DUMFRIES AND GALLOWAY NHS BOARD
PUBLIC MEETING

A meeting of the Dumfries and Galloway NHS Board will be held at 10am on Monday 2nd December 2019 in the Lecture Theatre, Education Centre, Dumfries and Galloway Royal Infirmary, Cargenbridge, Dumfries, DG2 8RX

AGENDA

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<tr>
<th>Time</th>
<th>No</th>
<th>Agenda Item</th>
<th>Who</th>
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<tbody>
<tr>
<td>10.00am</td>
<td>113</td>
<td>Apologies</td>
<td>L Geddes</td>
<td>Verbal</td>
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<tr>
<td>10.00am</td>
<td>114</td>
<td>Declarations of Interest</td>
<td>N Morris</td>
<td>Verbal</td>
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<tr>
<td>10.05am</td>
<td>115</td>
<td>Previous Minutes</td>
<td>N Morris</td>
<td>Attached</td>
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<tr>
<td>10.10am</td>
<td>116</td>
<td>Matters Arising and Review of Actions List</td>
<td>N Morris</td>
<td>Attached</td>
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QUALITY & SAFETY ASSURANCE

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<th>Time</th>
<th>No</th>
<th>Agenda Item</th>
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<tbody>
<tr>
<td>10.15am</td>
<td>117</td>
<td>Patient Services Feedback Report</td>
<td>E Docherty</td>
<td>Attached</td>
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<tr>
<td>10.30am</td>
<td>118</td>
<td>Healthcare Associated Infection Report</td>
<td>E Docherty</td>
<td>Attached</td>
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PERFORMANCE ASSURANCE

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<th>Time</th>
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<tbody>
<tr>
<td>11.00am</td>
<td>120</td>
<td>Governance arrangements for the Integration Joint Board</td>
<td>J White</td>
<td>Attached</td>
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<tr>
<td>11.15am</td>
<td>121</td>
<td>Performance Report</td>
<td>J White</td>
<td>To Follow</td>
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<tr>
<td>11.30am</td>
<td>122</td>
<td>NHS Mid Year Review with Scottish Government</td>
<td>J Ace / N Morris</td>
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FINANCE & INFRASTRUCTURE

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<tr>
<td>11.45am</td>
<td>123</td>
<td>Financial Performance Update</td>
<td>K Lewis</td>
<td>Attached</td>
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<tr>
<td>12.00pm</td>
<td>124</td>
<td>Capital Plan and Infrastructure Update</td>
<td>K Lewis</td>
<td>Attached</td>
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PUBLIC HEALTH & STRATEGIC PLANNING

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<th>Time</th>
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<th>Agenda Item</th>
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<tr>
<td>12.15pm</td>
<td>125</td>
<td>Board Regional Update</td>
<td>V Gration</td>
<td>Attached</td>
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<tr>
<td>12.30pm</td>
<td>126</td>
<td>Proposal for Establishment of a Public Health Governance Committee</td>
<td>V White</td>
<td>Attached</td>
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<td>Time</td>
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<tr>
<td>12.45pm</td>
<td>127</td>
<td>Board Briefing</td>
<td>J Ace</td>
<td>Attached</td>
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<tr>
<td>12.50pm</td>
<td>128</td>
<td>Corporate Risk Register</td>
<td>L Geddes</td>
<td>Attached</td>
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<tr>
<td>1.00pm</td>
<td>129</td>
<td>Integration Joint Board Directions to NHS Dumfries and Galloway</td>
<td>L Geddes</td>
<td>Attached</td>
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<tr>
<td>1.10pm</td>
<td>130</td>
<td>Committee Minutes and Matrix</td>
<td>L Geddes</td>
<td>Attached</td>
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<td></td>
<td>• Area Clinical Forum – 28 August 2019.</td>
<td>Committee Chairs</td>
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<td>• Performance Committee – 2 September 2019.</td>
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<td>• Audit &amp; Risk Committee – 29 July 2019.</td>
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<td>• Healthcare Governance Committee – 13 May 2019.</td>
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<td>• Healthcare Governance Committee – 8 July 2019.</td>
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<td>• Healthcare Governance Committee – 16 September 2019.</td>
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**ANY OTHER COMPETENT BUSINESS**

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<td>1.15pm</td>
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**DATE AND TIME OF NEXT MEETING**

- 3rd February 2020 @ 10am – 1pm. The venue for the meeting will be confirmed prior to the meeting.
DUMFRIES AND GALLOWAY NHS BOARD

NHS Board Meeting

Minutes of the NHS Board Meeting held on Monday 7th October 10am – 2.45pm in the Lecture Theatre, Education Centre, Dumfries and Galloway Royal Infirmary, Cargenbridge, Dumfries, DG2 8RX

Minute Nos: 90 - 112

Present
Mr N Morris (NM) - Chair
Mr J Ace (JA) - Chief Executive
Mr E Docherty (ED) - Nurse Director
Dr K Donaldson (KD) - Medical Director
Mrs K Lewis (KL) - Director of Finance
Ms L Bryce (LB) - Non Executive Member
Dr L Douglas (LD) - Non Executive Member
Ms G Cardozo (GC) - Non Executive Member
Mrs P Halliday (PH) - Non Executive Member
Mrs L Carr (LC) - Non Executive Member
Mrs R Francis (RF) - Non Executive Member
Ms M Gunn (MG) - Non Executive Member
Mr S Hare (SH) - Non Executive Member

In Attendance
Mrs C Cooksey (CC) - Workforce Director
Ms V White (VW) - Acting Interim Director of Public Health
Mrs J White (JW) - Chief Operating Officer/IJB Chief Officer
Mrs L Geddes (LG) - Corporate Business Manager
Mrs L McKie (LM) - Executive Assistant (Minute Secretary)
Mrs J Pollard (JP) - Associate Director of Allied Health Professions
Mrs V Gration (VG) - Deputy Head of Strategic Planning
Ms R Griffin (RG) - Strategic Planning & Commissioning Manager

Apologies
Mr A Ferguson (AF) - Non Executive Member

NM welcomed Board Members to NHS Board, highlighting to members that today’s meeting would be recorded as previously agreed by the Board. NM welcomed VW to the meeting, with JA advising members that VW would be attending on behalf of MMc during her period of absence.
90. **Apologies for Absence**

Apologies put forward for the meeting have been noted above.

91. **Declarations of Interest**

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

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

92. **Minutes of meeting held on 5th August 2019**

NM asked NHS Board Members if they had any points of accuracy with the minute. Board members were content to approve the minute as an accurate record of discussion, with the following amendments:

- **Patient Services Feedback Report:**
  LB requested that the wording within paragraph 2 on page 5 be amended to read:

  “LB highlighted the comments regarding reported stressed staff members, which had been raised at a recent Healthcare Governance Committee. CC highlighted the discussion from the recent Working Well Group meeting and the work undertaken by the performance and intelligence staff to see if it is possible to triangulate the data about staff stress with data about patient’s complaints about staff attitude”.

- **Governance Committee Minute Matrix 2018/19**
  LC requested that the initials within the update from the Area Clinical Forum – 24th April 2019 be amended to read:

  “LC presented the minute from the Area Clinical Forum meeting on 24th April 2019”

- **Reflective Session and Review of Agenda Matrix**
  A further request was put forward to amend the wording within item 87 on page 18 to read:

  “It was highlighted to NHS Board Members that NHS Dumfries and Galloway may be asked to provide information to Scottish Government on how the Board had successfully achieved the building of the new Dumfries and Galloway Royal Infirmary in response to recent incidents at the new Children’s Hospital in Edinburgh”
93. Matters Arising and Review of Actions List

NM asked NHS Board Members if they had any items to be discussed under matters arising that were not noted on the agenda or within the action list. No matters arising were put forward.

NM presented the Actions List, taking members through the updates that had been received, noting the following key points of progress for some of the actions:

- **Item 5 - Patient Services Feedback Report**  
  LG advised that although she had contacted the Scottish Public Services Ombudsman (SPSO) she was still awaiting confirmation on potential workshop dates, noting that she would approach them again this week for clarification.

- **Item 20 - Future delivery of Adult Urology Services in Dumfries and Galloway**  
  VG advised that Members would be updated on progress at the NHS Board in December.

- **Item 67 - Patient Services Feedback Report**  
  GC expressed an interest in how members of the public view the way in which the Board gathers information and to whether it would be useful to discuss with staff their thoughts on ways to improve the service. ED agreed that he would be happy to discuss with members of staff and share findings with Board Members.

- **Item 83 - Corporate Risk Register**  
  LG advised that due to the limitations around the level of detail that can be taken through the Public Board meeting regarding the risk register it may not be possible to provide the information being asked for, but agreed to discuss in more detail with LD outwith the meeting.

- **Item 198 - Scotland’s New Public Health Priorities**  
  LG advised that a paper would be presented to the February 2020 NHS Board meeting, which will give a comparison of roles between the NHS and Integration Joint Board governance frameworks to address potential changes that could be made to enhance the good governance practices within the Board. As part of the review consideration will also be given to the current arrangements in relation to Public Health and the re-establishment of the Public Health Committee.
• **Item 223 - Inequalities & Health Inequalities Report**  
VW advised that that due to capacity issues and competing workloads there has been a delay with the progression of the terms of reference for the Steering Group, however this is now being addressed and progress will continue over the coming months with a paper being presented to the NHS Board in December 2019.

• **Item 45 - Register of Members Interests 2019**  
NM advised that an updated version of the Register of Members Interests would be brought back to the NHS Board Meeting in December 2019 for review and approval.

NM asked NHS Board Members if they were satisfied to remove the closed actions from the grayed section of the Action list. Members were content to close and remove the grayed actions.

NHS Board noted the progress on the Actions List.

94. **Patient Services Feedback Report**

ED presented the Patient Services Feedback Report, asking NHS Board Members to note the Board’s complaints performance for July and August 2019, the key feedback themes and details of the resulting learning and improvements.

NHS Board Members were advised that Patient Services and the Community Health and Social Care Directorate are working together to undertake a test of change around capturing of compliments.

ED highlighted that there had been total of 50 complaints recorded for the month of August, highlighting that the majority of the complaints recorded were related to either parking or smoking outside DGRI.

NHS Board Members were advised that the Board had received five Care Opinion stories during the reporting period, with ED highlighting that when a story is added the relevant staff are alerted so they can view the feedback and respond as required.

GC asked for further details on the reference to premises within the report. ED advised that this was due to general maintenance concerns, which would be addressed at Healthcare Governance Committee in November 2019. Further information on this topic will be included within the paper being presented to Healthcare Governance Committee.
MG highlighted that she was happy to see that the “other” category had been removed from the list in the complaints information. MG further noted that number of waiting time complaints and asked whether there was work ongoing to improve the data. ED advised that he was aware of the number of waiting time complaints and was currently working on ways to improve the performance figures in collaboration with NHS24 to test the process for waiting times more effectively.

LB made reference to the Care Opinion Story within Appendix 2 on page 2 of the paper, enquiring to what improvements can be progressed. ED highlighted work with teams to improve support for patients across the system and support to learn from this experience.

LD enquired to whether there was any update on extensions for complaint processes. ED advised that although he was trying to implement extensions through front line managers, this was proving difficult due to the lack of ability to meet timescales. JP further noted that discussions had commenced with both the Chief Operating Officer and Deputy Chief Operating Officer on the understating of timeframes, prior to a report being presented to Healthcare Governance Committee or NHS Board for scrutiny.

Timeline issues meant that it would not be possible to present the paper through Health and Social Care Senior Management Team without the need to delay reports coming to Healthcare Governance Committee or NHS Board within the one month timeline. JW advised that is was extremely important to address the learning within teams and across the directorates, noting that it would be beneficially to gain a direction form Board Members on whether they would be supportive of a delay in reporting to Healthcare Governance Committee and NHS Board for discussion or to move to a virtual sharing with discussion at the next meeting. ED highlighted that he felt the best possible option would be the use of virtual sharing.

NM advised that he would be content to invite a directorate or team to present their learning to NHS Board on a rotational basis to give NHS Board Members the opportunity to gain assurance that the relevant improvements are being made to services.

GC highlighted the varied quality of learning within the summaries and the identified complaint themes that the Board could put to use to improve patient experiences.

NHS Board Members noted the Report.
95. Healthcare Associated Infection Report

ED presented the Healthcare Associated Infection Report, asking NHS Board Members to note the Board’s activity detailed within the paper and the Board’s approach to managing incidents where infection risk is identified.

It was highlighted that identified cases of both Staphylococcus Aureus Bacteraemia and Clostridium Difficile remained low and stable.

ED highlighted three incidents involving Dental Practices in the region, which have been resolved but resulted in unannounced inspections by the Board. Praise was given to the Public Protection Team for their involvement in the three incidents.

NHS Board Members were highlighted to the ongoing discussions at Management Team level regarding water in hospitals, which is currently the subject of much scrutiny in Scotland. ED advised that there was no record of patients having any associated infections in critical care areas, however, continuous testing and their results have been overseen by a designated Team.

NHS Board Members were highlighted to the changes in hand washing audit processes. ED confirmed he had discussed this change with the Lead Nurses and has stated that trends in hand hygiene must be visibly improved by mid October 2019 and continually monitored to maintain the improved position.

LD asked for an understanding to why the Body Mass Index (BMI) could be the cause for infection in a patient undergoing hip arthroplasty surgery. ED advised that this is due to the increased rates of periprosthetic infections, which could add complications to surgery.

JA advised NHS Board Members that due to a national interest in water quality, a report has been drafted by Ian Bryden, Head of Estates and Property and Nigel Calvert, Consultant in Public Health Medicine confirming that the Board’s main sites have been considered and assessed in terms of their water systems, giving assurance that no current issues had been highlighted. The NHS Dumfries and Galloway Water Quality report will be presented to the next Infection Control Committee and Healthcare Governance Committee for assurance.

RF enquired to the dental incidents recorded within the report and to whether this was the automatic process for all dental incidents. VW advised that in this instance Health Protection Scotland had been informed as an additional precautionary measure, with ED advising that assessments are carried out for all incidents whether any immediate action was required or not.

NHS Board Members noted the update paper.
96. Patient Safety and Improvement Annual Report 2018-2019

ED presented the Patient Safety and Improvement Annual Report asking NHS Board Members to approve the report for publication on the NHS Dumfries and Galloway website and for submission to Healthcare Improvement Scotland.

It was noted that the report has been reviewed at Healthcare Governance Committee where there had been extensive discussions on the improvements to the quality and safety of the key healthcare processes.

GC referred to the care opinion story within the report regarding one patient’s experience of pressure ulcers, asking for assurance that actions being taken around this are looking at prevention and not just patient treatment. ED advised that although the tissue viability nurse had had reduced involvement in this case, processes were in place to address any training needs on the management of pressure ulcers.

GC highlighted that she would be very interested to see the outcomes of patient experiences following the work on the Police Triage pilot to further develop links between Police and Mental Health Services. ED agreed to share the learning with GC outwith the meeting.

**Action: ED**

LB made reference to the outcomes from the Patient Safety Leadership Walkrounds, which were detailed on page 48 of the report, asking whether anything could be done to improve staff breakout areas within Dumfries and Galloway Royal Infirmary. ED advised that the breakout areas had been designed within the new hospital to encourage staff to take their breaks away from their area of work.

LB highlighted that due to pressures staff may be unable to take their breaks away from their place of work. JA noted that the main focus was to address staffing challenges to elevate pressures, which would allow staff to use the allocated breakout spaces.

CC highlighted the work that is being taken through the Workforce Sustainability Programme Board, to identify priorities for 2020, including addressing safe spaces for staff during their working day.

RF enquired to the accessibility of the report to the public and whether the public would find it easy to engage with. ED advised that he would be happy to address the language within the report to make it easier for the public to understand.

**Action: ED**
NM asked for clarity and assurance on category 1 “falls with Harm”; including whether a review was undertaken of all incidents and which committee the results are presented too. ED advised that all category 1 “falls with harm” are submitted to the Patient Safety Group and the appropriate Director for review, prior to submission at Healthcare Governance Committee for scrutiny.

NHS Board Members approved the Patient Safety and Improvement Annual Report.

97. Summary Performance Report

JW presented the Summary Performance Report, highlighting to NHS Board Members that there had been an increase in Treatment Time Guarantee breech figures due to capacity issues.

The Cancer Waiting Times figures for the “over 62 days” indicator was showing activity sitting at 84.8% for July, which is below the national standard of 95%. Performance for the quarter was likely to be close to 95% however.

JW highlighted that the percentage of people who waited longer than 12 weeks from referral to their first outpatient appointment was 90.9%. This is below the national standard of 95% for outpatient appointments for August 2019.

NHS Board Members were also made aware of the increase in the number of delayed bed days from 1,985 in May 2019 to 2,104 in August 2019.

PH enquired whether there was anything built into the action plan to address patient experience. JW advised that the Patient Access Team made regular contact with patients waiting beyond 12 weeks.

ED advised that he was very aware of the potential patient issues, work was ongoing with teams to capture the poor outcomes and patient experiences.

PH raised concerns for patients with challenging health issues and who may not have a carer, raising the issue that the increase in appointment waiting times may lead to some patients giving up their appointments. JW noted the flexibility of patient focused booking in arranging appointments.

GC asked for clarity on whether Treatment Time Guarantee letters are sent to all patients including psychology patients. JW advised that the letter sent by the Chief Executive does not cover psychology patients.
LD enquired to whether additional resources within the community could alleviate vacancy challenges and whether medical vacancies were on the list of priorities for 2020. JW advised that although there was little that could be achieved in the short term, the Vacancy Control Group were reviewing processes to address the longer term issues, which would assist the future model in the provision of care in the community.

NHS Board Members were highlighted to the recent British Medical Journal (BMJ) Careers Fair in London last week, which KD attended. LB requested that future reports could incorporate information on unpaid carers. JW said she would include more detail on support to unpaid carers in the 6 monthly performance reports and that we will continue to report separately on the implementation of the carers strategy.

Action: JW

NHS Board Members noted the report.

98. Integration Joint Board Annual Performance Report

JW presented the Integration Joint Board Annual Performance Report to NHS Board Members for review and noting.

It was highlighted that the Integration Joint Board Annual Review will take place on 31st October 2019 at the Cairndale Hotel in Dumfries.

NM highlighted that he would be interested in seeing how Workforce receives their direction from the Health and Social Care Partnership. VW advised that if re-established the Public Health Committee may be able to address integration issues around directions.

LD reflected on the NHS Scotland 2020 vision, asking whether the Board is doing enough on the prevention of inequalities within the region and whether more could be done. VW highlighted that although challenges are significant the Public Health Committee, if re-established, could look to address how prevention work can assist within the wider system.

NHS Board Members noted the Report.

99. Financial Performance Report

KL presented the Financial Performance Report, asking NHS Board Members to note the updated financial position at the end of August 2019, the ongoing level of financial risk, the reduction of the in-year savings gap from £9.1m to £5.8m, the reduction to the overall forecast deficit for 2019/20 to £4.8m as reported at Quarter One and the specific financial provision that has been made for a No-deal Brexit within the current financial position.
NHS Board Members were highlighted to the financial risks set out within the report, with KL noting the challenges around the Windows 10 migration and the ongoing clinical waste contract renewal that comes into play on 1st December 2019.

It was noted that Primary Care prescribing was showing an overspend of £465k at Month 5, which was due to service changes and capacity issues within the Pharmacy teams across the region.

In was noted that the Sustainability and Modernisation Programme (SAM) had received 511 ideas, which have been submitted through the ‘little change matters’ SAM intranet ideas page. The ideas are currently being reviewed and allocated to relevant management teams and workstreams.

KL highlighted that the NHS Board should receive the Scottish Government’s three year financial plan by mid December 2019, which will reflect the £4.8million overspend in Quarter one. However, it was noted that timings could be affected by the general election.

PH referred to the Primary Care overspend, and to whether the increase was due to more people within the region becoming ill as there is no evidence captured within the paper as to the reasons behind the increase in spend. KL advised that a discussion had been held with the Integration Joint Board and that a Workshop had been arranged to allow a more detailed discussion for members of both the NHS Board and the Integration Joint Board.

LD enquired to whether there were any set financial implications for the Sustainability and Modernisation Programme. KL advised that timelines for the various workstreams were under development.

MG enquired to whether there was any further update available on the Facilities and Clinical Support directorate overspend reported within Appendix 2 of the report. KL advised that once further information was available on the clinical waste cost, information would be available for NHS Board Members.

NHS Board Members noted:
- The updated financial position at the end of August 2019, month 5.
- The ongoing level of financial risk in the position.
- The improvement to the in-year savings gap from £9.1m to £5.8m, reducing the overall forecast deficit for 2019/20 to £4.8m as reported at Quarter One.
- The specific financial provision has been made for a No-deal Brexit within the current financial position.
100. Capital and Infrastructure Report

KL presented the Capital and Infrastructure Report, asking NHS Board Members to approve three amendments to the capital plan.

NHS Board Members were highlighted to a number of areas of development, such as the Mountainhall Treatment Centre and the relocation of the Ophthalmology Department, with further details on these areas coming back to the NHS Board meeting in December for approval.

LD highlighted that it was her understanding that the Mountainhall Treatment Centre residences had been declared surplus, however, she had been made aware that the flats where to be used for Scottish Graduate Entry Medicine (ScotGEM) Students. KL advised that there had been suggestions around declaring the residences as surplus, but nothing that been taken through NHS Board for approval, therefore, are able to be re-utilised for other purposes.

NHS Board Members approved the following three amendments to the capital plan for:

- the Sexual and Rape Crisis Centre.
- the National Internal Screening topslice.
- the Regional Laundry Equipment topslice

101. EU Withdrawal Planning Report

JA presented the EU Withdrawal Planning Report, asking NHS Board Members to note the arrangements to manage risks of a disorderly withdrawal from the European Union on 31st October 2019.

It was noted that the Yellowhammer planning assumptions highlight possible significant delays at ports following a disorderly withdrawal and prolonged reductions in the volumes of daily traffic able to enter the country.

NHS Board Members were advised that although there may be around a quarter of a million returning citizens from the European Union (EU) with chronic illnesses, those returning to Dumfries and Galloway are likely to be very small in numbers.

NHS Board Members were made aware that it seems very likely that a disorderly withdrawal from the EU will exacerbate the difficulties in retention and recruitment of staff required to deliver the full range of services delivered by the Board, which remains a significantly high risk to the Board.

It was noted that there is likely to be a significant effect on our financial position with the expected drop in the value of the British Pound and the rise in the cost of imported medicines and supplies after 31st October 2019.
The Executive Team also has significant concerns regarding the winter period, which brings a number of service challenges with increased admissions and the likelihood of flu outbreaks in any normal year, however, this year there is the additional challenges of the EU withdrawal. Regular updates on the current position will be provided to NHS Board Members as and when the information becomes available.

GC enquired to what engagement there will be with partners and to what the potential communication strategy will be with regards to the potential winter challenges and Brexit. JA advised that discussions were already well advanced through the Community Planning Executive Group and arrangements were in place with Dumfries and Galloway Council through the use of the Virtual Operations Support Team (VOST).

GC also asked whether the list of drugs highlighted on Social Media is an accurate list. JA advised that the list refers to current supply shortage and although there will likely be shortages with supplies after the first few weeks of transition, the Chief Medical Officer within Scottish Government is addressing the situation in conjunction with UK Government colleagues.

LD queried whether flu clinics had commenced for staff and to when the nasal vaccines for children will be received. JA advised that clinics had commenced for staff and the nasal vaccines for children were due to commence from 1st October 2019.

NM asked for Board Members agreement to add the EU Withdrawal Planning paper that was tabled at the Board meeting to be released on to the public website and to ensure that the Non-Executive Board Members make themselves available over the next two Mondays for any communication briefing around this matter.

Board members noted the report and agreed for the EU Withdrawal Planning report to be added to the NHS Dumfries and Galloway’s external website.

102. Dumfries and Galloway Future Alignment with Regional Cancer Planning Networks Report

NM welcomed RG to the meeting and asked NHS Board Members to note the complex nature of cancer care and treatment pathways, the shift towards ‘population based planning’ nationally, the emergence of new regional planning structures and also to approve the strategic position for NHS Dumfries and Galloway to allow the cancer care and treatment pathways for people in Dumfries and Galloway be realigned with the West of Scotland Cancer Network (WoSCAN).
NHS Board Members were made aware that the report had been presented to the Lead Cancer Team, Area Clinical Forum and will be presented to the Medical Staffing Committee on Thursday 10 October 2019 for consultation.

PH advised that it was her observation that there was little detail within the report that NHS Board Members were not already aware off. JA advised that the report sets out a strategic aspiration and if the Board approves the report, work can then commence on realigning cancer pathways with the West of Scotland Cancer Network (WoSCAN).

PH asked if it could be made clear that individuals from the west of the region would be able to access their treatment in Glasgow. KD advised that although all patients are given the choice of where to receive their treatment, occasionally this will be dependant of where the best treatment for the patient is delivered, which is outwith the control of the Board.

LD enquired what the benefits were in moving the service and whether patients will still have access to alternative centres such as Maggies. RG advised the hub of the report is around regional planning, highlighting that patients have requested more readily available information for support within their local area. VG continued to note that all information will be addressed within the 9 cancer pathways.

RF asked whether services in the east would cease before the west has the available capacity to support Dumfries and Galloway. KD highlighted that although it makes sense to have one singular service, the Board needs to recognise and learn from the relationships with NHS Lothian to develop relationships with the West.

KL advised that although the financial implications had not been addressed, NHS Dumfries and Galloway will have challenges in releasing their contract with NHS Lothian.

NHS Board Members noted the report and agreed the strategic position for the NHS Board so that cancer care and treatment pathways for people in Dumfries and Galloway can begin to be realigned with the West of Scotland Cancer Network (WoSCAN).

103. Corporate Objectives and Priorities Report

JA presented the Corporate Objectives and Priorities Report, asking NHS Board Members to note the progress against the each of the priorities for delivery in 2019/20.
NHS Board Members were made aware of the importance to note the priorities represent a very challenging workload for a system already stretched by workforce, service and financial pressures.

LD enquired whether staff were aware of the Board’s Corporate Objectives and Priorities. JA advised that the priorities have not been shared widely amongst staff as the Executive Team are keen to keep the key focus for staff on the Sustainability and Modernisation Programme (SAM), however, it was recognised that some staff would like to be aware of them and consideration will be given to a wider communication.

NHS Board Members noted the report.

104. Board Briefing

JA presented the Board Briefing paper to NHS Board Members, which raised awareness of events and achievements that have occurred within the Board over the past two months.

NHS Board Members were advised that the Board’s Maternity and Gynecology Unit have been noted as one of the top 10 performing units within the UK and have been highly commended for overall performance, gynecology training and professional development across all four nations based on the feedback from our trainees in 2018/2019.

NM asked that his diary heading within the Board Briefing was changed from Vice Chair to Chairman.

Action: LMcK

NHS Board Members noted the report.

105. Committee Structures Report

LG presented the Committee Structures Report, asking NHS Board Members to note the current governance structures that are in place across the Board, Committees and Professional Advisory Committees.

NHS Board Members were made aware that a larger piece of work is being undertaken across the integration of health and social care in relation to governance structures that are in place with the aim of streamlining the processes for the Health and Social Care Partnership, Local Authority and the NHS.
This paper was presented to NHS Board Members for information purposes to set out the governance structure as it currently stands. A further paper will be brought back to the December 2019 NHS Board meeting reflecting the outcome of the review of governance across Health and Social Care. At this point work will begin for the NHS Board to realign the current structure to the integrated structure. The new format will then be presented to NHS Board in February 2020 for approval and implementation.

NHS Board Members were highlighted to the diagram at appendix 1, which gave details of the Professional Advisory Committees and where they sit within the current structure. It was noted that LC is working with the Professional Advisory Committees Co-ordinator to pull together a more detailed paper on the role of each of the professional committees, promoting their use to the NHS Board in a consultative capacity. The aim would be to bring this paper to the February or April 2020 NHS Board for discussion.

NHS Board Members noted the report.

106. Corporate Governance Blueprint – Action Plan Update

LG presented the Corporate Governance Blueprint Action Plan Update to NHS Board Members, highlighting that following a full review of the Corporate Governance Blueprint and creation of the action plan in summer 2019 and update to the action plan is required to be submitted to Scottish Government by each Board before the end of October 2019.

NHS Board Members were made aware of the progress that has been made against all of the actions, with 5 of the 17 actions having been progressed to closure within the agreed timeframe.

NHS Board Members noted the update for onward submission to Scottish Government.

107. Schedule of Board Meeting Dates – April 2020 to March 2021

LG presented the Schedule of Board Meeting Dates for the period of April 2020 to March 2021, asking NHS Board Members to approve the proposed schedule of dates for publication on the NHS Dumfries and Galloway external website.

NHS Board Members approved the dates.
108. Integration Joint Board Membership

NM gave an update on the proposed membership changes for the Integration Joint Board as noted below:

- With effect from 31st October 2019, SH will step down a voting member of the Integration Joint Board.
- A suggest will be put forward to the Integration Joint Board to consider bringing SH back on to the Board in an advisory capacity, noting that only the Integration Joint Board can appoint advisor, not the NHS Board.
- As from 1st November 2019, MG will become a formal voting member of the Integration Joint Board.

NHS Board Members approved the membership changes.

109. Governance Committee Minute Matrix and Minutes

LG presented the Governance Committee Minute Matrix to Board members, which has been developed as part of recommendations from Internal Audit to ensure that all committee minutes are presented to NHS Board meetings throughout the year as part of the assurances for the Governance Statement process.

NM introduced the minutes from the various governance committees to NHS Board Members asking the Lead Director or Committee Chair to highlight any key points from the minute, for interest.

- **Area Clinical Forum – 26th June 2019**
  LC presented the minute from the Area Clinical Forum on 26th June 2019, which received an update on re-establishing of the Pharmacy Committee.

  NHS Board Members noted the minute.

- **Audit and Risk Committee – 28th January 2019**
  LD presented the minute from the Audit and Risk Committee meeting on 28th January 2019, which had received an update on risk management and audit actions.

  NHS Board Members noted the minute.

- **Audit and Risk Committee – 17th June 2019**
  LD presented the minute from the Audit and Risk Committee meeting on 17th June 2019, which received an update on various annual reports and scrutiny of annual accounts

  NHS Board Members noted the minute.
• **Performance Committee – 13th May 2019**
NM presented the minute from the Performance Committee meeting on 13th May 2019, which had received an update on financial performance. NM mentioned that he is not able to chair the next meeting of the committee on 4th November 2019 and has asked PH as Vice Chair to chair the committee on his behalf.

NHS Board Members noted the minute.

• **Person Centered Health and Care Committee – 24th June 2019**
PH presented the minute from the Person Centered Health and Care Committee meeting on 24th June 2019, which had received an update on the Role and Remit of the Committee.

NHS Board Members noted the minute.

• **Staff Governance Committee – 22nd July 2019**
LB presented the minute from the Staff Governance Committee on 22nd July 2019, which had received an update on the Committee Assurance Statement.

NHS Board Members noted the minute.

110. **Any Other Competent Business**

NHS Board Members were advised that NHS Dumfries and Galloway have been successful in achieving the Silver Award from the Defence Employer Recognition Scheme. A formal presentation will be made at Edinburgh Castle on 14th November 2019 by the Assistant Chief of the Defence Staff.

111. **Date of Next Meeting**

The next public meeting of the NHS Board will be held on 2nd December 2019 at 10am – 1pm in the Lecture Theatre, Education Centre, Dumfries and Galloway Royal Infirmary, Cargenbridge, Dumfries, DG2 8RX.
### Actions List from NHS Board – Public Meeting

<table>
<thead>
<tr>
<th>Date of Meeting</th>
<th>Agenda Item</th>
<th>Action</th>
<th>Responsible Manager</th>
<th>Current Status</th>
<th>Anticipated End Date</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>08/04/2019</td>
<td>20.</td>
<td>Future delivery of Adult Urology Services in Dumfries and Galloway</td>
<td>V Gration</td>
<td>Service changes means that further work is required. Board Members will be updated at the first possible opportunity when new information is available.</td>
<td>31/03/2020</td>
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<tr>
<td></td>
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<td>NHS Board Members discussed the input of the Integration Joint Board agreeing that VG would bring back any further developments of the future delivery of Urology services within Dumfries and Galloway to NHS Board for consultation.</td>
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<tr>
<td>10/06/2019</td>
<td>45.</td>
<td>Register of Members Interests 2019</td>
<td>L Geddes/ N Morris</td>
<td>An updated version of the Register of Members Interests will be brought back to the February 2020 NHS Board Meeting for review and approval.</td>
<td>28/02/2020</td>
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<td>NM mentioned that a review of the information being provided for the register needs to be looked at to ensure a consistent approach is adopted. It was agreed that NM and LG would review the information required and bring an updated register back to the August 2019 NHS Board meeting.</td>
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<tr>
<td>Date of Meeting</td>
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<tr>
<td>07/10/2019</td>
<td>96.</td>
<td>Patient Safety and Improvement Annual Report 2018-2019</td>
<td>E Docherty</td>
<td>ED to arrange a meeting with GC to discuss this matter further.</td>
<td>31/01/2020</td>
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<td></td>
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<td>GC highlighted that she would be very interested to see the outcomes of patient experiences following the work on the Police Triage pilot to further develop links between Police and Mental Health Services. ED agreed to share the learning with GC outwith the meeting.</td>
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<tr>
<td>07/10/2019</td>
<td>96.</td>
<td>Patient Safety and Improvement Annual Report 2018-2019</td>
<td>E Docherty</td>
<td>ED confirmed that the language within the annual report will be reviewed before the 20/21 version is published to ensure that plain English is used.</td>
<td>30/06/2020</td>
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<td></td>
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<td>RF enquired to the accessibility of the report to the public and whether the public would find it easy to engage with. ED advised that he would be happy to address the language within the report to make it easier for the public to understand.</td>
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<tr>
<td>07/10/2019</td>
<td>97.</td>
<td>Summary Performance Report</td>
<td>J White</td>
<td>Information on unpaid carers will be included within the next 6 monthly performance report, which will be brought back to the February 2020 NHS Board meeting.</td>
<td>28/02/2020</td>
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<td>JW said she would include more detail on support to unpaid carers in the 6 monthly performance reports and that we will continue to report separately on the implementation of the carers strategy.</td>
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<td>Date of Meeting</td>
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<td>Action</td>
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<tr>
<td>06/08/2018</td>
<td>198.</td>
<td>Scotland’s New Public Health Priorities</td>
<td>Jeff Ace</td>
<td>The following timeline has been agreed for papers in relation to the governance structure:</td>
<td>31/10/2019</td>
<td>07/10/2020</td>
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<td>AF asked for further clarity around why the Public Health Committee was disbanded, querying if it could be revived. JA advised that the Public Health Committee was disbanded due to the workload of Non Executive Board Members whom at the time were unable to commit to more than one day a week. NHS Board Members agreed to look at options outwith the meeting and bring a proposal back to the December 2018 NHS Board meeting.</td>
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<td>31/12/2019</td>
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<td>31/12/2019</td>
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<td>28/02/2020</td>
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<td>28/02/2020</td>
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<tr>
<td>01/10/2018</td>
<td>223.</td>
<td>Inequalities &amp; Health Inequalities Report</td>
<td>V White</td>
<td>Terms of Reference have been developed and are going to the IJB in December. First scheduled meeting is at the beginning of December at which a draft action plan will be shared.</td>
<td>31/12/2019</td>
<td>15/11/2019</td>
</tr>
<tr>
<td>04/02/2019</td>
<td>264.</td>
<td>Update on National Public Health Reform</td>
<td>J Ace/ N Morris/ L Geddes</td>
<td>Further to discussions at the October Board it was agreed that a paper outlining the proposal for a Public Health Governance Committee and draft terms of reference would be presented to the December Board meeting. This will support consideration of how this committee can fit within the review of governance.</td>
<td>28/02/2020</td>
<td>15/11/2019</td>
</tr>
<tr>
<td>Date of Meeting</td>
<td>Agenda Item</td>
<td>Action</td>
<td>Responsible Manager</td>
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<td>08/04/2019</td>
<td>5.</td>
<td>Patient Services Feedback Report</td>
<td>L Geddes</td>
<td>LG has spoken with SPSO, who have confirmed that the workshop will be held in March 2020 and will come back with the confirmed date once they have a draft programme for the workshop in place. It has been proposed to include an information session in relation to the Whistleblowing Standards as part of the workshop to raise awareness with Board Members on this piece of legislation. An invitation and draft programme will be issued to Board Members nearer the time of the workshop.</td>
<td>31/12/2019</td>
<td>02/12/2019</td>
</tr>
<tr>
<td>07/10/2019</td>
<td>104.</td>
<td>Board Briefing</td>
<td>L McKie</td>
<td>Heading changed on 08/10/2019</td>
<td>08/10/2019</td>
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<tr>
<td>Date of Meeting</td>
<td>Agenda Item</td>
<td>Action</td>
<td>Responsible Manager</td>
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<td>05/08/2019</td>
<td>67.</td>
<td><strong>Patient Services Feedback Report</strong>&lt;br&gt;PH highlighted the recent press/television coverage regarding a patient’s experience in the west of the region relating to cancer pathways, suggesting that this type of patient experience should also be reported to NHS Board Members and recorded within the report. ED suggested the use of a potential communications report, which would cover all press issues and could be submitted to Healthcare Governance Committee on a regular basis with an additional item on communication to be added to the patient feedback report submitted to the Board. ED was asked to look into this further and include in a future Board report.</td>
<td>E Docherty</td>
<td>Discussions are continuing with the Communications Team and media briefings will continue to be fed back to Board Members as they become available.</td>
<td>31/12/2019</td>
<td>02/12/2019</td>
</tr>
<tr>
<td>05/08/2019</td>
<td>83.</td>
<td><strong>Corporate Risk Register</strong>&lt;br&gt;LD enquired whether this version of the report could have mitigations added similar to the report that is submitted to Audit and Risk Committee as the mitigations add detail and depth to the report which gives the committee a detailed insight on all risk levels. LG agreed to add the current and further control measures into future reports.</td>
<td>L Geddes</td>
<td>There is limitations around the level of detail that can be taken through a public meeting in relation to the risk register, however, the information previously presented will be reviewed and additional information that can be shared will be included in the paper being presented to the December 2019 NHS Board meeting.</td>
<td>31/12/2019</td>
<td>07/12/2019</td>
</tr>
</tbody>
</table>
RECOMMENDATION

The Board is asked to discuss and note:
- the NHS Board’s complaints performance for September and October 2019, including key feedback themes and details of the resulting learning and improvements.

CONTEXT

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

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

Key messages:
- Complaints Handling and Investigation Skills training continues to be well attended.
- A session has been held with General Managers to finalise the Complaints Improvement Framework self assessment tool scoring.
- Complaints continue to exceed timescales with no extension in place.
## GLOSSARY OF TERMS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>DGRI</td>
<td>Dumfries and Galloway Royal Infirmary</td>
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<tr>
<td>SPSO</td>
<td>Scottish Public Services Ombudsman</td>
</tr>
<tr>
<td>NHS D&amp;G</td>
<td>NHS Dumfries &amp; Galloway</td>
</tr>
<tr>
<td>CHP</td>
<td>Complaints Handling Procedure</td>
</tr>
</tbody>
</table>

### Complaint:
NHS Dumfries and Galloway’s definition of a complaint is: (*An expression of dissatisfaction by one or more members of the public about the organisation’s action or lack of action, or about the standard of service provided by or on behalf of the organisation.*)

### Comment:
Comments, feedback or observations which reflect how someone felt about the service.

### Concern:
Concerns are matters where people require reassurance, further information or explanation to resolve a matter of concern. These fall short of a complaint as the person is not expressing significant dissatisfaction, but wishes to be more fully informed.

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>A&amp;D</td>
<td>Acute and Diagnostics</td>
</tr>
<tr>
<td>CH&amp;SC</td>
<td>Community Health and Social Care</td>
</tr>
<tr>
<td>MH</td>
<td>Mental Health</td>
</tr>
<tr>
<td>W,C&amp;SH</td>
<td>Women, Children’s and Sexual Health</td>
</tr>
</tbody>
</table>

### S1/Stage One:
Stage One complaint. This is the ‘early resolution’ stage of the complaints procedure where complaints are required to be responded to within 5 working days.

### S2/Stage Two:
Stage Two complaint. This is the ‘investigation’ stage of the complaints procedure where complaints are required to be responded to within 20 working days. Complaints can go ‘direct’ to Stage Two of the procedure or can be ‘escalated’ to that stage following a Stage One response.
### MONITORING FORM

| Policy / Strategy | Healthcare Quality Strategy  
Person Centred Health and Care Collaborative |
<table>
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<tr>
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</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>
</tbody>
</table>
| Consultation / Consideration | Healthcare Governance Committee  
Board Management Team |
| Risk Assessment | Actions from feedback followed through and reported to General Managers and Nurse Managers who have a responsibility to take account of any associated risk. |
| Risk Appetite | Low  
Medium  
X High  

It is considered that the risk appetite for this paper is medium in the context of Reputational where the Board has an expressed risk appetite of medium. |
| Sustainability | Not required |
| Compliance with Corporate Objectives | To promote and embed continuous improvement by connecting a range of quality and safety activities to deliver the highest quality of service across NHS Dumfries and Galloway |
| Local Outcome Improvement Plan (LOIP) | Outcome 2, 3, 6, 7 and 8 |
| Best Value | Vision and Leadership  
Effective Partnerships  
Governance and Accountability  
Performance Management |
| Impact Assessment | The failure to deliver adequate patient feedback functions could result in reputational damage and a failure to understand which services might be struggling to meet patient need.  
Not undertaken as learning from patient feedback applies to all users |
1. Introduction

This report outlines the patient feedback activity for NHS Dumfries and Galloway (NHS D&G) and performance against compliance targets for the period September and October 2019, set against an annualised pattern of feedback information. The report includes details of planned improvement actions.

2. Patient Feedback

This following section provides a commentary and summary statistics on feedback received throughout NHS Dumfries and Galloway for the period September and October 2019.

2.1 Feedback Received

The Board recorded 93 pieces of feedback in September 2019 and 104 in October 2019.

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<td>Complaints</td>
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<td>0</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>22</td>
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<tr>
<td>Compliments</td>
<td>18</td>
<td>11</td>
<td>12</td>
<td>11</td>
<td>17</td>
<td>22</td>
<td>16</td>
<td>10</td>
<td>10</td>
<td>17</td>
<td>25</td>
<td>33</td>
<td>202</td>
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<td>Concerns</td>
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<td>18</td>
<td>22</td>
<td>18</td>
<td>20</td>
<td>15</td>
<td>8</td>
<td>20</td>
<td>26</td>
<td>18</td>
<td>217</td>
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<tr>
<td>Total</td>
<td>69</td>
<td>55</td>
<td>66</td>
<td>69</td>
<td>77</td>
<td>83</td>
<td>92</td>
<td>68</td>
<td>56</td>
<td>89</td>
<td>93</td>
<td>104</td>
<td>921</td>
</tr>
</tbody>
</table>

Table 1
Feedback by month received

Chart 1
2.2 Care Opinion

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

NHS Dumfries and Galloway received 21 Care Opinion stories during the reporting period. At the time of writing, those 21 stories had been viewed 1087 times. Nine of the stories received during the period were about the Rapid Response team and all of those nine were compliments. The other stories were spread across various services. Care Opinion has an online reporting mechanism to provide a more detailed account of stories, including themes. The report can be found at:

http://www.careopinionstoryboard.dx.am/yfjnu6b390as.html

All NHS D&G stories are available to view at www.careopinion.org.uk. A summary of stories and responses is included in Appendices 1 and 2.

2.3 Compliments

During the period we recorded 58 formal ‘compliments’ in addition to those received by local teams. The themes recorded were as follows:

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<tr>
<td>Clinical Treatment</td>
<td>24</td>
<td>18</td>
<td>8</td>
<td>15</td>
<td>10</td>
<td>20</td>
<td>8</td>
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<td>12</td>
<td>19</td>
<td>21</td>
<td>23</td>
<td>187</td>
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<tr>
<td>Staff Attitude and Behaviour</td>
<td>9</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>8</td>
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Table 2
As previously reported, the Community Health and Social Care directorate are working with Patient Services to increase the promotion of feedback mechanisms with a view to improving the capturing of compliments. Initial planning meetings have taken place and agreed actions are due to commence from November 2019. More detailed updates will be shared in the February 2020 report to Board.

Physiotherapy has been actively promoting the ‘We Welcome Your Feedback’ leaflets to their patients and as a result they have received 27 compliments for the service during the period.

2.4 Concerns

During the period, 44 ‘concerns’ were recorded. The Complaints Handling Procedure details a concern as:

‘Concerns may be expressed in relation to proposed treatment or about any aspect of the service, from timing of appointments to getting to hospital for the proposed treatment or the actual treatment received. An example may be where someone has been referred to a consultant and is concerned about what this means. Concerns of this nature fall short of a complaint as the person is not expressing dissatisfaction, but wishes to be fully informed about what is to happen...’

The concerns received during the period had the following themes:

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NB: Feedback often contains more than one theme

Table 3
A number of comments and business as usual enquiries were also received by the Patient Services team during the period. These covered a wide variety of topics including smoking outside our buildings, contents of appointment letters, medication scheduling and queries regarding the flu vaccine.

2.5 Complaints

Of the 197 pieces of feedback received, 89 were complaints. The themes recorded were as follows:

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<td>Prison Regime</td>
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<td>0</td>
<td>0</td>
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<td>0</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>33</strong></td>
<td><strong>25</strong></td>
<td><strong>48</strong></td>
<td><strong>55</strong></td>
<td><strong>49</strong></td>
<td><strong>40</strong></td>
<td><strong>73</strong></td>
<td><strong>44</strong></td>
<td><strong>56</strong></td>
<td><strong>71</strong></td>
<td><strong>48</strong></td>
<td><strong>50</strong></td>
<td><strong>592</strong></td>
</tr>
</tbody>
</table>

NB: Feedback often contains more than one theme

Table 4
### Complaints by stage and month received

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No. Stage One</td>
<td>7</td>
<td>5</td>
<td>4</td>
<td>9</td>
<td>10</td>
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<td>9</td>
<td>6</td>
<td>10</td>
<td>8</td>
<td>15</td>
<td>99</td>
</tr>
<tr>
<td>Stage Two - Escalated</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>6</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>7</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>30</td>
</tr>
<tr>
<td>Stage Two - Direct</td>
<td>20</td>
<td>18</td>
<td>30</td>
<td>27</td>
<td>23</td>
<td>30</td>
<td>46</td>
<td>32</td>
<td>25</td>
<td>38</td>
<td>32</td>
<td>30</td>
<td>351</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>29</strong></td>
<td><strong>24</strong></td>
<td><strong>35</strong></td>
<td><strong>38</strong></td>
<td><strong>39</strong></td>
<td><strong>37</strong></td>
<td><strong>58</strong></td>
<td><strong>41</strong></td>
<td><strong>38</strong></td>
<td><strong>52</strong></td>
<td><strong>41</strong></td>
<td><strong>48</strong></td>
<td><strong>480</strong></td>
</tr>
</tbody>
</table>

Table 5

### Complaints by complaint stage by month received

- Stage 1
- Stage 2 - Escalated
- Stage 2 - Direct

![Chart 2](chart2.png)
The complaints received related to the following areas:

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute &amp; Diagnostics</td>
<td>18</td>
<td>18</td>
<td>25</td>
<td>24</td>
<td>29</td>
<td>24</td>
<td>42</td>
<td>28</td>
<td>23</td>
<td>36</td>
<td>29</td>
<td>35</td>
<td>331</td>
</tr>
<tr>
<td>CH&amp;SC</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>0</td>
<td>4</td>
<td>25</td>
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<tr>
<td>Prison</td>
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<td>0</td>
<td>2</td>
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<td>3</td>
<td>6</td>
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<td>4</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>31</td>
</tr>
<tr>
<td>Women's and Children</td>
<td>3</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>30</td>
</tr>
<tr>
<td>Corporate</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Mental Health</td>
<td>4</td>
<td>0</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>5</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>33</td>
</tr>
<tr>
<td>Operational Services</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>0</td>
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<td>1</td>
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<td>2</td>
<td>8</td>
</tr>
<tr>
<td>GP 2C</td>
<td>1</td>
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<td>0</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>4</td>
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<td>38</td>
<td>39</td>
<td>37</td>
<td>58</td>
<td>41</td>
<td>38</td>
<td>52</td>
<td>41</td>
<td>48</td>
<td>480</td>
</tr>
</tbody>
</table>

Table 6

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

The graphs associated with the above are included in Appendix 3.

The number of complaints open at the end of the period was as follows:

<table>
<thead>
<tr>
<th>Type</th>
<th>Total Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1</td>
<td>4</td>
</tr>
<tr>
<td>Stage 2 escalated</td>
<td>3</td>
</tr>
<tr>
<td>Stage 2 Direct</td>
<td>40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>47</strong></td>
</tr>
</tbody>
</table>

Table 7
Number of new complaints versus complaints closed 01/05/2018 – 31/10/2019

NB – This chart is an accumulation of all opened and closed complaints since the implementation of the new Complaints Handling Procedure in April 2017.
Independent Contractors

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

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

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

<table>
<thead>
<tr>
<th>Indicator One:</th>
<th>Learning from complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator Two:</td>
<td>Complaint process experience</td>
</tr>
<tr>
<td>Indicator Three:</td>
<td>Staff awareness and training</td>
</tr>
<tr>
<td>Indicator Four:</td>
<td>The total number of complaints received</td>
</tr>
<tr>
<td>Indicator Five:</td>
<td>Complaints closed at each stage</td>
</tr>
<tr>
<td>Indicator Six:</td>
<td>Complaints upheld, partially upheld and not upheld</td>
</tr>
<tr>
<td>Indicator Seven:</td>
<td>Average response times</td>
</tr>
<tr>
<td>Indicator Eight:</td>
<td>Complaints closed in full within the timescales</td>
</tr>
<tr>
<td>Indicator Nine:</td>
<td>Number of cases where an extension was authorised</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service</th>
<th>Sep-19 Number of responses</th>
<th>Sep-19 Number of complaints</th>
<th>Sep-19 % of all complaints</th>
<th>Oct-19 Number of responses</th>
<th>Oct-19 Number of complaints</th>
<th>Oct-19 % of all complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPs (n:28)</td>
<td>14</td>
<td>2</td>
<td>10</td>
<td>17</td>
<td>3</td>
<td>33</td>
</tr>
<tr>
<td>Pharmacy* (n:34)</td>
<td>14</td>
<td>18</td>
<td>86</td>
<td>15</td>
<td>5</td>
<td>56</td>
</tr>
<tr>
<td>Dental (n:34)</td>
<td>17</td>
<td>1</td>
<td>5</td>
<td>14</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Opticians* (n:21)</td>
<td>11</td>
<td>0</td>
<td>0</td>
<td>11</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Totals:</td>
<td>56</td>
<td>21</td>
<td>0</td>
<td>57</td>
<td>9</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 8

*NB - data for Pharmacy and Opticians is currently incomplete as the majority of these services report quarterly and the deadline for reporting is beyond submission dates for this paper.
Further details of the indicators can be found in appendix six of NHS Dumfries and Galloway’s Complaints Handling Procedure.

**Indicator 1 - Learning from complaints**

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

A meeting took place with General Managers on 1 October 2019 to work through the SPSO’s Complaints Improvement Framework self assessment tool. The framework is organised around six areas of good practice:

- Organisational Culture
- Process and Procedure
- Accessibility
- Quality
- Learning
- Complaints Handling

Directorates reviewed their scores against the 86 standards detailed within the tool. Following that discussion, priority areas will now be identified and improvement actions agreed. Progress updates will be included in future reports.

It has been agreed that in order to share understanding and learning across the organisation the Health Care Governance and Board Patient Feedback reports will be shared with Health and Social Care Senior Management Team.

Examples of Directorate learning summaries are included in Appendix 4.

**Indicator 2 - Complaints Process Experience**

‘A statement to report the person making the complaint’s experience in relation to the complaints service provided.’

Complainants are invited to share their experience of the complaints process when they receive their response letters. Complainants can answer via Survey Monkey or via hard copy questionnaire. They are asked 16 questions about their experience with the complaints process. These questions are based on guidance from the SPSO and are consistent with the questions asked by other Boards. NHS Dumfries and Galloway have been promoting the questionnaires since February 2018. A detailed report on these survey responses was included in the 2018/19 Annual Report.

Due to licensing issues with Survey Monkey, recent results have not been accessible. Patient Services are working with information technology colleagues to resolve this issue.

**Indicator 3 - Staff Awareness and Training**

“A statement to report on levels of staff awareness and training.”

Two training courses are run regularly; Complaints Handling and Investigation Skills. These courses are offered across the region and are delivered as both open sessions and team specific, tailored sessions.
They have been available since 2017 and continue to be well subscribed. Subject and team specific training also takes place as required. The following training took place during the period:

- Complaints Handling – 26 attendees
- Investigation Skills – 25 attendees
- Mediation Skills – 13 attendees

There is one further training day planned in 2019 to cover Complaints Handling and Investigation Skills with only one space remaining. Due to continued demand, these courses will continue in 2020.

**Scottish Mediation**

Three Mediation Skills workshops have been delivered by Scottish Mediation since June 2019, with a total of 38 attendees. The workshops have been well received, with positive feedback on every occasion. We are exploring options for continuing these workshops in 2020.

**Indicator 4: Total number of complaints received**

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

<table>
<thead>
<tr>
<th></th>
<th>Sept 19</th>
<th>Oct 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of complaints received</td>
<td>41</td>
<td>48</td>
</tr>
</tbody>
</table>

**Rate of Complaints received by service area (Rate per 1,000 staff)**

<table>
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<tr>
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<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Acute &amp; Diagnostics</td>
<td>9.4</td>
<td>9.4</td>
<td>13.0</td>
<td>12.5</td>
<td>15.1</td>
<td>12.5</td>
<td>21.9</td>
<td>14.6</td>
<td>12.0</td>
<td>18.8</td>
<td>15.1</td>
<td>18.2</td>
<td>14.4</td>
</tr>
<tr>
<td>CH&amp;SC</td>
<td>1.1</td>
<td>3.3</td>
<td>0.0</td>
<td>5.5</td>
<td>4.4</td>
<td>4.4</td>
<td>2.2</td>
<td>3.3</td>
<td>6.6</td>
<td>4.4</td>
<td>4.4</td>
<td>5.5</td>
<td>3.8</td>
</tr>
<tr>
<td>Women's and Children</td>
<td>6.9</td>
<td>2.3</td>
<td>11.6</td>
<td>9.3</td>
<td>4.6</td>
<td>2.3</td>
<td>6.9</td>
<td>2.3</td>
<td>6.9</td>
<td>9.3</td>
<td>4.6</td>
<td>2.3</td>
<td>5.8</td>
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<td>3.7</td>
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<td>1.9</td>
<td>0.0</td>
<td>0.0</td>
<td>0.9</td>
</tr>
<tr>
<td>Mental Health</td>
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<td>0.0</td>
<td>10.6</td>
<td>4.3</td>
<td>4.3</td>
<td>6.4</td>
<td>6.4</td>
<td>10.6</td>
<td>2.1</td>
<td>6.4</td>
<td>6.4</td>
<td>4.3</td>
<td>5.9</td>
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<td>Operational Services</td>
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<td>0.0</td>
<td>0.0</td>
<td>10.6</td>
<td>0.0</td>
<td>21.3</td>
<td>0.0</td>
<td>0.0</td>
<td>10.6</td>
<td>10.6</td>
<td>10.6</td>
<td>21.3</td>
<td>7.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>4.1</td>
<td>4.1</td>
<td>5.7</td>
<td>5.5</td>
<td>6.7</td>
<td>5.5</td>
<td>9.6</td>
<td>6.4</td>
<td>4.8</td>
<td>8.3</td>
<td>6.7</td>
<td>7.8</td>
<td>6.3</td>
</tr>
</tbody>
</table>

Table 9

* It is not possible to provide the rate of complaints in relation to patient episode as not all episodes are captured in an electronically searchable manner. Rate per 1,000 staff has therefore been selected as a proxy measure.
Definitions:
Stage One – complaints closed at Stage One Frontline Resolution;
Stage Two (direct) – complaints that by-passed Stage One and went directly to Stage Two Investigation (e.g. complex complaints);
Escalated Stage Two – complaints which were dealt with at Stage One and were subsequently escalated to Stage Two investigation (e.g. because the complainant remained dissatisfied)
All information from this point forwards relates to Complaints which have been completed i.e. have received a response.

**Indicator Five: Complaints closed at each stage**
“Details of the number of complaints responded to at each stage of the Complaints Handling Procedure.”

