

DUMFRIES AND GALLOWAY NHS BOARD



PUBLIC MEETING

A meeting of the Dumfries and Galloway NHS Board will be held at 10am on Monday 5th February 2018 in the Conference Room, Crichton Hall, Bankend Road, Dumfries.

AGENDA

Time	No	Agenda Item	Who	Attached / Verbal
10.00am	105	Apologies	L Geddes	Verbal
10.00am	106	Declarations of Interest	P Jones	Verbal
10.05am	107	Previous Minutes	P Jones	Attached
10.10am	108	Matters Arising and Review of Actions List	P Jones	Attached
QUALITY & SAFETY ASSURANCE				
10.15am	109	Patient Experience Report	E Docherty	Attached
10.30am	110	Healthcare Associated Infection Report	E Docherty	Attached
10.45am	111	Improving Safety, Reducing Harm Report	E Docherty	Attached
11.00am	112	Child and Young People's Improvement Collaborative	E Docherty	Attached
11.15am	113	Stillbirth Rates 2018	E Docherty	Attached
11.30am	114	Scottish Graduate Entry Medical School Update	K Donaldson	Attached
11.40am	115	Carers (Scotland) Act 2016 and the Scheme of Integration	V Freeman	Attached
PERFORMANCE ASSURANCE				
11.55am	116	At a Glance Performance Report	J White	Attached
12.05pm	117	Integration Joint Board Update	J White	Verbal
12.15pm	118	Update on Hospital Migration and Initial Operational Issues	J Ace	Attached
FINANCE & INFRASTRUCTURE				
12.25pm	119	Capital and Infrastructure Update	K Lewis	Attached
12.35pm	120	Financial Performance Update	K Lewis	Attached

NOT PROTECTIVELY MARKED

Time	No	Agenda Item	Who	Attached / Verbal
PUBLIC HEALTH & STRATEGIC PLANNING				
12.40pm	121	Regional Planning Update	J Ace	Verbal
12.45pm	122	Vaccinations in Scotland - NHS Dumfries & Galloway Transformation Programme	M McCoy	Attached
GOVERNANCE				
12.50pm	123	Freedom of Information Year End Report	L Geddes	Attached
12.55pm	124	Board Briefing	J Ace	Attached
1pm	125	<u>Committee Minutes</u> <ul style="list-style-type: none"> • Audit & Risk Committee Meeting – 2 October 2017 • Healthcare Governance Committee Meeting – 20 November 2017 • Person Centred Health & Care Committee 23 October 2017 • Staff Governance Committee Meeting – 25 September 2017 • Staff Governance Committee Meeting – 27 November 2017 	P Jones	Attached
ANY OTHER BUSINESS				
	126			
DATE AND TIME OF NEXT MEETING				
	127	<ul style="list-style-type: none"> • 9th April 2018 @ 10am – 1pm in the Conference Room, Crichton Hall, Bankend Road, Dumfries 		

DUMFRIES AND GALLOWAY NHS BOARD



NHS Board Meeting

Minutes of the NHS Board Meeting held on 4th December 2017 at 10am – 1pm in the Conference Room, Crichton Hall, Bankend Road, Dumfries, DG1 4TG.

Minute Nos: 82--102

Present

Mr P N Jones (PNJ)	-	Chairman
Mrs P Halliday (PH)	-	Vice Chair
Dr L Douglas (LD)	-	Non Executive Member
Ms L Bryce (LB)	-	Non Executive Member
Mrs L Carr (LC)	-	Non Executive Member
Ms G Stanyard (GS)	-	Non Executive Member
Mrs G Cardozo (GC)	-	Non Executive Member
Mr J Beattie (JB)	-	Non Executive Member
Dr K Donaldson (KD)	-	Medical Director
Mr E Docherty (ED)	-	Nurse Director
Mr J Ace (JA)	-	Chief Executive
Mrs K Lewis (KL)	-	Director of Finance

In Attendance

Mrs J White (JW)	-	Chief Officer
Ms C Sharp (CS)	-	Workforce Director
Ms M McCoy (MMc)	-	Interim Director of Public Health
Mrs V White (VW)	-	Consultant in Dental Public Health/Public Health
Mr Stephen Hare (SH)	-	Newly Appointed Employee Director
Mrs L Geddes (LG)	-	Corporate Business Manager
Mrs L McKie (LM)	-	Executive Assistant (Minute Secretary)

Apologies

Mr A Ferguson (AF)	-	Non Executive Member
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PNJ welcomed Board Members and members of the public to the NHS Board Meeting, noting that it was JB's last NHS Board meeting prior to his retirement at the end of January 2018. PNJ noted that JB had worked for 7 years as both Non Executive Member and Employee Director and wished JB all the best for the future.

PNJ continued to extend the welcome to Stephen Hare, the newly appointed Employee Director, who will take up his role and that as a Non Executive Member from 1st February 2018.

Update on Migration to new Dumfries and Galloway Royal Infirmary

Prior to the commencement of the agenda items, JW gave a presentation to NHS Board Members on the progress of the Migration to the New Hospital, following questions raised around validation processes for the new building by the Chairman prior to the NHS Board Meeting, to give assurance that all aspects had been considered and planned for prior to the migration and that the building had been signed off by the relevant authorities. Responses to the questions raised were covered in the key themes of the presentation.

JW continued to advise NHS Board Members that a similar process to the Major Incident Command and Control structure will be used during the migration. This process has three levels within the command structure. The staffing rosters for the migration period were highlighted for the three commands as Operational, Tactical and Strategic.

JA advised NHS Board Members that Dr Angus Cameron currently working as the West of Scotland Clinical Lead; had agreed to attend the migration weekend to support NHS Dumfries and Galloway with the transfer of patients at the strategic level.

JW continued to note the planned route for the transfer of patients, highlighting that alternative routes were available should any problems arise. Further information was provided to Board Members on the traffic management arrangements and the process for assessment of patients on the day prior to their planned move.

It was also noted that over the migration weekend, both Tactical and Strategic Commands will be utilising the new Patient Tracker dashboard, which gives a clear vision of patients in the old hospital, when they begin their transfer and when they arrive in their room at the new hospital. The system also identifies those patients being discharged prior to the move commencing.

From 4th – 6th December 2017, the current Dumfries and Galloway Royal Infirmary (DGRI) will run as normal on the Monday - Wednesday, noting that only emergency theatres will be in operation from 4pm on 6th December 2017 until the new theatres are fully operational in the new hospital on 11th December 2017.

NHS Board Members were made aware that at 8am on 8th December 2017 the Emergency Department would close on the current site and open at the new hospital. A Rapid Response Unit will be available at the current site after the department closes, to provide emergency care to members of the public who arrive. Road signs have also been erected to advise members of the public of the relocation of the Emergency Department.

JW highlighted that from 7th December 2017 ward assessments would commence prior to migrating on 8th December 2017.

Once the migration commences the current site will be known as Mountainhall Treatment Centre and the new hospital will become Dumfries and Galloway Royal Infirmary.

GS enquired to how many patients would either migrate to new hospital or be discharged; JW advised that she was unable to confirm the exact number of patients until the final patient assessments were completed. JW advised NHS Board Members that once patients were transferred families would be informed.

LD enquired to the role of the volunteers over the migration period. JW confirmed that volunteers would be in place to support both patients and their families, especially during the evening visiting period, to help navigate to the ward areas on the new site.

PNJ enquired to whether the independent tester has signed off the schedule of inspections that they were commissioned to undertake and give assurance that in their professional opinion that the new hospital is fit for purpose and ready for occupancy as a fully functioning district general hospital. JW advised that she would receive the final report today, which would include any outstanding items and was confident that the building would be ready for occupancy and the first patients transferring on 8th December 2017.

PNJ further enquired to whether the Board had sight of, and recorded receipt of, the Building Completion Certificates. JW advised that all equipment has been signed off by suppliers, noting that the Medical Physics department were currently working through processes for both Radiology and Laboratories. JW continued to note that there had been continual meetings with environmental control bodies, highlighting that the water and air quality tests would be completed and signed off today.

An update was given around telecommunication, WiFi and police airwave systems. Board Members were reminded of the challenges that have been faced around the WiFi and noted that the manufacturer has since been commissioned to retest the equipment prior to the completion certificate being issued and signed off on 6th December 2017.

JW continued to highlight that she would be meeting with Scottish Ambulance Service, Police Scotland and Fire Scotland colleagues to review the airwave requirements at a local level to ensure all requirements are available for the migration and longer term.

NHS Board Members were reminded of the testing of the command and control structure in September 2017, with JW highlighting that she was confident that as a Board, we had planned all aspects of the migration and would be able to deal with any eventualities.

PNJ praised the work completed, noting that NHS Board Members had been given the necessary assurance that all necessary steps have been taken and appropriate risk management arrangements have been adopted prior to migration on 8th December 2017.

JA confirmed that Strategic Command would give the final authorisation for the migration to go ahead on 8th December 2017, once they receive the first update in relation to patients, transport, staffing and equipment.

PNJ took the opportunity to thank staff for all the work that has been undertaken to get to this point and wished the teams luck for the migration.

82. Apologies for Absence

Apologies as noted above.

83. Declarations of Interest

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

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

84. Minutes of meeting held on 2nd October 2017

The minute of the previous meeting on 2nd October 2017 were approved as an accurate record of discussions, subject to the following amendment:

85. Matters Arising and Review of Actions List

PNJ presented the Actions List to members, noting that all actions listed were progressing well.

NHS Board Members noted the Actions List.

86. Patient Experience Report

ED presented the Patient Experience Report, asking NHS Board Members to note the Board's performance around complaints for the months September and October 2017.

NHS Board Members were highlighted to the continued work of the Spiritual Care Lead to develop the spiritual care service across NHS Dumfries and Galloway. A reminder was also noted in relation to the Annual Staff Christmas Carol service in the Crichton Memorial Church at 7pm on 12th December 2017.

It was noted that the number of feedback concerns recorded remain consistent with previous months and also consistent with the same period last year, with the majority of concerns relating to Acute Services. ED advised that the Deputy Nurse Director was linking with Acute Services to try to reach an early solution to challenges.

GC enquired to whether the board were aware of the different type of support young volunteers required, whether risk assessments had been completed and what links had been established with local agencies around the single room environment within the new hospital.

ED advised that all volunteer activities had been risk assessed, although was unsure of what links had been established and agreed to share this information once received with Board Members.

Action: ED

PH enquired as to whether the risk assessments undertaken for volunteers included those by building healthy communities and other agencies. ED advised that risk assessments were held by the commissioning group, which were fully supported by the Board's guidance, any issues would be escalated to Board Members.

LB enquired to whether volunteers had received any training in patient complaints. ED advised that during the transfer period volunteers had been instructed to signpost any complaint issues to a member of the Patient Services Team.

NHS Board Members:

- noted the Board's complaints performance for September 2017 and October 2017 including key feedback themes and details of the resulting learning and improvements.
- noted the continued success in recruiting volunteers to support the new Dumfries and Galloway Royal Infirmary and the developing interest from young volunteers.

87. Healthcare Associated Infection Report

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

NHS Board Members were advised that whilst the rate of Staphylococcus Aureus Bacteraemia (SAB) is above the Local Delivery Plan target it is below the Scottish mean for Healthcare Associated Infection Staphylococcus Aureus Bacteraemia (SAB) and only slightly above for the community acquired Staphylococcus Aureus Bacteraemia (SAB).

GS enquired whether, as a Board, there was anything that could be done to improve the situation. ED advised that the increasing infections of community origin, and the spread of antimicrobial resistance, clearly required new strategies and resource, but it is not yet clear whether this piece of work sits at a local level or nationally.

NHS Board Members noted the update.

88. Performance Report

JA presented the Performance Report, asking NHS Board Members to note the At A Glance performance report for July to September 2017.

JA made NHS Board Members aware of the increase in acute emergency admissions for the time of year, noting the return to normal activity within the last 3 to 4 days, although Scottish Government were fully aware of performance data.

GS enquired to whether the performance data would improve prior to NHS Board in February 2018. JA advised that going by historical figures there should be a slight dip in the key operational targets, although there should not be an impact on elective targets.

LD enquired to whether there was any improvement to staffing issues. ED advised that there had been an improvement in patient pathways, due to the recruitment of additional Allied Healthcare Professionals.

GS enquired as to whether patient risk assessments prior to migration included risks to patient stress levels and whether there was an expected increase in the mortality rate. ED advised that he did not foresee any change to the mortality rate and that there were mental health and listening teams in place to assist patients throughout the migration period.

GC asked whether patient experience from the migration was being captured. JA highlighted that all patient experience information including volunteers would be captured and Board Members notified of findings.

NHS Board Members noted the report.

89. Integration Joint Board Update

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

NHS Board Members were highlighted to the Integration Joint Board (IJB) Values Based Reflective Practice Session on 30th November 2017. The purpose of the session was to give an update on the 2017/18 Quarter 2 performance, to review the Service Planning Framework document and discuss the Dumfries and Galloway Carers Strategy 2017/2021.

PH noted the IJB Chairs meeting with Scottish Government on 11th December 2017 which will focus on partnership agencies and budget setting that could affect IJBs.

NHS Board Members noted the verbal update.

90. Integration Workforce Plan

CS presented the Integration Workforce Plan, asking NHS Board Members to note the 2016-2019 Integration Joint Board Workforce Plan (2017 edition).

NHS Board Members were made aware that Partnership organisations had consulted with relevant stakeholders on the core IJB Workforce Plan in 2016, the 2017 edition was endorsed by the Integration Organisational Development Steering Group on 30th August 2017, with feedback received from the Area Partnership Forum, Area Clinical Forum and Social Services Committee. The plan was then presented to the Health & Social Care Management Team on 11th October 2017 where it was approved for onward submission and final approval by the Integration Joint Board at their meeting on 30th November 2017.

GC noted the following errors within the report:

- Page 10, Table 5 - should read - *Dumfries & Galloway Council Social Care Workforce Summary by Directorate*
- Page 11, Table 7 – should read - *NHS Dumfries & Galloway Workforce by Locality.*

CS agreed to amend the report.

Action: CS

NHS Board Members the report.

91. Capital & Infrastructure Update

KL presented the Capital Update paper noting that allocations of £58.570million had been received from the Scottish Government Health and Social Care Directorate (SGHSCD), and the expenditure of £31.790million had been incurred prior to the end of October 2017.

KL advised that the following discussions with SGHSCD, it has been confirmed that an allocation deduction will be made later in the financial year to allow a capital to revenue transfer, this relates to equipment which is currently within the Capital Plan but does not meet the £5k capital threshold.

NHS Board Members were made aware that due to expenditure on equipment expected to increase significantly over the coming months, Project Sessions are planned with Locality Managers in the New Year to gain a more detailed position.

LD enquired to when Board Members could expect to view Locality Plans. KL advised that currently she was unable to commit to a date as yet, however, would give an update on the progress in the next Capital update paper for NHS Board.

NHS Board Members were made aware that the budget has been approved for the new Mountainhall Treatment Centre. The budget allocated in 2017/18 is to support the fees associated with the progression of the business case and design works to the next stage with the submission of the Full Business Case addendum anticipated in early 2018.

NHS Board Members noted:

- The allocations received to date.
- The capital expenditure incurred to date.
- The update on the 2017/18 programme of works.

92. Financial Performance Update

KL presented the Financial Performance Update, highlighting that the report reflects the year to date (YTD) position as at the end of October 2017. The current adverse variance of £1.2m reflects the revised progress towards the expected breakeven year end position, with further adjustments to the position to be made as part of the Mid Year Review.

It was noted that there were a number of financial challenges around Medical locum costs. Work has commenced to develop a longer term financial strategy which will be presented to Performance Committee for approval.

NHS Board Members were made aware that GP prescribing figures at month 5, showing a slightly improved underlying position due to a reduction in volume in August 2017 compared to previous indications, however, short term supply issues with certain tariff drugs are creating a potential cost pressure of £1.1m.

NHS Board Members were made aware that KL had been approached by Christine McLaughlin, Health Finance Director to be the Lead Director of the Community Pharmacy Group.

It was noted that there was concern on the scale of the financial gap for 2018/19, with a £10m recurring deficit in additional uplifts, with zero percentages forecasted for 2018/19. KL agreed to send budget information to PNJ for information.

PH enquired whether there was any additional funding expected for Scottish Health Boards following the Westminster announcement on extra funding for Mental Health Services. KL advised that she was not aware of any additional funding being allocated to Scottish Boards.

PH highlighted the need to have joint workshops for NHS Board and Integration Joint Board Members when at all possible. KL noted that she would welcome joint workshops, which would ease repercussion.

KL agreed that she would discuss possible options with JW.

Action: KL

NHS Board Members noted the report.

93. Declaration of Surplus Property at Ladyfield East and West, Dumfries

KL presented the declaration of surplus property at Ladyfield East and West in Dumfries, asking NHS Board Members to re-affirm that the properties were surplus to NHS requirements.

It was noted that both properties were previously declared surplus by the Board in 2008. Disposal at that time proved problematic due to planning concerns in respect of the potential proposals for housing development on adjacent, non NHS, land. These proposals are no longer being considered in the short to medium term within the Council's Local Development Plan.

NHS Board Members formally re-affirmed the following properties as surplus to NHS requirements:

- Ladyfield East, Glencaple Road, Dumfries.
- Ladyfield West, Glencaple Road, Dumfries.

94. Declaration of Surplus Property at the Residences, DGRI

KL presented the declaration of surplus property at the Residences, on the current Dumfries and Galloway Royal Infirmary site, asking NHS Board Members declare the properties surplus to NHS requirements.

GC enquired to whether the properties be advertised. JA advised that all properties will be marketed and advertised in the public arena.

GC enquired to whether the properties would be added to the Local Authority's Community Empowerment List of available properties, which can be viewed on the Local Authority's Website. JA advised that the properties would follow the written guidelines prior to advert.

GC further enquired to whether guidance from Scottish Government was available on the sale of surplus properties. JA advised that as a Board we must comply with the guidelines within the disposal of properties handbook, set out by Scottish Government.

KL agreed to look at the marketing issues relating to the properties with Ian Bryden, Head of Estates.

Action: KL

GC enquired to the decision making processes of surplus buildings involving

Third and Independent Sectors. KL agreed to look into this and report back to a future Performance Committee meeting.

Action: KL

LB asked what security will be in place once the current Hospital is decommissioned. JA advised that the Board has already engaged with an independent security company to patrol on a 24/7 basis.

NHS Board Members formally declared the following properties as surplus to NHS requirements:

- Residences Blocks A1-A10 and B1- B4 (inclusively) Glencaple Road, Dumfries.
- Bungalow (Infection Control), Glencaple Road, Dumfries.
- The garages and plant rooms associated with these buildings

95. Regional Planning Update

JA gave a verbal update on Regional Planning to Board Members, highlighting the service Model, workforce map and workstreams that are being progressed.

PNJ advised that John Burns, Chief Executive of NHS Ayrshire & Arran was presenting a paper to the NHS Chairs Group today on the West of Scotland Health and Social Care Delivery Programme. The paper would provide an update on the progress of the West of Scotland Health and Social Care Delivery Programme Board in developing the first Regional Delivery Plan. This work builds on the Discussion Paper prepared at the end of September 2017.

NHS Board Members noted the verbal update.

96. Lochside and Lincluden Oral Health Action Plan Update and Lochside Dental Clinic Withdrawal Update

KD presented the Lochside and Lincluden Oral Health Action Plan and Lochside Dental Clinic Withdrawal Update, asking NHS Board Members to note the update following the August 2017 NHS Board decision and agree that further updates on the Oral Health Action Plan and annual oral health monitoring framework will be reported to the Clinical and Care Governance Committee of the Integration Joint Board on an annual basis from March/April 2018.

VW advised NHS Board Members that since the NHS Board agreed to the withdrawal of NHS Dental Service Provision by the Public Dental Service from Lochside Clinic, 145 patients have noted their preferred practice and are in the process of completing the registration process.

NHS Board Members were made aware that only 11 individuals had attended the Drop in session at the Clinic on 3rd November 2017 and 15th November 2017 to ask questions on the transfer process, no further sessions have been planned.

PH thanked VW on behalf of NHS Board Members for the report and in supporting the community, enquiring whether it was possibly to have an idea of patient experiences regarding services that have been put in place to gain a person centred point of view to aid further engagement with the local community on patient experience. VW advised that this could be something to add to the engagement event planned with the Third and Independent Sectors.

PH further enquired to whether the communities of Lochside and Lincluden had participated in appraisals. VW advised that appraisals had been carried out at the start of the process and although the data confirmed that only 43% of patients resided in the Lochside and Lincluden areas, data was not available to break down any further. VW agreed to address data issues and feedback to Board Members at a later date.

Action: VW

GC asked what was being done to support vulnerable patients in this process. VW advised that patients had been sent leaflets, which included information on taxi card schemes, bus companies and active travel.

GS enquired to how the Stakeholder Event had been communicated with the public to aid community engagement. VW advised that work was continuing through the Community Council to aid the dialogue process.

PNJ highlighted the recent letter received from the Lincluden Community Council asking the NHS Board to reconsider the withdrawal of dental services for the Lochside Clinic asking members of both NHS Board and the Integration Joint Board to reinstate dental services.

NHS Board Members were highlighted to the discussion at the last Health and Social Care Management Team meeting, where Alistair Kelly noted his concerns at the lack of administrative provision for Podiatry Services. KL advised that there would be a further review of services to aid administration support and agreed to update Board Members accordingly.

Action: KL

LB enquired to services available for expectant mothers. VW advised that it was imperative that all expectant mothers register with the centre.

GS enquired to oral health partnership working with health visitors. VW advised that although referrals from Health Visitors working in the Lochside and Lincluden area appear to have increased in comparison to 2016 figures, oral health is embedded into child health smile programme

NHS Board Members:

NOT PROTECTIVELY MARKED

- NHS Board members noted the letter of representation and agreed that there would be no change to the decisions taken at the Board meeting of August 2017.
- Noted the update provided in respect of implementation of the withdrawal of routine General Dental Services by the Public Dental Service from Lochside Dental Clinic
- Noted the update provided regarding implementation of the Lochside and Lincluden Oral Health Action Plan.
- Noted the proposed annual oral health monitoring framework.
- Agreed that further updates on the Oral Health Action Plan and annual oral health monitoring framework will be reported to the Clinical and Care Governance Committee of the Integration Joint Board on an annual basis in March/April 2018.

97. Code of Corporate Governance

LG presented the Code of Corporate Governance, asking NHS Board Members to review and approve the revisions to the Code of Corporate Governance for onward publication.

GS requested the following amendment on page 93 of the Code of Corporate Governance: *Robert Allan as Chair of Audit and Risk*. LG agreed to make this change before it was published.

Action: LG

PH enquired to whether the Non Executive Membership noted within page 30, point 12 of the Code of Corporate Governance would be incorporated in the minute of the Healthcare Governance Committee. ED advised that this was correct.

NHS Board Members approved the revisions to the Code of Corporate Governance, with one adjustment.

98. FOI Six Monthly Update

LG presented the FOI Six Monthly Update, asking NHS Board Members to note the performance of and compliance with the Freedom of Information (Scotland) Act 2002 for the period 1st January 2017 – 31st October 2017.

NHS Board Members were advised that the Scottish Information Commissioner had released a revised Publication Scheme Template, which we are reviewing locally. Any revisions that are made to the Board's Guide to Information Available Through the Publication Scheme would be brought back to NHS Board for approval.

LG highlighted that 493 requests for information had been received between January – October 2017, which demonstrates a 5.7% increase on the same

period in 2016.

NHS Board Members noted the report.

99. Board Briefing

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

NHS Board Members were highlighted to the Celebration Event on 2nd December 2017 in the Dining Room at Dumfries and Galloway Royal Infirmary to celebrate and welcome the renaming of the current site to Mountainhall Treatment Centre and the opening of our new state-of-the-art Hospital on 8th December 2017.

NHS Board Members noted the verbal report.

100. Board Dates 2018-19

LG presented the proposed schedule of NHS Board meeting dates for the period April 2018 to March 2019, asking NHS Board Members to approve scheduled dates.

NHS Board Members approved the schedule of NHS Board meeting dates for the period April 2018 to March 2019.

101. Committee Minutes

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

- Audit and Risk Committee – 19th June 2017
PNJ presented the minute from the Audit and Risk Committee meeting on 19th June 2017, which received an update on the Standing Financial Instructions.

NHS Board Members noted the minute.

- Staff Governance Committee – 24th July 2017
PNJ presented the minute from the Staff Governance Committee meeting on 24th July 2017, where an update was given around the iMatter Board and National Reports.

NHS Board Members noted the minute.

- Performance Committee – 4th September 2017
PNJ presented the minute from the Performance Committee meeting on 4th September 2017, which received an update on the Acute Services Redevelopment Programme.

NHS Board Members noted the minute.

101. Any Other Competent Business.

NHS Board Members were highlighted to the recent letter from Shona Robison, Cabinet Secretary for Health and Sport regarding the recent NHS Dumfries and Galloway 2016/17 Annual Review on 25th September 2017.

The letter thanked NHS Dumfries and Galloway for hosting the review, which had been well received with attendees asking a variety of questions.

NHS Board Members noted the verbal update.

102. Date of Next Meeting

The next meeting of the NHS Board will be held on 5th February 2018 at 10am – 1pm in the Conference Room, Crichton Hall, Bankend Road, Dumfries, DG1 4TG.

Actions List from NHS Board – Public Meeting

Date of Meeting	Agenda Item	Action	Responsible Manager	Current Status	Date Completed
05/12/2016	125.	<p><u>Early Years Collaborative Progress Report</u></p> <p>A Non-Executive Board Member highlighted that this initiative will have an impact on several of the equality characteristics and asked if the enough work was being undertaken around attachment and implementation locally. The Nurse Director confirmed that a national event has been hosted and the Early Years Collaborative is seen as a significant platform to promote this piece of work. The Nurse Director confirmed that he would bring further information in relation to equalities back to Board within the next progress report.</p>	Eddie Docherty	An update on the impact of the initiative on equality characteristics will be presented back to Board in the next Early Years Collaborative Progress Report later in the year.	
05/12/2016	134.	<p><u>Adult Cancer Services in Dumfries and Galloway</u></p> <p>A question, around the use of volunteers to give emotional support to cancer patients, was raised by a Non-Executive Member. The Nurse Director confirmed that as yet this option had not been discussed; however, he would bring this to the next Volunteers Group for consideration.</p>	Eddie Docherty	An update on this item will be given under Matters Arising at the December 2017 NHS Board meeting.	04/12/17

Date of Meeting	Agenda Item	Action	Responsible Manager	Current Status	Date Completed
05/06/2017	30.	<p><u>Improving Safety Reducing Harm in Primary Care Report</u></p> <p>GC asked for further information to be made available on performance indicators for the Children's Service Plan. JW advised Members there work was ongoing nationally on indicators, but advised Members that a workshop on both Children and Young Adult Mental Health would be arranged to discuss local priorities.</p>	Alice Wilson	A workshop is being arranged and details will be forwarded to NHS Board members in due course.	
05/06/2017	38.	<p><u>Urological Cancer Update</u></p> <p>VF advised Members that to address recruitment challenges locally, work is being progressed with NHS Ayrshire and Arran to establish joint working arrangements for on-call and shared clinics in Stranraer. A further update on progress will be brought back to the August 2017 NHS Board meeting.</p>	Vicky Freeman	Information is still being gathered to allow a paper to be prepared. It has been agreed to push this paper back to the April 2018 Board meeting for review.	
07/08/2017	49.	<p><u>Patient Safety Annual Report</u></p> <p>LD asked for an update on expected results following the recent case review on the increase of stillbirths both locally and nationally. ED advised that he was currently in discussion with the Head of Midwifery and would provide an update back to LD when the information has been analysed.</p>	Eddie Docherty	An update on this item will be provided to Laura Douglas once the data has been analysed.	

Date of Meeting	Agenda Item	Action	Responsible Manager	Current Status	Date Completed
07/08/2017	49.	<p><u>Patient Safety Annual Report</u></p> <p>AF queried where the organisation records the statistics for adult and children protection outcomes and whether they could be added within the annual report. ED advised that currently the statistics were flagged to Healthcare Governance Committee on a regular basis and that all nurses were sighted on pathways, noting that a matrix could be added to future annual reports.</p>	Eddie Docherty	A matrix with the requested data will be added to the Patient Safety Annual Report when it is presented to NHS Board in Autumn 2018.	
07/08/2017	58.	<p><u>Tobacco Control Action Plan</u></p> <p>PH further noted the reduction of GP referrals being made to smoking services, noting that this was a national problem as Information Services Division data was also showing a 5% reduction in smoking cessation specialist services. PH requested data evidence of GP referrals be including within the next update to be brought back to NHS Board.</p>	Ken Donaldson	An update on this item will be brought back to NHS Board in early 2018, to include the data evidence of GP referrals.	

Date of Meeting	Agenda Item	Action	Responsible Manager	Current Status	Date Completed
04/12/2017	86.	<p><u>Patient Experience Report</u></p> <p>GC enquired to whether the Board were aware of the different type of support young volunteers required, whether risk assessments had been completed and what links had been established with local agencies around the single room environment within the new hospital. ED advised that all volunteer activities had been risk assessed, although was unsure of what links had been established and agreed to share this information once received with Board Members.</p>	Eddie Docherty	Volunteer link information will be forwarded to NHS Board members when available.	
04/12/2017	90.	<p><u>Integration Workforce Plan</u></p> <p>GC noted the following errors within the report:</p> <ul style="list-style-type: none"> • Page 10, Table 5 - should read - <i>Dumfries & Galloway Council Social Care Workforce Summary by Directorate</i> • Page 11, Table 7 – should read - <i>NHS Dumfries & Galloway Workforce by Locality.</i> 	Caroline Sharp	The changes noted have been made to the Integration Workforce Plan, in advance of submission to the Integration Joint Board.	04/12/17
04/12/2017	92.	<p><u>Financial Performance Update</u></p> <p>It was noted that there was concern on the scale of the financial gap for 2018/19, with a £10m recurring deficit in additional uplifts, with zero percentages forecasted for 2018/19. KL</p>	Katy Lewis	Budget information will be forwarded to PNJ when available.	

NOT PROTECTIVELY MARKED

Date of Meeting	Agenda Item	Action	Responsible Manager	Current Status	Date Completed
		agreed to send budget information to PNJ for information.			
04/12/2017	94.	<p><u>Declaration of Surplus Property at the Residences, DGR1</u></p> <p>GC further enquired to whether guidance from Scottish Government was available on the sale of surplus properties. JA advised that as a Board we must comply with the guidelines within the disposal of properties handbook, set out by Scottish Government.</p> <p>KL agreed to look at the marketing issues relating to the properties with Ian Bryden, Head of Estates.</p>	Katy Lewis	A meeting is being arranged to discuss the marketing issues. No further action for the NHS Board.	04/12/2017
04/12/2017	94.	<p><u>Declaration of Surplus Property at the Residences, DGR1</u></p> <p>GC enquired to the decision making processes of surplus buildings involving Third and Independent Sectors. KL agreed to look into this and report back to a future Performance Committee meeting.</p>	Katy Lewis	An update on this item will be taken to Performance Committee, when available. No further action for NHS Board.	04/12/2017

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

Date of Meeting	Agenda Item	Action	Responsible Manager	Current Status	Date Completed
04/12/2017	97.	<p><u>Code of Corporate Governance</u></p> <p>GS requested the following amendment on page 93 of the Code of Corporate Governance: <i>Robert Allan as Chair of Audit and Risk</i>. LG agreed to make this change before it was published.</p>	Laura Geddes	The Code of Corporate Governance has been updated and is being published on the intranet and internet sites.	19/01/2017

DUMFRIES and GALLOWAY NHS BOARD

5th February 2018



INVOLVING PEOPLE IMPROVING QUALITY Patient Experience Report

Author:

Emma Murphy
Patient Feedback Manager

Sponsoring Director:

Eddie Docherty
Executive Nurse Director

Joan Pollard
Associate Director of AHPs

Date: 16th January 2018

RECOMMENDATION

The NHS Board is asked to :

- consider this report which provides an update on the activities of the Patient Services team.
- note the Board's complaints performance for November 2017 and December 2017 including key feedback themes and details of the resulting learning and improvements.
- note the update on Spiritual Care and Volunteering

CONTEXT

Strategy / Policy:

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

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

Patient feedback provides key information about the areas where the Board is performing well and those where there is need for improvement. It also assists the Board in delivering our CORE values and remaining person centred.

Key messages:

- Patient Services are delivering a number of improvement activities within their key areas of responsibility.
- Progress continues within the establishment of Volunteering and the refresh of Spiritual Care support across the region.
- The Board continues to face some challenges around compliance with complaint timescales.
- Requests for extensions where complaint timescales cannot be met as improved.
- Patient Services are continuing to work with Responsible Managers and Feedback Co-ordinators to address these compliance issues.

GLOSSARY OF TERMS

NHS D&G	-	NHS Dumfries & Galloway
DGRI	-	Dumfries and Galloway Royal Infirmary
IJB	-	Integrated Joint Board
GCH	-	Galloway Community Hospital
CHP	-	Complaints Handling Procedure
SPSO	-	Scottish Public Services Ombudsman
PEN	-	Participation and Engagement Network
ISD	-	Information Services Division

MONITORING FORM

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

1. Introduction

The Patient Services team are responsible for a number of areas of work including; Spiritual Care, Volunteering, Patient Information, Patient Feedback and the Public Engagement Network. This report outlines the key activities of the team over the period November and December 2017 and details planned improvement actions and recent achievements.

2. Spiritual Care

2.1 Sanctuary within DGRI

Adjustments are being made to the Sanctuary space within DGRI to provide adequate privacy for prayer.

2.2. Bereavement Support

Plans around a bereavement workshop continue to be developed and it is anticipated that the workshop will take place in spring 2018.

2.3. Staff Support

Referrals remain low due to the DGRI relocation and annual leave. Information on the support available to staff is detailed on the intranet site, Beacon, and in information cards which have been made available on wards.

2.4. Spiritual Care Volunteering

A new spiritual care volunteer will commence their role in DGRI from January 2018 with a further volunteer joining the organisation in March 2018.

2.5. Carol Service

The Annual Staff Christmas Carol Service, which was well attended, took place on the 12 December 2017 at the Crichton Memorial Church. The NHS staff choir, supported by the Annan Academy School Band, were led by the Principal Teacher of Expressive Arts at Annan Academy. NHS staff participated in readings and the provision of catering. The sum of £151.72 was raised by a retrieval collection this year. Donations were provided to Dumfries & Galloway Women's Aid with a small contribution to Annan Academy School band.

2.6. Informal Carol Singing in the Atrium

In acknowledging the successful relocation of patients and staff into the new DGRI, a number of staff and their families and some patients and families gathered together in the atrium to sing popular Christmas carols and songs, led by members of the Annan Brass band.

3. Volunteering

3.1 Training

Corporate Induction training took place on 13 November in Lecture Theatre with 75 new volunteers attending. Over 30 of these volunteers were young people from local secondary schools and the Dumfries & Galloway College.

3.2 Recruitment

The recruitment of volunteers enabled the Board to provide over 600 volunteering hours between Friday 8 December and Sunday 17 December to support the Migration and staff and visitors in the first week of opening of the new hospital. The Board currently have 276 volunteers which include 50 Welcome Guides, 10 Critical Care Unit (CCU) Volunteers and over 100 Ward Volunteers.

The recruitment process will begin again in January 2018 for additional Ward and CCU Volunteers.

3.3 Volunteer Champions

The purpose of Volunteer Champions is to encourage and support new volunteers in their role and to ensure they feel valued as a part of the NHS team. There have been 24 Volunteer Champions recruited from staff teams across DGRI.

4. Participation and Engagement Network

Community Planning partners have agreed a coordinated approach to promoting the network going forward. Partners have now committed to promoting the network regularly through their individual social media and other public communication channels. Additionally there will be periods throughout the year of more focussed promotion where all partners will simultaneously share key messages with their patients, service users, clients and stakeholders, the aim being to increase awareness and membership.

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

5. Patient and Carer Information

Ward and bedside information folders have successfully been introduced across the Dumfries and Galloway Royal Infirmary:

- The ward folders include a number of information leaflets on subjects such as patient rights, feedback and infection control.
- The bedside folders include a wide variety of information about staying in hospital including details of catering, uniform identification and spiritual care.

The folders also include advice and signposting on key topics of concern. The introduction of these folders assists with version control and information accuracy. Patients can request their own copy of this information as required and the folders include signposting for staff to the location of each document on Beacon.

Leaflet stands have also been placed in the entrance areas of the new hospital. These include the same leaflets as the ward folders and are placed in the public seating areas in the main atrium, Accident and Emergency and the Women and Children’s waiting area.

Patient Services intend to provide additional support to the other hospital locations during 2018 with a view to introducing similar information solutions.

6. Patient Feedback

This following section provides a commentary and summary statistics on patient feedback throughout NHS Dumfries and Galloway for the period November and December 2017.

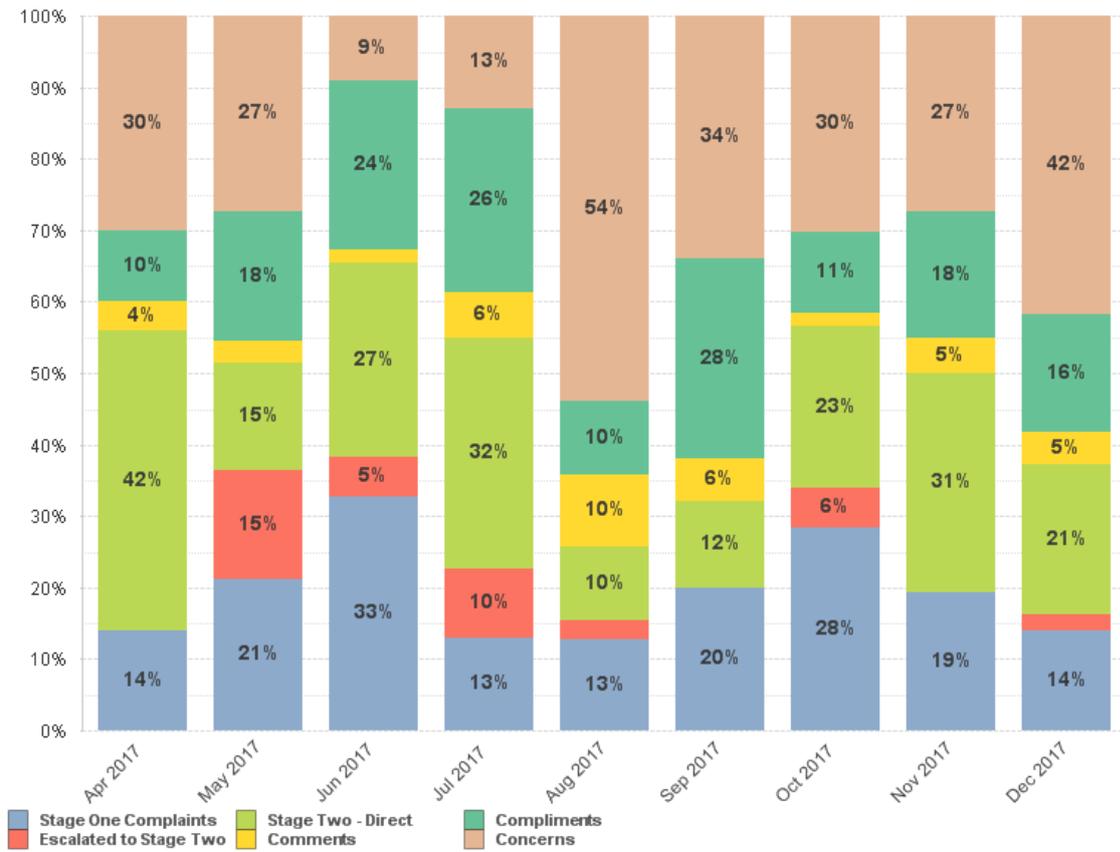
6.1 Feedback Received

Patient Services recorded 62 pieces of feedback in November 2017 and 43 in December 2017. Both months had fewer complaints than our 2016/17 annual average of 33 per month, and were lower than the same period in the previous year of 37 complaints in November 2016 and 27 in December 2016.

Feedback Type	November 2017		December 2017	
	Number	%	Number	%
Stage One Complaints	12	19%	6	14%
Escalated to Stage Two	0	0%	1	2%
Stage Two Complaints - Direct	19	31%	9	21%
Comments	3	5%	2	5%
Compliments	11	18%	7	16%
Concerns	17	27%	18	42%
Totals:	62		43	

Source: Qlikview – 03/01/2018

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



Source: Qlikview – 03/01/2018

6.3 Compliments

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

One of the more detailed compliments was shared by the Communications team on the NHS Dumfries and Galloway Facebook page. This was well received by the public and resulted in further positive feedback being shared on the Facebook post. The original story read as follows:

"Following my recent bowel cancer operation carried out at your hospital, I should like to extend my sincere thanks and congratulations on a job very well done. From beginning to end the surgeon has been exceptional in both work carried out and in the explanations given during the whole process. Anyone undergoing this procedure would be fortunate to have this very skilful surgeon perform their operation - he is an exceptional human being.

His example also permeates to the staff who work with him and I can only praise their efforts too. His Enhanced Recovery Nurse is worth her weight in gold. She has the wonderful knack of putting you at your ease and feeling safe in their hands. What a team this man leads - at all levels the staff go above and beyond.

The Enhanced Recovery Programme has certainly worked well for me. I felt this team deserved the recognition for having performed a "Job Very Well Done." Hopefully you will pass on this praise to all caregivers in my treatment - many are prepared to complain about NHS failures however, I experienced the NHS at its very best. This team are a credit to your hospital."

6.4 Complaints

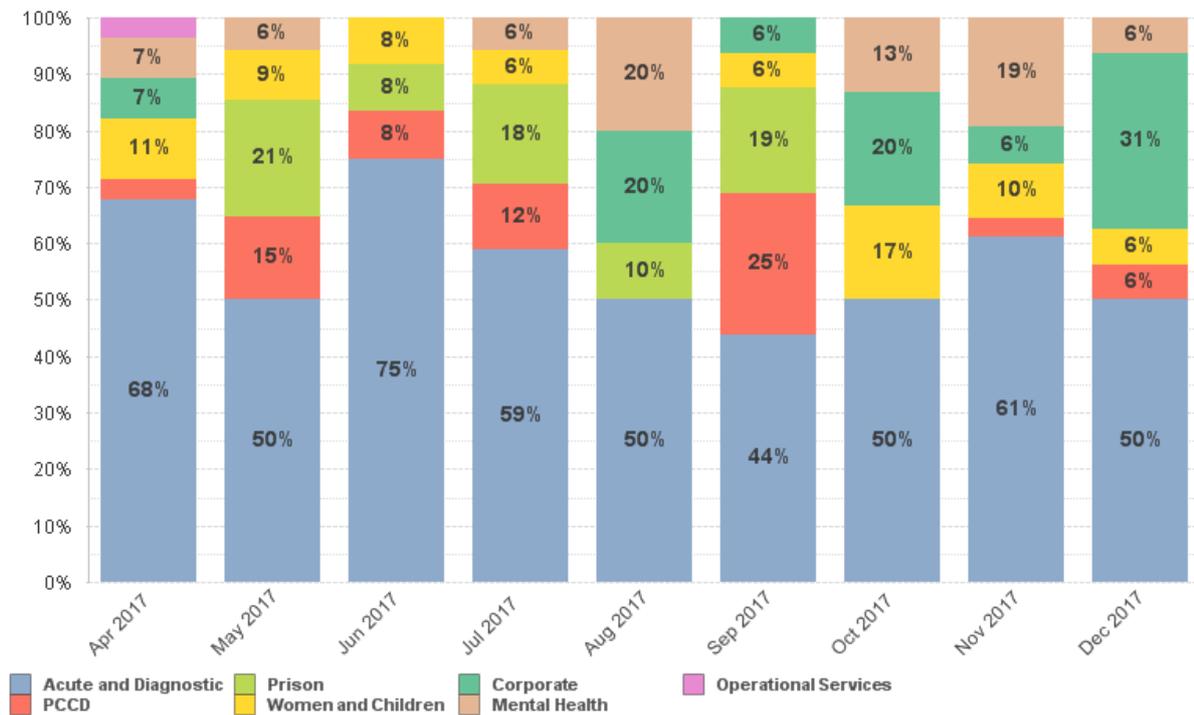
The complaints received related to the following areas:

Service	November 2017		December 2017	
	Number	%	Number	%
Acute and Diagnostic	19	61%	8	50%
PCCD	1	3%	1	6%
Prison	0	0%	0	0%
Women and Children	3	10%	1	6%
Corporate	2	6%	5	31%
Mental Health	6	19%	1	6%
Operational Services	0	0%	0	0%
Totals:	31		16	

Source: Qlikview – 03/01/2018

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

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



Source: Qlikview – 03/01/2018

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

Service	November 2017			December 2017		
	Number of responses	Number of complaints	% of all complaints	Number of responses	Number of complaints	% of all complaints
GPs (n:31)	29	3	75	27	1	50
Pharmacy* (n:34)	2	0	0	7	1	50
Dental (n:33)	16	1	25	14	0	0
Opticians* (n:21)	3	0	0	3	0	0
Totals:	50	4		48	2	

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

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

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

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

Indicator 1 - Learning from complaints

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

Whilst Patient Services are not yet in a position to comprehensively analyse and report learning activity and trends, it is possible to share some service specific examples:

Women and Children's Services

In response to a complaint the service are updating their care plan forms to include additional guidance and review date information.

Mental Health, Learning Disability and Psychology

In response to a complaint about communication, the service has reviewed their telephone message system and implemented a number of improvements to ensure messages are logged, forwarded and actioned consistently and efficiently.

Indicator 2 - Complaints Process Experience

These surveys were due to start in quarter two but information governance concerns were identified which delayed the introduction. In order to meet our obligations under the Data Protection Act 1998, the satisfaction survey will be shared with the complainants as part of the Complaints Handling Procedure on an 'opt in' basis. Complainants will now be welcomed to complete surveys from January 2018. The outcome of these surveys will be shared when available.

Indicator 3 - Staff Awareness and Training

Patient Services continue to work closely with teams across the Board to raise awareness of the Complaints Handling Procedure, including through attendance at team meetings. The complaints handling and investigation skills training continues to be in demand and well received. Bespoke sessions have also been delivered to some teams.

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

Definitions:

Stage One – complaints closed at Stage One Frontline Resolution;

Stage Two (direct) – complaints that by-passed Stage One and went directly to Stage Two Investigation (e.g. complex complaints);

Escalated Stage Two – complaints which were dealt with at Stage One and were subsequently escalated to Stage Two investigation (e.g. because the complainant remained dissatisfied)

Indicator 4 Total number of complaints received

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

Indicator 4 - The rate of complaints received per.....		
Description	Nov 2017	Dec 2017
Per 1000 population	0.02	0.01

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

Source – Qlikview – 03/01/2018

Indicator Five: Complaints closed at each stage

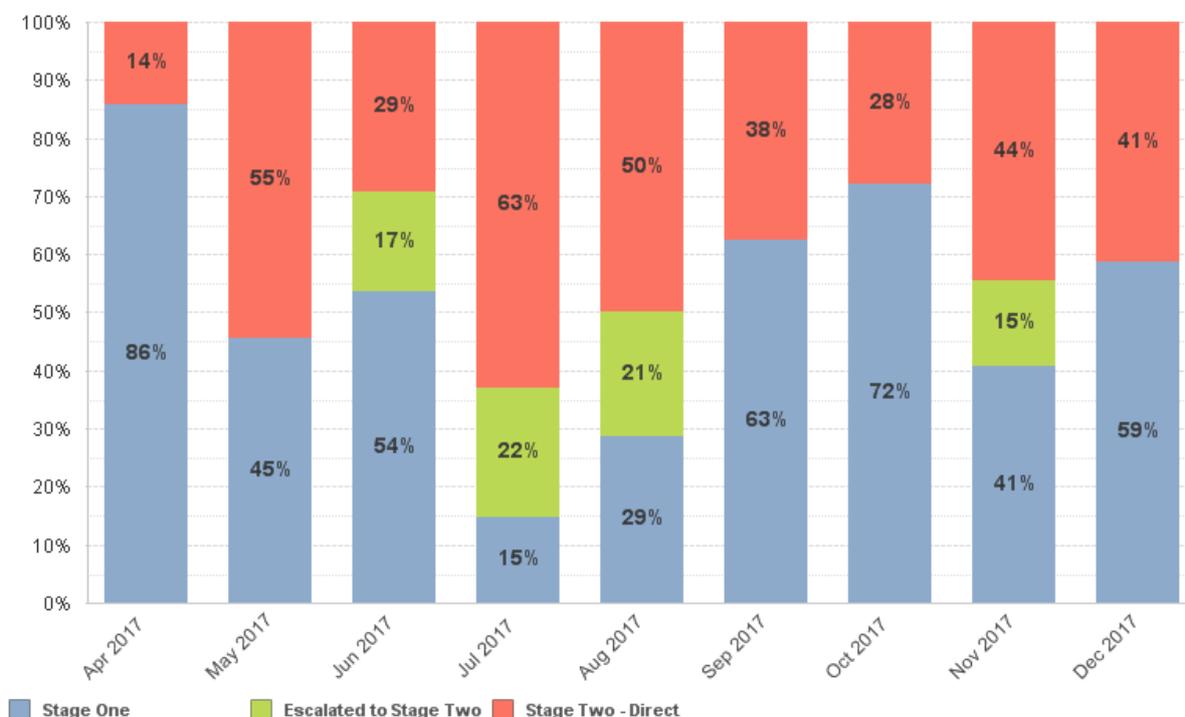
“Details of the number of complaints responded to at each stage of the Complaints Handling Procedure.”

Indicator 5 - Complaints closed (responded to) at Stage One and Stage Two as a percentage of all complaints closed.		
Description	November 2017	December 2017
Number of complaints closed at Stage One as % of all complaints closed	41% (11 of 27)	59% (10 of 18)
Number of complaints closed after Escalation to Stage Two as % of all complaints closed	15% (4 of 27)	0% (0 of 18)
Number of complaints closed at Stage Two as % of all complaints closed	44% (12 of 27)	41% (7 of 18)

NB: The escalated complaints referred to above were also responded at Stage One.

One of the December complaints referenced above was a historical complaint received pre 1 April 2017 and therefore has not been allocated to a ‘stage’ or included in the indicators below. The complaint related to historical issues and an external review was commissioned, which took some time. The response was provided at the beginning of December and advised that a number of the points were upheld.

Complaints Closed, based on closed date



Indicator Six: Complaints upheld, partially upheld and not upheld

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

Indicator 6 - The number of complaints upheld/ partially upheld/ not upheld at each stage as a percentage of complaints closed (responded to) in full at each stage.

Upheld		
Description	November 2017	December 2017
Number of complaints upheld at Stage One as % of all complaints closed at Stage One	36% (4 of 11)	30% (3 of 10)
Number Escalated to Stage Two complaints upheld at Stage Two as % of escalated complaints closed at Stage Two	0% (0 of 4)	- (0 of 0)
Number complaints upheld at Stage Two as % of complaints closed at Stage Two	8% (1 of 12)	14% (1 of 7)

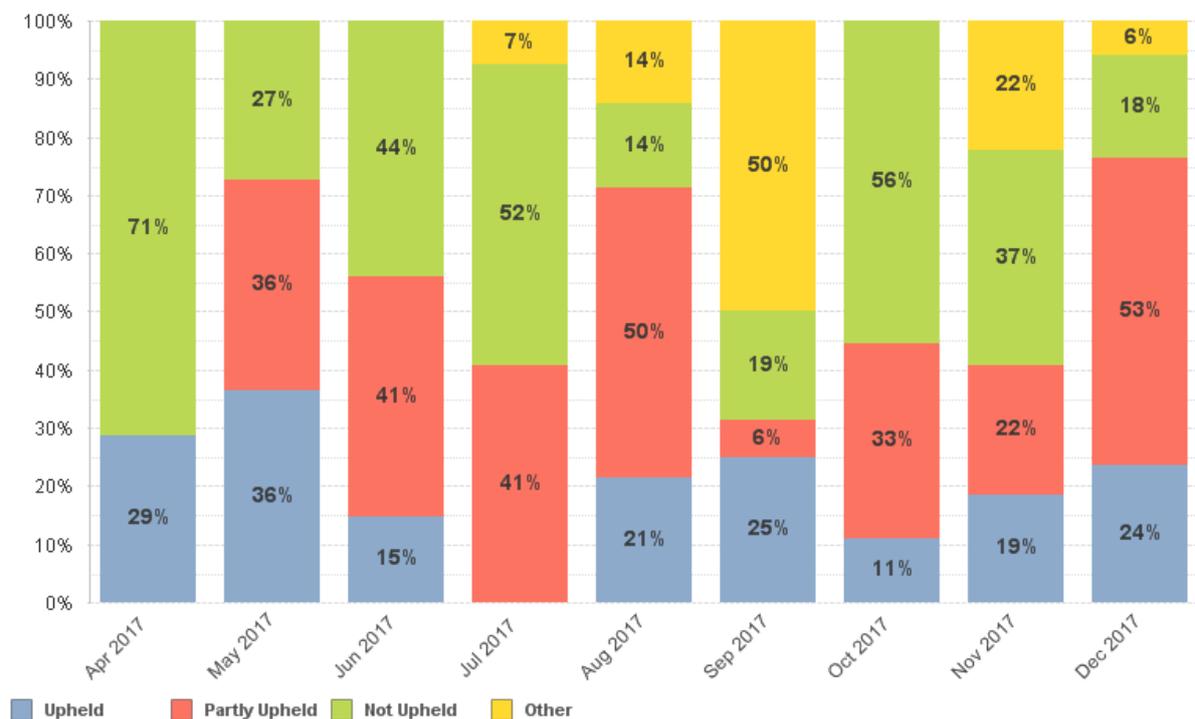
Partially Upheld		
Description	November 2017	December 2017
Number of complaints partially upheld at Stage One as % of all complaints closed at Stage One	9% (1 of 11)	50% (5 of 10)
Number Escalated to Stage Two complaints partially upheld at Stage Two as % of escalated complaints closed at Stage Two	25% (1 of 4)	- (0 of 0)
Number complaints partially upheld at Stage Two as % of complaints closed at Stage Two	33% (4 of 12)	57% (4 of 7)

Not Upheld		
Description	November 2017	December 2017
Number of complaints not upheld at Stage One as % of all complaints closed at Stage One	36% (4 of 11)	10% (1 of 10)
Number Escalated to Stage Two complaints not upheld at Stage Two as % of escalated complaints closed at Stage Two	75% (3 of 4)	- (0 of 0)
Number complaints not upheld at Stage Two as % of complaints closed at Stage Two	25% (3 of 12)	29% (2 of 7)

Other		
Description	November 2017	December 2017
Number of Stage 1 complaints where “other” outcome recorded as % of all complaints closed at Stage One	18% (2 of 11)	10% (1 of 10)
Number of complaints Escalated to Stage 2 where “other” outcome recorded as % of complaints closed at Stage Two	0% (0 of 4)	- (0 of 0)
Number of Complaints direct to Stage 2 where “other” outcome recorded as % of complaints closed at Stage Two	33% (4 of 12)	0% (0 of 7)

NB: ‘Other’ includes matters where consent has not been received; the complaint has been withdrawn or is resolved. It can also include complaints that have progressed down another route part way through the process (e.g. to an insurance claim) or where an outcome has not been recorded at the time of reporting.

Outcome of All Complaints Closed, based on closed date



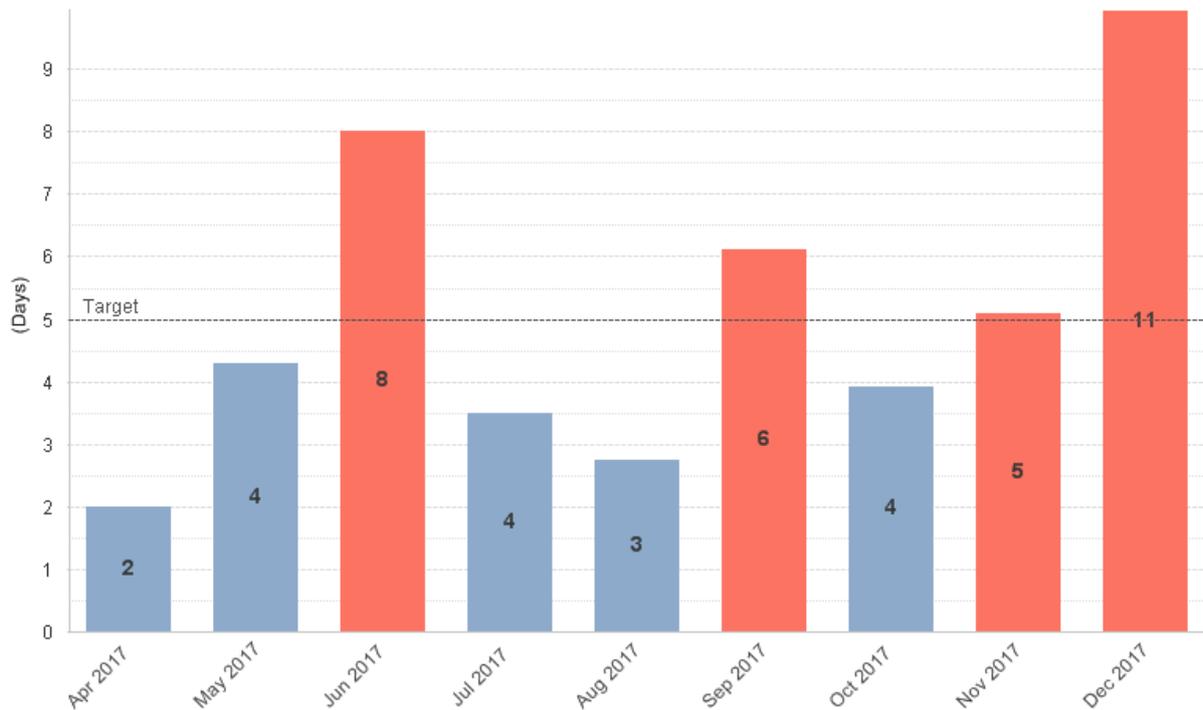
Indicator Seven: Average response times

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

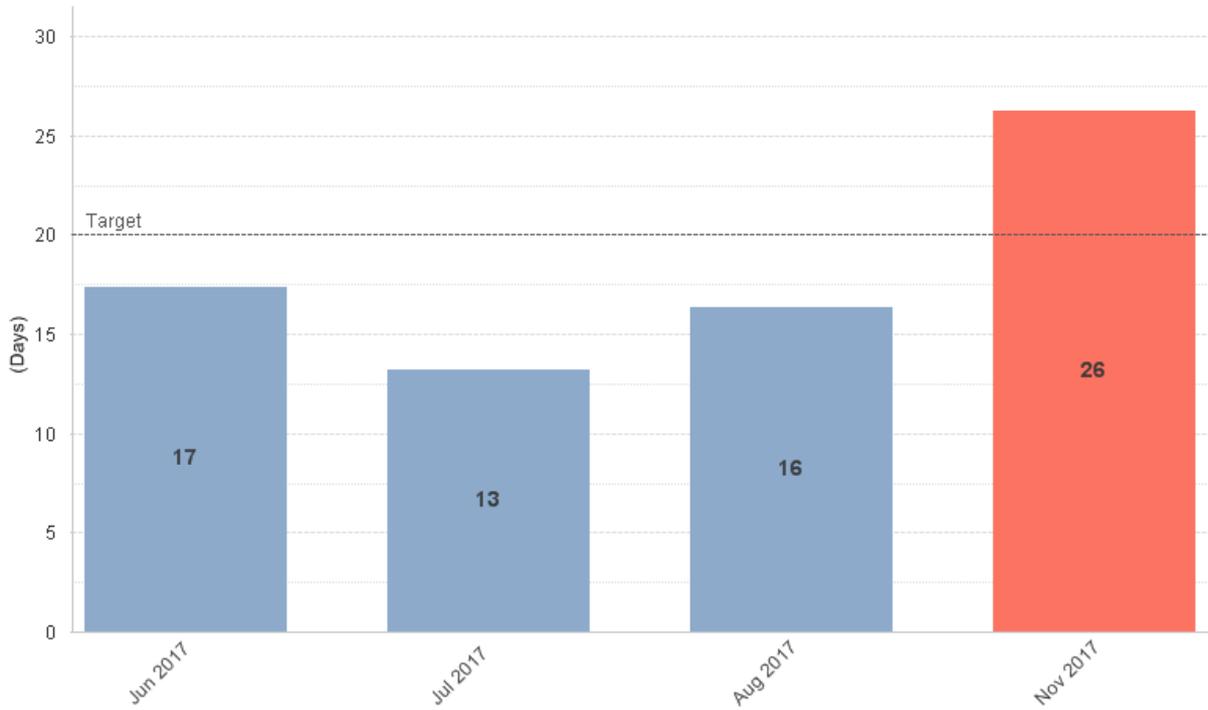
Indicator 7 - The average time in working days for a full response to complaints at each stage			
Description	November 2017	December 2017	Target
Average time in working days to respond to complaints at Stage One	5	11	5
Average time in working days to respond to complaints after Escalated to Stage Two	26	0	20
Average time in working days to respond to complaints at Stage Two	44	25	20

Complaints performance in November and December was affected by the additional workload pressures associated with opening the new hospital. This was anticipated and services communicated the expected delays with complainants and agreed extensions accordingly. There were also a number of complex complaints which took longer than the standard timescales to respond to.

