DUMFRIES AND GALLOWAY NHS BOARD
PUBLIC MEETING

A meeting of the Dumfries and Galloway NHS Board will be held at 10am on Monday 7 August 2017 in the Conference Room, Crichton Hall, Bankend Road, Dumfries.

AGENDA

<table>
<thead>
<tr>
<th>Time</th>
<th>No</th>
<th>Agenda Item</th>
<th>Who</th>
<th>Attached / Verbal</th>
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<tbody>
<tr>
<td>10.00am</td>
<td>45</td>
<td>Apologies</td>
<td>L Geddes</td>
<td>Verbal</td>
</tr>
<tr>
<td>10.00am</td>
<td>46</td>
<td>Declarations of Interest</td>
<td>P Jones</td>
<td>Verbal</td>
</tr>
<tr>
<td>10.05am</td>
<td>47</td>
<td>Previous Minutes</td>
<td>P Jones</td>
<td>Attached</td>
</tr>
<tr>
<td>10.10am</td>
<td>48</td>
<td>Matters Arising and Review of Actions List</td>
<td>P Jones</td>
<td>Attached</td>
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<tr>
<td></td>
<td></td>
<td>QUALITY &amp; SAFETY ASSURANCE</td>
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<tr>
<td>10.15am</td>
<td>49</td>
<td>Patient Safety Annual Report</td>
<td>E Docherty</td>
<td>Attached</td>
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<tr>
<td>10.25am</td>
<td>50</td>
<td>Patient Experience Report</td>
<td>E Docherty</td>
<td>Attached</td>
</tr>
<tr>
<td>10.40am</td>
<td>51</td>
<td>Healthcare Associated Infection Report</td>
<td>E Docherty</td>
<td>Attached</td>
</tr>
<tr>
<td>10.55am</td>
<td>52</td>
<td>Complaints Annual Report</td>
<td>E Docherty</td>
<td>Attached</td>
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<td></td>
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<td>PERFORMANCE ASSURANCE</td>
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<tr>
<td>11.10am</td>
<td>53</td>
<td>Performance Report</td>
<td>J White</td>
<td>Attached</td>
</tr>
<tr>
<td>11.25am</td>
<td>54</td>
<td>Integrated Joint Board Update</td>
<td>J White</td>
<td>Verbal</td>
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<td>FINANCE &amp; INFRASTRUCTURE</td>
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<tr>
<td>11.35am</td>
<td>55</td>
<td>Capital Performance Update</td>
<td>K Lewis</td>
<td>Attached</td>
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<tr>
<td>11.45am</td>
<td>56</td>
<td>Financial Performance Update</td>
<td>K Lewis</td>
<td>Attached</td>
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<td>PUBLIC HEALTH &amp; STRATEGIC PLANNING</td>
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<tr>
<td>12noon</td>
<td>57</td>
<td>Regional Planning Update</td>
<td>J Ace</td>
<td>Verbal</td>
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<tr>
<td>12.10pm</td>
<td>58</td>
<td>Tobacco Control Action Plan</td>
<td>T Grierson / M McCoy</td>
<td>Attached</td>
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<tr>
<td>12.20pm</td>
<td>59</td>
<td>Lochside Dental Service Review</td>
<td>V White</td>
<td>Attached</td>
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<td></td>
<td></td>
<td>GOVERNANCE</td>
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<tr>
<td>12.50pm</td>
<td>60</td>
<td>Board Briefing</td>
<td>J Ace</td>
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<tbody>
<tr>
<td>12.55pm</td>
<td>61</td>
<td><strong>Committee Minutes</strong></td>
<td>P Jones</td>
<td>Attached</td>
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<tr>
<td></td>
<td></td>
<td>- Area Clinical Forum minutes – 24 May 2017</td>
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<td></td>
<td></td>
<td>- Audit and Risk Committee minutes – 20 March 2017</td>
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<td>- Healthcare Governance Committee – 15 May 2017</td>
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<td></td>
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<td>- Person Centred Health &amp; Care Committee – 10th April 2017</td>
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<td>- Performance Committee – 6 March 2017</td>
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<td></td>
<td>- Performance Committee minutes – 8 May 2017</td>
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<td>- Staff Governance Committee – 2 May 2017</td>
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**ANY OTHER BUSINESS**

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<tr>
<td>1.00pm</td>
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**DATE AND TIME OF NEXT MEETING**

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<tr>
<td>63</td>
<td>2nd October 2017 @ 10am – 1pm in the Conference Room, Crichton Hall, Bankend Road, Dumfries</td>
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</table>
PNJ welcomed Board Members to the NHS Board Meeting, extending the welcome to LC, Chair of Area Clinical Forum and Non Executive Member and AF, newly appointed Local Council Representative, attending their first formal NHS Board meeting following appointment. It was noted that AF’s Non Executive status would be confirmed shortly by Cabinet Secretary.
25. **Apologies for Absence**

Apologies as noted above.

26. **Declarations of Interest**

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

27. **Minutes of meeting held on 3 April 2017**

The minute from the previous meeting on 3 April 2017 was approved as an accurate record of discussions, with no amendments.

NHS Board Members approved the minute.

28. **Matters Arising and Review of Actions List**

PNJ presented the Actions List to members, with JA noting that discussions had taken place between the Medical Director and the Council Education Director regarding school science teaching.

LB enquired as to whether there was further statistical information available with regards to the Equality and Diversity update. It was noted that the information has been received and passed to the Equality and Diversity Lead to review, prior to sharing with Board Members.

NHS Board Members noted the Actions List.

29. **Dental Salaried Service Review Newton Stewart Dental Clinic**

KL presented the Dental Salaried Service Review paper, asking NHS Board Members to note the report, which gave an update on the implementation of the return to a General Dental Practice based model of care within Newton Stewart.

KL took members through the background to this report, highlighting the accessibility and implementation processes. The outcome of the facilitated transfer process recorded that of the patients that were contacted in relation to the transfer, a total of 183 patients did not respond.

It was further noted that the highest range of non responders were in the 0-19 range and over 70 years.

LD enquired as to when as a Board we will stop trying to contact the non responders.
NHS Board Members were made aware that the Public Dental Service will try to contact parents/carers of children under 18 years and those over the age of 70 via telephone to further support those patients in accessing dental care.

KL advised that a further update would be given at the Performance Committee meeting on 10 July 2017.

NHS Board Members noted the update on a successful implementation of the return to a General Dental Practice based model of care within Newton Stewart.

30. **Improving Safety Reducing Harm in Primary Care Report**

AW presented the Improving Safety Reducing Harm in Primary Care Report, asking NHS Board Members to consider the proposed changes to the design of the ‘Improving Safety Reducing Harm’ paper going forward, by agreeing a schedule of reporting, agreeing changes to the design or addition of information.

AW advised members that currently such key themes as Patient Safety Walkrounds and Perinatal Beds, were reported separately to the board, the proposal is to report items such as these together to demonstrate the interconnections between the areas of risk and harm.

LB enquired to the frequency of directorate reports, AW advised that the reporting schedule to Board was listed on the back page of the report.

PH advised Members to read information available and feedback any identified risks to AW for comment.

GS enquired whether the learning from adverse events were reported to Board; AW advised that she would feedback to GS directly the reporting lines between the recording of an adverse incident and the dissemination of learning from its review.

**Action: AW**

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.

**Action: LG**

NHS Board members:
- Consider the proposed changes to the design of ‘Improving Safety Reducing Harm’ paper, agreed the schedule of reporting and any changes to the design and information presented.
- Noted the report from Women, Children and Sexual Health Directorate.
31. **Patient Experience Report**

AW presented the Patient Experience Report, asking NHS Board Members to note this report, which provides an update on the activities of the Patient Services team, including a review of the new Complaints Handling Procedure implemented in April 2017 and the Board’s performance with complaints handling in February and March 2017.

NHS Board Members were directed to the recent work of the newly appointed Spiritual Care Lead, in developing the spiritual care service across Dumfries and Galloway.

It was noted that the new National Delivery Plan for Health and Social Care Chaplaincy and Spiritual Care across Health and Social Care in Scotland is currently being finalised and will be implemented according to local context and resources.

NHS Board Members were made aware that the next cohort of volunteers would commence on 1 June 2017, with a Recruitment Day being planned to raise the profile of volunteering and to recruit new ward volunteers and welcome guides in advance of the new hospital opening.

It was further noted that the Volunteer Co-ordinator is working closely with Workforce to migrate the current volunteer data into the new NHS Volunteer Information System. This will begin late May 2017 with expected completion in July 2017.

AW noted the improved quality of complaint responses, due mainly to the new complaints handling procedure and the introduction of quality monitoring, which has improved internal performance reporting as a standardised approach to managing and responding to complaints.

LB enquired as to whether the Board recognised the Volunteers week, JA advised that the awareness week was promoted through the Core Briefing, NHS Facebook page and as a Flash Ad on the Board’s intranet.

LD enquired as to whether there was information available for Members interested in attending the Volunteering Day on 30 June 2017. AW advised that she would seek clarity with the Patient Feedback Manager and email information to Members.

**Action: AW**
GC asked for assurance on how as a Board we gain a rich mix of individuals to attend the Volunteering Day. GS also enquired about the status of the Staff Listening Service. AW advised that there was work ongoing with harder to reach groups and would ask the Associate Director of Allied Health Professions to give Members additional information on the diversity of groups across the region and would clarify the status of the Staff Listening Service with Colleagues.

**Action: AW**

RA highlighted that only 72% patients’ complaints across the reporting period were acknowledged within the national target of 3 working days and that he felt that there was no real improvement in speed of response. RA queried whether there was a more fundamental root cause to the overall problem. AW advised that the current position was due to vacancies in two key posts within Acute Services.

PH urged Members to attend the Person Centred Health and Care Committee if possible; in order to give the concerns raised around the table their full attention. Should Members be unable to attend, PH invited them to email the questions they would like answered and she would raise them at the Committee.

NHS Board Members noted:
- the report which provides an update on the activities of the Patient Services team.
- the implementation of the new Complaints Handling Procedure from 1 April 2017.
- the Board’s complaints performance for February and March 2017, including key feedback themes and details of the resulting learning and improvements.

**32. Healthcare Associated Infection Report**

AW presented the Healthcare Associated Infection Report, asking NHS Board Members to note the Board’s position with regard to the SAB and CDI HAI Local Delivery Plan (LDP) target.

Clostridium difficile infection (CDI) target is likely to be met as good performance is unchanged from the last Quarter.

Following the unannounced HEI inspection at the Galloway Community Hospital by Healthcare Environment Inspectorate, a report was published on 23 May 2017, which showed good adherence to standard infection control precautions, including the management of linen, waste and sharps. The staff observed also performed hand hygiene and used personal protective equipment appropriately and the report included very positive comments from patients regarding environmental cleanliness.
It was noted that continued monitoring of statutory and third sector drug and alcohol service waiting times during 2017/18 will ensure early detection of any challenges. High levels of staff sickness absence can also be challenging as it impacts on waiting time figures.

NHS Board members noted the report.

33. Performance Report.

JW gave an update on the Quarterly Performance Report to NHS Board Members, which detailed the most recent performance data in respect of the key operational targets. This is intended to supplement the quarterly performance report submitted to both NHS Board and Integration Joint Board.

NHS Board Members were made aware that the Golden Jubilee has offered to assist DGRI during the migration period with additional elective activity sessions.

JW advised that staff who will be working on the Combined Assessment Unit in the New DGRI have been on a rotation between Wards 6 and 7, identifying improved ways of working.

Delayed Discharge Co-ordinators have been introduced to identify any significant areas for improvement. Single figures on delayed discharges are being reported and daily meetings are being carried out with staff. The Day of Care Audit has reinforced this good working practice.

VF presented the Quarter 4 IJB Report, highlighting that we now have a full year of IJB performance reporting, which is being continuously developed. VF highlighted that the first Annual Report for the IJB is being drafted and will be made available by 31 July 2017.

JA advised that the UK Government has released £1 billion into Health and that the Scottish Government has indicated it will use a proportion of its Barnett consequential to support elective care. A bid from NHS Dumfries and Galloway is currently being prepared to request a proportion of this money to address elective waits.

LB enquired as to why Nithsdale were not included within the Health and Wellbeing Resilience Plans, VF advised that the Nithsdale area plan was currently under development and would be included in due course.

GS enquired as to the key challenges and the actions proposed to address the challenges of Alcohol Brief Interventions (ABI) in Dumfries and Galloway.
ACa advised that the issues had been included in a paper at the NHS Board Meeting in April 2017 and agreed to bring back further updates on performance in this area to a future NHS Board Meeting.

Action: ACa

Further to discussion NHS Board Members agreed that they would benefit from a joint workshop with IJB members to identify the risk areas, prioritisation and disinvestment process.

NHS Board Members discussed and noted the report.

34. Integration Joint Board Report

JW gave an update from the Integration Joint Board meeting on 25 May 2017 to NHS Board Members noting that the meeting had focussed on committee structure and governance issues, with KL and JW to bring back proposals to next IJB meeting on 28 June 2017.

It was noted that the Role of the Standard Officer was also discussed along with the development programme for members both individually and collectively.

Following significant discussion on Financial Performance papers and the Annual Accounts it was agreed to hold a further workshop on delayed discharges.

NHS Board Members were advised of the Council’s decision following the election process, to appoint the new IJB members as Ian Carruthers, Andy Ferguson, Ros Surtees, Jane Maitland and Tommy Sloan.

NHS Board Members noted the verbal update.


KL presented the Financial Performance update for the year end, highlighting the delivery of a breakeven position for 2016/17, as well as the ongoing financial risks and challenges going forward into 2017/18.

NHS Board Members were made aware that the External Auditors, Grant Thornton, had been on site from 2 May 2017.

KL advised that progress is being made on reassessing the current position over the next month to close the efficiency gap prior to submission of the Financial Plan to Scottish Government in July 2017, with a further workshop planned for NHS Board Members in July 2017.

NHS Board Members noted the final financial position for the year end.
36. **Asset Management Strategy (AMS)**

JA presented the Asset Management Strategy, asking NHS Board Members to approve NHS Dumfries and Galloway’s 2017 strategy submission and note that this has been forwarded to the Scottish Government’s Health and Social Care Directorate in draft form to meet the specified return date of 2 June 2017.

DB advised that NHS Dumfries and Galloway are required to prepare and submit an Asset Management Strategy to Scottish Government on a bi-annual basis with a brief update provided in intervening years, noting that if required would be happy to arrange a board workshop for additional clarity.

LD advised that although this work was important, she was unhappy that the report had been submitted to Scottish Government without consultation with Members. It was noted that a Board Workshop is being arranged to give additional clarity on the strategy, however, due to the timeframe for collation and submission of the strategy it was not possible to hold the workshop in advance of the Board Meeting or the submission date. LG was asked to confirm the workshop arrangements and circulate the details to members.

**Action:** LG

AF enquired whether there was an option for recycling specialist equipment from the current hospital, or could the equipment be utilised by the Localities. KL advised that the Board has a Disposal Policy, whereby equipment, if appropriate, can be transferred to the new hospital.

NHS Board Members approved the Board’s 2017 Asset Management Strategy for formal submission to Scottish Government. A workshop has been arranged to provide a detailed update on the report to Board Members and will take place on 2nd October 2017.

37. **Regional Planning Update**

JA gave a verbal update on Regional Planning to Board Members, highlighting the 4 planned workstreams, which will aid the establishment of the Regional Programme Board.

GC enquired as to what support Non Executive Board Members could give in relation to regional planning. JA advised that this was still to be talked through in detail, but agreed to raise it at the NHS Chief Executives meeting with Paul Gray on 13 June 2017.

**Action:** JA

NHS Board Members noted the verbal update.
38. **Urological Cancer Update**

VF presented the Urological Cancer Services paper to NHS Board Members, highlighting that the paper sets out the local approach to realignment of pathways for urological cancers for people within Dumfries and Galloway.

It was noted that there are significant challenges currently facing urology services, with existing pathways of care for cancer services needing to be reviewed to ensure that they remain sustainable and of high quality in the future.

Realignment of pathways for urological cancers for people from Dumfries and Galloway from east to west are being progressed as part of the West of Scotland review of adult urology services.

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.

*Action: VF*

LB enquired as to what transport facilities would be made available for those patients requiring travelling outwith the board area. VF advised that discussions were in the early stages for implications in changing pathways such as transport.

NHS Board Members noted:
- the current regional review of adult urology services;
- the current challenges in urology services at a local, regional and national level;
- the ongoing work in relation to redesigning pathways of care for urological cancers within West of Scotland; and
- the next steps and anticipated timescales for completion of this work.

39. **Board Agenda Matrix**

LG presented the Board Agenda Matrix, asking NHS Board Members to review and note the 2016/17 Board Agenda Matrix as a complete record of items taken to NHS Dumfries and Galloway Board Meetings in year, and to approve the 2017/18 Board Agenda Matrix as a plan of activity coming to NHS Dumfries and Galloway Board meetings between April 2017 – March 2018.

AF asked NHS Board dates could be sent direct into his diary.

*Action: LG*
NHS Board Members:

- reviewed and noted the 2016/17 Board Agenda Matrix as a complete record of items taken to NHS Dumfries and Galloway Board Meetings in year.
- approved the 2017/18 Board Agenda Matrix as a plan of activity coming to NHS Dumfries and Galloway Board meetings between April 2017 – March 2018.

40. **Register of Members Interests**

LG presented the Register of Members Interests, asking NHS Board Members to approve the revised Register for publication on the Board’s internal and external websites.

NHS Members approved the Register of Members Interests with the following amendments.

- Include Endowment Trustee and Integration Joint Board Member to Section 6 for the relevant Board Members.
- Move the entry for JA from Section 1 to Section 2.
- Amend the entry for PNJ in Section 1 to say “Executive” rather than “Retired Member”.
- GS’s entry in Section 6 should read “BACP” rather than “BACI”.

41. **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 recent Medical Recruitment of both a Micro Biologist and Acute Physician.

NHS Board Members noted the report.

41. **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:

- **Person Centred Health and Care Committee - 24 October 2016**
  PH presented the minute from the Person Centred Health and Care Committee meeting on 24 October 2016, which received an update paper on Equality and Diversity.

NHS Board Members noted the minute.
• Healthcare Governance Committee – 16 January 2017  
PNJ presented the minute from the Healthcare Governance Committee meeting on 16 January 2017, which received an update on the Palliative and End of Life Care.  

NHS Board Members noted the minute.

• Person Centred Health and Care Committee – 27 February 2017  
PH presented the minute from the Person Centred Health and Care Committee meeting on 27 February 2017, which introduced Dawn Allan, as the new Spiritual Care Lead.

NHS Board Members noted the minute.

• Healthcare Governance Committee – 13 March 2017  
PNJ presented the minute from the Healthcare Governance Committee meeting on 13 March 2017, which received an update on the Patient Experience: Healthcare Complaints Analysis Trial (HCAT).

NHS Board Members noted the minute.

• Staff Governance Committee – 27 March 2017  
GS presented the minute from the Staff Governance Committee meeting on 27 March 2017, which received an update on Staff Health, Safety and Wellbeing, as well as an update on Sickness Absence.

NHS Board Members noted the minute.

42. **Any Other Competent Business.**

No items were put forward for discussion under this item on the agenda.

43. **Date of Next Meeting**

The next meeting of the NHS Board will be held on Monday 7 August 2017 at 10am – 1pm in the Conference Room, Crichton Hall, Bankend Road, Dumfries, DG1 4TG.
### Actions List from NHS Board – Public Meeting

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<tr>
<th>Date of Meeting</th>
<th>Agenda Item</th>
<th>Action</th>
<th>Responsible Manager</th>
<th>Current Status</th>
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<tbody>
<tr>
<td>05/12/2016</td>
<td>125.</td>
<td>Early Years Collaborative Progress Report</td>
<td>Eddie Docherty</td>
<td>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.</td>
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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.

| 05/12/2016 | 134. | Adult Cancer Services in Dumfries and Galloway | Eddie Docherty | An update on this item will be brought back to Board following discussions at the Volunteers Group. No date has been confirmed for the initial discussions with the Volunteers Group. |

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.
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<tr>
<td>06/02/2017</td>
<td>157.</td>
<td>Integrated Joint Board Report</td>
<td>Phil Jones / Laura Geddes</td>
<td>Alternative arrangements are being worked through and will be presented to Board when available, following a review of existing committee membership and Non-Executive availability. A paper will be take to the IJB following presentation to the NHS Board, for formal acceptance.</td>
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<td>The Chief Operating Officer explained that due to guidance around membership the IJB were not able to approve Lorna Carr as both a voting substitute member and also a non-voting member. A review of the membership options would be undertaken and revised options presented to Board for endorsing before being taken to the next IJB meeting for approval.</td>
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<td>05/06/2017</td>
<td>30.</td>
<td>Improving Safety Reducing Harm in Primary Care Report</td>
<td>Alice Wilson</td>
<td>Information will be provided directly to Gillian Stanyard on this, no further action required by or information to come back to NHS Board.</td>
<td>28/07/2017</td>
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<td>GS enquired whether the learning from adverse events were reported to Board; AW advised that she would feedback to GS directly the reporting lines between the recording of an adverse incident and the dissemination of learning from its review.</td>
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<td>30.</td>
<td>Improving Safety Reducing Harm in Primary Care Report</td>
<td>Alice Wilson</td>
<td>A workshop is being arranged and details will be forwarded to NHS Board members in due course.</td>
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<tr>
<td>05/06/2017</td>
<td>31.</td>
<td>Patient Experience Report</td>
<td>Alice Wilson</td>
<td>Information was be provided directly to members on this, no further action required by or information to come back to NHS Board.</td>
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<td>05/06/2017</td>
<td>33.</td>
<td>Performance Report</td>
<td>Andrew Carnon</td>
<td>Further updates on the Alcohol Brief Interventions have been scheduled in to the Board Agenda Matrix to come back to NHS Board later in the year.</td>
<td>28/07/2017</td>
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<td>05/06/2017</td>
<td>36. Asset Management Strategy (AMS)</td>
<td>LD advised that although this work was important, she was unhappy that the report had been submitted to Scottish Government without consultation with Members. It was noted that a Board Workshop is being arranged to give additional clarity on the strategy, however, due to the timeframe for collation and submission of the strategy it was not possible to hold the workshop in advance of the Board Meeting or the submission date. LG was asked to confirm the workshop arrangements and circulate the details to members.</td>
<td>Laura Geddes</td>
<td>A workshop has been arranged to discuss the Asset Management Strategy, which was approved at NHS Board on 5th June 2017. The Board Members workshop will be held on 2nd October 2017.</td>
<td>28/07/2017</td>
</tr>
<tr>
<td>05/06/2017</td>
<td>37. Regional Planning Update</td>
<td>GC enquired as to what support Non Executive Board Members could give in relation to regional planning. JA advised that this was still to be talked through in detail, but agreed to raise it at the NHS Chief Executives meeting with Paul Gray on 13 June 2017.</td>
<td>Jeff Ace</td>
<td>Further information on this will be included within the Regional Planning updates at each NHS Board meeting.</td>
<td>28/07/2017</td>
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<tr>
<td>Date of Meeting</td>
<td>Agenda Item</td>
<td>Action</td>
<td>Responsible Manager</td>
<td>Current Status</td>
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<tr>
<td>05/06/2017</td>
<td>38.</td>
<td><strong>Urological Cancer Update</strong></td>
<td>Vicky Freeman</td>
<td>Information is still being gathered to allow a paper to be prepared. It has been agreed to push this paper back to the October 2017 Board meeting for review.</td>
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<td></td>
<td>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.</td>
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<tr>
<td>05/06/2017</td>
<td>39.</td>
<td><strong>Board Agenda Matrix</strong></td>
<td>Laura Geddes</td>
<td>Diary invites have been issued to all Board Workshops and NHS Board meetings.</td>
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<td></td>
<td></td>
<td>AF asked NHS Board dates could be sent direct into his diary.</td>
<td></td>
<td>28/07/2017</td>
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</table>
RECOMMENDATION

The Board are asked to note and seek assurance from the Patient Safety Annual Report for 2016-2017.

CONTEXT

Strategy / Policy:

This paper supports the both local and national legislation and guidance, including the Healthcare Quality Strategy and Delivering Scottish Government Health Department Scottish Patient Safety Programme (SPSP) guidance.

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

Improving Safety and Reducing Harm remains a strategic priority for NHS Dumfries and Galloway. The Patient Safety Annual Report sets out the progress in year with highlights from each of the programmes of work and the infrastructure required to continually improve the quality and safety of health and care in Dumfries and Galloway.

GLOSSARY OF TERMS

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
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<tbody>
<tr>
<td>SPSP</td>
<td>Scottish Patient Safety Programme</td>
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<tr>
<td>iHub</td>
<td>Healthcare Improvement Scotland Improvement Hub</td>
</tr>
<tr>
<td>CAUTI</td>
<td>Catheter Associated Urinary Tract Infections</td>
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<tr>
<td>MCQIC</td>
<td>Maternity &amp; Children's Quality Improvement Collaborative</td>
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<td>HAI</td>
<td>Healthcare Associated Infections</td>
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<tr>
<td>PVC</td>
<td>Peripheral Venous Catheter</td>
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<tr>
<td>MDT</td>
<td>Multidisciplinary Team</td>
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<tr>
<td>HIS</td>
<td>Healthcare Improvement Scotland</td>
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<tr>
<td>NHS D&amp;G</td>
<td>National Health Service Dumfries and Galloway</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>QI</td>
<td>Quality Improvement</td>
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<tr>
<td>HCGC</td>
<td>Healthcare Governance Committee</td>
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<tr>
<td>HSMR</td>
<td>Hospital Standardised Mortality Ratio</td>
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<tr>
<td>DGRI</td>
<td>Dumfries and Galloway Royal Infirmary</td>
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<tr>
<td>MEWS</td>
<td>Modified Early Warning Score</td>
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<tr>
<td>NEWS</td>
<td>National Early Warning Score</td>
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<tr>
<td>ACP</td>
<td>Anticipatory Care Plan</td>
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<tr>
<td>SUTI Network</td>
<td>Scottish Urinary Tract Infection Network</td>
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<tr>
<td>UTI</td>
<td>Urinary Tract Injury</td>
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<tr>
<td>OPAC</td>
<td>Older People in Acute Care</td>
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<td>PPH</td>
<td>Post Partum Haemorrhage</td>
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<tr>
<td>CTG</td>
<td>Cardiotocography</td>
</tr>
<tr>
<td>PEWS</td>
<td>Paediatric Early Warning Score</td>
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<tr>
<td>CAMHS</td>
<td>Child &amp; Adolescent Mental Health Service</td>
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<tr>
<td>MHSW</td>
<td>Mental Health Support Worker</td>
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<tr>
<td>CMHNT</td>
<td>Community Mental Health Support Worker</td>
</tr>
<tr>
<td>CATS</td>
<td>Crisis Assessment Team</td>
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<tr>
<td>HCSW</td>
<td>Health Care Support Worker</td>
</tr>
<tr>
<td>RPUCI</td>
<td>Reducing Pressure Ulcers in Care Homes</td>
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<tr>
<td>NSAIDS</td>
<td>Non Steroidal Anti Inflammatory drugs</td>
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<tr>
<td>LES</td>
<td>Local Enhanced Service</td>
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<tr>
<td>AKI</td>
<td>Acute Kidney Injury</td>
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<td>GI</td>
<td>Gastrointestinal</td>
</tr>
<tr>
<td>ECS</td>
<td>Electronic Care Summary</td>
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<tr>
<td>RAT</td>
<td>Rapid Assessment Treatment Box</td>
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<tr>
<td>RAB</td>
<td>Rapid Assessment Bag</td>
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<tr>
<td>NES</td>
<td>NHS Education Scotland</td>
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<td>SIS</td>
<td>Scottish Improvement Skills</td>
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<tr>
<td>CMS</td>
<td>Clinical Microsystems</td>
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<tr>
<td>H&amp;S CEI</td>
<td>Health &amp; Social Care Senior Management Team</td>
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<tr>
<td>DOIT</td>
<td>Delivering Outpatient Integration Together</td>
</tr>
<tr>
<td>ScIL</td>
<td>Scottish Improvement Leaders</td>
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<tr>
<td><strong>MONITORING FORM</strong></td>
<td></td>
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<td>---------------------</td>
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</tbody>
</table>
| **Policy/Strategy** | Healthcare Quality Strategy  
Delivering Scottish Government Health Department  
Scottish Patient Safety Programme (SPSP) |
| **Staffing Implications** | Encouraging staff across NHS Dumfries and Galloway to take forward learning from patient safety activities. |
| **Financial Implications** | None identified |
| **Consultation / Consideration** | No consultation required at this time as this is a nationally agreed programme. |
| **Risk Assessment** | Patient safety and risk management are connected activities. Improving patient safety reduces the risk to patients, staff and the organisation. |
| **Sustainability** | Embedding continuous improvement enables us to ensure sustainability and reliability of processes and outcomes for patients |
| **Compliance with Corporate Objectives** | Corporate Objective 2 |
| **Single Outcome Agreement (SOA)** | Reducing Risk and harm and improving patient safety contributes to keeping our population safe. |
| **Best Value** | Vision and Leadership:  
- Commitment and leadership  
- Sound governance at strategic and operational level  
- Sustainability  
A contribution to sustainable development |
| **Impact Assessment** | No Equality Impact Assessment required |
Patient Safety Annual Report 2016/2017
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1 Improving the Safety and Reliability of Care across NHS Scotland

The Scottish Patient Safety Programme (SPSP) was launched in 2008 and is a unique national initiative aimed to drive improvement across the whole of NHS Scotland.

The SPSP Programme is now part of Healthcare Improvement Scotland’s Improvement Hub (iHub for short) supporting improvement across health and social care.

The iHub, launched in 2016, is helping to ensure that health and care services continue to improve and evolve so that they meet the changing needs of people that use them. The Scottish Patient Safety Programmes remain in place but now form part of wider portfolios of work that are currently being defined.

SPSP aims to support National Health and Wellbeing Outcome 7: People using health and social care services are safe from harm.

The fundamental aim of the Safety Programme is to reduce avoidable harm to patients by improving the safety of patient care at all points of care delivery. At its outset, SPSP focused on acute (hospital based) care but, in subsequent years, its remit extended and now includes the programmes described below, most of which concluded their current phase of work during 2016/17:

1.1 Acute Adult
The Acute Adult programme works to reduce harm and mortality for patients in hospitals. Since the launch of the programme in 2008 there has been a tangible impact on patient outcomes such as the reduction of infection rates for ventilator associated pneumonia and central line bloodstream infections. There has also been the widespread implementation of safety briefs, daily goal-setting in intensive care units and surgical brief and pause, which ensures it is safe for an operation to proceed. Current work includes improving the recognition and treatment of deteriorating patients, the recognition and management of sepsis, reducing falls, reducing catheter associated urinary tract infections (CAUTI) and reducing pressure ulcers. The programme has contributed to a reduction in hospital standardised mortality of 16.9% and reduction in mortality from sepsis of 21%.
1.2 Maternity and Children
This programme encompasses the activity of the Scottish Patient Safety Programme’s maternity, neonatal and paediatric care. Managed through the Maternity and Children Quality Improvement Collaborative (MCQIC) the aim of the programme is to improve outcomes and reduce inequalities by providing a safe, high quality care experience for all women, babies and families. The programme was launched in March 2013 and the scope is wide ranging and includes a focus on reducing stillbirth and neonatal mortality, reducing severe post partum haemorrhage, reducing unplanned admissions of children to intensive care and delivering better identification and treatment of sepsis. Since its launch this work has contributed to a 15 percent reduction in stillbirths.

1.3 Mental Health
The Mental Health Programme seeks to reduce the harm experienced by individuals who are receiving care within mental health services. To meet this aim, the programme supports frontline staff to test and gather real-time data and reliably implement interventions. Through collaboration and innovation from staff, service users and carers and the use of quality improvement science over the last three years, we are now starting to see significant reductions in self harm, seclusion, violence and aggression, and restraint across a number of areas in Scotland.

1.4 Primary Care
The Primary Care programme aims to reduce the number of events which could cause harm from healthcare delivered in a primary care setting. To achieve this goal, the programme has developed a range of tools and resources to support those working within primary care. All of its work aims to develop and maintain a safety culture. Areas of focus include the monitoring of high risk medicines and implementing reliable and safe systems.
for communication between services relating to patients. In 2016/17 the programme extended to include pilot work in General Dental Practices and care homes to reduce pressure ulcers.

1.5 Dental
The dental arm of the SPSP Primary Care Programme is new. It seeks to embed quality improvement processes into everyday general dental practice. We will do this by identifying areas for improvement and introducing care bundles that have been informed by national guidance to reduce adverse events and raise awareness of a safety culture among practices. Dumfries & Galloway is one of three NHS boards participating in an 18 month collaborative.

1.6 Healthcare Associated Infection
Healthcare Associated Infection's (HAI) are an important public health threat; they are damaging and distressing, and can cause disability and death. Like many other public health problems, HAIs are substantially preventable. The challenge associated with preventing HAIs is to ensure best practice in prevention of HAI's is reliably implemented and sustained across a range of healthcare settings.

The HAI programme provides an improvement resource to support NHS boards and Health and Social Care Partnerships to deliver sustained improvements in the prevention and control of infections. Launched in early 2015, it includes improvement support activity in the prevention of CAUTI, reducing risk of infection from the use of peripheral venous catheters (PVC) and the use of standard infection control precautions, for example, hand hygiene.
1.7 Medicines Management

The programme aims to bring together current improvement activity related to medicines from across the SPSP Acute Adult, Primary Care, MCQIC and Mental Health programmes. The Medicines programme was launched in early 2015 and the first phase of work focuses on medication reconciliation across different healthcare settings and high risk medicines. Building on existing improvement activity within SPSP, we are supporting healthcare staff to take a ‘whole system approach’ to medicines, considering the patient as they move between care settings and home. Working with patients and all members of the multidisciplinary team (MDT) is essential.

1.8 Whole System Improvement

There is recognition from Health Improvement Scotland (HIS) of the need to move from a focus on silos of service delivery to one that looks at harm from the perspective of the whole patient journey as defined below.
With this in mind local plans are being developed to spread improvements and testing into community and care home settings, reflecting the patient’s journey.

1.9  Foreword:
Developing a culture of safety and reliability is a long term ambition for NHS Dumfries & Galloway (NHS D&G) that requires us to attend to how we manage, how we plan, how we deliver and how we support staff.

Building the foundations of a safety culture sits alongside the need for an infrastructure to deliver real improvement. This includes developing Quality Improvement (QI), capacity and capability; an effective measurement system to report and monitor progress, programme management, effective communication plans and clarity on how we manage the transitions of care for our patients. Our Leadership Walkrounds are a tool which helps to ensure that leaders are connected to front line staff, and that through these structured dialogues a shared understanding is created and commitment obtained to continuing improvement.

We have over the last ten years demonstrated that we can make improvements in the quality and safety of key healthcare processes. More challenging has been spreading that improvement amongst wards, units and services across our Board area. Sustaining that improvement and embedding it into day to day practice is our ultimate ambition but for some of our work that is not yet complete.

Delivery of our Patient Safety Programmes is supported and enabled by the Patient Safety and Improvement Team, but it has to be owned by the Directorate, Ward or Practice who are responsible for operational delivery.

Throughout the year the Healthcare Governance Committee (HCGC) has received progress reports on each of the Safety Programmes. The annual report sets out to provide highlights from each of the programmes but more importantly to provide an overview of where we are at a Board level with our leadership and infrastructure to support delivery.

![Organising for the future](image)

<table>
<thead>
<tr>
<th>Aim</th>
<th>Primary Drivers</th>
<th>Secondary Drivers</th>
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<tbody>
<tr>
<td>Through continually improving healthcare delivered in Scotland, we will reduce events that cause harm to people.</td>
<td>Strategic Priority</td>
<td>Ensure safety and quality are organisational priorities</td>
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<tr>
<td></td>
<td></td>
<td>Provide leadership and oversight to ensure delivery of programme</td>
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<td></td>
<td></td>
<td>Actively develop your safety culture</td>
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<tr>
<td>Infrastructure</td>
<td>Development and utilise local capacity and capability in QI</td>
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<td>Effective measurement systems</td>
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<td>Programme management</td>
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<td>Effective communication</td>
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<td></td>
<td>Manage transitions of care</td>
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<td>Point of Care</td>
<td>Acute Adult</td>
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<td>Maternity and Children Quality Improvement</td>
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<td></td>
<td>Collaborative</td>
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<td></td>
<td>Primary Care</td>
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<td>Mental Health</td>
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</table>
Developing capability and the capacity to deliver across all of the Safety Programmes and the other improvement programmes which we are involved with has been challenging, as has releasing people at the front line to learn about and put into practice their improvement skills. During 2016/17, this has been an area of continued focus with the development of a local Quality Improvement Hub and development of a local Quality Improvement Faculty to develop our staff with the skills, knowledge and behaviours to continually improve the quality and safety of care and services.

As Patient Safety and Improvement Manager I have overall responsibility for the design and delivery of the Safety and Improvement Programmes. We have Improvement Advisor and Project Officer Support for each of the programmes, although this has become stretched as the number of programmes has increased. Clinical Leadership is in place for most of the programmes and for some of the point of care priorities for Acute Care.

We recognise that we cannot deliver on this alone and have worked closely with colleagues in Infection Control, Mental Health, Practice Education & Development and Leading Better Care to integrate our support around the key themes.

Our Annual Report gives a flavour of the work we and many others across the organisation have supported and delivered. We are proud of the very real improvements in the quality and safety of care for our patients and look forward to the journey ahead of us.

Patient Safety and Improvement Manager
2 Acute Adult
The Acute Adult Scottish Patient Safety Programme concluded the current phase of work at the end of March 2016. In review of phase 2, HIS recognised that NHS Boards have undertaken significant work and achieved considerable improvements to patient safety since commencing Scottish Patient Safety Programme in 2008.

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

Review in September 2016 took account of the redesign of services, reconfiguration of the workforce in preparation for the new hospital build and feedback from HIS visit in July 2016, which indicated a need to scale back on current workload and focus energy on key areas of priority.

The PS&I team work with the Acute management team to ensure priority areas are supported and take account of capacity and prioritisation within Acute Services.

### Overall programme Outcomes:

- To reduce Hospital Standardised Mortality Rate (HSMR) by 20%.
- 95% of people in acute adult healthcare are free from the harms as defined by Scottish Patient Safety Indicators, which includes Cardiac Arrest, Pressure Ulcers and Falls with harm
- To reduce Catheter-Associated Urinary Tract Infection (CAUTI) by 30%

### 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 chart below indicates the HSMR for Dumfries & Galloway Royal Infirmary (DGRI), showing a reduction of 16.2%. 
Scottish Patient Safety Indicator-3

Goal- 95% of patients discharged from hospital without any of the 3 harms (falls with harm, pressure ulcer, in hospital cardiac arrest).

SPSI-3 as a composite measure demonstrates the percentage of patients discharged free from any of the harms. More than 99% of patients are discharged from DGRI free from these harms as demonstrated below.
Point of Care Priorities

Clinical Leads are in place for the Point of Care Priorities workstreams with established teams to support testing, implementation and spread.

PS&I provide programme management support to the Acute Management Team with on the ground improvement and measurement support for each of the Improvement Teams.

A formal measurement plan with process and outcome measures for each of the priority areas has been developed by HIS and supports the monitoring of progress locally and nationally.

Progress for each of the Priorities is described below:

2.1 Deteriorating Patient & Sepsis

Goals:
- Reduce Cardiac Arrests by 50%
- Reduce Mortality from Sepsis
- 95% of patients with Acute Sepsis will receive Sepsis 6 within one hour of recognition

Outcomes
Cardiac Arrest data below shows a sustained improvement, on target with a 52% reduction in Cardiac arrest data within DGRI.
Mortality from Sepsis is monitored nationally. The chart below demonstrates a sustained improvement in survival rates due in part to earlier recognition and application of Sepsis 6.

Sepsis 6 within 1 hour is showing sustained improvement with a current median of 69% (i.e. 69% of patients receive all of the elements of Sepsis 6 within 1 hour of identification of Sepsis).

Improvement Activity

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, exploring system enablers to improve timely interventions.

NHS Dumfries & Galloway moved from a locally developed Modified Early Warning System (MEWS) to National Early Warning Score system (NEWS):

**Phase 1:**
- Develop and implement a NEWS document to DGRI and Galloway Community Hospital – Complete
Phase 2:
- Implement NEWS to Midpark Hospital and Cottage Hospitals - training underway - planned implementation in July 2017.
- Local Prison Services – testing of adapted document is underway

Phase 3:
- Explore potential spread to areas outwith inpatient services. Early discussion has commenced with General Practitioners and Out Of Hours services.

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 now has a prompt for clinicians to consider sepsis which we hope will raise awareness and prompt earlier identification and treatment. Some other support measures introduced are outlined below:

- A morning cardiac arrest huddle has been developed, tested and successfully implemented. The huddle enables the arrest team for that day to meet, discuss roles and has improved team dynamics during arrest calls. The Resus team are working alongside clinicians to test an evening huddle

- A post cardiac arrest debrief is being developed and tested to support staff following what can be a traumatic event and share experience to gain learning

- Treatment escalation plans have been tested and embedded in pilot ward, spread is underway within critical care.

- Teams from across health and social care partnerships are jointly mapping the current picture regarding Anticipatory Care Planning (ACP) within Dumfries & Galloway seek to define ACP ambitions for Dumfries & Galloway and next steps.

2.2 Falls

Goals:

- 20% reduction in all falls
- 25% reduction in falls with harm

Outcome

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.
Pilot Ward 18 shows unsustained improvement in all falls rate whilst falls with harm data shows a sustained improvement, with fewer patients harmed by falls. It is too early to expect to see this improvement at site level. The challenge is to maintain reliability at pilot whilst preparing to scale up and spread.
Improvement Activity

- The falls bundle; tested within our pilot ward is now a core component of assessment documentation on admission for all inpatients in DGRI and cottage hospitals.

- Although wards reported reliable process data, outcome data was not improving.

- A deep drive to understand the factors behind patient falls is underway within pilot wards with a number of areas identified for further testing.

- Develop and test a daily activity programme within pilot ward 18, by use of social interaction and activities to enhance patient experience and potentially reduce levels of agitation and wandering behaviours.

2.3 Catheter Associated Urinary Tract Infection (CAUTI)

Goal:

- Reduce catheter usage

- 30% reduction in CAUTI

Outcome

The pilot ward is not yet seeing any reliable improvement in the reduction of catheter usage, they are beginning to see a reduction in the number of patients who have a CAUTI with longer periods of days between as shown below.
Improvement Activity

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, this was spread to all applicable areas in DGRI and cottage hospitals during 2016.

- An education package supported by clinical education, infection control and patient safety teams was positively received by staff teams.

- We are working with clinical teams to support data collection and evidence impact on patients care.

- NHS Dumfries & Galloway are collaborating with the Scottish Urinary Tract Infection (SUTI) Network and Quality Improvement Facilitators from HIS to develop and test a national passport document for patients as a pilot site with an aim 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.

• Extending beyond hospital care a “Go with the Flow” Event was held in October 2016 to engage with staff and carers from across health and social care. Work has begun between acute care & care homes to test the introduction of a Decision Aid to assist in the diagnosis and management of suspected urinary tract infection (UTI) in older people in care homes.

**Flavour of feedback from the event participants:**

- Learning new information, we need to change that way we think prior to doing - think of impact for our patient.
- Highly rate: the labs 'to wee or not to wee'- when to send a sample.
- Roger Hampshire: the patient's experience.
- Ian Russell: the bigger picture.
- New innovative information: to pass on to fellow colleagues.
- Gained information to improve clinical decision making and improve care.
- Awareness raised on the overuse of catheters and antibiotics. Better communication required with patients and staff.
- Improved knowledge: appropriate sampling and use of antibiotics, more use of flip flow for bladder retraining.
- Great to be included from private nursing home - networking with others.
- Improved knowledge: appropriate sampling and use of antibiotics, more use of flip flow for bladder retraining.

### 2.4 Pressure Ulcers

**Goal:**

- 300 plus days since last hospital acquired pressure ulcer
- 50% reduction in pressure ulcers by December 2017.

**Outcome**

Self reported data in pilot ward 14 shows extended periods without newly acquired pressure ulcers, each new pressure ulcer is investigated and learning shared with the team.
Improvement activity:

- Spread to site has began with staff receiving both clinical education on pressure ulcer prevention and improvement methodology to help them test and implement solutions in their care setting.

2.5 Plans for the Year Ahead

The national SPSP Acute Adult Programme now forms part of an overarching Acute Care Portfolio. The portfolio contains the SPSP Adult Acute Programme, SPSP Healthcare Associated infections and the Improving Older People’s Acute Care Programme (OPAC). We await further guidance on the content, delivery, governance, communication and engagement plan for the portfolio.

At a local level it is hoped this will in time support delivery of more integrated improvement activity. With shared opportunities to develop and tailor local priorities that improve our systems and bring value to people who access and work within our services.

The revision to the Acute Adult Safety Programme has been welcomed. It has taken account of the very real operational pressures that slowed the pace of Phase 2 of the programme and provides a more attainable focus to the safety programme in acute care.

The PS&I team have had a reduction in resource available to support clinical teams on the ground and have prioritised building improvement capability to maintain momentum. We continue to work collaboratively with clinical educators, infection control and management teams to collectively support staff to develop the knowledge and experience to test out new ideas and ways of working that have the potential to improve safety and reduce harm.

Measurement is critical to ensure that the changes we make are delivering the results we are looking for. The perceived burden of measurement can be a barrier to clinical teams, we are working with teams to reduce data collection where appropriate and utilise
resources in different ways with an emphasis on providing real time measures of patient safety.

Building improvement capability for clinical leads and front line staff involved in the improvement teams needs to be a continued focus for 2017/18 to ensure we build on their good will and underpin this with an understanding of improvement science. This is and will continue to be delivered through structured learning events, improvement workshops and individual and team coaching.

3 Maternity & Children’s Quality Improvement Collaborative:
The Maternity and Children Quality Improvement Collaborative oversees the activity of the SPSP’s maternity, neonatal and paediatric strands.

### Overall Programme Aim

Improve Outcomes and Reduce avoidable harm by 30% in the Maternity, Neonatal & Paediatric settings in Scotland by March 2016

3.1 Maternity

Goal:

- Improve experience of care
- Reduce stillbirths by 30%

Priorities:

- Reduce severe post partum haemorrhage (PPH) by 30%
- Introduce Cardiotocography (CTG) bundle

Outcome

Still Birth Rates and Neonatal Mortality Statistics

The rate of still births is increasing. This is a concern locally and nationally. A case review is underway to identify any common themes.
As CTG is new to the programme, we do not as yet have data. Data illustrating the improvement journey regarding PPH indicates an improving rate of compliance with the bundle of measures.

**Improvement Activity**

- Introduced CTG monitoring earlier in maternity pathway.
- Continuing to refine surgical checklist and briefs.
- Introducing shift huddles to improve communication and identify potential deterioration

### 3.2 Paediatrics

**Goal:** To reduce avoidable harm by 30%

**Outcome**

- The Paediatric harm indicator has not proved useful in identifying harm within DGRI Paediatric ward. The ward has continued with the case note review process with areas for improvement identified and fed into their improvement team.

**Improvement Activity**

The new National PEWS (Paediatric Early Warning System) is being rolled out across Scotland, NHS Dumfries and Galloway have been involved in its development and are looking forward to adopting it during Q2 2017. The compliance with the existing PEWS bundle remains high. This bundle helps to reduce serious safety events as well as assisting with early recognition of deterioration.
Ward 15 are working with pharmacy to improve current medicines reconciliation processes and have undertaken a number of tests of change to reduce prescribing and administration errors.

### 3.3 Neonatal

**Goal:** 30% reduction in avoidable harm in Neonatal Services by December 2015 by seeking to reduce:

- harm from mechanical ventilation
- harm from invasive lines
- harm from high risk medicines
- harm from transitions of care,
- and undetected deterioration

**Outcomes**

- Reducing harm from invasive lines through implementation of PVC insertion and maintenance bundle
- Reducing harm from high risk medicines through implementation of Gentamicin bundle
- Reducing harm at transitions through a focus on reducing the number of hypothermic babies coming into unit

The team have sustained improvement with PVC insertion bundle and are working to improve compliance with recording for the maintenance bundle. Please see charts below related to PVC and Gentamicin bundles.
Gentamicin bundle compliance has improved and the team are working to ensure this remains at 100%.

**Improvement Activity**

- Working with Maternity Services to introduce the Snuggle Bundle to ensure no baby enters the unit hypothermic.
- Incorporating PVC maintenance bundle into daily ward checklist.

**Early Years Collaborative**

The Early Years Collaborative has now joined with the Raising Attainment for All Collaborative to form the ‘Children & Young People Collaborative’. The work plan is incorporated within the Draft Children’s Services Plan.

There are currently 12 projects receiving active support which ranges from advice & guidance to facilitation and dedicated improvement support.

**Challenges and plans for the year ahead**

The Women and Children’s Directorate has undergone significant structural changes within management and is looking to a more streamlined approach to identify and support improvement priorities for the year ahead.

Staff have found it increasingly difficult to find the capacity to learn about improvement methodology and implement it in practice due to significant staffing pressures within the service. The PS&I team have prioritised building improvement capability within the directorate and would hope to see an increased focus on improvement for the year ahead.

**4 Mental Health: Inpatient Services**

The aim of the Scottish Patient Safety Programme for Mental Health is People are and feel safe, Staff are and feel safe.

The programme was first introduced to Mental Health in 2012 by testing and prototyping ideas and did not seek to cover every area. The initial focus commenced in Adult Inpatient Care Services.

**Phase 1** ran from August 2012 to September 2013. The local test site was Balcary Ward, which began testing within inpatients.

**Phase 2** then ran from September 2013 to September 2016. This phase consolidated and spread the improvement work into Ettrick, Nithsdale and Dalveen Adult Mental Health Inpatient Wards.

The end of Phase 1 & 2 review in November 2016 reported that through collaboration and innovation from a range of stakeholders and the use of quality improvement and improvement science, significant reductions in self harm, seclusion, violence and aggression and restraint have been reported across a number of Scottish NHS Boards.
Phase 3 began in September 2016 focuses on testing and spread into Child and Adolescent Mental Health (CAMHS), Community, Older Adult, Learning Disability & Perinatal Mental Health Services

4.1 Improvement Activity

Triangle of Care

The Triangle of Care is a simple tool designed to ensure a more collaborative model of care. It offers a chance to work in partnership with carers, families and those living with mental health problems.

The Triangle of care resources and standard have been adopted by mental health services in Dumfries and Galloway to improve both patient and carer experience. All areas within mental health have completed the self assessment and are currently testing improvements which include carer appointments. Feedback from staff has been positive with carers reporting reduced anxiety.

Development of HCSW Framework

A multi professional working group was set up to support the Development of the Health Care Support Worker (HCSW) Framework for Band 2 and Band 3 HCSW staff within the Mental Health Directorate. The framework was aligned to the National HCSW Framework. New Job Titles, Job Descriptions and Person Specs were developed to support the core competences required within the role.

Pre-implementation of a programme of communication and engagement roadshows were held with all HCSW staff affected and Registered Nursing Staff involved in the Personal development planning and mentoring of this valuable resource within the Directorate.

Mental Health Support Worker (MHSW) Role

Introduction of the MHSW role at Midpark Hospital was introduced to support enhancing the role and experience of the HCSW in providing safe effective care to those who use our service but also underpins the NHS objective of valuing staff.
Key areas of improvement have included:

Increased compliance with HOT Targets for HCSW staff which is inclusive of:

- Increased compliance with Personal Development Plans & Annual Development Review process (Permanent, Fixed Term and Bank staff)
- Corporate and local Induction completed of all new HCSW staff (Permanent, fixed term and Bank staff)
- 100% compliance with HCSW Standards for all new employees.
- 100% Compliance with mandatory training (any breaches have been related to Long term sickness, Maternity leave etc)
- Input to support strategies with attendance management
- Promoted the development of a learning culture for HCSW staff
- Talent based approach to learning and development of HCSW staff (Making people stronger in competences which suit them)
- Supported implementation of the HCSW Framework

### 4.2 Highlights and Challenges

Over recent years there have been some notable successes and a few examples are provided below:

- **Midpark Daily Safety Huddle and Friday 3pm pre weekend Huddle**
- **Implementation of the Nominated Hospital Lead Role**
- **Implementation of the MHSW role**
- **Midpark Senior Nurses weekly safety huddle**
- Learning from Adverse events - Midpark Weekly Risk Triage Meetings, Improved understanding of how restraint is viewed and management of stress and distress; Adverse incident debriefs following any adverse incident; Introduction of routine debriefs for staff post sensitive and stressful care and treatment planning
- **Safety Huddles in Annandale & Eskdale Community Mental Health Nursing Teams (CMHNTs)**
- **Transition between services SBARs (Inpatients, Crisis Assessment Treatment Service (CATS) and CMHNTs)**
- **Safety briefs implemented in all wards and within Nominated Hospital Lead role**
- **Improved compliance with prescribing standards, administration practice of as required medications**
- **Effective handovers (Daily Medical Handover to Senior MDT professionals) using SBAR within CORTIX system (Nursing Teams) resulting in reduction in inappropriate use of staff resource**
- **Improved carer experience with Triangle of Care implemented in 2 wards and spread has commenced in other 4 with Test of Change links identified to engage in the Self Assessment process**
- **Introduction of Estimated Date of Discharge in Nithsdale Ward, supportive of patient flow, discharge planning and pro-active with Delayed Discharges, spread commenced in Ettrick, Cree and Dalveen**
- **Improved safety and security (Review and audit of Responder and Fob alarm processes, system and procedure)**

There have also been a number of challenges such as:

- **Collation and analysis of data – National measures as well as local PDSA data**
• In March 31st 2016 funding was withdrawn for the SPSP Improvement Advisors post where the responsibility was handed over to the Inpatient Services Manager. (This has been noted as a challenge however should also be noted as a success as increased activity, buy in and improvement projects have been initiated and spread)

• Training and support- Hands-on support has been able to be provided on a regular basis over the last 12 months via project meetings, staff meetings and development of in-house training sessions which has proved to be invaluable in motivating staff, increasing their skills and confidence, and providing guidance and direction regarding improvement cycles, data collection and priorities. However, clinical pressures tend to restrict the number of staff who can attend the links meetings or WebEx sessions

• Sustainability and capacity -The provision of training alone does not guarantee that the programme will be successful and sustainable over time. Staff need to be given time to lead on improvement work, to have space to develop ideas, to collate and discuss data and outcomes of tests of change, and to continually update their knowledge and skills. This can occasionally be compromised as a result of staff shortages and ongoing clinical pressures.

4.3 Plans for the Year Ahead

Phase 3 of the programme will be introduced in 2017 where the main focus is on:

• Building on the work based achievements over Phase 1 and Phase 2 of the Programme
• Physical Health and well being.
• Spread of SPSP programme to other Services named above

Work has already commenced within Older Adult Inpatient Services, CATS & CMHNTs. A bi-monthly meeting has been set up, lead by the Inpatient Services Manager to support development of any new projects, identify learning needs, create opportunities for spread and sharing of good practice

New Projects for 2017:

• Improved Observation Practice - patient and staff experience Survey May - July 2017
• Improving awareness to management of the suicidal patient
• Senior Management Weekly Huddle
• High Risk Medication Management, Monitoring and Education
• Falls and multifactorial approach to assessment
• Physical Health Monitoring
• Improved risk assessment and management
• Benchmarking Mental Health and Learning Disability Services (Inpatient and Community Teams) who support Forensic patients against the Low Secure Standards developed by the Forensic Network Scotland
• Patient Safety Climate Tool
• Staff Climate Tool
• Spread of Estimated Date of Discharge to 6 wards at Midpark

There will inevitably be challenges in keeping momentum with the programme; however engagement, motivation and enthusiasm from staff, together with strong leadership in the clinical teams will continue to take forward the agenda inclusive of the safety principles of the programme.
5 Scottish Patient Safety Programme in Primary Care

The Scottish Patient Safety Programme in Primary Care has been developed around the following three work streams:

- **Safer medicines**: including the prescribing and monitoring of high risk medications and developing reliable systems for medication reconciliation in the community.

- **Safe and effective patient care across the interface** by focusing on developing reliable systems for handling written and electronic communication and implementing measures to ensure reliable care for patients.

- **Leadership and culture** using trigger tools (structured case note reviews) and safety climate surveys

Patients receive care from a range of primary care professionals including GPs, community and district nurses, community pharmacy and dental practice teams, as well as colleagues in out-of-hours and care home settings. We need to ensure that primary care is safe and that patients don’t fall through the gaps as they move across different parts of our health and social care system.

NHS Dumfries & Galloway are participating in the following SPSP’s in Primary Care:

- General Practice
- Dental Collaborative (Pilot)
- Reducing Pressure Ulcers in Care Homes (RPUCH) Improvement Programme

5.1 Scottish Patient Safety Programme in General Practice

**Year one** of the programme for Dumfries and Galloway came to an end on 31 August 2014. It focussed on Warfarin management.

**Year two** commenced in September 2014 and focused on Medicines Reconciliation.

**Year three** commenced in January 2016 and focused on High Risk Prescribing, specifically patients who are over 65 who receive the ‘triple whammy’ medication combination, and other combinations including Non Steroidal Anti Inflammatory Drugs (NSAIDs).

**Goal**

The Local Enhanced Service (LES) aims to reduce harm by ensuring Safe and Reliable Prescribing for Patients over 65 receiving NSAIDs on repeat prescription, especially when combined with other medicines. The LES aims to deliver high-level outcomes across three areas:

- **Patient experience** – increased awareness, involvement and joint decision making regarding commencement and continuation of high risk drug combinations. We believe that where patients are more involved in decisions and awareness of their medication, they can take better care of themselves. For example when patients become unwell, they may choose to stop and restart their own medication, and potentially prevent complications possibly leading to emergency admissions.
- Primary care – opportunities to review medication combinations which may result in reduced overall prescribing, reduced risk of upper Gastro Intestinal (GI) bleeds and Acute Kidney Injury (AKI), and increased patient satisfaction.
- Secondary care - Reduced emergency admissions due to upper GI bleeds and AKI.

Outcomes

An aim was set to reach 95% compliance with the improvement bundle by the end of the LES period (December 2016). All practices demonstrated improvement towards this aim.

In addition to the improvement in process’ for patients on this high risk medication combination we are also seeing the beginnings of a reduction of patients on this combination which would reduce the risk overall.

Improvement Activity

Patient Experience: The LES incorporated the newly commissioned Medicine Sick Day Rules cards, designed to empower patients to stop taking their medicines when sick.

Patients prescribed high risk medicines should receive key messages by their GP or practice staff at time of prescribing, and again at the time they collect their medicines, the sick day rules cards reinforce the key messages.
Primary Care: 26 out of 34 practices participated in year 3 LES.

Practices ran system searches to identify patients who were prescribed the relevant medicine combinations. Once identified, arrangements were made to review the patients’ prescribing, and potentially change their medicines to reduce the likelihood of AKI or upper GI bleeds.

Secondary Care Admissions: Outcome measures in terms of reduced admissions have been difficult to assess as people can present with AKI or upper GI bleeds for a variety of reasons. The impact is likely to be seen beyond the scope of the improvement intervention as practices continue to improve reliability across core process measures.

5.2 Plans for the Year Ahead

As the three year programme has now ended we and the national team at HIS will take time to evaluate the impact and consider next steps however, we can draw some conclusions that will help us to support future improvement work in General Practice and Primary Care more broadly.

Early work to develop a culture of safety and improvement within practices has left a legacy and capability around quality improvement to build on. This needs to be sustained to ensure we retain the capability we currently have as people move on. We must ensure education programmes and support are made available to the Primary Care community, and that their leadership are able to support and enable staff to access training in support of their improvement priorities.

Practices who have participated in the LES’s have been able to demonstrate the impact of their improvement efforts through measurement which has generated further enthusiasm and commitment from the practice team.

Capacity and recruitment challenges within General Practice did impact on practices’ ability to remain committed during year 3 of this programme.

The recent publication ‘Improving Together – A National Framework for Quality in General Practice’ issued by Scottish Government this month gives a flavour of how Boards, Health & Social Care Partnerships and GP Clusters might work collectively to continuously improve the quality and safety of care offered to our citizens and to improve the health and wellbeing of our population.

Local Practice Quality Leads and Cluster Quality Leads have been identified. The PS&I Team are working with Associate Medical Director, Primary Care and others to understand how we might approach this.

5.3 Primary Care in General Dental Practice Collaborative:

The dental arm of the SPSP Primary Care programme seeks to embed quality improvement processes into every day practice. Three NHS boards were selected to participating in this 18 month collaborative:

- NHS Fife
- NHS Ayrshire and Arran; and
The collaborative was initially due to run until December 2016 but was extended to 31 March 2017. During this time, dental practice teams:

- Learned about improvement methodology
- Piloted the use of tools and interventions to deliver safer, more reliable care
- Explored their safety climate by undertaking a safety climate survey, and
- Shared learning within their teams, across our board and with other NHS boards.

Locally we recruited a dentistry clinical lead, and four dental practice teams, to work together on testing the tools and interventions. They were supported by an Improvement Advisor and Project Officer from the PS&I Team.

The collaborative aimed to improve safety and reduce harm by:

- Integrating a high quality medical history into decision making with regard to treatment planning.
- Develop a culture within practices centred on safety & improvement.
- Create conditions whereby practices could work collaboratively.

Practices completed a Safety Climate Survey to help practices develop a positive safety culture, learn from mistakes and foster a culture where people feel comfortable to speak.

Data was collected over 12 months, with the first four months acting as the baseline.

The local collaborative set an aim to reach 95% compliance with the improvement bundle by the end of the pilot (March 2017). The measurement plan focused on 5 key areas:

- medical history form check
- operator evaluation of medical history
- patient engagement
- medical history integration into treatment plan decision making
- ongoing care management

All practices demonstrated significant improvement over the pilot.
Improvement Activity

Each of the practices worked on individual improvement projects, whilst measuring the impact of their changes using the local measurement plan. These include:

- Effectively documenting a full medication history (and dosage frequency) from patients taking medicines long term.
- Amending the medical history form to ensure accurate information is gathered.
- Ensuring that all patient records have an explicit statement of risk recorded within them, even if they do not have a relevant medical history.
- Including a recall reminder to ask patients to bring a list of their current medications with them to appointment.
- Removing all flags from all patient records except those with one of the 5 conditions highlighted.
- Include medical record keeping as part of the dentist induction process.
- Creation of patient information leaflets.
- Staff training.
- Creation of computer templates to ensure the correct questions are asked and responses recorded.
- Inclusion of Dental Nurses in taking medical histories alongside Dentists.
- Access to the Electronic Care Summary (ECS – the GP record of prescribed medicines).

5.4 Plans for the Year Ahead

The Patient Safety and Improvement Team are working with HIS, NHS Education and our local dental team to define the shape of improvement activity within General Dental Practice.

Access to ECS has been provided as part of this project, to one practice. This has been found to be beneficial on occasions when an additional source of information has been needed. This will be offered to other practices.

NHS Dumfries and Galloway Health Board will explore opportunities to support those practices who undertake improvement activity in terms of provision of relevant education. The PS&I Team will develop links between the local improvement team and the Dental Practice Advisor.

A Safety Climate Survey tool was tested by the practices involved. This may be made more widely available, as it serves to stimulate change around team dynamics, communication and flatten hierarchy of staff regarding decision making.

Of the 4 practices involved, all said they would continue to work on improvements and would encourage other practices to become involved with future improvement collaboratives.

5.5 Reducing Pressure Ulcers in Care Homes Collaborative:

Older people living in care homes are some of the most vulnerable people in society and have a high risk of developing pressure ulcers. Pressure ulcers are an unwanted complication of illness, severe physical disability or increasing frailty.
Building on the progress being made through the SPSP to reduce pressure ulcers within acute hospital settings and ongoing improvement activities currently being delivered within care homes, an ambitious aim to reduce pressure ulcers across all care settings by 50% was announced at the NHS Scotland event in June 2015. Boards were invited to apply to HIS to participate in the improvement programme and three Boards including NHS Dumfries & Galloway were selected to participate in May 2016 with work commencing in July 2016.

Locally we have recruited 5 care homes to participate and have developed a local steering group.

**Goal**

- 50% reduction in pressure ulcers by December 2017.

**Outcome**

Self reported consolidated data from the 5 care homes shows one newly acquired Pressure Ulcer since January 2017.

![Count of Newly Acquired Pressure Ulcers](image)

**Improvement Activity**

**Care home 1**

Have completed their first test of change towards their aim of

- To involve 25% of relative in the Pressure Ulcer Prevention collaboration by the end of April 2017

They developed a sticker that acts as a reminder to the staff member to talk to the relatives about the key factors of pressure ulcer prevention. This sticker can then be put into the residents notes.
The learning from these tests suggested the relatives were fully aware of the above key elements on how to prevent pressure ulcer occurrence. Care home 1 have decided to adapt their service user and carer questionnaire to include questions which will capture a base line of information regarding knowledge and understanding of pressure ulcer prevention amongst all relatives, carers and residents before proceeding with further testing.

The questionnaire results so far show that out of 19 responses only 1 required advice.

We are working together to develop a new aim to test the SSKIN bundle.

The care home manager is on the 2nd Cohort of our local Scottish Improvement skills course as a result of engagement with the collaborative.

**Care home 2**

We are working to improve engagement by having weekly sessions in the home. The home are currently collecting baseline data on staff knowledge and understanding of pressure ulcer prevention and are working with the PS&I team to understand their challenges and test solutions.

**Care home 3**

- Continue to engage in testing a sustainable training package for existing staff and induction programme for all new staff.
- Testing role of Pressure Ulcer Champion

**Care home 4**

The focus for care home 4 has been on creating the conditions for improvement by focusing on leadership, culture and engagement. They created aims in support of this:

- By the end of June 2017 60% of staff will have used the safety culture cards
- To engage our care home owner in our Pressure Ulcers Collaborative by End of March 2017-03-15
- By end of April 60% of staff will have engaged in our pressure ulcers collaborative

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- By the end of June 2017 60% of staff will have used the safety culture cards
- To engage our care home owner in our Pressure Ulcers Collaborative by End of March 2017-03-15
- By end of April 60% of staff will have engaged in our pressure ulcers collaborative
Care home 4 has had email communication with one of the owners saying they are supportive of the work that is ongoing.

The above graph shows they have achieved their target of engaging 60% of staff. We will now plan to engage the rest of staff within the home.

Care home 4 have now implemented the use of the safety culture cards in the home with plans for other staff to facilitate the use of these.

**Care home 5**

Care home 5 have been testing improvements in identifying patients at risk of developing pressure ulcers. Care home 5 have had 211 days since their last pressure ulcer...
5.6 Plans for the Year Ahead
The Patient Safety Programme in Primary Care will continue to evolve and change as the contracts for practitioner services are renegotiated nationally.

The PS&I team have had a reduction in resource available to support clinical teams on the ground and have prioritised building improvement capability to maintain momentum. We continue to work collaboratively with clinical educators, infection control and management teams to collectively support staff to develop the knowledge and experience to test out new ideas and ways of working that have the potential to improve safety and reduce harm.

Working with contracted services and the independent sector adds a further dimension which requires an ability to build and maintain effective relationships over time.

Measurement is critical to ensure that the changes we make are delivering the results we are looking for. The perceived burden of measurement can be a barrier and we will continue to look for light touch solutions with an emphasis on providing real time measures of patient safety.

Building improvement capability for clinical and care teams needs to be a continued focus for 2017/8 to ensure we build on their good will and underpin this with an understanding of improvement science. This is and will continue to be delivered through structured learning events, improvement workshops and individual and team coaching.

We have made inroads into exploring the potential of a truly collaborative approach between acute, primary care and community programmes to improve patient safety and experience wherever patients’ are within their care journey. Our workplan for 2016/17 reflects this.

6 Quality Improvement Infrastructure
“We believe that quality is the responsibility of every employee and promoting a culture of continuous improvement will allow organisations to do the right things at the right time, every time.”

This supports the strategic vision articulated within our Health & Social Care Strategic Plan:

‘Making our Communities the best place to live active, safe and healthy lives by promoting independence choice and control’

In addition to identifying specific pathways and conditions where a focus could reduce harm and improve outcomes we now understand that there are enablers for delivering safe and effective care. These include:

- Leadership
- Building the capacity and the capability of the system in quality improvement methodologies
- Effective communication
• Effective management of care at transitions between services
• Effective MDT working

The PS&I team will work with others across the health and care system to ensure we support services and teams to address these key enablers.

6.1 Dumfries & Galloway Quality Improvement Hub
In August 2016 the Health and Social Care Senior Management Team (H&SCSMT) approved a proposal to establish a QI Hub.

It is intended that the Quality Improvement Hub should have two key functions:

• to directly support agreed improvement priorities
• to build improvement capacity and capability

The QI Hub will provide direction to deliver on the agreed priorities and support working groups and services to test improvements at both small and large scale, focussed on an outcome based approach. This will include the consideration of running improvement collaboratives to deliver work across the system at scale where this approach has been proven to work.

The QI Hub will support a Quality Board (yet to be established) and H&SCSMT with decisions on testing at scale and spread by providing evidence on outcomes and/or the cost benefits of implementation of change across the system, focused around the Health & Social Care Strategic Plan.

There is a key role for the Quality Improvement Hub in co-ordinating and directly supporting the National Improvement Programmes that are required to be delivered locally. These include the SPSP, Early Years Collaborative, Six Essentials Actions for Improving Unscheduled Care, Delivering Outpatient Integration Together (DOIT) to name a few.

Goals:

The QI Hub will offer a route of access for signposting staff to resources and respond to requests for support. Initial criteria for agreeing the level of support required have been developed and are described in Table below. Support might range from guidance and signposting to facilitation or the consideration of dedicated improvement support which may be referred to the Quality Board.

The proposed Dumfries & Galloway Quality Improvement Hub will support, facilitate and contribute to improving the health and social care system for our population by:

• Working directly with individuals, teams and service areas to improve the quality of care and service delivered on objectives and priorities agreed by a Quality Board
• Establishing and managing a QI Network across D&G to share learning and promote collaborative working, empowering staff and teams to make improvements.
• Promoting QI methodology and create and deliver a range of QI learning and development opportunities for all levels of staff.
• Developing links with Healthcare Improvement Scotland, NES, other Health Boards and Health and Social Care Partnerships to share and learn.

The QI Hub was officially launched in April 2017 with 90+ staff and managers from across Dumfries & Galloway coming together to create a vision and energy to make QI Hub a reality.

### Improvement Support Criteria

<table>
<thead>
<tr>
<th>Guidance Criteria</th>
<th>Facilitation Criteria</th>
<th>Dedicated Support Criteria</th>
</tr>
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<tbody>
<tr>
<td>• Clear plan for improvement. Only requires direction to the best resources to utilise.</td>
<td>• Improvements linked to key priorities for the service.</td>
<td>• The required improvement is a Key organisational priority.</td>
</tr>
<tr>
<td>• No clear plan devised and requires tools to help focus improvement direction.</td>
<td>• Clear plan and actions identified.</td>
<td>• Specific support is required to co-ordinate, manage and/or lead the improvement.</td>
</tr>
<tr>
<td>• Plan devised but uncertain of level of support required.</td>
<td>• Requires facilitation with:</td>
<td>• Clear agreement in place on:</td>
</tr>
<tr>
<td>• Uncertain of clinical or cost effective benefits of proposed change.</td>
<td>• Use of tools &amp; techniques.</td>
<td>• Scope of the engagement.</td>
</tr>
<tr>
<td></td>
<td>• Testing changes.</td>
<td>• Project support roles.</td>
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<tr>
<td></td>
<td>• Data analysis and reporting</td>
<td>• Service roles and actions.</td>
</tr>
<tr>
<td></td>
<td>• Agreed short term facilitation needed to skill up staff within the service.</td>
<td>• Reporting routes.</td>
</tr>
</tbody>
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For further information please see the Workplan in Appendix 1.
6.2 Leadership Walkrounds

The Patient Safety Leadership Walkround process is designed to give frontline staff and senior leaders in the organisation an opportunity to discuss safety and improvement and the things which can help in delivering safe, effective, person-centred care. The walkround conversation is intended to engage staff in order that:

- They can discuss what they do well and are proud of.
- They can raise safety or quality concerns.
- The participants can agree actions and timescales to address any concerns.

