

## DUMFRIES AND GALLOWAY NHS BOARD

Agenda and notice for meeting on Monday 5 October, 2015 at 10 am.

VENUE: Chambers, Ashwood House, Sun Street STRANRAER DG9 7JJ

Jeff Ace  
Chief Executive

### AGENDA

109 Chairman's Opening Remarks

110 Apologies for absence

111 Declarations of Interest

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

112 Minute of the Meeting held on 3 August 2015

*The Board is asked to approve the minute of the meeting held on 3 August 2015.*

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113 Matters Arising

### INVOLVING PEOPLE, IMPROVING QUALITY

114 Improving Safety, Reducing Harm

*The Board is asked to note progress with the implementation of Early Years Collaborative in Dumfries & Galloway Community Planning Partnership.*

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115 Patient Experience Report

*The Board is asked to receive this report which provides an overview of the Board's performance for Quarter 1 (April – June 2015), key themes of formal complaints and general feedback and learning and improvements which have been made as a result of patient and family feedback.*

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116 Healthcare Associated Infection Report

*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 CDI HAI HEAT targets*

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117 Children's Services Plan Progress Report

*The Board is asked to note the progress made with the implementation of the Children's Services Plan*

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118 Galloway Community Hospital Update

*The NHS Board is asked to receive and note this paper with regard to a portfolio of activity being undertaken at Galloway Community Hospital. This includes changes to the Management Structure for the hospital and the follow up action plan for the Older People in Acute Hospitals Inspection. This action plan is attached at Appendix 1.*

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119 Equality and Diversity: Six Monthly Update

*The Board is asked to acknowledge and understand the requirement of NHS Dumfries and Galloway to comply with a number of actions set out in the Public Sector Equality Duty, and which are outlined in this paper and note and discuss the progress made towards these actions (as at September 2015).*

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**ITEMS OF GOVERNANCE**

120 Schedule of Board Meeting Dates: April 2016 to October 2016

*The Board is asked to agree the proposed schedule of meeting dates for the period April 2016 to October 2016.*

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121 Revalidation of Nurses and Midwives

*The Board Is asked to note the Nursing and Midwifery Council's proposal for the revalidation of all nurses and midwives.*

Page 101

**ITEMS OF PERFORMANCE / DELIVERY**

122 Revenue Financial Performance: 5 Months to 31 August 2015

*The Board is asked to discuss and consider this report.*

Page 109

123 Performance Report

*The Board is asked to discuss and note the contents of this report.*

Page 123

124 Capital Performance 2015/16

*The Board is asked to approve the £3.0m slippage between years related to the foul water and fibre projects in respect of Acute Services Redevelopment Project and note the allocations received to date, the project budget updates and capital expenditure incurred to date.*

Page 155

125 Dental Salaried Services Review Update

*The Board is asked to note this update in respect of the implementation of the October 2014 Board decision to accept the recommendations of the report of the review of the provision of general dental services by the salaried service and approve the proposal to undertake a further service review of the Salaried Dental Service to explore options for future service delivery of routine NHS General Dental Services from Lochside Dental Clinic.*

Page 165

126 Medical Staffing (Angus)

*The Board is asked to note the progress in recruiting to consultant posts and acknowledge the significant challenges that remain, especially in respect to primary-care GP recruitment. The GP recruitment challenge is probably the biggest risk that the Board faces.*

Page 172

127 Medical Education Annual Report (Angus / Jean Robson)

*The Board is asked to note the Annual Report on Medical Education that has been provided by Dr Jean Robson, Director of Medical Education and the challenges faced by the Education Department, as detailed within the paper.*

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**ITEMS FOR APPROVAL / DISCUSSION**

128 Outline Winter Plan 2015 / 2016

*The NHS Board is asked to endorse the outline Winter Plan 2015/16 for NHS Dumfries and Galloway and approve its publication on the Board website.*

Page 209

129 Board Briefing

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

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## ITEMS FOR NOTING

130 Minute of the Public Health Committee held on 25 May 2015

*The minute of the Public Health Committee held on 25 May 2015 is presented to Board*

131 Minute of the Area Clinical Forum held on 27 May 2015

*The minute of the Area Clinical Forum held on 27 May 2015 is presented to Board*

132 Minute of the Area Clinical Forum held on 29 July 2015

*The minute of the Area Clinical Forum held on 29 July 2015 is presented to Board*

133 Minute of the Healthcare Governance Committee held on 13 July 2015

*The minute of the Healthcare Governance Committee held on 13 July 2015 is presented to Board*

134 Minute of the Person Centred Health & Care Committee held on 29 June 2015

*The minute of the Person Centred Health & Care Committee held on 29 June 2015 is presented to Board*

135 Any Other Competent Business

*Members should notify the Corporate Business Manager of any items of business not on the agenda that they wish to raise prior to the commencement of Board Business at 10 am.*

136 Date of Next Meeting

*The next formal meeting of the NHS Board will be held on Monday 7 December, 2015.*

## DUMFRIES AND GALLOWAY NHS BOARD

Minute of the meeting Dumfries and Galloway NHS Board held on 3 August 2015.

Minute Nos: 78 - 108

### Present

Mr J Ace	Chief Executive
Mr R Allan	Non Executive Member
Mr J Beattie	Employee Director
Ms L Bryce	Non Executive Member
Dr A Cameron	Medical Director
Mrs G Cardozo	Non Executive Member
Mrs M Cossar	Chair of Area Clinical Forum
Mrs P Halliday	Vice Chair
Mrs K Lewis	Director of Finance
Miss G Stanyard	Non Executive Member

### Apologies

Mr P Jones	Chairman
Professor H Borland	Nurse Director
Dr L Douglas	Non Executive Member
Mr R Nicholson	Non Executive Member

### Attending

Mrs V Freeman	Interim Director of Planning ( <i>for item 86</i> )
Ms C Sharp	Workforce Director
Mrs A Wilson	Deputy Nurse Director
Mrs J Wilson	Corporate Business Manager

### 78 Chairman's Opening Remarks

The Chairman opened the meeting and highlighted the visit from the Cabinet Secretary for Health, Wellbeing and Sport on Thursday to launch the winter plan. The plan is being launched locally due to the successful implementation of the Board's winter plan last year and is a reflection, once again, on the commitment, professionalism and team work of our staff.

The Chairman commented that colleagues should take the time to thank staff for all their hard work and acknowledge the success they had last winter in the face of a lot of challenges.

79 Apologies for Absence

Apologies as noted above.

80 Declarations of Interest

There were no interests declared.

81 Minute of the Meeting held on 1 June 2015

The minute of the meeting held on 1 June 2015 was approved as an accurate record.

82 Matters Arising

There were no matters arising.

83 Improving Safety, Reducing Harm: Risk Annual Report

The Deputy Nurse Director presented the report which has been through the appropriate governance committees to outline progress against the workplan and audit report. Training is in place for staff on both an individual and a group basis and the Human Factors training has been particularly beneficial. There has been an overall improvement in risk management but it was acknowledged that there was work still to do, including work with partners on the integrated future.

In response to comment, Members were advised:-

- engagement with patients and families, specifically around adverse events and significant adverse events, focuses on what matters to them in any investigation;
- falls are one of the key areas of improvement but it is important to recognise that falls will happen and will continue to be a risk. However, there is a lot of work around the Scottish Patient Safety Programme that looks at falls and this focuses on the needs of individual patients;
- the Risk Executive Group is a relatively new group and has met five times to date. The structure is now established and minutes will be presented to Audit and Risk Committee to strengthen governance;
- there is far more awareness of incidents and there is now a system in place that people understand and are able to work with. Feedback to individuals and teams is improving but there remains further work to be done;
- the key theme remains communication; and
- each directorate has a risk facilitator but staff can also use their line manager or supervisor.

The Medical Director commented on the upset felt by clinical staff in the way the figures were handled by the press. Situations are reported that did not cause harm and we have a culture where people are more readily prepared to report something that was not quite right but did not cause harm, recognising

that raising awareness may prevent harm in future. It is also important to note that a very significant proportion of the incidents were instances of staff being subjected to violence and aggression.

The Board, following discussion,

- noted the report.

#### 84 Patient Experience Report

The Medical Director presented the report and highlighted:-

- Kate Granger's visit, a truly inspirational character who introduced the 'Hello my name is ..... 'campaign;
- the Spiritual Care Policy will be taken through the appropriate committee;
- the annual report on feedback, comments and complaints – there has been an increase in the number of complaints and a slow improvement in the handling of these, albeit this remains below the target;
- communication and attitude remain the most common reason for complaints although the frequency of this is reducing;
- complaints in primary care are often resolved by the front desk in the practice; and
- there are a high number of prison service complaints in the context of the small population but these often relate to requests for medication.

In response to comment Members were advised:-

- some practices in primary care may have a zero return but this can be followed up;
- staff are encouraged at the very outset to communicate positively and effectively – the challenge within the constraints of a time limited corporate induction process is that there are many competing bids and priorities but it is important to be aware that induction is a continuous process and not simply a two day event in Crichton Hall; and
- compliments are often directly to staff at ward level and are not collected through a formal process.

The Chairman honoured what Kate Granger had done in coming to Dumfries and acknowledged the depth of her character, courage and compassion. We also have that in our staff as we were privileged to view a video made by one of our staff members who was terminally ill, leaving a legacy for training and future staff.

Mrs Cardozo advised that she would be happy to champion communication.

The Board, following discussion,

- noted the report.

#### 85 Prevention and Control of Infection

The Chief Executive presented the report and advised that the Board had

formally missed the SAB (staphylococcus aureus bacteraemia) target, commenting that there was a degree of assurance in that the figures are falling to historic lows and NHS Dumfries and Galloway has the lowest, or second lowest, levels in Scotland.

The Clostridium difficile infection (CDI) position is less positive in terms of process. The Board is achieving historically low rates but have not achieved the Scottish Government target, in common with a number of health boards. The longer term data going back to 2010 evidences that all boards achieved a dramatic early reduction in levels of CDI but have found it much harder as a health system across Scotland to carry on that improvement. Colleagues are working with Scottish Government and other boards to explore if there is anything further we can do locally, with some focus on inappropriate antibiotic prescribing.

Surgical site infection (SSI) is very positive and again at historically low levels. This is reflected in hard indicators such as surgical re-admission rate, one of the lowest in Scotland and the lowest rate on seven day re-admission.

The report provided the usual data on hand washing and estate cleanliness.

In response to comment Members were advised:-

- currently out to recruitment for infection control nurses – have been successful in bringing high quality individuals who work for a few years and then move on. A vulnerability in a small team and difficult to buy in short term expertise. The team is a bit stretched at the moment but completing key tasks; and
- if SAB a factor of death a root cause analysis is undertaken – no systemic failures have been identified.

The Board, following discussion,

- noted the report.

## 86 Integration of Health and Social Care: Joint Strategic Plan Consultation Document

The Interim Director of Planning presented this item, reminding Members that the Public Bodies (Joint Working) (Scotland) Act 2014 established the legal framework for health and social care integration. The legislation requires a strategic plan to be developed and the document has been developed in line with the integration scheme by a strategic planning group. The document sits within a core framework of strategic documents being developed for the integration authority, including locality plans, financial plan, performance management framework and a market facilitation plan underpinned by a strategic needs assessment.

The consultation document sits in five main sections and the first consultation period runs from 22 June to 28 August with a series events currently being run across the region. It is intended to have a further period of consultation towards the end of this calendar year.

In response to comment Members were advised:-

- comments captured are being brought together and reaching as many different types of people as possible to inform the re-draft in October;
- there have been variable responses, individuals often provide more general comments about health and social care, the new hospital or topics of interest to them;
- there are also more general questions about integration – why are we doing it and what difference is it going to make;
- information can be made available in other languages if requested; and
- there has been good engagement with the Area Committees.

The Board, following discussion, noted:-

- the contents of the consultation document;
- the period of public consultation from 22 June to 28 August 2015; and
- a second period of consultation is planned for October / November 2015.

#### 87 Revenue and Capital Financial Performance: 3 Months to 30 June 2015

The Director of Finance presented the combined report across revenue and capital; there has been very little capital movement in the first quarter.

The Director of Finance highlighted:-

- an overspend of £440k after the first three months of the year;
- the tone of the report reflects the increased risk in the financial position;
- Quarter 1 review ongoing, bringing together the financial assumptions and a more detailed report will be presented to Performance Committee in September;
- risks as a Board remain unchanged, there being a change in the scale of the risk, particularly around medical locum costs;
- gap on efficiency plan currently sitting recurrently at £2.7m in year; and
- challenge around the cost of drugs, particularly GP prescribing.

The challenge around the use of locums is well documented and whilst the Board has been successful in recruiting to certain specialties there are still a number of gaps. There are discussions on a national basis looking at some of the contract with agencies and locum agencies.

The in-year gap in efficiency plans is £1.9m with a recurring gap of £2.7m. The finance team is engaging with the Chief Operating Officer and directorates on how schemes can be accelerated and to identify new schemes. A CRES (cash releasing efficiency savings) workshop is scheduled on 25 August and individual directorates are having sessions with their own teams.

The quarter one review of the revenue position is underway.

In response to comments Members were advised:-

- sickness absence levels remain above the 4% target and this continues

to be a very complex issue – the variety of interventions and review continue on an ongoing basis;

- there has been some negative movement from the time the financial plan was set but there is reasonable confidence that financial balance will be delivered;
- contractual situation around locums is a two tier approach – national and local. At national level locum contracts are negotiated through the procurement team in NSS Scotland. There are particular challenges around locums locally and as a significant number of national contracts predominately apply to the Central Belt the Board often goes off national contract providers; and
- the locum challenge has changed over the last few years – used to be short term gaps, maternity leave or sickness absence but the current challenge is posts being empty and the inability to recruit substantively to vacancies.

The Finance Director advised Members there was a risk around the classification of the acute services project, essentially whether the scheme is classified as public or private sector on the balance sheet of the Scottish Government. Working with Scottish Futures Trust (SFT) who are leading the discussions. The Board was aware of the classification review at the time the contract was signed and authority was provided by Scottish Government to continue with the contract. There is no risk to the cost and timescale for delivery of the new hospital.

The Finance Director undertook to keep Members updated.

The Board, following discussion,

- noted the report.

## 88 Performance Report

The Chief Executive presented the report advising that the Board was on track with elective and cancer targets and Accident and Emergency (A&E) performance was touching the 98% aspiration target well above the 95% hard target, a strong indicator that the system was flowing well.

The Chief Executive highlighted a number of areas including:-

- the elective cancellation rate sitting at 7.4%;
- the system is still not achieving the sort of improvement in return follow-up appointments that is required – this is challenging and tied to consultant availability and consultant gaps;
- orthopaedics is in a better place, particularly in terms of MSK (musculo-skeletal); and
- DNAs (did not attend) showed a huge improvement when it dropped from 11% to 5% and this is possibly as low as can be achieved. Text reminders and working with individual patients to choose the most appropriate time has supported that change but 1 in 20 DNAs appears to be the minimum to achieve. This is very frustrating as it results in

loss of capacity, difficulties in the system, waste and unnecessary cost.

The Board, following discussion:-

- noted the report.

89 Review of HEAT Targets and Standards: Quarter 4 – 2014 / 2015 Update (End of Year Report)

The Chief Executive presented the paper which contained the data for the annual review in September and set out performance against the panoply of HEAT (health improvement, efficiency, access, treatment) targets with a few unexpected variations.

The Chief Executive highlighted:-

- smoking cessation – traditionally exceed this target but struggling to meet it currently at 50%. There are a number of reasons for this – the target has changed and is much more focused on the more deprived section. There is also the e-cigarette effect, people seeing their own ability to quit enhanced;
- struggling to achieve faster access to psychological therapies – working to ensure pathways are robust enough and to understand the high referral rate from primary care. Have indicated this target will be achieved by the end of the calendar year; and
- early access to ante-natal services is fractionally below target but there is confidence that the work in progress will deliver.

In response to comment Members were advised:-

- mindfulness is an important tool, focused on trying to improve personal and community resilience. This could be taken through strategic and locality plans as we move in to integration;
- e-cigarettes are possibly a nice nicotine substitute but it is not known yet if it is a safe substitute which could be risky if not managed carefully. There is also the issue of people transferring one dependency to another;
- the levels of risk of harm associated with e-cigarettes is not known at this stage. Existing smokers might benefit if it assists quitting but there is also some suggestion that smokers may continue. Young people may also be drawn to these as they think they are not harmful and may become a route to smoking; and
- health inequalities affects almost all the indicators measured.

The Board, following discussion:-

- noted progress on and delivery of HEAT targets and HEAT standards to the fourth quarter of 2014 / 2015 (end of year update).

90 Board Briefing

The Chief Executive presented the Briefing and highlighted the work a number of clinicians had been engaged in to create a Critical Care Handbook for Global Surgery. This work was led by one of the local consultants with

support from others in Dumfries and Galloway and Scotland and the handbook has been downloaded in more than forty countries and requests have been made for numerous translations.

The Board

- noted the Briefing.

91 Area Clinical Forum Annual Report 2014 / 2015

The Chair of the Area Clinical Forum presented the report which is a high level overview and the first annual report published.

The Board:-

- noted the Annual Report.

92 Minute of the Staff Governance Committee held on 23 March 2015

The Board:-

- noted the minute of the Staff Governance Committee held on 23 March 2015.

93 Minute of the Performance Committee held on 11 May 2015

The Board:-

- noted the minute of the Performance Committee held on 11 May 2015.

94 Draft Minute of the Performance Committee held on 6 July 2015

The Board:-

- noted the draft minute of the Performance Committee held on 6 July 2015.

95 Minute of the Audit and Risk Committee held on 22 June 2015

Mr Allan highlighted the appointment of a lay member to the committee and Item 7, the Internal Audit Annual Report 2014 / 2015.

The Board:-

- noted the minute of the Audit and Risk Committee held on 22 June 2015.

96 Minute of the Area Clinical Forum held on 22 April 2015

The Board:-

- noted the minute of the Area Clinical Forum held on 22 April 2015.

97 Minute of the Healthcare Governance Committee held on 18 May 2015

The Board:-

- noted the minute of the Healthcare Governance Committee held on 18

May 2015.

98 Draft Minute of the Person Centred Health and Care Committee held on 20 April 2015

The Board:-

- noted the draft minute of the Person Centred Health and Care Committee held on 20 April 2015.

99 Minute of the Community Health and Social Care Partnership Board held on 15 June 2015

The Board:-

- noted the minute of the Community Health and Social Care Partnership Board held on 15 June 2015.

100 Date of Next Meeting

The next formal meeting of the NHS Board will be held on Monday 5 October in the Council Chambers, Ashwood House, Sun Street Stranraer.

101 Any Other Competent Business

The Chief Executive advised Members that this was the Corporate Business Manager's last formal meeting of the Board and expressed thanks to her for the support she had given to him personally and also to the Board.

The meeting concluded at 12.40 pm

**DUMFRIES and GALLOWAY NHS BOARD**

5 October 2015

**IMPROVING SAFETY REDUCING HARM****Early Years Collaborative Progress Report****Author:**

Maureen Stevenson  
Patient Safety & Improvement Manager

**Sponsoring Director:**

Hazel Borland  
Executive Nurse Director

**Date:** 14 September 2015**RECOMMENDATION**

The Board is asked to note progress with the implementation of Early Years Collaborative in Dumfries & Galloway Community Planning Partnership.

**CONTEXT****Strategy / Policy:**

The Early Years Collaborative is a national improvement programme designed to support implementation of The Early Years Framework published in 2008 and Getting it Right for Every Child (GIRFEC). It is designed to accelerate the conversion of these high level principles in to practical action that will:

- Deliver tangible improvements in outcomes and reduce inequalities for Scotland's vulnerable children
- Shift the balance of services towards early intervention and prevention
- Sustain the change over time

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

This paper provides a summary of how our local Community Planning Partnership have embraced the methodology of the Early Years Collaborative to create a structure whereby partner organisations work together to prioritise, test and implement interventions which we know or suspect will make a real difference to the lives of families and young people across our region.

**Key Messages**

- The prioritisation of this work has been influenced by the findings of the Children's Services Review and the resultant Children's Services Plan.
- Three priority Areas have been identified for Improvement:- Parenting; Speech, Language & Early Literacy; Vulnerability
- The focus for 2014-2016 will be on 0-3 age group

<b>GLOSSARY OF TERMS</b>	
EYC	Early Years Collaborative
CPP	Community Planning Partnership
GIRFEC	Getting It Right For Every Child
ISD Scotland	Information Services Division Scotland

### MONITORING FORM

<b>Policy / Strategy Implications</b>	Healthcare Quality Strategy Early Years Framework Children and Young Peoples (Scotland) Act 2014
<b>Staffing Implications</b>	Encouraging staff across NHS Dumfries and Galloway to take forward learning from patient safety activities.
<b>Financial Implications</b>	None at this time
<b>Consultation</b>	No consultation required at this time as this is a nationally agreed programme
<b>Consultation with Professional Committees</b>	Patient safety discussed at Area Clinical Forum
<b>Risk Assessment</b>	Patient safety and risk management are connected activities. Improving patient safety reduces the risk to patients, staff and the organisation.
<b>Best Value</b>	Vision and Leadership: <ul style="list-style-type: none"> <li>▪ Commitment and leadership</li> <li>▪ Sound governance at strategic and operational level</li> </ul> Sustainability <ul style="list-style-type: none"> <li>▪ A contribution to sustainable development</li> </ul>
<b>Sustainability</b>	Embedding continuous improvement enables us to ensure sustainability and reliability of processes and outcomes for patients
<b>Compliance with Corporate Objectives</b>	Corporate Objective 2
<b>Single Outcome Agreement (SOA)</b>	<b>Ambitions</b> 1.1 All our children will have the best possible health and wellbeing 1.2 All our children will have good literacy and numeracy skills.
<b>Impact Assessment</b>	No Equality Impact Assessment required as this is a programme that impacts on all patients receiving care and treatment.

## INTRODUCTION

The Early Years Collaborative (EYC) is the world's first multi-agency, bottom up quality improvement programme to support the transformation of early years. Launched in October 2012, it involves all 32 Community Planning Partnerships from across Scotland and a wide range of National Partners. Its focus is on strengthening and building on services using improvement methodology. This method enables local practitioners to test, measure, implement and scale up new ways of working to improve outcomes for children and families.

### **Ambition of Early Years Collaborative**

*To make Scotland the best place in the world to grow up in by improving outcomes and reducing inequalities for all babies, children, mothers, fathers across Scotland to ensure that all children have the best start in life and are ready to succeed.*

The programme has the following aims:

1. To ensure that women experience positive pregnancies which result in the birth of more healthy babies as evidenced by a 15% reduction in the rate of stillbirths and infant mortality (from 2010 to 2015)
2. To ensure that 85% of children have reached all of their developmental milestones at the time of their 27-30 month child health review by end of 2016
3. To ensure that 90% of all children have reached all of their developmental milestones at the time the child starts primary school by end 2017
4. To ensure that 90% of all children have reached all of their expected developmental milestones and learning outcomes by the end of Primary 4 by end of 2021.

### **Collaborative Structure**

Initially the structure of the national and our local EYC collaborative was divided into 4 workstreams determined by age and stage with each designed to address the stretch aims identified above:

1. Conception to one year
2. One year to 30 months
3. 30 months to start of primary school
4. From start of primary school to end of P4.

However, this has now changed to reflect key priorities to reflect the interventions that evidence has shown will make the biggest impact on the EYC aims. Nationally these have been divided into the following broad themes:

- Early support for pregnancy & beyond
- Attachment & Child Development
- Transitions of care
- 27-30 month review
- Family engagement
- Addressing child poverty – income maximisation
- Developing parenting skills

Locally our priorities have been identified as:

- Vulnerability
- Speech, Language & Early Literacy
- Parenting

Each of the priorities has an identified lead, deputy and a multiagency improvement team. The improvement teams report their progress and are guided by the Early Years Strategy Group, chaired by Executive Nurse Director. The Strategy Group reports to the Children’s Services Executive Group who report to the Community Planning Partnership.

**Theory of Change**

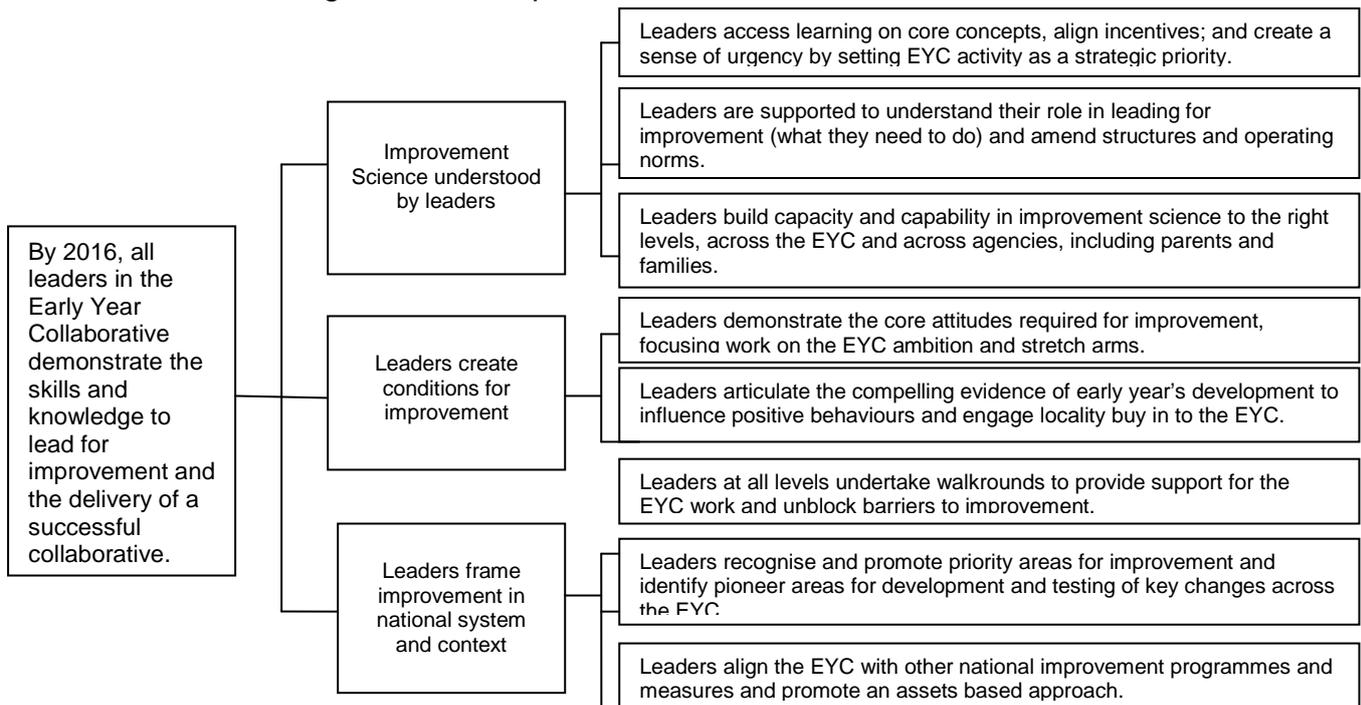
The Early Years Collaborative has been designed to engage and energise the early year’s workforce so that they have the knowledge and know how to adopt and use improvement methodology within a supportive environment, that will in turn improve outcomes for young children and families. The Programme has been divided in to 4 key stages:



We are currently between phase 2 and 3 whereby we are building improvement capability and learning to apply improvement methodology in practice.

**Leadership**

The leadership role is crucial in breaking down barriers between agencies, supporting integration and in creating the culture and knowhow for improvement to flourish. The Driver Diagram below expands on leaders’ role:



### Delivery Model

To date there have been seven National Learning Events with up to 20 local early years practitioners and leads attending these events.

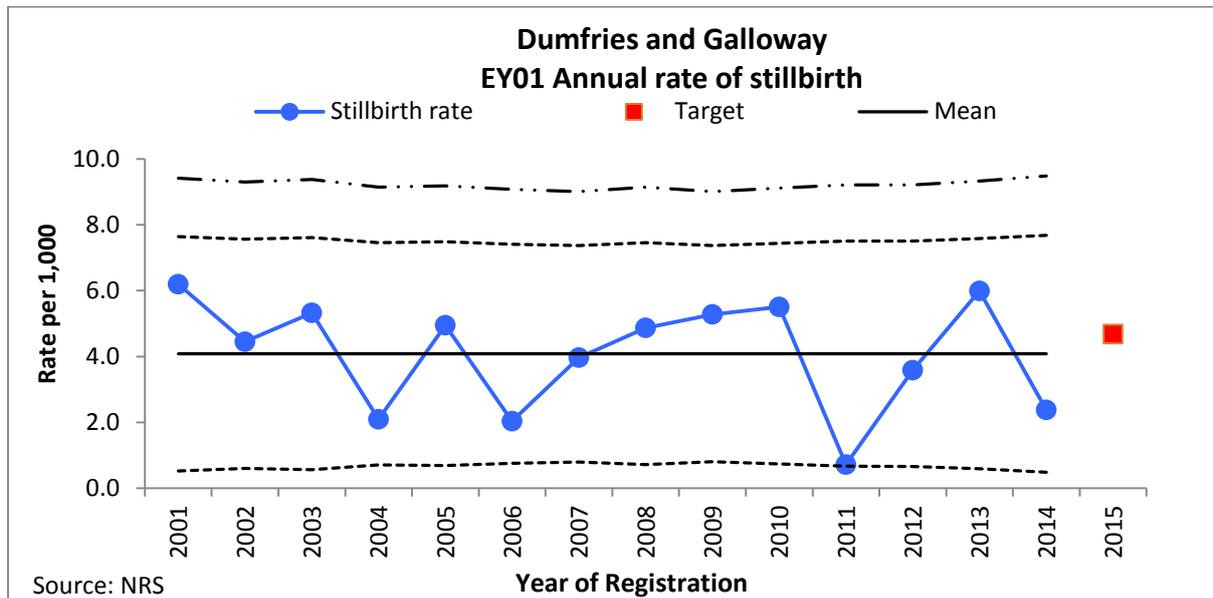
The real work of the collaborative happens away from these events, when practitioners have the opportunity to put into practice and share what they have learned. Local events have been held to engage, to inform and to build local improvement capability.

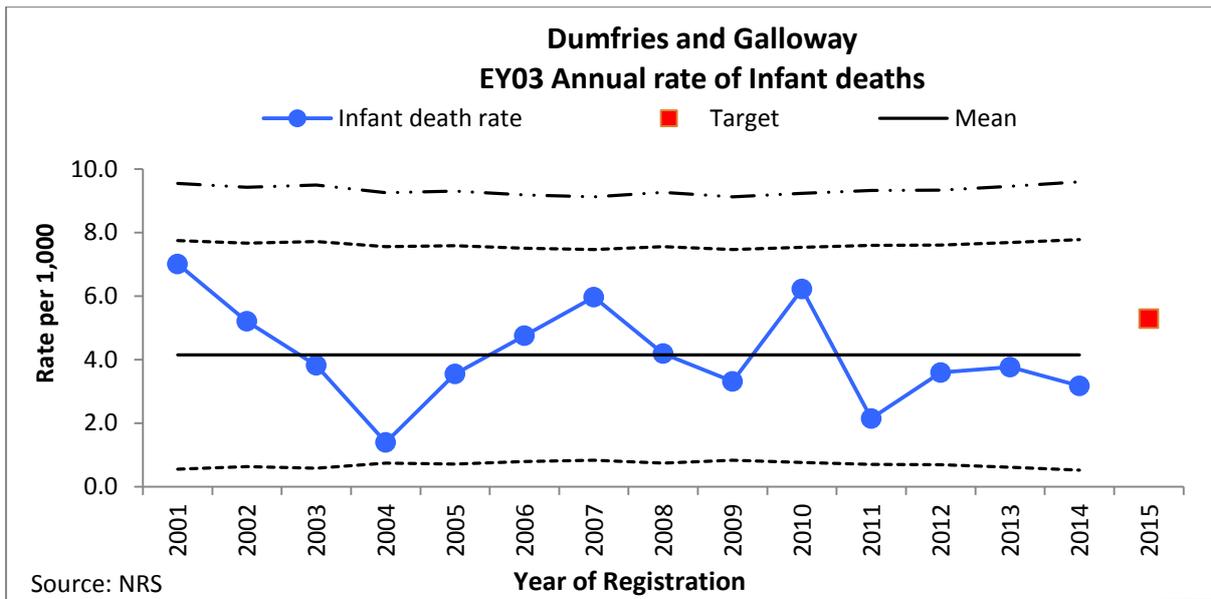
The three improvement teams described above now meet on a monthly basis to progress their aims through improvement workshops and design events. Each of the groups have developed Driver Diagrams to guide their work and are currently developing measurement and improvement plans.

### Monitoring Progress

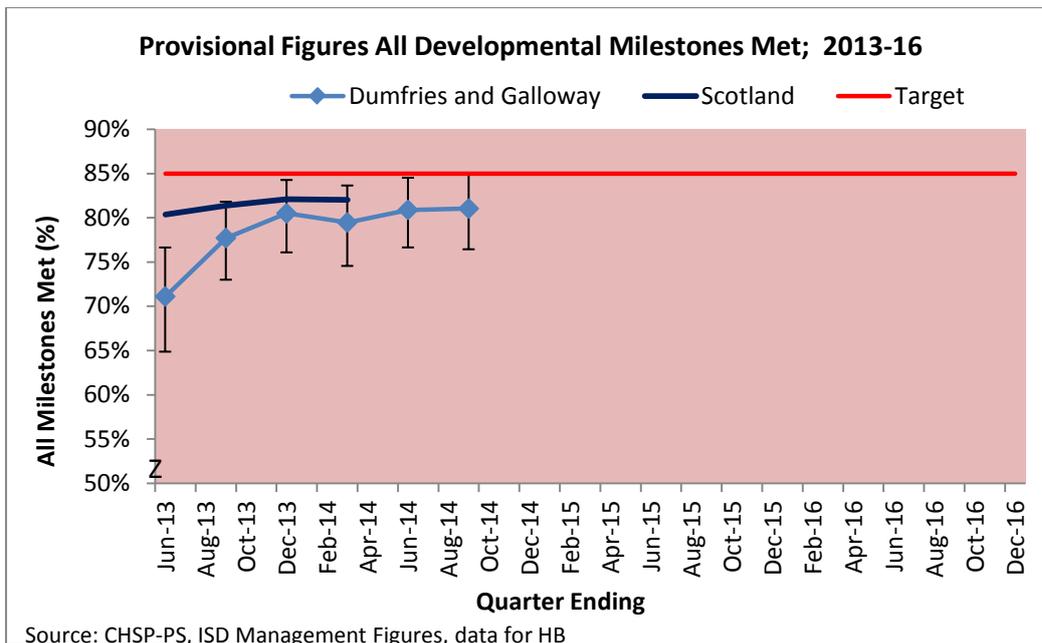
Progress is monitored via the Early Years Strategy Group which meets every month. Measuring progress towards meeting the overall programme aims is a challenge as some of the measurement tools do not currently exist.

Data on stillbirths and infant deaths is available and currently demonstrates a downward trend, although we are looking at very small numbers (3 stillbirths and 4 infant deaths in 2014). The charts below look at the rate of stillbirths and infant deaths; the red square denotes the target.





Data on 27/30 month assessments is also available and has helped to identify our need to focus on early speech, language and literacy skills, parenting and attachment. The chart below gives an indication that we are seeing an improvement over time but as this is only provisional data it should be interpreted with caution.



### Tests of change

29 tests of change are currently registered across the three improvement priorities and include

- aims to improve multiagency communication and information sharing for vulnerable mums to be,
- introduction of Wellbeing Assessments for all pregnant women,
- improve parenting skills for vulnerable families,

- improve efficiency of requests for assistance,
- increase number of parents reading to their child and
- reduce the number of children with impoverished language through the use of designated programmes and resources to name a few.

Tests are supporting local improvements in a range of areas including: increasing the uptake of Healthy Start Vouchers, joining up midwifery and addiction services for vulnerable families, encouraging more parents to read to and attach with their children, , increasing the number of families receiving income maximisation advice, and more generally, finding new, more person-centred ways to identify specific child health and wellbeing needs and better engage vulnerable families in support services.

The tests are at different stages of development ranging from an intent to participate to changes being tested through to significant improvement demonstrated. The challenge is to ensure that successful tests can be replicated and where relevant scaled up and spread across our region.

### **Capacity/Capability Building**

The national and local learning events have been the primary vehicle for introducing, engaging and training practitioners in improvement methodology.

This has been supplemented by national and a local 'improvement bootcamp' which is designed to provide practitioners with more in depth knowledge and ongoing support to test improvements in practice.

Our initial seven 'bootcampers' now act as improvement coaches with a further 17 in training. We currently have one expert improvement practitioner providing advice and support to the programme and one improvement advisor in training.

This is insufficient to meet the scale and scope of our ambition and to provide the programme management of EYC locally. Resources have been identified to recruit a programme manager/improvement advisor.

### **Conclusion**

The Early Years Collaborative within Dumfries & Galloway is integrating into existing structures and ambitions for early years.

It is not a programme of work that sits separate to core business but one that requires a multidisciplinary and multiagency approach to improve outcomes for children and families.

At its core is an improvement methodology that supports practitioners to identify and quantify what it is that they are aiming to achieve and to test whether their change ideas will lead to improved outcomes.

Measuring improvement has been challenging not least because measurement has traditionally focussed on inputs rather than outputs.

As the Early Years Collaborative moves into the next phase of development it will require a change in focus from raising awareness and training to an increased focus and targeted approach to improvement.

That is not to say that we do not still require to raise awareness and build capability but rather we build capability within the teams leading the improvements.

The recently established improvement teams, who have benefitted from increased support and capability building, should help to take us into phase 3 where we apply improvement methodology to test improvements that can be spread and scaled up across our region.

Obtaining and reporting on improvement data has been a real challenge not least because we are working across organisational boundaries, with different systems and looking for data that has not traditionally been collected. This will remain an area of continued focus for the Early Years Strategic Group and for each of the improvement teams.

The EYC ambitions are stretching but they are ambitions that could help us to achieve a real step change in outcome if we embrace the methodology, recognise the scale of the task ahead and give practitioners the time and support they need to embrace improvement as a core element of their role.

**DUMFRIES and GALLOWAY NHS BOARD**

5 October 2015

**INVOLVING PEOPLE IMPROVING QUALITY****Patient Experience Report****Author:**

Hazel Borland  
Executive Nurse Director

**Sponsoring Director:**

Hazel Borland  
Executive Nurse Director

**Date:** 15 September 2015**RECOMMENDATION**

The NHS Board is asked to receive this report which provides an overview of the Board's performance for Quarter 1 (April – June 2015), key themes of formal complaints and general feedback and learning and improvements which have been made as a result of patient and family feedback.

**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:**

Learning from patient experience in order to improve our services is one of the most important tools at our disposal.

**Key messages:**

- A significant amount of activity is taking place with the aim of improving patient experience from a number of different perspectives.
- The number of complaints received has increased by 53% in Quarter 1 from 73 in Q1 2014/15 to 112 in Q1 2015/16.
- The % response within 20 working days has increased by 31% from 49% in Q1 2014/15 to 80% in Q1 2015/16.

**GLOSSARY OF TERMS**

CCL Community Chaplaincy Listening  
NES NHS Education Scotland  
VBRP Values Based Reflective Practice

**MONITORING FORM**

Policy / Strategy	<i>Healthcare Quality Strategy Person Centred Health and Care Collaborative</i>
Staffing Implications	<i>Ensuring staff learn from patient feedback in relation to issues raised.</i>
Financial Implications	<i>Not required</i>
Consultation / Consideration	<i>Not required</i>
Risk Assessment	<i>Actions from feedback followed through and reported to General Managers and Nurse Managers who have a responsibility to take account of any associated risk.</i>
Sustainability	<i>Not required</i>
Compliance with Corporate Objectives	<i>To promote and embed continuous improvement by connecting a range of quality and safety activities to deliver the highest quality of service across NHS Dumfries and Galloway</i>
Single Outcome Agreement (SOA)	<i>Health inequalities</i>
Best Value	<i>Commitment and leadership Accountability Responsiveness and consultation Joint Working</i>
Impact Assessment	<i>Not undertaken as learning from patient feedback applies to all users</i>

## 1. Introduction

This report provides a commentary and summary statistics on complaints handling throughout NHS Dumfries and Galloway for the period Quarter 1 (April 2015 – June 2015). It looks at complaints received locally and by the Scottish Public Services Ombudsman (SPSO).

## 2. Complaints

Table 1 provides a summary of the number of formal complaints received in Quarter 1 (April 2015 – June 2015) and the combined overall totals.

**Table 1 Formal Complaints Data for Quarter 1 (April 2015 – June 2015)**

	<b>April 2015</b>	<b>May 2015</b>	<b>June 2015</b>	<b>Q1 Total</b>
Complaints received	<b>43</b>	<b>35</b>	<b>34</b>	<b>112</b>
Complaints acknowledged in 3 working days	42 (98%)	34 (97%)	33 (97%)	109 (97%)
Complaints completed in 20 working days	<b>28 (65%)</b>	<b>31 (89%)</b>	<b>31 (91%)</b>	<b>90 (80%)</b>
Complaints not completed in 20 working days	15 (35%)	4 (11%)	2 (6%)	<b>21 (19%)</b>
Complaints still ongoing	0	0	1 (3%)	<b>1 (1%)</b>
Complaints withdrawn	1 (2%)	0	1 (3%)	<b>2 (2%)</b>
<b>Outcome of complaints completed</b>				
Upheld	13 (30%)	12 (34%)	15 (44%)	<b>40 (36%)</b>
Upheld in Part	7 (16%)	7 (20%)	3 (9%)	<b>17 (15%)</b>
Not Upheld	21 (49%)	16 (46%)	14 (41%)	<b>51 (46%)</b>
Irresolvable - Expectation	1 (2%)	0	0	<b>1 (1%)</b>
Complaints Transferred to another department	0	0	0	<b>0</b>

The Board achieved 97% compliance across this reporting period for the percentage of complaints acknowledged within the national target of 3 working days. NHS Dumfries and Galloway has set a Board target of 70% for complaints to be responded to within 20 working days. The percentage response time achieved for this reporting period was 80%. This is a significant improvement in our performance in Quarter 1 2014/15 of 49%.

As a result of the average performance in 2014/15, Patient Services reviewed the complaints process in May 2015 and have introduced improvement measures in collaboration with the operational directorates.

Patient Services worked with IT to begin development of the *Qlikview* application for complaints and patient feedback statistics. This will be further developed over the coming months with the aim of providing a bank of data and reports for use by a range of Board Managers.

A key element of this was the introduction of an *Outstanding Records* report which is automatically emailed to each General Manager, every Monday morning, where there is an ongoing or outstanding complaint. It is believed that the introduction of this report has resulted in an improvement in complaint response times as complaints handlers and investigators are reminded regularly if they have outstanding records.

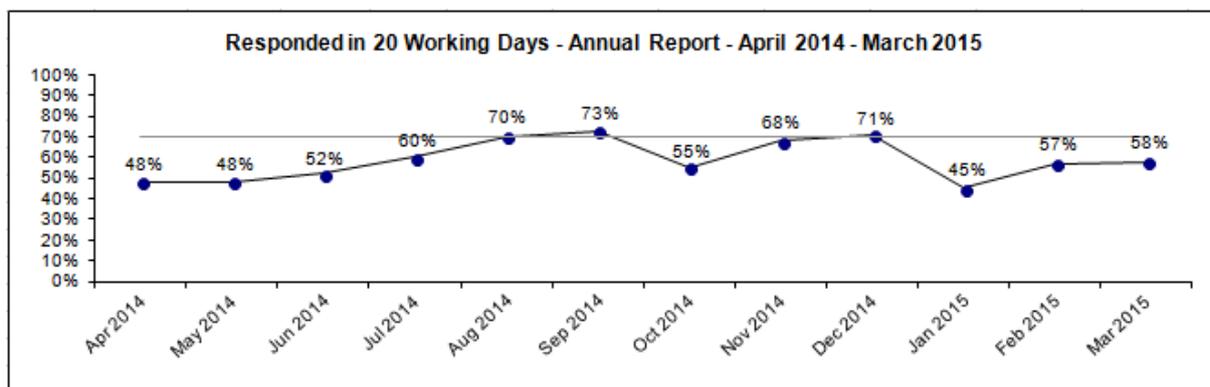
It was also agreed that Acute and Diagnostic Services and Women, Children & Sexual Health Directorates would test a revised process from 1 June 2015. A complaints tracker was introduced to ensure that when a complaint reaches day 15 in the process, a reminder is sent advising of this. There is also a clear escalation process should a response not be possible within the 20 working days.

This process seems to have worked well and has also contributed to the improvement in the Board's compliance with the 20 working day target. This process will now be rolled out to all other areas of the Board to ensure that a single complaints process is in operation Board-wide.

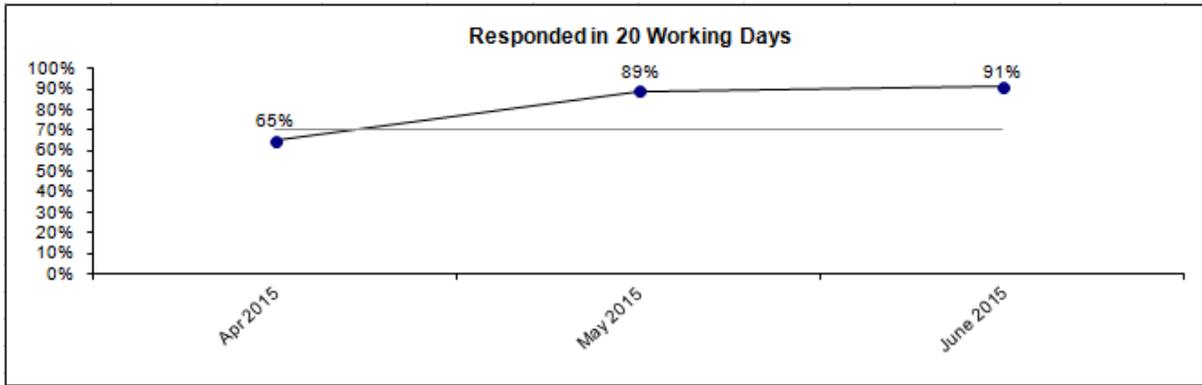
It is also recognised that additional resources have been implemented in Acute and Diagnostics to achieve and aim to sustain this performance. In the Women, Children & Sexual Health Directorate roles and responsibilities have been re-defined to ensure that all staff involved in complaint investigations are aware of the process. DATIX is being rolled out to key members of staff in the directorate and training is being provided.

Figure 1 summarises the level of activity for all complaints received from 1 April 2014 – 31 March 2015 for comparison with 2015-16.

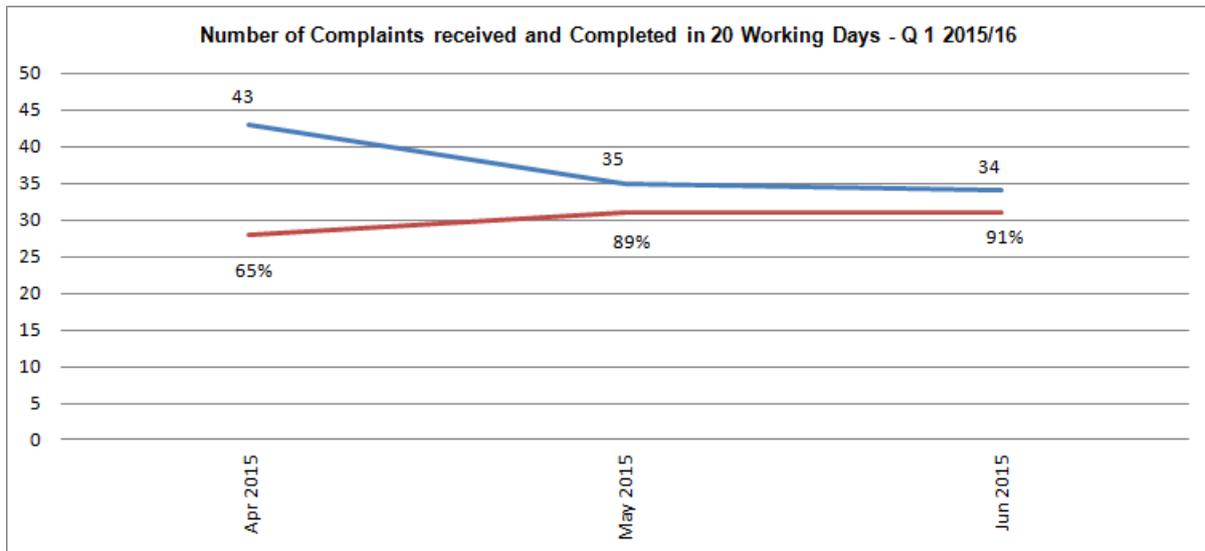
**Figure 1: Percentage of complaints completed within 20 Working days - 2014-2015**



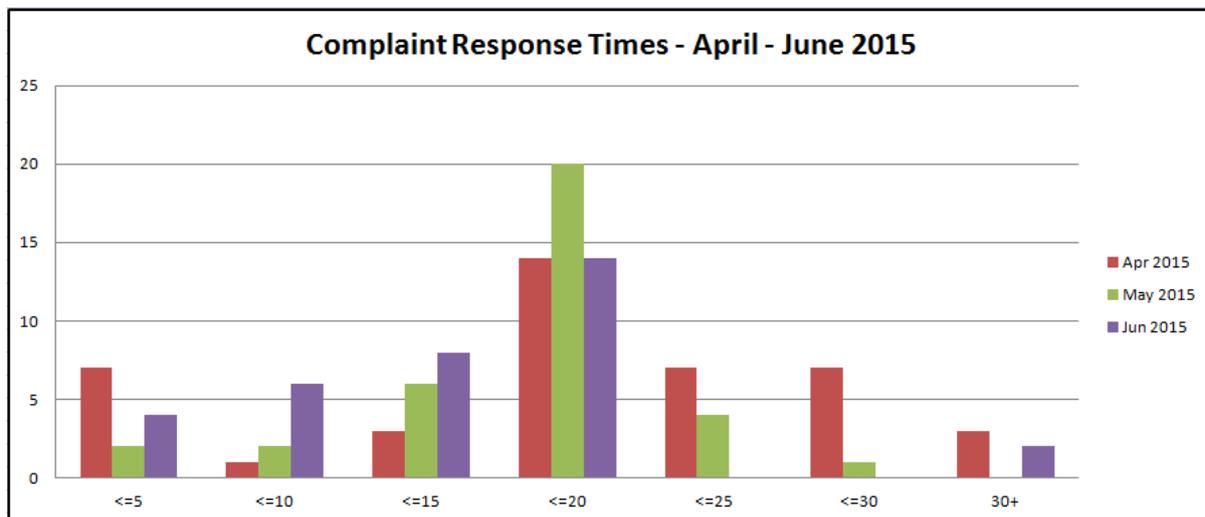
**Figure 2: Percentage of complaints completed within 20 Working days – Q1 2015-2016**



**Figure 3: Number of complaints received and completed in 20 working days Q1 2015/16**



**Figure 4: Complaint Response times**



## 2.1 Complaints by Directorate

**Table 2 Number of Complaints by Directorate and response (%) in 20 working days**

	April 2015		May 2015		June 2015	
<b>Acute Services/Diagnostics</b>	29	20 (69%)	21	18 (85%)	23	23 (100%)
<b>PCCD East/West</b>	6	3 (50%)	2	2 (100%)	4	3 (75%)
<b>Mental Health, Learning Disability, Psychology</b>	3	2 (66%)	2	2 (100%)	0	0
<b>Women and Children's Services</b>	3	1 (33%)	3	2 (66%)	3	1 (33%)
<b>Prison Services</b>	2	2 (100%)	6	6 (100%)	3	3 (100%)
<b>Corporate *</b>	0	0	1	1 (100%)	1	1 (100%)
<b>Operational Services</b>	0	0	0	0	0	0
<b>Totals:</b>	<b>43</b>	<b>28 (65%)</b>	<b>35</b>	<b>31 (89%)</b>	<b>34</b>	<b>31 (91%)</b>

\*Corporate (inc Finance, Medical, NMAHP, Public Health, Strategic Planning, Workforce Directorate)

## 2.2 Breakdown of Complaints by Category

The top three categories of complaint received by NHS Dumfries and Galloway for this reporting period remains consistent with previous months and relate to clinical treatment, staff attitude and behaviour and communication (oral).

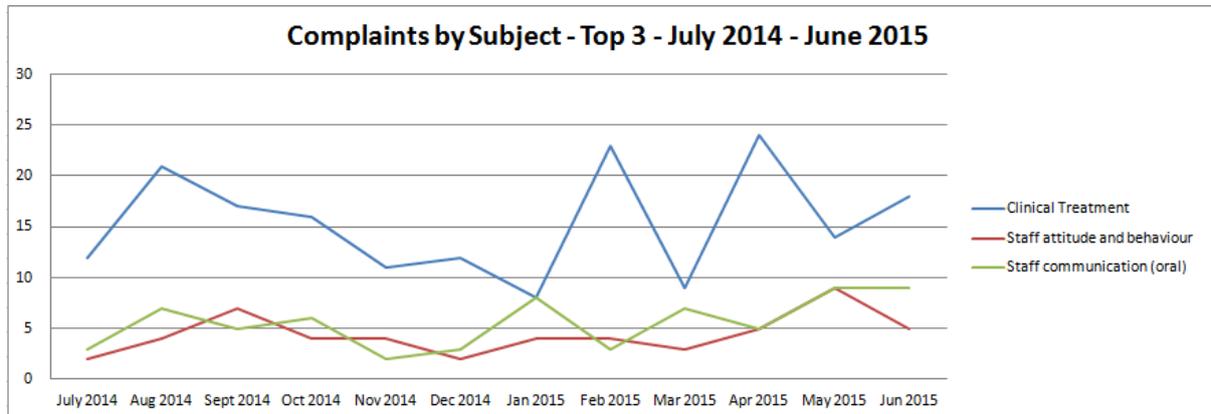
**Table 3 Complaint Issues by Category**

	Apr 2015	May 2015	Jun 2015
<b>Clinical Treatment</b>	24	14	18
<b>Staff communication (oral)</b>	5	9	9
<b>Staff attitude and behaviour</b>	5	9	5
<b>Waiting time for date for appointment</b>	4	5	1
<b>Staff communication (written)</b>	1	2	3
<b>Waiting time for date of admission/ attendance</b>	2	1	1
<b>Other</b>	10	4	4

These categories are consistent with national themes, both UK and Scotland wide. Communication issues are mainly related to verbal communication between staff and patients and/or relatives and often come down to differences in interpretation of what was said and what was understood. These are often linked to complaints about staff attitude - in many cases the complaints about attitude is linked to a perception of whether or not information was appropriately communicated or received.

Figure 5 below demonstrates that complaints about clinical treatment are approximately double those concerned with communication or staff attitude and behaviour.

**Figure 5 Complaints by Subject: Top 3 for July 2014 – June 2015**



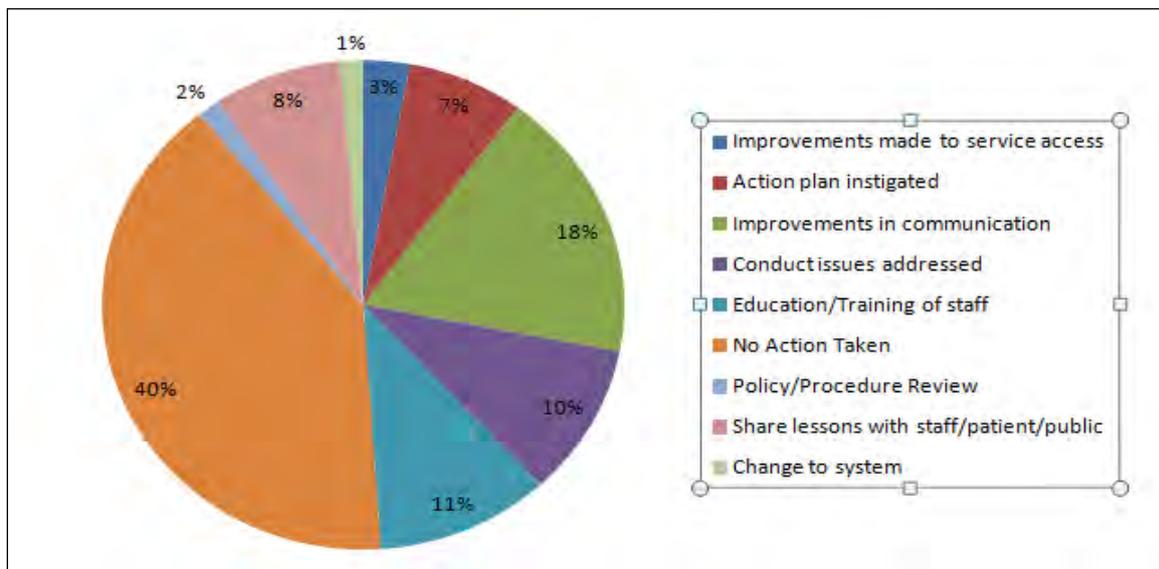
The main issues raised in relation to Clinical Treatment are from patients who disagree with the clinical treatment provided or the treatment plan and the co-ordination of their clinical treatment

**2.3 Improvement Actions**

From 1 April 2015 Information Services Division (ISD) has requested additional data from NHS Boards in relation to the actions taken to ensure learning and improvements are made as a result of complaints. Action codes have been agreed across NHSScotland and have been made mandatory from 1 April 2015. Any complaint which has been upheld or partially upheld must record the action the Board are taking to ensure learning and improvement.

Figure 6 details the Improvement actions taken as a result of complaints received in Quarter 1.

**Figure 6: Improvement Actions taken**



### **3. Patient Opinion Feedback**

An effective way to improve the experience of health and care services is to capture feedback from the patients, services users, carers and relatives. Patient Opinion is an online approach, actively supported by Scottish Government, which enables the public to provide and view feedback on the services they have received.

All Patient Opinion postings are shared with Healthcare Governance Committee at each meeting.

All NHS Dumfries and Galloway stories are available to view by visiting: [www.patientopinion.org.uk](http://www.patientopinion.org.uk).

### **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).

The Board currently have five complaints which are under investigation by the SPSO and one case file has just been sent for consideration. The SPSO will advise on completion of their processes of any actions required in relation to these cases.

Six further complaints which have been investigated by the SPSO have had recommendations made to the Board in respect of these complaints. Details of the recommendations and the actions taken to implement the recommendations for five of these cases have been discussed at Healthcare Governance Committee in September 2015.

### **5. Reports to the Procurator Fiscal**

There have been no complaints reported to the Procurator Fiscal in this reporting period. The Medical Director meets with the Procurator Fiscal regularly with regard to any other issues or cases out with complaints.

### **6. Conclusion**

The Board will be pleased to note significant improvements in the timeliness of our responses to patient and family complaints.

**DUMFRIES and GALLOWAY NHS BOARD**

5 October 2015

**Involving People, Improving Quality****Healthcare Associated Infection Report****Author:**

Elaine Ross  
Infection Control Manager

**Sponsoring Director:**

Professor Hazel Borland  
Executive Nurse Director

**Date:** 11 September 2015**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 CDI HAI HEAT targets.

**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 HEAT 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:**

- *Staphylococcus aureus* bacteraemia data is showing an encouraging downward trend.
- *Clostridium difficile* Infection is remaining static with slight seasonal variation. The HEAT target is vulnerable at this time.
- There have been disruptions to the endoscopy service due to sub optimal water quality results detected on routine sampling and a mechanical failure. These are now resolved. No patient risk was identified.
- An unannounced Healthcare Environment Inspectorate inspection took place at DGRI 11-12 August. The formal report will be published 6 October 2015.

**GLOSSARY**

<i>AOBD</i>	-	<i>Acute Occupied Bed Days</i>
<i>CDI</i>	-	<i>Clostridium difficile</i> Infection
HAI	-	Healthcare Associated Infection
HEI	-	Healthcare Environment Inspection
HPS	-	Health Protection Scotland
ICT	-	Infection Control Team
MSSA	-	Meticillin Sensitive Staphylococcus Aureus
MRSA	-	Meticillin Resistant Staphylococcus Aureus
<i>SAB</i>	-	<i>Staphylococcus aureus</i> bacteraemia
SSI	-	Surgical Site Infection
TOBD	-	Total Occupied Bed Days

**MONITORING FORM**

Policy / Strategy Implications	<i>Healthcare Quality Strategy Achievement of HAI HEAT targets</i>
Staffing Implications	<i>Nil</i>
Financial Implications	<i>Nil</i>
Consultation	<i>Update paper only consultation not required</i>
Consultation with Professional Committees	<i>Update paper only. Contents are agenda items for discussion at PCCD and HMG and SCN meetings Also presented to APF at each meeting.</i>
Risk Assessment	<i>Addressed through the corporate risk register</i>
Best Value	Governance and Accountability <ul style="list-style-type: none"> <li>• <i>sound governance at a strategic and operational level</i></li> </ul>
Sustainability	<i>Fewer infections will reduce bed occupancy and use of resources</i>
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.
Single Outcome Agreement (SOA)	<i>Keeping the population safe</i>
Impact Assessment	<i>Not required. Update paper only</i>

# 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

### Key Healthcare Associated Infection Headlines

- *Staphylococcus aureus* bacteraemia data is showing an encouraging downward trend.
- *Clostridium difficile* Infection is remaining static with slight seasonal variation. The HEAT target is vulnerable.
- There have been disruptions to the endoscopy service due to sub optimal water quality results detected on routine sampling and a mechanical failure. These are now resolved. No patient risk was identified.
- An unannounced Healthcare Environment Inspectorate inspection took place at DGRI 11/12 August. The formal report will be published 6 October 2015.

**1. *Staphylococcus aureus* (including MRSA)**

*Staphylococcus aureus* is an organism which is responsible for a large number of healthcare associated infections, although it can also cause infections in people who have not had any recent contact with the healthcare system. The most common form of this is Meticillin Sensitive *Staphylococcus Aureus* (MSSA), but the more well known is MRSA (Meticillin Resistant *Staphylococcus Aureus*), which is a specific type of the organism which is resistant to certain antibiotics and is therefore more difficult to treat. More information on these organisms can be found at:

*Staphylococcus aureus*:  
[http://www.nhs24.com/content/default.asp?page=s5\\_4&articleID=346](http://www.nhs24.com/content/default.asp?page=s5_4&articleID=346)

MRSA  
[http://www.nhs24.com/content/default.asp?page=s5\\_4&articleID=252](http://www.nhs24.com/content/default.asp?page=s5_4&articleID=252)

NHS Boards carry out surveillance of *Staphylococcus aureus* blood stream infections, known as bacteraemias. These are a serious form of infection and there is a national target to reduce them. The number of patients with MSSA and MRSA bacteraemias for the Board can be found at the end of section 1 and for each hospital in section 2. Information on the national surveillance programme for *Staphylococcus aureus* bacteraemias can be found at:  
<http://www.hps.scot.nhs.uk/haic/sshap/publicationsdetail.aspx?id=30248>

Our most recent SAB data (to end August 2015) is showing an encouraging downward trend – as illustrated by Figures 1 - 3 below. This data is discussed and analysed in detail at the HAI Executive Group and the Infection Control Committee. Members will recall that a significant amount of improvement activity has been undertaken with clinical teams across the organisation; the three improving data points in figure 2 reflect that activity.

**Figure1**

Quarterly rolling year *Staphylococcus aureus* Bacteraemia Rates per 1000 Acute Occupied Bed Days for HEAT Target Measurement

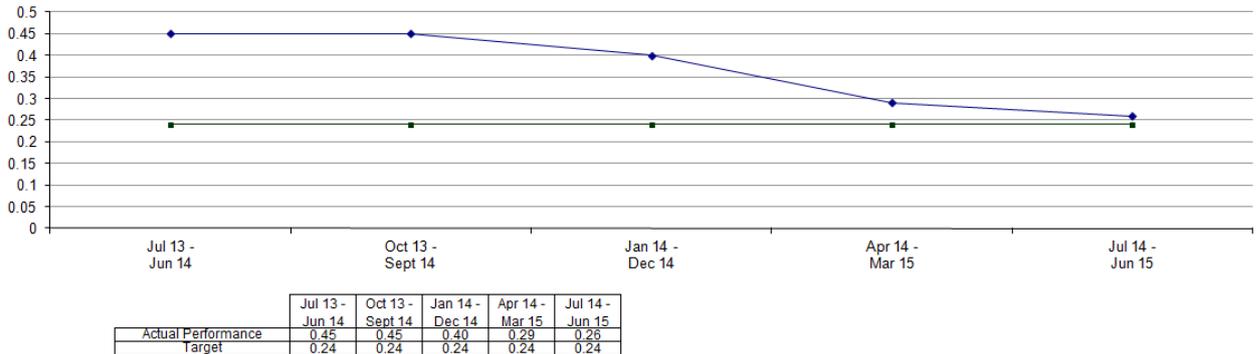


Figure 2

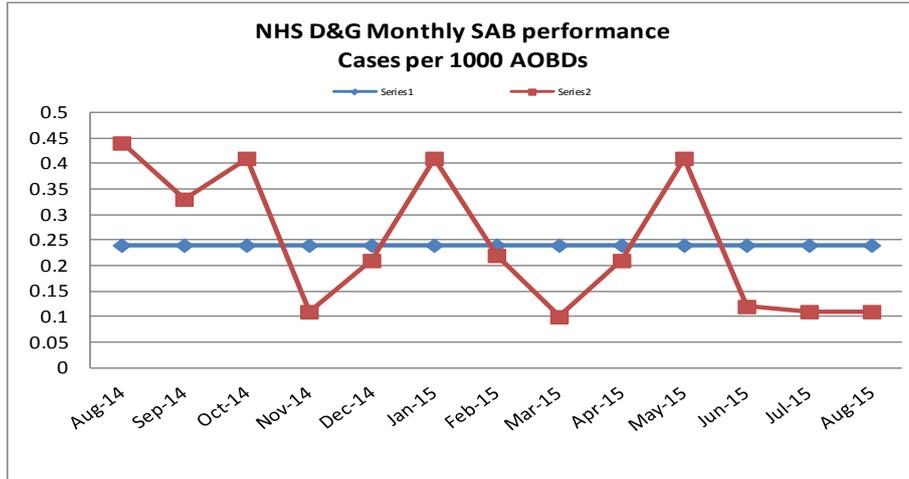
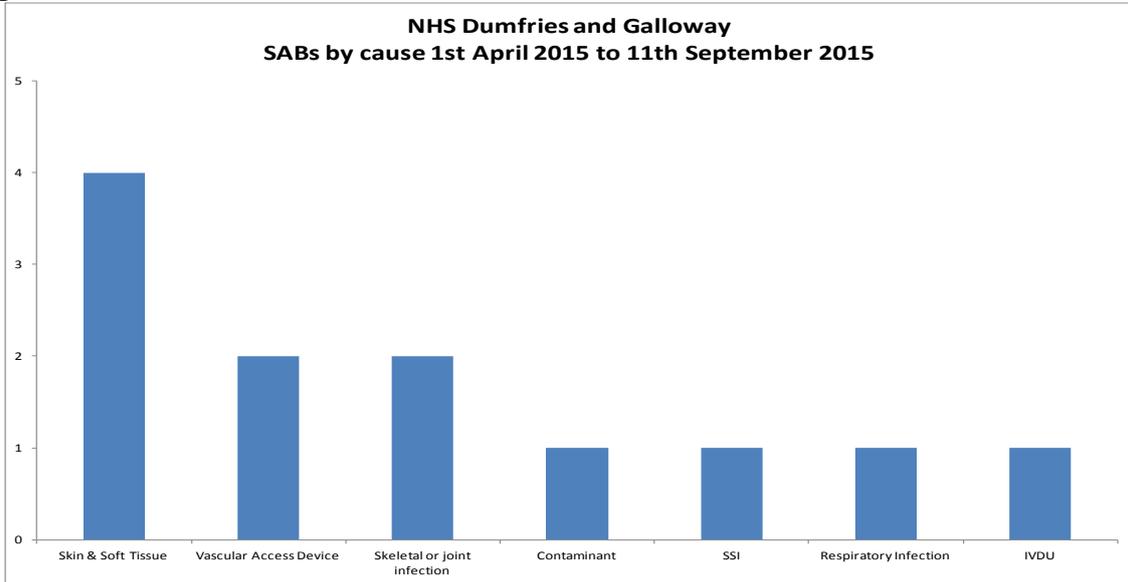


Figure 3



**2. Clostridium difficile**

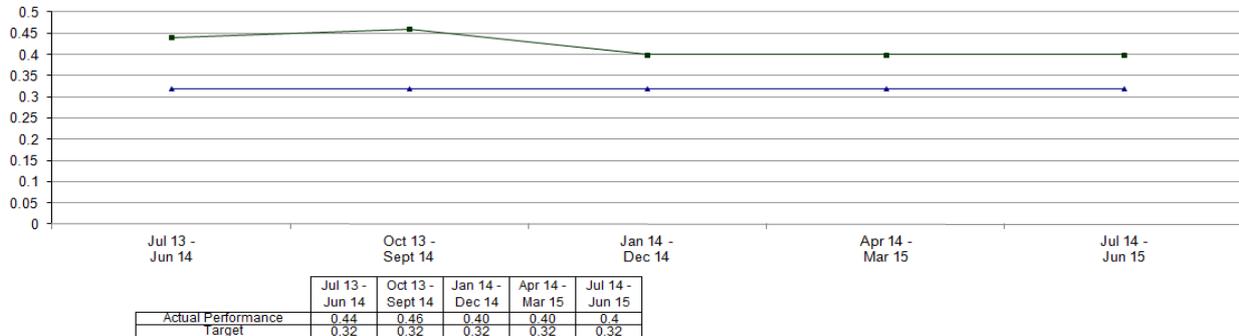
*Clostridium difficile* is an organism which is responsible for a large number of healthcare associated infections, although it can also cause infections in people who have not had any recent contact with the healthcare system. More information can be found at: <http://www.nhs.uk/conditions/Clostridium-difficile/Pages/Introduction.aspx>

NHS Boards carry out surveillance of *Clostridium difficile* infections (CDI), and there is a national target to reduce these. The number of patients with CDI for the Board can be found at the end of section 1 and for each hospital in section 2. Information on the national surveillance programme for *Clostridium difficile* infections can be found at: <http://www.hps.scot.nhs.uk/haic/sshaip/ssdetail.aspx?id=277>

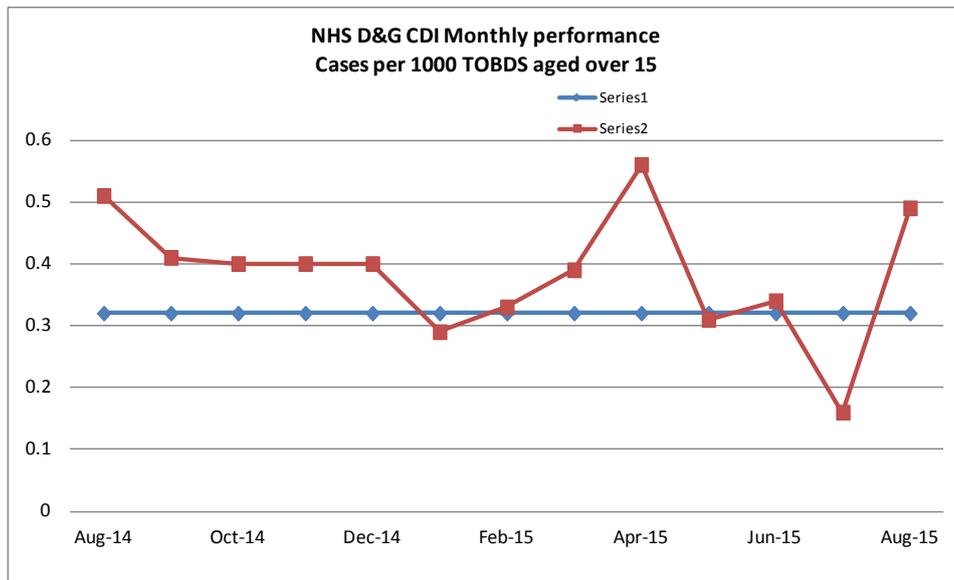
The September meeting of the Healthcare Governance Committee received a detailed paper on Clostridium Difficile. The continued local challenges and interventions being undertaken to continue to reduce harm, and the national picture with regard to this distressing infection were discussed in detail.

