

DUMFRIES AND GALLOWAY NHS BOARD



Agenda and notice for meeting on Monday 6 July 2009
at 1.30pm

VENUE: Duncan Rooms, Easterbrook Hall, The Crichton

John Burns
Chief Executive

AGENDA

1 Apologies for absence

2 Declarations of Interest

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

3 Minute of the Meeting held on 1 June 2009

The Board is asked to approve the minute of the meeting held on 1 June, 2009.

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4 Minute of the Meeting of the Special Board held on 25 June 2009

The Board is asked to approve the minute of the special meeting held on 25 June 2009.

Page 17

5 Matters Arising

- *Influenza*
- *Annual Review*

INVOLVING PEOPLE, IMPROVING QUALITY

6 Patient Safety

The spread of the patient safety programme continues through NHS Dumfries and Galloway and significant progress is being made within Community Hospitals. Following on from the third learning session this paper provides a summary of progress to date.

Page 19

7 Patient Experience: Reporting Period May 2009

This monthly report covers lines of enquiry, survey update, feedback to patient experience volunteers and involving people improving quality.

Page 23

8 Prevention and Control of Infection

This paper provides the monthly update on infection prevention and control across NHS Dumfries and Galloway.

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ITEMS OF GOVERNANCE

9 Minute of Scrutiny Committee held on 28 April 2009

The minute of the Scrutiny Committee held on 28 April 2009 is presented to Board.

Page

10 Register of Members' Interests

Board Members of devolved public bodies are required to give notice of their interests and the Board is required to maintain a Register. This is the most recent update of that Register as at 1 June 2009.

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11 Consultant Recruitment Process

This paper describes the key changes that will come into force on 1 July 2009 in respect of consultant recruitment across the NHS in Scotland and the implications for NHS Dumfries and Galloway in advance of the issue of a CEL from Scottish Government Health Directorate.

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ITEMS OF STRATEGY

12 Clinical Services Strategy

A verbal update will be provided.

ITEMS OF PERFORMANCE / DELIVERY

13 Financial Performance: Two Months to 31 May 2009

The purpose of this report is to advise the Board of the financial position for the first two months of the financial year 2009/10.

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14 Patients' Private Funds for the Year Ended 31 March 2009

The Board is required to maintain records of patients' funds to ensure that these funds are properly managed and assets are safeguarded in accordance with procedures. These records have been audited.

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15 Access and Activity Report

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ITEMS FOR APPROVAL

16 Redevelopment of Aseptic Suite – Pharmacy, Dumfries and Galloway Royal Infirmary

This papers seeks Board approval to tender for the redevelopment of the Aseptic Suite within the existing pharmacy footprint. The Aseptic Suite allows the aseptic preparation of pharmaceuticals for a range of patients, the major workload being the preparation of cytotoxic chemotherapy for the treatment of cancer.

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17 Enhancing Staff Security and Safety on the Crichton Campus

This paper describes the process and outcomes of a review of the safety and security of staff working on the Crichton Campus and advises the Board of a one year pilot that will be undertaken in partnership with Dumfries and Galloway Constabulary commencing August 2009 in support of this.

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18 Resilience Workplan Report

Page 99

19 Patients Failing to Attend Scheduled Dental Appointments at IDH Sites – Introduction of Penalty Charge

The introduction of patient non-attendance at IDH dental sites across the region inhibits the proper utilisation of contracted surgery capacity and contributes to unplanned fluctuation in patient through-put. Board is asked to agree the introduction of a routine penalty charge at all four IDH sites across Dumfries and Galloway.

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20 Professional Regulation

A variety of highly publicised events at the end of the last century led to a loss of confidence in the regulatory framework for doctors and the independence of the General Medical Council. This paper updates the Board on the programme of revalidation for all doctors registered in the United Kingdom.

Page 106

21 Speakeasy in Dumfries and Galloway

This report explores progress towards achieving the main aims of the Speakeasy pilot project in Dumfries and Galloway providing insights into how the course has benefited parents in terms of changes in knowledge, attitudes and behaviours.

Page 112

22 Schedule of Meeting Dates 2010 / 2011

The Board is asked to agree the schedule of meeting dates for the period April 2010 to March 2011.

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23 Board Briefing

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

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24 Any Other Competent Business

Members should notify the Board Administrator of any items of business not on the agenda that they wish to raise prior to the commencement of Board Business at 1.30 pm.

25 Date of Next Meeting

The next meeting of the NHS Board is Monday 7 September 2009.

ITEMS FOR NOTING

26 Note of the NHS Board Workshops held on 1 June 2009

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27 Note of the meeting of the Dumfries and Galloway Older People's Consultative Group held on 4 March 2009

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DUMFRIES AND GALLOWAY NHS BOARD

Minute of the meeting Dumfries and Galloway NHS Board held on 1 June 2009.



Minute Nos 66 - 89

Present

Mr M Keggans	Chairman
Mr J Burns	Chief Executive
Mr J Ace	Director of Health Services
Mrs H Borland	Nurse Director
Mrs H Brash	Non Executive Member
Dr A Cameron	Medical Director
Mr A Campbell	Non Executive Member
Dr D Cox	Director of Public Health
Mrs H Dykes	Chair of Area Clinical Forum
Mr E Hunter	Non Executive Member
Mr I Hyslop	Non Executive Member
Mr A Johnston	Non Executive Member
Mr D Lockhart	Employee Director
Mr C Marriott	Director of Finance
Dr R Park	Non Executive Member
Ms C Sharp	Director of HR and Workforce Strategy
Mr K Warford	Vice Chairman

Attending

Mr J Glover	Head of Communications
Mr G Graham	Deputy Chief Constable
Mrs A Henderson	Communications Officer
Ms K Herriott	Development Officer – Domestic Abuse
Mrs J Proctor	Head of Commissioning, Strategic Planning and Performance
Mrs A Wilson	Associate Nurse Director
Mrs J Wilson	Board Administrator

Chairman's Opening Remarks

The Chairman welcomed everyone to the June meeting of the NHS Board and noted the two workshops held during the morning; Resilience Planning and Corporate Manslaughter. Both of these workshops were very informative and helpful and thanks were given to Martin Ogilvie, David Irving and Norma Shippin for their contributions.

66 Apologies

Apologies as noted above.

67 Declarations of Interest

There were no declarations of interest intimated.

68 Minute of the Meeting held on 11 May 2009

The Minute of the meeting held on 11 May 2009 was approved as an accurate record with an amendment to paragraph 2 on page 11 to read 'a formal Medical Practices Committee.

69 Matters Arising

Influenza

The Director of Public Health advised Members that there was nothing fresh to update on and that, quite against expectation, the Board continued to be in the position of having no possible, probable or confirmed cases of flu. There has, however, been an enormous opportunity for plans to be tested and there is confidence that when this happens the Board is fully prepared. This position is unlikely to be sustained and enormous efforts will be required when the Board enters the containment phase. During this phase efforts will be required to identify, treat and isolate every contact to stop spread. The ambition is to stay in the containment phase until a vaccine is available; this is likely to be September.

The Board

- Noted the verbal report.

70 Patient Safety

The Nurse Director presented the monthly progress report and advised the main goals of the programme were reducing mortality, adverse events and adverse incidents. Highlighting the drivers, the Nurse Director reported more than 95% compliance with completion of the observations around the MEWS score with patients being picked up at an early stage, 80% of patients attending an out patient clinic bring a list of the medicines they are taking at home and 100% of patients having surgery in main theatres are discussed at a surgical pause before knife to skin.

There have been no central line infections in the Intensive Care Unit since December 2008 and the monthly audit in relation to antimicrobial management indicates a 40% reduction in Cephalosporin prescribing.

Local assessment of progress within Dumfries and Galloway Royal Infirmary (DGRI) indicates a score of 4 against the IHI (Institute for Healthcare Improvement)

assessment scale and the goal is to reach 5 by the end of the year. Community Hospitals are focusing on reducing the risk of falls, recognising the deteriorating patient, improving nutrition and improving communication.

Mr Warford noted the options to build capacity and capability at DGRI were being considered at the Board Management Group (BMG). The Nurse Director advised of discussions on how the learning set approach can be used to develop an improvement co-operative to recognise the progress and improvement staff are making and how this can be shared with other staff.

Mr Hunter asked if Members could be advised when walkrounds were taking place. The Nurse Director advised that the new schedule of leadership walkrounds had been approved the previous week; the programme was being reviewed and dates would be circulated to relevant areas.

The Board

- noted the report.

71 Patient Experience: Reporting Period – April 2009

The Nurse Director presented the regular report on patient experience. Investigation into complaints touch on several issues including discharge management and delayed treatment. In order to ensure best learning a number of complaints have been returned to services for a fuller investigation to understand what lies beneath the issues. This results in a short delay but allows a fuller response to be provided. One hundred percent of complaints are acknowledged within three days. Of twenty-one complaints received in April, fourteen remain open as they are currently being investigated.

The better together patient experience pilot now involves four wards. Seventy patients and their visitors have been engaged with volunteers. Comments lead to issues being dealt with there and then and volunteers get together once a month to share experiences. A full report on the pilot will be brought to Board in September and may be rolled out thereafter.

Dumfries and Galloway is taking part in a patient experience survey this month and will feedback at a later date.

In the May Board Report Members were advised that a case was being considered by the Public Services Ombudsman. Although the Ombudsman decided that there were no grounds for a formal investigation of the complaint, he did recommend that the Board consider improving and broadening discussions held at surgical morbidity meetings in order to raise awareness amongst staff. The Medical Director for Acute Services is taking forward the recommendation.

Dr Park noted the feedback from the volunteering project and highlighted a potential deficiency in the communication skills of staff. The Nurse Director advised that as well as any issues being raised with the Senior Charge Nurse, these issues were taken to monthly meetings with the Patient Services Manager who follows them up.

Mr Warford noted compliance to national timescales and whilst recognising the challenge of responding within five days, particularly when there is a need to pull together information, enquired of the ability and root causes of not achieving the

twenty day target. The Nurse Director suggested it would be wrong to speculate on what the reasons might be but suggested there could be several issues contributing, for example the complexity of the complaint or staff being on leave. It was also noted that some patient / carer complaints can spread across care that patients have received from a number of teams. However, Members were assured that officers were working with general managers and clinicians to improve the performance of complaints handling.

Mr Warford enquired as to the timescale to achieve compliance. The Nurse Director advised that compliance was the ambition every month and it was very disappointing that this had not been achieved. The national standard is 80% of complaints within twenty working days and this is proving challenging, the assumption being that this is due to the complexity of complaints.

The Medical Director advised that complaints can be very complex and that a number are dealt with by face to face meetings. This may result in not meeting the timescale but is a much better way to deal with a complaint. Instead of repeated correspondence patients and family can sit down and go through things in much more detail.

The Chief Executive recognised that more face to face meetings were required in the early stages as the delay can occur when correspondence has not resolved the issue and then meetings are offered. Where an issue is complex the first approach should be to invite the complainant to meet with staff to talk about their experience. This can move things along much faster and it is important that those responsible take ownership of the complaint and the response. The initial telephone call can be so important and the Patient Services Team are required to take an even more proactive approach. However, it should be recognised that not all complainants wish to meet.

The Board

- noted the report.

72 Prevention and Control of Infection Update

The Nurse Director presented the monthly update which specifically focused on the work being progressed in relation to surgical site infections, post discharge surgical site infections and some improvement activities in relation to the Obstetrics Unit. The Scottish Government Health Directorate has established a mandatory national infection surveillance programme which includes surgical site infections and all Boards are required to implement surveillance for at least two operative procedures. NHS Dumfries and Galloway routinely collects data on seven procedures. Initially post discharge surveillance was undertaken by the Infection Control Team but this has now been delegated to clinical teams. Clinicians from the specialist areas now follow up at thirty days and if there are issues these are handed to the Infection Control Team. The inpatient surgical site surveillance between 1 January 2008 and 31 December 2008 revealed the infection rate at 0.97% which is well within control limits but was significantly higher at that time than the national average. From 1 January to 31 March 2009 there were no surgical site infections, demonstrating a significant improvement.

NHS Dumfries and Galloway is one of the few Boards to do surgical site surveillance at thirty days and therefore this should not be used for national benchmarking. The

infection rate was 8.8% and the first quarter of 2009 demonstrates significant improvement in post discharge surveillance.

Health Protection Scotland undertook to look into post discharge surveillance in detail and chose caesarean section infection rates. There is now a CEL (Chief Executive Letter) advising Boards to do surveillance at ten days rather than thirty days, effective from 1 June. There has been a detailed review of the caesarean section rate and improvement activity to ensure any identified areas are addressed. There were a number of areas for improvement and these continue to be monitored. Audits are undertaken on a monthly basis and information is shared with the relevant areas.

The Chief Executive advised that the Infection Control Committee had met on 29 May when there was a very full discussion on the work being taken forward around surgical site infection. It was a very positive discussion and the Committee was pleased with the progress being made.

The Board

- noted the report.

73 Reports from Committee Chairs

Staff Governance

Mr Campbell reported on the Staff Governance Committee held during the morning. The Committee received routine papers in respect of Staff Governance Statistics and Mandatory Training as well as an end of term compliance report against HEAT targets in respect of sickness absence (4.4% in month figure against a target of 4%), KSF profiles (80% compliant) and Annual Development Reviews and Personal Development Plans (97% compliance). The Committee discussed in detail issues relating to the management of work related violence and aggression and have requested that a paper on this issue be brought to Board in July. The Committee reviewed the recommendations and actions taken from a Disclosure Scotland Compliance Audit undertaken in March and satisfied themselves that appropriate action had been taken that that compliance was satisfactory. The Committee also reviewed the process which will be used to undertake the 2008/09 Consultants Discretionary Points process. Finally, the Committee noted the positive partnership work undertaken at the last Partnership Conference to equality and impact assess the Board's Clinical Services Strategy options and noted the positive feedback from attendees who completed evaluation forms.

The Board

- noted the verbal report.

74 Clinical Services Strategy

The Chief Executive proved a verbal update and advised Members that work continues with the Independent Scrutiny Panel (ISP). The panel met with officers ten days previously to provide feedback on the discussions and review of the paperwork provided. Following that discussion it was agreed to prepare a single document for the panel that draws together the full story of the pre-consultation engagement from the Local Health Partnership (LHP) reviews through to the short-listing of the three potential options for consultation. The panel has specifically asked that the option appraisal in the Scottish Capital Investment Manual (SCIM) be addressed and this

work is now being taken forward. The document will be provided to the panel by the end of June. In order to achieve this, Tribal will work with the Board to pull together a single document from the wide range of evidence that has been amassed over the last two years. The final document will come to Board for endorsement as there will be, an economic analysis of the options.

The Chief Executive advised Members that he met with some young people on Saturday as part of the Youth Strategy and asked them how they would like to be engaged with clinical services change throughout Dumfries and Galloway. A report will be prepared from the useful information obtained as young people would like to be engaged differently. The opportunity was also taken to ask them what would make them consider a career in the NHS; this feedback will also be written up for the HR Director.

The Employee Director advised Members that the panel also met with the staff side of the Area Partnership Forum. This was an extremely positive engagement.

Mr Johnston commented that a fairly comprehensive document had been produced less than a month ago and enquired what additional information was sought.

The Chief Executive advised that a document setting out the very detailed pre-consultation engagement had been provided and the panel's observation was that 'we were not selling our story' from the great deal of evidence available. Tribal are bringing a skill set around presentation of the detailed analysis.

Mr Hyslop advised Members that he had also met with the panel who felt that the Board had not explored the financial implications from the perspective of other partners. This is an opportunity to provide improved services for the local population and it is important to have other partners on board. The Chief Executive has been asked to attend political groups to raise awareness and that opportunity was welcomed.

The Chief Executive also advised Members that the Scottish Health Council had concluded their interim report on the pre-consultation engagement and fully recognised the full engagement across Dumfries and Galloway. This was tested by not just attending meetings but holding their own focus groups to determine interest and engagement. The report endorses the pre-engagement process over the last two years and will sit with the ISP report with the Cabinet Secretary.

The Board

- noted the verbal report.

75 Domestic Abuse and Violence Against Women Strategic Framework 2009-12 and Action Plan 2009 – 10

The Director of Public Health introduced this item and highlighted that from a public health perspective this is very important as it can lead to considerable problems with mental health but is also associated with a wide range of general health issues.

Mr Graham, Deputy Chief Constable and Chair of the Domestic Abuse and Violence against Women Partnership, put context and background to the framework and action plan which is the result of a broad and sustained period of consultation. Action to reduce levels of domestic abuse will have a significant impact for health issues. The key actions include prevention and where prevention fails to provide protection to

those who suffer from abuse. Participation is important, particularly from those who access the services. The multi agency risk assessment conferences were launched recently and are proving highly effective. There is also a lot of administrative work going on in the background.

The Director of Public Health commented on the administrative resources which can be quite intensive. The pathfinder rolled out across Dumfries and Galloway has resulted in health visitors being informed of cases of domestic abuse that they were unaware of previously. This provides insights into families they are working with but increases the workload. The resource required to get this right is going to increase; the more detection there is, the greater the demand on services.

Mrs Brash welcomed the report and the level of detail and emphasised the need for building confidence among young people in schools. Mr Graham advised that one education department survey noted that a number of young girls expected to suffer abuse. The outlook of the strategy is to take that broad look at prevention and the message that resolving conflict or issues with violence is not a way forward.

Mr Johnston noted that at other points the Board has highlighted cultural diversity and some of this could be cultural. Given that there could be a conflict between two statements on abuse and cultural sensitivity, cultural diversity will have a lesser role than the tackling of abuse. Mr Graham advised that criminal behaviour is criminal behaviour and suggested that that may need to be stated in the strategy.

The Director of HR and Workforce Strategy advised that an impact assessment had been undertaken and there has been considerable discussion about equality and diversity implications.

The Medical Director noted the paper included comment on the need for staff training. There is a web based training resource and this could be delivered to both health staff and staff in other organisations.

The Board

- agreed the Dumfries and Galloway Domestic Abuse and Violence Against Women Strategic Framework 2009 – 12.

76 Financial Performance: 1 Month to 30 April 2009

The Director of Finance presented this item. Month one is very much a high level report with assumptions. Potential pressure are highlighted in summary fashion. Letters have been sent to all budget managers who are very clear on efficiency targets with twin responsibility of delivering financial balance and financial efficiencies. The Efficiency Group will work with managers to support them in terms of efficiency programmes. Appendix 2 provides some of the detail in terms of efficiency plans and the Scrutiny Committee will receive a much more detailed report.

The Board

- noted the report.

77 Waiting Time and Activity Report

The Director of Health Services presented this item. The first month is subject to a number of caveats and furthermore it is noticeable that for 2009/10 the range of

access targets has changed so significantly that this report does not provide the assurance the Board needs. A restructured paper will be presented next month. The eighteen week referral to treatment target is now included and the first snapshot of data is encouraging, being able to match over 70% of patient episodes. Of those 70% of patients matched, over 80% have beaten the eighteen week target. The eighteen week collaborative is beginning to deliver. Ultrasound waits are still proving challenging but an additional staff member has been appointed and another member of staff has returned from long term absence. Other waits look good and the position achieved in March has been maintained.

In terms of activity it is hard to draw conclusions in the first month of the year although winter activity seems to be over. The April performance in Accident and Emergency is 97.4%.

Winter planning for 2009/10 starts in two weeks' time and there is a workshop for Members on 25 June.

Mr Campbell noted the resource allocated to waiting and enquired on the financial position. The Director of Finance advised that as part of the clinical strategy there are individual strands where money is being released. In terms of waiting that includes additional money and efficiencies are being fed back into the system.

Mr Hunter asked if it would be helpful if Members knew the average wait, including breaches. The Director of Health Services advised that this was appropriate in cancer waiting times, the latest figure showing that 93.8% are treated within sixty-two days. The key areas being looked at are urology, colorectal and lung. Lung is a very complex pathway as it is heavily reliant on out of area pathways. In urology and colorectal there have been breaches by a day or two which were avoidable and with focus on those two areas 95% should be achieved very rapidly. The most common breach time for cancer is less than five days, what is being looked at is the time between clinic and the diagnostic test being ordered.

Mr Warford noted the number of inpatient bed days in mental health and the dramatic reduction. The Director of Health Services confirmed that the model being delivered in mental health is very impressive. Work with CATS (crisis assessment and treatment service) is producing this positive dynamic where people come in to hospital less times and stay for a shorter period when they do.

The Board

- noted the report.

78 Local Delivery Plan Performance Report 2008 / 09

The Director of Health Services presented this item and highlighted a number of targets including:

- dental registration for 3-5 year olds;
- smoking cessation;
- breastfeeding rates;
- sickness absence;
- day case rates;
- cancer waiting times;
- cash efficiencies;
- HAI targets; and

- Long term conditions.

The Medical Director enquired if the hospital admission for long term illness had been adjusted in any way, for example increased diabetes which may not be the reason for admission. The Director of Health Services advised that it was age adjusted only. Board Members were reminded that there had been some issues with clinical coding in the past but that the current figures are in line with the rest of Scotland and analysis is being undertaken to demonstrate if there is a real shift.

Mr Johnston highlighted anti depressant prescribing and enquired if there was anything more proactive the Board should be doing. The Director of Health Services advised that the last data release was December so there may be some movement. Across Scotland there are a range of activities going on and none of the initiatives seem to turning around this prescribing. The Medical Director confirmed that there is a lot of working ongoing to meet this target. It had been presumed that a lot of the prescribing was for new events but 60-80% is repeat prescribing.

The Board

- noted performance against the Local Delivery Plan trajectories for 2008/09.

79 Leading Better Care

Mrs Wilson presented this paper. Leading Better Care (LBC) is a national report and implementation plan resulting from the Senior Charge Nurse Review. The steering group was established at the end of 2008 to work through the new senior charge nurse role and have agreed that there is a lot of training and support available in the organisation. The important thing to look at is the links that the clinical quality indicators that support LBC have with other programmes. This is not a stand alone programme. The pilot phase of 'releasing time to care' is about to start and Dumfries and Galloway is one of the first Boards to do that. The programmes are very closely linked to the patient safety programme and the methodology it uses. Senior charge nurses advise that a lot of the work they are required to do with LBC has been started with 'excellence in care'; both have to be delivered but can be done in a timely fashion. Good progress is being made and now moving in to the training and development of the senior charge nurses towards that new role. Reports will be presented to Board every six months.

Mr Warford advised that a key element from the broad based consultation was that staff felt bogged down by the amount of paperwork and repetitive taking of data and that there was a disconnect of what was required from the strategic direction and activity of Boards. Mr Warford asked what was being done to address the administrative aspect of the work senior charge nurses do to release them to do other work.

Mrs Wilson noted the benefit in starting the programme so quickly after the pilot. Releasing time to care showed that a significant amount of time can be released for all staff, releasing time from things that don't need to be done and putting that time into staff development and hands on care. Senior charge nurses are the central person responsible for development and standards of patient care. There is a lot of paperwork to do but it is not an added extra, it is part of your care. Data collection within LBC is a small element of it, a similar methodology to that of the patient safety programme; measure a small number of things on a regular basis.

The Nurse Director commented that senior charge nurses sometimes feel they have

to do it all themselves and they don't. Responsibility for cleanliness audits and hand hygiene audits, for example, can be delegated to other staff which will then generate ownership of a whole range of activities. The Nurse Director advised Members that she was spending a day a month in uniform to connect with clinical areas, to challenge on issues and to highlight the strategic direction of the Board.

The Board

- noted progress on 'Leading Better Care'.

80 Health Resilience Update

The Chief Executive presented this item which builds on the workshop held during the morning and sets down formally for the Board the work that has been taken forward. A first step towards assurances on how the Board is taking forward Civil Contingency Act responsibilities.

The arrangement through the Service Level Agreement with the Council is working well with strategic advice from Martin Ogilvie and the health resilience programme adviser is part of the wider resilience team. There is now a very clear workplan owned by individual directors and central to the work is exercising and testing of the plans, a number of which have been held over the last eight months. This provides further assurance that we are preparing our plans, testing and learning. In terms of development of the senior team there have been partnership development opportunities through the Strategic Co-ordinating Group (SCG) and the Chief Executive and Director of Public Health have participated in government led personal development. As recently as last week the Board Management Group went through a full day of personal development, a combination of both learning how the SCG functions, who functions within it but also, importantly, a series of scenarios throughout the day testing abilities and confidence. There are some challenges around business continuity management with a recent full day workshop for about sixty middle managers and team leaders to progress the preparedness in that field. The arrangements building offer a degree of confidence to the Board's response to the CCA and demonstrates that we continue to build preparedness.

The Board

- noted the recent adoption of a Resilience Strategy;
- noted the significant recent developments in resilience; and
- agreed to receive further updates.

81 Patient Focus Public Involvement Self Assessment Report 2008/09

Mrs Wilson presented this paper most of the information having been presented to Board previously in quarterly reports over the last year. This self assessment is due to be returned to the Scottish Health Council and includes the key actions agreed with members of the public. The self assessment has to be published on the website and the PFPI summary submitted for the annual review.

The Board

- endorsed the Patient Focus Public Involvement Self Assessment for 2008 / 09; and
- endorsed the key actions for 2009 / 10.

82 Arrangements for NHS Patients Receiving Healthcare Services through Private

Healthcare Arrangements

The Medical Director presented this paper. There have been circumstances where patients have been acquiring private healthcare and under the directives in the NHS that meant they were not able to receive any other part of their care on the NHS. That was deemed to be unfair as every other patient in that group would have the ability to access that care. The Chief Medical Office (CMO) has issued a directive that it is acceptable to have private care and access NHS care, but only for certain conditions. The CMO has suggested Boards set out a framework that makes it quite clear when a patient is receiving some of their treatment from a private healthcare provider and some from the NHS that there is a sign-up beforehand to ensure there is good communications and perhaps also make sure that the exceptional prescribing policy has been thoroughly worked through to ensure that the patient wasn't entitled to that treatment on the NHS. It is difficult to produce a paper that covers every eventuality; in terms of the process, if a patient wants to have private treatment it is important to first of all ensure that they are not entitled to that treatment on the NHS, that they understand the process and what is happening and for the Medical Director of Acute Services to run through with the Chief Pharmacist and the Director of Health Services if necessary. This is a framework that will require some detailed adaptation and work when individuals come in but the framework addresses the ethical, clinical and legal issues.

Mrs Brash commented that it was quite a lot of work for potentially very little outcome and noted that appendix 1, question 2 would be difficult for a patient to fully understand. It is about ensuring that the patient knows exactly what he or she is getting in to. The Medical Director advised that patients can spend large amounts of money seeking private healthcare and it is important to advise them that experts have examined the treatment they are asking for.

The Director of Public Health advised that there was a need for flexibility and the policy as set out provides that.

The Board

- approved the framework.

83 Board Briefing

The Chief Executive presented this item and highlighted the integrated care pathways in mental health, a very significant piece of work that has received accreditation.

The Board

- noted the Briefing.

84 Any Other Competent Business

There was no other competent business.

85 Date of Next Meeting

The next meeting of the NHS Board will be held on Monday 6 July, 2009.

86 Note of the Board Workshop held on 11 May 2009

The Board

- noted the note of the Board Workshop held on 11 May 2009.

87 Minute of the Audit Committee held on 27 March 2009

The Board

- noted the Minute of the Audit Committee held on 27 March 2009.

88 Minute of the Area Clinical Forum held on 22 April 2009

The Board

- noted the Minute of the Area Clinical Forum held on 22 April 2009.

89 Minute of the West of Scotland Regional Planning Group held on 13 March 2009

The Board

- noted the Minute of the West of Scotland Regional Planning Group held on 13 March 20089.

DUMFRIES AND GALLOWAY NHS BOARD

Minute of the Special Meeting of Dumfries and Galloway NHS Board
held on 25 June, 2009



Minute Nos: 97 - 100

Present

Mr M Keggans	Chairman
Mr J Burns	Chief Executive
Mr J Ace	Director of Health Services
Mrs H Brash	Non Executive Member
Dr A Cameron	Medical Director
Mr E Hunter	Non Executive Member
Mr A Johnston	Non Executive Member
Mr C Marriott	Director of Finance
Ms C Sharp	Director of HR and Workforce Strategy
Mr K Warford	Vice Chairman

Apologies

Mrs H Borland	Nurse Director
Dr D Cox	Director of Public Health
Mr A Campbell	Non Executive Member
Mrs H Dykes	Chair of Area Clinical Forum
Mr I Hyslop	Non Executive Member
Mr D Lockhart	Employee Director
Dr R Park	Non Executive Member

Attending

Mrs M Christie	Associate Nurse Director
Mr J Steen	Head of Financial Services and Procurement
Mrs J Wilson	Board Administrator

Chairman's Opening Remarks

Welcome and thanks for taking the time this afternoon to attend this additional meeting.

97 Apologies

Apologies as noted above

98 Declarations of Interest

No declarations of interest were intimated.

99 Annual Accounts

The Director of Finance presented this item. The accounts have been to the Audit Committee where there was a useful discussion with KPMG in terms of the conduct of the audit. The Board has delivered against all key financial targets.

The Director of Finance expressed thanks to the wider organisation as the accounts and financial targets are delivered across the organisation. The support of the Finance Team was also recognised and formally acknowledged.

The Chairman commented on the smooth transition of the new Director of Finance and recorded thanks of the Board to wider Finance Team.

Mr Hunter enquired how this good news story could be shared with staff and the wider population across Dumfries and Galloway. The Chief Executive advised that the Communications Team were pro-actively engaging the media with key features.

The Chief Executive asked Members if they would wish to see an annual report although this cannot be produced until the annual accounts have been laid before Parliament. Mrs Brash suggested that a report for staff and an executive summary style report for the wider population would be useful. The Chief Executive confirmed he would ask the Communications Team to take this forward.

The Board

- approved the Annual Accounts.

100 Any Other Competent Business

There was no other competent business.

DUMFRIES AND GALLOWAY NHS BOARD

6 July 2009

PATIENT SAFETY



Author

Maureen Stevenson

Sponsoring Director

Hazel Borland, Nurse Director

Date: 25 June 2009

RECOMMENDATION

The Board is asked to note progress with the patient safety programme in Community Hospitals.

SUMMARY

The spread of the patient safety programme continues through NHS Dumfries and Galloway as we work towards achieving improved outcomes for patients using. Work continues, as in previous months, in all clinical and ward areas in DGRI to embed the improvement methodology and drive the implementation of the change package.

Significant progress is being made within Community Hospitals to drive the patient safety agenda forward. Following on from the third learning session this paper provides a summary of progress to date.

Spread of the Scottish Patient Safety Programme

The Scottish Patient Safety Programme will, over time, spread to all healthcare sectors across Scotland, however it is currently focused on patient safety in the acute hospital setting. Discussions with representatives from Primary Care and Paediatrics have recently taken place and plans are being developed to move this forward. A first national meeting to consider the aims, goals and change package for a Paediatric Patient Safety Programme will take place in August 2009.

Locally Children's Services have been fully involved with the patient safety programme, taking relevant elements of the acute hospitals change package and making process improvements in Ward 15, Oakfield and Netherlea. Staff from Maternity Services have been most closely involved with work to reduce surgical site infection and theatre safety briefings. A small team from Maternity Services attended the recent SPSP Capacity Building session as an introduction to the patient safety programme.

Spread beyond acute environments within DGRI has already started, making use of the general change package but providing an introduction to patient safety, process reliability and the improvement methodology. This will give staff in these areas a head start when national programmes specific to this area is agreed.

Community Hospitals Patient Safety Programme

Nationally there is no agreed patient safety programme tailored to Community Hospitals. As one of the first areas to take a Board wide approach to spreading patient safety to Community Hospitals it has been necessary to develop our own change package building on the elements of the acute care package. Community Hospitals across NHS Dumfries and Galloway are focused on the organisational goals of:

- Reducing mortality
- Reducing adverse events
- Reducing hospital associated infections

Within a short space of time improvement teams in Community Hospitals have made progress in developing their understanding of improvement methodology, raising awareness of patient safety and securing the support of colleagues in their hospital to make changes that impact on patient care. This experience has brought benefits not only for patients but also for staff, empowering them to change processes and in many instances increasing the time available for direct patient care.

Alongside the capability of frontline staff to lead improvements in patient care the need for the right infrastructure to support this is critical. LHP Nurse Managers and Clinical Governance Facilitators are working with frontline staff to provide this coaching and facilitation locally. Each LHP has developed a clear reporting structure through to their Management Team and to Patient Safety Delivery Group.

Progress has been made in all hospitals using a variety of approaches. Initial challenges resulting from person dependency are now being overcome. The power of local improvement data and patient stories to demonstrate the impact of a change have been utilised by the teams to bring colleagues on board.