From April 2016 to March 2017 a total of 43 Walkrounds took place across the organisation. Walkrounds take place each week in different areas of the organisation and are part of a continuing cycle of improvement.
Themes raised include:

<table>
<thead>
<tr>
<th>Theme</th>
<th>Discussion Points</th>
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</table>
| Staffing                     | • Concerns around staffing levels, sickness and maternity leave  
                                 | • Concerns around departmental changes and staffing  
                                 | • Concerns around skill mix and staff development  
                                 | • Concerns around staff working late  
                                 | • Concerns around using Bank or Locum staff who do not know the area or systems  
                                 | • Difficulties with recruitment                                                                                                                                 |
| IT Systems                   | • Issues around IT updates  
                                 | • Issues around training for IT systems  
                                 | • Issues around new IT Systems being rolled out or introduced  
                                 | • Issues around wifi/internet connection                                                                                                                                 |
| Visibility of the Leadership Team | • Concerns that frontline staff did not get the chance to meet with the Leadership Team  
                                 | • Concerns that the Leadership Team were not visible enough within departments                                                                                                                                 |
| Move to the New Hospital     | • Concerns around the new single room layout  
                                 | • Concerns around using the new systems  
                                 | • Concerns around bed numbers in the new hospital                                                                                                                                 |
| Patient Safety               | • Concerns around bed availability  
                                 | • Concerns about boarding out and delayed discharges                                                                                                                                 |

Actions identified during discussions are agreed and carried out by the senior managers or nominated staff members. Themes identified are discussed by Management Team and incorporated into business planning processes. A sample of actions are detailed below:

<table>
<thead>
<tr>
<th>Theme</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing</td>
<td>• Conversations with Workforce/management around recruitment, staffing, staff skill mix and development</td>
</tr>
<tr>
<td>IT Systems</td>
<td>• Conversations with IT to provide progress updates around ongoing projects or system updates</td>
</tr>
<tr>
<td>Visibility of the Leadership Team</td>
<td>• From April 2017 there will be 2 Leadership Walkrounds a week when possible to give staff more opportunities to meet with the Leadership Team.</td>
</tr>
</tbody>
</table>
| Move to the New Hospital     | • Opportunities for staff to visit the New build site  
                                 | • Conversations around plans for the new hospital and community care  
                                 | • Conversations with the New Build Project Team around opportunities for staff to test new patient flow systems before the move |
| Patient Safety               | • Conversations with Management around bed availability, boarding out and delayed discharge solutions and improvements. Hopefully the bigger assessment unit at the new hospital will help with patient flow. |
6.3 Building Capacity & Capability
The Quality Improvement Curriculum Framework developed by NES aims to support staff across all Public Services to access learning in improvement science thinking and techniques. Currently there are three levels of programmes.

- **Scottish Improvement Skills**. Open to all Public Services staff and aimed at Practitioner Level. NHS Dumfries & Galloway plan to deliver up to 2 cohorts annually from August 2016. A maximum of 30 places will be available on each cohort. In addition to the SIS core curriculum each participant will be allocated an ‘improvement coach’ and given the opportunity to develop their skills as a coach. 25 completed SIS during 2016/17.

- **Scottish Improvement Leader (ScIL)**. Open to all Public Services staff. Places allocated by assessed applications and aimed at individuals who can lead large-scale improvement projects and support capacity building within their organisations. Four cohorts per year. We aim to have at least one person on each cohort. 3 delegates from NHS Dumfries & Galloway completed during 2016/17.

- **Scottish Quality and Patient Safety Fellowship**. Open to all clinical staff. Run annually and places are allocated by assessed applications. This is aimed at building clinical leadership to support patient safety and quality improvement. We should aim to support at least one applicant annually. We currently have an Occupational Therapist on this programme.

The leadership programme places are allocated on assessed application only, the challenge for NHS Dumfries & Galloway lies with securing enough places in order build a sustainable capacity to deliver on and develop a QI infrastructure locally.

Within NHS and the local authority we have utilised these programmes offered and the previous Improvement Advisor Programmes run by the Institute of Healthcare Improvement and have some staff with knowledge and expertise that we do and can develop to teach and lead improvement development programmes within Dumfries & Galloway.

Building improvement capacity in Dumfries & Galloway has progressed within the last few years with local collaboratives, 2 day Improvement Bootcamps and practitioner and team coaching. This year has seen the introduction of SIS with 25 staff completing the programme. To date, this has been done mainly under the auspices of the PS&I Team, however we are now developing a local quality improvement faculty to teach and coach improvement practitioners.

The development of the QI Hub will further support improvement science being integrated into existing development programmes and will work with the H&SCSMT and the Quality Board to identify a plan to continue to build sustainable capacity to drive forward at scale and pace. This will include co-ordination and support for the national leadership programmes, ensuring we are identifying the right staff and maximising our chances of successful applications.
Quality Improvement Projects completed by SIS trainees 2016-17 include

Acute Care

- Developing and Implementing an Invasive Line Passport within the Critical Care Setting in DGRI to reduce infection. Progress to date shows a 70% compliance.
- Reduce colonoscopy cancellations to 5% in DGRI through the development of ‘patient friendly’ fasting guidelines. Aim achieved with learning now being spread to other procedures.

Primary Care

- To improve staff engagement in care home to maximise their contribution to reducing pressure ulcers collaborative. Engagement has improved and care home has not had a pressure ulcer in more than 300 days.
- Supporting hospital discharges in cottage hospitals – Langholm One Team are using improvement methodology to test changes to reduce admissions and to facilitate timely discharges. One example resulted in an early discharge saving of over £22,000.
- Dental practices improvement collaboration to reduce harm in dentistry. High risk criteria were identified, and processes in each practice were improved to ensure medical histories were at the heart of conversations between dental patients and staff, so that appropriate treatment plans are made. Results were fed back to the national team to feed into a potential national rollout of the initiative.

Mental Health

- Working to reduce instances of falls in Cree ward via a range of improvement ideas including a ward environmental checklist at night, and increasing training compliance.
- Medicines

Children and Younger People using AHP Services

- Three strands, physiotherapy, occupational therapy and speech and language therapy collaborated to streamline referral triage and appointment allocation, where children are referred to multiple AHP services.

All SIS participants presented their work either orally or in poster format at the QI Hub Launch.
7 The Year Ahead

The workplan of the Patient Safety & improvement Team for 2016/17 is detailed in appendix 1 and includes work that will continue from previous years and an indication of new programmes of work and new approaches to our work. The workplan will evolve over the year to take account of changing priorities both locally and nationally.

The work of the team is collaborative in nature and we will work with and in support of colleagues across all sectors of our organisation and with our partners in the local authority social care and education teams to deliver.

We will continue to build on our work around system enablers which underpin both the pathway specific improvement work and developing a culture and system attuned to continuously improving the quality and safety of care.

Infrastructure to support delivery will include:

- Leadership attuned to creating the conditions to continuously improve the quality, safety & effectiveness of care and services
- Measurement System: the effective use of data to drive improvement remains a key foundation in all our safety and improvement work. We will continue to refine and upgrade our measurement systems to ensure they enable ward to Board reporting functionality but more importantly support local teams on their improvement journey
- Building Quality Improvement Capacity & Capability at scale
- Delivery Method; we need to actively strengthen the active participation in the design and delivery of programmes by those responsible for delivering care and services and those in receipt of services. We will use a blend of approaches and test new models of delivery to augment The Model of Improvement and Collaboratives
- Learning / Knowledge Management System: We have recently invested in Life QI, which is a web based software platform built to support and manage quality improvement work in health and social care. It makes it easy for teams to run QI projects and organisations to report on QI activity. We will test this product throughout 2017/18, but will require additional funding to develop this in the future. This will enhance our ability to learn and share good practice across the system.

Integrating our approach

What is clear from what we have learned over the past number of years and more acutely in the last year is that we need to integrate our improvement effort across the system and prioritise areas of greatest impact that fit with our strategic priorities.

The development of the QI Hub and proposal for a QI Board will enhance our capability.
8 In Conclusion

The Scottish Patient Safety Programme is, without doubt, one of the most ambitious patient safety initiatives in the world – national in scale, bold in aims, and disciplined in science. It harnesses the energies and wisdom of Scotland’s healthcare leaders – all aligned toward a common vision, making Scotland the safest nation on earth from the viewpoint of healthcare.

- Don Berwick, former President and Chief Executive of the Institute for Healthcare Improvement

There is no doubt that significant improvements in the quality and safety of care are being made across the Safety & Improvement Programmes however the pace and scale of that improvement varies between the programmes each of which is at a different stage of maturity.

The SPSP has undoubtedly supported us to build improvement capability and to reduce harm. We have gained a significant amount of experience in identifying harm, in testing interventions to improve the safety, the reliability and the effectiveness of care. We now need to apply that learning and begin to integrate and coordinate our approach to improvement by attending to both the specific themes of deterioration, medication safety and the system enablers. Investment will be required to build the infrastructure to support this work both in terms of hard cash and time from different parts of the system if we are to realise our ambitions and deliver on a challenging agenda.

A key element of monitoring and guiding improvements is the use of data. All of the programmes are collecting and using local data to drive improvements, however there is significant variation in staff capability to understand and use data effectively. This can be a significant barrier to progress which the PS&I Team are working with colleagues in IM&T and each of the programs nationally and locally to overcome.

Developing the capacity and capability to improve is an integral component of our safety work we need to continue to work with local and Board Management Teams to ensure that staff undertaking this work are given sufficient time and space to learn how to improve, to test improvements in practice and to use data to understand whether these changes are leading to improvement. We have made a significant investment in building capability and will continue to do so but staff need the space to learn and apply their knowledge.

NHS D&G has embraced and enhanced the national safety programmes and can now evidence that harm is reducing and safety improving. However, we are on a journey and much still requires to be done to integrate all our streams of improvement work to ensure we maximise the potential gains for our patients and local communities.
DUMFRIES and GALLOWAY NHS BOARD

7 August 2017

INVOLVING PEOPLE IMPROVING QUALITY -
Patient Experience Report

Author: Emma Murphy, Patient Feedback Manager
Michaela Cannon, Patient Feedback and Complaints Co-ordinator

Sponsoring Director: Eddie Docherty, Executive Nurse Director

Date: 10 July 2017

RECOMMENDATION

The NHS Board is asked to:
• note this report which provides an update on the activities of the Patient Services team.
• note the continued work following the implementation of the new Complaints Handling Procedure from 1 April 2017.
• note the Board’s complaints performance for May 2017 and June 2017 including key feedback themes and details of the resulting learning and improvements.

CONTEXT

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

Organisational Context / Why is this paper important / Key messages:
Patient feedback provides key information about the areas where the Board is performing well and those where there is need for improvement. It also assists the Board in delivering our CORE values and remaining person centred.

Key messages:
• Patient Services are delivering a number of improvement activities within their key areas of responsibility.

• The number of complaints received by the Board remains reasonably consistent.

Key Messages: Cont/....
• The Board continues to face challenges around compliance with the 20 working day timescale for responding to complaints which remains below the target of 70%.

• There is a plan to address these compliance issues as part of the ongoing CHP implementation work.

GLOSSARY OF TERMS

CHP - Complaints Handling Procedure
SPSO - Scottish Public Services Ombudsman
DGRI - Dumfries and Galloway Royal Infirmary
PEN - Participation and Engagement Network
CCL - Community Chaplaincy Listening
ViS - Volunteer Information System
IiV - Investing in Volunteers
CAMHS – Child and Adolescent Mental Health Services
NCPAS - National Complaints Personnel Association of Scotland
ISD – Information Services Division
## MONITORING FORM

| Policy / Strategy                      | Healthcare Quality Strategy  
Person Centred Health and Care Collaborative |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing Implications</td>
<td>Ensuring staff learn from patient feedback in relation to issues raised.</td>
</tr>
<tr>
<td>Financial Implications</td>
<td>Not required</td>
</tr>
<tr>
<td>Consultation / Consideration</td>
<td>Not required</td>
</tr>
<tr>
<td>Risk Assessment</td>
<td>Actions from feedback followed through and reported to General Manages and Nurse Managers who have a responsibility to take account of any associated risk.</td>
</tr>
<tr>
<td>Sustainability</td>
<td>Not required</td>
</tr>
<tr>
<td>Compliance with Corporate Objectives</td>
<td>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</td>
</tr>
<tr>
<td>Single Outcome Agreement (SOA)</td>
<td>Health inequalities</td>
</tr>
</tbody>
</table>
| 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 Public Involvement. This report outlines the key activities of the team over the period May and June 2017 and details planned improvement actions as well as recent achievements.

2. Spiritual Care

The Spiritual Care Lead continues to focus upon the development of the spiritual care service across NHS D&G Acute Sector. A new spiritual care information leaflet has been designed to comply with the new NHS D&G leaflet approach providing i.e. A4 Word documents which are easily downloadable and to comply with the new “paper-light” policy for the new hospital. The new leaflet will be made available via the internal intranet and to the public via the NHS D&G internet site.

There is ongoing interest from local public in volunteering within Spiritual Care, 4 people have completed the NHS Volunteer Induction Programme with 5 other people, including someone from Interfaith, in the process of submitting applications.

The Spiritual Care Lead is developing the staff support / wellbeing service delivering staff support herself rather than using volunteers with referrals having been received from Occupational Health and NHS Dumfries and Galloway managers. Formal ‘referral forms’ will be designed and ‘tested’ as this service grows and develops.

Partnership working continues with neighbouring Boards to share good practice and resources, for example, reviewing volunteer training with NHS Tayside. NHS D&G spiritual care volunteers will be trained in the autumn prior to commencing their roles in the new hospital. The Community Chaplaincy Listening (CCL) service, now described as the Patient Listening Service is available at Gillbrae Health Centre, Dumfries and Craignair Health Centre, Dalbeattie, the training will continue to be described as CCL. Collaborative work continues with the Spiritual Care Lead and NHS Lanarkshire Spiritual Care Lead as the way forward for example: writing future polices and implementing and leading on Values Based Reflective Practice (VBRP).

3. Volunteering

**Volunteering Policy and Procedures:** The consultation period was concluded this month and the revised Volunteering Policy and Procedures were approved at Area Partnership Forum

**Volunteering Strategy:** Initial scoping around the development of a Volunteering Strategy has commenced. A steering group, chaired by a Non-Executive Director of the Board, has been established.

**Volunteer’s Recruitment Day:** A Volunteer Recruitment Day took place Friday 30th June, 2017 to raise the profile of volunteering and opportunities within NHS Dumfries & Galloway to become Ward Volunteers and/or Welcome Guides in preparation for the new hospital opening.
One hundred and sixteen potential new volunteers attended from as far as Gatehouse of Fleet and Kirkcudbright in the West to Lockerbie and Annan in the East. Ages varied from 15 – 80 with approximately 10 young people from Wallace Hall Academy and Dumfries High School who are all interested in volunteering.

A team of 22 volunteers, staff, other agencies and Scottish Health Council were involved in planning and organising the event showing a positive commitment to volunteering and working together. The format of the day involved an information session in our World Café which enabled an informal approach to engaging with groups of 4 to 15 new volunteers at a time. Here we were also able to gather information about how people found out about the Recruitment Day and what the benefits were for them to volunteer. The Lecture Theatre in DGRI provided the right environment to view the table top model of the new hospital and see the virtual tour which was facilitated by the new build Communications and Engagement Officer. The Infection Control Team, including their volunteers, promoted the importance of hand hygiene and raised awareness of infection control for all.

Volunteers were provided with applications forms and so far 63 applications have been completed and returned. Interviews are now arranged and will take place over four days in July. Volunteer Induction Training will take place on Thursday 3rd August.

**Volunteer Information System:** The process of transferring from HR.Net to the new Volunteer Information System continues with consent being sought from our existing volunteers to enable the transferring of data. We are still on target for completion of the transfer of existing volunteers’ data by July 2017.

**Investing in Volunteers:** is the UK quality standard for good practice in volunteer management. Volunteer Steering Group members have already undertaken the self assessment against six of the nine indicators in the Checklist. This process will be completed by 31st July and forwarded to Volunteer Scotland for comment. It is expected that the whole process will be completed within six months.

4. **Patient and Carer Information**

NHS Dumfries and Galloway are currently conducting a review of all patient and carer information leaflets with the aim to ensure that the information that is shared with patients continues to be consistent and accurate. The initial information gathering stage has now been completed within Dumfries and Galloway Royal Infirmary (DGRI) and the Patient Information Coordinator is now working with colleagues in DGRI to refresh the leaflets on display. This will ensure that the hard copy information available is up to date, appropriate and proportionate.

We are also reviewing how leaflets are printed and stored with a view to better utilising technology and reducing the number of out of date or unused leaflets on display. This will involve utilising the new Multi-Function Devices within our buildings so that patient information can increasingly be printed at the point of use.
5. Participation and Engagement Network

NHS Dumfries and Galloway greatly values public input and are keen to provide opportunities for local residents to participate in the development, design and delivery of our services. Working closely with a number of local partners, a Participation and Engagement Network (PEN) has been formed so that members of the public can 'sign up' to become more involved in local consultation and engagement activities.

New promotional materials have been designed for the PEN along with distinct branding. There is still some technical work to do before these are available for roll out, but we are now in the final stages.

The Patient Experience Manager is planning a programme of engaging with local groups, including wherever possible those groups supporting hard to reach communities, to seek engagement and feedback including complaints.

6. Patient Feedback

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

6.1 Care Opinion (formerly Patient Opinion)

Care Opinion is an online approach, actively supported by the Scottish Government, which enables the public to provide and view feedback on the services they have received. The organisation used to run two sites; Patient Opinion for stories about experiences in our hospitals and Care Opinion for stories about Primary Care and adult social care. In response to the increased integration of health and social care services across Scotland, Patient Opinion and Care Opinion merged into a single site and service from 1 May 2017.

NHS Dumfries and Galloway received 12 Care Opinion stories during the period, six of which were positive. Where a story is not positive we encourage the author to make contact with Patient Services in order that we provide further advice and support to resolve issues raised.

All NHS Dumfries and Galloway stories are available to view at www.careopinion.org.uk.

Patient Services are working with individual teams across the Board to help raise the profile of Care Opinion and are exploring opportunities to improve promotion to the general public.
6.2 Compliments

NHS Dumfries and Galloway received 14 formal ‘compliments’ during the period in addition to those received by local teams and via Care Opinion. This positive feedback was largely around the caring and professional attitude of staff and the excellent care and treatment received. We also recorded two comments.

We recognise that there is a large volume of positive feedback being provided at local level that we are not formally capturing and a plan is underway to begin improving that towards the end of this year.

6.3 Complaints

Update on the NHS Scotland Model Complaints Handling Procedure

Patient Services continue to work through the implementation action plan for the new NHS Model Complaints Handling Procedure (CHP). The CHP has been developed by the Scottish Public Services Ombudsman to ensure a consistent approach to complaints handling across public services in Scotland. NHS Dumfries and Galloway successfully implemented the CHP from 1 April 2017 and have written to the Scottish Government confirming compliance. As part of the implementation plan, Patient Services are in the process of rolling out complaints training, quality monitoring, improved internal performance reporting and a standardised approach to managing and responding to complaints. All of these actions, paired with the new CHP, will help to improve compliance with timescales.

More information on the changes to complaints handling in the NHS and wider public sector can be found at [www.valuingcomplaints.org.uk](http://www.valuingcomplaints.org.uk).

6.4 Complaints Performance

Complaints Handling Performance Indicators

As part of the new Complaints Handling Procedure, 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:
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicator One:</strong> Learning from complaints</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Indicator Two:</strong> Complaint process experience</td>
<td>A statement to report the person making the complaint’s experience in relation to the complaints service provided.</td>
</tr>
<tr>
<td><strong>Indicator Three:</strong> Staff awareness and training</td>
<td>A statement to report on levels of staff awareness and training.</td>
</tr>
<tr>
<td><strong>Indicator Four:</strong> The total number of complaints received</td>
<td>Details of the number of complaints received per episode of care and recorded against a consistent benchmark such as the number of staff employed.</td>
</tr>
<tr>
<td><strong>Indicator Five:</strong> Complaints closed at each stage</td>
<td>Details of the number of complaints responded to at each stage of the Complaints Handling Procedure.</td>
</tr>
<tr>
<td><strong>Indicator Six:</strong> Complaints upheld, partially upheld and not upheld</td>
<td>Details of the number of complaints that had each of the above listed outcomes.</td>
</tr>
<tr>
<td><strong>Indicator Seven:</strong> Average response times</td>
<td>Details of the average time in working days to close complaints at each stage of the Complaints Handling Procedure.</td>
</tr>
<tr>
<td><strong>Indicator Eight:</strong> Complaints closed in full within the timescales</td>
<td>Details of how many complaints were responses to within the timescales required of the Complaints Handling Procedure.</td>
</tr>
<tr>
<td><strong>Indicator Nine:</strong> Number of cases where an extension was authorised</td>
<td>Details of how many complaints required an extension to the standard timescales.</td>
</tr>
</tbody>
</table>

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

**Summary**

Patient Services recorded 36 pieces of feedback in June 2017 in comparison to 46 in May 2017. The number of complaints received by the Board for this reporting period was 57, (31 in June and 26 in May). We are typically receiving between 30 and 40 complaints per month.
In addition to those ‘new’ pieces of feedback we also escalated eight complaints from Stage One to Stage Two in May and three in June 2017. A complaint is escalated when the complainant is dissatisfied with our Stage One response or where we have been unable to answer or resolve the matter at Stage One because further investigation is required.
The complaints received related to the following area:

<table>
<thead>
<tr>
<th>Service</th>
<th>Jun 2017</th>
<th>%</th>
<th>May 2017</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute and Diagnostic</td>
<td>26</td>
<td>76%</td>
<td>17</td>
<td>50%</td>
</tr>
<tr>
<td>PCCD</td>
<td>2</td>
<td>6%</td>
<td>5</td>
<td>15%</td>
</tr>
<tr>
<td>Prison</td>
<td>3</td>
<td>9%</td>
<td>7</td>
<td>21%</td>
</tr>
<tr>
<td>Women and Children</td>
<td>3</td>
<td>9%</td>
<td>3</td>
<td>9%</td>
</tr>
<tr>
<td>Corporate</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Mental Health</td>
<td>0</td>
<td>0%</td>
<td>2</td>
<td>6%</td>
</tr>
<tr>
<td>Operational Services</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Totals:</strong></td>
<td><strong>34</strong></td>
<td></td>
<td><strong>34</strong></td>
<td></td>
</tr>
</tbody>
</table>

NB: The table above includes those complaints that were escalated to Stage Two.

Our independent contractors also provide us with regular performance figures in relation to complaints. Patient Services proposed that this information should be delivered monthly, using a set template. Some independent contractors have expressed a wish to continue with quarterly reporting using their own template. This matter is still under discussion. Patient Services will continue to support contractors to achieve an agreed solution. Meantime, we have received performance submissions for this period from 18 GP practices, two pharmacies, two dental practices and four ophthalmic practices.
<table>
<thead>
<tr>
<th>Service</th>
<th>Number</th>
<th>%</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPs</td>
<td>1</td>
<td>100%</td>
<td>5</td>
<td>100%</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Dental</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Ophthalmic</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Totals</td>
<td>1</td>
<td>0%</td>
<td>5</td>
<td>0%</td>
</tr>
</tbody>
</table>

**Indicator 1 - Learning from complaints**

Feedback provides a valuable opportunity for us to learn from the experiences of our patients, service users and their families. An important part of that learning process is direct and open dialogue between staff and those that use our services. In addition to the daily conversations that occur during care, we also offer explanatory and/or resolution meetings where we feel it may be beneficial. As part of the new performance indicators, the SPSO have asked that we record how many of these resolution meetings took place. We do not currently capture that information in a reportable format. Patient Services are therefore looking at ways we can update the complaints system (Datix) to aid us in gathering this data.

The new indicators also require us to record specific learning from complaints and to track and detail the resulting improvements. Whilst we do regularly identify learning from complaints, we recognise that our tracking and sharing of that learning should be better. This is a challenge that is reflected nationally across the public sector and one that the SPSO are keen to assist with. As part of that, they have recently formed a Learning and Improvement Unit which is developing a number of tools and resources and aid us in this quest.

Additionally, there is work going on locally to look at process and system improvements that can be made to ensure we are making the most of these learning opportunities. In this area we are exploring the use of the Health Care Analysis tool. This is supported by the use of a software programme that undertakes the qualitative analysis. Whilst a potential funding stream has been identified to support an initial test we await availability of time within the Information Management and Technology work plan to assess compatibility with systems. This is delayed due to their ongoing support to the new Hospital.

Our Patient Services team also highlight the importance of learning through the regular complaints training that is being delivered across the region. Whilst there is still a great deal of work to do in this respect, we are making progress. Meantime, learning and improvement performance information will be gathered manually by requesting examples from services prior to these reports.

**Women and Children Directorate**

A complaint was received regarding the appointment system for the Child and Adolescent Mental Health Service (CAMHS) Team. The patient cancelled an appointment and was sent another date, however, they felt the new appointment was too long a wait. When they contacted the administrative team they did not have access to the Consultant’s diary in order to arrange a more convenient appointment.
As a result administrative staff in CAMHS now have access to the Consultant diaries which allows the service to respond to appointment queries and requests in a timely way without the need to discuss with the Consultants first.

**Acute Services Directorate**

There was a complaint relating to the length of time taken to be seen in Accident and Emergency at Galloway Community Hospital. Staff did not keep the patient informed of the reason for the delay.

As a result printed notices about triage and the aim of the department, in line with national/government guidelines, are being produced.

The staff has also been reminded of the importance of communication with patients during the triage process.

The department will display a notice for patients to advise them to alert the reception staff if they have been waiting for more than one hour to be seen.

**Acute Services Directorate**

Patient contacted their MSP regarding their concerns that NHS Dumfries and Galloway were no longer offering treatment to patients suffering from sleep apnoea.

The Board’s response highlighted that we continue to provide a service for sleep breathing disorders; however the new patient diagnostic component was temporarily suspended between January and June 2017. This was due to a high number of new referred plus an increasing number of existing patients due for review which presented an unsustainable pressure on clinical staff. Senior Management review of the situation and an increase in staffing resources has resulted in the new patient diagnostic service being resumed. With the high number of new patients awaiting an initial assessment it will take some time to work through the list.

**Trends**

As part of this indicator, we are also required to report any trends in complaints. We are currently looking at solutions to assist us with this analysis, including the Healthcare Analysis Tool previously mentioned.

**Indicator 2 - Staff Awareness and Training**

In order to ensure the effective implementation of the new Complaints Handling Procedure, a number of awareness raising activities have taken place including:

- The development of a Feedback Coordinators network across the organisation. Feedback Coordinators will assist services with capturing, logging, tracking and responding to feedback.
• The review of our internal processes for handling complaints. As a result, General Managers and Health and Social Care Locality Managers will now take lead responsibility for complaints in their area. Patient Services have attended the General Managers meeting twice in recent months and have held a ‘development session’ with the senior Health and Social Care team to raise awareness of the new procedures and to provide support.

• The development of a suite of supporting guidance and templates to improve awareness of best practice and to assist staff dealing with complaints.

• Attendance at individual team meetings and local training sessions to raise awareness and provide an overview of the new procedures.

We are also planning to:

• Provide regular updates to general staff via the Core Briefing.

• Improve information available to both staff and the public through our website and intranet, Beacon.

• Improve hard copy information and promotion through the circulation of NHS Inform materials.

• Continue with awareness raising sessions through existing team meetings and training sessions (such as the ASPIRE course).

• Liaise directly with local established groups guided by the planned Equality Impact Assessment to assess and improve the accessibility of our Complaints Handling Procedure. This will also assist us in establishing links with these groups in order to better support their service users and communities.

Patient Services are also delivering regular complaints training across the region. These sessions have also been made available to our Independent Contractors and Health and Social Care colleagues. Since 1 April more than 60 staff have attended training on the Complaints Handling Procedure, with a further 90 already signed up to upcoming courses later in the year.

Feedback is being gathered from attendees and will be reported when available.

**Indicator 3 - Complaints Process Experience**

Patient Services have worked with colleagues from the National Complaints Personnel Association of Scotland group to develop an agreed approach to gathering feedback on the complaints process experience. A consistent approach across Boards will increase our opportunities for benchmarking and learning.

The question framework has been agreed and Patient Services plan to begin conducting ‘exit surveys’ with those that have completed the Complaints Handling Procedure from the end of quarter one. The surveys will assess:

• Ease of access to the process, including how easy it is to find on websites and via search engines.

• How the person making the complaint was treated by staff (for example were they professional, friendly, polite, courteous etc).

• Whether empathy was shown or an apology offered.

• Timescale in terms of responses being issued or updates as the case may be.
Clarity of decision and clarity of reasoning.

The outcome of these surveys will be shared when available.

**Complaints Performance**

The Board achieved 66% compliance across this reporting period for the percentage of complaints acknowledged within the national target of 3 working days in comparison to 73% compliance for the last period. Compliance with acknowledgement timescales has shown a decline since December 2016. The continued decline is due to staff resources and capacity around complaints handling. This will be addressed, in part, through the recent recruitment to the Patient Experience Officer post in Acute and Diagnostic Services and the planned recruitment to an Administrative post in Patient Services. Key administrative staff across the organisation have been identified and trained as ‘Feedback Coordinators’ to help manage the administrative demands around feedback and complaints. These activities along with the new procedure and improved processes should see compliance begin to recover in the coming months.

NHS Dumfries and Galloway have set a Board target of 70% for complaints to be responded to within 20 working days. Our compliance with timescales for those complaints going directly to Stage Two continues to be poor and in decline. Further interrogation of the data highlights a number of contributing factors including the complexity of issues raised, staff availability, operational pressures and in some cases the requirement to place the complaints procedure on hold in order that another process could take place. Furthermore, there were a number of cases where resolution meetings were arranged and due to the timescales in co-ordinating these it was not always possible to meet the 20 working day response time. As above, the improved procedure, admin structures and processes will help to address this compliance issue.

The June performance figures do demonstrate much better compliance with escalated Stage Two complaints. This may be due to escalated complaints having already been considered at Stage One and therefore part of the complaint response work will have already been undertaken and we will have a sounder understanding of the issues raised and preferred resolution from receipt.

A recent review of the information in Datix has identified that there continues to be inconsistencies with how complaints are recorded. An action plan is in place to address this to ensure that the information captured demonstrates an accurate and timely reflection of complaints data.

The remaining performance indicators focus on the quantitative data associated with our complaints handling 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);
Stage Two Escalated – complaints which were dealt with at Stage One and were subsequently escalated to Stage Two investigation (e.g. because the complainant remained dissatisfied)

Please note we are currently developing planning to represent this data over time in addition to the snap shot below.

Indicator 4 - Complaints per 1000 population

<table>
<thead>
<tr>
<th>Description</th>
<th>Jun 2017</th>
<th>May 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per 1000 population</td>
<td>0.23</td>
<td>0.23</td>
</tr>
</tbody>
</table>

Indicator 5 - Complaints closed (responded to) at Stage One and Stage Two as a percentage of all complaints closed (responded to).

<table>
<thead>
<tr>
<th>Description</th>
<th>Jun 2017</th>
<th>May 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of complaints closed at Stage One as % of all complaints closed</td>
<td>49% (18 of 37)</td>
<td>33% (12 of 36)</td>
</tr>
<tr>
<td>Number of complaints closed at Stage Two as % of all complaints closed</td>
<td>35% (13 of 37)</td>
<td>67% (24 of 36)</td>
</tr>
<tr>
<td>Number of complaints closed at Stage Two after escalation as % of all complaints closed</td>
<td>16% (6 of 37)</td>
<td>0% (0 of 36)</td>
</tr>
</tbody>
</table>

Notes:- The escalated complaints referred to above may also have been responded to at Stage One during the period.

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

<table>
<thead>
<tr>
<th>Description</th>
<th>Jun 2017</th>
<th>May 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of complaints upheld at Stage One as % of all complaints closed at Stage One</td>
<td>22% (4 of 18)</td>
<td>42% (5 of 12)</td>
</tr>
<tr>
<td>Number complaints upheld at Stage Two as % of complaints closed at Stage Two</td>
<td>23% (3 of 13)</td>
<td>25% (6 of 24)</td>
</tr>
<tr>
<td>Number escalated complaints upheld at Stage Two as % of escalated complaints closed at Stage Two</td>
<td>0% (0 of 6)</td>
<td>0% (0 of 0)</td>
</tr>
</tbody>
</table>
## Partially Upheld

<table>
<thead>
<tr>
<th>Description</th>
<th>Jun 2017</th>
<th>May 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of complaints partially upheld at Stage One as % of all complaints closed at Stage One</td>
<td>17% (3 of 18)</td>
<td>33% (4 of 12)</td>
</tr>
<tr>
<td>Number complaints partially upheld at Stage Two as % of complaints closed at Stage Two</td>
<td>46% (6 of 13)</td>
<td>42% (10 of 24)</td>
</tr>
<tr>
<td>Number escalated complaints partially upheld at Stage Two as % of escalated complaints closed at Stage Two</td>
<td>33% (2 of 6)</td>
<td>0% (0 of 0)</td>
</tr>
</tbody>
</table>

## Not Upheld

<table>
<thead>
<tr>
<th>Description</th>
<th>Jun 2017</th>
<th>May 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of complaints not upheld at Stage One as % of all complaints closed at Stage One</td>
<td>44% (8 of 18)</td>
<td>25% (3 of 12)</td>
</tr>
<tr>
<td>Number complaints not upheld at Stage Two as % of complaints closed at Stage Two</td>
<td>23% (3 of 13)</td>
<td>33% (8 of 24)</td>
</tr>
<tr>
<td>Number escalated complaints not upheld at Stage Two as % of escalated complaints closed at Stage Two</td>
<td>67% (4 of 6)</td>
<td>0% (0 of 0)</td>
</tr>
</tbody>
</table>

Notes:- 17% (3 of 18) of Stage One responses contained an outcome other than those above in Jun 2017. 8% (1 of 13) of Stage Two responses contained an outcome other than those above in Jun 2017.

‘Other’ includes matters where a resolution has been agreed, where we have been unable to obtain consent, where the complaint has been withdrawn or the complaint is irresolvable.
## Indicator 7 - The average time in working days for a full response to complaints at each stage

<table>
<thead>
<tr>
<th>Description</th>
<th>Jun 2017</th>
<th>May 2017</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average time in working days to respond to complaints at Stage One</td>
<td>8</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Average time in working days to respond to complaints at Stage Two</td>
<td>41</td>
<td>50</td>
<td>20</td>
</tr>
<tr>
<td>Average time in working days to respond to complaints after escalation</td>
<td>19</td>
<td>0</td>
<td>20</td>
</tr>
</tbody>
</table>

## Indicator 8 - The number and percentage of complaints at each stage which were closed (responded to) in full within the set timescales of 5 and 20 working days

<table>
<thead>
<tr>
<th>Description</th>
<th>Jun 2017</th>
<th>May 2017</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number complaints closed at Stage One within 5 working days as % of Stage One complaints</td>
<td>57% (12 of 21)</td>
<td>92% (11 of 12)</td>
<td>70%</td>
</tr>
<tr>
<td>Number complaints closed at Stage Two within 20 working days as % of Stage Two complaints</td>
<td>23% (3 of 13)</td>
<td>21% (5 of 24)</td>
<td>70%</td>
</tr>
<tr>
<td>Number escalated complaints closed within 20 working days as % of escalated Stage Two complaints</td>
<td>67% (4 of 6)</td>
<td>0% (0 of 0)</td>
<td>70%</td>
</tr>
</tbody>
</table>

## 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.

<table>
<thead>
<tr>
<th>Description</th>
<th>Jun 2017</th>
<th>May 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of complaints at Stage One where extension was authorised</td>
<td>5% (1 of 21)</td>
<td>8% (1 of 12)</td>
</tr>
<tr>
<td>% of complaints at Stage Two where extension was authorised</td>
<td>8% (1 of 13)</td>
<td>4% (1 of 24)</td>
</tr>
<tr>
<td>% of escalated complaints where extension was authorised</td>
<td>17% (1 of 6)</td>
<td>0% (0 of 0)</td>
</tr>
</tbody>
</table>
Complaint Issues by Category

<table>
<thead>
<tr>
<th></th>
<th>May</th>
<th>June</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Treatment</td>
<td>20</td>
<td>15</td>
<td>35</td>
</tr>
<tr>
<td>Staff attitude and behaviour</td>
<td>5</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Waiting time for date for appointment</td>
<td>3</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>Staff communication (written)</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Staff communication (oral)</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>3</td>
<td>8</td>
</tr>
</tbody>
</table>

*Total of issues may vary from number of complaints

These categories are consistent with national themes. Communication issues are mainly related to verbal communication between staff and patients and/or relatives. In many cases the complaints about staff attitude are linked to a perception of whether or not information was appropriately communicated or received.

**Improvement Actions**

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

The chart below details the Improvement actions taken as a result of complaints received in this reporting period.
Improvement Actions taken

Scottish Public Services Ombudsman Complaints

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

The SPSO have advised that they are currently investigating two complaints from NHS Dumfries and Galloway and we await the outcome of their investigations. We have also submitted files on three further complaints and await a decision on whether the Ombudsman will investigate these cases.
In addition to these complaints the SPSO have made recommendations in relation to three complaints. An action plan has been completed and sent to the SPSO in relation to two of those complaints and the Board is currently implementing an action plan in relation to the third complaint.

**Reports to the Procurator Fiscal**

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

**Conclusion**

The Patient Services team are undertaking a significant amount of improvement activity to identify and implement best practice within their remit. Whilst the team are supporting the Board to deliver a number of positive areas of work, there is much scope to improve. Particularly around how the Board manages and learns from patient feedback. The Patient Services team have clear plans to deliver these improvements and will ensure the Board remains updated on progress through regular reporting.
DUMFRIES and GALLOWAY NHS BOARD

7th August 2017

Involving People, Improving Quality - Healthcare Associated Infection Report

Author: Elaine Ross
Infection Control Manager
Date: 19th July 2017

Sponsoring Director: Eddie Docherty
Executive Nurse Director

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:

- Despite a good performance in the year ended December 2016 an increase in community acquired SAB. At this point we are a third over the number of cases set as our local target.
- Having performed exceptionally well to December 2016 there has been a rise in cases of CDI. The majority of these are classified as community acquired infections.
- At this point the LDP target is being met when judged by rolling quarterly average rates. However, this is a significant shift in our local epidemiology and one which we are investigating thoroughly.

Infection rates can no longer be tackled by simply focusing on the acute setting. Going forwards there needs to be a whole healthcare system approach.
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>AOBD</td>
<td>Acute Occupied Bed Days</td>
</tr>
<tr>
<td>CDI</td>
<td><em>Clostridium difficile</em> Infection</td>
</tr>
<tr>
<td>CAI</td>
<td>Community Acquired Infection</td>
</tr>
<tr>
<td>HAI</td>
<td>Healthcare Associated Infection</td>
</tr>
<tr>
<td>HPS</td>
<td>Health Protection Scotland</td>
</tr>
<tr>
<td>HEI</td>
<td>Healthcare Environment Inspectorate</td>
</tr>
<tr>
<td>MSSA</td>
<td>Meticillin Sensitive <em>Staphylococcus Aureus</em></td>
</tr>
<tr>
<td>MRSA</td>
<td>Meticillin Resistant <em>Staphylococcus Aureus</em></td>
</tr>
<tr>
<td>IVDU</td>
<td>Intravenous Drug User</td>
</tr>
<tr>
<td>SAB</td>
<td><em>Staphylococcus aureus</em> bacteraemia</td>
</tr>
<tr>
<td>TOBD</td>
<td>Total Occupied Bed Days</td>
</tr>
</tbody>
</table>
### MONITORING FORM

| **Policy / Strategy Implications** | Healthcare Quality Strategy  
Achievement of HAI LDP targets |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staffing Implications</strong></td>
<td>Nil</td>
</tr>
<tr>
<td><strong>Financial Implications</strong></td>
<td>Nil</td>
</tr>
<tr>
<td><strong>Consultation</strong></td>
<td>Update paper only consultation not required</td>
</tr>
</tbody>
</table>
| **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

Key Healthcare Associated Infection Headlines

- Despite a good performance in the year ended December 2016 an increase in community acquired SAB. At this point we are a third over the number of cases set as our local target.
- Having performed exceptionally well to December 2016 there has been a rise in cases of CDI. The majority of these are classified as community acquired infections.
- At this point the LDP target is being met when judged by rolling quarterly average rates. However, this is a significant shift in our local epidemiology and one which we are investigating thoroughly.
- Infection rates can no longer be tackled by simply focusing on the acute setting. Going forwards there needs to be a whole healthcare system approach

1. Staphylococcus aureus (including MRSA)

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


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

NHS Boards carry out surveillance of *Staphylococcus aureus* blood stream infections, known as bacteraemias. These are a serious form of infection and there is a national target to reduce them. The number of patients with MSSA and MRSA bacteraemias for the Board can be found at the end of section 1 and for each hospital in section 2. Information on the national surveillance programme for *Staphylococcus aureus* bacteraemias can be found at:

As reported to board previously, no national target for HAI reduction has been set as yet by the HAI policy unit at Scottish Government Health and Social Care department. NHS Dumfries and Galloway will continue to work to the previous local delivery plan (LDP) targets submitted.

Despite a good performance in the year ended December 2016 an increase in community acquired SAB, principally in people who inject drugs, has contributed to a rise in SAB seen over the first 6 months of 2017.

**Figure 1- Local data**

[Chart showing quarterly rolling year Staphylococcus aureus Bacteraemia Rates per 1000 Acute Occupied Bed Days for LDP Target Measurement]

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Actual Performance</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jul 15 - Jun 16</td>
<td>0.32</td>
<td>0.24</td>
</tr>
<tr>
<td>Oct 15 - Sept 16</td>
<td>0.28</td>
<td>0.24</td>
</tr>
<tr>
<td>Jan 16 - Dec 16</td>
<td>0.27</td>
<td>0.24</td>
</tr>
<tr>
<td>Apr 16 - Mar 17</td>
<td>0.32</td>
<td>0.24</td>
</tr>
<tr>
<td>Jul 15 - Jun 17</td>
<td>0.37</td>
<td>0.24</td>
</tr>
</tbody>
</table>

**Figure 2**

[NHS D&G Monthly SAB performance Cases per 1000 AOBDs]

As the board are aware, the numbers of SAB are very low and a change of just one or two cases can make a significant difference. At this point we are a third over the number of cases set as our local target.
2. Clostridium difficile

*Clostridium difficile* is an organism which is responsible for a large number of healthcare associated infections, although it can also cause infections in people who have not had any recent contact with the healthcare system. More information can be found at:

http://www.nhs.uk/conditions/Clostridium-difficile/Pages/Introduction.aspx

NHS Boards carry out surveillance of *Clostridium difficile* infections (CDI), and there is a national target to reduce these. The number of patients with CDI for the Board can be found at the end of section 1 and for each hospital in section 2. Information on the national surveillance programme for *Clostridium difficile* infections can be found at:


Having performed exceptionally well to December 2016 there has been a rise in cases of CDI. What is striking is that these cases are originating in the community. These are in people that have not had inpatient treatment in hospital in the previous 12 weeks.

Health Protection Scotland (HPS) classification of origin of infection Symptoms occurring:

- Within 48 hours of admission to hospital = Community Acquired Infection (CAI)
- 12 weeks or more since discharge from hospital = CAI

---

**Figure 3**

*NHS Dumfries and Galloway*

**Breakdown of SAB by Cause and Origin of Infection**

1 April to 30 June 2017
Within 4 weeks of discharge from hospital = Hospital Acquired (HAI)
Within 4-12 weeks of discharge form hospital= Unknown (UK)

At this point the LDP target is being met when judged by rolling quarterly average rates see figure 4 below. However, this is a significant shift in our local epidemiology and one which we are investigating thoroughly.

**Figure 4- Local data**

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

<table>
<thead>
<tr>
<th>Actual Performance</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jul 15 - Jun 16</td>
<td>0.28</td>
</tr>
<tr>
<td>Jul 16 - Dec 16</td>
<td>0.25</td>
</tr>
<tr>
<td>Jan 17 - Mar 17</td>
<td>0.25</td>
</tr>
<tr>
<td>Apr 17 - Jun 17</td>
<td>0.32</td>
</tr>
</tbody>
</table>

**Figure 5**

NHS D&G CDI Monthly performance
Cases per 1000 TOBDS aged over 15

A problem assessment group met and reviewed all cases. As stated earlier in this paper the majority (75%) were classed as CAI per the HPS definition. When extending the period for hospital admission to 6 months, whilst this number reduced, it remained apparent that 45% of all cases had not been in hospital within 6 months.

Antibiotic guidelines had been complied with and there were no obvious links between time, place or individuals.
As a precautionary measure cleaning was enhanced to incorporate the routine use of chlorine releasing agents (bleach) for one month in any hospital which had a case of CDI.

This data exceedance was reported to HPS and no further action was requested.

**Figure 6**

### Classification of CDI Cases 1st April 2017 to 26th June 2017

<table>
<thead>
<tr>
<th>Category</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAI</td>
<td>4</td>
</tr>
<tr>
<td>UK</td>
<td>1</td>
</tr>
<tr>
<td>CAI</td>
<td>16</td>
</tr>
</tbody>
</table>

3. **E. coli bacteraemia (ECB)**

Whilst E. coli bacteraemia is not currently an LDP or national target as yet, monitoring of E. coli bloodstream infections is mandatory.
The 'Lower UTI' represented above are largely occurring in patients without indwelling urinary catheters and are simple urinary tract infections.

The category ‘Hepatobiliary’ includes cases where there may be an underlying medical condition such as liver cancer or cirrhosis.

We do not underestimate the impact of these infections on health or the challenge that reducing the number of these infections will present.

4. Screening

Compliance with MRSA admission screening is a key performance indicator. Throughout the previous 4 quarters NHS Dumfries and Galloway have exceeded the rates achieved by other NHS boards in Scotland.

Results for quarter 1 indicate a 90% compliance rate against an NHS Scotland rate of 85%.

5. Conclusion

This report illustrates a changing picture in terms of our two LDP target infections and the emerging E.coli picture.
Infection rates can no longer be tackled by simply focusing on the acute setting. Going forwards there needs to be a whole healthcare system approach that includes all care sectors and national public health messaging to present information to enable individuals to approach their own infection prevention.

**NHS Dumfries and Galloway Board report card**

*Staphylococcus aureus* bacteraemia monthly case numbers

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA</td>
<td>0</td>
<td>0</td>
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*Clostridium difficile* infection monthly case numbers

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### Clostridium difficile infection monthly case numbers

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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

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Clostridium difficile infection monthly case numbers

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NHS OUT OF HOSPITAL REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

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### Cresswell Wing

- Birthing Suite 20 20 18 95%
- Maternity Suite 20 20 20 100%
- Antenatal 0 0 0 0%
- Neonatal 21 21 21 100%

### Midpark Hospital

- Balcany 22 22 19 85%
- Cree 20 20 20 100%
- Dalveen 29 29 29 100%
- Ettrick 0 0 0 0%
- Glencarn 0 0 0 0%
- Nithsdale 20 20 20 100%

### Galloway Community Hospital

- Garrick 0 0 0 0%
- Dalrymple 22 22 22 100%
- OPD 21 21 21 100%
- Day Surgery 21 21 21 100%
- Renal Unit 33 33 33 100%
- A&E 30 30 30 100%
- Clenoch 24 24 24 100%
- X-Ray 20 20 20 100%

### Cottage Hospitals

- Annan 20 20 20 100%
- Lochmaben 0 0 0 0%
- Thomas Hope 20 20 20 100%
- Moffat 20 20 20 100%
- Thornhill 28 28 28 100%
- Castle Douglas 21 21 21 100%
- Kinnoullbright 20 20 20 100%
- Newton Stewart 20 20 20 100%

The mandatory requirement for hand hygiene opportunities is 20 per month. Wards entering less than 5 opportunities per month.
DUMFRIES and GALLOWAY NHS BOARD

7th August 2017

IN VolVING PEOPLE IMPROVING QUALITY -
Annual Report on Feedback, Comments, Concerns and
Complaints – 2016-17

Author: Emma Murphy
Patient Feedback Manager

Joan Pollard
Associate Director Allied Health Professionals
and Patient Experience Lead

Date: 26th June 2017

RECOMMENDATION

The NHS Board is asked to:
- note the Annual Report on Feedback, Comments, Concerns and Complaints
  for 2016-17, which was submitted to the Scottish Health Council on 26 June
  2017.

CONTEXT

Strategy / Policy:
This work supports delivery of the Healthcare Quality Strategy Person Centred
Ambition.

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

NHS Dumfries and Galloway is striving to build a strong culture of being truly person
centred across a spectrum of contexts and learning from patient and family
experience is crucial to enabling us to do so.

Key Messages:
- Patient Services are delivering a number of improvement activities within their
  key areas of responsibility.
- The new NHS Complaints Handling Procedure (CHP) is on schedule to be
  implemented from 1 April 2017.
- The number of complaints received by the Board remains consistent.
- The Board continues to face some challenges around compliance with the 20
  working day timescale for responding to complaints and performance remains
  below the target of 70%.
Key Messages  Cont/...

- The Board continues to face some challenges around capturing learning from feedback and complaints and sharing this across the organisation.
- There is a plan in place to address these compliance issues as part of the ongoing CHP implementation work.

GLOSSARY

NHS   - National Health Service
CHP   - Complaints Handling Process
SHC   - Scottish Health Council
PASS  - Patient Advice and Support Service
CHP   - Complaints Handling Procedure
PEN   - Participation and Engagement Network
DG    - Dumfries and Galloway
SPSO  - Scottish Public Services Ombudsman
ISD   - Information Services Division
FHS   - Family Health Services
GPs   - General Practitioners
LUI   - Learning and Improvement Unit
### MONITORING FORM

<table>
<thead>
<tr>
<th>Policy / Strategy</th>
<th>Healthcare Quality Strategy: person centred ambition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing Implications</td>
<td>None</td>
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<td>Financial Implications</td>
<td>None</td>
</tr>
<tr>
<td>Consultation / Consideration</td>
<td>This paper is for consideration by this committee</td>
</tr>
<tr>
<td>Risk Assessment</td>
<td>None</td>
</tr>
<tr>
<td>Sustainability</td>
<td>None</td>
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<tr>
<td>Compliance with Corporate Objectives</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>Single Outcome Agreement (SOA)</td>
<td>Listening to our communities</td>
</tr>
<tr>
<td>Best Value</td>
<td>Not applicable at this time</td>
</tr>
<tr>
<td>Impact Assessment</td>
<td>Not required</td>
</tr>
</tbody>
</table>
Introduction

Feedback offers a valuable opportunity for us to learn and improve. This report provides an overview of feedback received from 1 April 2016 to 31 March 2017. The report is comprised of five sections and is in compliance with guidance issued by the Scottish Health Council (SHC) and the requirements set out in the Patient Rights (Scotland) Act 2011.

Section 1 - Encouraging and Gathering Feedback

1.1 General Feedback

What we are doing well

NHS Dumfries & Galloway is committed to delivering safe, effective and person-centred care. The use of feedback is central to ensuring delivery of these aims and we therefore offer a variety of approaches which allow people to choose a feedback mechanism that best suits their needs. These include:

- in writing via letters, surveys, consultations and feedback forms.
- by email via our Patient Services and DG Feedback email addresses.
- by telephone via Patient Services and direct to individual services.
- via Care Opinion and our own website.
- via social media via posts and links.
- face-to-face via scheduled events and daily contact with the public.

The Patient Advice and Support Service (PASS) provide a further communication route and source of advocacy support for anyone wishing to provide feedback or make a complaint. While PASS works independently of NHS Dumfries & Galloway, information about their services is widely available throughout our wards, clinic waiting areas, notice boards and intranet/internet.

All our feedback literature and promotion makes it clear that we welcome and encourage feedback. We also promote our commitment to learning and improving to reassure people that their feedback can and will make a difference.

NHS Dumfries & Galloway has a small Patient Services team who act as a central point of contact for feedback and support. The team deals with daily enquiries, concerns, compliments and complaints ensuring each is logged and directed to the most appropriate team so that it can be responded to appropriately. As part of that process, the team ensure that the person giving the feedback is clear about the next steps and any timescales associated with that.

NHS Dumfries and Galloway received 180 items of feedback from people who did not wish to raise formal complaints, a slight decrease from the 190 received in 2015/16.

The issues raised were consistent with our formal complaints in relation to care and treatment, attitude and behaviour and communication. Other issues raised included waiting times for appointments.
The majority 128 (71%) were received by Acute and Diagnostic Services Directorate which is the directorate that covers the largest number of specialties.

Acute and Diagnostic Services Directorate have a dedicated Patient Experience Officer who investigates and responds to complaints and feedback for the directorate and also have access to the electronic complaints system (DATIX) which allows them to capture feedback received in real time.

The Patient Services team have been working throughout 2016-17 to roll DATIX out across the Board in order that all Directorates can capture feedback regarding their services.

In preparation for the new Complaints Handling Procedure, due to be implemented from 1 April 2017, and in order to help us better manage feedback we have recently developed a network of “Feedback Coordinators” across the organisation. These coordinators will be trained to manage, progress, record and track feedback in their area and act as key points of contact for the Patient Services team. By having coordinators in place we can ensure we have strong local knowledge of the processes and procedures as well as support for staff within the local teams.

These Feedback Co-ordinators will also have responsibility for the input of information into DATIX and maintaining the system for their areas. Training has commenced and will continue on an ongoing basis to ensure improvement in the quality and integrity of data recording.

In addition to the feedback above, Patient Services received 77 compliments in relation to excellent care and services across the Board. It is also acknowledged that individual wards and departments also receive many other compliments directly throughout the year; however NHS Dumfries and Galloway have not yet developed a formal method of capturing this feedback. We are planning to trial a few initiatives in 2017-18 to be able to capture and report on this valuable information.

Where we can improve

Whilst we generally promote our feedback mechanisms well, we recognise that we could be more consistent in our approach. We note, for example, that there are a number of different comment and suggestion forms in use across the organisation. We are also aware that there are a number of different leaflets advising people how they can provide feedback. In order to improve, we are looking to introduce a simple leaflet summarising the different options available for giving feedback. This leaflet will also include a feedback form, will be distributed widely across the Board and will replace the comment and suggestion forms and leaflets currently in place. Local teams may still use their own templates for direct interactions with patients, but there will be one consistent leaflet and form on public display.

We recognise that we could be more proactive in our interactions with local established groups and that there is a particular need for us to improve how we support those from hard to reach and seldom heard groups to provide feedback to us.
The activities around the Participation and Engagement Network (referenced below) will assist with that. We are also planning to run our feedback policies, procedures and literature through an Equality Impact Assessment later this year to gather feedback on how we can further improve.

We are conscious that we could further improve how we learn from feedback. There is a great deal of work underway around learning and improving from complaints (see section 4 below) and we hope to extend that to all feedback in the near future. We are particularly aware that there is a great deal of learning potential from positive feedback as it is important that we understand what we are doing well as well as the areas in which we need to improve.

1.2 Participation and Engagement Network

What we are doing well

As a Board, we are keen to provide opportunities for local residents to participate in the development, design and delivery of our services. Working closely with a number of local partners, a Participation and Engagement Network (PEN) has been formed so that members of the public can ‘sign up’ to become more involved in local consultation and engagement activities.

The soft launch of the PEN has resulted in an initial bank of members being developed. Partners have begun sharing consultations with members and we are encouraging these to continue.

Where we can improve

We are committed to building a bank of network members that are representative of the local community. In order to do so, we recognise that we need to further develop our promotional materials and deliver a structured communications plan.

We are in the process of developing recognisable branding for the network which will be applied to our online promotional materials and leaflets. On completion, we will work with partners to promote the network more heavily through our websites and social media channels. In addition, we will work closely with local established groups to ensure they are receiving the information and support they need to encourage their members to sign up and become involved.

To encourage and retain involvement, we will ensure that network members are kept informed of activities and have opportunities to regularly engage with partners, even when they are not actively participating in formal consultation or engagement activities.

In addition to improved promotion, we also want to ensure that the consultation and engagement activities being run through the PEN are of an appropriate quality and standard. This will improve the experience of PEN members and will help to ensure our consultations are meaningful and robust. We are therefore developing a consultation toolkit, in partnership with the Centre of Excellence in Dumfries and Galloway Council, to assist partners in preparing and delivering their consultations.
1.3 Patient Opinion

What we are doing well

Patient Opinion is an online approach, actively supported by the Scottish Government, which enables the public to provide and view feedback on the health and care services they have received. It encourages people to share their story of their experience with our services and directs those stories to the services that provided them. In turn, we offer a personal response which is public and searchable for visitors to the site. The site is designed to be easy to use and accessible, providing an opportunity for people to provide feedback at a time and place that suits them. It also offers users the opportunity to submit stories by telephone and post.

In response to the increased integration of health and social care services across Scotland, Patient Opinion is merging its two ‘sister’ sites (Patient Opinion and Care Opinion) to ensure an improved experience for users. From 1 May 2017, the site will become Care Opinion and will gather stories from everyone in one place. Patient Opinion is actively promoted on our website, through our social media pages and via hard copy materials such as posters and leaflets. In March this year, the Dumfries and Galloway Health and Social Care Partnership extended our subscription to include the wider community services and GP practices.

NHS Dumfries and Galloway received 52 Patient Opinion stories during the period, 41 of which were positive. Where a story is critical or if we require further information, we encourage the author to make contact with Patient Services or the local service in order that we provide further advice and support to resolve issues raised.

Table 1 provides a summary of how critical the stories were and the number of times these were seen by the public and staff. Story criticality is rated by Patient Opinion and is a measure of how critical the most significant part of a story is, according to a criterion-based system.

<table>
<thead>
<tr>
<th>Criticality Score</th>
<th>Stories</th>
<th>Public Views</th>
<th>Staff Views</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criticality Score 3</td>
<td>1</td>
<td>2</td>
<td>368</td>
</tr>
<tr>
<td>(moderately critical)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Criticality Score 2</td>
<td>7</td>
<td>4</td>
<td>1590</td>
</tr>
<tr>
<td>(mildly critical)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Criticality Score 1</td>
<td>4</td>
<td>3</td>
<td>1628</td>
</tr>
<tr>
<td>(minimally critical)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Criticality Score 0</td>
<td>37</td>
<td>32</td>
<td>13873</td>
</tr>
<tr>
<td>(not critical)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>52</strong></td>
<td><strong>41</strong></td>
<td><strong>17459</strong></td>
</tr>
</tbody>
</table>
Where we can improve

Whilst Patient Opinion is promoted across the Board, we recognise that we could further improve awareness with both staff and the public. Patient Services are therefore developing a communications plan to better promote Patient Opinion to ensure that we are making best use of this positive resource. Awareness is also being raised via our regular complaints training (which provides a section on general feedback) and through Patient Services attendance at team meetings. The Patient/Care Opinion team are also offering support locally to assist the roll out of Patient/Care Opinion into the community.

Further information on Patient/Care Opinion, including details of our stories, can be found at www.careopinion.org.uk.

Section 2 Encouraging and Handling Complaints

2.1 Handling Complaints

A Scottish Health Council review published in November 2015 concluded that improvements were required to the Board’s handling of feedback and detailed 5 recommendations. In February 2016 an internal audit of our Complaints Management Process also concluded that improvements were required and detailed 18 recommendations.

Whilst improvements were underway in response to these recommendations, the Board received correspondence from the Scottish Government in October 2016 confirming that the new NHS Scotland Model Complaints Handling Procedure (MCHP) had been finalised and that it must be implemented by 1 April 2017. As the new MCHP would address the vast majority of the issues identified by the Scottish Health Council and the internal audit, it was agreed that any improvement actions taken would be completed as part of the MCHP implementation.

We have a detailed implementation plan and are on track to implement our new Complaints Handling Procedure (CHP) from 1 April 2017. Whilst the CHP will not go live until 1 April 2017, it important to share the work we have done in preparation for the new CHP in order to provide the appropriate context for where we are and what we hope to achieve in the near future.

More information on the Model Complaints Handling Procedure and associated requirements can be found at www.valuingcomplaints.org.uk.

What we are doing well

The public have access to a number of information sources regarding our complaints procedure, including:

- Web information locally, through NHS Inform and via the Scottish Public Services Ombudsman.
- NHS Inform leaflets detailing how to provide feedback and make complaints.
We recognise that making a complaint can be a daunting and at times intimidating prospect, particularly when you are also dealing with difficult personal circumstances such as illness or loss. There is support available to our patients, service users, carers and visitors via locally advocacy services and through the Patient Service team and local staff. We ensure this support is promoted in our literature and web information. This ensures that people can choose how involved they wish to be with the complaint.

Where we can improve

Whilst we have always been committed to local resolution, in preparation for the new CHP, we have increased our focus on this through the introduction of an additional complaints stage (Stage One – Early Resolution). With the development of our feedback coordinators, we aim to build on this commitment to ensure local ownership, accountability and a real commitment to resolving complaints as close to the point of experience as possible. We will also be shifting responsibility for complaints from the Nurse Director to the General Managers and Health and Social Care Locality Managers to further bolster that local accountability.

Whilst it is important to resolve complaints promptly, we also recognise the importance of quality. As part of the CHP implementation we will be introducing a training programme for staff across the Board as well as a toolkit of supporting documents, templates and guidance. This will assist us in improving the quality and consistency of our responses and handling for the coming year.

Whilst a significant amount of improvements were made to our handling of complaints in 2016/2017 we recognise that there is still a vast amount of improvement required to ensure we are delivering the quality and robust complaints service that we would seek to achieve.

As part of the implementation of the new CHP, we are undertaking a number of improvement actions including:

- Implementing Complaints Handling Procedure documents including our full Board procedure and the summarised ‘public facing’ procedure.
- Introducing customer satisfaction measuring for those that have been through the Complaints Handling Procedure.
- Improving how we capture, analyse and respond to learning from complaints including linking that analysis and learning to other relevant sources of information such as adverse events.
- Improving the training options available to staff around managing feedback and in particular, complaints.
- Improving our performance reporting to ensure we are meeting the requirements of the Scottish Public Services Ombudsman’s key performance indicators.
- Improving out analysis of complaints trends in order that we can learn in a wider sense and become more proactive in our approach to dealing with arising issues.
- Improving the accessibility to the Complaints Handling Procedure through an Equality Impact Assessment and work with local established groups.
• Revising our complaint response templates to ensure they are person centred and easy to read.

2.2 Summary Complaints Data

Figure 1 below provides an overview of the number of complaints received by the Board per year since 2008 to present and Table 2 shows a quarterly summary of complaints data for 2016/17. In the past year, NHS Dumfries & Galloway received a total of 397 complaints. This is an increase of 14% on 2015/16 which is the same percentage rise as the previous year. Whilst we are demonstrating a year on year rise, the numbers remain low in the context of the number of episodes of care delivered across the Board each year.

We expect that the number of complaints will continue to rise as we improve the promotion of and accessibility to our Complaints Handling Procedure. However, with the new CHP, we will be aiming to resolve the majority of our complaints at Stage One, to ensure early resolution wherever possible.

Figure 1 Number of complaints per year – 2012 – 2017

<table>
<thead>
<tr>
<th>Year</th>
<th>Complaints Received</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/13</td>
<td>225</td>
</tr>
<tr>
<td>2013/14</td>
<td>248</td>
</tr>
<tr>
<td>2014/15</td>
<td>306</td>
</tr>
<tr>
<td>2015/16</td>
<td>348</td>
</tr>
<tr>
<td>2016/17</td>
<td>397</td>
</tr>
</tbody>
</table>
### Table 2 Summary Complaints Data by Quarter & Annual Total (2016/17)

<table>
<thead>
<tr>
<th>Complaints received</th>
<th>Q1 (Apr-Jun 2016)</th>
<th>Q2 (Jul-Sept 2016)</th>
<th>Q3 (Oct-Dec 2016)</th>
<th>Q4 (Jan-Mar 2017)</th>
<th>Annual Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>103</td>
<td>108</td>
<td>103</td>
<td>83</td>
<td></td>
<td>397</td>
</tr>
</tbody>
</table>

| Complaints acknowledged within 3 working days | 99 (96%) | 106 (98%) | 95 (92%) | 66 (77%) | 366 (91%) |

| Complaints completed within 20 working days | 69 (68%) | 62 (57%) | 55 (53%) | 37 (46%) | 223 (56%) |

### Figure 2 Percentage of complaints responded to in 20 working days 2015-2017
Number of complaints received and completed in 20 working days 2016-17

(Data extracted from Qlikview – June 2017)

Of the 397 complaints received, 91% received an acknowledgement within three working days. Overall, this is an excellent compliance figure however we note compliance in Quarter 4 was significantly below this. Further interrogation of the data demonstrates that there was a number of contributing factors to this steep drop in compliance including staff absence and key posts being vacant. The recruitment to key posts along with the improvement actions implemented as part of the CHP should address this for 2017/18.

The figures also show that a total of 56% of complaints received a response within 20 working days. This is well below the Board’s target of 70% and shows a decline on the 71% compliance figure of 2015/2016. Whilst there can be genuine and appropriate reasons for complaints not being responded to within the 20 working day timescale, such as complexity of issues, resolution attempts (via meetings for example) and complainant or staff availability, we recognise that this figure needs to improve. The improvement actions detailed above will go some way towards addressing this along with the introduction of the additional complaints stage, which will reduce the number of Stage Two complaints requiring investigation.

Figure 2 provides a more detailed breakdown of the number of complaints received and responded to within 20 working days of each month.
2.3 Outcome of Complaints

As well as the speed of our responses, it is important for us to consider and understand the outcome of complaints. Where possible, we aim to have a clear upheld, not upheld or partially upheld outcome.

In 2016/2017 44% of our complaints were fully or partially upheld and 45% were not upheld. This demonstrates an improvement on the figures for 2015/16 which recorded 51% of complaints as fully or partially upheld and 40% as not upheld. The table below details a full breakdown of our response outcomes.

Table 3 Outcome of Complaints 2015/16

<table>
<thead>
<tr>
<th>Outcome of Complaints</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Upheld</td>
<td>177</td>
<td>45%</td>
</tr>
<tr>
<td>Upheld</td>
<td>109</td>
<td>27%</td>
</tr>
<tr>
<td>Partially Upheld</td>
<td>70</td>
<td>17%</td>
</tr>
<tr>
<td>Consent not Received</td>
<td>16</td>
<td>4%</td>
</tr>
<tr>
<td>Complaint withdrawn</td>
<td>14</td>
<td>3%</td>
</tr>
<tr>
<td>Still Open</td>
<td>5</td>
<td>1%</td>
</tr>
<tr>
<td>Irresolvable - Expectation</td>
<td>2</td>
<td>0%</td>
</tr>
<tr>
<td>Transferred to another Department</td>
<td>3</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Totals:</strong></td>
<td>396</td>
<td></td>
</tr>
</tbody>
</table>

Table 4 identifies the top five issues, which generated the most complaints. A complaint may be recorded under one issue or several different issues, depending upon the nature and complexity of the complaint. As is evident in the table the majority of complaints received by NHS Dumfries & Galloway were about clinical treatment, staff attitude and behaviour, communication and waiting times.

Table 4 Top 5 Complaints by Issue Category

<table>
<thead>
<tr>
<th>Complaint Issue</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Treatment</td>
<td>235</td>
<td>46%</td>
</tr>
<tr>
<td>Staff attitude and behaviour</td>
<td>77</td>
<td>15%</td>
</tr>
<tr>
<td>Staff communication (oral)</td>
<td>72</td>
<td>14%</td>
</tr>
<tr>
<td>Waiting time for date for appointment</td>
<td>40</td>
<td>8%</td>
</tr>
<tr>
<td>Staff communication (written)</td>
<td>14</td>
<td>3%</td>
</tr>
<tr>
<td>Other</td>
<td>76</td>
<td>15%</td>
</tr>
<tr>
<td><strong>Total issues raised</strong></td>
<td>514</td>
<td></td>
</tr>
</tbody>
</table>

Table 5 provides a more detailed breakdown of these complaint issues by location. As expected clinical treatment is the top complaint issue across all directorates and no specific trends or patterns have been identified.
Table 5 Top Complaints Issues by Directorate

<table>
<thead>
<tr>
<th>Complaint Issues</th>
<th>Acute &amp; Diagnostics</th>
<th>Prison</th>
<th>Women and Children Services</th>
<th>Community Health and Social Care</th>
<th>Mental Health</th>
<th>Corporate</th>
<th>Facilities</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Treatment</td>
<td>143</td>
<td>46</td>
<td>18</td>
<td>17</td>
<td>6</td>
<td>5</td>
<td>0</td>
<td>235</td>
</tr>
<tr>
<td>Staff attitude and behaviour</td>
<td>45</td>
<td>6</td>
<td>13</td>
<td>5</td>
<td>3</td>
<td>5</td>
<td>0</td>
<td>77</td>
</tr>
<tr>
<td>Staff communication (oral)</td>
<td>47</td>
<td>2</td>
<td>15</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>72</td>
</tr>
<tr>
<td>Waiting time for date for appointment</td>
<td>31</td>
<td>3</td>
<td>5</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>40</td>
</tr>
<tr>
<td>Staff communication (written)</td>
<td>8</td>
<td>1</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>14</td>
</tr>
<tr>
<td>Other</td>
<td>56</td>
<td>2</td>
<td>6</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>8</td>
<td>76</td>
</tr>
</tbody>
</table>

* Corporate Services includes Finance, Medical, NMAHP, Public Health, Strategic Planning and Workforce Directorate

2.4 Improvement Actions

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

Table 6 details the Improvement actions taken as a result of complaints received in 2016/17.

Table 6 – Improvement Actions

<table>
<thead>
<tr>
<th>Action Description</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Action Taken</td>
<td>211</td>
</tr>
<tr>
<td>Improvements in communication</td>
<td>50</td>
</tr>
<tr>
<td>Action plan instigated</td>
<td>38</td>
</tr>
<tr>
<td>Conduct issues addressed</td>
<td>32</td>
</tr>
<tr>
<td>Share lessons with staff/patient/public</td>
<td>82</td>
</tr>
<tr>
<td>Education/Training of staff</td>
<td>6</td>
</tr>
<tr>
<td>Improvements made to service access</td>
<td>7</td>
</tr>
<tr>
<td>Policy/Procedure Review</td>
<td>2</td>
</tr>
<tr>
<td>Change to system</td>
<td>1</td>
</tr>
<tr>
<td>Review of waiting times</td>
<td>4</td>
</tr>
<tr>
<td>Totals:</td>
<td>433</td>
</tr>
</tbody>
</table>
In line with our planned improvements above and the new Key Performance Indicator from the Scottish Public Services Ombudsman, it is important that we explore every opportunity to learn and improve as a result of complaints. If we are upholding or fully upholding 44% of our complaints, we should expect to have improvement actions in at least that many. We recognise this is an area in which we need to improve and actions are in place to do so.

2.5 Patient Advice and Support Service

NHS Dumfries and Galloway received six complaints through the Patient Advice and Support Service. No complaints were received through the Dumfries and Galloway Advocacy Service.

2.6 Scottish Public Services Ombudsman

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

In 2016/17 the Board had one Investigation Report laid before parliament and a further 16 decision letters were received from the SPSO. This is slightly higher than the 12 decision letters issued in 2015/16.

Of these 17 complaints 29 issues were raised.

<table>
<thead>
<tr>
<th>Issue</th>
<th>2016/17</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care and Treatment</td>
<td>16</td>
<td>14</td>
</tr>
<tr>
<td>Communication</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Complaint Handling</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Problems with Diagnosis</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Attitude and Behaviour</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Medication issues</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Waiting Times</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>0</td>
</tr>
</tbody>
</table>

SPSO decision on the 29 issues raised:

<table>
<thead>
<tr>
<th>Decision</th>
<th>2016/17</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upheld</td>
<td>13</td>
<td>11</td>
</tr>
<tr>
<td>Not Upheld</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>SPSO Not Investigating</td>
<td>5</td>
<td>7</td>
</tr>
</tbody>
</table>

Of the 17 complaints the SPSO made 42 Recommendations to the Board. For each recommendation made by the SPSO the Board develops an action plan, detailing the recommendations made and the actions taken to implement the recommendations. Each completed action plan is laid before the Board’s Healthcare Governance Committee to provide assurance that the recommendations have been implemented and appropriate lessons have been learned and action taken to improve services.
The complaint which was laid before Parliament was a complaint that originated from 2015 and was in relation to poor clinical treatment and care as well as the complaints handling.

The Scottish Public Services Ombudsman investigated two points, both of which were upheld:

(a) [NHS Dumfries and Galloway] unreasonably performed a procedure to which Miss C did not consent; and

(b) [NHS Dumfries and Galloway] unreasonably failed to follow up their initial discussion with Miss C (upheld).

The Scottish Public Service Ombudsman offered the following summary of the complaint:

‘Miss C complained about how the board had treated her finger injury and how they dealt with her complaint. Miss C was employed on a dairy farm, where she suffered a crush injury to her left ring finger. Miss C was taken to the Dumfries and Galloway Royal Infirmary where she underwent surgery. Miss C said she had been told that her finger would undergo a partial amputation, which she had consented to. This procedure would have allowed her to return to work in the shortest possible time period.