**Figure 4**

Quarterly rolling year *Clostridium difficile* Infection Cases Age 15 Years & Above per 1000 total occupied bed days for HEAT Target Measurement



**Figure 5**



Our focus continues to be on antimicrobial stewardship which will include a review of current prescribing guidance by the Antimicrobial Management Team together with a review of treatments for patients with recurrent infection.

**3. Hand Hygiene**

Hand hygiene data is collected and entered by wards and departments following the Scottish Patient Safety Programme methodology. The detail for this element of the report is included in the report cards as the appendix to this report.

**4. Disruption to Endoscopy service**

Endoscope reprocessing takes place in three units across NHS Dumfries & Galloway.

- Day surgery unit DGRI has one washer disinfector
- Theatres DGRI have two washer disinfectors
- Galloway community hospital theatres has one washer disinfector

All were installed in 2011 and there is an estimated lifespan of 6 to 7 years. The end rinse water is sampled weekly to national standards.

These are complex pieces of engineering and the potential for fungal or microbial growth in a moist environment is great and consequently endoscope rinse water quality is subject to review by the consultant microbiologist and action is taken should results be deemed to be sub optimal. This action may range from running additional disinfectant cycles to the replacement of filters and engineering works.

It is important to note that the washer disinfectors are cleaning and disinfecting the endoscopes appropriately and that the rinse water is used to remove any residual disinfectant.

During August 2015 sub optimal results were detected in the DGRI machines and resulted in a short disruption to service and no requirement for a patient notification exercise. Subsequently there was a mechanical failure at the Galloway Community Hospital which also caused a disruption to service. All issues have now been resolved and weekly sampling continues according to protocol. New machines will be procured for the new hospital.

## 5. HEI inspection

An unannounced inspection of DGRI took place on 11-12 August 2015. The inspecting team inspected against two full standards, standards 6 and 7 and standard 8 Criteria 8.1-4, the detail of which is given below.

- **Standard 6: Infection prevention and control policies, procedures and guidance**  
The organisation demonstrates implementation of evidence-based infection prevention and control measures.
- **Standard 7: Insertion and maintenance of invasive devices**  
Systems and processes are in place to ensure the safe and effective use of invasive devices, for example, peripheral venous catheters, central venous catheters and urinary catheters.
- **Standard 8: Decontamination**  
The environment and equipment (including reusable medical devices used) are clean, maintained and safe for use. Infection risks associated with the built environment are minimised.

The inspecting team thanked the board for the welcome and cooperation they received from all staff.

The report is due for publication on Tuesday 6 October 2015.

## Healthcare Associated Infection Reporting Template (HAIRT)

### Section 2 – Healthcare Associated Infection Report Cards

The following section is a series of ‘Report Cards’ that provide information, for each acute hospital and key community hospitals in the Board, on the number of cases of *Staphylococcus aureus* blood stream infections (also broken down into MSSA and MRSA) and *Clostridium difficile* infections, as well as hand hygiene and cleaning compliance. In addition, there is a single report card which covers all community hospitals [which do not have individual cards], and a report which covers infections identified as having been contracted from outwith hospital. The information in the report cards is provisional local data, and may differ from the national surveillance reports carried out by Health Protection Scotland and Health Facilities Scotland. The national reports are official statistics which undergo rigorous validation, which means final national figures may differ from those reported here. However, these reports aim to provide more detailed and up to date information on HAI activities at local level than is possible to provide through the national statistics.

#### Understanding the Report Cards – Infection Case Numbers

*Clostridium difficile* infections (CDI) and *Staphylococcus aureus* bacteraemia (SAB) cases are presented for each hospital, broken down by month. *Staphylococcus aureus* bacteraemia (SAB) cases are further broken down into Meticillin Sensitive *Staphylococcus aureus* (MSSA) and Meticillin Resistant *Staphylococcus aureus* (MRSA). More information on these organisms can be found on the NHS24 website:

*Clostridium difficile*:

[http://www.nhs24.com/content/default.asp?page=s5\\_4&articleID=2139&sectionID=1](http://www.nhs24.com/content/default.asp?page=s5_4&articleID=2139&sectionID=1)

*Staphylococcus aureus*:

[http://www.nhs24.com/content/default.asp?page=s5\\_4&articleID=346](http://www.nhs24.com/content/default.asp?page=s5_4&articleID=346)

MRSA:

[http://www.nhs24.com/content/default.asp?page=s5\\_4&articleID=252&sectionID=1](http://www.nhs24.com/content/default.asp?page=s5_4&articleID=252&sectionID=1)

For each hospital the total number of cases for each month are those which have been reported as positive from a laboratory report on samples taken more than 48 hours after admission. For the purposes of these reports, positive samples taken from patients within 48 hours of admission will be considered to be confirmation that the infection was contracted prior to hospital admission and will be shown in the “out of hospital” report card.

#### Targets

There are national targets associated with reductions in C.diff and SABs. More information on these can be found on the Scotland Performs website:

<http://www.scotland.gov.uk/About/Performance/scotPerforms/partnerstories/NHSScotlandperformance>

**Understanding the Report Cards – Hand Hygiene Compliance**

Hospitals carry out regular audits of how well their staff are complying with hand hygiene. Each hospital report card presents the combined percentage of hand hygiene compliance with both opportunity taken and technique used broken down by staff group.

**Understanding the Report Cards – Cleaning Compliance**

Hospitals strive to keep the care environment as clean as possible. This is monitored through cleaning and estates compliance audits. More information on how hospitals carry out these audits can be found on the Health Facilities Scotland website: <http://www.hfs.scot.nhs.uk/online-services/publications/hai/>

**Understanding the Report Cards – ‘*Out of Hospital Infections*’**

*Clostridium difficile* infections and *Staphylococcus aureus* (including MRSA) *bacteraemia* cases are all associated with being treated in hospitals. However, this is not the only place a patient may contract an infection. This total will also include infection from community sources such as GP surgeries and care homes and. The final Report Card report in this section covers ‘*Out of Hospital Infections*’ and reports on SAB and CDI cases reported to a Health Board which are not attributable to a hospital.

**NHS BOARD REPORT CARD*****Staphylococcus aureus* bacteraemia monthly case numbers**

	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015
<b>MRSA</b>	0	0	0	0	0	1	0	0	2	0	0	0
<b>MSSA</b>	3	4	1	2	4	1	1	2	2	1	1	1
<b>Total SABS</b>	3	4	1	2	4	2	1	2	4	1	1	1

***Clostridium difficile* infection monthly case numbers**

	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015
<b>Ages 15-64</b>	4	1	1	2	0	2	1	2	3	3	2	1
<b>Ages 65 plus</b>	2	4	4	3	4	2	4	5	1	1	1	5
<b>Ages 15 plus</b>	6	5	5	5	4	4	5	7	4	4	3	6

**Cleaning Compliance (%)**

	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015
<b>Board Total</b>	96.6	96.2	97.9	97.9	97.5	97.0	95.77	98.4	97.2	97.8	97.8	97.8

**Estates Monitoring Compliance (%)**

	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015
<b>Board Total</b>	98.3	98.8	99.3	99.0	98.9	98.9	98.86	99.0	99.5	99.5	99.7	99.7

## NHS HOSPITAL REPORT CARD - DGRI

### *Staphylococcus aureus* bacteraemia monthly case numbers

	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015
MRSA	0	0	0	0	0	1	0	0	2	0	0	0
MSSA	3	4	1	2	4	1	1	1	2	1	1	1
Total SABS	3	4	1	2	4	2	1	1	4	1	1	1

### *Clostridium difficile* infection monthly case numbers

	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015
Ages 15-64	2	0	0	1	0	1	0	2	2	1	1	0
Ages 65 plus	0	1	1	1	2	2	3	3	1	1	0	2
Ages 15 plus	2	1	1	2	2	3	3	5	3	2	1	2

### Cleaning Compliance (%)

	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015
Board Total	95.8	95.7	94.0	95.6	95.4	95.6	96.5	95.0	95.4	95.7	95.8	96.2

### Estates Monitoring Compliance (%)

	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015
Board Total	97.1	97.6	96.4	97.1	96.1	97.1	97	96.7	97.2	98.2	97.6	98.0

## NHS HOSPITAL REPORT CARD – Galloway Community Hospital

### Staphylococcus aureus bacteraemia monthly case numbers

	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015
MRSA	0	0	0	0	0	0	0	0	0	0	0	0
MSSA	0	0	0	0	0	0	0	1	0	0	0	0
Total SABS	0	0	0	0	0	0	0	1	0	0	0	0

### Clostridium difficile infection monthly case numbers

	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015
Ages 15-64	0	0	0	0	0	0	0	0	0	0	0	1
Ages 65 plus	1	0	0	0	0	0	1	1	0	0	0	0
Ages 15 plus	1	0	0	0	0	0	1	1	0	0	0	1

### Cleaning Compliance (%)

	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015
Board Total	98.0	98.4	98.2	98.4	97.9	99.3	98.2	99.4	97.0	98.1	98.3	97.9

### Estates Monitoring Compliance (%)

	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015
Board Total	99.8	99.7	99.7	99.9	99.5	99.8	99.5	99.5	100	100	100	100

## 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
- Allanbank

### *Staphylococcus aureus* bacteraemia monthly case numbers

	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015
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

	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015
Ages 15-64	0	0	0	0	0	0	0	0	0	0	0	0
Ages 65 plus	0	0	0	0	0	0	0	1	0	0	0	1
Ages 15 plus	0	0	0	0	0	0	0	1	0	0	0	1

## NHS OUT OF HOSPITAL REPORT CARD

### *Staphylococcus aureus* bacteraemia monthly case numbers

	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015
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

	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015
Ages 15-64	2	1	1	1	0	0	1	0	1	2	1	0
Ages 65 plus	1	3	3	2	2	1	0	0	0	0	1	2
Ages 15 plus	3	4	4	3	2	1	1	0	1	2	2	2

NOT PROTECTIVELY MARKED

Scottish Patient Safety Programme - Hand Hygiene Compliance August 2015				
DGRI				
Ward/Dept	Total number of opportunities entered	opportunity taken	correct technique	Overall Compliance
A&E	21	21	21	100%
Alex Unit	20	20	20	100%
Kennedy Suite	20	20	20	100%
ICU	20	20	20	100%
Day Surgery	20	20	19	95%
OOPD	20	20	20	100%
OPD	24	24	24	100%
Renal Unit	23	23	23	100%
Pre-assessment	20	20	20	100%
SHDU	20	20	20	100%
Reception/Recovery	21	21	20	95%
X-Ray	20	15	10	50%
Ward 3	20	20	20	100%
Ward 4	20	20	20	100%
Ward 6	20	20	20	100%
Ward 7	22	22	22	100%
Ward 8	20	20	20	100%
Ward 9	20	20	17	85%
Ward 10	0	0	0	0%
Ward 12	20	20	20	100%
Ward 14	20	20	20	100%
Ward 15	30	30	30	100%
Ward 16	20	20	20	100%
Ward 17	20	20	20	100%
Ward 18	20	15	15	75%
<b>Cresswell Wing</b>				
Birthing Suite	20	20	20	100%
Maternity Suite	20	20	20	100%
Antenatal	0	0	0	0%
Neonatal	20	20	20	100%
<b>Midpark Hospital</b>				
Balcary	4	4	3	0%
Cree	20	20	20	100%
Dalveen	20	20	20	100%
Ettrick	20	20	20	100%
Glencairn	21	21	21	100%
Nithsdale	20	20	19	95%
<b>Galloway Community Hospital</b>				
Garrick	22	22	22	100%
Dalrymple	20	20	20	100%
OPD	21	21	21	100%
Day Surgery	35	35	35	100%
Renal Unit	28	28	28	100%
A&E	20	20	20	100%
Clenoch	21	21	19	90%
X-Ray	20	19	17	85%
<b>Cottage Hospitals</b>				
Annan	20	20	20	100%
Lochmaben	20	20	20	100%
Thomas Hope	20	20	20	100%
Moffat	20	20	20	100%
Thornhill	31	31	31	100%
Castle Douglas	21	21	21	100%
Kirkcudbright	20	20	20	100%
Newton Stewart	20	20	19	95%

The mandatory requirement for hand hygiene opportunities is 20 per month.

Wards entering less than 5 opportunities per month.

**DUMFRIES and GALLOWAY NHS BOARD**

5 October 2015

**Children's Services Plan Progress Report****Author:**

Professor Hazel Borland  
Executive Nurse Director

**Sponsoring Director:**

Professor Hazel Borland  
Executive Nurse Director

**Date:** 15 September 2015**RECOMMENDATION**

The NHS Board is asked to receive this progress report with regard to our Dumfries and Galloway multi agency Children's Services Plan.

Board members will note that this report has also been presented to Dumfries and Galloway full council when it met at the end of September 2015.

**SUMMARY****Strategic Context**

Every Community Planning Partnership is required to be working towards implementation of the Children and Young Peoples (Scotland) Act 2014.

**Why is this report important?**

This Act comes into effect in August 2016 and requires us, and our partners, to implement the principles of Getting It Right For Every Child (GIRFEC).

Board members will recall previous reports with regard to our collective response to the Care Inspectorate Report published in April 2014.

**Key messages:**

- Significant improvements have been made since the inspection
- Plan are in place to ensure implementation of the above Act in August 2016

**GLOSSARY OF TERMS**

Contained in the report

**MONITORING FORM**

Policy / Strategy	<i>Healthcare Quality Strategy Children and Young Peoples (Scotland) Act 2014</i>
Staffing Implications	<i>These are referenced in the action plan</i>
Financial Implications	<i>These have been addressed as they have arisen by Chief Officers.</i>
Consultation / Consideration	<i>The content of this report has been agreed by appropriate senior managers</i>
Risk Assessment	<i>This has been considered for individual actions where appropriate</i>
Sustainability	<i>Sustainability of services has been a priority</i>
Compliance with Corporate Objectives	<i>To promote and embed continuous improvement by connecting a range of quality and safety activities to deliver the highest quality of service across Dumfries and Galloway</i>
Single Outcome Agreement (SOA)	<i>Keeping Children Safe</i>
Best Value	<i>Commitment and leadership Accountability Responsiveness and consultation Joint Working</i>
Impact Assessment	<i>The Children's Services Plan was the subject of an impact assessment. This is a progress report on our implementation of the plan.</i>

## CHILDREN'S SERVICES PLAN – 6 MONTH PROGRESS REPORT

### 1. Purpose of Report

The purpose of this report is to ask Dumfries and Galloway Council to note the progress of the Children's Services Plan (Phase 1: April 2015 to September 2016)

### 2. Recommendations

Members are asked to:-

- 2.1 Note the progress made with the implementation of the Children's Services Plan.

### 3. Background

3.1 Members will recollect that the current Children's Services Plan was developed as a short-term 18-month plan. Our aim is to develop a longer-term plan for children's services and the current plan effectively forms an 'initial phase' of this. The reason for this approach is that the current plan has been driven by the continued need to address the five inspection recommendations from the 2014 Joint Inspection of Children's Services in Dumfries and Galloway. The five recommended areas for improvement were allocated to four strategic groups: Child Protection Committee; Early Years Group; Corporate Parenting Group and GIRFEC Group and to the Children's Services Executive Group. The action plans of these groups are the delivery mechanism for the first phase of the Children's Services Plan.

3.2 Under the Children and Young People (Scotland) 2014 Act, there is a statutory duty from April 2017 for partners to jointly prepare a Children's Services Plan for a 3 year period. The current plan therefore, might be extended from September 2016 to April 2017 in order to align with the statutory requirement.

3.2 The current phase of the Children's Services Plan was agreed by D&G Council on 26 March 2015. The Council also agreed that both the Council and NHS Board would receive an annual report on the plan, and that the Council would also receive 6 monthly progress updates. This report is a 6-month update with a highlight report attached (appendix 1). There is a set of high-level annual performance indicators for this plan and these will be reported on in the full annual report in March 2016.

### 4. Considerations

#### 4.1 Progress against improvement areas

4.1.1 There has been significant progress in key areas, particularly with regard to child protection. New training, based on the National Risk Assessment Framework, has been introduced and staff report increased confidence in identifying risk. Initial Referral Discussions (IRDs) have been implemented and an electronic system is in place to facilitate these discussions between Health, Social Work and Police staff. There is regular reporting to the Children's Services Executive Group (CSEG) on IRDs and

there will soon be reporting on the new Pre-Birth protocol. We are confident that our actions will minimise risks to vulnerable children and young people.

4.1.2 Getting it right for every child (GIRFEC) processes are being implemented now in order to be ready to meet new statutory duties from August 2016. These include: the single Child's Plan; multi-agency Chronology and information-sharing. Staff training has been developed and delivered on these. The Early Years Group are leading on the development of a multi-agency Parenting Strategy for Dumfries and Galloway.

4.1.3 The Corporate Parenting Champions Board is established and a dedicated Looked-after Children's Health team is now operational and reports to the Corporate Parenting Group. Improved engagement and consultation with looked-after children and young people is starting to influence service planning.

4.1.4 Leaders have established robust reporting structures that support challenge. There are regular communications with staff across all agencies and an ongoing programme of multi-agency engagement events with staff and managers.

## 4.2 Challenges

4.2.1 With a plan of this size and complexity there is a risk of slippage leading to loss of momentum. In order to mitigate this risk we have refocused our planning and milestones and invested in additional resource. All actions require to be completed within the lifecycle of the plan. However some of the actions in the GIRFEC Group's action plan are dependent on, or will be impacted by, the release of the Scottish Government's Statutory Guidance on GIRFEC implementation. The release of this guidance has been delayed and it is not now expected until November 2015. This is currently impacting on some of the GIRFEC actions but the overall timescale remains unchanged as there is a statutory responsibility to implement the GIRFEC elements by August 2016.

4.2.2 The action plans contained within the Children's Services Plan have always been intended to evolve in response to new challenges and priorities. Action plans are regularly reviewed and actions may be re-prioritised. Reporting structures are in place for the action plans and the Chairs of the four strategic groups report to CSEG on progress with their plans.

4.2.3 Capacity remains a challenge but CSEG are addressing this by directing resources to development activities.

## 4.3 Priorities over the next six months

4.3.1 Priority actions include implementation of the multi-agency Pre-Birth Planning Pathway; the Parenting Strategy and GIRFEC processes (on release of the Statutory Guidance on GIRFEC implementation), and

development of a multi-agency Quality Assurance Framework for children's services.

4.3.2 Development of the next, longer term phase of the Children's Services Plan has already started. A multi-agency Engagement working group has convened and this group will co-ordinate stakeholder involvement in developing the next plan.

## 5. Governance Assurance

## 6. Impact Assessment

As this report does not propose a change in policy, the formal adoption of a plan, policy or strategy, it is not necessary to complete an Impact Assessment.

### Author(s)

NAME	DESIGNATION	CONTACT DETAILS
Colin Grant	Director Children, Young People and Lifelong Learning	<a href="mailto:Colin.Grant@dumgal.gov.uk">Colin.Grant@dumgal.gov.uk</a> 01387 260400

### Approved by

NAME	DESIGNATION
Gavin Stevenson	Chief Executive

### Appendices – 1

**Appendix 1:** Highlight Report on Children's Services Plan

# NHS DUMFRIES AND GALLOWAY CHILDREN'S SERVICES PROGRESS REPORT APPENDIX 2

## Highlight Report: Children's Services Plan

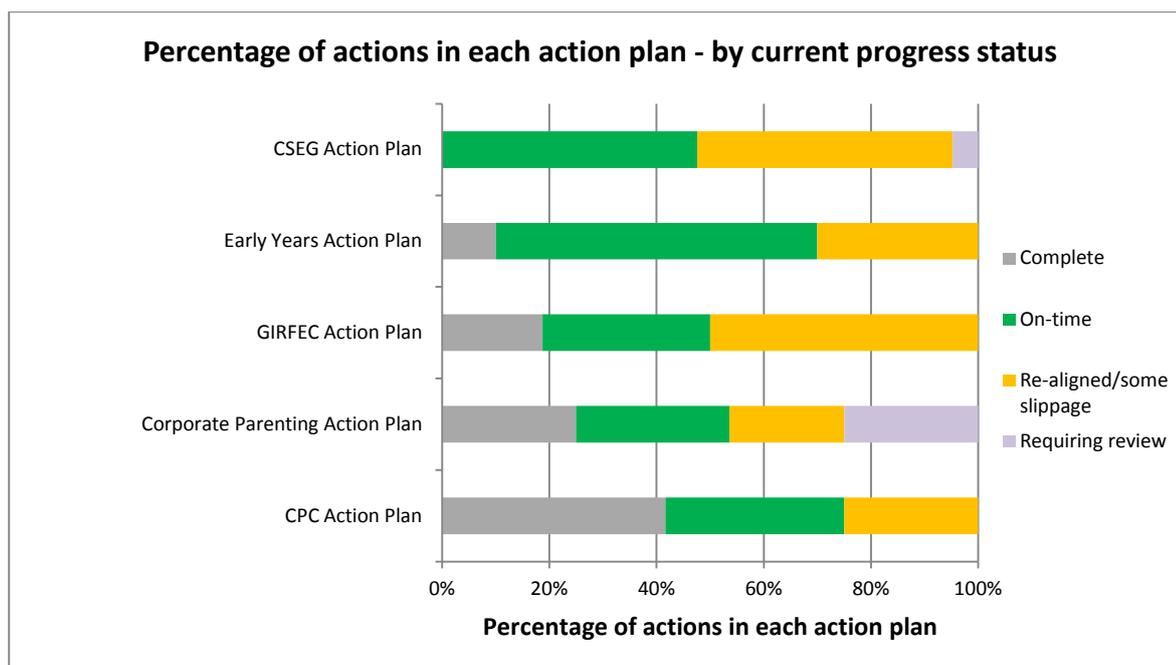
September 2015

<u>Action Plans within the Children's Services Plan</u>	-	<u>Current Status</u>			
		Number of actions complete	Number of actions on-time	Number of actions re-aligned	Number of actions on hold pending review
1. CPC Action Plan	12	5	4	3	
2. Corporate Parenting Action Plan	28	7	8	6	7
3. GIRFEC Action Plan	16	3	5	8	
4. Early Years Action Plan	10	1	6	3	
5. CSEG Action Plan	21	0	10	10	1

### Key:

- On-target actions are proceeding in line with original time-scales.
- Re-aligned actions have had their 'due dates' extended, but still need to be completed within the life-cycle of the current Children's Services Plan.
- Actions that are on-hold/pending review are those that for a number of different reasons may need to be either re-drafted or may no longer fit with current priorities.

**Note:** members of the Corporate Parenting Group are currently updating their actions and this reflects a current snapshot. The Corporate Parenting Group held a recent workshop with the aim of updating the plan and this has produced a clearer picture of progress. Four actions marked as 'complete' in last month's report are actually 'in progress'.



## NHS DUMFRIES AND GALLOWAY CHILDREN'S SERVICES PROGRESS REPORT APPENDIX 2

### **Context**

The Children's Services Plan is structured round the five 'recommendations' (improvement areas) in the Report on the Joint Inspection of Children's Services published in April 2014. To implement this plan, specific tasks were allocated to the four strategic groups: CPC; Early Years Group; GIRFEC Group and Corporate Parenting Group. The overarching/cross-cutting actions regarding Leadership, Quality Assurance, Performance Reporting and others were allocated to the Children's Services Executive Group (CSEG) although these are delivered by strategic working groups.

The reporting structure therefore, reflects individual action plans rather than the structure of the Children's Services Plan which is structured around the five inspection recommendations.

The CS Plan was first drafted in December 2014 and signed off by Full Council and the NHS Board in March 2015. A report on the CS Plan will be presented to D&G Council this September.

Inevitably with a plan of this size and complexity, and with structural changes, a number of actions have required re-alignment. This CS Plan is also subject to external factors for example the delay in publication of the Scottish Government's Statutory Guidance re GIRFEC implementation for the Children and Young People (Scotland) Act 2014. The Statutory Guidance on GIRFEC was anticipated earlier this year but is not now expected until November. The delay has had a direct impact on actions within the GIRFEC Implementation action plan. However, we still have a statutory duty to implement components of GIRFEC by August 2016 so the overall time-scale for the relevant actions in the GIRFEC action plan remains unchanged.

The previous report covered a 3-month period over the summer, and this report has not significantly changed since then. We will now move to a monthly reporting cycle.

**DUMFRIES and GALLOWAY NHS BOARD**

5 October 2015

**Galloway Community Hospital Update****Author:**

Professor Hazel Borland  
Executive Nurse Director

**Sponsoring Director:**

Julie White  
Chief Operating Officer

**Date:** 15 September 2015**RECOMMENDATION**

The NHS Board is asked to receive and note this paper with regard to a portfolio of activity being undertaken at Galloway Community Hospital.

This includes changes to the Management Structure for the hospital and the follow up action plan for the Older People in Acute Hospitals Inspection. This action plan is attached at Appendix 1.

**SUMMARY**

Healthcare Improvement Scotland (HIS) carried out a follow up inspection with regard to the Older People in Acute Hospitals Standards to Galloway Community Hospital – focussed on Dalrymple and Garrick wards – on 10 & 11 March 2015.

The attached action plan was originally submitted in May 2015 and was the focus of the routine 16 week follow up undertaken by HIS in July 2015.

**Key messages:**

- Significant improvements have been made since the inspection
- New management arrangements have been in place since 1 September 2015 which mean that the Galloway Community Hospital is now managed by the Acute Services Management Team. This is in recognition of the current and future role of the Galloway Community Hospital in relation to the provision of Acute services including A&E and an Acute Admissions Ward.

**GLOSSARY OF TERMS**

Contained in the report

**MONITORING FORM**

Policy / Strategy	<i>Healthcare Quality Strategy</i>
Staffing Implications	<i>These are referenced in the action plan</i>
Financial Implications	<i>Not required at this time</i>
Consultation / Consideration	<i>This report has been reviewed by appropriate senior managers and clinicians</i>
Risk Assessment	<i>This has been considered for individual actions where appropriate</i>
Sustainability	<i>Sustainability of services has been a priority</i>
Compliance with Corporate Objectives	<i>To promote and embed continuous improvement by connecting a range of quality and safety activities to deliver the highest quality of service across NHS Dumfries and Galloway</i>
Single Outcome Agreement (SOA)	<i>n/a</i>
Best Value	<i>Commitment and leadership Accountability Responsiveness and consultation Joint Working</i>
Impact Assessment	<i>Not undertaken as this is an external report</i>

## **Changes to the management structure at Galloway Community Hospital**

1. As part of the NHS Board's commitment to sustain the Galloway Community Hospital and in recognition of the vital role it plays in the delivery of Acute services in the Wigtownshire locality, new management structures have been introduced to the GCH. This involves the Acute Leadership team from DGRI and the Operations Directorate having more direct, visible management responsibility and accountability for GCH.
2. On the 24<sup>th</sup> July 2015, the Chief Operating Officer, along with General Managers and the Deputy Director of Nursing met with the staff at GCH on to inform them of the future arrangements and to ensure that they felt fully supported in this transition period.
3. As we gear up for the development of the new District General Hospital for Dumfries and Galloway and driving forward the health and social care integration agenda, these new arrangements help confirm the pivotal role that the Galloway Community Hospital will have.
4. The intention is to combine management and clinical leadership responsibilities across both sites enabling us to share both resources and solutions.
5. This new approach confirms our commitment to deliver safe services locally, retain close working with the wider community based services including General Practice and offer a seamless journey to the people of Wigtownshire. Every effort is being made to recruit and retain staff within NHS Dumfries and Galloway and it is hoped that this new arrangement will help to support some of the recruitment challenges currently faced by GCH. These include the locality Nurse Manager and the Locality Health and Social Care Manager.
6. Acute services including A&E and the Wards alongside Theatres, Outpatients etc will be managed by the General Manager for Acute Services and her leadership team including the 2 Associate Medical Directors, the Lead Nurse and the Improvement Manager. Services such as Laboratories, Imaging and Renal Services will continue to be managed as regional services via the Acute Directorate.
7. Operational Services will be managed by General Manager for Facilities and Clinical Support Services. This will ensure a consistent approach to the management of services such as catering, domestics and estates across the whole system.
8. The new locality structures and vision for integrated health and social care will further support the development of new and innovative ways of delivering care and support to our communities. The newly appointed General Manager for Health and Social Care Integration, together with the locality GP Clinical lead and the Interim Locality Manager, will be working closely with the General Managers for Acute Services and Facilities as we move forward.

**NOT PROTECTIVELY MARKED**

9. It is clearly important that there is strong, local leadership of the Galloway Community Hospital and these new arrangements will ensure regular, visible senior management within the hospital.

### Improvement Action Plan

#### Galloway Community Hospital – NHS Dumfries & Galloway

#### Care for older people in acute hospitals (follow-up) inspection

**Inspection Date: Tuesday 10 – Wednesday 11 March 2015**

#### Improvement Action Plan Declaration

It is essential that the NHS board's improvement action plan submission is signed off by the NHS board Chair and NHS board Chief Executive. It is the responsibility of the NHS board Chief Executive and NHS board Chair to ensure the improvement action plan is accurate and complete and that a representative from Patient/Public Involvement within the NHS board has been involved in developing the improvement action plan. By signing this document, the NHS board Chief Executive and NHS board Chair are agreeing to the points above.

#### NHS board Chair



Signature: \_\_\_\_\_

Full Name: Philip N Jones

Date: 13 July 2015

#### NHS board Chief Executive



Signature: \_\_\_\_\_

Full Name: Jeff A Ace

Date: 13 July 2015

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### Improvement Action Plan

#### Galloway Community Hospital – NHS Dumfries & Galloway

#### Care for older people in acute hospitals (follow-up) inspection

**Inspection Date: Tuesday 10 – Wednesday 11 March 2015**

Ref:	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
1.	<b><u>Recommendation</u></b> <b>Must ensure that all older people, who are being treated in accident and emergency or are admitted to hospital, are assessed within the national standard recommended timescales. This includes cognitive impairment, nutritional screening and assessment, falls management and pressure ulcer care.</b>		Lead Nurse  Associate Medical Director  Deputy Nurse Director	259 people work in Galloway Community Hospital including volunteers, AHP's, Hotel Services, Admin, Nursing and Medical Staff. Of these 75% (192) have now completed Dementia training in line with NHS Scotland Dementia Standards.  This includes 139 (88%) clinical in-patient area staff, including nursing , AHP and Medical staff.  Three more dates for training have been planned for three months time as most of the staff not trained are on Maternity leave or long term sickness absence.	<b>Complete</b>
	There is a package of training and support in place to improve knowledge of Adults with Incapacity and Cognitive screening.	From December 2014.Ongoing			
	The Associate Medical Director is leading work to embed cognitive screening and medicines reconciliation in Galloway Community Hospital	From December 2014.Ongoing			
	All registered nursing staff will undertake scheduled rotational audit of patient records to highlight inconsistencies.	From December 2014.Ongoing			

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**Improvement Action Plan**

**Galloway Community Hospital – NHS Dumfries & Galloway**

**Care for older people in acute hospitals (follow-up) inspection**

**Inspection Date: Tuesday 10 – Wednesday 11 March 2015**

	<p>Training planned for: MUST; risk assessment for falls and pressure injury prevention.</p>	<p>From May 2015</p>		<p>Further training is being planned for August and September 2015 , when those on maternity leave and Sick leave will have returned to work</p> <p>All Registered Nurses have now completed two rounds of self and team assessments in both wards in GCH. An 'Assessment Action Plan' is in place and in use to assist in further improvements. These Staff self audits will be ongoing.</p> <p>Audits are demonstrating that assessments are being completed timeously and evidence of this is available in the person's record. Care planning is improving, further work is ongoing on person</p>	
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**Improvement Action Plan**

**Galloway Community Hospital – NHS Dumfries & Galloway**

**Care for older people in acute hospitals (follow-up) inspection**

**Inspection Date: Tuesday 10 – Wednesday 11 March 2015**

				<p>centred care planning and 'wording' person centred plans. Both wards are now using the same patient records.</p> <p><i>Cortix</i> system re-introduced with ward boards out of public view. This system is being used for referrals to MDT. MDT are also using both <i>cortix</i> and the new patient record where appropriate. This is leading to the MDT being more assured that they have access to relevant and pertinent patient information..</p> <p>A new 'front sheet' for the assessment section of patient's records has been developed and will be rolled out over the summer of 2015. This document will allow detailing of the date,</p>	
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**Improvement Action Plan**

**Galloway Community Hospital – NHS Dumfries & Galloway**

**Care for older people in acute hospitals (follow-up) inspection**

**Inspection Date: Tuesday 10 – Wednesday 11 March 2015**

				<p>time and score of multiple assessments at a glance, as well as when they are due for review and whether a care plan is in place or required for this area of care. This includes: MUST, MRSA, Bed Rails, Waterlow &amp; Falls assessments</p> <p>All staff have received updates on risk assessment for falls. A new falls risk assessment for use as an aide memoir has been introduced across Galloway Community Hospital</p> <p>All staff have received updates on use of the National Association Tissue Viability Nurses Score Assessments and Care Plan. Further to this the National Documents is being adjusted locally to ensure that it</p>	
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### Improvement Action Plan

#### Galloway Community Hospital – NHS Dumfries & Galloway

#### Care for older people in acute hospitals (follow-up) inspection

**Inspection Date: Tuesday 10 – Wednesday 11 March 2015**

				has an area for date and time of initial assessment as well as ongoing assessments and care plans.	
2.	<b><u>Recommendation:</u></b> Should ensure that risk assessments are carried out before using any intervention to promote patient safety that may limit the right to freedom.		Lead Nurse	See progress update for recommendation 1	<b>Complete</b>
	See recommendation 1 and associated actions with regard to staff training.	See recommendation 1	Deputy Nurse Director		
3.	<b><u>Recommendation:</u></b> Must ensure that medicines reconciliation is fully completed within 24 hours of admission.		Associate Medical Director	Medicine Kardex's continue to be audited weekly within both inpatient areas. An action plan for improvement is maintained following each audit and shared with the medical and nursing team	<b>Immediate work completed.</b>  Other work ongoing.
	The Associate Medical Director is leading work to embed medicines reconciliation.	From December 2014.Ongoing		A bid has been submitted to the H&SCI Board for a WTE Band 7 Pharmacist for Galloway	
	Increased pharmacy support is being explored.	From April 2015			

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### Improvement Action Plan

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				Community Hospital after two weeks of pharmacy input and outcome modelling was tested at GCH. (advert imminent)	
4.	<b><u>Recommendation:</u> Must ensure that documentation is standardised and a consistent approach is applied.</b>		Lead Nurse	New documentation is in use in both wards within GCH. Action plans for both wards to implement are completed.	<b>Complete</b>
	New nursing documentation has been introduced to Dalrymple Ward.	February 2015. Ongoing	Deputy Nurse Director	<p>In addition new record keeping process initiated within ED at GCH for all patients being admitted to hospital</p> <p>The Community Nursing Team use of this same standardised approach has been brought forward. The Stranraer based Nursing Teams implemented use of this documentation in March 2015.</p> <p>The process for 'Photocopying</p>	

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**Improvement Action Plan**

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				<p>Nursing Documentation' records for use has been clarified and a clear process initiated.</p> <p>The use of <i>Cortix</i> has been re-instated using electronic ward boards. These boards are not visible in patient areas by anyone other than staff.</p> <p>The use of Cortix enhances MDT communication of care and not as a part of the record keeping /evidence, process. It assists in ensuring an 'at a glance' situation of each patient.</p> <p>Filing processes were reviewed in March 2015 and have now been implemented with success. Ensuring that patients records are tidy, filed and thus</p>	
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				<p>the risk of losing communication and 'evidence' has been minimised.</p> <p>A further review of the updates required for the new documentation (assisting to meet the standards and person centred care planning) has also been undertaken.</p>	
5.	<p><b><u>Recommendation:</u></b>  <b>Must ensure that all nursing and medical documentation is legible, dated, timed and signed. Documentation should provide details of any assessments and reviews undertaken, and provide clear evidence of the arrangements that have been made for future and ongoing care. It should also include details of information given about care and treatment.</b></p>		<p>Lead Nurse</p> <p>Deputy Nurse Director</p> <p>Associate Medical Director</p>	<p>See detail in update for recommendation 1</p>	<b>Complete.</b>
	All registered nursing staff will undertake audit of patient records, with the aim of highlighting inconsistencies.	From December 2014.Ongoing			
	Support and training for all staff around record keeping.	From December 2014.Ongoing			

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6.	<b><u>Recommendation:</u></b> Must ensure that patients have person-centred care plans in place for all identified care needs. These should be regularly evaluated and updated to reflect changes in the patient's condition or needs.		Lead Nurse Deputy Nurse Director	See detail in update for recommendation 1.  The audits of patient records are demonstrating a much more consistent use of person centred care planning based upon both patient wishes and needs as well as assessment findings	<b>Complete.</b>
	Staff training around record keeping will address care planning.	Immediately and ongoing			
	See also recommendation 5 and associated actions				
7.	<b><u>Recommendation:</u></b> Must ensure guidelines on the management of delirium are available to all staff who care for acutely unwell people.		Lead Nurse Deputy Nurse Director Associate Medical Director	See detail in update for recommendation 1.  The Mental Health Liaison Nurse is on site 3 days per week to support the ward teams. Further Improvements have been implemented and sustained with this work, in that the Mental Health Liaison nurse now provides a weekly diary to	<b>Complete.</b>
	A package of training and support developed to improve knowledge of delirium recognition and management is being delivered.	From December 2014.Ongoing			
	Support from the Mental Health Liaison Nurse based in GCH 3 days per week.	Ongoing			

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				<p>the wards of when she will be on site. Contact numbers are provided for times out-with these sessions.</p> <p>By the end of August 2015 the Mental Health Liaison Nurse will be provided with a hot desk within the Galloway Community Hospital to help build upon relationships and partnership working</p>	
8.	<p><b><u>Recommendation:</u></b>  <b>Must ensure that current legislation, which protects the rights of patients who lack capacity, is fully and appropriately implemented. When legislation is used, this must be fully documented in the patient health record, including any discussions with the patient or family.</b></p>			<p>See detail for recommendation 1 progress.</p> <p>88% of all Galloway Community Hospital Staff have completed Dementia Training at a level appropriate to them and in line with NHS Scotland Promoting Excellence.</p>	<b>Complete</b>
	<p>Package of training and support is in place to ensure staff are aware of the legislation and documentation both discussions and decisions.</p>	<p>From December 2014.Ongoing</p>	<p>Lead Nurse</p> <p>Deputy Nurse Director</p> <p>Associate</p>		

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	The Associate Medical Director is leading to work to ensure this is fully embedded.	From December 2014.Ongoing	Medical Director	New documentation being formed to assist in providing evidence of the assessment process having been undertaken and serve as a reminder regarding Power of Attorney records.	
	Band 6 Charge Nurse is supporting this by leading a group of nurses to ensure compliance.	From December 2014.Ongoing		<p>Mental Health Liaison Officer is devising a group audit tool, to investigate that Capacity Assessments are completed in full, to the benefit of the patient and that these are reviewed timeously.</p> <p>Nursing Teams working on this action point will review the audit data and identify any medical staff or nursing colleagues who are having difficulties in completing these assessments accurately and timeously.</p>	

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9.	<b><u>Recommendation:</u></b> <b>Must ensure systems are in place to record key personal information about people with dementia or other cognitive impairments. This should include establishing if a power of attorney is held. This information should be used and be shared with staff involved in the care of the patient.</b>		Lead Nurse  Deputy Nurse Director  Associate Medical Director	See detail for recommendation 1 and 8.	<b>Complete</b>
	As per recommendation 8 and associated actions	See recommendation 8			

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10.	<b><u>Recommendation:</u></b> Should ensure that where a welfare power of attorney is identified, the document is checked to establish what powers are held. This will ensure that the decisions being made are within a legal framework.		Lead Nurse Deputy Nurse Director Associate Medical Director	See detail for recommendation 1 and 8.	<b>Complete</b>
	As per recommendation 8 and associated actions	See recommendation 8			
11.	<b><u>Recommendation:</u></b> Must ensure that improvements to the ward and hospital environment are carried out to make it more suitable for people with dementia and cognitive impairment.		General Manager Lead Nurse	Alzheimer Scotland Dementia Consultant Nurse continues to provide further advice.  All areas have been checked; all handrails which were same colour as walls have now been changed: walls are now blue, handrails are pink. Dementia friendly clocks are being tested in Garrick Ward	<b>Complete</b>
	Advice and guidance for further environmental improvements, including colour contrasting currently being sought.	May 2015			
12.	<b><u>Recommendation:</u></b> Must ensure that food and fluid balance charts are started and accurately completed for patients who		Lead Nurse	Fluid Balance Records will only be instigated where there is a concern regarding a person's	<b>Complete</b>

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	<b>require them and appropriate action taken in relation to intake or output as required.</b>		Deputy Nurse Director	fluid stasis;	
	All registered nursing staff are involved in audit of fluid charts.	January 2015 and ongoing		Food and Fluid charts alongside Active Patient Care will assist the assessment process of where this is a concern;	
	Planned nutritional refresher training will include the importance of this being done accurately.	May 2015		DCN's and SCN's are reviewing fluid balance chart completion on the wards and departments daily and addressing any arising individual practice	
	Focus on Garrick ward whilst maintaining improvement in Dalrymple.	Immediately and ongoing		In collaboration with Dietetics it has been agreed that the MUST tool will be used as an 'aide memoir' documenting the findings, dated and timed, in the persons individual care record – highlighting the date a review is required within the persons care plan, providing updates of progress within the SBAR	
	Introduce new fluid chart.	May 2015			

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				<p>communication document.</p> <p>The dietetic team has provided an assessment tool for use when a patient cannot be weighed. They have also provided and continue to provide training for use of this tool and Nutritional Session Updates during June and July.</p> <p>By end July 2015 50% of staff will have completed training, allowing us to see that the timeline for training completion is on schedule</p>	
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13.	<b><u>Recommendation:</u></b> <b>Must ensure that the oral care needs of all patients are met and accurately recorded, especially for those patients who are not independent.</b>			New Active Patient Care record introduced on 9 February 2015.	<b>Complete</b>
	New Active Patient Care (APC) guidance has clear instructions on oral hygiene for those who are nil by mouth.	From February 2015	Lead Nurse	Data now demonstrating compliance with completion of APC at 98% for Dalrymple ward and 96% for Garrick ward.	
	Support and training on record keeping and the new documentation will support appropriate individualised care planning.	From January 2015	Deputy Nurse Director	Feedback from staff has been positive in that the new document relates directly to other assessment documents i.e. fluid balance, food and fluid charts, falls care plans etc.	
	A Band 6 Charge Nurse is leading work with a group of nurses to support appropriate and correct completion of APC records.	From February 2015		See also recommendation 1 and 8.	

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14.	<b><u>Recommendation:</u></b> <b>Should ensure consultants regularly attend multidisciplinary meetings.</b>			Medical division review completed to:	<b>Complete and ongoing</b>
	Associate Medical Director is working with Medical teams to ensure Consultant input into multi disciplinary meetings	By end of April 2015	Associate Medical Director	- Enable visiting consultants to attend ward for 2 hours Monday and Friday	
	Move to ' <i>Hospital Medical Team</i> ' with junior and senior medical staff covering both wards.	From February 2015		- Clinic provision - Care of the elderly consultant is now present at weekly multi disciplinary meetings - Permanent medical staff now in post - Associate Medical Director continues to provide weekly input and supervision	
15.	<b><u>Recommendation:</u></b> <b>Must ensure effective discharge planning begins when, or shortly after, a patient is admitted to hospital.</b>		Lead Nurse	New MDT Communication Record now in place for Dalrymple Ward. This is also used during weekly MDT	<b>Complete</b>

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	The Associate Medical Director and Lead Nurse are working with multi-disciplinary teams to improve discharge.	By end of May 2015	Associate Medical Director	<p>meeting, to ensure safe and effective communication of outcomes into the person's record.</p> <p>New Discharge Planning Record now in place in both ward areas, assisting to ensure that discharge is planned from admission.</p> <p>Garrick ward has a new substantive doctor who is keen to develop the ward round process as well as introduce a MDT meeting</p>	
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16.	<b><u>Recommendation:</u></b> <b>Must ensure that staff are aware of, and comply with, all legislative guidelines, professional guidelines and documentation in relation to patient care.</b>		Lead Nurse	See progress update for recommendation 1 and 8.	<b>Complete</b>
	All registered nursing staff will undertake scheduled rotational audit of patient records to highlight inconsistencies.	From January 2015 and ongoing	Deputy Nurse Director		
	There is support and training for all staff around record keeping.	From January 2015 and ongoing	Associate Medical Director		
	Review and update the new documentation on a regular basis to ensure that the records provided to staff for completion assist with meeting professional, legal and patient requirements.	First review April 2015			

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**DUMFRIES and GALLOWAY NHS BOARD**5<sup>th</sup> October 2015**Equality and Diversity: Six Monthly Update****Author:**

Lynsey Fitzpatrick  
Equality and Diversity Lead

**Sponsoring Director:**

Caroline Sharp  
Workforce Director

**Date:** 16<sup>th</sup> September 2015**RECOMMENDATION**

The Board is asked to:

- Acknowledge and understand the requirement of NHS Dumfries and Galloway to comply with a number of actions set out in the Public Sector Equality Duty, and which are outlined in this paper.
- Note and discuss the progress made towards these actions (as at September 2015).

**CONTEXT****Strategy / Policy:**

This paper supports the implementation of the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012.

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

NHS Dumfries and Galloway is legally bound to comply with the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012.

The purpose of this paper is to provide an update to the Board on the progress of NHS D&G to deliver on our legal duties, in particular the board equality outcomes, as at August 2015.

Within the 5 Board wide equality outcomes, two relate to workforce, two relate to healthcare services and one relates to the community and partnership working.

**GLOSSARY OF TERMS**

*EHRC – Equality and Humans Rights Commission*  
*PSED – Public Sector Equality Duty*

### MONITORING FORM

Policy / Strategy	Legislative requirement of the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012.
Staffing Implications	Staff have had to spend increased time on progressing some of the actions within their own areas. The requirements of the specific duties further reinforces the need for the organisation to acknowledge the time the Equality and Diversity Lead and Steering group representatives need to give this agenda the appropriate attention. The possibility of 'ring-fenced' time for Steering group to spend on equality and diversity issues must be considered. There is a requirement for equality and diversity to be mainstreamed in all areas and so is the responsibility of everyone across the Board.
Financial Implications	There are no immediate direct financial implications on the reporting arrangements, however, there will almost certainly be financial implications involved in ensuring that we are meeting the Public Sector Equality Duty.
Consultation / Consideration	The development of the Specific Duty requirements and internal reporting arrangements has been developed with the NHS Dumfries and Galloway Equality and Diversity Steering group. There is ongoing involvement with the Steering group and staff representatives. Six monthly updates are provided to the Board, Staff Governance Committee, Person Centred Health and Care Committee and Healthcare Governance Committee.
Risk Assessment	A risk assessment is not required as this is a legislative requirement. Having no internal reporting plan in place may present a risk to the organisation.
Sustainability	Developing equality within the workforce and the services we provide in Dumfries and Galloway, makes a significant contribution to social and economic sustainability in our region.
Compliance with Corporate Objectives	To reduce health inequalities across NHS Dumfries and Galloway.
Single Outcome Agreement (SOA)	This work potentially covers all of the Single Outcome Agreement priorities.
Best Value	Equality – Equal Opportunities Arrangements
Impact Assessment	This paper does not require an impact assessment.

**NOT PROTECTIVELY MARKED**

## **Introduction**

The purpose of this paper is to provide the Board with a six monthly update of the board's progress towards meeting the Equality Act 2010 (Specific Duties) (Scotland) Regulations.

Regular six monthly updates are also provided to Healthcare Governance Committee, Person Centred Health and Care Committee and Staff Governance Committee.

## **Legislative Background**

The Equality Act became law in 2010 and replaced several previous anti-discrimination laws with a single piece of legislation. It aims to ensure that everyone who is protected by law from discrimination, harassment or victimisation is afforded the same level of protection. The Equality Act introduced the concept of 9 protected characteristics, referred to in previous legislation as 'Equality Groups' or 'Equality Strands'.

The Protected Characteristics are:

- Age
- Disability
- Gender Reassignment
- Pregnancy and Maternity
- Race
- Religion and Belief
- Sex
- Sexual Orientation
- Marriage and Civil Partnership

The Equality Act applies to marriage and civil partnership, but only in respect of the requirement to have due regard to the need to eliminate discrimination. The Act stipulated that all Health Boards (as were all public bodies) across NHS Scotland were required to produce a number of documents which would contribute towards furthering one or more of the 3 needs of the **Public Sector Equality Duty (PSED/also know as General Duty)**. The PSED requires Scottish public authorities to pay 'due regard' to the need to:

- **Eliminate unlawful discrimination, harassment and victimisation**
- **Advance equality of opportunity**
- **Foster good relations**

The General Duty is supported by **Specific Duties**, set out in regulation, which came into force on 27 May 2012. The requirements of the Specific Duties are as follows:

- Duty to report progress on mainstreaming the equality duty
- Duty to publish equality outcomes and report progress
- Duty to assess and review policies and practices
- Duty to gather and use employment information

- Duty to publish gender pay gap information
- Duty to publish statements on equal pay, etc
- Duty to consider award criteria and conditions in relation to public procurement
- Duty to publish in a manner that is accessible
- Duty to consider other matters
- Duty of the Scottish Ministers to publish proposals to enable better performance

NHS Dumfries and Galloway had a legislative duty to **publish a set of equality outcomes, a mainstreaming report, a report breaking down the workforce by protected characteristic, gender pay gap information and a statement on equal pay** by 30 April 2013 which was met.

The Board were then required by law to publish an **up to date mainstreaming report, up to date gender pay gap information, a breakdown of our workforce in a range of areas by protected characteristic, and an update on our progress towards our equality outcomes** by 30<sup>th</sup> April 2015. Again, this requirement has been met.

This paper will detail the ongoing progress we are making towards each of our Specific Duty requirements as at September 2015.

### **Duty to Report Progress on Mainstreaming the Equality Duty**

In April 2013, an initial report was published, which detailed the ways in which NHS Dumfries and Galloway is continually working towards embedding equalities and the general equality duty, considering equalities as part of everything we do as a service provider and employer i.e. 'mainstreaming' equality and diversity into our day to day business.

By April 2015, the Board was required to publish an up to date mainstreaming report, to detail any progress made towards the embedding of equalities throughout all of our work. This included examples such as the Board's Equality and Diversity Steering group which has a member from each of the directorates, the process for recruiting Board members in order to attract a more diverse range of suitably skilled, equality impact assessments and training events to raise awareness amongst staff.

This deadline was again met and a copy of the most up to date Equality report can be found here: [http://www.nhsdg.scot.nhs.uk/About Us/Equality Diversity/ED Files/Final Equality Report 2015.pdf](http://www.nhsdg.scot.nhs.uk/About_Us/Equality_Diversity/ED_Files/Final_Equality_Report_2015.pdf)

In order to fully mainstream equality and diversity, we need to equip more of our staff with the knowledge and skills required around equality and diversity. We are currently looking at different options and resources available in which to develop our staff, in particular the equality representatives from each of our directorates.

### **Duty to assess and review policies and practices**

All public authorities have a requirement to equality impact assess all of their policy and practice; basically anything which we do which has an impact on people. At present, the Board's Equality Lead is working with public health staff and representatives from Dumfries and Galloway Council to develop a joint toolkit for carrying out equality impact assessments, and exploring the options for providing joint training on this. It is hoped that once the new toolkit is agreed, that there will be some further awareness-raising for staff and board members.

### **Duty to Gather and Use Employee Information**

The Specific Duties legislation also requires NHS Dumfries and Galloway to take steps to gather employee information annually and, if not reported elsewhere, report this information within the mainstreaming report. We also must report on our progress made in using the employee information to better perform the general equality duty.

Ideally, the employee information should include composition of our employees broken down by protected characteristic as well as recruitment, development and retention of employees broken down by protected characteristic. We should also be working towards gathering data in a whole range of other categories such as requests for flexible working, members of staff involved in grievance procedures and members of staff involved in organisational change, dismissals and retirement. This list is not exhaustive.

The employee data gathered for 2013/2014 was gathered and published in the Board's 2015 Equality Report. The data for 2014/2015 has been gathered and the Workforce Plan will be updated to include this information. This is to try to 'mainstream' this data into existing processes.

There are still some limitations to the amount of data which we are able to collect; however, we have been making progress each year. Once the Electronic Employee Support System is fully implemented, it should allow the collection of this data to be much more straightforward and will enable us to gather a wider range of information.

Recognising the gaps and following the release of the Equality and Human Rights Commission (EHRC) Report Measuring Up? Report 2, the NHS Human Resources Directors and NHS Equality and Diversity Lead Network jointly established a short life working group to assess current practice and recommend improvements which would increase the quality and consistency of staff equality data collection, use and reporting across NHS Scotland.

The group carried out a scoping exercise which identified both cultural and practical barriers to data collection and analysis. The group is currently developing an improvement plan to support joint action across NHS Scotland to increase disclosure rates, facilitate consistent reporting through established standard metrics and reporting processes and use the capabilities of a new Human Resources Management system to support data analysis at individual board and national NHS level.

As a board, we must get better at actually using the data which is being collected to allow us to better perform the Public Sector Equality Duty, as per the legislation.

### **Duty to Publish Gender Pay Gap Information/Duty to Publish Statements on Equal Pay**

NHS Dumfries and Galloway were required to publish information on our gender pay gap by the April 2013 and every two years after that. It is hoped that by monitoring the difference between men and women's pay, it will assist us to reduce inequality between our employees.

To calculate the pay gap we must use the most recent data available to work out the percentage difference between men's average hourly pay (excluding overtime) and women's average hourly pay (excluding overtime).

The most recent gender pay gap data was published within the 2015 Equality Report.

The NHS Dumfries and Galloway equal pay statement was published in 2013 and will be updated in 2017 to include the protected characteristics of race and disability.

Again, as a Board, we must get better at using the data gathered within this report to allow us to better perform the Public Sector Equality Duty.

### **Duty to consider award criteria and conditions in relation to public procurement**

To meet the requirements of the specific duty, a public authority must be able to demonstrate that it has had due regard to whether the award criteria and conditions relating to the performance of a relevant agreement should include considerations to enable it to better perform the equality duty.

Applying 'due regard' means that when making decisions about procurement, an authority subject to the duty must consciously consider the need to: eliminate discrimination, advance equality of opportunity, and foster good relations.

Deciding whether or not equality is related to the procurement exercise will require an assessment of how the subject matter relates to the needs of the general equality duty.

How public authorities establish the degree of relationship will vary according to the individual procurement but will be shaped by the value, scale and potential impact of the agreement and other factors such as level of contact with the public or the authority's workforce.

A section has been added into the NHS Dumfries and Galloway 'Competitive Quotations and Competitive Tenders Procedure' stating the requirements of the equality legislation on procurement as well as a link to the Equality and Human Rights Guidance on procurement.

## **Duty to Publish Equality Outcomes and Report Progress**

Outcomes are not what we do, but the beneficial change or effect which results from what we do. These changes may be for individuals, groups, families, organisations or communities.

Specifically, each of our Equality Outcomes should have achieved one or more of the following:

- Eliminate discrimination
- Advance equality of opportunity
- Foster good relations

An equality outcome is evidence to show that NHS Dumfries and Galloway intends to meet one or more of the three general duties. Equality outcomes were developed on the basis that they were short to medium term (1-4 years) and every protected characteristic has been covered by one or more of the outcomes. The equality outcomes were intended to produce results i.e. intended to achieve specific and identifiable improvements in people's life chances. These changes may be for individuals, groups, families, services or communities, they can relate to changes in behaviour, decision-making, attitudes, or better awareness.

In preparing our outcomes, we had to take reasonable steps to involve persons who share the relevant characteristics and those persons who appear to us to represent the interests of those persons. We also had to consider the relevant, available evidence relating to the protected characteristics and base our outcomes on the issues/areas which we felt were the most significant at the time. Consultation was carried out locally with a range of various equality groups, and a community survey was carried out to assess general satisfaction with the range of public services provided locally, from an equality and diversity point of view. The survey would allow us to start to build on some local evidence with which we could base our equality outcomes around.

The outcomes which were developed and published in April 2013 are as follows:

1. **Equality Outcome 1:** NHS Dumfries and Galloway is more equitable in the way in which it employs its workforce, which reflects more closely the diversity of the population it serves.
2. **Equality Outcome2:** Employees at NHS Dumfries and Galloway experience a safe, and more supportive workplace environment that contributes to their positive health and wellbeing.
3. **Equality Outcome 3:** Healthcare services, developments and policies are better able to meet the diverse health needs of local communities, promote well being and reduce health inequalities, and those who require health services will have more equal access to them.

4. **Equality Outcome 4:** NHS Dumfries and Galloway delivers person centred care and meets best practice standards in relation to equality and diversity, where patients can be confident that health services delivered and staff will respect their dignity and identity.
5. **Equality Outcome 5:** The people of Dumfries and Galloway experience an improved sense of community cohesion supported by the contribution of NHS Dumfries and Galloway, working in partnership with other local public and third sector organisations.

The table below gives an update on our progress towards meeting each of these outcomes and the actions which are part of the board wide plan.

## NHS Dumfries and Galloway – Equality Outcomes:

## Monitoring Report

Report Date: Aug 15

Outcome 1	NHS Dumfries and Galloway is more equitable in the way in which it employs its workforce, which reflects more closely the diversity of the population it serves.				
<b>Red</b> Not in place or not started yet	<b>Amber</b> On-going			<b>Green</b> In place	
Outputs	Actions	<b>R</b>	<b>A</b>	<b>G</b>	Current position
The number of staff willing to share protected characteristics increases	<ul style="list-style-type: none"> <li>Establish a programme which will promote and encourage our workforce to complete monitoring across all protected characteristics</li> </ul>	X			It was envisaged that the roll out of this system would begin towards the end of 2014, following which, consideration would be given as to how we can allow staff to update their personal details, in an appropriate and confidential manner. Since the publication of the equality outcomes in 2013, there have been some delays in the implementation date of the new system. Unfortunately, asking current staff to update their details at the moment would not be a good use of resources, however all new staff are asked to do this during induction. By January 2016, all staff will have access to the 'self-service' section of the new system which will allow them to update their own equality and diversity data. Once all staff have access there will be work undertaken to meet this action. In the meantime, NHS D&G has been inputting into a national working group which is looking at current practice and recommending improvements on the data which is being collected, to try and achieve consistency across all health boards. The introduction of the national HR system will certainly make this process easier, and will allow the development of national reports.
Baseline data established	<ul style="list-style-type: none"> <li>Review monitoring of PCs to ensure that recruitment, workforce profile, progression and leaving employment are</li> </ul>		X		Our Information Services team previously spent a considerable amount of time looking at our current recruitment system (MARJE) in an

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Outputs	Actions	R	A	G	Current position
	all fully monitored and reported appropriately across all of the PCs				attempt to make the equalities data useable and allow up to date data reports from the system. We have made significant progress with this and are now able to report on numbers of applications, shortlisted candidates, posts offered and accepted by 7 out of the 9 PCs. This action is ongoing as we continue to try to increase the amount of data we are able to collect.
Impact assessments complete and any actions addressed	<ul style="list-style-type: none"> <li>Impact assess our recruitment process, monitor number of applicants willing to disclose, become seen as an employer of choice for underrepresented groups and encourage applications from underrepresented groups</li> </ul>		X		The Recruitment and Selection policy was equality impact assessed in May 2015. Representatives from local equality groups were invited along to take part and also to give any feedback on how this policy could be more equitable. Further work to be undertaken within Workforce Directorate to encourage applications from underrepresented groups.
Recruitment panel staff must have completed Equality and Diversity training, either online or face to face.	<ul style="list-style-type: none"> <li>Targeted equality and diversity training for members of staff that sit on interview panels</li> </ul>		X		The corporate face to face induction training (which includes our current face to face Equality and diversity training) has been refreshed since the publication of the equality outcomes in 2013. Within the draft Equality and Diversity Policy it is mandatory that interview panel staff must have undertaken equality and diversity training, and that all members of an interview panel must have taken part in recruitment and selection training. The Workforce Directorate are currently updating the recruitment training to include a section on 'unconscious bias' particularly in relation to someone protected characteristics.
Increase in the number of work experience posts	<ul style="list-style-type: none"> <li>Develop and promote work placement opportunities created for people with disabilities to give them an opportunity to</li> </ul>		X		This issue was initially raised with the local diversity working group, however there has been some opposition to this approach, in that it could be considered 'tokenism'. Further

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Outputs	Actions	R	A	G	Current position
An increase in communication/staff awareness of flexible working options	gain some relevant work experience.				work required in conjunction with local equality groups and initial enquiries have been made around taking part in 'Project Search', a programme which helps young people with a disability to find and keep employment. NHS Dumfries and Galloway are currently taking part in the Glasgow Centre for Inclusive Living Equality Academy Professional Careers Programme. This programme involves NHS D&G providing a two year employment opportunity for a disabled graduate. It is hoped that this national programme will increase the representation of disabled people in training positions within the NHS and will provide valuable work experience for those taking part. This is currently at the recruitment stage.
	<ul style="list-style-type: none"> <li>Raise and maintain awareness of flexible working, at all levels, making sure staff are aware of their options, targeting carers as well as parents</li> </ul>		X		This action has been included within local E&D action plans. Future workforce paper will highlight this issue. Requirement to establish how we can begin to measure requests and uptake of flexible working by protected characteristic.
	<ul style="list-style-type: none"> <li>LGBT Charter Mark promoted amongst directorates</li> </ul>			X	Since the publication of the Equality Outcomes, there have been further directorates awarded and undertaking the Charter Mark. Operations Directorate have achieved the Foundation award and our Public Health department were the first organisation in Scotland to achieve the Gold award. Acute and Diagnostics recently signed up to undertake the Foundations award which was seen as a key area to be targeted. At present, we have 17 areas working towards this award, which is a fantastic achievement both locally and nationally when compared with other organisations and other areas

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Outputs	Actions	R	A	G	Current position
					across the country.

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## NHS Dumfries and Galloway – Equality Outcomes:

## Monitoring Report

Report Date: Aug 15

Outcome 2	Employees at NHS Dumfries and Galloway experience a safe and more supportive workplace environment that contributes to their positive health and wellbeing.				
<b>Red</b> Not in place or not started yet	<b>Amber</b> On-going	<b>Green</b> In place			
Outputs	Actions	R	A	G	Current Status
All staff will demonstrate high levels of appropriate behaviour	<ul style="list-style-type: none"> <li>Promotion of staff dignity at work policy, Give Respect, Get Respect, Code of Positive Behaviour</li> </ul>		X		This activity has been mainstreamed into directorate action plans, however still work to do around the best way to promote these policies and measure the effectiveness of them.
Established baseline of staff complaints, grievances and issues leading up to tribunal stage in relation to PCs	<ul style="list-style-type: none"> <li>Review of staff complaints, grievances and issues up to tribunal stage to look for patterns relating to PCs. Monitor reports of bullying and harassment cases, victimisation and discrimination</li> </ul>		X		As part of the Workforce Equality workforce data gathering we include grievance and disciplinary figures against 8 of the PCs. However, the small numbers and lack of data on our staff makes it very difficult to draw any conclusions. This information will continue to be published and it is hoped that over time, we build a more accurate picture of our staff in post against all of the protected characteristics. The introduction of EESS should make this process more straightforward and allow us to make better use of the data.
Established baseline of absenteeism against the protected characteristics	<ul style="list-style-type: none"> <li>Look at levels of staff absence against the PCs</li> </ul>	X			This area has not been considered as yet but it is hoped that over the next 6 months, there will be some work which will look at staff absence to attempt to gauge if there are any patterns emerging in relation to the PCs of staff.
Process review complete, data baseline established in relation to protected characteristics	<ul style="list-style-type: none"> <li>Review exit interview process and link to PCs</li> </ul>		X		This policy has been revised since the Equality Outcomes were published and despite not asking directly about discrimination, this policy now asks a wider range of questions which allows staff leaving the organisation to provide their thoughts on

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Outputs	Actions	R	A	G	Current Status
<p>NHS Dumfries and Galloway employee gender-based violence policy and monitoring system in place</p> <p>Managers trained on implementation of GBV policy</p>					<p>a wider range of issues within the organisation. One of the questions asks about how ethical the organisation is, and this may be a good opportunity for a staff member to raise equality issues. The policy also states that a staff member can choose to speak directly with the Workforce Directorate as opposed to their Line Manager, as it was felt that staff may not feel comfortable speaking directly to their Line Manager if the issue involved them. Equality Lead is hopeful that once EESS is implemented, we will be able to report the uptake of exit interviews against all of the protected characteristics.</p>
	<ul style="list-style-type: none"> <li>Implement national Gender Based Violence PIN Policy and work towards the development of a monitoring system</li> </ul>		X		<p>The NHS D&amp;G Employee Gender Based Violence policy was approved in 2014 and is available to view on HIPPO. Workforce Directorate paper in April 2014 highlighted the introduction of this policy and advised that an e-learning module is currently being developed to support staff with this policy. Safe, confidential monitoring system still to be developed.</p>

## NHS Dumfries and Galloway – Equality Outcomes:

## Monitoring Report

Report Date: Aug 15

Outcome 3	Healthcare services, developments and polices are better able to meet the diverse health needs of local communities, promote well being and reduce health inequalities, and those who require health services will have more equal access to them.				
<b>Red</b> Not in place or not started yet	<b>Amber</b> On going			<b>Green</b> In place	
Outputs	Actions	R	A	G	Current Status
Improved evidence base, including an increase in recorded data of the PCs	<ul style="list-style-type: none"> <li>Become involved in the development of a local evidence base</li> </ul>		X		Equality Leads from local statutory organisations carried out an up to date Community Survey in December 2014, similar to the one carried out in 2011, which informed our equality outcomes. We are currently awaiting detailed feedback from our Health Intelligence team. It is envisaged that this will be ongoing and carried out every two years, helping us to map progress with equality outcomes and consider which areas should be considered in future. This can then perhaps form the basis of further work to obtain evidence around local equality issues.
Increased patient data used to make services more appropriate and better able to meet the needs of patients	<ul style="list-style-type: none"> <li>Develop and implement a system which will record protected characteristics of patients, and inform patients of the benefits of identifying protected characteristics. This will allow us to track issues such as 'Did not Attends' and look at where barriers lie</li> </ul>	X			Equality Lead has had initial chat with IT around this area around how we capture an increased amount of this data and make use of it however, more work to be done around our position on this. In order to identify where there are access issues for example, we need to increase the level of data which we have on our systems about our service users, to allow us to build a clearer picture of where barriers may lie.
New Impact Assessment process implemented	<ul style="list-style-type: none"> <li>Implement new Impact Assessment process with support from NHS Health Scotland to train staff and implement the new Impact Assessment tool across NHS</li> </ul>		X		The Equality Impact Assessment policy and toolkit was last updated in April 2014. There is currently work ongoing to amend the policy and the toolkit, and to develop a joint EQIA toolkit with Dumfries and Galloway Council. D&G Council have also agreed that NHS D&G

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Outputs	Actions	R	A	G	Current Status
<p>Campaigns delivered, increased uptake of local health services by vulnerable and hard to reach people. Increase in breastfeeding rates, uptake of immunisations</p> <p>Campaigns delivered, analysis shows that we have reached out to those people with protected characteristics</p>	Dumfries and Galloway				staff will be able to make use of their EQIA training. Further discussion to be undertaken to make this a formal arrangement.
	<ul style="list-style-type: none"> <li>Provide outreach clinics to vulnerable individuals and communities eg. Gypsy travellers, Provision of onsite health checks within community based centres. Flexible models of service provision</li> </ul>	X			On reflection, following publication of the board's equality outcomes, and the chance to reflect over the first two years, it is felt that this action and the following two actions are perhaps not specific enough. Whilst it can be argued that there is a lot of good work being done in relation to these action points, it is too wide an area to provide a brief update, as well as measure success, and these actions will be reviewed over the next 12 months. Work to be done within the individual areas where there are specific issues in relation to these points.
	<ul style="list-style-type: none"> <li>Develop and implement specific health promotion activities to the protected characteristics</li> </ul>	X			In terms of developing specific health promotion activities, the Board Equality Lead has been making links with our Public Health Directorate to gain more of an insight into what we are already doing and where further work is required, and again, this will help shape our future equality outcomes. Examples of programmes of work include: Building Healthy Communities, Keep Well, Welfare Reform and Financial Inclusion, Teenage Pregnancy, Men who have sex with men project and Maternal and Infant Nutrition.
	<ul style="list-style-type: none"> <li>Develop inclusive and targeted preventative healthcare messages for hard to reach groups for example, cervical screening for lesbian women</li> </ul>	X			See above.