<table>
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<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Stage 1 Closed</td>
<td>11</td>
<td>6</td>
<td>3</td>
<td>9</td>
<td>9</td>
<td>7</td>
<td>8</td>
<td>12</td>
<td>6</td>
<td>8</td>
<td>7</td>
<td>13</td>
<td>99</td>
</tr>
<tr>
<td>% of all Closed</td>
<td>32.4%</td>
<td>21.4%</td>
<td>15.8%</td>
<td>24.3%</td>
<td>28.1%</td>
<td>20.6%</td>
<td>16.7%</td>
<td>27.9%</td>
<td>12.5%</td>
<td>21.6%</td>
<td>17.1%</td>
<td>28.3%</td>
<td>22.1%</td>
</tr>
<tr>
<td>Stage 2 - Escalated Closed</td>
<td>0</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>32</td>
</tr>
<tr>
<td>% of all Closed</td>
<td>0.0%</td>
<td>17.9%</td>
<td>15.8%</td>
<td>5.4%</td>
<td>6.3%</td>
<td>5.9%</td>
<td>6.3%</td>
<td>7.0%</td>
<td>4.2%</td>
<td>8.1%</td>
<td>7.3%</td>
<td>8.7%</td>
<td>7.2%</td>
</tr>
<tr>
<td>Stage 2 - Direct Closed</td>
<td>23</td>
<td>17</td>
<td>13</td>
<td>26</td>
<td>21</td>
<td>25</td>
<td>37</td>
<td>28</td>
<td>40</td>
<td>26</td>
<td>31</td>
<td>29</td>
<td>316</td>
</tr>
<tr>
<td>% of all Closed</td>
<td>67.6%</td>
<td>60.7%</td>
<td>68.4%</td>
<td>70.3%</td>
<td>65.6%</td>
<td>73.5%</td>
<td>77.1%</td>
<td>65.1%</td>
<td>83.3%</td>
<td>70.3%</td>
<td>75.6%</td>
<td>63.0%</td>
<td>70.7%</td>
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<tr>
<td>Total Closed</td>
<td>34</td>
<td>28</td>
<td>19</td>
<td>37</td>
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<td>43</td>
<td>48</td>
<td>37</td>
<td>41</td>
<td>46</td>
<td>447</td>
<td></td>
</tr>
</tbody>
</table>

Table 10

**Complaints by stage by month complaint closed**

![Chart 4](chart.png)

NOT PROTECTIVELY MARKED
Page 16 of 35
## Indicator Six: Complaints upheld, partially upheld and not upheld

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
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<th></th>
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<tbody>
<tr>
<td><strong>Stage 1</strong></td>
<td><strong>Upheld</strong></td>
<td># 7</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>7</td>
<td>5</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>2</td>
<td>52</td>
</tr>
<tr>
<td></td>
<td>% 63.6%</td>
<td>66.7%</td>
<td>100.0%</td>
<td>44.4%</td>
<td>55.6%</td>
<td>57.1%</td>
<td>87.5%</td>
<td>41.7%</td>
<td>50.0%</td>
<td>50.0%</td>
<td>57.1%</td>
<td>15.4%</td>
<td>57.4%</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Partially Upheld</strong></td>
<td># 2</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% 18.2%</td>
<td>33.3%</td>
<td>0.0%</td>
<td>33.3%</td>
<td>0.0%</td>
<td>14.3%</td>
<td>12.5%</td>
<td>25.0%</td>
<td>50.0%</td>
<td>50.0%</td>
<td>28.6%</td>
<td>23.1%</td>
<td>21.9%</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Not Upheld</strong></td>
<td># 2</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>8</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>% 18.2%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>22.2%</td>
<td>44.4%</td>
<td>28.6%</td>
<td>0.0%</td>
<td>33.3%</td>
<td>0.0%</td>
<td>25.0%</td>
<td>14.3%</td>
<td>61.5%</td>
<td>20.6%</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>11</td>
<td>6</td>
<td>3</td>
<td>9</td>
<td>9</td>
<td>7</td>
<td>8</td>
<td>12</td>
<td>6</td>
<td>8</td>
<td>7</td>
<td>13</td>
<td>99</td>
</tr>
</tbody>
</table>

| **Stage 2 - Escalated** | **Upheld** | # 0 | 1 | 1 | 1 | 0 | 0 | 2 | 0 | 1 | 0 | 1 | 2 | 9 |
|                        | % 0.0% | 20.0% | 33.3% | 50.0% | 0.0% | 0.0% | 66.7% | 0.0% | 50.0% | 0.0% | 33.3% | 50.0% | 25.3% |
|                        | **Partially Upheld** | # 2 | 2 | 1 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 6 |
|                        | % 0.0% | 40.0% | 33.3% | 50.0% | 0.0% | 0.0% | 0.0% | 0.0% | 50.0% | 0.0% | 33.3% | 0.0% | 17.2% |
|                        | **Not Upheld** | # 0 | 2 | 1 | 0 | 2 | 2 | 1 | 3 | 0 | 3 | 1 | 2 | 17 |
|                        | % 0.0% | 40.0% | 33.3% | 50.0% | 0.0% | 100.0% | 100.0% | 33.3% | 100.0% | 0.0% | 100.0% | 33.3% | 50.0% | 49.2% |
| **Total**             |        | 0 | 5 | 3 | 2 | 2 | 2 | 3 | 3 | 2 | 3 | 3 | 4 | 32 |

| **Stage 2 - Direct**  | **Upheld** | # 2 | 2 | 9 | 18 | 12 | 12 | 11 | 7 | 11 | 7 | 7 | 4 | 102 |
|                       | % 8.7% | 11.8% | 69.2% | 69.2% | 57.1% | 48.0% | 29.7% | 25.0% | 27.5% | 26.9% | 22.6% | 13.8% | 34.1% |
|                       | **Partially Upheld** | # 17 | 9 | 2 | 4 | 2 | 5 | 15 | 14 | 18 | 11 | 14 | 9 | 120 |
|                       | % 73.9% | 52.9% | 15.4% | 15.4% | 9.5% | 20.0% | 40.5% | 50.0% | 45.0% | 42.3% | 45.2% | 31.0% | 36.8% |
|                       | **Not Upheld** | # 4 | 6 | 2 | 4 | 7 | 8 | 11 | 7 | 11 | 8 | 10 | 16 | 94 |
|                       | % 17.4% | 35.3% | 15.4% | 15.4% | 33.3% | 32.0% | 29.7% | 25.0% | 27.5% | 30.8% | 32.3% | 55.2% | 29.1% |
| **Total**             |        | 23 | 17 | 13 | 26 | 21 | 25 | 37 | 28 | 40 | 26 | 31 | 29 | 316 |

Table 11
Outcome of all complaints Upheld or Partially Upheld by month complaint closed

Stage 1

![Stage 1 Graph]

Stage 2 - Escalated

![Stage 2 Escalated Graph]

Stage 2 - Direct

![Stage 2 Direct Graph]
Indicator Seven: Average response times
‘Details of the average time in working days to close complaints at each stage of the Complaints Handling Procedure.’

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Stage One (5 Working Days)</td>
<td>6</td>
<td>13</td>
<td>7</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>6</td>
<td>5</td>
<td>5</td>
<td>3</td>
<td>6</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Stage Two - Escalated (20 Working Days)</td>
<td>0</td>
<td>33</td>
<td>28</td>
<td>27</td>
<td>17</td>
<td>22</td>
<td>20</td>
<td>75</td>
<td>23</td>
<td>10</td>
<td>29</td>
<td>23</td>
<td>29</td>
</tr>
<tr>
<td>Stage Two - Direct (20 Working Days)</td>
<td>31</td>
<td>38</td>
<td>43</td>
<td>24</td>
<td>25</td>
<td>33</td>
<td>26</td>
<td>27</td>
<td>27</td>
<td>26</td>
<td>35</td>
<td>35</td>
<td>30</td>
</tr>
<tr>
<td>All Complaints</td>
<td>23</td>
<td>32</td>
<td>35</td>
<td>20</td>
<td>19</td>
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<td>25</td>
<td>24</td>
<td>20</td>
<td>29</td>
<td>26</td>
<td>25</td>
</tr>
</tbody>
</table>

Table 12

Average time for complaint to be closed

Stage 1 Complaints

Escalated to Stage 2

NOT PROTECTIVELY MARKED
Page 19 of 35
Direct to Stage 2

Chart 6

- Stage Two - Direct
- Median

Month Closed

No. of Working Days

- Target
Time for Complaint to be closed - Stage One

Chart 7
NB – One complaint responded to during the period had been ongoing for over a year. The service met with the complainant several times during that period and the complainant had requested some additional time to submit a Subject Access Request and consider the documents received in response.
**Indicator Eight: Complaints closed in full within the timescales**

‘Details of how many complaints were responded to within the timescales required by the Complaints Handling Procedure.’

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<thead>
<tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Closed Within Target</td>
<td>7</td>
<td>2</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>4</td>
<td>5</td>
<td>8</td>
<td>5</td>
<td>8</td>
<td>4</td>
<td>7</td>
<td>67</td>
</tr>
<tr>
<td>% Closed</td>
<td>63.6%</td>
<td>33.3%</td>
<td>66.7%</td>
<td>77.8%</td>
<td>88.9%</td>
<td>57.1%</td>
<td>62.5%</td>
<td>66.7%</td>
<td>83.3%</td>
<td>100.0%</td>
<td>57.1%</td>
<td>53.8%</td>
<td>67.7%</td>
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<td>3</td>
<td>9</td>
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<td>7</td>
<td>13</td>
<td>99</td>
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<td>Stage 2 - Escalated (20 Working Days)</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Closed Within Target</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>14</td>
</tr>
<tr>
<td>% Closed</td>
<td>0.0%</td>
<td>20.0%</td>
<td>66.7%</td>
<td>50.0%</td>
<td>100.0%</td>
<td>0.0%</td>
<td>66.7%</td>
<td>33.3%</td>
<td>0.0%</td>
<td>100.0%</td>
<td>33.3%</td>
<td>25.0%</td>
<td>43.8%</td>
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<tr>
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<td>3</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td>Stage 2 - Direct (20 Working Days)</td>
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<td></td>
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</tr>
<tr>
<td>Closed Within Target</td>
<td>13</td>
<td>10</td>
<td>5</td>
<td>12</td>
<td>9</td>
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<td>24</td>
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<td>17</td>
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<td>38.5%</td>
<td>46.2%</td>
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<td>32.1%</td>
<td>55.0%</td>
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<td>40</td>
<td>26</td>
<td>31</td>
<td>29</td>
<td>316</td>
</tr>
</tbody>
</table>

Table 13
Complaints closed in Set Timescale by month closed against a target of 70%

Stage 1 Complaints closed in 5 days

Escalated to Stage 2 closed in 20 days

Stage 2 Direct closed in 20 days
Indicator Nine: Number of cases where an extension was authorised

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

<table>
<thead>
<tr>
<th></th>
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<td>1</td>
<td>0</td>
<td>0</td>
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<td>0</td>
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<td></td>
<td>% Ext.</td>
<td>18.2%</td>
<td>16.7%</td>
<td>33.3%</td>
<td>0.0%</td>
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<td>28.6%</td>
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<td>13.3%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>11</td>
<td>6</td>
<td>3</td>
<td>9</td>
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<td>7</td>
<td>8</td>
<td>12</td>
<td>6</td>
<td>8</td>
<td>7</td>
<td>15</td>
</tr>
<tr>
<td>Stage 2 - Escalated (20 Working Days)</td>
<td>No. Ext.</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>% Ext.</td>
<td>0.0%</td>
<td>60.0%</td>
<td>33.3%</td>
<td>50.0%</td>
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<tr>
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<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
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</tr>
<tr>
<td>Stage 2 - Direct (20 Working Days)</td>
<td>No. Ext.</td>
<td>10</td>
<td>6</td>
<td>5</td>
<td>3</td>
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<td>12</td>
<td>9</td>
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<td>11</td>
<td>7</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>% Ext.</td>
<td>43.5%</td>
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<td>36.5%</td>
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<td>23.8%</td>
<td>48.0%</td>
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<td>21.4%</td>
<td>27.5%</td>
<td>26.9%</td>
<td>9.7%</td>
<td>27.6%</td>
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<td>28</td>
<td>40</td>
<td>26</td>
<td>31</td>
<td>29</td>
</tr>
</tbody>
</table>

Table 14

In complex complaints, it is sometimes necessary to go beyond the 20 working day timescale in order fully investigate and respond to issues raised. In such cases, the Complaints Handling Procedure requires an extension to be put in place and the complainant to be kept informed of progress.

The Board continues to issue responses over the 20 working day timescale without an extension being discussed with the complainant. There are already a number of provisions in place to support directorates with managing complaint timescales. The Datix system provides details of when complaint responses are due and regular Datix performance reports highlight overdue responses to directorates. Complaints training, templates and guidance documents provide supporting tools and information to assist directorates to manage timescales and the associated...
extension requirements. There are also feedback coordinators identified in each
directorate to track the progress of cases. Patient Services are actively reviewing the
cases that are going overdue without extension and are sharing findings with
Directorates along with an offer of support.

The Complaints Improvement Framework self assessment tool has standards that
relate to timescales and extensions. This issue will therefore be further explored and
addressed through that planned activity.
Complaints closed where extension to set timescale authorised by month closed

Stage 1 Complaints with authorised extension
- Stage One %  - Median

![Chart 10](image)

Escalated to Stage 2 Complaints with authorised extension
- Stage Two - Escalated %  - Median

![Chart 10](image)

Stage 2 Direct Complaints with authorised extension
- Stage Two - Direct %  - Median

![Chart 10](image)
2.5 Scottish Public Services Ombudsman Complaints

Individuals who are dissatisfied with NHS D&G’s complaint handling or response can refer their complaint for further investigation to the SPSO. At the time of producing this report, there were 8 live complaints with the SPSO for their consideration. Their status was recorded as follows:

<table>
<thead>
<tr>
<th>Case Status</th>
<th>A&amp;D</th>
<th>CH&amp;SC</th>
<th>MH</th>
<th>WC&amp;SH</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>File Requested</td>
<td>1</td>
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</tr>
<tr>
<td>The SPSO have received a new complaint and have requested our complaints file and the associated medical records</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under Investigation/File Sent</td>
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<td>2</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The SPSO are considering the complaint and files sent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Further Information Requested</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The SPSO have requested additional information</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Decision Letter Received – Recommendations Made</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>The SPSO have issued their decision and made recommendations to the Board</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decision Letter Received – No Recommendations Made</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>The SPSO have issued their decision and have not made any recommendations to the Board</td>
<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Action Plan Sent</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>We have responded to the Decision Letter providing evidence of those recommendations already undertaken and an action plan for those outstanding. At this stage we are awaiting the SPSO’s approval of what was provided.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report Laid Before Parliament</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The SPSO have decided to lay a report before Parliament.</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

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

Concordance with complaints timescales continues to be below target and to fluctuate. There are a number of reasons for this including the complexity of issues and capacity challenges. There also continues to be complaints that go over timescale without an extension being agreed with the complainant.

3. Conclusion

Concordance with complaint response timescales continues to present a challenge. Patient Services are working closely with services to ensure they are supported with training, templates, guidance and advice. Work is still required to ensure that the Board’s complaints provision is compliant with statutory requirements. The directorates are working through the Complaints Improvement Framework self assessment tool. This work will lead to agreed actions, with the intention of improving concordance with the Complaints Handling Procedure and in turn, an improved experience with the process for the complainant.
Appendix 3 - Complaints by Directorate and month received

*Data for other directorates under development at this point. It is worthy of note that the context around Acute changed with the opening of a new hospital in Dec 2017. The increase in complaints at this point is a recognised phenomenon. In addition information around how to provide feedback, including complaints was made readily available in the bedside folders at the point of the new DGRI opening.
Appendix 4 – Learning

**What happened?** Provide a brief background to the complaint (anonymised)

The forensic examination was delayed due to an emergency case being reviewed. Nursing staff did not communicate the reason for this delay or keep the parent informed of when the examination would take place.

The child was inappropriately discharged from the ward at 23.00 hours and the parent had no means of transport.

**What went well?**

The complainant had no issues with the manner in which the staff spoke to her and she advised that they were also accommodating when she needed to leave the Paediatric Ward due to experiencing a panic attack.

**What, if anything, could we improve?**

Communication between the ward staff and parents regarding the timing of the forensic examinations and the discharge arrangements

The Clinical Director for Child Health & Paediatrics and the Senior Paediatric Nursing Team recognise the need to review the process of forensic examinations on the ward. With the aim of ensure that such examination are carried out on a more timely basis as this child waited three days for their examination.

**What have we learnt?**

The nursing staff need to be recognise the importance of keeping families up to date with any changes in planned procedures.

The nursing staff need to assess the circumstances of discharges particularly out of hour and when the parent do not have access to their own transport.

**What actions are planned or have been taken?**

The Clinical Manager will raise the issue in relation to families not being kept up to date with changes in the timings of planned procedures at the next Paediatric Ward Staff Meeting on the 20 November 2019.

The Clinical Manager and the Senior Nurses Team on the Paediatric will raise the issue of inappropriate discharges with the nursing staff at the next Paediatric Ward Staff Meeting on the 20 November 2019.

As a result of this complaint were any services – IMPROVED X COMMUNICATION X
What happened? Provide a brief background to the complaint (anonymised)

Father was unhappy with manner in which the nurse disposed of his child’s juice/water bottle and that this made him feel his parenting skills were poor.

What went well?

Discussion with father and Investigating Officer was productive. Father felt that he had been listened to and accept apology for staff member’s inappropriate manner.

What, if anything, could we improve?

Staff member’s manner could have been more sensitive and appropriate in relation to the disposal of the juice/water bottle.

What have we learnt?

Staff member involved acknowledged that the manner in which she spoke to family member was inappropriate.

What actions are planned or have been taken?

Ward staff, including the Nurse in charge will undertake a course in relation to ‘Good Conversations’ as part of their on-going professional development. The Clinical Manager has confirmed that the training in relation to “Good Conversations” will be included in the planned CPD programme on Wednesday 11 and 18 December 2019.

As a result of this complaint were any services – IMPROVED X
Stories in summary

**About this report**
This report shows summary information about a selection of stories published on Care Opinion.

It was created on **08 November 2019**.

**Which postings are included?**
This report shows stories in the **NHS Dumfries and Galloway** subscription, which includes All stories about NHS Dumfries and Galloway.

The report is also filtered to show only All stories submitted between 01/09/2019 and 31/10/2019

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**Frequently asked questions**

**How is story criticality rated?**
Story criticality is rated by our moderators at the time each story is moderated. It is a measure of how critical the most critical part of a story is, according to a criterion-based system. Criticality is rated in order to support our filtered email alerting system for staff, and is not intended for publication.

**What do the story counts mean?**
To the right of an organisation/service you will see a count. This tells you the number of stories listed in the report about that organisation or service (including any services run by that organisation/service).

**What does "most popular" mean?**
The most popular stories are those which have been read most often per day, since publication. This measure does produce a small bias towards more recent stories, but at least it is simple to understand.

**Why might unexpected services appear in my report?**
The services listed in the report depend on the stories that are included, and that depends on how you have filtered the report. So, for example, if you have filtered only according to where authors live, you may find they have used services some distance away.

---

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**About Care Opinion**
Care Opinion is a not-for-profit social enterprise which enables people to share the story of their care, and perhaps help care services make changes.

[For more information](https://www.careopinion.org.uk), contact us via: https://www.careopinion.org.uk
This report summarises **21** stories

To date, the stories in this report have been viewed on Care Opinion **1,087** times in all

These are the three most popular stories, out of all the stories included in this report

*You can click the story title to see the story online*

---

**Poor communications and care failures - 92 views**

Posted by squeaky13 as a carer Last month

Husband was admitted to DGRI Dumfries on the evening of 6th. On 7th staff at the assessment unit were given a copy of his Cardiology outpatients appointment also at DGRI for 11th. The ward staff would liaise with Cardiology.

On 8th he was transferred to ward D7 room 18. Staff here were also informed of the Cardiology appt.

On 11th I arrived at the ward around 1000. He was brighter. He was sitting in bed attempting to take his tablets...

---

**Excellent service - Rapid Response - 87 views**

Posted by woodpeckertn67 as a service user 2 months ago

Today I had a fall, called the ambulance services, who then referred me to a team called RAPID RESPONSE who came out to see me the same day.

RAPID RESPONSE was a great help - supported me with my mobility, issuing elbow crutches which improved my walking and made me more steady at walking in the house, keeping me steady & safe at home. Issued me a grabber to support me as I have a bad back and struggle to bend - I can now reach lower half...

---

**I feel so let down - 83 views**

Posted by ellephant as a service user 2 months ago

I feel so let down, by everyone I have met in the adult team.

More than half of my appointments since December have been cancelled, some of them on the same day. It feels like nobody answers your calls even if you leave a message.

I feel belittled, unimportant, and most of the time invisible.

There have been times I have been told things by a member of staff which I considered inappropriate. I find this completely unacceptable. I feel...
When these stories were told

<table>
<thead>
<tr>
<th>Month</th>
<th>Number published in month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sep</td>
<td>14</td>
</tr>
<tr>
<td>Oct</td>
<td>7</td>
</tr>
</tbody>
</table>

How the authors of these stories identify themselves

- A relative: 24%
- A service user: 43%
- A carer: 24%
- The patient: 10%
Where these stories have come from

<table>
<thead>
<tr>
<th>Location</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Dumfries and Galloway</td>
<td>18</td>
</tr>
<tr>
<td>Unknown</td>
<td>3</td>
</tr>
</tbody>
</table>

Most common tags added by authors to these stories

**What's good?**
- staff: 5
- helpful: 3
- assessment: 2
- attentive: 2
- Care: 2
- professional: 2
- team: 2
- thorough: 2
- wonderful: 2
- advice: 1
- ambulance crew: 1
- app: 1
- approachable: 1
- attention: 1
- Care Assistant: 1

**What could be improved?**
- communication: 3
- Care: 2
- examination: 2
- kept informed: 2
- access to services: 1
- accuracy: 1
- admin: 1
- administering medication: 1
- answer the phone: 1
- appointments: 1
- attention: 1
- cancelled appointments: 1
- conflicting information: 1
- delays: 1
- diagnosis: 1

**Feelings**
- thank you: 8
- safe: 4
- fantastic: 3
- annoyed: 2
- at ease: 1
- belittled: 1
- blessed: 1
- brilliant: 1
- confidence: 1
- crisis: 1
- delighted: 1
- demoralised: 1
- desperate: 1
- fear: 1
- Feeling: 1
<table>
<thead>
<tr>
<th>Services the stories are about</th>
<th>Number of stories</th>
<th>Latest story</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NHS Dumfries and Galloway</strong></td>
<td><strong>21</strong></td>
<td><strong>28/10/2019</strong></td>
</tr>
<tr>
<td>Dumfries &amp; Galloway Community Services</td>
<td>11</td>
<td>28/10/2019</td>
</tr>
<tr>
<td>Midwifery</td>
<td>1</td>
<td>05/09/2019</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>1</td>
<td>18/09/2019</td>
</tr>
<tr>
<td>Rapid response service</td>
<td>9</td>
<td>28/10/2019</td>
</tr>
<tr>
<td>STARS (Short Term Assessment Reablement Service)</td>
<td>1</td>
<td>14/10/2019</td>
</tr>
<tr>
<td><strong>Dumfries &amp; Galloway Royal Infirmary</strong></td>
<td><strong>9</strong></td>
<td><strong>24/10/2019</strong></td>
</tr>
<tr>
<td>Accident &amp; Emergency</td>
<td>1</td>
<td>18/09/2019</td>
</tr>
<tr>
<td>Cardiology</td>
<td>1</td>
<td>17/09/2019</td>
</tr>
<tr>
<td>Service</td>
<td>Total</td>
<td>Date</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-------</td>
<td>------------</td>
</tr>
<tr>
<td>Care of the Elderly</td>
<td>1</td>
<td>21/10/2019</td>
</tr>
<tr>
<td>Day Surgery</td>
<td>2</td>
<td>24/10/2019</td>
</tr>
<tr>
<td>General Medicine</td>
<td>1</td>
<td>27/09/2019</td>
</tr>
<tr>
<td>General Surgery</td>
<td>1</td>
<td>26/09/2019</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>2</td>
<td>21/10/2019</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>1</td>
<td>17/09/2019</td>
</tr>
<tr>
<td>Midpark Hospital</td>
<td>1</td>
<td>05/09/2019</td>
</tr>
<tr>
<td>Adult psychiatry</td>
<td>1</td>
<td>05/09/2019</td>
</tr>
</tbody>
</table>
Story and response listing

About this report
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It was created on 08 November 2019.

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Frequently asked questions
How do I find the original story online?
If you are viewing the report on a computer, you may be able to click the reference number to the right of the story. This will take you to the story online. If you are viewing the report on paper, you can find story number X online at: https://www.careopinion.org.uk/X

Why might a story appear more than once in the list?
Some stories are about more than one service. If so, the story will be listed under each service it is about.

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What do the view counts mean?
The view count to the right of a story tells you the number of times the story has been viewed on Parameters!SiteName.Value by public users (excluding subscribers and the PO team).

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About Care Opinion
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My father had his first treatment of radio nucleotide therapy in London in August 2019, having been diagnosed with reoccurring NET cancer 3 years ago. The symptoms of his cancer is severe pain and fatigue. He has had to retire early at 56 years old as he is not fit to continue. As we are from Dumfries we were getting nervous as no date was through for next treatment. It is supposed to be 8 to 12 weeks for optimum results. Meaning next treatment was due in October. The date we have had to chase exhaustively is now late November. All the staff are excellent and provide exceptional care, but this cancer is killing him and there are no more treatment options, can anyone tell me why there is such a delay? I would dearly like to know why my father is being put through such admin stress when he is fighting for his life. This is no little matter. Any help is gratefully received.

Annette Finnigan
Senior Patient Experience & Safety Officer
NHS Dumfries and Galloway
21/10/2019

Dear sggibs,

I am sorry to hear that your father has experienced delays. If you could contact our Patient Experience Team on 01387 241690 or via dumf-uhb.acutequeries@nhs.net and provide your father's details, we would like to look at this in detail for you.

Regards, Annette

sggibs

Thank you Annette, I will email you.

Karen King
Head of Midwifery/Consultant Midwife
NHS Dumfries and Galloway
16/09/2019

I have had excellent experiences so far with the maternity services in a Dumfries.

The issue I would encourage you to address, however, is that I believe it is your policy to not signpost expectant parents to third or private sector services working in the locality.

You provide a very comprehensive app with a multitude of leaflets on that are very helpful, but, again, there are no leaflets advertising the third or private sector services.
Hi Pelinorwonder

I am very pleased to hear that your experience of maternity services has been so positive. I would also like to thank you for drawing our attention to the need to improve how we signpost expectant parents to other services.

As you may know maternity services across Scotland are currently in the process of implementing the Best Start plan for maternity and neonatal services in Scotland. I will ensure that this is taken forward as part of this work.

I would also like to take this opportunity to invite you to be part of the Best Start and shaping our services locally and if you think you may be interested in doing so please do not hesitate to get in touch.

Kind regards,

Karen King

Pelinorwonder

Hi Karen,

Thanks for responding.

For some reason my post doesn't appear to have been included in full. I hope that you were able to view the full post!

It would be great to be involved as you take the Best Start plan forward so please do keep a note of my contact details in case you're able to include me in any consultation etc.

Thanks!

Gina Alexander Director, Care Opinion Scotland Care Opinion 16/09/2019

Hi Pelinorwonder

I just read your last comment and realise we haven't communicated the way we should have. I am sorry about that.

We review any story we get against our moderation policy which you can [read here](http://careopinion.org.uk/info/moderation). We prefer stories to be about direct personal experiences of actual care. I think your story may have included other information which we didn't feel met this criteria and so we removed it. Karen and colleagues only receive the information which we publish on the website.

When we edit someone's story significantly we should really explain via email. Again I am sorry we didn't do that here.

Many thanks for taking the time to use Care Opinion and it's great to see that your feedback will inform change.

Best wishes

Gina

Pelinorwonder

Thanks for letting me know!
Care after a fall

couragerj47 a relative 18/09/2019

Mum attended A/E following a fall in September ‘19 (mum is 87 years of age)

She had a large lump on the back of her head and a very painful knee. We were in A&E for a total of 3 hours and at no point did they do any obs, BP, pulse or anything else and did not examine her or looked at bump on her head. Eventually sent her for a CT scan and xrayed knee and all normal. Mum was discharged home and informed that OT would be in touch the next day.

Had three phone calls in total from OT and rapid response team who came out and assessed mum including full obs, assessment, advise and reassurance. Great service and very obliging and friendly members of staff. Great backup at a very stressful time for a family.

Michaela Cannon  Patient Feedback and Complaints Co-ordinator  NHS Dumfries & Galloway 18/09/2019

Thank you very much for your feedback couragerj47, it is most gratefully received.

The Rapid Response Team work closely with our colleagues in A&E and we aim to keep people safe and well at home.

I am very pleased that we have been able to assist your Mum.

If we can help you with anything else or if you have any queries regarding Health and Social Care then please do not hesitate to contact the Single Point of Contact (SPoC) on 030 33 33 3001.

Thank you again for taking the time to feedback.

Kind Regards

Ruth Millican

(Rapid Response Clinical Team Leader)

Rapid response service

Excellent service - Rapid Response

woodpeckertn67 a service user 04/09/2019

Today I had a fall, called the ambulance services, who then referred me to a team called RAPID RESPONSE who came out to see me the same day.

RAPID RESPONSE was a great help - supported me with my mobility, issuing elbow crutches which improved my walking and made me more steady at walking in the house, keeping me steady & safe at home. Issued me a grabber to support me as I have a bad back and struggle to bend - I can now reach lower half (feet). RAPID RESPONSE also looked at my shower & now I am getting grab rails to support my balance in the shower.

I am very pleased with the service I have had today.

Excellent service.

Kenny McFadzean  Head of Service, Dumfries & Galloway Scottish Ambulance Service 04/09/2019
Hi Woodpeckertn67,

thank you for your posting, it is nice to receive feedback from patients who have benefited from the falls pathway of which SAS are an integral part.

I am glad to hear that the support you received following the home visit was beneficial in making you safer at home.

Kind Regards

Kenny McFadzean,

Emma Murphy  Patient Feedback Manager  NHS Dumfries and Galloway  06/09/2019

Thank you very much for your feedback woodpeckertn67, it is most gratefully received.

The Rapid Response Team work closely with our Scottish Ambulance Service colleagues and aim to avoid hospital admissions where possible and keep people safe and well at home. I am very pleased that we have been able to assist you.

If we can help you with anything else or if you have any queries regarding Health and Social Care then please do not hesitate to contact the Single Point of Contact (SPoC) on 030 33 33 3001.

Thank you again for taking the time to feedback.

Kind Regards

Ruth Millican

(Rapid Response Clinical Team Leader)

Thank you for being so thorough

omegahg86  a relative  04/09/2019

Over the past year and half Dad who is in his 90's has been falling the ambulance team come and get him back on his feet and mentioned slow pulse he gets taken into hospital to be on safe side, and recently after last fall changed a pill after visit from the doc.

Yesterday another fall ambulance called this time the ambulance technician phoned First Response to pay a visit. Lady came gave Dad a good check over slow pulse she in turn phoned doc practice giving them her findings another lady from the F.R. came this morning another examination. While doing this, Doc from practice came for visit and between them decided dad needs to see heart specialist. I would like to thank First Response for being so thorough

What was good?We would have been no further forward if the First Response team had not been involved

How did it make you feel?Reassured

What could have been better?If this intense care had happened sooner

Alan Martin  Patient Experience Manager  Scottish Ambulance Service  06/09/2019
Dear Omegahg86,

Thank you very much for taking the time to share your feedback on CareOpinion. I am sorry to read about what your father has had to endure over the past 18 months. This must be quite a challenging time for all of you with recurrent falls.

I am however pleased to read about the positive experience that you write about. Much work is being done to try and create and utilise alternative care pathways for patients so that not everyone gets taken into hospital every time. It is about what is right for the patient at that time and it would appear that this is what has happened here. Through collaborative working have provided what will hopefully be a better situation.

I wish you and your father all the very best and thank you again.

Kind Regards

Alan

Emma Murphy  Patient Feedback Manager NHS Dumfries and Galloway  06/09/2019

Thank you very much for your feedback omegahg86, it is most gratefully received.

The Rapid Response Team aim to provide a great service and our Advanced Nurse Practitioner (ANP), who is fairly new to the team, is proving to be of great benefit, as your feedback demonstrates. We are delighted to hear this and also that your Dad will now get appropriate attention and care – we wish him well.

We work closely with our Scottish Ambulance Service (SAS) colleagues to attend to people who have fallen to prevent hospital admissions where possible and aim to keep people safe and well at home.

If we can help you or your Dad with anything else or if you have any queries regarding Health and Social Care then please do not hesitate to contact the Single Point of Contact (SPoC) on 030 33 33 3001.

Thank you again for taking the time to feedback, and all our best to your Dad.

Kind Regards

Ruth Millican

(Rapid Response Clinical Team Leader)

Thanks from the bottom of my heart

runningpj93  a service user  09/09/2019

I am more than delighted about the wonderful service, Anita from Rapid Response, has given me today. Emotionally and mentally she has answered all questions I was worried about when I arrived from DGRI. Did not imagine I would find such a lovely person to put my mind at rest.

I have to say this new service is so needed. All patients will be feeling more safe.

I now feel superb. Before Anita arrived I was extremely worried. She has put everything into place for me, my mind is at ease. I did not know such a wonderful service is available. Thanks from the bottom of my heart.

Michaela Cannon  Patient Feedback and Complaints Co-ordinator NHS Dumfries & Galloway  10/09/2019
Thank you very much for your feedback runningpj93, it is most gratefully received.

The Rapid Response Team aim to keep people safe and well at home.

I am very pleased that we have been able to assist you. I will pass on your kind words to Anita.

If we can help you with anything else or if you have any queries regarding Health and Social Care then please do not hesitate to contact the Single Point of Contact (SPoC) on 030 33 33 3001.

Thank you again for taking the time to feedback.

Kind Regards

Ruth Millican (Rapid Response Clinical Team Leader)

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couragerj47 a relative 18/09/2019

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Michaela Cannon Patient Feedback and Complaints Co-ordinator NHS Dumfries & Galloway 18/09/2019

Thank you very much for your feedback couragerj47, it is most gratefully received.

The Rapid Response Team work closely with our colleagues in A&E and we aim to keep people safe and well at home.

I am very pleased that we have been able to assist your Mum.

If we can help you with anything else or if you have any queries regarding Health and Social Care then please do not hesitate to contact the Single Point of Contact (SPoC) on 030 33 33 3001.

Thank you again for taking the time to feedback.

Kind Regards

Ruth Millican

(Rapid Response Clinical Team Leader)
Fantastic in every way

mercurygh84 a service user 19/09/2019

My partner was a patient in Dumfries and Galloway Hospital for 4 months in 2016 then in Castle Douglas for 5 months after 2 massive strokes and pneumonia.

On returning home we were assigned 2 carers 4 times a day as he is completely paralysed down his left side.

I had no idea the problems I would have to deal with and to back up. The carers tried to control the situation.

Moving to June 2019, home after a near death experience in hospital. Septic shock. 2 weeks in Hospital in Critical Care.

We had the pleasure, meeting Michelle, Anna & team from Rapid Response. They were fantastic in every way. I cannot praise them enough. They have given me hope in the NHS.

Thank you girls

Ruth Millican Rapid Response Service, Team Lead NHS Dumfries and Galloway 19/09/2019

Thank you very much for your feedback mercurygh84, it is most gratefully received.

The Rapid Response Team aim to keep people safe and well at home.

I am very pleased that we have been able to assist you and your partner. I will pass on your kind words to Michelle and Anna.

If we can help either of you with anything else or if you have any queries regarding Health and Social Care then please do not hesitate to contact the Single Point of Contact (SPoC) on 030 33 33 3001.

Thank you again for taking the time to feedback.

Kind Regards

Ruth Millican (Rapid Response Clinical Team Leader)

Peace of mind for 3 daughters living at least 80 miles away.

cygnuswx74 a relative 26/09/2019

Our 91 year old mother became rather unwell last weekend. She lives independently although she has dementia, loves her house and garden and wants to carry on staying where she is.

Her GP assessed her, fast tracked extra care through the Rapid Response team.

The RRT sent Anna then Joan out to check the house, my mother and assess her needs. By 11am two days later we have carers arranged to come every morning for a short time, an appointment with CareCall coming to sort her out with a wrist band etc. Peace of mind for 3 daughters living at least 80 miles away.

Fantastic

Michaela Cannon Patient Feedback and Complaints Co-ordinator NHS Dumfries & Galloway 30/09/2019
Thank you very much for your feedback cygnuswx74, it is most gratefully received.

The Rapid Response Team work closely with our GP colleagues and aim to avoid hospital admissions where possible and keep people safe and well at home.

I am very pleased that we have been able to assist your Mum.

I will pass on your kind feedback to Anna and Joan.

If we can help you or your Mum with anything else or if you have any queries regarding Health and Social Care then please do not hesitate to contact the Single Point of Contact (SPoC) on 030 33 33 3001.

Thank you again for taking the time to feedback.

Kind Regards

Ruth Millican
(Rapid Response Clinical Team Leader)

Very approachable and understanding

lacertaxh98 a service user 26/09/2019

Came home from two hospital visits very weak and no confidence in ability to manage everyday life. The Rapid Response team (Ann) suggested lots of ways to help and had them in place the same day and they have changed many parts of being able to cope with confidence and assurance.

Very approachable and understanding and we are very grateful

Michaela Cannon Patient Feedback and Complaints Co-ordinator NHS Dumfries & Galloway 30/09/2019

Thank you very much for your feedback lacertaxh98, it is most gratefully received.

The Rapid Response Team aim to keep people safe and well at home.

I am very pleased that we have been able to assist you.

I will pass on your kind feedback to Anna.

If we can help you with anything else or if you have any queries regarding Health and Social Care then please do not hesitate to contact the Single Point of Contact (SPoC) on 030 33 33 3001.

Thank you again for taking the time to feedback.

Kind Regards

Ruth Millican
(Rapid Response Clinical Team Leader)

I had a beneficial meeting with rapid response

libraqn67 a relative 22/10/2019

Just to say I had a beneficial meeting with rapid response and thought the lady was very efficient and made us feel very comfortable in the advice she gave us. i.e. wheelchair, services and to support needed and the assistance required.

Ruth Millican Rapid Response Service, Team Lead NHS Dumfries and Galloway 23/10/2019
Thank you very much for your feedback libraqn67, it is most gratefully received.

The Rapid Response Team aim to provide a great service and keep people safe and well at home.

If we can help you or your relative with anything else or if you have any queries regarding Health and Social Care then please do not hesitate to contact the Single Point of Contact (SPoC) on 030 33 33 3001.

Thank you again for taking the time to feedback.

Kind Regards

Ruth Millican

(Rapid Response Clinical Team Leader)

Fantastic service  

normazq56 a service user 28/10/2019

Fantastic Service

Nurse definitely knew all about service. Great service available for the public, only wish it was advertised more. Has definitely helped my mother's situation greatly, will be telling everybody I know about this service, hopefully will be about for a long time.

Keep up the great work.

Staff are brilliant  

Charon a service user 14/10/2019

Emergency home care cover. Staff are brilliant. A special thanks to Katie for organising everything and setting up

Would recommend? (Friends and family test): Extremely likely
Dumfries & Galloway Royal Infirmary

Hospital injury

squeaky13 a carer 24/09/2019

A new (to us) Clinical Assistant came in and asked about my husband’s morning hygiene. I explained that I had previously been shooed out to the Socialisation Space while two staff carried out the procedure for him, but that I was willing to observe or assist as I had carried out personal care for him before his hospitalisation and would do so again after his discharge.

The Assistant received approval for me to help this time. All was well until we checked his catheter tube and urethra. There was staining on the pad he had been wearing and an 8 to 10mm tear in the lower part of his urethra. We completed the hygiene and I asked that a doctor be informed. I was told that he would see us shortly as part of his rounds. The doctor agreed with my suggestion that we restart intermittent self-catheterisation (which had been the system at home for the past 10 or 11 months). Some analgesic was applied to my husband's urethra.

Previously two days before he had complained of soreness in that area whilst he was being hoisted into the bedside chair. I alerted the physiotherapists as to the likely cause … his indwelling catheter being pulled by the under-leg sling.

The day before I saw the tear, a staff (I cannot recall which one) member referred to his catheter and some blood. I made the wrong decision to assume that this meant blood in the urine which sometimes happens, rather than investigating further. Had the morning hygiene staff carried out a thorough examination, the source and the cause of the blood would surely have been discovered and remedial action taken. Also that day he was unwilling to do physio, more than likely because of the above, and so a day’s opportunity was missed through this trauma not being identified.

Annette Finnigan Senior Patient Experience & Safety Officer NHS Dumfries and Galloway 04/10/2019

Dear squeaky13,

Thank you for taking the time to share your experience with us.

I understand that the Senior Charge Nurse and Nurse Manager have spent some time with you and your husband in order to discuss your concerns directly.

I know that you have also contacted our Patient Experience Team and that we will be responding to your concerns via that channel aswell.

I am sorry that you have had to raise concern regarding the care being provided to your husband and I hope that we can continue to work together to resolve your concerns and improve your experience.

Regards,

Annette
Care after a fall
couragej47 a relative 18/09/2019

Mum attended A/E following a fall in September ’19 (mum is 87 years of age)

She had a large lump on the back of her head and a very painful knee. We were in A&E for a total of 3 hours and at no point did they do any obs, BP, pulse or anything else and did not examine her or looked at bump on her head. Eventually sent her for a CT scan and xraye knee and all normal. Mum was discharges home and informed that OT would be in touch the next day.

Had three phone calls in total from OT and rapid response team who came out ans assessed mum including full obs, assessment, advise and reassurance. Great service and very obliging and friendly members of staff. Great backup at a very stressful time for a family.

Michaela Cannon  Patient Feedback and Complaints Co-ordinator NHS Dumfries & Galloway 18/09/2019

Thank you very much for your feedback couragej47, it is most gratefully received.

The Rapid Response Team work closely with our colleagues in A&E and we aim to keep people safe and well at home.

I am very pleased that we have been able to assist your Mum.

If we can help you with anything else or if you have any queries regarding Health and Social Care then please do not hesitate to contact the Single Point of Contact (SPoC) on 030 33 33 3001.

Thank you again for taking the time to feedback.

Kind Regards

Ruth Millican

(Rapid Response Clinical Team Leader)
Husband was admitted to DGRI Dumfries on the evening of 6th. On 7th staff at the assessment unit were given a copy of his Cardiology outpatients appointment also at DGRI for 11th. The ward staff would liaise with Cardiology.

On 8th he was transferred to ward D7 room 18. Staff here were also informed of the Cardiology appt.

On 11th I arrived at the ward around 1000. He was brighter. He was sitting in bed attempting to take his tablets from a small medicine pot. Some of them had spilled over the bed covers ... he has dexterity difficulties. I helped him take them with his dilute squash. Later I advised a nurse (and later a junior doctor) that, in my absence, my husband would need staff help to take his meds. On 12th a nurse had indeed helped him with his meds. However, on 13th, the pot was there full of untaken tablets. He was reluctant to take them. He was demoralised which is understandable. He had steadily deteriorated in his time in hospital with no sign of a meaningful diagnosis.

Back on 11th, I had reminded various staff of my husband's Cardiology appt. At 1430 I spoke to nurse to ask what the plan was for the appt. The nurse was unclear as to whether he would go over to Cardiology or staff would come to see him. They kindly offered to phone Cardiology to find out. The response was that they didn't take in-patients at the out-patients dept and that usually the appt would be rebooked for a later date. I told the nurse that this was not acceptable as we had already waiting 3 months for this Cardiology appt. The nurse called that dept back to express to them my concern. The response was that my husband would have an 'echo' test of his heart on the ward the following day and from that the ward doctors would liaise with Cardiology.

On 12th had visits from the physiotherapists and the consultant. The consultant explained that a previous xray of his stomach may have indicated a possible retention of gas so he would have a CT scan of the same area that day. At 1600 a junior doctor came to put a cannula in his arm ready for the scan. The doctor said they were in a hurry as the porters were on their way to collect him. At 1700 the porters had not arrived and meals were being handed out. I explained to the clinical assistant that my husband was expecting to go for a scan. It was unclear as to whether he should eat or not but decided it was better to miss dinner just in case. By 1845 nothing had happened to I asked 2 nurses who said they didn't think the scan would be happening today due to the late time. Also the porter had arrived but there was an issue with the wrong type of bed or trolley?

The fact that no-one had told us that there were problems is unacceptable. We had both psyched ourselves up for 2 tests that day but none were going to happen. I expressed my dissatisfaction with this to the senior junior doctor on duty at 1000 the following day, 13th. I also was concerned about my husband's very poor liquid intake and risk of dehydration, especially in view of the haematologist's 2012 instruction that his blood meds required that he takes lots of fluids. Apparently there are no longer key workers or nurses in charge of particular patients.

It has been very frustrating watching my husband decline and at the same time be fighting for him to have the care that he deserves. I realise staff are stretched but, down the line, it could be them or their loved ones in his position.

Annette Finnigan  Senior Patient Experience & Safety Officer NHS Dumfries and Galloway 17/09/2019

Dear squeaky13,

I am sorry to hear of your husband's experience in DGRI and I thank you for bringing this to our attention. It is disappointing to hear that we have not provided the high level of care that we would expect our teams to provide to all of our patients.

If you would be prepared to contact our Patient Experience & Safety Team directly on either 01387 241690 or via dumf-uhb.acutecomplaints@nhs.net we would like to look at this in more detail.

Regards, Annette
Communication difficulties
squeaky13 a carer 21/10/2019

Communications difficulties include ambulance trips, recordings of meds and fluids, and staff not following through on promises.

**Ambulances -** On one occasion we were advised by the consultant to be ready by 1030 in the morning in readiness for Opthamology Dept. appointment at 11.45. On the day, we watched the dial of the clock go around with increasing agitation. I spoke to a nurse who assured me that we had not been forgotten. Ambulance crew arrived at 11.32. While transferring to their stretcher, they confessed that they had been to the ward previously to collect a patient who had already made private transport arrangements but they had not been aware at that time that we were to be collected at the same time and hence the delay. What annoyed me was the crew's blase attitude, laughing as though this sort of confusion was a regular thing. It feels to me is as if there is an inertia, a culture of acceptance that standards will inevitably be poor. This is not helpful to the wellbeing of either the patient, or myself as his carer. In the wait, he was all for setting off to the appointment in a wheelchair!

Thankfully the staff at Opthamology accepted our late arrival and gave him the best optical assessment they could under the circumstances.

**Records -** My husband does not drink as much as he used to and this concerns me, especially as the lead Haematologist was very adamant that he should drink good quantities to deal with his meds. This was back when he was first diagnosed with Essential Thrombocythemia. In the first week I was reassured that blood tests would reveal if he was dehydrated or not. It turned out 'not' but recently the blood test frequency has reduced and now it must be several days since his last one.

Meanwhile on his fluid balance chart it states that during the night my husband took 100ml of a 200ml drink. I was with him all night and he certainly didn't have anything to drink at that time as he was sound asleep. I bring him drinks from the canteen and make him fruit squashes but nobody asks how much of these he has taken. Apart from when I leave notes, I haven't seen anybody record his urine output.

**Medications -** Sometimes my husband will refuse some meds. These we leave in the meds pot and I explain to the next nurse that these are rejects. But, from what have seen the staff always bin these rejects without any apparent recording of what was actually taken and what was not. This did change this morning when a new (to us) nurse left a paper note. The computer system seems to assume that meds dispensed equals meds taken.

The Physio staff have been very kind and helpful but they did promise an exercise sheet last week. This was so that I could help my husband keep more movement but the sheet has not been forthcoming. Can we please have what was promised?

Annette Finnigan Senior Patient Experience & Safety Officer NHS Dumfries and Galloway 24/10/2019

Dear squeaky13,

I am aware that you have previously raised concerns which were addressed by the ward staff so I am sorry to read that you have experienced further challenges. I will ensure that your feedback is shared with the ward to allow staff to reflect upon the points that you have raised. I will also contact the Physiotherapy Department and ask that your husband's exercise sheet is forwarded to you.

Regards,

Annette

Kenny McFadzean Head of Service, Dumfries & Galloway Scottish Ambulance Service 24/10/2019
Hi Squeaky13, thank you posting your concerns with regards to Ambulance attendance time for an Ophthalmology appointment for the patient you care for. I am sorry that your experience with the Scottish Ambulance Service did not meet your expectations and we are happy to discuss this further with you.

If you wish to do so, Frances Johnstone, Area Service Manager will be happy to discuss your experience with our Service and hopefully alleviate some of your concerns. She can be contacted on 0780 179 2435 or via e-mail [fjohnstone@nhs.net](mailto:fjohnstone@nhs.net).

Regards

Kenny McFadzean HOS

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Thanks to the team
merrington a service user 10/09/2019

I had a Colonoscopy last week and wanted to thank the team under Dr Darroch, the Endoscopist, for the care and attention I received.

I had no idea this site existed until my daughter in law, who works for the NHS, gave me the link.

Anyway my sincere thanks to all for the superb treatment from start to finish.

Kind regards,

Would recommend? (Friends and family test): Extremely likely

Annette Finnigan  Senior Patient Experience & Safety Officer  NHS Dumfries and Galloway 10/09/2019

Dear merrington,

Thank you for taking the time to share your feedback with us. I am pleased that you were well looked after by the team and I am sure they will be delighted to hear your kind words, which I will of course share with them.

Kind regards,

Annette

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Excellent service from start to finish
HappyPatient86 a service user 24/10/2019

Excellent service from start to finish today. The staff are very professional, thorough and attentive. I would like to thank the pre-assessment, dsu, anaesthetic, surgical and theatre staff for looking after me so well.

&nbsp;

Emma Murphy  Patient Feedback Manager  NHS Dumfries and Galloway 01/11/2019

Dear HappyPatient86,

Thank you for taking the time to provide your feedback. I am pleased to hear that you had such a positive experience and I know the teams concerned will be grateful for your kind words.

Best wishes

Emma Murphy

Patient Feedback Manager
Bed sores & communication
squeaky13 a carer 27/09/2019

He wanted to use the toilet for his bowels. A Clinical Assistant arrived and, as they were stretched and I wanted to know what to do, it was agreed that I should assist. The CA was informative, helpful and kind. During the procedure it was apparent that he had a dressing on his right buttock where there was a bed sore. I had not been aware of the bed sore previously. I had not been present at his previous morning hygiene and no-one had informed me.

Another day, similar thing occurred with the same CA in attendance and a new dressing applied. Not long after this a doctor on the ward was doing rounds and I informed of this situation. He had not been made aware of the bed sore. The doctor said that the next time a toilet event occurred they would like to see the sore. I then helped him onto his left side.

Shortly after this two physiotherapist staff arrived to see if he was able to sit in his chair for a few hours. I explained about the bed sore and, in view of it, they thought it best to leave him in his current position. The physios were unaware of the bed sore as it was not listed on his chart. (The sore probably explains discomfort in the chair the previous day).

A few hours later another movement was indeed needed. The doctor attended and agreed with the nurse that the dressings should be abandoned and around a two-hourly turn set in place to avoid putting unrelenting pressure on sore areas. Additionally barrier cream should be applied. No cream was applied and no-one attended to turn 3 hours later so I was starting to help him to turn when the original CA came in and we assisted together.

So, someone had identified the sore and dressed it but the information had not reached either the doctor or the physio. And after the doctor’s specific instructions for turning this was not followed through.

Annette Finnigan Senior Patient Experience & Safety Officer NHS Dumfries and Galloway 04/10/2019

Dear squeaky13,

Thank you for taking the time to share your experience with us.

I understand that the Senior Charge Nurse and Nurse Manager have spent some time with you and your husband in order to discuss your concerns directly.

I know that you have also contacted our Patient Experience Team and that we will be responding to your concerns via that channel aswell.

I am sorry that you have had to raise concern regarding the care being provided to your husband and I hope that we can continue to work together to resolve your concerns and improve your experience.

Regards,

Annette
Colonic Surgery

Wowed by Ward 9 the patient 26/09/2019

I was diagnosed with cancer of my colon. From the moment of my diagnosis until the moment I was released from hospital, the care, professionalism and complete experience, whilst brutal was absolutely second to none. There are so many people to thank but to name a few, the colonoscopy team, the anaesthesia team, Brian the Surgeon, the critical care staff, the staff on ward 9, the physio team, the pain relief guys, Fiona and Hazel post op who had me up and about and many many more. Of course a special mention all the nursing staff who were attentive, sympathetic and so utterly good at their jobs, always with a smile even though it was plain to see how busy they were. I am sorry if I have missed anyone out. I feel so blessed to have such a wonderful facility right on my doorstep. Faultless from start to where I am now. I am told I am now cancer free but even if I had had to undergo further treatment I know I was and would have been in the very best and safest hands. Words are difficult to find, to express my overwhelming gratitude. So just... thank you..... what an amazing organisation.

Annette Finnigan  Senior Patient Experience & Safety Officer NHS Dumfries and Galloway 26/09/2019

Dear Wowed by Ward 9,

Thank you so much for taking the time to share your experience with us. I am pleased to hear that our teams were able to turn such a distressing time into a positive experience for you.

I would like to share your feedback with the teams as I know that they will be delighted with your kind words. I can certainly forward your post to the team leads but if you would be so kind as to provide your details, I can ensure that your feedback reaches the individuals involved in your care. If you would be happy with this, you can provide your name and date of birth to the Patient Experience Team on 01387 241690 or via [dumf-uhb.acutecomplaints@nhs.net](mailto:dumf-uhb.acutecomplaints@nhs.net)

I am pleased to hear that your treatment has been successful and I wish you well for the future.

Kind regards, Annette

Ophthalmology

squeaky13  a carer 01/10/2019

Through the post my husband received his regular Ophthalmology appointment for 1300 at Mountainhall Centre. I showed the appointment letter to the Consultant last week. At that time they seemed confident that arrangements could be made so that he could attend.

However, yesterday, when doing rounds, the Consultant explained that Ophthalmology could not fulfill the appointment. The issue was with having my husband transfer from wheelchair to special chair next to the equipment. He has been designated as ‘hoist transfers’ and this was not possible at their site.

This lack of facility is extremely exasperating. There must be many patients in his position of mobility. Are they all just to be written off from the point of eye care? In 2017 Ophthalmology saved the sight in his right eye. At that time he was able to make the required transfers with relative ease. If his right eye condition had occurred now, in 2019, he would have had to contend with lack of eyesight as well as all his other afflictions.

This situation is not right. It is unacceptable.

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Regards,

Annette

squeaky13

The meeting with the Senior Charge Nurse and Nurse Manager was indeed helpful. We fully recognise the efforts made by all the staff at D7.

The Senior Charge Nurse (SCN) did explain that they hope to implement a more in-depth dialogue with family and carers of patients in the initial stages of admission. This will set parameters for how family and staff interact when looking after patients. This is all to the good.

One thing that still needs addressing in my opinion is the signage as to who to go to to ask questions and get information. Being of a certain age, I had imagined that it was the doctor on duty but it is, in fact, the SCN or nurse for the pod (2). But this is still not clear from the Patient Handbook or whiteboards in the room or corridor. A point of contact is important for reassuring patients and carers. Previously, I would ask whoever was available. Sometimes they were helpful but at other times I had to bite my tongue when I was told, 'Sorry, I can't help you. I don't normally work on this ward'!!

From my time in aviation, I would recommend an IT/software system where all patients' statuses and healthcare regimes were updated in real time for all relevant staff and departments to see at a touch of their mobile phones.

The Consultant did re-address the issue of my husband's Ophthalmology appointment for which we are grateful.
Communication difficulties

Communications difficulties include ambulance trips, recordings of meds and fluids, and staff not following through on promises.

**Ambulances -** On one occasion we were advised by the consultant to be ready by 1030 in the morning in readiness for Opthamology Dept. appointment at 11.45. On the day, we watched the dial of the clock go around with increasing agitation. I spoke to a nurse who assured me that we had not been forgotten. Ambulance crew arrived at 11.32. While transferring to their stretcher, they confessed that they had been to the ward previously to collect a patient who had already made private transport arrangements but they had not been aware at that time that we were to be collected at the same time and hence the delay. What annoyed me was the crew's blase attitude, laughing as though this sort of confusion was a regular thing. It feels to me is as if there is an inertia, a culture of acceptance that standards will inevitably be poor. This is not helpful to the wellbeing of either the patient, or myself as his carer. In the wait, he was all for setting off to the appointment in a wheelchair!

Thankfully the staff at Opthamology accepted our late arrival and gave him the best optical assessment they could under the circumstances.

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Regards

Kenny McFadzean HOS

**Poor communications and care failures**

*squeaky13 a carer 17/09/2019*

Husband was admitted to DGRI Dumfries on the evening of 6th. On 7th staff at the assessment unit were given a copy of his Cardiology outpatients appointment also at DGRI for 11th. The ward staff would liaise with Cardiology.

On 8th he was transferred to ward D7 room 18. Staff here were also informed of the Cardiology appt.