Miss C said that she had asked to speak to the board’s complaints team to make a formal complaint whilst still on the ward, but that no action had been taken by the board. She had subsequently submitted a formal complaint, but the board had maintained the surgery she underwent was the surgery she had consented to.

We took medical advice on Miss C’s treatment and the consent process undertaken by the board. The advice said that Miss C had not had her consent properly recorded. The procedure that was undertaken was not that listed on the form. Additionally no record had been made of any discussions with her, despite the form containing clearly marked sections for this. The advice said no treatment plan was recorded, nor was the rationale for performing surgery other than a partial amputation recorded. The advice stated the failure to perform a partial amputation on Miss C’s finger had significantly prolonged the healing process and it was clear from her submissions that her primary motivation was to return to work as soon as possible.

We found the board’s records of the consent process were inadequate and that the operation performed on Miss C was not the procedure she had consented to. The board were unable to explain this, instead maintaining that Miss C had undergone the appropriate surgery. We also found the board’s investigation into Miss C’s complaint had been inadequate. It had failed to identify the lack of records supporting her consent as a concern and had failed to obtain a statement from the doctor responsible for documenting this and performing the surgery for his actions. Additionally the board’s complaint response misrepresented the records of Miss C’s interactions with medical staff and failed to address Miss C’s concerns about the financial impact of the surgery on her.’
The Scottish Public Services Ombudsman recommended that we:

(i) review our process for obtaining informed consent, taking account of the failings the investigation identified and relevant guidance in this area;

(ii) provide evidence Doctor 1 had undergone training and suitable continuing professional development courses to improve their communication skills and understanding of the consent process;

(iii) carry out a significant event analysis ensuring that Doctor 2 reviewed his understanding of the consent process and the definition of a finger terminalisation procedure;

(iv) provide evidence that both Doctor 1 and Doctor 2 had reflected on the failings identified in the report as part of their appraisal process;

(v) review the complaints investigation in light of the comments from the adviser;

(vi) review the handling of Miss C's complaint in order to identify areas for improvement and ensure compliance with their statutory responsibilities as set out in the 'Can I Help You' guidance; and

(vii) apologise for the failings identified in the report, acknowledging that the procedure performed on Miss C was not the one that she wished to have carried out.

The Board accepted and completed all of the above, providing evidence to the Scottish Public Services Ombudsman to confirm our compliance.
2.7 Family Health Services (FHS), Independent Contractors Feedback, Comments and Complaints

Since April 2012 FHS contactors (GPs, Dentists, Pharmacies and Opticians) have been required by law to provide NHS Dumfries & Galloway with data on complaints they have received about their services.

Table 7 - Family Health Service/Independent Contractor Complaints

<table>
<thead>
<tr>
<th></th>
<th>General Practitioner</th>
<th>Dentist</th>
<th>Pharmacist</th>
<th>Optician</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number of contractors</td>
<td>35</td>
<td>33</td>
<td>35</td>
<td>20</td>
</tr>
<tr>
<td>No of Contractors replying</td>
<td>29</td>
<td>22</td>
<td>34</td>
<td>17</td>
</tr>
<tr>
<td>Complaints received</td>
<td>109</td>
<td>17</td>
<td>27</td>
<td>1</td>
</tr>
<tr>
<td>Complaints Withdrawn</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Complaints completed within 20 working days</td>
<td>99</td>
<td>16</td>
<td>19</td>
<td>0</td>
</tr>
<tr>
<td>Complaints where alternate dispute resolution was used</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Complaints upheld</td>
<td>24</td>
<td>9</td>
<td>22</td>
<td>1</td>
</tr>
<tr>
<td>Complaints Not upheld</td>
<td>64</td>
<td>5</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Complaints Partially Upheld</td>
<td>18</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Outcome Unknown</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Issues of complaints raised are consistent with other NHS services complaints with the top issues being Care and Treatment, Staff Attitude and Behaviour, Communication and Delays in appointment/Clinics.

Comparison of 2015/16 FHS data to 2016/17 FHS data

Contractors

The overall number of contractors replying has reduced from 110 in 2015/16 to 102 in 2016/17; an 82% response rate. Following a poor response rate in 2014/15 Patient Services spent a considerable amount of time trying to simplify the reporting process by designing a simplified form which mirrored the information requested by Information Services Scotland (ISD). Reminders were also sent to all contractors, reminding them of their obligation to provide the information. Each outstanding contractor has been contacted by telephone to try and ensure compliance. Despite this we have still not achieved 100% compliance.
It is felt that the time and effort required to collate this information outweighs any value in the information collected as only numerical data is provided therefore there is little substance in order to interrogate and establish trends or valuable learning from Family Health Service complaints.

In preparation for the new Complaints Handling Procedure a new template for collating of the new key Performance Indicators has been provided to all Family Health Services Contractors. Discussion is ongoing as to best practice in completing the forms and the frequency by which data should be submitted to the Board. Further discussion with the Primary Care Directorate and the Family Health Service Providers will be required to ensure improvements in compliance and quality of data.

**Complaint Numbers**

The overall number of complaints for this year is 154, which is a 25% increase on the number of complaints in 2015/16 which was 123.

**Response Times**

The number of complaints responded to within 20 days is 120, a 15% increase from 104 in 2015/16. The overall response time percentage within 20 days has increased from 83% in 2015/16 to 86% in 2016/17. It is very encouraging that 86% of Family Health Services Complaints are being responded to within 20 working days.

**2.8 Alternate Dispute Resolution**

In 2016/17 Alternate Dispute Resolution such as the Medication Service was used to resolve two complaints in Family Health Service Complaints. Anyone wishing to make a complaint is signposted to the Patient Advice and Support Service (PASS) for any assistance they might need and Patient Services do offer support to complainants when interacting with services.

**2.9 Prison Service Complaints**

NHS Dumfries & Galloway is responsible for the provision of healthcare to prisoners at HMP Dumfries. In 2016/17, NHS Dumfries & Galloway received a total of 57 formal complaints from prisoners.
Table 8 Summary of Prison Service Complaints Data by Quarter and Annual Total

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Complaints received</td>
<td>17</td>
<td>15</td>
<td>12</td>
<td>13</td>
<td>57</td>
</tr>
<tr>
<td>Complaints acknowledged within 3 working days</td>
<td>17 (100%)</td>
<td>15 (100%)</td>
<td>11 (92%)</td>
<td>13 (100%)</td>
<td>56 (98%)</td>
</tr>
<tr>
<td>Complaints completed within 20 working days</td>
<td>16 (97%)</td>
<td>13 (89%)</td>
<td>10 (83%)</td>
<td>13 (100%)</td>
<td>52 (92%)</td>
</tr>
</tbody>
</table>

Table 9 Summary of Prison Service Complaint Outcomes

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Upheld</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Partially upheld</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2 (4%)</td>
</tr>
<tr>
<td>Not upheld</td>
<td>15</td>
<td>12</td>
<td>12</td>
<td>13</td>
<td>52 (91%)</td>
</tr>
<tr>
<td>Withdrawn</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Irresolvable</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Transferred</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1 (2%)</td>
</tr>
</tbody>
</table>

In 2016/17 91% of prison healthcare complaints were not upheld which is comparable to the 90% of the previous period. Table 10 below provides a breakdown of prison healthcare complaints by issue. Most of the complaints received about clinical treatment relate to drug administration and the numbers of complaints are very high for the relative size of the population. NHS Dumfries & Galloway has been worked closely with HMP Dumfries to ensure that appropriate information on how to complain is available and that healthcare staff are aware of the NHS Dumfries & Galloway complaints process.
**Section 3 - Building a Culture of Learning from Feedback, Comments, Concerns and Complaints**

**What we are doing well**

In order to ensure the effective implementation of the new Complaints Handling Procedure, a number of awareness raising activities have recently taken place across the Board. Through this awareness raising we can strengthen the culture around feedback ensuring we continue to welcome and value it. Our recent activities include:

- The development of a Feedback Coordinators network across the organisation (as previously referenced).
- The review of our internal processes for handling complaints ensuring local ownership and accountability.
- Attendance at management team meetings.
- Delivering a ‘development session’ with the senior Health and Social Care team.
- The development of a suite of supporting guidance and templates to improve awareness of best practice and to assist staff dealing with complaints.
- Attendance at individual team meetings and local training sessions to raise awareness and provide an overview of the new procedures.

The Patient Services team are also delivering regular complaints training across the region. These sessions have also been made available to our Independent Contractors and Health and Social Care colleagues. Feedback is being gathered on this training to ensure we can deliver the most effective sessions possible.

As well as these local activities, we are also linking in to relevant national projects. The Scottish Public Services Ombudsman has recently developed a Learning and Improvement Unit (LIU). The LIU recently led on a national event, attended by the Patient Feedback Manager, to introduce a number of new tools and guidance documents specifically focussed on learning. These documents are being embedded in to our internal processes and training programme to ensure we are learning from best practice.

---

**Table 10  Top 4 Prison Healthcare Complaints by Issue Category**

<table>
<thead>
<tr>
<th></th>
<th>Clinical Treatment</th>
<th>Waiting time for appointment</th>
<th>Staff Attitude and Behaviour</th>
<th>Staff communication (oral)</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Complaints</td>
<td>46</td>
<td>3</td>
<td>6</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
Additionally, the Patient Services Team regularly link in with national and local colleagues from other organisations to share best practice and to offer support including:

- Attendance at the National Complaints Personnel Association of Scotland
- Working with Dumfries and Galloway Council colleagues to manage complaints about integrated services and the associated complaints handling changes that have recently been implemented around that.
- Working with complaints professionals across the public sector including local authorities and other Boards.

**Where we can improve**

We recognise that there is still work to do around building a strong feedback and learning culture. In addition to the above, we also plan to:

- Provide regular updates to general staff via the Core Briefing.
- Improve information available to both staff and the general public through our website and intranet, Beacon.
- Improve hard copy information and promotion through the circulation of additional NHS Inform materials.
- Continue with awareness raising sessions through existing team meetings and training sessions (such as the ASPIRE course).
- Liaise directly with local established groups guided by the planned Equality Impact Assessment to assess and improve the accessibility of our Complaints Handling Procedure. This will also assist us in establishing links with these groups in order to better support their service users and communities.

**Section 4 - Improvements to services (as a result of complaints and feedback)**

**What we are doing well**

Feedback provides a valuable opportunity for us to learn from the experiences of our patients, service users, carers and visitors. As well as our local commitment to learning and improving, we are also obliged to identify, record and report on learning under the Scottish Public Services Ombudsman’s new Performance Indicators. Whilst we are not yet capturing learning and improvements from every piece of feedback, we are identifying improvement opportunities in around 40% of complaints (as demonstrated above).

Over the period 2016/2017, NHS Dumfries and Galloway made the following changes and improvements as a direct result of feedback:

**Waiting Times Guarantee**

One complaint received earlier in the year was regarding a patient from Stranraer being offered an appointment in Dumfries in order to meet the Government Waiting Time Guarantee. A review of the appointment process was undertaken and it was agreed that in future the Board will contact patients whose nearest centre is Galloway Community Hospital and offer the patient an appointment in Stranraer.
This may mean that the patient will not be seen within the Government Waiting Time guidelines; however the patient will be able to make an informed choice as to whether to wait or whether to travel to Dumfries to be seen within the WTG timeframe.

**Urology Waiting Times**

Changes were made to the structure of the Urology team with the aim to improve Urology Waiting times.

**Pre-assessment Information**

In relation to a complaint regarding conflicting information being provided by the Pre-assessment Unit and the Patient Access Team, the Patient Access Manager met with the Senior Charge nurse in Pre-assessment regarding the process to ensure that consistent information is conveyed to the patient. A procedure was agreed which includes a table of medications and their standard stop times for the access team along with an agreement with pre-assessment that any deviations from the standard medication omissions are clearly indicated on the pre-assessment part of the waiting list cards that the access team deal with.

**Consent to Treatment**

Following a complaint to the Scottish Public Services Ombudsman the Board were asked to review their process for obtaining informed consent. The Deputy Medical Director met with relevant colleagues to discuss the matter of consent and a basic flowchart was produced to demonstrate the agreed process.

The Board is also aware of the new General Data Protection Regulations due for implementation in 2018 and the impact that will have on how consent is obtained and recorded. This was discussed during the Patient Information Working Group in January 2017.

**Chemotherapy**

In relation to a complaint about the short notice cancellation of chemotherapy treatment, a review of a number of patients who have had treatment cancelled at short notice revealed that in recent years it has become increasingly difficult to predict the patient bed occupancy rates in all hospitals on a Monday and the subsequent effects on scheduled care. As a result the Board is now moving the day of admission for over 80% of cases, to a Tuesday, where this is clinically suitable.

**Where we can improve**

Whilst we do regularly identify learning and improvements from complaints and other types of feedback, we recognise that our tracking and sharing of that information could be better. This is a challenge that is reflected nationally across the public sector and as referenced above, is one that the Scottish Public Services Ombudsman are keen to assist with.
In addition to the work of their Learning and Improvement Unit we are also looking at our own local processes and systems to help us capture, analyse and track these learning opportunities including:

- Looking at potential technical solutions to analyse trends and complaints data.
- Assessing how we can better share and analyse complaints learning against the learning from adverse events.
- Introducing improved templates and guidance for staff dealing with complaints.
- Ensuring learning and improving is a key focus of our training and promotional materials.
- Improving our performance reporting to ensure managers and key staff are getting a regular and comprehensive overview of the feedback their area is receiving.

Section 5 – Accountability and Governance

5.1 NHS Board

The Executive Nurse Director presents a bi-monthly Patient Experience Report at NHS Board meetings. The report provides summary statistics and commentary on complaints handling throughout NHS Dumfries & Galloway. The report contains statistical summaries of complaints, complaint themes, information on the timeliness of responses, Scottish Public Service Ombudsman referrals and details of service improvements and development. This allows Board Members to review the arrangements and handling of complaints within NHS Dumfries & Galloway and ask questions on any points of detail, trends or new and recent development.

5.2 Healthcare Governance Committee

A more detailed Patient Experience Report is presented at every Healthcare Governance Committee. This report contains anonymised summaries of individual concerns, complaints and compliments, together with the associated action plans and learning. All upheld SPSO complaints, recommendation and actions are presented at the Healthcare Governance Committee for further scrutiny.

5.3 Person Centred Health and Care Committee

The Person Centred Health and Care Committee is chaired by a Non-Executive Member of the Board and includes patient and public representatives. The committee feeds into the NHS Dumfries & Galloway Healthcare Governance Committee, which in turn reports to the NHS Board. The committee receives information, updates, reports and commission specific actions to enhance person centeredness and the quality of care delivery from the sources outlined below:

- Care environment observations
- Patient Experience Indicators
- Staff Experience Indicators
- Leading Better Care
• Volunteering and Patient Focus and Public Involvement  
• Older People In Acute Hospitals work  
• Learning from feedback, comments, concerns and complaints  
• Spiritual Care  
• Any actions arising from the Francis enquiry specific to this area  
• Integrated Health and Social Care

The committee is supported by individuals who have the above named activities within in their broad remit and is not supported by a dedicated person-centred/patient experience team or programme manager. However, the committee is responsible for identifying new and current initiatives, supporting measurement and reporting improvement. The committee also works proactively to anticipate or act on person centred health and care governance issues. This includes ensuring that causal links are made and that organisational learning opportunities are recognised, shared and used to direct improvement activities.

6. Conclusion

NHS Dumfries & Galloway will continue to actively encourage patients and service users to provide feedback through the mechanisms described in this report. This report highlights that more needs to be done to ensure complainants receive a timely and quality response with a focus on learning. With the introduction of the new Complaints Handling Procedure and the positive work that is being done around that to improve processes, procedures, awareness, access and support, we expect to be able to build on the strong foundation delivered by the Scottish Public Services Ombudsman in order that we can deliver an improved services going forward.

PARTICIPATION STANDARD SELF-ASSESSMENT

<table>
<thead>
<tr>
<th>Participation Standard Section 1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Drawing on Sections 1-4 of their annual report, NHS Boards should note here the self assessed level reached for Participation Standard Section 1 (Patient Focus).</strong></td>
</tr>
</tbody>
</table>

NHS Dumfries & Galloway considers that we have achieved Level 2: ‘implementing’ in Section 1 of the Participation Standard.

**Range of methods and approaches**

NHS Dumfries & Galloway is committed to delivering safe, effective and person-centred care. The use of feedback is central to ensuring delivery of these aims and we therefore offer a variety of approaches which allow people to choose a feedback mechanism that best suits their needs. These include:

- in writing via letters, surveys, consultations and feedback forms.  
- by email via our Patient Services and DG Feedback email addresses.  
- by telephone via Patient Services and direct to individual services.  
- via Patient/Care Opinion and our own website.
• via social media via posts and links.
• face-to-face via scheduled events and daily contact with the public.

Through our Patient Services Team and Patient Experience Officer (for the Acute and Diagnostics Directorate) we ensure that there are clear points of contact and support around the above for both staff and the public, locally and centrally.

As a Board, we are keen to provide opportunities for local residents to participate in the development, design and delivery of our services. Working closely with a number of local partners, a Participation and Engagement Network (PEN) has also been formed so that members of the public can ‘sign up’ to become more involved in local consultation and engagement activities.

The soft launch of the PEN has resulted in an initial bank of members being developed and consultations are now being shared. We are committed to building a bank of network members that are representative of the local community. In order to do so, we recognise that we need to further develop our promotional materials and deliver a structured communications plan.

We are in the process of developing recognisable branding for the network which will be applied to our online promotional materials and leaflets. On completion, we will work with partners to promote the network more heavily through our websites and social media channels. In addition, we will work closely with local established groups to ensure they are receiving the information and support they need to encourage their members to sign up and become involved.

Who has been involved?

Our Complaints Handling Procedure (CHP) reflects the ‘Can I Help You’ guidance. From 1 April 2017 we will be implementing a new CHP based on the Scottish Public Services Ombudsman’s model CHP, which underwent extensive national consultation. Locally, we recognise the need for us to better involve patients, carers and service users in the development and improvement of our feedback mechanisms. We therefore plan to run our feedback policies, procedures and literature through an Equality Impact Assessment later this year to gather feedback on how we can further improve.

We also recognise that we could be more proactive in our interactions with local established groups and that there is a particular need for us to improve how we support those from hard to reach and seldom heard groups to provide feedback to us. The activities around the Participation and Engagement Network (referenced above) and the Equality Impact Assessment will assist with that.

**Promoting Independent Advice**

We promote the Patient Advice and Support Service (PASS) and other local advocacy services widely through information in our wards, clinic waiting areas, notice boards and intranet/internet.
We also add signposting in to our template complaint letters and ensure that our feedback training has a focused section on advocacy services and the other support available for those wishing to bring feedback to the organisation.

**Publicising Our Approach**

We publicise feedback opportunities locally in our wards, waiting areas, notice boards and intranet/internet as above. We have a variety of promotional materials around feedback including NHS Inform and Patient/Care Opinion posters, cards and leaflets. We also promote all Patient/Care Opinion stories through our Facebook and Twitter accounts.

Whilst we generally promote our feedback mechanisms well, we recognise that we could be more consistent in our approach. We note, for example, that there are a number of different comment and suggestion forms in use across the organisation. We are also aware that there are a number of different leaflets advising people how they can provide feedback. In order to improve, we are looking to introduce a simple leaflet summarising the different options available for giving feedback. This leaflet will also include a feedback form, will be distributed widely across the Board and will replace the comment and suggestion forms and leaflets currently in place. Local teams may still use their own templates for direct interactions with patients, but there will be one consistent leaflet and form on public display.

**Training and Culture**

The Patient Services Team has developed ‘Complaints Handling’ and ‘Investigation Skills’ training which will be rolled out from 1 April 2017 to staff across the organisation. Our local independent contractors have also been invited to attend. This training has a substantial section on managing wider feedback with a clear focus on resolution and learning. The initial uptake for training has been excellent and regular sessions are planned for the remainder of the year. We have also benefitted from Patient/Care Opinion attending locally to deliver targeted training to a number of staff.

To ensure the training is effective and relevant, learning will be assessed on the day through pre and post raining questionnaires. An evaluation form will also be sent to participants after the session and they will be encouraged to provide honest feedback on the content and delivery of the sessions. Improvement suggestions will also be encouraged.

Whilst we generally have a very positive culture around encouraging feedback, there have been some challenges around the implementation of the new CHP due to anxieties about the implications of tighter timescales and a more detailed process. Through direct work with senior managers, independent contractors, teams and frontline staff, the Patient Services Team are offering support and reassurance to help address this.

Whilst we do regularly identify learning and improvements from complaints and other types of feedback, we recognise that our tracking and sharing of that information could be better.
This is a challenge that is reflected nationally across the public sector and as referenced above, is one that the Scottish Public Services Ombudsman are keen to assist with. In addition to the work of their Learning and Improvement Unit we are also looking at our own local processes and systems to help us capture, analyse and track these learning opportunities.

NHS Boards should note here the self assessed level reached for Participation Standard Section 3 (Governance of Participation).

NHS Dumfries & Galloway considers that we have achieved Level 2: ‘reviewing implementing’ in Section 3 of the Participation Standard.

The Executive Nurse Director presents a bi-monthly Patient Experience Report at NHS Board meetings. The report provides summary statistics and commentary on complaints handling throughout NHS Dumfries & Galloway. The report contains statistical summaries of complaints, complaint themes, information on the timeliness of responses, Scottish Public Service Ombudsman referrals and details of service improvements and development. This allows Board Members to review the arrangements and handling of complaints within NHS Dumfries & Galloway and ask questions on any points of detail, trends or new and recent development.

A more detailed Patient Experience Report is presented at every Healthcare Governance Committee. This report contains anonymised summaries of individual concerns, complaints and compliments, together with the associated action plans and learning. All upheld SPSO complaints, recommendation and actions are presented at the Healthcare Governance Committee for further scrutiny.

The Person Centred Health and Care Committee is chaired by a Non-Executive Member of the Board and includes patient and public representatives. The committee feeds into the NHS Dumfries & Galloway Healthcare Governance Committee, which in turn reports to the NHS Board. The committee receives information, updates, reports and commission specific actions to enhance person centeredness and the quality of care delivery.

Whilst the governance arrangements noted above work well, we recognise that there are opportunities for us to improve how we link feedback with adverse events. There are also opportunities for us to better analyse trends and themes. Our Quality and Patient Safety Leadership Group are currently exploring how we can improve in this respect and are working through potential solutions which we hope to implement later this year.

Public Endorsement of Self Assessment

Unfortunately we have not had the opportunity to involve the public in endorsing our self assessment this year as we do not currently have the structures in place to do so in a meaningful way. Through the work referenced above in further developing our Participation and Engagement Network and linking with local established groups, we are confident that we will be able to do so next year.
RECOMMENDATION

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

CONTEXT

Strategy / Policy:
Waiting Times / Patient Access

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

This report is an at a glance report of key operational targets.

As agreed at the NHS Board meeting in December, the “At a glance” Performance report provides NHS Board members with the most recent performance data in respect of the key operational targets. This is intended to supplement the quarterly performance reports submitted to NHS Board and Integration Joint Board.

GLOSSARY OF TERMS

NHS - National Health Service
DCAQ - Demand, Capacity, Activity & Queue
TTG - 84 Day Treatment Time Guarantee
AHP - Allied Health Professional
MSK - Musculoskeletal
<table>
<thead>
<tr>
<th>MONITORING FORM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy / Strategy</td>
</tr>
<tr>
<td><strong>Staffing Implications</strong></td>
</tr>
<tr>
<td><strong>Financial Implications</strong></td>
</tr>
<tr>
<td>Consultation / Consideration</td>
</tr>
<tr>
<td>Risk Assessment</td>
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<tr>
<td>Sustainability</td>
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<tr>
<td>Compliance with Corporate Objectives</td>
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<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td>Single Outcome Agreement (SOA)</td>
</tr>
<tr>
<td>Best Value</td>
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<tr>
<td></td>
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<tr>
<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Impact Assessment</td>
</tr>
</tbody>
</table>
## 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.*

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>April 2017</th>
<th>May 2017</th>
<th>Last 3 Months (Mar 17 - May 17)</th>
<th>Last 3 Months Last Year (Mar 16 - May 16)</th>
<th>Direction</th>
</tr>
</thead>
<tbody>
<tr>
<td>TTG ( % waited under 12 weeks for Treatment )</td>
<td>100%</td>
<td>84.9%</td>
<td>87.2%</td>
<td>84.3%</td>
<td>84.4%</td>
<td>▼</td>
</tr>
<tr>
<td>Dr Led New Outpatients ( % waiting under 12 weeks at end of month )</td>
<td>55%</td>
<td>91.2%</td>
<td>89.9%</td>
<td>91.0%</td>
<td>94.3%</td>
<td>▼</td>
</tr>
<tr>
<td>Diagnostics ( % waiting under 6 weeks at end of month )</td>
<td>100%</td>
<td>98.9%</td>
<td>99.1%</td>
<td>99.1%</td>
<td>97.8%</td>
<td>△</td>
</tr>
<tr>
<td>AHP MSK ( % waiting under 4 weeks at end of month )</td>
<td>50%</td>
<td>73.5%</td>
<td>73.8%</td>
<td>76.2%</td>
<td>86.4%</td>
<td>▼</td>
</tr>
<tr>
<td>Cancer ( Within 31 day target )</td>
<td>95%</td>
<td>100.0% (March 2017)</td>
<td>100.0% (April 2017)</td>
<td>100.0% Average (Feb 17 - Apr 17)</td>
<td>99.2% Average (Feb 16 - Apr 16)</td>
<td>△</td>
</tr>
<tr>
<td>Cancer ( Within 62 day target )</td>
<td>95%</td>
<td>100.0% (March 2017)</td>
<td>96.2% (April 2017)</td>
<td>96.0% Average (Feb 17 - Apr 17)</td>
<td>95.8% Average (Feb 16 - Apr 16)</td>
<td>△</td>
</tr>
<tr>
<td>18 Weeks Performance</td>
<td>90%</td>
<td>88.3%</td>
<td>90.4%</td>
<td>90.3% Average</td>
<td>90.3% Average</td>
<td>▼</td>
</tr>
<tr>
<td>18 Weeks Linkage</td>
<td>50%</td>
<td>96.5%</td>
<td>96.7%</td>
<td>96.7% Average</td>
<td>96.5% Average</td>
<td>△</td>
</tr>
<tr>
<td>Emergency Department (% Within 4 Hour)</td>
<td>96%</td>
<td>93.7%</td>
<td>95.3%</td>
<td>94.3%</td>
<td>95.5%</td>
<td>▼</td>
</tr>
<tr>
<td>Emergency Department (Absolute Attendances)</td>
<td>▼</td>
<td>4,107</td>
<td>4,497</td>
<td>12,706</td>
<td>12,568</td>
<td>△</td>
</tr>
<tr>
<td>Delayed Discharges (Bed Days Lost)</td>
<td>▼</td>
<td>1,161</td>
<td>908</td>
<td>2,789</td>
<td>3,723</td>
<td>▼</td>
</tr>
<tr>
<td>Dr Led Return Tickets (Beyond Lastest Date at end of month)</td>
<td>▼</td>
<td>5,268</td>
<td>4,950</td>
<td>15,044</td>
<td>18,088</td>
<td>▼</td>
</tr>
</tbody>
</table>
DUMFRIES and GALLOWAY NHS BOARD

7th August 2017

Capital and Infrastructure Update 30th June 2017

Author: Susan Thompson
Deputy Director of Finance

Sponsoring Director: Katy Lewis
Director of Finance

Date: 21st July 2017

RECOMMENDATION

The Board is asked to note:
• The allocations received to date.
• The capital expenditure incurred to date.
• The update on the 2017/18 programme of works.

The Board is asked to approve:
• The changes to allocations required and the respective changes to approved budgets as a result.

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 £3.475m have been received from the Scottish Government Health and Social Care Directorate (SGHSCD) to the end of June 2017.

Expenditure of £919k has been incurred to the end of June 2017.
## GLOSSARY OF TERMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASRP</td>
<td>Acute Services Redevelopment Project</td>
</tr>
<tr>
<td>BMS</td>
<td>Building Management System</td>
</tr>
<tr>
<td>CDC</td>
<td>Crichton Development Company</td>
</tr>
<tr>
<td>CIG</td>
<td>Capital Investment Group</td>
</tr>
<tr>
<td>CRL</td>
<td>Capital Resources Limit</td>
</tr>
<tr>
<td>CSSD</td>
<td>Central Sterilisation Services Department</td>
</tr>
<tr>
<td>D&amp;G</td>
<td>Dumfries and Galloway</td>
</tr>
<tr>
<td>HFS</td>
<td>Health Facilities Scotland</td>
</tr>
<tr>
<td>IM&amp;T</td>
<td>Information Management &amp; Technology</td>
</tr>
<tr>
<td>LDP</td>
<td>Local Delivery Plan</td>
</tr>
<tr>
<td>MYR</td>
<td>Mid Year Review</td>
</tr>
<tr>
<td>NBV</td>
<td>Net Book Value</td>
</tr>
<tr>
<td>NPD</td>
<td>Not for Profit Distribution</td>
</tr>
<tr>
<td>OBC</td>
<td>Outline Business Case</td>
</tr>
<tr>
<td>SGHSCD</td>
<td>Scottish Government Health and Social Care Directorate</td>
</tr>
<tr>
<td>YTD</td>
<td>Year to Date</td>
</tr>
</tbody>
</table>
## MONITORING FORM

<table>
<thead>
<tr>
<th>Category</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy/Strategy Implications</td>
<td>• Capital Plan, Property Strategy &amp; IM&amp;T Strategy</td>
</tr>
<tr>
<td>Staffing Implications</td>
<td>• Not Applicable</td>
</tr>
<tr>
<td>Financial Implications</td>
<td>• Capital charge and recurring revenue consequences built in as part of the financial planning and reporting cycle.</td>
</tr>
<tr>
<td>Consultation / Consideration</td>
<td>• Capital Investment Group, Management Team and Performance Committee</td>
</tr>
<tr>
<td>Risk Assessment</td>
<td>• No</td>
</tr>
<tr>
<td>Sustainability</td>
<td>• The capital plan supports the sustainability agenda through the delivery of capital schemes in line with the property strategy and efficiency procurement of equipment.</td>
</tr>
<tr>
<td>Compliance with Corporate Objectives</td>
<td>• 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.</td>
</tr>
<tr>
<td>Single Outcome Agreement (SOA)</td>
<td>• Not applicable.</td>
</tr>
<tr>
<td>Best Value</td>
<td>• This paper contributes to Best Value goals of sound governance, accountability, performance scrutiny and sound use of resources.</td>
</tr>
<tr>
<td>Impact Assessment</td>
<td>• Not Applicable</td>
</tr>
</tbody>
</table>
Allocations Update

1. Table 1 below shows the anticipated allocations from SGHSCD for capital. To the end of June 2017, a capital allocation of £3.475m has been received, with the final adjusted expected to be made in the August allocation letter.

2. No concerns have been highlighted from SGHSCD about the allocations set out in the table below.

Table 1

<table>
<thead>
<tr>
<th>ANTICIPATED ALLOCATIONS</th>
<th>2017-18 per LDP £’000</th>
<th>Adjustment £’000</th>
<th>Revised for Approval £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formula allocation</td>
<td>3,475</td>
<td>0</td>
<td>3,475</td>
</tr>
<tr>
<td>NPD - Asset Addition</td>
<td>28,503</td>
<td>(2,075)</td>
<td>26,428</td>
</tr>
<tr>
<td>NPD - Enabling Funding</td>
<td>27,101</td>
<td>0</td>
<td>27,101</td>
</tr>
<tr>
<td>Capital to Revenue Request</td>
<td>0</td>
<td>(5,000)</td>
<td>(5,000)</td>
</tr>
<tr>
<td>Return of 2016/17 virement</td>
<td>1,566</td>
<td>0</td>
<td>1,566</td>
</tr>
<tr>
<td>TOTAL</td>
<td>60,645</td>
<td>(7,075)</td>
<td>53,570</td>
</tr>
<tr>
<td>Receipts Returned to SGHSCD</td>
<td>(20)</td>
<td>20</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL ANTICIPATED</td>
<td>60,625</td>
<td>(7,055)</td>
<td>53,570</td>
</tr>
</tbody>
</table>

3. The Quarter 1 review has highlighted a number of adjustments require approval. Discussions have taken place with SGHCSD to highlight the changes anticipated since the submission of the LDP, and whilst are still subject to final discussions with Scottish Government are not expected to change materially from the position set out in this paper.

4. The NPD Asset Addition which is the allocation to cover the technical accounting entries for the new building was incorrectly stated in the LDP, this was as a result of the acceleration of construction in 2016/17, and this was an omission in the LDP. The total NPD asset addition remains as £212.513m over the construction period.

5. Following discussions with SGHSCD it is anticipated that an allocation deduction will be made to allow a capital to revenue transfer of £5m. This in the main relates to equipment which is currently within the capital plan but does not meet the £5k capital threshold.

6. It is now deemed unlikely that any asset sales will conclude this financial year and the return of receipts will not be delivered. The adjustment to the plan is to therefore to remove the anticipated £20k.

Budget and Expenditure Update

7. As part of the Quarter 1 review the budgets have been reviewed. Table 2 below shows the approved budget as per the LDP and the proposed changes to bring the expenditure in line with the revised allocations.
Table 2

<table>
<thead>
<tr>
<th>CAPITAL EXPENDITURE PLAN</th>
<th>2017-18 per LDP £'000</th>
<th>Adjustment £'000</th>
<th>Revised for Approval £'000</th>
<th>Capital to Revenue £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASRP - Signage</td>
<td>201</td>
<td>(201)</td>
<td>0</td>
<td>201</td>
</tr>
<tr>
<td>ASRP - Equipment</td>
<td>26,900</td>
<td>(4,799)</td>
<td>22,101</td>
<td>4,799</td>
</tr>
<tr>
<td>ASRP - Cresswell</td>
<td>1,649</td>
<td>0</td>
<td>1,649</td>
<td>0</td>
</tr>
<tr>
<td>ASRP - Asset</td>
<td>28,503</td>
<td>(2,075)</td>
<td>26,428</td>
<td>0</td>
</tr>
<tr>
<td>Replacement, Contingency &amp; Development Programme</td>
<td>3,392</td>
<td>0</td>
<td>3,392</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>60,645</strong></td>
<td><strong>(7,075)</strong></td>
<td><strong>53,570</strong></td>
<td><strong>5,000</strong></td>
</tr>
</tbody>
</table>

8. To the end of June only £919k of expenditure has been incurred on the capital programme (excluding the NPD Addition), the majority of which is on the new build equipping.

9. Expenditure is anticipated to increase significantly over the coming months as the new build equipping moves from the procurement stage, through the ordering and then to the delivery stage when invoices will then be paid.

10. Details of the individual programmes are included in Appendix 1.

Recommendation

11. The Board are asked to note the ongoing discussions with SGHSCD with regards to the Capital to Revenue transfer and to approve the respective changes to the plan.
Details on programme budgets

**ASRP Signage**

1. This is a small budget approved as part of the ASRP business case to support the new signage that will be required in the region to direct individuals to the new site. These costs are not capital in nature and have been included in the capital to revenue transfer proposed for 2017/18.

**ASRP Equipment**

2. £33m was approved as part of the Acute Services Redevelopment Project (ASRP) business case for equipping the new hospital.

3. The majority of this expenditure will be expensed during 2017/18 however circa £5m has been retained in future years of the plan to support the replacement of equipment which is transferring from the old site. Any underspend in year will be re-profiled to further augment this.

4. Equipping the new hospital includes equipment which would not traditionally be seen as a capital asset; as a result some of the budget will be transferred to revenue to deal with this type of equipment, £4.8m is currently forecast to transfer from Capital to Revenue.

5. Any remaining items which do not meet the capital criteria will be capitalised as one single equipping asset which is allowable under the Capital Accounting Manual for major hospital builds.

**ASRP Cresswell**

6. 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 3 below.

<table>
<thead>
<tr>
<th>Funding Approved in Addendum</th>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Dumfries &amp; Galloway</td>
<td>2,000</td>
</tr>
<tr>
<td>Scottish Government - already approved</td>
<td>13,989</td>
</tr>
<tr>
<td>Scottish Government - additional support</td>
<td>1,510</td>
</tr>
<tr>
<td></td>
<td><strong>17,499</strong></td>
</tr>
</tbody>
</table>

7. 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.

8. Construction costs will not be incurred until 2018/19 onwards.

9. This budget also includes provision for any works required in the existing DGRI while services remain there before the move to the new Mountainhall Treatment Centre.
ASRP NPD Addition

10. This budget relates to the technical accounting entry which is required to bring the Not for Profit Distribution (NPD) asset onto the balance sheet. This is based on certified work completed on the construction programme.

11. This is now in the final year as construction comes to an end this financial year with the final construction cost of £212.5m as per Table 4.

Table 4

<table>
<thead>
<tr>
<th>Financial Year Allocation</th>
<th>£'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15</td>
<td>27,600</td>
</tr>
<tr>
<td>2015/16</td>
<td>53,975</td>
</tr>
<tr>
<td>2016/17</td>
<td>104,510</td>
</tr>
<tr>
<td>2017/18</td>
<td>26,428</td>
</tr>
<tr>
<td><strong>Total NPD Addition</strong></td>
<td><strong>212,513</strong></td>
</tr>
</tbody>
</table>

Replacement Programme including Contingency

12. 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.

13. For 2017/18 given the priority of the new build the traditional replacement programme prioritisation is not going ahead and any replacements will be dealt with on a needs basis as they arise through a contingency of £541k being held.

14. A number of projects had already been approved previously to proceed and these continue to go ahead as per Table 5 below, the table also shows what contingency items have been committed do also:

Table 5

<table>
<thead>
<tr>
<th>Directorate</th>
<th>Item</th>
<th>Anticipated Expenditure £</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary and Community Care</td>
<td>Lochmaben Stroke and Rehab Unit</td>
<td>276,000</td>
</tr>
<tr>
<td>Acute &amp; Diagnostics</td>
<td>2 Field Analysers</td>
<td>72,000</td>
</tr>
<tr>
<td>Acute &amp; Diagnostics</td>
<td>4 Diagnostic sleep study sets</td>
<td>26,400</td>
</tr>
<tr>
<td>Acute &amp; Diagnostics</td>
<td>Ultrasound Echo Machine</td>
<td>11,753</td>
</tr>
<tr>
<td><strong>Replacement</strong></td>
<td></td>
<td><strong>386,153</strong></td>
</tr>
<tr>
<td>Acute &amp; Diagnostics</td>
<td>Biometer</td>
<td>36,365</td>
</tr>
<tr>
<td>Acute &amp; Diagnostics</td>
<td>Ventilator</td>
<td>14,000</td>
</tr>
<tr>
<td>Contingency balance</td>
<td></td>
<td>490,635</td>
</tr>
<tr>
<td><strong>Contingency</strong></td>
<td></td>
<td><strong>541,000</strong></td>
</tr>
</tbody>
</table>
Development Programme

15. 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 6 shows the schemes approved to proceed so far.

Table 6

<table>
<thead>
<tr>
<th>Directorate</th>
<th>Item</th>
<th>Anticipated Expenditure £</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ehealth</td>
<td>Critical Care system</td>
<td>184,000</td>
</tr>
<tr>
<td>Mental Health Directorate</td>
<td>Electronic Bedside Ordering</td>
<td>16,620</td>
</tr>
<tr>
<td>Operational Services</td>
<td>Bariatric Mortuary Trolley</td>
<td>12,010</td>
</tr>
<tr>
<td>Primary and Community Care</td>
<td>Communication Equipment</td>
<td></td>
</tr>
<tr>
<td>Primary and Community Care</td>
<td>SPLT</td>
<td>48,000</td>
</tr>
<tr>
<td>Ehealth</td>
<td>GP Digital Services</td>
<td>38,037</td>
</tr>
<tr>
<td>Development</td>
<td></td>
<td><strong>298,667</strong></td>
</tr>
</tbody>
</table>

Other programmes for which no budget allocated

Primary Care Premises

16. 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.

17. No budget has been set aside in 2017/18 for this.

Donated

18. Donated assets are not funded from within the Boards allocation. Donated assets are typically funded from League of Friends and the Boards Endowment Funds.
DUMFRIES and GALLOWAY NHS BOARD

7th August 2017

Financial Performance Update 2017/18 - Position to Month 3 – 30th June 2017

Author: Graham Stewart
Deputy Director of Finance

Sponsoring Director: Katy Lewis
Director of Finance

Date: 19th July 2017

RECOMMENDATION

The NHS Board is asked to note;
• The ongoing financial risks and challenges identified in the underlying financial position.
• The updated position on Efficiency Savings for 2017/18.
• The work ongoing to prepare a more detailed review of the quarter one position.
• The requirement to submit a revised Local Delivery Plan (LDP) to Scottish Government by 18th August 2017.
• Board workshop following the NHS Board meeting on 7th August.
• The Year to Date (YTD) position of £1.85m overspend against an LDP trajectory of £1.5m.

The continuing challenges on the delivery of the CRES target remains the focus of the Board in ensuring sustained recovery of the financial position.

It is essential to identify further improvements in delivery of additional efficiency schemes to ensure the outcome of a breakeven position.

Three key areas of focus for this delivery are;
• Sustained recovery in all areas 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.
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 June 2017, 3 months into the financial year.

Overall financial performance after the first 3 months of the year reports a £1.85m adverse variance to plan, mainly related to the current level of unidentified efficiency plans still to be resolved.

Cash Releasing Efficiency Savings (CRES) of £22.6m are required to be delivered in-year to deliver a break-even position. To date only £1.7m of schemes have been identified against a YTD target of £3.9m (43%), excluding any non-recurring support yet to be released.

GLOSSARY OF TERMS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRES</td>
<td>Cash Releasing Efficiency Savings</td>
</tr>
<tr>
<td>CRL</td>
<td>Capital Resource Limit</td>
</tr>
<tr>
<td>IJB</td>
<td>Integrated Joint Board</td>
</tr>
<tr>
<td>LDP</td>
<td>Local Delivery Plan</td>
</tr>
<tr>
<td>RRL</td>
<td>Revenue Resource Limit</td>
</tr>
<tr>
<td>YTD</td>
<td>Year to Date</td>
</tr>
</tbody>
</table>
## MONITORING FORM

<table>
<thead>
<tr>
<th>Policy/Strategy</th>
<th>Supports agreed financial strategy in Local Delivery Plan.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing Implications</td>
<td>Not required</td>
</tr>
<tr>
<td>Financial Implications</td>
<td>Financial reporting paper presented by Director of Finance as part of the financial planning and reporting cycle.</td>
</tr>
<tr>
<td>Consultation/Consideration</td>
<td>Board Management Team</td>
</tr>
<tr>
<td>Risk Assessment</td>
<td>Financial Risks included in paper</td>
</tr>
<tr>
<td>Sustainability</td>
<td>Financial Plan supports the sustainability agenda through the delivery of efficient solutions to the delivery of CRES. The current LDP submitted to SG in March has unidentified savings of £6m.</td>
</tr>
<tr>
<td>Compliance with Corporate Objectives</td>
<td>To maximise the benefit of the financial allocation by delivering efficient services, to ensure that we sustain and improve services and support the future model of services. To meet and where possible exceed Scottish Government goals and targets for NHS Scotland.</td>
</tr>
<tr>
<td>Single Outcome Agreement (SOA)</td>
<td>Not required</td>
</tr>
<tr>
<td>Best Value</td>
<td>This paper contributes to Best Value goals of sound governance, accountability, performance scrutiny and sound use of resources.</td>
</tr>
</tbody>
</table>

### Impact Assessment

A detailed impact assessment of individual efficiency schemes will be undertaken through this process as individual schemes are developed.
Summary Update 2017/18: YTD Position

1. NHS Dumfries and Galloway is reporting an overspend of £1.85m against the budget to date as at the end of June 2017.

2. The Board has received allocations to date of £315m, with £7.132m remaining as anticipated allocations. The focus by the Scottish Government is to issue the bulk of allocations within the first quarter but we will continue to follow up to ensure recovery of all funding due to the Board as part of the £7m outstanding. Of the additional £1.493m notified to support elective activity and waiting times, £0.4m is contingent on us demonstrating improvements in access. Further detail is provided in Appendix 1.

3. Table 1 below provides a high level summary of the income and expenditure position for the NHS Board showing the variance against plan for the first 3 months of the financial year;

<table>
<thead>
<tr>
<th>Summary Finance Position – Month 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Annual</strong></td>
</tr>
<tr>
<td>Budget</td>
</tr>
<tr>
<td>£000s</td>
</tr>
<tr>
<td>Pays</td>
</tr>
<tr>
<td>Non-pays</td>
</tr>
<tr>
<td>Drugs</td>
</tr>
<tr>
<td>Income</td>
</tr>
<tr>
<td>Unidentified CRES</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
</tbody>
</table>

4. As can be seen from the table above the key issue facing the Board Year to Date (YTD) relates to the level of unidentified CRES being held centrally as well as current levels of unidentified and unachieved CRES within the IJB delegated services. Further detail on the YTD position is included in Appendix 2.

5. The main variances within the £1.85m YTD adverse position is as follows;

- Pays – underspent by £734k, reflecting the level of vacancies across the service, most notably across Women and Children, PCCD and Corporate Directorates.

- Non-pays - £1,259k overspend, mainly relating to the level of unachieved and unidentified CRES allocated to Directorates.

- Drugs - £588k overspend, split primarily between Primary Care Prescribing (£453k) and Secondary Care (£105k). This reflects the level of unachieved and unidentified Prescribing CRES schemes to date.
6. The current summary position on the achievement of CRES targets is highlighted in table 2 below;

Table 2

<table>
<thead>
<tr>
<th></th>
<th>Total 17-18 Target £000</th>
<th>Total 17-18 Schemes £000</th>
<th>In Year 17-18 CRES Gap £000</th>
<th>17-18 Recurring CRES Gap £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>IJB Delegated Services</td>
<td>15,214</td>
<td>10,089</td>
<td>(5,125)</td>
<td>(8,569)</td>
</tr>
<tr>
<td>NHS Board Services</td>
<td>7,421</td>
<td>6,485</td>
<td>(935)</td>
<td>(1,703)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>22,635</strong></td>
<td><strong>16,574</strong></td>
<td><strong>(6,060)</strong></td>
<td><strong>(10,272)</strong></td>
</tr>
</tbody>
</table>

Efficiency Savings

7. As identified above there is currently a significant level of unidentified CRES outstanding as at month 3. A combined IJB CRES target of £2.5m is being held centrally, reflecting the level of CRES not currently delegated to individual services across the IJB. This is linked with the property strategy and realistic medicines targets identified as part of the CRES planning. Some work has progressed on these, which is not reflected in achievement to date.

8. The Corporate CRES target of £1,000k is being held centrally, with £557k identified to date against this target which is an improvement on month 2 position. Corporate areas continue to identify and develop their CRES ideas associated with the overall Corporate target, as part of the quarter one process.

9. The remaining CRES targets have been devolved to each Directorate and have either been identified and removed from budget or form part of the YTD variance within Non-pays.

10. The combined YTD variance on CRES across both unidentified and unachieved stands at £2.2m, with a detailed breakdown by Directorate provided in Appendix 3.

11. The current forecast gap on 2017/18 CRES is £6m, which includes overall non-recurring corporate support of £6.2m, leaving a recurring gap of £10.2m.

12. Within the overall level of CRES identified, 77% are classified as high risk, with 5% medium risk and 18% low risk.

13. Currently the in-year gap of £6m accounts for 27% of the total CRES target.
Key Actions and Recommendations

14. To date there is only April’s actual data for Primary Care Prescribing and an estimate for May’s volume which has been factored into the position. The level of unidentified CRES remains the key challenge to delivering a balanced position within prescribing as a whole. The position has worsened since month 2 given a reassessment of deliverability of prescribing savings. This still remains a prudent position, highlighting the risks associated with achieving all plans in full.

15. Significant work remains across the organisation in order to identify and progress plans that will create further opportunities to release additional savings in-year.

16. Whilst the Local Delivery Plan submitted in March recognises a £6m gap overall, there are still a significant level of savings plans that are yet to be confirmed as achieving, despite being included as an identified scheme.

17. The YTD 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.

Financial Plan 2017/18

18. The LDP submitted by Dumfries and Galloway Health Board (confirming the level of NHS delegated budgets to the IJB) demonstrated an ongoing financial gap of £6m.

19. 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.

20. Ongoing work is looking at other measures that are required to be implemented within the financial year to ensure the remaining £6m gap is closed further.

21. Workshops and ongoing Budget Scrutiny Meetings have been organised to review current workstreams across all Directorates to identify further efficiencies that need to be made in order to deliver a break-even position.

22. A revised LDP has been requested to be submitted to the Scottish Government by 18th August, detailing an update on the progress made by the Board in relation to the sustainability and value programme, based upon the Quarter one position.

Financial Risks

23. 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 £6m gap.
• Assessment of the increasing requirement and impact of medical temporary staffing across all sites and services.
• 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.

24. It is envisaged that given the increase in medical staffing vacancies during 17/18 this will impact on the adequacy of our locum reserve, despite the savings envisaged through the implementation of Retinue.

Key Actions and Recommendations

25. A workshop is planned in August to review the Quarter one position as a whole and provide an in-depth analysis of the key issues and their scale forecasted to the end of the financial year.

26. Budget Scrutiny Meetings are scheduled for August to undertake a detailed assessment of the quarter one position, with the Director of Finance and the Chief Operating Officer.

27. Whilst plans continue to be developed across all services, there remains a significant level of work to be undertaken to close the £6m gap as reported to the Scottish Government. This is being progressed by the senior finance team through the quarter one review process.

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), now has the Project Manager in place and are working through the initial areas identified by Finance and Health Intelligence. This group will be supported by Health Intelligence and Finance Teams to identify potential areas of opportunity to reduce clinical variation, where appropriate and necessary. A conference has been organised for September and a detailed report is being prepared for update at September Performance Committee.

Conclusion

30. A significant level of further work is required across the Integration Joint Board and Corporate Directorates to develop recovery plans and further levels of savings in-year in order for the Quarter one position review to consider a reduction on the current gap of £6m, as reported to the Scottish Government.

31. A more detailed report based upon the Quarter one position will be brought to the September Performance Committee.
## Revenue Allocation as at 31st May 2017

### Bundles
- Outcomes Framework: £3,758
- Mental Health Bundle: £354
- PMS Bundle Part 2: Direct Enhanced Services (DES): £482
- PMS Bundle Part 2: Scottish Enhanced Services Programme (SESP): £384
- PMS Bundle Part 1: Primary Medical Services Bundle: £22,591

### Other
- Access Support Funding 2017-18: £1,120
- Cancer Improvement Plan Access Support: £85
- CGM Insulin Pumps: £42
- Community Pharmacy Practitioner Champions: £9
- GP Digital Services Fund: £33
- NSD Risk Share Adult Bone Marrow: £1,120
- NSD Risk Share Chest Wall Deformity: £5
- NSD Risk Share Deep Brain Stimulation: £47
- NSD Risk Share Renal transplant: £5
- NSD Risk Share Selective Dorsal Rhizotomy: £4
- Open University Pre-Reg Nursing Education Programme: £27
- Orthopaedics Access Support: £107
- Primary Care Funding Pharmacists in GP Practices: £221
- Public Dental Service (Salaried) GDS Costs: £1,183
- Sustainability Awareness Campaign: £3
- Veterans/carers: £210

### Total Allocations
<table>
<thead>
<tr>
<th>Baseline Recurring £000s</th>
<th>Earmarked Recurring £000s</th>
<th>Non Recurring £000s</th>
<th>Non Core £000s</th>
<th>Total £000s</th>
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</thead>
<tbody>
<tr>
<td>284,830</td>
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<td>0</td>
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<td>284,830</td>
</tr>
</tbody>
</table>

## Revenue Allocation as at 30th June 2017

### Bundles
- Outcomes Framework: £3,758
- Mental Health Bundle: £354
- PMS Bundle Part 2: Direct Enhanced Services (DES): £482
- PMS Bundle Part 2: Scottish Enhanced Services Programme (SESP): £384
- PMS Bundle Part 1: Primary Medical Services Bundle: £22,591

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### Total Allocations
<table>
<thead>
<tr>
<th>Baseline Recurring £000s</th>
<th>Earmarked Recurring £000s</th>
<th>Non Recurring £000s</th>
<th>Non Core £000s</th>
<th>Total £000s</th>
</tr>
</thead>
<tbody>
<tr>
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## Anticipated Allocations
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<th>Earmarked Recurring £000s</th>
<th>Non Recurring £000s</th>
<th>Non Core £000s</th>
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<td>1,393</td>
<td>6,906</td>
<td>7,132</td>
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</table>

## Total Revenue Allocation (excl FHS)

<table>
<thead>
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<th>Baseline Recurring £000s</th>
<th>Earmarked Recurring £000s</th>
<th>Non Recurring £000s</th>
<th>Non Core £000s</th>
<th>Total £000s</th>
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</thead>
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<tr>
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<td>2,938</td>
<td>27,653</td>
<td>6,906</td>
<td>322,481</td>
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</tbody>
</table>

## Family Health Services Non Discretionary Allocation
15,485

## Total Revenue Allocation (incl FHS)
337,966
### Appendix 2

**NHS DUMFRIES AND GALLOWAY**

**EXPENDITURE ANALYSIS - 3 MONTHS TO 31ST JUNE 2017**

<table>
<thead>
<tr>
<th>AREA</th>
<th>Pay £000's</th>
<th>Non Pay £000's</th>
<th>Income £000's</th>
<th>Total £000's</th>
<th>Budget £000's</th>
<th>Actual £000's</th>
<th>Variance £000's</th>
<th>Budget £000's</th>
<th>Actual £000's</th>
<th>Variance £000's</th>
<th>Budget £000's</th>
<th>Actual £000's</th>
<th>Variance £000's</th>
<th>Variance £000's</th>
<th>Variance %</th>
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<tbody>
<tr>
<td><strong>IJB DELEGATED SERVICES</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Acute &amp; Diagnostics</td>
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<td>100,230</td>
<td>19,617</td>
<td>19,619</td>
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<td>6,176</td>
<td>6,577</td>
<td>(401)</td>
<td>(367)</td>
<td>(345)</td>
<td>(22)</td>
<td>(25,425)</td>
<td>(25,851)</td>
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<td></td>
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<td>0</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Facilities &amp; Clinical Support</td>
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<td>9,948</td>
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<td>895</td>
<td>799</td>
<td>96</td>
<td>2,307</td>
<td>2,485</td>
<td>(178)</td>
<td>(396)</td>
<td>(364)</td>
<td>(33)</td>
<td>(2,804)</td>
<td>(2,919)</td>
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<td>4,755</td>
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<td>(189)</td>
<td>(190)</td>
<td>0</td>
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<td>6,723</td>
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<td>17,151</td>
<td>17,891</td>
<td>(740)</td>
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<td>(1,169)</td>
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<td>23,019</td>
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<td>Womens &amp; Childrens Directorate</td>
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<td>4,694</td>
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<td>205</td>
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<td>(208)</td>
<td>(202)</td>
<td>(202)</td>
<td>0</td>
<td>4,910</td>
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<td>E Health</td>
<td>2,644</td>
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<td>5,740</td>
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<td>613</td>
<td>53</td>
<td>514</td>
<td>612</td>
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<td>(24)</td>
<td>(13)</td>
<td>(12)</td>
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<td>(625)</td>
<td>(625)</td>
</tr>
<tr>
<td><strong>IJB SERVICES TOTAL</strong></td>
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<td>31,477</td>
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<td>(2,343)</td>
<td>(2,303)</td>
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<td>64,910</td>
<td>66,518</td>
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<td><strong>BOARD SERVICES</strong></td>
<td></td>
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<td></td>
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<td>555</td>
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<td>(44)</td>
<td>(44)</td>
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<td>559</td>
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<td>(79)</td>
<td>(74)</td>
<td>(4)</td>
<td>481</td>
<td>490</td>
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<td>720</td>
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<tr>
<td>Non Recurring Projects</td>
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<td>13</td>
<td>40</td>
<td>(27)</td>
<td>63</td>
<td>39</td>
<td>24</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>75</td>
<td>79</td>
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<td>21</td>
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<td>0</td>
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<td>(759)</td>
<td>(759)</td>
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<td>(443)</td>
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<td>0</td>
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<td>0</td>
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<td>38,050</td>
<td>37,345</td>
<td>705</td>
<td>29,203</td>
<td>31,477</td>
<td>(2,273)</td>
<td>(2,343)</td>
<td>(2,303)</td>
<td>(40)</td>
<td>64,910</td>
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<td><strong>NON CORE &amp; RESERVES TOTAL</strong></td>
<td>1,533</td>
<td>53,659</td>
<td>0</td>
<td>55,192</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1,080</td>
<td>1,081</td>
<td>(0)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1,080</td>
<td>1,081</td>
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<td><strong>GRAND TOTAL</strong></td>
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<td>357,389</td>
<td>42,014</td>
<td>41,281</td>
<td>734</td>
<td>37,458</td>
<td>40,041</td>
<td>(2,582)</td>
<td>(4,587)</td>
<td>(4,589)</td>
<td>2</td>
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**Note:** Variance values are calculated as the difference between the budget and actual figures, and are represented as both an absolute value and a percentage of the budget.
## Recurring

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Recurring 17-18 Target £000</th>
<th>NR 17-18 Target £000</th>
<th>Total 17-18 Target £000</th>
<th>YTD Planned Savings £000</th>
<th>YTD Actual Savings £000</th>
<th>Scheme Variance YTD £000</th>
<th>17-18 Recurring Schemes £000</th>
<th>NR 17-18 Schemes £000</th>
<th>Total 17-18 Schemes £000</th>
<th>In Year 17-18 CRES Gap £000</th>
<th>17-18 Recurring CRES Gap £000</th>
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<td>Acute and Diagnostics</td>
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<td>3,139</td>
<td>816</td>
<td>659</td>
<td>(157)</td>
<td>441</td>
<td>2,071</td>
<td>2,512</td>
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<td>Facilities and Clinical Support</td>
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<td>779</td>
<td>195</td>
<td>30</td>
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<td>529</td>
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<td>529</td>
<td>(1,108)</td>
<td>(1,108)</td>
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<tr>
<td>Women and Children's Directorate</td>
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<td>276</td>
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<td>329</td>
<td>67</td>
<td>16</td>
<td>(52)</td>
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<td>3,023</td>
<td>523</td>
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<td>5,094</td>
<td>10,089</td>
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### Board Services

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<thead>
<tr>
<th>Scheme</th>
<th>Recurring 17-18 Target £000</th>
<th>NR 17-18 Target £000</th>
<th>Total 17-18 Target £000</th>
<th>YTD Planned Savings £000</th>
<th>YTD Actual Savings £000</th>
<th>Scheme Variance YTD £000</th>
<th>17-18 Recurring Schemes £000</th>
<th>NR 17-18 Schemes £000</th>
<th>Total 17-18 Schemes £000</th>
<th>In Year 17-18 CRES Gap £000</th>
<th>17-18 Recurring CRES Gap £000</th>
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<tr>
<td>External's</td>
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<td>1,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
<td>0</td>
<td>(1,000)</td>
<td>(1,000)</td>
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<td>Corporate CRES</td>
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<td>557</td>
<td>(443)</td>
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<td>50</td>
<td>0</td>
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<td>2,200</td>
<td>285</td>
<td>174</td>
<td>(111)</td>
<td>497</td>
<td>260</td>
<td>757</td>
<td>(1,443)</td>
<td>(1,703)</td>
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</table>

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Recurring 17-18 Target £000</th>
<th>NR 17-18 Target £000</th>
<th>Total 17-18 Target £000</th>
<th>YTD Planned Savings £000</th>
<th>YTD Actual Savings £000</th>
<th>Scheme Variance YTD £000</th>
<th>17-18 Recurring Schemes £000</th>
<th>NR 17-18 Schemes £000</th>
<th>Total 17-18 Schemes £000</th>
<th>In Year 17-18 CRES Gap £000</th>
<th>17-18 Recurring CRES Gap £000</th>
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<td>5,728</td>
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<td>0</td>
<td>5,728</td>
<td>5,728</td>
<td>507</td>
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<tr>
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<td>22,635</td>
<td>3,942</td>
<td>1,694</td>
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<td>11,082</td>
<td>16,575</td>
<td>(6,060)</td>
<td>(10,272)</td>
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### Risk Profile of Identified Schemes

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<tr>
<th>Category</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>High</td>
<td>76.71%</td>
</tr>
<tr>
<td>Medium</td>
<td>5.31%</td>
</tr>
<tr>
<td>Low</td>
<td>17.98%</td>
</tr>
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</table>
DUMFRIES and GALLOWAY NHS BOARD

7th August 2017

Tobacco Control:- One year on

Author: Trish Grierson
Tobacco Control Lead/Service Manager

Sponsoring Director: Michele McCoy
Interim Director of Public Health

Date: 28th July 2017

RECOMMENDATION

The NHS Board is asked to:

- Note progress in implementing the NHS Dumfries and Galloway three year Tobacco Control Action Plan (agreed in August 2016).

- Note areas of work where progress remains challenging, particularly with regard to meeting the target set for smoking cessation services.

- Note that along with the wider context of tobacco prevention and control our future plans remain focussed in trying also to address the target for smoking cessation services.

CONTEXT

The health service spends annually a minimum of £300m on treating tobacco related illnesses. Scotland, overall, has been making great progress in reducing the harm caused by tobacco, for example, the percentage of the population being described as smokers has reduced from 31% in 1999 compared with 20% in 2014. Smoking related deaths have also reduced in that time period from 13,000 annually to under 10,000. It would appear that local and national investment in the development of smoking cessation services along with the legislative and control measures taken have a cumulative effect of driving down smoking levels generally, including in areas of deprivation.

The Scottish Governments national strategy “Creating A Tobacco Free Generation” is due to be revised and updated in 2018. Tobacco control remains an important public health measure in improving health, and can contribute to health inequalities.
Organisational Context / Dumfries & Galloway

Along with a Local Delivery Plan (LDP) target (previously HEAT target) for smoking cessation, NHS Boards have been tasked with ensuring that a local Tobacco Control Action plan is agreed and that this plan should reflect a shared aspiration for a smoke free region and nation. This work needs strong support from leaders across the NHS, Dumfries & Galloway Council and Health and Social Care.

Why is this paper important

In Dumfries and Galloway the annual costs of treating smoking related illnesses is £15-20m. Smoking is the primary preventable cause of premature death and is one of the major causes of health inequalities.

Key messages

If population health is to be improved along with a reduction in health inequalities, investment in activities to prevent the uptake of smoking as well as provide smoking cessation support must continue. The locally agreed action plan addresses this need.

GLOSSARY OF TERMS

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
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<tbody>
<tr>
<td>LDP</td>
<td>Local Delivery Plan</td>
</tr>
<tr>
<td>HEAT</td>
<td>Health Improvement, Efficiency, Access to treatment, Treatment</td>
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### MONITORING FORM

<table>
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</thead>
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<tr>
<td>Staffing Implications</td>
<td>This action plan creates no additional staffing resource however service re-design may have implications on staff roles and responsibilities</td>
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<tr>
<td>Financial Implications</td>
<td>There are no financial implications identified.</td>
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<tr>
<td>Consultation / Consideration</td>
<td>Consultation has taken place with a wide number of partner organisations, colleagues within the NHS, Smoking Matters Team, NHS Pharmacy services and Locality teams.</td>
</tr>
<tr>
<td>Risk Assessment</td>
<td>No formal risk assessment has been carried out in certain actions risk is identified in service documentation for example HEAT target risk</td>
</tr>
<tr>
<td>Sustainability</td>
<td>In writing this plan consideration has been given to ensure the long term sustainability of programmes of work whilst also being as efficient and effective as possible.</td>
</tr>
<tr>
<td>Compliance with Corporate Objectives</td>
<td>All of the organisational objectives are bedded into this plan, with a special focus on items 1, 3, 5 and 6</td>
</tr>
<tr>
<td>Single Outcome Agreement (SOA)</td>
<td>Not applicable</td>
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<tr>
<td>Best Value</td>
<td>All Best value themes are implied through the plan with a special focus on Effective partnerships, Use of resources and Sustainability</td>
</tr>
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**Impact Assessment**

A quality impact assessment has been carried out on the national Tobacco Control Strategy for Scotland.
The Dumfries and Galloway Tobacco Control Action Plan was approved by the NHS Board in August 2016 (see Appendix A for the complete list of actions). Since then most of the 27 agreed actions have been progressed and where this has not been the case this has been noted. Appendix B provides a brief summary of the status of each action. There has been particular success with the following actions:

- **Action 4.** Identify organisations who deliver services for Looked After and Accommodated Children and Youth Justice and work in partnership to deliver smoke-free approach as part of a wider programme to reduce risk taking behaviour

- **Action 5.** Address high levels of smoking in the 16-24 age group, particularly those from most deprived backgrounds

- **Action 6.** Work in partnership to reduce the availability of illicit tobacco

- **Action 8.** Undertake a pilot of ASSIST in Partnership with NHS Ayrshire & Arran and running in conjunction with the national pilot programmes in three other Health Boards (ASSIST is a peer led smoking cessation programme currently being trialled by the Scottish Government in three Boards in Scotland)

- **Action 10.** Advice on creating a smoke-free home should be a feature of all ante- and post-natal services and adoption, foster, kinship and residential care services

- **Action 11.** We will ensure that advice to reduce exposure to second hand smoke as well as cessation advice and support, is fully incorporated in the range of services offered as part of the universal health visitors pathway in Scotland

- **Action 20.** The Maternity Care Quality Improvement Collaborative will combine a focus on improving the public health role of maternity services alongside improvements in clinical care. Its aim is to improve inequalities in outcomes in maternity settings in Scotland. This also includes measures to improve the numbers of women who are engaged and improvements in the clinical management of risks for women who smoke

- **Action 21.** NHS Boards should develop systems and provide training to ensure clear and effective care pathways for smoking in pregnancy in line with current guidance

- **Action 22.** As part of the wider monitoring framework for the Health Promoting Health Service, the Scottish Government, NHS Health Scotland and NHS Boards will ensure progress in improving the level of support on managing temporary abstinence in acute setting across NHS Scotland
In the last year there have been some challenges in progressing Actions 1 and 2 as they both require staff to take them forward and this resource still has to be identified. Action 13 which seeks to create a smoke free prison is still to be progressed.

It is important to note with the Board that action number 27 is the Local Delivery Plan target (LDP) is to sustain and embed successful smoking quits at 12 weeks post quit in the 40% SIMD areas. In Dumfries & Galloway our target number for 2016/17 is 230 successful quits at 3 months post first quit and it is expected that we will only achieve 65%-70% of this target (final data will be released by ISD in October 2017)

There are a number of possible reasons for why the smoking cessation service is under achievement in meeting the LDP target. These include:

- Over the past 5 years and across Scotland there has been a year on year drop in the numbers of smokers using specialist services, and the pattern in Dumfries & Galloway is similar with a reduced number of referrals being made to stop smoking services. To meet the target, smoking cessation specialist services (Smoking Matters, Community Pharmacies and SPS) require a set number of referrals from various routes. A sampling of GP practice referrals indicates a drop by 50% in referral numbers in 9 out of 14 practices (over a three year period) and in the remaining 5 practices there has also been a drop in numbers, but not so significant.

- In terms of stopping smoking the profile of a smoker has altered significantly in recent years. Smokers going through a quit programme today often require more intensive support to achieve success in stopping smoking. Smokers may be more addicted and have more complex medical needs resulting in a more intensive intervention.

- The availability of E-cigarettes has had a role in helping some smokers to stop smoking, but more smokers use them in combination with the use of traditional tobacco products. Smokers may use this product as a replacement product to cigarette smoking in places where you are unable to smoke cigarettes.

- The performance and outcomes of each stop smoking service in Dumfries and Galloway (Prison services, Community Pharmacies and Smoking Matters) varies considerably between services. Given that the numbers of smokers accessing services are reduced and particularly in areas of deprivation it has become increasingly important that every opportunity is taken to encourage smokers to quit. Every effort is being made to ensure that the standard of each supported quit attempt is of the highest quality in every circumstance. However the NHS specialist service by comparison to a small number of community pharmacies (in key areas), has much higher quit rates, and so the overall performance against our target is compromised through a lack of consistency in all areas of service delivery.
To address this challenge the following actions from the agreed plan are key:

- Action 4 - Increase referrals from agencies working with 'looked after and accommodated children
- Action 10 and 11 - Increase referrals through Second hand smoke programme
- Action 12 - Support prison services in their role in smoking cessation
- Action 17 - Implement all quality and improvement measures
- Action 19 - Improve to a consistent level across the region community pharmacy stop smoking performance
- Action 20 and 21 - Improve access and update of pregnant women who smoke
- Action 22 - Increase profile and referral numbers in the acute setting
- Action 23 - Increase referral pathways through Health and Social Care

In conclusion, progress on implementing the agreed action plan continues in partnership to support individual behaviour change and create smoke free environments.
Appendix A

Tobacco Action Plan

“Let’s be Tobacco Free”

(2016-2019)
Introduction

Since our last Tobacco Control Strategy in Dumfries & Galloway there has been a number of developments, and the most important of these is that all our efforts collectively (in Scotland and locally), are making a difference. The number of smokers in Scotland has reduced significantly from 31% in 1999 to 20% in 2014. Added to this, recently published data (ISD 2016) shows that tobacco related deaths in Scotland are reducing. These results demonstrate clearly that our joint strategic and local efforts in Tobacco Control are making an important difference, as smokers themselves are choosing to take the single most important step to improve their health, by stopping smoking.

It is now time to build on this success and plan for the future. Unless we address tobacco on all fronts, smoking will continue to affect those who are most vulnerable in our society, this cannot be acceptable. We have the skills and expertise to make a difference and this plan has been written to move forward with an even greater need to reduce the harm caused by tobacco in a collective and shared way.

The Strategic context - Scottish Government

As set out in the Tobacco Control Strategy for Scotland (2013) “Creating a Tobacco Free Generation, The Scottish Government has an ambition that by 2034 only 5% or less of the population will be smokers. To take this forward the Scottish Government has set out a total of 46 actions on how we can all contribute to achieving a smoke free nation. In Dumfries & Galloway we share this vision and this plan states how we can at a local level show our commitment and effort to making this region smoke free.

In order to achieve a smoke free nation we need to ensure that we are putting in place good evidenced measures that have proven outcomes. Typically this includes Prevention (e.g. reducing the number of young people starting to smoke through educational programmes) Protection & Control (e.g. protecting the vulnerable from exposure to Second Hand Smoke as well as restricting access to cigarettes/nicotine based products) and Cessation (having funded stop smoking services to help more smokers stop smoking). It is important and evidence tells us that a combined approach in tobacco control will have the greatest effect in reducing the uptake and prevalence of smoking.
The first recommendation from the Scottish Government’s “Creating a Tobacco Free Generation” (2013) states:

“Local Authorities and NHS Boards should work with partners in the voluntary sector and local communities to develop a local tobacco action plan for the region and these plans should be integrated with wider health improvement activity to help Community Planning partnerships reduce health inequalities as set out in the single outcome agreement 2013 this should be integrated with wider health improvement activity to help community planning partnerships reduce health inequalities.”

Inequalities and Tobacco

“The combination of the greatly increased mortality of smokers with the now much lower prevalence of smoking among the more affluent is the major contribution to the widening health inequalities observed in the UK”

(Gruer et al, Paisley study 2009)

Smoking is not the only cause of health inequalities, but is a significant contributor.

This study concludes that being a smoker and living in the most affluent area, your health outcomes are significantly worse than being a non-smoker and living in a deprived area. Therefore smoking itself was a greater source of health inequality than social position and when put into the context of social deprivation the effects of being a smoker and living in socially deprived circumstances has serious health and social consequences.

Ongoing smoking is also a significant risk factor that is strongly linked to many diseases and long-term conditions.

Our aim in this plan is to co-ordinate all tobacco related work, communicate this widely, and create an interest and commitment to joining together to making tobacco use unattractive, and this is particularly important if we are to address the “hugely disproportionate effect” smoking has on individual health.
In Dumfries & Galloway

We have an established Tobacco Control Alliance and as an alliance we support “Scotland’s Charter for a Tobacco Free Generation” and we invite all other organisations, community groups, businesses and individuals in Dumfries & Galloway to join us and sign up to the ASH Scotland Charter.