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



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

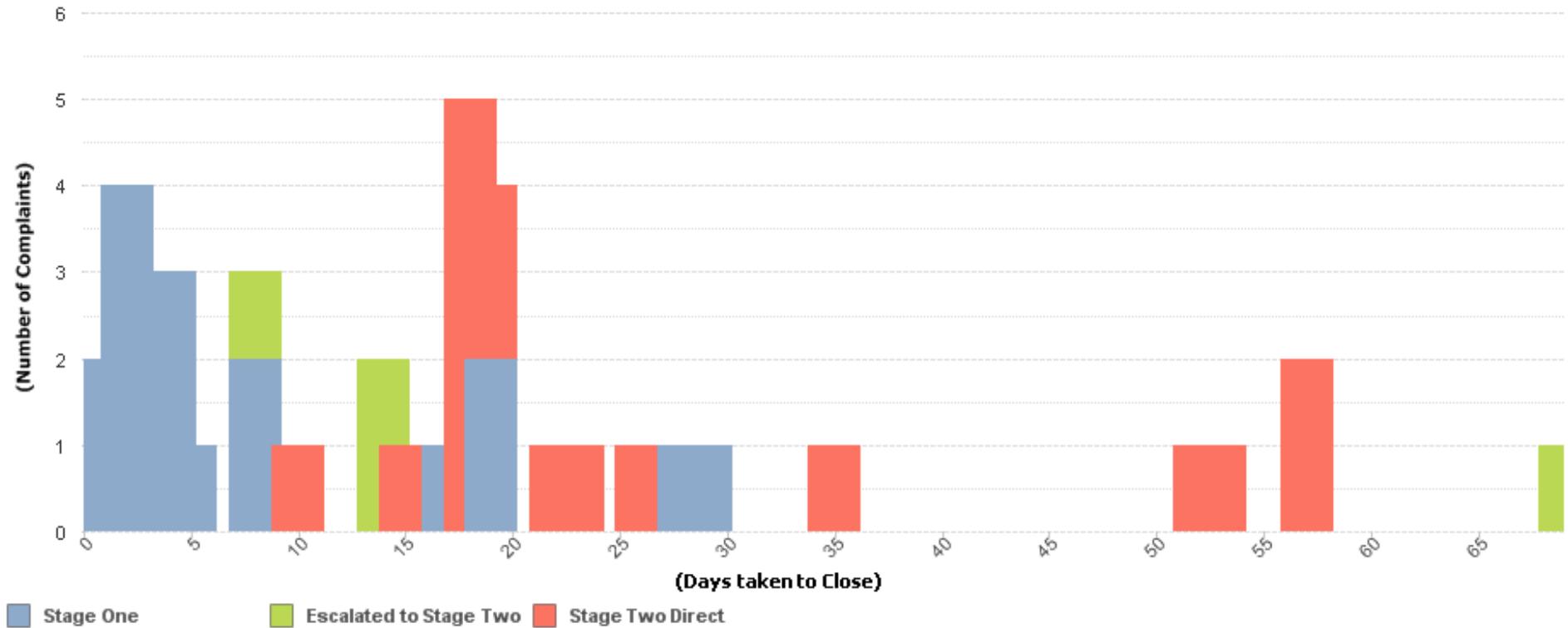


NB – Some months there are no Stage Two Escalated complaints.

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



Distribution of time for Complaint to be closed



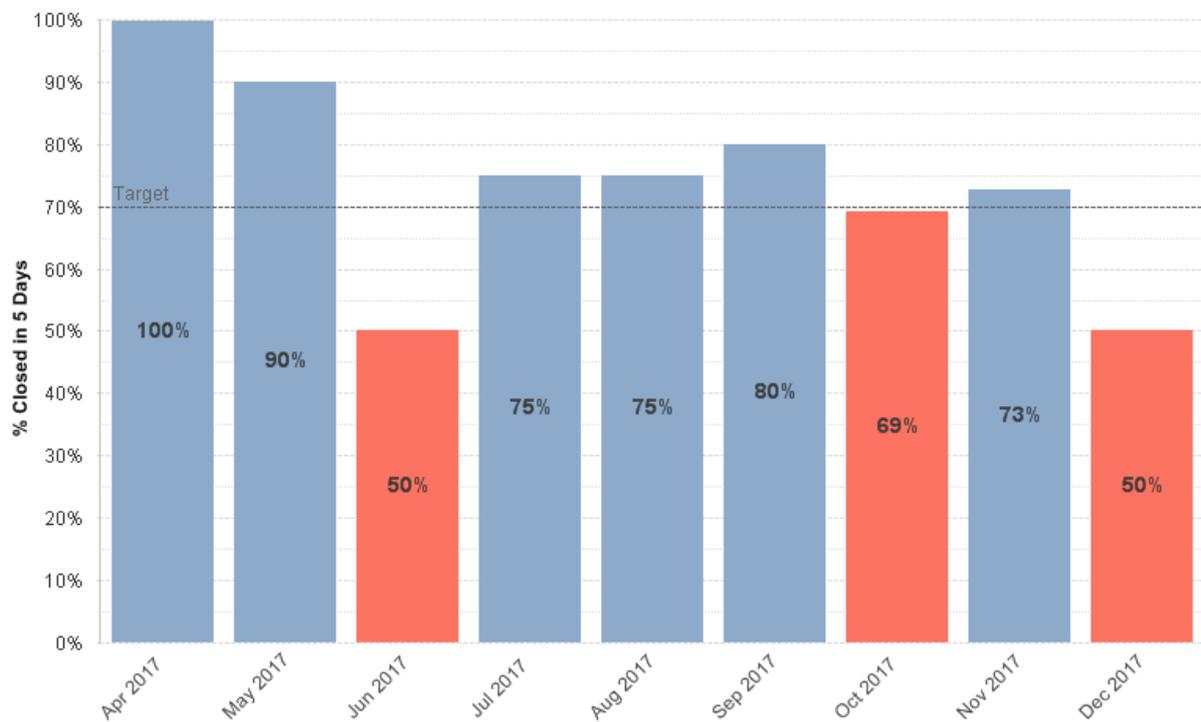
The Complaints Handling Procedure states that Stage One complaints should be responded to within 5 working days and Stage Two complaints within 20 working days. The procedure does make provision for extensions to be requested in exceptional circumstances. Indicator 9 details the number of cases where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

Indicator Eight: Complaints closed in full within the timescales

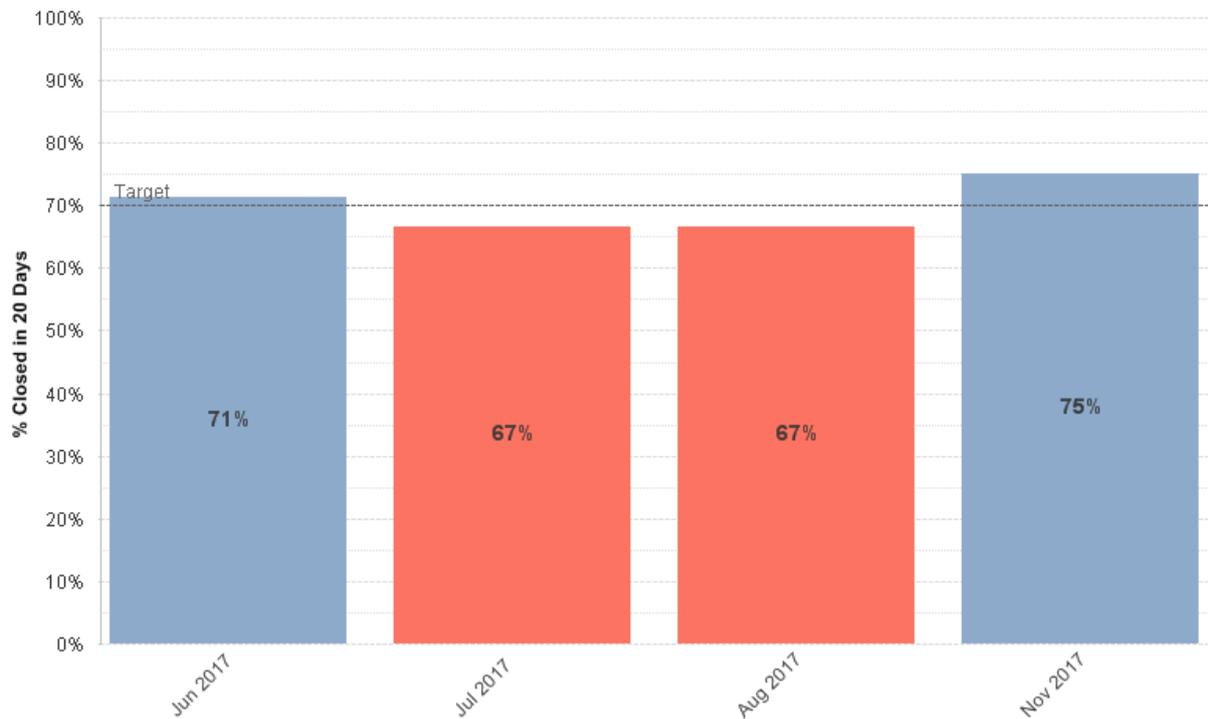
"Details of how many complaints were responses to within the timescales required of the Complaints Handling Procedure."

Indicator 8 - The number and percentage of complaints at each stage which were closed (<i>responded to</i>) in full within the set timescales of 5 and 20 working days			
Description	November 2017	December 2017	Target
Number complaints closed at Stage One within 5 working days as % of Stage One complaints	73% (8 of 11)	50% (5 of 10)	70%
Number complaints escalated to Stage Two closed within 20 working days as % of escalated Stage Two complaints	75% (3 of 4)	- (0 of 0)	70%
Number complaints closed at Stage Two within 20 working days as % of Stage Two complaints	42% (5 of 12)	71% (5 of 7)	70%

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

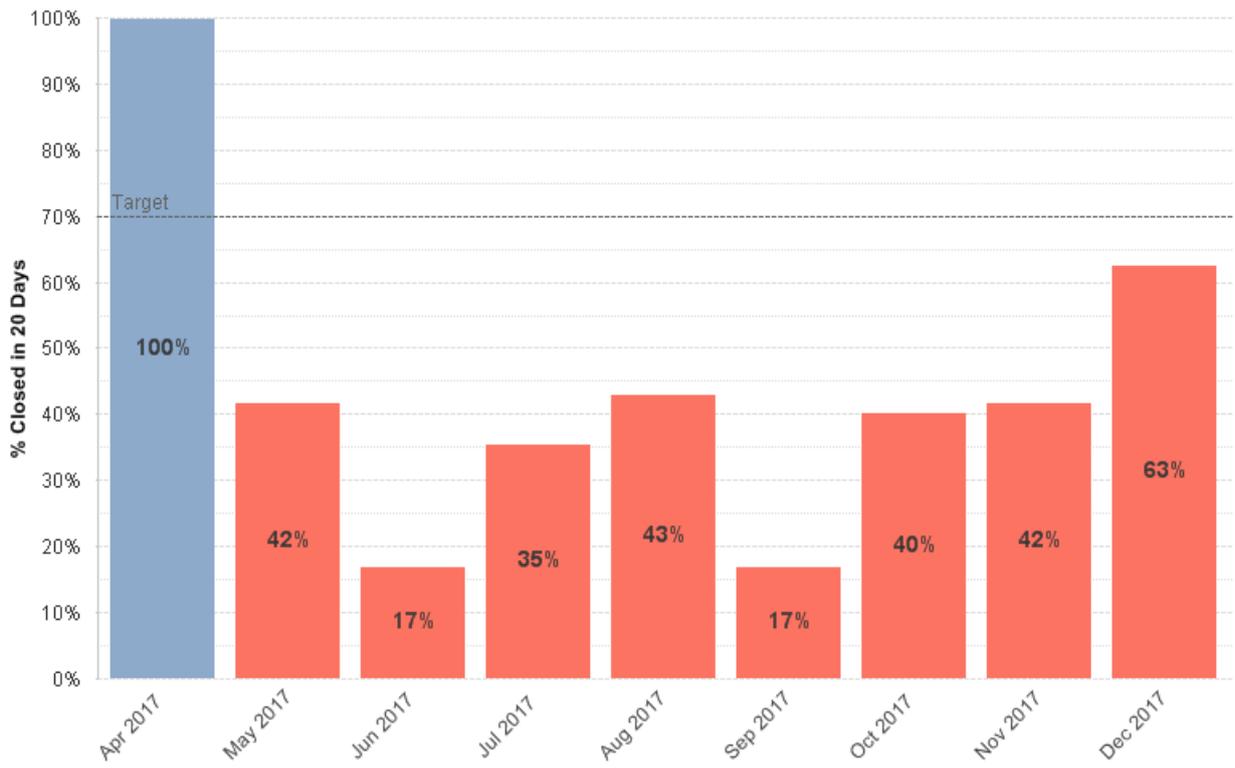


Escalated to Stage Two - Complaints Closed in Set Timescale, based on closed date



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

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



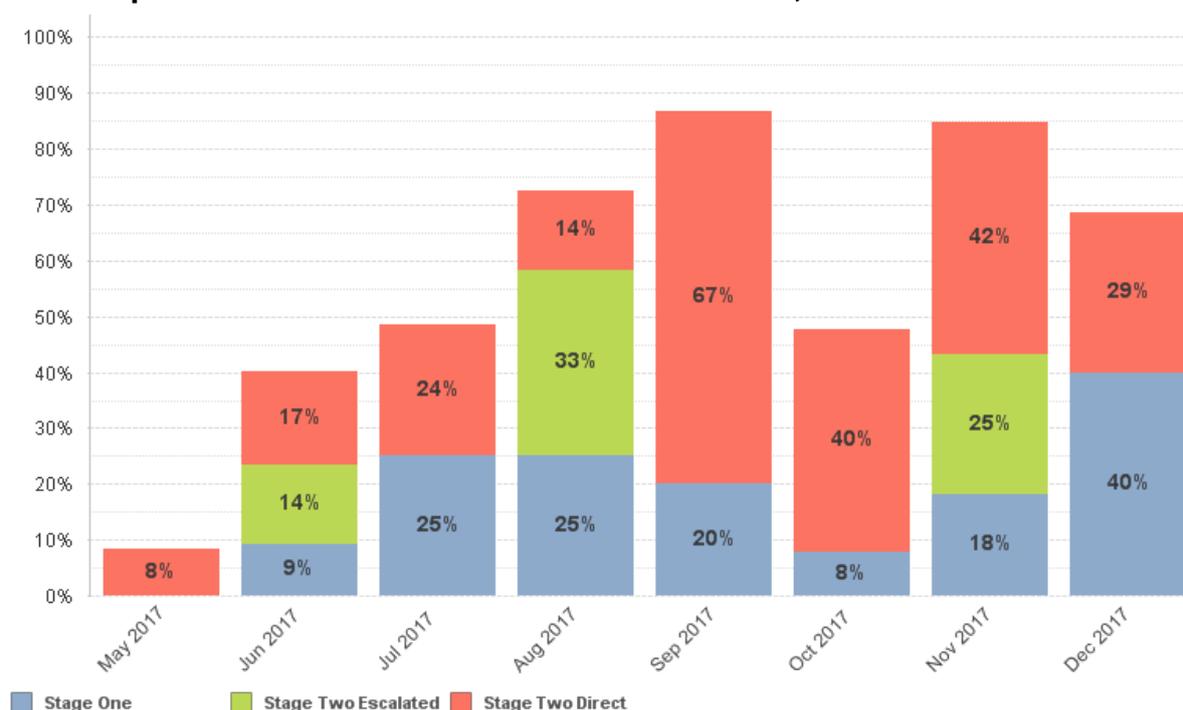
Indicator Nine: Number of cases where an extension was authorised

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

Indicator 9 - The number and percentage of complaints at each stage where an extension to the 5 or 20 working day timeline has been authorised.		
Description	November 2017	December 2017
% of complaints at Stage One where extension was authorised	18% (2 of 11)	40% (4 of 10)
% of Escalated to Stage Two complaints where extension was authorised	25% (1 of 4)	- (0 of 0)
% of complaints at Stage Two where extension was authorised	42% (5 of 12)	29% (2 of 7)

Our compliance with extension agreements has improved in recent months. During this period, extensions were arranged for the majority of cases where a timely response was not possible.

Complaints Closed where Extension Authorised, based on closed date



6.4 Scottish Public Services Ombudsman Complaints

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

There are currently 14 complaints with the SPSO for their consideration. One file has been requested and is being prepared for submission to the SPSO; ten complaints are currently under investigation and await the Ombudsman's decision on these complaints.

The SPSO have issued a decision letter regarding one complaint and the recommendations are currently being actioned. Once complete an action plan will be sent to the SPSO for their consideration.

One complaint was laid before Parliament in November 2017 and the Board are currently implementing actions to address the recommendations made. An action plan will be sent to the SPSO for their consideration.

7. Conclusion

Compliance with response timescales continues to present a challenge. We have improved our compliance with extension requests which ensures good communication with complainants when their response will not be delivered in line with expected timescales. We will continue to build on this.

Patient Services will continue to work with services to ensure they are support with training, templates, guidance and advice as required.

DUMFRIES and GALLOWAY NHS BOARD

5th February 2018



INVOLVING PEOPLE, IMPROVING QUALITY Healthcare Associated Infection Report

Author:

Elaine Ross
Infection Control Manager

Sponsoring Director:

Eddie Docherty
Executive Nurse Director

Date: 16 January 2018

RECOMMENDATION

The Board is asked to receive this Healthcare Associated Infection report and note in particular the position of NHS Dumfries and Galloway with regard to the SAB and CDI HAI LDP targets.

CONTEXT

Strategy / Policy

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

Organisational Context / Why is this paper important?

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

Key messages:

- The move to the new DGRI was successfully achieved without incident over a 3 day period 8-10 December. The ICPT were involved in patient assessment prior to transfer and overseeing equipment decontamination.
- The change to 100% single rooms has brought benefits and challenges.
- 2 wards in DGRI were affected by Norovirus. Once the initial cases had

presented there was no onward transmission.

- There have been large numbers of community acquired cases of flu A & B which have presented to and in many cases, required admission to DGRI.
- Castle Douglas, Moffat and Newton Stewart hospitals have been closed due to Influenza acquired whilst in hospital.
- Cases of *Clostridium difficile* have reduced to target levels.
- *Staphylococcus aureus* bacteraemia cases remain slightly above target levels but remain comparable with other NHS boards.

GLOSSARY

AOBD	-	Acute Occupied Bed Days
CDI	-	Clostridium difficile Infection
CAI	-	Community Acquired Infection
ECB	-	Escherichia coli Bacteraemia
HAI	-	Healthcare Associated Infection
HPS	-	Health Protection Scotland
HEI	-	Healthcare Environment Inspectorate
MSSA	-	Meticillin Sensitive Staphylococcus Aureus
MRSA	-	Meticillin Resistant Staphylococcus Aureus
IVDU	-	Intravenous Drug User
SAB	-	Staphylococcus aureus bacteraemia
ROBD	-	Total Occupied Bed Days

MONITORING FORM

Policy / Strategy Implications	Healthcare Quality Strategy Achievement of HAI LDP targets
Staffing Implications	Nil
Financial Implications	Nil
Consultation	Update paper only consultation not required
Consultation with Professional Committees	Update paper only. Also presented to APF at each meeting.
Risk Assessment	Addressed through the corporate risk register
Best Value	Governance and Accountability sound governance at a strategic and operational level
Sustainability	Fewer infections will reduce bed occupancy and use of resources
Compliance with Corporate Objectives	7. To meet and where possible, exceed goals and targets set by the Scottish Government Health Directorate for NHS Scotland, whilst delivering the measurable targets in the Single Outcome Agreement.
Single Outcome Agreement (SOA)	Keeping the population safe
Impact Assessment	Not required. Update paper only

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

Section 1– Board Wide Issues

This section of the HAIRT covers Board wide infection prevention and control activity and actions. For reports on individual hospitals, please refer to the 'Healthcare Associated Infection Report Cards' in Section 2.

A report card summarising Board wide statistics can be found at the end of section 1

- The move to the new DGRI was successfully achieved without incident over a 3 day period 8-10 December. The ICPT were involved in patient assessment prior to transfer and overseeing equipment decontamination.
- The change to 100% single rooms has brought benefits and challenges.
- 2 wards in DGRI were affected by Norovirus. Once the initial cases had presented there was no onward transmission.
- There have been large numbers of community acquired cases of flu A & B which have presented to and in many cases, required admission to DGRI.
- Castle Douglas, Moffat and Newton Stewart hospitals have been closed due to Influenza acquired whilst in hospital.
- Cases of *Clostridium difficile* have reduced to target levels.
- *Staphylococcus aureus* bacteraemia cases remain slightly above target levels but remain comparable with other NHS boards.

1. Staphylococcus aureus (including MRSA)

There has been a drop in number of cases of SAB seen over the year however we remain above our LDP target.

In November and December there were 7 new SAB. 5 of these were skin and soft tissue infections and 1 in a patient with a peripheral vascular cannula and another following a chest infection.

Invasive devices will be a focus for improvement work in the coming year.

Figure 1- Local data

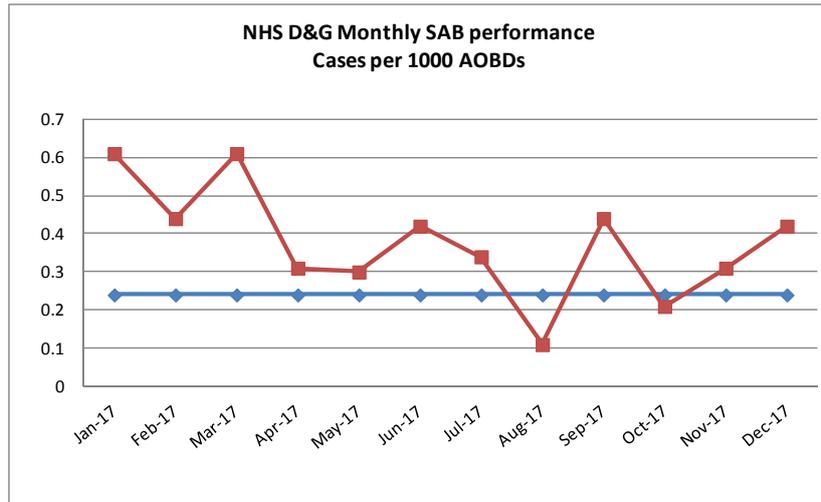
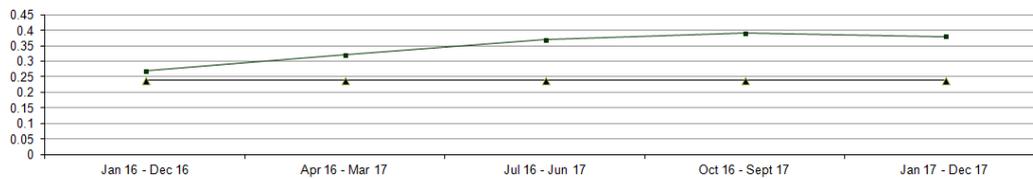


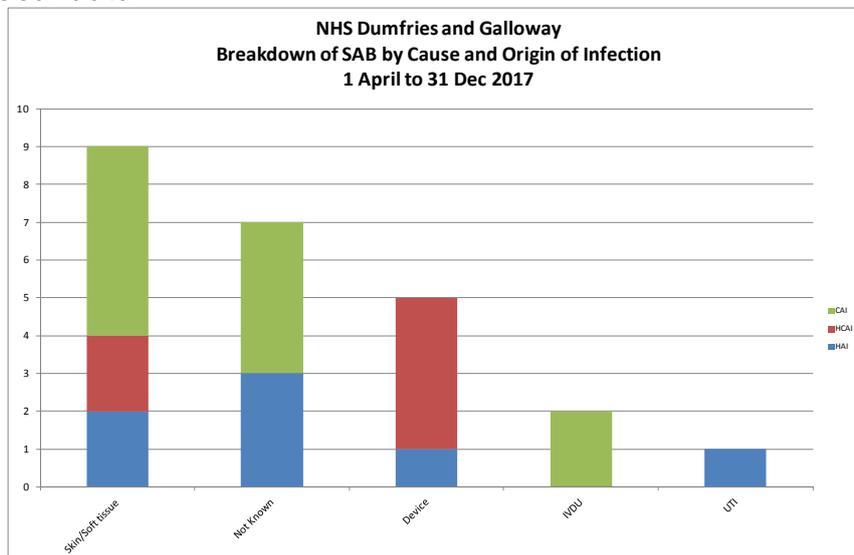
Figure 2- Local data- Performance against LDP target

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



	Jan 16 - Dec 16	Apr 16 - Mar 17	Jul 16 - Jun 17	Oct 16 - Sept 17	Jan 17 - Dec 17
Actual Performance	0.27	0.32	0.37	0.39	0.36
Target	0.24	0.24	0.24	0.24	0.24

Figure 3- Local data



2. Clostridium difficile

There has been a reduction in the number of case of CDI following the actions previously presented to board following the C. Diff summit meetings.

A decision to re introduce Tazocin as part of the local acute antimicrobial prescribing policy in October and a focus on Co amoxiclav use in primary care may have had an impact on number of cases, though these are just part of multiple other actions taken.

We would expect to see an increase in cases related to antimicrobial treatment for chest infections during the winter and we will continue to monitor the situation closely.

Figure 4- Local data

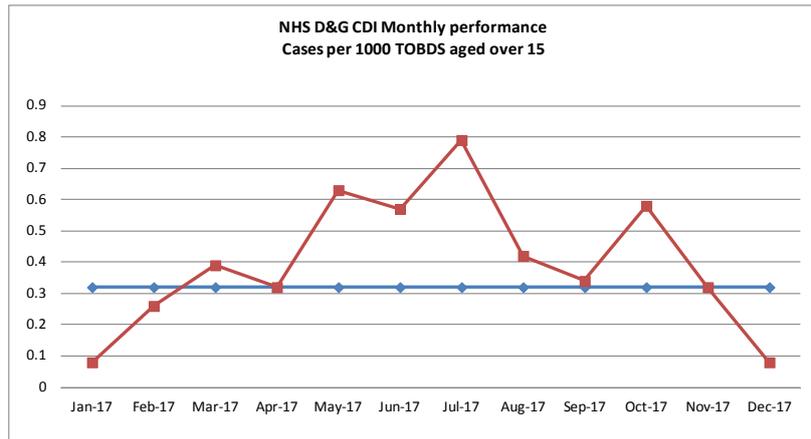


Figure 5- Local data- CDI cases by origin

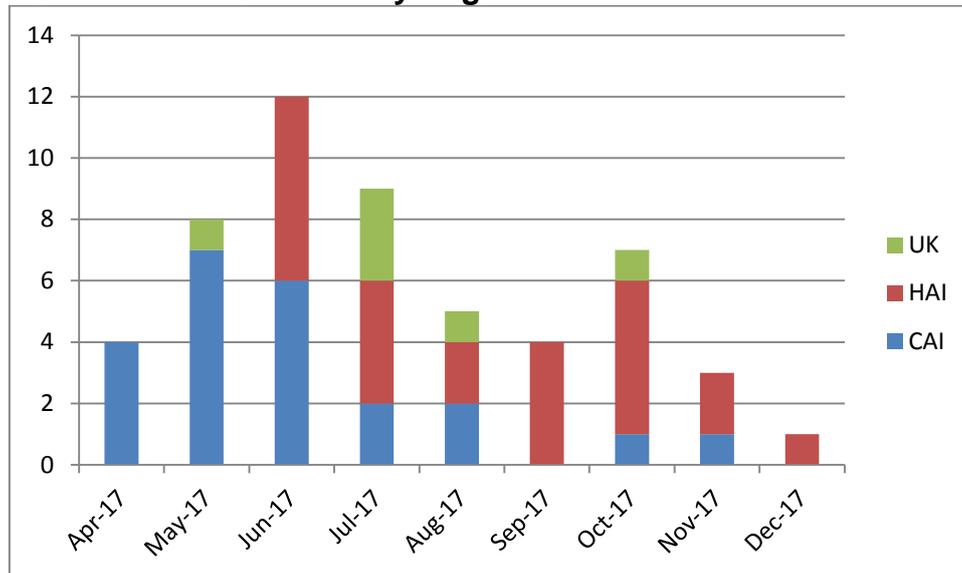
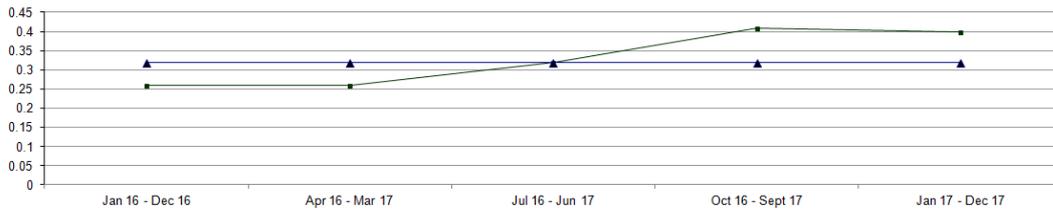


Figure 6- Local data- Performance against LDP target

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



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

3. Norovirus

Ward B2 experienced a confirmed outbreak of Norovirus affecting 9 patients and 6 staff. This ward was closed overnight but no beds were blocked and it was possible for the ward to function normally throughout the rest of the outbreak.

Ward C4 had a confirmed outbreak of Norovirus affecting 4 patients and 3 staff. The ward remained open and functioning normally throughout the outbreak.

In both cases the outbreaks were contained and there was no onward transmission to patients.

This is testament to excellent application of infection prevention precautions. Single rooms have a part to play in reducing the spread of infection but without the consistent application of hand hygiene and cleaning the impact of these would be limited.

4. Influenza

Influenza A & B are extremely prevalent in the community and we are now seeing large numbers of patients requiring admission to DGRI with approximately 6-8 new cases a day being admitted at the time of writing. This does not include patients being seen at ED and GPs.

There has been a large amount of press interest with a particular interest in the impact of single rooms. Whilst the single rooms have greatly assisted patient placement and containment of droplet spread of infection, the high bed occupancy rate has meant it has been a challenge to get these rooms terminally cleaned due to the lack of availability of an empty room to move a patient to once they are no longer infectious. This results in isolation precautions being used for longer than they are strictly necessary.

Castle Douglas hospital has been closed due to an outbreak of confirmed Flu B affecting 7 patients.

Moffat hospital has been closed due to an outbreak of confirmed Flu A affecting 5 patients.

Newton Stewart hospital has been closed due to an outbreak of confirmed Flu A affecting 8 patients.

PCR testing has been extremely useful in enabling swift diagnosis and prescription of Tamiflu, either as treatment or prophylaxis for at risk individuals.

There have been 2 cases of HAI flu in DGRI. This means they have contracted flu whilst inpatients in DGRI and we will never be certain of the origin of infection as both patients received visitors and will have been cared for by a large number of staff.

This is a very low number given the current prevalence of flu. Again, this is testament to the excellent work by staff and the advantage of single rooms.

5. E. coli bacteraemia (ECB)

E.coli is a leading cause of sepsis and is now the most prevalent infection in hospitals according to the 2016 Scottish HAI and AMR point prevalence survey report. The challenge is that most of these infections requiring hospital admission originate in the community as figure 8 illustrates.

Figure 7- Local data

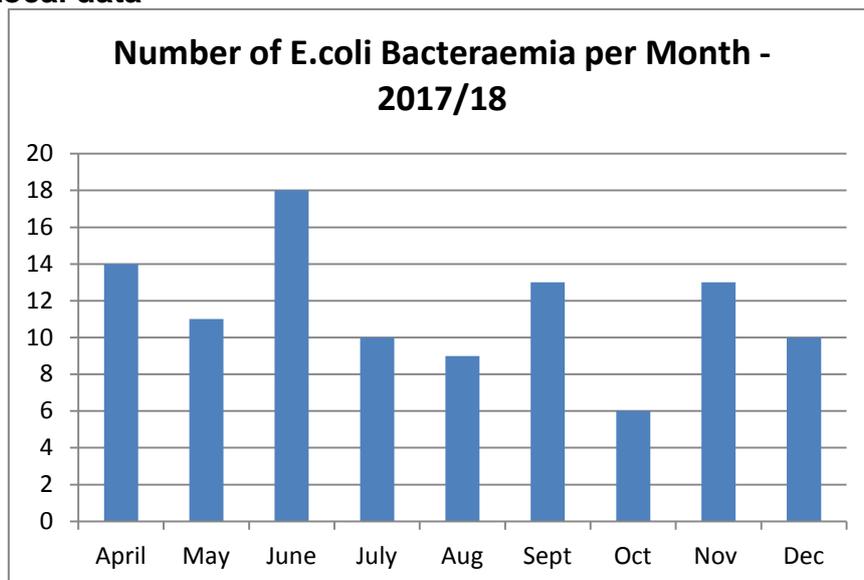
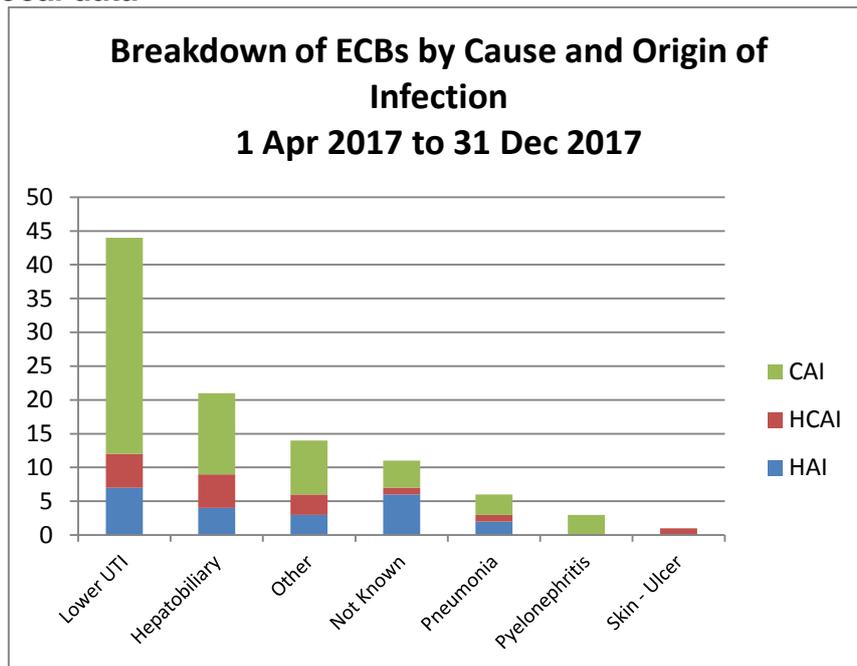


Figure 8- Local data



Much is being done to address the causes of ECB both locally and nationally.

Locally many of the actions that were taken to address device related SAB are the same as those required to address ECB. These include work on peripheral vascular cannula and central lines and work to address Catheter Associated Urinary Tract infection (CAUTI).

It is interesting to note from figure 8 above that CAUTI is not a cause of ECB in NHS Dumfries & Galloway.

Nationally, a public and health and social care facing hydration campaign is being prepared to help to prevent the lower urinary tract infections that affect people in the community and contribute to the development of ECB. This is an excellent initiative as it may yield additional benefits in reducing falls, confusion, improved oral health and skin integrity.

6. Cleaning

Our domestic services teams have worked tirelessly both prior to the DGRI move, during and afterwards. The cheerful 'can do' attitude they have demonstrated during periods of exceptional pressure is to be commended and their efforts are appreciated by the IPCT as they work closely with us to ensure the environment is safe and clean and available for patient care.

There are no audit figures available electronically due to technical difficulties which Health Facilities Scotland are aware of and are working to address. Audits are being completed on paper at present and will be included in the next report.

7. Conclusion

NHS Dumfries and Galloway have been through a time of unprecedented change in terms of location and service delivery. This has then been followed by extreme demand for services due to winter pressures including respiratory illness.

The co location of the IPCT within the DGRI building and close to the Acute and Diagnostic management teams has facilitated close working and collaborative decision making that has to be of benefit to safe effective patient care.

NHS Dumfries and Galloway Board report card

Staphylococcus aureus bacteraemia monthly case numbers

	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017
MRSA	0	0	1	0	0	0	0	0	0	0	0	0
MSSA	6	4	5	3	3	4	3	1	4	2	3	4
Total SABS	6	4	6	3	3	4	3	1	4	2	3	4

Clostridium difficile infection monthly case numbers

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

Cleaning Compliance (%)

	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017
Board Total	97.1	97.4	96.6	96.5	96.3	96.9	96.5	96.9	96.7	97.0	96.3	

Estates Monitoring Compliance (%)

	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017
Board Total	99.8	99.6	99.9	99.8	99.7	99.7	99.7	99.7	99.8	99.6	99.7	

NHS HOSPITAL REPORT CARD - DGRI

Staphylococcus aureus bacteraemia monthly case numbers

	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017
MRSA	0	0	1	0	0	0	0	0	0	0	0	0
MSSA	6	4	5	3	3	4	3	1	4	2	2	4
Total SABS	6	4	6	3	3	4	3	1	4	2	2	4

Clostridium difficile infection monthly case numbers

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

Cleaning Compliance (%)

	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017
Board Total	96.3	95.7	96.0	96.0	95.8	95.9	95.2	95.5	95.3	94.1	95.8	

Estates Monitoring Compliance (%)

	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017
Board Total	99.8	99.5	99.2	98.8	99.2	98.9	98.2	98.6	98.9	97.8	98.9	

NHS HOSPITAL REPORT CARD – Galloway Community Hospital

Staphylococcus aureus bacteraemia monthly case numbers

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

Clostridium difficile infection monthly case numbers

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

Cleaning Compliance (%)

	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017
Board Total	96.4	98.2	96.2	96.2	95.5	96.6	95.1	96.9	97.2	98.1	97.2	

Estates Monitoring Compliance (%)

	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017
Board Total	99.2	99.1	99.7	99.2	98.9	98.8	99.4	98.9	99.2	98.8	98.6	

NHS COMMUNITY HOSPITALS REPORT CARD

The community hospitals covered in this report card include:

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

Staphylococcus aureus bacteraemia monthly case numbers

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

Clostridium difficile infection monthly case numbers

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

NHS OUT OF HOSPITAL REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

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

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

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

DUMFRIES and GALLOWAY NHS BOARD

5th February 2018

Improving Safety, Reducing Harm: Acute and Diagnostics Directorate



Author:

Maureen Stevenson
Patient Safety and Improvement Manager

Sponsoring Director:

Eddie Docherty
Executive Nurse Director

Date: 11th October 2017

RECOMMENDATION

The Board is asked to:

- Note the report from Acute and Diagnostic Directorate in the agreed new format.

CONTEXT

Strategy / Policy:

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

This fits with the National Quality Strategy and the 20:20 Workforce Vision and locally with the ambition to connect quality and safety within operational Directorates.

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

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

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

Appended to this front cover is the Acute and Diagnostic Improving Safety Reducing Harm paper.

GLOSSARY OF TERMS

iHub	-	Improvement Hub
OPAC	-	Older People in Acute Care
HSMR	-	Hospital Standardised Mortality Ratio
ISD	-	Information Services Division
DGRI	-	Dumfries and Galloway Royal Infirmary
SPSP	-	Scottish Patient Safety Programme
NEWS	-	National Early Warning Score
ACP	-	Anticipatory Care Planning
CAUTI	-	Catheter Associated Urinary Tract Infection
SUTI	-	Scottish Urinary Tract Infection
HIS	-	Healthcare Improvement Scotland

MONITORING FORM

Policy / Strategy	Healthcare Quality Strategy
Staffing Implications	Nil
Financial Implications	Nil
Consultation / Consideration	Nil
Risk Assessment	Not applicable
Sustainability	Within current resources
Compliance with Corporate Objectives	2
Single Outcome Agreement (SOA)	Not applicable
Best Value	Supports the principles of best value Vision and leadership Governance & Accountability
Impact Assessment	
Not required	

News in Brief

Managing Risk and Protecting Patient Safety

Proactive Risk Management

The Acute and Diagnostic Directorate have identified 6 high level risks:

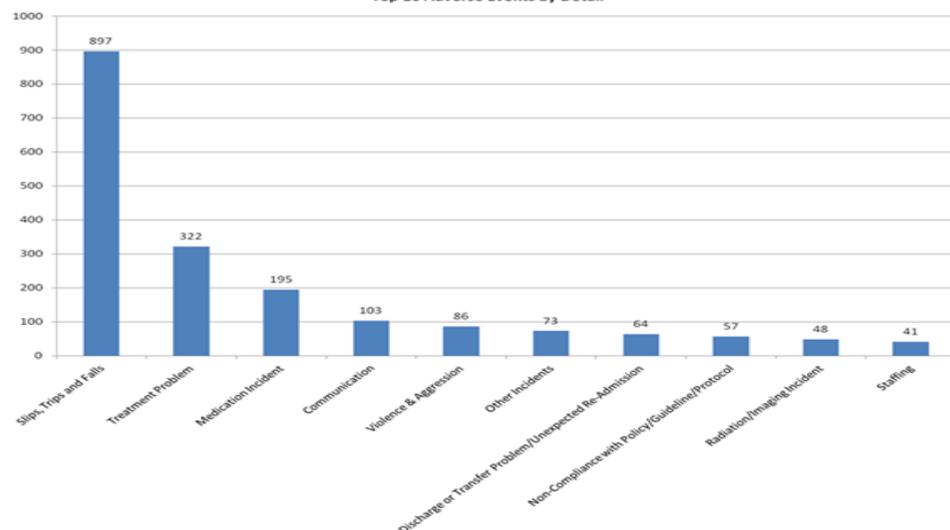
- Failure to recruit medical staff
- Failure to meet all speciality waiting times
- Nurse staffing (ratio)
- Medical staffing of Galloway Community Hospital
- Failure to meet financial target
- Sustainability of Galloway Community Hospital

A number of these risks have been escalated to Corporate Risks whilst the Acute Team do what they can operationally to reduce impact and sustain services.

Adverse Events

There were 2236 adverse events recorded from 1 Sept 2016 to 31st Aug 2017. Of these 1840 resulted in no harm, 378 resulted in harm with 13 of these resulting in significant harm or death (18 were not categorised). Slips, trips and falls incidents made up 48% of overall total number of incidents in the top 10 and almost 2/3 of incidents reported within Acute and Diagnostic Directorate.

Top 10 Adverse Events by Detail



Scottish Patient Safety Programme – Adult Acute

The Acute Adult aim continues to be to **reduce harm and mortality** in hospitals.

Since its launch in 2008, the Acute Adult programme has contributed to a significant reduction in harm and mortality to acute adult inpatients. The infographic overleaf gives background to the scale of the problem Current workstreams include:

Point of care workstreams

- **Deteriorating Patient**
- **Falls**
- **Pressure ulcers**
- **Catheter Associated Urinary Infections(CAUTI)**

SPSP Acute Adult Portfolio Update- September 2017

As part of Healthcare Improvement Scotland's Improvement Hub (ihub), the Acute Care portfolio, established on 1 April 2017, aims to improve the quality of care outcomes experienced for those receiving acute care. The portfolio includes the Older People in Acute Care (OPAC) and SPSP Acute Adult programmes.

Walkrounds

There have been 26 walkrounds within the acute directorate from the period 1st September 2016 to 31st August 2017. 6 were cancelled as staff at the locations were unable to attend due to capacity issues.

Issues discussed included the implementation of new core processes, capacity of wards, sickness absence, staffing issues (mainly related to vacancies and the use of locums), flexible/ 7 day working and the new build.

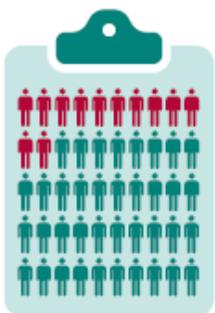
Actions identified from the walkrounds include:

1. Liaise with HR regarding ECG staff development to ensure sustainability of service.
2. Contact Conflict Management Officer to ask him to provide staff with training which will allow them to deal with violent and aggressive situations when they occur with patients.
3. Escalate concerns to medical directorate with regards to training for middle grade and junior doctors with regards to hand hygiene due to compliance being recorded as only 50% within a medical ward.

Deteriorating patient and sepsis

60%

of cardiac arrests, deaths or transfers to ICU followed recognised physiological changes.¹



Over 40% of people who develop septic shock will die.²



Sepsis is life threatening and needs urgent attention.

¹ NICEPOD report (2005)

² Maryn Singer, MD, FRCP, Clifton S. Deschman, MD, MS; Christopher Warren Seymour, MD, MS; et al - JAMA. 2016; 315(8):801-810. doi: 10.1001/jama.2016.0287

Pressure ulcers



Around 1 in 20 people admitted to hospital unexpectedly will develop a pressure ulcer.³

150

More than 150 grade 2-4 pressure ulcers are reported from Scotland's acute hospitals every month.⁴

165 in DGRI between 1st Sept 2016 and 31st August 2017

£3.8m

Treating pressure ulcers costs the NHS in England and Wales more than £3.8 million every day.⁵

³ NHS Choices <http://www.nhs.uk/Conditions/Pressure-ulcers/Pages/introduction.aspx>
⁴ SSP National Data Dashboard
⁵ <http://nhs.uk/press/pressure-ulcers>



Hospital

Falls



Fall incidents have been demonstrated to account for 1/3 of all reported patient safety events.⁶



Over 2000 falls are reported in Scottish acute hospitals every month.⁷



63% of Dumfries and Galloway's falls happened within the Acute Directorate – this equates to almost 2/3

English and Welsh hospitals a national observational study based on retrospective analysis of 12 months of patient safety incident reports. Hazley P, Scoble S, Oliver D, Pryor A, Thomson R, Gampson B. Qual Saf Health Care. 2008; 17(8):e24-30. doi: 10.1136/qshc.2007.024885.
⁷ SSP National Data Dashboard

Catheter Associated Urinary Tract Infection (CAUTI)



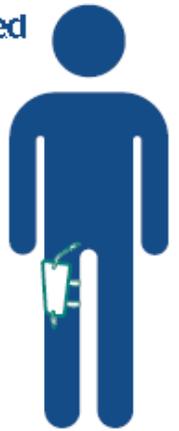
Over 22% of all Healthcare Acquired Infections are UTI⁸



4% of patients who are diagnosed with a CAUTI will go on to develop bacteraemia or sepsis.⁴



50% of all patients diagnosed with a UTI had an indwelling urethral urinary catheter (UUC) in the week before the infection.⁹



⁸ Scottish National Point Prevalence Survey of Healthcare Associated Infection and Antimicrobial Prescribing 2011. <http://www.scottishnhs.uk/infected/2011>



News in Brief Continued - Acute Improvement Updates



The new DGRI which will open its doors in December has been designed to improve the safety, the effectiveness and the experience of care. Single rooms will improve infection control and afford patients and their families a level of dignity and respect not

afforded in the current hospital set up. New models and pathways of care will become possible in this purpose built facility with a new Emergency Care Centre, offering ambulatory care; a combined medical and surgical Assessment Unit; a Critical Care Unit and a Stroke and Rehab Unit.

-  Clinically Focussed And Empowered Hospital Management
-  Capacity And Patient Flow Realignment
-  Patient Rather Than Bed Management
-  Medical And Surgical Processes Arranged To Pull Patients From ED
-  7 Day Services
-  Ensuring Patients Are Cared For In Their Own Homes

The Acute team are participating in a number of national initiatives to improve flow variability in unscheduled care. They have a number of initiatives to improve orthopaedic pathways and waiting times by offering early triage by a member of the MDT; implementation of 'enhanced recovery' for hip and knee replacement which supports early discharge of patients and implementation of national hip fracture standards.

As part of the national Excellence in Care programme, a local Care Assurance process has been piloted with 3 acute wards within DGRI between September to December 2016. The local Care Assurance process is designed to provide evidence on the quality of safe, effective and person centred care being provided, for people who use the services within NHS Dumfries & Galloway and is now being rolled out to all wards within DGRI. Separate reports are received by Healthcare Governance Committee.

SPSP Dashboard

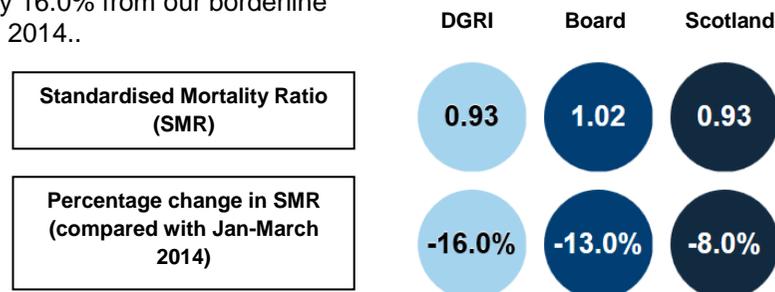
Hospital Standardised Mortality Ratio (HSMR)

HSMR will continue to be used as an indicator of the Acute Adult Safety Programme. The methodology used by Information Services Division (ISD) was updated in August 2016.

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

HSMR = Observed Deaths / Predicted Deaths.

ISD has produced quarterly HSMR for all Scottish hospitals participating in the Scottish Patient Safety Programme since December 2009; the revised programme aim is to reduce hospital mortality by 10% by the end of December 2018. The data below indicates the HSMR for Dumfries & Galloway Royal Infirmary (DGRI), has reduced by 16.0% from our borderline position in 2014..



SPSP Progress Update

Established teams continue to support testing, implementation and spread, at a much slower pace currently due to increased activity and resources required until migration to new hospital is complete.

We are in a period of change with a shift from national set aims to NHS boards asked to identify and agree local priorities and aims to improve patient safety and experience.

Deteriorating Patient, Cardiac Arrests and Sepsis

Recognition and response to deterioration has been a key focus throughout 2016/17, with improvement teams for deteriorating patients and sepsis taking a collective approach to improve timely interventions.

NHS Dumfries & Galloway moved to National Early Warning Score (NEWS) in line with recommendations from Health Improvement Scotland. **Phase 1&2** are complete with implementation in DGRI and Galloway Community Hospital, Mental Health Inpatient and Cottage Hospitals.

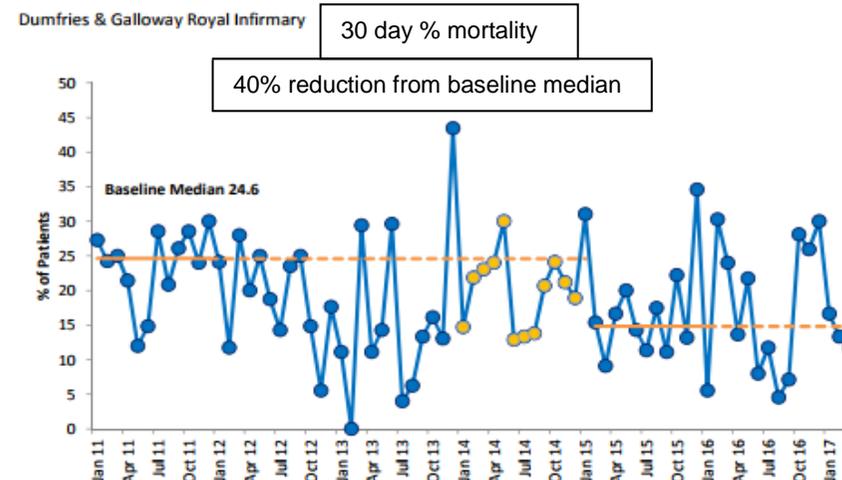
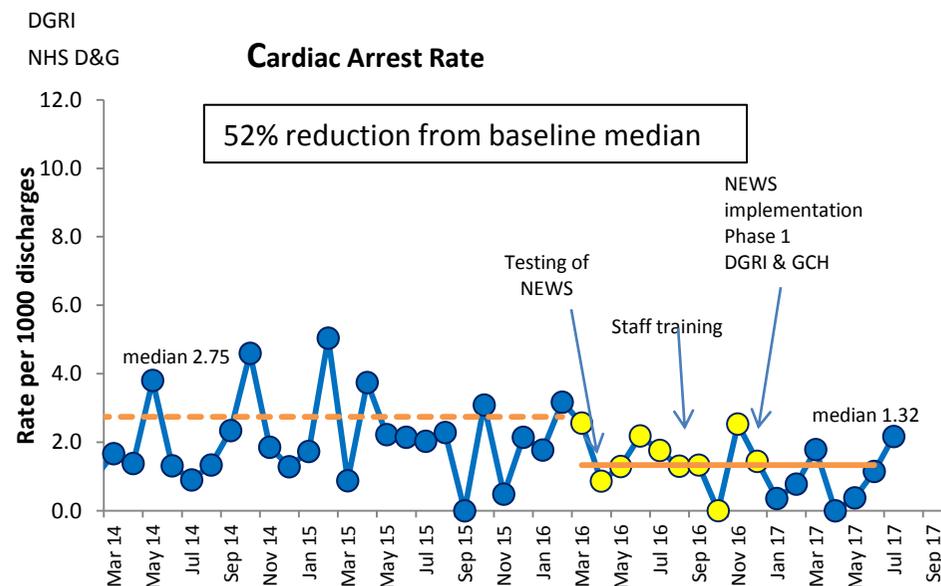
Phase 3: Explore potential spread to Primary care.

The adoption of NEWS and testing of a structured response and review has improved the reliability of processes to identify, escalate and timely response to deterioration. NEWS has a prompt for clinicians to consider Sepsis to raise awareness and prompt earlier identification and treatment. Some other support measures introduced are outlined below:

- A cardiac arrest huddle has been successfully implemented and spread to twice daily
- A post cardiac arrest debrief has been developed and staff response to testing is positive, as it supports staff to share experience to gain learning
- Treatment escalation plans have been tested and embedded in pilot ward and spread within critical care units, plans for further spread underway
- A process for case note reviews for all cardiac arrests is being tested to share good practise and learning
- We have a new clinical lead for sepsis and there is a renewed energy to revisit our current process and outcomes we have liaised with other boards to learn from their success.
- Acute leads are working jointly with teams from across health and social care partnerships to map the current picture regarding Anticipatory Care Planning (ACP) within Dumfries & Galloway.
- ACP will enable clinical teams to understand patient's choices regarding care and treatment in the event of a flare up or deterioration in their condition.

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

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



NHS Dumfries and Galloway were invited to present at a national Deteriorating Patient event in August; on the implementation of the National Early Warning Score and outcomes for patients.

Falls

Falls continue to be the most frequently reported adverse event in Acute Care: 378 people suffered harm as a result of a fall in the last year. Date below indicates that our falls rate is increasing.

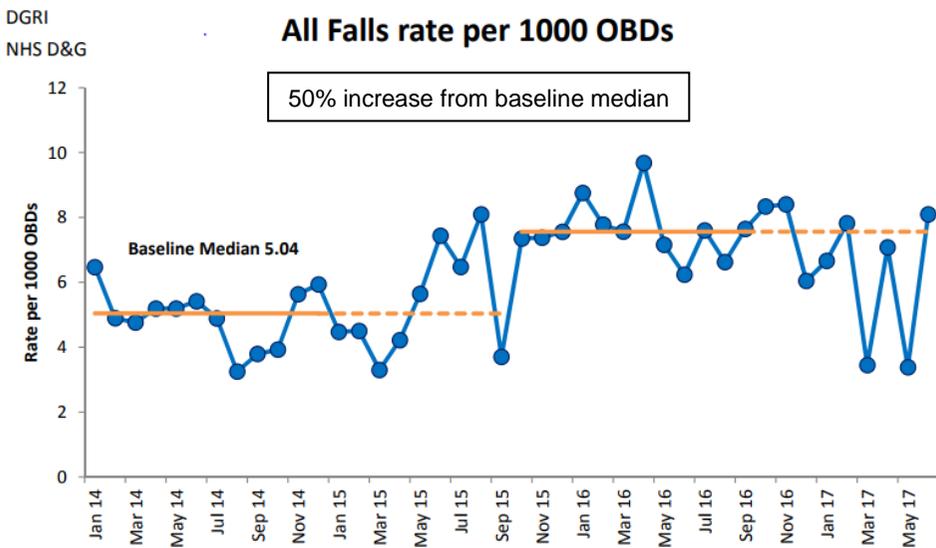
The falls bundle; is now a core component of assessment documentation on admission for all inpatients in DGRI and cottage hospitals.

A project is to commence to develop and test a daily activity programme within ward 10 by use of social interaction and activities to enhance patient experience and potentially reduce levels of agitation and wandering behaviours.

Outcome: Pilot Ward 18 shows unsustainable improvement in all falls rate whilst falls with harm data shows improvement, on target, with fewer patients harmed by falls. The challenge is to maintain reliability at pilot whilst preparing to scale up and spread.

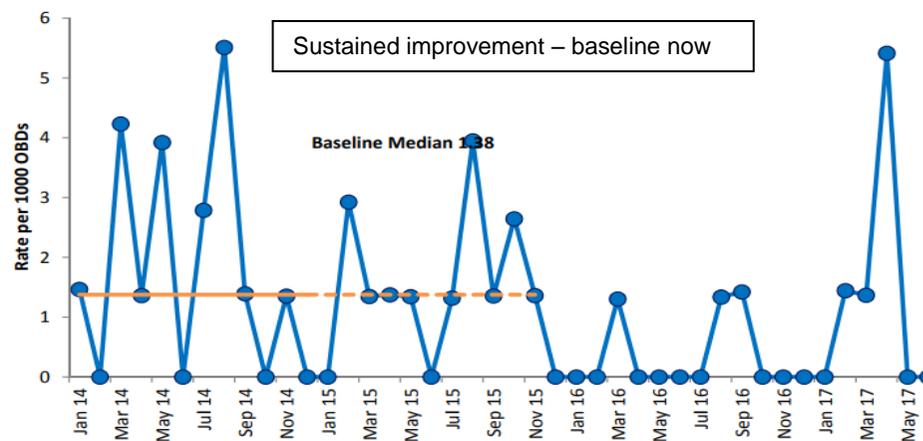
Outcome data at hospital level is getting worse with an increase in the overall numbers of falls reported and no decrease in falls with harm. Data below shows a sustained deterioration in all falls in DGRI with an increase of 50% from the baseline median and no improvement in falls with harm at site level.

We believe this increase is due to improved reporting and an increase in frailty of the patient population. There have also been challenges in maintaining clinical lead and frontline engagement in the falls improvement workstream. We have aligned with the quality assurance process and are working with clinical education to support individual areas with improvement.



Ward 18, DGRI
NHS D&G

Falls with Harm Rate



Pressure Ulcers

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

There is currently no clinical lead for pressure ulcers which has limited progress of improvement.

An aligned SPSP improvement project to reduce pressure ulcer within care homes has looked at whole system approaches and resulted in further exploration of data over the patient's journey. Confirming suspected belief that the recording and learning process are not standardised and therefore available data is not accurate or highlighting the outcomes and understanding to drive improvement in prevention.

Further exploration and planning to progress is currently underway with Acute Management Team and the Tissue Viability Group.

Catheter Associated Urinary Tract Infections (CAUTI)

Following a revised national definition, we have tested methods of measuring incidents of CAUTI and the processes that will reduce them. The interventions have focused on the use of evidence-based bundles for catheter insertion and maintenance avoidance of catheter insertion and reduction of length of catheterisation.

- The bundle has been tested and reliably implemented in pilot ward 14, and has been spread to all applicable areas in DGRI and cottage hospitals, with An education package supported by clinical education, infection control and patient safety teams
- We are working with clinical teams to support data collection and evidence impact on patients care.
- NHS Dumfries & Galloway collaborated with the Scottish Urinary Tract Infection (SUTI) Network and Quality Improvement Facilitators from HIS to develop and test a national passport document for patients which aims to:
 - Improve information and experience for people with catheters.
 - Improve communication at points of transition.
 - Reduce the number of catheter related calls in Out Of Hours.

The Catheter passport is to be made available at point of catheter insertion for all patients.

Learning from Significant Adverse Events

13 Category GHI were reported, 4 were commissioned as SAERs, 6 were local reviews and 3 are pending. Of the 13 reported GHI category Datix incidents 4 were category I, 3 were category H and 6 were category G. Thus far 1 of these SAERs has been concluded and reported to QPSLG. The other 12 are at various different stages of the investigation process, with QPSLG awaiting an update.

7 SAERs related to Acute Care have been completed within the period of 1st September 2016 to 31st August 2017. Learning from SAERs is considered by QPSLG and the Acute Management Team who have responsibility for reviewing recommendations and agreeing actions with QPSLG. A separate paper considers some of these learning summaries. A number of the actions feed into improvement programmes e.g. Deteriorating Patients.

Diary of Events 2017

October

- 6th-QI Connect WebEx-NASA Astronaut: Dr Tom Marshburn who will share his experience of healthcare from the world of aerodynamics.
- 31st- Improvement programme for FY1 Dr's commences

November

- 7th- National Pressure Ulcers Networking Day
- 15th- SIS Cohort 3 commences
- 21st- QI Connect WebEx. Scottish broadcaster and writer: Sally Magnusson to learn about Playlist for Life which, through music, provides comfort to people living with dementia, their family and carers.

Building Improvement Capability -Scottish Improvement Skills

To date 10 people have completed the SIS programme and their projects are listed below, which are taking place within acute or have an impact on the Acute Directorate:

Name	Project
Cohort 1	
Kim Britton Staff Nurse	Reduce colonoscopy cancellations due to inadequate fasting
Donna Craig Care Home Education Facilitator	To reduce acquired Pressure Ulcers within the care homes.
Kirsty Forrest Capacity Manager	To increase flow and ensure that patients receive the right care in the right place at the right time.
Jill Gardiner Clinical Educator	Develop a Healthcare Support Worker Development Passport to ensure healthcare support workers have equal access to education
Karen Hills, Excellence in Care Lead	Developed and implemented process of care assurance.
Paul Muir, Staff Nurse	Minimise inappropriate blood sampling
Pam Sawden Charge Nurse	Implement an Invasive line passport within the amalgamated critical care service.
Cohort 2	
Charlene Anderson Infection Control Advisor	Reduce surgical site infections
Anne Wilkinson Clinical Educator	Implement clinical skills passport to Midpark hospital
Shona Service Staff nurse	Implement treatment escalation plans within the amalgamated critical care service.