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## NHS Dumfries and Galloway – Equality Outcomes:

## Monitoring Report

Report Date: Aug 15

Outcome 4	NHS Dumfries and Galloway delivers person centred care and meets best practice standards in relation to equality and diversity, where patients can be confident that health services delivered and staff will respect their dignity and identity.				
<b>Red</b> Not in place or not started yet	<b>Amber</b> On going			<b>Green</b> In Place	
Outputs	Actions	R	A	G	Current Status
Increased staff awareness and understanding of person centred approaches and how equality and health inequalities are integral to this	<ul style="list-style-type: none"> <li>Review equality and diversity training to meet individual, team and service user requirements</li> </ul>		X		Since the publication of the equality outcomes, equality and diversity online mandatory training has recently been updated and moved onto our 'Learn Pro' system. The face to face training at induction has also been refreshed. The Equality Lead in conjunction with the Training Managers will now have to consider the introduction of some more specific modules, perhaps on each of the protected characteristics. There are also ongoing discussions amongst the Equality and Diversity Steering group about the most effective way to carry out training for staff, as they need for an element of face to face training has been raised by various staff members from within a range of directorates, and it is hoped that at some point, more specific, tailored training can be provided within individual areas, however, there would obviously be costs associated with this.
Patient experience and levels of satisfaction recorded regularly and systematically and used to enhance services Reduction in patient and carer complaints around staff attitudes and behaviour	<ul style="list-style-type: none"> <li>Review/enhance arrangements to encourage feedback, comments, complaints so that patients have the opportunity to improve service development and learning within the organisation. Patient experience to include equalities monitoring and reported as part of Board reports</li> </ul>		X		Equality Lead was previously involved in the Board Patient Experience Group which was hoped would influence some of the work on patient experience from an equalities perspective. Further work required in respect of monitoring complaints by protected characteristics. When this has been tried in the past, there has been feedback that the public have been wary about sharing this

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Outputs	Actions	R	A	G	Current Status
Clearer guidance for staff on how to access communication support and increased awareness amongst patients of the available options	<ul style="list-style-type: none"> <li>Promotion of interpreting, translation and communication support arrangements for languages others than English and those who are hard of hearing, deaf and deaf blind people</li> </ul>		X		<p>information in relation to a complaint.</p> <p>The Board Equality Lead and Patient Information Officer have recently started to consider communication support issues for our service users. It is planned that initial feedback will be sought from local communication support groups to find out if indeed there are any issues locally, as well as awareness raising with key staff on best practice around communication support.</p>
Improved patient experience	<ul style="list-style-type: none"> <li>Decisions about patient care/treatment plans must be developed with the patient at the centre and in conjunction with individuals and their families</li> </ul>	X			<p>On reflection this should not be in the action plan as this is an activity which should be mainstreamed into our day to day business.</p>
Increase in number of GPs and reception staff trained Patients report improved experience	<ul style="list-style-type: none"> <li>Develop and implement a programme of training and awareness raising with GP surgeries on registration policies, equality and diversity and communication</li> </ul>		X		<p>Difficult to influence GP surgeries in relation to training and awareness raising, however there is some work being done by the West of Scotland Managed Clinical Network and some NHS D&amp;G Staff. This is specifically related to men who have sex with men (MSM) but has an overall equalities focus. The group have developed an equalities poster which will be displayed in surgeries and have also linked in with Practice Nurses across the region to increase awareness, along with some tips for clinicians and managers about how to ask about someone's sexual orientation and why this is important. An online training module for healthcare staff is also being considered.</p>

Outputs	Actions	R	A	G	Current Status
Transgender policy in place	<ul style="list-style-type: none"> <li>Development of our Transgender Policy and process for Gender Reassignment treatment.</li> </ul>		X		<p>This policy has been drafted and a copy of the policy was taken to the local Transgender group for comments. The policy has also been sent to the Scottish Transgender Alliance who have also been asked to provide any comments or feedback which would help us to improve the policy and ensure that it is fit for purpose and meets the correct standards in terms of the Gender Recognition Act for example. It is deemed necessary to have this 'expert' input into this policy given its sensitive nature.</p>

## NHS Dumfries and Galloway – Equality Outcomes:

## Monitoring Report

Report Date: Aug 15

Outcome 5	The people of Dumfries and Galloway, including those with Protected Characteristics experience an improved sense of community cohesion, supported by the contribution of NHS Dumfries and Galloway, and working in partnership with other local and public and third sector organisations.				
<b>Red</b> Not in place or not started yet	<b>Amber</b> On going	<b>Green</b> In place			
Outputs	Actions	R	A	G	Current Status
Increase in involvement of local people and contribution to decision making within NHS Dumfries and Galloway	<ul style="list-style-type: none"> <li>Continue and develop local diversity working group which involves people from other statutory bodies as well as local representative groups through involvement events and the ongoing contribution to setting and reviewing of outcomes</li> </ul>		X		There has been ongoing work over the past twelve to eighteen months to review the remit and membership of the local Community Planning Diversity Working Group, supported by NHS D&G. Further work is required with regards to Diversity Working Group to increase membership so that the group is representative of all of the PCs. Some good work has been done using the Council's performance management system to monitor performance of the group in a more coherent manner. There has also been an increase in the number of occasions where the local Diversity Working Group have been invited to take part in NHS D&G Equality Impact Assessments and involvement events, and this data will now start to monitored as evidence.
Increase in awareness and reporting of hate crime in the region	<ul style="list-style-type: none"> <li>Work with partner agencies and stakeholders to promote third party reporting as an effective and safe way of reporting instances of hate crime</li> </ul>		X		NHS D&G have fully supported the ongoing work on Hate Crime. The Equality Lead has been involved in the Hate Crime Third Party Reporting working group, and those areas undertaking the Charter Mark process have been looking at Hate Crime and promoting Third Party Reporting Centres. Members of the internal E&D Steering group have been displaying posters on Hate Crime in their own areas to raise awareness of this issue. This action is not marked as complete as this is currently an ongoing exercise.

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Outputs	Actions	R	A	G	Current Status
At least one third party reporting centre developed within NHS Dumfries and Galloway	<ul style="list-style-type: none"> <li>Work with partner agencies to identify where a third party reporting centre would be best placed within NHS D&amp;G. Staff trained on hate crime and their role as a third party reporting centre.</li> </ul>			X	NHS Dumfries and Galloway Drugs and Alcohol Service and the CAHMS team have both completed their training and are now recognised Hate Crime Third Party reporting Centres.
E-learning module in place Staff have an increased understanding of Gender-based violence, shown and demonstrated in day to day interactions Increase in levels of gender based violence reported	<ul style="list-style-type: none"> <li>Development of staff training e-learning module on Gender Based Violence which will raise awareness of gender-based violence, the impact this can have on health and the key principles of a sensitive and appropriate response</li> </ul>		X		There is a standard e-learning module available from learn pro. Equality Lead in the process of using this as a template and building on it to make it more relevant for staff and managers within NHS Dumfries and Galloway.
Representative involvement in stakeholder engagement for the new DGRI	<ul style="list-style-type: none"> <li>Work together with the local diversity working group in the development of plans for the new DGRI</li> </ul>		X		This action has been met but will continue to be 'ongoing' as the new build project moves forward. To date there have been two specific meetings held to which members from various local equality groups were invited to, and comments/feedback given. There has been representation so far from DG VOICE, Dumfries and Galloway Multicultural Association, Dumfries and Galloway Interfaith group, as well as a range of people individually representing various faith groups. There was also a specific event held for members of the local LGBT community to view the most up to date plans and provide comments and feedback. Aside from the specific equality events, there has been a wide range of consultation carried out in the community which will continue as the project moves forward.

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**DUMFRIES and GALLOWAY NHS BOARD**5<sup>th</sup> October 2015**Schedule of Board Meeting Dates - April 2016 to October 2016****Author:**

Laura Geddes  
Corporate Business Manager

**Sponsoring Director:**

Jeff Ace  
Chief Executive

**Date:** 23<sup>rd</sup> September 2015**RECOMMENDATION**

The Board is asked to agree the proposed schedule of meeting dates for the period April 2016 to October 2016.

**Strategy / Policy:**

This paper supports the governance arrangements laid out within the Board's Standing Orders.

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

Noted below is the proposed schedule of meeting dates for the April 2016 to October 2016.

It is proposed to continue with the programme of a public meeting every second month with a governance committee on alternative months until the end of October 2016. A review will be undertaken in May 2016 looking at the frequency of NHS Board meetings, following the establishment of the Integrated Joint Board. It is anticipated that there will be a workshop style event on every meeting date.

If Board agrees the schedule of meeting dates for the period April 2016 to October 2016 this will facilitate scheduling all committee meetings throughout that period including Audit and Risk Committee and Staff Governance Committee and allow the public meeting dates to be posted on the intranet and Board website.

**Key Messages:**

This will also facilitate management of the corporate diary with all statutory governance and other Board committees being scheduled in to the programme.

**GLOSSARY OF TERMS**

*NHS* - *National Health Service*

**MONITORING FORM**

Policy / Strategy	<i>Complies with Board's Standing Orders.</i>
Staffing Implications	<i>Not relevant.</i>
Financial Implications	<i>Not relevant.</i>
Consultation / Consideration	<i>None.</i>
Risk Assessment	<i>Not required.</i>
Sustainability	<i>Supports the Board to carry out its statutory obligations in terms of governance etc.</i>
Compliance with Corporate Objectives	<i>Supports the Board to fulfil its obligations in terms of all corporate objectives.</i>
Single Outcome Agreement (SOA)	<i>Not required.</i>
Best Value	<i>Sound Governance. Accountability.</i>
Impact Assessment	<i>Not required.</i>

## Introduction

1. The meeting dates proposed follow the agreed pattern of meeting dates. However, Board Members are only being asked to agree the pattern of dates from April – October 2016. A review of the dates for the remainder of the year will be undertaken in May 2016, to look at the impact that the Integrated Joint Board has had on the frequency of the NHS Public Board meetings.

## Proposed Meeting Dates

*April 2016 to October 2016*

4 April 2016	Board Meeting and Workshop
6 June 2016	Board Meeting and Workshop
1 August 2016	Board Meeting and Workshop
3 October 2016	Board Meeting and Workshop

## Governance

2. If Board agrees the schedule of dates proposed the public meeting dates will be posted on the intranet and the Board's website.
3. This will also facilitate management of the corporate diary with all statutory governance and other Board committees being scheduled in to the programme.
4. A paper will be brought back to the June 2016 NHS Public Board meeting with proposed meeting dates for the remainder of the 2016/17 financial year.

**DUMFRIES and GALLOWAY NHS BOARD**Monday 5<sup>th</sup> October 2015**Revalidation of Nurses and Midwives****Author:**

Margo Christie  
Associate Nurse Director

**Sponsoring Director:**

Hazel Borland  
Executive Nurse Director

**Date:** 21<sup>st</sup> September 2015**RECOMMENDATION**

The Board is asked to note the Nursing and Midwifery Council's proposal for the revalidation of all nurses and midwives.

**CONTEXT****Strategy / Policy:**

This paper supports a number of local and national strategies, including the Staff Governance Standards (2012), NHS Scotland's Healthcare Quality Strategy (2010) and 2020 Vision for Health and Social Care (2013).

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

The NMC model proposes:

- Replacement of the current 3 yearly Notification to Practice Form
- Registered nurses and midwives will hold personal responsibility for declaring their Fitness to Practise alongside provision of:
  - A receipt of confirmation that declaration of fitness to practise is reliable in accordance with the Code
  - Receipt of third party feedback which has informed reflection on practice
  - Evidence that the nurse/midwife has met requirements for practice hours and Continuing Professional development (CPD) proposed as 40 hours (20 in participatory learning)

**GLOSSARY OF TERMS**

NMC – Nursing and Midwifery Council  
eKSF – electronic Knowledge and Skills Framework

**MONITORING FORM**

Policy / Strategy	Staff Governance Standards (2012) NHS Scotland's Healthcare Quality Strategy (2010) 2020 Vision for Health and Social Care (2013)
Staffing Implications	As yet undetermined until process is clarified
Financial Implications	As yet undetermined until process is clarified
Consultation / Consideration	Pilots have been held in the 4 UK countries
Risk Assessment	Not Applicable
Sustainability	Not Applicable
Compliance with Corporate Objectives	Complies with Corporate Objectives within the above policies/strategy.
Single Outcome Agreement (SOA)	Not Applicable
Best Value	Vision and Leadership Governance and Accountability
Impact Assessment	Not Applicable

## REVALIDATION FOR ALL REGISTERED NURSES AND MIDWIVES

### 1. INTRODUCTION

The Nursing and Midwifery Council (NMC) has proposed a new model for the revalidation of all nurses and midwives.

The NMC is the largest health professional regulator in the world and ensures public protection through regulation of nursing and midwifery professionals. It has a registrant body in excess of 680,000, approximately 10% of who work in Scotland. Implementation of the NMC revalidation proposals will affect all nurses and midwives in Scotland, including those who work in NHS Scotland, the care sector, and the independent and third sectors.

Following a number of reviews of NMC processes (Council for Healthcare Regulatory Excellence 2012, Francis Report 2013) the NMC has committed to introducing a more robust system of assurance for ensuring the on-going fitness to practise of nurses and midwives and has confirmed to the Health Select Committee of the UK Parliament that this system will be launched in October 2015 and in place by 31<sup>st</sup> March 2016.

### 2. THE MODEL

The NMC model proposes:

- Replacement of the current 3 yearly Notification to Practice Form
- Registered nurses and midwives will hold personal responsibility for declaring Fitness to Practise alongside provision of:
  - A receipt of confirmation that declaration of fitness to practise is reliable in accordance with the Code
  - Receipt of third party feedback which has informed reflection on practice
  - Evidence that the nurse/midwife has met requirements for practice hours and Continuing Professional development (CPD) proposed as 40 hours (20 in participatory learning)

This proposal supports the implementation of NHS Scotland's Healthcare Quality Strategy (2010), Staff Governance Standards (2012) and the Route Map to the 2020 Vision for Health and Social Care (2013), ensuring a workforce fit to practise and to deliver safe, effective, person-centred care for people of all ages in a range of health and social care environments.

The NMC revalidation model seeks to be proportionate, risk-based and aligned with existing processes, such as employer-led appraisal processes. It will consist of:

- Self-confirmation from the registrant
- Reflection on the revised Code
- Satisfaction of the required hours of CPD and hours of practice
- Confirmation of good health and good character
- Confirmation that Professional Indemnity Insurance is in place

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- Third party input – confirmation and feedback
- Random risk-based audit by the NMC regarding compliance

The NMC is preparing to launch revalidation in October 2015, with the first nursing and midwifery registrants progressing revalidation in April 2016.

### **3. NHS BOARD PILOTS**

Each of the four UK countries has identified organisations to test and evaluate the proposed revalidation model, and NHS Tayside has been nominated by the Scottish Government Revalidation Programme Board and Scottish Executive Nurse Directors to lead the pilot on behalf of Scotland.

NHS Tayside Board accepted the position of Pilot NHS Board and became a Pilot site in January 2015 to host the Pilot programme within the dedicated timeline of January – June 2015.

#### **3.1 The Infrastructure**

The following information summarises the infrastructure established to host the Scottish Pilot.

NHS Tayside, through the Nurse and Midwife Director and delegated authority given the one of the Associate Nurse Directors was responsible for:

- Co-production with Scottish Government colleagues in the design and planning for the pilot, including data collection requirements
- Undertake to progress work internally to test the NMC revalidation model
- Receive support to identify relevant staff within partner organisations for pilot participation
- Liaison with respective organisations to consider possible implications for their business and care delivery, and undertake to progress revalidation through respective management structures
- Provision of reports, completed data and qualitative templates as the pilot progresses, at agreed milestones
- Receive support in two-way communications with the NMC and Scottish Government via NHS Tayside as central 'hub'

#### **3.2 Stakeholders**

The Pilot progressed in partnership between a range of organisations including:

- The University of Dundee
- Care Inspectorate
- Social Work
- NHS Tayside services, including Prisoner Healthcare
- General Practice
- Nursing/Care Homes
- Private Practice
- Island NHS Boards

### **3.3 Participants - Familiarisation and Meeting Requirements**

The support and commitment of personnel from NHS Education for Scotland was secured to help facilitate a learning environment, through workshops held across Tayside, supporting staff to gain further understanding around the guidance and use of anticipated templates provided by the NMC to support Revalidation in practice.

Feedback from the evaluation of the pilot has informed next step development needs for registrants and organisations, i.e.:

- Developing a portfolio
- The NMC confirmation process
- Using reflective models
- Having reflective discussions
- Providing feedback to colleagues
- Preparing for appraisal
- Undertaking appraisal
- Other - IT skills

## **4. LEARNING, CHALLENGES AND POTENTIAL RISKS**

The NMC has developed revalidation guidance.

Key points for consideration:

### **4.1 Professional Leadership and Governance**

The Associate Nurse Director for NHS Dumfries and Galloway will provide strategic professional leadership, governance and regulatory direction and guidance for all Registered nurses and midwives progressing through revalidation for the first time during the first years 2016-19. This role will facilitate;

- Sufficient numbers of trained Confirmers/Registrants with ability to facilitate reflection/reflective practice
- Policies and procedures for identifying and responding to concerns
- Linkage with Clinical Governance Systems with supporting information/data repositories (for clinical audit data) enhancing evidence for practice.

### **4.2 Registration Renewal Dates**

There is no local organisational system through which a registrant's place within their 3 yearly renewal of registration can be identified. That relationship has historically been one established and recorded only between an individual registrant and the NMC.

As a result of the Pilots providing early comment to the NMC, prompt action has been taken by the NMC to address this position through a registrant's date of renewal now being made available on the NMC Register.

Identification of all local registrant's date of renewal is currently underway and will be complete by end of October 2015.

### **4.3 Pre-employment/employment Assurances**

Suggestion has been made towards a standardised approach being established through NHS Scotland recruitment process and enabling the date of Registration renewal and the date of the registrant's last Confirmation conversation being held within recruitment applications and reference letters and ensuring these employment and engagement processes are consistently applied and meet expectations of NMC Revalidation.

Organisational Information Sharing Protocols should be established to support personnel whose employment crosses organisational boundaries.

### **4.4 Appraisal System**

A set of Principles aligned to the appraisal system will be beneficial;

- Up to Date Appraisal System (consideration required for the NHS given impending changes to e-KSF including a registrant's 3 year renewal and revalidation date).
- Appraisal systems incorporating the four elements of the Code as measurement dimensions.

## **5. LEGAL IMPLICATIONS**

Revalidation will be a mandatory requirement for all registered nurses and midwives. NMC registration is at risk without active participation.

## **6. PRACTICAL RESOURCES**

Education resources have been published on the NMC website to support nurses, midwives, their managers and employers:

- Full guidance for nurses and midwives
- Templates
- A guide for employers on how to support revalidation
- Case studies for nurses and midwives working in different areas
- Examples of good practice emerging from the pilots.

## **7. LOCAL ACTION TO DATE**

- Gillian Costello, National Lead for Revalidation, came to Dumfries to highlight the national perspective and to advise on local implementation. Over one hundred registrants attended the event.

- Identification of all registrant's date of renewal is currently work in progress and will be complete by the end of October 2015.
- Awareness raising presentations are being delivered to the wide range of internal Management Boards, Councils and Committees.
- A Revalidation Steering Group is being established. This group will be chaired by the Executive Nurse Director and will include wide representation (Appendix 1).
- Road shows and training sessions will be delivered across the region during October and November 2015.
- Additional 1:1 support will be given to the first tranche of registrants.

## **8. STATE OF READINESS**

At the time of writing this paper the NMC has not confirmed a state of readiness with regard to the launch in October. However, all of the above actions are being progressed locally.

**Revalidation Strategy Group Membership**

- Executive Nurse Director
- Associate Nurse Director
- Deputy Director of Human Resources and Workforce Development
- Finance representation
- Staff side representation
- University of the West of Scotland
- Information Technology
- General Management
- Private and Third Sector
- Medical/Clinical Directors
- Practice Manager – General Practice
- Lead Nurses/Midwives

## DUMFRIES and GALLOWAY NHS BOARD

### PERFORMANCE COMMITTEE



5<sup>th</sup> October 2015

### Revenue Financial Performance: 5 Months to 31<sup>st</sup> August 2015

**Author:**

Graham Stewart  
Deputy Director of Finance

**Sponsoring Director:**

Katy Lewis  
Director of Finance

**Date:** 14<sup>th</sup> September 2015

#### RECOMMENDATION

The Board is asked to discuss and consider this report.

#### CONTEXT

**Strategy / Policy :**

The Board has a statutory financial target to deliver a breakeven position against its Revenue Resource Limit (RRL).

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

The Board has a statutory financial target to deliver a breakeven position against its Revenue Resource Limit (RRL). The financial position presented reflects the initial revenue resource limit set by the Scottish Government which is in line with the LDP.

The Acute Services Redevelopment Project has required that **£9m** of funding over the last three years has been banked with the Scottish Government that will be drawn down in future years to support transitional costs, with £2m drawn down in 2015/16.

This report reflects the month 5 position for 2015/16 and provides a summary of the main financial issues during this period, including the delivery against efficiency plans, the growing pressure on medical locum costs, as well as pressures within the Acute and Diagnostics directorate as it continues to meet Access Targets.

The year to date (YTD) position of **£358k** over-spend, highlights the increasingly difficult financial challenge facing the Board in delivering a breakeven position against a background of escalating finance pressures across the system.

**GLOSSARY OF TERMS**

ADTC	-	Area Drugs and Therapeutics Committee
ASRP	-	Acute Services Redevelopment Project
CIG	-	Capital Investment Group
CNORIS	-	Clinical Negligence and Other Risks Scheme
CRES	-	Cash Releasing Efficiency Scheme
CRU	-	Compensation Recovery Unit
DGRI	-	Dumfries and Galloway Royal Infirmary
IM&T	-	Information Management and Technology
IPTR	-	Individual Patient Treatment Request
LDP	-	Local Delivery Plan
MYR	-	Mid-Year Review
QOF	-	Quality and Outcomes Framework
PFI	-	Private Finance Initiative
RRL	-	Revenue Resource Limit
SGHSCD	-	Scottish Government Health & Social Care Directorates
SMC	-	Scottish Medical Consortium
UNPACS	-	Unplanned Activity
WTR	-	Working Time Regulations
YTD	-	Year To Date

**MONITORING FORM**

Policy / Strategy Implications	Supports agreed financial strategy in Local Delivery 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 Group
Risk Assessment	Financial Risks included in paper
Sustainability	Financial plan supports the sustainability agenda through the delivery of efficient solutions to the delivery of CRES.
Compliance with Corporate Objectives	<p>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.</p> <p>To meet and where possible exceed Scottish Government goals and targets for NHS Scotland.</p>
Single Outcome Agreement (SOA)	Not required
Best Value	This paper contributes to Best Value goals of sound governance, accountability, performance scrutiny and sound use of resources.
Impact Assessment	<p>Financial decisions are impact assessed at the point service and financial planning and therefore no specific action required for this paper.</p>

## Summary Financial Position 2015/16

1. The Board has a statutory financial target to deliver a breakeven position against its Revenue Resource Limit (RRL). Whilst there are significant pressures developing so far this year, overall the Board is forecast to have a breakeven position (no additional carry forward) for 2015/16.
2. This report is to provide the Board with a monthly update on progress towards delivery of both the breakeven for 2015/16 and efficiency savings required to deliver this financial position. The report provides a narrative on a range of financial analysis which are presented as appendices to this report and based on the overall Board financial position. In addition it will highlight financial risks and challenges which we must manage as a Board.
3. The financial position reported reflects the underlying variance to plan after taking into consideration decisions on funding of cost pressures made as part of the Quarter One Review, the details of which are included later in the paper.

## Financial Position

4. The Board is reporting an over-spend of **£358k** against budgets based on five months expenditure to 31<sup>st</sup> August 2015. This is as per the financial analysis presented in Appendix 2. This position reflects the growing pressures that were identified last year and continue to be incurred so far this year. Specifically, pressures around the increasing costs associated with medical locum cover for vacancies (inclusive of on-call shifts), delivering the Access Targets, Primary Care Prescribing, as well as the on-going gap in delivery of savings schemes are the main areas for concern.

## Key Financial Risks

5. The key financial risks as identified are summarised as follows:
  - Delivery of in-year Cash Releasing Efficiencies Savings, identifying recurring plans to ensure these are identified in full by the year end (**£2.2m** recurring gap).
  - The continued high costs associated with medical locums and cover of medical staffing rotas (**£5.2m** YTD - **£4.0m** within Acute and Diagnostics Directorate).
  - GP prescribing and the uncertainty of possible future unknown costs (**£380k** YTD).
  - The on-going costs of maintaining and achieving Access Targets, particularly in relation to activity sent outside of the Health Board's services, provided by other organisations on our behalf (**£1.55m**). (Annual budget agreed YTD, with on-going discussions with the SG on additional investment to achieve Targets for the remainder of the year).

### Revenue Resource Limit (RRL)

6. The Revenue Resource Limit is notified monthly by the Scottish Government Health & Social Care Directorates (SGHSCD) and once the baseline allocation has been issued, further allocations are issued in year.
7. The forecast RRL for 2015/16 (excluding Family Health Services allocation) is **£304.7m**. This includes a confirmed revenue allocation of **£303.2m** based on the August allocation schedule, with an additional **£1.5m** included in anticipated allocations which relates to funding movements we have been advised to expect but where the Scottish Government Health and Social Care Directorates have not yet confirmed formally in the allocation schedule.
8. In addition Family Health Services Non Discretionary allocation of **£15.5m** has been added to this schedule to provide an overall projected Revenue Resource Limited for 2015/16 of **£320.2m**.
9. Appendix 1 provides details of allocations received during August 2015.

### Efficiency Delivery Plan (CRES)

10. The financial plan for 2015/16 identified the need to deliver recurring efficiencies of **£7.96m**. This plan is split **£7.5m** cash releasing efficiencies and **£460k** productivity savings. Whilst only a modest increase over last year's requirement, the Directorates continue to struggle to identify the savings plan in full as at the end of August 2015. A plan has been agreed by the Board which identified efficiency schemes and this will be used to monitor and manage plans against in year.
11. For this year a new methodology has been agreed that places greater emphasis on delivering the savings targets through identified workstreams, each led by a General Manager and an Executive Director.
12. CRES targets have been removed from directorate budgets in accordance with where each workstream has identified specific savings. In terms of any remaining balance, or slippage in-year against identified schemes, this target is held by the Chief Operating Officer on behalf of the Operational Directorates as a whole, so as to ensure focus remains on the delivery of the remaining balance across all operational Directorates as a whole.

13. The Summary CRES position, by workstream, as shown in Appendix 3, is summarised in Table 1 below:

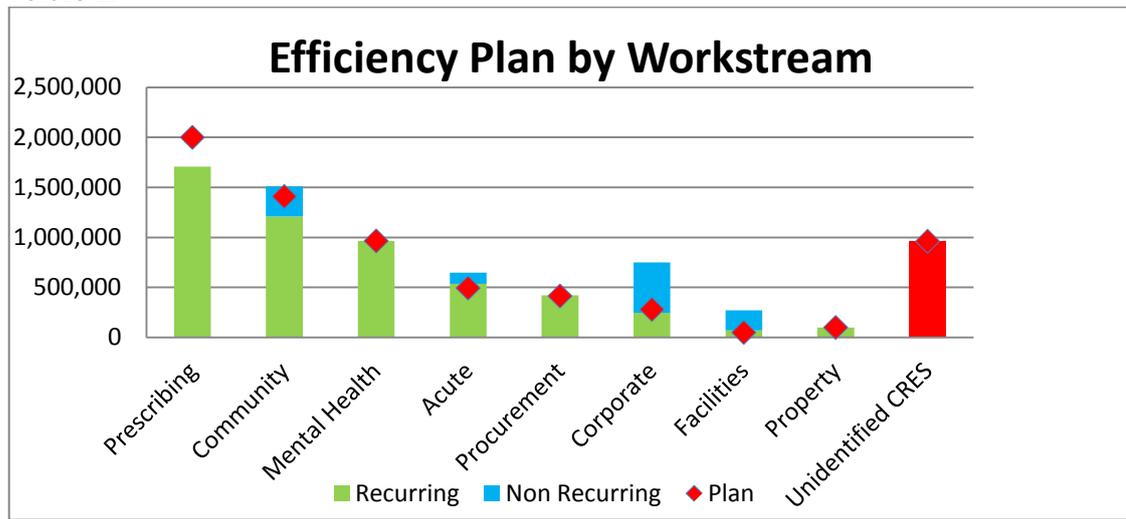
**Table 1**

Workstream			Total Savings Plan £k	CRES GAP		YTD Variance £k
	Original Recurring Schemes £k	Original Non-recurring Schemes £k		In Year 15/16 £k	Recurring 16/17 £k	
Acute Services Clinical Change	494	153	647	1	41	0
Community Services Clinical Change	1,409	300	1,709	(200)	(200)	(83)
Corporate Services	280	536	816	(67)	(171)	(18)
Estates & Facilities Review	50	220	270	0	0	0
EMI Redesign	965	0	965	0	0	0
Prescribing	2,000	0	2,000	(291)	(291)	(209)
Procurement	414	17	431	(10)	8	(4)
Property Strategy	100	0	100	0	0	0
Unidentified CRES	962	(400)	562	(562)	(1,632)	(317)
<b>Workstream Total</b>	<b>6,674</b>	<b>1226</b>	<b>7,500</b>	<b>(1,128)</b>	<b>(2,245)</b>	<b>(631)</b>
Productivity Savings	460	0	460	0	0	0
<b>Combined Total</b>	<b>6,734</b>	<b>1226</b>	<b>7,960</b>	<b>(1,128)</b>	<b>(2,245)</b>	<b>(631)</b>

14. It is important to note that these targets do not reflect the level of savings relating to each Directorate, but are the total savings across the system as identified in each agreed workstream.
15. Whilst the profile of the savings schemes to-date show an underachievement of **£454k** against CRES, from the table above, this under-scores the significant level of challenge that remains this year in identifying the balance of **£1,128k** for 2015/16 and the **£2,245k** recurrently as we move into the next financial year.
16. This represents an improvement of **£52k** in year on the CRES position with a **£124k** improvement on the recurrent gap on CRES from last month. This main improvement from last month relates to an identification of a review of maternity services (**£51k**) within the Community Services Clinical Change Workstream and additional staffing reviews within the Acute Services Clinical Change Workstream (**£41k**).
17. All remaining recurring gaps on Operational Directorates have also been moved to the Operational Unidentified CRES workstream so they can all be considered in totality as part of the review currently being led by the Chief Operating Officer.

18. In identifying further opportunities for CRES this year, the Corporate Directorates have identified a further **£400k** worth of savings non-recurrently this year to help off-set the level of unidentified CRES in the Operational Services, reducing the 2015/16 gap from **£962k** to **£562k**.
19. The graph at Table 2 below illustrates the achievement of delivery against each workstream for 2015/16 financial year.

**Table 2**



20. Risk analysis of the deliverability of the current CRES plan has been reviewed as at end of month 5 and shows that 28% of schemes are now high risk, 42% are medium risk and 30% are low risk.
21. Progress against the Efficiency plan compared to the projected trajectory within the LDP at the start of the year remains ahead of plan slightly, with **£2,248k** of savings achieved against a YTD plan in the LDP of **£1,752k**.
22. Detailed monitoring of all the efficiency schemes is carried out on an ongoing basis by the Efficiency Group, supported by the Senior Finance Team, to assess and highlight risks of CRES delivery.
23. Following on from the CRES workshop that took place on 25<sup>th</sup> August the following actions have been identified going forwards to continue to close the current size of the gap on the Efficiency Plan;

**Short term**

- Implementation of a more rigorous, in-depth monthly budget scrutiny meeting with each General Manager, led by the Chief Operating Officer and supported by the Deputy Director of Finance and the Efficiency and Productivity Manager.
- An enhanced Quarterly Review process, focussing on each Directorate with at least one Executive Director present at each review.
- An overall strengthening of the Mid-Year Review and Annual Review process, injecting a greater level of scrutiny and challenge into the process.

### Medium term

- Review the role of the Clinical Leads and Clinical Directors to ensure a more active participation in the Quality and Efficiency Agenda.
  - Restore the Committee previously known as the Area Clinical Activity Committee (ACAC) which will look at procedures of limited clinical value, referral rates and variation using benchmarking data, so as to link this to the review of clinical leadership.
  - A new programme based approach for all health services directorates which will come under the Integrated Joint Board (IJB), in order to create a series of Integrated Design Groups to take forward transformational change.
  - Bring forward proposals for where there is compelling evidence from quality and safety perspective to look at significant re-design and/or re-provision of services.
24. The Chief Operating Officer will report back in 6 weeks on the progress made on the above actions.

### Operating Directorates Summary

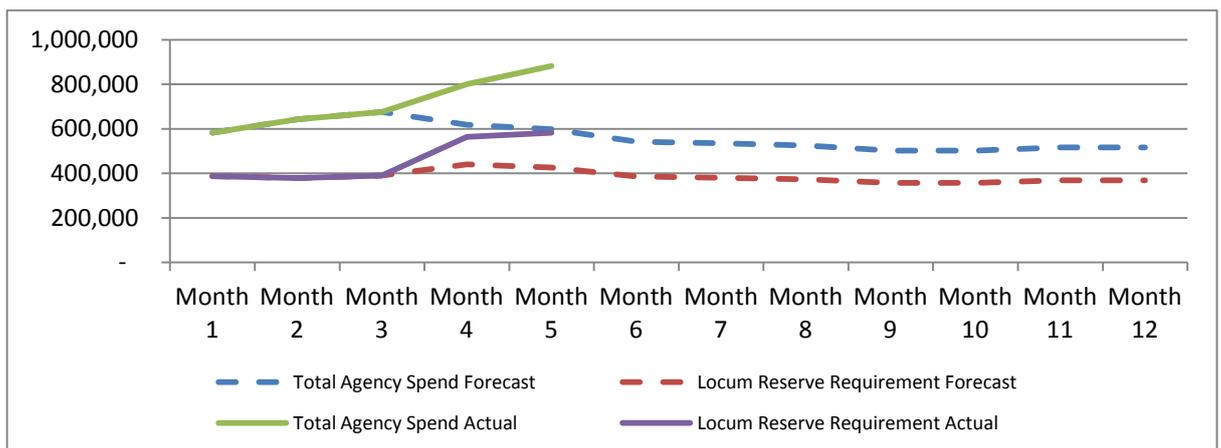
25. The operational Directorates are showing an over-spend position as at 31st of August of **£516k** with a **£317k** over-spend relating to unidentified CRES YTD (excluding the gap on Prescribing plans).
26. The table below highlights the summary variance by operating service as at end of August 2015;

Directorate	YTD Budget £k	YTD Actual £k	YTD Variance £k	Prior month variance £k	Q 1 Forecast Variance £k
Acute & Diagnostics Directorate	36,130	36,443	(313)	(253)	(250)
Facilities & Clinical Support	7,305	7,337	(32)	19	0
Mental Health Directorate	8,315	8,089	226	159	117
Primary & Community Care	25,646	25,753	(107)	77	(561)
Women & Children's Directorate	8,208	8,181	27	(8)	0
Operational Services CRES	(317)	0	(317)	(321)	(962)
<b>Sub Total–Operating Directorates</b>	<b>85,288</b>	<b>85,803</b>	<b>(515)</b>	<b>(326)</b>	<b>(1,656)</b>

27. The main pressures facing the Operational Directorates are related to pressures within Acute and Diagnostics, Primary Care Prescribing and the YTD gap on 2015/16 CRES plans. The sections below highlight the main issues affecting each Directorate.

**Acute and Diagnostic Services**

- 28. The main pressure within Acute and Diagnostics reflects the increased level of Emergency activity experienced across the Directorate in the first 5 months of this year compared to last year.
- 29. Medical Pays are currently **£241k** over spent as at the end of August, after additional locum funding of **£425k** was released to budget in the month, increasing the YTD support to **£2,046k**. This reflects the additional costs of covering locum pressures, the most significant of which are in Cardiology, Radiology, Urology and General Medicine. This is higher than what was originally estimated at the beginning of the year and further work is being undertaken within the Directorate to review and update the forecast locum expenditure for the year as a whole. There are however, four new consultants starting in the coming weeks/months, but unfortunately this has been off-set through recent retirements and resignations within the consultant cohort which will impact in August/September.
- 30. The graph below shows the movement between the forecast expenditure on locum staffing compared to the actual reserve requirement:-



- 31. The largest financial risks associated with delivering a breakeven position for Acute and Diagnostics Directorate continues to be the management of providing safe and sustainable clinical care with the increasing numbers of vacancies across Medical staffing, the on-going costs of hitting the Access Targets, increased expenditure related to the increasing levels of activity and the identification of recurring CRES solutions.

**Mental Health Directorate**

- 32. The Mental Health Directorate are reporting an under-spend of **£226k** at August 2015 (**£159k** under-spend at July), with **£200k** of this within staffing budgets.
- 33. The main areas of under-spend are within the Learning Disability Community Teams (**£66k**), medical staffing within Adult and Older Adult Services due to vacancies (**£53k**), Mental Health Community Teams (**£24k**), consultant vacancy in Substance Mis-use (**£22k**) and Mental Health OT (**£21k**).

34. Non-pays are under spent by **£21k** YTD, mainly related to the under spend in the Police Custody Service and some GP Payments which is off-setting payments now processed through Payroll, previously actioned through Non-pays. Work is currently being progressed on re-aligning the budgets to reflect the new method of provision of this service.

### **Facilities & Clinical Support**

35. Facilities & Clinical Support are reporting an over-spend of **£32k** at 31<sup>st</sup> August 2015.
36. The over-spend in non-pays year to date (**£108k**) is mainly due reactive maintenance and the continued pressure in laundry of **£75k** to date, relating to increased occupancy and infection control guidance in Community Hospitals.
37. An under recovery in income of **£52k** relates to carbon reduction scheme, which continues to be monitored and assessed by the Estate's team.
38. Pays continues to be under spent (**£128k**) reflective of the number of vacancies across the service. In particular, vacancies across CSSD, telephony and catering.

### **Primary and Community Care Directorate**

39. Primary and Community Care Directorate is reporting an over-spend of **£107k** to August 2015 (**£77k** under-spend at July). This includes an over-spend on Primary Care Prescribing of **£404k** YTD (**£258k** at July).
40. Primary Care prescribing expenditure is overspent by **£404k**, most of which is due to the over-spend in GP prescribing of **£380k** due to volume and price issues continuing on the same basis as last year, with the remaining overspend of **£24k** relating to activity within Community Hospitals YTD.
41. The over-spend across GP Prescribing is mainly due to the mix of volume and price issues being incurred this year. The year to-date figure is currently estimated to be 3.21% over-spent, reflecting the pressures seen in recent months as well as slippage to CRES plans YTD (**£154k**). The total gross ingredient cost has seen a 4.89% increase comparing April to June 2014 to April to June 2015, whilst volume is broadly the same over this time-frame.
42. Some of the largest swings have meant price increases of up to 10 times the price paid last year (Metformin for example), with a number of drugs now between 1.5 to 6 times more expensive than last year. This is mainly due to changes in tariff regimes agreed nationally across the UK.
43. The Pays position of **£225k** underspend across the Directorate helps to off-sets the adverse Prescribing variance. The under spends across Pays relate primarily to the level of vacancies across Management and Governance (**£35k**), STARS (**£83k**), with the remaining underspend relating to vacancies across the Community Hospitals.

## Women and Children

44. The Women and Children's Directorate is reporting an overall under-spend of **£27k** to August 2015.
45. Pays are **£138k** under-spend at August 2015. This is made up of **£146k** under-spend within nursing, **£24k** under-spend within AHPs and **£28k** under-spend within administration due to vacancies across the service. There is a **£62k** over-spend across medical staffing, which reflects additional hours undertaken by paediatric registrars as well as other doctors covering colleague's on-call. In addition there was a pressure against Specialty Doctors budget as extra hours paid covering a Registrar vacancy.
46. Non-pays across Women and Children's Directorate are **£108k** over-spent YTD, made up of Gynae Theatre supplies overspends related to activity pressures (**£34k**) and the unidentified CRES target 2015/16 of **£127k** and an underspend within travel and training of **£48k**.

## Corporate Services

47. The Corporate Directorates are reporting an overall under-spend of **£225k**. This is mainly related to the level of vacancies across the pays budget within Public Health, Nursing, workforce and Finance Directorates, resulting in an overall under-spend on pays of **£241k** (**£210k** under-spend at July). The most significant under-spend is within the Public Health Directorate which is showing an under-spend of **£132k** (on-going vacancies across the service).
48. The under-spend in non pays of **£12k** relates to underspends on recruitment YTD of **£23k** as well as an underspend in Medical Director of **£26k**. The further **£400k** of additional non-recurrent Corporate CRES targets agreed for 2015/16 has helped to off-set the level of unidentified CRES in the Operational Directorates.

## Strategic Services

49. Strategic services has an over-spend of **£68k** at August.
50. Central income is below plan by **£33k** due to a reduction in income relating to NES Medical training income YTD of **£38k** and an over achievement of RTA income of **£10k**.
51. Primary Care budgets comprise payments to primary care contractors including General Practitioners, Dentists, Opticians and Pharmacists. Budgets are over spent by **£17k** at end of August 2015.

## Non-core Expenditure

52. Non core expenditure comprises spend on depreciation, PFI charges, certain provisions and building impairments and is funded by a separate Revenue Resource Limit.
53. The non-core budget is **£6.261m**, with a breakdown of the expenditure as follows:

Area	Annual Budget £000
PFI Depreciation	214
Capital Grants	369
Depreciation	4,400
Provisions	100
Annually Managed Expenditure (Donated Assets Depreciation)	178
Annually Managed Expenditure (impairments)	1,000
<b>Total</b>	<b>6,261</b>

## Quarter One Update

54. The Quarter One Review as presented to the Performance Committee last month still forecasts a break-even position for the Health Board, based upon the Quarter One position.
55. The table below provides a high level summary of the YTD variance of each directorate as at end June 2015 and the estimated forecast position for the end of the financial year.

Division	Q1 Variance	Forecast
	£000s	£000s
Operating Directorates	(294)	(1,656)
Corporate Directorates	142	400
Externals/Strategic	(251)	(42)
<b>Total Health Board YTD/Forecast Overspend</b>	<b>(404)</b>	<b>(1,298)</b>

56. This is the position before allocating any reserves or uncommitted cost pressures but reflects the significant challenges within the financial position, reflected in the monthly reports.
57. In determining the level of non-recurrent resource available to help bridge the in-year gap on CRES this year, a number of cost pressures were agreed and released to the Directorates as part of the Quarter One Review.

58. These included :-

- funding the slippage on the notice period on the contract with external providers on the EMI strategy and Community Services work-streams of **£364k**.
- Funding the SLA with NHS Lothian to reflect the higher levels of activity and complexity relating to current referral patterns (**£750k**) – see paper on Lothian presented to committee.
- Increasing non-pay budgets within the Acute and Diagnostics Directorate to reflect the growth on activity over the past three years (**£380k**).

59. New funding received in-year has also been reviewed in assessing the commitment of resources for the rest of the financial year. The largest allocation received to-date relates to the New Medicines Fund (NMF) of **£2.9m**. It is anticipated that whilst a significant portion of this will be required to fund the increased levels of associated high-cost drugs, there may be some non-recurring benefit in-year to help off-set further cost pressures and slippage to CRES plans. This is currently being assessed.

60. A more detailed assessment of non-recurring opportunities will be undertaken later in the year as part of the Mid-year Reviews, when a further analysis of reserves and commitments will be completed to quantify any further benefit that may be utilised to help support the break-even position.

61. Whilst the Quarter One position reflects an overspend at operational budget level, driven by the pressures highlighted, the review of reserves flexibility, together with the actions from the CRES workshop will enable the Board to bridge the in-year gap and deliver a breakeven position for 2015/16.

62. As highlighted in the Quarter One Review, there does however, still remain some significant challenges to be resolved in ensuring the expected break-even year end position. In particular the following are the main issues as identified as part of the Quarter One Review process:-

- Delivery of CRES in-year.
- Reduction on Medical Locum expenditure, especially across Acute and Diagnostics Directorate.
- On-going pressures and increasing costs within Primary Care Prescribing.
- Achievement of Access Targets within Acute and Diagnostics, with on-going reliance on other providers, to help maintain the planned level of performance, given the current level of demand in the system.
- The increasing pressure on External SLAs for activity sent out-with the Health Board's boundaries, particularly to Lothian and the increasing incidence of external high cost drugs

## Key Financial Risks

63. Following on from the risks as identified as part of the Quarter one Review, the NHS Board is asked to note the following key financial risks as at the end of August;
- Continuing medical vacancies, combined with significant increased locum expenditure to cover. The expectation is that the Directorates will need to manage this pressure within the overall funding set aside at the start of the year;
  - Recurrent identification and achievement of CRES
  - Prescribing pressures (both volume and tariff related) as well as the gap on identified and evidenced CRES plans, (given the delay in up to date 15-16 costs and the assumed level of savings targeted towards this area);
  - Increasing levels of activity across Acute and Diagnostics, reflecting the pressure of achieving the Access Targets as well as genuine increases in activity across all areas.
64. The report includes the following appendices:
- i. Appendix 1 provides details of all revenue allocations received during the current month. 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 30<sup>th</sup> June 2015. 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 2015/16.
  - iv. Appendix 4 provides a summary of expenditure variances across the organisation by expenditure type. This provides a more detailed analysis of expenditure patterns per directorate.
  - v. Appendix 5 provides further detail behind the under and over-spends in nursing pay budgets.
  - vi. Appendix 6 provides details of expenditure on locum staff.

<b>NHS DUMFRIES AND GALLOWAY REVENUE RESOURCE ANALYSIS At 31st August 2015</b>					
	<b>Baseline Recurring £000s</b>	<b>Earmarked Recurring £000s</b>	<b>Non Recurring £000s</b>	<b>Non Core £000s</b>	<b>Total £000s</b>
<b>Revenue Allocation as at 31st July 2015</b>	267,344	30,523	(891)	4,400	301,377
<b>Bundles</b>					
<b>Other</b>					
AAA Screening Programmes in Scotland	42				42
Advocacy Additional Funding		15			15
NDC Topsliced Contributions		(348)			(348)
Prescribing for Excellence - Primary Care Fund		36			36
Prescribing for Excellence - Primary Care Fund			37		37
Carry Forward 2014-15			2,029		2,029
					0
<b>Non Core</b>					0
Total Allocations	42	(297)	2,066	0	1,811
<b>Revenue Allocation as at 31st August 2015</b>	<b>267,386</b>	<b>30,226</b>	<b>1,175</b>	<b>4,400</b>	<b>303,188</b>
Anticipated Allocations		(1,479)	1,128	1,861	1,510
<b>Total Revenue Allocation (excl FHS)</b>	<b>267,386</b>	<b>28,747</b>	<b>2,303</b>	<b>6,261</b>	<b>304,698</b>
Family Health Services Non Discretionary Allocation					15,546
<b>Total Revenue Allocation (incl FHS)</b>					<b>320,244</b>

**NHS DUMFRIES AND GALLOWAY  
EXPENDITURE ANALYSIS  
5 Months Ended 31st August 2015**

Annual Budget				Area	Pays Ytd			Non Pay Ytd			Income Ytd			Total Ytd			
Pay £000	Non Pay £000	Income £000	Total £000		Budget £000	Actual £000	Variance £000	Variance %									
<b>Operating Directorates</b>																	
62,663	22,259	(340)	84,582	Acute & Diagnostics Directorate	26,591	26,712	(122)	9,728	9,911	(183)	(189)	(180)	(8)	36,131	36,443	(313)	-1%
8,260	11,688	(1,491)	18,456	Facilities & Clinical Support	3,433	3,305	128	4,434	4,542	(108)	(562)	(511)	(52)	7,305	7,337	(32)	0%
19,422	1,760	(1,460)	19,722	Mental Health Directorate	8,121	7,921	200	830	810	21	(635)	(641)	6	8,315	8,089	226	3%
30,152	32,774	(1,290)	61,636	Primary & Community Care	12,651	12,426	225	13,597	13,956	(360)	(601)	(629)	28	25,646	25,753	(107)	0%
18,888	1,337	(829)	19,397	Womens & Childrens Directorate	7,844	7,706	138	612	720	(108)	(247)	(244)	(3)	8,208	8,181	27	0%
<b>139,385</b>	<b>69,818</b>	<b>(5,410)</b>	<b>203,793</b>		<b>58,639</b>	<b>58,070</b>	<b>569</b>	<b>29,201</b>	<b>29,939</b>	<b>(738)</b>	<b>(2,235)</b>	<b>(2,206)</b>	<b>(29)</b>	<b>85,605</b>	<b>85,803</b>	<b>(198)</b>	<b>0</b>
<b>0</b>	<b>(562)</b>	<b>0</b>	<b>(562)</b>	Op Services Remaining CRES	<b>0</b>	<b>0</b>	<b>0</b>	<b>(317)</b>	<b>0</b>	<b>(317)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(317)</b>	<b>0</b>	<b>(317)</b>	<b>100%</b>
<b>139,385</b>	<b>69,256</b>	<b>(5,410)</b>	<b>203,231</b>	<b>Sub Total - Operating Directorates</b>	<b>58,639</b>	<b>58,070</b>	<b>569</b>	<b>28,884</b>	<b>29,939</b>	<b>(1,055)</b>	<b>(2,235)</b>	<b>(2,206)</b>	<b>(29)</b>	<b>85,288</b>	<b>85,803</b>	<b>(515)</b>	<b>102%</b>
<b>Corporate Services</b>																	
562	424	0	986	Chief Executive	234	234	(0)	190	187	3	0	0	0	424	421	3	1%
2,023	178	(195)	2,007	Dir Nursing, Midwifery & Ahp's	853	834	19	75	64	11	(164)	(167)	2	763	731	32	4%
2,374	1,104	(120)	3,358	Finance Directorate	989	969	20	41	39	1	(42)	(46)	3	988	963	24	2%
7,558	6,016	(1,051)	12,523	Medical Director	3,100	3,052	47	2,283	2,257	26	(281)	(275)	(6)	5,101	5,035	67	1%
323	499	(232)	590	Non Recurring Projects	166	166	0	203	203	0	(232)	(232)	0	137	137	0	0%
2,822	337	(427)	2,732	Public Health	1,184	1,052	132	87	140	(53)	(180)	(180)	(0)	1,091	1,012	79	7%
763	1,068	(26)	1,804	Strategic Planning	281	264	17	498	498	1	(25)	(25)	0	754	736	18	2%
1,662	318	(285)	1,695	Workforce Directorate	686	680	6	132	110	22	(103)	(76)	(27)	715	714	2	0%
<b>18,087</b>	<b>9,944</b>	<b>(2,337)</b>	<b>25,694</b>	<b>Sub Total - Corporate Services</b>	<b>7,492</b>	<b>7,251</b>	<b>241</b>	<b>3,509</b>	<b>3,497</b>	<b>12</b>	<b>(1,028)</b>	<b>(1,000)</b>	<b>(28)</b>	<b>9,972</b>	<b>9,748</b>	<b>225</b>	<b>2%</b>
<b>Strategic</b>																	
0	0	(4,986)	(4,986)	Central Income	0	0	0	0	0	0	(2,078)	(2,045)	(33)	(2,078)	(2,045)	(33)	2%
0	35,482	(3,035)	32,447	External & Resource Transfer	0	0	0	13,064	13,106	(42)	(1,227)	(1,251)	24	11,837	11,855	(18)	0%
778	1,953	0	2,731	Minor Capital Projects	326	341	(15)	977	962	15	0	0	0	1,303	1,303	(0)	0%
385	40,405	(1,885)	38,905	Primary Care	160	161	(0)	16,682	16,698	(17)	(785)	(785)	(0)	16,057	16,074	(17)	0%
<b>1,163</b>	<b>77,839</b>	<b>(9,906)</b>	<b>69,096</b>	<b>Sub Total - Strategic</b>	<b>487</b>	<b>502</b>	<b>(15)</b>	<b>30,723</b>	<b>30,766</b>	<b>(43)</b>	<b>(4,090)</b>	<b>(4,081)</b>	<b>(9)</b>	<b>27,120</b>	<b>27,187</b>	<b>(68)</b>	<b>2%</b>
<b>0</b>	<b>6,261</b>	<b>0</b>	<b>6,261</b>	Non Core Expenditure	<b>0</b>	<b>0</b>	<b>0</b>	<b>1,905</b>	<b>1,905</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1,905</b>	<b>1,905</b>	<b>0</b>	<b>0%</b>
<b>158,635</b>	<b>163,300</b>	<b>(17,652)</b>	<b>304,282</b>	<b>Total Operating Budgets</b>	<b>66,617</b>	<b>65,823</b>	<b>795</b>	<b>65,021</b>	<b>66,108</b>	<b>(1,087)</b>	<b>(7,353)</b>	<b>(7,287)</b>	<b>(66)</b>	<b>124,285</b>	<b>124,643</b>	<b>(358)</b>	<b>106%</b>
<b>2,506</b>	<b>13,456</b>	<b>0</b>	<b>15,961</b>	Reserves	<b>0</b>	<b>0</b>	<b>0</b>	<b>0%</b>									
<b>161,141</b>	<b>176,755</b>	<b>(17,652)</b>	<b>320,244</b>	<b>Grand Total</b>	<b>66,617</b>	<b>65,823</b>	<b>795</b>	<b>65,021</b>	<b>66,108</b>	<b>(1,087)</b>	<b>(7,353)</b>	<b>(7,287)</b>	<b>(66)</b>	<b>124,285</b>	<b>124,643</b>	<b>(358)</b>	<b>106%</b>

Efficiency Delivery Plan 2015-16 Position at 31st August 2015										
Description	Original			Forecast Outturn Savings		CRES GAP		Delivered Savings 2015-16		
	Original £	Original Non £	Total Saving £	In Year 2015- £	Full Year £	In Year 2015- £	Recurring 2016- £	YTD plan £	YTD actual £	YTD Variance £
<b>Workstream</b>										
Acute Services Clinical Change	494,000	152,500	646,500	647,281	535,040	781	41,040	231,675	231,675	0
Community Services Clinical Change	1,409,480	300,000	1,709,480	1,510,249	1,210,249	-199,231	-199,231	372,700	289,685	-83,015
Corporate Services	280,114	535,846	815,960	748,960	244,853	-67,000	-171,107	247,075	228,740	-18,335
Estates & Facilities Review	50,000	220,000	270,000	270,000	70,000	0	0	41,665	41,665	0
Mental Health EMI Redesign	965,000	0	965,000	965,000	965,000	0	0	402,085	402,085	0
Prescribing	2,000,000	0	2,000,000	1,708,500	1,708,500	-291,500	-291,500	833,325	624,370	-208,955
Procurement Savings	414,040	17,500	431,540	421,540	421,540	-10,000	7,500	200,510	196,345	-4,165
Property Strategy	100,000	0	100,000	100,000	100,000	0	0	41,665	41,665	0
Unidentified CRES	961,520	-400,000	561,520	0	0	-561,520	-1,631,520	316,967	0	-316,967
<b>Corporate Total</b>	<b>6,674,154</b>	<b>825,846</b>	<b>7,500,000</b>	<b>6,371,530</b>	<b>5,255,182</b>	<b>-1,128,470</b>	<b>-2,244,818</b>	<b>2,687,667</b>	<b>2,056,230</b>	<b>-631,437</b>
<b>Total</b>	<b>6,674,154</b>	<b>825,846</b>	<b>7,500,000</b>	<b>6,371,530</b>	<b>5,255,182</b>	<b>-1,128,470</b>	<b>-2,244,818</b>	<b>2,687,667</b>	<b>2,056,230</b>	<b>-631,437</b>
Productivity Savings	460,000	0	460,000	460,000	460,000	0	0	191,665	191,665	0
<b>Combined Total</b>	<b>7,134,154</b>	<b>825,846</b>	<b>7,960,000</b>	<b>6,831,530</b>	<b>5,715,182</b>	<b>-1,128,470</b>	<b>-2,244,818</b>	<b>2,879,332</b>	<b>2,247,895</b>	<b>-631,437</b>

# NHS D&G: Subjective Report

		Year	2015	Variances - Year To Date Month:						August	
Account Type	Account Summary	Acute & Diagnostics Dir	Mental Health Directorate	Primary & Community Care	Womens & Childrens Directorate	Corporate Services	Strategic	Non Core Expenditure	Facilities & Clinical Support	Op Services Remaining Cres	Total
		Ytd Variance £000	Ytd Variance £000	Ytd Variance £000	Ytd Variance £000	Ytd Variance £000	Ytd Variance £000	Ytd Variance £000	Ytd Variance £000	Ytd Variance £000	Ytd Variance £000
Pay	Admin & Clerical	37	(0)	14	23	31	(14)		26		117
	Ahp	(20)	21	(7)	24	25			(5)		37
	Ancillary	1	(4)	46	8	2	(1)		110		162
	Health Science Services	49	37	17	(2)	(0)			(3)		100
	Med/Dental Support	(12)	0			15					3
	Medical & Dental	(241)	55	15	(62)	136	(3)				(99)
	Miscellaneous		4	(3)		(5)					(4)
	Nursing	64	86	144	146	40	2		0		481
	Senior Managers					(3)					(3)
<b>Pays</b>		<b>(122)</b>	<b>200</b>	<b>225</b>	<b>138</b>	<b>241</b>	<b>(15)</b>	<b>0</b>	<b>128</b>	<b>0</b>	<b>795</b>
Non Pay	Clinical	(42)	(2)	(44)	(34)	(23)	(0)		(41)		(186)
	Drugs	(25)	(7)	(24)	(6)	13	(0)		(0)		(50)
	Equipment & Service Contracts	(10)	2	(49)	3	16	(0)		90		52
	Excluded - CRES	0	(0)	12	(127)	(9)	0		(0)	(317)	(441)
	Externals	(3)	(7)	(22)	(0)	23	(42)				(52)
	Family Health Services			(384)		0	(22)				(405)
	General Services	(21)	2	(2)	(5)	(17)	(1)		16		(28)
	Hotel Services	(7)	1	(24)	0	(13)	(1)		(127)		(170)
	Other	(19)	35	159	15	9	21		(45)		175
	Property	(6)	(1)	(17)	(3)	(24)	4	0	0		(46)
	Publicity & Advertising	7	(2)	(5)	0	7	(1)		1		7
	Travel/ Training/ Recruitment	(57)	(1)	39	48	30	(2)		(2)		56
<b>Non Pay</b>		<b>(183)</b>	<b>21</b>	<b>(360)</b>	<b>(108)</b>	<b>12</b>	<b>(43)</b>	<b>0</b>	<b>(108)</b>	<b>(317)</b>	<b>(1,087)</b>
Income	Fhs Income			3		(3)	(0)				1
	Hch Income	(10)	7	25	(1)	(9)	(8)		(3)		1
	Other Operating Income	1	(1)	(0)	(2)	(16)	(1)		(49)		(67)
<b>Income</b>		<b>(8)</b>	<b>6</b>	<b>28</b>	<b>(3)</b>	<b>(28)</b>	<b>(9)</b>	<b>0</b>	<b>(52)</b>	<b>0</b>	<b>(66)</b>
<b>TOTAL</b>		<b>(313)</b>	<b>226</b>	<b>(107)</b>	<b>27</b>	<b>225</b>	<b>(68)</b>	<b>0</b>	<b>(32)</b>	<b>(317)</b>	<b>(358)</b>

## Nursing: Variance Report

Aug 2015

4CCN - Level 4 Cost Centre Name	5CCN - Level 5 Cost Centre Name	Apr Variance £000	Jun YTD Variance £000	Jul YTD Variance £000	Aug YTD Variance £000	Aug YTD Variance %	Comments
<b>Acute &amp; Diagnostics Dir</b>		<b>1</b>	<b>10</b>	<b>22</b>	<b>64</b>	<b>0.57</b>	
Mental Health Directorate	Learning Disabilities Dir	19	42	38	81	9.87	Relates to Community Teams - recruitment underway.
	Mental Health Community	-13	8	29	28	2.44	Funding now allocated for CATS pilot team.
	Mental Health Inpatient	46	-32	18	-6	-0.24	Relates to Mid Park. Bank usage has started to drop significantly. CRES actioned Month 2 re Treastaigh. Offset by Glenkiln EMI staff costs.
	Mental Health Management	-3	17	5	-13	-5.76	
	Prison & Police Custody H/C	0	3	7	7	8.64	
	Psychology Directorate	-2	-6	-8	-10		
	Substance Misuse	-1	0	-1	-1	-0.14	
<b>Mental Health Directorate</b>		<b>46</b>	<b>33</b>	<b>87</b>	<b>86</b>	<b>1.63</b>	
Primary & Community Care	Pccd1 Regional Services	23	41	60	80	30.30	Underspend relates to STARS. Band 8a nurse vacancy filled by non nursing Council employee. Also nursing vacancies at Band 3 filled by council employees.
	Pccd2 A&E Locality	14	55	80	97	6.02	Underspend in Thomas Hope, Lochmaben, Moffat and Annan Hospitals due to efficient rostering in ward in line with activity levels. In additional vacancy due to 1 Band 7 working across both Moffat and Thomas Hope Hospitals.
	Pccd3 Nithsdale Locality	-8	-94	-73	-88	-8.21	Underspends in the following areas: £5k Locality Management, £1k Community Nursing, £23k Thornhill, £7k Managed Clinical Network. This offsets a £47k over spend in B2 nursing in GP OOH (Budget for Band 2 sits within Support Services) and £78k over spend in Allanbank staff costs.
	Pccd4 Stewartry Locality	0	9	9	8	0.81	Mainly under spend at Castle Douglas Hospital and District Nursing.
	Pccd5 Wigtownshire Locality	-12	26	44	47	2.05	Management and Admin £33k under spend due to Band 6 and 8a vacancy. £41k under spend in Community Nursing due to retirees end April recruitment underway - internal promotions from July. £6k under spend in Hospice at Home. £11k under spend at Newton Stewart Hospital. This offsets an over spend of £44k at Galloway Community Hospital due to ENP Nurse spend to assist covering medical staff.
<b>Primary &amp; Community Care</b>		<b>17</b>	<b>38</b>	<b>120</b>	<b>144</b>	<b>2.31</b>	
Womens & Childrens Directorate	W&C Cmhs	5	18	24	28	7.65	Band 7 vacancy - appointed to June (which as a result has now created a Band 6 vacancy). Band 6 Maternity Leave backfilled by Band 5.
	W&C Gynaecology	-3	0	0	0	0.67	
	W&C Learning Disability	9	19	21	24	7.10	Vacancies temporarily backfilled at a lower grade.
	W&C Management & Governance	4	13	17	-1	-0.77	Vacancy due to Band 7 postholder who retired March 15. Post now taken as CRES
	W&C Midwifery	-17	-20	-40	-46	-2.88	Cost pressure re midwifery protections.
	W&C Neonatal	4	12	18	26	6.82	Underspend due to efficient rostering on the ward in line with activity levels.
	W&C Public Health Nursing	13	48	59	76	7.11	Vacancies throughout region. Recruitment underway - interviews mid July. Some of the posts will be filled from September.
	W&C Sexual Health	-2	-5	-7	-9	-8.97	
	W&C Ward 15	8	25	38	48	8.20	Underspend due to efficient rostering on the ward in line with activity levels. Vacancies within Community Childrens Nursing - Service Review recently completed and recruitment underway - postholders due to start October
<b>Womens &amp; Childrens Directorate</b>		<b>22</b>	<b>109</b>	<b>130</b>	<b>146</b>	<b>3.16</b>	
Corporate Services	Dir Nursing, Midwifery & Ahp'S	-8	-6	-11	-2	-0.42	
	Medical Director	3	10	13	16	81.99	
	Non Recurring Projects	-5	0	0	0	0.07	
	Public Health	-1	8	7	20	8.19	Immunisation team - maternity leave not backfilled and another vacancy filled by ad hoc hours as and when required. Underspend within Wish Keep Well
	Workforce Directorate	1	3	4	5	2.62	
<b>Corporate Services</b>		<b>-11</b>	<b>15</b>	<b>13</b>	<b>40</b>	<b>4.40</b>	
<b>Strategic</b>		<b>0</b>	<b>1</b>	<b>1</b>	<b>2</b>	<b>1.16</b>	
<b>Facilities &amp; Clinical Support</b>		<b>-1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	
		<b>74</b>	<b>206</b>	<b>374</b>	<b>481</b>	<b>1.69</b>	

## NHS D&G: Locum Costs

### Actual Locum Costs: Internal & External

#### 2015-16

	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Directorate	Apr-15	May-15	Jun-15	Jul-15	Aug-15	YTD	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Total
Acute & Diagnostics	682	746	743	913	882	3,966								3,966
Mental Health	9	42	34	1	23	109								109
Primary & Community	175	158	121	290	105	849								849
Womens & Childrens	16	34	8	(1)	36	93								93
Other	27	34	28	38	31	158								158
<b>Total</b>	<b>909</b>	<b>1,014</b>	<b>934</b>	<b>1,241</b>	<b>1,077</b>	<b>5,175</b>	<b>0</b>	<b>5,175</b>						

#### 2014-15

	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Directorate	Apr-14	May-14	Jun-14	Jul-14	Aug-14	YTD	Sep-14	Oct-14	Nov-14	Dec-14	Jan-14	Feb-15	Mar-15	Total
Acute & Diagnostics	481	577	608	412	692	2,770	735	628	615	608	591	748	1,023	7,718
Mental Health	0	27	25	36	113	201	0	46	32	17	20	39	40	395
Primary & Community	132	184	141	167	196	820	181	175	193	215	177	148	178	2,087
Womens & Childrens	22	33	13	23	36	127	11	33	51	40	48	44	30	384
Other	24	35	30	26	27	142	30	53	63	46	82	30	67	513
<b>Total</b>	<b>659</b>	<b>856</b>	<b>817</b>	<b>664</b>	<b>1,064</b>	<b>4,060</b>	<b>957</b>	<b>935</b>	<b>954</b>	<b>926</b>	<b>918</b>	<b>1,009</b>	<b>1,338</b>	<b>11,097</b>
<b>Cumulative (Over) / Under</b>	<b>(250)</b>	<b>(158)</b>	<b>(117)</b>	<b>(577)</b>	<b>(13)</b>	<b>(1,115)</b>	<b>957</b>	<b>935</b>	<b>954</b>	<b>926</b>	<b>918</b>	<b>1,009</b>	<b>1,338</b>	<b>5,922</b>

### Locum Funding from Reserves

#### 2015-16

	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Directorate	Apr-15	May-15	Jun-15	Jul-15	Aug-15	YTD	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Total
Acute & Diagnostics	388	378	391	464	425	2,046	420	420	400	400	400	400	400	4,886
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Primary & Community	43	53	1	124	(40)	181	50	75	75	75	75	75	75	681
Womens & Childrens	10	10	0	0	15	35	10	10	10	10	10	10	10	105
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0
<b>Actual Ytd and Projection</b>	<b>441</b>	<b>441</b>	<b>392</b>	<b>588</b>	<b>400</b>	<b>2,262</b>	<b>480</b>	<b>505</b>	<b>485</b>	<b>485</b>	<b>485</b>	<b>485</b>	<b>485</b>	<b>5,672</b>

#### 2014-15 Locum Reserve Funding

**4,850**

#### 2014-15

	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Directorate	Apr-14	May-14	Jun-14	Jul-14	Aug-14	YTD	Sep-14	Oct-14	Nov-14	Dec-14	Jan-14	Feb-15	Mar-15	Total
Acute & Diagnostics	197	213	267	222	321	1,220	330	412	349	333	331	251	260	3,486
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Primary & Community	46	0	0	129	60	235	40	24	27	118	104	32	31	611
Womens & Childrens	0	0	0	57	27	84	0	18	42	33	31	35	0	243
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0
<b>Total</b>	<b>243</b>	<b>213</b>	<b>267</b>	<b>408</b>	<b>408</b>	<b>1,539</b>	<b>370</b>	<b>454</b>	<b>418</b>	<b>148</b>	<b>466</b>	<b>318</b>	<b>291</b>	<b>4,340</b>

**DUMFRIES and GALLOWAY NHS BOARD**5<sup>th</sup> October 2015**Performance Report**

**Author:**  
Chris Sanderson  
Efficiency & Productivity Manager

**Sponsoring Director:**  
Julie White  
Chief Operating Officer

**Date:** 21<sup>st</sup> September 2015

**RECOMMENDATION**

The Board is asked to discuss and note the contents of this report.

**CONTEXT****Strategy / Policy:**

*Waiting Times / Patient Access*

**Key messages:**

This report is split into three sections. Section 1 provides information on the level of clinical activity and access times achieved within services to 31/08/2015. Section 2 highlights data on efficiency of clinical services as measured against clinical efficiency targets. Finally, section 3 summarises a wider range of activity and provides data on bed occupancy throughout the system.

The month of August 2015 has seen in-patient TTG breaches and Outpatient 12 week breaches increase slightly due to pressures particularly within the Orthopaedics specialty. Diagnostic breaches improved as did 18 week Referral to Treatment Performance whilst cancer performance (both 31 and 62 day targets) remain above target. Emergency Department 4 hour performance continues to be strong at 97.9% in-month, almost reaching the stretch target of 98%.