On 11th I arrived at the ward around 1000. He was brighter. He was sitting in bed attempting to take his tablets from a small medicine pot. Some of them had spilled over the bed covers ... he has dexterity difficulties. I helped him take them with his dilute squash. Later I advised a nurse (and later a junior doctor) that, in my absence, my husband would need staff help to take his meds. On 12th a nurse had indeed helped him with his meds. However, on 13th, the pot was there full of untaken tablets. He was reluctant to take them. He was demoralised which is understandable. He had steadily deteriorated in his time in hospital with no sign of a meaningful diagnosis.

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The fact that no-one had told us that there were problems is unacceptable. We had both psyched ourselves up for 2 tests that day but none were going to happen. I expressed my dissatisfaction with this to the senior junior doctor on duty at 1000 the following day, 13th. I also was concerned about my husband’s very poor liquid intake and risk of dehydration, especially in view of the haematologist’s 2012 instruction that his blood meds required that he takes lots of fluids. Apparently there are no longer key workers or nurses in charge of particular patients.

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**Annette Finnigan  Senior Patient Experience & Safety Officer NHS Dumfries and Galloway 17/09/2019**
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I am sorry to hear of your husband's experience in DGRI and I thank you for bringing this to our attention. It is disappointing to hear that we have not provided the high level of care that we would expect our teams to provide to all of our patients.

If you would be prepared to contact our Patient Experience & Safety Team directly on either 01387 241690 or via dumf-uhb.acutecomplaints@nhs.net we would like to look at this in more detail.

Regards, Annette

Midpark Hospital

Adult psychiatry

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I feel so let down

ellephant a service user 05/09/2019

I feel so let down, by everyone I have met in the adult team.

More than half of my appointments since December have been cancelled, some of them on the same day. It feels like nobody answers your calls even if you leave a message.

I feel belittled, unimportant, and most of the time invisible.

There have been times I have been told things by a member of staff which I considered inappropriate. I find this completely unacceptable. I feel that my appointments are far too spaced apart. When in a crisis, I don't think you should have to wait 4+ months for a doctor appointment.

Emma Murphy Patient Feedback Manager NHS Dumfries and Galloway 09/09/2019

Dear Ellephant.

Thank you for taking the time to share you story with us. I am so sorry to hear of the challenges you have been facing when trying to get an appointment and communicating with the service.

It would be useful to get more information from you so that we can investigate this further and see what we can do to help. If you are happy to discuss this with us directly, please contact Justina Ritchie (Lead Nurse Community Mental Health) on 01387 244007. If you don't wish to speak to the Mental Health team directly, you can contact Patient Services on 01387 272 733 or at dg.complaints@nhs.net.

Thank you once again for your feedback.

Emma Murphy

Patient Feedback Manager
DUMFRIES and GALLOWAY NHS BOARD

2nd December 2019

Involving People, Improving Quality
Healthcare Associated Infection Report

Author: Elaine Ross
Infection Control Manager

Date 14th November 2019

RECOMMENDATION

The Board is asked to discuss and note the following points:
- The update within this paper.
- The approach to managing incidents where infection risk is identified.

CONTEXT

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

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

Key messages:

New standards for Healthcare Acquired infections rates have been set by Scottish Government and were communicated via the CNO in a letter dated 10th October.

These standards are expected to be met by end March 2022 and are based on individual board rates for the year 2018-19.

The standards for a 25% reduction in E.coli bacteraemia (ECB) will be a significant challenge. This equates to no more than 45 HAI cases in a year which is a reduction of 15 HAI cases.
The 10% reduction in Staphylococcus aureus bacteraemia (SAB) and Clostridioides difficile infection (CDI) is the equivalent of a reduction of 2 SAB HAI cases and 4 HAI CDI cases in a year.

There were no HAI SAB in October.

An Incident Management Team continues to meet to monitor water sample results and agree actions in augmented care areas. This is a precautionary response as there have been no clinical cases associated with water in DGRI and enhanced surveillance is in place.

**GLOSSARY OF TERMS**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
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<tbody>
<tr>
<td>CPE</td>
<td>Carbapenemase Producing Enterobacteriaceae</td>
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<tr>
<td>CVC</td>
<td>Central Vascular Cannula</td>
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<td>CDI</td>
<td>Clostridium difficile Infection</td>
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<td>CAI</td>
<td>Community Associated Infection</td>
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<td>ECB</td>
<td>E.coli Bacteraemia</td>
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<td>ERAS</td>
<td>Enhanced Recovery After Surgery</td>
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<td>HCAI</td>
<td>Healthcare Associated Infection</td>
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<td>HEI</td>
<td>Healthcare Environment Inspectorate</td>
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<td>HPS</td>
<td>Health Protection Scotland</td>
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<td>Health Protection Team</td>
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<td>IMT</td>
<td>Incident Management Team</td>
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<td>IPCT</td>
<td>Infection Prevention and Control Team</td>
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<tr>
<td>IVDU</td>
<td>Intravenous Drug Users</td>
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<tr>
<td>ISD</td>
<td>Information and Statistics Division</td>
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<tr>
<td>KPI</td>
<td>Key Performance Indicator</td>
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<tr>
<td>LDP</td>
<td>Local Delivery Plan</td>
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<tr>
<td>MDRO</td>
<td>Multi Drug Resistant Organism</td>
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<td>PVC</td>
<td>Peripheral Vascular Cannula</td>
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<td>PICC</td>
<td>Peripheral Inserted Central Catheter</td>
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<tr>
<td>SAB</td>
<td>Staphylococcus aureus bacteraemia</td>
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<td>SSI</td>
<td>Surgical Site Infection</td>
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<td><strong>MONITORING FORM</strong></td>
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<td>---------------------</td>
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<tr>
<td><strong>Policy / Strategy</strong></td>
<td>Healthcare Quality Strategy: reduction of harm. Achievement of HAI LDP targets</td>
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<tr>
<td><strong>Staffing Implications</strong></td>
<td>Nil</td>
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<tr>
<td><strong>Financial Implications</strong></td>
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<td><strong>Consultation / Consideration</strong></td>
<td>Healthcare Governance Committee Board Management Team</td>
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<td><strong>Risk Assessment</strong></td>
<td>Addressed through corporate risk register</td>
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<tr>
<td><strong>Risk Appetite</strong></td>
<td>Low [X]  Medium [ ]  High [ ]</td>
</tr>
<tr>
<td>This paper gives an update on the progress in relation to infection control within the Board, which is directly related to Patient Safety, therefore, a low risk appetite has been noted above.</td>
<td></td>
</tr>
<tr>
<td><strong>Sustainability</strong></td>
<td>Fewer infections will reduce bed occupancy and use of resources</td>
</tr>
<tr>
<td><strong>Compliance with Corporate Objectives</strong></td>
<td>This paper supports corporate objectives 2 and 7.</td>
</tr>
<tr>
<td><strong>Local Outcome Improvement Plan (LOIP)</strong></td>
<td>Outcome 6. People are safe and feel safe</td>
</tr>
</tbody>
</table>
| **Best Value** | Performance Management  
  - sound governance at a strategic and operational level |
| **Impact Assessment** | No impact assessment was undertaken as part of this paper. |
1. **Standards on Healthcare Associated Infections and Indicators on Antibiotic Use**

New standards have been approved by the Cabinet Secretary for Health and Sport and were published in a CNO letter 10 October.

They are intended as benchmarks to support quality improvement.

**Antibiotic use indicators**

1. A 10% reduction of antibiotic use in Primary Care (excluding dental) by 2022, using 2015/16 data as the baseline (items/1000/day).
2. Use of intravenous antibiotics in secondary care defined as DDD / 1000 population / day will be no higher in 2022 than it was in 2018.
3. Use of WHO Access antibiotics (NHSE list) ≥60% of total antibiotic use in acute hospitals by 2022.

**Gram-negative bacteraemia standard**

Reduction of 50% in healthcare associated E. coli bacteraemia by 2023/24, with an initial reduction of 25% by 2021/22. 2018/19 should be used as the baseline for E. coli bacteraemia reduction.

**Staphylococcus aureus bacteraemia (SAB) standard**

Reduction of 10% in the national rate of healthcare associated SAB from 2019 to 2022, with 2018/19 used as the baseline for the SAB reduction target.

**Clostridioides difficile infection (CDI) standard**

Reduction of 10% in the national rate of healthcare associated CDI from 2019 to 2022, with 2018/19 used as the baseline for the CDI reduction target.

The percentage reductions in SABs, CDI and ECB will be measured against individual NHS Scotland Boards’ current levels, rather than taking a “best in class” approach as previously.

**What this means for NHS Dumfries and Galloway**

**Figure 1**

<table>
<thead>
<tr>
<th></th>
<th>Baseline / 100,000TOBDs</th>
<th>Baseline cases</th>
<th>Reduction</th>
<th>Cases</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ECB</strong></td>
<td>34.2</td>
<td>60</td>
<td>25%</td>
<td>15</td>
<td>25.65</td>
</tr>
<tr>
<td><strong>SAB</strong></td>
<td>9.1</td>
<td>16</td>
<td>10%</td>
<td>1.6</td>
<td>8.19</td>
</tr>
<tr>
<td><strong>CDI</strong></td>
<td>20.00</td>
<td>35</td>
<td>10%</td>
<td>3.5</td>
<td>18.00</td>
</tr>
</tbody>
</table>

These reduced rates will be set as our local target and our local monthly data plotted against this.
2. **Staphylococcus aureus bacteraemia (SAB)**

Please note that TOBDs are now taken direct from QlicView and may differ slightly from later published ISD figures but are helpful for provisional monitoring and action purposes.

When calculating HAI rates all HAI and HCAI will be reported as HAI. Figure 2 illustrates the breakdown between the two categories.

**Figure 2 - Local data**

<table>
<thead>
<tr>
<th></th>
<th>HAI</th>
<th>HCAI</th>
<th>CAI</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>February</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>March</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>April</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>May</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>June</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>July</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>August</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>September</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>October</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Figure 3 - Local HAI SAB data Using TOBDs**

![Graph](image)

All HAI SAB are reported and investigated using the DATIX and Serious Adverse Events process.
Figure 4- National data - Funnel plot of SAB incidence rates (per 100,000 TOBD) in healthcare associated infection cases for all NHS boards in Scotland in Q2, 2019

Figure 5- Local CAI SAB data using Population

There is no standard set for community acquired SAB. We will keep this under enhanced surveillance and when themes and trends emerge will engage with other teams in the community to address these.
If contaminated samples and SABs from PVC use can be eliminated then the standard would be exceeded.

3. **Clostridium difficile**

Scientific literature and HPS now refer to *Clostridioides difficile* infection. For the purpose of board reporting CDI will be used.

**Figure 7 - CDI Cases per month by origin- local raw data unadjusted for recurrence.**

<table>
<thead>
<tr>
<th>Month</th>
<th>HAI</th>
<th>CAI</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2019</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>February 2019</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>March 2019</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>April 2019</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>May 2019</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>June 2019</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>July 2019</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>August 2019</td>
<td>3</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>September 2019</td>
<td>3</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>October 2019</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

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

From now on reporting HAI and Unknown cases will be reported as HAI, having occurred between 4 and 12 weeks of a hospital admission.
Figure 8 - Local HAI CDI data using TOBDs

NHS Dumfries & Galloway HAI CDI 2019-20

Figure 9- National data- Funnel plot of CDI incidence rates (per 100,000 TOBD) in healthcare associated infection cases for all NHS boards in Scotland in Q2, 2019.
4. **E.coli bacteraemia**

The same criteria now apply to reporting of E.coli bacteraemia. There is no standard set for community ECB however the IPCT will still keep this under enhanced surveillance and liaise with Primary Care teams when trends or themes are observed.

Themes are as previously reported to board: Lower Urinary Tract, Renal and Hepatobiliary in origin.
Figure 12- National data- Funnel plot of ECB incidence rates (per 100,000 TOBD) in healthcare associated infection cases for all NHS boards in Scotland in Q2 2019.

Figure 13 - Local CAI ECB data using Population
Figure 14 - Local data

Figure 15 - National data – Funnel plot of caesarean section SSI incidence (per 100 procedures) in inpatients and PDS to day 10 for all NHS boards in Scotland in Q2 2019.

5. Surgical Site Infection

Figure 15 - National data – Funnel plot of caesarean section SSI incidence (per 100 procedures) in inpatients and PDS to day 10 for all NHS boards in Scotland in Q2 2019.
These funnel plots show extremely low rates of infection across Scotland.

6. Multi Drug Resistant Organism (MDRO) Screening

Audits of compliance with mandatory admission screening are completed on a monthly basis by the IPC Audit Nurse and results are reported nationally every quarter. 90% compliance with MRSA screening is an NHS Board KPI and is consistently met in NHS D&G.

<table>
<thead>
<tr>
<th>MRSA Uptake</th>
<th>2018_19 Q3</th>
<th>2018_19 Q4</th>
<th>2019_20 Q1</th>
<th>2019_20 Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>90%</td>
<td>90%</td>
<td>97%</td>
<td>97%</td>
</tr>
<tr>
<td>Scotland</td>
<td>83%</td>
<td>83%</td>
<td>89%</td>
<td>88%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CPE Uptake</th>
<th>2018_19 Q3</th>
<th>2018_19 Q4</th>
<th>2019_20 Q1</th>
<th>2019_20 Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dumfries and Galloway</td>
<td>85%</td>
<td>93%</td>
<td>87%</td>
<td>97%</td>
</tr>
<tr>
<td>Scotland</td>
<td>78%</td>
<td>81%</td>
<td>86%</td>
<td>86%</td>
</tr>
</tbody>
</table>
RECOMMENDATION

The Committee is asked to discuss and note:
• Duty of Candour Annual Report 2018 – 2019

CONTEXT

Strategy / Policy:

• Duty of Candour is a National priority backed up by legislation and enshrined in; Local Outcome Improvement Plan, Outcome 6. People are safe and feel safe

• Implementation of Duty of Candour is a legal requirement as set out in the Health (Tobacco, Nicotine etc. And Care) (Scotland) Act 2016.

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

Duty of candour is a legal requirement for Health, Care Services and Social Work to inform people (and their families) of incidents where they have been harmed as a result of the care or treatment they received. The intention of the legislation is to promote openness and transparency and ensure individuals are made aware of occurrences.

GLOSSARY OF TERMS

DoC: Duty of Candour
GM: General Manager
HR: Human Resources
NHS D&G: NHS Dumfries and Galloway
PSG: Patient Safety Group
QI: Quality Improvement
## Duty of Candour

**Policy / Strategy**

Duty of Candour is a National priority backed up by legislation and enshrined in; Outcome 7. People using health and social care services are safe from harm. Implementation of Duty of Candour is a legal requirement as set out in the Health (Tobacco, Nicotine etc. And Care) (Scotland) Act 2016.

**Staffing Implications**

Encouraging staff across NHS Dumfries and Galloway to take forward learning from patient safety activities and have an awareness of their statutory obligations.

**Financial Implications**

Nil

**Consultation / Consideration**

IJB, Area Clinical Forum; NHS Healthcare Governance Committee.

**Risk Assessment**

No risk assessment was undertaken as part of this report.

**Risk Appetite**

Low [X]  Medium  High

This paper supports the transparency and openness involved in ensuring high quality care to our patients, therefore, a low risk appetite has been noted against this paper.

**Sustainability**

Not applicable.

**Compliance with Corporate Objectives**

Meets objective 2.

**Local Outcome Improvement Plan (LOIP)**

Outcome 6: People are safe and feel safe

**Best Value**

Meets themes:
- Vision and Leadership
- Effective Partnerships
- Governance and Accountability
- Performance Management

**Impact Assessment**

Not required.
Duty of Candour – NHS Dumfries and Galloway

1. Introduction

NHS Dumfries and Galloway (NHS D&G) serves a population of 151,324. We cover a diverse geographical area, including small towns as well as rural areas. Our aim is to provide high quality care for every person who uses our services and where possible help people to receive care at home or in a homely setting.

All health and social care services in Scotland have a statutory duty of candour. This is a legal requirement which means that when unintended or unexpected events happen that result in death or harm as defined in the Act, the people affected understand what has happened, receive an apology, and that organisations learn how to improve for the future.

Within NHS D&G potential incidents which trigger the duty of candour are identified through the Adverse Event Management process.

An important part of this duty is that we provide an annual report about how the duty of candour is implemented in our services. This short report describes how NHS D&G has operated the duty of candour during the time between 1 April 2018 and 31 March 2019. We hope you find this report useful.

2. Policies and procedures

Every adverse event is reported through our local reporting system as set out in our adverse event management policy. Through our adverse event management process we identify incidents that trigger the duty of candour procedure. Our adverse event management policy contains a section on implementing the duty of candour.

Each adverse event is reviewed to understand what happened, why it happened and how we might improve the care we provide in the future. The level of review depends on the severity of the event as well as the potential for learning. All significant adverse events are reviewed by the Executive chaired Patient Safety Group (PSG) to determine level of review. Level 1 Significant Adverse Event Reviews are commissioned by and report back to the PSG.

Recommendations are made as part of the adverse event review, and Directorate management teams develop improvement plans to meet these recommendations. They share their wider improvements plan with the PSG.

Training on adverse event management and implementation of the duty of candour is available for staff to access, to ensure they understand when it applies and how to trigger the duty. Additional online training and guidance is also available and for those who are our key risk contacts in the Directorates we provide regular development sessions.

All regulated healthcare professionals have a personal duty of care which includes:

- A duty to be open and honest with patients in your care, or those close to them, if something goes wrong. This includes offering an apology
• A duty to be open and honest with your organisation, and to encourage a learning culture by reporting adverse incidents that lead to harm, as well as near misses.

We know that adverse events can be distressing for staff as well as people who receive care. We have support available for all staff through our line management structure as well as through occupational health.

3. How many incidents happened to which the duty of candour applied

Between 1 April 2018 and 31 March 2019, there were 25 incidents where the duty of candour applied. These are unintended or unexpected incidents that result in death or harm as defined in the Act, and do not relate directly to the natural course of someone’s illness or underlying condition. NHS D&G identified these incidents through our adverse event management process.

It should be noted that some incidents reported in the period covered by this report may still be open i.e. under investigation, and as such it may not be possible to say yet whether duty of candour applied.

All incidents and complaints are reviewed during the investigation process to consider whether they trigger any of the duty of candour conditions. It may not be clear at the beginning of an investigation whether the incident was preventable or part of the natural disease progression which can result in a delay in confirming duty of candour and thus in informing patients and their families.

Table 1 below summarises the number of incidents identified in each category between 1 April 2018 and 31 March 2019.

<table>
<thead>
<tr>
<th>Type of unexpected or unintended incident</th>
<th>Number of times this happened</th>
</tr>
</thead>
<tbody>
<tr>
<td>A person died</td>
<td>5</td>
</tr>
<tr>
<td>A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions</td>
<td>0</td>
</tr>
<tr>
<td>A person’s treatment increased</td>
<td>13</td>
</tr>
<tr>
<td>The structure of a person’s body changed</td>
<td>0</td>
</tr>
<tr>
<td>A person’s life expectancy shortened</td>
<td>2</td>
</tr>
<tr>
<td>A person’s sensory, motor or intellectual functions was impaired for 28 days or more</td>
<td>1</td>
</tr>
<tr>
<td>A person experienced pain or psychological harm for 28 days or more</td>
<td>1</td>
</tr>
<tr>
<td>A person needed health treatment in order to prevent them dying</td>
<td>3</td>
</tr>
<tr>
<td>A person needing health treatment in order to prevent other injuries listed above</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>25</strong></td>
</tr>
</tbody>
</table>
4. To what extent did NHS D&G follow the duty of candour procedure?

NHS D&G followed the correct procedure in 20 out of the 25 occasions (80% of the time).

This means:
- we informed the people affected and offered to meet with them
- we apologised to them
- we reviewed what happened and what went wrong to try and learn for the future.

Table 2 below summarises the steps staff are required to document and the compliance for each of the triggers.

In 5 out of the 25 cases, no apology was documented in the notes. We are working with staff to understand why, to offer training on giving an apology and to modify the system to ensure the reasons for this are documented in future.

Table 2

<table>
<thead>
<tr>
<th>Trigger</th>
<th>Total</th>
<th>Patient/Family Informed</th>
<th>Apology Offered</th>
<th>Recorded In Patient's Notes</th>
<th>Relevant Manager Notified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase in treatment</td>
<td>13</td>
<td>11</td>
<td>10</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Death of the person</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Shortening of the life expectancy</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Person experienced pain or psychological harm which has been, or is likely to be, experienced by the person for a continuous period of at least 28 days</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Impairment of the sensory, motor or intellectual functions of the person which has lasted, or is likely to last, for a continuous period of at least 28 days</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Required treatment by a Registered Health Professional to prevent (i) the death of the person or (ii) any injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>TOTAL</td>
<td>25</td>
<td>22</td>
<td>20</td>
<td>24</td>
<td>24</td>
</tr>
</tbody>
</table>
5. What has changed as a result?

We have made a number of changes to our procedure and systems for recording adverse events as well as changes to clinical processes following review of duty of candour events.

- A Learning Summary is produced and disseminated following all Significant Adverse Event Reviews.
- Family feedback has enabled us to produce an information leaflet and standard letter templates to keep families informed throughout the investigation process. This is now incorporated into our framework.
- A review of Mental Health ward pass (time out of the hospital) arrangements has commenced with some immediate recording issues strengthened.
- Maternity, neonatal and paediatric teams have agreed that a multidisciplinary meeting should be arranged with parents ahead of planned pre term births to discuss possible complications, management plans and any anxieties.
- Following an incident where people were harmed as a result of scalds, we rapidly disseminated a risk awareness notice to make all staff aware of the hazard and importance of risk assessment.

6. Conclusion & Next Steps

This is the first year of the duty of candour being in operation and it has been a year of learning and refining of our existing adverse event management processes.

Ensuring that staff understand the requirements of the duty of candour legislation and the requirement to document that the actions have been taken are key areas that we will address in the year ahead.

Understanding that, in some cases it is not immediately apparent that an incident triggers duty of candour, has been learning for us and has meant that patients and their families have waited longer than we would have anticipated to be informed, to be offered an apology and to be invited to participate in the review process.

Much of what we have learned has been case specific but we have where it was appropriate to do so shared the themes and learning beyond the teams immediately involved.

There is much for us to build on in the year ahead to ensure that patients, their families and our staff are supported when things go wrong and that we continue to strive to keep people safe, well and free from harm when they are in our care.

If you would like more information about this report, please contact us using these details: mstevenson@nhs.net
Governance Arrangement for the Integration Joint Board

Author: Julie White
Chief Officer

Sponsoring Director: Julie White
Chief Operating Officer

Date: 21st November 2019

RECOMMENDATION

The Board is asked to approve the following points:

- Governance Arrangements for the Integration Joint Board

The Board is asked discuss and note the following points:

- This paper is also being presented to the Integration Joint Board and Dumfries and Galloway Council for approval and noting.

CONTEXT

Strategy / Policy:

9 National Health and Wellbeing Outcomes for Health and Social Care

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

It is important that the NHS Board is fully signed up to the governance arrangements of the Integration Joint Board to support ongoing delivery of Health and Social Care Integration at a local level

GLOSSARY OF TERMS

NHS D&G  NHS Dumfries and Galloway
CFO  Chief Finance Officer
GP  General Practitioner
HSCP  Health and Social Care Partnership
HSCSMT  Health and Social Care Senior Management Team
IJB  Integration Joint Board
NHS  National Health Service
SPG  Strategic Planning Group
## MONITORING FORM

<table>
<thead>
<tr>
<th>Policy / Strategy</th>
<th>9 National Health and Wellbeing Outcomes for Health and Social Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing Implications</td>
<td>There are no staffing implications as a result of this report</td>
</tr>
<tr>
<td>Financial Implications</td>
<td>There are no financial implications as a result of this report</td>
</tr>
<tr>
<td>Consultation / Consideration</td>
<td>This Paper has been shared with Health and Social Care Senior Management Team, the Integration Leadership Group and a seminar for elected Members and IJB and NHS Board Members.</td>
</tr>
<tr>
<td>Risk Assessment</td>
<td>As this report does not propose a change in policy a risk assessment is not required.</td>
</tr>
<tr>
<td>Risk Appetite</td>
<td>Low [ ] Medium [ ] High [ ]</td>
</tr>
<tr>
<td>The content of this report relates solely to the governance of the Integration Joint Board which is a separate entity to NHS Dumfries and Galloway therefore this does not pose a risk to NHS D&amp;G.</td>
<td></td>
</tr>
<tr>
<td>Sustainability</td>
<td>To ensure sustainable delivery of health and social care services across Dumfries and Galloway</td>
</tr>
<tr>
<td>Compliance with Corporate Objectives</td>
<td>This report complies with all of the Corporate Objectives of NHS Dumfries and Galloway</td>
</tr>
<tr>
<td>Local Outcome Improvement Plan (LOIP)</td>
<td>Outcomes 3 and 6</td>
</tr>
<tr>
<td>Best Value</td>
<td>Vision and Leadership, Effective Partnerships, Governance and Accountability</td>
</tr>
<tr>
<td>Impact Assessment</td>
<td>As the content of this Paper does not propose a change in Policy an Impact Assessment is not required.</td>
</tr>
</tbody>
</table>
1. Introduction

1.1 Since November 2015 and the formal establishment of Dumfries and Galloway Integration Joint Board, work has been underway to integrate health and social care services in line with the requirements of the Public Bodies (Joint Working) Scotland Act 2014.

1.2 The Integration of Health and Social Care Services is intended to ensure that we are providing the right support to individuals, in the right place, at the right time and that people have a positive experience of Health and Social care provision. Within Dumfries and Galloway, our vision for integration is that by working together we will “support our communities to become the best place to live safe, healthy and active lives by promoting independence, choice and control.”

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

Some of the principles underlying integration include the premise that services should be:

- Designed and developed with people who use them and our communities
- Focused on prevention and anticipatory care
- Personalised
- Well co-ordinated across sectors including the third and independent sectors.
- Developed with family and carers.

1.4 Importantly, Health and Social Care Integration is intended to improve outcomes for individuals and deliver progress against the 9 national health and wellbeing outcomes listed below.

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

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

2 Background

Dumfries and Galloway Integration Joint Board

2.1 The Public Bodies (Joint Working) (Scotland) Act 2014 requires Health Boards and Local Authorities to integrate planning for, and delivery of, certain adult health and social care services. In Dumfries and Galloway the Health Board and the Local Authority chose to delegate certain functions (described below) to a third public body called Dumfries and Galloway Integration Joint Board (IJB). The legislation sets out the functions and budgets that must be delegated and those that may be delegated.

2.2 The Dumfries and Galloway Integration Scheme sets out the detail as to how the Health Board and the Local Authority has integrated services and includes matters prescribed in the regulations underpinning the Act. The Integration Scheme is attached at Appendix 1.

2.3 The Integration Joint Board is a separate legal entity and is responsible for the strategic planning and commissioning of the functions delegated to it. The IJB is also responsible for ensuring the delivery of its functions through the locally agreed operational arrangements set out in the Integration Scheme. These locally agreed operational arrangements will be discussed more fully later in the paper.

2.4 The IJB is required (by section 29 of the Public Bodies (Joint Working) (Scotland) Act 2014) to prepare a Strategic Plan also known as a Strategic Commissioning Plan which sets out the arrangements for carrying out the integration functions and describes how these arrangements will contribute to achieving the 9 national health and wellbeing outcomes.

2.5 The responsibility for decisions about the planning and strategic commissioning of all health and social care functions that have been delegated to the IJB sits wholly with the IJB as a statutory public body. Such decisions do not require ratification by the Health Board or Local Authority, both of which are represented on the IJB. The IJB has full power to decide how to use resources and deliver delegated services to improve quality and deliver the 9 national health and wellbeing outcomes.

2.6 Membership of the IJB, operational delivery arrangements and performance monitoring arrangements are set out in the Integration Scheme (Appendix 1).

2.7 The diagram below sets out the roles and responsibilities and accountabilities of the three Parties as they relate to the business of the IJB.
Delegated Functions to the IJB

2.8 The functions that must be delegated by the Local Authority and Health Board are set out in the Public Bodies (Joint Working) (Prescribed Local Authority functions etc.) (Scotland) (Regulations 2014)

2.9 The functions delegated from the Council are the statutory functions are set out in Annex 2, part 1 of the Integration Scheme (Appendix 1) and are determined by 13 different pieces of legislation including:

- National Assistance Act 1948
- The Disabled Person’s (Employment) Act 1958.
- The Social Work (Scotland) Act 1968
- The Local Government and Planning (Scotland) Act 1982
- Disabled Persons (Services, Consultation and Representation) Act 1986
- The Adults with Incapacity (Scotland) Act 2000
- The Housing (Scotland) Act 2001
- The Community Care and Health (Scotland) Act 2002
- The Mental Health (Care and Treatment) (Scotland) Act 2003
- The Housing (Scotland) Act 2006
- The Adult Support and Protection (Scotland) Act 2007
- Social Care (Self-directed Support) (Scotland) Act 2013
- Mental Health (Scotland) Act 2015
2.10 The services delegated to the Health and Social Care Partnership (HSCP) to deliver these functions are set out in Annex 2, part of the Integration Scheme and include:

Social Work Locality Teams

- Adult protection and domestic abuse
- Social Work Services and support for adults with physical disabilities, learning disabilities and mental health – Adult Placement Services – respite provision.
- Social Work Services for Adults and Older People – Day Services; Care Home Services
- Carers Support Services
- Support Services
- Occupational Therapy – Aspects of housing support including aids and adaptations.
- Reablement Services – Equipment and Telecare
- Learning Disability Services – Regulated provision; local area coordination
- Drug and Alcohol Services

2.11 There are a range of functions not delegated to the IJB, for which the Local Authority retains full accountability and responsibility for planning and delivery.

These include:

- Children and Family Services
- Criminal Justice
- Mental Health Statutory Team
- Social Work Out of Hours Services

2.12 The functions delegated to the IJB by the Health Board are set out in Annex 1, part 1 of the Integration Scheme (Appendix 1)

2.13 Within Dumfries and Galloway, the Health Board made the decision to delegate additional functions to those prescribed in the legislation. Uniquely, Dumfries and Galloway Health Board delegated all of its Acute Hospital functions (including scheduled and unscheduled services) to the IJB.

2.14 The services delegated by the Health Board to the Health and Social Care Partnership to deliver the functions delegated to the IJB include:

- District General Hospital inpatient (scheduled and unscheduled)
- Diagnostic Services
- Community Hospital services
- Inpatient Mental Health
- Paediatrics
- Community Hospitals
- Hospital Outpatient Services
- Community Services
- Community Children's Services
- Public Health Practitioner services
- GP Services
- GP Prescribing
- General and Community Dental Services
- Hotel services and facilities management

2.15 The IJB is responsible for the development and delivery of the Strategic Commissioning Plan pertaining to the functions delegated to the IJB.

**The Strategic Commissioning Plan**

2.16 In order for the IJB to deliver its requirement to strategically plan and commission the functions delegated to it by the Local Authority and the Health Board, it has developed a suite of documents which form the overarching Strategic Commissioning Plan.

These include:

- 3 year Strategic Plan
- 4 Locality Health and Social Care Plans
- A Strategic Needs Assessment
- A Financial Plan
- A Performance Management Framework
- An Integrated Workforce Plan

2.17 Each of these documents is presented to the IJB as part of its Strategic Commissioning process and helps inform the decision making of the IJB.

**Delegated Budget and Services**

2.18 In 2018 / 2019, the delegated budget to the IJB was £367m (£295m from NHS and £72m from Council)

2.19 The diagram below sets out how this budget is allocated across the Health and Social Care Partnership.
2.20 The Integration Scheme (Appendix 1) sets out how over / under-spends are dealt with as a Partnership.

2.21 Dumfries and Galloway is unique in Scotland with all Clinical Services and adult Social Care Services being delivered via the Health and Social Care Partnership.

3. **Main Body of the Report**

3.1 The Integration Joint Board must produce a Strategic Commissioning Plan that sets out how it will plan and deliver services across Dumfries and Galloway using the integrated budget under its control.

3.2 After a formal review, as required in the Public Bodies (Joint Working) Scotland Act 2014, the Integration Joint Board decided on 5th April 2018 to retain the current Strategic Plan for Health and Social Care. Stakeholders were fully engaged in the preparation, publication and review of our Strategic Plan in order to establish a meaningful co-production approach which enables our IJB to make progress towards delivering the 9 national outcomes.

3.3 The new period of relevance for our Strategic Plan is now April 2018 – April 2021.
The Governance Framework

3.4 Audit Scotland published its latest report on Health and Social Care Integration on the 15th November 2018. This report sets out key features of Health and Social Care systems that support meaningful integration. Exhibit 7, from the report, reproduced below, provides a framework for IJB, Health Boards and Local Authorities to consider in order to support effective integration.

Features Supporting Integration

- Collaborative leadership & building relationships
- Integrated Finances and financial Planning
- Effective Strategic planning for Improvement
- Agreed governance & accountability arrangements
- Ability & willingness to share information
- Meaningful & sustained engagement

3.5 The Audit Scotland Report confirms that the presence of a clear governance structure where all partners agree responsibility and accountability is vital.

3.6 The following diagram sets out the map of governance arrangements within Dumfries and Galloway. This has been developed and presented at workshops and seminars involving, IJB, NHS and Local Authority members.

The Governance Map – Key Roles and Responsibilities

Integration Joint Board

3.7 The IJB is a separate legal entity and is responsible for the Strategic Planning and Commissioning of the functions delegated to it. The IJB is also responsible for ensuring the delivery of its functions through the locally agreed operational arrangements and has operational oversight of the delivery of the functions through the use of Directions.
3.8 The IJB is responsible for the creation of its strategic plan and should do so with full engagement of all partners including the Health Board, Local Authority, Third Sector, Independent Sector and Local Communities. The Strategic Planning Group has a key role in the development, monitoring and delivery of the Strategic Plan. (See below SPG). The below link to the animation sets out how the governance arrangements are locally.

3.9 Once the IJB has agreed elements of its Strategic Plan, it issues directions to Dumfries and Galloway Council, NHS Dumfries and Galloway or both.

3.10 The IJB then seeks assurances from both the Health Board and the Local Authority regarding the implementation of the Directions.

3.11 The IJB requires its own assurances on the Strategic Plan and will receive those assurances through 4 key committees:

   a) Performance and Finance
   b) Audit and Risk
   c) Clinical and Care Governance

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**Figure 1 – The Governance Map**

... Provide functions to run
- Delegate in Strategy development
- Delegate out operational delivery

Reporting and Assurances
Accountability for Delivery of Strategic Plan

<table>
<thead>
<tr>
<th>Functions</th>
<th>- Nursing, Medical etc</th>
</tr>
</thead>
<tbody>
<tr>
<td>HR</td>
<td>- Social Work</td>
</tr>
<tr>
<td>Finance</td>
<td>- Emergency Planning</td>
</tr>
<tr>
<td>Public Health</td>
<td>- Infection Control</td>
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<tr>
<td>Internal Audit</td>
<td>- Patient Experience</td>
</tr>
<tr>
<td>Risk Management</td>
<td>- Complaints</td>
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<tr>
<td>Incident Reporting</td>
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<tr>
<td>Professional Leadership</td>
<td></td>
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</tbody>
</table>

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Page 10 of 68
d) Strategic Planning Group

Performance and Finance Committee

3.12 The terms of reference for Performance and Finance Committee are set out in the Scheme of Delegation attached at Appendix 2.

3.13 The key roles and functions of the Performance and Finance committee is to:

- Consider regular reports in relation to the financial performance of the Partnership in respect of the delegated functions and associated budgets
- Monitor delivery of the financial plan for the IJB
- Consider regular reports in relation to the operational performance of the Partnership in respect of the delegated services and the delivery of the 9 national health and well being outcomes as set out in the Performance Framework

Audit and Risk Committee

3.14 The remit and powers of the IJB Audit and Risk Committee are set out in the Scheme of Delegation attached at Appendix 2.

3.15 The key roles and functions of the Audit and Risk Committee is to:

- Review the effectiveness of the IJB’s framework of governance, risk management and internal control.
- Approve and consider the annual internal audit plan and to consider the external audit plan
- Consider unaudited accounts and the governance statement of the IJB

Clinical and Care Governance Committee

3.16 The remit and powers of the IJB Clinical and Care Governance Committee are set out in the Scheme of Delegation at Appendix 2. The function of this Committee is set out in the Integration Scheme (Appendix 1).

3.17 The key role and functions of the Clinical and Care Governance Committee is to:

- Provide an effective overview of clinical and care governance across integrated services
- Ensure that quality monitoring and governance arrangements are in place for safe and effective health and social care service delivery in Dumfries and Galloway
3.18 The Clinical and Care Governance Committee is responsible for the continuous review of the arrangements for clinical and care governance which is fundamental to the partnership delivering its ambitions. The Clinical and Care Governance Committee will provide to the IJB the required assurance of the quality and safety of services delivered. This Committee consists of senior managers and professional leadership from within the Partnership alongside voting members of the IJB and provides an effective overview of the clinical and care governance agenda across the delegated integrated services. The Chief Social Work Officer, Executive Nurse Director and Medical Director are the professional members of this Committee. The Committee is currently chaired by one of the NHS non-executive members of the Integration Joint Board.

3.19 Assurance to the IJB and subsequently to the Parties in respect of the key areas of clinical and care governance is achieved through explicit and effective lines of accountability. Professional responsibility and accountability for Nursing, Midwifery and Allied Health Professional practice is devolved to the Executive Nurse Director of NHS Dumfries and Galloway. Professional responsibility and accountability for Social Work practice is to the Chief Social Work Officer of the Council. Professional responsibility and accountability for Medical Staff is devolved to the Medical Director of NHS Dumfries and Galloway. Operational management, responsibility and accountability rest with the Chief Officer.

3.20 In accordance with the arrangements sets out in the Integration Scheme (Appendix 1) and the IJBs Scheme of Delegation (Appendix 2) the Clinical and Care Governance Committee are required to report to the IJB, the Health Board’s Healthcare Governance Committee and the Council’s Social Work Services Committee in order to provide assurances regarding the quality and safety of services commissioned by the IJB and delivered by the Health and Social Care Partnership.

**Strategic Planning Group**

3.21 The terms of reference for the Strategic Planning Group are set out in Appendix 4.

3.22 The key role and functions of the Strategic Planning Group is to:

- Have a role in shaping and influencing the Strategic Plan for health and social care.
- Review progress against the statutory outcomes for health and wellbeing and the associated performance indicators.
- Provide a view to the IJB on the effectiveness of the arrangements for carrying out the integration functions.
- Provide a view to the IJB on any significant decisions outwith the Strategic Plan.

3.23 The Strategic Planning Group currently consists of over 40 representatives of key stakeholder groups within the Health and Social Care Partnership and was instrumental in reviewing the existing Strategic Plan which was retained by the IJB in April 2018.
The Importance of ‘Directions’

3.24 Integration Authorities require a mechanism to action their Strategic Commissioning Plans and this is laid out in Section 26 to 28 of the Public Bodies (Joint Working) Scotland Act 2014. This mechanism takes the form of “binding directions” from the Integration Authority to one or both of the Health Board and the Local Authority.

3.25 Directions are a legal mechanism and are intended to clarify responsibilities and requirements between the IJB, the Local Authority and the Health Board. Directions are the means via which clarity on decision making is achieved under Integration.

3.26 Directions enable all stakeholders to be transparent about which body decided what, which body is responsible for what and which body should be audited for what, whether in financial or decision making terms.

3.27 The IJB must issue a direction in respect of every function that has been delegated to it. The direction must set out how each integrated function is to be exercised and identify the budget associated with it. Directions must be in writing and should be sufficiently detailed to ensure the intention of the IJB is adequately captured and effectively communicated.

3.28 Directions are the end point of a process of decision making by the IJB. Directions should not contain surprising or completely unknown information about service change or redesign and should follow a period of wider engagement on the function(s) that are the subject of the direction. This would normally be part of the service planning and design phase of strategic commissioning and would involve engagement and consultation with delivery partners including the Health Board and the Local Authority.

3.29 The IJB has been established to put in place plans to improve the health and wellbeing of our local population and have an agenda of change and improvement. The IJB makes decisions about service change, service redesign, investment and disinvestment. Such decisions will necessitate directions to the Health Board or Local Authority or both.

3.30 Delivery partners (i.e. Health Board and Local Authority) are required to comply with all directions received from the IJB and may not amend, ignore, appeal or vet any direction. This requires a mature and collaborative approach to the planning and delivery of change in health and social care services that improves quality and outcomes for local populations.

3.31 Delivery partners should be involved from an early stage in the strategic commissioning process and should therefore be appropriately engaged in the process leading up to the issuing of a Direction.

3.32 Directions must clearly identify which of the delegated health and social care functions they relate to and must include detailed information on the financial resources that are available for carrying out the functions that are the subject of the direction.
3.33 A direction will remain in place until it is varied, revoked or superseded by a later direction.

3.34 To assist with monitoring and reviewing directions issued, the IJB may seek information from the Health Board or Local Authority, or both, about the delivery of the function that is the subject of the direction. Directions, therefore, give the IJB the “operational oversight” referred to in the Integration Scheme.

3.35 The importance of directions as a vital aspect of governance and accountability between partners cannot be overstated. The Local Authority and the Health Board, as the key delivery partners, will continue to work with the new arrangements and respond to directions issued to them.

3.36 All directions will be reviewed on an annual basis by the IJB Performance and Finance Committee.

3.37 Initially in Dumfries and Galloway, directions were broad and covered a wide range of functions. They have become more focused over the last year. A copy of the directions template is included at Appendix 3.

**Dumfries and Galloway Health Board**

3.38 As detailed in the Integration Scheme (Appendix 1), NHS Dumfries and Galloway (the Health Board) delegates a range of functions (and their associated services and budgets) to the IJB. This is shown by the solid blue arrow in Figure 1 – The Governance Map.

3.39 The IJB is then responsible for the development of the Strategic Plan in relation to those functions. Following a process of decision making by the IJB about the Strategic Plan in relation to redesign, investment or disinvestment, the IJB will issue a direction to the Health Board in relation to the delivery of one or more of the functions delegated to the IJB. This is shown by the solid green arrow in Figure 1 – The Governance Map.

3.40 The Health Board then delegates implementation of the Direction and operational responsibility of the service to the Health and Social Care Partnership via the Chief Officer.

3.41 The Health Board also provides NHS Dumfries and Galloway retained functions to the Health and Social Care Partnership to support the running of the Partnership e.g audit, HR.

3.42 The Health and Social Care Partnership (via the Chief Officer) provides reporting and assurances to the Health Board regarding the operational delivery of the functions delegated to the IJB.
3.43 The Health Board retains accountability for the quality and safety of services delivered on its behalf via the Health and Social Care Partnership. The Health Board receives its own assurances and implements its own internal controls via its governance arrangements e.g Healthcare Governance Committee, Performance and Finance Committee, Audit and Risk Committee.

3.44 The Health Board provides assurances to the IJB on the delivery of the Strategic Plan by reporting on implementation of directions issued to it by the IJB.

**Dumfries and Galloway Council**

3.45 As detailed in the Integration Scheme (**Appendix 1**), Dumfries and Galloway Council (the Local Authority) delegate a range of functions (and their associated services and budgets) to the IJB. This is shown by the solid blue arrow in Figure 1 – The Governance Map.

3.46 The IJB is then responsible for the development of the Strategic Plan in relation to those functions. Following a process of decision making by the IJB about the Strategic Plan in relation to service change, service redesign, investment and disinvestment, the IJB will issue a direction to the Council in relation to one or more of the functions delegated to it. This is shown by the solid green arrow in Figure 1 – The Governance Map.

3.47 It should be noted that a direction will be issued at the end of a process of service planning and design. Directions should not contain surprising or completely unknown information about service change or redesign and should follow a period of wider engagement on the function(s) that are the subject of a direction e.g with Social Work Committee or full Council.

3.48 It has been agreed with Dumfries and Galloway Council that, in order to provide Elected Members with an opportunity to debate and discuss outcomes of consultations undertaken by the Dumfries and Galloway Health and Social Care Partnership in relation to delegated functions and services, that the Chief Social Work Officer reports these matters to Full Council in advance of the IJB in order to obtain the view of the Local Authority, whilst recognising the final decision rests with the IJB.

3.49 Elected members receive 6 monthly reports on local progress with delivery of the Strategic Plan at Area Committee meetings. The Integration Scheme (**Appendix 1**) clearly sets out that Area Committees will scrutinise the delivery of Locality Plans against the planned outcomes established within the Strategic Plan.

3.50 The Chief Officer provides reports (3 times per year) to the Social Work Committee on the work of the Clinical and Care Governance Committee. It is for Social Work Committee to determine the matters of material importance that must be presented to Full Council for consideration.
The Health and Social Care Partnership

3.51 The Health and Social Care Partnership (HSCP) is a local partnership formed as the delivery arm of the integration of services delegated by the Health Board and the Local Authority.

3.52 The Health and Social Care Partnership is jointly run by the Health Board and the Local Authority through the appointment of the Chief Officer who is responsible for the operational management and delivery of the services delegated to the Partnership. The HSCP manages a range of health and social care services including:

Local Authority Services:

- Social Work Locality Teams
- Adult protection and domestic abuse
- Social Work Services and support for adults with physical disabilities, learning disabilities and mental health – Adult Placement Services – respite provision.
- Social Work Services for Adults and Older People – Day Services; Care Home Services
- Carers Support Services
- Support Services
- Occupational Therapy – Aspects of housing support including aids and adaptations.
- Reablement Services – Equipment and Telecare
- Learning Disability Services – Regulated provision; local area coordination
- Drug and Alcohol Services

Health Services including:

- District General Hospital inpatient (scheduled and unscheduled)
- Diagnostic Services
- Community Hospital services
- Inpatient Mental Health
- Paediatrics
- Community Hospitals
- Hospital Outpatient Services
- Community Services
- Community Children's Services
- Public Health Practitioner services
- GP Services
- GP Prescribing
- General and Community Dental Services
- Hotel services and facilities management

3.53 The Health and Social Care Senior Management Team (HSCSMT), led by the Chief Officer, is responsible for providing leadership and senior managerial oversight of the functions and services delegated to the HSCP.
3.54 The Health and Social Care Senior Management Team provides strategic direction and guidance to the directorates within the HSCP to ensure delivery of the vision. It also monitors the financial position for the HSCP to ensure delivery of financial targets. Regular performance reports are presented to HSCMT with regards to delivery of the key performance indicators.

3.55 HSCSMT oversees the delivery of safe and effective services across the Partnership and leads on the engagement of staff across the Partnership to deliver the change of culture set out in the cultural diagnostic work.

The Role of the Chief Officer

3.56 The Chief Officer is appointed in accordance with section 10 of the Act.

3.57 The Chief Officer of the IJB has a dual responsibility:

- As Chief Officer to the IJB responsible for the effective strategic planning and commissioning of the delegated functions. In this role, the CO is accountable to the IJB
- As Chief Officer of the Health and Social Care Partnership, responsible for the operational management of the functions and services delegated to the IJB, including Acute care.

3.58 The Chief Officer reports to the Chief Executives of the Health Board and the Local Authority. Joint performance reviews involving both Chief Executives and the Chief Officer take place on a regular basis.

3.59 The Chief Officer is a member of the Senior Leadership Team in the Council and the NHS Board’s senior Management Team.

3.60 The Chief Officer is jointly accountable to the Chief Executives for the operational management of the integrated services. For other functions, the Chief Officer is accountable to the IJB.

Integrated Finances and Financial Planning

3.61 A combined integrated finance plan setting out the overall delegated budget is included in the IJB’s Strategic Plan. Dumfries and Galloway Integration Scheme is unique in that the entirety of operational /clinical services are delegated by the Health Board to the IJB.

3.62 There are challenges around the different financial timeframes for Local Authority, NHS and Scottish Government which impacts on timely agreement of the IJB budget. Each year, however, the draft budget is presented to the IJB meeting in April.

3.63 The IJB have established a Performance and Finance Committee where papers on the Partnership’s financial position are regularly presented. Regular financial reporting arrangements to the Health and Social Care Senior Management
Team, Performance and Finance Committee and the IJB Board are well established.

3.64 A joint audit of the financial planning processes will be undertaken in 2019/20.

3.65 The HSCP is now able to present a combined report on the financial position of the localities. Resources delegated to the Partnership at local level are able to be used flexibly across the Partnership.

3.66 A range of benchmarking tools including Discovery, Integrated Resource Framework and Cost Book are used to monitor financial performance and delivery.

3.67 The Chief Officer is expected to deliver the outcomes contained within the Strategic Plan within the total delegated resources and where there is a forecast overspend, the Chief Officer and the Chief Finance Officer must agree a recovery plan to balance the overspending budget in partnership with the Health Board and the Local Authority.

The role of the Chief Finance Officer

3.68 The Chief Finance Officer is responsible for providing financial advice to the Chief Officer on the operational services and to the IJB on the delivery of the delegated budget.

3.69 The Chief Finance Officer produces financial reports a part of the financial performance structure provided to the IJB.

3.70 The CFO is responsible for preparing the Annual Accounts for the IJB.

3.71 Finance staff resources are made available from both the NHS and the Local Authority to deliver financial services for the IJB and the HSCP.

Scrutiny of the Performance of the IJB

3.72 Annual Performance Reports are written for the public, using plain English, attractive graphics and people’s stories. The content includes progress and challenges, benchmarking and examples of learning, exceeding the statutory minimum content. An executive summary handout and short animated infographics for social media are also produced.

3.73 In addition to the annual reports, the Partnership reports quarterly on the Ministerial Strategic Group priorities, 6 monthly locality progress towards delivery of the Strategic Plan and a mid-year interim performance report. Monthly ‘at a glance’ performance reports on operational delivery of KPIs are currently being revised to include a wider range of indicators.

3.74 All performance reports are published in the public domain on the Partnership’s website (www.dghscp.co.uk) after they have been approved by the Performance and Finance Committee or the IJB Board.
3.75 Dumfries and Galloway is the first Partnership to hold an Annual Review in public, based on the annual performance report. Open to the public, the venue rotates through the localities. Last year, the event was also live streamed.

4. Conclusions

4.1 This paper sets out Governance arrangements which enable the IJB to fulfil its duties as set out in the Public Bodies (Joint Working) (Scotland) Act 2014.

4.2.1 It is important that all three public bodies are fully signed up to the Governance arrangements to support the ongoing delivery of Health and Social Care Integration at a local level.
Health and Social Care Integration

Integration Scheme between

NHS Dumfries and Galloway

and

Dumfries and Galloway Council
1. Introduction

Background

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

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

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

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

Working in partnership

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

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

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

Supplementary information

Once approved by Scottish Ministers, the contents of this Integration Scheme shall be full and final and, in terms of the Act, it shall not be possible to make any modifications to the Integration Scheme without a further consultation on a revised Integration Scheme being carried out jointly by the Health Board and the Local Authority and subsequent further approval by Scottish Ministers. For this reason, the Integration Scheme sets out the core requirements for the IJB and will be supplemented by separate documents which will provide further detail in respect of the workings and arrangements for the IJB.

As the IJB develops, it may be necessary to make changes and improvements to certain operational arrangements, and this can be achieved through modification of the separate documents supplementing this Integration Scheme. Any changes to
the supplementary documents may be made by the approval of the IJB as it sees fit from time to time and such changes will not require to be intimated to, or approved by, Scottish Ministers.

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

2. **Aims and Outcomes of the Integration Scheme**

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

2.1 **National Health and Wellbeing Outcomes**

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

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

2.2 **Our Vision**

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

2.3 **Our Principles**

In 2012, local principles were agreed as the foundation on which we will build and progress our plans for integration. These include:
2.3.1 Integration must focus on improved health and wellbeing outcomes for local people; quality of care and the needs of the individual are central to how we plan and provide services
2.3.2 Self-determination and a commitment to a person-centred approach to care are central in our considerations and decisions
2.3.3 All adult health and social care services, including acute services, will be included from the outset; opportunities to extend integration across other service areas will be actively explored
2.3.4 Services will be provided at community or locality level wherever possible and we will avoid unnecessary hospital admissions and duplication of professional input
2.3.5 Local GPs must be at the heart of our community and locality services
2.3.6 Clear and robust decision-making structures will fully reflect the unique and different roles of the NHS and the Local Authority, retaining the respective accountability for resources, outcomes and performance and quality of services through a continuing commissioning approach
2.3.7 The IJB will have oversight of the delivery of all commissioned services
2.3.8 Health and social care services in each locality will be accountable to their local community through the Area Committees and to the IJB
2.3.9 Clear and robust structures will provide for full delegation and empowered decision-making
2.3.10 Professional leadership and oversight and practice development should remain with senior professional officers in each organisation
2.3.11 Professionals will be freed up to focus on delivery and solutions, learning from experience through, for example, Joint Future
2.3.12 An integrated budget shall be in place to respond to all situations; the work being progressed in Dumfries and Galloway on a Joint Resourcing Framework will assist
2.3.13 1 April 2015 will see the development of our proposals for integration, with the aim of delivering a fully integrated model by 1 April 2016 in line with the legislative timetable. Our aim is to achieve excellence immediately post-integration
Dumfries and Galloway Integration Scheme

The Parties:

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

And

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

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

1. Definitions and Interpretation

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

“The Act” means the Public Bodies (Joint Working) (Scotland) Act 2014;
“The Parties” means Dumfries and Galloway Council and NHS Dumfries and Galloway;
“IJB” means the Integration Joint Board to be established by Order under section 9 of the Act;
“Outcomes” means the National Health and Wellbeing Outcomes prescribed by the Scottish Ministers in Regulations under section 5(1) of the Act;
“The Scheme” means this Integration Scheme;
“Integration Planning and Delivery Principles” means the principles through which all integration activity should be focussed to achieve the Outcomes in accordance with sections 4 and 31 of the Act;
“Strategic Plan” means the plan which the Integration Joint Board is required to prepare and implement in relation to the delegated provision of health and social care services to adults in accordance with section 29 of the Act; and
“Strategic Planning Group” means the group which the Integration Joint Board is to establish in accordance with section 32 of the Act.

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

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

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

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

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

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

2.4.1 The Chief Officer of the IJB
2.4.2 The Chief Social Work Officer of the Council
2.4.3 The Chief Finance Officer of the IJB
2.4.4 A registered medical practitioner whose name is included in the list of primary medical services performers prepared by NHS Dumfries and Galloway
2.4.5 A registered nurse who is employed by NHS Dumfries and Galloway or by a person or body with which NHS Dumfries and Galloway has entered into a general medical services contract
2.4.6 A registered medical practitioner employed by NHS Dumfries and Galloway and not providing primary medical services

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

2.5.1 Staff of the Parties engaged in the provision of services provided under the Scheme
2.5.2 Third sector bodies carrying out activities related to health or social care in the Dumfries and Galloway area
2.5.3 Service users residing in the Dumfries and Galloway area
2.5.4 Persons providing unpaid care in the Dumfries and Galloway area

2.6 The IJB may, from time to time, appoint such additional non-voting
members as it considers necessary and expedient for the effective discharge of its functions as specified in the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014.

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

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

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

3.3.1 The entirety of Acute Hospital Services; and

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

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

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

4. Local Operational Delivery Arrangements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) a list of any targets, measures and arrangements which relate to functions of the Parties which are not Integration Functions but which are to be taken account of by the IJB when preparing the Strategic Plan (“Non-integration Functions Performance Target List”); and

(b) a list of all targets, measures and arrangements which relate to Integration Functions and for which responsibility is to transfer, in full or in part, to the IJB, including a statement of the extent to which responsibility for each target, measure or arrangement is to transfer (“Integration Functions Performance Target List”).

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Page 28 of 68
4.18 The Integration Functions Performance Target List will be prepared by the Parties in two stages:

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

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

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

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

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

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

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

5. Clinical and Care Governance and Professional Oversight

5.1 The Parties and the IJB are accountable for ensuring appropriate clinical and care governance arrangements in respect of their duties under the Act. The Parties also recognise that the establishment and continuous review of the arrangements for clinical and care governance are fundamental to the IJB delivering its ambitions. The clinical and care governance arrangements described below will provide to the IJB the required assurance of the quality and safety of service delivered. The Parties will have regard to the principles of the Scottish
5.2 The Act does not change the professional regulatory framework or established professional accountabilities currently in place. The Parties will ensure that explicit arrangements are made for professional supervisions, learning, support and continuous improvement for all staff.

