620**	**7,993**	**9,747**
	PWC	4,367	4,298	5,670
	Carers	2,367	2,197	3,169
Lanarkshire (3,500)	All visits	**4,775**	**6,247**	**6,824**
	PWC	2,141	3,066	3,295
	Carers	1,792	2,396	2,655

PWC – People with cancer

Appendix C

Potential location for Maggie's at the new Dumfries Royal Infirmary

Agenda Item 168

DUMFRIES and GALLOWAY NHS BOARD

4th June 2018

Population Health and Wellbeing Interventions: Cost Effectiveness and Contribution to Sustainability of NHS Services

Authors:
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Strategic Planning Manager/ Commissioner

Sponsoring Director:
Michele McCoy
Interim Director of Public Health

Date: 10th May 2018

RECOMMENDATION

The Board is asked to note the evidence that a number of population health and wellbeing interventions:

1) Can be very cost effective;
2) Can work in the short to medium term as well as over longer periods;
3) Support sustainability of Health Services.

The Board is asked to continue to support evidence-based population health and wellbeing interventions.

CONTEXT

Strategy / Policy:

Nationally this paper supports the aim in the Health and Social Care Delivery Plan to improve population health through targeting particular health behaviours, acting to reduce avoidable harm and illnesses and taking a population- and lifetime-wide approach to prevention and early intervention treatment. It is in line with the section 'A Realistic Approach to Population Health' in the Chief Medical Officer for Scotland's Annual Report 2016/17: *Practising Realistic Medicine*.

It also supports three of the Scottish Government's health and wellbeing outcomes:

- People are able to look after and improve their own health and wellbeing and live in good health for longer;
- Health and social care services contribute to reducing health inequalities;
- Resources are used effectively and efficiently in the provision of health and social care services.

Locally the paper supports similar outcomes in the Health and Social Care Strategic Plan.

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

The paper presents evidence that certain population health and wellbeing interventions can help achieve important health and wellbeing outcomes. In addition, current patterns of use of health and social care services are widely recognised as not sustainable. Making maximum use of effective population health and wellbeing interventions can help to ensure the sustainability of health and social care services.

GLOSSARY OF TERMS

BCR	-	Benefit cost ratio
DALY	-	Disability-adjusted life year
NICE	-	National Institute for Health and Care Excellence
QALY	-	Quality-adjusted life year
ROI	-	Return on investment
SIMD	-	Scottish Index of Multiple Deprivation
WHO	-	World Health Organisation

MONITORING FORM

Policy / Strategy	Health and Social Care Strategic Plan.
Staffing Implications	Not applicable to this general strategic discussion paper.
Financial Implications	No financial implications for this strategic discussion paper. Any financial implications associated with the delivery of recommendations will be identified and reported to appropriate structures.
Consultation / Consideration	Strategic paper discussed with NHS Board Chief Executive and Chief Officer of the Integrated Joint Board.
Risk Assessment	Strategic discussion paper hence no formal risk assessment carried out. The paper can help to address the major risk of lack of sustainability of health and social care services.
Risk Appetite	Low [ ] Medium [X] High [ ] The paper addresses the business risk category of reducing or preventing demand for services (high risk appetite) and the finance risk category of unsustainable provision of services (low risk appetite). Overall risk appetite is therefore assessed as medium.
Sustainability	This paper supports more sustainable needs for health and social care services.
Compliance with Corporate Objectives	1. To reduce health inequalities across NHS Dumfries and Galloway. 5. To maximise the benefit of the financial allocation by delivering clinically and cost effective services efficiently. 6. Continue to support and develop partnership working to improve outcomes for the people of Dumfries and Galloway.
Local Outcome Improvement Plan (LOIP)	Outcome 3: Health and wellbeing inequalities are reduced.
Best Value	• Use of resources • Equality • Sustainability
Impact Assessment Impact assessment has not been carried out as this is a general strategic discussion paper and does not propose specific work programmes. Any new proposals that may arise from the paper will have impact assessment carried out as part of their planning.	

An Executive Summary of the report **Population Health and Wellbeing Interventions: Cost Effectiveness and Contribution to Sustainability of NHS Services** is given in the main body of this paper, with the full report as Appendix.

EXECUTIVE SUMMARY

This report was commissioned by the Chief Executive of NHS Dumfries & Galloway to support consideration of population interventions that:

1) contribute to the improvement of health, reduction of ill health in the population and reduction in health inequalities;
2) maximise return on investment across the population;
3) assist in reducing demand for NHS services.

It is anticipated that the report will prompt local discussions that will contribute to the future planning of population health and wellbeing interventions.

Section 1 of this report begins with the necessity for change in how services are provided in Dumfries & Galloway.

It displays key findings from the Scottish Burden of Disease Study, which show that the top contributors to early death and disability are in order of magnitude:

1. ischaemic heart disease
2. neck and lower back pain
3. depression
4. chronic obstructive airways disease
5. lung cancer
6. stroke
7. Alzheimer's and other dementias
8. drug use
9. disorders of sense organs
10. anxiety

Many of these conditions are potentially preventable and can be addressed by population health actions.

Section 2 of the report presents the context for population health in Dumfries & Galloway in terms of demographics, the particular importance of health and wellbeing in children and young people, and the relevance of health inequalities and socioeconomic deprivation.

A vision for health and wellbeing is set out, which supports all three aims identified by the Chief Executive. The benefits and challenges of preventative spending in a time of financial stringency are noted. The section finishes with explanations of measures used to assess and compare the cost effectiveness of interventions (Return on Investment, Benefit to Cost Ratio, Disability-Adjusted Life Years and Quality-Adjusted Life Years). These measures can be applied to preventative interventions as well as to treatment interventions such as drug treatments.

Section 3 investigates how population health approaches can be part of the solution to the unsustainability of current services.

It discusses the benefits of population health approaches and identifies four mechanisms for delivery of these approaches:

1. national interventions delivered nationally (e.g. smoke-free public places);
2. programmes planned nationally and delivered locally (e.g. immunisation programmes);
3. local programmes led by Public Health services (e.g. initiatives to increase physical activity in communities);
4. local disease prevention approaches led by services other than Public Health services (e.g. hospital weight management clinics).

All four types of preventative interventions have potential benefits and can help support sustainable health and care systems.

Three reviews provide good overviews of cost effectiveness of population health interventions. These are:

A. The case for investing in public health (World Health Organisation, 2014)
B. The cost effectiveness of public health interventions (Owen et al, 2011)
C. Return on investment of public health interventions – a systematic review (Masters et al, 2017)

Section 4 presents details of the findings from the three reviews under the different mechanisms for delivery of population health approaches and draws out important aspects.

Section 5 identifies key messages from the findings. These include:

- Many health and wellbeing interventions are worth investing in. They either save money directly or are very cost effective compared with the thresholds used by the National Institute for Health and Care Excellence (NICE).
- Some population health interventions give relatively quick wins (less than five years to have positive outcomes) while others take longer but still show benefits. Examples of interventions that can give returns on investment in 1-2 years include mental health promotion, promoting physical activity, some immunisations, healthy employment, violence prevention and road traffic injury prevention.
- The most cost effective preventative programmes led by Public Health services include increasing physical activity, smoking cessation, a healthier diet and workplace interventions.
- Other interventions with lower cost effectiveness (but still cost effective according to the NICE thresholds) include certain interventions to prevent sexually-transmitted infections and under 18 conceptions, to reduce substance misuse among vulnerable young people, to increase mental wellbeing in older people, and to prevent harmful drinking.
- Not all preventative interventions are cost effective, e.g. advice about physical activity to older people.
- A number of preventative interventions usually led by services other than Public Health also show cost effectiveness.
- Community falls prevention has a particularly striking level of cost effectiveness and most of the savings from preventative actions accrue directly to health and social care services.

The report ends with a number of recommendations. One important message is that cost-effective preventative interventions and programmes should be a priority and should continue to be supported even in a challenging financial environment.

Failure to support cost-effective population interventions will lead to increased costs of treatment and a continued lack of sustainability of NHS and other services.

Appendix 1

POPULATION HEALTH AND WELLBEING INTERVENTIONS:

COST EFFECTIVENESS AND CONTRIBUTION TO SUSTAINABILITY OF NHS SERVICES

CONTENTS

1. THE NECESSITY FOR CHANGE

The economic crisis that began in 2008-09 has led to increased pressures on health and social care funding. Simultaneously the rising costs of health care, the development of new medicines and technologies, the impact of ageing populations, social isolation, reduced social care services and high patient expectations have increased demand and added to financial pressure on health services. From all of these factors, the one certainty is that health and social care face considerable and ongoing funding challenges.

The current pattern of health and social care services is widely recognised as unsustainable. The key drivers for change can be summarised as:

- The need to respond to changing conditions in Dumfries & Galloway's population
- Unsustainable current and predicted future costs of ill-health
- Long term health and social care service challenges including the staffing of services
- The need to continue to improve, or at least to maintain, the quality of health and social care services.

1.1 Strategy and Policy

The challenges facing health and social care services are well recognised. A number of national strategic and policy approaches articulate Scottish Government's ambition to ensure the future health and wellbeing of Scotland's population. Addressing inequalities in life circumstance, focusing on prevention and early intervention, building a personalised approach to care, reducing unnecessary variation, innovating and reshaping health and social care are among the strategies that provide a direction of travel for the NHS and its partner organisations.

Links to major national strategies and policies are provided below:

- Fairer Scotland Action Plan (Scottish Government, 2016a) http://www.gov.scot/Publications/2016/10/9964
- Realistic Medicine: The Chief Medical Officer's Annual Report 2014/15 (Scottish Government, 2016b) http://www.gov.scot/Publications/2016/01/3745/0
- Realising Realistic Medicine: The Chief Medical Officer's Annual Report 2015/16 (Scottish Government, 2017) http://www.gov.scot/Publications/2017/02/3336
- Practising Realistic Medicine: The Chief Medical Officer's Annual Report 2016/17 (Scottish Government, 2018) http://www.gov.scot/Publications/2018/04/6385/0
- The Public Bodies (Joint Working) (Scotland) Act 2014 (Scottish Government, 2014) http://www.legislation.gov.uk/asp/2014/9/pdfs/asp_20140009_en.pdf
- Scotland's Health and Social Care Delivery Plan (Scottish Government, 2016c) (http://www.gov.scot/Publications/2016/12/4275/downloads

Within Dumfries & Galloway, the Health and Social Care Strategic Plan aims to bring about radical service change: http://www.dg-change.org.uk/strategic-plan/

Taken together, these strategies have considerable potential to improve health and social services, yet they may still fail to ensure the sustainability of services. One important approach that is largely missing from the above is making the maximum use of interventions and programmes that have been shown to reduce future demand on services.