**GLOSSARY OF TERMS**

HEAT	-	Health Improvement, Efficiency, Access and Treatment Quality and Patient Experience
ED	-	Emergency Department
BADS	-	British Association of Day Surgery
DNA	-	Did not attend
TTG	-	84 Day Treatment Time Guarantee

**NOT PROTECTIVELY MARKED**

**GLOSSARY OF TERMS Cont/...**

AMU	-	Acute Medical Unit
ISD	-	Information Services Division
QoF	-	Quality Outcome Framework
DGRI	-	Dumfries and Galloway Royal Infirmary
GCH	-	Galloway Community Hospital
LDP	-	Local Delivery Plan
LUCAP	-	Local Unscheduled Care Action Plan
INR	-	International Normalised Ratio
ENT	-	Ear Nose and Throat
PCCMB	-	Primary and Community Care Management Board
HMB	-	Hospital Management Board
STARS	-	Short Term Assessment and Reablement Service

**MONITORING FORM**

Policy / Strategy	<i>Waiting Times</i>
Staffing Implications	<i>Additional demand may impact on staffing levels, however this is managed within the operational teams.</i>
Financial Implications	<i>Discussed with Director of Finance and Chief Operating Officer</i>
Consultation / Consideration	<i>As above</i>
Risk Assessment	<i>Not applicable</i>
Sustainability	<i>A risk assessment has been undertaken with regards overdue return appointments. This was assessed initially as high but control measures are now in place and this currently remains assessed as medium.</i>
Compliance with Corporate Objectives	<p><i>Complies with</i></p> <ul style="list-style-type: none"> <li>• <i>to deliver excellent care that is person-centred, safe, effective, efficient and reliable.</i></li> <li>• <i>to reduce health inequalities across Dumfries and Galloway.</i></li> </ul>
Single Outcome Agreement (SOA)	<i>Not applicable</i>
Best Value	<p><i>Complies with key principles:</i></p> <ul style="list-style-type: none"> <li>• <i>Commitment and leadership</i></li> <li>• <i>Sound governance at a strategic, financial and operational level</i></li> <li>• <i>Sound management of resources</i></li> <li>• <i>Use of review and option appraisal</i></li> </ul>
Impact Assessment	<i>Not Required</i>

## At a Glance Performance Indicators

Note: The directional arrow is comparing performance in the last three months v the same three months, in the previous year

Indicator	Target	August 2015	Last 3 Months (Jun 15 - Aug 15)	Last 3 Months Last Year (Jun 14 - Aug 14)	Direction	15 Month Trend
TTG ( % waited under 12 weeks for Treatment )	100%	91.6%	94.5%	99.3%	▽	
Dr Led New Outpatients ( % waiting under 12 weeks at end of month )	95%	90.2%	91.3%	97.2%	▽	
Diagnostics ( % waiting under 6 weeks at end of month )	100%	99.6%	99.5%	99.8%	▽	
AHP MSK ( % waiting under 4 weeks at end of month )	90% (target starts April 2016)	87.4%	85.1%	34.9%	△	
Cancer ( Within 31 day target )	95%	97.9% (July 2015)	99.3% Average (May 15 - Jul 15)	99.4% Average (May 14 - Jul 14)	▽	
Cancer ( Within 62 day target )	95%	96.3% (July 2015)	97.5% Average (May 15 - Jul 15)	94.9% Average (May 14 - Jul 14)	△	
18 Weeks Performance	90%	89.9%	89.7% Average	93.1% Average	▽	
18 Weeks Linkage	90%	96.6%	96.0% Average	92.3% Average	△	
Emergency Department (% Within 4 Hour)	98%	97.9%	97.6%	97.1%	△	
Emergency Department (Absolute Attendances)	▽	4,120	12,069	12,445	▽	
Delayed Discharges (Bed Days Lost)	▽	598	1,778	2,867	▽	
Dr Led Return Tickets (Beyond Lastest Date at end of month)	▽	5,973	17,793	18,107	▽	

## 1. CURRENT POSITION AGAINST ACCESS TARGETS

Appendix 1 shows the status of patients treated in the month of August 2015 under the 84 day Treatment Time Guarantee (TTG). The appendix also shows waiting times for 'stage of treatment' targets at 31/08/2015 for out-patient appointments and key diagnostic tests which the Scottish Government continue to monitor us on.

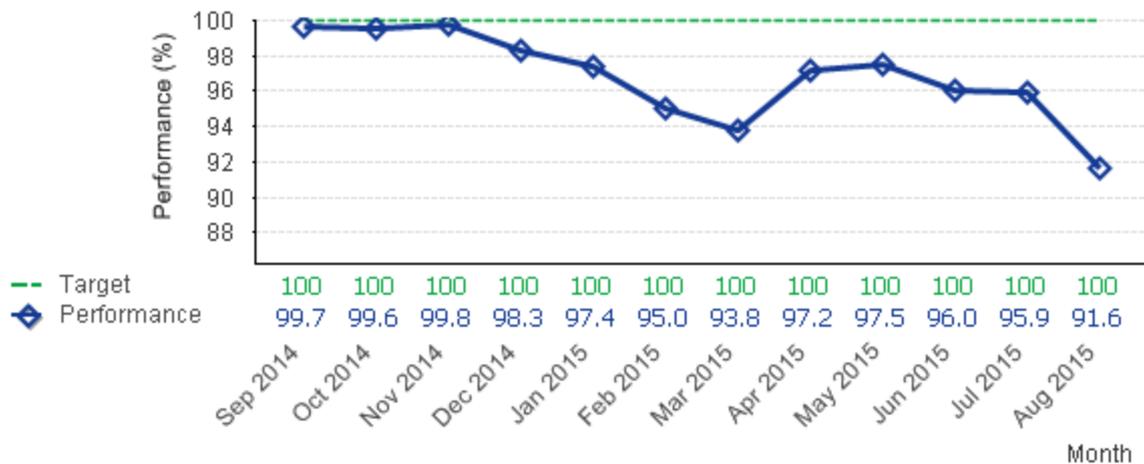
Please note that this data is provisional management information.

### In-patients/Day Cases

There were 955 in-patients / day cases in the month of August 2015 and of these, there were 80 TTG breaches (8.4%). The patients have been informed in writing. The 12 month rolling trend is shown in the table below.

#### Trend

TTG - Patients Treated Within 12 Weeks - Performance (%)  
Last 12 Months



There have now been a total of 528 TTG breaches since October 2012 when the legal guarantee came into place. During this time, a total of 29,464 patients have been treated, with TTG breaches representing 1.8% of this total.

	Apr 2014 - Aug 2014	Apr 2015 - Aug 2015
Inpatient/Daycases Treated Outwith Guarantee Date	67	197
Inpatient/Daycases Treated Within Guarantee Date	4645	4242

	Apr 2014 - Aug 2014	Apr 2015 - Aug 2015
TTG Under 12 Weeks (%)	98.6%	95.6%

TTG breaches in August were again predominantly in the Orthopaedic and Oral / Maxillofacial specialties. In the case of Orthopaedics, the specialty specific demand and capacity work around the Inpatient/Daycase figures to inform sustainable planning of the Orthopaedic service is progressing. Operationally we will have one further month of pressure before we should have rectified the breaching patients with

September hopefully seeing a vast improvement. The outlook is positive against predictions for September.

For Oral / Maxillofacial surgery as mentioned last month our single handed consultant has resigned from post and we are carrying out a fundamental review of what this service looks like for the future. In the short term have had success linking up with Greater Glasgow and Clyde for consultant cover at DGRI. This interim service is due to commence on the 17<sup>th</sup> of September with a weekly head and neck clinic. We plan to have weekend cover from two consultants providing clinics and theatre sessions on alternating weekends. Trauma cover will be provided by Greater Glasgow and Clyde on a 24/7 basis.

The directorate is still aiming towards an internal standard of 9 weeks to improve the achievement of the 12 week target. By booking to 9 weeks this will provide a 3 week window to address any unforeseen circumstances, the Government are aware of our current position and our recovery plan.

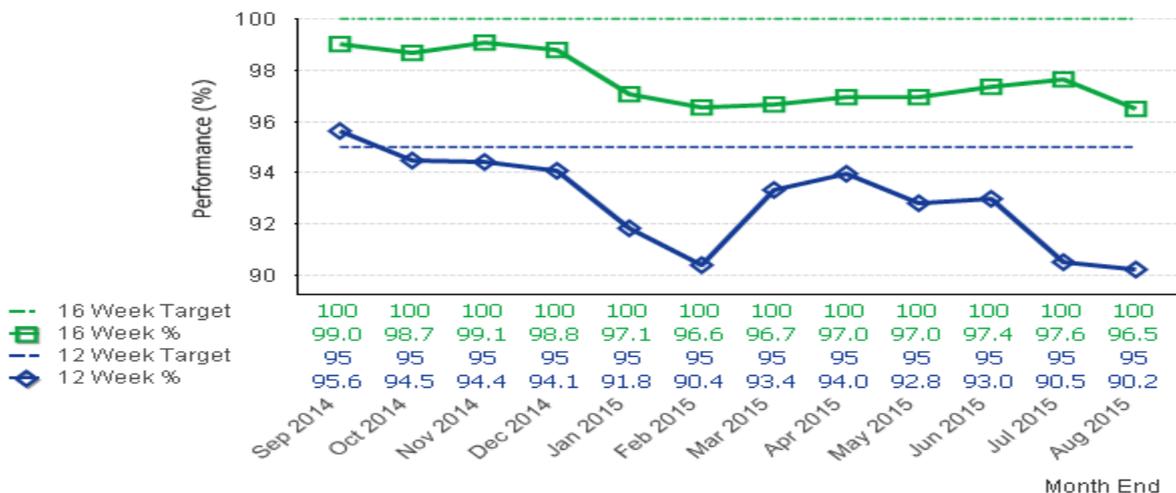
**Note:** Current Scottish Government guidelines mean that a TTG breach is recognised on the day that the patient is treated, beyond the 84 day guarantee period. As the Performance Report cycle has to cut off at every month end and report the position at the last day of each month a scenario can arise whereby the 84 day period can have elapsed but the patient has not received treatment until into the next reporting month. The reporting convention is therefore that patients who breach the TTG will be reported against the month in which they were actually treated.

**Out-patients**

At the end of month snapshot, there were 6,616 people waiting for a consultant-led new out-patient appointment. Of this total there were 646 breaches (9.8%) of the 12 week out-patient standard. It should be noted that July 2014 is the first month in which measurement of out-patient waiting times has changed to mirror that of in-patient waiting times, i.e., following the calculation rules described within the TTG regulations.

**Trend**

**New Outpatients (Consultant-Led) Performance Trend Last 12 Months**



## Analysis

The predominant specialties contributing to the outpatient breaches in August were again Orthopaedics and Neurology. Unfortunately we have as previously indicated had no success in recruiting to our vacancy for a Consultant Neurologist; however we have secured high quality locum cover in the short to midterm which will allow us to accommodate a large number of the patients waiting over 12 weeks and funding has been identified from national sources to support further cover.

Secondly, within Orthopaedics, we are progressing through an action plan with the senior management team to address capacity issues and anticipate numbers to drop significantly within the TTG side and then plan to focus on outpatients.

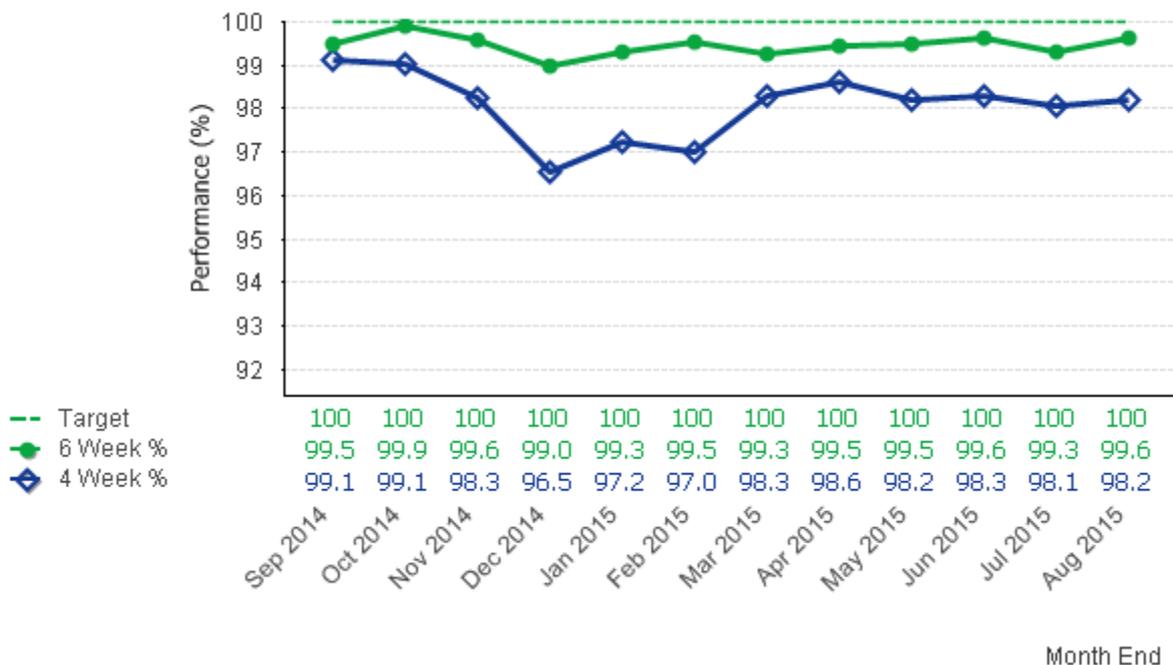
Within Ophthalmology, we had successful interviews for vacancies with new candidates appointed with a full team of consultants and middle grade staff expected by mid September 15.

## Diagnostics

At the month end snapshot, there were 1297 patients waiting to undergo key diagnostic tests. Of this total, there were 23 breach(es) of our internal 4 week treatment standard (1.8%). We operate and report to a 4 week standard for diagnostic tests, although the national target we are held accountable for is 6 weeks. Against the national 6 week target there was 5 breach(es) (0.4%).

### Trend

**Key Diagnostics - Patents waiting under 6 weeks - Performance (%)  
Last 12 Months**

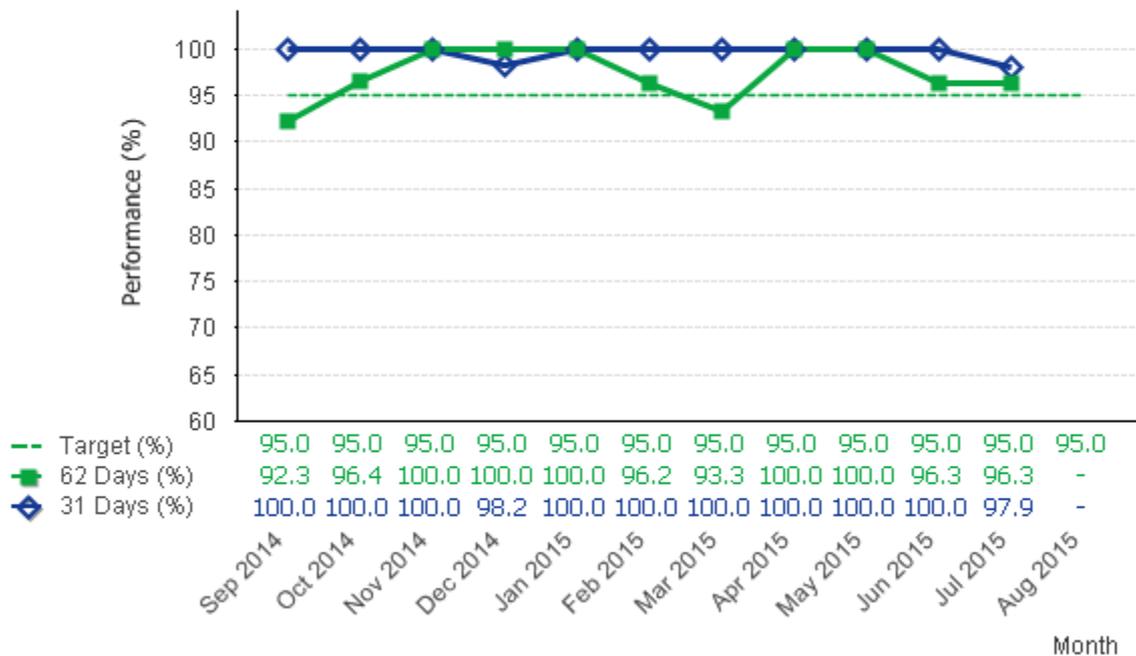


**Cancer Treatment**

**Monthly Trend – management information**

Most recent period of measurement	Waiting Time Standard	Target	Actual
July 2015 (Management Information)	31 days from decision to treat to first cancer treatment	95%	<b>97.9%</b>
	62 days from urgent referral with a suspicion of cancer to first cancer treatment	95%	<b>96.3%</b>

**Cancer Treatment (Management Information)  
Last 12 Months**

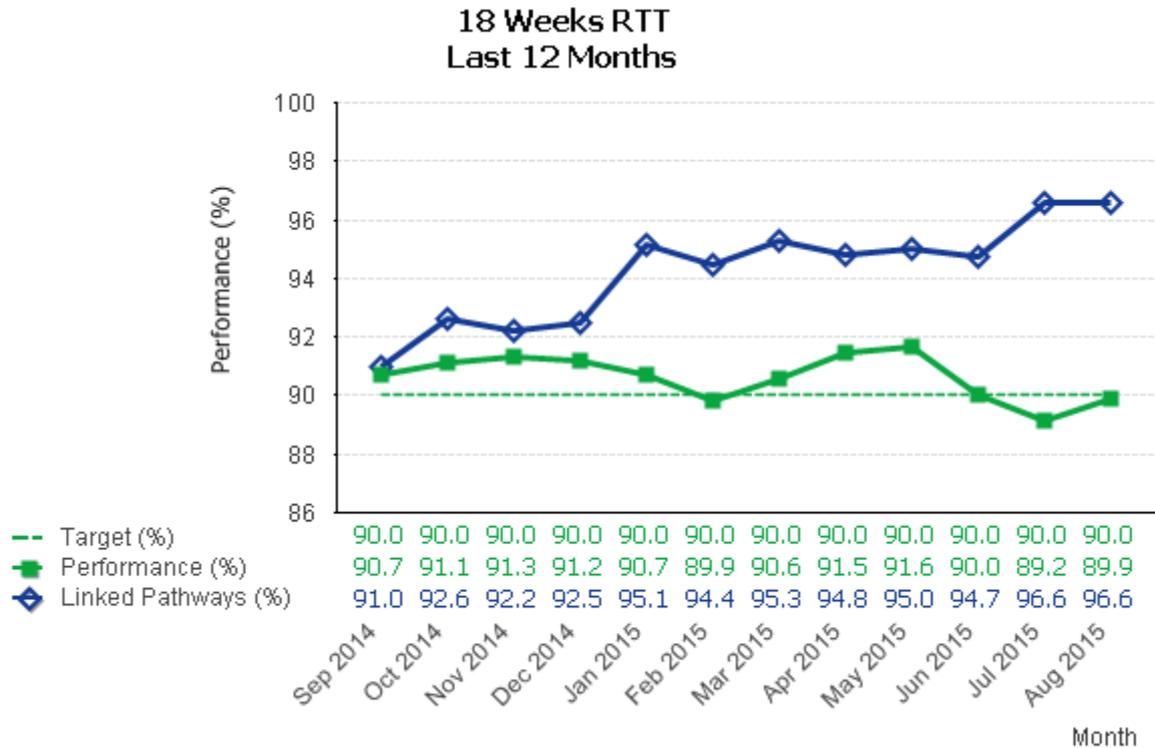


**Analysis**

Performance for the 31 day target has dropped slightly to 97.9% but remains above the 95% target. Performance for the 62 day target has remained at 96.3% for the second month in a row, again, above the 95% target.

**18 Week Referral to Treatment Standard**

Measure	Period	Target	Actual
Linked Pathways	August 2015	90%	96.6%
Performance	August 2015	90%	89.9%



**Analysis**

Since the beginning of the new calendar year we have seen a sustained improvement in our ability to link pathways at around 95% (in excess of the 90% target). This has now climbed to 96.6% for the last two months.

In terms of the overall 18 week performance for those linked pathways, the most recent month has seen an improvement in performance to 89.9% - just below the 90% target. As we improve our outpatient and inpatient positions we will continue to improve our performance and this will allow us to deliver closer to our internal target of getting to 95% performance.

**Note:** The 18 week standard is different to the Treatment Time Guarantee and also the out-patient and diagnostic ‘stage of treatment’ standards in that it is a measure of the whole pathway from referral up to the point the patient is treated. The target is 90% for both measures (90% for Performance and Linked Pathways).

‘Linked Pathways’ is a measure of the percentage of patient journeys for which we have data relating to the entire journey or pathway from referral to treatment.

‘Performance’ measures the percentage of complete journeys which have taken no more than 18 weeks to complete.

The “Unique Care Pathway Number” is a unique identifier allocated to new referrals to a consultant led service, to enable identification of patient pathways.

**Emergency Department (ED) Performance**

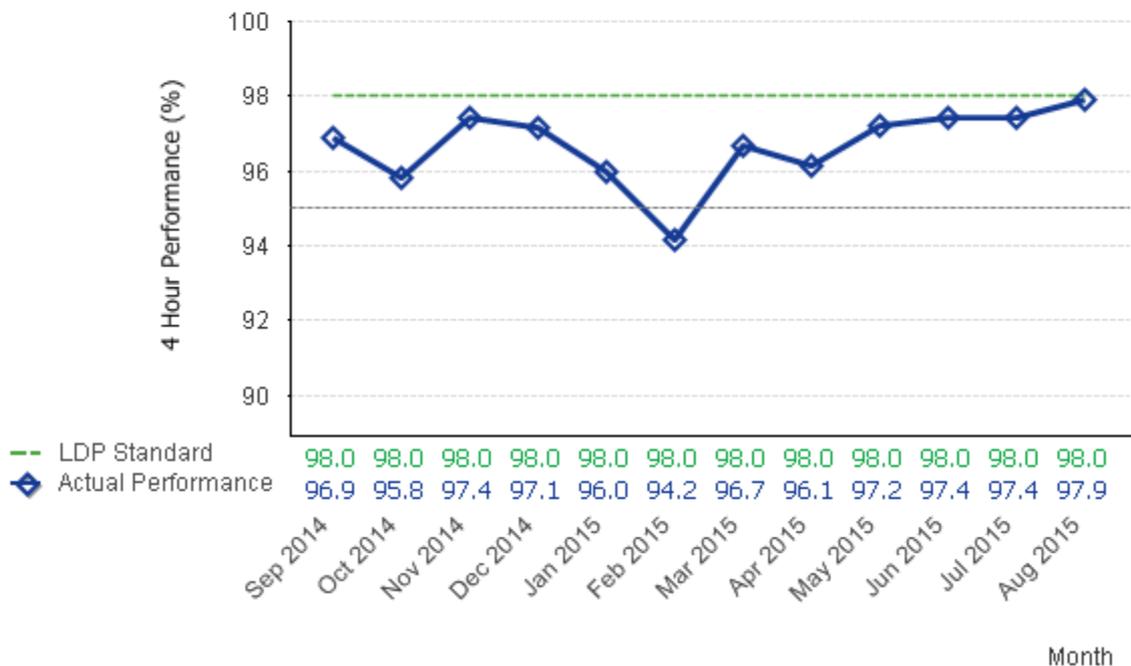
Indicator	Most recent period of measurement	Target	Actual
% of ED waits under 4 hours	August 2015	95%*	97.9%
Attendances per 100k population (rolling 12 month average)	August 2015	**	2,541

An interim ED 4 hour compliance HEAT target commenced in April 2013. The HEAT Standard of 98% remains in place.

\*\* The T10 HEAT Target ended in March 2014. The attendances per 100,000 population (rolling 12 month average) is shown as an internal performance measure only and is subject to review.

**ED 4 Hour Performance – Trend**

Emergency Department - Patients Seen Within 4 Hours - Performance (%) Last 12 Months

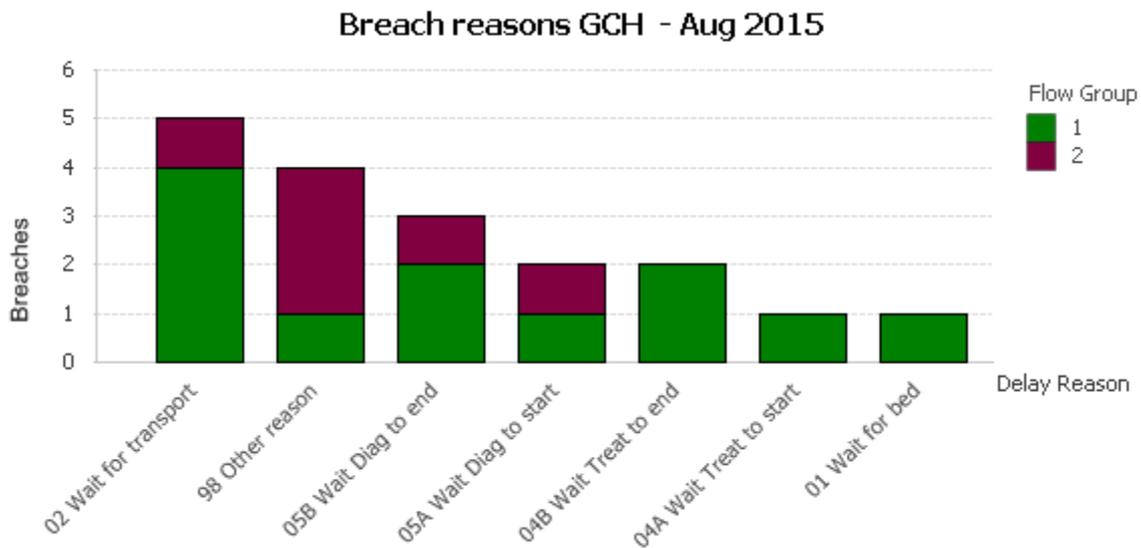
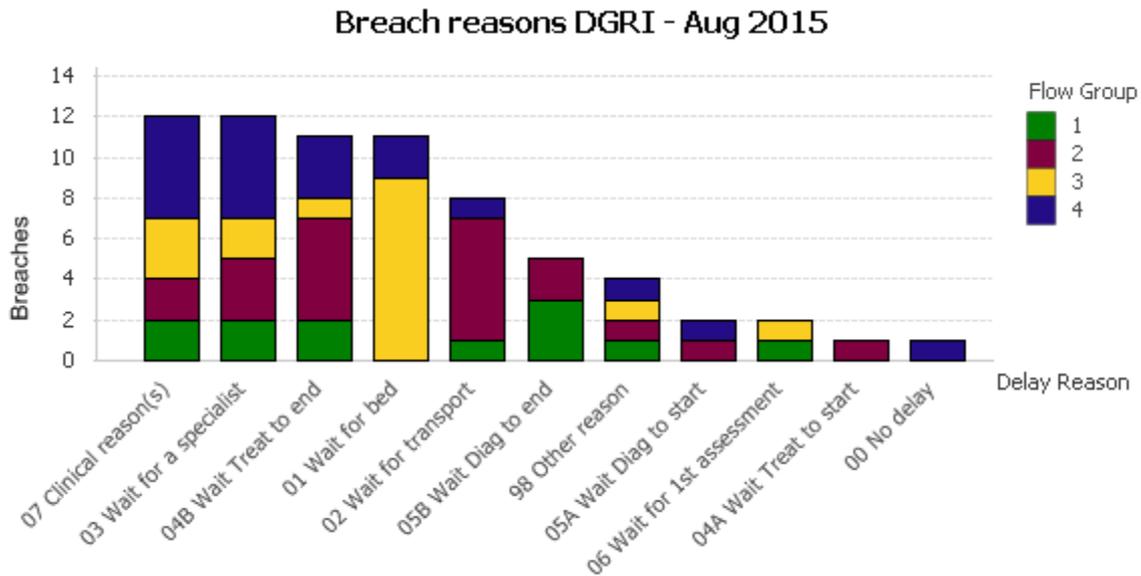


**ED 4 Hour Performance - Analysis**

In the last 12 months, the ED 4 hour performance has stabilised between the interim 95% performance target and the 98% performance standard (the average over the last 12 months is 96.7%). Our local Unscheduled Care Action Plan contains a number of measures aimed at pushing this on and stabilising performance to the 98% level.

### Breach Reasons

There were 87 four hour breaches in August 2015. Breach reasons are very different between DGRI and the Galloway Community Hospital and are shown in the tables below.



The four hour waiting times within the emergency department is seen as a measure of how well the system is working together to support provision of urgent care to people in times of crisis. Locally work towards delivering 98% against the four hour target is driven by the **Local Unscheduled Care Action Plan (LUCAP)**.

In May a new Unscheduled Care Collaborative was launched with a focus upon six essential actions to improve unscheduled care with the first learning session meeting the 13<sup>th</sup> May. The six essential actions include management of the following:

- Clinically focussed and empowered hospital management
- Hospital capacity and patient flow realignment
- Patient rather than bed management – operational performance
- Medical and Surgical Processes arranged to pull patients from the ED
- 7 day services
- Ensuring patients are cared for in their own homes

The Unscheduled Care Action plan will now begin to focus upon delivering these essential actions. From a DGRI perspective the following strands of this work are already in place

#### Clinically Focused and Empowered Hospital

- Triumvirate Management
- Clinical Leadership
- Escalation
- Safety Huddles

#### Hospital Capacity and Patient Flow

- Use of bed planning toolkit approaches linked to new DGH
- Workforce Capacity Toolkit

#### Patient rather than bed management

- Patient tracking through the system
- Admission prediction
- Ongoing work around balancing capacity and demand

#### Medical and Surgical Processes arranged to pull patients from ED

- Triage to appropriate assessment
- Good flow through ED

Our priorities for next year have been identified as follows:

#### Hospital Capacity and Patient Flow

Guided patient flow analysis: The initial analysis for the Scottish Patient Flow Programme commenced with the submission of a qualitative assessment submitted in June and then a series of data analyses. These will be discussed and ratified with relevant clinicians and managers prior to an assessment upon potential for improvement. It is anticipated that the complete analysis will take until the end of October. Thereafter areas of greatest potential improvement will be identified.

#### Patient rather than bed management

- Proactive Discharge Management. Work has commenced within an initial pilot ward to explore potential to improve multidisciplinary discharge planning.
- The Orthopaedic Quality Drive has provided focus and funding to test models of care to support the management of frail elderly patients following trauma – early indications suggest earlier discharge planning and a reduction in length of stay.

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Medical and Surgical Processes arranged to pull patients from the ED

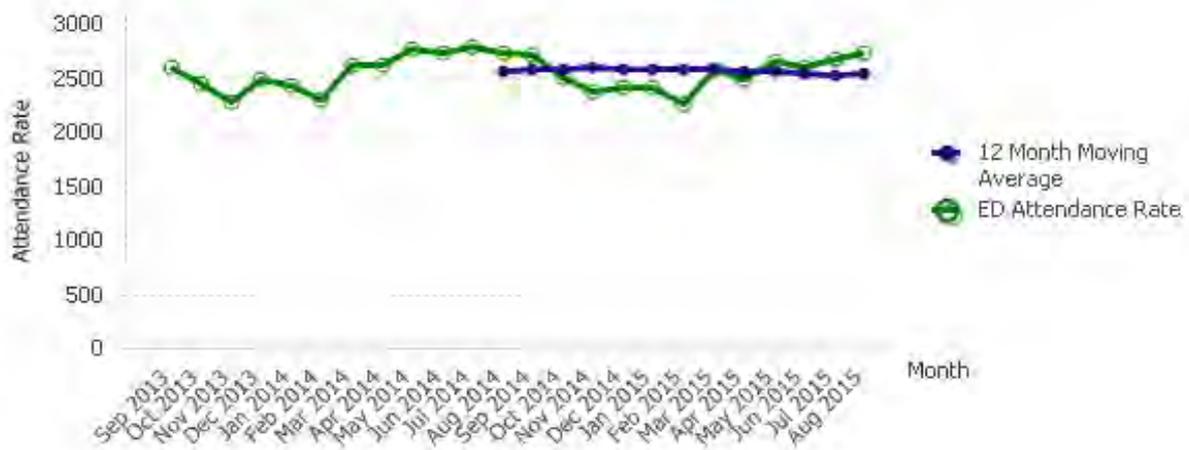
- Access to senior decision maker AMU/ CAU
- Access to assessment/ diagnostics

7 day services

- Smooth admission/ discharge profile – particular focus upon weekend discharge. Agreement has been reached to support the weekend discharge piloted last winter and so we are currently planning to have increased AHPs, Pharmacy and Social Work Care Co-ordinators in place at the weekend from the beginning of November.

**ED Attendances – Trend**

**Emergency Department Attendances per 100,000 Population  
12 month moving average**

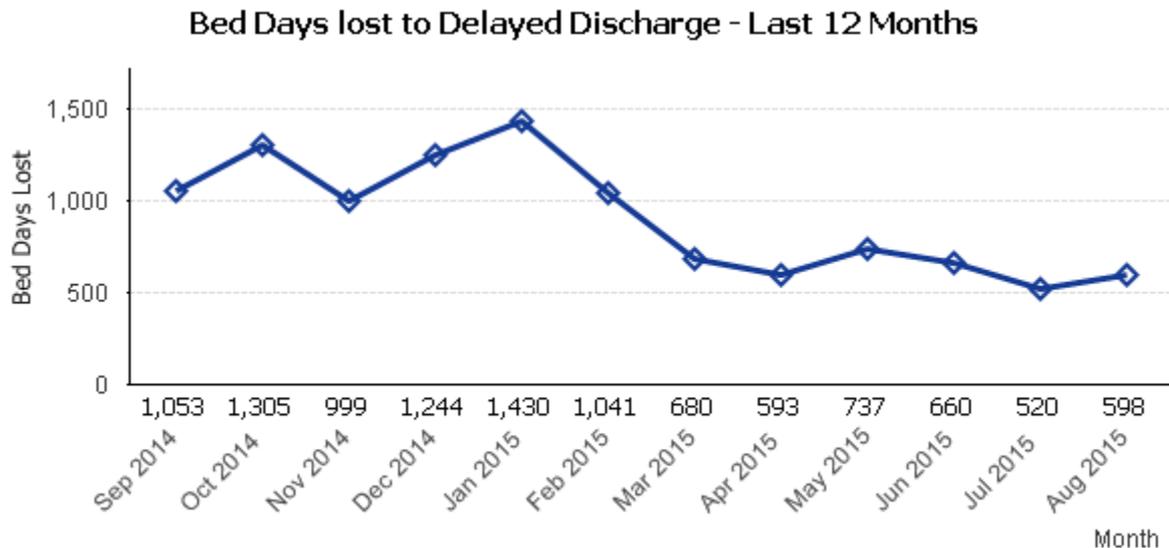


Month	ED Attendances	Population Base	ED Attendance Rate	12 Month Moving Average
Sep 2013	3,930	150,270	2,615	-
Oct 2013	3,687	150,270	2,454	-
Nov 2013	3,436	150,270	2,287	-
Dec 2013	3,750	150,270	2,496	-
Jan 2014	3,665	150,270	2,439	-
Feb 2014	3,460	150,270	2,303	-
Mar 2014	3,955	150,270	2,632	-
Apr 2014	3,951	150,141	2,632	-
May 2014	4,174	150,141	2,780	-
Jun 2014	4,124	150,141	2,747	-
Jul 2014	4,207	150,141	2,802	-
Aug 2014	4,114	150,141	2,740	2,577
Sep 2014	4,085	150,141	2,721	2,586
Oct 2014	3,766	150,141	2,508	2,590
Nov 2014	3,583	150,141	2,386	2,599
Dec 2014	3,632	150,141	2,419	2,592
Jan 2015	3,623	150,141	2,413	2,590
Feb 2015	3,396	150,141	2,262	2,587
Mar 2015	3,876	150,141	2,582	2,583
Apr 2015	3,742	150,141	2,492	2,571
May 2015	4,004	150,141	2,667	2,562
Jun 2015	3,926	150,141	2,615	2,551
Jul 2015	4,023	150,141	2,679	2,540
Aug 2015	4,120	150,141	2,744	2,541

**NOT PROTECTIVELY MARKED**

## Delayed Discharge Performance

The chart below shows delayed discharges over the last 12 months expressed as bed days lost.



In August, bed days lost to delayed discharge were 598. Delayed Discharges are discussed on a monthly basis at the Primary and Community Care Management Board chaired by the Chief Operating Officer and including all of the key stakeholders who influence delayed discharge performance. Priority actions include:

- Robust implementation of Choice guidance across the region.
- Weekly delayed discharge meetings with Senior Social Workers, Nurse Managers, Locality Managers to discuss individual delayed discharges.
- Work is being undertaken to improve flows within DGRI and out to Cottage Hospitals, for example, the review of the admission, transfer and discharge policy, tests of seven day discharge approaches, criteria led discharge.
- Patient Flow Co-ordinators are managing the flow of patients ensuring that each individual is on the correct pathway. They are currently undertaking some small tests of change in specific wards with DGRI.
- Transport Hub – the four week trial with Rural Transport Solutions, Scottish Ambulance Service and the Royal Voluntary Service is currently being evaluated.
- Capacity issues in relation to care packages are being escalated every Wednesday to Commissioning colleagues which also takes into account the positioning of the STARS re-ablement team

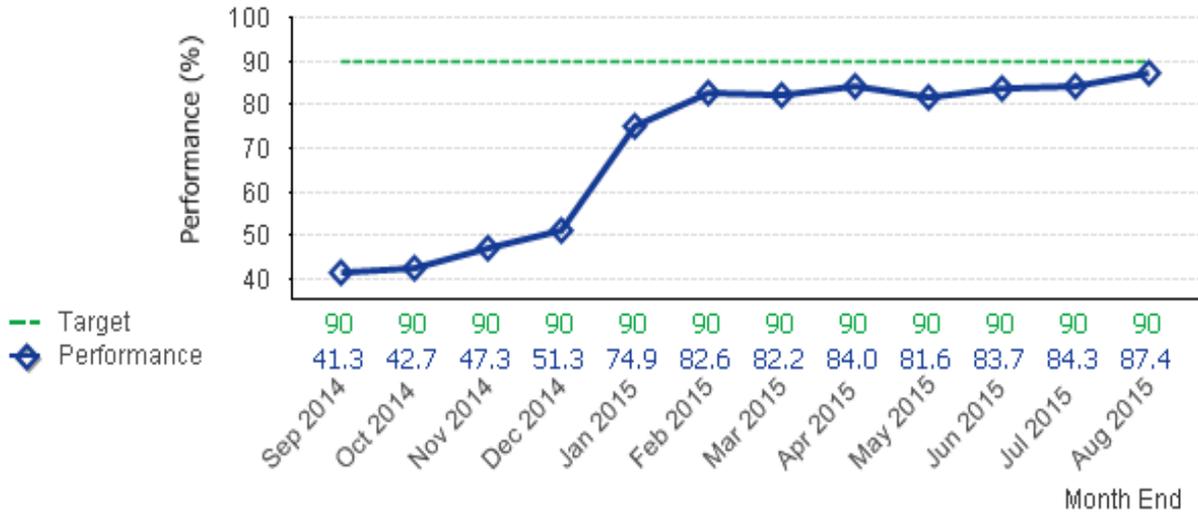
## Allied Health Professional Musculoskeletal Services (AHP MSK)

A target for Allied Health Professional Musculoskeletal Services has been set by the Scottish Government, 'From 1st April 2016, the maximum wait for AHP MSK Services from referral to first clinical out-patient appointment will be 4 weeks'.

**NOT PROTECTIVELY MARKED**

The target will be attained when no more than 10% of AHP MSK referrals are waiting more than 4 weeks for their appointment at the month end census point.

**AHP MSK - Patients waiting under 4 weeks - Performance (%)  
Last 12 Months**



**Patient Access – Use of Patient Unavailability Code**

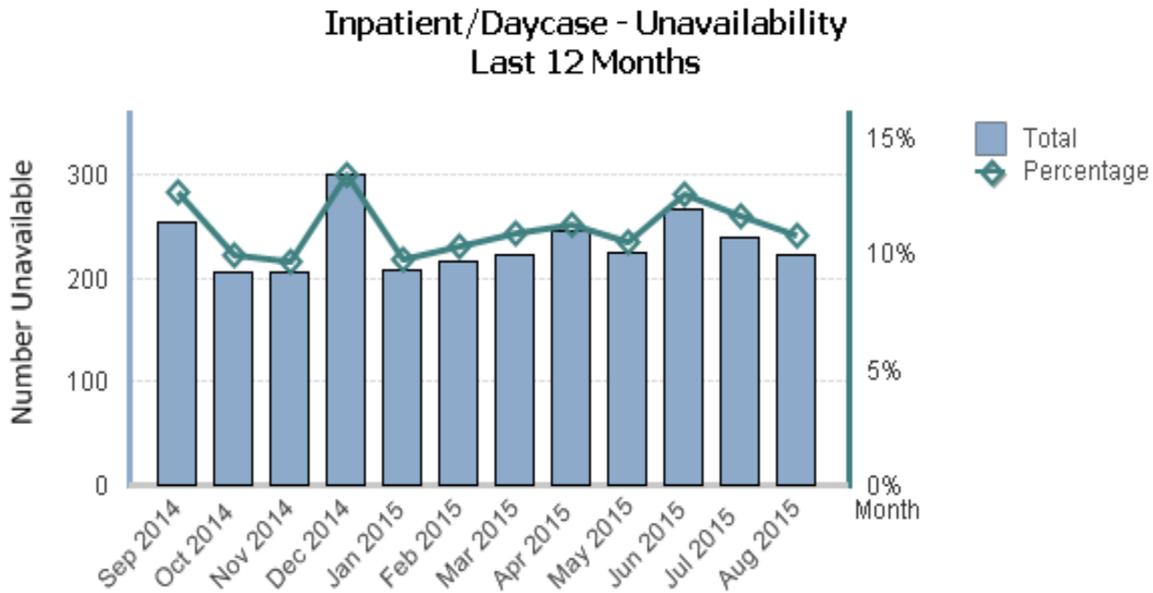
As part of our commitment to meeting the recommendations of the recent internal audit into management of waiting times, we are developing a suite of indicators to allow executive and non-executive directors to challenge board performance.

The range of information is now quite extensive, however within this report we have focused on the high level trend data. We intend to bring a separate paper on a regular basis to Board / Board Performance Committee which will cover this area in more depth.

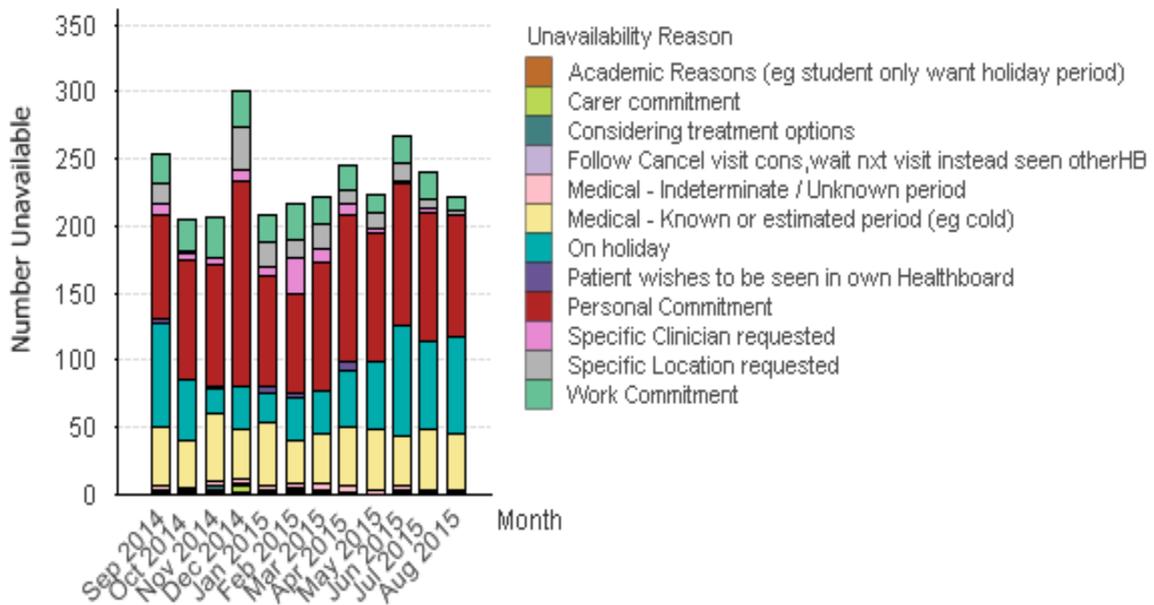
The following charts show the extent to which patient unavailability is being recorded within inpatients, diagnostics (scopes) and outpatients and includes a breakdown of the reasons for unavailability.

Percentage unavailable in all specialties - 12 months to August 2015

Inpatient/Daycases

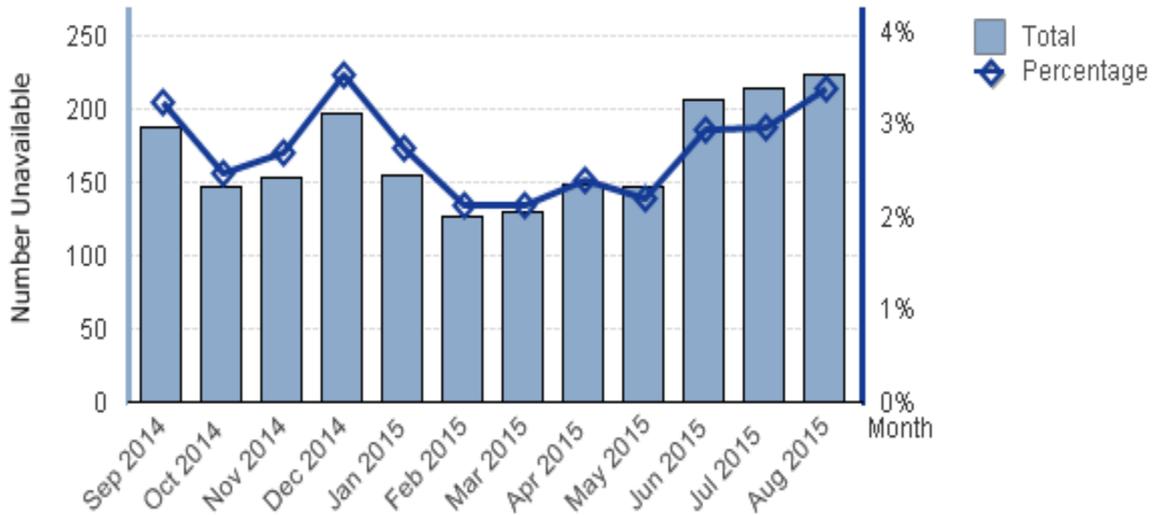


### Inpatient/Daycases - Reason for Unavailability

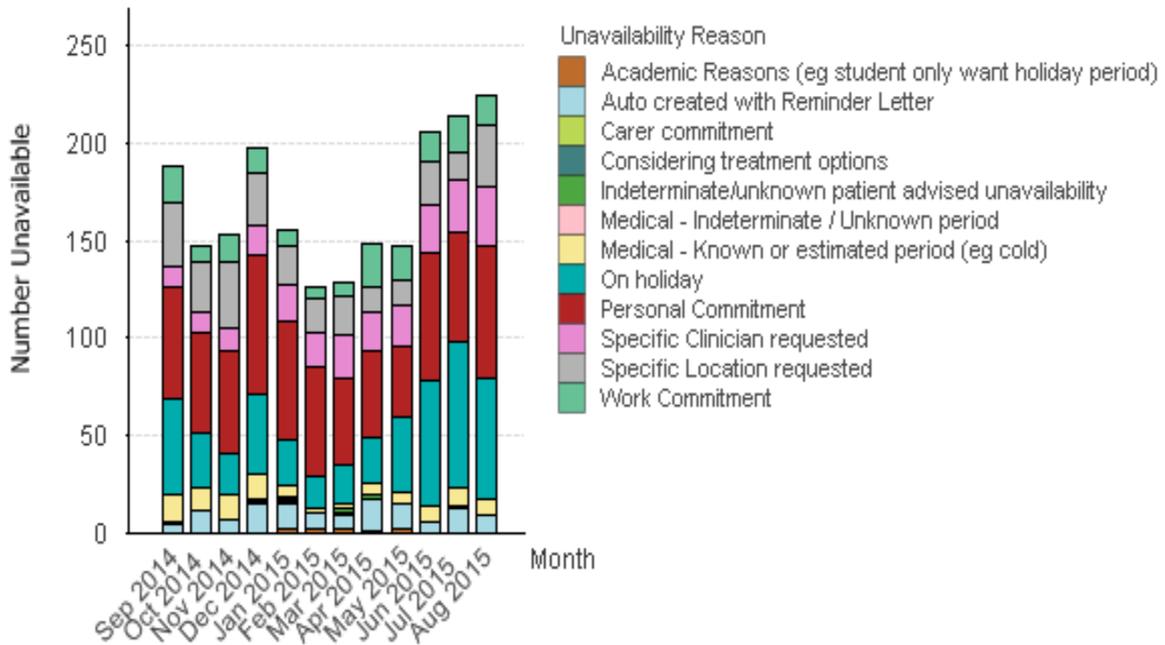


**New Outpatients (Consultant-Led)**

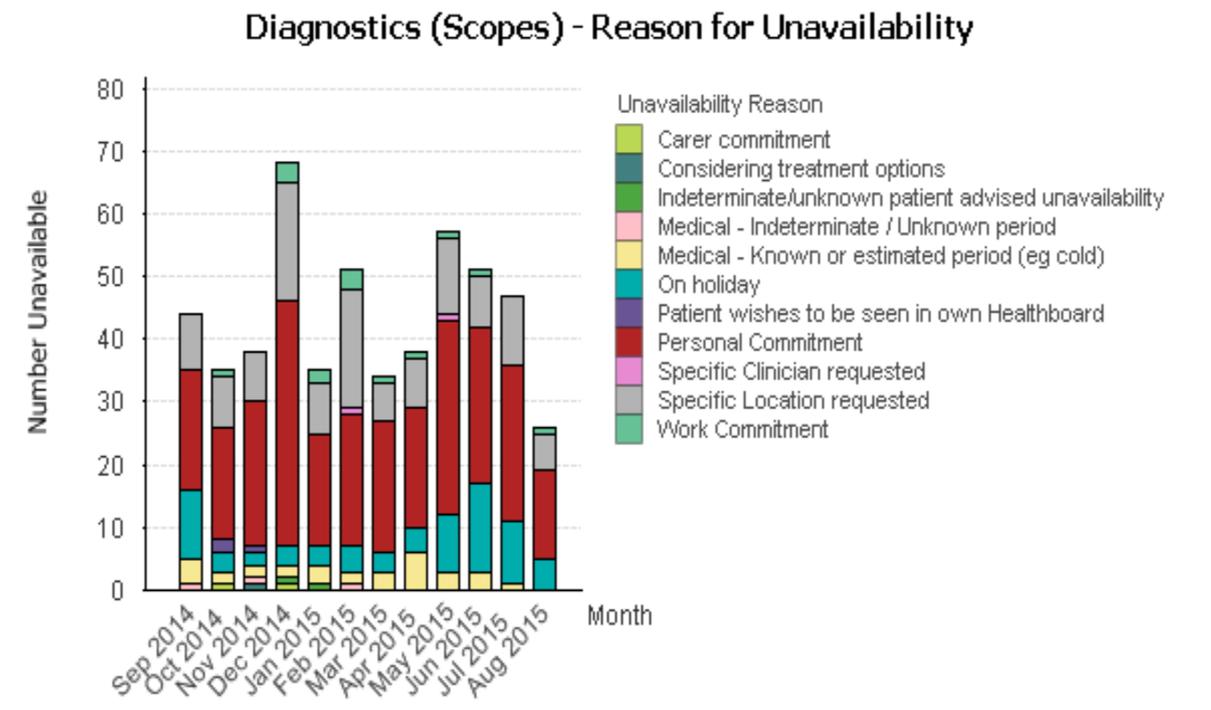
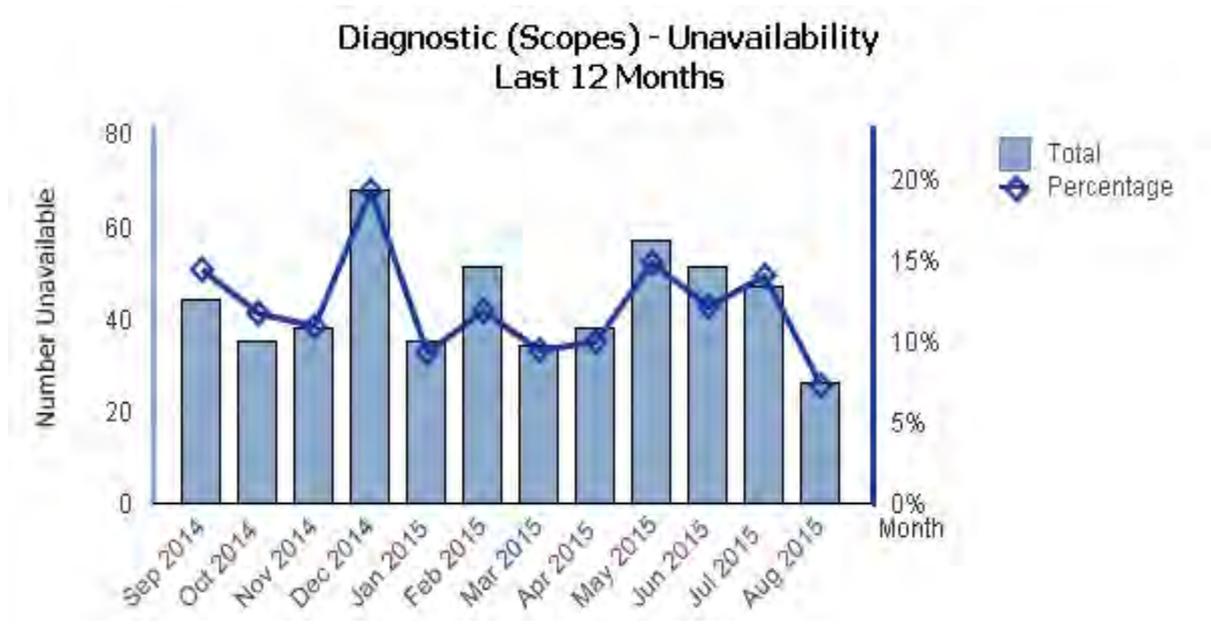
**New Outpatient (Consultant-Led) - Unavailability  
Last 12 Months**



**New Outpatient (Consultant-Led) - Reason for Unavailability**



**Diagnostics (Scopes)**



## 2. CURRENT PERFORMANCE AGAINST CLINICAL EFFICIENCY TARGETS

The table below shows the current performance against our internal clinical efficiency targets.

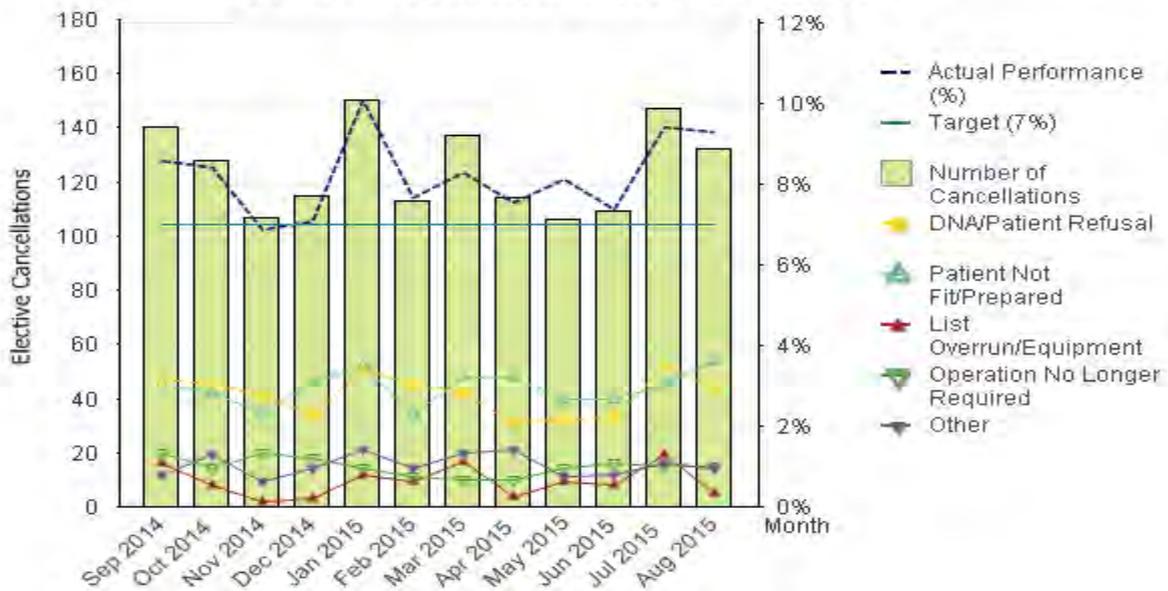
Efficiency Targets		Internal Target	Actual Performance (August 2015)	RAG Status
Day Case rates (BADS procedures)		81.5%	91.8%	Green
Non elective In-patients Average Length of Stay (days)		8.0	7.2	Green
Review per new out-patient attendance (ratio)		1.9	2.2 (year to date)	Amber
Out-patient DNA rates	New	4.8%	6.5% (year to date)	Amber
	Return	TBC	6.4% (year to date)	TBC
Pre-operative Length of Stay (days)		0.58	0.2	Green
Elective Operations cancelled by Theatre		7%	9.3%	Red
No of Sleepers		TBC	224	TBC

- ALOS based on all non routine episodes and not completed hospital stays
- Pre-operative LOS is for elective surgical procedures.
- Cancelled Operations on Mon-Fri scheduled morning / afternoon sessions

### Elective Cancellations

There were 132 elective cancellations in the month of August 2015. This represented 9.3% of the planned elective programme in month. The following chart shows the trend over the last 12 months.

**Elective Cancellations Trend - Last 12 Months**



Month	Actual Performance (%)	Target (7%)	DNA/Patient Refusal	Patient Not Fit/Prepared	List Overrun/Equipment Not Ready	Operation No Longer Required	Other	Number of Cancellations
Sep 2014	8.6%	7.0%	47	45	16	20	12	140
Oct 2014	8.4%	7.0%	45	42	8	14	19	128
Nov 2014	6.9%	7.0%	41	35	2	20	9	107
Dec 2014	7.1%	7.0%	34	46	3	18	14	115
Jan 2015	10.1%	7.0%	51	52	12	14	21	150
Feb 2015	7.7%	7.0%	45	34	9	11	14	113
Mar 2015	8.3%	7.0%	42	48	17	10	20	137
Apr 2015	7.5%	7.0%	31	48	4	10	21	114
May 2015	8.1%	7.0%	32	40	9	14	11	106
Jun 2015	7.4%	7.0%	33	40	8	16	12	109
Jul 2015	9.4%	7.0%	52	45	19	15	16	147
Aug 2015	9.3%	7.0%	44	54	5	15	14	132

The data continues to be shared at the Theatre Users Group where the agenda has been focussed on theatre efficiency with a particular emphasis on turnaround times between patients which will help to reduce the number of cancellations. The patient access team are also currently working with the day surgery team on how to reduce the DNAs and the patient refusal.

Recent benchmarking data shows that NHS Dumfries & Galloway was placed 4<sup>th</sup> best amongst the Scottish Boards in terms of percentage of elective cancellations. Performance ranged from 4.9% to 20.2% so our current performance would indicate that we are not an outlier; however the local team are not complacent and recognise that there is significant room for improvement.

### 3. ACTIVITY

The activity tables below show year to date activity levels to the month of August 2015 v the same time period in previous fiscal year across a range of measures.

**Activity**

Activity Type	Apr 2014 - Aug 2014	Apr 2015 - Aug 2015	% Change	Source
Emergency Department Attendances (Planned)	803	759	-5.5%	EDIS/TED
Emergency Department Attendances (Unscheduled)	20570	19814	-3.7%	EDIS/TED
Non-Elective Admissions (excluding Mental Health & Obstetrics)	7317	7656	4.6%	Topas
Elective Daycases (excluding Mental Health & Obstetrics)	5854	6028	3.0%	Topas
Elective Inpatients (excluding Mental Health & Obstetrics)	1786	1500	-16.0%	Topas
Births	544	570	4.8%	Scottish Birth Record
Obstetric Admissions	672	734	9.2%	Topas
New Outpatient (Dr-Led) All Booked Slots	17784	18477	3.9%	Topas
New Outpatient (Dr-Led) DNAs	1129	1210	7.2%	Topas
Return Outpatient (Dr-Led) All Booked Slots	39174	40880	4.4%	Topas
Return Outpatient (Dr-Led) DNAs	2647	2597	-1.9%	Topas
Radiology (GP referral based activity)	7605	7756	2.0%	RIS
Mental Health Admissions	593	624	5.2%	Topas

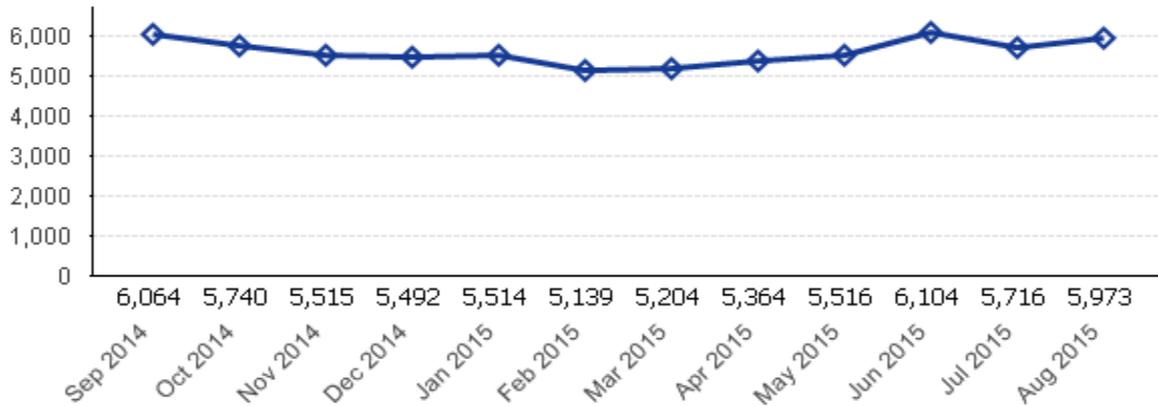
**Occupied Beds**

Ward Set Description	Apr 2014 - Aug 2014	Apr 2015 - Aug 2015	% Change	Source
Community	16371	15988	-2%	Topas
DGRI Day Surgery	1186	1440	21%	Topas
DGRI Main Wards (not 17)	37602	38300	2%	Topas
External eg GJ, Carrick Glen	525	699	33%	Topas
Galloway	5532	4910	-11%	Topas
Maternity	1721	1982	15%	Topas
Mental Health	11981	10665	-11%	Topas

**Return Out-patient Appointments**

At the end of August 2015, there were 7490 patients waiting to come in for a Doctor-led return out-patient appointment, of which 1517 were in the 'Before Latest Date' category. Appendix 2 contains a chart showing a full specialty breakdown for the month of August 2015. The following chart and table shows the trend in the last 12 months.

**Return Outpatient Open Tickets (Consultant-Led) - (Beyond Latest Date)  
Number waiting at Month End Snapshot  
Last 12 months**



Month	0-6 Weeks Beyond Latest Date	6-9 Weeks Beyond Latest Date	9-12 Weeks Beyond Latest Date	12+ Weeks Beyond Latest Date	Total Beyond Latest Date
Sep 2014	2,405	710	592	2,357	6,064
Oct 2014	2,109	720	617	2,294	5,740
Nov 2014	2,052	675	531	2,257	5,515
Dec 2014	2,106	653	538	2,195	5,492
Jan 2015	2,089	604	516	2,305	5,514
Feb 2015	1,867	604	432	2,236	5,139
Mar 2015	2,026	495	468	2,215	5,204
Apr 2015	2,149	591	362	2,262	5,364
May 2015	2,211	641	452	2,212	5,516
Jun 2015	2,532	706	532	2,334	6,104
Jul 2015	2,240	727	513	2,236	5,716
Aug 2015	2,474	725	545	2,229	5,973

**Note:** Patients are given a 'ticket' for their return appointment with a target date. The appointment itself should be in a window within a tolerance of 5% before the target date (the earliest date) and 15% after the target date (the latest date). The term 'before latest date' is a reference to the latest date of the window as previously described. 0-6 weeks and beyond refer to those waiting in excess of the latest date of the tolerance window.

We are currently progressing a trial of virtual clinics. This is being rolled out across all specialities to allow clinicians a better overall view of the requirement for patients to attend a return outpatient appointment. Also referral pathways and management of test results are being looked at as further options

The top three impacting specialties in terms of +12 week waits beyond the tolerance window are Ophthalmology, Urology and Cardiology. The following actions are being taken to reduce these backlogs:

### Ophthalmology

We had successful interviews in Ophthalmology with new candidates being appointed to commence mid September. Once the new consultants come into post we plan to look at a redesign of the service starting with highest volume conditions.

**NOT PROTECTIVELY MARKED**

## **Urology**

A combination of a new Clinical Nurse Specialist who start the on 1st July and a new middle grade doctor who will take in a broader scope of work is allowing us the opportunity to refine roles and responsibilities and we plan to subcategorise return patients in order to inform pathway discussions.

## **Cardiology**

The Cardiology service has had a reduction in its consultant capacity with one consultant away on training and this has been further impacted upon by annual leave. The service has been highly dependant upon locums however we are currently out to advert for substantive consultant positions and have a promising level of interest.

## **4. Conclusions**

The month of August 2015 has seen in-patient TTG breaches and Outpatient 12 week breaches increase slightly due to pressures particularly within the Orthopaedics specialty. Diagnostic breaches improved as did 18 week Referral to Treatment Performance whilst cancer performance (both 31 and 62 day targets) remain above target. Emergency Department 4 hour performance continues to be strong at 97.9% in-month, almost reaching the stretch target of 98%.

## APPENDIX 1 – WAITING TIMES POSITION AT END August 2015

### In-patients / Day Cases treated - in month calculation

Specialty	0-6 Weeks	6-9 Weeks	9-12 Weeks	12+ Weeks	Total
Orthopaedics	19	51	61	52	183
Oral - MaxFac	49	15	61	20	145
Ophthalmology	84	38	73	5	200
Ear Nose & Throat	13	12	17	1	43
Urology	17	12	38	1	68
General Surgery	51	34	71	1	157
General Medicine	0	1	1	0	2
Gastro-Enterology	1	0	0	0	1
Palliative Medicine	1	0	0	0	1
Haematology	2	0	0	0	2
Vascular Surgery	4	1	6	0	11
Anaesthetics	6	2	12	0	20
Community Dental	7	7	8	0	22
Medical Paediatrics	9	1	0	0	10
Respiratory Medicine	11	0	0	0	11
Cardiology	17	0	0	0	17
Gynaecology	33	17	12	0	62
<b>Total</b>	<b>324</b>	<b>191</b>	<b>360</b>	<b>80</b>	<b>955</b>

### Diagnostics waiting list analysis – at month end

#### Internal 4 Week Target

Description	0-4 Weeks	4+ Weeks	Total
Magnetic Resonance Imaging	236	17	253
Cystoscopy	97	3	100
Endoscopy	131	2	133
Computer Tomography	225	1	226
Flexible Sigmoidoscopy	21	0	21
Colonoscopy	102	0	102
Non-obstetric Ultrasound	462	0	462
<b>Total</b>	<b>1274</b>	<b>23</b>	<b>1297</b>

#### National 6 Week Target

Description	0-6 Weeks	6+ Weeks	Total
Magnetic Resonance Imaging	250	3	253
Endoscopy	132	1	133
Cystoscopy	99	1	100
Flexible Sigmoidoscopy	21	0	21
Colonoscopy	102	0	102
Non-obstetric Ultrasound	462	0	462
Computer Tomography	226	0	226
<b>Total</b>	<b>1292</b>	<b>5</b>	<b>1297</b>

### New Outpatient (Consultant-Led) waiting list analysis – at month end

Specialty	0-6 Weeks	6-9 Weeks	9-12 Weeks	12+ Weeks	Total
Orthopaedics	666	239	234	241	1380
Neurology	108	39	33	128	308
Rheumatology	103	51	44	90	288
Ophthalmology	347	109	55	40	551
Dermatology	334	137	131	31	633
Gastro-Enterology	117	43	53	27	240
Diabetes	33	5	4	19	61
Cardiology	196	79	75	19	369
Medical Paediatrics	118	27	9	18	172
Orthodontics	52	25	27	11	115
Endocrinology	41	15	6	5	67
Gynaecology	253	56	30	5	344
Ear Nose & Throat	349	102	40	3	494
Anaesthetics	107	32	27	2	168
Oral - MaxFac	240	84	25	2	351
Palliative Medicine	4	2	2	1	9
Clinical Oncology	9	1	0	1	11
Vascular Surgery	46	12	1	1	60
Urology	143	67	15	1	226
General Surgery	413	77	39	1	530
Rehabilitation Medicine	2	3	0	0	5
Communicable Diseases	8	0	0	0	8
Clinical Chemistry	9	1	0	0	10
Nephrology	20	7	2	0	29
Endocrinology & Diabetes	22	2	0	0	24
Haematology	23	3	0	0	26
General Medicine	33	5	2	0	40
Geriatric medicine	36	8	2	0	46
Respiratory Medicine	47	4	0	0	51
<b>Total</b>	<b>3879</b>	<b>1235</b>	<b>856</b>	<b>646</b>	<b>6616</b>

## APPENDIX 2 - Out-patient Return Appointments (Dr. Led) waiting list

Based on August 2015 month end 'snapshot'

Specialty	Before Latest Date	0-6 Weeks Beyond Latest Date	6-9 Weeks Beyond Latest Date	9-12 Weeks Beyond Latest Date	12+ Weeks Beyond Latest Date	Total Beyond Latest Date
Ophthalmology	197	677	165	120	658	1,620
Urology	147	226	136	109	104	575
Cardiology	207	235	48	30	190	503
Gastro-Enterology	63	104	35	31	206	376
Orthodontics	20	106	43	30	136	315
Neurology	70	95	38	30	124	287
Orthopaedics	72	123	34	36	66	259
Dermatology	125	148	39	27	32	246
Diabetes	31	77	18	20	125	240
Ear Nose & Throat	129	133	38	25	34	230
Medical Paediatrics	159	103	12	8	64	187
General Surgery	36	68	14	11	86	179
General Psychiatry (Mental Health)	0	43	10	4	114	171
Endocrinology	23	52	19	16	71	158
Psychiatry of Old Age	0	28	7	7	98	140
General Medicine	66	62	28	15	34	139
Clinical Oncology	4	40	6	10	19	75
Gynaecology	35	22	9	5	12	48
Child Psychiatry	3	21	4	4	17	46
Respiratory Medicine	66	26	4	0	5	35
Nephrology	0	16	3	3	3	25
Haematology	34	20	0	1	2	23
Geriatric medicine	12	14	5	0	1	20
Anaesthetics	0	13	4	1	1	19
Oral - MaxFac	6	6	0	1	7	14
Rheumatology	8	8	1	0	2	11
Learning Disability	0	0	0	0	9	9
Endocrinology & Diabetes	2	4	1	0	1	6
Clinical Psychology	0	0	0	0	5	5
Adolescent Psychiatry	0	2	1	0	2	5
Obstetrics Antenatal	1	1	2	1	0	4
Vascular Surgery	1	1	1	0	0	2
Orthoptists	0	0	0	0	1	1
<b>Total</b>	<b>1,517</b>	<b>2,474</b>	<b>725</b>	<b>545</b>	<b>2,229</b>	<b>5,973</b>

**Note:** Patients are given a 'ticket' for their return appointment with a target date. The appointment itself should be in a window within a tolerance of 5% before the target date (the earliest date) and 15% after the target date (the *latest date*). The term 'before latest date' is a reference to the latest date of the window as previously described. 0-6 weeks and beyond refer to those waiting in excess of the latest date of the tolerance window.