The tables below provide a summary of the activity ongoing in Community Hospitals.

Our Goal: To reduce non-palliative care mortality		
Driver: Reduce Adverse Events		
Early identification of patient deterioration	Medical Early Warning System	Implemented - Thornhill Hospital, Galloway Hospital (Garrick ward)
Prevent pressure ulcers	Pressure Sore Care Bundle	Preparing to test - Pressure sore care bundle is being developed by NHS QIS. Input from Tissue Viability Nurse to recent Community Hospitals learning session. To be developed at the next Community Hospitals learning session.
Optimise communication	Admission Processes	Implemented - Traffic light system Thornhill Hospital Testing - Traffic light admission process Annan Hospital
	SBAR	Implemented for handover - Galloway, Newton Stewart and Thornhill Hospitals Testing for handover - Castle Douglas Hospital, Moffat Hospital and Annan Hospital, Rehabilitation Day Unit Thornhill Hospital Testing for Multi-Disciplinary Meetings - Rehabilitation Day Units (Galloway / Newton Stewart) Improved handover of information between Community Hospitals, DGR1 and tertiary centres has been a key focus for all throughout the programme.
	Theatre Safety Briefings	Testing - Galloway Hospital Theatres
	Ward Processes	Testing - Castle Douglas Hospital
Optimal nutrition	Nutritional Screening	Implemented - MUST tool used to assess all patients in all Community Hospitals. The Nutrition Champion is fully involved in the support for the patient safety programme.
	Optimal Hydration	Testing - Thomas Hope, Kirkcudbright Hospitals
	Appropriate Nutrition	Testing - Thomas Hope Hospital, Kirkcudbright Hospital
Prevent falls	Falls Risk Assessment and Care Planning	Implemented - Annan Hospital, Newton Stewart Hospital, Galloway Hospital (Dalrymple Ward), Castle Douglas Hospital, Kirkcudbright Hospital.
	Equipment to Prevent Falls	Implemented - Annan, Kirkcudbright, Galloway, Thomas Hope Hospitals
	Medication Review	Implemented - Patients on 4 or more medications have this reviewed by a doctor in all Community Hospitals on the request of nursing staff
	Standardised Processes	Testing - LHP wide falls groups established in Wigtonshire and Stewartry to share learning and drive work to prevent falls forward The Falls Coordinators continue to work with the Community Hospitals throughout the programme
	Information for Patients and Families	Spreading - Falls leaflet tested in the Dalrymple Ward, Galloway Hospital being adapted for use across the Board
Reliable processes for medicine management	Medicine Reconciliation	Preparing to test - Medicine Reconciliation - Kirkcudbright Hospital
	Medicine Safety	Testing - Galloway Hospital (patient's own drugs standard operating procedures), Rehabilitation Day Units Stranraer and Newton Stewart (safety of assisting patients with their medication)

Our Goal: To reduce non-palliative care mortality		
Driver: Reduce Hospital Associated Infections		
Hand hygiene	Hand hygiene audit	Implemented - all Community Hospitals
	Information for patients	Implemented - Moffat Hospital (hand washing prior to meals), Newton Stewart Rehabilitation Day Unit Testing - Newton Stewart Hospital (hand washing prior to meals)
	Information for families and visitors	Testing - Thomas Hope Hospital, Moffat Hospital
Reduce infections	Urinary tract infection	Testing - Thomas Hope, Newton Stewart Hospitals
	Antimicrobial prescribing	Testing - Castle Douglas Hospital

Conclusions and Recommendations

The Board are asked to note the progress of the improvement work beyond the acute unit and continue to provide support and encouragement to front line teams delivering a challenging agenda.

MONITORING FORM

Policy/Strategy Implications	<i>Delivering SGHD SPSP</i>
Staffing Implications	<i>Encouraging staff across NHS Dumfries and Galloway to take forward learning from patient safety activities.</i>
Financial Implications	<i>None at this time</i>
Consultation	<i>No consultation</i>
Consultation with Professional Committees	<i>Patient safety discussed at Area Clinical Forum</i>
Risk Assessment	<i>Patient safety and risk management connected activities.</i>
Best Value	<i>Commitment and leadership Sound governance at strategic and operational level Contribution to sustainable development</i>
Compliance with Corporate Objectives	<i>Corporate Objective 2</i>
Impact Assessment <i>No Equality Impact Assessment required.</i>	

DUMFRIES and GALLOWAY NHS BOARD

6 July 2009

**Patient Experience
Reporting Period – May 2009****Author:**
Carol Reece, Patient Services Manager**Sponsoring Director:**
Hazel Borland, Nurse Director**Date:** 24 June 2009**RECOMMENDATION**

The Board is asked to consider the Patient Experience report for May 2009.

SUMMARY

Patient Services presents an evolving monthly report based on the summation of Patient Experience information.

This report covers:

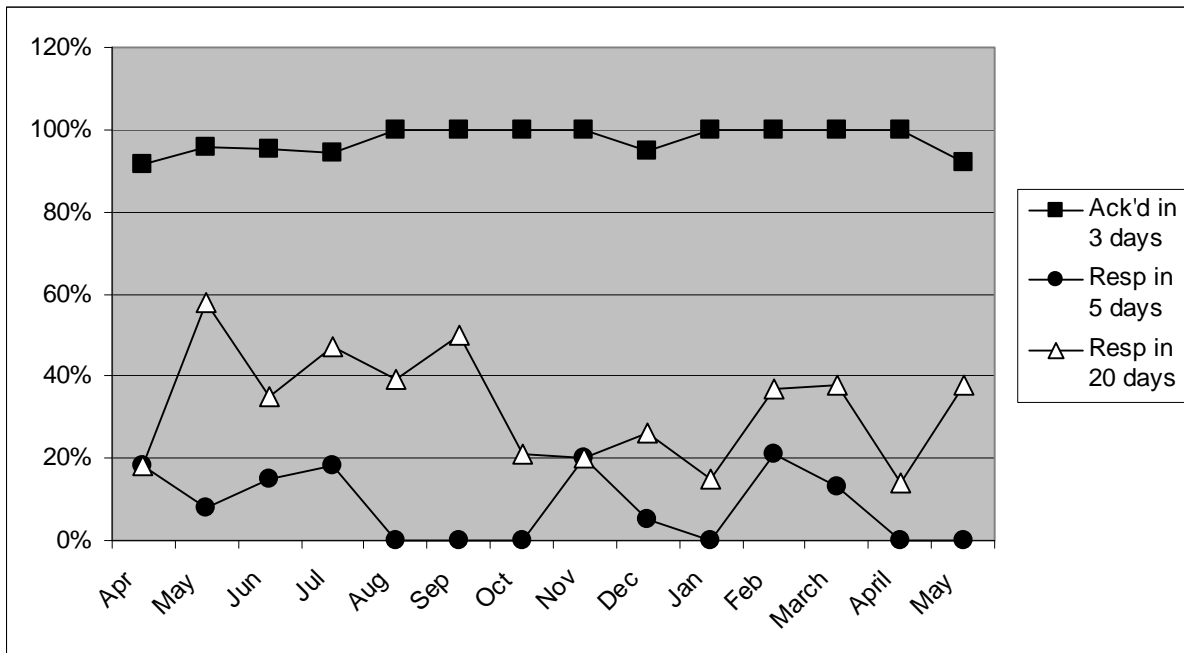
- Lines of enquiry and complaints
- Learning from patient experience
- Patient experience volunteers
- *'Better Together'*

INTRODUCTION

In this reporting period the Patient Services Team have received 33 lines of enquiry of which 13 were complaints (39%). Seven letters of appreciation regarding staff and services have been received through Patient Services Office, which does not account for the number received by individual services.

Enquiries handled over the period include waiting times for appointments, medication and dental and accessing support.

COMPLIANCE WITH NATIONAL TIMESCALES



A period of intensive work in the investigation and reporting process has seen an improvement in target response times for May.

Of the 13 complaints, 5 remain open (38%). Of the 8 closed, 5 were upheld, 1 was upheld in part and 2 were not upheld. Issues include attitude and communication.

Learning from patient experience

We know from feedback that attitude and communication are key reasons for complaint. To address this, work is in hand to raise awareness of patient experience with staff and to provide practical experience in handling and learning from complaints. The work has included the use of local patient stories in a live event and in the creation of a DVD resource. The campaign, aimed at challenging the perception of staff attitude, is due to be launched on 24 August 2009.

Systems aimed at improving the flow of patient experience feedback include 'complaints dashboards' which will provide electronic monthly information for staff.

Examples of some recent changes made as a result of patient feedback:

- A review and subsequent development of patient information prior to obtaining patient consent for procedures and treatments, and also during hospital stays.
- The development of the Carers Support Service.
- Patient focussed out-patient appointment booking for an increasing number of Specialties.
- The design of a post breast surgery exercise class is being changed prospectively according to the needs and wishes of the participants

- Wigtownshire Local Healthcare Partnership (LHP) is trialling a 3 point patient feedback questionnaire in 3 patient areas. It is early days for this project, but the staff are enthusiastic about the method and are ready to respond to the feedback. Results will be monitored by the LHP Quality and Safety Committee.
- Stewartry Community Hospitals now offer patients and relatives the opportunity to share their hospital experience on a 1:1 basis. This is offered alongside a discharge questionnaire. They are looking at further developing this with Council colleagues with the aim of providing a more holistic, caring, person-centred approach to care in the community.
- A cancer patient / carer support group has been set up, drawing on the experiences of patients and their families, which offers the group a forum to voice their ideas for improvements and a link to make those improvements with colleagues in DGRI. In particular, this group is looking at improving the information / support available locally.

Patient Experience Volunteers

As a result of forthcoming interviews, the aim is to recruit a number of new volunteers to enable further focused ward based work. The final report on the pilot will be available at the end of July 2009.

***Better Together:* NHSScotland Patient Experience Programme**

It is anticipated that Pricewaterhouse Cooper, the coordinating and support centre for the programme, will be dispatching questionnaires for the pilot survey during the first week of July 2009.

MONITORING FORM

Policy / Strategy Implications	<i>Complaints Policy.</i>
Staffing Implications	<i>Ensuring staff learn from complaints in relation to issues raised.</i>
Financial Implications	<i>None</i>
Consultation	<i>None</i>
Consultation with Professional Committees	<i>None</i>
Risk Assessment	<i>Actions from complaints followed through and reported to General Managers and Clinical Nurse Managers who have a responsibility to take account of any associated risk.</i>
Best Value	<i>Commitment and leadership Accountability Responsiveness and consultation</i>
Compliance with Corporate Objectives	<i>To promote and embed continuous improvement by connecting a range of quality and safety activities to deliver the highest quality of service across NHS Dumfries and Galloway</i>
Impact Assessment	<i>Not undertaken as applies to all users.</i>

DUMFRIES and GALLOWAY NHS BOARD

6 July 2009

Prevention and Control of Infection**Author:**

Sam Whiting, Infection Control Manager

Sponsoring Director:

Hazel Borland, Nurse Director

Date: 22 June 2009**RECOMMENDATION**

The Board is asked to note this report which provides an update on infection prevention and control across NHS Dumfries and Galloway.

SUMMARY

This paper is a routine monthly update on specific aspects of Infection Control. The Scottish Government Health Directorate requires all NHS Boards to receive bi-monthly infection control updates from January 2009. The first such update was provided for Board in November 2008.

NHS Dumfries and Galloway has a Health improvement, Efficiency, Access and Treatment (HEAT) target of a 30% reduction in SAB bacteraemia by 2010. Our average SAB rate is currently 4.58 per month against a HEAT trajectory of 4.21 for May 2009.

The Scottish Government Health Directorate (SGHD) has set a HEAT target of a 40% reduction in CDI rates for NHS Dumfries and Galloway. Performance against trajectory calculations will be included in future Board updates.

The Scottish Government requires all NHS Boards to receive a bi-monthly infection control update on the following areas which are all addressed in this paper:-

- Infection surveillance
- Hand hygiene by hospital (including visitors)
- Education
- Outbreaks
- Cleaning
- Risks and incidents

The Scottish Government Health Directorate has also issued an action plan for NHS Boards to implement relating to Healthcare Associated Infection (HAI). Each Board

is required to provide the Cabinet Secretary for Health and Wellbeing with a monthly progress report on the implementation of the actions.

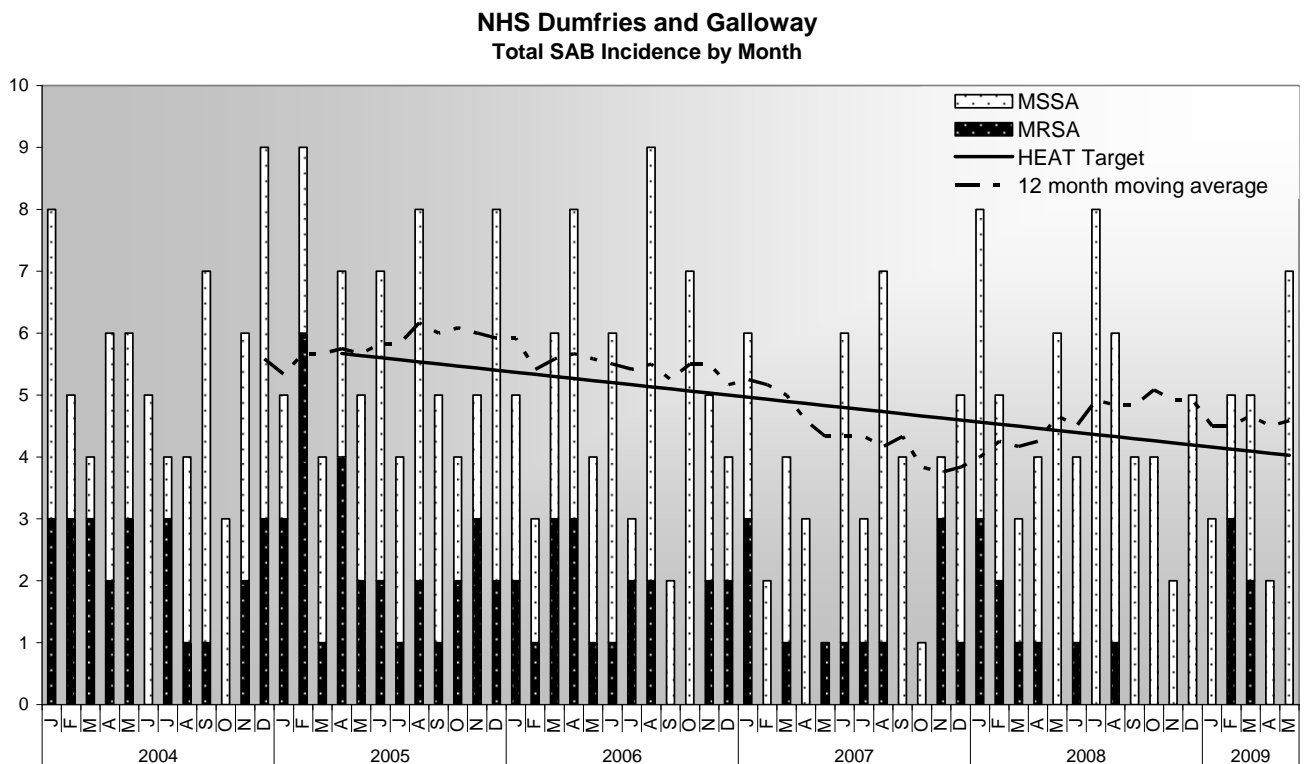
Through the proactive approach taken by NHS Dumfries and Galloway on key infection control issues including mandatory training, antimicrobial prescribing, cleaning and hand hygiene, NHS Dumfries and Galloway has been able to confirm implementation of 22 of the 24 actions (Appendix A). Work is ongoing to implement the remaining two actions. One action is for all staff to have an HAI objective in their personal development plan and this remains a challenge although a work plan and trajectory for achieving the related HEAT target has been established.

Infection Surveillance

In NHS Dumfries and Galloway, infection control surveillance includes close monitoring of *Clostridium difficile* infection (CDI) and *Staphylococcus aureus* bacteraemia (SAB).

As at the date of this report, 3 days have elapsed since the last Meticillin Resistant *Staphylococcus aureus* (MRSA) bacteraemia and 13 days have elapsed since the last Meticillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemia in Dumfries and Galloway.

NHS Dumfries and Galloway has a Health improvement, Efficiency, Access and Treatment (HEAT) target of a 30% reduction in SAB bacteraemia by 2010. Ongoing work to reduce cases is required to ensure that this target is met. The graph below shows the monthly SAB incidence against the HEAT target trajectory.



In May 2009, there were two SAB recorded in Galloway Community Hospital with the remaining within Dumfries and Galloway Royal Infirmary.

There is no new information on average SAB rates for Scotland since the April Board update paper. However, the quarterly report on SAB from Health Protection Scotland is due to be published in the next few weeks and data from that report will be included in the next Board update.

Ongoing initiatives to reduce SAB cases includes:-

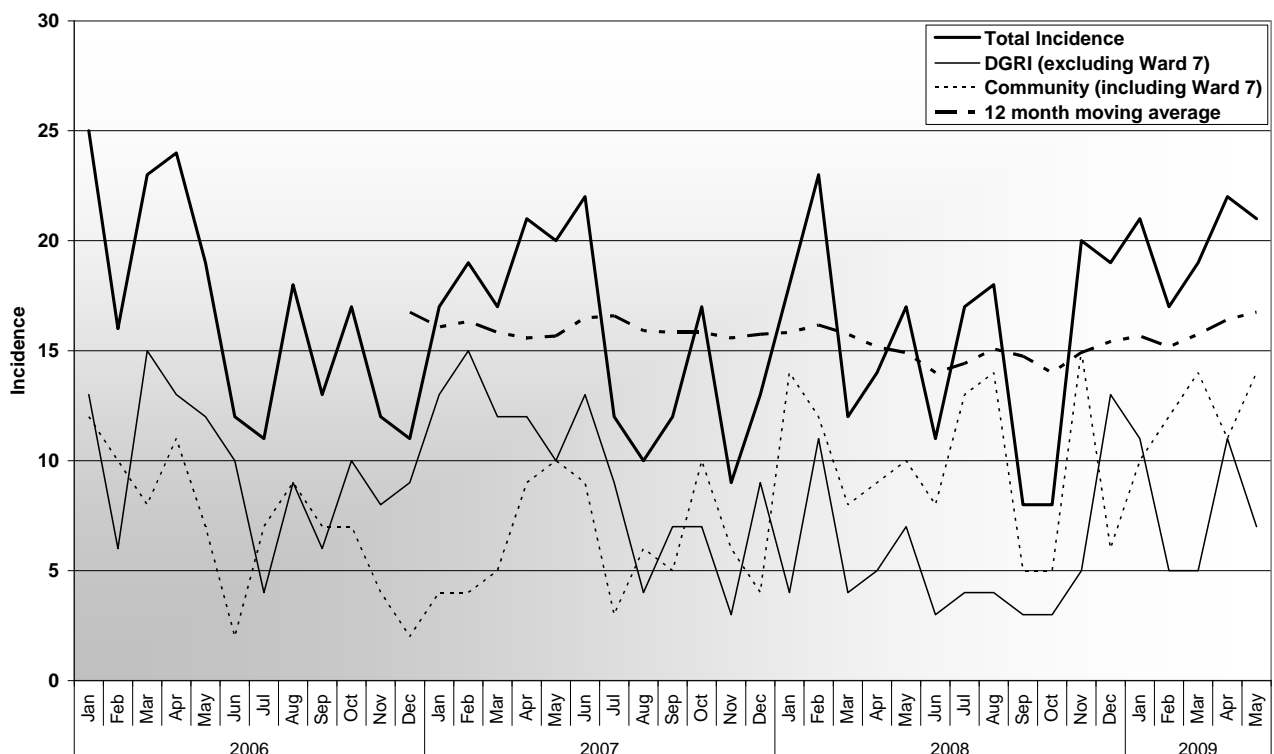
- Through the Patient Safety Programme, a care bundle for the use of peripheral intravenous cannula is currently being tested in a number of clinical areas within Dumfries and Galloway Royal Infirmary (DGRI).
- MRSA screening increased from February 2009.
- Ongoing compliance with risk assessed MRSA screening together with an Integrated Care Pathway (ICP) to improve the management and care of MRSA positive patients is helping to reduce the risk of colonisation leading to infection of self and colonisation of others.
- All SAB cases are fully investigated using a standardised tool which is completed by the clinical team caring for the patient.
- Infection surveillance data is fed back to clinical managers.

Clostridium difficile Infection (CDI)

The graph below shows the total monthly incidence of *Clostridium difficile* infection (CDI) from January 2006 to May 2009 across NHS Dumfries and Galloway.

The data in all the graphs below have duplicates removed (as per HPS data definitions). If a case is diagnosed twice within a 28 day period, the second toxin positive test is considered a duplicate.

NHS Dumfries and Galloway Total Clostridium difficile Incidence
January 2006 - May 2009

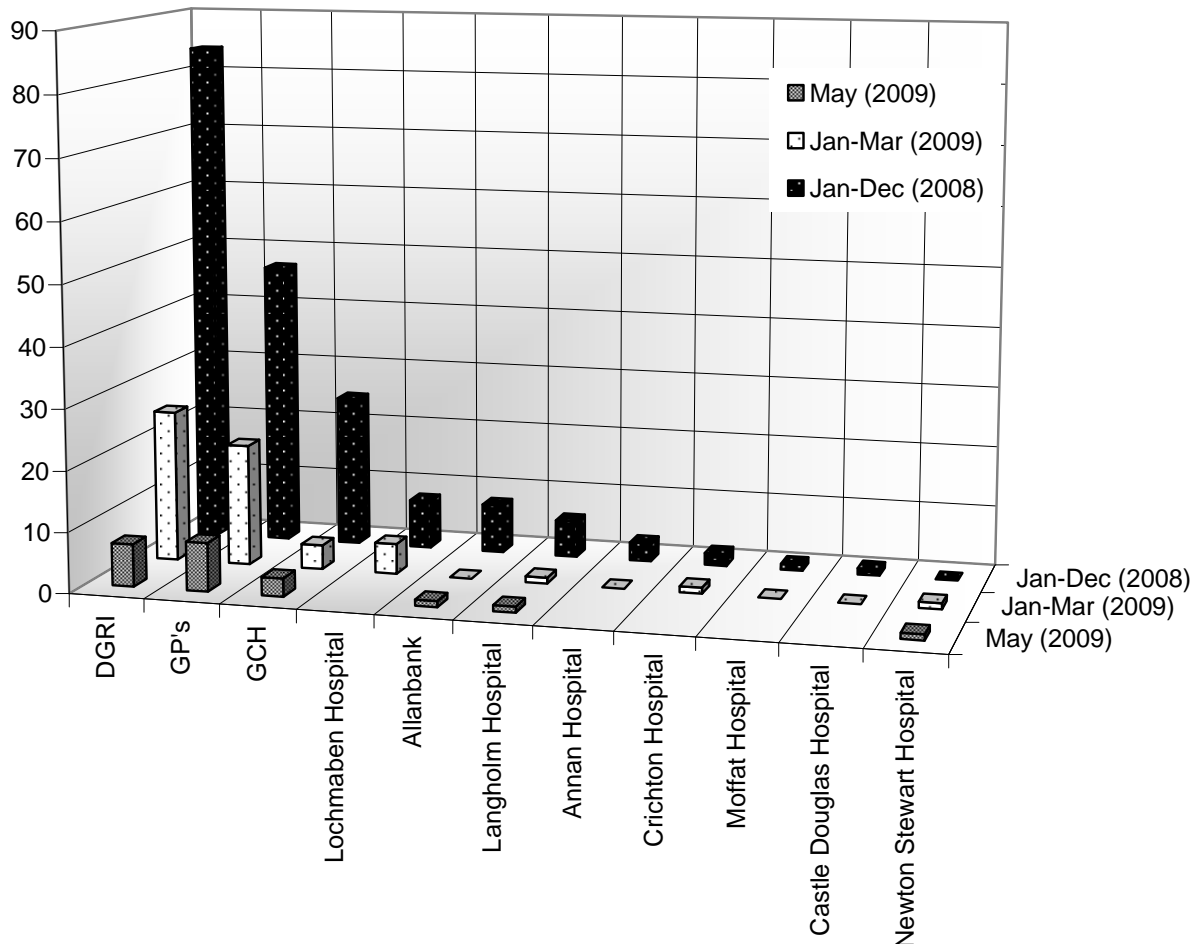


There is no new information on average CDI rates for Scotland since the April Board update paper. However, the quarterly report on CDI from Health Protection Scotland is due to be published in the next few weeks so data will be included in the next Board update.

The Scottish Government Health Directorate (SGHD) has set a HEAT target of a 40% reduction in CDI rates. Performance against trajectory calculations will be included in future Board updates.

The following graph shows the incidence of CDI by location for the last month, quarter and year.

NHS Dumfries and Galloway
Total Clostridium difficile Incidence by Location (Last Month, Last Quarter, Last Year)



Antimicrobial Stewardship

In addition to general infection control improvements such as hand hygiene, antimicrobial stewardship is essential to drive down CDI rates. The Antimicrobial Management Team (AMT) is leading a programme of work to improve antimicrobial stewardship and has already implemented a range of actions together with the Infection Control Team:

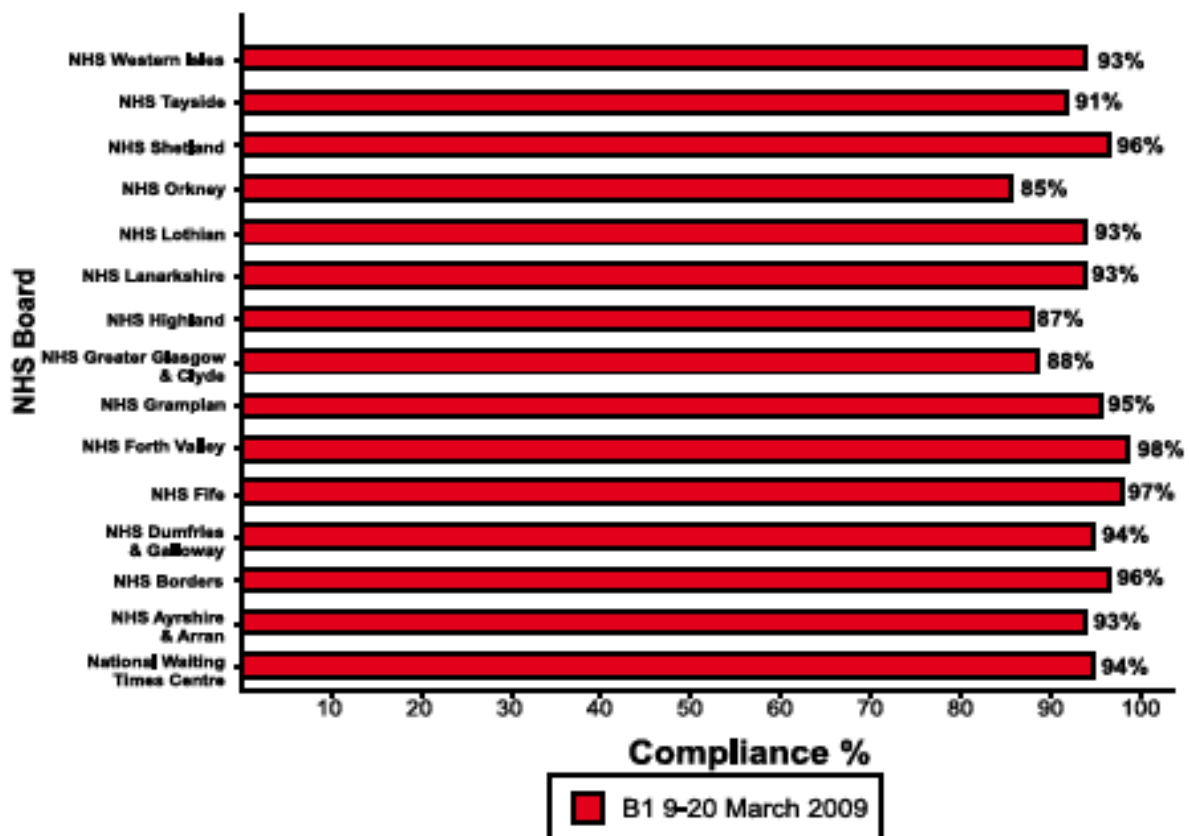
- Implementation of a CDI focussed acute antimicrobial formulary
- GP formulary reviewed and updated
- The Microbiology laboratory has stopped reporting cephalosporin sensitivity
- Antimicrobial restricted list developed and in use.
- Antimicrobial Formulary compliance audits are conducted weekly
- Feedback and education to prescribing doctors
- A letter has been sent from the Medical Directors to all GPs regarding antimicrobial prescribing
- Completed IV to oral switch policy
- Completed paediatric antimicrobial policy
- CDI Integrated Care Pathway (ICP) developed and in use.
- Emergency CDI outbreak formulary developed.
- Implemented Integrated Care Pathway for CDI positive patients
- All CDI cases are fully investigated using a standardised tool which is completed by the clinical team caring for the patient.

Hand Hygiene

Staff hand hygiene compliance is monitored through daily audits as part of the Patient Safety Programme. In addition, bi-monthly hand hygiene audits are conducted in each NHS Board as part of the national hand hygiene campaign.

In May 2009, HPS published the latest Hand Hygiene compliance report for NHS Scotland. The results are summarised in the graph below which shows NHS Dumfries and Galloway achieved 94%.

Audit results for Compliance with Hand hygiene Compliance by NHS Board



Education

Staff across NHS Dumfries and Galloway are supported to complete the Cleanliness Champions Programme developed by NHS Education Scotland (NES). As at the date of this report there are 647 completed Cleanliness Champions and 499 in training in Dumfries and Galloway. There are also a further 34 members of staff working through a NES Decontamination Programme.

NHS Dumfries and Galloway continues to develop the mandatory training programme and has taken forward on-line training for infection control. All new employees joining the organisation receive mandatory training including infection control prior to starting in the workplace.

Outbreaks

There have been no outbreaks since the April Board update paper.

Cleaning

Recent cleaning results by locality are listed below. These are aggregated cleaning audit scores for the months of April and May 2009 based on compliance with the national cleaning specification.

Area	Cleaning audit Scores	
	April	May
Stewartry Locality	98.9%	99.4%
Annandale and Eskdale Locality	98.1%	99.0%
Wigtownshire Locality	98.3%	98.2%
Dumfries and Galloway Royal Infirmary	95.5%	96.4%
Nithsdale Locality	96.1%	95.2%
Crichton Site	97.1%	97.3%

Incidents and Risk

In March, the Infection Control Team were notified of 15 incidents of which 12 related to staff being exposed to a risk of infection through sharps injuries and lab samples. The remaining 3 incidents did not result in any patients getting an infection.

The Corporate Risk Register for NHS Dumfries and Galloway incorporates the risk of HAI. The Infection Control Team also holds a risk register which considers operational risks and works with clinical teams to reduce those risks. This is kept in constant review.