1.2 The Burden of Disease in Scotland

Burden of disease is a measure of population health which quantifies the difference between living to old age in good health and the opposite, where healthy life is shortened by illness, injury, disability and early death. The Scottish Burden of Disease Study 2015 (NHS Health Scotland and ISD Scotland, 2017) has recently been published and gives an overview of the major disease burden affecting the population. There are not at present data giving specific burden of disease for Dumfries & Galloway, but the picture will be very similar to that for Scotland overall.

When looking at broad groups of diseases, conditions and injuries in Scotland, cancer causes the biggest burden, followed by cardiovascular diseases and mental and substance use disorders. Table 1 ranks the top 10 individual diseases by overall disease burden, which includes both early death and disability. The measure of disease burden used is the disability-adjusted life year (DALY) which takes account of both early death and disability. It is explained in more detail in Section 2.6 on cost effectiveness.

Table 1: Burden of disease (DALY) ranked by individual diseases with the highest burden, Scotland 2015

Rank	Disease	Total DALYs
1	Ischaemic heart disease	100,400
2	Neck and lower back pain	90,200
3	Depression	76,000
4	Chronic obstructive airways disease	60,700
5	Lung cancer	59,200
6	Stroke	56,900
7	Alzheimer's and other dementias	56,300
8	Drug use disorders	46,900
9	Sense organ diseases	34,300
10	Anxiety disorders	30,100

Burden of disease due to individual health problems can be separated into the greatest burdens caused by early deaths (Table 2) and greatest burdens caused by disability (Table 3).

Table 2: Leading causes of early death (ranked by years of life lost), Scotland 2015

Rank	Disease	Years of Life Lost
1	Ischaemic heart disease	86,100
2	Lung cancer	58,200
3	Chronic obstructive airways disease	42,000
4	Stroke	40,800
5	Alzheimer's and other dementias	36,800
6	Drug use disorders	26,000
7	Chronic liver diseases	24,600
8	Colorectal cancer	23,500
9	Suicide and self-harm related injuries	21,800
10	Lower respiratory infections	20,600

Table 3: Leading causes of disability (ranked by years of life lived with disability, Scotland 2015

Rank	Disease	Years of Life with Disability
1	Neck and lower back pain	90,200
2	Depression	76,000
3	Sense organ diseases	34,300
4	Anxiety disorders	30,100
5	Migraine	27,800
6	Drug use disorders	20,900
7	Alzheimer's and other dementias	19,600
8	Alcohol dependence	19,000
9	Chronic obstructive airways disease	18,800
10	Diabetes	18,100

There were more person-years lived in less than ideal health due to neck and lower back pain in 2015 than there were lost to early heart disease deaths, and more person-years lived with disabling depression than lost to early lung cancer deaths. This serves as a reminder that living longer does not necessarily equate to a healthy, happy life. It is right that services aim to prevent and tackle diseases that can kill like heart disease or lung cancer but it is equally important to address the burden of living in less than ideal health (NHS Health Scotland and ISD Scotland, 2017).

It is notable that many diseases on the above lists have causes that include our inability (for multiple reasons) to live in ways that create and sustain health and wellbeing (relating to food, activity, tobacco, alcohol and drugs). Other diseases on the lists are associated to some extent with living longer.

1.3 Three Core Aims

Scottish Government has set out nine national health and wellbeing outcomes (Scottish Government, 2015). Three of the outcomes are particularly relevant to this report:

- Outcome 1: People are able to look after and improve their own health and wellbeing and live in good health for longer;
- Outcome 5: Health and social care services contribute to reducing health inequalities;
- Outcome 9: Resources are used effectively and efficiently in the provision of health and social care services.

Public Health leads on improving health and wellbeing and reducing health inequalities. It cannot achieve these outcomes on its own, but works towards them by leading, facilitating and working with professionals, other partner organisations and the public. What may be less obvious are the Public Health contributions to ensuring efficient and effective use of resources.

There is now considerable evidence that population health approaches can help to achieve greater efficiency in use of health and social care resources. Specifically, there is increasing review-level evidence that population approaches can help towards reducing the population's need for and use of services. Some of the population approaches fall within the provenance of Public Health while others include population and preventative actions taken by others. Importantly, some of the population approaches work over the medium to longer term but others can have positive effects in a fairly short timescale.

This report sets out an overview of evidence for population approaches reducing use of services and makes recommendations as to which approaches are most cost effective.

2. CONTEXT

2.1 Population Profile

Dumfries & Galloway is one of the most rural areas of Scotland, where issues such as transport, access to services and rural deprivation can have a marked impact. The region covers 6,426 square kilometres with a population of approximately 150,270 people. Almost half of the population (46%) live in areas classified as rural, which is defined as living in settlements with fewer than 3,000 people and many (22%) live in remote rural locations. The only urban areas are the towns of Dumfries and Stranraer, though neither of these is classified as a large urban area. In terms of accessibility, just over a quarter (27%) of the population live in areas classified as remote (remote rural or remote small towns), which are defined as further than 30 minutes' drive away from a large town.

The latest population projections from the National Records of Scotland indicate that over the next 25 years younger people will make up a smaller proportion of our population than is currently the case. By 2037 it is projected that (Dumfries & Galloway Integrated Joint Board, 2016):

- The number of young people aged 12 to 18 will decrease by 17%
- The number of children under 3 will decrease by 14%
- The working age population of Dumfries & Galloway will decline by 14%
- The number of older people (aged 75 and over) living alone is likely to nearly double by 2037
- There will be an increase in the number of people living with two or more long term conditions.

2.2 Children and Young People

The above figures demonstrate that the number of children and young people is likely to fall over the next 20 years. In the same time period however the number of older adults will increase substantially. The demographics mean that much attention inevitably will focus on providing services and care for the growing number of older people. As the integration of health and social care begins to address the challenges of the ageing population, it is very important not to diminish the priority we give to children and young people and services that support their needs. There are three reasons for this.

To create the long-term gains in population health that will reduce demand on health and care services, it is crucial to focus interventions on the population of children and young people who live in the region. This holds potential for the biggest gains in future health and wellbeing. Evidence supports this approach, as experience in early childhood is shown to be a key driver of future health and wellbeing (Marmot Review, 2010).

In addition, children and young people make up key parts of the future population of Dumfries & Galloway and many will go on to work in health, social care and other

services locally, providing services for others including the increasing numbers of older people and those with multiple long term conditions.

Furthermore, addressing health inequalities at an early stage is believed to result in significant future economic benefits (Wave Trust, 2013). One of the key messages of the Early Years Framework is that effective interventions in the early years can generate significant future financial savings, as development during childhood influences not only the individual's health and wellbeing in adult life but also their employment and social participation, all of which have economic implications (Scottish Government, 2008).

2.3 Health Inequalities and Socio-economic Deprivation

Health inequalities can be defined as differences in health status or in the distribution of health determinants between different population groups. These could arise from issues such as variations in access to health or social care, uptake of heath or social care or the quality of care delivery. In reality however they are far more likely to result from factors outside the direct control of the NHS, such as income, employment, lifestyle and environmental considerations.

Socio-economic deprivation increases use of health services. In the UK, hospital admission rates are significantly correlated with measures of social deprivation. GP practices serving the most deprived populations have emergency admission rates that are around 60–90% higher than those serving the least deprived populations (Purdy, 2010).

In Dumfries and Galloway, deprivation is often hidden. Analysis for the Health and Social Care Strategic Needs Assessment 2016-19 (Dumfries & Galloway Integrated Joint Board, 2016) has shown that 82.4% of income-deprived and 82.8% of employment-deprived people live in areas of the region considered not to be particularly deprived according to the Scottish Index of Multiple Deprivation (SIMD) 2016. The SIMD is a geographic measure of deprivation that includes a large number of factors in several different domains including income, employment, crime levels, education, health, housing and access to services. The areas where there is the highest concentration of recognised deprivation are Northwest Dumfries, Central Stranraer, Annan and Upper Nithsdale. The large majority of people who are significantly income or employment deprived however do not live in these areas but are distributed throughout other parts of Dumfries & Galloway.

2.4 A Vision for Health and Wellbeing

To improve the health of the population there is a need to adopt approaches based on prevention and self-management. Early intervention to address the fundamental causes of ill-health and increasing demand on services must be taken forward. This requires building a culture in which healthy behaviours are normal throughout our lives from pre-birth to old age.

In developing services based around the promotion and maintenance of health and wellbeing we need to create:

- Personal ownership of actions that impact on health and wellbeing
- People-centred partnerships between people who use services and those who provide them
- Individuals and communities that are resilient to challenges and adversity
- Improved educational attainment
- Positive employment or other form of contribution
- Reduced absence from work and school
- Realistic expectations of services that can be provided
- Use of 'Realistic Medicine'
- Reduced demand on services due to preventable physical and psychological ill-health

2.5 Preventative Spending

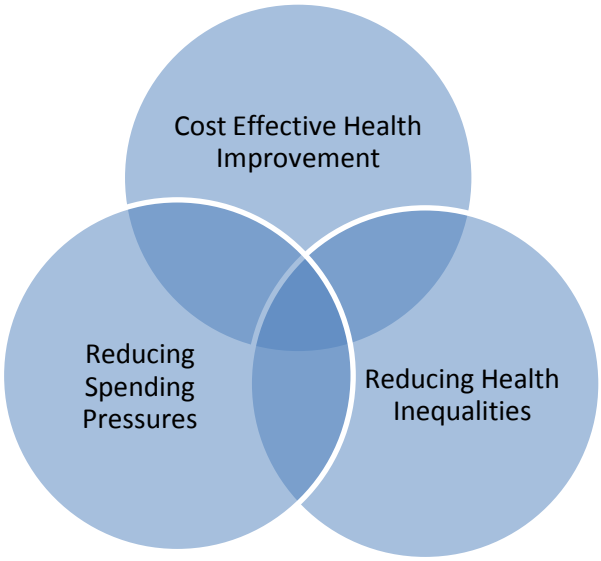
Prevention can help reduce public spending pressures by:

- Reducing the level of ill health or time spent in ill health
- Reducing demands for public services
- Freeing up resources for other uses

Preventative spending has the potential to reduce avoidable spending on health and social care use. This is detailed in Section 4 of the report. It can also address the other two of the three core aims identified in Section 1.3: to improve health and wellbeing and to decrease health inequalities (Craig, 2014).