The Scottish Government has listed 46 areas of action that require to be taken, some of these are actions will be taken forward at a strategic level. All our actions at a local level are itemised in the plan. The areas of work we are focussing on are where we know there are proven benefits, along with areas of work that must be addressed locally (e.g. high levels of smoking in pregnancy) and we have added innovative approaches in prevention to test out peer led interventions. For the complete list of actions that will be undertaken (46) please refer to Creating a Tobacco Free Generation (pages 40-44)

Our priority groups of smokers are:-

- Families with children
- People experiencing mental ill health, chronic physical illness and long term conditions
- People living in harder to reach or more deprived communities
- People who are in hospital
- Pregnant women and their partners
- Prison populations
- Our staff
- Young people
Abbreviations used:-
ASSIST - The DECIPHER-ASSIST programme (ASSIST) is a peer led intervention for young people in secondary education  
CO - Carbon Monoxide  
CP - Community Pharmacy Services  
GIRFEC - Getting It Right for Every Child  
MCN - Managed Clinical Network  
PHP - Public Health Practitioner  
REFRESH - Reducing Families Exposure to Second-Hand Smoke in the Home  
SMS - Smoking Matters Service  
SALSUS - The Scottish Schools Adolescent Lifestyle and Substance Use Survey  
SHS - Second Hand Smoke

NB this plan uses Tobacco free and Smoke free. To explain further, A definition of Tobacco Free includes the following - maintain and continue to enforce our Tobacco legislation, Reduce exposure to Second Hand Smoke (SHS) and provide and deliver specialist stop smoking support and a definition of Smoke-free – is reducing or eliminating the behaviour of smoking on various sites, e.g. making smoking less visible.
People who have helped produce this plan and have agreed to be part of a local Tobacco Control Alliance

Elkie Astley (D&G Council/HR Business Partner)
Jackie Davies (NHS D&G/Acohol Services Co-ordinator)
Greg Douglas D&G Council/Service Manager Environmental Standards
Sandra Harkness D&G Council/Service Manager, Trading Standards
Scott Jardine (Police Scotland)
Karen King (NHS D&G/Consultant Midwife)
Veronica King (NHS D&G Health & Wellbeing Specialist)
Sue Lindsay (D&G Council/Environmental Standards)
Phil Myers (NHS D&G/Health & Wellbeing Specialist)
Sheelagh Rusby (D&G Council/Education Officer)
Martin Taylor (D&G Council/Environmental Standards)
Smoking Matters Service/Staff (NHS D&G)
Catherine Smith (NHS D&G/Pharmacy Services Development Manager)
Sharon Walker (NHS D&G/Public Health Practitioner)

ASH Scotland have kindly helped with content and longer term support in taking work forward

Along with the Alliance the Public Health Directorate has endorsed this plan

Useful websites and sources of information on Tobacco
www.ashscotland.org.uk
www.canstopsmoking.com
www.healthscotland.com
www.nhsinform.co.uk
www.smokingmatters.scot.nhs.uk

If you would like more information locally please contact:-
Smoking Matters Service

e- dgsmokingmatters@nhs.net       t- 0845 602 6861
Understanding how this plan is set out

In the following pages actions have been grouped into

**Prevention, Protection & Cessation**

and there is an underlying assumption that within each action tackling inequalities in relation to tobacco is central to this work and so our approach is target our work.
### Prevention

<table>
<thead>
<tr>
<th>Actions</th>
<th>Outputs (Evidence of measures that the action is being put into place)</th>
<th>Timescales &amp; Progress</th>
<th>Outcome measures (Short/Medium term/long term)</th>
<th>Lead and partners</th>
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</table>
| 1. Implement a tobacco policy for all secondary schools in the region  | A working group established and two secondary schools selected to pilot                                                          | Start August 2016     | An effective policy in place that all parties involved with the school are in agreement                        | Stranraer Academy/ SMS/Dumfries High School  
ASH Scotland |
<p>|                                                                        | Use the ASH Scotland/GG&amp;C schools policy template                                                                               |                       | No smoking or e-cigarette use on all secondary school sites                                                 |                                          |
|                                                                        | This work will cross reference to ongoing work in education (action 2 and 8)                                                     |                       | A reduction in young peoples smoking (SALSUS substance use survey)                                          |                                          |</p>
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<td>2. Deliver across the region targeted programmes of the tobacco element of health improvement programmes within Curriculum for Excellence. Ensure these programmes interlink with other preventative substance use work in the educational setting. Ensure engagement of young people in the development of tobacco programmes.</td>
<td>A dedicated staffing resource to lead in delivering smoking prevention. Tobacco Prevention activities designed for key stages in Nursery, Primary &amp; Secondary Education with discussion and testing with young people. Working together with partners in delivery e.g. pupil and staff planning groups.</td>
<td>Currently in place and planned to continue delivery over lifetime of action plan with annual review &amp; involvement of young people in revision of materials used.</td>
<td>Young peoples Representation in tobacco programme developments. Increased profile of tobacco in all sectors of education. Effective and exciting programmes of work for young people. Reduction in prevalence of smoking in Children &amp; Young People (SALSUS substance use survey).</td>
<td>D&amp;G Council Education/NHS D&amp;G Smoking Matters Service (SMS).</td>
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<td>3. Work with other Services (e.g. Drug &amp; Alcohol Services) to contribute to a broader programme of educational programmes that addresses risky/addictive behaviour in young people.</td>
<td>Pilot a joined up approach between alcohol/tobacco Drugs in education. A working group to take forward the above and agree a project over a agreed time</td>
<td>2016 onwards group established funding being pursued and evaluate 2017</td>
<td>Evidence of effective joined up work through all substance use delivery programmes</td>
<td>NHS D&amp;G - SMS/ Drug &amp; Alcohol Services/Public Health Practitioners</td>
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<td>An overall reduction in smoking/alcohol and drug use (SALSUS Substance use survey)</td>
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| 4. Identify all organisations who deliver services for children (Looked After & Accommodated Children-LAAC, Youth Justice) and work in Partnership to deliver Smoke-free approach as part of a wider programme to reduce risk taking behaviour. | Identify all residential units and homes for looked after children in D&G  
Staffing resource identified to take forward Greater Glasgow & Clyde & ASH Scotland policy  
Ensure this work is linked to other health improving work in this setting | Currently being progressed (2015-onwards)                     | Evidence of Tobacco Policy adopted in different units  
Increased Uptake of Stop Smoking services by young people  
Raised knowledge of Smoke free  
Reduction in smoking on grounds for staff and young people | NHS D&G SMS & individual organisations                               |
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| 5. Address high levels of smoking in 16-24 age group particularly those from most deprived backgrounds | Devise a specific working group and action plan for 16-24 year olds (including 16-24 year olds in the plan)  
Seek partners in further Education and youth groups  
Review materials & resources provided and tobacco control component being delivered | 2016 onwards | Targeted partnership group established  
New resource packages being used for key groups of smokers  
Engagement of young people in stop smoking services (ISD reports)  
Reduction in prevalence of smoking in 16-24 age group (Scottish Household Reports) | D&G Council Education/ Youth work/ NHS D&G SMS |
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<td>6. Work in partnership to reduce the availability of illicit tobacco.</td>
<td>Share intelligence with partner agencies on alleged suppliers of illicit tobacco and monitor online trading sites (including social media) for the sale of tobacco. Use the sniffer dog to uncover hidden stores of tobacco.</td>
<td>Targeted enforcement plan has taken place. The dog has been used successfully at the ports (Cairnryan) and in premises near Dumfries. This provided an excellent consumer education opportunity stimulated by media interest and this will be repeated.</td>
<td>Initially more stores of illicit tobacco seized. Increased awareness and knowledge of the risks associated with the use of illicit tobacco in with all partner agencies. Reduction in the use of illicit tobacco.</td>
<td>D&amp;G Council Trading Standards/ Education/Police Scotland/NHS D&amp;G SMS</td>
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<td>7. Ensure the effective implementation of the Enhanced Tobacco Sales Programme and work with a local tobacco alliance to increase knowledge and understanding of tobacco laws and how this fits within a wider tobacco control programme of work for the region.</td>
<td>Check that local retailers are registered to sell tobacco. Test purchase tobacco using an underage test purchaser Inspect retailers to ensure that they have implemented the tobacco display ban</td>
<td>Currently in place &amp; 20% of registered retailers receive business advice every year Test purchase at 10% of tobacco retailers annually</td>
<td>Increased levels of compliance with age restricted sales legislation Increased knowledge of young people in school setting of Tobacco programmes</td>
<td>D&amp;G Council Trading Standards/Police Scotland/SMS &amp; Education</td>
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| 8. Undertake a pilot of ASSIST in Partnership with NHS Ayrshire & Arran running in conjunction with the national pilots. (ASSIST is a peer led smoking cessation programme currently being trialled by the Scottish Government in three Boards in Scotland at present) | Appointment of a co-ordinator within SMS  
Over a three year period implementation in all 16 secondary schools  
Training & protected time for staff to take forward  
Appropriate funding required annually and approval in place  
An internal report to be produced alongside the national evaluation by Scottish Government | Training delivery to be prioritised in key areas commencing 2016 (for a 3 year Period)  
Increase secondary school uptake in years 2 & 3 | Final year (2018) Provide an evaluation of the programme and of the partnership  
Seek agreement nationally and locally the continuation of programme  
Reduction in prevalence of smoking in Children SALSUS Local reports | D&G Council Education/NHS D&G  
SMS Service/ NHS Ayrshire & Arran |
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<td>9. Sign up our organisation to Scotland’s Charter for a tobacco free</td>
<td>Seek senior commitment to the charter</td>
<td>Work on the Charter starting June 2016 and</td>
<td>Organisational understanding and commitment to the principles of the Charter</td>
<td>NHS D&amp;G / SMS/D&amp;G Council Education/ASH</td>
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<td>generation and encourage and work with other organisation to do similar</td>
<td>Promote through various means the value of the Charter</td>
<td>ongoing</td>
<td>other than specialist services/organisations and other services adopting the Charter</td>
<td>Scotland/Private Nursery Education/Businesses etc</td>
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<td>Integrate into existing programmes of work and giving the Charter as the important theme</td>
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<td>Reduction in smoking/Second Hand smoke around young people/children</td>
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### Actions

10. Advice on creating a Smoke Free home should be a feature of all ante- and post-natal services and adoption, foster, kinship and residential care services. Therefore, in keeping with GIRFEC principles, service providers should ensure that practitioners have access to appropriate resources to support families to make their homes smoke-free.

### Outputs

- Training programme organised on REFRESH. Deliver this training to NHS Staff groups (Midwives & Health Visitors) and Social services and other partner organisations & agencies
- Dedicated staff time to take this work forward
- Agreed programme and intervention using Air quality monitors
- “Home Sweet Home” Pilot programme in Nursery schools and then rolled out

### Timescales & Progress

- Early 2016 onwards
- Pilot being taken forward

### Outcome measures

- Increased knowledge and understanding of SHS with health professionals, Nursery staff, parents and children
- Increased number of referrals through other pathways
- Increased use of air quality machines in planned programmes of work and through joint working with social services
- Reduction in child exposure to SHS in the home

### Lead and partners

- NHS D&G SMS/D&G Council – Childrens Services/Social work/Private nurseries
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<td>11. We will ensure that advice to reduce exposure to Second-Hand Smoke as well as cessation advice and support, is fully incorporated in the range of services offered as part of the Universal Health Pathway in Scotland (Scottish Government, October 2015) and includes changes to legislation (planned 2016)</td>
<td>Work alongside Early years collaborative Agreement of REFRESH training package to be used Develop a pilot programme in Nursery education with intention to deliver across all nurseries Integrate national communication into all programmes of work in relation to SHS i.e. Smoking Prohibition (Children in Motor Vehicles (Scotland) Bill (agreed December 2015 expected to be Act late 2016)</td>
<td>Early 2016 onwards</td>
<td>Increased knowledge understanding for staff improved number of referrals through Health visiting services to specialist services increased Reduction in child exposure to SHS in the home</td>
<td>NHS D&amp;G D&amp;G Council - Childrens Services/NHS D&amp;G includes Early Years Collaborative/ School nurses/ SMS/Health &amp; Wellbeing specialist Early Years)</td>
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<td>12. The Scottish Government will work in partnership with the Scottish Prison Service and local NHS Boards to take forward the national specification on delivering smoking cessation in prisons.</td>
<td>Dedicated staff Currently take forward new prison specification with intention to expand to Smoke free Review of Health Improvement Working group for Prisons services will support going forward with Smoke free</td>
<td>Existing work in SMS and will require development &amp; strategic agreement in the next 2/3 years</td>
<td>Increased number of staff training sessions and an increase in number of quit attempts Smoke free prison achieved during lifetime of this action plan and a reduction in prevalence of smoking in prisons</td>
<td>NHS D&amp;G Prison services &amp; SMS</td>
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<tr>
<td>13. NHS Dumfries &amp; Galloway in line with national direction undertake to work towards creating a Smoke Free prison (similar to Carstairs model) and as a result of a successful outcome of the judicial review</td>
<td>Local Health improvement working group to take forward discussions Review of the Carstairs model Dedicated staff time</td>
<td>If agreed planned to implement 2017 With 2016 being the initial stages of discussions/agreement</td>
<td>Increased understanding of Tobacco use, Second Hand Smoke Tobacco policy in place (2017) Increased number of quit attempts Reduction in smoking prevalence in HM prison in Dumfries</td>
<td>NHS D&amp;G prison services/SMS</td>
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<td>14. All NHS Boards will implement and enforce Smoke Free grounds by March 2015. Smoke-free status means the removal of any designated smoking areas in NHS Board buildings or grounds. We will work with Boards to raise awareness of the move to smoke-free hospital grounds. This action will not apply to mental health facilities.</td>
<td>Implementation group for NHS D&amp;G Monitoring progress 2015 onwards Work to improve consistency between our local E.cigarette friendly services and use of e.cigarettes on NHS grounds Review policy as information becomes available on e.cigarettes and cross reference to Progression of smoke free grounds to mental health facilities</td>
<td>In place 2015 and ongoing</td>
<td>Full compliance with new smoke free policy by April 2015 Review of smoke free grounds policy in place</td>
<td>NHS D&amp;G – Tobacco Policy group and partners</td>
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<td>15. Local authority premises to implement smoke-free grounds focussing on nursery primary secondary and further education first with a plan to implement over all LA sites</td>
<td>Review Smoking Policy and implement revised “Smoke Free Policy”  Provide clarity to staff and the public by defining no smoking areas and discourage/restrict smoking amongst the workforce.  Develop smoking cessation support to enable further improvements to support the health of our workforce  Develop appropriate signage for display in all agreed Council smoke free grounds/areas</td>
<td>Reviewed policy planned launch 2016</td>
<td>Increased knowledge &amp; understanding about the importance of Smoke Free and how this is part of the wider Tobacco Control agenda  Staff who choose to smoke are compliant with policy content  Increased protection against second hand smoke</td>
<td>D&amp;G Council HR Dept./ Education services/NHS D&amp;G SMS</td>
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| 16. Continued effective monitoring and enforcement of Smoking Health & Social Care (Scotland) Act 2005 | As appropriate monitoring of licensed premises across D&G - continued enforcement  
More involvement from other services to become aware of Tobacco Free e.g. other tobacco related services maintain profile of legislation | Ongoing in Environmental Health | Continued high compliance locally and nationally of this law  
Cultural change of smoking associated with drinking and a reduction in smoking at doors of licensed premises/external places  
Continued reduction of smoking (Scottish Household Survey) | D&G Council Environmental Standards/NHS D&G SMS |
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| 17. NHS Dumfries & Galloway will implement the recommendations of the national review of smoking cessation services and this will include specific actions that are person centred and support the needs of people living in deprived areas along with specific groups of smokers where tobacco use plays a key role in unequal health outcomes. | Review all operational delivery of smoking cessation services in Smoking Matters Service, Community Pharmacy & H M Prison services and develop an improvement plan for all services – (N.B. currently in place)  
Comply with the national procurement recommendations on treatment methods  
Review all specific patient pathways i.e. Mental health/Pregnancy/Young people/Acute services/  
Work with Third Sector partners & social services to open up new areas of referral | 2015 plan currently in place and continuous working on this | Increased engagement with different client groups - ISD National database  
Increased numbers of clients who are still with services at 1 and 3 months in different groupings  
Increased awareness of staff of relationship smoking plays in exacerbating health inequalities and a subsequent increase in referrals in relation to different groupings  
Reduction in prevalence of smoking in harder to reach groups of smokers | NHS D&G SMS, Pharmacy Services & H M Prison Health care staff/Third Sector |
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<td>18. Integrate smoking cessation services locally into one single service and contribute to strategic developments in relation to the national development of stop smoking services</td>
<td>Review of service delivery locally and produce a report with recommendations for future development. Seek agreement locally with regards to national procurement of medication. Work with national group to deliver centralised booking, training and resources and implement locally.</td>
<td>Begin 2016 planning</td>
<td>Removal of duplication of service delivery. A plan in place for 2017 which will include an easy to use referral pathway for stop smoking services. Re-focus of specialisms in smoking cessation with key groups of service users. Increased number of quit attempts from key groups of service users and a reduction in levels of smoking with key groups.</td>
<td>NHS D&amp;G SMS/Pharmacy services/Pharmacy Champions</td>
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<td>19. The Scottish Government and NHS Health Scotland will continue to work closely with NHS Boards and Community Pharmacy Scotland to implement changes required to ensure service improvement in relation to the Community Pharmacy contract on smoking cessation</td>
<td>Specialist service and pharmacy work alongside to improve performance in service delivery which will include training/supporting with resources/ and provision of local reports to all Community Pharmacies Target setting and ongoing monitoring of data</td>
<td>2015 plan currently in place</td>
<td>Effectiveness of Community Pharmacy smoking cessation equal to specialist service (ISD annual publication of data) Joint working and streamlining to become one stop smoking services for the region Quality assurance of service delivery in all three services Overall reduction in prevalence of smoking in adults over 16 (SHS)</td>
<td>NHS D&amp;G SMS/ Pharmacy Services/ Independent contractors</td>
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<td>20. The Maternity Care Quality Improvement Collaborative will combine a focus on improving the public health role of maternity services alongside improvements in clinical care. Its aim is to improve inequalities in outcomes in maternity settings in Scotland. This action will include measures to improve the numbers of women who are referred to smoking cessation services and improvements in the clinical management of risks for those women who are unable or unwilling to stop smoking. Key aims of the collaborative will be: to refer 90% of women who have raised CO levels or who are smokers to smoking cessation services and to provide a tailored package of care to all women who continue to smoke during pregnancy.</td>
<td>As per national guidelines put in place and monitor smoking cessation Integrated Care Pathway between maternity and specialist services. Administrative process in place. Incentivisation reviewed and considered locally owing to high number of women who smoke in pregnancy in D&amp;G. A sustained programme of training/resources provided to all midwives and all specialist service staff provided with annual updates on pregnancy care pathway. Participation in multi-agency clinic in Cresswell/ Clennoch. Carry out a Review of the Integrated care Pathway along with training/resources/ support for Midwife Practitioners, Service users and Stop Smoking Advisors. Undertaking a survey to find out about barriers and positives to engaging with pregnant women who smoke. Locally set targets with reference to the 90% Collaborative figure.</td>
<td>In place and ongoing monitoring</td>
<td>Increased knowledge of smoking &amp; pregnancy for all relevant staff. Increased number of referrals through Care Pathway. Improvement in uptake of women engaging and attending first appointment. Increased number of quit attempts. Reduction in prevalence of smoking in pregnancy.</td>
<td>NHS D&amp;G Maternity Services/ SMS/ Community Pharmacy Services</td>
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<td>21. NHS Boards should develop systems and provide training to ensure clear and effective care pathways for smoking in pregnancy in line with current guidance. This should include CO monitoring at booking and automatic referral to smoking cessation services.</td>
<td>Opt out referral pathway monitored and review annually. Training provided continuously. Ensure continuous supply of nationally agreed resources. Monitor and review pregnancy data. Conduct a survey with pregnant women to ascertain their favoured clinic i.e. Community pharmacy or Smoking Matters. Carry out interdisciplinary process mapping exercise to ensure each health professional group is aware of the needs of pregnant women who are smokers and to ensure joint working and communication takes place across all disciplines.</td>
<td>Currently in place and is regularly reviewed</td>
<td>Increased knowledge of smoking &amp; pregnancy for all relevant staff. Increased number of referrals through care pathway. Improvement in uptake of women engaging and attending first appointment. Increased number of quit attempts. Reduction in prevalence of smoking for smoking &amp; pregnancy in D&amp;G.</td>
<td>NHS D&amp;G Maternity services/SMS/Community Pharmacy services.</td>
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| 22. As part of the wider monitoring framework for the Health Promoting Health Service, the Scottish Government, NHS Health Scotland and NHS Boards will ensure progress in improving the level of support on managing temporary abstinence in acute setting across NHS Scotland. This will include offering specialist smoking cessation support and ensuring pre-admission and post-discharge care pathways. | Care Pathways agreed and implemented  
Training continuous programme for all staff working with admissions re smoking status recording  
Work with Managed Clinical Networks, Pre-assessment, Primary Care, Outpatients  
Give consideration to maternity in-patients e.g. for induction of labour or elective caesarean section  
Consider families visiting neonatal unit who smoke as an opportunity to discuss smoking cessation | Dedicated Stop Smoking Advisors currently in hospital setting | Increased number of referrals in the acute setting  
Increase number of referrals for patients being sent on to secondary care for further investigations  
Numbers of acute setting training sessions increased  
Increased number of referrals to SMS  
Increased use of temporary support medication in hospital  
No patients at front door smoking  
Increased number of quit attempts through Primary Care/pre-assessment | NHS D&G SMS/Staff in Secondary Care/Community Pharmacy/GP practices |
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<td>23. Within the context of Health and Social care integration, NHS Boards should take action to ensure health and social care professionals address smoking in all care settings and provide effective and person-centred referral pathways to appropriate smoking cessation support.</td>
<td>Work alongside Integration Managers/PHPs to secure a Tobacco control profile in the PH agenda and to ensure that the importance of targets are being addressed at a locality and regional level.</td>
<td>2016 onwards</td>
<td>Good organisational understanding of the role tobacco use plays in contributing to Public health challenges relating to health inequalities. Increased number of referrals from Social services/Third sector along with NHS/Primary Care referrals</td>
<td>NHS D&amp;G SMS/PHPs/Integration Managers/Third sector</td>
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Combined training events
Working with Third Sector partners
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<td>24. Follow national and local procedures in relation to E.cigarette use through Prevention, cessation and control programmes and that within these programmes the E.cigarette is also considered in a wider context of controlled drugs and illegal highs</td>
<td>National guidance on e.cigarette &amp; cessation translated into local practice. Cross reference over to other NHS policies and ensure consistency. All prevention programmes updated with key educational areas being covered. Practitioner protocol developed and agreed and set within wider prescribing context for smoking cessation &amp; Patient Information Leaflet developed. Work with pharmacy services locally/nationally to seek changes to pharmacy contract. Work with other service providers (Police Scotland and Trading Standards) to extend Tobacco prevention programmes and to include information about the wider use of devices that are designed to deliver highly toxic substances.</td>
<td>2015 &amp; Ongoing Latest guidance has been updated (nov 2015) Local service protocols required early 2016 for frontline staff</td>
<td>Increase knowledge &amp; Understanding of the opportunities/threats in relation to E.cigarettes on different substances. Those using e.cigarettes doing so only as a transitory stage (ISD national database) Low number if any, uptake of young people (who would not have been a smoker) taking it up (SALSUS survey)</td>
<td>D&amp;G Council Trading standards/NHS D&amp;G SMS &amp; NHS Health Scotland</td>
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<tr>
<td>25. A training programme that has specifically designed programmes to address smoking cessation in all sectors (focusing on skill development) and ensure our local work fits within the newly developed national training programme</td>
<td>Dedicated staff capacity to take forward joined up Brief Intervention training programmes with other services (i.e. alcohol) Specific training programmes in Tobacco Control extending delivery into Third sector and Social Care with programmes in the following REFRESH All relevant and up to date training for all smoking cessation specialists (SMS, CP, H M Prison services) Midwife training sessions in Integrated care pathway and smoking in pregnancy Acute services DGRI/GCH Integrated Care Pathway Motivational interviewing Tobacco Control Champion Training</td>
<td>Ongoing programme annually updated over lifetime of action plan</td>
<td>Fully trained and equipped staff across all sectors (SMS training records) More smokers through key areas accessing services (ISD reports) More smokers in key areas stopping smoking (ISD reports) A reduction in prevalence of smoking</td>
<td>NHS D&amp;G - SMS/NHS Pharmacy services/ Communications dept./Third Sector/Drug &amp; Alcohol services</td>
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<tr>
<td>Actions</td>
<td>Outputs (Evidence of measures that the action is being put into place)</td>
<td>Timescales &amp; Progress</td>
<td>Outcome measures (Short/Medium term/long term)</td>
<td>Lead and partners</td>
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<td>26. Create a planned programme of activity on social media and website development complimented with targeted local programmes and media interest</td>
<td>Dedicated staff resource to regularly create interest through digital storytelling, news items etc.</td>
<td>Ongoing work within SMS and needs greater focus over next 2 years as we develop further the prevention programme</td>
<td>Consistently visible on social media/twitter etc. More young people in specific age categories using stop smoking services (ISD reports)</td>
<td>NHS D&amp;G / Communications/SMS</td>
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<tr>
<td>Actions</td>
<td>Outputs</td>
<td>Timescales &amp; Progress</td>
<td>Outcome measures (Short/Medium term/long term)</td>
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<tr>
<td>27. Meet the Scottish Government HEAT target for smoking cessation (in relation to inequalities)</td>
<td>Work with GP practices to increase number of referrals</td>
<td>Ongoing work alert senior managers to quarterly results</td>
<td>More smokers being referred from GP practices</td>
<td>NHS D&amp;G SMS/Pharmacy/CPs</td>
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<td></td>
<td>Ask for senior support emphasise benefits to NHS</td>
<td></td>
<td>Improvement and consistently of performance in community pharmacies (ISD reports)</td>
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<td>Work with Community Pharmacy to improves outcomes</td>
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<td>Relapse support offered to all service users</td>
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<td></td>
<td>Use a range of means of communication to encourage more smokers who previously used stop smoking services to be invited back</td>
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</table>
Appendix B

Tobacco Control Action Plan
“Let’s be Tobacco Free”, one year on............
Introduction to this update on tobacco control programmes
This is a progress report on the Tobacco Control Action Plan approved by the Board in August 2016. Each action number correlates to the August 2016 plan (see attached Appendix A and there is a brief summary in terms of status included alongside the action

Indicates work has been progressed and will

Indicates work has not been progressed at this
<table>
<thead>
<tr>
<th>Action</th>
<th>Update/progress</th>
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<tbody>
<tr>
<td>1. Implement a <strong>tobacco policy</strong> for all secondary schools in the region</td>
<td><strong>This is a new area of work to be taken forward subject to having staff in place</strong></td>
</tr>
<tr>
<td>2. Deliver across the region targeted programmes of the <strong>tobacco element of health improvement programmes</strong> within Curriculum for Excellence</td>
<td>We have a well established programme of tobacco prevention work including classroom and workshops in 75 out 101 primary schools in the region. We target our work by age and area initially and also cover a range of requests from individual schools. Other activities include regional poster competitions and participation in young peoples events. 13 out of 16 secondary schools have become involved in a combination of activities, this includes classroom (targeting S1 &amp; S3 and in key areas) assemblies on request and the delivery of the peer-led ASSIST programme. <strong>Ongoing work</strong></td>
</tr>
<tr>
<td>3. Work with other Services (e.g. Drug &amp; Alcohol Services) to <strong>contribute to a broader programme of educational programmes</strong> that addresses risky/addictive behaviour in young people</td>
<td>We have included information about other substances into Smoking prevention programmes and now need to work with partners for tobacco to be included in drug/alcohol educational programmes as appropriate. <strong>Ongoing work</strong></td>
</tr>
<tr>
<td>4. Identify organisations who deliver services for <strong>Looked After and Accommodated</strong> Children and Youth Justice and work in partnership to deliver smoke-free approach as part of a wider programme to reduce risk taking behaviour</td>
<td>We have made good progress in achieving a profile and inclusion of smoking assessment for young people within the NHS and with partner organisations in this area. Our work includes supporting organisations to implement smoke-free policies, training and stop smoking support. <strong>Ongoing work</strong></td>
</tr>
<tr>
<td>5. Address high levels of <strong>smoking in the 16-24 age group</strong>, particularly those from most deprived backgrounds</td>
<td><strong>This is a new area of work to be taken forward subject to having staff in place</strong></td>
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<tr>
<td>6. Work in partnership to reduce the availability of illicit tobacco</td>
<td>Good progress made in using the sniffer dog with regards to illicit tobacco searches. This exercise will be repeated <strong>Ongoing work</strong></td>
</tr>
<tr>
<td>7. Ensure the effective implementation of the Enhanced Tobacco Sales Programme and increase knowledge and understanding of tobacco laws in the region</td>
<td>As part of the Tobacco Sales programme 72 retailers have been visited =20% and the target set has been achieved, and 41 test purchases carried out = 10% of overall and the target set has been achieved. Retailers selling Nicotine Vapour products to be registered by September 2017 and similar to the above, these retailers will be monitored and targets set for Trading Standards visits over 2017/18 <strong>Ongoing work</strong></td>
</tr>
<tr>
<td>8. Undertake a pilot of ASSIST in Partnership with NHS Ayrshire &amp; Arran and running in conjunction with the national pilot programmes in three other Health Boards (ASSIST is a peer led smoking cessation programme currently being trialled by the Scottish Government in three Boards in Scotland)</td>
<td>Over the three year license period this work has been successfully delivered in 8 secondary schools with a further 5 planned 2017/18 <strong>Ongoing work until license conclusion (mar 2018) thereafter clarity at a national level will be required for ongoing local commitment - discussions taking place</strong></td>
</tr>
<tr>
<td>9. Sign up our organisation to Scotland’s Charter for a Tobacco Free Generation and encourage and work with other organisations to do similarly</td>
<td>J. Ace has signed up NHS D&amp;G and Smoking Matters continues to promote the principles of the charter in all areas of our work and specifically through young peoples and Second-hand smoke work <strong>Ongoing work</strong></td>
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<td>10. Advice on creating a <strong>smoke-free home</strong> should be a feature of all ante- and post-natal services and adoption, foster, kinship and residential care services.</td>
<td>This work has started with Health visitor and Nursery Nurse training and a referral pathway in place. This work also relates to actions 4 &amp; 20 where we are delivering training, support and resources to various organisations and departments involved. <strong>Ongoing work</strong></td>
</tr>
<tr>
<td>11. We will ensure that advice to <strong>reduce exposure to SHS</strong> as well as cessation advice and support, is fully incorporated in the range of services offered as part of the universal health visitors pathway in Scotland.</td>
<td>As above this started with training and support for Health Visitors, School Nurses and Nursery Nurses. <strong>Ongoing review and updates to be provided to teams in localities</strong></td>
</tr>
<tr>
<td>12. The Scottish Government will work in partnership with the <strong>Scottish Prison Service</strong> and local NHS Boards to take forward the national specification on delivering smoking cessation in prisons.</td>
<td>Currently offer and provide support to SPS in Dumfries in the form of resources and administrative support. <strong>Ongoing work with further updates expected from SPS &amp; SG</strong></td>
</tr>
<tr>
<td>13. NHS Dumfries &amp; Galloway in line with national direction undertake to work towards creating a <strong>smoke-free prison</strong>.</td>
<td>Recent publications have indicated the timetable for achieving Smoke free prisons in Scotland (2018). NHS D&amp;G will have an important supporting and resourcing role for SPS Dumfries. <strong>Work to be planned for and undertaken for the following 18 months</strong></td>
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<td><strong>14.</strong> All NHS Boards will implement and enforce Smoke Free grounds by March 2015. Smoke-free status means the removal of any designated smoking areas in NHS Board buildings or grounds. This action will not apply to mental health facilities</td>
<td>NHS Dumfries and Galloway implemented a smoke free grounds policy (April 2015). The Policy applies to all hospitals and covers all grounds. Legislation (as part of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016) which will make it an offence to smoke within a designated boundary of a hospital building will be enacted in late 2017/early 2018. There will be national and local work in taking this forward in the coming months.</td>
</tr>
<tr>
<td><strong>15.</strong> Local authority premises to implement smoke-free grounds focusing on nursery, primary, secondary and further education first with a plan to implement over all LA sites</td>
<td>Will continue to pursue</td>
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<tr>
<td><strong>16.</strong> Continued effective monitoring and enforcement in relation to the Smoking Health &amp; Social Care (Scotland) Act 2005</td>
<td>Environmental Health act on complaints in relation to this law and have received no complaints during 2016/17 therefore Environmental Health (EH) have assumed that compliance is high as has been consistently reported. Ongoing work and reviewed as appropriate by EH</td>
</tr>
<tr>
<td><strong>17.</strong> NHS Dumfries &amp; Galloway will implement the recommendations of the national review of smoking cessation services</td>
<td>We have implemented all the national recommendations and we continue to make improvements to service delivery, prescribing and support for patient using services (for example relapse follow-up, increased appointment times, e-cigarette friendly for cessation support, prescribing changes in general practice supporting best evidence). Ongoing work</td>
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<td><strong>18. Integrate</strong> smoking cessation services locally into one single service and contribute to strategic developments in relation to the development of stop smoking services</td>
<td>Currently working on this but there are challenges to overcome in terms of initially ensuring that all services are working to the same or a similar standard of support, and unless this can be achieved services who deliver smoking cessation support will vary considerably and the this will play a part in continuing to compromise the LDP target. Review of work this currently taking place along with a planned way forward</td>
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<tr>
<td><strong>19.</strong> The Scottish Government and NHS Health Scotland will continue to work closely with NHS Boards and Community Pharmacy Scotland to implement changes required to ensure service improvement in relation to the Community Pharmacy contract on smoking cessation</td>
<td>Community Pharmacy reports, feedback, training resource and administrative support has been offered and provided during 2016/17 to all Pharmacies in the region. This work will now focus in a targeted way with key pharmacies to address factors affecting our overall performance in smoking cessation and trying to increase access to these services through promotional activities. This is linked to action 18 Ongoing work</td>
</tr>
<tr>
<td><strong>20.</strong> The Maternity Care Quality Improvement Collaborative will combine a focus on improving the public health role of maternity services alongside improvements in clinical care. Its aim is to improve inequalities in outcomes in maternity settings in Scotland. This also includes measures to improve the numbers of women who are engaged and improvements in the clinical management of risks for women who smoke</td>
<td>Since implementation there has been a significant rise in numbers of pregnant women who smoke being referred to Smoking Matters. Maternity services and Smoking Matters have collaborated successfully to implement this and have a good referral and monitoring pathway in place Monitored and reviewed regularly with ongoing work planned</td>
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<tr>
<td>21. NHS Boards should develop systems and provide training to ensure clear and effective care pathways for <strong>smoking in pregnancy</strong> in line with current guidance</td>
<td>Work has been completed with all midwife teams which includes Carbon Monoxide monitoring for all pregnant women at first booking and referral and monitoring pathways in place. This is linked to action 20 <strong>Ongoing work</strong></td>
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<tr>
<td>22. As part of the wider monitoring framework for the Health Promoting Health Service, the Scottish Government, NHS Health Scotland and NHS Boards will ensure progress in improving the level of support on managing temporary abstinence in <strong>acute setting</strong> across NHS Scotland</td>
<td>We have increased our work in DGRI/GCH in terms of training sessions for staff, and increased Smoking Matters attendance in all wards to provide patients with brief advice or stop smoking support. Further work planned for preparing patients before coming into hospital <strong>Ongoing work</strong></td>
</tr>
<tr>
<td>23. Within the context of Health and Social care integration, NHS Boards should take action to ensure health and social care professionals address <strong>smoking in all care settings</strong> and provide effective and person-centred referral pathways</td>
<td><strong>Work to be carried out 2017/18 with partner organisations</strong></td>
</tr>
<tr>
<td>24. Follow national and local procedures in relation to <strong>e-cigarette</strong> use through prevention, cessation and control programmes</td>
<td>E-cigarette information has been included into a brief training session on the development of the product to date. E-cigarettes information has been included into childrens and young peoples programmes. Specialist services also provide patients with the most up to date information and Health Scotland have recently produced a patient information leaflet on e-cigarettes <strong>Ongoing work</strong></td>
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<tr>
<td>25. Devise a <strong>training programme</strong> that has specifically designed programmes to address smoking cessation in all sectors and ensure local work fits within the newly developed national training programme.</td>
<td>Smoking Matters has a training programme available on the intranet and training is delivered on an ongoing basis with different staff groups (for example Community mental health champions, Community Pharmacies, Briefing sessions in DGR/GCH) and training for external organisations. <strong>Ongoing work</strong></td>
</tr>
<tr>
<td>26. Create a planned programme of activity on social media and website development complemented with targeted local programmes and media interest.</td>
<td>Smoking Matters has throughout the year been carrying out themed social media messages with good engagement and this work will continue. <strong>Ongoing work</strong></td>
</tr>
<tr>
<td>27. Meet the Scottish Government LDP target for smoking cessation in relation to inequalities.</td>
<td>It is unlikely we will meet the LDP target (2016/17) please see note overleaf on this action. <strong>Continuing to address this difficulty</strong></td>
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</table>
N.B. Action 27: As is expected the comments made against this action may be of most concern and interest to the board, therefore I have taken the opportunity to add further notes of explanation in relation to the smoking cessation target. This target in Scotland is a challenge for all boards to meet, and it is expected that NHS D&G will not meet the Local Delivery Plan target (previously known as the HEAT target) by approximately 30-35% (final data will be released October 2017, ISD).

The reasons for this are the following:-

- Overall in Scotland there has been a drop each year (for the past 5 years) in numbers of smokers using specialist services and this is a similar pattern in Dumfries & Galloway, a drop in referrals to services. Services require a set number of referrals from various routes to meet this target. A sampling of referral numbers from GP practices indicates a drop by 50% in referral numbers in 9 out of 14 practices (over a three year period) and the remaining 5 practices there has been a drop in numbers but not so significant.

- The profile of a smoker in terms of stopping smoking has altered significantly since previous years. Smokers going through a quit programme today may require more intensive support to achieve stopping smoking, may be more addicted and require a combination of medications and may have more complex medical needs.

- E-cigarettes have had a role in helping some smokers to stop smoking, but more use it in combination with the use of traditional tobacco products and therefore may use this product as a replacement product to cigarette smoking in places where you are unable to smoke cigarettes.

- The performance and outcomes of each stop smoking service in Dumfries & Galloway (Prison services, Community Pharmacies and Smoking Matters) varies considerably between services. Given that our numbers of smokers accessing services are reduced and in areas that matter most in meeting the LDP target. From a target perspective (but also importantly from a smoking cessation perspective) every potential quitter matters to us, and along with this the standard of each supported quit attempt needs to be of the highest quality in every circumstance. The outcomes of the specialist services doubles (in key areas) by comparison to a small number of community pharmacies (in key areas), which is another factor in affecting our overall performance as a board.
DUMFRIES and GALLOWAY NHS BOARD

7th August 2017

Lochside Dental Clinic Review

Author: Valerie White
Consultant in Dental Public Health

Sponsoring Director: Angus Cameron
Medical Director

Katy Lewis
Director of Finance

Date: 19th July 2017

RECOMMENDATION

The Board is asked to:

- **Note** the content of the attached Difficult Decisions Proposal which outlines two options for future delivery of NHS Dental Services from Lochside Dental Clinic by the Public Dental Service.

- **Preferred option** - complete withdrawal of routine NHS General Dental Services at Lochside Dental Clinic, with patients being supported to transfer to Independent Dental Contractor Practices for continued provision of NHS Dental Services.

- **No change** - continued provision of routine NHS General Dental Services at Lochside dental clinic for the patients currently registered.

- **Note** that the Boards agreed preferred option will be presented to the Integration Joint Board (IJB) on the 27th of July 2017 to seek agreement that it is consistent with the IJB Strategic Plan. A verbal update will be provided to NHS Board members on the outcome of the IJB consideration at the Board meeting.

- **Agree** which of the above options is the way forward in delivery of routine NHS General Dental Services by the Public Dental Service from Lochside Dental Clinic.

- **Note** that if withdrawal of service is agreed by the NHS Board as the way forward this would not be progressed until the required capacity for dispersal within the Independent Dental Contractor Sector was re-confirmed.

- **Note** that an action plan is now in place to progress implementation of the recommendations from the Oral Health Needs Assessment of the Lochside and Lincluden area.
CONTEXT

Strategy/Policy:

Scottish Government guidance states that in areas of improved access to NHS dental services, NHS Boards should be reviewing their provision of routine NHS dental services by the Public Dental Service.

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

At its meeting on 6th October 2014, Dumfries & Galloway Health Board approved the recommendations of the (then) Salaried Service Review which concluded that General Dental Services continue to be provided at Lochside Clinic by the Independent Dental Contractor sector via a lease arrangement. A tendering exercise was undertaken during 2015 for the provision of NHS General Dental Services from Lochside Clinic; no alternative service provider applied to take over service provision.

In October 2015, the NHS Board approved the proposal to undertake a further service review to explore options for future service delivery of routine NHS General Dental Services from Lochside Clinic.

Following an options appraisal process the proposed preferred option identified was:

**Option 2** complete withdrawal of routine NHS General Dental Services at Lochside Dental Clinic, with patients being supported to transfer to Independent Dental Contractor Practices for continued provision of NHS Dental Services.

Following discussion at the IJB in November 2016, the IJB directed the NHS Board to consult on more than one option before coming to a final decision on the proposal. The following two options were then consulted on:

- **Proposed preferred option** - complete withdrawal of routine NHS General Dental Services at Lochside Dental Clinic, with patients being supported to transfer to Independent Dental Contractor Practices for continued provision of NHS Dental Services.

- **No change** - continued provision of routine NHS General Dental Services at Lochside dental clinic for the patients currently registered.

Appendix 1 (page 6) of this report presents the fully developed Difficult Decisions Proposal. This is supported by the following Appendices:

**Appendix 2** (page 26) Engagement Plan: Review of Provision of Routine General Dental Services by the Public Dental Service From Lochside Clinic

**Appendix 3** (page 36) Oral Health Needs Assessment Lochside and Lincluden and Action Plan
Glossary of Terms

IJB - Integration Joint Board
CPD - Continuing Professional Development
FIAT - Financial Inclusion and Assessment Team
EU - European Union
OHNA - Oral Health Needs Assessment
## MONITORING FORM

<table>
<thead>
<tr>
<th>Policy / Strategy</th>
<th>In line with Scottish Government guidance regarding review of provision of Public Dental Services provision of routine NHS General Dental Services in areas of improved dental access.</th>
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| Staffing Implications | Will vary dependent on outcome implemented.  
Progression of **Preferred Option** would mean staff would be subject to the NHS Boards Organisational Change policy. It is acknowledged that redeployment of dental staff can be difficult.  
Progression of **No Change Option** would require staffing complement to be increased to cover 5 days a week. |
| Financial Implications | Financial implications for all short listed options considered have been assessed as part of the options appraisal process.  
**Preferred Option**: Is estimated to cost £52K and save £105K recurrently compared to No Change Option, assuming full redeployment  
**No Change Option**: Is estimated to cost £157K recurrently |
| Consultation / Consideration | The Scottish Health Council provided advice and support in development of the review engagement plan which has been implemented (**Appendix 2**). The Scottish Health Council have confirmed that the engagement process followed during the review has been proportionate and inclusive to allow for full participation. Unison and the British Dental Association participated in the options appraisal process. The proposal has been presented to the following Board committees with the following outcomes:  
**Health and Social Care Senior Management Team** – have endorsed both options  
**Dental Advisory Committee** – have endorsed both options  
**Area Clinical Forum** – have endorsed both options  
**Area Partnership Forum** – have endorsed both options  
Agreement will also be sought from the IJB that the agreed preferred option is consistent with the IJB Strategic Plan. |
## Risk Assessment

Risk Area for the **Preferred Option** are: patient experience, public perception, health inequalities, independent dental contractor capacity, staff redeployment.

Risk areas for the **No Change Option** are: service sustainability, staff recruitment, staff experience, patient experience, public perception, Scottish Government policy direction.

## Sustainability

Sustainability of services was considered as a key aspect of the appraisal process for all options considered. During the qualitative aspect of the options appraisal the **Preferred Option** scored more highly on sustainability/deliverability compared to the **No Change Option**.

## Compliance with Corporate Objectives

3. To review the model of service delivery across Dumfries and Galloway to deliver person-centred services as close to home as clinically appropriate.

5. 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.

6. 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

- Commitment and leadership
- Responsiveness and consultation
- Sound governance at a strategic, financial and operational levels
- Sound management of resources
- Use of review and option appraisal
- Accountability
- Joint working
- Equal opportunities arrangements

## Impact Assessment

Equality and Diversity has been considered throughout the review process. A final impact assessment was undertaken using the joint Council and NHS Toolkit. This involved members of the review team, a patient representative and the sections on age and disability were also discussed with a representative from DG Voice. Both options were impact assessed and the details of this are reported in the Difficult Decisions Proposal and [Appendix 5](#). It should be noted that both options had potential positive and negative impacts. None of the impacts were felt to be unjustifiable and actions to mitigate the effect of the possible impacts have been identified.
Appendix 1

Service Change / Disinvestment template

<table>
<thead>
<tr>
<th>Title of Proposal</th>
<th>Review of Provision of routine NHS General Dental Services Provision from Lochside Clinic</th>
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<tbody>
<tr>
<td>Stage (delete as appropriate)</td>
<td>Full</td>
</tr>
<tr>
<td>Lead Manager/Clinician</td>
<td>Valerie White Consultant Dental Public Health/Public Health</td>
</tr>
<tr>
<td>COO/ Sponsoring Director</td>
<td>Angus Cameron, Medical Director and Katy Lewis, Director of Finance</td>
</tr>
</tbody>
</table>

1. Brief description of proposal:
   (clarify whether: budget reduction; redesign of service to make efficiency savings; service withdrawal/disinvestment; other)

   Scottish Government guidance states that in areas of improved access to NHS dental services NHS Boards should be reviewing their provision of routine NHS dental services provided by the Public Dental Service.

   At its meeting on 6th October 2014, Dumfries & Galloway Health Board approved the recommendations of the (then) Salaried Service review which concluded that General Dental Services continue to be provided at Lochside Clinic by the Independent Dental Contractor sector via a lease arrangement. A tendering exercise was undertaken during 2015 for the provision of NHS General Dental Services from Lochside clinic, no alternative service provider applied to take over service provision.

   In October 2015, the NHS Board approved the proposal to undertake a further service review to explore options for future service delivery of routine NHS General Dental Services from Lochside Clinic.

   Following the Boards approval of the recommendation to explore options for future delivery of routine NHS General Dental Services from Lochside clinic, it was agreed by the Review Team that undertaking a further options appraisal exercise would be the most appropriate way forward.

   A review engagement plan was developed in partnership with the Scottish Health Council, see Appendix 2. Patients registered to receive dental treatment from Lochside Dental Clinic were written to at the beginning of January 2016 advising that this further review would take place.

   Lochside Clinic is situated in North West Dumfries, in an area classified as within the 20% most deprived areas in Scotland. Poor oral health is associated with deprivation. During the initial options appraisal exercise in 2014, the option to withdraw NHS General Dental Services from this clinic was not shortlisted for further appraisal by the Review Team for the following reasons:

   No other accessible dental service within the vicinity
   Cost of public transport
   Current need for the service
   Area of deprivation
It was agreed that the above areas required further exploration and an Oral Health Needs Assessment (OHNA) was undertaken to help inform the options appraisal process. The OHNA looked at relevant quantitative data regarding oral health and access to dental services and also included qualitative data gathered from the Lochside and Lincluden Community via Participatory Appraisal. Lochside patient feedback on what was important to them regarding provision of their dental care was also collated and reviewed. The OHNA report is presented in Appendix 3. A summary of the findings are:

**Oral Health**

- The Oral Health of Primary 1 children in the Lochside and Lincluden area does appear to be poorer than for Primary 1 children more generally in Dumfries and Galloway. This is not unexpected given the deprivation level of the area.
- Data on the oral health of adults for the Lochside and Lincluden area is not available; however, it is likely that oral health of adults will generally be poorer due to the deprivation status of the area, compared to those in more affluent areas.
- At a Scottish level a significant proportion of the adult population report some level of anxiety about attending the dentist. Barriers to attending the dentist reported at a Scottish level include difficulty in getting an appointment that suits, the expense of dental treatment, difficulty in getting time off work and distance to go to a dentist.

**Dental and Oral Health Services**

- Dental Registration figures for the Lochside and Lincluden area are high, 86% of the population are registered with an NHS dentist.
- The vast majority (79%) of registrations are with Independent Dental Contractor practices.
- It is estimated that 6.9% (458 people) of the Lochside and Lincluden population are registered for dental care at the Lochside Clinic. This represents 34% of the clinics registered patients.
- 66% (876) of the people registered to receive dental care at Lochside Clinic live outwith the Lochside and Lincluden area.
- Dental Registration rates are lowest for the 0-2years 11month age group at 37% of this age groups population, current figures for this age group for Dumfries and Galloway are 48%.
- About 950 people living in the Lochside and Lincluden area are not registered with a NHS dentist (14% of the population of this area). For Dumfries and Galloway as a whole, 15% of the population are not registered with an NHS dentist.
- Of those people living in the Lochside and Lincluden area registered with Lochside clinic, 267 have some form of exemption status either based on level of income, age, educational status or pregnancy. This figure reduces to 135 when looking at the number of individuals in receipt of income related exemptions.
- The location of Lochside dental clinic does not necessarily influence people’s attendance for NHS dental services.
- The nurseries and primary schools in the Lochside and Lincluden area benefit from taking part in the Childsmile Oral Health Improvement Programme.

**Access to General Medical Practice**

- Individuals living in the Lochside and Lincluden community are registered at a number of different General Medical Practices throughout Dumfries Town.

**Public Transport**

- Frequent bus routes were noted to connect Lochside and Lincluden to Dumfries town centre.
Engagement Work

- Whilst transport/access was mentioned by a number of individuals as an issue for accessing dental services, wider and more complex reasons which may contribute to attendance at the dentist were also identified including costs of dental treatment, fear of dental treatment, lack of awareness of the need to attend a dentist (particularly for those wearing dentures) and reported poor previous experiences.
- A number of those who participated in the engagement exercise did advise that they would like to be registered at the Lochside clinic.
- The majority of individuals who participated in the engagement exercise registered with an Independent Contractor Dental practice advised their last visit to the dentist was a positive event.
- Patients registered with Lochside clinic reported that they highly value the existing dental service provided from Lochside Clinic and see the clinic as being convenient and having adequate parking.

After consideration of the OHNA Report and the Equality and Diversity Impact Assessment undertaken for the 2014 review, the Review Team assessed the potential options available for this clinic and identified a long list of options for the clinic (see section 13 for other potential options considered). The long list was then examined further by the Review Team to develop a short list of potentially feasible options which would go through an options appraisal process.

The first stage in the options appraisal was a qualitative appraisal. This qualitative stage involved reviewing the risks and benefits of each short listed option and then scoring each option against the following criteria:

Patient Experience
Workforce
Deliverability/Sustainability
Strategic Direction

An agreed weighting was applied to each criteria, which allowed a final qualitative score to be calculated. Sensitivity analysis of the qualitative scoring was also undertaken to assess the effect of weighting given and also to assess the effect of any extremes of scoring. There was representation from the following at this stage of the appraisal; clinic patients, DG Voice, UNISON, British Dental Association, Independent Dental Contractors, Human Resources, Nithsdale Health and Social Care Partnership Locality, Public Dental Service Management, Finance, Public Health and Primary Care Development.

A separate financial appraisal of each option was undertaken and this involved costing each option appraised.

The results of the qualitative and financial appraisal were then combined using a 60/40 weighting with the 60 weighting given to the qualitative aspect of the appraisal and 40 to finance.

The short listed options appraised and the overall results of the appraisal are detailed in Table 1. Further details of the qualitative aspects of the options appraisal are outlined in Appendix 4. The estimated costs of each option are outlined in Table 2.
<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
<th>Qualitative Score</th>
<th>Financial Score</th>
<th>Combined Score</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Complete withdrawal of service with facilitated transfer of registered patients to independent dental contractor practices</td>
<td>36.35</td>
<td>40.00</td>
<td>76.35</td>
<td>1st</td>
</tr>
<tr>
<td>1</td>
<td>Status Quo - no change in current service provision</td>
<td>30.81</td>
<td>13.35</td>
<td>44.16</td>
<td>2nd</td>
</tr>
<tr>
<td>9a</td>
<td>Retention of all existing registered patients and building capacity to utilise the 2 dental surgeries to provide dental services to people resident in the Lochside and Lincluden area (maximum capacity 3000) (1500 additional Lochside and Lincluden area residents) Two dentist model</td>
<td>34.96</td>
<td>8.54</td>
<td>43.51</td>
<td>3rd</td>
</tr>
<tr>
<td>9b</td>
<td>Retention of all existing registered patients and building capacity to utilise the 2 dental surgeries to provide dental services to people resident in the Lochside and Lincluden area (maximum capacity 3000) (1500 additional Lochside and Lincluden area residents). One dentist and one therapist model.</td>
<td>32.77</td>
<td>9.90</td>
<td>42.67</td>
<td>4th</td>
</tr>
<tr>
<td>3</td>
<td>Facilitated transfer to independent dental contractor practices of only those registered patients living out with the Lochside and Lincluden area and utilising remaining capacity to provide dental services to people resident in the Lochside and Lincluden area (maximum capacity 1500)</td>
<td>27.81</td>
<td>12.26</td>
<td>40.07</td>
<td>5th</td>
</tr>
<tr>
<td>4a</td>
<td>Facilitated transfer to independent dental contractor practices of only those registered patients living out with the Lochside and Lincluden area and building capacity to utilise the 2 dental surgeries to provide dental services to people resident in the Lochside and Lincluden area (maximum capacity 3000). Two dentist model</td>
<td>31.85</td>
<td>7.98</td>
<td>39.83</td>
<td>6th</td>
</tr>
<tr>
<td>4b</td>
<td>Facilitated transfer to independent dental contractor practices of only those registered patients living out with the Lochside and Lincluden area and building capacity to utilise the 2 dental surgeries to provide dental services to people resident in the Lochside and Lincluden area (maximum capacity 3000). One dentist and one therapist model.</td>
<td>29.89</td>
<td>9.15</td>
<td>39.04</td>
<td>7th</td>
</tr>
</tbody>
</table>
The complete options appraisal process resulted in Option 2 – Withdrawal of service – becoming the Proposed preferred option. Due to the additional costs involved with options 3, 4a&b, and 9a&b Option 2 - No Change - came second.

Following direction from the IJB to consult on more than one option, the Health Board Management Team agreed that due to the additional costs of options 3, 4a&b and 9a&b only the Proposed preferred option and the No Change option should be consulted on given the challenging financial situation facing the NHS Board. This consultation has now been completed and The NHS Board is asked to agree which option is implemented:

- **Preferred option** - complete withdrawal of routine NHS General Dental Services at Lochside Dental Clinic, with patients being supported to transfer to Independent Dental Contractor Practices for continued provision of NHS Dental Services

- **No change** - continued provision of routine NHS General Dental Services at Lochside dental clinic for the patients currently registered

This Difficult Decisions Template outlines key considerations for the NHS Board in respect of both options.

## 2. Contribution to planning &/or corporate objectives:

Implementation of **Preferred option (Withdrawal)** would:

- Be in line with government policy of Independent Dental Contractors being the preferred service delivery model for routine General Dental Services.
- Maximise the benefit of the financial allocation by delivering clinically and cost effective services efficiently through utilisation of existing Independent Contractor Dental services

## 3. Impact on service and staff:

(include details of workforce - by staff group & wte /training /locations)

Implementation of **Preferred option (Withdrawal)** would have the following impacts:

### Service

There would be no provision of NHS dental services from Lochside Clinic.

### Staff

- 1 x 0.8 WTE Dentist
- 1 x 0.8 WTE Dental Nurse
- 1x 1 WTE Receptionist (Fixed Term Contract)

Staff would be covered by the Boards Organisational Change policy. It is acknowledged however, that

### Table 2 – Total Annual Costs of Implementation of Each Option

<table>
<thead>
<tr>
<th>Option 1</th>
<th>Option 2*</th>
<th>Option 3</th>
<th>Option 4a</th>
<th>Option 4b</th>
<th>Option 9a</th>
<th>Option 9b</th>
</tr>
</thead>
<tbody>
<tr>
<td>£157,158</td>
<td>£52,443</td>
<td>£171,114</td>
<td>£262,752</td>
<td>£229,178</td>
<td>£245,533</td>
<td>£211,959</td>
</tr>
</tbody>
</table>

*Assuming full redeployment
re-deployment of dentists and dental nurses is difficult.

Implementation of the **No Change Option** would have the following impact:

**Staff**

- The staffing complement would need to be increased to provide Monday-Friday five day a week service i.e. staffing complement would need increased by 1 x 0.2 WTE Dentist and 1 x 0.2 WTE Dental Nurse

**Service**

- There would continue to be provision of NHS dental services from Lochside clinic.
- Criteria would need to be developed to allow prioritisation of any additional capacity to those who would benefit most from accessing local care. Any criteria developed would need to be equality and diversity impact assessed.
- There would be a need to change emergency dental cover arrangements when the dentist is not available, currently patients may be required to travel to Sanquhar to access care in these circumstances. Appropriate arrangements with Independent Dental Contractor practices within Dumfries would need to be put in place. Provisional exploration of this has taken place and should be achievable.

### 4. Assessment of impact on:

#### i) All patients:

Implementation of **Preferred option (Withdrawal)** would have the following impacts:

All patients would need to change the current location of provision of NHS dental care and also change their dentist. However, they would continue to receive dental care under the same NHS General Dental Service terms and conditions. This transfer would be facilitated by the Health Board.

Implementation of the **No Change Option** would have the following impact:

All existing registered patients could continue to receive NHS dental care at the clinic. There would be a small amount of additional capacity (approximately 250 people) to allow additional registrations. Clear criteria for allocation of any additional capacity would have to be developed.

#### ii) Different equality groups (legislated protected characteristics)*:

Equality and Diversity has been considered throughout the review process. A final impact assessment was undertaken using the joint Council and NHS Toolkit. This involved members of the Review Team, a patient representative and the sections on age and disability were also discussed with a representative from DG Voice. A summary of the results of the impact assessment are presented below. The required Impact Assessment Summary Sheet is presented in **Appendix 5**. A summary of the capacity and accessibility of Independent Dental Contractor Practices is available in **Appendix 7**.
Implementation of **Preferred option (Withdrawal)** was assessed as having the following potential impacts:

<table>
<thead>
<tr>
<th></th>
<th>Negative</th>
<th>Positive</th>
<th>No Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Disability</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Gender Re-assignment</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Marriage/Civil Partnership</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Pregnancy/Maternity</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religion or Belief</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Health and Wellbeing Inequalities</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

In summary this option was noted as having:

- 8 Positive Impacts (All Low)
- 26 No Impacts
- 12 Negative Impacts (3 Low and 9 Medium)

None of the impacts were felt to be unjustifiable. The areas of potential impact, explanation and action to be taken to mitigate are outlined in **Table 3**
<table>
<thead>
<tr>
<th>Impact Area</th>
<th>Explanation and action to be taken</th>
</tr>
</thead>
</table>
| Age, Disability, Pregnancy and Maternity, Health and Wellbeing and Health Inequalities | Withdrawal of a service which is highly valued by registered patients and is well equipped for a variety of age ranges, those with disabilities and pregnant women. Location of new dental clinic may be less convenient in terms of access and location. Accessible clinics are available for continued NHS dental treatment in Dumfries town.  
**Mitigating Actions**  
- Transfer to another practice would be facilitated by the Health Board and would involve provision of information in accessible format and include information on accessibility of other practices, transport routes and the taxi card scheme. Drop in sessions to support the transfer would also be held at the clinic  
- Implementation of the OHNA recommendations to help support wider determinants of oral health. |
| Pregnancy and Maternity                                     | Women who are pregnant or 12 months following the birth of their child are entitled to free dental care as they are potentially at greater risk of developing dental problems.  
**Mitigating Actions**  
- Add recommendation into the OHNA regarding working with maternity services to support pregnant women to obtain dental treatment for themselves and their baby when born. |
| Health and Wellbeing and Health Inequalities                  | People who live in areas of deprivation are at greater risk of experiencing poorer oral health. Registered patients living in Lochside and Lincluden (noted as an area of deprivation) may experience greater inequalities due to increase in travel time and travel costs to access other dental practices. Noted that the vast majority of those living in Lochside and Lincluden area currently access NHS dental services within Dumfries Town.  
**Mitigating Actions**  
- Liaise with Financial Inclusion and Assessment Team (FIAT) to link up facilitated transfer process to information on benefit and financial support  
- Implementation of the OHNA recommendations to help support wider determinants of oral health. |
| Race                                                         | Patients whose first language is not English may not be able to understand the information on how to transfer their dental registration.  
**Mitigating Actions**  
- Identify any patients whose first language isn’t English and ensure they are supported through the transfer process. |
Implementation of the **No Change Option** was assessed as having following potential impact:

<table>
<thead>
<tr>
<th></th>
<th>Negative</th>
<th>Positive</th>
<th>No Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Disability</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Gender Re-assignment</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marriage/Civil Partnership</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy/Maternity</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Religion or Belief</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Health and Wellbeing Inequalities</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

In summary this option was noted as having:

10 Positive Impacts (9 High, 1 Low)
29 No Impacts
9 Negative Impacts (9 Medium)

None of the impacts were felt to be unjustifiable. The areas of impact, explanation and action to be taken to mitigate are outlined in **Table 4**.
### Table 4 No Change Option Areas of Potential Impact and Mitigating Actions

<table>
<thead>
<tr>
<th>Impact Area</th>
<th>Explanation and action to be taken</th>
</tr>
</thead>
</table>
| Age, Disability, Pregnancy and Maternity and Health and Wellbeing Inequalities | Emergency Cover arrangements would need to be altered if this option was progressed as currently patients may be required to travel to Sanquhar for emergency treatment. **Mitigating Actions**  
- Arrangements would need to be put in place to with local Independent Dental Contractor practices in Dumfries to allow access closer to home for management of a dental emergency. Access requirements of individuals with an emergency would need to be considered during triage. |
| Age, Disability, Pregnancy and Maternity and Health and Wellbeing Inequalities | There is limited additional capacity to take on new patient registrations with this option. **Mitigating Actions**  
- Agreed criteria would have to be developed to prioritise how this capacity was used. These criteria would need to be subject to equality and diversity impact assessment. Any criteria agreed would need to be implemented in an open and transparent way to help mitigate impacts on good relations between groups. |
| Health and Wellbeing inequalities | There is limited opportunity to influence inequalities with this option and a risk that the option increases inequalities. **Mitigating Actions**  
- Implementation of the OHNA recommendations is required to help support the wider determinants of oral health. |

### iii) Other NHS services:

Podiartry Services are currently the only other service being provided from Lochside Clinic. They are reviewing their service accommodation model in light of the new hospital build. Podiartry services are currently provided from Lochside Clinic two days a week (Mon and Thursday) with an additional clinic provided once a month on a Wednesday. The podiarty clinics utilise the support of the Dental Receptionist to assist with running of the clinic i.e. letting people into the clinic, being a presence should a patient take unwell. If the Preferred option (withdrawal) were implemented Podiarty Services would need to consider how to provide the necessary clinic support, if they are to continue to utilise Lochside Clinic.

Whilst Speech and Language Therapy for Children and Young People previously held clinics within Lochside Clinic, they have now relocated their services to the Lochside Children’s Services Centre which is currently being developed into a Family Centre. This will allow them to further integrate and develop their services in partnership with the other services and families using this facility.

If the Preferred option (withdrawal) were implemented there would be a reduction in through put of dental equipment for Central Sterilisation Services (CSSD).

As identified within the OHNA recommendations there will be a need to increase collaborative work between the Oral Health Team and with other Health and Social Care services, such as Health Visiting, Maternity Services and Nithsdale Health Improvement team to address some of the wider determinants.
of poor oral health. This would be the case whichever option were implemented.

iv) Partner organisations:

As identified within the OHNA recommendations there will be a need to increase work with partner organisations, such as education, early years services, welfare services and the Third and Independent Sector to address some of the wider determinants of poor oral health. This would be the case whichever option were implemented.

v) The local economy and suppliers:

If the **Proposed Preferred option (withdrawal)** were implemented this would increase sustainability of the independent dental contractor sector and should support jobs in the local economy.

vi) Other stakeholders:

Not applicable

5. Accommodation/estates impact (particularly in respect of access issues):

The NHS Boards Asset Management Strategy is to rationalise the estate and to vacate underutilised or inefficient properties.

If the **Preferred option (withdrawal)** were implemented the Boards Asset Management Group would be able to consider the long term future of the clinic in line with the Asset Management Strategy.

If the **No Change Option** were implemented the Boards Asset Management Group would be able to consider how to best to use the existing space within the clinic in line with the Asset Management Strategy.

6. Health Inequalities and Wellbeing

Lochside Clinic is situated in North West Dumfries, in an area classified as within the 20% most deprived areas in Scotland.

Poor oral health is associated with deprivation. Children living in deprived areas are more likely to have had experience of dental decay than those living in more affluent areas. Adults living in more deprived area are more likely to have no natural teeth and oral cancer most commonly occurs in those living in areas of deprivation.

NHS Dumfries and Galloway has a clear purpose:

- To deliver excellent care that is person centred, safe, effective, efficient and reliable
- To **reduce health inequalities** across Dumfries and Galloway

and believes that for services to **reduce health inequalities**

- We should focus health improvement and prevention efforts on those people and areas where wellbeing is already low or who are most at risk of future ill health and disease.
- Within the limits of clinical safety, we will provide enhanced access to services across the region to those people who are most at risk of future ill health and disease.
Feedback from the Consultation on the two options highlighted concern both of patients and the community that the closure of the clinic would be a loss to the community, particularly as this is classified as an area of deprivation. Concerns were also raised about the potential impact of withdrawal on those who could potentially struggle to attend for dental care in another location. Feedback from both the Consultation and Participatory Appraisal undertaken as part of the OHNA identified that people living in the area would like to register with the Clinic.

The Participatory Appraisal work also highlighted that whilst transport/access was mentioned by a number of individuals as an issue for accessing dental services, wider and more complex reasons which may contribute to attendance at the dentist were also identified; including costs of dental treatment, fear of dental treatment, lack of awareness of the need to attend a dentist (particularly for those wearing dentures) and reported poor previous experiences. It also demonstrated that the majority of individuals living in the Lochside and Lincluden area registered with an Independent Contractor Dental practice advised that their last visit to the dentist was a positive event.

The above may seem at odds with a Preferred option of Withdrawal of a dental service from an area of deprivation. It must be remembered that the options appraisal process assessed each option against a number of criteria, which whilst considering health inequalities also looked at a range of other important criteria, including patient experience, workforce, sustainability and strategic direction. It also included financial benchmarking.

The remainder of this section highlights some of the history of establishment of this clinic, the data regarding access to dental services for the Lochside and Lincluden population and some of the qualitative responses received as part of the participatory appraisal. It is important to consider this when assessing the potential impact of the two options on health inequalities.

The Lochside Dental Clinic was established as a (then) Salaried Dental Service Clinic in 2006 in an attempt to address the challenges regarding access to NHS dental services across the region. Lochside clinic was chosen as a site for a Salaried Dental Service as the existing clinic had space available to accommodate the dental service. The clinic was not sited in North West Dumfries due to the deprivation status of the area nor was it established to specifically address oral health inequalities. At the time this clinic, and other Salaried Dental Clinics opened, the NHS Board held a dental allocation list. This was a list of people who were awaiting allocation to a NHS Dental practice when a place became available. Individuals/families were allocated to clinics across the region dependent on their position on this list and places available. There was no priority given to people living in the Lochside and Lincluden Area for registration at the clinic and inevitably this meant that people from across Dumfries and Galloway were originally allocated to the dental clinic at Lochside. The clinic has been closed to new dental registrations since 2012 as the list size was at capacity for the dentist. Since this review has been ongoing there has been a reduction in the numbers of patients registered, but it was not felt to be appropriate to register patients when the future of the clinic was uncertain and there was capacity within the Independent Dental Contractor practices in Dumfries.

As part of the OHNA the dental registrations for Lochside clinic were reviewed. This identified that of the 1,334 individuals registered to receive dental treatment at the clinic, it is estimated that 458 were resident in the Lochside and Lincluden area, with the remaining 876 living outwith this area.

Dental registration rates for the Lochside and Lincluden area population were also reviewed. This demonstrated that 86% of the population were registered with a NHS dentist, 79% of which being registered with Independent Dental Contractor practices and only 7% being registered with the Lochside Clinic. Whilst this does suggest that 14% (approximately 950 people) living in the Lochside and Lincluden area are not currently registered with an NHS dentist, some may be registered with a private dentist, and some may not wish to be registered with an NHS dentist preferring to only access care when they chose or in an emergency situation. Unfortunately some individuals may be living in such challenging circumstances that attending a dental service, regardless of how accessible it is, may not be
possible. It is noted that currently eight dental practices within Dumfries Town are accepting NHS patients for registration. Access to emergency only treatment is available through the Dental Helpline during the day and via NHS 24 out of hours.

Data regarding dental participation rates was also reviewed. This is defined as the percentage of those registered who have had contact with an NHS dentist in the previous two years. The participation figures for Scotland are 72%, Dumfries and Galloway figures are slightly higher at 77%. The figure for those living in the Lochside and Lincluden area overall was 70%, but the figures for those living in the Lochside and Lincluden area who accessed Independent Dental Contractors was 71% percent with the figure for those living in the Lochside and Lincluden area registered at the Lochside Clinic being 61%. This does perhaps suggest that it is not necessarily having a local clinic that influences participation in NHS Dental Services.

Although the Lochside and Lincluden area is classified as an area of deprivation according to the Scottish Index of Multiple Deprivation, this does not mean that all people living in this area are income deprived. The review of exemption status from dental charges of patients attending Lochside clinic who reside in the Lochside and Lincluden area identified that 135 individuals are exempt from paying NHS dental treatment charges due to some form of income exemption category, when broadened to include exemption categories; of under 18 years of age, educational status and pregnancy the total came to 267. These figures are perhaps more appropriate estimates of the number of patients on low incomes/from low income families living in the Lochside and Lincluden area who attend the Lochside clinic.

Health inequalities were considered during the options appraisal and this was considered in further detail during the impact assessment, which concluded that:

If the Preferred option (withdrawal) were implemented there would potentially be medium negative impacts in terms of health inequalities and wellbeing. There was also a potential low positive impact if during the transfer process links could be made with the FIAT team to support financial inclusion and also from implementation of the OHNA recommendations.

If the No Change Option were implemented there would potentially be high positive impacts for patients living in the Lochside and Lincluden area. There may also be medium negative impacts in terms of health inequalities and wellbeing, due to the limited capacity of the clinic to take on all patients who may wish to be registered. It was also felt that due to the original set up of the clinic it may be that health inequalities are actually being increased because the service is being accessed by those living in areas outwith the areas classified as deprived.

The impact assessment would suggest that neither of the options is a panacea to address oral health inequalities, and that neither option is likely to have a significant effect on health inequalities at a population level.

Whilst access to dental services is an important factor in maintaining oral health it must be recognised that there are many factors that influence an individual’s general and oral health and wellbeing. Many of the common oral health diseases are preventable with appropriate self care and reduction in the frequency and consumption of sugar containing foods and drinks, cessation of smoking and moderation of excessive drinking habits. These are also risk factors common to many other chronic disease and often affected by the wider determinants of health.

Emerging research aimed at tackling oral health inequalities is challenging the current “downstream” approach which tends to focus on disease specific individual prevention and outlines the need to work in partnerships across sectors and disciplines to address the wider determinants of health including the social, economic, community and environmental factors. The importance of giving priority to
interventions targeting early life is also promoted.

There is a great deal of excellent partnership work already ongoing in the Lochside and Lincluden area. The following recommendations identified in the OHNA outline some additional areas of work that should be taken forward to improve population health and wellbeing and support a reduction in both general and oral health inequalities. The 1986 WHO Ottawa Charter outlined five key areas of action for promoting health. This framework has been used to structure the OHNA recommendations which will support a reduction in both general and oral health inequalities and should be implemented regardless of which option is pursued.

- **Healthy Public Policy**

  Link with colleagues across Dumfries and Galloway and nationally to increase action/advocacy for:

  - Reduction in sugar consumption
  - Restriction of marketing of unhealthy foods and drinks to children and improved food labelling.

- **Creating Supportive Environments**

  - Ensure oral health is included in health and wellbeing plans for schools and nurseries
  - Provide additional support to schools/nurseries/early years groups in the Lochside and Lincluden area re development of healthy food and drink policies and in their implementation.
  - Work with schools in the Lochside and Lincluden area to support expansion of the school toothbrushing programme all through the school
  - Work with health visiting teams in the Lochside and Lincluden area to increase the amount of support provided to young families via the Childsmile practice programme to encourage increased rates of dental registration in the early years of life.
  - Work with maternity service teams in the Lochside and Lincluden area to increase the support provided to expectant mothers regarding dental and oral health.
  - Engage with other key health and social care professionals to ensure consistency of messages regarding oral health and to maximise existing opportunities to promote improved oral health.
  - Link with Third and Independent Sector organisations working in the Lochside and Lincluden area to maximise capacity to support improved oral health.
  - Strengthen follow up support pathways for children identified as having potential dental problems following fluoride varnish application in nurseries and schools in the Lochside and Lincluden area
  - Explore the opportunity to include toothpaste and toothbrushes in food bank packages for families living in the Lochside and Lincluden area.