Glossary

NEWS	National Early warning Score
CAUTI	Catheter associated Urinary Tract Infection
ACP	Anticipatory Care Plan
DGRI	Dumfries and Galloway Royal Infirmary
NATVNS	National Association Tissue Viability Nurse Specialist
EPUAP	European Pressure Ulcer Advisory Panel
ANMAC	Area Nursing & Midwifery Advisory Committee
QPSLG	Quality Patient Safety Leadership Group
SAE	Significant Adverse Events

DUMFRIES and GALLOWAY NHS BOARD

5th February 2018



Child and Young People's Improvement Collaborative - update on attachment and implementation locally

Author:

Dr Louise Cumbley
Consultant Clinical Psychologist /
Director of Psychology

Sponsoring Director:

Eddie Docherty
Executive Nurse Director

Date: 19th January 2018

RECOMMENDATION

The Board is asked to take note of the progress of the Child and Young People's Improvement Collaborative in relation to attachment, its underpinning of the parenting work and implementation locally

CONTEXT

Strategy / Policy:

The Children and Young People Improvement Collaborative (CYPIC) brings together the Early Years Collaborative (EYC) and the Raising Attainment for All programme to deliver quality improvement throughout the child's journey.

The purpose of the CYPIC is to support schools and services for children, young people and families to be as good as they can be, based on evidence of what works in improving outcomes and life chances. The CYPIC is closely aligned with the Maternity and Children Quality Improvement Collaborative where the focus is on maternity, neonatal and paediatric healthcare settings.

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

The CYPIC is a core component of the action plan for the Early Years Strategy group. The principles of the improvement collaborative underpin the work currently being undertaken to measure the impact of work with children and their families in the early years. Our current focus is particularly around parenting interventions and their impact.

GLOSSARY OF TERMS

<i>CYPIC</i>	–	<i>Children and Young People’s Improvement Collaborative</i>
<i>EYC</i>	–	<i>Early Years Collaborative</i>
<i>LAC</i>	–	<i>Looked after Children</i>

MONITORING FORM

Policy / Strategy	<i>Early Years Strategy. Children's Service Plan.</i>
Staffing Implications	<i>Not applicable</i>
Financial Implications	<i>Not applicable</i>
Consultation / Consideration	<i>Early Years Strategy Group</i>
Risk Assessment	<i>Not applicable</i>
Sustainability	<i>The training of existing staff allows for increased capacity within the system to take a collaborative approach across services to address attachment in early years.</i>
Compliance with Corporate Objectives	1,2,4 & 6
Single Outcome Agreement (SOA)	<p>Interim Local Outcomes Improvement Plan (LOIP) Outcomes Outcome 3: Health and wellbeing inequalities are reduced</p> <p>Children's Services Plan 2015-2016 Outcomes 2. We will ensure children and young people get support at the earliest appropriate time through prevention and early intervention</p> <p>2.5 Review and refine the current suite of parenting approaches and programmes –discussions are ongoing with Scottish Government re possible engagement with PoPP (Psychology of Parenting Project).</p>
Best Value	Vision and Leadership Effective Partnerships Sustainability
Impact Assessment	Not applicable

CYPIC update

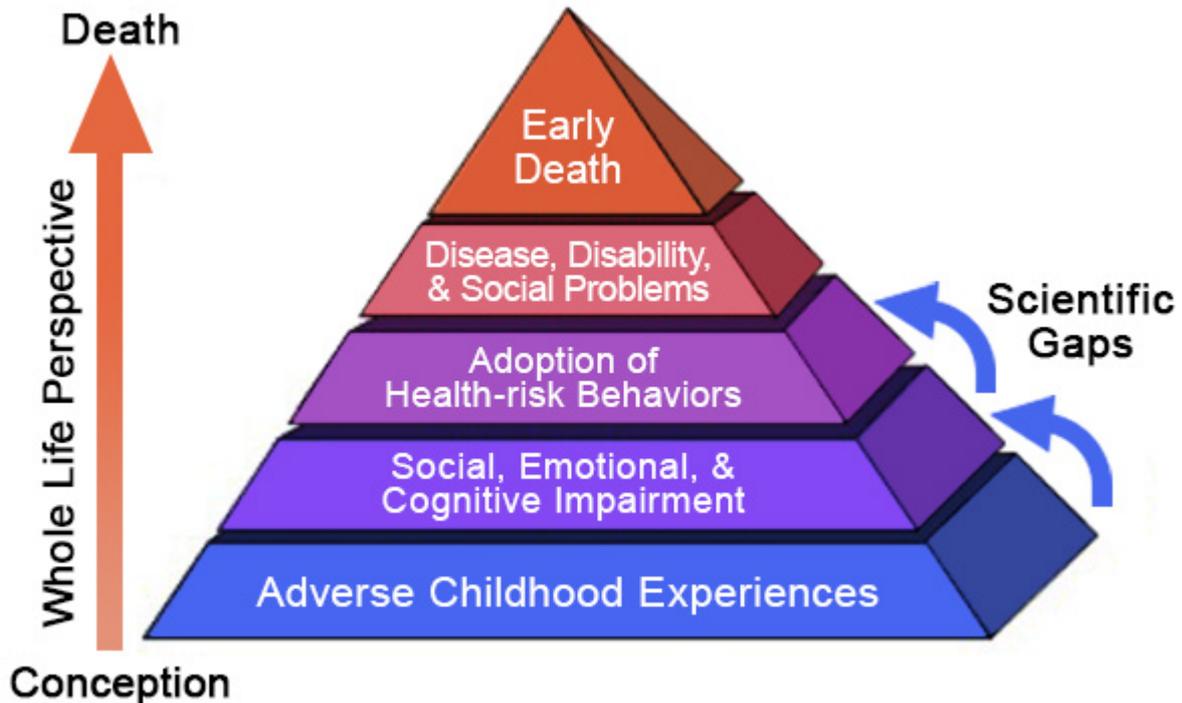
The Children and Young People's Improvement Collaborative recently held a national event and this was well attended by staff from across services in Dumfries and Galloway. There are a number of improvement projects ongoing including those in relation to the CYPIC stretch aims; language and literacy, health visitor pathway transition to school at 4/5years and neonatal and midwifery pathways for vulnerable women.

Quality Improvement methodology is now embedded in core practice in a number of services. The Early Years Strategy Group have identified areas for further QI work in relation to the Children Services Plan relating to parenting approaches. QI methodology is being used to measure the impact of parenting interventions at the universal, optional and intensive tiers across the suite of parenting interventions available.

Following a meeting with the national lead for CYIC from Scottish Government, the CYPIC sub-group of the Early Years Strategy Group is being reviewed. Progress reports are expected quarterly.

Attachment

Understanding attachment is a key component of working in early years. Staff working with children and their families have a crucial role to play in promoting positive attachments and identifying early, where extra help may be needed. The implications for children who go on to develop insecure attachments should not be underestimated. Children who experience trauma, neglect or parental substance misuse in their early years are at greater risk of social isolation, school exclusion and mental health difficulties themselves. Adverse childhood events (ACEs) have been the subject of many longitudinal studies and the outcomes are stark.



The Scottish Government has argued for services to embed a focus on preventing ACEs and their impact. The pupil equity fund is designed to be used to tackle inequality experienced as a result of social and parenting factors.

<http://www.healthscotland.scot/media/1517/tackling-the-attainment-gap-by-preventing-and-responding-to-adverse-childhood-experiences.pdf>

Local Delivery

Attachment and its relevance to the core business of those working in Early Years run through the Learning and Development offered to staff. The Learning and Development Report (appendix 1) highlights the work completed in 2016-17 and reports on planned training for 2018. Attachment features in training such as neglect toolkit, working with resistant families and introduction to mental health and attachment.

Recently the health visiting staff group have completed a masterclass in the new health visitor pathway delivery. Attachment was a key focus of this training.

The Looked after Children's Mental Health team have embarked on an ambitious programme of training and coaching staff across services. A summary of the training they have completed is attached (appendix 2).

The Early Years Strategy group have been reviewing the suite of parenting interventions available to children and their families in Dumfries and Galloway. The Strategy group have endorsed a universal parenting approach to underpin the work that we do with families. Using the Solihull Approach Model, staff across all services have been offered training in this approach.

The Solihull Approach has a strong evidence base and is focussed on the emotional health and wellbeing of infants and young children. The approach uses the triad of attachment, containment and reciprocity and behaviour management.

The training of staff in this model began in 2005 and since that time, over 80 child and family social work staff, 45 midwives, 60 health visitors, 90 education staff and 60 others, including those from 3rd and independent sector, have been trained.

Currently we are collating numbers still to be trained and arranging refresher sessions for those who trained more than 3 years ago. Having a sufficient pool of facilitators to complete this work is an issue. Currently we only have 2 facilitators, both in Early Years and Childcare who continue to train pre-school staff in early years package from Solihull. A paper is being prepared for CSEG (Children's Service Executive Group) about the gap in the ability to ensure Solihull continues to be embedded across all staff groups.

Conclusions

The combination of work currently being undertaken demonstrates the importance of early years and attachment for statutory, 3rd and independent bodies working with children and families. From QI projects, review and refinement of our parenting interventions, training and coaching in attachment and the reinforcement of a single model underpinning all our work, there is an array of work being undertaken in this area to meet the boards commitment to the CYPIC and its work.



Early Years Strategic group

Title/Subject: Children's Services Learning & Development Report August 2016 – July 2017

Meeting: Early Years strategy Group

Date: 13 December 2017

Submitted by: Karen Brown, Children's Services Planning and Development Officer

Action: For noting

1. Introduction

- 1.1 To report to Early Years Strategic Group on the multi-agency Learning and Development activity that was undertaken during the year 1 August 2016 to 31 July 2017.
- 1.2 To ask Early Years Strategic Group to note the multi-agency Learning and Development Calendar for 2018 agreed by CSEG on 14 November 2017.

2. Recommendations

The Early Years Strategic Group is asked to:

- 2.1 note the multi-agency learning and development activity that has taken place in 2016/17.
- 2.2 note the agreed multi-agency learning and development calendar for 2018

3. Summary and Considerations

- 3.1 The Children's Services multi-agency Learning and Development Group have delivered 29 courses over the 12 month period from 1st August 2016 – 31 July 2017, which involved 415 individual places.
- 3.2 These 415 training places were taken up by a total of 268 staff across partner agencies and the Third Sector. The breakdown of this information is contained within Table 1 and Graph 1.

- 3.3 The 29 courses have involved 10 individual programmes delivered on a number of occasions over this period as shown in Table 2. Of the courses developed by the Group and delivered in 2016-17 one (child protection) is new and four have been reviewed to ensure that the content and delivery remains relevant and takes account of any new information or findings from previous evaluation.
- 3.4 E-learning basic awareness courses including GIRFEC and Child Protection have been amended this year and continue to be available to both NHS and Council staff as well as, on request, to Third Sector organisations.
- 3.5 Both the number of training places delivered and the number of staff taking part in multi-agency learning and development have increased from 2016-17. However it is more problematic to evidence whether the training is effectively reaching the 'target' audience since the calendar and places are offered to all staff and it is the responsibility of individual staff and their line managers to identify which courses are relevant. Turnover of staff and roles means that producing % numbers of total staff attendance is not precise. The data from the Learning and Development database is available on request to any service or agency for performance management /staff supervision purposes.
- 3.6 A competency framework is available for staff fulfilling named persons roles and child protection responsibilities and it is being used by some agencies and services to identify suitable courses and assess competency. The use of the competency framework is not yet sufficiently embedded to fully inform the priorities for the Learning and Development Calendar.
- 3.7 The multi-agency Learning and Development Group do not have an allocated budget and delivery of courses is dependent on the team of 'trainers' from all agencies who develop and deliver the courses required with support and materials provided by DAT. In September 2017 a session was held with all 'trainers' to provide an opportunity to discuss the current provision and support provided and to identify any areas for improvement.
- 3.8 Although the evaluation reports from the courses present a positive picture of current learning and development, accurately evidencing the impact of learning and development on improvement in practice remains a complex issue. Further work needs to be done on this and consequently a short life working group is being set up in 2018 to take this forward.

4. Identification of Priority Learning and Development for 2017-18

- 4.1 The Children's Services multi-agency Learning and Development Group have considered all the feedback from course evaluations, staff engagement sessions, and returns from the Competency Framework to develop the agreed calendar of events for 2018.
- 4.2 Consultation also took place with the Strategic Group Chairs to ensure that the calendar includes any training identified as a priority in their strategic plans. Findings from Self Evaluation/Quality Assurance/SCR activity have also been taken into account in identifying the priorities for 2018.

- 4.3 The Children's Services Learning and Development Calendar 2018 may be subject to change when clear guidance is received on Information Sharing from the Scottish Government, however we will keep CPC informed of any changes.
- 4.4 As Neglect remains a priority for the Child Protection Committee the Children's Services Learning and Development Group has commissioned a Training for Trainers session for staff within D&G to enable continued delivery of the Neglect and Introduction to Neglect Toolkit training course throughout 2018, to ensure that all key staff can access this training.
- 4.5 The attached multi-agency Learning and Development Calendar currently includes the courses coordinated and delivered by the Learning and Development Group only. The Calendar which will be published on the website and when the information is available will also include multi-agency courses delivered by other agencies/services – DAT support some of the coordination of these other courses by processing applications and the production of reports from the database.

5. Current/Future Developments

- 5.1 In response to findings from audit activity and SCRs the Child Protection Committee have tasked the Learning and Development Group with implementing the West of Scotland Practitioner Portfolio – Working with Resistance. The group agreed that this would need to be supported by multi-agency training and a small working group has been identified to take forward to the development of this training over the winter period and we hope to deliver at least three sessions of this new training in 2018.
- 5.2 In recognition of the need to expand the range and approach to learning and development the Learning and Development Group have also developed a Reflective Practice Framework and are piloting two sessions in December. These sessions are aimed at testing more intensive reflective approaches to learning modelled on the Care Inspectorate Network of Support focus group approach and using some action learning methodology. The two sessions will involve staff involved in the 'network of support' around an individual case. The purpose is to reflect on multi-agency practice not to problem solve so the cases identified are either closed or active but 'settled'. Once this pilot has been completed and evaluated, the Learning and Development Group will consider how this can be embedded in future practice.

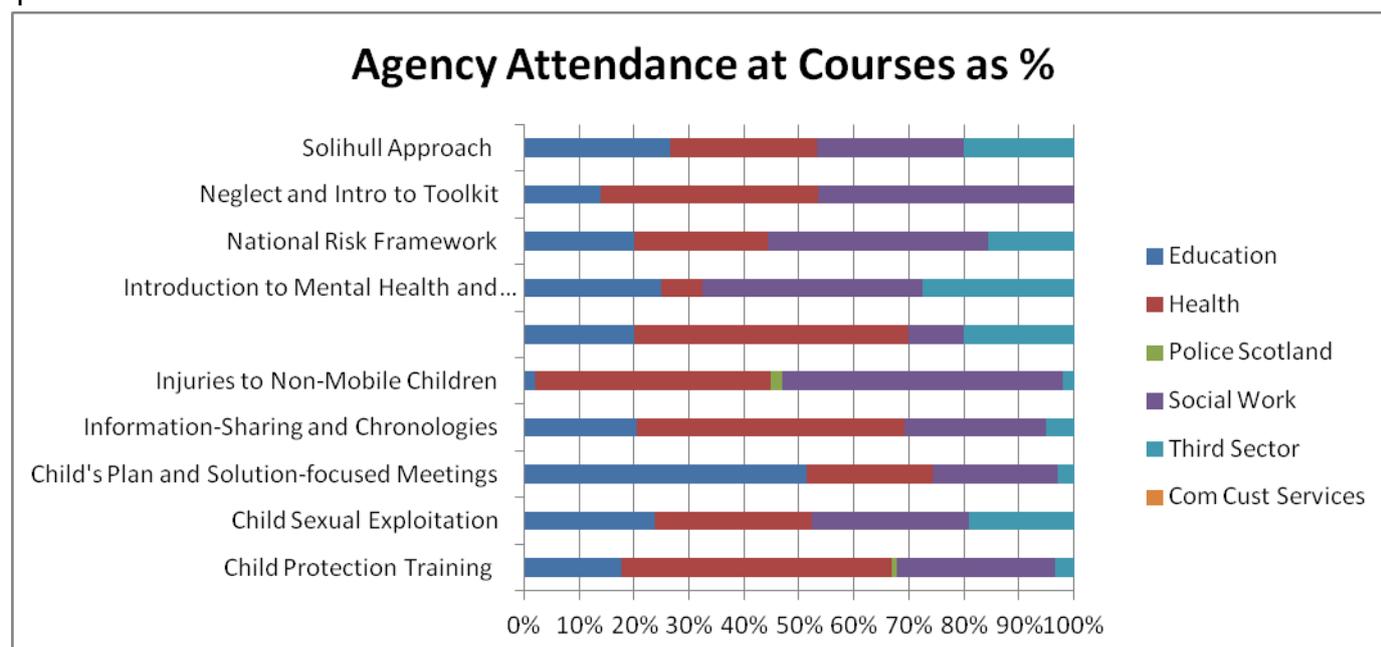
6. Training Attendance

6.1 The following table (Table 1) and graph (Graph 1) outlines the attendance by agency at the various courses delivered from August 2016 to July 2017.

	Education	Health	Police Scotland	Social Work	Third Sector	Com Cust Services	Totals
Child Protection Training	21	58	1	34	4	0	118
Child Sexual Exploitation	5	6	0	6	4	0	21
Child's Plan and Solution-focused Meetings	18	8	0	8	1	0	35
Information-Sharing and Chronologies	8	19	0	10	2	0	39
Injuries to Non-Mobile Children	1	21	1	25	1	0	49
Introduction to Child and Adolescent Mental Health	2	5	0	1	2	0	10
Introduction to Mental Health and Attachment in LAC	10	3	0	16	11	0	40
National Risk Framework	9	11	0	18	7	0	45
Neglect and Intro to Toolkit	6	17	0	20	0	0	43
Solihull Approach	4	4	0	4	3	0	15
Totals	84	152	2	142	35	0	415

Source – Children's Services Learning and Development Database

Graph
1



6.2 This table (Table 2) represents the number of training courses delivered by course, the staff attendance by course, the Named Person attendance by course and the percentage of Named Persons against total Named Person numbers, attendance by course.

Learning and Development Course	No of Events	No of Staff Attended	Named Persons Attendance	% Named Persons Attendance
Child Protection Process	7	118	26	11%
Child Sexual Exploitation	2	21	5	2%
Child's Plan and Solution-focused Meetings	4	35	18	8%
Information-Sharing and Chronologies	4	39	7	3%
Injuries to Non-Mobile Children	3	49	10	4%
Intro to Child and Adolescent Mental Health	1	20	2	1%
Intro to Mental Health and Attachment of LAC	2	40	2	1%
National Risk Framework	3	45	8	3%
Neglect & Intro to Toolkit	2	43	17	7%
Solihull Approach Multi-Agency	1	15	4	2%
Totals	29	415	99	

Source – Children's Services Learning and Development Database

6.3 The following table (Table 3) shows staff and Named Person attendance at the 20 courses delivered from August 2016 to July 2017.

Course Attendance	No of Staff	No of Named Persons	No of Course Attendees
1 Course Attendance	124	42	166
2 Courses Attendance	49	18	67
3 Courses Attendance	15	3	18
4 Courses Attendance	7	0	7
5 Courses Attendance	6	0	6
6 Courses Attendance	0	2	2
7 Courses Attendance	1	0	1
8 Courses Attendance	1	0	1
Total	197	63	268

6.4 The following table (Table 4.) shows the number of staff attending courses from each agency.

Agency	No of Staff
Education	50
Health	103
Social Work	87
Police	2
Third Sector	26
Totals	268

6.5 An increasing issue for the delivery of learning and development courses is attendance at courses – both staff who book and cancel at short notice and staff who book and neither cancel nor attend this has meant that some courses have been run with very low numbers. Non-attendance at training courses in 2016/17 has been recorded on the database.

A total of 34 staff booked on training courses then failed to attend or cancel their place prior to the course delivery date. This meant that we had 35 places on training events which had been booked and were not utilised. This non-attendance was spread across 10 of the courses and affected 12 delivery sessions.

The table below (Table 5) outlines the agency/service breakdown of staff who booked but then subsequently failed to attend but who did not cancel their place prior to the course taking place.

Table 5. Breakdown of staff who did not attend/cancel by agency and service		
Agency	Service	No of Staff
NHS	CAMHS	1
	Health Visiting	3
	Midwifery	1
	School Nursing	3
Education Services	Educational Visitor	1
	Primary Schools	2
	Secondary	1
Social Work Services	Children and Families	12
	Youth Justice	3
Third Sector Services	Various	7
Totals		34

Table 6. below outlines the courses and dates affected by non-attendance.

Table 6. Courses affected by non-attendance by title and date		
Course	Delivery Date	No of places
Child Protection	08/11/2016	3
	07/12/2016	2
Child Sexual Exploitation	22/11/2016	1
Child's Plans & Solution Focused Meetings	30/03/2017	1
Injuries to Non-Mobile Children	14/09/2016	5
	09/02/2017	2
Information Sharing and Chronologies	24/11/2016	3
Introduction to Child and Adolescent Mental Health	27&28/4/17	11
Intro to Mental Health and Attachment in Looked After Children	27/02/2017	2
Neglect and Introduction to Neglect Toolkit	23/03/2017	2
Risk, Risk Assessment and National Risk Framework	01/09/2016	1
Solihull Approach	17/03/2017	2
Totals		35

6.6 Cancellation of places on training courses is also recorded on the Database. These cancellations are sometimes received just prior to or on the day of training, which again contributes to low numbers on some courses.

The following table (Table 7.) gives the number of cancellations received by course :

Table 7. No. of cancellations by course and date		
Course	Delivery Date	No of places
Child Protection	15/11/2016	2
	07/12/2016	5
	18/01/2017	1
	22/02/2017	1
	07/03/2017	
	07/06/2017	5
	Total	15
Child Sexual Exploitation	22/11/2016	3
	23/05/2017	3
	Total	4
Child's Plans & Solution Focused Meetings	30/03/2017	1
<i>Injuries to Non-Mobile Children</i>	14/09/2016	5
	09/02/2017	2
	Total	7
Information Sharing and Chronologies	24/11/2016	3
Introduction to Child and Adolescent Mental Health	27&28/4/17	11
Intro to Mental Health and Attachment in Looked After Children	27/02/2017	2
Neglect and Introduction to Neglect Toolkit	23/03/2017	2
Risk, Risk Assessment and National Risk Framework	01/09/2016	1
Solihull Approach	17/03/2017	2
Grand Total		35

6.7 In response to the issue of non-attendance at courses the Learning and Development Group have identified an amended process for staff cancelling training places, or for when there is non-attendance, as follows:

Staff booking on courses should seek prior approval from your line managers and immediately put the date in your work calendar and keep the date clear. We realise that sometimes other priorities occur or staff are off work through illness, but if this is the case, we will require your notification of cancellation as soon as identified – notification of cancellation will also need to be approved by your Line Manager.

If delegates have booked on a course and have not cancelled prior to the event, but subsequently do not attend the course, contact will be made with Line Managers directly to inform them of the non-attendance and requesting an explanation, for lack of attendance.

Children's Services Learning & Development Calendar 2018

Date	Session Timing (approx.)	Multi Agency Event
Tuesday 16 January	9.30am to 4.30pm	Risk, Risk Assessment and the National Risk Framework
Wednesday 24 January	9.30am to 1.00pm	GIRFEC Assessment : Information Gathering and Analysis
Tuesday 6 February	9.30am to 4.30pm	Neglect and Introduction to Neglect Toolkit
Wednesday 7 February	9.30am to 4.30pm	Child's Plans and Solution Focused Meetings
Tuesday 20 February	9.30am to 12.30pm	Child Protection Process Training
Tuesday 20 February	1.30pm to 4.30pm	Attendance at Child Protection Case Conferences and Core Groups
Wednesday 7 March	9.30am to 4.30pm	Child Sexual Exploitation
Thursday 15 March	9.30am to 4.30pm	Risk, Risk Assessment and the National Risk Framework
Tuesday 20 March	9.30am to 4.30pm	Neglect and Introduction to Neglect Toolkit
Wednesday 25 April	9.30am to 1.30pm	Injuries to Non Mobile Children
Tuesday 1 May	9.30am to 1.00pm	GIRFEC Assessment : Information Gathering and Analysis
Wednesday 16 May	To be confirmed	Working with Resistant Families Application form not yet available

Date	Session Timing (approx.)	Multi Agency Event
Tuesday 22 May	9.30am to 4.30pm	Information Sharing and Chronologies
Tuesday 29 May	9.30am to 4.30pm	Child Sexual Exploitation
Thursday 7 June	9.30am to 12.30pm	Child Protection Process Training
Thursday 7 June	1.30pm to 4.30pm	Attendance at Child Protection Case Conferences and Core Groups
Wednesday 20 June	9.30am to 1.30pm	Injuries to Non Mobile Children
Tuesday 26 June	To be confirmed	Working with Resistant Families Application Form not yet available.
Wednesday 29 August	9.30am to 4.30pm	Information Sharing and Chronologies
Tuesday 4 September	9.30am to 1.30pm	GIRFEC Assessment : Information Gathering and Analysis
Wednesday 5 September	9.30am to 4.30pm	Child Sexual Exploitation
Tuesday 11 September	9.30am to 4.30pm	Child's Plans and Solution Focused Meetings
Tuesday 18 September	To be confirmed	Working with Resistant Families Application Form not yet available
Wednesday 26 September	9.30am to 4.30pm	Neglect and Introduction to Neglect Toolkit
Tuesday 2 October	9.30am to 12.30pm	Child Protection Process Training

Date	Session Timing (approx.)	Multi Agency Event
Tuesday 2 October	1.30pm to 4.30pm	Attendance at Child Protection Case Conferences and Core Groups
Wednesday 10 October	9.30am to 1.30pm	GIRFEC Assessment : Information Gathering and Analysis
Tuesday 30 October	9.30am to 4.30pm	Child's Plans and Solution Focused Meetings
Tuesday 6 November	9.30am to 4.30pm	Information Sharing and Chronologies
Thursday 15 November	9.30am to 4.30pm	Child Sexual Exploitation
Tuesday 20 November	9.30am to 12.30pm	Child Protection Process Training
Tuesday 20 November	1.30pm to 4.30pm	Attendance at Child Protection Case Conferences and Core Groups
Wednesday 28 November	9.30am to 4.30pm	Risk, Risk Assessment and the National Risk Framework
Wednesday 5 December	9.30am to 4.30pm	Neglect and Introduction to Neglect Toolkit

Appendix 2

Introduction to mental health and attachment - This is a 4 hr training session which introduces staff and carers to mental health and attachment. It looks briefly at the impact of trauma on the whole person including the brain and introduces participants to attachment based parenting. This course is a prerequisite for our more in depth 7 week programme.

Multi agency training x3 total **65** attended
Foster Carer training - total **17** carers
Private provider residential units - **9** staff
Local authority residential units - **27** staff
Behaviour support teachers and learning assistants - **160** staff
Teaching staff Laurieknowe and Troqueer- **31** teachers

Nurturing Attachments 7 week Training

This is an intensive training which equips front line social work staff to work confidently in identifying attachment issues and ways to work with families where attachment is an area of need.

7 week nurturing attachments - total **12** Social Work staff
Local authority residential staff began this training 1 day per month from November - total **12** staff

Unmet areas and plans for 2018

We have had a number of further requests from education to deliver our introduction training including 2 more primary schools and a secondary school. We are evaluating the delivery of the training in different formats e.g twilight sessions, full days etc to see what works best. We have a small group of education staff who we will be setting up coaching sessions with to try and embed the training. There has been an additional request from AHP's to deliver our introduction training to them as a group and we have agreed to do a bespoke training for Health Visitors and School Nurses

DUMFRIES and GALLOWAY NHS BOARD

5th February 2018



Stillbirth rates

Author:
Karen King
Head of Midwifery Consultant Midwife

Sponsoring Director:
Eddie Docherty
Executive Nurse Director

Date: 17th January 2018

RECOMMENDATION

The Board is asked to receive this report and note the progress to date on actions to contribute to a reduction in stillbirth rates.

CONTEXT

Strategy / Policy:

Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) Report (2017), Each Baby Counts Report (2017), Healthcare Improvement Scotland Review of Ayrshire Maternity Unit, University Hospital Crosshouse, NHS Ayrshire & Arran (Adverse Events) (2017), Cabinet Secretary's letter of 27 June 2017

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

This paper gives reassurance that all avenues have been explored and action taken to reduce stillbirth rates within NHS Dumfries and Galloway.

As the MBRRACE-UK report states: "Each perinatal death represents the tragic loss of a much-loved and much-wanted child. For every family affected, the death of a baby is also the loss of a family's hopes and dreams for the future."

The maternity care staff are also affected by each loss and require appropriate support and education to ensure they can fulfil their role.

GLOSSARY OF TERMS

AFFIRM	-	Can Promoting <u>A</u> wareness of <u>F</u> etal movements and <u>F</u> ocussing <u>I</u> nterventions <u>R</u> educe Fetal <u>M</u> ortality - a stepped wedge cluster randomised trial?
CO	-	Carbon monoxide
GAP	-	Growth Assessment Programme
MBRRACE-UK	-	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
McQIC	-	Maternity and Children Quality Improvement Collaborative
SPSP	-	Scottish Patient Safety Programme

MONITORING FORM

Policy / Strategy	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) Report (2017), Each Baby Counts Report (2017), Healthcare Improvement Scotland Review of Ayrshire Maternity Unit, University Hospital Crosshouse, NHS Ayrshire & Arran (Adverse Events) (2017), Cabinet Secretary's letter of 27 June 2017
Staffing Implications	None
Financial Implications	None
Consultation / Consideration	Executive Nurse Director consultation
Risk Assessment	Not applicable
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>
Single Outcome Agreement (SOA)	Not applicable
Best Value	<ul style="list-style-type: none"> • Vision and Leadership • Effective Partnerships • Performance Management
Impact Assessment	Not applicable

NOT PROTECTIVELY MARKED

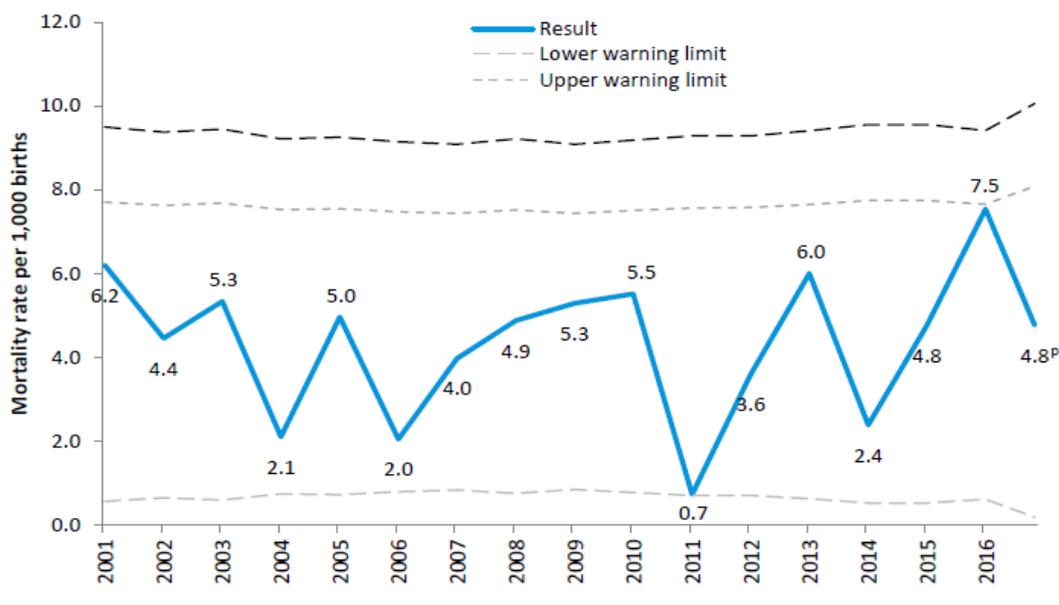
Stillbirth rates in Scotland decreased by 19% from 2011-2015 to a rate of 3.8 per 1000 births exceeding the aim of a 15% decrease set by Maternity and Children Quality Improvement Collaborative (McQIC). This was the lowest rate ever recorded in Scotland and it was recognised that this was encouraging but that no factor or programme could be attributed to the decline. In 2016 the rate rose to 4.3/1000 this is considered to be explained by common variation.

NHS Dumfries and Galloway rates are detailed in the table below. The provisional rate for 2017 was taken in October there have been no losses since then so provisionally the rate will be 3.9/1000 as calculated from Badgernet data. Due to the relatively small numbers of births in Dumfries and Galloway the numbers do fluctuate across the years however they remain within the warning limits. Whilst the 2016 rate was very concerning it was within the normal variation.

I3 Perinatal Mortality

National Outcome	Dumfries and Galloway Priority Area	Last Reported: 30/10/2017 Frequency: Yearly Source: BadgerNet
0	0	

Rate of stillbirths per 1,000 births by year, Dumfries and Galloway, 2001-2016 (2017 provisional result)



The maternity service have been working closely with Healthcare Improvement Scotland and the local patient safety and improvement team to ensure all necessary actions are being taken in relation to reducing stillbirths.

The maternity stream of the Scottish Patient Safety Programme (SPSP) Maternity and Children Quality Improvement Collaborative (McQIC) has set the following two measures that pertain directly to reducing stillbirth:

1. Smoking cessation:

1.1 % of pregnant women offered carbon monoxide (CO) monitoring.

1.2 % of pregnant women with a CO level \geq 4ppm (or who say they are current or recent smokers) referred to smoking cessation services.

1.3 % compliance with attendance at first appointment at smoking cessation services.

1.4 % of pregnant women who continue to smoke provided with tailored package of care.

NHS Dumfries and Galloway were consistently reporting 100% for measures 1.1 and 1.2 therefore these are no longer measured. Nationally there has been high percentage compliance with these measures however there is little change in quits or quit attempts.

Measure 1.3 we have challenges with consistently obtaining these figures from Smoking cessation services. A patient safety and improvement advisor is working with that team to look at interventions and data collection.

Measure 1.4 we have not been collecting this data however women who smoke more than 10 per day do have a package of care that includes regular scans and obstetric care. Consideration will be given to those who smoke 10 or less.

2. Reduced fetal movements

% of women with documented discussion regarding fetal movement.

NHS Dumfries and Galloway consistently recorded 100% of women having documented discussion regarding reduced fetal movement. In addition all women are issued with an information leaflet produced by the AFFIRM study. However this does not give any indication of the quality of the discussion or consistency between midwives. A community midwife in Stranraer is currently working with a patient safety and improvement advisor to test a specific script with women and utilise a teach back method to ensure that women have understood the key messages.

In addition to the McQIC programme work the maternity team have fully implemented the Growth Assessment Programme (GAP) which ensures a consistent approach to diagnosis of faltering growth and has a clear protocol for subsequent management. This includes the use of individualised growth charts.

The Maternity Service signed up to participate in the AFFIRM research project looking at the impact of reduced fetal movement. The research has concluded and the service continues to follow the guidance until research findings are published as recommended by Scottish Government. The target timeline for publication was early 2018.

Finally the Maternity Service has also benchmarked against the recommendations from MBRRACE-UK, Each Baby Counts and the Review of Ayrshire Maternity Unit. This is attached as appendix A.

Actions are currently being put into place to fully implement all recommendations and an improvement plan is to be developed by the multi-disciplinary team. A multi-disciplinary team meeting is scheduled to review all cases from 2015-2017 to ascertain if any themes are evident and any other actions are required for which an external reviewer is sought. In conjunction with this work a plan is in place to increase capacity within the specialty for quality improvement work.

In summary the rates of stillbirth within Dumfries and Galloway continue to fluctuate but remain within warning limits whilst the 2017 figure is more in keeping with the national average. The reduced rate for 2017 is reassuring but like the national work cannot be attributed to any particular activity but will be a combination of many initiatives.

The Maternity Service will continue to implement all the national evidence based interventions and recommendations whilst seeking to establish if there are any NHS Dumfries and Galloway issues which need to be addressed. The service will continue to ensure staff are provided with the appropriate support and development to ensure they have the necessary resilience to cope with pregnancy loss and the ability to contribute to improvement work to reduce stillbirth rates.

Appendix A

NHS Dumfries and Galloway Maternity Service Benchmarking exercise July 2017

Recommendation	Progress/comments
Each Baby Counts June 2017	
<p>1. Women who are apparently at low risk should have a formal fetal risk assessment on admission in labour irrespective of the place of birth to determine the most appropriate fetal monitoring method. The development of IT tools that bring together data from across a trust's systems to support accurate, easily accessible risk assessment should be prioritised.</p>	<p>Formal risk assessment is integral to Badger electronic record keeping.</p> <p>Badger electronic record and clinical portal bring together all the information required on each woman and are easily accessible from computers within the NHS buildings. Challenges are still being addressed around accessing systems in the community.</p>
<p>2. NICE guidance on when to switch from intermittent auscultation to continuous cardiotogography (CTG) monitoring should be followed. This requires regular reassessment of risk during labour.</p>	<p>NHS D&G guidance for fetal heart rate monitoring is based on NICE guidance.</p> <p>Regular reassessment of labour includes fetal heart rate monitoring type in Badger electronic record.</p>
<p>3. Staff tasked with CTG interpretation must have documented evidence of annual training.</p>	<p>K2CTG package is mandatory annually for all staff tasked with CTG interpretation.</p> <p>There is a dedicated member of staff who regularly updates compliance and reports to appropriate leads. Previous to the MBRRACE-UK Report publication local recommendation was for 2 yearly completion.</p>

NOT PROTECTIVELY MARKED

	<p>Staff were advised that this was changing to annual following the report's recommendation – this is partly reflected in the rates below.</p> <p>K2 CTG package completion rates August 2016-17</p> <table border="1" data-bbox="1070 416 2047 719"> <thead> <tr> <th>Location</th> <th>CTG and acid base</th> <th>One section only</th> <th>Neither</th> </tr> </thead> <tbody> <tr> <td>Core</td> <td>78%</td> <td>11%</td> <td>11%</td> </tr> <tr> <td>ANC</td> <td>20%</td> <td>0%</td> <td>80%</td> </tr> <tr> <td>Community</td> <td>55%</td> <td>11%</td> <td>33%</td> </tr> <tr> <td>Clenoch</td> <td>66%</td> <td>33%</td> <td>0%</td> </tr> <tr> <td>Permanent medical staff</td> <td>11%</td> <td>0%</td> <td>89%</td> </tr> </tbody> </table>	Location	CTG and acid base	One section only	Neither	Core	78%	11%	11%	ANC	20%	0%	80%	Community	55%	11%	33%	Clenoch	66%	33%	0%	Permanent medical staff	11%	0%	89%
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<p>4. Key management decisions should not be based on CTG interpretation alone. Healthcare professionals must take into account the full picture, including the mother's history, stage and progress in labour, any antenatal risk factors and any other signs the baby may not be coping with labour.</p>	<p>A great deal of work has been undertaken to encourage multi-disciplinary decision making putting the woman at the centre of decisions.</p> <p>Incident reviews always take a view of the whole pregnancy, labour and birth. They do not focus solely on the incident and actions around that time.</p>																								
<p>5. If therapeutic hypothermia is being considered, continuous monitoring of core temperature must be undertaken. Early efforts to passively cool the baby should also be considered (turn off the heater, take off the hat).</p>	<p>Current local practice is to commence passive cooling whilst awaiting the transport team.</p>																								

NOT PROTECTIVELY MARKED

<p>6. The paediatric/neonatal team must be informed of pertinent risk factors for a compromised baby in a timely and consistent manner.</p>	<p>Evidence from local Datix submissions suggest that paediatric/neonatal team are not always called as appropriate. Need for timely communication reinforced.</p>
<p>7. All members of the clinical team working on the delivery suite need to understand the key principles of maintaining situational awareness to ensure the safe management of complex clinical situations.</p>	<p>Senior Charge Midwife Shift Co-ordinators have all undertaken or have a place booked to undertake Human Factors training.</p> <p>Agree training plan for middle grade doctors.</p>
<p>8. A senior member of staff must maintain oversight of the activity on the delivery suite, especially when others are engaged in complex technical tasks. Ensuring someone takes this 'helicopter view' will prevent important details or new information from being overlooked and allow problems to be anticipated earlier.</p>	<p>There is a Senior Charge Midwife Shift Co-ordinator rostered for each shift 24/7 whose responsibility it is to maintain that oversight. However these midwives are also counted as part of the team delivering direct clinical care. Therefore during the busiest times when the "helicopter view" is most pertinent they may be needed to provide clinical care.</p>
<p>9. Decision making is more difficult when staff feel stressed and/ or tired. A different perspective improves the chances of making a safe decision. Clinical staff should be empowered to seek out advice from a colleague not involved in the situation who can give an unbiased perspective (either in person or over the phone).</p>	<p>Culture of being able to speak out and seek help from other colleagues from within the Department or at home if out of hours.</p>
<p>10. When managing a complex or unusual situation involving the transfer of care or multiple specialties, conduct a 'safety huddle' – a structured briefing for the leaders of key clinical teams. This will ensure everyone understands their roles and responsibilities and shares key clinical information relevant to patient safety.</p>	<p>When complexity/severity is recognised a safety brief will take place between all disciplines.</p> <p>Work needs to be done on earlier recognition.</p>

NOT PROTECTIVELY MARKED

11. All eligible babies should be reported to Each Baby Counts within 5 working days.	System has been introduced to ensure the lead clinician is alerted to all eligible babies as they are reported onto Datix.
12. All local reviews of Each Baby Counts babies should contain sufficient information to determine the quality of the care provided.	Local tool has been developed to collate information on each case which is reviewed by the multi-disciplinary team. The plan is to use the national tool once it is available.
13. All trusts and health boards should inform the parents of any local review taking place and invite them to contribute in accordance with their wishes.	A system has been implemented whereby a named person is allocated to the family. The aim is to let them know we are reviewing their case and to invite their input to that review.
14. All local reviews must have the involvement of an external panel member.	National work is ongoing with Obstetric leads and Heads of Midwifery to agree a process that is consistent and does not over stretch capacity of any one Board. External review is not sought on all cases currently.
15. All reviews of liveborn Each Baby Counts babies must involve neonatologists/neonatal nurses.	All of these babies would be reported through Datix and reviewed at Clinical Incident Review Group and the membership includes an Advanced Neonatal Nurse Practitioner and Consultant Paediatrician.
MBRRACE-UK – UK Perinatal Deaths for Births from January to December 2015	
16. Close monitoring of mortality rates is required to ensure that the decline in rates of stillbirth is continued in order to meet Government ambitions.	
17. A renewed focus on neonatal deaths is required in order to achieve a significant reduction in neonatal mortality rates from the position seen over the past three years.	

NOT PROTECTIVELY MARKED

<p>18. More research is required to identify the extent to which deaths before 32 weeks gestational age are avoidable and to try to develop practices and policies which could reduce potential variation in management across the UK.</p>	
<p>19. A national forum should be established by NHS England, NHS Scotland, NHS Wales, and Health and Social Care in Northern Ireland, in conjunction with professional bodies and national healthcare advisors responsible for clinical standards in relevant specialties, to agree the appropriate approach to reporting the influence on overall mortality rates of neonatal deaths and late fetal losses amongst babies born before 24 weeks gestational age and of deaths due to congenital anomalies.</p>	
<p>20. Those Trusts and Health Boards providing the most complex care to particularly high-risk mothers and babies should ensure that the data provided to MBRRACE-UK is of the highest quality. This will permit more appropriate sub-analyses and comparisons.</p>	
<p>21. Sustainability and Transformation Plans (STPs) in England need to address existing inequalities, particularly in relation to neonatal mortality.</p>	
<p>22. All Trusts and Health Boards should endeavour to continue to improve the quality and completeness of data reported to MBRRACE-UK. Children's hospitals should develop and embed systems that allow for consistent liaison with birth hospitals to facilitate the collection of maternal details.</p>	

<p>23. Placental histology should be undertaken (if possible) for all stillbirths, preferably by a perinatal pathologist.</p>	<p>All placentae from stillbirths and compromised babies are sent to Glasgow for placental histology.</p>
<p>24. Trusts and Health Boards should ensure that systems are in place to implement appropriate national guidance related to monitoring fetal growth.</p>	<p>NHS D&G utilise the GAP/GROW system for measuring fetal growth which produces individualised growth charts.</p>
<p>25. There is a continuing need for Trusts and Health Boards with a stabilised & adjusted extended perinatal mortality rate that falls in the red or amber band to conduct a local review in order to develop an action plan to improve the quality of their care provision. However, all Trusts and Health Boards, irrespective of their extended perinatal mortality rate, should investigate individual stillbirths and neonatal deaths using a standardised process and independent multidisciplinary peer review as recommended in the Report of the Morecambe Bay Investigation as well as by the Perinatal Mortality Review Task and Finish Group convened by Sands and the Department of Health.</p> <p>The information within the MBRRACE-UK Perinatal Surveillance Reports (including the reports for individual Trusts and Health Boards) and recommendations from MBRRACE-UK Confidential Enquiries can facilitate this process.</p>	<p>All cases of stillbirth, neonatal death and morbidity are reported through Datix and reviews are undertaken. For the years 2015-17 those reviews have been looked at as a whole to identify any themes to inform improvement work and an action plan is being developed.</p>

Healthcare Improvement Scotland Review of Ayrshire Maternity Unit, University Hospital Crosshouse, NHS Ayrshire & Arran (Adverse Events) June 2017

<p>26. Strengthen the process The NHS board must strengthen its current adverse event management policy to make sure it adheres to the National Framework and provides useful and practical processes that can be quickly and simply followed.</p> <p>The revised adverse event management policy must provide information for families about stillbirth, neonatal death and adverse events that communicates accurate, clear and consistent messages about the type of review that is being undertaken. This should aim to avoid any additional distress by raising uncertainty about the type of review that is being conducted.</p>	<p>For NHS D&G Board to consider.</p>
<p>27. Improve family engagement NHS Ayrshire & Arran must make sure that families are provided with appropriate information, support and opportunities to enable them to be involved in any significant adverse event process, in line with the National Framework.</p>	<p>A system has been implemented whereby a named person is allocated to the family. The aim is to let them know we are reviewing their case and to invite their input to that review.</p>
<p>28. Support for staff NHS Ayrshire & Arran staff must be adequately supported to be involved in the management of adverse events across the maternity unit. This support must include:</p> <ul style="list-style-type: none"> - dedicated and protected time for staff to be involved in all aspects of adverse event reviews, 	<p>Currently there is no dedicated and protected time for staff to be involved.</p>

<ul style="list-style-type: none"> - appropriate support to undertake the review process, including co-ordination and administrative support, and - training in adverse event reviews for those taking part in this process. 	<p>Administrative support is in place.</p> <p>In Liaison with Patient Safety Team training is being sought for those involved in adverse event reviews.</p>
<p>29. Promote shared learning NHS Ayrshire & Arran should promote, internally and externally, the changes and learning resulting from their improvement work, including the publication of learning summaries of adverse event reviews.</p>	<p>Learning is shared within the Department but work needs to take place to widen the scope of learning in line with the work of QPSLG and nationally for the specialty.</p>
<p>30. Improve staff training and education NHS Ayrshire & Arran must make sure that the training and development needs of staff are identified and met in a timely manner. This should include:</p> <ul style="list-style-type: none"> - producing a training needs analysis - ensuring access to training programmes, and - monitoring attendance at training. 	<p>A Clinical Performance Manager has been appointed who is currently undertaking a training needs analysis with a view to developing a training plan.</p> <p>Line managers will liaise with Clinical Performance Manager to monitor attendance at training as required.</p>

DUMFRIES and GALLOWAY NHS BOARD

5th February 2018



Scottish Graduate Entry Medical School Update

Author:
Dr Fiona Graham
Director of Medical Education

Sponsoring Director:
Dr Ken Donaldson
Medical Director

Date: 24th January 2018

RECOMMENDATION

The Board is asked to note this development, which has considerable potential to aid recruitment to local General Practice – though the full impact will not be felt for several years.

Dumfries & Galloway is a founding partner in the development of a Scottish Graduate Entry Medical School.

CONTEXT

Strategy / Policy:

This paper supports a number of local and national policies and strategies to enhance the sustainability of medical staffing.

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

NHS Dumfries & Galloway has been working with St Andrews University, Dundee University, NHS Fife and NHS Highland to deliver the Scottish Government's commitment to develop a Graduate Entry Medical School.

Delivery of this project should increase recruitment in the short-term, and in the much longer term.

The Medical School is being structured so as to educate rural General Practitioners.

GLOSSARY OF TERMS

Scottish Graduate Entry Medical School (ScotGEM)
Case Based Learning (CBL)
Full Time Equivalent (FTE)
Generalist Clinical Mentors (GCMs)
Longitudinal Integrated Clerkship (LIC)

MONITORING FORM

Policy / Strategy	Supports sustainability of medical staffing
Staffing Implications	See paper
Financial Implications	Not applicable
Consultation / Consideration	Regular collaboration with all stakeholders, especially St Andrews and Dundee University Awareness raising only
Risk Assessment	There remains a risk that we do not have enough capacity in general practice secondary care to sustain teaching.
Sustainability	Not applicable
Compliance with Corporate Objectives	Objective 3, 4, 6 and 7.
Single Outcome Agreement (SOA)	Not applicable
Best Value	<ul style="list-style-type: none"> • Sustainability • Performance Management • Effective Partnerships • Vision and Leadership
<p>Impact Assessment</p> <p>The Universities have policies on supporting students with characteristics protected under discrimination law: we will follow these to ensure that our portion of the training does not present barriers to any potential students.</p>	

SCOTTISH GRADUATE ENTRY MEDICINE (ScotGEM)

An update for NHS Dumfries and Galloway

This paper should be read in the context of 'ScotGEM update 23/3/17'

Background

*'ScotGEM is designed to develop doctors interested in a career as a generalist practitioner within NHS Scotland, with a focus on rural medicine and healthcare improvement. It offers a unique and innovative 4-year graduate entry medical programme tailored to meet the contemporary and future needs of the NHS in Scotland'*¹

Prior to advent of the ScotGEM programme, any Scottish based graduate who wished to study medicine had to begin again with an undergraduate course or move elsewhere. The Scottish Government prioritised the development of a graduate entry medicine course and asked the Scottish medical schools to tender for this. A collaboration between the University of Dundee, University of St Andrews, University of the Highlands and Islands (UHI) and NHS Scotland (specifically NHS Fife, Tayside, Highland and Dumfries and Galloway) was the successful bid. The partnership approach, innovative curriculum and aim to support teaching, training and recruitment to rural areas in Scotland all contributed to the bid's success.

ScotGEM was initially granted 40 medical school places but was subsequently allocated a further 15 places by the Scottish Government in December 2017. Thus 55 students will be recruited to begin training in August 2018. The first interviews were held in Dundee in December 2017 and a further round will be held in March 2018.

¹ <http://medicine.st-andrews.ac.uk/graduate-entry-medicine/>

Scottish/EU student's fees will be met and a bursary of £4000/year is available. If the bursary is accepted the student must undertake to work for a year in NHS Scotland for each year of the bursary.

Staffing

The Programme Director is Prof Jon Dowell, Professor of General Practice, University of Dundee. Recruitment of the key staff members is well underway. Key to the programme are the Generalist Clinical Mentors (GCMs). These are GPs who will coordinate and deliver teaching and training across all years. Dr Robert Scully was appointed Lead GCM in November 2017 and will be oversee the appointment of the other GCMs required. Initially 7 GCM are needed for Fife, as the students spend their first year based at St Andrews University. Other posts are required at St Andrews to deliver the curriculum with the First Year Lead Dr Andrew O'Malley already in post and an 'Agents of Change' (AoL - see below) lead post about to go out to advert.

Three GCMs will be needed in Dumfries and Galloway (D&G) to begin in April 2019. These are 0.4-0.5 full time equivalent (FTE) ScotGEM posts that will be linked to clinical sessions at a GP base. Ideally these will be 'new blood' appointments that will bring GPs with an interest in education into the area but may also be suitable for local practitioners looking at career development. For the 3rd year, a further GCM will be needed to oversee the Longitudinal Integrated Clerkship (LIC - see below) students and up to 15 Practice Based Tutors. These posts are already included in the ScotGEM financial plan but there will be scope for identification of specific staffing needs in NHS D&G (e.g. Clinical Teaching Fellows within secondary care) where bids can be developed for ScotGEM funding.

Curriculum/Timetable

ScotGEM will use a Case Based Learning (CBL) approach with students relating all their learning, including the basic sciences, to a patient. From the beginning of their first year, when they are based at St Andrews University/NHS Fife, they will meet on a weekly basis with their GCM to consider a case and set learning objectives for that week. There will also be 'Vertical Themes'² which will run throughout the course that are aimed at making ScotGEM graduates 'Agents of Change', future leaders in Scottish healthcare.

In the 2nd year the students will follow 6 week 'Lifecycle' blocks and will be dispersed across the partner health boards. Between 10-15 students will be based in Dumfries and Galloway from August 2019. The three Dumfries and Galloway GCMs will each have responsibility for 5 students and will meet with them weekly, at their GP practice base, to discuss the previous week's cases and introduce a new one. There will also be centrally organised teaching (by the universities) and a day based in secondary care.

The 3rd year will follow a Longitudinal Clerkship (LIC) approach where students will be based in a general practice, with a practice based tutor (GP) for the year. LICs have been used across the world in the training of doctors (Australia, Canada, USA and South Africa) and have been shown to increase patient centeredness and the return to rural areas to work when qualified. Again 10-15 students will spend this year in Dumfries and Galloway with the first cohort starting in 2020. In D&G we are currently involved in a pilot project where two 4th year students, from the existing 5 year MBCHB course at the University of Dundee, are undertaking a LIC for 40 weeks.

² Informatics, Prescribing & Therapeutics, Public Health, Quality Improvement, Service Learning

One student is based in Dalbeattie and the other in Newton Stewart. Our second group of LIC students, they are helping us plan for the 3rd year of ScotGEM. D&G staff in primary and secondary care have been enthusiastic and supportive. The student feedback has been positive and, as a result, we have recruited 6 students for 2018-19.

All students will be based in Dundee for the 4th year.

Challenges for NHS D&G

1. Staffing – medical manpower will be essential to the success of ScotGEM both in primary and secondary care and we are already working at identifying suitable practices as 2nd year GCM bases and for LIC in third year. With respect to the 2nd year, larger practices might be needed to accommodate meetings of six on a weekly basis. For LIC students we plan to group them in the 4 localities, with 3-4 based in each. Within secondary care, ScotGEM's own plan is less developed, but within NHS D&G we need to give careful thought to the development of secondary care posts that will support ScotGEM most effectively
2. Accommodation – The first students will arrive in Dumfries and Galloway in the summer of 2019 and will need to be accommodated. In summer 2020 the 15 LIC students will need accommodated around the region. We feel quality accommodation is essential to welcome the students to our region. We are considering options for this e.g.
 - 2.1. Is there scope for retaining a block of residences at Mountainhall Treatment Centre to accommodate the 2nd year students during their 6 week blocks?
 - 2.2. Can we work with our colleagues on the Crichton Campus (UWS, Glasgow University) to develop student accommodation?

2.3. Can we group the LIC students together in the localities e.g. Annan, Dumfries, Castle Douglas and Newton Stewart thus achieving economies of scale and addressing possible isolation?

Opportunities for NHS D&G

1. Staffing – ScotGEM offers the opportunity to recruit new medical staff to the area and career development for those already here.
2. Training the next generation of doctors who are more likely to return to the region after qualifying
3. Multidisciplinary teaching and learning – there will be opportunities for other staff groups e.g. pharmacists in the Prescribing and Therapeutics vertical theme and nursing staff in simulation.
4. Partnership with universities and health boards across Scotland
5. Learning about new ways of teaching, training and evaluation
6. Developing/strengthening links with other local education providers e.g. UWS and Glasgow University input on Vertical themes, Dumfries and Galloway College collaboration on supporting students from the region to apply for ScotGEM

The Next Step

The ScotGEM team is visiting Dumfries and Galloway for a ScotGEM ‘Roadshow’ 13th/14th March 2018. Confirmed to attend are:

1. Prof Jon Dowell, Programme Director
2. Dr Robert Scully, Lead GCM
3. Prof Maggie Bartlett, Professor of General Practice, University of Dundee, LIC lead
4. Isla Taberrer, ScotGEM Programme Manager, University of St Andrews

The timetable (tbc) is:

Tuesday 13th March

1. Lunchtime presentation/Q&A Education Centre DGRI
2. Afternoon meetings with secondary care stakeholders
3. Early evening reception hosted by Crichton Campus Leadership Group to include interested parties from across the region

Wednesday 14th March

1. Morning meetings central and D&G ScotGEM team
2. Lunch, lecture and workshop at GP Protected Learning Time event, Easterbrook Hall

Further details or clarification on any aspect of ScotGEM are available from:

Dr Fiona Graham

Interim DME ScotGEM/DLIC

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DUMFRIES and GALLOWAY NHS BOARD

5th February 2018



Carers (Scotland) Act 2016 and the Scheme of Integration

Author:

Linda Owen
Strategic Planning & Commissioning
Manager

Sponsoring Director:

Vicky Freeman
Head of Strategic Planning

Date: 15th January 2018

RECOMMENDATION

NHS Board is asked to agree amendments to the Dumfries and Galloway Scheme of Integration (please see appendix one)

CONTEXT

Strategy / Policy

Organisational Context / Why is this paper important / Key messages

The Carers (Scotland) Act 2016 (the Carers Act) is due to come into effect on 1 April 2018. Implementation of this Act has implications for integration authorities, local authorities and health boards, as new duties come into force.

All integration authorities are responsible for the provision of support to adult Carers as part of their responsibilities for adult social care and through a variety of other legislation such as

- the Social Care (Self Directed Support) (Scotland) Act 2013 and
- Social Work (Scotland) Act 1968.

Legislation relating to the provision of support for Carers is now contained within the Carers (Scotland) Act 2016.

Amendment to current schemes of integration is required to be made to reflect these legislative changes.

GLOSSARY OF TERMS

NHS - National Health Service

MONITORING FORM

Policy / Strategy	This is in line with the 9 national health and wellbeing outcomes and also the Integration Joint Board Health and Social Care Strategic Plan.2016-2019.
Staffing Implications	Not applicable
Financial Implications	No resource implications
Consultation / Consideration	The appendix has been shared with the Carers Reference Group, the Carers Interest Network, Carers Programme Board. NHS Management Team, Health and Social Care Senior Management Team, Corporate Business Services and the NHS Central Legal Office.
Risk Assessment	Should the scheme of integration not be amended, then there will be a risk that the partnership will not comply with the Carers (Scotland) Act 2016, which could leave the local authority and the NHS Board open to legal challenge.
Sustainability	Not applicable
Compliance with Corporate Objectives	Continue to support and develop partnership working to improve outcomes for the people of Dumfries and Galloway
Single Outcome Agreement (SOA)	Not applicable
Best Value	<p>Effective Partnerships</p> <ul style="list-style-type: none"> • <i>joint working</i> • <i>responsiveness and consultation</i> <p>Governance and Accountability</p> <ul style="list-style-type: none"> • <i>responsiveness and consultation</i> • <i>commitment and leadership</i> • <i>accountability</i>
Impact Assessment	Not applicable

1. Background

- 1.1 The Carers (Scotland) Act 2016, which will take effect from 1 April 2018, is a key piece of legislation designed to 'promote, defend and extend the rights' of Adult and Young Carers across Scotland. It brings a renewed focus to the role of unpaid Carers and challenges the statutory, independent and third sector to provide greater levels of help and support to Carers to maintain their health and wellbeing.
- 1.2 Supporting Carers is identified as one of the 10 priority areas of focus in the 'Dumfries and Galloway Integration Joint Board Health and Social Care Strategic Plan 2016 – 2019' (aligned to the nine national health and wellbeing outcomes).
- 1.3 The Act introduces:
 - Adult Carer Support Plans and Young Carer Statements to help identify the needs of Carers. These were previously known as Carers' Assessments
 - Eligibility criteria to enable the provision of appropriate levels of support to Carers
 - Carer involvement in hospital discharge of the cared for person
 - Short breaks statements
 - A National Charter for Carers
- 1.4 Duties relating to the provision of support to Carers such as providing an information and advice service and involving Carers in care planning have, to date, been placed local authorities. These duties have been extended further in the Carers (Scotland) Act and will now be delegated to integration authorities.

2. Main Body of the Report

- 2.1 The Scottish Government wrote to Chief Officers on 17 November 2017 to advise that Schemes of Integration should be amended to support the Carers (Scotland) Act 2016.
- 2.2 The government have already introduced an amendment through the Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Amendment Regulations 2017. This covers Section 21 of the Carers Act and places a duty on integration authorities to set local eligibility criteria for Carer support in relation to adult services and where appropriate the delegated functions relating to children's services.

- 2.3 A consultation on local eligibility criteria for Dumfries and Galloway was undertaken with Carers, Carers Organisations and staff across the partnership between October and December 2017 and a paper will be brought to the relevant committee of the Integration Joint Board for approval prior to the 31 March 2018 as prescribed by the regulation outlined in section 2.2 above.
- 2.4 As well as the regulation relating to eligibility criteria, the government has laid two further statutory instruments with the Scottish Parliament to accommodate the remaining necessary changes. These came into force on 18 December 2017. The regulations outline the changes that must be made to all schemes of integration across Scotland in relation to functions delegated by the local authority and functions that may be delegated to the Integration Joint Board from NHS Boards. An amended Scheme of Integration with tracked changes is attached as Appendix 1 (pages 31 – 37).
- 2.5 The changes to the Dumfries and Galloway Scheme of Integration are technical to accommodate the new legislation and are clearly laid out in the statutory instruments.
- 2.6 The process for making this amendment is time critical in that the Scottish Government Integration Department require that revised schemes are submitted to them no later than **2 March 2018**.
- 2.7 As per regulations relating to the Public Bodies (Joint Working) (Scotland) Act 2014, members of the Dumfries and Galloway Integration Joint Board Strategic Planning Group will be notified of these changes.
- 2.8 The Scottish Government suggests that integration authorities consider how they will incorporate their new duties within the context of their strategic plan. The Dumfries and Galloway Carers Strategy 2017-2021 approved at the Integration Joint Board meeting on 30 November 2017, includes the newly delegated duties.