Figure 1 shows how the three aims can overlap. Best buys in prevention might be regarded as prevention activities that achieve as many as possible of the three aims. Given current pressures on public spending, priorities for prevention should include those population interventions that have been shown to reduce service spending pressures.

Figure 1: Identifying best buys in prevention (Craig, 2014)



In practice, the impacts of preventative spend on future demands for health and social care will depend on whether three important conditions are met (Craig, 2014):

1. The spending must reduce the length of time people spend in ill health, not just increase life expectancy; i.e. it must achieve compressed morbidity.

2. Where reduced demands for public services are achieved, spending must reduce in those areas if resources are to be freed up for other uses. For example, if demand for a hospital clinic reduces by 25%, excess spending on that clinic must be reduced proportionately and the costs stripped out. This can be a difficult task. There are frequently fixed costs to running services and reducing demand may result in a higher-quality service being provided rather than a service of the same quality being provided at reduced capacity and reduced cost.

3. Funds previously spent on meeting avoidable demands on services must not be diverted simply to meet other demands on services that can be avoidable. They must be freed up to invest in other programmes preventing these demands arising in the first place.

2.6 Cost Effectiveness

Value for money in healthcare is more complex than monetary costs alone. A number of measures are used in assessing value for money including: Return on Investment (ROI), Benefit Cost Ratio (BCR), Disability-adjusted life years (DALYs) and Quality-adjusted life years (QALYs):

- ROI – Return on investment is a performance measure used to evaluate the efficiency of an investment or to compare the efficiency of a number of different investments. To calculate ROI, the return of an investment (savings – cost) is divided by the cost of the investment.

- BCR – Benefit cost ratio is another indicator that attempts to summarize the overall value for money of a project or proposal. A BCR is the ratio of the benefits of a project or proposal, expressed in monetary terms, relative to its costs, also expressed in monetary terms. Essentially it is savings divided by cost and is related to return on investment: ROI = BCR-1.

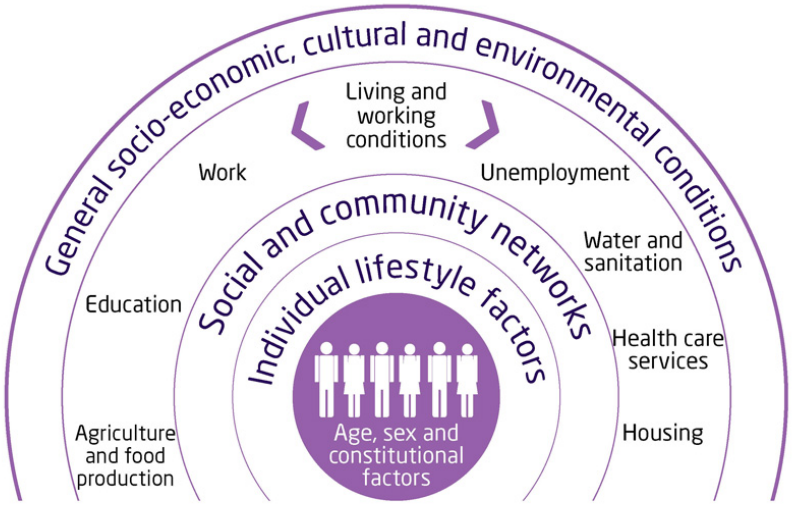
- DALYs - Burden of disease is measured using the disability-adjusted life year (DALY) which combines measures of death and disease. Deaths are measured using years of life lost due to premature mortality and disease; disability is measured using years of life lost due to time lived in less than full health – years of life with disability. One DALY is equivalent to one lost year of healthy life.

- QALYs - The quality-adjusted life year is a generic measure of disease burden, including both the quality and the quantity of life lived. It is used in economic evaluation to assess the value for money of medical interventions. One QALY equates to one year in perfect health.

3. HOW POPULATION HEALTH APPROACHES ARE PART OF THE SOLUTION

3.1 The Benefits of Population Health Approaches

Health is determined by a complex interaction between individual characteristics, lifestyle and the physical, social and economic environment. The circumstances in which people live impact directly on their health, both mental and physical. These broader determinants of health are more important than health care in nurturing a healthy population (Kings Fund, 2017). This is shown graphically in the model from Dahlgren and Whitehead below (1993):



The World Health Organisation (WHO) acknowledges that although expenditure on the prevention of ill health is typically a small proportion of overall health spending, it represents excellent value for money. Both short and long term benefits to health and social care sectors can be evidenced from population health actions. Some health costs can be avoided by focusing investment to prevent harm or disease, increase the promotion of health and wellbeing, and protect the population's health (WHO, 2014).

Investment in preventative spending can impact positively on improving health and reducing health inequalities; whilst helping to mitigate pressures arising from demand on health and social care services (NHS Health Scotland, 2016).

Preventative spending can improve population health by any or all of:

- Primary Prevention - preventing health problems developing in the first place
- Secondary Prevention - stopping health problems from getting worse
- Tertiary Prevention - reducing the impact of disease on people's health and wellbeing

3.2 Four Mechanisms for Delivering Population Health Approaches

A number of mechanisms for delivering population health approaches can be identified and all can potentially help reduce service spending pressures. Four of these approaches are:

1) National population health interventions, often based on legislation, and delivered at national level. Some examples include smoke-free public places, alcohol minimum pricing and road safety campaigns.

2) Public health programmes that are planned nationally but delivered to individuals at local levels. Examples include immunisation and screening programmes.

3) Local programmes and approaches led by Public Health. Some examples are smoking cessation services, alcohol brief interventions, improving nutrition in schools, initiatives to increase physical activity in communities.

4) Local disease preventative approaches led by services other than Public Health. Primary and secondary care services offer some of these approaches, for example the weight management service.

National population programmes for prevention (types 1 and 2) are in general found to be the most effective. Nevertheless, all four types of prevention interventions have potential benefits and can help to support sustainable health and care systems. These are covered in section 4.

3.3 Published Reviews of Evidence

The UK is experiencing pressure on health and social care budgets, including public health budgets, due to pressures on public spending. There is increasing interest in the role of public health or preventative interventions in supporting a sustainable health and social care system. This has resulted in a growing number of research papers and reviews investigating the cost effectiveness of public health interventions.

Three reviews give good recent overviews of the state of knowledge and these are drawn upon in section 4 of this report:

A. The Case for Investing in Public Health (WHO, 2014). This comprehensive report lists population health interventions of three of the types listed above that have been found to be cost effective: type 1 (national programmes, nationally delivered), 2 (national programmes, locally delivered) and 3 (local programmes, locally delivered by Public Health). It divides interventions into those giving quick wins (timescale up to five years) and those resulting in longer term gains (timescale over five years). It includes interventions to build resilience as well as those addressing risk factors.

B. The Cost Effectiveness of Public Health Interventions (Owen et al, 2011). This review examines all National Institute for Health and Care Excellence

(NICE) Public Health guidance issued between 2005 and 2010 and assesses it for cost effectiveness. It mostly covers interventions of type 3 above (local programmes, locally delivered).

C. Return on Investment of Public Health Interventions: a Systematic Review (Masters et al, 2017). This review identifies studies that reported a return on investment of public health interventions delivered in industrialised countries providing universal healthcare. Interventions of types 1-4 above are all included.

3.4 Broader benefits of population health approaches

Population health approaches can bring wider benefits in addition to benefits to health and the contribution towards more sustainable health and social care services. In taking forward population approaches to health, a number of broader benefits were found to accrue, such as community cohesion, positive employment, improved leisure environments, reductions in school and workplace absence (Ham and Alderwick, 2015). Many of these potential benefits apply to children and young people. They may be particularly important therefore in Dumfries & Galloway, given the decreasing number of children and young people on whom the future economic wellbeing and workforce of the region will depend.

Investing in health in general has been shown to provide economic returns to the health sector, other sectors and the wider economy, with an estimated fourfold return on every dollar invested (Reeves et al, 2013). For example, interventions that promote positive mental health during childhood contribute to better educational outcomes and employment prospects; while those interventions that target workplace health can demonstrate increased productivity and economic returns.
Furthermore, investing in early preventative approaches during childhood contributes to more sustainable well-being throughout life (Nurse, 2010). The WHO (2014) recommends strengthening the integration of Public Health services within the overall health system to both provide cost-effective interventions and maximise health and wellbeing in a sustainable way.

4. COST-EFFECTIVE POPULATION HEALTH APPROACHES TO REDUCE FUTURE DEMAND ON SERVICES IN DUMFRIES & GALLOWAY

4.1 Cost-effective interventions from the WHO report (A)

Table 4 summarises interventions found to be cost effective from the WHO report (WHO, 2014). This table includes national population health interventions, public health programmes planned nationally and delivered locally, and local programmes delivered and led by Public Health.

Table 4: Summary of cost-effective health interventions from WHO report

Intervention Focus	Quick Wins (0-5 years)	Longer-term Gains (> 5 years)
Environmental determinants	Road traffic injury prevention	Chemical regulation
	Active transport	Removal of lead and mercury
	Safe green spaces	
	Heat wave plan	
Social determinants	Healthy employment programmes	
	Insulating homes	
	Housing ventilation for asthma	
	Community falls prevention	
Resilience	Violence prevention legislation	Pre-school programmes
	Prevention of postnatal depression	Prevention of conduct disorder
	Family support projects	Multisystemic therapy for juvenile offenders
	Social emotional learning	Detection of and care for victims of intimate partner violence
	Bullying prevention	
	Mental health in the workplace	
	Psychosocial groups for older people	
	Parenting programmes	
	Depression prevention	

Intervention Focus	Quick Wins (0-5 years)	Longer-term Gains (> 5 years)
Behaviour	Lifestyle diabetes prevention programme	Alcohol minimum price
	Restricting alcohol availability	Counselling to smokers
	Community-based youth tobacco control intervention	Alcohol brief interventions
	Workplace obesity intervention	Alcohol driving breath tests
	Tobacco legislation, taxation and control	
	Alcohol legislation, taxation and control	
	Nutrition – reducing salt; replacing trans fatty acids; raising public awareness of healthy diets	
	Physical activity mass media awareness	
Immunisation	For children: norovirus, pneumococcus, rotavirus, influenza	Influenza
		Pneumococcus
		Measles Mumps Rubella
		Diphtheria Pertussis Tetanus
		Human Papilloma Virus
		Hepatitis B
		Meningitis C
Screening	Screening for abdominal aortic aneurysm	Breast cancer screening
	Cervical cancer screening	Colorectal cancer screening
	Screening for depression in diabetes	Screening for diabetes and impaired glucose tolerance
		Vascular disease health checks

WHO advocate relatively small shifts in spending from treatment to prevention and health promotion, with a focus on cost-effective solutions to help reduce health costs. Returns on investment from preventative spend can occur within 1-2 years, examples include:

- Mental health promotion
- Promoting physical activity
- Healthy employment
- Immunisations
- Violence prevention
- Road traffic injury prevention.