- **Strengthening Community Action**

  - Undertake community engagement with families and older people living in the Lochside and Lincluden area regarding oral health.

- **Supporting Behaviour Change**

  - Provide Continued Professional Development (CPD) opportunities to those involved in supporting oral health behaviour change to ensure that behaviour change techniques are based on evidence based psychological theory.
• Re-orientation of dental healthcare systems
  • Provide CPD opportunities for dentists and dental teams regarding oral health inequalities
  • Work with dental practices to ensure that appropriate clinical prevention is provided to children and adults at high risk of developing dental decay
  • Work with dental practices to review their appointment systems for those individuals who may require a greater degree of flexibility due to challenging personal circumstances.
  • Provide support to dental practices to help them link to other relevant services and agencies within their local community
  • Promote the opportunity for individuals within the Lochside and Lincluden Community to receive dental treatment via the Dental Student Outreach Teaching and Dental Therapy School at Dumfries Dental Centre.

7. Anticipated full and part year savings:
   (include gross savings & any ‘spend to save’ investment required)
   Estimated costs of Implementation of each option are outlined in Table 5

Table 5 – Total Estimated Annual Costs of Implementation of Each Option

<table>
<thead>
<tr>
<th>Option 1</th>
<th>Option 2*</th>
<th>Option 3</th>
<th>Option 4a</th>
<th>Option 4b</th>
<th>Option 9a</th>
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<td>£157,158</td>
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<td>£211,959</td>
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</table>

*Assuming full redeployment.

If the Preferred option (withdrawal) were implemented this would result in an estimated net saving of £105K. With a reduction of £157K from Health Board Public Dental Service Budget and an estimated resultant increase of £52K spend from the non-discretionary Scottish Government held General Dental Services Budget.

If the No Change Option were implemented the Health Board Public Dental Service Budget would be required to continue to cover the £157K running costs.

Options 3, 4a&b and 9a&b would have required additional investment ranging from £14K-£106K dependent on the option compared to Option 1 (Status Quo). On cost grounds these options were not consulted on.

It is not anticipated that additional resources are required for implementation of the OHNA recommendations as the majority of actions are based on working in a more collaborative way to maximise the opportunities and resources that currently exist.

8. Benchmarking / Best Value:
   (describe how the proposal has been benchmarked & best value assured)
   This has been undertaken via the financial aspect of the options appraisal process.

9. Key tasks required to deliver outcome:
If the Preferred option (withdrawal) were implemented:

- Priority given to completing outstanding courses of treatment for patients
- Capacity re-confirmed with Independent Dental Contractor practices
- Patient transfer documentation produced and issued
- Drop in clinics held to support individuals requiring additional support with the transfer process
- Patient transfer process completed.

If the No Change Option were implemented

- Review of provision of emergency care when dentist not available
- Recruitment of 0.2 WTE Dentist and 0.2 WTE Dental Nurse to staff clinic 5 days a week.
- Criteria developed for acceptance of new patients where capacity allows

Both options will require implementation of the OHNA recommendations as per the action plan.

10. Consultation/communication required/ undertaken:
(include Staff Partnership process)

The Scottish Health Council provided advice and support in development of the review engagement plan which has been implemented (see Appendix 2). They have confirmed that the engagement process followed during the review has been proportionate and inclusive to allow for full participation.

Following direction from the IJB to consult on more than one option, the Health Board Management Team agreed that due to the additional costs of options 3, 4a&b and 9a&b only the Preferred option (withdrawal) and the No Change option should be consulted on given the challenging financial situation facing the NHS Board.

Feedback on the Preferred option of withdrawal and No Change Option, was sought from patients registered to receive dental treatment from Lochside Clinic. Feedback on these options was also received from Community Representatives and Organisations. 160 patient responses were received, approximately 13% of the registered patients. However, it must be noted that responses were sometimes submitted on behalf of other family members so it is likely that this represents the views of greater than 13% of the registered patient population. In summary the key points raised by registered patients and Community Representatives were as follows:

- It is clear that those patients who commented highly value the service they receive and would like to continue to receive dental services from the Lochside Dental Clinic. These patients will live in both the Lochside and Lincluden area, and also areas outwith this.

- A high number of comments received were from patients confirming their satisfaction of the level of service provided, accessibility and parking at the Lochside Dental Clinic.

- Many patients and community representatives were also concerned that the closure of the clinic would be a loss to the community, particularly as this is classified as an area of deprivation and were also concerned about the potential impact on those who could potentially struggle to attend for dental treatment in another location. There was also a feeling that opportunities exist to expand the services from the clinic both from a dental perspective but also through other health and social care services.

- Other key themes that emerged were concern over the; sustainability of other practices to continue to provide NHS services, level of service provided at other NHS practices and concern over access and parking at alternative practices. There was also a feeling that the changes were
being driven by finance as opposed to improved patient care.

Some concerns were raised regarding the level of community engagement during the review process.

Feedback on the options were also sought from local dental teams. Only one response was received which was supportive of the Proposed Preferred option.

The IJB Strategic Planning Group were also given the opportunity to comment on the options. Only one respondent commented on the options. This respondent indicated support for the Preferred option as long as the recommendations from the OHNA report were implemented.

A report providing further information on the Consultation is presented in Appendix 6. As is outlined in the review Engagement Plan (Appendix 2) a review will be undertaken of the engagement process to identify any lessons that could learned for when undertaking future engagement exercises.

Both UNISON and the British Dental Associate have been involved in the review process.

11. Key risks / How risks will be managed:
   (consider use of Board’s risk management matrix)

If the Preferred option (withdrawal) were implemented the following risks may be encountered:

Patient Experience

Patients have made it clear that they highly value the service they receive from Lochside Clinic and would like to continue to receive dental services from the Clinic. Patients have noted access/parking, including disabled parking, and convenient location of the clinic as key features.

Where withdrawal and transfer of patients from the Public Dental Service to the Independent Dental Contractor Sector has occurred previously, steps to mitigate concerns were put in place which included provision of information on location and accessibility of Independent Dental Contractor practices to support patient choice. The NHS Board is not aware of any complaints following the transfer of patients to the Independent Contractor sector following withdrawal of routine General Dental Services from Lochmaben and Dumfries Dental Centre.

Public Perception

This option is contentious. The feedback from patients during the engagement process, Local councillors, and local Community Councils indicates strong opposition to the Proposed Preferred option (withdrawal).

Health Inequalities

It is acknowledged that those living in the Lochside and Lincluden area registered at Lochside Clinic would need to travel into Dumfries Town for their dental care. Increased travel costs and time for travel could be a barrier to people accessing dental services. However, we know from the review of dental registration data that an estimated 79% of the Lochside and Lincluden population currently make this journey to access dental care. It is unlikely that this option will impact significantly on health inequalities at a population level. Facilitated transfer of patients with the view to work with the FIAT team to support financial inclusion during the transfer process may help to mitigate this. Implementation of the OHNA recommendations will also help to address the wider determinants of poor oral health through an increased focus on preventive activity.
Independent Dental Contractor Capacity

At present capacity reported by the Independent Dental Contractor sector is far in excess of that required to disperse patients from Lochside clinic (capacity of 12,500+ across Annandale and Eskdale, Nithsdale and Stewartry reported as available, with 8600+ reported available in Nithsdale). However, it is recognised that a proportion of this capacity is provided by dentists who come from the European Union (EU). It is not yet known what the impact of withdrawal of the UK from the EU will have in regards to this. However, two practices have indicated they are finding recruitment challenging. These practices are actively recruiting, utilising skill mix of dental therapists and have arrangements in place to provide continuing care of registered patients. The Board is currently developing a recruitment and retention action plan to ensure a sustainable Independent Dental Contractor workforce and remote and rural recruitment has been raised with the Chief Dental Officer. Current workforce estimates demonstrate that there should be sufficient number of dentists to provide NHS dental care in Scotland. It is considered by the review team that should Independent Dental Contractor workforce become challenging that this would become a much wider regional issue, that keeping Lochside clinic would not in itself address and other solutions would be required. Of our current Independent Dental Contractor workforce 45% are from the EU.

Staff Redeployment

It is acknowledged that it can be challenging to redeploy dentists and dental nurses, redeployment would be actively progressed by Human Resources.

If the No Change Option were implemented the following risks may be encountered:

Service Sustainability

One of the criteria reviewed as part of the options appraisal was service sustainability. As a single handed dental clinic this service is vulnerable as should the dentist be off for any reason there is not capacity to provide emergency cover or ongoing care for patients at this clinic from within the Public Dental Service. Arrangements would therefore need to be agreed with Independent Dental Contractors to provide emergency care in event the dentist is not available.

Staff Recruitment

Recruiting the additional 0.2 WTE dentist and 0.2 WTE dental nurse to provide the Monday to Friday service may be challenging.

Staff Experience

It is recognised that single handed services are not ideal from a clinical governance perspective. Whilst the services provided by the dental team are not in question and are indeed very highly thought of by patients, over the longer term, isolation from other clinical team members may impact on the overall staff experience and limit staff development.

Patient Experience

Service provision at the clinic is limited to NHS dental services and not all dental treatment is available on the NHS. This means, if patients wish to have private treatment options they would be required to attend another dentist, which could reduce continuity of care. If an additional dentist were recruited to provide cover for the additional day a week this would result in restriction of appointment days for those patients registered with that dentist.
Public Perception

Feedback from the Consultation advises that many people would like to register at Lochside clinic now that they are aware that it is there. There is only limited capacity for additional registrations and this may cause upset within the community that not everyone who wishes to be registered there can be. Criteria for any additional capacity will need to be developed and implemented in a clear and transparent way.

Health Inequalities

Whilst this option may appear to address health inequalities, due to the current patient make up of the clinic i.e. many of those registered living outwith the area of deprivation, the opportunity to influence this is limited and it is unlikely that progression of this option will impact positively on oral health inequalities at a population level. There is a danger that choosing this option is seen as solution to addressing oral health inequalities in this area and that the recommendations from the OHNA are not implemented. Progression of the OHNA action plan must be progressed regardless of which option is agreed on.

Scottish Government Policy Direction

Scottish Government Policy direction is for routine General Dental Services to be provided by the Independent Dental Contractor sector. Given the capacity currently available within our Independent Dental contractor sector in Dumfries town this option is against this overall strategic direction. A strong rationale for choosing this option will be required to ensure funding continues to be available for the clinic.

12. Potential Unintended Consequences / How these will be managed:

If the Preferred option (withdrawal) were implemented there may be increased waiting times for appointments in the Independent Dental Contractor sector. Managed by transferring patients at the end of a course of treatment, or those who have completed treatment and are awaiting a routine recall appointment. This would mean that the majority of patients transferred should be dentally fit and not have high treatment needs. Work could also be undertaken with the independent contractor dental practices to explore means of increasing service capacity through changes in skill mix.

Withdrawal of the Public Dental Service Clinic may leave a gap in the market which an Independent Dental Contractor may look to fill by opening a dental clinic. The Board has no control over the opening of independent dental contractor practices, but given the strength of local feeling regarding access to NHS dental services this could be viewed positively by the community. Funding for this would be from the GDS non-discretionary Scottish Government held budget.

13. Potential Other Options:

The following options were considered but were not put through the options appraisal process for the reasons outlined below:

Option 5 Retention of Service until the dentist leaves then move to withdraw

Reason For Rejection

- Not appropriate to plan service provision based on personal circumstances of staff

Option 6 Retention of Lochside and Lincluden area patients with dispersal of those living out with this area

Reason for Rejection

- Clinic would become inefficient
- Number of patients would not warrant full time dentist therefore would become difficult to provide
the service according to NHS General Dental Service Terms and Conditions

**Option 7 Re-attempting Leasing of clinic to the independent Dental Contractor Sector**

Reason for Rejection
- The regulations surrounding TUPE make this option non-viable in the short to medium term.

**Option 8 Provide Special Care Programme from Clinic**

Reason for Rejection
- Previously been agreed to centralise the special care programme in Dumfries Dental Centre and Stranraer to make most efficient use of specialist resources

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**For Fully Developed Proposal**

In addition to completion of template, confirm that all requirements are completed and information/ details attached (Tick)

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Engagement Plan: Review of Provision of Routine General Dental Services by the Public Dental Service From Lochside Clinic

Background

The NHS Reform (Scotland) Act 2004 states that Health Boards should ensure patients are involved in planning and developing services. Involving patients can help services meet need. It can build a relationship of trust between patients and services, and can help to manage expectations.

In 2006, registration with an NHS Dentist in Dumfries and Galloway stood at 33% of the population, with a waiting list of over 30,000. Consecutive Scottish Governments have implemented various policy initiatives to improve access to NHS Dental Services. One method of addressing the difficulties in access was to increase provision of Salaried General Dental Services in areas where access to Independent Contractor General Dental Services was poor. NHS Dumfries and Galloway established 7 Salaried Dental Clinics throughout the region including: Dumfries Dental Centre, Lochmaben, Lochside, Castle Douglas, Newton Stewart, Sanquhar and Stranraer. Withdrawal of provision of routine General Dental Service by the Salaried Dental Service was undertaken in Castle Douglas in 2008 and in Stranraer in 2012.

In April 2013, a new financial governance framework was introduced for Salaried General Dental Services. As part of this new financial framework an Annual Integrated Service and Financial Plan for the Salaried Dental Service had to be submitted to the Scottish Government before they would agree the release of an earmarked financial allocation directly to the Board. In the guidance accompanying the financial plan Scottish Government advised that:

“Salaried GDS should only be established in areas of unmet need or where there is difficulty in accessing GDS services. Equally, as access improves in an area, boards should be actively managing a reduction in the size of the Salaried GDS workforce.”

Since then a review of access to NHS dental services concluded that access to NHS dental services had significantly improved and that a number of Independent Dental Contractors reported that they had capacity to take on additional patients. This led to the undertaking of a review of provision of routine NHS general dental services by the Salaried Dental Service from its existing clinics. Following agreement of the NHS Board this resulted in withdrawal of routine NHS General Dental Services by the Salaried Dental Services at Dumfries Dental Centre (Specialist Dental Services and Training still remaining), Lochmaben Dental Clinic and Newton Stewart Dental Clinic. The Board attempted to progress leasing arrangements of Sanquhar Dental Clinic and Lochside Clinic for the continued provision of NHS Dental Services however, these arrangements were not able to be progressed. In October 2015 the NHS Board agreed that the situation with regard to Lochside should be further reviewed.

Who are we going to involve?

- The target audience are patients currently registered to receive NHS dental services from the Lochside Dental clinic and those individuals who are resident in the Lochside and Lincluden area.
• We will need to take steps to ensure involvement from different sectors of the community. The process should be inclusive so that participation is possible for everyone, across the equality strands.

• Discussions with the clinic staff regarding the review are ongoing.

• Views of independent dental contractors will also be required.

Benefits of involving our local communities

• The involvement of local people goes some way to ensure that local health needs are met.
• Improves local peoples understanding of delivery of dental services
• Encourages collaboration between groups that would not traditionally work together in a planning process
• Gives insights into a community's needs and values that may not otherwise be obtained.
• People may take more ‘ownership’ of their dental service and therefore utilise it and use it appropriately.

Possible drawbacks

• The Board may decide to proceed with recommendations that patients and/or the Community are not happy with. A summary of patient and community feedback regarding the preferred option will be used to inform the final equality and diversity impact assessment and a summary of the feedback will be included in the final Board paper. This will hopefully provide reassurance that the views of patients and community have been considered.

Do we need any resources?

Some resources will be needed to carry out the proposal. These are:
  a) Staff time – The Consultant Dental Public Health and Dental Services Manger will be responsible for devising the engagement process with contributions from the Review Team. Staff at the dental clinics will also need to contribute some time to help in the recruitment of volunteers.
  b) Expenses - some volunteers and patients may need assistance with; travel or childcare costs.
  c) Refreshments will also be required
  d) Materials –patient letters, posters, information leaflets and patient questionnaires.

How are we going to involve people?

The following involvement is proposed:

Phase 1 - Engaging Patients and Lochside and Lincluden Community
Phase 2 – Options Appraisal
Phase 3 – Consulting on Preferred and No Option Change Option
Phase 4 – Informing of the NHS Board’s Decision
Phase 5 – Reflecting and Learning
These Phases are now detailed below.

**Phase 1 – Engaging Patients and Lochside and Lincluden Community**

**Expected Outcomes**
- Patients will be aware of the review and able to provide feedback on what matters to them regarding dental service provision
- Members of the Lochside and Lincluden Community will be able to provide feedback on their oral health needs and their experience of accessing dental services
- Volunteers for the options appraisal process will be identified
- Information gained from this phase, in conjunction with other data sources will be used to inform development of a short list of options for future service delivery from Lochside Clinic, which will then go through an options appraisal process.
**Phase 1 – Engaging Patients and the Lochside and Lincluden Community**

**Aims**
To advise those registered patients of Lochside clinic of the review and gain feedback on what matters to them in terms of dental services provision. To obtain information on the reported oral health needs and accessibility of dental services for the Lochside and Lincluden community. Volunteers for the options appraisal will be recruited.

**Method**
- Letters will be sent to patients on the review and a questionnaire seeking feedback on what matters to them will be enclosed with the letter
- Information on the review will be posted on the Health Board’s website
- The Participatory Appraisal network will undertake work within the Lochside and Lincluden Community to gain feedback on oral health needs and accessibility of dental services
- Information received will be used by the review group to inform a short list of options for future service delivery.

**Responsibility**
- The Dental Services Manager will develop the patient letter, leaflet and questionnaire in conjunction with the Scottish Health Council
- The Dental Services Manger will be responsible for uploading relevant information on to the Health Board website
- The Dental Services Manager will be responsible for providing a report on patient feedback
- The Consultant in Dental Public Health will work with the Participatory Appraisal Network to design the Lochside and Lincluden Community engagement
- Clinic staff will help identify patients living in the Lochside and Lincluden Community who may be willing to be involved in the participatory appraisal
- Consultant in Dental Public Health will be responsible for producing Oral Health Needs Assessment Report of the Lochside and Lincluden Area which will include findings of the Community Engagement.

**Cost**
- Staff costs will be absorbed through existing budgets
- Poster and leaflet costs will be absorbed through existing budgets

**Timelines**
- Feedback from patients will be gathered between 6th January 2016 to 10th February 2016
- Volunteers for the options appraisal will be identified by the 30th of June 2016
- The Participatory Appraisal will be undertaken between the 26th of May and the 24th of June with a report provided by the 4th of July 2016
- Review group meet on 14th of July 2016 to consider patient feedback and Oral Health Needs Assessment to develop a short list of future service delivery options.
Phase 2 – Options Appraisal

Expected Outcomes:

- Options Appraisal will be completed with patient and community representation
- Preferred Option will be identified

Phase 2 Part 1 - Options Appraisal Volunteer Preparation

Aim
Volunteers will be appropriately prepared for participation in the options appraisal process.

Method
Volunteers will be required to attend an initial briefing session prior to the options appraisal this will last 2 hours. This will include the following elements and will allow participants an opportunity to ask further questions:

- Presentation, including background to review and process to date (including overview of how the long list was developed into a short list)
- Discussion of the background information document to ensure participants can understand the documents provided
- Outline of the options appraisal process and how it will work
- A member of the Scottish Health Council will attend the session to support participants.

Responsibility
- It will be the responsibility of the Consultant Dental Public Health and Dental Service Manager to provide the briefing session and provide those involved with a background information document containing relevant information and overview of the options appraisal process.

Costs

- Staff time will be absorbed through existing budgets
- Expenses for participants will be meet through Dental Services Budget

Timeline

- It is hoped that background documentation will be shared 1 week prior to the options appraisal.
Pre options appraisal session will be undertaken the day prior to the options appraisal.
Phase 2 Part 2 – Options Appraisal Session

Aim
Volunteers will participate in an options appraisal process together with representatives from DG Voice Public Dental Services, Primary Care Development, Public Health, Nithsdale Health and Social Care Locality, Independent Dental Contractors, Human Resources, Estates and Finance.

Method
Volunteers supported by Scottish Health Council will participate in the options appraisal. It is anticipated the options appraisal will last 5 hours. An outline of the options appraisal process is detailed below:

- Aims and Objectives
- Overview of how short list was developed
- Benefits and Risks of short listed options
- Benefits Criteria
- Rank and Weighting
- Scoring Process – Consensus on the day
- Next Steps

Responsibility
- It will be the responsibility of the Consultant Dental Public Health and Dental Service Manager to develop and circulate the documentation required for the options appraisal
- It will be the responsibility of the Consultant in Dental Public Health to secure a facilitator for the session
- It will be the responsibility of the Dental Services Manager to provide a note taker for the session

Costs
- Staff time will be absorbed through existing budgets
- Expenses for participants will be meet through Dental Services Budget

Timeline
- The aim is to complete the qualitative aspects of the options appraisal on the day via undertaking consensus scoring.
- The financial appraisals will be undertaken following the outcome of the qualitative appraisal.
Phase 3 Consulting on Proposed Preferred Option and No Change Option

Expected outcomes

- Patients will be informed of the Proposed Preferred Option (withdrawal) following the options appraisal and No Change Option
- Patients will understand what the results of any proposed change would mean for them
- Patients will be able to provide their feedback on the options for the Lochside clinic
- Feedback will be given to the Lochside and Lincluden Community on the findings of the Oral Health Needs Assessment
- Feedback from patients and the Lochside and Lincluden Community will help inform the decision making process
- Patients will understand when and where a decision will be made
- Feedback on the Needs Assessment will be sought from key stakeholders

Phase 3 – Informing and Engaging of Proposed Preferred and No Change Option

Aim

Patients are aware of the options for Lochside Clinic, are knowledgeable about what this might mean for them and are able to provide their feedback on this. The Lochside and Lincluden Community will be aware of the recommendations from the needs assessment and have been able to provide their feedback. This feedback will help to inform the final decision making process.

Method

This can be achieved through:

- Letters will be sent to options appraisal participants outlining the preferred option and the next steps.
- Production of a patient feedback sheet outlining what the options would mean for them and where they can get further information will be available at the clinic and the Health Board Website
- Individual patients will be lettered on the two options, given a patient information leaflet and provided with a feedback form
- Both options for the clinic will be displayed at the clinic and on the Board Website
- Links to the Board website will be posted on the Board Facebook page
- A high level summary of the needs assessment findings will be made available at community sites involved in the participatory appraisal with information available on how to provide feedback on this. This information will also be circulated to the Engagement and Participation Network
- Drop in sessions will be held for patients and Community members to find out further information about the Options and the Needs Assessment
- Comments on the options and Needs Assessment will be sought from key stakeholders
- Comments received from patients and the Lochside and Lincluden Community will be summarised and used to inform the final equality and diversity impact assessment and a summary of comments will be included in the final Board paper
- A summary document of the responses will be uploaded to the Board website and will be available on request.
Phase 3 – Informing and Engaging of Proposed Preferred and No Change Option
(Continued)

Responsibility

• It will be the responsibility of the Dental Services Manager to provide letters/posters/info leaflets/Patient feedback sheets for the patients / clinic, these will be developed in partnership with the Scottish Health Council.
• It will be the responsibility of the Dental Services Manager to upload these documents on the Board website.
• It will be the responsibility of the Consultant in Dental Public Health to send a letter to the Options Appraisal participants to advise of the Consultation
• It will be the responsibility of the Consultant Dental Public Health to liaise with colleagues to make information available in the Lochside and Lincluden Community regarding the Needs Assessment.
• It will be the responsibility of the Consultant in Dental Public Health/Dental Service Manager to produce the feedback summary report of the Consultation in collaboration with the Scottish Health Council

Costs

• Staff costs will be absorbed through existing budgets
• Poster and leaflet costs will be absorbed through existing budgets

Timeline

• The Consultation period will last for a 9 week period.
Phase 4 Informing of the NHS Board’s Decision

Expected outcome

- The decision made by the Board will be reported to options appraisal participants, patients and public. The method of doing this will depend on the decision as different levels of informing/engagement may be required. It is anticipated that the review will be completed by August 2017.

Phase 4 Informing of the NHS Board’s Decision

Aim

Decisions are fed back to the patients and the Lochside and Lincluden Community.

Method

This can be achieved through:

- Press release will be issued following the Board meeting
- Letter will be written to those involved in the options appraisal advising of the Board decision
- Patients will receive individual letters advising of decision and what that means for them
- Letters will be sent to those Community Representatives/Community Organisations who responded to the Consultation.

Responsibility

- It will be the responsibility of the Consultant Dental Public Health to liaise with the Communications team regarding the press release
- It will be the responsibility of the Consultant Dental Public Health to notify the options appraisal patient participant, key stakeholders and Community Representatives/Community Organisations of the NHS Board decision
- It will be the responsibility of the Dental Services Manger to provide the patient letter, posters and patient information leaflets in collaboration with the Scottish Health Council.
- Relevant documentation relating to the review will be placed on the Health Board website.

Costs

- Staff costs will be absorbed through existing budgets
- Poster and leaflet costs will be absorbed through existing budgets

Timeline

- The Board meeting will take place in public therefore the decision will become public knowledge very quickly. Posters and patient information leaflets will be available in clinics and on the Board website at most one week following the Board decision.
Phase 5 Reflection and Learning

Expected Outcome

Lessons are learned from the patient public involvement approach used

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<tr>
<td><strong>Aim</strong></td>
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<tr>
<td>To learn lessons from the approach to public involvement undertaken.</td>
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**Method**
This can be achieved through:

- Invitation from Consultant Dental Public Health for meeting/telephone call, to discuss with participants on their thoughts on involvement in the options appraisal process.
- Discussions with staff involved in process, Scottish Health Council colleagues and key stakeholders
- Report on process and learning produced

**Responsibility**

- It will be the responsibility of the Consultant Dental Public Health produce this report

**Costs**

- Staff costs will be absorbed through existing budgets

**Timeline**

- The report should be produced with 3 months of the final Board decision.
Assessing Oral Health Needs of the Lochside and Lincluden Community
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Glossary of Terms

SIMD – Scottish Index of Multiple Deprivation
CHI – Community Health Index population data
P1 – Primary 1
P7 – Primary 7
ISD - Information Services Division
w.t.e – whole time equivalent
Executive Summary

This Oral Health Needs Assessment Exercise reviewed a number of information sources e.g. oral health status, information on dental and oral health services. Engagement exercises were also undertaken with patients of the Lochside Dental Clinic and the Lochside and Lincluden Community. A summary of the findings and the resultant recommendations are outlined below:

Summary of Key Findings

Oral Health

- The Oral Health of Primary 1 children in the Lochside and Lincluden area does appear to be poorer than for Primary 1 children more generally in Dumfries and Galloway. This is not unexpected given the deprivation level of the area.
- Data on the oral health of adults for the Lochside and Lincluden area is not available; however, it is likely that oral health of adults will generally be poorer due to the deprivation status of the area, compared to those in more affluent areas.
- At a Scottish level a significant proportion of the adult population report some level of anxiety about attending the dentist. Barriers to attending the dentist reported at a Scottish level include difficulty in getting an appointment that suits, the expense of dental treatment, difficulty in getting time off work and distance to go to a dentist.

Dental and Oral Health Services

- Dental Registration figures for the Lochside and Lincluden area are high, 86% of the population are registered with an NHS dentist.
- The vast majority (79%) of registrations are with independent dental contractor practices.
- Dental Registration rates are lowest for the 0-2years 11month age group at 37% of this age groups population.
- It is estimated that 458 people from the Lochside and Lincluden area are registered at the Lochside clinic (6.9% of the Lochside and Lincluden population)
- 66% (876) of the people registered to receive dental treatment at the clinic live outwith the Lochside and Lincluden area.
- About 950 people living in the Lochside and Lincluden area are not registered with an NHS dentist (14% of the population of this area). For Dumfries and Galloway as a whole, 15% of the population are not registered with an NHS dentist.
- The location of Lochside dental clinic does not necessarily influences people’s attendance for NHS dental service.
- The nurseries and primary schools in the area benefit from taking part in the Childsmile Oral Health Improvement Programme.
Access to General Medical Practice

- Individuals living in the Lochside and Lincluden community are registered at a number of different General Medical Practices throughout Dumfries Town.

Public Transport

- Frequent bus routes were noted to connect Lochside and Lincluden to Dumfries town centre.

Engagement Work

- Whilst transport/access was mentioned by a number of individuals as an issue for accessing dental services, wider and more complex reasons which may contribute to attendance at the dentist were also highlighted including costs of dental treatment, fear of dental treatment, lack of awareness of the need to attend a dentist (particularly for those wearing dentures) and reported poor previous experiences.
- A number of those who participated in the engagement exercise did advise that they would like to be registered at the Lochside clinic.
- The majority of individuals who participated in the engagement exercise registered with an independent contractor dental practice advised their last visit to the dentist was a positive event.
- Patients registered with Lochside clinic reported they highly value the existing dental service provided from Lochside Clinic and see the clinic as being convenient and having adequate parking.

Recommendations

It is recognised that the Lochside and Lincluden area is classified as being within the most deprived areas in Scotland. However, it is important to recognise that it is a diverse community with many assets. The NHS Board therefore wish to strengthen work with partners to support the Lochside and Lincluden community through carrying out the following recommendations to support improved oral health of the whole community. The recommendations are listed using the Ottawa Charter for Health Promotion Framework.

- **Healthy Public Policy**

  Link with colleagues across Dumfries and Galloway and Nationally to:

  - Increase advocacy for reduction in sugar consumption
  - Increase advocacy for restriction of marketing of unhealthy foods and drinks to children and improved food labelling.

- **Creating Supportive Environments**

  - Ensure oral health is included in health and wellbeing plans for schools and nurseries
o Provide additional support to schools/nurseries/early years groups in the Lochside and Lincluden area regarding development of healthy food and drink policies and in their implementation.

o Work with schools in the Lochside and Lincluden area to support expansion of the school toothbrushing programme all through the school.

o Work with health visiting teams in the Lochside and Lincluden area to increase the amount of support provided to young families via the Childsmile practice programme to encourage increased rates of dental registration in the early years of life.

o Work with maternity service teams in the Lochside and Lincluden area to increase the support provided to expectant mothers regarding dental and oral health.

o Engage with other key health and social care professionals to ensure consistency of messages regarding oral health and to maximise existing opportunities to promote improved oral health.

o Link with Third and Independent Sector organisations working in the Lochside and Lincluden area to maximise capacity to support improved oral health.

o Strengthen follow up support pathways for children identified as having potential dental problems following fluoride varnish application in nurseries and schools in the Lochside and Lincluden area.

o Explore the opportunity to include toothpaste and toothbrushes in food bank packages for families living in the Lochside and Lincluden area.

o Work with council colleagues and dental practices to identify opportunities to improve parking, including disabled parking and support use of public transport within/to Dumfries Town Centre.

- **Strengthening Community Action**

  - Undertake community engagement with families and older people living in the Lochside and Lincluden area to increase awareness of the importance of regular dental checks particularly for those who wear dentures.

- **Supporting Behaviour Change**

  - Provide Continuing Professional Development (CPD) opportunities to those involved in supporting oral health behaviour change to ensure that behaviour change techniques are based on evidence.

- **Re-orientation of dental healthcare systems**

  - Provide CPD opportunities for dentists and dental teams regarding oral health inequalities.

  - Work with dental practices to ensure that appropriate clinical prevention is provided to children and adults at high risk of developing dental decay.

  - Work with dental practices to review their appointment systems for those individuals who may require a greater degree of flexibility due to challenging personal circumstances.

  - Provide support to dental practices to help them link to other relevant services and agencies within their local community.
• Promote the opportunity for individuals within the Lochside and Lincluden Community to receive dental treatment via the Dental Student Outreach Clinic at the Dumfries Dental Centre.

Resources Required to Implement the Recommendations

At this stage it is anticipated that additional resources will not be required to implement the recommendations of this Needs Assessment. Whilst there are a number of pieces of work to take forward, it is not about undertaking new pieces of work, but rather working in a more collaborative way to maximise the opportunities and resources that currently exist.
1.0 Introduction

Oral health is important for general health and wellbeing. In the last 10 years there have been significant improvements in both the oral health of the population and access to NHS dental services. However, just as with health inequalities, inequalities in oral health still exist with those living in more deprived areas often suffering poorer oral health.

2.0 Background

In 2006, registration with an NHS Dentist in Dumfries and Galloway stood at 33% of the population, with a waiting list of over 30,000. Consecutive Scottish Governments have implemented various policy initiatives to improve access to NHS Dental Services.

One method of addressing the difficulties in access was to increase provision of Salaried General Dental Services (now termed Public Dental Services) in areas where access to Independent Contractor General Dental Services was poor. NHS Dumfries and Galloway established 7 Public Dental Service clinics throughout the region including: Dumfries Dental Centre, Lochmaben, Lochside, Castle Douglas, Newton Stewart, Sanquhar and Stranraer. Withdrawal of provision of routine General Dental Service by the Public Dental Service was undertaken in Castle Douglas in 2008 and in Stranraer in 2012.

Following guidance from the Scottish Government NHS Dumfries and Galloway has undertaken a review of its provision of routine General Dental Services provided by the Public Dental Services which has resulted in the withdrawal of routine NHS General Dental Services at Dumfries Dental Centre (Specialist Dental Services and training still remaining) and Lochmaben Dental Clinic. Plans are also in place for the withdrawal of services from Newton Stewart dental clinic in 2017.

The NHS Dumfries and Galloway Board attempted to progress leasing arrangements of Sanquhar Dental Clinic and Lochside Clinic for the continued provision of NHS Dental Services by the independent contractor sector however it was not possible to progress these arrangements. In October 2015, the NHS Board agreed to a further review of service delivery of routine NHS General Dental Services from Lochside Clinic.

As part of this review it was important to undertake an in depth look at the oral health needs of the Lochside and Lincluden population. This would help inform development of any actions required to support the oral health needs of this community and also to help inform the decision making process with regard to future provision of dental services from the Lochside clinic.
3.0 Aim

To undertake an oral health needs assessment of the Lochside and Lincluden Community which would help inform actions required to support identified gaps in oral health need and also inform future dental service provision from Lochside clinic.

4.0 Objectives

The objectives of this needs assessment are to:

- describe the population make up of the Lochside and Lincluden area
- outline the oral health needs of people living in the Lochside and Lincluden area
- describe the provision of oral health care services and oral health improvement programmes available to the Lochside and Lincluden community
- engage with both patients of the Lochside clinic and Lochside and Lincluden community regarding the importance of oral health to them and their experience of accessing dental care
- identify potential gaps in provision of oral health care services and oral health improvement programmes available to the Lochside and Lincluden community
- make recommendations for actions to support improved oral health for the Lochside/Lincluden Community.

5.0 Population Demographics and Variables

The Lochside and Lincluden areas are located in North West Dumfries. Both areas are separated from the main town of Dumfries by the A75 although there is a footbridge which crosses over the A75. For the purposes of data analysis it was necessary to define the area to be classified as the Lochside and Lincluden area. Following analysis of the options it was agreed that the Lochside and Lincluden area would be defined by the core area and college Main data zones outlined in red and green respectively in Figure 1 (also highlighted in red and yellow).

This area was chosen as it contained most of the population living in the Lochside and Lincluden area. These data zones fall into the Scottish Index of Multiple Deprivation Categories (SIMD) 1 and 2, most deprived. The Cuckoo Bridge data zone (outlined and shaded blue in Figure 1) was excluded as the majority of residents of this data zone lived on the town side of the A75 and may not identify themselves as living in either Lochside or Lincluden. This area was identified as SIMD 4 (second least deprived quintile).
The proportion of the population living in each of the areas by SIMD category is demonstrated in Table 1.

Table 1: Populations and deprivation rankings

<table>
<thead>
<tr>
<th>Area</th>
<th>Total census population as at 2011</th>
<th>Proportion of population by SIMD quintile datazone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Quintile 1 (Most deprived 20% in Scotland)</td>
</tr>
<tr>
<td>Core area</td>
<td>5433</td>
<td>77%</td>
</tr>
<tr>
<td>College Mains datazone</td>
<td>690 (includes 160 on town centre side of A75)</td>
<td>100%</td>
</tr>
<tr>
<td>Cuckoo Bridge datazone</td>
<td>1130 (includes 880 on town centre side of A75)</td>
<td></td>
</tr>
</tbody>
</table>
The population data in Table 1 relates to 2011 Census data. Further local analysis has been undertaken using the Community Health Index (CHI) population data (April 2016) for this area. According to the CHI data the population of the defined Lochside and Lincluden area is 6,656. The age breakdown of the Lochside and Lincluden area is outlined in Table 2.

Table 2: Age Breakdown of the Lochside and Lincluden Area

<table>
<thead>
<tr>
<th>Age band</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 2 years</td>
<td>239</td>
<td>4%</td>
</tr>
<tr>
<td>3 to 5 years</td>
<td>286</td>
<td>4%</td>
</tr>
<tr>
<td>6 to 12 years</td>
<td>586</td>
<td>9%</td>
</tr>
<tr>
<td>13 to 17 years</td>
<td>346</td>
<td>5%</td>
</tr>
<tr>
<td>18 to 24 years</td>
<td>705</td>
<td>11%</td>
</tr>
<tr>
<td>25 to 34 years</td>
<td>1,032</td>
<td>16%</td>
</tr>
<tr>
<td>35 to 44 years</td>
<td>786</td>
<td>12%</td>
</tr>
<tr>
<td>45 to 54 years</td>
<td>970</td>
<td>15%</td>
</tr>
<tr>
<td>55 to 64 years</td>
<td>706</td>
<td>11%</td>
</tr>
<tr>
<td>65 to 74 years</td>
<td>560</td>
<td>8%</td>
</tr>
<tr>
<td>75 years and over</td>
<td>440</td>
<td>7%</td>
</tr>
<tr>
<td>All children (0 to 17 years)</td>
<td>1,457</td>
<td>22%</td>
</tr>
<tr>
<td>All adults (18 years and over)</td>
<td>5,199</td>
<td>78%</td>
</tr>
<tr>
<td>All ages</td>
<td>6,656</td>
<td>100%</td>
</tr>
</tbody>
</table>

Life expectancy varies across different areas of Nithsdale with Lochside and Lincluden having lower life expectancy rates for both males and females. Table 3 outlines the average life expectancy of people living in different parts of Nithsdale and affected by health inequalities.

Table 3 Average life expectancy of people living in different parts of Nithsdale

<table>
<thead>
<tr>
<th>Area</th>
<th>Life Expectancy (Years)</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Georgetown</td>
<td>80.2</td>
<td>89.8</td>
<td></td>
</tr>
<tr>
<td>Lochside and Lincluden</td>
<td>73.0</td>
<td>78.2</td>
<td></td>
</tr>
<tr>
<td>Upper Nithsdale</td>
<td>78.3</td>
<td>79.7</td>
<td></td>
</tr>
</tbody>
</table>

6.0 Determinates and Impacts of Oral Health

Good oral health is essential as it influences the general health and quality of life of people. Having good oral health contributes to an individual’s ability to eat, speak, smile, and socialise. As with health generally, a large spectrum of factors have been identified by contemporary public health research as influencing oral health.

These factors are found to range from economic and social policy to individual health behaviours (see Figure 2). Approaches to improving oral health and reducing oral
health inequalities therefore need to address the range of factors which influence oral health and not just focus on modifying individual behaviours.

**Figure 2** Determinates of Health and Wellbeing

![Determinates of Health and Wellbeing](image)


The most common conditions affecting the oral cavity are tooth decay, gum disease and toothwear. Although not common, oral cancer can have a devastating impact on sufferers and has a poor 5 year survival rate.

Many of these oral conditions are preventable. The main cause of tooth decay is the frequency and amount of sugar consumed. As well as directly affecting oral health, high sugar intake is also linked to other chronic diseases such as diabetes and obesity. Smoking and alcohol are also risk factors for oral cancer, which in turn are risk factors for a number of chronic conditions. This has led to the conclusion that a “common risk factor” approach should be adopted wherever possible. This approach is an integrated way of promoting general health by controlling a small number of common risk factors that can potentially impact on a large number of chronic diseases. This is more efficient than disease specific approaches.
7.0 Epidemiology of Oral Disease

7.1 Oral Health of Children

The National Dental Inspection Programme carries out dental inspections for all children in Primary 1 (P1) and Primary 7 (P7). There are two levels of the programme, detailed and basic inspections. Detailed inspections are carried out on a sample of children (alternating between P1 and P7 each year) and provide information to allow monitoring of trends in oral health. The basic inspection is offered to every child in P1 and P7 each year and informs parents/carers of the oral health status of their child.

Significant improvements in the oral health of P1 children have been seen in both Scotland and Dumfries and Galloway in recent years (see Figure 3). However, inequalities in oral health remain. In 1996 only 33% of P1 children in Dumfries and Galloway had no obvious dental decay experience in their deciduous teeth, this figure now stands at 66%. Another means of measuring dental health (deciduous teeth) is the decayed, missing and filled teeth index ($d_{3mft}$). In 2014, the average $d_{3mft}$ for P1 children in Dumfries and Galloway was 1.20 with the score for those having decay being 3.64, for Scotland the figures being 1.27 and 3.97.

**Figure 3 Proportion of P1 children free of obvious decay experience, Dumfries and Galloway compared to Scotland, 1988 to 2014**

Steady but significant improvements have also been seen in the oral health of P7 children in Dumfries and Galloway and Scotland (see Figure 4). In 2005, 66.7% of P7 children in Dumfries and Galloway had no experience of tooth decay in their adult teeth, in 2015 this had improved to 75.1%.
The decayed, missing and filled teeth index permanent teeth (D₃MFT) in 2015 was 0.54 for the whole Primary 7 population but 2.13 for those who had experience of decay, for Scotland the figures are 0.53 and 2.16 respectively\(^6\).

**Figure 4** Proportion of P7 children free of obvious decay experience Dumfries and Galloway compared to Scotland, 2005 to 2015

As all children are offered a basic dental inspection data can be broken down to a smaller area level. However, the data must be interpreted with caution as the numbers become smaller, and large changes in overall percentages may be caused by changes occurring in a small number of individuals. To help inform this needs assessment, data from the P1 basic dental inspection was analysed for primary schools in the Lochside and Lincluden area:

The percentage of P1 children with no obvious decay experience in Dumfries and Galloway and the Lochside and Lincluden area between 2011 and 2015 is presented in **Figure 5**.
Figure 5  Percentage of P1 children with no obvious decay experience in Dumfries and Galloway and the Lochside and Lincluden area 2011 - 2015

Figure 6 presents the basic inspection results for the Lochside and Lincluden area compared to the national data available for the percentage of children with no obvious decay experience in SIMD 1 and SIMD 2 for 2012 and 2014.

Figure 6  Percentage of P1 children with no obvious decay experience SIMD 1 & 2 and Lochside and Lincluden area
Whilst the results presented in Figure 5 appear to suggest that the oral health status of P1 children in the Lochside and Lincluden area does appear to be lower when compared to D&G children generally, this difference is only a statistically significant difference in 2012 and 2015. It should be borne in mind that this difference may be due to small numbers in the Lochside and Lincuden area and therefore should be interpreted with caution. In Figure 6, in 2012 the oral health of P1 children living in the Lochside and Lincluden area was comparable to that of the oral health status of children living in the most deprived quintiles in Scotland. However, in 2014 the oral health status of children living in the Lochside and Lincluden area appears to be better than that of children living in the most deprived quintiles. Again this needs to be interpreted with caution due to the small number of children in the Lochside and Lincluden area.

7.2 Oral Health of Adults

The availability of oral health data for adults is limited both at national and local level. Self-reported data on dental health is available via the Scottish Health Survey. These surveys report that an increasing proportion of the population are retaining at least some natural teeth, with the 2013 figure standing at 92% of the population. However, it is noted at a Scottish level that those living in the more deprived areas are more likely to have no natural teeth (see Figure 7).

Dumfries and Galloway’s changing demographics and patterns of oral health mean that whilst those younger age groups may not require as much restorative dental treatment as in the past, our ageing population may require much more complex dental treatment. In some cases this will be combined with significant co-morbidities.

Figure 7 Percentage of Adults over 16 with no natural teeth by SIMD Quintile

The incidence of oral cancer in Scotland appears to be increasing, and most commonly occurs in those living in areas of deprivation. With an approximate 50% survival rate this is a devastating disease for sufferers and their families.

Information on accessing dental services is included biannually in the Scottish Health survey. The 2013 Scottish Health Survey reported that improvements had been seen in the percentage of adults reporting that they had accessed dental services in the last year, although older people over the age of 75 were less likely to report visiting.
the dentist in the last year. Twenty three percent of respondents advised they felt a bit nervous about going to the dentist and 16% reported feeling very nervous about going to visit the dentist. Participants were presented with a list of potential barriers to visiting a dentist, 72% advised that they did not experience any difficulties when visiting a dentist. The responses to this question are detailed in Table 4.

**Table 4** Responses to reported difficulties when visiting a dentist.

<table>
<thead>
<tr>
<th>Difficulty</th>
<th>% of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulty in getting time off work</td>
<td>5</td>
</tr>
<tr>
<td>Difficulty in getting an appointment that suits me</td>
<td>10</td>
</tr>
<tr>
<td>Dental treatment too expensive</td>
<td>9</td>
</tr>
<tr>
<td>Long way to go to the dentist</td>
<td>5</td>
</tr>
<tr>
<td>I have not found a dentist I like</td>
<td>3</td>
</tr>
<tr>
<td>I cannot get dental treatment under the NHS</td>
<td>3</td>
</tr>
<tr>
<td>I have difficulty in getting access, e.g. steps, wheelchair access</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
</tr>
<tr>
<td>None of these</td>
<td>72</td>
</tr>
</tbody>
</table>

Source: Scottish Health Survey 2013

8.0 Provision of Oral Healthcare Services

8.1 Overview of NHS dental service provision in Dumfries and Galloway

Routine NHS General Dental services in Dumfries and Galloway are currently provided by different workforces:

8.1.2 Independent Dental Contractors

These practitioners provide dental services on behalf of the NHS Board under nationally defined terms and conditions of service. They are obliged to provide all necessary NHS care to their NHS registered patients. However, they are able to decide whether or not they will register patients on the NHS. They are also able to offer private dental treatment should patients wish to receive it.

Independent dental contractors are paid for providing NHS care on the basis of
payments for ongoing continuing care and capitation for their registered patients, additional payments for items of treatment service provided and a number of allowances, as dictated by the Statement of Dental Remuneration. This represents the Scottish Government’s preferred model of provision of NHS Dental Services. It should be noted that General Medical Practitioners, Pharmacists and Opticians also operate as independent contractors.

There are no controls on where an independent contractor dental practice can be established but this will usually be dictated, as with any business, by market forces. Any new dental practice opening which wishes to provide NHS dental treatment must achieve compliance with the requirements of the Scottish Government produced Combined Practice Inspection checklist.

8.1.3 Public Dental Service

The Public Dental Service was established in 2014 and combined the remits of the Community Dental Service and the Salaried Dental Service. The Public Dental Service’s remit is outlined below and is implemented dependent on local need:

- provision of a full range of treatment services to patients with special care needs (both adults and children),
- a referral service for other health and social care practitioners,
- dental care for socially excluded people who would have difficulties accessing independent contractor dental services,
- specialised and specialist services, for example special care dentistry, paediatric dentistry, sedation and general anaesthesia,
- access services e.g. gap in independent contractor service provision, out of hours (OOH) services,
- a public health function – inspections, screening, health promotion and epidemiology,
- teaching & research – undergraduate and dental core training.

The Health Board is the operator of Public Dental Services and employs all staff working in the Public Dental Service. Public Dental Services can only provide NHS Dental Care.

Due to previous challenges in access to NHS Dental Services NHS Dumfries and Galloway established 7 Public Dental Service Clinics throughout the region including: Dumfries Dental Centre, Lochmaben, Lochside, Castle Douglas, Newton Stewart, Sanquhar and Stranraer. Withdrawal of provision of routine General Dental Services by the Public Dental Service was undertaken in Castle Douglas in 2008, Stranraer in 2012, Lochmaben in 2015 and Dumfries Dental Centre 2015 (with specialist dental services and teaching still provided ), and withdrawal from Newton Stewart is planned for Spring 2017.
8.2 Emergency Dental Service Provision

8.2.1 Dental Emergencies Unregistered Patients in Hours

Individuals who are not registered with a dental practice and have a dental emergency during office hours can contact the NHS Dumfries and Galloway Dental Helpline. These individuals are then triaged and if appropriate emergency dental appointments are arranged. In the East of the region individuals are offered appointments with:

- the student clinic at Dumfries Dental Centre
- an independent dental contractor practice
- or with Lochside or Sanquhar clinic.

In the West of the region patients are seen by independent dental contractor practices.

Figure 8 Demonstrates the fall in in-hours calls to the Dental Helpline since 2011. In 2015/16, 574 people received emergency dental treatment in the Public Dental Service. This equates to roughly 11 patients a week.

8.2.2 Out of Hours Dental Emergencies

Individuals who have a dental emergency out of hours contact NHS 24. They are then triaged and appropriate arrangements for necessary dental care are made. If individuals require clinical care within 1 hour, they are requested to attend the Emergency Department of either Dumfries Royal Infirmary or the Galloway Community Hospital. If they require clinical care within 24 hours they are advised to contact their registered dental practice the next day. If unregistered they will be contacted by the Dumfries and Galloway Dental Helpline who will help support registration. If they require care at the weekends
they are appointed to emergency dental clinics which operate on a Saturday and Sunday afternoon from Dumfries Dental Centre and either Newton Stewart dental clinic and the Stranraer dental clinic at the Galloway Community Hospital. These weekend clinics are staffed by both independent dental contractors and Public Dental Service dentists and support staff. All independent dental contractor practices in the region, except one, operate within this framework.

8.3 Costs of NHS Dental Services

NHS dental services are provided free to:

- Those under 18 years
- 18 year olds who are in full time education
- Pregnant women and for 12 months following child birth
- Patients who are in receipt of (or who have a partner in receipt of):
  - Income support
  - Universal credit
  - Income-related employment and support allowance
  - Pension credit guarantee credit
  - NHS tax credit exemption certificate

Those on low incomes who have difficulty paying NHS dental charges may qualify for help with charges under the NHS low income scheme. This scheme requires completion of an HC1 form.

Those who pay NHS dental charges pay 80% of the NHS charges up to a maximum of £384 per course of treatment. Charges for NHS dental treatment are set by the Scottish Government and do not vary by provider.

8.4 Location of Dental Practices in Dumfries and Galloway

The location of Independent Contractor Dental Practices and Public Dental Service clinics are demonstrated in Figure 9.
8.5 Registration with NHS Dental Services

8.5.1 Registration of Dumfries and Galloway Population

NHS dental registration is defined in this report as any patient registered with an NHS dentist. It does not include registrations with private dentists\(^\text{10}\). As at 31\(^{\text{st}}\) of March 2016, 91\% of the Scottish population were registered with a NHS dentist, for Dumfries and Galloway the overall figure was 85\%. Figures 10 to 11, demonstrate the NHS dental registration figures for Dumfries and Galloway for children and adults, demonstrating that the registration figures are broadly in line with that of other Health Board areas.

**Figure 10: Percentage of children registered with an NHS dentist in Scotland by NHS Board as at 31\(^{\text{st}}\) of March 2016**

Source: Information Services Division (ISD), MIDAS, data extracted in April 2016
Figures 12 to 13 outline the trend in NHS dental registrations for Dumfries and Galloway between 2000 and 2016 for children and adults, which demonstrates an increase in number of dental registrations over time. In 2006, changes to government policy which led to the establishment of lifelong registration with a dental practice have contributed to the increases in dental registration figures. In Dumfries and Galloway it is likely that the greatest driver of increased registration figures has been the increase in the number of independent dental contractor practices and practitioners in the region in recent years.

Figure 12  Percentage of the population registered with an NHS dentist in Dumfries and Galloway from 30th September 2000 to 31st March 2016 - Children

Source: ISD, MIDAS, data extracted in April 2016
Figure 13 Percentage of the population registered with an NHS dentist Dumfries and Galloway from 30th September 2000 to 31st March 2016 - Adults

Dumfries & Galloway

Source: ISD, MIDAS, data extracted in April 2016

8.5.2 Dental Registration and Deprivation

At a Scottish level for children there are no longer differences in registrations rates between children living in the most deprived and least deprived areas. However, adults living in SIMD 1 and 2 quintiles are more likely to be registered with an NHS dentist than adults living in other deprivation quintiles. Reasons for this could include the availability of free dental treatment to those on certain benefits, the Scottish Dental Access Initiative Grants introduced in 1997, which targeted dental practices to open in more deprived and rural areas and also the possible uptake of private dental treatment by those living in less deprived quintiles.

8.5.3 Dental Registration at Lochside Clinic and of the Lochside and Lincluden Community

Lochside Dental clinic is situated in Shirley Road in Lochside (see Figure 1). It was established at a time when access to independent dental contractor practices was limited and the Health Board held a dental registration list from which individuals were allocated a space at a dental practice as one became available. Patients were therefore allocated to Lochside clinic from this registration list and not on the basis of any geographical boundary. Therefore anyone living anywhere in Dumfries and Galloway could have been offered a space at the Lochside clinic.

Lochside Dental Clinic is staffed by 1 dentist who currently provides 0.8 whole time equivalent (w.t.e), with a 0.2 w.t.e additional dentist backfill, a 0.8 w.t.e dental nurse (0.2 backfill), 1 x w.t.e receptionist (fixed term contract). The clinic has 2 dental surgeries.

As at January 2016, there were 1,334 individuals registered to receive NHS dental care from the Lochside clinic. It is estimated that 458 (34.3% of the clinic population) were resident in the Lochside and Lincluden area, with 876 (65.7% of the clinic
population) living outwith this area. As at July 2016, it was estimated that 12% of those registered lived in Summerville, 12% lived in Dumfries West, 7% lived in Nithsdale and Nunholm, 5% living in Dumfries South and Lower Nithsdale with the reminder coming from various datazones across the region Figure 13 demonstrates the intermediate datazones in Dumfries and Galloway.

Local data analysis of the Lochside and Lincluden area estimated that 85.7% of the total Lochside and Lincluden area population were registered with an NHS dentist, with only 458 (6.9%) of this population being registered at the Lochside clinic. The remaining 78.8% (5249) of the Lochside and Lincluden area population were registered with Independent Dental Contractor practices elsewhere in Dumfries and Galloway.

It is estimated that 949 people living in the Lochside and Lincluden area are not registered with an NHS dentist (14.3% of the population living in this area).

**Figure 14 Intermediate Data Zones in Dumfries and Galloway**

The age breakdown of the Lochside and Lincluden area population registered with a NHS Dentist is detailed in Table 5. With the age breakdown of patients registered for dental treatment at Lochside clinic detailed in Table 6. This demonstrates that the 0-2 years 11 month age group has the lowest percentage registration, with only 37% of this population age group registered with an NHS dentist, this rises to 83% for the 3-5 year olds and 98% for 6-12 year olds. The percentage dental registration figures
for the Lochside and Lincluden community remain high until the 45-54 years age category where they fall to 76% and tend to decline with age with registration for the 75 years and over being 62% of that population. This pattern is also seen in data at Scottish level.

Table 5  
**Age breakdown of Lochside and Lincluden area population registered for NHS Dental Care**

<table>
<thead>
<tr>
<th>Age band</th>
<th>Number of Lochside and Lincluden area residents registered with any dentist</th>
<th>Percentage of Lochside and Lincluden area residents registered with any dentist</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 2 years</td>
<td>88</td>
<td>37%</td>
</tr>
<tr>
<td>3 to 5 years</td>
<td>236</td>
<td>83%</td>
</tr>
<tr>
<td>6 to 12 years</td>
<td>577</td>
<td>98%</td>
</tr>
<tr>
<td>13 to 17 years</td>
<td>331</td>
<td>96%</td>
</tr>
<tr>
<td>18 to 24 years</td>
<td>605</td>
<td>86%</td>
</tr>
<tr>
<td>25 to 34 years</td>
<td>904</td>
<td>88%</td>
</tr>
<tr>
<td>35 to 44 years</td>
<td>673</td>
<td>86%</td>
</tr>
<tr>
<td>45 to 54 years</td>
<td>742</td>
<td>76%</td>
</tr>
<tr>
<td>55 to 64 years</td>
<td>511</td>
<td>72%</td>
</tr>
<tr>
<td>65 to 74 years</td>
<td>365</td>
<td>65%</td>
</tr>
<tr>
<td>75 years and over</td>
<td>273</td>
<td>62%</td>
</tr>
<tr>
<td>No age stated</td>
<td>402</td>
<td></td>
</tr>
<tr>
<td>All children (0 to 17 years)</td>
<td>1232</td>
<td>85%</td>
</tr>
<tr>
<td>All adults (18 years and over)</td>
<td>4073</td>
<td>78%</td>
</tr>
<tr>
<td>All ages (including no age stated)</td>
<td>5707</td>
<td>86%</td>
</tr>
<tr>
<td>Age band</td>
<td>Total Number of clinic patients</td>
<td>Patients living in Lochside and Lincluden area</td>
</tr>
<tr>
<td>---------------</td>
<td>--------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>0 to 2 years</td>
<td>15</td>
<td>&lt;20</td>
</tr>
<tr>
<td>3 to 5 years</td>
<td>30</td>
<td>&lt;20</td>
</tr>
<tr>
<td>6 to 12 years</td>
<td>137</td>
<td>58</td>
</tr>
<tr>
<td>13 to 17 years</td>
<td>94</td>
<td>36</td>
</tr>
<tr>
<td>18 to 24 years</td>
<td>117</td>
<td>57</td>
</tr>
<tr>
<td>25 to 34 years</td>
<td>139</td>
<td>53</td>
</tr>
<tr>
<td>35 to 44 years</td>
<td>149</td>
<td>51</td>
</tr>
<tr>
<td>45 to 54 years</td>
<td>177</td>
<td>46</td>
</tr>
<tr>
<td>55 to 64 years</td>
<td>152</td>
<td>48</td>
</tr>
<tr>
<td>65 to 74 years</td>
<td>143</td>
<td>43</td>
</tr>
<tr>
<td>75 years and over</td>
<td>118</td>
<td>26</td>
</tr>
<tr>
<td>No age stated</td>
<td>63</td>
<td>23</td>
</tr>
<tr>
<td>All children (0 to 17 years)</td>
<td>276</td>
<td>111</td>
</tr>
<tr>
<td>All adults (18 years and over)</td>
<td>995</td>
<td>324</td>
</tr>
<tr>
<td>All ages (including no age stated)</td>
<td>1334</td>
<td>458</td>
</tr>
</tbody>
</table>

8.6 Participation in NHS Dental Services

8.6.1 Participation in NHS Dental Services in Dumfries and Galloway

Participation in NHS Dental Services is defined as any patient who is registered with an NHS Dentist and who has had contact with NHS dental services for examination or treatment in the last two years. At a Scottish level at March 2016, 72% of those registered had seen an NHS dentist within the last two years, 85% of children registered and 69% of registered adults. For Dumfries and Galloway, 76% of the total registered population participated with 85% of children registered and 73.5% of registered adults participating. Nationally there has been a steady decline in participation rates since the change in the registration rules in 2006. Children are more likely than adults to have seen an NHS dentist within the last two years (85% compared to 69%). The trends for participation in Dumfries and Galloway for children and adults are demonstrated in Figures 15 and 16 respectively.
Figure 15  Percentage of registered patients participating in NHS Dental Services in NHS Dumfries and Galloway 30th September 2006 to 31st March 2016 – Children

Source: ISD, MIDAS, data extracted in April 2016

Figure 16  Percentage of registered patients participating NHS Dental Services in NHS Dumfries and Galloway from 30th September 2006 to 31st March 2016 – Adults

Source: ISD, MIDAS, data extracted in April 2016
8.6.2 Dental Participation and Deprivation

Those living in the most deprived areas were less likely to see their dentist within the last two years than those living in the least deprived areas. At a Scottish level for children living in the most deprived areas 81% had participated, with 90% having participated in the least deprived areas. For adults the figures for those living in the most deprived were 65% versus 75% in the least deprived areas.

8.6.3 Participation in NHS Dental Services Lochside and Lincluden area residents

Local analysis was undertaken based on data available as at 31st of January 2016 for participation of those living in Dumfries and Galloway and the Lochside and Lincluden area - both for those registered at the Lochside clinic and those registered elsewhere. (NB this analysis was undertaken using CHI populations and therefore varies slightly from the ISD figures for participation for Dumfries and Galloway which used population estimates). The results of this analysis are outlined in Table 7.

Table 7 Percentage participation in NHS Dental Services

<table>
<thead>
<tr>
<th></th>
<th>Scotland*</th>
<th>D&amp;G All residents</th>
<th>Lochside Lincluden Area- All residents</th>
<th>Lochside Lincluden Residents - Registered outwith Lochside clinic</th>
<th>Lochside Lincluden - Registered at Lochside Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Participated in NHS Dental Services in the last 2 years</td>
<td>72%</td>
<td>77%</td>
<td>70%</td>
<td>71%</td>
<td>61%</td>
</tr>
</tbody>
</table>

* Information Services Division Data

8.7 Capacity Within Independent Dental Practice

All localities in Dumfries and Galloway have dental practices accepting registrations of NHS patients. A new dental practice opened in Lochthorn Medical Practice in Locharbriggs in 2016.

8.8 Accessibility of Independent Contractor Dental Practices

The equality and diversity impact assessment undertaken in 2014 regarding provision of routine General Dental Services by the Public Dental Service reviewed information on the accessibility of independent contractor dental practices. This assessment concluded that there was a choice of independent dental contractor practices which were accessible and had facilities for disabled patients in Nithsdale and Annadale and Eskdale. Accessible independent contractor practices are also available in the Stewartry and Wigtownshire. However, the equality and diversity impact assessment did acknowledge that the Public Dental Service Clinics were excellent in terms of accessibility and facilities for the disabled, and that not all independent contractor practices were of the same standard in this regard11.
8.9 Dental Public Health Services

8.9.1 Dental Public Health Programmes in Scotland

Childsmile is a national programme, implemented in Dumfries and Galloway in 2011, which aims to improve the oral health of children in Scotland. It seeks to reduce inequalities both in dental health and in access to dental services by shifting the balance of care towards more preventive and anticipatory care and promoting health improvement from infancy. The programme was informed by published clinical guidelines and by experience gained from previous child oral health improvement programmes in Scotland. These had a focus on health visitor-led health promotion, clinical prevention within primary dental care, and community development based initiatives.

The Childsmile programme consists of 3 elements:

Childsmile Core Programme

- Issue of free toothpaste and toothbrush packs to children on at least 6 occasions in the first 5 years of life
- All nursery schools (local authority and private) invited to participate in daily supervised toothbrushing programme
- Primary schools identified as those most likely to benefit are invited to participate in daily supervised toothbrushing programme (all schools in Dumfries and Galloway) P1&2 are prioritised for this activity although some schools continue this through to P7.

Childsmile Practice

- Facilitated support via Health Visiting Teams and the Oral Health Improvement Team to encourage dental registration from a young age
- Raising parental awareness of good oral health behaviours and supporting parents to put them into practice
- Increasing the provision of oral health promotion and clinical prevention (i.e. fluoride varnish application) within dental primary care

Childsmile Nursery and School

- Targeted to priority nurseries and primary schools (10 in Dumfries and Galloway)
- Programme of 6-monthly fluoride varnish applications throughout nursery and primary school via Extended Duty Dental Nurses
- Follow-up of children who are not regular dental attenders
8.9.2 Supervised Toothbrushing Programme – Schools in Lochside and Lincluden Area

All schools in the Lochside and Lincluden area participate in the supervised toothbrushing programme, with the programme being extended from P1-P7 for all schools in the area with the exception of one. Table 8 demonstrates the percentage of children consented to participate in the nursery and school supervised toothbrushing programme for the 2015/16 school year for schools in the Lochside and Lincluden area.

Table 8 Percentage of pupils by nursery and school consented to participate in the nursery and school supervised toothbrushing programme 2015/16

<table>
<thead>
<tr>
<th></th>
<th>North West Dumfries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursery</td>
<td>98%</td>
</tr>
<tr>
<td>Primary 1-7 *</td>
<td>88%</td>
</tr>
</tbody>
</table>

*one school P1-P2 only figures excluded

8.9.3 Childsmile Practice Lochside and Lincluden Area

Between May 2015 and June 2016 there were 12 referrals from the Northwest Dumfries area to Dental Health Support workers to help facilitate registration with dental practices. Registration of these individuals would have been with a Dumfries Town Centre practice. This is perhaps lower than would have been expected given the population of the area and the SIMD of the area. Whilst all dental practices in Dumfries and Galloway offer the Childsmile programme it is noted that the rates of fluoride varnish application are not as high as they could be.

8.9.4 Childsmile Fluoride Varnish Schools and Nurseries Lochside and Lincluden Area

Only 10 nurseries and schools in Dumfries and Galloway were identified as priority schools for participation in the Fluoride varnish programme. St Ninians, Lincluden and Lochside Nurseries and Primary Schools participate in the programme. The fluoride varnish programme is made available to all children up to Primary 4 in these schools. Table 9 outlines the percentage of children consented for participation in the programme by nursery and school for the 2015/16 school year.
Table 9  Percentage of pupils by nursery and school consented to participate in the fluoride varnish programme (First Session) 2015/16

<table>
<thead>
<tr>
<th>Nursery</th>
<th>North West Dumfries</th>
</tr>
</thead>
<tbody>
<tr>
<td>97%</td>
<td>Derby</td>
</tr>
<tr>
<td>Primary 1-4</td>
<td>99%</td>
</tr>
</tbody>
</table>

9.0  Registration with General Medical Practices of those living in the Lochside and Lincluden area

Analysis was undertaken of where those living in the Lochside and Lincluden area access their general medical care. The general medical practices of those living in the Lochside and Lincluden area are detailed in Table 10. The location of these practices is illustrated in Figure 16.

Table 10  Percentage of Lochside and Lincluden area residents by registered medical practice

<table>
<thead>
<tr>
<th>GP Practice</th>
<th>Percentage of total (N=6,656)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charlotte Medical Practice</td>
<td>29%</td>
</tr>
<tr>
<td>Greyfriars Medical Centre</td>
<td>28%</td>
</tr>
<tr>
<td>St Michaels Medical Centre</td>
<td>17%</td>
</tr>
<tr>
<td>Gillbrae Medical Practice</td>
<td>17%</td>
</tr>
<tr>
<td>Cairn Valley Medical Practice</td>
<td>4%</td>
</tr>
<tr>
<td>Shebburn Medical Practice</td>
<td>2%</td>
</tr>
<tr>
<td>Lochthorn Medical Centre</td>
<td>2%</td>
</tr>
<tr>
<td>Other GP Practices</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100%</td>
</tr>
</tbody>
</table>
10.0 Patient and Community Engagement

In addition to the analysis of available quantitative data, two aspects of engagement were undertaken for inclusion in this needs assessment exercise.

- Lochside Clinic Registered patient engagement through questionnaires
- Participatory Appraisal with the Lochside and Lincluden Community

10.1 Lochside clinic patient engagement through questionnaires

10.1.2 Methods

All families/individuals registered at Lochside clinic were sent a letter to advise of the further review of provision of services from the clinic and a feedback form was enclosed. Letters were sent to 831 separate addresses as families were grouped together. Sixty eight completed feedback forms were returned, representing an 8% response rate. Following review of responses, themes were identified and comments were allocated themes. The results to the questions are summarised below.
10.1.3 Results

Q1. What is important to you and your family about accessing your dentist?

Summary of themes identified is detailed in Table 11

Table 11 Summary of ‘What is important to you and your family about accessing your dentist?’

<table>
<thead>
<tr>
<th>Theme</th>
<th>Feedback Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to a good service with appropriately trained staff</td>
<td>17</td>
</tr>
<tr>
<td>Convenient location of Clinic</td>
<td>14</td>
</tr>
<tr>
<td>Convenient appointments and regular opening hours</td>
<td>13</td>
</tr>
<tr>
<td>Access for regular dental check ups</td>
<td>12</td>
</tr>
<tr>
<td>Having trust and confidence in the dentist</td>
<td>9</td>
</tr>
<tr>
<td>Access to Disabled Parking</td>
<td>8</td>
</tr>
<tr>
<td>Access to Parking</td>
<td>7</td>
</tr>
<tr>
<td>Friendly staff</td>
<td>7</td>
</tr>
<tr>
<td>Local location of clinic</td>
<td>6</td>
</tr>
<tr>
<td>Access to NHS dental care</td>
<td>5</td>
</tr>
<tr>
<td>Access for dental emergency care</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Access to ground floor dental care</td>
<td>&lt;5</td>
</tr>
<tr>
<td>No comment</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Access to transport to attend clinic</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Access to speedy repairs of dental equipment e.g. dentures</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Access to speak to the dentist</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Total</td>
<td>111</td>
</tr>
</tbody>
</table>

Of the 111 themed comments received and based on the post codes provided, 12 themed comments (representing 6 completed forms) were recorded from patients living in the ‘Lincluden or Lochside’ area. The total numbers of comments per completed form for each theme ranged from 1 to 4, themes were as follows:

- Convenient location of Clinic
- Friendly staff
- Access for dental emergency care
- Access for regular dental check ups
- Access to Parking
- Convenient appointments and regular opening hours
- Having trust and confidence in the dentist
- Local location of clinic

Q2. How do you currently travel to the dental clinic?

Summary of themes identified is detailed in Table 12
Table 12  Summary of ‘How do you currently travel to the dental clinic?’

<table>
<thead>
<tr>
<th>Theme</th>
<th>Feedback Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Car (driver)</td>
<td>33</td>
</tr>
<tr>
<td>Car (driver) / Car (passenger)</td>
<td>10</td>
</tr>
<tr>
<td>Car (passenger)</td>
<td>8</td>
</tr>
<tr>
<td>Walk</td>
<td>5</td>
</tr>
<tr>
<td>Car (driver) / Walk</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Taxi</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Bus / Walk</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Bus</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Car (driver) / Walk / Bicycle</td>
<td>&lt;5</td>
</tr>
<tr>
<td>No Answer</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Total</td>
<td>68</td>
</tr>
</tbody>
</table>

The majority of respondents travelled to the clinic by car. Of the 68 patient feedback forms received and based on the post codes provided, 6 were recorded from patients living in the Lincluden or Lochside area. These respondents advised they either travelled to the clinic by car or walked.

Q3. What importance would you put on your dental clinics opening hours and what should they be to meet your needs?

Summary of themes identified is detailed in Table 13

Table 13  Summary of ‘What importance would you put on your dental clinics opening hours and what should they be to meet your needs?’

<table>
<thead>
<tr>
<th>Theme</th>
<th>Feedback Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday to Friday (standard hours) / existing clinic hours</td>
<td>34</td>
</tr>
<tr>
<td>Monday to Friday (standard hours) plus Saturday and Sunday for emergencies only</td>
<td>8</td>
</tr>
<tr>
<td>Monday to Friday (standard hours) plus Saturday am</td>
<td>6</td>
</tr>
<tr>
<td>Any</td>
<td>5</td>
</tr>
<tr>
<td>No comment</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Monday to Friday (standard hours) plus early evening</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Monday to Saturday (standard hours)</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Monday am</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Thursday</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Monday to Friday (standard hours) plus early evening and weekend sessions</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Monday to Saturday (standard hours) plus Sunday for emergencies</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Monday to Friday (standard hours) plus early evening and Saturday sessions</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Monday to Friday am</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Total</td>
<td>68</td>
</tr>
</tbody>
</table>
The majority of respondents reported that standard hours of Monday to Friday would meet their needs.

**Q4. Do you feel you would receive the right dental services if you were registered with an Independent Contract Dental Practice?**

Summary of responses is outlined in **Table 14**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Feedback Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Don’t Know</td>
<td>36</td>
</tr>
<tr>
<td>No</td>
<td>22</td>
</tr>
<tr>
<td>No Answer</td>
<td>5</td>
</tr>
<tr>
<td>Yes</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>68</strong></td>
</tr>
</tbody>
</table>

Respondents were asked to explain their answer, which led to the identification of the following themes.

**Table 15 Summary by theme for the answers to Q4**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Feedback Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfied with current level of service</td>
<td>27</td>
</tr>
<tr>
<td>Unsure about level / quality of service of GDP</td>
<td>16</td>
</tr>
<tr>
<td>No comment</td>
<td>14</td>
</tr>
<tr>
<td>Concern about level / quality of service with GDP</td>
<td>12</td>
</tr>
<tr>
<td>Concern over sustainability of NHS services / increase of costs</td>
<td>6</td>
</tr>
<tr>
<td>Satisfied if NHS provided</td>
<td>&lt;5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>78</strong></td>
</tr>
</tbody>
</table>

**Q5. What challenges would there be for you if your dental practice was in an alternative location?**

Summary of responses is outlined in **Table 16**
Table 16 Summary of ‘What challenges would there be for you if your dental practice was in an alternative location?’