3. Conclusions

- 3.1 The Dumfries and Galloway Scheme of Integration requires to be amended to accommodate new legislative requirements

Appendix 1 – Dumfries and Galloway Scheme of Integration



Health and Social Care Integration

**Integration Scheme between
NHS Dumfries and Galloway
and
Dumfries and Galloway Council**

1. Introduction

Background

1.1 The Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) requires Health Boards and Local Authorities to integrate planning for, and delivery of, certain adult health and social care services and that they prepare jointly an Integration Scheme setting out how this joint working is to be achieved.

1.2 The Act provides a choice of ways in which they may do this. In Dumfries and Galloway, the Health Board and the Local Authority have chosen to delegate to a third body called the Dumfries and Galloway Integration Joint Board (IJB). This is known as a “body corporate” arrangement¹.

¹ 1(4)(a) delegation of functions by the local authority to a body corporate that is to be established by order under section 9 (an “integration joint board”) and delegation of functions by the Health Board to the Integration Joint Board, Public Bodies (Joint Working) (Scotland) Act 2014

1.3 This Dumfries and Galloway Integration Scheme sets out the detail as to how the Health Board and Local Authority will integrate services and includes the matters prescribed in the Regulations underpinning the Act.

1.4 The IJB is responsible for the strategic planning of the functions delegated to it and for ensuring the delivery of its functions through the locally agreed operational arrangements set out within the Integration Scheme.

Working in partnership

1.5 The establishment of a fully integrated IJB will help ensure good levels of health and wellbeing for individuals, families and communities in our region. Bringing together separate adult health and social care services will see us building on, and improving, existing good practices and strengthening our relationships with local people, our staff and our partners and providers across all sectors.

1.6 Engaging and consulting with individuals, families, carers and communities will be crucial in all that we do: listening to, and taking into account, their views, experiences and ideas will help the IJB to ensure that the design and delivery of services meet identified local needs and aspirations now and in the future.

1.7 No single organisation can successfully plan and/or provide the varied and often complex integrated health and social care services adults can require: the Third and Independent sectors have a key role in working with the IJB to ensure the effective delivery of services.

Supplementary information

Once approved by Scottish Ministers, the contents of this Integration Scheme shall be full and final and, in terms of the Act, it shall not be possible to make any modifications to the Integration Scheme without a further consultation on a revised Integration Scheme being carried out jointly by the Health Board and the Local Authority and subsequent further approval by Scottish Ministers. For this reason, the Integration Scheme sets out the core requirements for the IJB and will be supplemented by separate documents which will provide further detail in respect of the workings and arrangements for the IJB. As the IJB develops, it may be necessary to make changes and improvements to certain operational arrangements, and this can be achieved through modification of the separate documents supplementing this Integration Scheme. Any changes to the supplementary documents may be made by the approval of the IJB as it sees fit from time to time and such changes will not require to be intimated to, or approved by, Scottish Ministers.

2. Aims and Outcomes of the Integration Scheme

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

2.1 National Health and Wellbeing Outcomes

The Integration Scheme is intended to achieve the National Health and Wellbeing Outcomes prescribed by the Scottish Ministers in Regulations under section 5(1) of the Act, namely:

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

2.1.2 People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community

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

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

2.1.5 Health and social care services contribute to reducing health inequalities

2.1.6 People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing

2.1.7 People using health and social care services are safe from harm

2.1.8 People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide

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

2.2 Our Vision

A Dumfries and Galloway where we share the job of making our communities the best place to live active, safe and healthy lives by promoting independence, choice and control.

2.3 Our Principles

In 2012, local principles were agreed as the foundation on which we will build and progress our plans for integration. These include:

2.3.1 Integration must focus on improved health and wellbeing outcomes for local people; quality of care and the needs of the individual are central to how we plan and provide services

2.3.2 Self-determination and a commitment to a person-centred approach to care are central in our considerations and decisions

2.3.3 All adult health and social care services, including acute services, will be included from the outset; opportunities to extend integration across other service areas will be actively explored

2.3.4 Services will be provided at community or locality level wherever possible and we will avoid unnecessary hospital admissions and duplication of professional input

2.3.5 Local GPs must be at the heart of our community and locality services

2.3.6 Clear and robust decision-making structures will fully reflect the unique and different roles of the NHS and the Local Authority, retaining the respective accountability for resources, outcomes and performance and quality of services through a continuing commissioning approach

2.3.7 The IJB will have oversight of the delivery of all commissioned services

- 2.3.8 Health and social care services in each locality will be accountable to their local community through the Area Committees and to the IJB
- 2.3.9 Clear and robust structures will provide for full delegation and empowered decision-making
- 2.3.10 Professional leadership and oversight and practice development should remain with senior professional officers in each organisation
- 2.3.11 Professionals will be freed up to focus on delivery and solutions, learning from experience through, for example, Joint Future
- 2.3.12 An integrated budget shall be in place to respond to all situations; the work being progressed in Dumfries and Galloway on a Joint Resourcing Framework will assist
- 2.3.13 1 April 2015 will see the development of our proposals for integration, with the aim of delivering a fully integrated model by 1 April 2016 in line with the legislative timetable. Our aim is to achieve excellence immediately post-integration

Dumfries and Galloway Integration Scheme

The Parties:

Dumfries and Galloway Council, established under the Local Government etc (Scotland) Act 1994 and having its principal offices at English Street, Dumfries DG1 2DD (“the Council”);

And

Dumfries and Galloway Health Board, established under section 2(1) of the National Health Service (Scotland) Act 1978 (operating as “NHS Dumfries and Galloway”) and having its principal offices at Crichton Hall, The Crichton, Dumfries DG1 4TG (“NHS Dumfries and Galloway”); and

(together referred to as “the Parties”; individually referred to as “the Party”).

1. Definitions and Interpretation

In this Integration Scheme the following terms shall have the following meanings:

“The Act” means the Public Bodies (Joint Working) (Scotland) Act 2014;

“The Parties” means Dumfries and Galloway Council and NHS Dumfries and Galloway;

“IJB” means the Integration Joint Board to be established by Order under section 9 of the Act;

“Outcomes” means the National Health and Wellbeing Outcomes prescribed by the Scottish Ministers in Regulations under section 5(1) of the Act;

“The Scheme” means this Integration Scheme;

“Integration Planning and Delivery Principles” means the principles through which all integration activity should be focussed to achieve the Outcomes in accordance with sections 4 and 31 of the Act;

“Strategic Plan” means the plan which the Integration Joint Board is required to prepare and implement in relation to the delegated provision of health and social care services to adults in accordance with section 29 of the Act; and

“Strategic Planning Group” means the group which the Integration Joint Board is to establish in accordance with section 32 of the Act.

In implementation of their obligations under the Act, the Parties hereby agree as follows:

In accordance with section 1(2) of the Act, the Parties have agreed that the integration model set out in section 1(4)(a) of the Act will be put in place for the delegation of functions by the Parties to a body corporate that is to be established by Order under section 9 of the Act. This Scheme comes into effect on the date the Parliamentary Order to establish the Integration Joint Board comes into force.

2. Local Governance Arrangements

2.1 The IJB will be a distinct legal entity and will be autonomous.

2.2 The arrangements for appointing the voting membership of the IJB are that the Council and NHS Dumfries and Galloway will each appoint 5 representatives to be members of the IJB. The IJB members appointed by the Parties will hold office for a maximum period of 3 years. IJB members appointed by the Parties will cease to be members of the IJB in the event that they cease to be a non-executive Board member of NHS Dumfries and Galloway or, where applicable, cease to be an appropriate person for the purposes of article 3(5) of the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014, or an Elected Member of the Council.

2.3 The first Chair of the IJB will be an IJB member nominated by the Council and they will hold office as Chair for a period of 2 years. NHS Dumfries and Galloway will nominate the Vice-Chair and the Vice-Chair will hold office for a period of 2 years. At the end of the period of 2 years, responsibility for appointing the Chair and Vice-Chair will transfer to the other Party and a new Chair and Vice-Chair will be appointed for a period of 2 years. Thereafter, responsibility for appointing the Chair and Vice-Chair will alternate between the Parties and the appointments will be made for a period of 2 years.

2.4 When established, the IJB must include the following non-voting members as specified in the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014:

2.4.1 The Chief Officer of the IJB

2.4.2 The Chief Social Work Officer of the Council

2.4.3 The Chief Finance Officer of the IJB

2.4.4 A registered medical practitioner whose name is included in the list of primary medical services performers prepared by NHS Dumfries and Galloway

2.4.5 A registered nurse who is employed by NHS Dumfries and Galloway or by a person or body with which NHS Dumfries and Galloway has entered into a general medical services contract

2.4.6 A registered medical practitioner employed by NHS Dumfries and Galloway and not providing primary medical services

2.5 When established, the IJB must also appoint at least one non-voting member in respect of each of the following groups as specified in the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014:

2.5.1 Staff of the Parties engaged in the provision of services provided under the Scheme

2.5.2 Third sector bodies carrying out activities related to health or social care in the Dumfries and Galloway area

2.5.3 Service users residing in the Dumfries and Galloway area

2.5.4 Persons providing unpaid care in the Dumfries and Galloway area

2.6 The IJB may, from time to time, appoint such additional non-voting members as it considers necessary and expedient for the effective discharge of its functions as

specified in the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014.

3. Delegation of Functions

3.1 The functions that are to be delegated by NHS Dumfries and Galloway to the IJB are set out in Part 1 of Annex 1. The services to which these functions relate, which are currently provided by NHS Dumfries and Galloway and which are to be integrated, are set out in Part 2 of Annex 1. The functions in Part 1 are delegated only to the extent that they relate to services listed in Part 2 of Annex 1.

3.2 The functions that are to be delegated by the Council to the IJB are set out in Part 1 of Annex 2. The services to which these functions relate, which are currently provided by the Council and which are to be integrated, are set out in Part 2 of Annex 2.

3.3 In addition to the services that must be integrated, NHS Dumfries and Galloway has agreed to add the following:

3.3.1 The entirety of Acute Hospital Services; and

3.3.2 The following health services as they relate to provision for people under the age of 18:

- (a) Primary Medical Services and General Medical Services (including GP Pharmaceutical services)
- (b) General Dental Services, the Public Dental Service
- (c) General Ophthalmic Services
- (d) General Pharmaceutical Services
- (e) Out of Hours Primary Medical Services
- (f) Acute Hospital Services
- (g) Community Health Services including Health Visiting and School Nursing

3.4 In exercising its functions, the IJB must take into account the Parties' requirements to meet their respective statutory obligations. Apart from those functions delegated by virtue of this Scheme, the Parties retain their distinct statutory responsibilities and therefore also retain their formal decision-making roles.

4. Local Operational Delivery Arrangements

Strategic Planning

4.1 The Parties note that the IJB is required by section 29 of the Act to prepare a Strategic Plan which must set out the arrangements for carrying out the integration functions and how those arrangements are intended to achieve or contribute to achieving the Outcomes. The IJB directs the Parties to deliver services [relating to the functions] in accordance with the Strategic Plan.

4.2 The Strategic Plan will be prepared and consulted on to ensure it meets the principles of integration and describes how it will deliver on strategic commissioning priorities to meet the health and social care needs of local people and evidence this against the Outcomes.

4.3 The Parties will provide support to the IJB for the purposes of preparing and reviewing a Strategic Plan and for carrying out integrated functions that it requires to discharge under the Act and other legislation to which it operates.

4.4 The Parties will share with the IJB the necessary activity and financial data for services, facilities or resources that relate to the planned use of services by service users within Dumfries and Galloway for their services and for those provided by other Health Boards and by other Local Authorities.

4.5 The Parties agree to use all reasonable endeavours to ensure that any other relevant Integration Authority will share the necessary activity and financial data for services, facilities and resources that relate to the planned use by service users within the area of their Integration Authority.

4.6 The Parties shall ensure that their Officers acting jointly will consider the Strategic Plans of other Integration Joint Boards or Integration Authorities to ensure that they do not prevent the Parties and Dumfries and Galloway IJB from carrying out their functions appropriately and in accordance with the Integration Planning and Delivery Principles, and to ensure they contribute to achieving the Outcomes.

4.7 The Parties shall advise the IJB where they intend to change service provision of non-integrated services that will have a resultant impact on the Strategic Plan.

Operational Delivery Arrangements

4.8 Under section 26 of the Act, the IJB will give directions to the Parties to carry out the functions delegated to the IJB. The local operational arrangements agreed by the Parties are:

4.8.1 The IJB has responsibility for the planning of services. This will be achieved through the Strategic Plan.

4.8.2 The IJB is responsible for the operational oversight of integrated services, including the entirety of Acute Hospital Services, and through the Chief Officer will be responsible for the operational management of integrated services. The Acute Services Management Team of NHS Dumfries and Galloway, and the Chief Social Work Officer of the Council, will provide information on a regular basis to the Chief Officer on the operational delivery of these services. This information will inform the Chief Officer's performance reports to the IJB as set out in Clause 4.23.

4.9 The IJB may agree with the Parties or another IJB in another area that operational delivery arrangements for delegated functions will be hosted by one of them. In those cases, the Parties, the IJB and the other IJB will agree the operational delivery, management, monitoring and reporting arrangements.

4.10 The Chief Social Work Officer of the Council, the Executive Nurse Director and the Medical Director of NHS Dumfries and Galloway (or such other nominated officer) will have a key role in the planning and delivery of integrated services and the IJB and these senior professional leads shall liaise with each other, and the Chief

Officer, regarding the planning and delivery of integrated services and non-integrated services to ensure that these are appropriately co-ordinated.

Provision of corporate support services

4.11 In order for the IJB to both prepare the Strategic Plan and effectively carry out the integration functions, the Parties agree that technical, professional and administrative resources will require to be provided by them to the IJB.

4.12 There is agreement and commitment to provide corporate support services to the IJB. The arrangements for providing these services will be reviewed by March 2016 and appropriate models of service will be agreed. This process will involve senior representatives from the Parties and the Chief Officer. The models agreed will be subject to further review as the IJB develops and as part of the planning processes for the IJB and the Parties.

4.13 The Parties will provide the IJB with the corporate support services it requires to fully discharge its duties under the Act.

Performance

4.14 The Parties will identify a core set of indicators that relate to services from publicly accountable and national indicators and targets against which the Parties currently report. The Parties will, in consultation with stakeholders, establish a Performance Management Framework (PMF) focused on the delivery of the Outcomes. The PMF will provide the necessary activity and financial data for planned use of services in the Dumfries and Galloway area, including targets and measures. The Parties will share all information from the PMF with the IJB. The Framework will ensure that there are clear linkages between the Outcomes, the Dumfries and Galloway Single Outcome Agreement, the Strategic Plan, Locality Plans and the Parties' delivery plans for services.

4.15 The PMF will be reviewed regularly to ensure the improvement measures it contains continue to be relevant and reflective of the Outcomes and local outcomes.

4.16 A key element of the PMF will be to ensure continuous engagement with local communities, local staff and clinicians to inform improvements in integrated services and outcomes. The IJB will engage locally to identify and agree local improvement activity.

4.17 In preparing the PMF, the Parties will ensure the following lists are prepared and included in the PMF:

- (a) a list of any targets, measures and arrangements which relate to functions of the Parties which are not Integration Functions but which are to be taken account of by the IJB when preparing the Strategic Plan ("Non-integration Functions Performance Target List"); and
- (b) a list of all targets, measures and arrangements which relate to Integration Functions and for which responsibility is to transfer, in full or in part, to the IJB, including a statement of the extent to which responsibility for each target, measure or arrangement is to transfer ("Integration Functions Performance Target List").

4.18 The Integration Functions Performance Target List will be prepared by the Parties in two stages:

(a) all existing targets, measures and arrangements will be identified and consolidated in one document which will set out the integrated services covered by each target, measure or arrangement, the values of each under current service provision [and a statement of the extent to which responsibility for each target, measure or arrangement is to transfer and to whom]; and

(b) those targets, measures and arrangements will be reviewed to ensure that (i) they continue to be appropriate under the IJB and (ii) any gaps are identified and appropriate targets, measures or arrangements recommended for the approval of the IJB.

4.19 The Non-integration Functions Performance Target List will similarly be prepared by the Parties and consolidated in one document and will identify the extent to which responsibility for the targets, measures and arrangements will lie with the IJB.

4.20 The Lists will be prepared by 31 December 2015 to support the development of the Strategic Plan and will be reviewed annually by the Parties and the IJB.

4.21 The Parties recognise the need for local community ownership in the development of health and social care services. In developing this Scheme and the Strategic Plan, democratic accountability to local communities will be important to the progress and success of integration. In Dumfries and Galloway, the Parties have agreed that Area Committees will scrutinise the delivery of Locality Plans against the planned outcomes established within the Strategic Plan.

4.22 The Chief Officer will provide regular performance reports on the Strategic Plan to the IJB for the IJB to scrutinise performance and impact against planned outcomes and priorities. The IJB will also provide a report on the delivery of the Strategic Plan each year.

4.23 The IJB will also receive regular performance reports from the Chief Officer, in consultation with the Parties, on the operational delivery of services delegated to the IJB. These reports will include information on the activity and resources that relate to the planned and actual use of services, including the patterns of use of health and social care resources by locality.

5. Clinical and Care Governance and Professional Oversight

5.1 The Parties and the IJB are accountable for ensuring appropriate clinical and care governance arrangements in respect of their duties under the Act. The Parties also recognise that the establishment and continuous review of the arrangements for clinical and care governance are fundamental to the IJB delivering its ambitions. The clinical and care governance arrangements described below will provide to the IJB the required assurance of the quality and safety of service delivered. The Parties will have regard to the principles of the Scottish Government's Clinical and Care Governance Framework, including the focus on localities, and service user and carer feedback.

5.2 The Act does not change the professional regulatory framework or established professional accountabilities currently in place. The Parties will ensure that explicit arrangements are made for professional supervisions, learning, support and continuous improvement for all staff.

5.3 Assurance to the IJB and subsequently, to the Parties, in respect of the key areas of clinical and care governance will be achieved through explicit and effective lines of accountability. Professional responsibility and accountability for Nursing, Midwifery and Allied Health Professional practice is devolved to the Executive Nurse Director of NHS Dumfries and Galloway. Professional responsibility and accountability for social work practice is to the Chief Social Work Officer of the Council. Professional responsibility and accountability for Medical Staff is devolved to the Medical Director of NHS Dumfries and Galloway. Operational management, responsibility and accountability rest with the Chief Officer. Clinical and care governance will be embedded at the clinical/professional interface using the framework outlined below and at Annex 3.

5.4 The clinical and care governance framework will encompass the following:

- 5.4.1 Service user/patient experience of integrated service delivery, including complaints raised by service users, carers and families
- 5.4.2 Achievement of personal outcomes
- 5.4.3 Risk Management, including adverse event reporting and learning systems
- 5.4.4 Inspection activity and associated improvement plans
- 5.4.5 Research and Development
- 5.4.6 Quality and safety of care, including continuous improvement
- 5.4.7 Statutory and legal requirements
- 5.4.8 Quality Assurance in commissioned services
- 5.4.9 Workforce development and regulation

5.5 The Parties will be responsible, through commissioning and procurement arrangements, for the quality and safety of services procured from the Third and Independent sectors and to ensure that such services are delivered in accordance with the Strategic Plan.

5.6 The Locality Teams will be responsible for embedding clinical and care governance and quality improvement practice across the services they manage and deliver. Reports for assurance will be provided by the localities to the Clinical and Care Governance Committee.

5.7 Clinical and care governance oversight will be undertaken through a Clinical and Care Governance Committee. This Committee will bring together senior management and professional leadership from within the Parties and provide an effective overview of the clinical and care governance agenda across integrated services. The Chief Social Work Officer, Executive Nurse Director and Medical Director will be members of this Committee. This Committee, chaired by one of its members, will ensure that quality monitoring and governance arrangements are in place for safe and effective health and social care service delivery in Dumfries and Galloway and will include as a minimum all those elements listed in section 5.4.

5.8 The Clinical and Care Governance Committee will provide reports to the IJB, NHS Dumfries and Galloway's Healthcare Governance Committee and the Council's Social Work Services Committee in order to provide assurance with regards to the quality and safety of services being delivered via the IJB. The Clinical and Care Governance Committee will receive reports from, and provide oversight of the work of, the locality services. The Clinical and Care Governance Committee will also provide advice to any established Strategic Planning Group, Management Board and localities.

5.9 The Medical Director and Executive Nurse Director have joint accountability for clinical governance of NHS Dumfries and Galloway services as a responsibility/function delegated from the Chief Executive of NHS Dumfries and Galloway.

5.10 The Medical Director and the Executive Nurse Director remain accountable for quality of care and professional governance with regard to the NHS Dumfries and Galloway functions delegated to the IJB.

5.11 In addition, the Medical Director:

5.11.1 Holds the delegated responsibility for information governance with regard to NHS Dumfries and Galloway services, and is also the Caldicott Guardian

5.11.2 Is the Responsible Officer within the terms of the Medical Profession (Responsible Officers) Regulations 2010, including the statutory role in making recommendations about the revalidation of doctors with a prescribed connection to NHS Dumfries and Galloway

5.11.3 Is responsible for under and post graduate education and training and teaching of medical students and this will continue to be discharged through the Director of Medical Education

5.12 In addition, the Executive Nurse Director:

5.12.1 Has delegated responsibility with regard to the Local Supervisory Authority for NHS Dumfries and Galloway Midwifery Practice

5.12.2 Is responsible for all undergraduate and post-graduate nurse and midwifery education and evaluation of student nurse clinical placements for all NHS Dumfries and Galloway services

5.12.3 Is responsible for revalidation of Nurses and Midwives by the Nursing and Midwifery Council (NMC), and Allied Health Professionals by the Health and Care Professions Council (HCPC)

5.13 The Chief Social Work Officer will ensure that the IJB maintains an overview of the quality assurance of social work services delegated to the IJB. The Chief Social Work Officer is held to account by the Council for the quality of social work practice and will continue to report to the Council's Social Work Services Committee. The Chief Social Work Officer's Annual Report on these matters will be reported to the Council, NHS Dumfries and Galloway and the IJB.

5.14 The Chief Social Work Officer will provide appropriate professional advice in relation to the Council's statutory social work duties and make certain decisions in

terms of the Social Work (Scotland) Act 1968. In line with 'Changing Lives' 2006, the governance and professional leadership role of the Chief Social Work Officer will be to oversee social work services and ensure delivery of safe, effective and innovative practice. The Chief Social Work Officer will support the Council and its Elected Members in ensuring that this statutory post not only enhances professional leadership and accountability, but provides a key support and added value to the Council and its partners in delivering positive outcomes locally within the Scheme.

5.15 The Chief Social Work Officer and the Executive Nurse Director and Medical Director will be non-voting members of the IJB, providing clinical and care governance and professional advice at that level. These professional leads will also advise the Chief Officer in all matters pertaining to professional issues covered by the clinical and care governance framework.

5.16 In addition, professional advice will be available to the IJB (and any groups it chooses to establish) and localities through an Integrated Professional Advisory Committee comprising health and social care professionals. Existing advisory committees will also be available for the provision of advice as required, for example, the Area Nursing and Midwifery Advisory Committee and the Area Medical Advisory Committee. A complementary Social Work Advisory Committee will be established.

6. Chief Officer

6.1 The IJB shall appoint a Chief Officer in accordance with section 10 of the Act. Before appointing a person as Chief Officer the IJB is to consult the Parties.

6.2 The Chief Officer will have operational management responsibility for the delivery of all integrated services to the IJB. The Chief Officer will report to the IJB on the delivery of the Strategic Plan.

6.3 The Chief Officer will report to the Chief Executives of the Parties. Joint performance review meetings involving both Chief Executives and the Chief Officer will take place on a regular basis.

6.4 The Chief Officer will be a member of the appropriate senior management teams of NHS Dumfries and Galloway and the Council. This will enable the Chief Officer to work with senior management of both Parties to carry out the functions of the IJB in accordance with the Strategic Plan.

6.5 The Chief Officer, through the IJB, will be jointly accountable to the Parties for the operational management of the integrated services and will be jointly managed by the Chief Executives of the Parties. For other functions the Chief Officer is accountable only to the IJB.

6.6 In addition, the Chief Officer requires to establish and maintain effective relationships with a range of key stakeholders across NHS Dumfries and Galloway, the Council, the Third and Independent sectors, service users, carers, Scottish Government, Trades Unions and professional organisations.

6.7 In accordance with the Public Bodies (Joint Working) (Integration Scheme) (Scotland) Regulations 2014, in the event that the Chief Officer is absent on an unplanned basis, or otherwise unable to carry out his or her functions, at the request of the IJB a suitable interim replacement for the Chief Officer will be nominated by the Parties and submitted to the IJB for approval.

7. Workforce

Successful delivery of integrated services will be dependent on an engaged workforce and this will be achieved through effective leadership, management, support, learning and development.

The following principles will apply to staff delivering integrated services:

7.1 The employment status of staff will not change as a result of the Scheme i.e. staff from the Parties involved in delivering integrated services will continue to be employed by their current employer and retain their current terms and conditions of employment and pension status.

7.2 Any future changes that may be required within the Parties will be agreed and promulgated following the engagement of those affected by the proposal in accordance with established policies and procedures.

7.3 Both Parties are committed to ensuring staff are equipped with the necessary knowledge, skills and values base to deliver high quality services across the communities they serve and a workforce plan, which will include development and support for the workforce, will be prepared and put in place by 1 April 2016 which will provide for this. The workforce plan will be reviewed annually and the IJB will be invited to be party to this review.

7.4 Core Human Resources and Learning and Organisational Development (OD) services will be provided from existing organisational resources and services and a plan for this will be prepared and put in place by 1 April 2016. The plan will be reviewed annually and the IJB will be invited to be party to this review.

7.5 Support in relation to cultural change, consultation and engagement, communication and structures and management will be provided through existing corporate support services.

7.6 Joint Appointments will take account of the existing recruitment policies and practice that exist within the Parties. Joint positions can be hosted by either Party and operationally managed within a structure appropriate to the delivery of the integrated services.

8. Finance

8.1 Resources

8.1.1 The Parties will agree and set out the method of determining amounts to be paid by the Parties to the IJB in respect of each of the functions delegated by them to the IJB.

8.1.2 Payment in the first year to the IJB for delegated functions

The payment for the shadow year 2015/16 will reflect the baseline established from a review of 2014/15 financial year and will reflect agreed changes through the 2015/16

budget setting process, to provide the Parties and the IJB with assurance that the delegated resources are sufficient to deliver the agreed delegated functions and level of service to be provided. These amounts will recognise existing plans for the Parties for the functions which are to be delegated, adjusted for material items in the shadow period. These figures will be agreed as part of a due diligence procedure as agreed between the Parties. The payment will be linked through to patient activity information and the latest Integrated Resources Framework (IRF) will be referred to when deriving the allocation to localities.

8.1.3 Payment in subsequent years to the IJB for delegated functions

In subsequent years the Chief Officer and the IJB Chief Finance Officer will develop a case for the Integrated Budget based on the Strategic Plan. The Parties will review this as part of the required budget process. The case should be evidenced, with full transparency demonstrating the following assumptions:

- 8.1.3.1 Activity Changes
- 8.1.3.2 Cost inflation
- 8.1.3.3 Required Efficiency Savings
- 8.1.3.4 Performance against outcomes
- 8.1.3.5 Legal and statutory requirements
- 8.1.3.6 Transfers to/from the budget for hospital services
- 8.1.3.7 Adjustments to address equity of resource allocation

The Parties will evaluate the case for the Integrated Budget and agree their respective contributions accordingly.

If the Strategic Plan sets out a change in hospital and community capacity, the resource consequences will be determined through a bottom up process based on:

- 8.1.3.8 Planned changes in activity and case mix due to interventions in the Strategic Plan
- 8.1.3.9 Projected activity and case mix changes due to changes in demography
- 8.1.3.10 Analysis of the impact on the affected hospital and community care budgets, taking into account cost behaviour (i.e. fixed, semi fixed, and variable costs) and timing differences (i.e. the lag between reduction in capacity and the release of resources)

8.1.4 The Parties will consider the following when reviewing the Strategic Plan:

- 8.1.4.1 The Local Government Financial Settlement
- 8.1.4.2 The uplift applied to NHS Board funding from Scottish Government
- 8.1.4.3 Efficiencies to be achieved
- 8.1.4.4 Specific funding provided to either Party or the IJB to support delegated functions or integration

The allocations will be based on priority and need.

8.1.5 Further due diligence will be undertaken during the 2015/16 financial year to assess the adequacy of the initially determined payments to the IJB to help inform payment levels from the 2016/17 financial year.

8.1.6 Method for determining the amount set aside for Hospital Services

In the current proposed model the entirety of Hospital Services are included in the payment to the IJB, therefore there will be no amount set aside for Hospital Services.

8.1.7 Schedule of Payments

The net difference between payments made to the IJB and resources delegated by the IJB, Resource Transfer and virement between the Parties and IJB will be transferred between the Parties on a six monthly basis, with a final adjustment on closure of the Annual Accounts. The timetable and payment schedule will be prepared in advance of the start of the financial year.

8.2 Integrated Budget In-Year Variations

8.2.1 Process for resolving budget variances

Overspend

8.2.1.1 The Chief Officer is expected to deliver the outcomes within the total delegated resources and where there is a forecast overspend against an element of the operational budget, the Chief Officer, the Chief Finance Officer of the IJB and the relevant finance officers of the Parties must agree a recovery plan to balance the overspending budget.

8.2.1.2 In addition, the IJB may increase the payment to the relevant organisation responsible for commissioning/providing services, by either:

- (a) Utilising an underspend on the other arm of the operational Integrated Budget to reduce the payment to that body; and/or
- (b) Utilising the balance on the general fund, if available, of the IJB in line with the reserves policy.

8.2.1.3 If the recovery plan is unsuccessful and there are insufficient general fund reserves to fund a year end overspend, then the partners have the option to:

- (a) Make additional one-off payments to the IJB; or
- (b) Provide additional resources to the IJB which are then recovered in future years, subject to scrutiny of the reasons for the overspend and assurance that there is a plan in place to resolve this.

8.2.1.4 As a default position, should the recovery plan be unsuccessful, the IJB may request that the payment from the Parties be adjusted to take account of any revised assumptions. It is expected that as we move towards fuller integration as the IJB matures, that the Parties will share out the additional contributions, if required based on the proportion of their allocations. At the initial stage (until the end of 2016/17),

prior to fuller integration, it will be incumbent on the Party who originally delegated the budget to make the additional payment to cover the shortfall.

Underspend

8.2.1.5 Where there is a forecast underspend in an element of the operational budget, the first priority for use of the forecast underspend will be to offset any forecast overspend within the operational budget. If a total underspend remains to be forecast the IJB should forecast the retention of the underspend, except where material errors in the assumptions made in the method to determine the payment for the function. In these circumstances the payment for this element should be recalculated using the revised assumptions.

8.2.1.6 In the event of a forecast underspend the IJB will be required to decide whether this results in a re-payment to the relevant Party or whether any surplus funds will contribute to the IJB's reserves.

8.2.1.7 The Chief Officer and the Chief Finance Officer of the IJB will agree a reserves policy for the IJB prior to the end of financial year 2015/16.

8.2.1.8 In the event of a return of funds to the Parties, the split of the re-payment will be based upon the Parties' proportionate share of the baseline payment to the IJB, regardless of the operational budget in which the underspend has occurred.

8.2.1.9 Similarly, underspends in "ring fenced" allocations may not be available for alternative use and may need to be returned to Scottish Government.

8.2.2 Non Integrated Budgets

8.2.2.1 In the event of a projected in-year overspend elsewhere across the Parties' non-integrated budgets, they should contain the overspend within their respective non-integrated resources.

8.2.2.2 In exceptional circumstances should they require the IJB to contribute resources to offset the overspend, they must do this by amending their contributions to the IJB. This provision should only be used in extremis, and will be subject to consultation with the IJB. The Chief Officer will determine the actions required to be taken to deliver the necessary savings, to fund the reduction in contributions and should be approved by the IJB. If necessary, either Party may increase its in year payment to the IJB.

8.3 Managing Financial Performance

8.3.1 A Chief Finance Officer will be appointed to by the IJB.

8.3.2 The IJB Chief Finance Officer will establish a process of regular in year reporting and forecasting to provide the Chief Officer with management accounts for both arms of the operational budget and for the IJB as a whole.

8.3.3 The Chief Finance Officer will provide the Chief Officer with financial advice for the respective operational budgets.

8.3.4 The preparation of financial reports will be produced as part of the financial performance structure provided to the IJB. Reports will initially be produced on a quarterly basis and the content and frequency will be agreed with the IJB. The reports will set out information on actual expenditure and budget for the year to date and forecast outturn against budget together with explanations of significant variances and details of actions required. These reports will also set out progress with achievement of any budgetary savings.

8.3.5 The IJB will receive financial management support from the Chief Finance Officer.

8.3.6 Initially, the consolidation of financial information for the IJB will take place outwith the core financial ledgers.

8.3.7 Financial advice and support will be provided to the Chief Officer by the Chief Finance Officer of the IJB, supported by the finance staff who currently support the operational budgets for delegated functions.

8.3.8 Services for processing transactions for the delegated functions (e.g. payment of suppliers, payment of staff, raising invoices) will also continue to be provided to the IJB by the Parties.

8.3.9 The responsibility for preparing the Annual Accounts of the IJB will reside with the Chief Finance Officer of the IJB, who will also be responsible for agreeing a timetable for the preparation of the Annual Accounts in conjunction with the Director of Finance of NHS Dumfries and Galloway and the Head of Finance of the Council. The Chief Finance Officer will also be responsible for the financial planning input to the Strategic Plan.

Prior to 31 January each year the Chief Finance Officer of the IJB will agree with the Head of Finance of the Council, and the Director of Finance of NHS Dumfries and Galloway, a procedure and timetable for the coming financial year end for reconciling payments and agreeing any balances.

8.3.10 The Parties will allocate a share of the corporate overhead costs (matched by a corresponding budget allocation) to the IJB at the end of the financial year in order to comply with Local Authority accounting regulations.

8.4 Arrangements for Asset Management and Capital

8.4.1 The IJB will not receive any capital allocations, grants or have the power to borrow to invest in capital expenditure. The Parties will continue to own any property and assets used by the IJB and have access to appropriate sources of funding for capital expenditure.

8.4.2 The Chief Officer of the IJB will feed in the needs of integrated health and social care services to the overall capital investment considerations of the Parties and should consult with the Parties to make best use of existing resources.

9. Participation and Engagement

Principles

9.1 The Parties have established shared Principles as follows:

The Parties will

- 9.1.1 Work across organisational boundaries
- 9.1.2 Inform, engage and feed back to people and organisations as appropriate
- 9.1.3 Recognise the importance of partnership and team working
- 9.1.4 Work in a way that is inclusive and accessible
- 9.1.5 Ensure that engagement and participation is open and transparent
- 9.1.6 Respect people's privacy, dignity and confidentiality
- 9.1.7 Use modern methods of communication to ensure that the widest range of individuals and communities can participate
- 9.1.8 Ensure that there are adequate resources allocated to this work, including staff with the necessary skills and confidence
- 9.1.9 Ensure that engagement and participation work informs and influences the design and delivery of services and programmes

9.2 A joint consultation took place on the Scheme in February - March 2015. The stakeholders who were consulted in this joint consultation were:

- 9.2.1 Local communities/general public
- 9.2.2 Health professionals, including GPs
- 9.2.3 Users of health care
- 9.2.4 Carers of users of health care
- 9.2.5 Commercial providers of health care
- 9.2.6 Non-commercial providers of health care
- 9.2.7 Dumfries and Galloway Council employees
- 9.2.8 NHS Dumfries and Galloway employees
- 9.2.9 Dumfries and Galloway Council Elected Members
- 9.2.10 Dumfries and Galloway NHS Board members
- 9.2.11 Social care professionals
- 9.2.12 Users of social care
- 9.2.13 Carers of users of social care
- 9.2.14 Commercial providers of social care
- 9.2.15 Non-commercial providers of social care
- 9.2.16 Staff of the Health Board and Local Authority who are not health professionals or social care professionals
- 9.2.17 Non-commercial providers of social housing
- 9.2.18 Third sector bodies carrying out activities related to health or social care
- 9.2.19 Trades Unions
- 9.2.20 Dumfries and Galloway Community Planning Partnership
- 9.2.21 Dumfries and Galloway Community Planning Stakeholders Group

- 9.2.22 Dumfries and Galloway Adult Protection Committee
- 9.2.23 Learning Disability Interest Groups
- 9.2.24 Accessible Transport Forum
- 9.2.25 Older People's Consultative Group
- 9.2.26 Alzheimers Scotland
- 9.2.27 Day Centres
- 9.2.28 Dumfries and Galloway Over 50s Group
- 9.2.29 Royal Voluntary Service
- 9.2.30 The Food Train
- 9.2.31 Dumfries and Galloway Carers Centre
- 9.2.32 Capability Scotland
- 9.2.33 Third Sector, Dumfries and Galloway (Interface)
- 9.2.34 Department of Work and Pensions
- 9.2.35 Dumfries and Galloway Citizens Advice Service
- 9.2.36 Further/Higher Education
- 9.2.37 DG Voice
- 9.2.38 Dumfries and Galloway Multicultural Association
- 9.2.39 Dumfries and Galloway Inter Faith Group
- 9.2.40 MPs, MSPs, MSYPs
- 9.2.41 Age Scotland
- 9.2.42 Dumfries and Galloway LGBT Centre
- 9.2.43 User and Carer Involvement (UCI)

9.3 The range of methodologies used to contact these stakeholders included the Parties' websites and intranets; e-mail; in writing; survey monkey; and face to face contact. Dumfries and Galloway NHS Board met in workshop session and its Performance Committee considered the Scheme and the Council held an Elected Members' Seminar to discuss the Scheme.

9.4 This Scheme was Impact Assessed (IA), involving a range of stakeholders including representatives of equality groups, carers, patients and users and this considered a wide range of issues particularly relevant to health and social care integration including equalities, human rights, health and health inequalities, economic and social sustainability and environment. The results of the IA informed the Scheme.

Consultation responses

9.5 All consultation responses received were fully considered by the Parties and taken into account prior to finalisation of the Scheme.

Strategy for engagement

9.6 The Parties have both adopted the National Standards for Community Engagement and committed to using the VOiCE (Visioning Outcomes in Community Engagement) a web-based tool used to plan and deliver engagement activity. The Remote Rural Practice Advice Note (produced as part of the National Standards) is particularly relevant to local arrangements given the geography of the area.

9.7 The Parties will support the IJB to develop a Participation and Engagement Strategy in accordance with the National Standards for Community Engagement.

9.8 The Parties will commit all necessary resources to ensure the development of the Participation and Engagement Strategy.

9.9 The IJB's Participation and Engagement Strategy will be completed by 1 April 2016 and will address:

- 9.9.1 Communication routes
- 9.9.2 Hard to reach groups
- 9.9.3 Plain English
- 9.9.4 Training and development
- 9.9.5 Public Involvement Panel
- 9.9.6 Community Councils
- 9.9.7 Locality and thematic partnerships
- 9.9.8 Employee engagement
- 9.9.9 Impact Assessment

10. Information-Sharing and data handling

10.1 The Parties have already worked up a sharing accord under the Scottish Accord on the Sharing of Personal Information (SASPI) and are now developing a supporting Information Sharing Protocol (ISP). Joint working is well underway to share information initially through the use of a single shared information Portal. The ISP will support the regular sharing of personal information between the Parties going forward. The IJB will be invited to join the Accord.

10.2 The Parties have developed an ISP which covers guidance and procedures for staff for sharing of information.

10.3 All staff managed within the delegated functions will be contractually required to comply and adhere to respective local information security policies and procedures including data confidentiality policies of their employing organisations and the requirements of the IJB's agreed ISP.

10.4 The Parties will establish a group to agree the ISP and procedures before 1 April 2016. Agreements and procedures will be reviewed annually by the group, or more frequently if required. The NHS Dumfries and Galloway Information Assurance Group and the Council's Information Security Group, acting on behalf of the Parties, will meet to review the ISP for the consideration of the IJB.

10.5 With regard to individually identifiable material, data will be held in both electronic and paper formats and only be accessed by authorised staff, in order to provide the patient or service user with the appropriate service. This will be invoked through our Information Sharing PORTAL.

In order to provide fully integrated services it may be necessary to share information within the delegated functions and with external agencies. Where this is the case the IJB will seek the consent of the service user for the sharing of data, unless a statutory requirement exists. In order to comply with the Data Protection Act 1998, the IJB will always ensure that personal data it processes will be handled fairly, lawfully and within justification.

10.6 In order to comply with the Data Protection Act 1998 the IJB will ensure that any personal data it holds will be processed in line with the Data Protection Principles contained within Schedule 1 of the Act.

11. Complaints

11.1 The Protocol below sets out how the Parties will work jointly to achieve an integrated approach to handling complaints about any integrated health and social care service from service users, patients, carers and any other authorised representatives.

The Parties agree that:

11.1.1 The responsibility for handling complaints by patients/carers/service users will be delegated to the Party responsible for the delivery of the particular health or social care service being complained about, with an overview by the Chief Officer and a commitment to joint working, wherever necessary, between the Council and NHS Dumfries and Galloway when dealing with complaints about integrated services.

11.1.2 This provides for the respect to be given to the existing separate statutory complaint handling arrangements in place for health and social work services, which in the event where a complainant may be dissatisfied with the Chief Social Work Officer's decision in relation to a complaint about social work services, the complainant has a legal right to access a third stage independent review by an Independent Complaints Review Committee, whereas legislation only provides for the complainant with a health care complaint to pursue any appeals direct with the Scottish Public Services Ombudsman (SPSO), after the one-stage complaint procedure has been exhausted.

11.1.3 Service users, patients, carers and others, authorised to act as their representatives, will continue to make complaints either to the Council or NHS Dumfries and Galloway, by submitting an online complaint form, by telephoning the relevant department or attending in person or in writing.

11.1.4 A properly developed framework will be published, showing clearly the lead Party for each integrated service and the contact details for those who will be responsible for progressing any complaints received. The lead Party will take responsibility for the triage of the complaint upon its receipt, and liaise with the other Party to develop a joint response where that may be required.

11.1.5 There are currently 3 key established processes for a complaint about health and social care services to follow depending on the lead Party:

- Dumfries and Galloway Council Complaints Handling Procedure (CHP)
- Dumfries and Galloway Council's Statutory Social Work Complaints Procedure
- NHS Dumfries and Galloway Complaints Procedure

11.1.6 External providers - All external providers commissioned by the Parties to provide services to the IJB will be required to have their own Complaints Procedure in place which will be quality assured by the Parties. Where complaints are received

that relate to a service provided by an external provider, the lead Party will refer the complainant to the external provider for resolution of their complaint. This may be done by either provision of contact details or by the lead Party passing the complaint on, depending on the approach preferred by the complainant.

11.1.7 Each Party will have a clearly defined description of what constitutes a complaint contained within its complaints handling documentation, although for consistency, and since the Scottish Public Services Ombudsman (SPSO) exercises regulatory and scrutiny functions over health and social care, it is reasonable to adopt the SPSO's definition of a complaint, which is '*an expression of dissatisfaction by one or more members of the public about the local authority's (or NHS) action or lack of action, or about the standard of service provided by or on behalf of the local authority (or NHS).*'

11.1.8 Should there be any data sharing requirements in relation to any complaint, the data sharing protocol referred to in Clause 10 of this Scheme (Information-Sharing and data handling) will detail how this will be managed.

11.1.9 All complaints will be signed off as per the lead Party's procedure. The Chief Officer will monitor the level and nature of complaints received.

11.1.10 Staff shall follow the complaints handling process of their employing Party. The employing Party will take responsibility for the triage of the complaint, and liaise with the other Party where required.

11.1.11 The current process for gathering service user/patient/carer feedback within the Parties, how it has been used for making improvements and learning, and how it is reported, will continue.

11.1.12 Existing performance information, and lessons learned relating to complaints investigations, will be collected and reported to the IJB in line with Clause 5 (Clinical and Care Governance and Professional Oversight) of this Scheme.

11.1.13 Performance information and lessons learned relating to complaints investigations will be reported to the IJB at its next meeting following reporting to the Dumfries and Galloway NHS Board or the Council's Audit and Risk Management Committee.

11.1.14 The proposed arrangements will be monitored and evaluated annually.

12. Claims Handling, Liability and Indemnity

12.1 The Parties and the IJB recognise that they could receive a claim arising from or which relates to the work undertaken on behalf of the IJB.

12.2 The Parties agree to ensure that any such claims are progressed quickly and in a manner which is equitable between them.

12.3 So far as reasonably practicable the normal common law and statutory rules relating to liability will apply.

12.4 Each Party will assume responsibility for progressing and determining any claim which relates to any act or omission on the part of one of their employees.

12.5 Each Party will assume responsibility for progressing and determining any claim which relates to any building which is owned or occupied by them.

12.6 In the event of any claim against the IJB or in respect of which it is not clear which Party should assume responsibility then the Chief Officer (or his/her representative) will liaise with the Chief Executives of the Parties (or their representatives) and determine which Party should assume responsibility for progressing the claim.

13. Risk Management

13.1 A standing risk management sub-group, consisting of voting and non-voting members of the IJB, will be established. The sub-group will:

13.1.1 Develop a risk management strategy by 31 December 2015 for approval by the IJB

13.1.2 Advise on the appropriate risk appetite for the IJB

13.1.3 Advise on any subsequent changes to the strategy and risk appetite, for approval by the IJB

13.1.4 Consider the effectiveness of the risk management process, ensuring that significant risks are being adequately managed

13.1.5 Monitor implementation of improvement action plans

13.2 The risk management strategy will:

13.2.1 Include the responsibilities of the Chief Officer, risk owners, and the Parties

13.2.2 Describe acceptable processes for mitigating risks

13.2.3 Propose that significant risks be reviewed every quarter by the risk management sub-group, along with progress on agreed actions

13.2.4 Set out the agreed reporting standard that will enable significant risks identified by the Parties to be compared across the Parties. These risks will be reviewed either annually or every six months. Information on risks will be effectively communicated through the use of a shared system to record and monitor any action being taken

13.3 The Parties will jointly identify, assess and prioritise risks related to the delivery of services under integration functions, particularly any which are likely to affect the IJB's delivery of the Strategic Plan, by 1 April 2016. Amendments to the risk register will be subject to scrutiny by the risk management sub-group.

13.4 The Parties will provide appropriate resource to ensure that the risk management of the IJB is delivered to a high standard.

14. Dispute resolution mechanism

Where either of the Parties fails to agree with the other on any issue related to this Scheme, then they will follow the process as set out below:

(a) The Chief Executives of the Parties will meet to resolve the issue;

(b) If unresolved, the Parties will each prepare a written note of their position on the issue and exchange it with the other within 21 calendar days of the meeting in (a);

(c) In the event that the issue remains unresolved, representatives of the Parties will proceed to mediation with a view to resolving the issue;

(d) A representative of each of the Parties will meet with a view to appointing a suitable independent person to act as mediator. If agreement cannot be reached a referral will be made to the President of the Law Society of Scotland inviting the President to appoint a person to act as mediator. The mediation process will commence within 28 calendar days of the meeting in (c); and

(e) Where the issue remains unresolved after following the processes outlined in (a) - (d) above, and if mediation does not allow an agreement to be reached within 6 months from the date of its commencement, or any other such time as the Parties may agree, either Party may notify Scottish Ministers that agreement cannot be reached.

Annex 1

Part 1 Functions delegated by NHS Dumfries and Galloway to the Integration Joint Board

Column A

Column B

The National Health Service (Scotland) Act 1978

All functions of Health Boards conferred by, or by virtue of, the National Health Service (Scotland) Act 1978

Except functions conferred by or by virtue of—
section 2(7) (Health Boards);

section 2CB(1) (functions of Health Boards outside Scotland);

section 9 (local consultative committees);

section 17A (NHS contracts);

section 17C (personal medical or dental services);

section 17I(2) (use of accommodation);

section 17J (Health Boards' power to enter into general medical services contracts);

section 28A (remuneration for Part II services);

section 48 (residential and practice accommodation);

section 55(6) (hospital accommodation on part payment);

section 57 (accommodation and services for private patients);

section 64 (permission for use of facilities in private practice);

section 75A(7) (remission and repayment of charges and payment of travelling expenses);

section 75B(8) (reimbursement of the cost of services provided in another EEA state);

section 75BA(9) (reimbursement of the cost of services provided in another EEA state where expenditure is incurred on or after 25 October

Column A

Column B

2013);

section 79 (purchase of land and moveable property);

section 82(10) use and administration of certain endowments and other property held by Health Boards);

section 83(11) (power of Health Boards and local health councils to hold property on trust);

section 84A(12) (power to raise money, etc., by appeals, collections etc.);

section 86 (accounts of Health Boards and the Agency);

section 88 (payment of allowances and remuneration to members of certain bodies connected with the health services);

section 98(13) (charges in respect of non-residents); and

paragraphs 4, 5, 11A and 13 of Schedule 1 to the Act (Health Boards);

and functions conferred by—

The National Health Service (Charges to Overseas Visitors) (Scotland) Regulations 1989 (14);

The Health Boards (Membership and Procedure) (Scotland) Regulations 2001/302;

The National Health Service (Clinical Negligence and Other Risks Indemnity Scheme) (Scotland) Regulations 2000;

The National Health Service (Primary Medical Services Performers Lists) (Scotland) Regulations 2004;

The National Health Service (Primary Medical Services Section 17C Agreements) (Scotland) Regulations 2004;

The National Health Service (Discipline Committees) (Scotland) Regulations 2006;

NOT PROTECTIVELY MARKED

Column A

Column B

The National Health Service (General Ophthalmic Services) (Scotland) Regulations 2006;

The National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009;

The National Health Service (General Dental Services) (Scotland) Regulations 2010; and

The National Health Service (Free Prescriptions and Charges for Drugs and Appliances) (Scotland) Regulations 2011(15).

Disabled Persons (Services, Consultation and Representation) Act 1986

Section 7

(persons discharged from hospital)

Community Care and Health (Scotland) Act 2002

All functions of Health Boards conferred by, or by virtue of, the Community Care and Health (Scotland) Act 2002.

Mental Health (Care and Treatment) (Scotland) Act 2003

All functions of Health Boards conferred by, or by virtue of, the Mental Health (Care and Treatment) (Scotland) Act 2003.

Except functions conferred by—

section 22 (approved medical practitioners);

section 34 (inquiries under section 33: co-operation)(16);

section 38 (duties on hospital managers: examination, notification etc.)(17);

section 46 (hospital managers' duties: notification)(18);

section 124 (transfer to other hospital);

section 228 (request for assessment of needs: duty on local authorities and Health Boards);

section 230 (appointment of patient's responsible medical officer);

section 260 (provision of information to patient);

<i>Column A</i>	<i>Column B</i>
	<p>section 264 (detention in conditions of excessive security: state hospitals);</p> <p>section 267 (orders under sections 264 to 266: recall);</p> <p>section 281(19) (correspondence of certain persons detained in hospital);</p> <p>and functions conferred by—</p> <p>The Mental Health (Safety and Security) (Scotland) Regulations 2005(20);</p> <p>The Mental Health (Cross border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2005(21);</p> <p>The Mental Health (Use of Telephones) (Scotland) Regulations 2005(22); and</p> <p>The Mental Health (England and Wales Cross-border transfer: patients subject to requirements other than detention) (Scotland) Regulations 2008(23).</p>
Education (Additional Support for Learning) (Scotland) Act 2004	
Section 23 (other agencies etc. to help in exercise of functions under this Act)	
Public Services Reform (Scotland) Act 2010	
All functions of Health Boards conferred by, or by virtue of, the Public Services Reform (Scotland) Act 2010	<p>Except functions conferred by—</p> <p>section 31(public functions: duties to provide information on certain expenditure etc.); and</p> <p>section 32 (public functions: duty to provide information on exercise of functions).</p>
Patient Rights (Scotland) Act 2011	
All functions of Health Boards conferred by, or by virtue of, the Patient Rights (Scotland) Act 2011	<p>Except functions conferred by The Patient Rights (complaints Procedure and Consequential Provisions) (Scotland) Regulations 2012/36(24).</p>

Part 2
Services currently provided by NHS Dumfries and Galloway which are to be integrated

- District General Hospital inpatient (scheduled and unscheduled)
- Diagnostic Services
- Community Hospital services
- Inpatient Mental Health
- Paediatrics
- Community Hospitals
- Hospital Outpatient Services
- NHS Community Services (Nursing, Allied Health Professionals, Mental Health Teams, Specialist End of Life Care, Older Adult Community Psychiatric Nursing, Re-ablement, Learning Disability Specialist, Community Midwifery, Speech and Language Therapy, Occupational Therapy, Physiotherapy, Audiology)
- Community Children's Services - Child and Adolescent Mental Health Service, Primary Mental Health workers, Public Health Nursing, Health visiting, School Nursing, Learning Disability Nursing, Speech and Language Therapy, Occupational Therapy, Physiotherapy and Audiology, and Community Paediatricians
- Public Health Practitioner services
- GP Services
- GP Prescribing
- General and Community Dental Services
- Hotel services and facilities management

Annex 2

Part 1 Functions delegated by the Council to the Integration Joint Board

Column A Enactment conferring function	Column B Limitation
National Assistance Act 1948(1)	
Section 48 (duty of councils to provide temporary protection for property of persons admitted to hospitals etc.)	
The Disabled Persons (Employment) Act 1958(2)	
Section 3 (provision of sheltered employment by local authorities)	
The Social Work (Scotland) Act 1968(3)	
Section 1 (local authorities for the administration of the Act)	So far as it is exercisable in relation to another integration function.
Section 4 (provisions relating to performance of functions by local authorities)	So far as it is exercisable in relation to another integration function.
Section 8 (research)	So far as it is exercisable in relation to another integration function.
Section 10 (financial and other assistance to voluntary organisations etc. for social work)	So far as it is exercisable in relation to another integration function.
Section 12 (general social welfare services of local authorities)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 12A (duty of local authorities to assess needs)	So far as it is exercisable in relation to another integration function.
Section 12AZA (assessments under section 12A - assistance)	So far as it is exercisable in relation to another integration function.
Section 12AA	

Column A Enactment conferring function	Column B Limitation
(assessment of ability to provide care)	
-Section 12AB (duty of local authority to provide information to carer)	
Section 13ZA (provision of services to incapable adults)	So far as it is exercisable in relation to another integration function.
Section 13A (residential accommodation with nursing)	
Section 13B (provision of care or aftercare)	
Section 14 (home help and laundry facilities)	
Section 28 (burial or cremation of the dead)	So far as it is exercisable in relation to persons cared for or assisted under another integration function.
Section 29 (power of local authority to defray expenses of parent, etc., visiting persons or attending funerals)	
Section 59 (provision of residential and other establishments by local authorities and maximum period for repayment of sums borrowed for such provision)	So far as it is exercisable in relation to another integration function.
The Local Government and Planning (Scotland) Act 1982(4)	
Section 24(1) (The provision of gardening assistance for the disabled and the elderly)	
Disabled Persons (Services, Consultation and Representation) Act 1986(5)	
Section 2 (rights of authorised representatives of disabled persons)	

Column A Enactment conferring function	Column B Limitation
Section 3 (assessment by local authorities of needs of disabled persons)	
Section 7 (persons discharged from hospital)	In respect of the assessment of need for any services provided under functions contained in welfare enactments within the meaning of section 16 and which are integration functions.
Section 8 (duty of local authority to take into account abilities of carer)	In respect of the assessment of need for any services provided under functions contained in welfare enactments (within the meaning set out in section 16 of that Act) which are integration functions.
The Adults with Incapacity (Scotland) Act 2000(6)	
Section 10 (functions of local authorities)	
Section 12 (investigations)	
Section 37 (residents whose affairs may be managed)	Only in relation to residents of establishments which are managed under integration functions.
Section 39 (matters which may be managed)	Only in relation to residents of establishments which are managed under integration functions.
Section 41 (duties and functions of managers of authorised establishment)	Only in relation to residents of establishments which are managed under integration functions.
Section 42 (authorisation of named manager to withdraw from resident's account)	Only in relation to residents of establishments which are managed under integration functions.
Section 43 (statement of resident's affairs)	Only in relation to residents of establishments which are managed under integration functions.
Section 44 (resident ceasing to be resident of authorised establishment)	Only in relation to residents of establishments which are managed under integration functions.
Section 45	Only in relation to residents of

Column A Enactment conferring function	Column B Limitation
(appeal, revocation etc)	establishments which are managed under integration functions.
The Housing (Scotland) Act 2001(7)	
Section 92 (assistance for housing purposes)	Only in so far as it relates to an aid or adaptation.
The Community Care and Health (Scotland) Act 2002(8)	
Section 5 (local authority arrangements for residential accommodation outwith Scotland)	
Section 14 (payments by local authorities towards expenditure by NHS bodies on prescribed functions)	
The Mental Health (Care and Treatment) (Scotland) Act 2003(9)	
Section 17 (duties of Scottish Ministers, local authorities and others as respects Commission)	
Section 25 (care and support services etc)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 26 (services designed to promote well-being and social development)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 27 (assistance with travel)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 33 (duty to inquire)	
Section 34 (inquiries under section 33: Co-operation)	
Section 228 (request for assessment of needs: duty on local authorities and Health Boards)	

Column A Enactment conferring function	Column B Limitation
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Section 259
(advocacy)

The Housing (Scotland) Act 2006(10)

Section 71(1)(b) (assistance for housing purposes)	Only in so far as it relates to an aid or adaptation.
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The Adult Support and Protection (Scotland) Act 2007(11)

Section 4
(council's duty to make inquiries)

Section 5
(co-operation)

Section 6
(duty to consider importance of providing advocacy and other services)

Section 11
(assessment Orders)

Section 14
(removal orders)

Section 18
(protection of moved persons property)

Section 22
(right to apply for a banning order)

Section 40
(urgent cases)

Section 42
(adult Protection Committees)

Section 43
(membership)

Social Care (Self-directed Support) (Scotland) Act 2013(12)

~~Section 3 (support for adult carers)~~

Section 5

Column A Enactment conferring function	Column B Limitation
(choice of options: adults)	
Section 6 (choice of options under section 5: assistances)	
Section 7 (choice of options: adult carers)	
Section 9 (provision of information about self- directed support)	
Section 11 (local authority functions)	
Section 12 (eligibility for direct payment: review)	
Section 13 (further choice of options on material change of circumstances)	Only in relation to a choice under section 5 or 7 of the Social Care (Self-directed Support) (Scotland) Act 2013.
Section 16 (misuse of direct payment: recovery)	
Section 19 (promotion of options for self- directed support)	
Carers (Scotland) Act 2016	
Column A Enactment conferring function Section 21 (duty to set local eligibility criteria) Section 6 (duty to prepare adult carers support plan) Section 24 (duty to provide support) Section 25 (provision of support to carers; breaks from caring) Section 31 (duty to prepare local carer strategy) Section 34 (information and advice services for carers) Section 35 (short break services statements)	Column B Limitation

Functions, conferred by virtue of enactments, prescribed for the purposes of section 1(7) of the Public Bodies (Joint Working) (Scotland) Act 2014

Column A
Enactment conferring function

Column
B
Limitation

The Community Care and Health (Scotland) Act 2002

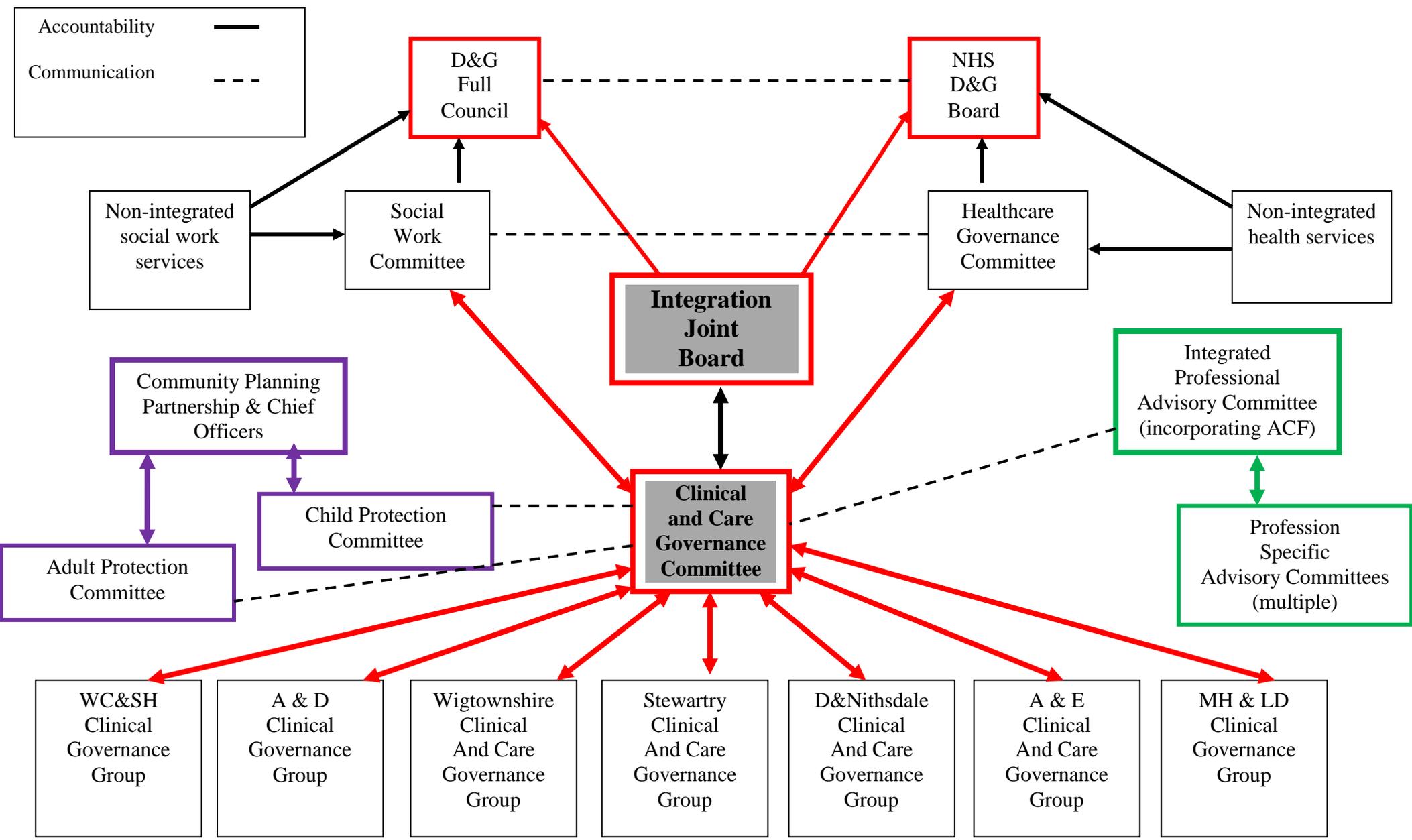
Section 4([13](#))

The functions conferred by Regulation 2 of the Community Care (Additional Payments) (Scotland) Regulations 2002([14](#))

Part 2

Services currently provided by the Council which are to be integrated

- Social work services for adults and older people
- Services and support for adults with physical disabilities and learning disabilities
- Mental health services
- Drug and alcohol services
- Adult protection and domestic abuse
- Carers support services
- Community care assessment teams
- Support services
- Care home services
- Adult placement services
- Health improvement services
- Aspects of housing support, including aids and adaptations
- Day services
- Local area co-ordination
- Respite provision
- Occupational therapy services
- Re-ablement services, equipment and telecare



DUMFRIES and GALLOWAY NHS BOARD

5th February 2018



Performance Report – At a glance

Author:

Ananda Allan
Performance and Intelligence Manager

Sponsoring Director:

Julie White
Chief Operating Officer

Vicky Freeman
Head of Strategic Planning

Date: 24th January 2018

RECOMMENDATION

The NHS Board is asked to note and discuss the monthly 'At A Glance' Performance Report (**Appendix 1**).