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

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

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

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

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

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

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

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

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

5.11 In addition, the Medical Director:

5.11.1 Holds the delegated responsibility for information governance with regard to NHS Dumfries and Galloway services, and is also the Caldicott Guardian
5.11.2 Is the Responsible Officer within the terms of the Medical Profession (Responsible Officers) Regulations 2010, including the statutory role in making recommendations about the revalidation of doctors with a prescribed connection to NHS Dumfries and Galloway
5.11.3 Is responsible for under and post graduate education and training and teaching of medical students and this will continue to be discharged through the Director of Medical Education

5.12 In addition, the Executive Nurse Director:

5.12.1 Has delegated responsibility with regard to the Local Supervisory Authority for NHS Dumfries and Galloway Midwifery Practice
5.12.2 Is responsible for all undergraduate and post-graduate nurse and midwifery education and evaluation of student nurse clinical placements for all NHS Dumfries and Galloway services
5.12.3 Is responsible for revalidation of Nurses and Midwives by the Nursing and Midwifery Council (NMC), and Allied Health Professionals by the Health and Care Professions Council (HCPC)

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

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

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

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

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

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

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

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

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

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

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

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

The following principles will apply to staff delivering integrated services:

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

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

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

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

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

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

8. Finance

8.1 Resources

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

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

The payment for the shadow year 2015/16 will reflect the baseline established from a review of 2014/15 financial year and will reflect agreed changes through the 2015/16 budget setting process, to provide the Parties and the IJB with assurance that the delegated resources are sufficient to deliver the agreed delegated functions and level of service to be provided. These amounts will recognise existing plans for the
Parties for the functions which are to be delegated, adjusted for material items in the shadow period. These figures will be agreed as part of a due diligence procedure as agreed between the Parties. The payment will be linked through to patient activity information and the latest Integrated Resources Framework (IRF) will be referred to when deriving the allocation to localities.

8.1.3 Payment in subsequent years to the IJB for delegated functions

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

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

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

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

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

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

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

The allocations will be based on priority and need.

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

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

8.1.7 **Schedule of Payments**

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

8.2 **Integrated Budget In-Year Variations**

8.2.1 **Process for resolving budget variances**

**Overspend**

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

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

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

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

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

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

**Underspend**

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

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

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

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

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

8.2.2 Non Integrated Budgets

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

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

8.3 Managing Financial Performance

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

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

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

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

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

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

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

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

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

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

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

8.4 Arrangements for Asset Management and Capital

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

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

Principles

9.1 The Parties have established shared Principles as follows:

The Parties will

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

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

9.2.1 Local communities/general public
9.2.2 Health professionals, including GPs
9.2.3 Users of health care
9.2.4 Carers of users of health care
9.2.5 Commercial providers of health care
9.2.6 Non-commercial providers of health care
9.2.7 Dumfries and Galloway Council employees
9.2.8 NHS Dumfries and Galloway employees
9.2.9 Dumfries and Galloway Council Elected Members
9.2.10 Dumfries and Galloway NHS Board members
9.2.11 Social care professionals
9.2.12 Users of social care
9.2.13 Carers of users of social care
9.2.14 Commercial providers of social care
9.2.15 Non-commercial providers of social care
9.2.16 Staff of the Health Board and Local Authority who are not health professionals or social care professionals
9.2.17 Non-commercial providers of social housing
9.2.18 Third sector bodies carrying out activities related to health or social care
9.2.19 Trades Unions
9.2.20 Dumfries and Galloway Community Planning Partnership
9.2.21 Dumfries and Galloway Community Planning Stakeholders Group
9.2.22 Dumfries and Galloway Adult Protection Committee
9.2.23 Learning Disability Interest Groups
9.2.24 Accessible Transport Forum
9.2.25 Older People’s Consultative Group
9.2.26 Alzheimers Scotland
9.2.27 Day Centres
9.2.28 Dumfries and Galloway Over 50s Group
9.2.29 Royal Voluntary Service
9.2.30 The Food Train
9.2.31 Dumfries and Galloway Carers Centre
9.2.32 Capability Scotland
9.2.33 Third Sector, Dumfries and Galloway (Interface)
9.2.34 Department of Work and Pensions
9.2.35 Dumfries and Galloway Citizens Advice Service
9.2.36 Further/Higher Education
9.2.37 DG Voice
9.2.38 Dumfries and Galloway Multicultural Association
9.2.39 Dumfries and Galloway Inter Faith Group
9.2.40 MPs, MSPs, MSYPs
9.2.41 Age Scotland
9.2.42 Dumfries and Galloway LGBT Centre
9.2.43 User and Carer Involvement (UCI)

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

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

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

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

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

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

9.9 The IJB’s Participation and Engagement Strategy will be completed by 1 April 2016 and will address:
9.9.1 Communication routes
9.9.2 Hard to reach groups
9.9.3 Plain English
9.9.4 Training and development
9.9.5 Public Involvement Panel
9.9.6 Community Councils
9.9.7 Locality and thematic partnerships
9.9.8 Employee engagement
9.9.9 Impact Assessment

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

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

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

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

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

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

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

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

The Parties agree that:

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

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

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

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

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

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

11.1.6 External providers - All external providers commissioned by the Parties to provide services to the IJB will be required to have their own Complaints Procedure in place which will be quality assured by the Parties. Where complaints are received that relate to a service provided by an external provider, the lead Party will refer the complainant to the external provider for resolution of their complaint. This may be done by either provision of contact details or by the lead Party passing the complaint on, depending on the approach preferred by the complainant.
11.1.7 Each Party will have a clearly defined description of what constitutes a complaint contained within its complaints handling documentation, although for consistency, and since the Scottish Public Services Ombudsman (SPSO) exercises regulatory and scrutiny functions over health and social care, it is reasonable to adopt the SPSO’s definition of a complaint, which is ‘an expression of dissatisfaction by one or more members of the public about the local authority's (or NHS) action or lack of action, or about the standard of service provided by or on behalf of the local authority (or NHS).’

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

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

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

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

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

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

11.1.14 The proposed arrangements will be monitored and evaluated annually.

12. Claims Handling, Liability and Indemnity

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

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

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

12.4 Each Party will assume responsibility for progressing and determining any claim which relates to any act or omission on the part of one of their employees.
12.5 Each Party will assume responsibility for progressing and determining any claim which relates to any building which is owned or occupied by them.

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

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

13.1.1 Develop a risk management strategy by 31 December 2015 for approval by the IJB
13.1.2 Advise on the appropriate risk appetite for the IJB
13.1.3 Advise on any subsequent changes to the strategy and risk appetite, for approval by the IJB
13.1.4 Consider the effectiveness of the risk management process, ensuring that significant risks are being adequately managed
13.1.5 Monitor implementation of improvement action plans

13.2 The risk management strategy will:

13.2.1 Include the responsibilities of the Chief Officer, risk owners, and the Parties
13.2.2 Describe acceptable processes for mitigating risks
13.2.3 Propose that significant risks be reviewed every quarter by the risk management sub-group, along with progress on agreed actions
13.2.4 Set out the agreed reporting standard that will enable significant risks identified by the Parties to be compared across the Parties. These risks will be reviewed either annually or every six months. Information on risks will be effectively communicated through the use of a shared system to record and monitor any action being taken

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

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

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

(a) The Chief Executives of the Parties will meet to resolve the issue;
(b) If unresolved, the Parties will each prepare a written note of their position on the issue and exchange it with the other within 21 calendar days of the meeting in (a);
(c) In the event that the issue remains unresolved, representatives of the Parties will
proceed to mediation with a view to resolving the issue;

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

(e) Where the issue remains unresolved after following the processes outlined in (a) • (d) above, and if mediation does not allow an agreement to be reached within 6 months from the date of its commencement, or any other such time as the Parties may agree, either Party may notify Scottish Ministers that agreement cannot be reached.
### Annex 1

#### Part 1

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

<table>
<thead>
<tr>
<th>Column A</th>
<th>Column B</th>
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<tbody>
<tr>
<td><strong>The National Health Service (Scotland) Act 1978</strong></td>
<td>All functions of Health Boards conferred by, or by virtue of, the National Health Service (Scotland) Act 1978</td>
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<tr>
<td>Except functions conferred by or by virtue of—</td>
<td>section 2(7) (Health Boards);</td>
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<td>section 2CB(1) (functions of Health Boards outside Scotland);</td>
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<td>section 9 (local consultative committees);</td>
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<td>section 17A (NHS contracts);</td>
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<td>section 17C (personal medical or dental services);</td>
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<td>section 17I(2) (use of accommodation);</td>
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<td>section 17J (Health Boards' power to enter into general medical services contracts);</td>
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<td>section 28A (remuneration for Part II services);</td>
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<td>section 48 (residential and practice accommodation);</td>
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<td>section 55(6) (hospital accommodation on part payment);</td>
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<tr>
<td>section 57 (accommodation and services for private patients);</td>
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<td>section 64 (permission for use of facilities in private practice);</td>
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<tr>
<td>section 75A(7) (remission and repayment of charges and payment of travelling expenses);</td>
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<tr>
<td>section 75B(8) (reimbursement of the cost of services provided in another EEA state);</td>
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<tr>
<td>section 75BA(9) (reimbursement of the cost of services provided in another EEA state where expenditure is incurred on or after 25 October</td>
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</table>
section 82(10) use and administration of certain endowments and other property held by Health Boards;

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

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

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

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

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

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

and functions conferred by—

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

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

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

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

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

The National Health Service (Discipline Committees) (Scotland) Regulations 2006;
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<th>Column A</th>
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<tr>
<td></td>
<td>The National Health Service (General Ophthalmic Services) (Scotland) Regulations 2006;</td>
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<td>The National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009;</td>
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<td></td>
<td>The National Health Service (General Dental Services) (Scotland) Regulations 2010; and</td>
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<td></td>
<td>The National Health Service (Free Prescriptions and Charges for Drugs and Appliances) (Scotland) Regulations 2011(15).</td>
</tr>
</tbody>
</table>

**Disabled Persons (Services, Consultation and Representation) Act 1986**

Section 7  
(persons discharged from hospital)

**Community Care and Health (Scotland) Act 2002**

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

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

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

- section 22 (approved medical practitioners);  
- section 34 (inquiries under section 33: co-operation)(16);  
- section 38 (duties on hospital managers: examination, notification etc.)(17);  
- section 46 (hospital managers’ duties: notification)(18);  
- section 124 (transfer to other hospital);  
- section 228 (request for assessment of needs: duty on local authorities and Health Boards);  
- section 230 (appointment of patient’s responsible medical officer);  
- section 260 (provision of information to patient);
section 264 (detention in conditions of excessive security: state hospitals);

section 267 (orders under sections 264 to 266: recall);

section 281(19) (correspondence of certain persons detained in hospital);

and functions conferred by—

The Mental Health (Safety and Security) (Scotland) Regulations 2005(20);

The Mental Health (Cross border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2005(21);

The Mental Health (Use of Telephones) (Scotland) Regulations 2005(22); and

The Mental Health (England and Wales Cross-border transfer: patients subject to requirements other than detention) (Scotland) Regulations 2008(23).

Education (Additional Support for Learning) (Scotland) Act 2004

Section 23
(other agencies etc. to help in exercise of functions under this Act)

Public Services Reform (Scotland) Act 2010

All functions of Health Boards conferred by, or by virtue of, the Public Services Reform (Scotland) Act 2010

Except functions conferred by—

section 31(public functions: duties to provide information on certain expenditure etc.); and

section 32 (public functions: duty to provide information on exercise of functions).

Patient Rights (Scotland) Act 2011

All functions of Health Boards conferred by, or by virtue of, the Patient Rights (Scotland) Act 2011

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

- District General Hospital inpatient (scheduled and unscheduled)
- Diagnostic Services
- Community Hospital services
- Inpatient Mental Health
- Paediatrics
- Community Hospitals
- Hospital Outpatient Services
- NHS Community Services (Nursing, Allied Health Professionals, Mental Health Teams, Specialist End of Life Care, Older Adult Community Psychiatric Nursing, Re-ablement, Learning Disability Specialist, Community Midwifery, Speech and Language Therapy, Occupational Therapy, Physiotherapy, Audiology)
- Community Children’s Services - Child and Adolescent Mental Health Service, Primary Mental Health workers, Public Health Nursing, Health visiting, School Nursing, Learning Disability Nursing, Speech and Language Therapy, Occupational Therapy, Physiotherapy and Audiology, and Community Paediatricians
- Public Health Practitioner services
- GP Services
- GP Prescribing
- General and Community Dental Services
- Hotel services and facilities management
## Annex 2

### Part 1

**Functions delegated by the Council to the Integration Joint Board**

<table>
<thead>
<tr>
<th>Column A</th>
<th>Column B</th>
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<tbody>
<tr>
<td>Enactment conferring function</td>
<td>Limitation</td>
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</tbody>
</table>

#### National Assistance Act 1948(1)

Section 48  
(duty of councils to provide temporary protection for property of persons admitted to hospitals etc.)

#### The Disabled Persons (Employment) Act 1958(2)

Section 3  
(provision of sheltered employment by local authorities)

#### The Social Work (Scotland) Act 1968(3)

Section 1  
(local authorities for the administration of the Act)  
So far as it is exercisable in relation to another integration function.

Section 4  
(provisions relating to performance of functions by local authorities)  
So far as it is exercisable in relation to another integration function.

Section 8  
(research)  
So far as it is exercisable in relation to another integration function.

Section 10  
(financial and other assistance to voluntary organisations etc. for social work)  
So far as it is exercisable in relation to another integration function.

Section 12  
(general social welfare services of local authorities)  
Except in so far as it is exercisable in relation to the provision of housing support services.

Section 12A  
(duty of local authorities to assess needs)  
So far as it is exercisable in relation to another integration function.

Section 12AZA  
(assessments under section 12A - assistance)  
So far as it is exercisable in relation to another integration function.
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<th>Column A</th>
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<tr>
<td>Enactment conferring function</td>
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</table>

Section 13  
(power of local authorities to assist persons in need in disposal of produce of their work)  
Section 13ZA  
(provision of services to incapable adults)  
So far as it is exercisable in relation to another integration function.  
Section 13A  
(residential accommodation with nursing)  
Section 13B  
(provision of care or aftercare)  
Section 14  
(home help and laundry facilities)  
Section 28  
(burial or cremation of the dead)  
So far as it is exercisable in relation to persons cared for or assisted under another integration function.  
Section 29  
(power of local authority to defray expenses of parent, etc., visiting persons or attending funerals)  
Section 59  
(provision of residential and other establishments by local authorities and maximum period for repayment of sums borrowed for such provision)  
So far as it is exercisable in relation to another integration function.  

The Local Government and Planning (Scotland) Act 1982(4)  
Section 24(1)  
(The provision of gardening assistance for the disabled and the elderly)
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<tr>
<td>Enactment conferring function</td>
<td>Limitation</td>
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</table>

**Disabled Persons (Services, Consultation and Representation) Act 1986(5)**

Section 2
(rights of authorised representatives of disabled persons)

Section 3
(assessment by local authorities of needs of disabled persons)

Section 7
(persons discharged from hospital)
In respect of the assessment of need for any services provided under functions contained in welfare enactments within the meaning of section 16 and which are integration functions.

Section 8
(duty of local authority to take into account abilities of carer)
In respect of the assessment of need for any services provided under functions contained in welfare enactments (within the meaning set out in section 16 of that Act) which are integration functions.

**The Adults with Incapacity (Scotland) Act 2000(6)**

Section 10
(functions of local authorities)

Section 12
(investigations)

Section 37
(residents whose affairs may be managed)
Only in relation to residents of establishments which are managed under integration functions.

Section 39
(matters which may be managed)
Only in relation to residents of establishments which are managed under integration functions.

Section 41
(duties and functions of managers of authorised establishment)
Only in relation to residents of establishments which are managed under integration functions.

Section 42
(authorisation of named manager to withdraw from resident’s account)
Only in relation to residents of establishments which are managed under integration functions.

Section 43
(statement of resident’s affairs)
Only in relation to residents of establishments which are managed under integration functions.
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<tr>
<td>Enactment conferring function</td>
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<tr>
<td>Section 44 (resident ceasing to be resident</td>
<td>Only in relation to residents of establishments which are managed under</td>
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<td>of authorised establishment)</td>
<td>integration functions.</td>
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<tr>
<td>Section 45 (appeal, revocation etc)</td>
<td>Only in relation to residents of establishments which are managed under</td>
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<td>integration functions.</td>
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<tr>
<td>The Housing (Scotland) Act 2001(7)</td>
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<td>Section 92 (assistance for housing purposes)</td>
<td>Only in so far as it relates to an aid or adaptation.</td>
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<td>The Community Care and Health (Scotland) Act</td>
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<td>Section 5 (local authority arrangements for</td>
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<td>residential accommodation outwith Scotland)</td>
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<td>Section 14 (payments by local authorities</td>
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<td>towards expenditure by NHS bodies on</td>
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<td>prescribed functions)</td>
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<td>The Mental Health (Care and Treatment) (Scotland) Act 2003(9)</td>
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<td>Section 17 (duties of Scottish Ministers,</td>
<td>Except in so far as it is exercisable in relation to the provision of</td>
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<td>local authorities and others as respects</td>
<td>housing support services.</td>
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<td>Commission)</td>
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<td>Section 25 (care and support services etc)</td>
<td>Except in so far as it is exercisable in relation to the provision of</td>
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<td>housing support services.</td>
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<td>Section 26 (services designed to promote</td>
<td>Except in so far as it is exercisable in relation to the provision of</td>
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<td>well-being and social development)</td>
<td>housing support services.</td>
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<tr>
<td>Section 27 (assistance with travel)</td>
<td>Except in so far as it is exercisable in relation to the provision of</td>
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<td>housing support services.</td>
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<tr>
<td>Section 33 (duty to inquire)</td>
<td></td>
</tr>
<tr>
<td>Section 34 (inquiries under section 33:</td>
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</tr>
<tr>
<td>Co-operation)</td>
<td></td>
</tr>
<tr>
<td>Column A</td>
<td>Column B</td>
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<td>----------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Enactment conferring function</td>
<td>Limitation</td>
</tr>
<tr>
<td>Section 228</td>
<td>(request for assessment of needs: duty on local authorities and Health Boards)</td>
</tr>
<tr>
<td>Section 259</td>
<td>(advocacy)</td>
</tr>
</tbody>
</table>

**The Housing (Scotland) Act 2006(10)**

Section 71(1)(b) Only in so far as it relates to an aid or (assistance for housing purposes) adaptation.

**The Adult Support and Protection (Scotland) Act 2007(11)**

Section 4 (council’s duty to make inquiries)

Section 5 (co-operation)

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

Section 11 (assessment Orders)

Section 14 (removal orders)

Section 18 (protection of moved persons property)

Section 22 (right to apply for a banning order)

Section 40 (urgent cases)

Section 42 (adult Protection Committees)

Section 43 (membership)
<table>
<thead>
<tr>
<th>Column A</th>
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<tr>
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<td>Limitation</td>
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</tbody>
</table>

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

Section 5  
(choice of options: adults)

Section 6  
(choice of options under section 5: assistances)

Section 7  
(choice of options: adult carers)

Section 9  
(provision of information about self-directed support)

Section 11  
(local authority functions)

Section 12  
(eligibility for direct payment: review)

Section 13  
(further choice of options on material change of circumstances)  
Only in relation to a choice under section 5 or 7 of the Social Care (Self-directed Support) (Scotland) Act 2013.

Section 16  
(misuse of direct payment: recovery)

Section 19  
(promotion of options for self-directed support)

**Carers (Scotland) Act 2016**

<table>
<thead>
<tr>
<th>Column A</th>
<th>Column B</th>
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<tbody>
<tr>
<td>Enactment conferring function</td>
<td>Limitation</td>
</tr>
</tbody>
</table>
| Section 21  
(duty to set local eligibility criteria) | Section 6  
(duty to prepare adult carer support plan) |

Section 24  
(duty to provide support)
Section 25  
(provision of support to carers: breaks from caring)  
Section 31  
(duty to prepare local carer strategy)  
Section 34  
(information and advice services for carers)  
Section 35  
(short break services statements)  

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

<table>
<thead>
<tr>
<th>Column A</th>
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<tbody>
<tr>
<td>Enactment conferring function</td>
<td>Limitation</td>
</tr>
</tbody>
</table>
The Community Care and Health (Scotland) Act 2002

Section 4(13)
The functions conferred by Regulation 2 of the
Community Care (Additional Payments) (Scotland)
Regulations 2002(14)

Part 2
Services currently provided by the Council which are to be integrated

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

<table>
<thead>
<tr>
<th>DOCUMENT CONTROL</th>
<th>POLICY NO.</th>
<th>IJB02</th>
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<tr>
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<td>IJB Governance Documents</td>
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</tr>
<tr>
<td>Author</td>
<td>Katy Lewis</td>
<td>Version no.</td>
</tr>
<tr>
<td>Reviewer</td>
<td>Julie White</td>
<td>Implementation date</td>
</tr>
<tr>
<td>Scope (Applicability)</td>
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<td></td>
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<tr>
<td>Status</td>
<td>Approved</td>
<td>Next review date</td>
</tr>
<tr>
<td>Approved by</td>
<td>IJB</td>
<td>Last review date:</td>
</tr>
</tbody>
</table>
1. **General**

1.1 The Standing Orders as adopted by the Board on 17th March 2016, as amended if applicable, shall apply to the meetings of committees.

1.2 The quorum for any meeting of a committee shall be half of its voting members.

1.3 Substitutes are permitted from the membership of the Integration Joint Board, but a voting member may not attend as a substitute for a non-voting member.

1.4 A substitute voting member of the Integration Joint Board may be a committee member.

1.5 Minutes of the committee are to be reported and approved at the next meeting of the committee.

1.6 Approved minutes of committee meetings will also be reported to the Integration Joint Board for noting.

2. **Committees**

2.1 The Integration Scheme sets out 2 Committees that the Board would delegate authority to – these being a Clinical and Care Governance Committee and the Risk Management Sub-Group.

2.2 Given that there is also a statutory requirement for an Audit Committee to be established to ensure compliance with relevant legislation it is proposed that in total 3 committees are established being:-

- Audit and Risk Management Committee
- Clinical and Care Governance Committee
- Performance and Finance Committee

2.3 The committee remits in the sections that follow, reflect what we said we would do in the Integration Scheme for each committee.

2.4 Dependent on the business need for further committees, this Scheme may be amended as required by the Board.

3. **Audit and Risk Management Committee**

Remit and Powers

1. To appoint an Internal Auditor.

2. To review the effectiveness of the Board’s framework of governance, risk management and internal control.

3. To approve the annual risk based internal audit plan and monitor internal audit work against the plan.
4. To consider the annual external audit plan.

5. To approve the internal audit charter and monitor the independence and effectiveness of the internal audit function.

6. To consider internal and external audit reports and receive assurance that agreed recommendations have been timeously and effectively implemented.

7. Consider the unaudited accounts and governance statement.

8. To redirect internal audit resources as and when deemed appropriate.

9. To make recommendations to the Board on any matters within its remit which are otherwise referred to it by the Board.

10. To develop a risk management strategy for approval by the Board.

11. To advise on the appropriate risk appetite for the Board.

12. To advise on any subsequent changes to the risk management strategy and risk appetite for approval by the Board.

13. To consider the effectiveness of the risk management process, ensuring that significant risks are being adequately managed.

14. To monitor implementation on improvement action plans.

Membership

1. Six Members of the Board comprising 2 voting members appointed by NHS Dumfries and Galloway and 2 voting members appointed by Dumfries and Galloway Council, and 2 non-voting members.

2. The Chair and Vice-Chair of the Committee are to be appointed by the Board.

3. The Chair and Vice-Chair of the Board may not be members of the Committee.

4. In Attendance – Lead Audit and Risk Officers from both parties.

Frequency of Meetings

At least three time per annum. Additional meetings can be agreed by the Chair if required.
4. Clinical and Care Governance Committee

Remit

1. To provide an effective overview of the clinical and care governance agenda across integrated services.

2. To ensure that quality monitoring and governance arrangements are in place for safe and effective health and social care service delivery in Dumfries and Galloway and will include as a minimum these elements listed below:
   - Service user/patient experience of integrated delivery, including complaints raised by service users, carers and families.
   - Achievement of Personal outcomes.
   - Risk management, including adverse event reporting and learning systems.
   - Inspection activity and associated improvement plans.
   - Research and development.
   - Quality and safety of care, including continuous improvement.
   - Statutory and legal requirements.
   - Quality assurance in commissioned services.
   - Workforce development and regulation.

Membership

1. Four voting members comprising 2 from Dumfries and Galloway Council and 2 from Dumfries and Galloway NHS Board.

2. Four non-voting Board Members being:
   - the Chief Officer,
   - the Chief Social Work Officer,
   - the Medical Director (Registered Medical Practitioner (not Primary Medical Services ) representative); and
   - the Director of Nursing (Registered Nurse Representative)

3. The Chair and Vice-Chair are to be appointed by the Board.

Frequency of Meetings

At least three time per annum. Additional meetings can be agreed by the Chair if required.
1. The specific focus of the Performance and Finance Committee will be to report to the Integration Joint Board (IJB) following review, discussion and assessment of the effectiveness of:

- Plans to achieve financial balance within any given year.
- Development of Revenue Finance Plans for the Integration Joint Board.
- Overall Performance against the Strategic Plan, National Outcomes/Local Delivery Plan/HEAT Targets and the locality plans.
- Outcomes from the Integration Joint Board’s investment decisions and scrutiny of investment decisions to ascertain value for money.
- To consider external inspections and value for money reports and their application and to make recommendations to the Integration Joint Board on the outcome of the scrutiny process.
- Achievement of the Integration Joint Board’s efficiency plans and targets.
- Development of the Strategic Plan including the Locality Plans.
- How the financial governance and strategic risks are being managed, as well as noting the operational risks managed by the partnering agencies.
- To ensure that Best Value is achieved in the decision making processes, through the impact of decisions on policy and in service delivery.
- To review key performance indicators and targets in respect of the scrutiny function and to assure continuous improvement in delivery of key performance indicators.

Membership

1. Six voting members, including the Committee Chair, comprising three from Dumfries and Galloway Council and three from Dumfries and Galloway NHS Board.

2. The Chair of the Integration Joint Board will undertake the role of Chair of the Committee.

3. Three non-voting Board Members being:
   - the Chief Officer,
   - the Chief Finance Officer
   - the Chief Social Work Officer

Meeting frequency

Committee meetings will be held on a quarterly basis throughout any given year.
1.1. Please ensure that all acronyms etc are set out in full. All acronyms must be set out in full the first time they appear in a paper with the acronym following in brackets.
Dumfries and Galloway Integration Joint Board

DIRECTION

(ISHED UNDER SECTIONS 26-28 OF THE PUBLIC BODIES (JOINT WORKING) (SCOTLAND) ACT 2014)

<p>| | |</p>
<table>
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<tbody>
<tr>
<td>1.</td>
<td>Title of Direction and Reference Number</td>
</tr>
<tr>
<td>2.</td>
<td>Date Direction Issued by Integration Joint Board</td>
</tr>
<tr>
<td>3.</td>
<td>Date from which Direction takes effect</td>
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<td>4.</td>
<td>Direction to</td>
</tr>
<tr>
<td>5.</td>
<td>Does this direction supersede, amend or cancel a previous Direction? If yes, include the reference number(s)</td>
</tr>
<tr>
<td>6.</td>
<td>Functions covered by Direction</td>
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<tr>
<td>7.</td>
<td>Full text of Direction</td>
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<tr>
<td>8.</td>
<td>Budget allocated by Integration Joint Board to carry out Direction</td>
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<tr>
<td>9.</td>
<td>Desired Outcomes</td>
</tr>
<tr>
<td>10.</td>
<td>Performance Monitoring Arrangements</td>
</tr>
<tr>
<td>11.</td>
<td>Date Direction will be Reviewed</td>
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</tbody>
</table>
Dumfries and Galloway Health and Social Care
Partnership

Strategic Planning Group
Terms of Reference

Introduction
Section 32 of The Public Bodies (Joint Working) (Scotland) Act 2014 requires that Integration Authorities establish a Strategic Planning Group (SPG). The Act further stipulates the membership, role and function of the SPG, these are reflected in this terms of reference document.

1 Membership
The SPG must involve a range of relevant stakeholders including representatives of groups prescribed by Scottish Ministers as having an interest in health and social care. These are:

- Users of health care
- Carers of users of health care
- Commercial providers of health care
- Non-commercial providers of health care
- Health professionals
- Social care professionals
- Users of social care
- Carers of users of social care
- Commercial providers of social care
- Non-commercial providers of social care
- Non-commercial providers of social housing
- Third sector bodies carrying out activities related to health or social care

The Dumfries and Galloway Integration Joint Board (IJB) also requires the SPG have representation from:

- Staff
- Diversity groups

An up to date membership list, including contact details is published on the Dumfries and Galloway Health and Social Care Partnership Website (include link).
Appointment

Members will be nominated from the groups they represent and appointed by the IJB. It is for the IJB to decide whether persons are suitable to represent the interests of the group or locality that has nominated them.

Replacement or removal

The IJB may appoint members in place of members who resign or who are removed from membership of the group.

The IJB may remove persons from the membership of the group, for example if it is felt that there is over representation to one of the prescribed groups.

The validity of the work undertaken by the SPG is not affected by any vacancy in its membership.

Code of conduct

Members are representatives of wider stakeholder groups across the Dumfries and Galloway Health and Social Care Partnership. As such it is expected that each individual will adhere to the seven principles of public life (https://www.gov.uk/government/publications/the-7-principles-of-public-life/the-7-principles-of-public-life--2)

1. Honesty
2. Openness
3. Accountability
4. Integrity
5. Objectivity
6. Selflessness
7. Leadership

In addition members are expected to show respect for all people and their views or opinions regardless of race, age, disability, gender, sexuality, religion or belief.

Members should prepare for all meetings and conduct themselves appropriately during meetings. Members will respect any confidential information shared with them during the course of meetings.

2 Role and Function

Development of Strategic Plan

The SPG has a role in shaping and influencing the Strategic Plan for health and social care and in continuing to review progress measured against the statutory outcomes for health and wellbeing, and associated indicators.

Review of Strategic Plan

The IJB has a requirement to review the effectiveness of its strategic plan,
whilst having regard to the views of its SPG on:
- The effectiveness of the arrangements for carrying out the integration functions
- When there IJB prepare a replacement strategic plan

**Significant Decisions outwith the Strategic Plan**
The IJB must seek and have regard to the view of its SPG on any significant decisions outwith the strategic plan. Significant decisions are defined as decisions which the IJB considers might significantly affect the provision of a service provided in pursuance of the integrated functions.

**Shaping and Influencing Strategy and Plans**
Any strategy or plan being developed by the IJB should seek the views of the SPG at an early stage. This will allow the SPG to shape and influence the development of the strategy or plan.

### 3 Objectives

To shape and influence the development of health and social care strategic plan
To support the review of health and social care strategic plan as necessary (at least once every three years)
To provide views to IJB in regard to whether a replacement health and social care strategic plan is required
To provide views to IJB in regard to significant decisions outwith the strategic plan
To shape and influence the development of IJB strategies and plans

### 4 Operating Arrangements

Members will be invited to meetings/sessions in good time (with at least 4 – 6 weeks’ notice) and in locations across the region.

The programme of all meetings/sessions will be published on the SPG page of the [Dumfries](#) and Galloway Health and Social Care Partnership website (link to be added)

Any papers to be discussed will be provided to members electronically and in hard copy at the meeting as appropriate.

Communication between meetings will be electronically by email unless otherwise requested.

**Expenses**
Members will be reimbursed ‘out of pocket’ expenses in line with current volunteer expenses guidance. See Appendix 1

### 5 Frequency of Meetings
The SPG will meet 2 times per year, more if required. The group has flexibility to meet in small group sessions and/or large group of all members as required.

6 Support

To enable the Strategic Planning Group to properly fulfil its role it will be supported and facilitated by the Governance Officer for the Health and Social Care Partnership. Wider support from across the Health and Social Care Partnership will be identified to source and provide information to assist the SPG in fulfilling its role and function. Further they will support members to engage effectively with the organisations they represent.

7 Review

These terms of reference will be reviewed as part of the review of The Health and Social Care Strategic Plan, at least every three years. This will include a review of the membership to ensure a balance of the group is maintained.

<table>
<thead>
<tr>
<th>Author</th>
<th>Designation</th>
<th>Published</th>
<th>Review</th>
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<tr>
<td>Viv Gration</td>
<td>Strategic Planning &amp; Commissioning Manager</td>
<td>December 2016</td>
<td>November 2018</td>
</tr>
<tr>
<td>Linda Owen</td>
<td>Strategic Planning and Commissioning Manager</td>
<td>July 2019</td>
<td>June 2021</td>
</tr>
</tbody>
</table>
Summary Performance Report up to 31st October 2019

Author: George Noakes
Assistant. Performance and Intelligence Manager

Sponsoring Director: Vicky Freeman
Head of Strategic Planning

Date: 25th November 2019

RECOMMENDATION

The Board is asked to discuss and note the Summary Performance Report

CONTEXT

Strategy / Policy:

- NHS Dumfries and Galloway, Annual Operational Plan 2019/20
- Dumfries and Galloway Integration Joint Board Strategic Plan
- Scottish Government, Waiting Times Improvement Plan (October 2018)
- Scottish Government, National Unscheduled Care - 6 Essential Actions Improvement Programme
- Scottish Government, Health and Social Care Delivery Plan (2016)
- Scottish Government, Mental Health Strategy 2017-2027

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

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

GLOSSARY OF TERMS

AHP - Allied Health Professional
CAU - Combined Assessment Unit
CAMHS - Child and Adolescent Mental Health Service
ED - Emergency Department
ISD - Information Service Division (part NHS National Services Scotland)
MSG - Ministerial Strategic Group
MSK - Musculoskeletal
TTG - Treatment Time Guarantee
## MONITORING FORM

| Policy / Strategy                                                                 | • NHS Dumfries and Galloway, Annual Operational Plan 2019/20  
|                                                                                   | • Dumfries and Galloway Integration Joint Board Strategic Plan  
|                                                                                   | • Scottish Government, Waiting Times Improvement Plan (October 2018)  
|                                                                                   | • Scottish Government, National Unscheduled Care - 6 Essential Actions Improvement Programme  
|                                                                                   | • Scottish Government, Health and Social Care Delivery Plan (2016)  
|                                                                                   | • Scottish Government, Mental Health Strategy 2017-2027  
|                                                                                   | • Scottish Government, The Best Start (2017)  |

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<tr>
<th>Staffing Implications</th>
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<tr>
<td>Financial Implications</td>
<td>None</td>
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| Consultation / Consideration | • NHS Dumfries and Galloway Chief Executive and Executive Management Team  
|                             | • NHS Dumfries and Galloway Board  
|                             | • NHS Dumfries and Galloway Performance Committee  
|                             | • Dumfries and Galloway Health and Social Care Senior Management Team  
|                             | • Dumfries and Galloway Integration Joint Board (the revised performance framework)  |

<table>
<thead>
<tr>
<th>Risk Assessment</th>
<th>Risks will be considered by the NHS Board</th>
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</thead>
</table>
| Risk Appetite   | Low [x] Medium [ ] High [ ]  
|                 | Performance includes many aspects of clinical care, which the NHS Board has designated a low appetite for risk.  |

| Sustainability | Individual measures can be an indicator of ongoing sustainability |

<table>
<thead>
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<th>Compliance with Corporate Objectives</th>
<th>This paper supports the Corporate Objectives 2, 5 and 7.</th>
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<th>This paper support Outcomes 3 and 6.</th>
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<th>Performance Management</th>
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<tr>
<th>Impact Assessment</th>
<th>Not Applicable</th>
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NOT PROTECTIVELY MARKED

Page 2 of 4
1. Situation

This Summary Performance Report gives an overview of operational performance for key measures relating to NHS Dumfries and Galloway’s priorities.

Most of the information in the Summary Performance Report is automatically generated from local information systems. These figures are an early indication of activity and may not exactly match the National Official Statistics publications which are issued later in time.

Operational performance is reported in more detail at General Managers’ senior management teams.

2. Key points from the Summary Performance Report (Appendix 1)

Community Based Health and Social Care

- **The number of adults admitted in an emergency** – The figure for October 2019 is 1,363 people. The target trajectory for October 2019 is 1,265 people.

- **The number of bed days for adults admitted in an emergency** – The figure for October 2019 is 12,241 bed days. The target trajectory for October 2019 is 10,630 bed days.

- **Delayed discharges** – The figure for October 2019 is 2,344 bed days. The target trajectory for October 2019 is 1,109 bed days.

- **AHP MSK 4 weeks** – The figure for October 2019 is 47.0%. The target is 90%.

Acute and Diagnostics

- **Outpatient appointments** – The figure for October 2019 is 91.6%. The target is 95.0%.

- **6 week wait for diagnostic tests** – The figure for October 2019 is 96.2%. The target is 100%.

- **18 weeks referral to treatment** – The figure for October 2019 is 85.3%. The target is 90%.

- **Emergency department (B19 and E3)** – The figure for October 2019 is 90.9%. The target is 95%.

- **Attending the emergency department** – The figure for October 2019 is 4,230 people. The target trajectory for October 2019 is 3,852 people.
Mental Health

- Psychological Therapies (18 weeks) – The figure for September 2019 is 57.7%. The target trajectory for September 2019 is 78.0%.

Women and Children’s

- The number of young people admitted in an emergency – The figure for October 2019 is 227 young people. The target trajectory for October 2019 is 216 young people.

Corporate Services

- Sickness Absence – This information is provided through a national system. To produce results takes approximately 6 to 8 weeks. The most recent available result is for September 2019 when the sickness absence rate for NHS Dumfries and Galloway was 5.0%. The target is 4%.

3. Recommendations

NHS Board is asked to discuss and note the NHS Board Summary Performance report.
## Community Health and Social Care

**E1.2 (LS)** The number of people admitted as an emergency, people aged 18 or older

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Latest Figure</th>
<th>Previous Figure</th>
<th>25 month trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct 2019</td>
<td>1,363</td>
<td>1,265 (TT)</td>
<td></td>
</tr>
<tr>
<td>Sep 2019</td>
<td>1,284</td>
<td>1,265 (TT)</td>
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</table>

**E2.2 (LS)** The number of bed days for people admitted as an emergency, people aged 18 or older, acute specialties

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Latest Figure</th>
<th>Previous Figure</th>
<th>25 month trend</th>
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</thead>
<tbody>
<tr>
<td>Oct 2019</td>
<td>12,241</td>
<td>10,630 (TT)</td>
<td></td>
</tr>
<tr>
<td>Sep 2019</td>
<td>11,781</td>
<td>10,649 (TT)</td>
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</tbody>
</table>

**E4 (LS)** The number of bed days occupied by all people experiencing a delay in their discharge from hospital, per month, people aged 18 and older

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Latest Figure</th>
<th>Previous Figure</th>
<th>25 month trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct 2019</td>
<td>2,344</td>
<td>1,019 (TT)</td>
<td></td>
</tr>
<tr>
<td>Sep 2019</td>
<td>1,906</td>
<td>1,019 (TT)</td>
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</table>

**B21 (LS)** Percentage of people who wait no longer than 4 weeks from referral to first appointment with the Allied Health Professional (AHP) Musculoskeletal (MSK) service

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Latest Figure</th>
<th>Previous Figure</th>
<th>25 month trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct 2019</td>
<td>47.0%</td>
<td>90.0% (T)</td>
<td></td>
</tr>
<tr>
<td>Sep 2019</td>
<td>45.0%</td>
<td>90.0% (T)</td>
<td></td>
</tr>
</tbody>
</table>

### Key
- ↑: Statistical tests suggest the number has increased over time
- ↘: Statistical tests suggest the number has decreased over time
- ⇔: Statistical tests suggest there is no change over time
- (S): The number we compare against is the result for Scotland
- (T): The number we compare against is a target set by the Scottish Government
- (TT): The number we compare against is an agreed Target Trajectory
- (LS): The result presented here is a Local Statistic calculated using data held in Dumfries and Galloway
- (OS): The result presented here is an Official Statistic provided by ISD Scotland
### Acute and Diagnostics

<table>
<thead>
<tr>
<th>RAG</th>
<th>Time Period</th>
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<th>Comparison</th>
<th>Previous Figure</th>
<th>Comparison</th>
<th>25 month trend</th>
</tr>
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<tr>
<td></td>
<td>Oct 2019</td>
<td>77.3%</td>
<td>75.0% (TT)</td>
<td>Sep 2019</td>
<td>81.3%</td>
<td>75.0% (TT)</td>
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<tr>
<td>B4</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Oct 2019</td>
<td>91.6%</td>
<td>95.0% (T)</td>
<td>Sep 2019</td>
<td>90.2%</td>
<td>95.0% (T)</td>
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<tr>
<td>B6</td>
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<tr>
<td></td>
<td>Oct 2019</td>
<td>96.2%</td>
<td>100.0% (T)</td>
<td>Sep 2019</td>
<td>94.7%</td>
<td>100.0% (T)</td>
</tr>
<tr>
<td>B7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Oct 2019</td>
<td>85.3%</td>
<td>90.0% (T)</td>
<td>Sep 2019</td>
<td>85.1%</td>
<td>90.0% (T)</td>
</tr>
<tr>
<td>B5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Oct 2019</td>
<td>90.9%</td>
<td>95.0% (T)</td>
<td>Sep 2019</td>
<td>91.9%</td>
<td>95.0% (T)</td>
</tr>
<tr>
<td>B19</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Oct 2019</td>
<td>4,230</td>
<td>3,852 (TT)</td>
<td>Sep 2019</td>
<td>4,312</td>
<td>3,852 (TT)</td>
</tr>
<tr>
<td>E3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Oct 2019</td>
<td>6,287</td>
<td></td>
<td>Sep 2019</td>
<td>6,167</td>
<td></td>
</tr>
<tr>
<td>B22</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sep 2019</td>
<td>96.1%</td>
<td>95.0% (T)</td>
<td>Aug 2019</td>
<td>96.4%</td>
<td>95.0% (T)</td>
</tr>
<tr>
<td>B2(1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sep 2019</td>
<td>100.0%</td>
<td>95.0% (T)</td>
<td>Aug 2019</td>
<td>97.5%</td>
<td>95.0% (T)</td>
</tr>
<tr>
<td>B2(2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Mental Health

**B11 (LS) Psychological therapies waiting times:** Percentage of people who commence Psychological Therapy based treatment within 18 weeks of referral

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Dumfries and Galloway</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sep 2019</td>
<td>57.7%</td>
<td>78.0% (TT)</td>
</tr>
<tr>
<td>Aug 2019</td>
<td>70.7%</td>
<td>77.7% (TT)</td>
</tr>
</tbody>
</table>

### Women and Children's

**B10 (OS) CAMHS waiting times:** Percentage of young people who commence treatment for specialist Child and Adolescent Mental Health Services within 18 weeks of referral

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Dumfries and Galloway</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct 2019</td>
<td>100.0%</td>
<td>90.0% (T)</td>
</tr>
<tr>
<td>Sep 2019</td>
<td>99.2%</td>
<td>90.0% (T)</td>
</tr>
</tbody>
</table>

**E1.1 (LS) The number of people admitted as an emergency, people aged under 18**

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Dumfries and Galloway</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct 2019</td>
<td>227</td>
<td>216 (TT)</td>
</tr>
<tr>
<td>Sep 2019</td>
<td>243</td>
<td>216 (TT)</td>
</tr>
</tbody>
</table>

### Corporate Services

**B18 (LS) Sickness absence rate:** Proportion of hours lost to sickness absence amongst NHS Dumfries and Galloway employees

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Dumfries and Galloway</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sep 2019</td>
<td>5.0%</td>
<td>4.0% (T)</td>
</tr>
<tr>
<td>Aug 2019</td>
<td>4.5%</td>
<td>4.0% (T)</td>
</tr>
</tbody>
</table>
### Background

**E1.1: Number of emergency admissions, people aged under 18**

This indicator is reported to the national Ministerial Steering Group (MSG) every quarter. The desired trajectory has been agreed between the NHS Board, IJB and MSG.

**E1.2: Number of emergency admissions, people aged 18 or older**

This indicator is reported to the national Ministerial Steering Group (MSG) every quarter. The desired trajectory has been agreed between the NHS Board, IJB and MSG.

**E2: Emergency bed days people aged 18 or older**

This indicator is a measure of the number of bed days that are occupied by people who have been assessed as appropriate to be discharged to another setting. It includes all hospital settings, acute, community, cottage and mental health and hospital to hospital transfers (which the national figures do not). These figures are for people aged 18 or over.

**E4: Delayed Discharges bed days lost**

This indicator is a measure of the number of bed days that are occupied by people who have been assessed as appropriate to be discharged to another setting. It includes all hospital settings, acute, community, cottage and mental health and hospital to hospital transfers (which the national figures do not). These figures are for people aged 18 or over.

**B21: AHP MSK 4 weeks**

Allied Health Professional Musculoskeletal service. This is a combined measure for a range of professional groups, all supporting different aspects of the musculoskeletal service.

**B4: TTG 12 weeks**

The Treatment Time Guarantee (TTG) is set out in 'The Patient Right's (Scotland) Act 2011' which places a legal requirement on health boards. Once planned inpatient or day case treatment has been agreed, the person must receive that treatment within 12 weeks. Scottish Government has issued boards with interim targets for TTG: 75% by October 2019; 85% by October 2020; 100% by March 2021

**B6: Dr lead new outpatients 12 weeks**

Not all outpatient clinics are led by doctors. This figure only includes doctor led clinics.

**B7: Diagnostic 6 weeks**

This is a combined result for key tests including upper gastro-inestinal endoscopy, flexible sigmoidoscopy, colonoscopy, cystoscopy, CT scans, MRI scans and non-obstetric ultrasound scans. An aspirational local target is set at 4 weeks.

**B5: 18 weeks performance**

The complete 18 week waiting times journey from referral to treatment is impacted by all the above partial segments of the 18 week pathways.

**B19: Emergency Department 4 hours**

This measure indicates the length of time people experience between arrival and discharge from the emergency department (ED). Boards have been asked to commit to bring performance back to the level at March 2017, which was a target of 92.2%

**E3: Emergency department attendances**

The management of the combined assessment unit (CAU) affects how activity seen in the ED is managed. This area is the focus of large scale redesign work supported by Scottish Government.

**B22: Dr Led return tickets**

This measure is about the efficient use of outpatient appointments.

**B2(1): Cancer 31 days**

This indicator is 1 of 2 Local Delivery Plan (LDP) Standards, chosen by the Scottish Government, that focus on the efficient delivery of support and treatment when a suspicion of cancer is raised. Due to the small numbers involved the monthly figures presented here are only intended as a very early indication of performance. Official statistics are published using quarterly rates, the variation from local to official figures is +/- 3%

**B2(2): Cancer 62 days**

This indicator is the second Local Delivery Plan (LDP) Standards, chosen by the Scottish Government, that focus on the efficient delivery of support and treatment when a suspicion of cancer is raised. Due to the small numbers involved the monthly figures presented here are only intended as a very early indication of performance. Official statistics are published using quarterly rates, the variation from local to official figures is +/- 3%

**B11: Psychological Therapies 18 weeks**

The 18 week waiting times journey from referral to the start of psychological therapy treatment. This information is taken from reports published by ISD Scotland.

**B10: CAMHS 18 weeks**

The 18 week waiting times journey from referral to the start of treatment by the Child and Adolescent Mental Health Service (CAMHS).

**E1.1: Number of emergency admissions, people aged under 18**

The national figures provided to MSG for children admitted as an emergency are approximately 13% higher than local figures as these include admissions that occur out of area. The desired trajectory has been agreed between the NHS Board, IJB and MSG.

**B18: Sickness Absence**

The proportion of days lost to sickness absence amongst NHS Dumfries and Galloway employees was 4.97%. The national target is 4% or lower.
DUMFRIES and GALLOWAY NHS BOARD

2nd December 2019

Financial Performance Update 2019/20
Quarter Two Forecast Update and position to Month 7 as at 31st October 2019

Author: Graham Stewart
Deputy Director of Finance

Sponsoring Director: Katy Lewis
Director of Finance

Kelly McClure
Strategic Finance Manager

Date: 11th November 2019

RECOMMENDATION

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

- The overall forecast deficit for 2019/20 currently projected at £3.4m based on the Quarter Two financial review.
- The updated financial position at the end of October 2019 (month 7) reflects an overspend year to date of £2.564m.
- The ongoing level of financial risk in the position.
- No specific financial provision has been made for a No-deal Brexit within the current financial position.

CONTEXT

Strategy/Policy:

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

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

This report provides the position as at 31st October 2019, month 7. The Medium Term Health and Social Care Financial Framework requires NHS Boards to deliver financial break-even over a three year planning period with the first year of the new cycle set as 2019/20. Boards have flexibility to report underspends or overspend of up to one per cent of Boards core revenue funding. For Dumfries and Galloway, 1% flexibility would equate to £3.4m.
## GLOSSARY OF TERMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AOP</td>
<td>Annual Operation Plan</td>
</tr>
<tr>
<td>CNORIS</td>
<td>Clinical Negligence and Other Risks Scheme</td>
</tr>
<tr>
<td>CRES</td>
<td>Cash Releasing Efficiency Savings</td>
</tr>
<tr>
<td>DE</td>
<td>Direct Engagement</td>
</tr>
<tr>
<td>ECC</td>
<td>Emergency Care Centre</td>
</tr>
<tr>
<td>FHS</td>
<td>Family Health Services</td>
</tr>
<tr>
<td>IJB</td>
<td>Integration Joint Board</td>
</tr>
<tr>
<td>NMF</td>
<td>New Medicines Fund</td>
</tr>
<tr>
<td>NSD</td>
<td>National Services Division</td>
</tr>
<tr>
<td>RRL</td>
<td>Revenue Resource Limit</td>
</tr>
<tr>
<td>SAM</td>
<td>Sustainability and Modernisation Programme</td>
</tr>
<tr>
<td>SLA</td>
<td>Service Level Agreement</td>
</tr>
<tr>
<td>SMC</td>
<td>Scottish Medicines Consortium</td>
</tr>
<tr>
<td>TAVIs</td>
<td>Heart valve procedures</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 the Annual Operational 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>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>
</tbody>
</table>
| Risk Appetite                     | Low [x] Medium [ ] High [ ]  
- The Board has an in-year financial savings target of £19.6m and is looking to deliver a breakeven position through making further savings. The current projected deficit if £3.4m. |
| Sustainability                    | The Financial Plan supports the sustainability agenda through the delivery of efficient solutions to the delivery of CRES. Key to the ongoing achievement of savings plan will be the delivery of significant transformational changes to services. |
| Compliance with Corporate Objectives | To maximise the benefit of the financial allocation by delivering efficient services, to ensure that we sustain and improve services and support the future model of services.  
- To meet and, where possible, exceed Scottish Government goals and targets for NHS Scotland. |
| Local Outcome Improvement Plan (LOIP) | Not required.                                                      |
| Best Value                         | This paper contributes to Best Value goals of sound governance, accountability, performance scrutiny and sound use of resources. |
| Impact Assessment                  | A detailed impact assessment of individual efficiency schemes will be undertaken through this process as individual schemes are developed. |
EXECUTIVE SUMMARY

Quarter Two Position

1. Following the Quarter Two review meetings and the detailed finance reviews as at month 6, overall, the Board is forecasting an improved outturn position for the year of £3.4m deficit (as compared to original Financial Plan position of £9.1m), this is despite the higher financial risk areas which are explained below.

2. The Quarter Two review of the financial position has now been concluded following a series of directorate meetings with all General Managers, led by the Director of Finance and Deputy Chief Operating Officer and a detailed review of financial estimates by the senior finance team.

3. There are a number of key areas of higher risk which are reflected in the position, specifically the Acute and Diagnostics Directorate, GP prescribing and External Service Level Agreement (SLA) contracts. The increased level of financial pressure across these areas alone is £2.5m (this is in addition to the Quarter One forecast projections). These risks are offset by underspends elsewhere which improve the position overall to the £3.4m deficit projection.

4. The significance of this latest projection is that the Medium Term Health and Social Care Financial Framework still requires NHS Boards to deliver financial break-even over a three year planning period with the first year of the new cycle set as 2019/20. However, Boards can overspend by a maximum of 1% of their baseline allocation in any given year, as long as over the three year planning period they achieve break-even overall. Whilst the revised forecast of a £3.4m deficit falls within this 1% limit, it is important to reiterate the requirement and intention of the Board to deliver a break-even position, with any overspend in this financial year having to be repaid over the next two financial years of the planning cycle.

5. The latest savings plan confirms an overall improvement of £4m in savings delivered in-year from the opening plan; this reflects the additional non-recurring measures and savings identified at Quarter Two. However, this still reflects a significant recurring savings gap of £14m which will be brought forward into 2020/21 and will add to the challenges for future years.
6. The overall Quarter Two position is summarised in the table below:

<table>
<thead>
<tr>
<th>QUARTER TWO SUMMARY 2019/20</th>
<th>Quarter One Forecast £000s</th>
<th>Quarter Two Forecast £000s</th>
<th>Movement £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>IJB DELEGATED SERVICES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute &amp; Diagnostics</td>
<td>(2,236)</td>
<td>(3,000)</td>
<td>(764)</td>
</tr>
<tr>
<td>Facilities and Clinical Support</td>
<td>(400)</td>
<td>(174)</td>
<td>226</td>
</tr>
<tr>
<td>Mental Health</td>
<td>647</td>
<td>222</td>
<td>(425)</td>
</tr>
<tr>
<td>Community Health and Social Care - NHS</td>
<td>0</td>
<td>(1,983)</td>
<td>(1,983)</td>
</tr>
<tr>
<td>Primary Care Services</td>
<td>(268)</td>
<td>(113)</td>
<td>155</td>
</tr>
<tr>
<td>Women and Children's</td>
<td>999</td>
<td>173</td>
<td>(826)</td>
</tr>
<tr>
<td>E-Health</td>
<td>14</td>
<td>32</td>
<td>18</td>
</tr>
<tr>
<td>Subtotal</td>
<td>(1,244)</td>
<td>(4,843)</td>
<td>(3,599)</td>
</tr>
<tr>
<td>IJB Strategic Services</td>
<td>53</td>
<td>0</td>
<td>(53)</td>
</tr>
<tr>
<td>IJB Savings</td>
<td>(5,512)</td>
<td>(2,345)</td>
<td>3,167</td>
</tr>
<tr>
<td>IJB Reserves</td>
<td>867</td>
<td>928</td>
<td>61</td>
</tr>
<tr>
<td>IJB DELEGATED BUDGETS TOTAL</td>
<td>(5,836)</td>
<td>(6,261)</td>
<td>(425)</td>
</tr>
<tr>
<td>BOARD SERVICES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corporate Directorates</td>
<td>147</td>
<td>132</td>
<td>(15)</td>
</tr>
<tr>
<td>Strategic Capital</td>
<td>21</td>
<td>326</td>
<td>306</td>
</tr>
<tr>
<td>Central Income</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Externals</td>
<td>(683)</td>
<td>(917)</td>
<td>(233)</td>
</tr>
<tr>
<td>Non Core</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Board Corporate Savings</td>
<td>(26)</td>
<td>(253)</td>
<td>(227)</td>
</tr>
<tr>
<td>Board Reserves</td>
<td>2,856</td>
<td>3,673</td>
<td>817</td>
</tr>
<tr>
<td>BOARD SERVICES TOTAL</td>
<td>2,314</td>
<td>2,962</td>
<td>648</td>
</tr>
<tr>
<td>DIRECTORATE FORECASTS</td>
<td>(3,522)</td>
<td>(3,299)</td>
<td>223</td>
</tr>
<tr>
<td>Additional Financial Risks not reflected above</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Waste</td>
<td>(400)</td>
<td>0</td>
<td>400</td>
</tr>
<tr>
<td>Superann Increased Cost</td>
<td>(609)</td>
<td>(832)</td>
<td>(223)</td>
</tr>
<tr>
<td>Outcome Framework reduction</td>
<td>(118)</td>
<td>(118)</td>
<td>0</td>
</tr>
<tr>
<td>Windows 10/microsoft licencing</td>
<td>(135)</td>
<td>0</td>
<td>135</td>
</tr>
<tr>
<td>Dental allocation reduction</td>
<td>0</td>
<td>(47)</td>
<td>(47)</td>
</tr>
<tr>
<td>Increase in national top slices</td>
<td>0</td>
<td>(67)</td>
<td>(67)</td>
</tr>
<tr>
<td>Car-T risk share</td>
<td>0</td>
<td>145</td>
<td>145</td>
</tr>
<tr>
<td>Review of accruals, allocations, risks and opportunities</td>
<td>0</td>
<td>800</td>
<td>800</td>
</tr>
<tr>
<td>subtotal</td>
<td>(1,262)</td>
<td>(119)</td>
<td>1,143</td>
</tr>
<tr>
<td>Revised Forecast including additional risks</td>
<td>(4,784)</td>
<td>(3,418)</td>
<td>1,365</td>
</tr>
</tbody>
</table>

7. This reflects the overall forecast positions by operational directorates, based on the month 6 year to date position. The budgets delegated to the Integration Joint Board are reporting an overall outturn forecast position of £6.261m deficit, reflecting the level of unidentified savings and the increasing pressures and risks within the Health and Social Care Partnership operational budgets.
8. The Acute and Diagnostics Directorate is projecting an overspend of £3m for 2019/20, reflecting the risks across a range of service pressures which factor into an overall increased financial risk across the Board. DGRI continues to see increasing demand across all areas with the rising levels of activity resulting in growing/rising financial pressures on activity related costs; specifically nursing and supplies costs. The additional “winter beds” which are supporting the increased inpatient activity as a consequence of delayed discharges, have remained open for much of the year. Pressures associated with the cost of covering services with medical locums continue to increase, reflecting an additional pressure of £0.75m in-year. The overall in-year impact is mitigated by the savings delivered of £0.6m but remains a significant financial risk.