<table>
<thead>
<tr>
<th>Theme</th>
<th>Feedback Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parking including disabled</td>
<td>31</td>
</tr>
<tr>
<td>No comment</td>
<td>11</td>
</tr>
<tr>
<td>None</td>
<td>7</td>
</tr>
<tr>
<td>Less convenient to access services</td>
<td>6</td>
</tr>
<tr>
<td>Increased distance to clinic</td>
<td>6</td>
</tr>
<tr>
<td>Transport</td>
<td>6</td>
</tr>
<tr>
<td>Continuity of care</td>
<td>5</td>
</tr>
<tr>
<td>Depends on location of clinic</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Longer to walk to clinic</td>
<td>&lt;5</td>
</tr>
<tr>
<td>If level access would be available</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Using congested roads</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Additional costs e.g. petrol, parking</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Ability to take mobility scooter to clinic</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Access to hospital in emergency</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Total</td>
<td>89</td>
</tr>
</tbody>
</table>

Of the 89 themed comments received and based on the post codes provided, 10 themed comments (represented by 6 completed forms) were recorded from patients living in the Lincluden or Lochside area. The total numbers of comments per completed form for each theme ranged from 1 to 4, themes were as follows:

- Parking including disabled
- Transport
- Depends on location of clinic
- Increased distance to clinic
- Less convenient to access services
- Longer to walk to clinic

10.2 Participatory Appraisal with the Lochside and Lincluden Community

10.2.1 Methods

The Dumfries and Galloway Participatory Appraisal Network (PA network) was commissioned to undertake some focussed engagement work with those living in the Lochside and Lincluden Community. Participatory Appraisal (PA) is described as a range of approaches and methods to enable people to share their views and experiences which can contribute to service planning and delivery. This is particularly useful in that service planners can listen and gain valuable insight to community issues before embarking on changing services. The methods used during PA include visual questions that are engaging, involving and enable open honest and relaxed discussions that give immediate feedback.
Building Healthy Communities who have many years of experience using these approaches have now established a Dumfries and Galloway region wide PA network of volunteers and local people trained with the appropriate skills.

The PA network identified settings in which they would be able to access a mix of Lochside and Lincluden area residents ranging from all ages and circumstances. They are outlined below:

- A focus group of dental patients registered at Lochside Clinic
- North West Dumfries Resource Centre – activity groups and the Resource Centre Café
- A few shops in the area– approaching the customers
- With parents and carers at
  - Maxplay2 (Day-care)
  - Maxwelltown Play care (Day-care)
  - St Ninian’s Primary School and Nursery
  - Lochside Primary School and Nursery

In order to help understand the oral health needs of the Lochside and Lincluden area residents, it was determined that it would be helpful to have respondents split into 3 separate categories as outlined below:

1) Lochside and Lincluden residents who are registered with Lochside Clinic
2) Lochside and Lincluden residents – registered with a dentist elsewhere
3) Lochside and Lincluden residents- not registered with any dentist.

The following questions were asked of participants:

1) Is having good oral health important? Yes why? No why? What are your comments?
2) Is it easy for you to look after your oral health on a daily basis? Yes why? No why not? How could it be different?
3) Has it been easy for you to visit a dentist? Yes why? No why not? What are your suggestions?
4) Was your last visit to the dentist a positive event? Yes why? No why not? How could it be different?

Additional prompt questions
  a. Do you travel into Dumfries town centre?
  b. Are there any barriers to you travelling into Dumfries town centre?

10.2.2 Results

One hundred and sixty two individuals participated in the PA exercise, with 97 identifying themselves as living in the Lochside area, 56 Lincluden and 9 other areas. The age breakdown of residents is detailed in Table 17.
Table 17  Age range of PA participants

<table>
<thead>
<tr>
<th>Age Range</th>
<th>16 -24</th>
<th>25 - 64</th>
<th>65 - 74</th>
<th>75 +</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Totals</td>
<td>25</td>
<td>95</td>
<td>33</td>
<td>9</td>
<td>162</td>
</tr>
</tbody>
</table>

The dental registration status of PA participants is detailed in Table 18.

Table 18  Dental registration status of PA participants

<table>
<thead>
<tr>
<th>Residents</th>
<th>Registered with Lochside clinic</th>
<th>Registered with a dentist - Not Lochside clinic</th>
<th>Not registered with any dentist</th>
</tr>
</thead>
<tbody>
<tr>
<td>n= 162</td>
<td>25 (15.5%)</td>
<td>107 (66%)</td>
<td>30 (18.5%)</td>
</tr>
</tbody>
</table>

The following sections summarise the findings of the PA broken down by registration category.

10.2.3  Category 1: Lochside and Lincluden residents registered with the Lochside clinic

Q 1. IS HAVING GOOD ORAL HEALTH IMPORTANT? (n=25)

All 25 (100%) participants who fell into this category indicated a clear understanding that oral health was more than just dental care. Their comments include:

- To generally stay well and healthy x 3
- Yes, for health and appearance x 2
- If I had cared for my teeth when younger I might not need to be receiving dental treatment now! x 10
- ‘Don’t want treatment in the future if it can be avoided‘ x 7
- ‘I now have false teeth and still like to visit my Dentist. I am in the process of being fitted for new dentures’ x 4

Q 2. IS IT EASY FOR YOU TO LOOK AFTER YOUR ORAL HEALTH ON A DAILY BASIS? (n=25)

Yes=24 (96%), No=0 Don’t know=1 (4%)

The majority of respondents said it was easy to maintain good oral health as they have developed a routine for dental brushing and oral hygiene. Individuals who had received treatment were keen to prevent any further need for treatments and indicated the need to encourage their children:

- ‘I want to show my kids the importance of good mouth/tooth care’
- ‘to set an example’ x 2
- ‘They watch me brush my teeth and I watch them’ x 9
One participant said it was easier now to register with a dentist than it was 10 years ago and therefore more regular oral health check-ups. One individual was not sure if they were looking after their dentures and oral health correctly.

Q 3. HAS IT BEEN EASY FOR YOU TO VISIT A DENTIST? (n=25)

Yes=23 (92%). No=2(8%) Don’t Know=0

It is clear from the responses that as a whole those attending Lochside Clinic were happy with the services they receive. Key themes emerging were:-

- **Access (15)**
  - ‘Handy, on a bus route or can walk. Appointments made to suit me. Would not like to go elsewhere’.
  - ‘I live not too far away so I can walk easily with the kids. Happy to come here. I’ve not always been happy to visit the Dentist’
  - ‘I drive and plenty of parking (Resident out with Lochside/Lincluden)

- **Appointments (12)**
  - ‘Appointments are flexible’ ‘Easy to get appointments’
  - ‘Appointments are made in advance. They fit around me and the children’

- **Friendly and helpful staff (17)**
  - ‘Happy with the surroundings of the clinic. I like that my money has not been spent on fancy surroundings. Staff and treatments are great. I have no hesitation about coming here. I would not want to go elsewhere!!
  - ‘I feel very comfortable here. That has not been the case at other practices I have visited
  - ‘Yes, it’s friendly, i have a huge lot of trust in the staff and the service is brilliant. They really put me at ease. Appointments are changed if required’
  - ‘Great dentist who is very approachable and friendly’

- **Worry that the facility closes (5)**
  - ‘Concerns about the facility closing I have been really worried as previous talk of closing. This would put me back to square one. I would probably not visit the Dentist again’ (4)
  - ‘Happy at the dentist here – terrified of dentists’, ‘devastated if closed – don’t think I would go to another dentist’
Two negative issues were raised about the facility (6)

- ‘Reasonably happy with the practice but they do cancel appointments quite a lot and don’t tell me the reason’, Waiting so long for appointment after cancellation’ (2)
- ‘Could not register with the practice’ (4)

Q 4. WAS YOUR LAST VISIT TO THE DENTIST A POSITIVE EVENT? (n=25)

Yes=22 (88%) No=3 (12%)

Respondents in this category were generally satisfied with the service they received. Key statements include:-

- All okay. Both children visit Child Smile here and I visit the dentist. All of our appointments have been fine as no treatment required
- I did need some treatment but I was happy to come back to complete.
- Yes, I can walk here. It would be a nightmare if I had to take a bus into town with kids and pushchairs etc. The Staff are so kind and give loads of re-assurance.
- Upset by the possible closure of this place – I would be devastated. Don’t think I would then go to a Dentist.
- Don’t close the clinic been terrified of Dentists and I’m happy here and come regularly

10.2.4 Category 2:- Lochside and Lincluden residents registered with a dentist elsewhere

107 (66%) participants who took part in the overall PA (n=162) were registered with other dental practices out with Lochside. This group were approached via local activity groups, school playgrounds, shops and streets.

Q1. IS HAVING GOOD ORAL HEALTH IMPORTANT? (n=107)

Yes = 105 (98%) No = 2 (2%)

105 (98%) participants in this category said ‘Yes’ that oral health is important and 21 (13%) said that they have always looked after their teeth ‘Yes it’s my responsibility to care for my health including my teeth and gums’, ‘my teeth are strong and I want to keep them that way’.

A list of reasons for ‘good oral health’ given by the participants in this group has been grouped under key themes:

- Maintenance and prevention (53)

It is clear that the majority of participants wanted to prevent dental problems and indicated the importance of routine ‘prevention’ and maintenance. Key outcomes of prevention include:
Avoiding dentures (15) ‘My Dad has false teeth and I DON’T want them’ ‘Don’t want dentures’ ‘Don’t want treatment in the future if it can be avoided’

Avoiding pain (10)

Avoiding expensive treatments (8). ‘Need to look after teeth as I can’t afford to get expensive treatment’, ‘Have veneers and spent a lot of money on them’.

The responses indicated a belief that attending the dentist is part of their oral health and believe they should be attached to a dentist who knows them.

**Effects overall health (13)**

- 18 participants said that health is impacted by poor oral health regime and advocated ‘Hygiene, long term health and maintenance of teeth’. They indicated looking after their teeth to maintain ‘good general health…your mouth is a window to the world’.
- Eating is affected by poor teeth and participants indicated the need ‘To keep my teeth and gums healthy’, ‘need teeth to eat and communicate’, ‘If you have good dental health you feel better in general, you can’t eat if you’re in pain’
- There were a few people who commented effects on their teeth due to medication:-‘Calcium deficiencies’ (3) ‘Now have false teeth as mine rotted with taking cholesterol tablets’

**Regrets (12)**

- A few people voiced their ‘regrets’ (12) to not looking after their teeth when they were younger ‘If I had cared for my teeth when younger I might not need to be receiving dental treatment now’ and want better for their children (21) ‘I like my kids seeing me go to the dentist now – very important for me and my family’

**Image / appearance (20)**

- ‘Having a nice smile as it’s the first thing people notice about you (15)’‘Your confidence, you don’t feel happy if you can’t smile’ It is good to have ‘Fresh breath’ and ‘clean mouth’

**Dental services contribute to good oral health (13).**

- Participants indicated attending the dentist regularly was key to good oral health and one participant shared their confidence in attending a dentist as they knew someone who had had oral cancer identified by a dentist. ‘It’s really important to go to the dentist – if you don’t you might get gum disease’
• Example to my children (21)

Participants showed clear motivation to maintain good oral health and in particular their children’s:

- ‘I have had bad teeth, but want my children to have better oral health’;
- ‘Setting an example to my kids – don’t want them to go through the experiences I had as a child’;
- ‘I have two kids and try to set an example. They watch me brush my teeth and I watch them’;
- ‘Yes, for health and appearance. I want to show my kids the importance of good mouth/tooth care’;
- ‘Because I have a friend whose young child has had lots of teeth out already’

No responses

2 people thought this question did not apply to them as they had dentures

Q2. IS IT EASY FOR YOU TO LOOK AFTER YOUR ORAL HEALTH ON A DAILY BASIS? (n=107)

Yes=94 (88%) No=10 (10%) Don’t Know=3 (2%)

Of those responding yes 70 of the 94 indicated that teeth brushing and mouth care is easy now as it is part of a daily routine:

- ‘Morning and night regime – you easily get into the habit’ yes I brush twice daily’.
- ‘It is what you have done since a child… It is second nature’
- ‘Children get tooth brushing at nursery’
- A few older people (4) with dentures indicated that it is important to look after your mouth, use mouth washes, tooth paste and attend the dentist: ‘As I get older oral health is more important’

Those who indicated No it was not easy to look after oral health identified the following issues:

- Costs of dental supplies: e.g. toothbrushes, electric tooth brushes, mouth washes etc. ‘Getting the kids to brush regularly and long enough can be difficult. They want expensive tooth brushes now - electric. I can’t really afford this but if it makes them want to clean their teeth it might be worth the cash’. ‘The cost of toothpaste and brushes is expensive’.
- Parents indicated some challenges in getting their children to brush their teeth especially once they reach secondary school age. ‘We need to find ways to encourage teenage boys to clean their teeth’
- Time: - ‘I don’t really think about my teeth – not got the time’, ‘not bothered’
- Dentures: - ‘Don’t have any teeth – only dentures’, ‘haven’t got great teeth’
Health conditions affecting oral health: ‘I struggle as I have a long term condition – really tiring cleaning my teeth sometimes’ ‘It would be good to get right advice when taking new medication’ ‘advice when ill’ (2) ‘Depression sometimes stops me “Now I know about Lochside clinic access could be easier’ (4)

A few participants responded as don’t know and cited the following reasons:

- ‘Have dentures and not sure if looking after them correctly’ ‘Can I get a set of new dentures?’
- ‘Not sure if my medication is affecting my oral health… do I need advice’
- ‘Do I need to go to a dentist… have no teeth’.

Q3. HAS IT BEEN EASY FOR YOU TO VISIT A DENTIST? (n=107)

Yes= 60 (56%), No =47 (44%)

There were mixed responses to this question depending on what people see as key to accessing a dentist or where the dentist is located. The ‘yes’ responses were mainly people who had no transport issues i.e. they had a car or were ok with the bus service into town, whereas the ‘no’ responses indicated they were people who had family responsibilities, disabilities, long term conditions and/or affordability issues which presented a few challenges in getting to a dentist in town.

Key themes emerging from both the Yes and No responses are:-

- Appointments

There seems to be a variation of experiences when arranging appointments. 52 participants said the dentists were accommodating:

- ‘Able to book appointments to fit in with my travel to Dumfries for other appointments’
- ‘Able to make bookings for the same time for me and kids so not having to make several trips’
- ‘Dentist has early and late appointments available which helps when you work’

Although ‘accessing a dentist seems to be less of a problem than 10 years ago’ – 14 participants did have problems in getting an appointment: - ‘Did have problems 10+ years ago trying to register with a Dentist but much better now … though there are times we cannot’.

Some people have experienced:

- Long wait – ‘sometimes we have a long wait’
- Children get preferential access: ‘Easier to get an appointment for the children than me’ (a parent)
Others indicated they attend the dental appointments when they can but sometimes have to cancel them due to commitments as a carer or if their ‘long term condition’ is affecting them. ‘Depends on my partner’s health as I may have to look after them.’

- **Access**

While a majority of participants said they don’t have issues with access to dentists in town - ‘have cars so OK for me’ the ‘Bus is ok’, 19 people had some constraints and gave reasons such as family commitments, require the use of public transport and costs: - ‘Travel costs for buses’, ‘taxis’, ‘and parking in town’ and highlighted these as barriers to attending the town dentists. They are participants who attend dentists in Dumfries town centre and although some do so, it is not without a lot of effort.

  - One participant said they had ‘2 children and a disabled partner – difficult to get into town by bus’, and a few others (5) others flagged up the issues of ‘Finding a parking space in Dumfries is challenging’.

Some participants (26) who said they had not realised there was a dental clinic locally (Lochside clinic), wish they could be registered there.

- **Dental costs**

One participant benefited from ‘Being able to make part payments so I can budget for my treatments’

Others said the ‘Expense of treatment’ stopped them from accessing dental services on a regular basis.

5 participants explained they had teeth extracted as they could not afford root canal treatment to try and save their teeth.

- **Fear of dentist and treatment**

Fear of the dentist can make it difficult for some to attend ‘Frightened of the dentist – just go in an emergency when needed’.

**Q4. WAS YOUR LAST VISIT TO THE DENTIST A POSITIVE EVENT? (n=107)**

Yes=80 (75%), No= 27 (25%)

75% of participants said their last visit was a positive one giving reasons such as:

- ‘Kindness and understanding’ (x12)
- ‘Treatment good’ (x15)
- Dentist explains what is happening (x10) - ‘The dentist is very helpful and explains everything’
- Good with children (x10) - ‘Dentist gentle and patient with kids’
- Knowing the dentist (x3) ‘I have got to know the dentist and it is important they knows me well’
- ‘Visited dentist after 7 years and required 4 fillings. Now completed the treatment and this dentist has restored my faith in dentists’.

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Of those who indicated that their last visit to the dentist was not a positive one. Reasons given were:

- False teeth/ plates not fitting well (x11) ‘Poor fitting of dentures never sorted out properly so I gave up trying’ ‘I have a plate, it doesn’t fit well. I can only wear it for a few hours. It really hurts – don’t want to go back – they will think I am just being awkward’.
- Painful treatment (x4)
- Poor quality of treatment(x3)
- Travelling into town ‘Waiting to be seen so I missed my bus’
  ‘Frazzled getting in for appointment’
  ‘Access for push chairs could be better’
- Parents:
  - ‘I have 3 children and a disabled partner – find it difficult to get into town by bus’
  - ‘My work routine and looking after my children doesn’t make it easy to attend the dentist’ (x4)
  - ‘Difficult to attend the dentist as I need someone to look after the kids’
  - One mum had 3 young children – she said ‘it would be good to have some help in managing this and a local dentist would help’

Other reasons were – ‘dislocated my jaw …so wary now (x1) ‘Intolerance to needles’ (x2) ‘Local reaction to the anaesthetic’ (x1) ‘Dentist always telling me off ...want to change my dentist’ (x2)

10.2.5 Category 3: Lochside and Lincluden residents not registered with any dentist (n=30)

30 (18.5%) of the participants who took part in the PA were not registered with any dentist.

Q1. IS HAVING GOOD ORAL HEALTH IMPORTANT? (n=30)

Yes=15 (50%), No=3 (10%), Don’t Know = 5 (17%) and 7(23%) said the question was not applicable to them).

While 50% (15) participants believe that good oral health is important they associate attending the dentist with caring for teeth and as they have dentures they do not attend.

Those responding as ‘no’ giving their reasons as:

- ‘I don’t really think about my teeth – not got the time’, ‘not bothered’
- ‘Don’t have any teeth – only dentures’,
- ‘haven’t got great teeth’
- ‘Frightened of the dentist .... just go in an emergency -when needed’.

Those who responded as don’t know or not applicable advised:
• ‘Didn’t know I need to do anything’ (wears dentures),
• I have not been to a dentist in 30 years (still got dentures).

Q2. IS IT EASY FOR YOU TO LOOK AFTER YOUR ORAL HEALTH ON A DAILY BASIS? (n=30)

Yes = 6 (20%), No = 0, Don’t Know = 10 (33%), No response = 14 (47%)

6 participants said yes it was easy and said ‘I brush my dentures and soak them overnight’, ‘just need mouth washes’

A number of participants advised they didn’t know and outlined the following:

• ‘Have dentures and not sure if looking after them correctly’ ‘Can I get a set of new dentures?’
• ‘Not sure if my medication is affecting my oral health... do I need advice’
• ‘Do I need to go to a dentist... have no teeth’.

However some said

‘Not sure if my medication is affecting my oral health’, It would be good to get advice when taking new medication’ (x 2)

Q3. HAS IT BEEN EASY FOR YOU TO VISIT A DENTIST? (n=30)

Yes=1 (3%), No=21 (70%) No Comment=8 (27%)

All 30 participants reported not having attended the dentist during the last 2 years or more. (4 participants had not attended for over 20 years). One participant said ‘Didn’t know I need to do anything’ (wears dentures), ‘I have not been to a dentist in 30 years’ (still got dentures)

Five of those in this category were under the age of 20 years and had not been to the dentist since turning 18 years of age and 20 participants felt they would only go to the dentist if they had a problem with their teeth.

Those who responded that it had not been easy to visit a dentist gave the following reasons:

• Wearing dentures :- a big perception that there is no need for treatment or check-ups. Only a few individuals with dentures were aware they still needed to attend the dentist for oral check-ups. Most had not been for years and the PA study offered the opportunity to advise that they should make an appointment. ‘Did not know that should still visit my dentist now that I have dentures’
• Time - ‘It has been 7-8 years – I have no time to get into town’
• ‘To be honest I put off for various reasons – time, money, transport, fear, not feeling well…’
• Cost of treatment and travel (9) – particularly those who find it challenging to access – ‘more hassle than it is worth approach’ - ‘I have not been for over a year – worry how much treatment is going to cost – I decide not to go as having food or paying rent is my priority’
• One participant felt that because they have a ‘chequered history they cannot get registered’.
• Failed treatments or frightening experiences
  o ‘Nervous/anxiety about going to dentist due to previous experience’
  o ‘Bad experience as a child and scared to go to dentist now’
  o ‘Scared – have a phobia – so will not got to a clinic’ (information was given to this participant on how to access support)
• Personal barriers to attending the dental services
  o ‘Finding someone to watch the kids so I can go’
  o ‘Life just gets in the way’,

One participant said ‘Yes’ they could access a dentist when they required emergency treatment.

22 participants said they would attend the Lochside dental clinic if they had known it was there

Q4. WAS YOUR LAST VISIT TO THE DENTIST A POSITIVE EVENT? (n=30)

Yes=0, No=7 (23%), No Comment=23 (77%)

Some were more than 20 years ago and cannot remember, others expressed that their last experience is the reason they have not gone back

Although 23 had no comment – most could not remember. 7 participants responding ‘no’ gave reasons such as:

• Bad experiences and painful treatment.
• False teeth/plates not fitting well and did not go back.
• Dentist attitude and lack of explanation on treatments
• 3 participants said cost of treatment was a major factor.

Those who participated in the PA made some suggestions to help make access to NHS Dental Services easier these are outlined below:

• Appointments
  o ‘Dentists contacting you to remind you to go’ ‘Sending out reminders would be helpful (x14)
  o ‘Maybe open late for those who work during the day’.
  o If the dental practice could always make your next check-up appointment when treatment or check-up finishes (x6)
• Registration
  o 'Be good to change my dentist to the Lochside clinic as would be more accessible’, ‘nearer’, (x22)
  o ‘Whole families to be registered with the same practice’
  o ‘Let me and my family register at Lochside clinic- it is on my door step’ (x6)

• Attitude of dental staff
  o ‘Being treated like a human being’
  o ‘NHS patients need to be treated like those that pay’
  o ‘Being listened too’

• Good oral health advice for those with dentures
  o ‘Get out the message that oral health is about your mouth and not just teeth’.

10.2.6 BREAKDOWN OF RESPONSES ACCORDING TO EACH OF THE CATEGORIES

1. **Is having good oral health important?**  Yes why? No why?  What are your comments?

<table>
<thead>
<tr>
<th></th>
<th>Category 1 (n=25)</th>
<th>Category 2 (n=107)</th>
<th>Category 3 (n=30)</th>
<th>Totals n=162</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lochside clinic</td>
<td>Not Lochside clinic</td>
<td>Not registered</td>
<td>All participants</td>
</tr>
<tr>
<td>Yes</td>
<td>25 (100%)</td>
<td>105 (98%)</td>
<td>15 (50%)</td>
<td>145 (90%)</td>
</tr>
<tr>
<td>No</td>
<td>2 (2%)</td>
<td>3 (10%)</td>
<td>5 (3%)</td>
<td>5 (3%)</td>
</tr>
<tr>
<td>Don’t know</td>
<td></td>
<td>5 (7 said Question not applicable) (40%)</td>
<td>12 (7%)</td>
<td></td>
</tr>
</tbody>
</table>

% are for each of the categories

2. **Is it easy for you to look after your oral health on a daily basis?**  Yes why? No why not? How could it be different?

<table>
<thead>
<tr>
<th></th>
<th>Category 1 (n=25)</th>
<th>Category 2 (n=107)</th>
<th>Category 3 (n=30)</th>
<th>Totals n=162</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lochside clinic</td>
<td>Not Lochside clinic</td>
<td>Not registered</td>
<td>All participants</td>
</tr>
<tr>
<td>Yes</td>
<td>24 (96%)</td>
<td>94 (88%)</td>
<td>6 (20%)</td>
<td>124 (77%)</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
<td>10 (10%)</td>
<td>0</td>
<td>10 (6%)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>1 (4%)</td>
<td>3 (2%)</td>
<td>10 (14 no response)</td>
<td>14 (8.5%)</td>
</tr>
</tbody>
</table>

% are for each of the categories
3. **Has it been easy for you to visit a dentist?** Yes why? No why not? What are your suggestions?

<table>
<thead>
<tr>
<th>Category 1</th>
<th>Category 2</th>
<th>Category 3</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lochside clinic</td>
<td>Not Lochside clinic</td>
<td>Not registered</td>
<td>All participants</td>
</tr>
<tr>
<td>Yes</td>
<td>23 (92%)</td>
<td>60 (56%)</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>No</td>
<td>2 (8%)</td>
<td>47 (44%)</td>
<td>21 (70%)</td>
</tr>
<tr>
<td>No comment</td>
<td>8 (27%)</td>
<td>8 (5%)</td>
<td></td>
</tr>
</tbody>
</table>

% are for each of the categories

1. not registered but finds it easy to go when in emergency

4. **Was your last visit to the dentist a positive event?** Yes why? No why not? How could it be different?

<table>
<thead>
<tr>
<th>Category 1</th>
<th>Category 2</th>
<th>Category 3</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lochside clinic</td>
<td>Not Lochside clinic</td>
<td>Not registered</td>
<td>All participants</td>
</tr>
<tr>
<td>Yes</td>
<td>22 (88%)</td>
<td>80 (75%)</td>
<td>102 (63%)</td>
</tr>
<tr>
<td>No</td>
<td>3 (12%)</td>
<td>27 (7 not attended in over 3 years) (25%)</td>
<td>7 (23%)</td>
</tr>
<tr>
<td>No comment</td>
<td>23 (77%)</td>
<td>23 (14%)</td>
<td></td>
</tr>
</tbody>
</table>

11.0 **Lochside Dental Clinic Staff Feedback**

A meeting was held with staff of the Lochside clinic to discuss any potential areas of concern they had regarding service provision for the Lochside and Lincluden community. The clinic staff raised the following points.

- Some concern was raised that there are potentially some Lochside and Lincluden area residents that may have been told not to come back to dental practices because they haven’t paid bills, but in fact they have not been formally de-registered.
- Staff advised that the clinic had some patients who despite best efforts to contact them did not attend for regular treatment.
- Staff thought that it was very possible that some residents in the Lochside and Lincluden area were not aware that the clinic existed.
- It was noted that although there are some enquiries regarding registration, this is not at levels seen in the past, and it is not known if those contacting are registered elsewhere. It is noted that the clinic has been closed to new registrations since 2012.
• Parking at the clinic was seen as being of benefit to many, but it was acknowledged that some patients resident in the local area either walk, or take a taxi due to mobility issues.
• Staff felt that the opening hours of the clinic could be a barrier for some people using the clinic as they needed appointments later in the evening when the clinic was not open.

12.0 Parking and Public Transport Routes

As parking and public transport were issues that arose during the patient and community engagement. The current situation with regard to parking and public transport within Dumfries was reviewed and is summarised in the following sections.

12.1 Parking

Dumfries & Galloway operate a disc parking scheme in council car parks. It is possible to park for free in these areas for a limited period by displaying a clock disc. The maximum stay in each disc zone is marked on the signs on the street. Although various parking is available throughout the centre of Dumfries, it is recognised that patients attending dental appointment may need to spend longer than the usual parking allowance will permit. Dumfries & Galloway Council advise that there are no time constraints for patients displaying a ‘blue badge’ parking in a ‘disabled’ parking space. There are also private car parking available within Dumfries town centre.

12.2 Public Transport

Various transport options are available throughout Dumfries & Galloway into the town centre of Dumfries.

12.2.1 Bus

Lochside (taking in Alloway Road, Carrick Road, Kenilworth Road and Lochside Road) is linked to Dumfries town centre (Burns Statue) by a bus every 12 minutes Monday to Saturday daytime and every 30 minutes on Sunday daytime (Stagecoach service number 10 as at 28th June 2016). Journey time from Kenilworth road to Burns Statue is 16 minutes.

Lincluden (taking in Newbridge Drive, Maple Avenue and Lincluden Primary School) is linked to Dumfries town centre (Burns Statue) by a bus every 30 minutes Monday to Saturday daytime and around every 90 minutes on Sunday daytime (Stagecoach service number 12 as at 28th June 2016). Journey time from Maple Avenue to Burns Status is 19 minutes.

To travel from Lincluden to Lochside or vice versa requires a change of bus, either on Glasgow Road or Dumfries town centre. The bus routes are indicated in Figure 18.
Figure 18  Bus routes from Lochside and Lincluden Area into Dumfries Town Centre

Frequency of service (Source: Dumfries and Galloway Council website, 29th June 2016)

- Bus passes are available for disabled people to travel free.
- Bus passes are available if you are 60 or over and live in Dumfries and Galloway.

12.2.2 Taxicard scheme

Individuals can apply for a Taxicard if they have difficulty using public transport because of serious mobility impairment. The card lets you use taxis at a reduced cost for journeys starting or finishing in Dumfries and Galloway.

12.2.3 Community Transport

Community Transport includes schemes such as community bus and car schemes. These services are provided by a number of voluntary organisations who make transport available to members of the community who do not have full mobility and usual public transport services are not suitable for their travel needs.
13.0 Key Findings

This report has looked at the Oral Health Needs of the Lochside and Lincluden community. Oral health data is often not available at small area level and therefore proxy information based on oral health data at similar deprivation levels has been used. The report has identified a number of key findings:

Demographics

- The vast majority of the Lochside and Lincluden population live in an area that is classified as being in SIMD1 (the 20% most deprived areas in Scotland), the remainder of the population live in areas classified as being in SIMD 2 (within the 40% most deprived areas in Scotland).
- There is a mixture of age ranges living in the Lochside and Lincluden area 22% under the age of 18 years, 63% 18-65 years and 15% 65 years plus.
- Life expectancy for both males and females is lower in Lochside and Lincluden than in other parts of Dumfries and Galloway.

Oral Health

- Although it requires interpretation with caution, the Oral Health of Primary 1 children in the Lochside and Lincluden area does appear to be poorer than Primary 1 children more generally in Dumfries and Galloway. This is not unexpected given the deprivation level of the area.
- Data on the oral health of adults for the Lochside and Lincluden area is not available; however, it is likely that oral health of adults will generally be poorer due to the SIMD status of the area, compared to those in more affluent areas. At a Scottish level a significant proportion of the adults population report some level of anxiety about attending the dentist. Barriers to attending the dentist reported at a Scottish level include difficulty in getting an appointment that suits, the expense of dental treatment, difficulty in getting time off work and distance to go to a dentist.

Dental and Oral Health Services

- The percentage of the population registered with an NHS dentist has increased significantly in Dumfries and Galloway from 33% of the population in 2006, to 85% of the population at 31st March 2016.
- Dental Registration figures for the Lochside and Lincluden area are high, with 86% of the population estimated as registered with an NHS dentist.
- Seventy nine percent of the Lochside and Lincluden community are registered with a dentist outwith the Lochside and Lincluden area, with an estimated 7% (458) of the Lochside and Lincluden population registered at the Lochside clinic. It is estimated that approximately 950 people living in the Lochside and Lincluden area are not registered with an NHS dentist (14% of the population of this area).
- 66% of the people registered to receive dental treatment at the Lochside clinic live outwith the Lochside and Lincluden area.
In the Lochside and Lincluden community the 0-2 years 11 month age group has the lowest percentage registration, with only 37% of this population age group registered with an NHS dentist, which rises to 83% for the 3-5 year olds and 98% for 6-12 year olds.

Percentage dental registration figures for the Lochside and Lincluden community remain high until the 45-54 years age category where they fall to 76% and tend to decline with age with registration for the 75 years and over being 62% of that population.

Participation with NHS dental services for Dumfries and Galloway as a whole stands at 77% of the registered population, with a lower percentage 70% for the Lochside and Lincluden population. Figures at a Scottish level indicate that those living in a deprived area are less likely to see their dentist within a 2 year period compared to those living in a more affluent area. It does appear that participation figures are higher for those Lochside and Lincluden residents registered with independent dental contractor practices compared to those currently registered with the Lochside clinic.

Several independent dental contractor practice report having capacity to accept NHS patients and a new dental practice opened in Lochthorn Medical Centre in September 2016.

All primary schools and nurseries in the Lochside and Lincluden area participate in the Childsmile supervised toothbrushing programme with consent rates high and all primary classes brushing up to Primary 7 with the exception of one school where brushing includes P1&2 only.

St Ninian’s, Lincluden and Lochside primary schools participate in the Childsmile fluoride varnish programme.

The number of referrals of children/families into the Childsmile practice programme is lower than perhaps would have been expected for the area.

Access to General Medical Practice

Individuals living in the Lochside and Lincluden community are registered at a number of different General Medical Practices throughout Dumfries Town.

Public Transport

Frequent bus routes were noted to connect Lochside and Lincluden to Dumfries town centre.

Lochside clinic registered patient engagement

Those responding to the patient engagement exercise outlined the following key themes in their responses:

- Patients highly value the existing dental service provided from Lochside clinic.
- They have trust and confidence in the dental team.
- The clinic location is seen as convenient with adequate parking.
- There is a level of uncertainty/concern surrounding service provision from the independent dental contractor sector.
The greatest challenge identified by respondents if their dental service was provided from a different location was parking including disabled parking and the clinic being in a less convenient location.

Engagement with the Lochside and Lincluden Community

The Participatory Appraisal engaged with three distinct groups: those registered at Lochside clinic, those registered elsewhere and those not registered:

- Those registered for dental care at Lochside clinic all felt that having good oral health was important, advised that it was easy for them to maintain their own oral health and that it had been easy for them to visit a dentist. Respondents also advised that their last visit had been a positive event. The engagement re-emphasised the themes identified in the patient feedback response, with some individuals advising that if the clinic were to close they didn't think they would be able to visit another dentist.

- Those registered for dental care with an independent dental contractor practice also reported that having good oral health was important. The vast majority advised that it was easy for them to look after their oral health on a daily basis, those who did indicate challenges outlined issues with getting children to brush their teeth and also the costs of toothpaste and toothbrushes. Some also reported lacking motivation to maintain their own oral health or outlined health conditions which made looking after their oral health difficult. There was a mixed response from this group regarding how easy it had been for them to visit a dentist:
  - those who had commitments as a carer or had a long term condition sometimes found it difficult to keep appointments.
  - Whilst the majority of respondents did not report difficulty in accessing dental practices in town, there were a number of people who felt transport costs were a barrier and parking in the town was highlighted as an issue.
  - Costs of dental treatment were also cited as a barrier to accessing regular dental care, fear of dentists and dental treatment was also cited as a barrier.

Amongst this population of respondents a quarter of participants were not aware there was a clinic in Lochside and reported they would like to register there. The majority of this group responded that their last visit to the dentist had been a positive event. Those who indicated that their last experience hadn't been positive gave reasons such as painful or perceived poor quality treatment and challenges in getting children to appointments in the town.
Those individuals not registered with any dentist, appeared to be more ambivalent about the importance of their oral health. It did appear that many of these individuals wore dentures and did not think they needed to attend a dentist. This group also appeared to indicate that it had not been easy for them to visit a dentist, reasons given included concern over costs of treatment and travel, lack of time and fear. Many respondents advised they would attend the Lochside clinic if they had known it was there. In terms of how positive their last visit had been themes included bad experiences and costs.

14.0 Conclusion

This needs assessment has demonstrated that the vast majority of those living in the Lochside and Lincluden area do have access to NHS dental services and that there is an awareness within the population of the importance of maintaining good oral health. The area also benefits from inclusion in the Childsmile Oral health improvement programmes. Whilst the Lochside and Lincluden area is a diverse population, which in many areas has a strong sense of community, it does as with all communities, face challenges and unfortunately many people living in the area do suffer from the effects of social inequality which in turn leads to inequalities in oral health. However, the collated information in the needs assessment does not appear to necessarily support the conclusion that having a clinic in Lochside is key in reducing oral health related inequalities - although transport/access was mentioned by some individuals in the participatory appraisal as an issue for accessing dental services, wider and more complex reasons which may contribute to attendance at the dentist were highlighted, including:

- costs of dental treatment
- fear of dental treatment
- lack of awareness of the need to attend a dentist (particularly for those wearing dentures)
- and reported poor previous experiences.

As was outlined in section 6.0 of this report, Determinants and Impacts of Oral Health, there are many factors that influence an individual’s general and oral health and wellbeing.

Emerging research aimed at tackling oral health inequalities is challenging the current “downstream” approach which tends to focuses on disease specific individual prevention and outlines the need to work in partnerships across sectors and disciplines to address the wider determinants of health including the social, economic, community and environmental factors.

The importance of giving priority to interventions targeting early life is also promoted.

There is a great deal of excellent partnership work already ongoing in the Lochside and Lincluden area - one key piece of work that will contribute to the inequalities agenda more generally is the implementation of the national living wage for NHS and council employed staff.
The recommendations in this report outline some additional areas of work that should be taken forward to help address some of the challenges identified.

15.0 Recommendations

In 1986 the WHO published the Ottawa Charter which outlined five key areas of action for promoting health. This framework has been used to structure the recommendations of this report which will support a reduction in both general and oral health inequalities. These recommendations have also been reviewed in line with the recommendations made in the 2014 Public Health England Evidence Informed Toolkit: Local authorities improving oral health: commissioning better oral health for children and young people.

- Healthy Public Policy

  Link with colleagues across Dumfries and Galloway and Nationally to:
  
  - Increase advocacy for reduction in sugar consumption
  - Increase advocacy for restriction of marketing of unhealthy foods and drinks to children and improved food labelling.

- Creating Supportive Environments

  - Ensure oral health is included in health and wellbeing plans for schools and nurseries
  - Provide additional support to schools/nurseries/early years groups in the Lochside and Lincluden area re development of healthy food and drink policies and in their implementation.
  - Work with schools in the Lochside and Lincluden area to support expansion of the school toothbrushing programme all through the school
  - Work with health visiting teams in the Lochside and Lincluden area to increase the amount of support provided to young families via the Childsmile practice programme to encourage increased rates of dental registration in the early years of life.
  - Work with maternity service teams in the Lochside and Lincluden area to increase the support provided to expectant mothers regarding dental and oral health.
  - Engage with other key health and social care professionals to ensure consistency of messages regarding oral health and to maximise existing opportunities to promote improved oral health.
  - Link with Third and Independent Sector organisations working in the Lochside and Lincluden area to maximise capacity to support improved oral health.
  - Strengthen follow up support pathways for children identified as having potential dental problems following fluoride varnish application in nurseries and schools in the Lochside and Lincluden area
  - Explore the opportunity to include toothpaste and toothbrushes in food bank packages for families living in the Lochside and Lincluden area.
- Work with council colleagues and dental practices to identify opportunities to improve parking, including disabled parking and support use of public transport within/to Dumfries Town Centre.

**Strengthening Community Action**

- Undertake community engagement with families and older people living in the Lochside and Lincluden area to increase awareness of the importance of regular dental checks particularly for those who wear dentures.

**Supporting Behaviour Change**

- Provide CPD opportunities to those involved in supporting oral health behaviour change to ensure that behaviour change techniques are based on evidence based psychological theory.

**Re-orientation of dental healthcare systems**

- Provide CPD opportunities for dentists and dental teams regarding oral health inequalities
- Work with dental practices to ensure that appropriate clinical prevention is provided to children and adults at high risk of developing dental decay
- Work with dental practices to review their appointment systems for those individuals who may require a greater degree of flexibility due to challenging personal circumstances.
- Provide support to dental practices to help them link to other relevant services and agencies within their local community
- Promote the opportunity for individuals within the Lochside and Lincluden Community to receive dental treatment via the Dental Student Outreach Clinic at the Dumfries Dental Centre.

**16.0 Resources Required to Implement Recommendations**

At this stage it is anticipated that additional resources will not be required to implement the recommendations of this Needs Assessment. Whilst there are a number of pieces of work to take forward, it is not about undertaking new pieces of work, but rather working in a more collaborative way to maximise the opportunities and resources that currently exist.

**17.0 References**


<table>
<thead>
<tr>
<th>Proposed Action</th>
<th>Milestone Tasks (Key tasks that need to be carried out to implement actions)</th>
<th>Responsible Person</th>
<th>Partners to consult / engage</th>
<th>Target Date</th>
<th>Success Indicator</th>
<th>Progress</th>
</tr>
</thead>
</table>
| Increase advocacy for reduction in sugar consumption | • Establish links with National Groups regarding this agenda  
• Discuss with relevant colleagues in Health and Social Care to determine value of a local approach to this | Consultant Dental Public Health (CsDPH) | Health Scotland  
Paediatrics  
Diabetes Service  
Locality Health Improvement Teams | March 2018 | To be confirmed | Awaiting Action |
| Increase advocacy for restriction of marketing of unhealthy foods and drinks to children and improved food labelling. | As above | CsDPH | As above | March 2018 | To be confirmed | Awaiting Action |
### Appendix 1 – Oral Health Needs Assessment Action Plan

<table>
<thead>
<tr>
<th>Proposed Action</th>
<th>Milestone Tasks (Key tasks that need to be carried out to implement actions)</th>
<th>Responsible Person</th>
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<th>Target Date</th>
<th>Success Indicator (How you can measure that an action is complete)</th>
<th>Progress (Details of progress to date, useful information, barriers encountered etc)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure oral health is included in health and wellbeing plans for schools and nurseries</td>
<td>• Include this topic in schools action plan</td>
<td>• Oral Health Programme Manager (OHPM)</td>
<td>Oral health • School Staff • Locality Health Improvement Team</td>
<td>December 17</td>
<td>• Meetings arranged with all schools – for new session</td>
<td>This work is now included in the role of the Dental Health Officers who are linked with each school.</td>
</tr>
</tbody>
</table>
| Provide additional support to schools/nurseries/early years groups in the Lochside and Lincluden area re development of healthy food and drink policies and in their implementation. | • Set up schools group - May 17 – Group named SugarSmart  
• Engage with partners  
• Hold initial meeting  
• Gathering information  
• Draft action plan | OHPM  
OHTM | School reps Locality Health Improvement Team  
Family Learning  
Oral health Community Parents  
Public Health Education Parents & families | October 17 | • Group will be set up  
• Dialogue will be opened up  
• Action Plan Agreed | • Group met – not all schools were represented  
• Initial information gathered – some really good ideas and enthusiasm for going forward  
• 2nd meeting taken place – further actions identified  
• 3rd Meeting taken place. Funding bids in place – individual school action plans underway.  
• SugarSmart Group have the following objectives:  
  • To raise awareness with the school / nursery population about the impact of sugar  
  • To work with and engage school communities and |
<table>
<thead>
<tr>
<th>Task Description</th>
<th>Responsible Parties</th>
<th>Date</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work with colleagues in Education and the school meal provider to discuss free school meals and what foods are sold during school breaks.</td>
<td>OHPM, OHTM</td>
<td>August 17</td>
<td></td>
</tr>
<tr>
<td>Initial discussions by August 17.</td>
<td>OHPM, OHTM</td>
<td>August 17</td>
<td></td>
</tr>
<tr>
<td>To support a range of education inputs on the impact of sugar consumption and how to make healthier choices</td>
<td>OHPM, OHTM</td>
<td>August 2018</td>
<td>Updated Snack Policy in Place</td>
</tr>
<tr>
<td>To work with a range of partners to ensure flexible and accessible ways for schools and communities to be part of this work</td>
<td>OHPM, OHTM</td>
<td>August 2018</td>
<td>Draft action plan will be complete July 17. Next meeting set for August 17 to agree action plan</td>
</tr>
<tr>
<td>Update June 17 – have agreement from Education and School Meal provider to look at this</td>
<td>OHPM, OHTM</td>
<td>August 2018</td>
<td></td>
</tr>
<tr>
<td>Proposed Action</td>
<td>Milestone Tasks</td>
<td>Responsible Person</td>
<td>Partners to consult / engage</td>
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<tr>
<td>• Work with existing early years groups to explore snack provision and support in snack policy development</td>
<td>• Initial discussions by August 17.</td>
<td></td>
<td>Partners unknown at this stage</td>
</tr>
<tr>
<td>Work with schools in the Lochside and Lincluden area to support expansion of the school toothbrushing programme all through the school</td>
<td></td>
<td><strong>OHPM</strong></td>
<td><strong>OH team, Schools, teaching staff parents</strong></td>
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</tbody>
</table>
| Work with health visiting teams in the Lochside and Lincluden area to increase the amount of support provided to young families via the Childsmile practice programme to encourage increased rates of dental registration in the early years of life. | Meet with all HV teams  
Discuss barriers to referral  
Update and review pathways | **OHPM**           | Health Visiting teams  
Childsmile staff  
Dental practice staff | **On-going** | Increased number of referrals to Childsmile from the area  
Increased dental registration for 0-2 years 11 months | All HV meetings attended  
HV management meetings held  
Outlined barriers to referral  
Beginning to look at pathways.  
Referrals to Childsmile being monitored. |
## Appendix 1 – Oral Health Needs Assessment Action Plan

<table>
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<th>Success Indicator</th>
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</thead>
<tbody>
<tr>
<td>Work with maternity service teams in the Lochside and Lincluden area to increase the support provided to expectant mothers regarding dental and oral health.</td>
<td>Increase awareness within maternity services around oral health messages and referral pathways for Childsmile</td>
<td>OHPM</td>
<td>Childsmile Team Maternity Service</td>
<td>March 2018</td>
<td>Increased dental registration rates for 0-2 years age group</td>
<td>Contact made with midwifery manager to begin discussions. Progress as at June 17. Meetings held with midwifery staff. Developing mechanisms to support pregnant women who are not registered</td>
</tr>
<tr>
<td>Engage with other key health and social care professionals to ensure consistency of messages regarding oral health and to maximise existing opportunities to promote improved oral health.</td>
<td>Mapping of key health and social care professional groups Communications plan developed.</td>
<td>OHPM</td>
<td>Health and Social Care Locality Teams</td>
<td>June 2018</td>
<td>All relevant teams updated in key oral health messages</td>
<td>Contact made with PHP – Nithsdale HWB Team Exploration of meeting dates</td>
</tr>
<tr>
<td>Link with Third and Independent Sector organisations working in the Lochside and Lincluden area to maximise capacity to support improved oral health.</td>
<td>Explore the opportunities available to work with the Third and Independent Sector Develop an action plan</td>
<td>OHPM</td>
<td>OHPM Locality Health Improvement Team Third and Independent sector</td>
<td>June 2018</td>
<td>Action plan developed</td>
<td>Contact made with PHP – Nithsdale HWB team Exploration of meeting dates</td>
</tr>
<tr>
<td>Proposed Action</td>
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<tr>
<td>Strengthen follow up support pathways for children identified as having potential dental problems following fluoride varnish application in nurseries and schools in the Lochside and Lincluden area</td>
<td>Develop support pathway</td>
<td>OHPM &amp; OH Team</td>
<td>OHPM, OH Team, schools</td>
<td>September 2017</td>
<td>Pathway prepared and ready for roll out</td>
<td>Pathway drafted and currently being piloted. Progress as at June 17 - pathway piloted. Will be ready for complete roll out in new school session</td>
</tr>
<tr>
<td>Explore the opportunity to include toothpaste and toothbrushes in food bank packages for families living in the Lochside and Lincluden area.</td>
<td>Map out current food banks &amp; make contact</td>
<td>OHPM &amp; OH Team</td>
<td>OH Team, OHPM and Foodbank organisers and staff</td>
<td>December 2017</td>
<td>Food banks including free toothbrushes and toothpastes as appropriate.</td>
<td>Plan in place to commence this work</td>
</tr>
<tr>
<td>Work with council colleagues and dental practices to identify opportunities to improve parking, including disabled parking and support use of public transport within/to Dumfries Town Centre.</td>
<td>Identify Council Colleague to link with re parking and public transport</td>
<td>CsDPH</td>
<td>Council Colleagues</td>
<td>August 2017</td>
<td>Feedback given to Council following the needs assessment</td>
<td></td>
</tr>
<tr>
<td>Proposed Action</td>
<td>Milestone Tasks (Key tasks that need to be carried out to implement actions)</td>
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</tr>
<tr>
<td>Undertake community engagement with families and older people living in the Lochside and Lincluden area to increase awareness of the importance of regular dental checks particularly for those who wear dentures.</td>
<td>Identify colleagues to begin engagement</td>
<td>OHPM</td>
<td>OHPM, OH Team, Community Learning and Development, Locality Staff, Families &amp; older people</td>
<td>April 2018</td>
<td>Actions agreed and implemented</td>
<td>Date set with locality staff to explore options</td>
</tr>
</tbody>
</table>
| Provide Continuous Professional Development (CPD) opportunities to those involved in supporting oral health behaviour change to ensure that behaviour change techniques are based on evidence based psychological theory. | **o** Discuss with NES and Glasgow University opportunities for course development  
**o** Develop appropriate course                                                   | CsDPH              | NES, University of Glasgow                                                                   | June 2018    | CPD sessions provided                    | Initial discussion had with University of Glasgow and meeting date to be arranged.  |
## Proposed Action

<table>
<thead>
<tr>
<th>Proposed Action</th>
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<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide CPD opportunities for dentists and dental teams regarding oral health inequalities</td>
<td>☐ Discuss with NES and Glasgow University opportunities for course development</td>
<td>CsDPH</td>
<td>NES University of Glasgow</td>
<td>June 2018</td>
<td>CPD sessions provided</td>
<td>Initial discussion had with University of Glasgow and meeting date to be arranged.</td>
</tr>
<tr>
<td>Work with dental practices to ensure that appropriate clinical prevention is provided to children and adults at high risk of developing dental decay</td>
<td>Provide benchmarking information to Dental practices on current activity</td>
<td>OHPM and Dental Practice Advisor (DPA)</td>
<td>OHPM OH Team Dental Practice teams PCD</td>
<td>December 2018</td>
<td>Increased provision of fluoride varnish in General Dental Practice</td>
<td>Board participating in Supporting Better Practice Pilot and plans being developed to disseminate information on Fluoride varnish to practitioners.</td>
</tr>
<tr>
<td>Work with dental practices to review their appointment systems for those individuals who may require a greater degree of flexibility due to challenging personal circumstances.</td>
<td>Add this into current practice meetings</td>
<td>OHPM</td>
<td>As above</td>
<td>As above</td>
<td>As above</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>
### Proposed Action
Provide support to dental practices to help them link to other relevant services and agencies within their local community

**Milestone Tasks**
Pilot developed and implemented in partnership with University of Glasgow

**Responsible Person**
OHPM

**Partners to consult / engage**
Dental Teams, Locality Health Improvement Team, Health and Social Care Services, Independent and Third Sector

**Target Date**
June 2018

**Success Indicator**
- Dental practices have increased knowledge of local agencies and services within their community i.e. FIAT team, Carers Centre
- Dental practices sign'post patients to relevant local services and community sectors

**Progress**
Initial discussion had with University of Glasgow and meeting date to be arranged.

---

### Proposed Action
Promote the opportunity for individuals within the Lochside and Lincluden Community to receive dental treatment via the Dental Student Outreach Clinic at the Dumfries Dental Centre.

**Milestone Tasks**
- Develop Communications Plan to increase knowledge of how to access treatment via Dental Student Outreach and Therapy School

**Responsible Person**
OHPM and Dental Services Manager

**Partners to consult / engage**
University of Glasgow Dental School, University of Highland and Islands School of Hygiene/Theapy

**Target Date**
September 2018

**Success Indicator**
- Communications Plan Implemented
- People living in the Lochside and Lincluden area are aware of how they can access dental treatment through these routes

**Progress**
Posters and leaflets now available in the Lochside and Lincluden Community promoting this services. Promotion will also be included in other work done with the community in other actions.
**OPTION APPRAISAL DETAILS**

**Evaluation of: Future provision of NHS General Dental Services From Lochside Dental Clinic**

**Clear description of the issue being addressed:**

The aim of this options appraisal process is to help inform recommendations made to NHS Dumfries and Galloway about the provision of general dental services from Lochside Dental Clinic.

**Date of meetings held:**

- 14th July 2016 (Health Board Review Group met to develop long list of options and agreed draft short listed options)
- 11th August 2016 (Options Appraisal of short listed options for Lochside Dental Clinic)

**Scoring Panel:**

- (Public Health)
- (Primary Care)
- (Public Dental Service)
- (Public Dental Service)
* (Finance)
- (Human Resources)
- (Estates)
General Dental Practitioner
Lochside Clinic Patient
Lochside Clinic Patient
- (Staff Side - Unison)
- (Staff Side - British Dental Association)
- (Representative Nithsdale Locality)
DG Voice Representative
* (Scottish Health Council)

( ) Indicates who the member represents
* Indicates non scoring attendees

Facilitated by:

- Senior Manager

**SHORT LIST OF OPTIONS**

| OPTION 1: Status Quo - no change in current service provision |
| OPTION 2: Complete withdrawal of service with facilitated transfer of registered patients to independent dental contractor practices |
| OPTION 3: Facilitated transfer to independent dental contractor practices of only those registered patients living out with the Lochside and Lincluden area and utilizing remaining capacity to provide dental services to people resident in the Lochside and Lincluden area (maximum capacity 1500) |
| OPTION 4: Facilitated transfer to independent dental contractor practices of only those registered patients living out with the Lochside and Lincluden area and building capacity to utilize the 2 dental surgeries to provide dental services to people resident in the Lochside and Lincluden area (maximum capacity 3000) |
| OPTION 4a: Option 4 with 2 dentists |
| OPTION 4b: Option 4 with 1 dentist and 1 dental therapist |
| OPTION 9: Retention of all existing registered patients and building capacity to utilize the 2 dental surgeries to provide dental services to people resident in the Lochside and Lincluden area (maximum capacity 3000) |
surgeries to provide dental services to people resident in the Lochside and Lincluden area (maximum capacity 3000) (1500 additional Lochside and Lincluden area residents)

**OPTION 9a:** Option 9 with 2 dentists  
**OPTION 9b:** Option 9 with 1 dentist and 1 dental therapist

Options 5, 6, 7 & 8 of the long list of options were previously rejected.
### BENEFITS & RISKS IDENTIFIED

The group identified the following benefits and risk of the agreed shortlisted options by way of a facilitated discussion:

<table>
<thead>
<tr>
<th>OPTION</th>
<th>BENEFITS</th>
<th>RISKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>- Minimal change for staff&lt;br&gt;- Consistency &amp; continuity for retained patients&lt;br&gt;- Quality - Access, disabled &amp; equipment&lt;br&gt;- Easy Access for retained patients&lt;br&gt;- Parking including disabled&lt;br&gt;- Additional surgery available if faults with working surgery arise</td>
<td>- Vulnerable re cover holidays, sickness etc. Emergency cover provided at Sanquhar, travel costs for patients&lt;br&gt;- Limited development opportunities for patients while restricted to providing no more than current service&lt;br&gt;- Singled handed dentist, staff experience&lt;br&gt;- Health inequalities are not being specifically addressed&lt;br&gt;- Limited capacity to 1500 (Patient categories for acceptance may need to be agreed to prevent too much demand on clinic)&lt;br&gt;- Removal of second surgery to best utilize estate&lt;br&gt;- Sustainability (cover holidays, sickness etc)&lt;br&gt;- Limited clinical options (no private treatment)&lt;br&gt;- Against SG policy direction of independent contractors being preferred model</td>
</tr>
<tr>
<td>2</td>
<td>- Support from / to Independent Contractor Practices (Open lists, access initiative grants)&lt;br&gt;- Flexibility of patient choice (appointments, treatments)&lt;br&gt;- Option for 'Other Services' to utilize the building&lt;br&gt;- Sustainability (staff cover, patient choice, access)&lt;br&gt;- Equitable provision&lt;br&gt;- Patients will be supported to transfer&lt;br&gt;- In line with SG policy direction of independent contractors being the preferred model&lt;br&gt;- Efficient use of resource</td>
<td>- Access / parking including disabled potentially not as good as Lochside clinic&lt;br&gt;- Uncertainty / inconvenience to patients: parking, travel for Lochside Community &amp; travel costs / Social mobility&lt;br&gt;- Public Perception 'Politics'&lt;br&gt;- Patient demotivation&lt;br&gt;- Displacement of staff (Suitable alternative would be sought)&lt;br&gt;- Choice may be compromised (number of places available at open practices)</td>
</tr>
<tr>
<td>3</td>
<td>- Minimal change for staff&lt;br&gt;- Consistency &amp; continuity for retained patients&lt;br&gt;- Quality - Access, disabled &amp;</td>
<td>- Vulnerable re cover holidays, sickness etc. Emergency cover provided at Sanquhar, travel costs for patients&lt;br&gt;- Limited development opportunities for</td>
</tr>
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<td>BENEFITS</td>
<td>RISKS</td>
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<tr>
<td>4a</td>
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<tr>
<td>4b</td>
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<td></td>
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<tr>
<td></td>
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<tr>
<td></td>
<td>Consistency &amp; continuity for retained patients</td>
<td>Single handed dentist, staff experience</td>
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<tr>
<td></td>
<td>Quality - Access, disabled &amp; equipment</td>
<td>Inequitable service - only certain patients can be registered</td>
</tr>
<tr>
<td></td>
<td>Easy Access for retained patients</td>
<td>Logistics / deliverable</td>
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<td></td>
<td>Parking including disabled</td>
<td>Reduced efficiency</td>
</tr>
<tr>
<td></td>
<td>Sustainability (staff cover, patient choice, access)</td>
<td>Staff experience reduced</td>
</tr>
<tr>
<td></td>
<td>Perception that it will address inequalities</td>
<td>Stigmatization for Community over time</td>
</tr>
<tr>
<td></td>
<td>Possibility that it may contribute to reducing health inequalities</td>
<td>Against SG policy direction of independent contractors being preferred model</td>
</tr>
<tr>
<td></td>
<td>Lochside Community only - Opportunity to access &amp; register</td>
<td>Potential underutilization (3,000)</td>
</tr>
<tr>
<td></td>
<td>Professional peer support</td>
<td>Service in competition with Independent Dental Contractors</td>
</tr>
</tbody>
</table>

- Easy Access for retained patients
- Parking including disabled
- Additional surgery available if faults with working surgery arise
- Lochside Community only - Opportunity to access & register
- Perception that it will address inequalities
- Possibility that it may contribute to reducing health inequalities
- Singled handed dentist, staff experience
- Limited capacity to 1500 (Patient categories for acceptance may need to be agreed to prevent too much demand on clinic)
- Removal of second surgery to best utilize estate
- Limited clinical options (no private treatment)
- Inequitable service - only certain patients can be registered
- Logistics / deliverable
- Sustainability (cover holidays, sickness etc)
- Reduced efficiency
- Staff experience reduced
- Stigmatization for Community over time
- Against SG policy direction of independent contractors being preferred model
- Vulnerable re cover holidays, sickness etc. Emergency cover provided at Sanquhar, travel costs for patients
- Single handed dentist, staff experience
- Limited clinical options (no private treatment)
- Inequitable service - only certain patients can be registered
- Minimal change for staff
- Consistency & continuity for retained patients
- Quality - Access, disabled & equipment
- Easy Access for retained patients
- Parking including disabled

NOT PROTECTIVELY MARKED
Page 109 of 140
<table>
<thead>
<tr>
<th>9a</th>
<th>9b</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perception that it will address inequalities</td>
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</tr>
<tr>
<td>Lochside Community only - Opportunity to access &amp; register</td>
<td>Policy direction use of therapists</td>
</tr>
<tr>
<td>Efficient use of skills: 1 dentist / 1 therapist</td>
<td>Logistics / deliverable</td>
</tr>
<tr>
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<td>Sustainability (cover holidays, sickness etc)</td>
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<tr>
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<tr>
<td>Stigmatization for Community over time</td>
<td>Capacity for Dentist (Additional emergencies)</td>
</tr>
<tr>
<td>Peer support reduced</td>
<td>Against SG policy direction of independent contractors being preferred model</td>
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<tr>
<td>Against SG policy direction of independent contractors being preferred model</td>
<td>Reduced efficiency</td>
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<td>Reduced efficiency</td>
<td>Staff experience reduced</td>
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<tr>
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<td>Stigmatization for Community over time</td>
</tr>
<tr>
<td>Stigmatization for Community over time</td>
<td>Recruitment challenges</td>
</tr>
<tr>
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<tr>
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<td>Against SG policy direction of independent contractors being preferred model</td>
</tr>
</tbody>
</table>
LIST OF CRITERIA AGAINST WHICH OPTIONS ARE EVALUATED

The following criteria, rank and weighting were agreed with group consensus following a wide discussion.

<table>
<thead>
<tr>
<th>Criteria summary</th>
<th>Key Features of the criteria</th>
<th>Rank</th>
<th>Weighting</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Experience</strong></td>
<td>• Access&lt;br&gt;• Continuity of care&lt;br&gt;• Flexible treatment / Appointment times&lt;br&gt;• Patient choice</td>
<td>1</td>
<td>30%</td>
</tr>
<tr>
<td><strong>Workforce</strong></td>
<td>• Stability&lt;br&gt;• Opportunity&lt;br&gt;• Moral</td>
<td>4</td>
<td>18%</td>
</tr>
<tr>
<td><strong>Deliverability / Sustainability</strong></td>
<td>• Feasible&lt;br&gt;• Viable on an ongoing basis&lt;br&gt;• Effective and efficient&lt;br&gt;• Impact on other services</td>
<td>1</td>
<td>30%</td>
</tr>
<tr>
<td><strong>Strategic Direction</strong></td>
<td>• Address health inequalities&lt;br&gt;• Equitable&lt;br&gt;• SG Policy independent contractor preferred model</td>
<td>3</td>
<td>22%</td>
</tr>
</tbody>
</table>

TOTAL 100%

SCORING SCALE USED

The scoring scale was discussed and agreed with the group before proceeding with the scoring. Although individual scorings were taken, differentials were discussed with the opportunity for members to amend their score before the average (Mean) scoring was confirmed and agreed.

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Could hardly be better, perfection</td>
</tr>
<tr>
<td>9</td>
<td>Excellent, almost perfect</td>
</tr>
<tr>
<td>8</td>
<td>Very Good</td>
</tr>
<tr>
<td>7</td>
<td>Good</td>
</tr>
<tr>
<td>6</td>
<td>Quite Good</td>
</tr>
<tr>
<td>5</td>
<td>Adequate</td>
</tr>
<tr>
<td>4</td>
<td>Less Good</td>
</tr>
<tr>
<td>3</td>
<td>Poor</td>
</tr>
<tr>
<td>2</td>
<td>Very Poor</td>
</tr>
<tr>
<td>1</td>
<td>Could hardly be worse</td>
</tr>
</tbody>
</table>
SENSITIVITY TESTING

It was confirmed that sensitivity testing/analysis would be completed:

- Criteria given equal weighting
  - TRIMMEAN (15% to 90%)
  - Mode

EQUALITY IMPACT ASSESSMENT

Equality impact assessment has been ongoing throughout the review process.

ISSUES RAISED / DISCUSSED

- The final preferred recommendation/s will be created from combining the qualitative and the financial appraisals.
- The qualitative appraisal will represent 60%; the financial appraisal will represent 40% of the final scoring.
- Option 4 and Option 9 requires additional investment from the Health Board.
- Building costs are the next highest costs after staff costs. The Estate should be utilized to the fullest, which is not currently the case. If the dental service was withdrawn, the Board would either look to utilize the building with other services or release the asset.
- There are a number of Dumfries practices (6) open to patients for NHS dental registration with an additional new practice due to open soon. The patients who are currently registered at Lochside Dental Clinic were allocated when the allocation list was at its highest; these patients were not specific to the Lochside and Lincluden area.
- It was recognized that the dentist may not always be a constant as they are able to leave.
- It was confirmed that it was considered acceptable to provide services specific to a community if there was evidence to support that there were justifiable grounds to do this.
- It was outlined that there have been some challenges as people living out with Lochside and Lincluden were accessing services initially set up for people from the area. Whilst people from the Lochside and Lincluden area were not tending to access these services as much despite mechanisms to inform people locally e.g. mother and toddler groups, breastfeeding groups. This highlighted that tackling inequality is complex.
- It was recognized that some people will choose not to use dental services regardless of ease of access.
- It was agreed that in all options, standards and quality would be met.
- It was acknowledged that there would be no difference between either the salaried service or independent contractors when it came to provision of clinical treatment.
- It was agreed that option 3 would allow for approx 1,000 additional new patients to be registered from Lochside and Lincluden at the Lochside Dental Clinic.
- Options 4a and 4b allow for approx 2,500 additional new patients to be registered from the Lochside and Lincluden area at the Lochside Dental Clinic.
- Option 9a and 9b allows for approx 1,500 additional new patients to be registered from the Lochside and Lincluden area at the Lochside Dental Clinic.
- Discussions were undertaken for each criteria prior to scoring. Any scoring differences were explored to understand the rationale behind them and to allow scoring modifications to be made by individuals following this discussion. The average total was agreed for each criteria for each option.
- The grand total by option was provided to the group.

- Confidentiality of the outcome was discussed and agreed by all. A financial appraisal would still be required along with sensitivity analysis prior to a final recommendation/s being made.

- It was noted that staff would be informed of the outcome following completion of the financial appraisal.

**SUMMARY OF OUTCOME**

<table>
<thead>
<tr>
<th>Option</th>
<th>Score *</th>
<th>%</th>
<th>Ranking</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 2</td>
<td>626.62</td>
<td>62.66%</td>
<td>1&lt;sup&gt;st&lt;/sup&gt;</td>
<td>Complete withdrawal of service with facilitated transfer of registered patients to independent dental contractor practices</td>
</tr>
<tr>
<td>Option 9a</td>
<td>584.15</td>
<td>58.42%</td>
<td>2&lt;sup&gt;nd&lt;/sup&gt;</td>
<td>Retention of all existing registered patients and building capacity to utilize the 2 dental surgeries to provide dental services to people resident in the Lochside and Lincluden area (maximum capacity 3000) (1500 additional Lochside and Lincluden area residents) with 2 dentists</td>
</tr>
<tr>
<td>Option 9b</td>
<td>546.46</td>
<td>54.65%</td>
<td>3&lt;sup&gt;rd&lt;/sup&gt;</td>
<td>Retention of all existing registered patients and building capacity to utilise the 2 dental surgeries to provide dental services to people resident in the Lochside and Lincluden area (maximum capacity 3000) (1500 additional Lochside and Lincluden area residents) with 1 dentist and 1 dental therapist</td>
</tr>
<tr>
<td>Option 4a</td>
<td>524.62</td>
<td>52.46%</td>
<td>4&lt;sup&gt;th&lt;/sup&gt;</td>
<td>Facilitated transfer to independent dental contractor practices of only those registered patients living out with the Lochside and Lincluden area and building capacity to utilise the 2 dental surgeries to provide dental services to people resident in the Lochside and Lincluden area (maximum capacity 3000) with 2 dentists</td>
</tr>
<tr>
<td>Option 1</td>
<td>511.23</td>
<td>51.12%</td>
<td>5&lt;sup&gt;th&lt;/sup&gt;</td>
<td>Status Quo - no change in current service provision</td>
</tr>
<tr>
<td>Option 4b</td>
<td>491.54</td>
<td>49.15%</td>
<td>6&lt;sup&gt;th&lt;/sup&gt;</td>
<td>Facilitated transfer to independent dental contractor practices of only those registered patients living out with the Lochside and Lincluden area and building capacity to utilise the 2 dental surgeries to provide dental services to people resident in the Lochside and Lincluden area (maximum capacity 3000) with 1 dentist and 1 dental therapist</td>
</tr>
<tr>
<td>Option 3</td>
<td>450.92</td>
<td>45.09%</td>
<td>7&lt;sup&gt;th&lt;/sup&gt;</td>
<td>Facilitated transfer to independent dental contractor practices of only those registered patients living out with the Lochside and Lincluden area and utilising remaining capacity to provide dental services to people resident in the Lochside and Lincluden area (maximum capacity 1500)</td>
</tr>
</tbody>
</table>
Proposed Preferred option from the qualitative stage:

Option 2 - Complete withdrawal of service with facilitated transfer of registered patients to independent dental contractor practices

There is 42.46 points (4.25%) of difference between the 1st ranked option 2 and the 2nd ranked option 9a.
There is 80.15 points (8.02%) of difference between the 1st ranked option 2 and the 3rd ranked option 9b.
There is 102 points (10.20%) of difference between the 1st ranked option 2 and the 4th ranked option 4a.
There is 115.38 points (11.54%) of difference between the 1st ranked option 2 and the 5th ranked option 1.
There is 135.08 points (13.51%) of difference between the 1st ranked option 2 and the 6th ranked option 4b.
There is 175.69 points (17.57%) of difference between the 1st ranked option 2 and the 7th ranked option 3.
The actual figures, rounded to 2 decimal places, were used to calculate these differences.
**SENSITIVITY ANALYSIS**

### Criteria Sensitivity

Scores: Criteria given equal weighting

<table>
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<th>Option</th>
<th>Score</th>
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</thead>
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<tr>
<td>Option 1</td>
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<td>51.35%</td>
<td>5&lt;sup&gt;th&lt;/sup&gt;</td>
</tr>
<tr>
<td>Option 2</td>
<td>605.77</td>
<td>60.58%</td>
<td>1&lt;sup&gt;st&lt;/sup&gt;</td>
</tr>
<tr>
<td>Option 3</td>
<td>463.46</td>
<td>46.35%</td>
<td>7&lt;sup&gt;th&lt;/sup&gt;</td>
</tr>
<tr>
<td>Option 4a</td>
<td>530.77</td>
<td>53.08%</td>
<td>4&lt;sup&gt;th&lt;/sup&gt;</td>
</tr>
<tr>
<td>Option 4b</td>
<td>498.08</td>
<td>49.81%</td>
<td>6&lt;sup&gt;th&lt;/sup&gt;</td>
</tr>
<tr>
<td>Option 9a</td>
<td>582.69</td>
<td>58.27%</td>
<td>2&lt;sup&gt;nd&lt;/sup&gt;</td>
</tr>
<tr>
<td>Option 9b</td>
<td>546.15</td>
<td>54.62%</td>
<td>3&lt;sup&gt;rd&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

Change: No change to ranking

### Scoring Sensitivity

Scores: minimum - maximum (Actual Average / Mean)

<table>
<thead>
<tr>
<th></th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
<th>Option 4a</th>
<th>Option 4b</th>
<th>Option 9a</th>
<th>Option 9b</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Experience</td>
<td>5-9 (6.8)</td>
<td>3-8 (6.3)</td>
<td>3-7 (4.6)</td>
<td>3-8 (5.5)</td>
<td>3-7 (5.2)</td>
<td>5-8 (7.2)</td>
<td>5-8 (6.7)</td>
</tr>
<tr>
<td>Workforce</td>
<td>4-8 (6.2)</td>
<td>2-5 (3.7)</td>
<td>3-7 (5.5)</td>
<td>3-8 (6.4)</td>
<td>4-7 (5.9)</td>
<td>4-8 (6.6)</td>
<td>3-7 (6.0)</td>
</tr>
<tr>
<td>Deliverability / Sustainability</td>
<td>2-5 (3.8)</td>
<td>3-9 (7.2)</td>
<td>2-6 (3.5)</td>
<td>3-8 (4.9)</td>
<td>2-7 (4.4)</td>
<td>3-7 (5.1)</td>
<td>2-7 (4.5)</td>
</tr>
<tr>
<td>Strategic Direction</td>
<td>2-8 (3.8)</td>
<td>4-9 (7.0)</td>
<td>3-8 (4.8)</td>
<td>2-8 (4.5)</td>
<td>3-6 (4.4)</td>
<td>2-7 (4.5)</td>
<td>3-7 (4.6)</td>
</tr>
<tr>
<td>Mean Total</td>
<td>20.5</td>
<td>24.2</td>
<td>18.5</td>
<td>21.2</td>
<td>19.9</td>
<td>23.3</td>
<td>21.8</td>
</tr>
</tbody>
</table>

Scores: TRIMEAN 15% to 90%

<table>
<thead>
<tr>
<th>Option</th>
<th>Actual</th>
<th>15%</th>
<th>20%</th>
<th>30%</th>
<th>40%</th>
<th>50%</th>
<th>60%</th>
<th>70%</th>
<th>80%</th>
<th>90%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>51.12%</td>
<td>51.12%</td>
<td>50.73%</td>
<td>50.73%</td>
<td>50.89%</td>
<td>51.57%</td>
<td>51.57%</td>
<td>52.20%</td>
<td>52.07%</td>
<td>52.07%</td>
</tr>
<tr>
<td>2</td>
<td>62.66%</td>
<td>62.66%</td>
<td>64.04%</td>
<td>64.04%</td>
<td>64.11%</td>
<td>64.40%</td>
<td>64.40%</td>
<td>64.68%</td>
<td>64.60%</td>
<td>64.60%</td>
</tr>
<tr>
<td>3</td>
<td>45.09%</td>
<td>45.09%</td>
<td>45.55%</td>
<td>45.55%</td>
<td>44.33%</td>
<td>44.23%</td>
<td>44.23%</td>
<td>44.04%</td>
<td>44.20%</td>
<td>44.20%</td>
</tr>
<tr>
<td>4a</td>
<td>52.46%</td>
<td>52.46%</td>
<td>52.20%</td>
<td>52.20%</td>
<td>52%</td>
<td>51.69%</td>
<td>51.69%</td>
<td>51.56%</td>
<td>52.27%</td>
<td>52.27%</td>
</tr>
<tr>
<td>4b</td>
<td>49.15%</td>
<td>49.15%</td>
<td>49.31%</td>
<td>49.31%</td>
<td>49.33%</td>
<td>48.94%</td>
<td>48.94%</td>
<td>48.08%</td>
<td>48.07%</td>
<td>48.07%</td>
</tr>
<tr>
<td>9a</td>
<td>58.42%</td>
<td>58.42%</td>
<td>59%</td>
<td>59%</td>
<td>59.64%</td>
<td>60.54%</td>
<td>60.54%</td>
<td>61.12%</td>
<td>60.87%</td>
<td>60.87%</td>
</tr>
<tr>
<td>9b</td>
<td>54.65%</td>
<td>54.65%</td>
<td>54.95%</td>
<td>54.95%</td>
<td>55.22%</td>
<td>55.54%</td>
<td>55.54%</td>
<td>54.72%</td>
<td>54.80%</td>
<td>54.80%</td>
</tr>
</tbody>
</table>
The 1st ranking is shown highlighted which consistently shows the Proposed Preferred option as Option 2. Trimming the mean eliminates the extreme percentage of the scores before calculating the mean.