CONTEXT

Strategy/Policy:

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

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

This performance report is a monthly review of key current performance measures.

GLOSSARY OF TERMS

AHP	-	Allied Health Professionals
MSK	-	Musculoskeletal
TTG	-	Treatment Time Guarantee

MONITORING FORM

Policy/Strategy	Dumfries and Galloway Integration Joint Board Strategic Plan
Staffing Implications	None
Financial Implications	None
Consultation / Consideration	NHS Performance Committee
Risk Assessment	Risks will be considered by the NHS Board.
Sustainability	Individual measures can be an indicator of ongoing sustainability.
Compliance with Corporate Objectives	Performance against corporate objectives reported
Single Outcome Agreement (SOA)	Health Care
Best Value	<ul style="list-style-type: none"> • Governance and Accountability • Performance Management
Impact Assessment	
Not applicable	

Background

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

Key points from 'At A Glance' (Appendix 1)

2. **Treatment Time Guarantees** – These continue to be very challenging. The new doctor led outpatient appointments seen within 12 weeks is the lowest it has been in 15 months.

Recommendations

3. NHS Dumfries and Galloway Health Board is asked to note and discuss the NHS Board 'At A Glance' Report.

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	October 2017	November 2017	Last 3 Months (Sep 17 - Nov 17)	Last 3 Months Last Year (Sep 16 - Nov 16)	Direction	15 Month Trend
TTG (% waited under 12 weeks for Treatment)	100%	90.4%	86.2%	88.3%	91%	▽	
Dr Led New Outpatients (% waiting under 12 weeks at end of month)	95%	84.3%	82%	84.3%	90.3%	▽	
Diagnostics (% waiting under 6 weeks at end of month)	100%	98.9%	97.1%	98.4%	99.0%	▽	
AHP MSK (% waiting under 4 weeks at end of month)	90%	69.0%	73.7%	70.8%	85.4%	▽	
Cancer (Within 31 day target)	95%	97.6% (September 2017)	96.4% (October 2017)	95.3% Average (Aug 17 - Oct 17)	95.5% Average (Aug 16 - Oct 16)	▽	
Cancer (Within 62 day target)	95%	100.0% (September 2017)	100.0% (October 2017)	97.0% Average (Aug 17 - Oct 17)	95.2% Average (Aug 16 - Oct 16)	△	
18 Weeks Performance	90%	89.4%	87.8%	88.8% Average	90.2% Average	▽	
18 Weeks Linkage	90%	97.3%	97.9%	97.7% Average	97.0% Average	△	
Emergency Department (% Within 4 Hour)	98%	93.6%	92.0%	92.6%	95.0%	▽	
Emergency Department (Absolute Attendances)	▽	4,037	3,922	12,350	11,682	△	
Delayed Discharges (Bed Days Lost)	▽	1,081	1,068	3,149	3,713	▽	
Dr Led Return Tickets (Beyond Latest Date at end of month)	▽	4,059	4,029	12,043	18,057	▽	

DUMFRIES and GALLOWAY NHS BOARD



5th February 2018

Acute Services Redevelopment Programme Update on Hospital Migration and Initial Operational Issues

Author:
Jeff Ace
Chief Executive

Sponsoring Director:
Jeff Ace
Chief Executive

Date: 23rd January 2018

RECOMMENDATION

The Board is asked to note and consider the successful migration of acute hospital services to the new DGRI and the initial summary of operational performance of this site and that of the Mountainhall Treatment Centre.

The Board is asked to convey formal thanks for the outstanding assistance of our partner agencies including;

- Scottish Ambulance Service
- Police Scotland
- Scottish Fire Service
- Dumfries & Galloway Council

in facilitating the migration and note with thanks the efforts of our project team, staff and volunteers in managing this enormous undertaking successfully.

CONTEXT

Strategy / Policy:

The acute services redevelopment programme has been the cornerstone of the Board's aim of providing excellent services to those in need of acute care. The new hospital provides a facility designed to sustain acute services in the region for at least the next 60 years.

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

This is the largest, most complex and highest risk change programme undertaken by the Board and its success is critical to the safe care of some of our most vulnerable patients. The change directly affected the working environment of over 2,000 staff and required transfer of over 170 patients whilst maintaining seamless emergency, obstetric and critical care.

This paper highlights;

- The three day transfer of patients, staff and services was completed as planned. No significant deviations from plan were required.
- Processes put in place to ensure patient safety were effective and no patient harm occurred during the migration.
- Emergency and critical care services became operational at 8am on 8th December with full elective care (including outpatients and elective operations) operational from 10am on 11th December.
- Mountainhall Treatment Centre at the site of the old hospital was fully operational from 9am on 11th December.

The paper also considers the initial operational experience at the new site and updates Board on service provision at Mountainhall Treatment Centre.

The paper is not intended as a post project evaluation, which will follow in far greater detail at a later stage, but as an immediate update and assurance briefing to Board following migration.

GLOSSARY OF TERMS

<i>NHS</i>	-	<i>National Health Service</i>
<i>DGRI</i>	-	<i>Dumfries and Galloway Royal Infirmary</i>

MONITORING FORM

Policy / Strategy	This paper supports both national and local legislation that was adhered to by the Acute Services Redevelopment Project during the term of the project.
Staffing Implications	There are no staffing implications noted within this paper.
Financial Implications	There are no financial implications noted within this paper.
Consultation / Consideration	Regular updates to Performance Committee, Management Team and NHS Board throughout the term of the project.
Risk Assessment	Risk assessments were undertaken on all aspects of the project throughout its duration.
Sustainability	Not applicable
Compliance with Corporate Objectives	This paper and the overall project supports all Corporate Objectives.
Single Outcome Agreement (SOA)	Not applicable
Best Value	<ul style="list-style-type: none"> • Vision and Leadership • Performance Management • Use of Resources • Effective Partnerships • Equality
<p>Impact Assessment</p> <p>No impact assessment was undertaken as part of this paper, however, Impact Assessments were undertaken at various points throughout the duration of the project.</p>	

NHS Board Due Diligence Questions

1. At the NHS Board meeting of December 2017, Non Executive Members requested assurance on a number of key issues as set out in Appendix 1. The process of migration and initial operation has validated all assurances provided at that meeting.

The Migration Week

2. Support services such as laboratories were established in the new hospital in week beginning 3rd December to enable the transfer of patient services to begin as planned on 8th December. The migration was supervised by a three tier command structure;
 - Operational
 - Tactical
 - Strategic
3. which came into operation from around 6.30am on the 8th. At around 7.40am, Strategic Command had received all required assurances on readiness for move and Julie White, Chief Operating Officer, was able to declare formally the start of transfer of patients and staff to the new hospital.

Day 1: 8th December

4. Emergency Department, Combined Assessment, Critical Care, Orthopaedic ward and Women and Children's services (including maternity) transferred successfully. No patients came to harm in the move and there was no substantial deviation from plan.

Day 2: 9th December

5. Two medical wards and one surgical ward of patients were transferred successfully. The oncology department also moved across on this day. No patients came to harm in the move and there was no substantial deviation from plan.

Day 3: 10th December

6. One surgical ward, three medical wards and palliative care services transferred successfully. No patients came to harm in the move and there was no substantial deviation from plan.

Day 4: 11th December

7. Day 4 was part of contingency planning arrangements in case of deferred migration of any wards of services. This contingency was not required and, following a 'hot' debrief on the migration and on overall operational readiness, the hospital was declared ready for full elective work from 10am on 11th December. This concluded the migration process.

Initial Operational Experience

8. The hospital has opened in particularly challenging circumstances. NHS D&G is experiencing its busiest winter on record for acute admissions and is managing substantial numbers of vacancies of clinical staff. In this context, key operational performance issues to note include;
- Our half-ward future-proof capacity intended to meet demographic growth pressures in the 2020s was opened on 30th December. This increased bed capacity to 10 more than available in the old hospital but led to increased pressures on staffing. It is our intention to close these surge beds as soon as safely possible.
 - We have seen unprecedented demand for critical care and for patients requiring ventilation. We have repeatedly ventilated six patients simultaneously (and on occasion seven), considerably in excess of the four patient capacity at the old hospital.
 - Performance against the four hour target for emergency patients has deteriorated due to bed pressures but remains above Scottish average for this winter.
 - The Combined Assessment Unit has been consistently operating at full capacity and we will review both patient flow and staffing arrangements in this area to ensure best patient and staff experience.
 - We underestimated the impact of contractor vehicles and additional staffing (during the annual leave moratorium) on car park capacity in the first few days of opening. The problem was exacerbated by high visitor numbers and the unavailability of the final 50 spaces currently under construction. Increased use of the excellent public transport available and the introduction of a staff shuttle bus between DGRI and the Mountainhall site have improved the parking situation somewhat. We will review demand and capacity again following opening of the additional capacity in February and introduce further measures if required.
 - There has been a degree of publicity over poor mobile phone coverage in the area. As reported to the Board, we have installed all required infrastructure for mobile providers to boost and distribute their signal through the hospital systems and are in unfortunately protracted discussion with the companies to try to accelerate their adoption of this service.
 - All major equipment and infrastructure at the new site has performed to expectations. Minor snagging works are ongoing and will continue as part of our support contracts.

Mountainhall Treatment Centre

9. During the migration weekend NHS estates teams worked to amend access and signage at the old hospital facility in order for Mountainhall Treatment Centre to be fully operational from Monday 11th December. Further reconfiguration will be undertaken to improve the environment for patients and staff during the transitional period before migration into the redeveloped Creswell Unit. NHS Board will receive regular updates on this critical project which is now the Board's largest infrastructure change programme.

Conclusions

10. Migration of acute services was achieved successfully due to the quality of planning from our project team and the efforts of NHS and partner agency staff over the three day period. Initial operational experience at the new hospital has been positive and its additional capacity, particularly in critical care, has proven invaluable during the winter surge in admissions.

NHS D&G Board Due Diligence DGRI and Mountainhall Treatment Centre

In advance of the 8th December 2017 migration and management of change date it is important to complete the Board's own final stage due diligence to provide the necessary assurance that all necessary steps have been taken and appropriate risk management arrangements have been adopted.

The Board meeting of 4th December 2017, whilst not examining operational detail, should reassure itself on the following issues recognising of course that comprehensive progress and issues reports have been presented to and discussed by the Performance Committee throughout the project lifecycle.

Construction

- 1) Has the independent tester signed off the schedule of inspections that they were commissioned to undertake and given assurance that in their professional opinion that the new hospital is fit for purpose and ready for occupancy as a fully functioning district general hospital?
- 2) Has the Board had sight of and recorded receipt of the Building Completion Certificate issued by the Council's Building Standards Department?
- 3) Has all other necessary certification to operate the facility been received?

Operational Infrastructure

- 4) Have all key pieces of equipment and infrastructure been calibrated, tested and signed off by the suppliers and Board's technical and professional officers?
- 5) Have environmentally controlled spaces and water/ air quality tests been undertaken and signed off?
- 6) Have telecommunication, WIFI and police Airwave systems been delivered to a state of completion that provides adequate opening day service?

Management of Change

- 7) Have all workstream leads satisfied the Programme Board that sufficient progress has been made to give confidence that 8th December opening date is appropriate consistent with the Risk Management Framework that has been adopted for the project?
- 8) Have all stakeholder / partner organisations confirmed their readiness and support for an 8th December opening date?

Command Structure

- 9) Is the Programme Board satisfied that the Gold, Silver and Bronze command structure has been adequately tested and is equipped for the challenging task ahead?

General

- 10) Are there any other important issues that the Board should be aware of and any decisions that the Board, not the Executive, need to be prepared to make?

Philip N Jones
Chairman NHS Dumfries and Galloway
29 November 2017

DUMFRIES and GALLOWAY NHS BOARD

5th February 2018



Capital and Infrastructure Update 31st December 2017

Author:
Susan Thompson
Deputy Director of Finance

Sponsoring Director:
Katy Lewis
Director of Finance

Date: 3rd January 2018

RECOMMENDATION

The Board is asked to approve:

- The allocations received to date
- The budget adjustments required

The Board is asked to note:

- The capital expenditure incurred to date
- The update on the 2017/18 programme of works

CONTEXT

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 £40.6m have been received from the Scottish Government Health and Social Care Directorate (SGHSCD) to the end of December 2017.

Expenditure of £36.129m has been incurred to the end of December 2017 which includes the final NPD asset addition.

GLOSSARY OF TERMS

ASRP	-	Acute Services Redevelopment Project
CIG	-	Capital Investment Group
CRL	-	Capital Resources Limit
CSSD	-	Central Sterilisation Services Department
D&G	-	Dumfries and Galloway
DRC	-	Depreciated Replacement Cost
FBC	-	Full Business Case
HFS	-	Health Facilities Scotland
IM&T	-	Information Management & Technology
LDP	-	Local Delivery Plan
MYR	-	Mid Year Review
NPD	-	Not for Profit Distribution
OBC	-	Outline Business Case
SGHSCD	-	Scottish Government Health and Social Care Directorate
YTD	-	Year to Date

MONITORING FORM

Policy/Strategy Implications	Capital Plan, Property Strategy & IM&T Strategy
Staffing Implications	Not applicable
Financial Implications	Capital charge and recurring revenue consequences built in as part of the financial planning and reporting cycle
Consultation / Consideration	Capital Investment Group, Management Team and Performance Committee
Risk Assessment	No
Sustainability	The Capital Plan supports the sustainability agenda through the delivery of capital schemes in line with the property strategy and efficiency procurement of equipment.
Compliance with Corporate Objectives	To maximise the benefit of the financial allocation by delivering efficient services, to ensure that we sustain and improve services and support the future model of services.
Single Outcome Agreement (SOA)	Not applicable
Best Value	This paper contributes to Best Value goals of sound governance, accountability, performance scrutiny and sound use of resources.
Impact Assessment	Not Applicable

Allocations Update

- Table 1 below shows the anticipated allocations from SGHSCD for capital. To the end of December 2017, a capital allocation of £40.6m has been received.

Table 1

ANTICIPATED ALLOCATIONS	Budget Approved Dec 2017 £000	Budget Adjustments Required £000	Budget Requested Feb 2018 £000	Allocation Received to Date £000
Formula allocation	3,475	0	3,475	3,475
NPD - Asset Addition	26,428	0	26,428	26,428
NPD - Enabling Funding	27,101	0	27,101	27,101
NPD – Equipping Fees	0	0	0	0
Capital to Revenue	-5,000	-2,000	-7,000	-7,000
Return of 2016/17 virement	1,566	0	1,566	1,566
Virement 2017/18	0	-11,000	-11,000	-11,000
Ophthalmology Equipment		30	30	30
	53,570	-12,970	40,600	40,600

- Following agreement with SGHSCD, the allocation adjustments detailed below require approval.
- A capital to revenue transfer of £5m was previously approved to cover items which do not meet the capital criteria. Following a further review of the new build equipment that has cost less than £5k capital threshold, an additional £2m transfer is requested.
- As part of the approved Acute Services Redevelopment Project (ASRP) business case, £33.8m was approved for supporting equipment expenditure. This was profiled across a number of years to support the replacement of equipment for the opening of the hospital as well as the ongoing replacement of equipment transferred in future years. Equipping is nearly complete for this financial year and as a result a re-profile of £11m has been agreed with SGHSCD.
- The table below shows a summary of the £11m movement by category.

Table 2

Budget Allocated	Equipment £m	IT £m	Contingency £m	CSSD £m	Total £m
Original	19.62	4.06	2.58	0.64	26.90
Revised	12.52	3.12	0.17	0.21	16.01
Movement	7.10	0.94	2.42	0.43	10.89

NOT PROTECTIVELY MARKED

6. There are a variety of reasons behind the reduction which are detailed below:
- A 10% contingency was set aside to cover unforeseen price changes, additions to the equipment requirements and any impact of changes to transfer levels. A sum was approved and allocated for RFID tagging which is a system to support the tagging of medical equipment. The price increases envisaged did not materialise and where they did were offset by other price decreases. Transfers increased rather than decreased therefore no additions were required. £2.42m remains to be re-profiled over future years.
 - A number of the IT projects continue to be ongoing, with £0.94m to be re-profiled over future years.
 - Additional budget was included for CSSD instrumentation as a result of providing the service off site. Currently the service has only requested an element of this budget until the hospital is fully operational and any residual requirements can be assessed as the service settles into business as usual. £0.43m remains to be re-profiled over future years.
 - From the equipment database, it can be identified that 1,512 items which were budgeted as replacement purchases in 2017/18 have not been purchased, the number of transfers has increased by 1,735. £3.7m remains to be re-profiled over future years to support these purchases.
 - The £33.8m was based on estimated prices calculated from the equipment database pulled together by HFS at the time of developing the FBC. The net effect of price changes is £3.4m lower than originally estimated. This requires to be re-profiled into future years to ensure sufficient budget is available to cover the replacement of transfer equipment that will require to be replaced.
7. A new allocation has been received as a contribution to an OCT machine in Stranraer which is used in Ophthalmology. This was a specific bid made to SGHSCD by the service for funding. The procurement process is underway and the remaining budget required for the purchase will be supported by the Boards development programme. The cost is anticipated to be circa £70k.
8. A further allocation is anticipated to cover the equipping fees that are being incurred from Health Facilities Scotland for the New Hospital. A final estimate is not yet known, this will be updated in due course.

Budget and Expenditure Update

9. To the end of December, £36.129m of expenditure has been incurred on the capital programme including the NPD Addition.
10. Table 3 below shows the budget approved by Board in October 2017, the changes that require approval as a result of allocation changes and the expenditure to date end of December 2017.

Table 3

CAPITAL EXPENDITURE PLAN	Approved Budget Oct 2017 £000	Changes for Approval £000	Budget Requested Dec 2017 £000	Capital Expenditure to Dec 17 £000
ASRP – Equipment	22,101	-11,038	11,063	8,917
ASRP – Cresswell	1,649	-300	1,349	418
ASRP – Asset	26,428	0	26,428	26,428
Replacement, Contingency, Development	3,392	-1,632	1,760	366
Total	53,570	-12,970	40,600	36,129

11. The opportunity has been taken to show the capital to revenue transfer of £7m against the correct budget lines, this had previously all been shown against ASRP – Equipment.

12. Details of the individual programmes are included in **Appendix 1**.

Recommendation

13. The Board is asked to approve:

- The allocations received to date
- The budget adjustments required

14. The Board is asked to note:

- The capital expenditure incurred to date
- The update on the 2017/18 programme of works

Details on Programme Budgets**ASRP Equipment**

1. £33.8m was approved as part of the Acute Services Redevelopment Project (ASRP) business case for equipping the New Hospital.
2. As has been highlighted within the paper, SGHSCD have agreed to re profile £11m of this budget to future years to reflect the equipment purchases at this time.
3. Expenditure on equipping continues to increase as orders are receipted following delivery and invoices are paid. Table 4 below shows the progress of the orders which have already been placed for the equipping project.

Table 4

	Hospital Equipment via HFS	IT Equipment via Local IT Team	Other Equipment via Local Team	Total
	£000	£000	£000	£000
Receipted and Paid	6,730	1,245	185	8,160
Ordered Not Yet Receipted	5,603	2,041	210	7,854
As at 31/12/17	12,333	3,286	395	16,014

ASRP Cresswell

4. This budget was approved as part of the ASRP business case for the delivery of the Cresswell Building Project and further amendments approved as part of the OBC Addendum approved by CIG in June 2017 as per Table 5 below.

Table 5

Funding Approved in Addendum	£
NHS Dumfries & Galloway	2,000
Scottish Government - already approved	13,989
Scottish Government - additional support	1,510
	17,499

5. The budget allocated in 2017/18 is to support the fees associated with progressing the business case and design works to the next stage with the submission of the FBC addendum anticipated in early 2018. £300k of the 2017/18 budget is anticipated to be incurred on costs that are revenue in nature and have been included in the £7m capital to revenue transfer.
6. Expenditure continues to remain on target within the existing project plan.

ASRP NPD Addition

7. This budget relates to the technical accounting entry which is required to bring the NPD asset onto the balance sheet. This is based on certified work completed on the construction programme. The construction is now complete with a final construction cost of £212.5m added to the Balance Sheet as previously reported.
8. The Board has requested the appointed valuers to complete the first formal valuation of the building following completion. This is likely to reduce the holding value as it is held at Depreciated Replacement Cost (DRC). Impairment funding is provided by SGHSCD to cover this movement. This remains outstanding at this time.

Replacement Programme including Contingency

9. This budget covers all capital equipment or plant which requires to be replaced. This is devolved to Capital Investment Group (CIG) to manage at a local level.
10. Table 6 shows the current commitments against the programme for both replacement and contingency.

Table 6

Directorate	Item	Anticipated Expenditure £
Primary and Community Care	Lochmaben Hospital Stroke and Rehab Unit	307,000
Acute & Diagnostics	2 Field Analysers	72,577
Acute & Diagnostics	4 Diagnostic sleep study sets	26,400
Acute & Diagnostics	Ultrasound Echo Machine	11,753
Acute & Diagnostics	GCH Endoscope Reprocessor - linked to NB	181,000
Acute & Diagnostics	Analyser Coagulation	48,000
Acute & Diagnostics	Blood Track Kioak	5,100
Acute & Diagnostics	Endoscope Cabinet	23,000
Acute & Diagnostics	Dialysis Machines	60,000
Operational Services	Annan Hospital AHU and infrastructure	40,000
Operational Services	GCH renal replacement RO & Loop	100,000
Replacement		874,830
Acute & Diagnostics	Biometer	36,365
Acute & Diagnostics	Ventilator	14,174
Acute & Diagnostics	Dialysis machine	15,000
Acute & Diagnostics	2 x UV Hand and Foot Treatment Lamps(Dermatology)	21,060
Contingency		86,599

Development Programme

11. This budget is set aside to cover any developments which the Board or CIG have approved. This budget covers all developments; equipment, IT equipment and property developments. All developments approved have a revenue consequence and this requires to be funded separately through the Revenue Plan. Table 7 shows the schemes approved to proceed so far.

Table 7

Directorate	Item	Anticipated Expenditure £
Operational Services	Residences Room Management System	744
Ehealth	Critical Care system	184,000
Operational Services	Electronic Bedside Ordering	15,876
Operational Services	Bariatric Concealment Mortuary Trolley	12,010
Primary and Community Care	Communication Equipment SPLT	6,893
Ehealth	Portal	50,400
Ehealth	GP Digital Services	38,037
Acute & Diagnostics	Ophthalmology Equipment	70,000
Development		377,960

12. No issues have been identified with the delivery of these schemes within 2017/18.

Other programmes for which no budget allocated

Primary Care Premises

13. It is recognised that there are a number of challenges and opportunities around our Primary Care infrastructure and this is being considered by the Locality Managers. Initial work has commenced to develop infrastructure plans for each of the four localities to support the Health and Social Care Locality plans. More detail will be presented as these plans emerge but it is recognised that this is a critical element of our overall capital, infrastructure and service planning.

14. No budget has been set aside in 2017/18 for this.

Donated Assets

15. Donated assets are not funded from within the Boards allocation. Donated assets are typically funded from League of Friends and the Boards Endowment Funds.
16. No donated assets have been received or indicated for 2017/18.

DUMFRIES and GALLOWAY NHS BOARD



5th February 2018

Financial Performance Update 2017/18 Position to Month 9 as at 31st December 2017

Author:
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Sponsoring Director:
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Date: 17th January 2018

RECOMMENDATION

The NHS Board is asked to note:

- The financial position to month 9 2017/18.
- The ongoing financial risks and challenges identified in the underlying financial position.
- The current financial position for the services delegated to the IJB.
- The updated position on Efficiency Savings for 2017/18.
- The ongoing pressure and growth on External Service Level Agreements (SLAs) with both Scottish and English Providers.
- The assessment of the Scottish Government Budget for 2018/19 and the Draft Financial Plan for 2018/19.

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:

This report provides an update on the Year to Date (YTD) financial performance as at the end of December 2017, nine months into the financial year.

The NHS Board is reporting an overspend position of £616k as at the end of December which is an improved position as compared with November, and is in line with the improved forecast of break-even by the end of the year. The £616k adverse variance to plan relates to the current level of unidentified efficiency plans still to be resolved, increased levels of activity sent outwith NHS Dumfries and Galloway and growth in Prescribing costs.

This underlying position is being offset with non-recurrent funding, providing additional time for the Directorates to continue to work towards achieving further Cash Releasing Efficiency Savings (CRES) recurrently.

Achievement of the remaining CRES target is the focus of the Board in ensuring sustained recovery of the financial position. CRES of £22.6m is required to be delivered in-year to deliver a break-even position. To date, almost £12.9m of schemes have been identified against a year to date target of £13.1m (99%), which excludes any non-recurring support yet to be released from reserves. The focus remains on the Directorates' plans to identify further progress on the delivery of their efficiency plans and control of expenditure on a recurring basis.

The recurring gap on CRES is now £9.7m as at the end of December (£9.8m in November).

The key areas for ensuring a sustained recovery continue to be:

- Control of medical locum expenditure and recruitment to remaining vacancies.
- Identification of additional saving schemes where there still remains a shortfall in the achievement of efficiency plans.
- Driving robust delivery profiles for 2017/18 plans and follow through of transformative plans already identified.
- Ongoing focus of achieving a breakeven position for 2017/18.
- Identification of transformational plans to deliver recurring savings moving into 2018/19 and beyond.

GLOSSARY OF TERMS

AME	-	Annually Managed Expenditure
CRES	-	Cash Releasing Efficiency Savings
CRL	-	Capital Resource Limit
DEL	-	Department Expenditure Limit
FHS	-	Family Health Services
FHS	-	Family Health Services
IJB	-	Integrated Joint Board
LDP	-	Local Delivery Plan
NMF	-	New Medicines Fund
NRAC	-	National Resource Allocation Formula
PASS	-	Patient Advice & Support Service
PCCD	-	Primary and Community Care Directorate
PFI	-	Private Finance Initiative
PPP	-	Public-private partnership
RRL	-	Revenue Resource Limit
SLA	-	Service Level Agreement
YTD	-	Year to Date

MONITORING FORM

Policy/Strategy	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 Team
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. The Board is now forecasting to achieve a break-even position, through a variety of non-recurring funding streams. The level of the recurrent gap remains at £9.7m
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>A detailed impact assessment of individual efficiency schemes will be undertaken through this process as individual schemes are developed.</p>

Summary Update 2017/18: Year to Date Position

1. NHS Dumfries and Galloway is reporting an overspend of £616k against the budget to date as at the end of December 2017. This is an improvement of £375k in line with the revised break-even position by the year end.
2. The Board has received allocations to date of £343.6m, with £12.4m remaining as anticipated allocations. The majority of the anticipated allocations yet to be issued relate to the funding of the New Hospital's unitary charge and depreciation costs as well as the transitional monies in-year. Further detail is provided in **Appendix 1**.
3. The table below provides a high level summary of the income and expenditure position for the services delegated to the IJB and the NHS Board services, showing the variance against plan for the first nine months of the financial year:

Table 1

Service	YTD Budget £000s	YTD Actuals £000s	YTD Variance £000s	YTD Variance %
IJB Delegated Services	211,991	213,737	(1,746)	-1%
NHS Board Services	38,354	37,223	1,132	4.0%
Total NHS Board	250,346	250,960	(616)	-0.2%

Month 9 Financial Position - Delegated Services to IJB

4. Table 2 below summarises the current year to date position by main expenditure category for services delegated to the IJB:

Table 2

Expenditure Type	Annual Budget £000s	YTD Budget £000s	YTD Actuals £000s	YTD Variance £000s	YTD Variance %
Pays	154,604	114,615	113,811	804	0.70%
Non-pays	89,868	67,270	68,675	(1,406)	-2.49%
Drugs	49,133	36,869	38,064	(1,194)	-3.78%
Income	(8,602)	(6,764)	(6,813)	50	0.74%
Total	285,003	211,991	213,737	(1,746)	-0.82%

5. Within this position is the year to date under achievement on CRES schemes, mainly related to Non-pays and Drugs. Of the planned £11.4m CRES to date, only £10.0m has been achieved, leaving a year to date under achievement of £1.34m. The amount of recurring schemes identified is expected to be £5.5m, leaving a recurring gap on CRES of £8.1m.
6. Within the overall CRES delivered to date, prescribing accounts for £3.3m of the year to date target, with a year to date achievement of only £2.3m, contributing £1m towards the YTD adverse variance.

7. This level of overspend is offset with the underspend across Pays, reflecting the level of vacancies across the system as a whole, mainly within Acute and Diagnostics (£181k), Primary and Community Care Directorate (PCCD) (£309k), Facilities (£175k) and E-Health (£131k).
8. The table below provides a high level summary of the IJB year to date position by Directorate.

Table 3

	Pays Variance	Non- pays variance	Drugs Variance	Income Variance	Total variance
IJB DELEGATED SERVICES	£000s	£000s	£000s	£000s	£000s
Acute & Diagnostics	181	(884)	168	(23)	(558)
Facilities & Clinical Support	175	(449)	0	3	(272)
Mental Health	(67)	141	(76)	4	1
Primary & Community Care	309	(557)	(1,209)	41	(1,416)
Women's & Children's	18	24	(78)	0	(35)
E-Health	131	(404)	0	8	(265)
Strategic IJB Services	57	(2)	0	17	(72)
Property CRES	0	(327)	0	0	(327)
IJB Unidentified CRES	0	1,053	0	0	1,053
IJB SERVICES TOTAL	804	(1,405)	(1,194)	50	(1,746)

9. Key Variances within the IJB:

Acute and Diagnostics - £558k overspend

- The Directorate is overspent by £558k as at 31st December 2017, an in month favourable variance of £185k.
- The underspend in month is an interim position due to the transition and migration during December of DGRI to the new site and the phasing of released budgets relating to new staffing levels. These should rectify themselves by the end of January when more accurate costs will be available. The forecast position for the directorate has not changed but will continue to be monitored closely.
- Pays – £181k underspent
- Acute and Diagnostics main underspends relate to vacancies across the nursing areas in the Surgical wards and the Galloway Community Hospital. Labs are underspent by £155k due to the current number of vacancies. Pressures in Radiology, due to recruitment difficulties in ultrasound and use of agency, and medical wards pays offset the overall pay underspend by £224k.

- Non-pays are now £716k overspent, with £443k of this related to unachieved CRES and £80k of remaining Prescribing CRES. However, continued underspends across prescribing areas are off-setting the remaining level of CRES target to be identified. The remaining pressures reflect activity being outsourced to the Nuffield in Radiology (£82k), travel and patient transport (£117k), Labs pressures on managed service in Biochemistry (£141k) and Audiology costs of hearing aids (£61k).
- Income is now £23k below plan, mainly due to decreased revenues taken within the Catering Department at DGRI.

Facilities and Clinical Support - £272k overspend

- The Directorate is overspent by £272k year to date, with an in month adverse variance of £29k.
- The directorate remains underspent on Pays by £175k due to a number of vacancies across the directorate. This has slowed down since the beginning of the year with a number of posts filled or taken to CRES, however, the directorate continues to carry a level of vacancies. Of the £175k year to date underspend, £145k relates to vacancies and unfilled posts within Property Services and Maintenance. These areas are currently under review with regards to restructuring, the New Hospital and CRES savings.
- The directorate has overspent by £449k on Non-pays up to month 9. However, with £176k of this related to unachieved CRES. December has seen a £70k overspend, mainly related to the overspends within heating, light and power, now £71k over YTD, Laundry, £54k YTD and waste, £19k over YTD on clinical waste and £103k YTD on 'black bag' waste.

Mental Health - £1k underspend

- Pays £67k overspent, offset by underspends of £65k in Non-pays budgets.
- The main areas of Pays variances are overspends within Learning Disabilities £176k and Medical £34k offset by underspends in Community £35k, Occupational Therapy £34k and Psychology £39k.
- Non-pays are underspent across the Directorate as a whole, with the IDEAS team in Community Mental Health - £34k, and £24k underspends across police custody. The remaining underspends relate to travel/training and recruitment of £7k year to date. Unfavourable shift of £32k mainly due to higher package costs agreed with Dumfries and Galloway Council in Learning Disabilities, £5k unachieved Drugs CRES, £7k voice recognition software purchase in month.

- Drugs is £46k overspent YTD relating to the level of unidentified CRES - £35k YTD and the increases in the cost of certain drugs as well as an overall increase in use, reflecting the case-mix of patients being treated within community services.

Primary and Community Care - £1,416k overspend

- The main variance within Primary Care continues to be across Prescribing, reflecting the level of unidentified and unachieved CRES, as well as the increased costs associated with short-supply issues - £1,209k in total.
- Of this year to date overspend in Primary Care Prescribing, £975k relates to unidentified CRES, with a total forecast gap of £1.3m still to find.
- Further pressures on volume increases combined with increased levels of drugs identified as being on short supply, contribute to the remaining pressure. Overall, volume as at end November 2017, is a 2.42% reduction from 12 months ago, but with price and drug mix impacts reflecting the increasing cost base this year.
- The remaining unidentified Directorate CRES now stands at £267k, which is offset by the underspend across Pays of £309k.
- The main areas of underspend within Pays relates to the level of vacancies across Nursing - £133k, AHP - £75k, Health Sciences - £52k and Admin posts - £57k. Medical budgets are £22k overspent YTD.

Women & Childrens' Directorate - £35k overspent

- The Women, Children and Sexual Health Services Directorate is reporting an overall overspend of **£35k** to December 2017.
- Pays are underspent across the following areas due to vacancies – Ward 15 - £26k, Neonatal - £25k, Learning Disability, £24k, Public Health - £45k and Midwifery - £54k. The pressure on medical pays budgets of £163k relates to the locum pressures across Obstetrics and Gynaecology and Paediatrics, which is offset by the above underspends.

E-Health - £265k overspend

- The largest pressure within the Non-pays overspend of £404k, relates to £249k on increased service contracts year to date and the level of unidentified CRES YTD – 155k. Finance are working with the service to understand in more detail the pressures impacting upon the service contracts since the opening of the New Hospital (DGRI).
- Work progresses with E-Health management to identify the ongoing pressures associated with increasing service contract expenditure, some of which is attributable to the move to the New Hospital.

- The Pays underspend of £131k, reflects the general level of vacancies across the Directorate, off-setting the pressures on Non-pays.

Strategic Services - £72k underspend

- The main variance within this Directorate relates to the Pays underspend of £57k, which relates to vacancies within the Health Intelligence Unit of £37k YTD and within Strategic Planning of £27k.

10. Further detail on the year to date position by directorate is included in **Appendix 2**.
11. The expenditure on medical locums has increased this year as compared to 2016/17, which is reflective of two key issues. The first relates to the overall level of vacancies are higher in the first six months of this year compared to previous years, averaging a 25% vacancy rate overall. The second issue reflects the changing market on the provision of agency staff generally after the implementation of IR35. This has led to an overall increase in the rate of pay for medical locums which has been managed through our engagement with Retinue. It is estimated that the impact of IR35 has led to a 15% increase in the average hourly rates charged by temporary staff and agencies, reducing the expected level of savings on medical staffing by over £500k this year.

Services Retained by the Health Board

12. Overall the functions not delegated to the IJB and retained by the Health Board are reporting a year to date underspend of £1.1m. These include all of the corporate budgets managed directly by the NHS Directors and External Contracts with other Health Boards and external companies.
13. The main variances relating to Health Board corporate services is summarised in the table below

Table 4

Health Board Non-delegated Services	Pays Variance	Non-pays variance	Drugs Variance	Income Variance	Total variance
	£000s	£000s	£000s	£000s	£000s
Chief Executive	23	(45)	20	0	(3)
Public Health	(35)	89		(11)	43
Medical Director	199	18	(120)	(62)	35
Nursing Directorate	72	12		(3)	82
Workforce Directorate	96	(36)		2	63
Finance Directorate	63	(24)		10	50
Non Recurring Projects	(24)	25		0	1
Strategic Capital	(1)	(67)		30	(38)
Central Income	0	0		(49)	(49)
Externals	0	(1,252)		226	(1,026)
Board Unidentified CRES	0	1,973		0	1,973
IJB SERVICES TOTAL	394	694	(100)	144	1,132

14. The main variances in the Corporate areas are as follows:

- Pays are £394k underspent, reflecting the level of variances across Medical Director (Dental services), Workforce, Nursing Directorate and Finance. Directors continue to manage vacancies conservatively in supporting the CRES target non-recurrently.
- Whilst Non-pays are £694k underspent YTD, there is an underlying pressure across External SLAs of £1,252k YTD, showing the level of growth in activity being sent outwith the Board. In particular, as identified above, activity at both Newcastle and Carlisle has increased, with ongoing increases being seen across high cost excluded drugs recharged by Glasgow, Lothian and English Trusts.
- Non-recurrent support of £1.97m has been identified as reported in the Mid-year Review, as the NHS Board moves to a break-even position overall.

Efficiency Savings

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

Table 4

	Total 2017/18 Target £000	Total 2017/18 Schemes £000	In Year 2017/18 CRES Gap £000	2017/18 Recurring CRES Gap £000
IJB Delegated services	15,214	13,448	(1,766)	(8,078)
NHS Board services	7,421	9,052	1,631	(1,623)
TOTAL	22,635	22,500	(135)	(9,701)

16. As identified above, there is currently a significant level of unidentified recurring CRES outstanding as at month 9 (£9.7m).
17. The level of unidentified Prescribing schemes in-year is £1.38m. The recurring gap on Prescribing CRES as at month 9 now stands at £2.1m.
18. A breakdown of CRES by Directorate is provided in **Appendix 3**. The current forecast gap on 2017/18 CRES is £135k, which includes overall non-recurring corporate support of £11.2m, leaving a recurring gap of £9.7m. Within the overall level of CRES identified, 33% are classified as high risk, with 5% medium risk and 62% low risk. Currently, the in-year gap of £135k accounts for 0.6% of the total CRES target.

Key Actions and Recommendations

19. Significant work remains across the organisation in order to identify and progress plans that will create further opportunities to release additional savings in-year and in particular identify more schemes on a recurring basis.

20. The year to date position reflects this level of risk by assuming that all high risk schemes are profiled in equal 12ths until such time there is confirmation that they are going to be achieved.
21. The IJB continues to pursue further opportunities to identify CRES in-year and is working closely with the Finance team to identify and agree transformational schemes to identify recurring plans for efficiency moving forwards. At this time, whilst the IJB's year to date position reflects a £1.7m overspend, managers are actively reviewing all other means of identifying further recurring and non-recurring initiatives.

Financial Plan 2017/18

22. The LDP submitted by Dumfries and Galloway Health Board (confirming the level of NHS delegated budgets to the IJB) demonstrated an in-year financial gap of £6m.
23. Since the submission of the LDP to the Scottish Government, all Directorates have continued to re-assess the level of efficiency plans identified within their services to ensure that all schemes identified will be delivered.
24. Directorates are currently reviewing the month 9 position to produce an updated Quarter 3 review position. The Board is still forecasting a break-even position, assuming all CRES schemes identified are delivered and Directorates' positions do not deteriorate further.

Financial Risks

25. The Financial Plan for 2017/18 reflects all known financial risks and these have been highlighted as part of the LDP process and include the following:
 - Deliverability of CRES – both from a recurrent and non-recurrent position.
 - Identification of further options/ flexibility required to close the in-year £0.1m gap.
 - Assessment of the increasing requirement and impact of medical temporary staffing across all sites and services (an overall increase of £2m over the LDP assessment).
 - Transition to the opening of the New Hospital.
 - Review of Primary Care Prescribing practices and growth.
 - Review of Secondary Care Prescribing Services.
 - Growth on activity sent out of area to other providers.
26. It is envisaged that given the increase in medical staffing vacancies during 2017/18, this will impact on the adequacy of our locum reserve, despite the savings envisaged through the implementation of Retinue. This will require services to monitor the level of demand and supply of medical locums to ensure they remain within the available budget set aside this year.

Key Actions and Recommendations

27. Whilst plans continue to be developed across all services, there remains a significant level of work to be undertaken to close the £9.7m recurring gap which will be reported to Scottish Government.
28. Further work is required across all corporate areas to fully embrace the principals of shared services and regional working to ensure the maximum level of service efficiency and effectiveness is delivered in the coming months.
29. The Clinical Efficiency Group (Realistic Medicine) will be supported by Health Intelligence and Finance Teams to identify potential areas of opportunity to reduce clinical variation, where appropriate and necessary. Workstreams continue to challenge areas of significant clinical variation in order to identify further efficiencies to be made.

2018/19 Financial Plan

30. An initial draft Financial Plan has been developed that will require significant further work before a balanced position can be proposed. This update provides the Board on the position as at the end of January and will be further revised and updated for the Board in April.
31. On 14th December 2017, the Scottish Government published its draft budget for 2018/19 which informs the NHS Boards setting process.
32. The budget advises an increase of £66m for Council Funding (for Social Care to support, living wage, sleepover pressures, Carers Act, Free Personal Care and other Social Work pressures) and £354.5m funding increases for NHS Boards (£175m directed towards reform and £179.5m into Boards' baselines).
33. There are a number of areas to consider around the baseline funding of £179.5m and these are set out below:
 - 1.5% uplift for territorial boards
 - £30m for NRAC (National Resource Allocation Formula) parity
 - £6m to Scottish Ambulance Service
 - £350m to be transferred to Social Care (as previously agreed)
 - £20m to Alcohol and Drug partnerships
34. Scottish Government has increased investment in reform and this is detailed below totalling £175m :

Table 5

	2017/18 (£m)	2018/19 (£m)	Increase for 2018/19 (£m)
Transformational Change Fund	25	126	101
Primary Care	60	110	50
Mental Health	30	47	17
Trauma Networks	5	10	5
Cancer	8	10	2
Total investment in reform	128	303	175

35. This funding will be used to support:
- Regional delivery plans/service plans/new models/digital capability
 - Elective performance improvements
 - New GP contract
 - Increase in Mental Health workforce
 - Trauma Networks/Cancer
36. The impact for NHS Dumfries and Galloway is summarised in the table below;

Table 6

NHS D&G Resource Uplift	2018/19 £m	
Resource Budget	284.8	
Baseline Uplift	4.3	1.50%
NRAC Parity	0.0	0.00%
Subtotal	4.3	1.50%
TOTAL	289.1	

37. Clarification is required on a number of additional allocations with the New Medicines Fund (NMF) assumed as £35m and no confirmation on the bundled allocations.
38. As required by Scottish Government a 3 year plan has been initially developed for 2018/19-2021, a breakdown of which is provided in **Appendix 4**.
39. A wide range of assumptions have been used to construct the current draft of the Financial Plan, which will be reviewed and reassessed during February/ March. Based upon these assumptions, the CRES gap for 2018/19 has been initially quantified at £23.4m.
40. The CRES requirement of £23.439m in 2018/19 increases up to £42m recurring requirement over the three year planning timescale can be summarised below

Table 7

Summary CRES	£000s
Recurring balance b/f	9,791
Medical Locums	5,000
Recurring 2018/19 CRES	7,895
Non-recurring 2018/19 CRES	2,853
Reserve Review/ Cost Pressure Review	(2,100)
TOTAL	23,439

41. This represents an 8.01% target (for 2018/19) when compared to the Board's recurring baseline allocation and 6.7% when compared to total spend. This far exceeds CRES targets previously delivered as a Board.
42. Work to allocate this target across the IJB and Health Board is ongoing and will be developed as the CRES position is worked through. It is envisaged the principle of passing on the full NHS Board Uplift to the IJB will be continued.
43. Work is ongoing through the IJB to further progress the business transformation programme and a workshop is planned for IJB members on 1st February 2018.
44. Quantification on the scale and deliverability of savings for 2018/19 is underway.

Local Delivery Plan

45. No guidance has yet been received from Scottish Government advising of the requirement for the NHS Boards LDP for 2018/19. We are aware that both a national and regional financial framework for Scotland is under development and will share more information with the NHS Board as this emerges.

Regional Plan

46. NHS Greater Glasgow and Clyde are leading workstreams across the West of Scotland NHS Boards, supported by a consultancy firm (Carnal Farrar) to develop a finance model that takes a 5 year view on the impact of current activity and growth assumptions until 2022/23.
47. To date, a number of workshops and meetings have involved all West of Scotland NHS Boards and Chief Finance Officers of IJBs in the region in agreeing the assumptions built into the model.
48. Work is continuing to refine and agree a final baseline assessment of a "business as usual" model, so a number of scenarios can be built around the level of recovery required across the region over the next 5 years.

Overall Position

49. The Board is required to achieve a balanced financial position for 2018/19 onwards and has a statutory requirement to breakeven. This Financial Plan reflects an unprecedented level of financial risk for the Board with an unidentified CRES requirement of £23.4m.
50. Provision will be made for all known cost pressures/developments/inflationary impacts and changes to costs, which have been quantified to ascertain the level of financial risk.
51. Work is ongoing to further progress workstreams on savings to identify how this level of efficiency can be delivered to achieve a break-even position over the three year period.

**NHS DUMFRIES AND GALLOWAY
REVENUE RESOURCE ANALYSIS
At 31st DECEMBER 2017**

	Baseline Recurring £000s	Earmarked Recurring £000s	Non Recurring £000s	Non Core £000s	Total £000s
Revenue Allocation as at 30th November 2017	284,983	3,507	27,413	26,926	342,828
Other					
Medical Research (R&D) CSO			262		262
Allied Health Professions Musculoskeletal (MSK) MATS			(12)		(12)
Increasing SACT Capacity			119		119
Combined ERAS & colorectal nursing Role			48		48
LDP Capacity Building for Psychological Therapies and CAMHS			201		201
Develop National IV Fluids Protocol			40		40
Additional Winter Pressures Contribution			239		239
Primary Care Fund - Additional Pharmacists Part 2		48			48
Distinction Awards		56			56
NSD Positron Emission Tomography		(201)			(201)
Total Allocations	0	(96)	896	0	800
Revenue Allocation as at 31st December 2017	284,983	3,411	28,308	26,926	343,628
Anticipated Allocations		(360)	12,725		12,365
Total Revenue Allocation (excl FHS)	284,983	3,051	41,033	26,926	355,993
Family Health Services Non Discretionary Allocation					16,128
Total Revenue Allocation (incl FHS)					372,121

NHS DUMFRIES AND GALLOWAY
EXPENDITURE ANALYSIS - 9 MONTHS TO 31st DECEMBER 2017

AREA	Annual Budget				Pays Ytd			Non Pay Ytd			Income Ytd			Total Ytd			
	Pay £000	Non Pay £000	Income £000	Total £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Variance %
IJB DELEGATED SERVICES																	
Acute & Diagnostics	80,117	24,011	(1,165)	102,963	59,370	59,188	181	18,041	18,757	(716)	(910)	(887)	(23)	76,501	77,059	(558)	-1%
Acute Services Redesign	390	1,060	(0)	1,450	390	390	0	1,060	1,060	(0)	(0)	(0)	(0)	1,450	1,450	0	0%
Facilities & Clinical Support	3,490	10,592	(1,121)	12,962	2,626	2,451	175	7,387	7,836	(449)	(936)	(939)	3	9,077	9,348	(272)	-3%
Mental Health Directorate	19,251	2,525	(576)	21,200	14,362	14,430	(67)	1,864	1,799	65	(478)	(482)	4	15,749	15,747	1	0%
Primary & Community Care	28,881	74,372	(4,704)	98,549	21,022	20,712	309	55,682	57,449	(1,766)	(3,681)	(3,722)	41	73,024	74,439	(1,416)	-2%
Womens & Childrens Directorate	19,089	1,909	(804)	20,194	14,295	14,277	18	1,432	1,486	(54)	(653)	(653)	0	15,075	15,110	(35)	0%
E Health	2,678	3,461	(232)	5,906	2,019	1,887	131	2,805	3,209	(404)	(106)	(114)	8	4,717	4,982	(265)	-6%
Strategic IJB Services	709	20,103	0	20,812	532	475	57	15,141	15,144	(2)	0	(17)	17	15,673	15,601	72	0%
Property CRES	0	(436)	0	(436)	0	0	0	(327)	0	(327)	0	0	0	(327)	0	(327)	100%
IJB Unidentified CRES	0	1,404	0	1,404	0	0	0	1,053	0	1,053	0	0	0	1,053	0	1,053	100%
IJB SERVICES TOTAL	154,604	139,001	(8,602)	285,003	114,615	113,811	804	104,139	106,739	(2,600)	(6,764)	(6,813)	50	211,991	213,737	(1,746)	-1%
BOARD SERVICES																	
Chief Executive	943	1,087	(21)	2,009	663	641	23	684	710	(25)	(16)	(16)	0	1,332	1,335	(3)	0%
Public Health	2,067	460	(553)	1,974	1,549	1,584	(35)	245	156	89	(31)	(19)	(11)	1,764	1,721	43	2%
Medical Director	5,144	2,558	(979)	6,723	3,764	3,565	199	1,854	1,956	(102)	(265)	(203)	(62)	5,354	5,319	35	1%
Nursing Directorate	2,256	165	(226)	2,196	1,697	1,624	72	37	25	12	(182)	(179)	(3)	1,552	1,471	82	5%
Workforce Directorate	1,995	245	(315)	1,925	1,496	1,400	96	139	175	(36)	(246)	(248)	2	1,389	1,326	63	5%
Finance Directorate	2,583	(1,862)	(938)	(216)	1,868	1,805	63	(2,935)	(2,911)	(24)	(910)	(920)	10	(1,977)	(2,026)	50	-3%
Non Recurring Projects	91	472	0	563	78	102	(24)	204	179	25	0	0	0	282	281	1	0%
Strategic Capital	873	13,541	(653)	13,761	684	685	(1)	7,278	7,345	(67)	(15)	(45)	30	7,947	7,985	(38)	0%
Central Income	0	0	(4,986)	(4,986)	0	0	0	0	0	0	(3,740)	(3,691)	(49)	(3,740)	(3,691)	(49)	1%
Externals	0	24,332	(3,010)	21,322	0	0	0	17,739	18,991	(1,252)	(2,252)	(2,478)	226	15,487	16,513	(1,026)	-7%
Board Unidentified CRES	0	2,631	0	2,631	0	0	0	1,973	0	1,973	0	0	0	1,973	0	1,973	100%
BOARD SERVICES TOTAL	15,951	43,630	(11,680)	47,901	11,799	11,405	394	27,220	26,627	594	(7,656)	(7,800)	144	31,363	30,232	1,132	4%
Non Core	0	10,575	0	10,575	0	0	0	6,991	6,991	(0)	0	0	0	6,991	6,991	(0)	0%
Reserves	0	28,641	0	28,641	0	0	0	0	0	0	0	0	0	0	0	0	0%
NON CORE & RESERVES TOTAL	0	39,216	0	39,216	0	0	0	6,991	6,991	(0)	0	0	0	6,991	6,991	(0)	0%
GRAND TOTAL	170,556	221,847	(20,282)	372,121	126,414	125,216	1,198	138,351	140,357	(2,008)	(14,419)	(14,613)	194	250,346	250,960	(616)	0%

NHS DUMFRIES AND GALLOWAY SUMMARY CRES PLAN 2017/18

	Recurring 2017/18 Target £000	Non recurring 2017/18 Target £000	Total 2017/18 Target £000	YTD Planned Savings £000	YTD Actual Savings £000	Scheme Variance YTD £000	2017/18 Recurring Schemes £000	Non Recurring 2017/18 Schemes £000	Total 2017/18 Schemes £000	In Year 2017/18 CRES Gap £000	2017/18 Recurring CRES Gap £000
Delegated Services - IJB											
Acute and Diagnostics	1,489	1,650	3,139	2,374	1,930	(443)	441	2,107	2,548	(591)	(1,048)
Facilities and Clinical Support	779		779	641	465	(176)	288	257	545	(234)	(491)
Mental Health	1,228		1,228	921	921	0	891	337	1,228	0	(337)
Primary and Community Care	1,637		1,637	1,228	1,027	(201)	529	841	1,370	(267)	(1,108)
Women and Children	1,102		1,102	827	789	(38)	352	700	1,052	(50)	(750)
E-Health	329		329	202	47	(155)	122	0	122	(207)	(207)
Prescribing	4,500		4,500	3,318	2,262	(1,056)	2,405	711	3,116	(1,384)	(2,095)
Property CRES	1,000		1,000	750	423	(327)	458	106	564	(436)	(542)
IJB Unidentified CRES	1,500		1,500	1,125	2,178	1,053	0	2,904	2,904	1,404	(1,500)
Delegated Services - IJB Total	13,564	1,650	15,214	11,385	10,042	(1,342)	5,486	7,962	13,448	(1,766)	(8,078)
Board Services											
External SLAs	1,000		1,000	750	0	(750)	0	0	0	(1,000)	(1,000)
Corporate CRES	1,000		1,000	765	2,738	1,973	377	3,254	3,631	2,631	(623)
Procurement	200		200	150	150	0	200	0	200	0	0
Board Services Total	2,200	0	2,200	1,665	2,888	1,223	577	3,254	3,831	1,631	(1,623)
Non-Recurring Central Support		5,221	5,221			0		5,221	5,221	0	0
Grand Total	15,764	6,871	22,635	13,050	12,931	(119)	6,063	16,437	22,500	(135)	(9,701)

Risk Profile of Identified Schemes	
High	33.62%
Medium	4.53%
Low	61.85%

NHS DUMFRIES AND GALLOWAY FINANCIAL PLAN 2018 - 19

SUMMARY	2018/19		
	Recurring £000s	Non Recurring £000s	TOTAL £000s
Allocation Uplifts			
Baseline Uplift	4,300		4,300
New Medicine Fund		1,025	1,025
Release of Brokerage		3,000	3,000
Total Uplifts	4,300	4,025	8,325
Pressures and Uplifts			
Pay Uplifts - Agenda for Change	3,520	0	3,520
Pay Uplifts - Medical Staff	690	0	690
Price Uplifts - excluding Energy	1,050	0	1,050
Price Uplifts - Energy	181	0	181
Price Uplifts - Rates revaluation	1,500	0	1,500
Primary Care Drugs	1,568	0	1,568
Secondary Care Drugs	1,186	0	1,186
New Medicines Drugs Costs	0	1,878	1,878
Cost Pressures	2,500	1,000	3,500
Acute Redevelopment/ Double Running	0	4,000	4,000
Total Pressures and Uplifts	12,195	6,878	19,073
Savings requirement brought forward	9,791		9,791
Medical Locums	5,000		5,000
Reserve review	(2,100)		(2,100)
Increased Savings Requirement	7,895	2,853	10,748
TOTAL Savings Requirement	20,586	2,853	23,439
Increased Savings			10,748

2021

2019/20			2020/21		
Recurring £000s	Non Recurring £000s	TOTAL £000s	Recurring £000s	Non Recurring £000s	TOTAL £000s
		0			0
	1,025	1,025		1,025	1,025
		0			0
0	1,025	1,025	0	1,025	1,025
3,610	0	3,610	3,720	0	3,720
700	0	700	710	0	710
1,071	0	1,071	1,092	0	1,092
196	0	196	33	0	33
0	0	0	0	0	0
1,000	0	1,000	750	0	750
1,280	0	1,280	1,383	0	1,383
0	1,878	1,878	0	1,878	1,878
2,000	1,000	3,000	2,000	1,000	3,000
0	0	0	0	0	0
9,857	2,878	12,735	9,688	2,878	12,566
20,586		20,586	30,443		30,443
		0			0
		0			0
9,857	1,853	11,710	9,688	1,853	11,541
30,443	1,853	32,296	40,131	1,853	41,984
		8,857			9,688

DUMFRIES and GALLOWAY NHS BOARD

5th February 2018-01-23



Modernising the Delivery of Vaccinations in Scotland – NHS Dumfries & Galloway Transformation Programme

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Sponsoring Director:
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Interim Director of Public Health

Date: 23rd January 2018

RECOMMENDATION

The Board is asked to note the request made by the Scottish Government Health Protection and Primary Care Divisions (SGHP&PCDs) for NHS Boards to work with the Scottish Government Divisions to develop and deliver the Vaccination Transformation Programme (VTP), and, also the progress made to date in preparation for the programme commencing in April 2018/

CONTEXT

Strategy / Policy:

A VTP Business Case was circulated to NHS Boards in a letter from SGHP&PCDs (24th February 2017). The Business Case sets out the Scottish Governments desire for a new VTP and the proposed structure. Boards have been asked to provide support and agreement to working together to develop, and deliver, this new programme. The VTP will deliver a major transformation in the way the NHS in Scotland provides vaccinations for the public. The work will be undertaken over a three year period with the 2018/19 financial year being year one.

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

- The review of the delivery of vaccinations led by Scottish Government (SG) will provide an opportunity to modernise the delivery of vaccination programmes.
- Rather than proceeding on the basis of single national approaches and viewing primary care as default/preferred provider, the SGHP&PCDs have recognised there is a value in considering alternative or more flexible approaches to meet the needs of patients/population and to reflect the likely future growth in complexity of vaccination schedules.
- This transformation programme will progress alongside the Primary Care Transformation Programme (PCTP)

GLOSSARY OF TERMS

D&G	-	Dumfries & Galloway
GMS	-	General Medical Services
GPs	-	General Practitioners
IJB	-	Integrated Joint Board
PCTP	-	Primary Care Transformation Programme
SG	-	Scottish Government
SGHP&PCDs	-	Scottish Government Health Protection and Primary Care Divisions
VTP	-	Vaccination Transformation Programme

MONITORING FORM

Policy / Strategy	Primary Care Transformation Programme
Staffing Implications	<p>There will be two new fixed term posts to support the implementation of the programme; a Programme Manager who will manage the programme on a day to day basis taking responsibility for the key programme deliverables and, a Support Officer who will play a central role in co-ordinating and supporting the activities of the VTP.</p> <p>Long term staffing implications for the ongoing delivery of the programme will be identified through a modelling process which will take place for each immunisation programme.</p>
Financial Implications	<p>The costs associated with the programme are in the form of new/additional costs. It is not yet known what they will be.</p> <p>The Board has received funding from SG for the Programme Manager and Support Officer posts for this financial year.</p> <p>Confirmation has been provided, in a letter from the Scottish Government Population Health Directorate Health Protection Division to NHS Directors of Finance dated 7th November 2017, that there will be recurring funding (subject to the normal Parliamentary approval process) to deliver national vaccination programmes after the transformation programme closes.</p>
Consultation / Consideration	NHS Management Team Health & Social Care Senior Management Team
Risk Assessment	Risk assessment will be ongoing throughout the duration of the VTP.
Sustainability	The VTP will provide NHS Dumfries & Galloway with an opportunity to develop high quality sustainable models for the delivery of immunisation programmes across a rural region.
Compliance with Corporate Objectives	The VTP will support the Board in working to achieve all of the Corporate Objectives.
Single Outcome Agreement (SOA)	Keeping the population safe

NOT PROTECTIVELY MARKED

Best Value	Vision and Leadership Effective Partnerships Governance and Accountability Use of Resources Performance Management Equality Sustainability
Impact Assessment Equalities implications will be considered by the VTP Project Board as the work progresses with appropriate impact assessments being undertaken.. An equalities impact assessment for the VTP is to be undertaken at a national level, this will be used to inform a local assessment.	