HAI ACTION PLAN

All Boards will empower their Charge Nurses to deliver against their responsibilities
Status: Complete

Implement the recommendations in the Senior Charge Nurse Review
Completion Date: December 2010 Status: Green

HAI SCRIBE (Healthcare Associated Infection System for Controlling Risk in the Built Environment) sections 3 &4 to be applied to all existing buildings to ensure fabric of healthcare facilities maintained to minimise risk of infection
Status: Complete

Planned preventative maintenance programmes reflect requirements of prevention and control of infection
Status: Complete

NHS Boards to have 'zero tolerance' to non-compliance with hand hygiene
Status: Complete

NHS Boards to report hand hygiene compliance (staff and visitors) and facilities on a hospital basis to 2 monthly Board meetings
Status: Complete

NHS Boards to ensure HAI budget requirements are reflected in capital, maintenance and operational programmes
Status: Complete

NHS Boards to have identified budget for urgent repairs and replacement equipment available to Charge Nurses
Status: Complete

All patients to receive information on HAI
Status: Complete

All information is available in a variety of formats that facilitates public understanding
Status: Complete
Scottish Patient Safety Programme (HAI elements) are integrated with HAI agenda at NHS Board level
Status: Complete

Progress on implementation of Scottish Patient Safety Programme (HAI elements) to be included in HAI reports to 2 monthly Board
Status: Complete

NHS Board's infection control policies include primary and community care
Status: Complete

Structure and resources to provide effective infection control service across NHS Board area (hospital and community) assessed and agreed by NHS Boards, including:

- Human resources

- Equipment
- Budget

Status: Complete

NHS Boards policy/guidance on completing death certificates reviewed to include documenting death associated with HAI

Status: Complete

NHS Boards local surveillance to include setting of control limits and trajectories for reduction of rates / incidence of HAI

Status: Complete

NHS Boards Risk Register details HAI risks

Status: Complete

HAI incidents and issues recorded on NHS Boards Risk Register reporting systems and reported to 2 monthly Board meetings

Status: Complete

NHS Boards to self assess current compliance with QIS HAI Standards (March 2008)

Status: Complete

All healthcare workers receive appropriate level of HAI education and training in line with position, including antimicrobial prescribing and resistance

Status: Complete

Infection Control staff undertake appropriate level of education and training

Status: Complete

Cleaning matrix and schedule including discipline responsible for cleaning is available in all healthcare settings

Status: Complete

All staff to have HAI objective in annual professional development plans

Completion Date: April 2009

Status: Amber (target completion 30/09/09)

MONITORING FORM

Policy / Strategy Implications	<i>HEAT targets</i>
Staffing Implications	<i>Not required</i>
Financial Implications	<i>Not required</i>
Consultation	<i>Not required</i>
Consultation with Professional Committees	<i>Not required</i>
Risk Assessment	<i>Addressed through Corporate and Infection Control Team risk register</i>
Best Value	<i>Best Value Public Involvement Partnership working</i>
Compliance with Corporate Objectives	<i>2,3,7</i>
Impact Assessment <i>General update paper – not applicable</i>	

DUMFRIES AND GALLOWAY NHS BOARD

Scrutiny Committee



Minutes of the Scrutiny Committee held on Tuesday 28 April 2009 at 1.00pm, in Room 3, Crichton Hall, Dumfries.

Present

Mike Keggans (Chairman)
 Jeff Ace
 Andrew Campbell
 Ed Hunter
 Katy Lewis
 Craig Marriott
 Keith Warford

Attending

Diane Bentley
 Mike Pratt, Paul Beardon, Susan Roberts, Gill Stewart - for item 4
 Vicky Freeman - for item 5
 Penny McWilliams, Paul McCulloch - for item 6

1. Apologies for absence

Apologies were received from John Burns.

2. Minutes of meeting held on 24 March 2009

These were approved.

3. Matters arising:

None.

4. NHS Dumfries and Galloway Prescribing Expenditure

MP confirmed a high proportion of the total NHS expenditure is spent on medicines. Growth is low in Primary Care but has increased in Secondary Care. Efficiency savings will be released through the work being done by the Prescribing Support Team and formal monitoring of performance.

New, expensive treatments present a significant risk. Protocols to be put in place on the usage of new drugs locally following SMC approval. Action plans have been produced to:

- Promote cost effective prescribing;
- Engage more with secondary care clinicians;
- Ensure key individuals are aware of SMC decisions/recommendations and support development of a business case, if appropriate;
- Promote more appropriate prescribing of oral nutritional products
- Highlight to the public how to avoid waste through campaigns.

EH highlighted incentive scheme graphs to members of the committee which will be circulated.

Action: GS/DB

MP explained the GP incentive scheme which allows money to go back into the practice when prescribing savings have been made with prescribing targets set locally by the Area Drugs and Therapeutics Committee. This has been successful in engaging with GPs around cost-effective prescribing.

CM requested that a paper is brought to the next meeting on QOF.

Action: LB

It was acknowledged that to significantly influence change in prescribing practice this should be done nationally in relation to dispensing doctors and pharmacy control regulations.

MP informed the committee that a Stoma working group had been set up to review spending levels on stoma products as NHS Dumfries and Galloway has the highest spend in Scotland.

Electronic prescribing in hospitals is being evaluated at the moment.

Lucentis – NHS Dumfries and Galloway had the second highest spend in Scotland but more recently, this has reduced to fourth in Scotland. The committee agreed that performance requires to be approved.

MK suggested a Board workshop to discuss all the issues.

The Scrutiny Committee agreed to:

- A Board workshop on Prescribing **Action: JGB/MK/MP**
- Progress on action plan to come back in 6 months (4 November) **Action: GS**
- A QOF report to come back to the next meeting **Action: LB**
- A benchmark report to be produced. CM offered some non recurring funding to support this. **Action: MP**
- An incentive scheme approach should be looked at with regard to prescribing of anti depressants (HEAT target). **Action: MP**

MK thanked MP, PB, SR, GS for attending and they left the meeting.

5. Regional Radiotherapy Staffing Business Case

VF provided background to the paper explaining that the original business case was now over two years old. The existing paper is a précis of the original business case.

It was highlighted that the funding contained within this paper did not include medical staffing costs or costs to fund horizon scanning future developments. It is anticipated that papers relating to these two areas of service will be submitted in due course.

This paper is looking to fund core non-medical radiotherapy staffing to maintain the current service based on the increasing number of patients diagnosed with cancer and the changing modalities of radiotherapy delivery.

It was confirmed that this business case was included within the priorities for SEAT and CM confirmed that monies have been identified within the Financial Plan as a regional development.

The Chair asked what the consequences were of not funding the business case. VF stated that Lothian has confirmed that patient safety is and will remain the priority. Non-funding of the business case would result in the limitation of some modalities of radiotherapy, future development and clinical trials.

There was a brief discussion regarding the current status with regard to Lothian oncology cover on a Monday. VF confirmed that the oncologist from Lothian who usually provides this service is off sick and Lothian state that they are unable to provide any cover from the cancer centre. Lothian and Dumfries and Galloway have implemented a contingency plan in the meantime ensuring that patients are saved from travelling wherever possible and their care continues to be delivered in DGRI wherever deemed clinically appropriate to do so.

There was some discussion around cost-benefit analysis for treatments and medication.

The Committee approved the paper subject to clarification of governance.

Action: CM

MK thanked VF for attending and she left the meeting.

6. Dumfries Dental Centre (DDC)

PMcC confirmed this project had been completed on time and on budget as per the Business Case. An award had been received due to its success.

However, the late decision to relocate Nithbank Dental Service presented pressures to the original building specification.

There needs to be clarity as to who has the authority to make late business case changes; clearly defined roles and responsibilities are required. This will be controlled in future projects via the newly formed CIG.

PMcC to provide a post project evaluation to CM which will be compliant with the Scottish Capital Investment Manual (SCIM). This was also agreed for all future projects.

Action: PMcC

PMcW confirmed:

- the appointment of a Dental Therapist was a new development;
- Dental Practitioners are not at full complement;
- An additional outreach tutor has just been appointed;
- Emergency service is provided on Sundays;
- Currently, Loreburn Dental Centre provides emergency service on Saturdays although by the Autumn, the DDC should be providing this.

The Committee noted the life span of the building to be 60 years. The efficient usage of the centre continues to be an issue and will require to be addressed as part of the estate review.

The Committee noted the report.

MK thanked PMcC and PMcW for attending and they left the meeting.

7. Endowment Investment Strategy

The Committee noted the report and agreed to the recommendations on the basis of the paper.

8. Efficiency Programme 2009/10

CM informed the Committee of the formation and objectives of the Efficiency Group.

The Committee noted:

- the remit and membership of the newly formed Efficiency Group;
- the progress on the programme for 2009/10;
- the intention to provide a level of detail in monthly reports to Board.

Action: CM/JA

9. Revenue and Capital – Month 12 Position

A verbal update was provided by KL who confirmed that the Board had achieved financial targets for 2008/09, subject to audit. The Committee acknowledged this achievement.

10. Capital Investment Group (CIG)

CM and JA will assist the Hospital Management Group (HMG) and the Local Health Partnership Management Group (LHPMG) to filter and prioritise any proposals before their submission to the CIG. Representatives from each of these groups will be designated as members of the CIG.

Action: CM/JA

The Committed noted:

- the revised approval process for Capital projects;
- the remit and membership of the group.

11. Short-Term Augmented Response Service (STARS)

JA confirmed this paper had previously been presented to the Social Work Committee. An SLA has been produced for both the Council and Health Finance Departments for this service which has still to be agreed.

The Council has approved this paper with a caveat re financial costs. KL to lead on work to develop SLA.

The Committee noted a further report will be required.

Action: JA/KL

12. Costed Project Plan for DGRI Refurbishment and Mental Health

JA/KL tabled a report.

JA to present a report to the May Board 'In Committee' for formal approval.

The Committee:

- noted local companies will be used as sub contractors;
- agreed to the principles and recommendations of the paper which will be submitted to the May Board meeting;
- requested a paper to come back to the Scrutiny Committee for a fuller discussion.

Action: KL/JA

13. Any other business

- (i) JA to bring back to the next meeting a revised Performance Report presentation.

Action: JA

- (ii) GG to be asked to attend the next meeting to give a presentation on Data Dashboards.

Action: GG

14. Date and time of next meeting: Tuesday 30 June 2009 at 9.00m.

DUMFRIES and GALLOWAY NHS BOARD

6 July, 2009

Register of Members' Interests**Author:**
Jennifer Wilson, Board Administrator**Sponsoring Director:**
John Burns, Chief Executive**Date:** 5 June, 2009**RECOMMENDATION**

The Board is asked to note the revised Register of Members' Interests.

SUMMARY

Board Members of devolved public bodies are required to give notice of their interests and the NHS Board is required to maintain a Register of Members' Interests. The register is updated on a regular basis to reflect changes in Members' entries.

Whilst it is the responsibility of each Member to advise the Board Administrator of any changes within one month of the change arising, the register will be reviewed twice a year and presented to Board for their interest and note.

The Board Administrator will keep the register of interests available for public inspection at the Board's offices during normal working hours without charge.

MONITORING FORM

Policy / Strategy Implications	<i>No policy / strategy implications.</i>
Staffing Implications	<i>No staffing implications.</i>
Financial Implications	<i>No financial implications.</i>
Consultation	<i>Complies with regulations, no consultation required.</i>
Consultation with Professional Committees	<i>Complies with regulations, no consultation required.</i>
Risk Assessment	<i>Ensure compliance with regulations.</i>
Best Value	<i>Sound governance.</i>
Compliance with Corporate Objectives	<i>Corporate Objective 7.</i>
Impact Assessment	<i>Not required.</i>

DUMFRIES AND GALLOWAY NHS BOARD



REGISTER OF MEMBERS INTERESTS

June 2009

Registration of Interests

Board members of devolved public bodies are required by the Regulations to give the 'Standards Officer' notice of their interests. The Register must state:

the name of the board member;

their interests which fall within the categories listed below and as set out in the member's code of conduct; and

if they have nothing to register they must record that fact under each applicable category.

It is the responsibility of each board member to ensure that their entry in the register is kept up to date. Any changes to the information first registered, must be given in writing to the standards officer, in the prescribed format, within one month of the change arising.

The 'Standards Officer' (Board Administrator) will keep the register of interests available for public inspection at the Board's offices during normal working hours and without charge.

Column 1 Registerable interest category	Column 2 Description of interest	Column 3 Members Registering an Interest in this Category (and Description of interest)	
		MEMBER	REGISTERED INTEREST
Gifts and hospitality	A description of any gifts or hospitality received .		No Member registered an Interest in this Category
Category 1 - Remuneration NOTE: You do not need to register the amount of remuneration	A description of (a) remuneration received by virtue of being:– (i) employed or self-employed; (ii) the holder of an office; (iii) a director of an undertaking; (iv) a partner in a firm; and (v) involved in undertaking a trade, profession, vocation or any other work; (b) any allowance received in relation to membership of any organisation; (c) the name, and registered name if different, and nature of any applicable employer, self-employment, business, undertaking or organisation; (d) the nature and regularity of the work that is remunerated; and (e) the name of the directorship and the nature of the applicable business.	Mr D Lockhart Mrs H Dykes Dr A Cameron Mrs H Brash Dr R Park Mr E N Hunter MBE Mr I Hyslop Mr A Johnston Mr A Campbell	Senior Charge Nurse, Dumfries and Galloway Health Board AHP Clinical Head of Service Partner, Bygate Hall Farming Partnership Convener, Waterwatch, Scotland General Medical Practitioner Lead Clinician, Dumfries and Nithsdale LHCC Lead Clinician, Out of Hours Service Mentoring for Business Gateway Local Councillor and Leader, Dumfries and Galloway Council Service Development Manager, Multiple Sclerosis Society Area Co-ordinator and Board Member of Scottish Natural Heritage Partner, Messrs Andrew R Campbell Farming

Category 2 - Related undertakings	A description of a directorship that is not itself remunerated, but is of a company or undertaking which is a parent or subsidiary of a company or undertaking which pays remuneration.		
Column 1 Registerable interest category	Column 2 Description of interest		
Category 3 - Contracts	A description of the nature and duration, but not the price of, of a contract which is not fully implemented where:- (a) goods and services are to be provided, or works are to be executed for the NHS; and (b) any responsible person has a direct interest, or an indirect interest as a partner, owner or shareholder, director or officer of a business or undertaking, in such goods and services.		No Member registered an Interest in this Category
Category 4 - Houses, land and buildings	A description of any rights of ownership or other interests that may be significant to, of relevance to, or bear upon, the work or operation of the NHS Board		No Member Recorded an interest in this category
Category 5 - Shares and securities	A description, but not the value, of shares or securities in a company, undertaking or organisation that may be significant to, of relevance to, or bear upon, the work or operation of the NHS Board		No Member Recorded an interest in this category

Category 6 - Non-financial interests	A description of such interests as may be significant to, of relevance to, or bear upon, the work or operation of the NHS Board, including without prejudice to that generality membership of or office in:– (a) other public bodies; (b) clubs, societies and organisations; (c) trades unions; and (d) voluntary organisations.	Mr K Warford Mr D Lockhart Mr M Keggans Ms Caroline Sharp Mr Andrew Campbell Dr R Park Mrs H Brash Mr E Hunter Mr I Hyslop	Member, Castle Douglas Rotary Club Member, Scottish Terms and Conditions Group Member, Scottish Diversity Group Chairman, Crichton Development Company Director, Crichton Trust Trustee, Crichton Foundation Board Member, Nith District Salmon Fishery Board Secretary, Templand Community Council Scottish Director, NFU Mutual Member, Scottish National Heritage Board Member, Castle Douglas Rotary Crichton Development Company Member British Medical Association Director, Alcohol and Drugs Support SW Scotland Member, Relationships Scotland Dumfries & Galloway Chair, Clarebrand Village Hall Committee Member Thornhill and District Rotary Club Trustee, Wanlockhead Lead Mining Museum Director, Solway Heritage Director, Crichton Trust
Election expenses	A description of, and statement of, any assistance towards election expenses relating to election to the devolved public body.		No Member Recorded an interest in this category

DUMFRIES and GALLOWAY NHS BOARD

6 July 2009

Consultant Recruitment Process



Author:

Caroline J Sharp
Director of HR & Workforce Strategy

Sponsoring Director:

Caroline J Sharp
Director of HR & Workforce Strategy

Date: 26 June 2009

RECOMMENDATION

The Board is requested to formally accept ownership and responsibility of the Consultant recruitment process for NHS Dumfries & Galloway, with effect from 1 July 2009 in accordance with CEL(2009)25 and note that the management of and decisions taken regarding the appointment of Consultant posts advertised on or after 1 July 2009 are the responsibility of NHS Dumfries and Galloway. The Board is further requested to formally delegate authority for offers of employment to the nominated Chair for selection panels.

SUMMARY

This paper describes the key changes that came into force on 1 July 2009 in respect of Consultant recruitment across the NHS in Scotland and the implications for NHS Dumfries and Galloway.

Introduction

The regulations and practices for Consultant Recruitment have been reviewed by SGHD in consultation with the service and all other key stakeholders.

Previously subject to extensive regulation, the consultant recruitment process for NHS in Scotland has been revised, providing NHS Dumfries and Galloway with ownership of the Consultant appointment process for appointments in our Board for all posts advertised on or after 1 July 2009. CEL(2009)25 – The NHS (Appointment of Consultants)(Scotland) Regulations 2009 was issued on 29 June 2009 and provides direction to Boards

Externality is required within this process and Regulations require NHS Dumfries and Galloway to include an External Advisor in the appointment of doctors to the Consultant grade.

The inclusion of a trained External Advisor from a different Board is intended to ensure that the clinical quality of appointed candidates is maintained. The External Advisor will have been trained in selection process and, with experience of other appointments, can provide advice on the appointment from a different perspective than the local clinical team.

Regulation of the Consultant Recruitment Process

Whilst the majority of the actions within the Consultant recruitment process, which were previously subject to regulation, now lie with the Health Board who hold responsibility for the process, elements of the process are still subject to regulation and remain under statutory control.

The regulations are set out within The National Health Service (Appointment of Consultants) (Scotland) Regulations 2009, and in summary apply to the following aspects of the Consultant recruitment process:

- i. the delegation of authority of the Chair to make Consultant appointments on behalf of the Health Board;
- ii. the inclusion of an External Advisor and their role within the Consultant recruitment process
- iii. the requirement for and composition of an assessment panel to conduct the candidate selection and make a decision by vote

To ensure clarification during the transition to this revised recruitment process the regulations also confirm the effective date for the application of this revised Consultant recruitment process as being 1 July 2009 and describe the transition arrangements for posts advertised prior to that date.

Key Roles within the Recruitment Process

Within the revised process it is for NHS Dumfries and Galloway to determine the staff and their roles within the process, however our recruitment process should include the following key roles:

The Board Lead Officer

The Board should identify a Lead Officer to manage an individual recruitment process with support from the HR department. Within the revised process it is anticipated that this Lead Officer will often be a medical manager, or a lead clinician from within the service or the service manager.

Chair

The Chair of the panel has delegated authority from the recruiting Board to make an offer of employment. This authority is contained within the regulations. We may choose to delegate this authority to the Lead Officer, or may alternatively choose a senior manager to chair the assessment panel.

External Advisor

The regulations require that a single External Advisor is included on the assessment panel for Consultant appointments within NHS in Scotland. The role of the External Advisor will be to advise NHS Dumfries and Galloway on each stage in the process, including commenting and advising on the job description, person specification, the selection methodology and participating in the selection process. This External Advisor is identified from the list of External Advisors maintained by the Royal Colleges and must be external, ie. not employed by NHS Dumfries and Galloway and must be in the same specialty as the post being appointed to. In rare instances of small specialties it may be necessary to seek an External Advisor from outwith Scotland.

The Assessment Panel

The assessment panel is convened by the Board to conduct the candidate assessment. Within this revised process we determine both the selection methodology for appointing to Consultant posts and the assessment panel appropriate to best support and facilitate the methodology chosen to assess the suitability of candidates. This assessment may include profiling, aptitude tests or multi-station interviews. The panel should include as least one Consultant from the specialty.

While there is no set limit on the size of the panel, under the regulations it remains that the panel must include a Chair, with delegated authority from the Board, and an External Advisor as outlined above. All members of the assessment panel hold equal responsibility for raising concerns at any stage within the recruitment process with the Chair, and procedures should be in place to deal with concerns raised.

Policies, Procedures and Processes

CEL (2009)25 places an expectation of Boards to draw up a policy on the use of visits as part of the employment process and to communicate this policy to all applicants and across the Board to ensure the policy is applied fairly and consistently.

Boards will also be expected to advertise details of vacant posts widely and use the SHOW (Scotland's Health on Web) vacancy database.

Boards will be expected to have and conduct a thorough and robust appointment process, including sourcing and utilisation of the external advisor as described in the regulations, taking responsibility for offering and contracting successful candidates and notifying the external advisor of unsuccessful candidates. Candidate appeals will be dealt with through the appointing Board.

The Director of HR & Workforce Strategy, together with the Medical Director, will ensure that policies and procedures are developed and implemented in accordance with the CEL and that these policies and procedures are communicated to panels, candidates and other stakeholders.

MONITORING FORM

Policy / Strategy Implications	This paper supports the Boards workforce strategy
Staffing Implications	The CEL will impact on Consultants recruited into our workforce
Financial Implications	None identified
Consultation	This has been set under direction from SGHD
Consultation with Professional Committees	This has been set under direction from SGHD
Risk Assessment	A risk assessment is not appropriate for this paper
Best Value	This paper has been set under direction from SGHD
Compliance with Corporate Objectives	Corporate objective 3
Impact Assessment	This paper has been set under SGHD direction. Subsequent locally developed policies and procedures will require to be impact assessed during development

DUMFRIES and GALLOWAY NHS BOARD

6 July 2009

Financial Performance: 2 Months to 31 May 2009



Author: Katy Lewis
Deputy Director of Finance

Sponsoring Director: Craig Marriott
Director of Finance

Date: 18th June 2009

RECOMMENDATION

The Board is asked to note the report.

SUMMARY

The purpose of this report is to advise the Board of the financial position of NHS Dumfries and Galloway for the first two months of the financial year 2009/10.

Summary Financial Position

1. Overall NHS Dumfries and Galloway is reporting an underspend to date of £335k for the first two months of the financial year.
2. Efficiency savings of £2.8m have been deducted from operational budgets at the start of the financial year. Additional funding of £0.732m recurring and £0.76m non recurring has been released into opening budgets to cover known overspends and cost pressures.
3. The Board reporting has been revised this month from previous years to reflect an Acute/Primary Care/Corporate split to expenditure and hence the narrative follows. This is in line with the revised governance structures which directly reports through the Hospital and LHP Management Groups.
4. Appendix 2 provides a detailed analysis by department of the financial position to 31st May 2009. This will be further refined during 2009/10 to enhance the quality of reporting provided to Board Members.

Revenue Resource Limit (RRL)

5. The revenue resource limit as notified by the Scottish Government Health Department (SGHD) has increased by £4.728m to £237.63m since the baseline allocation was notified in February. In addition a further £29.313m is expected to be received during the year, resulting in an anticipated RRL of £266.943m. The final carry forward position from 2008/09 is £4.484m and the RRL figures include this as an anticipated allocation for 2009/10.

6. Appendix 1 provides details of allocations received during April and May. This confirms that Sexual Health Strategy and Smoking Prevention and Cessation allocations are now recurrent.
7. An indicative allocation of £14.111m to match Family Health Services net expenditure forecast during 2009/10 is included in the financial plan. This relates to Dental, Ophthalmic and Pharmacy costs which are financed through the existing "Non Cash Limited" funding streams. This funding can be drawn done to match exactly expenditure which is still classified under these areas.

Acute Services

8. Acute services is reporting an overall overspend of £3k at 31st May 2009.
9. The main area which are contributing to the overspend is the Surgical Directorate (£102k). This is offset by compensating underspends in Allied Health Professionals (£29k) and Anaesthetic Directorate (£40k). Refer to Appendix 2 for further details.
10. Medicine, Surgery and Anaesthetics combined are £64k overspent to date with pay expenditures, including medical and nursing pays, contained within budget. It is anticipated that medical pay budgets will come under some considerable pressure over the next few months due to high levels of long term sickness and these will need to be carefully monitored.
11. Non pays are overspent by £116k to May, primarily in surgical stores (£49k) and drugs (£47k). A review of the use of new SMC approved drugs is underway scheduled to complete for the quarter 1 financial review, and it is expected that some of this overspend will be attributed to new drugs. However the high and increasing use of Lucentis continues and despite rebasing drugs budgets at the start of 2009/10 to reflect current activity levels, ophthalmology drugs budgets are showing an overspend at May 2009. Surgical stores and other direct clinical supplies are overspent by £49k to May. The General Manager is leading work to identify why the overspend highlighted during 2008/09 is continuing despite additional funding released to budgets at the start of the year. This includes reviewing changes to activity, use of loan kits and, phasing of spend, high cost cases to understand what the impact will potentially be on the outturn position. Some of the costs can be attributed to the increase in prices from the National Distribution Centre but this only explains part of the increase.
12. The ongoing underspend in Allied Health Professionals of £29k to May 09 reflects the continued difficulty to recruit to staff. This will continue to be monitored as the need for ongoing service provision through use of locums may impact adversely on the financial position.

Community and Primary Care Services

13. Community and primary care services are reporting an overall underspend to date of £288k.

14. All LHPs, with the exception of Wigtownshire, are showing an underspent position at May, even with the reduction of budgets for efficiency savings.
15. Wigtownshire LHP year to date position to May 2009 is £26k overspent, this is after reducing budgets by the efficiency target of £165k. The key areas of concern are District Nursing (£17k), Newton Stewart Health Centre property costs (£9k) and Galloway Community Hospital Hotel Services (£16k) which are all overspent as at May.
16. Budgets for District Nursing have been rebased this month and corrective action has been agreed to bring the costs within budget. A review by the central estates team is planned for all property costs with the variability of energy costs under the new contract, to assess potential for efficiencies and to identify the main risks.
17. Prescribing budgets show a balanced position for the period to May as no actual information has yet been received for 2009/10. A report detailing the final year end position for 2008/09 is included at Appendix 3, which shows that overall we underspent by just over £400k. Prescribing income is under budget to May but is expected to pick up during the year, the financial gap due to the phase out of prescription charges will be funded by SGHD.
18. The GMS contract agreement for 2009/10 has been reached in line with Doctors and Dentist Review Body (DDRB) recommendations. This allows for greater certainty for Primary Medical Services Allocations, which historically have not been released until much later in the financial year. The gross uplift to global sum figures of 2.29% means that on a national basis an additional £12m (approx) additional funding will be released to GMS practices. Budgets will need to be rebased to reflect the increases and the revised global sum position, there is not anticipated to be any financial impact.

Corporate Services

19. Corporate services are reporting an overall underspend to date of £49k.
20. Whilst externals and resource transfer expenditure is within budget to May, there are a number of pressures expected to impact on this budget during the year. This includes the impact of the higher average activity levels impacting on contractual agreements, MRI activity reductions as a result of local facility and high levels of out of region psychiatry activity levels further increasing from previous levels.
21. Operational services budgets show an underspend of £26k to May. Whilst this is encouraging, a number of areas within this directorate which have previously overspent are under review including maintenance expenditure, energy costs and domestic services. The outcome of this review will confirm whether the current reported position is sustainable.
22. The overspend in nursing directorate (£22k) is primarily related to the costs of the STARS extension project (£29k). A service level agreement is currently being worked on to reach agreement with Dumfries and Galloway Council on future funding mechanisms of the pilot.

Efficiencies

23. The Board has a 2% efficiency target for 2009/10, the agreed target for each budget area has been deducted from the opening budget position at the start of the financial year. Managers are expected to work with the Senior Finance Team to ensure the delivery of Cash Releasing Efficiency Savings (CRES) for 2009/10 and to develop plans for future years. Current government forecasts indicate that further efficiencies above 2% will require to be delivered from 2010/11 onwards.
24. Details of the CRES schemes are included in Appendix 4. Processes are being introduced to monitor monthly delivery against target and results will be reported from Month 3.

MONITORING FORM

Policy/Strategy Implications	N/A
Staffing Implications	N/A
Financial Implications	<i>Part of the financial planning and reporting cycle</i>
Consultation	N/A
Consultation with Professional Committees	N/A
Risk Assessment	<i>Part of paper.</i>
Best Value	<i>This paper contributes to Best Value goals of sound governance, accountability, performance scrutiny and sound use of resources.</i>
Compliance with Corporate Objectives	<i>Underpins achievement of many corporate objectives.</i>
Impact Assessment	
N/A	

**NHS DUMFRIES AND GALLOWAY
REVENUE RESOURCE ANALYSIS
AS AT 31st MAY 2009**

	Baseline Recurring £000s	Earmarked Recurring £000s	Non Recurring £000s	Total £000s
Formula Allocation	232,902			232,902
NHS Carer Information Strategy			97	97
Sexual Health Strategy	147			147
Blood Borne Virus Prevention	142			142
Nutrition Champion			40	40
Maternal and Infant Nutrition			207	207
Transition Fund for HLC			70	70
Drug Treatment and Rehabilitation		568		568
Drug and Alcohol Action Team Support		132		132
Mental Health Collaborative Q1			23	23
18 Week Referral to Treatment time Q1			67	67
Long Term Conditions Collaborative Q1			23	23
Access Support Cardiac funding		44		44
Access Support General Waiting Times		325		325
Access Support Diagnostics funding		465		465
Patients Right & Waiting Times - 15 & 12 weeks		1,069		1,069
CYP Specialist Services National Delivery Plan			209	209
Smoking Prevention Action Plan	54			54
Smoking Cessation Services	231			231
Enhanced services additional allocation		382		382
Respiratory MCN			50	50
Hepatitis C phase 2 Action Plan			383	383
Revenue Allocation as at 31st May 2009	233,476	2,985	1,169	237,630
Anticipated Allocations		21,795	7,518	29,313
Total Revenue Allocation	233,476	24,780	8,687	266,943

NHS DUMFRIES AND GALLOWAY EXPENDITURE ANALYSIS 2 MONTHS ENDED 31st MAY 2009																	
Annual Pay Budget £000	Annual Supplies Budget £000	Annual Income Budget £000	Total Budget £000		Pays			Supplies			Income			Total			Cum Var %
					Expend £000	Budget £000	Variance £000	Expend £000	Budget £000	Variance £000	Income £000	Budget £000	Variance £000	Expend £000	Budget £000	Variance £000	
				Acute Services													
15,763	5,700	(17)	21,447	Medical Directorate	2,593	2,632	39	953	908	(45)	(7)	(3)	5	3,538	3,537	(2)	0.0%
13,080	3,886	(17)	16,948	Surgical Directorate	2,220	2,190	(30)	702	626	(76)	(7)	(3)	4	2,915	2,813	(102)	-3.6%
8,056	1,384	(3)	9,437	Anaesthetics Directorate	1,302	1,343	41	222	220	(2)	(3)	(2)	1	1,521	1,561	40	2.6%
3,273	77	0	3,350	Access and Waiting Times	326	358	31	77	77	0	0	0	0	403	434	31	7.2%
1,823	1,977	(109)	3,691	Cancer Services Directorate	304	307	3	321	316	(5)	(25)	(25)	0	599	598	(2)	-0.3%
8,231	723	(25)	8,929	Womens Directorate	1,410	1,406	(3)	124	121	(3)	(5)	(4)	1	1,529	1,523	(6)	-0.4%
2,636	530	(30)	3,136	Allied Health Professionals	417	444	27	80	83	3	(15)	(15)	(1)	483	512	29	5.7%
5,111	2,217	(51)	7,277	Labs Directorate	832	852	20	384	369	(15)	(7)	(9)	(2)	1,209	1,213	4	0.3%
2,586	570	(14)	3,143	Radiology Directorate	471	446	(25)	63	90	27	(5)	(2)	2	529	534	5	0.9%
60,560	17,065	(267)	77,357		9,874	9,977	103	2,925	2,809	(116)	(74)	(63)	10	12,726	12,723	(3)	0.0%
				Community & Primary Care Services													
6,543	1,211	(211)	7,543	Annandale & Eskdale	1,074	1,080	5	193	196	4	(38)	(35)	2	1,229	1,241	11	0.9%
4,770	1,416	(236)	5,950	Nithsdale	821	803	(18)	174	233	59	(44)	(39)	4	951	997	46	4.6%
3,802	976	(313)	4,465	Stewartry	605	634	29	140	156	17	(56)	(52)	4	689	738	49	6.7%
8,640	1,744	(383)	10,000	Wigtownshire	1,429	1,426	(3)	308	287	(20)	(61)	(64)	(2)	1,676	1,650	(26)	-1.6%
0	28,883	(885)	27,999	Prescribing	0	0	0	4,814	4,820	6	(124)	(147)	(24)	4,690	4,672	(18)	-0.4%
325	37,148	(1,302)	36,172	Primary Care	61	54	(7)	6,100	6,182	82	(217)	(217)	0	5,944	6,019	75	1.2%
11,458	1,152	(246)	12,363	Mental Health Directorate	1,877	1,910	33	187	180	(7)	(42)	(41)	1	2,022	2,049	27	0.3%
3,417	155	(943)	2,629	Learning Disability Directorate	572	570	(2)	22	25	2	(157)	(157)	(0)	437	437	(0)	0.0%
2,141	138	(424)	1,855	Psychology Directorate	348	364	16	28	22	(7)	(89)	(75)	15	287	311	24	7.7%
1,125	651	(80)	1,696	Substance Misuse	173	187	14	115	108	(7)	(12)	(13)	(1)	277	283	6	2.1%
6,146	533	(492)	6,187	Child Health	964	1,024	61	87	89	2	(68)	(82)	(14)	982	1,031	49	4.7%
951	150	(597)	505	Community Dental	153	159	5	11	25	13	(106)	(99)	6	59	84	25	29.5%
1,199	100	(245)	1,054	Speech & Language Therapy	187	200	13	16	17	1	(41)	(41)	1	162	176	14	7.8%
2,964	261	(203)	3,022	GP Out of Hours	466	494	28	39	35	(4)	(31)	(34)	(3)	475	495	21	4.2%
506	73	(2)	578	Family Planning & Sexual Health	89	84	(4)	22	12	(10)	(0)	(0)	0	111	96	(14)	-14.8%
53,987	74,591	(6,561)	122,017		8,819	8,988	169	12,258	12,389	131	(1,086)	(1,098)	(12)	19,991	20,279	288	1.4%
				Corporate Services													
1,493	30,038	(3,665)	27,865	Externals & Resource Transfer	223	249	26	5,155	5,147	(9)	(602)	(609)	(6)	4,776	4,786	11	0.2%
8,641	11,559	(1,102)	19,098	Operational Services	1,405	1,438	33	1,864	1,867	3	(174)	(184)	(10)	3,095	3,121	26	0.8%
1,146	106	(58)	1,195	Medical Director	198	191	(7)	27	17	(10)	(11)	(10)	1	214	198	(16)	-8.0%
1,881	537	(573)	1,845	Director of Nursing and Quality	343	316	(28)	90	93	3	(98)	(96)	3	335	313	(22)	-7.1%
3,673	1,677	(669)	4,681	Director of Public Health	625	625	(0)	263	286	23	(108)	(120)	(11)	780	791	11	1.4%
595	76	0	670	Director of Health Services	98	98	(0)	14	8	(7)	0	0	0	113	106	(7)	-6.4%
407	1,281	0	1,689	Chief Executive	68	67	(0)	203	200	(2)	0	0	0	270	268	(3)	-1.0%
2,220	10,330	(5,174)	7,376	Finance Directorate	353	370	17	1,589	1,577	(12)	(900)	(862)	38	1,041	1,084	43	4.0%
1,097	527	(79)	1,545	Director of HR & Workforce Strategy	186	177	(8)	67	71	4	(12)	(14)	(2)	240	234	(6)	-2.5%
1,251	1,180	(153)	2,277	eHealth	201	208	8	152	158	6	(78)	(80)	(1)	275	287	12	4.2%
0	11,839	0	11,839	Reserves	0	0	0	0	0	0	0	0	0	0	0	0	0.0%
22,404	69,151	(11,475)	80,080		3,699	3,739	40	9,424	9,423	(2)	(1,984)	(1,974)	11	11,139	11,188	49	0.4%
136,951	160,807	(18,303)	279,455	Total	22,393	22,705	312	24,607	24,620	13	(3,144)	(3,134)	9	43,856	44,191	335	0.8%

PRESCRIBING EXPENDITURE IN PRIMARY CARE (GENERAL PRACTICE)

Budget and Expenditure April 2008 - March 2009 – Year End Position

The underspend for the month of March was much higher than predicted, at £278k. This appears to be mostly due to a very high allocation in March and means the overall underspend has increased to £875,169 (GIC) or 2.85%. Underspend at NIC is just over £400k. See Table 1 for details.