Interventions that result in 'quick wins' (0-5 years) focus on healthy behaviours in individuals and building community resilience, as well as addressing environmental and social determinants of health. For example, tackling risk factors for coronary heart disease (smoking, physical inactivity, high blood pressure and reducing cholesterol) has resulted in an estimated 50-70% decline in global deaths from CHD with treatment of the disease resulting in only 25-50% decline in global deaths. The report warns against inaction driven by concerns about upfront costs and the intangibility of outcomes, and cites the costly and unsustainable consequences of a treatment-only approach.

4.2 National public health programmes from Masters review (C)

Many national programmes and interventions are included in the WHO report (Table 4 above). Some additional, mainly national, population health interventions that were found to be cost effective were identified by Masters et al in their review (Masters et al, 2017). These are given in Table 5, which includes either benefit-cost ratio or return on investment, depending on which measure was given in the underlying research paper. The table also shows the time horizon of the study for savings to accrue.

Table 5: National cost-effective population health interventions from systematic review

Intervention	Benefit-Cost Ratio	Return on Investment (per $ or euro)	Time Horizon of Study
Improved walking and cycling infrastructure	1.87		10 years
Speed cameras in urban settings		€ 6.80	2 years
Water fluoridation		$ 1.51	10 years
Intensive early education programme for socioeconomically deprived families		$ 3.97 (school age) $10.83 (pre-school)	20 years
Parenting programmes for prevention of persistent conduct disorders	7.89		35 years
Sugar-sweetened beverage tax		$ 55	10 years
Family planning services	11.09-29.39		Lifetime
Universal school nursing service		$2.20	1 year

4.3 Local programmes and approaches led by Public Health services from Owen reporting on NICE guidance (B)

The cost effectiveness of individually-based public health interventions is often high, i.e. cost per QALY is low. NICE has been making evidence-based Public Health guidance available since 2005. A review by Owen et al assessed the cost effectiveness of all NICE Public Health guidance between 2005 and 2010 (Owen et al, 2011).

In general, interventions costing less than £20,000 per QALY are considered by NICE to be cost effective. Interventions costing between £20,000 and £30,000 per QALY may be considered cost effective if certain conditions are satisfied. NICE does not usually recommend an intervention if it costs more than £30,000 per QALY (other than for certain end-of-life treatments) unless a strong case can be made that it is an effective use of NHS resources (NICE, cited in Owen 2011).

Some public health interventions were cost saving, that is the intervention was both more effective and cheaper than the comparator. Other interventions were more effective than comparator but had a cost per QALY gained, which in most cases was very modest in comparison with clinical treatments. The median cost per QALY for the public health interventions costing less than £20,000 per QALY was only £365.

Table 6 shows a selection of public health interventions from the NICE guidance that were cost saving or have cost per QALY below £20,000. A number of interventions had higher costs per QALY and are not recommended.

Table 6: Public health interventions that are cost saving or have cost per QALY < £20,000 from NICE guidance

Topic	Intervention	Comparator	Median Cost per QALY (£)
Increasing physical activity	Exercise prescription	Advice	77
	Interviews with exercise voucher	Advice	227
	Intensive interviews with exercise voucher	Advice	430
	Exercise prescription with intensive GP training	Advice	437
Preventing sexually transmitted infections and under 18 conceptions	Tailored skill session	Usual care and didactic messages	3,200
	Brief counselling	Didactic messages	12,194
	Information, motivation and behaviour skills	Didactic messages	14,143
Interventions to reduce substance misuse among vulnerable young people	Life skills training	Normal education	3,492
Workplace interventions to promote smoking cessation	Brief advice	Background quit rate	Cost saving
	Brief advice + self help material	Background quit rate	Cost saving
Healthy diet	Media promotion of healthy eating	No intervention	87
Smoking cessation services	Brief advice	Background quit rate	Cost saving
	NRT + pharmacy consultation	Background quit rate	Cost saving
	Brief advice + self help material + NRT	Background quit rate	984
	Brief advice + self help material + NRT + specialist clinic	Background quit rate	Cost saving
Promoting physical activity in the workplace	Physical activity counselling	No intervention	864
	Walking programme	No intervention	686

Topic	Intervention	Comparator	Median Cost per QALY (£)
Mental wellbeing and older people	Tri-weekly walking programme	Information and education	7,400
Management of long term sickness and incapacity for work	Workplace intervention	Usual care	Cost saving
	Physical activity and education	Usual care	2,758
Promoting wellbeing at work	Individual stress management	No intervention	4,998
Preventing harmful drinking	Screening and brief advice during GP consultation	No intervention	3,300
	Screening and brief advice during Accident & Emergency consultation	No intervention	10,400

It is important to note that not all public health interventions have been found to be cost effective using the NICE thresholds. Table 7 shows public health interventions with costs per QALY greater than 20,000.

Table 7: Public health interventions with cost per QALY ≥ £20,000 from NICE guidance

Topic	Intervention	Comparator	Median Cost per QALY (£)
Preventing sexually transmitted infections and under 18 conceptions	Intensive counselling	Treatment as usual	24,000
	Enhanced counselling	Didactic messages	45,606
	Behavioural skills counselling	Standard 15 mins risk reduction counselling	96,000
Interventions to reduce substance misuse among vulnerable young people	'Say yes first'	Normal education	90,786
	Teacher training	Normal education	157,384
Social and emotional wellbeing in primary education	Focussed intervention (2 level)	No intervention	177,560
	Focussed intervention (1 level)	No intervention	988,404
Mental wellbeing and older people	Advice about physical activity	Usual care	35,900
Promoting physical activity for children and young people	Dance class programme	No intervention	27,570
	Free swimming	No intervention	40,462
	Community sports	No intervention	71,456

4.4 Local preventative approaches led by health or other services from Masters review (C)

A considerable number of research studies have looked at preventative programmes that are led by health or other services rather than Public Health. These have been assessed in the systematic review by Masters et al (C). Table 8 shows interventions assessed as of good or very good study quality, that are believed to be applicable to the population of Dumfries & Galloway, and with positive cost effectiveness for health services (Masters et al, 2017).

Table 8: Preventative Interventions led by health or other services

Intervention	Benefit-Cost Ratio	Return on Investment (per $ or euro)	Time Horizon of Study
Supervised injection facilities	5.12		Lifetime
Community-based falls prevention	20.6		18 months
Health promotion programme for hospital staff		$ 2.87	1-4 years
Workplace health management		$ 4.61	3.2 years
Telemedicine for depression		€ 1.45 – 1.76	5 years

5. DISCUSSION AND RECOMMENDATIONS

5.1 Discussion

In a time of great pressure on health and social care budgets, concern about costs can lead to questions over the benefits of investing in public health interventions. Another factor that is sometimes raised is the length of time till the positive outcomes from population preventative interventions are achieved. In reality however, cuts to public health and preventative budgets represent a false economy and are likely to generate considerable additional costs to health and social care services. The alternative of treating the consequences of poor health is likely to be unnecessarily costly and unsustainable over time (WHO, 2014).

Prevention can be the most cost-effective way to maintain the population's health in a sustainable way and creating healthy populations benefits everyone (WHO, 2014). The evidence shows that many health and wellbeing interventions are worth investing in. They either save money directly or are very cost effective compared with the NICE thresholds and with many clinical interventions. They can reduce future need for health and social services. Some population health interventions give relatively quick wins and can reduce service demand in less than five years, while others take longer but still show benefits.

Health economic evaluations are complex and usually cannot be carried out directly in Dumfries & Galloway. It is important therefore to use the evidence from the growing number of well-conducted research studies and reviews of population health and preventative interventions.

The evidence shows that a wide range of preventative approaches are cost effective, including interventions that address the environmental and social determinants of health, build resilience and promote healthy behaviours. The cost effectiveness of immunisation and screening programmes also is high.

5.2 Key Messages

1. The Scottish Burden of Disease study identified the largest overall disease burdens as attributable to ischaemic heart disease, neck and lower back pain, depression, chronic obstructive airways disease, lung cancer and stroke. Much of this burden has causes that include our inability (for multiple reasons) to live in ways that create and sustain health and wellbeing (food, physical activity, tobacco, alcohol and drugs). Resilience is also very important in reducing the burden of disease and demand on services.
2. Population health and preventative interventions are delivered in a number of ways. These include: national interventions delivered nationally (e.g. alcohol minimum pricing), public health programmes planned nationally and delivered locally (e.g. immunisation programmes), local programmes led by Public Health professionals (e.g. smoking cessation programmes), and local preventative programmes led by health services other than Public Health (e.g. weight management clinic). All of these can be cost effective and can help to support sustainable health and social care systems.
3. Prevention is cost effective in both the short and longer term. Examples of interventions that can give returns on investment within 1-2 years include (WHO):
    - Mental health promotion
    - Promoting physical activity
    - Some immunisations
    - Healthy employment
    - Violence prevention
    - Road traffic injury prevention
4. NICE guidance shows that many preventative programmes led by Public Health are cost effective, often highly so. The most cost-effective interventions include interventions in increasing physical activity, smoking cessation, a healthier diet and workplace interventions.
5. Other interventions with lower cost effectiveness (but still cost effective according to the NICE thresholds) include certain interventions to prevent sexually transmitted infections and under 18 conceptions, to reduce substance misuse among vulnerable young people, to increase mental wellbeing in older people and to prevent harmful drinking.
6. Not all preventative interventions are cost effective however, e.g. advice about physical activity to older people, or dance classes to promote physical activity in children and young people.
7. A number of preventative interventions usually led by other health services rather than Public Health also show cost effectiveness. Cost effectiveness is particularly striking for community falls prevention, which can provide more than 20-fold savings for each pound spent, with most of the savings accruing to health and social care services.
8. Investment in public health and preventative interventions can help to create more sustainable health and social care systems.