Background

The Scottish Government is undertaking a review of the delivery of vaccinations in Scotland. This work has been prompted by a number of developments, including transformation in Primary Care and the General Medical Services (GMS) review and by recent significant extension of the vaccination schedule. The majority of vaccinations across Scotland are currently administered under the responsibility of General Practitioners (GPs). As part of the work to modernise Primary Care there is a stated desire from GP leaders that responsibility for this activity, together with other related and relevant changes, is transferred to other parts of the NHS service provision. Primary Care as preferred provider for vaccinations in Scotland is now seen as out-dated. A Vaccination Transformation Programme (VTP) Business Case was circulated to NHS Boards in a letter from Scottish Government Health Protection and Primary Care Divisions (SGHP&PCDs) dated 24th February 2017. The Business Case sets out the basis for a new VTP to deliver a major transformation in the way the NHS in Scotland provides vaccination for the public. NHS Boards have been asked to provide support and agreement to working together to develop and deliver this new programme. It is anticipated this work will be undertaken over a three year period with the 2018/19 financial year being year one.

This review will provide the opportunity to modernise the delivery of vaccination programmes. Rather than proceeding on the basis of single national approaches and primary care as default/preferred provider the SGHP&PCDs have recognised there is a value in considering alternative or more flexible approaches to meet the needs of patients and to reflect the likely future growth in complexity of vaccination schedules.

The purpose of this paper is to provide an introduction to the VTP and highlight some of the areas that will need to be considered to support the commissioning of an immunisation service to a standard that will achieve high levels of vaccine coverage across Dumfries & Galloway and continue to minimise the infections and outbreaks caused by vaccine preventable diseases.

To begin the implementation of the Vaccination Programme an option appraisal has been completed by the SGHP&PCDs, the preferred option is to establish a national, Scottish Government-led programme, but with sufficient local leadership and engagement in the programme to ensure local ownership of its success.

A programme for change is to be established using the principles of Managing Successful Programmes (MSP), project management and business change management. The programme will be led by the Head of Health Protection Division in Scottish Government as the Senior Responsible Owner. The Programme Board will involve senior representation from all stakeholders including NHS Boards, Public Health Leaders, Integrated Joint Boards, Health Protection Scotland and Primary Care Leaders. NHS Board Immunisation Coordinators will be expected to act as local Business Change Authority (i.e. lead the programme locally).

Immunisation is one of the most successful and cost effective health protection interventions and is a cornerstone of public health. High immunisation rates are key to preventing the spread of infectious disease, complications and possible early death among individuals and to protecting the populations health through both individual and herd immunity. The existing, successful national immunisation programme provides a firm platform on which local services can develop and innovate to better meet the needs of their local population and work towards improving outcomes.

The current delivery of immunisations across NHS Dumfries & Galloway is effective with consistently high immunisation uptake rates across the programmes when compared to other NHS Boards in Scotland. A mixed model approach is utilised with a large proportion of immunisations administered by GPs. However, some preschool and school immunisations are administered by an immunisation team that sits within the Directorate of Public Health (This team moved to Public Health in 2014). Other immunisations are administered by the District Nursing service (over 30% of influenza vaccines) and other clinical teams depending on the client group requiring vaccination.

When considering vaccination transformation it is essential to take into consideration that immunisation schedules can and do change and evolve in light of emerging best practice and scientific evidence.

The vaccination schedule has increased in complexity in recent years, starting with the addition of the pneumococcal conjugate vaccine (PCV), meningococcal C vaccine (MenC) and a booster dose of Haemophilus influenzae type B (Hib) and MenC vaccine in September 2004. The Human Papillomavirus (HPV) vaccination for schools programme was implemented in 2008. Further expansion has included shingles vaccination, rotavirus vaccination, childhood flu vaccination and meningitis B (MenB) vaccination. The replacement of the pentavalent vaccine (5 in 1) which includes diphtheria, tetanus, pertussis, polio and Hib to a hexavalent vaccine (6 in 1) to include Hepatitis B (HepB) vaccine took place on 1st October 2017 for babies born on or after 1st August 2017.

A number of existing vaccinations, in particular the seasonal flu vaccination, also have a complex set of qualifying conditions which need to be assessed by practitioners. Other vaccinations are live vaccines and have potentially serious clinical implications if administered to individuals who should not receive them.

The scope of the VTP extends only to those vaccines provided by the NHS to protect individuals or populations against infectious disease, and travel vaccinations including:

- Routine infant and childhood vaccinations,
- School-age vaccinations delivered in schools
- Adult vaccinations
- Vaccinations delivered to individuals on the basis of specific clinical need or identified risk factors (for example, people who are immunocompromised), Pertussis vaccination for pregnant women.

- NHS funded travel vaccinations diphtheria, polio & tetanus (combined booster), typhoid, hepatitis A and cholera, and those which are provided privately and from which the NHS may derive income

Out of scope are any vaccinations which are provided as part of an occupational health function of employers (including the NHS as employer); and any vaccinations delivered privately for non- travel purposes

Progress to date

A planning proposal has been developed for the D&G VTP 2017/18 (see appendix 1 for further details)

NHS Dumfries & Galloway has received funding for this financial year from Scottish Government for a programme manager and support officer to progress the vaccination transition process.

Governance of the programme will be incorporated in the governance for the Primary Care Transformation programme. The structure is currently being finalised.

Consultation

As part of the D&G VTP development, consultation will be undertaken with key stakeholders to gauge opinion on the programme and proposed models for delivery. Participatory appraisal will be used to consult with service users.

Next Steps

Delivery of the Scottish vaccination programme is very complex; its success is based on the effective collaboration of many disciplines working with people of all ages in order to ensure individuals receive an appropriate offer of vaccination.

As part of the PCTP the VTP will be implemented over the same time frame, therefore the programme is scheduled to complete in March 2021.

Modelling work for each of the immunisation programmes has commenced and preparation is underway to advertise for the posts which will support the delivery of this programme within the given timescale.

NHS Dumfries & Galloway Vaccination Transformation Programme Planning Proposal 2017/18

1. National Vaccination Transformation Programme

1.1 Scope

The scope of the programme extends only to those vaccines provided by the NHS to protect individuals or populations against infectious disease, and travel vaccinations including:

- Routine infant and childhood vaccinations,
- School-age vaccinations delivered in schools
- Adult vaccinations
- Vaccinations delivered to individuals on the basis of specific clinical need or identified risk factors (for example, people who are immunocompromised), Pertussis vaccination for pregnant women.
- NHS funded travel vaccinations diphtheria, polio & tetanus (combined booster), typhoid, hepatitis A and cholera, and those which are provided privately and from which the NHS may derive income.

Out of scope are any vaccinations which are provided as part of an occupational health function of employers (including the NHS as employer); and any vaccinations delivered privately for non- travel purposes.

1.1.1 Aims

The overall aim of the national immunisation programme is to protect the population from vaccine preventable diseases reducing the associated morbidity and mortality.

1.1.2 Objectives

The aim will be achieved by delivering an evidence-based, population wide immunisation programme that:

- Identifies the eligible population and ensures effective, timely delivery with optimal coverage based on the target population
- Is safe, effective, of a high quality and is independently monitored
- Is delivered and supported by suitably trained, competent and qualified prescribers, clinical and non-clinical staff who participate in recognised ongoing training and development
- Delivers, manages and stores vaccines in accordance with national guidance e.g. Chapter 3 of the Green Book
<https://www.gov.uk/government/publications/storage-distribution-and-disposal-of-vaccines-the-green-book-chapter-3>

- Is supported by regular and accurate data collection at local and national level using the appropriate returns e.g. Child Health Surveillance Programme, (Scottish Immunisation Recall System (SIRS) and Child Health System (schools)) and GP systems.

1.1.3 Direct health outcomes

The national immunisation programme aims to:

- Protect the health of individuals and the wider population
- Reduce the number of preventable infections and their onward transmission
- Achieve high coverage in the target cohorts
- Minimise adverse physical/psychological/clinical aspects of immunisation (e.g. anxiety, adverse reactions)
- Reduce hospital admissions
- Reduce the use of antimicrobials

1.1.4 Reduction of health inequalities

Reducing health inequalities means that NHS services must be easily accessed by those more disadvantaged and vulnerable groups.

Local users shall be consulted who reflect the diversity in the local community including those with protected characteristics.

The programme shall be delivered in a way which addresses local health inequalities, tailoring and targeting interventions where necessary e.g. looked after and accommodated children and young people, gypsy travellers

The service shall be delivered in a way that is culturally sensitive to meet the needs of the population e.g. offering alternative vaccines to those that contain porcine gelatine

1.2 Current service governance/care pathway

1.2.1 Roles

Scottish Government Health Protection Division (SGHPD) is responsible for commissioning the local provision of immunisation services and the implementation of new programmes. Local implementation is supported by the Scottish Health Protection Network (SHPN) Scottish Immunisation Implementation Group (SIIG).

Health Protection Scotland (HPS) is responsible for providing consistent, efficient and effective coordination of the Scottish Immunisation Programme. This is achieved through the provision of expert advice, surveillance and planning and implementation guidance to Boards about the national immunisation schedule, including the national communication strategy, setting standards and following

recommendations as advised by the Joint Committee on Vaccination and Immunisation (JCVI) and other relevant organisations.

Directors of Public Health (DPHs) provide appropriate support, advocate within the Board and with key stakeholders to improve access and uptake to immunisation programmes.

Each NHS Board has a nominated Immunisation Coordinator, whose role is to lead and coordinate the immunisation programmes locally. The Immunisation Coordinators work closely with colleagues involved in the programme across their NHS Board and in partner Boards where appropriate and represents their Board as a member of the SHPN SIIG.

1.2.2 Local Service Delivery

The delivery of the primary childhood immunisation programme which includes vaccines to protect against diphtheria, tetanus, pertussis, polio, haemophilus influenzae type B (Hib) pneumococcal disease, rotavirus and meningococcal type B (MenB) uses a mixed model approach. In some areas of Dumfries and Galloway, General Practice employed staff administer the vaccines (40%) whilst in other areas the NHS Dumfries & Galloway Immunisation Service administer the vaccines (60%) on behalf of the practices. Current arrangements have been in place for a long time.

When the new GMS contract was introduced in 2004 existing arrangements continued, those practices who received Board nursing support to administer vaccinations continued to do so.

School- age vaccinations (Tetanus, diphtheria and polio boosters, Human Papilloma virus (HPV), Meningococcal ACWY (MenACWY) and childhood flu) are all delivered in schools by the NHS Dumfries & Galloway Immunisation Service.

Adult vaccines such as flu and shingles are administered by GPs and District Nurses

Vaccinations delivered to individuals on the basis of specific clinical need (influenza, pneumococcal and vaccinations required by individuals post splenectomy) or identified risk factors (tuberculosis, hepatitis B) are delivered by a number of clinical teams across NHS Dumfries & Galloway including GPs, midwives, sexual health services, HIV services and the immunisation service.

Travel vaccinations are delivered by GPs and via a private travel health clinic in the region. What is included and not included in this work or the volume of work involved is currently unknown as there isn't consistency across practices.

1.3 Service delivery transformation

It is essential, in order to promote a nationally aligned, high-quality programme focussing on improved outcomes, increasing coverage and local take-up that all the following core elements are included in specifications

- Target population
- Reducing variation across communities and population groups

- Vaccine schedule
- Consent
- Requirements prior to immunisation
- Vaccine administration
- Vaccine storage and wastage
- Vaccine ordering
- Documentation
- Reporting requirements (including adverse events, untoward incidents and vaccine preventable diseases where applicable)
- Staffing and training
- Premises and equipment
- Patient involvement
- Governance
- Service improvement
- Disposal of clinical waste
- Interdependencies
- Local communications strategies

To begin the VTP process at a local level contact has been made with representatives from the clinical teams identified above and other key stakeholders including GP Sub Committee, Primary Care Manager, Associate Medical Director Primary Care and Chief Pharmacist. From these meetings stakeholders have been identified and two initial meetings have been held.

Given the significant changes that are taking place in wider primary care, it has been agreed the VTP will be a work stream of the Primary Care Transformation Programme; a proposal for the governance structure is currently being developed.

1.4 Costs

Additional costs are associated with the programme. It is not yet known what they will be for any new delivery models. Boards have been requested to submit bids for funding requirements for implementing plans for years two and three by May 2018.

As described above, immunisation delivery across Dumfries and Galloway is underpinned by a multidisciplinary approach which has evolved over time. Therefore the current costs associated with delivery are not fully understood.

The costs of local Business Change Managers to support local operational transformation will be met by the Scottish Government. For the current financial year the proposal is for a scoping exercise to be undertaken to identify the vaccination workload across all areas and the associated costs. SG has agreed funding for a Programme Manager, who will support the Nurse Consultant in Health Protection through managing the programme on a day to day basis taking responsibility for the key Programme deliverables, and, also for a Support Officer who will co-ordinate and support the activities of the VTP by providing practical administrative support in the planning, implementation and delivery of the programme outcomes.

Once the scoping exercise has been completed it is anticipated the costs for years two and three of the programme and for future service delivery will be better understood.

It is expected there will be some national IT development costs, the programme will not be able to move forward without access to individual health data currently held by GP practices. These costs will be identified as the programme moves forward.

It is also anticipated there will be costs incurred in engaging with the public, local users shall be consulted to try to ensure they are kept informed throughout the process and any change in service delivery will meet their needs.

1.4.1 Costs 2017/18

Funded by Scottish Government

- Band 7 Nurse 1 wte
- Band 4 Administrator 1 wte

1.5 Benefits

The programme will provide the opportunity to develop more flexible delivery mechanisms to ensure the continued sustainability and success of vaccination for the future in a rural area.

It is anticipated the investment in the VTP will generate realistic options for future delivery of vaccinations that meet the needs of a rural population

The programme will provide an opportunity to generate best value options for solutions offering greatest benefits

1.6 Risks

There are potential major risks with the transformation programme that may follow from the identified alternative delivery models including:

- the risk of reduction in vaccine uptake rates;
- the risk of new vaccine delivery models requiring additional staff and our ability to recruit;
- the loss of multiple opportunities for vaccination offer the GP practice delivery model provides e.g. attendance chronic disease management, repeat prescriptions, special clinics etc.
- the risks associated with the safe sharing of data necessary to support the programme, how will this be done, who owns the data, responsibility etc.

2. Planning

2.1 Work to be undertaken in 2017/18

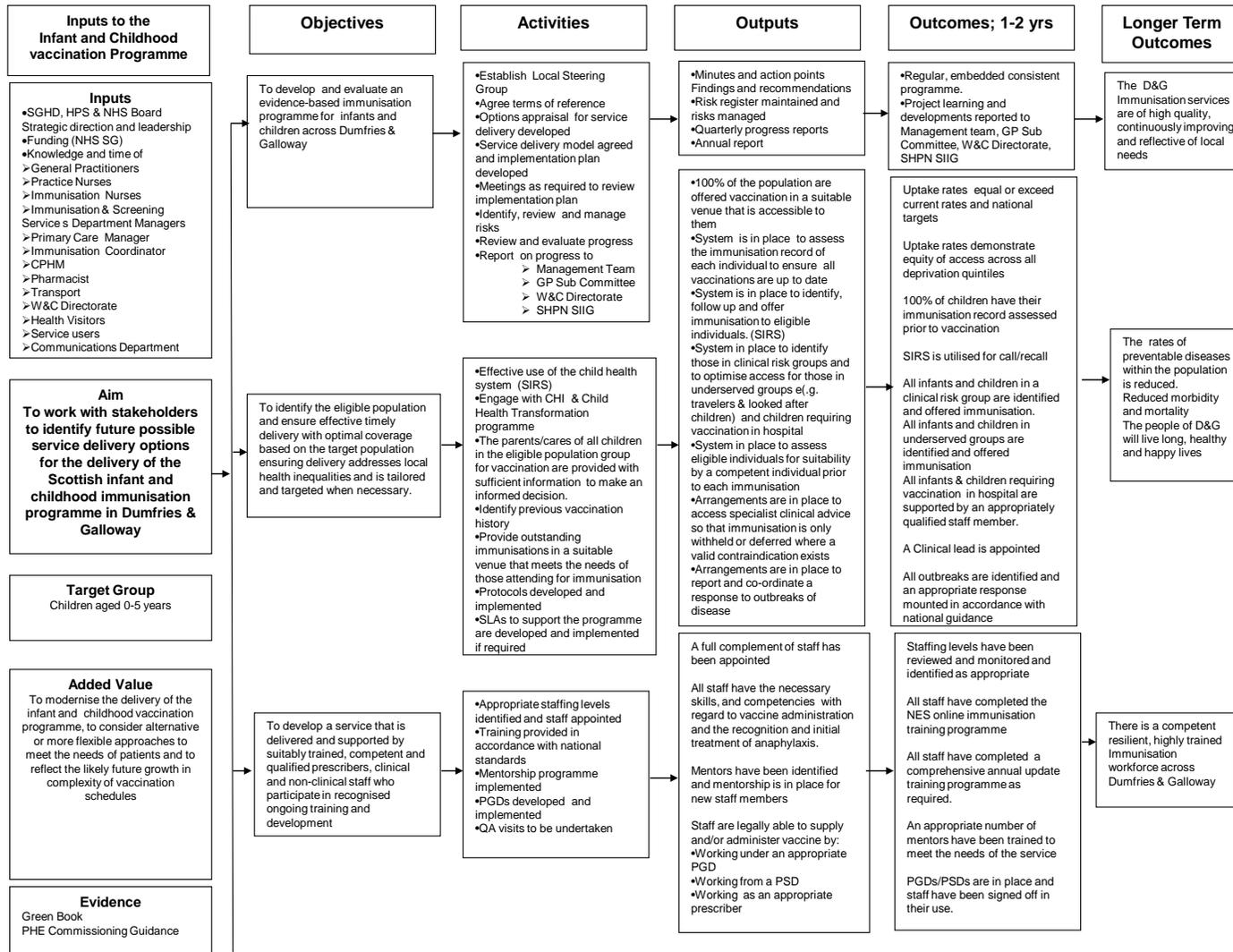
In the first year the programme will:

- Establish structures, roles and governance

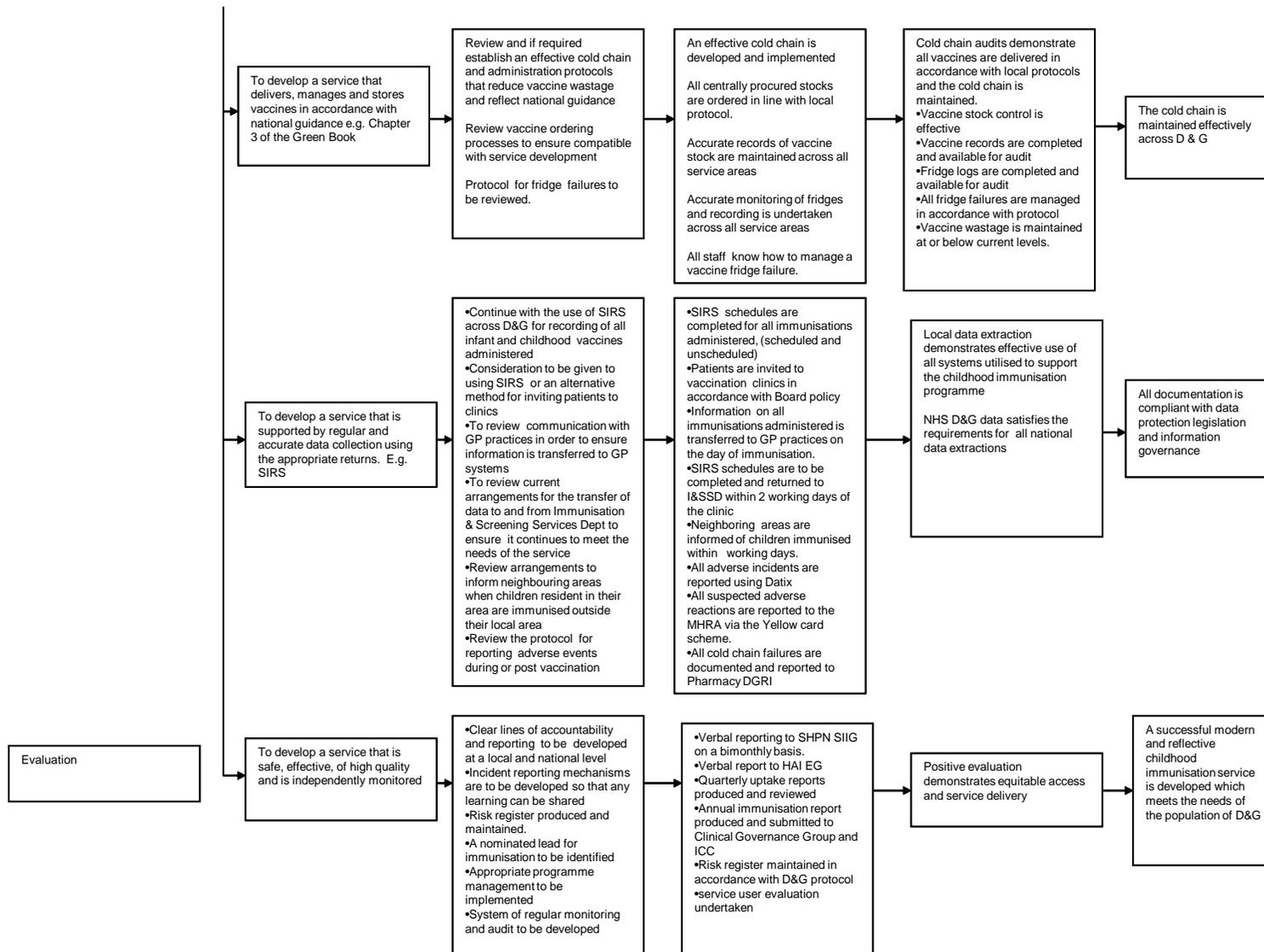
- Identify the vaccination workload across all of the immunisation programmes (i.e. adult vaccinations, childhood schedule, clinical at risk groups and travel vaccines)
- Communicate and engage with the range of stakeholders involved
- Options appraisal to be developed to consider alternative models of delivery
- Seek agreement on future delivery of the immunisation programmes
- Seek agreement on implementation with a view to a phased implementation process
- Proposal for change to be developed for each programme
- Identify potential costs for service delivery
- Risk register to be developed
- Plan future work for subsequent years of the programme

An initial focus will be to review the delivery of the childhood preschool immunisation programme and the preschool work of the immunisation team. The draft Outcome Focussed Plan (appendix 1) provides an indication of the complexity of the VTP outlining the areas to be considered for one of the immunisation programme work streams during the review.

Appendix 1 Routine Infant and Childhood Vaccinations



NOT PROTECTIVELY MARKED



DUMFRIES and GALLOWAY NHS BOARD



5th February 2018

Freedom of Information (Scotland) Act 2002 – Year end Report

Author:
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Sponsoring Director:
Jeff Ace
Chief Executive

Date: 23rd January 2018

RECOMMENDATION

The Board is asked to note this report on the performance of and compliance with the Freedom of Information (Scotland) Act 2002 for the period 1st January – 31st December 2017.

CONTEXT

Strategy / Policy:

This paper supports national legislation through implementation of the Freedom of Information (Scotland) Act 2002 and the local Freedom of Information Policy.

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

On 1st January 2005 Scottish Government implemented new legislation around the general public's statutory right of access to information held by Scottish public bodies, including NHS Boards.

This paper demonstrates the performance of NHS Dumfries and Galloway during 2016 to comply with the Freedom of Information (Scotland) Act 2002.

GLOSSARY OF TERMS

Act	-	Freedom of Information (Scotland) Act 2002
Commissioner	-	Scottish Information Commissioner
FOI	-	Freedom of Information
FOISA	-	Freedom of Information (Scotland) Act 2002
OSIC	-	Office of the Scottish Information Commissioner

MONITORING FORM

Policy / Strategy	<ul style="list-style-type: none"> • Freedom of Information (Scotland) Act 2002 • Freedom of Information Policy • Guide to information available through the Model Publication Scheme
Staffing Implications	There are no staffing implications related to this paper.
Financial Implications	There are no financial implications related to this paper.
Consultation / Consideration	This paper has been reviewed by the Chief Executive prior to being presented at NHS Board for noting.
Risk Assessment	No risk assessment was required as part of the preparation of this paper.
Sustainability	Not applicable.
Compliance with Corporate Objectives	This paper supports all of the Board's Corporate Objectives.
Single Outcome Agreement (SOA)	Not applicable.
Best Value	<ul style="list-style-type: none"> • Vision and Leadership • Governance and Accountability • Use of Resources • Performance Management
<p>Impact Assessment</p> <p>An impact assessment has been undertaken in regard to the Freedom of Information Policy and has been published on the external website, no further impact assessment was required as part of the paper.</p>	

Introduction

1. The Freedom of Information (Scotland) Act 2002 (the Act) came into force on 1st January 2005. The Act provides a statutory right of access to information held by Scottish public bodies including NHS Boards.
2. Information is available through links within the Board's "Guide to information available through the Model Publication Scheme" and our external website, which can be found at www.nhsdg.scot.org.uk
3. Where information is not available through these sources an applicant can, under the Act, make a request for information. The request must be in a permanently recorded form, for example a letter or an e-mail and can be made by anyone, whether resident in the UK or not, for information held prior to enactment of the Act and after.
4. While most information requested can be released, some information is exempt under the Act. The right of access to information is subject to a number of exemptions within the Act and may also require public interest or harm test to be applied.

Freedom of Information Request

5. The Act requires that requests for information are acknowledged and responded to within twenty working days. As mentioned above there will be occasions where the issue of the information may not be appropriate, as it could identify a patient, which would breach the confidentiality section of the Act and also the Data Protection principles. The Act details a number of exemptions that the Public Body should consider when being asked for information and if the decision is made by the Freedom of Information Officer or Freedom of Information Lead to withhold specific information then the response must clearly state the exemption being applied and the justification for the application of the exemption.

Request for Review

6. Following a request for information, an applicant has a right to ask for a review of the Board's handling of a request to be undertaken, if they are dissatisfied with the response received. An applicant has up to forty working days following receipt of a response in which to submit their request for a review. The Board must acknowledge receipt of the request for review and provide a full response within twenty working days.
7. During 2017, 13 requests for a review of the initial response issued by NHS Dumfries and Galloway were received.

Scottish Information Commissioner

8. The Scottish Information Commissioner is an independent body, who has been given designated authority by Scottish Government to administer this piece of legislation and to hold Scottish public authorities to account through the implementation of the criteria within the Act.
9. Following receipt of the response to a review request from the Board, if the applicant remains dissatisfied, they have a further right of appeal to the Scottish Information Commissioner. An applicant has up to six months following the outcome of the review from the Public Body, in which, to apply to the Commissioner.
10. The Commissioner will investigate the application and will make a decision on evidence provided as to whether compliance with the Act can be demonstrated. Once a decision has been made a formal decision notice will be issued that confirms the outcome of the review and sets out any steps the authority should take, for example by giving all or part of the information requested. If the Board fails to take these steps, the Commissioner can inform the Court of Session that the authority has not done so, who will then undertake their own investigate and may find the Board in contempt of court, which could result in an unlimited fine.
11. Following a decision by the Commissioner an applicant who remains dissatisfied has a further right of review to the Court of Session, but on a point of law only.

Application

12. Since the Act came into force on 1 January 2005 NHS Dumfries and Galloway has sought to ensure that robust arrangements for managing requests for information are in place. These arrangements have been adapted where necessary to respond to the increasing number of requests in an appropriate and timely manner and to ensure the Board complies with legislation.
13. Requests are managed through the Chief Executive's Office who gather the information from various teams and departments throughout the service to compile the appropriate response to the requester.
14. Freedom of Information requests are in the main received electronically via dg.feedback@nhs.net with a small number of requests received in writing.
15. Where in previous years statistical information has been presented within the Board Briefings at each public meeting, a review of the process has been undertaken and, going forward, Board Members will receive two reports throughout any given calendar year charting the activity to date in relation to the Act.

16. Progress is being made to publish detailed information on the Board's external website, which will look at the number of requests received, the percentage of requests that are responded to within twenty days and a list of all the Freedom of Information requests received within the current calendar year.

Number of Requests Received

17. 598 requests for information were received in 2016, which demonstrates a 2.4% increase on 2015, where 584 requests were received. Of the 598 requests received 30 requests were handled as Environmental Information Requests and the remaining 568 requests have been dealt with through the Freedom of Information (Scotland) Act 2002.
18. Within 2017, the Board responded to 82% of the information requests within the 20 days response period stated within the legislation, which is an reduced position compared to 2016 where 94% of responses were issued within the same time period. A breakdown of the breaches to the time period are noted below:

Month response due in 2017	Period breached beyond 20 days timeline			
	1-5 days	6-10 days	11-20 days	21+ days
January	0	0	0	0
February	1	1	1	1
March	5	5	2	2
April	2	1	3	0
May	0	1	1	1
June	2	0	2	4
July	3	1	3	5
August	5	3	2	5
September	5	1	1	2
October	1	4	1	1
November	8	9	1	4
December	4	0	2	2
TOTAL	36	26	19	27

19. A significant decrease in our performance against the legislation is noted above, one of the reasons thought to contribute to this performance was the additional workload faced by existing staff the commissioning and migration to our new district general hospital at the beginning of December 2017, where we can see a spike in the above figures during the month of November 2017.
20. Attached at **Appendix 1** is a summary of all the requests received between 1st January 2017 – 31st December 2017, highlighting where the breaches have occurred, the information requests where a review has been requested and also if any Scottish Information Commissioner requests have been received in year.

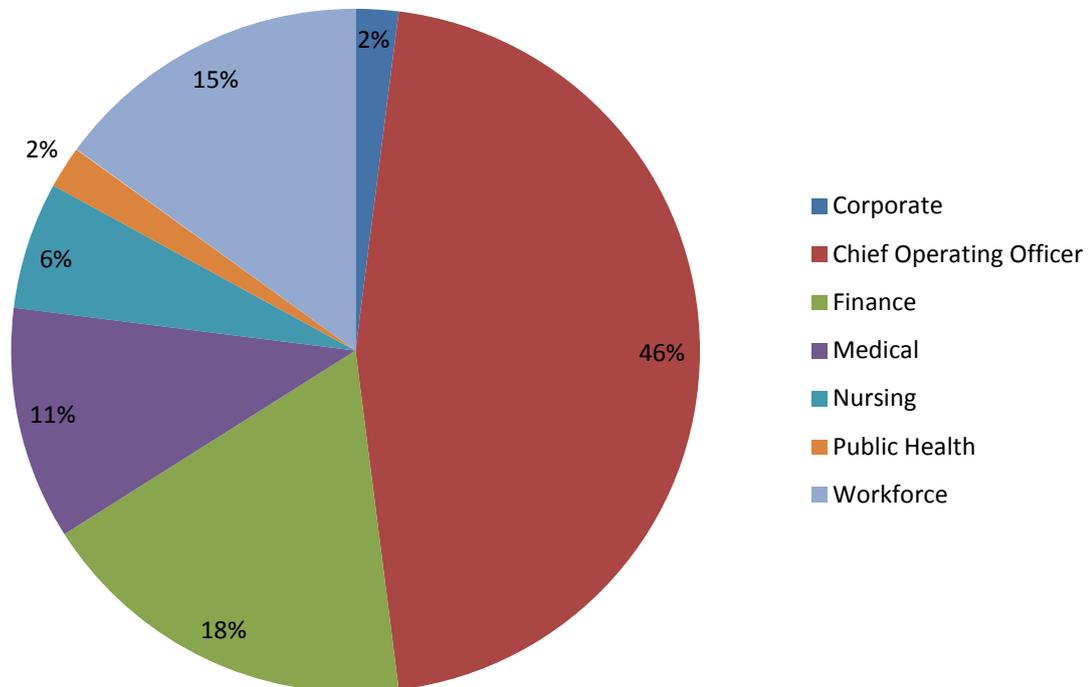
Scottish Information Commissioner Applications

21. A review of the Freedom of Information requests has confirmed that to date no applications have been made to the Scottish Information Commissioner in relation to requests received in 2017.
22. However, a Formal Decision Notice was issued for one application received within 2017, which related to Freedom of Information requests received and responded to in 2016.
23. Details of the notices received are noted below, along with a link to the Scottish Information Commissioners website, where more detailed information can be viewed on the full decision report.

SIC Reference	Decision Date	Outcome and link to SIC website	Action Required
137/2017	29/08/2017	<p>NHS Dumfries and Galloway as incorrect to inform Mr R that some of the information he asked for was exempt from disclosure under section 25(1) of FOISA, being otherwise accessible to him. NHS Dumfries and Galloway did not hold the recorded information requested by Mr R, and failed to give him notice of this under section 17(1) of FOISA.</p> <p>https://www.itspublicknowledge.info/uploadedFiles/Decision137-2017.pdf</p>	No action required by NHS Dumfries and Galloway.

Directorate Providing Information for Responses - 2017

24. The diagram below details the volume of requests that have been handled through each of the Board's directorates.



Type of Information Requested

25. A wide range of information has been requested from NHS Dumfries and Galloway, which often contain a significant number of separate elements and varying degree of complexity. A number of themes were identified including:-

- Acute Services
- Assaults on Staff
- Delayed Discharges
- Finance
- Workforce
- Maternity
- Pharmacy / Prescribing

Publication Scheme

26. As part of the implementation of the Act, the Scottish Information Commissioner requires all Scottish public authorities to be proactive in regard to information requests and publish a "Guide to Information available through the publication Scheme", which is based on the Commissioners Model Publication Scheme template. A copy of the Board's Guide is available on the Board's internal and external websites for reference.

27. The key benefits that can be seen through proactive publication are to:-
- demonstrate accountability and transparency to build reputation;
 - engage and communicate to build relationships; and
 - increase efficiency by reducing the impact of request handling.
28. The reputational benefits are derived from being open about who we are, what we do and how we do it, which leads to actual and perceived accountability and transparency demonstrating that the organisation has nothing to hide.
29. Communication is an iterative process between those giving a message and those receiving it. Proactive publication is about initiating a conversation and then being prepared to listen. The board achieves a reputation of being an organisation that listens.
30. Following the release of legislation from Scottish Government in early 2015 around Open Data, a section has been added to the Model Publication Scheme template, which has been included within the Board's "Guide to Information available through the Publication Scheme". This section looks at all statistical information held within public authorities and encourages publication of the information to as low a level as possible without breaching confidentiality and the Data Protection Principles.
31. NHS Dumfries and Galloway are looking at options around the publication of the information and is working with the Information Assurance Committee to agree the most effective approach to ensure openness and transparency of the information held.

'Popularity' of FOISA

32. The figures below demonstrate the increased 'popularity' of Freedom of Information and Environmental Information requests since its introduction in 2005.

<i>Year</i>	<i>No of Requests</i>	<i>% change from previous year</i>	<i>% increase from 2006</i>
2017	598	+3%	504%
2016	584	+16%	490%
2015	505	+3%	410%
2014	492	+13%	397%
2013	434	+5%	338%
2012	413	+22%	317%
2011	339	-7%	242%
2010	364	+48%	268%
2009	246	+37%	148%
2008	180	+84%	82%
2007	98	-1%	1%
2006	99	N/A	N/A

Conclusion

33. The Freedom of Information (Scotland) Act 2002 generates an increasing number of requests for information and we will continue to strive to improve performance and compliance rates whilst acknowledging the number of requests received and the challenge this presents to teams and departments.
34. Thanks are due to all colleagues who provide detail to inform a response and their continued co-operation and support is very much appreciated to ensure compliance with the legislation.

File Number	EIR/FOI	Date Received	Due date	Date Closed / withdrawn	Breach 20 days	Breach 1-5 days	Breach 6-10 days
17-001	FOI	04/01/2017	01/02/17	06/01/2017	No		
17-002	FOI	04/01/2017	01/02/17	20/01/2017	No		
17-003	FOI	04/01/2017	01/02/17	04/01/2017	No		
17-004	FOI	04/01/2017	01/02/17	13/01/2017	No		
17-005	FOI	04/01/2017	01/02/17	30/01/2017	No		
17-006	FOI	04/01/2017	01/02/17	31/01/2017	No		
17-007	FOI	04/01/2017	01/02/17	11/01/2017	No		
17-008	FOI	05/01/2017	02/02/17	24/01/2017	No		
17-009	FOI	05/01/2017	02/02/17	02/02/2017	No		
17-010	FOI	05/01/2017	02/02/17	23/01/2017	No		
17-011	FOI	06/01/2017	03/02/17	26/01/2017	No		
17-012	FOI	06/01/2017	03/02/17	30/01/2017	No		
17-013	FOI	10/01/2017	07/02/17	24/01/2017	No		
17-014	FOI	10/01/2017	07/02/17	31/01/2017	No		
17-015	FOI	11/01/2017	08/02/17	07/02/2017	No		
17-016	FOI	11/01/2017	08/02/17	24/01/2017	No		
17-017	FOI	11/01/2017	08/02/17	30/01/2017	No		
17-018	FOI	11/01/2017	08/02/17	06/02/2017	No		
17-019	FOI	12/01/2017	09/02/17	24/01/2017	No		
17-020	FOI	12/01/2017	09/02/17	06/02/2017	No		
17-021	FOI	23/01/2017	20/02/17	14/02/2017	No		
17-022	FOI	12/01/2017	09/02/17	08/02/2017	No		
17-023	FOI	12/01/2017	09/02/17	09/02/2017	No		
17-024	FOI	13/01/2017	10/02/17	06/02/2017	No		
17-025	FOI	13/01/2017	10/02/17	20/02/2017	Yes		Yes
17-026	FOI	13/01/2017	10/02/17	30/01/2017	No		
17-027	FOI	13/01/2017	10/02/17	08/02/2017	No		
17-028	FOI	16/01/2017	13/02/17	08/02/2017	No		
17-029	FOI	16/01/2017	13/02/17	08/02/2017	No		
17-030	FOI	16/01/2017	13/02/17	08/03/2017	Yes		
17-031	FOI	18/01/2017	15/02/17	09/02/2017	No		
17-032	FOI	18/01/2017	15/02/17	24/01/2017	No		
17-033	FOI	18/01/2017	15/02/17	03/03/2017	Yes		
17-034	FOI	19/01/2017	16/02/17	13/02/2017	No		
17-035	FOI	19/01/2017	16/02/17	08/02/2017	No		
17-036	FOI	19/01/2017	16/02/17	24/01/2017	No		
17-037	FOI	20/01/2017	17/02/17	09/02/2017	No		
17-038	FOI	20/01/2017	17/02/17	09/02/2017	No		
17-039	FOI	23/01/2017	20/02/17	09/02/2017	No		
17-040	FOI	23/01/2017	20/02/17	15/02/2017	No		
17-041	FOI	23/01/2017	20/02/17	15/02/2017	No		
17-042	FOI	23/01/2017	20/02/17	31/01/2017	No		
17-043	FOI	25/01/2017	22/02/17	22/02/2017	No		
17-044	FOI	25/01/2017	22/02/17	15/02/2017	No		
17-045	FOI	24/01/2017	21/02/17	24/01/2017	No		
17-046	FOI	26/01/2017	23/02/17	15/01/2017	No		
17-047	FOI	26/01/2017	23/02/17	13/02/2017	No		
17-048	FOI	26/01/2017	23/02/17	14/02/2017	No		
17-049	FOI	26/01/2017	23/02/17	21/02/2017	No		
17-050	FOI	26/01/2017	23/02/17	14/02/2017	No		

17-051	FOI	26/01/2017	23/02/17	17/02/2017	No	
17-052	FOI	27/01/2017	24/02/17	16/02/2017	No	
17-053	FOI	27/01/2017	24/02/17	14/02/2017	No	
17-054	FOI	27/01/2017	24/02/17	16/02/2017	No	
17-055	FOI	27/01/2017	24/02/17	13/02/2017	No	
17-056	FOI	30/01/2017	27/02/17	01/03/2017	Yes	Yes
17-057	FOI	30/01/2017	27/02/17	27/02/2017	No	
17-058	FOI	30/01/2017	27/02/17	30/01/2017	No	
17-059	FOI	31/01/2017	28/02/17	14/02/2017	No	
17-060	FOI	01/02/2017	01/03/17	27/02/2017	No	
17-061	FOI	01/02/2017	01/03/17	28/02/2017 & 24/03/2017	No	
17-062	FOI	02/02/2017	02/03/17	16/02/2017	No	
17-063	FOI	02/02/2017	02/03/17	16/02/2017	No	
17-064	FOI	02/02/2017	02/03/17	16/02/2017	No	
17-065	FOI	03/02/2017	03/03/17	16/02/2017	No	
17-066	FOI	06/02/2017	06/03/17	16/02/2017	No	
17-067	FOI	06/02/2017	06/03/17	16/02/2017	No	
17-068	FOI	06/02/2017	06/03/17	10/03/2017	Yes	Yes
17-069	FOI	06/02/2017	06/03/17	07/03/2017	Yes	Yes
17-070	FOI	06/02/2017	06/03/17	28/02/2017	No	
17-071	FOI	07/02/2017	07/03/17	28/02/2017	No	
17-072	FOI	07/02/2017	07/03/17	16/02/2017	No	
17-073	FOI	07/02/2017	07/03/17	16/02/2017	No	
17-074	FOI	07/02/2017	07/03/17	16/02/2017	No	
17-075	FOI	08/02/2017	08/03/17	06/03/2017	No	
17-076	EIR	08/02/2017	08/03/17	07/03/2017	No	
17-077	FOI	08/02/2017	08/03/17	20/02/2017	No	
17-078	FOI	09/02/2017	09/03/17	17/03/2017	Yes	Yes
17-079	EIR	09/02/2017	09/03/17	06/03/2017	No	
17-080	EIR	10/02/2017	10/03/17	03/03/2017	No	
17-081	FOI	10/02/2017	10/03/17	06/03/2017	No	
17-082	FOI	13/02/2017	13/03/17	21/02/2017	No	
17-083	FOI	13/02/2017	13/03/17	10/03/2017	No	
17-084	EIR	13/02/2017	13/03/17	08/03/2017	No	
17-085	FOI	13/02/2017	13/03/17	20/02/2017	No	
17-086	FOI	28/02/2017	28/03/17	17/03/2017	No	
17-087	FOI	14/02/2017	14/03/17	20/02/2017	No	
17-088	FOI	15/02/2017	15/03/17	10/03/2017	No	
17-089	FOI	15/02/2017	15/03/17	06/03/2017	No	
17-090	FOI	14/02/2017	14/03/17	24/03/2017	Yes	Yes
17-091	FOI	17/02/2017	17/03/17	17/03/2017	No	
17-092	FOI	17/02/2017	17/03/17	14/03/2017	No	
17-093	FOI	17/02/2017	17/03/17	07/03/2017	No	
17-094	FOI	20/02/2017	20/03/17	28/03/2017	Yes	Yes
17-095	FOI	20/02/2017	20/03/17	17/03/2017	No	

17-096	FOI	20/02/2017	20/03/17	13/03/2017	No		
17-097	FOI	21/02/2017	21/03/17	17/03/2017	No		
17-098	FOI	21/02/2017	21/03/17	24/03/2017	Yes	Yes	
17-099	FOI	21/02/2017	21/03/17	14/03/2017	No		
17-100	FOI	22/02/2017	22/03/17	24/03/2017	Yes	Yes	
17-101	FOI	22/02/2017	22/03/17	13/03/2017	No		
17-102	FOI	22/02/2017	22/03/17	17/03/2017	No		
17-103	FOI	24/02/2017	24/03/17	11/04/2017	Yes		
17-104	EIR	24/02/2017	24/03/17	24/02/2017	No		
17-105	FOI	27/02/2017	27/03/17	05/04/2017	Yes		Yes
17-106	FOI	27/02/2017	27/03/17	03/04/2017	Yes		Yes
17-107	FOI	28/02/2017	28/03/17	19/04/2017	Yes		
17-108	FOI	28/02/2017	28/03/17	31/03/2017	Yes	Yes	
17-109	FOI	28/02/2017	28/03/17	02/05/2017	Yes		
17-110	EIR	01/03/2017	29/03/17	10/03/2017	No		
17-111	FOI	01/03/2017	29/03/17	11/04/2017	Yes		
17-112	FOI	01/03/2017	29/03/17	29/03/2017	No		
17-113	FOI	02/03/2017	30/03/17	23/03/2017	No		
17-114	FOI	02/03/2017	30/03/17	15/03/2017	No		
17-115	FOI	03/03/2017	31/03/17	24/03/2017	No		
17-116	FOI	07/03/2017	04/04/17	07/04/2017	Yes	Yes	
17-117	FOI	06/03/2017	03/04/17	29/03/2017	No		
17-118	FOI	07/03/2017	04/04/17	11/04/2017	Yes		
17-119	FOI	06/03/2017	03/04/17	03/04/2017	No		
17-120	FOI	08/03/2017	05/04/17	23/03/2017	No		
17-121	FOI	08/03/2017	05/04/17	17/03/2017	No		
17-122	FOI	08/03/2017	05/04/17	19/04/2017	Yes		
17-123	FOI	08/03/2017	05/04/17	14/03/2017	No		
17-124	FOI	08/03/2017	05/04/17	29/03/2017	No		
17-125	FOI	09/03/2017	06/04/17	11/04/2017	Yes	Yes	
17-126	FOI	09/03/2017	06/04/17	13/04/2017	Yes		Yes
17-127	FOI	13/03/2017	10/04/17	29/03/2017	No		
17-128	FOI	13/03/2017	10/04/17	29/03/2017	No		
17-129	FOI	13/03/2017	10/04/17	10/04/2017	No		
17-130	FOI	14/03/2017	11/04/17	16/03/2017	No		
17-131	FOI	14/03/2017	11/04/17	14/03/2017	No		
17-132	FOI	14/03/2017	11/04/17	11/04/2017	No		
17-133	EIR	14/03/2017	11/04/17	10/04/2017	No		
17-134	FOI	15/03/2017	12/04/17	29/03/2017	No		
17-135	FOI	15/03/2017	12/04/17	06/04/2017	No		
17-136	FOI	15/03/2017	12/04/17	29/03/2017	No		
17-137	FOI	16/03/2017	13/04/17	06/04/2017	No		
17-138	FOI	16/03/2017	13/04/17	11/04/2017	No		
17-139	FOI	16/03/2017	13/04/17	06/04/2017	No		
17-140	FOI	16/03/2017	13/04/17	29/03/2017	No		
17-141	FOI	16/03/2017	13/04/17	12/04/2017	No		
17-142	FOI	20/03/2017	17/04/17	11/04/2017	No		
17-143	FOI	20/03/2017	17/04/17	23/03/2017	No		
17-144	FOI	21/03/2017	18/04/17	29/03/2017	No		
17-145	FOI	21/03/2017	18/04/17	29/03/2017	No		

17-146	FOI	23/03/2017	20/04/17	11/04/2017	No
17-147	FOI	24/03/2017	21/04/17	30/03/2017	No
17-148	FOI	25/03/2017	22/04/17	11/04/2017	No
17-149	FOI	26/03/2017	23/04/17	11/04/2017	No
17-150	FOI	29/03/2017	26/04/17	19/04/2017	No
17-151	FOI	29/03/2017	26/04/17	26/04/2017	No
17-152	FOI	30/03/2017	27/04/17	21/04/2017	No
17-153	FOI	31/03/2017	28/04/17	09/05/2017	Yes
17-154	FOI	03/04/2017	01/05/17	27/04/2017	No
17-155	FOI	03/04/2017	01/05/17	21/04/2017	No
17-156	FOI	03/04/2017	02/05/17	02/05/2017	No
17-157	FOI	05/04/2017	03/05/17	24/04/2017	No
17-158	FOI	05/04/2017	03/05/17	02/05/2017	No
17-159	FOI	05/04/2017	03/05/17	24/04/2017	No
17-160	FOI	05/04/2017	03/05/17	24/04/2017	No
17-161	FOI	05/04/2017	03/05/17	24/04/2017	No
17-162	FOI	05/04/2017	03/05/17	10/04/2017	No
17-163	FOI	05/04/2017	03/05/17	25/04/2017	No
17-164	FOI	05/04/2017	03/05/17	02/05/2017	No
17-165	FOI	05/04/2017	03/05/17	07/04/2017	No
17-166	FOI	06/04/2017	04/05/17	27/04/2017	No
17-167	FOI	07/04/2017	05/05/17	11/04/2017	No
17-168	FOI	07/04/2017	05/05/17	04/05/2017	No
17-169	FOI	11/04/2017	11/05/17	19/06/2017	Yes
17-170	FOI	11/04/2017	11/05/17	23/05/2017	Yes
17-171	FOI	13/04/2017	11/05/17	19/04/2017	No
17-172	FOI	13/04/2017	11/05/17	27/04/2017	No
17-173	EIR	13/04/2017	11/05/17	27/04/2017	No
17-174	FOI	13/04/2017	11/05/17	21/04/2017	No
17-175	FOI	18/04/2017	16/05/17	16/05/2017	No
17-176	FOI	19/04/2017	17/05/17	16/05/2017	No
17-177	FOI	19/04/2017	17/05/17	21/04/2017	No
17-178	FOI	18/04/2017	16/05/17	25/04/2017	No
17-179	FOI	13/04/2017	11/05/17	10/05/2017	No
17-180	FOI	20/04/2017	18/05/17	16/05/2017	No
17-181	EIR	20/04/2017	18/05/17	27/04/2017	No
17-182	EIR	20/04/2017	18/05/17	10/05/2017	No
17-183	EIR	20/04/2017	18/05/17	16/05/2017	No
17-184	FOI	20/04/2017	18/05/17	10/05/2017	No
17-185	FOI	20/04/2017	18/05/17	26/04/2017	No
17-186	FOI	20/04/2017	18/05/17	21/04/2017	No
17-187	FOI	21/04/2017	19/05/17	24/05/2017	Yes
17-188	FOI	21/04/2017	19/05/17	16/05/2017	No
17-189	FOI	24/04/2017	22/05/17	18/05/2017	No
17-190	FOI	24/04/2017	22/05/17	16/05/2017	No
17-191	FOI	16/05/2017	13/06/17	16/05/2017	No
17-192	FOI	25/05/2017	22/06/17	24/05/2017	No
17-193	FOI	27/04/2017	25/05/17	23/05/2017	No
17-194	FOI	02/05/2017	30/05/17	16/05/2017	No

Yes

17-195	FOI	02/05/2017	30/05/17	23/05/2017	No	
17-196	FOI	02/05/2017	30/05/17	18/05/2017	No	
17-197	FOI	02/05/2017	30/05/17	16/05/2017	No	
17-198	FOI	03/05/2017	31/05/17	23/05/2017	No	
17-199	FOI	04/05/2017	01/06/17	30/05/2017	No	
17-200	FOI	04/05/2017	01/06/17	30/05/2017	No	
17-201	FOI	04/05/2017	01/06/17	23/05/2017	No	
17-202	FOI	05/05/2017	02/06/17	16/05/2017	No	
17-203	FOI	08/05/2017	05/06/17	01/06/2017	No	
17-204	FOI	08/05/2017	05/06/17	30/05/2017	No	
17-205	FOI	09/05/2017	06/06/17	07/06/2017	Yes	Yes
17-206	FOI	09/05/2017	06/06/17	25/05/2017	No	
17-207	FOI	09/05/2017	06/06/17	09/05/2017	No	
17-208	FOI	09/05/2017	06/06/17	16/05/2017	No	
17-209	FOI	09/05/2017	06/06/17	10/05/2017	No	
17-210	FOI	09/05/2017	06/06/17	18/05/2017	No	
17-211	FOI	09/05/2017	06/06/17	01/06/2017	No	
17-212	FOI	09/05/2017	06/06/17	10/05/2017	No	
17-213	FOI	09/05/2017	06/06/17	31/05/2017	No	
17-214	FOI	18/05/2017	15/06/17	18/05/2017	No	
17-215	FOI	09/05/2017	06/06/17	09/05/2017	No	
17-216	FOI	09/05/2017	06/06/17	10/05/2017	No	
17-217	FOI	09/05/2017	06/06/17	31/05/2017	No	
17-218	FOI	15/05/2017	12/06/17	11/07/2017	Yes	
17-219	FOI	12/05/2017	09/06/17	01/06/2017	No	
17-220	FOI	12/05/2017	09/06/17	01/06/2017	No	
17-221	FOI	15/05/2017	12/06/17	01/06/2017	No	
17-222	FOI	15/05/2017	12/06/17	08/06/2017	No	
17-223	FOI	15/05/2017	12/06/17	01/06/2017	No	
17-224	FOI	09/05/2017	06/06/17	19/05/2017	No	
17-225	FOI	15/05/2017	12/06/17	09/06/2017	No	
17-226	FOI	15/05/2017	12/06/17	12/06/2017	No	
17-227	FOI	16/05/2017	13/06/17	12/06/2017	No	
17-228	EIR	17/05/2017	14/06/17	01/06/2017	No	
17-229	FOI	18/05/2017	15/06/17	02/08/2017	Yes	
17-230	FOI	18/05/2017	15/06/17	01/06/2017	No	
17-231	FOI	18/05/2017	15/06/17	08/06/2017	No	
17-232	FOI	19/05/2017	16/06/17	01/06/2017	No	
17-233	FOI	19/05/2017	16/06/17	01/06/2017	No	
17-234	FOI	22/05/2017	19/06/17	19/06/2017	No	
17-235	EIR	22/05/2017	19/06/17	08/06/2017	No	
17-236	FOI	22/05/2017	19/06/17	01/06/2017	No	
17-237	EIR	22/05/2017	19/06/17	23/05/2017	No	
17-238	FOI	22/05/2017	19/06/17	30/06/2017	Yes	
17-239	FOI	24/05/2017	21/06/17	19/06/2017	No	
17-240	FOI	24/05/2017	21/06/17	16/06/2017	No	
17-241	FOI	24/05/2017	21/06/17	16/06/2017	No	
17-242	FOI	25/05/2017	22/06/17	02/08/2017	Yes	
17-243	FOI	26/05/2017	23/06/17	23/06/2017	No	
17-244	FOI	26/05/2017	23/06/17	19/06/2017	No	
17-245	FOI	26/05/2017	23/06/17	27/06/2017	Yes	Yes
17-246	FOI	30/05/2017	27/06/17	12/07/2017	Yes	
17-247	FOI	30/05/2017	27/06/17	16/06/2017	No	
17-248	FOI	30/05/2017	27/06/17	27/06/2017	No	
17-249	FOI	31/05/2017	28/06/17	03/08/2017	Yes	
17-250	FOI	31/05/2017	28/06/17	16/06/2017	No	

17-251	FOI	31/05/2017	28/06/17	23/06/2017	No	
17-252	FOI	26/05/2017	23/06/17	31/05/2017	No	
17-253	FOI	31/05/2017	28/06/17	01/06/2017	No	
17-254	FOI	02/06/2017	30/06/17	26/06/2017	No	
17-255	FOI	02/06/2017	30/06/17	23/06/2017	No	
17-256	FOI	02/06/2017	30/06/17	30/06/2017	No	
17-257	FOI	02/06/2017	30/06/17	23/06/2017	No	
17-258	FOI	05/06/2017	03/07/17	23/06/2017	No	
17-259	EIR	06/06/2017	04/07/17	14/08/2017	Yes	
17-260	FOI	06/06/2017	04/07/17	29/06/2017	No	
17-261	FOI	06/06/2017	04/07/17	04/07/2017	No	
17-262	FOI	06/06/2017	04/07/17	28/06/2017	No	
17-263	FOI	06/06/2017	04/07/17	28/06/2017	No	
17-264	FOI	07/06/2017	05/07/17	28/06/2017	No	
17-265	EIR	06/06/2017	04/07/17	04/07/2017	No	
17-266	FOI	07/06/2017	05/07/17	11/07/2017	Yes	Yes
17-267	FOI	12/06/2017	10/07/17	04/07/2017	No	
17-268	EIR	12/06/2017	10/07/17	28/06/2017	No	
17-269	FOI	12/06/2017	10/07/17	11/07/2017	Yes	Yes
17-270	FOI	13/06/2017	11/07/17	03/07/2017	No	
17-271	FOI	14/06/2017	12/07/17	16/06/2017	No	
17-272	FOI	14/06/2017	12/07/17	08/08/2017	Yes	
17-273	FOI	15/06/2017	13/07/17	11/07/2017	No	
17-274	FOI	16/06/2017	14/07/17	29/06/2017	No	
17-275	FOI	16/06/2017	14/07/17	11/10/2017	Yes	
17-276	FOI	08/06/2017	06/07/17	29/06/2017	No	
17-277	FOI	20/06/2017	18/07/17	11/07/2017	No	
17-278	FOI	21/06/2017	19/07/17	11/07/2017	No	
17-279	FOI	21/06/2017	19/07/17	20/07/2017	Yes	Yes
17-280	EIR	21/06/2017	19/07/17	11/07/2017	No	
17-281	FOI	21/06/2017	19/07/17	11/07/2017	No	
17-282	FOI	22/06/2017	20/07/17	18/07/2017	No	
17-283	FOI	22/06/2017	20/07/17	29/06/2017	No	
17-284	FOI	22/06/2017	20/07/17	29/06/2017	No	
17-285	FOI	22/06/2017	20/07/17	25/07/2017	Yes	Yes
17-286	FOI	22/06/2017	20/07/17	29/06/2017	No	
17-287	FOI	22/06/2017	20/07/17	07/08/2017	Yes	
17-288	FOI	22/06/2017	20/07/17	29/06/2017	No	
17-289	FOI	22/06/2017	20/07/17	20/07/2017	No	
17-290	FOI	23/06/2017	21/07/17	13/07/2017	No	
17-291	EIR	23/06/2017	21/07/17	13/07/2017	No	
17-292	EIR	26/06/2017	24/07/17	17/07/2017	No	
17-293	FOI	26/06/2017	24/07/17	17/07/2017	No	
17-294	FOI	26/06/2017	24/07/17	11/07/2017	No	
17-295	FOI	27/06/2017	25/07/17	07/08/2017	Yes	
17-296	FOI	27/06/2017	25/07/17	11/07/2017	No	
17-297	FOI	27/06/2017	25/07/17	20/07/2017	No	
17-298	FOI	29/06/2017	27/07/17	17/07/2017	No	
17-299	FOI	30/06/2017	28/07/17	11/10/2017	Yes	
17-300	FOI	30/06/2017	28/07/17	20/07/2017	No	
17-301	EIR	30/06/2017	28/07/17	24/07/2017	No	
17-302	FOI	03/07/2017	31/07/17	24/07/2017	No	
17-303	FOI	03/07/2017	31/07/17	31/08/2017	Yes	
17-304	FOI	03/07/2017	31/07/17	05/07/2017	No	
17-305	FOI	03/07/2017	31/07/17	24/07/2017	No	
17-306	FOI	03/07/2017	31/07/17	24/07/2017	No	
17-307	FOI	03/07/2017	31/07/17	03/07/2017	No	
17-308	FOI	03/07/2017	31/07/17	18/08/2017	Yes	

17-309	FOI	04/07/2017	01/08/17	23/08/2017	Yes	
17-310	FOI	05/07/2017	02/08/17	25/07/2017	No	
17-311	FOI	06/07/2017	03/08/17	07/08/2017	Yes	Yes
17-312	FOI	06/07/2017	03/08/17	07/08/2017	Yes	Yes
17-313	FOI	06/07/2017	03/08/17	27/07/2017	No	
17-314	FOI	06/07/2017	03/08/17	16/08/2017	Yes	
17-315	FOI	06/07/2017	03/08/17	06/07/2017	No	
17-316	FOI	07/07/2017	04/08/17	25/07/2017	No	
17-317	FOI	07/07/2017	04/08/17	25/07/2017	No	
17-318	FOI	10/07/2017	07/08/17	14/08/2017	Yes	Yes
17-319	FOI	10/07/2017	07/08/17	28/07/2017	No	
17-320	FOI	10/07/2017	07/08/17	15/08/2017	Yes	Yes
17-321	FOI	11/07/2017	08/08/17	08/08/2017	No	
17-322	FOI	11/07/2017	08/08/17	18/08/2017	Yes	Yes
17-323	FOI	11/07/2017	08/08/17	09/08/2017	Yes	Yes
17-324	EIR	11/07/2017	08/08/17	28/07/2017	No	
17-325	FOI	11/07/2017	08/08/17	09/08/2017	Yes	Yes
17-326	FOI	11/07/2017	08/08/17	09/08/2017	Yes	Yes
17-327	FOI	12/07/2017	09/08/17	11/10/2017	Yes	
17-328	FOI	12/07/2017	09/08/17	09/08/2017	No	
17-329	FOI	12/07/2017	09/08/17	09/08/2017	No	
17-330	FOI	12/07/2017	09/08/17	27/07/2017	No	
17-331	FOI	14/07/2017	11/08/17	09/08/2017	No	
17-332	FOI	14/07/2017	11/08/17	09/08/2017	No	
17-333	FOI	17/07/2017	14/08/17	20/07/2017	No	
17-334	FOI	17/07/2017	14/08/17	27/07/2017	No	
17-335	FOI	18/07/2017	15/08/17	09/08/2017	No	
17-336	EIR	18/07/2017	15/08/17	27/07/2017	No	
17-337	FOI	18/07/2017	15/08/17	09/08/2017	No	
17-338	FOI	19/07/2017	16/08/17	01/08/2017	No	
17-339	FOI	19/07/2017	16/08/17	27/07/2017	No	
17-340	EIR	19/07/2017	16/08/17	09/08/2017	No	
17-341	FOI	19/07/2017	16/08/17	09/08/2017	No	
17-342	FOI	19/07/2017	16/08/17	09/08/2017	No	
17-343	FOI	21/07/2017	18/08/17	14/08/2017	No	
17-344	FOI	24/07/2017	21/08/17	09/08/2017	No	
17-345	FOI	24/07/2017	21/08/17	09/08/2017	No	
17-346	FOI	09/08/2017	06/09/17	16/08/2017	No	
17-347	FOI	24/07/2017	21/08/17	16/08/2017	No	
17-348	FOI	24/07/2017	21/08/17	11/10/2017	Yes	
17-349	FOI	24/07/2017	21/08/17	26/07/2017	No	
17-350	FOI	26/07/2017	23/08/17	04/09/2017	Yes	
17-351	EIR	26/07/2017	23/08/17	09/08/2017	No	
17-352	FOI	26/07/2017	23/08/17	11/10/2017	Yes	
17-353	FOI	26/07/2017	23/08/17	16/08/2017	No	
17-354	FOI	27/07/2017	24/08/17	16/11/2017	Yes	
17-355	FOI	27/07/2017	24/08/17	16/08/2017	No	
17-356	FOI	28/07/2017	25/08/17	23/08/2017	No	
17-357	FOI	28/07/2017	25/08/17	21/08/2017	No	
17-358	FOI	31/07/2017	28/08/17	18/08/2017	No	
17-359	FOI	31/07/2017	28/08/17	16/08/2017	No	
17-360	FOI	01/08/2017	29/08/17	21/08/2017	No	
17-361	FOI	02/08/2017	30/08/17	21/08/2017	No	
17-362	FOI	02/08/2017	30/08/17	21/08/2017	No	