Table 1 – Primary Care Prescribing Expenditure, April-March 200/098 (GIC)

LHP	Allocation (£)	Expenditure (£)	Over(-)/underspend (£)	Over(-)/underspend (%)
Dumfries & Upper Nithsdale	£10,073,863	£9,730,457	£343,406	3.4%
Annandale & Eskdale	£6,880,176	£6,610,787	£269,389	3.9%
Stewartry	£4,397,107	£4,239,538	£157,569	3.6%
Wigtownshire	£6,434,945	£6,000,236	£434,709	6.8%
Non-LHP Expenditure plus High Cost Drugs	£2,931,563	£3,261,470	-£329,907	-11.3%
TOTAL	£ 30,717,654	£ 29,842,487	£875,167	2.85%

Table 2 below compares expenditure in April 07 - March 08 with April 08 - March 09. The year on year change for Dumfries and Galloway was a decrease of 0.6%, slightly lower than last month. This compares favourably with Scotland as a whole where expenditure actually increased by 0.5%.

Table 2 – Comparison of Expenditure 2007/08 and 2008/09 (GIC)

LHP	Expenditure to March 08 (£)	Expenditure to March 09 (£)	Increase Year on Year (%)
Dumfries & Upper Nithsdale	£ 9,810,338	£9,730,457	-0.8%
Annandale & Eskdale	£ 6,677,880	£6,610,787	-1.0%
Stewartry	£ 4,302,249	£4,239,538	-1.5%
Wigtownshire	£ 6,327,080	£6,000,236	-5.2%
Non-LHP Expenditure incl. High Cost Drugs	£ 2,892,881	£3,261,470	12.7%
TOTAL	£ 30,010,427	£ 29,842,487	-0.6%
<i>Scotland</i>	£ 968,033,562	£973,310,735	0.5%

Although total expenditure in Dumfries & Galloway fell by 0.6%, the level of prescribing, as measured by Daily Defined Doses (DDDs) has increased by 4.8%, see Table 3. DDDs in Scotland overall increased by an average of 5.7%.

Table 3 – Comparison of DDDs prescribed, 2007/08 and 2008/09

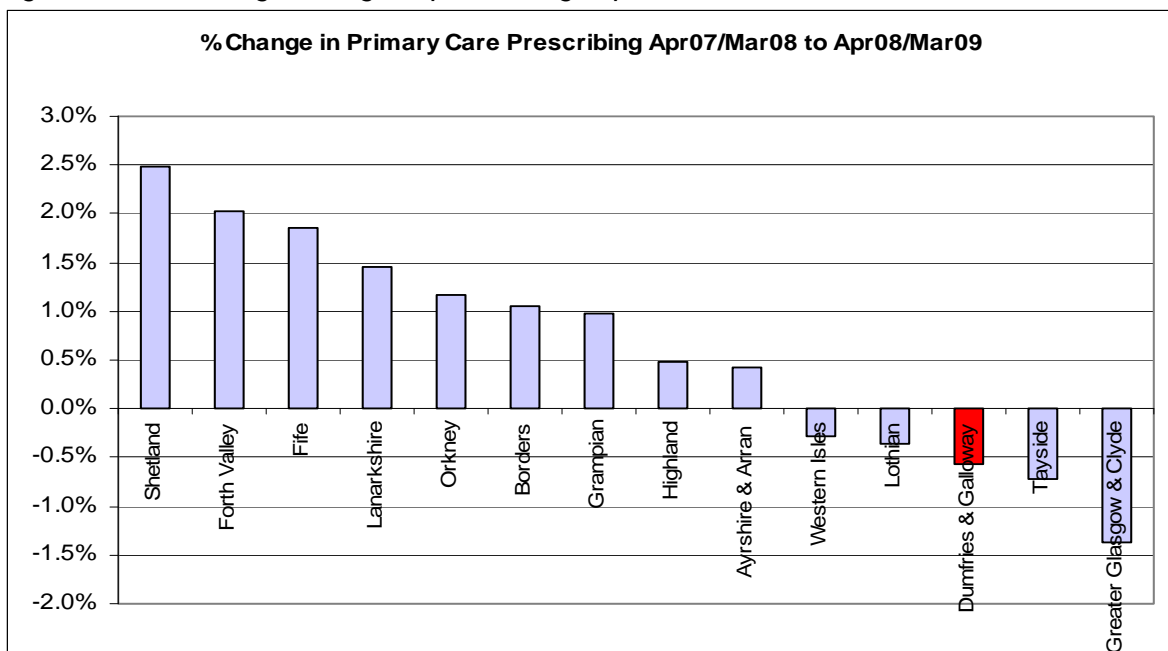
LHP	DDDs prescribed to March 07	DDDs prescribed to March 08	Increase Year on Year (%)
Dumfries & Upper Nithsdale	30,549,825	32,062,724	5.0%
Annandale & Eskdale	21,508,092	22,531,250	4.8%
Stewartry	12,794,982	13,465,038	5.2%
Wigtownshire	18,293,001	19,051,491	4.1%
DUMFRIES & GALLOWAY LHP TOTAL	83,145,900	87,110,503	4.8%
<i>Scotland</i>	2,086,864,305	2,205,551,311	5.7%

Comparison of spend with other Scottish Health Boards

Total Spend

As discussed above, Primary Care prescribing was lower in 2008/09 than the previous year. One reason for this is that there have been significant price reductions. However, when comparing ourselves to other Scottish Health Boards, we see that NHS Dumfries and Galloway has performed far better than the majority, despite the fact that all have faced the same price falls. See Figure 1 below. Over this period we also moved the prescribing of anticholinesterase drugs (over £250k) from secondary to primary care, if this had not happened the fall would have been even larger.

Figure 1 – Percentage change in prescribing expenditure



Cost per Patient

We now have the full year's data for 2008/09 so this is a good time to review our comparative cost per patient with other Scottish health Boards. In 2006/07 NHS Dumfries and Galloway had the highest unweighted cost per patient (mainland health boards), we now have the 4th highest, see Table 4.

Are we comparing like with like? It is difficult to be sure but over this period we have transferred some secondary care prescribing to primary care (e.g. anticholinesterase drugs) and it seems that some health boards, e.g. Tayside, Forth Valley, continue to prescribe these in secondary care. Our performance may therefore be even better than these figures imply.

Table 4 – Cost per Unweighted Patient

	2006/07	2007/08	2008/09
Fife	£193.72	£196.70	£196.45
Forth Valley	£192.76	£193.53	£195.87
Lanarkshire	£193.70	£193.56	£195.36
Dumfries & Galloway	£195.23	£193.76	£191.57
Ayrshire & Arran	£190.82	£191.02	£191.06
Tayside	£186.96	£184.58	£183.38
Highland	£182.73	£182.68	£181.61
Greater Glasgow & Clyde	£186.19	£184.47	£180.35
Borders	£161.27	£163.00	£160.38
Grampian	£157.00	£155.85	£156.09
Lothian	£145.80	£144.56	£142.68

Despite the above comments, we know there is more we can do to reduce cost per patient, as discussed at recent ADTC meetings.

EFFICIENCY MONITORING SCHEDULE 2009/10

Appendix 4

		Data				
Division	Directorate/ Department	Sum of SGHD Target Figure	Sum of Deducted in base budget 2008/09	Sum of Deducted in base budget 2009/10	Sum of Still to be deducted from budgets 2009/10	Sum of Projected Saving CRES 09/10
Acute	Acute Services	250,000		250,000		250,000
	Allied Health Professionals	29,000		29,000		29,000
	Cancer Services	36,000		36,000		36,000
	Labs Directorate	72,000		72,000		72,000
	Radiology	31,000		31,000		31,000
	Waiting Times	600,000		600,000		600,000
	Womens Directorate	85,000		85,000		85,000
Acute Total		1,103,000		1,103,000		1,103,000
Corporate	Chief Executive	11,000		11,000		11,000
	Corporate	912,000	529,000	142,000	241,000	383,000
	Director of Health Services	10,000		10,000		10,000
	External Contracts	31,000		31,000		31,000
	Finance Directorate	47,000		47,000		47,000
	Human Resources	26,000		26,000		26,000
	IM&T	41,000		41,000		41,000
	Medical Director	24,000		24,000		24,000
	Medical Staff	110,000	110,000			0
	Nursing Directorate	49,000		49,000		49,000
	Operational Services	1,141,000	730,000	257,000	154,000	411,000
	Pharmacy Dept	22,000		22,000		22,000
	Public Health	70,000		70,000		70,000
Telecoms	200,000			200,000	200,000	
Corporate Total		2,694,000	1,369,000	730,000	595,000	1,325,000
LHP	Annandale & Eskdale LHP	144,000		144,000		144,000
	Child Health	63,000		63,000		63,000
	Community Dental	13,000		13,000		13,000
	Family Planning & Sexual Health	5,000		5,000		5,000
	GP Prescribing Efficiencies	223,000		39,000	184,000	223,000
	GPOOH	33,000		33,000		33,000
	Learning Disabilities	33,000		33,000		33,000
	Mental Health Service	250,000		250,000		250,000
	Nithsdale & Dumfries LHP	121,000		121,000		121,000
	Psychology	21,000		21,000		21,000
	Speech & Language Therapy	13,000		13,000		13,000
	Stewartry LHP	81,270		81,270		81,270
	Substance Misuse	12,000		12,000		12,000
Wigtownshire LHP	165,000		165,000		165,000	
LHP Total		1,177,270		993,270	184,000	1,177,270
(blank)	Name of Department/ Directorate Against which efficiency is relevant					0
(blank) Total						0
Grand Total		4,974,270	1,369,000	2,826,270	779,000	3,605,270

DUMFRIES and GALLOWAY NHS BOARD

6 July 2009

**Patients' Private Funds
for the year ended 31 March 2009**

Author:
Jim Steen, Head of Financial Services and
Procurement

Sponsoring Director:
Craig Marriott, Director of Finance

Date: 29 June 2009

RECOMMENDATION

The Board is asked to note the report.

SUMMARY

The Board is required to maintain records of patients' funds to ensure that these funds are properly managed and assets are safeguarded in accordance with procedures. These records have been audited and it is the auditor's opinion that they present fairly the state of the funds administered by the Board on behalf of its patients as at 31 March 2009.

MONITORING FORM

Policy/Strategy Implications	N/A
Staffing Implications	N/A
Financial Implications	N/A
Consultation	N/A
Consultation with Professional Committees	N/A
Risk Assessment	N/A
Best Value	N/A
Compliance with Corporate Objectives	N/A
Impact Assessment	
<ul style="list-style-type: none"> ▪ N/A 	



DUMFRIES AND GALLOWAY NHS BOARD

PATIENTS PRIVATE FUNDS

For the year ended 31 March 2009

INDEPENDENT AUDITORS' REPORT TO THE TRUSTEES OF DUMFRIES AND GALLOWAY HEALTH BOARD PATIENTS' FUNDS

We have audited the Abstract of Receipts and Payments of Dumfries and Galloway Health Board Patients Funds for the year ended 31 March 2009.

This report is made solely to the Trust. Our audit work has been undertaken so that we might state to the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of the Trust and Auditors

The Trust is required to maintain books and records of patients' funds to ensure that the funds are properly managed and assets safeguarded in accordance with procedures.

Our responsibility is to audit the Abstract of Receipts and Payments prepared by the Trust in accordance with International Standards on Auditing (UK and Ireland).

We report to you our opinion as to whether the Abstract of Receipts and Payments present fairly the state of the funds administered by the Trust on behalf of its patients. We also report to you if, in our opinion, the Trust has not kept proper accounting records, or if we have not received all the information and explanations we require for our audit.

Basis of audit opinion

We conducted our audit in accordance with International Standards on Auditing (UK and Ireland) issued by the Auditing Practices Board. An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the Abstract of Receipts and Payments.

We planned and performed our audit so as to obtain all the information and explanations which we considered necessary in order to provide us with sufficient evidence to give reasonable assurance that the Abstract of Receipts and Payments is free from misstatement, whether caused by fraud or other irregularity or error.

In forming our opinion we also evaluated the overall adequacy of the presentation of information in the Abstract of Receipts and Payments.

Opinion

In our opinion the Abstract of Receipts and Payments presents fairly the state of the funds administered by the Trust on behalf of its patients as at 31 March 2009.

Emphasis of Matter

In forming our opinion, we have relied on the systems of control implemented by the Trustees especially with regard to incoming resources received in cash. Where independent confirmation of the completeness of the accounting records was not therefore available we have accepted assurances from the management that all the transactions been reflected in the records. Our opinion is not qualified in this respect.

Armstrong Watson,
Accountants and Financial Advisors
51 Rae Street,
Dumfries.
DG1 1JD

NHS DUMFRIES & GALLOWAY

SFR 19.0

PATIENTS PRIVATE FUNDS

FOR THE YEAR ENDED 31 MARCH 2009

2008 £		TOTAL £
	RECEIPTS	
	Opening Balances:	
201459	Cash in Bank	211634
1700	Cash on Hand	1700
0	Other Funds	0
<u>203159</u>		<u>213334</u>
225494	From or on behalf of Patients	214397
12363	Interest on Patients' Fund Account	7079
<u>441016</u>	Total Receipts	<u>434810</u>
	PAYMENTS	
227682	To or on behalf of Patients	208214
0	Extra Comforts etc.	0
	Closing Balances:	
211634	Cash in Bank	224897
1700	Cash on Hand	1700
0	Other Funds	0
<u>213334</u>		<u>226597</u>
<u>441016</u>	Total Payments	<u>434811</u>
	Closing Balances accounted for as:	
	Patients' Personal Accounts	
213334	Credit Balances	226597
0	Less: Debit Balances	0
<u>213334</u>		<u>226597</u>
0	Interest Received but not Credited	0
<u>213334</u>	Total Closing Balance	<u>226597</u>

I certify that the above abstract of Receipts and Payments is correct, and in accordance with the Books of Account and that the Register of Valuables has been inspected and checked with property held.

Director of Finance _____ Date _____

The abstract of Receipts and Payments was submitted at the NHS Board Meeting on _____
and duly approved.

Chief Executive _____ Date _____

Auditor's Certificate

DUMFRIES and GALLOWAY NHS BOARD

6 July 2009

Access and Activity Report

Author:
Jennifer Watt, Divisional Finance Manager

Sponsoring Director:
Jeff Ace, Director of Health Services

Date: 30 June 2009

RECOMMENDATION

The Board is asked to note the contents of this report

SUMMARY

This report provides information on the level of clinical activity and access times achieved within services. It also highlights data on efficiency of services as measured against current HEAT targets

1. BACKGROUND

Table 1 summarises the access targets approved as part of our Local Delivery Plans from April 2009.

Table 1**Access to Service – recognising patients' need for quicker and easier use of NHS services**

- 48 Hour Access – GP Practice team
- Advance booking - GP
- Suspicion-of-cancer referrals (62 days)
- All Cancer Treatment (31 days)
- 18 weeks RTT
- New outpatients: Maximum 12 weeks from referral
- Inpatients & Day cases: Maximum 12 weeks
- Faster access to treatment for drug misusers
- Faster access to specialist Child and Adolescent Mental Health Services (CAMHS)

In addition to those above the following targets remain in place

Delayed Discharges	Zero
Ophthalmology	18 weeks from referral to procedure for cataracts
Cardiology	total target of 16 weeks for new angina patients (including tertiary treatment)
A&E	98% within 4 hours
Hip Fractures	98% surgery within 24 hours of admission

2. Current Position against Access Targets

Appendix 1 shows the waiting times for referral to treatment as at 31st May 09 for patients waiting for out patient appointments and inpatient / day case treatment. There were no breaches of the twelve week targets as at the end of May 2009.

The appendix also shows the waiting times for the key diagnostic tests as of 31st May 09. Diagnostic targets are all 4 weeks except ultrasound which is working towards 4 weeks by October 2009.

Table 2

The table below shows the current position against target in other areas.

	Most recent period of measurement	Target	Actual
Cancer			
62 Day Referral to Treatment Target for suspicion of cancer	To Mar 09	95%	94.2%
All cancer treatment 31days	To Mar 09	70%	73%
18 week RTT			
Admitted patient pathway performance	May 09	60%	87%
Admitted Patient pathway completeness	May 09	55%	67%
A&E attendances			
Attendances per 100k population	May 09	2720	2944
% of A&E waits under 4 hours	May 09	98%	98%

The above table is not complete. Information services are working with the relevant departments to be able report in full to the next Board. This work forms part of the "Data Dashboard" performance management data suite.

3. Current Performance against Clinical Efficiency Targets

The table below shows the current average performance against previous years average and year end target for clinical efficiency targets.

Table 3

Efficiency Targets	Target as at 31/3/10	Average 2008/09	Average to date 2009/10
Day Case rates	86%	73.6%	74.5%
Non routine Inpatients average length of stay	4	4.1	4.1
Review to new outpatient attendance ratio	1.9	2.0	2.2
Outpatient DNA rates New	4.8%	4.79%	4.45%

4. Activity

Appendix 2 shows the comparison of activity for the two months April and May for 2008/09 and 2009/10.

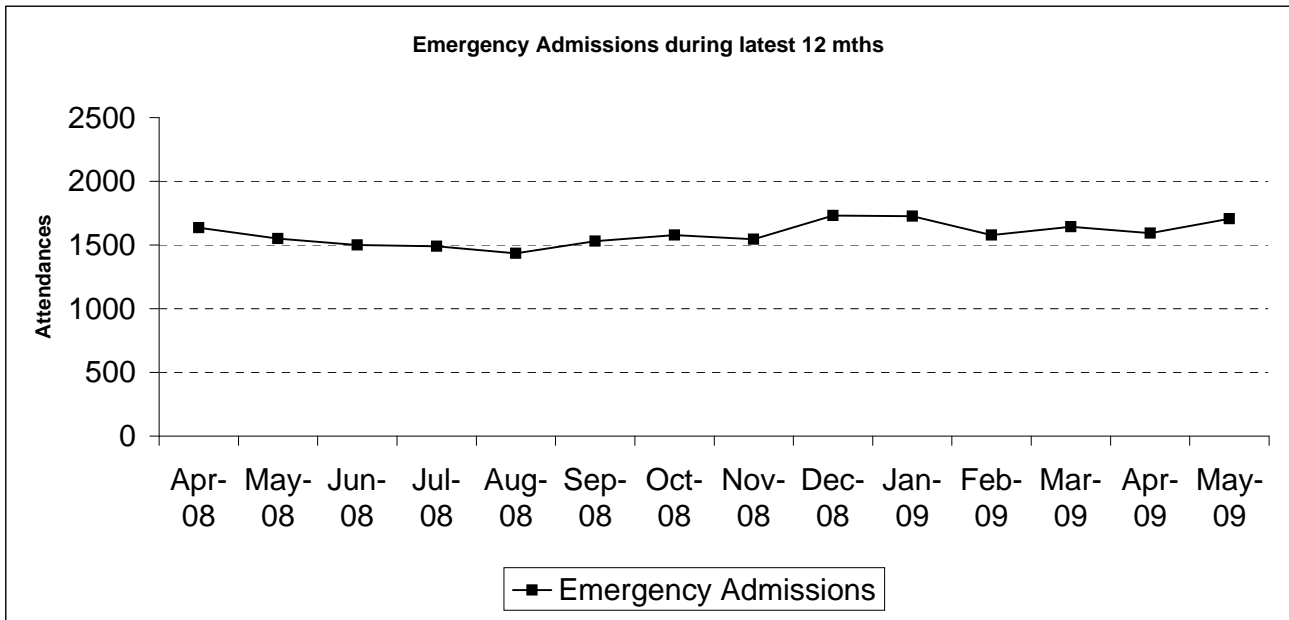
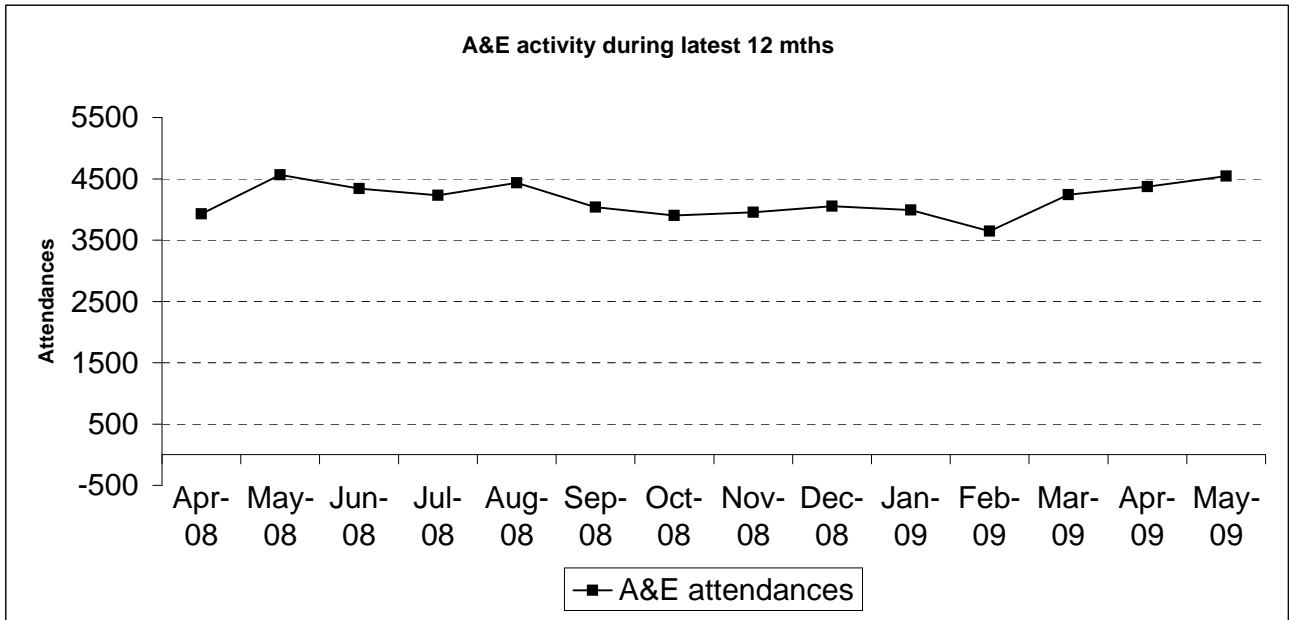
Appendix 3 shows trends in A&E activity and emergency admissions over a rolling 12 month period.

5. Conclusion

The performance against access and efficiency targets continues to be satisfactory in the majority of areas. Substantial work is ongoing to address improvement in a small number of areas.

MONITORING FORM

Policy / Strategy Implications	<i>Waiting Times</i>
Staffing Implications	<i>Additional internal capacity may impact on workload/staffing levels</i>
Financial Implications	<i>Discussed with Director of Finance and Director of Health Services</i>
Consultation	<i>As above</i>
Consultation with Professional Committees	<i>N/A</i>
Risk Assessment	<i>N/A</i>
Best Value	<i>Complies with principles of Best Value</i>
Compliance with Corporate Objectives	<i>Corporate Objective 7</i>
Impact Assessment	<i>Not required</i>



NHS Dumfries and Galloway

Comparison of Activity
April & May 2008/09 and 2009/10

		Cum Apr- May-08	Cum Apr- May-09	% Variance
Elective	(Acute, Maternity and Geriatric)			
	Inpatients	1,315	1,315	0.0%
	Day Cases	2,523	2,698	6.9%
	Day Patients (Haemodialysis)	1,486	1,461	-1.7%
	New Out patients	6,113	5,786	-5.3%
	Return Outpatients	12,257	12,280	0.2%
Emergency	(Acute, Maternity and Geriatric)			
	Inpatients	3,201	3,299	3.1%
	A&E	8,492	8,913	5.0%
Births		227	227	0.0%
Community Hospitals				
	Occupied bed days	7,443	7,343	-1.3%
Mental Health	(General & Psychogeriatric - CRH)			
	Inpatients	99	84	-15.2%
	Occupied bed days	3,994	3,926	-1.7%
Labs		418,028	424,118	1.5%
Radiology (GP referral based activity)		2,709	2,593	-4.3%

Laboratory activity is estimated

DUMFRIES and GALLOWAY NHS BOARD

6 July 2009



Redevelopment of Aseptic Suite – Pharmacy DGRI

Author:

Michael Pratt, Chief Pharmacist

Sponsoring Director:

Jeff Ace, Director of Health Services

Date: 16 June 2009

RECOMMENDATION

It is recommended that approval be given to proceed to tender for the redevelopment of the aseptic suite within the existing pharmacy footprint (Option 2). It is anticipated this redevelopment will have a total project cost in the region of £800k.

SUMMARY

The Aseptic Suite based in Pharmacy D&GRI allows the aseptic preparation of pharmaceuticals for a range of patients in the Board area. The major workload is preparation of cytotoxic chemotherapy for treatment of Cancer patients. There is also a requirement to prepare other aseptic products such as antimicrobials for neutropenic or other 'at risk' patients and total parenteral nutrition.

The existing suite was built as a sterile manufacturing unit at the time of opening D&GRI in 1975. Its function has been modified over the years but despite significant efforts of both pharmacy and estates staff, it is becoming increasingly challenging to maintain a functioning suite. It is noteworthy that in the last 12 months we have had 3 incidents of bacterial/fungal contamination, resulting in service reduction. Additionally there has been a flood, resulting in the unit being closed for 3 weeks. Short term contingency plans were invoked in this period. We have also been subject to significant criticism of the quality of the facility in a recent external audit report.

Failure to redevelop the aseptic suite will increase the exposure of our services, and consequently our patients, to risk. The risks we are facing are as follows:

1. increasing risk of exposing our patients, who are often immunocompromised, to bacterial/ fungal contamination. This may well have severe consequences for patients.
2. service continuity risk from further deterioration of the facility which may well result in a 'Critical Failure' classification being received in the external audit, which will require us to cease using the facility. This will have a dramatic effect on the Boards ability to provide cytotoxic chemotherapy to our cancer patients.

Action is required to provide an aseptic facility that is “fit for purpose” and will allow a safe and dependable service for our patients.

Strategic context

NHS Dumfries and Galloway Draft Cancer Plan 2009-10

The following extracts from the NHS D&G draft Cancer Plan 2009-10 sets the strategic context for the ongoing provision of a local Pharmacy Aseptic Service

‘Over 95% of chemotherapy treatments are provided locally. There are presently 4 chemotherapy clinics at DGRI per week - haematology, breast, colorectal/upper GI and lung/gynae etc. The team are now looking to establish the feasibility of also providing a urology chemotherapy service within DGRI

Chemotherapy is now prescribed by those medical and nursing staff trained in this area specifically. The drugs are prepared by the local pharmacy service and administered by chemotherapy trained nurses.

As predicted in previous cancer plans, chemotherapy activity has increased over recent years and this is set to continue.’

‘A tool has been developed by ASSIG which models capacity planning for aseptically prepared products dispensed from pharmacy. The model incorporates a complexity factor for preparation in addition to the number of items prepared. This model has recently been applied to our 2007 workload figures for aseptically prepared items. The pharmacy aseptic workload is primarily chemotherapy (84%) but also includes the preparation of CIVA (Centralised Intravenous Additive)(8.8%), TPN, and paediatric rheumatology chemotherapy (Methotrexate). The CIVA service is almost exclusively antibiotics prepared for neutropenic patients under the care of cancer services. Therefore cancer related services account for 93% of aseptic workload.’

‘Plan to replace existing Aseptic Unit in 3-5 years

This has become a priority in the last year with an increased number of planned (for essential maintenance) and unplanned shut-downs which have involved implementation of the contingency plan for preparation of chemotherapy off-site at the Cumberland Infirmary. The last unplanned shut-down, as a result of a flood in June 2008, meant that the Unit was closed for 3 weeks. During this time the clinics were condensed into 4 days (Tues – Fri). All chemotherapy was prepared using the pharmacy facilities at the Cumberland Infirmary and DGRI pharmacy and nursing staff worked extended hours in order to ensure that there was minimum disruption to patient’s treatment schedules. We were very fortunate that the Cumberland Infirmary were able to accommodate us and that no patients presented requiring urgent

unplanned chemotherapy. During the shut-down no TPN or antibiotics were prepared.

Plans for a new aseptic unit are currently being discussed with Estates, and a business case will be prepared and presented. This will be a significant capital investment for the Board.'

Need for Expenditure

The most recent external audit of our facility in 2008 (summary report attached as appendix A) categorised our facilities as a major deficiency, and were in such a condition that it was “difficult to apply the audit acceptance criteria in this Facilities section correctly”.

Recent bacterial and particulate contamination has resulted in a reduced level of service and even temporary closure of the facility on several occasions recently. The attached bacteriological report (Appendix B) emphasises the critical nature of this situation.

1) NHS HDL (2005)29 Guidance for the Safe Use of Cytotoxic Chemotherapy

The above document identifies a requirement for ALL cytotoxic chemotherapy to be supplied from a pharmacy controlled facility, dispensed and labelled for the individual patient and to be prepared in accordance with legislative requirements, national standards and guidelines. It also highlights the requirement for the organisation to abide by the findings of the external auditing process. Therefore we are already ‘at risk’ due to the Major grading of our current non-conformance.

2) NHS HDL(2006)11 Guidance on the Safe Handling of Intrathecal and Intraventricular Injections

This document complements the above and reinforces the need that all intrathecal cytotoxic injections MUST be prepared in a pharmacy aseptic facility.

The above identifies the clear requirement for a pharmacy aseptic service in NHS D&G. It also highlights that our existing suite is failing. The fabric of the interior is failing, with the excessive cleaning of the suite resulting in the walls shedding high levels of particles (a risk in themselves, but also a source of microbial contamination). Additionally the proximity of the suite next to both a main pharmacy corridor and a storeroom housing quantities of cardboard boxes adds to this problem. Communication from our microbiologists (Appendix B) support this.