**NOT PROTECTIVELY MARKED**

**DUMFRIES and GALLOWAY NHS BOARD**5<sup>th</sup> October 2015**Capital Performance 2015/16****Author:**

Susan McMeckan  
Deputy Director of Finance

**Sponsoring Director:**

Katy Lewis  
Director of Finance

**Date:** 18<sup>th</sup> September 2015**RECOMMENDATION**

The Board is asked to approve:

- The £3.0m slippage between years related to the foul water and fibre projects in respect of Acute Services Redevelopment Project.

The Board is asked to note:

- The allocations received to date.
- The project budget updates.
- The capital expenditure incurred to date.

**Strategy / Policy:**

The Board has a statutory financial target to deliver a breakeven position against its Capital Resource Limit (CRL).

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

Allocations of £10.187m have been received from Scottish Government Health and Social Care Directorate (SGHSCD) to the end of August 2015.

**Key Messages**

SGHSCD have confirmed their support of the transfer of £3.0m between financial years re foul water and fibre.

Expenditure of £1.381m has been incurred to the end of August 2015. Receipts of £0.074m have been received in respect of the sale of Maryfield lodge.

**GLOSSARY OF TERMS**

SGHSCD	-	Scottish Government Health and Social Care Directorate
LDP	-	Local Delivery Plan
YTD	-	Year to Date
IM&T	-	Information Management & Technology
CIG	-	Capital Investment Group
MYR	-	Mid-Year Review
ASRP	-	Acute Services Redevelopment Project
MoU	-	Memorandum of Understanding

**MONITORING FORM**

Policy/Strategy Implications	<ul style="list-style-type: none"> <li>• Capital Plan, Property Strategy &amp; IM&amp;T Strategy</li> </ul>
Staffing Implications	<ul style="list-style-type: none"> <li>• Not Applicable</li> </ul>
Financial Implications	<ul style="list-style-type: none"> <li>• Capital charge and recurring revenue consequences built in as part of the financial planning and reporting cycle</li> </ul>
Consultation / Consideration	<ul style="list-style-type: none"> <li>• Capital Investment Group, Management Team and Performance Committee</li> </ul>
Risk Assessment	<ul style="list-style-type: none"> <li>• No</li> </ul>
Sustainability	<ul style="list-style-type: none"> <li>• The capital plan supports the sustainability agenda through the delivery of capital schemes in line with the property strategy and efficiency procurement of equipment.</li> </ul>
Compliance with Corporate Objectives	<ul style="list-style-type: none"> <li>• 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.</li> </ul>
Single Outcome Agreement (SOA)	<ul style="list-style-type: none"> <li>• Not applicable.</li> </ul>
Best Value	<ul style="list-style-type: none"> <li>• This paper contributes to Best Value goals of sound governance, accountability, performance scrutiny and sound use of resources.</li> </ul>
Impact Assessment	<ul style="list-style-type: none"> <li>• Not Applicable</li> </ul>

## Allocations Update

1. To the end of August 2015 a capital allocation of £10.187m has been received; no increase to that previously reported to Board in August.
2. A reduction in allocation of £0.369m is still anticipated in respect of the capital grant as part of the ASRP project.
3. An increase in allocation of £0.186m is still anticipated in respect of the equipping costs for the Acute Services Redevelopment Project (ASRP) due from Health Facilities Scotland (HFS).
4. A reduction in allocation of £3.0m is anticipated in respect of slippage of foul water and fibre projects re ASRP. This £3.0m is committed to specific projects but tendering has not yet taken place and is a timing issue. SGHSCD have confirmed their support for this reallocation of budgets between financial years.
5. Taking account the outstanding adjustments noted the final anticipated allocation for the year is currently £7.004m, compared to the £10.004m reported at August meeting.

## Budget and Expenditure Update

6. The table below shows the revised budget position and expenditure to August 2015 which has been adjusted to reflect changes in anticipated allocations. Further details on the programmes is also included below.

2015-16 Capital Budget	Approved August	Adjustments	Total budget for approval	Expenditure to August 2015
	£000s	£000s	£000s	£000s
Women and Children Services Hub	3,143	(231)	2,912	875
Acute Services Enabling Works	3,478	(3,000)	478	229
Replacement Programme	2,800	0	2,800	253
Developments	937	0	937	24
HFS Equipping	186	0	186	0
Unallocated	0	231	231	0
<b>Gross Direct Capital Expenditure</b>	<b>10,544</b>	<b>(3,000)</b>	<b>7,544</b>	<b>1,381</b>
Less Capital Income - NBV	(540)	0	(540)	(74)
<b>Net Capital Expenditure</b>	<b>10,004</b>	<b>(3,000)</b>	<b>7,004</b>	<b>1,307</b>

### Women and Children HUB

7. The Women and Childrens HUB development is now underway and is planned for delivery within this financial year. £231k has been identified as revenue expenditure for which provision has been made within the revenue plan. This capital balance has been reallocated for investment within the overall capital plan.

### Acute Services Redevelopment Project

8. A budget of £3.847m was included within the LDP for the Acute Services Redevelopment Project which was in line within the planning estimates made within the £61.711m included within the FBC plus the later addition of £1.2m for further support of the revised foul water solution.
9. When the FBC was produced timings were estimated based on the information available and the Board have previously managed timing issues over years where possible without support from the Scottish Government. However, given the limited number of projects being taken forward in year the Director of Finance has secured support from SGHSCD for transfer of £3.0m in respect of foul water and fibre projects to next financial year.
10. The table below shows the profile of the budget against the individual enabling work elements as per the FBC and the current expenditure plan known at September 2015. Further details of the individual lines are also included below.

ASRP PROJECT BUDGET	Budget	Q1 Forecast	Adjustment
	£000s	£000s	£000s
Foul water	1,597	0	1,597
Fibre	1,143	0	1,143
Fees	599	170	429
Aquifer	0	308	-308
Balance	139	0	139
<b>TOTAL BUDGET EXC. GRANT</b>	<b>3,478</b>	<b>478</b>	<b>3,000</b>
Capital Grant - Road improvements	369	369	0
<b>TOTAL BUDGET INC. GRANT</b>	<b>3,847</b>	<b>847</b>	<b>3,000</b>

11. The final value of the foul water solution has not been quantified. Tenders are due back late September 2015 with work anticipated to start at the beginning of next financial year. Regular team meetings have been set up to keep finance updated.
12. The fibre project is being progressed in conjunction with Dumfries and Galloway Council. There are two parts to the project; the fibre infrastructure and the infrastructure provision. A Memorandum of Understanding (MoU) was drawn up to form a partnership between Dumfries & Galloway Health Board and Dumfries & Galloway Council. This MoU was signed by the respective CEOs in December 2014.

13. The project is planned to be in a position that the fibre infrastructure works will be completed up to the boundary of the new site by the end of Q3 2016 noting a 6 month buffer.
14. The accounting treatment is also to be considered and agreed for both the fibre and foul water.
15. A provision is included for all fees related to the capital enabling works.
16. The Acute Services Redevelopment Programme Board has approved the borehole feasibility for the aquifer amounting to £0.308m including VAT. This cost was not budgeted in original FBC and has been funded from savings made against the overall £61.7m capital budget. This is anticipated to complete within the financial year, £109k has been invoiced in August as part of the staged payment.
17. A capital grant of £0.369m is payable to Dumfries and Galloway Council for works to be undertaken as part of the Acute Redevelopment Project. This payment covers 50% of the local road improvements identified and 100% of the cycle route extension as agreed under a Section 69 agreement.
18. The profile of the remainder of the ASRP spend (particularly equipment) is being reviewed and there is likely to be a change to the phasing as part of the 16/17 LDP process.

#### **Replacement Programme**

19. A budget of £2.8m was set aside for the Boards replacement programme as part of the LDP.
20. During Qtr 1 a request for bids was circulated to General Managers and Directors, following this a prioritisation process was undertaken and £1.586m was approved by CIG against Tranche 1. A further prioritisation process took place at September CIG and £0.732m was approved against Tranche 2. To end of August 2015 only £0.093m has been committed against the contingency which is low compared to previous years.
21. A total of £2.411m has been approved as per the table below; a full list of the approved programme is included as Appendix 1.

<b>REPLACEMENT PROGRAMME</b>	<b>Budget</b>	<b>Committed</b>	<b>Uncommitted</b>
	<b>£000s</b>	<b>£000s</b>	<b>£000s</b>
Tranche 1	1,760	1,586	174
Tranche 2	540	732	(192)
Contingency	500	93	407
<b>TOTAL BUDGET</b>	<b>2,800</b>	<b>2,411</b>	<b>389</b>

22. An exercise is now underway to identify the expenditure profile in advance of midyear review to identify slippage on the in year programme. A further review

of contingency will be carried out at MYR and slippage added back to the overall capital plan for reinvestment.

### Developments

23. A budget of £0.937m was set aside for the Boards development programme as part of the LDP.
24. A prioritisation process took place at September CIG which approved bids of £1.077m as per the table below; a full list of the approved programme is included as Appendix 2.

DEVELOPMENT PROGRAMME	Budget	Committed	Uncommitted
	£000s	£000s	£000s
Previous Commitments	20	20	0
Tranche 1	917	0	917
Tranche 2	0	1,077	(1,077)
<b>TOTAL BUDGET</b>	<b>937</b>	<b>1,097</b>	<b>(160)</b>

25. As per the replacement programme, an exercise is now underway to identify the expenditure profile in advance of midyear review to identify slippage on the in year programme. It is not anticipated that the budget will overspend and no additional allowance has been provided.
26. All developments have a recurring revenue impact. To support this plan above requires £0.26m of revenue to cover service contract support and the annual depreciation charge. Provision for this has been made within the recurring revenue plan.

### Health Facilities Scotland Equipping

27. SGHSCD have provided an estimate of the work to be carried out during this financial year 2015/16 of £0.186m. Any movement on this would be funded centrally.

### Capital Income

28. Capital income of £0.540m is currently anticipated this financial year for the sale of properties. As per Scottish Government guidance this is returned nationally for overall re-prioritisation. If the Board is unable to deliver the receipts the Board must manage this slippage locally by adjusting the planned capital expenditure for the year.

### Donated

29. Donated assets are not funded from within the Boards £7.004m allocation however a separate non-core allocation is required. This is currently forecast at £0.4m.

30. The table below shows the estimates at August for use of donated funds.

<b>Name</b>	<b>Estimate £000s</b>
LOF Confirmed 2nd OCT machine for Ophthalmology	100
LOF Anticipated Mini C Arm	54
LOF Anticipated Fibro Scanner	70
Sono site - Ultrasound for A&E Stranraer	30
Bariatric bed - NS Hospital	15
Bariatric bed - GCH	15
Hoist – Thornhill Hospital	7
	<b>291</b>

### **Summary**

31. A further round of expenditure will be committed to the equipment replacement programme once the review of timing has been completed to ensure delivery of the overall capital plan within the approved budget. This will accelerate planned expenditure for 2016/17.
32. The review of timing will also provide the detail of what has been committed and proceeding against the 2016/17 capital programme.
33. Further clarity on the Mid Year Review will be provided in the December Board update.

## Appendix 1 – Replacement Programme

Directorate	Description	Estimate
Acute & Diagnostics	OCT	54
Acute & Diagnostics	Blood Transfusion eqpt. £72000	72
Acute & Diagnostics	Video Cystoscopes *3	72
Acute & Diagnostics	Breast Ultrasound	90
Acute & Diagnostics	Mobile Image Intensifier -Angiography	146
Acute & Diagnostics	Pulmonary Function Unit	44
Acute & Diagnostics	Treadmill Stress System	31
Acute & Diagnostics	Obstetric US Unit	90
Acute & Diagnostics	Video Cystoscopes *3	72
Acute & Diagnostics	Colonoscope - Endoscopy	43
Acute & Diagnostics	Gastroscope *3	116
Acute & Diagnostics	PUVA light cabinet	25
Acute & Diagnostics	UVB light cabinet	25
Acute & Diagnostics	Renal Dialysis machine *3	45
Acute & Diagnostics	Renal Multifiltrate machine *2	22
Acute & Diagnostics	Particle counter - Microbiology	14
Acute & Diagnostics	Obstetric US Unit	90
Acute & Diagnostics	Mobile Image Intensifier - Cardiac	96
Acute & Diagnostics	Nasal Endoscope - Paediatrics (prev £45k)	7
Women & Childrens	Incubator *3	43
Women & Childrens	Resuscitaire *3	43
Facilities	Gas ovens for seven Cottage Hospitals	140
Facilities	Electric oven for DGRI kitchen	6
Facilities	Thomas Hope Boilers	50
Facilities	De-watering GCH	37
Facilities	DGRI CSSD - Autoclaves	450
Facilities	Galloway Residences - Heating, Bathroom & Kitchen	60
Public Health	Retinal cameras * 2	31
IM&T	CITRIX UPGRADE to Appliance Boxes + Licenses	12
IM&T	WAAS for Community Hospitals	54
IM&T	Replace Old Blades ( no SW equired)	41
IM&T	Upgrade fiber in CRH and Switches	168
Mental Health	Dental chair Prison	13
Mental Health	Desk - Workbase x 2	16
		<b>2,318</b>

## Appendix 2 – Development Programme

Directorate	Description	Capital Estimate	Revenue Impact
Acute & Diagnostics	Surestore endoscopy storage system	30	24
Acute & Diagnostics	Nerve ablation - Chronic pain	22	4
Acute & Diagnostics	Microbiology - part of our automation of bacterial identification	144	46
Acute & Diagnostics	Physiological Measurement Xcelera £10549	11	2
Acute & Diagnostics	Philips V60 Non Invasive Ventilator - Intensv Care/Aneas	14	3
Acute & Diagnostics	Temperature Management System - Anaesthetics	19	12
Acute & Diagnostics	Hologic Thin Prep T2000 - Pathology	34	9
Acute & Diagnostics	DGRI Renal Store	20	0
Acute & Diagnostics	DGRI - Wards 5 and 10	5	0
Acute & Diagnostics	Development of Phlebotomy Room, Outpatients, DGRI	51	0
Facilities	Ride on Scrubber/ Dryer	7	2
Facilities	Shrink Wrapping Packaging Machine	8	1
Facilities	Dental Centre Point of Use Water	30	0
Facilities	Outpatient Endoscopy Ventilation	56	0
Facilities	Tents to control airborne particulates	13	2
Primary & Community	Eye Gaze Tracking Communication System	8	2
Primary & Community	Annan Hospital Suspended Ceilings	60	1
IM&T	Wi-Fi contingency Link	48	20
IM&T	iGrow	41	24
IM&T	New Blades	78	16
IM&T	Application Virtualisation Software (AppV)	106	21
IM&T	Network tester	8	3
IM&T	Critical Care system	225	64
Mental Health	6 smart boards	39	9
		<b>1,077</b>	<b>264</b>

## DUMFRIES and GALLOWAY NHS BOARD

5<sup>th</sup> October 2015

### Dental Salaried Service Review Update



**Author:**  
Linda Bunney  
Head of Primary Care Development

**Sponsoring Director:**  
Angus Cameron  
Medical Director

Katy Lewis  
Director of Finance

**Date:** 24<sup>th</sup> September 2015

#### RECOMMENDATION

The Board is asked to:

- Note this update in respect of the implementation of the October 2014 Board decision to accept the recommendations of the report of the review of the provision of general dental services by the salaried service.
- Approve the proposal to undertake a further service review of the Salaried Dental Service to explore options for future service delivery of routine NHS General Dental Services from Lochside Dental Clinic.

#### CONTEXT

##### Strategy / Policy:

Independent dental contractors are the Scottish Governments preferred service delivery model for the provision of routine General Dental Services.

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

NHS Dumfries and Galloway is required to submit a 3 year service and financial plan to the Scottish Government regarding the Salaried Dental Service. Salaried Dental Services must now operate within a set financial allocation and service redesign is required to continue operation within this allocation.

This paper:

- Provides background to the outcome of the Salaried Services review; and
- Provides an update on the implementation progress of each location.

**GLOSSARY OF TERMS**

GDS - General Dental Services  
NHS - National Health Service

**MONITORING FORM**

Policy / Strategy Implications	NHS Dumfries and Galloway is required to submit a 3 year service and financial plan to the Scottish Government regarding the Salaried Dental Service. Independent dental contractors are the Scottish Governments preferred service delivery model for the provision of routine General Dental Services.
Staffing Implications	The review has significant implications for staff and would involve both organisational change and potentially Transfer of Undertakings Protection of Employment (TUPE). Unison have been involved throughout the process and the British Dental Association (BDA) have been kept informed of progress regarding the review. An implementation plan has been developed in consultation with staff and relevant Staff Representative Groups.
Financial Implications	Salaried Dental Services must now operate within a set financial allocation and service redesign is required to continue operation within this allocation. This is particularly important as a review of the provision of services for those with additional dental support needs has identified that additional capacity within this programme (Special Care Dentistry) is required and resources for this need to be identified. Implementation of the review recommendations will help to achieve this. Ultimately implementation of the review recommendations would lead to a saving to NHS Scotland as a whole.
Consultation	Consultation regarding the implementation continues with staff, independent dental contractors and stakeholders in the clinics. The Scottish Health Council have been closely involved in the review and will continue to consider proposed communications with patients regarding the implementation of the recommendations.
Consultation with Professional Committees	<p>The draft review report and its recommendations were presented to and endorsed by the following Board Committees:</p> <ul style="list-style-type: none"> <li>• Dental Advisory Committee Area Clinical Forum</li> <li>• Area Partnership Forum</li> <li>• Primary and Community Care Joint Management Board</li> </ul>

Risk Assessment	Risks have been assessed and mitigations have been identified.
Best Value	<ul style="list-style-type: none"> <li>• Commitment and leadership</li> <li>• Responsiveness and consultation</li> <li>• Sound governance at a strategic, financial and operational levels</li> <li>• Sound management of resources</li> <li>• Use of review and option appraisal</li> <li>• Accountability</li> <li>• Joint working</li> <li>• Equal opportunities arrangements</li> </ul>
Compliance with Corporate Objectives	<p>4. To review the model of service delivery across Dumfries and Galloway with the aim of delivering services as locally as possible.</p> <p>5. 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.</p>
<p>Impact Assessment</p> <p>Equality and Diversity Impact Assessment has been ongoing throughout the review process. This led to an additional assessment being undertaken regarding the accessibility and disabled facilities of independent dental contractor practices in those practices reporting capacity to accept NHS patients. During the Equality and Diversity Impact Assessment it was acknowledged that the Salaried Service Clinics were excellent in terms of accessibility and disabled facilities. As the recommendations for Lochside and Sanquhar are to maintain service provision from the existing clinic site there would be no change in accessibility or disabled facilities for those registered patients. If patients were to be dispersed from Dumfries Dental Centre and Lochmaben dental clinic it was recognised that there is a choice of independent contractor practices which are accessible and had facilities for disabled patients. However, it was acknowledged that they were not quite of the same standard as those provided in the Salaried Clinics. One area that it was felt could help to address this was for independent dental contractor practices to install an appropriately signposted call/door bell system to notify staff that there may be a patient requiring some assistance with entry to the premises. It was also agreed at the impact assessment that it was essential for patients to be given the locality summary information regarding accessibility and disabled facilities of practices to help inform their choices and to include a helpline number if patients felt that they needed to have further discussion regarding their access needs. In regards to Newton Stewart Dental Clinic, those participating in the Equality and Diversity Impact assessment felt that at the present time there is not yet the range of suitable alternative fully accessible independent contractor practices to allow complete dispersal. The review working group then considered this at some length and acknowledged that this was an area that did require some further focussed work with existing independent contractors in Newton Stewart prior to full withdrawal of salaried NHS dental services from this clinic site.</p>	

## 1. BACKGROUND

At its meeting on 6<sup>th</sup> October 2014, Dumfries & Galloway Health Board approved the recommendations of the Salaried Service review:

- General Dental Services patients at Dumfries Dental Centre and Lochmaben Dental Clinic to be dispersed to the independent contractor sector;
- General Dental Services to continue to be provided at Sanquhar and Lochside by the independent contractor sector via a lease arrangement;
- Further work with local independent dental contractors and Salaried Dental Service staff to be undertaken to ensure sustainable, accessible routine NHS dental services for patients in this area prior to the complete withdrawal of routine NHS dental services by the Salaried Dental Service.

## 2. IMPLEMENTATION GROUP

Following the decision of the October Board the Service Review Group, chaired by Valerie White, held its last meeting on the 7 October and handed over to the new Implementation Group, chaired by Linda Bunney.

This group has operational responsibility for ensuring the implementation of the Board decisions and has ownership of the Implementation Plan. Since its formation, the group has worked closely with the Partnership Working Group.

## 3. PARTNERSHIP WORKING GROUP

The Partnership Working Group, chaired by Kim Jakobsen, Dental Services Manager, was established in August 2014, to prepare for staff and management to work together in partnership in implementing the outcome of the salaried service review.

The last meeting took place on 2<sup>nd</sup> March 2015 followed by a staff development day on Monday 30<sup>th</sup> March 2015 to support the transition of staff starting their new roles in the Public Dental Service from Monday 13<sup>th</sup> April 2015.

Following a joint meeting with Lochside and Sanquhar dental clinic staff on 3<sup>rd</sup> June 2015, agreement has been reached to progress updates on leasing and TUPE with clinic staff individually through the Implementation Plan.

## 4. IMPLEMENTATION PLAN

The implementation plan is a live document subject to review by the Implementation Group.

#### **4.1 DISPERSAL OF PATIENTS FROM DUMFRIES DENTAL CENTRE AND LOCHMABEN DENTAL CLINIC**

Early in January 2015, patients were notified of the withdrawal of general dental services from Dumfries Dental Centre and Lochmaben Dental Clinic with effect from Friday 10<sup>th</sup> April 2015.

Approximately 2,000 of the 2,651 patients affected by this dispersal arrangement have been successfully transferred to the independent contractor practice of their choice. The remaining 600 did not respond to follow up correspondence. The 600 non-responders were reviewed and the clinicians did not consider that there were any vulnerable patients to whom we should consider contacting further. Registrations will be reviewed later in the year to see if these patients have in fact registered elsewhere.

#### **4.2 LOCHSIDE AND SANQUHAR DENTAL CLINICS - ARRANGEMENTS TO LEASE PREMISES**

A patient and staff questionnaire was issued 3<sup>rd</sup> December 2014 to seek views to incorporate into the tender information.

An advert was placed in the British Dental Journal by Ryden, the Board's Property Advisers on Friday 12<sup>th</sup> June 2015. Notification of the advert was also e-mailed to local independent dental contractors and those who had indicated an interest in leasing during the Service Review.

The evaluation process for Sanquhar has commenced and is now on hold pending further information from SGHD regarding future pension arrangements for staff potentially transferring. The dentist at Sanquhar retired in August and a fixed term dentist is currently in place continuing to provide services to patients.

At the closing date on 23<sup>rd</sup> July 2015 there were no applications received in respect of Lochside. As it has not been possible to progress the recommendation and it is not clear that any change to the future pension arrangements noted above would impact on the outcome it is considered that the current service be reviewed to consider the provision of general dental services to patients registered at Lochside Dental Clinic.

#### **4.3 NEWTON STEWART DENTAL CLINIC – FURTHER WORK**

The recommendation approved by Board in October 2014 in respect of Newton Stewart was:

“Further work with local independent dental contractors and Salaried Dental Service staff to be undertaken to ensure sustainable, accessible routine NHS dental services for patients in this area prior to the complete withdrawal of routine NHS dental services by the Salaried Dental Service”.

The paper presented to Board noted that “in regards to Newton Stewart Dental Clinic, those participating in the Equality and Diversity Impact assessment felt that at the present time there is not yet the range of suitable alternative fully accessible independent contractor practices to allow complete dispersal. The review working group then considered this at some length and acknowledged that this was an area that did require some further focussed work with existing independent contractors in Newton Stewart prior to full withdrawal of salaried NHS dental services from this clinic site.”

The current situation in Newton Stewart is:

- A single-handed salaried dental practitioner providing general dental services to approximately 700 patients;
- Two independent contractor practices operate from the town providing general dental services to approximately 6,633 and 1,511 patients respectively.

One of the practices in Newton Stewart is proposing to expand their facilities to incorporate additional surgery space and improve the practice accessibility. This would ensure that capacity and accessibility is available to ensure a sustainable service for patients in the Newton Stewart area.

Detailed plans and timescale for the proposed expansion are awaited to confirm that the accessibility and capacity issues raised can be addressed prior to the complete withdrawal of routine NHS dental services by the Salaried Dental Service

It is anticipated that the outcome of the review of the detailed plans and timescale will be available for consideration at the December meeting of the Board. At a recent Area Committee meeting in Newton Stewart Jeff Ace, Chief Executive, reassured the meeting that a proposal to withdraw services would be presented to Board only when he had the assurance that the issues highlighted have been addressed.

**DUMFRIES and GALLOWAY NHS BOARD**5<sup>th</sup> October 2015**Medical Staffing Update****Author:**

Dr Ewan Bell  
Associate Medical Director - Acute and  
Diagnostics

**Sponsoring Director:**

Dr Angus Cameron  
Medical Director

**Date:** 3<sup>rd</sup> September 2015

**RECOMMENDATION**

The Board is asked to note the progress in recruiting to consultant posts and acknowledge the significant challenges that remain, especially in respect to primary-care GP recruitment. The GP recruitment challenge is probably the biggest risk that the Board faces.

**CONTEXT****Strategy / Policy:**

The safe and effective delivery of high quality services is dependent on our recruitment of a skilled and engaged medical workforce. Where we have been unable to recruit permanent staff we have maintained services only by the use of extremely expensive locum staff.

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

NHS Dumfries and Galloway, in keeping with other NHS Scotland Boards, is currently facing challenges in relation to recruitment and retention of all grades of medical staff. This problem is not unique to Dumfries & Galloway: Nationally, there are currently 440 vacant consultant posts across Scotland, with around 175 being long-term, that is, still vacant after more than 6 months of advertising.

Failure to recruit substantive Medical staff results in excessive reliance on Locums, which has deleterious financial, quality and safety implications.

**GLOSSARY OF TERMS**

*NHS* - *National Health Service*

**MONITORING FORM**

Policy / Strategy	Local and national clinical strategies as well as the workforce strategy
Staffing Implications	Vacancies within medical staff has caused additional pressures to existing staff and has required the use of expensive locum staff.
Financial Implications	Significant financial impact has been identified through Locum costs and has been discussed with the Director of Finance.
Consultation / Consideration	Performance Committee Audit and Risk Committee NHS Board Other governance committees
Risk Assessment	Yes and noted within the Corporate Risk Register.
Sustainability	Not applicable
Compliance with Corporate Objectives	<p>2. To promote and embed continuous quality improvement by connecting the range of quality and safety activities which underpin delivery of the three ambitions of the Healthcare Quality Strategy, to deliver a high quality service across NHS Dumfries and Galloway.</p> <p>3. To review the model of service delivery across Dumfries and Galloway to deliver person-centred services as close to home as clinically appropriate.</p> <p>4. To ensure that NHS Dumfries and Galloway has an engaged and motivated workforce that is supported and valued in order to deliver high quality service and achieve excellence for the population of Dumfries and Galloway.</p>
Single Outcome Agreement (SOA)	Not applicable
Best Value	<ul style="list-style-type: none"> <li>• Vision and Leadership</li> <li>• Use of Resources</li> </ul>
Impact Assessment	Not applicable

**NOT PROTECTIVELY MARKED**

## Consultant Recruitment

### 1. Acute and Diagnostics

To address medical staffing recruitment and retention challenges within DGRI, the Acute and Diagnostics Division have appointed, for 12 months provisionally, a Medical Recruitment Officer. She has been in post since January 2015. Her role is to bring together all aspects of recruitment and to be the single point of contact.

Acute and Diagnostics has 90 funded Consultant posts. Currently there are 17 vacancies. All of the vacancies are covered by locum consultant staff, of whom 9 are NHS Locums, and 8 are Agency Locum Consultants.

The breakdown of the 9 NHS Consultant locums is as follows;

- 1 in Respiratory Medicine (a retired D&G Consultant)
- 1 in Cardiology (who has applied for the substantive Consultant post)
- 1 in the Emergency Department
- 1 in Ophthalmology (23 month contract ?substantive post in the future)
- 3 in Radiology (one of whom is a returning retired D&G Consultant)
- 1 in Pathology (who has applied for the substantive Consultant post)
- 1 in ENT (long-term NHS Locum)

The breakdown of the 8 Agency Locum Consultants is as follows;

- 1 in Acute Medicine (failed to appoint at interview)
- 3 in Diabetes (to cover 3 Doctors' Maternity Leave)
- 1 in Cardiology
- 1 in Urology
- 1 in Infectious Diseases (new post)
- 1 in Ophthalmology (who leaves in November)

This is an improvement compared to January 2015, when there were 23 consultant vacancies in Acute and Diagnostics, so a 25% reduction. Nationally, we have a disproportionately high vacancy rate, per head of population.

### 2. Mental Health

There are currently 12.2 funded Consultant posts in Mental Health, with 10 substantive Consultants and 2.1 vacancies filled by 2.1 NHS Locums;

- 1 in Adult Psychiatry (who has applied for the substantive post)
- 1 in Drugs and Alcohol (following a retirement)
- 0.1 to backfill SG secondment

### 3. **Obstetrics, Gynaecology and Paediatrics (including CAMS)**

There are currently 13.9 funded Consultant posts with no Locums and no vacancies (but Locum Consultants out-of-hours on occasions to support rota).

#### **Consultant Summary**

Number of funded Consultants – 116.1

Number of Consultant vacancies – 19.1 (16.5%)

Number of NHS Locums – 11.1 (9.5%)

Number of Agency Locums – 8 (6.8%)

#### **GP Recruitment**

##### **Current vacancies;**

Castle Douglas Medical Group – 3

Waverley Medical Centre - 2

Kirkcudbright - 2

Newton Stewart

Thornhill

Sanquhar

Moffat

Canonbie

With many more due to retire within the next 3 years (possibly 25%).

The total number of posts at present is approximately 132 with 12 currently unfilled. There is a shortage of locum availability in Dumfries & Galloway, and practices struggle to recruit to fill all of the sessions that they require.

A further primary care workforce survey is being urgently conducted and will be completed by the end of the month. The medical director has arranged a crisis meeting at the end of the month with the general managers for primary & community care, the 4 clinical leads and the manager of the primary care department.

A short video has been made to promote General Practice in D&G, and we have supported practices by arranging flash-adds. An advert had been placed in the Journal of The Royal College of GPs in Holland.

All trainees were interviewed at the end of the academic year and 5 were persuaded to stay in the area. We advertised for 2 training fellows in general practice, but only recruited one. The individual subsequently decided not to take up the post.

An initiative to recruit nurses to train as ANPs to work in General Practice only recruited 2 trained ANPs, one of whom has resigned before even starting.

The impact of the GP shortages is being felt within practices and in the hospital, but is also leading to increasing spending on locums within the Out-Of-Hours service. As a consequence of these pressures, GPs report that they will be unable to attend locality integration meetings.

The GP recruitment challenge is probably the biggest risk that the Board faces.

## **Speciality Doctors**

We have a full complement of SDs in most specialties, although we have medium to long term vacancies in:

- Anaesthetics – 2 month vacancy
- Emergency Department – upcoming vacancy as 1 SD is leaving to move to provide Locum cover for OOH
- Urology - >1 year
- General Surgery - > 6 months

These posts are filled by a variety of short to long term locums.

## **Trainee Doctors**

Recruitment difficulties to permanent middle grade and consultant posts in medicine and surgery has impacted on the level of clinical supervision available for trainees, this is further exacerbated by unfilled junior medical posts and reliance on locums, and in medicine by the lack of senior trainees that are allocated to posts in Dumfries. Our permanent medical staff are exceptionally committed to supporting trainees, however the increasing demands and continuing need to employ locums cannot fully compensate. Safety of trainees is clearly impacted upon by levels of supervision.

## **Current Situation**

### **FY1s**

FY1: All filled.

FY2: 16 posts were filled and two locums appointed for service. In 2015-16 1 post is unfilled.

### **GPST training posts**

Recruitment was low - 5 of 10 posts have been filled for August 2015 - this was not unexpected since our posts are often filled late with trainees failing to gain posts in England. Last year England failed to fill on the first two rounds of recruitment, sadly the situation has deteriorated and only 4 of our 14 places available in 2015 have been filled. This has potentially very serious consequences as over the next 3 years training post gaps will result in attempts to recruit locum doctors.

**Other** posts are parts of programmes based elsewhere; most gaps are filled with LAT trainees, with remaining one St3 post in medicine and 2 ST psychiatry posts unfilled.

### **Initiatives**

1. Careers Fair - Dumfries and Galloway took a stand at the Scottish Medical Careers Fair in 2014 and will do so again in 2015.
2. Development of fellowships in rural medicine and quality improvement have been unsuccessful in attracting candidates
3. Longitudinal Clerkships - Dundee University and NHS Dumfries and Galloway are developing a pilot, hosting 6 students in practices for a period of 17 months during their final and penultimate year. The aim is that students will become embedded in the community whilst also achieving educational objectives, and develop greater understanding of rural medicine.

**DUMFRIES and GALLOWAY NHS BOARD**5<sup>th</sup> October 2015**Medical Education Committee Annual Report**

**Author:**  
Jean Robson  
Director of Medical Education

**Sponsoring Director:**  
Angus Cameron  
Medical Director

**Date:** 24<sup>th</sup> September 2015

**RECOMMENDATION**

The Board is asked to note the Annual Report on Medical Education that has been provided by Dr Jean Robson, Director of Medical Education.

The Board should note that the Education Department has faced challenges due to a number of reasons:

1. Difficulties in reaching full recruitment of consultants.
2. Challenges meeting the new and stricter rules to maintain training status approval from the General Medical Council
3. The need to develop more simulation training.

Despite all of the difficulties it should be noted that the feedback from both undergraduates and post-graduates has been largely positive, though there are concerns about high workloads for junior doctors where vacancies have existed.

The Medical Education department continues to perform strongly considering the size of Dumfries & Galloway – and the success of the training provided is probably important in augmenting our chances of recruitment with a difficult medical recruitment market in the next few years.

**CONTEXT****Strategy / Policy:**

The quality of medical education in Dumfries & Galloway is important to maintain patient safety, and to aid recruitment to this area.

It is important that we continue to meet the GMC standards otherwise we could potentially lose our training status and have doctors in training withdrawn. Due to the work being led by the Education Committee this does not seem to a high risk in NHS D&G at the moment, but we require to maintain the focus on providing high quality training to ensure that we meet the increasingly challenging standards.

#### **GLOSSARY OF TERMS**

GMC - General Medical Council  
NHS - National Health Service

**MONITORING FORM**

Policy / Strategy	We must retain our high quality of supervision and training of both undergraduates and junior doctors to ensure we have a service staffed by skilled and trained staff.
Staffing Implications	There are ongoing negotiations at national level to seek to address some of the disparity between Health Boards in allocation of senior medical trainees.  We may require to fund non-training doctors to maintain appropriate seniority of cover overnight
Financial Implications	Under assessment
Consultation / Consideration	The annual report has been considered and approved as a report of the year's activities by Education Committee
Risk Assessment	The principle risk of failure to provide a high quality training environment is withdrawal of training status
Sustainability	The resources available to support effective medical education are sufficient to sustain the current service
Compliance with Corporate Objectives	Quality improvement
Single Outcome Agreement (SOA)	Not applicable.
Best Value	Performance Management Use of Resources
Impact Assessment	Not applicable

## Medical Education in Dumfries and Galloway

### Annual Report

#### General Commentary

NHS Dumfries and Galloway aims to ensure that each doctor in training or medical student is given the support required to reach their potential whilst working in the region. In order to support this aim there is a need to value the educational role of permanent staff, providing time to deliver education, and development opportunities for educators; value the feedback received and act upon it; provide a safe environment for trainees to work, with adequate and appropriate clinical supervision, time for learning, and systems which recognise areas of risk and act upon those. A number of these requirements are currently challenged in some departments.

GMC has recently published standards for Local Education providers, ([http://www.gmc-uk.org/Promoting\\_excellence\\_standards\\_for\\_medical\\_education\\_and\\_training\\_0715.pdf](http://www.gmc-uk.org/Promoting_excellence_standards_for_medical_education_and_training_0715.pdf) 61939165 .pdf) these standards come into effect on 1<sup>st</sup> January 2016, these standards provide further impetus to address the issues identified.

**Recruitment** difficulties to permanent middle grade and consultant posts in medicine and surgery has impacted on the level of clinical supervision available for trainees, this is further exacerbated by unfilled junior medical posts and reliance on locums, and in medicine by the lack of senior trainees that are allocated to posts in Dumfries. Our permanent medical staff are exceptionally committed to supporting trainees, however the increasing demands and continuing need to employ locums cannot fully compensate.

Failure to appoint any substantive consultants to ENT resulted in a need to remove trainees from that department for a 6 month period.

**Feedback** on undergraduate placements is good and no changes are planned. However feedback on postgraduate posts reflects the difficulties in supervision for medical trainees. A piece of work has been undertaken to determine the requirements for optimal training in the medical department, and options identified. Requests to increase the seniority profile of allocated trainees have not been accepted by NHS Education for Scotland. Other solutions will require significant financial input in terms of increasing medical and advanced nurse practitioner workforce, and would also be difficult to recruit to.

**Safety** of trainees is clearly impacted upon by levels of supervision. Additionally it is known that handover and medicines management are areas in which errors frequently occur, both have working groups addressing issues currently. Locum cover is an additional risk, work to address induction of locums is progressing.

**Time for educating** is challenged by recruitment difficulties; although NHS Dumfries and Galloway accepts fully the GMC recommendations that time must be available in job plans for permanent staff to deliver training, and provides this, the reality is that in departments where recruitment to permanent positions is incomplete that time is often used on clinical work.

**Faculty** development opportunities are available and additional options will be added next year, simulation is an important area of development which requires some additional support which has been requested.

**Performance** against the GMC standards has been evaluated in Appendix A, some of the requirements are not currently met and additional support is required. A request for non-executive Board input to the Education Committee has been made.

## Sections

1. Recruitment
2. Student Feedback
3. GMC Trainee survey
4. Additional Experiences
5. Patient and Trainee Safety
6. Speciality and Associate Specialist (SAS) doctor support opportunities
7. Locum Support
8. Work Experience
9. CPD
10. Faculty
11. Facilities
12. Performance against GMC Standards for Education Providers
13. Progress against D&G Strategy for Medical Education

## 1. Recruitment

### 1.1 Current Situation

#### FY1 -2

FY1: All filled for 2014-15

FY2: 16 posts were filled and two locums appointed for service. In 2015-16 1 post is unfilled.

#### GPST training posts

Recruitment was low 5 of 10 posts filled for August 2014, this was not unexpected since our posts are often filled late with trainees failing to gain posts in England, last year England failed to fill on the first two rounds of recruitment, sadly the situation has deteriorated and only 4 of our 14 places available in 2015 have been filled. This has potentially very serious consequences as over the next 3 years training post gaps will result in attempts to recruit locum doctors.

**Other training** posts are parts of programmes based elsewhere, most gaps are filled with LAT trainees, for 2015-16 there remains two ST3s post in medicine.

### 1.2 Initiatives

Many opportunities to value add posts are already in place (see section 4)

#### 1.2.1 Careers Fair

Dumfries and Galloway took a stand at the Scottish Medical Careers Fair in 2014 and will do so again in 2015.

1.2.2 Development of fellowships in rural medicine and quality improvement have been unsuccessful in attracting candidates

#### 1.2.3 Longitudinal Clerkships

Dundee University and NHS Dumfries and Galloway are developing a pilot, hosting 6 students in practices for a period of 17 months during their final and penultimate year. The aim is that students will become embedded in the community whilst also achieving educational objectives, and develop greater understanding of rural medicine.

2. Student feedback 2014-15

National Feedback



2014-15 Detailed Undergraduate Teaching Report:  
NHS Dumfries and Galloway

School	Site	Specialty	Year	Overall Satisfaction Block Organisation	Teaching Delivery Teaching Quality Total: Teaching	Learning Opportunities Clinical Experience Total: Experience	Assessment Feedback Total: Assessment	Learning Support Pastoral Support Total: Support	IT Equipment Access to Software Total: IT	Teaching Equipment Teaching Accommodation Total: Facilities	Number of respondents
Glasgow	All GP Practices	General Practice	4/5	▲▲	▲▲▲	▲▲▲	▲▲▲	▲▲▲	▼▲▲	▲▲▲	19 (24)
Dundee	All GP Practices	General Practice	5	▲▲	▲▲▲	▲▲▲	▲▲▲	▲▲▲	▲▲▲	▲▲▲	29 (35)
Aberdeen	All GP Practices	General Practice	5	▼▼	▲▼▼	▼▼▼	▼▼▼	▼▲▼	▲▲▲	▲▼▼	28 (35)
Dundee	Crichton Royal Hospital	Psychiatry	4	▲	▲	▲	▲	▲	▲	▲	6 (7)
Edinburgh	Dumfries & Galloway Royal Infirmary	Child Life and Health	5	▲▲	▲▲▲	▲▲▲	▲▲▲	▲▲▲	▲▲▲	▲▲▲	8 (10)
Glasgow	Dumfries & Galloway Royal Infirmary	Emergency Medicine	4/5	▲▲	▲▲▲	▲▲▲	▲▲▲	▲▲▲	▲▲▲	▲▲▲	7 (16)
Glasgow	Dumfries & Galloway Royal Infirmary	Medicine	3/4	▲▲	▲▲▲	▲▲▲	▲▲▲	▲▲▲	▲▲▲	▲▲▲	8 (20)
Edinburgh	Dumfries & Galloway Royal Infirmary	Medicine of the Elderly	5	▲	▲	▲	▲	▲	▲	▲	4 (8)
Edinburgh	Dumfries & Galloway Royal Infirmary	Obstetrics and Gynaecology	4	▲	▲	▲	▼▼	▲	▼▲	▲	10 (14)
Glasgow	Dumfries & Galloway Royal Infirmary	Surgery	3/4	▲	▲▲	▲▲	▲▲	▲▲	▲▲	▲▲	5 (27)
Edinburgh	Midpark Hospital	Psychiatry	4	▲	▲	▲	▲	▲	▲	▲	12 (24)

- Undergraduate**
- Score less than 0
  - Score 0 to less than 0.55
  - Score 0.55 to less than 1.55
  - Score more than or equal to 1.55
  - No results published

**Notes**  
This report utilises the Scottish Student Evaluation Survey. "Number of respondents" is the total responses received; the number of responses received for some questions may be significantly fewer. Results are shown only if there are at least 5 respondents. Figures in brackets are the potential number of respondents. Trend data: ▲ indicates an improvement in the flag from the previous year, ▼ a deterioration and — no change. If no prior data is available the cell is blank. Scores are calculated based on Universities' scoring scales converted to Likert scale of between -2 and +2. Results from "General Practice" are aggregated over a three year period.

**Scoring 1-5 from 22 point questionnaire – 2014-2015**

<b>Teaching</b>							
	<b>Paediatrics</b>	<b>Obs and Gynae</b>	<b>Geriatrics</b>	<b>Psychiatry</b>	<b>Medicine</b>	<b>Surgery</b>	<b>A&amp;E</b>
Staff are good at explaining things	4.4	4.3	4.4	4.2	4.9	4.3	4.5
Staff have made the subjects interesting	4.3	4.1	4.3	4.06	5	4.3	4.6
Staff are enthusiastic about what they are teaching	4.5	4.4	4.3	4.2	5	4.1	4.9
The course is intellectually stimulating	4.4	4.4	4.1	3.9	4.9	4.3	4.8
The criteria used in marking have been fair	4.2	4.1	4.5	3.9	4.8	4.2	4.5
Assessment arrangements and marking have been fair	4.3	4.1	4.5	4.04	4.8	4.4	4.4
Feedback on my work has been prompt	4.5	4.02	4.8	3.4	4.9	4.4	4.5
I have received detailed comments on my work	4.2	3.8	4.6	3.8	5	4.1	4.8
Feedback on my own work has helped me clarify things I did not understand	4.1	4.03	4.4	3.7	5	4.2	4.9
I have received sufficient advice and support with my studies	4.4	4.01	4.5	4.1	4.8	4.07	4.5
I have been able to contact staff when I needed to	4.7	4.2	4.7	4.1	4.7	4.4	4.6
Good advice was available when I needed to make study choices	4.6	3.9	4.6	4.05	4.7	4.03	4.7
The timetable works efficiently as far as my activities are concerned	3.7	3.7	4.3	3.9	4.4	4.1	4.9
Any changes in the course or teaching have been communicated effectively	4.2	3.5	3.9	4.3	4.5	4.02	4.4
The course is well organised and is running smoothly	3.9	3.7	4.6	4.1	4.8	4.07	4.5
The library resources and services are good enough for my needs	4.7	4.7	4.9	4.7	4.4	4.8	4.7
I have been able to access general IT resources when I needed to	4.7	4.6	4.8	4.7	4.8	4.8	4.8
I have been able to access specialised equipment, facilities or room when I needed to	4.6	4.5	4.8	4.5	4.6	4.6	4.5
The placement has helped me present myself with confidence	4.1	4.2	4.3	4.07	4.7	4.4	4.8
My communication skills have improved	4.3	4.2	4.3	4.3	4.9	4.2	4.8
As a result of the course, I feel confident in tackling unfamiliar problems	4.03	4.2	4.2	4.1	4.7	4.1	4.7
Overall, I am satisfied with the quality of the course	4.2	4.2	4.5	4.1	4.9	4.3	5

\* students are asked to score from 1-5 (5 being the best)

## <sup>186</sup> **2.1. Paediatrics**

The reductions in teaching assessment and whole block satisfaction noted on national feedback last year have improved. The improvements in local and regional feedback are impressive as the lead clinician was absent for a large period of the year.

## **2.2. Emergency Medicine**

An excellent first year of UG training resulted in top 25% scores in every aspect of the national assessment

## **2.3. Obstetrics and Gynaecology**

Reductions in scores in feedback and assessment are disappointing; however investigation has shown that this is likely to be a result of changes in roster planning in the department. An audit is underway to clarify the issues and changes will then be developed.

## **2.4 Geriatrics**

Insufficient national results were obtained for publication; local results demonstrate pleasingly high scores in all but one area.

## **2.5 Surgery**

The programme has been completely restricted for this year with a move to a more team based approach. The national results show pleasing improvements in satisfaction with teaching. This is achieved despite inability to recruit to posts, which have an educational component.

## **2.6 Psychiatry**

All scores are within the average range except overall satisfaction from Dundee students which is in the top quartile. The department has reduced the student intake slightly to allow more student centred work.

## **2.7 Medicine**

Excellent local and national feedback has been obtained with scores in national feedback in top quarterly in every area.

## **2.8 GP Placements.**

Average or above average scores were obtained from all universities. The Aberdeen scores are not as high as Dundee and Glasgow and more work is required to determine the significance of this

## **2.9 Elective Placements**

We have continued to welcome elective students during the summer period when accommodation is available.

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**3 GMC Survey of trainees 2014**

Post\_speciality\_by\_trust\_outlier\_summary\_v2.pdf - Adobe Reader

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1 / 1 83% Find

Report By is equal to / is in Post Specialty by Trust/Board  
 and Survey Year is equal to 2015  
 and Trust / Board is equal to Please select , Dumfries & Galloway  
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Post Specialty	Trust / Board	Indicators													
		Overall Satisfaction	Clinical Supervision	Clinical Supervision out of hours	Handover	Induction	Adequate Experience	Supportive environment	Work Load	Educational Supervision	Access to Educational Resources	Feedback	Local Teaching	Regional Teaching	Study Leave
Acute Internal Medicine	Dumfries & Galloway														
Anaesthetics	Dumfries & Galloway														
Emergency Medicine	Dumfries & Galloway														
General (internal) medicine	Dumfries & Galloway														
General Practice	Dumfries & Galloway														
General psychiatry	Dumfries & Galloway														
General surgery	Dumfries & Galloway														
Obstetrics and gynaecology	Dumfries & Galloway														
Paediatrics	Dumfries & Galloway														
Palliative medicine	Dumfries & Galloway														
Trauma and orthopaedic surgery	Dumfries & Galloway														
Vascular surgery	Dumfries & Galloway														

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### 188 3.1. Patient Safety Questions

Trainees are asked to report in the GMC questionnaire any patient safety issues not reported to the hospital, three were reported this year, these were investigated but no significant issues identified.

### 3.2 Anaesthetics

NHS Education for Scotland have directed that in Dumfries anaesthetic trainees should not be on-call without senior on-site presence until they have obtained full obstetric competences. The department challenged the NES view that this rule should be applied in Dumfries but not in other units; this was followed by a Speciality Training Board visit and resolution to the problem to the satisfaction of all parties.

Scores in the pink region are difficult to interpret, however an indication to consider. Trainees have been consulted and no indication to be concerned about feedback or induction identified.

### 3.3 Emergency Medicine

Excellent scores in handover reflecting work to improve this. It is pleasing that local teaching is appreciated. The department struggles to allow trainees study leave at times; this is attempted but cannot always be achieved.

### 3.4 Medicine

GMC has just published Standards for Educational providers; currently the department of medicine is unable to achieve these because of staffing levels.

Trainees are required to be supervised at all times by someone competent to do so, and FY2 doctors should never be the most senior person on call. Currently NHS Dumfries and Galloway is allocated on 1 ST3 or above doctor in medicine, consultants feel that this is the level required to support more junior doctors. (As do physicians across NHS Scotland). On current staffing levels it is impossible to support junior trainees with a middle grade trainee at ST3 or above level. Consultants on call currently stay on the premises until 10pm, very significantly reducing the risk, however diminishing pool of consultants working on - call for general medicine and failure to recruit to vacancies is jeopardising this. In addition gaps in junior allocations, and requirements to use locums to cover consultant and junior gaps results in support of variable quality. Trainees feel the support of the consultants is excellent; however recognise that consultant support is at the expense of the consultants who are doing what in all other units would be regarded as middle grade work.

The survey results undoubtedly are a result of

1. Inadequate middle level tier – ST3 or above level
2. Increasing numbers of consultant and middle grade locums providing support

In order to address issues of support for very junior trainees an options appraisal has been carried out, resulting requests to increase the seniority profile of allocated trainees have not been accepted by NHS Education for Scotland. Other solutions will require significant financial input in terms of increasing medical and advanced nurse practitioner workforce, and would also be difficult to recruit to.

### 3.5 Psychiatry

There have been improvements in scores in several areas, and discussion between DME and trainee group highlighted no major issues

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**3.6 Surgery**

There has been a decline in scores for local teaching which the department intends to address.

Clinical supervision is also highlighted, particularly in FY1 where a red flag was scored. DME has met with trainees and identified

- a. Ongoing problems for FY1s accessing advice from middle grade trainees when they are in theatre. This is a continual issue however FY1s are explicitly made aware of sources of support on these occasions, and the option of visiting theatre to discuss cases. The non-team based structure for FY1s is a contributory factor but not possible to address on current staffing levels.
- b. There have been a small number of instances where locum consultant support was inadequate this has been robustly addressed.

**3.7 Obstetrics and Gynaecology**

Good overall results, and very pleasing that the red flag in handover has been lost as a result of the good work the department is doing in this area.

The possibility that theatre time is restricted by possible impacts on waiting times has been raised and this will be audited

**3.8 Paediatrics**

Very pleasing that the red flag in handover has been lost as a result of the good work the department is doing in this area.

**3.9 Palliative Care**

No GMC scores will be obtained since only one trainee works in the department; however cumulative scores over the last 3 years have shown excellent feedback.

**3.10 ENT**

Trainees were removed from the department this year because no substantive consultant was in post.

**3.11 Ophthalmology**

Trainees were removed from the department this year because no substantive consultant was in post in ENT.

**3.12 Orthopaedics**

No GMC scores will be obtained since only two specialty trainees work in the department; however cumulative scores over the last 3 years have shown good feedback.

**3.13 Public Health**

No national feedback has been received by the national programme from public health trainees in Dumfries and Galloway.

**3.14 Primary Care**

Feedback from trainees in primary care showed a pink flag (bottom 25<sup>th</sup> percentile) for Educational supervision, however more detailed evaluation revealed that almost every site in UK showed this and statisticians inform us that this is because the results for all sites were so close to 100% that sites not scoring 100% on every question were allocated a pink flag. NHS Education for Scotland advise that pink flags for this should be ignored.

**4.0 Additional Trainee experiences**

**4.1 Travelling Fellowship**

No applications were submitted this year

## <sup>190</sup> **4.2 Dyslexia Support**

A national study aiming to develop understanding of and support for trainees with has now been published, and recommendations made available to all Scottish GP trainers.

## **4.3 National Courses**

A number of national courses are delivered locally – IMPACT, ALS, APLS, BASICS (part 1), SCOTTIE and are available to trainees.

## **4.4 International Graduates**

A limited consultation skills and communication course was delivered to 4 doctors

## **4.5 Quality Improvement/ Poster competition**

The quality improvement competition again provided interesting projects, some of which have lasting impact. Concern persist that trainees do not seek sufficient guidance and support before embarking on projects, despite this been offered.

To encourage development of high quality projects with greater chance of impact trainees were offered the option to join the 11 QI groups running in the region, gaining support from QI advisers. Trainees volunteering to join the groups were invited to attend a series of skills development workshops; sadly attendance at these was limited. Impact of staffing issues in QI department have limited the support available, and better engagement with the clinical leads will be developed next year.

## **4.6 Handbook**

The medical hospital handbook is available on intranet; internet access has encountered some problems but will be resolved shortly.

## **4.7 Interdisciplinary learning**

Development of trainee involvement in the QI groups in addition to enhancing opportunities to learn about QI science will develop trainee skills at working as part of a multidisciplinary improvement group

# **5. Patient and Trainee safety**

## **5.1 Incident Reporting**

Currently when an incident is reported reporters are invited to name junior doctors involved, the aim is to facilitate early support if required, and to alert supervisors to the fact that their trainee is involved. We are still struggling to develop an effective system here; a new method is to be piloted shortly. The effectiveness of DME notification of doctors in training involvement in serious incidents has also been incomplete, as of July 2015 the responsibility to do this has been passed to the serious incident review group

## **5.2 Medicines Safety**

Some work is in progress on ward 16

The transition to electronic prescribing is underway; all trainees using the system are required to complete training. Information on issues identified as the system is rolled out is being collected.

## **5.3 Handover**

It is internationally acknowledged that handover is a high risk activity for trainees, and GMC and BMA have advised education providers to consider this. A Handover group has been established, has run an awareness raising week, developed a Board strategy, and is working to support projects in different departments. Challenges because of limited QI adviser availability and failure to achieve any medical time allocated to the work limit what can be achieved, but 8 hours of nursing time is very helpful.

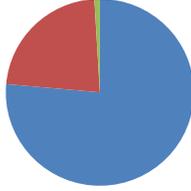
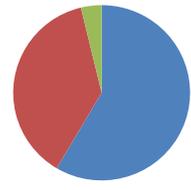
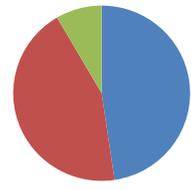
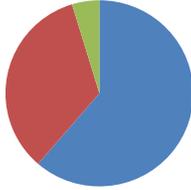
#### 191 **5.4 Human Factors Training**

Human factors training aims to increase the understanding of factors involved in human error, and developing this understanding across NHS Dumfries and Galloway is leading to changes in how risk is managed, and incidents handled. The course is aimed at team leaders ideally, anyone is welcome. Some doctors in training have attended however the course is directed at permanent staff aiming to result in improved incident management and reliability, thus impacting on doctors in training

# 192 Human Factors Training Course Feedback

Cumulative: September 2013 - June 2015, 8 Sessions, 108 delegates

## Part B Complete at end of day 2

1. To what extent has participation in this activity enabled you to:		<i>Not at all</i> → <i>Significantly</i>				Average (n=108)	CHART
		1	2	3	4		
a)	Understand the value of recognising Human Factors in medical error causation.	1 (n=0)	2 (n=1)	3 (n=24)	4 (n=81)	3.74	 <ul style="list-style-type: none"> <li><span style="color: blue;">■</span> 4</li> <li><span style="color: red;">■</span> 3</li> <li><span style="color: green;">■</span> 2</li> <li><span style="color: purple;">■</span> 1</li> </ul>
b)	Consider performance influencing factors in medical staff which precipitate error and limit reliability	1 (n=0)	2 (n=4)	3 (n=40)	4 (n=62)	3.55	 <ul style="list-style-type: none"> <li><span style="color: blue;">■</span> 4</li> <li><span style="color: red;">■</span> 3</li> <li><span style="color: green;">■</span> 2</li> <li><span style="color: purple;">■</span> 1</li> </ul>
c)	Develop strategies to reduce medical error.	1 (n=0)	2 (n=9)	3 (n=47)	4 (n=51)	3.39	 <ul style="list-style-type: none"> <li><span style="color: blue;">■</span> 4</li> <li><span style="color: red;">■</span> 3</li> <li><span style="color: green;">■</span> 2</li> <li><span style="color: purple;">■</span> 1</li> </ul>
d)	Know how to use recognised tools to improve reliability.	1 (n=0)	2 (n=5)	3 (n=36)	4 (n=65)	3.57	 <ul style="list-style-type: none"> <li><span style="color: blue;">■</span> 4</li> <li><span style="color: red;">■</span> 3</li> <li><span style="color: green;">■</span> 2</li> <li><span style="color: purple;">■</span> 1</li> </ul>

## 6. Speciality Doctor Support

### 6.1 Access to National Funding

A speciality doctor CPD adviser is now in place, and this has supported the application for short term Scottish Government funding for SAS doctors to develop skills. To date NHS D&G has submitted 20 applications 11 of which have been funded

### 6.2 Rural Fellowship

Recruitment to rural training fellowship for Galloway Community Hospital was unsuccessful, as was recruitment to an addition community based fellowship programme

## 7. Locum support

### 7.1 Induction

The importance for locums in junior doctor shift gaps having an induction to the post on arrival has been acknowledged by the Board, and a policy to ensure that generic and departmental inductions are delivered is in place.

In the first 7 months of 2015 68 locums required induction, about 50% were seen by Education centre staff the rest receiving written information as they arrive out of hours, prior to departmental induction. Locums are required to return documentation after a shift if they have not done so recently providing information about competence, and evidence that induction was completed. Only 33% of the forms are returned despite efforts from Education centre staff this represents a risk for the organisation should regulatory bodies request evidence in the future.

### 7.2 Revalidation

Doctors in training in training posts are revalidated on the recommendation of the PG Dean, for doctors working for Locum agencies the agency is responsible for appraisals, however for locums in LAS (Locum appointments to service) the responsible Officer for Dumfries and Galloway is responsible for the recommendation. All doctors commencing LAS posts in 2014-15 are provided with written advice on evidence collection.

## 8.0 Work Experience

All applications from school pupils interested in a career in medicine are now submitted via the regional council, this ensures equity of access across the region, for all young people with appropriate academic qualifications, and irrespective of geography.

## 9. CPD

CPD accredited sessions have been delivered throughout the year subject to identified needs and Board priorities.

## 10. Faculty

### 10.1 Faculty Development opportunities

Opportunities have been offered to medical educators including teleconferenced sessions from the Edinburgh group, faculty development alliance courses, medical student tutors specific sessions. From January 2016 Edinburgh faculty will be providing more input on a regular basis.

### 10.2 Simulation in Teaching

Simulation in teaching is increasingly important as simple education and for real time testing of emergency response plans; we have a group of staff trained to deliver this, and this year have re-structured the clinical skills room to allow better multidisciplinary teaching. We have been allocated national funding to purchase a new simulator and the option assessment is almost complete.

In order to deliver modern simulation and emergency response testing it is felt that there is need for some dedicated time from a. A simulation lead (consultant anaesthetist) responsible for considering plans and simulation supporting faculty b. Some increase in Resuscitation Training Officer time (to support increased multidisciplinary scenario delivery).

## <sup>194</sup> **10.3 Recognition of trainers**

The GMC and NHS Education for Scotland require doctors with a significant educational role to be identified, appraised in that role, and provide evidence of competence, and have time to undertake the role in job plans. Agreements have been reached on which groups of doctors are included, and those working in Dumfries and Galloway have been notified and made aware of the requirements which must be met before August 2016. Courses are available to allow trainers to meet the requirements.

All trainers need time to fulfil the role and clinical leads have been made aware of the minimum time which must be available to trainers to fulfil GMC requirements. There are concerns that, particularly where departments are stretched because of recruitment challenges, despite allocation of time in job plans essential responsibilities for patient care erodes this time.

## **11 Facilities**

### **11.1 New hospital**

Plans for a new department combining Resuscitation training team, and mandatory training will enable improved multidisciplinary and simulation training

## **12. Performance against GMC Standards for Educators**

GMC has recently published standards for local education providers which organisations are required to meet. Appendix A details the standards and NHS D&G performance in each area.

Key areas in which NHS D&G cannot meet the Standards are

- a) Study leave entitlement available in Medicine and Emergency departments
- b) Supervision in Medicine

## **13. Progress against D&G strategy for medical education**

The area which has not yet been developed is lay representation on the Education Committee, further discussion has identified the fact that the preference would be initially at least for a non-executive member. *(Laura Douglas agreed to join 3.9.15)*

Jean Robson  
August 2015

## ACTION PLAN

Item	Plan	Timescale	Responsible person
Surgical allocation of time in job plans for student teaching	When recruitment complete allocate SAS doctor and consultant time	ASAP	F.Dreyer
Allocation of time in job plans for all Educational and clinical supervisors and leads for medical students in departments	Clinical directors will allocate time at job planning	ongoing	Clinical Directors / Associate Medical Directors
Recognition and approval of trainers	Provide information to trainers and arrange appropriate courses to facilitate approval of trainers	ongoing	J. Robson / A.M. Coxon
Study leave	Review of frequency of inability to deliver in A&E, medicine see rosters	12 months	P Armstrong / J.Robson, AMDs, MD
Local Teaching	Local teaching to be considered in surgery	3 months	F.Dreyer, M Bews- hair
Medicine rosters	Development of the options for change identified	6 months	J.Robson, AMDs, MD
Obstetrics and Gynaecology	Audit effect of middle grade rotas on teaching delivery	3 months	A Leacock
Obstetrics and Gynaecology	Audit theatre time allocated to trainee surgery	2 months	W. Forson
Primary Care	Investigate differences between Aberdeen and other university experiences	6 months	JRobson
Trainees involved in Patient Safety Incidents	Review the current system of notifying supervisors and ensuring final reports are seen by DME	12 months	J.Robson
Medicines Safety	Medicines group to be revitalised	12 months	P. Sammon
Enhance trainee experience of QI activity	Further develop trainee links with QI groups	6 months	J. Robson M. Stevenson
Simulation teaching	Develop simulation faculty	ongoing	J Robson, J Muthias, W.Pollock
Review return of locum forms	Review return of locum forms	3 months	S. Japp / AM Coxon
Recruitment	Develop Longitudinal Clerkships	12 months	J Robson / S. Law
Non-executive Representation on education committee	To be considered ( <i>Laura Douglas agreed 3.9.15</i> )	12 months	J.Robson

## GMC Standards for Local Education Providers

	<b>Requirement</b>	<b>Met / working towards / Not met</b>	<b>Situation</b>
	1. Learning Environment and Culture		
R1.1	Organisations must demonstrate a culture that allows learners and educators to raise concerns about patient safety, and the standards of care or of education and training, openly safely and without fear of adverse consequences	Met	Specifically encouraged to do so at induction, and at educational sessions.
R1.2	Organisations must investigate and take appropriate action locally to make sure concerns are properly dealt with. Concerns affecting the safety of patients or learners must be addressed immediately and effectively	Met	Regional policy
R1.3	Organisations must demonstrate a culture that investigates and learns from mistakes and reflects on incidents and near misses. Learning will be facilitated through effective reporting mechanisms and clinical governance activities	Met	In addition to routine investigations human factors training to promote a culture of learning from error and developing reliability is in place
R1.4	Organisations must demonstrate a learning environment and culture that supports learners to be open and honest with patients when things go wrong – known as their professional duty of candour – and help them to develop the skills to communicate with tact, sensitivity and empathy.	Met	Support by supervisors and Human Factors course develops the culture
R1.5	Organisations must demonstrate a culture that both seeks and responds to feedback from learners and educators on compliance with standards of patient safety and care, and on education and training.	Met	Encouraged to report issues and feedback actively sought, but questionnaire format discouraged by NES and as yet not receiving NES results
R1.6	Organisations must make sure that learners know about the local processes for educational and clinical governance and local protocols for clinical activities. They must make sure learners know what to do if they have concerns about the quality of care, and they should encourage learners to engage with these processes.	Met	Induction programmes

R1.7	Organisations must make sure there are enough staff members who are suitably qualified, so learners have appropriate clinical supervision, working patterns, workload, for patients to receive care that is safe and of a good standard, while creating the required learning opportunities.	Not met	Use of locum middle grade doctors in all departments results in supervision by doctors whose competence is difficult to guarantee.  In medicine recruitment difficulties to consultant positions, gaps in rotas, and lack of senior trainees allocated to Dumfries result in on-call rosters where trainees below ST3 level are frequently the most senior doctor on site between 10pm and 8am.  Options appraisal to address this is underway
R1.8	Organisations must make sure that learners have an appropriate level of clinical supervision at all times by an experienced and competent supervisor, who can advise or attend as needed. The level of supervision must fit the individual learner's competence, confidence and experience. The support and clinical supervision must be clearly outlined to the learner and the supervisor.  Foundation doctors must at all times have on-site access to a senior colleague who is suitably qualified to deal with problems that may arise during the session.* Medical students on placement must be supervised, with closer supervision when they are at lower levels of competence.	Not met	As 1.8  In Paediatrics consultants stay in hospital when no middle grade locum is available.  In A&E there is a 30 min period where there is no senior presence on occasional mornings (this is felt acceptable)  Very rarely hospital practitioners are called out from Emergency dept leaving a junior trainee, this has not happened in the last 12 months
R1.9	Learners' responsibilities for patient care must be appropriate for their stage of education and training. Supervisors must determine a learner's level of competence, confidence and experience and provide an appropriately graded level of clinical supervision.	Not met	As 1.6
R1.10	Organisations must have a reliable way of identifying learners at different stages of education and training, and make sure all staff members take account of this, so that learners are not expected to work beyond their competence.	Met	Induction
R1.11	Doctors in training must take consent only for procedures appropriate for their level of competence. Learners must act in accordance with General Medical Council (GMC) guidance on consent. <sup>5</sup> Supervisors must assure themselves that a learner understands any proposed intervention for which they will take consent, its risks and alternative treatment options.	Met	Trainees asked to decline if asked to do consents they don't feel happy with

R1.12	<p>Organisations must design rotas to:</p> <ul style="list-style-type: none"> <li>a make sure doctors in training have appropriate clinical supervision</li> <li>b support doctors in training to develop the professional values, knowledge, skills and behaviours required of all doctors working in the UK</li> <li>c provide learning opportunities that allow doctors in training to meet the requirements of their curriculum and training programme</li> <li>d give doctors in training access to educational supervisors</li> <li>e minimise the adverse effects of fatigue and workload.</li> </ul>		<ul style="list-style-type: none"> <li>a. See 1.7</li> <li>b. Providing out patient experience is challenging in some departments because of clinic space. The new hospital will address this. Meanwhile trainees asked to be proactive around opportunities</li> </ul>
R1.13	<p>Organisations must make sure learners have an induction in preparation for each placement that clearly sets out:</p> <ul style="list-style-type: none"> <li>a their duties and supervision arrangements</li> <li>b their role in the team</li> <li>c how to gain support from senior colleagues</li> <li>d the clinical or medical guidelines and workplace policies they must follow</li> <li>e how to access clinical and learning resources.</li> </ul> <p>As part of the process, learners must meet their team and other health and social care professionals they will be working with. Medical students on observational visits at early stages of their medical degree should have clear guidance about the placement and their role.</p>	Met	All trainees required to get evidence of departmental induction verified
R1.14	Handover* of care must be organised and scheduled to provide continuity of care for patients and maximise the learning opportunities for doctors in training in clinical practice.	Working towards	Board has developed a handover strategy with the aim of incrementally addressing all handovers
R1.15	Organisations must make sure that work undertaken by doctors in training provides learning opportunities and feedback on performance, and gives an appropriate breadth of clinical experience.	Met	

R1.16	<p>Doctors in training must have protected time for learning while they are doing clinical or medical work, or during academic training, and for attending organised educational sessions, training days, courses</p> <p>and other learning opportunities to meet the requirements of their curriculum. In timetabled educational sessions, doctors in training must not be interrupted for service unless there is an exceptional and unanticipated clinical need to maintain patient safety.</p>	Not met	Although attempts are made to protect learning time this is challenging particularly for trainees in medicine, and GPSTs attending local programme teaching
R1.17	Organisations must support every learner to be an effective member of the multiprofessional team by promoting a culture of learning and collaboration between specialties and professions.	Met	
R1.18	Organisations must make sure that assessment is valued and that learners and educators are given adequate time and resources to complete the assessments required by the curriculum.	Working towards	Although supervisors have time in job plans the reality of that time is frequently challenged when recruitment adds load
R1.19	<p>Organisations must have the capacity, resources and facilities* to deliver safe and relevant learning opportunities, clinical supervision and practical experiences for learners required by their curriculum</p> <p>or training programme and to provide the required educational supervision and support.</p>	Met	<p>Providing out patient experience is challenging in some departments because of clinic space. The new hospital will address this. Meanwhile trainees asked to be proactive around opportunities.</p> <p>Difficulties in allocating sufficient time for junior surgeons in theatre to operate to be audited</p>
R1.20	Learners must have access to technology enhanced and simulation based learning opportunities within their training programme as required by their curriculum.	Working towards	Simulation is used, and is being developed as a multidisciplinary opportunity
R1.21	Organisations must make sure learners are able to meet with their educational supervisor or, in the case of medical students, their personal adviser as frequently as required by their curriculum or training programme.	Met	
R1.22	Organisations must support learners and educators to undertake activity that drives improvement in education and training to the benefit of the wider health service.	Met	Faculty development opportunities available
	2. Educational Governance and Leadership		
R2.1	Organisations* must have effective, transparent and clearly understood educational governance systems and processes to manage or control the quality of medical education and training.	met	Overseen by Education committee

R2.2	<p>Organisations must clearly demonstrate accountability for educational governance in the organisation at board level or equivalent. The governing body must be able to show they are</p> <p>meeting the standards for the quality of medical education and training within their organisation and responding appropriately to concerns.</p>	Working towards	<p>2014 – Started annual reporting to Board</p> <p>2015 – Requesting non-executive Board membership on Education committee</p>
R2.3	<p>Organisations must consider the impact on learners of policies, systems or processes. They must take account of the views of learners, educators and, where appropriate, patients, the public, and employers. This is particularly important when services are being redesigned.</p>	Met	
R2.4	<p>Organisations must regularly evaluate and review the curricula and assessment frameworks, education and training programmes and placements they are responsible for to make sure standards are being met and to improve the quality of education and training.</p>	Met	
R2.5	<p>Organisations must evaluate information about learners' performance, progression and outcomes – such as the results of exams and assessments – by collecting, analysing and using data on quality and on equality and diversity.</p>	Not met	? Done by NES
R2.6	<p>Medical schools, postgraduate deaneries and LETBs must have agreements with LEPs to provide education and training to meet the standards. They must have systems and processes to monitor the quality of teaching, support, facilities and learning opportunities on placements, and must respond when standards are not being met.</p>	Met	
R2.7	<p>Organisations must have a system for raising concerns about education and training within the organisation. They must investigate and respond when such concerns are raised, and this must involve feedback to the individuals who raised the concerns.</p>	Met	
R2.8	<p>Organisations must share and report information about quality management and quality control of education and training with other bodies that have educational governance responsibilities. This is to identify risk, improve quality locally and more widely, and to identify good practice.</p>	Met	
R2.9	<p>Organisations must collect, manage and share all necessary data and reports to meet GMC approval requirements.</p>	Met	LEP has been asked to stop local questionnaire use but is currently not provided with data from Scottish Survey.