17-363	FOI	02/08/2017	30/08/17	18/08/2017	No		
17-364	FOI	03/08/2017	31/08/17	21/08/2017	No		
17-365	FOI	03/08/2017	31/08/17	31/08/2017	No		
17-366	FOI	04/08/2017	01/09/17	25/08/2017	No		
17-367	FOI	04/08/2017	01/09/17	16/08/2017	No		
17-368	FOI	04/08/2017	01/09/17	30/08/2017	No		
17-369	FOI	07/08/2017	04/09/17	25/08/2017	No		
17-370	FOI	07/08/2017	04/09/17	31/08/2017	No		
17-371	FOI	07/08/2017	04/09/17	25/08/2017	No		
17-372	FOI	07/08/2017	04/09/17	10/08/2017	No		
17-373	FOI	08/08/2017	05/09/17	08/08/2017	No		
17-374	FOI	08/08/2017	05/09/17	11/10/2017	Yes		
17-375	FOI	08/08/2017	05/09/17	25/08/2017	No		
17-376	FOI	09/08/2017	06/09/17	31/08/2017	No		
17-377	FOI	10/08/2017	07/09/17	07/09/2017	No		
17-378	FOI	11/08/2017	08/09/17	25/08/2017	No		
17-379	FOI	11/08/2017	08/09/17	25/08/2017	No		
17-380	EIR	11/08/2017	08/09/17	30/08/2017	No		
17-381	FOI	14/08/2017	11/09/17	25/08/2017	No		
17-382	FOI	14/08/2017	11/09/17	15/08/2017	No		
17-383	FOI	15/08/2017	12/09/17	05/09/2017	No		
17-384	FOI	16/08/2017	13/09/17	05/09/2017	No		
17-385	FOI	16/08/2017	13/09/17	05/09/2017	No		
17-386	FOI	17/08/2017	14/09/17	05/09/2017	No		
17-387	FOI	17/08/2017	14/09/17	07/09/2017	No		
17-388	FOI	18/08/2017	15/09/17	18/09/2017	Yes	Yes	
17-389	FOI	21/08/2017	18/09/17	14/09/2017	No		
17-390	FOI	21/08/2017	18/09/17	25/09/2017	Yes		Yes
17-391	FOI	21/08/2017	18/09/17	14/09/2017	No		
17-392	FOI	21/08/2017	18/09/17	06/09/2017	No		
17-393	FOI	22/08/2017	19/09/17	06/09/2017	No		
17-394	FOI	22/08/2017	19/09/17	15/09/2017	No		
17-395	FOI	24/08/2017	21/09/17	25/09/2017	Yes	Yes	
17-396	FOI	23/08/2017	20/09/17	12/09/2017	No		
17-397	FOI	23/08/2017	20/09/17	03/11/2017	Yes		
17-398	EIR	24/08/2017	21/09/17	11/09/2017	No		
17-399	FOI	25/08/2017	22/09/17	15/09/2017	No		
17-400	FOI	25/08/2017	22/09/17	25/09/2017	Yes	Yes	
17-401	FOI	29/08/2017	26/09/17	30/08/2017	No		
17-402	FOI	29/08/2017	26/09/17	27/09/2017	Yes	Yes	
17-403	FOI	29/08/2017	26/09/17	27/09/2017	Yes	Yes	
17-404	FOI	30/08/2017	27/09/17	12/10/2017	Yes		
17-405	FOI	29/08/2017	26/09/17	29/08/2017	No		
17-406	FOI	30/08/2017	27/09/17	27/09/2017	No		
17-407	FOI	30/08/2017	27/09/17	27/09/2017	No		
17-408	FOI	31/08/2017	28/09/17	19/09/2017	No		
17-409	FOI	31/08/2017	28/09/17	27/09/2017	No		
17-410	FOI	01/09/2017	29/09/17	28/09/2017	No		
17-411	FOI	04/09/2017	02/10/17	03/11/2017	Yes		
17-412	FOI	04/09/2017	02/10/17	15/09/2017	No		

17-413	FOI	05/09/2017	03/10/17	28/09/2017	No		
17-414	FOI	05/09/2017	03/10/17	11/10/2017	Yes		Yes
17-415	FOI	07/09/2017	05/10/17	02/10/2017	No		
17-416	FOI	07/09/2017	05/10/17	28/09/2017	No		
17-417	FOI	07/09/2017	05/10/17	29/09/2017	No		
17-418	FOI	08/09/2017	06/10/17	06/10/2017	No		
17-419	FOI	11/09/2017	09/10/17	28/09/2017	No		
17-420	FOI	11/09/2017	09/10/17	28/09/2017	No		
17-421	FOI	11/09/2017	09/10/17	28/09/2017	No		
17-422	FOI	11/09/2017	09/10/17	03/10/2017	No		
17-423	FOI	12/09/2017	10/10/17	28/09/2017	No		
17-424	FOI	11/09/2017	09/10/17	28/09/2017	No		
17-425	FOI	13/09/2017	11/10/17	28/09/2017	No		
17-426	FOI	13/09/2017	11/10/17	28/09/2017	No		
17-427	FOI	15/09/2017	13/10/17	06/10/2017	No		
17-428	FOI	19/09/2017	17/10/17	09/10/2017	No		
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17-430	FOI	19/09/2017	17/10/17	06/10/2017	No		
17-431	FOI	20/09/2017	18/10/17	11/10/2017	No		
17-432	FOI	20/09/2017	18/10/17	12/10/2017	No		
17-433	FOI	22/09/2017	20/10/17	11/10/2017	No		
17-434	FOI	27/09/2017	25/10/17	03/11/2017	Yes		Yes
17-435	FOI	27/09/2017	25/10/17	01/11/2017	Yes		Yes
17-436	FOI	28/09/2017	26/10/17	12/10/2017	No		
17-437	FOI	29/09/2017	27/10/17	14/11/2017	Yes		
17-438	FOI	28/09/2017	26/10/17	09/10/2017	No		
17-439	FOI	28/09/2017	26/10/17	09/10/2017	No		
17-440	FOI	29/09/2017	27/10/17	01/11/2017	Yes	Yes	
17-441	FOI	02/10/2017	30/10/17	11/10/2017	No		
17-442	FOI	02/10/2017	30/10/17	03/10/2017	No		
17-443	FOI	03/10/2017	31/10/17	10/11/2017	Yes		Yes
17-444	FOI	05/10/2017	02/11/17	06/11/2017	Yes	Yes	
17-445	FOI	05/10/2017	02/11/17	08/11/2017	Yes		Yes
17-446	FOI	06/10/2017	03/11/17	01/11/2017	No		
17-447	FOI	06/10/2017	03/11/17	12/10/2017	No		
17-448	FOI	06/10/2017	03/11/17	13/10/2017	No		
17-449	FOI	09/10/2017	06/11/17	07/11/2017	Yes	Yes	
17-450	FOI	09/10/2017	06/11/17	27/11/2017	Yes		
17-451	FOI	09/10/2017	06/11/17	N/A	Yes		
17-452	FOI	10/10/2017	07/11/17	24/10/2017	No		
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17-457	FOI	11/10/2017	08/11/17	12/10/2017	No		
17-458	FOI	11/10/2017	08/11/17	19/10/2017	No		
17-459	FOI	11/10/2017	08/11/17	17/10/2017	No		
17-460	FOI	12/10/2017	09/11/17	24/10/2017	No		
17-461	FOI	12/10/2017	09/11/17	13/11/2017	Yes	Yes	
17-462	FOI	12/10/2017	09/11/17	04/12/2017	Yes		

17-463	FOI	13/10/2017	10/11/17	24/10/2017	No		
17-464	FOI	13/10/2017	10/11/17	19/10/2017	No		
17-465	FOI	13/10/2017	10/11/17	17/11/2017	Yes		Yes
17-466	FOI	13/10/2017	10/11/17	09/11/2017	No		
17-467	FOI	17/10/2017	14/11/17	10/11/2017	No		
17-468	FOI	17/10/2017	14/11/17	24/10/2017	No		
17-469	FOI	17/10/2017	14/11/17	24/10/2017	No		
17-470	FOI	17/10/2017	14/11/17	24/11/2017	Yes		Yes
17-471	FOI	17/10/2017	14/11/17	17/11/2017	Yes	Yes	
17-472	FOI	18/10/2017	15/11/17	06/11/2017	No		
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17-474	FOI	19/10/2017	16/11/17	10/11/2017	No		
17-475	FOI	19/10/2017	16/11/17	22/11/2017	Yes		Yes
17-476	FOI	19/10/2017	16/11/17	10/11/2017	No		
17-477	FOI	20/10/2017	17/11/17	08/11/2017	No		
17-478	FOI	20/10/2017	17/11/17	22/11/2017	Yes	Yes	
17-479	FOI	23/10/2017	20/11/17	09/11/2017	No		
17-480	FOI	24/10/2017	21/11/17	01/12/2017	Yes		Yes
17-481	FOI	24/10/2017	21/11/17	22/11/2017	Yes	Yes	
17-482	FOI	24/10/2017	21/11/17	28/11/2017	Yes		Yes
17-483	FOI	25/10/2017	22/11/17	21/11/2017	No		
17-484	FOI	25/10/2017	22/11/17	27/11/2017	Yes	Yes	
17-485	FOI	25/10/2017	22/11/17	28/11/2017	Yes		Yes
17-486	FOI	26/10/2017	23/11/17	28/11/2017	Yes	Yes	
17-487	FOI	26/10/2017	23/11/17	07/11/2017	No		
17-488	FOI	26/10/2017	23/11/17	17/11/2017	No		
17-489	FOI	24/11/2017	22/12/17	27/11/2017	No		
17-490	FOI	30/10/2017	27/11/17	13/12/2017	Yes		
17-491	FOI	30/10/2017	27/11/17	03/01/2018	Yes		Yes
17-492	FOI	30/10/2017	27/11/17	03/01/2018	Yes		Yes
	FOI	31/10/2017	28/11/17	01/11/17	No		
17-493							
17-494	FOI	30/10/2017	27/11/17	21/11/2017	No		
17-495	FOI	01/11/2017	29/11/17	10/11/2017	No		
17-496	FOI	03/11/2017	01/12/17	22/11/2017	No		
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17-499	FOI	02/11/2017	30/11/17	27/12/2017	Yes		
17-500	FOI	02/11/2017	30/11/17	09/11/2017	No		
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17-502	FOI	02/11/2017	30/11/17	24/11/2017	No		
17-503	FOI	03/11/2017	01/12/17	28/11/2017	No		
17-504	FOI	03/11/2017	01/12/17	09/11/2017	No		
17-505	EIR	06/11/2017	04/12/17	01/12/2017	No		
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17-508	FOI	07/11/2017	05/12/17	28/11/2017	No		
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17-511	FOI	07/11/2017	05/12/17	30/11/2017	No	
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17-513	FOI	08/11/2017	06/12/17	28/11/2017	No	
17-514	FOI	09/11/2017	07/12/17	01/12/2017	No	
17-515	FOI	09/11/2017	07/12/17	07/12/2017	No	
17-516	FOI	09/11/2017	07/12/17	28/11/2017	No	
17-517	FOI	09/11/2017	07/12/17	06/12/2017	No	
17-518	FOI	09/11/2017	07/12/17	04/12/2017	No	
17-519	FOI	04/11/2017	02/12/17	17/11/2017	No	
17-520	FOI	09/11/2017	07/12/17	28/11/2017	No	
17-521	FOI	10/11/2017	08/12/17	01/12/2017	No	
17-522	FOI	13/11/2017	11/12/17	28/11/2017	No	
17-523	FOI	14/11/2017	12/12/17	21/11/2017	No	
17-524	FOI	14/11/2017	12/12/17	07/12/2017	No	
17-525	FOI	10/11/2017	08/12/17	11/12/2017	Yes	Yes
17-526	FOI	14/11/2017	12/12/17	10/01/2018	Yes	
17-527	FOI	14/11/2017	12/12/17	12/12/2017	No	
17-528	FOI	14/11/2017	12/12/17	21/11/2017	No	
17-529	FOI	14/11/2017	12/12/17	28/11/2017	No	
17-530	FOI	14/11/2017	12/12/17	11/12/2017	No	
17-531	FOI	15/11/2017	13/12/17	28/11/2017	No	
17-532	FOI	15/11/2017	13/12/17	21/11/2017	No	
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17-534	FOI	15/11/2017	13/12/17	13/12/2017	No	
17-535	FOI	20/11/2017	18/12/17	20/12/2017	Yes	Yes
17-536	FOI	21/11/2017	19/12/17	07/12/2017	No	
17-537	FOI	21/11/2017	19/12/17	08/12/2017	No	
17-538	FOI	21/11/2017	19/12/17	21/12/2017	Yes	Yes
17-539	FOI	21/11/2017	19/12/17	07/12/2017	No	
17-540	FOI	21/11/2017	19/12/17	07/12/2017	No	
17-541	FOI	21/11/2017	19/12/17	07/12/2017	No	
17-542	FOI	21/11/2017	19/12/17	03/01/2018	Yes	
17-543	FOI	22/11/2017	20/12/17	14/12/2017	No	
17-544	FOI	22/11/2017	20/12/17	07/12/2017	No	
17-545	FOI	22/11/2017	20/12/17	07/12/2017	No	
17-546	FOI	22/11/2017	20/12/17	08/12/2017	No	
17-547	FOI	22/11/2017	20/12/17	28/11/2017	No	
17-548	FOI	22/11/2017	20/12/17	28/11/2017	No	
17-549	FOI	23/11/2017	21/12/17	08/12/2017	No	
17-550	FOI	23/11/2017	21/12/17	14/12/2017	No	
17-551	FOI	23/11/2017	21/12/17	08/12/2017	No	
17-552	FOI	23/11/2017	21/12/17	15/12/2017	No	
17-553	FOI	24/11/2017	22/12/17	16/01/2018	Yes	
17-554	FOI	24/11/2017	22/12/17	14/12/2017	No	
17-555	FOI	24/11/2017	22/12/17	19/12/2017	No	
17-556	FOI	24/11/2017	22/12/17	03/01/2018	Yes	
17-557	FOI	24/11/2017	22/12/17	14/12/2017	No	
17-558	FOI	24/11/2017	22/12/17	15/12/2017	No	
17-559	FOI	24/11/2017	22/12/17	13/12/2017	No	
17-560	FOI	27/11/2017	27/12/17	13/12/2017	No	

17-561	FOI	14/12/2017	11/01/18	21/12/2017	No	
17-562	FOI	29/11/2017	29/12/17	14/12/2017	No	
17-563	FOI	29/11/2017	29/12/17	15/12/2017	No	
17-564	FOI	01/12/2017	31/12/17	21/12/2017	No	
17-565	FOI	04/12/2017	03/01/18	14/12/2017	No	
17-566	FOI	04/12/2017	03/01/18	21/12/2017	No	
17-567	FOI	04/12/2017	03/01/18	21/12/2017	No	
17-568	FOI	04/12/2017	03/01/18	03/01/2018	No	
17-569	FOI	05/12/2017	04/01/18	N/A	Yes	
17-570	FOI	05/12/2017	04/01/18	14/12/2017	No	
17-571	FOI	06/12/2017	05/01/18	10/01/2018	Yes	Yes
17-572	EIR	06/12/2017	03/01/18	03/01/2018	No	
17-573	FOI	04/12/2017	01/01/18	N/A	Yes	
17-574	FOI	06/12/2017	03/01/18	14/12/2017	No	
17-575	FOI	06/12/2017	03/01/18	05/01/2018	Yes	Yes
17-576	FOI	07/12/2017	04/01/18	10/01/2018	Yes	Yes
17-577	FOI	07/12/2017	04/01/18	21/12/2017	No	
17-578	FOI	08/12/2017	05/01/18	21/12/2017	No	
17-579	FOI	08/12/2017	05/01/18	14/12/2017	No	
17-580	FOI	08/12/2017	11/01/18	11/01/2018	No	
17-581	FOI	11/12/2017	08/01/18	22/12/2017	No	
17-582	FOI	11/12/2017	08/01/18	14/12/2017	No	
17-583	FOI	11/12/2017	08/01/18	03/01/2018	No	
17-584	FOI	15/12/2017	12/01/18	23/01/2018	Yes	
17-585	FOI	12/12/2017	09/01/18	14/12/2017	No	
17-586	FOI	18/12/2017	15/01/18	18/12/2017	No	
17-587	FOI	19/12/2017	16/01/18	22/12/2017	No	
17-588	FOI	19/12/2017	16/01/18	10/01/2018	No	
17-589	FOI	16/12/2017	13/01/18	10/01/2018	No	
17-590	FOI	20/12/2017	17/01/18	10/01/2018	No	
17-591	FOI	20/12/2017	17/01/18	N/A	Yes	Yes
17-592	FOI	20/12/2017	17/01/18	16/01/2018	No	
17-593	FOI	20/12/2017	17/01/18	03/01/2018	No	
17-594	FOI	20/12/2017	17/01/18	10/01/2018	No	
17-595	FOI	21/12/2017	22/01/18	19/01/2018	No	
17-596	FOI	22/12/2017	23/01/18	19/01/2018	No	
17-597	FOI	22/12/2017	19/01/18	05/01/2018	No	
17-598	FOI	22/12/2017	19/01/18	17/01/2018	No	

Breach 11-20 days	Breach 21+ days	Summary of Request	Review Request Received
		Prescribing Incentive Scheme Compensation for staff Number of schools Violent incidents against staff Out of area inpatient treatment Alcohol and drug budget Emergency attendances due to virtual reality headsets Pest control incidents 2014-17 Out of area inpatient treatment spend Professionals job titles by gender Agency midwives Distinction/discretionary points Cancelled Operations Obesity patient beds and other facilities Consultant overtime working rates Long term sickness Community Mental Health Teams Patients seen by hour and year in A&E Wifi availability Spend and source of hospital food Support from the Red Cross etc Doctors permanent residency outside Scotland Communications between the HB and SG re Agency Nurses Intra-vitreous vials/implants Orthotic contracts Maternity Units closures patients on Oral Nutritional Supplements referred to a dietitian. Out of Hours GPs contracts Healthcare information systems Spend on mesh implants for transvaginal procedures	
	Yes	Patients boarding in non medical beds Ambulance transfers Asbestos related illness and records within NHS Properties Maternity patient safety events Consultants working privately Money owed by overseas patients CRRT machine numbers Dietetic team caseload in Primary Care Support Staff at Galloway Community Hospital Spend on A&E locum doctors HB Budgets for 2017 GP, nursing and consultant post vacancies Eye procedures Spend on taxis Pharmacy staffing Paediatric continence Scanners operating within the Health Board Speech and Language Therapy for stammering in adults IT Spend Rheumatoid arthritis patients	
Yes			

Patients receiving treatment under the European
Cross-border Healthcare Directive
Concussion attendances at A&E and Neurology
waiting times
blood glucose test strip rebate schemes
Referrals for breast reduction
MS Licensed drugs
Mental health A&E attendances
Patients transferred to private mental health inpatient
units
Recycling of medical aids
Patient Access Scheme for Juvenile Idiopathic
Arthritis
patients with Multiple Sclerosis have been treated with
MS disease modifying drugs
Distinction/merit award payment

Spend on Grant Thornton
Breakdown of oral nutrient supplements by hospital,
primary care
Women transferred out of area to access neonatal
facilities
Amount spent on accommodation for patients treated
at other health boards
Use of complementary alternative medicine
Supplier of patient administration systems
immigration health surcharge number of treatments

Walking aids available and those not returned
Minor injury unit attendances at cottage hospitals
LGBT bullying and harassment acknowledgement in
the Workforce Data Report
IMT Middle Management Chart
Bacterial outbreaks
Compensation payouts
Spend on acupuncture
Outsourcing grounds maintenance
Job description for Accounts Payable Manager
Medical attendances at HMP
Asbestos within NHS Properties
Grounds maintenance
Spend on toilet rolls, paper towels and hand wash
Remuneration Committee minutes
Non mesh continence procedures
Pest control incidents 2013-16
Ambulance queuing
Oral contraception prescriptions
Foreign nationals receiving treatment
non-tuberculosis mycobacterium diagnosis and
treatment
Depression and anxiety in cancer patients and staff
sickness due to stress
Spend on Hospital Based Complex Clinical Care
Helicobacter Pylori infections
Amount spent on private ambulances
Looked after children referrals
Missed appointments
Interpreting and translating costs

Contracts and payments made between the Health Board and GP practices and hospital doctor provision

ICT plans and strategies

Hospital risk management process following an incident

Refusal of medical treatment or postponement due to weight criteria

Non compliant payments to junior doctors

Meningitis vaccine uptake for under 5s

Surgical errors

Yes Locum spend over the last 5 years

Car parking charges

Child and Adult dental registrations in DG2

Paediatric general anaesthetic dental extractions

Yes Third Sector organisations funded by the NHS

Dermatology Agency Staff Spend last 6 months

Yes Surgical activity contracted to non-NHS providers

Potential structural defects in NHS buildings

Yes Mortuary capacity

Supplier used for PAS Scheduling Letters

Expenditure against collection and disposal of feminine hygiene waste.

Zero contract hours

Premature baby deaths

Referrals for clinical rehabilitation

Lochside Dental Clinic

Yes Transport of patients, including taxi journeys

Medication usage

Patients treated for Melanoma

Incorrect medical procedures

Yes Maternal / child death figures

Stocks of transvaginal implants

Surgical equipment donated or exported to foreign countries

Homeless people admitted to hospital

Perinatal mental health condition

Baby Friendly Hospital Initiative accreditation

Employment references

Children and Adult Team contact details

Consultant annual job planning software

Body-worn cameras

Patients treated with a chemotherapy agent

Clinical waste bag ties

Staff Nurses from EU Countries

Locum spend within radiology from August 16 - January 17

Workforce statistics by nationality.

Cataract procedures

Employee References

Stillbirth

Acute agency spend on locum doctors Aug 16-Jan 18

HR Software

Workforce statistics for Mental Health Workers,

School Counsellors and School Nurses

Use of Private Ambulances for patients.

Information on PD-L1 testing

Cyber Security breaches

Patient treated with specific drugs for Rheumatoid Arthritis, Ankylosing Spondylitis and Psoriatic Arthritis

Information regarding Plastic Surgery procedures and their criteria for approval.

Artificial Nutrition diagnosis in the Scottish Prison Service

Suicide stats within Mental Health between April 13 - March 16

Online appointment and repeat prescription orders within GP surgeries

GP Practices run by Health Boards

Annual date for hospital stays with VTE/DVT diagnosis.

Yes

Neurological Service Plan

Vacancies

Unfilled vacancies

Medicine usage

Endovascular Procedures

Contract information at PQQ and ITT stages

Cortisone injections for sciatica patients.

GP surgery closures

Hospital meal choices and cost

Register of people with disabilities

Redundancy

Distinction/discretionary points

Translation/interpreting spend

Non-EU nationals funding

Fellowships posts in Radiology

Referrals for physical and mental therapy services

CAMHS Waits

Yes

Yes

Parkinsons - Self administration of drugs and open visiting for carers

Specific mental health diagnosis

GP closed patient register

Buildings at risk

Ophthalmology payments

Addiction Staffing and caseload

Mental health delayed discharges

Diagnosis of mental health conditions

CRI NHS Dumfries Board Members 1993-95

Treatment of Hepatitis C

Child and adolescent admissions to mental health units

Temporary accommodation use for A&E provision

List of public buildings in the NHS

Backlog maintenance

Patients with HER2 Breast Cancer

IT systems

Sexual Health Strategy Minutes

Incidences of VTE/DVT

Pharmacy Minutes for Creebridge

Prolift devices purchased by your NHS Board

Patients treated with specific drugs

Telephone system maintenance contract

Antibiotic-resistant bacteria

Electronic Health Records within Mental Health

Continence Service

	Looked After Children and Young People assessments	
	Confidential Alert line	
	Doctors struck off by the General Medical Council	
	Fentanyl related drug deaths	
	Contraception issued to under 16 year olds	
	Viscosupplementation injections	
	Borderline Personality Disorder	
	Web Filtering Solution	
	Facial palsy procedures	
	Interpreting and translating services	
	Sub-contracts and sub-sub-contracts	
	Total number of staff employed	
	Ambulance response time	
	PFI contracts	
	Multiple Sclerosis treatment	
	Vaginal mesh claims	
	Red Cross support	
	Cyber attack	
	Consultants on 9-1 hour contract	
	Psychiatric Care units	
	Ambulances road worthy and fully stocked	
	Ambulance journeys directed to Minor Injury Units	
	Vaccination for Meningitis B	
Yes	Cyber security	
	GP suspensions	
	Health and Social Care GP Cluster Groups	
	Network and security information for IT systems and equipment	
	Cost of C Card programme	
	Cyber security	
	Medical Consultants	Yes
	Ransomware viruses	
	Accusations of misconduct against surgeons	
	Cleavage sparing mastectomies	
	Energie contract information	
Yes	Data breaches	
	Social media breaches	
	Gaelic speaking memners of staff	
	Prescriptions of medical grade heroin	
	Enhanced Recovery after Surgery Protocol	Yes
	Medical locum doctors	
	Hospital premises	
	Intra-vitreial vials/implants	
Yes	Fleet vans	
	Reception service in hospitals	
	Management of pre-term labour protocols or guidelines	
	Medical consultant posts	
	Orthodontists	
Yes	Ransomware hacking	
	Males Eating Disorders Units around the UK	
	Workforce Spend	
Yes	Eating disorders	
	Epilepsy Service	
	Hair loss	
	Breast reconstruction	
Yes	LAN Contracts	
	Thefts from hospitals	

	Resus trolleys	
	Orthotic contracts	
	Home Schooling	
	Public Dental Service	
	GIST Cancer	
	Suspended Doctors	
	Deaths under GA in Dental	
Yes	ONS Treatment for Migraines	
	PFI/PPP Projects	
	Closed GP lists	
	Staff Pay	
	Severe Asthma	
	Schizophrenia	
	Tattoo removal	
	Maintenance Contracts	
	Oncology Medicine Usage	
	Special Purpose Vehicles	
	Relocation tender	Yes
	Tier 2 weight management	
	Specialist breast nurses	
	Ante Natal Scans	
Yes	Dermatology/gastroenterology drug use	
	Infection Control WTE	
	Staff dress code/uniform policy	
Yes	Mobile contract information	
	Contact details for Heads of Service	
	Consultant vacancies	
	Ophthalmology	
	Establishment control useage	
	Multi-storey hospitals	
	Gastroenterology	
	Eating disorders	
	Code Black calls in hospitals	
	Prompt payments	
	Contract information for services	
Yes	Observation Policy	
	Childhood Obesity	
	Gifts and Hospitality register for staff	
	Junior Doctor hours worked	
	Out of Hours GP requirements	
	Energy efficiency and carbon footprint	
	Car parking charges	
	Abstinence-based drug treatment programmes	
Yes	Management Structure/General Manager Contacts	
	BSL Interpreters	
	Doctors in training for Radiology	
	Mental Health Patients treated out of area	
	Paid as if at work entitlement	
Yes	Telephone system maintenance contract	
	Support for breastfeeding	
	Ventilators, patient warming units and anaesthetic machines	
	DOACs listed on publicly funded drug plans	
Yes	New Medicines Fund	
	Clinical Lead for Out of Hours	
	Diagnosed eye condition	
	Over 65 year old patient discharged overnight	
	Category A callouts for ambulances	
Yes	Private procedures and costs	

	Yes	Unplanned admissions Child and Adolescent Mental Health Service referrals	
		Out of area Mental Health Treatment - Adults Translation costs	
Yes		High blood pressure Inpatient suicides Medical Records Multiple Sclerosis diagnosis Hepatitis C diagnosis Regional Workforce Networks, Forums and Collaborations Lead authority and Lead Commissioner details Refreshment costs Assaults recorded against staff Blood glucose strips/meters Neonatal Abstinence Syndrome Services operating within rented premises Missing patients	Yes
	Yes	International English Language Test Systems Information technology expenditure Medical staff headcount Patient deaths - catergosed as dehydration Workforce headcount - medical Sanitary products Remuneration for Mechanical Engineer / Technician and Electrical Engineer / Technician Auxiliary Nurse Job Description Medical Locum/Doctor agency spend Insulin pumps Retail premises within hospitals Bed capacity Disciplinary of managerial staff Prostate Cancer Survey Fire stopping and fire proofing measures Equal pay claims Mental Health issues faced by staff Adoption of one supplier within tenders Urology doctors Sick days taken by staff Elective surgery statistics Cancer Patients travelling out of area	
	Yes	IT forecast spend GP locum spend	
Yes		Professor McGowan report Carbon Monoxide presentations at A&E	
	Yes	Capital expenditure GP practices directly managed by the health board	
	Yes	Use of Bank Staff Antenatal depression Staff and Associate Specialist doctors employed by the Board Cataract surgery under local anaesthetic Assaults recorded against staff Information Services systems Nursing and midwifery posts HIV patients treated Trade Union Facilities time	

	Car parking charges
	Falls prevention teams
	Public Health interventions
	Managed Ophthalmology Services
	Review of Scottish NHS Board structures
	Spend on crutches
	Staffing numbers
	Serious incidents and adverse event reports
	Number and types of specific medical devices within the Board
	Design services
	Maternity Units closures
Yes	Information governance structures
	Chairmen/women, Directors, Assistant directors and Heads of Services within the Board
	Number of complaints registered against specific doctors
	Workforce planning
	GP surgery closures
	Intersex baby operations
	Email contacts for IT/electronic disposal or recycling
	Number of hours staff took off work for mental health reasons
	Ambulance callouts for mental health
	Number of occasions patients and visitors have been caught smoking
	Waiting time for cataract operations
	18 years old who have spend time on adult psychiatric wards
	Oral surgeon details
	High blood pressure
	Haemodialysis patients
	Diagnosis of Chronic Lymphocytic Leukaemia
	Urgent/emergency ophthalmology service
	In-patient mental health services
	Multiple sclerosis patients treated out of area
	Expenditure for direct recruitment
	Cosmetic surgery procedures
	Serious incidents recorded within the Health Board
	NICE guidance
Yes	Research projected funded by the Chief Scientist Office
	NHS premises
	Physiotherapy and support worker vacancies
	Prescribing decision support system
	Patients missing from Health Board services
	Significant Adverse Event Reports
Yes	Disabled facilities for in-patients
	Outpatient parental antimicrobial therapy
	Mobile Theatres
	Expenditure for mental health
	In-patient mental health services
	Taxi Fares for patient transfer
	Patients treated for cancer
	Dentist and dental staff WTE
Yes	Research funded projects
	Audiology services

	Medical staffing levels at Galloway Community Hospital	
	Child admissions with the primary cause of obesity.	
	Children tested for STIs	
	Children referred to weight management services	
	Children referred for obesity management	
	Multiple sclerosis treatment	
	Patients removed from GP patient register	
	Intra-vitreous vials/implants	
	Transvaginal tape implants	
	Patient admissions coded as Obesity	
	First contact physiotherapy roles in General practice	
	Staff underpayments due to change	
	People treated by Alcohol and Drug Partnerships	
	Pharmacists in the Health Board area	
	Patients treated with specific drugs	
	Diagnosis with Lipoedema	
	Contact details for bloodbanks/haematology department	
	Contact details for the Sterile Services Department	
	IT equipment	
	Reported thefts of inpatient personal items	
	Recruitment of nurses directly employed by the NHS	
	IT Service Management software	
	Adverse events recorded for delay in diagnosis for breast cancer	Yes
Yes	Community Psychiatric Nurses	
	Payments to suppliers	
	Locum GP costs	
	Breakdown of savings	
	Longest time taken to fill a vacancy	
	Child bereavement councillors	
	On-site nursery provision	
	PRS and PPL licence costs	
	Spend on external agency services	
	GP Out of Hours	
	Spend on advertising vacancies at Galloway Community Hospital	
	Specialist registration within Stroke Medicine	
	Prone positioning pillows	
	Insulin Pen Neddles	
Yes	Market research for a potential new lung cancer diagnosis method	
Yes	Outpatient clinics closed	
	Medical locum doctors in Stroke medicine	
	Falls prevention policies	
	Doctors partaking in training fellowships	
	Interpretation services	
	Hearing Aid Dispensers	
	Specialist registration within Elderly Care	
	Sick leave for stress-related illnesses	
	GP Practice list closure	
	Treatment of chronic Obstructive Pulmonary Disease	
	Pinnacle metal-on-metal hips	
Yes	Operations undertaken in English Hospitals	

Obesity related conditions
Staff Sickness Absence
Treatment outwith Scotland
Staff Turnover for the Board
Sepsis deaths
Specialist registration within Radiology
Injuries and patients treated 25 December 2016
Attacks on staff
Board Member expense claims
Medical Locum spend within Oncology
Doctor and Consultant head counts and work contracts
Sick Day through mental health
Policies under the Mental Health Act
Cancer Waiting Times
Staffing Level concerns
Female Genital Mutilations statistics
New Staff recorded as EU Nationals
Patients treated for Acromegaly with specific drugs

Waiting times for beds once admitted through A&E

Projections and plans for staff beds for all acute specialties

Urothelial Cell Cancer Questionnaire

Non-Small Cell Lung Cancer Questionnaire

Treatment for Chronic Migraine and Headache

Deaths records on NHS premises by type

Formulary on Blood Glucose Test Strips and Insulin

Pen Needles

Specialist registration within Stroke Medicine

Personal information

Staffing structure for mental health care

Procurement of Ophthalmology - DGRI

Procurement of Ophthalmology - Galloway

Community Hospital

Contact details for Children's Commissioning

Manager and Mental Health Commissioning Manager

Yes

More than 18 weeks waiting times for CAMHS

Delayed discharge

Incidents logged on Datix by staff

Patients missing from Health Board services

Prone restraint useage

Yes

Electroconvulsive Therapy for patients

Complaints recorded relating to Sexual Harassment in the workplace

Specialist sexual abuse recovery services

Waiting time for hip replacement

Interview paperwork

Hours lost due to sickness

Financial deductions imposed for service failure

Alterations in A&E and admission services at

Galloway Community Hospital

Spend on private operations

Prisoners treated for mental health conditions

Viagra prescriptions

International patients treated within the Health Board area

Yes

	Admissions to hospital for drug overdoses	
	Use of gloves by medical staff	
	Total agency spend for medical locum doctors in Radiology	
	Training budgets	
	Nursing Workforce	
	Maternal use of drugs	
	Volume of posts advertised	
	Weight management referrals	
	Cleaning monitoring in Out Patients in October 2017	Yes
	Interpreter services	
	Policy on Health apps	
	Carers employed by the Health Board	
	Spend on Ophthalmology Agency Spend	
	Presentations at A&E for dog bite injuries	
	Medical consultant remuneration	
Yes	Suicides and attended suicides within health board facilities	
	Referral policies for elective procedures	
	Spend on Agency doctors and Nurses	
	Premium rate phone line useage	
	Adult severe asthma patients	
	Dumfries Prisoners who have self-declared themselves with mental health problems	
	IVF Services	
	Cancer diagnosis in the region	
	Special Leave Policy	
	Patients with surgical infections	
	Doctors partaking in training fellowships	
	Children diagnosed with STIs	
	A&E attendance due to needle stick injuries	
	Hydrotherapy pools	
	Spend on agency staff for clinical areas	
	Spend on overtime / additional payments to medical staff	
Yes	Patient accommodation out of area	
	Amputation due to an infection	
	Senior managers with terminated contracts due to performance	
	New outpatient GP referrals to adult mental health services	
	CA125 blood tests	
	IT Contracts	
	Information regarding workplace injury on new hospital site	
	Tattoo removal	Yes
	PACS system	
	List of all GP Federations	
	Orthotics service	
Yes	Assess the incidence of systemic anti-cancer treatment (SACT) extravasation in clinical practice	
	Number of trained doctors employed by specialty	
	Spend on art	
Yes	Inpatient beds in Psychiatric Intensive Care Units	
	GP surgeries permanently closed	
	Incidents records at NHS mortuaries	
	Research into Idiopathic Pulmonary Fibrosis	
	Sexual Assault Referral Centre incidents on Datix	

	Moderate or severe atopic dermatitis
	Waiting time for knee replacement
	Spend on Gastroenterology Locums
	A&E attendance by postcode area
	General Data Protection Regulations
	Permanent vacancies for doctors
	Doctors partaking in training fellowships
	Eating disorder treatment
Yes	Personal Health Record / Patient Portal
	Pharmaceutical samples
	Significant Adverse Event Reports
	Survey of GMS premises
Yes	Fixed Telecommunications and Internet Services
	Hepatitis C patients
	Diagnosis for all inpatient admissions to Child and Adolescent Mental Health services
	Workforce
	Children referred to private or independent sector mental health treatment
	Otolaryngology Doctors
	GP practices with closed or limited lists
	Clinical Psychology Programme contracts
	Incentive schemes for GP practices
	Recruitment difficulties in GP Practices
	Doctors partaking in training fellowships
Yes	Telehealth
	GP practice branch surgeries closed
	Car Parking charges
	Teir 3 Adult Drug Treatment Services (Drug and Alcohol Services and Prisons)
	Models of clinical equipment e.g crutches
	Copy minutes re Acorn House
	Serious Incident Reports for GP Out of Hours
	Biologics and biosimilar prescribing
	Sleep Deprivation Survey
	Charges to administer check-off for specific unions
	Contact details for consultants in Care of the Elderly, Neurology and Psychiatry
	Ovarian Cancer Survey
	Muscular Dystrophy stats for young adults
	Information on where self-referral is available for children and young people requiring treatment for an eating disorder.
	Banking Supplier

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Application
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DUMFRIES and GALLOWAY NHS BOARD

5th February 2018



BOARD BRIEFING

Author:
Rachel Hinchliffe
Communications Assistant

Sponsoring Director:
Jeff Ace
Chief Executive

Date: 24th January 2018

RECOMMENDATION

The Board is asked to note the Board Briefing.

CONTEXT

Strategy / Policy:

This paper supports the Board's Communication Strategy and gives recognition to key events within the Board.

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

The paper of this paper is to raise awareness of the events and achievements that have been acknowledged within the Board over the past 2 months, as well as giving an indication of the consultations that are currently underway and the commitments for both the Chief Executive and Chairman going forward.

GLOSSARY OF TERMS

NHS - National Health Service

MONITORING FORM

Policy / Strategy	<i>NHS Dumfries and Galloway Communication Strategy</i>
Staffing Implications	<i>Not applicable</i>
Financial Implications	<i>Not applicable</i>
Consultation / Consideration	<i>The information within this 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>This paper encompasses all 7 Corporate Objectives.</i>
Single Outcome Agreement (SOA)	<i>Not applicable.</i>
Best Value	<ul style="list-style-type: none"> • Vision and Leadership • Effective Partnerships • Use of Resources • Performance Management • Equality
Impact Assessment	Not applicable.

NOT PROTECTIVELY MARKED

Introduction

Section 1 – Events

Two Local Nurses Receive Honour of Becoming Queen's Nurses

Two community nurses were among a group of 20 to have been awarded the title of Queen's Nurse, marking the first time the honour has been made in Scotland for almost 50 years in December 2017.

Hazel Hamilton and Kelvin Frew were selected earlier this year to take part in a nine-month development programme run by the Queen's Nursing Institute Scotland (QNIS).

Hazel, senior charge nurse for community nursing in Annandale and Eskdale, and Kelvin, a community psychiatric nurse who is team leader of the NHS Dumfries & Galloway Crisis, Assessment and Treatment Service (CATS), were nominated by their managers for providing high quality, compassionate nursing care.

After completing the nine-month QNIS programme, they have earned the right to use the Queen's Nurse Title which dates back to the late 19th century when nurses trained at institutes across the country until 1969.

They were presented with a certificate and badge by Great British Bake Off judge Prue Leith during the QNIS awards ceremony in Edinburgh.

Strategic Inspection of Clinical Pathways

Between January and March 2016, the Care Inspectorate and Healthcare Improvement Scotland carried out a joint inspection of Adult Services within Dumfries and Galloway, which evaluated the partnership against 10 quality indicators.

Dumfries & Galloway has now been selected as a pilot site for a Strategic Inspection of Clinical Pathways by Healthcare Improvement Scotland. This is a new inspection methodology which has been developed by Healthcare Improvement Scotland and will focus on particular clinical pathways. These are Anticipatory Care Planning and Health Inequalities and Equity of Access to Health and Social Care. The inspection will be conducted by Healthcare Improvement Scotland but will be supported by representatives from other agencies including Care Inspectorate.

The inspection process will be managed on behalf of Health and Social Care Senior Management Team by Graham Abrines, General Manager Community Health and Social Care and Alice Wilson, Deputy Nurse Director and will be supported by Sandra Graham, Project Officer.

Next Steps

Information Services Division will provide a case sample of 16 individuals (4 per locality) who meet agreed criteria; age, residential status, frequency of unscheduled care and regular prescribing and care costs.

Initial contact will be made with each individual to explain the process and gain their consent to participate. A case file review of the records is planned for 19 February 2018 and will be conducted by representatives from Healthcare Improvement Scotland and Care Inspectorate, with support from local staff.

Once this is complete, Inspectors will meet with individuals, family members and carers to discuss the delivery of care and their experience. We will also invite staff representatives who have been directly responsible for the delivery of care to attend meetings with the inspectors, these will focus on discussions around integrated working and how the delivery of care enables individuals to achieve personal outcomes. This is provisionally planned for 19 March 2018.

For further information about this inspection please contact Sandra Graham sgraham3@nhs.net

Section 2 – Staffing Changes, including new starts, retirements

Specialist Drug and Alcohol Service

Lucy McHarrie joined the Specialist Drug and Alcohol service as Health Care Support Worker from Monday 18 December.

Specialist Addiction Nurse, Lisa Stanley joins the Specialist Drug and Alcohol Service. Lisa started on Monday 8 January 2018 and will be working with the West Team.

Smoking Matters

Susan McKie moves from Smoking Matters to take up a new post as the MPower implementation Lead in Wigtownshire.

Finance

Kyle McKie moved from Communications/Business Intelligence to Administration Assistant in Finance

Loyalty Awards

Please see below name of those who have received Loyalty Awards in November 2017:

Lynn Harvey	Staff Nurse	Ward 7, DGR1	02/04/1990
Pippa Mulhearn	Podiatry Assistant	Gardenhill Health Centre, Castle Douglas	14/09/1992
Gavin Brotherston	Senior HCSW	Balcary Ward, Midpark Hospital	14/09/1992

Introduction

Section 3 - Current Consultations

From	Topic	Response due by
Scottish Government	Minimum Pricing <i>Response Submitted</i>	26/01/2018
Scottish Government	Revised Ovarian Cancer Quality Performance Indicators Consultation	24/01/2018
Scottish Government	Consultation on a Diet and Obesity Strategy for Scotland	31/01/2018

Section 4 – Chief Executive and Chairman Commitments

Chief Executive's Diary		Chairman's Diary	
Key Events		Key Events	
February		February	
13/14	NHS Chief Executives Meeting	23	West of Scotland Chairs Group
20	Management Team		
March		March	
6/7	NHS Chief Executives Meeting	1	West of Scotland Health and Social Care Delivery Plan Engagement Even
20	Management Team	16	Non-Executive Directors Networking Event
		26	NHS Chairs Meeting

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
- Chair of the SI National Planning Forum - HM Membership Committee

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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

DUMFRIES AND GALLOWAY NHS BOARD



Audit and Risk Committee

Minutes of the Audit and Risk Committee meeting held on Monday 2nd October 2017 at 1.30pm – 4.00pm in the New Boardroom, Crichton Hall, Bankend Road, Dumfries, DG1 4TG.

Present

Dr L Douglas	LD	Non-Executive Board Member (Chair of Committee)
Ms L Bryce	LBr	Non-Executive Board Member
Mrs G Cardozo	GC	Non-Executive Board Member
Ms G Stanyard	GS	Non-Executive Board Member

In Attendance

Mr J Ace	JA	Chief Executive
Mrs K Lewis	KL	Director of Finance
Mr E Docherty	ED	Nurse Director
Ms J Watters	JW	Chief Internal Auditor
Ms L Bass	LBa	Executive Assistant to Director of Finance (Minute Secretary)
Mr G Gault	GG	General Manager ICT (Item 14 only)

Apologies

Ms J Brown	JBr	External Auditor – Grant Thornton UK LLP
Mrs R Francis	RF	Audit and Risk Committee Lay Member
Ms S Thompson	ST	Deputy Director of Finance

Mr Robert Allan

It was with much sadness and deepest sympathy that the Committee acknowledged that Mr Robert Allan, Chair of the Audit and Risk Committee, Counter Fraud Champion and Non-Executive Board Member, passed away on 27th August 2017. Robert was a very active member of the Board and made a significant contribution to NHS Dumfries and Galloway. Robert will be sadly missed by all those that had the pleasure of working with him. The Committee paid tribute to Robert's leadership as Chair of the Audit and Risk Committee, recalling his achievements, significant experience, wide ranging skills, comradeship and dedication to colleagues, staff and patients throughout NHS Dumfries and Galloway.

Chair of the Audit and Risk Committee

It was noted that LD had formally accepted an invitation to become Chair of the Audit and Risk Committee. LD expressed her admiration and respect for Robert and hoped that she would be able to honour Robert's legacy by continuing to work diligently as Chair of the Audit and Risk Committee.

1. Apologies for Absence

Apologies as noted above.

2. Declarations of Interest

The Committee Chair asked members if they had any declarations of interest in relation to the items listed on the agenda for this meeting. It was noted that no declarations of interest were put forward at this time.

3. Minutes of meeting held on 19th June 2017

Two comments were made in relation to actions from the minutes. For completeness, these have been noted under Item 4 (Matters Arising).

Audit and Risk Committee approved the minutes from the previous meeting on 19th June 2017.

4. Matters Arising and Review of Actions List

The following items were noted from the minutes:

- Page 8, bullet point 1 – Whistleblowing investigation. GS referred to learning around this, noting that *“the policy had been written more from the Whistleblowers perspective and that clear processes need to be in place to ensure the right people are kept informed”*. Committee agreed that assurance for this should be sought from Staff Governance Committee. This will be added to the Actions List.

Action: LBa/Staff Governance Committee

- Page 8, bullet point 4 – Historical issue around learning disability housing. It was noted that *“Penny Halliday (Non-Executive Board Member/Vice-Chair), would be requesting an update at the next Health Care Governance meeting.”* Committee were not aware that an update had been provided; ED will follow up. This will be added to the Actions List.

Action: LBa/ED

KL took members through the actions from previous meetings. A number of areas were discussed, as follows:

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- Assurance Map – KL advised that Laura Geddes and JW are working on this and a draft document will be presented to December Audit and Risk Committee.
- LBr referred to the action re the Audit and Risk Committee Self Assessment and that this would be discussed at the next Chairs session. It was noted that a Chairs session is still to take place; LD will follow this up.

Action: LD

- In terms of the work around historical audit actions, KL recalled that this was an exceptionally busy period with the New Hospital and although good progress has been made over the past year, progress is likely to dip over the coming months. LD acknowledged this and agreed that a pragmatic approach was required. LD sought assurances that high risk outstanding actions be addressed first. GC suggested that a review be undertaken to ascertain if a 'collection' of outstanding actions could lead to high risk. *Note: Discussion and action around this continued under Item 8.*

Audit and Risk Committee noted the Actions List.

5. 2017/18 Audit and Risk Committee Agenda Matrix

KL presented the paper and advised that the matrix has been refreshed for 2017/18. The matrix also reflects the format of the June meeting which has a different order to business as a result of the presentation of the Annual Report and Accounts. As per the Audit Committee Handbook, the Chair should take ownership of, and have final say in the decisions about what business will be pursued at any particular meeting.

Audit and Risk Committee:

- Approved the 2017/18 matrix and approved the use of this as a template for drafting the meeting agenda recognising that the Chair has the ability to adjust the agenda as required to fulfil the needs of the Committee.

JA arrived at this point in the meeting.

6. External Audit Quarterly Progress Update

KL provided an update on Grant Thornton's behalf:

- 'NHS in Scotland 2017' report planned for late October publication by Audit Scotland. Expected to continue to give hard messages on workforce and financial sustainability.
- Audit planning guidance for 2017/18 was published by Audit Scotland last week – no significant changes.
- External Audit Plan will come to December Audit and Risk Committee.

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- Plan is for session to be arranged with Grant Thornton in late October to look at what went well/less well in the 2016/17 audit and agree a timetable and plan for 2017/18.

KL added that various work is also ongoing around accounting for the New Hospital.

Audit and Risk Committee noted the report.

7. Audit Scotland Reports Update

KL presented the paper advising that a register is maintained of all reports received from Audit Scotland. The full register for 2017/18 was attached as an appendix. Two reports have been issued from Audit Scotland which have not previously been reported at Audit and Risk Committee; these were attached as appendices and are noted below:

- NHS Workforce Planning - The clinical workforce in secondary care
- Principles for a Digital Future - Lessons learned from public sector ICT projects

In terms of the Good Practice Note for improving the quality of NHS annual report and accounts, KL advised that that was issued quite late for full incorporation into the 2016/17 accounts but will be considered more fully for the 2017/18 accounts.

In terms of the NHS in Scotland 2017 report due in October 2017, KL advised that this will be circulated to Board Members and action taken accordingly.

A number of queries were made in relation to the NHS Workforce Planning report:

- GC noted that NHS Dumfries and Galloway has the highest rates for cancelled interview panels for consultants. GC queried if there were any specific reasons for this. JA advised that he has discussed this with the Workforce Director and this is mainly an administrative issue, due to the regular scheduling of panels which then result in cancellations due to lack of suitability/candidates.
- Committee sought assurances that this report would feed into the NHS Dumfries and Galloway Workplan; this will be fed back to the Workforce Director.

Action: KL

- LBr queried how the NHS Dumfries and Galloway Workplan would fit with integration. KL confirmed that an Integrated Workplan will be developed which will encompass NHS, Social Work and Third Sector.

- In terms of assurances and ensuring links are made across the Committees/Directorates, JW commented that a review of the Governance Statement could perhaps support this and provide an opportunity to identify gaps. LD added that the Assurance Map would also support this.

Audit and Risk Committee noted the paper.

8. Internal Audit Activity Quarterly Progress Update

JW presented the report which provided an update on progress against the 2017/18 Internal Audit Plan. JW highlighted the key points from the paper:

Overview

- There has been another audit concluded in this period from the 2016/17 audit year in relation to the IJB audit plan. This audit is being reported separately through the IJB's Audit and Risk Committee.
- An appendix was included which demonstrated progress against the 2017/18 Audit Plan. Two audits have been completed to Preliminary reporting stage and 1 audit to Final reporting stage.
- In terms of the New Hospital - Migration and Commissioning Plans audit, JW advised reporting is being progressed at an early stage, noting that it was important to feedback promptly to support the move to the New Hospital.
- JW highlighted the table and diagram showing the status of audit actions. JW provided further analysis advising that 131 are overdue; these are graded as follows - Low: 10, Medium: 61 and High: 60. It was noted that 60 have been overdue for over a year.
- JW highlighted some common themes/trends in terms of areas falling behind eg. policy reviews, risk registers, cross-directorate work.

There was brief discussion with the following noted:

- LD reiterated the earlier comment around busy workloads and a focus on high risk outstanding actions. JA and KL advised of continuing work in Management Team to highlight audit actions, noting that some good improvement has been made over the last year.
- Committee agreed that KL would review outstanding audit actions from a management perspective to ascertain:
 - Which items are high risk and what progress is being made
 - If there is a 'collection' of outstanding actions that could lead to a high risk in specific areas.

Action: KL

- GC referred to the selection process for the Internal Audit Plan and queried if community engagement should be considered for inclusion in 2018/19. KL and JW explained the process for selection of internal audits within the Audit Plan.

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- JW noted that it may be useful to involve Non-Executives in the planning process for next year. Committee agreed this would be useful.

Action: JW

- There was also discussion around the Assurance Map with LD highlighting that once this is established, both the Non-Executives and Internal Audit will be able to utilise this strategically for looking at pertinent areas for future Internal Audit Plans.

Key Performance Indicators (KPIs)

JW advised that, as discussed in previous meetings, the Internal Audit team have reviewed the KPIs for the department. The Chief Internal Auditor met with the Chief Executive and the Chair of Audit and Risk Committee to formally agree objectives for the year. Concurrent to this, the Chair of Audit and Risk Committee sought the views of Committee members on proposed KPIs. Feedback received indicated a view that KPI's should be focussed on outcomes and suggested a focus on Cost, Quality and Delivery. These factors have been incorporated into the proposed KPI's indicated in the appendix to the paper.

In terms of the continuous improvement KPI, JW advised that a voluntary questionnaire is issued after each audit and the return is around 27%. JW queried if this should be mandatory to complete. Committee had a number of views on this, with some members agreeing that it should be to ensure this KPI is measurable, whilst others commented on time restraints and ensuring the content is meaningful (rather than quick completion as seen as a requirement). It was felt that this was an operational decision for Internal Audit to consider.

Audit and Risk Committee:

- Noted the report.
- Approved the proposed KPIs and agreed to receive information on performance against these at future Committee meetings

Action: JW

9. Limited Assurance Update

JW presented the paper and advised that that there have been no Limited Assurance audit reports issued since the last Committee meeting in June 2017. An update on outstanding Limited Assurance audits was provided. These are:

- RM/01/13 Risk Management – 2 remain open
- A/03/15 CEL's and other SG guidance - 1 remain open
- A/06/15 Waste Management – 3 remain open
- A/06/16 - Theatre Stores and Stock Controls – 1 remains open

Committee noted that steady progress is being made with these audits. KL referred to work on the Risk Appetite Statement and queried whether the Risk Management audit actions could now move towards completion. Committee acknowledged that work was still required around embedding the statement.

Audit and Risk Committee noted the report.

10. Business Continuity Audit (A-04-16) Progress Update

JA presented the paper (from David Irving (DI) (Resilience Co-ordinator)) recalling that an initial report was submitted to the Audit and Risk Committee in March 2017. The Committee requested an update report be presented at the September 2017 meeting.

The following key points from the paper were noted:

- Internal audit carried out an audit of Business Continuity in 2016. Thirteen specific issues were identified and an agreed Management Response Action Plan was produced with target dates ranging from 31 December 2016 to 30 April 2020. A copy of the Management Action Plan was attached as an appendix and demonstrated progress against each recommendation.
- As detailed in the last report, primary focus for Business Continuity was in developing plans and arrangements for our eight critical services. Details of progress made in these areas were detailed in the paper.

Committee reviewed the paper and acknowledged that steady progress had been made. LD felt that some further detail was required in the 'Progress to date' column to highlight if work had commenced and what stage it was at. JA will feed this back to DI. KL advised that a Director's Business Continuity session will be taking place in November to review plans in place.

There was a brief discussion on plans and exercises for mass casualties and work around the Prevent Strategy.

Audit and Risk Committee noted the report.

11. Property Transactions Monitoring 2016/17

JW presented the paper, advising that the requirements of the NHSScotland Property Transactions Handbook have been complied for all transactions concluded in 2016/17. An Annual Property Transactions Return was attached as an appendix and will be issued to the Scottish Government Health and Social Care Directorates (SGHSCD) by the 30th October 2017 deadline.

JW advised that the following transactions were reviewed to address the stipulations for disposals as defined by the Handbook:

- Disposal by sale - Garrick Hospital Site, Stranraer
- Disposal by sale - Huntingdon House, Dumfries

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For the property transactions concluded during the financial year, all confirmed a monitoring Category A denoting the proper conduct of each transaction.

GC queried if the NHSScotland Property Transactions Handbook needed to be updated in relation to the Community Empowerment Act. There was a brief discussion around this and also alignment with the Asset Transaction Handbook. KL agreed to look into this further.

Action: KL

Audit and Risk Committee noted the paper and the Annual Property Transactions Return.

12a. Risk Appetite Statement

ED presented the paper noting that the Risk Appetite Statement has been presented and reviewed on a number of occasions over the past few months. Following the Audit and Risk Committee meeting in June 2017, a number of amendments have been made. An updated simplified version was presented today for review and approval.

ED suggested that, if approved, the Risk Appetite Statement be incorporated into all Committee papers. It was also suggested that the statement be reviewed on an annual basis, as part of the Audit and Risk Committee matrix.

The Committee considered how the Risk Appetite Statement would be used going forward eg. communication methods, application, monitoring, reporting etc. It was noted that the Core Briefing, Beacon and external NHS Dumfries and Galloway website could be used to promote the statement. Committee felt we should aim for the statement to be launched and initially embedded within a 6 month period.

Audit and Risk Committee

- Approved the amended Risk Appetite Statement for inclusion in the Risk Management Strategy and implementation Board-wide.
- Agreed that a review of the latest version of the Risk Appetite Statement will be reviewed and brought back to Committee for discussion and approval in September 2018 and annually thereafter, unless otherwise requested.
- Agreed that a formal report should be submitted to Audit and Risk Committee in March 2018 to advise how the Risk Appetite Statement has been implemented Board-wide.

Action: ED

12b. Risk Management Assurance Update

ED presented the Risk Management Assurance Update paper. The paper included updates on:

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- The Corporate Risk Register
- Risk Executive Group
- Risk Steering Group
- Risk Management Strategy

LD queried if it would be possible to include an overview of key highlights from the Corporate Risk Register into future reports. ED agreed to look at this for the next meeting.

Action: ED

LBr queried if risks around the Volunteer Strategy had been noted in any risk registers. ED suggested that the Risk Appetite Statement could be applied to support this and advised that this would sit with the Person Centred Health and Care Committee.

There was a brief discussion around risk related roles:

- LD confirmed that it is her intention to continue in her role as Risk Champion.
- The role of Counter Fraud Champion will be considered in due course.

Audit and Risk Committee

- Noted the report.
- Approved the Risk Management Strategy, which includes the revised Risk Appetite Statement.
- Agreed that assurances on the risks around the Volunteer Strategy be sought from the Person Centred Health and Care Committee.

Action: ED

13. ASRP Programme Board Risk Register

KL presented the paper and advised that the approach to risk management follows the Board's overall Risk Management Strategy and is as follows:

- Risk workshops are held on a bi-monthly basis, with the Operational Team, to review and update all open risks and to consider any additions or deletions. It was noted that the report advised that a meeting had taken place on 13th June 2017 and LD queried if another one had taken place. KL advised she would clarify this.

Post meeting note: Because of the run up to hospital practical completion on 11th September 2017, no Risk Workshops took place in August and September. The next workshop will take place on 11th October 2017 in time for the next update at the end of the month (25th).

- Following the workshops, schedules of the updated risks are shared with the executive owners for comment.

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- A Risk Management paper is presented to the Acute Services Redevelopment Programme Board for scrutiny and noting on a bi-monthly basis.
- The latest risk register and report to the Programme Board was attached as an appendix to the report.

JA briefly spoke of the four highest risks noted in the paper. In terms of the two risks around roadwork alternations, JA noted the frustrations around this, however, provided assurances that these were manageable and would not cause major disruption.

Committee acknowledged that the risks and movement on these was updating regularly as we move closer to the move. It was noted that two additional high risks were reported to the NHS Board meeting on 2 October 2017 around telephones and wifi. Board were reassured at the Board meeting that these issues were under control.

KL advised that the Mountainhall Risk Register will be presented to the Audit and Risk Committee in December.

Audit and Risk Committee noted the report.

It was agreed to move to Item 15 at this point in the meeting.

15. Compliance with Standing Financial Instructions (SFIs) Update

KL presented the Compliance with Standing Financial Instructions SFIs paper to Committee. KL advised that this report has previously focussed on two elements of the SFIs:

- Satisfying the requirements to report to Audit and Risk Committee on the procurements over £50k that have taken place during the period
- Waivers which have been approved.

KL advised that, to support development of the report to consider further aspects of compliance with SFIs, a review of different sections will be included in each report going forward. For this quarter's review, the focus is on areas where Audit and Risk Committee are specifically mentioned in the SFIs as having a role.

A number of appendices were included:

- Appendix 1 provided a breakdown of each mention of Audit and Risk Committee within the SFIs.
- Appendix 2 detailed any specific duties of the Audit and Risk Chair for information.
- Appendix 3 provided detail of the procurements over £50k which have been run and accepted since 1 April 2017 by the Board.

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- Appendix 4 set out the general waivers which have been approved which can be for any area of the SFIs
- Appendix 5 set out the waivers which have been approved in relation to Section 11 (Purchase of Supplies and Services) excluding the new build.
- Appendix 6 set out the waivers which have been approved in relation to Section 11 (Purchase of Supplies and Services) for the new build. These are exceptional and will drop off once the project is complete.

KL advised that there is increased scrutiny around waivers to ensure these are compliant with SFIs, which has resulted in an increase in volume. 44 waivers have been approved since April 2017.

GC queried if there had been an increase in Freedom of Information (FOI) requests from suppliers over the past few months. KL advised that there have been a few more recently around procurement and provided some examples. KL added that a Procurement Strategy Update will be presented to Performance Committee in January 2018.

Audit and Risk Committee noted the report.

GG joined the meeting at this point.