3) Therapeutic Trends

Future trends in the treatment of cancer will be associated with dose intensification and the use of more complex chemotherapy regimes. Recent SMC recommendations, and the SMC horizon scanning document Forward Look have indicated significant increases in the numbers of infusion-based treatments which have limited shelf lives and therefore require preparation on site.

A key clinical driver is the need for a rapid response to patient specific medication required as soon as possible, together with some products which have a very short shelf life of a matter of hours.

The products currently used at D&GRI are 70% infusions and 30% syringes. There exists the opportunity to reduce the volume of infusions prepared and to purchase dose banded syringes, at a premium cost. This is done minimally however because these are currently unlicensed medicines and cannot be prescribed by independent non-medical prescribers, and therefore present a significant difficulty to our service. This difficulty however does not detract from the requirement to redevelop our aseptic suite.

The future trend is that workload will increase, particularly for infusions and combination chemotherapy. Given the demands within the Cancer Plan and following a number of treatments recently approved by SMC or highlighted in the SMC Forward Look, recent growth in demand is likely to be maintained. The growth of new and more effective treatments coupled with an ageing population where the incidence of cancer is likely to increase, we can only expect the need for a local aseptic facility to be increased in the future.

4) Monoclonal and Gene Therapies

New research has led to the introduction of biotechnology agents such as monoclonal antibodies eg Rituximab, Trastuzumab and Infliximab as well as gene therapies. Monoclonal technologies and gene therapy regimes are likely to be growth areas. Monoclonal antibodies require ideally a separate unit, but could be prepared in dedicated isolator in a general aseptic unit. These very expensive products are with us now and should be controlled within the pharmacy environment, from both a financial and clinical risk viewpoint.

Gene therapy uses viral vectors which require a separate aseptic unit and isolators. It is however anticipated that gene therapy will NOT be managed with the aseptic service in DGRI and will be delivered through the tertiary centres. **No facility is therefore included for preparation of gene therapies.**

5) Clinical Risk Issues

Aseptic products are by their nature mainly for very ill patients, often immunocompromised. Accuracy of dosage and guaranteed sterility are essential, as is the preparation of these products in a safe environment by skilled staff. Failure to redevelop the existing aseptic suite will increase the exposure of our services, and consequently our patients, to clinical risk. The risks we are facing are as follows:

3. increasing risk of exposing our patients to bacterial/ fungal contamination. This may well have severe consequences for patients.
4. service continuity risk from further deterioration of the facility which may well result in a 'Critical Failure' classification being received in the external audit, which will require us to cease using the facility. This will have a dramatic effect on the Boards ability to provide cytotoxic chemotherapy to our cancer patients.

Products such as cytotoxics and monoclonal antibodies also require protection for staff preparing such products. Such functions must be centralised in a Pharmacy run facility. As part of that facility there needs to be a fail safe capability. Plans are therefore being considered for a dual air handling unit giving back up capability should one fail.

List of options

1. Do minimum
2. Redevelop unit within existing pharmacy
3. Build new Unit near Cancer Unit
4. Build a new unit external to existing DGRI footprint
5. 'Buy in' service from another Board/Trust

Option appraisal

Option 1 cannot be considered as a serious option, as this will require a substantial investment but does not overcome some of the fundamental contamination issues being experienced.

Option 2 is the development of a new unit within the existing pharmacy footprint. The new unit will comprise of the floor area within the existing unit but will also include, and therefore eliminate, a corridor and two additional rooms which are recognised as sources of contamination. This option will allow the unit to meet current day requirements as well as providing capacity to future proof the facility.

Option 3 will allow the build of a brand new unit without constraints of the existing pharmacy building, and in an area which is more convenient for service users. However, the timing of the DGRI refurbishment we have assumed will necessitate substantial work, equivalent to Option 2, to be done to allow the aseptic service to function for the required period.

Option 4 allows a new build as a stand alone project without constraints. It was recognised that although this has many attractions, it would be difficult to find a suitable site around DGRI, without making the unit too remote geographically.

Option 5 has been explored and dismissed. Capacity does not exist in neighbouring Boards. Cumberland Infirmary and Ayrshire & Arran, have both built new facilities in recent years. These facilities were designed to accommodate the workload requirements of the Trust/Board they are servicing. Capacity does not exist to absorb the required activity of NHS D&G. Consideration has been given to extended hours working in other units. This will have significant financial costs (from increased wastage and unsocial hours payments) and service implications (no ability to manage late therapy changes), which would greatly erode the financial benefits of a shared arrangement. The most likely other partner is Lothian Health Board, as SCAN lead. However conversations with the LHB Director of Pharmacy has revealed that they are currently at a very early stage of reviewing their existing aseptic services with a view to developing a Business Case for potentially a number of new aseptic facilities, but not in a timeframe that meets our requirements. Also, use of a number of short shelf life products will require us to have an aseptic facility

in DGRI even if we could buy in some of the service. Therefore any potential benefit of option 5 is greatly reduced.

The table below shows a summary of the capital and revenue expenditure associated with each of the four remaining options. Further detail and assumptions can be found in Appendix C.

	Option 1	Option 2	Option 3	Option 4
Aseptic Suite indicative Capital costs	Do minimum	Redevelop in existing pharmacy	New build as part of redevelopment	New build outwith DGRI
Construction	105,750	432,118	957,578	682,381
Fees	4,500	53,664	120,744	74,363
Equipment	74,025	240,875	240,875	240,875
Contingency	4,054	73,605	134,033	101,063
TOTAL	188,329	800,262	1,453,230	1,098,682
Draft split between revenue/capital				
Revenue	43,804	533,041	704,943	167,379
Capital	144,525	267,221	748,286	931,303
TOTAL	188,329	800,262	1,453,230	1,098,682
Aseptic Suite indicative additional on going revenue costs	Do minimum	Redevelop in existing pharmacy	New build as part of redevelopment	New build outwith DGRI
Capital Charges	0	2,349	18,189	35,964
H,L,P, Rates etc	0	0	0	1,039
TOTAL	0	2,349	18,189	37,003

Preferred option funding arrangements

The preferred option, to redevelop within the existing pharmacy, has a total project cost of £800k which includes works, fees, and equipment. VAT has been assumed at 17.5% on all except the fees where the VAT is recoverable. A contingency of 10% has also been included on relevant items.

It is estimated that 67% of costs, £533k would be of a revenue nature due to the high level of refurbishment work. The move to accounting under International Accounting standards in 2009-10 is likely to give additional scope for elements of refurbishment work to be capitalised. Further exploration of this will be done when moving forward with the business case.

The ongoing revenue costs for the preferred option are minimal, a small increase in the current capital charges associated with the aseptic suite of £2.3k and as there

will be no increase in the footprint no additional costs are anticipated by the estates department.

Stakeholder involvement

A multidisciplinary group of pharmacy, estates and finance staff have developed the Abbreviated Business Case this group has included Pharmacy Quality assurance expertise courtesy of GG&CHB . During the development of the case consultation has taken place with bacteriology and cancer services.

Equality and diversity

This case will have no direct impact on equality and diversity arrangements.

Implementation plan

Full Business Case to be presented to March Board, and with approval to proceed to tender in April 2009, project completion could be achieved by August 2010, but there is a degree of flexibility dependent on financial management issues.

MONITORING FORM

Policy / Strategy Implications	<i>NHS Dumfries and Galloway Draft Cancer Plan 2009-10</i>
Staffing Implications	<i>Nil</i>
Financial Implications	<i>Finance involved in development of Business Case</i>
Consultation	<i>There has been direct involvement of service users, estates, finance, microbiology and external Pharmacy QA in the development of the business case.</i>
Consultation with Professional Committees	<i>Need for this development has been highlighted in the Cancer Plan, which has undergone wide professional consultation.</i>
Risk Assessment	<i>External QA Audit has been undertaken, as has expert input from microbiology/COI. Documentary evidence provided as part of Business Case.</i>
Best Value	<i>The principles of Best Value been taken into account in development of this proposal.</i>
Compliance with Corporate Objectives	<i>Improve and embed a patient safety culture. Meet Scottish Government Goals and Targets. Improve Patient Experience.</i>
Impact Assessment	n/a

The National Health Service in Scotland

Page 1 of 3

External Audit of Aseptic Dispensing Facilities: Summary Report

Hospital: Dumfries and Galloway Royal Infirmary

Activity: Provision of Chemotherapy, Total Parenteral Nutrition and IV Additives

Date of Audit: 26/03/08

Date of Previous Audit: 20/04/05

The above aseptic dispensing facility has been evaluated by an external auditor against the Aseptic Dispensing Services Audit Schedule (Fourth Edition) produced by the Aseptic Services and Quality Assurance Specialist Interest Groups. The findings are summarised below.

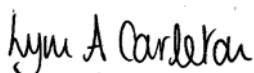
The main areas of good practice are:

A great deal of work has obviously been done in order to comply with as many standards in the audit schedule as possible. There has been a huge commitment to completion of all the necessary documentation systems. From documentation review dates it is clear that maintenance and review of documentation is done on a regular basis and the unit is well-managed. Both auditors were particularly impressed with the systems in place to ensure compliance with the Risk Management and Management sections of the audit schedule.

The main areas of deficiency are:

The aseptic unit is old and the design and layout of the rooms does not now meet the standards required for an aseptic dispensing facility. There are signs of wear and tear due to the age of the rooms and the laminar air flow cabinets, and although repairs have been done as far as possible, these are unlikely to last in the long term. (Staff in the unit demonstrate a clear dedication to cleaning, environmental monitoring and adherence to Standard Operating Procedures which allows the unit to function safely in spite of these defects.)

The audit result and summary of each section of the audit schedule is listed on pages 2 and 3.



(Lead Auditor)

26/03/08

(Date)

External Audit of Aseptic Dispensing Facilities: Summary Report

Page 2 of 3

Hospital: Dumfries and Galloway Royal Infirmary
26/03/08

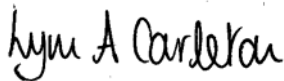
Date of Audit:

CATEGORY	AUDIT RESULT (*)	COMMENTS and ACTION REQUIRED
Risk Management	Satisfactor y	-
Management	Satisfactor y	-
Formulation, Stability and Shelf Life	Satisfactor y	-
Facilities	Major	<p>Please see first page of this report for general comments. As the unit is in need of a complete redesign it is difficult to apply the audit acceptance criteria in this category correctly. Issues identified during the audit include:</p> <ul style="list-style-type: none"> - No change room / area for the support room. - Entry to change room is off a "dirty" corridor therefore separation of different stages of change cannot be achieved. - The unit should be fitted with visual and audible air pressure alarms (in addition to the alarm currently linked to the hospital switchboard) <p>Although the unit has been recently painted and repaired as far as possible there are still signs of wear and tear such as rusty hinges on the transfer hatch doors, and small chips on the exterior surfaces of the Laminar Air Flow cabinets.</p>
Documentation	Other	Written evidence of successful retrieval of archived documentation is required.
Personnel, Training and Competency Assessment	Other	Staff training manuals require expansion to ensure that there is evidence of supported questioning when reassessing competency of staff to work in the aseptic unit.
Aseptic Processing	Satisfactor y	-
Monitoring	Other	<p>Gauges are not fitted to Laminar Air Flow Cabinets and therefore daily checks on airflow rates are not possible (due to the age of the cabinets)</p> <p>Monthly air sampling for airborne viable organisms requires to be done in isolator transfer hatches in addition to isolator work zones.</p> <p>The hospital Microbiology Laboratory which carries out testing on behalf of the aseptic unit needs to be audited to ensure compliance with required standards for processing pharmacy samples.</p>
Cleaning	Satisfactor y	-
Starting Materials, Components and Other Consumables	Satisfactor y	-

Product Approval	Other	The procedure for receiving requests for intravenous additive products requires review in order to ensure that written confirmation is received before products are released.
CATEGORY	AUDIT RESULT (*)	COMMENTS and ACTION REQUIRED
Storage and Distribution	Satisfactory	-
Internal and External Audit	Satisfactory	-

(*)

Critical = **Critical Deficiencies with immediate action required**
Major = **Major Deficiencies with action required as soon as possible**
Other = **Minor Deficiencies**
Satisfactory = **Complies with standards**



26/03/08

 (Lead Auditor)

 (Date)

A copy of this summary report is sent by the lead auditor for distribution to Richard Williamson (e-mail richard.williamson@aaaht.scot.nhs.uk) and to Liz Stanley (e-mail liz.stanley@luht.scot.nhs.uk) for collation.

19 January 2009

Mr Michael Pratt
Chief Pharmacist
NHS D&G

Dear Mr Pratt,

ASEPTIC SUITE PHARMACY DGRI

As you are aware, the Area Department of Microbiology undertakes routine microbiological monitoring of the Pharmacy Aseptic Suite. Over the past year there have been 3 major episodes of microbiological failure within the Aseptic Suite, which have resulted in service reduction and given some concern to the Consultant Microbiologists and Infection Control Team. This has prompted me to further investigate the potential for microbiological contamination within this facility.

The microbiological monitoring results from the Aseptic Suite for Oct-Nov 08 have been reviewed. A total of 238 sets of microbiological cultures were analysed within the Area Dept of Microbiology, of which 88 (37%) had evidence of micro-organism contamination. Fungal spores, which are more representative of air or environmental contamination rather than from human skin, was detected on 44 individual microbiology test samples. Areas where fungal pathogens have been isolated include Change Room (18), Preparation Room (10), Aseptic Room (2), Cytotoxic Room (2), Airlock (1), Isolator 1 (4), Isolator 2 (2), Finger Dabs (3) and Room 1 (2).

At the invitation of Pharmacy staff I inspected the Aseptic suite, and was rather concerned by the poor fabric of this facility during my visit, which would support the consistent poor microbiological findings. I was informed that a redevelopment of the Aseptic Suite was required, and that the current facility had been criticized in an external audit. As Infection Control Doctor for NHS D&G, I must highlight my concerns to you regarding the current environmental fabric of this facility, and the potential to cause serious infection to already immunocompromised patients. Every encouragement and support, as a priority, should be given to a redevelopment of the Aseptic Suite.

Kind regards

Dr Martin P Connor
Consultant Microbiologist and Infection Control Doctor

Appendix C		Option 1 Do minimum	Option 2 Redevelop in existing pharmacy	Option 3 New build as part of redevelopment	Option 4 New build outwith DGRI
Aseptic Suite indicative Capital costs					
Area m2		0	178.88	178.88	198.30
Construction Cost estimate per m2		£0	£2,000	£2,500	£2,500
PROJECT COSTS					
Land		0	0	0	0
Commissioning		0	10,000	10,000	10,000
Construction Cost		0	357,760	447,200	495,750
Construction Cost - refurbishment		30,000	0	357,760	0
Service Installation		60,000	0	0	75,000
VAT	17.50%	15,750	64,358	142,618	101,631
		<u>105,750</u>	<u>432,118</u>	<u>957,578</u>	<u>682,381</u>
Fees	15.00%	4,500	53,664	120,744	74,363
Equipment		63,000	205,000	205,000	205,000
VAT	17.50%	11,025	35,875	35,875	35,875
		<u>74,025</u>	<u>240,875</u>	<u>240,875</u>	<u>240,875</u>
		184,275	726,657	1,319,197	997,619
Contingency - Build	10.00%	3,450	42,142	93,570	65,511
Contingency - Equipment	10.00%	0	20,500	20,500	20,500
VAT	17.50%	604	10,962	19,962	15,052
		<u>4,054</u>	<u>73,605</u>	<u>134,033</u>	<u>101,063</u>
TOTAL		188,329	800,262	1,453,230	1,098,682
Draft split between revenue/capital					
Revenue		43,804	533,041	704,943	167,379
Capital		144,525	267,221	748,286	931,303
TOTAL		188,329	800,262	1,453,230	1,098,682

Aseptic Suite indicative additional on going revenue costs		Option 1 Do minimum	Option 2 Redevelop in existing pharmacy	Option 3 New build as part of redevelopment	Option 4 New build outwith DGRI
Capital Charges (based on lifetime ave)		0	2,349	18,189	35,964
Maintenance	16	0	0	0	311
Rates	15	0	0	0	291
Heat, Light & Power	22.5	0	0	0	437
Domestics		0	0	0	0
TOTAL		0	2,349	18,189	37,003

NOTES & ASSUMPTIONS

1. Option 2 does not include costs for double running, it is expected that this project may be able to be done on a phased basis to allow the unit to still run while work is undertaken
2. A more detailed revenue / capital split will be require to identified
3. VAT has been assumed at 17.5%, a slight saving will be made if the rate remains at 15%
4. Optimism bias assessment should be done to replace contingency
5. Revenue costs based on additional costs to be incurred not total cost.
6. Option 1,2,3 assumes no additional ongoing property costs as not increasing existing footprint
7. Capital Charges assumes capital works would not increase life of building for Options 1,2,3 only enhance the value
8. Capital Charges for Option 2 based on 16yrs life as per remaining life of DGRI on current asset register
9. Capital Charges for Option 3 based on 9yr life for refurbishment element until DGRI complete This would reduce to a £4k difference when the new build was included within the DGRI redevelopment based on a 38yr life.
10. Capital Charges for Option 4 based on 38yr life for new build
11. No buildings inflation assumed

Severity x Likelihood = Risk Criteria e.g. Moderate x Possible = Medium Risk	Likelihood of Occurrence Chance of event occurring within the next year				
	Rare <i>(Little chance of occurrence)</i> (can't believe this event would happen – will only happen in exceptional circumstances (5-10 years))	Unlikely <i>(Probably won't occur)</i> (not expected to happen, but definite potential exists – unlikely to occur (2-5 years))	Possible <i>(May occur)</i> (may occur occasionally, has happened before on occasions – reasonable chance of occurring (annually))	Likely <i>(Probably will occur)</i> (strong possibility that this could occur – likely to occur (quarterly))	Almost Certain (this is expected to occur frequently/ in most circumstances – more likely to occur than not (daily/weekly/ monthly))
Negligible, e.g. ♦ Minor injury, not requiring first aid ♦ Unsatisfactory patient experience not directly related to patient care and readily resolvable ♦ Partial loss of service ♦ Financial impact less than £5K	Low	Low	Low	Medium	Medium
Minor, e.g. ♦ Minor temporary injury or illness, first aid treatment required ♦ Unsatisfactory patient experience directly related to patient care – rapidly resolvable ♦ Individual service objectives only partially achievable ♦ Financial impact £5K - £50K	Low	Medium	Medium	Medium	High
Moderate, e.g. ♦ Significant injury or ill health requiring medical intervention – temporary incapacity ♦ Patient outcome or experience below reasonable expectations in a number of areas ♦ Unable to achieve service objectives without substantial additional costs or delays ♦ Financial impact £50K - £500K	Low	Medium	Medium	High	High
Major, e.g. ♦ Single avoidable death or long term incapacity or disability ♦ Significant impact on ability to deliver service objectives, service may have to be discontinued ♦ Major financial loss £500K - £2.5M	Medium	Medium	High	High	Very High
Extreme, e.g. ♦ Multiple or repeated avoidable fatalities or major permanent incapacity/disability ♦ Sustained loss of service with serious impact on delivery of patient care, major contingency plans invoked. ♦ Corporate obligations not met. ♦ Severe financial loss £2.5M +	Medium	High	High	Very High	Very High
Low	Low: No additional risk controls required. The person responsible shall document assurance that existing controls or contingency plans remain effective and ensure any weaknesses are addressed				
Medium	Medium: Further action shall be taken to reduce the risk but the cost of control should be proportionate. The person responsible shall ensure additional risk control measures are introduced within a defined timescale. Assurance that risk controls or contingency plans are effective shall be documented and evaluated by the relevant Head of Service and any weaknesses addressed				
High	High: Further action, possibly urgent and requiring considerable resources, shall be taken to reduce the risk. Responsibility for introducing risk control measures within a set timescale shall be explicitly defined by the appropriate Director or General Manager and followed up through the performance review process. Assurance that risk controls or contingency plans are effective shall be documented and evaluated by the relevant Director or General Manager				
Very High	Very High: If confirmed to be unacceptable, the risk should be escalated immediately to Director level. An immediate action plan should be drawn up with Executive level leadership. If appropriate, suspension of the activity until the risk has been reduced should be considered. The risk and the action taken to reduce it to an acceptable level should be taken to the next available Board				

Ref:

Date of Assessment:

Location	DGRI	Department	Pharmacy	Manager	M.Pratt	Assessors	
Is Risk on Risk Register?	Y				Ref No:		
Description of Operation/Activity/Task/Area/Environment/Issue						<i>Complete the relevant details of the activity or issue being addressed</i>	
Preparation of Aseptic products within the Aseptic Suite Pharmacy DGRI							
Identify Hazards							
Increasing risk of exposing our patients, who are often immunocompromised, to bacterial/ fungal contamination. This may well have severe consequences for patients.							
Individuals or Groups Exposed						<i>Highlight the people at risk and the likely maximum numbers exposed</i>	
Cancer patients and those with haematological malignancies							

Current Control Measures							
<p>Restricted product shelf life (24 hours). This limits the risk but also has knock on service implications.</p> <p>Increased cleaning programme which has staffing implications, but is also leading to increased degradation of fabric of current suite, due to the nature of cleaning chemicals.</p> <p>Limit range of products prepared to essential products only.</p> <p>Prepare business case to replace aseptic unit with a new 'fit for purpose' unit.</p>						<i>List current control measures, including physical controls but do not forget to include other controls including safe working procedures, information, instruction and training</i>	

INITIAL RISK RATING

Risk Rating Using information above and the risk matrix and taking into account the control measures in position, decide the Likelihood and Severity, and calculate the risk rating.	Likelihood Rarely happens Unlikely to occur Possibly can occur Likely to occur Almost certain	Severity Negligible injury, illness, loss Minor injury, illness, loss Moderate injury, illness, loss Major Injury, illness or loss Extreme loss, fatality, disaster	Rating R = L x S
Calculate Rating = Likelihood x Severity	<i>Possibly can occur</i>	<i>Major</i>	<i>High</i>

Further Control Measures Required/Action Plan	<i>Include any additional controls identified to eliminate or reduce the risk further – or state whether the risks are already as low as reasonably practicable</i>
<p>All possible precautions, short of replacing the facility are being taken.</p> <p>There is evidence that the existing suite is failing, and without action risk will increase.</p>	

RE-ASSESSED RISK RATING

Risk Rating Using information above and the risk matrix and taking into account the further control measures in position again decide the Likelihood and Severity, and calculate the risk rating.	Likelihood Rarely happens Unlikely to occur Possibly can occur Likely to occur Almost certain	Severity Negligible injury, illness, loss Minor injury, illness, loss Moderate injury, illness, loss Major Injury, illness or loss Extreme loss, fatality, disaster	Rating R= L x S
Calculate Rating = Likelihood x Severity			

Date:	23 March 209	Review Date:	
Assessors Names:	M.Pratt		
Comments:			

Severity x Likelihood = Risk Criteria e.g. Moderate x Possible = Medium Risk	Likelihood of Occurrence Chance of event occurring within the next year				
	Rare (<i>Little chance of occurrence</i>) (can't believe this event would happen – will only happen in exceptional circumstances (5-10 years))	Unlikely (<i>Probably won't occur</i>) (not expected to happen, but definite potential exists – unlikely to occur (2-5 years))	Possible (<i>May occur</i>) (may occur occasionally, has happened before on occasions – reasonable chance of occurring (annually))	Likely (<i>Probably will occur</i>) (strong possibility that this could occur – likely to occur (quarterly))	Almost Certain (this is expected to occur frequently/ in most circumstances – more likely to occur than not (daily/weekly/ monthly))
Negligible, e.g. ♦ Minor injury, not requiring first aid ♦ Unsatisfactory patient experience not directly related to patient care and readily resolvable ♦ Partial loss of service ♦ Financial impact less than £5K	Low	Low	Low	Medium	Medium
Minor, e.g. ♦ Minor temporary injury or illness, first aid treatment required ♦ Unsatisfactory patient experience directly related to patient care – rapidly resolvable ♦ Individual service objectives only partially achievable ♦ Financial impact £5K - £50K	Low	Medium	Medium	Medium	High
Moderate, e.g. ♦ Significant injury or ill health requiring medical intervention – temporary incapacity ♦ Patient outcome or experience below reasonable expectations in a number of areas ♦ Unable to achieve service objectives without substantial additional costs or delays ♦ Financial impact £50K - £500K	Low	Medium	Medium	High	High
Major, e.g. ♦ Single avoidable death or long term incapacity or disability ♦ Significant impact on ability to deliver service objectives, service may have to be discontinued ♦ Major financial loss £500K - £2.5M	Medium	Medium	High	High	Very High
Extreme, e.g. ♦ Multiple or repeated avoidable fatalities or major permanent incapacity/disability ♦ Sustained loss of service with serious impact on delivery of patient care, major contingency plans invoked. ♦ Corporate obligations not met. ♦ Severe financial loss £2.5M +	Medium	High	High	Very High	Very High
Low	Low: No additional risk controls required. The person responsible shall document assurance that existing controls or contingency plans remain effective and ensure any weaknesses are addressed				
Medium	Medium: Further action shall be taken to reduce the risk but the cost of control should be proportionate. The person responsible shall ensure additional risk control measures are introduced within a defined timescale. Assurance that risk controls or contingency plans are effective shall be documented and evaluated by the relevant Head of Service and any weaknesses addressed				
High	High: Further action, possibly urgent and requiring considerable resources, shall be taken to reduce the risk. Responsibility for introducing risk control measures within a set timescale shall be explicitly defined by the appropriate Director or General Manager and followed up through the performance review process. Assurance that risk controls or contingency plans are effective shall be documented and evaluated by the relevant Director or General Manager				
Very High	Very High: If confirmed to be unacceptable, the risk should be escalated immediately to Director level. An immediate action plan should be drawn up with Executive level leadership. If appropriate, suspension of the activity until the risk has been reduced should be considered. The risk and the action taken to reduce it to an acceptable level should be taken to the next available Board				

Ref:

Date of Assessment:

Location	D&GRI	Department	Pharmacy	Manager	M.Pratt	Assessors	
Is Risk on Risk Register?	Y					Ref No:	
Description of Operation/Activity/Task/Area/Environment/Issue						<i>Complete the relevant details of the activity or issue being addressed</i>	
Preparation of Aseptic products within the Aseptic Suite Pharmacy DGRI							
Identify Hazards							
Service continuity risk from further deterioration of the facility which may well result in a 'Critical Failure' classification being received in the external audit, which will require us to cease using the facility. This will have a dramatic effect on the Boards ability to provide cytotoxic chemotherapy to our cancer patients.							
Individuals or Groups Exposed						<i>Highlight the people at risk and the likely maximum numbers exposed</i>	
Cancer patients and those with haematological malignancies							

Current Control Measures		
<p>Restricted product shelf life (24 hours). This limits the risk but also has knock on service implications.</p> <p>Increased cleaning programme which has staffing implications, but is also leading to increased degradation of fabric of current suite, due to the nature of cleaning chemicals.</p> <p>Limit range of products prepared to essential products only.</p> <p>Prepare business case to replace aseptic unit with a new 'fit for purpose' unit.</p>		<i>List current control measures, including physical controls but do not forget to include other controls including safe working procedures, information, instruction and training</i>

INITIAL RISK RATING

Risk Rating Using information above and the risk matrix and taking into account the control measures in position, decide the Likelihood and Severity, and calculate the risk rating.	Likelihood Rarely happens Unlikely to occur Possibly can occur Likely to occur Almost certain	Severity Negligible injury, illness, loss Minor injury, illness, loss Moderate injury, illness, loss Major Injury, illness or loss Extreme loss, fatality, disaster	Rating R= L x S
Calculate Rating = Likelihood x Severity	<i>Likely</i>	<i>Extreme</i>	<i>Very High</i>

Further Control Measures Required/Action Plan	<i>Include any additional controls identified to eliminate or reduce the risk further – or state whether the risks are already as low as reasonably practicable</i>
<p>All possible precautions, short of replacing the facility are being taken.</p> <p>There is evidence that the existing suite is failing, and without action risk will increase.</p> <p>We have had a significant adverse comment in our last external audit and it is highly likely that if no clear plan is in place to replace the existing failing facility, then a 'critical failure' will be given which will effectively stop the unit functioning.</p>	

RE-ASSESSED RISK RATING

Risk Rating Using information above and the risk matrix and taking into account the further control measures in position again decide the Likelihood and Severity, and calculate the risk rating.	Likelihood Rarely happens Unlikely to occur Possibly can occur Likely to occur Almost certain	Severity Negligible injury, illness, loss Minor injury, illness, loss Moderate injury, illness, loss Major Injury, illness or loss Extreme loss, fatality, disaster	Rating R= L x S
Calculate Rating = Likelihood x Severity			

Date:	23 March 2009	Review Date:	
Assessors Names:	M.Pratt		
Comments:			

DUMFRIES and GALLOWAY NHS BOARD

6 July 2009

**Enhancing Staff Security and Safety on the Crichton Campus**

Author: Caroline Sharp, Director of HR & Workforce Strategy, NHS D&G
 Brian Anderson, Chief Superintendent, D&G Constabulary

Sponsoring Director:
 Caroline Sharp

Date: 26 June 2009

RECOMMENDATION

The Board are requested to endorse the partnership pilot planned for developing a police presence on the Crichton Campus, together with enhanced training and support for staff in high risk areas with the aim to reduce the number of violent and aggressive incidents against NHS staff, and to increase NHS staff confidence and wellbeing at work.

SUMMARY

This paper describes the process and outcomes of a review of the safety and security of staff working on the Crichton Campus, and advises the Board of a one year pilot that will be undertaken in partnership with D&G Constabulary commencing August 2009 in support of this.

Background

The Board have undertaken a programme of assessment to review the suitability of current staffs' personal safety and hospital security arrangements within DGRI and across the Crichton Campus within the context of a rising number of aggressive and violent incidents by patients against staff over the last 12 months.

Issues in relation to staff safety and security were flagged through the Corporate Health and Safety Committee structure and were raised at Staff Governance Committee in 2008. Safety and security of our staff has also been raised through discussions regarding the DGRI internal emergency response team and its suitability and capability to respond to emergency violent incidents involving staff members in DGRI.

In October 2007 an internal Audit of Security was completed. In June 2008 there was a serious incident of violence toward several members of staff within DGRI. Detailed risk assessments were undertaken in September 2008, and have been reviewed and updated throughout this assessment programme to test and validate the evolving strategy for enhancing staff security and safety on the Crichton Campus.

Options Development and Assessment

A evolving series of papers have been presented to BMG and Board members on possible security options in relation to

- enhanced internal security cover provision in DGRI
- establishing a police presence in DGRI

Options were debated within a context of a 'do nothing' option, which was dismissed as an option in recognition of the importance of Health and Safety for staff across the organisation, and the fundamental issues raised regarding the fitness for purpose of the emergency response team.

Following further discussions it was agreed to contact the local Police to ascertain if it would be possible to have on site Police presence based in DGRI. Possible benefits identified for this option included added value in respect of partnership working, community engagement, training and skills development and maintenance and wider security benefits for DGRI such as dealing with thefts. Chief Superintendent Brian Anderson has since been working in partnership with NHS D&G to assess options available to the police and NHS D&G.

The following key principles have been agreed as essential to meet the needs of all stakeholders identified;

- The solution agreed must support the removal of the NHS DGRI emergency response team from supporting violent or aggressive staff / patient incidents
- The solution should ideally provide visibility and reassurance by covering the hospital 24/7, as the distribution of violent incidents analysed as part of the groups original research demonstrated incidents throughout the 24 hour period, and on all days of the week.
- The solution had to meet Police criteria of proportionality and cost effectiveness, NHS best value principles as well as the Boards Health and Safety obligations
- Police deployment of resources must be founded on analysis of risk, demand, need and comparison of other beats and areas
- A similar risk assessment process must be undertaken for Galloway Community Hospital following this exercise.

Four options have been considered by NHS D&G and the police;

1. 1.5 police officers - police funded plus redefined internal response structure
2. 1.5 police officers – police funded, plus enhanced crime prevention and training support for NHS staff – NHS funded, plus redefined internal response structure

3. 1.5 police officers – police funded, plus 4 police officers – NHS funded, to achieve 24/7/365 rota coverage
4. 1.5 police officers – police funded plus 1 – 2 police officers – NHS funded.

Based on the principles outlined above, option 2 has been agreed by the Board Management Group as the preferred option and is now being progressed in partnership with the police. Planning is underway for implementation on 20th August 2009 for a pilot period initially of 1 year, with an evaluation at the end of this period to determine whether the model meets the needs of the Crichton campus workforce, the Board and the police, or whether a revised model is required.