5.3 Recommendations

Pressures on health and social care services will continue. Population health interventions which target the underlying environmental and social determinants of health, build resilience, address mental ill-health, promote healthy behaviours as well as screening and immunisation programmes can be cost effective in the short and longer term and contribute to the sustainability of clinical services.

1. Cost-effective preventative interventions and programmes should have a high priority and continue to be supported even in a difficult financial environment. Failure to do so will lead to increased costs and lack of sustainability of health and social care services.

2. Preventative interventions that are not shown to be cost effective and effective should not be supported.

3. It should be recognised that research and knowledge are continuing to develop. Other preventative programmes not included in the reviews assessed in this paper may have been shown to be cost effective as well. This includes, for example, social prescribing.

4. The evidence indicates that community falls prevention can have very substantial return on investment benefits. It is important that community prevention is addressed systematically across Dumfries & Galloway, to ensure the benefits of preventing falls, often in frail older people, are fully realised. This could mean assessing a range of actions in the older population in care homes or their own homes. Actions could include home hazard reduction, assessment of medications, exercise or balance training. Some of this occurs at the moment but it is likely that more could be done.

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Agenda Item 169

DUMFRIES and GALLOWAY NHS BOARD

4th June 2017

Register of Members' Interests

Author:
Laura Geddes
Corporate Business Manager

Sponsoring Director:
Jeff Ace
Chief Executive

Date: 17th May 2017

RECOMMENDATION

The Board is asked to approve the revised Register of Members' Interests.

CONTEXT

Strategy / Policy:

This paper support good governance through local and national policies and guidance, including the Board's Standing Orders and Code of Conduct.

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

Board Members of devolved public bodies are required to give notice of their interests and the NHS Board is required to maintain a Register of Members' Interests. The register is updated on a regular basis to reflect changes in Members' entries.

Whilst it is the responsibility of each Member to advice the Corporate Business Manager of any changes within one month of the change arising, the register will be reviewed twice per year and presented to Board for the revisions to be approved for publication.

The Corporate Business Manager will keep the register of interests available for public inspection at the Board's offices during normal working hours without charge. The register of interests is also routinely posted on the Board's website.

GLOSSARY OF TERMS

NHS - National Health Service

MONITORING FORM

Policy / Strategy	This paper supports the Board's Standing Orders and Code of Conduct policy, as well as various nationally issued guidance material.
Staffing Implications	Not applicable
Financial Implications	Not applicable
Consultation / Consideration	Consultation on the existing register of interests was undertaken with all Board Members and other Directors and Senior Managers.
Risk Assessment	Not applicable
Risk Appetite	Low [✓] Medium [ ] High [ ] The information within this paper demonstrates compliance with nationally adopted guidance relating to the conduct of staff, financial impact, clinical delivery and reputational risk, therefore, a low risk appetite has been noted against this paper.
Sustainability	Not applicable
Compliance with Corporate Objectives	7 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
Best Value	• Vision and Leadership • Governance and Accountability
Impact Assessment Not applicable	

DUMFRIES AND GALLOWAY NHS BOARD

REGISTER OF BOARD MEMBERS INTERESTS – MAY 2018

Registration of Interests

Board members of devolved public bodies are required by the Regulations to give the 'Standards Officer' notice of their interests The Register must state:

the name of the board member;

their interests which fall within the categories listed below and as set out in the member's code of conduct; and

if they have nothing to register they must record that fact under each applicable category.

It is the responsibility of each board member to ensure that their entry in the register is kept up to date. Any changes to the information first registered, must be given in writing to the standards officer, in the prescribed format, within one month of the change arising.

The 'Standards Officer' (Corporate Business Manager) will keep the register of interests available for public inspection at the Board's offices during normal working hours and without charge.

Column 1 ***Registerable interest category***	**Column 2** ***Description of interest***	**Column 3** ***Members Registering an Interest in this Category (and Description of interest)***	
		MEMBER	**REGISTERED INTEREST**
Gifts and hospitality	A description of any gifts or hospitality received.		Members interests noted in the Gifts and Hospitality Register.
Category 1 - Remuneration **NOTE: You do not need to register the amount of remuneration**	A description of (a) remuneration received by virtue of being:– (i) employed or self-employed; (ii)the holder of an office; (iii) a director of an undertaking; (iv) a partner in a firm; and (v) involved in undertaking a trade, profession, vocation or any other work; (b) any allowance received in relation to membership of any organisation; (c) the name, and registered name if different, and nature of any applicable employer, self-employment, business, undertaking or organisation; (d) the nature and regularity of the work that is remunerated; and (e) the name of the directorship and the nature of the applicable business.	Vicky Freeman Katy Lewis Stephen Hare Michele McCoy Melissa Gunn Lorna Carr Eddie Docherty Penny Halliday Phil Jones	NHS Dumfries and Galloway NHS Dumfries and Galloway NHS Dumfries and Galloway NHS Dumfries and Galloway Non-Executive Director, NHS Health Scotland Lecturer, University of the West of Scotland Small Town Sounds CIC NHS Dumfries and Galloway NHS Dumfries and Galloway Non-Executive Member, Sleeping Giants Dumfries and Galloway Council – Pension Trustee of Crichton Trust

Column 1 ***Registerable interest category***	**Column 2** ***Description of interest***	**Column 3** ***Members Registering an Interest in this Category (and Description of interest)***	
		MEMBER	**REGISTERED INTEREST**
Category 2 - Related undertakings	A description of a directorship that is not itself remunerated, but is of a company or undertaking which is a parent or subsidiary of a company or undertaking which pays remuneration.	Penny Halliday Phil Jones	Non-Executive Member, Sleeping Giants NHS Dumfries and Galloway Endowment Trustee
Category 3 - Contracts	A description of the nature and duration, but not the price of, of a contract which is not fully implemented where:– (a) goods and services are to be provided, or works are to be executed for the NHS; and (b) any responsible person has a direct interest, or an indirect interest as a partner, owner or shareholder, director or officer of a business or undertaking, in such goods and services.		
Category 4 - Houses, land and buildings	A description of any rights of ownership or other interests that may be significant to, of relevance to, or bear upon, the work or operation of the NHS Board		
Category 5 - Shares and securities	A description, but not the value, of shares or securities in a company, undertaking or organisation that may be significant to, of relevance to, or bear upon, the work or operation of the NHS Board		

Column 1 ***Registerable interest category***	**Column 2** ***Description of interest***	**Column 3** ***Members Registering an Interest in this Category (and Description of interest)***	
		MEMBER	**REGISTERED INTEREST**
Category 6 - Non-financial interests	A description of such interests as may be significant to, of relevance to, or bear upon, the work or operation of the NHS Board, including without prejudice to that generality membership of or office in:– (a) other public bodies; (b) clubs, societies and organisations; (c) trades unions; and (d) voluntary organisations.	Vicky Freeman	Unison Member
		Katy Lewis	Public Sector Director of South West Hub NHS Dumfries and Galloway Endowment Trustee Integration Joint Board Chief Finance Officer
		Lesley Bryce	Scottish Trustee, Carers UK Member of Scotland Advisory Committee, Carers Scotland
		Stephen Hare	Unison (Chairperson for Dumfries and Galloway Branch)
		Jeff Ace	Member of Chartered Institute of Public Finance Member of Ospreys Rugby Club Member of Nunholm Squash Club
		Melissa Gunn	Member of The Stove Member of Midsteeple Quarter Community Benefit Society
		Nick Morris	Secretary & Member, Anwoth and Girthon Curling Club
		Lorna Carr	Unison Member
		Phil Jones	Chairman, NHS Dumfries and Galloway

Agenda Item 170

DUMFRIES and GALLOWAY NHS BOARD

4th June 2018

Integration Joint Board – Non-Executive Membership

Author:
Laura Geddes
Corporate Business Manager

Sponsoring Director:
Jeff Ace
Chief Executive

Phil Jones
Chairman

Date: 25th May 2018

RECOMMENDATION

The Board is asked to discuss and approve the proposed membership and substitute amendments for the NHS members of the Integration Joint Board:

- Agree that Lorna Carr Non-Executive Board Member to stand down as a voting Integration Joint Board Member with effect from 31st October 2018;
- Agree for Nick Morris Non-Executive Board Member to fill the vacant post as an Integration Joint Board Voting Member from 1st November 2018;
- Agree that the Integration Joints Board substitute voting members for the NHS will be Melissa Gunn and Lorna Carr, Non-Executive Board Members, with effect from 1st November 2018;
- Agree that the substitute voting members for the Integration Joint Board for the period 1st June 2018 – 31st October 2018 will be Melissa Gunn and Nick Morris.

CONTEXT

Strategy / Policy:

This paper supports the legal requirements set out for the Integration Joint Board through the national Public Bodies (Joint Working) (Scotland) Act and the local Integration Scheme.

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

A number of changes have been notified in regard to the membership and substitute nomination for the Integration Joint Board since September 2016. This paper sets out a proposal for Board Members to consider and approve, with a view to notifying the IJB of the decision in July 2018.

GLOSSARY OF TERMS

NHS - National Health Service
IJB - Integration Joint Board

MONITORING FORM

Policy / Strategy	Public Bodies (Joint Working) (Scotland) Act Integration Joint Board - Integration Scheme
Staffing Implications	No staffing implications have been identified.
Financial Implications	No financial implications have been identified.
Consultation / Consideration	Consultation has taken place with the staffing members noted within the proposed changes.
Risk Assessment	No risk assessment was required at this time.
Risk Appetite	Low [✓] Medium [ ] High [ ] The Integration Joint Board will consider service redesign, financial implications, clinical impact and information governance on a range of issues; therefore, the membership is a significant decision for the NHS Board to make. A low risk tolerance has been assigned to this paper.
Sustainability	Not applicable.
Compliance with Corporate Objectives	6. Continue to support and develop partnership working to improve outcomes for the people of Dumfries and Galloway.
Local Outcome Improvement Plan (LOIP)	Outcome 6
Best Value	• Vision and Leadership • Effective Partnerships • Governance and Accountability
Impact Assessment No impact assessment was undertaken in regard to the proposed changes.	

Introduction

1. The Integration Joint Board (IJB) was initially introduced in 2014/15 and formally began as an independent entity from 1st April 2016. The Integration Joint Board is made up from five Non-Executive Board Members from NHS Dumfries and Galloway and five elected members from Dumfries and Galloway Council, who are appointed as full voting members.