9. The Primary Care prescribing forecast is based on the overspend of £688k at month 6, combined with a detailed review of ongoing pressures across the system. Four months data has now been received and volume is now showing as a 3% increase compared to the same time period last year. The forecast as compared with Quarter One has worsened by £1.1m to £2.5m overspend and presents significant financial risk to delivery of financial targets for 2019/20. This is due to a combination of unachieved CRES of £283k, increase in volumes of £290k and cost increases of £115k. The General Manager and Director of Pharmacy have developed an action plan to both accelerate a number of additional savings schemes and also assess the workload priorities for the Prescribing Support teams. A range of scenario modelling has been undertaken with a worst case forecast for this area suggesting a further £1m potential pressure.

10. The increasing pressures across the External SLAs, predominantly relate to high cost procedures undertaken at tertiary centres and an increasing level of cardiac work treated at the Golden Jubilee Hospital. Finance is working with services to understand the reason in the increasing level of referrals for high cost out of area work to evaluate whether this increased activity was a spike or an ongoing trend. Areas of risk include Glasgow exclusions (£438k) with an increase in pacemakers and spinal cord stimulators, Golden Jubilee (£454k) with an increase in the number of TAVIs (heart valve procedures) increasing to 13 referrals to date, compared to 6 overall in 2018/19, and Private UNPACS (£135k) due to an unforeseen mental health placement.

11. The Mental Health and Women’s and Children’s directorates, despite showing an adverse movement, have remained relatively stable overall. The reason for the shift in forecast relates to the release of the £1m non-recurring savings target from the opening Financial Plan which was held centrally in Quarter One and has now been moved to the directorates in Quarter Two, which reflects the worsening of the directorate reported position.

12. Release of accruals, use of balance of Integrated Care Fund and review of allocations has improved the unallocated saving balance for the IJB delegated services by £1.8m to mitigate the additional pressures which are being reported this quarter.
13. There are a number of key actions associated with short term measures which are assumed to improve the position in-year following discussions through the quarterly review meetings. These will be factored into the financial position as they crystallise over the next couple of months. They include ensuring all income opportunities are maximised, further review of financial estimates, identification and maximisation of other sources of funding, reviewing areas where spend can be reduced in-year, and a range of other financial control measures.

14. Longer term sustainability and other measures are being assessed as part of the draft Financial Plan for 2020/21 onwards through a range of priorities and measures being considered through the Sustainability and Modernisation (SAM) programme.

**Month 7 Financial Position**

15. The overall position for the Board at month 7 is reporting an overspend of £2.564m (£3.091m at month 6). There is an improvement of the monthly trend primarily related to the release of further savings identified in Quarter Two.

16. The Board has received confirmed allocations to October 2019 from Scottish Government of £353.3m. Further allocations for 2019/20 are currently assessed at £8.5m, this includes £2.4m for the New Medicines Fund (NMF). **Appendix 1** provides a summary of the confirmed allocations received during October 2019.

17. As at 31\textsuperscript{st} October 2019, the Board is reporting an adverse variance of £2.564m. The split between IJB delegated services and Board services to date are shown in Table 1.

<table>
<thead>
<tr>
<th>Service</th>
<th>YTD Budget £000s</th>
<th>YTD Actual £000s</th>
<th>YTD Variance £000s</th>
<th>YTD Variance %</th>
</tr>
</thead>
<tbody>
<tr>
<td>IJB Delegated Services</td>
<td>180,266</td>
<td>183,622</td>
<td>(3,356)</td>
<td>(1.86%)</td>
</tr>
<tr>
<td>NHS Board Services</td>
<td>34,292</td>
<td>33,500</td>
<td>791</td>
<td>2.31%</td>
</tr>
<tr>
<td><strong>Total NHS Board</strong></td>
<td><strong>214,558</strong></td>
<td><strong>217,122</strong></td>
<td><strong>(2,564)</strong></td>
<td><strong>(1.20%)</strong></td>
</tr>
</tbody>
</table>

18. The services delegated to the IJB are overspent by (£3.356m) year to date (YTD). The level of unidentified savings YTD (£1.452m) reflects the scale of the savings challenges still to be found. This is offset by the release of IJB reserves (as agreed at Quarter One) of £541k.

19. Board services are currently showing a YTD underspend position of £791k, reflecting the level of Board reserves released into the YTD position. Many of these are non-recurrent in nature, reflecting one-off areas of flexibility or slippage on in-year expenditure plans.
20. The main areas of YTD overspend across Board services are unidentified savings (£731k) and externals (£583k) which are offset by the release of Board reserves (as agreed in Quarter One) of £2.041m.

21. Details of the key variances across both Board and IJB are included in Appendix 2 and 3 of this report.

Efficiency Savings and Strategy

22. The Board is required to achieve a balanced financial position for 2019/20 onwards and has a statutory requirement to break-even. The Financial Plan had an unidentified savings requirement of £9.1m against an original planned requirement of £19.68m. The updated position has improved to indicate an in-year gap of £5.08m at month 7 after the Quarter Two review of commitments against allocations, as set out in Appendix 4. The risks associated with this savings delivery is factored into the overall Quarter Two summary in Table 1.

Financial Risks

23. The financial risks schedule has been updated to reflect the current position and is included in Appendix 5. This reflects a high level summary of the main risks affecting NHS Dumfries and Galloway, highlighting the level of financial risk associated with each one; this has been updated with the current status and any movement from the original plan. It reflects the risk position at Quarter Two.

24. Additional risks not reflected in the financial position outlined in this paper are set out below:

- No provision has been made for financial risks associated with a No-deal Brexit. A bi-weekly meeting chaired by the Chief Executive has been set up to monitor issues impacting from Brexit. This has been stepped down during the UK election period.
- Additional pressures associated with move to new hospital including a review of staffing templates in nursing and safer staffing.
- Delivery of elective waiting times improvement without further additional resource identified.

25. Appendices to this paper are noted below:

- Appendix 1 – Revenue Resource Analysis
- Appendix 2 – Key Variances within Directorates for month 7
- Appendix 3 – Expenditure Analysis by Directorate for month 7
- Appendix 4 - Summary Savings Plan at month 7
- Appendix 5 – Financial Risks based on Quarter Two
# Revenue Resource Analysis

**At 31st October 2019**

<table>
<thead>
<tr>
<th></th>
<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>
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<tr>
<td><strong>Revenue Allocation as at 30th September 2019</strong></td>
<td>306,868</td>
<td>41,254</td>
<td>4,827</td>
<td>0</td>
<td>352,949</td>
</tr>
<tr>
<td><strong>Other</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NSD Positron Emission Tomography</td>
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<td></td>
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<td></td>
</tr>
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<td>Open University Pre-Reg Nursing Education Programme</td>
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<td>Pharmacy pre registration students to NES</td>
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<td></td>
<td></td>
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<td>Waiting Times - AOP 19-20</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Children's Vitamins</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Nurse Partnership Programme</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Winter Money Estimate</td>
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<tr>
<td><strong>Total Allocations</strong></td>
<td>0</td>
<td>(71)</td>
<td>468</td>
<td>0</td>
<td>397</td>
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<tr>
<td><strong>Revenue Allocation as at 31st October 2019</strong></td>
<td>306,868</td>
<td>41,183</td>
<td>5,295</td>
<td>0</td>
<td>353,346</td>
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<tr>
<td><strong>Anticipated Allocations</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Total Revenue Allocation (excl FHS)</strong></td>
<td>306,868</td>
<td>41,674</td>
<td>3,355</td>
<td>9,977</td>
<td>361,874</td>
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<td><strong>Family Health Services Non Discretionary Allocation</strong></td>
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<td>17,339</td>
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<tr>
<td><strong>Total Revenue Allocation (incl FHS)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>379,213</strong></td>
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</table>
**Key Variances within the delegated budget**

<table>
<thead>
<tr>
<th>Directorate</th>
<th>Month 07 Position</th>
<th>Risks/Issues/Challenges and Opportunities</th>
</tr>
</thead>
</table>
| Acute and Diagnostics  | (£1.619m) Overspend | The Acute Directorate is overspent by (£1.619m) as at 31st October 2019. High levels of activity, acuity and delayed discharges continue to put pressure on the Acute care system. These linked with the recruitment pressures of nurses and medics, and the continued reliance on supplementary staffing remains the biggest financial risk within the directorate. 

The overall nursing position is £760k overspent with a £468k spend on agency nurses to date, a reduction on the spend of £547k in the same period in 2018/19.

The CRES target for Acute and Diagnostics in 2019/20 is £1.6m. In-year savings of £358k have been recognised so far, of which, £29k is recurrent. The remaining £1.25m relates to target to reduce medical locums. There have been saving made due to move to Direct Engagement (DE) and Clinical Development Fellow (CDF) recruitment but these have not yet been recognised within the directorate. The Remaining target id phased M7 to M12 so we are beginning to recognize underachievement of this in the position.

The drugs position at month 7 is showing an overspend of £177k, with the main overspending sitting in surgery mainly due to increased prescribing of drugs for treatment of Wet AMD in ophthalmology.

There is increasing spend throughout surgical consumables. It is £206k over budget in 7 months. This is a continuation of previous year’s pressures - respiratory, Emergency Care Centre (ECC) and theatres in particular, however there is an increase in spend overall. Travel and patient transport continue to have recurring issues which are contributing to the Non-pays overspend. Underlying inflation on catering provisions is approximately 5% in year but this requires evidencing in more detail. The move to new hospital has skewed the figures and we are working through new income projections and trying to isolate reasons for increased costs. |
## Facilities and Clinical Support

- **Position**: Overspend
- **Month 07**: (£294k)

The Facilities and Clinical Support directorate is reporting an overspend of (£294k).

Pays are underspent by £163k which reflects the current vacancies across the main team as well as within Medical Physics. This is an interim position as the directorate works towards recruiting to the new model post new hospital.

Non-Pays are overspending by (£411k); this is due to security measures (£121k) for both Crichton Hall and Mountainhall as well as the stewarding of car parks at DGRI. The directorate is currently (£163k) overspent in relation to heat, light and power. The delay in the implementation of the new national clinical waste contract has resulted in a pressure of (£150k) year to date. The new contract was expected to come into force from 2nd August 2019. The directorate received non-recurrent cost pressure funding to cover the cost of the contingency arrangements in place up until that point. These arrangements will continue to cause a pressure of £50k per month until the new contract is operational.

## Mental Health Directorate

- **Position**: Underspend
- **Month 07**: £143k

The Mental Health Directorate are reporting an under spend of £143k at Oct 19, of which £81k relates to Pays budgets and £63k in Non Pay budgets.

The main areas of Pays variances are under spends within Community £95k, Learning Disability £48k, O.T £58k, Psychology £35k, Substance Misuse £25k offset by £154k over spend in Management, Inpatient (£13k) and Medical (£15k).

Non-pays are under spent by £63k mainly due to under spends in travel £50k, Externals £20k general £48k offset by over spends in drugs (£27k), Clinical (£4k), Equipment/Service Contracts (£24k).
<table>
<thead>
<tr>
<th>Directorate</th>
<th>Month 07 Position</th>
<th>Risks/Issues/Challenges and Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health &amp; Social Care (NHS)</td>
<td>(£746k) Overspend</td>
<td>The Community Health and Social Care Directorate is reporting an overspend of (£746k). The Pays position is £321k underspent across the Directorate. £90k relates to Nursing budgets, Health Sciences £104k under, Ancillary £102k, Admin £49k under off-set by AHP budgets which are over spent by (£86k). Ancillary and Nursing budgets are underspent due to vacancies across Cottage Hospitals and Community Nursing. Health Sciences are underspent due to vacancies in community pharmacist posts. The favourable swing in month is lower than the year to date trend due to the increased cost of nursing, covering vacancies and maternity leaves. The Non-pays position is overspent by (£1.066m) across the Directorate. This mainly relates to Prescribing (£996k) overspend. Five months data has now been received, the total over spend at Month 7 is £996k, this is an additional spend of £309k in the month. £90k of this relates to an under accrual of August data. Volume is up 2.3% on last financial year which has resulted in an increased cost of £298k and an increase in cost of £0.11 per item has resulted in an increase cost of £171k. The unachieved CRES for month 7 within the GP prescribing budget is £411k. There is also an underachievement of Generic discount achieved of £79k year to date. There are also overspends against surgical sundries and equipment purchases and service contract.</td>
</tr>
</tbody>
</table>

MANAGEMENT IN CONFIDENCE
Page 3 of 5
### Primary Care Services

<table>
<thead>
<tr>
<th>Position</th>
<th>Risks/Issues/Challenges and Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>(£120k) Overspend</td>
<td>Primary Care Services are reporting an overspend of (£120k). The Pays position is (£305k) overspent, (£287k) relates to Medical and Dental and (£48k) Nursing budgets off-set by Admin budgets which are underspent by £42k. Medical pays budgets are overspent due to GP locum charges within 2C practices of (£329k), off-set by underspends of £42k within Dental Services due to historic recruitment issues. The Non-pays position is underspent by £161k across Primary Care Services. This mainly relates to Family Health Services, due to a review of rent charges across GP premises.</td>
</tr>
</tbody>
</table>

### Women's and Children's

<table>
<thead>
<tr>
<th>Position</th>
<th>Risks/Issues/Challenges and Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>£200k Underspend</td>
<td>The Women, Children and Sexual Health Services Directorate is reporting an overall underspend of £200k. Pays overall are £271k under spent mainly due to Neonatal efficient rostering £53k, Public Health Nursing £163k Learning Disability £52k, CAMHS £28k and Midwifery £334k off set by (£389k) in Management &amp; Governance. Non-pays across Directorate are (£69k) over spent YTD, made up of Drugs (£106k), (Includes drug CRES of £27k), Equipment and Service Contracts (£48k) offset by under spends of Clinical £48k, over achieved CRES £31k and General £6k.</td>
</tr>
</tbody>
</table>

### e-Health

<table>
<thead>
<tr>
<th>Position</th>
<th>Risks/Issues/Challenges and Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>(£16k) Overspend</td>
<td>The e-Health Directorate is reporting a (£16k) overspend. Pays overall are £103k underspent due to various vacancies within the department. Non-pays across Directorate are (£104k) overspent YTD. Mainly due to Mountainhall Project, double running costs, timing of invoices and the difficulty in accessing one bill. Income is under achieved by (£15k) YTD.</td>
</tr>
</tbody>
</table>
### Directorate | Month 07 Position | Risks/Issues/Challenges and Opportunities
--- | --- | ---
IJB Strategic Services | £6k Underspend | Strategic Services are underspending YTD due to a change of work pattern and a small number of vacancies.
Board Corporate Services | £791k Underspend | There are a number of small overspends within Board services, however, the main areas of overspend are externals (£583k) and the balance of Board savings (£731k) YTD still to be identified.

The Externals overspending (£583k) is mainly due to Glasgow exclusions (£414k) with an increase in pacemakers and spinal cord stimulators, Golden Jubilee (£271k) with an increase in the number of TAVIs 13 referrals to date and Private UNPACS (£93k) due to an unforeseen mental health placement.

Offset by the release of Board reserves to the position of £2.041m.
### NHS Dumfries and Galloway

**Expenditure Analysis - 7 Months To 31st October 2019**

<table>
<thead>
<tr>
<th>AREA</th>
<th>Pay £000</th>
<th>Non Pay £000</th>
<th>Income £000</th>
<th>Total £000</th>
<th>Variance £000</th>
<th>Variance £000</th>
<th>Variance £000</th>
<th>Variance £000</th>
<th>Variance %</th>
<th>Variance £000</th>
<th>Variance £000</th>
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<tr>
<td><strong>IJB Delegated Services</strong></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute &amp; Diagnostics</td>
<td>96,043</td>
<td>25,991</td>
<td>(3,089)</td>
<td>118,946</td>
<td>(644)</td>
<td>(998)</td>
<td>23</td>
<td>(1,619)</td>
<td>-2%</td>
<td>(1,187)</td>
<td>(433)</td>
</tr>
<tr>
<td>Facilities &amp; Clinical Support</td>
<td>3,556</td>
<td>13,106</td>
<td>(690)</td>
<td>15,972</td>
<td>163</td>
<td>(411)</td>
<td>(46)</td>
<td>(294)</td>
<td>-3%</td>
<td>(320)</td>
<td>26</td>
</tr>
<tr>
<td>Mental Health Directorate</td>
<td>21,927</td>
<td>2,801</td>
<td>(445)</td>
<td>24,823</td>
<td>81</td>
<td>63</td>
<td>(0)</td>
<td>143</td>
<td>1%</td>
<td>160</td>
<td>(17)</td>
</tr>
<tr>
<td>Community Health &amp; Social Care (NHS)</td>
<td>31,654</td>
<td>33,884</td>
<td>(1,571)</td>
<td>63,966</td>
<td>321</td>
<td>(1,606)</td>
<td>7</td>
<td>(746)</td>
<td>-2%</td>
<td>(477)</td>
<td>(269)</td>
</tr>
<tr>
<td>Primary Care Services</td>
<td>4,809</td>
<td>47,248</td>
<td>(5,104)</td>
<td>46,952</td>
<td>(305)</td>
<td>161</td>
<td>24</td>
<td>(120)</td>
<td>0%</td>
<td>(150)</td>
<td>31</td>
</tr>
<tr>
<td>Womens &amp; Childrens Directorate</td>
<td>21,318</td>
<td>2,316</td>
<td>(622)</td>
<td>23,013</td>
<td>271</td>
<td>(69)</td>
<td>(1)</td>
<td>200</td>
<td>2%</td>
<td>162</td>
<td>38</td>
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<tr>
<td>E Health</td>
<td>2,671</td>
<td>2,604</td>
<td>(181)</td>
<td>5,094</td>
<td>103</td>
<td>(104)</td>
<td>(15)</td>
<td>(16)</td>
<td>-1%</td>
<td>15</td>
<td>(30)</td>
</tr>
<tr>
<td>Strategic Services</td>
<td>1,716</td>
<td>17,056</td>
<td>(205)</td>
<td>18,567</td>
<td>(66)</td>
<td>2</td>
<td>70</td>
<td>6</td>
<td>0%</td>
<td>6</td>
<td>(0)</td>
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<tr>
<td>Savings</td>
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<td>(2,489)</td>
<td>0</td>
<td>(2,489)</td>
<td>0</td>
<td>(1,452)</td>
<td>0</td>
<td>(1,452)</td>
<td>100%</td>
<td>(2,077)</td>
<td>625</td>
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<td>Budget Reserves</td>
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<td>1,271</td>
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<td>1,315</td>
<td>0</td>
<td>541</td>
<td>0</td>
<td>541</td>
<td>100%</td>
<td>433</td>
<td>108</td>
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<tr>
<td><strong>IJB Services Total</strong></td>
<td>183,739</td>
<td>143,788</td>
<td>(11,908)</td>
<td>315,619</td>
<td>(77)</td>
<td>(3,327)</td>
<td>48</td>
<td>(3,356)</td>
<td>-2%</td>
<td>(3,435)</td>
<td>79</td>
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</table>

| BOARD SERVICES                            |          |              |             |            |               |               |               |               |            |               |               |
| Board Corporate Services                  | 12,779   | 3,209        | (1,725)     | 14,263     | (61)          | (62)          | 1             | (122)         | -2%        | (92)          | (31)          |
| Strategic Capital                         | 150      | 17,465       | (77)        | 17,538     | 0             | 58            | 69            | 126           | 1%         | 101           | 25            |
| Central Income                            | 0        | 0            | (5,196)     | (5,196)    | 0             | 60            | 60            | 60            | -2%        | 76            | (16)          |
| Externals                                 | 0        | 28,440       | (3,039)     | 25,401     | 0             | (881)         | 298           | (583)         | -4%        | (544)         | (39)          |
| Non Core                                  | 0        | 9,977        | 0           | 9,977      | 0             | (0)           | 0             | (0)           | 0%         | (0)           | 0             |
| Savings                                   | 0        | (1,253)      | 0           | (1,253)    | 0             | (731)         | 0             | (731)         | 100%       | (626)         | (104)         |
| Budget Reserves                           | 194      | 2,669        | 0           | 2,863      | 0             | 2,041         | 0             | 2,041         | 100%       | 1,428         | 613           |
| **BOARD Services Total**                  | 13,124   | 60,507       | (10,036)    | 63,594     | (62)          | 425           | 428           | 791           | 2%         | 344           | 447           |

| GRAND TOTAL                               | 196,863  | 204,295      | (21,944)    | 379,213    | (139)         | (2,902)       | 476           | (2,564)       | -1%        | (3,091)       | 526           |
## NHS DUMFRIES AND GALLOWAY
### SAVINGS PLAN 2019-20

<table>
<thead>
<tr>
<th></th>
<th>2019/20 Plan</th>
<th>2019/20 Forecast</th>
<th>Movement</th>
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<td>2019/20 UB £000s</td>
<td>2019/20 UB £000s</td>
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<tr>
<td><strong>Recurring Savings</strong></td>
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<tr>
<td><strong>(from long list)</strong></td>
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<tr>
<td>eHealth</td>
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<td>253</td>
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<tr>
<td>Locum Other</td>
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<td>250</td>
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<tr>
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<tr>
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<tr>
<td>Properly</td>
<td>985</td>
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<td>1,198</td>
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<td>Transformation</td>
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<td>230</td>
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<tr>
<td><strong>Subtotal</strong></td>
<td>4,884</td>
<td>0</td>
<td>3,791</td>
</tr>
<tr>
<td><strong>Recurring Savings – other</strong></td>
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<td></td>
</tr>
<tr>
<td>Directorate efficiency (Operational CRES)</td>
<td>500</td>
<td>0</td>
<td>500</td>
</tr>
<tr>
<td>Corporate CRES/CNORIS</td>
<td>0</td>
<td>450</td>
<td>450</td>
</tr>
<tr>
<td>Rates</td>
<td>0</td>
<td>0</td>
<td>647</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>500</td>
<td>450</td>
<td>950</td>
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<td><strong>Recurring Savings Total</strong></td>
<td>5,384</td>
<td>450</td>
<td>5,834</td>
</tr>
<tr>
<td><strong>Non recurring Savings</strong></td>
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<td></td>
</tr>
<tr>
<td>Balance sheet/accruals review</td>
<td>300</td>
<td>0</td>
<td>300</td>
</tr>
<tr>
<td>Sale of equipment</td>
<td>0</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Review of commitments against allocations</td>
<td>2,000</td>
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<td>2,000</td>
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<tr>
<td>In year flexibility on allocations</td>
<td>1,000</td>
<td>0</td>
<td>1,000</td>
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<tr>
<td>Non recurring staff savings/underspends</td>
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<td>1,000</td>
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<tr>
<td>Corporate CRES</td>
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<tr>
<td>Rates</td>
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<td>0</td>
<td>612</td>
</tr>
<tr>
<td><strong>Sub-total</strong></td>
<td>4,300</td>
<td>400</td>
<td>4,700</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>9,684</td>
<td>850</td>
<td>10,534</td>
</tr>
</tbody>
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### LDP Financial Plan 2019/20 Submission
#### Risks and Assumptions – Update Month 7 2019/20

<table>
<thead>
<tr>
<th>Key Assumptions/Risks</th>
<th>Risk rating</th>
<th>Impact/£</th>
<th>Latest Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allocation Uplift</td>
<td>High Risk</td>
<td>Only 2019/20 uplift has been confirmed by the Scottish Government to date. Future years’ uplifts have yet to be notified.</td>
<td></td>
</tr>
<tr>
<td>CRES Delivery</td>
<td>High Risk</td>
<td>Of the current CRES requirement of £19.682m, £10.534m has been identified, leaving a gap of £9.149m. A further assessment is yet to be undertaken of any additional saving that could be used to close this gap further.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Delivery of CRES programme progressing, update included in paper. Increase in non-recurring savings due to rates rebate of £612k and prescribing rebates of £770k. Will remain high risk until plan is delivered. Savings delivery has been fully reassessed as part of the Quarter Two review. Revised gap of £5.08m</td>
</tr>
<tr>
<td>Assumptions/Risks</td>
<td>Risk rating</td>
<td>Impact/£</td>
<td>Latest Update</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-------------</td>
<td>---------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Prescribing (General)</strong></td>
<td>High Risk</td>
<td>Opportunities to continue to deliver the level of savings as identified in previous years are reducing as all significant areas of transformation have been delivered and reviewed over the past number of years. The ongoing level of risk has been assessed as part of the continued review of financial risks of new drugs and increasing growth (taking into account national indicators and local knowledge). There remains a significant level of risk associated with new drugs that will continue to be approved by SMC. The current budget setting paper sets out the methodology and risks associated with the expected level of increases moving forwards.</td>
<td>Review of savings potential reassessed for 2019/20 and scope to deliver as per target. Budget rebased as part of Financial Plan for 2019/20. A further paper was presented to performance committee in November reflecting the additional risks and the deteriorating position in the quarter two forecasts.</td>
</tr>
<tr>
<td><strong>Community Pharmacy Contract</strong></td>
<td>Medium Risk</td>
<td>The impact of any subsequent agreements by Scottish Government with Community Pharmacy Contractors has not been provided for in the Financial Plan.</td>
<td>Reduced to medium risk as contract for 2019/20 now concluded and the clawback benefit factored into year end projections. The clawback has been altered based on a new circular in November 2019, this is being assessed to understand the impact.</td>
</tr>
<tr>
<td><strong>Prescribing - New Medicines Fund</strong></td>
<td>High Risk</td>
<td>An assessment has been undertaken within the plan to incorporate estimates of likely growth of drugs in this area. However, there is an expectation that the funding available will be less than the increasing costs of new drugs being prescribed within NHS Dumfries and Galloway - £1.1m.</td>
<td>Remains very high risk especially with CAR-T and other new drugs/treatments being approved through Scottish Medicines Consortium (SMC). Risk being monitored and reviewed through Medicines Resource Group. One confirmed CAR-T patient, the costs for which have been assessed in the Quarter One position. Its now confirmed we are moving to a risk share for this nationally which improves the position.</td>
</tr>
<tr>
<td>Key Assumptions/Risks</td>
<td>Risk rating</td>
<td>Impact/£</td>
<td>Latest Update</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-------------</td>
<td>--------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Workforce/Recruitment</td>
<td>High Risk</td>
<td>Recruitment to medical vacancies has remained a significant challenge for the Board, with the average level of vacancy for NHS consultants continuing to remain above 20%. In addition, there has been a rise in the level of gaps across the junior doctor rotas (especially within GP training posts) which are not expected to be remedied in the forthcoming financial year. This is an increasing problem across Scotland and the UK as a whole. An assessment of the additional cost of medical locum provision has been included within the Financial Plan, along with assumptions of reducing cost and demand with the investment of a new permanent recruitment project team. This team will also focus on filling the increasing levels of vacancies across nursing associated with the increased levels of complexity of care within the new hospital, especially associated with the new emergency care centre - £1m. The level of risk across the system is an additional cost of £5.8m for medical locums in-year with plans in place to reduce the requirement for nurse agency back down to historic levels.</td>
<td>Recruitment and Sustainability Programme Board has met twice and key role to support the programme has been appointed to. Work is ongoing to progress various initiatives to fill vacancies and this will be accelerated once we have capacity in place to support the work. Focus to date has been on medical and nursing vacancies but has been expanded to review and include impact across all services in the partnership. No further update.</td>
</tr>
<tr>
<td>Key Assumptions/Risks</td>
<td>Risk rating</td>
<td>Impact/£</td>
<td>Latest Update</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>-------------</td>
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</tr>
<tr>
<td>Health and Social Care Integration</td>
<td>High Risk</td>
<td>Significant improvements have been delivered through the plans agreed for Health and Social Care integration (H&amp;SCI) locally. No financial provision/risk is assumed in the Local Delivery Plan (LDP) beyond ensuring provision has been made for supporting and resourcing the implementation within the allocation identified going forward. Whilst NHS Dumfries and Galloway has made good progress with Council colleagues in progressing H&amp;SCI, a significant level of system risk remains in ensuring resources around the delegated budgets are sufficient to deliver the planned level of service within the Strategic Plan.</td>
<td>Relationships across the partnership remain good. Work to develop the self assessment was undertaken in partnership with no major differences in view as to how we are performing as a partnership. IJB governance work is progressing with workshop arranged for 18th September 2019 on governance arrangements. No further update.</td>
</tr>
<tr>
<td>Externals (Out of Area SLAs)</td>
<td>Medium Risk</td>
<td>Whilst the level of activity sent outwith the Board’s area has remained largely unchanged, the levels of cost increases experienced across the main SLAs has averaged well above inflation. This has been challenged but the costs included within the SLAs have seen a substantial increase in certain high cost specialties. This continues to be of concern to NHS Dumfries and Galloway who continue to refer only appropriate tertiary activity to other Boards across Scotland as is necessary. Whilst financial provision has been made in the Financial Plan, the scale of the cost increases relating to complex and high cost services remain a high risk to the Board. The level of risk built into the Financial Plan is over £800k.</td>
<td>Information now received from both of the large Boards would reduce this risk to medium. Additional pressures emerging in Quarter Two which are noted in the overall report.</td>
</tr>
<tr>
<td>Key Assumptions/Risks</td>
<td>Risk rating</td>
<td>Impact/£</td>
<td>Latest Update</td>
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<tr>
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</tr>
<tr>
<td>SLAs and Non-Contract Activity with English Providers</td>
<td>High Risk</td>
<td>Referrals to Carlisle from local GP practices in the East and South of the region continue to remain stable. However, there continues to be a growth in tertiary referrals from North Cumbria to Newcastle for specialised and complex pathways where provision is available within Scotland. Work continues with service management across the border to ensure appropriate referrals back to Scottish providers should be undertaken where appropriate. Financial risk of £250k.</td>
<td>Latest financial risk factored into Quarter Two projected position.</td>
</tr>
<tr>
<td>Inflation Uplifts</td>
<td>Medium Risk</td>
<td>In addition to building in the known inflation costs (including pay, incremental drift and NI increases) already announced, an in-depth review of historic trends, combined with best available knowledge has been modelled in determining projected increases. Information has been shared and discussed with colleagues across the Corporate Finance Network, providing further assurance on the appropriateness of planning assumptions.</td>
<td>Factored into opening plan and allocated to budgets. Increased pressures around gas and electric costs from plan but have been accommodated within overall uplift. No further update.</td>
</tr>
<tr>
<td>Developments and Cost Pressures</td>
<td>Medium Risk</td>
<td>A sum of £4.5m has been set aside to cover the costs of future regional and national developments, cost pressures and any other critical or must do developments.</td>
<td>Cost pressures assessed as part of Quarter One and Quarter Two positions indicates some benefit from the opening plan, this has been factored into the forecast position.</td>
</tr>
<tr>
<td>Pay Inflation/Incremental Drift</td>
<td>Medium Risk</td>
<td>Robust financial planning information exists to allow accurate estimates of basic pay settlements for 2019/20 and beyond (based upon current assumptions of 3% pay awards and revised pay schedules).</td>
<td>Financial planning estimates being reviewed as part of the opening budget allocation. No significant issues have emerged.</td>
</tr>
<tr>
<td>Key Assumptions/Risks</td>
<td>Risk rating</td>
<td>Impact/£</td>
<td>Latest Update</td>
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<tr>
<td>------------------------</td>
<td>-------------</td>
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</tr>
<tr>
<td>Superannuation increase to 21%</td>
<td>High Risk</td>
<td>No provision has been made in the Financial Plan as per Scottish Government advice that this will be fully funded through additional consequentials made in 2019/20. However, there remains a level of anxiety that the full cost associated with this increase will not be met in full by the UK treasury.</td>
<td>Allocations now clarified indicates a £600k financial risk to the Board, comprising two elements the fact that funding hasn’t been received for vacant posts and the increased cost of service agreements with other NHS Boards with SLA uplift increasing to 5.12%. This financial risk has increased to £832k due to revised SLA percentage and additional costs of NSD topsliced services.</td>
</tr>
<tr>
<td>Transformational Change Programme</td>
<td>High Risk</td>
<td>Following from the initial work of the Business Transformation Programme, the IJB has established a range of programme boards take forward service transformation across the Health and Social Care Partnership. A process has been agreed whereby a long list of savings plans have been developed, scored and assessed as to deliverability and priorities. This remains one of the key strands of the IJB’s sustainability and efficiency work with the Plan developing options over a three year time frame.</td>
<td>This has been incorporated into the new programme work moving forward, the success of this programme still needs to be assessed.</td>
</tr>
<tr>
<td>Key Assumptions/Risks</td>
<td>Risk rating</td>
<td>Impact/£</td>
<td>Latest Update</td>
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<tr>
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</tr>
<tr>
<td>Delivery of Elective Waiting Time Targets</td>
<td>Medium Risk</td>
<td>No additional provision has been made in year to support waiting time pressures within the Acute and Diagnostics Directorate. It has been assumed this will be supported by Scottish Government (at least in part) through additional funding. Potential financial risk associated with this is between £2m-£4m.</td>
<td>Discussions with Scottish Government around the Annual Operational Plan (AOP) has meant that this risk is likely to be reduced. Initial funding has been confirmed and will be reviewed along with overall AOP performance assessment. Latest position indicates some concerns around our performance to date this year and limited additional funding anticipated and some significant challenges in delivery of performance targets.</td>
</tr>
<tr>
<td>BREXIT</td>
<td>High Risk</td>
<td>It has not been able to ascertain what the full financial impact of BREXIT may mean to NHS Dumfries and Galloway. Escalated business continuity plans have been established to ensure all issues are dealt with from an operational perspective led by the Chief Executive.</td>
<td>Remains high risk due to the uncertainty associated with Brexit. Will be reassessed on a monthly basis. Local Brexit sub-group has been re-established and will continue to meet regularly. Finance input to the group will flag financial risks as they emerge. CEO will provide regular updates.</td>
</tr>
<tr>
<td>Statutory Change/Changes to legislation</td>
<td>Unknown</td>
<td>The Financial Plan reflects the current known position in relation to any statutory compliance in relation to VAT/NI and pensions. Any future changes to current regulations and compliance would impact on the overall Financial Plan. These are reviewed regularly by the central financial team and any changes reflected through financial estimates.</td>
<td>No update.</td>
</tr>
<tr>
<td>Key Assumptions/Risks</td>
<td>Risk rating</td>
<td>Impact/£</td>
<td>Latest Update</td>
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<tr>
<td>-----------------------</td>
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</tr>
<tr>
<td>IT development</td>
<td>Medium</td>
<td>Windows 10 and Office 365 upgrades – these are currently not provided for within the Financial Plan as it is still envisaged funding will be made available from the national procurement of these upgrades. However, there does remain a risk that the licensing costs of moving to these new arrangements could lead to a significant increase in cost for local health boards. Information regarding the implications at a local level have been provided to the Scottish Government and we await an update on the funding model for deployment on a national level.</td>
<td>Confirmation received from Scottish Government that Boards will need to fund the additional costs of the upgrade for 2019/20. Current position reflects that likely limited financial impact for 2019/20 although additional capital funding has been allocated to support additional IT infrastructure. The ongoing position is being reviewed and will be incorporated into financial planning process for 2020/21.</td>
</tr>
</tbody>
</table>
DUMFRIES and GALLOWAY NHS BOARD

2nd December 2019

Capital Plan and Infrastructure Update

Author: Susan Thompson
Deputy Director of Finance

Sponsoring Director: Katy Lewis
Director of Finance

Date: 15th November 2019

RECOMMENDATION

The Board is asked to **discuss and note** the various updates presented in the report.

The Board is asked to **approve** the following points:

- Amendments to the Capital Plan for:
  - Reduction in allocation for SGHSCD Specific Allocation in year.
  - Increase in the Capital to Revenue Requirement in year.

- The Terms of Reference for Strategic Capital Programme Board

CONTEXT

Strategy/Policy:

As per the Scheme of Delegation, the Board have responsibility for approving the Capital Plan with the Strategic Capital Programme Board (SCPB) responsible for the operational delivery of this within delegated limits.

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

NHS Dumfries and Galloway receive a formula allocation for capital of £6.674m per annum and additional project specific allocations for which Scottish Government Health and Social Care Directorate (SGHSCD) have given business case approval for. The allocation for 2019/20 is anticipated to be £3m with a capital to revenue allocation of £2m.
### GLOSSARY OF TERMS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASRP</td>
<td>Acute Services Redevelopment Project</td>
</tr>
<tr>
<td>CIG</td>
<td>Capital Investment Group</td>
</tr>
<tr>
<td>CRL</td>
<td>Capital Resources Limit</td>
</tr>
<tr>
<td>NPD</td>
<td>Not for Profit Distribution</td>
</tr>
<tr>
<td>RDC</td>
<td>Replacement, Development and Contingency</td>
</tr>
<tr>
<td>SCPB</td>
<td>Strategic Capital Programme Board</td>
</tr>
<tr>
<td>SGHSCD</td>
<td>Scottish Government Health and Social Care Directorate</td>
</tr>
</tbody>
</table>
### Policy / Strategy
This paper supports the delivery of the capital strategy set out and approved in the Annual Operational Plan.

### Staffing Implications
There are no staffing implications for this paper; all staffing implications are built in to the individual business cases brought forward for approval.

### Financial Implications
This paper is presented as part of the reporting against the approval Capital Plan for 2019/20 and is managed through the SCPB of which the Director of Finance is a key member.

### Consultation / Consideration
The content of this paper is regularly discussed at SCPB.

### Risk Assessment
The risk of delivery against the plan is included in the paper and discussed at SCPB.

### Risk Appetite
<table>
<thead>
<tr>
<th>Low</th>
<th>Medium</th>
<th>High</th>
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<tbody>
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</tbody>
</table>

Whilst the Board's appetite to financial risk is generally low, capital expenditure is much more controllable and therefore the risk of not delivering within approved budget remains low. Continued communication with SGHSCD about profiling of project budget is important in the delivery of this.

### Sustainability
The Capital Plan supports the sustainability agenda through the delivery of capital schemes in line with the property strategy and efficiency procurement of equipment.

### Compliance with Corporate Objectives
To delivery of the Capital Plan to ensure that the Board meets its Corporate Objective to maximise the benefit of the financial allocation by delivering clinically and cost effective services efficiently.

### Local Outcome Improvement Plan (LOIP)
Although this has been considered the paper has no direct link to the 8 outcomes however ensuring that the Board has the most suitable accommodation and equipment ensures that the overall system can effectively contribute.

### Best Value
This paper contributes to Best Value goals of sound governance, accountability, performance scrutiny and sound use of resources.

### Impact Assessment
There is no impact assessment for this paper however detailed impact assessments would be carried out as part of the business case process in requesting capital funding for any service changes.
Strategic Capital Programme Board Update

1. With the introduction of Capital Investment Group (CIG), the meeting frequency of SCPB has now been adjusted. SCPB now meets every two months to progress both the delivery of the Capital Plan and in its role of maintaining oversight of the strategic projects that are underway within the Board.

2. The Terms of Reference for the group has been refreshed and ratified by SCPB, this is included as Appendix 1 for approval.

3. Work has been progressing within the newly formed CIG to review approval routes for requesting capital as well as the planning cycle. This will provide clarity within the Board on how to access capital funding.

4. The process for requesting capital funding for 2019/20 has now been closed with the exception of major business cases which were already planned. A small contingency sum is being held for unforeseen replacements. The planning focus now moves to 2020/21.

5. Any amendments to the overall Capital Plan require to be presented to Board for approval.

Major Project Updates

6. At present the only major project that is being managed by SCPB is the Mountainhall Treatment Centre Project.

7. The next major milestone will be the presentation of the business case for the Ophthalmology department move. SCPB will review this at the next meeting to allow this to be presented to Board for approval, this is currently anticipated to be February 2020 meeting.

Asset Acquisitions/Leases/Disposals

8. SCPB continue to be updated on the progress of any acquisitions, leases and disposals currently underway within the Board and these are monitored through Performance Committee, any impact on the Capital Plan will be presented to Board for approval as they arise.

9. In addition any request to declare land or buildings requires Board approval following review by SCPB, a number of requests have been presented to SCPB and will be presented to Board for consideration in due course.

Capital Plan Update

10. The Board previously approved the current year capital plan of £8.626m funded by the Boards formula allocation and project specific funding for the Acute Service Redevelopment Project (ASRP).
11. A review of planned expenditure against allocated budgets has now taken place as part of the Mid-Year Review process and has identified slippage within the capital programme. The review also looked at the split between capital and revenue funding requirements.

12. The outcome of the Mid-Year Review shows a movement to an anticipated Capital Plan of £3m based on the following information:

- **Mountainhall**
  The business case will not be presented to Board until February 2020 and therefore no works will be undertaken in this financial year. A budget for fees only has been assumed and the balance required to fund the projects from Phase 1 which were due to complete this financial year.

- **Replacement, Development and Contingency including DGRI equipment**
  The capital programme is now closed and the schemes which were approved have been reviewed for completion timescales and nature of expenditure. A contingency of £0.15m has been retained.

- **Capital to Revenue**
  An additional transfer from Capital to Revenue of £1m is now required, this is across the whole programme and simply reflects the nature of the works being carried out.

**Allocation Update**

13. The outcome of the Mid-Year Review is presented in Table 1 for approval with anticipated allocations for the year of £3m with a capital to revenue transfer of £2m.

<table>
<thead>
<tr>
<th>ALLOCATIONS</th>
<th>Approved Oct 2019</th>
<th>Proposed Dec 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formula allocation</td>
<td>3,475</td>
<td>3,475</td>
</tr>
<tr>
<td>Asset sale proceeds reapplied</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hub/NPD Enabling funding</td>
<td>6,000</td>
<td>1,374</td>
</tr>
<tr>
<td>Sexual &amp; Rape Crisis</td>
<td>199</td>
<td>199</td>
</tr>
<tr>
<td>Internal Screening Project – Top Slice</td>
<td>(6)</td>
<td>(6)</td>
</tr>
<tr>
<td>West of Scotland Laundry – Top Slice</td>
<td>(42)</td>
<td>(42)</td>
</tr>
<tr>
<td>Capital to Revenue</td>
<td>(1,000)</td>
<td>(2,000)</td>
</tr>
<tr>
<td><strong>TOTAL CAPITAL RESOURCE LIMIT (CRL)</strong></td>
<td><strong>8,626</strong></td>
<td><strong>3,000</strong></td>
</tr>
</tbody>
</table>

14. As you can see from Table 1, the revised position impacts only on the specific allocation approved from SGHSCD, all other allocations remain as expected. To the end of October 2019, an allocation of £6.7m has been received from SGHSCD, this will therefore require to be adjusted.
15. Discussion will now take place with SGHSCD with regards to the future year profile of this specific allocation.

**Budget Update**

16. The current budget available for use has been adjusted to reflect the anticipated allocation adjustments highlighted above, DGRI has now been included within the RDC (Replacement, Development and Contingency) programme as this is how it is managed operationally by CIG.

17. The revised budget across the capital programme along with the expenditure to end of October 2019 is shown in Table 2 below.

<table>
<thead>
<tr>
<th>Programme</th>
<th>Approved Budget Oct 2019</th>
<th>Proposed Budget Dec 2019</th>
<th>Expenditure Incurred to 31 Oct 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>RDC Programme including DGRI (Replacement, Development &amp; Contingency)</td>
<td>5,626</td>
<td>2,750</td>
<td>1,331</td>
</tr>
<tr>
<td>Mountainhall Project</td>
<td>3,000</td>
<td>250</td>
<td>206</td>
</tr>
<tr>
<td><strong>TOTAL BUDGET</strong></td>
<td><strong>8,626</strong></td>
<td><strong>3,000</strong></td>
<td><strong>1,537</strong></td>
</tr>
</tbody>
</table>

18. To the end of October expenditure of £1.5m has been incurred on the capital programme. As in previous years this level of expenditure is not uncommon at this stage in the year and have been reviewed as part of Mid-Year Review.

**Recommendation**

19. The Board is asked to note the update provided and approve the changes to the Capital Plan as presented.
A Strategic Capital Programme Board (SCPB) has been established to support the Board in their responsibilities for the delivery of the Capital Plan.

1. Objectives

The SCPB will ensure NHS Dumfries and Galloway deliver against the capital resource limit set whilst acting within statutory financial and other constraints including adherence with the Property Transaction Handbook and Scottish Capital Investment Manual.

It will also be responsible for ensuring effective internal control are in place for the capital funding allocated to ensure the delivery of best value.

2. Delegated Authority

The Programme Board can make decisions based on the Board approved 5 year capital plan within delegated limits.

The Scheme of Delegation sets out that SCPB has authority for:

- Approval of capital business cases <£0.5m
- Approval of capital business cases £0.5m - £3m prior to going to Board for approval
- Approval of capital business cases >£3m prior to going to Board and SGHSCD for approval

The Programme Board is authorised to obtain outside legal or other independent professional advice, and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary as long as it is within the funds delegated to them.

3. Reporting Arrangements

The SCPB reports to the NHS Dumfries and Galloway Health Board on all aspects of the delivery of the Capital Plan including significant project updates through its two monthly reported update.

4. Sub Groups

Capital Investment Group (CIG) reports directly to SCPB and has delegated responsibility to approve and prioritise replacements and service change requests for less than £0.25m.

CIG is required to have an approved terms of reference and report at each meeting of SCPB on progress against plans.

5. Roles and Responsibilities
SCPB will be responsible for:

- Agreeing and prioritising the 5 year capital plan ahead of submission by the Director of Finance to the Board.
- Ensuring the Asset Management Strategy is aligned to the overall strategy for the Board recognising the linkages with the Integrated Joint Board and ensuring a balance between replacement programmes and service development priorities.
- Approving business cases in line with delegated authority set
- Approving the budget delegated to CIG for the current year (plus two) for replacements and service change.
- Agreeing the approval routes for capital requests through the use of existing Board management structures and sub groups and holding them to account for delivery.
- Providing the appropriate level of scrutiny on major projects being taken forward including review of project delivery, risk registers, project management arrangements and budget scrutiny.
- Act as a Project Board for smaller projects which do not require an individual Project Board set up. This will include all the requirements of a project Board including management of project plans, budget, appointment of advisors/project managers and risk management.
- Reviewing all Post Project Evaluations to identify areas of improvement to be shared to future projects.
- Approval of acquisitions, disposals and lease arrangements being entered into on behalf of the Board.
- Dispute resolution, not resolved at project or CIG level.

6. Membership and Quorum

SCPB will consist of:

- Chief Executive
- Director of Finance
- Chief Operating Officer
- Employee Director
- Head of Estates and Property
- Deputy Chief Operating Officer
- Deputy Director of Finance

For all significant projects that are being progressed a representative for the project will also be in attendance.

All Directors have an open invitation to attend.

The meeting will be chaired by the Chief Executive or Chief Operating Officer or Director of Finance in their absence.

The Programme Board will be quorate with:

- 2 Executive Directors, one of which must be the Chief Executive, Chief Operating Officer or Director of Finance
• Deputy Chief Operating Officer or Deputy Director of Finance representing CIG

7. Confidentiality

There may be times when members will be required to treat discussions, documents or other information relating to the work of Dumfries and Galloway Health Board in a confidential manner. Members will often receive information of a private nature which is not yet public, or which perhaps would not be intended to be public. Members must always respect the confidential nature of such information and comply with the requirement to keep such information private.

It is unacceptable for members to disclose any information to which they have privileged access, for example derived from a confidential document or from a private meeting, either orally or in writing. In the case of other documents and information, members are requested to exercise judgement as to what should or should not be made available to outside bodies or individuals.

8. Agendas and Papers

Agendas will be agreed in advance of the meeting with the Programme Board Chair and papers prepared, using the Programme Board’s approved format.

Papers will be required to be submitted ten days prior to the meeting and distributed to Programme Board members one week in advance of the meeting, where possible.

9. Frequency of Meetings

The Programme Board will meet on a two monthly basis throughout any given financial year for a maximum of 3 hours per meeting.

The Chair may convene additional meetings, as deemed necessary.

10. Review

The Terms of Reference will be reviewed on an annual basis.
DUMFRIES and GALLOWAY NHS BOARD

2nd December 2019

Board Regional Update

Author: Ruth Griffith
Strategic Planning and Commissioning Manager

Sponsoring Director: Vicky Freeman
Head of Strategic Planning

Viv Gration
Deputy Head of Strategic Planning

Date: 15th November 2019

RECOMMENDATION

The Board is asked to discuss and note the update on the current regional planning work that relates to the planning and delivery of services for people in Dumfries and Galloway.

CONTEXT

Strategy / Policy:
Health and Social Care Delivery Plan Health and Social Care Delivery Plan
National Clinical Strategy National Clinical Strategy

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

This paper provides an update of the work ongoing at a regional level relevant to Dumfries and Galloway. It is the second of two biannual updates to Board.

GLOSSARY OF TERMS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>DGRI</td>
<td>Dumfries and Galloway Royal Infirmary</td>
</tr>
<tr>
<td>LMBD</td>
<td>Laboratory Medicine Delivery Board</td>
</tr>
<tr>
<td>WoS</td>
<td>West of Scotland regional planning</td>
</tr>
<tr>
<td>SEAT</td>
<td>South East and Tayside regional planning</td>
</tr>
<tr>
<td>NoS</td>
<td>North of Scotland regional planning</td>
</tr>
<tr>
<td>WoSCAN</td>
<td>West of Scotland Cancer Network</td>
</tr>
<tr>
<td>SCAN</td>
<td>South East Scotland Cancer Network</td>
</tr>
<tr>
<td>NoSCAN</td>
<td>North of Scotland Cancer Network</td>
</tr>
</tbody>
</table>
## MONITORING FORM

| Policy / Strategy                        | National Clinical Strategy  
|                                         | National Health and Social Care Delivery Plan  
|                                         | Dumfries and Galloway Health and Social Care Strategic Plan |
| Staffing Implications                   | No staffing implications were identified as part of the paper. |
| Financial Implications                  | No financial implications were identified as part of the paper. |
| Consultation / Consideration            | Not applicable. |
| Risk Assessment                         | Risk assessments will be completed as part of specific pieces of work within regional planning. |
| Risk Appetite                           | Low [x]  
|                                         | Medium [ ]  
|                                         | High [ ]  
|                                           | The content of this paper relates to the delivery of services to the population of Dumfries and Galloway, therefore, a low risk appetite has been noted against this paper. |
| Sustainability                         | Not applicable |
| Compliance with Corporate Objectives    | Corporate Objectives 2, 3, 5 and 6 |
| Local Outcome Improvement Plan (LOIP)   | Outcome 6 |
| Best Value                              |  
|                                         | • Effective partnerships  
|                                         | • Use of resources  
|                                         | • Sustainability  
| Impact Assessment                       |  
|                                           | No Impact Assessment was undertaken in preparation for submission of this paper. |
1. Introduction

1.1 This paper provides an update of the current work ongoing at a regional level that is relevant to Dumfries and Galloway. For Dumfries and Galloway a regional approach creates and provides opportunities to establish and/or maintain safe, efficient and sustainable services within regional networks.

2. Background

2.1 In Scotland, regional planning is broadly divided into three geographical areas:

- **West of Scotland (WoS)** - NHS Greater Glasgow and Clyde, NHS Lanarkshire, NHS Ayrshire and Arran, NHS Dumfries and Galloway and NHS Forth Valley
- **South East and Tayside (SEAT)** – NHS Lothian, NHS Borders, NHS Fife and NHS Tayside
- **North of Scotland (NoS)** – NHS Grampian, NHS Highland, NHS Orkney, NHS Shetland and NHS Western Isles

2.2 There are three established cancer networks in Scotland:

- **West of Scotland Cancer Network (WoSCAN)** - NHS Greater Glasgow and Clyde, NHS Lanarkshire, NHS Ayrshire and Arran, NHS Forth Valley
- **South East Scotland Cancer Network (SCAN)** – NHS Lothian, NHS Borders, NHS Fife and NHS Dumfries and Galloway
- **North of Scotland Cancer Network (NoSCAN)** – NHS Grampian, NHS Highland, NHS Orkney, NHS Shetland, NHS Western Isles and NHS Tayside

2.3 National strategic direction and the unprecedented challenges facing health and social care means that regional groups are now focussed much more towards ‘population based planning’. Population based planning is predicated on, ideally, a population of 500,000 or more and planning, shaping and providing services around these.

2.4 Dumfries and Galloway is currently aligned to West of Scotland (WoS) for regional planning and South East Scotland Cancer Network (SCAN) for cancer care and treatment pathways.

3. West of Scotland Regional Planning Update

3.1 There are a number of worksteams currently within West of Scotland. Dumfries and Galloway are represented within each of these.
3.2 Major Trauma Programme

3.2.1 The Chief Medical Officer’s Report ‘Saving Lives, Giving Life Back’, (2016) set out the plan for a National Trauma Network. Dumfries and Galloway Royal Infirmary (DGRI) will be a trauma unit. Work continues on track with the five year plan. An engagement plan for use across the region and an approach to repatriation of people to their home health board area has been developed.

3.3 Ophthalmic Service Review

3.3.1 The ophthalmology service review report was agreed at the West of Scotland Health and Social Care Delivery Plan Programme Board. As a result the Ophthalmology Review Steering Group is being repurposed to an Implementation Oversight Board.

3.3.2 The Implementation Oversight Board is supporting geographical boards to develop action plans relating to:

- Effective provision of cataract services
- Supporting introduction of Ocular Coherence Tomography (OCT) to the diabetic retinol screening service. OCT is highly advance eye screening technology.
- Implement virtual clinics for glaucoma and the management of glaucoma in the community
- The introduction of Avastin. This is a medication used to treat a number of types of cancers and eye diseases. This will be an alternative to the more expensive Lucentis.

3.4 Urology Service Review

3.4.1 This review continues to progress, with the steering group shifting focus to support the implementation of the agreed urology handbook in local board areas. This handbook sets out agreed practice across all of the West of Scotland.

3.4.2 The model for nurse led cystoscopy is expected to be finalised at the end of 2019 along with the proposal for a regional service for the treatment of stones.

3.4.3 The next phase of the review to develop a centralised model for specialist cancer, female and reconstructive surgical care continues.
3.4.4 Locally there are still challenges in the delivery of urology services. NHS Ayrshire and Arran provide out of hours emergency service, but are no longer able to provide visiting surgeons to Dumfries and Galloway Royal Infirmary or Galloway Community Hospital. DGRI currently has one locum consultant and a middle grade doctor in place. Ayrshire and Arran are supporting Dumfries and Galloway to scope potential for the development of Advanced Nurse Practitioner posts to implement the forthcoming regional model.

3.4.5 The uro-oncology pathway remains with South East Cancer Network (SCAN).

3.5 Vascular Service Review

3.5.1 The first phase of implementing the Hairmyres vascular network commenced on 2 September 2019. This network comprises the centre at Hairmyres Hospital and vascular units in Lanarkshire, Ayrshire and Dumfries and Galloway. This network is due to be fully operational in August 2020. The other centre will be at Queen Elizabeth Hospital, Glasgow and will support Forth Valley.

3.5.2 Following the resignation of one of the vascular surgeons in Dumfries and Galloway it became necessary to alter the model for delivery of vascular services locally. The remaining vascular surgeon in Dumfries and Galloway now contributes to the Hairmyres vascular network rota and performs surgery at Hairmyres. This means that all vascular emergencies are now managed through the Hairmyres network.

3.5.3 There are challenges in meeting all the needs of Dumfries and Galloway within Hairmyres as the centre is not yet fully developed. However, the support from vascular colleagues across the whole of West of Scotland has seen the region operate collaboratively to provide the best service possible.

3.6 Ear, Nose and Throat (ENT) Service Review

3.6.1 The ENT review has not progressed as the scoping work resulted in a consensus of clinical opinion that there are limited opportunities for service redesign. A report is being prepared to close the current workplan.

3.6.2 Nursing workforce opportunities in regard to ENT will be taken forward by the West of Scotland Nurse Directors Forum and boards will continue to contribute to the national ENT Access Collaborative.

3.7 Cardiac Service Review

3.7.1 A Regional Cardiac Strategy for the West of Scotland is being developed and is expected in December 2019. The six sub groups established continue to meet every 6-8 weeks. The sub groups are
• Acute coronary syndromes
• Cardiac surgery
• Electrophysiology and devices
• Structural heart disease
• Cardiac imaging
• Heart failure

3.7.1 Dumfries and Galloway are represented on each of these sub groups and attended a recent stakeholder engagement event.

3.8 Review of Child and Adolescent Mental Health Services (CAMHS)

3.8.1 CAMHS services across WoS face a number of challenges and pressures, at all levels. Work is underway to develop a regional model that provides equity of care and access to community services across the WoS. An options appraisal outlining alternative models of care for CAMHS is expected to be completed in November 2019. A review of the current CAMHS landscape and a proposal for future WoS CAMHS is expected in early 2020.

4. South East Scotland Cancer Network (SCAN) update

4.1 Work is continuing in SCAN to redevelop the Edinburgh Cancer Centre. This will include reconsideration of the existing pathways of cancer care across the region.