Change: With the exception of TRIMMEAN at 70% where option 4a and option 1 switch ranking from 4th and 5th to 5th and 4th the remaining rankings remains unchanged throughout.

Scores: Using the Mode of the actual scores

<table>
<thead>
<tr>
<th>Option</th>
<th>Score</th>
<th>%</th>
<th>Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 1</td>
<td>574</td>
<td>57.40%</td>
<td>4th</td>
</tr>
<tr>
<td>Option 2</td>
<td>706</td>
<td>70.60%</td>
<td>1st</td>
</tr>
<tr>
<td>Option 3</td>
<td>476</td>
<td>47.60%</td>
<td>5th</td>
</tr>
<tr>
<td>Option 4a</td>
<td>462</td>
<td>46.20%</td>
<td>6th</td>
</tr>
<tr>
<td>Option 4b</td>
<td>432</td>
<td>43.20%</td>
<td>7th</td>
</tr>
<tr>
<td>Option 9a</td>
<td>656</td>
<td>65.60%</td>
<td>2nd</td>
</tr>
<tr>
<td>Option 9b</td>
<td>596</td>
<td>59.60%</td>
<td>3rd</td>
</tr>
</tbody>
</table>

The Mode is the actual score that occurs most frequently.

Comparison, full range for TRIMMEAN available above

<table>
<thead>
<tr>
<th>Option</th>
<th>Mean (Actual)</th>
<th>Equal Criteria Weighting</th>
<th>TRIMMEAN (20%)</th>
<th>TRIMMEAN (40%)</th>
<th>Mode</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 1</td>
<td>51.12%</td>
<td>5th</td>
<td>51.35%</td>
<td>5th</td>
<td>50.73%</td>
</tr>
<tr>
<td>Option 2</td>
<td>62.66%</td>
<td>1st</td>
<td>60.58%</td>
<td>1st</td>
<td>64.04%</td>
</tr>
<tr>
<td>Option 3</td>
<td>45.09%</td>
<td>7th</td>
<td>46.35%</td>
<td>7th</td>
<td>45.55%</td>
</tr>
<tr>
<td>Option 4a</td>
<td>52.46%</td>
<td>4th</td>
<td>53.08%</td>
<td>4th</td>
<td>52.20%</td>
</tr>
<tr>
<td>Option 4b</td>
<td>49.15%</td>
<td>6th</td>
<td>49.81%</td>
<td>6th</td>
<td>49.31%</td>
</tr>
<tr>
<td>Option 9a</td>
<td>58.42%</td>
<td>2nd</td>
<td>58.27%</td>
<td>2nd</td>
<td>59%</td>
</tr>
<tr>
<td>Option 9b</td>
<td>54.65%</td>
<td>3rd</td>
<td>54.62%</td>
<td>3rd</td>
<td>54.95%</td>
</tr>
</tbody>
</table>
## SUMMARY SHEET
### SUMMARY OF IMPACT ASSESSMENT (IA)

<table>
<thead>
<tr>
<th>Policy</th>
<th>Date of process</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is a review of routine General Dental Service Provision from Lochside Clinic by the Public Dental Service – Proposed Preferred option Withdrawal.</td>
<td>14th April 2017</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lead service</th>
<th>Contact person for process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Dental Service</td>
<td>Valerie White Consultant Dental Public Health</td>
</tr>
</tbody>
</table>

### Names of those involved in process
- Valerie White, Consultant Dental Public Health
- Kim Jakobsen – Dental Services Manager
- Laura Nisbet – Human Resources Officer
- Julie Hunter – Oral Health Improvement Programme Manager
- Carol Stewart – Programme Manager Public Health
- Patient Representative
- DG Voice Representative – was consulted on age and disability sections

### Summary of IA

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

**Research and data (section 3)**

<table>
<thead>
<tr>
<th>Documents reviewed as part of the IA</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Previous EQDIA undertaken in September 2016</td>
</tr>
<tr>
<td>- Oral Health Needs Assessment Feedback draft</td>
</tr>
<tr>
<td>- Capacity and Access Report Independent Dental Contractors – Draft</td>
</tr>
<tr>
<td>- Lochside Dental Clinic Consultation Report – DraftV1 21.3.17</td>
</tr>
</tbody>
</table>

Key aspects considered for the two options during the options appraisal also referred to.

Equality and Diversity Impact Assessment undertaken in July 2014 regarding previous review of
Routine General Dental Service Provision by the Salaried Dental Service was also referenced.

**Impact Assessment (section 4)**

From the summary table at number 25 list the:-
Positive Impact(s) – 8 Low impacts
No Impact(s) – 26
Negative Impact(s) – 3 Low impacts and 9 Medium

**Monitoring and review (section 5)**

Public Dental Service one month then annually.

---

**Summary of actions arising from the Impact Assessment**

Transfer details from table at number 26

<table>
<thead>
<tr>
<th>Actions</th>
<th>Responsibility</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional recommendation to be added to the needs assessment regarding work with maternity services</td>
<td>Consultant Dental Public Health</td>
<td>Immediate</td>
</tr>
<tr>
<td>Recommendations of the Oral Health Needs Assessment Require to be implemented</td>
<td>Consultant Dental Public Health</td>
<td>As per action plan.</td>
</tr>
<tr>
<td>Individuals whose first language is not English identified for additional support through process</td>
<td>Dental Services Manager</td>
<td>Prior to transfer if agreed</td>
</tr>
<tr>
<td>Discuss with FIAT team about joint facilitated transfer clinics</td>
<td>Dental Services Manager</td>
<td>As above</td>
</tr>
<tr>
<td>Transfer documentation reviewed to ensure is accessible and understandable for all, including information about taxi card scheme</td>
<td>Dental Services Manager</td>
<td>As above</td>
</tr>
<tr>
<td>Feedback to council colleagues regarding concerns raised about crossing the road to access bus stop at Alloway Road and Lochside Road.</td>
<td>Consultant Dental Public Health</td>
<td>Within 1 month of EQDIA undertaken</td>
</tr>
</tbody>
</table>
### SUMMARY SHEET
### SUMMARY OF IMPACT ASSESSMENT (IA)

<table>
<thead>
<tr>
<th>Policy</th>
<th>Date of process</th>
<th>14th April 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is a review of routine General Dental Service Provision from Lochside Clinic by the Public Dental Service No Change Option</td>
<td>Contact person for process</td>
<td>Valerie White Consultant Dental Public Health</td>
</tr>
<tr>
<td>Lead service</td>
<td>Public Dental Service</td>
<td>Name of those involved in process</td>
</tr>
<tr>
<td>Names of those involved in process</td>
<td>Valerie White, Consultant Dental Public Health/Public Health</td>
<td></td>
</tr>
<tr>
<td>Kim Jakobsen – Dental Services Manager</td>
<td>Laura Nisbet – Human Resources Officer</td>
<td></td>
</tr>
<tr>
<td>Julie Hunter – Oral Health Improvement Programme Manager</td>
<td>Carol Stewart – Programme Manager Public Health</td>
<td></td>
</tr>
<tr>
<td>Patient Representative</td>
<td>DG Voice Representative – was consulted on age and disability sections</td>
<td></td>
</tr>
</tbody>
</table>

### Summary of IA

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

#### Research and data (section 3)

- Previous EQDIA undertaken in September 2016
- Oral Health Needs Assessment Feedback draft
- Capacity and Access Report Independent Dental Contractors – Draft
- Lochside Dental Clinic Consultation Report – DraftV1 21.3.17

Key aspects considered for the two options during the options appraisal also referred to. Equality and Diversity Impact Assessment undertaken in July 2014 regarding previous review of Routine General Dental Service Provision by the Salaried Dental Service was also referenced. Consideration was given to clinic data on exemption status for dental treatment and DNA data for the clinic.
Impact Assessment (section 4) | From the summary table at number 25 list the:- Positive Impact(s) – 9 high 1 low No Impact(s) – 29 Negative Impact(s) – 9 medium
---|---
Monitoring and review (section 5) | Public Dental Service one month then annually.

Summary of actions arising from the Impact Assessment
Transfer details from table at number 26

<table>
<thead>
<tr>
<th>Actions</th>
<th>Responsibility</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provision of Emergency Care when Dentist not available would require review</td>
<td>Dental Services Manager</td>
<td>1 month of decision</td>
</tr>
<tr>
<td>Criteria agreed for utilisation of any capacity. This will require an EQDIA.</td>
<td>Dental Services Manager</td>
<td>2 months of decision</td>
</tr>
<tr>
<td>Recommendations of the Oral Health Needs Assessment Require to be implemented</td>
<td>Consultant Dental Public Health</td>
<td>As per action plan.</td>
</tr>
<tr>
<td>Section</td>
<td>Title</td>
<td>Page</td>
</tr>
<tr>
<td>---------</td>
<td>----------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>1.0</td>
<td>Summary of Consultation Process on Agreed Options and Oral Health Needs Assessment</td>
<td>122</td>
</tr>
<tr>
<td>2.0</td>
<td>Patient Responses</td>
<td>123</td>
</tr>
<tr>
<td>2.1</td>
<td>Summary of Patient Responses</td>
<td>123</td>
</tr>
<tr>
<td>2.2</td>
<td>Attendance at drop in sessions</td>
<td>123</td>
</tr>
<tr>
<td>2.3</td>
<td>Summary of Key Themes Emerging From Patient Comments Forms</td>
<td>123</td>
</tr>
<tr>
<td>3.0</td>
<td>Feedback from non patient sources</td>
<td>125</td>
</tr>
<tr>
<td>3.1</td>
<td>Discussions with Stakeholders re Needs Assessment</td>
<td>125</td>
</tr>
<tr>
<td>3.2</td>
<td>Feedback from Dental Teams</td>
<td>125</td>
</tr>
<tr>
<td>3.3</td>
<td>Feedback from Integration Joint Board Strategic Planning Group</td>
<td>126</td>
</tr>
<tr>
<td>4.0</td>
<td>Feedback on Options and Needs Assessment from Community Representatives</td>
<td>126</td>
</tr>
<tr>
<td>5.0</td>
<td>Summary of Points Highlighted During the Consultation Period</td>
<td>126</td>
</tr>
</tbody>
</table>
1.0 **Summary of Consultation Process on Agreed Options and Oral Health Needs Assessment**

A detailed engagement plan for the review of provision of routine General Dental Services by the Public Dental Service service from Lochside Dental Clinic was developed in collaboration with the Scottish Health Council, copies are available on request. Phase 3 of the engagement process was Informing and Engaging of the Proposed Preferred option. Following discussion at the Integration Joint Board (IJB), the IJB directed the NHS Board to consult on more than one option. The NHS Board agreed to consult on the following two options:

- **Proposed preferred option** - complete withdrawal of routine NHS General Dental Services at Lochside Dental Clinic, with patients being supported to transfer to Independent Dental Contractor Practices for continued provision of NHS Dental Services

- **No change** - continued provision of routine NHS General Dental Services at Lochside dental clinic for the patients currently registered

This report summaries the consultation undertaken and its findings. Colleagues from the Scottish Health Council provided advice and support in development of this document.

The consultation period began on the 16th of January 2017 and closed on the 20th of March 2017 (9 weeks).

On the 11th January 2017, the 1255 patients registered for Dental Services at Lochside Dental Clinic were sent letters regarding the options and were also provided with a summary of the draft Lochside and Lincluden Oral Health Needs Assessment findings and recommendations. This correspondence included an invite to attend two drop in sessions at the clinic to obtain further information and also signposted patients to further sources of information via website links, e-mail addresses and phone numbers. A feedback form was also included with a closing date of 20th March 2017.

On 16th January 2017 a message was published on the NHS Board Facebook with links to the NHS Board website which contained the patient information issued and documentation regarding the draft Lochside and Lincluden Oral Health Needs Assessment.

A number of key stakeholders were sent copies of the draft Oral Health Needs Assessment, including those in Education, North West Dumfries Schools and Nurseries, Health Visiting Teams, Maternity Services, Nithsdale Health Improvement Team, DG Health and Wellbeing, Community Development Colleagues North West Dumfries Resource Centre. Posters and information leaflets on the Needs Assessment were also located in community venues in North West Dumfries where participatory appraisal work had been conducted.

Drop-in sessions were held at the clinic for any patient or community member interested in finding out more about the review process or the Oral Health Needs Assessment.
Assessment. These sessions took place on Thursday 2nd February, 10am - 7pm and Tuesday 7th February, 9am - 4.30pm.

A request for feedback on the two consultation options and the Oral Health Needs Assessment was also made to members of the Integration Joint Board Strategic Planning Group. This was sent via e-mail on the 20\textsuperscript{th} of January with a reminder e-mail sent on the 27\textsuperscript{th} of February 2017.

The recently established Participation and Engagement Network were also circulated information on the Oral Health Needs Assessment on the 13\textsuperscript{th} of February requesting any comments.

Local Dental Teams, staff of the Public Dental Service and the NHS Boards Dental Advisory Committee were also circulated information regarding the two options and the Oral Health Needs Assessment and their feedback sought.

2.0 Patient Responses

2.1 Summary of Patient Responses

All completed forms were collated and summarised into key themes after 20\textsuperscript{th} March 2017. Responses received up until the 31\textsuperscript{st} of March 2017 are included in this report.

A summary of the number of responses received either by completed comments form or via e-mail is shown in Table 1. Please note that comments forms were often completed on behalf of families so the actual patient response rate is only an estimate*.

<table>
<thead>
<tr>
<th>Comment forms returned</th>
<th>Number of Patients invited to comment</th>
<th>Estimated Percentage Response Rate*</th>
</tr>
</thead>
<tbody>
<tr>
<td>160</td>
<td>1255</td>
<td>13%</td>
</tr>
</tbody>
</table>

2.2 Attendance at Drop-in Sessions

Seventeen people attended the clinic drop in sessions. Attendees included both registered patients and other members of the local community. Individuals attending the session asked a variety of questions regarding the review process and the oral health needs assessment and were supported to complete patient comments forms as required. The majority of those attending found the sessions helpful and welcomed the opportunity to hear more detail about the process.

2.3 Summary of Key Themes Emerging From Patient Comments Forms

The vast majority of respondents (90\%) indicated either directly or indirectly that they would prefer the no change option. Only 2 respondents indicated that whilst they
would prefer no change they would consider transfer. Seven percent of responses suggested that there could/should be expansion of the dental services and/or integration of dental services with other services. Five main theme areas were identified following review of responses. These were:

- Standards of care
- Transport and parking
- Accessibility
- Effect on local population
- Access to continued NHS dental care

Table 2 outlines these main theme areas and the key aspects indicated in their responses. In addition to these theme areas, respondents also indicated that they felt this decision was being driven by finance (7), three indicated they were concerned about the review process and three indicated concern for the staff working at the clinic. Three responses also questioned the evidence base of the needs assessment. Continued access to treatment by dental students at Dumfries Dental Centre was also highlighted.

Table 2 Theme areas from patient consultation feedback

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sub Theme</th>
<th>Number of Responses including Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standards of Care</td>
<td>Satisfied with level of service at existing practice</td>
<td>83</td>
</tr>
<tr>
<td></td>
<td>Concern about level of service at other NHS dental practices</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Has trust in dentist at existing practice</td>
<td>5</td>
</tr>
<tr>
<td>Transport and Parking</td>
<td>Satisfied with convenient location of current practice</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td>Satisfied with parking at current practice</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>Concern over town centre parking at other NHS dental practices</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Concern with Public Transport for attending alternative practice</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Concern of increased travel costs for attending alternative practice</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Patient inconvenience if withdrawn</td>
<td>3</td>
</tr>
<tr>
<td>Accessibility</td>
<td>Satisfied with access at current practice</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Satisfied with disabled parking at current practice</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Concern over access at alternative practices</td>
<td>3</td>
</tr>
<tr>
<td>Effect on Local Population</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>Closing would be a loss to the Community</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Concern about access in an area of deprivation</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Concern that compulsory transfer would result in patients not attending</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Concern about longer term costs of health care</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Withdrawal not considered an acceptable second choice</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Access to continued NHS Care</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Concern over sustainability of other NHS dental practices to continue to provide NHS services</td>
<td>13</td>
</tr>
</tbody>
</table>

### 3.0 Feedback from Non-Patient Sources

#### 3.1 Discussions with Stakeholders re Needs Assessment

The document was circulated for comment and used to support discussions between key stakeholders regarding the recommended actions. One formal comments form was received which advised that the document was comprehensive and identified opportunities for linking work on oral health to other health improvement topic areas. Informal feedback received following discussions with other key stakeholders identified the document as providing a useful summary of the key issues within the community and provided a foundation on which to take forward the recommended areas of work.

#### 3.2 Feedback from Dental Teams

Only one feedback form was received from local dental team members. The key points in this feedback advised that the review process appeared thorough and robust. It supported the Proposed Preferred option of withdrawal and highlighted the need to support staff going through this process and for this to continue if withdrawal is progressed.

#### 3.3 Feedback from Integration Joint Board Strategic Planning Group

The response from the Integration Joint Board Strategic Planning Group was limited. Four responses were received. One member felt unable to comment and the other declared an interest, two included relevant responses. One response provided feedback on the accessibility of the information provided, and shared some guidance on how to present information to ensure it is accessible to people with disabilities. The other responses key points included that the needs assessment appeared thorough and comprehensive and that greater focus is required to support this community, although acknowledging this may not necessarily be through clinic provision. In terms of the needs assessment recommendations, it acknowledged they are not new or innovative but rather...
building on existing work, which was felt to be important to continue. The opportunities to work more closely with the third sector who are already working within this community was highlighted as an area that should be developed. The response also indicated support for the Proposed Preferred option, as long as the needs assessment recommendations were implemented.

4.0 Feedback on Options and Needs Assessment from Community Representatives

Formal responses on the options were also received from interested stakeholders who included: one MP, one Councillor; Lincluden Community Council, Lochside and Woodlands Community Council, Maxwelltown North Tenants and Residents Association and Creative Futures, a community based organisation in North West Dumfries who following an approach from local people undertook some engagement work within the North West Dumfries area, their findings are also included in the summary of key themes below,: 

The themes from these responses included:

- All were in favour of keeping the clinic open
- Advised the clinic is seen as a community asset
- Noted concern over increasing inequalities and the potential detriment to oral health and potential longer term financial costs this could incur.
- Travel and transport, including costs, raised as a potential barrier for seeking dental care
- Reported that local people would be interested in registering at the clinic if they had the opportunity
- Reported local people were either not aware there was a clinic there or were not able to register at the clinic due to a restriction on new patient registrations.

5.0 Summary of Points Highlighted During the Consultation Period

It is clear that those patients who commented highly value the service they receive and would like to continue to receive dental services from the Lochside Dental Clinic. These patients will live in both the Lochside and Lincluden area and also areas outwith this. 

A high number of comments received were from patients confirming their satisfaction of the level of service provided, accessibility and parking at the Lochside Dental Clinic.

Many patients and community representatives were also concerned that the closure of the clinic would be a loss to the community, particularly as this is classified as an area of deprivation and were also concerned about what the potential impact of this would be on those who could potentially struggle to attend for dental treatment in another location. There was also a feeling that opportunities exist to expand the services from the clinic both from a dental perspective but also through other health and social care services.
Other key themes that emerged were: concern over the sustainability of other practices to continue to provide NHS services, concern about the level of service provided at other NHS practices and concern over access and parking of alternative practices. There was also a feeling that the changes were being driven by finance as opposed to improved patient care.

Some concerns were raised regarding the level of engagement of the community during the review process.
### Appendix 7

**Summary of Capacity Required for Dispersal of Patients and Potential NHS Capacity Reported within Existing Independent Contractor Practices**

Table 1 Capacity Required for Dispersal of Patients and Potential NHS Capacity Reported Within Existing Practices

<table>
<thead>
<tr>
<th>Locality of Residence</th>
<th>Estimated Number of Patients Registered at Lochside Dental Clinic *</th>
<th>Potential NHS Capacity Reported available within existing practices</th>
<th>Number of Practices Reporting Potential capacity with 3 months notice</th>
<th>Are there any restrictions on the categories of patients to be registered</th>
<th>Practices reporting currently accepting patients for NHS Registration</th>
<th>Practices reporting agreeable to treat unregistered patients following triage by dental helpline staff, Mon - Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annandale and Eskdale</td>
<td>32</td>
<td>3650</td>
<td>3</td>
<td>No</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Nithsdale</td>
<td>1195</td>
<td>8600+</td>
<td>10</td>
<td>All advised that there are no restrictions on categories of registration. 3 practices not suitable for patients in wheelchairs or with mobility problems</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>Stewartry</td>
<td>47</td>
<td>250</td>
<td>3</td>
<td>1 practice not suitable for patients in wheelchairs or with mobility problems</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1277</strong></td>
<td><strong>12,500</strong></td>
<td><strong>16</strong></td>
<td></td>
<td><strong>14</strong></td>
<td><strong>12</strong></td>
</tr>
</tbody>
</table>
* Estimated Registrations as at July 2016
+Includes one practice not giving a number for potential capacity but reporting able to accept patients willing to transfer therefore their capacity not included
<table>
<thead>
<tr>
<th>Location</th>
<th>Church Court Dumfries</th>
<th>Lochthorn Dental Clinic</th>
<th>47 Bank Street, Dumfries</th>
<th>DADDS Dental Practice</th>
<th>Blue Door Dental Practice</th>
<th>Great King street Dental Practice</th>
<th>DG Smile</th>
<th>Thornhill Dental Surgery</th>
<th>Lochside Dental Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Available Parking</td>
<td>Town Centre Parking</td>
<td>Private Car Park</td>
<td>Town Centre Parking – private and public car parking available, including on street parking</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Designated Disabled Parking</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Approach/Access with/without steps</td>
<td>Single step or flight of steps from pavement to practice entrance. 50mm door threshold</td>
<td>Level access to main entrance from car park</td>
<td>Paved/cobbled street to single step access to hallway leading to flight of steps to first floor practice.</td>
<td>Main entrance risen threshold. Side entrance is used for disabled access but does have a single step 150mm step. Ramp being sourced.</td>
<td>Tarred pavement. Level access is available at the rear of the property. Flight of steps up from street to front door.</td>
<td>Paved street with ramped access</td>
<td>Tarred pavement with steps up to front door. There is level access at the rear of the practice.</td>
<td>No level access to the practice – ramp provided if required. Door bell provided for patients requiring assistance</td>
<td></td>
</tr>
</tbody>
</table>

**NOT PROTECTIVELY MARKED**

Page 131 of 140
### SUMMARY OF ACCESS REVIEW FOR INDEPENDENT PRACTICES REPORTING POTENTIAL NHS CAPACITY – COMPARED TO LOCHSIDE CLINIC - NITHSDALE

<table>
<thead>
<tr>
<th>Access to Main Door eg manual or automated</th>
<th>Church Court Dumfries</th>
<th>Lochthorn Dental Clinic</th>
<th>47 Bank Street, Dumfries</th>
<th>DADDS Dental Practice</th>
<th>Blue Door Dental Practice</th>
<th>Great King street Dental Practice</th>
<th>DG Smile</th>
<th>Thornhill Dental Surgery</th>
<th>Lochside Dental Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location of Reception</td>
<td>First Floor</td>
<td>Ground Floor</td>
<td>First floor</td>
<td>Ground floor</td>
<td>Ground floor</td>
<td>Ground Floor</td>
<td>Ground Floor</td>
<td>Ground Floor</td>
<td>Ground Floor</td>
</tr>
<tr>
<td>Reduced height reception desk</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes in part</td>
<td>Yes</td>
</tr>
<tr>
<td>Ground Floor Surgery Available</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Aids e.g. induction loop, sign language</td>
<td>Some staff trained in British Sign Language</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>Induction loop provided</td>
<td>None</td>
<td>None</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**NOT PROTECTIVELY MARKED**

Page 132 of 140
<table>
<thead>
<tr>
<th>WC Facilities</th>
<th>Church Court Dumfries</th>
<th>Lochthorn Dental Clinic</th>
<th>47 Bank Street, Dumfries</th>
<th>DADDS Dental Practice</th>
<th>Blue Door Dental Practice</th>
<th>Great King street Dental Practice</th>
<th>DG Smile</th>
<th>Thornhill Dental Surgery</th>
<th>Lochside Dental Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>WC facilities are available but not accessible for all</td>
<td>Accessible WC available</td>
<td>WC facilities are available. May not be suitable for patients with limited mobility.</td>
<td>Accessible WC available</td>
<td>Accessible WC available</td>
<td>Accessible WC available</td>
<td>WC facilities are available. May not be suitable for patients with limited mobility.</td>
<td>Accessible WC available</td>
<td>Accessible WC available</td>
<td>Accessible WC available</td>
</tr>
</tbody>
</table>
### SUMMARY OF ACCESS REVIEW FOR INDEPENDENT PRACTICES REPORTING POTENTIAL NHS CAPACITY – COMPARED TO LOCHSIDE CLINIC - NITHSDALE

<table>
<thead>
<tr>
<th>Practice reports that patients in wheelchairs can be seen and treated within a dental surgery at the practice</th>
<th>Church Court Dental Clinic</th>
<th>Lochthorn Dental Clinic</th>
<th>47 Bank Street, Dumfries</th>
<th>DADDS Dental Practice</th>
<th>Blue Door Dental Practice</th>
<th>Great King Street Dental Practice</th>
<th>DG Smile</th>
<th>Thornhill Dental Surgery</th>
<th>Lochside Dental Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Blue Door Two</td>
<td>Oasis Dental Care</td>
<td>Lochside Dental Clinic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>--------------------------------------------</td>
<td>---------------------------------------</td>
<td>--------------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Location</strong></td>
<td>Dumfries Town Centre</td>
<td>Dumfries Town Centre</td>
<td>Lochside</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Available Parking</strong></td>
<td>Town Centre Parking – private and public car parking available, including on-street parking</td>
<td>Town Centre Parking – private and public car parking available, including on-street parking</td>
<td>Designated Car Park</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Designated Disabled Parking</strong></td>
<td>Designated Disabled Bay at rear of practice – Shared with neighbouring practice</td>
<td>Town Centre Designated Spaces Available both private and public</td>
<td>Designated Disabled Parking</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Approach/Access with/without steps</strong></td>
<td>Practice on first floor but level access is available at the rear of neighbouring practice.</td>
<td>Tarred pavement. There is no level access to the Practice. Access to practice is by 4 sandstone steps from Castle Street.</td>
<td>Level Access from pavement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Access to Main Door eg manual or automated</strong></td>
<td>Manual to the front of building. Electronic to rear access into neighbouring practice</td>
<td>Manual</td>
<td>Manual</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Location of Reception</strong></td>
<td>First floor, however less mobile patients can use reception area in neighbouring practice as per joint agreement of the two practices</td>
<td>First floor</td>
<td>Ground Floor</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reduced height reception desk</strong></td>
<td>Yes, in the neighbouring practice as per joint agreement of the two practices</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## SUMMARY OF ACCESS REVIEW FOR INDEPENDENT PRACTICES REPORTING POTENTIAL NHS CAPACITY – COMPARED TO LOCHSIDE CLINIC - NITHSDALE

<table>
<thead>
<tr>
<th>Ground Floor Surgery Available</th>
<th>Blue Door Two</th>
<th>Oasis Dental Care</th>
<th>Lochside Dental Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, in the neighbouring practice as per joint agreement of the two practices</td>
<td>Yes – but no level access to practice.</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Aids e.g. induction loop, sign language</td>
<td>None</td>
<td>None</td>
<td>Yes</td>
</tr>
<tr>
<td>WC Facilities</td>
<td>Yes, on first floor. Also accessible WC available in neighbouring practice on ground floor as per joint agreement of the two practices</td>
<td>There is a WC for patient use. It may not be suitable for patients with limited mobility.</td>
<td>Accessible WC available</td>
</tr>
</tbody>
</table>

Practice reports that patients in wheelchairs can be seen and treated within a dental surgery at the practice

| Yes, in the neighbouring practice as per joint agreement of the two practices | No | | Yes |
### SUMMARY OF ACCESS REVIEW FOR INDEPENDENT PRACTICES REPORTING POTENTIAL NHS CAPACITY – COMPARED TO LOCHSIDE CLINIC - STEWARTRY

<table>
<thead>
<tr>
<th></th>
<th>King Street Dental Practice</th>
<th>Garden Hill Dental Clinic</th>
<th>Kirkcudbright Dental Clinic</th>
<th>Lochside Dental Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Location</strong></td>
<td>Castle Douglas</td>
<td>Castle Douglas</td>
<td>Kirkcudbright</td>
<td>Lochside, in residential area</td>
</tr>
<tr>
<td><strong>Available Parking</strong></td>
<td>Private and Public car parking, including on street parking available within Castle Douglas Town Centre</td>
<td>There is dedicated car parking that is shared with the rest of Gardenhill Primary Care Centre</td>
<td>Public car parking, including on street parking is available within Kirkcudbright town centre</td>
<td>Dedicated car park</td>
</tr>
<tr>
<td><strong>Designated Disabled Parking</strong></td>
<td>There is designated disabled parking in both private and public car parks and on street designated spaces</td>
<td>Yes</td>
<td></td>
<td>Dedicated disabled parking</td>
</tr>
<tr>
<td><strong>Approach/Access with/without steps</strong></td>
<td>Paved pavement with stepped entrance</td>
<td>Paved access. Level access to building</td>
<td>Flat paved pavement. There is level access to the practice.</td>
<td>Level access from pavement</td>
</tr>
<tr>
<td><strong>Location of Reception</strong></td>
<td>First Floor</td>
<td>Ground floor</td>
<td>Ground floor</td>
<td>Ground floor</td>
</tr>
<tr>
<td><strong>Reduced height reception desk</strong></td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>
## SUMMARY OF ACCESS REVIEW FOR INDEPENDENT PRACTICES REPORTING POTENTIAL NHS CAPACITY – COMPARED TO LOCHSIDE CLINIC - STEWARTRY

<table>
<thead>
<tr>
<th></th>
<th>King Street Dental Practice</th>
<th>Garden Hill Dental Clinic</th>
<th>Kirkcudbright Dental</th>
<th>Lochside Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ground Floor Surgery Available</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Aids eg induction loop, sign language</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>WC Facilities</td>
<td>WC facilities are available. May not be suitable for patients with limited mobility</td>
<td>Accessible WC available</td>
<td>Accessible WC available</td>
<td>Accessible WC facilities available</td>
</tr>
<tr>
<td>Practice reports that patients in wheelchairs can be seen and treated within a dental surgery at the practice</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>summary of access review for independent practices reporting potential nhs capacity –compared to lochside clinic annandale and eskdale</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>------------------------------------------</td>
<td>------------------------------------------</td>
<td>------------------------------------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>location</td>
<td>Lochside Dental Clinic*</td>
<td>Lochmaben Smile Centre</td>
<td>Lockerbie Dental Surgery</td>
<td>Moffat Dental Centre</td>
</tr>
<tr>
<td></td>
<td>Lochside – Residential Area</td>
<td>Lochmaben High Street</td>
<td>Lockerbie High Street</td>
<td>Moffat Town Centre</td>
</tr>
<tr>
<td>available parking</td>
<td>Dedicated car park</td>
<td>On-street parking</td>
<td>Parking in Town Centre car park at the rear of the building.</td>
<td>Car Parks and on street parking available in town centre.</td>
</tr>
<tr>
<td>designated disabled parking</td>
<td>Designated disabled bays in car park</td>
<td>On-street disabled bay next door to the practice.</td>
<td>Designated disabled parking in Town Centre car park at rear of building.</td>
<td>Town Centre Designated Disabled Spaces</td>
</tr>
<tr>
<td>approach/access with/without steps</td>
<td>No steps to approach threshold flush</td>
<td>Paved approach. Level access</td>
<td>Paved approach. Level access</td>
<td>There is a ramp leading to the practice entrance. The approach to the ramp is rough and uneven.</td>
</tr>
<tr>
<td>access to main door e.g. manual or automated</td>
<td>Manual</td>
<td>Manual</td>
<td>Manual</td>
<td>Manual</td>
</tr>
<tr>
<td>location of reception</td>
<td>Ground floor</td>
<td>Ground floor</td>
<td>Ground Floor</td>
<td>Ground Floor</td>
</tr>
<tr>
<td>reduced height reception desk</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes – in part</td>
<td>In part</td>
</tr>
<tr>
<td>Ground Floor Surgery Available</td>
<td>Lochside Clinic</td>
<td>Lochmaben Smile Centre</td>
<td>Lockerbie Dental Surgery</td>
<td>Moffat Dental Centre</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-----------------</td>
<td>------------------------</td>
<td>--------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Aids eg induction loop, sign language</th>
<th>Lochside Clinic</th>
<th>Lochmaben Smile Centre</th>
<th>Lockerbie Dental Surgery</th>
<th>Moffat Dental Centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>None</td>
<td>Yes at reception</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>W C Facilities</th>
<th>Lochside Clinic</th>
<th>Lochmaben Smile Centre</th>
<th>Lockerbie Dental Surgery</th>
<th>Moffat Dental Centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accessible WC available</td>
<td>Yes</td>
<td>Accessible WC available</td>
<td>Accessible WC available</td>
<td>WC facilities are available. May not be suitable for patients with limited mobility.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Practice reports that patients in wheelchairs can be seen and treated within a dental surgery at the practice</th>
<th>Lochside Clinic</th>
<th>Lochmaben Smile Centre</th>
<th>Lockerbie Dental Surgery</th>
<th>Moffat Dental Centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
DUMFRIES and GALLOWAY NHS BOARD

7th August 2017

BOARD BRIEFING

Author: Rachel Hinchliffe
Communications Assistant

Sponsoring Director: Jeff Ace
Chief Executive

Date: 28th July 2017

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
PAWS - Paediatric Advanced Warning Score
DGRI - Dumfries and Galloway Royal Infirmary
## MONITORING FORM

<table>
<thead>
<tr>
<th>Policy / Strategy</th>
<th>NHS Dumfries and Galloway Communication Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing Implications</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Financial Implications</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Consultation / Consideration</td>
<td>The information within this briefing is populated with items of interest provided by any member of staff.</td>
</tr>
<tr>
<td>Risk Assessment</td>
<td>Not applicable.</td>
</tr>
<tr>
<td>Sustainability</td>
<td>Not applicable.</td>
</tr>
<tr>
<td>Compliance with Corporate Objectives</td>
<td>This paper encompasses all 7 Corporate Objectives.</td>
</tr>
<tr>
<td>Single Outcome Agreement (SOA)</td>
<td>Not applicable.</td>
</tr>
</tbody>
</table>
| Best Value | - Vision and Leadership  
- Effective Partnerships  
- Use of Resources  
- Performance Management  
- Equality |
| Impact Assessment | Not applicable. |
Introduction

Section 1 – Events

Children’s Ward Celebrates PAWS Success
Ward 15 celebrated 10 years of using the PAWS (Paediatric Advance Warning Score) charts. PAWS is an early warning score tool which developed through the patient safety programme back in 2007.

Dumfries and Galloway Royal Infirmary (DGRI) is the first district general hospital in Scotland to use this tool and are very proud to say that we are now in the process of being involved in the implementation of the national tool for paediatrics.

Children’s Ward Staff Nurse Sharron McGarva and Consultant Paediatrician Andrew Eccleston have presented the tool at both national and international events.

The Scottish Health Awards 2017
The Scottish Health Awards 2017 ceremony will take place on Thursday 2nd November 2017, at The Corn Exchange, Edinburgh. These awards will recognise those that go that extra mile to improve the health and wellbeing of the people of Scotland.

The Scottish Health Awards recognise the extraordinary work of the people on the frontline of healthcare provided by our NHS and its partners.

We want to know about the people who have genuinely made a difference to your life or to the lives of your family or friends. It might be an individual or a team who have provided outstanding care to their patients or those who are in jobs that normally don't have a high profile and who generally should be recognised for their commitment to the NHS and its partners.

There are seventeen award categories - whether it's the local doctor or dentist, the support worker, nurse, paramedic or volunteer. No matter what their title, or where they are based, if they have made a difference, we want to know about it.

Submit your nominations for the Scottish Health Awards 2017 online by 5pm on Thursday 31st August 2017 at www.scottishhealthawards.com

Volunteers Week – 1-7 June 2017
This is a UK-wide celebration of volunteering and provides an opportunity to raise awareness of volunteering. NHS Dumfries and Galloway took advantage of this opportunity to thank all our volunteers for their continued dedication and commitment.

Realistic Medicines Conference
The conference will take place on Wednesday 20th September 2017. The aim is for health-care professionals to share and learn about Realistic Medicine projects going on in Dumfries and Galloway and beyond. Delegates from all over the country are expected to attend, alongside local clinicians and professionals.
Section 2 – Staffing Changes, including new starts, retirements

Carol Stewart
Carol Stewart left NHS Dumfries & Galloway in July 2017 after 30 years. Carol started as a student nurse in 1987 and had most recently been a key member of the Public Health Directorate. Carol leaves to take up the post of Public Health Manager with NHS Orkney. We wish her every success in her new and exciting venture.

Mental Health Appointments
The Mental Health Directorate is delighted to announce appointments to the Lead Nurse and Professional Manager posts for both the Community Mental Health Nursing and the Inpatient Nursing Service.

Linda McKechnie has taken on the role of Lead Nurse for Community Mental Health Nursing and Lynnette Dickson to the Lead Nurse for Inpatient Nursing Services.

Senior Biomedical Scientist – Microbiology
Rab (Robert) Walker, Senior Biomedical Scientist in Microbiology retired at the end of June 2017. Rab has worked for NHS Dumfries and Galloway for 37 years.

Cancer & Palliative care Services
Helen Keen retired following 13 years as Lead Nurse / Nurse Manager in the Alexandra Unit / Macmillan Centre.

Ward 9
Marion Smith retired at the end of June with 43 years of service. She started working within Domestic Services before a change of career to a Healthcare Assistant on Ward 9 in 2011.

Radiology
Karen Flaws retired from the Radiology Department at the end of June 2017 after nearly 40 years service. Karen started work as Radiographer in the late 1970's and went on to train to become a Sonographer in the early 90's. Since then, she has scanned in DGRI and Cresswell.

Out of Hours
Assistant Out of Hours Manager, Linda Davidson retired from her role within NHS Dumfries and Galloway at the end of July 2017, having worked as assistant manager for the last 20 years.

Anne Scott, administrative assistant, left NHS Dumfries and Galloway in June 2017, after 14 years.

Community Nurses
Annette Gibson retired from in June 2017. Annette qualified in 1981 and has worked as a community nurse for the last 16 years.

Children’s Ward
Elizabeth Hallmark retired earlier this year, having worked within Ward 15 at Dumfries and Galloway Royal Infirmary.
### Section 3 - Current Consultations

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<tr>
<th>From</th>
<th>Topic</th>
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<tr>
<td>Fire Scotland</td>
<td>Consultation for Draft Local Fire and Rescue Plan for Dumfries and Galloway 2017</td>
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### Section 4 – Chief Executive and Chairman Commitments

#### Chief Executive’s Diary

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<td>NHS Board Workshop – Finance</td>
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<td>NHS Chief Executives Meeting</td>
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<td>Scottish Institute of Healthcare Managers (SIHM) Council Meeting</td>
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<td>West of Scotland Planning Group</td>
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<td>West of Scotland Chairs group</td>
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#### Chairman’s Diary

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<td>NHS Chairs Group</td>
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<td>TCAT Programme Board</td>
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<td>MP / MSP Quarterly Briefing</td>
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<td>25</td>
<td>NHS Dumfries and Galloway - Non-Ministerial Annual Review</td>
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<td>National Specialist Services Committee</td>
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#### Chairman’s Diary

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</table>
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

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

Area Clinical Forum

Minute of the Area Clinical Forum meeting held in the
Education Centre, DGRI on Wednesday 24th May 2017

Present
Lorna Carr, (Chair)
Moira Cossar, Heather Currie,
Bill Irving, Ruth Millican, Ranjit Thomas

Apologies
Fraser Gibb, Kim Heathcote, Ross Warwick

In Attendance
Jan McCulloch, Professional Committees’ Co-ordinator
From 7.00pm: Jeff Ace, Margo Christie, John Knox

1. Apologies and Welcome

2. Minute of Previous Meeting
The Note of the meeting held on Wednesday 26th April 2017 was approved.

3. Matters Arising

4. Volunteering Policy and Procedures Consultation
Members ratified the ACF response to the consultation and noted the
following comments have been sent to Joan Pollard, Associate Director
Allied Health Professions:

Members had no comment about the content of the policy.

Members agreed this Policy was fairly comprehensive, with no significant
differences/changes to the previous policy.

It was pointed out that the flowchart on Page 15 - 3.1 diagram B did not
have Yes/No boxes at the beginning of the chart after the box ‘if there has
been a serious breach of the code of conduct’.

It was highlighted that in the policy Page 6 Para 2 Purpose and Scope.
Point 1) ‘Establish NHS D &G as an organisation that is welcoming to
volunteers’ ... It was felt that this has already been established and
embedded for a number of years.
Point 7) Establish relationships between Voluntary Organisations in D &G
and NHS D & G in order to improve the volunteer experience and it was also
felt this already existed.
During a wide range of discussions it was recognised the challenges in recruiting a large number of volunteers for the new hospital. There were some concerns raised that, if there were difficulties in achieving the number of volunteers required to operate the welcome desk and stations at each ward, this may have an impact on staffing capacity. ACF asked if there are potential risks to patient safety should this happen and if there were contingency plans should the organisation fail to recruit the number of volunteers needed and would welcome a progress report.

There were also some discussions around future volunteers and involving young people at an early stage and members asked if there were plans to raise awareness with schools e.g. Careers Fairs etc.

5. Standing Items
   a) Chair’s Report
      Lorna informed members that she will be attending the ACF Chairs’ meeting on the 7th June.

   b) The Change Programme
      • Work streams
        It was noted that the business plan for the existing Cresswell building has not yet been signed off by the Government.

   c) Integrated Joint Board
      Following the local elections, the council have still to agree council reps for the IJB; the Health Board Vice Chair, Penny Halliday has now taken over as the IJB Chair for next 2 years.

   d) Feedback from Committees
      Area Medical Committee: Medical Staff Sub Committee
      Following continuing concerns about medical recruitment and retention, there had been an extraordinary meeting of Medical Staff Committee and the Workforce Director to raise issues about processes. The main outcome from the meeting has been a working group to be established to address issues and the Medical Staffing Team and Deputy Director of HR moving to the Admin Corridor of DGRI to build better communications. It was agreed that this had been a very positive result for MSC and could also be positive for other professions if there is improvement to ways of recruiting.

      Rehab Services in Lochmaben hospital – MSC acknowledged the opinion of the Medical Staff, Nursing and AHP Advisory Committees was given and advice accepted by board management team in making decisions about future rehab services.

      GP Sub Committee
      Citizens Advice representatives attended to talk about Welfare Benefits and how CAB could help GPs.

     NOT PROTECTIVELY MARKED
The committee received a presentation on the review of the chronic pain service.

**ANMAC**  
Consultations on the Volunteering Policy and Urinary Catheter Passport and response.  
Concerns raised whether are there enough nurses for double running period during migration to the new build. CAU needing 12 nurses. Nurse Recruitment day takes place on 24th June with fixed terms agreed this time.

It was agreed that difficulties arise when departments are looking for staff from within the same pool and the knock on effect this has when vacancies are filled internally.

UWS are struggling to recruit to nursing places this year. This year’s course finishes in July but registration is not until October.

**AHPAC**  
Retention issues as AHP staff are only coming to D & G for short time and then leaving after the organisation has invested time and development.  
Pilot taking place for an O/T Assistant Practitioner post in Newton Stewart.

**Joint Session 7pm**

6. **New Hospital Update Margo Christie, John Knox**  
Margo and John updated members from the downstream meeting this afternoon when the agreed model was affirmed. It has now been decided that everyone will be moved over by the Sunday night. The downstream meeting also identified additional resources needed for double running.

A Table top simulation exercise has also been organised with SAS and the removal company for finer detail.

Ward 16 will move on the Friday, moving critical care patients first. A cross referencing event will take place on the 26th June. Due to logistics, 3 theatres will be up and running in the first week. Anxieties have been reassured and 3 wards will be fully equipped by the Monday Tuesday and 2 medical and 2 surgical by the Wednesday. Straight swaps have been achieved in most areas. Annual leave has been cancelled for 2 weeks in December and where people, who are non clinical personnel, could be used is being looked at.

A Community Workshop been arranged for Monday with Graham Abrines, looking at having additional community staff remaining to augment services.
for patients who no longer require medical care but who’s care packages are not yet available.

It was acknowledged that this would be an extraordinary situation and a number of early familiarisation visits have been arranged and been well received. Pamela Jamieson, HR is leading the orientation process for staff over a period of 9 weeks.

Members raised concerns about staffing during the double running period and Margo said that completed rosters had been done until December for nursing. John said that there was a need to involve medics more around the double running. Some specialties need to provide cover on both sites and this would have issues for middle and junior grades. Jeff said that they were looking at locum bookings and locum banks.

Heather commented that the move would take place at the same time as changeover week for junior doctors, affecting about 30 doctors and as this would affect their orientation Heather said that they need to be oriented to the dept that they will be going to and not their current one.

John said there would be no outpatient clinics on the Friday and Monday and that this included specialist nurses clinics that would also need to be cancelled. John commented that it had been fortunate additional slots had been allocated by the Golden Jubilee from November to January.

Lorna spoke about anxieties raised around the services and people who would be left on the ‘old hospital’ site and John agreed that in managing the services that remain there is a need to ensure security for all.

John said that the new site will be called Mountainhall Treatment Centre, Renal will remain in situation, the Diabetes Centre and diabetic retinopathy will move from Crichton Hall early next year along with Podiatry moving from the Nithbank site. Ophthalmology will be migrating from the 3rd to the ground floor.

Adverts have been placed for Critical Care Unit posts; a consultant physician with experience in Critical Care and also re-advertising for 2 x anaesthetists’ posts with experience in critical care.

Combined Assessment Unit - Patient pathways are nearing completion with a 14/8 new model; Sian Finlay is looking at the management of assessment beds.

Ward 6 and 7 nursing staff are rotating and Team passports have been established.

John said that Admin staff will be staffing the ward welcome desks across hospital and there is a recruitment drive being arranged in June to recruit volunteers to support the welcome desks.
The efficiencies and use of theatres and theatre timetables are also being looked at, ensuring no duplication or omission. The current number of half day sessions in theatres are not effective or efficient and later start times and earlier finishes are also being looked at. Heather said there were issues around theatre efficiencies that would not be fixed by the new build and agreed that the transition will provide an opportunity to look at better ways of working.

John informed members that a National Review of Ophthalmology Services is currently underway and would be identifying efficiencies.

It was agreed that effective, regular communications with staff and public was essential. Margo said that a communications strategy is being managed by Kirsten Moffat who is looking at working hard to ensure information is being distributed. An information booklet about the building is also being put together.

To raise staff awareness about progress Margo said an A4 laminated information sheet will be placed regularly on tables in the DGRI dining room showing updates and changes and this should help to scorch any rumours developing.

John said that Patient information leaflets are being updated and have started to be uploaded on to Equitrack. Future appointment cards will include letters explaining about the move and the renaming of the old hospital to Mountainhall.

Transition planning – The tabletop exercise for Paediatrics, theatres and labs had all been very successful and identified some areas requiring further consideration. An open day for labs will be held.

Ranjit asked if there would be dedicated space for doctors to do dictation and Margo confirmed there would be no additional space out with the wards’ interview room that would have additional space for doctors and that the SCN office and MDT room were also available when required. John confirmed that office accommodation for consultants has been allocated and will be posted in the Education Centre and Admin corridor; it was also confirmed that there was no reduction in bed numbers.

Members congratulated the Project team on the job they had done and involving all Healthcare Professionals.

7. Integrated Joint Board
Jeff confirmed it had been announced that following the recent local council elections there will be 5 new council members on the Integrated Joint Board and that councillor Andy Ferguson will be the new council member on the Health Board.
Proposals to streamline committees and have one audit and one health governance and one performance committee are currently being considered and a paper will come to the Health Board in August.

8. Any Other Business

a) Jeff informed member that following recent terrorist attacks the resilience level had been raised to critical with the resilience office at the government, although there is no known threat updates about availability are required every few hours.

Heather commented that the IT had done very well following the recent cyber attack and communications had been good. Jeff agreed and said that the Patches installed in the New Year had worked well.

b) Position of Joint Health Boards
Jeff informed members that although there is no immediate talk about Health Boards amalgamating or merging, Chief Executives have been instructed to have a joint delivery plan meeting on Monday when they can put combined pressures on table. Jeff suggested that he circulates a presentation received at the last Chief Executives’ meeting to ACF members.

Lorna concluded that this had been a very positive meeting and that ACF had a strong membership with professional advisory committees that were keen to be involved and included.

Date of Next Meeting 28th June 2017
DUMFRIES AND GALLOWAY NHS BOARD

Audit and Risk Committee

Minutes of the Audit and Risk Committee meeting held on Monday 20\textsuperscript{th} March 2017 at 10.00 am – 1.00 pm in the New Boardroom, Crichton Hall, Bankend Road, Dumfries, DG1 4TG.

Present

Mr R Allan RA Non-Executive Board Member (Committee Chair)
Ms L Bryce LBr Non-Executive Board Member
Mrs G Cardozo GC Non-Executive Board Member
Dr L Douglas LD Non-Executive Board Member
Ms G Stanyard GS Non-Executive Board Member
Mrs R Francis RF Audit and Risk Committee Lay Member

In Attendance

Mr J Ace JA Chief Executive
Mrs K Lewis KL Director of Finance
Ms J Watters JW Chief Internal Auditor
Ms J Brown JBr External Auditor – Grant Thornton UK LLP
Ms L Bass LBa Executive Assistant to Director of Finance (Minute Secretary)
Mr D Irving DI Emergency Planning Officer (Item 11 only)
Mr G Gault GG General Manager of ICT (Item 13 only)

Apologies

Mr P Jones PNJ Chair/Non-Executive Board Member
Mr E Docherty ED Nurse Director
Ms S Thompson ST Deputy Director of Finance

The Committee Chair welcomed members to the Audit and Risk Committee meeting, thanking other colleagues for their attendance. It was noted that Item 11 would be taken earlier on in the agenda.

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
3. **Minutes of meeting held on 19th December 2016**

Audit and Risk Committee approved the minutes from the previous meeting on 19th December 2016.

4. **Matters Arising and Review of Actions List**

KL took members through the actions from previous meetings, giving an update on the progress made against each point.

GS referred to Item 3 and the suggestion that the complaints procedure be incorporated into induction training. GS asked that this be added to the actions list and an update be provided on progress.  

**Action: LBa and ED**

LB queried progress with establishing the Chairs Group. It was agreed that a 30 minute slot will be allocated at the Non-Executive Board Members meetings to co-ordinate communication between the Chairs of the Committees (other Non-Executive Board Members can be in attendance also).

**Action: RA**

Audit and Risk Committee noted the Actions List.

5. **External Audit Quarterly Progress Update**

JBr presented the External Audit Quarterly Progress Update. The report provided an update on:

- Progress updates to 3rd March 2017, including agreement of fees, Annual Audit Plan, interim accounts audit, ICT control environment, onsite meetings and handover with PwC.
- Review of predecessor audit work.
- Sector updates, including Health Tech and Improvement Focus Governance.
- Wider scope risk extracted from the final audit plan.

LD asked for clarity over the materiality figures/percentages. JBr provided further detail on this and explained that Grant Thornton are using 1% gross expenditure for Overall Materiality and 65% on Performance Materiality this year as a benchmark; this will be monitored on an ongoing basis.

JBr provided further information on the ICT control environment. Grant Thornton have undertaken a review of IT general controls and are awaiting information from the IT Delivery Manager to finalise documentation; a report will be provided to management on completion.

Audit and Risk Committee noted the report.
6. **Audit Scotland Reports Update**

KL presented the Audit Scotland Reports Update paper to the Audit and Risk Committee. The report provided a register of all reports received from Audit Scotland in this financial year and included details of Lead Director and local communication/discussion. Since the last meeting, one briefing paper has been received. This was attached as an appendix and is noted below:

- Scotland’s NHS Workforce – the current picture. Two reports will be published from this; the first report will focus on overall workforce planning and workforce pressures in hospitals and will be published in summer 2017. The second is due out in 2018/19 and will explore primary care and GP workforce issues.

LD referred to the vacancies graph in the briefing and the note that NHS Ayrshire and Arran and NHS Western Isles currently have higher rurality levels than the Scottish average but low vacancy rates. LD queried if there was any learning for NHS Dumfries and Galloway re this. JA advised that the CEO group regularly reviews this type of data with a view to sharing successes/practices. JA provided more specific information around these two areas, commenting on issues with long term sustainability.

Audit and Risk Committee noted the report.

*DI arrived at this point the meeting.*

11. **Business Continuity (Audit A-04-16) Progress Update**

At the last Audit and Risk Committee meeting, a number of questions were raised around the Business Continuity (Audit A-04-16). It was subsequently agreed that an update be presented to Committee; DI was in attendance to present the report.

DI explained that the aim of the audit was to promote the establishment of a structured and practical framework and process in preparing for and managing business continuity issues which might impact on the board’s ability to deliver its core functions. A copy of the management action plan for the audit was attached as an appendix and progress against each action included. The paper detailed the progress made in completing the range of actions set out in the audit and also highlighted the need to cross reference commonalities between the audit, the resulting management action plan and the objectives set out in Scottish Government’s NHS Scotland Standards for Organisational Resilience.

DI highlighted key points from the paper including:

- Update on the current status of the audits noting that 13 specific issues were identified and an agreed management response action plan was produced.
• NHS Dumfries and Galloway have identified 8 critical services, which were outlined in the paper. Evaluation of these critical services identified 65 critical supporting activities.
• DI advised that good progress has been made and all target dates have been fully met.
• DI added that it should be recognised that in planned and live event tests of business continuity capabilities and plans, the service has been dynamic and adept at implementing arrangements that support maintenance of safe services.

DI provided further detail on the Scottish Government’s NHS Scotland Standards for Organisational Resilience:

• The Scottish Government Health Resilience Unit (SGHRU) has introduced a programme of Standards for Organisational Resilience for all NHS Boards in Scotland. The programme is a three year rolling programme of developmental enhancement for the 41 resilience standards identified. Returns are to be submitted 6 monthly, the next was due in April 2017, however, SGHRU have recently announced that this is being deferred until August 2017. The first return – an explanatory report – was submitted to Scottish Government in October 2016; we are awaiting feedback on this.
• It is with this underlying 3 year rolling programme we have considered and set our audit target for completion dates so as to align the input and outcome measures for the internal audit and the SGHRU Standards of Organisational Resilience.

DI concluded by advising that a consistent message is being relayed to management at all levels to promote the establishment and ownership of a structured and practical framework.

The Committee discussed the paper at length with the key points noted below:

• RA queried if this was the first Business Continuity audit. DI advised that this was the 2nd; some actions were not completed during the 1st audit and these have been encompassed into the 2nd audit.
• RA asked for clarification around the Business Continuity Plan we currently have in place and to which standards we are working to. JA confirmed that we have created a Business Continuity Plan to our own standards; this is fully established and implemented throughout the organisation. We are waiting for the Scottish Government Standards for Organisational Resilience to be fully implemented/embedded, and we will streamline our Plan alongside these standards. RA asked for assurance that we have a robust Plan in place. DI and JA provided assurances on this, confirming that we have a portfolio of business continuity plans across the organisation which we are continually reviewing and developing.
GC referred to the transition to the New Hospital and sought assurance that business continuity plans are in place for this. JA advised that we are developing a comprehensive transition plan for the move; this will be submitted to Performance Committee but can also be submitted to Audit and Risk Committee for assurance if required. JA added there have been many recent examples where services have responded remarkably well in a business continuity scenario, and demonstrated considerable resilience. Debrief meetings take place immediately after such incidents and learning is carefully considered.

GC referred to the monitoring form within the paper and the comment that an equality impact assessment had not been undertaken; GC felt that there needed to be further clarification/detail around equality impact assessments across all Committee/Board papers, as this was often omitted/vague. Committee acknowledged that it was not clear if the impact assessment question related to the paper or the subject matter; further clarification is required on this.

LD acknowledged the complexities and priorities at the current time, and was keen to establish whether the deadlines for April 2017 were realistic and achievable. DI advised that these may need to be reviewed and spoke of a number of contributing factors. DI added that reporting to Committee today has prompted further engagement and improved momentum to address some areas.

RF and RA referred to the progress updates and deadlines in the report and felt it was important to ensure that there was further transparency; more detail was required on the progress of each action to ensure the Committee has evidence to support the assurances given.

Some of the challenges of fine tuning the current business continuity plans/fulfilling the audit were discussed. It was noted that the main challenge was the administrative requirements and capacity (eg. formalising plans, reporting back, level of detail, adapting and tailoring). Ownership and leadership were also seen as contributing factors.

There was a discussion around staff and management engagement, and conflicting priorities, including the move to the New Hospital. JA gave some examples around this. JA acknowledged that there may be some movement around deadlines dates but provided assurance that the audit will be fulfilled.

The Committee acknowledged this and were reassured that progress was being made. The Committee also acknowledged the significant pressures faced by staff at the current time.

In conclusion, the Committee:

- Noted the report.
- Were keen to ensure that engagement continues and to see evidence to support that progress is being made with the business continuity audit. It was agreed that DI would present another report to Audit and Risk Committee in 6 months time, at the meeting on 18th September 2017.
7. Internal Audit Quarterly Progress Report – Audit Activity to end February 2017

JW presented the Internal Audit Quarterly Progress Update Paper to the Committee. Audit and Risk Committee were asked to:

- Note the report which provided an update on progress against the 2016/17 Internal Audit Plan and detailed key outcomes from audit work undertaken.
- Approve the removal of the Child Protection and Service Redesign and Sustainability audits from the 2016/17 plan with coverage in the 2017/18 Audit Plan.

JW highlighted the key areas of the report which included:

- An appendix showing progress against all audits in the 2016/17 plan.
- To date, 4 audits have been completed to Preliminary reporting stage and 5 audits to Final reporting stage.
- A table identifying 5 Preliminary and Final reports issued since the last Committee meeting (FM/01/17 – Financial Planning and Budgetary Control, TS/73/17 – Patient’s Travel Expenses, A/06/17 – Use of Flexible Workforce, A/03/17 – Register of Interests and Gifts and Hospitality, RM/01/17 – Risk Management)
- Status of audit actions as at 1 March 2017.

JW explained that at various points in the audit year, the Chief Internal Auditor undertakes a review of the remaining audit work required to provide assurances for year end and the resource available to complete this. A number of time commitments and pressures were noted for this year including the EQA assessment and the Chief Internal Auditor being appointed as investigator for an issue that has been brought forward. JW advised that as a result, the audit plan for 2016/17 is therefore not going to be completed to enable the reporting of assurances for June Audit and Risk Committee. This has led to discussions with management around the timing of the remaining audits and other assurances that are provided in these areas. Two audits have been identified:

- In light of recent external reviews and inspections it is proposed that the Child Protection audit (A/11/17), is moved into the 2017/18 audit plan and is timed with a view to report back to the December 2017 or March 2018 Audit and Risk Committee meeting. This will allow for actions from the various inspections and reviews to be implemented.
- It is proposed that the Service Redesign and Sustainability (A/04/17) audit is removed from the 2016/17 plan and that elements of this are rolled into the scope of the 2017/18 audit in relation to the New Hospital – Migration and Commissioning. This also gives consideration to some of the work pressures on management at this time and will

**NOT PROTECTIVELY MARKED**
allow assurances to be provided over the move to the New Hospital. JW advised that these proposals have been discussed with the Chair of Audit and Risk Committee, Director of Finance, Nurse Director and Chief Executive who are in agreement with this approach.

JA left at this point in the meeting.

RF noted that the Child Protection audit had been rated high last year and asked if we were satisfied with assurances from other sources. RF also queried how the audits are rated in terms of priority/importance. JW referred to previous discussions around the establishment of an Assurance Map, noting that some work is being done on this and completion will support reporting of assurances across the organisation. JW provided examples of how priorities are established eg. legislation, discussion with Management Team, previous audits etc. KL added that work on the Assurance Map is ongoing; this is quite a complex piece of work. In terms of the Child Protection audit, KL explained that external scrutiny via joint inspections and reports submitted via other committees, supports assurances around this audit.

Audit and Risk Committee:

- Noted the report
- Approved the removal of the Child Protection and Service Redesign and Sustainability audits from the 2016/17 plan with coverage in the 2017/18 Audit Plan.


JW presented the paper and advised that no Limited Assurance audit reports have been issued since the last Committee meeting in December 2016. The report included updates on Limited Assurance audits that have actions remaining (RM/01/13 Risk Management, A/03/15 CEL’s and other SG guidance, A/06/15 Waste Management, A/06/16 Theatre Stores and Stock Control).

RA referred to the Theatre Stores and Stock Control audit and the note in the report that two of these actions still remain open, in relation to the security of the fire door and the reporting of system access issues with PECOS. RA recalled that progress reports had been submitted to Audit and Risk Committee on 19th September 2016 and 19th December 2016, and sought clarification in relation to the fire door; RA felt that this could be a potential risk and sought assurances that this is being addressed. KL agreed to clarify this information and circulate to Audit and Risk Committee by email at the earliest opportunity.

Action: KL

In reference to the Waste Management audit, LB noted that no actions have been closed off since the last Audit and Risk Committee meeting; 6 remain outstanding. KL agreed to follow this up as part of outstanding actions report which will be presented to Audit and Risks Committee in June 2017.
LD referred to the CEL’s and other SG guidance audit, noting that an update was received in December 2016, however, internal audit have not been able to close yet. JW confirmed that evidence was required to confirm closure; KL explained that some spreadsheet work was required around this which is being worked through at present.

This led to a general discussion around priorities and responsibilities. RF spoke about managers’ responsibilities to progress and report on their action plan; the Committee recognised the role of internal audit in scrutinising actions and evidence. JW provided further information on the process for this.

Audit and Risk Committee noted the report.

9. Internal Audit Plan 2017/18

JW presented the Internal Audit Plan 2017/18 paper to Committee. This included a number of appendices:

- Internal Audit Strategy for 2017 onwards
- Revised Internal Audit Charter
- Risk and Audit Universe – This details areas that are not included in this year’s Internal Audit Plan and will link with work on the Assurance Map.
- Internal Audit Plan for 2017/18 - The Audit Plan should provide sufficient coverage to achieve the objectives of Internal Audit, which are to provide an independent opinion on the effectiveness of risk management, internal control and governance processes within the Board.
- A Balance Scorecard of Performance Measures was also included this year which outlined internal audit goals and measures.

Committee discussed the paper with the key points noted below:

- JW advised that 308 audit days have been allocated for 2017/18. A table outlining the 15 selected audits, risks/priority and number of days was included in the paper.
- 20 of these days have been allocated to Corporate Support. JW provided further information of the type of work included here (eg. providing advice to staff, procedural guidance).
- RA referred to the Audit Charter and the requirement for Internal Audit to liaise with External Audit to avoid duplication. RA noted that External Audit would be including ledger controls and reconciliations and cash and banking within their audit and noted the two proposed internal audits (Ledger Controls and reconciliations; Cash Controls and Banking). RA noted pressure on audit days and queried if there were options around this and asked if there had been liaison. The Committee discussed the distinction between the two types of audit, with External Audit checking the materiality and accuracy of data,
whilst Internal Audit’s focus is more on the operational side/broader controls. LD noted that these 2 audits were assessed as low. JW advised the Committee that there had been liaison with External Audit although they had not seen the plan in advance. JW assured the Committee that Internal Audit would continue to liaise with External Audit to prevent any duplication. JW provided explanation as to how audits are selected. JW advised that some testing within finance/transactions is required to ensure an independent view is provided. KL highlighted the levels of assurance she receives from Internal Audit; over a period of 3 years, all parts of finance are audited and this provides essential feedback to the team.

- Discussion focussed on the Risk Universe and links to the Assurance Map. It was felt that it would be useful to expand the Risk Universe to include when the last audit took place. This would feed into Assurance Map developments.

  **Action: JW**

- Committee felt that the development of an Assurance Map would help to identify where assurances can be sought outwith Internal Audit. This would provide a clearer understanding and reasoning for selection of audits going forward. KL will feed this back to Management Team.

  **Action: KL**

- GC referred to the explanation in the paper around risk weightings and asked for clarity around this. JW provided detail on the weightings within the risk assessment and explained that this is a dynamic document which is reviewed each year. It was queried why the CRES audit was given a medium rating in the risk assessment when meeting efficiencies was a very high risk to the Board. It was explained that the CRES audit was completed 2/3 years ago and determined that the process for identifying, monitoring and reporting on efficiencies was robust. KL said that she will be reassessing this risk on the corporate risk register.

- It was noted that the Chief Internal Auditor reports managerially to the Chief Executive. GC queried the external support also available and whether this was adequate. JW referred to the results of the EQA report which detailed that whilst managerially reporting to the Chief Executive, there is also the role of Audit and Risk Committee to hold Internal Audit to account. KL stated that the EQA gives assurance on the quality of the Internal Audit provision.

- RA asked Committee for their views on the 20 days set aside for corporate work. GC asked how many of these were proactive/reactive. JW advised that this could be both and provided some examples. JW highlighted that she was keen to continue to be available for advice and consultancy as required. RF suggested that it would be useful to include in the Internal Audit Annual Report how many days have been spent in the various areas, so we can measure this against the
original/future plan. JW said that this is part of annual reporting and will continue to be so.

**Action: JW**

- RA asked Committee for their views on drawing up KPIs (as recommended by the EQA assessment). It was agreed that Audit and Risk Committee members will support the development of KPIs via email communication.

**Action: JW**

- LD queried how the IJB responsibilities fitted into the audit plan days. JW and KL advised that no formal decision has been made in terms of this; these have not been included in the audit plan at this stage. KL advised of ongoing discussions and developments; a number of options are being considered. JBr advised that other IJBs are also facing this challenge and it is proving to be quite a complex area. KL will provide an update at the next Audit and Risk Committee meeting.

**Action: KL**

- **Audit and Risk Committee:**
  - Agreed the Internal Audit Strategy for 2017 onwards
  - Approved the revised Internal Audit Charter
  - Noted the Risk and Audit Universe
  - Approved the proposed Internal Audit Plan for 2017/18

### 10. Internal Audit – External Quality Assessment (EQA)

JW presented the paper and asked Committee to note the findings within the attached EQA report by KPMG on the Internal Audit function and agree to receive ongoing updates on the action plan. JW highlighted the key points from the paper as follows:

- A validation of the Internal Audit function’s own self-assessment against the Public Sector Internal Audit Standards (PSIAS) was commissioned in November 2016. This covered all aspects of Internal Audit, including a wide range of indicators to identify conformance with both Attribute and Performance Standards. KPMG were selected to conduct the EQA and commenced their work in November 2016.
- The final report was attached as an appendix and determined that Internal Audit function conforms to PSIAS, and demonstrates several areas of good practice and effective corporate governance.
- The recommendations have been responded to and an action plan was attached as an appendix.
- JW highlighted the recommendation that the Audit and Risk Committee should consider the risk register in conjunction with the Assurance Map and ensure there is sufficient assurance coverage of all risks.

The Committee discussed the paper with the key points noted below:
RA wished to focus on two of the findings, as noted below:
  - There is no succession plan for the Internal Audit team. The Audit and Risk Committee, CEO and the Chief Internal Auditor should work with the wider organisation to introduce a business partnering model for Internal Audit.
  - Limited resource within the internal Audit team means that the annual audit plan could have the same auditors performing similar reviews each year based on their skill set and competencies. This could limit the independence of the function. The CIA should ensure that there is sufficient rotation of auditors on the audit plan for reviews that fall within the same.

In terms of succession planning, JW advised that this work is in progress. KL added that Internal Audit is a very successful but small team. This does bring challenges and there are ongoing discussions around potential future developments and joint/regional working.

JW referred to the recommendation to rotate staff within the team. JW highlighted the challenges around this and the areas of expertise within the team; it was important to utilise/target relevant skills accordingly, therefore it is not always possible to rotate staff.

RF commented that it may be useful to have staff outwith the audit department undertake work within the team as internal audit are well placed to have oversight of the business. RF also suggested that outsourcing was a useful tool to support flexibility within the team (although it was recognised that resources would be required to fund this). RF noted that it would be useful to have an overview of the Internal Audit budget/expenditure. It was agreed that this could be added to the Internal Audit Annual Report.

\[\text{Action: JW}\]

There was brief discussion on data analytics and how this can support Internal Audit work.

GC acknowledged that Internal Audit was an important function and felt it would be useful to include a few more days in the plan for staff investment/development, noting potential issues if staff were off long term.

LD queried if there was a national group for NHS Internal Audit. JW advised that there is not a formal network but there is potential for an NHS group to be established.

Audit and Risk Committee noted the findings within the attached EQA report by KPMG on the Internal Audit function and agreed to receive ongoing updates on the action plan.

12. Risk Management Assurance Quarterly Update

KL presented the Risk Management Assurance Quarterly Update paper. Committee were asked to:

- Note the quarterly update on risk management activity for the Board

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• Approve the revisions made to the Risk Management Strategy
• Discuss the role and appoint a Non-Executive Risk Champion

KL highlighted the key points from the paper which included:

• Risk Executive Group Update – Copy of the minute from 5th December 2016 was attached.
• Risk Co-ordinator - Revision to the job description has been undertaken to clarify the skill base that is required by the post holder. The post has been re-advertised and the post has recently been successfully appointed to.
• Risk Steering Group - Copy of minute from 8th December 2016 was attached as an appendix.
• An abbreviated copy of the new Corporate Risk Register was included as appendix. Some of the corporate risks will be updated in the coming months.
• Risk Management and Integration Joint Board (IJB) - A Risk workshop was held for Health and Social Care Senior Management Team members on 10th November 2016.
• Risk Management Strategy - A copy of the updated strategy was attached for Audit and Risk Committee to review and approve. This included the following appendices: Reporting Structure, Risk Appetite Statement; Risk Matrix; Risk Framework. KL commended the work of Laura Geddes, Corporate Business Manager, in producing the Strategy.
• Risk Champion - Following the recent Risk Management Audit, one of the recommendations within the action plan is for consideration to be given to the appointment of a Risk Management Champion. The role of the Risk Management Champion would be to drive and promote organisational risk management and to ensure that robust assurances are being received. It was felt that an Audit and Risk Committee Non-Executive Board Member would be best placed in this role given the Committee’s role in the oversight of organisational risk management.