2. The IJB also has a number of non-voting members, who are integral to the operation of the Board, as they are able to provide specialist advice and guidance on clinical issues, staffing challenges and financial considerations.

3. Both NHS Dumfries and Galloway have the opportunity to nominate up to five substitute members to stand in for their own organisations voting members, to ensure an appropriate level of representation at each meeting.

4. NHS Dumfries and Galloway had appointed a substitute for the Integration Joint Board voting members in July 2016, however, the member withdrew from this role in September 2016 and since that point no substitute members have been re-appointed.

Consultation

5. The legislation for the Integration Joint Board states that the membership should be reviewed on a 2 yearly cycle. At present the membership consists of the following Non-Executives:

    - Penny Halliday, Chair of Integration Joint Board
    - Laura Douglas, Non-Executive Integration Joint Board voting Member
    - Grace Cardozo, Non-Executive Integration Joint Board voting Member
    - Lesley Bryce, Non-Executive Integration Joint Board voting Member
    - Lorna Carr, Non-Executive Integration Joint Board voting Member

6. A review has been undertaken between the Chairman, Chief Executive and Corporate Business Manager to review the membership, with the proposed changes being circulated to the Non-Executive Board Members and Executive Directors for review and comment.

7. The revised membership for the Integration Joint Board will take effect from 1st November 2018 and the following structure has been proposed for the voting members:

    - Penny Halliday, Chair of Integration Joint Board until April 2019, then becomes a normal Integration Joint Board Voting Member;
    - Laura Douglas, Non-Executive Integration Joint Board voting Member
    - Grace Cardozo, Non-Executive Integration Joint Board voting Member
    - Lesley Bryce, Non-Executive Integration Joint Board voting Member
    - Nick Morris, Non-Executive Integration Joint Board voting Member

8. The change that is being proposed if for Lorna Carr to stand down as a voting Integration Joint Board Member and for Nick Morris to take on this position.

9. In relation to substitute voting members, who will be asked to attend meetings where one of the NHS voting Integration Joint Board Members is not able to attend. As previously mentioned at the moment there are no approved substitute voting members form the NHS, therefore, a proposal is being put forward for Lorna Carr and Melissa Gunn to be nominated as voting substitute members, with effect from 1st November 2018.

10. In addition to this, it is also proposed that in the interim period from 1st June 2018 – 31st October 2018 that Melissa Gunn and Nick Morris be appointed as substitute voting members on the Integration Joint Board, to ensure an appropriate level of representation is given from the NHS side of the membership.

11. From 1st November 2018, Nick would then take on the role of Integration Joint Board voting member and Lorna Carr would then take his place as the second substitute voting member. Melissa would continue in her role as a substitute voting member from 1st November 2018, with no further changes or approvals required.

Recommendation

12. The Board is asked to discuss and approve the proposed membership and substitute amendments for the NHS members of the Integration Joint Board:

- Agree that Lorna Carr Non-Executive Board Member to stand down as a voting Integration Joint Board Member with effect from 31st October 2018;

- Agree for Nick Morris Non-Executive Board Member to fill the vacant post as an Integration Joint Board Voting Member from 1st November 2018;

- Agree that the Integration Joints Board substitute voting members for the NHS will be Melissa Gunn and Lorna Carr, Non-Executive Board Members, with effect from 1st November 2018;

- Agree that the substitute voting members for the Integration Joint Board for the period 1st June 2018 – 31st October 2018 will be Melissa Gunn and Nick Morris.

Agenda Item 171

DUMFRIES and GALLOWAY NHS BOARD

4th June 2018

BOARD BRIEFING

Author:
Rachel Hinchliffe
Communications Assistant

Sponsoring Director:
Jeff Ace
Chief Executive

Date: 25th May 2018

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 paper 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 appetitie 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

Nominations for Global Citizens

The NHS Scotland Global Citizenship Programme Leads recently met with NHS Scotland's Chairs and Chief Executives to get input to the early development of the NHS Scotland Global Citizenship Programme. As a result they are establishing a network of NHS Board Global Citizenship Champions to help share best practice, learning, knowledge and information across NHS Scotland. They hope to encourage as many staff as possible from across all staff groups to sign up as our NHS Board Global Citizenship Champions. For more information and to access the nomination form click on the link below:

http://hippo.citrix.dghealth.scot.nhs.uk/sorce/apps/sorce_doc_manager/Actions/view_doc.aspx?docid=1021914&revid=1023908

NHSScotland Event 2018

Registration is now live for the NHSScotland Event 2018, which is being held on 18th and 19th June 2018 at the Scottish Event Campus (SEC), Glasgow. The theme of this year's Event is '*Delivering Now - Improving for the Future'.*

This year marks the 70th Anniversary of the NHS providing us with an opportunity to celebrate what this has meant for people in Scotland, to recognise and thank staff for their outstanding contribution, and confirm our continuing commitment to the founding principles of the NHS for the future.

This year's Event will also provide an opportunity to celebrate 50 years of Social Work in Scotland and 10 years of the Scottish Patient Safety Programme.

Register now via **www.nhsscotlandevent.com**.

The Duty of Candour

The Duty of Candour became a legal requirement for all health and social care organisations on 1st April 2018.

The purpose of the new duty of candour provisions is to support the implementation of consistent responses across health and social care providers when there has been an unexpected event or incident that has resulted in death or harm which is not related to the course of the condition the person is receiving care for.

Duty of Candour incidents may arise from an adverse event, a complaint or Whistleblowing.

Information on Duty of Candour can be found on the Scottish Government website at: http://www.gov.scot/Topics/Health/Policy/Duty-of-Candour

SECTION 2 – STAFFING CHANGES, INCLUDING NEW STARTS, RETIREMENTS

Nurse Manager for Nithsdale – Tricia Kirk - Retirement

Tricia Kirk, the acting Nurse Manager for Nithsdale retired in April 2018 after working in NHS Dumfries and Galloway for around 38 years in many different areas.

Health and Social Care – New Appointment

The Directorate of Health and Social Care welcomed Hannah Green to the team in April 2018 as the Office Administrator.

Rheumatology Consultant Appointment

The Rheumatology Department has the pleasure of welcoming a new Consultant Rheumatologist, Dr Andrew Russell.

Assistant Performance and Intelligence Manager Appointment

The Performance and Intelligence team are delighted to congratulate George Noakes in his promotion to the post of Assistant Performance and Intelligence Manager.

Associate Medical Director for the Acute and Diagnostics Directorate - Appointment

Dr Christiane Shrimpton started in April 2018 as the new Associate Medical Director for the Acute and Diagnostics Directorate. Christiane is an Ophthalmologist who has come to us from Morecombe Bay NHS Foundation Trust.

Associate Medical Director for the Community Health and Social Care Directorate

Dr Grecy Bell, who has been in an interim role as Associate Medical Director for the Community Health and Social Care Directorate has been confirmed as a permanent appointment.

SECTION 3 - CURRENT CONSULTATIONS

From	Topic	Response due by
Scottish Government	Revised Sarcoma Quality Performance Indicators – Consultation	11/05/2018
Disclosure Scotland	PVG and Disclosure Consultation	18/07/2018
Scottish Water	Shaping the Future – Helping to shape water and waste water services	31/07/2018
Scottish Government	Increasing Employment of Disabled People in the Public Sector	15/08/2018

SECTION 4 – CHIEF EXECUTIVE AND CHAIRMAN COMMITMENTS

Chief Executive's Diary **Key Events**		**Chairman's Diary** **Key Events**
June		**June**
1st - Scottish Radiological Society Spring Meeting 4th - NHS Board Meeting 5th - Board Workshop on Annual Accounts 6th - Diagnostic Steering Group 7th - Chair and Vice Chair Meeting 11th - Endowment Trustees Meeting 12th - NHS Chief Executives Meetings 13th - NHS Chief Executives Meetings 15th - Transforming Care after Cancer Treatment Programme Board 14th - Scottish Radiology Transformation Programme Conference 18th - Audit and Risk Committee and Special Board Meeting 19th - NHS Scotland Event 26th - Board Management Team 27th Strategic Capital Programme Board 29th - West of Scotland Health and Social Care Delivery Group		4th - NHS Board Meeting 5th - Board Workshop on Annual Accounts 11th - Endowment Trustee 18th - Special Board Meeting 19th - NHS Scotland Event 22nd - Community Planning Partnership Board 29th - West of Scotland Regional Chairs Group
July		**July**
12th - Official Opening of DGRI 16th - Healthcare Governance Committee 23rd - Staff Governance Committee 24th - Management Team 25th - Strategic Capital Programme Board		9th - Performance Committee 12th - Official Opening of DGRI 28th - Staff Governance Committee

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 172

DUMFRIES AND GALLOWAY NHS BOARD

PERSON CENTRED HEALTH AND CARE COMMITTEE

21 August 2017
10 am, New Board Room, Crichton Hall

Present:	Ms. Penny Halliday	Non Executive Member (Chair)
	Mr. Jim Beattie	Non Executive Member Chair – Area Partnership Forum
	Mr. Eddie Docherty	Nurse Director
	Dr. Ken Donaldson	Associate Medical Director
	Ms. Lynsey Fitzpatrick	Equality and Diversity Lead
	Ms. Vicky Freeman	Head of Strategic Planning
	Ms. Carolyn Hornblow	Volunteer Member
	Ms. Jan Lethbridge	Inter Faith Council Member
	Ms. Michele McCoy	Interim Director of Public Health
	Ms. Sue Newberry	Regional Integration Manager, Scottish Care
	Mrs. Joan Pollard	Associate Director for Allied Health Professionals
	Ms. Mandy Spence	Midwifery Representative
	Ms. Gillian Stanyard	Non Executive Member
Apologies:	Ms. Dawn Allan	Spiritual Care Lead
	Ms. Claire Brown	Lead Officer Integration Project (East), Third Sector
	Ms. Lorna Carr	Chair – Area Clinical Forum
	Ms. Caroline Sharp	Workforce Director
	Ms. Shirley Turberville	University of West of Scotland
	Ms. Phyllis Wright	Council Representative
In Attendance:	Margaret Johnstone	E.A. to Nurse Director
	Ms. Grace Cardozo	Non Executive Member
	Ms. Margaret McGroggan	Volunteer Co-Ordinator

1. **Apologies for Absence**
   Apologies as noted above.