The model will deliver the following;

- One officer working 5/7 day/backshift cover, based in a dedicated office in DGRI, with a beat covering the Crichton Campus. This will give high day and evening visibility both in A&E, and also more widely across the campus for staff, patients and the public
- One officer working Friday and Saturday part night shift, based in DGRI, providing high visibility at peak weekend night activity times
- Enhanced, specialist training and support for staff, utilising the expert skills of the police, to complement the core and advanced training offered to staff by our own internal violence and aggression trainer / advisor
- Disbanding of the DGRI emergency response team who act as a first response for violent and aggressive incidents against staff in DGRI currently.

In addition, this evaluation has identified further developments required as followed, which are being progressed as part of this work programme;

There is a need for the development of ward based clinical response teams in particular in higher risk wards, focused on providing rapid intervention clinical assessment and / or support for patients in particular for those who are disturbed or confused. The structure, responsibilities and training requirements for members of these teams is being developed by the Director for Nursing and Patient Safety for implementation in parallel with the revised security arrangements

The Medical Director and Director for Nursing and Patient Safety are undertaking a review of clinical information recorded and communicated during patient journeys, to ensure that systems are in place to appropriately flag any patient entering the system that could pose a safety threat to staff, and that appropriate risk assessment and mitigation plans are in place to address the risks identified.

This pilot provides the Board to work closely with the police over the coming year to enhance safety and security for both staff and patients across the Crichton Campus. In building our staffs' capability and confidence, we aim not only to enhance their own sense of wellbeing at work, but also to reduce the actual number of violent and aggressive incidents in the workplace, and thus reduce sickness absence associated with these incidents. Each of these will have a direct and positive impact on the care provided to patients within our services, enhancing both patient safety and experience within NHS Dumfries and Galloway.

The Board are requested to endorse the partnership pilot planned for developing a police presence on the Crichton Campus, together with enhanced training and support for staff in high risk areas with the aim to reduce the number of violent and aggressive incidents against NHS staff, and to increase NHS staff confidence and wellbeing at work.

MONITORING FORM

Policy / Strategy Implications	<i>This paper supports achievement of the Board's health and safety strategies</i>
Staffing Implications	<i>This paper has implications for staff across the organisation and has been developed in partnership with Staff Side</i>
Financial Implications	<i>This paper indicates possible costs in respect of staff training which have been discussed</i>
Consultation	<i>Consultation has been taken with Staff Side</i>
Consultation with Professional Committees	<i>Corporate Health & Safety Committee Staff Governance Committee</i>
Risk Assessment	<i>Yes</i>
Best Value	<i>Commitment and leadership, sound governance, sound management of resources</i>
Compliance with Corporate Objectives	<i>Corporate objectives 3, 5 & 6</i>
Impact Assessment	<i>No, an EQIA has not been carried out on this proposal</i>

DUMFRIES and GALLOWAY NHS BOARD

6 July 2009

Business Continuity Strategic Aim**Author:**

Martin Ogilvie
 Operations Manager
 Civil Protection, Resilience and Corporate Risk

Sponsoring Director

John Burns, Chief Executive

Date: 2 July 2009**RECOMMENDATION**

The Board is asked to endorse a Strategic Aim for the new Business Continuity Management Guide.

SUMMARY

NHS Dumfries and Galloway have recently undertaken to review its business continuity arrangements and part of this exercise is the issue of an appropriate management guide. The BMG approved the Guide on 2 June 2009 following a workshop for Managers and Heads of Service. However it was proposed by BMG that the Strategic Aim set out below required Board endorsement.

Proposed wording of a Strategic Aim for the Business Continuity Management Guide

NHS Dumfries and Galloway will have in place, and maintain, robust business continuity and service recovery plans to ensure that critical services continue to be delivered at the appropriate level during a disruptive challenge in order to provide essential health care for the people of Dumfries and Galloway.

MONITORING FORM

Policy / Strategy Implications	<i>It is envisaged that formal adoption of a Strategic Aim and the issue of a Business Continuity Management Guide will make a positive contribution towards embedding Integrated Emergency Management and improve Health Resilience.</i>
Staffing Implications	<i>Not required</i>
Financial Implications	<i>Not required</i>
Consultation	<i>BMG approved wording 2 June 2009</i>
Consultation with Professional Committees	<i>Not required</i>
Risk Assessment	<i>Not required</i>
Best Value	<i>Not required</i>
Compliance with Corporate Objectives	<i>Not required</i>
Impact Assessment	<i>Not required</i>

DUMFRIES AND GALLOWAY NHS BOARD

6 JULY 2009



PATIENTS FAILING TO ATTEND SCHEDULED DENTAL APPOINTMENTS (DNAs) AT IDH SITES – INTRODUCTION OF PENALTY CHARGE

AUDIT INFORMATION FOR FURTHER CONSIDERATION

Author Linda Bunney

Sponsoring Director
Angus Cameron, Medical Director

Date 30 June 2009

RECOMMENDATION

Board is asked to re-consider and agree the introduction of a routine penalty charge (currently £1 per minute at other IDH sites) at all four IDH sites across Dumfries and Galloway.

SUMMARY

The impact of patient non-attendance at IDH dental sites across the region inhibits the proper utilisation of contracted surgery capacity and contributes to unplanned fluctuation in patient through-put. The introduction of the penalty charge would, in any event, anticipate the application of such penalty charges by IDH Group at the conclusion of the Board's contract with the Group on 31 March 2010 for Loreburne, Moffat, and Whitecross Clinics. IDH will at that time assume General Dental Service status, which enables dental contractors to levy penalty charges for scheduled surgery time which is not utilised by appointed patients.

Section 1

1. BACKGROUND and CONTEXT

- 1.1 Routine contract monitoring since 2006 with the IDH Group, which provides General Dental Services on behalf of NHS Dumfries and Galloway across 4 sites - at Dumfries, Moffat, Stranraer and, since 1 December 2008, Castle Douglas - has demonstrated that significant numbers of patients are failing to attend scheduled appointments, in spite of robust reminder systems in place.
- 1.2 Data submitted to the Board by IDH indicated that over a six-month period in 2008, a total of 2,974 patients across three sites (excluding Castle Douglas at that time) missed appointments, representing a total of £54,890 lost to the practices in chair-time. This figure did not include additional staff costs incurred in endeavouring to contact patients.

- 1.3 DNA costs directly contribute to the value of the top-up element of the Operating Payment payable to the IDH Group in accordance with the terms of the Letter of Agreement. It is projected, subject to year-end figures, that the top-up element in 2008-09 for the three sites (Dumfries, Moffat and Stranraer) will be considerably higher than the previous financial year and one of the casual factors may be attributed to the cost/ value of DNAs.
- 1.4 At the meeting on 1 December 2008, BMG was asked to agree the introduction of a routine penalty charge (currently £1 per minute in other IDH sites) in respect of DNAs at all IDH dental centres in the region, with appropriate safeguards in place for vulnerable categories of patients.
- 1.5 BMG requested that additional audit information be obtained to better understand the causes for the unexpectedly high level of DNAs and the results of the audit are provided below.

2. AUDIT RESULTS

- 2.1 IDH undertook an audit of DNAs during a five-week period from 26 January 2009 over three sites.
- 2.2 IDH identified all patients who had failed to attend during the audit period. Initial contact was attempted by telephone in order to schedule new appointments. A number of re-appointments were made by the end of the audit period and more would be expected as patients acted on the subsequent reminder letters issued by the practices.

Table 1 below indicates the results:

Dental Centre	Total Appointments	Number of DNAs	Percentage DNAs	No of Patients Re-appointed
Loreburne, Dumfries	1,354	147	10.86%	62
Moffat	735	52	7.07%	17
Whitecross, Stranraer	724	68	9.39%	16

Patients not re-appointed at this stage remain within the practice system in accordance with the timetable for Continuing Care (adults) and Capitation arrangements (i.e. registration with the practice) and may access General Dental Service at their own discretion.

- 2.3 Table 2 shows the number of historical DNAs for individual patients during the audit period at Moffat and Whitecross (details for Loreburne not available).

Table 2

Dental Centre	Number of appointments audit population has missed since registration										
	0	1	2	3	4	5	6	7	8	9	10
Moffat	16	10	9	7	4	2	4	0	0	0	0
Whitecross	7	20	12	7	4	0	8	3	4	2	1

- 2.3 Where possible to contact by telephone, patients provided 2 main reasons for missing appointments: (a) they had simply forgotten the appointment/or were confused about the appointment times, and (b) they were unwell and had not notified the practice that they were unable to attend. More commonly, the data reflects the difficulty that IDH Group reports in making daytime telephone contact on occasions, which necessitates the issue of letters inviting patients to contact their practice to reschedule missed appointments. This involves additional practice resources, both financial and workforce.

Table 3 below indicates patient reasons for failing to attend and the practices' difficulties in contacting patients.

Table 3

Dental Centre	Patient ill/unwell	Patient forgot, or confused about the appointed date & time	Phone message left	No reply to call/letter issued	No phone or answer machine/letter issued	Total contacts
Loreburne	19	28	27	67	6	147
Moffat	4	14	4	25	3	50*
Whitecross	1	16	3	18	30	68

* Moffat Dental Centre – total events were 52, but one patient was deceased and another had transferred registration to another practice.

3. PATIENT EDUCATION

- 3.1 IDH Group reports that in their dental centres in other areas of the country a DNA penalty charge of £1 per minute per scheduled appointment is levied as the very minimum, sustainable response to the challenge of DNAs. Positive results are reported, with a noted decrease in the number of failed attendances.
- 3.2 Such a penalty charge would be applied with the appropriate degree of discrimination. For example, IDH Group does not apply a penalty charge to cancellations (with due notice), cancellations arising from emergency situations, patients with dementia, etc.

- 3.3 If a DNA penalty charge is approved by BMG, IDH Group would be instructed to ensure that adequate information is given in its patient literature, including letters of invitation to appointment, concerning DNA penalty charges.
- 3.4 All steps would be taken to encourage patients to appreciate the need for the charge and to comply. Patients will not be prevented from accessing NHS dental services if they default; however, appropriate access restrictions may be introduced, as applicable in individual cases.

4. CONCLUSION

- 4.1 The additional audit information indicates that there is continuing patient failure to attend scheduled appointments, despite the best efforts of the IDH Group to contact patients in this category. In many cases, it is not possible to establish the reason for non-attendance, as contact with patients could not be made via the day-time telephone number provided.
- 4.2 The contract with IDH Group in respect of the Loreburne, Moffat and Whitecross Clinics will conclude on 31 March 2010 at which time the contractor will assume routine General Dental Service status, i.e. without the top-up element to remuneration. In accordance with its operating policy elsewhere and the sanction of the Dental Regulations, IDH Group will apply penalty charges at all of its sites across Dumfries and Galloway, as required.
- 4.3 BMG is requested to consider this request and approve the immediate introduction of a DNA penalty charge (currently, £1 per minute) for missed appointments (relative to the named categories as indicated in (3.2) above at all aforementioned IDH Group dental sites in the region, including Garden Hill Dental Clinic.

MONITORING FORM

Policy/Strategy Implications	<i>Dental Action Plan – improvements in dental access for patients</i>
Staffing Implications	<i>None for IDH.</i>
Financial Implications	<i>Reduction in top-up monies payable by Board to IDH.</i>
Consultation	<i>Board and contractor personnel</i>
Consultation with Professional Committees	<i>Independent contractors may already de-register patients, including for failure to attend.</i>
Risk Assessment	<i>Patients will not be barred from access to NHS dental services</i>
Best Value	<i>Reducing misuse of public resources and expenditure</i>
Compliance with Corporate Objectives	<i>Ongoing improvements to NHS dental access for patients – Dental Action Plan</i>
Impact Assessment	All patients in the Board's area have access to NHS dental service.

DUMFRIES and GALLOWAY NHS BOARD

6 July 2009

**PROFESSIONAL REGULATION****Author:** Dr Angus Cameron**Sponsoring Director:**
Dr Angus Cameron**Date:** 26 June 2009**RECOMMENDATION**

A variety of highly publicised events at the end of the last century led to a loss of confidence in the regulatory framework for doctors and the independence of the General Medical Council.

Since then considerable progress has been made on reviewing Professional Regulation, summarised in the United Kingdom Government's White Paper on Professional Regulation "Trust, Assurance and Safety – the Regulation of Health Professionals in the 21st Century".

This paper updates the Board on the programme of revalidation for all doctors registered in the United Kingdom.

SUMMARY

It is recommended that the Medical Director should provide a further report to the Board in 6 months time having, in engagement with senior medical leaders, developed proposals for the local implementation of revalidation.

It is also recommended that the Appraisal Assurance Group should provide 6-monthly reports to the Healthcare Governance Committee to provide assurance that a thorough Local Appraisal System is in place for all doctors and to assure the Committee that appropriate procedures exist for the identification and management of poorly performing doctors.

The Board Medical Director and Associate Medical Director will introduce a pilot of multi-source feedback for Consultants in DGRI commencing later this year and they will report to the Healthcare Governance Committee on the effectiveness and benefits of this process early next year.

BACKGROUND

Prior to the changes in medical regulation initiated by the General Medical Council (GMC) doctors were not required to demonstrate that they maintained and developed appropriate professional skills. A culture existed that was high on trust and did not see a need to formally require doctors to provide evidence that they firstly practised within acceptable generic standards, and secondly maintained the knowledge and skills appropriate for any specialist role.

A system of annual appraisal was set up 6 years ago and now all Consultants, Speciality Doctors and General Practitioners are required to undergo appraisal. Appraisal however as currently practised is a supportive, formative and reflective session which probably does not have enough rigour to provide assurance to the public that doctors are maintaining standards and skills appropriate for the delivery of a high quality service.

In response to that criticism a process of revalidation has been developed for all doctors within the UK. This will involve two strands; relicensing (confirming that doctors practice in accordance with the General Medical Council's generic standards), and recertification (confirming that doctors on the Specialist and GP Registers maintain skills and knowledge appropriate for the continuing delivery of their speciality of medicine).

REVALIDATION

Revalidation therefore will consist of two processes :

1. **Relicensing** – The relicensing component of revalidation will rely on annual locally based appraisal informed by, amongst other evidence, periodic multi-source feedback (otherwise known as 360° feedback). To ensure that NHS appraisal has the consistency to provide appropriate assurance, the system will require that a standardised module of appraisal, agreed by the GMC, should be included in all appraisal systems. The other aspects of appraisal will be a matter for local employers. The standardised module will be derived from the GMC's "Good Medical Practice".

Relicensing will have 3 main elements :

- a) Participation in annual appraisal within the workplace (based on the doctor's folder of information).
- b) Participation in an independent process for obtaining feedback from patients (where applicable) and colleagues.
- c) Confirmation from the "responsible officer" (usually the Medical Director) in their local Health Board or organisation that any concerns about their practice have been resolved.

The responsible officer will provide a recommendation to the GMC on the

basis of which the GMC will make a decision whether the doctor's license will be renewed.

All doctors practising in the UK at present will be relicensed in the autumn unless they wish to withdraw from licensing. Following that, in order to maintain licensing they will require to demonstrate the 3 elements described above on an annual basis.

2. **Appraisal**

It is clearly an essential feature of the new regulatory structures that local annual appraisal is quality assured and that there are appropriate structures connecting to appraisal to ensure that any areas of concern noted in the appraisal process are appropriately and fairly addressed, seeking always to identify any problems early and to ensure that they are robustly addressed.

Within NHS Dumfries and Galloway there are 3 main strands of appraisal – GP Appraisal, Consultant Appraisal and Speciality Doctor (previously Staff and Associate Specialist Grade) Appraisal. The structures for the 3 strands of appraisal are different with different paperwork and processes arranged.

The Board has set up a local Appraisal Assurance Group chaired by the Medical Director which will ensure that there is 100% uptake of appraisal amongst doctors working for the Board, ensure that appropriate reports are provided to NHS QIS for external assurance purposes for all 3 streams of appraisal and lastly, ensure that adequate arrangements are in place to ensure that areas of concern are identified early through the appraisal process and are then addressed satisfactorily.

The Appraisal Assurance Group will also explore the possibilities of, and make recommendations on, the development of a local process for multi-source feedback, taking note of the GMC recommendations.

RECERTIFICATION

Recertification will provide assurance that a doctor on the Specialist or GP Register maintains the appropriate skills and knowledge for that speciality of medicine. The recertification component of revalidation will therefore involve the specification of a clear set of standards, for each speciality, formulated by each Medical Royal College working in collaboration with specialist associations and other advisers. The methods used for evaluating specialist practice will vary across specialities but will need to be rooted in evidence of the doctor's actual practice. A great deal of work needs to be done on the detail of recertification before it can be introduced. The GMC has established a series of joint working groups with the Academy of Medical Royal Colleges to help develop appropriate processes for recertification. Although this work is at an early stage the set of propositions that provide the starting point for the work has been developed, namely :

- a. There is a need to minimise the burden of recertification and avoid duplication.
- b. The purpose of recertification is to demonstrate that doctors on the Specialist Register or the GP Register continue to meet the particular standards that apply to their medical speciality or area of practice.
- c. Recertification must command the confidence of patients, the profession, the NHS and other healthcare providers, and the medical schools / Medical Royal Colleges. The Medical Royal Colleges and specialist associations will be responsible for defining the standards appropriate to a speciality or area of practice and the methods used to assess them. Evidence should be drawn from a range of sources and activities which may include appraisal structured on good medical practice, multi-source feedback, clinical audit, simulator tests, knowledge tests, continuing professional development and observation of practice.
- d. The standards for remaining on the Specialist Register and the GP Register will be the same as the standards currently required for entry to those registers. However, the range of competencies and evidence to be demonstrated for recertification will relate to the doctor's actual practice.

The combination of relicensing and recertification leading to revalidation will require that the Board maintains a quality assured appraisal process, maintains appropriate clinical governance structures to provide information for recertification, has appropriate processes in place for the identification and rectification of poor practice, and through the responsible officer provides evidence to the GMC supporting recommendations on revalidation.

At a local level the responsible officer (usually the Medical Director) will ensure that appraisal is carried out to a good standard, will work with doctors to support them in addressing any shortfalls, ensure any concerns or complaints have been addressed, and will collate this information to support a recommendation on the relicensing of a doctor.

Provided this has been done the responsible officer's role in relation to the 5-yearly revalidation cycle should consist of a final check that :

- Successive appraisals and multi-source feedback provide support to recommend revalidation, and
- Any concerns flagged up during the intervening 5 years have been resolved and all remedial action completed.

Just as revalidation for the individual doctor will be a process, so too will be the introduction of the system of revalidation. The roll-out of both relicensing and recertification will be incremental as the capacity and capability of local clinical governance and appraisal systems develops and as the standards and assessment work of individual Royal Colleges is completed. To ensure effective, proportionate and sensitive introduction of these systems many aspects will be piloted, evaluated and adapted prior to implementation.

ASSESSMENT

Medical revalidation will bring additional responsibilities to NHS Boards that will require the creation of a responsible officer role as set out in “Good Doctors, Safer Patients” and developed further in the White Paper. For revalidation every doctor in the UK will need to relate to one (and only one) responsible officer.

Revalidation will be a continuous 5 year process. The responsible officer will therefore need systems to review the practice and conduct of all the doctors for whom he is responsible. Where significant concerns are raised the responsible officer will need to ensure that they, or another senior doctor, review the evidence to decide whether there is an issue that could put revalidation at risk and if so, what remedial or developmental action is needed.

There are several challenges to implementation :

- a) **Logistic** – Large numbers of doctors need to be covered by the scheme which encompasses a great diversity of roles and practice settings. For example within NHS Dumfries and Galloway there are approximately 135 GPs and 110 Consultants not to mention locums and non career-grade doctors who will also be covered by the requirements to relicense.
- b) **Connections** – A large number of systems and organisations examine the quality of healthcare in the NHS and many will throw light on doctors’ performances and practice. Where appropriate effective connections need to be made between them and the system of revalidation and there needs to be a concerted effort to avoid duplication and bureaucracy.
- c) **Information** – High quality data on clinical outcomes of care are vital to effective assessment of clinical practice. These have been lacking in the past and must be developed more quickly with an emphasis on accurate and verifiable data.
- d) **Cultural** – To be valued, and valuable to doctors and patients, revalidation must be seen primarily as a mechanism for quality improvement and not merely spotting “bad apples”. The involvement of patients and the public will greatly enhance the quality of the process of revalidation and help promote public confidence in the profession itself.

MONITORING FORM

Policy / Strategy Implications	<i>Consistent with improving quality.</i>
Staffing Implications	<i>Not yet clear</i>
Financial Implications	<i>Not yet clear</i>
Consultation	<i>Widespread GMC consultation</i>
Consultation with Professional Committees	<i>Not yet discussed with ACF or LMC</i>
Risk Assessment	<i>Risk that there will be significant cost in both time and cost of 360° feedback</i>
Best Value	<i>Consistent with improving quality</i>
Compliance with Corporate Objectives	<i>Consistent with improving quality</i>
Impact Assessment	<i>n/a</i>

DUMFRIES and GALLOWAY NHS BOARD

6 July 2009

Speakeasy in Dumfries and Galloway**Author:**
Laura Fairbairn**Sponsoring Director:**
Dr Derek Cox, Director of Public Health**Date:** May 2009**RECOMMENDATION**

The Board is asked to note the latest evaluation of the Speakeasy pilot project.

SUMMARY

The purpose of this report is to explore progress towards achieving the main aims of the Speakeasy pilot project in Dumfries and Galloway, providing insights into how the course has benefited parents in terms of changes in knowledge, attitudes and behaviours. The results strongly suggests that Speakeasy in Dumfries and Galloway is meeting its aims and objectives.

Speakeasy **in** **Dumfries and Galloway**

Project Evaluation

May 2009

Laura Fairbairn
Health Improvement Project Specialist/
Co-ordinator Speakeasy
Directorate of Public Health and Strategic Planning
NHS Dumfries and Galloway

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Report summary

The purpose of this report is to quantitatively and qualitatively explore progress towards achieving the main aims of the Speakeasy project in Dumfries and Galloway, providing insights into how the course has benefited parents in terms of changes in knowledge, attitudes and behaviours.

Project outputs

Ninety seven parents completed the full Speakeasy course between April 2008 and May 2009, and it is estimated that around 1020 people have benefited from the project. 94.8% of parents who attended the course submitted their portfolio for Open College Network accreditation and all successfully gained this.

Project outcomes

In addition to completing a registration form to enable collection of demographic details each parent was asked to complete an evaluation form before and after the course. These asked parents to rate their confidence and knowledge on key areas relating to the aims of the Speakeasy course. Findings of the analysis of these evaluation forms shows:

- Confidence in talking to their children about sex and relationships increased by 59.4%
- Knowledge of the topics including puberty, contraception, sexually transmitted infections (STIs) and keeping safe increased by an average of 47.4%
- The number of parents agreeing or strongly agreeing with the statement “I feel able to talk to my children openly about sex and relationships” increased by 37.4%
- The course successfully alerted parents to opportunities to raise issues with their children. The number of parents agreeing or strongly agreeing with the statement “I am aware of opportunities to raise issues with my children” rose to 95.8% after the course, an increase of 40.5%.

Focus group summary

In summary all the focus group participants stated that Speakeasy had been a positive experience and they would recommend it to other people. The key themes which emerged from the four discussions were an increase in confidence in talking to children about sex and relationships, an increase in knowledge of the related topics, enjoyment of the activities and resources used throughout the course and a positive response about the dynamics of the groups. Some learners identified challenging aspects of the course and suggested improvements.

Training other Speakeasy facilitators

In April 2009 the Project Co-ordinator trained 16 new facilitators across the region to deliver Speakeasy. Some were trained to deliver Speakeasy as part of their current employment whilst others will deliver courses as an NHS volunteer.

Conclusion

The number of people benefiting from speakeasy is impressive and the evidence generated from both the evaluation forms and the focus groups suggests that this two year pilot project of the fpa’s Speakeasy programme in Dumfries and Galloway is achieving its desired aims of providing parents/carers with the knowledge and skills to communicate confidently with their children and encouraging and supporting parents to take on the role of “sex educator” in the

home. Speakeasy has had a very positive impact on those who have participated and this is likely to continue as the new facilitators begin to deliver more courses across the region.

1. The Speakeasy programme

Speakeasy aims to encourage parents and carers to talk confidently with their children about sex, relationships and growing up. Speakeasy is run by the Family Planning Association (fpa) in Ireland, England, Wales and now Scotland and is for parents and carers of children of all ages. The course is usually delivered over an 8 week period, though this is flexible, and it is delivered by trained facilitators. The 8 sessions are as follows:

Table 1: Speakeasy sessions

Session	Topic
1	Puberty
2	Age appropriate topics
3	Questions children ask and resources
4	Cultural influences
5	Contraception
6	Sexually Transmitted Infections
7	Keeping children safe from harm
8	Sex and Relationships Education in schools

The five main aims of fpa Speakeasy are to:

- Increase parents confidence and communication skills with their children;
- Help parents show a more positive and open approach to discussions of sex, sexuality and sexual health;
- Increase parents factual knowledge around sex and sexual health;
- Provide a step towards further learning or professional development for traditionally excluded groups of parents; and
- Enable health and educational professionals to give higher priority to work with parents and carers, with the backing of accredited Speakeasy training so that large numbers of parents through England will have access to a Speakeasy course.

Parents who attend Speakeasy are offered the opportunity to work towards accreditation with the Open College Network (OCN) at either level 1 or level 2. This accreditation is gained through assessment of the evidence produced in relation to the learning outcomes of the Speakeasy course. This evidence is collated into a portfolio which is then assessed by the course facilitator and moderated by fpa and the Open College Network.

In 2004 Triangle Consulting conducted an evaluation of the first 3 years of Speakeasy and in 2007 the Trust for the Study of Adolescence (TSA) conducted an independent evaluation of Speakeasy in England. Throughout chapters 2 and 3 of this report the findings of Speakeasy in Dumfries and Galloway are compared with those from these two studies, where appropriate..

1.1 Speakeasy in Dumfries and Galloway

Speakeasy was identified by the NHS Dumfries and Galloway's Health Improvement Programme Lead for Sexual Health as one possible contributor to achieving the long-term local and national goals of reducing unwanted pregnancy and Sexually Transmitted Infection (STI) rates. NHS Inequalities funding was awarded for a two year pilot of Speakeasy and a Project Co-ordinator was recruited in November 2007 to establish, deliver and evaluate the programme.

The Dumfries and Galloway approach to delivering Speakeasy is unique. To date Speakeasy has predominantly been delivered by fpa facilitators in Ireland, England, Wales and now in central Scotland. Dumfries and Galloway is therefore the first area where the NHS has funded and recruited an employee for the purpose of establishing, delivering and evaluating Speakeasy.

The aims of the Speakeasy pilot project in Dumfries and Galloway are:

- To establish and run the speakeasy pilot project with parents and carers who are socially and economically deprived, for a two year period;
- To provide parents/carers who experience social and economic disadvantage with the knowledge and skills to be able to communicate confidently with their children about sex, relationships and growing up;
- To encourage and support parents/carers to provide positive sex and relationships education in the home environment;
- To encourage and support parents/carers to take on the role of “sex educator”; and
- To provide other organisations within Dumfries and Galloway with the skills to deliver Speakeasy training to parents/carers.

The following desired outcomes were identified prior to the project receiving funding:

- Parents/carers will have the confidence and communication skills to enable them to communicate effectively with their children on sexual health and relationship issues;
- Parents/carers will have a positive and open approach towards discussions around sex, relationships and growing up;
- Parents/carers will have a high level of factual knowledge around sex and relationships;
- Parents/carers will attain the learning accreditation; and
- Speakeasy training will eventually be provided by a number of organisations across Dumfries and Galloway.

1.2 Marketing courses

As the Project Co-ordinator does not work ‘on the ground’ with parents and carers who might be interested in Speakeasy, to recruit parents for the course it is important that positive relationships are established with partner organisations who offer services or support to parents and carers. It is therefore critical that strong relationships are formed and maintained with partner organisations.

To date the Project Co-ordinator has established relationships with the following partners: Criminal Justice, Child and Adolescent Mental Health, Home Link Workers, School Cluster Co-ordinators, Public Health Nurses (including School Nursing and Health Visiting), Fostering and Adoption, Loreburn Housing Support, Community Planning, Building Health Communities, Public Health Practitioners, Working For Families, Social Services, Fairer Scotland Fund, Prince’s Trust for Carers, Children’s Service Centres and some Community Learning and Development teams.

These relationships have been achieved through delivering short presentations about Speakeasy to staff teams, by offering taster sessions to potential parents, by attending health events and by disseminating course information through colleagues in both the public and third sectors.

1.3 Steering Group

The Project Co-ordinator identified potential key partners and convened a multi-agency Steering Group to oversee the development of the project. The first meeting took place in February 2008 where the aims and objectives for the Steering Group were agreed and key actions were decided. Members of this Steering Group include representation from Health Improvement, Dept. of Family Planning, Education, Social Work, Parenting Services and Public Health Nursing. A full list of members is contained in Appendix 1. The Project Co-ordinator sought the guidance of the Steering Group on matters including advertising courses, evaluation and identifying further partners.

Some difficulties were encountered in creating relationships with a very small number of potential partners, though the Project Co-ordinator continued to work with her line manager to build on these. There was an apparent lack of commitment in attending Steering Group meetings and this prompted the decision to progress with six-monthly rather than quarterly meetings. Between meetings the co-ordinator continued to communicate with the group via email. Further investigation of why members failed to attend will be useful in a final project evaluation.

1.4 The Speakeasy budget

As previously stated NHS Dumfries and Galloway awarded Inequalities funding for a two year pilot of Speakeasy. To date £67,489 has been spent as follows:

Table 2: The Speakeasy budget

	2007/8	2008/9	Total spend
Pays	14120	32163	46283
Travel	796	4050	4126
Stationary	137	626	763
Venue hire + hospitality	58	911	969
Press	0	2239	2239
Furniture and fittings	1115	0	1115
Computer equipment	928	0	928
Professional fees (fpa)	90	10256	10346
Total spend	17244	50245	67489

This leaves £27,511 for the remaining 6 months of the pilot project. Unfortunately because of the methods the Finance Dept use to categorise spending we are unable to interpret from budget statements exact costs for items such as childcare. However keeping records of invoices received indicates that approximately £1700 has been spent, at time of writing, on childcare provision for parents attending Speakeasy courses.

1.5 Addressing health inequalities

Although the funding received from NHS Dumfries and Galloway aims to address health inequalities the Project Co-ordinator and Steering Group decided that it was important not to stigmatise the course in any way and therefore the course would not be advertised as aiming

to tackle health inequalities. Instead efforts are made to deliver the course in identified areas of deprivation within the region. However being aware that some 80% of deprived people (either in terms of income or employment) within Dumfries and Galloway do not actually live within these identified areas (Cox and Ajetunmobi 2007) the Project Co-ordinator has established positive relationships with organisations across the region which support vulnerable families to ensure that courses are advertised and marketed to these families.

Note: Throughout this report the term “parents” is used to include all parents, carers and also grandparents and others in a caring role

2. Project outputs

2.1 Number of parents and families benefiting

Fifteen courses were delivered between April 2008 and May 2009 with a total of 97 parents completing. Though course sizes varied between 3 and 9 the average number of parents per course was 6. Five courses were delivered in Dumfries, 4 in Stranraer, two in Newton Stewart, two in Annan, one in Castle Douglas and one in Lockerbie.

In addition the 21 parents who did not complete the full course all attended between 1 and 5 sessions. Taster sessions were often delivered prior to the commencement of a full course and it is estimated that 25 parents attended these taster sessions but for various reasons did not attend a full course. Parents who attended part of the course or a taster session will have increased knowledge and awareness to some extent so therefore will have benefited in part. This means that approximately 145 parents have benefited from Speakeasy. Assuming that approximately half of these parents will discuss with their partners and that all will discuss with at least one member of their extended family or a friend and that each of these adults will in turn discuss with the average number of children (2.3) then we can see that potentially 1020 people will have benefited from the Speakeasy pilot project to date in Dumfries and Galloway.

Table 3: Beneficiaries of Speakeasy

Direct benefit	children	partners	Friends/family	Children of friends/family	Total benefited
145	330	70	145	330	1020

2.2 Gender, ethnicity, age, number of children and work status

Similarly to Speakeasy courses delivered in other areas of the UK the vast majority of course parents in Dumfries and Galloway were female (91.2%). Interestingly though the percentage of male parents in Dumfries and Galloway (8.2%) is noticeably more than the Trust for the Study of Adolescence found in their 2007 Evaluation of Speakeasy in England (5%).