The Committee discussed the paper with the key points noted below:

• RA noted that the job title for the Risk Coordinator had been updated to Adverse Events Coordinator and queried if there was still a main focus on risk. KL provided background information on this and confirmed that the job description content was essentially the same; there is still a strong focus on risk.
• RA noted that the Risk Steering Group minutes have not been updated to the new Committee/Board template format. It was noted that the format was to be reflected within Information Assurance Committee minutes and Risk Steering Group minutes. This will be fed back to the Committees.

Action: Corporate Business Manager
• LB queried the progress with embedding the Risk Appetite Statement across the organisation. KL agreed to take this back to the Risk Executive Group.

  **Action: KL**

• GC queried if we were confident that the current corporate risk register provided a good reflection of our risks, and that it encompassed external challenges and emerging issues. KL provided feedback on recent meetings to fine tune the risk register. There are a number of challenges that are difficult to anticipate; some examples were provided. These are exceptional times and Directorates are using this more to try and anticipate the challenges ahead. It was noted that a significant amount of work has been done on risk in relation to clinical change and the transition to the New Hospital. KL advised that there will be a focus on different risk areas over the next 6-9 months.

• LD commented that it would be useful to include bullet points on mitigation plans within the next risk register; this will be incorporated for the June meeting.

  **Action: KL**

• It was noted that LD had expressed an interest in become the Non-Executive Risk Champion for NHS Dumfries and Galloway. The Committee agreed to this appointment.

• The Committee reviewed the Risk Appetite Framework within the Risk Management Strategy. The Committee felt there was confusion around some of the terminology and agreed that clarification was required. This will be reviewed to ensure this is clearly defined.

  **Action: Corporate Business Manager**

The Audit and Risk Committee:

• Noted the paper to provide assurance to the Board that the appropriate processes are in place to ensure that risks are identified and captured within the Board’s various risk registers.
• Approved the revisions made to the Risk Management Strategy.
• Agreed that some of the terminology in the Risk Appetite Framework should be reviewed to ensure this is clearly defined.
• Agreed to the appointment of LD as the Non-Executive Risk Champion.

*GG arrived at this point in the meeting.*

13. **Information Assurance Quarterly Update**

GG presented the Information Assurance Quarterly Update. The paper included:

• Copy of Information Assurance Committee meeting minutes 13th February 2017.
• Copy of Information Assurance Framework, as requested at the last Audit and Risk Committee meeting. GG advised that Dr Angus Cameron has recently been appointed the Senior Information Risk Officer (SIRO) and he will have overall responsibility for the framework.
• Copy of the updated Mobile Phone devices paper.

The Committee discussed the report with the following key points noted:

• RA queried if further liaison with Internal Audit would strengthen the Assurance Framework. GG recalled that Internal Audit attend the Information Assurance Committee; KL added that Internal Audit engage with ICT on a frequent basis in relation to audit work. JW felt that the Framework provided a good basis for reporting 'what was discussed and when', which would then become embedded into standard reporting.
• RF asked how separate audits undertaken by ICT are fed into the process. GG confirmed that these are reported via the Information Assurance Committee. RF felt it would be useful to add these to the Framework.
• GS asked for any update on the Fair Warning System and what risks remain. GG provided an update, advising that this is continually monitored and audited. GG added that he was keen to revisit the system to make further improvements.
• GC asked for clarification around procurement/purchase of mobile phones. GG explained the process, advising all mobile devices are purchased only through the approved framework/national contract by ICT.

Audit and Risk Committee noted the report.

GG left at this point in the meeting.

14. Compliance with Standing Financial Instructions (SFIs) update

KL presented the Compliance with SFIs update paper to the Audit and Risk Committee. The report included:

• The tendering report, advising that one electronic tender has been received or awarded since the last meeting.
• A table detailing the waivers that have been approved since the last meeting of the Audit and Risk Committee.

KL advised that work is ongoing to develop the waiver form and capture all required information. KL added that a large number of waivers are currently being processed for the New Hospital; this is being supported by national procurement and the Central Legal Office. Stringent processes are in place for this.
RF noted the new category of ‘specification can only be met by a single supplier’ and queried what controls were in place around this. KL advised that the team regularly challenge submissions; KL added that this category is often used when there is a requirement for the item to be compatible with existing equipment. RF referred to the waiver for hand hygiene dispensers and the use of the ‘single supplier’ category; KL agreed to clarify this with colleagues to ascertain the background to this waiver request.

**Action:** KL

Audit and Risk Committee noted the report.

### 15. Audit and Risk Committee Self Assessment Checklist

RA presented the Audit and Risk Committee Self Assessment Checklist paper to Committee. As part of the audit requirements set out in the Scottish Government Audit Committee Handbook, each Board must circulate a copy of the Self Assessment Checklist to Non-Executive Board Members who sit on the Board’s Audit and Risk Committee for completion, then analyse the results and feedback from the checklist at a future Audit and Risk Committee meeting.

Key points from the paper were noted:

- This year, it was agreed that the Self Assessment Checklist would be undertaken collectively by Audit and Risk Committee Non-Executive Board Members. A session took place on 30 January with 4 Non-Executive Members in attendance. One Non-Executive Board Member submitted their response in advance for inclusion at the meeting but did not attend. Notes of the meeting are attached at Appendix 1.

- The completed Self Assessment was attached. 72 questions were asked in total: 70 were answered as ‘Yes’ and 2 as ‘No’. Comments have been added throughout to demonstrate further evidence or suggestions for improvement. These comments were fed into the overall action plan.

- RA proposed that a small Sub-Committee be formed to maintain momentum and implement necessary actions. It is proposed the Sub-Committee consists of the Committee Chair and one other member of the Audit and Risk Committee. It will report back to Audit and Risk Committee at the September meeting.

GS referred to question 14 of the Self Assessment Checklist “Has the Audit and Risk Committee considered the arrangements for assessing the attendance and performance of each member”. GS also referred to guidance in the Audit Handbook around this. It was agreed that this will discussed at the next Chairs session (within the next Non-Executive Board Members meeting).

**Action:** Chairs Group

Audit and Risk Committee:
• Noted and approved the completed Self Assessment Checklist.
• Approved the establishment of a small Sub-Committee to take forward the actions and report back to September Audit and Risk Committee.

16. Board Diagnostic Self Assessment

KL presented the Board Diagnostic Self Assessment paper to Committee. The Board Diagnostic Self Assessment was introduced by NHS National Services Scotland (NSS) as a best practice tool to allow Boards to be able to undertake a self assessment against a wide range of areas, including the Board’s strategic priorities and objectives, engagement with stakeholders and its effectiveness. The completed questionnaire was agreed at a meeting of the Chairs of the Boards relevant Governance Committees in collaboration with the Chairman and the Chief Executive. Audit and Risk Committee were asked to review and discuss the report.

The Committee acknowledged that this was a useful and comprehensive document. It was important to consider the findings and results fully. It was agreed that a Board Workshop should be arranged to facilitate this; it was suggested that this could work alongside the next transformational workshop at a Performance Committee meeting.

Action: Corporate Business Manager/LBa

Audit and Risk Committee noted the report.

17. Quarterly Fraud Update

JW presented the Quarterly Fraud Update paper to the Committee and provided an overview:

• A number of specific areas have been taken forward in the last quarter, including:
  o Circulation of CFS reports (report for December 2016 was attached as an appendix).
  o Bribery and Corruption - Following a recent Scottish Government communication, all NHS Boards are encouraged to engage CFS to deliver a Bribery and Corruption presentation. This was delivered on 6th March to approximately 20 key individuals within the Board. This proved very worthwhile and attendees were asked to consider who within their areas should be part of the next stage of presentations.
• Referrals and live cases - There have been a number of discussions with CFS following on from issues raised by staff, which have resulted in four referrals since the last meeting.
• CFS Intelligence Alerts – There have been five intelligence alerts since the last Audit and Risk Committee meeting. Details are these and previous alerts were included as an appendix.

Action: RA

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The Committee provided positive feedback from the Bribery session on 6\textsuperscript{th} March 2017.

Audit and Risk Committee noted the report.

18. National Fraud Initiative (NFI) Update

JW presented the National Fraud Initiative (NFI) Update paper to the Committee. The report summarised the preparation and progress against the 2016/17 NFI exercise and detailed early plans to deal with identified matches. Key points highlighted included:

- The National Fraud Initiative (NFI) is a data matching exercise led in Scotland by Audit Scotland and overseen by the Cabinet Office for the UK as a whole. Whilst the majority of identified frauds and savings are not significantly attributed to NHS bodies, the data matching with NHS information does help to identify irregularities, fraud and overpayments in other areas such as housing benefit payments within local authorities. NHS Dumfries and Galloway are participating in the 2016/17 exercise.
- The key contact for NHS Dumfries and Galloway is the Chief Internal Auditor. Due to the resource required for this exercise a wider support network has been established with Payroll, Creditors and Workforce colleagues to ensure that we can respond appropriately to the data matches.
- As the data matching progresses, any relevant fraud issues or areas of concern will be reported back to Audit and Risk Committee as and when appropriate.

Audit and Risk Committee noted the report.

19. Financial Reporting Quarterly Update

KL presented the Financial Reporting Quarterly Update paper to the Committee. The paper covered the following key areas:

- Annual Account Preparation.
- Technical bulletin summary.
- Information on losses and special payments.

In addition, a list of bad debts, totalling less that £2K, which have been written off as part of the Quarter 3 review within delegated limits, was attached as an appendix. LD noted that a very minor amount was included on the bad debts list and that three letters had been issued to follow this up. LD suggested that a principled but pragmatic approach should be considered in this situation. This was noted.

In relation to the IJB, KL advised that a workshop and a follow up meeting has taken place nationally to clarify the accounting treatment of the IJB with the NHS Board accounts.
Audit and Risk Committee noted the report.

20. Date and Time of the Next Meeting

The next meeting of the Audit and Risk Committee will be held on 19th June 2017 at 10.00 am – 1.00 pm in the New Boardroom, Crichton Hall, Dumfries. It was noted that a Special NHS Board Meeting for the Annual Accounts will be held directly after this in the New Boardroom from 1.30 pm to 3.00 pm.
Patient Story
Mr. Martin Charters (MC) attended to present his very positive Patient Experience Story. He was accompanied by Claire Hope (CH), Senior Physiotherapist, Pulmonary Rehabilitation/COPD Service. ED highlighted MC’s influence in driving forward the development of the Pulmonary Rehabilitation service. MC explained that his aim is to help other patients benefit from the service. He attends the first session of each course, in Annan, to tell patients his story and how if they make an effort to put in to the service they will get the best from the service. The outcome from this is that there has been a massive improvement in the number of patients attending and finishing the courses. MC noted that he has been asked to speak at an event in Stirling later this year.

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GB commented that empowering patients is what we try to do and sometimes it is difficult to make a change and asked MC how to change from not doing much to wanting to do something. He responded that when his doctor said to him about a slow suicide he felt that he had to change but patients have to make this decision themselves and we can help by talking to them and encouraging them. AC highlighted new ways in which things could be improved such as social events and setting up a choir as singing seems to help. He asked MC if there were things like that we could do to make rehabilitation more attractive. MC replied that there is an “Easy Breathers” group but no-one is under 65 in this group and as he is only 49 he did not attend although you can go to the gym. CH highlighted joint work with the Council around making gyms accessible to patients and explained that the BLF had a local singing tutor but acknowledged this could be better. CH noted that the biggest challenge is the waiting list for the service with a common theme of ill health. MC highlighted a video, which will be shared on Youtube and in GP practices, to let people know what they can expect from the service as most people do not know much about it. The educational part of the course about self management is as important as the exercise.

LD asked MC if there had been any transport issues when moving about the different hospitals and he responded that he had encountered no problems with the Ambulance Service but he had a mobility car and was able to drive himself to appointments. MC accepted it was his responsibility to get there and would not use NHS transport if he could get himself there.

GS asked MC what was one thing he had learned about himself from his experience that was a surprise and he responded that it was dedication, if you put the effort in you will get the results but you have to make the changes and stick to them, he did not miss a class.

JA commented that the NHS had almost given MC a double lung transplant, however his self management had changed his quality of life without surgical intervention and he is now demonstrating that this would have been the wrong thing to do. MC acknowledged that four years ago this was not an option and that something within his body had changed, his lung capacity increased and he could do more. JA noted that the way MC approached this had resulted in a very different outcome.

PH highlighted MC talking about what he went through and asked if there were times when there were more downs than ups and MC responded that he did not ask for emotional support as he did not suffer from depression, he just got on with life, you do not lie down to it. He acknowledged that a lot of people suffer depression and anxiety but you have to fight through this and get on. PH commented that peer support can be so powerful and your story is so powerful you should give your peer group belief in themselves. MC explained that this is why he likes to talk to people, having this illness and realising that he can help other people, highlighting participation in the Patient Experience Event at Easterbrook Hall last year and explaining that talking to patients is where we have seen the biggest difference. PH
thanked MC for coming to the Committee to tell his story.

**Hacking Incident**

At PHs request JA explained that the incident had occurred in the middle of the day on Friday 12 May 2017. Three GP practices had their systems penetrated and a couple of national systems were taken down as a precaution. There were no further issues this morning and the Board has been successful in being resilient. NHS Lanarkshire appeared to have the biggest disruption with Wales having none at all.

1. **Apologies for Absence**
   
   Apologies as noted above.

2. **Declarations of Interest**

   Nil.

3. **Notes of the meeting held on 13 March 2017**

   Approved with a minor change.

4. **Matters Arising**

   *Hospital Standardised Mortality Ratio (HSMR)*

   AC explained that new information had been released on Friday 12 May 2017 and he would circulate to the Committee by email.

5. **Action List**

   LD again requested action points in the action plan.

**STANDING ITEMS**

6. **Patient Experience Report**

   JP presented the report highlighting the increased number of volunteers supporting Community Chaplaincy Listening (CCL), noting thanks to Rev. Robin Paisley, and his wife, who travelled from Glasgow after retirement to keep the service/training running in the gap between Ewan Kelly leaving and Dawn Allan starting. We now have fourteen volunteers in place and fourteen currently undergoing induction. Discussions are planned with John Knox, and the new hospital team, around a recruitment day in June.

   JP highlighted Patient Opinion noting that we are currently transferring information to be held electronically and checking around what is to be mandatory and available in paper copy for other groups. She explained that Patient Opinion will become Care Opinion from 1 May 2017, and we are working on rolling this out to include GP practices, units under health and social care and all appropriate care agencies.

   JP noted that complaints performance for January and February was poor due to staff vacancies, however, the Patient Experience Officer post in DGRI has now been filled and training is ongoing for the co-ordinators. She noted that in a few months time we should see the figures beginning to improve,
reminding the Committee that we are working three months behind. JP explained that the top three themes remain as clinical treatment, communication and staff attitude/behaviour with improvement plans in place around this. She noted that the “Good Conversations” training started last week.

LD highlighted the response within 20 working days figures noting that Acute and Diagnostics is very poor. JP explained that the majority of complaints go to DGRI and some of them are very complex which do take time to respond to. The Patient Experience Officer had also moved on and as the Team were working to put the new system in place they were unable to support this post. She noted that the post has now been filled. LD then asked if we are doing anything to keep in touch with people and JP highlighted our approach to complaints around early resolution and that we are already making this change.

LB asked if we are monitoring diversity of volunteers and JP assured her that this was in place outlining the opportunities available for volunteers to tell us of their diversity.

The Committee:
- Noted the report
- PH requested that a letter of thanks be sent to Rev. Robin Paisley and his wife on behalf of the Committee

7. H.A.I. Report
PH, on behalf of the Committee, congratulated the Infection Control Team on their success. ER thanked PH and said she had nothing further to add.

The Committee:
- Noted the report

AW highlighted the proposed different format to the report bringing safety, improvement and risk together. ED commented that he was supportive of this change explaining that the combined approach structure ties in with the national approach looking at themes rather than single pieces of work.

In response to LD asking that although not focussing on risks in patient safety will we keep the bigger picture on risk for other areas and AW assured her this would happen.

The Committee:
- Agreed to changes in the design of the report
- Agreed to the proposed reporting schedule

INTERNAL REPORTS

9. Services in the West
JA gave a presentation on services in the West followed by discussion. PH
PH commented the local people do not understand why we cannot have more services within the GCH and suggested the public involvement groups, and perhaps the Cancer Centre groups, be included in the planned engagement work, asking how we would communicate this and gain the trust of the community. JA responded that Nicole Hamlet is working on the West of Scotland Local Delivery Plan in liaison with NHS Ayrshire and Arran, in relation to Stranraer, with a view to providing services although this will not be financially driven as patient safety will also be considered. A Board Workshop will take place in the summer where options will be presented. In response to LB asking if there was a Flow Co-Ordinator Post, JW responded that this was covered by the Wigtownshire post.

The Committee:
- Noted the presentation

10. **Palliative and Specialist Palliative Care**
PH requested, and it was agreed, that she and VF meet for discussion outwith the meeting. PH then asked VF to present the key messages.

VF highlighted work around looking at models and exploring services to provide sustainability for going forward as we cannot sustain the current model. She explained that the work was around looking at where people were dying as opposed to where they say they want to die which is at home, noting that only 25% of deaths are at home. VF emphasised that we are talking about people in the last twelve months of life here and one in ten people are in acute care during this time. Our current model is not the most efficient, is not giving quality of life in the last six months and not providing the level of support required and a change is required for sustainability. Key message is to recruit a second Palliative Care Consultant, although this will have cost implications, and assess services whilst work is ongoing to drive the culture change forward. Supporting people to die well is a success story for health care. VF briefly mentioned Specialist Bereavement which requires more support around providing care teams.

PH highlighted the Marie Curie three month project explaining that we will know more once it is complete but this is more about health, public health and 3rd Sector who are introducing this piece of work which fits in with what JP is going to talk about under any other business.

LB asked how confident are doctors to have discussions with patients around their end of life and AC responded that the situation has improved considerably although sometimes conversations are not timely enough, should be six to twelve months before. He commented that he was not saying this is the right model but we just have to do this. PH commented that the GPs in Stranraer are keen to be involved pro-actively in the Palliative Care Service.
LD welcomed how this is going to evolve, noting that she understands the sticky situation we are in just now and that we need a second consultant. LD asked AC, given the challenges around consultant recruitment how confident are we that we will get someone for this post and he responded that a community post has more appeal, we have an excellent team and this helps, so it is possible that this will not be the hardest post to fill. LD asked if the post would be recruited to as soon as possible and JW confirmed that the Team are drawing up a job description but that funding is required for the post and she is looking into this with the post being advertised as quickly as possible. JW explained that we may not have someone in post until the end of this year, acknowledging the challenges that the current consultant has, who is confident we will have some interest in this post.

GB commented that the GPs and DNs do not keep people at home when they die because overnight we do not have anyone to look after them therefore the Marie Curie Nurses are an option. LB highlighted help for the family and carers.

GS asked about the Lymphoedema Service and JW responded that there had been physiotherapy input for this service but no recurring funding. JP explained that this could be carried out by either a physiotherapist or a nurse but currently we do not have anyone with the skills. Physiotherapy did try to keep the service afloat but do not have anyone now. Some of the DNs had training on this but we have also lost these skills. We have asked nationally for support but nothing fresh is coming from these resources. JW will look into this, commenting that GS was right to flag up as an issue as we need to keep service provision but funding is required for this.

The Committee:
- Noted the report
- Requested update on the recruitment of the Consultant
- Requested that Marie Curie Project Report come to September meeting

11. Care of Older People in Hospital: Care Assurance

AW presented the paper explaining that this is the first report on Level 3 Care Assurance to ensure the Committee understands the detail of what is being looked at which tells the ward where they are and what they need to work on. The proposal was that Level 3 reports would come to the Committee but AW noted that it would be unrealistic to bring individual reports due to number of reports coming through and suggested that they go to the Excellence in Care/Care Assurance Steering Group and she would bring a composite to Committee which was agreed.

PH asked what the response from staff around this way of working was and AW explained that the feedback is interesting, focussing on clinical supervision. Feedback from patients and families is being shared with the Teams and having a big impact. Piloting three areas in DGRI and one cottage hospital, sharing the benefits from this and as a strategy it is paying
dividends.

LD highlighted pressure ulcers noting that compliance is very low and asked if something was done about this and AW responded yes, an action plan is in place, explaining that the SCN in the ward is the lead for tissue viability and was very disappointed in this.
The Committee:
- Noted the report

12. **Scottish Ambulance Service Briefing**

Mr. Kenny McFadzean (KMcF) attended the meeting to present the paper highlighting Primary Percutaneous Coronary Intervention (PPCI) and changes in the patient care pathway which have improved the service with an increased number of patients in Dumfries and Galloway receiving PPCI rather than rescue and patients attending Hairmyres Hospital, which is closer, rather than the Golden Jubilee. KMcF noted the biggest change is around the New Clinical Response Model which is a complete change in how the service operates, outlining the new timescales and the management of calls. The model is under continual review. KMcF highlighted reconfiguration of the workforce highlighting the specialist paramedics in training in the West of the region with GB explaining she is keen on having paramedics working with the GP practices. KMcF explained that the service is also being restructured, moving from five to three regions, although this is still in progress and not finalised.

PH explained that she was also Chair of the Person Centred Health and Care Committee (PCH&CC) and asked how the SAS engaged with patients and if they had been consulted about these changes or been involved in the decision making process and KMcF responded that there was a central Patient Focus Group run from HQ. PH highlighted patient transport explaining that from time to time issues arise around patient transport in particular and also long waits for ambulances, asking how this would be fed back to the service from patients within the region. Agreed that PH and KMcF would discuss what input patients can have regarding Ambulance Services locally outwith the meeting.

GB commented that the new system is working really well, practices are comfortable with the changes, they way they process patients has changed and they are happy to be working more closely with the service, using more resources from primary care in the surgery to avoid sending patients to hospital.

JW highlighted the former Ambulance Liaison Committee, the long waits for an ambulance at GCH and the flexibility of the discharge vehicle at DGRI, asking if KMcF would meet with the General Managers to discuss and address any issues which arise and this was agreed.

The Committee:
- Noted the report
13. **Local Supervising Authority Midwifery Annual Report**
ED presented the paper highlighting the national changes around the Supervision of Midwives which is mandatory and responsibility will now be held at Board level. He explained that operationally this will have little impact and there is an ongoing piece of work to ensure we have a robust supervision structure in place and so far no particular issues have arisen.

BR highlighted “Discussion at Meeting” within the Perinatal Mortality Review Group paper and the comment that there is often little communication from Glasgow in relation to these cases and this had been an ongoing issue for years. ED explained that discussions have taken place in relation to this at the Quality and Patient Safety Leadership Group where the Perinatal Review Group provided assurance that this is still within their control and did not see any difference.

The Committee:
- Noted the report

14. **The Best Start : A Five Year Plan for Maternity Care in Scotland**
ED presented the paper in relation to a national piece of work around changes in Maternity Services, strategies and policies. There is no confirmation as yet but the Midwifery Team would rather be ahead of the curve, have already had discussions about being an early adopter site and are working towards this. LD asked how will we do the continuity of care approach and ED responded that we will engage with the national team for help and advice when taking this on and come up with innovative solutions.

The Committee:
- Noted the report

**ITEMS FOR NOTING**

15. **Circulars and Safety Action Notices Update**
The Circulars and Safety Action Notices Update was noted.

16. **Notes of Board Donation Committee**
The notes of the Board Donation Committee held on 15 December 2016 were noted.

17. **Notes of the Health Adult Support and Protection Committee**
The notes of the Health Adult Support and Protection Committee held on 16 February 2017 were noted.

18. **Notes of the Healthcare Scientists Advisory Committee**
The notes of the Healthcare Scientists Advisory Committee held on 17 January 2017 were noted.

19. **Notes of the Health Child Protection Committee**
The notes of the Health Child Protection Committee held on 7 December 2016 were noted.
20. **Notes of the Hospital Transfusion Committee**
The notes of the Hospital Transfusion Committee held on 18 April 2017 were noted.

21. **Notes of the Infection Control Committee**
The notes of the Infection Control Committee held on 17 January 2017 were noted.

22. **Notes of Resuscitation Committee**
The notes of the Resuscitation Committee held on 21 February 2017 were noted.

23. **Any Other Competent Business**

*Chair of Healthcare Governance Committee*
PH noted that with effect from today’s meeting she will take over the Chair of the Healthcare Governance Committee from PJN.

*Person Centred Health and Care Vision*
PH highlighted the Vision explaining that JP would present an update from a recent workshop. PH asked the Committee for their thoughts around understanding the vision and what they are trying to do.

ED added some context by explaining that initially this group was a standing governance group where papers etc would be presented but had been destabilised in relation to what it was trying to do, with a change in focus and no structure in place, therefore how do we put structures back in place rather than a formal committee type of approach. JW noted that she did not disagree and would support this but the key challenge is how we move this on in everyday business and how do we make this into something that makes a difference, how do we get ownership within the IJB for this and how do we translate this down to the front line; what does this mean in how we do our business and where to do reporting through IJB structures as this needs to be in a more operational way. PH highlighted the business of this Committee and asked if PCH&CC did not exist would it matter and that person centred care needs to be exactly that, about social care, local authority, independent sector and health and social care. She asked if this is integration, it sits within health but we do not need to create another Committee for IJB. ED commented that the staff should be doing this rather than the Committee who are far removed. JW suggested reporting through the Health and Social Care Management Team.

AW highlighted the presentation commenting that the Committee is not doing all this work, most is done in other places supported by co-ordinated, joint inspection action plans and crossovers. ED commented that a charter approach would really suit this. PH asked how do we know we are a person centred Board and answered because we have VBRP and this gives focus across whole service.

JW noted that this was an opportunity to merge two reporting mechanisms.
to fit in with the Board and the IJB. ED explained that we do need to extend this for the right level of engagement which should include IJB members. ED and JW will discuss how this would work in terms of governance outwith this meeting.

Date of Next Meeting
Monday 17 July 2017, at 10 am, New Board Room, Crichton Hall.
1. **Apologies for Absence**
   Apologies as noted above.

2. **Declarations of Interest**
   Nil.

3. **Notes of meeting – 27 February 2017**
   Accepted.

4. **Matters Arising**
   GC intimated that the Committee would be unable to make any decisions due to the absence of the Chair and Vice-Chair.
Feedback from small group around vision
GC presented the Vision suggestions explaining that the small group had been unable to meet so this had been done via email. Full discussion took place around the three suggestions and it was agreed to pull together the best options from all three. GC asked for volunteers and it was agreed that PH, DA and JP would meet as a small group to work on a more detailed vision/mission and bring back for discussion at the next meeting.

5. Good Conversations
JP explained that Gordon Dunbar had visited last year to discuss what person centred might be with the key thing from that discussion being to give our staff tools to get to good person centred conversations. Piece of work around this and the benefits which good conversations would offer us, linking this to our cultural diagnostics. Proposing to bring Gordon and Ross to work with the partnership and the opportunity for 3 day training sessions. Taster sessions are arranged for May/June 2017 and then training sessions for 20-25 people every month or so for a year. JP explained that the plan is to train some local co-ordinators and request funds for this from Endowments and asked the Committee to support this direction of travel.

NM explained that this is talking about simple language, bringing together what people raise around person centred and having a respectful, honest conversation with a person and taking responsibility around where you are coming from and where your client is coming from. At a face to face level, have a conversation and the needs we are talking about around person centred will fall out of this. CS highlighted the culture development work within the Dumfries and Galloway Integration Joint Board Health and Social Care Strategic Plan 2016 – 2019, with one of the elements being identified as the delivery opportunity that is being presented here. She requested that the Committee support the positive direction of our commitment to pull together strategic leaders from across the organisation.

SN commented that it was good to see this and to hear about cultural diagnostics. She highlighted Thistle being in at the beginning, taken forward with bit of understanding and research for training and skills approach both in 3rd and Independent Sector. However, have taken a different approach which is outcomes focussed and have a draft model working with care providers now. Have lots of supervisors and line managers but who may not have had positive experiences or role models on their way up. The first training sessions would be for managers. Meeting tomorrow to draft training.

ED noted that, for this Committee, we are speaking about tangible delivery and clear levels of what we are trying to do. GC highlighted the training noting that if we have 20/25 at each session that’s 300 people and that 3 days is a lot for people to be released, asking if backfill was required. CS explained that this will be a request to the Endowment Trustees but her understanding is that they will not support backfill. The leadership support of this group will go through the managerial structure and a request made to release endowments. CS/ED will reinforce at Management Team. JP noted
that the plans are not worked through in detail as yet.

SN asked for an action to be agreed to tie this up and CS confirmed it would be on the agenda for the Steering Group.

The Committee:
- Supported the proposal

6. **What Matters to You Day – 6 June 2017**

JP highlighted the date explaining that bits and pieces of work around this are going on in individual practices. The NHS Blog will showcase this the week before and plans are in place for all staff to have this conversation on 6 June. GC requested an update for the June meeting.

7. **Implementation of New Complaints Handling Procedure**

JP highlighted the new model Complaints Handling Procedure, which is in line with the Council model, and has been implemented as per the guidelines with the documentation signed off. She explained that Feedback Co-Ordinators have been identified and further training is in place for complaints management and investigation skills. Outstanding action around further advertising and promotion on the internet. Reporting will be via Healthcare Governance Committee and Board.

8. **Bereavement Update**

DA updated on the mapping work she is undertaking looking at bereavement support that exists across the organisation, and in the 3rd Sector, noting that there are some massive gaps. She explained that there is good support for young people and children, particularly if involved with drug and alcohol abuse. DA will focus on spiritual care and staff support within the Acute Services initially, particularly in relation to the transition to the new hospital and will focus on bereavement support early next year by scoping our assets and tapping in to the people out there. DA shared books and other resources which will be sited within “The Sanctuary” and the “Spiritual Space” in the new build for anyone to access. She noted that 10-12% of people will take up an offer of support. VF highlighted bereavement support and specialist support, noting that there are District Nurses/Macmillan Nurses in various places to provide a level of bereavement support and to communicate in terms of bereavement support. She highlighted the gap we are trying to fill asking if we need to do something around general bereavement support or are we looking at specialist bereavement support with DA responding that it would be bereavement support in a generalised way and not more complex. In response to GC asking for timescales DA confirmed either at the end of this year or early next year. GC asked how the CCLS links in with this as well and would be interested to hear about this.

CH explained that the Bereavement Group had halted last year and were advised to wait for DA to arrive. JP explained that setting up dates had been in process and that we are trying to re-start this group. CH commented on the need to learn to handle death better in hospitals and would support that we have a Bereavement Group up and running again.
KD explained that the hospital is pre-bereavement and having difficult conversations is the reality with DA commenting that staff are in need support to know that is normal. ST commented that the whole thing is later, with communication being the key to providing care and if we get this right the need for bereavement care will be reduced. JL asked if this would not be part of basic training and ED confirmed that this is included in training but people do tend to shy away from this.

MS noted that the Bereavement Group has meetings with SANDS regularly where we discuss how staff have reacted, been supported and do some teaching around this. Medics are also invited along and feedback is that they find this beneficial. KD highlighted good conversations and has been doing a bit of work around this, although a degree of it comes from complaint meetings he has with families, noting that if people had known their loved one was dying it would have made a difference. He highlighted patient and staff experience, looking at where this has gone well or not with conversations in the middle of this.

VF highlighted that 50% of people die in hospital but 75% of people want to die at home. Regardless of where they live 25% will die at home. Although the figures are small across Scotland people are in places where they do not want to be. She highlighted palliative care, someone in the last 12 months of life, explaining that in any acute hospital 30% of people will be in the last 12 months of life. Professionals will identify people in the last 12 months who may need some palliative and end of life support with anticipatory plans of care, some die unexpectedly and because of that anticipatory plans are not in place. VF noted that end of life is the last 3 days. She highlighted “Have a Good Death” and that giving people this is a big thing. DA commented that staff are dealing with sudden death and need support with this. She highlighted a “Death Cafe” being held in Thornhill with JL suggesting we tap into this.

CH agreed with VF and suggested the bereavement title may not be right, commenting that people are fortunate if they get into palliative care as most people die in an acute hospital ward and from a spiritual care support aspect we are letting them down.

SN highlighted key areas for next year with Scottish Care embracing the palliative care aspect of their work and discussions around their experiences. She highlighted a scenario in “Trees that Bend in the Wind” where carers go into a home and the patient is dead, they have built a relationship with them and their families and want to support them. Have started a conversation about death and want to continue this conversation in Dumfries and Galloway working with colleagues to provide training around how to support
someone to have a good death.

9. **Any Other Competent Business**

**Volunteer Strategy**
GC highlighted the Volunteer Strategy and JP responded that she did not realise that a Strategy document had been requested. The Policy has been refreshed via a small steering group, currently still in draft form and when finalised will be issued for consultation to various groups, of which this Committee will be one, in May 2017. JP will bring to June Committee.

**Date of Next Meeting**
Monday 12 June 2017, at 10 am – 12 noon, in the New Board Room, Crichton Hall.
Roger Frost (Project Director, Laing O’Rourke) welcomed members to the New Hospital. A site visit would be taking place after the meeting which provided an opportunity for members to see the progress that has been made over the past year. PNJ thanked Roger and all those involved for arranging the meeting and tour today, adding that this was a significant milestone for NHS Dumfries and Galloway (D&G).
1. **Apologies for Absence**

Apologies for the meeting have been noted above.

2. **Declarations of Interest**

The Chair asked Committee 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 6th March 2017**

The Performance Committee agreed the minute taken at the previous meeting on 6th March 2017.

4. **Matters Arising and Review of Actions List**

The outstanding actions from previous meetings were noted.

5. **Update on Medical Staffing**

AC presented the Update on Medical Staffing paper to Performance Committee. Committee were asked to note the current position and the steps that are being taken to attract Doctors to the area in a very challenging medical labour market. AC expressed his concerns and advised that attracting medical staff is a major priority for the Board, adding that this is a complex situation which is changing day to day. The paper outlined the programme of work that is being undertaken to address the situation.

AC highlighted key points from the paper including:

- We currently have 30+ consultant vacancies across the organisation. This is the highest figure we have experienced in recent years. 6 of these posts have been newly established and never been filled. As most of these posts are covered by higher cost Locums, the Board continues to spend a significant sum on Consultant Locums.
- The spend on Middle Grade and Junior Medical Staff Locums remains high. Recent developments to influence the cost of Locums have been introduced.
- In General Practice, there has been a slight improvement, however, the concentration of vacancies in various areas, and the ongoing difficulties that practices experience in engaging Locums, means that the sustainability of rural General Practice in D&G remains at significant risk.
- AC spoke about the effect on morale and workloads; dependency on locums; sustainability; pressures of a new hospital.
- AC advised that 5 Consultant posts are currently being advertised via the British Medical Journal (BMJ). We will continue to advertise via our medical recruitment website and the Scottish Health on the Web national
website for NHS vacancies. It is recognised that a more targeted approach via social media may be required and work is ongoing to look at this.

- Dedicated resource within the Workforce Directorate has been identified to support the medical recruitment programme and work is being undertaken on job descriptions.
- In terms of GPs, this is a rapidly changing picture with practices occasionally being able to recruit Doctors, but other practices are losing Doctors due to retirement or resignation.
- AC has arranged to meet GP trainees currently in D&G as they have indicated that they have ideas that will help make postings to the west of the region more attractive.
- AC spoke of the barriers around international recruitment and ongoing liaison with medical recruitment agencies and the Chief Medical Officer (CMO) to support this. It was noted that AC has written to the CMO to enquire if consideration can be given for GPs to be added to the Scottish Shortage Occupations list. An update was also provided on exchange work that is being considered.
- AC highlighted some specific disincentives for medical staff coming to D&G eg. lack of specialism; junior/medical grade less senior here than in other hospitals; consultants having more on call duties due to small numbers.

The Committee recognised this significant issue and were supportive of the wide range of measures outlined in the paper. The Committee discussed the paper in detail with the key points noted below.

- It was acknowledged that medical recruitment had been a major challenge for a number of years. A proactive programme of activity needs to continue to review all options and encourage candidates to the area. It was recognised that this is a national issue, however, it has a greater impact on rural areas (it was noted that the challenge is particularly prevalent in D&G).
- PNJ spoke about the benefits of localised training and links with education to encourage staff to train and then stay in the area.
- PH queried the support from Scottish Government (SG). AC advised that SG is aware of the situation and highlighted a number of initiatives that have been discussed with them.
- PH spoke about the new GP system in the west involving phone calls to support the appointment system; it was noted that some residents have mentioned that if they can’t get an appointment they need to go to A&E. AC provided clarity on the system in place and stressed that doctors will call back patients that day to assess the situation; AC strongly advised patients to use this port of call in the first instance. It was noted that messaging re the new system was important going forward.
- PH advised that an open and transparent conversation is required to ensure the community are aware of the recruitment challenges. The Integration Joint Board (IJB) is a good platform for this and it was suggested that a workshop be held to facilitate this.
• GSta noted the anaesthetics vacancies at Galloway Community Hospital (GCH) and the comment that other solutions to the provision of management of trauma patients are to be considered. GSta queried progress on this. JW advised that Nicole Hamlet is currently undertaking a significant piece of work to look at a sustainable solution going forward. This will be from a medical, GP and ambulatory perspective. This is a complex piece of work and will involve looking at challenges, outpatients, risks, safety and pathways. Data will be collated and an initial report presented to the Health Care and Governance Committee. It is anticipated that a board-wide workshop will be arranged thereafter.

It was noted that work is ongoing across NHS Scotland in terms of regionalisation, and there will be some specialities/services that could be shared in the future. However, the Committee acknowledged that the main challenge around medical recruitment is attracting people to move to D&G to work. It was recognised that this is a region wide issue, across all types of business and employment, including local authorities and education. Discussion focussed on this issue, with some key points noted below:

• Engagement with local councillors and the community will be paramount to supporting a successful marketing drive for D&G. Working closely with the local authority will be key to supporting momentum for this long term initiative.
• In terms of NHS marketing, the promotion of NHS D&G as a positive place to work, and the benefits of working in a brand new hospital, will support messaging going forward.
• GC highlighted the need for a long term D&G economic strategy, which involves a wider range of groups, connections and communications (eg. social/third sector networks, D&G media).
• GC queried if a specialist team was required to help support communications. AC advised that specialist advice had been sought around social media, noting that improvements could be made in this area. Work is ongoing on this.
• There was a brief discussion around the possibility of using internships; the importance of seeking views from young people/trainees; communications support.
• The Committee recognised that we need to develop an economic vibrancy and attract people to the region. The region’s Strategic Partnership Forum will be key to this; JA and PNJ spoke of their involvement within this group.

In conclusion, Committee:

• Acknowledged the comprehensive report and supported the programme of measures outlined to address the medical recruitment issues across the region.
• Agreed that the role of the Strategic Partnership Forum required clarification and focus, to ensure that a drive for economic vibrancy is fully supported. JA and PNJ will feedback this back to the next meeting of the Forum.

Action: PNJ and JA

• Agreed that the IJB workshop in June 2017 should encompass a medical staffing update, to ensure that IJB members are fully informed on the current position.

Action: JW

6. Acute Services Redevelopment Programme - Update (PART 1)

JW welcomed staff from the ASRP team to the meeting and advised that this section would focus on the following areas:

a. Construction - CC
b. Clinical Change - JK
c. EHealth - GG
d. Cresswell - DB
e. Commissioning Plan - NP
f. Current Risks - JW

Copies of the presentations (a-e) were circulated to Committee in advance. The section on Current Risks (f) will be a verbal update.

JW advised that considerable work has been undertaken by all members of the ASRP team, with new challenges and developments occurring on a daily basis. Significant process is being made and staff were thanked for their ongoing commitment to the project.

For the purposes of the minutes, the key points from each presentation are noted below.

a. Construction (presented by CC)

• We are currently on programme (11th Sept 17 handover). NHS D&G commissioning will take 12 weeks and first patient will be treated on 8th Dec 2017.
• Enabling works (gas, electricity, water) and building envelope complete
• Fit Out is well underway and complete in some areas
• Landscaping (including car parks) well advanced
• Beneficial Access starts 23rd May 2017
• Equipment procurement well underway for major items
• External Stakeholder engagement underway
• Tabletop Exercises planned
• Removal company engaged
• Community benefits – All targets included within PA have been met
• Communication - media campaign is about to commence

NOT PROTECTIVELY MARKED
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Areas of discussion

- GC queried if there is a breakdown of the public’s Frequently Asked Questions (FAQs). CC and JW advised of various events in the community to gather this information; significant work has been undertaken. Lessons learned from other areas (eg. Glasgow) have also been taken in consideration. JW added that the Communications Plan will be presented to the IJB once finalised.
- LB suggested that it would be useful to incorporate awareness of the benefits of the new hospital, new models of care etc. PH felt it would be useful to engage with the third sector to gather their ideas on the communications strategy, particularly in terms of hard to reach or vulnerable groups. LD noted it would be useful for the Board to see what is being considered (particularly around ‘who, what, why, how’) and for them to have some input.

Following discussion, it was agreed that:

- A session will be arranged to enable Board Members to feed into the New Hospital Communications Plan.

**Action: JW**

At this point in the meeting, it was agreed to move onto the Current Risks section (f).

f. Current Risks (presented by JW)

JW wished to highlight 2 current risks and provided comprehensive background information to Performance Committee.

The Committee acknowledged the risks outlined and fully supported the Executives with the actions taken to address these issues.

GSta and PH left at this point in the meeting.

g. Clinical Change (presented by JK)

- JK advised that good progress has been made with the work on the New Models of Care.
- Update provided on the Critical Care Unit, medical/nursing staff, standardising of systems and processes, and Combined Assessment Unit.
- Update provided on education and training plan, and department timetabling.
- Large range of patient information is being updated eg. in-house leaflets, stationery, information booklets.
- Detail on forthcoming tabletop exercises was provided. A Major Incident Plan has been drafted for comment and will be followed up with exercise in October.
• JK concluded by providing an update on the Workforce and Transition Programme (2235 staff) and Orientation Programme (2700 staff).

Due to time restraints it was agreed to move onto other areas in the agenda at this point and revisit the ASRP at the end of the meeting.

8. Financial Performance Update – 12 months to 31st March 2017

GSte presented the Financial Performance Update – 12 months to 31st March 2017 paper to Committee. The Committee was asked to note and consider the final financial position for the year end and in particular:

• Delivery of a breakeven position for 2016/17, showing a small surplus of £77k for the year.
• Cash Releasing Efficiency Savings (CRES) have been identified in full in-year through the release and identification of non-recurring solutions, but there remains a £5.23m recurring gap on efficiency plans that now forms part of the efficiency gap for 2017/18.
• The final Revenue Resource Limit (RRL) and Capital Resource Limit (CRL) have been agreed and notified to us by the Scottish Government, with allocations. These were detailed within an appendix to the paper.
• The Board’s Financial Plan identifies the requirement to deliver recurring cash efficiencies of £12.77m. Development of efficiency plans for 2016/17 has been progressing and recurring schemes to the value of £7.29m have been indentified and are being progressed and implemented.
• A breakdown of financial risks were outlined in the paper.

The Committee acknowledged the considerable work that has been undertaken to achieve a breakeven position this year, noting the significant financial challenges faced by the Board. JA acknowledged the excellent level of financial reporting throughout the year, to ensure the Board has been appropriately informed throughout the process.

Performance Committee noted the report.

9. Capital and Infrastructure Update to 31st March 2017

GSte presented the Capital and Infrastructure Update to 31st March 2017 paper. The Committee was asked to:

• Note the allocations received to date
• Note the capital expenditure incurred to date
• Note the capital expenditure for 2016/17 was delivered within the Capital Resource Limit (CRL) for NHS D&G, with a small underspend of £23k.
• Formally approve the changes within the Capital Plan, as outlined in the paper.
The Committee noted the report and formally approved the changes within the Capital Plan.

10. Progress Report on Refreshing Volunteering in Dumfries and Galloway

ED presented the Progress Report on Refreshing Volunteering in Dumfries and Galloway paper. ED provided a brief overview of the background, current developments, appointment of Volunteer Co-ordinator, programme of work and progress to date.

Performance Committee noted the report.

11. Review of Winter

JW presented the Review of Winter paper which asked Committee to note and discuss highlights from the winter period. JW highlighted the key messages, including:

- High quality patient care and patient flow throughout the service was achieved by the dedication and commitment of staff across the whole of NHS Dumfries & Galloway (Acute Services and Community Care) and that of our partners within Social Work Services and Care Providers who have worked very closely with us to ensure timely discharges and transfers to maintain acute capacity for admissions.
- The festive fortnight seemed smoother with improved arrangements in place, despite an overall increase in attendances and admissions.
- This was achieved by following the lessons learned from the previous festive period of 2015/16. It was noted that early planning encouraged services to adopt a proactive approach to covering services, especially during the public holiday periods.

Performance Committee noted the report.

12. Regional Planning Update

JA advised that the first meeting of the new West of Scotland Regional Planning Group took place at the end of April. The first Regional Plan will be due in September. A steady flow of proposals will be coming through shortly for consideration. This will include an early proposal on how we satisfy our requirements around Public Health in Scotland.

Performance Committee noted the update.

13. Draft Performance Committee Agenda – 10th July 2017

Committee members noted the draft Performance Committee Agenda 10th July 2017.

At this point in the meeting, discussion returned to the remaining ASRP
c. **eHealth (presented by GG)**

GG provided a brief overview of his presentation.

- Work plans have been underway for 2 years. Significant design work has been undertaken to specify the ICT requirements for the new building
- Extensive procurement has exercise taken place to kit out the New Hospital
- Test of change (Telephony, Checkin kiosk, A&E system change) completing
- Planned new ways of working progressing
- Dual running systems in place (Fibre delivery, telephony, Clinical Access, WAN reconfiguration)
- Overview provided on Digital Hospital work (Facilities management, ICT systems/infrastructure and other digital enablement)
- eHealth Delivery Plan provided – progressing well
- Outline of key programmes provided eg. Joint Fibre, Data Centres
- Key dates for transition outlined to Committee.

**Areas of discussion**

- JW expressed thanks to Donald Millar (Project Manager - Joint Fibre Project) for the significant work he has undertaken on the Fibre Project.
- AC highlighted his role as Senior Information Risk Officer and acknowledged the considerable work that has been undertaken by ICT around information security for the ASRP.

Unfortunately, due to time restraints, Committee were unable to fully discuss Cresswell and the Commissioning Plan. The Committee was keen to ensure that these are fully considered and it was agreed that these should be added to the 5th June Board agenda (in committee).

**Action: LBa**

On behalf of the Committee, PNJ commended all staff involved in the ASRP for the huge amount of work that has completed to date; the programme has been outstanding. JA and JW echoed these sentiments.

**10. Date and time of next meeting**

The next Performance Committee meeting will be held on 10th July 2017 at 10.00 am – 1.00 pm in the New Boardroom, Crichton Hall, Dumfries.

*The meeting finished at 1.00 pm, with a number of members participating in a walkthrough of the New Hospital.*
Performance Committee

Minutes of the Performance Committee meeting held on 6th March 2017 at 10.00 am in the New Boardroom, Crichton Hall, Dumfries.

Present

Mr P N Jones  PNJ  Chair of the Board
Mrs K Lewis  KL  Director of Finance
Mr R Allan  RA  Non-Executive Board Member
Ms L Bryce  LB  Non-Executive Board Member
Mrs G Cardozo  GC  Non-Executive Board Member
Dr L Douglas  LD  Non-Executive Board Member
Mrs P Halliday  PH  Non-Executive Board Member
Mrs J White  JW  Chief Operating Officer

Apologies

Mr J Ace  JA  Chief Executive
Dr A Cannon  AC  Joint Interim Director of Public Health
Ms L Carr  LC  Non-Executive Board Member
Ms M McCoy  MM  Joint Interim Director of Public Health
Mr R Nicholson  RN  Non-Executive Board Member
Ms C Sharp  CS  Workforce Director

In Attendance

Mr J Beattie  JB  Non-Executive Board Member
Dr A Cameron  AC  Medical Director
Mr E Docherty  ED  Nurse Director
Ms V Freeman  VF  Head of Strategic Planning
Ms G Stanyard  GS  Non-Executive Board Member
Mrs L Davidson  LD  Deputy Director of HR & Workforce Development
Ms L Bass  LBa  Executive Assistant to Director of Finance
(Minute Secretary)

1. Apologies for Absence

Apologies for the meeting have been noted above.

2. Declarations of Interest

The Chair asked Committee 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 30\textsuperscript{th} January 2017

The Performance Committee agreed the minute taken at the previous meeting on 30\textsuperscript{th} January 2017.

4. Matters Arising and Review of Actions List

KL took Committee members through the Actions List from previous meetings, highlighting the progress that had been made in relation to the outstanding actions.

5. Draft Financial Plan 2017/18

KL presented the Draft Financial Plan 2017/18 paper to Performance Committee. Work is ongoing to progress the Financial Plan and to look at identifying savings schemes to develop a balanced Financial Plan for 2017/18, given the savings requirement of £22.6m. Draft templates for the financial aspects of the Local Delivery Plan (LDP) have been completed and submitted to Scottish Government (SG) on 28\textsuperscript{th} February 2017. These were attached to the paper as appendices. These demonstrate unidentified savings of £10.785m.

The final initial draft of the LDP is to be submitted to SG on 31\textsuperscript{st} March 2017. However, given timings for approval and Board meetings, SG will be contacted to request that the LDP be submitted following formal approval at the NHS Board on 3\textsuperscript{rd} April 2017 (ie. submission to SG 4\textsuperscript{th} April 2017).

KL highlighted key points from the paper including:

- Budget Scrutiny meetings took place with the Health and Social Care Management Team in January and February to work up detailed savings schemes.
- The Chief Executive, Chief Operating Officer and Director of Finance met with Scottish Government on 2 March 2017 to provide an update on financial and performance plans via the Mid Year Review process.
- Confirmation has been received on revised assumptions for the New Medicines Fund giving a £267k benefit; this reduces the savings requirement to £22.393m.
- An assessment of savings to be delivered for 2017/18 has identified potential savings of £11.608m to date including £5m non-recurring savings and £6.608m savings which are to be agreed through the Integrated Joint Board (IJB). KL advised that there is still a substantial gap of £11m and significant further work is required before a balanced financial position can be brought to Board for approval.
- The IJB Performance and Finance Committee is scheduled to meet on 10\textsuperscript{th} March 2017. This meeting has been extended to all IJB members and will be used to discuss and agree savings plans for 2017/18, including a number of schemes being assessed through the difficult decisions process.
• Focussed work is being undertaken to devise savings plans and close the gap for next year which include:
  o Reviewing medical locum, nurse agency and bank spend (two strands, reducing both demand and reducing cost).
  o Further challenge back to General Managers and budget holders to identify further savings.
  o Assessing the opportunity for further non-recurring savings.
  o Property strategy and infrastructure work.
  o All funding and allocations expected to be received in 2017/18 (including Integrated Care Fund).
  o New hospital transition and ongoing costs.
  o Further development of corporate savings (£200k to date against a £1m target).
  o Review of external contracts to identify savings, opportunities and assess risks.
  o Review of balance sheet and other options for non-recurring flexibility.
  o Assessment of further procurement opportunities.
  o Review of any other potential savings opportunities.

KL outlined the next steps as follows:

• IJB Performance and Finance Committee on 10\textsuperscript{th} March 2017 to agree savings.
• Monthly Budget Scrutiny reviews with General Managers during 2017/18.
• Revised draft of Financial Plan to NHS Board 3\textsuperscript{rd} April 2017.

KL stressed that NHS Dumfries and Galloway was facing significant financial challenges and pressures. This was an exceptional and unique situation for the Board; we have not faced this scale of financial challenges and savings previously. All staff are working incredibly hard to look at ways at bridging the gap but there is a significant amount of work required to reach a balanced financial position. JW added that substantial work if being undertaken with the General Managers and all ideas/saving schemes are being considered/presented at this stage; there are no additional/secondary lists. Some schemes are operational in nature; some will require the difficult decisions framework; some may require major service change or will provide longer term savings. All ideas are being considered. KL added that the full list of savings schemes will be presented to IJB Performance and Finance Committee on 10\textsuperscript{th} March 2017 for consideration; these will be circulated to NHS Board for information also.

**Action:** KL

Performance Committee discussed the paper with the following key points noted:

• The Committee recognised the significant challenges faced by NHS Dumfries and Galloway. There was discussion around perception, engagement and messaging; it was felt that a public engagement plan would be required going forward. It was felt that the IJB played a key role
in communicating the challenges ahead and explaining some of the difficult decisions faced by both the Board and Council. If we are implementing savings, then it was felt that an honest discussion with the public was required.

- PNJ and VF provided an update on regional planning work. It was noted that a Regional Plan will be in place later this year (likely Sept), which will focus on population based planning. Three areas have been identified – West, East and North (NHS Dumfries and Galloway comes under West). There was discussion on mechanisms for feedback and decision making.
- There was a brief discussion around delayed discharges, reporting and potential links with readmission rates across NHS Boards. JW advised that there had been a significant improvement in delayed discharges since the winter period.

Performance Committee noted the report.

6. **2017/18 Final Local Delivery Plan (LDP) Submission**

VF presented the 2017/18 Final Local Delivery Plan (LDP) Submission paper to Committee. This year’s LDP has been developed in line with the Scottish Government Health Directorate (SGHD) Guidance of 16th January 2016 and aligns with the Health and Social Care Delivery Plan, December 2016. The LDP sets out the initial planned actions and milestones being taken forward in 2017/18. It also sets out the early steps we are taking to ensure that we are fully engaged in regional planning. The LDP continues to evolve, moving away from emphasis on the achievement of LDP targets and standards into a more strategic document. There are 4 sections to the 2017/18 LDP:

- Improvement Priorities
- LDP Standards
- Financial Planning
- Workforce Planning

As previously advised, the initial LDP will be submitted to SG after the NHS Board meeting on 3 April 2017 (feedback from SG will be received shortly after this). Information will be provisional at this stage; final LDPs are not due to be submitted until 30 September 2017 to enable LDPs to take account of the new arrangements for regional planning and delivery of services, and the national review of targets and indicators.

NHS Boards are required to engage with Health and Social Care Partnerships in the preparation of their LDPs. Section leads of the LDP have ensured that there is alignment between the content of this LDP and the Health and Social Care Delivery Plan, Dec 2016.

The Committee discussed the paper with the following key points noted:

- PNJ queried the governance/reporting mechanisms in terms of the Regional Plan and the LDP. VF understood the Regional Plan wouldn’t
come back to Boards for approval. AC provided an update on processes in place for feedback, advising that the planning team would communicate weekly with local teams, and Boards will have a chance to comment on the plans from Sept 17-March 18. The Committee discussed a number of avenues for engagement with regional planning. It was recognised that clarity was required around processes to ensure that NHS Dumfries and Galloway are aware of developments and have an opportunity to shape and input into the Regional Plan.

- PNJ noted the tight timeframes for approval and submission of the LDP. JW explained the complexities around the guidance, change in format and timescales this year, which has unfortunately resulted in a tight turnaround for approval and presentation to Board and SG.

Performance Committee noted the report.

7. Financial Performance Update – 10 months to 31st January 2017

KL presented the Financial Performance Update – 10 months to 31st January 2017 paper to Committee. KL highlighted the key points from the paper including:

- The Board has a statutory financial target to deliver a breakeven position against its Revenue Resource Limit (RRL). The Quarter 3 financial review for 2016/17 confirms that delivery of a breakeven position for 2016/17 can be achieved.
- Directorates continue to work towards identifying all further recurring opportunities to close the recurring gap for 2016/17, but the recurrent financial gap is still significant and is currently being factored into the Financial Plan moving forwards.
- The report highlighted separately the financial performance of the NHS services delegated to the IJB.
- A detailed schedule was provided as an appendix showing the current budgets under/overspends position by Directorate. It also reflected the split of budgets and services which are now delegated to the IJB.
- KL added that the team are currently looking at maximising flexibility into next year, particularly in terms of the Social Care Fund and IJB. There was a brief discussion around Council contributions to the IJB in 2017/18.

The Committee discussed the paper with the following key points noted:

- There was a brief discussion around planning frameworks, decision making, priorities, perceptions and the need for a strategic debate on the challenges ahead.
- GC provided feedback from a recent Non-Executive regional meeting and suggestions made by other local authorities around saving schemes. GC queried if Dumfries and Galloway Council/NHS Board were able to participate in wider national discussions around saving schemes.

Performance Committee noted the report.
8. **Acute Services Redevelopment Programme Update**

JW presented the Acute Services Redevelopment Programme Update paper. Performance Committee were asked to note:

- The current status of the construction programme for the New Hospital.
- The progress being made on the equipping programme.
- The work being undertaken by the project team relating to commissioning and migration to the new facilities.
- The Change Programme Status Report and the key areas of work being taken forward.
- The work undertaken by the Workforce and Transition Workstream.
- The update on Information Communication Technology at the New Hospital.
- The update on the Cresswell Redevelopment.

JW advised that the programme remains on schedule for Practical Completion on 11th September 2017. JW highlighted some current risks to Performance Committee.

In terms of commissioning and migration, JW advised that:

- Familiarisation visits are taking place on a weekly basis. The visits are cootted by department/discipline and are designed to provide users with early insights to their department layouts to assist with the commissioning and migration process.
- Plans are in place for major piece of work testing prior to the move – 1 day in June; 2 days in September (this session will be in live time).

It was noted that further detail will be coming back to Committee following the learning from the Edinburgh Schools report.

PH noted the update in the paper on the Volunteering Scoping Project and commented that a Volunteer Strategy had not been presented to the Person Centred Health and Care Committee (PCHCC). It was agreed to that this should be presented to the next PCHCC meeting.

**Action: ED**

It was noted that the Volunteer Strategy is on the Performance Committee agenda for 8th May 2017.

Performance Committee noted the report.

9. **Draft Performance Committee Agenda – 8th May 2017**

Committee members noted the draft Performance Committee Agenda 8th May 2017.

**NOT PROTECTIVELY MARKED**

*Page 6 of 7*
10. **Date and time of next meeting**

    The next Performance Committee meeting will be held on 8\textsuperscript{th} May 2017 at 10am – 1pm in the New Boardroom, Crichton Hall, Dumfries.

*VF presented a Strategic Change Board Workshop to Committee. The notes from this workshop are minuted separately.*
Staff Governance Committee  
New Board Room, Crichton Hall  
Minutes of the Meeting held on 22 May 2017 at 10am

Present

Gill Stanyard  Non Executive Board Member (Chair)  
Jim Beattie  Employee Director  
Laura Douglas  Non Executive Board Member  
Val Douglas  Staff Side Representative  
Alf Hannay  Staff Side Representative  
Philip Jones  Chairman

In Attendance

Dawn Allan  Spiritual Care Lead  
Linda Davidson  Deputy Director of HR  
Pamela Jamieson  Workforce Manager  
Ros Kelly  Occupational Health Manager  
Katy Lewis  Finance Director  
Arlene Melbourne  Executive Assistant to Workforce Director  
Fiona Patterson  Workforce Manager  
Caroline Sharp  Workforce Director  
Alice Wilson  Deputy Nurse Director

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<th>ACTION</th>
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<tr>
<td><strong>1</strong> Welcome, Introduction and Apologies</td>
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<td>Apologies were received from Jeff Ace, Penny Halliday and Julie White.</td>
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<tr>
<td><strong>2</strong> Draft Minutes of the Previous Meeting held on 27 March 2017</td>
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<td>The minutes were approved as a true and accurate record.</td>
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<tr>
<td>Page 4, item 6 - Gill Stanyard asked Ros Kelly if the number of staff who attended their GP surgeries for their flu vaccinations were included in the figures and Ros confirmed that they were.</td>
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Matters Arising

eESS Update

Caroline Sharp updated that there had been national challenges around eESS but there had been a change in the programme board so there was now a national push and goal for all Boards to have fully adopted eESS by the end of March 2019. She reported that in the past couple of months eESS has been picked up with the team and have now established an ongoing maintenance of the resources already in place to bring eESS into the organisation and now have a full action plan in place which has been agreed by Management Team. She also advised that eESS will be the platform which will bring in and use of the electronic national recruitment.

Philip Jones entered the meeting

The roll out will start in September to bring Managers and Staff on Board to use the system but Acute staff will not need to do training until February 2018 so they can concentrate on the move to the new hospital. We hope to be fully rolled out and operational by July 2018.

Alice Wilson stated that nurses book their leave on e-rostering and Caroline responded that there will only be one point for staff to enter leave and the eESS team are working in detail with representatives in the service looking at current processes and will determine how those processes need to change to fit with eESS. The single point of entry for leave potentially for nursing staff will be to run with e-rostering. There is a culture shift which will be a challenge but Management Team is the Programme Board which is backing this.

Locum/Retinue Update

Caroline updated that medical recruitment issues continue to be extremely challenging and on the back of a series of conversations in the past few weeks, she took the decision to support the work that is necessary, to pull Linda Davidson out of all HR activity to work directly with Ken Donaldson on medical recruitment. A shortlife working group has been set up and a 3 month programme has been agreed recognising that dealing with the current locum situation and Retinue is one part of it, but that as an organisation they need to tackle the broader and longer term issues of the difficulty of being able to recruit.
Retinue – challenges have been continuing and conversations between Retinue, members of the HR team and operational managers have continued. Discussions have been held around what can be done to facilitate bringing in short term temporary locum cover to deal with particular issues. Jeff Ace, Caroline Sharp and Julie White have been clear that they fully support all solutions as long as they are not ultra vires in terms of payments.

Pamela Jamieson stated that meetings had been held with the MD of Retinue.

Katy Lewis stated that the reason why the shortlife working group had been set up was to have these discussions and understand all of the issues and problems and reported some savings have already been made.

Jim Beattie agreed that it was the bigger picture that needed looking as it was not just with Retinue where the difficulties lie, so need to keep working away to tackle the issues by actively putting things in place.

Gill asked Pamela for the outcome of the meetings held with the MD of Retinue. Pamela replied that the main people had been directly involved in the meetings.

Caroline stated that the expectation nationally was that there should be a medical bank established nationally/regionally and Angus Cameron and Caroline have been very clear that they support it, however the situation in Dumfries & Galloway is unique as individuals cannot readily commute easily so a national / regional bank may not be a solution for here. This problem is not going to go away and fully support the work that Ken and Linda are doing but the problem is a national issue and being in a remote rural area does not attract people to the region.

Phil thanked Caroline for freeing up Linda to focus on this piece of work as we need to be seen to be doing something. He also offered the support of the Board.

Alf Hannay

Caroline stated that this was Alf’s last Staff Governance meeting and she wanted to take the opportunity on behalf of Staff Governance Committee to acknowledge the huge contribution, over the years that Alf has been here, that he
has made to Staff Governance Committee and all the work he has done around that. Gill also wished him well on behalf of Committee.

4 Corporate Risk Register Update

Caroline Sharp gave her regular update on the 2 risks which are Health & Wellbeing for Staff and Sustainable Workforce. She stated that the cover paper gives a bit more detail and she intends to continue to update this. She reported that since the paper was prepared, she was now getting support from Laura Geddes to work through the Corporate Risk Register entries bi-monthly and therefore an update had been made the previous week.

Laura Douglas was meeting with Laura Geddes that afternoon and was also going to the Risk Committee.

Gill stated that she appreciated the narrative provided which was helpful. She asked Caroline if she had the support she required in managing the risks. Caroline replied that she was happy with the support around the Staff Health and Wellbeing piece and awaits the outcome of that. Gill asked when Staff Governance Committee would receive the report and Caroline responded that it was due by the end of September.

The Committee noted the update.

5 Staff Governance Annual Monitoring Return

Caroline Sharp reported that pulling this information together had been challenging and it has been fully informed by the Directors’ engagement with the operational directorates at the Annual Reviews. The paper is a summary front cover to formally approve the 2016/17 Staff Governance Self Service Audit Return. The corporate return is different from the local returns as the local returns have more information in them.

Staff Governance Committee was asked if they wished the Directorate Level reports to also be submitted to Scottish Government.

Laura Douglas stated that it felt the right thing to do to send the extra information and asked if there was a reason not to send everything. Caroline responded no and Laura said it made sense to send them then.

Linda Davidson said she felt it would show the great amount of work that had been done and Staff Side agreed.
There was discussion around whether formats of returns would be altered in future and Caroline responded that Scottish Government were looking to try and streamline this work in line with LDP work. Caroline expects that having done this document she was not expecting to complete another fulsome return for the Annual Review as this would be used as the Scottish Government’s form of analysis for the Review. Directorate level reports are a very important part of the information that Directors use to shape and frame conversations with Directorates. The information provided has enabled a very rounded conversation with the General Managers and teams around the dimensions that make up the framework of assessment that is reflected on and used to guide the work fed into the Staff Governance Committee.

Val Douglas had a concern around the bullying and harassment figures and asked at what stage were issues logged and Pamela agreed to discuss the figures with Val.

Alice Wilson had concerns with some of the information which could be seen as contradictory and possibly unable to evidence. Caroline agreed that she would pick up the language around it before it was submitted.

Gill thanked everyone for their work on the documents.

Staff Governance Committee approved the SAAT return and also agreed the submission of the Directorate Level reports as well.

6 **Staff Health, Safety and Wellbeing Report including Sickness Absence Update**

Ros Kelly presented the report and highlighted the following areas:

*National Staff Flu Campaign* – There had been a 17% reduction in the uptake due to the different way of rollout out the programme but NHS D&G were still 2nd nationally, with Ayrshire & Arran being 1% more. The national average was 33.7%. Will continue to look at how staff can be reached for next year. There is a new database for the iMatter programme so can look at it about reaching all staff.

*iMatter* – As previously reported, by the end of 2017 iMatter will be fully implemented. Now commencing the first anniversary of Cohort 2.
Accident Reduction Plan – this was attached.

The paper contained general information about HSE visits and we are fully aware of what is happening and looking at our own processes and procedures in case we get a visit.

Laura Douglas asked what do we locally want to achieve as a target and Ros replied that the previous HEAT target was 65% and we had been achieving more than that. Laura asked if there was something else that can be done to increase the returns? Ros felt it was down to staff receiving appointments but now individuals were left to their own devices. The usual advertising was done internally and also went to the staff's workplace and held drop in clinics. We are now looking at sending appointments to staff via the Manager.

Alf Hannay left the meeting

Caroline stated that we now need to capture an evaluation of what was expected and what has happened and this will go to Management Team as a paper.

Gill asked if the figure included staff who had had the flu vaccination at their GP and Ros replied yes, 100 staff had had it done at their GP.

Ros was also looking at the previous data from the flu immunisation programme and was capturing mobile numbers so they could maybe look at text messaging.

Attendance Management

The sickness absence information was taken from SWISS and the figures reported were from January-March. Occupational Health was maintaining the number of medical referrals coming in and reduced the number of reviews. There has been a drop in CBT and self help referrals due to the absence of the CBT Therapist. Caroline highlighted the positive work done by the Occupational Health team in the last quarter around review and return appointments.

Gill asked what psychological reasons may be being caused by work referred to in table 4, reasons for referral? Ros replied that they were finding it can be anxiety related, could be interpersonal relationships problems, increasing stressors in the workplace, personal stressors. It is mainly anxiety and low mood that are the main reasons. She stressed that it was about catching it at an early stage and providing appropriate
interventions. Gill asked if she felt staff were comfortable to say to their Line Manager or is it later and Ros said it was a mix of both, some will go to Managers and some will self refer. Some Managers recognise it in staff that they maybe don’t recognise themselves and do a management referral. Gill asked if something more proactive can be done and Ros replied they could always be more proactive but they are providing stress awareness courses for staff and managers. They are signposting mindfulness courses in the community as these are not done in house as it is a long time to commit to be off work. Ros stated that with the resources they have and can facilitate, they are doing everything they can.

Gill asked if someone presented with compassionate leave do they require a certificate from their GP and Ros replied No. Caroline stated that there is a Special Leave Policy which comprises compassionate and bereavement leave and these would be handled through their line management. Ros stated that they record on their systems if absence is required because of bereavement.

The Committee noted the report.

7 Workforce Report

Linda Davidson reported that she was meeting the General Managers in a couple of weeks and will raise Fixed Term contracts with them again. Pamela updated that acute were looking at the number of vacancies they have and are currently in the process of writing to Band 5 staff to offer them the opportunity to apply for permanent posts but had a very low uptake so far, and will also do the same for Band 2 staff. An open day is being held in June and a number of different initiatives will be happening to fill the gaps.

_Dawn Allan entered the meeting_

Laura asked if there was any reason why people would not want to apply for the permanent posts. Pamela replied that people may want to stay where they are and may get their contracts extended where they are. She was trying to get messages back that not everyone may be able to stay where they are.

Gill asked Linda what 3 core groups were identified and Linda replied that it was general recruitment, issues with locums and also retention. Gill asked how long she has got to work on this and Linda replied 3 months. She was having regular update meetings along with Ken Donaldson and Management
Caroline stated that £20,000 of advertising had been done in the BMJ and Angus Cameron had reflected that he had received no response from this. The update was noted.

### Apprenticeship Levy/Opportunities for Young People in NHS D&G

Caroline Sharp gave apologies to the Committee as they had asked for an update on the apprenticeship levy and a member of Pamela’s team had prepared, in good faith, the paper which not only offered the background but also offered a couple of options around where we might go and Caroline thinks a little more work needs to be discussed and debated before this comes to Staff Governance Committee. She asked the Committee to use the first part of the paper around the levy but not to discuss the proposed actions. A paper would come to a future meeting.

£800k of Boards finance was going to the UK Government and then back to the Scottish Government but would not come back to Boards. Gill stated that she knew some MAs who had to leave due to the funding and they were disappointed and would want to come back. Jim Beattie said it was disappointing and he had met with SERCO who are looking at the local workforce.

### New Trade Union Legislation and Requirement for Facilities Time Reporting

Caroline Sharp reported that there has been a new Trade Union Legislation brought in with effect from April 2017 and it places a requirement on organisations to record and report around facilities time ie. time that individuals are taking up within the workplace of undertaking Trade Union duties. The first Board level report which is due to be published, is due in July 2018, and in discussion with Jim Beattie and Staff Side colleagues at APF, current requirements set out in the local policy, and which is fully compliant with the national PIN policy, we are ensuring we are fully compliant within that with our recording. It is likely that the templates in the PIN may need adjustment because it is not fully aligned with what legislation is asking for but this is being looked at nationally in order that all systems are able to report. The agreed national approach is to capture everything and Caroline will bring back a fulsome report to Staff Governance Committee for members.
to see the aggregated value and contribution that Staff Side make to the functionality to the organisation.

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<th><strong>Spiritual Care for the Workforce</strong></th>
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<td>Everyone introduced themselves to Dawn Allan who is the new Spiritual Care Lead. Dawn reported that since taking up post she has been round all the hospitals in the region except for 3. She has been meeting and listening to staff. She has also been recruiting volunteers and has a total of 9 so far and is still recruiting more. Gill said her approach feels very refreshing. She has been offering staff support and the current focus for staff is the imminent move to the new hospital and she offers ways of coping and encourages staff not to feed the negativity. She is organising a Carol Service at the Crichton Church around celebrating amalgamating.</td>
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<td>Gill asked what themes apart from the move have been identified. Dawn replied that the cottage hospitals which have been reshaped need a high level of support for people with dementia and a number of lead nurses are looking forward to that as it is new, and training is being offered and is being tapped into. She stated that the community hospitals and their communities are very tight which is positive but visitors having to travel from Dumfries to these hospitals but are unable to, is a concern.</td>
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<td>Pamela said she would like to catch up with Dawn as she is heavily involved with the move to the new hospital so she can let her know what is being done.</td>
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<td>Val Douglas stated that the staff at Midpark Hospital had benefitted from the staff listening service and Dawn said she would go there and do a more formal meeting. Gill asked to catch up with Dawn to go over the staff listening service.</td>
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<td><em>Dawn Allan left the meeting</em></td>
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<th><strong>Items to Note</strong></th>
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<tr>
<td>11 APF Minutes – February 2017 - Noted</td>
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<td>12 Good Conversations – Noted</td>
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<td>13 School Nursing – Noted</td>
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<th>14</th>
<th><strong>Any Other Business</strong></th>
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<td>Workforce Plan – Gill stated that she had not wanted this item to be under AOB. Caroline advised that this was a late paper which came in after the agenda was set to follow up from the</td>
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paper at the last meeting which described the process. This paper is just giving a real time update on the information which has been collated. She wanted the Committee to be sighted on the issues and themes coming through on this. It captures a significant number of challenges and this is not the final narrative but is part of the journey.

Gill asked when it would come back to the Committee and Caroline responded that the discussion at the last meeting had been to agree to concentrate on the IJB Workforce Plan but to try to get a Board Workforce Plan by the due date of 31 August, realising that the date may slip. Tracy Parker reports in the cover paper to say that update on progress will be brought to the Committee on 24 July and further reiterated at APF on 24 August and will then go through the formal approval process.

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<td>The next meeting will be held on Monday 24 July 2017 at 10am in the New Board Room, Crichton Hall.</td>
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