2. **Declarations of Interest**
   Nil.

3. **Notes of meeting – 12 June 2017**
   Accepted.

4. **Matters Arising**

   Action List
   PH requested an action list be added as a standing agenda item.

Mindfulness
PH highlighted the performance details for this project, as raised by VF at the last meeting, suggesting that we should have quantitative and qualitative outcomes data to ensure we know how many are benefitting from this, requesting that this information be included in an update for the December meeting. PH commented that this is a good resource but she is keen to develop and look at doing something differently. ED responded that this is not unreasonable explaining that over the next 6 – 12 months this would be a good study to do and we could generate some KPIs from this. In response to VF asking who would lead on this work MMcC explained that Jo Kopela and Tina Gibson are leading on this in Public Health which has a different element for outcome focussed planning but she will relay the request and come back initially with a proposal of what could be measured and see if this is sufficient. JP highlighted also working with staff also and PH agreed that we need to know what is going on and this information would be really valuable. GC commented that the outcomes are important to let us know if we are making a difference, suggesting that any reports for the Committee, for any project, should highlight how this helps staff to become more resilient. JB commented that a member of staff had been recipient of this service and acknowledged that this had made a real difference to that person.

The Committee:

- Requested an update for the December meeting

Bereavement
PH explained that she had spoken to Jeff Ace and Phil Jones around the need to take this to Board. ED commented that there is quite a lot of work around this going on in the community but it is difficult to measure. PH accepts that we could do better but require resources for this, saying that the critical point is how do we generate this culture of good conversations, good listening skills and assisting grieving people, asking if the Committee would take a strong view on this around what is the Board's line on bereavement support. ED commented that this keeps coming up suggesting that we take this outwith the Committee structure and set up either a short life working group or a workshop with a workshop being agreed. VF asked if the Service Planning Manager could be included in this, agreed. GC highlighted DAs report, Item 10, which notes that currently NHS D&G is not meeting the government bereavement support guidelines, agreeing with PH that we need investment and support for this. JP commented on EDs earlier point about the work in the community agreeing that it may be out there but is not being co-ordinated. She highlighted PETAL (people experiencing trauma and loss) which is Scottish Government funded and supports people who have lost family through murder or suicide.

VF asked if there was something here about how we ask GPs, community staff and nursing staff about bereavement; but also talk about services we don't have such as a pro-active bereavement service or a link to a telecare service where, when someone has lost someone, they get a direct call following that person's death. She agreed that when we expand and digest this we will find a lot out there but there are gaps.

PH commented that people are not using the faith groups as much as before acknowledging that a support group can also be a negative experience. JL noted that she had been involved in the updating of the Chaplain's contact list recently and had mentioned bereavement in passing saying that different people/groups would be interested in anything being developed.

GS and SN welcomed the workshop with GC commenting that we should remember that the person who dies has a lot of people who will grieve their loss, asking about children and friends. KD responded that this is an easy aspect to get lost in and although we want to raise awareness we should not forget that bereavement is normal and we can stop people moving on, our responsibility is for people to have a good death. PH highlighted palliative and end of life care work to make it easier for people to talk about death and dying, highlighting workshops for children to come to terms with grief and loss.

PH suggested that we have this person centred care workshop in the Autumn where we will identify what we mean by bereavement care as a Board and as a Committee. GC agreed we need some sort of review/needs assessment to take to management as a proposal. PH suggested asking Board Members to attend the workshop with a view to an endowment bid and what we want this to look like as this needs to be sustainable.

The Committee:

- Agreed an Autumn Person Centred Care Workshop

5. **Volunteer Strategy**

VF presented the draft paper which, as part of the work for the new hospital, pulls together a briefing on volunteering in health and social care going forward and what this would look like. She commented that we should move from thinking of volunteers as an "add on" to the services to absolutely critical to the services, using as an example, the police force with "special constables" covering the whole range of duties. VF is thoughtful about where we do not have volunteers rather than where we do, saying that there are no volunteers within the District Nursing Service. VF highlighting the recommendations, noted the vision, objectives and outcomes; the development of a single volunteer strategy which will include the independent sector as part of this; the development of an accredited volunteer scheme and the initial focus of the strategy in developing young volunteers, explaining that 2018 is the Year of Young Person.

JP highlighted the NHS Board's participation in the "Investing in Volunteers Award" accreditation scheme which is being led by the Volunteer Co-Ordinator. JP has had detailed discussions with Anne Hislop, Volunteer Scotland, who advises that the NHS Board, the Council and the 3rd Sector should have separate standards and that the NHS Board should proceed to develop a strategy before moving to partnership.

LF noted that it was good to see a focus on young volunteers within the outcomes asking, in the interests of equality and diversity, if there was any scope for under represented groups with PH saying this is a definite yes, the

strategy will not discriminate around hard to reach groups and this is a positive opportunity for young people. JP highlighted a piece of work with HR around involving the young workforce.

ED commented that from an accreditation point of view it was worthy to note the change we have seen around volunteering within the Board suggesting that the next step is around how we continue this resource and investment, how we tie things in with key individuals and systems to link with the strategy as it moves forward. PH commented that part of this has to be with the 3rd Sector and with a good, effective partnership we will be able to make best use of resources we have in the community. GC commented that this is a very positive suggestion and hopefully we'll have one Volunteer Manager who can provide day to day support. She recognised EDs point that the policy and strategy is just a step. She went on to say, noting LFs point in terms of young people, that we need to think about young disabled people. In response to PH asking about numbers of young volunteers, MMcG confirmed that we have 30 young people, with 10 included on the list from the recruitment day. PH commented that it would be good to hear outcomes from the volunteers around what their experience has been like and ED suggested that we could bring a volunteer to the Healthcare Governance Committee (HCGC) to tell their story.

GC highlighted the Building Healthy Communities (BHC) volunteers asking where they stand and MMcC responded that they are different and do not come under the NHS although they work with a member of the NHS Public Health Team. GC commented that they would not come under corporate risk and asked where that responsibility would fall and PH responded that it would lie with Jeff Ace. JP commented that although BHC are supported by an NHS member of staff they have their own constitution and recruit their own volunteers, explaining that she would like to have a conversation around what volunteer agreement arrangements we have with other 3rd Sector agencies, if any, noting that a piece of work around this will be picked up by MMcG. PH asked where BHC would fit in with our strategy and JP responded that MMcG is already scoping this work and we will make sure we have a memo of understanding to give us assurance something is in place and that they have a copy of our policy and procedure which will bring them into line with what the Board requires.

KD left the meeting.

MMcC noted that BHC workers are employed by NHS D&G, led by Thomasena Lochhead (TL), who can very clearly document insurance paid for volunteers through Public Health Services. TL has been asked to document what is expected and laid down for them which may be helpful. PH noted that this should be raised as a governance issue at HCGC with ED commenting that if a risk is identified it will be added to the Risk Register. PH asked if there was anything else anyone wanted to bring up under recommendations and in response to MMcG asking if this would be an NHS strategy only PH confirmed that it would be the NHS Dumfries and Galloway Strategy. VF asked if the IJB required its own policy and PH responded that as she had said earlier governance issues will be passed to HCGC but the

IJB does need something in the strategy even if it is only one line. VF commented that it seemed things are implicit but they need to be explicit.

PH confirmed the Committee had agreed the Strategy would be for the NHS Board only and would include the four bullet points:

- The vision, objectives and outcomes for volunteering
- The development of a single volunteer strategy for NHS Dumfries and Galloway
- The development of an organisational accredited volunteer scheme (Investing in Volunteers)
- The initial focus of the strategy will be on developing and engaging volunteers that are representative of the local community

GS commented that the Strategy should be as wide and inclusive as we can possibly get. VF asked who would be taking this work forward and it was agreed that JP and MMcG would pick this up.

The Committee:

- Agreed to move forward with a Strategy for the NHS Board

MMcC left the meeting.

6. **Volunteer Recruitment for DGRI**

Margaret McGroggan (MMcG) presented the update explaining that since the New Year she has been working on volunteer recruitment and, along with LF, on the policy and procedures. A pilot was carried out in Wards 10 and 18, who welcomed the volunteers, and came up with role descriptors. Dementia Care (IDEAS Team) and Ward 15 (Children and Families) are keen to be involved. The policy and procedures which were approved at the June 2017 Area Partnership Forum. MMcG explained that a volunteer agreement is now in place having been approved at the Volunteer Steering Group (VSG). She highlighted ongoing work around the Volunteer Information System and updated on the recruitment day held at the end of June. MMcG highlighted Investing in Volunteers explaining that we were last involved three years ago but are now looking to update this, outlining the next steps as detailed in the handout. PH requested a regular update on volunteering. She noted that time was set aside for the Board to meet the volunteers and to thank them for giving of their time. GS thanked MMcG, saying very well done, and to LF for her input as well. JB commented that he had been in on this from the start commenting that the resource had been well worth it with good national support and it's good to see this coming through. GC commented that this was good work and the report has brought this to life asking what kind of demographics do we have in the volunteers, how can we continue to develop a wide diversity of people as volunteers, how do we retain volunteers and how do we support them. PH asked GC if she would like to see this within the papers which will come to the Committee and when she responded yes, PH asked MMcG to include this in the updates saying that she would be interested to hear some staff views around the volunteers and the difference they are making.

The Committee:

- Requested a regular Volunteering Update

7. **PCH&C Vision and Logic Model**

JP noted that any comments were welcome, will update and circulate final version to Committee.

PH noted that this is what the Committee will be concentrating on for the next few years. VF commented that we could use this as a base to develop an action plan from and measure performance, suggesting this comes back to the Committee every 6 months, agreed.

The Committee:

- Requested review in 6 months (April 2018)

8. **Terms of Reference Review**

ED presented the Terms of Reference for review and following discussion it was suggested that the membership be expanded to include the Volunteer Co-Ordinator and a Member of the Integrated Joint Board. VF noted that she would like to be included in the membership and commented that no patients/citizens were included. LF noted that Equality and Diversity Lead is not included. JL commented that the Chaplain's list has been updated and could we draw a representative from that list and will agree who with DA as she is meeting with her around this in September. PH suggested that the Committee re-visits the Terms of Reference at the October meeting and look at ways of engaging with spiritual leaders locally. ED will add the suggested changes and bring back to next meeting.

PH noted that the Rev Douglas Irving had retired and requested that a letter of thanks be sent to him for his contribution to the Spiritual Care/Person Centred Care Committee.