Almost all parents (98%) described themselves as White British or White Scottish with 1% describing themselves as African and 1% as Chinese. In comparison 71% of parents in the TSA's evaluation described themselves as White British. This may reflect the comparatively small ethnic minority population in Dumfries and Galloway, but Speakeasy is marketed towards a variety of cultures and as suitable for people whose first language is not English.

Over a third of parents (35.1%) were aged 20 to 29, 28.9% were aged 30 to 39, a quarter (24.8%) were aged 40 to 49 and 10.3% were aged 50 to 59. Triangle Consulting's 2004 evaluation similarly found that 60% of parents were aged 25 to 40 but interestingly only 10% of parents were aged over 40, compared to over 35% of parents in Dumfries and Galloway. This may reflect that Speakeasy in Dumfries and Galloway was marketed not only to parents but to other carers including grandparents and people with a caring role within their workplace.

The 97 parents who completed the course had 193 children between them. One fifth (19.6%) of course parents had one child, 43.3% had two children, 11.3% of parents had three children, and 4.1% of parents had four, 8.2% had 5 children and 1% had 6 children. 12.4% of parents had no children. The average number of children was therefore 2.3% (excluding those

with no children). The TSA's 2007 Evaluation had similar findings, with the average number of children being exactly two and 17% of parents having no children. The ages of the parents' children varied: 15% were pre-school aged, 44.6% were primary school aged, 18.7% were aged 12 to 15 years and 21.2% were aged 16 or over (many of these parents/carers were completing Speakeasy as part of their work role).

In terms of their work status, 33% of parents described themselves as registered unemployed, 9.3% of parents described themselves as unwaged and not seeking work, 28.9% described themselves as employed part-time, 17.5% described themselves as employed full-time. 5.2% described them self as a student, 2.1% described themselves as a full-time carer (an option they added themselves), 2.1% did not answer the question and 2.1% chose not to state their employment status. As the largest proportion of parents described themselves as registered unemployed this demonstrates that the project is reaching the targets groups, those experiencing social or economic disadvantage.

2.3 Learning and development

6.2% of parents stated that Speakeasy was the first course they had taken since leaving school and 93.8% stated that Speakeasy was not the first course they had taken since leaving school.

Almost half of parents (46.4%) did not consider themselves to have a learning difficulty and/or disability and 52.6% did not answer this question, 1% chose not to state their answer. It is believed that the high number of people not completing this question was because of the layout of the fpa's evaluation form.

As previously stated 94.8% of parents opted to work towards OCN accreditation, all at level 2, and all were successful with this. This is a noticeably higher proportion than that of the 2004 evaluation of Speakeasy in England which found that 86% of parents gained OCN accreditation.

2.4 Those who did not complete the full course

One hundred and eighteen people started the Speakeasy course and, as previously stated, 97 people completed it. This equates to a drop-out rate of 17.8%. This rate is higher than that calculated in the 2004 3 year Speakeasy Evaluation. Reasons for dropping out included: current or new work commitments, their own or their child's health problems; change of job; and prior conflict with another member of the group. In addition it is believed that the demise of Working for Families contributed to a small number of parents failing to complete the course as WFF provided encouragement to attend and support with childcare and transport costs.

3 Project outcomes

Each parent was asked to complete an evaluation form before and after the course which asked them to rate themselves on key areas relating to the aims of the Speakeasy course including confidence in talking to their child about sex and relationships, and knowledge in relation to puberty, contraception, sexually transmitted infections and keeping safe from harm. Start evaluation forms were unavailable for 4 of the 97 parents who completed the course and end evaluation forms were unavailable for 1 of the parents. All data was adjusted accordingly.

The most informative data from the evaluation forms are derived from Questions 1-3 and concern self perceived confidence about discussing sex and relationships issues with their children (Q1), perceived knowledge in relation to puberty, sexually transmitted infections (STIs), contraception and keeping safe from harm (Q2a-d) and attitudes towards sexual health and relationships education and further learning (Q3a-e).

The results from each of these questions will be outlined by comparing the pre and post course findings. For the first and second questions the findings were derived from 5 point scales. Parents were asked to self rate themselves on a scale of 1 to 5 with 1 being 'not confident' or 'little knowledge' to 5 being 'very confident' or 'very knowledgeable'. Therefore a positive effect of Speakeasy would be reflected in an increase in the average score for each question.

Parents were asked to rate their confidence in response to the question 'at the moment how confident do you feel talking to your children about sex and relationships?'. Table 1 below shows the self reported scores of parents both before and after the course.

Table 4: self-rated confidence in talking about sex and relationships

Before course average out of 5	After course average out of 5	Score change	% change in average score
2.88	4.59	1.71	+59.4%

Before the course confidence in talking to their children about sex and relationships was self reported at 2.88 out of 5. This increased by 1.71 to 4.59 after the course. A 59.4% increase in the average self rated confidence score is a very encouraging finding and suggests that the course has significantly affected parental confidence in talking to children about sex and relationships. The TSA's 2007 evaluation also showed an increase (47%) but not as great as that in Dumfries and Galloway.

Four questions measured parental knowledge in relation to sex and relationships. These focused on how much knowledge parents felt they had to talk to their children about: changes during puberty, STIs, contraception and keeping safe.

Again parents were asked to rate their knowledge of the topics, including puberty, STIs, contraception and keeping safe. Table 2 shows the self-rated scores of parents before and after the course:

Table 5: self-rated knowledge scores out of 5

Knowledge	Average Pre-course score (out of 5)	Average Post-course score (out of 5)	Score change (%)
Changes during puberty	3.01	4.59	1.58 (+52.5%)
STIs	2.69	4.45	1.76 (+65.4%)
Contraception	3.47	4.64	1.17 (+33.7%)
Staying safe	3.24	4.61	1.37 (+42.3%)
Average score for all 4 topics	3.1	4.57	1.47 (+47.4%)

Overall knowledge of the topics including puberty, STIs, contraception and keeping safe increased from a score of 3.1 before the course to 4.57 after the course, an increase of 47.4%. Significant score increases are observable in all individual knowledge areas, of particular interest is the dramatic increase in knowledge about STIs. These increases in knowledge are in line with those found by the TSA in their 2007 Evaluation of Speakeasy and the above results suggest that the course had a positive effect on parents and that Speakeasy is meeting its aim of increasing factual knowledge around sex and sexual health

The Project Co-ordinator observed that although some parents self-rated their knowledge on the topics of contraception and STIs fairly highly at the start of the course, following the relevant sessions the parents often expressed their surprise at how little they actually did know. Therefore taking into consideration that some parents initially overestimate their knowledge about contraception and STIs, giving themselves too high a score at the start, this suggests that in reality the increase in these topics may in fact be higher. This was similarly reported in the 2004 3 year evaluation of Speakeasy by Triangle Consulting.

Question 3 consisted of five statements which parents were asked to consider and rate their agreement with. Parents scored themselves on a 5 point scale between strong agreement with the statement to strong disagreement with the statement. The statements cover 2 of the key aims of the Speakeasy course: to assist parents in having a more open approach to discussing sex and relationships; and also to provide a step towards further learning. These aims will be considered separately. Table 3 shows the percentage of parents who 'strongly agreed' or 'agreed' with statements relating to both openness before and again after the course was completed.

Table 6: Parents strongly agreeing or agreeing with the statements about an open approach to sex education

Statement	Before the course			After the course		
	Strongly agree (%)	Agree (%)	Both %	Strongly agree (%)	Agree (%)	Both (%)
I want to talk with my children openly	64.9	29.8	94.7	76.7	20.2	98.9
I feel able to talk to my children openly about sex	19.1	38.3	57.4	63.9	30.9	94.8
I am aware of opportunities to raise issues with my children	10.6	44.7	55.3	68.1	27.7	95.8

For all three statements the percentage of parents ‘strongly agreeing’ and ‘agreeing’ show increases after the course. The most noticeable swings in response are in relation to being aware of opportunities to raise issues with their children. In addition there is a noticeable increase in the number of parents agreeing or strongly agreeing that they feel able to talk openly about sex and relationships with their child. These findings presented in table 3 continue to show a positive response to the course and are similar to those from the TSA’s 2007 Evaluation

The final two statements of Question 3 related to the Speakeasy aim to provide a step towards further learning. The parents’ self rated scores both before and after the course are presented below:

Table 7: Percentage of parents who ‘strongly agree’ or ‘agree’ with the statements about further learning

Statement	Before the course			After the course		
	Strongly agree	Agree	Both	Strongly agree	Agree	Both
I feel confident about learning as a member of a Speakeasy course	24.5%	64.9%	89.4%	77.4%	21.5%	98.9%
I have been considering going back to learning/ further education	32.3%	38.7%	71%	35.9%	39.1%	75%

These results show that the percentage of parents who ‘strongly agree’ or ‘agree’ with the statement “I feel confident learning as a member of a Speakeasy course” rose from 89.4% before the course to 98.9% after the course. This increase suggests that the Speakeasy learning experience had improved the confidence about learning for some of the parents. The percentage of parents who ‘strongly agree’ or ‘agree’ that they had been considering going back to learning or further education rose from 71% before the course to 75% after the

course. This demonstrates that by completing the Speakeasy course an additional 4% of parents were considering further educational opportunities.

Parents were also asked if they were intending to do any courses at college or an adult education centre this year or next. Before the course 33% of parents intended to go on to further learning and after the course this increased to 57.8%. Interestingly, in comparison, the TSA 2007 Evaluation found only a very slight increase in the number of parents intending to go on to further learning.

The evaluation forms also collected data relating to wider attitudes towards educating children about sex and relationships (Q5).

Table 8: Who has the main responsibility for telling children about sex and relationships

Who has the main responsibility for telling your children about sex, sexuality, sexual health and relationships	Before the course	After the course
Parents	96.8%	100%
Teachers	24.5%	51.1%
School Friends	7.4%	11.7%
Other family members	6.4%	14.9%
Others	5.3%	9.6%

Prior to the course most parents (96.8%) stated that parents had or shared the main responsibility for telling children about sex, sexuality, sexual health and relationships and those who stated that parents shared the main responsibility stated that they shared this with teachers school friends, other family members and others (including school nurses, older siblings and youth workers. After the course this increased to all of parents agreeing that parents had the main responsibility, however the number of parents who stated that teachers, school friends, other family members or other people also had some responsibility increased. This does not reflect the findings of the TSA's 2007 Evaluation but might suggest that an increased number of parents view SRE as a shared responsibility. Whilst participating in the course parents were informed that SRE was not currently statutory in Scotland and therefore there were inconsistencies in what schools delivered. However they were also informed that there was a new curriculum in development which included outcomes on relationships, sexual health and parenthood for all young people aged 3 to 18. This information is likely to have influenced how parents responded to this question about who has the main responsibility for telling children about sex and relationships when they were asked after the course.

Finally, the end evaluation forms also contained three further open ended questions about the course (Q8, 9, 10). Firstly parents were asked what two things about the course they had really enjoyed. The most frequent response was in relation to group work, discussions and working with/meeting other people:

“Meeting people within the group and hearing their stories/experiences”

“Being able to talk openly with the group about everything – that’s where a lot of my learning has been done”

Some parents identified specific topics which they enjoyed learning about and the activities which assisted this learning. Most of these comments were about the sessions on STIs and contraception:

“I really enjoyed gaining more info on STIs and participating in all the hands on activities”

“Resources and visual aids”

Some parents described their increasing confidence about sexual health and relationships issues as the most enjoyable part of the course:

“The amount of information I felt was really good also covered a broad range on each topic which left me feeling armed and ready to talk to my children about issues that could be affecting them”

“It gave me confidence to talk to my children”

Some of the comments from parents were less specifically about particular aspects of the course, stating that they had generally enjoyed the whole course:

“Actually enjoyed it all”

“Can’t name two because I enjoyed it all”

Some parents commented that for them the most enjoyable aspect of the course was the varied learning styles utilised by the facilitator:

“The different learning styles, pictures, body boards, contraception – actual etc”

“Enjoyed ‘popular education’ approach – group work, peer group learning, discussions, small workshops, such as body boards, jigsaws”

Secondly parents were asked if there was anything about the course they didn’t enjoy. It is important to note that this question generated far less response than the things that parents did enjoy. Also some responses were very positive to this question with around 80% of parents stating that there was nothing that they did not enjoy:

“Enjoyed all of the course”

“No nothing at all as it was very informative and enjoyable”

However those who did comment on aspects of the course they did not enjoy mostly stated concerns with the volume of writing, paperwork and homework required in the short two hour sessions:

“Could have been a half to an hour longer in each session”

“For a level 2 accreditation the time for the amount of work required was perhaps a little mean”

“A lot of writing. I think if people had literacy issues they would struggle with it”

A small number of parents reported feeling uncomfortable during some of the sessions including cultural influences on sex and relationships education (such as race and religion) and child protection:

“Felt uncomfortable doing the part on cultural issues but have found it helped me on understanding this subject more”

“Some parts were difficult to talk about but doing it and getting info helps”

Finally, parents were asked how they were intending to use the OCN credit they had gained. A large number of parents commented that Speakeasy will help them talk to their children more confidently:

“ Will use my information to speak to my own children who are ages, 4, 11 and 12 and now have more knowledge and information to answer any of my children’s questions. And my folder and leaflets to look back on”

“To help my children through the difficult times of puberty and growing up, to help them learn about all aspects of sex and relationships”

In addition to stating that the credit would help them feel confident talking to their own children several parents also stated that they felt able to help other people including clients at their place of work, supporting other parents or working with young people:

“I am a youth drop-in facilitator, meeting young people every day at work, hopefully use my knowledge and pass it on to them”

“I will use it at my work in a Learning Centre in a secondary school”

A few parents commented that the OCN credit would be helpful with their future career aspirations:

“It will also go towards my entrance requirements for the Uni when I do my Social Work degree”

“I am hoping to work in the community eventually and this course will help if I work with youths”

In response to this question a number of parents expressed a desire to become Speakeasy facilitators. Also some parents were planning to help spread the word about Speakeasy by telling their friends and family about it:

“Use my knowledge to speak to other parents and encourage them to go on course if an opportunity arises”

In addition some parents chose this space, or the question about the aspects of the course they enjoyed the most, to comment on the course facilitator:

“Course facilitator – first class delivery of material, presented in a confident, easy pace, knowledgeable manner”

“The facilitator was very easy to get on with and extremely approachable and knowledgeable”

4. Focus group findings

Two celebration events were held in August 2008 where, in addition to being presented with their OCN certificates, all parents were invited to participate in a focus group discussion about their experience of Speakeasy. The purpose of these focus group discussions was to gather qualitative data which would supplement the quantitative findings of the Speakeasy in Dumfries and Galloway Progress Report and Interim Evaluation. Four discussions took place, all led by colleagues of the course facilitator. This ensured that the data generated by the discussions was not influenced by the facilitator being present. The focus groups followed a similar format to the Trust for the Study of Adolescence's (TSA) 2007 evaluation of Speakeasy and a scribe took notes of each discussion. At the Dumfries event two focus groups were held: one with parents and carers and another with people who had attended Speakeasy because of the organisation they work or volunteer with. Any differences in experience between these two groups of people will be explored.

In the weeks prior to the focus group discussions the Project Co-ordinator was contacted by BBC Scotland's Health Correspondent, Eleanor Bradford, to discuss the possibility of filming a Speakeasy session to feature in a BBC Scotland news bulletin about positive sex education. With the permission of all parents it was arranged that BBC Scotland would film a mock session and interviews with parents directly after the certificate presentations at the Dumfries celebration event.

4.1 Confidence

From the four focus group discussions the main theme which emerged was an increase in confidence from attending Speakeasy. Many of the parents stated that their confidence in talking about sex and relationships issues had increased and that their confidence in talking to their children about these issues had increased.

“Before the course I would have been embarrassed to talk about some of the issues but now I'm far more sure of how to deal with it.”

Some parents also stated that their increased confidence in talking about sex and relationships had encouraged them to talk openly with their children about other issues such as bullying, drinking, smoking and peer pressure;

“My confidence has definitely increased which has definitely improved talking to my children about sexual health issues, but also about all other aspects of life, we now talk about everything and I feel so much better for it and now we are really close.”

Some parents discussed how speaking openly about issues including sex and relationships had improved their relationship with their children:

“Speakeasy has made a big difference with my relationship with my son, not just about being able to talk to him about this but being able to talk to him better about everything.”

Some of the parents stated that they had gained more confidence in discussing these issues with their children than they had originally expected. A number of parents commented that although they stated before the course that they felt reasonably confident, they had since realised that they were not that confident as they had avoided certain situation or avoided

answering certain questions. This might indicate that the measured increase in confidence from the quantitative evaluation may actually be lower than in reality.

It was clear from the focus group discussions that, as intended, this increase in confidence in discussing growing up, sex and relationships was a direct result of both gaining skills to help talk about the issues and on increased knowledge of the topic areas:

“I know enough to be able to talk to my children with confidence”

4.2 Knowledge

All of the parents stated that their knowledge of the topics discussed on Speakeasy (body changes, STIs, contraception, keeping safe) had increased and all parents agreed that the course had been an “eye-opener” in all the subjects covered. Many of the parents stated that they enjoyed that the “real names for things” were being taught but that it was also useful to learn about the different terminology children are currently using.

The topics which particularly stood out for parents were STIs and contraception. Many of the parents expressed surprised at how little they knew before the course:

“The STIs, I did not know there were so many of them”

“The STIs, it was really eye opening and quite scary”

Some of the parents commented that it was useful to learn what is appropriate to discuss and explain at different ages and that Speakeasy encouraged them to think about age appropriate language (expand?)

4.3 Activities and resources

Many parents commented on the range of resources and learning activities used by the facilitator throughout the course. The resources and activities which were particularly enjoyed by the parents included the body boards, the question cards and the milk game. Some parents who had completed the course because of the organisation they work or volunteer with commented that the methods and approaches used were excellent and would be useful with their own client groups. In addition many parents stated that they found the range of leaflets and booklets gathered throughout the course were very useful to have for future reference. A few of the parents described using these leaflets and booklets as a tool to initiate conversations with their children by leaving them around the house for them to look at or read and then encouraging them to discuss.

“resources list was really useful. I missed using it when my folder was away (for accreditation)”

4.4 Communication

Many of the parents described how their communication with their children had improved by attending Speakeasy. A few parents stated that their children simply knowing that they were attending the Speakeasy course had encouraged them to talk about sex and relationships issues:

“Just telling the kids about the course triggered lots of questions at home over tea”.

One parent explained how attending Speakeasy had encouraged her child to trust the information she discusses with him:

“My son seems to believe what I say more now, now that I am an ‘expert!’”

Several parents described how this increase in communicating openly with their children about sex and relationships had encouraged their children to talk with them about other issues:

“Opens up doors to other subjects. Kids can feel its safe to talk about X so maybe it would be ok to also bring up Y”

“We can now talk about lots of different things that we never did before.”

Although some parents were unsure if any of the information they are discussing with their children is being passed on to their friends, one parent was more confident about the information her children were discussing with their friends;

“I spoke to my child about things and they speak to their friends like they have always done, but now I know that they have the right information.”

Parents also reported that Speakeasy had impacted on other members of their family;

“It had a positive impact on their dad, he is happier to talk about things, communication is much more open and honest”

However one parent described concern from her wider family that now that she was openly discussing issues around body changes, sex and relationships with *her* children this would have a negative impact on her sisters’ children because they might discuss inappropriate issues with her younger children:

“My sister was worried that my child would talk to her younger children about sex”

4.5 Group dynamics

Many of the parents commented on the interaction between the members of the group as they had found this to be one of the most positive aspects of the course:

“The participation on the course was really good”

Several parents described how useful it had been to hear a range of different views and opinions from the different group members and that this had added value to the learning experience:

“Getting other people’s opinions, even if you don’t agree with them was really interesting.”

Many of the activities in the Speakeasy course are based on group work and shared learning and some of the parents commented that they had really enjoyed this approach:

“good to work together as a group”

“I enjoyed the group work and the shared learning”

Many of these group work activities involve sharing your experiences with the group so that parents can learn from one another. Some parents stated that they had found this helpful:

“sharing things with the group was really good”

Groups were often made up of a mixture of parents/carers and people who were attending the course because of the organisation they work or volunteer with. A number of parents commented that they had found this mix to be valuable for their learning. Some of the parents felt that involving health and other professionals in the training was worthwhile:

“Involvement of health visitors for instance is an extremely positive step”

In addition some parents stated that it was beneficial that groups were not made up of parents/carers of children of similar ages:

“Good that the group comprised of people with kids of different ages so that those with younger children could see what lay ahead”

4.6 Information gaps

Parents stated that there were no gaps in the information which was delivered on the course. One parent explained why this was the case:

“no real topic missing because the group discussions lead to other discussions, anything we wanted to talk about could be brought up”

One parent compared the course to building blocks leading on to further areas of discussion as the sessions progressed. This was because the group felt they could bring up any topic without embarrassment:

“Someone would always voice a point of view that would lead to further discussions”

4.7 Challenges aspects of Speakeasy

Some of the parents stated that they found the course *“a little uncomfortable”* to begin with. As our culture does not currently tend to encourage open discussion of sex and relationships this is understandable. For some parents some of the topics and discussions were *“a bit of a shock sometimes”* however these parents also appreciated that the facilitator had explained that as they would be discussing sensitive issues throughout the course it would be acceptable to take a break and return later in the session:

“If something was too difficult for you Laura made it clear that we could leave if we found it uncomfortable”

One parent from one of the groups was from a different ethnic background and a few parents stated that they had felt a bit awkward on her behalf; although they enjoyed hearing about her culture and opinions some of the group felt aware she may have different views on certain issues. The parent from a different ethnic background did not take part in the focus group sessions but it would be interesting to hear her views on this.

There was one male parent in three of the first four courses. During the focus group discussions some parents explained that they had been very impressed by the single male parent in their group, although they did feel slightly uncomfortable on his behalf because he was the only male, particularly in the session where the group explored physical and emotional changes in boys and girls during puberty.

A few parents, both parents and people attending because of the organisation they work with, expressed some difficulty, and sometimes embarrassment, with writing up worksheets; they felt that because they had to write small and neat to fit their answers into the worksheets they were not able to complete them as fast as some other members of the group. However parents stated that because they felt they could express this feeling to the course facilitator she was then able to take action to improve the situation:

“It was helpful that Laura copied worksheets to A3 for later sessions as this solved the writing issue in a lot of cases”

Some parents stated that they were a little concerned that the facilitator was delivering the course alone and may find it difficult to continue to deliver the session whilst offering support to a parent who was needed to discuss a difficult issue or situation:

“maybe use an additional facilitator just in case someone has issues which need support”

4.8 Improvement

When asked how the course could be improved most comments were with regard to the length of the course and sessions. Surprisingly most parents felt that the sessions should be a bit longer as this would be helpful in completing the worksheets or continuing discussions:

“extra time would be useful rather than homework, maybe three hour sessions”

“build in an extra half hour or hour to the session time for those who wished to carry on with discussions or for those who were struggling with the written work”

Other suggestions for improving things for those who were finding it difficult to complete the written work included offering one to one sessions in addition to the two hour session.

Other suggested improvements included encouraging other people such as teachers to do Speakeasy, to improve their skills and link it in with Sex and Relationships Education (SRE) in schools. One parent highlighted the fact that there is only one facilitator in the region and she suggested that more facilitators would ensure the course could be delivered wider across the region.

A few parents stated that they did not want the course to end after the 8 sessions, they would have liked it to have been longer or to continue:

“The worst thing for me was I really missed it when it finished”

Other suggestions included developing a course tailored for young people aged 12 to 14, beginning SRE earlier (from 8 or 9 years old) and ensuring that SRE became a statutory requirement in all primary and secondary schools.

4.9 Further study

Some parents stated that doing Speakeasy had influenced their thoughts about further study, and a number of parents expressed an interest in training to become Speakeasy facilitators. Since completing the Speakeasy course a number of parents had completed other short training courses in their local communities.

Most parents stated that it was too early to tell if the OCN accreditation would be of use to them, although one parent had already used it.

4.10 Organisations

A few of the parents who had completed Speakeasy because of the organisation they work or volunteer with stated the topic of STIs had been a real eye-opener to the young people they work with. In addition contraception is now discussed more openly and the people they support and work with are more knowledgeable of where to go to get information and help about sexual health matters.

Some of the parents from organisations stated that their course folder has generated wider interest amongst colleagues in issues around sexual health and relationships. It was felt that Speakeasy is *“a good course for professionals to help parents out”* and that it *“helped to network with other agencies”*

4.11 The facilitator

Several of the parents commented on the qualities of the course facilitator:

“good facilitator, relaxed and knowledgeable”

“Laura was easy to talk to, the perfect person to run the course. She was so relaxed and made it fun”

“Laura was brilliant, really approachable which stopped it being difficult”

“Laura made us feel we could ask anything and discuss anything”

This emphasised that it is very important that Speakeasy facilitators are non-judgemental, approachable, knowledgeable and down to earth, a lesson which can be taken forward in decisions around the future of the Speakeasy project in Dumfries and Galloway.

4.12 Focus group summary

In summary all the focus group participants stated that Speakeasy had been a positive experience and they would recommend it to other people and some had already begun to do so. The following comment appears to summarise the experience of the Speakeasy parents:

“Out of all the courses I’ve been to over the past years its been the best and most fun”

5. Training Speakeasy facilitators

One of the key desired outcomes for the Speakeasy two year pilot project in Dumfries and Galloway was that Speakeasy will eventually be provided by a number of organisations across Dumfries and Galloway. In February 2009 the Project Co-ordinator completed the relevant training to enable her to deliver the 3 day facilitators training course. To become a Speakeasy facilitator people must attend 3 days training and achieve OCN level 3 accreditation in two modules; Exploring Sexual Health; and Planning & Assessing a Speakeasy Programme. In April 2009 the opportunity to become a Speakeasy facilitator was offered to parents who had previously completed the course and to other partner organisations. Sixteen people completed days 1 and 2 of the training and are, at time of writing, planning their first Speakeasy course across the region. New facilitators will then return for day 3 of the facilitator training programme where they will learn to assess parents' folders and complete their level 3 portfolio before submitting it for moderation. Once level 3 OCN accreditation is achieved facilitators will then be able to deliver Speakeasy in whole or in part.

Sixteen new facilitators attended the course in either Dumfries or Stranraer. Eight will be delivering Speakeasy courses as part of their paid employment, 7 are volunteering to deliver Speakeasy and one will be both volunteering and delivering as part of her paid employment. All 16 new facilitators are female and 14 had previously achieved level 2 OCN accreditation whilst participating in Speakeasy. The remaining two facilitators are both experienced health improvement practitioners. Those who are delivering Speakeasy as volunteers will be formal NHS volunteers and are currently undergoing the relevant processes such as Disclosure Scotland checking and local NHS induction training.

Six of the new facilitators will be delivering courses in Wigtownshire, 4 in Nithsdale and 3 in Annandale and Eskdale. In addition one new facilitator will be delivering courses across Wigtownshire and Nithsdale, one will be delivering across Nithsdale and Annandale and Eskdale and one will be delivering courses throughout the whole region. Unfortunately this leaves a gap in the Stewartry area. The organisations who have supported a member of their staff in becoming a Speakeasy facilitator are Loreburn Housing, the NHS's Public Health teams in Wigtownshire and Annandale and Eskdale, Community Learning and Development teams in Wigtownshire and Nithsdale, one NHS Health Visitor, Encouraging Community Health Options (ECHO) and Dicks Hill Crèche.

Following their training each new facilitator was asked which groups they would be focusing on delivering their first courses to and the following were suggested: new mums, PTA groups, Women's Aid, school council, parent and toddler groups, men's/dad's groups, Building Healthy Communities, young people at risk of homelessness, kinship carers, parents with young families, parents with children at risk of entering the Children's Hearing System and parents who use the crèche.

New facilitators were also asked to consider any potential barriers they may encounter whilst planning and delivering Speakeasy courses. The main anticipated barrier was funding to cover the costs of delivering courses. Other anticipated barriers included; conflicting work commitments, not being able to drive and access to resources

6. Lessons learned

At the outset of the project it was intended that crèche facilities would be provided for parents with pre-school aged children where childcare was necessary for attendance at a Speakeasy course. During the first round of training parents attending only the Dumfries course required childcare to be able to attend. Fortunately the community building where the course was to be delivered also housed a local childcare facility and the Project Co-ordinator was able to secure the required number of places (n=9). However the cost of these places far exceeded that expected and this resulted in the Steering Group taking the decision not to include the offer of free childcare places when advertising future courses but to offer this on the request of a parent or their support organisation. It was anticipated that this decision might have resulted in fewer parents of pre-school aged children who require childcare signing up for the course though in reality this appeared not to be the case and all parents who requested assistance with childcare were fully supported with their request.

The Project Co-ordinator sought informal feedback from parents at the end of each session. As a result a few minor changes were made including increasing the size of Assessed Worksheets from A4 to A3 to allow more room for completion. For some parents completing the required assessment criteria for the OCN accreditation was arduous in the given timescale. The Project Co-ordinator offered an optional session at the end of each course to support the completion of the assessed worksheets. Feedback from the parents who first took up this offer was very positive and therefore the decision was taken to offer this additional session to all future course participants.

There was a short period of time between finishing the delivery of the course and the parents' folders of evidence being submitted for moderation for OCN accreditation. As the Project Co-ordinator was required at times to request additional evidence from a small number of parents, following her assessment of their portfolios of evidence, this short timescale proved difficult to achieve. The Co-ordinator took the decision to shorten the content of session 8 to ensure there was adequate time to check each individual parents' folder so that once it was submitted assessment could take place immediately. This proved beneficial and ensured all parents' folders were ready for assessment on submission.

The physical demands of delivering Speakeasy courses were underestimated by the Project Co-ordinator. Taking course materials, resources, IT equipment and parents' folders along to each course proved physically strenuous. This coupled with a third floor office and venues with varying accessibility encouraged the Co-ordinator to purchase a trolley and containers for transporting materials to and from courses. This proved a valuable purchase and eased some of the physical strain of preparing for and delivering courses.

At the outset of the project it was anticipated that courses could be delivered throughout the year however recruiting parents for taster sessions and full courses during the school holidays proved difficult. The fpa advise that there should be a maximum of one break during each course. Because of the structure of school terms, with some being shorter than the required 8 weeks for Speakeasy, this limits the possibilities of when courses can start. The academic year must therefore be considered when planning courses.

As part of the fee paid to fpa (£10,000) the Project Co-ordinator was provided with 100 posters and 1000 leaflets branded with the NHS Dumfries and Galloway logo but based on those used by fpa in England to advertise courses. Once supplies of these ran out the decision

was taken by the Steering Group not to order further copies but to devise our own more informative versions which would advertise future course and taster session details, would be cheaper to produce and could be circulated electronically.

Towards the end of the first year of the project the Steering Group opted to trial advertising courses in local newspapers. This trial provided valuable lessons for the project's future. At a cost of over £2000, which was substantially more than originally quoted, adverts for courses in Stranraer, Dumfries, Annan and Newton Stewart were placed in several local newspapers. Unfortunately these adverts generated very few enquiries about the course and the decision was taken by the Steering Group not to repeat such advertising for future courses. This further enhanced the belief that word-of-mouth advertising from people who have all ready completed the course is by far the most beneficial way of encouraging other parents to participate in Speakeasy.

Additionally the word 'sex' was removed from course advertisements placed in the local press. This decision was taken by the Steering Group following the Project Co-ordinator's reports that often when people hear the word 'sex' they can misinterpret the purpose of the course. Instead the phrase 'helping you talk to you children about body changes, relationships and growing up' was adopted.

8. Conclusion

The number of people benefiting from Speakeasy is impressive and the evidence generated from both the evaluation and the focus groups suggests that this two year pilot project of the FPA's Speakeasy programme in Dumfries and Galloway is achieving its desired aims of providing parents/carers with the knowledge and skills to communicate confidently with their children, encouraging and supporting parents/carers to provide positive sex and relationships education in the home, encouraging and supporting parents to take on the role of "sex educator", and providing other organisations within Dumfries and Galloway with the skills to deliver Speakeasy training to parents and carers.

The analysis of the evaluation forms also shows that Speakeasy has a very positive impact on those who attended and demonstrates that Speakeasy has a widening impact; parents are showing increased communication with friends and family about sex and sexual relationships. In addition interest in further education has also developed.

These findings also suggest that Speakeasy is making significant progress towards achieving its final aim of providing other organisations within Dumfries and Galloway with the skills to deliver Speakeasy training to parents/carers as there are now 16 new facilitators across the region.