4.2 Population based planning is enabling health and social care services to address the unprecedented financial and workforce challenges. Services are now being planned and shaped around much bigger populations to enable the use of available resources to be maximised.

4.3 NHS Dumfries and Galloway have a strategic intention to seek the transfer of cancer pathways from east to west. This decision will require careful and robust planning with WoSCAN, SCAN and West of Scotland regional planning colleagues and will take considerable time.

5. Conclusions

5.1 There is a significant level of regional strategic and service planning currently underway across the West of Scotland Planning and the South East Scotland Cancer Network that is essential to us developing, maintaining and sustaining, safe, high quality and efficient health and care services going forward.

5.2 It is vital, that Dumfries and Galloway maintains a good and appropriate level of representation in all of the relevant workstreams and service reviews.
DUMFRIES and GALLOWAY NHS BOARD

2nd December 2019

Proposal for Establishment of a Public Health Governance Committee

Author: Valerie White
Acting (Interim) Director of Public Health

Sponsoring Director: Valerie White
Acting (Interim) Director of Public Health

Date: 22nd November 2019

RECOMMENDATION

The Board is asked to discuss and note:

• The increased requirement of the Board to demonstrate leadership and assurance regarding Public Health work, in particular in relation to the 6 National Public Health Priorities and the need to embed this within Board governance structures.

The Board is asked to approve:

• The proposal to establish a Public Health Governance Committee
• The proposed draft terms of reference of such a committee – Appendix 1

CONTEXT

Strategy / Policy:

The health and wellbeing challenges facing Dumfries and Galloway’s population are complex. Poor health has significant impacts on the quality of life of individuals and translates into additional demand on our health and social care system, a demand which is forecast to increase over the next decade. Increasing healthy life expectancy and reducing health inequalities are two of the biggest challenges we face.

The most recent data on life expectancy in Scotland for 2016-2018 (published on 25 September 2019) shows that life expectancy has remained effectively unchanged since 2012-2014, this is in contrast to other countries where life expectancy has continued to increase.

Considerable health inequalities persist: people in the most deprived communities continue to live shorter lives compared with those in the least deprived communities but, also, within those shorter lives, experience fewer years of good health. A concerted system wide effort to tackle these challenges is required.
The Public Health Reform programme jointly led by Scottish Government and COSLA is delivering the recommendations of the 2015 Public Health Review which include:

1. Publication of six National Public Health Priorities
   - A Scotland where we live in vibrant, healthy and safe places and communities
   - A Scotland where we flourish in our early years
   - A Scotland where we have good mental wellbeing
   - A Scotland where we reduce the use of and harm from alcohol, tobacco and other drugs
   - A Scotland where we have a sustainable, inclusive economy with equality of outcomes for all
   - A Scotland where we eat well, have a healthy weight and are physically active

2. Establishment of a new, single, national body for Public Health – Public Health Scotland, which will strengthen national leadership, visibility and critical mass for Public Health, and ensure we can make the best use of our national professional and data assets;

3. Supporting and strengthening local partnerships to enable them to create the conditions for good health across our communities.

Public Health Reform’s key message is of the need to have collective leadership for a Whole System Approach (WSA) to delivering improvements in the health and wellbeing of the population. There is also an increased focus on accountability for improvements in population health at National, Health Board and Health and Social Care Partnership level. This is recognition of the need to work collaboratively across a range of agencies, partners, with our local communities and individuals to develop a culture where we have an economic, social and physical environment which drives, enables and sustains improved Health and Wellbeing. The role of the Community Planning Partnership is also key in driving forward a WSA through its Local Outcome Improvement Plan (LOIP) – a key requirement of the Community Empowerment (Scotland) Act.

The inclusion of Public Health within the NHS Boards Annual Operating plans for 2020/21 emphasises the need for Boards to have robust governance systems in place to:
   - ensure; local system wide delivery of work to address the Public Health Priorities,
   - monitor improvements in population health via a range of indicators
   - make sure strong links are established with Public Health Scotland
   - assure itself of work undertaken in relation to Health Protection, Immunisation and screening.
Organisational Context / Why is this paper important / Key messages:

In addition to the above National drivers, members of the Board have expressed a keen interest in both understanding and providing leadership to drive forward change to tackle Public Health issues in particular addressing health inequalities.

The current assurance framework does not provide an opportunity to provide assurance on the totality of Public Health work. Neither does it ensure that the overall activities of the Board are scrutinised with a focus on ensuring change programmes, service improvements and service planning are appraised against longer term health impacts and objectives that have a positive outcome on reduced inequalities for the local population.

It is therefore proposed that NHS Dumfries and Galloway establish a Public Health Governance Committee which set within the context of a revision of the Board governance framework, will provide an opportunity to balance the Boards perspective towards longer term planning and sustainability – and provide an enhanced status to Public Health as a key part of the role and function of a high performing Board.

The proposed terms of reference for a Public Health Governance Committee are outlined in Appendix 1.

GLOSSARY OF TERMS

NHS - National Health Service
WSA – Whole System Approach
## Monitoring Form

<table>
<thead>
<tr>
<th><strong>Policy / Strategy</strong></th>
<th>Public Health Reform – sets a clear challenge to NHS Boards to provide leadership and governance for action to improve Public Health. This is emphasised in the Annual Operating Plan for 2020-21.</th>
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<tr>
<td><strong>Staffing Implications</strong></td>
<td>Not applicable.</td>
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<tr>
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<td>Not applicable.</td>
</tr>
<tr>
<td><strong>Consultation / Consideration</strong></td>
<td>Draft remit shared with Director of Public Health NHS Health Scotland and Dumfries and Galloway Community Planning Manager.</td>
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<td><strong>Risk Assessment</strong></td>
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<td><strong>Risk Appetite</strong></td>
<td>Low [X] Medium [ ] High [ ]</td>
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<td>Annual Operational plan for 2020.21 requires the Board to evidence work in relation to Public Health.</td>
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<td><strong>Sustainability</strong></td>
<td>The committee would consider emerging public health threats and this would include climate change and environmental sustainability.</td>
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<tr>
<td><strong>Compliance with Corporate Objectives</strong></td>
<td>This paper support Corporate Objectives 1, 6 and 7.</td>
</tr>
<tr>
<td><strong>Local Outcome Improvement Plan (LOIP)</strong></td>
<td>This paper supports all 8 outcomes within the Local Outcome Improvement Plan.</td>
</tr>
<tr>
<td><strong>Best Value</strong></td>
<td>Establishment of this Committee should support delivery of all the Best Value Themes.</td>
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<tr>
<td></td>
<td>• Vision and Leadership</td>
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<td>• Effective Partnerships</td>
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<td>• Equality</td>
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<td>• Sustainability</td>
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<tr>
<td><strong>Impact Assessment</strong></td>
<td><em>Not required for this committee proposal.</em></td>
</tr>
</tbody>
</table>
1. Introduction and Remit
The health and wellbeing challenges facing Dumfries and Galloway’s population are complex. Poor health has significant impacts on the quality of life of individuals and translates into additional demand on our health and social care system, a demand which is forecast to increase over the next decade. Increasing healthy life expectancy and reducing health inequalities are two of the biggest challenges we face. The Public Health Reform programme jointly led by Scottish Government and COSLA has recognised the need for collective leadership and a system wide approach to tackle these challenges. There are now strong expectations that robust assurance mechanisms are in place to ensure delivery of actions to improve public health. The remit of the Committee will be to:

- provide assurance to the NHS Board that public health governance is being discharged in relation to the Board’s statutory duty for quality of care and protection and improvement of the health of the population
- ensure there is development and implementation of work at strategic, tactical and operational levels to underpin a system wide approach to addressing the Public Health Priorities, with a specific focus on improving population health and wellbeing and addressing inequalities
- ensure there is development and implementation of work that relates to the health protection, immunisation and screening functions of public health
- monitor key public health measures with a clear focus on inequalities
- provide leadership to reshape NHS Dumfries and Galloway services to have a greater emphasis on prevention, early intervention and tackling inequalities
- promote effective partnership working arrangements between NHS Dumfries and Galloway, the Health and Social Care Partnership, the Local Authority, Community Planning Partnership, the Third Sector and local Communities to achieve the Public Health Priorities
- Provide leadership and advocacy for Public Health work in Dumfries and Galloway.

2. Arrangement for Conduct of Business
The Public Health Governance Committee will operate as a committee of the Board as described in the Board’s Scheme of Delegation/Standing Orders.

3. Meetings & Membership
Number of Meetings and Quorum
The committee will have at least four meetings in a year. The Chair of the committee may convene additional meetings as they deem necessary. The committee will be regarded as quorate if three members are present.
### 3. Meetings & Membership

**Membership**

The committee’s membership shall consist of at least four independent non-executive members of the Board. The Board will appoint one of these members to be the Chair of the committee.

A non-executive Board member who is also an employee of a NHS Board will not be regarded as independent.

The following will also be members of the Committee:

- The Director of Public Health
- Member of the Integration Joint Board
- Representative from Public Health Scotland

The Board may appoint independent external members if there is an insufficient number of non-executive Board members to form the committee.

The Board will appoint non-executive committee members for a period of no more than three years, but may re-appoint a member.

**Attendees**

The committee will normally invite the Chief Executive of the NHS, The Chief Officer for Health and Social Care, The Nurse Director, The Medical Director, Head of Strategic Planning, Community Planning Manager, and representative of Third Sector Dumfries and Galloway. All Directors and Board Members have an open invitation to attend. The committee may also invite other officers to attend meetings to support the consideration and discussion of particular items of business.

**Private Meetings**

The committee may meet in private if an item presented is considered to be confidential in nature.

### 4. Key Duties of the Committee

The committee will generally discharge its remit by:

- Receiving reports on regional workplans for each of the 6 public health priority areas led by the NHS Board and Health and Social Care Partnership
- Scrutinising and discussing key population health indicators
- Considering performance reports of key strategies and plans of local partners and partnerships as they relate to the Public Health Priorities
- Reviewing reports on progress of the Inequalities Steering Group action plan
- Receive and discuss reports relating to emerging threats to public health in Dumfries and Galloway
- Receiving reports relating to:
  - [Health Protection Incidents](#)
4. **Key Duties of the Committee**

- Immunisation Programmes
- Screening Programmes
- Work lead by the Public Health Directorate in relation to Healthcare Public Health such as Needs Assessments.

- Scrutinise significant strategic change programmes in order to ensure there is an adequate focus on achieving a positive impact on health and well being, and a positive impact (where possible) on health inequalities.

The committee will consider also:

- Review and constructively challenging the assurances that have been provided, as to whether their scope meets the needs of the population of Dumfries and Galloway
- Commissioning further assurance work for areas that are not being subjected to sufficient review
- Seek assurance that management are taking action to address key issues relating to Public Health
- Where necessary escalate key public health issues to Public Health Scotland or other relevant partner or agency
- Engage with the Community Planning Partnership about Whole Systems Approaches and key Public Health issues.

The committee will develop a work plan to discharge its remit and duties, which will determine the information that it requires at meetings and consequently the agenda for those meetings.

The committee will also annually review its performance and its terms of reference, and reflect the outcome from this in its annual report to the Board.

5. **Authority**

The committee may:

- Investigate any activity which is within its terms of reference, and in doing so, is authorised to seek any information it requires from any Board member or employee. All members and employees are directed to co-operate with any request made by the Committee;

- obtain specialist ad-hoc advice at the expense of the organisation, subject to the budgets agreed by the Board and the Chief Executive; and

- co-opt additional members for a period not exceeding one year to provide specialist skills, knowledge and experience.
6. **Reporting Arrangements**

The committee Chair will provide a report to the Board and the NHS Chief Executive after each meeting of the committee.

This report will summarise the business taken by the committee, explaining if necessary why that business was regarded as important. The report will also offer the views and advice from the committee on issues that it considers the Chief Executive and the Board should take action on.

A copy of this report will be shared with Public Health Scotland.

The Board will receive the minutes of the committee meetings only when the committee has reviewed and approved them, and the Chair has signed the approved minutes. The above report will ensure that the Board is informed in a timely manner of any relevant issues.

The committee will provide an annual report to the Board which is timed to support the preparation of the Board Annual Report. This annual report will also be shared with the Community Planning Partnership and Public Health Scotland.

7. **Supplementary Information for Boards and Committee Members**

1. Public Health Reform Website: [https://publichealthreform.scot/](https://publichealthreform.scot/)


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<tr>
<td>Version 1</td>
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</table>
RECOMMENDATION
The Board is asked to discuss and note the Board Briefing.

CONTEXT
Strategy / Policy:
This paper supports the Board’s Communication Strategy and gives recognition to key events within the Board.

Organisational Context / Why is this paper important / Key messages:
The paper of this paper is to raise awareness of the events and achievements that have been acknowledged within the Board over the past 2 months, as well as giving an indication of the consultations that are currently underway and the commitments for both the Chief Executive and Chairman going forward.

GLOSSARY OF TERMS
NHS - National Health Service
RCPSG - Royal College of Physicians and Surgeons of Glasgow
RCOG - Royal College of Obstetricians and Gynaecologists
ERS - Employer Recognition Scheme
RMN - Registered Mental Health Nurse
ANP - Advanced Nurse Practitioner
IJB - Integration Joint Board
## MONITORING FORM

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<th>Policy / Strategy</th>
<th>NHS Dumfries and Galloway Communication Strategy</th>
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</tr>
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<td>This paper encompasses all 7 Corporate Objectives.</td>
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| Best Value | • Vision and Leadership  
• Effective Partnerships  
• Use of Resources  
• Performance Management  
• Equality |
| Impact Assessment | Not applicable. |
SECTION 1 – EVENTS

- **Wigtownshire Prescribing Support Team Achieve Second Scottish Pharmacy Award**
  The Wigtownshire Prescribing Support Team lifted the award for ‘innovation in prescribing’ for the second year running, this time for development of pharmacy hubs at the Scottish Pharmacy Awards.

- **Queen Nurses in Scotland Awards**
  Jeanie Gallacher is the fourth member of staff from NHS Dumfries and Galloway to be awarded the prestigious Queen’s Nurse Title at the Queen’s Nurse Award ceremony at the end of November 2019. Jeanie works in the Community Mental Health Service in Annandale and Eskdale. Other local Queen’s Nurses are Dementia Specialist Nurse - Lorraine Haining, Mental Health Nurse - Kelvin Frew and Senior Community Charge Nurse – Hazel Hamilton.

- **Annual Christmas Celebration**
  The Annual Christmas Celebration featuring a choir made up of NHS staff takes place on 10th December at Dumfries and Galloway Royal Infirmary Atrium from 7pm.

SECTION 2 – STAFFING CHANGES, INCLUDING NEW STARTS, RETIREMENTS

**New Appointments**

- **Chief Resident**
  Alison Bradley, Specialty Registrar in General Surgery has been appointed NHS Dumfries and Galloway’s first Chief Resident at Dumfries and Galloway Royal Infirmary. Having previously worked at the old Hospital on Bankend Road, Alison has returned as a highly experienced senior trainee having completed her PhD.

  Alison’s role will be one of leadership amongst trainee doctors working within NHS Dumfries and Galloway, hosting trainee forums and representing junior doctors, whilst supporting service and educational development.

- **Area Medical Physics Manager**
  Stephen Scott has been appointed the new Area Medical Physics Manager. Stephen was previously the Service Manager for Althea who provided a range of services for the North West Anglia NHS Foundation Trust, based at Peterborough City Hospital.

- **New Spiritual Care and Wellbeing Lead**
  Rev. Dr Ewan Kelly recently started in post as Spiritual Care and Wellbeing Lead at the end of September 2019. Ewan started off his working life in the NHS as a junior doctor and has more than 25 years experience in the field of spiritual care.
He is delighted to be back working in NHS Dumfries and Galloway and is based in the Sanctuary at the Dumfries and Galloway Royal Infirmary.

- **Specialist Drug and Alcohol Service**  
The Specialist Drug and Alcohol service welcomed, Stephanie Dobson, Mental Health nurse specialist – addictions, Mary Gibson, Addiction liaison nurse based Dumfries and Galloway Royal Infirmary and Jill Murchie, Community Nurse Addictions - west of the region, to the team.

- **Intellectual Disability Service**  
Lesley Robinson relocated from Intellectual Disability to the Acute Liaison Service.

  Carole Patrick has recently joined the team as a administrative assistant.

- **Audiology**  
Caoilin Howat joins the Audiology team as Trainee Audiologist based at Mountainhall Treatment Centre.

**Retirement**

- **Quit Your Way**  
Quit Your Way (Previously Smoking Matters) Manager, Trish Grierson, retired in October 2019.

### SECTION 3 - CURRENT CONSULTATIONS

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<td>Healthcare Improvement Scotland</td>
<td>Prevention and Management of Pressure Ulcer Standards</td>
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## SECTION 4 – CHIEF EXECUTIVE AND CHAIRMAN COMMITMENTS

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<tr>
<th>Chief Executive’s Diary</th>
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<tr>
<td><strong>Key Events</strong></td>
<td><strong>Key Events</strong></td>
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<tr>
<td><strong>December</strong></td>
<td><strong>December</strong></td>
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<tr>
<td>3&lt;sup&gt;rd&lt;/sup&gt; - South East Payroll Services - Single Employer Decision Making Panel</td>
<td>3&lt;sup&gt;rd&lt;/sup&gt; - Board Members Discovery Sessions</td>
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<tr>
<td>4&lt;sup&gt;th&lt;/sup&gt; - EU Exit Committee</td>
<td>3&lt;sup&gt;rd&lt;/sup&gt; - Meeting with Chair of NES (as Vice Chair of Chairs Group)</td>
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<tr>
<td>4&lt;sup&gt;th&lt;/sup&gt; – Community Justice Partnership Meeting</td>
<td>6&lt;sup&gt;th&lt;/sup&gt; - WoS Chairs Assurance and Scrutiny Group</td>
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<td>4&lt;sup&gt;th&lt;/sup&gt; - Chief Officers Group - People Protection</td>
<td>9&lt;sup&gt;th&lt;/sup&gt; - NHS Board Chairs Group/Meeting with Cabinet Secretary</td>
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<tr>
<td>5&lt;sup&gt;th&lt;/sup&gt; - Diagnostic Steering Group</td>
<td>10&lt;sup&gt;th&lt;/sup&gt; - Meeting with Area Nursing and Midwifery &amp; Allied Health Professionals</td>
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<tr>
<td>6&lt;sup&gt;th&lt;/sup&gt; - SAM Executive Group</td>
<td>10&lt;sup&gt;th&lt;/sup&gt; - Dr Neil Kelly - Annandale and Eskdale Cluster Meeting</td>
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<tr>
<td>6&lt;sup&gt;th&lt;/sup&gt; - WoS Health and Social Care Delivery Plan Programme Board</td>
<td>12&lt;sup&gt;th&lt;/sup&gt; - Information Assurance Committee</td>
</tr>
<tr>
<td>9&lt;sup&gt;th&lt;/sup&gt; - Unscheduled Care Programme Board</td>
<td>12&lt;sup&gt;th&lt;/sup&gt; - Integration Assurance Group</td>
</tr>
<tr>
<td>9&lt;sup&gt;th&lt;/sup&gt; - Risk Executive Group</td>
<td>13&lt;sup&gt;th&lt;/sup&gt; - Chair and Vice Chair Meeting</td>
</tr>
<tr>
<td>10&lt;sup&gt;th&lt;/sup&gt; - NHS Chief Executives Meeting</td>
<td>16&lt;sup&gt;th&lt;/sup&gt; - Endowment Trustees Committee</td>
</tr>
<tr>
<td>11&lt;sup&gt;th&lt;/sup&gt; - NHS Chief Executives Meeting</td>
<td>16&lt;sup&gt;th&lt;/sup&gt; - NHS Board Agenda Setting Meeting</td>
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<tr>
<td>11&lt;sup&gt;th&lt;/sup&gt; - Community Partnership Executive Group</td>
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<td>12&lt;sup&gt;th&lt;/sup&gt; - Sustainability &amp; Value Programme Board</td>
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<tr>
<td>12&lt;sup&gt;th&lt;/sup&gt; - Once for Scotland Workforce Policies Programme Board</td>
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<td>13&lt;sup&gt;th&lt;/sup&gt; - SAM Executive Group</td>
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<tr>
<td>13&lt;sup&gt;th&lt;/sup&gt; - Corporate Risk Register Review</td>
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<td>16&lt;sup&gt;th&lt;/sup&gt; - Endowment Trustees Committee</td>
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<td>16&lt;sup&gt;th&lt;/sup&gt; - NHS Board Agenda Setting Meeting</td>
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<td>9&lt;sup&gt;th&lt;/sup&gt; - Risk Executive Group</td>
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<td>16&lt;sup&gt;th&lt;/sup&gt; - WoS Chief Executives meeting</td>
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<td>17th</td>
<td>Board Management Team</td>
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<tr>
<td>18th</td>
<td>EU Exit Committee</td>
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<tr>
<td>19th</td>
<td>Area Partnership Forum</td>
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<tr>
<td>20th</td>
<td>SAM Executive Group</td>
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<tr>
<td>20th</td>
<td>West Regional Laboratory Medicine Board</td>
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<td>27th</td>
<td>SAM Executive Group</td>
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<td>20th</td>
<td>SAM Executive Group</td>
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<td>27th</td>
<td>SAM Executive Group</td>
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**January**

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
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<tbody>
<tr>
<td>3rd</td>
<td>SAM Executive Group</td>
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<tr>
<td>20th</td>
<td>Healthcare Governance Committee</td>
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<tr>
<td>9th</td>
<td>Once for Scotland' Workforce Policies Engagement Event</td>
</tr>
<tr>
<td>20th</td>
<td>Board Agenda Setting Meeting</td>
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<tr>
<td>21st</td>
<td>Crichton Trust Heritage Advisory Group</td>
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<tr>
<td>10th</td>
<td>SAM Executive Group</td>
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<tr>
<td>27th</td>
<td>NHS Board Chairs Private Meeting</td>
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<tr>
<td>14th</td>
<td>NHS Chief Executives Meeting</td>
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<tr>
<td>27th</td>
<td>NHS Board Chairs meeting with Cabinet Secretary</td>
</tr>
<tr>
<td>15th</td>
<td>NHS Chief Executives Meetings</td>
</tr>
<tr>
<td>27th</td>
<td>Staff Governance Committee</td>
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<tr>
<td>13th</td>
<td>NHS Chief Executives Meetings</td>
</tr>
<tr>
<td>27th</td>
<td>Remuneration Sub Committee</td>
</tr>
<tr>
<td>16th</td>
<td>Once for Scotland Workforce Policies Engagement Event</td>
</tr>
<tr>
<td>27th</td>
<td>Audit and Risk Committee</td>
</tr>
<tr>
<td>17th</td>
<td>SAM Executive Group</td>
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<tr>
<td>20th</td>
<td>Healthcare Governance Committee</td>
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<tr>
<td>20th</td>
<td>Board Agenda Setting Meeting</td>
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<td>21st</td>
<td>Board Management Team</td>
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<tr>
<td>22nd</td>
<td>Strategic Capital Programme Board</td>
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<td>24th</td>
<td>SAM Executive Group</td>
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<tr>
<td>24th</td>
<td>Scottish Access Collaborative - Programme Board</td>
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<tr>
<td>27th</td>
<td>Staff Governance Committee</td>
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<tr>
<td>27th</td>
<td>Remuneration Sub Committee</td>
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<tr>
<td>27th</td>
<td>Audit and Risk Committee</td>
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<tr>
<td>28th</td>
<td>Once for Scotland Workforce Policies Programme Board</td>
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<tr>
<td>27th</td>
<td>Scheduled Care Programme Board</td>
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<tr>
<td>30th</td>
<td>Scheduled Care Programme Board</td>
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<tr>
<td>31st</td>
<td>SAM Executive Group</td>
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<tr>
<td>Executive Appointments to Regional and National Groups</td>
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<tr>
<td>Chair of NHS Board Chief Executives</td>
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<td>Chair of Transforming Care after Cancer Treatment Programme Board</td>
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<tr>
<td>Chair of Radiology Transformation Board</td>
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<tr>
<td>Co-Chair of Sustainability and Value Board</td>
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<tr>
<td>Chair of Diagnostic Steering Group</td>
<td></td>
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<tr>
<td>Member of Children and Young People’s Cancer MSN</td>
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</tbody>
</table>

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<thead>
<tr>
<th>Chairman Appointments to Regional and National Groups</th>
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</thead>
<tbody>
<tr>
<td>Member of Fit for Work Scotland - Programme Board</td>
</tr>
<tr>
<td>Member of Quality of Care Design Panel and Strategic Group Meeting</td>
</tr>
<tr>
<td>Member of West of Scotland Regional Chairs</td>
</tr>
<tr>
<td>Member of Guiding Coalition - Integration Workstream</td>
</tr>
</tbody>
</table>
DUMFRIES and GALLOWAY NHS BOARD

2nd December 2019

Corporate Risk Register

Author: Laura Geddes  
Corporate Business Manager

Sponsoring Director: Jeff Ace  
Chief Executive

Date: 15th November 2019

RECOMMENDATION

The NHS Board is asked to discuss and note the Corporate Risk Register to ensure it is aligned to the Corporate Objectives and Priorities.

CONTEXT

Strategy / Policy:

The paper supports the active management of risk within the organisation in line with the Board’s Risk Management Strategy and Risk Register Policy and Procedures.

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

Since presenting the Corporate Risk Register to NHS Board in August 2019, significant changes have been made to the Information Security risk, enhancing the information relating to the risk to link it with the tactical and operational risks identified by the General Manager for Information Communication Technology.

GLOSSARY OF TERMS

NHS - National Health Service
DATIX - Board Risk Management recording system
### MONITORING FORM

| Policy / Strategy                      | Risk Management Strategy  
<table>
<thead>
<tr>
<th></th>
<th>Risk Register Policy and Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing Implications</td>
<td>No staffing implications were identified as part of this paper.</td>
</tr>
<tr>
<td>Financial Implications</td>
<td>No financial implications were identified as part of this paper.</td>
</tr>
</tbody>
</table>
| Consultation / Consideration         | Each Director has reviewed the details within the corporate risks they are responsible for.  
|                                      | Management Team – November 2019 |
| Risk Assessment                      | No risk assessment was undertaken as part of this paper; however, individual risk assessments were undertaken for each of the Corporate Risks prior to them being added to the register on Datix. |
| **Risk Appetite**                    | Low  
|                                      | Medium ✓  
|                                      | High  |
|                                      | The corporate risk register covers all aspects of the Board’s business, from safe and effective patient care to business development opportunities; therefore, a medium risk tolerance has been added to this paper. |
| Sustainability                       | Not applicable |
| Compliance with Corporate Objectives | This paper covers all of the Corporate Objectives. |
| Local Outcome Improvement Plan (LOIP) | Outcome 6 |
| Best Value                           | This paper covers all areas of best value |
| Impact Assessment                    | No impact assessment was undertaken as part of this paper. |
Introduction

1. NHS Board has a responsibility to regularly review and assess the risks within the Corporate Risk Register; however, Board Members have delegated authority the day to day management of the risks to the Executive Directors.

2. The Executive Directors meet with the Corporate Business Manager on a quarterly basis to review each item on the register to ensure it continues to reflect the risk to the Board, to ensure all hazards relating to the risk has been identified and that the control measures in place and planned have been highlighted to help mitigate against the risk identified.

3. An update on the review of each risk is included within the Risk Management report, which is taken to Audit and Risk Committee for review on a quarterly basis. The report gives assurance that the appropriate processes and monitoring has been put in place to manage risk within the organisation, however, the register is ultimately the responsibility of the Board and should be reviewed on a regular basis by NHS Board Members to ensure the risks are being appropriately managed and that they continue to cover the Corporate Objectives and Priorities of the Board.

Changes to the register

4. Since the last update all risks within the Corporate Risk Register have been reviewed and updated with the Executive Directors to ensure that hazards relating to the risks are captured on Datix and that all current and future control measures are captured that will help to mitigate the risks and work towards achieving the target risk rating that has been set.

5. Attached at Appendix 1 is a summary of the corporate risk register for members to review.

6. A new corporate risk is being developed in relation to the impact delayed discharges is having on patient services and the financial challenges. It is hoped that this new risk will be approved and included within the next risk register report to NHS Board.

7. Earlier this year, the General Manager for Information, Communication and Technology (ICT) developed an initial risk assessment tool to use within his department to allow all of the potential hazards that exist within his directorate area to be identified and reported on. This tool in no way substitutes the Datix Risk Management System and all risks identified have been uploaded to Datix for onward management.

8. The assessment tool gives the opportunity to list all of the areas covered by the Directorate, the legislation, guidance and policies that the Directorate must adhere to, the practices that are in place to deliver on the national and local requirements and where gaps in assurance may arise, creating a potential risk to the Board.
9. As part of the review a robust set of hazards for both the tactical and the operational Directorate risks were identified, some of which should also have been identified as part of the strategic corporate level risk.

10. The Corporate Business Manager met with the General Manager for ICT and the Medical Director to undertake a full review of the corporate risk. The changes that have been made to the hazards within the risk have been highlighted within the table below. The updated risk also noted within Appendix 1.

Table 1 – changes to the Hazards within the Information Security corporate risk

<table>
<thead>
<tr>
<th>Information presented in July 2019 update paper</th>
<th>New information presented in Appendix 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Information systems accessed by hackers and cease to function effectively.</td>
<td>• Insufficient safeguards with our data stores may result in the loss of or inappropriate access to sensitive personal information.</td>
</tr>
<tr>
<td>• Insufficient safeguards result in loss of or inappropriate access to sensitive personal information.</td>
<td>• Users ignoring local guidance/national Legislation and not complying with Mandatory Training to be compliant with the specified level of security on devices and the management of data (Information Governance, GDPR Guidance)</td>
</tr>
<tr>
<td>• Failure to effectively store and access information results in a poor standard of care for patients or staff.</td>
<td>• Failure to effectively physically store, transport and dispose of confidential information (paper/redundant electronic media)</td>
</tr>
<tr>
<td>• Threat of internal security hacks.</td>
<td>• System passwords are not securely held or effectively managed resulting is failure to comply with industry good practice guidance and giving possibility to breach our confidential information.</td>
</tr>
<tr>
<td>• Failure to effectively store, transport and dispose of confidential information.</td>
<td>• Laptops and mobile devices are not secure and effectively managed, allowing a breach in access to confidential information.</td>
</tr>
<tr>
<td>• Information Assurance Committee did not meet between May - December 2018 due to the complete review of the group.</td>
<td>• Users are not protected from active and passive attacks from viruses, malware and unsafe browsing.</td>
</tr>
<tr>
<td></td>
<td>• Security measures are not in place, therefore, maximising opportunities to access to our secure networks from both internal and external locations.</td>
</tr>
<tr>
<td></td>
<td>• If Software is out of date it therefore can open security exposure to our business.</td>
</tr>
</tbody>
</table>
Recommendation

11. The NHS Board is asked to discuss and note the Corporate Risk Register to ensure it is aligned to the Corporate Objectives and Priorities.
<table>
<thead>
<tr>
<th>ID</th>
<th>Ref</th>
<th>Description</th>
<th>Hazards</th>
<th>Risk Level (Initial)</th>
<th>Risk level (Current)</th>
<th>Risk level (Target)</th>
<th>Risk Appetite Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>2392</td>
<td>New Corp Risk 1 (2392)</td>
<td>Failure to recruit and retain essential and sustainable workforce poses a significant risk to service sustainability. This could result in a lack of availability of suitably qualified and competent medical (including GPs), other clinical and other staff/carers/volunteers, resulting in inability to deliver services for partners as set out in the IJB Strategic Plan.</td>
<td>Unable to deliver care/services to the patients of NHS D&amp;G. Unable to recruit right staff (of all disciplines - medical, other clinical and other staff). Unable to attract independent contractors (GPs, pharmacists etc) to region to deliver independent contractor services. Impact of staff challenges adversely affects staff health, wellbeing and experience of remaining staff team members which adversely impacts on retention levels. Number of staff available does not meet the needs of the service. Unable to deliver Board objectives. Failure to recruit substantive staff increases the risk of excessive temporary staffing costs, in excess of organisation budgets.</td>
<td>Medium</td>
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<tr>
<td>2393</td>
<td>New Corp Risk 2 (2393)</td>
<td>Failure of the Board to meet financial target</td>
<td>Risk of adverse publicity/damage to reputation of Board. Board not able to deliver against financial targets. Ensuring that the financial position does not impact on patient safety.</td>
<td>Low</td>
<td></td>
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</tr>
<tr>
<td>2394</td>
<td>New Corp Risk 3 (2394)</td>
<td>Infrastructure is inadequate to meet both physical and technological service user needs in future.</td>
<td>Failure to deliver Primary and Secondary Care Services. Hazards are principally of business continuity - water, steam, fire control, electrical, air handling and medical gas systems require major life cycle replacement or maintenance which cannot be delivered whilst maintaining usual hospital services. Failure of such systems could lead to substantial service disruption and interruption. Failure to develop new models of health and social care in the community setting which meet the needs of our local population. Failure to deliver a local digital strategy to optimise the impact from technology.</td>
<td>High</td>
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<tr>
<td>ID</td>
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<td>Description</td>
<td>Hazards</td>
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<tr>
<td>2395</td>
<td>New Corp</td>
<td>Risk 4 (2395)</td>
<td>Failure to address inequalities resulting in poorer health outcomes for certain groups or parts of the population. Lack of funding for current and changing service provision. Working on basis of evidence to effectiveness. Failure to undertake impact assessment across whole system. The risk is that health inequalities in Dumfries &amp; Galloway are not reduced or mitigated against. If health inequalities are not reduced this will pose a number of risks to the organisation. These include but may not be limited to: poorer health outcomes, greater provision of interventions required, higher treatment costs, adverse outcomes for people from groups suffering exclusion, increased demand on services and damage to Board reputation. Worsening social and economic circumstances across D&amp;G. Not implementing evidenced based approaches. Non-delivery of actions within the Locality Plans Organisational resource pressures. Agenda not being embedded across the NHS and Health and Social Care system. Lack of partnership working.</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
<td>Medium</td>
</tr>
<tr>
<td>2396</td>
<td>New Corp</td>
<td>Risk 5 (2396)</td>
<td>A person dies or comes to significant harm as a result of failure to protect vulnerable individuals / support families. Failure for multi agencies to communicate appropriate information on vulnerable individuals or families. Staff unable to meet clinical demands due to capacity. Failure to adhere to protocols. Effective assessment of vulnerable individuals or families not being carried out. Failure to respond effectively to the requirement of vulnerable individuals or families.</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>2397</td>
<td>New Corp</td>
<td>Risk 6 (2397)</td>
<td>Unable to redesign quickly enough to meet the demands of the service. Services will need to be redesigned to address demographic / workforce / financial realities into 2020s. Lack of pace due to scale of change required. Inability to train and recruit to new models. Political opposition to radical change. Change capacity inadequate. Savings accrue too slowly to provide financial liquidity. Drug and other health technology change increases cost base faster than redesign savings. Delayed discharges increased to a level that disrupts safe service provision.</td>
<td>Low</td>
<td>Low</td>
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<td>Low</td>
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<tr>
<td>ID</td>
<td>Ref</td>
<td>Description</td>
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<tr>
<td>2398</td>
<td>New Corp</td>
<td>Risk 7 (2398)</td>
<td>Failure to realise optimal health and wellbeing of staff impacts adversely on service delivery and financial sustainability.</td>
<td>Increase costs due to excessive locum and agency use. Reduction in service quality due to inconsistent and or fluctuating team membership. Increase workload for managers, staff-side and support services (HR and Occupational Health). Reduction in quality of staff experience. Potential reduction in quality in patient experience. Unable to deliver services to patients, due to staff being off sick. Poor motivation of staff. Further absence of other staff members. Failure to meet government standards. Increase in critical incidents.</td>
<td>Medium</td>
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<tr>
<td>2399</td>
<td>New Corp</td>
<td>Risk 8 (2399)</td>
<td>Failure to assure and improve quality of care and services.</td>
<td>Complexity of changing patient and workforce demographics changing and complexity of health care Recruitment and retention. Financial challenge</td>
<td>Low</td>
<td></td>
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</tr>
<tr>
<td>2400</td>
<td>New Corp</td>
<td>Risk 9 (2400)</td>
<td>Loss of focus on operational delivery due to other significant change programmes, such as the Integration of Health and Social Care and the Primary Care Transformation Programme.</td>
<td>Restrictions to resources and poor management would result in continued breaches to the TTG Performance and other key performance indicators. Failure to monitor operational activity on a regular basis. Financial constraints leading to reduced services and failure to deliver the Strategic Plan. Failure to deliver a sustainable model of primary care resulting in increased pressure on secondary care services. Failure to deliver sufficient social care capacity resulting in increased activity and demand on primary and secondary care services. Failure to address delayed discharges resulting in increased activity and demand on secondary care services. Failure to address significant operational delivery challenges in the Out of Hours Service resulting in risks to patient safety and increased pressure on acute services. Failure to implement changes as a result of SAM which would lead to unsustainable models of Health and Social Care.</td>
<td>High</td>
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<tr>
<td>ID</td>
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<tr>
<td>2401</td>
<td>New Corp Risk 10 (2401)</td>
<td>Failure to take action on prevention and early intervention which impacts on future health and wellbeing of our population in medium to long term.</td>
<td>Lack of funding for current and changing service provision. Not implementing evidenced based approaches. Non-delivery of actions within the Locality Plans Organisational resource pressures. Agenda not being embedded across the NHS and Health and Social Care system. Lack of partnership working.</td>
<td><img src="Consequence" alt="Likelihood" /> <img src="Consequence" alt="Likelihood" /> <img src="Consequence" alt="Likelihood" /></td>
<td><img src="Consequence" alt="Likelihood" /> <img src="Consequence" alt="Likelihood" /> <img src="Consequence" alt="Likelihood" /></td>
<td><img src="Consequence" alt="Likelihood" /> <img src="Consequence" alt="Likelihood" /> <img src="Consequence" alt="Likelihood" /></td>
<td>Low</td>
</tr>
<tr>
<td>2402</td>
<td>New Corp Risk 11 (2402)</td>
<td>Emergency Planning – failure to plan for major incidents and disasters. This could lead to harm to patients &amp; staff (as well as reputational damage) through the failure of effective business continuity processes.</td>
<td>Gaps in comprehensive business continuity plans. Unexpected events for which no plans exist. Failure to respond appropriately to changes in UK threat level escalations.</td>
<td><img src="Consequence" alt="Likelihood" /> <img src="Consequence" alt="Likelihood" /> <img src="Consequence" alt="Likelihood" /></td>
<td><img src="Consequence" alt="Likelihood" /> <img src="Consequence" alt="Likelihood" /> <img src="Consequence" alt="Likelihood" /></td>
<td><img src="Consequence" alt="Likelihood" /> <img src="Consequence" alt="Likelihood" /> <img src="Consequence" alt="Likelihood" /></td>
<td>Low</td>
</tr>
<tr>
<td>2403</td>
<td>New Corp Risk 12 (2403)</td>
<td>Failure to maintain information security standards leading to loss of reputation and severe financial penalty.</td>
<td>• Insufficient safeguards with our data stores may result in the loss of or inappropriate access to sensitive personal information. • Users ignoring local guidance/national Legislation and not complying with Mandatory Training to be compliant with the specified level of security on devices and the management of data (Information Governance, GDPR Guidance) • Failure to effectively physically store, transport and dispose of confidential information (paper/redundant electronic media) • System passwords are not securely held or effectively managed resulting in failure to comply with industry good practice guidance and giving possibility to breach our confidential information. • Laptops and mobile devices are not secure and effectively managed, allowing a breach in access to confidential information. • Users are not protected from active and passive attacks from viruses, malware and unsafe browsing. • Security measures are not in place, therefore, maximising opportunities to access to our secure networks from both internal and external locations. • If Software is out of date it therefore can open security exposure to our business.</td>
<td><img src="Consequence" alt="Likelihood" /> <img src="Consequence" alt="Likelihood" /> <img src="Consequence" alt="Likelihood" /></td>
<td><img src="Consequence" alt="Likelihood" /> <img src="Consequence" alt="Likelihood" /> <img src="Consequence" alt="Likelihood" /></td>
<td><img src="Consequence" alt="Likelihood" /> <img src="Consequence" alt="Likelihood" /> <img src="Consequence" alt="Likelihood" /></td>
<td>Low</td>
</tr>
<tr>
<td>2404</td>
<td>New Corp Risk 13 (2404)</td>
<td>Board breaches compliance with standards on Corporate Governance including risk of best value not being obtained.</td>
<td>Risk of preventable harm to patients or staff if corporate governance fails. Litigation and criminal proceedings eg fraud. The Board may be unable to provide required assurance to government. Adverse reputation or publicity if corporate governance fails. Qualified accounts Best Value not being obtained.</td>
<td><img src="Consequence" alt="Likelihood" /> <img src="Consequence" alt="Likelihood" /> <img src="Consequence" alt="Likelihood" /></td>
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<tr>
<td>ID</td>
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<td>Description</td>
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| 2405 | New Corp  | Strategic commissioning fails to identify and adequately plan for the health and care needs of the people of Dumfries and Galloway                                                                                       | * Strategic Commissioning and Planning  
  * Reduced staffing capacity resulting in potential insufficient contract management, strategic and service planning.  
  * Challenges in recruiting staff experienced in planning and commissioning.  
  * Dual procurement systems with NHS and Council  
  * Inconsistent practices with Council and NHS staff in the department.  
  * Lack of single systems and processes between the NHS and Council.  
  * Performance and Business Intelligence  
  * Challenges in recruiting staff experienced in performance management.  
  * Challenges in meeting statutory performance reporting requirements due to imbalance of demand and capacity with regard to business intelligence information.  
  * Challenges in identifying capacity to undertake comprehensive needs assessment | ![Chart](chart1.png) | ![Chart](chart2.png) | ![Chart](chart3.png) | Medium |
| 2553 | New Corp  | Potential confusion exists around information sharing due to changes in legislation regarding information sharing across professional groups within Children’s Services. This can allow practitioners and children potentially to be at risk due action or omission.      | Lack of clarity in the legislation.  
 Difficulties of interpretation.  
 Potential contradictory advice from national directives.  
 Practitioners and children potentially at risk due to action or omission. | ![Chart](chart4.png) | ![Chart](chart5.png) | ![Chart](chart6.png) | Low |
| 2565 | New Corp  | Failure of the organisation to have a culture, systems and processes in which staff feel safe and confident to speak up and raise concerns and ideas for improvement, resulting in adverse impact on staff and/or patient safety, health, wellbeing and/or relationships and reputation of the Board.  
 This could result in a risk that the IJB fails to deliver anticipated cultural change resulting in fragmentation and disjointed services which have an adverse impact on patient / user and staff experience | Staff experience  
 Patient/user/carer experience  
 Impact on reputation  
 Impact on patient safety and care  
 Impact on relations with IJB partners  
 Failure to deliver the IJB strategic plan  
 Failure to deliver the Board’s Corporate Objectives | ![Chart](chart7.png) | ![Chart](chart8.png) | ![Chart](chart9.png) | Medium |
| 2635 | New Corp  | Exit from EU creates disruption to required availability of staff, goods and services necessary for the provision of safe care.                                                                                       | No deal creating immediate disruption.  
 Deal that fails to provide adequate access to staff, goods and services.                                                                                                                                                                                                                                      | ![Chart](chart10.png) | ![Chart](chart11.png) | ![Chart](chart12.png) | Low |
DUMFRIES and GALLOWAY NHS BOARD

2\textsuperscript{nd} December 2019

Integration Joint Board Directions to NHS Dumfries and Galloway

Author: Laura Geddes
Corporate Business Manager

Sponsoring Director: Jeff Ace
Chief Executive

Date: 18\textsuperscript{th} November 2019

RECOMMENDATION

The Board is asked to discuss and note the Directions that have been issued from the Integration Joint Board on the delivery of delegated services.

CONTEXT

Strategy / Policy:

This paper support both local and national guidance on the delivery of Health and Social Care functions, specifically the national Public Bodies (Joint Working) (Scotland) Act 2014 and the local Strategic Plan.

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

This paper gives details on the Directions or instructions that have been passed to the NHS Board from the Integration Joint Board in relation to the delivery of services that have been delegated to the Board to deliver.

Updates on the Directions will be brought back to NHS Board on a six monthly basis.

GLOSSARY OF TERMS

NHS - National Health Service
IJB - Integration Joint Board
HSCP - Health and Social Care Partnership
### MONITORING FORM

<table>
<thead>
<tr>
<th>Policy / Strategy</th>
<th>Public Bodies (Joint Working) (Scotland) Act 2014 Strategic Plan</th>
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<tbody>
<tr>
<td>Staffing Implications</td>
<td>No staffing implications were identified as part of this paper.</td>
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<tr>
<td>Financial Implications</td>
<td>No financial implications were identified as part of this paper.</td>
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<tr>
<td>Consultation / Consideration</td>
<td>Chief Executive Board Management Team</td>
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<tr>
<td>Risk Assessment</td>
<td>No risk assessment was undertaken as part of this paper.</td>
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<tr>
<td>Risk Appetite</td>
<td>Low [✓]</td>
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<td></td>
<td>The Directions cover all areas of NHS Board business, from clinical service delivery to financial management; therefore, a low risk appetite has been placed on this paper.</td>
</tr>
<tr>
<td>Sustainability</td>
<td>Not applicable.</td>
</tr>
<tr>
<td>Compliance with Corporate Objectives</td>
<td>This paper supports all of the Board's Corporate Objectives</td>
</tr>
<tr>
<td>Local Outcome Improvement Plan (LOIP)</td>
<td>Outcome 6</td>
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<tr>
<td>Best Value</td>
<td>• Vision and Leadership</td>
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<td>• Effective Partnerships</td>
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<td>• Governance and Accountability</td>
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<td>• Performance Management</td>
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<td>Impact Assessment</td>
<td>No impact assessment was undertaken as part of this paper.</td>
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</table>
Introduction

1. The Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) places a duty on the Integration Joint Board to develop a Strategic Commissioning Plan for integrated functions and budgets under their control. The plan will indicate how the Integration Joint Board will deliver the national outcomes for health and wellbeing, and achieve the core aims of integration.

2. Integration Joint Boards (IJBs) are required to give clear directions in respect of every function that has been delegated to the Health Board or Local Authority by the IJB to deliver. A direction must set out how each integrated health and social care function is to be exercised, and where possible identify the budget associated with that function.

Directions to NHS Dumfries and Galloway

3. In April 2018, the Chief Officer for the Dumfries and Galloway Health and Social Care Partnership wrote to the Chief Executive’s of both NHS Dumfries and Galloway and the Local Authority, with clear binding directions that had been agreed at the IJB meeting in November 2017.

4. The Health Board received 7 directions from the IJB in relation to the delivery of the delegated services in line with the Integration Joint Board Strategic Plan and Scheme.

Monitoring Performance

5. Following review of the Integration Joint Board Governance Structures paper at NHS Board, it is important to ensure that NHS Board Members have sight of the Directions that the Board have been issued.

6. Detailed in the table at Appendix 1 is a list of the Directions that have been received to date, for Board Members to review.

7. It is proposed that new directions received from the Integration Joint Board, in year, will be added to the table at Appendix 1 and brought to the next available NHS Board Meeting following receipt, for information.

8. In addition to this process an annual progress update against each of the Directions will be presented to NHS Board for discussion, to give assurance that the activities undertaken in year are helping to deliver against each of the directions. The first annual report will be brought to the NHS Board in April 2020.

Recommendations

9. The Board is asked to discuss and note the Directions that have been issued from the Integration Joint Board on the delivery of delegated services.
## Directions from IJB to NHS Dumfries and Galloway

<table>
<thead>
<tr>
<th>Direction Ref.</th>
<th>Date of Issue</th>
<th>Description of Direction</th>
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| 00012017       | 27/04/2018    | To note the key messages within the Scottish Governments Mental Health Strategy 2017-2027 and commit to a local, multi-agency response that works in partnership with service users, families and Carers, to develop a meaningful local response.  
To support the development of a mental health multiagency strategy group to coordinate the local response to the national Mental Health Strategy and define clear ownership and leadership on the actions set out in the strategy  
To support the development of efficient and effective governance arrangements for on-going monitoring and review of local performance against the strategy actions, that will reduce the potential for duplication of effort  
To approve an approach in Dumfries and Galloway, which embeds the combined ethos of public mental health and mental health service delivery within a local response to the national strategy.  
To nominate the Mental Health General Manager to take lead responsibility for overseeing the delivery of all elements of the Dumfries and Galloway Mental Health strategy |
| 00022017       | 27/04/2018    | Undertake a scoping exercise to include all Adult Learning Disability Services provided by the NHS, Council Third and Independent Sector.  
The aim of this scoping is to identify and begin to address the challenges within current service models and how these impact on the delivery of key outcomes as reflected in the national Learning Disability strategy for Scotland “The Keys to Life” and the IJB Strategic Plan |
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<tr>
<th>Direction Ref.</th>
<th>Date of Issue</th>
<th>Description of Direction</th>
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| 00032017      | 27/04/2018    | The following requirements of the Carers (Scotland) Act 2016 are to be implemented:  
• Preparation of Adult Carer Support Plans  
• Support to Carers  
• Short Breaks Service Statement  
• Development of a local Carers Strategy  
• Development and implementation of Local Eligibility Criteria  
• Carer Involvement in planning services  
• Carer Involvement in hospital discharge |
| 00042017      | 27/04/2018    | Ensure that appropriate local links to regional planning arrangements/structures are established and maintained for those areas of service and functions delegated to the Integration Joint Board that are or could be impacted by regional plans. |
| 00052017      | 27/04/2018    | Develop a model of sustainable, safe and effective health and social care service that meets the needs of the local community  
Co-produce the review and design of health and social care services in Wigtownshire with the local community and stakeholders  
Apply the six essential planning principles as contained within the Service Planning Framework to the redesign of health and social care services in Wigtownshire (i.e. person centred, outcome focussed, sustainable, effective and efficient, co-produced and equitable) |
| 00062017      | 27/04/2018    | Develop a service planning framework for Dumfries and Galloway integration Joint Board that supports staff teams to adopt a consistent approach to service planning that fits within the context of national, regional, local and financial planning  
Ensure that all services are reviewed regularly utilising the framework |
| 00072017      | 27/04/2018    | Utilising the Dumfries and Galloway Integration Joint Board Service Planning Framework undertake an options appraisal for the provision of vascular surgery for the people of Dumfries and Galloway. |
DUMFRIES AND GALLOWAY NHS BOARD

Area Clinical Forum

Minute of the Area Clinical Forum meeting held in the Education Centre, DGRI on Wednesday 28th August 2019

Present
Lorna Carr (Chair)
Adele Foster, Bill Irving, Ruth Millican, Ranjit Thomas

In Attendance
Jan McCulloch, Professional Committees’ Co-ordinator

Apologies
Fraser Gibb, Kim Heathcote, John Higgon, Ross Warwick, Carolina Mroczkowski, Jim Lemon

1. Apologies

2. Minute of Previous Meeting
The Minute of the meeting held on Wednesday 26th June 2019 was approved.

3. Matters Arising
   a) Urology Service Update
      Members noted that there have been no major changes and that this is work in progress.

   b) Maggie’s Centre Update
      Lorna reported that she had been unable to attend the recent visit to a Maggie’s Centre in Forth Valley, but had learned that it had been a good, informative visit. NHS D & G is still willing to look at models when proposed and Maggie’s is prepared to have dialogue about skills and meet staff. It was agreed this item should be kept as a standing item on all PAC agendas for updates and information.

   c) Vascular Services Update
      Members noted that from 8am on 2nd September 2019, Emergency Vascular Cover will move from Cumberland Infirmary (Carlisle) to Hairmyres University Hospital (NHS Lanarkshire) and that only one vascular surgeon will be available at DGRI.

      It was agreed that unfortunately there is no quick solution to the current situation and the Board will be aware of the risks involved. Members noted that vascular surgery referral pathways will be in place from the 1st September and that a paper regarding the service will go to the Performance Committee on the 2nd September.
d) Safer Staffing
Bill informed members that legislation will be brought in on 5th April 2020 about safer staffing for nursing in hospitals and will bring an update to the next meeting September meeting. It was suggested that it may be beneficial if Eddie Docherty, Nurse Director, was invited to the meeting.

4. Update Paper for Interpretation and Translation
Paper submitted by Lynsey Fitzpatrick, Equality and Diversity Lead
Members received and noted the update - JMC will feedback

5. Workforce sustainability update
Paper submitted by Caroline Cooksey, Workforce Director
It was agreed this should be a standing item for future ACF agendas

Lorna told members that as ACF Chair she was now a member of the Workforce sustainability group. Lorna said that the group was not only looking at recruitment, but also at retention and how to make NHS D &G an attractive set up that would encourage people to come here. The workforce directorate was looking at the 72 hardest to fill posts, across all professions to see if they could be filled in a different way. A new Workforce Manager appointment has been made and they will be looking at branding and various ways of attracting people to work here as well as how to develop supporting people already here. It was agreed that she should be invited to a future ACF meeting. Lorna said that social work has also been invited onto the group and there will be a meeting within the next couple of weeks about recruitment process and systems.

It was anticipated that the ACF/APF event on the 3rd October would be looking at these issues collectively, along with a group from the IJB, but Lorna has not had sight of the final agenda yet which has been set by Caroline Cooksey. Members agreed that the lack of suitable accommodation has had a significant impact on AHP and nursing and there a future implications for all professions, not just medics. It was agreed this needed to be fed into the group workshops on the 3rd October

Members questioned what has been achieved by some groups that have been set up and are they value for money

6. Sustainability and Modernisation (SAM) Group and the role of ACF
ACF Chair

Lorna highlighted that the SAM group has been holding promotional meetings throughout the region and speaking to staff groups about the future for NHS D & G. Although it was appreciated that there needed to be a quick mechanism for engagement it was agreed that the SAM group should have ACF representation to ensure that the clinical groups are engaged and that ideas need to be safe. It was agreed that Realistic medicine needed to link in with SAM as was the need to also include and engage with the care agencies. It was also agreed that keeping the public informed and involved about the changing situation would be key and members questioned how that would be achieved.

Lorna will take forward how ACF should link in with SAM.
6. Standing Items
   a) Chair’s Report
   Lorna informed members that she had recently met with Eddie Docherty, Nurse Director to discuss the difficulties ANMAC were having in maintaining a sustainable professional advisory committee. Lorna said that she had met with the nurse director as ACF Chair and he had been understanding and supportive and appreciated the governance issues that arose due to the committee not being more robust. Eddie will take the issues about the committee to the next senior nurse leadership team meeting and stress the need to get the message out to all nursing staff about the importance of ANMAC as a statutory advisory committee to the Board. Lorna has been invited to attend the senior nurse leadership meeting to outline the purpose of and for the advisory committees and how they provide impartial advice to the Board.

   b) Recruitment Issues
   See item 5

   c) Feedback from Committees
   Area Pharmacy Committee - APAC
   - A Short life working group has now been established to facilitate the resurrection of the committee.

   Area Medical Committee - AMC
   Next meeting 19th September
   In order to assist GP attendances at AMC meetings it was agreed that any member of GP Sub can attend AMC. There are serious concerns that the lack of GP attendance at AMC and ACF means that GPs are becoming disengaged from other PACs.

   Medical Staff Committee - MSC
   - Urology Service - update
   - Vascular Service - update
   - Ophthalmology – Concerns had been raised by Ophthalmology about the increasing delays in moving the dept. to the old Cresswell building

   Allied Health Professions Advisory Committee - AHPAC
   - Nithsdale in Partnership Rapid Response Team is making progress with Mosaic and the systems from NHS and Council are now speaking to each other
   - Restructure and redesign of AHP has been approved in principle
   - AHP Leads – discussions at the next AHPAC meeting about proposed different pathways and the lack of communication with staff

7. Any Other Business
   Date of Next Meeting TBC
1. Apologies for Absence

Apologies noted above.

2. Declarations of Interest

The Committee Chair asked members if they had any declarations of interest in relation to the items listed on the agenda for this meeting. It was noted that no declarations of interest were put forward at this time.
3. Minutes of meeting held on 17th June 2019

The following amendment was noted:

- Page 3, Item 6, paragraph 3 – MD should read MG.

With this amendment, Audit and Risk Committee approved the minutes of the meeting held on 17th June 2019.