R2.10	Organisations responsible for managing and providing education and training must monitor how educational resources are allocated and used, including ensuring time in trainers' job plans.	Working towards	Departmental clinical leads are issued with guidance on time that should be in the depts. Job plans for education and training responsibilities. The compliance with this will be monitored in 2015-16
R2.11	Organisations must have systems and processes to make sure learners have appropriate supervision. Educational and clinical governance must be integrated so that learners do not pose a safety risk, and education and training takes place in a safe environment and culture.	Not met	As 1.7
R2.12	Organisations must have systems to manage learners' progression, with input from a range of people, to inform decisions about their progression.	Met	Trainees in difficulty group, departmental meetings
R2.13	Medical schools must have one or more doctors at the school who oversee medical students' educational progression. They must have one or more doctors at each LEP who coordinate training of medical students, supervise their activities, and make sure these activities are of educational value.	Met	
R2.14	Organisations must make sure that each doctor in training has access to a named clinical supervisor who oversees the doctor's clinical work throughout a placement. The clinical supervisor leads on reviewing the doctor's clinical or medical practice throughout a placement, and contributes to the educational supervisor's report on whether the doctor should progress to the next stage of their training.	Met	
R2.15	Organisations must make sure that each doctor in training has access to a named educational supervisor who is responsible for the overall supervision and management of a doctor's educational progress during a placement or a series of placements. The educational supervisor regularly meets with the doctor in training to help plan their training, review progress and achieve agreed learning outcomes.  The educational supervisor is responsible for the educational agreement, and for bringing together all relevant evidence to form a summative judgement about progression at the end of the placement or a series of placements.	Met	

<p>202 R2.16</p>	<p>Organisations must have systems and processes to identify, support and manage learners when there are concerns about a learner's professionalism, progress, performance, health or conduct that may affect a learner's wellbeing or patient safety.</p>	<p>Met</p>	<p>TPDs responsible in Foundation and GPST working with Deputy Directors</p> <p>Departmental leads take local lead where TPD is outwith region</p> <p>DME involved in place of Deputy Directors in LAS trainees</p> <p>HR support process</p>
<p>R2.17</p>	<p>Organisations must have a process for sharing information between all relevant organisations whenever they identify safety, wellbeing or fitness to practise concerns about a learner, particularly when a learner is progressing to the next stage of training.</p>	<p>Met</p>	<p>standard</p>
<p>R2.18</p>	<p>Medical schools (and the universities of which they are a part) must have a process to make sure that only those medical students who are fit to practise as doctors are permitted to graduate with a primary medical qualification. Medical students who do not meet the outcomes for graduates or who are not fit to practise must not be allowed to graduate with a medical degree or continue on a medical programme. Universities must make sure that their regulations allow compliance by medical schools with GMC requirements with respect to primary medical qualifications. Medical schools must investigate</p> <p>and take action when there are concerns about the fitness to practise of medical students, in line with GMC guidance. Doctors in training who do not satisfactorily complete a programme for provisionally</p> <p>registered doctors must not be signed off to apply for full registration with the GMC.</p>	<p>Met</p>	
<p>R2.19</p>	<p>Organisations must have systems to make sure that education and training comply with all relevant legislation.</p>	<p>Met</p>	
<p>R2.20</p>	<p>Organisations must make sure that recruitment, selection and appointment of learners and educators are open, fair and transparent.</p>	<p>Met</p>	
	<p>3. Supporting Learners</p>		
<p>R3.1</p>	<p>Learners must be supported to meet professional standards, as set out in <i>Good medical practice</i> and other standards and guidance that uphold the medical profession. Learners must have a clear way to raise ethical concerns.</p>	<p>Met</p>	<p>Learners are advised on actions should they have concerns about care , and sources of advice in times of concern about end of life care. The specific advice that this includes ethical issues will be emphasised next year.</p>

R3.2	<p>Learners must have access to resources to support their health and wellbeing, and to educational and pastoral support, including:</p> <ul style="list-style-type: none"> <li>a confidential counselling services</li> <li>b careers advice and support</li> <li>c occupational health services.</li> </ul> <p>Learners must be encouraged to take responsibility for looking after their own health and wellbeing.</p>	Met	Induction
R3.3	Learners must not be subjected to, or subject others to, behaviour that undermines their professional confidence, performance or self-esteem.	Met	Any reports investigated
R3.4	<p>Organisations must make reasonable adjustments for disabled learners, in line with the <i>Equality Act 2010</i>.*</p> <p>Organisations must make sure learners have access to information about reasonable adjustments, with named contacts.</p>	Met	Standard
R3.5	Learners must receive information and support to help them move between different stages of education and training. The needs of disabled learners must be considered, especially when they are moving from medical school to postgraduate training, and on clinical placements.		Met
R3.6	When learners progress from medical school to foundation training they must be supported by a period of shadowing† that is separate from, and follows, the student assistantship. This should take place as close to the point of employment as possible, ideally in the same placement that the medical student will start work as a doctor. Shadowing should allow the learner to become familiar with their new working environment and involve tasks in which the learner can use their knowledge, skills and capabilities in the working environment they will join, including out of hours.	Met	
R3.7	Learners must receive timely and accurate information about their curriculum, assessment and clinical placements.	Met	
R3.8	<p>Doctors in training must have information about academic opportunities in their programme or specialty and be supported to pursue an academic career if they have the appropriate skills and</p> <p>aptitudes and are inclined to do so.</p>	Met	
R3.9	Medical students must have appropriate support while studying outside medical school, including on electives, and on return to the medical programme.	Met	Elective programmes offered in line with regional guidelines

R3.10	Doctors in training must have access to systems and information to support less than full-time training.	Met	
R3.11	Doctors in training must have appropriate support on returning to a programme following a career break.	Met	
R3.12	Doctors in training must be able to take study leave appropriate to their curriculum or training programme, to the maximum time permitted in their terms and conditions of service.	Not met fully	Trainees in medicine and A&E are unlikely to be able to access full study leave entitlements particularly in GPST training where allowance is particularly high
R3.13	Learners must receive regular, constructive and meaningful feedback on their performance, development and progress at appropriate points in their medical course or training programme, and be encouraged to act on it. Feedback should come from educators, other doctors, health and social care professionals and, where possible, patients, families and carers.	Met	
R3.14	Learners whose progress, performance, health or conduct gives rise to concerns must be supported where reasonable to overcome these concerns and, if needed, given advice on alternative career options.	Met	
R3.15	Learners must not progress if they fail to meet the required learning outcomes for graduates or approved postgraduate curricula.	Met	
R3.16	Medical students who are not able to complete a medical qualification or to achieve the learning outcomes required for graduates must be given advice on alternative career options, including pathways to gain a qualification if this is appropriate. Doctors in training who are not able to complete their training pathway should be given career advice.	Met	
	4. Supporting Educators		
R4.1	Educators must be selected against suitable criteria and receive an appropriate induction to their role, access to appropriately funded professional development and training for their role, and an appraisal against their educational responsibilities.	Met	
R4.2	Trainers must have enough time in job plans to meet their educational responsibilities so that they can carry out their role in a way that promotes safe and effective care and a positive learning experience.		As 2.10
R4.3	Educators must have access to appropriately funded resources they need to meet the requirements of the training programme or curriculum.	Met	
R4.4	Organisations must support educators by dealing effectively with concerns or difficulties they face as part of their educational responsibilities.	Met	

R4.5	Organisations must support educators to liaise with each other to make sure they have a consistent approach to education and training, both locally and across specialties and professions.	Met	However limited time availability limits uptake
R4.6	Trainers in the four specific roles must be developed and supported, as set out in GMC requirements for recognising and approving trainers.	Met	
	5. Developing and implementing curricula and assessments		
R5.1	Medical school curricula must be planned and show how students can meet the outcomes for graduates across the whole programme.	NR	
R5.2	The development of medical school curricula must be informed by medical students, doctors in training, educators, employers, other health and social care professionals and patients, families and carers.	NR	
R5.3	<p>Medical school curricula must give medical students:</p> <ul style="list-style-type: none"> <li><b>a</b> early contact with patients that increases in duration and responsibility as students progress through the programme</li> <li><b>b</b> experience in a range of specialties, in different settings, with the diversity of patient groups that they would see when working as a doctor</li> <li><b>c</b> the opportunity to support and follow patients through their care pathway</li> <li><b>d</b> the opportunity to gain knowledge and understanding of the needs of patients from diverse social, cultural and ethnic backgrounds, with a range of illnesses or conditions and with protected characteristics</li> <li><b>e</b> learning opportunities that integrate basic and clinical science, enabling them to link theory and practice</li> <li><b>f</b> the opportunity to choose areas they are interested in studying while demonstrating the learning outcomes required for graduates</li> <li><b>g</b> learning opportunities enabling them to develop generic professional capabilities</li> <li><b>h</b> at least one student assistantship during which they assist a doctor in training with defined duties under appropriate supervision, and lasting long enough to enable the medical student to become part of the team. The student assistantship must help prepare the student to start working as a foundation doctor and must include exposure to out-of-hours on-call work.</li> </ul>	NR	

R5.4	<p>Medical school programmes must give medical students:</p> <ul style="list-style-type: none"> <li><b>a</b> sufficient practical experience to achieve the learning outcomes required for graduates</li> <li><b>b</b> an educational induction to make sure they understand the curriculum and how their placement fits within the programme</li> <li><b>c</b> the opportunity to develop their clinical, medical and practical skills and generic professional capabilities through technology enhanced learning opportunities, with the support of teachers, before using skills in a clinical situation</li> <li><b>d</b> experiential learning in clinical settings, both real and simulated, that increases in complexity in line with the curriculum</li> <li><b>e</b> the opportunity to work and learn with other health and social care professionals and students to support interprofessional multidisciplinary working</li> <li><b>f</b> placements that enable them to become members of the multidisciplinary team, and to allow team members to make reliable judgements about their abilities, performance and progress.</li> </ul>	NR	
R5.5	<p>Medical schools must assess medical students against the learning outcomes required for graduates at appropriate points. Medical schools must be sure that medical students can meet all the outcomes before graduation. Medical schools must not grant dispensation to students from meeting the standards of competence required for graduates.</p>	NR	
R5.6	<p>Medical schools must set fair, reliable and valid assessments that allow them to decide whether medical students have achieved the learning outcomes required for graduates.</p>	NR	
R5.7	<p>Assessments must be mapped to the curriculum and appropriately sequenced to match progression through the education and training pathway.</p>	NR	
R5.8	<p>Assessments must be carried out by someone with appropriate expertise in the area being assessed, and who has been appropriately selected, supported and appraised. They are responsible for honestly and effectively assessing the medical student's performance and being able to justify their decision.</p>	Met	

R5.9	<p>Postgraduate training programmes must give doctors in training:</p> <p><b>a</b> training posts that deliver the curriculum and assessment requirements set out in the approved curriculum</p> <p><b>b</b> sufficient practical experience to achieve and maintain the clinical or medical competences (or both) required by their curriculum</p> <p><b>c</b> an educational induction to make sure they understand their curriculum and how their post or clinical placement fits within the programme</p> <p><b>d</b> the opportunity to develop their clinical, medical and practical skills and generic professional capabilities through technology enhanced learning opportunities, with the support of trainers, before using skills in a clinical situation</p> <p><b>e</b> the opportunity to work and learn with other members on the team to support interprofessional multidisciplinary working</p> <p><b>f</b> regular, useful meetings with their clinical and educational supervisors</p> <p><b>g</b> placements that are long enough to allow them to become members of the multidisciplinary team, and to allow team members to make reliable judgements about their abilities, performance and progress</p> <p><b>h</b> a balance between providing services and accessing educational and training opportunities. Services will focus on patient needs, but the work undertaken by doctors in training should support learning opportunities wherever possible.<sup>9</sup> Education and training should not be compromised by the demands of regularly carrying out routine tasks or out-of-hours cover that do not support learning and have little educational or training value.</p>	Working towards	<p>b. Clinic space limits out patient experience particularly in medicine</p> <p>g. Doctors in medicine rotate through teams very rapidly, the options appraisal looking at trainee rosters in medicine aims to address this.</p> <p>FY1 doctors are ward based rather than team based, this is recognized as an issue.</p> <p>h. FY doctors on MAU are task focused, our options appraisal aims to address this.</p>
R5.10	Assessments must be mapped to the requirements of the approved curriculum and appropriately sequenced to match doctors' progression through their education and training.	Met	
R5.11	Assessments must be carried out by someone with appropriate expertise in the area being assessed, and who has been appropriately selected, supported and appraised. They are responsible for honestly and effectively assessing the doctor in training's performance and being able to justify their decision. Educators must be trained and calibrated in the assessments they are required to conduct.	Partially met	Some work has been done to calibrate some WBAs and clinical supervisor reports

R5.12	Organisations must make reasonable adjustments to help disabled learners meet the standards of competence in line with the <i>Equality Act 2010</i> , although the standards of competence themselves cannot be changed. Reasonable adjustments may be made to the way that the standards are assessed or performed (except where the method of performance is part of the competence to be attained), and to how curricula and clinical placements are delivered.	Met	
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**DUMFRIES and GALLOWAY NHS BOARD**5<sup>th</sup> October 2015**Outline Winter Plan 2015/ 16****Author:**

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**Sponsoring Director:**

Julie White  
Chief Operating Officer

**Date:****RECOMMENDATION**

The NHS Board is asked to endorse the outline Winter Plan 2015/16 for NHS Dumfries and Galloway and approve its publication on the Board website.

**CONTEXT****Strategy / Policy:**

This paper sets out plans for managing winter pressures on local health services in 2015/16. The paper is structured around the National Unscheduled Care Programme: Preparing for Winter 2015/16 self assessment from the Scottish Government.

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

Health Boards are required to demonstrate preparedness against a set of core action points as detailed in this paper. NHS Dumfries and Galloway has thoroughly reviewed its preparations and has in place a robust plan for managing service pressures.

**GLOSSARY OF TERMS**

**DGRI** – Dumfries and Galloway Royal Infirmary  
**STARS** – Short Term Augmented Response Service  
**OOHs** - Out of Hours  
**HR** – Human Resources  
**ED** – Emergency Department  
**IPCT** - Infection Prevention and Control Teams  
**eKIS** – Electronic Key Information Summary  
**CMO** – Chief Medical Officer  
**HPS** – Health Protection Scotland  
**HPT** – Health Protection Team  
**EDD** – Estimated Date of Discharge

**GLOSSARY OF TERMS Cont/...**

**AHP** – Allied Health Professional

**CATS** – Crisis Assessment Team

**LUCAP** – Local Unscheduled Care Plan

**COPD** – Chronic Obstructive Pulmonary Disease

**MONITORING FORM**

Policy / Strategy Implications	<i>Operational changes only</i>
Staffing Implications	<i>Not applicable</i>
Financial Implications	<i>Absorbed within existing financial budgets</i>
Consultation	<i>Not applicable</i>
Consultation with Professional Committees	<i>Will be presented to ACF</i>
Risk Assessment	<i>Evaluation through Hospital Management Group and Primary and Community Care Management Group</i>
Best Value	<i>Monitored through HEAT efficiency Key Performance Indicators (KPIs)</i>
Sustainability	<i>Not applicable</i>
Compliance with Corporate Objectives	<i>Objective 7</i>
Single Outcome Agreement (SOA)	<i>Not applicable</i>
Impact Assessment	<i>Not applicable</i>



1. In July 2015 Scottish Government issued the “National Unscheduled Care Programme: Preparing for Winter 2015/16” self assessment document outlining areas for consideration within their winter planning preparations. This report follows the recommended format and sets out NHS Dumfries and Galloway’s preparedness against each of the core planning areas outlined.

### **Priority Actions**

#### **Board Overview: Resilience Preparedness**

2. Under this broad heading, Health Boards are required to demonstrate preparedness against six core action points:

*Priority Action Resilience 1: The Board has robust business continuity management arrangements in place to manage and mitigate all key disruptive risks including the impact of severe weather.*

3. The Met Office new National Severe Weather Warning Service was introduced in 2011 and provides excellent advance data on likely weather disruption in particular areas. These warnings will again inform local capacity planning.
4. NHS Dumfries and Galloway has established Business Continuity Management Framework arrangements in place leading to a range of well used business continuity plans to cover potential disruption to services. These plans set out the triggers and steps to be taken and allow for dynamic escalation of response. The experience of the last two winters has tested these and informed further development of these plans.
5. The Resilience Officer is involved in all aspects of winter planning and promotes Business Continuity Management as a key consideration within these plans.
6. We work closely with partner agencies on areas of joint importance. We have participated in multi-agency winter preparedness conferences and will take part in any being organised to test individual and joint plans to cope with disruption this year.

*Priority Action Resilience 2: The Board’s business continuity plans take into account the organisation’s critical activities, analysis of the effects of disruption and the actual risks of disruption and develop plans based on risk-assessed worst case scenarios.*

7. Business Continuity plans covering all critical activities are currently under review and realignment.
8. As with 2014/15 an increase to the staffing template for ward 4 has been agreed for the period of 1<sup>st</sup> of November to 31<sup>st</sup> March to enable this ward to remain open seven days per week to support increased demands for admissions.

9. Following a successful pilot in the winter of 2014/15 the Board has agreed to a small increase in staffing for key services to support discharged being able to flow seven days per week. This resource is planned to be in place year round but will commence from the end of October 2015.
10. There has been a successful recent round of recruitment to increase resources within the Nurse Bank to allow access to relief staff during periods of high activity and staff sickness.
11. The Board is a key partner in the Dumfries and Galloway Multi-agency Major Emergency Scheme and supports functional/operational teams within this arrangement.
12. The Board and its partners have well established arrangements in place for mutual aid covered by our Major Emergency scheme.

*Priority Action Resilience 3: The Board has HR policies in place that cover what staff should do in the event of severe weather hindering access to work and how the appropriate travel advice will be communicated to staff and patients.*

13. NHS Dumfries and Galloway has an adverse weather policy in place. This policy provides a clear framework for managers and staff detailing service expectations, responsibilities, reporting arrangements and entitlement since the event of adverse weather within the region.
14. Travel advice is provided by Local Authority sources and is distributed by email to a predetermined cascade by the General Manager on call.

*Priority Action Resilience 4: The Board's website will be used to indicate advice on travel to hospital appointments during severe weather.*

15. Processes are in place and tested around the use of the Board's website and social media to provide travel advice during severe weather.

*Priority Action Resilience 5: NHS Boards and Local Authorities are working together to create a capacity plan to manage demand for mortuary services over the winter period.*

16. Mortuary capacity is managed on a day to day basis by the Laboratory Manager for Microbiology, Pathology and Mortuary. Clear triggers are in place and in the event of demand rising there are close working relationships with the local undertakers as the Dumfries and Galloway Council does not offer mortuary services.
17. A contingency plan is in place linked to Mass Fatality Plans should demand for mortuary services exceed local capacity and the Board Resilience Officer and Laboratory Manager for Microbiology, Pathology and Mortuary participate in national excess death planning events.

*Priority Action Resilience 6: The Board will test its winter plan by 30 Nov with stakeholders to ensure that they are effective and that they are convergent with the relevant plans of Local Authorities and other key partners.*

18. Multi-agency Winter Workshops are well established feature of local Winter Planning and are held annually with the event for 2015 scheduled for 30<sup>th</sup> October. These events review planning and response arrangements and promote good practice and horizon scanning.

### **Unscheduled/Elective Care**

19. Under this broad heading, Health Boards are asked to demonstrate preparedness against seven core action points:

*Priority Action Unscheduled/Elective Care 1: Clinically focussed and empowered hospital management.*

20. The acute hospital site is managed using a triumvirate approach inclusive of General Management Lead Nurse and Associate Medical Directors supported by Capacity Management.
21. Effective communication links are in place between clinical departments and senior managers to ensure potential system pressures are identified. Escalation procedures within the Emergency Department and the Acute Medicine Unit are currently undergoing review to ensure pressures are flagged in a timely manner.
22. A twice daily whole hospital safety and flow huddle is well established and includes representation from key areas across the hospital and includes social work representation. This meeting is chaired by a member of the senior management team ensuring their awareness of pressures and supporting action planning and escalation as required. The output from this meeting is captured electronically and shared widely across the system and with partners such as Scottish Ambulance.
23. Cottage hospital capacity information is shared with Acute on a daily basis to support alignment of system demand.
24. Each Community Mental Health Team has Business Continuity Plans in place, and alignment and cover between teams is clarified. These plans dovetail with the Midpark Business Continuity Plans.
25. From a mental health perspective daily planning is co-ordinated by the Midpark “huddle” and pulling of necessary resources from community will be arranged, if required.
26. Close working relationships already exist between community mental health teams and between community teams and the mental health inpatient unit.

27. Community Mental Health Nursing Teams and Crisis Assessment Teams (CATS) already provide support to individuals at home, to prevent admission to hospital. Cross cover within the community teams, with alternate use of base to accommodate this service during crisis will be enacted. Prioritisation of resources to those most in need will be coordinated by team leaders. All team leaders have access to mobile numbers for all staff across teams. In patient managers have access to all Team leaders mobile numbers
28. Escalation processes are in place with good communication between acute and community management when bed pressures are identified.
29. A weekly meeting has been established between the Discharge Manager, Patient Flow Co-ordinators, Social Work team leads and local authority housing to discuss delays and complex discharges.
30. Each of the four Localities in Dumfries and Galloway has a monthly multi-agency meeting focusing on building system resilience. As part of this work, a communications protocol is being developed to ensure key contact information is readily available.
31. Effective communication takes place with external care providers through the Approved Provider Forum and Care Home Managers meetings supported by individual contract monitoring discussions.
32. Close working relationships between health and social services are well established with a Social Work base within Dumfries and Galloway Royal Infirmary (DGRI).
33. An escalation plan is critical to ensure that emerging problems are rapidly identified and resolved using the full range of the Board's resources. The current plan for NHS Dumfries and Galloway is attached at Appendix 1 and was revised following live escalations during Winter 2014/15.
34. One of the key early indicators if emerging problems is an increase in wait times in the Emergency Department (ED). An escalation policy to alert the wider managerial and clinical teams of developing issues is being refined, automated alerts have been developed.
35. In order to assess performance throughout the year we have developed a suite of indicators as listed below which are available using the intranet-based *Qlikview* system, giving a close to real time view of how we are managing demand including:
  - a) Number and rate of admissions
  - b) Length of stay data by Hospital, Specialty, Pathway (e.g. Fractured Neck of Femur, stroke, Care of the Elderly)
  - c) Bed occupancy
  - d) Sleepers
  - e) Emergency readmissions - 7 and 28 days
  - f) Emergency Department +4 hour waits

- g) Emergency Department attendances
- h) Admissions to the Acute Medical Unit

36. Information on ED performance and status, NHS D&G beds, Waiting list performance and Sleepers is shared across acute and community services with an update emailed to key post holders on a three times a day basis.

*Priority Action Unscheduled/Elective Care 2: Undertake detailed analysis and planning to effectively schedule elective activity (both short and medium-term) based on forecast emergency and elective demand, to optimise whole system's business continuity. This has specifically taken into account the surge in activity in the first week of January.*

37. For the past five winters, the Board has attempted to minimise elective inpatient activity in early January as recognition of the bed pressures often evident at this time. This has reduced the number of elective cases subject to short notice cancellation despite historically high surges in non elective activity.
38. The ambulatory care unit (Ward 4) continues to provide the opportunity to deliver a high proportion of elective activity undertaken on a 23-hour stay and offer access to day case approaches for both surgical and medical scheduled procedures.
39. This, supported by the Day Surgery Unit and the developing day of surgery admission approach, should further reduce elective inpatient admissions throughout the winter.
40. We are currently working to reduce the waiting time down to 9 or 10 weeks in order to enable us to plan for restricted elective activity on the first two weeks in January to maximise system resilience and minimise any potential impact on the Treatment Time Guarantee. The exclusions to this will be patients on a cancer pathway.
41. We have adopted an ambulatory assessment approach within the medical emergency admission flow of patients by adopting an out-patient clinic type approach to assessment for appropriate patients. Whilst the ability to provide an ambulatory approach can on occasion be compromised by staffing levels this has the potential to reduce the number of patients admitted to the main medical ward base.
42. A whole hospital safety and flow huddle is held twice daily as routine and processes are agreed should there be requirements to reschedule future elective activity if forecasts on extreme weather or admissions surges make this prudent.

43. At times of extreme bed pressure, the Board has in the past made use of local hotel capacity for a small number of elective pre-operative patients who have travelled from outside the Dumfries area for surgery the next day. Whilst this has attracted some media interest, it remains an effective alternative to short notice cancellation and may again be considered this winter if appropriate.

*Priority Action Unscheduled/Elective Care 3: Agree staff rotas in October for the fortnight in which the two festive holiday periods occur to match planned activities and projected peaks in demands.*

44. Confirmation has been received from the General Managers of our five operating directorates that appropriate staffing rotas will be in place for medical, nursing, Allied Health Professions (AHP) and support staff.
45. Confirmation has been received from the Out of Hours Service that appropriate support staffing rotas are in place. Medical staffing rotas are prepared based on data awareness and local/NHS24 predictions. These rotas are being filled and actively pursued at this time.
46. Key contact information is cascaded during all weekend and holiday periods.
47. Mental Health out of hours access route is well established, in addition the Crisis Assessment and Treatment Service is available in a 24/7 basis to discuss alternatives to admission to hospital for individuals.

*Priority Action Unscheduled/Elective Care 4: Optimise patient flow by proactively managing Discharge Process utilising Estimated Date of Discharge as soon as patients are admitted or scheduled for admission with supporting processes (e.g.) multi-disciplinary ward rounds. This will support the proactive management of discharge ensuring there are no delays in patient pathways.*

48. There is an established Admission, Transfer and Discharge Policy, agreed in partnership with social work, in place
49. The use of an estimated date of discharge (EDD) is built into the processes and documentation for the admission or discharge planning of patients through DGRI and in addition, the bed management system uses the EDD as a key indicator in the management of beds in the system.
50. The Lead Nurse in DGRI is supporting the use of whiteboards, cortex and daily discharge huddles in the wards to proactively manage the discharge process and ensure no delays in patient pathways.
51. In 2015 we have introduced a Patient Flow Co-ordinator post to focus on the co-ordination of the processes supporting complex discharges as a test of change.
52. The morning whole hospital safety and flow huddle identifies potential discharges and any support required from services to enable the discharge to take place.

53. Daily huddles at Midpark are now in place. Highly successful model that looks at the demand, capacity and risks across the inpatient unit, and involves CATS service, ensuring maximal use of current resources.
54. Further development of proactive multidisciplinary discharge planning is being taken forwards within cottage hospitals
55. The Local Unscheduled Care Action Plan includes for continuation of weekend discharge ambulance provision.
56. A service level agreement is in place with Third Sector providers to support alternative discharge transport in period of high demand.
57. Emergency admission predictions are provided by high level specialties.

*Priority Action Unscheduled/Elective Care 5: Ensure that senior clinical decision making capacity is available for assessment, care planning, MDT and discharge and that AHP rotas are structured to facilitate the discharging of patients throughout weekends and the fortnight in which the two festive holiday periods occur in order to maximise capacity.*

58. Following a successful test of change during last winter the Board has agreed to fund additional hours within key services (including AHP, Pharmacy and Social Work Services) to ensure discharge process can continue on a seven day a week basis.
59. Annual leave across both Acute and Community Services is planned in advance to ensure adequate staffing levels across the festive period.

*Priority Action Unscheduled/Elective Care 6: Agree anticipated levels of homecare packages that are likely to be required over the winter period (especially festive) period and utilise intermediate care options to facilitate discharge.*

60. There are well established processes and forums which support partnership with the third and independent sector. This includes specific discussion and agreement of arrangements over festive holiday periods.
61. Confirmation has been received that discussions are underway between local partners around the capacity to accommodate predicted discharge levels.
62. A partnership approach has been in place for several years and seeks to use all the information and resources available to meet predicted discharge levels. This will be augmented within integration with each of the four localities' monthly meeting focusing upon building system resilience. This will include taking steps to identify social care and third sector capacity to support predicted discharge levels.

63. The Short Term Assessment and Reablement Service will be operational over weekends the festive period providing the opportunity for intermediate care options.
64. Enhanced supported discharge to facilitate specialist mental health interventions is supported by CATS services.
65. Anticipatory care planning is a current focus within the GP Quality Outcome Framework and this year should see a significant increase in anticipatory care plans being shared with OOHs, Scottish Ambulance Services (SAS) and NHS 24 via the electronic Key Information Summary.
66. All Emergency Care Summaries and electronic Key Information Summaries can be accessed by key clinicians upon admission to acute sector.

*Priority Action Unscheduled/Elective Care 7: Ensure that communications between key partners, staff, patients and the public are effective and that key messages are consistent.*

67. Communication within the service and with other NHS Boards is well integrated into normal ways of working and has proven resilience during times of winter pressure.
68. Our Escalation Plan is a multi agency document that addresses issues of joint response to particular pressures.
69. In terms of our Communications Department, we will be making use of the National Campaign material for winter planning as well as local messaging to local media in the run up to winter. We will continue to issue important messages via our Medical Director to augment national messaging. These include website, intranet and internal messages linked to topical items such as flu vaccination.
70. The Communications Team are already working on a series of focussed communications messages in liaison with Emergency Department consultants and the Meet ED campaign. This will include local feature articles in local papers; some linked broadcast media work and local messaging around using services properly.
71. Effective communication takes place with external care providers via the Approved Provider Forum and Care Home Managers meetings and distribution lists.

### **Out of Hours**

72. Under this broad heading, Health Boards are asked to demonstrate preparedness against fourteen core action points. These are covered in detail within the OOHs Winter Plan attached for information in Appendix 3.

### **Prepare for and implement Norovirus outbreak control measures**

73. Under this broad heading, Health Boards are asked to demonstrate preparedness against 11 core action points.

*Priority action Norovirus outbreak 1: Infection Prevention and Control Teams (IPCTs) should read the HPS Norovirus Outbreak Guidance 2015, due to be published in Aug/Sept, to ensure that the Board is optimally prepared.*

74. IPCTs will read the evaluation report and are working to ensure the Board is optimally prepared.

*Priority action Norovirus outbreak 2: IPCTs will be supported in the execution of a Norovirus Preparedness Plan before the season starts.*

75. In place and tested successfully within previous outbreaks.

*Priority action Norovirus outbreak 3: HPS Norovirus Control Measures (or locally amended control measures) are easily accessible to all staff, e.g. available on ward computer desk tops, or in A4 folders on the wards.*

76. All wards have been issued with outbreak packs.

*Priority action Norovirus outbreak 4: Board communications regarding bed pressures and Norovirus ward closures are optimal and everyone will be kept up to date in real time.*

77. Building upon successful communications plans from last year the IPCT and Communications team will continue to work closely together to use same approaches this year.

*Priority action Norovirus outbreak 5: Debriefs will be provided following individual outbreaks or end of season outbreaks to ensure system modifications to reduce the risk of future outbreaks.*

78. Debriefs are firmly established within our protocols and practice.

*Priority action Norovirus outbreak 6: IPCTs will ensure that the Board is kept up to date regarding the national Norovirus situation.*

79. The Infection Control Manager receives prevalence report weekly and cascades as required.

*Priority action Norovirus outbreak 7: Before the Norovirus season has begun, staff in emergency medical receiving areas will confirm with the IPCTs the appropriateness of procedures to prevent outbreaks when individual patients have Norovirus symptoms, e.g. patient placement, patient admission and environmental decontamination post discharge.*

80. Procedures are well established and tested within emergency receiving areas.

*Priority action Norovirus outbreak 8: Boards must ensure arrangements are in place to provide adequate IPCT cover across the whole of the festive holiday period*

81. The local IPCT does not routinely provide seven day cover however arrangements are in place for Infection Control Nurse cover at a weekend or public holiday to support teams in the event of an ongoing outbreak.

*Priority action Norovirus outbreak 9: The Board is prepared for rapidly changing Norovirus situations, e.g. the closure of multiple wards over a couple of days.*

82. In the event of a Norovirus outbreak there are regular update meetings involving the IPCT, senior nurses from affected areas, capacity manager, senior management team and communication teams to manage the outbreak and mitigate impact. The introduction of Polymerase Chain Reaction testing locally last year afforded earlier confirmation/ exclusion of a Norovirus diagnosis and provided opportunity to manage patients more appropriately meaning that earlier in a patient episode it was possible to identify where symptoms were not attributed to Norovirus and hence support the earlier opening of potentially affected areas. This combined with the managed closures of affected bays rather than whole wards where appropriate reduced the impact of the outbreak and supported the Board in managing the situation.

*Priority action Norovirus outbreak 10: There will be effective liaison between the IPCTs and the HPTs to optimise resources and response to the rapidly changing Norovirus situation.*

83. There are regular meetings between IPCT and HPTs and HPTs are invited to, and attend, the daily outbreak meetings.

*Priority action Norovirus outbreak 11: The Board is aware of Norovirus publicity materials and is prepared to deploy information internally and locally as appropriate, to spread key messages around Norovirus and support the 'Stay at Home Campaign' message.*

84. Representatives from the Communications team are in attendance at outbreak meetings and are kept closely abreast of developments. This allows for the provision of regular bulletins to media and updates on the Board website supporting key messages around Norovirus.

### **Seasonal Flu, Staff Protection and Outbreak Resourcing**

85. Under this broad heading, Health Boards are asked to demonstrate preparedness against 5 core action points:

*Priority action Seasonal Flu 1: At least 50% of all staff working in areas with high risk patients such as paediatric, oncology, maternity, care of the elderly, haematology, ICUs, etc., have been vaccinated to prevent the potential spread of infection to patients.*

86. Vaccination of at risk groups will be undertaken according to the protocols successfully established in previous years and we anticipate continued high uptake of vaccine.

*Priority action Seasonal Flu 2: All of our staff have easy and convenient access to the seasonal flu vaccine. In line with recommendations in CMO Letter (2014)12 clinics are available at the place of work and include clinics during early, late and night shifts, at convenient locations. Drop-in clinics are also available for staff unable to make their designated appointment and peer vaccination is facilitated to bring vaccine as close to the place of work for staff as possible*

87. Staff vaccination programmes are already underway and we anticipate maintaining our excellent record in uptake. Programme includes clinics during early, late and night shifts and drop in clinics.

*Priority action Seasonal Flu 3: The winter component of our LUCAP takes into account the predicted surge of flu activity that can happen between October and March and we have adequate resources in place to deal with potential flu outbreaks across this period.*

88. The Local Unscheduled Care Action Plan has identified additional staffing for surge capacity within the ambulatory care ward in DGRI from 1<sup>st</sup> November 15 to 31<sup>st</sup> March 16. Plans are underway to secure staffing.

*Priority action Seasonal Flu 4: HPS weekly updates, showing the current epidemiological picture on influenza infections across Scotland, will be routinely monitored over the winter period to help us detect early warning of imminent surges in activity.*

89. The HPT receives the weekly updates and routinely monitor the local picture on a weekly basis. This is discussed at regular team meetings.

*Priority action Seasonal Flu 5: Adequate resources are in place to manage potential outbreaks of seasonal flu that might coincide with Norovirus, severe weather and festive holiday periods.*

90. Recent successful recruitment to the nurse bank offers resources to support surges in activity and demands due to sickness over the winter period.

### **Respiratory Pathway**

91. Under this broad heading, Health Boards are asked to demonstrate preparedness against 5 core action points.

*Priority action Respiratory Pathway 1: There is an effective, co-ordinated respiratory service provided by the NHS board.*

92. There are established local guidelines in place for patients with exacerbations. These are well used by local clinicians (GPs, OOHs and ED).

93. GPs are actively working with the electronic Key Information Summary (eKIS) and sharing anticipatory care plans with partners within OOHs, NHS 24 and Scottish Ambulance Services. There are close working links between primary care and the Respiratory Team and the GP teams will include any relevant secondary care information within the eKIS.

94. Patients are supported in managing their own condition:
- a. Asthma Action plans are in use throughout both paediatric and adult services
  - b. Pulmonary Rehabilitation is available throughout the region
  - c. Patients are provided with British Lung Foundation supporting information

*Priority action Respiratory Pathway 2: There is effective discharge planning in place for people with chronic respiratory disease including COPD.*

95. Discharge planning from DGRI includes medication review ensuring correct usage/ dosage, good inhaler technique and advice on self care. Information around discharge plans are shared with community teams as appropriate. All required medications are provided to the patient at the point of discharge and review planned with appropriate secondary or intermediate care team or indicated to the primary care team.

*Priority action Respiratory Pathway 3: People with chronic respiratory disease including COPD are managed with anticipatory and palliative care approaches and have access to specialist palliative care if clinically indicated.*

96. Anticipatory care planning and end of life care planning is well established within Primary Care. As already described above close links exist between the Respiratory Team in Acute Sector and Primary Care and therefore if any palliative care discussions take place during an inpatient stay this information is conveyed to the Primary Care Team and incorporated within the eKIS.

97. The Specialist Palliative Care team in NHS Dumfries and Galloway provides support and care to cancer and non cancer patients alike.

*Priority action Respiratory Pathway 4: There is an effective and co-ordinated domiciliary oxygen therapy service provided by the NHS Board.*

98. Procedures for obtaining/ organising home oxygen services are well established with referral routes in place to access home oxygen service over the winter period.

*Priority action Respiratory Pathway 5: People with an exacerbation of chronic respiratory disease/COPD have access to oxygen therapy and supportive ventilation where clinically indicated.*

99. All walk-in centres have access to pulse oxymetry to enable rapid identification of hypoxaemia.

100. Information to identify patients at risk of retaining CO2 is shared with NHS 24 and Out of Hours Emergency Centres via the use of anticipatory care plans and the eKIS. Information is provided by the Respiratory Team, where appropriate, for addition to special notes in OOHs.
101. Access to Non-invasive Ventilation is available although there is a finite resource and therefore can at times be limited due to availability of equipment.

### **Management Information**

102. Under this broad heading, Health Boards are asked to demonstrate preparedness against 4 core action points.

*Priority action Management Information 1: Admissions data will be input to the System Watch predictive modelling system as close to real time as possible.*

103. Admissions data is input on a daily basis.
104. System Watch predictive data is available via a link from Hippo. Information Services is currently exploring options to make this more readily accessible for key staff groups.

*Priority action Management Information 2: Effective reporting lines are in place to provide your Scottish Govt contact with routine weekly management information and any additional information that might be required on an exception / daily basis. In cases where 4 hour emergency access performance deviates significantly from agreed LUCAP trajectories, or where 12 hour waits occur, processes are in place to provide your Scottish Government contact with explanatory narrative outlining the reason for the deviation / wait and detailing any actions that have been taken to recover performance and ensure quality of care. This narrative should accompany the weekly performance data return.*

105. The Board will make weekly returns of key performance data to the Scottish Government to allow high level review of the effects of winter across the country. These reports are presented to NHS Board in collated form on a monthly basis. We are also required to provide immediate notification of significant service pressures including;
- closure of a hospital to emergencies for any reason,
  - unplanned closure of a ward or a number of beds,
  - cancellation of elective procedures because of a lack of capacity,
  - trolley waits exceeding 12 hours,
  - significant outbreak of infection, or
  - significant increase in expected demand
106. Should an exception report be required, it will be sent to NHS Board members as well as to Scottish Government. Our Information Services Team is aware of the reporting requirements and timescales and is set up to submit the required management information.

107. Accountable Managers provide narrative should as per Scottish Government Requirements outlining reason for deviation / wait and detailing any actions that have been taken to recover performance and ensure quality of care. This narrative is prepared for submission in line with reporting schedule.

*Priority action Management Information 3: Where SAS or NHS 24 performance is significantly below agreed performance standards, processes are in place to provide your Scottish Government Performance Management Team with explanatory narrative detailing any actions that have been taken to recover performance and maintain services*

108. Close working arrangements are in place between NHS Dumfries and Galloway and SAS to ensure ongoing dialogue and management of any performance issues.

*Priority action Management Information 4: Effective reporting lines are in place to provide the SG Directorate for Health Workforce & Performance with immediate notification of significant service pressures that will disrupt services to patients as soon as they arise.*

109. Reporting lines are in place to provide Scottish Government notice of significant service pressures.

## **CONCLUSION**

The winter planning of NHS Dumfries and Galloway has been tested and refined through experience of recent challenging winters. Enhancements to patient pathways, a formalisation of escalation protocols and the continuation of excellent joint working with partner agencies put the Board in a strong position to maintain safe and effective services throughout the winter of 2015/16.

NHS Board will receive monthly updates on our performance and receive any exception reports on particular pressures as required throughout this period.

## Capacity Management Procedure

Author:	Original author: Joan Pollard, Service Improvement and Redesign Manager. Updated by Capacity Management Team. Nov 12 Updated by Joan Pollard Improvement Lead Updated By Peter Bryden & Callum Ambridge December 14
Owner	Capacity Management Team
Version	Version 3.1 Date 10/12/14

Dumfries and Galloway  
CAPACITY MANAGEMENT PROCEDURE/ BUSINESS CONTINUITY PLAN

NHS Dumfries and Galloway  
Dumfries and Galloway Council Social Work Services  
Scottish Ambulance Service

## 1 INTRODUCTION – WHY WE NEED A PROCEDURE AND PLAN

- 1.1 This policy has been produced to assist in the management of health and social care capacity across Dumfries and Galloway during periods when **the whole system or one constituent part of the system** is unable to manage the demand being placed upon it. This capacity management plan is separate to the Emergency Planning policy which deals with exceptional, immediately presented demand for emergency care.
- 1.2 In developing this procedure it is assumed that the key partners responsible for delivery of care within Dumfries and Galloway have, in normal operating circumstances, sufficient capacity to provide emergency care services and planned elective activity in accordance with agreed targets.
- 1.3 The health and social care organisations party to this procedure are:
- NHS Dumfries and Galloway Acute and Primary and Community Care Directorates
  - Local authority social work services
  - Scottish Ambulance Service

## 2 GLOSSARY of TERMS

<b>Capacity</b>	The ability of the hospital or service to accommodate the needs of the individual requiring examination, treatment, care or conveyance. It encompasses such things as numbers and availability of staff, beds, care packages, and equipment.
<b>Co-ordinated System</b>	A co-ordinated network of services where everyone works together on behalf of the patient/service user
<b>SAS</b>	Scottish Ambulance Service
<b>AHP</b>	Allied Health Professional
<b>ED</b>	Emergency department
<b>ITU</b>	Intensive Treatment Unit
<b>HDU</b>	High Dependency Unit
<b>STARS</b>	Short Term Assessment and Reablement Service
<b>DNS</b>	District Nursing Service
<b>CPN</b>	Community Psychiatric Nursing

## 3 PRINCIPLES

A set of principles underpin this procedure and have been accepted by all the constituent agencies. These are set out below, with scenario examples of how these principles may apply.

**NOT PROTECTIVELY MARKED**

- **Capacity is managed as a coordinated system across separate organisations and within organisations.**
- **No action will be taken by one constituent part of the system, without prior discussion, which will undermine the ability of any other parts of the system to manage their core business.**
- **As far as is possible to determine, relative clinical priority of patients across all care groups and categories of service (i.e. between emergencies and electives) will be the key determinant of when and where patients are treated and cared for, e.g. this may mean that some emergency patients are given lower clinical priority than urgent elective patients.**
- **Managing patients at a time of increased capacity management problems will require accepting and managing additional risk across organisations, e.g. as individual decisions on patients' care are taken. The capacity management procedure will be based upon an integrated i.e. multi-organisation status report with differing levels of capacity availability and trigger indicators e.g.**
  - **Green** – There are early warnings of pressure in one or more parts of the system and need to manage pressure out of the system. (Pressure in Green is described as ~ limited availability of beds in which to admit emergency patients).
  - **Amber** – Escalating pressure in one of more parts of the system and need for affirmative action across the system to manage capacity and demand. (Pressure in Amber is described as ~ currently no beds available in which to admit emergency patients).
  - **Red** – Demand outstrips capacity and full implementation of contingency plan arrangements. (Pressure in Red is described as ~ despite all actions initiated in Green and Amber there are no beds or any likelihood of beds for emergency admissions).
- **De-escalation will follow the reverse of the processes above.**

#### **4 INFORMATION AND MANAGEMENT**

Arising from the first principle set out above, that capacity is managed as a coordinated system across separate organisations and within organisations, is the requirement to have in place:

- a system to maintain 'real time' information, based upon the key indicators which will feed the management arrangements, to determine the capacity status of the system and inform decisions on remedial action.
- the development of predictive indicators, which can then be used to warn the system of the need to pre-plan capacity arrangements e.g. System Watch.

- arrangements to monitor these indicators and manage the actions required to maintain the system, in accordance with the plan.

## 5 COMMUNICATIONS

It is essential that there are internal i.e. within the health system, and external communication arrangements that can be activated.

Internal communication systems are required to:

- **be predictive** – to prepare staff across the system of future likely capacity requirements and difficulties
- **be ‘real time’** – so that staff are aware of the current position so that action and decisions can taken with accurate information
- **be reassuring** – to give confidence to staff that appropriate action is being taken to manage any difficulty.

All organisations will develop communication mechanisms to respond to communication needs, fed by the capacity management arrangements.

External communication systems are required for similar reasons. The PR/communications leads of all organisations will devise a process for assisting in the handling of external communications.

## 6. DELEGATED AUTHORITY

Acceptance of the principles set out in section 2 above must result in a new way of working together across organisations, particularly decision-making. Currently decisions are taken separately within organisations and action cascades within the separate organisations. If capacity is to be managed as a coordinated system a certain level of joint decision-making, delegated to an operational level, must be accepted across all the organisations in a way that has not occurred systematically in the past. A certain level of co-ordination will also be required.

The use of trigger indicators to activate actions across organisations, as set out in the Plan; will result in ‘automatic’ corrective action being taken to respond to pressures in one or more part of the system. However, if demand is outstripping capacity more considered action will be required. Such action may adversely affect one or more parts of the system e.g. a decision to cancel elective surgery may prejudice waiting time targets.

It is proposed that whenever the Capacity Management Procedure is activated, authority is delegated to the duty directors or managers of each organisation to liaise and report directly to the individual identified at each alert status in the plan.

Those with delegated authority will be provided with the necessary information set out in section 3.

Red alert can **only** be initiated by the Executive Director on call for NHS Dumfries and Galloway.

**NHS Dumfries and Galloway & Partners**

**CAPACITY MANAGEMENT PROCEDURE**

**Indicators**

<b>DUMFRIES AND GALLOWAY CAPACITY MANAGEMENT PROCEDURE – GREEN STATUS</b>			
Early warnings of pressure in one or more parts of the system and need to manage pressure out of the system			
<b>ED and INPATIENT (Acute)</b>	<b>PRIMARY AND COMMUNITY CARE DIRECTORATES</b>	<b>SCOTTISH AMBULANCE SERVICE (SAS)</b>	<b>SOCIAL WORK SERVICES</b>
<b>Indicators</b>	<b>Indicators</b>	<b>Indicators</b>	<b>Indicators</b>
<ul style="list-style-type: none"> <li>• Reduction in capacity to meet elective and emergency admissions i.e.               <ul style="list-style-type: none"> <li>- Challenge to meet ED 4 hours target</li> <li>- All electives allocated a bed</li> </ul> </li> <li>• Staffing levels under pressure to deliver workload</li> <li>• Adult ITU/HDU beds available</li> <li>• Emergency theatre available</li> <li>• No significant problems reported with clinical support services (theatres, pathology, pharmacy, supplies/equipment etc.)</li> </ul>	<ul style="list-style-type: none"> <li>• Pressure on available capacity to meet elective and emergency admissions</li> <li>• Staffing levels under pressure to deliver workload</li> </ul>	<ul style="list-style-type: none"> <li>• Pressure on available capacity to accommodate additional short notice transport requests</li> <li>• Staffing levels under pressure to meet additional demand</li> </ul>	<ul style="list-style-type: none"> <li>• Pressure on beds across the care home sector</li> <li>• Staffing levels under pressure to meet demand</li> <li>• Staffing levels-vacancy factor, inability to recruit to key posts</li> <li>• Domiciliary care-reduced availability of service from the independent sector/in-house sector</li> <li>• Equipment -reduced availability and delay in supply and fitting</li> <li>• Pressure to meet deadlines as per Admission, Discharge &amp; Transfer procedure</li> </ul>

**NOT PROTECTIVELY MARKED**

			<ul style="list-style-type: none"><li>• All patients funded by Local Authority discharged by 48 hours</li></ul>
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## Intervention

<b>DUMFRIES AND GALLOWAY CAPACITY MANAGEMENT PROCEDURE – GREEN STATUS</b>			
Early warnings of pressure in one or more parts of the system and need to manage pressure out of the system			
<b>ED and INPATIENT (Acute)</b>	<b>PRIMARY AND COMMUNITY CARE DIRECTORATES</b>	<b>SCOTTISH AMBULANCE SERVICE (SAS)</b>	<b>SOCIAL WORK SERVICES</b>
<b>Intervention</b>	<b>Intervention</b>	<b>Intervention</b>	<b>Intervention</b>
<ul style="list-style-type: none"> <li>• All patients must have a daily ward round by a Registrar or Consultant</li> <li>• Consultant presence is mandated in Ward 7, DGRI during daytime hours</li> <li>• Consultant led ward rounds in Ward 7 DGRI at least twice per day</li> <li>• Nurse in charge of ward informs Capacity Manager / Site Manager or Duty Manager of ward status identifying:-               <ul style="list-style-type: none"> <li>○ Additional, next day discharges, ensure AHP input when appropriate, and discharge appropriately</li> <li>○ All patients suitable for transfer to Cottage Hospitals today, next day and next 72 hours</li> <li>○ Identify both Delayed Discharge patients and those suitable for sleeping out-with specialty if necessary</li> </ul> </li> </ul> <p><b>Actions to be taken before moving to Amber</b></p> <ul style="list-style-type: none"> <li>• Convene the daily Capacity meeting</li> <li>• Identify patients awaiting investigation who could potentially be discharged to have investigation as an out-patient</li> <li>• Identify elective medical patients for potential discharge or cancellation</li> <li>• Consider any further transfers to community hospitals, involving:-               <ul style="list-style-type: none"> <li>- Medical staff</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Identify patients for early discharge to facilitate step down from acute hospital and accommodate emergency admission from community</li> </ul>	<ul style="list-style-type: none"> <li>• Ongoing monitoring of ability to accommodate additional short notice transport requests.</li> </ul>	<ul style="list-style-type: none"> <li>• Collate and monitor bed availability</li> <li>• Pressure to meet deadlines as per Admission, Discharge &amp; Transfer procedure</li> <li>• All services to maintain information flow</li> <li>• Reassess patients suitability for discharge as part of MDT process in wards</li> </ul>

**NOT PROTECTIVELY MARKED**

<ul style="list-style-type: none"><li>- Community Hospital staff</li><li>- Allied Health Professionals (AHP),</li><li>- Short term augmented response service</li><li>- Pharmacy</li><li>- Scottish Ambulance Service (SAS)</li></ul> <p>All services to maintain information flow of current and expected activity and staff levels coordinated Capacity Manager / Site Manager or Duty Manager</p>			
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## Accountability

<b>DUMFRIES AND GALLOWAY CAPACITY MANAGEMENT PROCEDURE – GREEN STATUS</b>			
Early warnings of pressure in one or more parts of the system and need to manage pressure out of the system			
<b>ED and INPATIENT (Acute)</b>	<b>PRIMARY AND COMMUNITY CARE DIRECTORATES</b>	<b>SCOTTISH AMBULANCE SERVICE (SAS)</b>	<b>SOCIAL WORK SERVICES</b>
<b>Accountability for Interventions</b>	<b>Accountability for Interventions</b>	<b>Accountability for Interventions</b>	<b>Accountability for Interventions</b>
<ul style="list-style-type: none"> <li>• Nurse in charge of ward area (including ED)</li> <li>• Capacity Manager / Site Manager / Nurse Manager</li> <li>• Duty General Manager</li> <li>• STARS</li> <li>• Community Rehabilitation Teams (Out of Hours Cottage Hospital Nurse in charge)</li> <li>• Medical Staff each ward area</li> <li>• Allied Health Professionals (AHPs)</li> <li>• Pharmacy</li> <li>• Community/Community Hospital staff</li> </ul>	<ul style="list-style-type: none"> <li>• Nurse in charge of ward area</li> <li>• Capacity Manager / Site Manager or Duty Manager</li> <li>• STARS</li> <li>• Community Rehabilitation Teams (Out of Hours Cottage Hospital Nurse in charge)</li> <li>• Medical Staff each ward area</li> <li>• Allied Health Professionals</li> <li>• Pharmacy</li> <li>• Community/Community Hospital staff</li> <li>• GP in charge of inpatient areas</li> </ul>	<ul style="list-style-type: none"> <li>• All services to determine medical requirement for ambulance transport</li> <li>• All services to consider alternative methods of transport</li> </ul>	

**NOT PROTECTIVELY MARKED**

If Green status continues beyond 6 hours with no decrease of pressure across the system then the Capacity Manager / Duty Manager will initiate **Amber Status**. NO SITE WILL CLOSE EXCEPT ON THE INSTRUCTION OF THE EXECUTIVE ON CALL  
DE-ESCALATION WILL FOLLOW THE SAME PRINCIPLES REVERSED

## Indicators

DUMFRIES AND GALLOWAY CAPACITY MANAGEMENT PROCEDURE – AMBER STATUS			
Escalating pressure in one or more parts of the system and need for affirmative action across the system to manage capacity and demand			
ED and INPATIENT (Acute)	PRIMARY AND COMMUNITY CARE DIRECTORATES	SCOTTISH AMBULANCE SERVICE (SAS)	SOCIAL WORK SERVICES
Indicators	Indicators	Indicators	Indicators
<ul style="list-style-type: none"> <li>• Number of elective/emergency admission is causing significant pressure on available bed capacity</li> <li>• Considerable pressure on staffing levels to provide safe and appropriate care i.e.               <ul style="list-style-type: none"> <li>○ Delays in beds available in Ward 7</li> <li>○ Patients in ED waiting &gt; 4 hours for transfer to wards</li> <li>○ Impacting on elective admissions</li> <li>○ ED department breaching 4 hour target</li> </ul> </li> <li>• Adult ITU/HDU beds under pressure</li> <li>• Emergency theatre available</li> <li>• Intermediate problems reported with clinical support services (Theatres, Pathology, Pharmacy, Supplies etc)</li> <li>• Any incident that <b>significantly</b> affects patient flow</li> <li>• Infection control concerns that may impact on bed availability (see relevant infection control policy)</li> </ul>	<ul style="list-style-type: none"> <li>• Increasing pressure on bed capacity within community bed setting</li> <li>• Considerable pressure on staffing levels to provide safe and appropriate care</li> <li>• Infection control concerns</li> <li>• Any incident that <b>significantly</b> affects admission or discharge</li> </ul>	<ul style="list-style-type: none"> <li>• No capacity to accommodate transport requests at short notice for <b>outpatient appointments</b></li> </ul>	<ul style="list-style-type: none"> <li>• Bed availability – reduction in beds available across the care home sector</li> <li>• Staffing levels- vacancy factor unable to recruit to key posts</li> <li>• Domiciliary care- no availability of service from the independent sector/in-house</li> <li>• Equipment- waiting lists and delay in supply and fitting</li> <li>• Pressure to meet deadlines as per Admission, Discharge &amp; Transfer procedure</li> </ul>

**NOT PROTECTIVELY MARKED**

## Intervention

<b>DUMFRIES AND GALLOWAY CAPACITY MANAGEMENT PROCEDURE – AMBER STATUS</b>			
Escalating pressure in one or more parts of the system and need for affirmative action across the system to manage capacity and demand			
<b>ED and INPATIENT (Acute)</b>	<b>PRIMARY AND COMMUNITY CARE DIRECTORATES</b>	<b>SCOTTISH AMBULANCE SERVICE (SAS)</b>	<b>SOCIAL WORK SERVICES</b>
<b>Intervention</b>	<b>Intervention</b>	<b>Intervention</b>	<b>Intervention</b>
<ul style="list-style-type: none"> <li>• <b>All Green Status Interventions completed</b></li> <li>• <b>Additional consultant ward rounds will be initiated in all wards</b></li> <li>• Nurse in Charge to inform Capacity Manager / Site Manager or Duty Manager</li> <li>• Consultant presence required on ward 7 and in ED DGRI and medical presence in GCH</li> <li>• Capacity Manager / Duty Manager inform Cascade List and initiate following actions:-</li> <li>• Discharge those awaiting investigation identified in Green</li> <li>• Inform Community Care, NHS 24, Out of Hours Service and SAS of amber status</li> <li>• Establish as early as possible staffing potential for Opening all closed beds including Day Surgery Unit for overnight care.</li> <li>• Where appropriate identify low clinical patients and transfer out to cottage hospitals.</li> <li>•</li> <li>• Consider based on intelligence informing communications team to prepare press/media statement</li> <li>• Consider based on intelligence and with medical support cancelling all elective activity (excluding angiograms) within Medicine</li> <li>• Consider based on intelligence and with medical support</li> </ul>	<p><b>All Green Status Interventions completed</b></p> <p>Nurse in Charge to inform Cottage Hospital Service Manager of current status, Community Service Manager to inform Capacity Manager / Site Manager or Duty Manager, Cancel all elective admissions GP ward rounds within Community hospitals to identify and facilitate early discharges</p> <p><b>Maximise ALL resources available in Community, i.e.</b></p> <ul style="list-style-type: none"> <li>• Intermediate care</li> <li>• District Nursing</li> </ul>	<p><b>All Green Interventions made</b></p> <p>No short notice requests for ambulance transport to be accepted</p>	<p><b>All Green Interventions made</b></p> <ul style="list-style-type: none"> <li>• Inform all other agencies of situation</li> <li>• Consider delaying all non-critical respite admissions to care homes</li> <li>• Contact all relevant agencies to assist</li> </ul>

**NOT PROTECTIVELY MARKED**

<p>identifying and cancelling non-urgent elective surgery (including specialist services, orthopaedics, gynaecology and medical angiograms) activity in discussion with the clinical director/manager</p> <p><b>Actions to be taken before moving to Red</b> Capacity Manager / Site Manager or Duty Manager inform Cascade List and initiate following actions:-</p> <ul style="list-style-type: none"> <li>• All surgical specialties to identify and prioritise urgent surgical patients for <b><i>potential</i></b> cancellation</li> <li>• Inform Diagnostics, Pharmacy and AHPs to assist in further discharging by rapid processing of patients</li> <li>• Full use of Infection Control Team where appropriate</li> </ul>	<p>Services</p> <ul style="list-style-type: none"> <li>• Community rehabilitation teams</li> <li>• CPN teams</li> <li>• Full use of infection control team</li> </ul>		
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### Accountability

<b>DUMFRIES AND GALLOWAY CAPACITY MANAGEMENT PROCEDURE – AMBER STATUS</b>			
Escalating pressure in one or more parts of the system and need for affirmative action across the system to manage capacity and demand			
<b>ED and INPATIENT (Acute)</b>	<b>PRIMARY AND COMMUNITY CARE DIRECTORATES</b>	<b>SCOTTISH AMBULANCE SERVICE (SAS)</b>	<b>SOCIAL WORK SERVICES</b>
<b>Accountability for Interventions</b>	<b>Accountability for Interventions</b>	<b>Accountability for Interventions</b>	<b>Accountability for Interventions</b>

<ul style="list-style-type: none"><li>• Nurse in charge of ward area</li><li>• Capacity Manager / Site Manager</li><li>• STARS</li><li>• Consultant medical staff each ward area</li><li>• Communications team</li><li>• Infection control team</li><li>• Duty General Manager</li></ul>	<ul style="list-style-type: none"><li>• Nurse in charge of ward area</li><li>• Service Managers</li><li>• Community Teams</li><li>• GP for ward beds</li><li>• DNS</li><li>• CPN service</li><li>• Community Rehabilitation teams</li></ul>		
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**NOT PROTECTIVELY MARKED**

Cascade list for notification	Cascade list for notification		Cascade list for notification
<p>All GREEN interventions completed All AMBER interventions completed</p> <p>Cascade notification list for Capacity Manager / Site Manager or Duty General Manager</p> <ul style="list-style-type: none"> <li>• ED Consultant</li> <li>• Executive on call</li> <li>• Switchboard</li> <li>• Consultants/On-call Consultants</li> <li>• Pharmacy (To maximise all further discharges)</li> <li>• Duty AHPs</li> <li>• Communications team – to prepare media release in consultation with Executive on call</li> <li>• Scottish Ambulance Service</li> <li>• Practice Managers (in hours) (Emergency admissions only), Out of hours - NHS 24 and local out of hours services)</li> </ul> <ul style="list-style-type: none"> <li>• Contact Dumfries and Galloway Social Services</li> <li>• Contact Duty General Manager Primary and Community Care Directorates</li> </ul>			<p>Once all capacity maximised, inform Locality managers and Head of Social Work Services or out of hours the on call senior manager via Social Work Standby service</p>

If Amber status continues beyond 4 hours with no likely decrease of pressure across the system then the EXECUTIVE ON CALL for NHS Dumfries and Galloway will initiate **Red Status**.

EXECUTIVE ON CALL will contact switchboard to trigger calls to CONTINGENCY PLANNING TEAM.

DE-ESCALATION WILL FOLLOW THE SAME PRINCIPLES REVERSED

**NOT PROTECTIVELY MARKED**

## Indicators

DUMFRIES AND GALLOWAY CAPACITY MANAGEMENT PROCEDURE – RED STATUS Demand outstrips capacity contingency plan arrangements			
ED and INPATIENT (Acute)	PRIMARY AND COMMUNITY CARE DIRECTORATES	SCOTTISH AMBULANCE SERVICE (SAS)	SOCIAL WORK SERVICES
Indicators	Indicators	Indicators	Indicators
<p><b>All Amber interventions completed across all sectors</b></p> <p><b>Unlikely to return to Amber status within next 4 hours</b></p> <p><b>All bed capacity fully utilised across all sectors</b></p> <p>Adult ITU/HDU beds under <b>significant</b> pressure (see ITU/HDU escalation policy)</p> <p>Emergency theatre limited capacity/unavailable</p> <p>Shortage of equipment / supplies in key areas</p> <p>Significant problems reported with clinical support services (Theatres, Pathology, Pharmacy etc)</p> <p>Any incidents that <b>significantly</b> affect patient flow</p> <p>Infection control concerns <b>significantly</b> impacting on bed availability (see relevant infection control policy)</p>		<p>Inability to accommodate additional transport requests</p>	<p>Bed availability – no beds available across the care home sector/ local authority or out of area</p> <p>Staffing levels- inability to recruit to key posts</p> <p>Sickness absence- significant staff in key posts unavailable to work</p> <p>Domiciliary care- fully maximised resource no service available from the independent sector/in-house service</p> <p>Equipment –no availability to supply and fit</p>

NOT PROTECTIVELY MARKED

## Intervention and Accountability

<b>DUMFRIES AND GALLOWAY CAPACITY MANAGEMENT PROCEDURE – RED STATUS</b>			
<b>Demand outstrips capacity contingency plan arrangements</b>			
<b>ED and INPATIENT (Acute)</b>	<b>PRIMARY AND COMMUNITY CARE DIRECTORATES</b>	<b>SCOTTISH AMBULANCE SERVICE (SAS)</b>	<b>SOCIAL WORK SERVICES</b>
<b>Intervention &amp; Accountability</b>	<b>Intervention &amp; Accountability</b>	<b>Intervention &amp; Accountability</b>	<b>Intervention &amp; Accountability</b>
<p><b>All Amber interventions completed. The Capacity Manager / Site Manager or Duty General Manager will contact Executive on call, who will trigger contingency planning team meeting.</b></p> <p>Contingency planning team convened within ONE hour in DGRI</p> <ul style="list-style-type: none"> <li>• Received status report from Capacity Manager / Site Manager or Duty General Manager</li> <li>• Inform all agencies of alert status</li> <li>• Identify private sector capacity for transfer delayed discharged patients</li> <li>• Utilise all available transport (e.g.) Local Authority provision</li> <li>• Medical Director to lead on prioritising patients for:-               <ul style="list-style-type: none"> <li>○ Discharge from all specialties including all electives admitted that day</li> <li>○ Cancellation of prioritised urgent surgical list</li> <li>○ Cancellation of elective admissions for the following day</li> </ul> </li> <li>• Medical Director will discuss with on Call Consultants the temporary use of short stay ward capacity</li> <li>• Redeployment of theatre/recovery staff</li> <li>• Release statement to press/media</li> <li>• Capacity must be maintained in ED at all times to receive trolley bound emergency patients</li> </ul>		<p><b>Amber interventions completed</b></p> <ul style="list-style-type: none"> <li>• Request assistance from Social Work department</li> <li>• Cancel transport for non-essential outpatients.(contact clinics with details and clinics to contact patients</li> <li>• Request staff to work overtime</li> </ul>	<p><b>All Amber interventions completed</b></p> <ul style="list-style-type: none"> <li>• Establish bed availability out of area</li> <li>• Senior management to identify resources available for purchasing additional beds</li> <li>• Centralized control over deployment of available home care resources in both in-house and independent sectors</li> </ul>

NOT PROTECTIVELY MARKED

**Contingency Planning Team**

Contingency planning team are contacted by switchboard (numbers held by switchboard) and comprise of :-

- Executive on call/Chief Operating Officer
- Director of Nursing NHS Dumfries and Galloway
- Associate Medical Director
- Health Strategy Team
- Infection Control
- Local Authority
- Scottish Ambulance Service
- Communications team
- Dumfries and Galloway Emergency Planning Officer

The contingency planning team has the discretion to contact other relevant key personnel as required.

**DE-ESCALATION WILL FOLLOW THE SAME PRINCIPLES REVERSED**



**Emergency Department**  
Escalation Policy

Author:	Original author: Joan Pollard, Service Improvement and Redesign Manager. Updated by DGRI Emergency Department and Capacity Management Team.
Owner	DGRI Emergency Department and Capacity Management Team.
Version	Version 2 Date 8/11/12

## Emergency Department Escalation Policy

### Introduction and Scope

The following policy outlines a whole system approach to escalating problematic situations that may arise when trying to meet the 4-hour Emergency Department (ED) standard of 98%. It is intended to shift the focus from problems being held in Emergency Department to being communicated and action taken by relevant individuals in NHS Dumfries and Galloway and its partner organisations. It also provides, at the appropriate point clarity, to external organisations about NHS Dumfries and Galloway's alert status and the response required in the community. This escalation policy affects every department within the hospital and the specific responses required by key people are outlined in the document.

The aim of this policy is to ensure that:

- There is efficient patient flow through emergency care
- Patients are not compromised by waiting unnecessary lengths of time on an Emergency Department trolley and that a decision about their care is made in a timely manner.
- Patient needs and their journey towards the 'right place at the right time' are facilitated
- The profile of 24/7 safety is highlighted
- There is enhanced communication within team and all visiting staff will clearly understand status of workload in Emergency Department.
- There is an evidence based criteria for ensuring safe working levels
- Criteria used in the policy are based on local experience and multidisciplinary agreements.