References

Burns, S (2004) *fpa Speakeasy Longitudinal Outcomes Study and Year 3 Evaluation* Triangle Consulting; London

Coleman, L., Cater, S., Ramm, J. and Sherriff, N. (2007) *Evaluation of fpa Speakeasy course for parents: 2002 to 2007* Trust for the Study of Adolescence; Brighton

Cox, D and Ajetunmobi, O (2007) *Whit fettle? Dumfries and Galloway Wellbeing and Lifestyle Survey* NHS Dumfries and Galloway; Dumfries

Appendix 1: Speakeasy Steering Group membership

Name	Organisation	Role
Laura Fairbairn	NHS Dumfries and Galloway	Health Improvement Project Specialist/ Co-ordinator Speakeasy
Carol Stewart	NHS Dumfries and Galloway	Health Improvement Programme Lead – Sexual Health
Fiona Gleghorn	NHS Dumfries and Galloway	Nurse Co-ordinator, Dept. Family Planning and Sexual Health
Veronica King	NHS Dumfries and Galloway	Health Improvement Programme Lead – Early Year
Julie Hunter	NHS Dumfries and Galloway	Health Improvement Officer – Education and Young People
Robert McQuistan	Dumfries and Galloway Council	Education Development Officer – Personal Support
Jackie Gattey	Dumfries and Galloway Council	Senior Social Worker – Fostering and Adoption
Tina Gibson	NHS Dumfries and Galloway	Public Health Practitioner (Nithsdale)
Joanna Wright	Dumfries and Galloway Council	Parenting Services Co-ordinator
Sharon Walker	NHS Dumfries and Galloway	Public Health Practitioner (Stewartry)
Heather Solley	NHS Dumfries and Galloway	Public Health Nurse (Stewartry)
Elaine Lamont	NHS Dumfries and Galloway	Public Health Practitioner (Annandale and Eskdale)
Fiona Bell	NHS Dumfries and Galloway	Public Health Nurse (Nithsdale)
Elma Hogg *	NHS Dumfries and Galloway	Nurse Manager (Stewartry)
Kathleen Wallace *	NHS Dumfries and Galloway	Nurse manager (Wigtownshire)
Julie Currie *	NHS Dumfries and Galloway	Public Health Practitioner (Wigtownshire)
Gail Bell	NHS Dumfries and Galloway	Public Health Nurse (Upper Nithsdale)

* receive minutes only

Appendices 2 – 4 are attached as separate PDF files.

MONITORING FORM

Policy / Strategy Implications	Part of the implementation of the Dumfries and Galloway Sexual Health Strategy
Staffing Implications	Not required
Financial Implications	Not required
Consultation	Detailed in report
Consultation with Professional Committees	Speakeasy Steering Group
Risk Assessment	Not required
Best Value	Accountability Responsiveness and consultation Use of review and option appraisal Equal opportunities arrangements Joint working
Compliance with Corporate Objectives	To reduce inequalities across NHS Dumfries and Galloway
Impact Assessment	An Equality Impact Assessment has been carried out and an electronic copy has been forwarded to the NHS D&G Equality Lead for publication on the NHS D&G website in accordance with equality legislation.

DUMFRIES AND GALLOWAY NHS BOARD

6 July 2009

**Proposed Schedule of Meeting Dates April 2010 –
March 2011****Author:**

Jennifer Wilson, Board Administrator

Sponsoring Director

John Burns, Chief Executive

Date: 26 June 2009**RECOMMENDATION**

The Board is asked to agree the proposed schedule of meeting dates for the period April 2010 – March 2011

SUMMARY

Noted below is the proposed schedule of meeting dates for the period April 2010 to March 2011. It is anticipated that there will be workshops prior to every Board meeting and there will be a full programme for the day.

Monday	12 April 2010	<i>(Easter Monday 5 April 2010)</i>
Monday	10 May 2010	
Monday	7 June 2010	
Monday	5 July 2010	
Monday	6 September 2010	
Monday	4 October 2010	
Monday	1 November 2010	
Monday	6 December 2010	
Monday	10 January 2011	
Monday	7 February 2011	
Monday	7 March 2011	

MONITORING FORM

Policy/Strategy Implications	<i>Not relevant</i>
Staffing Implications	<i>Not relevant</i>
Financial Implications	<i>Not relevant</i>
Consultation	<i>None</i>
Consultation with Professional Committees	<i>None</i>
Risk Assessment	<i>Not relevant</i>
Best Value	<i>Sound governance at a strategic and operational level Accountability</i>
Compliance with Corporate Objectives	<i>All</i>
Impact Assessment	<i>Not relevant</i>

DUMFRIES AND GALLOWAY NHS BOARD

July 2009



Board Briefing

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 Delivering Dynamic Leadership Programme

REGULAR FEATURES

Delivering for Health Update
 New from the Scottish Executive including HDLs
 Freedom of Information Requests
 Current Consultations
 Chief Executive's Diary
 Chairman's Diary

Delivering for Health Update

CHP Committee

As agreed at the Board meeting in April, the CHP Committee has been reconvened and held its first meeting on 25 June. The meeting focused on Long Term Conditions Management and Shifting the Balance of Care. Future quarterly meetings will be held in public and minutes will be made available to the Board.

Major Incident Exercise

On 16 June 2009 the Galloway Community Hospital ran a Major Incident Exercise; due to the current flu pandemic situation it was scaled down to NHS Staff and observers from the Council. The incident involved an explosion in an industrial estate with seven casualties of varying severity, a number required stabilisation (varying interventions including Intubation and ventilation) and onward transfer.

The event ran most of the day and was viewed as a success with a few minor alterations on the current major incident plan.

Voice Activated Directory Goes Live

A SPEECH-recognition-based call routing system has gone live across NHS Dumfries and Galloway. By dialling internally on 34305 and saying the name of the person or department, staff can be directed to the person or department they require. The number is also available for callers outside NHS Dumfries and Galloway on 01387 244305.

Run 4 Health

Over 800 women and children took part in the Run 4 Health event held on Sunday 28 June in Dumfries. The event which was co-organised by Dumfries Devorgilla Rotary Club, the Council and NHS Dumfries and Galloway' Health Improvement Team at Nithbank was officially started by Chief Executive John Burns. Apart from the obvious health benefits afforded by the run itself a number of health-related services benefited greatly from the fund raising associated with the run. These included NHS Dumfries and Galloway's Continence Service, the Alexandra Unit's Care Fund for Patients in the Community, DGRI Osteoporosis Service, Alzheimer Scotland and Southwest Scotland Rape Crisis Service. Representatives of these services and many other NHS staff, families and friends took part in the event. An added attraction at the event was the opportunity for participants to make their own "fruit smoothies" using produce from the Allotment using a special "Smoothie" bike. NHS Dumfries and Galloway's Nithsdale based Health Improvement Team are to be commended for their significant input to the event.

The Allotment – DGRI Branch Opens

Board Members are asked to note that a satellite market stall of the successful town-based Allotment is opening at Dumfries and Galloway Royal Infirmary. The stall will open between 9.30am and 2.45pm based in the main foyer of the Royal Infirmary.

The High Street and satellite shop is a non-profit organisation run by volunteers and supported by its organisers Nithsdale Council of Voluntary Service and NHS Dumfries and Galloway. It does not just sell fruit and vegetables from local producers but also acts as a hub to teach the public how to cook as well the values of nutrition.

Mobile Phone Zones

Designated zones for the use of mobile phones have been established at Dumfries Infirmary. Staff, patients and visitors can make calls via mobiles in the front hall, canteen and seating areas at either side of the lifts in all three floors of the hospital. All staff are reminded to be aware of the Board's mobile phone policy.

Sexual Health Department, Nithbank - Charter Mark Award

Sexual Health Services Department has now moved into their impressive purpose built facilities at Laurel Bank, Nithbank, Dumfries. Representing an investment by the Board in excess of £500,000, the new facilities offer modern fit-for-purpose consulting clinic drop-in, waiting and support services accommodation which matches the best available elsewhere in Scotland. In addition, the Department is celebrating after being awarded a special Charter Mark award in recognition of the positive work carried with the LGBT community (Lesbian, Gay, Bisexual Transgender). This builds on similar recognition received over the past year and the department's ongoing commitment to provide a positive and pro-active sexual health service to the wider community

Healing Heroes

Do you know a healing hero?

Nominations are being sought for The Scottish Health Awards 2009. The Award ceremony takes place on 11 November 2009 at the Corn Exchange in Edinburgh.

There is a category for every NHS worker and the areas they work in – categories include Doctors Award, Nurses Award, Therapists Award, Unsung Hero Award, Support Workers Award, Volunteers Award, NHS Top Manager Award, Top Team Award, Older People Care Award, Equality in Healthcare, Mental Health Care Award, Cancer Care Award, Health Care Award, Women & Children's Services Award, NHS Healthy Lifestyle Award, Community Care Award, Improvement and Innovation Award.

Various awards will be presented to unsung heroes across Scotland who have gone beyond the call of duty to provide first class healthcare.

Nominations should be put forward to www.scottishhealthawards.com

National Falls Awareness Day – 23 June 2009

NHS Dumfries and Galloway's Falls Co-ordinators Sarah Kirk and Maggie Morrison played a leading role in the local response to the National Falls Awareness Campaign run by Age Concern and Help the Aged.

The Falls Co-ordinators held information sessions using the "Big Red Bus" at Tesco in Castle Douglas and at Morrisons in Dumfries to mark the occasion. The theme of the Awareness Day was "Get on Board" and the overall aim of the day was to raise awareness of the risk of falling as people age and to promote practical ways to reduce the risk of falls and fractures. The awareness sessions proved very positive and a good number of our local community took the opportunity to visit the bus to learn more.

Michelle Mitchell, Charity Director at Age Concern and Help the Aged, said: "Just one fall can devastate an older person's life – aside from the serious effect on long-term mobility, it can make that person too afraid to leave their home or to get out and

about as they did before. Falls are also the greatest cause of accidental death among older people. These events are a vital way to encourage older people to get their falls risk assessed by a local falls service and help them maintain their independence.”

Cervical Screening Programme – numbers remain high

According to Dr David Breen, Consultant in Public Health, the untimely passing of “Jade Goody” has continued to have a positive effect on the numbers of women locally coming forward for cervical screening testing. “There continues to be a very positive response from local women coming forward to have smear tests carried out. We expect the numbers to remain high for some time and we anticipate this having a significant benefit for the future health of local women.”

Accident and Emergency Department DGRI – Refurbishment Project

The £500,000 refurbishment programme for the Board’s main Accident and Emergency department at DGRI is progressing well. The project which has been following a five phase modernisation programme, provides new fit-for-purpose Accident and Emergency reception and treatment facilities for staff and patients. This latest phase has provided 4 new treatment rooms and an upgraded waiting and reception area. Work is expected to be completed shortly and the new facilities will enhance the continuing high quality service provided by frontline Accident and Emergency staff.

NHS Retirement Fellowship – Dumfries Branch

The Dumfries Branch of the NHS Retirement Fellowship held its 2008/09 annual general meeting recently. The Branch, which numbers around 43 retired former NHS employees was given initial start –up financial support by the NHS Board and has been in existence for a number of years.

Information about the Retirement Fellowship is routinely sent out to retiring staff by the Scottish Public Pensions Agency, and as a result of the 25 local people given information recently, 8 have indicated their intention to join the Dumfries Branch.

As well as enabling retired staff of all disciplines to keep in touch not only with each other but also in NHS developments, the Branch organises a broad range syllabus of talks lectures and social activities for members. The retiring chairman of the Dumfries Branch, Peggy Grieve, has written to the Board to express the appreciation of the Fellowship of the support and interest they receive. The new chairman for 2009/10 is Margaret Smith, formerly a senior nurse with NHS Dumfries and Galloway.

Degree Success for Local NHS Managers

Sharon Millar until recently Organisational Development Manager and Joan Pollard, Service Improvement Manager were in the past week graduated in MSc Leading Sustainable Organisational Change at Glasgow University. The NHS Board

congratulates both ladies on their success and commends their commitment and dedication in achieving their degrees over the 2 year programme of the course

Delivering Dynamic Leadership Programme

The latest session in the Delivering Dynamic Leadership Programme took place on Monday 29th June 2009. During the day there was a “Dragons Den” type presentation which focussed on the key elements of valuing staff and innovative ways of enabling improved communications, attitudes and behaviours. Also discussed on the day were ideas for a special annual awards event.

Margo Christie and Alice Wilson, Associate Nurse Directors, have been tasked to develop ideas for the proposed annual excellence awards event and will work closely with colleagues to develop plans for a first event next year.

New from Scottish Executive Health Department

PCA (M)2009 6 Correction to NHS Circular PCA(M)(2008)14: Scottish Enhanced Services Programme for Primary and Community Care (SESP): 2009/10

Advises NHS personnel of amendment to calculation and allocation of funding for the Scottish Enhanced Services Programme 2009/10.

PCS (DD) 2009/3 Pay and Conditions of Service: Remuneration of Hospital Medical and Dental Staff and Doctors and Dentists in Public Health Medicine and the Community Health Service

This circular includes increases to national salary scales and uplifts to fees and allowances. The changes take effect from 1 April 2009

PCA (M) (2009) 7 GMS Contract Agreement for 2009/10 - Update

This circular provides a further update of the agreed approach to the financial uplift to the GMS Contract for 2009/10, and relates to circular PCA(M)(2008)10_issued on 28 October 2008.

PCA (D) (2009) 4 General Dental Services - revised form GP14

This letter advises NHS Boards of the issue of a revised GP14

CMO (2009) 5 Update on Influenza A (H1N1) in Scotland

Contains advice on how hospitals should respond to possible influenza A (H1N1) cases.

CEL 20 (2009) Influenza A (H1N1) ('Swine Flu') Regulatory Amendments: Pharmaceutical Services, NHS Charges and NHS Charges for Overseas Visitors

Regulatory arrangements to offer flexibility to NHS Boards in the event of an emergency arising out of a threat to human welfare which is caused or may be caused by an illness.

PCA(D)(2009)05 General Dental Services: Amendment no 114 to the Statement of Dental Remuneration: Changes to the Frequency of Deprived Areas Enhancement (Item 41(E))

The changes take effect from 1 April 2009.

CMO (2009)4 Influenza A (H1N1): fit testing of FFP3 face masks for healthcare staff

The majority of healthcare staff in contact with cases of influenza A (H1N1) would do so wearing a surgical face mask as part of their Standard / Droplet Infection Control Precautions in dealing with these patients.

PCS(DD) 2009/4 Associate Adviser / Assistant Director Pay Scales

This pay circular notifies employers of new rates of pay for Associate Advisers and Assistant Directors from 1 April 2009.

CEL 24 (2009) Termination of Bilateral Health Agreement with the Channel Islands

Advised of the termination of the bilateral health agreement. Advises actions to be taken in regard to potential patients following termination of the agreement.

CEL 23 (2009) Improving Health and Wellbeing of People with Long Term Conditions in Scotland: A National Action Plan

Better Health Better Care indicated that we would be producing what was then referred to as a Long Term Conditions Delivery Plan. That work has now reached fruition as the Action Plan attached to this CEL.

PCA(D)(2009)05 erratum General Dental Services: Erratum to NHS PCA(D)(2009)5: Amendment no 114 to the Statement of Dental Remuneration: Changes to the Frequency of Deprived Areas Enhancement

CEL 26 (2009): Health Improvement and Community Health Partnerships: Advice Note

This CEL provided updated advice to NHS Board Chief Executives and Directors / General Managers of Community Health (and Social / Care) Partnerships (CHPs) on improving health and reducing health inequalities in the context of the Single Outcome Agreement process.

CEL (2009) 21 and CEL (2009) 22: Safe Administration of Intrathecal Cytotoxic Chemotherapy and Safe Administration of Vinca Alkaloids

CEL (2009)21 updates a previous HDL (2004)30 and CEL (2009)22 is a new complementary guidance document specifically relating to the safe administration of vinca alkaloids. This is a risk management and clinical governance issue.

Freedom of Information Requests

During May seventeen requests were made under the Freedom of Information Act and all responses met the twenty working day requirement.

Date Received	Name and Contact Details	Nature of Request	Reply Sent
11/5/2009	David Hill	The address of vacant or empty NHS properties that are in Dumfries. Of those empty or vacant properties which you would consider for sale or rent A contact name, phone number and email address to supply further property details.	2/6/09
14/5/09	Rhona Brankin, MSP	Secondary Teachers working in hospitals.	20/5/09
15/5/09	Cara Suliman	How many foreign objects were left in patients after surgery in 2007? Please break down into type and number of foreign item eg. Swab, needle, etc. How many foreign objects were left in patients after surgery in 2008? Please break down into type and number of foreign item eg. Swab, needle, etc. How many compensation actions have been raised against the trust as a result of foreign objects being left in patients after surgery in 2007? How many compensation actions have been raised against the trust as a result of foreign objects being left in patients after surgery in 2008? How many compensation claims raised against the trust as a result of foreign objects being left in patients after surgery were successful in 2007? How many compensation claims raised against the trust as a result of foreign objects being left in patients after surgery were successful in 2008? For each successful compensation claim please say the type of foreign object left in them, and how much compensation they won. What is the procedure in place for retrieving foreign objects that have been left in patients after surgery?	15/6/2009

19/5/2009	Andrew Picken	I would like to establish the number of hospital meals which went unused for each of the last three financial years. Can you also please provide an approximate cost of the unused meals.	15/6/2009
19/5/2009	Mary Scanlon Scottish Parliament	How many patients are currently on the waiting list in your Health Board for weight loss surgery. Can I also ask what alternative weight loss procedures are offered?	2/6/2009
19/5/2009	Jenny Crawford Scottish Parliament	Info re equipment for obese patients.	2/6/2009
19/5/2009	Danielle Revers	Supplementary request re lost data	18/6/2009
20/5/2009	Kevin Keane	Car Parking Charges	22/5/2009
14/5/2009	Graeme Stewart	Bronchitis, Respiratory Virus and Emphysema sufferer myself I am conducting some entirely private enquiries that require access to NHS (or other) published figures detailing the frequency of The Above Diseases in the Dumfries and Galloway and Stewartry Areas in comparison if possible with the same occurrence rates in other NHS Geographic areas.	25/5/2009
26/5/2009	Hannah Cornelius Health Direction Hampshire	Wound care formulary	1/6/2009
25/5/2009	Cara Suliman Deadline Press	Tattoo removal	1/6/2009
26/5/2009	Kathy Long BBC Radio Scotland	Complaints-claims re misdiagnosis	
28/5/2009	Shelly Matheson	1. Have you at any time (the past or present) offered prizes or	2/6/2009

	Scottish Sun	<p>cash incentives to give smoking, drugs or pursue a healthier lifestyle?</p> <ol style="list-style-type: none"> 2. If so at how much did this cost? 3. If not do you have plans to do this in the future and what do these plans include? 4. Do you as a health board advocate these incentives and why? 5. Have you any evidence that these schemes work and how do you ensure the candidates are keeping to the agreement? 	
6/5/2009	Julia Belgutaay The Sunday Times	Could you please provide a full list of all the foreign medical staff (doctors, nurses, midwives etc) you have employed over the past three years, either directly or through an agency. Please provide a breakdown by job title, country of origin, hours worked and hourly rate, the kind of service provided and the period during which they were employed. If possible, provide the names of the individuals. Could you also provide details of any complaints about or disciplinary procedures taken against any of these individuals with details of the nature of the allegation and outcome of any investigation?	29/5/2009
29/5/2009	Richard Simpson Scottish Parliament	Pandemic Planning	18/6/2009
28/5/2009	Fiona Reid DG Media	Gastric band surgery that has been funded by NHS Dumfries and Galloway. Please can you provide the numbers of patients who have either had this surgery in the region, or have been referred by doctors, in the last 2 years? Also, I'd like an age breakdown please. Furthermore, can you detail what other types of weight loss surgery are offered by NHS D&G?	16/6/2009
28/5/2009	Hannah Cornelius	1. A list of your GP's with a specialist interest (GpWSI) and	10/6/2009

	Health Direction Hampshire	where they are based 2. Enhanced Services Provided to include Direct Enhanced Services (DES), National Enhanced Services (NES) and Local Enhanced Services (LES) at Practice level3. Where the above services are based	
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Current Consultations

From	Topic	Response due by
BMA Scotland	Key issues in general practice in Scotland <i>No response sent</i>	22/5/2009
NHS24	Equality and Diversity <i>Response sent 22/5/09</i>	22/5/2009
Food Standards Agency	Consultation on Strategy for 2010 – 2015 <i>Response sent 28/5/2009</i>	30/5/2009
Home Office	Reducing the vulnerability of crowded places to terrorist attack	10/7/2009
Equality Human Rights	Equality Bill Guidance Consultation	7/6/2009
Historic Scotland	The Ancient Monuments and Listed Buildings (Amendment) (Scotland) Bill	14/8/2009
Scottish Government	National Eligibility Criteria for Adult Social Care and Waiting Times for Personal and Nursing Care	17/7/2009
Scottish Government	Better Diabetes Care	22/8/2009
Department of Health	The General and Specialist Medical Practice (Education, Training and Qualifications) Order 2010 The Postgraduate Medical Education and Training Order of Council 2010	29/8/2009

DUMFRIES AND GALLOWAY NHS BOARD

Minute of the Dumfries and Galloway NHS Board workshops held on 1 June 2009.



Present

Mr M Keggans	Chairman
Mr J Burns	Chief Executive
Mr J Ace	Director of Health Services
Mrs H Borland	Nurse Director
Mrs H Brash	Non Executive Member
Dr A Cameron	Medical Director
Mr A Campbell	Non Executive Member
Dr D Cox	Director of Public Health
Mrs H Dykes	Chair of Area Clinical Forum
Mr E Hunter	Non Executive Member
Mr I Hyslop	Non Executive Member
Mr A Johnston	Non Executive Member
Mr D Lockhart	Employee Director
Mr C Marriott	Director of Finance
Dr R Park	Non Executive Member
Ms C Sharp	Director of HR and Workforce Strategy
Mr K Warford	Vice Chairman

Attending

David Irving	Resilience Programme Lead
Martin Ogilvie	Operations Manager, Civil Protection, Resilience and Corporate Risk
Mrs J Proctor	Head of Commissioning, Strategic Planning and Performance
Mrs N Shippin	Central Legal Office
Mrs A Wilson	Associate Nurse Director
Mrs J Wilson	Board Administrator

Workshop 1: Resilience Planning

The Chief Executive introduced the workshop and gave resilience some context in terms of risk management, the NHS QiS self assessment and peer review, the challenges and the importance of understanding the work that is being done. Resilience in general has a high profile in Scotland with the Civil Contingencies Act and NHS Boards such as Dumfries and Galloway have a very real role to play. There is a Service Legal Agreement (SLA) with the Council; Martin Ogilvie is the strategic lead and with David the Resilience Programme Lead for health has strengthened our resilience and our approach to resilience.

Following the presentation discussion included:

- assurance that the Board is addressing the requirements of the Civil Contingency Act (CCA) ;
- leadership to take forward appropriate development and learning;
- skill set to manage any crisis and to work with partners;
- the structure to ensure the SLA continues to be reviewed, evaluated and enhanced; and
- inter-relationship with other health boards.

Workshop 2: Corporate Manslaughter

Norma Shippin presented to Board and set out the relevant legislation and what that means for the NHS Board. The discussion that followed explored some scenarios and what the implications were in relation to the Act. The role of the Health and Safety Executive was also described in terms of its different powers.

DUMFRIES AND GALLOWAY OLDER PEOPLE'S CONSULTATIVE GROUP

NOTE OF MEETING

4th March 2009 1.30pm, North West Resource Centre, Dumfries

PRESENT Councillor Lorna McGowan, Chair,
 Andrew Johnston, Vice Chair, Health Board Non Executive Member
 Mairi Telford Jammeh, Corporate Commissioning Manager, Older People, Correspondence Secretary
 Lou Howson, Elderly Forum
 Frank Smith, Treasurer, Elderly Forum
 Gordon Tremble, Rtd MTGRMA
 Lynne Dinnell, Admin
 Angela McGeoch, Commissioning Officer, Older People
 Verena Wilson, Elderly Forum, Lockerbie & District
 Edith McDonald Dumfries University of the 3rd Age
 Ann Gault WRVS
 Ron Spencer, Elderly Forum, Stewartry
 Irving Stuart, Langholm Day Centre
 John Scott, Langholm Day Centre
 Alan Sidaway, Unite Retired Members Association
 Duncan McEachran, Food Train
 Ann Stephenson, Age Concern Scotland
 Dorothy Robertson, Elderly Forum
 Ella Dickson, Loreburn Retirement Group
 Ian Walker, Accessible Transport Forum
 John Dowson, member of the public

APOLOGIES Bob Legget, Elderly Forum
 Roberta C Copeland, Lockerbie Retired & Independent Ladies
 Margaret Dobie, University of the 3rd Age
 Bob Robertson, Users and Carers Involvement
 Lt. Col M R Rowney, British Legion
 John Walker, Civil Service Retirement Fellowship

1. Councillor McGowan welcomed the group and everyone confirmed they'd seen the notes of the previous meeting.

2. **Matters Arising from previous notes**

Mr Tremble asked for confirmation about how often the meetings would take place. Councillor McGowan confirmed that they would be held 2 monthly.

Andrew Johnston added that this is supposed to be a consultative committee and to a large extent this has not been achieved. He asked members to consider the purpose of meeting rather than having meetings for their own sake.

Mr Tremble raised his issues in item 6 of the previous notes and there was some discussion around this. Councillor McGowan confirmed that she asked Mr Tremble to speak directly to John Alexander about these issues and Mr Tremble replied that he did not want to speak to John Alexander alone, he wanted the support of the group.

Andrew Johnston added that he understood the frustration of this but is unclear of the actual issue and it was suggested that Mr Tremble do a briefing paper for the next meeting and we would ask a Social Work Manager to come to the meeting to respond. Mr Tremble replied saying that he would give a copy of the Courier where the article was published but Councillor McGowan added that this was not be sufficient, that a proper briefing paper is needed. Mr Tremble eventually agreed to write some points down but wanted it recorded that he dissents from this decision.

Mr Howson said if it would benefit to have a specific meeting to discuss the constitution but no-one agreed with this suggestion and it was mentioned that certain points just need to be highlighted. It was suggested that it might be beneficial for the presentation that was made at the first meeting be sent to everyone again and it was **AGREED** that this would be a good idea.

3. Code of Conduct for members of OPCG

Councillor McGowan read a paragraph from the Code of Conduct in the Constitution about people treating each other with respect and she asked that the group read this again and stick to it.

4. Presentation by Colin Douglas, Service Manager, Transportation, Dumfries and Galloway Council

Colin Douglas talked through some photographs he had of different kinds of transport in the region, the following services were covered:- Ring and Ride; Low Rise Buses; Long Distance Buses; Links with trains at Lockerbie; services for people who use walking sticks.

Discussions took place about some of the services and it was noted that bus services in European countries are much better than here. Colin added that the Council are trying to make more use of their own fleet which was initially used for schools. He also informed the group that bus shelters are being renewed and some are receiving a realtime system where information about if buses are on time etc is provided, this is being

rolled out at a shelter at DGOne soon. He also mentioned work on the shelter at Dumfries Station.

Questions/Discussion points

Lou Howson asked how much the Council is allocated for community transport and how much the buses cost. Colin replied that it is approximately £170k and they have remained within budget and that buses cost between £34k and £52k depending on the specification.

Lou Howson added that Highland get grants for community transport because they are remote and rural and he asked if Dumfries & Galloway receive this because we are remote and rural too. Colin advised that we do not get this kind of help even though we are remote and rural but in his opinion we do okay and get a fair amount of resource.

Colin informed the group that there are 2 organisations in Dumfries who deal with transport: the Council and SWESTtrans, he advised that decisions re community transport are taken by SWESTtrans and decisions re schools etc are taken by the Council.

Alan Sidaway raised the issue of buses from Carsphairn to Ayr, there is no direct bus and you have to get a bus to Dalmellington and by the time you have done that, there is only 20 minutes to spend in Ayr before getting the bus back. Colin responded by saying that although they get a fair amount of funding for transport, some services had to be cut and the cross boundary ones were the ones that had to suffer. This is not a high priority but they are looking for funding from Stewartry area committee to deal with this.

Alan also raised the question of people getting taxicards instead of bus passes but said that these can't be used in other areas. Colin responded by informing the group that people have been allowed to have both in the last couple of years. It was also noted that a lot of taxicards are not being used and therefore is seen as a waste of money. He will be reporting on the taxicard scheme to Committee shortly and a review of the scheme will be done. Someone mentioned that low usage is because taxis are inaccessible. Colin said Ian would say more about the issue of taxis being accessible.

Alan finally mentioned that there are 2 bus services running on the 75 service. Colin advised that this is because one is funded by public money (the Kings bus) and the other commercially (Stagecoach). Kings won the tender for this route but Stagecoach continued to run a service there. Because of tendering issues the Council is reluctant to do anything.

Mr Tremble asked about funding for bus passes. Colin advised that it is not costing the Council anything, it is funded but bus passes cannot be used on community transport because for refunds to take place there must be a regular timetable.

The issue about consultation on committee reports for Council was raised and Colin suggested feeding views on this through Community Planning. Mairi said she would aim to get an answer on this for the Group.

Verena raised the issue about the Moffat-Lockerbie-Gretna-Carlisle service which she said is unsatisfactory. Colin said this change came about following proposals made to SWESTtrans from Stagecoach who agreed this change. There is no problem using bus passes from Gretna to Carlisle. Colin is meeting Stagecoach staff in the next few weeks to discuss routes.

SWESTtrans consists of elected members, an NHS Board member and a member from Scottish Enterprise. The Chair is Councillor Brian Collins.

Verena also raised the issue about trains from Lockerbie – Colin said most train timetabling is determined at Westminster and that to get changes it is best to lobby David Mundell MP. He agreed there is a lot of demand and latent demand for train services.

Mr Howson asked why we didn't write to SWESTtrans as a body.

AGREED to submit a letter to SWESTtrans regarding timetable changes that came in from December 2008.

Colin said that a good bus service is the Lockerbie – Dumfries one which is run on a commercial basis by Stagecoach and which is being used by a lot of people.

Duncan mentioned the need for buses and trains to be co-ordinated.

Colin circulated new timetables to those present.

5. Presentation by Ian Walker, Accessible Transport Forum

Accessible Taxis Ian Walker of Accessible Transport Forum said he had visited Ayrshire the previous day. In South Ayrshire the local authority has insisted on 100% accessible taxis to ensure good coverage – this has been done through the licensing process. Taxi staff must also attend training on accessibility and taxis are inspected.

Mr Howson said that no taxis in Dalbeattie accept taxicards. Colin said this may be because taxi firms are under the impression that it is hard to recoup costs. The system has now become electronic and he said that perhaps firms didn't know that. He would write to the taxi operators.

Mr Howson mentioned the difficulty in using a taxi card for emergency purposes and used the example of a young woman with children who had a medical emergency. Colin said that young people cannot get taxicards. Taxicards are only for people who meet the criteria and these are disability and age – people are assessed by Social Services who check this.

Colin said they are currently looking for European funding for a 'Transport with Care' project. The plan would be to set up a Call Centre to deal with those kinds of situations. There would be one number to call if transport to NHS facilities is required.

Ian showed a film about Community Transport in Dumfries and Galloway.

The Chair then thanked Colin and Ian for their input.

6. Any Other Business

Mr Tremble asked for three points to be considered:

- He would like the minutes of the meetings to be headed as 'Minutes' as a note of a meeting is different whereas a minute has to say exactly what has happened.
- Minutes of meetings were not being passed to the Social Work Services Committee.
- He would like a sub Committee of the Social Work Services Committee to clarify the remit of OPCG and proposed a meeting. Mr Howson seconded this proposal.

Andrew Johnston said there was sufficient clarity already about constitution and that the document should be used to assist and not inhibit discussion. He proposed an amendment to Mr Tremble's motion by deletion of point 3. He was seconded by Mr Frank Smith and Mr Duncan McEachran.

This was put to the vote. Votes: 3 for the motion and 10 for the amendment. It was therefore **AGREED** not to ask for a meeting with a sub group of the Social Work Committee. Mr Tremble asked that his dissent be recorded to allow him to take this elsewhere.

Those present agreed that a verbatim minute was not required.

Mairi said that she had now passed 3 sets of notes to the secretariat for the Social Work Services Committee and these should be distributed in due course. This had been an oversight on her part and she apologised for not doing this before.

Mr Tremble asked that point 6 b in the note of the previous meeting be amended. This was **AGREED**.

Timing of meetings: **AGREED** to go to 2 monthly meetings after June.

DATE OF NEXT MEETING: 3 JUNE 1.30PM at DGOne, Dumfries
Agenda item: 'Your NHS Your Future' John Burns Chief Executive NHS Dumfries and Galloway