JL asked if tours of the new hospital would be offered and PH assured her that local spiritual leaders would be invited.

The Committee:

- Agreed to re-visit the Terms of Reference at the October meeting

9. **Good Conversations – feedback from first cohort**

JP highlighted the key messages confirming that funding from Endowments had supported the provision of twelve cohorts of training commencing in September with three running before Christmas, with discussions taking place around using two cohorts to provide training for local trainers. She noted that excellent feedback had been received from the initial cohort run in May and June. JP explained that an application has been made to the AHP Career Fellowship for funding, one day per week, to release time over the course of the programme to evaluate the impact.

PH commented that she was looking forward to the taster session for NEMs and invited anyone on the Committee who would like to attend saying they would be very welcome and the date will be circulated. GC highlighted the really good feedback with GS commenting that it speaks for itself. GS likes

the idea of training local trainers and is looking forward to the taster session.

PH noted the report suggesting that the Endowment Trustees should receive an update around how this programme is being received by staff and how the money has been spent.

The Committee:

- Noted the report
- Taster session date to be circulated
- Requested an update paper go to the Endowment Trustees

10. **Spiritual Care and Bereavement Update**

ED commented that bereavement is a key element of this paper and this has already been discussed.

The Committee:

- Noted the update

Any Other Competent Business

Nil.

Date of Next Meeting

Monday 23 October 2017, at 1.30 pm – 3.30 pm, in the New Board Room, Crichton Hall.

Agenda Item 172

DUMFRIES AND GALLOWAY NHS BOARD

PERSON CENTRED HEALTH AND CARE COMMITTEE

28 February 2018

1.30 pm, New Board Room, Crichton Hall

Present:	Ms. Penny Halliday	Non Executive Member (Chair)
	Mrs. Joan Pollard	Associate Director for Allied Health Professionals
	Ms. Lynsey Fitzpatrick	Equality and Diversity Lead
	Ms. Vicky Freeman	Head of Strategic Planning
	Ms. Mandy Spence	Midwifery Representative
	Ms. Gillian Stanyard	Non Executive Member
	Ms. Dawn Allan	Spiritual Care Lead
	Mrs. Lorraine Haining	Partnership Lead/Specialist Nurse Practitioner
	Mrs. Margaret McGroggan	Volunteer Co-Ordinator
	Ms. Phyllis Wright	Council/Social Work Representative
	Ms. Caroline Sharp	Workforce Director
	Mr. Stephen Hare	Employee Director, UNISON Branch Officer
Apologies:	Mr. Eddie Docherty	Nursing, Midwifery and AHP Director
	Ms. Claire Brown	Lead Officer Integration Project (East), Third Sector
	Ms. Lorna Carr	Chair – Area Clinical Forum
	Ms. Michele McCoy	Interim Director of Public Health
	Ms. Sue Newberry	Regional Integration Manager, Scottish Care
	Ms. Shirley Turberville	University of West of Scotland
In Attendance:	Ms. Claire Thirlwall	Health & Wellbeing Specialist
	Mr Kenny Degnan	Alzheimer Scotland
	Ms. Nicola Ross	PA, Associate Director of AHPs
	Ms. Amy Sellors	Patient Services Administrator

1. **Apologies for Absence**
   GS chair the meeting initially as PH had been held up at previous engagement. Apologies noted as above.

2. **Declarations of Interest**
   Nil.

3. **Notes of meeting – 18 December 2017**
   Notes agreed as accurate.

4. **Matters Arising**
   Bereavement Strategy Update:

DA provided an update on the Bereavement Strategy on behalf the small working group that has been working on this. Members of this group include representatives from NHS, Dumfries & Galloway Council and Third Sector. A paper was recently submitted to the Health & Social Care Senior Management Team and they have approved the development of a strategy and support the scoping and co-design of this work.

PH entered the meeting.

The workshop will take place in the form of a 'Learn and Listen' event and will be held in April/May 2018. Members of NHS, Dumfries & Galloway Council and IJB will be invited to attend.

VF asked for clarity on the Bereavement Strategy as it needs to be clear what the aim is and that the work meets the expectations of those who are supporting it. There is a difference between a Strategy and a service plan.

LH asked that the small working group were mindful of the Dementia Strategy as it has a number of different strands, of which some will feed into this strategy and need to ensure that work is not being duplicated.

The Committee:

- Noted the update

Amendments to Terms of Reference:
JP advised the group that a section on Confidentiality has been added to the Terms of Reference by the Corporate Business Manager.

PH requested that under Section 4- Objectives, that PCHCC receive regular updates on the co-production work.

The Committee:

- Approved the Terms of Reference with this change.
- Requested that PCHCC receive regular updates on co-production

5. **Action List**

PH updated the committee that the Mindfulness Update had been deferred to April 2018 due to staff sickness. PH stated that this has been deferred for a couple of meetings and would really like to the update in April 2018. JP advised that she had already spoken to the team regarding this update and there is a member of staff available to attend the meeting on 16 April with the report.

6. **Social Prescribing**

Claire Thirlwall (CT) attended the meeting to give an update on the Social Prescribing Framework which had previously been circulated. The update was received well by all in attendance.

CT advised that there is a student working on this project and will be compiling a report based on their findings. CT advised this will go to Health & Social Care Senior Management Team for approval. PH asked for this to be shared at the PCHCC once it has been approved. CT hoped it would be completed by June 2018.

LF noted from the paper circulated that an impact assessment will be carried out as part of the work. LF asked for this to be carried out as soon as possible to ensure compliance.

The Committee:

- Noted the update
- Requested a copy of the final report in June 2018

KD entered the meeting.

7. **Dementia Friendly Communities**

Kenny Degnan (KD) from Alzheimer Scotland attended to provide an update on Dementia Friendly Communities in Dumfries & Galloway. This is a 3 year project that was government funded and is due to come to an end in March 2018. The team was made up of four locality managers, two activity workers and a member of the user and care centre. The activity workers will still continue some of the work they have been doing on a voluntary basis.

KD informed the group that this project has been very successful and the profile of Dementia has been raised significantly in a number of public areas eg. Tesco, local pharmacies and GP surgeries are keen to receive some training.

PH asked KD if any work had been carried out in cottage hospitals across the region to make them more Dementia Friendly. KD advised that there would be changes that could be made, and these may be small but make a significant impact. KD advised that Julie Sinclair, Operation Manager for Alzheimer Scotland could possibly support any work through the Dumfries & Galloway Older People Steering Group as she sits on this group.

MMcG will also be recruiting volunteers for the Cottage Hospitals this year and all volunteers will receive Dementia Training prior to commencing their role.

KD advised that Dementia Friendly Communities are also working with Dental Practices in Stranraer.

GS asked if any changes had been to patients with Dementia. KD advised that people who are suffering from Dementia have been given cards to show in shops which gives a bit of information about they struggle with and always shop staff etc to respond appropriately.

VF asked how our Dementia Champions can support Palliative Care as the amount of support which families receive will vary. LH advised that there is an educational need for training for staff around Dementia as some staff are not recognising that patients can die from this illness.

KD and CT left the meeting.

The Committee:

- Noted the update

8. **Spiritual Care and Bereavement Support**

DA attended to give an update on the above. DA has now met with the Senior Nurse

in Acute Group to provide them with more information on the Spiritual Care Service and to inform them that there will be more Spiritual Care volunteers starting in the next few months with further recruitment this year to Cottage Hospitals. DA has seen a rise in the referrals that she has received since the move to the new hospital however; these are still manageable at present.

GS asked when the recruitment for Cottage Hospitals will commence and DA advised it will take place along with the recruitment of ward volunteers throughout the coming months. DA is looking to recruitment two volunteers per cottage hospital to begin with.

Labrith workshops will take place later in 2018 and will be available to all staff.

The Committee:

- Noted the update

9. **Volunteering Update**

MMcG updated the committee on the number of volunteers that have been recruited as this has now increased to 261. Orthopaedic outpatients had requested a volunteer in their service and this is currently being trialled. MMcG also received a request from a Nurse Manager to ask if it would be possible for Volunteers to support some wards in the mornings to help with patients who are at risk of falls. This is also being trialled with patients being identified at the morning huddles.

MMcG is working with the Dementia Nurse Consultant to look at the socialisation area in ward C4 and how this can be used to enhance patient experience.

MMcG has done 11 Peer Support Group meetings with volunteers to allow them the opportunity to meet other volunteers and feedback any findings they have. PH noted that she has received some positive feedback regarding the volunteers and how beneficial they were at the migration. PH asked MMcG to ensure that this was fedback to the Volunteers on behalf of the committee. CS also noted that she was impressed with two of the school volunteers she met with.

PH requested that volunteers would come to the PCHCC twice per year to give their story. PH would also like a report to be submitted to PCHCC regarding the volunteer numbers, how many of volunteers have progressed on to get new jobs as a result. PH would also like to arrange a Celebration Event for volunteers. MMcG suggested that something was done in June as this is Volunteer Week and the volunteers are already looking at different ideas to raise awareness.

LF raised an issue from the Volunteering paper around wheelchair assistance with patients/visitors in the new hospital. LF noted concerns as this will have significant implications on the Board if we are not adhering to the Equality Act with regards to having the correct processes in place to allow patients/visitors to get to the appropriate services.

JP advised that there have been numerous conversations with regards to this and a paper is being drafted for APF. CS and SH both agreed that this paper should be submitted to them in the first instance to progress this as the next APF isn't for 2 months. PH has asked that this is reviewed as a matter of urgency and assurance provided to PCHCC. PH has also asked for this to be raised with Audit and Risk

Committee and sit as a directorate risk under acute and cottage hospitals. CS will provide PCHCC with a report at the next meeting.

The Committee:

- Noted the update
- Requested volunteers attend twice per year to provide their story
- Requested a report on volunteering twice per year
- Requested a Celebration Event for Volunteers
- Requested an update on the Wheelchair Issues at the next Committee.

CS left the meeting.

10. **Any other Competent Business**

VF informed the committee that there have been discussions with Alliance and they are going to arrange to come and deliver a full day introduction session around co-production in end of April/May 2018. VF will have the opportunity to work with the team in drafting the agenda.

PH would like to thank the representatives from D&G Cancer Voices for attending the December 2017 meeting.

Date of Next Meeting

Monday 16 April 2018, at 1.30 pm – 3.30 pm, in the New Board Room, Crichton Hall.