### 1.0 Process

1.1 The purpose of the escalation policy is to ensure that key individuals are made aware of a potential problem in achieving the 4-hour standard and assist wherever possible.

1.2 The key indicator for initiating the escalation process is the 3-hour waiting time. If patients have reached a 3-hour waiting time and they are unlikely to achieve the 4-hour target the escalation process **must** be initiated.

1.3 The Situation Report flowchart indicates the key individual to contact if a problem requiring the escalation policy to be initiated occurs. The nurse in charge of the Emergency Department contacts the individual indicated under each specific area. Once passed on it is then up to that individual to contact the next key person if the problem cannot be resolved. However it is

expected that before it is passed up individuals complete their tasks outlined in this policy.

1.4 Details of the role of each key person, when contacted as part of the escalation process, are included in the following document. Please note: *Communication processes may differ in-hours and out of hours.*

1.5 If at any stage the Emergency Department staff is unsure whom to contact and the patient has passed the 3-hour stage, the Capacity Manager / Site Manager must be contacted and their presence requested in the department.

1.6 Users of the policy must be aware that there is less than 1 hour from initiation of escalation policy to avoid the 4 hour breach; therefore escalation of the policy must be fairly swift. Also please ensure that senior managers are informed before the breach has taken place so action can be taken, however they will have expected all tasks prior to that escalation point have been completed.

1.7 Notification Triggers by Email from EDIS are as follows:

- 3 hours to Capacity / Site Manager
- 4.5 hours to Duty Manager on call
- 7.5 hours to Executive Director on call
- >10 hours to Chief Executive

## **2.0 Example**

The basis of this policy is a common sense approach to escalation; an example may be delays due to bed capacity. Following alert from the Emergency Department Senior Nurse, the Capacity Manager/Site Manager must escalate as soon as possible following completion of tasks outlined in this Policy. They will then contact relevant Department Managers to request assistance if the problems have not been resolved. It is important to bear in mind that we are working towards 100% of patients being seen/treated/discharged/admitted or transferred in <4 hours so if in doubt escalate the process.

## **3.0 Key Roles**

### **3.1 Role of the Emergency Department Nurse in Charge**

- To monitor waiting times and ensure relevant individuals are contacted at the key indicator of 3-hour wait, if the waiting patient may breach the 4-hour target and the problem cannot be resolved.
- Ensure majors and minors streams are working as effectively as possible.
- To ensure high quality and efficient patient care is maintained throughout the patient's time in the Emergency Department.

- To contact Capacity Manager/Site Manager as per the Situation Report flow table (mainly diagnostic/bed capacity or transport problems).
- To inform the Emergency Department Nurse in Charge OR Emergency Department Consultant (In-hours) or Site Manager, (Out-of-hours) at 3-hour wait if the patient's care is compromised or the escalation policy has been initiated and no response is found.
- If the Surgical/Paediatric/Orthopaedic second on-call (decision maker i.e. SHO) has been bleeped and there is no response after 30 minutes, initiate on-call system and contact the Consultant on-call directly, explaining the problem. Document, sign and date on the patient notes the decisions made. If the department is under exceptional pressure this action may be escalated to the site manager.

### **3.2 Role of the Emergency Department Consultant**

- When informed of escalating problems assist in department wherever possible i.e. assist with backlog of patients.
- If problems remain with contacting specialist teams, inform relevant consultants when appropriate (i.e. ensure on-call arrangements are being adhered to for General Surgery/Orthopaedics/Paediatrics).

### **3.3 Role of Site Manager**

- Utilise the Situation Report escalation matrix to assess the status of the Board.
- Inform the community when we reach amber status and then the transition from amber to red.
- Respond to Emergency Department request to help resolve potential 4-hour breach.
- Consider redistribution of staff if necessary
- Contact relevant Department Manager or On-call Manager (out-of-hours) to resolve department specific problems that will potentially cause a 4-hour breach.
- Contact relevant on-call specialist teams and request assistance with admission/discharge procedures as necessary.
- To feedback to the 'escalator' on action taken within 15 minutes of initial contact.
- Ensure that the on-call manager and Executive have been made aware of any specific problems or initiation of escalation procedures before completion of the shift.

- Liaise with emergency ambulance control as necessary to understand what is on the stack for NHS Dumfries and Galloway.

The Site Manager (In Hours) will walk around the wards and departments and ensure the following:

- Transport for patients awaiting discharge is organised and facilitates timely discharge.
- Patients awaiting Discharge medication have been identified and nurses in charge are chasing Discharge medication.
- The Nurse in Charge in each ward and department will clarify reasons for delayed discharges and ensure patients are received from the Emergency Department within 15 minutes of the bed being allocated.
- Update bed state.
- Review current elective admissions status, liaising with Departmental Managers or designated deputy.
- Liaise with ward staff to facilitate medical staff identifying patients for prompt discharge referring to Clinical Director if significant problems are highlighted.
- Call an emergency escalation meeting with Capacity Manager / Site Manager / Departmental Managers etc if the problem is likely to continue to escalate without this intervention.
- If In-Hours the escalation policy is initiated as a result of severe bed capacity problems an escalation meeting must be called (In-hours) or the on call manager contacted (Out of Hours). If the problem cannot be resolved the on-call Executive must be informed for a decision regarding further action.

#### **3.4 Role of On-Call Manager (NB- May be carried out by phone)**

- Ensure all actions in escalation process have been followed and the relevant people have been informed.
- Identify the specific area of problem i.e. bed capacity/diagnostic process delays etc.
- If there is a bed capacity problem:
  - Ensure TTO requests have been dispensed.
  - Ensure an up-to-date bed state has been produced including any elective admissions awaiting admission.
  - Consider possible cancellations if bed capacity is the problem.

- Ensure all medical/surgical teams have undertaken comprehensive ward rounds to assess patient's fit for discharge.
- Ensure Primary & Community Care Directorates have been asked to identify extra capacity – including Community Hospital/ Community Rehabilitation/district nursing/GP's etc.
- Consider re-distribution of staff if appropriate.
- Feedback must be given to the escalator within 15 minutes of action taken.
- If at 7.5 hours, once all queries have been answered and if the waiting time problem is not resolved, inform Executive on-call alerting them to significant problems affecting the achievement of the 4-hour turnaround target.
- A Board decision must then be made at this point if no capacity is available and problem is escalating (multiple potential 4-hour breaches).

### **3.5 Role of General Manager**

- If contacted to attend an emergency escalation meeting this and any actions from the meeting pertaining to the particular department must be dealt with as a priority.
- Feedback regarding action taken must be given to the Capacity Manager (In-hours), within 15 minutes of escalation, who will inform relevant departments.

### **3.6 Role of Consultant General Surgeon/ Orthopaedic Consultant/ Paediatric Consultant On-call**

**Please note:** It is the duty of every on-call consultant in every speciality to ensure that one member of their on-call team can assess patients promptly in the Emergency Department to ensure they receive efficient assessment and treatment and when necessary admission to wards.

- Respond to the Emergency Department when block on-call system initiated (this will usually be as a result of the Emergency Department being unsuccessful in contacting the second on-call of that speciality).
- Attend the Emergency Department to see the patient for senior review as soon as possible.
- Patients should not be automatically admitted if they have not been seen by a doctor in the Emergency Department to minimise risks associated with patients waiting on wards without a care plan.

**OR...**

If the patient is admitted to a ward without being seen by a doctor they must have a senior review within 30 minutes of being admitted to the ward.

*NB: For Orthopaedics - patients with fractured hip may be fast tracked to the ward following the new integrated care pathway.*

### **3.7 Role of Radiology/Orthopaedic wards**

Surgical procedures such as emergency Dynamic Hip Screws that may be carried out at the weekends require a radiographer for the procedure and thus at weekends this will hold the only on-call Radiographer. This may cause 4-hour breaches for patients awaiting diagnosis. It is vital that the wards inform Radiology as soon as they are aware of procedures that will be carried out OOH/Weekends involving a Radiographer in order that steps can be taken to mitigate the impact.

### **3.8 Role of on-call Executive**

- Ensure all appropriate action has been taken to achieve waiting time target (see other roles)
- Consider re-distribution of staff if appropriate and if it has not already taken place.
- Consider treat and transfer options if appropriate.
- Inform Chief Executive if all avenues have been explored and the difficulty cannot be resolved and multiple 4-hour breaches will occur.

**3.9 National Standard: 100%** (98% allowing for clinical exceptions), of patients to spend less than 4 hours in the Emergency Department from arrival to admission/discharge.

**Situation Report: Key Triggers & Actions Escalation Matrix**

STATUS / COLOUR	CRITERIA / KEY TRIGGERS	ACTIONS
<i>Status/colour Illustrated on 'SIT REP' Board at Nurses' Station in Emergency Department (ED)</i>		
<b>GREEN</b>		
	<ul style="list-style-type: none"> <li>Capacity Satisfactory</li> </ul>	<ul style="list-style-type: none"> <li>Maintain active awareness of Patient Expects</li> </ul> Consider moving to <b>AMBER</b> if: <ul style="list-style-type: none"> <li>more than one hour from time of referral to review by specialist has passed</li> <li>more than one hour from time of informing bed manager to availability of bed</li> </ul>
<b>AMBER</b>		
	<ul style="list-style-type: none"> <li>4+ Patients not seen by Medical Staff or Nurse Practitioner (NP).</li> <li>Cat 4 Triage not seen by Medical staff or NP within 1 hour.</li> <li>&gt;6 GP to other Team admissions in ED</li> <li>&gt;6 Cat 3 Triage or above</li> <li>12 or more Amber &gt;120 mins on EDIS</li> <li>Combination of above triggers</li> <li>Infective Isolation case in ED</li> <li>High Volume of ED cases &amp; &gt;6 on Patient Expects</li> <li>Ward 7 Assessment bays full</li> <li>ED Nurse Staffing on duty is less than routine allocation, e.g. &lt;4+2, &lt;4+2, &lt;3+1</li> <li>ED Cubicle capacity – Resus, Majors &amp; Minors reaching capacity</li> <li>Amber Situation is Dynamic and therefore flexibly defined by Senior Doctor &amp; Nurse in Charge on duty.</li> </ul>	Green actions + <ul style="list-style-type: none"> <li>ED Nurse in Charge &amp; ED Senior Medical on duty to assess and take internal steps to rectify.</li> <li>Request attendance of ED Consultant if not already in Department.</li> <li>Inform Capacity / Site Manager as early as possible.</li> <li>Assign Nurse to Triage Role.</li> <li>Use Room 'A' as dedicated Triage Cubicle.</li> <li>Inform Out of Hours Service when they are operational.</li> <li>Re-triage cases to OOH.</li> </ul> If remedial actions are unsuccessful escalate to Sit Rep ' <b>RED</b> '

<b>RED</b>	
	<ul style="list-style-type: none"> <li>• No ED Medical staff on duty...</li> <li>• or more patients expected requiring in Trauma Call.</li> <li>• Ongoing Resuscitations</li> <li>• Patient in a bed in ED owing to ward based capacity issues</li> <li>• Patients requiring immediate escorted transfer to tertiary care</li> <li>• Mobile Surgical Team deployed.</li> <li>• CBRN Incident.</li> <li>• Major Incident standby.</li> <li>• Major Incident confirmed.</li> </ul>
	<p>Amber actions +</p> <ul style="list-style-type: none"> <li>• Nurse in Charge removed from clinical workload – Co-ordinator role only.</li> <li>• Nurse in Charge request Capacity / Site Manager for support staff to assist care and transfer of patients</li> <li>• Request attendance of Receiving Team Consultant as appropriate.</li> <li>• Triage GP Direct to receiving Wards.</li> <li>• Respective Receiving Team Consultant on call must be notified if patients taken directly to receiving ward</li> <li>• Arrange transfer of stable admissions to wards.</li> <li>• Commence Situation Action Report.</li> </ul>

## OOHs Planning for Winter 2015/2016

### Introduction

*Planning for the winter and particularly the festive period is ongoing within the Out of Hours Service. Modifications to our processes and capacity are being arranged, building on our experience of previous years. These arrangements will ensure that we will deliver a quality service locally which can work with NHS24 and our partner colleagues, e.g. GP Surgeries, Emergency Department, Mental Health Services, Scottish Ambulance Service, our Nursing Teams, district general and community hospitals, care and nursing homes etc, to help manage patient requirements and be responsive to any spikes in demand which may occur.*

The planning activity is best described under separate headings:

1. Capacity planning for the local service.
2. Recruitment
3. Integrated working with the Emergency Department and other partners
4. Transport
5. NHS24 Satellite Centre
6. Staff health and fitness - Flu vaccination programme
7. Community Pharmacy arrangements
8. Social Services
9. Demand Management & Communications

### **1. Capacity Planning for the Local Service**

The Out of Hours Service capacity over the 2015/2016 winter and festive period is being planned to reflect the predicted demand over the period based on:-

- Activity over the winter of 2004/05 through to the winter period of 2014/15
- Demand over the festive periods for the years 2004/05 through to 2014/15
- Ongoing activity and trends
- Information and predictive material from NHS D&G Public Health Services
- NHS24 predictions based on computer simulations
- Consultation with staff
- Feedback from service users
  - NHS24 predictions based on computer simulations

- Consultation with staff
- Feedback from service users

In regard to the wider winter period the following call demand has been recorded, the steady reduction in overall calls to the Service in recent times, being reversed last winter, call volume returning to historical levels. The face to face involvement in Primary Care Centre (PCC) attendances and community calls, e.g. Home Visits, Nurse Visits plus Telephone Advice calls continue to be the main commitment with NHS24 staff effectively managing and screening a large volume of the overall calls.

<b>OOH Activity 1 November - 31 January</b>									
<b>Call Type</b>	<b>2006/07</b>	<b>2007/08</b>	<b>2008/09</b>	<b>2009/10</b>	<b>2010/11</b>	<b>2011/12</b>	<b>2012/13</b>	<b>2013/14</b>	<b>2014/15</b>
<b>GP Advice</b>	984	867	1,007	1,489	1176	1096	1148	1084	1293
<b>PCC</b>	2,924	2,571	3,146	3,295	3039	2629	2721	2474	2837
<b>Visit</b>	2,271	2,039	2,046	2,122	1903	1886	1816	1824	1954
<b>Inpatient Advice (Community Hospitals)</b>	3	17	13	19	29	34	22	45	60
<b>Inpatient Visit (Community Hospitals)</b>	18	81	138	172	217	267	145	184	244
<b>A&amp;E Nurse</b>	0	235	267	302	281	271	264	283	380
<b>District Nurse</b>	391	222	234	296	281	325	279	333	397
<b>Cuedoc (Carlisle OOHs)</b>	48	25	24	24	39	40	35	26	35
<b>NHS24 Advice</b>	3,175	2,933	3,065	3,058	2963	2616	2650	2396	2762
<b>Marie Curie Nurse</b>							8	21	23
<b>Total Calls</b>	<b>9,814</b>	<b>8,990</b>	<b>9,940</b>	<b>10,777</b>	<b>9,928</b>	<b>9,178</b>	<b>9,088</b>	<b>8,671</b>	<b>9,985</b>

**NOT PROTECTIVELY MARKED**

As background, over the festive holidays, the following contacts were received by NHS24 for Dumfries and Galloway:-

### **2009/2010**

Predictions for call demand over the two week festive period were provided by NHS24 and accurately anticipated demand. Over the four day period from 18.00hrs on Christmas Eve 1,089 calls were made to NHS24 with 373 of these requiring Primary Care Centre consultations and 291 calls to community/home visits or community hospital in patients. For the same period over the New Year – 411 Primary Care Centre consultations were undertaken with 270 'community visit' type calls.

### **2010/2011**

Predictions for call demand over the two week festive period were provided by NHS24 and accurately anticipated demand. Over the four day period from 18.00hrs on Christmas Eve 1,216 calls were made to NHS24 with 478 of these requiring Primary Care Centre consultations and 240 calls to community visits or community hospital in patients. For the same period over the New Year 1365 calls were made to NHS24 – 510 Primary Care Centre consultations were undertaken with 270 community type calls.

### **2011/2012**

Predictions for call demand over the two week festive period were provided by NHS24 and accurately anticipated demand. Over the four day period from 18.00hrs on Friday 23<sup>rd</sup> December 947 calls were made to NHS24 with 320 of these requiring Primary Care Centre consultations and 191 calls to community visits or community hospital in patients. For the same period over the New Year 1123 calls were made to NHS24 – 399 Primary Care Centre consultations were undertaken with 211 community visit type calls. In comparison to last year calls of Christmas period were down by 22% and at New Year 18%.

### **2012/2013**

Again, NHS24 predictions were accurate and followed the historical charting. During the 18.00hrs on Christmas Eve through to 07.59hrs on 27 December 2012, 443 calls were made to NHS24, all managed by the duty staff. 537 calls were received during the similar period over New Year – 18.00hrs 31 December 2012 to 07.59hrs on 3 January 2013. Medical and support staffing was in place to manage the anticipated demand.

### **2013/2014**

During the 18.00hrs on Tuesday 24 December 2013 through until 08.00hrs on Friday 27 December 2013, 469 calls were recorded across the area, in line with NHS24 predictions and planned staffing. The New Year period – 18.00hrs on 31 December 2013 through to 08.00hrs on Friday 3 January 2014, saw 510 patient calls, again all dealt with within planned resource.

**2014/2015**

The '4 day' period 18.00hrs on Wednesday 24 December 2014 through to 08.00hrs on Monday 29 December 2014 had 1,064 calls reflecting the 'four day'. 390 (36.65%) of these calls were dealt with at the Primary Care Centre (PCC) and 297 (27.9%) on community visits. The New Year period – 18.00hrs on Wednesday 31 December 2014 to 08.00hrs on Monday 05 January 2015 saw 1,150 calls, 405 (35.22%) being seen at the PCC and 333 (28.9%) community visits.

Year	2009/10 4 days	2010/11 4 days	2011/12 4 days	2012/13 2 days	2013/14 2 days	2014/15 4 days
<b>Christmas</b>	<b>1089</b>	<b>1216</b>	<b>947</b>	<b>443</b>	<b>421</b>	<b>1064</b>
PCC	373	478	320	153	107	390
HV	291	240	191	111	143	297
<b>New Year</b>	<b>1148</b>	<b>1365</b>	<b>1123</b>	<b>537</b>	<b>510</b>	<b>1150</b>
PCC	411	510	399	187	165	405
HV	270	270	211	254	254	333

**2015/2016** - Work is ongoing to staff the service in line with this historical and predicted call demand. NHS24 predictions are yet to be received. The Festive 'holiday' period is again over a 4 day weekend effectively from 18.00hrs on Thursday 24 December 2015 through to 08.00hrs on Tuesday 29 December 2015 and 16.00hrs on Thursday 31 December 2015 through to 08.00hrs on Tuesday 05 January 2016. Continuous monitoring will ensure adjustments to staffing and resources depending upon local and national circumstances, trends.

**NHS24 - DGSPOC FESTIVE PREDICTED  
OUTCOMES - 2015/16**

*At time of reporting – predictions are awaited from NHS24.*

It is noted that some 25% of calls now received at the Out of Hours Service 'Hub' are out-with NHS24 screening, being recorded directly by the Service 'Hub' communication co-ordinator support staff, these calls coming in on the 'professional' lines and requiring cataloguing and in most cases, triaging by the duty GP. Staffing will be managed to ensure this level of additional contact is appropriately managed.

**NOT PROTECTIVELY MARKED**

## **2. Recruitment**

### **2015/2016**

As indicated, this winter sees the Public Holidays fall into the four day weekend period, service provision required from 18.00hrs on Thursday 24 December 2015 through to 08.00hrs on Tuesday 29 December 2015 and again from 18.00hrs on Thursday 31 December 2015 through to 08.00hrs on Tuesday 5 January 2016. The Public Holiday Medical Rotas will be issued week commencing 10 August 2015 earlier than normal this year. Also GP rotas are normally issued for each quarter. This past year has seen significant difficulty in filling the GP rota. To try and assist with our GP's own scheduling and availability, on this occasion we shall make the rotas available for a full 6 month period – 01 October 2015 to 31 March 2016, covering the peak periods of Festive and Easter holidays. We hope to see a good response to this sought after initiative. Historically we would anticipate a 75% early take up of the winter and Festive sessions with management activity pursuing to ensure a fully staffed Festive period. Any vacant sessions will be advertised to Locum Agencies that have assisted in ensuring full staffing complement. It is accepted that filling of some shifts may prove challenging but efforts will be progressed over the coming weeks and any issues of concern escalated at the earliest.

Neither Salaried GPs nor support staff have routinely been allocated annual leave during the main two week festive period, support staff rosters are currently being worked on. Sessions for Galloway Community Hospital and Emergency Department are being monitored; Out of Hours medical staff will assist where necessary.

Staffing limitations due to any return of Influenza or other community ailment and general sickness are being monitored, with planning in place for business resilience.

Recruitment to Medical and Health Care Support Worker-Driver roles is currently ongoing.

### **3. Integrated working with the Emergency Department and other partners.**

The co-location of the OOHs service and the ED allows for joint working between the two services, it is recognised that there is considerable overlap between the patient groups that attend each department.

There is continuing and increasing staff co-operation between the Emergency Department and Out of Hours Service, staffing being successfully 'shared' at Dumfries on Monday to Thursday overnights since 1 June 2010. The OOHs and ED medical staff are co-located at the Galloway Community Hospital, Stranraer and the Machars OOHs GP operates from the Minor Injuries Unit at Newton Stewart Hospital.

The Emergency and Unscheduled Care Nursing Service has been successfully operating since 3 September 2007, fully supported by OOH, including transport assistance. This unit will further assist in the response to patient demand, as does the Marie Curie Nursing Service which operates in the evening and overnight periods.

Advanced Nurse Practitioner cover will be in place within the Emergency Department over the festive period. The Scottish Ambulance Service report they are fully prepared and the good linkages already in place will be consolidated during the festive break.

The Out of Hours Service Health Care Support Worker-Driver team are available to assist within OOHs and ED services and also support patient transport and where necessary patient discharge from hospital.

#### **4. Transport**

There are a number of vehicles distributed across Dumfries & Galloway throughout the out of hours period which has proved more than adequate for meeting the needs of patients fit enough to attend the OOHs centres, but who do not have access to transport. This passenger transport service facility will continue to be available over the winter and festive period for OOH, supplemented as necessary by the Board's Hospital Taxi service. All OOH drivers/Health Care Support Worker-Drivers have undergone basic life support/resuscitation training.

On fleet are four 4x4 power driven vehicles, providing business resilience for any adverse weather. An additional 4x4 vehicle will be secured from the Board's Transport Department for the duration of the festive period to support the patient transport service. Access to the NHS Dumfries & Galloway 4x4 fleet through the Transport Department is also in place; albeit it is appreciated these vehicles may be in significant demand by other colleagues. OOH is also linked to the local Community Planning Partnership involving the Local Authority, Police, Fire and other key community groups such as the Mountain Rescue Teams in the area. This arrangement offers the potential for access to 4x4 vehicle support.

In the event of severe snow and life-threatening emergencies, the locally resident GPs will be asked to assist and if possible attend their nearby patients. Consideration can also be given to the potential use of air support from both Scottish Ambulance Service and the national military emergency response units.

A transport business continuity resilience plan will be produced for the festive period.

An enhanced OOH patient transport service is an option for the Board; this service would operate to assist to transport either to home or to community hospitals for patients discharged from DGRI. If agreed and funded, in-house arrangements can be quickly put in place.

### **5. NHS24 Satellite Centre**

The Dumfries and Galloway NHS24 satellite centre has been operating since November 2005 and is now a well established feature of OOH contact arrangements with our residents. The main benefits of the service have proven to be:-

- Increased triage capacity
- Local knowledge of D&G and improved dispositions
- Improved collaboration with the local Out Of Hours service.

Locally based Nurse Advisors will be on all the NHS24 staffed shifts during the festive period.

By arrangement and agreement with NHS24, pre-prioritised (un-triaged) calls at a rate of 8 per hour will be agreed for key dates once OOH GP staffing has been confirmed. Pre-prioritised calls will be dealt with by OOH GPs based at DGRI but covering the Board area.

### **6. Staff Flu Vaccination**

Sickness absence within the OOH service normally runs at a low level.

As always, staff will be encouraged to participate in the seasonal 'flu' vaccination programme; there is normally a high take-up of this provision.

### **7. Community Pharmacist Arrangements**

Through excellent linkage with Pharmacy Services and local GP services, patients are well advised in regard to managing their own medicinal needs. As an added safeguard, attention will be drawn to the Urgent Supply Service, which allows Community Pharmacies to make a supply of chronic medication to patients where they are at risk of running out.

Pharmacists will be opening during the festive season. A fully detailed description of what service is available will be shared with NHS24. Details of these arrangements will also be advertised in the local press.

## **8. Social Services links**

The Emergency & Unscheduled Care Nursing Service based at Dumfries & Galloway Royal Infirmary, Emergency Department will be appropriately staffed and available to provide any necessary Nursing input to the Locality areas in Annandale, Stewartry and Nithsdale. The Wigtown Locality will make appropriate arrangements for nursing cover; liaison is ongoing with the Locality Management. Transportation for these nurses will be provided via OOH should it be required.

Advanced Nurse Practitioners (ANPs) are utilised in the joint ED and OOH environment at both DGRI and the Galloway Community Hospital.

OOHs Health Care Support Workers-Drivers are available on shift at the Dumfries and Stranraer OOHs bases.

The Mental Health Clinicians have a Crisis Assessment and Treatment Service (CATS), a team based overnight in OOHs, Dumfries. It is understood CATS will be available, along with a limited but still functional Community Mental Health team over the festive period. A full note of the planned Mental Health support services will be produced in conjunction with the General Manager for that service.

## **9. Demand Management & Communications**

NHS Dumfries and Galloway has:-

- A robust protocol for communications with NHS24.
- A local Pandemic Flu Plan which has been fully applied during any pandemic which may arise.
- An external communications plan which is managed by our Communications Manager with appropriate out of hours on call/duty manager arrangements with senior staff.
- A departmental Communications Strategy addressing the OOH service need to interact at all levels.
- In liaison with our national and winter planning colleagues, a planned publicity campaign for local media and community awareness.
- A programme to publicise out of hours/public holiday/GP contact arrangements in the local press.
- Noted the connection between in-hours availability of appointments and the use of OOH services and will therefore again be asking GPs to ensure the availability of acute appointments before and after the Festive breaks.

Work will continue over the coming weeks to finalise the preparations and consolidate formal business continuity plans.

*John McGoldrick, Service Manager*

*5 August 2015*

**NOT PROTECTIVELY MARKED**

**DUMFRIES and GALLOWAY NHS BOARD**

5 October 2015

**BOARD BRIEFING****Author:**

Rachel Hinchliffe  
Communications Assistant

**Sponsoring Director:**

Jeff Ace  
Chief Executive

**Date: 5 October 2015****RECOMMENDATION**

The Board is asked to

- note the briefing.

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**REGULAR FEATURES**

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**Key Messages:****GLOSSARY OF TERMS**

**MONITORING FORM**

Policy / Strategy	<i>None</i>
Staffing Implications	<i>None</i>
Financial Implications	<i>None</i>
Consultation / Consideration	<i>None. However, Briefing is populated with items of interest provided by any member of staff.</i>
Risk Assessment	<i>Not applicable.</i>
Sustainability	<i>Not applicable.</i>
Compliance with Corporate Objectives	<i>Corporate Objective 4</i>
Single Outcome Agreement (SOA)	<i>Not applicable.</i>
Best Value	<i>Not applicable.</i>
Impact Assessment	<i>Not applicable.</i>

### **New NHS Organ Donor Register launched**

A new, updated version of the NHS Organ Donor Register was officially launched across the UK in July, extending the choices a person has about their organ donation wishes.

As well as being able to record a decision to be an organ donor, the new Register will now, for the first time, enable people in Scotland to record their choice not to be an organ donor.

Existing registrations from the old NHS Organ Donor Register have been transferred to the new Register by NHS Blood and Transplant.

### **Sheena is a Diabetes Champion**

A dietician from NHS Dumfries and Galloway has joined a select few as a diabetes champion after facing stiff competition in a national search for experts in the field by charity Diabetes UK.

Sheena MacDonald, Specialist Dietician with the Diabetes and Weight Management Team is one of only 20 Diabetes UK Local Clinical Champions whose role will be to act as catalysts for change to improve the quality of diabetes care locally.

### **Service Offers Free Home Visits to Reduce Fire Fatalities**

Fire-fighters were at Dumfries and Galloway Royal Infirmary twice in June as part of their week of action aimed at preventing accidental house fires and the tragedies they cause.

The week of action was the result of a recent appeal from the Scottish Fire and Rescue Service (SFRS) for the public to help it reach those most likely to be killed or injured as a result of fire in the home.

### **Active Dalbeattie Launch Event - Core Path 20**

The Active Dalbeattie Partnership hosted an official launch in August, to see the official opening of the work, which was attended by Jamie Hepburn MSP, Minister for Sport, Health Improvement and Mental Health and Aileen McLeod MSP, Minister for Environment, Climate Change and Land Reform

A public event was held to showcase improvements made at the Town Wood Car Park as well as along Core Path 20. This event also saw the launch of a new footpath along the Colvend to Rockcliffe Road. This runs for almost 300 metres alongside the narrowest section of the road, and has been made possible through the goodwill of local landowners, Mr and Mrs J Gourlay and Mr and Mrs I Billson, and funding from E.ON and the Stewartry Area Committee.

### **NHS Scotland Staff Survey Launched**

This year's NHSScotland Staff Survey was launched in August across all 22 Health Boards. Every member of NHS staff had the opportunity to participate in the survey which was live until Monday 21 September.

### **Health Secretary Visit**

Health Secretary Shona Robison MSP visited Dumfries and Galloway Royal Infirmary in August where she met staff and issued guidance for winter 2015/16 to all health boards.

She thanked NHS staff for their fantastic efforts not only last winter but all year round. She said it was important health boards drew on the lessons learned from last year's challenging winter and were on the front foot this year.

### **Hospital tree planting marks service success**

Planting schemes have been carried out in the grounds of local hospitals to mark the environmental benefits of a redesigned pattern of home deliveries for patients in Dumfries and Galloway.

Six trees were planted at the Galloway Community Hospital in Stranraer, and six fruit bushes were planted at Newton Stewart Hospital. While at Nithbank Hospital in Dumfries, planters have been installed with a range of shrubs for patients and visitors to enjoy.

### **Suicide Prevention Week - Monday 7 to Sunday 13 September**

If you can read between the lines, you can save lives. That's the message Choose Life is sending out to people in Dumfries and Galloway to mark Suicide Prevention Week from Monday 7 to Sunday 13 September.

Last year 17 people in Dumfries and Galloway took their own lives, leaving a lasting impact on families, friends and communities.

The Read between the lines campaign calls on everyone to be alert to the warning signs of suicide in people close to them. The message is that if you're worried about someone - such as a friend, family member or workmate - asking them directly about their feelings can help to save their life.

### **Modern Apprentices Welcomed to the NHS**

NHS Dumfries and Galloway welcomed 16 young people to its Modern Apprenticeship programme in September.

The latest intake took part in a rigorous assessment and interview process which tested their commitment and potential. They will take up their new roles in departments across the organisation in October and will complete vocational qualifications covering specialisms such as business and administration, life sciences, finance and patient care.

### **Cree Ward at Midpark receives bench donation**

The Cree Ward at Midpark Hospital recently received a donation of £400 for a garden bench for dementia patients on the ward. The money was raised by Mrs Judith Pierro in memory of her late husband, Ricardo Italo Pierro.

### **Retirals**

Farewell to Alison Burns

Alison Burns, General Manager of the Primary and Community Care Directorate, NHS Dumfries and Galloway retired in August 2015 after 28 years service. She enjoyed a celebration tea with friends and colleagues at the Galloway Community Hospital.

Jeff Ace, Chief Executive, NHS Dumfries and Galloway gave a retirement speech and everyone agreed that the organisation owes Alison a debt of gratitude for her many years of dedicated service. We wish Alison all the best for a long and happy retirement.

Nancy Wilson

Colleagues past and present at Lochfield Road in May to say thank you and best wishes for a long and happy retirement to Nancy Wilson. Nancy worked with the Specialist Drug and Alcohol Service for 20 years and will be remembered by those who worked with her as conscientious and committed to meeting the needs of people using the service.

## Freedom of Information – 1 July – 31 August 2015

A total of 108 Freedom of Information requests have been received from the 1 July (54) to the 31 August 2015 (54)

15-223	01/07/2015	Political	1. The number of vacancies for GPs advertised as at 1st July 2015 broken down by (a) part time and (b) full time 2. The number of vacancies for GP practice nurses advertised as at 1st July 2015 broken down by (a) part time and (b) full time	21/07/2015
15-224	01/07/2015	Media	Can you tell me please how many patients were referred for treatment in another hospital in 2014-15 and 2015-16 to date. Please provide a breakdown for each year of which types of patients these were, for example with categories including cancer patients, emergency patients from A&E, children. Please provide a breakdown for each year of how many times this was done to meet a waiting times target, and what these waiting times targets were. For each year, can you tell me which hospitals patients were transferred to (making it clear which types of patients were moved to each named hospital. For each year, how many patients were transferred to England, how many to Wales and how many to Northern Ireland? How many were sent to other countries, and which countries were these? How many patients had air fares refunded for each year, for their travel to another hospital, and which hospitals were these? Can you please tell me what the highest air fare was in each year and which hospital it was for.	28/07/2015
15-225	03/07/2015	Media	1. How many medical staff are employed by your health board? 2. How many of your medical staff were born in the UK? 3. How many of your medical staff were born in the EU, but outside the UK? 4. How many of your medical staff were born outside of the EU? 5. How many auxiliary staff are employed by your health board? 6. How many of your auxiliary staff were born in the UK? 7. How many of your auxiliary staff were born in the EU, but outside the UK? 8. How many of your auxiliary staff were born outside the EU?	21/07/2015
15-226	03/07/2015	Political	1) The number of prisoners being prescribed methadone within your NHS Board from November 2011 to date; 2) The cost of methadone maintenance per prisoner; 3) The quantity of methadone (in litres) dispensed annually to prisoners since November 2011 to date.	21/07/2015

**NOT PROTECTIVELY MARKED**

15-227	03/07/2015	Business	<p>Please provide me with further information relating to the supply of Agency Allied Health and Health Science Professions for the 2014-2015 Financial year. I would be grateful if you could please provide the following information:</p> <ul style="list-style-type: none"> <li>* Spend on Agency Dieticians for the April 2014 – March 2015 Financial Year</li> <li>* Spend on Agency Podiatrists for the April 2014 – March 2015 Financial Year</li> <li>* Spend on Agency Arts Therapists for the April 2014 – March 2015 Financial Year</li> <li>* Spend on Agency Chaplains for the April 2014 – March 2015 Financial Year</li> <li>* Spend on Agency Clinical Psychologists, Counsellors or Psychotherapists for the April 2014 – March 2015 Financial Year</li> <li>* Spend on Agency Orthoptists for the April 2014 – March 2015 Financial Year</li> <li>* Spend on Agency Play Specialists for the April 2014 – March 2015 Financial Year</li> <li>* Spend on Agency Sexual Health Advisors for the April 2014 – March 2015 Financial Year</li> <li>* Spend on Agency Diagnostic Radiographers and Sonographers for the April 2014 – March 2015 Financial Year</li> <li>* Spend on Agency Therapy Radiographers / Radiotherapists for the April 2014 – March 2015 Financial Year</li> <li>* Spend on Agency Physiotherapists for the April 2014 – March 2015 Financial Year</li> <li>* Spend on Agency Speech &amp; Language Therapists for the April 2014 – March 2015 Financial Year</li> <li>* Spend on Agency Occupational Therapists for the April 2014 – March 2015 Financial Year</li> <li>* Spend on Agency staff within Pharmacy (Pharmacists, Technicians &amp; ATO's) for the April 2014 – March 2015 Financial Year</li> <li>* Spend on Agency Audiologists for the April 2014 – March 2015 Financial Year</li> <li>* Spend on Agency Mortuary Technicians/Anatomical Pathology Technicians for the April 2014 – March 2015 Financial Year</li> <li>* Spend on Agency Cancer Screeners for the April 2014 – March 2015 Financial Year</li> <li>* Spend on Agency Cytology Screeners for the April 2014 – March 2015 Financial Year</li> <li>* Spend on Agency Healthcare Scientists for the April 2014 – March 2015 Financial Year</li> <li>* Spend on Agency Dental Staff for the April 2014 – March 2015 Financial Year</li> <li>* Spend on Agency Optometry Staff for the April 2014 – March 2015 Financial Year</li> <li>* Spend on Agency Phlebotomists for the April 2014 – March 2015 Financial Year</li> <li>* Spend on Agency Biomedical Scientists &amp; Medical Lab Assistants for the April 2014 – March 2015 Financial Year</li> <li>* Spend on Agency Genetic Counsellors for the April 2014 – March 2015 Financial Year</li> <li>* Spend on Agency Clinical Physiologists (Including Cardiac) for the April 2014 – March 2015 Financial Year</li> <li>* Spend on Agency Medical Physicists for the April 2014 – March 2015 Financial Year</li> </ul>	21/07/2015
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15-228	06/07/2015	Other	<p>Does NHS Dumfries and Galloway collect whistleblowing data according to the parameters suggested by the government in its 2011 guidance? [1] This guidance encourages collection of and learning from this data: 1) "the nature and number of concerns raised" 2) whether concerns are investigated and resolved 3) factors leading to whistleblowing incidents and whether issues should have been detected and resolved at an earlier stage 4) whether constructive and timely feedback is given to staff 5) evidence that staff who raise concerns have not been fairly treated as a result of raising a concern 6) exit interviews that are relevant to whistleblowing 7) claims under PIDA and other claims 8) survey of staff experience with regards to whistleblowing, with these questions: • "Have you been troubled about some malpractice in the past three years? If so, did you raise the concern, and with what result? • How aware are you of the whistleblowing arrangements? • How likely are you to raise a whistleblowing concern with your manager and with senior managers? • How confident are you that there will be no negative repercussions for raising the matter with your manager and those above? • How confident are you that the matter will be addressed properly by your manager and those above? • How likely is it that your colleagues would raise a whistleblowing concern with their manager or with senior managers?" Please could NHS Dumfries and Galloway provide all data collected on its whistleblowing governance for years 2013 and 2014, including any from the above fields, and any other data in addition the above. If NHS Dumfries and Galloway collects data on whether staff have not been fairly treated as a result of raising a concern, could it advise on the parameters used (for example, does it track whether staff are disciplined, suspended, dismissed or made redundant after raising a concern). Please provide the full data regarding any specific parameters that NHS Dumfries and Galloway tracks.</p>	28/07/2015
15-229	06/07/2015	Media	<p>-The number of junior doctors who have been signed off work with stress/anxiety related illnesses over the past three years. If possible could you please break this information down by year and their specific role - for example, are they GPs, accident and emergency based, etc. - How many days in total have been lost by junior doctors due to stress/anxiety related illnesses in the last three years. Again, could you please break this down by year.</p>	21/07/2015
15-230	06/07/2015	Media	<p>Please provide a list and details of all bariatric items and equipment which have been bought by the health boards in the last five years for use in pediatric wards/departments or in Children's hospitals. -Could you also provide the cost of each item. Please break the information down by year, and if possible hospital.</p>	21/07/2015

15-231	06/07/2015	Media	1. Can you please provide the amount of money spent on employing agency staff over each of the past three years. 2. How many staff were supplied for each of the following areas – audiology, consultants, dentists, GPs, junior doctors, lab technicians, nurses, occupational therapists, operating departmental staff, practitioners, pharmacists, physiotherapists, podiatrists and radiographers. 3. For each area listed above, please provide the total cost and the most expensive member of staff (including travel and accommodation costs). 4. For the most expensive member of staff in each area, please provide their individual cost, broken down into salary, agency cost, travel and accommodation. Please state their job title, how many hours they worked, the agency which supplied them, if they were male or female and if they were hired from abroad. Please also provide the reason why they were needed.	28/07/2015
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15-232	06/07/2015	Media	1. Can you tell me please how many nurses are currently working at acute hospitals in the health board area. 2. Can you break these down into how many are British and how many are from other countries. 3. For those from abroad, please provide a breakdown of which countries nurses are from, how many are from each country, what their job titles are, which wards or specialisms they work in, and if they are having English lessons (either through the board or voluntarily) if this is known.	28/07/2015
15-233	06/07/2015	Media	Details of any incentives which are used to encourage pediatric patients/children to lose weight. Please provide full details of the incentives and how much they cost the health board. How many times/how often are any incentives used? Details of when an incentive would be used? For example, but not limited to, when a child reaches a certain weight that is unhealthy for their height/age?	28/07/2015
15-234	06/07/2015	Media	Can you please provide details of all centralisations within the health board area – where a hospital or ward has been closed or downgraded and a service switched to another hospital or building – in the last five years.	04/08/2015
15-235	07/07/2015	Other	Request for reports	03/08/2015
15-236	08/07/2015	Political	For each year since 2007 can you provide a) information showing the total numbers of mesh devices that your board has purchased broken down by the products bought b) the total cost of using mesh devices broken down by the cost you have incurred from each of the different products you have used and c) the unit cost of each individual product.	11/08/2015
15-237	08/07/2015	Political	The total number of women who, during the period 17 June 2014 and 8th July 2015, have been implanted, with polypropylene mesh medical devices as part of their treatment for Pelvic Organ Prolapse (POP) and/or Stress Urinary Incontinence (SUI). The total number of women who, during the period 17 June 2014 and 8th July 2015, have had either a partial or complete explant of the polypropylene mesh medical devices which they had implanted as part of their treatment for POP and/or SUI.	04/08/2015
15-239	09/07/2015	Media	1. Can you tell me please how many GPs there are in each practice within the health board area, and (for each practice) how many vacancies there are – plus how long those posts have been vacant. 2. For each practice, please tell me how many patients there are and if the health board has a preference or policy for how many patients there should be for each GP. 3. Please provide a figure for the number of practices which have closed down in the last five years – with the reasons why.	04/08/2015

15-240	09/07/2015	Media	Can you tell me please if any patient treatments or services done by hospital or family doctors have been transferred to nurses, pharmacists or other medical staff in an effort to reduce their workload? I apologise of this request is vague, but I am looking for a broad answer if possible and am hoping that any examples would be part of a health board policy change.	31/07/2015
15-241	09/07/2015	Political	1. The number of complaints from staff members regarding a member of management in each year since 2010. 2. The main reasons for staff complaints towards a member of management in each year since 2010. 3. The number of repeat complaints from a member of staff towards a member of management in each year since 2010 (a repeat complaint would be the second time any staff complaints about the same member of management for the same reason) – please break down by number of complaints (e.g. 3 times for person X. – please do not include names). 4. The number of managerial changes that occurred in each year since 2010.	31/07/2015
15-242	13/07/2015	Other	I would be grateful if you can supply the exact contract details for the taxi contract as supplied by maxis/Mcleans taxis If you can supply the amounts paid per journey or the amount per mile and all other associated costings as set by the Health board or the taxi company. Plus all other financial amounts that relate to the contract	31/07/2015
15-243	13/07/2015	Political	1) How many of your nursing staff are non-EU citizens and how many of these are paid under £35,000 per year? 2) How many of your other staff are non-EU citizens and how many of these are paid under £35,000 per year?	31/07/2015
15-244	14/07/2015	Other	How many machines do you have for continual renal replacement (CRRT) in the intensive care unit/critical care unit? 1a. Can you split these by manufacturer and age of machine please? 2. Are you in a contract for your machines, if so when does the contract expire? 3. How many CRRT treatments were carried out in 2014 (or the latest 12 month period you have data for)? 4. How many bags of fluid did you use for CRRT in 2014 (or the latest 12 month period you have data for)? 5. Who is your current manufacturer of fluids for CRRT? 6. Are you in a contract for fluids, if so, when does this expire and is it linked in with the machine contract? 7. What was your total spend on CRRT fluids in 2014 (or the latest 12 month period you have data for)? 8. What was your total spend on CRRT consumables (eg. consumable sets for the machines) in 2014 (or the latest 12 month period you have data for)?	12/08/2015

15-245	14/07/2015	Other	<p>1. Contract Type: Maintenance, Managed, Shared (If so please state orgs) 2. Existing Supplier: If there is more than one supplier please split each contract up individually. 3. Annual Average Spend: The annual average spend for this contract and please provide the average spend over the past 3 years for each provider 4. Number of Users: 5. Hardware Brand: The primary hardware brand of the organisation's telephone system. 6. Application(s) running on PBX/VOIP systems: Applications that run on the actual PBX or VOIP system. E.g. Contact Centre, Communication Manager. 7. Telephone System Type: PBX, VOIP, Lync etc 8. Contract Duration: please include any extension periods. 9. Contract Expiry Date: Please provide me with the day/month/year. 10. Contract Review Date: Please provide me with the day/month/year. 11. Contract Description: Please provide me with a brief description of the overall service provided under this contract. 12. Contact Detail: Of the person from with the organisation responsible for each contract full Contact details including full name, job title, direct contact number and direct email address. If the service support area has more than one provider for telephone maintenance then can you please split each contract up individually for each provider. If the contract is a managed service or is a contract that provides more than just telephone maintenance please can you send me all of the information specified above including the person from with the organisation responsible for that particular contract. If the maintenance for telephone systems is maintained in-house please can you provide me with: 1. Number of Users: 2. Hardware Brand: The primary hardware brand of the organisation's telephone system. 3. Application(s) running on PBX/VOIP systems: Applications that run on the actual PBX or VOIP system. E.g. Contact Centre, Communication Manager. 4. Contact Detail: Of the person from with the organisation responsible for telephone maintenance full Contact details including full name, job title, direct contact number and direct email address. Also if the contract is due to expire please provide me with the likely outcome of the expiring contract. If this is a new contract or a new supplier please can you provide me with a short list of suppliers that bid on this service/support contract?</p>	04/08/2015
15-246	16/07/2015	Business	<p>Please could you let me know the number of people admitted to hospital or visiting A&amp;E suffering from food poisoning for 2011/2012, 2012/2013 and 2013/2014? If possible, could you also break these down by: * Month * Gender * Age groups: under 10, 10 – 19, 20 – 29, 30 - 39 etc</p>	12/08/2015
15-247	17/07/2015	Media	<p>The number of children (aged under 16) who have been diagnosed with type 2 diabetes in the last five years. Could you please break this down by year and age. If you cannot give me a complete breakdown based on age, is it possible to state the youngest someone has been diagnosed with the condition?</p>	04/08/2015

15-248	20/07/2015	Media	The number of children (aged under 16) who have been treated for complications related to type 2 diabetes. This could include, but should not be limited to, amputation, kidney disease, strokes, feet problems, etc. Could you please break this down by condition and if possible age. If the number is too low, could you please just provide a list of the complications children have been treated for in relation to diabetes.	04/08/2015
15-249	20/07/2015	Media	1.) How many complaints have been made against staff in hospitals across your board by patients and/or their families? I am not requesting complaints made by members of staff, and am specifically seeking information relating to staff working in your hospitals. I would be grateful if you could please provide the information in calendar years for i)2012 ii)2013 iii)2014 iv)2015 (between January and June) 2.) Please break down by each hospital, and by the staff member's position: For instance, midwives, nurses, doctors etc. If the staff member's role was not specified in the complaint, or the complaint concerned more than one member of staff, please also provide this. 3.) If possible, please provide any detail you hold about each complaint made. If this would exceed cost limit, please just provide details of all complaints made in December 2014. If retrieving this information would still exceed cost limit, please exclude this point (3.) from my request.	21/09/2015
15-250	20/07/2015	Other	Please can you provide me with the organisation's existing contracts relating to facilities management for each of the categories below: A. Property and Building Services Maintenance B. Cleaning and Janitorial Services C. Security Services- From building and car park security to prisoner escorting services D. Catering Services For each of the contract above can you please provide me with the organisation's primary/main contracts that are above £1,000.00. If there isn't 1. What is the type of contract please pick from one of the categories above? If the organisation has a fully managed contract please state "Managed". 2. Who is the supplier for this contract? Please can you provide me with the contract information for each individual supplier? 3. What is the annual average spend? Please can you provide me with the contract information for each individual supplier? 4. What is the contract duration? Please also provide me with any extensions that maybe offered to the supplier. 5. What is the contract expiry date? Please at least provide me with the month and year. 6. When will this contract be reviewed? Please at least provide me with the month and year. 7. Can you please provide me with the total number of sites the contract covers? An estimate will also be acceptable. 8. What services are provided under this contract? A brief description will be acceptable 9. Who is the main contact from within the organisation responsible for reviewing this contract? Can you please provide me with their full name, actual job title, contact number and direct email address?	24/08/2015

15-251	20/07/2015	Organisation	My request is that you provide me with a copy of progress reports submitted to your Board which details what steps you have taken to meet this duty in relation to the political opinions of your workforce, and those who have applied to join your workforce, and what future work is to be undertaken by the Board to meet this part of the duty and in relation to these grounds. I also request that you provide me with a copy of any reports made to your Board in relation to how you have been linking work on meeting the Scotland Act 1998 duty with the general equality duty you have under the Equality Act 2010.	11/08/2015
15-252	20/07/2015	Business	1. Does your trust/area run compulsory pre-school orthoptic vision screening tests (POVS)? Please answer 'yes' or 'no'. 2. What percentage of nursery and pre-school children aged three and over in your area have had this test over the past five years? Please provide a percentage for 2011, 2012, 2013, 2014 and 2015. 3. Among those children who do not attend nursery/preschool and are aged 3 and over, are they referred to an eye clinic to have their eye screening? Please answer 'yes' or 'no'. If this is not the case, please can you explain what the protocol is in your area?	11/08/2015
15-253	21/07/2015	Other	I wish to submit a freedom of information request to the organisation with regards to their current recycling and waste support and maintenance contracts. Examples of recycling contracts you could have:* Green Waste Disposal * Household Waste Recycling Centres* Refuse Recycling Street Cleaning* Recycling Collection Services Examples of waste management contracts you could have:* Waste Development Environmental Assessment* Waste Transfer & MRF (Materials recovery facility)* Waste Disposal Landfill* Bulky Waste For each of the types of contract above please can you send me :1. Contract Type- From the examples given above please state what type of contract this is. Please state other and type of contract if the type of contract is not listed above. In some cases the organisation will have one or two big contracts that is covered in a managed contract please state in the contract description what services the contract provides as well. 2. The supplier of the recycling or waste contract 3. What is the annual average spends for each of the suppliers. For those organisations with new contracts can you please specify the estimated spend? 4. A brief description of what the contract entails. Please to specific to the services provided under these contract(s). Please provide me with a few sentences. 5. What is the contract duration of the each of the contract(s)? 6. What is the start date of each contract(s)? 7. What is the expiry date of each contract(s)? 8. When does the organisation intend to review these contract(s)9. Who is responsible for reviewing this contract please send me their full name, actual job title, contact number and their direct email address. Even if the organisation has a managed contract please can you send me all the contract information I have requested including the contact details	11/08/2015

15-254	22/07/2015	Media	Please tell me (a) how many FOI requests have been received, per month, between 1 Jan 2010 and 22 July 2015, (b) per month how many of these did not receive a response within the statutory 20-day period, and (c) how many of these requests were subsequently appealed to the Scottish Information Commissioner on the grounds of a response not being received during the statutory timescales.	11/08/2015
15-255	22/07/2015	Media	A list of all the hotels which are used by the health board to put up staff/doctors who are covering shifts. This could be, but should not be limited to, agency staff, staff from other health boards or overseas staff covering shifts. Please specify the name of the hotel, location, how many nights it was used and the cost. Could you also please include details of the why the hotel was needed - for example. a staff member was off sick and someone needed to cover. Details should also include where the covering member of staff was from (ie. an agency or another health board.)I would like this information to cover the last 2 years.	12/08/2015
15-256	23/07/2015	Media	I would like a copy of all inspection reports from the inspection of kitchens in the hospitals in your area since 1 January 2012.	21/09/2015
15-257	23/07/2015	Media	The top 100 internet sites accessed by employees using hospital computers between 1 January 2015 and 23 July 2015. If this information is only available for a shorter time period (i.e. only the last month) then that will suffice; * For each of the 100 websites listed above, please list the number of hits for each site (each time a page on that site was accessed).	11/08/2015
15-258	27/07/2015	Business	Biologic Use	20/08/2015
15-259	27/07/2015	Other	2. How long is waiting list for ENT appointments?  3. What is the length of time from initial consultation to fitting off hearing aid(s)?	21/09/2015
15-260	29/07/2015	Other	I am writing to request for information and minutes and outcomes of any meetings from any Applications to your Health Board by a company Elixir Healthcare Ltd for new contract applications from 2008 to date.	11/08/2015
15-261	27/07/2015	Other	Please treat this emailed communication as a Freedom of Information request and provide the following information regarding suppliers invoices paid in the period from 1 April 2015 to 30 June 2015. Total No. of invoices paid Total value of invoices paid Nos of invoices paid within 10 working days % Of invoices paid within 10 working days Nos of invoices paid within 30 calendar days % Of invoices paid within 30 calendar days	11/08/2015

15-262	27/07/2015	Other	<p>1) Which makes and models of Continuous Subcutaneous Insulin Infusion (CSII) pumps are currently used by NHS Dumfries and Galloway.</p> <p>2) What is the current cost of each of these types of CSII pumps to NHS Dumfries and Galloway, including both initial cost and the supply of consumables.</p>	11/08/2015
15-263	28/07/2015	Other	<p>1. What is the main Operating system used on PC and Laptops within your facility e.g. Windows 7? 2. If other operating systems are used please list these Internet browser 1. What is the main browser used in your facilities? 2. What version no. of this browser is used? 3. If other browsers are used, please list browser names and version numbers.</p> <p>Access to equipment 1. How many PC &amp; laptops in total do you have within Dumfries and Galloway Royal Infirmary? 2. Can staff access internet sites using Trust PC &amp; laptops? * If yes, are there any restricts to the access? * If yes, what are the restrictions? 3. Ward staff access to PC's &amp; Laptops * Do any ward staff have a Trust PC or laptop provided for their specific use (i.e. not a shared computer). If so how many in Dumfries and Galloway Royal Infirmary. 4. How many wards are there in Dumfries and Galloway Royal Infirmary? 5. How many shared computers on wards in Dumfries and Galloway Royal Infirmary? 6. How many staff deployed to wards in Dumfries and Galloway Royal Infirmary during normal staffing level during the daytime? Mobile devices 1. Are any staff in your trust provided with mobile devices by the trust (smart phone, tablet) * If so please name make and model * Number of each * Staff job titles that have this benefit 2. Are there any shared mobile devices? * If so how many are shared use? 3. Can staff on the wards use mobile phones? 4. Can patients in the wards use mobile phones? 5. Are there any areas in the hospital in which staff are not allowed to use mobile phones?</p>	21/09/2015
15-264	28/07/2015	Media	<p>How much did NHS Dumfries and Galloway spend to refer patients for NHS treatment in other health board areas in Scotland and/or to NHS hospitals in England? (ie. amount paid to other health boards/trusts to take on NHS D&amp;G patients)How many patients did this include in each of the above years? How much was spent sending patients to the private sector for treatment in each of the above years? For each year, how many patients were sent to the private sector?</p>	24/08/2015
15-265	29/07/2015	Media	<p>Please could you provide me with details of the number of patients reported as suffering from pressure ulcers or sores whilst under your care in the last 5 years ( 2010-2014). Can you provide details of the number of patients who died as a direct result of an infected pressure sore or ulcer within the same time period? Can you also provide details of the number of patients for whom a pressure ulcer was an underlying cause of death within the same time period?</p>	24/08/2015

15-266	29/07/2015	Other	Number of HIV tests undertaken 2012- 2013, 2013-14, 2014-2015. How much funding was received from The Scottish Government for sexual health and BBV, and how much was allocated to HIV. 2012-13, 2013-14, 2014-15 How much was spent on HIV testing 2012-13, 2013-14, 2014-15 What was the number of HIV positive people in specialist care 2012-13, 2013-14, 2014-15 What was the number in specialist care and eligible for anti-retroviral therapy (ART) who have been treated in 2012-13, 2013-14, 2014-15 What was the number of those treated who have an undetectable viral load in 2012-13, 2013-14, 2014-15 How much spent on treatment for HIV 2012-13, 2013-14, 2014-15 What changes are planned with the integration of Health & Social Care with respect to HIV treatment.	24/08/2015
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15-267	29/07/2015	Other	How many Clinical Chemistry Testing Analysers does your NHS board have in its facilities? * Which companies have you purchased Clinical Chemistry Testing Analysers from? * Are they due to be updated to a newer Clinical Chemistry Testing Analysers to ensure best health practice? * How much have these cost your NHS board over the last 3 to 5 years? * Are there plans to purchase more of them in the next 12 to 24 months and if so do you go out to tender for them? Also in addition to the above can you provide an organogram (organisational structure chart) of your purchasing department &/or the department/s that are liable for the upkeep and replacement of Clinical Chemistry Testing Analysers in your NHS board please.	24/08/2015
15-268	29/07/2015	Political	On how many occasions (in days format) in the past five years has a mobile breast screening unit been operational in your health board area? Could this please be broken down by year	31/07/2015
15-269	30/07/2015	Other	I require the organisation to provide me with the following contract information relating to the following corporate software/applications: 1. Enterprise Resource Planning Software Solutions (ERP) 2. Customer Relationship Management (CRM) Solutions 3. Human Resources (HR) and Payroll Software Solutions 4. Finance Software Solutions Along with the actual contract information for the above can you also provide me with the maintenance and support contract associated with each of the categories above if it not already within the existing contract. For each of the categories above can you please provide me with the relevant contract information listed below: 1. Software Category: ERP, CRM, HR, Payroll, Finance 2. Software Supplier: Can you please provide me with the software provider for each contract? 3. Software Brand: Can you please provide me with the actual name of the software. Please do not provide me with the supplier name again please provide me with the actual software name. 4. Contract Description: Please do not just state two to three words can you please provide me detail information about this contract and please state if upgrade, maintenance and support is included. Please also include the modules included within the contract. 5. Number of Users/Licenses: What is the total number of user/licenses for this contract? 6. Annual Spend: What is the annual average spend for each contract? 7. Contract Duration: What is the duration of the contract please include any available extensions within the contract. 8. Contract Start Date: What is the start date of this contract? Please include month and year of the contract. DD-MM-YY or MM-YY. 9. Contract Expiry: What is the expiry date of this contract? Please include month and year of the contract. DD-MM-YY or MM-YY. 10. Contract Review Date: What is the review date of this contract? Please include month and year of the contract. If this cannot be provide please provide me estimates of when the contract is likely to be reviewed. DD-MM-YY or MM-YY. 11. Contact Details: I require the full contact details of the person within the organisation responsible for this particular software contract. If the organisation have an outsourced provider that looks after all software can you please request this information from your provider? If any of the information is not available please can you provide me with the notes on the reasons why?	26/08/2015

15-270	30/07/2015	Media	Please provide the top three medical reasons for carrying out a hysterectomy procedure from 1st July 2014 to 1st July 2015, and the number of hysterectomies that were carried out for each reason from 1st July 2014 to 1st July 2015. In total, how many hysterectomy procedures were carried out by your Trust from 1st July 2014 to 1st July 2015? What proportion of women referred to the Trust for treatment for heavy periods underwent a hysterectomy between 1st July 2014 to 1st July 2015? How many hysterectomies were carried out by your Trust as an abdominal hysterectomy from 1st July 2014, to 1st July 2015?	24/08/2015
15-271	30/07/2015	Business	ICT Strategy- I require the document that hold future plan and strategy of the organisation's ICT department. ICT Departmental Business Plan ICT Technical Strategy ICT Structure ICT Capital budgets and programmes If you feel that your organisation or the department hold other documents that relate to my request or the document above please send them accordingly. Lead member: Cabinet Member for ICT and Telecommunications come under? Please can you provide me with their direct contact details including their Full Name, Actual Job Title, Contact Number and Direct Email Address? Can you please provide me with a direct link to this committee?	11/08/2015

15-272	30/07/2015	Political	1. How much was spent in the last two financial years (2013/14 and 2014/15) on contracts across the health board delivered by private contractors. 2. What proportion of overall private contractor spend in each of the last two financial years related directly to healthcare provision (i.e. not cleaning or maintenance etc). 3. Please provide details of all healthcare related contracts which have been awarded to organisations outside of NHS Scotland (e.g. screening provided by a private hospital) in the last two financial years.	21/09/2015
15-273	31/07/2015	Political	Question 1) How much does your health board receive from the Scottish Government to spend on local enhanced services? Question 2) How much did your health board spend on the Scottish Enhanced Services programme in (a) 2011-2012, (b) 2012-2013 and (c) 2013-2014, broken down by (i) general practice and (ii) other primary care*.	08/09/2015
15-274	31/07/2015	Political	Question 1) Please list, by area, the number of GP trainee posts available and the number filled in (a) 2013/2014, (b) 2014/ 2015 and (c) 2015/2016	21/09/2015
15-275	31/07/2015	Political	Question 1) Does your health board have a general practice 'risk register' listing practices that are having problems with the recruitment partners, sessional doctors or locums for maternity or long term sickness, or any other reason? Question 2) How many practices are in your board area and how many were on the 'risk register' at any point during (a)2011/12, (b) 2012/13, (c) 2013/14, (d) 2014/15 and (e) 2015/16?	12/08/2015
15-276	31/07/2015	Political	Question 1) How many patients have you had to allocate to GP practices (requiring them to take patients on) in each of the last nine quarters? Question 2) (a) How many practices have restricted the registration of new patients and (b) please list those practices, include type of restriction e.g. the numbers per week or to households already registered or any other restriction? Question 3) How many practices are (a) directly managed, (b) have been dissolved with patients being dispersed, (c) have asked the board for help and (d) have asked to be able to remove Patients from their list because of difficulties in recruiting GP partners or sessional doctors?	14/08/2015
15-277	31/07/2015	Political	Question 1) How many GP out of hours centres do/did you operate in (a) 2013/2014, (b)2014/2015 and (c) currently Question 2) What is the normal number of GP sessions expected to cover the centre each week in (a) 2013/2014, (b)2014/2015 and (c) currently Question 3) How many out of hours GP sessions have you been unable to fill in the last three months by centre	24/08/2015

15-278	03/08/2015	Media	Request: How many children in care have suffered or were diagnosed with the following emotional harm and mental health issues AFTER children were removed from parents' care:a) Self-harmed; b) Committed suicide - please state methods; c) Attempted suicide - please state methods; d) Sectioned; e) Abused in care.; i) Physically; ii) Emotionally; iii) Sexually; ; f) Anorexia; g) Bulimia; h) Drug or substance abuse; i) Depression or anxiety disorder; j) Suicidal thoughts; k) Bipolar or personality disorders; l) Psychosis; Please provide this information for each of the last three full years.	21/09/2015
15-279	03/08/2015	Media	For each of the last five years (whether recorded Jan-Dec or Apr-Mar):1) How many patients have sought compensation from your NHS Trust due to a delayed cancer diagnosis, or a misdiagnosis?2) How many patients have successfully won compensation for a delayed cancer diagnosis, or a misdiagnosis?3) What sum was awarded in each case?	21/09/2015
15-280	04/08/2015	Business	With regard to surgical waiting times targets, please can you disclose your current waiting time from the date of referral for a Cataract operation.	21/09/2015

15-281	04/08/2015	Media	<p>1. For each year in the last five calendar years, can you please list the number of referrals made each month to your Child and Adolescent Mental Health Services (CAMHS) either, (A) as a result of a child or young person taking legal highs, or (B) where legal highs have been implicated in the referral. 2. For each referral, please indicate the reason for the referral being made (eg: depression, psychosis etc) 3. For each, please indicate the type of treatment took place (eg: section, residential treatment, community treatment, counselling, medication etc) *NB: (By legal highs, I mean substances that could variously be described under the following terms: New Psychoactive Substances, Novel Psychoactive Substances, NPS, incense, bath salts, research chemicals, plant food, Zeus, YPD Out, Worskid, Voodoo, Vertex, Train Wreck, Meow Meow, Synthacaine, Spell Weaver, Snow White, Schnuff, Qush, Quicksilver, Reloaded, Psy-Clone Pink, Psy-clone, Psychlone, Porpheus Matrix, Link Joker, Spice, Purple Haze Poppers, Krocodile, King Liquid Gold, Karma, Hot Box, Happy Joker Red, Happy Joker, Gold Gocaine, Exodus Damnation, Exodus, Excudus, Etizolam, Drone, Dragonfly, Dark Til Dawn, Crocodile, Crystal Clear, Clockwork Orange, Columbiana, China White, Spunout, White mm, Blue Cheese, Blue Stuff, Black Mamba, Bombay Blue, Biff, Banshee Dust, Annihilation, Armageddon, Herbs of God, Ice N Berg, Brown Voodoo, Blue Voodoo, Greengo, Happy Me Dos, Happy Me Lounge E, Voodoo Gold, Olympic Legacy, Exodus Red, YPDOUT, Happy Joker Blueberry, Happy Joker Juicy Fruit, Rapture, Cheesus, Pink Panther, Ethylphenidate, Methiopropamine, MPA, No Paine, Mind Melt, Sparkle, White Columbian, Iceberg, Charly Sheen, Exodus Blue, Gocaine, Layer Cake, Cherry Bomb, Blue Pyramid, Auto Purple, Pandora's Box, Barney's Farm, Happy Me, Super Lemon Haze.)</p>	21/09/2015
15-282	04/08/2015	Media	<p>Under freedom of information I would like to know how many people were diagnosed with multiple sclerosis in your health board in the past ten years. I would like these figures separated year by year, by gender and also in age groups (for e.g. 16-25, 26-35 etc).</p>	21/09/2015
15-283	04/08/2015	Media	<p>Under FOI I would like to know how many pregnant women in labour had to be turned away or diverted from your maternity wards in the past three years due to the ward being over-subscribed. I would like to know what happened to these women (i.e. were they diverted to another hospital or asked to come back later). I would like these information separated year by year.</p>	21/09/2015
15-284	04/08/2015	Media	<p>Under FOI I would like to know how many times staff at your hospitals have been attacked verbally or physically while working in the past two years. I would like these figures separated year by year. I would also like to know details from each attack (e.g. which hospital they occurred in, whether it was a physical or verbal assault, who was subjected to the attack - nurse/doctor/porter etc and any more information that can be provided).</p>	31/08/2015

15-285	05/08/2015	Other	<p>"1.) How many drugs, medicines etc. procured by your board were wasted (thrown away), as they were not used by the use by/ expiration date. I am looking for the total number of products, and the total estimated cost broken down for the last three financial years (2012-13, 2013-14, and 2014-15). If possible, I would also like a breakdown of the drugs and costs individually. If it is easier for you to retrieve, please break down by group instead of label. E.g. anti-inflammatories instead of each individual type. However, if it is easier to provide the name of each medication individually, please provide this instead. 2.) If the information is jointly recorded with medication/drugs that have been damaged (i.e spilt, broken packaging etc.) and cannot be provided separately, I would still like this information. However, if information relating to damaged products is held separately, please provide this in a separate list, again broken down by the financial years stated above, the drug name (or type, whichever is easier to provide), and the estimated cost. If you hold no information relating to damaged medication/drugs or it is not easily retrievable, please do not delay my request to inform me, but exclude point 2. from my request, and just provide the information requested in 1. Please provide the information in electronic form to this email address, in an excel spread sheet."</p>	21/09/2015
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15-286	05/08/2015	Business	I would like to request the following information regarding residential care placements for 18-65s with home care packages for continuing healthcare needs. 1. Please could you supply the names, email addresses and telephone numbers of commissioners of CHC funded community services? 2. Please could you outline the CSU's responsibilities with regards to CHC commissioning?3. If relevant, please could you list the providers on your framework for complex home care?	31/08/2015
15-287	05/08/2015	Media	"1.) How many patient falls have been recorded over the last three financial years in hospitals across your board? (i.e. where a patient fell over on hospital grounds/wards, or fell out of bed). Please break down by i) 2012-13 ii)2013-14 iii)2014-15 2.) Please also break down by the severity of injury, however you record it on your system.For example: no injury, minor injury, serious injury and death. 3.) If possible, and providing it does not exceed cost limit, please break down by hospital. 4.) For the yearly totals across the board, please include how many of the falls occurred in patients aged over 65.If the information outlined in either (3.) or (4.) is not easily retrievable, please do not delay my request to inform me, but provide the information requested in (1.) and (2.)Please provide the information in electronic form to this email address, preferably in an excel spread sheet."	21/09/2015
15-288	10/08/2015	Media	Please provide details on the number of healthcare professionals hired as a direct result of advertising/marketing campaigns aimed to attract them to positions based within your health board. These details such include month/year of hire, salary, position, and location of position (village, town or city).	21/09/2015
15-289	10/08/2015	Media	Please provide me with a breakdown of the amount spent on advertising/marketing campaigns (between 1 January 2014 and 1 August 2015) to attract healthcare professionals to work within your health board. This breakdown should include, but not be limited to, costs associated with each campaign such as: bus advert costs, billboard van costs, billboard poster and billboard rental costs, paper/TV/radio adverts, consultancy/marketing company fees, advertising agency fees etc.	04/09/2015
15-290	10/08/2015	Media	I seek the following information for the years 2012-13, 2013-14, 2014-15 ; - How much your health board spent on agency nursing staff ; - What your budget was for agency nursing staff; - The number of times your health board had to use an agency nurse for cover; - Which hospital / home / department used the most agency nurses ; - Which agency was used most by your health board;	21/09/2015