4. Matters Arising and Review of Actions List

KL took members through the Actions List and provided brief updates on the following:

- Health and Safety Policies and Procedures Internal Audit - In terms of the outstanding action relating to Agility software, KL advised that funding is supported in principle, however, further information has been requested from the service to support this. This will be reviewed at Strategic Capital Programme Board on 31 July 2019.
- Risk actions
  - Risk Management Training – LD noted the update advising that training sessions had been poorly attended and queried the reasons for this. MS advised that service demands/inability to release staff had contributed to this. Committee agreed that this action should remain open, noting that this referred to risk management training for senior management (some training has taken place but not at senior level).
  - Risk Register Target Risk Levels – KL confirmed that Management Team has reviewed these and are comfortable with the risk levels; further work is being undertaken around the presentation of data and a further update will be provided at the next meeting. LD highlighted an example risk register from Dumfries and Galloway Council whereby the scoring matrix had been incorporated into the main columns of the register; LD felt this made the register much clearer in terms of understanding of likelihood and impact of risks, and it provided helpful context to risk scoring, particularly in cases where the target risk scoring looked the same as the current risk scoring. LD suggested that this could be adopted within the NHS Corporate risk register. KL advised that this could be looked at as part the of risk strategy review.
  - It was noted that updates on the remaining risk actions were included in the Risk Management Quarterly Report at Item 9.

Committee noted the Actions List.

5. Audit Scotland Reports Update

KL presented the Audit Scotland Reports Update report to Committee, advising that 2 new reports have been received since the previous meeting:
• Drug and Alcohol Services: An Update
• Public Health Reform in Scotland

KL recalled that Audit and Risk Committee previously requested that the ‘Withdrawal from the European Union’ entry on the register remains open. Committee reflected that this could now be closed, noting that any future updates on Brexit will be presented to Audit and Risk Committee (and any other committees/Board) as required. It was noted that JA will provide an update on Brexit under Item 9.

Audit and Risk Committee noted the report.

6. Internal Audit Activity Quarterly Progress Report

JW presented the paper which provided an update on the progress against the 2018/19 and 2019/20 Audit Plan. JW highlighted key points from the paper including:

• Audit activity to the end of June has consisted of audit work from the 2018/19 and 2019/20 audit plans and follow-up work to verify closure of actions from previous audit work undertaken.
• JW advised that a considerable amount of time has been spent supporting the outstanding actions exercise. 44 actions are currently open, with 28 overdue. The momentum to close off actions has continued with a significant number of actions being closed in recent months. JW added that a number of ‘end dates’ have been revised as part of this exercise.

LD referred to the table outlining audit action progress by Directorate, noting that Workforce, Chief Executive, Medical and Public Health currently had no actions overdue; this was a great achievement. LD also noted that both Nursing and Finance had increased numbers of overdue actions since April 2019.

Audit and Risk Committee noted the report.

It was agreed at this point to incorporate the update on the outstanding audit actions noted at Item 8

KL noted that, as at end of 30 June, 28 actions were overdue. KL provided an update on recent activity in relation to the three COO/IJB/Integration actions. In terms of the Finance actions, KL recalled that, due to the nature of finance work, the directorate is subject to a large proportion of audits. KL provided an update on the nine overdue actions, adding that some of these will be considered as part of a wider review in relation to the Sustainability and Modernisation (SAM) Programme. These include work around authorised signatories and the scheme of delegation.
It was noted that the Nursing Directorate currently has 16 overdue actions. Audit and Risk Committee agreed that an update report on these should be provided at the next Audit and Risk Committee meeting in November 2019.

**Action: MS/ED**

KL advised that she had undertaken a review of all outstanding actions and reiterated JW’s comments (as per her paper) that no actions have been identified as irrelevant or obsolete and that all are still valid and require the relevant action identified.

KL referred to the appendix detailing work against the 2018/19 audit plan and queried if Internal Audit required any further support to finalise the outstanding audits, noting that these were normally concluded by this point in the cycle. JW advised that many of these are work in progress and near reporting stage. JW spoke of various factors that had impacted on the delay eg. vacant post/recruitment, issuing of self evaluation questionnaires, support for outstanding actions. JW reassured Committee that the majority of the 2018/19 audits would be completed by the November Audit and Risk Committee meeting. KL noted that Internal Audit are awaiting the return of the Transport and Waste Management action plans and asked if any support was needed to progress these; JW advised she would look into further and seek support if required.

Audit and Risk Committee noted the Internal Audit Activity Quarterly Progress Report and the verbal update on the outstanding audit actions.

### 7. Limited Assurance Audit Update

LD recalled that in March 2015, Audit and Risk Committee agreed that Limited Assurances will remain a standing item on the agenda until all actions relating to the audits have been closed off, with update reports presented to Committee to allow detailed scrutiny. LD asked Committee if they continued to support this arrangement; Committee confirmed this was still appropriate. LD noted to Committee that if they would like to see the detail of any other Internal Audit reports then they should request them directly from the Internal Audit team.

JW presented the paper which provided a summary of the progress against the actions relating to previous Limited Assurance audits. These were noted as:

- **RM/01/13 Risk Management** – One remaining action open relating to the structure of Datix. It was noted that a further update on this was provided under Item 9.
- **A-02-18 Health and Safety Policy and Procedures** – One remaining action open. This relates to lack of clarity around the reporting of maintenance issues through Agility that are also Health and Safety risks and when there is a requirement to report these through Datix as an incident.
LD recalled that Committee had requested that an update report on the Health and Safety Policy and Procedures audit be presented to today’s Audit and Risk Committee. KL apologised for this omission, recalling that this had been deferred to the Audit and Risk Committee meeting in November (noting that Strategic Capital Programme Board would be reviewing a funding application in relation to this in July 2019). Committee agreed to add to the November Audit and Risk Committee agenda.

Action: LB (add to agenda); Ian Bryden (provide paper)

It was noted that there have been no further Limited Assurance audit reports issued since April’s Audit and Risk Committee meeting.

Audit and Risk Committee noted the report.

8. Outstanding Audit Actions Management Update

This item was covered under Item 6.

9. Risk Management Assurance Update

MS presented the paper which provided an update on the risk management activity for the Board, including the Corporate Risk Register, Risk Executive Group, the establishment of the Tactical Safety and Risk Group and an update on the limited assurance outstanding audit action.

MS highlighted some key points in the paper including:

- The Risk Steering Group has been reviewed and subsequently disbanded to allow the new Tactical Safety and Risk Group to be established, which will focus on all aspects of risk and health and safety within the Board. A copy of the draft remit was attached as an appendix. The first meeting of the group will be on 6th August 2019.
- A new risk assessment system has been created by the General Manager for IM&T (Graham Gault (GG) to capture all operational and tactical risks within the Directorate, which links directly with the corporate risks. MS added that Risk Executive Group (REG) has suggested that General Managers be invited to future Audit and Risk Committee meetings to provide an update on risk from an operational perspective within their directorates. Committee agreed this would be useful.

Action: LB

- An update was provided from the one remaining limited assurance outstanding audit action (RM/01/13). It has been agreed to split the corporate category on Datix into individual directorates which will allow for easier reporting and more accurate details on their own risks. Work on this has commenced and once confirmed, will be incorporated in the Datix system. It is anticipated that this will be concluded by the next Audit and Risk Committee in November.
• An appendix was included which outlined our performance against key performance indicators. This was reviewed at the REG on 25th July 2019.
• A copy of the notes from the REG meeting on 16th May were included as an appendix.

KL provided further updates from the REG meeting on 25th July 2019:

• REG discussed milestones for risk development, noting that a refresh of the Risk Management Strategy is underway.
• A Tactical Risk Workshop for various NHS stakeholders has been scheduled for 22 August 2019. The purpose is to review our current risk system, with a view to shaping the risk management strategy.
• KL noted that the Deputy Chief Operating Officer (Nicole Hamlet (NH)) is co-chairing the Tactical Safety and Risk Group; KL advised that NH will be key to supporting the group, noting her role as line manager to the GMs.
• Work will shortly commence on devising a programme for the Board workshop. It is anticipated that the workshop will take place Dec 2019/Jan 2020.
• REG acknowledged that work is also required around the IJB risk processes, however, recognised that we needed to ensure our NHS risk strategy is fully effective in the first instance prior to streamlining across the various bodies.
• In terms of the Risk Management Annual Report, REG agreed that these would be separated out, with the adverse events data attached as an appendix only. The action plans for risk and adverse events will also be separated. KL suggested that the risk action plan and the risk milestones be included in the quarterly Risk Management Assurance Report going forward; Committee agreed.

Action: MS

LD thanked MS and KL for the update and highlighted a number of thoughts:

• LD recognised that the Risk Steering Group was not working effectively and there was a need for a refresh. However, LD had some concerns on the role of the new Tactical Safety and Risk Group, noting that this incorporated a large range of health and safety objectives within its remit; LD was concerned that the risk element could be diluted. As Chair of the Committee, LD was keen for our risk work to be strengthened over the coming year and sought assurances that the Tactical Safety and Risk Group will be able take this forward effectively and provide sufficient time within its meetings to address risk issues fully.
• LD recognised the important work in progress around our Risk Management Strategy, noting that this would help shape our processes, governance and systems going forward. LD felt that it would have been useful to delay the establishment of any new groups until this had been finalised. LD was keen to ensure that our Risk Strategy shapes our governance requirements (rather than the other way around).
Discussion continued on this with the following points noted:

- KL recognised that the establishment of the Tactical Safety and Risk Group would not resolve all our risk challenges, however, there was an enthusiasm to move things forward and NH’s role was key to driving this. KL suggested that NH be invited to the next Audit and Risk Committee to help provide some assurances in this area; Committee agreed.

  **Action: KL**

- MS and JW acknowledged some of LD’s concerns and advised of various liaison with the group and NH to ensure risk is a key focus. MS added that she is working with John Knox on a piece of work around governance arrangements and will highlight as part of this also.

- LD commented that it would be useful to see a map of how risk is being strengthened across the organisation, noting the various workstreams and recent developments and milestones.

- LD referred to the chart outlining Health and Safety Governance, noting that LD should be removed from the REG membership (had previously been agreed that the Chair of the Audit and Risk Committee may attend if deemed appropriate but not a member of the REG as such).

LD reflected on the Corporate Risk Register and had a number of suggestions on this. In terms of the current control measures, LD felt these could be expanded to explain further why these help us reduce risks (rather than provide a list). LD also asked that the measures be reviewed to ensure these reflect current activity and are still relevant, noting that there are some references to past activity eg. 2017 campaigns.

  **Action: Management Team**

JA provided an update on Brexit planning and risks associated with this:

- Further to recent developments, there is a greater possibility of a No-deal Brexit as at 31 October 2019. This brings a number of high risks and significant challenges. The Scottish Government has reinstated the EU Brexit Sub-Group and is looking at scenario planning. NHS Dumfries and Galloway will be reinstating the weekly Brexit Group meetings shortly and we are looking at key issues at a local level.

- JA advised of the potential impact of a No-deal Brexit in relation to transport, food and medicines. Economic impacts were also noted eg. fishing, agriculture. The key risk area at the present time is around potential civil unrest and policing. In terms of health, the Scottish Government has undertaken significant planning work to identify key lines of stock and ensure appropriate stock piling; a 5-6 week programme is in place to support NHS requirements, however, there is a risk of service disruption after this time frame.

- JA highlighted that the Scottish Government has agreed that elective activity should not be rescheduled at the current time.

- JA concluded by advising that he would continue to keep the NHS Board and Committees informed of ongoing developments.
LD queried our views (NHS Dumfries and Galloway) on the decision not to reschedule elective activity in preparation for a No-deal. JA explained that these are normally scheduled 6 weeks in advance and we are comfortable that we will have the required equipment/resources to support elective activity for the initial period. JA advised that we are reviewing all our requirements and ensuring effective control measures are in place, adding that our business continuity plans are also being reviewed.

Discussion focussed on the KPI data provided at appendix 3 of the paper:

- LD felt that the information presented was not KPI data as such, as there was a lack of targets, graphical/reference keys and context to allow comparisons. LD asked for this to be revisited for the next meeting.

  **Action:** MS

- LD referred to the overdue risks by directorate and asked if these would be addressed by the Tactical Safety and Risk Group; KL confirmed these would. LD advised that Committee would be looking for the Tactical Safety and Risk Group to review and make timely progress with these overdue actions.

  **Action:** KL (to feedback to NH)

Audit and Risk Committee noted the report.

10. Mountainhall Risk Register

KL presented the paper which provided an update on the residual risks from Phase 1 of the project and an update on those transferred to Phase 2. A copy of the risk register was included as an appendix.

There are eight remaining risks which have been transferred to Phase 2 of the project. Phase 2 is in development and has been sub-divided into two main streams; Ophthalmology and Nithbank Services. Workshops have been held to inform the business cases and will be followed up with Risk workshops. The Phase 2 Risk Register is under development and will be presented to Audit and Risk Committee in November.

LD queried if the business cases will be brought to Committee. KL advised that this would be dependent on the scale and scope of the business cases. KL added that a more detailed paper on Mountainhall and Nithbank is being presented to Board on 5 August 2019.

LD referred to the risk register and queried the liability around MTC-02 (buyer of CRH does not progress with the redevelopment works following the sale). JA advised this was more around a reputational risk in line with the local historical value of Crichton Hall. This will be reviewed as part of the Phase 2 risk register.
LD noted that MTC-033 and MTC-034 appeared to be the same but with different lead directors. KL confirmed that one was clinical and one non-clinical; it is likely these will be combined in the Phase 2 register.

Audit and Risk Committee noted the report.

CC arrived at this point in the meeting.

11. Workforce Sustainability Programme Board Update

CC presented the paper which advised of the establishment of the Workforce Sustainability Programme Board and asked Committee to discuss the risks as outlined in the initial risk register provided. A copy of the Terms of Reference for the Programme Board were attached as an appendix.

CC provided the following update.

- The Programme Board has met four times to date. All partner members have now been in attendance at least one of the meetings.
- The programme is in a ‘settling in’ stage. CC advised that a detailed action plan will be devised shortly. CC acknowledged that the counter measures in the risk register are at a high level at the moment; this will be drilled down as the risk register is developed.
- At the last Programme Board meeting, it was recognised that the risks needed to be split into three categories: tactical, operational and strategic, noting that some of the actions were at a national level and an exercise needs to be undertaken to determine what is within NHS Dumfries and Galloway's direct control.
- CC confirmed that we have now successfully recruited to the Workforce Sustainability Manager post; this will support the development of the risk register.
- The Programme Board will continue to review priorities; CC added that her main priority going forward was to reduced vacancies in NHS Dumfries and Galloway by 50% over the coming year.

LD acknowledged that the Programme Board was in its early stages and that the action plan and risk register are still under development. LD encouraged the team to fully use the current Risk Management Strategy to assess the individual mitigation strategies per risk.

Committee agreed that the Workforce Sustainability Programme Board Risk Register should be submitted to Audit and Risk Committee every second meeting, with an updated register presented to Audit and Risk Committee in January 2020.

Action: CC

Audit and Risk Committee noted the report.

CC left at this point in the meeting. GB and KW joined the meeting.
12. Primary Care Transformation Board Risk Register

GB presented the paper advising the Risk Register is reviewed by the Primary Care Transformation Board at each meeting. Ten risks have been identified and added to Datix. Each workstream will also develop its own Risk Register. In terms of key risks at the current time, GB advised these are Risk 2 (lack of funding availability), Risk 5 (indecision or inappropriate decision making) and Risk 8 (inability to recruit to the required workforce). LD queried if any support was required around these. GB commented that linking with appropriate expertise throughout the directorates would continue to help support ongoing requirements.

Audit and Risk Committee noted the report.

GB and KW left at this point it in the meeting. KD joined the meeting.

13. Information Assurance Quarterly Update

KD presented the paper which provided a number of updates on various activity including:

- The Annual Information Assurance Programme. A copy of the 2019/2020 agenda setting matrix was attached.
- An update to the Corporate Risk Information Security.
- Network and Information Systems (NIS) Directive progress. A copy of a presentation to Management Team was attached.
- Internal Audit update. A summary update of progress to date was attached as an appendix.

KD highlighted the following key points:

- Datix issues – Sessions will be held next month to support ongoing awareness.
- Upgrading to Windows 10 is a major piece of work with various challenges. It is anticipated this will be delivered by January 2020.
- A short life working group has been established to support the NIS Directive. It is envisaged that the first meeting will take place in September 2019.

LD acknowledged the improvements in the reporting and assurance structures and thanked KD and the IT team for the robust report and information provided.
In terms of the fairwarning system, LD noted that there are still some instances of staff accessing their own data and queried what activities are taking place to deter this. KD advised that there does need to be further awareness sessions around this.

It was noted that the fairwarning system relates to medical records only. This led to a general discussion around data protection and control measures within Payroll and HR, noting that various processes are in place to support this.

*KD left at this point in the meeting.*

14. **Audit and Risk Committee Self Assessment Action Plan**

LD presented the paper noting that following the annual self assessment session in March 2019, Audit and Risk Committee approved the action plan presented in April 2019. It was agreed that a progress report on the Action Plan would be brought back to each Audit and Risk Committee meeting; this was attached as an appendix with a number of status updates included.

Audit and Risk Committee noted the report.

15. **National Fraud Initiative (NFI) 2018/19 Progress**

JW presented this paper which provided an overview of Audit Scotland’s NFI and detailed progress to date within the Board in relation to clearance of the matches and outcomes of the matches. JW provided information on the background, compliance, data submission and data matches. JW highlighted the key points from the paper including:

- A programme of detailed work has been undertaken to review and clear the data matches. A number of payroll updates have been recorded within the NFI system, although the matches have not been closed. This will be reviewed further and all outcomes noted in the final NFI report due to Audit and Risk Committee in January 2020.
- A new match introduced in this exercise is a comparison of Payroll and Creditors’ data matched with Companies House information. The purpose of this match is to “identify potential undeclared interests that have given a pecuniary advantage”. These matches are being reviewed to verify that no staff have been involved in procurement of goods or services where they have been a Director or similar with a company.
- An exercise is being undertaken by the Corporate Business Manager to invite all staff to complete a Register of Interests form. The data matches will be compared with these declarations and where staff have not completed the forms they will be reminded to do so. This exercise will be completed by the end of August 2019.
LD noted the new match exercise relating to Companies House and was keen for Committee to be updated on progress around this. JW confirmed that an overall update on the NFI exercise will be provided at the next Audit and Risk Committee meeting.

Action: LB (add to agenda); JW (provide paper)

Audit and Risk Committee noted the update.

16. Fraud Quarterly Update

JW presented the paper advising that one alert has been received since the last meeting. JW highlighted key points from the paper including:

- It was noted that the intelligence alert relating to a controlled medicine incident was highlighted by Dumfries and Galloway Royal Infirmary Pharmacy dept (further enquiries by CFS revealed that the matter relates to an issue within the external distribution firm). JW confirmed that an audit of Pharmacy Stores and Stock Control is scheduled in the 2019/20 audit plan which will support any learning from this.
- JW recalled that at Audit and Risk Committee in June 2019, it was queried whether fraud was included within our risk register and it was agreed that a risk assessment be undertaken to allow review of this; an initial assessment has been undertaken and was attached as an appendix.
- JW advised that there is an outstanding action in relation to the Counter Fraud Assessment Tool (copy of the self assessment was attached as an appendix). A workshop has been considered as an approach to completion of this, however, JW noted that an alternative approach may be that the Fraud Liaison Officer and Counter Fraud Champion review this on behalf of Committee.

In terms of completion of the Counter Fraud Assessment Tool, KL suggested that a small group be established to complete this. LD confirmed she would be happy to work with JW on this and invited Committee members to be involved should this be of interest.

Action: JW/LD/Audit and Risk Committee Members

In terms of the fraud risk assessment, KL advised that fraud is included on the finance risk registers (due to the nature of the business) and that individual directorates should consider including where appropriate. LD asked whether fraud should be included as a standalone item in our corporate risk register. and queried if other Boards included in their risk registers. JA advised that this varied across Boards. KL reiterated that the corporate risks have been updated to include an aspect of fraud. JW suggested that we retain the assessment as an appendix to the quarterly Fraud report to allow further review as required. LD acknowledged that fraud has been embedded into governance and financial risks registers but felt it would be useful to retain the risk assessment as an appendix to the report going forward to allow further review as needed.

Action: JW
Audit and Risk Committee noted the report.

ST arrived at this point in the meeting.

17. Financial Reporting Quarterly Update

ST presented the paper which provided an update on the following areas:

- Reporting and approval requirements for Audit and Risk Committee in line with SFI – update was provided as an appendix. ST highlighted an error under ‘Approval of changes to Standing Financial Instructions’; this should be flagged as amber instead of green, noting that an update will be submitted to the next Audit and Risk Committee in November.
- Banking Arrangements – a summary was attached as an appendix.
- Procurement of Supplies and Services – awards were attached as an appendix. Further detail was provided on the taxi contract, noting only one submission was received.
- Losses and Special Payments – a summary was attached as an appendix. Following the query at the last Audit and Risk Committee meeting, an update on the Theatre Stock write off was requested and an update included as an appendix.
- Technical Bulletin summary
- Annual Accounts De-brief - A date for this is still be arranged. ST will take forward.

Action: ST

- Review of fraud and irregularities. ST recalled that Audit and Risk Committee had previously requested a review of the Boards local arrangements in relation to the significant fraud committed at Dundee City Council. In addition, improved processes have been implemented within the Finance Department to ensure that all relevant fraud and irregularities reported are reviewed and any actions followed up. A log has been created which shows the status of each one received, this was included as an appendix. A review of the Dundee City Council review was also attached as an appendix.

LD sought further information on taxi usage relating to the contract highlighted. ST confirmed this mainly related to renal treatment. JA explained the complexities around this in terms of frequency and treatment. ST spoke about the scale of the contract and the supporting business documentation/evidence required for the procurement process. There was a brief discussion around the community transport initiative.

KL highlighted that ST and her team are undergoing a considerable review of processes to support the SAM programme and ensuring we have ‘financial grip’. A new post has been established which will support this. ST advised that this will provide resource to fully review our procedures and compliances (eg. authorised signatories, SFI compliance).
LD referred to the losses register and noted that a number of these related to loss of clothing and queried what these would be. ST provided a brief overview and advised that she would bring a more detailed update to the next Audit and Risk Committee meeting in November.

**Action: ST**

Audit and Risk Committee noted the report.

18. **Date and Time of Next Meeting**

*Please note updated date and venue*

The next meeting of the Audit and Risk Committee will be held on 18th November 2019 at 10.00 am to 1.00 pm at Willows Meeting Room, Children, Young People and Family Centre, The Crichton, Dumfries, DG1 4TG.
DUMFRIES and GALLOWAY NHS BOARD

2nd December 2019

Governance Committee Minute Matrix 2019/20

Author: Laura Geddes
    Corporate Business Manager

Sponsoring Director: Jeff Ace
    Chief Executive

Date: 18th November 2019

RECOMMENDATION

The Board is asked to discuss and note the following points:
- The matrix of governance committee minutes that have been taken through NHS Board meetings.
- The minutes from various committees being presented for information.

CONTEXT

Strategy / Policy:

This paper support good governance best practice within the Board, by ensuring that all minutes from governance committees reporting to the Board are reviewed.

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

The matrix included within this paper highlights all of the committee meetings throughout the year and when the minutes were taken to NHS Board for information. Board members are asked to review and note the following committee minutes that are being presented to NHS Board members for information:

- Area Clinical Forum - 28th August 2019
- Audit and Risk Committee – 29th July 2019
- Healthcare Governance Committee – 13th May 2019
- Healthcare Governance Committee – 8th July 2019
- Healthcare Governance Committee – 16th September 2019
- Performance Committee – 2nd September 2019

A verbal update will be given by the Committee Chair or Lead Director for each of the above committees to highlight the key messages that should be acknowledged from the most recent meeting or from points within the minutes being presented.

GLOSSARY OF TERMS

NHS - National Health Service
| **Policy / Strategy** | Code of Corporate Governance  
|                     | Good Governance Blueprint |
| **Staffing Implications** | No staffing implications were identified as part of this paper. |
| **Financial Implications** | No financial implications were identified as part of this paper. |
| **Consultation / Consideration** | Management Team and all Board Governance Committees were consulted on the minutes supporting this paper prior to it being presented to NHS Board. |
| **Risk Assessment** | No risk assessment was undertaken as part of this paper. |
| **Risk Appetite** | Low ☐  
|                      | Medium ☑  
|                      | High ☐  
| A medium risk tolerance has been noted against this paper as it gives assurance to the Board that all areas of business have been notified to Board, specifically around changes to services or financial challenges. |
| **Sustainability** | Not applicable. |
| **Compliance with Corporate Objectives** | This paper supports all of the Corporate objectives for the Board. |
| **Local Outcome Improvement Plan (LOIP)** | Outcome 6 |
| **Best Value** | • Vision and Leadership  
|                     | • Effective Partnerships  
|                     | • Governance and Accountability  
<p>|                     | • Performance Management |
| <strong>Impact Assessment</strong> | No impact assessment was undertaken as part of this paper. |</p>
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<tr>
<th>Committee Name</th>
<th>Committee Meeting Date</th>
<th>Date minute taken to NHS Board</th>
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<tr>
<td>Audit and Risk Committee</td>
<td>29&lt;sup&gt;th&lt;/sup&gt; April 2019</td>
<td>5&lt;sup&gt;th&lt;/sup&gt; August 2019</td>
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<td>Audit and Risk Committee</td>
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<td>Audit and Risk Committee</td>
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<td>Healthcare Governance Committee</td>
<td>13&lt;sup&gt;th&lt;/sup&gt; May 2019</td>
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<td>Healthcare Governance Committee</td>
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<td>Performance Committee</td>
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<td>Person Centred Health &amp; Care Committee</td>
<td>29&lt;sup&gt;th&lt;/sup&gt; April 2019</td>
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<td>Person Centred Health &amp; Care Committee</td>
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<td>Person Centred Health &amp; Care Committee</td>
<td>21&lt;sup&gt;st&lt;/sup&gt; October 2019</td>
<td>Meeting Cancelled – no minutes</td>
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Patient Story
Former patient, accompanied by a Consultant Psychiatrist, attended to share their patient experience of the Community Adolescent Mental Health Service (CAMHS).

Patient outlined first contact with CAMHS four years ago, saying that they struggled to respond to staff but gradually became more comfortable. Highlighted bullying at school, low self-esteem and self-harm issues, saying that they were very poorly when the CAMHS Team came along. Twelve weeks IPT was provided by CAMHS who also helped with family problems and helped by doing things with patient that taught them to cope and develop good relationships and good mental health. Was prescribed three lots of medication before they getting the right one and they realised CAMHS wanted to see them get on with life and give them a sense of purpose.
Patient transferred to KITS and the Team came out to visit every day which really did help and after two weeks patient wanted to go out.

Family bereavements raised some issues but CAMHS were on hand whenever needed to support and this gave closure. The Consultant Psychiatrist made patient understand what they could do and had two CAMHS appointments per week to give structure and time to go through the grieving process. Patient acknowledged that the appointments gave her something to focus on, with mental health staff making them go out and go to college, they also accompanied to visit the graves and just having someone there to support was a big help.

Patient was discharged from the service just after 18th birthday which was traumatic as they could not get in touch with them. However, is now at college, has passed driving test and is working with the mental health service as a volunteer. Patient said thank you to the CAMHS staff who helped through this very difficult time saying that without them would not be here and that the biggest thing was having someone to trust and talk to, an open relationship and everything on the table.

When asked about having had regular appointments which stopped when turning 18, patient responded that they were lost in the middle, saying that lots of support and more action at school would have been good, there is a need for counsellors, but the school just handed over to CAMHS. Explained that when turning 18, services are available but most are Dumfries based, did not have somewhere to go in own area and that living in a rural area was hard, anxieties about getting bus and train. Although on medication, GP had not been in contact and the practice checking in now and again would be good, highlighting the need to be more aware of who you can see and be referred to.

1. **Apologies for Absence**
   Apologies as noted above.

2. **Declarations of Interest**
   Nil.

3. **Notes of meeting held on 13 May 2019**
   Accepted.

   *Health Adult Support and Protection Update*
   AW clarified with PH that the Committee had agreed to move to an annual update rather than six-monthly.

4. **Matters Arising**

   *Care Assurance*
   AW commented that following the May meeting there had been no questions and reminded the Committee that these should be sent to her, next presentation is at November meeting. PH requested that an email be sent to the Committee to jog memories. LB commented that she had not been at the last meeting and AW agreed to discuss with her outwith the meeting.
5. **Reminder List and Draft Agenda**

ED noted that the HASP Significant Case Review and the Mental Health Review are deferred again, awaiting confirmation from Procurator Fiscal.

**STANDING ITEMS**

6. **Patient Services Feedback Report**

PH noted the key messages on the front page. JP noted 93 complaints received within the reporting period, 49 of which are still open, with a higher than average number of complaints received in May which relates to a spike in the Acute and Diagnostics Directorate. The top themes are clinical treatment, staff attitude/behaviour and waiting times. JP highlighted training, noting an excellent CPD event recently with a high attendance from Dental, and the Scottish Mediation session around raising awareness for individuals when having this service involved in complaints would be useful. JP noted improvement in Stage 1 and Stage 2 response timescales, Stage 1 at 61.5% and Stage 2 at 57.5%.

NM highlighted the rise in complaints in May asking if this was across lots of different areas and in keeping with the level of business at this time, are there any themes and how do we deal with this. CS responded that admissions through the Emergency Department in May were very high and the number of delayed discharges is also rising which causes reduced availability in the hospital. She noted that on the recent day of care 29% of patients did not need to be in hospital but there are a lot of system issues underlying this. CS explained that we have not closed the winter beds which causes problems with patients not being in the right place and results in different nursing staff being in unfamiliar areas. She noted that this is being looked at along with suggestions of changing the number of speciality beds around. PH asked if we had more medical beds are we in danger of people being in hospital longer and CS responded we would need to look closely at what these beds will be. ED commented that we have these patients in anyway and the shift in bed space is due to what we are seeing. NM asked if busyness in the area is resulting in staff getting frustrated and CS responded that there is an element of people being in the wrong place, a step beyond normal working areas but we do not have the capacity to do this. NH commented that the winter beds are normally open for January only but have been open until May this year, as well as an extra half ward open. She noted we have been using agency staff who do not know the policies and procedures as well as our own staff and so we may not be maintaining the level of care we pride ourselves on, this is having a significant impact and takes extra time.

GB highlighted her recent admission to DGRI saying that everyone is trying to do their best and everyone was kind to her, there is a lot of kindness but staff have less time to be kind when they are busy and they are working flat out every day and do struggle at times. She felt we should be mindful of this, patient may not have water when next door needs urgent care.
PH highlighted the increase in admissions saying that we know people are staying in hospital for longer causing capacity issues which affects our staff and if it affects staff, it affects patient care. She noted we need to look at this as a Board, part of this is interaction around quality of care and how do we approach this in a pro-active way. PH noted that NH had presented this at the Audit and Risk Committee.

JP highlighted a conversation we have had about linking this in with the corporate paper, Directorate Improvement and Risk paper, and asked about including complaints in this paper. ED commented that he would support this saying that if HCAT is up and running we could also see this globally. This suggestion was agreed by the Committee.

GC commented that she agreed with what GB was saying around the challenges staff are facing and supporting them in their busy periods. We understand the whole system better and can empathise with staff in a way that patients can't. Patients will have a good or bad experience. GC noted there were eleven compliments in May saying that patient experience is being compromised by this busy period. We need to recognise kindness and find ways of including this. She noted communications comes up all the time, asking how can we communicate more effectively and suggesting using Facebook to let the public know staff are struggling. NH responded by asking what can we do, we are doing something, sustainability and supporting staff is about pace for me, staff wellbeing and how they have resilience to deliver care. We are using the sustainability programme and the Team will continue to plan around what we can change.

JP highlighted British Sign Language and the geographical variance, we do not have local service but have strong routes of access to the central service. There is new guidance on Beacon and we are in the process of creating a service level agreement with Signlanguage Interactions around video conferencing opportunities and having conversations with IT locally to support the delivery and hope to get this in place shortly.

NM commented that it would be good to bring complaints into the Directorate business. He noted we have this complaints paper here, it is not being critical of the staff, but of the issues the organisation is facing and the majority sit in the Acute & Diagnostics Directorate. NH said we need to tackle this and take pressure out of the system and are we doing this often enough, 1 issue will become 12 issues. How do we communicate with staff our responsibility for their behaviour with patients, they should know we are doing something about this to get on top of this.

LB suggested the Working Well people could come in around this. PH noted a link at Staff Governance regarding spike in complaints and system data we are sharing. We look at what is going on with staff because something has happened to the patients. LB will speak to Caroline Cooksey.

LB highlighted the learning summaries asking for a glossary to be included and JP agreed to include this.
PH agreed JPs suggestion that the complaints information is shared in the Directorate reports. We will extend communications and as part of the strategy will be able to pick up when admissions are high and tell people via Facebook we are busy. She highlighted sustainability and complex issues around this and NHs comments about timing and the frustration around how long this will take, staff say nothing is happening. HCGC will support anything that will make a difference.

The Committee:
- Agreed complaints information is shared in the directorate reports
- Discussed and noted the report

7. Spiritual Care, Volunteering, Patient and Carer Information Report
JP presented the paper highlighting support for young people who are bereaved and recent discussions around this. She highlighted staff care and support, noting that Dawn Allan has left and outlining arrangements until her replacement is in post, interviews will be held on 22 July with, hopefully, a September start date. JP noted that we have already spoken about Interpretation and Translation.

NM explained that he has been working with JA around moving the Board meeting around the region, saying that a meeting in Stranraer Academy may be coming up and suggesting an afternoon workshop with the 6th Form students to engage with us on mental health, requesting that the Committee get back to him with any thoughts they may have around developing better relationships with our youth. PH commented that there would be no gain from students attending the Board meeting and GC commented on aspiring to change and how to make decision-making available to young people.

The Committee:
- Discussed and noted the paper

8. Clear Pathway Update
JP provided an update on the Clear Pathway, which came through the Lampard Report and the Jimmy Saville investigation, around working with volunteers and other agencies in the Third Sector. JP explained that we have been working with Volunteer Health Scotland since the end of last year along with fourteen specific groups, four of which have a Service Level Agreement (SLA) in place. Margaret McGroggan has been working with the other twelve groups, and our two local Hale and Hearty Groups, to develop an agreement which is now sitting with the Central Legal Office (CLO) for assurance. There has been some debate around Building Healthy Communities (BHC) as the governance is so complex but we have taken guidance from CLO and are now in conversation with BHC around either formally separating from us or coming back to NHS D&G as direct volunteers and we are awaiting confirmation around this. PH commented it was good to have this update on the agenda and unfortunate MMcG is not here as we need to agree this, they are supported by NHS staff but are neither NHS volunteers nor independent volunteers. We need to use BHC staff to support our direct volunteers and the situation must come to an end now.
JP explained that CLO has helped us to move this forward and we are nearly there and PH asked how long this will take with JP responding that a meeting is being arranged this week and hopefully by the next Committee meeting we will have clear direction on the way ahead.

The Committee:
- Noted the update

9. **Healthcare Associated Infection Report**
ER presented the paper highlighting that the infection rates remain within acceptable limits across the Board. She explained that the hospital having been under great pressure had resulted in an observed decrease in compliance with hand hygiene and some elements of infection prevention as the staff have been putting patient care first. Hand hygiene is being raised at the huddles and the IPCT will continue to support staff at ward level and address issues seen. ER highlighted increasing awareness using the “MEG” tool which measures the ward compliance with hand hygiene.

ER explained that a recent inspection revealed concerns that the general areas in the ward utility and storage areas are not being cleaned as regularly as they should be although we have a planned programme of cleaning for this. She noted that, with the use of agency and bank staff, it is not always the same staff in each area but said that this clearly delegated responsibility seems to be getting missed and an SBAR has been sent to senior nursing management for consideration. ER highlighted that staff are monitored for the time taken to answer buzzers so they are switching them off before doing hand hygiene and that there is a piece of work to be done around making the alcohol rub more accessible for them but that this will take time.

LB said that she was quite concerned that this issue could impact on patient safety, asking how we know if agency staff training is up to date. ED responded that there is a training template across NHS Scotland to ensure we have assurance at a national level. LB asked if they are given induction training in our organisation and ED responded that they are inducted by the staff in the ward they are working in and ER noted that bank staff go through the organisation’s induction training. In response to PH asking if this is the issue, ER responded that it is part of it but shortened induction time has also had an impact and she will raise this issue at the HAI Executive Group.

The Committee:
- Considered the report

NM and GB left the meeting.

10. **Improving Safety, Reducing Harm : Risk Management Annual Report**
PH commented that the whole aspect of Realistic Medicine presents a risk with CS responding that it should reduce the risk rather than increase it. ED commented that we should ask for a risk statement rather than for risk appetite and that KD can provide the potential for the operational risks and benefits that can come from this.
PH said we do not have the background on medicines which is easily a risk for us and she wonders about this with CS responding that this is a discussion between a doctor and their patient and understanding their viewpoint around their treatment. PH commented that she hears complaints around communications, is aware that we are not good at communication and feels there is a risk to the Board as we are weak regarding communications. ED suggested finding out when the report is due and including this. AW highlighted a piece of work as part of the Realistic Medicine Programme.

GC highlighted themes from the Leadership Walkrounds, page 18, in particular “staffing”, asking what is happening around information from the walkrounds as in “you said” and “we did”. ED responded that he does not think the walkrounds do what they say on the box and is suggesting reformatting the walkrounds by asking the Directors to give one to two hours per week and implement this across the Board as an opportunity to do something and improve things. GC asked how we feedback information from the walkrounds and ED responded that the notes are shared with the staff and actions taken from these. GC highlighted the themes asking if staff are seeing these and ED responded that we are working towards this, right now it sits very much as direct questions being responded to by a Director. GC suggested taking the themes and putting something out to staff saying this is what we have done and ED responded that he would not like to do this just on the basis of walkrounds.

LB asked if any themes had come from the breakfast conversations JW is leading on and NH responded there had only been three so far and the theme coming through was the care at home aspect.

PH suggested consulting with a small group of staff around what they are looking for, perhaps social media or newsletters, organising and sending the right information and getting this out to people.

BR noted on Page 15 that one of the top adverse events was a growth in violence and aggression towards staff saying that we are seeing this on the news in the retail sector. ED noted that the Scottish Patient Safety Programme is focussing on this and he will ask their lead, Jo Matthews, for an update.

LD noted that the Audit and Risk Committee had received this report and requested that the adverse events are separated out from risk management so that we received a report on adverse events and a report on risk management. AW has fed this back and the team is clear this is to happen.

The Committee:
- Discussed and noted the report

INTERNAL REPORTS

11. **Overview of Current Screening Issues**

NC highlighted a number of changes in the screening programmes for which the Board is responsible, saying that there are no major changes but a few small changes.
Abdominal Aortic Aneurysm
NHS D&G had a five year joint vascular contract with Carlisle, however vascular services are transferring to Hairmyres Hospital which will have no effect on the screening but there will be travel issues around this.

Bowel
Introduction of new test for just one sample sent through the mail which has resulted in increased uptake, which in turn has increased the number of colonoscopies required. There is a national issue around waiting times for colonoscopy.

Breast Cancer
This was discussed at a previous meeting noting the slippage within the service.

Cervical Cancer
As a greater understanding of the link between cervical cancer and HPV has developed, HPV is to become the first line test with effect from March 2020. These new arrangements will reduce demand on cytology services. A self-sampling postal study is planned for NHS D&G, aiming to increase uptake in women who have defaulted from the programme and access hard-to-reach groups.

Diabetic Retinopathy
Software change will support risk-based changes in frequency of screening and we are working with the ophthalmologists to introduce this non-risk project which will incur some costs.

Pregnancy and Newborn
Highlighted scenario around newborn bloodspot test saying that overall we have a safe system for tests in place. An additional non-invasive prenatal test is being introduced in 2020 and will be offered to women who have had a high risk result on the standard Downs test.

Cervical Cancer - GC asked how women would access the self-sampling swabs and NC responded that we have a list of women who have not engaged with the screening service and a postal service will be offered to them. GC asked if there was postal testing for HIV etc and NC responded that this is in place. GC highlighted the Blood Borne Virus Managed Clinical Network run by Maggie Gurney which is working well. LB asked how we will engage with people in temporary accommodation, homeless, etc and NC replied that Public Health staff will help here.

Pregnancy and Newborn – LD commented that it was good to hear of the Downs Syndrome test offer coming in which is a good step forward.

The Committee:
• Discussed and noted the report

Scottish Abdominal Aortic Aneurysm Screening Programme Update
NC presented the annual report highlighting the change of location for services from Carlisle to Hairmyres Hospital.
NC explained that it had come to light last September that the sonographers who carry out the scanning, although qualified, were not fully accredited to participate in the screening programme. It was recommended that our sonographers undergo training and have a sample of their images quality assessed and this is now complete. We have a monitoring evaluation group and action plan in place with a retrospective external audit of sample images planned. In reply to PH asking about numbers NC noted that we only have one or two cases per year, not picking up as many as we thought as people are not smoking so much.

The Committee:
- Discussed and noted the report

NC presented the annual report highlighting some slippage in the programme nationally due to recruitment difficulties but a recovery plan is in place. He highlighted negative feedback around accessibility and travelling to Irvine.

PH highlighted breast radiographers asking if we have the number we need and NC responded yes, we have four who are integrated into imaging and getting the work done but do struggle at times to cover all appointments.

The Committee:
- Discussed and noted the report

14. **Screening Inequalities Engagement Programme (SIEP)**
AR presented the paper highlighting the SIEP project which aims to improve the uptake of cancer screening services (breast, bowel and cervical) for people who have experience of homelessness and/or who have poor mental health, using methodology to understand the needs of people’s expectations, what is the actual problem, the extent of the problem and how we can alleviate this, in ways that have not already been tested. LB highlighted homelessness and AR responded that the population in D&G is not like a city, we have sofa surfers and temporary accommodation and are not sure what effect this has on health. Other problems are addiction, family break up and violence within the home which are health factors on their own.

PH highlighted alcohol and drug addiction with families drawn into this chaos, asking how SIEP will engage with this particular group, asking about supporting mechanisms for people and how they will access them, noting the existing services we have in place. AR responded that we will try to contact people when they reach out to Social Services and groups such as Women’s Aid, the Dementia Association and the Carers Association. He noted that some groups provide catering, such as Kate’s Kitchen, Kaleidoscope, Bethany Charity Trust and the Salvation Army and these are good places for contact. The approach so far is an “open door” invitation. AR noted that about half the people we engage with have mental health and homeless needs and the other half are having bad experiences. He highlighted the CCL volunteers, and discussions with the SCL, who can refer into more formal pathways and feel this is a good first stage for issues that come up.
JP commented that due to the low numbers of listeners and what they can provide, and the SCL has now left service, she requested that this issue discussed outwith the meeting and this was agreed.

GC commented that it was good to see planning around this work and is curious about how we record and capture potential information to help improve services outwith the research.

PH requested an update report for the September meeting with a full description of the package to be delivered including the quality of delivery of services and what form will this take; what engagement will take place with existing groups and assurance about what support has been thought of and will be provided.

The Committee:
- Requested an update report for the September meeting

15. Equality and Diversity Update
NatM presented the paper highlighting a very positive report from the Local Authority and NHS D&G in relation to compliance under the Equality Act although there is still more to do. NatM noted an update on British Sign Language will come to Committee in September as work is still ongoing about the services available. She highlighted the gender pay gap within the organisation saying that the work is having an impact but we need to do more.

LD highlighted the case studies, asking why there was no mention of the Developing the Young Workforce Group and ensuring case studies are covering all aspects. NatM responded that the Group is included but timescales did not allow inclusion in the report.

The Committee:
- Discussed and noted the report

ITEMS FOR NOTING

CS commented that she had no concerns about this report, they are doing very well. She would have expected a secondary care report. PH requested report for the next meeting.

The Committee:
- Discussed and noted the report
- Requested a secondary care report for the November meeting

17. Exceptional Referrals Annual Report 2018 – 2019
Deferred to November meeting.

GC asked about transgender requests and things not being granted because they are outwith standard protocol CEL 2012 and not core treatment. PH requested that the question from GC be responded to at the November meeting.
GC highlighted the system policies for Autistic Spectrum Disorder (ASD) saying that she was concerned we do not have local or national policies for this. GC explained she has been approached by the parents of young children who are waiting for over two years for outcomes and requested an update around pathways and support. ED will ask KD for paper for November meeting.

The Committee:
- Deferred the paper to the November meeting
- Requested an update paper on pathways and support for ASD

18. **Notes of the Health Adult Support and Protection Committee – 23 January 2019**
PH asked if these notes should go to the IJB and AW advised that this group reports through the Public Protection Committee which reports to IJB.

PH highlighted chronologies and AW explained that this group has just started, with Kim Black as Chair, and is a complex thing to do particularly in primary care. AW has spoken with Charlie Dunnett, and will attend GP Sub Group in August 2019, in relation to how we engage with primary care in supporting chronologies and to request primary care representation for the Chronologies Sub Group. PH asked how the Committee would be informed about this work and AW responded that the Chronologies Sub Group would feed into the HASP Committee which provides assurance to HCGC and also through the annual HASP paper.

PH noted she had asked about the membership of this Group previously and AW responded that we had previously talked about the membership, explaining that not all the members are expected to attend every meeting, but with two members from each area, one is expected to attend.

The notes of the Health Adult Support and Protection Committee held on 23 January 2019 were noted.

19. **Notes of the Healthcare Scientists Advisory Committee – 21 May 2019**
PH highlighted concerns around attendance at this meeting and will raise with Ken Donaldson.

The notes of the Healthcare Scientists Advisory Committee held on 21 May 2019 were noted.

20. **Notes of the Hospital Transfusion Committee – 10 December 2018**
CS commented that the notes were December’s and there had been a meeting in April 2019. AW described the approval process for notes from groups which feed through HCGC.

The notes of the Hospital Transfusion Committee held on 10 December 2018 were noted.

21. **Notes of the Infection Control Committee – 20 March 2019**
The notes of the Infection Control Committee held on 20 March 2019 were noted.
22. **Notes of the Resuscitation Committee – 4 March 2019**

The notes of the Resuscitation Committee held on 4 March 2019 were noted.

*Any Other Competent Business*

Nil.

*Date of Next Meeting*

16 September 2019, at 10 am, Meeting Room 1, Mountainhall Treatment Centre.
DUMFRIES AND GALLOWAY NHS BOARD

HEALTHCARE GOVERNANCE COMMITTEE

13 May 2019
10 a.m., Meeting Room 1, Mountainhall Treatment Centre

Present:
Ms. Penny Halliday  Non Executive Member (Chair)
Mr. Eddie Docherty  Nurse Director
Mr. Jeff Ace  Chief Executive
Ms. Lorna Carr  Chair – Area Clinical Forum
Dr. Ken Donaldson  Medical Director
Ms. Laura Douglas  Non Executive Member
Ms. Michele McCoy  Interim Director of Public Health
Mr. Nick Morris  Chair
Mr. Bill Rogerson  Lay Member
Ms. Elaine Ross  Infection Control Manager
Ms. Christiane Shrimpton  Associate Medical Director, Acute
Ms. Alice Wilson  Deputy Nurse Director

Apologies:
Dr. Grecy Bell  Associate Medical Director, Primary Care
Ms. Lesley Bryce  Non Executive Member
Dr. Martin Connor  Infection Control Doctor
Ms. Grace Cordozo  Non Executive Member
Ms. Joan Pollard  Associate Director of AHPs
Ms. Julie White  Chief Operating Officer

In Attendance:
Ms. Margaret Johnstone  E.A. to Nurse Director
Ms. Dawn Allan  Spiritual Care Lead
Ms. Alison Bunce  Compassionate Inverclyde
Ms. Lynda Forrest  Lead OT & AHP Co-ordinator
Ms. Viv Gratton  Interim Head of Planning and Commissioning
Ms. Jenny Halliday  Consultant Child & Adolescent Psychiatrist and Specialty Lead, CAMHS & HLAC
Ms. Karen Hamilton  Excellence in Care Lead
Ms. Margaret McGroggan  Volunteer Co-Ordinator
Ms. Emma Murphy  Patient Feedback Manager
Ms. Paula Riley  Improvement Advisor
Ms. Gail Robertson  Patient Flow and Discharge Manager

Care Assurance
AW and KH presented on Excellence in Care and Care Assurance.

PH commented that there were lots of questions around the table saying that this is important for HCGC and requested a follow-up at the end of summer/early autumn. PH suggested, and it was agreed, that questions should be sent to AW and KH who will bring them into the presentation later in the year.
Following discussion AW commented that the work is not just about complaints but about adverse events and the pressure ulcer work, highlighting Levels 1, 2 and 3 of care assurance and how that works at the different levels.

AW noted the presentation was in lieu of the Older People paper which comes to the Committee asking if this was still required and it was agreed PH and AW would discuss outwith the Committee.

LD thanked AW and KH for the presentation saying that she had a good understanding around care assurance now and asking if the Committee should receive care assurance reports to see if the system is working, who has received awards and if there are any gaps. PH suggested taking this away to talk about.

The Committee:
- Requested an update presentation late summer, early autumn

Internal Reports and Standing Items
PH asked what the Committee wants to achieve from our meetings, saying that there are three updates today and she would not expect these to take time. She explained that the Committee will take internal reports, which should have been read, and go straight to questions, and similarly with standing items which we agree to discuss and note, or approve.

1. **Apologies for Absence**
   Apologies as noted above.

2. **Declarations of Interest**
   Nil.

3. **Notes of meeting held on 18 March 2019**
   Accepted with undernoted changes.

   ER, page 6 – end of paragraph should read “ER noted the Facility Monitoring Tool (FMT) will include issues such as broken vinyl but that there is no facility for this to link to the Agility estates reporting system. She noted that whilst it is possible for us to pick up the issues using MFT we have not made it easy for staff to report these for rectification through Agility and that this is an organisational risk as identified issues may be known but not acted upon. There is a method by which FMT and Agility may be linked electronically and this has been raised at the HAI Executive Group.”

   LD, page 14, name change from Pickford to “Pickstock”.

4. **Matters Arising**

   **Patient Story**
   PH highlighted the sentence on Page 3, “AC explained that this had been discussed afterwards and family were quite understanding and happy”, saying that she would like feedback around this and to see evidence that the person, or family, have been involved in finding a solution. ED responded that we can arrange for Committee questions to be answered.
Out of Hours
PH highlighted Page 8 requesting an update from the Directorate on the actions list.

Palliative and End of Life and Bereavement Strategy
PH highlighted Page 14 and the situation in the West linked to Out of Hours and requested an update of what is happening in the West. ED responded that Mhairi Hastings has done a paper around some proposals for this and he will discuss this with JA in the first instance.

5. Reminder List and Draft Agenda
LD requested a brief summary be included in the Reminder List and it was agreed this would be added to new items.

MMcC highlighted the Inequalities Project Report and the Breast Feeding Programme Report saying that these are two separate reports for Committee rather than one including the other.

INTERNAL REPORTS

6. Falls, Falls with Harm Update
GR and PR attended to present the paper. NM commented on previous conversations about falls and the move to DGRI highlighting no improvement in our falls rate and an increase in falls with harm. PH highlighted reporting asking if one person has more than one fall, are they recorded as three or four falls, or just one and GR responded that we record every fall so yes it could be the same person and we can check on this. PR commented that we can’t pull this information as a report from datix but that ward staff know their patients and can tell us if this is happening. ED commented that we would rather see all records rather than one which says the patient keeps falling. He highlighted lots of work going on around this with the next step being to set up a Falls Collaborative which will be commissioned at the Nursing and Midwifery Strategic Leadership Council this week. GR noted a multi-agency Falls Prevention Masterclass held in February attended by Health, Care Home and Care at Home staff, highlighting the need to look at this collaboratively through the whole system. GR noted that the trend is the same across the whole region, not just in relation to single rooms, and there are lots of contributing factors around this. NM noted that the data points are not significant on their own, asking what is causing this to occur. PH responded that her understanding is that this is right across the region, including cottage hospitals and community, asking if a patient is sent home from hospital what assurance do staff have that the home is not full of hazards causing another fall and landing in hospital again. She acknowledged the STARS Team and other services are involved. PH asked if there was a rise in falls in other health boards and ED responded that, as Chair of the National Acute Care Portfolio Delivery Group, we are seeing a sustained rise in falls, saying that part of this is about risk taking with individuals and having systems in the home rather than hospital, minimising risk for both staff and patients. ED commented that it is safe to say that we could do better and GR agreed that when patients go home there is room for improvement along the lines of risk assessments of the home environment and early intervention of care services in the community.
MMcC suggested, and it was agreed, linking this programme to work with the Public Health work on physical activity which is being undertaken around strength and balance which is crucial for older people. GR highlighted the Loreburn Housing Project where clients wear “fitbits” which records their physical activity and has resulted in good outcomes and social activity. PH commented she had spoken with the Chair of Loreburn Housing around the project and it seems to be working well. MMcC agreed there are a number of things going across the region which will fit in with this.

PH noted an increase in falls across the region and the best way forward to understand and evidence this will be a Falls Collaboration. PH requested an update on the work of the collaborative and the difference it could make around falls and harm in six months.

PR concluded by highlighting the ongoing falls prevention work with frontline teams to reduce falls with harm acknowledging that teams are working hard. Patients identified as high risk of falls are highlighted at the daily site huddle and data shows that a large percentage of these patients are kept safe from falls due to preventative care interventions.

The Committee:
- Requested an update from Falls Collaborative in six months

7. **Looked After Children (LAC) Update**

JH attended to present the paper. PH congratulated JH on the difference made since the Committee first looked at this service. ED commented that this was a good piece of work across LAC and the challenges we have in D&G saying that a number of other Boards are interested in the work that is going on. LD highlighted children coming into the region and the difficulties in obtaining the relevant information, asking if this is still a challenge and that children are not being left as vulnerable. JH responded that it is challenging but it is better, LAC have now built a better reputation and the Social Work Department are quicker in contacting us and in turn we are asking for information with Social Workers now coming along to the first consultation meetings, sharing information and this gets us off to a good start. LD asked if we are sending children out of the region are we doing this ourselves and JH responded that we have very few children placed out of the region, HLAC are on the group monitoring this, however we do have a couple of young people in secure units and are involved in their health care and we are definitely better at communication. ED commented that Social Work has a strong role in this connectivity, much stronger than a year ago. PH noted that she likes the plan for 2019, particularly the six week attachment course for carers and kinship carers. She asked about the system around adverse childhood events and if this was having an impact and JH responded that HLAC have a Steering Group around LAC and a Corporate Parenting Group established around vulnerable children in schools, and not in schools, and we continue to build on our trauma training. This is not just about Health LAC, but the support services available for these young people are less and this makes a significant difference, Corporate Parenting works to keep these children in mind. LD asked if child is looked after and if things progress positively for them and they return to their own home, what happens then, do we keep an eye on them.
JH responded that she was not sure if we have data to underpin assurance, saying that if a child is back home it is unlikely they would continue on a supervision order but would be in kinship care and liaising with services, normal checks would be done and the Paediatric Looked After Nurse and Paediatric Consultant would be aware of meeting the complex needs of the child. She confirmed no-one would be lost but we do not have a measure for this. PH commented that she feels assured services do talk to each other when the child goes home. ED commented that if the child goes back to family they would not fall into the direct LAC situation, clinical complexities as such would fall into clinical services and communication is very effective around this. PH commented that all services are available whether a child is a looked after child or not. She noted that the service is progressing well and we could move to a yearly report, asking JH if it had helped having the HCGC have a focus on this and JH responded that it is very helpful, makes you ask questions and what is important to prioritise here.

The Committee:
- Discussed and noted the report
- Requested a further report next year

8. **Patient Safety Group : Significant Adverse Events**

AW presented the paper. ED commented, as an observation, on the concerns around future commissioning saying that the HIS overview has come together and we are well within the norm and tying in with national points which is useful for reassurance to the Committee that we are there. NM highlighted the positive culture of safety saying that we could clearly see the gradual rise in the process and the appropriate classification for what becomes action learning which needs to be in place, more robustly, out in the organisation. ED agreed this was not as good as it could be but has significantly improved although we still have a bit of work to do around this. NM highlighted better reporting asking what does this say and if we are learning from other areas. AW responded that we are not outliers when it comes to sharing learning, we share information on incidents but do not utilise the national HIS community of practice to share learning as we are not in a position to do so yet. ED highlighted sharing across Boards saying that NHS 24 could give something in this joint role. He noted that we have a database of learning summaries and AW commented on the HIS site saying that there are a number of reasons we have not used this yet and are taking time to consider using this, having lots of learning summaries is not enough to help us learn. KD commented that we send learning stuff out and this is not always being read according to feedback from some clinicians.

LD asked for assurance that all families in these adverse events have been involved and ED responded that it is done as core business what their questions are and we share our reports with them as per the duty of candour guidelines.