14. Information Assurance Update

GG presented the Information Assurance update and advised of the following key points:

- The Information Assurance Committee has met once (8th August 2017) since the last Audit and Risk Committee. Copy of the minute was attached as appendix.
- The Information Assurance Framework has been updated and was attached as an appendix.
- Audit and Risk Committee previously requested an update on the Management response to the external Security Audit undertaken by Pricewaterhouse Coopers (PwC). A copy of the PwC report and management response was attached as an appendix.

GG talked through the Framework and the Management Response to the PwC report with the following key points noted:

- A new dedicated Security Officer has recently been appointed.
- An update was provided on the equipment, networks and the Virtual Desktop Infrastructure solution for the New Hospital. Further security measures will be in place on the new systems.
- Work is underway to streamline products on a local and national level.
- More proactive monitoring is now taking place.
- An update was provided on protection in place for virus attacks.

- Noted that Dr Angus Cameron has recently retired and that Senior Information Risk Officer (SIRO) role is currently vacant. Options for this are being considered.

Committee discussed the report with the following noted:

- LD referred to the target dates in the Management Response and queried if these were achievable. LD was keen to ensure these were stretching yet achievable and realistic for the team. GG felt these were achievable.
- KL referred to the Information Assurance Committee minutes and noted delays with signing of the information data sharing document between NHS Dumfries and Galloway and Dumfries and Galloway Council. GG confirmed that the Service Level Agreement (SLA) for sharing of adult information has been signed and is progressing.
- JW referred to the first two actions in the Management Actions, noting that these involved cross directorate workings and this could be challenging. GG felt this was manageable but noted that timescales could be dependent on other areas progressing their areas of work.
- GS noted the reference to DATIX in the Information Assurance Committee minutes and comments around ownership. GG and ED provided background information to this and explained processes further.

Audit and Risk Committee:

- Noted the report.
- Approved the Information Assurance Framework.
- Noted the PwC report and Management Action Summary and agreed that a progress report be included in the Information Report presented to Audit and Risk Committee at each meeting.

Action: GG

GG and ED left at this point in the meeting.

16. Legal Claims and Clinical Negligence and Other Risks Indemnity Scheme (CNORIS) update

JA presented the paper which provided an update on:

- Types of claims (clinical and public liability) and how these are managed.
- A quarterly report from CNORIS was included in the paper. JA referred to the NHS Boards benchmarking graph within the CNORIS report, highlighting NHS Dumfries and Galloway's performance in relation to other Boards.
- Details on current claims
- National Updates
- Mesh Litigation - JA provided further detail around Mesh Litigation, advising of impact on a national and local level

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- Historic Child Abuse Inquiry - JA provided background information to this. At this stage, there does not appear to be any areas of specific concern, however, JA was keen to keep the Committee informed.

Audit and Risk Committee noted the report.

17. Fraud Quarterly Update

JW presented the Fraud Quarterly Update. Audit and Risk Committee was asked to note the paper which included five Intelligence Alerts received from Counter Fraud Services (CFS). The two latest alerts will be communicated via the Core Briefing and Beacon.

KL added that Counter Fraud Services delivered four Combating Bribery and Fraud sessions to over 50 staff in August and September 2017.

Audit and Risk Committee noted the report.

18. National Fraud Initiative (NFI) 2016/17

JW presented the paper advising that the NFI data matching exercise for 2016/17 is co-ordinated by Audit Scotland on behalf of the Audit Commission. The paper covered the following key points:

- Background
- Compliance
- Data Submission
- Data Matches

JW advised that the data matches were released in two stages and provided further information on the process. This will be reviewed further and all outcomes noted in the final NFI report due to Audit and Risk Committee in March 2018.

Audit and Risk Committee noted the report.

19. Finance Quarterly Update

KL presented the Finance Quarterly Update paper to Committee. The report covered the following areas, with KL providing brief detail on each area:

- Technical Bulletin summary
- Changes in accounting for leases
- Annual Accounts preparation
- Accounting for the New Hospital as a Non Profit Distributing model
- IR35
- Cash arrangements following migration to New Hospital
- Bank Signatories

- Information on losses and special payments

Audit and Risk Committee noted the report.

20. 2018 Audit and Risk Committee meetings

A timetable for proposed 2018 Audit and Risk Committee meetings was presented to Committee.

JW advised of challenges around running reports for Committee deadlines and queried if meetings could be scheduled for later in the month in 2019 eg. last Monday of the month. Committee noted this and also acknowledged the complexities of the corporate diary and other meeting commitments. JA advised of ongoing work to look at the corporate diary and Committee meetings in general.

Audit and Risk Committee approved the timetable for 2018. LBa will circulate meeting appointments.

Action: LBa

21. AOCB

a. Whistleblowing Policy

GS (Whistleblowing Champion) advised of ongoing work on the Whistleblowing policy and queried if Audit and Risk Committee should be presented with the report on this. It was confirmed the Audit and Risk Committee will seek assurance on this from Staff Governance Committee.

Action: GS

b. Reports to Audit and Risk Committee

LD thanked leads for tightening up the length of reports; this has resulted in shorter and succinct reports this month. LD added that it would also be useful for recommendations to be firmed up a little to ensure these are meaningful and provide clear direction to Committee.

Action: Leads submitting reports

22. Date and Time of Next Meeting

The next meeting of the Audit and Risk Committee will be held on 18th December 2017 at 10.00 am – 1.00 pm in the New Boardroom, Crichton Hall, Dumfries.

DUMFRIES AND GALLOWAY NHS BOARD

HEALTHCARE GOVERNANCE COMMITTEE

20 November 2017

10 a.m., New Board Room, Crichton Hall

Present:	Mrs. Penny Halliday Mr. Jeff Ace Ms. Lorna Carr Dr. Martin Connor Mr. Eddie Docherty Dr. Ken Donaldson Ms. Laura Douglas Mrs. Joan Pollard Mr. Bill Rogerson Mrs. Elaine Ross Ms. Gillian Stanyard Mrs. Alice Wilson	Non Executive Member (Chair) Chief Executive Chair – Area Clinical Forum Infection Control Doctor Nurse Director Medical Director Non Executive Member Associate Director of AHPs Lay Member Infection Control Manager Non Executive Member Deputy Nurse Director
Apologies:	Dr. Greycy Bell Ms. Lesley Bryce Mr. Phillip N. Jones Ms. Michele McCoy Mrs. Julie White	Associate Medical Director for Primary Care Non Executive Member Chairman Interim Director of Public Health Chief Operating Officer
In Attendance:	Helen and Jack Ms. Grace Cordozo Mrs. Vicky Freeman Ms. Emma McGauchie Ms. Amanda Roddick Ms. Ananda Allan Ms. Nicole Hamlet Ms. Annette Finnegan Ms. Margaret Johnstone	Patient Story Non Executive Member Head of Strategic Planning Adverse Events Co-Ordinator (shadowing AW) Occupational Therapist (shadowing JP) Health Intelligence Specialist General Manager A&D Complaints Co-Ordinator E.A. to Nurse Director

Patient Story

KK introduced Helen and her baby son. Helen explained that she had emailed Maternity Services to offer thanks to and say what a fantastic team we have and KK had asked her to come along to HCGC to tell her story in relation to the birth of her son. She outlined a very positive story but as the birth had happened so quickly she was unsure about things and was pleased to be given the opportunity to come back for a debrief meeting with the midwives involved in her care.

In response to JA asking about the debrief KK explained that women can request their notes and are then offered a follow-up meeting with the staff involved in their care who go through the notes with them and let them know what happened although this is different for everyone. LD commented that she had not had a debrief and asked what was the trigger for this with KK responding that an informal debrief is normal in midwifery, either by the midwives in Cresswell or the Community Midwives who usually ask “how did things go” and “how are you feeling”? “Time to Talk” cards are given on discharge with the invite to come back any time and women can self refer or be referred by their Health Visitor. C-Section patients come back to see the Consultants. KK noted that some work needs to be done around the “Time to Talk” cards as we are not very good at this.

GC asked Helen if, in her role as a nurse, following her intimate experience with the midwives were there things people could learn in the wider nursing background from her story. Helen highlighted the “fresh eye” scenario she had described saying that this was a really good thing. She explained that everything was well co-ordinated, she was given fluids and had bloods taken prior to the midwife calling the anaesthetist and as Helen was nervous and upset the midwives called a female doctor. Helen commented that in the general wards this sort of holistic approach is not taken, saying that the Consultant was in the room with her husband keeping him informed at all times and they both really appreciated this. PH asked Helen if she felt safe and Helen responded that yes she did, she had been chatting to the midwives around what to expect and what would happen and they were very reassuring so she felt really safe. GS commented that the communication Helen received would help to make her feel safe and for her husband to know what was going to happen next would have supported her as well. Helen agreed that she had been able to ask lots of questions and the midwives had made time to answer them, did not rush her and ensured that she understood what was going on, for example, the reason for the high blood pressure alarms going off.

PH commented that as Helen had reflected on her experience, she was hearing that she had learned from this and Helen responded that she will be changing her nursing practice as she realised that as a patient it’s all the little things you remember and these small things are really special. PH commented that this was good person centred care, that patient stories are really important and thanked Helen for taking the time to come along to talk to the Committee.

1. **Apologies for Absence**
Apologies as noted above.

2. **Declarations of Interest**
Nil.

3. **Notes of meeting held on 17 July 2017**
Accepted.

4. **Matters Arising**
Care of Older People in Hospital
AW highlighted the Healthcare Improvement Scotland (HIS) informal visit in September explaining that the visit had started off with a presentation on Care Assurance which resulted in no questions from HIS as we had provided everything they were looking for although they did visit a couple of wards where they talked to staff about DNACPR and the Anticipatory Care Plan.

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HIS have written back to us noting the improvements and to say that they have no intention of visiting DGRI for some time.

PH asked for one thing HIS had taken away and AW responded that this would be the care assurance work as the ward staff were able to talk to them about this which was really good. ED commented that the programme key is the level of supervision and support it gives to staff and if this works it will be great, rather than waiting for the SCN staff will generate their own action plans. He noted that this is a strong piece of work which is being led by AW and Karen Hills. AW highlighted care assurance in Ward 14 saying that the impact of this has shown a reduction in falls which was not a specific aim but has happened. PH commented that it would be interesting to find out why this is happening and make this link. ED commented that we are approaching this programme so that it does not become just a check list, senior staff are providing clinical supervision for all levels of staff, supervising and assessing all of the care. PH commented that this is an internal quality assurance system with staff supervising and supporting each other but it would be interesting to hear how the staff feel about this. AW explained that the staff felt threatened at the beginning but now we are going through the programme we are receiving good feedback.

5. **Action List and Draft Agenda**
Accepted.

STANDING ITEMS

6. **Patient Experience Report**
JP presented the update on the activities of the Patient Services Team.

Spiritual Care

JP noted that the Spiritual Care Lead (SCL) is arranging a Bereavement Workshop, working with the Health and Social Care Group, to highlight gaps and needs across the region.

The SCL and the local Inter-Faith Group plan to create “paper leaves” of remembrance to be available for people who visit the Sanctuary to write prayers, wishes, loved ones names etc on the leaves and hang them on a “display tree”. An electronic remembrance board will be available to all staff. JP confirmed that a tree is being planted in the garden in remembrance of Robert Allan.

Volunteers

JP noted that 250 volunteers have been recruited and are in place for the opening of the new DGRI with 23 of them being between the ages of 16 and 25. JP noted that work is ongoing on the Strategy which is almost ready to process.

Patient and Carer Information

JP noted that we are in the final piece of work in relation to ward folders which will be attached to the end of every bed in each of the rooms.

Participation and Engagement Network

JP tabled the “Participation and Engagement Network” leaflet which, along with a suite of promotional materials from Communications, will be launched in January.

Patient Feedback

JP noted that 38 pieces of feedback were received in September of which 16 were complaints, noting that currently 5 complaints are being investigated by the Scottish Public Services Ombudsman (SPSO). JP explained that we are still below target for Stage 2, 33% instead of 80%, acknowledging that these are more complex complaints which take longer to close and we have negotiated extensions with the complainants. JP confirmed that the national template has been agreed. JP highlighted Learning from Complaints, explaining that we are hopeful that "Nvivo" will move forward when the new build pressures on IT end.

ED commented that Acute and Diagnostics (A&D) have taken a very strong view on the challenges of complaints and as we have had concerns for a while AW is engaging with A&D to support the process around complaints and adverse events until this is embedded. He explained that the Patient Experience Team will be on site at the new hospital, over the migration spell, to take any complaints/patient feedback. JA explained that both Forth Valley and Glasgow had a spike in their complaints when they moved and he is expecting this will happen with our move and an increased presence on site is good. JP noted that, apart from A&D, performance is outstanding and ED commented that we have turned complaints around. JP explained that if we want to give A&D good outcomes it will take a longer time to respond due to the complexity of the complaints.

NH highlighted improvements made in A&D in the last few months, the main one being AF making contact with complainants. She noted a lot of Stage 1s had been escalated to Stage 2 and she was not comfortable around this, feeling that we were unable to understand what the individuals were concerned about. NH explained this had been a good process as we can now deal with complaints more informally and build relationships around how we fix things although most people want us to make sure their experience doesn't happen to someone else. NH feels Stage 1 is now improved but at Stage 2 performance is not good in terms of 20 days but this is due to complex complaints, people who have lost people, tertiary centres, a number of individuals delivering care and not about meeting a 20 day deadline. NH feels we should get the staff who delivered the care involved in meetings with the individual to discuss their patient experience although this will require behavioural changes. She acknowledged that we did not let people know it would take longer than 20 days to respond but now AF contacts individuals, keeps in touch with them and makes sure they know why it is taking so long and are aware of what's happening. NH acknowledged that this is someone's life which has been turned upside down and we have a part to play in this, it's about people feeling they are being listened to. NH noted that currently the new hospital is taking up a lot of time but she is committed to driving forward improvements and AW has volunteered to help with this. She explained that she expects feedback to rise with the move to the new build and will gather this feedback around fixable things like signage.

AF highlighted the concerns around Stage 1 and 2 explaining that she and Peter Bryden now meet with the Management Group weekly and hopes this new development will make a difference with actions being allocated appropriately.

LD said “well done” to the Team acknowledging that the quality of what you are doing is leaps and bounds from where we were. GC commented that this is the most reassuring input she had ever heard on complaints, highlighting the drive and human element, engaging and supporting people through the process and encouraging staff to hear what people have experienced is interesting. She highlighted this morning’s patient story of an experience in midwifery and the importance of the debrief suggesting that we would be wise to build on this and use the “Time to Talk” cards where we can and give a human approach. NH responded that within care assurance there is an opportunity for conversations to happen when people are in our care and capture our feedback then rather than them going away and writing a letter. She acknowledged that there is still a long way to go and will continue to drive this forward. JP commented that there is a section in the patient leaflet inviting feedback and this should encourage feedback within the hospital. AW highlighted the link to care assurance saying that asking patients “what would have made this better?” will be built in to the programme to bring in a more routine way of asking for feedback.

PH commented that the Committee is satisfied with the quality of what is happening with complaints. She agreed that as the outcome is important, a more person centred approach from us would take more than 20 days, saying that it is understandable that when a complaint is about care from another health board, or care home, it will take longer. KD commented that we will have more and more of these complaints but they are still our patients even if treatment is from outwith the area. PH noted the expected spike in complaints during migration and the practical steps to take to make improvements saying that we are miles away from where we were and we now have a better understanding of what is involved in dealing with complaints.

LD highlighted the Volunteering Champions and JP responded that this would come under the strategy and through the PCH&CC.

Scottish Public Services Ombudsman

PH highlighted the SPSO report to be laid before Parliament and JP outlined the recommendations explaining that the complaint raises the potential for the Board to pay a proportion of costs for people in care homes. The concern around this is a reputational one and that of setting a precedent. ED commented that our processes had been maintained and this is not about anything we have done but is a test case and what this will mean across the rest of Scotland. JA commented that this goes back to our ability to make payment unless we have a local parameter. PH requested an update at Performance Committee to include the challenges and criteria, and where we are now, explaining that this will also be an Integrated Joint Board (IJB) issue, this is a grey area we need an answer to.

JP commented that we followed the national process and PH noted this is about how we get the message across to people that we follow national guidelines and protocols, saying it would be interesting to see the outcome of this case.

The Committee:

- Considered the report

7. **H.A.I. Report**

ER presented the paper noting the previous discussion on patient experience and highlighting the patient experience of a patient with C.Diff.

ER explained that the numbers continue to rise and we have missed the local delivery planned target. She highlighted outcomes from the "C.Diff Summit", held on 2 November with very helpful input from Health Protection Scotland (HPS), saying that there is no outbreak, no obvious link between cases and a high number of community cases for the first two quarters of this year. The Team had looked at prescribing and ER explained that we had stopped using Tazocin, despite there being evidence this is protective of C.Diff, and when we changed antibiotics in May/June the community case numbers dropped and there was a rise in cases of healthcare associated infections. ER thinks this is a link with prescribing and we will move back to Tazocin and wait to see if this makes a difference. ER noted that lots of detective work had taken place and we have a clean hospital with staff who know what they are doing. HPS are confident the Board has handled this well.

ER highlighted MRSA screening noting that we have an alert system in place which works well and our compliance rate is at 100%, the highest Board in Scotland.

ER emphasised that our challenge is the community and we need to think about how we can deal with this in care homes and care at home, noting that discussions are starting with Public Health around resources to address this.

ER highlighted the flu cases in Ward 9 saying that the staff were alert to this and there were no staff transmissions and no cross transmissions which was very positive and well done to all the staff who achieved the shortest length of ward closure with hospital management supporting our strategies.

PH noted the good news around compliance with the MRSA target. She highlighted care delivery in people's homes saying that we would expect to see infections from the community and assuming that Public Health will raise awareness around hand washing. ER noted the Health Protection Team deliver to care home staff but there is no audit or inspection of care homes so we do not know what this will look like nationally or how much surveillance is required and we do not have the resources to deliver what we would like to.

ED commented that we are good at managing in-patient areas but what does the next tier of this look like. He said that the C.Diff Summit, which was a multi-disciplinary group, went well with high levels of support from operational management team and offered congratulations to everyone involved in this. A follow up meeting will take place on 27 November to ensure actions are ongoing.

JA noted how well managed Ward 9 was, in a busy week for DGRI with January levels rather than November levels and the respiratory out in the community which pushes us to high end systems for the move although we can cope with the numbers and they will be as heavy as we thought they would be.

MC commented that over the next few years more varied infections will come up and we can find out what we are dealing with within hours, it's important to identify these things quickly. PH said the move to the new hospital will help and MC responded that the use of single rooms will go a long way to controlling infections as long as people wash their hands. PH asked if hand washing was the same as using the gel and MC responded no with ER explaining that hand washing is best but damages the skin long term. She highlighted the current talk of using "fit-bits" in the new hospital for staff to measure how far they are walking, saying that a "bare below the elbow" campaign will be in place. ED commented that the wearing of fit-bits will be unacceptable and he will put this statement out, pedometers will do the same.

The Committee:

- Considered the paper.

8. **Patient Safety Report : Acute Directorate**

AW presented the joint Patient Safety/Acute and Diagnostic Teams paper highlighting a couple of things which are concerning, pressure ulcers and falls, both of which have increased reporting. A comment had been made to AW around falls that staff had just got better at reporting and she acknowledged that this may be right but that we do not know this and we need to query the reason for an increase and look at falls. AW noted that the impact of Care Assurance had shown a reduction in falls in Ward 14 suggesting that there was something we could do around this. Pilot Ward 18 shows a reduction in falls with harm.

AW noted that pressure ulcers are being reported more but we are putting a spotlight on them with Datix showing that the grading is not right and this is the next piece of work we have to do. ED commented on the new presentation format for this report explaining that this is a national strategy which is receiving good feedback across Scotland and would echo the points AW has made, saying that pressure ulcers are a big worry. This has been discussed at the Quality and Patient Safety Leadership Group (QPSLG) where it was noted we don't have a Tissue Viability Nurse so assessments are not followed up. We now have an understanding of what our problems are, pressure ulcers and falls with harm, so we need to identify what is going on and get on top of pressure ulcers as soon as possible.

PH commented that pressure ulcers is something she remembers happening to old people who were in bed for a long time and AW responded that there are a number of factors to developing a pressure ulcer and the biggest thing to reduce or prevent is taking pressure off people. She highlighted the frequency of care saying that we have no clinical lead for pressure ulcers and this is an issue and we may be at a disadvantage not having someone. ED noted that this conversation will be taken forward and we will drill down a bit more, tying in frailty (Frailty at the Front Door) with falls and pressure ulcers as all these things will interlink very well and we need to do something about tissue viability.

ER noted that most of our SABs are skin and soft tissue and MC suggested linking with the Antimicrobial Team and in turn the Infection Control Team. KD noted that Dr. Fiona Green was the TV Lead but due to pressure of work could not continue this.

ED explained that there are areas of excellence across Scotland with Glasgow seeing some results so we should be able to lift from this. PH commented that a clinical lead and co-ordinator would provide a focus and she would support this.

The Committee:

- Considered the report and agreed the new format.

INTERNAL REPORTS

9. Quality and Patient Safety Leadership Group (QPSLG) : Significant Adverse Events

AW presented the paper explaining that this was the first paper for some time, requesting a reporting timetable and suggesting six monthly. She noted that the paper outlined the number and type of incidents and the challenges around sharing learning. AW highlighted the Healthcare Improvement Scotland (HIS) template (Appendix 3) asking if this format could be shared with staff and with the Committee, explaining that there has been discussion at QPSLG around how we move this forward as it contains information which can identify teams and this has already been raised by staff. She asked the Committee how we might use this as a newsletter or update and what they thought of it as an idea. PH commented that the paper is here to talk about the process not the content.

ED noted that the form is a version of what the military uses for incidents or events and there's lots of work to be done around what the format looks like. He noted that we tested a newsletter but the content was not right. ED highlighted challenges across Scotland within Freedom of Information (FOI) requests, for example, one Health Board shared SAERs on their website but had to remove this, but another Board was criticised for not giving enough information. ED agreed with the suggested six monthly reporting.

PH noted the Committee is asked to discuss and seek assurance on the process with ED commenting that this is the Adverse Events process and a paper will go to Management Team on how this will look. He noted that Mental Health and Midwifery are very good at internal reviews but do not call them SAERs. AW commented that the involvement of families and people in adverse events can be agreed at the beginning of the process, with someone keeping in touch, sharing our report with them and giving the opportunity for someone to sit down with them and discuss the report. PH commented that she was not sure what the process for managing adverse events is from the paper and ED explained that the QPSLG meets weekly to review G, H and I (cause harm or death to patients) adverse events. This is a multi-disciplinary group which makes a decision on does this require to be investigated, an SAER, and communicates this and follows up with the complainant/family being involved. Any recommendations go to the Directorate and they complete an action plan closing all loops. PH asked what assurance do we have that adverse events are being reported at ward level and AW responded that the Adverse Events Co-Ordinator links across Board on how Datix is being used with ED commenting that we cannot say the process is perfect but it is robust. GC asked how do you make sure that families have good communications throughout this process and ED responded that this is an effective process for us, the lead investigator will link with the family asking what questions do you have and will set timescales, outlining how systems will work.

GC commented on the transparency, confidentiality and very sensitive information and PH commented that from looking at this paper, in a small board like ours, someone will know someone from this information. AW commented that we have taken out lots of information and it is nameless but agreed it is a delicate balance, there is sensitivity for staff around this and patients may not agree to us sharing this.

JA commented the issue is what should this be, asking if this would be learning or improvements around how we describe events. ED commented that we need to move forward as, highlighting the described FOI, we have not got this right yet. PH commented that we should be sharing information locally and nationally as soon as we start to think we have problems. LD asked how QPSLG satisfy themselves action plans are appropriate and ED responded that we share recommendations and agree the action plan reflects work that is going on, routinely asking for updates until the action plan is signed off. GC suggested that the risk appetite framework could be used around this with JA commenting that this was a good point and ED agreed that this should be a board level discussion, as did PH.

GS asked if this is this national criteria and ED responded that yes it is, identify as G, H, I and then local decision making, explaining he would rather do ten investigations than miss one.

PH noted the Committee is asked to discuss and seek assurance around the process for managing SAERs and agree the timetable.

The Committee:

- Considered the report and agreed reporting timetable.

10. **Recruitment of Palliative Care Consultant**

JA updated that we are currently in discussions, at the job plan stage, with an individual but no appointment has been made as yet. In response to PH saying that the post had been vacant for almost a year and asking for a timeline JA explained that he could not guarantee a timeline and that there had been no other applications or expressions of interest. PH asked what happens if we cannot recruit to this post and JA explained that we have really struggled with this post and he is hopeful we can appoint but cannot guarantee this and if not it will be back to square one.

The Committee:

- Noted the update

11. **Mental Health Change Programme**

DM presented the paper as a summary of the work taken forward as outlined in the Mental Health Change Programme plan. DM highlighted Wigtownshire which was a challenge for the Team moving forward with the programme and described developments which have been completed in the Crisis and Treatment Service (CATs) across Dumfries and Galloway, in the IDEAS Team and in the development of the home based Managing Rehabilitation.

She highlighted the closure of Darataigh and the impact this has had in the area with the development of services we did not have before, CATs 24 hour service, IDEAS team across 4 localities which has benefitted the area, taking forward mobile solutions for community nurses and pilot models for groups of nurses.

PH highlighted the three additional Healthcare Support Workers asking if this was three full-time posts and DM responded that they were two full-time and one thirty hour posts.

PH highlighted the GP pilot noting that this covers deprived areas and the reduction of people who are being readmitted to Midpark Hospital with DM explaining that the pilot works out of Waverley Medical Centre covering areas of deprivation and we are receiving positive feedback from GPs and service users. She explained that in relation to patient experience feedback around quality of care we have not been good at picking this up and are planning, as part of wider development, to look at how we capture this using a range of questions and tools. DM noted that the increase in admissions to Midpark Hospital demonstrates access to in-patient services, which may have been blocked before due to capacity, and represents improved patient flow.

PH highlighted EMI beds in the community and in care homes, which are a challenge in Wigtownshire, asking how does this affect quality of care and DM responded that the IDEAS work is looking at and contributing to how we support the community as best we can, managing people in Stress and Distress effectively and efficiently. Community mental health nurses are attached to each of the care homes in the four localities and are accessible for advice. PH asked if there are challenges within care home provision and DM responded that this may have a consequence for us around how we review EMI placements as people move on, teams change and people become frail and less challenging to remain within EMI and how we move people out and create capacity.

PH suggested raising awareness in the community about the difference this has made and the success we have had, letting people know they have had better services, for individuals and families, since Darataigh closed.

LD highlighted computerised CBT (cCBT) asking if there was any feedback. DM explained that this is still in the early days, only been running for six months, but people are using this and moving through the process quite successfully and we are encouraging people to use this resource.

GC highlighted Wigtownshire asking if there was a miss-match on what the community thinks the improvements have been and what we think there is, we need feedback from the community to continually improve. DM commented that we still have a number of individuals who push against what we have taken forward and object to what we say has been a success, however, the Community Mental Health Team are looking at holding some drop in sessions, CATs is being developed further and we are engaging with the community. GC commented that engaging with the community is really important, highlighting the 3rd Sector and asking if engaging with the 3rd Sector is being addressed and DM responded that lots of work is taking place around the patient experience triangle of care and how we engage with carers and people who use our services and what their expectation is.

DM noted the mental health services had received a national award recently from the Mental Health Nurse Forum and have been short listed for another.

GS highlighted emotionally unstable people saying that the evidence based intervention clinical management programme could be applied here using the stress and distress management model of care. DM confirmed that patients can access a range of different services for support which keeps them in a safe place.

PH commented that lots of good work is happening and we need to share this.

The Committee:

- Considered the report

12. **Adult Supported Accommodation and Residential Placement Panel**

SY presented the paper outlining the role of the panel in managing access to specialist resources for adults with complex health and social care needs across Dumfries and Galloway, along with a copy of the nomination form. SY explained that the current panel replaced the Social Services Learning Disability Placement Panel and the Access to Housing for Vulnerable People Panel in June 2016. She noted that the Panel is still in its infancy and the hope is that it will become more of a multi-disciplinary panel with input from health. PH suggested that this would become an Integrated Joint Board document as we move forward.

GC highlighted the Service User Group section of the form suggesting that it would be useful to have a little bit more space to add in LGBT identification under "Other" and GS asked if the "Service User" title was appropriate. SY responded that the process is set by Social Services and she would take both comments back to the Panel. LD thanked SY for her very clear report and asked about accommodation and SY responded that there is a definite shortage of very specialist accommodation and we can have people waiting for this. There is no information and data on future needs but it is hoped to gather this in the future. LD asked if the accommodation was on a first come first served basis, how do the Panel agree who gets the accommodation and is there a clear criteria and SY responded that the Panel looks at the level of need and a number of other factors including risk to the patient and/or family. She noted that there is no written criteria and the decision is based on the information presented.

PH highlighted secure accommodation, asking if a young person was completely out of control and not suitable for residential care, would they go out of region. SY explained that the panel tends to focus on adults and has not looked at out of region placements since she joined. PH highlighted that the Scottish Government is talking about extending the terms of Looked After Children to age 25. PH invited SY to go along to the IJB Committee meeting to talk about the Panel.

The Committee:

- Considered the report

13. **Burial and Cremation (Scotland) Act 2016 : Progress Report**
ED updated on the local position with regard to the Burial and Cremation (Scotland) Act 2016 explaining that the key point is that the prescribed forms and information will be laid before Parliament by the end of this year and entered into statute at the beginning of 2018. ED noted that our current Service Level Agreement (SLA) 2015 covers the work taking place.

GC highlighted the language within the paper saying that both “pregnancy loss” and “foetus” are used and asked what happens if parents refuse a shared cremation. ED will pick up with KK and come back to GC.

The Committee:

- Considered the report.

ITEMS FOR NOTING

14. **HCGC Dates for 2018**
The Committee noted the dates of meetings for 2018.
15. **Tuberculosis Annual Report 2016**
The Committee noted the report.
16. **Circulars and Safety Action Notices 2017-18**
The Committee noted the report.
17. **Notes of the Health Adult Support and Protection Committee – 9 August 2017**
The notes of the Health Adult Support and Protection Committee held on 9 August 2017 were noted.
18. **Notes of the Health Child Protection Committee – 3 July 2017**
The notes of the Health Child Protection Committee held on 3 July 2017 were noted.
19. **Notes of the Infection Control Committee – 5 July 2017**
The notes of the Infection Control Committee held on 5 July 2017 were noted.
20. **Any Other Competent Business**
PH offered congratulations to ED who has received an award for outstanding achievements in Advanced Practice.

PH offered thanks to Gill Stanyard for the blog she had written about the late Robert Allan.

Date of Next Meeting

Monday 15 January 2018, at 10 am, in the New Board Room, Crichton Hall.

DUMFRIES AND GALLOWAY NHS BOARD

PERSON CENTRED HEALTH AND CARE COMMITTEE

23 October 2017

1.30 pm, New Board Room, Crichton Hall

Present:

Ms. Penny Halliday	Non Executive Member (Chair)
Mr. Eddie Docherty	Nurse Director
Mrs. Joan Pollard	Associate Director for Allied Health Professionals
Ms. Lynsey Fitzpatrick	Equality and Diversity Lead
Ms. Caroline Sharp	Workforce Director
Ms. Vicky Freeman	Head of Strategic Planning
Ms. Jan Lethbridge	Inter Faith Council Member
Ms. Michele McCoy	Interim Director of Public Health
Ms. Mandy Spence	Midwifery Representative
Ms. Gillian Stanyard	Non Executive Member
Ms. Dawn Allan	Spiritual Care Lead
Mr. Dennis Cameron	Third Sector Representative
Ms. Phyllis Wright	Council/Social Work Representative
Ms. Shirley Turberville	University of West of Scotland

Apologies:

Mr. Jim Beattie	Non Executive Member Chair – Area Partnership Forum
Ms. Claire Brown	Lead Officer Integration Project (East), Third Sector
Ms. Lorna Carr	Chair – Area Clinical Forum
Dr. Ken Donaldson	Associate Medical Director
Ms. Sue Newberry	Regional Integration Manager, Scottish Care
Mrs. Grace Cardozo	Non Executive Member

In Attendance:

Miss. Nicola Ross	PA to Associate Director or AHPs
Ms. Maureen Stevenson	Patient Safety & Improvement Manager
Mrs. Kerry Willacy	Project Support Officer

1. Apologies for Absence

Apologies as noted above. PH advised the committee that Douglas Irving has now retired but he will contact Dumfries & Kirkcudbright Presbytery Clerk with a view to securing a replacement to attend at future meetings.

2. Declarations of Interest

Nil.

3. **Notes of meeting – 21 August 2017**

Mindfulness – MMcC raised a query around the recording in the minutes of what had been agreed at the August meeting. MMcC recollection was that the J. Kopela would provide a regular updates to the committee which would include qualitative and quantitative data. PH agreed that this was correct. Agreed minutes accurate otherwise.

4. **Matters Arising**

Bereavement

JP advised the group that the Bereavement Workshop will be arranged for the New Year once the move to the New Build has taken place. DA will lead on this workshop. DA will work with others to identify the Board's responsibility for Bereavement. JP commented the outcomes will be reported to Board following the workshop. PH agreed this was appropriate.

Logic Model

JP has circulated a first draft of the logic model and is working on a second draft based on the feedback she has received so far. This will be brought to the Committee once it is completed.

5. **Action List**

Agreed to add the Bereavement Workshop.

6. **Anticipatory Care Planning**

Maureen Stevenson, Patient Safety and Improvement Manager and Kerry Willacy, Project Support Officer attended the meeting and provided the group with an overview on what Anticipatory Care Planning (ACP) is. Maureen Stevenson gave a presentation to the group (attached).

The National launch of the ACP will take place in November 2017.

PH advised that she had been present at the recent GP Cluster meeting and was concerned about the response from a number of GPs that they had little/no time to complete the document as it was too large. MS advised that they would continue to work with the GPs to look at different options. One of the key messages is that the ACP document does not belong to the GP and therefore, it is the individuals to complete as they wish however they may require some support/conversations with their GP to help with the completion.

PW commented that she had attended the last Anticipatory Care Stakeholder meeting and there was a change in culture from some of the GPs by the end of the event. Some of the GPs that are working in Out of Hours are already seeing the benefits of an ACP and it is reducing the number of times patients are being seen or admitted to hospital.

KW provided some positive feedback from the Stakeholder Group. Care Homes have really made progress with their plans and GPs are now seeing less of the same patients. In most care homes, there is a contractual agreement that Care Home staff must complete a similar document within the first 24 hours of their residence.

The Committee:

- Agreed to have an update on ACP in 6 months

7. **Terms of Reference**

JP presented the Terms of Reference and advised that the proposed changes from the August meeting had been made. PH noted that the membership of the Committee has changed slightly as the Committee business has changed over the last few years. VF commented that Social Work were missing from the Terms of Reference however, the committee agreed that PW would represent Council and Social Work.

PH reminded the Committee that Carolyn Hornblow now has retired and asked how we can recruit a new representative on behalf of patient/carers. PH suggested Third Sector and ED also mentioned the Public Engagement Network. PH suggested a Carer Representative. VF suggested that Linda Owen would be able to assist in seeking a Carer/Carer representative but the committee need to be clear what their role in the committee would be and who they would represent. It was recognised that any member lay member of the committee would require support. JP and PH agreed that they would be able to provide support to this person along with VF's team. PW advised that Claudine Brindle has also noted an interest in the group who would be keen to attend however, PH is keen that this representative is a Carer.

CS raised a question around Spiritual Care representation. CS wondered if we should continue to have a single faith representative within the Committee. PH recollection around why Church of Scotland is represented as they have the biggest denomination however, LF commented that for Equality and Diversity, we should really be looking for a representative from a minority group to ensure that their voices are being heard. Following a discussion, the Committee agreed that DA would represent all faith groups and DA would invite particular faith groups if required, rather than them being a member. MMcC noted that we should be seeking assurance that the Committee are representing all faiths and young carers. DA agreed that she could provide this assurance. PH feels that there are wider strategic issues with young people across the region. PH agreed a representative from Carers Reference Group should be recruited.

The Independent Sector representative would be Dr Sue Newberry.

PW asked who the Mental Health representative is and this is currently a vacancy. JP will recruit a member for future meetings.

Following a discussion, the Committee agreed to add 'using a co-production approach' would be added the Objectives section of the Terms of Reference.

The Committee agreed:

- Adjust the membership as discussed
- DA would represent all faith groups
- There would be no Church of Scotland representation
- Co-production will be added to the Objective section

8. **Spiritual Care and Bereavement Support**

DA referred the Spiritual Care & Bereavement Support update which had previously been circulated and raised key points:

Bereavement

Following earlier discussion around the Bereavement Workshop, DA noted that she had met with Alex Little to take this forward and arrange it for the New Year. DA will invite Alex Little along to the next Person Centred Care Committee to provide an update.

Bereavement Policy – DA is waiting on feedback from colleagues at a national level to see if she can create something based on policies which already exist. DA will keep the Committee updated with progress.

New DGRI Hospital

DA commented that she has recently been made aware that there is no access from Women & Children's to the Sanctuary from the outside, the only access is through the staff corridors. DA reassured the Committee that blessings, communion and prayers will be able to take place at the bedside and DA has suggested to the team at Cresswell that we may need to look for an alternative space when the move has taken place. MS raised that this issue was identified at the start of the planning stages however; DA had only been made aware of this recently.

Spiritual Care has purchased a new piano which will be situated in the Sanctuary at the new hospital initially with an idea that it is moved to the atrium once the hospital is opened to allow anyone to play it. This has still to be agreed.

Volunteers

Spiritual Care Volunteers have now been recruited for the New Hospital and will have their induction on 20 November 2017. The Alexandra Unit has their own Volunteer. GS asked DA what the role of the Spiritual Care Volunteer is and DA responded they often are there to offer a listening ear to relatives, have a conversation with the patients/visitors, arrange religious requests and provide general support. DA is also attending the Macmillan Clinical Nurse Specialist meetings to support them and the families they are dealing with.

Sanctuary

DA explained an idea for the Sanctuary which is a 'tree' which will allow staff/visitors to leave their own quotes/messages/thoughts on leaves on the tree. DA has been in discussion with Jamie Buchanan, Artist/Sculptor and it is hoped he will facilitate a hand held labyrinth workshop for 6 DGRI staff to enable them to take 'ownership' of the new sanctuary as a space they will benefit from.

PW asked DA if the Bereavement Group will be multi-agency or multi-disciplinary. DA advised it will be both and she will be contacting agencies/disciplines for representatives.

GS discussed Staff Listening and asked DA how does she keep her finger on the pulse of how our staff are? DA advised that the staff who are currently seeing her are usually one off consultations. DA ensures that the service she provides does not create dependency on her and teaches self support or will refer onto other agencies if appropriate. CS recognised the value of having independence and confidentiality is a key part of this relationship between organisation/professions.

The Committee:

- Considered the report.

MS left the meeting.

CS left the meeting.

9. **Volunteering Update**

JP presented this paper in the absence on Margaret McGroggan, Volunteer Co-ordinator. JP provided an update on the recruitment of Volunteers. DC would like Third Sector to work alongside the NHS to spread volunteering across the region. PH requested that DC reported back to the Committee regarding Third Sector/Integration when he felt it was appropriate.

PH would like the committee to have a discussion in the new year about how we can thank and congratulate our volunteers for all their hard work over the years, especially the Volunteers who have dedicated years to the service.

The Committee:

- Considered the report

10. **AOCB**

GS would like to plant a commemorative tree at the New Hospital for Robert Allan, Non Executive Member who sadly passed away a couple of months ago. GS asked if anyone else would like to support this and DA agreed she would be happy to take this forward and will speak to the Project Workers for the New Hospital grounds. DA is also looking into an 'Absent Friends' Remembrance Wall' This would be an electronic space where staff could pay their respects to other members of staff who have passed away.

Date of Next Meeting

Monday 18 December 2017, at 1.30 pm – 3.30 pm, in the New Board Room, Crichton Hall.



**Staff Governance Committee
New Board Room, Crichton Hall
Minutes of the Meeting held on 27 November 2017 at 10am**

Present

Gill Stanyard	Non Executive Board Member (Chair)
Val Douglas	Staff Side Representative
Stephen Hare	Staff Side Representative
Penny Halliday	Non Executive Board Member
Philip Jones	Chairman

In Attendance

Jeff Ace	Chief Executive
Lynsey Fitzpatrick	Equality & Diversity Lead (for Item 6)
Pamela Jamieson	Workforce Manager
Ros Kelly	Occupational Health Manager
Arlene Melbourne	Executive Assistant to Workforce Director
Tracy Parker	Workforce Systems Manager (for Item 7)
Caroline Sharp	Workforce Director
Julie Watters	Chief Internal Auditor (for Item 5)

		ACTION
1	<p>Welcome, Introduction and Apologies</p> <p>Apologies were received from Jim Beattie, Laura Douglas and Alice Wilson.</p>	
2	<p>Draft Minutes of the Previous Meeting held on 25 September 2017</p> <p>The minutes were approved as a true and accurate record.</p>	
3	<p>Matters Arising</p> <p><i>Working Well Steering Group</i> – Gill Stanyard asked for an update on the group. Caroline Sharp responded that the initial group had met and had agreed to meet again before Christmas. Caroline had also briefed Stephen Hare and also had a conversation with Richard Smith from Public Health. Ellen Jardine would also be picking up with a couple of people as well.</p>	

	<p>In 2018 the Steering Group will be set up and will evaluate the membership to drive forward as a system. Stephen will co-chair the Group with Caroline is it will be a partnership led Steering Group. Gill was encouraged by this.</p>	
<p>4</p>	<p>Staff Governance Corporate Risks</p> <p>Caroline Sharp reported that the paper describes the changes and updates that have happened to the 2 corporate risks. She proposed to add a further risk going forward. She has undertaken a separate exercise to start working up the risks for the IJB and these are:</p> <ul style="list-style-type: none"> • Sustainable workforce • Culture <p>Penny Halliday advised that she had met with Greycy Bell who had brought her up to date with GPs and had stated that more ANPs were needed and something needed to be done or it will be a risk. Penny asked if this lies with GPs or Staff Governance.</p> <p>Caroline responded that her focus had been around core workforce but as it has now broadened out she would be looking at capturing some narrative around it and also reported that Eddie Docherty was leading work nationally around ANPs so was fully sighted on it. Penny asked where it would be scrutinised and how we assure ourselves that GPs understand that ANPs are not the answer to every problem that they have. Caroline reassured Staff Governance Committee that the issue was ongoing at Management Team. She also agreed to bring it in as part of Staff Governance to ensure that periodically Eddie can talk about it and will also invite Greycy Bell along as well.</p> <p>Staff Governance Committee were happy with the proposed action.</p>	
<p>5</p>	<p>Whistleblowing; Review, learning and actions from Whistleblowing Event</p> <p>Gill stated that Julie Watters would be joining for this item.</p> <p><i>Julie Watters entered the meeting</i></p> <p>Gill stated that this had been a coherent piece of work and she had been impressed by the leadership she had seen by the putting together of the process hoped that the Committee gets a real sense of the process.</p>	

Caroline reported that the paper follows the internal audit in 2016. In 2017 the organisation had to deal with its first Whistleblowing case and it felt right that the team agreed at the end that they would use the opportunity to reflect and evaluate what had happened and what had been learned to make improvements. The output from the review meeting is in the paper.

Julie Watters gave an overview of the 2016 audit highlighting:

- That the audit was completed in June 2016
- Assurances were needed around process and preparedness
- Audit scoped up with 4 objectives
- From the audit there were 9 recommendations to look at the process and enhance it and any issues brought forward would be dealt with appropriately
- Some recommendations have already been closed
- It was a learning curve for those involved

Philip Jones felt that it showed that when concerns are raised they are taken seriously.

Caroline gave clarification that Gill Stanyard was the Whistleblowing Champion and that she was the Whistleblowing Lead and outlined their roles.

Lynsey Fitzpatrick entered the meeting

Philip asked Gill if she felt empowered by the role rather than just observe and she replied that she definitely had an active role. The review has put the Champion and Lead back to being fully involved.

Philip asked if someone whistleblow about Jeff Ace how would that be applied and Caroline responded in the exact same way. Gill stated that when the policy is reviewed next year there will be a more coherent framework and flow.

Gill asked about the remaining recommendations and if there was any cause for concern and Julie responded that they were all being addressed.

Caroline highlighted the following from the Improvement Plan:

- Clarity with the policy, which is drawn from the PIN, is not sufficient and it needs supplemented with a Standard Operating Procedure
- The review of the policy is scheduled for next year

	<ul style="list-style-type: none"> • A fundamental risk is the introduction of a 3rd corporate risk to sit under Caroline's leadership and Staff Governance direction going forward around the risk of the failure of the organisation to have a culture, systems and processes in which staff feel safe and confident to speak up and raise concerns, resulting in adverse impact on staff and / or patient safety, health, wellbeing and / or relationships and reputation of the Board <p>Caroline stated that it was a very strong tie to the cultural work. Julie stated that she was happy with the Improvement Plan.</p> <p>Gill asked that thanks be passed to Ingrid Wilson for her work and it was also clarified that Caroline is the contact person for Public Concern at Work.</p> <p>Staff Governance Committee noted the review which had been undertaken and agreed the details set out in the improvement plan, to support improvements in the Boards approach and handling of future whistleblowing concerns going forward.</p> <p><i>Julie Watters left the meeting</i></p>	
6	<p>Equality & Diversity Workforce Data Report</p> <p>Lynsey Fitzpatrick was looking for agreement from Staff Governance Committee to publish the report on the website which is done annually. She talked about discrimination and reported that this was just one part of the jigsaw and there are other sources that are used to set actions. She highlighted the following:</p> <ul style="list-style-type: none"> • data on pregnancy and maternity is not published as the work on this is done at Manager level so she needs to do some work on this • the induction process is being reviewed and she will ensure that staff are asked to update their details • the new HR system will link with the recruitment model • the previous report included information from the last staff survey but we now have the Dignity at Work survey with questions around discrimination <p>Philip Jones reported that the Non Executives had submitted a return to Scottish Government and the response back was that it had been a comprehensive reply and we were seen as a diverse Board.</p>	

	<p>Gill asked Pamela what it means for the future and she responded that the Scottish Government want to ensure that Public Sector bodies make decisions that are more representative to the communities they serve.</p> <p>Caroline talked about the issue of the numbers of EU/non UK nationals working within the systems and advised that we have no way of establishing whether an individual is a non UK national or not. It is a big gap in data as we have not been asked for this information or needed it previously but in the last few months there have been a number of FOI requests asking for this.</p> <p>There was discussion about people being asked for information and what would be done with it.</p> <p><i>Tracy Parker entered the meeting</i></p> <p>There was debate around drug and alcohol addiction and how Boards can address the prejudice and stigma around this. Lynsey responded that in terms of this particular work those conditions were not protected characteristics but it may be included under disability.</p> <p>Staff Governance Committee acknowledged and understood the requirement of NHS Dumfries & Galloway to comply with the requirement to publish equality and diversity employee information and agreed that the employee data report for 2016/17 can be published on the NHS D&G website, and then used to better perform the Public Sector Equality Duty.</p> <p><i>Lynsey Fitzpatrick left the meeting</i></p>	
7	<p>Workforce Planning</p> <p><u>Integrated Workforce Plan Progress Update/ Audit Scotland Report on Workforce Planning</u></p> <p>Tracy Parker explained that this was the Integrated Workforce Plan which is reaching the final stages of the 2017 process and has been to various committees and the final stage will be for it to go the IJB on 30 November, so is here for Staff Governance Committee to note the progress. It will then go to the NHS Board on 4 December. Included in the plan is a Health Statement which is for the NHS to save doing 2 separate documents. Tracy had been trying to refine the Integrated Workforce Plan and provide a bit more detail around the actions and this will go to the Integration OD Steering Group in December. Gill stated that it was a very comprehensive report and she found the case studies helpful.</p>	

	<p>Penny Halliday stated that there was a lot of work in the report and it provided a lot of information. She stated it must be difficult to put plans together when we were unaware of the long term financial forecast each year. She felt it would have been helpful if the Workforce Plan could be linked with the financial plan showing what savings could be made and what it will be in the future but she recognises that we do not know the costs involved.</p> <p>Caroline advised that when looking at individual service changes operationally, the joined up thinking and service, financial and workforce planning happens better on the ground.</p> <p>Penny asked what is the Health Board looking for from the IJB with regard to scrutiny of the Plan that week? Caroline responded as follows:</p> <ul style="list-style-type: none"> • it does follow directly to Staff Governance Committee to approve the Health Statement as it is the Health Board's compliances in workforce planning • the Council and Social Services have put forward some narrative to give a broader picture which was included and it has also been through the Social Work Committee <p>Tracy stated that this particular document is a review and refresh of the 2016 plan which the IJB approved last year.</p> <p>Staff Governance Committee noted the governance and approvals for the Dumfries & Galloway Integration Joint Board Workforce Plan 2016-2019 (2017 edition) and approved the NHS Board Workforce Statement.</p> <p><i>Tracy Parker left the meeting</i></p>	
8	<p>The Future Model of Services for Occupational Health</p> <p>Ros Kelly reported that this model had been approved at Management Team in September and endorsed by APF in October. She gave the background of the opportunity to review the service provision and exploring of alternative options.</p> <p>Penny asked if some data could be provided on how the model is fairing showing challenges and successes as a follow up as this could then be fed back to staff.</p>	

	<p>She would also like to see if it makes a difference to early intervention and stated that Occupational Health also need to have premises which are adequate for services to be delivered.</p> <p>Gill asked if other Boards had been approached about the new model and Ros responded that she had been in touch with other Boards and will get data of what they are doing, particularly around early interventions.</p> <p>Staff Governance Committee noted the future model of OH Service delivery.</p>	
9	<p>Staff Health, Safety and Wellbeing Report including Sickness Absence Update</p> <p>Ros Kelly presented the routine report and highlighted the following areas:</p> <p><i>imatter</i> – she confirmed that there will only be one run in 2018. Along with Emma Morning and the workforce team she will be create a buzz and do a lot of work around cleansing data.</p> <p><i>Seasonal flu</i> – she reported that the last clinic is being held today. If the uptake is higher than last year then they will run with the imatter data for appointments again next year.</p> <p><i>Accident Reduction Plan</i> – Alice Wilson had previously raised a query of some accidents and incidents being wrongly recorded on DATIX and Ros had checked this with Andy Howat who had looked into it and agreed that some had been wrongly coded and he had tidied up the system and will continue to monitor it. Andy would pick up ward staffing levels directly with Alice and Caroline also agreed to have a conversation with Eddie Docherty about this.</p> <p>Gill had some questions around violence but would pick these up with Ros outside the meeting.</p> <p><u>Attendance Management</u></p> <p>This was the routine paper reporting on sickness absence statistics and Occupational Health activity. Ros highlighted:</p> <ul style="list-style-type: none"> • There was a typing mistake under national trends, it should read 2017 and not 2018 • In September the absence figure was 5.2% against the national average of 4.95% but year to date it was recording the lowest absence rate 	<p>AH/AW</p> <p>CJS/ED</p> <p>GS/RK</p>

	<ul style="list-style-type: none"> • There was a 44% reduction in management referrals • There is an increase in physiotherapy self referrals • Anxiety, stress and depression absence reasons are high but it mirrors musculo-skeletal, back problems, injury and fractures. <p>Gill had some questions but would pick these up with Ros outside the meeting.</p> <p>Staff Governance Committee noted the reports.</p>	GS/RK
10	<p>Workforce Report</p> <p>Caroline Sharp reported that one thing being looked at in 2018 is a refresh of the Workforce internal Directorate Targets and the impact on the whole of the organisation and she was also looking for help from the Health Intelligence team around presentation of the data.</p> <p>Caroline also reported that with effect from 1 January 2018 she will have a different structure in her team.</p> <p><i>Jeff Ace left the meeting</i></p> <p>She was no longer having a Deputy Director of HR and 2 Workforce Managers and the OD capacity has also been decreasing over the past couple of years. She will be reprofiling to 3 Heads of Service reporting directly to her. Ros Kelly will be the Head of Service for Occupational Health, Pamela Jamieson will be the Head of Service for HR and Natalie Morel will be the Head of Service for OD which will include Equality & Diversity. Stephen Hare will be an honorary fifth member of the team.</p> <p>Caroline advised that Linda Davidson is now working in the regional arena supporting and building the regional workforce planning.</p> <p>Gill congratulated Caroline on what looks like a coherent structure.</p> <p>Philip Jones asked if the new Heads of Service could attend a Staff Governance Committee next year to talk about their roles and priorities going forward.</p> <p>Val Douglas asked if Acute and Community were now rolled into one and it was confirmed that it would be.</p> <p>Pamela updated that 2834 people had been orientated in the new build and 60 staff have not been yet.</p>	

	The update was noted.	
	Items to Note	
11	<u>APF Minutes – August 2017</u> – Noted	
12	<u>Remuneration Sub Committee Update</u> – Noted	
13	Any Other Business	
14	Date of Next Meeting The next meeting will be held at 10am on Monday 22 January 2018 in the New Board Room, Crichton Hall.	



**Staff Governance Committee
Conference Room, Crichton Hall
Minutes of the Meeting held on 25 September 2017 at 2pm**

Present

Gill Stanyard	Non Executive Board Member (Chair)
Jim Beattie	Employee Director
Laura Douglas	Non Executive Board Member
Val Douglas	Staff Side Representative
Stephen Hare	Staff Side Representative
Penny Halliday	Non Executive Board Member
Philip Jones	Chairman

In Attendance

Jeff Ace	Chief Executive
Pamela Jamieson	Workforce Manager
Ellen Jardine	Applied Psychologist in Health Improvement (for item 8)
Ros Kelly	Occupational Health Manager
Arlene Melbourne	Executive Assistant to Workforce Director
Caroline Sharp	Workforce Director
Alice Wilson	Deputy Nurse Director

		ACTION
1	<p>Welcome, Introduction and Apologies</p> <p>No apologies were received.</p>	
2	<p>Draft Minutes of the Previous Meeting held on 24 July 2017</p> <p>The minutes were approved as a true and accurate record.</p>	
3	<p>Matters Arising</p> <p>There were no matters arising.</p>	

4	<p>Corporate Risk Register Update</p> <p>Caroline Sharp advised that in accordance with the request at the last meeting and following development work undertaken by Laura Geddes, the paper now included an extract from the register with narrative, which Caroline inserts on a routine basis, to give the Committee more information. This narrative also goes to Audit and Risk Committee.</p> <p>The Committee were happy with the new format presented and noted the update.</p>	
5	<p>Meeting Dates in 2018</p> <p>Staff Governance Committee were asked to note the dates.</p>	
6	<p>Staff Health, Safety and Wellbeing Report including Sickness Absence Update</p> <p>Ros Kelly presented the routine report and highlighted the following areas:</p> <p><i>iMatter</i> – Ros reported that the last remaining cohort for the year was now complete. She reported that the figures were disappointing in terms of completed action plans but were aware of why this was happening. The proposal was to go from 3 cohort runs a year to just 1, with it being in April/May next year and it will reduce the resource going into it.</p> <p>Gill Stanyard asked if the risk of lack of responses would be minimised and Ros confirmed that it would. Laura Douglas asked if people were actually seeing the value of doing iMatter and what value have teams seen who have completed action plans. Ros replied that a strategy group had been set up to look at this and will work with staff to ensure that action plans are getting done. The Workforce Business Partners and OD staff are going out and speaking to Managers. Caroline stated if Ros and Emma Morning give a clear timeline of what the targets are to check against then she thinks it will help to make the next step shift.</p> <p>Alice Wilson thought it would be sensible to do one run a year as then everyone hears the message at the same time. It could be done as a test at least one time.</p> <p>Ros explained that the assigned rights of hierarchy were being changed to include a sub Directorate level for General Managers, rather than just Directors.</p>	

<p>Penny asked what the Committee was being asked to do with this paper and Ros responded that it was for discussion and noting. Penny asked was it also for scrutiny and Ros replied that it was.</p> <p>Gill asked what the capacity was in Occupational Health to respond to staff issues around staff absence since Dr Swales had moved on. Caroline clarified that Dr Swales had not been at work since last year and Occupational Health staff had worked without a substantive medical Consultant for 7 months and Ros and the team had worked together to ensure that there was no detriment to the service. A paper was going to the next APF in October for them to assess and make a decision on the future model of Occupational Health services.</p> <p>Laura asked for future reports if one or two bullets could be provided around occupational health activity and medical reviews.</p> <p>Jim Beattie reported that the Occupational Health staff had responded amazingly well under the circumstances and sickness levels have come down and the reason for that is the partnership working with case conferences and getting people back to work earlier than they should.</p> <p>Penny asked if processes were working where staff were asked to return to work to do light duties and also what would happen if we found ourselves in a situation if staff have not had the flu vaccination and there is a high level of sickness when moving to the new hospital.</p> <p>Jeff responded that he was encouraged by the trends in sickness figures and happy with the partnership approach and the changes in the Occupational Health services which are working very positively.</p> <p>Penny asked if there had been a spike in the sickness levels once staff moved to the new Glasgow hospital and Jeff replied that there was.</p> <p>Alice advised that they could bring staff back in to do light some light duties but cannot put them in uniform as there would then be an expectation on them to do things that would put a risk on both patients and staff but there are plenty of things that can be done which is not a uniformed job. Ros agreed that alternative roles could be found rather than returning to substantive roles.</p>	
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	<p>Stephen Hare asked if there had been an increase in sickness levels in Mental Health and Ros replied that it was consistent in Mental Health and had not notified a significant rise.</p> <p>Gill asked to have a meeting with Ros outside the meeting to understand the Occupational Health service and will contact her to get a date.</p> <p>The Committee had also applied scrutiny to the paper as well as noting the report.</p>	GS/RK
7	<p>Workforce Report</p> <p>Caroline Sharp reported that this was the routine paper from May to July. A significant amount of work had been undertaken over the summer for staff joining to be ready for the new hospital and the paper flags some gaps.</p> <p>Laura Douglas asked that in future could the Committee see what the figures tells them and how it will be acted upon.</p> <p>Gill Stanyard asked about fixed term contract figures and Pamela Jamieson responded that there had been a number of recruitment drives on whilst moving to the new hospital and a lot of posts were time limited with money coming from Scottish Government or to do a specific piece of work.</p> <p>Gill asked about the disclosure of disability figures and Stephen stated that some people do not see themselves as disabled therefore do not declare it as it is personal. Pam stated that some people do not think it is relevant to their job.</p> <p>The update was noted.</p>	CJS
8	<p>Working Well Report</p> <p>Ellen Jardine stated that the report was about the prevention of sickness absence and she took the Committee through each section of the report. She confirmed that this piece of work had been looking at NHS sickness absence only and the report presents key themes to make improvements.</p> <p>Laura Douglas stated that this was a great piece of work and thanked Ellen for taking the Committee through it so comprehensively and the recommendations made sense and asked what would be done next.</p>	

	<p>Caroline responded that subject to the conversation at Staff Governance today, the first next step is to initiate a Steering Group. Caroline is drawing back together the individuals from HR, Occupational Health and Public Health who were in the group that initiated everything then assess with that group what is the right membership of a Steering Group. Caroline will update on the representation of the Steering Group to the Committee at the next meeting</p> <p>Gill stated that it was crucial to the work of Staff Governance Committee and she thanked Ellen for the report.</p> <p style="text-align: center;"><i>Ellen Jardine left the meeting</i></p>	CJS
9	<p>Mandatory Training Audit</p> <p>Caroline reported that this was a copy of the preliminary report that was conducted by the Internal Audit team which was completed in June. She had brought it to Staff Governance Committee to sight them on the outcomes of the audit and the actions that Caroline has committed her team to in terms of taking management action to address the findings of the audit. There were a couple of outcomes that Caroline did not agree with but she had not received feedback from Internal Audit yet.</p> <p>Stephen stated that one of the figures included was 78% compliance with moving and handling and asked if that was the main cause of musculo-skeletal referrals to Occupational Health. Caroline replied that if an individual has not had any moving and handling training then they are very vulnerable and all new starts into the organisation get the training when they join. Alice did not think this could be answered unless when people attend Occupational Health they were asked if they had attended their training. Ros stated that people they were seeing with musculo-skeletal problems were the older age population and self referrals.</p> <p>Laura Douglas asked for assurances that the other related audits on page 4 with outstanding actions would be completed and that there was a loophole in the electronic system where people have all the answers. Caroline stated that she had had considerable debate with the auditor. She confirmed that for the majority of tests there are a bank of questions but not all and you don't get the answers if you fail, you have to start again.</p> <p>This audit will be going to the Audit and Risk Committee.</p>	

<p>10</p> <p>11</p> <p>12</p>	<p>Items to Note</p> <p><u>APF Minutes – June 2017 – Noted</u></p> <p><u>Equality & Diversity - Disability Confident Award and the Equality for All Project – Noted</u></p> <p><u>Workforce Planning – Noted</u></p>	
<p>13</p>	<p>Any Other Business</p> <p><i>iMatter (Dignity at Work Survey)</i> – one of the additional elements the central iMatter team have been working on is the Dignity at Work Survey, which has been developed nationally for all staff to provide specific information which has been in previous Staff Surveys on how staff feel in terms of bullying and harassment and reporting arrangements. The timing for this survey is the last 4 weeks before the migration weekend and Caroline had flagged this to Scottish Government. Promotion materials for this survey had now been received. Caroline asked Staff Governance Committee to support her sending a message to Scottish Government to run the survey but flag to them that there is a risk that the take up may or may not be predictable due to landing this on a workforce who is moving to a new hospital.</p> <p>Staff Governance Committee agreed to support her.</p> <p><i>Activation of Whistleblowing Policy</i> – Gill wished to report and follow up on process and our response.</p>	
<p>14</p>	<p>Date of Next Meeting</p> <p>The next meeting will be held at 10am on Monday 27 November 2017 in the New Board Room, Crichton Hall.</p>	