15-291	10/08/2015	Media	<p>1. How many under 18s have been treated for illness in A&amp;E caused by alcohol in the past five years inclusive ie. 2010-2015? Can you break this number down i. by year ii. by age</p> <p>2. How many were admitted to hospital? 3. Can you break this number down i. by year ii. by age 4. What age was the youngest child treated and the age of the youngest admitted to hospital?</p>	04/09/2015
15-292	10/08/2015	Other	<p>1.) How many inpatients self-discharged from hospitals across your board over the last three years? (This could include, but is not exclusive to: discharge against medical advice, walk-outs, discharge by relative, discharge without waiting for approval by consultant). Please provide the information in financial years for: i) 2012-13 ii) 2013-14 iii) 2014-15 Please break down by the hospital the patient was in when they self-discharged. 2.) For each of the yearly totals, please provide the number of patients who self-discharged who were aged 65 and over.</p>	15/09/2015
15-293	10/08/2015	Organisation	<p>I am writing to obtain information about the amount your organisation pays to the Confederation of British Industry and its subsidiaries. Please provide the amount paid to the CBI (and its regional subsidiaries) (a) in membership fees (b) fees for one off conferences or other events and (c) fees paid to the CBI for any other services. Please make clear if the response includes payments from any Non-Departmental Public Bodies, Executive Agencies etc which fall under the department and please provide a breakdown of what payments came from which agency/body. Please provide this information for the period 2009-2015 set out by calendar or financial year.</p>	21/09/2015
15-294	10/08/2015	Media	<p>This is a Freedom of Information request regarding deaths at weekends in hospitals. 1. Can you please provide the number of deaths in hospital for each day (dated) of 2014-15. 2. For those which occurred at weekends, can you please provide a total number and a breakdown of which wards they died in and the conditions they died of. 3. Can you please provide the number of deaths during weekday nights (5pm to 9am) also. For each day, I am looking for the figure of those who died during the day and those who died at night. 4. Finally, can I have the total number of staff who work in the health board area's main hospitals on weekdays during the day, and the total number who work at night and, separately, at weekends.</p>	08/09/2015

15-295	10/08/2015	Media	This is a Freedom of Information request regarding out of hours GPs. 1. Can you please list the centres and hospitals which patients in the area are sent to out of hours. 2. How many out of hours GPs currently work within the health board area, excluding locums? 3. Please provide the total number of GP surgeries in the area and list those which have opted out of out of hours care. 4. How many GPs currently work out of hours within the health board area, including locums? 5. Please provide the number of full-time equivalent GPs currently working out of hours within the health board area.	21/09/2015
15-296	10/08/2015	Political	Question 1) How many redundancies have been made by your health board to (i) clinical and (ii)non-clinical staff during (a)2012/2013, (b)2013/2014 and (c)2014/2015 Question 2) What was the total amount of redundancy payments made to (i) clinical and (ii)non-clinical staff during (a) 2012/2013, (b)2013/2014 and (c)2014/2015 Question 2) How many (i) clinical and (ii)non-clinical employees, who have been made redundant between April 2011 and August 2015, have been employed in any capacity subsequently to receiving a redundancy payment.	07/09/2015
15-297	10/08/2015	Political	Question 1) What was the (a) maximum, (b) minimum and (c) average number of specialists working in your health board on any day between Monday 6th July and Friday 10th July (excluding A&E)? Question 2) What was the average ratio of Doctor Specialist to hospital bed between Monday 6th July and Friday 10th July (excluding A&E)? Question 3) What was the (a) maximum, (b) minimum and (c) average number of specialists working in your health board on any day between Saturday 11th July and Sunday 12th July (excluding A&E)? Question 4) What was the average ratio of Doctor Specialist to hospital bed between Saturday 11th July and Sunday 12th July (excluding A&E)? Question 5) What was the (a) maximum, (b) minimum and (c) average number of specialists working in your health board on any day between Monday 8th June and Friday 12th June (excluding A&E)? Question 6) What was the average ratio of Doctor Specialist to hospital bed between Monday 8th June and Friday 12th June (excluding A&E)? Question 7) What was the (a) maximum, (b) minimum and (c) average number of specialists working in your health board on any day between Saturday 13th June and Sunday 14th June (excluding A&E)? Question 8) What was the average ratio of Doctor Specialist to hospital bed between Saturday 13th June and Sunday 14th June (excluding A&E)? Question 9) What was the (a) maximum, (b) lowest and (c) average fee for a Doctor Specialist to be called out (a) mid-week and (b) weekend in (i)2014/2015 and (ii) 2015/2016?	03/09/2015

15-298	10/08/2015	Political	Question 1) What was the weekday mortality rate in your health board hospital(s) for each of the last 4 quarters? Question 2) What was the weekend mortality rate in your health board hospital(s) for each of the last 4 quarters?	21/09/2015
15-299	11/08/2015	Political	The total number of IVF cycles funded by your health board in each of the last five available years. The average cost of an IVF cycle funded by your health board in each of the last five available years. The number/percentage of IVF cycles funded by your health board that were for each of the following age groups within each of the last five available years: Under 35 Aged 35 – 37 Aged 38 – 39 Aged 40 – 42 Aged 43 – 44 Over 44 The number/percentage of IVF cycles funded by your health board that were for the first, second, third, or subsequent cycles in each of the last five available years.	07/09/2015
15-300	11/08/2015	Media	Please provide the number of occasions that junior doctors have been scheduled to work any shift on eight or more consecutive days, broken down by month for every month from June 2014 to present. For each occasion, please provide the number of consecutive days scheduled.	21/09/2015
15-301	11/08/2015	Media	Please provide the following details in respect of overtime payments made to junior doctors for hours worked in excess of the European Working Time Directive, for each month from June 2014 to present: a) The number of individuals in receipt of payments in that month b) The total sum paid for hours worked in that month c) The number of hours worked in that month subject to payment	21/09/2015
15-302	11/08/2015	Media	-The number of patients who have been recorded as suffering from pressure ulcers or sores whilst in your care in the past three years. -The number of patients who have died as a direct result of an infected pressure ulcer or sore in the past three years? -The number of patients who have died and a pressure ulcer or sore has been recorded as an underlying cause of death. Again, can this be in the past three years. Could you please break this information down by year, and if possible provide the age of the patients. If you cannot provide the exact age, if you could use age ranges such as 20-25, etc.	21/09/2015
15-303	12/08/2015	Media	The number of people on the waiting list for mental health services - How many of these people were waiting to be referred to a community psychiatric nurse- How many of these were waiting to be referred to a psychologist - How many of these people were waiting to be referred to a psychiatrist - How long it took for the average person to be referred to the specialist they were waiting on.- If applicable, how many sessions the average person received with the specialist	07/09/2015

15-304	12/08/2015	Political	1) The number of patients recorded as attending accident and emergency and discharged with a diagnosis involving new psychoactive substances or so-called 'legal highs' for each of the past three years.	12/08/2015
15-305	12/08/2015	Other	1) How many non-out-of-hours salaried GPs does NHS Dumfries & Galloway employ? (ie those employed to provide daytime services in General Practice and similar eg prisons/challenging behaviour/homeless/other health board type GP care) 2) What is the range of salaries/pay (whole time equivalent) for these GPs? 3) In the current or most recent contract for your salaried GPs, what is the (wte) payscale? 4) In the current or most recent contract for your salaried GPs, is there a built in increment / pay progression? (To be specific, not a cost of living uplift, rather an annual increment progression similar to that in the hospital doctors/doctors in training/consultant contracts under NHS Dumfries & Galloway) 5) If the answer to Q4 is YES and there is increment/pay progression in the contract, what is this scale? If NO, are there plans to implement pay progression in the contract for salaried GPs and what is the timeline for this?	16/09/2015
15-306	14/08/2015	Other	I'm working on a project that requires the information namely for what framework and non framework locum agencies you use for each of the following : Doctors Nursing staff Doctors and nursing staff I also want to know do you have a staff bank ? Do you with any particular agencies as a rule and others when simply in need ? I'm trying to gather all of this in one place to be able to make certain comparisons and a possible tool for doctors looking for these agencies ...as in they would like to decide firstly which hospital they would like to work with and then approach a locum agency that supplies said hospital.	
15-307	14/08/2015	Other	MRI Survey	14/08/2015

15-308	14/08/2015	Political	Question 1) On how many occasions did a Junior Doctor work more than 48hours in any 7 day period in your last 26week review? Question 2) On how many occasions did a Junior Doctor work more than 60hours in any 7 day period in your last 26week review? Question 3) On how many occasions did a Junior Doctor work more than 80hours in any 7 day period in your last 26week review? Question 4) On how many occasions did a Junior Doctor work more than 100hours in any 7 day period in your last 26week review? Question 5) What was the greatest number of hours that a Junior Doctor worked over any 7 day period during your last 26week review? Question 6) What were the dates, starting from and ending with, for your last 26week review?	07/09/2015
15-310	17/08/2015	Other	A. Does NHS Dumfries and Galloway fund homeopathy? Are there any plans to change this status? B. If so, please state how much, and give details of the funding (e.g. does it go to the Glasgow Homeopathic Hospital, a local homeopath, etc. C. If homeopathy is funded, when is this decision up for review?	15/09/2015
15-311	18/08/2015	Other	What percentage of GP consultations involve some form of mental health component? How much did these mental health consultations and associated treatment cost the primary health care services in 2014 - 2015? How much does Dumfries & Galloway NHS spend annually on mental health concerns? Does the supply of mental health services in Dumfries & Galloway currently satisfy demand without having to resort to waiting lists for care? If not what is the current waiting list for care? Is the mental health of the population of Dumfries & Galloway addressed from a public health perspective? If so, are there any current gaps in public health provision for mental health services in Dumfries & Galloway? From a public health point of view does the physical environment in which people live influence their mental health?	08/09/2015
15-312	19/08/2015	Other	The reason for my appointment falling outwith the 12 week target time for an outpatient appointment; Clarification as to how D&G NHS calculate the target weeks; An explanation as to why there is no data on NHS Scotland's website for Outpatient waiting times; Details of D&G NHS's actual performance against the 12 weeks maximum target for the last financial year.	27/08/2015

15-313	19/08/2015	Other	Please provide information on the manufacturer used, licence expiry, and licence cost including duration for each of the following IT security areas within the organisation: 1. Desktop anti-virus 2. Protection of Microsoft Exchange environment (please state if this is not applicable due to the use of NHSmail/NHSmail2) 3. Email gateway (please state if this is not applicable due to the use of NHSmail/NHSmail2) 4. Web gateway 5. Mobile device management/enterprise mobility management 6. Hard disk encryption 7. Removable media encryption 7. Firewall 8. VPN 9. Two factor authentication provider 9. Wireless network provider 10. Virtual server software provider and number of virtual servers (e.g. VMWare, Hyper-V etc.) 11. VDI software provider and number of VDI instances 12. Network access control solution provider 13. Security information and event management (SIEM) solution provider Please also provide: 1. The total number of computers within the organisation. 2. The total number of smartphones within the organisation. 3. The total number of tablet devices within the organisation. 4. Details of whether IT security is provided by an in-house team or by a third party – if by a third party please state who provides the service and when the contract expires.	11/09/2015
15-314	19/08/2015	Political	How many registered patients each Renal Unit in your health board has had in each year since 2007, broken down by patient's age (0-18 and 18+) in each Unit. How many nurses each Renal Unit in your health board has had in each year since 2007.	
15-315	19/08/2015	Other	I would like to request details of financial spend and forecast information for FY 2013-14, FY 2014-15 and FY 2015-16 under Freedom of Information Act (2000).	09/09/2015
15-316	19/08/2015	Media	How much has the health board spent in each of the last four years on taxis for staff?	22/09/2015
15-317	20/08/2015	Media	Please can you tell me how many consultants are on-site in each of your board's hospitals between midnight and 8am? In your response I would be grateful if you could state the name of the hospital, the number of consultants working in the period outlined above and – if applicable - which department they were working in. If the number of consultants working in the hospitals varies depending on what day it is, please can you give me the details for the following snapshot dates: July 8 and July 11, 2015.	07/09/2015
15-318	20/08/2015	Other	1) How many samples were sent to sending laboratories (broken down by laboratory) in NHS Dumfries and Galloway preferably over the last five years? 2) At these laboratories, where do the samples come from (i.e. which hospitals without a sending laboratory send their samples to which hospitals with sending labs)? 3) What has been the budget and expenditures of sending laboratories in NHS Dumfries and Galloway over the past five years?	22/09/2015

15-319	20/08/2015	Political	How many people have used the service "Keep Well" in each year since 2010? In how many cases was a potential or existing heart disease identified in the service users? In how many cases was diabetes identified in the service users?	22/09/2015
15-320	20/08/2015	Other	Could you please provide me with the following numbers of patients treated in the last six months with the following drugs for crohn's disease and ulcerative colitis	
15-321	20/08/2015	Business	Please can you supply me with the total number of patients treated in the last 6 months with the following drugs (including those on patient registries, if and where possible) Genotropin/Humatrope/Norditropin/NutropinAq/Omnitrope/Salzen/Valtropin/Zomacton	
15-322	20/08/2015	Trade Union	We would require information primarily on the number of assaults, but information about the nature of the assault and a breakdown of the category of worker and area, e.g. A & E/ Acute/ Primary Care/Community would also be helpful.	10/09/2015
15-323	20/08/2015	Political	How many GP surgeries in your health board area currently have restricted waiting lists whereby they only accept new patients that are either new-born babies or partners of existing patients	
15-324	24/08/2015	Business	Obtain a PPI Music Licence	07/09/2015
15-325	24/08/2015	Political	How many children were referred or sent to a paediatric weight management program run by your health board since 2011 for being overweight or obese? Please provide a breakdown of their ages, from the lowest that was referred to the maximum age that the programs cover. How much money was (a) allocated and (b) spent on paediatric weight management programs since 2011?	11/09/2015
15-326	24/08/2015	Other	I require to know from you as the ultimately responsible Officer the number of runs completed in each month by "Blood Bikes" for NHS Dumfries and Galloway	21/09/2015

15-327	25/08/2015	Media	<p>The number of deaths at your health board registered between 2010 and the present day where malnutrition was cited as a primary cause. The number of deaths at your health board between 2010 and the present day where malnutrition was cited as a primary cause and the deceased was aged 60 or over. The number of deaths at your health board between 2010 and the present day where malnutrition was cited as a primary cause and the deceased was aged 18 or under. The number of deaths at your health board between 2010 and the present day where malnutrition was cited as a secondary cause. The number of deaths at your health board between 2010 and the present day where malnutrition was cited as a secondary cause and the deceased was aged 60 or over. The number of deaths at your health board between 2010 and the present day where malnutrition was cited as a secondary cause and the deceased was aged 18 or under.</p>	21/09/2015
15-328	26/08/2015	Other	<p>Please provide the below information for the following conditions that can be treated through drug-delivery to home: Multiple Sclerosis (MS) and Rheumatoid Arthritis (RA). 1. For each of the above conditions/therapies, please indicate how many patients are treated under the following circumstances: Total number of patients Condition Drug 2011/12 2012/13 2013/14 In hospital e.g. RA Drug 1 In hospital e.g. RA Drug 2 In hospital e.g. MS Drug 1 Hospital-provided at-home treatment Hospital-provided at-home treatment At-home treatment delivered by home healthcare providers Total Note: if year-end patient numbers are not available, please provide either a) average number of active patients during the year or b) total number of unique patients during the year. Please specify which metric you have used 2. For each home healthcare provider of drug delivery services that you use, please indicate for the last three years: a. Name of provider b. Which home-treatment appropriate conditions they treat c. Which drugs are provided in this service d. How many patients are treated with the drug by this provider each year Total number of patients Condition Drug 2011/12 2012/13 2013/14 Provider 1 e.g. RA Drug 1 Provider 1 e.g. RA Drug 2 Provider 2 e.g. MS Drug 1 Provider 2 Provider 2 Provider 2 Provider 2 Provider 3 3. For each of the above, please indicate the spend per-provider per-drug in each year Total cost in year Condition Drug 2011/12 2012/13 2013/14 Provider 1 e.g. RA Drug 1 Provider 1 e.g. RA Drug 2 Provider 2 e.g. MS Drug 1</p>	

15-329	26/08/2015	Other	<p>1. Over the last four years, how many persons employed across your board have/have been:</p> <p>i) Dismissed from employment/terminated employment/sacked ii) Suspended on full/part pay – please include the number of weeks or days spent off work on full pay for each individual iii) Suspended without pay – please include the number of weeks or days spent off work for each individual iv) Received a verbal or written warning v) Faced disciplinary action not specified above – please specify Please break down by the above categories and by the following years 2011-2012 2012-2013 2013-2014 2014-2015 2. Please break down by job type. For instance, consultant, nurse, midwife, physiotherapist, administration, management, catering staff, 3. Please also provide a full list of reasons why the action took place for each case. For example: patient neglect, fatal error, accessing personal social security records, high absenteeism rate, drug/alcohol misuse etc.</p>	14/09/2015
15-330	22/09/2015	Organisation	<p>a. What is your NHS Board's current policy on funding the use of enzalutamide after abiraterone for patients with advanced prostate cancer who have already undergone chemotherapy? How many applications were there for the treatment in this setting before the Scottish Medicines Consortium's (SMC) approval of enzalutamide without restriction on 11th November 2013? Out of these applications, how many were approved? How many applications have there been for the treatment in this setting since the SMC's approval of enzalutamide without restriction on 11th November 2013? Out of these applications, how many were approved? a. What is your NHS Board's current policy on funding the use of abiraterone after enzalutamide for patients with advanced prostate cancer who have already undergone chemotherapy? How many applications were there for the treatment in this setting before the SMC's approval of enzalutamide without restriction on 11th November 2013? Out of these applications, how many were approved? How many applications have there been for the treatment in this setting since the SMC's approval of enzalutamide without restriction in on 11th November 2013? Out of these applications, how many were approved? a. How many IPTR applications were there for enzalutamide for patients with advanced prostate cancer who had not already undergone chemotherapy before the SMC's rejection of the treatment in this setting on 10th August 2015? Out of these applications, how many were approved? b. How many IPTR applications have there been for enzalutamide for patients with advanced prostate cancer who had not already undergone chemotherapy since the SMC's rejection of the treatment in this setting on 10th August 2015? Out of these applications, how many were approved? a. How many IPTR applications were there for abiraterone for patients with advanced prostate cancer who had not already undergone chemotherapy before the SMC's rejection of the treatment in this setting on 9th February 2015? Out of these applications, how many were approved?</p>	21/09/2015

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15-333

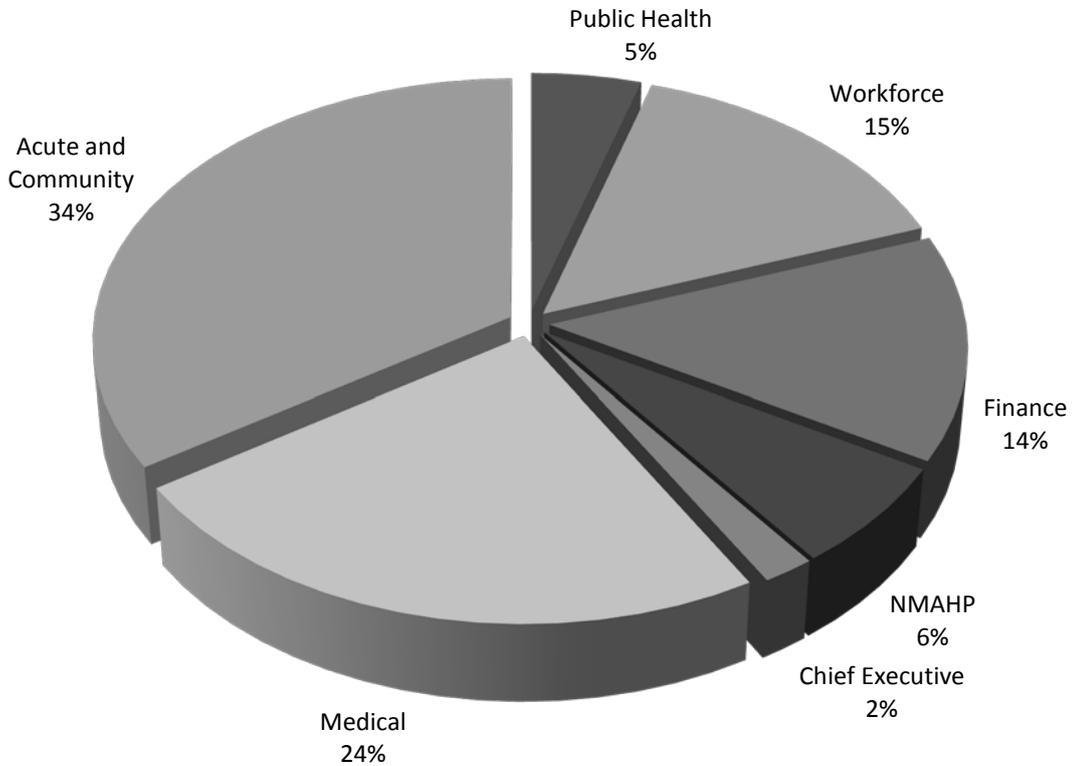
31/08/2015

Media

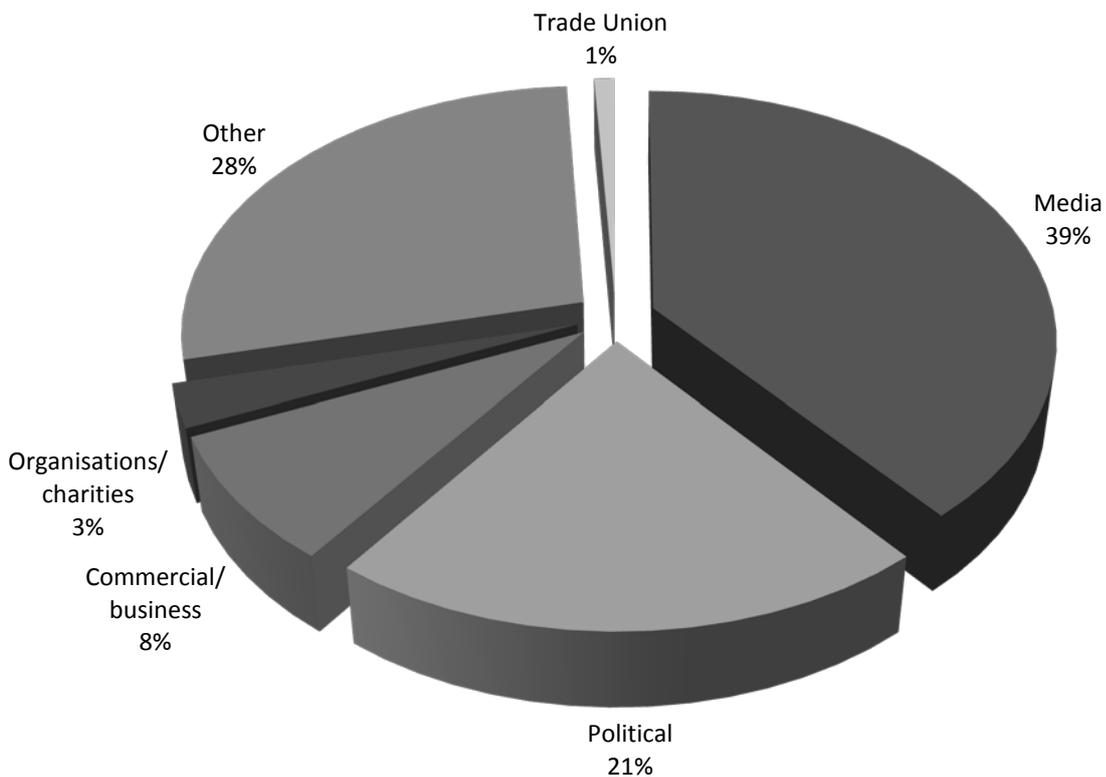
The number of people who have contracted surgical infections while being treated in hospitals over the last five years. Please provide the name of infection and how the infection is believed to have been contracted (if possible). Could you also please break this information down by year, and hospital. -The number of people who have died after contracting surgical infections while in hospital. Again, please provide the name of the infection, and break this information down by year and hospital. If possible, could you also please state whether it is believed the infection was a) the main cause of death, or b) contributed to their death. As different health boards answer using different terms it would be very much appreciated if you could please state MAIN or CONTRIBUTING when answering this question

### Freedom of Information – 1 July to 31 August 2015

The following chart illustrates the Directorate responsible for supplying the response to requests within the timeframe.



The following chart illustrates the source of requests within the timeframe.



## Current Consultations

From	Topic	Response due by
Scottish Government	Health (Tobacco, Nicotine etc and Care) (Scotland) Bill <i>Response Submitted</i>	21/08/2015
Scottish Government	Missing Persons <i>No Response Submitted</i>	31/08/2015
Scottish Government	Scottish National Research Framework for Problem Drug Use	06/09/2015
National Services Scotland	Quality of Care Review	30/09/2015

**Chief Executive's Diary  
Key Events**

<b>October</b>	
6/7	NHS Chief Executives
13	Management Team
20	Management Team
22	APF
23	WoS RGP
31	Board Event Day
<b>November</b>	
3	NHS Chief Executives
4	NHS Scotland Senior Leaders Forum
9	Healthcare Governance Committee
10	Management Team
23	Staff Governance
24	Management Team
<b>December</b>	
1/2	NHS Chief Executives

**Chairman's Diary  
Key Events**

<b>October</b>	
26	NHS Chairs Meeting
<b>November</b>	
4	NHS Scotland Senior Leaders Forum
9	Healthcare Governance Committee
23	Staff Governance
30	NHS Chairs Meeting
<b>December</b>	
3	Fit for Work Scotland

**Chief Executive Appointments to Regional and National Groups**

Member of Children and Young People's Cancer MSN

Chair of Facilities Shared Services Programme Board

Chair of Transforming Care after Cancer Treatment Programme Board

Member of the Scottish Medicines Consortium

Chair of the West of Scotland Regional Planning Group

Member of the National Out-of-Hours Review Group

**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

**NOT PROTECTIVELY MARKED**

## PUBLIC HEALTH COMMITTEE

Monday 25 May 2015  
New Board Room, Crichton Hall,  
Bankend Road, Dumfries



- Present:** Dr Laura Douglas (Chair)  
Ms Michele McCoy (Joint Interim DPH/Consultant in Public Health)  
Mrs Moira Cossar (Non Executive Member)  
Grace Cardozo (Non Executive Member)  
Mr Robert Allan (Non Executive Member)
- Apologies:** Mr Richard Grieveson (Head of Resource & Community Service)  
Councillor Andy Ferguson  
Catherine Mackereth (Consultant in Public Health)  
Mrs Julie White (Chief Operating Officer)  
Diane Brough (Executive Assistant to Director of Public Health)
- Attending:** Dr Andrew Carnon (Joint Interim DPH/Consultant in Public Health)  
Jo Kopela (Health & Wellbeing Specialists)  
Tina Gibson (Public Health Practitioner)  
Sheila Campbell (Building Healthy Communities Manager)  
Stuart Hamilton (Principal Officer Safe & Healthy Communities)  
Katherine Ellwood (PA to Consultant in Public Health)

Item	
1	<p><b>Apologies for absence</b> Apologies for absence were noted as above</p>
2	<p><b>Declarations of Interest</b> There were no declarations of interest noted</p>
3	<p><b>Minutes of Meeting 23 February 2015</b> The minutes of the meeting held on 23 February 2015 were agreed as an accurate record.</p>
4	<p><b>Matters Arising and Review of Actions List</b></p> <p><b>Mental Wellbeing &amp; Community Resilience : 12 December 2014 - Agenda Item 4</b> Michele McCoy highlighted Catherine Mackereth, Consultant in Public Health, was currently on leave and an update relating to Suicide Review Protocols, which are being developed, will be brought to the next meeting on 24 August 2015.</p> <p><b>Health Inequalities : 23 February 2015 - Agenda Item 6</b> The Chair noted that this had been actioned. Michele McCoy explained that the Directorate of Public Health is progressing action on the development of a 'Health Inequalities Framework' which presents the vision, what is to be achieved, how to work with partners and action is being taken to ensure that this work links closely with Dumfries and Galloway Council's workstreams on addressing inequalities and anti-poverty.</p>

NOT PROTECTIVELY MARKED

	<p><b>Addressing Obesity Levels in Children and Young People in Dumfries and Galloway : 23 February 2015 - Agenda Item 7 -</b></p> <p><i>Breastfeeding Rates –</i> Dr Andrew Carnon updated on discussions following the last meeting of the committee when concerns were expressed about the possible impact of length of stay in maternity units affecting the likelihood of breastfeeding. Dr Carnon stated that Joyce Reekie attended a review relating to early post natal discharge where it had been noted that length of stay did not have an impact. No local research is currently available but noted resources are accessible within the communities to help support breast feeding.</p> <p><i>Nutritional Information to Families</i> Michele McCoy reported that a discussion has taken place between Christopher Topping, Health and Wellbeing Specialist, and Councillor Andy Ferguson around health and wellbeing coaching with volunteers. Christopher Topping to meet with Council Sport Services who are providing a resource and this can be an opportunity to incorporate messages out to the community. A pilot to be held pre summer.</p> <p><b>Physical Activity 23 February 2015 Agenda 8</b> Stuart Hamilton reported Social and Community Service colleagues in the Council are working on a scheme relating to free access to local facilities for 'looked after children'. The scheme should be ready to launch early July 2015 and an activated card for 'child for free access' should be available. Stuart will confirm when date agreed.</p> <p><b>Action: Stuart Hamilton</b></p>
5	<p><b>Mindfulness</b> Jo Kopela, Health and Wellbeing Specialist and Tina Gibson, Public Health Practitioner explained 'Mindfulness Based Stress Reduction' (MBSR) noting that it is a form of mental training that helps people change the way they think and feel about their experiences. Jo stated Mindfulness eight week courses, which are supported by NHS Education Scotland, are being offered throughout Dumfries and Galloway. These courses help people become more aware of their thoughts feelings and body sensations supporting improved wellbeing. This work is being led by herself and Tina Gibson as part of their existing roles and responsibilities.</p> <p>Health and Social Care staff have recognised the potential impact of Mindfulness for staff and have requested more courses to be available. The Psychology Department have several teachers currently providing courses for service users which meet specific criteria in some clinical settings.</p> <p>Mindfulness is a life skill which children, young people and adults can learn and can be incorporated into daily life that can result in a wide range of benefits and currently exploring opportunities to implement in the school setting.</p> <p>The plan is to roll out 'Mindfulness' learning opportunities across the region and also to develop a network of teachers. It was highlighted the development of teachers is a lengthy process that takes more than a year – new teachers are expected to complete the Mindfulness course and practice Mindfulness for some time, developing their skills before they are allowed to teach. Two colleagues from the Council currently teach Mindfulness, however their approach does not follow the NHS-approved style. The team are working closely together to ensure that our Council colleagues understand all of the NHS-approved approaches, to ensure that we have a consistent approach to</p>

	<p>the teaching of Mindfulness across the region.</p> <p>Committee members noted this work with interest and encouraged continuation of the work programme and linkage with other workstreams, for example, HSCI, Person Centred Care and Spiritual Care.</p>
6	<p><b>Community Involvement</b></p> <p>Michele McCoy, Joint Interim DPH/Consultant in Public Health explained that the purpose of the paper was to let the Public Health Committee note the work of the Building Healthy Communities (BHC) programme within the Directorate of Public Health. Building Health Communities is a region wide community development project which supports the building of community resilience by involving communities in identifying and addressing their own health needs. Michele highlighted the importance of this work as it contributes to improved health and wellbeing and the national outcomes for Health and Social Care Integration.</p> <p>Sheila Campbell, BHC Manager, highlighted that local people engage in strategic decision making within their community and those who wish to volunteer deliver activities which include individuals with a long term condition.</p> <p>Michele McCoy highlighted NHS Dumfries and Galloway were innovative with resourcing a community development programme and that this was not the case everywhere.</p> <p>The Chair commended the Building Valued Relationships/Enabling Meaningful Integration event held in Easterbrook Hall and recognised that the work BHC are undertaking helping the broader community and noted how the NHS can make further interactions with people in the community.</p> <p>Sheila Campbell explained BHC engages in a range of activities within the communities. BHC Area Partnerships use the Participatory Appraisal (PA) tool to identify gaps within the communities and then how local people can be better involved. Michele McCoy highlighted that community development requires a long term commitment and an approach which means handing over 'ownership' to the communities.</p> <p>The Committee noted that the initiative 'Our Place', a national project from Glasgow funded by the Big Lottery, is being set up in Lochside, Lincluden. The initiative is investing in areas of deprivation and the Committee expressed interest in maximising funding locally. The Committee asked Sheila to make contact with the project co-ordinator so that the work from this project complimented that of BHC. Sheila was also asked to feed back to the Committee.</p> <p><b>Action Sheila Campbell</b></p> <p>It was noted the Performance Committee are concerned that the Organisation does not have a footprint within the community and should utilise people who are already engaged. The Group recognised this as an opportunity to use the Participatory Appraisal tool to harness ideas from local people and strengthen communities. Unfortunately GP's are not able to attend PA events to get an understanding of the tool. Sheila highlighted BHC has completed PA with NHS clinical staff, dental services and hard to reach groups. BHC is currently developing a PA network and have trained a range of partners who are able to teach small groups within the region.</p>

<p><b>7</b></p>	<p><b>Update on Public Health input to Health and Social Care Integration</b></p> <p>Dr Carnon noted that the draft Joint Strategic Needs Assessment (JSNA) for adults and elderly adults is out in the public domain. A final version will be available by September. Dr Carnon stated that the Knowledge Hub is available to download documents within NHS and requested feedback/comments. When questioned about the location of Public Health teams as part of Health and Social Care Integration, Michele noted that those teams already managed in the localities would remain there.</p> <p>The Directorate of Public Health will continue to support various strategic and operational functions. Michele McCoy noted that the Directorate of Public Health takes a strategic approach to addressing the health needs of the population in Dumfries and Galloway. The aim is to support a flexible approach in delivering programmes that meet the needs of the population.</p> <p>It was also noted that the national Review of Public Health should report in the Autumn and seeks to maximise resource for Public Health across Scotland. One of the key priorities is to achieve the necessary change for improved health and wellbeing and a reduction in health inequalities.</p>
<p><b>8</b></p>	<p><b>AOB</b></p> <p>The Public Health Committee agreed that the approach of having more in depth discussion about items brought to meetings was helpful and this method will allow airing of complexities with the Public Health agenda.</p>

**DUMFRIES AND GALLOWAY NHS BOARD**

Agenda Item 131

**Area Clinical Forum**

Minute of the Area Clinical Forum meeting held in the Education Centre, DGRI on Wednesday 27<sup>th</sup> May 2015

**Present**

Moira Cossar (Chair)  
Heather Currie, Adele Foster, Bill Irving,  
Simon Willetts

**In Attendance**

Jeff Ace, Chef Executive  
Hazel Borland, Executive Nurse Director,  
Jan McCulloch, Professional Committees Co-ordinator

**Apologies**

Paul Beardon, Lorna Carr, Kim Heathcote,  
James Lemon, Alison Milne

**1. Apologies****2. Minute of Previous Meeting**

The Minute of the meeting held on Wednesday 22<sup>nd</sup> April 2015 was approved.

**3. Matters Arising**a) Joint ACF/ APF Event 27<sup>th</sup> April

Moira said that there has been positive feedback from the event with a need to ensure that the agreed action plans for learning are carried forward. At the event, Dr Cameron, Medical Director had compared relationships and behaviours in another Board with NHS D & G and it was agreed that overall communications have to be improved and that NHS D & G should not be complacent about the current position. A meeting will be arranged for further discussions about how to progress actions, with the Chairs of ACF and APF and the Directors of HR and Nursing. Moira will feedback to ACF on progress.

**4. Standing Items**a) Chair's Report

At a recent Board Management Team meeting, Moira raised some concerns Medical Staff committee have about the DNACPR policy as at present there is some confusion whether local policy reflected national policy and Medical Staff were seeking clarification.

Jeff Ace, Chief Executive invited Moira, as ACF Chair, to attend a meeting with Paul Gray, Chief Executive, NHS Scotland who was visiting NHS D & G earlier this month. Moira fed back to members that the meeting had been interesting with open discussions about various issues including medical recruitment. It was noted that Paul Gray also met with staff from Cresswell and Mid Park.

**NOT PROTECTIVELEY MARKED**

- b) Quality and Patient Safety Leadership Group
- c) The Change Programme  
 There had been a work stream meeting held at Easterbrook Hall. Many staff have expressed their disappointment that only one weeks' notice about the meeting had been given, making it difficult for many clinicians to attend. Work stream Chairs and members have been identified and it is anticipated that communications will improve once there is more joined up working. The Change programme leads for medical and nursing and Lead General Manager will link up with the advisory committees and ACF in the future.

- d) Health and Social Care Integration  
 The Primary Care Manager and 4 locality managers have now been appointed. It was agreed that it is critical to ensure that GPs are included and involved in all discussions and Simon highlighted the serious concerns of the GP Community about being able to commit time to attend meetings due to GP shortages and a lack of locums. Simon spoke of the recruitment difficulties across Scotland including city practices and how this will impact greatly on secondary care.

Moira informed members that the Integrated Joint Board (IJB) will have 5 councillors and 5 non executive Board members who will have voting rights. At present the ACF Chair will be one of the non executive members on the IJB, but this cannot be guaranteed in the future. The Chair of the IJB will be from the Council representatives and Vice Chair from Health Board representatives.

- e) Feedback from Committees  
Area Nursing and Midwifery Committee
- The Success of the Quality and Improvement huddles at DGRI
  - The Change Programme and what it means for nursing
  - HEI Report on Galloway Community Hospital

Healthcare Scientists' Committee

- National Delivery Plan Launched earlier this month
- Karen Stewart, Health Care Science Officer for Scotland, coming to Dumfries next week to present and discuss the HCS National Delivery Plan with HCS staff and attend HCSAC meeting.

Area Medical Committee

- Simon said that issues are being dealt with by Medical Staff and GP sub committees due to lack of business forthcoming to AMC from Board. It was suggested that this was possibly due to continued demands of the Integration and Change programmes. Moira commented that she did not believe there has been much activity recently for committees to comment or give advice on.

GP Sub Committee

- KIS –The usefulness of KIS (Key Information Summary)
- DNA CPR – item for future discussions.

### Medical Staff Committee

- DNA CPR – Future discussions
- Change Programme and Work streams
- Changes to Medical Staff Committee Terms of Reference
- Clinical Portal for case notes –development
- Response to article in Standard

#### **5. Polypharmacy Guidance**

Deferred in the absence of Paul Beardon.

#### **6. ACF Annual Report**

Moira has prepared a draft Annual Report to go to Augusts Board meeting and asked for any comments and suggestions to be sent to her by the end of July.

### ***Joint Session***

#### **7. National Strategy**

In the absence of Angus Cameron, Medical Director, Jeff Ace Chief Executive updated members from a recent meeting of Chief Executives with Scottish Government about the National Strategy. Jeff said that the position with the Government was for Boards to pull together practical steps to provide and affordable service and create a quality driven change programme without being political. Angus Cameron is looking at a number of international systems, including investing in lower level primary care services. There have been discussions about what the Scottish configuration should look like and there will be reporting back in April 2016 whether proposals can be delivered.

Jeff also said that future recruitment and training remains an issue with 15% consultant vacancies and 20% GP vacancies locally. In addition Hazel Borland so commented that one third of nursing staff in Dumfries and Galloway will be aged over 55 in the near future.

#### **8. Risk Appetite**

Hazel Borland, Nurse Director spoke about recent initial discussions regarding risk appetite that have taken place across the region. The Board's Audit and Risk committee want to shape and manage discussions about risk and Board members are keen to be involved. A Matrix will be developed to help measure high level risks and a Risk Appetite Workshop will be held on 15<sup>th</sup> June for Board members and General Managers and will discuss shaping quality and safety.

Hazel Borland said that the organisation also needs to decide what levels of risk it is prepared to accept and this will help to formulate and articulate levels of substitution needed.

Hazel also spoke about the Vale of Leven Report and comparisons locally.

The 65 recommendations as a result of the report are for all health boards to consider and to raise awareness through ACF and APF about key messages around documentation, escalation, communication, relationships.

The Chief Nursing Officer has been asked by the Government to consider a national documentation system for nursing and the National Nurse Directors are looking at 3 issues that focus on processes and not outcomes that have been tested successfully in 3 Board areas.

Hazel asked how would ACF like to be involved and should an ombudsman's report come to ACF. Members said that the report should come to ACF and could be shared with professional advisory committees as it was important for the organisation to learn from these reports.

Hazel reported that the recent Children's services inspection report had shown significant improvement. There will also be an Older people's inspection in Jan – March 2016 and this will be in the form of a case note review. An adult executive group, similar to the children's services is being set up ahead of the inspection and ACF is encouraged to contribute.

Simon informed members that Prof, Sir Lewis Ritchie came to Dumfries yesterday to discuss OOH care. Police custody issues and Out of Hours cover for prisons were also discussed. There had also been some discussions about the current crisis in recruiting GPs and how consideration was being given for some services to be nurse led in the future with the development of Advanced Nurse Practitioners in some areas.

Hazel said that a paper would be discussed at Board Management Team looking at the potential for Advanced Nurse Practitioners that would look at more than GP Practices and would include looking at different levels and areas and models that are already established. Simon said that the risks and responsibilities also needed to be explored.

**9. Vale of Leven Report**

Discussions, Hazel Borland, Nurse Director  
See discussions above

**10. Joint Strategic Planning Group**

Moira informed members that the Joint Strategic Planning Group has 40 members from Health, Social Care and 3<sup>rd</sup> sector and Vicky Freeman will bring plans to a future ACF meeting for discussion. This will be a high level over arching strategic plan designed from the locality plans. Vicky's team is also pulling together plans for public consultation that will be user friendly.

**11. Galloway Community Hospital Report**

Noted

**12. Any Other Business**

- a) Vascular Access Matters Conference 11<sup>th</sup> June 2015  
Bill asked members to promote and encourage colleagues to attend the conference taking place on 11<sup>th</sup> June.  
**Date of Next Meeting 24<sup>th</sup> June 2015**

**DUMFRIES AND GALLOWAY NHS BOARD****Area Clinical Forum**

Minute of the Area Clinical Forum meeting held in the Education Centre, DGRI on Wednesday 29<sup>th</sup> July 2015

**Present**

Moira Cossar (Chair)  
Lorna Carr, Heather Currie, Adele Foster, Alyson Turnbull,

**In Attendance**

Vicky Freeman, Acting Head of Strategic Planning  
Vivienne Graiton, Programme Manager, Strategic Planning  
Caroline Sharp, Workforce Director  
Chris Lyons,  
John Knox, Lead General Manager,  
Jan McCulloch, Professional Committees' Co-ordinator

**Apologies**

Paul Beardon, Kim Heathcote, Jim Lemon,  
Alison Milne, Ian Peacock, Ross Warwick, Simon Willetts

**1. Apologies****2. Minute of Previous Meeting**

The Minute of the meeting held on Wednesday 27<sup>th</sup> May 2015 was approved.

**3. Matters Arising****4. Standing Items****a) Chair's Report**

Moira fed back to ACF members from recent Board Management Team (BMT) meetings and confirmed that the Chair of ACF will be a member of the Integrated Joint Board. It was highlighted that the outcomes from the joint APF/ACF Event did not appear to have been pursued and Moira will raise with BMT again.

**b) Quality and Patient Safety Leadership Group**

No update

**c) The Change Programme**

John Knox attended As above.

**d) Health and Social Care Integration**

- Locality Managers Posts have been filled
- Consultation period for the Strategic Plan ends 28<sup>th</sup> August

e) Feedback from Committees

Healthcare Scientists Committee

Adele informed members that the committee is focusing mainly on the National Delivery Plan and will bring a presentation about the delivery plan to next month's ACF meeting.

Medical Staff Committee

- The introduction of the Electronic Patient Record and standardising forms and templates.
- Medical Staff Recruitment update
- National Clinical Strategy and the future of NHS Services in Scotland.

**5. Dumfries and Galloway Partnership Strategic Plan**

Vicky Freeman, Acting Head of Strategic Planning, attended with Vivienne Graiton, Programme Manager to present to members the Strategic Plan Consultation Document.

Vicky explained that the strategic plan is for those people for whom we are integrating health and social care services. All adult social care, adult primary, community and acute health care services, as well as some elements of housing, are included within the new Integrated Authority. This will include all partners, NHS, Council, Third and Independent sector in a change in delivery, with less focus on services, more focus on community.

There are nine national outcomes and will be the method by which we will be measured. These can be found on the Scottish Government website.

The consultation document focuses on outcomes and centred around people not services including changing

- Cultures
- Relationships
- Partnerships
- Approaches
- Models

The Strategic Planning Group has 44 members and includes representation from

- People who use healthcare and/or social care services
- Carers of people who use healthcare and/or social care services
- Commercial and non commercial bodies providing health and/or social care services
- Health and Social Care professionals
- Non commercial social housing providers
- Third sector bodies carrying out activities related to health or social care

The public consultation on the strategic plan will run for 10 weeks from June 22<sup>nd</sup> – Aug 28<sup>th</sup> 2015 and a second round of consultation will take place in October/November 2015.

Moira thanked Vicky for the presentation and although there was general agreement that the 'we will' aspects of the plan would be difficult to feedback on, encouraged members to feedback individually and collectively.

## 6. **PREVENT Strategy**

Caroline Sharp, Workforce Director attended along with Chris Lyons to ask ACF for early initial comments help to shape policy for staff groups.

Caroline explained that as part of the UK Government Strategies in dealing with risk, terrorism and radicalisation, the UK government has said that each Board must have a policy in place to support individual staff and patients who may be vulnerable to radicalisation to protect staff and patients.

A small working group has been set up whose aim is to deliver PREVENT objectives without the need for additional policies. Vulnerable adults and children who have the potential to be exploited will be the starting point.

Caroline said that as Health staff are very good at awareness with the ability to highlight issues it was important to develop support for individuals through training /briefing documents that will provide a level of knowledge to spot any triggers identify signs of vulnerability and give staff confidence to refer. The focus will be on existing support and interventional measures and focus on fairness with a fair and supportive ethos

Members agreed these were sensitive and difficult issues and engaging the public would also be challenging. Caroline agreed and spoke of the good engagement and links with the council and the principled engagement with APF and ACF.

There was some discussion about the difficulties in challenging people's personal views and sensitivities and cultural differences.

Caroline thanked members for their helpful and informative discussions and will arrange to meet with Heather to discuss further ways of accessing appropriate input. Caroline will bring a draft policy to ACF in future.

## 7. **Any Other Business**

### a) **Redevelopment Project**

John Knox attended meeting to update members on the Redevelopment Project and Change Programme.

John explained that the Project Board has now become the Programme Board and the Redevelopment Project is now moving into a different phase. The Acute Services Redevelopment Programme. The Programme has 5 strands with their own governance arrangements :

- New Hospital Project
- Clinical and Service Change Programme
- Cresswell Redevelopment
- Property and Asset Management Strategy
- Information Technology Projects

The Change Programme that needs to be in place by the end of September 2016 and before migration to the new hospital at the end of 2017 and work will continue with the Highwood Health as an operational team.

Familiarisation visits 2017 – Structured visits by staff groups to hospital.  
Future use of rest of DGRI site up for discussion

Although the move to the new build hospital should be complete by December 2017, services at the Cresswell building will not move until end of 2019 and will continue to run from DGRI in the meantime. It has been decided to refer to this building as the PFI building to avoid confusion with the Cresswell Unit at the new build.

There are 17 workstreams previously chaired by the projects teams that are now chaired by operational managers, giving responsibility for communications and feeding back from meetings to colleagues.

Using the Critical Care Unit Work stream as an example John updated members on the progress of the wide ranging objectives of the work stream including standardising operational templates for departments.

A new CCU model, led by anaesthetists and intensivists will require a detailed staff data base along with workforce planning requirements and associated sensitivities. Recruitment and retention challenges remain and detailed requirements, including staff training across multi disciplinary areas will be needed so 5, supported and funded, tests of change will take place over the next 12 months.

Complex and time consuming audits of equipment and decisions how and what to transfer to the new build will take place between September and December 2015.

John reinforced the importance of cross checking important and the need for good clinical representation across the workstreams with representatives from depts. to feedback to colleagues a very important part of the process.

Heather highlighted some difficulties with the arrangements of some work stream meetings and that they had been arranged for days when she, as Chair of the work stream could not attend.

It was agreed that the new build will be catalyst for change and was the opportunity for change. John had appreciated that there had been some problems recently about the timing of some workstreams for discussions about theatre sessions and allocations and was working on arranging times to suit. John also spoke of the importance to have meetings out with the workstreams if necessary.

John had met with Jan McCulloch and Kirsten Moffat, Communications Officer for the redevelopment programme this afternoon to discuss how the professional advisory committees and ACF can improve communications with the programme and the provide opinion when necessary. John was keen for the ACF to advise on how the programme should be delivered and welcomed future discussions.

**Date of Next Meeting 26<sup>th</sup> August 2015**

## DUMFRIES AND GALLOWAY NHS BOARD

### HEALTHCARE GOVERNANCE COMMITTEE

**18 May 2015**

**9.30 a.m., New Board Room, Crichton Hall**

Present:	Mr. Phillip N. Jones	Chairman (Chair)
	Prof. Hazel Borland	Nurse Director
	Dr. Angus Cameron	Medical Director
	Dr. Andrew Carnon	Joint Interim Director of Public Health
	Mrs. Moira Cossar	Chair – Area Clinical Forum
	Dr. Laura Douglas	Non Executive Member
	Mrs. Penny Halliday	Non Executive Member
	Mrs. Gillian Stanyard	Non Executive Member
	Mr. Bill Rogerson	Lay Member
	Mrs. Julie White	Chief Operating Officer
	Mrs. Alice Wilson	Deputy Nurse Director
Apologies:	Mr. Jeff Ace	Chief Executive
	Dr. Ewan Bell	Associate Medical Director
	Ms. Lesley Bryce	Non Executive Member (Shadow Chair)
	Dr. Martin Connor	Infection Control/Consultant Microbiologist
	Dr. Ken Donaldson	Associate Medical Director
	Dr. John Locke	Lead Clinician, Primary Care
	Mrs. Elaine Ross	Infection Control Manager
In Attendance:	Margaret Johnstone	E.A. to Nurse Director

The Chairman noted that Chair Skills Training would be included in the Non Executive Members development plan.

1. **Apologies for Absence**  
Apologies as noted above.
2. **Declarations of Interest**  
Laura Douglas declared an interest in Item 11, "Chemotherapy in Dumfries and Galloway".
3. **Minute of the meeting held on 18 May 2015**  
Approved.
4. **Matters Arising**  
A Non Executive Member highlighted the Public Involvement Panel Update and the Nurse Director confirmed that an update would be provided at the August meeting of the Person Centred Health and Care Committee.

A Non Executive Member asked about the poor complaint response times in Primary Care and if there had been any progress on this. The Medical Director explained that complaints made in relation to GPs and their services are dealt with by the GP Practices and the Board does not have locus in resolving GP complaints. The Nurse Director commented that in the Annual Complaints Report the Scottish Government do expect the Board to provide data on complaints involving family health services such as dental and GPs.

A Non Executive Member had met with our locum Consultant Surgeon in Breast Care, who has agreed to stay with the Board for a year, and highlighted good feedback from the Team.

A Non Executive Member raised the issue of papers being deferred. The Nurse Director explained that the National Standards of Care for Older People in Acute Hospitals had only just been published by H.I.S. and will come to the next meeting providing information on our current status. She went on to explain that the Board had just received the HIS Galloway Community Hospital Older People in Acute Hospitals sixteen week follow-up report and confirmed that although this report will be on the agenda for the next Committee meeting she would circulate it prior to the next meeting to provide assurance. The Nurse Director noted that the Chief Nursing Officer had written to her, and the Chief Executive, to give thanks for the progress made between the two reports.

The Medical Director noted that a great deal of work has been done in relation to the West and asked for comments on the perception of the community. The Non Executive Member responded highlighting a local campaign for after care cancer services. Following discussion around bespoke pieces of work which are ongoing it was agreed that the Non Executive Member, the Nurse Director and the Medical Director would discuss this outwith the meeting.

A Non Executive Member highlighted the “Blood Bikes” and a local newspaper article stating the Board had refused to fund this. The Medical Director outlined the Board’s position in relation to this service.

#### 5. **Action List**

Updated action list discussed.

The Deputy Nurse Director confirmed that the National Standards of Care for Older People in Acute Hospitals had now been published and she would bring a report to the September meeting.

### **THEME: Patient Experience**

#### 6. **Patient Story**

Following screening of the digital patient story the Nurse Director explained that the patient story was not a complaint but a patient telling us of their experience to enable us to learn from it. She explained that her plan was to use the story in a number of learning ways, engaging with staff to promote thought as to “could this happen in my hospital?” and “could this happen in

my ward?”.

A Non Executive Member commented on the clear difference between complaints and feedback, saying that we need to be open with patients and ask them if they want us to investigate or is this for learning and then let them know what we have done and how learning has been shared. The Nurse Director responded that we already ask patients this question.

The Deputy Nurse Director explained that there is always consultation on staffing and what are the right numbers? She noted that national workforce tools which also help us use professional judgement are in place. She noted that nursing staff are under a lot of pressure. The Deputy Nurse Director highlighted the Emotional Touchpoint Tool used to encourage patients to tell us how it feels for them and explained that an extra day has been included in the Nursing Induction Days featuring a similar video clip to the one seen today.

A Non Executive Member explained that she had shadowed a Senior Charge Nurse (SCN) last week and the experience had left her with empathy for the pressured nursing staff. She highlighted sick leave and the effect this has on the ward noting that what may seem like anger to patients is actually a symptom of stress. She highlighted members of staff becoming patients and what a strange experience this must be for them. The Chief Operating Officer commented that she understood why a Non Executive Member might feel like this but we need to ask questions about the staffing levels and there are a number of issues that we would consider as unacceptable. The Chief Operating Officer outlined a recent scenario in relation to sickness and the impact this has on the wards by putting pressure on other staff. She outlined steps to be taken by the Lead Nurse to address this issue.

A Non Executive Member asked about the formalised list of opportunities where the Non Executives could visit and the Nurse Director explained that this is a piece of work which is currently being pulled together by the Board Corporate Secretary. The Chair explained that he would follow this up at the Non Executive Members afternoon meeting. A Non Executive Member read out an excerpt from the Francis Report, Chapter 20, suggesting her colleagues would find this useful and asked for this to be circulated to the Committee. The Deputy Nurse Director, supported by the Chief Operating Officer, suggested that there should be communication with the staff before the Non Executives start going out and about to ensure everyone is clear about the purpose.

7. **Patient Experience Report**

The Nurse Director presented the report explaining that the focus was on April 2015 and highlighting the overviews of the Scottish Public Services Ombudsman and Patient Opinion. She was happy to note that the complaint response time is going in the right direction, 70% for May 2015. She highlighted the categories of complaints outlining a change in the format of the report for the next meeting. The Nurse Director highlighted a recent scenario where Care Opinion (used in Ayrshire and Arran) and Patient Opinion had shared a posting which ran into problems due to the differing policies of both systems and explained she would include this in the report for the next meeting.

The Committee:

- Noted the report and improved performance

8. **Complaints Policy and Unacceptable Actions Policy**

The Nurse Director presented the paper explaining that the item had been deferred a couple of times to allow for the completion of the Equality and Diversity Impact Assessment (EQIA). The policies will be updated annually. The Chair of the Area Clinical Forum noted that both policies had been approved at Area Clinical Forum with no concerns. Brief discussion took place in relation to clarifying the use of these policies which are for patient/patient family/carer complaints only with the Chief Operating Officer suggesting that this be discussed outwith the meeting as there is a need to develop a process that we use consistently to deal with the general public and other agencies in the community who raise challenges about health services.

The Committee:

- Noted the report

## STANDING ITEMS

9. **Patient Safety Report – Leadership Walkrounds**

The Deputy Nurse Director presented the paper explaining that the Walkrounds, which focus on patient safety, continue on a weekly basis and any outstanding actions are addressed by the Management Team. The Chair explained that the Walkrounds are not just something that we do but are part of a national programme where we pick up issues, ideas and good practice from staff, and he is pleased with the way this is progressing.

The Committee:

- Noted the report

10. **H.A.I. Report**

The Nurse Director presented the paper highlighting SAB, C.Diff and SSI and explaining that Dumfries and Galloway do a lot more surveillance than other Boards. She noted that the HEAT targets would remain the same as last year explaining that a significant number of Boards had not been able to deliver these targets last year. Progress is ongoing with a Root Cause Analysis (RCA) being carried out for each SAB and C.Diff. Work is also underway in areas where blood cultures are taken and feedback on the rate of contaminated samples being shared with the Infection Control Team.

Non Executive Members raised the issue of recruitment within the Infection Control Team and the Nurse Director acknowledged the difficulties, not only in Dumfries but across Scotland. She outlined steps which had been taken locally to address the issue and noted that she was meeting with the Infection Control Manager this week to review the position as this is a continued challenge for us with the team being very stretched.

The Committee:

- Noted the report.

11. **Healthcare Governance Briefing Paper**

The Medical Director presented the paper highlighting:

*The Penrose Public Inquiry*

The Medical Director noted that this related to Scotland continuing to provide blood transfusions when there was a risk issue. As no patients in Dumfries and Galloway were involved this is irrelevant to the Committee.

*Heart Failure*

The Medical Director noted that this is dealt with appropriately in Dumfries and Galloway with good access to investigation and medication. He highlighted the BNP blood test which was pioneered in Dumfries and Galloway and feels our figures are higher because we have a greater population of older people. The Medical Director noted that we have a Managed Clinical Network with cases being discussed at multi-disciplinary team meetings. We have two heart failure specialist nurses who help to target ideas and thoughts within the Board. He reassured the Committee that patients have access to good treatment and things are going well.

*Suicide*

The Medical Director noted that 2014 – 2015 numbers are due out next month so the report focuses on the twenty-four deaths in Dumfries and Galloway in 2013 - 2014. He explained that we have an action plan in place locally which is multi-agency involving health, prison, social work, mental health and voluntary organisations. He highlighted a huge amount of training which is ongoing to try to identify where a patient is at significant risk of suicide.

A Lay Member suggested that there should be police input into the suicide work and this was supported by a Non Executive Member as a high percentage of suicides are not in touch with any services. The Medical Director said he would pass this comment on. The Interim Director of Public Health explained that he was the Chair of the Drug Death Group and there is police representation on that group which feeds into the wider Suicide Group. He noted that doctors are also a high risk group outlining a couple of helplines available to them.

A Non Executive Member asked if GPs would refer patients to the Community Chaplaincy Listening Project (CCLP) and the Nurse Director responded that patients would be referred for professional support within the health services but if they were only looking for someone to talk to and listen to them it may well be that the CCLP would be helpful. The Chair of the Area Clinical Forum confirmed that if a suicide had been in contact with any service in the previous year a full multi-agency review would take place. She explained that the Drug and Alcohol Service patient deaths may be a drug overdose or a suicide. She explained that the Prison Services also works well with the NHS in this field.

#### *Chemotherapy*

The Medical Director highlighted the Systematic Anti Cancer Therapy (SACT) Annual Report noting the support provided by the Pharmacy Aseptic Service. He explained that an external quality assurance group had just carried out an audit of the service which came out with a very high rating.

The Committee:

- Noted the report

## **EXTERNAL REPORTS**

### **12. Francis Progress Report**

The Nurse Director presented the paper noting that although papers had previously been presented to the Committee a decision around how to move this forward had not been made. She asked the Committee for their thoughts in relation to previous scrutiny reports, explaining that a Report Log is in place following receipt of the Francis, Vale of Leven, Lanarkshire, Grampian and Morecambe Bay reports. She highlighted the schedule of workshops outlined on Page 4 of the report noting that some of these had already taken place.

Non Executive Members highlighted the role of Non Executive Members and the role of Executive Directors, what provides assurance and what is reassurance. Noted that the Board in the Francis Report was described as dysfunctional. In response to a suggestion that this be discussed at the Non Executive Members meeting later that day the Chair agreed that the challenge days had not covered all these themes and future workshops should address themes from these reports.

The Chief Operating Officer commented that it would be appropriate to understand each other's roles and that it was important the Board hears about the themes and challenges within these reports as we are in a vulnerable position until these are addressed.

A Non Executive Member commented that the Committee had touched on each report but had not drilled down to where we are and what are the key issues level. The Nurse Director highlighted the number of recommendations in the reports and suggested looking at themes rather than the individual recommendations. She explained that Internal Audit had pointed out that the Committee needed to reflect the in depth discussion with appropriate actions.

It was agreed that the Nurse Director, Medical Director and Chief Operating Officer would pull together a piece of work around the Board's position in relation to themes from the reports and key outcomes. This will be discussed with the Non Executives outwith the committee meetings.

The Committee:

- Noted the report
- Requested that piece of work will come back to NEMs

### 13. **Morecambe Bay Report**

The Nurse Director presented the report noting that Dr. Kirkup had visited Dumfries and Galloway in May 2015. She explained that the Scottish Government had asked each NHS Board to ensure this report was shared at Healthcare Governance Committees. The Nurse Director explained that the report had 44 recommendations and the action plan (Appendix 1) will be submitted to the Scottish Government who plan to visit every Board with a particular focus on Recommendations 1 – 18. She explained that the risk is that the report focuses on midwifery but the issues described were organisation wide. A piece of work around birth rates for the last five years will be presented at Management Team on 14 July. The Chair highlighted the work of the SANDS group and the Nurse Director highlighted the Midwifery Link Group along with previous reports to the Committee providing reassurance from the LSAMO and NMC Audits.

A Non Executive Director highlighted Recommendation 5 in relation to promoting effective multi-disciplinary team-working and asked about non-attendance by medical staff. The Chief Operating Officer noted that the patient experience events led by the Associate Medical Director are multi-disciplinary and it is always a challenge to get medical staff to attend. She highlighted the Gynaecology and Obstetrics Team who lead team sessions, case reviews and incident reviews which are multi-disciplinary and include medical staff. She acknowledged that this is a cultural issue and a real challenge for the Board.

The Committee:

- Noted the paper
- Noted that update will come back to future committee

**ITEMS FOR NOTING**

14. **Minutes of the Adult Protection Committee – 19 March 2015**  
The minutes of the Adult Protection Committee held on 19 March 2015 were noted.
15. **Minutes of the Healthcare Scientists Advisory Committee – 5 March 2015**  
The minutes of the Healthcare Scientists Advisory Committee held on 5 March 2015 were noted.
16. **Minutes of the Infection Control Committee – 27 January 2015**  
The minutes of the Infection Control Committee held on 27 January 2015 were noted.
17. **Minutes of the Point of Care Testing Management Group – 15 May 2015**  
The minutes of the Point of Care Testing Management Group held on 15 May 2015 were noted.
18. **Any Other Competent Business**  
Nil.
19. **Date of Next Meeting**  
Monday 14 September 2015, at 9.30 am, New Board Room, Crichton Hall.

## **NHS DUMFRIES AND GALLOWAY**

### **PERSON CENTRED HEALTH AND CARE COMMITTEE**

Notes of Meeting held on Monday 29 June 2015

Present: Penny Halliday, Non-Executive Director (Chair)  
 Jim Beattie, Employee Non Executive Director  
 and Chair of Area Partnership Forum  
 Gillian Stanyard, Non Executive Director  
 Miss Carolyn Hornblow, Volunteer Member  
 Mr. Andrew Ratnam, Volunteer Member  
 Rev. Douglas Irving, Kirkcudbright  
 Rev. Canon Robin Paisley, Dumfries  
 Dr. Ken Donaldson, Consultant Physician  
 Ms. Mandy Spence, Midwife

Attending: Andrew Carnon, Interim Director of Public Health  
 Caroline Sharp, Workforce Director  
 Laura Douglas, Non Executive Member

Apologies: Hazel Borland, Nurse Director  
 Moira Cossar, Non-Executive Director and Chair of Area Clinical Forum  
 Ewan Kelly, Spiritual Care Lead  
 Dr. James Clark-Maxwell, G.P., Dalbeattie  
 Ms. Lynsey Fitzpatrick, Diversity and Equality Lead  
 Mrs. Vicky Freeman, Acting Head of Strategic Planning  
 Ms. Lesley Grainge, Midwife  
 Mrs. Jan Lethbridge, Inter Faith Council Member  
 Jill Osborne, Lead Officer Integration Project (East), Third Sector  
 Shirley Turberville, University of the West of Scotland  
 Phyllis Wright, D&G Council Representative

1. **Apologies**  
As above.
2. **Declarations of Interest**  
There were no declarations of interest.
3. **Notes of meeting held on 25 April 2013**  
Approved.

#### 4. **Matters Arising**

##### *Patient Experience*

The Chair noted that the Patient Stories Framework is still in draft form.

##### *Participation Standard*

The Chair noted the self assessment was included in Item 10.

##### *Spiritual Care Policy*

The Chair noted that the Spiritual Care Policy will be discussed at a local stakeholder group in early July and deferred to the August meeting.

##### *Community Resilience*

The Chair had spoken with the Acting Head of Strategic Planning and highlighted the current consultation requesting that members of the Committee participate.

##### *Public Involvement Panel*

The Chair noted that she had some concerns around this and will meet with the Scottish Health Council and report back at the August meeting.

#### 5. **Staff Listening Service Pilot**

Rev. Canon Robin Paisley presented (copy attached), on behalf of the Spiritual Care Lead and the Workforce Director, on a concept for the development of a staff listening service pilot in NHS Dumfries and Galloway and to agree the proposal for further development and testing. He highlighted his attendance at the “Humanising Healthcare” event which focussed on integrating spiritual care into the community and there was lots of interest from people involved in staff care. Our Workforce Director’s plan now is to improve staff care in NHS Dumfries and Galloway.

In response to being asked when this would be up and running, the Workforce Director explained that we are still at the conversation stage and this proposal has been brought to the Committee to ask if they feel it would be an appropriate use of resources to run a pilot on this and she would expect it to be in place by the autumn.

In discussion it was agreed by the Committee that this would be a very positive piece of work and is welcomed. The issue of confidentiality was raised and the Workforce Director and the Associate Medical Director recognised the need to address this, suggesting the appraisal system method of “if I hear something that concerns me, I can take up with someone else”. Will encourage people to take action themselves, for example, a doctor might say to a patient who is no longer allowed to drive, “you should contact the DVLA but if you don’t then I will”.

In response to being asked how the pilot would be evaluated, the Workforce Director explained that this had not yet been discussed.

It was noted that a piece of work being done by the UWS on Patient Report Outcomes Measures could be useful in this pilot.

Noted that the Values Based Reflective Practice (VBRP) is an excellent piece of work, a very good idea and will help staff through this very difficult period. For integration to work you are talking about everyone in Dumfries and Galloway working together because this change will be like no other change we have seen and the majority of people do not understand what is going to happen.

The Committee:

- Agreed in favour of the Staff Listening Service proposal, which will start off with a small pilot and then evaluation.
- Requested an update for October meeting

#### 6. **Staff Experience Update**

Following full discussion at the Staff Governance Committee the Workforce Director highlighted the three main points:

- Human Synergistics, a specialist company in developing organisational cultures who are recognised and have a validated model, have been appointed to take forward a significant piece of work across integration, i.e., health, council, police, third sector, in relation to cultural diagnostics and to support us through this change. Company meeting with Organisational Development Workstream next week.
- iMatter staff engagement/staff experience tool has been developed nationally, on the back of some local work, and just about to complete the first round of the process with a small questionnaire to the workforce to test this. In response to a query around timelines for feedback which appear to be around six weeks, the Workforce Director confirmed that timelines are set nationally. Locally, when working through the process, this does not feel like a long time.
- 2015 Staff Survey will run through the autumn. Discussion at Area Partnership Forum (APF) in terms of what we need to do locally before the survey comes out will result in a series of communications being put in place. APF agreed to shape up three questions in relation to local needs to give baseline information for the key communications measures around integration, new hospital and clinical service change.

The Chair requested a briefing on the iMatter programme and a copy of the 2014 Staff Survey questionnaire. The Workforce Director agreed to circulate to the Committee.

7. **Senior Charge Nurse (SCN) Shadow Day**

A Non Executive Member explained that, as a member of the Healthcare Governance Committee, and following the Healthcare Improvement Scotland inspection, she had been given the opportunity to shadow a Senior Charge Nurse (SCN) and had opted to visit the Galloway Community Hospital. Noted that the staff had been through a rough time and there had been a lot of sickness/absence. However, she was impressed by the new SCN's personal leadership and manner of encouraging her staff. She highlighted a real challenge in relation to patients being discharged home and processes around this, in particular, the multi-disciplinary team meetings for each patient.

8. **Patient Experience – Patient Opinion Report**

The Chair noted the report.

9. **Annual Complaints Report**

The Chair noted the report to be submitted to the Scottish Health Council. She explained that the report is the focus of the national Participation Standard and the self assessment is included at Appendix 2.

The Associate Medical Director commented that it would be nice to hear about compliments received, highlighting an initiative in Cumbria which may be useful in Dumfries and Galloway. Brief discussion about using the word “feedback” instead of “complaint” to describe patient comments.

10. **Spiritual Care Briefing**

*Spiritual Care Policy*

Noted that the Spiritual Care Policy will be discussed at a local stakeholder group in early July.

*Feedback from the “Enabling Meaningful Integration” Conference*

The very positive feedback, which included Values Based Reflective Practice, for this conference was noted. The Chair commented that we need more of this type of event and asked if there were any more planned and it was confirmed that an event is planned in each of the four localities. Dates will be circulated when available.

*Community Chaplaincy Listening (CCL)*

The Chair noted the briefing.

*Proposal for Endowment Funding: Co-Ordination of Bereavement Care Information Sharing, Support and Education*

Following a brief discussion around the Bereavement Group, the Committee approved the proposal which will now move forward to request funding.

11. **PCH&CC Annual Report 1014 – 2015**

The Chair noted the report.

12. **Vale of Leven Update**

The Chair noted the report.

**13. Any Other Competent Business***Communication Needs*

The Workforce Director explained that within the equality outcomes update issues had been raised in relation to patients with specialist communication support needs. During these conversations it was confirmed that the use of "Language Line", for those where English is not their first language, is in place. She highlighted an issue raised in NHS Tayside where a patient had hearing difficulties. The Workforce Director, the Nurse Director, the Equality and Diversity Lead and the Patient Information Co-Ordinator had met and a stocktaking piece of work is in place for us to learn from and to try to address any gaps in our service, with an awareness raising week planned for the summer. The Workforce Director will bring an update to the October meeting.

**14. Date and Time of Next Meeting**

17 August 2015, at 9.30 am, in the New Board Room, Crichton Hall