PH commented that we have a clear understanding of where we are with this, making lots of progress, information for learning on database but challenge in sharing this. She noted that ED has suggested the way forward for this is collaborating with NHS 24 and he will explore this.
The Committee:
• Discussed and noted the report

9. **Health Adult Support and Protection Update**
AW presented the paper noting that the number of referrals is still increasing and the continuing pieces of work around this, saying that 86% of referrals are true ASP as we are recognising the issue of coming through case reviews is focussed on a person’s capacity to make decisions however we are not always recognising people who are vulnerable and the vulnerability of adults is something we need to focus on across the multi-agency group.
PH commented that she had asked questions before about the ASP Committee which was not well attended, asking if this is improving now and AW responded that it is a totally different committee which now looks at health’s contribution to the wider agenda. She noted that at the last meeting we have made a step forward around more understanding and clarity of health’s role, this has taken quite a bit of time but we are now in a very different place. PH asked do we have assurance that AP people are sharing information with each other and AW responded that due to GDPR people are a bit anxious about sharing information but getting comfortable about sharing on the basis of a concern about an individual.
LD highlighted training asking how well trained is everyone and AW responded that the numbers look good saying that the training is helping staff across all agencies understand the need to do something around vulnerability in patient’s own homes, in care homes and in hospital although we still have with work to do around this. The Public Protection Committee (PPC) has agreed sub groups which focus on this good piece of work. PH commented that the PPC gives assurance to this Board.

JA commented that a recent Significant Case Review (SCR) would draw the attention of the Procurator Fiscal and PH requested an early update around this for the Committee.

The Committee:
• Discussed and noted the report
• Requested an early update on SCR to PF

10. **HSMR Update**
KD presented the paper. PH highlighted the three points on the front page.
JA commented that it was interesting to see the trends, saying that the Board’s HSMR remains higher that DGRI alone but not enough to raise any significant concern providing a positive cultural message. KD agreed the Committee should be reassured by this.

PH commented that this is interesting saying that D&G have the oldest population in Scotland along with other factors around good self management in long term care with safer hospitals.
LD asked if is there a low point we should be worried about, keeping someone alive and not dying as expected. KD responded that this was an interesting question with no answer. JA commented that something interesting is going on but we cannot tell what.
PH commented that people are living longer and asking if Realistic Medicine (RM) will make any difference to these figures. KD noted that RM has been running for four years now. NM noted something different suggesting that social pursuits such as yoga, or things like this, may help.

The Committee:
- Discussed and noted the report
- Requested further update in six months

11. **HCGC Terms of Reference**

NM noted that the Terms of Reference should be accepted by the Committee and then taken to Board for approval.

One minor change in Section 3, the Quality and Patient Safety Leadership Group is now the Patient Safety Group.

The Committee:
- Accepted the Terms of Reference

12. **HCGC Assurance Statement**

PH, as Chair of the Healthcare Governance Committee, requested that the Committee approve the Assurance Statement.

The Committee:
- Approved the assurance statement

**STANDING ITEMS**

13. **Improving Safety Reducing Harm – Mental Health Directorate**

LF presented the paper requesting approval for the development of an Estimated Date of Discharge (EDD) Policy as a test of change and the development of Day of Care Criteria for mental health in-patient settings. BR thanked LF for a very clear, concise report.

JA asked if the discharge protocols will potentially be nurse led and LF confirmed they would be. NM asked about future development and LF confirmed that once the policy is approved, EDD will happen and the process will be effective.

PH highlighted the test of change on Page 3 in relation to Occupational Therapy saying that we have challenges around recruitment within AHPs and asking how sustainable would this be. LF responded that the performance framework will help to answer these questions, saying that we are now funded for more posts and will focus on outcome measures, do less of and add more to.

PH highlighted the falls/falls with harm prevention work incorporating good dementia care in Cree Ward and LF responded that a robust EDD process with discussions around risks for each patient is a good thing to do, with a discussion around falls within the 72 hour assessment period.
LD asked how are the staff group feeling about this being developed and part of daily work. LF responded that staff are positive around this as it reflects the structure of the directorate, the Team Lead and SCN are at operational level, with improvement being managed and reflected back to them resulting in less people falling and less suicides, it's hard not to get excited about this.

The Committee:
- Approved the plan

14. **Healthcare Associated Infection Report**

ER presented the paper. LD commented that it was good to see we are in a good place asking ER for her thoughts around E.coli national targets. ER responded that there are none so far, but may well be for a 50% reduction, explaining that this will be tough as most cases are in the community.

NM commented on the good work and improvement around C.Diff asking if the work done recently was having an impact and ER responded yes, there had only been two cases in April but now we will just have to wait and see. ED commented that HPV was discussed at HAI EG and ICC before planning to do this. JA commented that we should not let HPV be seen as the magic cure, hand hygiene etc is just as important and we should continue best practice and monitoring of standards with HPV as part of the toolkit. ER noted that we were an outlier for C.Diff based on national reporting by HPS and recognising this, took actions which have benefitted us.

PH highlighted the conclusions and there was a short discussion about animals in hospitals with JA highlighting the Board’s Pets in Hospital Policy.

PH offered congratulations to ER and her Team, saying that HPV is a good example of another solution.

The Committee:
- Discussed and noted the report

15. **Patient Services Feedback Report**

16. **Feedback, Comments, Concerns and Complaints Annual Report**

EM presented the paper requesting that the Committee look at both papers together. PH commented on the challenges around complaints. ED explained that nationally and locally we are making some progress around learning, similar to that for adverse events, but this will always be a challenge, noting that we continue to use learning to result in improvements. EM noted that we have tested the use of HCAT which categorises complaints and we still have a bit of work around how we use this but progress is being made.

LD highlighted timescales noting that Stage 2 is still a challenge and asking what can you do differently to address this. EM responded that the Scottish Public Services Ombudsman (SPSO) had visited and JA, NH, JP and EM had attended the informal discussion, SPSO do not have any concerns around timescales and we fit with other Boards. EM noted that we try to achieve the timescales but this is balanced with accuracy, we take personal approach and meet with families, and feel we are getting the balance right.
There will be a small number we will not meet timescales in but see this as an improvement. LD commented that it was good to hear this reassurance from SPSO. She highlighted Stage 2 complaints and not offering formal extensions to them and ED responded that this will be addressed in the Complaints Improvement Report. EM noted that there has been improvement, we do not ask for an extension if we are only a day late and she will add this into the report. ED noted that the Scottish Government review of the first year shows a number of areas of good practice in D&G fitting with the progress we are making. We are not we would like to be but are where we expect to be.

JA noted that the SPSO were complimentary about EM and her Team and have offered to come down for Board Workshop where NEMs can get this reassurance directly. JA will follow this up.

NM suggested looking at training in other Boards and drawing from that for our own training.

PH noted that we are in a totally different place regarding complaints and we cannot just be focused on targets, saying that this about patient experience and they are all different, we are dealing with people and what their needs are, and this lends itself to what you are describing around extensions.

BR highlighted staff working with individual complainants, saying that staff work Monday to Friday but that complaints is seven days a week, noting the response time of 5 – 20 days, suggesting that moving out to the Directorates and handing responsibility to the General Managers empowering them to deal with complaints and work around shift patterns and ED responded that although the core team work Monday to Friday, the Executive Director on duty will manage teams at the weekend and deal with complaints quickly and effectively. He said the Patient Experience Team is doing co-ordination rather than response. ED noted that if it is dealt with immediately it goes well and we are getting there but down the line people are not available for various reasons. He would like something outwith office hours and is looking at this to get the balance right one teams are in place and we can see where the gaps are.

EM noted that the key to lots of this is early resolution and overall staff are becoming more confident around this, when someone complains do they automatically go through the process or staff can ask if they can help with it, and early resolution is happening.

The Committee:
- Discussed and noted the report

**Complaints Improvement Report**
ED noted that a meeting was held with the Scottish Public Services Ombudsman (SPSO) who highlighted key points around coding which is not quite right yet; re-visiting our self-assessment process and our person centred approach to staff trying to reach early resolution. SPSO have offered to run a Board Workshop and this has been accepted. ED noted that we are performing well against Borders and Highland and SPSO are comfortable with where we are.
The Committee:
  • Noted the update

18. **Spiritual Care, Volunteer, Patient and Carer Information Report**
    MMcG and DA presented the paper. LD noted that the Volunteer Programme is doing really well and saying that it was good to hear about the pilot in Midpark Hospital. She asked how, as a Board, are we celebrating Volunteer Week, and highlighting the workforce for the future, asked if we are doing something around how young people can gain qualifications via volunteering to enter NHS careers.

    MMcG responded that a planning group of volunteers are running a Quiz Night in June and there will be a photo shoot to celebrate the Investing in Volunteers Award at that event. She explained that the volunteer who ran the quiz last year had passed away and the group are keen to run the Quiz Night in Alan’s memory. MMcG highlighted a health walk followed by afternoon tea to be held at Mabie House on 20 June.

    MMcG explained that a few volunteers had gone on to employment in pharmacy, medicine and physiotherapy but young people may well be looking for work placements rather than volunteering. Skills Development Scotland are holding an open day for volunteers looking for employment on 31 May and MMcG and a few volunteers will attend.

    PH commented that the end of year Volunteering Report will be ready in June asking if it will include what happens to volunteers when they leave and what difference volunteers make. AW highlighted expectations of SVQs and MMcG explained that there had been a pilot with two volunteers one of whom is now in employment and the other attending the day on 31 May. MMcG noted that it costs £500 for each SVQ and we do not have the capacity or the funding to take this forward.

    The Committee:
    • Discussed and noted the report

**ITEMS FOR NOTING**

    The notes of the Health Child Protection Committee held on 6 February 2019 were noted.

20. **Infection Control Committee Notes – 8 January 2019**
    The notes of the Infection Control Committee held on 8 January 2019 were noted.

**Compassionate Inverclyde**
Presentation from Alison Bunce who set up Compassionate Inverclyde in 2017 to help people at the end of their lives.
Any Other Competent Business

AW highlighted the HIS Quality of Care Review noting the self-evaluation should be submitted by 22 May, with a visit planned for 24 and 25 June 2019. HIS plan to meet with staff groups and individuals, attending some of our Committee meetings which are yet to be identified. The Scottish Health Council will provide public and patient feedback. HIS will provide high level feedback on 25 June, followed by their report in August and a Board workshop in September, with the report being published in mid October 2019.

Date of Next Meeting

Monday 8 July 2019, 10 am, Meeting Room 1, Mountainhall Treatment Centre.
Patient Story
A video was shared with Health Care Governance Committee regarding difficulties a family experienced whilst their son was in hospital. This family use British Sign Language as their means of communication and experienced difficulties in accessing appropriate support either in a face to face or electronic method both to understand the care being offered and to gain entry to premises.
The video was created in order for the experience to be shared to support learning. The story was narrated in BSL and interpreted and the narrator and BSL interpreter were in attendance.

1. **Apologies for Absence**  
Apologies as noted above.

2. **Declarations of Interest**  
Nil.

3. **Notes of meeting held on 8 July 2019**  
Accepted.

NM highlighted his comments around Stranraer Academy saying that this was around engaging as a Board with the Stranraer community, and students, around accessing mental health care.

4. **Matters Arising**

   **Patient Story**  
RF highlighted the patient story and PH explained that she had discussed this with AW and agreed that a synopsis of the story will be included in the meeting notes.

PH highlighted learning from previous patient stories asking what difference is it making, saying that we need to catch up and suggesting a paper update come to Committee. AW suggested, and it was agreed, that rather than an update paper, as each directorate brings a patient safety paper to the Committee that patient story updates are included in that paper, saying that there are lots of stories out there not just the ones that come to Committee.

   **Power of Attorney (PoA)**  
PH highlighted a scenario of someone paying £500 for PoA and no-one could tell them if they could get help with this, suggesting that this is something we should look at when communicating with members of the public, asking how do we support people in accessing PoA and saying that we have more problems with people not accessing PoA.

5. **Reminder List and Draft Agenda**  
PH asked why the Exceptional Referrals and Palliative Care papers were being deferred with LD commenting that the November agenda looked lengthy. KD and JA explained why papers were deferred. LD asked JA if the Committee could be assured that Equality Impact Assessments have been done and he responded that the Palliative Care Strategy will not come to Committee until we have a positive response to that question. GC highlighted other items on the Reminder List saying that there had been a conversation last month at the IJB Performance and Finance Committee and we need to be clear about what we are looking for to come back to Committee, noting that teams will be working on the Sustainability and Modernisation Programme (SAM), asking if we really need a paper or is there another way we can get these updates, suggesting checking back through the agendas around what we are looking for.
PH agreed that she would discuss with ED anything that does not need to come to Committee. NM agreed with GC saying that we may just need a simple answer to the question rather than a paper. PH commented that we need to get the balance right, we need written evidence for assurance as well and need to be clear as part of the Committee structure around what we are asking for.

STANDING ITEMS

6. **Patient Services Feedback Report**
JP presented the paper noting that the increased figures in April and May had reduced for June and July with 70% of complaints being upheld or upheld in part.

She highlighted details of planned improvement actions including taking forward extension of the team in Acute and Diagnostics and the table top exercise in Galloway Community Hospital. JP noted looking at learning from incidents and complaints, saying patient experience is a standing agenda item for all team meetings including the Senior Nurse Lead Group with a planned mediation skills workshop in place. JP noted complaints continue to exceed timescales with no extension in place. LD commented that the SPSO encourage use of extensions but there are a number of complaints without extensions, asking why does this not happen and what are the underlying reasons for this? She highlighted trialling new things for feedback saying thank you for this piece of work. EM responded that she is aware of this saying that she too would like to understand this and will be looking into it, some may just be a day late, and will include her findings in her next report.

EM highlighted compliments saying that she has just not had time to prioritise this but will start to do this. Care Opinion is becoming well known and Teams are inviting her out to talk about this and positive stories are coming through. Other Boards gather thank you cards and take photos of them. EM noted no specific timescale but will think about this and come back to Committee when we have something in place.

LD highlighted the two learning summaries, both in relation to people passing away in hospital alone, saying that the steps in these actions are similar, asking what are we doing as a Board to ensure no-one dies alone within our facilities. AW highlighted the difference between families being present and someone being with a patient when they pass away. KD highlighted people who are alone and receiving end of life care saying there is no answer to this but it needs to be looked at. LD asked will we do this and AW responded highlighting the learning from organisational complaints and feedback and taking this there. This also brings in care assurance and pro-active feedback we get from people around things going well and things that could be better. PH commented that the Palliative Care Strategy will cover this and AW commented that the deteriorating patient may also address this.
GC commented that the learning summaries highlight communication issues, saying that this week she had referred someone to Care Opinion who could not get a reply/information about their relative from the hospital. She highlighted themes across the Board, saying the second summary was about communication and documentation at a Senior Nursing Action Group, Learning Summary 1 says SCN will do something but where else is this happening and how can this learning be shared more widely?

BR highlighted 20 days and then an extension, asking if there was some kind of alert that could be added to the complaints process before it reaches 20 days. EM responded that the system does let us know that this is going to happen and we need to explore this to see why this is happening and put things in place to prevent this. EM noted that we have improved but not sure what the real issues are, it may be that we missed the post on day 20, or the person to sign the letter is not there. She said we need to promote ways we can gather feedback.

EM noted that the learning summaries came in from services and we need to produce better quality summaries, this has been a challenge for a long time and we are discussing this across adverse events and complaints. We need to help staff to do this and share learning wider.

PH highlighted comments about Patient Opinion saying that people are using it a lot for compliments, asking if there was an opportunity to train volunteers in using Care Opinion and get them out to the community groups around using this. LD suggested this could be a point of reflective practice when there is learning from complaints.

The Committee:
- Discussed and noted the report

7. **Spiritual Care, Volunteering, Patient and Carer Information Report**

   JP presented the paper noting that Ewan Kelly, Spiritual Care Lead, will take up post on 30 September 2019.

   LD commented that it was good to hear about volunteering and particularly that some were linking in with ScotGEM. She also highlighted the feedback from volunteers saying that it was good to hear this and that they are taking learning from this.

   PH commented that she is proud of where we are with volunteers, highlighting the current TV programme about volunteers in the NHS in England, saying that we have been doing all this for a while and that we know and value the difference volunteers are making and the value they add to our services.

The Committee:
- Discussed and noted the paper
8. **Healthcare Associated Infection Report**

ER presented the paper saying that this regular paper tells us we are doing quite well. She highlighted a change to the national reporting requirements for infection data, rates are reported as healthcare or community associated rather than as a total rate for the Board. ER noted we have a low rate of hospital acquired infections and the challenge remains in the community.

ER highlighted continued interest around water and ventilation issues across Scotland explaining that we are under scrutiny due to the problems in Glasgow and Edinburgh hospitals. She explained that a chemical dosing plant is being installed at DGRI and we hope to be in a better position at the end of the year. ER noted there have been no clinical cases. PH asked if we have found the same bacteria in the water in DGRI and MC responded that in Glasgow yes but that in Edinburgh it is ventilation. In DGRI there is a design outlet issue with the taps and currently extra flushing is being carried out and water testing is in place. JA noted that the Head of Estates and Public Health are taking a paper from the Water Quality Group to the Infection Control Committee, outlining the actions being taken to keep things as safe as we can, and this paper can come to the Committee.

PH asked about ventilation and MC responded that he is confident about ventilation in the new DGRI and this is not a concern at all. MC commented that the input of the IPCT in the design of the new hospital had proved beneficial, saying that Glasgow and Edinburgh did not do this and are now referring to the “Dumfries Model” and adding this to future plans. LB asked and MC responded that we are monitoring samples from the labs and looking at each case individually. PH said well done to the IPCT saying that again we are in a position where the central belt is taking a lead from us.

The Committee:
- Considered the report
- Requested that the Water Quality Report come to November Committee


MS presented the paper noting that this is a summary of the activity we have undertaken saying that the Committee receive update papers at every meeting from each Directorate which gives more details of what they are doing. MS explained the paper gives an update on all the programmes, saying that there has been a change nationally around Patient Safety and Improvement and Quality Improvement and how we are adapting to this change.

MS noted 17 September is International Patient Safety Day so information will be issued tomorrow and over the rest of the week.

MS highlighted creating conditions for quality improvement and patient safety and building capacity and capabilities around this at programme level and team level, noting that we have 200 plus people trained in quality improvement and now trying to get to the 500 target we set 2 years ago.
She highlighted discussion on HSMR which relates to work in acute care and although there has been an upturn in the rate for the latest quarter, this is less than for the same period last year, and overall there has been a reduction to within 20%. MS highlighted working with the IPCT which has shown an increase in capability and use of improvement methodology ensuring a safe place to deliver care, this is not without issues to work on around the patient safety agenda.

PH thanked MS for an extensive and detailed report which was interesting and easy to read. She highlighted the themes from the Patient Safety Leadership Walkrounds and how the themes have been addressed.

LB thanked MS for this very helpful report asking about moving forward and the challenge to support improvement, if we spread these improvements across the Board what is the barrier and what can we do to help. MS responded that the challenge is to take what we have learned and share it in other areas saying that we need to build a narrative around how we got to this improvement and the key tools we used to help. NM asked, as well as the will from the Teams, where can you work with this and MS responded that through the SAM Programme we can look at what we have done and how do we take to full scale, we currently have one GP Practice around medication safety and will model how we move from one to five and then up to all. MS noted that we do not always invest resources because we always have something else we want to do. There is a challenge of getting buy in from Teams and managers across learning.

The Committee:
- Discussed and noted the report

**INTERNAL REPORTS**

AW presented the paper noting that we generally have good compliance with the standards and this year there has been a rise in improvements through the care assurance work, small things which have a big impact, such as patient being given hand wipes with their meals and the completion of fluid charts. AW explained that there is a big challenge coming around the “Food in Hospitals Review”, due at the end of 2019. This will include a new self-assessment model which will cause a significant amount of work. She explained that a nutritional analysis will be required for each recipe we use, including gluten free and vegetarian, saying that we have one part-time person and this is only a part of her job although she has done really well despite DGRI and the cottage hospitals having different menus.

PH highlighted the challenge single rooms has given us and AW responded that comments have been made by staff around the additional workload that single rooms bring that we did not know about until we had them.

LB asked if we have volunteers assisting at mealtimes and JP responded that Scottish Government do not allow volunteers to assist with meals although they can be present at mealtimes.
AW commented that this could be captured through care assurance and will include this in the update at the November meeting. LB highlighted the move away from red trays and red napkins and AW responded that this is a source of frustration and that we have moved away because we cannot get red trays to fit the new meal trolleys. JP highlighted a piece of work with the volunteers in the wards, which Margaret McGroggan is leading, and will feed this into the conversations. NM commented that there were no numbers within the paper, highlighting training and saying we do not know how many this will be suggesting that this be backed up by some quantitative information. AW agreed she would look at numbers around training, explaining that the Training Group had changed from a Short Life Working Group to a sub-group of the Nutrition and Hydration Strategic Group, and this information was being gathered. NM commented that there are lots of standards to be met and the numbers have to tell us about this.

The Committee:
- Discussed and noted the report


MS presented the paper noting that the Sponsoring Director should be Ken Donaldson and not Eddie Docherty. MS explained that Duty of Candour (DoC) became legislation we had to put in place in April 2018 and part of that is for the Board to produce an annual report which will be placed on our external facing website. MS highlighted changes to our processes and procedures to ensure they cover DoC saying that there are discrepancies in the figures due to the way the financial year works. We had 25 cases, from April 2018 to March 2019, and in 20 of them the Board was compliant with all requirements of duty of candour and in 5 of them were not. Non compliance was around not recording whether family had been contacted and spoken to and whether an apology had been given. MS noted there is an issue around confidence and capability in having these conversations, saying that people are still fearful and reluctant to have these conversations. MS explained that a short life working group has been set up and we have an action plan of what we need to do, people need support at the time of the conversation. PH asked if we are able to do this and MS explained that the group, comprising Psychology, Occupational Health and Medics, is meeting next week and this will allow us to understand what it is we are dealing with. PH commented that this reflects on an individual’s opportunity to communicate something really difficult and one of our key complaints themes is staff communication.

PH highlighted that the paper recommendation was to “discuss and note” asking if this should be “accept and agree” and NM commented that the Board needs to have sight of this but the Committee has no right to agree the document, suggesting that this is discussed outwith the meeting.

NM asked if all 25 cases have been through review independently from the Team managing the case and MS confirmed this.

The Committee:
- Discussed and noted the report
12. **Interpretation and Translation Update**

Paper taken directly after the Patient Story.

LF presented the paper noting that this work, which was generated by a complaint to NHS Tayside, has been ongoing since long before today’s patient story complaint. LF highlighted the Equality Act 2010 and the British Sign Language (BSL) Scotland Act 2015. She explained that she has been working with Patient Services to explore options for a more robust interpretation and translation provision locally, with the key change being that a central budget has been allocated. LF noted Patient Information leaflets are now available on Beacon along with the processes for booking interpretation and translation. She explained that we also use Languageline Solutions which is a 24/7 telephone interpreting service and for face to face interpreting for non-English we contact Global Language Services to arrange, and for face to face BSL interpretation we use Sign Language Interactions, as for this morning’s patient story. LF explained that a local BSL interpreter is no longer available and others are all based in the central belt. The Board has agreed the implementation of a BSL video Remote Interpreting Service where staff can access BSL interpreters via a video link 24/7. The options around this service are being considered with a roll out date for late 2019. LF noted that Contact Scotland provide a free service, funded by the Scottish Government, to BSL users across the community and this is included in the BSL action plan. LF noted there is a national Interpretation and Translation Policy out for consultation and the Board has been advised that this will be ready for implementation by the end of this financial year.

LF highlighted training and awareness saying that staff need to know how to use this information and to date 27 members of staff have been on training and informal feedback is positive. This training module will be available online by the end of September 2019. LF noted she is working with IT to ensure we have this information available for staff and that this has been added to the Risk Register and she has also attended a session with SAM around this. LF will feedback to the Induction Training for inclusion. PH asked if this covered community nursing staff and LF confirmed that it covers the whole health and social care partnership.

GC commented that the patient story had highlighted wi-fi and accessing iPads, asking if we were sure this would not be an issue, for example, District Nurse in someone’s home will have access; SAS through patient transfer. LF responded that we need to take this into account, at the moment not sure we have the technology to support this. We are starting out in Accident & Emergency and Midpark Hospital and roll out will take this into consideration.

GC highlighted BSL asking if this is something that could be developed in the action plan and LF responded there are a number of actions in the local partnership plan and this will be taken on board.
LB also highlighted the lack of wi-fi in GP services and midwifery, asking if we have recruitment information available in BSL. LF responded that the work we are doing will cover the GP practices but that recruitment is not accessible in BSL and we need to make reasonable adjustments.

LB asked if the patient story video could be shared and JP confirmed we could do this and that support will be available in GP practices. EM confirmed that the video will be shared across GP practices, acknowledging that wi-fi is better in public areas.

PH highlighted the budget for BSL course asking if the Learning Fund could be used for this and LF explained that the Workforce Development Fund has been used, at the start of the year we are asked how many places do you want, but we need buy in from managers to allow staff to attend and need to look at target audience and link into funding that is available. Looking at options around training and awareness to get best fit.

NM commented that wi-fi in MTC/DGRI is fine but community hospitals do not have this and JA commented that this is improving.

NM suggested using our public facing web pages to bring this in, saying that we have had 30 people on a training course but we need 4000 people to be aware. He suggested having people as champions, asking how do we get the message to different groups. LF responded that we have issues we try to address and have an action plan around what we can to first along with a structured plan relating to equality issues and what we can do.

LF explained that every two years there is a Quality Mainstream Report which looks at specific characteristics mainstreaming in everyday business and this is part of the development work within the Equality and Diversity Steering Group. We need to format networking as we need to have a look at this to see if you are doing quality work, lots of learning around this ongoing piece of work.

PH highlighted this morning’s story, impact assessment complaint within hospital, asking why we are missing this and what is the learning behind this.

The Committee:
- Discussed and noted the report

NC presented the report highlighting that the programme is performing very well with a high level of uptake due to lots of people with Type 2 Diabetes in the area and people aged 12 and upwards being invited for an annual screening. The programme software has been upgraded and is now known as Vector rather than Soarian and a national data cleanse has been carried out. NC noted that Vector will move to a new version by April 2020 and that we are planning for this and are not expecting any issues.
LD highlighted that we have the highest uptake in Scotland and are the only Board to have met the KPI, asking about the 11.5% who were not screened and if there were any inequalities at play and NC responded that he did not know that there were but would look into this as the local service could know and this fits in with the SIEP programme for homelessness and mental health issues. GC highlighted the pathway of care in light of patient story this morning around lack of access, saying that it would be useful to engage with the deaf community and NC confirmed he would raise this with the Team.

The Committee:
- Endorsed the report

14. **Influenza Immunisation Report**
NC presented the report highlighting the flu immunisation programme for the winter of 2018–2019, concerns about the Australian experience and arrangements for the coming winter including the Vaccination Transformation Programme. PH highlighted the Australian version this year and evidence that it is a particularly virulent strain facing us this winter and that a letter has been sent by the BMA/College of GPs that we may not have access to the vaccines we need. JA responded that we are trying to get assurance around the Brexit issues but it is difficult to be certain and that if the vaccines are not here we will have problems. NC commented that we have a much higher uptake in Scotland than there is in Australia and they do not promote “At Risk” groups nor do they have a school programme in place. Hopefully we will get the vaccines in time and be able to deliver this service.

The Committee:
- Noted the report

15. **Community Acquired E coli Bacteraemia in Dumfries and Galloway**
AR presented the paper highlighting the incidence of E coli in D&G, noting that numbers are small, 164 in the last year, saying that we live in a rural area and there is a fair amount of E coli in our environment and we have an increasing elderly population. Statistically, there is no difference between D&G and the rest of Scotland. NM highlighted the confidence intervals overlapping and AR responded that there is no way to say these are different. ER commented, as an observation, that this question came from the Board HAI paper which had drawn attention to this as we are still waiting for targets from Scottish Government which is likely to be a 50% reduction in E coli infections and that it will be hard to influence infections in the community. MC asked if this would be an opportunity to ask GPs to decrease prescribing antibiotics and AR responded not in these infections, saying that there was no data to compare with but we are aware of this. NM commented that we have a more vulnerable population, statistics by age would be helpful and AR agreed he would bring this information back to the Committee.
The Committee:

- Noted the report

16. **Screening Inequalities Engagement Programme (SIEP)**
AR presented the paper, following on from the report at the last meeting, saying that nothing had been changed but explained more clearly what they are doing as the Committee had concerns around the wellbeing of participants. AR explained that as a project this has been far more scrutinised and we have undertaken far more engagement with groups across D&G. 206 participants have engaged with the project and so far we have had no issues or concerns around wellbeing. He noted that a process using the Community Chaplaincy Listening Service (CCL) had been agreed, but not utilised, with the previous Spiritual Care Lead (SCL) who has now left and the Committee felt that until we have a new SCL this was not appropriate. AR highlighted the normal routes into primary care through GP practices and the community groups we engage with, saying that the focus is on mental health and working alongside group leaders and volunteers who work within these groups. The SIEP Team consists of two Social Workers trained in participatory appraisal approaches along with an experienced participatory appraisal practitioner and have undertaken further training in “mental health first aid”.

TL noted that the SIEP is working with the Community Action through Participation and Engagement (CAPE) network, which ensures supervision, in engaging with the wider community across D&G and in doing so will include individuals/groups who may have known/unknown mental health or homelessness issues and circumstances they may find themselves in to try and include them in the screening programmes. TL highlighted confidentiality issues and ensuring this is a person’s choice, saying that the 206 people who have engaged have no problems with it.

AR highlighted team development and reflective practice around the scenarios we come across and how to address this.

The Committee:

- Discussed and noted the report

**ITEMS FOR NOTING**

17. **Notes of the Health Child Protection Committee – 17 April 2019**
The notes of the Health Child Protection Committee 17 April 2019 were noted.

18. **Notes of the Hospital Transfusion Committee – 29 April 2019**
The notes of the Hospital Transfusion Committee held on 29 April 2019 were noted.

The notes of the Infection Control Committee held on 15 May 2019 were noted.
Any Other Competent Business
Nil.

Date of Next Meeting
11 November 2019, at 10 am, Meeting Room 1, Mountainhall Treatment Centre.
DUMFRIES AND GALLOWAY NHS BOARD

Performance Committee

Minutes of the Performance Committee meeting held on Monday 2nd September 2019 from 10.00 am to 1.00 pm in Meeting Room 1, Mountainhall Treatment Centre, Bankend Road, Dumfries

Present

Mr N Morris NM  Chair
Mrs K Lewis KL  Director of Finance
Mr J Ace JA  Chief Executive
Ms L Bryce LBr  Non-Executive Board Member
Dr L Douglas LD  Non-Executive Board Member
Mr A Ferguson AF  Non-Executive Board Member
Mrs J White JW  Chief Operating Officer

Apologies

Mrs G Cardozo GC  Non-Executive Board Member
Ms L Carr LC  Non-Executive Board Member
Mr E Docherty ED  Nurse Director
Ms V Freeman VF  Head of Strategic Planning
Ms M Gunn MG  Non-Executive Board Member
Mrs P Halliday PH  Non-Executive Board Member
Mr S Hare SH  Non-Executive Board Member
Ms M McCoy MM  Interim Director of Public Health

In Attendance

Ms A Allan AA  Performance and Intelligence Manager (Item 5 only)
Ms G Brydson GB  Head of Education, Dumfries and Galloway Council (Item 12 only)
Mrs C Cooksey CS  Workforce Director
Dr K Donaldson KD  Medical Director
Mrs R Francis RF  Non-Executive Board Member
Ms L Gibson LG  Health and Wellbeing Specialist DG Health and Wellbeing (Item 12 only)
Ms V Graton VG  Deputy Head of Strategic Planning (on behalf of VF)
Mrs C Morton CM  General Manager Acute and Diagnostics (Item 10 and 13 only)
Mrs J Pollard JP  Associate Director of Allied Health Professions (Item 7 only)
Ms L Bass LBa  Executive Assistant to Director of Finance (Minute Secretary)
Opening Comments

Presentation of papers

NM noted that a number of papers were being discussed today and spoke of the range, style and content of some of the papers presented. NM reflected that some papers required further work and structure to ensure Committee are fully informed on the content and recommendations.

Following discussion, it was agreed that Item 8 (Child and Adolescent Mental Health (CAMHS) Improvement Plan) should be removed from today’s agenda. JW provided further background on the information presented and recalled that the paper should be submitted to the Health and Social Care Senior Management Team (HSCSMT) in the first instance. JW recalled that the CAMHS team have been asked to provide information via a number of avenues and perhaps needed clearer direction on the type of information that is being requested. Committee agreed that a report on how CAMHS was performing against national targets was more appropriate; JW will feedback to the service and a revised report submitted to Performance Committee in due course.

LD referred to the Compliance with Corporate Objectives section within the monitoring form of the Committee template, and noted recent work around our aims and setting strategic objectives. NM acknowledged that further work could be undertaken to align these with a view to updating the Board templates in due course.

New Non-Executive Board Member

Ros Francis was welcomed to her first Performance Committee meeting following her appointment as a new Non-Executive Board Member on 1 August 2019.

1. Apologies for Absence

Apologies as noted above.

2. Declarations of Interest

The Chair asked members if they had any declarations of interest in relation to the items listed on the agenda for this meeting. It was noted that no declarations of interest were put forward at this time.

3. Minutes of meeting held on 13th May 2019

One amendment to the previous minutes was noted as follows:

- Page 4, paragraph 2 – PD should read PH. Action Notes also to be updated with this.

With the amended noted above, the minutes of the Performance Committee meeting held on 13th May 2019 were approved.
4. **Matters Arising and Review of Actions List**

KL took members through the Actions List and the following updates were provided:

- LBr referred to the Corporate Governance Blueprint action whereby PH had suggested that it would be beneficial for the Board to participate in a values based reflection exercise. LBr queried if we had any practitioners in place to support this; KD confirmed that we had.
- Mapping exercise: assurance in relation to CRES, clinical impact and patient safety – KL advised that these areas will be discussed at the SAM workshop on 9th September 2019. NM queried if the workshop would provide Non-Executives with a framework that they can fully engage with; KL confirmed this would be included.
- KL confirmed that work around Discovery trends would be incorporated into the SAM programme. JA spoke of national work relating to trends and outputs. It was agreed that this item should remain on the actions list to enable feedback from this.
- In terms of the request for a Board Workshop on TEC, NM advised that a programme of Board Workshops for next year will be devised shortly. This will be presented to Board Members to consider in line with our strategic priorities. In terms of Technology Enabled Care (TEC), LD added it would be useful to see how we are monitoring quality in addition to quantity.
- Various actions in relation to the dental recruitment and retention challenges were noted. JA referred to the meeting with Scottish Government on 8th August 2019 and advised that it had been useful to keep Scottish Government briefed on issues.

Performance Committee noted the Actions List.

5. **Summary Performance Report**

AA presented the Summary Performance Report which provided an overview of operational performance for key measures relating to NHS Dumfries and Galloway’s priorities.

AA highlighted the key points from the report:

- AA circulated a revised page 3 which included updated psychological therapies data. This was down on last month and was currently 52%. AA provided further information around why this figure was so low eg. long breaches in group therapies, IT issues around TOPAS.
- **Post meeting note:** The Chair has requested that a psychological therapies exceptions report be presented at Performance Committee in November 2019 (noting that the psychological therapies waiting times data was recorded at 52% and was a significant dip).

*Action: Julie White/Louise Cumbley*
• Delayed discharges – The number of delayed bed days has increased. Delayed discharges are a focus for the SAM programme.

• Treatment Time Guarantees – The figure for July 2019 was 79.3%. Scottish Government has issued Health Boards with interim targets as noted in the paper.

• Cancer Waiting Times (31 and 62 day) – AA advised that following the assessment of how much the monthly figures changed between provisional and final versions, it was found that monthly figures were too incomplete and may be misleading. AA suggested that these be reported quarterly in a more accurate format.

Committee discussed the report with a number points noted:

• In terms of delayed discharges, LB r queried how many planned elective procedures are being cancelled as a result of this. JW advised that approx 1-2% of elective procedures are cancelled due to capacity therefore the impact is relatively small. Approx 8-9% are due to other reasons eg. patient not being fit enough, patient cancelling. JW explained the process for rescheduling an elective procedure and informing patients.

• In terms of ongoing risks, JW reiterated that delayed discharges continued to be our biggest challenge at the current time and this will be a key focus for the SAM programme. JW spoke of the complexities involved and the significant amount of work that is being undertaken to address this.

• In terms of the CAMHS reporting, AF queried if we monitor the timescales between initial concerns being raised eg. by a school and the first point of contact with a professional (eg. point of need to point of assessment). JW explained that monitoring is from the first point of contact with the NHS to treatment, adding that this was currently 100% in terms of the 18 week referral. There was a brief discussion around this and the challenges of quantifying contact outwith this route.

• In terms of delayed discharges, RF and LD queried if there are desired trajectories around these; AA confirmed that these are in place locally.

• LD queried if the SAM workshop would be looking at the issues around delayed discharges. JW advised not specifically (the session would be more of an overview of the programme), however, detailed papers on delayed discharges are regularly submitted to the IJB. JW explained that delayed discharges is a Health and Social Care Partnership (HSCP) issue and explained the governance structure of the IJB in relation to this and its responsibility for monitoring delivery. LD felt that the NHS Board needed to have some assurances around the discussions being held on delayed discharges. This led to a lengthy discussion with a number of views expressed. In concluding, Committee agreed that it would be useful for JW to submit copies of IJB delayed discharges paper to the NHS Performance Committee also to help inform Board Members of any ongoing issues/actions and to support assurances in relation to issues within the NHS Board’s control.

• There was a brief discussion around delayed discharges and the corporate risk register; JA noted it would be useful to review the register to ensure the risks and actions are appropriately recorded in relation to this.

Action: JA/JW
• LD noted that the Treatment Time Guarantee figure had risen slightly and queried how we ensure that this doesn’t dip again. JW spoke of various challenges around capacity. JA advised of ongoing discussions with the Scottish Government around targets and our Annual Operational Plan and our ongoing capacity challenges.

KD temporarily left at this point in the meeting.

• LD noted that our Accident and Emergency waiting times were down in July and queried why July had been so busy. LD also asked if we are aware of any impact on people not seen within the 4 hour window in A&E. JW advised that the primary reason for delays was related to bed flow. JW advised that we are averaging a 20 minute turnaround from arrival to assessment. JW reassured Committee that patient safety was not compromised in relation to waiting times.

• In terms of busyness, JW noted that there has been an increase in young people (20-30s) attending A&E; NM commented that this was a national trend. There was a brief discussion around this and some thoughts on different solutions for tackling urgent care. eg. primary care setting, clinics. It was noted that this will feed into the SAM programme.

• NM referred to AA’s suggestion re cancer waiting times data. NM acknowledged that the figures may change between provisional and final versions, however, felt that data should continue to be reported on a monthly basis. An explanatory paragraph can be included to provide further narrative and an update on validated figures provided at a later date as required. There was a brief discussion around this; Committee agreed with this approach. AA agreed to look into this further.

  Action: AA

• NM noted that a number of other developments were underway in relation to the Summary Performance Report. NM asked that the next paper to Performance Committee (Nov 2019) provide further detail on the timescales for taking these actions forward.

  Action: AA

Performance Committee noted the report.

6. Financial Performance – Position to Month 4 as at 31st July 2019

KL presented the paper which provided an update on the financial position at the end of July 2019. KL highlighted the key points from the paper:

• The overall position for the Board at month 4 is reporting an overspend of £2.46m (£2.016m at month 3). This is an improved position following the Quarter One review of the overall projected position.

• The Quarter One review of the financial position has now been concluded with the Board’s projected deficit reduced to £4.8m, a £4.3m overall improvement in the position for 2019/20 (as compared to original Financial Plan position of £9.1m).
• The update to the savings plan indicates an improved position with a reduction in the in-year savings gap to £6m. This reduction in the savings requirement is due to identification of additional recurring schemes of £1.1m as well as non-recurring savings from prescribing rebates of £720k and rates refund of £612k.

• KL referred to Table 5 in the report and highlighted key financial risks related to clinical waste, superannuation increased costs, outcome framework reduction and windows 10/Microsoft licensing. KL also highlighted pressures in relation to locums (Acute and GP) and delivery of our elective trajectory. JA added that there are also risks around Brexit, although figures are unknown at the current time.

• The SAM Programme work has now commenced and a series of roadshows took place in August 2019 across the region. A workshop has been organised for 9th September 2019 for NHS Board Members, where a more detailed update will be provided on progress with the programme to date.

• KL spoke of some positive movements to support the Quarter One position eg. Glasgow and Lothian SLAs; release of corporate contingency reserves.

• KL provided an update on new risks that have recently arisen, specifically a reduction in the allocation for salaried dental services and activity on TAVIs going to Golden Jubilee.

• KL was keen to highlight that recruitment was the Board’s number one priority and there are no vacancy freezes. This has been emphasised throughout the SAM tour and will continue to be reinforced. We are keen to address some misconceptions around this. A full review of our recruitment process is underway to see how we can improve systems. However, we are still required to have a level of robust scrutiny to assess post requirements going forward.

Committee reviewed the report with the following points noted:

• NM was keen to ensure Board Members have a clear understanding of any financial information presented to them and the ‘story’ behind the savings; it is important that Non-Executives are able to convey this if required and highlighted accountabilities. RF commented that she may be able to provide some input on the presentation of the finance paper from a new Non-Executive perspective; KL and RF are meeting today and will discuss further.

• This led to a general discussion on reserves, with KL providing a brief overview of the process. It was agreed that KL will provide a detailed paper on reserves at the next Performance Committee meeting in November 2019.

Action: KL

KD rejoined the meeting at this point. JP joined the meeting.
• LBr referred to recent communications and perceptions around management of vacancies. There was a brief discussion on this with CC explaining further the processes for recruitment and vacancy control, adding that we are looking at ways of speeding up our processes. LBr will discuss further with CC outwith the meeting.

• AF queried if target setting is being considered for services. KL advised this will be discussed further at the SAM workshop but targets will be set for all of the workstreams.

Performance Committee noted the report.

_It was agreed to move to Item 12 at this point in the meeting. LG and GB joined the meeting._

12. **Child Poverty Action Report**

LG presented the paper and introduced Gillian Brydson (GB), Head of Education at Dumfries and Galloway Council. LG advised that, as part of the Child Poverty (Scotland) Act 2017, NHS Dumfries and Galloway have a statutory duty to work in partnership with the local authority and other Community Planning Partners to develop actions which address child poverty within Dumfries and Galloway. The paper provided information on the requirements of the Act and presented the Child Poverty Action Report for Dumfries and Galloway.

LG highlighted the key points from the paper including:

- Background - consequences of children living in poverty; causes of poverty; four key measurements set by Scottish Government and national figures relating to these; child poverty statistic in Dumfries and Galloway.
- Assessment - child poverty delivery plans, local child poverty action reports and national support. Local partners have been requested to aim for submission of their reports by 30th June each year. Locally this deadline was met, with the Child Poverty Action Report for Dumfries and Galloway being submitted to the Scottish Government on 30th June 2019. LG explained further the establishment of a project group to develop the report, and engagement/activity that was undertaken with various partners.
- Local Authorities and Health Boards are expected to use local Child Poverty Action Reports to drive forward progress against Scottish income-based child poverty reduction targets.
- Actions to reduce child poverty specific to the NHS were highlighted eg. interventions to maximise income for families and children, ensuring we are child poverty sensitive, signposting to specialist services, raising awareness.
- GB added that all partners have a key role around signposting and influencing where they can.

Committee discussed the report with the following noted:
• LD queried if there was any specific areas that could be improved on. GB advised that the local authority and NHS have a good relationship. Developments could be made around data sharing to enable us know the scales of the challenges across partners. LG added that we had good national networks also.

• NM commented that a new Public Health related governance committee would be established shortly and felt this would be a good avenue for this type of report in the future.

• AF queried NHS budgets to support the Action Plan; KL advised she was not aware of any budgetary requirements. NM advised that the local authority were leading the plan and NHS support was more around signposting, awareness raising and working with partners. GB added that many of the actions outline the Council’s core business as it stands with some additionally; it is an aggregation of what we currently do. GB also confirmed that the plan also links with the overall poverty strategy review.

• VG advised that the Board would be able to assist with any wider work around health inequalities.

• NM queried if there was any further education in relation to cash versus credit. GB confirmed that financial education is included in the school curriculum. CC added that an initiative will shortly be launched for NHS employees around financial health and well being.

Performance Committee noted the report.

LG and GB left the meeting.

It was agreed to move to Item 7 at this point in the meeting.

7. Allied Health Professions (AHP) Musculoskeletal (MSK) Waiting Times Update

JP presented the paper which reported the current concordance with the AHP MSK target as at 30th June 2019 and provided an update on the action plan to address the situation. JP highlighted the following key points from the paper:

• There has been a slight decline in performance for the reporting period April to June 2019 (33% compared to 34% in March) and there continues to be ongoing capacity challenges across all services.

• There has been a slight improvement within Physiotherapy and Orthotics towards the end of the reporting period of June 2019, with a decline in Podiatry and Occupational Therapy.

• No individual profession was achieving the target as at 30th June 2019. Referrals have remained relatively static across all the professions for this reporting period.
Physiotherapy – Two MSK posts have been recruited to: 1 in Dumfries and 1 in Annandale and Eskdale. A locum is in place at the Galloway Community Hospital from July. Cover for 3 days a week is being provided from bank staff into Newton Stewart. Development Bands 5/6 have recently been recruited to. There has been a significant reduction in those waiting longest for an appointment.

Challenges around sickness, maternity leave and retirement were highlighted.

An MSK Improvement Group has been convened and an initial meeting has taken place. A series of individual single professional meetings have taken place during July 2019. This has identified a range of short, medium and long term measures to improve and maintain concordance.

Weekly meetings are now taking place to review the current situation and action plan.

JP provided updates on other actions/areas eg. targeted telephone calls via NHS 24; increase in OT workload due to rise in acute injuries; writing to people who have had a long wait to check if still require appointment.

Committee discussed the report with the following noted:

- LD noted that one Board were achieving 92%; JP confirmed that this was a relatively small NHS Board.
- AF queried the AHP MSK pathway for patients having treatment externally eg. hip/knee treatment at Golden Jubilee and returning to Dumfries and Galloway. JP provided some background on this, advising the majority of this type of surgery does not require post operative AHP MSK.

Performance Committee noted the report.

Post meeting note: The Chair has confirmed that an update report should be submitted to Performance Committee in November 2019.

JP left the meeting at this point. It was agreed to move onto Item 9.

CM joined the meeting at this point.

9. Acute Services Re-development Programme Post-Project Evaluation

JW presented the paper which provided a Post Project Evaluation Report on the Acute Services Re-development Programme. JW highlighted the importance of this piece of work, which provided an opportunity to reflect on the significant programme of work which was undertaken to build the new hospital.

JW explained that the Post-Project Evaluation (PPE) is an essential part of the assurance process for capital developments, and encompasses three elements:
• **Post-Project Review** - This examines the performance of the project/project team (including project delivery against time, budget and scope/quality expectations) and addresses lessons learned from particular aspects of the project that can be shared with the wider project management system.

• **Post-Implementation Review** - This examines what the project achieved (product/outcome).

The above reviews are carried out 12-18 months following the opening of the new hospital.

• **A Post-Occupancy Evaluation** – This is due to be carried out in December 2019, two years after occupancy however, practical arrangements for taking this forward are to be discussed with the Division of Health Finance and Infrastructure, Scottish Government Health and Social Care Directorate; a summary of initial issues were included in the report. This will also include the measurement of the anticipated and any additional business benefits achieved and also whether they had been planned or became apparent during or after implementation, and to recommend the actions required for achievement of their maximisation.

JW took members through the paper, highlighting specifically the lessons learned for each area. Full details were included in the report; for the purposes of the minutes, the key areas discussed are noted below:

**Post-Project Review - lessons learned**

• Overall - Ability of the Project Board being able to respond quickly and systematically to unexpected challenges; importance of identifying potential key project “infrastructure” blockers early on in the programme
• Investment Decision - Size of NHS Dumfries and Galloway in terms of due scrutiny. Role of Project Board and Performance Committee.
• Procurement
• Finance
• Project Management and Implementation - Noted the importance of providing dedicated senior consultant and nurse support from the Board’s Infection Control Team to the project.
• Organisational impact and change management – Wide range of workstreams noted.
• External support and relationships
• Design and technical information

RF queried how these lessons would be feedback nationally. JW advised that once agreed, the plan would be submitted to the Scottish Government and would be available to other Boards.

JA and JW concluded by advising that our New Hospital Project has been the biggest undertaking in the history of Dumfries and Galloway Health Board.
The new build was delivered on schedule with handover taking place on 11th September 2017 and our first patients accepted, 12 weeks later, on 8th December 2017. It was noted that key to its success was the building of relationships between our partners in the project and our Project Team, together with all the clinical and support staff who worked with them, which enabled prompt resolution of any problems as they arose. The timescales for completion were incredible, noting that any slippages could have had a significant impact on costs. KL added that all financial requirements had been concluded within 12 months.

NM noted the excellent achievements of all those involved and felt that an external publication may be beneficial to promote the good work of the programme and share learning. NM added that it appeared our management of relationships with partners had played a key role in the project’s success.

A discussion took place on a number of areas including risks, clinical engagement, learning and knowledge sharing, maintaining organisational memory, added value to the economy, community benefits.

It was noted that learning from the programme will be fed into the work on the SAM programme and the Primary Care Transformation Board. NM noted that the SAM programme will be subject to similar levels of scrutiny and internal control systems, therefore it will be important to apply any lessons learned from the ASRP.

Post-Implementation review - Lessons learned

JW took Committee through each area of this section of the report and spoke in detail about the following areas:

- Outpatients
- Critical Care Unit (CCU)
- Assessment Unit
- Theatres
- Wards
- Technology
- Volunteers
- Car Parking
- Workforce

There was some brief discussion around the following areas: reduction in infection control issues since opening new hospital, positive feedback on single rooms, areas being considered to support isolation, size of assessment unit and challenges faced in first few months, work being undertaken around falls, work of volunteers.

NM noted that there are a number of areas that we are continuing to work on (eg. falls) and queried if these are being collated to ensure these are not lost in the system. JW confirmed that John Knox is maintaining a list of projects for this purpose.
In concluding, it was confirmed that this paper required approval from the Board. As per the Performance Committee Terms of reference, the Performance Committee has “deferred authority from the Board to approve time critical issues that fall outwith the bi-monthly Board meeting cycle. For these items, the Performance Committee will note within the minute that they are making the decision as a quasi-board”. Therefore, the following decision was made as a quasi-board.

The Performance Committee:

- Approved the Acute Services Re-development Programme - Post-Project Evaluation report.

CC left at this point in the meeting.

10. Doctor Led Return Appointments

CM recalled it been noted at the last Performance Committee meeting that there has been an increase in the number of Doctor led returns over the last few months. CM presented the paper which outlined the challenges faced within specific specialties around doctor led return appointment and the improvement work being undertaken within out-patients. The paper set out the number of patients waiting less than 12 weeks and the number of patients waiting over 12 weeks, along with key areas where improvement work is being undertaken. CM acknowledged that further focus was required at the ‘front end’ to support this and spoke of various measures to address this. CM highlighted the following key areas:

- The data in the paper is also presented to the Acute Management Board as part of the wider performance paper.
- Within the Acute and Diagnostics directorate and Women and Children’s directorate, a Modernising Outpatient Group is in place which focuses on improving the pathway and journey of those requiring an appointment. This work is lead by the Associate Medical Director for Women and Children’s. A modernising outpatient event was held locally in May 2019.
- The modernising outpatient programme is focussing on several key areas and improvement work is being implemented across multiple specialties eg. patient initiated follow-up, Active Clinical Referral Triage (ACRT), Attend Anywhere, using new technologies.
- CM highlighted challenges and improvement work within Diabetes, Ophthalmology, Cardiology and Neurology.
- There was brief discussion around expectations (patient, control expectations with locums, GP).
- Challenges around vacancies were highlighted.
- Work is also being undertaken in other specialties to spread the learning and implement new ways of working to address how patients both interact and are interacted with throughout their journey.
LD queried if we are setting any targets/prioritising in relation to doctor led returns. CM confirmed that some work is being done at a local level on this and we do have some trajectories in place.

NM queried if this programme of work would be considered as part of the SAM programme; it was confirmed it would.

Performance Committee:

- Noted the ongoing work within Return Out-patients
- Agreed that a follow up report in 6 months time evaluating the above Improvement Projects.

**Action: CM**

*It was agreed to move to Item 13 at this point in the meeting.*

13. **Vascular Services Update**

VG presented the paper which advised that, due to ongoing workforce challenges and the need to meet Vascular Society clinical guidance, the future sustainability of vascular services in Dumfries and Galloway is dependent upon joining a regional vascular network. VG highlighted the key points from the paper:

- There are two regional vascular networks being developed in the West of Scotland. The first will have a ‘vascular centre’ at Hairmyres Hospital supporting ‘vascular units’ in Lanarkshire, Ayrshire and Dumfries and Galloway. The other centre will be at Queen Elizabeth University Hospital in Glasgow, supporting Forth Valley.

- It was noted that following the recent resignation of one of the Dumfries and Galloway consultant vascular surgeons, we now have one vascular consultant surgeon. This has impacted on the progression of the original Phase 2 arrangements which would put at risk the delivery of both emergency and elective vascular surgery locally.

- Dumfries and Galloway joined the Hairmyres Vascular network as at 2 September 2019. VG confirmed that all emergencies should now be referred to Hairmyres Vascular on-call.

- The risks relating to carrying out complex elective procedures locally at DGRI was explained. The consensus clinical opinion across the Hairmyres Vascular Network is that, under the current circumstances, it will be unsafe to undertake any complex elective procedures at DGRI. If these are to be undertaken, then it must be at a different acute site.
At the current time there is no concrete solution to accommodating the complex elective procedures that people from Dumfries and Galloway require, however, the West of Scotland Chief Executives reaffirmed the commitment of all the Boards to support Dumfries and Galloway to undertake both urgent surgeries and ongoing management of elective and emergency care for people until the Hairmyres Vascular Network is fully operational by summer 2020.

- It was noted that NHS Dumfries and Galloway have secured a locum vascular consultant to start in Sept 2019 (although it was noted that they will not undertake endovascular procedures so clinical concerns remain in terms of carrying out procedures at DGRI).

VG explained that the remaining Dumfries and Galloway vascular consultant will be fully involved in regional meetings and weekly disciplinary meetings at Hairmyres, and will be included in the on-call service.

AF commented on potential travel issues for relatives visiting patients in Hairmyres. VG confirmed that, as most interventions relate to emergencies, the aim is that all patients would be repatriated back to Dumfries and Galloway within 24 to 48 hours. VG provided some background information on engagement with the vascular service and patients as part of the service redesign.

LD noted capacity challenges and the need to ensure patient safety. LD queried the situation should further vascular vacancies arise in NHS Dumfries and Galloway; CM confirmed that support would continue to be provided by Lanarkshire and Glasgow. JA added that we will continue to try to recruit to the Vascular Consultant post but recalled that recruitment to this area was also a national issue.

NM thanked VG and CM for their input and extended thanks to the Vascular team for their work in taking this solution forward.

Performance Committee noted the report.

**CM left the meeting at this point.**

11. **Primary Care Transformation Programme Update**

JW presented the paper, advising that over the last twelve months, there has been a significant amount of progress in relation to the Primary Care Transformation Programme across the six priority areas.

- Pharmacotherapy
- Additional Professional Roles – Mental Health
- Physiotherapy
- Urgent Care
- Vaccination Transformation Programme
- Community Treatment and Care
The Primary Care Improvement Plan will be updated in October 2019 and a further update on the Primary Care Improvement Programme will come to the Performance Committee in due course.

NM recognised the considerable transformational work now taking place and queried if we had any baseline measures to evaluate progress. JW advised that there are no measures as such and spoke of a number of challenges around measuring outcomes. It was also noted that we don’t have the same access to GP data as we have to secondary care data.

VG left at this point in the meeting.

14. Brexit

JA provided a brief update on Brexit arrangements following the extension of Article 50 period to 31 October 2019 and the potential of a No-Deal. The fortnightly national Brexit infrastructure meetings have been reinstated, as have our weekly internal NHS Dumfries and Galloway Brexit meetings. JA provided a number of updates around potential impact eg. freight, fuel, waste disposal, vaccines, unrest, supplies. It was noted that should a No-Deal be agreed, then this will be dealt with as a Major Incident. A paper will be submitted to the October NHS Board providing further detail around risks and mitigation.

AF asked if a similar report could be submitted to the IJB; JA confirmed he would take this forward.

Performance Committee noted the verbal report.

15. Self-evaluation for the Review of Progress with the Integration of Health and Social Care

JW presented a copy of the Self-evaluation for the Review of Progress with the Integration of Health and Social Care paper which was presented to the IJB on 29th May 2019. It was noted that the IJB approved submission of this final report to Scottish Government.

This was presented to NHS Board for information only. It was noted that a covering paper explaining the purpose of the paper would have been useful to include.

Performance Committee noted the report.

16. Draft Performance Committee Matrix

KL presented the draft Performance and Board Matrix which aims to outline the key areas of business for the Board and Performance Committee at each of its meetings. Committee members were asked to feedback any comments on the matrix to LBa/KL.
Performance Committee noted the report.

17. **Date and Time of Next Meeting**

The next meeting of the Performance Committee will be held on 4th November 2019 at 10.00 am to 1.00 pm in Meeting Room 3, Mountainhall Treatment Centre, Dumfries.